AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 17 May 2017

10:00am

Note:

- **Open Meeting from 10:00am**
- **Public Excluded to follow**

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

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Published 11 May 2017

Agenda
Meeting of the Board
17 May 2017

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

Time: 10.00am

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

Agenda

Please note that agenda times are estimates only

10.00am **1. ATTENDANCE AND APOLOGIES**

Executive Leadership Team Members: Shayne Tong and Margaret Wilsher

2. REGISTER OF INTEREST AND CONFLICTS OF INTEREST

Does any member have an interest they have not previously disclosed?

Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

3. CONFIRMATION OF MINUTES 05 APRIL 2017

10.05am **4. ACTION POINTS 05 APRIL 2017**

4.1 Mandatory Health and Safety training and 100% compliance

10.10am	**5.**	**EXECUTIVE REPORTS**
	5.1	Chief Executives Report
	5.2	Health and Safety Report
	5.3	Auckland DHB Marker Report
10.45am	**6.**	**PERFORMANCE REPORTS**
	6.1	Financial Performance Report
	6.2	Funder Update Report
11.05am	**7.**	**COMMITTEE REPORTS**
	7.1	Minutes of the Hospital Advisory Committee
	7.2	Minutes of the Disability Support Advisory Committee
	7.3	Minutes of the Community and Public Health Advisory Committee
11.10am	**8.**	**DECISION REPORTS**
	8.1	MoU Auckland DHB and Cancer Society
	8.2	Review of Progress Against Auckland DHB Strategy
11.25am	**9.**	**INFORMATION REPORTS**
	9.1	Human Resources Report
	9.2	Leadership Development Programme
	9.3	Auckland DHB Health and Disability Service Standards Certification Audit
	10.	**GENERAL BUSINESS**
11.45am	**11.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 28 June 2017 at 10.00am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

Members	22 Feb. 17	05 Apr. 17	17 May. 17	28 Jun. 17	09 Aug. 17	20 Sep. 17	01 Nov. 17	13 Dec. 17
Lester Levy (Chair)	1	1						
Joanne Agnew	1	1						
Doug Armstrong	1	1						
Michelle Atkinson	1	1						
Judith Bassett	1	1						
Zoe Brownlie	1	1						
James Le Fevre	1	1						
Lee Mathias	1	1						
Robyn Northey	1	1						
Sharon Shea	1	1						
Gwen Tepania-Palmer	1	1						
Key: 1 = present, x = absent, # = leave of absence, c = cancelled								

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Board

Member	Interest	Latest Disclosure
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman – Counties Manukau District Health Board Chairman - Auckland Transport Chairman – Regional Governance Group – northern District Health Boards Chairman – Health Research Council Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Professor (Adjunct) of Leadership – University of Auckland Business School (part time) 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	15.03.2017
Jo AGNEW	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, minority shareholder)	17.01.2017
Michelle ATKINSON	Evaluation Officer – Counties Manukau District Health Board Director – Stripey Limited Trustee - Starship Foundation	29.03.2017
Doug ARMSTRONG	Shareholder - Fisher and Paykel Healthcare Shareholder - Ryman Healthcare Shareholder – Orion Healthcare (no personal beneficial interest as it is held through a Trust) Trustee – Woolf Fisher Trust Trustee- Sir Woolf Fisher Charitable Trust Daughter – Partner Russell McVeagh Lawyers Member – Trans-Tasman Occupations Tribunal	16.01.2017
Judith BASSETT	Shareholder - Fisher and Paykel Healthcare Shareholder - Westpac Banking Corporation Husband – Fletcher Building Husband - shareholder of Westpac Banking Corporation Granddaughter - shareholder of Westpac Corporation Daughter – Human Resources Manager at Auckland DHB	26.01.2017
Zoe BROWNLIE	Community Health Worker – Auckland DHB Member – PSA Union Partner – Youth Connections, Auckland Council Son – Aro Arataki Childcare Centre	20.01.2017
James LE FEVRE	Board member – Waitemata DHB Emergency Medicine Specialist - Adult Emergency Department, Auckland DHB DHB Representative (Auckland and Waitemata DHBs) – Air Ambulance Codesign Procurement Governance Board Fellow - Australasian College for Emergency Medicine - FACEM	05.05.2017

	Shareholder - Pacific Edge Diagnostics Ltd Trustee - Three Harbours Health Foundation Member – Australasian College for Emergency Medicine Hospital Overcrowding Subcommittee Wife - Medicolegal advisor, Medical Protection Society Wife – Employee Waitemata DHB Department of Anaesthesia and Perioperative Medicine	
Lee MATHIAS	Chair - Health Promotion Agency Chair - Unitec Acting Chair - Health Innovation Hub Director - Health Alliance Limited (ex officio Counties Manukau DHB) Director/shareholder - Pictor Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Member – New Zealand National Party	15.03.2017
Robyn NORTHEY	Trustee - A+ Charitable Trust Shareholder of Fisher & Paykel Healthcare Member – New Zealand Labour Party Husband - member Waitemata Local Board Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation Husband – Chair, Community Housing Foundation	22.02.2017
Sharon SHEA	Principal - Shea Pita Associates Ltd Contracted to Manaia PHO – delivery of workforce development training Provider - Maori Integrated contracts for Auckland and Waitemata DHBs Provider – Ministry of Health National Results Based Accountability training for Maori health organisations Provider – Plunket outcomes implementation framework Project member – Auckland and Waitemata DHB Maori Workforce Development project Project member - Te Runanga o Te Rarawa Outcomes Project Provider - multiple management consulting projects for Te Putahitanga o Te Waipounamu Whanau Ora Commissioning Agency Strategic Advisor – Alliance Health Plus PHO Strategic Planning Project Iwi Affiliations: Ngati Ranginui, Ngati Hine, Ngati Hako and Ngati Haua Husband - Part owner Turuki Pharmacy Ltd, Auckland Husband - Board member - Waitemata DHB Husband – Director Healthcare Applications Ltd	15.03.2017
Gwen TEPANIA-PALMER	Board Member - Manaia PHO Board Member - Health Quality and Safety Commission Board Member – Terenga Paraoa Ltd Northland Committee Member - Te Taitokerau Whanau Ora Committee Member - Lottery Northland Community Committee Chair - Ngati Hine Health Trust Life member – National Council of Maori Nurses Alumnus – Massey University	22.02.2017

Minutes
Meeting of the Board
05 April 2017

Minutes of the Auckland District Health Board meeting held on Wednesday, 05 April 2017 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 10:15am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Dr Lester Levy (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Karen Bartholomew	Acting Director of Health Outcomes – Auckland HB/Waitemata DHB
Doug Armstrong	Margaret Dotchin	Chief Nursing Officer
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Judith Bassett	Dr Debbie Holdsworth	Director of Funding – Auckland DHB/Waitemata DHB
Zoe Brownlie	Fiona Michel	Chief Human Resources Officer
James Le Fevre (Deputy Board Chair)	Rosalie Percival	Chief Financial Officer
Dr Lee Mathias	Shayne Tong	Chief of Informatics
Robyn Northey	Dr Margaret Wilsher	Chief Medical Officer
Sharon Shea		
Gwen Te Pania - Palmer	**Auckland DHB Senior Staff Present**	
	Kim Herrick	Organisational Development Practice Lead
	Gil Sewell	Director, Organisational Development
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. ATTENDANCE AND APOLOGIES

That the apologies from Dr Andrew Old, Chief of Strategy, Participation and Improvement and Sue Waters, Chief Health Professions Officer be received.

2. CONFLICTS OF INTEREST

The following interests were declared:

Michelle Atkinson advised of her appointment to the board of the Starship Foundation.

Sharon Shea advised of a contract she had taken with the New Zealand Government Social Investment Unit.

There were no identified conflicts of interest for this agenda. However, Sharon Shea wished it noted that in terms of item 9.2 she did have a contract with Auckland and Waitemata DHBs relating to Maori Health integrated contracting.

3. CONFIRMATION OF MINUTES 22 FEBRUARY 2017 *(Pages 8-27)*

Resolution: Moved Robyn Northey / Seconded Zoe Brownlie

That the minutes of the Board meeting held on 22 February 2017 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS 22 FEBRUARY 2017 *(Page 28)*

There were no current action points to report on.

5. EXECUTIVE REPORTS

5.1 Chief Executive's Report *(Pages 29-40)*

Ailsa Claire, Chief Executive asked that her report be taken as read, highlighting as follows:

- Acknowledgement was made of those board members who attended a briefing on the security for safety programme on 8 March 2017. Members were shown the new CCTV coverage and occupational violence button in ED, the local lockdown capabilities at CFU and the upgrade to security and new access control at the Co Gen Bike Park and were given a demonstration of the ability to lockdown particular areas and the virtual guard capabilities of the new system.
- An analysis of 91 Crown entities across New Zealand saw Auckland DHB, for the second year, among those ranked equal-first at 100% for compliance with 'Good Employer' principles. This result corresponds closely with the results obtained in the recent certification audit. The auditors gave some great feedback and singled out the areas they saw as being done particularly well. These included: MOS (our Management Operating System), Releasing Time to Care, our Values work, cellulitis, using the hospital wisely, our approach to quality improvement, rapid rounds, discharge planning, and communication. The patients and families/whānau who were interviewed made very positive comments to the auditors about the care that they or their family members were receiving.
- 60 members of the cleaning services team have completed the nationally recognised qualification, NZQA Certificate in Cleaning. This involved 30 modules of work and demonstrates a high level of commitment from these staff.
- More than 380 managers have been trained on our new Safety Management System (Datix), which is on track to go live in April.
- Events, led by Barry Snow, are underway today, for "Conversations that Count Day 2017", a national day that aims to raise awareness about advance care planning, and inspire people to think about, talk about and plan for their future and end-of-life care. Board members are encouraged to visit the website: http://www.advancecareplanning.org.nz/ctc/
- A recent cardiac intensive care open day had allowed staff to show family what they did at work.
- This quarters ED target had been achieved despite difficult circumstances during a period of high acuity within the hospital and fluctuating but increasing numbers

attending ED.

The following points were covered in discussion:

- The initiative for cleaning staff was good to see and addressed a number of issues, personal development among them. However, training had historically been heavily weighted toward clinical staff and there are other non-clinical areas that would benefit from such opportunities. A question was asked as to whether this progression for cleaning staff assisted with remuneration levels and what level of migration had there been of these staff being able to step up to a healthcare assistant role?
  Fiona Michel advised that this was step one in a programme of work underway to make currently offered training more widely available to a larger percentage of the workforce. A dedicated Remuneration Manager was now investigating all roles, particularly those in lower paid positions. A close association was also being developed with the Ministry of Social Development to ensure staff were receiving full entitlements and support for debt issues. In addition Auckland DHB was working with other agencies to support people into work placements who had been out of the workplace due to health or other issues.

Action

That Fiona Michel investigate and provide data on whether programmes for low paid workers had assisted with remuneration levels and if this training had enabled these staff to step up to a healthcare assistant role

That the chief Executives Report for March 2017 be received.

Carried

5.2 Health and Safety Report *(Pages 41-106)*

Rosalie Percival, Chief Financial Officer asked that the report be taken as read, drawing attention to points made in the executive summary.

The following points were covered in discussion:

- Pages 58- 60 of the agenda indicated that perhaps there was a gap between what was being reported and what was actually claimed. It was explained that this data was not related to compensation revenue but to reported injuries and that many injuries do not result in an actual claim being made.
- A number of projects relating to pedestrian safety are underway or planned for both Grafton and Greenlane Clinical Centre sites. A deep dive report would be submitted to the 28 June Board meeting.
- Sharon Shea asked that the target be adjusted to 100% on page 48 of the agenda.
- It was advised that a report would be brought back to the Finance, Risk and Assurance committee in relation to the liability on the Auckland DHB in relation to contracted provider breaches of the Act.
- Board members emphasised the point that managers of people must take steps to

ensure all training records are completed and filed. Mandatory means what it implies and if the target is not being met then the process needs to be reviewed and redesigned.

- It was noted that Perioperative Services appeared to be able to meet the target and was doing well in comparison to other services and what they are doing might be able to be shared.
- A comparison across the three boards in relation to mandatory Health and Safety training would be helpful as regional consistency was desirable.

Action

That a paper be brought to the next Board meeting dealing with the issue of mandatory training and 100% compliance.

Resolution: Moved Lee Mathias / Seconded Judith Bassett

That the Board:

1. **Receives the Health and Safety Performance report for February 2017.**
2. **Endorses the reporting of progress.**
3. **Identify any further format or reporting changes required to the performance report.**

Carried

5.3 Health and Safety Mid-Year Review: July – December 2016 *(Pages 107-119)*

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

Resolution: Moved Lee Mathias / Seconded Jo Agnew

That the Board:

Receives the Health and Safety mid-year review report for July – December 2016.

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report ***(****Pages 120-126)*

Rosalie Percival, Chief Financial Officer spoke to her report advising:

- The financial result for the month of February 2017 was a surplus of $3.6M which was slightly unfavourable to budget by $91K. The Year to Date (YTD) reflects a surplus of $8.4M, unfavourable to budget by $6.3M. This reflects a $16M unfavourable Provider arm result, partially offset by a $10.6M favourable Funder arm result. The overall DHB YTD result was driven by less revenue realised than planned.
- Two major contributors to the unfavourable position have been the impact of the

additional transplant activity that has been undertaken above the current funded levels, (Compensation for this is being sought from the Ministry of Health) and the under delivery of inpatient and additional electives volumes (net $5.7M adverse wash-up provision).

The following points were covered in discussion:

- It was advised that a $4.5 M year end surplus was forecast in the budget. Every service was required to provide a service forecast which was then compared to volumes. Currently orthopaedics and elective services are unable to do this which has obscured and added to the uncertainty of the final position.
- 84 transplants have been contracted to be performed this year. It is likely that by year end 95 will have been performed, up 20 over last year and up 100% over the position five years ago. The success rate; or five year survival rate for recipients of transplants remains high by international benchmarking standards for a hospital of Auckland DHBs size. It is anticipated that this increase in transplants will increase as donation rates are lifting in response to a government campaign. It had been previously agreed to develop capacity to meet this demand.

Resolution: Moved James Le Fevre / Seconded Lee Mathias

That the Board receives this Financial Report for February 2017.

Carried

6.2 Funder Update Report *(Pages 127-141)*

Dr Debbie Holdsworth, Director Funding asked that the report be taken as read. The highlights of the report were:

- HPV testing for cervical screening was an example of the team taking a lead role in influencing the national agenda and HPV self-sampling in our view is the innovative technology that will hopefully be a game changer in improving equity for Maori. The results of the initial focus group were very encouraging.
- We were also pleased from an equity point of view that when Māori women attend colposcopy they have a good experience. The Colposcopy Experience Survey which was conducted by an experienced Māori telephone interviewer. The results were encouraging with 97.1% of patients being 'extremely likely' or 'likely' to recommend the service to their friends and family who needed a similar service.
- We continue to work collaboratively regionally and very pleased we have agreed a single metro Auckland approach for after-hours across the region and are ready to release the After Hours RFP
- We have also agreed a single child obesity plan across the three metro Auckland DHBs. This needs to go out to consultation and will be brought back to the respective DHB Board meetings in due course.

The key issues being dealt with are:

- Orthopaedic electives discharge target
- The challenge of meeting health care targets in primary care particularly around smoking and Rheumatic
- The lack of a funding envelope so late in the year to inform what community investments can be made to address the above

The following points were covered in discussion:

- The rheumatic fever target was not being met because what currently was being done was just not working with a highly dispersed population and a small budget. No gain had been made with the Pacifica population nationally. A good discussion was held at CPHAC about the challenges and we were currently revisiting our proposed plan for 17/18 which would need to come back to the Board as there will be investment considerations. We are looking to focus on the 15,000 Pacific youth aged between 5 and 15 who are the population most at risk. The key question is how to deliver an efficient throat swabbing programme given the dispersed population recognising approximately 50% do not report a sore throat.
- Gwen TePania-Palmer made the point that these initiatives do work when the community is engaged. A review in strategy around how throat swabbing is delivered is required. Train members of communities at risk to do the swabbing and a more agile response would be forthcoming.

Resolution: Moved Lee Mathias / Seconded Jo Agnew

That the Funder Update Report for March 2017 be received.

Carried

7. COMMITTEE REPORTS

7.1 Minutes of the hospital Advisory Committee (*Pages 142-155)*

A correction is required on page 146 of the agenda. The minutes at 5.4 should refer to "primary birthing" and not "primary nursing".

Resolution: Moved Gwen Tepania-Palmer / Seconded Jo Agnew

That the Hospital Advisory Committee draft minutes be received.

Carried

8. DECISION REPORTS

8.1 Auckland DHB Employee Metrics (*pages 156-159)*

Fiona Michel, Chief Human Resources Officer asked that the report be taken as read, advising as follows:

With the introduction of the Auckland DHB People Strategy, the employee metrics have been reviewed to ensure the effective assessment and monitoring of progress, and to enable the Board to govern workforce issues more effectively and be assured that a healthy culture exists and that the organisation is tracking in the path required.

It is recommended that some old metrics be dropped and some new ones be introduced. This type of metric is very difficult to report on and what can be given is a collective outcome or view of Auckland DHB down to a Directorate view.

The following points were covered in discussion:

- While it was acknowledged that it would be good to see a regionally aligned dataset and work was being done to achieve this, it currently was not possible as each DHB dashboard was constructed differently.
- A discussion was had around the merits of the "Good Employer" survey with advice given that it's use could be looked at in the future but that Auckland DHB was not in a developed enough position to add this to its toolkit yet.
- Lee Mathias recommended including metrics to reflect the link between employees and cost or value to the organisation.

Action

That Fiona Michel provide a breakdown of ratio of FTE versus actual head count for the workforce

Resolution: Moved Jo Agnew / Seconded Judith Bassett

That the Board:

1. **Approve the employee metrics proposed for regular reporting to the Board.**
2. **Approve the recommended approach to targets and monitoring.**
3. **Note the impact of current data quality, manual and decentralised record keeping that may affect the integrity of employee metric reporting.**
4. **Note the need to develop suitable external or independent benchmarking for stretch targets.**

Carried

9. INFORMATION REPORTS

9.1 Human Resources Report *(Pages 160-164)*

Fiona Michel, Chief Human Resources Officer asked that the report be taken as read, drawing attention to:

- The pilot of the "Navigate" programme which occurred on 3 April. This replaces the old "Welcome Day". Early indications are that significantly stronger engagement from participants was experienced on the day.
- There will be a deep dive report on the next Board agenda looking specifically at the

Leadership Programme.

The following points were covered in discussion:

- Sharon Shea was advised that progression of any and all FTE within the organisation could be measured via an FTE retention and progression report.

Resolution: Moved Jo Agnew / Seconded Lee Mathias

That the Board receives the Auckland DHB Human Resources report for April 2017.

Carried

9.2 Maori Health Workforce Development Alliance Leadership Team Update *(Pages 165-172)*

Gil Sewell, Director, Organisational Development and Kim Herrick, Organisational Development Practice Lead asked that the report be taken as read and highlighted as follows:

- The MALT Action Plan for this financial year lists three priority areas of activity; recruitment and retention, pipeline development and leadership development. The Programme is an excellent example of collaboration across the Auckland and Waitemata DHBs.
- Of concern is the lack of a formalised project and inadequate resources to deliver the 2017/18 Action Plan.

Gwen Tepania - Palmer congratulated staff and expressed hope that the initiatives would gain momentum.

Resolution: Moved James Le Fevre / Seconded Zoe Brownlie

That the Board:

1. **Receives the Māori Health Workforce Development Alliance Leadership Team (MALT) update report for April 2017.**
2. **Notes that status and progress of Māori Health Workforce Development Alliance Leadership Team (MALT) and endorses the work plan**

Carried

9.3 Auckland DHB EPMO and Strategic programme Update *(Pages 173-187)*

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

An options paper to agree an operating model for the EPMO will be presented to the next Finance, Risk and Assurance Committee, and the Board will be kept apprised of developments with the Strategic Portfolio through both scheduled and ad hoc reporting.

Following an initial meeting in February between Auckland DHB and Waitemata DHB, the first regional P3M3 meeting was held between Counties Manukau DHB, Waitemata DHB, Auckland DHB and Northland DHB in March 2017.

Waitemata DHB is developing some of the tools required for the programmes and the intent is that Auckland DHB will adopt those too.

The following points were covered in discussion:

- It was advised that this programme of work fits with the requirements around investor confidence rating and will be audited against those projects in the next audit. It also fits with the strategy to improve asset management.

Resolution: Moved Lee Mathias / Seconded Jo Agnew

That the Board:

1. **Notes the status of Portfolio, Programme and Project Management development for Auckland DHB**
2. **Notes that an options paper for development of an Enterprise Portfolio Management Office will be presented to the Finance, Risk and Assurance Committee in April 2017**
3. **Notes the development and content of a Strategic Portfolio of programmes as the key mechanism to deliver the Auckland DHB Strategy**
4. **Notes that a Strategic Portfolio report will become part of regular Board reporting**
5. **Notes that the Strategic Portfolio will be dynamic and the Board will be asked to discuss and approve any changes as required.**

Carried

10 GENERAL BUSINESS

Question – Workforce Policy

Jo Agnew asked whether the Board had a written policy which stipulated that the DHB workforce should demographically mirror or reflect the population which it serves.

It was noted that there was not a policy as such but that there was a local and regional strategy to that effect. MALT was an example of taking appropriate action during the recruitment process and where professional groups were targeted to remove barriers.

11. RESOLUTION TO EXCLUDE THE PUBLIC *(Pages 188-190)*

Resolution: Moved Jo Agnew / Seconded Robyn Northey

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies		That the public conduct of the whole or the relevant part of the

		meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. Register and Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 22 February 2017	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]
4. Confidential Action Points 22 February 2017	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Chief Executives Confidential Report	Commercial Activities To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] Negotiations Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982	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]

	s9(2)(j)] Privacy of Persons Information relating to natural person(s) either living or deceased is enclosed in this report [Official Information Act s9(2)(a)] Prejudice to Health or Safety Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]	
6.1 Minutes of the Finance, Risk and Assurance Committee 15 March 2017	Confirmation of Minutes As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the New Zealand Public Health and Disability Act [NZPH&D Act 2000]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Minutes of the Confidential Hospital Advisory Committee 15 March 2017	Confirmation of Minutes As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the New Zealand Public Health and Disability Act [NZPH&D Act 2000]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 One Link Contract	Commercial Activities To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] Negotiations Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

7.2 PAE Contract Extension	Commercial Activities To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] Negotiations Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.3 Westpac Banking Arrangement Extension Letter	Commercial Activities To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] Negotiations Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8. Discussion Reports - NIL		That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 NRLTIP Board Update	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

	Confidence Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]	6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Human Resources Report	Privacy of Persons Information relating to natural person(s) either living or deceased is enclosed in this report [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]

Carried

The meeting closed at 11.45am.

Signed as a true and correct record of the Board meeting held on Wednesday, 05 April 2017

Chair: _____ Date: _____

Lester Levy

Action Points from 17 May 2017 Open Board Meeting

As at Wednesday, 17 May 2017

Meeting and Item	Detail of Action	Designated to	Action by
11 May 2016 *Item 8.2* HAC (Transfer from)	**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*.] *Update: Item to be transferred to the 5 April 2017 Board agenda*	Andrew Old/ Margaret Dotchin	Verbal update report
5 April 2017 Item 5.1	**Cleaning Staff** That Fiona Michel investigate and provide data on whether programmes for low paid workers had assisted with remuneration levels and if this training had enabled these staff to step up to a healthcare assistant role.	Fiona Michel	TBA
5 April 2017 Item 5.2	**Health and Safety - Training** That a paper be brought to the next Board meeting dealing with the issue of mandatory training and 100% compliance.	Sue Waters	17 May 2017
5 April 2017 Item 8.1	**FTE versus actual head count** That a breakdown of ratio of FTE versus actual head count for the workforce be provided to the next Board meeting.	Fiona Michel	17 May 2017 (Verbal report)

Tracking Mandatory Health and Safety Training

Recommendation

That the Board endorses the plan to resolve tracking of Mandatory Health and Safety Induction Training.

Prepared by: Gil Sewell (HR Director Organisational Development) and Denise Johnson (Occupational Health and Safety Manager)
Endorsed by: Fiona Michel (Chief Human Resources Officer), Sue Waters (Chief Health Professions Officer)

1. Executive Summary

This update is provided in response to the Boards request to understand what plans Auckland DHB has to improve reported Health and Safety mandatory induction in the future.

Human Resources (HR) and Health and Safety (H & S) met to confirm the current state for recording compliance with mandatory training for Health and Safety induction, and identify improvements for the future.

2. Current State

There are four current streams of H&S Training as listed below. The first two are the focus of this update as they relate to mandatory Health and Safety induction processes.

1. **Mandatory:** Local H&S induction, conducted by the Manager and H&S Representative using a checklist for consistency and a requirement for managers to register completion on the H&S page on Hippo.
2. **Mandatory:** Online compliance training in the form of a workbook to read, followed by a quiz. (part of the local H&S induction to be completed within the first week of an employee's on-boarding)
3. Managing Safely, a day course for all people managers.
4. H&S Representative training

Currently three teams from two departments are involved in the recording process associated with local induction: Payroll and Organisational Development from HR, and Health & Safety.

Training for induction is recorded manually in four different systems: Leader, Kiosk, Hippo and LEARN. These systems are not integrated with one another nor do they interface with one another. The data recorded and used for reporting purposes has been variable which leads to varied results against our local induction standards.

Auckland DHB has noted and reported improved performance through the use of LEARN, the online component of local H&S induction.

The H&S Team works to emphasise the critical nature of local H&S inductions and tracks completion of all of the above training through the following channels:

- Road show to all Directorates to update on Health & Safety at Work Act 2015 was used to emphasise the importance of local H&S induction.
- Managers are required to register all completed local H&S inductions for new starters on the H&S page on Hippo. This step is clearly indicated in the H&S Induction Checklist.
- Online H&S induction course completion on LEARN is manually exported and uploaded to Leader, to minimise manual input.

- Reminder emails are sent to managers who have not registered all completed local H&S inductions for new starters on Hippo 4 weeks after their start date.
- At our refreshed orientation event, Navigate-Kai Arahi, visiting the Health & Safety stand is part of the compulsory activities, allowing the H&S team the opportunity to emphasise to all new starters that local H&S induction must be completed.
- H&S Team report to Directorate H&S Committees on KPIs and non-compliance, providing backup data so the Clinical Director or Committee Chair can follow up.
- Managing Safely, our manager training day emphasises the process for local H&S inductions
- Reminder of the process is regularly included in H&S Directions, the monthly H&S education update.
- Special Datix training has been held for all H&S Reps on how to use the new safety management system, including a reminder session about the requirements of local H&S Induction.

3. Risks of current state

We have a manual recording process which is cumbersome and results in variable reporting results against our local induction standards.

4. Planned improvements to mitigate risk

We recognise the need for more robust reporting to ensure confidence that we are meeting all H & s compliance expectations. We have identified a number of leading and lagging system improvements to mitigate our current risk.

Automation

- We are looking into technical automation for all on boarding including H & S using the Taleo recruitment system. This work is in progress, but limited, shared resource across the three metro-DHBs means it is not progressing quickly.
- Until automation can be achieved, we will design a Welcome Email for all new starters to emphasise the expectation to attend our orientation event, Navigate - Kai Arahi and complete mandatory local H&S induction. This will be copied to the Line manager, and sent weekly to all new starters.
- The 4-week reminder email will be reworked to allow managers to use a feedback button to immediately confirm local H&S induction completions, and to submit a scanned copy of the completed H&S Induction Checklist direct to the HR Service Centre for inclusion into personal files.

Audit

- Six-monthly spot audits for new starter H & S induction checklists are to be conducted by Internal Audit. These will be added to the Audit Schedule reported to the Finance Risk and Assurance Committee.

Communications

- A Communications campaign, fronted by the Professional Leads and Director, Provider Services will increase the profile of our H & S induction processes

Our initial approach is to improve completion rates by making it easier to respond. Should this not close the gap, a focus on performance improvement will be activated in line with our normal policy and process.

5. Timeline for Improvements

We plan to have these improvements completed early in the new financial year.

Chief Executive's Report

Recommendation

That the Board receives the Chief Executive's Report for May 2017.

Prepared by: Ailsa Claire (Chief Executive)

Glossary

1. Introduction

This report covers the period from 18 March – 28 April 2017. It includes an update on the management of the wider health system and is a summary of progress against the Board's priorities to confirm that matters are being appropriately addressed.

2. Events and News

2.1 Notable visits and programmes

Employee Survey Results

In April our Employee Survey results were shared organisation-wide through a survey summary report. Survey results by question were also published on Hippo (the intranet) and a summary published on the external website. The senior managers continued to work with their teams to share the results and develop plans to address key areas.

Navigate

A new approach to welcoming new starters to Auckland DHB launched in April with 120 attendees. Part of the work underway to implement our new People Strategy, Navigate Kai Arahi will take place every month in the CEC and provides an improved experience for our new people, covering the information they need for a 'quality start' in a fun and engaging way. All new employees are expected to attend the sessions. The next session takes place on 29 May 2017, and Board members are welcome to attend this or any future sessions.

Health Innovation TIKI Tour

Auckland DHB hosted an innovation showcase to highlight the latest in healthcare research and technologies on 1 May in conjunction with the Consortium for Medical Device Technologies and Medical Technologies Centre of Research Excellence. (https://www.cmdt.org.nz/)

The Technology Innovation and Knowledge Interchange (TIKI) Tour provided participants with information around these topics provided by the following range of exhibitors and was well attended.

Rehabilitation: Rex Bionics, AbleX Healthcare
Education Support: kuraCloud, Healthpoint, The Clinician (PROMS)
Automation, sensing and tracking: BUPA (Jupl watch)
Health and Safety: Endotechnologies (Endoscope cleaning), Veriphi (IV drug identification)
Virtual Reality in health: Auckland DHB
Pulmonary Medicine: Auckland Bioengineering Institute & Auckland DHB
Tissue Geometry and Measurements: Auckland Bioengineering Institute
Rehabilitation Innovation Centre: Auckland University of Technology
Design Innovation: Auckland University of Technology & Auckland DHB
Self Manage and Self Care Tech: Adherium (smart inhalers), Melon Health (mental health/diabetes management)

2.2 Health sector partnerships

2.2.1 Typhoid outbreak

Auckland DHB provided clinical resources and communications leadership to the Auckland Regional Public Health Service (ARPHS) from 4 April to support their response to the recent typhoid outbreak.

In addition to clinical management of the outbreak, APRHS had significant core communications tasks through the period, to ensure stakeholders and the public were informed in a timely and effective manner and the clinical risk was well understood by the public. Key areas of activity were:

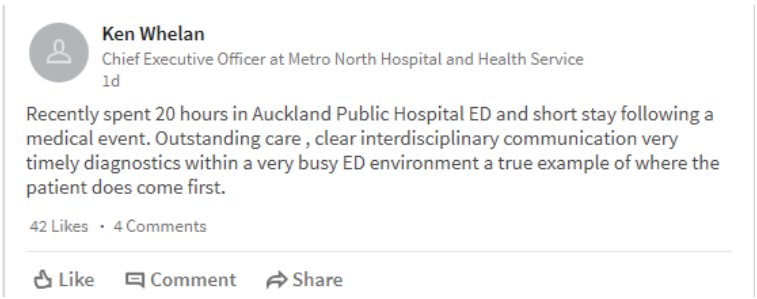
- Media management
- Communication with the family and congregation impacted by the outbreak
- Communication with Wesley Primary School
- Communication and engagement with the wider Pacific community
- Communication with other stakeholders.

Auckland DHB Communications received support from Waitemata DHB, Counties Manukau DHB, Healthline, the Ministry of Health, Minister Coleman's office, the Ministry of Pacific Peoples and the Ministry of Education.

2.3 Patient and Community

2.3.1 Acknowledgements

The CEO of an Australian Public Health body, Ken Whelan, shared his positive patient experience in our Adult ED with his LinkedIn followers:



2.3.2 Email enquiries

Communications manages a generic communication email box, responding to all emails and connecting people to the correct departments. For this period, 230 emails were received. Twenty-one were not communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

2.4 External and Internal Communications

2.4.1 External

We received 106 requests for information, interviews or for access from media organisations between 18 March and 28 April 2017. Media queries included enquiries about our CFU services, an interview with our Clinical Director of ED

regarding research about alcohol related harm, and an enquiry about the of the bus stop at Greenlane Clinical Centre.

Approximately 20 percent of the enquiries over this period sought the status of patients admitted following road accidents and other incidents or who were of interest because of their public profile.

The DHB responded to 32 Official Information Act requests over this period.

2.4.2 Internal

- Three CE blog posts were published, one on our new approach to welcoming our people, the second on privacy in a digital world, and the third on doing our life's best work.
- 45 news updates were published on Hippo, the DHB intranet.
- Seven eNova (weekly electronic newsletters) were published.
- The April/May edition of Nova was printed and distributed.
- 'In the Know' sessions took place on 6 and 7 April, with approximately 110 managers attending. The next sessions will be held on 18 and 19 May.

2.4.3 Events and Campaigns

Flu Vaccination

5,776 or approximately 57 per cent of Auckland DHB employees, contractors, students and volunteers were vaccinated against influenza in the first phase of vaccination clinics.

A second phase of vaccination clinics is due run 15 until 19 May 2017. In-team vaccinators are continuing to vaccinate throughout this time.

Our message to our people is that Influenza is serious, highly contagious and largely preventable. One of the best ways we can protect our patients and ourselves is to get vaccinated.

New Safety Management System (Datix)

Our new Safety Management System (Datix) went live in April. The new system centralises risk management and incident reporting across the DHB, and will make it easier for staff to report incidents and near misses. The new system also provides feedback once the investigation into a recorded incident has been completed, and proactively helps identify incident and risk hotspots.

World Earth Day

Earth day was celebrated on 22 April 2017 to encourage people across the world to be more environmental friendly. More than 1 billion people in more than 192 countries took part.

Auckland DHB took the opportunity to use Earth Day to highlight our commitment to reducing our carbon footprint. Partner organisations including Auckland Council, Auckland Transport and Waste Management joined us on the day.

Our aim is to reduce our waste to landfill by an additional 20 – 50 per cent by introducing small 'desk cubes' in offices.

In 2016 we reduced our carbon emissions by 13 per cent. These savings are equivalent to the carbon emissions of 4,280 return economy flights from Auckland to London.

World Hand Hygiene Day

Taking a moment to perform good hand hygiene is a basic way health professionals can contribute to fighting antibiotic resistance.

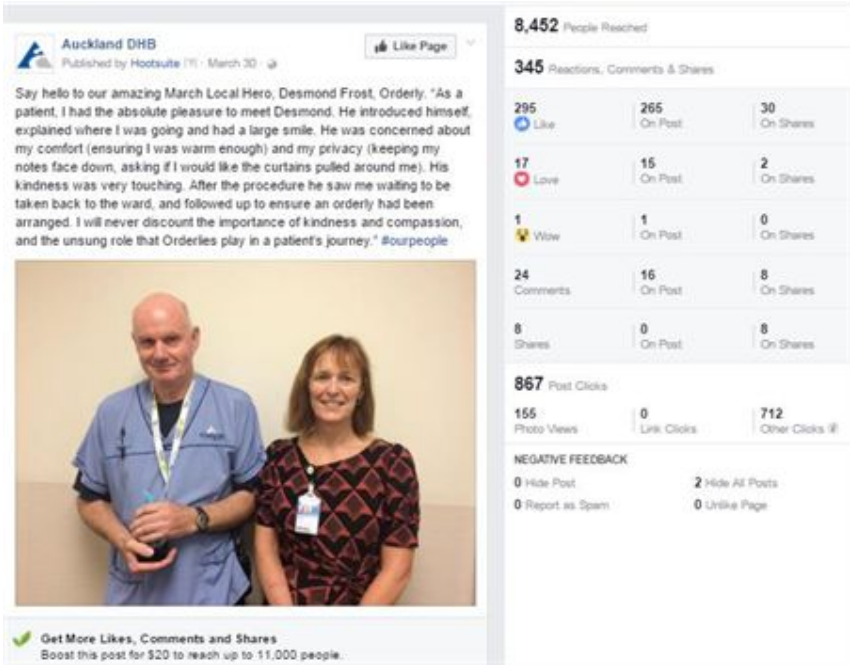
On Friday 5 May, World Hand Hygiene Day, the Infection Prevention team had a stand on level 5 to encourage and reinforce good hand hygiene for everyone – staff, patients and visitors.

2.4.4 Social Media

Followers:
Twitter: 2922
Instagram: 198
Facebook: 4464
LinkedIn: 5811

Top Posts:

- March local hero



- Administrative Professionals Day thank you

Our People

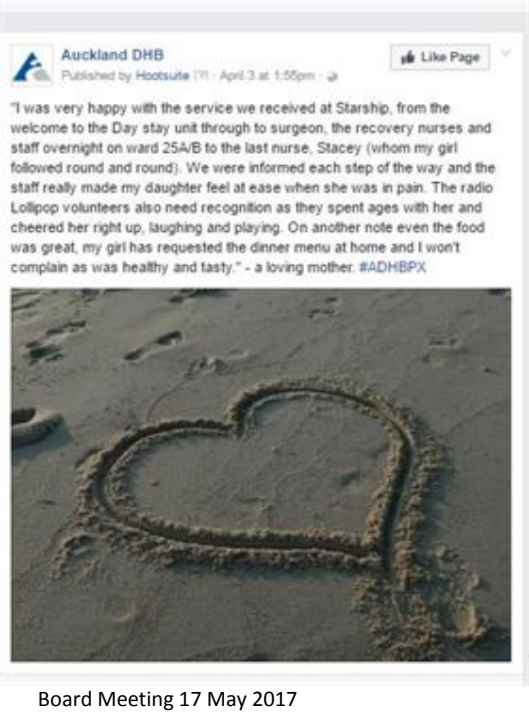
- CSSD Team appreciation
- Administrative Professionals Day thank you
- 2017 Local Heroes Video, congratulations and nomination promotion
- Play specialist awareness
- Thank you to staff working over the Easter holidays
- A+ Trust Pasifika Nursing Graduates
- Cleaner's Graduation
- Debra Lampshire – Supreme Winner at Attitude Awards

World Class Healthcare

- Nova article promotion re Fibroscan donation
- Professor Ed Gane
- TIKI Tour Promotion
- Staples VR

Patient Experience

- PEX letters
- Blues Visit Starship patients



Healthy Communities

- April Falls prevention – general awareness, posts for the aging as well as children
- Conversations that Count Day promotions
- Fight Flu – general awareness, internal vaccination promotion, pregnant mothers promotion
- Cyclone Cook update - where should I go?
- Typhoid updates
- Mobile cervical smear clinic
- MOH Green Prescription programme
- Healthpoint Maternity Services
- Rheumatic Fever awareness
- Safe Kids, make your home a safety zone

Recruitment/Organisational News

- Weekly recruitment wrap ups
- MOH Volunteer Awards promotion
- Sustainability at ADHB video
- Earth Day Celebration promotion
- Māori and Pacific HCA Cadetship recruitment
- Helicopter delivering water pipes for facility works
- First ambulance at Auckland Hospital
- RMO Careers Day

2.4.5 Our People

Memorial for Ngahou Pirihi

Whānau and friends of Ngahou Pirihi came together on Sunday 30 April to unveil a plaque in Ngahou's memory at Auckland City Hospital.

Ngahou was an orderly in the Emergency Department for many years before he sadly passed away in 2016. The plaque is in the atrium space on level 2, where Ngahou, used to enjoy taking his meal breaks with friends and whānau.

Whānau travelled from Australia and Northland for the memorial service, which for them was the final part of the journey to lay Ngahou to rest.

Local Heroes

There were 27 people nominated as local heroes during March and April.

Our April Hero is Denise le Lievre, Charge Nurse on Ward 83.

The person nominating Denise said, "I have been working in Starship, almost eight years as kaiatawhai, I don't normally go to Auckland Hospital. However, last week I met with the charge nurse on ward 83 Denise Le Lievre, regarding a patient and whānau I was supporting.

In the few days I spent on the ward, the whānau expressed how overwhelmed and thankful they were for Denise going over and beyond her job.
The most important person within the whānau pointed at Denise whispered in my ear, she has been a beautiful and wonderful caring person during their time on the ward.

She also spoke highly of how Denise has been graceful, and updated the whānau regularly on the patient's situation.

The patient died on the weekend, and before the whānau travelled home to Christchurch with their brother. They wanted to thank Denise for all the love and support she gave to the whānau. They will not forget what she did during their time in Auckland Hospital."

Our May Hero is Arlene Laurenciana, Staff Nurse on Totara Ward.

Arlene was nominated by a team member who said: “My local hero is Arlene! She is a wonderful RN to have on the ward as her care is always professional and warm to her patients, commonly being named on ward feedback by patients as a nurse that goes above and beyond.

She is thorough with her responsibilities, and a role model whom always takes time to share her knowledge and lift the confidence of those around her. I enjoy working alongside her when we are under pressure as I know she is a team player, a strong leader, and being around her encourages others to perform at their best.

She most recently spent hours of her own time developing a project with a patient focus that will improve the patient experience and will benefit us all greatly through time saving measures. Thank you Arlene for all that you do.”

Arlene’s presentation is currently being arranged.

Recognising our Nurses and Midwives

International Day of the Midwife (5 May) and International Day of Nursing (12 May) will be celebrated at the annual Nursing and Midwifery Awards on 11 May. On the respective days screen savers will be shown on computers across the organisation, and played on the level 5 video wall throughout the day.

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary[1]

	Status	Comment
Acute patient flow (ED 6 hr)		Feb 93.5%, Target 95%
Improved access to elective surgery (YTD)		96% to plan for the year, Target 100%
Faster cancer treatment		Jan 91%, Target 85%
Better help for smokers to quit:		
• Hospital patients		Feb 94.73%, Target 95%
• PHO enrolled patients		Dec Qtr 88%, Target 90%
• Pregnant women registered with DHB-employed midwife or lead maternity		Dec Qtr 94%, Target 90%
Raising healthy kids		Feb 99%, Target 95%
Increased immunisation 8 months		Dec Qtr 95%, Target 95%

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

[1] *As of 8 May, the April health target performance was not yet available for inclusion in this report.*

Note that effective July 2016, ***Raising Healthy Kids*** has replaced More Heart & Diabetes Checks.

Also note that although the Primary Care ***Better Help for Smokers to Quit*** has changed (50% of all current smokers will be quit at 4 weeks after entering a programme to so; 5% of the currently smoking population will be engaged in the programme), both the Hospital Target (95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking) and the Maternal Health Target (90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking) remain.

3.1.2 National Health Targets – YOY comparison Auckland region DHBs

	Auckland Region	2015/16				2016/17			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
 95% of patients will be admitted, discharged, or transferred from an emergency department within six hours.	**Auckland DHB**	**93**	**95**	**95**	**95**	**95**	**95**		
	Waitemata DHB	93	95	96	95	97	97		
	Counties Manukau	95	95	96	96	96	96		
	All DHBs	92	94	94	94	93	94		
 The volume of elective surgery will be increased by an average of 4000 discharges per year.	**Auckland DHB**	**93**	**98**	**98**	**101**	**93**	**97**		
	Waitemata DHB	101	101	102	106	105	106		
	Counties Manukau	99	103	105	109	110	108		
	All DHBs	104	105	106	108	105	103		
 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016, increasing to 90% by June 2017.	**Auckland DHB**	**66**	**70**	**75**	**77**	**79**	**88**		
	Waitemata DHB	74	68	70	75	86	90		
	Counties Manukau	70	72	70	74	75	74		
	All DHBs	69	75	75	74	78	82		
 95% of 8-months-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time.	**Auckland DHB**	**95**	**94**	**94**	**94**	**94**	**95**		
	Waitemata DHB	93	95	93	92	94	92		
	Counties Manukau	95	95	94	95	94	94		
	All DHBs	93	94	93	93	93	93		
 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. (Other targets also exist)	**Auckland DHB**	**85**	**86**	**88**	**91**	**87**	**88**		
	Waitemata DHB	85	88	90	91	87	88		
	Counties Manukau	87	88	89	92	89	89		
	All DHBs	83	85	86	88	87	86		
 95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017.	**Auckland DHB**	Note: this target replaced ***More Heart and Diabetes Checks*** from July 2016				**79**	**97**		
	Waitemata DHB					83	100		
	Counties Manukau					29	62		
	All DHBS					**49**	**72**		

Source: http://www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing
Quarter 3 results not published as at 8 May 2017.

3.2 Financial Performance

The DHB financial performance for the nine months to March 2017 was a surplus of $5.4M was realised, unfavourable to budget by $6.5M. This reflects a $20M unfavourable Provider arm result, partially offset by a $14M favourable Funder arm result. The year to date revenue was unfavourable to budget by $9.2M. The year to date expenditure is favourable to budget by $2.7M. Less than budgeted revenue is mainly due to under delivery of inpatient and additional electives volumes (net $5.7M adverse wash-up provision); less than planned Public Health revenue ($1.2M, timing only); Haemophilia funding ($1.7M, due to lower blood product usage); donation income ($1M, timing only) and interest income ($2.4M, lower interest rates). These are offset by favourable IDF Inflows ($1.3M, service changes and wash ups) and other income ($4.3M, mainly research grants and drug trial revenue with corresponding costs, gains on valuation of Trust investments). Favourable expenditure is mainly in the Funder NGO expenditure ($19M, mainly pharmaceuticals, Age Related Residential Care and Mental Health services), which fully offset unfavourable expenditure in net personnel and outsourced personnel costs ($8.4M); clinical supplies ($7.4M) and infrastructure/ non-clinical supplies ($4M).

The full year plan is a surplus of $4.5M and is currently at risk, with the year-end forecast surplus at $3.2M. Achieving the full plan is dependent on the DHB resolving the IDF pricing issues and transplant funding shortfall to meet costs associated with higher volumes (with support from the Ministry of Health and/or other DHBs) and also realising the savings included in the plan (or other offsets for those no longer achievable).

Work is underway to develop the 2017/18 financial plans and price volume schedules. However, financial planning is challenging at present considering that we have not yet received the full 2017/18 Funding Advice (which is expected during May 2017). We are also facing significant cost pressures including that arising from costs of settlement expected (or indicated) to be above the DHB funded levels for Multi-Employer Contract Agreements (MECAs) and for contracts with NGO Community Service Providers. For MECAs, salary increases reflect a price change (rather than volume change) and every 1% salary increase (across all employment categories) has an operational cost impact of at least $8.5M p.a. The implied cost pressure adjustor included in recent funding envelopes for DHBs has been significantly below 1%.

For NGO Community Service Providers, there is traditionally substantial cost pressure resulting from the application of sector wide price increases for services funded by way of national contracts. Age Related Residential Care (ARRC) and Primary Care Services being the most significant, followed by Community Pharmacy. These sectors also are adept lobbyists and pricing decisions agreed within these sectors are often used as a catalyst by other NGO service providers to promote equivalent price increases. The timing relative to the forthcoming elections is also a contributing factor in this regard. Price based cost increase is also compounded by population growth which, based on the latest Ministry Series 16 Projections for

Health is forecast at 3.92% for Auckland DHB. The ADHB 2016/17 forecast expenditure for ARRC is $103M and essentially every 1% of price increase equates to an additional $1M of cost, as does every 1% of volume growth. Co-incidentally, this circumstance applies almost exactly to the ADHB PHO Capitation expenditure which is forecast at $99M for 2016/17. The component of Community Pharmacy being impacted by equivalent pricing pressures relates mostly to Delivery (dispensing) with a forecast 2016/17 expenditure of $39M. It is being reliably reported that the Minister is receiving strong messages from this sector about the weighted average cost pressure for the sector running at around 2.55% and also noting that the minimum wage increase alone at 3.3% has impacted the entire sector to some degree.

4. Clinical Governance

4.1 Auckland Academic Health Alliance

The University of Auckland's Faculty of Medical and Health Sciences and the Auckland Academic Health Alliance warmly invite you to attend our AAHCI International Fall Meeting being held in Auckland between 30 November and 1 December 2017**.**

Our two-day meeting themed *Creating Effective Partnerships between Universities & Hospitals for Advancing Health Care,* will provide participants with a unique opportunity for networking, exchanging ideas, and sharing best practices with leaders from academic health centres and systems in New Zealand, Australia, and worldwide.

Highlighted sessions include:

- Introducing the NZ Health system
- Rising cost of healthcare: lessons from respective member countries
- Designing and training the health workforce for future need.

To register to attend please click here.

Health and Safety Performance Report

Recommendation

That the Board:

1) **Receives the Health and Safety Performance report for March 2017.**
2) **Endorses reporting of progress.**
3) **Identify any further format or reporting changes required to the performance report.**

Prepared by: Denise Johnson (Manager Health and Safety)
Endorsed By: Sue Waters (Chief Health Professions Officer)

Glossary

BBFA:	**Blood and/or Body Fluid Accident**
EAP:	**Employee Assistance Programme (Counselling)**
EYNZ:	**Ernst and Young Limited**
HSNO:	**Hazardous Substance New Organisms Act**
HSWA:	**Health and Safety at Work Act 2015**
LTI:	**Lost Time Injury (work injury claim)**
MFO:	**Medical Fees Only (work injury claim)**
MOS:	**Management Operating System**
NE:	**Notifiable Events reportable to WSNZ (Replaces Serious Harm)**
NFA:	**No further action by WSNZ following a notification**
Officer:	**of the PCBU, a manager in a directing role**
PCBU:	**Person in Charge of a Business or Undertaking**
PES:	**Pre-employment Health Screening**
RMO:	**Registered Medical Officer**
SFARP:	**So far as reasonably practicable**
WSNZ:	**Worksafe New Zealand**

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	*Supports Patient Safety, workplace safety, visitor safety*
Evidence informed decision making and practice	*Demonstrates Integrity associated with meeting ethical and legal obligations*
Operational and financial sustainability	*Addresses Risk minimisation strategies adopted*

2. Executive Summary

This report provides details of the health and safety performance at Auckland District Health Board including compliance, leading and lagging indicators, issues, risks and health and safety activities.

The Health and Safety Score Card has been reformatted to place similar lagging indicators together. This will give the reader an opportunity to evaluate associated KPIs for a specific Health and Safety system.

Improvements to be noted: Pre employment screening before start date remains high, 80+ per cent of the Directorate Hazard Registers are current using the pre-Datix system. Contractor and hazardous substance audit compliance remains high.

Activities that require more focus continues to be local health and safety inductions. A 30-60-90 day action plan has been implemented and the Directorates are receiving compliance lists from the Health and Safety department to discuss at the Directorate Health and Safety Committees.

Improvement in the area will also be discussed with each of the Directorate management teams as part of the Health and Safety Update Road show during March and April. Health and Safety will work with Organisational Development to develop an organisation wide approach to improving this requirement.

Health and Safety Risks: This table lists eight significant risks with seven of them being amber. Note that the glass balustrades at Greenlane Clinical Centre Dental Clinic have been added as a risk. The risk register has been updated. The risk calculation (consequence/likelihood) has been added. Updates for each of the action plans have been included in the report. A number of projects have been prioritised for the Traffic management/Pedestrian Safety risk at Auckland City Hospital and Greenlane Clinical Centre. Please see the table for details.

WorkSafe NZ Notifications: Health and Safety was not informed of any incidents (involving workers, patients or others) that required notification to WorkSafe in March 2017.

Staff Incidents (employees): 183 incidents were reported by staff in March2017. This is 30% higher than the number reported in February. Fifteen of the March incidents resulted in injury requiring medical care. Two of these were lost time injuries. The injuries are primarily sprains and contusions. The Lost Time injury Frequency Rate history is now displayed in this section of the report, the drop in the rate is related to the decrease in lost time injuries from the previous month. Please note the lost time injury reports can be delayed.

The Health and Safety Department continues to be involved in many activities to improve the health and safety management within the organisation. Priority activities for March were again preparation for working with the quality team to develop the Health and Safety modules in the new Safety Management System, supporting the Health and Safety Committees, arranging for Health and Safety Rep training to comply with the new standards in HSWA and improvements to the supply of equipment required for bariatric patient moving and handling. New projects include planning for a second external health and Safety systems review (deep dive) for Auckland DHB and planning for the 2017 Board Safety engagement visits and further exploring Regional collaboration opportunities.

The work plan to implement all of the system improvements required to meet the standards within the new Health and Safety legislation is now substantially complete. The new “Health and Safety Marker Report” provides this information in a different format.

Facilities and Development update: Section 12 of this report provides an overview of recent health and safety initiates within Facilities and Development Department. These include a Facilities due diligence Health and Safety audit of Contractor management conducted by an external reviewer. A number of continuous improvement initiates will be developed as a result of this audit. The report also includes graphs showing Health and Safety induction, incident reporting, safety inspections and toolbox meetings for the period.

Health and Safety reports have been provided for all directorates, these show improvements in a number of the KPIs most notably incident follow up by managers. The Health and Safety scorecards for each of the directorates will be discussed as part of the Health and Safety Update Road show.

Health and Safety Performance Report – March 2017

Contents

3. Purpose of Report

The purpose of the health and safety report is to provide reporting on the health and safety performance including compliance, indicators, issues and risks to the District Health Board. Please note that an individual Health and Safety report has been provided for each Directorate (see appendix 1).

4. Health and Safety Scorecard for March 2017

The Leading and Lagging indicators in the scorecards are indicative of Health and Safety performance across the organisation. Using trends and traffic light indicators will emphasise the areas where we are on or progressing towards our targets and when we need to improve. Some of our targets are staged to action improvement over time

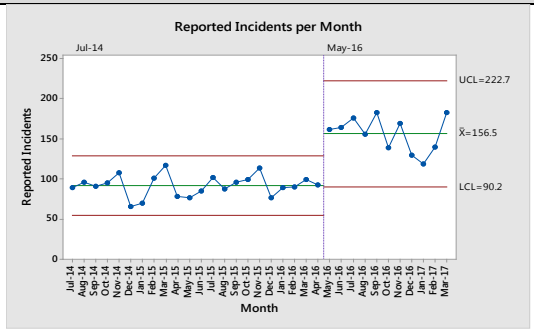
Lagging Indicators

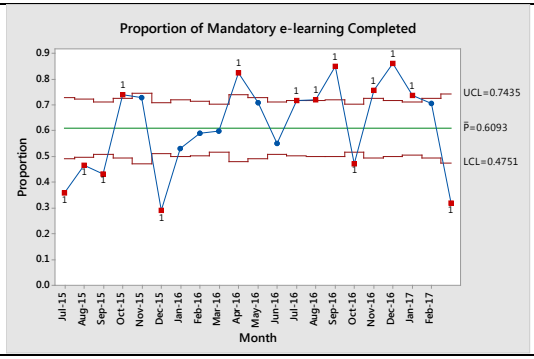
	Actual	Target	Trend
Lost Time Injury Frequency Rate	2	8	
Number of Injury Claims	17	35	
Lost Time Injury Severity Rate	0	2	
Lost Time Injury	2	10	
Cost of Injury Claims (000's)	4	80	
Excess Annual leave: % of workers with excess annual leave	9	6	
Number of Reported H&S Incidents			
Staff	183	200	
Contractors	15	50	
Students	0	10	
Volunteers	0	10	
Number of Notifiable Events			
Staff	0	0	
Contractors	0	0	
Students	0	0	
Volunteers	0	0	
Patients	0	0	
Other	0	0	
Top 3 Accident types that caused harm			
Physical Environment (Slip/Trips/Falls)	5	0	
Workplace Violence and Aggression	4	0	
Patient Handling	0	0	
Lone/Off site workder safety; total recorded incidents and severity	10	10	
Lone/Off site workder safety; total recorded claims	0	0	

Leading Indicators

	Actual	Target	Trend
% Pre-employment screening before start date	99	100	
% Pre-employment screening completed	90	90	
% Significant Hazard Registers current	83	80	
% completed hazard remediation	RU	80	
Management of Reisidual Risk action plans	RU	80	
% local H&S Induction completed	36	100	
% OH&S mandatory e learning completed	60	100	
Number of H&S Representative Vacancies	17	25	
% H&S Representative Training	61	80	
% of reported H&S Incidents investigated- 14 days	67	80	
# of outstanding H&S Incident investigations	23	10	
Number of contractor audits completed	20	10	
Level of compliance contractor audits	96	90	
# of Hazardous Substance audits conducted	11	10	
% Hazardous Substance audits compliant	83	80	
Safety Secuity Audits conducted	RU	0	
% training completed in high risk WV areas	76	95	
Health and Wellbring Programmes: new and underway	RU	0	
%Employee engagement satisfaction levels	70	0	
Number of staff Seasonal Influenza Vaccinations (YTD) 2015	4720	7923	
Contact Tracing (events)	1	0	
Contact Trace (headcount exposed)	44	0	

5. Commentary on Health and Safety indicators exceptions

Indicator	Issue		Action
Local Health and Safety Induction Completed within seven days. Mandatory Health and Safety training required for all new staff.	Some local Health and Safety induction are not reported to the Health and Safety office. This may indicate that local Health and Safety induction is not being provided to new staff and therefore they may not understand how to engage with Auckland DHB Health and Safety systems.		A 30-60-90 day action plan has been developed this includes reminders to managers when Health and Safety inductions are not received by Health and Safety. Detailed reports are provided to directorates. Further action will be planned in conjunction with Organisational Development.
% Health and Safety Rep training	Health and Safety Reps training was delayed following the introduction of the new Health and Safety legislation due to the move to NZQA standards.		An external training partner has been sourced and Health and Safety rep training sufficient to train all Reps is scheduled from Feb – June 2017. 70 Health and Safety Reps have attended this training to date. 136 Health and Safety Reps completed Transitional Training for a total of 206 /317 Health and Safety Reps trained under the new Health and Safety legislation.
Number of outstanding Health and Safety incident investigations within 30 Days.	Some managers do not complete the required investigation before the incident is closed by Health and Safety (30 days).		Monthly reports sent to all Directorate Health and Safety Committee chair re: Occurrence reporting follow up non-compliance. Reminders generated with the new

Indicator	Issue		Action
			Safety Management System will assist. Transition to the new Safety management system is underway. Review of worker incident follow up is underway.
Percentage training completed in high risk workplace violence areas	Some staff do not complete violence and aggression training within the required timeframes.		Health and Safety Advisor has been appointed to support this project. A work plan will identify any risks which cannot be controlled; these and any mitigating actions will be reported as a Health and Safety Risk on the organisational Risk Register. E learning pilot to be implemented before the end of June.
% Mandatory Health and Safety induction training completed (Ko Awatea LEARN)	Some staff do not complete the mandatory on line Health and Safety induction course provided on Ko Awatea LEARN.		60% of new starters completed the training in March 2017. A data base has been developed and reminders sent to managers where Health and Safety Inductions are not recorded.
% Significant Hazard Registers Current	Some managers do not document identified hazards on the Hazard register. Many hazard registers still paper based.		The new risk/incident programme (Datix) was launched in March 2017. Health and Safety will work with Directorates to move Hazard registers to the new system. Tracking of compliance will be improved.

6. Health and Safety Risks

The table below outlines our key health and safety risks together with commentary on the current status/issues related to that risk and any actions to address issues. The table has been organised to list the Hazards (Risks) from higher risk to lower risk items. Please note that the table lists only the remaining amber and red risks. One Green risk (Hazardous Substances) remains on the table because of its significance within the organisation and the recent action to reduce it.

There are now seven risks on the table. One risk remains high, and six are amber risks. One risk was removed (Starship elevator issues) as the action plan to address is now part of an organisation wide plan for elevator safety. No new risks have been added for this report.

See Risk Matrix used to inform the Residual risk calculation in Appendix 5.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
Site Security 483RR	Access Control System and CCTV system experience on-going outage which occurs on a daily basis due to the age of both systems and lack of a preventative maintenance program over the past few years. Upgrade the maintenance protocols to reduce the down-time is required. Commercial Services now have operational control over both Access control and CCTV systems and are currently in the process of upgrading the access control system to a newer platform. The CCTV system is also being replaced by a new IP and VMS based CCTV system. Fortlock security systems have been selected as the preferred Contractor to carry out all works on the systems	A business case for an upgrade to the Access control and CCTV at both sites was accepted by the Board in December 2014. Steering group formed to oversee the management of this risk. Independent Consultant has reviewed plans and advised re the implementation model. There is an identified asbestos issue throughout Grafton and Greenlane sites but this is being carefully worked through by Facilities Management and close liaison with Commercial Services is underway in order to determine a safe pathway to accommodate the security systems upgrade. February 2017:: The steering committee continues to meet monthly; Good progress is being made with the new ID cards for all workers and the lock down technology	The risk remains high until the work to improve site and security systems is completed at Grafton, Greenlane Clinical Centre and Point Chevalier. This work is expected to be on-going for the next 12 months. Considerable progress has been made on prioritised areas in year one of the project. However a greater body of work will be required before the risk rating can be reduced.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
	upgrade and to carry out future R+M work on all security systems.	This project will be the focus of the March 2017 Board Health and Safety Engagement visit.	
Original Risk			Residual Risk (5x3) 15
Aggression - Physical and Verbal 479RR	Physical and verbal abuse directed at workers from patients and visitors primarily occurs in Mental Health, Adult ED, and some children's services. Although most result in minor harm each one has the potential to be very serious.	Safe Practice in the community (SPIC) training and the National collaborative on Safe Practice Effective communication (SPEC) has been agreed and training will commence in 2017. Discussion with a potential supplier for training for physical health area is underway and a tender process is to commence in early 2017. The steering committee Terms of Reference are under review and a new committee chair has been appointed. The committee will meet in May 2017 and identify goals and objectives for the coming year. A Health and Safety Advisor has been appointed to support this work.	Remains a medium risk while incidents are occurring. However work is being done to close any gaps in security and safety in the community. We are not sure if all accidents/near misses are reported.
Original Risk			Residual risk (4x3) 12
Auckland City Hospital Atrium Walkway barriers	The glass barriers on some of the levels of the Auckland City Hospital atrium walkway are lower than others. The lower barriers allow for people to climb over	Approval for part of the project was obtained in June 2016. Handrails have been removed to prevent	This risk could result in a death of a person attempting suicide. This is possible but rare. The risk will remain amber until the remediation is completed.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
563RR	them. Two recent attempts have been made by a member of the public both were interrupted by passers-by. There was a successful jump from level 6, three years ago. The person survived. Note that the existing barriers are compliant with the building codes for user safety in relation to accidental falls, the issue here is intentional falls related to suicide attempts.	climbing points.	
Original Risk			Residual Risk (5x2) 10
Greenlane Clinical Centre Dental Clinic	The design of the glass balustrades allow for people (patients and children) to climb over them.	Facilities and Development have investigated possible solutions using the existing materials. Due to new building regulations a retro fit solution is not possible. New balustrades are required and being quoted. As an interim measure a security guard has been posted in the areas to ensure that no one is allowed to climb onto the balustrade.	This risk could result in a serious injury or death if someone was permitted to climb onto the balustrade. The security guard is in place to mitigate this from happening. This scenario is possible but rare. The risk will remain amber until new balustrades are installed.
Original Risk			Residual Risk (5x2) 10
Slips, Trips and Falls (related to hazards in grounds and	Making up almost 25% of our incidents, slips, trips and falls, continue to be one of the most significant hazards as they are with any other industry worldwide.	Continue to report trends and liaise regularly with Facilities when repairs are required. Liaise regularly with the cleaning service to ensure that best	Risk remains at a medium level because of the unpredictable nature of this incident type. Many pieces of work are underway to minimise physical environment risk.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
buildings.) 478RR		practice wet floor risk management is a continual focus. A Pedestrian Safety committee was established in late 2016 and meets monthly to drive priorities based on risk.	
Original Risk			Residual Risk (3x3) 9
Traffic Management (loading bays/ parking) 388RR 465RR	The level 5 loading bay at Grafton has been identified as a Health and Safety hazard by Auckland DHB. The risk for pedestrians at both the Grafton and Greenlane sites is due to high volume of interactions between trucks, vehicles and pedestrians (including staff, patients, contractors, couriers, ambulance services and visitors) The Auckland DHB Traffic Management plan is awaiting direction from the Public Spaces Project.	A Pedestrian Safety steering group has been formed and monthly meeting are being held to agree priorities for remediation. Projects are being progressed with a risk based prioritisation approach. Pedestrian Safety Project update <u>Auckland City Hospital Grafton</u> • Pedestrian crossing outside Transition Lounge o x2 (1 each side of crossing) • Cart Docks o x1 between Cart dock 1 and 2 o x1 at end of Cart dock 3 • Building A08 o x1 under the Air Bridge to A01 o x1 at stop sign at intersection of A01/A08/A07 o x1 at A08 main entry side stairs,	The risk remains moderate until the work to improve traffic safety is completed at Grafton and Greenlane Clinical Centre and a Traffic management plan is established.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
		o x1 at bottom end of A08 on exit road to Domain • Building A35 (Mental Health) o x1 before the pedestrian crossing • Building A15 (FMU) o x1 before the pedestrian crossing. • Building A43 (Marion Davis Library) o x1 uphill from bend in roadway before the pedestrian crossing becomes visible. o Paint the existing Marion Davis library pedestrian crossing in-laid asphalt judder bar with road marking colours as per Car park B • Starship/Car park B Vicinity o x2 full road width judder bars o Paint out the existing pedestrian crossing in-laid asphalt judder bar with road marking colours as per Car park B <u>Greenlane Clinical Centre Greenlane</u> • Building G04 main entrance o Upgrade current width 50mm height with 75mm full width	

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
		• Building G17 o x1 close to bus stop on road to Claude Road. • Building G16 – o x1 at a mid-point between Claude Road Entrance Gate and G15 pedestrian crossing. Install works anticipated commencement in 2 weeks. Works to be conducted is the Claude Road Entrance – Install new pedestrian crossing with footpath ramps just above vehicle gates/Gate House.	
Original Risk			Residual Risk (4x3) 12
Asbestos 524RR	There are a number of buildings utilised by Auckland DHB that contain asbestos. The Auckland DHB Facilities Asbestos register requires updating. Contractor compliance with asbestos hazard management is unclear.	Collaboration with Waitemata DHB is underway in relation to asbestos management plan and communication plan. The main Auckland DHB contractors likely to undertake work in areas where asbestos have been identified are required to undertake Asbestos Awareness Training. Building surveys are nearly complete and the Asbestos Management Plan has been reviewed by Health and Safety specialists	Asbestos in situ is safe if in good condition and not disturbed. The risk remains moderate due to the extent of asbestos in our buildings and the requirement to undertake planned and unplanned work on the structure of the buildings.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
		at Meredith Connell. And recommended changes made.	
Original Risk			Residual Risk (4x2) 8
Facilities Lifts 502RR	A number of issues in relation to elevator repairs and maintenance. This has resulted in lift malfunction where people have been trapped in the lifts.	Five year Lift replacement plan in place.	The risk reduced to moderate as the review of all lifts is now completed and remedial work is underway.
Original Risk			Residual Risk (4x3) 12

7. WorkSafe NZ Notifications

Notifiable Events (Staff) (previously called Serious Harm)
Auckland DHB noted the following serious incidents (now Notifiable Events) reported to WorkSafe NZ in the 2016/17 fiscal year.

Staff Notifiable Events (1 July 2016- 31 March 2017)

1)	28 August 2016	Severe Laceration	Dog Attack
2)	16 January 2017	fractured ankle	Trip/Fall community visit

There was no Notifiable Events in March 2017.

Notifiable Events/ Incidents (Patients and Visitors)
No Notifiable injury or illness to patients or visitors was reported in March 2017

Notifiable Events/ Incidents (Other Workers)

No Notifiable Events to other workers reported to WorkSafe NZ in March 2017

8. Staff Reported Incidents

The number of reported incidents by staff (occurrences) during the period 1-31 March 2017 amounted to 183, an increase of 31 % from last month. Please note that not all incidents result in harm to staff.

Directorate Abbreviations for Table 2:

AMS: Adult Medical Services Directorate
C&B: Cancer and Blood Services Directorate
CS: Cardiac Services Directorate
CH: Children's Health Services Directorate
CSS: Clinical Support Services Directorate
CLTC: Community and Long Term Conditions Directorate
Corp: Corporate Services
MH: Mental Health Services Directorate
NCSS: Non-Clinical Support Services
POS: Perioperative Services Directorate
SS: Surgical Services Directorate
WH: Woman's Health Services Directorate

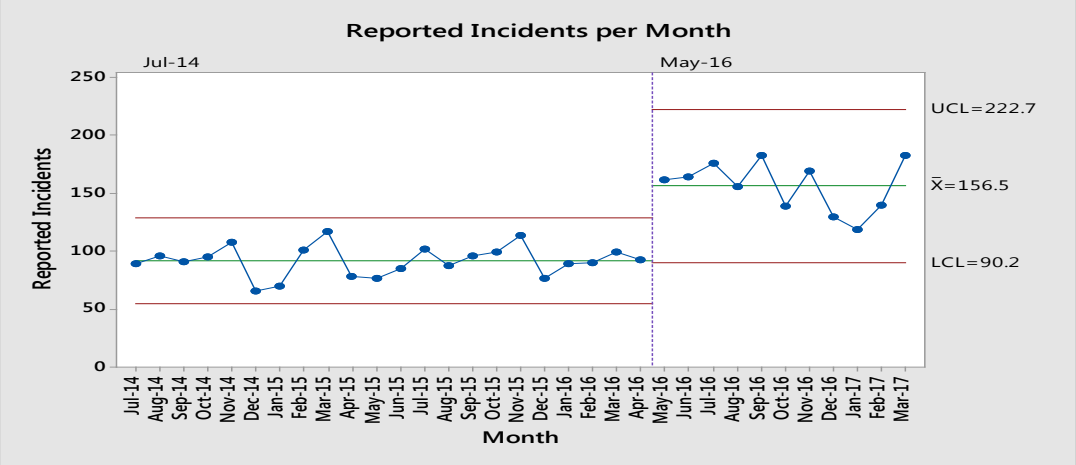


Table 1 – Total incidents reported by staff per month to March 2017.

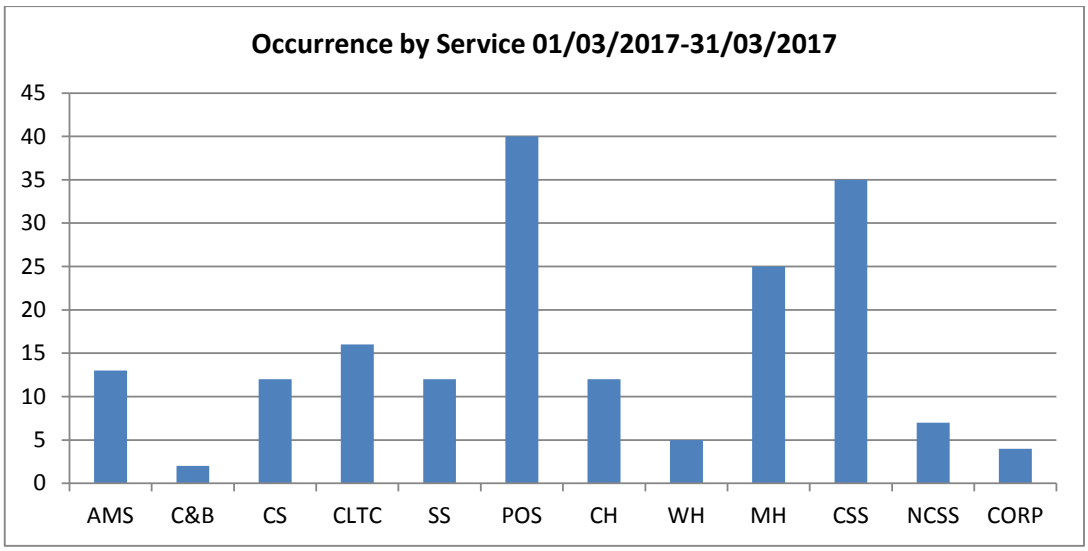


Table 2 – Incidents by Directorate – 1 - 31 March 2017

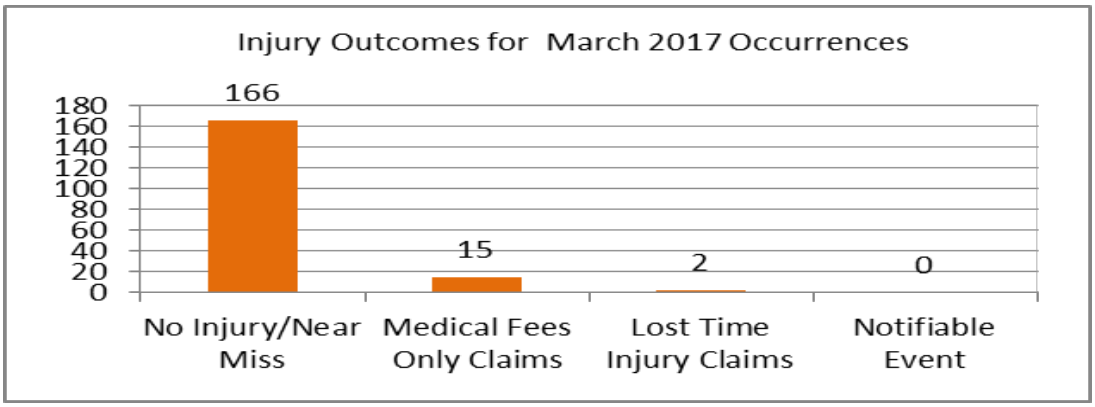


Table 3 – Incidents by Injury outcomes – 1 - 31 March 2017.

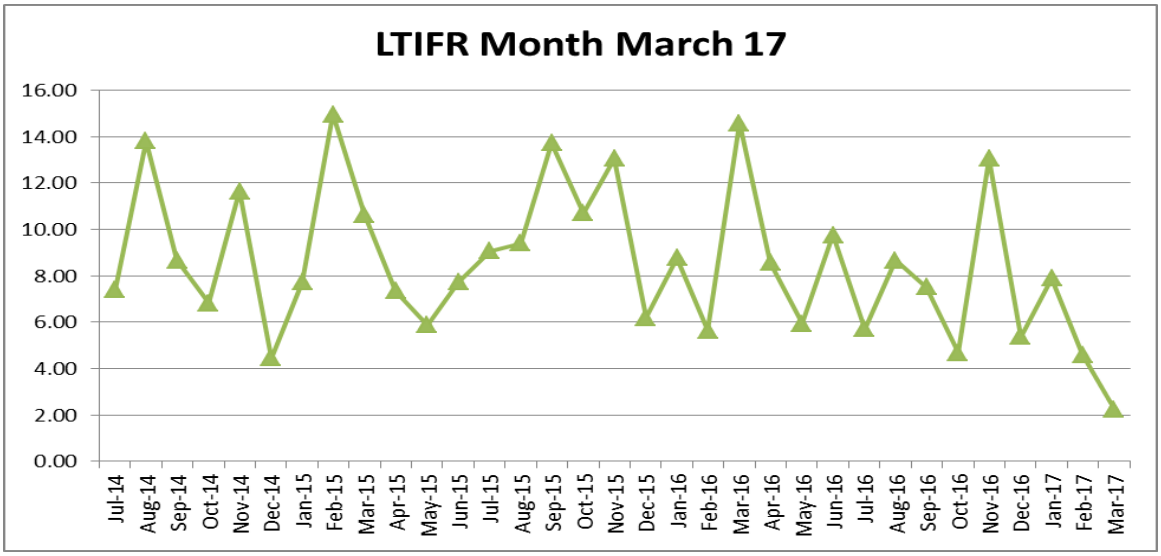


Table 4 – Lost Time Injury Frequency Rate by Month (August'14 – March'17)

Table 5 - 21 claims by Injury type for March 2017

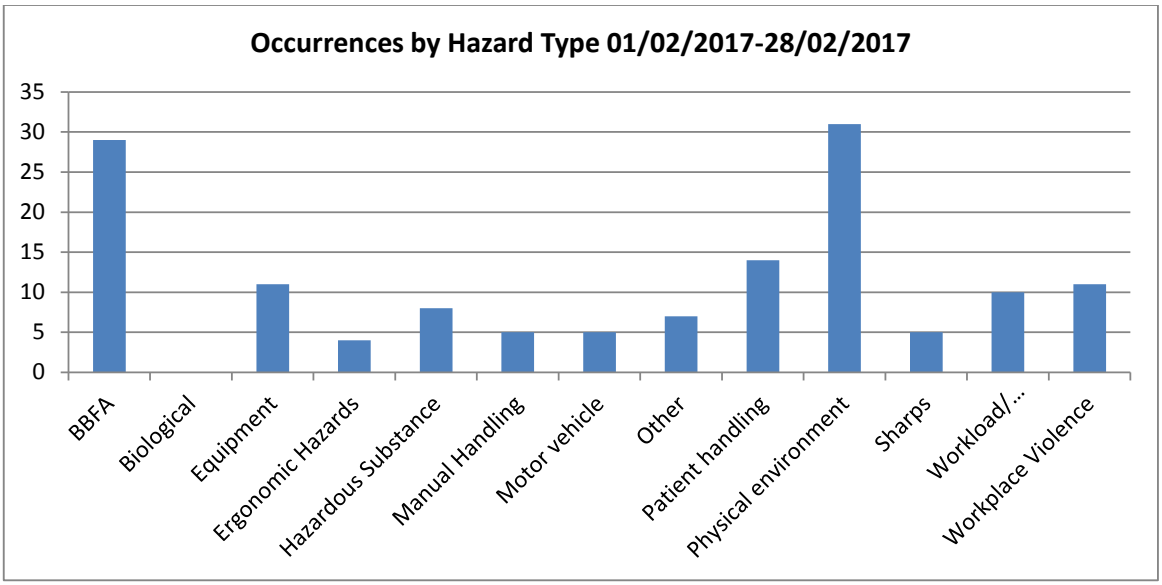
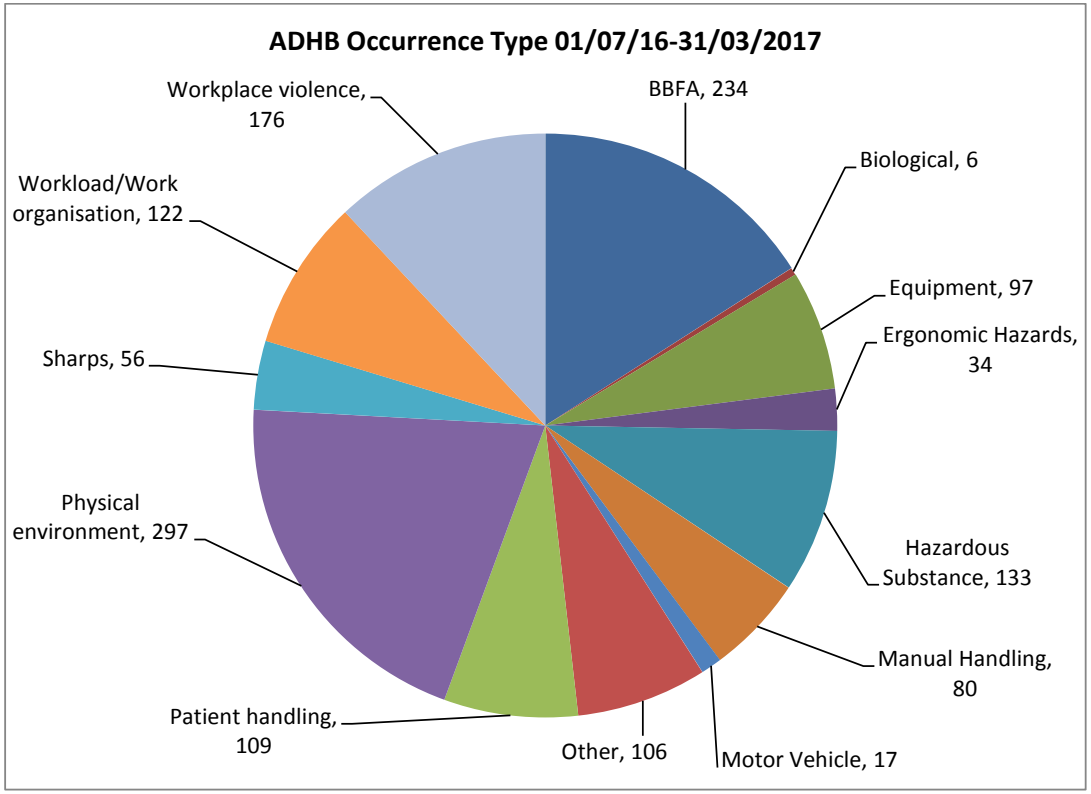


Table 6 – 183 Incidents (Ocurrences) By Hazard Type – March 2017.

Table 7 – Fiscal Year to date Occurrences by Hazard type (YTD for 16/17 fiscal year).

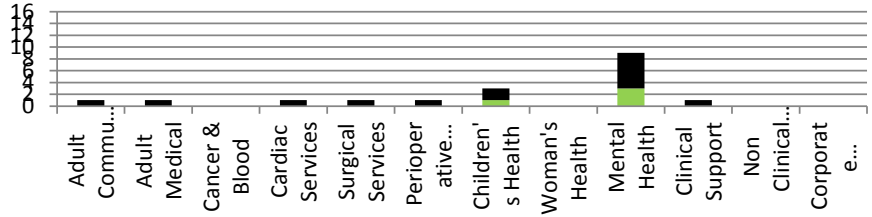


9. Top Three Incident Types Which Caused Harm (Occurrences and Claims)

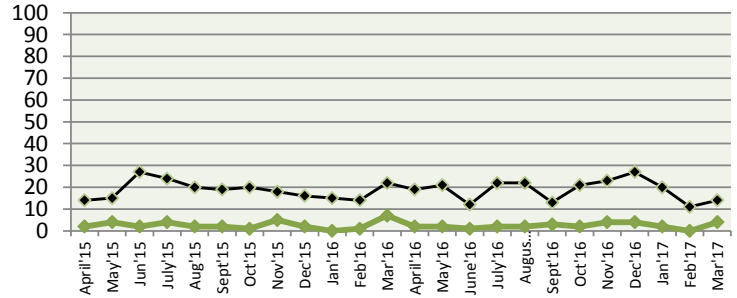
CLAIMS OCCURANCE

WORKPLACE VIOLENCE AND AGGRESSION:

Workplace Violence Injuries 01/03/2017 - 31/03/2017

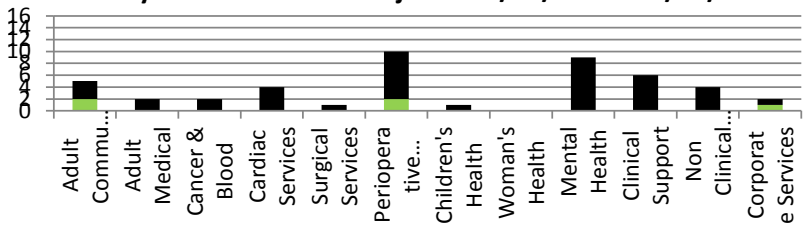


From 2 Year Rolling

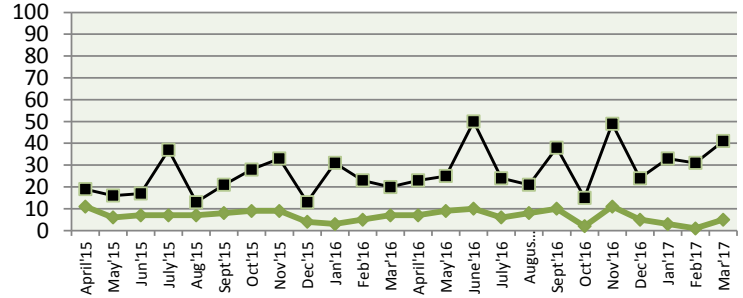


PHYSICAL ENVIRONMENT:

Physical Environment Injuries 01/03/2017 - 31/03/2017

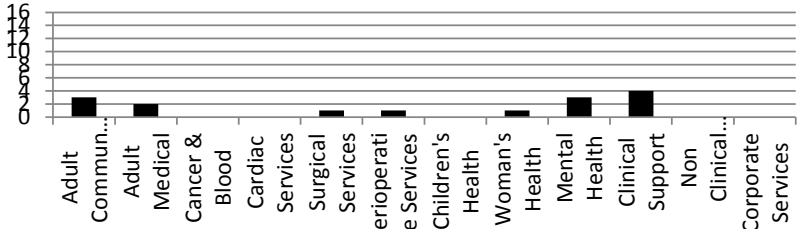


From 2 Year Rolling

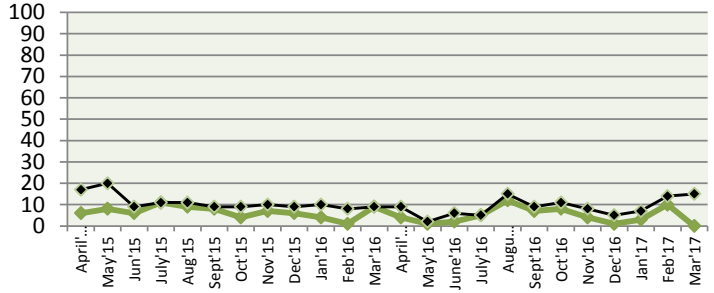


PATIENT HANDLING:

Patient Handling Injuries 01/03/2017 - 31/03/2017



From 2 Year Rolling



10. Health and Safety Activities

ACC Partnership Programme Audit: Audit date: 6-9 December 2016
The audit consists of a Health and Safety systems and Injury Management systems desk top audit, site inspections, case reviews and focus groups. Audit completed, Tertiary maintained. Action plan to implement auditor's recommendation in place. Progress is reported to Finance Risk and Audit Committee. The next audit will be in late 2017.

Health and Safety Rep Training
As per HSWA, external training is now required for Health and Safety Reps. A supplier has been selected and NZQA stage one training scheduled to June 2017. Eight courses are now in KIOSK (February to June 2017). Approx. 190 out of 317 (61%) Health and Safety reps are now trained under the new legislation.

Asbestos
The Asbestos Management Group meets monthly. The Asbestos Management Plan is nearing completion and a communication plan has been developed. A presentation on understanding the asbestos management approach at Auckland DHB has been prepared and is being presented at all Directorate Health and Safety Committees. The Asbestos Management Plan has been review by Auckland DHB external legal firm.

Managing Safely
The courses for 2017 have been set up in Kiosk. This has been promoted through the Directorate leadership team. Courses are well subscribed for early 2017. Approximately 220 managers have now completed this course.

Board Health and Safety site visits
A new schedule for visits in 2017 has been developed. Risk topics for March, April and May have been set. The dates of the visits have been aligned with the Finance, Risk and Assurance Committee meeting and will occur one week before this meeting. Board members are scheduled as per their availability and on the advice of the Chair. The March 2017 visit focused on the Security for Safety Project, April: Moving and Handling and May: Hazardous Substances and June: Traffic Management/Pedestrian Safety at Grafton.
The next visit is 31 May 2017.

Month	Day	Visit Date	Finance, Risk and Assurance Committee Meeting Date
April	Wednesday	**19 April 2017**	26 April
May	Wednesday	**31 May 2017**	7 June
July	Wednesday	**12 July 2017**	19 July
August	Wednesday	**23 August 2017**	30 August
October	Wednesday	**4 October 2017**	11 October
November	Wednesday	**15 November 2017**	22 November

Health and Safety Update Road Show:
A Health and Safety update presentation has been developed and will be presented to all Directorate management Teams by Sue Waters and Denise Johnson throughout March and April. The presentation provides updates on Health and Safety process and system changes since

then new legislation as well as recommendations regarding Health and Safety performance improvements in relation to the individual Health and Safety score cards.

Regional Employee Participation agreement with the joint Unions:
The agreement has been reviewed as per HSWA and is being circulated for signing. Two or three of the unions have not yet signed.

Auckland DHB Health and Safety Committees
The Auckland DHB Health and Safety Governance Committee meets six-weekly, chaired by Sue Waters, and last met on 19 April 2017. All Directorate Health and Safety committees continue to meet regularly. Monthly Directorate Health and Safety Reports are provided to support the committees.

Safety Management System (Datix):
Health and Safety is working with the Quality team to implement the new Safety Management System. Health and Safety incident reporting and Hazard reporting has transitioned to the new system. . Health and Safety participated in the manager training forums. Training for Health and Safety Reps was provided in April. Health and Safety will continue to support the transition to the new system.

Auckland DHB Moving and Handling Steering Committee
The Auckland DHB Moving and Handling steering committee chaired by Brenda McKay meets monthly. The Bariatric Bundle trial now completed and a paper will be presented to the ELT. Work has commenced on a fall retrieval bundle. Moving and Handling was the topic for the April Board Safety Engagement Visit.

Auckland DHB Violence and Aggression Steering Committee
Violence and Aggression Steering Committee Terms of Reference are under review to ensure membership includes all stakeholder groups. The Chairperson is Anna Schofield. A Health and Safety Advisor has been appointed to support this work. The committee will meet in May 2017.

New Health and Safety Legislation
See Appendix 3 for a detailed work plan with due dates and accountability.

Health and Safety Team
There are currently two vacancies on the Health and Safety Team. Recruitment will continue for two Health and Safety Advisors and contractors have been engaged to provide services in the interim. Health and Safety Advisor Team Leader position is on hold and current being filled by a contractor.

Deep Dive Audits
A proposal for a repeat deep dive review of Auckland DHB Health and Safety systems audit has now been agreed. Preparation is now underway to undertake this audit in June 2017 with a report to the Board in July 2017.

Waitemata DHB was approached for feedback in relation to a joint audit as per the Ernst and Young Systems review conducted in 2015. They have declined as their internal audit schedule for 2017 is already set. We have agreed to meet to share audit results and learning when the June Audit is completed.

Regional Collaboration:
There are a number of Regional Collaboration activities underway between the three Metro DHBs. Some examples are: Regional Employer Assistance Programme Supplier, Asbestos Management, Hazardous Substances, the Employee Participation Regional Agreement with the Joint Unions, KoAwatea Learn courses as possible, Safe Practice training in Mental Health Services, Community Safety training, as well as Health and Safety report sharing and alignment as practical.

Auckland DHB is now also aligned with WDHB and CMDHB in relation to the ACC Partnership Programme third party administrator. All there DHB now use Wellnz. Regional benchmarking of injury management related data is being discussed.

11. Facilities and Development Health and Safety Report on Activity

Contractor Management

Auckland DHB Facilities and Development department continues to work Leigh's Construction Limited to ensure that the contractors and workers they have engaged to work on the refurbishment of Level 5 of Starship Hospital are loaded into the contractor management system. This information provides Auckland DHB with an oversight of the contractor's safety management systems and processes.

Leigh's have combined the PAE induction process into their own site inductions so that they can inform workers of the Auckland DHB specific requirements and their own site expectations. The inductions were found to be informative and well run. They include a quiz, with questions on the key points. Each worker signs a deceleration that they have received and understood the information prior to being loaded into the Leigh's contractor database and being given access to their site.

Leigh's also holds a site health and safety meeting for all of their contractors, the minutes and discussion held during the meeting were found to be relevant and topical. Reported incidents and feedback from audits were discussed, as well as the mandatory PPE requirements and Auckland DHB health and safety expectations.

Currently Leigh's are actively managing there PPE requirements and have adopted a one strike (if a worker is caught without the appropriate PPE) and you get a verbal warning. For re offending the worker will be stood down for a day. Auckland DHB will follow this initiative closely to see how effective these measures are at improving worker behaviours and safety performance.

Facilities have been asked by Commercial Services to be involved with the planned work to remove the two small freezers in the kitchen. The work commissioned by Compass Group has involves critiquing the Site Specific Safety Plan (SSSP), site visits, scoping the area for asbestos. The only potential area of asbestos could be under the freezer floor plate depending on if the vinyl floor tiles have been previously removed or not. Controls will be put in place to manage this if asbestos is detected when the floor plates are ready to be up lifted. The contractors involved with this project have also been loaded in to the Auckland DHB contractor management database.

Current Initiatives

As an initiative based on the findings from the external health and safety review undertaken on a range of the Auckland DHB key contractors. Facilities are organising a contractor's forum. The aim of this forum is to provide an opportunity to engage with PCBU's and discuss WorkSafe NZ initiatives and how they are responding to the Act.

It is also to share information and organisational initiatives, look for opportunities to improve and to get the different PCBU's working at Auckland DHB Engaged. A focus for 2017 will be to have initiatives that provide focus, information, practical solutions and ways that the organisations could improve to meet Auckland DHB health and safety expectations and the requirements of the new legislation.

Facilities are also working with Watercare Services Limited on a Trade Waste Agreement for Auckland City Hospital. This process has involved providing estimated volumes of water usage from high demand plant such as RO (Reverse Osmosis) plant used to sterilise water, boilers and the kitchen area. Information has also been provided on estimated building occupants and staff

numbers. Watercare have also reviewed documentation including the Auckland DHB Trade Waste Policy, Hazardous Substance Inventory and staff awareness information or previous campaigns relating to what is allowed to be put into the drains and what is not. As a result of their feedback it is planned to tidy up the Auckland DHB documentation and communicate with staff on the Watercare requirements, so that we can fulfil our obligations.

The initiatives that are currently a focus are: Modifying the Take 5 process. It has been decided to use the PAE and the handyman service as a sounding board prior to modifying this process. PAE undertake approximately 3000 jobs per month, ranging from very low risk to high risk. Feedback is currently being sought from these workers on possible improvements to the form.

This process has been well received by the incumbent contractors at Auckland DHB, so the intention now is to 'beef up' the process so that we move from just a tick box check sheet to a process that will require the contractors to provide comments and additional information for some of the questions.

ConstructSafe

Facilities have followed on the information sent to Auckland DHB Board members and Senior Management from the Construction Safety Council NZ, in relation to their scheme based on assessing the competencies' of construction workers.

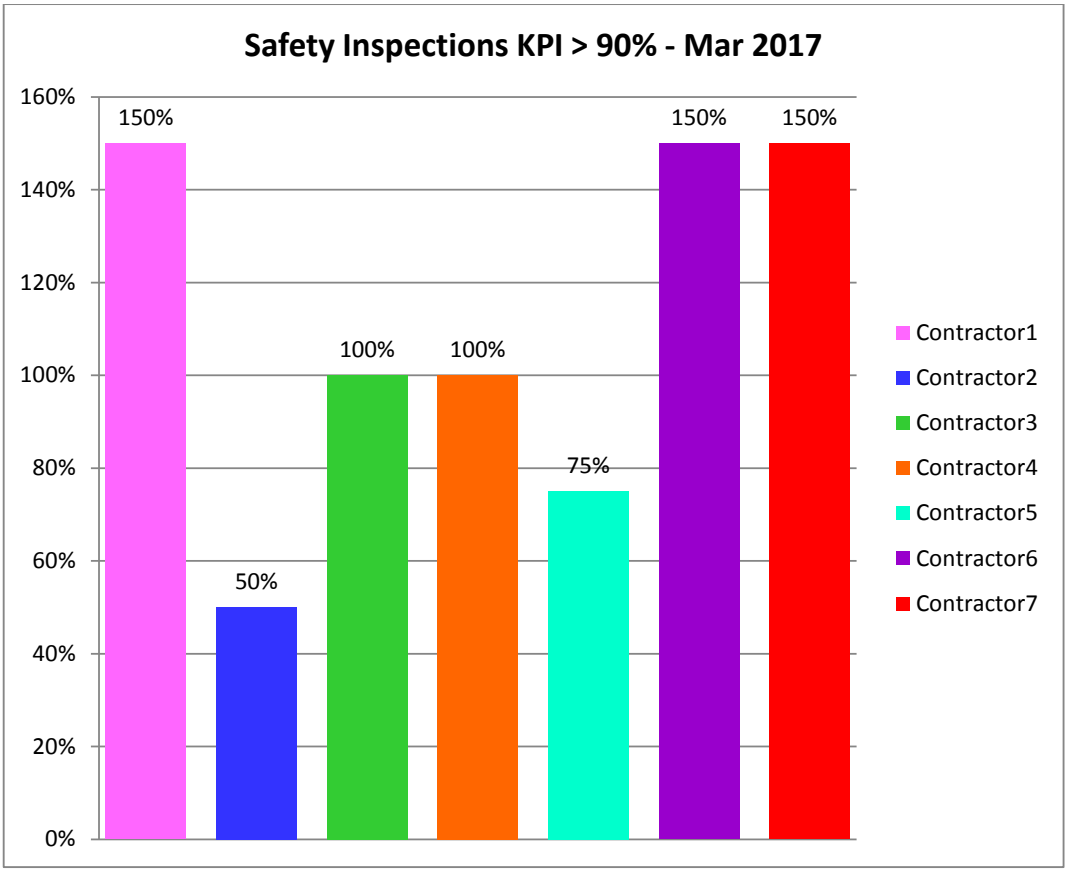
The test is interactive and arranged via an accredited ConstructSafe test centre. A ConstructSafe card is issued to those who successfully pass the test so they can prove that they have the necessary skills and knowledge to carry out work safely.

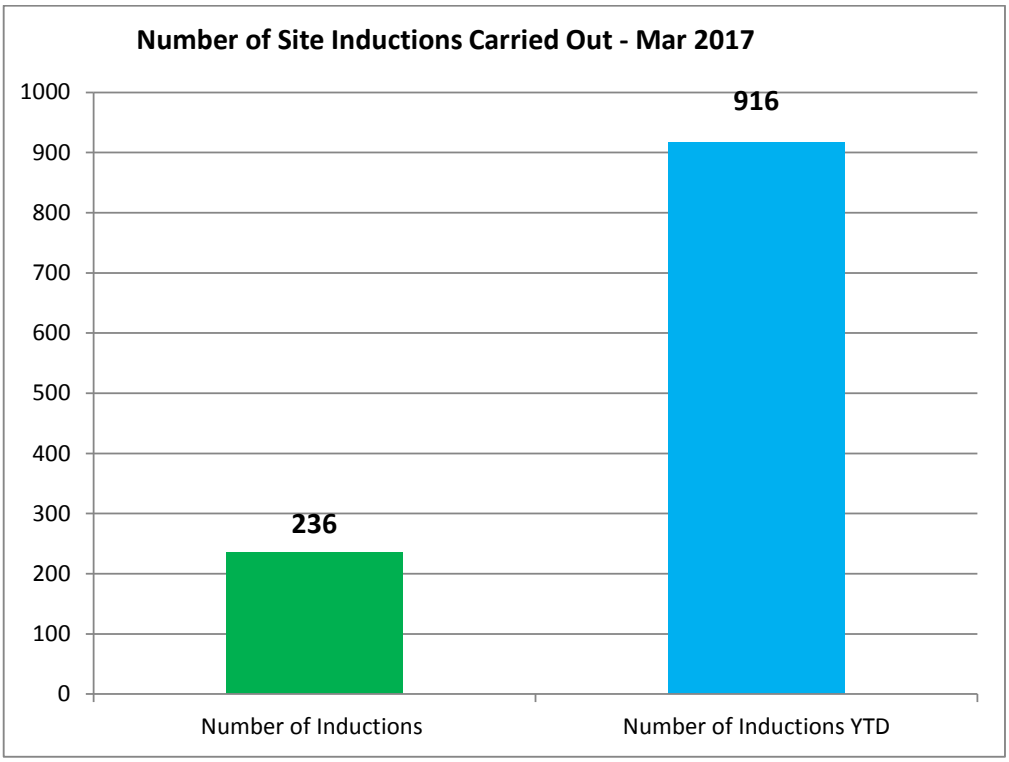
All of the Facilities staff that took the test passed.

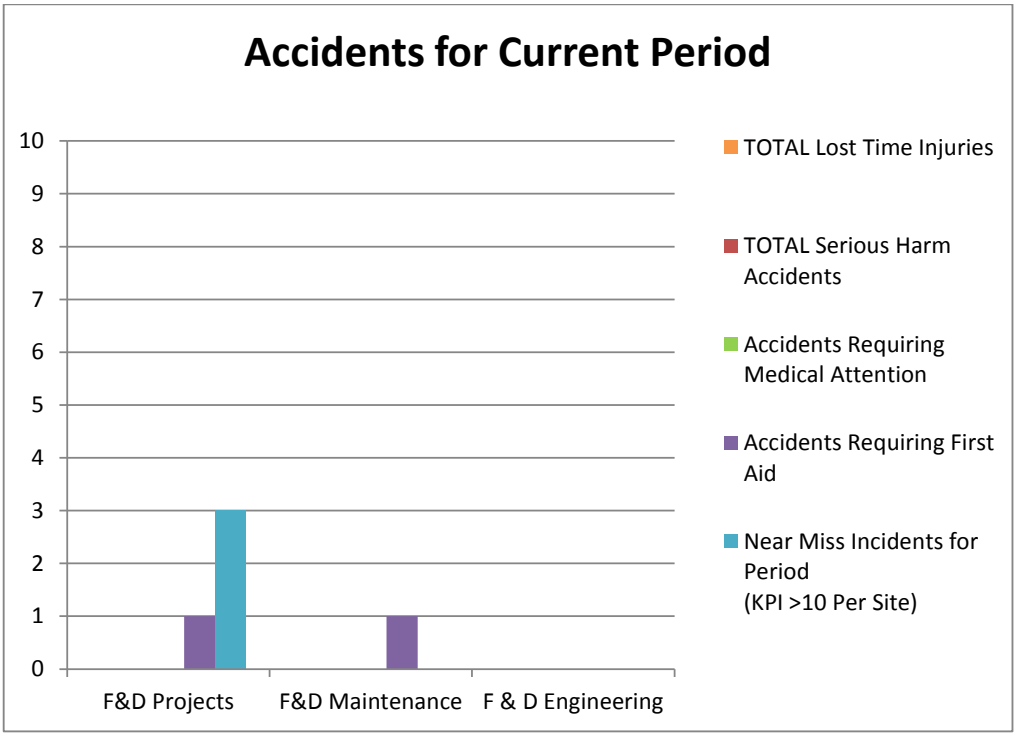
Facilities and Development Monthly Statistics

236 contractors have been inducted onto site during March and the yearly total is now standing at 916 inductions completed for workers physically working on site.

The number of inductions reflects the volume of work and projects that Facilities and Development are currently managing especially around Starship.


Safety Inspections KPI > 90% - Mar 2017
160%
140%
120%
100%
80%
60%
40%
20%
0%
150%
50%
100%
100%
75%
150%
150%
Contractor1
Contractor2
Contractor3
Contractor4
Contractor5
Contractor6
Contractor7


Number of Site Inductions Carried Out - Mar 2017
1000
900
800
700
600
500
400
300
200
100
0
236
916
Number of Inductions
Number of Inductions YTD



Two minor first aid incidents were reported in March. One involved a Metalworker that was undertaking work on the Cath Lab stair installation. He caught his lower leg on bottom plate of stanchion resulting in a small cut to his left leg. The other incident involved a plumber being struck by pipe work that he was installing. The main cause of this accident was due to the working area being set up poorly. The outcome of the investigation was raised the weekly safety meeting *to remind all of the consequences when working at height off a platform ladder either with demolition, or installation of new services/plant.*

This is a perfect example of carrying out a 5x5, as discussed during our site induction, before and during your works. Step back 5 paces and think for 5 minutes and plan your work.

A fine example of a minor injury which was very easily preventable.

12. Directorate Health and Safety Reports

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

Click on Directorate Title to access the report.

- Adult Medical
- Cancer and Blood
- Cardiac Services
- Children's Health
- Clinical Support
- Corporate
- Community and LTC
- Mental Health
- Non Clinical Support
- Perioperative
- Surgical Services
- Women's Health

Adult Medical Services Health and Safety Report

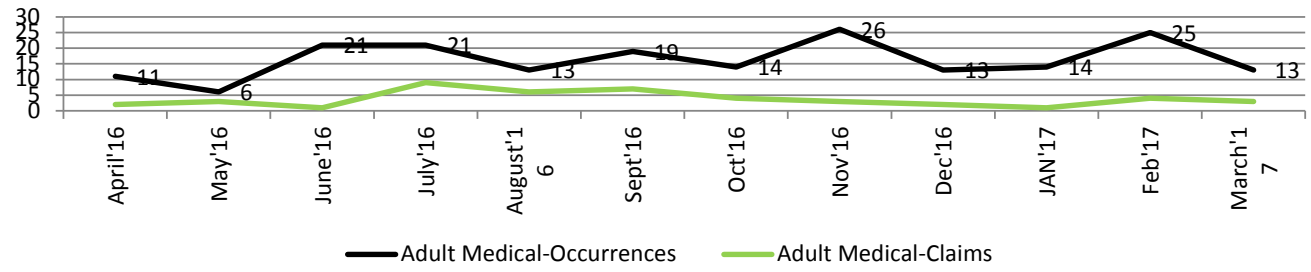
Lagging

	Actual	Target	Trend
H&S Incidents	13	20	
Work Injury Claims	3	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

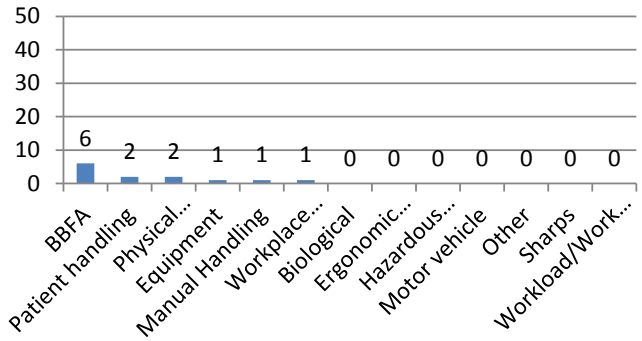
Leading

	Actual	Target	Trend
%H&S Inductions	25	100	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	50	80	
%6 Monthly Workplace Checklist	78	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	75	80	

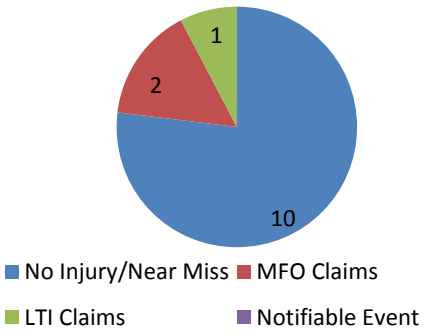
Health and Safety Incidents and Claims for 12 months



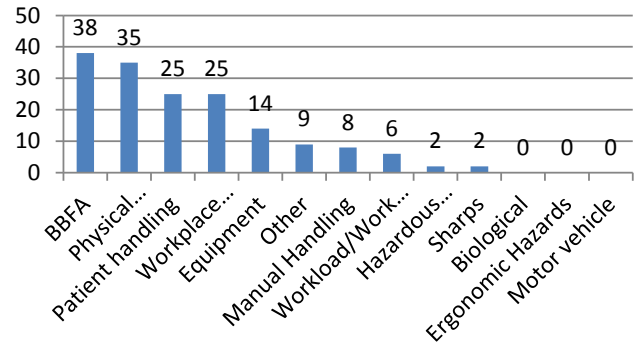
Health and Safety Incident by Hazard Type for March 2017



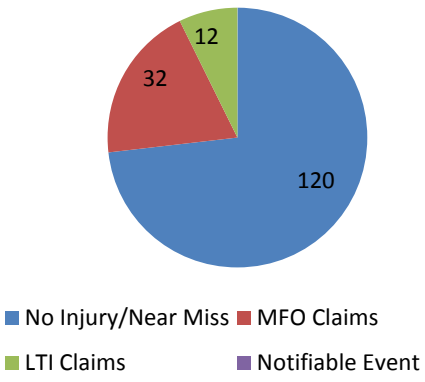
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)



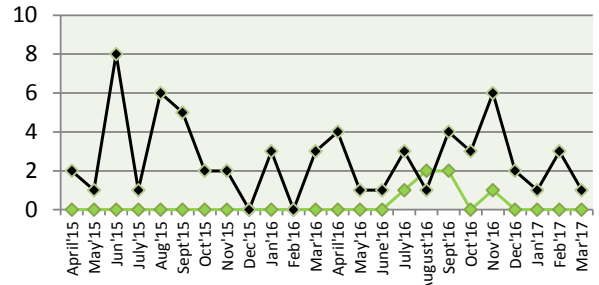
Work Injury by Outcome Type – YTD (2016-2017)



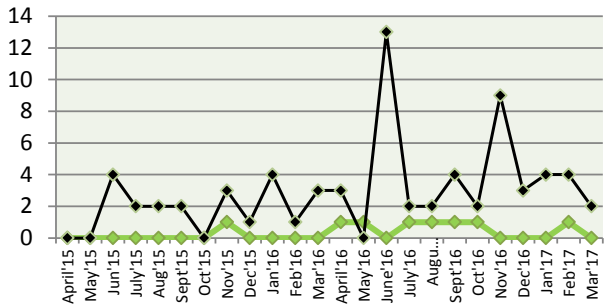
Adult Medical Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

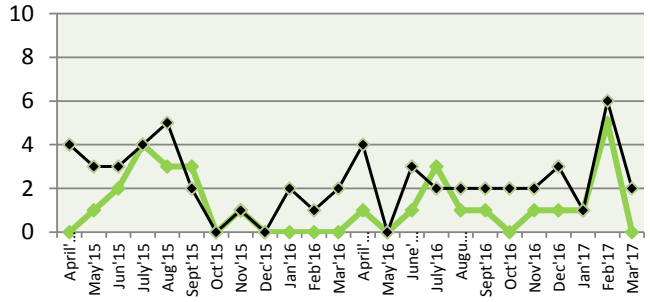
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



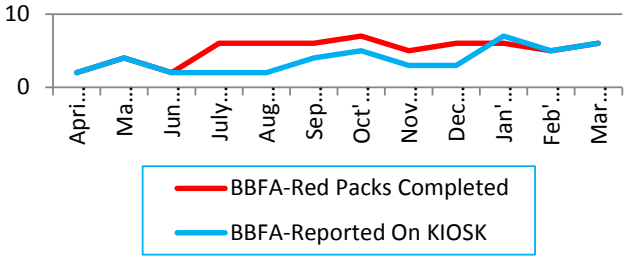
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

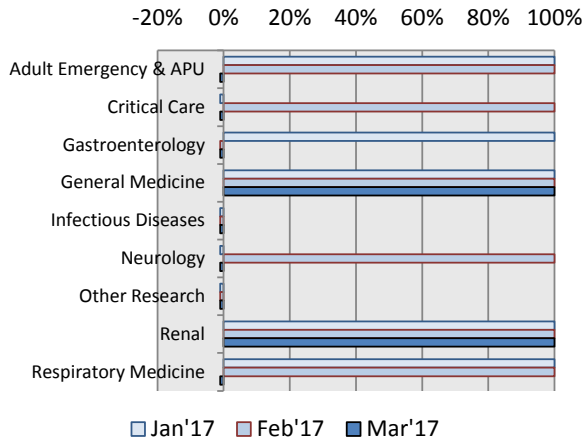


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



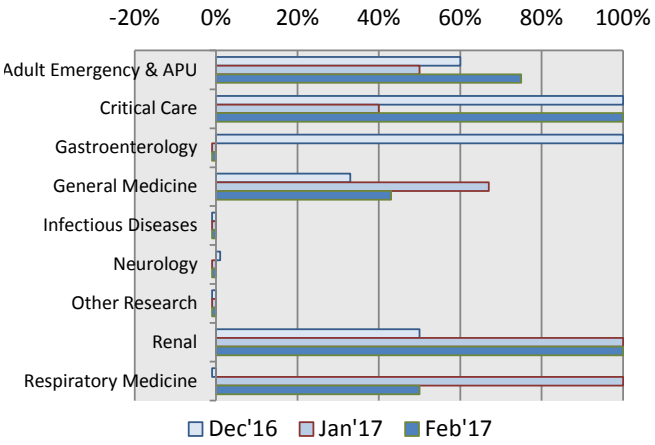
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	81%	67%	75%



Information data accurate as of 4/4/2017

*Incident data 1 month lag to allow for Manager's investigations

Cancer and Blood Services Health and Safety Report

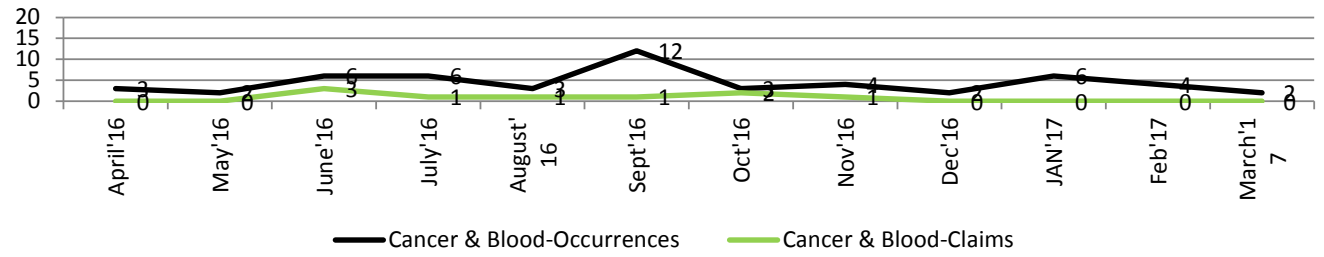
Lagging

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

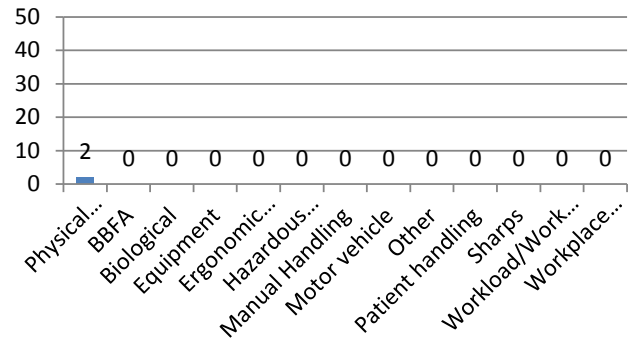
Leading

	Actual	Target	Trend
%H&S Inductions	0	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	40	80	
%H&S Rep Checklist	43	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	50	80	

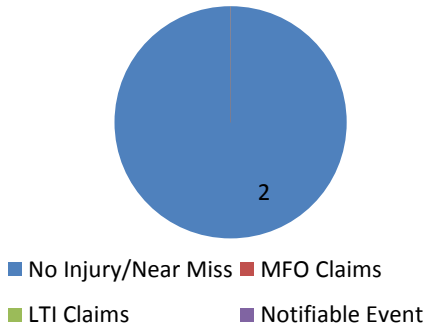
Health and Safety Incidents and Claims for 12 months



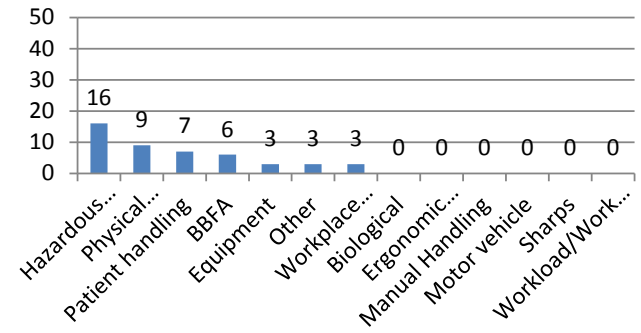
Health and Safety Incident by Hazard Type for March 2017



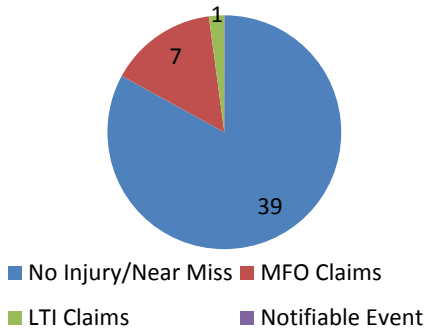
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)

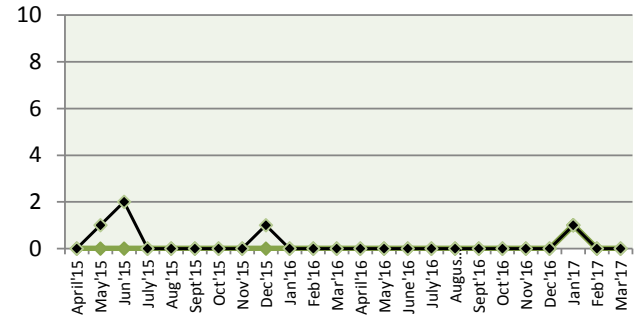


Work Injury by Outcome Type – YTD (2016-2017)

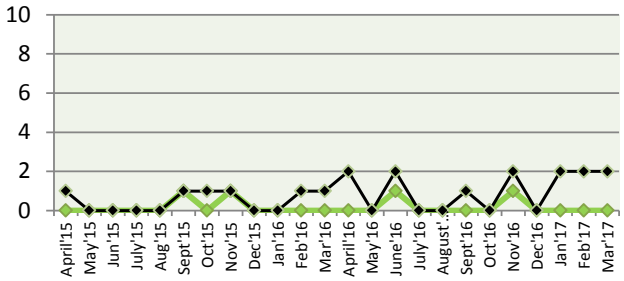


LEGEND: CLAIMS Health and Safety INCIDENT

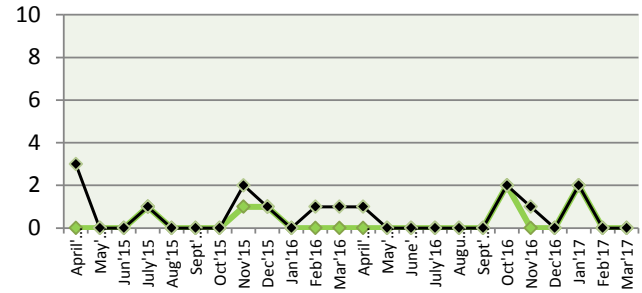
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



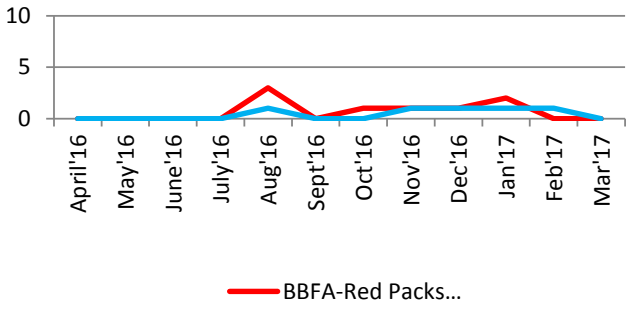
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

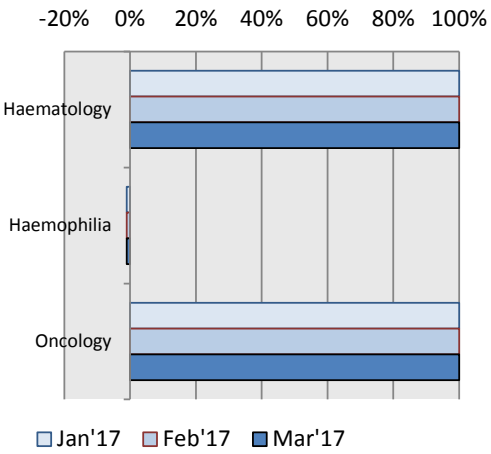


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



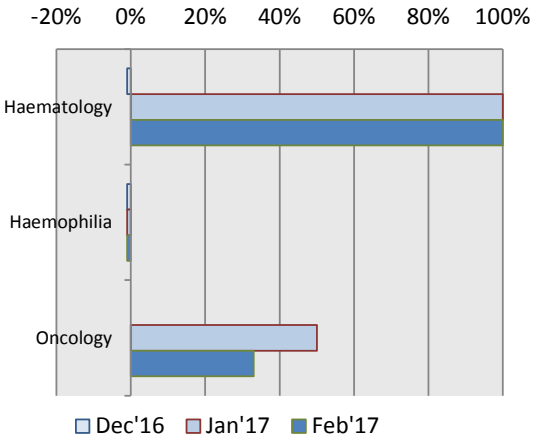
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	100%	67%	50%



Information data accurate as of 4/4/2017

*Incident data 1 month lag to allow for Manager's investigations

Cardiac Services Health and Safety Report

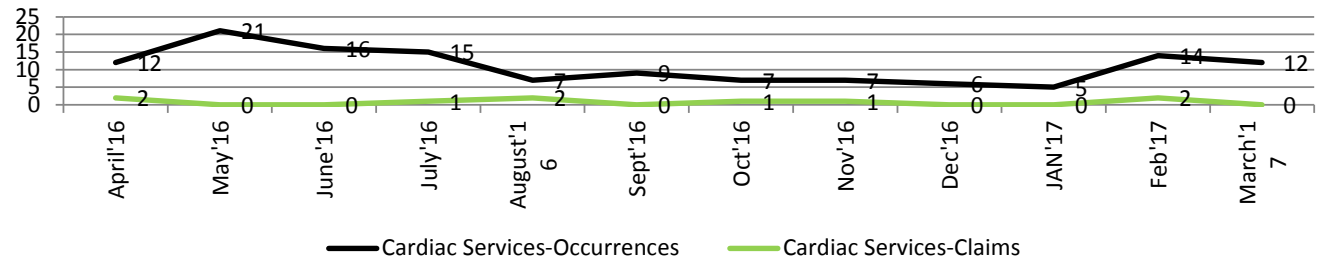
Lagging

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

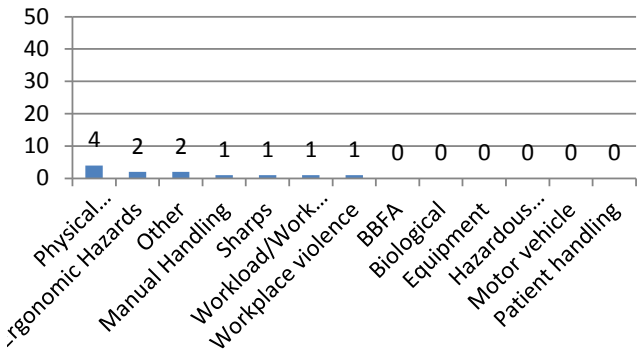
Leading

	Actual	Target	Trend
%H&S Inductions	29	100	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	63	80	
%6 Monthly Workplace Checklist	60	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	60	80	

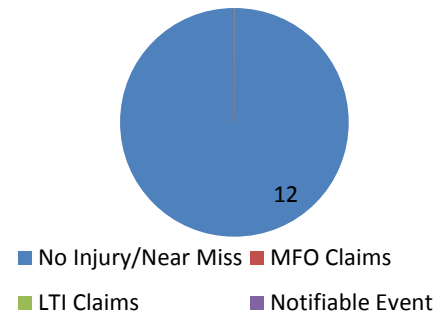
Health and Safety Incidents and Claims for 12 months



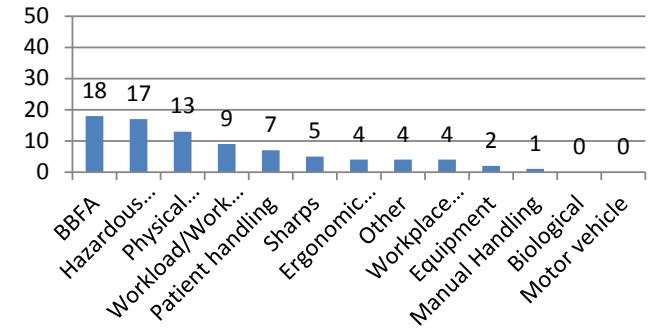
Health and Safety Incident by Hazard Type for March 2017



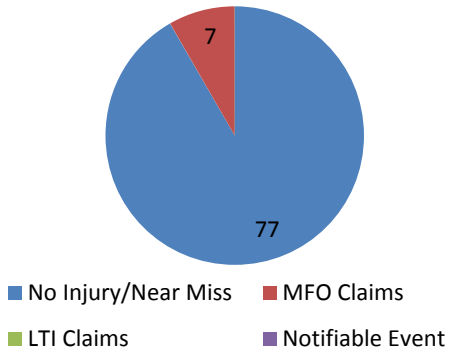
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)



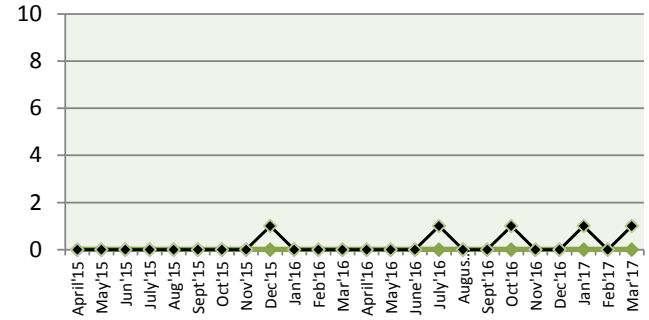
Work Injury by Outcome Type – YTD (2016-2017)



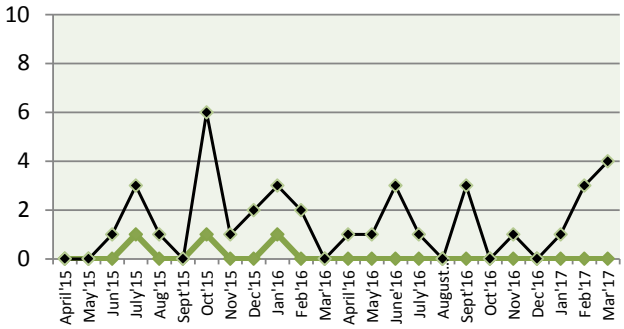
Cardiac Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

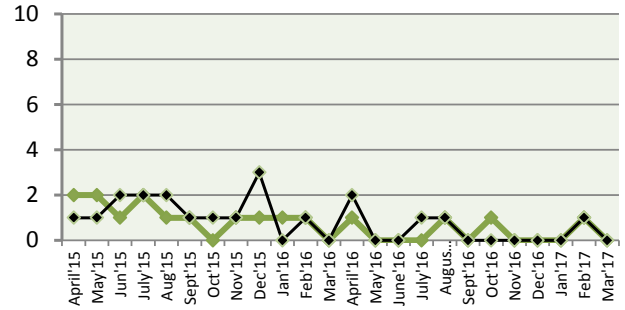
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



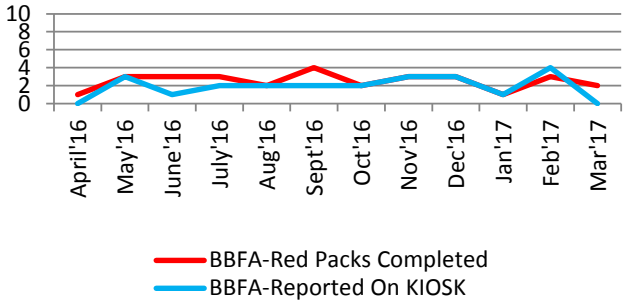
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

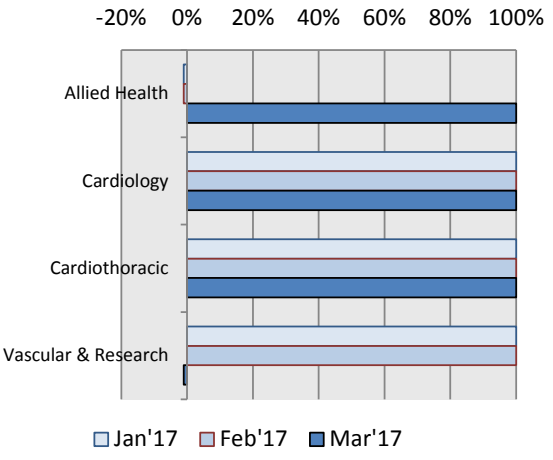


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



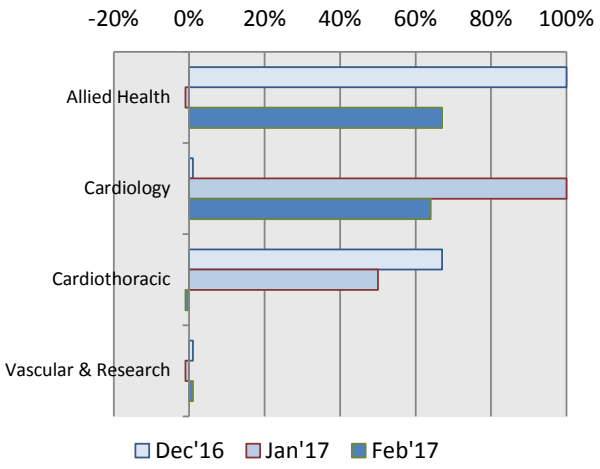
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	50%	60%	60%



*Incident data 1 month lag to allow for Manager's investigations

Information data accurate as of 4/4/2017

Children's Services Health and Safety Report

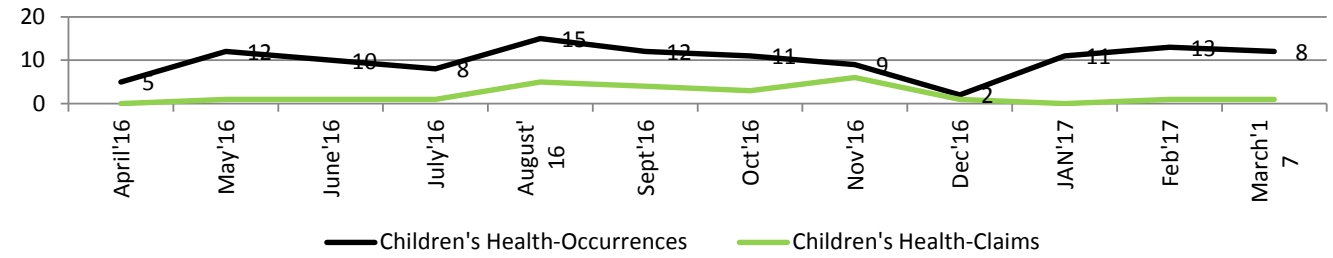
Lagging

	Actual	Target	Trend
H&S Incidents	12	20	
Work Injury Claims	1	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

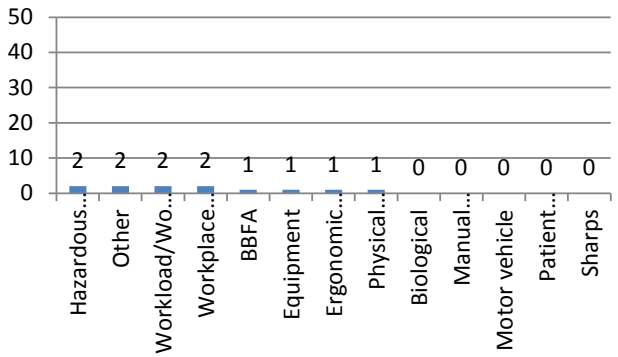
Leading

	Actual	Target	Trend
%H&S Inductions	50	100	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	55	80	
%6 Monthly Workplace Checklist	30	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	64	80	

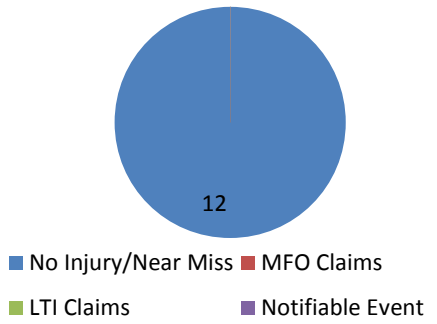
Health and Safety Incidents and Claims for 12 months



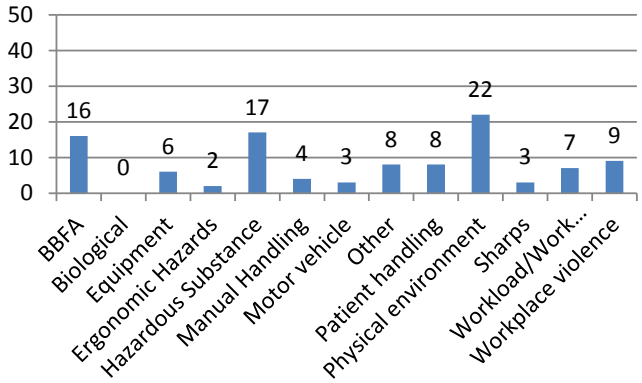
Health and Safety Incident by Hazard Type for March 2017



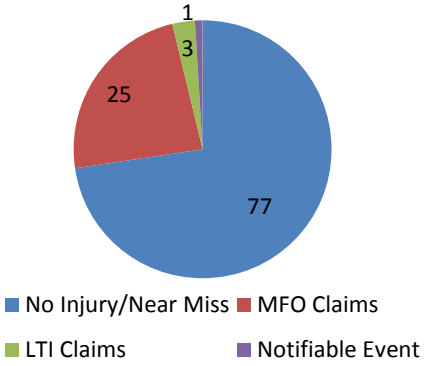
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)

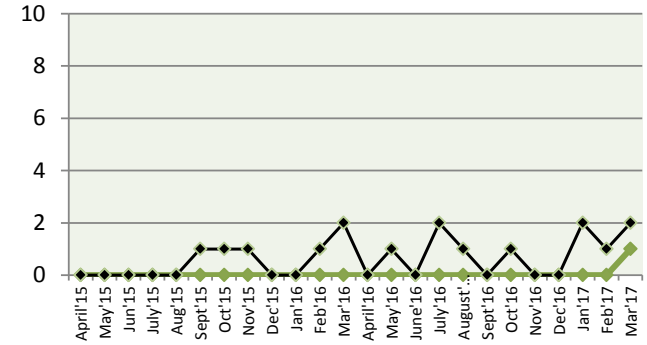


Work Injury by Outcome Type – YTD (2016-2017)

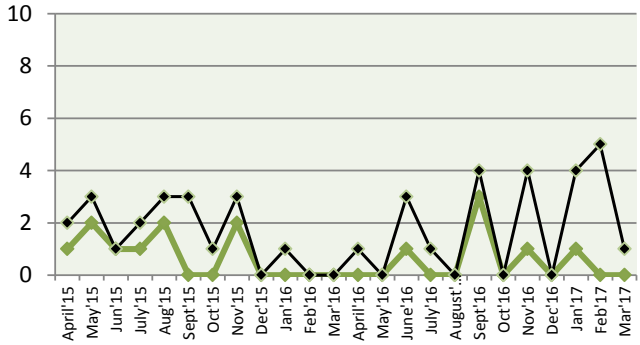


LEGEND: CLAIMS Health and Safety INCIDENT

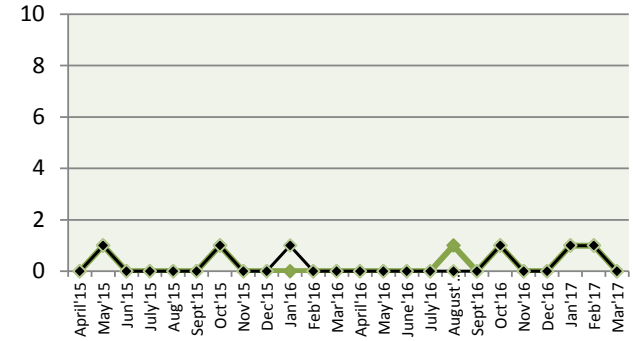
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



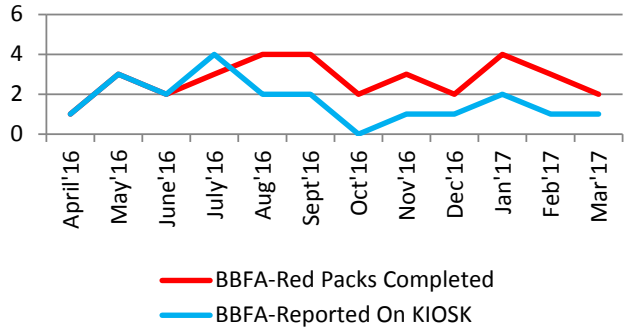
PHYSICAL ENVIRONMENT
((From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

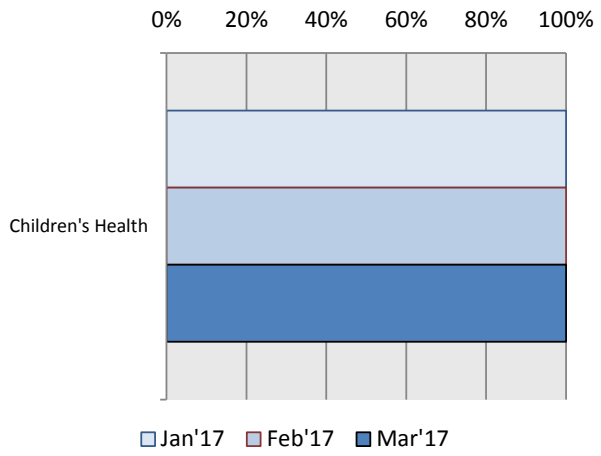


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



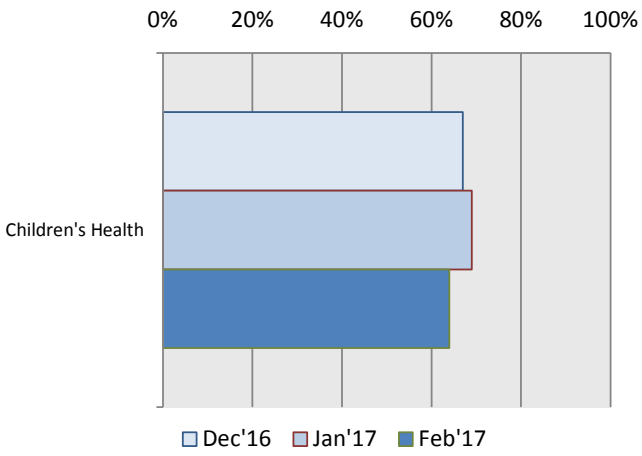
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	64%	69%	64%



*Incident data 1 month lag to allow for Manager's investigations

Information data accurate as of 4/4/2017

Clinical Support Health and Safety Report

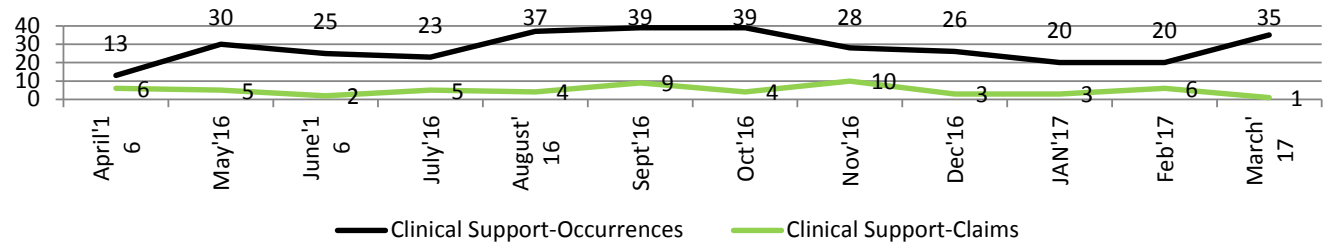
Lagging

	Actual	Target	Trend
H&S Incidents	35	20	
Work Injury Claims	1	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

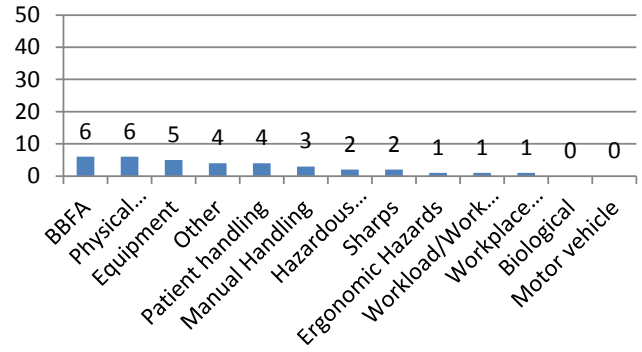
Leading

	Actual	Target	Trend
%H&S Inductions	80	100	
H&S Rep Vacancies No.	7	2	
%H&S Rep Training	67	80	
%6 Monthly Workplace Checklist	58	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	54	80	

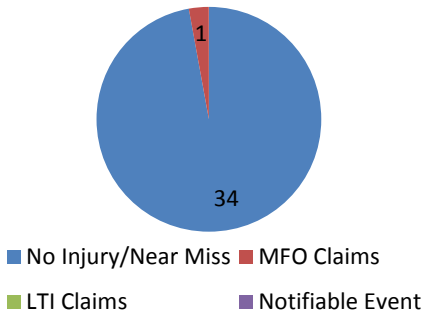
Health and Safety Incidents and Claims for 12 months



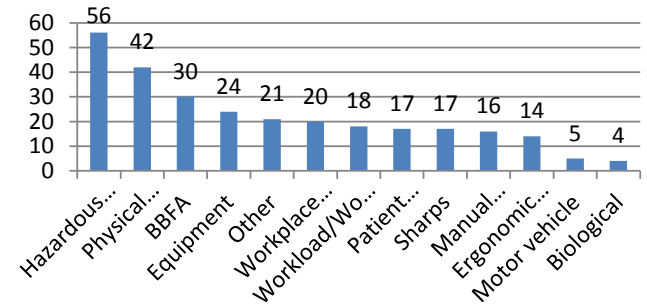
Health and Safety Incident by Hazard Type for March 2017



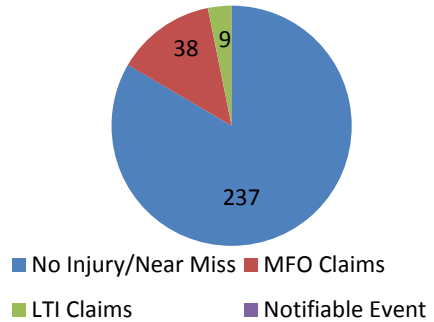
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)



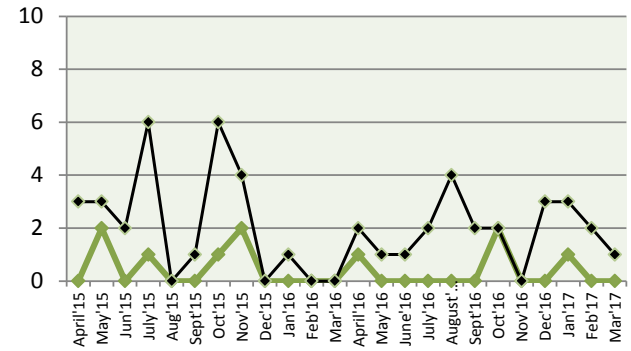
Work Injury by Outcome Type – YTD (2016-2017)



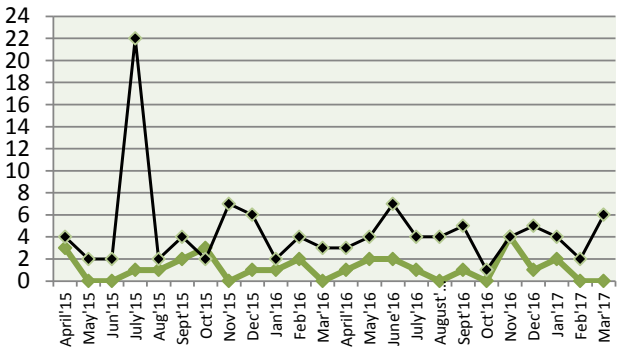
Clinical Support Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

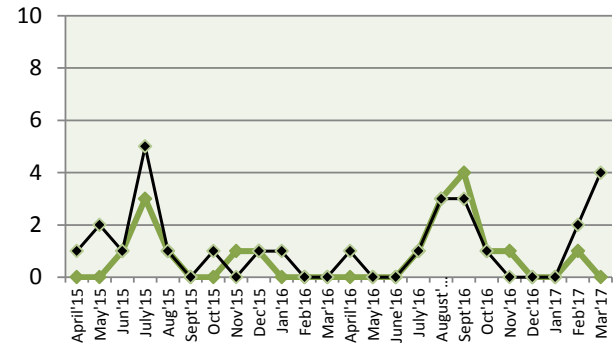
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



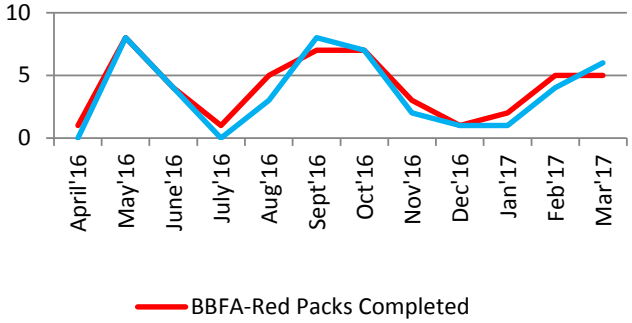
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

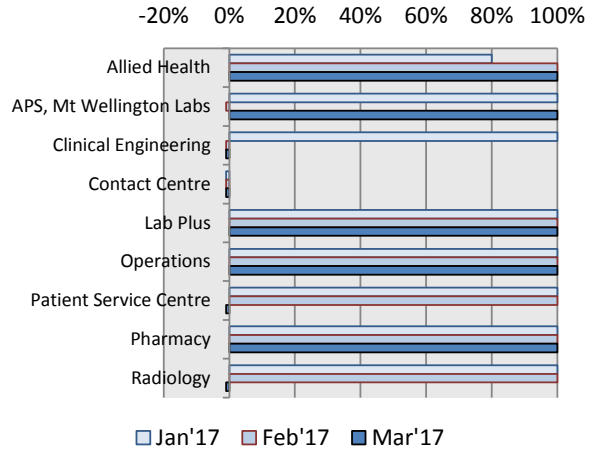


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



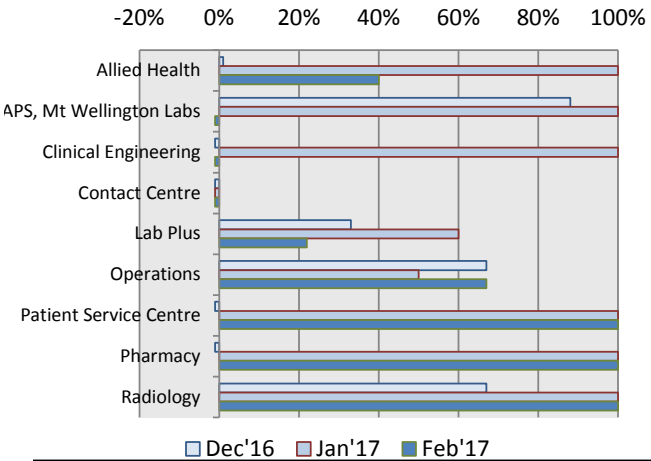
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	98%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	86%	74%	54%



*Incident data 1 month lag to allow for Manager's investigations

Information data accurate as of 4/4/2017

Corporate Services Health and Safety Report

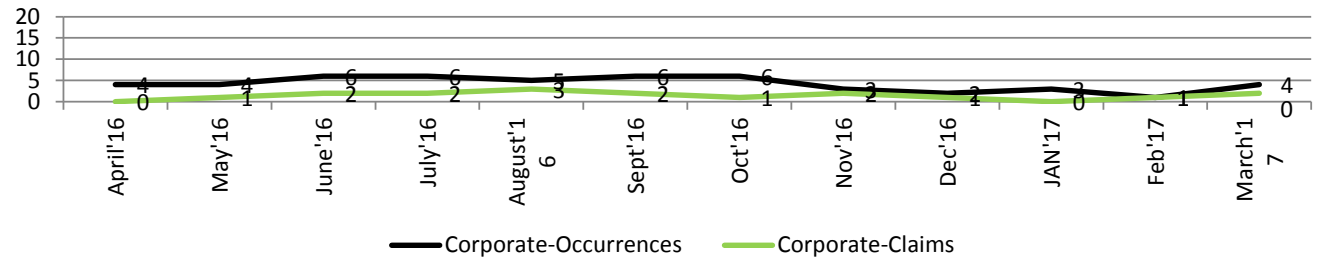
Lagging

	Actual	Target	Trend
H&S Incidents	4	20	
Work Injury Claims	2	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

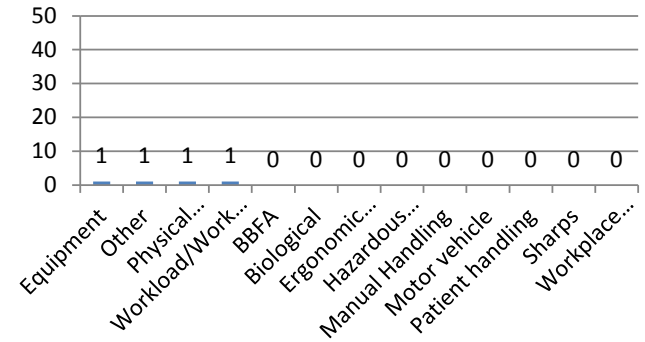
Leading

	Actual	Target	Trend
%H&S Inductions	13	100	
H&S Rep Vacancies No.	3	2	
%H&S Rep Training	77	80	
%6 Monthly Workplace Checklist	50	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	50	80	

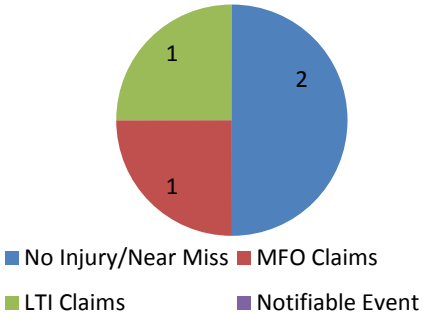
Health and Safety Incidents and Claims for 12 months



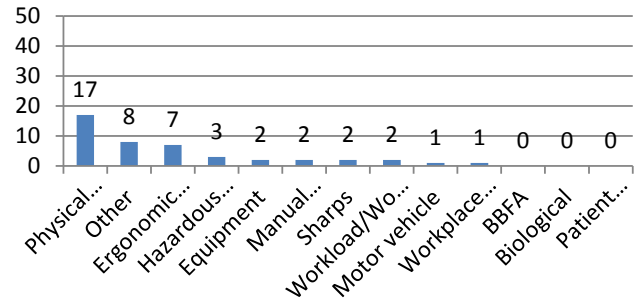
Health and Safety Incident by Hazard Type for March 2017



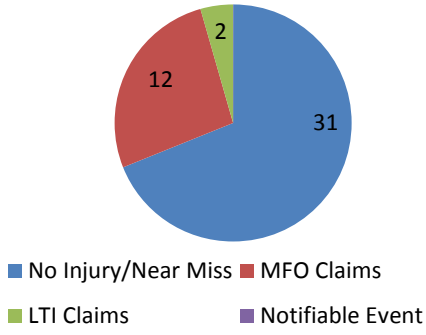
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)

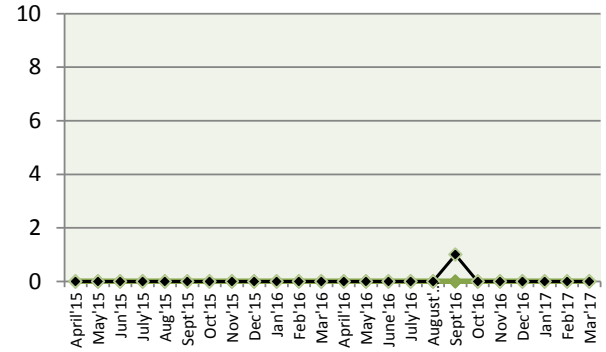


Work Injury by Outcome Type – YTD (2016-2017)

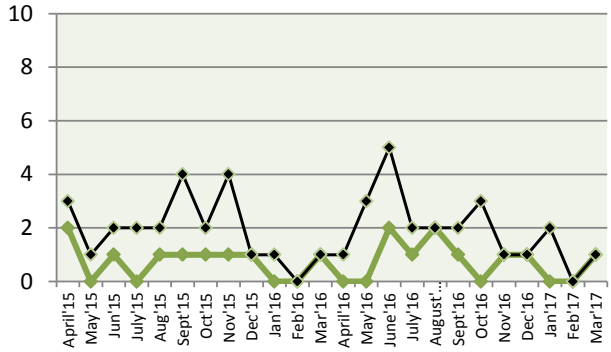


LEGEND: CLAIMS Health and Safety INCIDENT

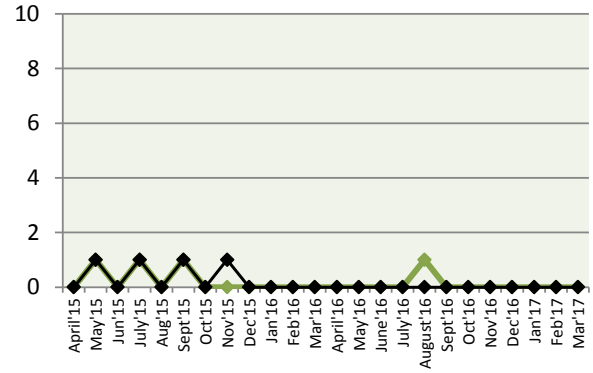
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



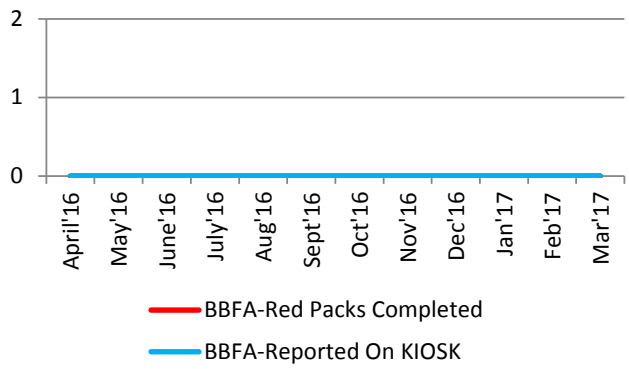
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



MANUAL HANDLING
(From 2 Years Rolling)

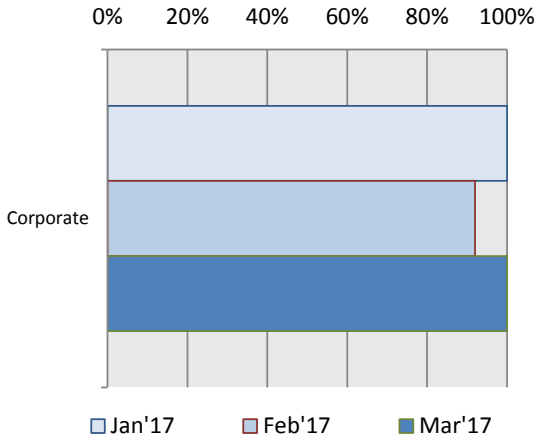


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



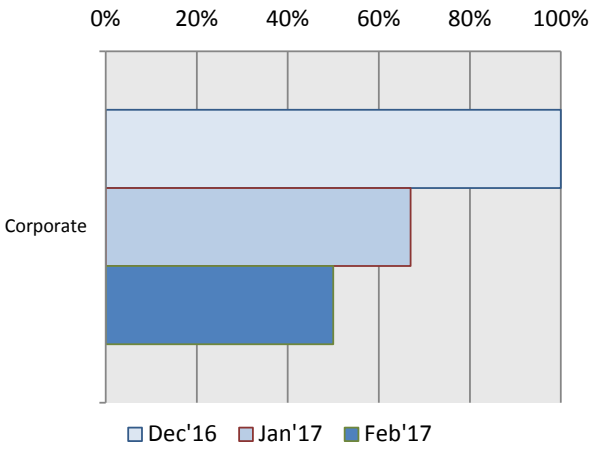
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	100%	92%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	100%	67%	50%



*Incident data 1 month lag to allow for Manager's investigations

Information data accurate as of 4/4/2017

Community and Long Term Conditions Health and Safety Report

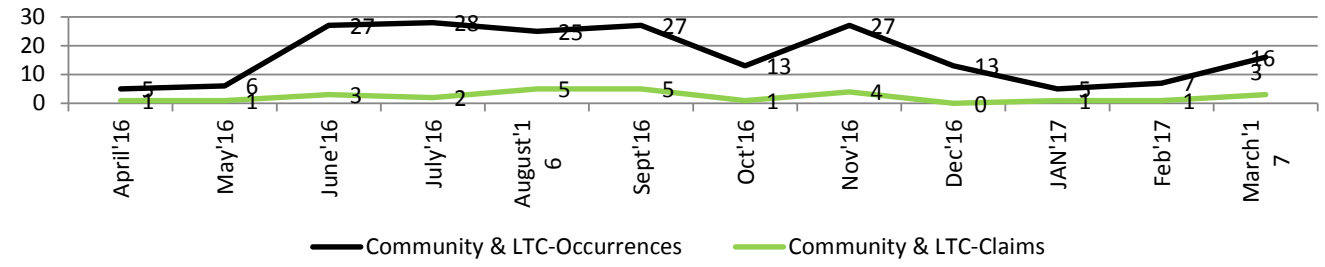
Lagging

	Actual	Target	Trend
H&S Incidents	16	20	
Work Injury Claims	3	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

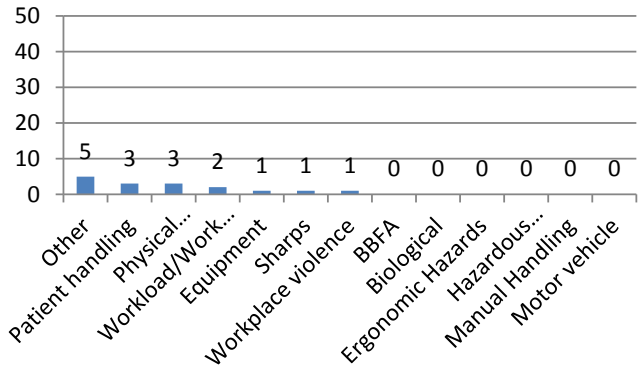
Leading

	Actual	Target	Trend
%H&S Inductions	20	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	82	80	
% 6 monthly Workplace Checklist	35	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	86	80	

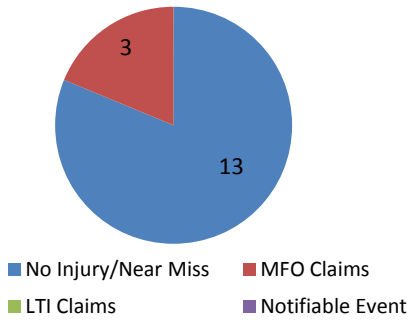
Health and Safety Incidents and Claims for 12 months



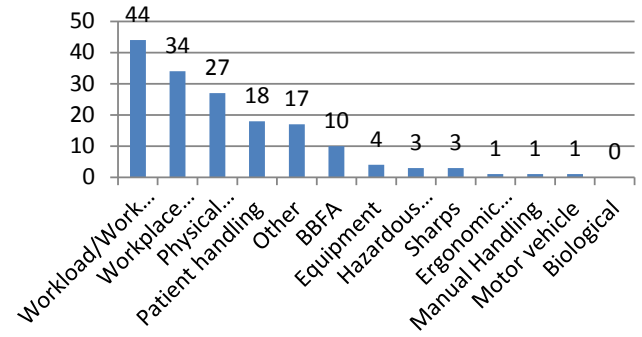
Health and Safety Incident by Hazard Type for March 2017



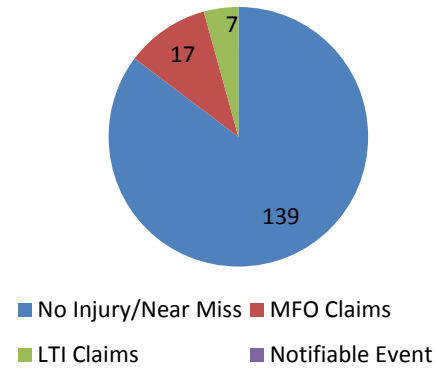
Work Injury by Outcome Type for March 2017



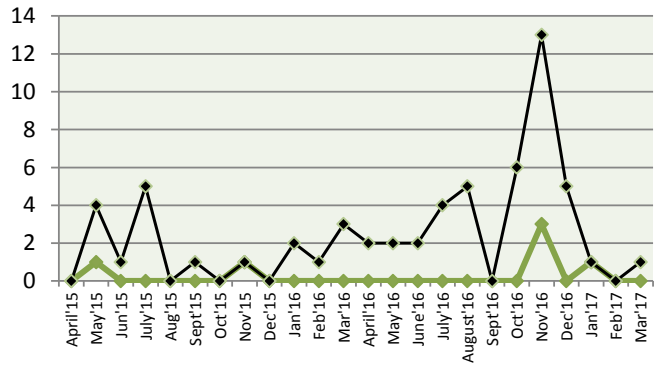
Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)



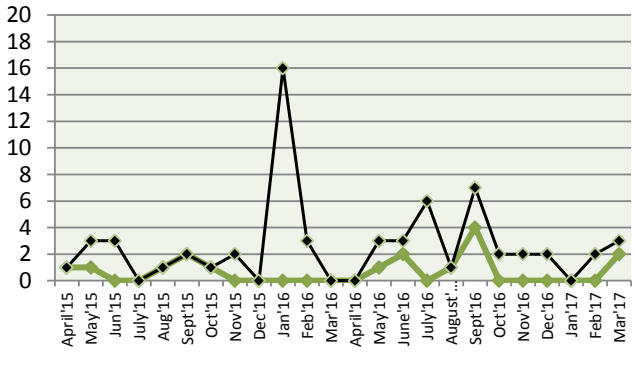
Work Injury by Outcome Type – YTD (2016-2017)



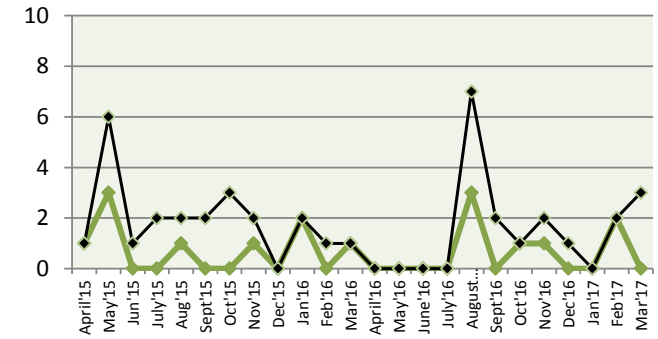
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



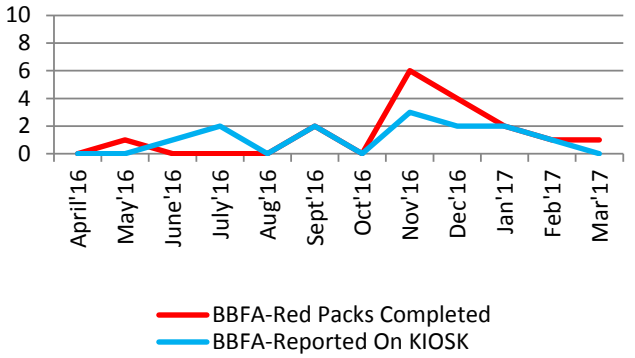
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

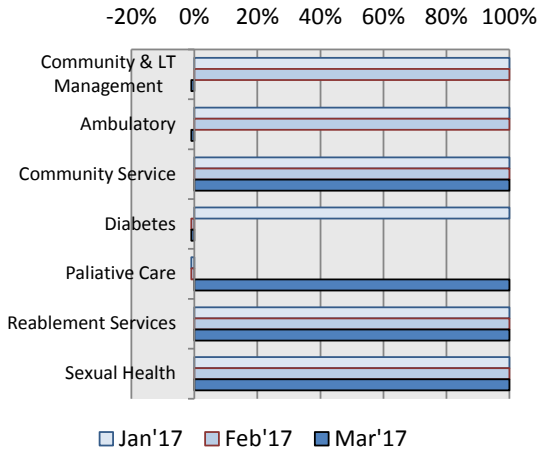


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



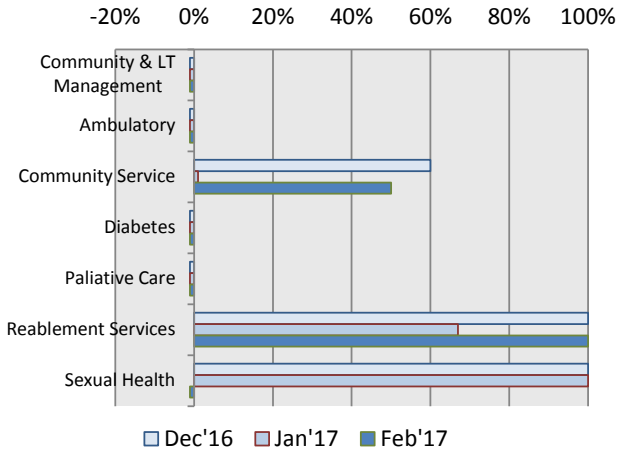
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	90%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	88%	60%	86%



Information data accurate as of 4/4/2017

*Incident data 1 month lag to allow for Manager's investigations

Mental Health Services Health and Safety Report

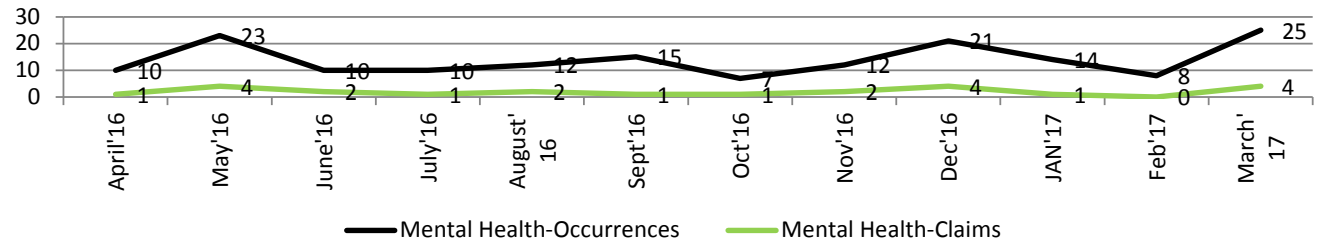
Lagging

	Actual	Target	Trend
H&S Incidents	25	20	
Work Injury Claims	4	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

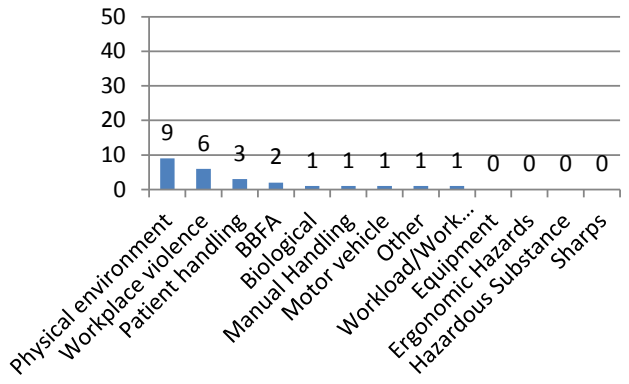
Leading

	Actual	Target	Trend
%H&S Inductions	75	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	62	80	
%6 Monthly Workplace Checklist	43	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	56	80	

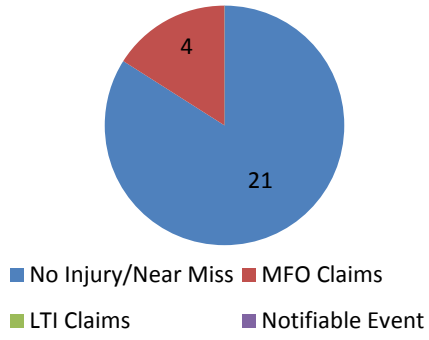
Health and Safety Incidents and Claims for 12 months



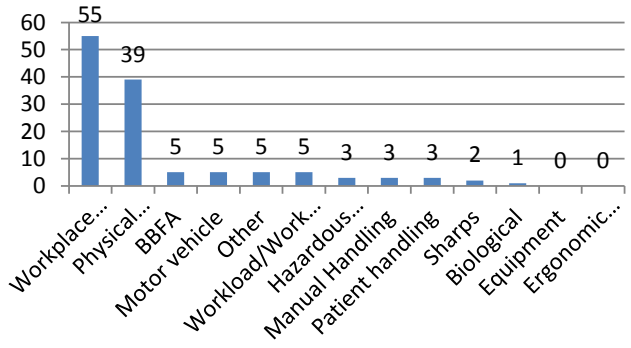
Health and Safety Incident by Hazard Type for March 2017



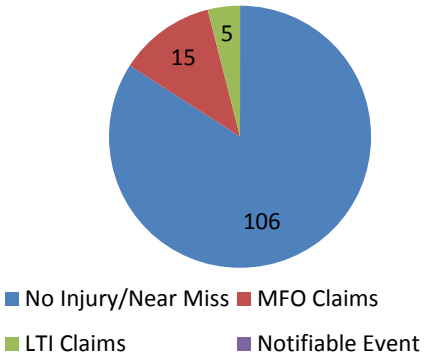
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)

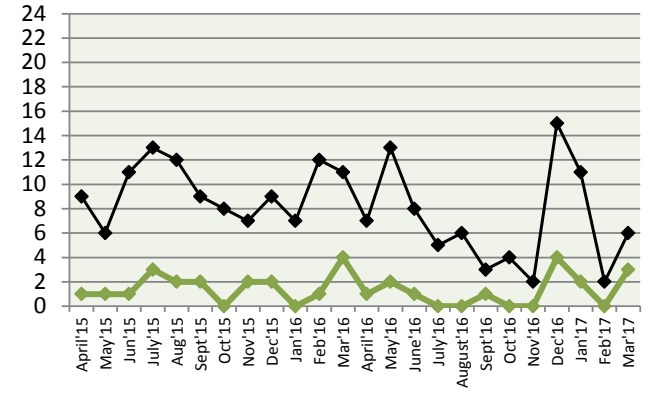


Work Injury by Outcome Type – YTD (2016-2017)

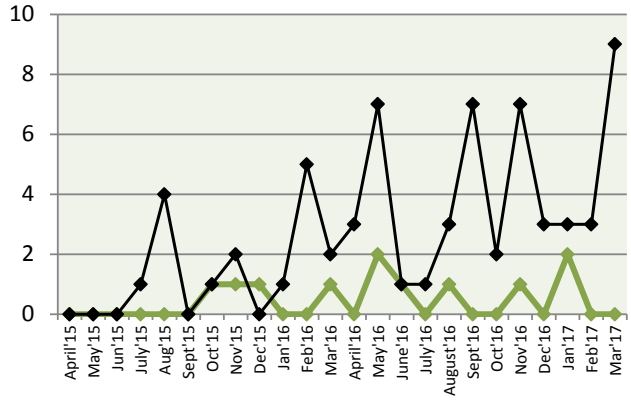


LEGEND: CLAIMS Health and Safety INCIDENT

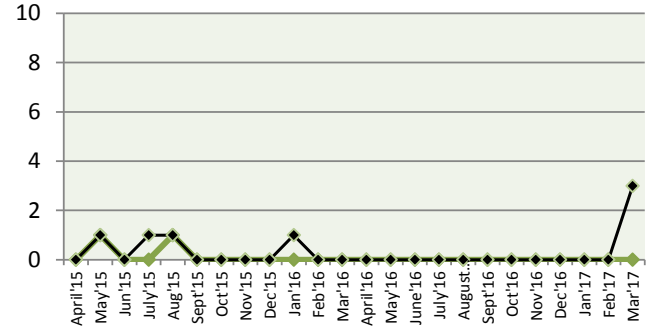
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



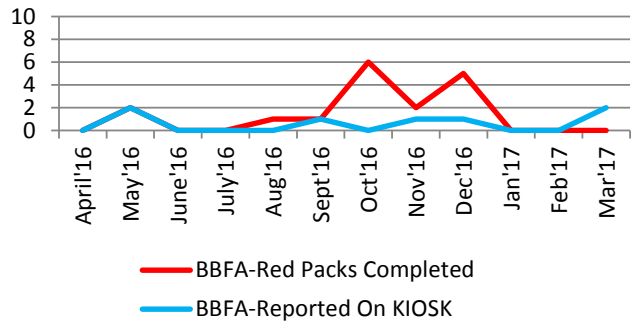
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

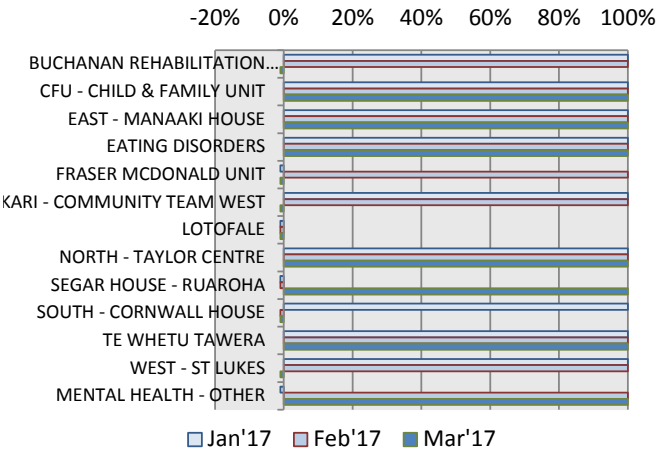


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



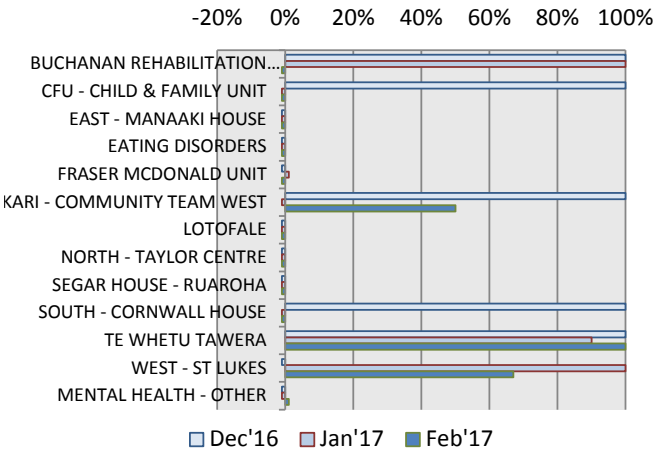
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	75%	86%	56%



*Incident data 1 month lag to allow for Manager's investigations

Information data accurate as of 4/4/2017

Non Clinical Support Health and Safety Reports

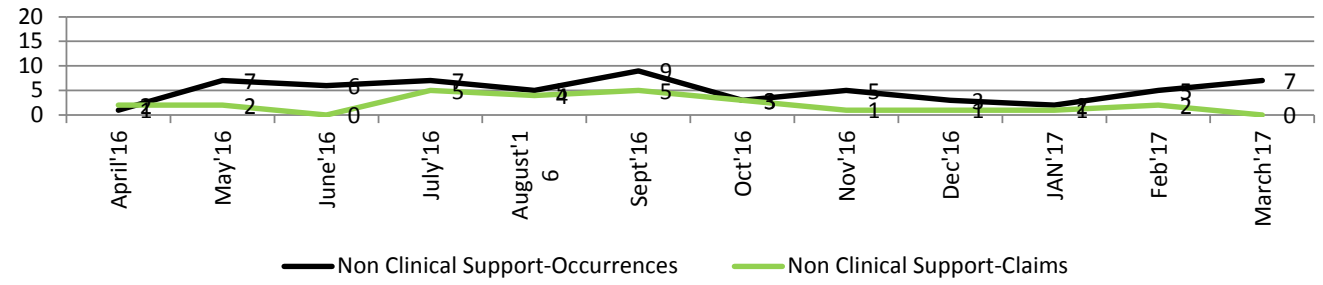
Lagging

	Actual	Target	Trend
H&S Incidents	7	20	
Work Injury Claims	0	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

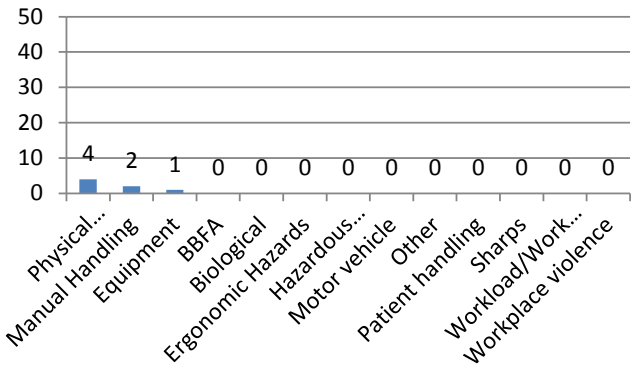
Leading

	Actual	Target	Trend
%H&S Inductions	N/A	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	33	80	
%6 Monthly Workplace Checklist	40	80	
%PES before start date	N/A	100	
%H&S Incidents Follow up 14 days	100	80	

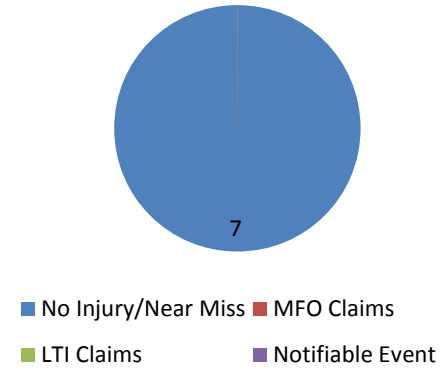
Health and Safety Incidents and Claims for 12 months



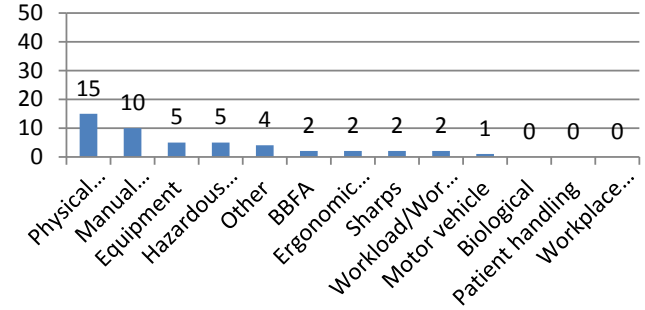
Health and Safety Incident by Hazard Type for March 2017



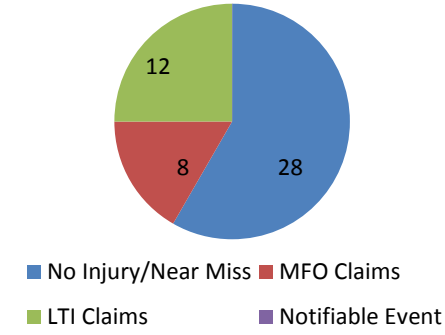
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)



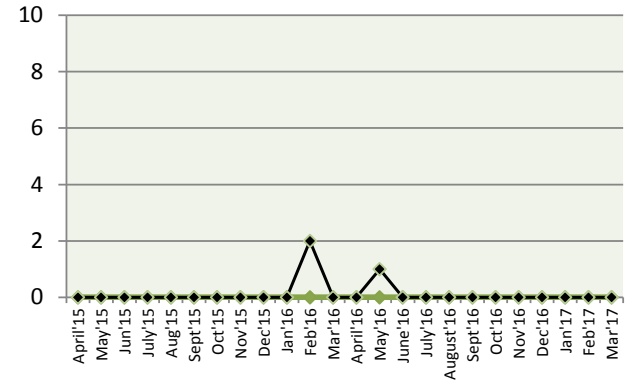
Work Injury by Outcome Type – YTD (2016-2017)



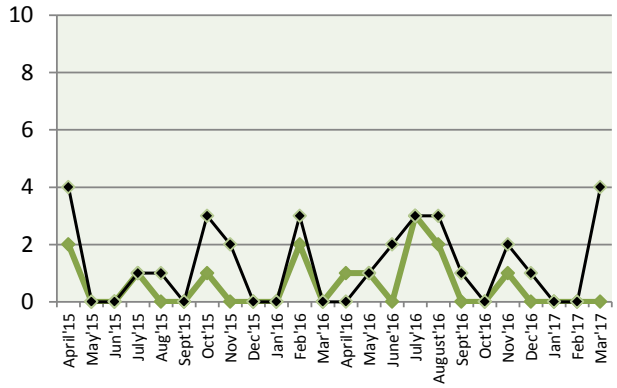
Non Clinical Support Health and Safety Reports (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

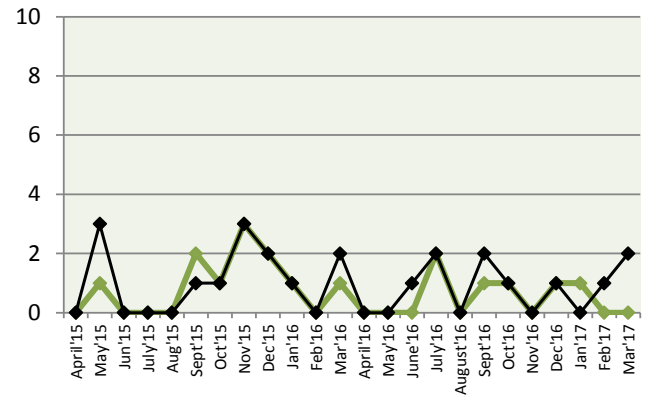
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



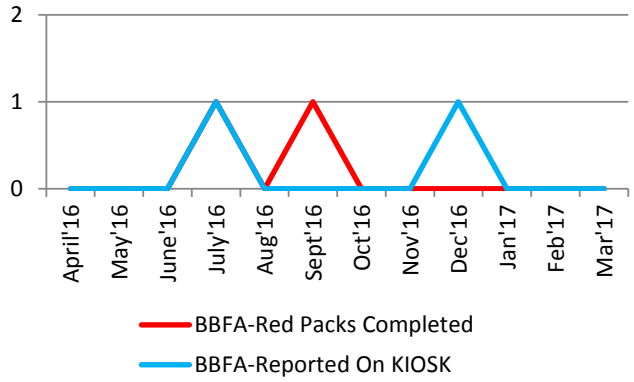
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



MANUAL HANDLING
(From 2 Years Rolling)

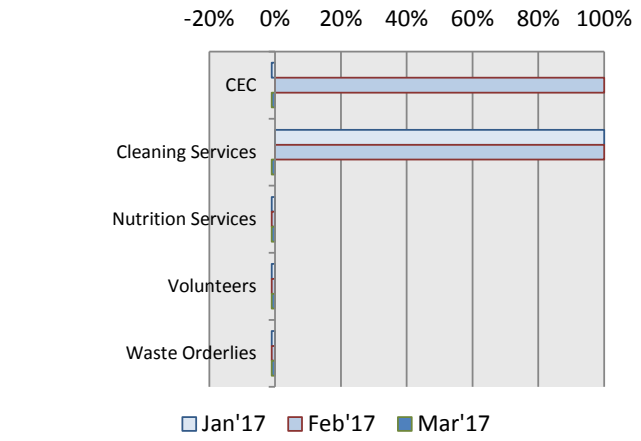


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



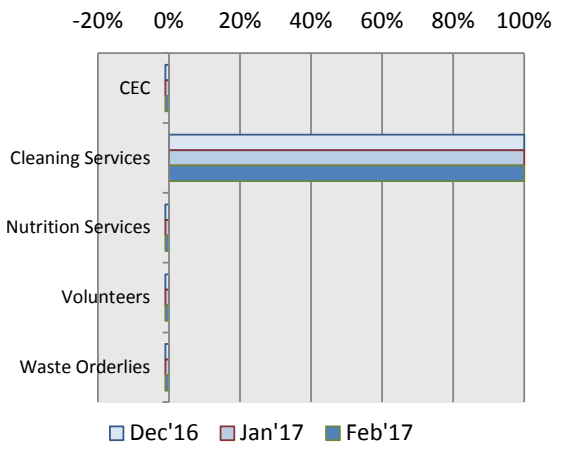
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	100%	100%	-1%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	100%	100%	100%



*Incident data 1 month lag to allow for Manager's investigations

Information data accurate as of 4/4/2017

Perioperative Health and Safety Report

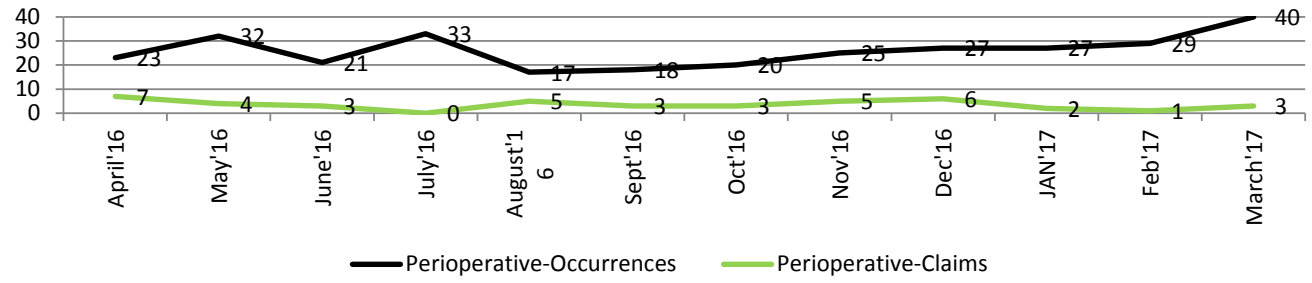
Lagging

	Actual	Target	Trend
H&S Incidents	40	20	
Work Injury Claims	3	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

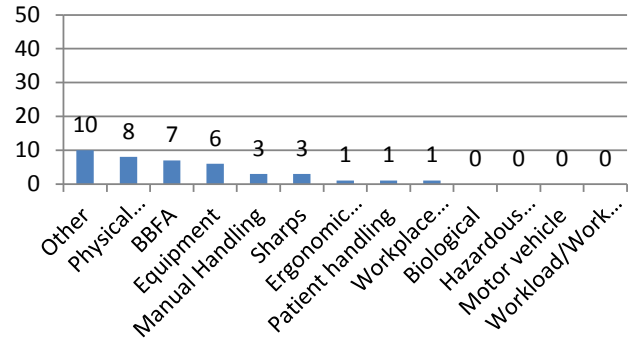
Leading

	Actual	Target	Trend
%H&S Inductions	75	100	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	81	80	
%6 Monthly Workplace Checklist	50	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	65	80	

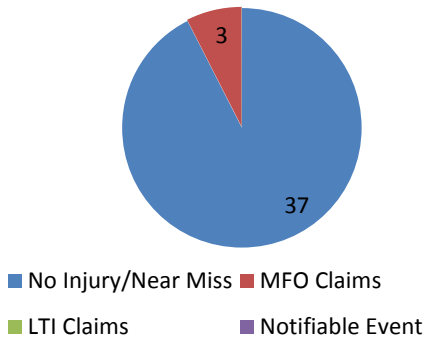
Health and Safety Incidents and Claims for 12 months



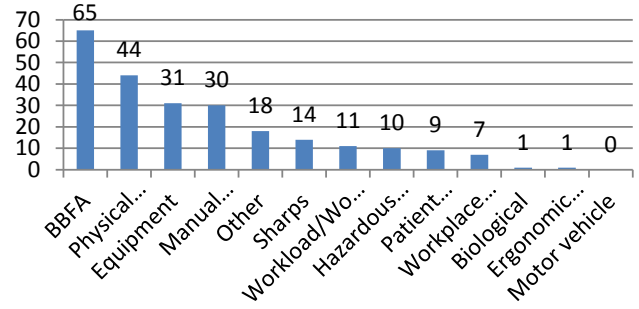
Health and Safety Incident by Hazard Type for March 2017



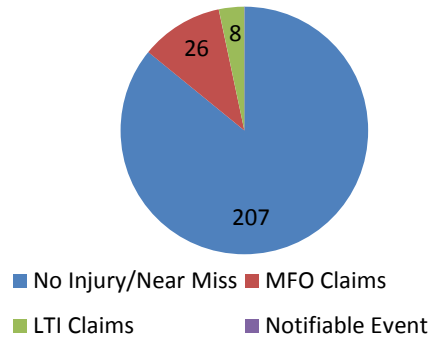
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)



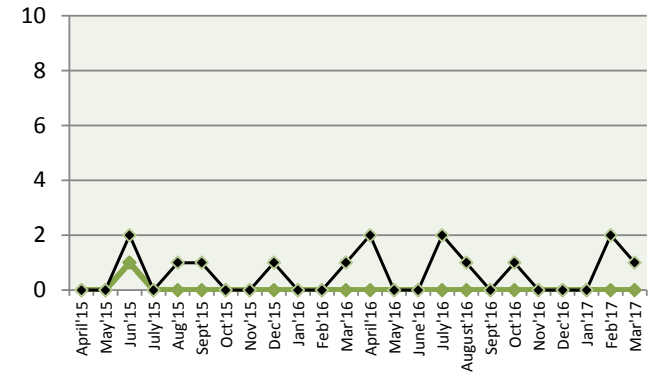
Work Injury by Outcome Type – YTD (2016-2017)



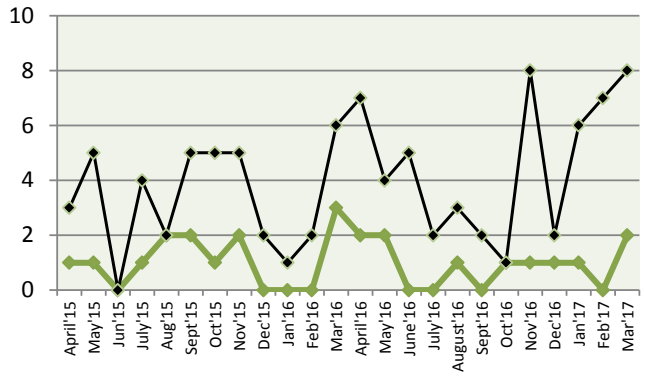
Perioperative Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

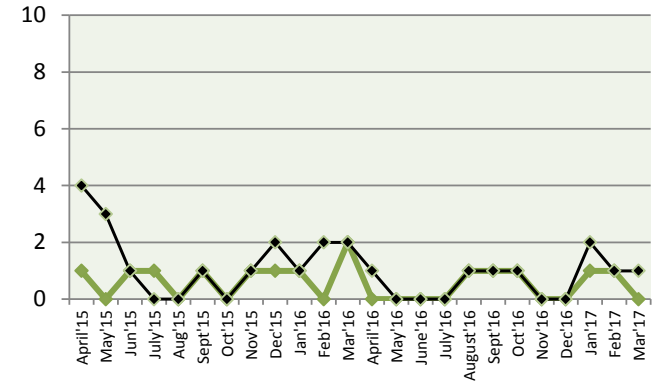
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



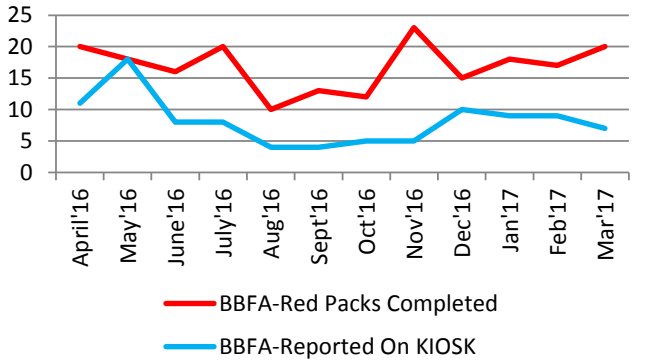
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

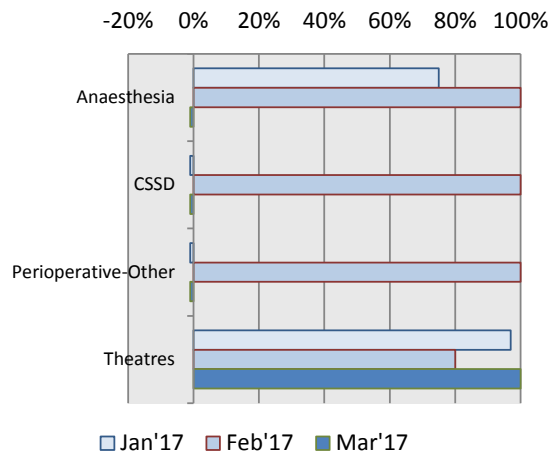


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



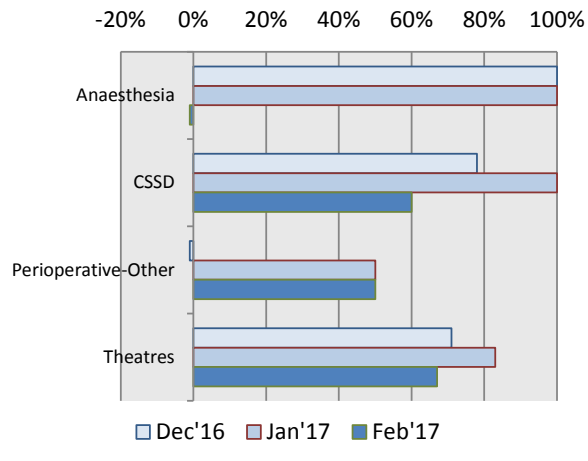
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	100%	92%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	72%	85%	65%



*Incident data 1 month lag to allow for Manager's investigations

Information data accurate as of 4/4/2017

Surgical Services Health and Safety Report

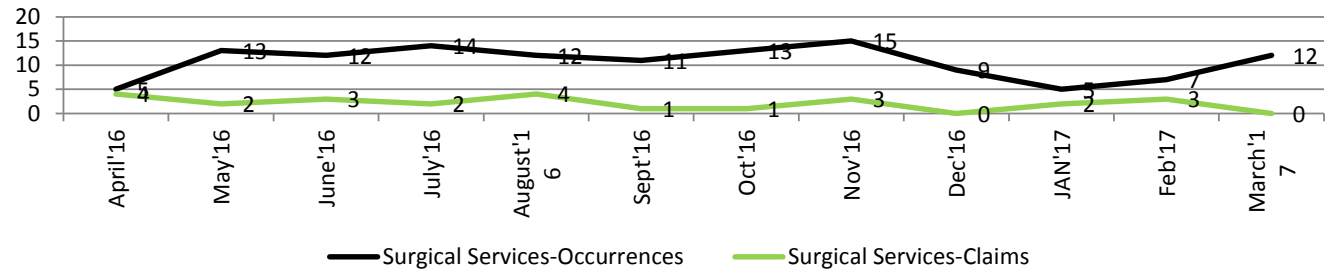
Lagging

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

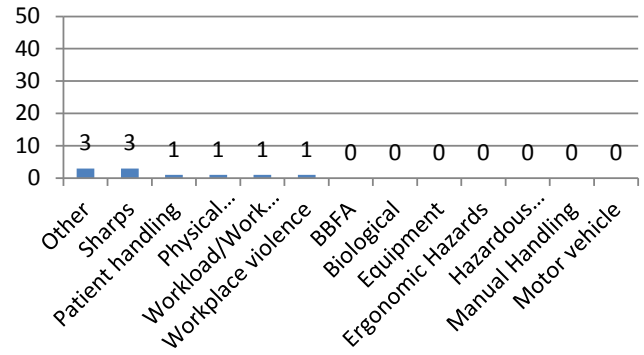
Leading

	Actual	Target	Trend
%H&S Inductions	17	100	
H&S Rep Vacancies No.	3	2	
%H&S Rep Training	50	80	
%6 Monthly Workplace Checklist	45	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	100	80	

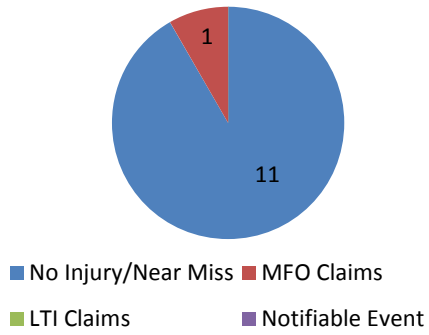
Health and Safety Incidents and Claims for 12 months



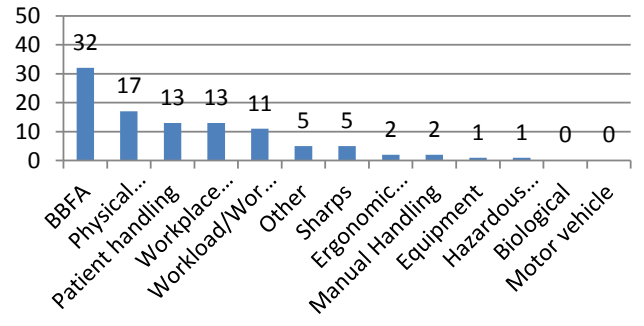
Health and Safety Incident by Hazard Type for March 2017



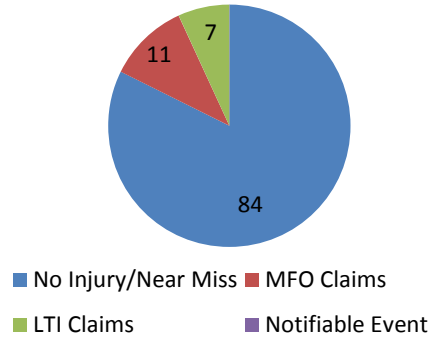
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)

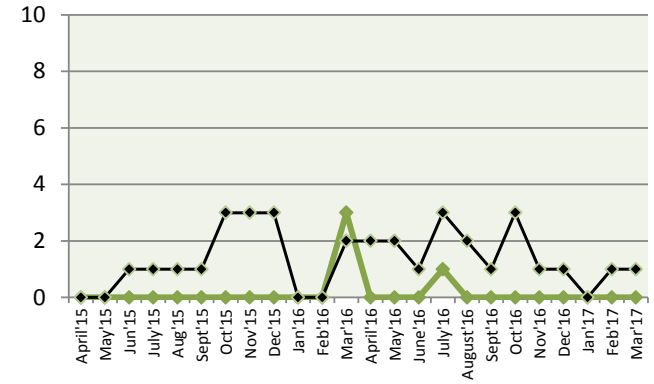


Work Injury by Outcome Type – YTD (2016-2017)

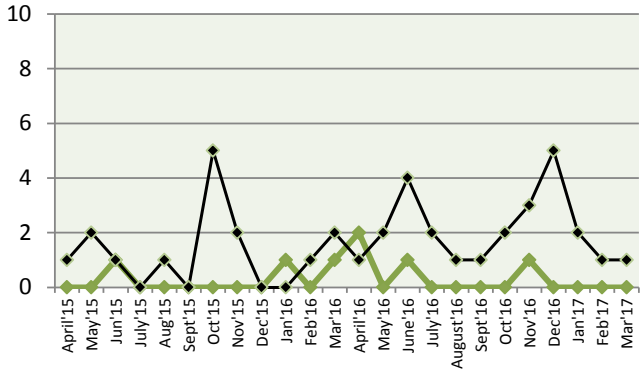


LEGEND: CLAIMS Health and Safety INCIDENT

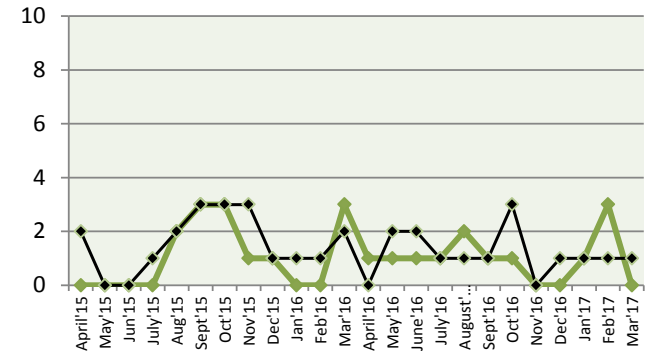
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



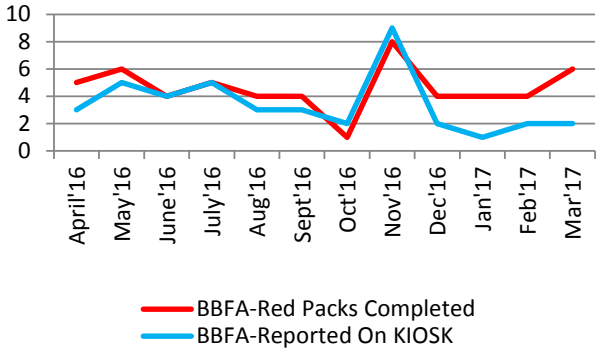
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

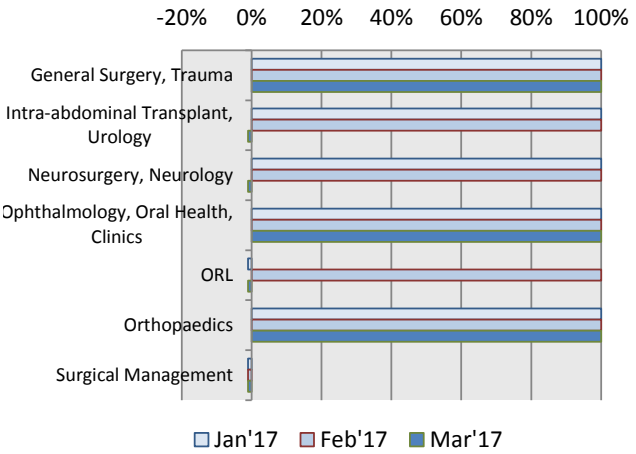


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



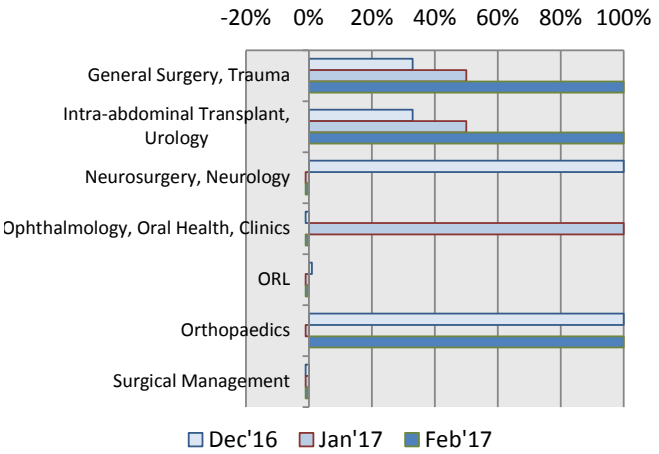
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	50%	60%	100%



*Incident data 1 month lag to allow for Manager's investigations

Information data accurate as of 4/4/2017

Women's Health and Safety Report

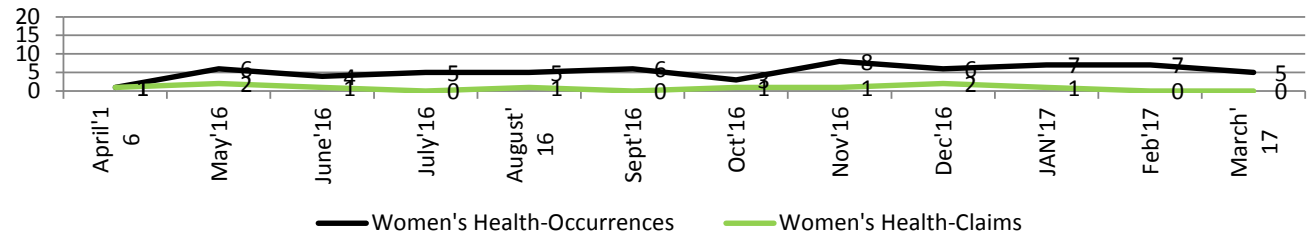
Lagging

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

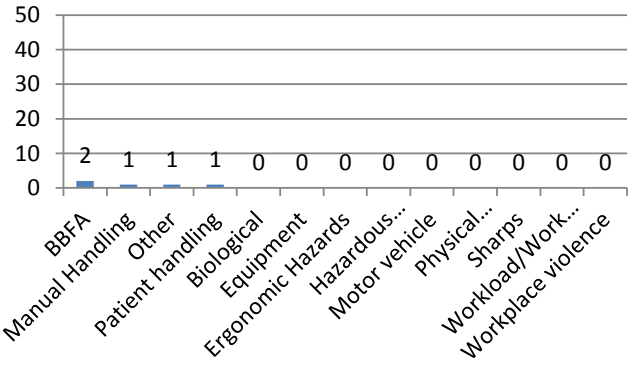
Leading

	Actual	Target	Trend
%H&S Inductions	17	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	44	80	
%6 Monthly Workplace Checklist	25	80	
%PES before start date	86	100	
%H&S Incidents Follow up 14 days	86	80	

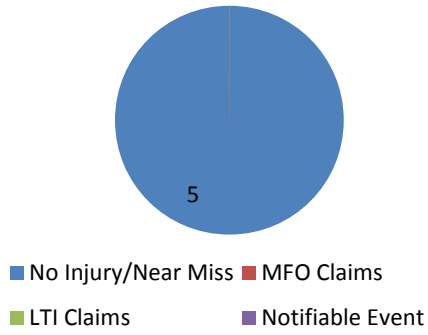
Health and Safety Incidents and Claims for 12 months



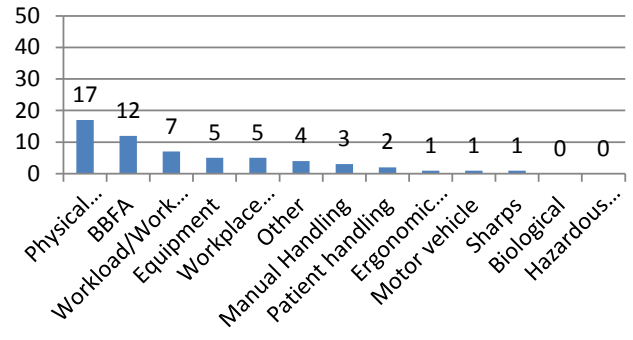
Health and Safety Incident by Hazard Type for March 2017



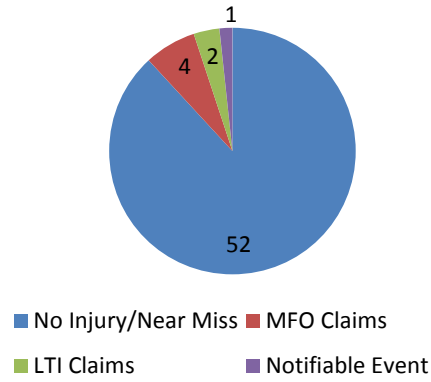
Work Injury by Outcome Type for March 2017



Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)



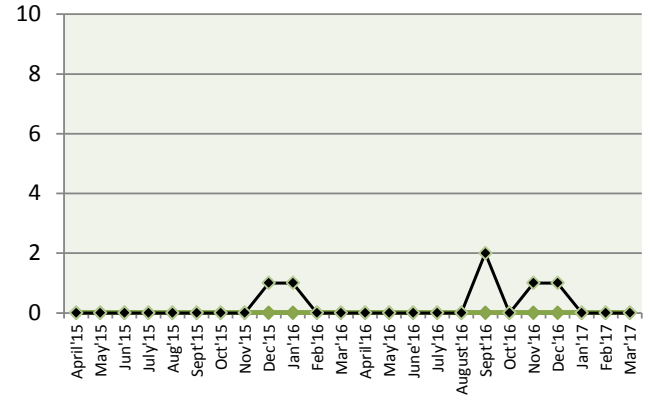
Work Injury by Outcome Type – YTD (2016-2017)



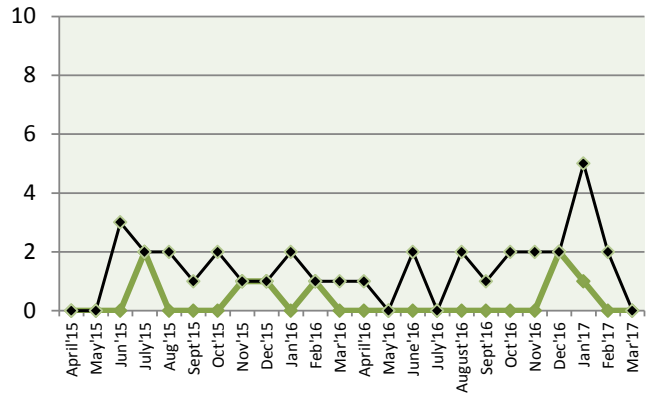
Women's Health and Safety Report (continued)

LEGEND: CLAIMS | Health and Safety INCIDENT

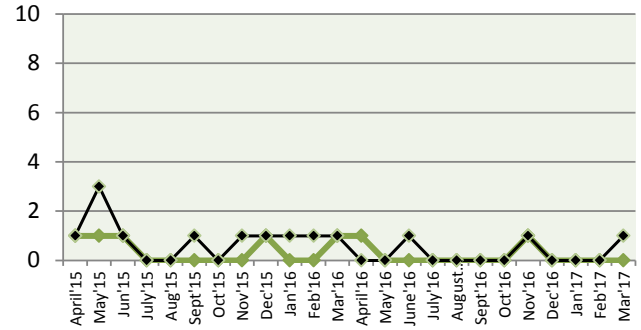
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



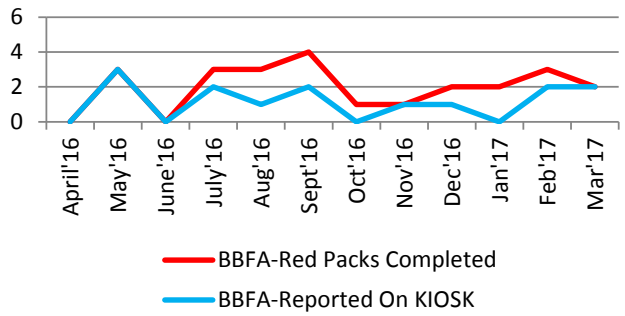
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

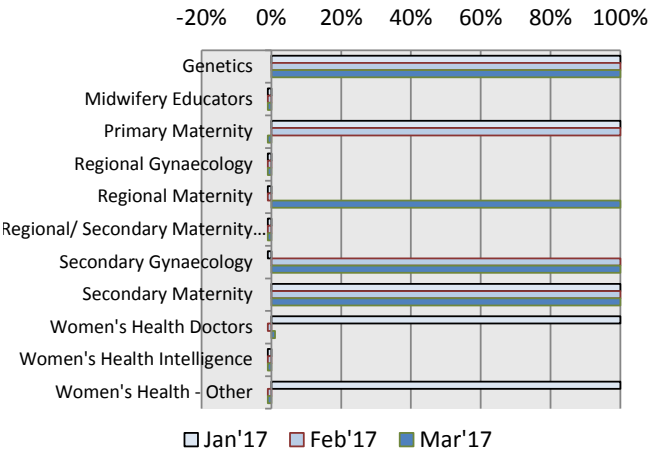


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



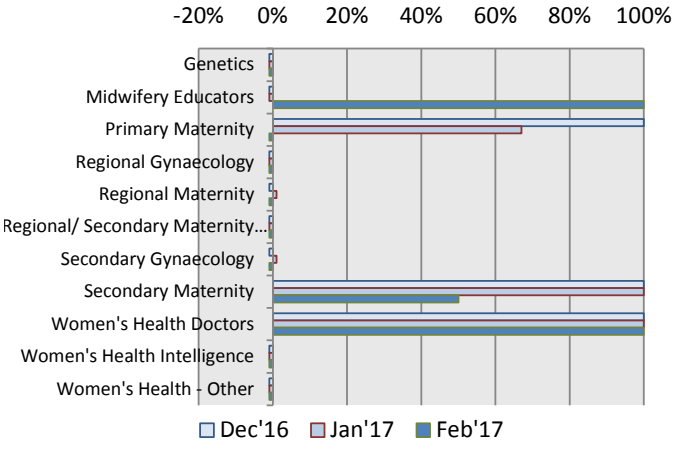
PRE-EMPLOYMENT SCREENING

TARGET	January'17	February'17	March'17
90%	80%	100%	86%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	December'16	January'17	February'17
80%	50%	57%	86%



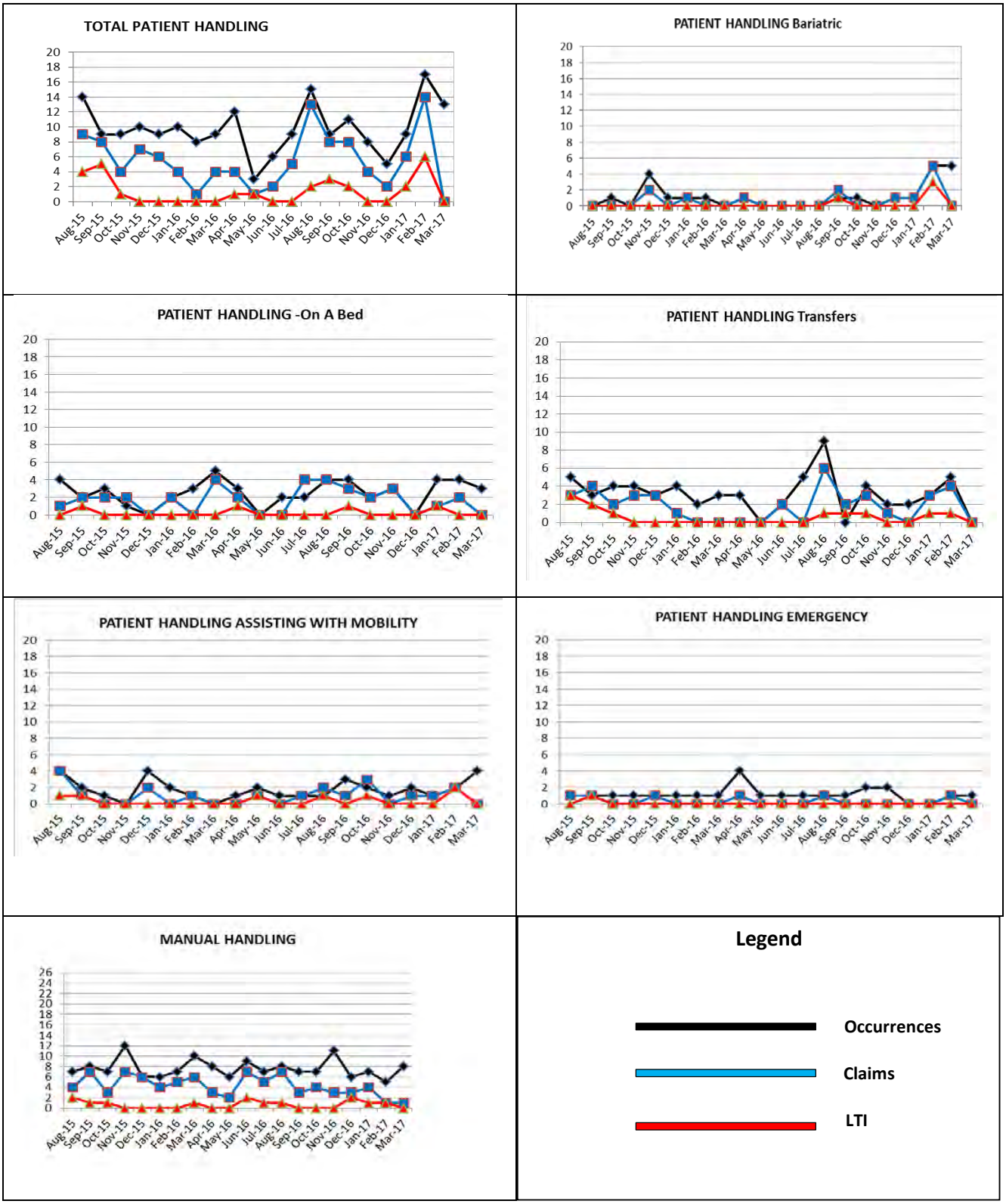
*Incident data 1 month lag to allow for Manager's investigations

Information data accurate as of 4/4/2017

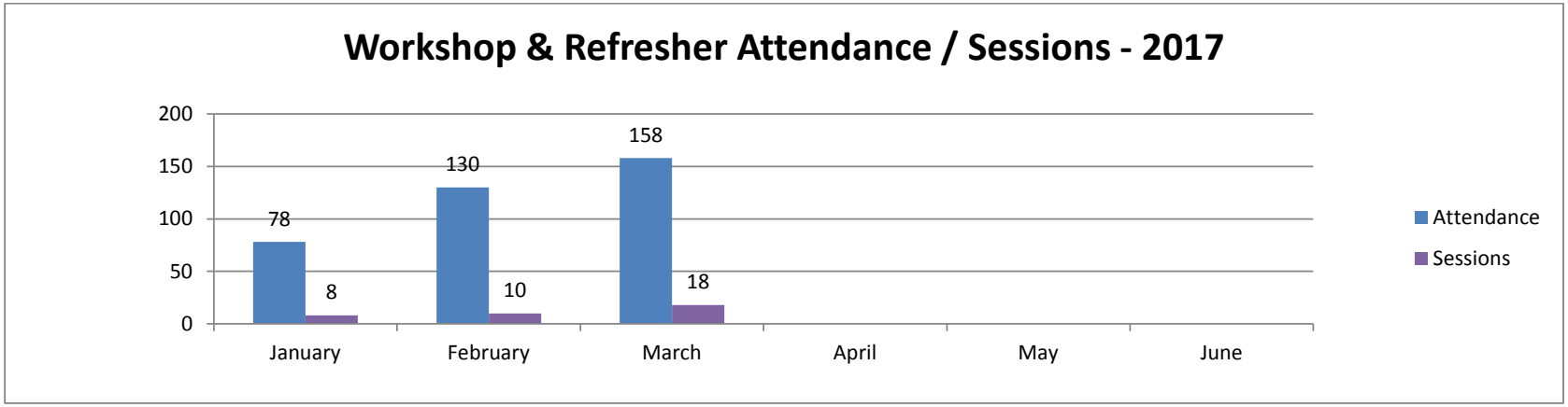
Appendix 1 - Moving and Handling

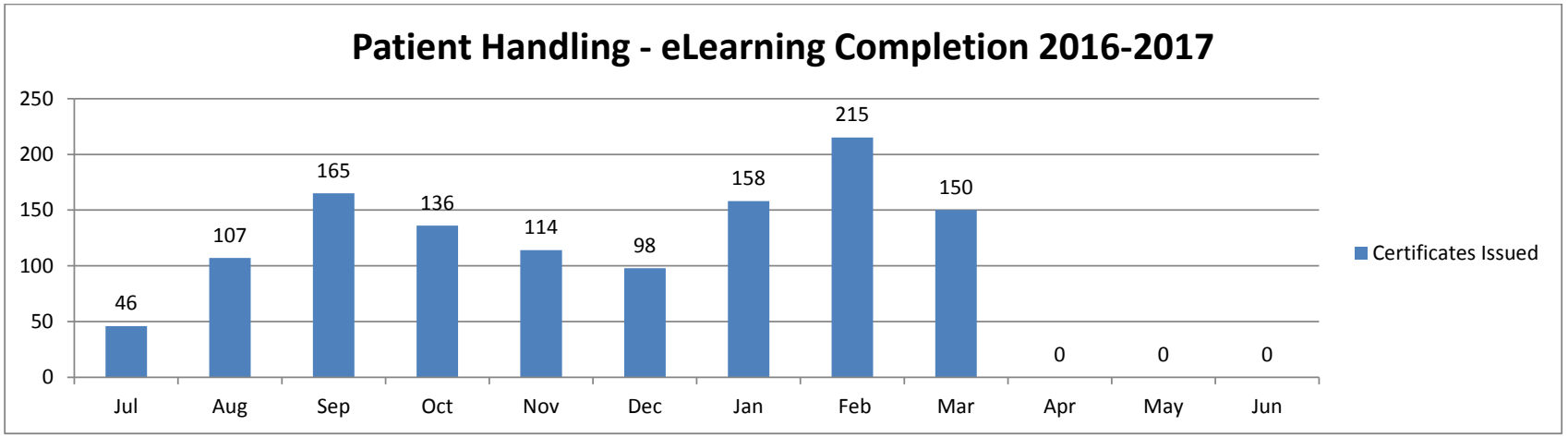
Please note; Occurrence and Claims and Training Data for March 2017

Table 5.1: Moving and Handling Injury causation



Appendix 2: Moving and Handling Workshops and Attendances from July 2016 – March 2017





Appendix 3 - Workplace Violence

1 – 31 March 2017

Auckland DHB	Workplace Violence reported on RISKPRO				Workplace Violence reported on KIOSK				Workplace Violence CLAIMS
Directorate	March	% Reported	YTD	% Reported	March	% Reported	YTD	% Reported	
Community & LTC	0	3%	23	11%	1	7%	34	19%	0
Adult Medical	8	3%	58	8%	1	7%	25	14%	0
Cancer & Blood	1	0%	5	1%	0	0%	3	2%	0
Cardio-Vascular	0	3%	3	1%	1	7%	4	2%	0
Children's Health	2	5%	10	3%	2	14%	9	5%	1
Clinical Support	0	3%	6	7%	1	7%	20	11%	0
Corporate	0	0%	0	0%	0	0%	1	1%	0
Mental Health	26	15%	166	19%	6	43%	55	31%	3
Non Clinical Support	0	0%	2	0%	0	0%	0	0%	0
Perioperative	0	3%	3	2%	1	7%	7	4%	0
Surgery	2	3%	13	4%	1	7%	13	7%	0
Women's Health	0	0%	7	2%	0	0%	5	3%	0
Total Auckland DHB	39		296		14		176		4

A Code orange call is activated by staff whenever they feel that their safety or that of others is compromised and their own methods to resolve the issue have not worked. A Code Orange team comprises of Duty Manager (Team Leader) Liaison Psychiatry, (Adult Services only), Clinical Nurse Advisor, and Security. Other personnel are utilised as required. This will be assessed and implemented by the Team Leader. All other team members and staff associated with the challenging behaviour/situation, follow the direction of the team leader to ensure management of the situation is effectively co-ordinated.

Appendix 4 - Work plan to align Health and Safety systems and policies to new legislation

NO.	Element	#	Detail Action	Assigned to	Due Date	Status	Remark
1	Health and Safety Policy Reviews	1.1	Health and Safety Policy (Board policy)	DJ	30/03/16	**Completed**	Policy published
		1.2	Health and Safety Committee Terms of Reference	DJ	30/03/16	**Completed**	Policy published
		1.3	Hazard Identification and Risk Management	DJ/DL	30/03/16	**Completed**	Guideline published
		1.4	Health and Safety Occurrence reporting (Staff Incidents)	DJ/DL	30/03/16	In progress	This policy will be converted to a guideline, and aligned to Datix system, awaiting final development of the module.
		1.5	Hazardous Substance Policy	DJ/TS	30/11/15	**Completed**	Policy now published
		1.6	Pre-Employment Health Screening	DJ/Clinic Team	31/12/15	**Completed**	Policy now published
		1.7	Visual Display Unit Policy	DJ/PMc	31/12/15	**Completed**	Published
		1.8	Contractors Health and Safety Management of	DJ/JM	31/12/15	**Completed**	Published in June.
		1.9	Asbestos Management	DJ/KW	30/11/15	**Completed**	Published
		1.10	Workplace Violence Prevention	DJ/DL	31/12/15	**Completed**	Policy published.
		1.11	Lone Worker Policy	DL	31/12/15	in progress	Consultation with all Directorate Health and Safety Committees now completed. The policy will now advance to organisation wide consultation vie document control and be tabled to the Board.
2	Health and Safety Information	2.1	Health and Safety intranet resign and content review to ensure all content is updated to reflect requirements of the new Health and Safety legislation	DJ/DL	30/03/16	**Completed**	This review will include all Health and Safety advice sheets, forms, processes etc. on the Health and Safety intranet site. New site how now been published in HIPPO

NO.	Element	#	Detail Action	Assigned to	Due Date	Status	Remark
			and codes of practice released by WorkSafe NZ.				
3	Training	3.1	Directing Safely: • Board, ELT and Directors • Apply legal requirements to operational environment • 2-3 hours	DJ/DL	30/03/16	Substantially Completed	Ko Awatea Learn course has been adapted and will be piloted in May.
		3.2	Managers: Managing Safely • Line managers • Full day • Pre-reading/assessment • Post course assignment	DJ/DL	30/03/16	**Completed**	Redesign of current managers course. Based on content of new Health and Safety legislation and Regulations and Health and Safety document reviews. Course schedule for 2017 published.
		3.3	Staff: Working Safely • Welcome Day • Health and Safety handbook/Ko Awatea Learn • Local Health and Safety Induction • Hazard specific training	DJ/DL	30/03/16	**Completed**	Review of current tools required to update and align to new legislation. Hazard specific training includes aggression relation safety training, and hazardous substance training
		3.4	Health and Safety Reps: • Health and Safety Rep Orientation • Core Training (NZQA) • Topic Training (CPD)	DJ/DL	30/03/16	**Completed**	Health and Safety Rep elections held in June 2016. External "Core" Training will be required. Supplier engaged. Courses for 2017 in KIOSK.
4	On Line Hazard Register	4.1	On Line Hazard Management system: Install and train Directorates:	DJ/DL	31/12/2016	**Completed**	Focus of this project has moved to preparing the services for transition to new Risk management software acquisition that is in final stages.

NO.	Element	#	Detail Action	Assigned to	Due Date	Status	Remark
			• Sequential implementation (by Directorate) • One commenced per month throughout 2016 • Manager Training Health and Safety Rep training				Health and Safety is working with the Directorates to prepare for transition to Datix Hazard Register. 6 out of 12 directorates have initiated the electronic Hazard Register
		4.2	Development of Risk management module in new Risk Management system: • Develop Risk Register in new system (31/12/16)		31/12/2017	**Competed**	New Safety management system went live in March. Health and Safety will support the transition to the new system.

Appendix 5 - Definitions

Definitions for Monthly Performance Scorecard

Lost Time Injury Frequency Rate	LTIFR refers to the number of lost time injuries occurring in a workplace per one million man-hours worked. An LTIFR of seven, for example, shows that seven lost time injuries occur on a jobsite every one million man-hours worked. The formula gives a picture of how safe a workplace is for its workers. Lost time injuries (LTI) include all on-the-job injuries that require a person to stay away from work more than 24 hours, or which result in death or permanent disability. This definition comes from the Australian standard 1885.1– 1990 Workplace Injury and Disease Recording Standard.[1][2]
Lost Time Injuries	Any injury claim resulting in ONE or more full days lost time on an ACC45
Notifiable Events (The previous Health and Safety legislation referred to Serious Harm Injuries, the new legislation now called these Notifiable Events. The criteria has changed to include injury, illness and near-misses in some cases)	The Health and Safety at Work Act 2015 defines Notifiable event as: A notifiable event is a: • death • notifiable illness or • injury, or • notifiable incident Occurring as a result of work. Only serious events are intended to be notified.
Pre- Employment Screening	• Percentage of Auckland DHB employee where PES has been completed • Percentage of new starts where PES was completed before start date

Notifiable Events:

A notifiable event is when any of the following occurs as a result of work:

- **Notifiable Death -** A person has been killed as a result of work. If someone has been killed as a result of work, then WorkSafe NZ must be immediately informed (Health and Safety Department will arrange this).

- **Notifiable Injury** - Any injury that requires (or would usually require) the person to be admitted to hospital for immediate treatment (see below for full details):
    - Amputation
    - Serious Head Injury
    - Serious Burn
    - Spinal Injury
    - Loss of Bodily Functions
    - Serious Laceration
    - Skin Separation

- **Notifiable illness**

If a person contracts an illness as a result of work and needs to be admitted to hospital for immediate treatment or needs medical treatment within 48 hours of exposure to a substance.
In addition, you MUST notify WorkSafe if a person contracts a serious illness as a result of:

- working with micro-organisms
- providing treatment or care to a person
- contact with human blood or bodily substances
- handling or contact with animals, their hides, skins, wool or hair, animal carcasses or waste products
- handling or contact with fish or marine animals
- Exposure to a substance, natural or artificial such as a solid, liquid, gas or vapour.

- **Notifiable Incident**

Is an unplanned or uncontrolled incident occurs where people's health and safety is seriously endangered or threatened, then you must notify us.

This must be an immediate danger or imminent danger.

People can be at serious risk even if they are some distance from the incident (e.g. gas leak).
For further details visit the WorkSafe NZ Notifiable Events Website

Risk Matrix

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

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

Table 3 - Risk Score & Grading = Consequence X Likelihood					
Likelihood	Consequence				
	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 - Almost Certain	5	10	15	20	25
4 - Likely	4	8	12	16	20
3 - Possible	3	6	9	12	15
2 - Unlikely	2	4	6	8	10
1 - Rare	1	2	3	4	5

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

Appendix 6 Annual ACC Partnership Programme Audit

Background to the ACC Partnership Programme (ACCPP):

ACC requires an independent annual audit against a set of standards (ACC440) and places employers in the programme at primary, secondary or tertiary (highest) status. The Audit has two parts: Workplace Safety Management Systems (Part A) and Injury Management Systems (Part B). Accredited employers at Tertiary status are permitted to undertake a partial audit on alternative years. Auckland DHB has been Tertiary in the ACCPP programme for 10 years and is entitled to partial audits alternative years.

2016 ACCPP Audit

A Full Audit was conducted 6 – 9 December 2016. The full audit reviews Workplace safety management systems (Part A) and Injury Management (Part B). ACC selected the audit areas and the relevant Directorate management teams were notified. They were:

- Mental Health Service: Te Whetu Tawera
- Perioperative: Central Sterile Supply
- Non Clinical Support: the Cleaning Service Auckland City Hospital
- Clinical Support: APS Mt Wellington

The audit was conducted by an independent ACC approved auditor provided by Price Waterhouse Coopers. The auditor has recommended to ACC that Auckland DHB maintain Tertiary status in the programme. The copy of the auditor's report has been accepted by ACC and Auckland DHB has been confirmed as Tertiary Status for another year.

A number of positive comments on observed improvements in Health and Safety systems since the 2015 audit were noted in the report including;

- the development of a Board Health and Safety Charter
- Board safety engagement visit programme
- Senior management's acknowledgment of Safety performance (excellent Health and Safety Report for the Board)
- Increase in Health and Safety Team resources
- Directorate MOS Board system including Health and Safety KPI
- Well established competency based training programme in CSSD
- Robust local Health and Safety orientation programme in the Cleaning Services
- Capital improvement to APS Mt Wellington related to Formaldehyde extraction
- Security for Safety project
- Engagement of Health and Safety Manager for Facilities and a number of contractor management initiatives put in place.
- Robust process for review of Rehabilitation outcomes

Five Recommendations were given: see table to follow below

Element	Recommendation	Action Plan
1.1.1 Health and Safety Policy statement	Consider the development of a succinct health and Safety policy statement which can be displayed on notice boards.	**Health and Safety Policy statement for display will be agreed with ELT.**
1.2.2 Health and Safety Policy Review	Note that the audit requirement is for review of the Health and Safety Policy every 2 years.	**Two year policy review is in place**
4.3.2 Training database	To increase the visibility of completed training and improve bring up reminders; work to centralise this system is supported.	**Organisation Development is currently reviewing all L&D related systems and processes.**
14.1.2	Letter acknowledging request to review application needs to be amended. The claimant has the right to lodge a review application irrespective of the informal dispute resolution process.	**Request for letter change has been made to the TPA.**
18.5	One way to increase the visibility of the importance of near miss reporting would be to recognise those reports that result in health and safety improvements.	**Health and Safety will increase communication regarding improvements resulting from proactive reporting.**

Appendix 7 Terms of reference for 2017 Health and Safety Review

Purpose

Following the 4 April 2016 passing into law of the Health and Safety at Work Act 2015 the Auckland DHB Board wishes to better understand the current level of actual Health and Safety risk within the organisation. To this end a deep-dive health and safety management systems review has been requested by management. The purpose of this review is to assist in the identification of areas which require improvement.

Background

A deep-dive health and safety systems audit was conducted by an external auditor in late 2014 and early 2015. This was an exercise requested by Lester Levy to be conducted by both Auckland DHB and Waitemata DHB. The purpose of the audit was to identify health and safety policy and process gaps in relation to preparation for the new Health and Safety legislation expected in early 2016.

The 2014/15 audit consisted of:

- A desk top examination of the health and Safety management system to assess compliance against the (then) Health and Safety reform Bill 2014.
- Interviews with Auckland DHB board members, senior executives, senior managers, and the Health and Safety team to assess their understanding of Health and Safety Risk within the organisation.
- Testing against the documented controls currently in place. Seven risks were selected and ten areas reviewed.

The audit took place between November 2014 and February 2015. A report with a number of recommendations was provided to the Auckland DHB Board. The Board accepted the recommendations and an action plan was developed to implement the recommendations, the progress followed by the Auckland DHB Board and the Audit and Finance Committee.

The Auckland DHB Board now wishes to conduct a follow-up audit to identify the level of the compliance and current level of Health and Safety Risk within the organisation against the Health and Safety at Work Act 2015.

Scope of work

- Review the follow-up risk management actions in relation to the high risk hazards identified by the original audit. (Workplace Violence and the level 5 loading dock safety)
- Develop an internal audit testing programme based on a new set of agreed prioritised risk and areas.
- Perform control effectiveness testing and site walkthroughs and observations at approximately 12 worksites representing all of the Auckland DHB Clinical Directorates, Corporate Services, Clinical Support Services and Non-clinical Support Services for the agreed key health and safety risks listed below.

- The areas/departments to be selected/agreed for site observations to represent all Auckland DHB Directorates and the appropriate associated Health and Safety risks, yet to be agreed.

Hazard/Risk description
Community Worker Safety (including lone working)
Moving and Handling of patient/ goods and equipment
Blood and Body Fluid Exposures
Workplace Violence and Aggression (patients and visitors to staff)
Pedestrian safety (including traffic management)
Psychosocial hazards (shift work/ fatigue/ workload)
Security and general site safety in relation to access and lockdown
Emergency Management (including Fire Safety)
Bullying and Harassment (staff to staff)
Hazardous Substances
Physical environment (our buildings including infrastructure)

Deliverables

An audit report identifying areas of good practice and areas for improvement to enhance the Health and Safety management and practises within the Directorates of Auckland DHB.

Timeframes

The audit is to be conducted within the month of June 2017 and a report provided to the Auckland DHB Board before the end of July 2017.

Health and Safety Marker Report – update March 2017

Recommendation

That the Board:

1. **Receives the Health and Safety Marker Report – update March 2017.**
2. **Endorses the areas noted for improvement and the actions to address these areas.**
3. **Notes that progress on areas identified for improvement will be reported in this report in the future.**

Prepared by: Denise Johnson (Auckland DHB Health and Safety Manager)
Endorsed by: Sue Waters, Chief Health Professions Officer

Purpose of report

The purpose of this report is to provide an update on progress towards meeting the expectations of the Health and Safety at Work Act 2015, which came into effect on 4 April 2016.

1. Executive Summary

The new Health and Safety at Work Act 2015 came into force on 4 April 2016. The new legislation is the result of work from the health and safety taskforce established in 2012 to evaluate whether the workplace and safety system in New Zealand was fit for purpose, and to recommend practical strategies for reducing the high rate of workplace fatalities and serious injuries by 2020. From taskforce recommendations made in 2013, WorkSafe NZ was established with one goal – to reduce workplace deaths and injuries by 25% by 2020.

The DHB has been working on key aspects of the legislation specifically those around employee participation and engagement and work with PCBUs where we share accountability and procurement processes. While updating key policy and work methods, the DHB continues to have an active programme in place to measure and mitigate any resulting or residual risks. To monitor our compliance a number of audits are scheduled for 2016/17.

A summary of our compliance with the Act is outlined below and details are outlined in Appendix 1.

Key
High – complies substantially or fully with Act
Good – some actions to be completed
Low – significant or some key actions to be completed

Topic	Level of performance	Outstanding actions
1. Policy	High	No outstanding Actions
2. Worker engagement, participation, and representation	Good	Region work participation agreement still in discussion.
3. Notifiable events	High	No outstanding actions
4. Health and Safety Committee	High	No outstanding actions

5. Orientation	Low	An action plan to achieve a higher level of compliance with all mandatory training is to be developed in conjunction with Organisational Development.
6. Risk Management	High	No further action required in relation to provision of hazard management systems. Action plans developed to manage hazards new hazards or continually review and improve hazard management are on-going.
7. Contractors (Facilities, Health Alliance and Information Technology, Commercial Services)	Good	The DHB is working with health Alliance about site orientation, safety and procurement processes Commercial Services contractor H&S induction process to be implemented.
8. Hazardous substances	High	No Further Action required except continuous Improvement review on-going
9. Health of workers	High	Continuous Improvement review on-going
10. Equipment and Maintenance	Good	No specific action identified except continuous Improvement review on-going
11. Training	Good	A review of H&S induction training compliance is underway to address the areas where compliance could be improved.
12. Audits	High	No Further Action required except continuous Improvement review on-going
13. Reporting	Good	Regional review to work towards alignment
14. Resources	Good	Some roles still in recruitment.

2. Glossary

PCBU – person conducting a building or undertaking, and has a primary duty of care to ensure the health and safety of workers. The DHB is the PCBU.

Officers - Includes Board Directors and the Senior Management team who make governance decisions that significantly affect the business. Officers have a duty of due diligence to ensure their business complies with its health and safety obligations. Officers may be found guilty of an offence under the Act, in addition to the PCBU.

Due Diligence – taking steps to acquire and keep up to date knowledge of health and safety matters. Gain an understanding of the business and hazards and risk associated with that business. Ensure PCBU has available and uses appropriate resources and processes to manage risk. Ensure PCBU has appropriate processes for considering incidents, hazard and risks in a timely way. Ensure PCBU implements processes for complying with obligations under the Act, validates the provision and use of resources and processes to comply with obligations under the Act.

Workers - Workers have a duty to take reasonable care for their own safety and that their own actions do not adversely affect the safety of others. They need to comply with reasonable health and safety instructions from the PCBU and co-operate with health and safety policies and procedure.

Workers are people who work at the DHB and include employees, contractors, sub-contractors or their employees, apprentices, trainees, persons gaining work experience, employees of a labour hire company and volunteers.

Other people - People who come to the workplace such as visitors or customers also have duties to comply with health and safety processes. Our patients and visitors are in this group.

Notifiable injury or illness – an injury or illness that requires immediate treatment (i.e. amputation, serious burn, serious head injury or burn), admission to hospital, serious infection and medical treatment within 48 hours of exposure. All notifiable injuries or illnesses are to be reported to WorkSafe NZ.

Notifiable incident - an incident that is an unplanned or uncontrolled incident in a workplace and that exposes a worker or other person to a serious risk to health and safety.

Notifiable incidents include events such as: a spillage or leak of a substance; explosion or fire; escape of gas or steam; falls; electric shocks; structural collapses; in rush of water, gas or mud; interruption of underground ventilation. All notifiable instances are to be reported to WorkSafe NZ.

Health and Safety Representative - a person elected to represent the workers in relation to health and safety matters. The representative has specific functions and roles under Schedule 2 of the Act.

Appendix 1

Progress implementing the Health and Safety at Work Act 2015

1. Policy

The DHB policies have been reviewed and are aligned to the new legislation. Changes and updates to policy will occur over the next few years as new regulations, audits and experimental learnings lead to new processes. All H&S policy reviews are to be endorsed by the Board.

2. Worker engagement, participation, and representation

What the Act says	A PCBU must: • Initiate election of health and safety representatives on request of workers. • Agree the work groups that are represented by a health and safety representative. • Consult about matters related to health and safety • Provide information as requested with due consideration to the Privacy Act • Allow a health and safety representative time to discharge their powers under the act • New regulations on worker engagement, participation and representation were introduced in February 2016 and outline the functions, number, training, powers and participation expectations of health and safety representatives.
How do we comply?	We have approx.300 Health and Safety Representatives (HSR) throughout the organisation, most of whom had received baseline health and safety representative training, as endorsed by MBIE. HSR election was held in June 2016 and a review of work groups was conducted as part of this election process. All elected HSRs have the opportunity to attend Health and Safety Committee for their Directorate. In addition, the twice yearly Workplace Checklist (self- assessment audit) conducted by HSRs this includes a review of all hazards on the hazard register for their area and compliance with ADHB H&S systems. Representatives also undertake other tasks such as local H&S inductions and team safety briefings, There are 12 Directorate H&S Committees that all HSRs are free to attend. Transitional training for HSRs was provided in mid- 2016 and NZQA training is offered for all HSRs who have not year attended. Approx. 65% of our HSRs have attended training as stipulated by the act. Training is scheduled to June 2017.
What is outstanding?	• The regional employee participation agreement between the Northern Region DHBs and unions has not yet been signed by the Unions. The Regional managers group is working with the national bipartite group

	on an agreed way to include other PCBUs (e.g. compass and health alliance) in the agreement. • Meeting with on-site contractors to establish health and safety representatives and discuss health and safety matters together are commencing.
Consequences	There are fines for not having appropriate employee participation processes in place.

3. Notifiable events

What the Act says	A PCBU must • Report on notifiable injury, illness and incidents as soon as possible after being made aware of them. • Secure a site if a notifiable event has occurred. • Keep a record of notifiable events
How do we comply?	We currently have notifiable event reporting and recording processes in place.
What is outstanding?	There are no outstanding actions
Consequences	There are fines for not notifying workplace injury or illness as soon as possible after being made aware of them.

4. Health and Safety Committee

What the Act says	A PCBU must: • Put in place a health and safety committee if requested by a worker. • Establish a health and safety committee within two months of this request. • Consult about health and safety matters with the committee. • Allow time for members to attend and carry out functions as a member of the committee. • Provide information to the committee • Within a reasonable time, adopt recommendations made by the committee. A PCBU can also establish a Health and Safety Committee on its own initiative.
How do we comply?	The DHB has an organisation wide Health and Safety Committee. (meeting 6 weekly) As well as a H&S committee for each Directorate chaired by the Director of the Directorate or someone from the Directorate SMT. (meeting vary, minimum quarterly) The chair of the Directorate H&S Committee attends the Organisation wide H&S Committee. Many larger services have Service level H&S committee such as Lab Plus, Theatres, and Buchanan. Health and Safety risks are discussed at the MOS meetings at ward, service

	and Directorate levels.
What is outstanding?	There are no outstanding actions.
Consequences	There are fines for not setting up a Health and Safety Committee if requested, and if a PCBU does not: allow time for members to attend committee meetings/consider matters raised at the committee; or if a PCBU does not implement recommendations from the committee.

5. Orientation

What the Act says	Orientation to a workplace is an important part of complying with the duty of care to ensure the provision and maintenance of a workplace that does not give rise to health and safety risks.
How do we comply?	Lester Levy's "Safety First' video is used for all new staff orientation, training and general health and safety messaging. A Health and Safety information station is provided at "Navigate" the organisation on boarding event for all new staff. HSRs are trained to provide the local H&S Induction; this consists of a check list to review specific H&S information for an area and an E learning course to provide ADHB H&S systems information. The local H&S induction checklist can be used for Students, Volunteers and contractors. House officer and large student groups receive an introduction to H&S as part of their orientation day. H&S induction for Facilities managed contractors is in place and compliance is monitored by Facilities. H&S induction for Commercial Service contractors is under development.
What is outstanding?	Compliance in relation for local H&S Induction for new employees indicated that some new staff may not receive a local H&S induction within required time frames. An action plan to integrate this requirement with all mandatory training is to be developed in conjunction with Organisational Development. A suitable H&S induction for Commercial Services contractors is under development.
Consequences	There are fines and criminal punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

6. Risk Management

What the Act says	PCBUs have a duty of care to ensure the health and safety of another person is not put at risk from work carried out as part of the conduct of the business or undertaking. Risks must be eliminated or minimised so that a PCBU can, in so far is reasonably practicable: • Provide a workplace without risk • Provide and maintain safe systems, plant and structures • Ensure the safe handling, storage and use of plants, substances and structures • Provide training or supervise to protect persons from risk • Maintain accommodation so a worker is not exposed to risk
How do we comply?	The Hazard identification form and Hazard Register are modules in the organisations new fully integrated Safety Management System. Risk assessment and rating is part of the Hazard Identification process. Health and Safety Hazards /risks are recorded, controlled and regularly reviewed by the services and can be can be viewed at all levels of the organisation so that Directorates have an oversight of H&S risks within their services. Hazards related to repairs and maintenance is logged onto the BIEMS system managed by Facilities. Facilities have access to ring fenced funding for urgent repairs required to manage H&S risks with ADHB buildings and grounds. Hazards/Risks are reviewed a minimum of every 12 months by the divisional lead manager and Health and Safety Representatives. Key H&S Hazards are elevated to the Risk Register, updates are provided to the Board in each H&S report. H&S Policy and/or performance improvement action plans are in place for all key hazards such as.: • Facilities Safety • Pedestrian Safety and traffic management • Asbestos Management • Moving and Handling • Hazardous substances • Workplace Violence • Security for Safety Containers for sharps, hazardous materials and substances are provided on each site. Staff are provided with personal protective equipment (PPE) to wear. PPE requirements are outlined in various policies including the hazardous substances register, use of lasers, gloves, etc. Installation of signage close to potential slip, trip and fall hazards has occurred and cleaner are asked to regularly monitor wet areas. Regular communication on hazards is issued.

What is outstanding?	No further action required in relation to provision of hazard management systems. Action plans developed to manage hazards new hazards or continually review and improve hazard management are on-going.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

7. Contractors (Facilities, Health Alliance and Information Technology and Commercial Services)

What the Act says	The PCBU, as well as ensuring the health and safety of its employees (workers), is also required to ensure the health and safety of other workers, as well as ensuring that plant, fixtures and fittings are without risks to health and safety of any person. There are new asbestos regulations that require a change in how PCBU's currently manage and remove asbestos.
How do we comply?	**Facilities Selection of Contractors**: The DHB has moved to a process of selecting a panel of preferred contractors who can tender for DHB construction and refurbishment work as it arises. Each main contractor has to first qualify to be a part of the panel by satisfactorily completing contractor health and safety questionnaire which allows the organisation to demonstrate their performance against 12 health and safety criteria. Maintenance contractors do not have a preferred supplier arrangement in place as yet but contracts are in place and current for main contractors. **Supplier Contracts and RFP processes:** DHB contracts provide a standardised health and safety statement for minor or individual contracts. This clause is confirmed as satisfying the Act. **Orientation:** Construction contractor induction is in place and completed prior to gaining access to the relevant site. **Site access:** All building contractors must report to Facilities before commencing their work and all Health Alliance (hA) staff (IT) will report to security. In addition, • New projects must be agreed and coordinated with Facilities prior to commencing • New contractors must complete induction prior to starting work • All contractors must have a ADHB photo ID which will only be issued after completing induction) • Pre-work Safety checklist is printed on all work orders and monitored by the Facilities H&S manager. All healthAlliance staff and contractors are required to have healthAlliance issued photo identification on them at all times and visible. Usually if they are based on a particular site on a regular basis (i.e. not just visiting) then we will request a security access card with photo ID for that staff member from the site. **On the job:** Toolbox meetings occur on a scheduled basis. There is active management and collaboration with architects and designers to meet design expectations and requirements. Wwork impact meetings to assess

	risk occur regularly and ensure contractor health and safety plans are implemented. All Project managers are Site Safe certified. Regular meeting with construction contractors are occurring. **Asbestos Register:** All contractors have access to the Asbestos register and are required to review prior to every job. Asbestos register is updated as new surveys are completed. Corrective actions are being implemented to mitigate identified hazards. Asbestos management plans are being developed and implemented. This work is being led by the Auckland DHB Asbestos Management Steering Committee. **Incidents and Accidents:** Reporting of incidents and accidents follow the DHB process. Contractors experiencing any accident or incident are required to notify the DHB, investigate and report back any findings. **On site audits:** Regular external audits are conducted for construction site work. Project managers also undertake audits of their projects. **On the job:** A pre start safety meeting process is in development for all build projects, as well as ensuring work impact meetings occur regularly during the project. Safety in design guidance is in development. **Maintenance work review and sign off:** For IT project work related to moves and new fit-outs, the desktop team work closely with the Auckland DHB Project Manager who reviews and signs-off that the work is complete. **Building project health and safety management and sign off:** A performance review is done mid-way through each major building project. Health and Safety design sign off and pre-occupation processes are complete. The building sign off process follow the relevant policy. **Post Implementation Reviews (PIRs):** PIRs are done for each facility build project and results provided to the contractor selection panel. **Health Alliance procurement processes:** Documentation is under review to ensure that it is adequate for the new Act. **Commercial Services Contracts**: All commercial services contractors were audited by H&S in 2016 against the requirement of the ADHB H&S Requirements for Contactors policy. All gaps identified were discussed with the PCBU of the contact supplier. A consistent H&S induction process for non-Facilities managed contractor groups is under development.
What is outstanding?	***health Alliance processes:*** The DHB is working with health Alliance about site orientation, safety and procurement processes Commercial Services contractor H&S induction process to be implemented.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

8. Hazardous substances

What the Act says	A PCBU has a primary duty of care to provide for staff use, handling and storage of substances. The DHB is also required to comply with the Hazardous Substances and New Organisms Act 1996 which requires the DHB to prevent and manage adverse effects of hazardous substances and new organisms.
How do we comply?	In Preparation for the new legislation the Hazardous Substance management across ADHB was audited by an external hazardous substance specialist company in mid- 2015. An action plan was developed to implement the recommendations. The completion of the actions required was overseen be the (then) Audit and Finance Committee. Performance improvement has focused on areas with high volume use of hazardous substances. Now almost 1000 substances have been identified and added to the online inventory register of substances available on Hippo. ADHB also have a full Hazardous substance Safety Data Sheet (SDS) library for all substance recorded in the inventory with quick reference cards available for most substances accessible to all staff on Hippo. There is a schedule of monthly self- assessment audits that is overseen by H&S. Follow up reviews for these audits in relation to outcomes and compliance are conducted by a subject matter expert in H&S. A Hazardous Substance policy has been developed and published on the intranet, with a strong focus on roles and responsibilities. The H&S hazardous substance intranet site now contains hot links to information covering: • Policy document • Full database of all hazardous substances identified, including constituents, product state, UN number, CAS number, identified hazards, exposure limits, HSNO class and PPE specific to each substance. • Master Material Safety Data Sheets (MSDS) repository • Wastewater disposal instructions included in inventory information • Training resources, including introductory PowerPoint • List of all Approved Handlers and their locations • Emergency response requirements • Specific spill kit contents list • Managers responsibilities • Key contacts for staff Approved handler training has been delivered for high risk areas. ADHB is collaborating with CMDHB and WDHB with healthAlliance, to ensure that Material Safety data Sheets are supplied for all new chemicals being procured and central SDS access is provided to all regional DHBs.
What is outstanding?	There are no outstanding actions.

Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness. It is worth noting that hazardous substances are covered under three sets of national legislation, as well as local bylaws (Health and Safety at Work Act 2015, Hazardous Substances and New Organisms (HSNO) Act 1996, Resource Management Act 1991 and Auckland Council's 'Water Supply and Wastewater Bylaw'), under all of which fines can be payable.

9. Health of workers

What the Act says	A PCBU must ensure that the health of workers and conditions of the workplace are monitored for the purpose of preventing injury or illness. The PCBU must, as far as reasonably practicable, maintain accommodation so that the worker is not exposed to risks to health and safety.
How do we comply?	Pre-employment screening is required for all new DHB staff including internal transfers and RMOs new to the DHB. Area managers are required to ensure this is completed before the new employee starts work in their area. Compliance with the requirement to complete this process prior to starting work is 99%. Where staff that do not complete the process prior to commencing work are tracked and completion of the process is overseen by H&S. Free Vaccinations for Measles, Mumps, Rubella, Chicken pox, Hep B and pertussis are provided to patient contact staff. Blood & Body Fluid Accidents (BBFA) are followed up as a top priority by the occupational Health team and any on-going health monitoring continues for up to 2 years. Contact Traces for unprotected exposures to air borne infections diseases (such as TB, chicken pox) are conducted by the Occupational Health Service and on-going health monitoring is put in place as required. We undertake other occupational health monitoring for exposure to hazardous substances such as lead, cadmium, TB, formalin. Staff required to wear N95 particulate respirators are monitored annually in relationship to the effectiveness of the personal protective equipment. Monitoring for exposure for radiation (Radiology, Cardiac Catheter Lab) occurs externally. We provide free influenza and other vaccinations to all workers including students, volunteers and contractors. Infection control processes are in place to manage any disease outbreaks and exposure.

What is outstanding?	There are no outstanding actions.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

10. Equipment and Maintenance

What the Act says	A PCBU must provide and maintain a work environment that is without risk to health and safety.
How do we comply?	ADHB provides a repairs and maintenance work order request programme (BIEMS) that is accessible by all work areas. Progress on the work orders can be tracked by the services. Health and Safety related R&M receive priority processing .when at all possible. A fast track process is in place to approve maintenance triggered for health and safety reasons. A Board approved funding pool for major Health and Safety purchases has been accrued for activation by the Chief Financial Officer as relevant. All bio-medical equipment is maintained by the Clinical Engineering team Other equipment that is broken repaired or removed from service. Replacement is escalated for capital replacement as relevant. A register of capital assets is in place and being added to, to ensure that equipment is budgeted for replacement according to the life span of that equipment. All Capex application for equipment that is used by our staff required H&S endorsement. Requirement for this has been included in the Capital Acquisition policy.
What is outstanding?	There are no outstanding actions.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

11. Training

What the Act says	A PCBU must provide any information, training, instruction and supervision necessary to protect all persons from risks to health and safety arising from work carried out by the DHB.
How do we comply?	Health and Safety induction for all new staff is required. Health and Safety Reps are trained to provide the local H&S induction. This induction consists of a local face to face component and e-learning. Compliance is tracked and managers receive reminders when this does not occur. Health and Safety representatives are provided with two days of training delivered by an external NZQA qualified trainer. The two day course is

	followed by a competency assignment to achieve the NZQA unit standard. HSRs also have access to a 4 hour HSR orientation course delivered by the H&S department that covers the regular tasks required for HSRs at ADHB The H&S department also provides training in hazardous substance management for managers and HSRs. Training is provided on departmental specific instances such as moving and handling in patient areas, crisis intervention in areas where aggressive clients may be experienced, calming and restraint in mental health services, laser care in theatre, handling sharps by infection prevention and control. As already noted, approved handler training is in place for hazardous substances in areas where required under HSNO. On line learning is provided on how to access our new Safety Management System incident management, risk register and hazard register systems, with additional face to face training for HSRs Managing Safely is a one day training for all people managers to assist them with understanding their H&S responsibilities and how to manage hazards and risk within their area or responsibility. Directing Safely is an E-Learning course that is in final stages of development that will inform senior managers of their due diligence obligations under the act. Emergency Response Training occurs regularly • Fire Response and Evacuation Training occurs for all new staff and annually online and face to face in key areas • Fire Evacuation Training occurs across all DHB areas six monthly which means each week there are activities in order to cover all areas • Warden Training occurs on all sites annually for all wardens and deputy wardens. This is for all areas so requires multiple sessions annually • Incident Management Team training occurs quarterly • Key staff are required to attend Health CIMS2 training – which is available monthly and is done as a regional programme with the other DHBs. This is open to all health settings including PHO's Accident and Medical centres and Residential Aged Care key staff • Key staff attend CIMS4 training quarterly • The DHB runs particular Health CIMS4 training with a provider twice a year for key areas that have identified a need.
What is outstanding?	A review of H&S induction training compliance is underway to address the areas where compliance could be improved.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

12. Audits

What the Act says	An Officer of a PCBU must verify the provision and use of resources and processes put in place by the DHB.
How do we comply?	Since early 2015 we have completed a number of readiness audits to access compliance with the new health and safety legislation and to assess new or different resources needed. Going forward the Northern region has agreed to undertake two audits during 2015-2017 which includes community workers and contractor management. A ADHB governance audit was completed in May 2016 and corrective actions have been completed.. An audit programme for 2016/2017 has been agreed with ADHB Finance Risk Assurance Committee that includes a second deep dive audit on Health and Safety systems to occur in June 2017.
What is outstanding?	There are no outstanding actions.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

13. Reporting

What the Act says	An Officer of a PCBU must ensure they acquire and keep up to date on health and safety matters.
How do we comply?	Monthly reports on health and safety matters are provided to the Board meeting and the Finance, Risk Assurance Committee. All DHB directorate receive a monthly H&S report that can be used at H&S committee meetings as well and MOS reviews. Collaboration with WDHB and CMDHB is underway to review the reporting format and content.
What is outstanding?	There are no outstanding actions.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

14. Resources

What the Act says	An Officer of a PCBU must verify the provision and use of resources and processes put in place by the DHB.
How do we comply?	The new legislation increased the request for advice and assistance from the services and a request for 2 additional H&S Advisor FTE to provide this

	support to management was provided in January 2017. The Health and Safety Team at ADHB consists of the following (FTE): • 4 H&S Advisors • 1 H&S Advisor Team leader 2 Nurses • 1 Doctor • 2.7 Admin Support • 1 in house work injury Case manager • 1 Vocational Wellbeing Advisor • 1 moving and handling trainer When vacancies occur H&S contractors are sourced when possible to maintain resource levels.
What is outstanding?	There are no outstanding actions.
Consequences	There are fines and punishments of imprisonment for reckless conduct in respect to duty of care, and fines for failing to comply with risks that expose individuals to death or serious injury/illness.

Financial Performance Report

Recommendation

That the Board receives the Financial Performance Report for March 2017.

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

The DHB financial result for the month of March 2017 was a deficit of $3M which was unfavourable to budget by $165K. For the Year to Date (YTD), a surplus of $5.4M was realised, unfavourable to budget by $6.5M. This reflects a $20M unfavourable Provider arm result, partially offset by a $14M favourable Funder arm result. The overall DHB YTD result was mainly driven by less revenue realised than planned.

YTD revenue was unfavourable to budget by $9.2M. Key contributors to unfavourable revenue include: under delivery of inpatient and additional electives volumes (net $5.7M adverse wash-up provision); less than planned Public Health revenue ($1.2M, timing only); Haemophilia funding ($1.7M, due to lower blood product usage); donation income ($1M, timing only); and interest income ($2.4M, lower interest rates). These are offset by favourable IDF Inflows ($1.3M, service changes and wash ups) and other income ($4.3M, mainly research grants and drug trial revenue with corresponding costs, gains on valuation of Trust investments).

YTD expenditure is favourable to budget by $2.7M. This is primarily due to favourable Funder NGO expenditure ($19M, mainly pharmaceuticals, Age Related Residential Care and Mental Health services). This offsets adverse expenditure in net personnel and outsourced personnel costs ($8.4M); clinical supplies ($7.4M) and infrastructure/ non-clinical supplies ($4M).

The planned surplus of $4.5M is at risk, with the current year end forecast surplus of $3.2M. We remain committed to living within our means and effort is being made to resolve the IDF pricing and transplant funding issues with MoH and other DHBs so that our funding reflects what it costs to provide services. Achieving the full year plan is dependent on these issues being resolved prior to year end and to more savings being achieved.

Summary Results as at 31 March 2017

$000s	Month (March-17)			YTD (9 months ending 31 March-17)			Full Year (2016/17)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
MOH Sourced - PBFF	98,866	98,860	5 F	889,802	889,744	58 F	1,186,378	1,186,325	53F
MoH Contracts - Devolved	7,394	9,011	1,617 U	74,585	81,100	6,515 U	104,966	108,134	3,168U
	106,260	107,872	1,612 U	964,387	970,844	6,457 U	1,291,344	1,294,459	3,115U
MoH Contracts - Non-Devolved	4,844	5,070	227 U	41,174	44,446	3,272 U	57,787	59,538	1,751U
IDF Inflows	52,739	52,772	33 U	476,220	474,946	1,274 F	639,776	633,262	6,514F
Other Government (Non-MoH, Non-OtherDHBs)	3,314	3,101	213 F	28,621	28,291	329 F	37,796	37,738	58F
Patient and Consumer sourced	2,084	1,631	453 F	13,888	14,313	425 U	18,573	19,207	634U
Inter-DHB & Internal Revenue	1,333	1,326	7 F	10,115	11,715	1,600 U	14,040	15,791	1,751U
Other Income	5,930	4,194	1,736 F	41,920	37,606	4,314 F	50,944	48,721	2,223F
Donation Income	1,304	593	711 F	4,376	5,378	1,003 U	8,272	8,907	635U
Financial Income	411	662	251 U	3,498	5,836	2,338 U	4,839	7,606	2,767U
Total Income	**178,219**	**177,220**	**999 F**	**1,584,198**	**1,593,376**	**9,177 U**	**2,123,371**	**2,125,229**	**1,858U**
Expenditure									
Personnel	76,804	76,757	47 U	663,140	662,591	548 U	894,817	889,213	5,604U
Outsourced Personnel	2,218	1,111	1,107 U	17,918	10,070	7,848 U	22,802	13,402	9,400U
Outsourced Clinical Services	1,978	2,062	84 F	16,983	18,756	1,773 F	26,800	24,923	1,877U
Outsourced Other Services (incl. hA/funder Costs)	5,124	5,041	84 U	46,193	45,366	827 U	60,263	60,488	225F
Clinical Supplies	25,050	22,087	2,963 U	194,108	186,704	7,403 U	259,471	254,983	4,488U
Funder Payments - NGOs	44,113	47,642	3,529 F	409,571	428,780	19,209 F	547,118	571,707	24,589F
Funder Payments - IDF Outflows	9,587	9,567	20 U	85,727	86,100	372 F	115,557	114,800	757U
Infrastructure & Non-Clinical Supplies	12,756	11,124	1,632 U	105,511	101,433	4,078 U	137,957	135,452	2,505U
Finance Costs	64	1,052	987 F	7,865	9,466	1,601 F	12,537	12,621	84F
Capital Charge	3,533	3,622	89 F	31,799	32,274	475 F	42,842	43,140	298F
Total Expenditure	**181,229**	**180,065**	**1,164 U**	**1,578,814**	**1,581,540**	**2,726 F**	**2,120,164**	**2,120,729**	565F
Net Surplus / (Deficit)	**(3,010)**	**(2,844)**	**165 U**	**5,385**	**11,836**	**6,451 U**	**3,207**	**4,500**	**1,293 U**

2. Result by Arm

Result by Division	Month (March-17)			YTD (9 months ending 31 March-17)			Full Year (2016/17)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	3,721	375	3,346 F	17,344	3,375	13,969 F	(18,889)	4,500	23,389U
Provider	(6,471)	(3,219)	3,252 U	(11,196)	8,461	19,657 U	22,500	0	22,500F
Governance	(259)	0	259 U	(763)	0	763 U	(404)	0	404U
Net Surplus / (Deficit)	**(3,010)**	**(2,844)**	**165 U**	**5,385**	**11,836**	**6,452 U**	**3,207**	**4,500**	**1,293 U**

The favourable YTD Funder result reflects lower expenditure for Community Pharmacy due to substantive changes in PHARMAC forecasts relative to their original budget advice. Also contributing are one off upsides from 2015/16 which had a positive impact on Age Related Residential Care, Mental Health and Other Personal Health expenditure positions. These were offset by adverse electives wash up provisions for the under delivery of services.

The unfavourable YTD Provider Arm result is driven by less revenue than planned mainly reflecting under-delivery of elective volumes, lower interest and donation income than planned. Expenditure was also unfavourable primarily in Outsourced Personnel, clinical supplies and Infrastructure and Non Clinical Supplies costs. These variances are described further in section 3 below.

3. Financial Commentary for March 2017

Month Result

Major Variances to budget on a line by line basis are described below.
Revenue was more than budget by $1M (0.6%), mainly driven by:

- MoH Devolved contract revenue $1.6M (18%) unfavourable due to under delivery of inpatient and additional electives services.
- Other income $1.7M (41%) favourable mainly due to Research grant income.
- Donation income $711k (120%) favourable mainly due to $600k favourable variance in Child Health donations for Starship L3 & L5 refurbishment.

These are offset by minor favourable and unfavourable movements across various income streams.

Expenditure was adverse to budget by $1.2M (0.6%) with significant variances in:

- Funder NGOs favourable by $3.5M (7.4%), mainly in Community Pharmacy due to upside occurring as a result of substantive changes in PHARMAC forecasts relative to their original budget advice. Other favourable positions were from budgeted service not yet contracted for.
- Combined Personnel and Outsourced Personnel costs were $1.1M (1.5%) unfavourable, mainly in Medical, Nursing and Management & Admin costs. Total FTEs at 8,686 are 343 FTE above budget – the unfavourable FTE variance is primarily due to savings targets incorporated into the budget but also reflects a temporary spike in Nursing FTE following the main intake of new graduates in February (this should reduce over the next month). The cost impact of FTE above budget is partially offset by lower cost per FTE due to reductions in overtime and other premium payments.
- Clinical supplies $3M (13%) unfavourable with key variances including a $1.3M one off impact of asset data cleansing for disposals; Medical Oncology net $452K unfavourable variance as a result of increased cost of Herceptin drugs combined with unbudgeted new high cost drug Pertuzumab and $283K Child health – Pediatric Orthopedics surgery volume higher than planned.
- Infrastructure and non-clinical supplies is a combination of various immaterial unfavourable variances.
- Finance costs were $1M favourable due to the Crown Debt Equity swap effected on 15 February which has removed interest expense for the rest of the year, although this is bottom-line neutral as matched by revenue reduction.

Year to Date Result
Major Variances to Budget on a line by line basis are described below.

Revenue was less than the budget by $9.2M (0.6%). Significant movements underlying this included:

- MOH devolved contract revenue is $6.5M (8%) adverse against budget YTD. The YTD adverse variance is mainly due to the creation of a revenue risk provision for the under delivered inpatient services and additional electives (net $5.7m). Included in the month and YTD result are reductions in revenue for Debt/Equity swap cost treatment (i.e. interest cost removed matched by revenue reduction - $4.3M for 2016/17), change in capital charge rate from 8% to 7% ($6.1M for 2016/17) offset by an increase in revenue due to asset revaluation at June 2016 ($5.6M for 2016/17). To a much lesser extent there is also an element of Funded Initiatives influencing the year to date. These are offset by equivalent expenditure variances and have a nil effect on the overall result.
- IDF Inflow revenue, $1.3M (0.3%) favourable YTD, is funding received from other DHBs and much of this revenue is variable according to service delivery and therefore at risk if under delivered. IDF Inflow revenue is also influenced by post budget service changes against budget but this is usually marginal. Also affecting variances are service changes and wash ups. Services changes include lower than budgeted inflows for Paediatric and Adult Congenital Cardiac starting from November offset by higher than budgeted inflows for PCT Melanoma starting from December. Wash ups include the favourable impact of the Ministry's PHO quarterly wash-ups settled in August and November as well as a favourable last quarter 2015/16 adjustment for Paediatric and Adult Congenital Cardiac inflow.
- Research and drug trial Income $2.9M favourable, offset by equivalent expenditure and bottom line neutral.

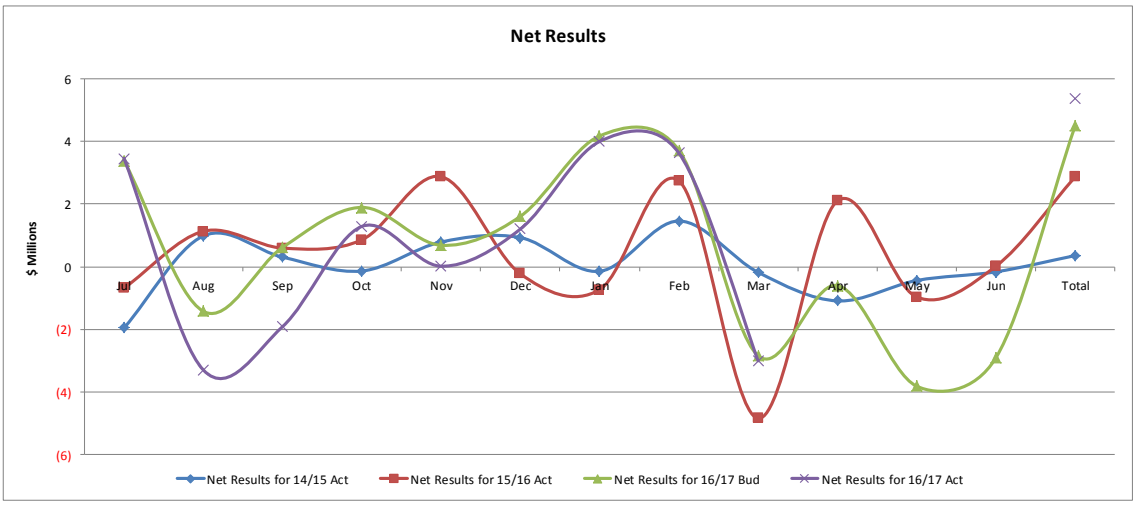
- Non-devolved income $3.2M (7.4%) unfavourable mainly due to Radiology planned additional revenue for Clot Retrieval not yet received $.2M, offset by on call roster not implemented and additional service billing so cost neutral for directorate.
- ACC revenue $1.8M favourable – with the variance reflecting a combination of one off revenue for new contracts and a small number of high value elective cases.
- Donations $1M unfavourable – revenue fluctuates from month to month, depending on timing of key projects, with the full year budget still expected to be achieved.
- Haemophilia funding $1.9M unfavourable for low blood product usage, bottom line neutral as offset by reduced expenditure.
- Other income includes a $0.8M gain on the valuation of A+ Trust financial assets.
- Financial Income $2.3M unfavourable driven by lower interest rates than assumed in the budget.

Expenditure was less than budget YTD by $2.7M, with significant underlying variances as follows:

- Combined Personnel and Outsourced Personnel Costs $8.4M (1.2%) unfavourable, mainly in Medical ($5.6M), Nursing ($3.2M) and Management & Admin ($1.2M) categories offset by Allied Health which is $2M favourable. YTD combined FTEs were 213 (2.5%) above budget due to FTE savings targets incorporated into the budget not achieved. However, the cost impact was partially offset by lower cost per FTE due to reductions in overtime and other premium payments.
- Clinical Supplies $7.4M (4%) unfavourable comprising the following key variances:
  - Haemophilia blood products $0.5M favourable due to low product usage year to date (highly variable), but offset by reduced income.
  - PCT (cancer) drugs $2.1M unfavourable due to increased volumes of Herceptin and melanoma drugs combined with unbudgeted new high cost drug Pertuzumab (note partially offset by additional revenue of $1.1M YTD, and will be subject to full IDF washup at year end).
  - Cardiovascular $0.8M unfavourable reflecting volume growth over the same period last year for both Cardiology and Cardiothoracic combined with a small number of patients with very high blood costs.
  - Orthopaedics $1M unfavourable due to partial achievement of procurement savings target in the pricing of implants.
  - One off costs for asset data cleansing to reflect disposals, $1.3M.
- Outsourced Clinical Services $1.7M (9.5%) favourable, reflecting no Orthopaedic elective surgery outsourcing YTD ($5.6M favourable but this is offset by an unfavourable Orthopaedics elective revenue position), and this is offset by costs of additional outsourcing in Ophthalmology to address waitlist and meet MOH targets.
- Funder Payments to NGOs are YTD favourable $19.2M (4.5%) and mainly driven by favourable variances from Community Pharmacy which continues to be the predominant contributor of the favourable YTD variances with a significant component of this upside occurring as a result of substantive changes in PHARMAC forecasts relative to their original budget advice. Also of note are one off upsides relating to 2015/16 year-end adjustments impacting favourably on Community Pharmacy as well as Age Related Residential Care, Mental Health and Other Personal Health expenditure positions. Other contributions to the favourable variance are from budgeted service lines that are not yet contracted for. There are also variances related to new funded initiatives expenditure that are offset by equivalent revenue variances and have a nil net impact on the core result.
- Infrastructure and Non Clinical Supplies $4M (4%) unfavourable primarily reflecting unfavourable facilities costs due to additional health and safety related expenditure.

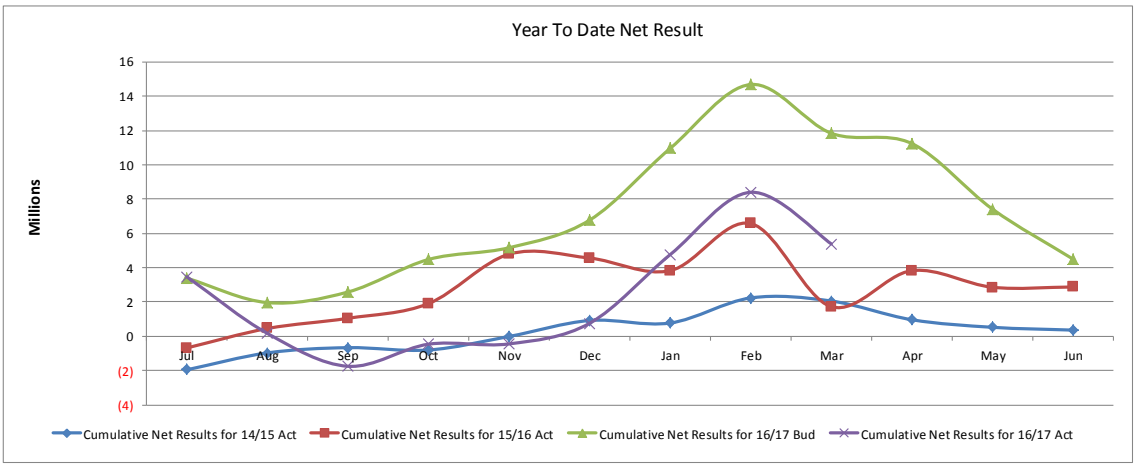
4. Performance Graphs

Figure 1: Consolidated Net Result (Month)



$ millions	July	August	Spetember	October	November	December	January	February	March	April	May	June	Total
Net Result for 14/15 Act	(1.957)	0.984	0.306	(0.137)	0.790	0.931	(0.147)	1.462	(0.179)	(1.093)	(0.441)	(0.164)	0.355
Net Result for 15/16 Act	(0.683)	1.133	0.595	0.859	2.881	(0.227)	(0.734)	2.747	(4.850)	2.101	(0.967)	0.015	2.871
Net Result for 16/17 Bud	3.385	(1.426)	0.619	1.897	0.686	1.610	4.182	3.727	(2.844)	(0.600)	(3.819)	(2.916)	4.500
Net Result for 16/17 Act	3.462	(3.302)	(1.914)	1.290	0.017	1.203	4.004	3.636	(3.010)				5.385

Figure 2: Consolidated Net Result (Cumulative YTD)



$'millions	July	August	September	October	November	December	January	February	March	April	May	June
Cumulative Net Results for 14/15 Act	(1.957)	(0.973)	(0.668)	(0.804)	(0.014)	0.916	0.770	2.232	2.053	0.960	0.519	0.355
Cumulative Net Results for 15/16 Act	(0.683)	0.450	1.045	1.904	4.785	4.557	3.824	6.571	1.721	3.822	2.855	2.871
Cumulative Net Results for 16/17 Bud	3.385	1.959	2.578	4.476	5.161	6.772	10.953	14.681	11.836	11.236	7.417	4.500
Cumulative Net Results for 16/17 Act	3.462	0.159	(1.755)	(0.465)	(0.448)	0.755	4.759	8.394	5.385			
Variance to Budget for 2016/17	0.076	(1.800)	(4.333)	(4.941)	(5.610)	(6.017)	(6.195)	(6.286)	(6.452)			

5. Efficiencies / Savings

Savings reported for the YTD to March 2017 of $16.5M were unfavourable to the budget of $31.6M by $15M. Savings achieved to date mainly relate to personnel/FTE/vacancy management, bed management, Laboratory/Radiology efficiencies and supply chain and Funder reported savings. Initiatives being implemented take time for the savings to start coming through. A financial

sustainability programme has been established to oversee identification, implementation and realisation of savings from the Get on Track and Think Tank initiatives.

6. Financial Position

6.1 Statement of Financial Position as at 31 March 2017

$'000	31-Mar-17			28-Feb-16	Variance	30-Jun-16	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Crown Equity	881,298	576,798	304,500F	881,298	0F	576,798	304,500F
Reserves	-	-	0F	-	0F	-	0F
Revaluation Reserve	508,998	438,457	70,541F	508,998	0F	508,998	0F
Cashflow-hedge Reserve	(3,328)	(3,327)	1U	(3,374)	46F	(3,742)	414F
Accumulated Deficits from Prior Year's	(461,173)	(461,653)	480F	(461,173)	0F	(461,173)	0F
Current Surplus/(Deficit)	5,386	11,831	6,445U	8,396	3,010U	-	5,386F
	49,883	(14,692)	64,575F	52,847	2,964U	44,083	5,800F
Total Equity	**931,181**	**562,106**	**369,075F**	**934,145**	**2,964U**	**620,881**	**310,300F**
Non Current Assets							
Fixed Assets							
Land	282,803	249,006	33,797F	282,803	0F	282,803	0F
Buildings	612,052	586,071	25,981F	610,790	1,262F	619,402	7,350U
Plant & Equipment	86,523	89,892	3,369U	84,108	2,415F	92,164	5,641U
Work in Progress	43,035	61,010	17,975U	48,773	5,738U	45,236	2,201U
	1,024,413	985,979	38,434F	1,026,474	2,061U	1,039,605	15,193U
Derivative Financial Instruments	-	-	0F	-	0F	-	0F
Investments	-						
- Health Alliance	57,637	53,103	4,534F	57,637	0F	53,103	4,534F
- HBL	12,420	12,420	0U	12,420	0F	12,420	0F
- ADHB Term Deposits > 12 months	-	-	0F	-	0F	5,000	5,000U
- Other Investments	505	503	2F	505	0F	503	2F
	70,562	66,026	4,536F	70,562	0F	71,026	464U
Intangible Assets	565	1,281	716U	542	24F	762	197U
Trust Funds	15,933	14,494	1,439F	15,689	244F	14,495	1,438F
	87,060	81,801	5,259F	86,792	268F	86,283	778F
Total Non Current Assets	**1,111,473**	**1,067,780**	**43,693F**	**1,113,266**	**1,793U**	**1,125,888**	**14,415U**
Current Assets							
Cash & Short Term Deposits	90,159	57,592	32,566F	85,893	4,266F	34,461	55,698F
Trust Deposits > 3months	8,000	11,500	3,500U	9,000	1,000U	11,500	3,500U
ADHB Term Deposits > 3 months	11,000	5,000	6,000F	11,000	0F	15,000	4,000U
Debtors	28,590	29,872	1,281U	21,233	7,357F	29,869	1,279U
Accrued Income	39,984	32,179	7,805F	42,778	2,794U	32,179	7,805F
Prepayments	1,592	1,679	87U	2,005	413U	1,679	87U
Inventory	14,663	14,239	424F	14,545	118F	14,239	425F
Total Current Assets	**193,989**	**152,061**	**41,928F**	**186,455**	**7,534F**	**138,928**	**55,061F**
Current Liabilities							
Borrowing	(494)	(429)	65U	(429)	65U	(429)	65U
Trade & Other Creditors, Provisions	(164,063)	(194,662)	30,599F	(156,026)	8,036U	(133,316)	30,747U
Employee Benefits	(170,319)	(168,687)	1,632U	(169,932)	387U	(166,232)	4,087U
Funds Held in Trust	(1,255)	(1,239)	16U	(1,255)	0U	(1,239)	16U
Total Current Liabilities	**(336,131)**	**(365,017)**	**28,886F**	**(327,643)**	**8,488U**	**(301,217)**	**34,914U**
Working Capital	**(142,142)**	**(212,956)**	**70,814F**	**(141,189)**	**953U**	**(162,289)**	**20,147F**
Non Current Liabilities							
Borrowings	(497)	(255,065)	254,568F	(279)	218U	(305,065)	304,569F
Employee Entitlements	(37,653)	(37,653)	0F	(37,653)	0F	(37,653)	0F
Total Non Current Liabilities	**(38,150)**	**(292,718)**	**254,568F**	**(37,932)**	**218U**	**(342,718)**	**304,569F**
Net Assets	**931,181**	**562,106**	**369,075F**	**934,145**	**2,965U**	**620,881**	**310,299F**

Comments

Category	Comment
Crown Equity and Borrowings	In February 2017, $304.5M of the Auckland DHB debt was converted to Crown Equity. This was in terms of a change in government policy impacting how DHB capital is financed.
Fixed Assets	The full revaluation of land and buildings completed at 30 June 2016 resulted in an increase in revaluation reserve of $70.5M ($33.8M for land and $36.7M for buildings), these revaluation adjustments were not accounted for in the 2016/17 budget. This is offset by less spend of capital expenditure against budget of $26M due to the delayed approval of the Capex Budget by the Board as a result of an extensive Capex prioritisation process for the 2016/17 Capex Budget.
Cash & short term deposits	Capex spend is $26M behind, due to delayed Board approval of 2016/17 capex budget. $20M favourable variance in payments to NGO funder providers. These are offset by $4.5M investment in healthAlliance for the transfer of IT assets C class shares which was not in the budget and $9m less revenue mainly due to under delivery of inpatient and additional electives volume.
Creditors	Trade & Other Payables: $50M favourable is as a result of the conversion of Crown Debt to equity in February; and other differences reflect timing differences for creditors accruals $12M and income in advance $5M.

6.2 Statement of Cash flows (Month and Year to Date March 2017)

$000's	Month (March-17)			YTD (9 months ending 31 March-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	175,663	176,559	896U	1,578,568	1,587,537	8,969U
Payments						
Personnel	(76,418)	(76,484)	66F	(659,052)	(660,137)	1,085F
Suppliers	(41,084)	(38,007)	3,077U	(327,369)	(327,034)	335U
Capital Charge	0	0	0F	(21,199)	(21,408)	209F
Funder payments	(53,700)	(57,209)	3,509F	(495,296)	(514,881)	19,585F
GST	(135)	0	135U	987	0	987F
	(171,336)	**(171,700)**	364F	**(1,501,930)**	**(1,523,460)**	21,530F
Net Operating Cash flows	**4,327**	**4,859**	**532U**	**76,638**	**64,077**	**12,561F**
Investing						
Interest Income	411	662	252U	3,498	5,835	2,337U
Sale of Assets	494	0	494F	494	0	494F
Purchase Fixed Assets	(2,248)	(5,905)	3,657F	(26,669)	(53,149)	26,480F
Investments and restricted trust funds	1,000	0	1,000F	10,820	15,000	4,180U
Net Investing Cash flows	**(343)**	**(5,243)**	**4,899F**	**(11,857)**	**(32,314)**	**20,457F**
Financing						
Other Equity Movement	0	(1)	1F	1	3	2U
Interest paid	282	(439)	721F	(9,083)	(6,486)	2,597U
Net Financing Cashflows	**282**	**(440)**	**722F**	**(9,082)**	**(6,483)**	**2,599U**
Total Net Cash flows	**4,266**	**(824)**	**5,089F**	**55,700**	**25,280**	**30,420F**
Opening Cash	85,893	58,418	27,476F	34,461	32,314	2,147F
Total Net Cash flows	4,266	(824)	5,089F	55,700	25,280	30,420F
Closing Cash	**90,160**	**57,594**	**32,566F**	**90,161**	**57,594**	**32,567F**

ADHB Cash	85,094	**55,059**	30,035F
A+ Trust Cash	1,491	**479**	1,012F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	3,576	**2,056**	1,520F
	90,161	**57,594**	**32,567F**
ADHB - Short Term > 3 months	11,000	**5,000**	6,000F
A+ Trust Deposits - Short Term > 3 months	8,000	**11,500**	3,500U
ADHB Deposits - Long Term	0	**0**	0F
A+ Trust Deposits - Long Term	15,933	**14,494**	1,439F
Total Cash & Deposits	**125,094**	**88,588**	**36,506F**

Funder Update

Recommendation

That the Board receives the Funder Update Report for April 2017.

6.2

Prepared by: Wendy Bennett (Manager Planning and Health Intelligence); Joanne Brown, (Funding & Development Manager Hospitals); Tim Wood, (Funding & Development Manager Primary Care); Kate Sladden, (Funding and Development Manager Health of Older People); Ruth Bijl, (Funding & Development Manager Women, Children & Youth); Trish Palmer, (Funding & Development Manager Mental Health & Addictions); Aroha Haggie, (Manager Māori Health Gain); Lita Foliaki, (Manager Pacific Health Gain); Samantha Bennett, (Manager Asian Health Gain)
Endorsed by: Dr Debbie Holdsworth, (Director Funding)

Glossary

AAA	-	Abdominal Aortic Aneurysm
AF	-	Atrial Fibrillation
AH+	-	Alliance Health Plus
AOD	-	Alcohol and Other Drugs
ARC	-	Aged Residential Care
DHB	-	District Health Board
DSLA	-	Diabetes Service Level Alliance
HCSS	-	Home and Community Support Services
HVAZ	-	Healthy Village Action Zones
LMC	-	Lead Maternity Carer
MoH	-	Ministry of Health
MSD	-	Ministry of Social Development
NGO	-	Non-Governmental Organisation
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
RFP	-	Request For Proposal
SACAT	-	Substance Addiction Compulsory Assessment and Treatment
SLM	-	System Level Measures
WCTO	-	Well Child Tamariki Ora

Summary

This report updates the Auckland District Health Board (DHB) Board on planning and funding activities and areas of priority, since its last meeting on 5 April 2017.

1. Planning

1.1 System Level Measures (SLM)

The two new developmental measures (below) had their components confirmed by the MoH in late April, with implementation guidance due to be released 1 May 2017. These confirmed indicators are being incorporated into the data monitoring and reporting framework. The SLM will be reported quarterly, as soon as the data is available. The data has been requested from the MoH.

The two new developmental measures for 2017/18 are:

1. Youth access to and utilisation of youth-appropriate health services
2. Proportion of babies who live in a smoke free household at six weeks post birth, measured by Well Child Tamariki Ora providers.

The MoH have elected to use a composite Youth health measure (see below), with initial 2017/18 activity focused in only one domain. The MoH expects activity to be managed through the existing Youth Service Level Alliance Teams.

Table 1: Domains, outcomes and indicators for youth SLM

Domain	Outcome	National Indicator
Youth Experience of Health System	Young people feel safe and supported by health services	Child and Adolescent Mental Health Services (CAMHS) Real-Time Survey results for 10-24 year olds
Sexual and Reproductive Health	Young people manage their sexual and reproductive health safely and receive youth friendly care	Chlamydia testing coverage for 15-24 year olds
Mental Health and Wellbeing	Young people experience less mental distress and disorder and are supported in times of need	Self-harm hospitalisations and short stay ED presentations for <24 year olds
Alcohol and other Drugs	Young people experience less alcohol and drug related harm and receive appropriate support	Alcohol-related ED presentations for 10-24 year olds
Access to Preventive Services	Young people receive the services they need to keep healthy	Adolescent oral health utilisation for school year 9-17 years of age

A SLM socialisation workshop for the wider health sector is taking place on 28 April, and feedback from this workshop will be included in the final version of the plans. The local improvement plans for each of the six measures are being developed, including the metrics associated with each of the activities.

2. Hospitals

2.1 IDF Arrangements

2015/16

The MoH data error delaying the Counties Manukau Health/Auckland DHB outpatient wash up has now been corrected, allowing this to be finalised and the wash-up to be settled.

2016/17

Wash-up forecasts are routinely monitored and changing trends reviewed by the funder. There is ongoing increased use of Pharmaceutical Cancer Treatments for breast cancer and all costs associated with this change are subject to full wash-up.

2017/18

Work is underway currently to review Elective service forecasts for all IDF populations. Both Counties Manukau Health and Northland DHBs demand for elective services in 2016/17 exceeds the funding allocated to electives in 2017/18 and the funder will initiate discussions with these DHBs' to increase the funding allocation next year.

New funding agreements for Clot Retrieval services will be established with other funders including the Midland region over the next 4-6 weeks and both Waitemata and Counties Manukau DHBs' are taking proposals to local Boards for consideration of funding in the next few weeks following Regional endorsement of the proposed new services.

2.2 Policy Priority areas

Colonoscopy Indicators

Auckland DHB has continued to achieve all colonoscopy waiting time indicators in February as validated by MoH reporting although further work is needed to ensure 100% of patients receive services within the maximum waiting times. Auckland DHB is successfully providing additional colonoscopy services for the Waitemata population and this is expected to continue at the same rate throughout 17/18.

Radiology Indicators

As of the end of March, the Auckland DHB provider achieved 97% outpatient CT completed within six weeks, an improvement from February. MRI performance improved slightly in March to 66% against the 85% target. 88% of outpatient ultrasounds were completed within six weeks against a DHB target of 95%. The pressures in MRI and US production due to high numbers of staff vacancies have continued; however, the Auckland DHB provider has made good progress to address these workforce issues. These initiatives and some outsourcing arrangements are expected to improve performance further.

Bone Marrow Waiting Times

No patients waited longer than the clinically recommended six weeks maximum waiting time guideline in March, with the service expected to maintain compliance with the guidelines going forward.

2.3 National services

The DHB has been advised the funding for National Intestinal Failure (Coordination) Services is to be continued for a further 3 years from 1 July 2017. Further discussion is under way to confirm the current coordination service and governance arrangements are sustainable.

Auckland DHB is waiting for further advice from the MoH regarding sustainable funding of the transplant service arrangements.

2.4 Regional Service Review Programme

The regional workplan includes prioritised activity relating to the configuration of Regional Head and Neck Services, Regional Oral Health services and Urology services. Work is already underway on the Head and Neck service discussions with a regional process relating to Oral Health due to commence in May.

A regional review of Cardiac Catheter Laboratory capacity has been completed and an options analysis for the next investment step in the region is near completion. Both Counties Manukau Health and Northland DHB have signalled their desire to respectively increase and establish capacity.

3. Primary Care

3.1 Health Targets

Better Help for Smokers to Quit

Generally PHO performance against this target is lifting with two PHOs Auckland and ProCare at the target with Alliance Health Plus (AH+) near the target. National Hauora Coalition is well below the target with an over 10% point improvement needed for achievement. Overall the DHB is two percentage points off the 90% target.

3.2 Auckland Waitemata Alliance

The MoH have provided comment on the 2016/17 improvement plan, which is minor in nature. The deadline for a finalised plan to be submitted has been extended due to the finalisation of the measures for the two new SLM.

The Diabetes Service Level Alliance (DSLA) has recently presented to the Alliance a high level implementation plan inclusive of priorities. This has been approved and the DSLA are now working up the detail for the first set of priorities; (i) retinal screening, (ii) co-design model prototyping and (iii) foot protection service.

Further the Alliance approved a standardised methodology for PHO reporting of five diabetes and cardiovascular clinical indicators. This will allow for consistent analysis and reporting of performance for these indicators at both a PHO and DHB level.

3.4 Safety in Practice

The aim of the Safety in Practice programme is to enhance the quality improvement capability of General Practices. The programme has a specific focus on patient safety thereby reducing the number of events which could cause avoidable harm from healthcare delivered in the Primary Care setting.

Safety in Practice is an adaptation of the Scottish Patient Safety Programme in Primary Care. A range of tools and resources, alongside coaching from improvement and clinical experts, supports General Practice teams to bring about a patient safety culture.

Dr Neil Houston, who was instrumental in the development of the programme in Scotland, has joined the funding team. The programme is looking at opportunities to expand both the range of safety bundles and the scope. Key safety areas to date have been; (i) laboratory results handling, (ii) medication reconciliation, (iii) prescribing, (iv) monitoring of warfarin and (v) opioid management. Additional areas are now in development. Discussions are underway to pilot the programme in community pharmacy.

The Royal New Zealand College of General Practice has confirmed that involvement in this programme will contribute to General Practice requirements for Cornerstone Accreditation. The Cornerstone programme is the Royal New Zealand College of General Practice approach to determining if General Practices achieve the standard known as Aiming for Excellence. This standard reinforces the College's commitment to supporting quality and maintaining high standards for general practice in New Zealand.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)

Guaranteed hours for HCSS support workers came into effect on 1 April 2017 including payment for unavoidable cancelled visits. This was a significant development for the Sector and all Auckland DHB HCSS contracts were varied accordingly. Claiming will use a similar process to Inbetween Travel claims and the DHB will receive regular reporting to monitor spend and address any issues that may arise with the process.

The Pay Equity Settlement for the aged care workforce (includes both HCSS and ARC support workers) has been announced by the Minister of Health. We are awaiting details of the funding and contracting requirements of this Settlement and will prepare a Board Paper detailing these and any implications.

4.2 Aged Residential Care (ARC)

Age Related Residential Care Agreement changes for 2017/18 are progressing as part of the A21 Annual Review of the contract. Outstanding is the price increase for 2017/18 and the Chair of the Health of Older People Steering Group has highlighted that DHBs' will need a rationale to support whatever increase is offered to ARC.

A feasibility pilot is being planned for Auckland DHB ARC facilities using an early warning system to identify early deterioration in residents. The aim is for early recognition and intervention to prevent hospital admissions.

4.3 Other Health of Older People Activity

The In-Home Strength and Balance Programme to reduce falls in frail older adults has been launched and is receiving referrals; the service has been promoted to primary care. A feasibility study is currently being scoped for delivery of strength and balance exercises through HCSS providers, this study will inform a trial comparing the traditional In-Home Strength and Balance Programme with a modified version delivered through HCSS.

5. Women, Children and Youth

5.1 Immunisation Health Target

For the third quarter, Auckland DHB achieved 94.4% of infants fully immunised at 8 months of age. This is a decrease on last quarter's result. Results are summarised in the table below.

Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: total**	**Change: Māori**
Q1 2016/17	94.0%	87.5%	95.1%	92.3%	0.3%	-1.3%
Q2 2016/17	95.4%	90.7%	94.5%	95.3%	1.4%	3.2%
Q3 2016/17	94.4%	89.4%	93.4%	93.6%	-1.0%	-1.3%
Q4 2016/17						

Summary of changes since last quarter

- Decrease of 1% in total coverage in Q3 2016/17 compared with Q2 2016/17 – coverage still higher than Q1 results.
- Decrease of 1.3% in coverage for Maori in Q3 2016/17 compared with Q2 2016/17 – coverage still higher than Q1 results.
- Decrease of 1.1% in coverage for Pacific in Q3 2016/17 compared with Q2 2016/17.

Activities currently underway to increase coverage include:

- The Maori case review group continues to meet with Ngati Whatua, well Child Tamariki Ora (WCTO), oral health, NIR/OIS and the DHB to share information and support whanau and tamariki who are overdue immunisations. This group discusses Māori tamariki turning six months of age
- The Māori Health Gain Team will develop and support the implementation of an action plan to eliminate the equity gap between Māori and non-Māori eight month immunisation coverage. This involves conducting a barriers and solutions workshop with key stakeholders
- Changes implemented in Outreach Immunisation Service follow up include early referrals at eight weeks of age for babies without a nominated provider and an additional referral point at five months of age for babies who are overdue immunisations

- Joint DHB/PHO education sessions are underway for primary care practice staff and Lead Maternity Carers (LMC)
- Working with PHOs to support practices in localities with high decline rates
- The cold chain failure in Quarter 2, 2016/17 has impacted the immunisation coverage with some babies unable to catch up on their vaccines by eight months. This failure and the one in the Waitemata DHB area has led to a review of refrigerator stock and cold chain management, including a data logger audit to ensure fridges are appropriately managed
- We are journeying with Quarter 4 babies to improve processes as this cohort moves through the stages to reach eight months of age. They are now due for their five month immunisation event and immunisation coordinators are following up on those not yet fully immunised
- A multiple newborn enrolment information sheet "Free Health Services for Your Baby" for parents and caregivers was launched in Maternity services earlier this year. The next step is to extend the information to primary birthing units and to obtain translations into priority languages.

5.2 Obesity Health Target – 'Raising Healthy Kids'

Since our last report, Auckland DHB has increased from 97% of obese children identified having their referral acknowledged, to 99%. This remains an outstanding achievement. The target is, by December 2017, 95% of obese children identified in the Before School check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

The DHB has a focus on declines, aiming to ensure all families offered a referral take the opportunity for extra support. This is being achieved through training for health professionals on having conversations with families around child healthy weight. We are implementing an audit process to assess if declines are consistent across nurses and geographical areas. Extra support in harder to engage areas may be needed.

Auckland DHB is working closely with Waitemata DHB and Counties Manukau Health to ensure consistency of care models across Metro Auckland. The DHBs' are also collaborating across the region on training of health professionals and consistency of health worker service offered to provide brief intervention tool.

5.3 Rheumatic Fever

As previously reported, we have not achieved a reduction in reported first hospitalisations for first episodes of Rheumatic Fever, with a rate of 5.4 per 100,000 in the 2016 calendar year. In March, the Funder along with provider arm and health gain leadership, brought detailed information to the Community and Public Health Advisory Committee. The Committee endorsed the development of a business case for consideration by Finance, Risk and Assurance. In essence, Auckland DHB has not been funded, nor invested to the same level as Counties Manukau Health, nor can it achieve the same level of coverage of the target population through a school based programme. The business case will be considering all aspect of the programme such as health promotion and awareness raising, primary care and school based programmes. The establishment of the expanded Healthy Housing Initiative has been progressing well.

6. Mental Health and Addictions

6.1 Auckland DHB Review of Residential Rehabilitation

Five beds with Affinity Services Ltd were identified by the Mental Health Local Coordination Service as suitable to be reconfigured. These beds were transferred to support hours on 1 April 2017, with Board approval.

Six beds with Emerge Aotearoa Ltd and a further five beds with Affinity Services Ltd have been identified by the Local Coordination Service as suitable to be reconfigured and Auckland DHB Board approval is being sought for these transitions elsewhere on the agenda.

6.2 Health Needs Assessment Project

This period we have generated, consulted on, and refined a proposal and data protocol. The Research Office has been contacted regarding data sharing, privacy assessment, Māori review and we have completed those processes. We have also submitted to the Regional Ethics Committee for an expedited review and spoken to the PHOs in different forums, we are about to meet with them to explore what data is potentially available.

We have received the cohort data for Auckland DHB so can start the basic demographic descriptive analysis. We are waiting to hear about the PHO register matching. The MoH are preparing a letter of agreement to provide us with an equivalent (anonymised) dataset by which we can look at secondary care and laboratory utilisation.

7. Māori Health Gain

7.1 Abdominal Aortic Aneurysm (AAA)/ Atrial Fibrillation (AF) update

In late 2016 approval was granted to fund an extension of the Waitemata DHB AAA; enlarged aortas ultrasound screening pilot for Māori. The approved funding was sought to offer screening to all eligible Māori men and women enrolled with general practices in both Auckland DHB and Waitemata DHB as a one off screen in order to reduce AAA associated mortality for Māori. Cost effectiveness was demonstrated for men in a slightly narrower age band than the pilot; more data was required to confidently determine cost effectiveness for women. Extension of the pilot will answer the question of cost effectiveness for women and also allow a new innovation to be tested; detection of AF, which is a modifiable risk factor for stroke. AF detection was a new element of the health check associated with the AAA screening (other components include an updated cardiovascular risk assessment, blood pressure check and offer of cessation support for identified smokers). This required further pathways of confirmation of AF and notification to primary care for ongoing management. These are being tested and refined as part of the pilot.

The pilot extension commenced in early February 2017 and is now screening at full capacity. The extension included a new role; Invitation Coordinator, who has a focus on improving the invitation and booking process, and on accessibility of screening in the community. This commitment to securing screening locations in the community has involved three locations within Waitemata DHB, community locations are still being sourced for the wider Auckland DHB area. Two Saturday morning sessions are also available each month. In close collaboration with primary care the programme is also booking clinics in rural health centres patients enrolled in the two general practices in Warkworth have been screened at Kawau Bay Health. Uptake at the community and primary care locations has been high and the Did Not Attend rates low (rebooking is completed rapidly).

Approximately 1,600 people will be invited for the pilot extension. As of 6 April 2017 there have been 225 people screened with 11 cases of AAA detected. These patients have been referred to the vascular service for surveillance. There have also been 16 cases of AF detected and the ECG traces

and their interpretation from the cardiac physiologists have been sent to their GP for follow up. In addition several people with severe hypertension were identified and a new pathway for a rapid referral for review has been established. In an associated co-benefit seven smokers took up the offer of support for smoking cessation and they have been referred to the appropriate service.

8. Pacific Health Gain

8.1 Renewing Pacific Health Action Plan (PHAP)

The PHAP 2016 – 2020 was endorsed by the Community and Public Health Advisory Committee on 29 March 2017. We will report on the implementation of the eight priorities of the new Plan at the next report.

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

One Triple P parenting programme has been delivered with a Tongan Seventh Day Adventist Church. 26 parents enrolled in the four workshop programme, with 11 attending and completing all workshops. Most parents attended at least two workshops, two attended the Introductory session but did not attend any workshops. Overall more males than females attended these workshops.

The formative evaluation survey showed that most parents were satisfied with quality of the discussion group and they received the type of help that they wanted from the programme. Three more programmes will be implemented during May/June.

Discussions with the Ministry of Social Development (MSD) about the Living without Violence programme is ongoing, further meetings will be held to confirm how MSD, Auckland DHB and Waitemata DHB will work together to address family violence within Pacific families.

The Tongan Catholic Chaplaincy of the Auckland Diocese of Auckland has decided to include a health programme as part of their Chaplaincy programme, starting with a focus on child health. The Chaplaincy has 22 Tongan groups across Auckland. The first health workshop will be held on 29 April at a church in Mt Wellington, addressing rheumatic fever, oral health and healthy nutrition for children. Input into the workshops will be provided by staff from The Pacific Team, the Auckland Regional Dental Service, the Pacific Heartbeat, National Heart Foundation and Alliance Health Plus (AH+).

8.3 PHAP Priority 2 –Pacific People are smoke-free

Work is being done with the smokers in two Samoan congregations in the Auckland DHB area. Church ministers and health committees of these churches have initiated discussions with members who are smokers, which have resulted in them agreeing to participate in a quit smoking assistance programme. We intend to work with other churches in similar ways.

Members of the Pacific Team were invited by Siaola, the Health and Social Services Committee of the 36 member congregation of the Tongan Methodist Circuit in Auckland, to present to their annual planning weekend on the health needs of Tongan/Pacific people. The Circuit decided that they will work on two health priorities; all of their properties will be smoke free and to address childhood obesity. We will support the Circuit in the implementation of their health objectives.

The Catholic Diocese of Auckland has given instructions to all of their member churches that smoking and alcohol consumption will no longer be allowed in any church property. A high percentage of Tongans and Samoans are members of the Catholic Church, so this policy of the Diocese will further support the journey towards smoke free environments.

8.4 Priority 3 – Pacific people are active and eat healthy

The 14 churches that are part of the Healthy Village Action Zones (HVAZ) programme and under the management of AH+, have decided to hold their own Aiga Challenge, starting in April. Maintaining weight loss is a continuing challenge, which all HVAZ/Enua Ola struggle with, the decision by AH+ to hold a second Aiga Challenge within a 12 month period is one attempt to support people to maintain their weight loss.

8.5 PHAP Priority 4–People seek medical and other help early

As part of the review of the parish community nursing service, the Public Health Physician attached to the Pacific team has been attending and observing work parish community nurses are undertaking in churches. The connection between the parish nurses and Primary Care providers of the people they see in the church context continues to be a challenge. This will be a major focus of the renewal of the current contract.

9. Asian, Migrant and Refugee Health Gain

9.1 Increase Access and Utilisation to Health Services

Indicators:

- **Increase by 2% the proportion of Asians who enrol with a PHO to meet 75% target by 30 June, 2017 (current rate 69% as at Jan 2017)**
- **80% of eligible Asian women will have completed a cervical sample by 2020 (current rates 59.2% as at Dec 2016)**

A multi-lingual social media campaign will roll out for eight weeks (April to June) focusing on Asian new migrants and students – primarily Chinese, Indian, Korean and Filipino living in the Auckland DHB area. The campaign leverages off the phase one campaign efforts delivered in 2016 to Asian migrants and students in the city centre and inner fringe suburbs. The aim of the phase two campaign is to reduce acute flow to Auckland Hospital's Emergency Departments by highlighting the benefits of seeing a family doctor (GP), pharmacist or urgent care clinic, and promoting cervical screening to Asian women in the 25–29 age group who have low coverage.

The Campaign will also leverage on other partner online social media platforms such as Universities and Private Training Establishments, cross central government agencies, settlement agencies, ethnic associations, libraries and sporting bodies e.g. Sport Auckland, Auckland Badminton Association. For more information, visit www.yourlocaldoctor.co.nz


HEALTHCARE
1
2
3
WHERE SHOULD I GO?
FAMILY DOCTOR/ PHARMACY
ACCIDENT & MEDICAL CLINIC
HOSPITAL EMERGENCY DEPARTMENT
1
FAMILY DOCTOR/ PHARMACY
For urgent, less serious health concerns
• Call or visit your family doctor (GP)
• Get advice and treatment for common minor illness from your community pharmacist
2
ACCIDENT & MEDICAL CLINIC (URGENT CARE CLINIC)
For urgent, less serious health concerns when you can't see your family doctor or after hours
• Call your family doctor to find your closest Accident & Medical Clinic (Urgent Care Clinic)
3
HOSPITAL EMERGENCY DEPARTMENT
Seriously unwell and need emergency care
• Go to the hospital Emergency Department or call 111
Need free 24/7 telephone health advice from trained registered nurses? Phone 0800 611 116
To find your nearest family doctor, pharmacy or Accident & Medical Clinic (Urgent Care Clinic) visit
www.healthpoint.co.nz www.yourlocaldoctor.co.nz
Healthline
0800 611 116
healthpoint
AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Hospital Advisory Committee Meeting 26 April 2017 - Draft Unconfirmed Minutes

Prepared by: Michelle Webb (Corporate Committee Secretary)

Recommendations

That the Hospital Advisory Committee draft unconfirmed minutes be received.

Minutes
Hospital Advisory Committee Meeting
26 April 2017

Minutes of the Hospital Advisory Committee meeting held on Wednesday, 26 April 2017 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 1.30pm

Committee Members Present		**Auckland DHB Executive Leadership Team Present**	
Judith Bassett (Chair)		Ailsa Claire	Chief Executive Officer
James Le Fevre (Deputy Chair)		Joanne Gibbs	Director Provider Services
Jo Agnew		Fiona Michel	Chief Human Resources Officer
Michelle Atkinson		Rosalie Percival	Chief Financial Officer
Doug Armstrong		Shayne Tong	Chief of Informatics
Dr Lee Mathias		Sue Waters	Chief Health Professions Officer
Gwen Tepania-Palmer [arrived during Item 6.1]		Dr Margaret Wilsher	Chief Medical Officer
		Auckland DHB Senior Staff Present	
		Dr Vanessa Beavis	Director Perioperative Services
		Jo Brown	Funding and Development Manager Hospitals
		Judith Catherwood	Director Long Term Conditions
		Ian Costello	Director of Clinical Support Services
		Dr Sue Fleming	Director Women's Health
		Sarah Little	Nurse Director, Child Health
		Mr Arend Merrie	Director Surgical Services
		Anna Schofield	Director Mental Health and Addictions
		Samantha Titchener	General Manager Cardiovascular Services
		Dr Barry Snow	Director Adult Medical
		Dr Richard Sullivan	Director Cancer and Blood and Deputy Chief Medical Officer
		Michelle Webb	Corporate Committee Administrator
		(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. APOLOGIES

The apologies of senior staff members Margaret Dotchin, Andrew Old, Mark Edwards, Michael Shepherd and John Beca were received.

It was advised that Sarah Devine, Online Participation Manager was in attendance as delegate for Andrew Old and Margaret Dotchin.

Michelle Atkinson observed that her surname had been misspelled in the attendance register.

2. REGISTER AND CONFLICTS OF INTEREST

James Le Fevre informed that he was no longer a member of the Association of Salaried Medical Specialists and this could be removed from the register.

3. CONFIRMATION OF MINUTES 15 March 2017 (Pages 8 to 23)

Resolution: Moved Jo Agnew / Seconded Michelle Atkinson

That the minutes of the Hospital Advisory Committee meeting held on 15 March 2017 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (Pages 24 to 25)

All items were either complete or in progress.

4.1 People Metrics for Directorate Reports (verbal update)

Fiona Michel, Chief Human Resources Officer advised that the proposed alternative People Metrics for Directorate reports had been approved by the Board and would be incorporated into the directorate reports to the next Hospital Advisory Committee meeting.

4.2 Auckland DHB Training for Resilience (Pages 26 to 28)

Fiona Michel, Chief Human Resources Officer spoke to the report, advising that there were a range of programmes provided to support staff resilience and stress management.

The following matters were covered in response to questions:

- Wellbeing is one of the core promises we make to staff as part of the DHBs People Strategy. The Resilience and Stress training programmes were one of the tools being built to support achievement of the strategy.
- Individual services had implemented their own programmes to respond to local needs, such as the Critical Support tool that was developed by Women's Health.
- To ensure alignment with other DHBs elements of the support frameworks used by Waitemata DHB had been considered and incorporated where relevant.
- A series of bite-sized learning sessions were being developed to meet core needs across the organisation such as 'Challenging Conversations' and 'Resilience and Stress Management'.

That the Hospital Advisory Committee receives the background information for key themes of the resilience training delivered within Auckland DHB.

5. PERFORMANCE REPORTS (Pages 29 to 158)

5.1 Provider Arm Operational Performance – Executive Summary (Pages 29 to 34)

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

Jo Gibbs, Director Provider Services spoke to the report highlighting the following:

- Good progress was being made against implementation of the new 24/7 Hospital Functioning model of care

- Funding for the proposed Hyperacute Stroke Service had been approved by the Auckland DHB Finance Risk and Assurance Committee. A report seeking support would also be submitted to the Waitemata and Counties Manukau DHB Boards.
- The key issues and risks from a provider and operational perspective were:
  - Financial sustainability and capital investment pressure
  - The dependency of Mental Health Facilities on the private rental market
  - The ongoing workforce challenges and recruitment risks especially those being faced in Women's Health
  - New emerging service risks in Pathology and Cardiology
  - The high number of transplant services being provided above contract volumes and potential impacts of the draft Ministry of Health Organ Donation Strategy
  - The Orthopaedic surgery waitlist
  - Performance for Quarter 3 against the 6 hour target for the Adult Emergency Department which has not been met due to the sustained increase in presentation volumes.

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

- Planning for specialist service models across metro-Auckland would focus next on Head and Neck Cancer.
- Timing for transition to the new 24/7 Hospital Functioning model of care was as per the planned timeline. Recruitment to all roles was still in progress.

5.2 Provider Arm Scorecard (Pages 35 to 40)

Jo Gibbs, Director Provider Services advised that the Provider Scorecard was currently being reviewed. Changes had been implemented for this reporting period with a more finalised scorecard to be presented at the June meeting. A new 'In Year' target had been included to demonstrate progress made to date towards achievement of the overall target.

Members agreed that the new scorecard format was much improved.

[Secretarial Note: Item 5.4 was taken next]

5.3 Clinical Support Services (Pages 41 to 47)

[Secretarial Note: this item was taken after Item 6.1]

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

- Positive improvements had been made against achievement of the MRI target
- A new Service Manager Clinical Engineering had been appointed
- A third pharmacist prescriber had qualified

In response to earlier discussion during Item 5.10 regarding improvements being made to outpatient correspondence, advice was given that that the directorate had upgraded its texting capability and was now working on improvements to email correspondence.

[Secretarial Note: item 5.5 was taken next]

5.4 Women's Health Directorate (Pages 48 to 56)

[Secretarial Note: this item was considered after Item 5.2]

Sue Fleming, Director Women's Health asked that the report be taken as read highlighting that the continuing critical issue was staffing within maternity services.

The following matters were covered in response to questions:

- Whilst there was a Maori Workforce strategy under development there was not yet a specific programme for Pacific students identified. To support engagement, the Nurse Unit Manager was working actively in the Pacific community.
- There was still room for improvement in achieving a maternity workforce that was representative of the Auckland population. This was influenced by a number of factors including some ethnicities experiencing varying levels of engagement with tertiary education.

[Secretarial Note: Item 5.11 was taken next]

5.5 Child Health Directorate (Pages 57 to 68)

Sarah Little, Nurse Director Child Health spoke to the report highlighting the following:

- Good progress had been made towards implementation of the redesigned Community Services locality model.
- Good progress continued to made on the Clinical Excellence Programme
- Safe and high quality services had been maintained throughout the refurbishment of Starship Hospital and level 5.

The increase in Paediatric Intensive Care admissions was noted. Advice was given that high intensity treatments were being performed. There was also an increase in the admission of long stay patients. This trend was also being observed internationally.

The Chair expressed interest in receiving information on the progress of the quality research proposals approved as part of the Starship Foundation Research, Training and Education Programme.

Action:

That an update on the progress of the quality research proposals approved as part of the Starship Foundation Research, Training and Education Programme be provided within the Child Health directorate report when available.

5.6 Perioperative Services Directorate (Pages 69 to 76)

Vanessa Beavis, Director Perioperative Services asked that the report be taken as read.

Members queried the progress of the Single Instrument Tracking project. Advice was given that there had been no change in status and that further legal advice to inform how best to proceed was awaited.

5.7 Cancer and Blood Directorate (Pages 77 to 83)

Richard Sullivan, Director Cancer and Blood asked that the report be taken as read highlighting that the alignment project to realign services and space for implementation of a tumour stream approach had commenced.

There were no questions.

5.8 Mental Health Directorate (Pages 84 to 98)

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

- There had been increasing pressures in adult mental health due to growth in demand and acuity. The escalation plan to improve patient flow and access was now business as usual and assisting to manage flow however ongoing increases in demand were impacting on waitlists and creating work pressures for staff.
- Media and messaging relating to the release of the "Peoples Review" inquiry into the public mental health system had generated some discomfort for staff and potential negative perceptions of mental health services in the public.
- The Auckland housing market had resulted in a shortage of availability of rental facilities to accommodate respite care.
- The Child and Family Unit had commenced work on escalation planning for complex clients.
- Collaborative work with agencies on integrating the specialist stepped care model was in progress.

Matters covered in response to questions included:

- A range of tools and actions had been implemented to ensure appropriate support for staff experiencing work pressures. Consideration was also being given to utilising resources differently to ease pressure on staff.
- The Strategic Facilities plan was on track and would be reported to the Committee in July.

5.9 Adult Medical Directorate (Pages 99 to 105)

Barry Snow, Director Adult Medical asked that the report be taken as read highlighting the following:

- An unseasonal surge in demand had put pressure on acute flow and resulted in work pressures for staff. Staff health and wellbeing was imperative and had been identified as a key priority within the next Provider Services Business Plan.
- Despite these pressures there had been a sustained decrease in sick and annual leave taken by staff.

Lee Mathias commented that the efficacy of the Ebola virus vaccine had been challenged in a Wall Street journal article and may warrant investigation.

[Secretarial Note: item 5.12 was taken next]

5.10 Community and Long Term Conditions Directorate (Pages 106 to 114)

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

Clarification was sought regarding the process to reduce rescheduling rates. Advice was given that this was an activity of the Outpatients Improvement Programme. It was intended to reduce the number of appointments rescheduled by the service to demonstrate the value placed on patient time and choice.

Judith Catherwood advised that recruitment for the Palliative Care service had been re-advertised with good response received.

The Chair requested that the Committee be kept informed on progress against the DNA action plan, with a particular focus on the Diabetes Service.

Action

That an update on the progress of the DNA Action Plan be provided to the Hospital Advisory Committee when available.

[Secretarial Note: Item 5.13 was taken next]

5.11 Surgical Services Directorate (Pages 115 to 125)

[Secretarial Note: this item was considered after Item 5.4]

Arend Merrie, Director Surgical Services was welcomed by the Committee and asked that the report be taken as read.

The unfavourable variance in revenue was noted. Advice was given that it was predominantly attributable to the increased number of transplants being performed above contract volumes and outsourcing in ophthalmology services to resource cataract surgeries.

[Secretarial Note: Item 6.1 was taken next]

5.12 Cardiovascular Directorate (Pages 126 to 133)

Samantha Titchener, General Manager Cardiovascular spoke to the report highlighting the following:

- The waitlist position for cardiothoracic surgery was positive
- The Room 1 Angiography Investigations Unit installation had been successfully completed

It was asked whether or not the increases in the elective procedures waitlist could be attributed to population growth. Advice was given that clinicians had recently completed a validation process and needed to further analyse the data before reasons for increases could be formally confirmed.

[Secretarial Note: item 5.10 was taken next]

5.13 Non-Clinical Support Services (Pages 134 to 143)

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

- An NZQA Level 3 graduation ceremony had been held on 13 March 2017 for Cleaners and Supervisors whom had successfully completed the qualification
- A further Workplace Literacy programme for staff had commenced in late February 2017.
- Cleaning services staff had continued to maintain high standards and receive positive feedback.
- The Inventory Management Category review was in progress.

A brief discussion took place regarding the capacity and effectiveness of the Transition Lounge. It was noted that this area appeared to be very busy. A patient benefit of the way the transition lounge now operated was the wide range of qualified people available to ensure the patient was ready for discharge. The average wait time for patients in the lounge was dependent on the arrival time of their pick up. The Committee noted that the Transition Lounge appeared to be working very well and that renovations and further improvements were planned for approximately September 2017.

It was observed that the figure appearing in the Support Services scorecard on page 135 of the agenda relating to the Voluntary turnover rate for less than one year appeared unusually high. Fiona Michel, Chief Human Resources Officer undertook to investigate and report back on this.

Action

That the Voluntary turnover rate figure appearing in the February 2017 Support Services scorecard be investigated.

5.14 Provider Arm Financial Performance Report (Pages 144 to 158)

Rosalie Percival, Chief Financial Officer asked that the report be taken as read highlighting that the current position was behind target. Wash ups would address some issues however the Provider continued to struggle with personnel and outsourcing costs. This predominantly reflected FTE targets incorporated into the budget.

That the Provider Arm Performance report for April 2017 be received.

6. INFORMATION REPORTS (Pages 159 to 163)

6.1 Patient Experience Update (Pages 159 to 163)

[Secretarial Note: this item was considered after Item 5.11]

Sarah Devine, Online Participation Manager spoke to the report.

In 2015 the Board requested the development of a Net Promoter Score that would allow comparison with Waitemata DHB. To achieve this, Auckland DHB had included the Friends

and Family Test question in the National Patient Experience Survey. From April 2016 Waitemata DHB had included the same question within its National Patient Experience Survey which has enabled comparison reporting.

[Secretarial Note: Gwen Tepania-Palmer joined the meeting at 1.57pm].

Matters covered in response to questions included:

- The survey was carried out predominantly online by randomly selecting an extract of patients seen within a particular period.
- The National Patient Experience Survey required each DHB to survey 400 patients per quarter.
- The proportion of patients with email was increasing with approximately 40% of patients across the DHB identifying as having an email address. Surveys were also sent in hard copy by post for completion by writing if preferred.
- It was acknowledged that email was more reliable than the postal service. The work relating to the Outpatient Model of Care within the Clinical Support directorate included improvements being made to patient correspondence including the email and texting programmes.

That the Hospital Advisory Committee receives the Patient Experience Update report.

[Secretarial Note: Item 5.3 was taken next]

7. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 164 to 167)

Resolution: Moved James Le Fevre / Seconded Jo Agnew

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

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

3. Confirmation of Confidential Minutes 15 March 2017	**Confirmation of Minutes** As per the resolution(s) from the open section of the minutes of the above meeting, in terms of the New Zealand Public Health and Disability Act [NZPH&D Act 2000]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Provider Services Business Plan 2017/2018	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.2 Seasonal Variation Plan – Winter 2017	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.3 Elective Delivery Plan 2017/2018	**Commercial Activities** Information contained in this report is related to commercial	That the public conduct of the whole or the relevant part of the meeting would be likely to result in

	activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	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]
5.4 Women's Health Workforce Challenges and Strategy	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Orthopaedic Services	**Commercial Activities** Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Transplant Services	**Commercial Activities** Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982	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

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

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

Carried

The meeting closed at 3.56pm.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 26 April 2017

Chair: _____ Date: _____

Judith Bassett

Disability Support Advisory Committee Meeting 29 March 2017 – Draft Unconfirmed Minutes

Prepared by: Michelle Webb (Corporate Committee Secretary)

Recommendations

That the Disability Support Advisory Committee draft unconfirmed minutes be received.

Minutes
Disability Support Advisory Committee Meeting
29 March 2017

Minutes of the Disability Support Advisory Committee meeting held on Wednesday, 29 March 2017 in the Auckland Deaf Society Terrace Boardroom, 164 Balmoral Road, Auckland commencing at 1.30pm

Committee Members Present	**Auckland and Waitemata DHB Staff Present**	
Jo Agnew (Chair)	Samantha Dalwood	Disability Advisor Waitemata DHB
Michelle Atkinson	Dr Debbie Holdsworth	Director of Funding Auckland and Waitemata DHBs
Edward Benson-Cooper	Gil Sewell	Director Organisational Development Auckland DHB
Matire Harwood (Deputy Chair)	Kate Sladden	Funding and Development Manager, Health of Older People
Robyn Northey [arrived during item 5.3]	Michelle Webb	Committee Secretary
Allison Roe	Sue Waters	Chief Health Professions Officer
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

KARAKIA

Nga Mihi

Matire Harwood led a Karakia and welcomed everyone present.

1. ATTENDANCE AND APOLOGIES

The apologies of executive staff Dale Bramley, Ailsa Claire and Fiona Michel and of senior staff member Kim Herrick were received.

2. CONFLICTS OF INTEREST

The following amendments were advised:

- Michelle Atkinson requested that her interest in the Starship Foundation be added.
- Matire Harwood advised her role with the Stroke Foundation NZ (Maori Health) was incorrectly appearing as the 'State' Foundation and should be amended.

There were no declarations of interest for any item on the agenda.

3. MINUTES 16 November 2016 (Pages 7 to 12)

These minutes were confirmed and signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 16 November 2016 by the outgoing Chairperson and Chief Executive under Standing Order 2.12.2. They were submitted for the information of the new committee.

4. ACTION POINTS (Pages 13 to 14)

All actions were either in progress or complete. The Chair advised that the actions relating to the Disability Support Advisory Committee Terms of Reference would be incorporated into discussion of Item 5.2 of this agenda.

5. CHAIR'S REPORT (Pages 15 to 30)

5.1 The Authority of a Statutory Advisory Committee (Pages 18 to 19)

Jo Agnew, Committee Chair spoke to the report highlighting the functions and authorities of the Disability Support Advisory Committee, the role of the Committee and that whilst Auckland and Waitemata DHBs have separate constituted their own Disability Support Advisory Committees they meet and act as one committee.

Resolution: Moved Michelle Atkinson / Seconded Allison Roe

That the Disability Support Advisory Committee:

1. **Receives the Authority of a Statutory Advisory Committee report.**
2. **Notes that the function of advisory committees is to provide advice and recommendations to the Board for consideration and decision.**
3. **Notes that advisory committees focus purely on the strategic aspects of the DHB.**
4. **Notes that advisory committees have no delegated decision-making powers.**

Carried

5.2 Disability Support Advisory Committee Terms of Reference (Pages 20 to 26)

The Chair highlighted that:

- The role of the Committee was to focus on strategic matters and future discussions would be positioned at a high level.
- Separate agencies hold funding responsibilities for disability support services mainly dependent on patient age. DHBs are responsible for funding services for over 65 year old people (or those who are close in age) with age related disabilities. The Ministry of Health fund services for people who present for assessment before the age of 65 years.

Debbie Holdsworth, Director Funding informed that, because DHBs do not hold the funding and contract management responsibilities for disability support services for under 65 year olds, reporting effectively to the Committee on these matters had previously been challenging.

The Chair added that reporting on this topic could be provided by the Ministry of Health. To obtain this, the Chair had sent correspondence to Ministry of Health management inviting the attendance of a Ministry representative at Disability Support Advisory Committee meetings. A positive response had been received and was tabled (attached to these minutes as Item 5.2.1).

It was noted that Terms of Reference currently assigned responsibility to the Disability Support Advisory Committee for receiving reporting on Health of Older People across the full range of issues and services for the over 65 year old age group. Formal reporting on the broader issues in Health of Older People might more appropriately sit with the Community Public Health Advisory Committee (CPHAC), with the Disability Support Advisory Committee retaining responsibility for the disability specific aspects. An amendment to the Terms of Reference supported by a recommendation to the Auckland and Waitemata DHB Boards would be required to action this transfer of reporting to CPHAC. Members agreed and were supportive of this approach.

The Chair informed that the Board Chair had signalled the intention for a regional Disability Support Advisory Committee from June 2017 onwards. This would also need to be taken into account when revising the Committee Terms of Reference.

A discussion was held regarding membership and attendance, and what considerations the Committee might need to make regarding appointment to the two vacant external appointee roles. It was agreed that until it was known what composition future Disability Support Advisory Committee meetings would have any decisions on co-opted roles be placed on hold.

Actions:

That the Disability Support Advisory Committee Terms of Reference be amended to reflect a proposed transfer of reporting for Health of Older People to the Community Public Health Advisory Committee.

That a recommendation report on the proposed changes to the Terms of Reference for the Disability Support Advisory Committee be presented to the next Disability Support Advisory Committee meeting.

Resolution: Moved Matire Harwood / Seconded Michelle Atkinson

That the Disability Support Advisory Committee:

1. **Receives the Disability Support Advisory Committee Terms of Reference.**
2. **Notes the responsibilities of the Disability Support Advisory Committee as per the Terms of Reference.**
3. **Considers and discusses whether the Terms of Reference require amendment.**

Carried

5.3 Draft Work Programme for 2017 (Page 27)

The Chair asked management how a regional Disability Support Advisory Committee meeting might impact on the proposed work programme presented. Advice was given that work of committees was already well aligned as demonstrated at the previous regional Disability Support Advisory Committee meeting held in June 2016.

[Secretarial note: Robyn Northey joined the meeting].

It was commented that if Disability Support Advisory Committee meetings were to become regional the current duration of meetings may need to be extended.

5.4 Draft Future Agenda Outline (Page 28)

Sue Waters advised that the outcomes of the New Zealand Disability Strategy had been incorporated into the draft agenda outline. The standing items had been aligned with both the new Disability Strategy and the existing work programmes currently in action at Auckland and Waitemata DHBs to give effect to the previous strategy.

Matire Harwood observed that the new Disability Strategy had eight outcomes in total whilst the draft agenda outline addressed only a selection of those outcomes. It was clarified that some of the outcomes in the strategy may not fall within the remit of the Disability Support Advisory Committee or the DHBs and so the agenda outline focussed on what activities were relevant and already in action. Other outcomes could become relevant in the future and be reported on at that time.

Gil Sewell, Director Organisational Development advised that in relation to Outcome 2: Employment a workforce strategy was in the early stages of development and took into consideration employment opportunities for disabled people. The Committee agreed that a progress report on this at its next meeting would be useful.

It was noted that management hold the community liaison role and would be best placed to report on collaboration and service coordination activities in the community. A standing item for an update report from the Disability Advisor would be valuable for future meetings.

Matire Harwood drew attention to Outcome 7: Choice and Control and asked whether the revised Terms of Reference for the Disability Support Advisory Committee could reflect how the disability community could engage in DHB decision making relating to policies concerning disability supports and services. Advice was given that the Auckland and Waitemata DHB communities differ in how they are arranged and so consultation with those communities required tailored approaches. It was agreed that further discussion between the Committee Chair, Director Funding and Chief Health Professions Officer take place outside of the meeting to consider this.

It was emphasised that progress reporting needed to remain at strategic level, with any operational matters directed to Management.

Actions:

That a progress report on the development of the Auckland DHB workforce strategy be provided to the next Disability Support Advisory Committee meeting.

That a Disability Advisor Community Update report be added to the standing items of future Disability Support Advisory Committee agendas.

That the Committee Chair, Director Funding and Chief Health Professions Officer consider and discuss how the disability community can effectively engage in DHB decision-making processes.

5.5 The Role of the Disability Support Advisory Committee in DHB Submissions to Government

It was noted that the Outcomes Framework that supports implementation of the new Disability Strategy was still in development. Public consultation commencing in mid-2017 would provide opportunities for Disability Support Advisory Committee to comment and to make submissions on the draft framework. Sue Waters encouraged the Committee to consider the responsibilities of the DHBs to disabled people and their families/whānau within the context of any submissions made.

It was advised that any opportunities for consultation and/or submission would be tabled by the Committee Secretary under the advice and guidance of Samantha Dalwood, Disability Advisor. Where timeframes for submissions fell outside of scheduled Disability Support Advisory Committee meeting timeframes, the circulated resolutions process would be employed to enable the Committee to meet closing dates.

5.6 Senior Staff Supporting the Disability Support Advisory Committee (Pages 29 to 30)

Each senior staff member introduced their role, highlighting their key responsibilities relevant to supporting the Disability Support Advisory Committee.

Debbie Holdsworth, Director Funding Auckland and Waitemata DHBs

Key responsibilities:

- Understanding the health needs of the combined Auckland and Waitemata districts.
- Ensuring services delivered within the districts meet the health needs of the population served.
- Delivery of the actions in the Auckland and Waitemata DHB Annual Plans.
- Achieving equity and ensuring services are physically accessible.

Matters covered in discussion and in response to questions included:

- The Director Funding role has no direct authority or accountability for Ministry of Health funding for Disability Support Services. There is a demarcation of responsibility for contract management of disability support services for those people assessed under 65 years and those with age related disabilities.
- The age criteria for Needs Assessment is a potential service access barrier. Regular meetings take place with the Ministry of Health contract manager and Taikura Trust to resolve these boundary issues.
- Responsibility for employment opportunities for disabled staff within the DHBs sits within DHB HR functions.

Sue Waters, Chief Health Professions Officer

Key responsibilities:

- Clinical governance including Allied Health.
- Professional standards and practice.
- Health and safety.

Sue advised that she applies a diversity focus and disability lens to all areas of her portfolio of work. This approach is integrated into work across the entire organisation, supported by disability champions within each service. This includes the interface of health and safety

with facilities. To ensure physical accessibility is consistently applied to facilities modifications, Barrier Free Assessments have been allowed for in the Capex budget and all Facilities staff have received Barrier Free training.

Fiona Michel, Chief HR Officer

[Secretarial note: Gil Sewell spoke on behalf of Fiona Michel]

Key responsibilities:

- Organisation culture.
- People systems opportunities.
- Leadership and capability development.
- The People and Workforce strategies.

Samantha Dalwood, Disability Advisor Waitemata DHB

Key responsibilities:

- Addressing inequity in health outcomes.
- Community relationships, collaboration and coordination.
- Delivery of staff awareness training.
- Provision of environmental accessibility advice for building works and refurbishments.

Resolution: Moved Robyn Northey / Seconded Michelle Atkinson

That the Disability Support Advisory Committee:

1. **Receives the report.**
2. **Notes the key roles and responsibilities of the Executive team members supporting the Disability Support Advisory Committee.**

Carried

6. STANDARD REPORTS (Pages 31 to 91)

6.1 New Zealand Disability Strategy 2016 to 2026 (Pages 31 to 82)

It was noted that the pending Outcomes framework and action plan were required to enable an implementation plan for Auckland and Waitemata DHBs to be developed.

Resolution: Moved Edward Benson-Cooper / Seconded Michelle Atkinson

That the Disability Support Advisory Committee:

1. **Receives the New Zealand Disability Strategy 2016 to 2026.**
2. **Notes that the new Disability Strategy 2016 to 2026 has been launched and replaces the Disability Strategy 2013 to 2016.**
3. **Notes that an Outcomes Framework is currently under development and will be consulted on by the Office of Disability Issues in mid-2017.**
4. **Notes that the Disability Action Plan is being updated to align with the new Disability Strategy 2016 to 2026.**

Carried

6.2 Final Report: Implementation of the New Zealand Disability Strategy in Auckland and Waitemata DHBs (Pages 83 to 91)

It was advised that this would be the final report against the previous New Zealand Disability Strategy Implementation Plan 2013 to 2016 in this format. There would be ongoing elements where activities currently in progress would still be relevant to the new strategy. These would be reported in a new format. Management were currently considering the best way to report this information in the future.

Action:

That revised reporting on implementation of the New Zealand Disability Strategy within Auckland and Waitemata DHBs be provided to the June 2017 Disability Support Advisory Committee meeting.

Resolution: Moved Allison Roe / Seconded Matire Harwood

That the Disability Support Advisory Committee:

1. **Receives the report.**
2. **Notes that this is the final report on the implementation of the 2013 to 2016 Disability Strategy.**
3. **Notes that reporting on implementation of the new Disability Strategy 2016 to 2026 will commence in June 2017.**

Carried

7. INFORMATION REPORTS (Pages 92 to 99)

7.1 Ministry of Health Disability Sector Update (Pages 92 to 99)

A copy of the quarterly newsletter produced by the Ministry of Health was included in the agenda. The newsletter is also available electronically on their website and by email on registration.

In future, sector updates can be provided by the Ministry of Health representative in attendance at the meeting.

8. GENERAL BUSINESS (verbal)

Members suggested a later start time be considered for future meetings to allow those travelling from the Community Public Health Advisory Committee meeting in the morning to arrive on time. This would need to be discussed with the Board Chair prior to any new start time coming into effect.

Action:

That the Disability Support Advisory Committee Committee Secretary seeks Board Chair approval for Disability Support Advisory Committee meetings to commence at a later time to allow adequate travel time for members attending prior meetings on the same day.

The meeting closed at 3.06pm.

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 29 March 2017

Chair: _____ Date: _____

Jo Agnew

Community and Public Health Advisory Committee Meeting 29 March 2017 - Draft Unconfirmed Minutes

Prepared by: Marlene Skelton (Corporate Business Manager)

Recommendations

The following items are submitted by the Community and Public Health Advisory Committee for consideration and approval by the Board. These items are:

3.1 Equally Well Consensus Position paper (*Pages 14-24, Community and Public Health Advisory Committee agenda)*

That it be recommended to the Auckland District Health Board:

That the Board endorses the "Equally Well" consensus position paper.

RESOLUTION TRANSFERRED FROM THE CONFIDENTIAL AGENDA TO OPEN AGENDA

C2.1 Rheumatic Fever Prevention Programme

The following item was considered as part of the confidential agenda (item 2.1) and the Committee agreed that the following recommendation be transferred to the open agenda.

Recommendation

That the Community and Public Health Advisory Committee recommends to the Board:

That the Board:

a) **Notes neither Auckland DHB nor Waitemata DHB has achieved the government's Better Public Services target of reducing Rheumatic Fever by two thirds by 2017; with rates in 2016 the highest yet at:**
   - **5.4/100,000 in Auckland against a target of 1.1/100,000**
   - **3.1/100,000 in Waitemata against a target of 0.7/100,000.**

b) **Notes that Acute Rheumatic Fever is a third world condition, which still exists in New Zealand and is associated with significant inequities.**

c) **Notes that Auckland DHB and Waitemata DHB have implemented a multi-pronged prevention programme, some of which has been implemented well, but the existing programme does not provide sufficient coverage to the at-risk populations to achieve the required reduction in Rheumatic Fever rates.**

d) **Endorses the development of business cases to be submitted to the respective Audit and Finance Committees to recommend to each Board additional investment to expand the current Rheumatic Fever Prevention Programmes, including:**
   i. **Continuing the implementation of the expanded healthy housing initiative**
   ii. **Intensifying awareness raising activities in targeted communities**

iii. **Maintaining and strengthening the school-based primary care service in low decile schools**
iv. **Ensuring appropriate and free healthcare to under 13s in traditional primary healthcare settings; and developing primary care chronic care management**
v. **Offering more choices for free health care to young people 13-18 years of age (such as through youth health clinics)**
vi. **Continuing existing secondary prevention and disease management improvement activities.**

e) **Note that any additional funding is dependent on availability of new funding and that at this time the 2017/18 Health Funding Envelope has not yet been issued. All calls on demographic funding will be brought back to each Board for review of confirmation once the complete funding envelope has been received.**

PLEASE BE ADVISED THAT THIS ATTACHMENT HAS BEEN WITHDRAWN

Community and Public Health Advisory Committee Meeting
29 March 2017 - Draft Unconfirmed Minutes

PLEASE BE ADVISED THAT THIS ATTACHMENT HAS BEEN WITHDRAWN

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Community and Public Health Advisory Committee Meeting
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Memorandum of Understanding:
Auckland District Health Board and Cancer Society Auckland Northland

Recommendation

That the Board approves the signing of the Memorandum of Understanding between Auckland DHB and the Cancer Society Auckland Northland.

Prepared by: Deirdre Maxwell (General Manager, Cancer and Blood Directorate)
Endorsed by: Richard Sullivan (Director, Cancer and Blood Directorate)
Endorsed by Executive Leadership Team: Tuesday, 18 April 2017

Glossary

MOU	Memorandum of Understanding
RCABS	Regional Cancer and Blood Service
CSAN	Cancer Society Auckland and Northland

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	This MOU will formalise the working relationship between the two organisations. This relationship is premised on providing an integrated service for patients/whanau requiring cancer services within this regional context.
Emphasis/investment on both treatment and keeping people healthy	Patients/whanau requiring cancer treatment are supported to attend appointments, and access community nursing and other services.
Service integration and/or consolidation	This long-standing close working relationship between organisations meets service integration imperatives.
Intelligence and insight	Sharing appropriate service information between organisations assists in the provision of high quality services to patients/whanau
Evidence informed decision making and practice	Sharing appropriate patient information between organisations in a safe and monitored fashion assists patient care.
Outward focus and flexible service orientation	This MOU formalises a functional way of working across both organisations, to better meet patient/whanau need.
Operational and financial sustainability	This MOU facilitates the ongoing provision of services in accordance with each organisation's mandate, noting that these are complementary.

2. Executive Summary

Regional Cancer and Blood staff have been working with the Cancer Society to agree the content of a Memorandum of Understanding between our organisations. This is to formalise and recognise the great working relationship that exists for the benefit of our patients and families.

- The MOU covers the range of services including community liaison nursing, psychology, and the volunteer driving service.
- We have worked out how to better facilitate these services for our patients through allowing appropriate clinical access to Concerto, and to ensure that all the requisite privacy, and audit arrangements are adhered to.
- And as a matter of course we have documented the requirements around health and safety for staff, Vulnerable Children's Act requirements, pre-employment screening, building access, vehicle safety requirements and others.
- We have built in a review mechanism to ensure a regular review and update process.

We are pleased to have reached the point of signing, having achieved approval from the Executive Leadership Team, and specifically Sue Waters (Chief Health Professions Officer) and Bruce Northey (General Counsel); Richard Sullivan (Director, Cancer and Blood) and our senior clinical, occupational health and IT staff; and the Cancer Society team including Chief Executive John Loof and Manager of Supportive Care Michelle Gunderson-Reid.

We seek Board approval to sanction the formalisation of this relationship between the Auckland DHB and the Cancer Society Auckland Northland. This would be formalised by Ms Ailsa Claire as Chief Executive signing on behalf of Auckland DHB.

3. Introduction/Background

The MOU development process has been in train for some three years. It has included discussion between Auckland DHB (staff and advisors) and Cancer Society staff across the range of content areas including:

1. Cancer Society services including community liaison nursing, psychology, and the volunteer driving service.
2. Appropriate clinical access to Concerto, and to ensure that all the requisite privacy, and audit arrangements are adhered to
3. The requirements around health and safety for staff, Vulnerable Children's Act requirements, pre-employment screening, building access, vehicle safety requirements and others.
4. A review mechanism to ensure a regular review and update process.

4. Costs/Resources/Funding

There are no additional costs to Auckland DHB or the Cancer Society incurred through this MOU process.

5. Risks/Issues

The following risk issues have been identified, with mitigation strategies noted as included in the MOU:

1. Potential privacy breaches through allowing access to Concerto – arrangements secured through IT and legal process, formalised in the MOU.
2. Complexity concerning DHB liability through any potential privacy breach – arrangements secured through legal indemnity process, formalised in the MOU.
3. DHB risk concerning use of Cancer Society transportation by patients – required arrangements secured through health and safety advisor, formalised in the MOU.
4. DHB risk concerning aspect of the relationship not formally documented in the MOU – we have agreed a 2 year review process from the date of signing, to allow the wider scope of issues to be reviewed and included/amended as required at that time.
5. The formalisation of this relationship produces a precedent for other organisations seeking to also formalise their arrangements with Auckland DHB – appropriate staff engagement through drafting and review process.

10. Conclusion

The formal establishment of an MOU between Auckland DHB and the Cancer Society will benefit both organisations, as it provides the platform from which discussion can be had about ways to work together in support of better patient/whanau care.

We believe we have reached a point of agreement between the organisations, and seek Auckland DHB Board review of this work, and if comfortable, agreement to proceed to signing.

The Cancer Society would like to request a formal signing ceremony, with the ADHB Chief Executive, as a means to highlight this significant event.

Appendix 1:

DRAFT Memorandum of Understanding

Dated

- **Auckland DHB Regional Cancer and Blood service, Auckland City Hospital (RCABS)**
- **Cancer Society Auckland Northland (CSAN)**

1 INTRODUCTION

1.1 This MOU is intended to document the close relationship between RCABS and CSAN, to formalise the understanding of the respective roles and responsibilities of CSAN and RCABS, and clarify arrangements to provide support for cancer patients in the community. There is a longstanding relationship between RCABS and CSAN.

1.2 CSAN health professionals liaise closely with all referrers, including RCABS, so that CSAN supportive care services may provide services to people with a cancer diagnosis and their supporters. CSAN supportive care services include:

- Community Liaison Nursing Service (CSLN)
- Psychology Service (CPS)
- Volunteer Driving Service (VDS)

1.3 RCABS supports CSAN every Daffodil Day by showing good will and allowing promotional material to be placed in the department, and CSAN staff to deliver 'fresh Daffodils' to outpatient reception for patients and supporters. The delivery of 'fresh Daffodils' is not to extend into oncology daystay and/or treatment areas for infection control purposes.

1.4 **This memorandum is not intended to be a legally binding agreement.**

2 RELATIONSHIP MANAGEMENT

2.1 The relationship between RCABS and CSAN has been maintained through regular meetings with management and through health professional to health professional communication. CSAN board membership includes senior ADHB clinicians.

2.2 CSAN research centre and clinical trials, jointly managed and funded by CSAN indirectly impacts on patients receiving trial treatment while under the care of ADHB clinicians.

2.3 The parties believe it is important that a spirit and culture of co-operation and respect is maintained, particularly on issues of mutual concern, and that this co-operation is essential

for this agreement to work effectively. The parties are committed to the following core principles, which will guide the relationship and the day-to-day communications and interactions between the parties:

2.3.1 Mutual recognition and understanding of the roles and responsibilities of the other party;

2.3.2 An alertness to each party's interests and needs;

2.3.3 Not to do anything that would prejudicially affect the reputation of the other party.

2.3.4 Commitment to successful outcomes for the health benefit of New Zealanders;

2.3.5 Openness in communications;

2.3.6 Good faith;

2.3.7 Working together to solve problems; and

2.3.8 Sharing of information in a timely and effective manner.

2.4 The parties will co-operate with each other and use all reasonable endeavours to resolve any disputes or differences arising under this agreement. Should the matter not be capable of resolution by the respective Chief Executives then the matter may be escalated to the respective Chairs for resolution.

3 ACCESS TO AUCKLAND CITY HOSPITAL (ACH) AND OFFICE

3.1 RCABS agrees to have Community Liaison Nursing Service (CSLN) and Psychology Service (CPS) staff, and CSAN volunteers, named 'Yellow Shirts' in the department. 'Yellow Shirt' volunteers assist patients with drinks, reading material, directions and information on how to access Cancer Society support and work under supervision and delegation of appropriate ADHB staff. All CSAN volunteers have a police check prior to taking on any volunteer roles at CSAN. In addition, all oncology volunteers 'Yellow Shirts' undergo Vulnerable Children's Act (VCA) checking by CSAN paid staff prior to commencing the role at RCABS.

3.2 RCABS will assist in the initial and ongoing training of these volunteers. Feedback on concerns will be given to CSAN; CSAN will appraise RCABS on what action was taken as a result.

3.3 CSLN and CPS presence at ORL clinics or other ADHB clinics or departments not in RCABS will be authorised and agreed on by department management in conjunction with CSAN.

3.4 CSAN has had a VDS office located within RCABS ACH for over 30 years. RCABS acknowledges the historical agreement to support a VDS office; CSAN agrees to use the office only for coordinating the VDS.

3.5 The current VDS office is situated in the Radiotherapy department, RCABS, Building 8, ACH. No fee is charged for the use of the office and ADHB meets all utility costs.

3.6 CSAN employs two staff in the office Monday to Friday, 8 am to 4 pm. CSAN driving office staff has ADHB identity security cards and have had security access to work after 4 pm. These CSAN staff members work and liaise with RCABS staff on a daily basis. CSAN volunteers and staff also attend at ACH from time to time.

3.7 RCABS will provide an induction to the RCABS service, aiming to have concluded this induction (including a H&S induction as per ADHB requirements) within the first week of CSAN staff/volunteers joining. This training will be provided subsequent to the issuance of security cards/clearance so as to allow entry to clinical areas for this induction process. Prior to this, CSAN and RCABS staff will liaise to agree the timing of such inductions, to ensure that sessions can be coordinated with wider clinical service provision issues and include the requisite RCABS staff who need to be involved.

3.8 CSAN personnel, both staff and volunteers, must observe ADHB's policies and procedures including those relating to health and safety, security Work Flow, Infection Control and Asbestos Contamination Control. RCABS will advise CSAN what the relevant policies and procedures are and either give CSAN staff a copy of or provide an internet link. CSAN's staff (i.e. driving coordinators, liaison nurse coordinator) will also participate in ADHB's bi-annual site safety course. RCABS may deny access to the site to any of the CSAN's personnel who do not comply with the requirements of this clause.

3.8.1 CSAN must take all steps necessary to ensure that no act or omission by it or its personnel;

3.8.2 Causes a health hazard or harm to any person on, in or about ADHB's facilities;

3.8.3 Is a breach of or causes the breach of any duty or obligation of ADHB under any relevant statute or regulation; or

3.8.4 Does or is likely to give rise to the issue of an improvement or prohibition notice, enforcement proceedings or a prosecution under the Health and Safety At Work Act against ADHB.

3.8.5 CSAN will ensure that all volunteers have undertaken pre-employment health screening consistent with ADHB requirements for volunteers with patient contact.

3.8.6 CSAN will ensure that all volunteer drivers have a valid NZ driver's licence at all times they are transporting RCABS patients/families.

3.8.7 CSAN will ensure that the vehicles used to transport ADHB patients/families are roadworthy at all times as determined by current WOF, and that volunteer drivers maintain appropriate insurance requirements.

CSAN must notify RCABS immediately it becomes aware that it is or may be in breach or is likely to be in breach of this clause.

3.9 CSAN will maintain a process for screening all personnel on an ongoing basis to ensure ADHB's requirements for security and confidentiality are met and ensure that when any of its personnel enter onto ADHB sites they:

3.9.1 Behave and speak in a manner appropriate to the environment.

3.9.2 Are aware of and comply with all fire and emergency management plans and other security and safety measures from time to time in force at ADHB's premises.

3.9.3 Take all reasonable steps to keep ADHB's sites in an orderly state and in such a condition as to avoid nuisance and danger to persons and damage to property. Any damage caused by the CSAN to an ADHB site or to ADHB's property or to any person lawfully on ADHB's sites will be made good by the CSAN at the CSAN's expense.

3.9.4 Wear an identification card approved by ADHB, visibly affixed to their clothing at all times while on an ADHB site.

4 HEALTH INFORMATION PRIVACY

4.1 Regional Cancer and Blood service provides an automatic referral via the chemotherapy orientation list to the Community Liaison Nursing Service. Letters to patients advising them of their first specialist appointment date and time will have a clause stating that the Cancer Society may be in touch and will include the 0800 CANCER (226 237) number so patients can self-refer.

4.2 CSAN and RCABS will ensure individual patient consent is provided and documented for the release of appropriate and recent patient clinical information and other relevant personal information to CSAN for the purposes of CSAN supportive care services to that individual, for example radiotherapy schedules for patients VDS.

4.3 Provision of health information by RCABS to CSAN for the provision by CSAN of supportive care services in this situation is obligatory under s22F of the Health Act.

4.4 All Cancer Society staff and volunteers sign an undertaking that they understand and will abide by the Health Information Privacy Code; all are provided with a copy.

4.5 RCABS and CSAN will establish a compliant basis for disclosure or access to health clinical information such as clinic letters and reports; CSAN will hold that information pursuant to the Rules of the Health Information Privacy Code. For example:

4.5.1 Clinical information is scanned or attached as a pdf on a secure password protected patient database. All hard copies to be destroyed by shredding or through a confidential bin situated at 1 Boyle Crescent, Grafton.

4.5.2 Access to clinical information is restricted within CSAN supportive care through strict control levels of access. CSAN Supportive Care staff such as the Volunteer Driving coordinators have no access to nursing or psychology notes. Psychology health professionals are not able to view nursing notes and vice versa.

4.5.3 RCABS and CSAN will continue to explore the best means to ensure safe and effective information availability in support of patient care, and in accordance with the Code as above.

4.6 ADHB will provide CSAN staff access to Concerto for the purposes of working with RCABS cancer patients/families. In order to ensure compliance with the Health Information Privacy Code 1994:

4.6.1 CSAN access will be monitored by ADHB, via regular audits.

4.6.2 CSAN will provide ADHB with a list of users and user names, updated as staff leave or new staff commence.

4.6.3 Each CSAN staff member will acknowledge their obligations, including explanation of access to any documents not related to cancer treatment.

4.6.4 ADHB has the right to exclude any non-employee from an on-going role should they breach their agreement.

4.7 To ensure appropriate Concerto access and audit requirements, ADHB will require the following from CSAN:

4.7.1 ADHB will limit CSAN access to records of patients who have been recently attending or are attending RCABS services.

4.7.2 ADHB can enable access to community dispensing result via Éclair, with access enabled for only these results for patients within the 4.7.1 cohort.

4.7.3 CSAN will supply a list of the staff who work for their service (within RCABS) – updated as staff leave and new staff are engaged – and their email addresses so ADHB can contact them if required.

4.7.4 CSAN agrees to respond to any 'please explain' email sent to CSAN within a requested timeframe, usually 5 days. ADHB will send such an email in regard to any documents accessed by CSAN staff that is not cancer related, with a CSAN manager copied into this request.

4.7.5 CSAN agrees that any breach investigation will be managed under CSAN disciplinary policy and followed up appropriately. CSAN will notify ADHB which manager is the contact person for this activity.

4.7.6 CSAN staff will sign the ADHB confidentiality form (as per 4.4 above).

4.7.7 The ADHB audit process includes as follows:

4.7.7.1 CSAN staff listed as having Concerto access will be audited monthly, using the updated list (as per 4.7.1 above).

4.7.7.2 Any CSAN staff accessing documents outside the cancer service will be sent a 'please explain' email.

4.7.7.3 If any CSAN response indicates possible inappropriate access, ADHB will refer to a CSAN senior manager to manage an investigation process.

4.8 In consideration of ADHB allowing CSAN employees (registered health professionals) access to Concerto CSAN agrees to indemnify ADHB should their staff access information beyond that for which they have express consent from the individual. CSAN acknowledges that should such a breach of privacy occur, ADHB would advise the patient of the breach. If there was to be a consequent claim for interference with privacy, the two parties will jointly manage the claim, with all compensation and costs, including external legal fees but excluding ADHB's internal costs, being met by CSAN.

5 REVIEW

The term of this MOU is two years. Prior to expiry the parties will undertake to review the arrangement and terms to inform the development of a further memorandum, if agreed by both parties.

Regional Cancer and Blood Service, Auckland District Health Board [ADHB]

Cancer Society Auckland Northland

Review of progress against the Auckland DHB Strategy

Recommendations

That the Board:

1. **Endorses the areas of continued focus for the next 12 months.**
2. **Notes progress against themes and priority actions in the Auckland DHB Strategy to 2020.**
3. **Considers possible adjustments required to keep up-to-date with emerging opportunities within the sector.**

Prepared by: Julie Helean, Assistant Director Strategy
Approved/Endorsed by: Dr Andrew Old, Chief of Strategy, Participation and Improvement and Ailsa Claire, Chief Executive
Endorsed by the Executive Leadership Team on 2 May 2017

1. Background

The June 2016 meeting of the Board endorsed the Strategy to 2020 for Auckland DHB with the final version presented in August 2016. Our organisational strategy aims to keep our work focused on seven strategic themes and achieving our longer-term vision: Healthy communities, World-class healthcare, Achieved together, *Kia kotahi te oranga mo te iti me te rahi o te hāpori.*

Once published, the strategy was placed on our website and distributed as hard copies to directorates and key stakeholders in the sector, along with an undertaking to review progress in August each year. We have brought this annual review forward to the May meeting of the board for several reasons:

- We have new members of the board who may not be familiar with the strategy
- There is considerable work underway (through our annual plan and the enterprise portfolio management (epmo) development work) on organisational priorities, which makes it timely to review the alignment of programmes and projects to our strategy
- There is an opportunity for a more deliberate metro-auckland approach to dhb planning and more impetus to line-up our various strategic plans and priorities, particularly in light of the current regional long term investment planning (ltip) process
- The ministry of health expects dhbs to demonstrate alignment to the new zealand health strategy and its five strategic themes
- Since releasing the auckland dhb strategy, the ministry of social development (office of disability issues) has released the nz disability strategy. This document sets national health and wellbeing outcomes for agencies to achieve.

Our strategy contains seven strategic themes and 42 priority actions. There are some major programmes of work underway, some of which were established before the Auckland DHB Strategy was released. These typically contribute to more than one of our strategic themes, for example, 'Using the Hospital Wisely' and 'Primary and Community' are two priority programmes that advance all seven strategic themes.

The HealthCERT Service Provider Audit Report (March 2017) noted that 'Overall the audit identified a strong focus on meeting patient needs and working as a team with good communication to achieve this'. The auditors (DAA Group LTD) particularly acknowledged continuous improvement achievements in five areas:

- Embedding and understanding of the values of the organisation
- The introduction of the management operating system
- Improvement initiatives, and
- Improved patient flow and infection surveillance.

Work underway in these five areas advances many of our strategic themes but particularly 'Consistent evidence-informed decision making and practice', and 'Outward focus and flexible service orientation'. In future we will improve how we monitor our progress against the strategic themes, especially measuring how well our activities are contributing to patient outcomes and reduced inequities.

Some of our priority activities are not yet underway but will be started in the 2017/18 year. The development of IT systems and facilities remediation work, because of their size, complexity and costs associated, will be developed over a much longer-term horizon than other work in the strategy.

Our strategy is considered a living document in the sense that it may be updated in step with changes to the sector and our own operating environment. Of note is the increasing emphasis from the Minister of Health regarding his expectation that local initiatives demonstrate a good fit to the New Zealand Health Strategy. DHBs are expected to demonstrate delivery of the New Zealand Health Strategy through the Annual Planning process and through quarterly reporting. Our compliance documents are now oriented towards show outcomes against the national themes.

Our review of the 42 actions included in the Auckland DHB Strategy indicates a need to streamline these into a more condensed suite of actions with a clear owner for each. In future there will be a clear line of sight between the priority programmes and initiatives across the enterprise wide portfolio (the collective investment in change initiatives) to those in our Strategy, and through to the national health and disability strategies.

Finally, the recent release of the New Zealand Disability Strategy draws a focus on the need for increased access to healthcare for disabled people. Together these national and local documents focus attention on longer-term health outcomes by directing effort to our greatest challenges.

2. Progress against our Strategic Themes

The following table provides a snapshot of progress against our DHB strategic themes and also shows where this work connects, or could potentially connect, with regional activity. A more detailed view of this table is contained in the appendix.

Summarised activity under each strategic theme

	Activity under seven strategic themes		Regional opportunities
	Community, family/whānau and patient-centric model of healthcare		
	Underway:	*Planned for the future:*	*Current & potential*
	Tāmaki wellness project Releasing Time to Care Families as Partners in Care	Navigation services for patients with complex or multiple treatment pathways	Child health advocacy and health promotion work Health of Older People

Activity under seven strategic themes		Regional opportunities
Patient experience feedback to services Public spaces work to create healing environments Shared care plans Advance Care Planning Healthy Village Action Zones Patient and Family Centred Care Programme	Support services to stand beside' patients and families/whānau e.g. care navigation Further development of the Tāmaki mental health and wellbeing initiative Reorganisation of some services into locality teams	Addressing equity issues

Emphasis and investment on treatment and keeping people healthy

Underway:	*Planned for the future:*	*Current & potential*
Primary and community programme Starship community services redesign work Mental health programme Early intervention work Tāmaki Care navigation framework	Focus on vulnerable children Engage with iwi and whanau ora supports Better access to early interventions for elective surgery and high risk people Improve management of long term conditions	Informing families: health promotion work Inter sector work on child health Equity across each clinical network area with identification of issues

Service integration and/or consolidation

Underway:	*Planned for the future:*	*Current & potential*
Daily hospital functioning Primary and community work programme Waiheke patients with hemochromatosis have been provided with venesection kits Increased access to Ferinject in the community Primary health care nursing strategic framework and plan Mental health and addictions programme board established Diabetes Service Level Alliance work programme includes a new diabetes model of care A business case for Point of Care Testing for Great Barrier and Waiheke 17 general practices participating in the Safety in Practice programme Regional long term investment plan Regional cancer board	Move less complex care into community settings More options for acute care in the community Whanau Ora network and related model of care Diabetes model of care that aligns services Support primary care development Agree regional standards/ consistency of care	'Knowing every child': enhanced systems of enrolment for engaging with universal healthcare Dementia and psychogeriatric care to support people in the community Strengthening care in ARRC and Home Based Care District Strategic Alliances to strengthen relationships with primary care Locality teams, including NGOs, drive changes to clinical practice in primary care and community.

Activity under seven strategic themes		Regional opportunities
Intelligence and Insight		
Underway:	*Planned for the future:*	*Current & potential*
IS stabilisation planning Telehealth panel selection (technology to enable care closer to home) Review of the Northern Regional Electronic Health Record Project Virtual reality innovations as non-pharmacological solutions to support patients by helping to reduce clinical pain, anxiety and depression Technology enablers focused on information security for mobile devices Replacement plans to replace "dial and txt" mobile phones with smart phones, and tablets	Information Systems Strategic Plan (ISSP) consultation IS stabilisation execution Community worker mobile technology rollout Innovation alignment programme (including rollouts of existing innovation initiatives) Optimisation and automation programme planning Big data programme planning Improve the quality of the data we collect Develop a baseline for diabetes and CVD Drive down DNA rates for Māori and Pacific Regional work to advance clinical developments	Regional Information Systems Strategic Plan (ISSP) Regional Informatics work to progress the Electronic Health Record Enhancements to delivery of core information, communication and technology [ICT] Regional Clinical Networks
Consistent evidence-informed decision making and practice		
Underway:	*Planned for the future:*	*Current & potential*
Afterhours safety programme Security for safety programme Patient safety programme Northern region cancer board Deteriorating patients programme Review of high dependency care 24/7 hospital functioning Clinical Services Planning: Regional and Local Site Master Planning and Long Term Investment Planning	Workstreams on patient safety Full use of Datix system to report and respond to incidents Secure hub for smart devices will be rolled out to ensure information is held securely Regional collaboration in clinical and health services planning for sustainable northern region services Commissioning approach to planning and funding health services based on population needs Investments in primary care areas known to reduce demand for hospital services Inpatient ward nursing standards of care certification programme	Regional Patient Safety Network Regional collaboration to meet targets and develop new models of care Supra regional Eating Disorders Services National Hepatitis C initiative Local oncology service delivery model Hyper-acute stroke service improvements Reduced elective services wait time

Activity under seven strategic themes		Regional opportunities
Outward focus and flexible service orientation		
Underway:	*Planned for the future:*	*Current & potential*
People strategy and programme Auckland DHB Nursing and Midwifery Strategy Primary health care nursing strategic framework and plan Campaign to reduce bullying and violence Māori and Pacific recruitment and development Future workforce planning Single community rehabilitation service, including the early supported discharge service Needs Assessment and Service Coordination services embedded into all hospital teams and locality teams New intermediate care services and integrated models of care with Home and Community Support Services	Action on feedback from our staff engagement survey Organisational development practice leaders will develop our leadership capabilities Partnerships with businesses More rehabilitation and support services	Regional enablers of service delivery with an emphasis on workforce Māori Health Workforce Development Alliance Leadership Team (MALT)
Emphasis on operational and financial sustainability		
Underway:	*Planned for the future:*	*Current & potential*
Using the hospital wisely programme Provider financial sustainability Asset management improvement programme Outpatients model of care Review of the skill mix and structure of our patient administration system (PAS) Investment Capability Improvement Programme, including improved investment decision making policies, processes and criteria Improved management of investment Portfolios, Programmes and Projects through development Collaboration, regional and national, to improve asset management maturity including defining asset service	Using our resources wisely to consolidate savings initiatives Review how we procure goods and services Review tertiary services Opportunities for public/private work Opportunities for revenue Create a dedicated enterprise wide portfolio management office (EPMO) to support improvement in portfolio, programme and project management Work with the metro-Auckland DHBs to plan clinical and capital investment requirements Ensure buildings and essential equipment are safe and fit for purpose and meet current and future needs	Long Term Investment Plans

	Activity under seven strategic themes		Regional opportunities
	levels and improving asset performance Facilities infrastructure remediation programme Benefits realisation framework developed and implemented Completed MBIE procurement Capability Self Assessment from which improvement initiatives will be developed Contracting initiative underway to a central repository of contracts Procurement workstream underway A revenue workstream has been set up with some areas of focus identified	Effective asset management, maintenance and planning for renewals and upgrades to meet future service growth requirements Sustainable investment planning, decision making, implementation and delivery to realise investment objectives	

The specific programme of work for the 2017/18 year is contained in our Annual Plan and in the updated Provider Plan (under development). Reports on progress against the five national strategic themes are provided to the Ministry of Health each quarter, and to the Hospital Advisory Committee.

This paper presents progress against the strategy released by the board in August 2016. We invite discussion on progress to date and on any modifications required to keep the document up-to-date and to serve as our guide to future local, regional and national improvements.

Appendix: Year one progress against the 42 priorities in the Auckland DHB Strategic Plan

The work underway for each priority activity is covered in the middle column. The right hand column shows how this work aligns to the wider health sector strategic themes (The NZ Health Strategy). The 42 priority actions sit within seven strategic themes.

Priority work in our strategy	Progress to date	Alignment to NZHS
Community, family/whānau and patient-centric model of healthcare		
1. Continuous connections and partnerships with local populations, to achieve shared health service planning and delivery, and with a focus on areas and groups with the highest need (our localities approach)	Tāmaki wellness project is progressing with a service established: *Awhi Ora*. This connects people in Tāmaki with mental health problems to GP and NGO services. Healthy Village Action Zones to link Pacific church communities to primary health services. Refer to priority 7 also.	People powered Closer to home One team
2. Improve the experience and choice that patients have when they use our services, by partnering with people and service users in the design, delivery and evaluation of services, with an initial focus on diabetes and mental health	Patient and whanau centred care. Projects: • Releasing Time to Care • Families as Partners in Care • patient experience insights • public spaces improvements • healing environments.	People powered One team
3. Reorient services so there are seamless pathways across settings, and navigation services for patients trying to coordinate complex or multiple treatment pathways, with a focus on Māori, Pacific, older people and those managing diabetes	Care Navigation Framework completed for Auckland DHB and now being considered regionally. This involves PHOs, NGOs and Provider Services, and includes our Māori and Pacific Health Teams.	People powered One team
4. Invest in a greater range of supports for services which 'stand beside' patients and families/whānau e.g. care navigation	Some care navigation work undertaken in reablement services.	People powered One team
5. Support people to manage their own care record and care plan with specific measures to judge how well we respond	Community and long term conditions directorate is implementing shared-care plans in several services. This uses a goal-based restorative model of care which engages consumers and family in developing the care plan.	People powered Smart system
6. More people have Advance Care Plans, with supports to ensure plans get actioned when the person is unable to	This work is progressing nationally, with Auckland DHB involved and expanding awareness. First national forum for ACP was held in November 2016. Local awareness-raising day held at our hospitals this April to reach patients, visitors and staff.	People powered One team

Priority work in our strategy	Progress to date	Alignment to NZHS
Emphasis and investment on treatment and keeping people healthy		
7. Implement programmes across the whole health system that help people to make the lifestyle changes needed to drive down rates of smoking, heart disease, diabetes, cancer and mental health problems	Primary and community programme underway: • Tāmaki mental health and wellbeing • Tāmaki health hub • care navigation • Mt Roskill CVD and COPD initiative • locality planning team • early years hub • postnatal care re-design • community and long term conditions locality model • diabetes locality support • single point of access to community service • community palliative care • intermediate care services.	People powered Closer to home One team
8. Advance child health through the Child Health Plan, taking a focus on vulnerable children and those who are currently missing out on services and supports	Improvements are underway and documented in the Starship Community Services Redesign Decision document. Community redesign work emphasises whanau-centred care, strengthened community connections through a locality based model and a commitment to reducing inequities for priority populations.	People powered One team
9. Improve Māori health through increasing engagement with iwi, Primary Health Organisations and by expanding access to other culturally appropriate health care and whanau ora supports in the community	Te Runanga o Ngāti Whātua, via a Memorandum of Understanding and operational contract with the DHB, improves the health outcomes and wellbeing of Māori through strategic planning advice and guidance. The Runanga informs the DHB about current health issues and challenges for Māori through their links with the Maori community and health providers. Te Runanga o Ngāti Whātua is also part of the Auckland metro Whanau Ora collective which has reducing obesity in Maori communities as a top priority.	People powered Closer to home One team
10. Focus on timely access to early interventions and to effective treatments, with an emphasis on elective surgery, 'high risk individuals' in the community, and people with a high risk of cancer	Referrals for elective surgery are managed in line with waiting times targets for FSA and elective surgery through clinical prioritisation. Difficulties achieving targets for orthopaedics relate to production and capacity. Recovery plans are in place. Systems and processes for achieving the 'Faster Cancer Targets' are in place across the region so patients with High Suspicion of Cancer can be managed in a timely way	

Priority work in our strategy	Progress to date	Alignment to NZHS
	through Tumour Stream Pathways. Programmes around patients with long term/chronic conditions in place including the Auckland DHB Rapid Response Service, Early Supported Discharge programme and Falls Prevention Programme (with ACC).	
11. Work with other sectors and with communities to address the factors that contribute to morbidity and mortality associated with mental health problems and mental illness	Early intervention work underway in the Tāmaki area. Mental health programme. Primary and community.	People powered Closer to home One team
12. Improve the management of long term conditions such as cardiovascular disease, diabetes and mental illness, by providing more of the required support in community settings	Care Navigation Framework completed for Auckland DHB and now being considered regionally. This involves PHOs, NGOs and Provider Services, and includes our Māori and Pacific Health Teams.	People powered Closer to home One team
Service integration and/or consolidation		
13. Enhance the quality and integration of services available to the Auckland DHB population, while making sure that resources are directed to those with greatest need, with a focus on reducing inequity	Daily hospital functioning. Projects underway include: • integrated operations centre • variance response management • operational intelligence and forecasting • transition hub.	Value and high performance One team Smart system
14. Where indicated, move less complex care into community settings and reserve expensive hospital facilities for complex care, and include more options for acute care in the community	Primary and community work programme. Waiheke Island patients with hemochromatosis have been provided with venesection kits to manage their blood disorder. The nurse time required to deliver the venesection service is also funded. Project underway for people with an iron deficiency disorder to increase their access to Ferinject in the community.	People powered Closer to home Value and high performance One team
15. Implement a Community Nursing Strategy that gets the best use of community nursing skills for patients and family, and for people with long term conditions	A primary health care nursing strategic framework and development plan has been developed. This sits alongside the Auckland DHB nursing and midwifery strategy and advances the community nursing theme.	Value and high performance One team
16. Implement the Whanau Ora Network and related model of care, accelerating work across services and sectors that achieves the greatest gain for Maori, Pacific and other communities with unequal health outcomes	Pacific health providers who are Whanau Ora providers are now part of the Pacific Whanau Ora Commissioning Agency Network. The fanau ola model of care is being implemented by Alliance Health + PHO through its Pacific providers. The model	

Priority work in our strategy	Progress to date	Alignment to NZHS
	responds to health and social service needs via a multidisciplinary nurse-led team. Discussions about outcomes-based pricing are occurring with MBIE, MOH and MSD and will help arrive at the right funding model for the future.	
17. Transition plans and other recovery supports in place for people receiving help for mental health and addiction problems, with a special focus on children and young people	Mental health. This programme is in the scoping stages and will start with forming a programme board. The mental health and addictions programme board will provide leadership, strategic oversight and advice to the Auckland DHB board and will be responsibility for running a strategic programme of work.	People powered Closer to home Value and high performance One team
18. Develop a Diabetes Model of Care that aligns services across Auckland and Waitemata DHBs using a whole-of-system approach	The Diabetes Service Level Alliance has a work programme which includes prototyping a new diabetes model of care across Auckland and Waitemata DHBs. This is ready to be presented to the Alliance Leadership Team for approval.	Value and high performance One team
19. Support primary care development through capacity and capability development programmes (e.g. Safety in Practice) and support for the Healthcare Home model	A business case to support Point of Care Testing for Great Barrier and Waiheke Islands is underway through the Rural Alliance. This allows rapid decision-making from assessment and diagnostics to treatment, avoiding unnecessary ED presentations and hospitalisations. 17 general practices are currently participating in the Safety in Practice programme.	People powered Closer to home Value and high performance One team
20. Work with the northern region DHBs to consolidate regional services and agree: the standards and consistency of care delivery across our region; the models of care that will get the best clinical outcomes; and the best use of the region's health resources	A regional long term investment plan is underway. Regional cancer board.	Value and high performance
Intelligence and Insight		
21. Work with our neighbour DHBs to develop a regional patient IT system that integrates medical records and gives patients access to these	Regional planning is underway on the Information Systems Strategic Plan (ISSP) and will be completed by June 2017. The northern region has agreed to a set of priority developments for the future. The Deloitte review of the Northern Regional Electronic Health Record Project will also shape the direction of ISSP.	People powered One team Smart system

Priority work in our strategy	Progress to date	Alignment to NZHS
	A stabilisation plan has been commissioned to review our IS systems and assess which of our many applications need to be updated in future. This ensures existing technology assets reliably support Auckland DHB.	
22. Improve the quality of the data we collect, to better understand trends, to gain accuracy in ethnicity data, and to improve how we manage risks in the provider arm	Primary care training tool for PHOs targeted at frontline administrative staff in practices to improve ethnicity data collection. Contribute to the Ministry of Health Working Group to refresh the ethnicity data protocols. Primary care Ethnicity Data Audit Toolkit rolled out to more than 95% practices across Auckland and Waitemata. Our Annual Plan for 2017/18 includes a new measure based on the Ethnicity Data Audit Toolkit. Secondary care audit coming out this year which is signalled in our Maori Health Plan. Auckland DHB has been working with the Ministry of Health on: • Ethnicity Data Protocols to establish an IS process which all hospital and primary/community systems will comply with • an electronic collection and recording tool that uses the census question and automatically records the correct code to our HR systems. The Maori Alliance Leadership Team (MALT) has improved the quality of staff ethnicity data across our HR systems.	One team Smart system Value and high performance
23. Develop a baseline for diabetes and cardiovascular disease indicators to track progress on these diseases	A reporting template enables standardised reporting on regionally agreed diabetes and cardiovascular disease (CVD) clinical indicators. This ensures consistency of reporting on indicators across PHOs. It allows the Funding, Planning and Outcome team to analyse and compare PHO and DHB performance against the five Metro Auckland Clinical Governance Forum diabetes and CVD targets. The template will establish a reliable baseline for CVD and diabetes.	Value and high performance Smart system
24. Explore the use of technology for the development of virtual medicine and personalised	An innovation programme addresses the need for affordable and effective non-pharmacological solutions to reduce clinical pain, anxiety and depression.	Smart system

Priority work in our strategy	Progress to date	Alignment to NZHS
healthcare	Five products were developed based upon a virtual reality platform and these platforms are in the process of being implemented. More virtual reality innovations will be advanced over 2017/18. Innovation alignment provides greater governance across initiatives and focuses on outcomes (linking people, process, and technology innovation programmes).	
25. Link the systems that collect data and use this to better understand, track and drive down DNA rates for Māori and for Pacific and other underserved groups	Joint Auckland and Waitemata DHB DNA strategy endorsed by the Hospital Advisory Committee and respective Boards in August 2016. This directs activities to reduce DNAs, particularly focused on Māori and Pacific. The actions in the strategy are owned by the Hospital Directors. Actions are in different stages of progression particularly via outpatient redesign work at both DHBs.	Value and high performance Smart system
26. Collaborate with Auckland metro DHBs to advance clinical developments, investigating where to extend use of, or invest in, electronic technology, in order to make it easier for patients to get the care and support they need within their homes, or within their community	Technology enablers are in place to securely allow workers with mobile devices to be more efficient, and to improve information at the point of care. Plans are in place to replace "dial and txt" mobile phones with smart phones and tablets. This takes advantage of new technology for use in the community. Telehealth-based technology is being investigated to reduce the need for onsite visits for patients where this is clinically appropriate to do so.	People powered Close to home Smart system
Consistent evidence-informed decision making and practice		
27. Address every issue that compromises our ability to guarantee world-class health services, with a goal of the provider being a leader in the quality and safety of specialist care	Afterhours safety programme. Projects underway: • information for afterhours staff • handover • out of hours theatre access and anaesthetic cover • future oversight of afterhours inpatient safety • 24/7 hospital functioning. Security for safety programme. Projects underway: • lockdown and code black • culture and performance • access plans • access control and CCTV • security / ID Card	Value and high performance One team Smart system

Priority work in our strategy	Progress to date	Alignment to NZHS
	• security control room • security staffing and services • security alarm monitoring • lone workers • contractor training • keeping weapons out of hospital • security in hospital sites.	
28. Continue to support the patient safety and clinical governance activities of both our provider and our primary care and community partners, through a stronger focus on applied research, on quality IT systems, on reduced variation in clinical practice, and better benchmarking e.g. Health Round Table	Patient safety. Improvement programmes currently inflight include: • safe after hours care • deteriorating patient. Projects in planning • extended electronic prescribing • extended Venous Thromboembolism (VTE) risk recognition and prevention. Continuing streams of work: • healthcare acquired infection • early recovery after surgery • falls and pressure injury prevention.	People powered Value and high performance One team Smart system
29. Standardise care and benchmarking by reducing clinical variation, improving diagnostic testing, and making better use of the Regional Clinical Practice Committee to guide decision making	A northern region cancer board is in place. This will determine the best approaches for the treatment of cancer, with a focus on research and research-enabled cancer care. Cancer priorities are determined by the northern DHB working regionally.	People powered Value and high performance One team Smart system
30. Develop plans and service options based on evidence, specifically: • improve the safety of care provided to inpatients after-normal working hours • programme for people with dementia and their family/whānau carers • managing deteriorating patients • redesigning our outpatient model • critically reviewing acute and elective models of care	Deteriorating patients programme. Projects underway include: • introducing a patient-at-risk service involving: - prevention and early identification of deteriorating patient - response to deteriorating patient - governance of deteriorating patient management • review of high dependency care areas outside the formal High Dependency Unit settings • 24/7 hospital functioning.	People powered Value and high performance One team
Outward focus and flexible service orientation		
31. Strengthen the health workforce by developing healthier workplaces, promoting cultural diversity and programmes that empower workers to be proactive	People programme. Projects underway: • management practicing certificate • leadership, coaching and communication • access to HR services, info and tools • career pathways and benefits • orientation process • workplace behaviours	People powered Close to home Value and high performance One team

Priority work in our strategy	Progress to date	Alignment to NZHS
And 32. Develop more skills training and mentoring for staff in leadership positions and use these skills to build better staff engagement and sense of satisfaction	• Speak up campaign to reduce bullying and harassment • Māori and Pacific employee recruitment and development • future workforce planning. Auckland DHB nursing and midwifery strategy: • integrated new models of nursing and midwifery, co-designed to provide care closer to home • expanded nursing practice roles • build a resilient multipurpose workforce • nurse-led rapid response service to support early discharge and admission avoidance • nurse prescribing • Nurse Practitioner pathway developed • regional nurse prescribing framework • community nursing roles including a community health assistant role.	
33. Explore opportunities to partner with businesses, both to enhance our internal capability through learning from others and to enable us to do more and faster, through co-investment, public/private partnerships or similar	Get on Track programme underway which continually investigates opportunities for savings.	Value and high performance
34. Expand the range of rehabilitation and support services through a 'needs assessment' process which makes sure all the services needed are well coordinated	Community and long term conditions directorate has a single community rehabilitation service, including early supported discharge service. Needs Assessment and Service Coordination services are embedded into all hospital teams and in all locality teams. Improvements are on-going including reduction in waiting times, new intermediate care services and integrated models of care with Home and Community Support Services.	People powered Closer to home Value and high performance One team
Emphasis on operational and financial sustainability		
35. Increase productivity and the best use of resources by using hospital services more wisely, with an initial focus on discharge planning, improved patient pathways, and day services	Using the hospital wisely programme. Current projects underway: • discharge planning • palliative Care • end-to-end pathways • day of surgery admission • intermediate care • bed modelling and ward realignment.	Closer to home Value and high performance One team

Priority work in our strategy	Progress to date	Alignment to NZHS
	Provider financial sustainability. Projects under development: • systems, frameworks and integration • productivity • procurement and logistics • corporate • revenue • reporting and monitoring.	
36. Develop our people so we get the best from our workforce	Refer action 31.	One team Value and high performance
37. Develop a 10-25 year facilities plan for all DHB sites including improving the data on our capital assets	Asset management improvement programme. Projects under development: • long term investment plan • policies, process and strategy improvement • asset data and systems • asset performance • plan integration and process • programme design.	Value and high performance
38. Redesign the model of care for outpatients so this is more patient-centric, freeing up staff and patients' time and reducing costs	Outpatients model of care. Current projects: • access, booking and choice (ABC) policy • business rules • performance visibility • tele-interpreters project • letters management • PAS skill mix and structure review • review of clinic working hours • reduction of DNA rates (regional focus and localised initiatives).	Closer to home Value and high performance One team Smart system
39. Review processes for procurement of goods and services to ensure value	Completed MBIE procurement Capability Self Assessment from which improvement initiatives will be developed. This work will be added to the Investor Confidence Rating assessment in the next round. Contracting initiative underway to identify all contracts in place for the DHB and create a central repository so these can be assessed and managed. Working closely with healthAlliance and the business to ensure value for money on contracts in place. Procurement workstream underway.	Value and high performance
40. Complete a review of our tertiary services to get the right mix of service and volume of service available to patients outside our DHB with a focus on ensuring the revenue covers the	The tertiary services review has now been completed. Recommendations and actions are pending.	Value and high performance One team

Priority work in our strategy	Progress to date	Alignment to NZHS
treatment of patients referred from other DHBs		
41. Identify opportunities for public/private work which increases efficiency and/or generates revenue	Developing the Facilities Infrastructure Remediation programme which will consider the possibility of public private partnerships.	Value and high performance
42. Identify other opportunities for revenue through maximising our retail offerings, investigating judicious use of advertising and exploring our 'exportable' commodities e.g. training	A revenue workstream has been set up with some areas of focus identified ie. IDFs, non-resident payments, ACC, with others under development.	Value and high performance

Auckland DHB Human Resources Report

Recommendation

That the Board receives the Auckland DHB Human Resources report for May 2017.

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

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	• Adopt a visible, purposeful employee value proposition, to focus attraction and retention efforts and investment. • Create useful channels to involve our people in the design and implementation of our employment environment and mutual expectations. • Build management and coaching capability, and capacity for personal development planning. • Address inequities within our workforce to ensure we role model the behaviours and solutions we want for our communities.
Emphasis/investment on both treatment and keeping people healthy	• Ensure our people are set up for success from the start of their employment with us. • Embed a health and safety culture and mind-set. • Rehabilitate or remove bullies. • Foster workplace programmes to promote and support mental health in our workforce. • Role model resilience, wellness and wellbeing through leadership behaviours, colleague care and personal responsibility. • Provide safe, early intervention for those who may be experiencing problems at work.
Service integration and/or consolidation	• Create simple, easy-to-use HR policies, processes and forms. • Provide easily-accessed, consistent, quality support from HR. • Enable and empower our people to control their own employment experience.
Intelligence and insight	• Improve employment data integrity and standardise people information and insights, based on relevant benchmarks. • Create channels to receive real-time feedback from our people to co-create and improve their employment experience.
Evidence informed decision making and practice	• Embed our values, and value-based decision making tools and frameworks. • Develop an employment info-base to record precedents and organisational best practice. • Adopt a 'Learning Organisation' mind-set, championing education, transparency, fairness and openness.
Outward focus and flexible service orientation	• Innovate and experiment with international practices to improve and streamline our employment experience. • Implement an agile HR Operating Model to optimise funding, workflow and to enable us to move quickly on workforce opportunities.
Operational and financial sustainability	• Reduce time spent on HR 'bureaucracy' to replace with value-add employment activity that enhances both the employee experience and patient care through effective individual, team and system development. • Creatively share resources and solutions with partner organisations. • Ensure employment terms and conditions are accurately implemented, mutually beneficial, affordable and fit for the future. • Evolve the workforce to ensure we have the right people, in the right place, in the right roles, at the right times, with the right skills.

2. Delivering the Auckland DHB People Strategy

The new HR Operating Model has been in place since 1 March 2017. We are actively monitoring trends (askHR), resolution rates and use of our online self-service information (myHR). Anecdotal feedback about the value of the service has been extremely encouraging, and we will formally seek feedback after the askHR service has been in place for 90 days.

After 60 days of operation, askHR has logged 2951 employment-related enquiries, with only 3.37% currently unresolved (usually due to issue complexity).

Open Issues (duration)	Actual Number	% of Total
Less than 5 Days	34	1.1%
5 – 10 Days	26	0.8%
11 – 20 Days	23	0.8%
More than 20 Days	20	0.67%

3. Pay Equity

The Government has announced that it has entered into a 'pay equity' settlement in relation to the government-funded service sectors of aged residential care, home support and disability services.

It has been reported that the settlement will cover 55,000 care workers, providing them with a pay rise of between 15 and 49 per cent, depending on their qualifications.

The settlement is the culmination of a line of cases relating to a claim made by Kristine Bartlett, a rest home caregiver, against her employer, Terranova Homes and Care Ltd. Ms. Bartlett claimed that both male and female caregivers are paid at a lower rate than would be the case if caregiving of the elderly was not predominantly performed by women (i.e. that her work has been systematically undervalued due to current, historical and structural gender discrimination).

Considering Ms. Bartlett's case, the Court of Appeal confirmed that, in deciding pay equity claims, the courts may have regard to what is paid to males in other sectors (meaning dissimilar sectors) if enquiries within the same sector would not yield an appropriate "comparator group".

The matter was referred back to the Employment Court for guidance on the general principles to be observed in implementing equal pay. However, the Government then stepped into the process to negotiate a settlement.

What are the implications for the health care sector?

The Government has stated that the settlement package will result in costs of more than $2 billion, funded through increases in the Health and ACC budgets. Minister of Health, Jonathan Coleman, has also indicated that it could eventually require a lift in ACC levies or higher fees for aged care residents.

In terms of the wider care sector, we expect that the Government's settlement will have a flow on effect by setting a benchmark that the unions will seek to emulate for private sector employees. If private sector employers do not increase wages in line with the Government, they may face difficulties in recruiting and retaining good employees. They would also face a high risk of pay equity claims being brought against them.

What are the wider implications for the DHB?

It is likely that we will also see a range of claims brought by employees in other female-dominated sectors (for example, we understand that special education support workers, social workers and midwives have already been involved in pay equity claims).

To assist in dealing with anticipated claims, in October 2015 the Government established a Joint Working Group on Pay Equity to develop recommendations for practical guidance to employers and employees in implementing pay equity.

The Government accepted the Working Group's recommendations in November 2016. The recommendations include principles to provide guidance to employers and employees in identifying, assessing and resolving pay equity claims and a process to follow to address pay equity, including a bargaining process. Changes to the Equal Pay Act 1972 and the Employment Relations Act 2000 will be needed to implement these changes and the Government expects to introduce legislation this year.

4. Employee Engagement Survey

Our organisation-wide results have been published internally, to our Unions and a synopsis made publicly available on Auckland DHB's external website. There was brief media interest in the results in early May.

Action planning is beginning to gain momentum, and reporting to the Hospital Advisory Committee on actions underway will commence in June.

5. Diversity, Talent and Inclusiveness

Ethnicity survey

Through a recent campaign, 93% of our employees have now formally identified their ethnicity in their employment records (up from about 75%) increasing the number of Māori and Pacific employees as a percentage of our workforce by approximately 0.5% each.

Rangatahi Programme

A one year extension has been made to the existing contract with programme partners, Te Runanga o Ngati Whatua. A Request for Proposal to establish our ongoing partner for this programme will take place in Q1-2 F17/18.

6. Talent and Leadership across the State Sector

The 20 DHBs Chairs and Chief Executives meeting on 8 December 2016 gave the green light for national DHB adoption of the State Services Commission's Leadership and Talent Development Framework. This is a comprehensive and robust approach to Leadership and Talent Development which will take some time to integrate and implement fully across DHBs.

Auckland DHB is represented on the DHB Working Group that is preparing national and regional approaches to implementation to be adopted over the coming 24 months.

Auckland DHB has also initiated participation on the Auckland Career Board, which is a quarterly meeting to profile talent and share development opportunities across the Public Service, and is working proactively across the Region as 'early adopters'.

Agreed Implementation Principles

The following principles acknowledge the context for the implementation of a shared approach across 20 DHBs. To support DHBs with the implementation of this shared approach, we will:

- Work with and build on what already exists within each DHB.
- Recognise that each DHB will start where it makes best sense for them to do so.
- Work with the willing, noting the mandate.
- Nationally facilitate any system-wide customisation of the SSC's Leadership Success Profile for the health sector.
- Support regionally and locally driven implementation, sharing good learning as it emerges.
- Reprioritise investment in leadership development over time to support implementation of the shared approach.
- Implement this shared approach across the whole DHB workforce.
- Support professional /regulatory bodies and leaders to align their current leadership practices with the shared approach.
- Connect with, participate in and help shape the long term ambition and goals of a shared approach across the core public sector.

Leadership Development Programme

Recommendation

That the Board:

1. **Receives the Leadership Development Programme (LDP) update.**
2. **Notes the participation to date, and feedback received on the value of the programme.**
3. **Notes ongoing risks, particularly the significant length of time it will take for all leaders to participate in the programme.**
4. **Notes the intention to measure correlation of LDP participation and the achievement of organisation goals and targets.**

Prepared by: Gil Sewell, Director – Organisational Development, Anne Silva, OD Practice Leader and Monique Le Heron, OD Coordinator
Endorsed by: Fiona Michel (Chief HR Officer)
Endorsed by: Ailsa Claire (Chief Executive)
Endorsed by: Executive Leadership Team Date: Tuesday, 02 May 2017

Glossary

LDP	Leadership Development Programme
RFP	Request for Proposal
SSC	State Services Commission
Wave	Sub-set of participants in a cohort
Coffee Group	Peer support and learning group within a cohort

Board Strategic Alignment

Community, whanau and patient-centred model of care	Leadership development is instrumental to achieving our determined model of care, ensuring efforts, resources and energy are directed in the best way
Emphasis/investment on both treatment and keeping people healthy	Leadership development is instrumental to achieving our determined model of care, ensuring efforts, resources and energy are directed in the best way
Service integration and/or consolidation	LDP equips our leaders to collaborate more effectively and to envision and implement the seamless experience of care
Intelligence and insight	LDP data informs ADHB where to target the leadership development dollar
Evidence informed decision making and practice	LDP is an evidence-based programme in alignment with this theme, enabling leaders to respond to the challenges we face
Outward focus and flexible service orientation	LDP offers our leaders opportunities to improve their practice and increase their skills
Operational and financial sustainability	LDP sharpens our leaders' focus on leading efficient operations and refines their approach to getting the best from their people

1. Introduction/Background

This report offers a deep dive into the Leadership Development Programme at Auckland DHB to give the Board a clear picture of the impact the programme has had on our leaders and what they are doing differently as a result.
It contains:

- A brief background to the programme and how it fits into development at Auckland DHB
- Programme structure and attendance information
- Evaluation approach
- Results from evaluations
- Future projections and intended enhancements

The need for a Leadership Development Programme at Auckland DHB became evident following the restructure of the DHB to focus on a single point of leadership accountability in each Directorate. Respected senior clinicians were taking on leadership roles for which they had had little formal training or development during their careers. The purpose of the LDP is to equip and support participants with a leadership mindset, skillset and toolkit to deliver safe, quality care through their teams and to lead culture change to create an engaging environment where teams feel valued and supported to be at their best, enabling patients to feel safe.
The RFP process was completed in December 2015, with the pilot group starting in March 2016.

The design of the programme included a check on alignment to the State Services Commission's Leadership and Talent Development Framework and to the Leadership Domains described separately by both the national DHB's GMsHR working group and the Health, Quality & Safety Commission.

The LDP is provided by external specialists, Jumpshift. The programme is structured into 4 modules, run 3 to 4 weeks apart, allowing participants time to put new skills into practice. It is topped and tailed with Initiate and Celebrate sessions respectively. Each participant completes a 360 report before embarking on the programme. Twice during the programme duration, we hold a video conference Inspire session, led by Jumpshift's Research Advisor, Nick Petrie, Senior Faculty member at the Center for Creative Leadership, Colorado Springs, with a New Zealand-based facilitator in the room. Continuous support and embedding is provided by the Jumpshift online "Knowledge-to-Action" platform, which mimics human coaching for participants.

To optimise flexibility and penetration, the programme is run in Waves. Each Wave consists of 3 Groups of 15 (Group, A, B and C). Each Group's modules are scheduled for different days. If someone cannot make their regular Tuesday Group, for example, they can swap into another one. Participants like the flexibility of this approach and it means fewer people miss out on core modules.

Each Group sub-divides into Coffee Groups, scheduling their own meetings and driving the subject matter explored at those meetings.

2. Progress/Achievements/Activity

Progress to date

A total of 150 people have attended LDP so far. See Appendix 2 for detailed breakdown by cohort and Directorate. Wave 3 has included professional leads.

With a total of 150 participants over the course of 18 months, it will take us past 2020 to see our 450 leaders at Tiers 2-4 complete LDP.

The success of the programme has resulted in the organisation (and the NZNO) requesting that LDP be extended to Charge Nurse level (and their peers in other professional group), meaning we could consider a future target audience of up to 1,000 leaders. To enable all of these leaders to attend the programme at current throughput rates will take almost 10 years in total.

Executives and participants' line managers visibly support the final Celebrate session, with strong attendance.

Programme Feedback

- Participants self report an average improvement in their leadership of 31% in a pre- and post-programme survey
- 90% would recommend the programme to colleagues
- Key reported impact from the 76 participants in Waves 1 and 2:
    - Improved use of time resulting in greater feelings of control
    - Using a team approach to solving issues
    - Improved communication and better staff engagement
- Points to note from 360 reports:
    - Extremely high response rate of 86.63%
    - Qualitative comments are considered, comprehensive and constructive
- Key qualitative themes from Waves 1 and 360 reports:
    - Leaders are seen as principled, professional, high calibre of delivery
    - High workload
    - Communication could be improved (reduce reliance on email)
    - Compassionate
    - Provide more development and allow two-way feedback
    - Strong focus on patient care and outcomes
    - Frustration with organisational structure/culture/constraints

See Appendix for more detail.

Enhancements

- We hold regular review six monthly meetings with Jumpshift, most recently in December 2016, were we discussed low usage of the online platform. Jumpshift have now changed it to better support our leaders in light of our feedback. The main benefit is that the platform really works alongside the face to face workshops rather than being seen as an optional extra. Users experience a more guided approach to using the platform (pre- and post-workshop) and see the value more quickly, rather than just logging in to the platform whenever and if they felt like it.
- Longer-term impact assessment has begun, through the mechanism of a mini-360 survey of alumni one year post-programme completion, to track progress made in focal areas and includes generic items about the extent to which leadership and team engagement have improved. Results from the Pilot programme will be available in June.
- We are researching the most suitable way to add a Leadership Wellness element to the programme.

- Work is underway to include Maori and Pacific Leaders either as a unique cohort or as part of the regular Groups.

3. Costs/Resources/Funding

Cost per person:

- $2,200 for Jumpshift programme
- $650 for 360 survey, report and 1 hour debrief
- $2,816.00 for each Leadership Lecture (= approx. $70 pp)

Total: $2,920.00

Cost per Wave with 3 Groups = $131,400; Annual cost of 3 x Waves of 3 Groups = $394, 200.

Cost per Wave with 2 Groups = $87,600; Annual cost of 3 x Waves of 2 Groups = $262,800.

Evaluation costs:

- Jumpshift provide themed feedback after every Wave at no charge.
- Their Psychologist partners, Added Insight provide themes from the 360 reports after every Wave, also at no charge.
- Mini-360 $95 per participant if managed in-house; full outsourced service would be $380 per participant. Evaluation of Pilot group will be $1,140 and heavily reliant on internal resource.

The programme requires coordination resource, heavily at times of Wave commencement (up to 60% of coordinator's time) with a lighter touch during the programme itself (down to around 25% of coordinator time). The mini-360 for longer term evaluation also requires heavy coordination input if managed in-house.

4. Risks/Issues

Risk	Planned Mitigation
Funding The programme is carefully managed financially and has made continuous improvements such as adjustments to venue and catering in the interests of efficiency. However, these measures are not always well received by participants, taken as a lack of valuing of them as individuals.	Continue to target development to maximise return on investment by: • Focusing on capabilities of greatest need • Targeting appropriate levels of leaders • Measuring individuals' readiness for programme • Building into governance meetings regular review of how to maximise impact and cost-effectiveness
Length of time to put all leaders through the LDP At current rate, it will take another 9.5 years from now to have all 1,000 people leaders attend the programme. New leaders will join over that period, and leadership needs will	Widen impact of leadership development programme by: • Focusing on higher level leaders first so that they can role model effective behaviours and leadership practices to next tier of leaders • Providing guidelines for participants,

Risk	Planned Mitigation
inevitably change over that time, requiring programme evolution.	highlighting how they can share new tools and improved practices within their teams • Supplementing programme with short, focused 'skills clinics' for all leaders / managers to attend as needed
Transfer of learning There is a risk that participants recall and application of learning decreases over time. Some Coffee Groups continue to meet, strengthening their members' maintenance of learning. We also have a Nursing Hons. student who is researching ways of embedding leadership learning with our LDP alumni.	Further embed learning by: • Providing guidelines and tools for leaders / managers of participants to support embedding of learning • On-going encouragement of peer coffee groups to share learning • Building in structured self-reflection post the programme • Establishing structured alumni sessions and sharing success stories and case studies • Introducing supplementary learning through the Auckland DHB People Strategy – including the SSC Talent & Leadership framework and the Auckland DHB Management Practicing Certificate.

5. Conclusion

The LDP is a well-timed and well-targeted intervention which is shifting leaders' mindsets and equipping them with core leadership skills. Participants describe valuable insights and lessons (see Appendix 4). The programme has gained popularity and momentum from word-of-mouth referral, and waiting lists are full.

Measures and comparisons are still under development to identify if participation on the LDP correlates to stronger results in strategic and operational goals and targets. For instance, are employees of LDP participants more engaged? Are patients cared for by teams lead by LDP participants safer?

The role of the LDP alongside other management and leadership development activities will be further clarified this year, to incorporate our national commitment to the SSC Leadership & Talent framework, and to ensure leadership pathways are transparent to all.

Appendix

Leadership Development Programme Participants

- Pilot Programme launched on 29 March 2016 with 12 participants
- Wave 1 launched on 8 June 2016 with 40 participants
- Wave 2 launched on 25 August 2016 with 36 participants
- Provider Directors (10) took part in a condensed version of the programme in July 2016
- General Managers (9) took part in a condensed version of the programme in September 2016
- Wave 3 launched on 14 March 2017 with 43 participants

Breakdown by Directorate

Adult Community and LTC	**Cancer & Blood**	**Women's Health**	**Perioperative**	**Adult Medical**
13	11	10	9	13
Mental Health	**Surgical Services**	**Children's Health**	**Clinical Support**	**Cardiac Services**
13	17	30	18	16

Participants can only miss one workshop throughout the whole programme (otherwise they get deferred to another programme) and they make this commitment up front. We therefore have a minimum attendance rate of 80%. However, most participants do not miss any modules. See breakdown below:

- Pilot /12 – no drop off
- Wave 1 /40 – 1 resigned, 1 had high workload
- Wave 2 /36 – 1 resigned
- Wave 3 /43 – no drop off so far

360 Surveys

All participants in the Pilot, Waves 1, 2 and 3 have participated in a 360 survey.

- Starting to build useful benchmarking 360 data of leaders at Auckland DHB
- 12 month follow up mini-360 will be offered to all alumni, currently underway for the 12 Pilot Participants
- This will provide useful data in terms of measuring the impact of the programme

Verbatim Feedback

Quotes from Celebrate evenings:

"Enormous value of this programme has been the opportunity to reflect, by surrounded by like-minded people, and fed tools that we could use."

"Part of being a leader is to step back and let others generate ideas and problem solve. A measure of how well you lead your team is how well they can continue on without you".

"I have noticed my participant challenging me and is constantly in a really open-minded space"

"My team member has really flourished and taken on this challenge. She is now challenging SMO's which is critical….a potential future SCD".

"Great connections and how important that has been. Has highlighted that others have similar challenges in different areas of the organisation…..Given me a mind-set shift and has made me look at things differently. Cultural mind-set shift."

"The programme…taught me a sense of ownership. Showed me there are great people in this organisation that I can go to for support."

"Small details matter... How we live those small details. Making those relationships across the organisation to help you stay true to your values….Ask questions we don't know the answer to. Courageously hold others accountable. Be authentic, kind but tough when I need to be".

"I feel fresh, capable and connected, and when I don't feel this way, I know who my support network is… Enjoying having learning pushed on me. Being courageous is not a comfortable place for me... Being courageous felt good. Using learning, insights and actions in new projects. "

"Self-directed learning… building meaningful relationships and networks across multidisciplinary groups. Challenge status quo. Appreciate the investment…"

"What resonated with me most was 'starting with why'. I have reframed my own and my team's mindset to 'protect their Why' and to keep the patient at the centre of what they do."

Auckland DHB Health and Disability Service Standards Certification Audit Report

Recommendations

That the Board:

1. **Receives the report from the organisation wide Certification Audit carried out between 28 February 2017 to 3 March 2017.**
2. **Notes that this is the final report received from the auditors in late April**
3. **Notes the significant progress made since the Surveillance Audit carried out in 2015.**

Prepared by: Jo Gibbs (Director of Provider Services) Sue Waters (Chief Health Professions Officer)
Endorsed by: Ailsa Claire (Chief Executive)

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	The Health and Disability Services Standards 2008 set the standards for care delivery in the NZ Health Sector. They have specific criteria relating to consumer rights, organisation management, and quality and safety and assessment against them provides a good benchmark for our performance against these three strategic themes in particular.
Emphasis/investment on both treatment and keeping people healthy	
Service integration and/or consolidation	

2. Executive Summary

The report detailing the certification audit period for our inpatient services is now complete. A team of 20 auditors were on-site in all of our inpatient facilities across physical health and mental health services from 28th February to 3rd March 2017.

The report provides great feedback and emphasises the areas the auditors saw as us doing particularly well in. These include: MOS (our Management Operating System), Releasing Time to Care, our values work, cellulitis, using the hospital wisely, our approach to quality improvement, rapid rounds, discharge planning, and communication.

Overall, the patients and whānau who were interviewed made very positive comments to the auditors about the care that they and/or their family members were receiving. This is to be commended, and highlights the way we are all working together to provide a high level of care to those we are serving.

This final version of the report incorporates feedback from Auckland DHB and has now been formally submitted to the Ministry of Health. Key highlights include:

- Of the ~130 criteria standards, there were only 14 that haven't fully met the standard (the detail is attached in appendix 1)
- None of these are high risk, and just two moderate risk
- The lead auditors comment was that this was “a very, very good outcome for a DHB this size”

There are five areas awarded a 'continuous improvement' (excellent) rating as advised in the auditor's feedback.

3. Background

The Health and Disability Services (Safety) Act 2001 is the legislation that underpins the certification of health care services. As a District Health Board we are required to be certified and need to demonstrate that our services comply with all relevant approved standards.

Hospitals, rest homes, and some providers of residential disability care need to meet the Health and Disability Services Standards 2008 (the Standards). The Standards came into effect on 1 June 2009 and replaced the Health and Disability Standards 2001. They were developed through an extensive collaboration process with many groups including consumers, providers, government and non-government agencies and the Ministry of Health.

The Standards are made up of four sets of Standards as below:

- NZS 8134.0:2008 Health and Disability Services (General) Standard
- NZS 8134.1:2008 Health and Disability Services (Core) Standards
- NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards
- NZS 8134.3:2008 Health and Disability Services (Infection Prevention and Control) Standards

To prove compliance with the Standards, District Health Boards are regularly audited against the Standards with the period between certifications lasting one to four years based on audit results.

Between 28 February and 3 March 2017, Auckland DHB had a full, organisation wide certification audit carried out by DAA Group, one of New Zealand's leading providers of assessment and evaluation services, against all four standards. There were 20 auditors (12 from DAA Group and 8 Ministry of Health appointed technical assessors) onsite for four days. They undertook 12 in-depth patient tracers, one on medication safety and one on infection prevention and control and visited the majority of our inpatient areas.

4. Highlights / Strengths

The auditors held daily feedback meetings on their findings, and a summary feedback session on the final afternoon. Some of the specific highlights they made mention of, as outlined in the final report, include:

- Our governance systems and structures
- The visible demonstration of our values - and them setting a culture
- Management Operating System
- Project design and delivery - some fantastic projects happening
- Excellent examples of team work and communication
- Good focus on patients and patient needs - "patient at the centre of what we do"
- "Overall compliance to the standard is a real strength"

The auditors were particularly impressed that everything that they raised as issues were already known about and had work underway to address.

The report also makes special note of the penetration of our vision and values work through the organisation. Everywhere the auditors went, people spoke positively and knowledgably about the vision and values and saw the connection to their work. This was seen as a real organisational strength, and a rarity amongst other organisations audited.

5. Continuous Improvement Grades

"Continuous Improvement" is a grade that is awarded where organisations are seen to be demonstrating excellence against a particular standard. The report acknowledges five areas of continuous improvement. These relate to the embedding and understanding of the values of the organisation, the introduction of the management operating system, improvement initiatives, improved patient flow and infection surveillance.

The areas noted for continuous improvements include the following:

- Standard 1.2.1/1.2.2 – Organisation Management for our vision and values penetrance.
    - "Everywhere we went, people knew the values and examples of them being lived at all levels". The auditors used the example of cleaner "we were met with a smile. She expressed feeling part of the team and felt very supported." A particular example was the translation of Standard Operating Procedures into seven languages and pictures, and our efforts to introduce literacy and computer literacy training.
- Standard 1.2.3.6 – Quality and safety systems for good use of data
    - It was noted that 'Using the Hospital Wisely' has made good progress, and good evidence of rapid rounding, use of Estimated Day of Discharge and introduction of winter and summer plans

Furthermore, the reviewers closed our final feedback session by asking themselves if they would be happy to be treated in our facilities - and there was a unanimous 'yes' from the team.

6. Improved Results

Below is the current performance of the audit comparing the surveillance audit 2015 and full certification audit Physical and Mental Health 2017:

Auckland DHB including MH			**Risk Classification for 'Partially Achieved'**		
Audit	Continuous Improvement	Partially Achieved	Low	Mod	High
2015 Surveillance	1	24	17	7	0
2017 Full	5	14	11	3	0

Key Points:

1. For the first time Auckland DHB has a record of 5 (likely) Continuous Improvement ratings.
2. There has been a 42% reduction in Partially Achieved standards.
3. There has been a 35% decrease in low corrective actions.
4. There has been a 57% decrease in Moderate corrective actions.
5. This is the lowest number of corrective actions we have achieved in any audit over the last 7 years.
6. Just two standards increased their risk from low to moderate:

Standard	**2015**	**2017**
1.2.9.7 Information of a private or personal nature is maintained in a secure manner.	low	moderate
1.3.5.2 Service delivery plans describe the required support to achieve the desired outcomes.	low	moderate

7. For first time over the last 7 years, Incident management and particularly the management of Serious Adverse Events did not receive any corrective actions.
8. Quality management (framework) did not receive a corrective action as in previous audits.

7. Conclusion

The feedback from our recent full organisation audit is extremely good and something that we should be proud of. It also represents considerable improvement on our surveillance audit result from 2015, a direct result of our intense focus on improving our quality and safety systems over the last few years.

HealthCERT Service Provider Audit Report (version 6.2)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of a health and disability service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Auckland District Health Board
Certificate name:	Auckland District Health Board

Designated Auditing Agency:	The DAA Group Limited

Types of audit:	Certification Audit
Premises audited:	Auckland City Hospital; Auckland DHB X 3 Units - Mental Health; Rehab Plus; Tupu Ora; Greenlane Clinical Centre; Buchanan Rehabilitation Centre
Services audited:	Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Children's health services; Residential disability services - Psychiatric; Hospital services - Surgical services; Hospital services - Maternity services
Dates of audit:	**Start date:** 28 February 2017 **End date:** 3 March 2017

Proposed changes to current services (if any):
None

Total beds occupied across all premises included in the audit on the first day of the audit:	1070+

Audit Team

Lead Auditor	Janice McEwan	**Hours on site**	32	**Hours off site**	32
Other Auditors	Jacqueline Horn, Elaine Elbe, Alison Gallagher, Kirsty Rance, Sarah Harnisch, Chris McLelland, Jan Dewar, Cate Tyrer	**Total hours on site**	152	**Total hours off site**	40
Technical Experts	Deb Pittams, Nicola Pereira, Grant Pidgeon, Annette Van Zeist – Jongman, David Warrington, Michele King, Wendy Diamond- Hill, Dawn Tucker.	**Total hours on site**	88	**Total hours off site**	0
Consumer Auditors	Sal Faid, Debs Craig	**Total hours on site**	32	**Total hours off site**	6
Peer Reviewer	Joanna Harper			**Hours**	9

Sample Totals

Total audit hours on site	304	Total audit hours off site	87	Total audit hours	391

Number of residents/patients interviewed	42	Number of staff interviewed	150	Number of managers interviewed	81
Number of residents'/patients' records reviewed	139	Number of staff records reviewed	64	Total number of managers (headcount)	460
Number of medication records reviewed	150	Total number of staff (headcount)	10,400	Number of relatives interviewed	21
Number of residents'/patients' records reviewed using tracer methodology	12			Number of GPs interviewed (Residential Disability providers only)	0

Declaration

I, Janice McEwan, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Monday, 27 March 2017

Executive Summary of Audit

General Overview

The Auckland District Health Board (ADHB) is responsible for providing health services to approximately 510,450 people living mainly in Auckland city as well as Great Barrier and Waiheke areas. In addition, the hospital provides specialist tertiary level services at local, regional and national level. This certification audit against the Health and Disability Service Standards included site visits to Starship Hospital, Auckland City Hospital, Auckland Hospital Mental Health Services including Tupu Ora Eating Disorder Residential Service, Green Lane Hospital, Buchanan Rehabilitation Centre and Rehab Plus. The audit included a review of organisation management, quality, risk and reporting management systems, human resources and safe staffing requirements, care delivery, the environment and supporting services, infection prevention and control and restraint minimisation.

The audit team interviewed managers and reviewed records, including clinical records and other documentation. Interviews were also conducted with patients, their families, and a range of staff across different roles and departments. The environment and practices were assessed throughout the audit.

Fourteen areas were identified as requiring improvement; of these, two were rated as a moderate risk and twelve as low risk. These related to privacy of some records, the document control system to maintain current policies and procedures, establishing time frames for risk reviews, a process for performance appraisals, and the monitoring of food fridges. Within the clinical standard, improvements are needed in relation to planning of care, documentation of patient outcomes, evaluation, transfer and discharge information, and aspects of medicine management. Areas for improvement in mental health include meeting the Health of the Nation Outcomes Scales targets, complying with the smoke free legislation, re-establishment of the regular evaluation of restraint and the less restrictive practices governance group.

Areas of continuous improvement is acknowledged in five areas. These relate to the embedding and understanding of the values of the organisation, the introduction of the management operating system, improvement initiatives, improved patient flow and infection surveillance.

Outcome 1.1: Consumer Rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is visible around all areas of the DHB. Patients and families/whanau reported an awareness of the Code and that their rights were upheld. All patients spoke positively about their care, treatment and communication with staff. Staff were observed respecting patients' rights, including their privacy.

The organisation has a strong commitment to providing services that meet the cultural needs of its diverse catchment area.

Innovative approaches to delivering care and examples of evidence based practice were evident throughout the services. Promotion of patient safety and a safe environment were noted across services.

Communication with patients and families was open and honest and examples of open disclosure were evident where required. Interpreter services are readily available and widely used.

Adequate information is provided to patients to assist them to make informed decisions and provide both written and verbal consent

Complaints processes are well managed according to Right 10 of the Code. Patients knew how to make a complaint and complaints have been resolved within the required timeframes. Learning and improvement from complaints was evident. Patients and families interviewed were satisfied with the care and services provided.

Outcome 1.2: Organisational Management

ADHB's values are well embedded in the culture of the organisation. The values support the vision of the organisation Healthy communities – World-class healthcare – Achieved together. Throughout the audit staff at all levels demonstrated understanding and support for the values of the organisation.

A Management Operating System has been established and rolled out over some years with service and department levels included. The system links strategies with objectives and measurements as well as communicating day to day operational information and risk reporting. The key outcome areas are providing synergy with the annual plan and the clinical services plan.

Quality, participation and improvements were evident across the different areas of the DHB, enabled and supported by the management operating system and roles developed to focus on improvement and quality. There is a commitment from the organisation to invest in the infrastructure which will support development of improved services, such as the Datix incident management system, the upgrade of the 3M file viewer, and the developments within the 24-hour operation centre.

Consumer participation is described as a comprehensive partnership with consumers and consumer leaders. This partnership happens at three levels, the clinical intervention level, the service development level and the organisational level.

There is a well-documented and effective process for managing incidents of all levels of severity. The serious events are subject to appropriate reviews and the time frames for completion of these are closely monitored and continue to improve.

Good human resources systems are in place around recruitment and staff orientation and induction. Much work has been done to increase the use of on-line resources for this, resulting in improvements in monitoring. Credentialing of senior medical staff is effective. The training needs of staff have been under review. Departments and services continue to develop and offer training directed at their specialist needs.

Auckland DHB have a 24-hour bed management centre and a 'patient flow' manager who is responsible for accommodating all patients and supporting efficient patient flow through the clinical areas. Highly visible electronic information that is area specific provides up to date information on the patients and staff status for the hospitals.

Staffing level guidelines are in-place and implemented. Where vacancies existed, processes were underway for recruitment to fill the vacancy. Escalation plans are in place and can be activated as needed.

Consumer information and records are maintained to ensure the completeness and integrity of the record and to manage privacy and confidentiality, with the exception of one area.

Outcome 1.3: Continuum of Service Delivery

Patients access services based on needs and this is guided by policy. Waiting times are managed and monitored. Risks are identified for patients through the use of screening tools. Pre-admission assessment processes are used where appropriate. Entry is only declined if the referral criteria are not met, in which case the referrer and patients are informed of the reasons why and any alternatives available. Initiatives have been undertaken to improve timeliness and access to services with good outcomes.

Twelve patients' 'journeys' were reviewed as part of the audit process and involved the emergency department, surgical, medical, paediatrics, maternity, older persons' health and mental health departments and wards, including cardiovascular intensive care and the operating theatre suite. Auditors and technical expert assessors worked collaboratively with staff reviewing the relevant documentation and interviewing medical, nursing and allied health team members, patients and families/whanau. Additional sampling was undertaken throughout the audit.

A qualified and skilled multidisciplinary team provides services to patients and there were good examples of teamwork throughout clinical areas. Shift handovers are efficiently managed and include an office and bedside handover.

Assessments are undertaken in a timely manner with results reviewed, discussed and actioned as appropriate. This was supported by patients and family members interviewed. Admission assessment tools utilised are based on best practice. Various care plans and pathways were evident throughout the hospitals. Most areas were using the early warning score (EWS) to prompt triggers when a patient's condition deteriorates, and this tool was generally well completed. Evaluation is undertaken of patients' progress on a regular basis and includes progress towards discharge.

Activities meet the requirements of the individual patients and these are particular to the various specialty settings.

Overall the audit identified a strong focus on meeting patient needs and working as a team with good communication to achieve this.

Policies and procedures provide guidance for staff on medicines management. The national medicine chart is in use. Allergies are assessed and communicated. Clinical pharmacists provide support in the majority of areas. Medicines are generally stored safely and managed effectively throughout the organisation.

Food, fluid and nutritional needs are being met, although there is variation across the service reported in the quality of meals. A new steam system for meal service has been introduced into most clinical areas.

Outcome 1.4: Safe and Appropriate Environment

Facilities across the sites meet the needs of the various patient groups and are well maintained. The organisation has a long-term plan for ongoing building, equipment and refurbishment in place. All sites have a current building warrant of fitness. Reactive and proactive maintenance of equipment and facilities is undertaken, with staff reporting that this service is responsive to their needs and that there is enough of the right

equipment to support good practice. All regulatory requirements are being met, with the exception of a smoke free environment in an area of mental health services.

Planning for all types of emergencies is well developed and suitable equipment and supplies are available. Evacuation drills are undertaken by specific areas to ensure staff are able to manage this process and a six-monthly area by area inspection occurs.

Cleaning and laundry are well managed, with a particularly high standard of cleanliness noted in all areas visited.

Management of waste and storage of chemicals and hazardous substances meets requirements with staff trained to manage any related emergencies. Appropriate personnel protective equipment is available specific to the area requirements.

Sufficient toilets and personal spaces are available. Patient areas have adequate natural light, heating and ventilation, with three exceptions which are being managed.

Security includes, an onsite contracted security team and closed circuit television. There is monthly reporting on security activities to senior management, which includes their role in restraint minimisation.

Outcome 2: Restraint Minimisation and Safe Practice

The organisation has systems in place to support best practice processes in the application of enablers and restraints. Personnel knew and implemented the practices that are documented in policies and procedures and had been sanctioned by the Restraint Minimisation Steering Group. Throughout the wards a culture of commitment to minimise restraint and enabler use was apparent. This was shown by the reduction of seclusion within the Mental Health and Addiction Directorate and through the use of bedrails, mechanical restraints and the implementation of enabler/restraint alternatives through-out the general hospital. Specialist committees and working groups address issues that had been identified through analysis of enabler and restraint data. This included a focus on training and pro-active strategies to minimise restraints and workplace violence.

Outcome 3: Infection Prevention and Control

ADHB has an effective infection control programme in place to manage the environment which minimises the risk of infection to patients, staff and visitors. This experienced infection prevention and control committee and team have developed policies, processes and information to support staff, patients and visitors in infection prevention and management.

The surveillance programme has undertaken an improvement initiative in this organisation to monitor possible as well as actual infection rates. Monthly surveillance data is reported to the infection control committee with variances reported. Surveillance data is collated with expert analysis for developing trends and recommendations are made to guide prevention practices.

Multi-resistant organism identification and management practices were reviewed in depth and found to be consistently utilised and well managed.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	46	0	10	1	0	0
Criteria	5	122	0	12	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	0
Criteria	0	0	0	0	0	0	0	0

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.4	There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Low	Since the last audit, the work performed is evident; more so since January 2017 when the joint plan was commenced and the management of overdue documents has improved, however, at the time of audit 16.8% of controlled documents remain overdue for a review.	Policies and procedures are approved, up to date and reflect current legislation and regulations to guide practice in both the clinical and corporate support areas.	180
HDS(C)S.2008	Criterion 1.2.3.9	Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice,	PA Low	Risks on both the corporate register and service level registers were classified as major risks with spasmodic review timeframes, for example, some	Ensure that the risk management policy stipulates the review requirements of risk determined by the risk classification.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.		risks were being reviewed one, two, three or four monthly with no guidance behind the review timeframe explicit in the risk management policy.		
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	ADHB requires that all employees have a performance appraisal annually. The responsibility for this sits with managers. Some service managers provided evidence of having completed appraisals within this period but this is inconsistent across the organisation. There is no process in place for the organisation to measure achievement of this requirement.	There is a process in place to monitor and ensure that all employees of the ADHB have a performance appraisal annually as required by Board policy.	180
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.7	Information of a private or personal nature is maintained in a secure manner that is not	PA Moderate	Patient information including names, addresses and clinical information is visible and	Ensure that all patient information is maintained in a secure manner and is not	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		publicly accessible or observable.		accessible to the public in ward areas of Starship hospital.	publicly accessible.	
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Individual assessment needs, desired outcomes and goals are not consistently documented throughout most service streams as a basis for informing care plans and service delivery.	Interventions required to achieve the desired outcomes and goals are documented in a service delivery plan.	180
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.2	Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Evaluation of interventions and the responses to treatment are inconsistently documented throughout most service streams.	Ensure evaluation tools are completed and inform the care planning process	180
HDS(C)S.2008	Criterion 1.3.8.4	Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if appropriate.	PA Low	The service has not achieved the HoNOS targets during 2016.	Develop and implement a plan to ensure HoNos compliance.	180
HDS(C)S.2008	Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	PA Low			
HDS(C)S.2008	Criterion 1.3.10.2	Service providers identify, document, and minimise risks associated with each consumer's	PA Low	Discharge planning is not consistently being documented throughout most service streams.	Ensure discharge and transfer planning is documented, timely and minimises the risks	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.			associated with discharge and/or transfer.	
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	Medicine reconciliation, fridge temperature monitoring, expired insulin remaining in the fridge are areas that were inconsistently evidenced throughout service streams.	All aspects of medicines management comply with legislation and best practice requirements.	90
HDS(C)S.2008	Criterion 1.3.12.6	Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	Medication management information was inconsistently recorded, for example, completing VTE assessments, indications for use of pro re nata (PRN) medications, prescriber's signature not evident, and the handwritten recording of the patient's name and NHI.	All aspects of prescribing, assessment and documentation comply with legislation.	180
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	Freezers that store expressed breastmilk in Starship Hospital are not monitored. The policy for safe storage of expressed breast milk has conflicting timeframes	Ensure that food storage and monitoring processes comply with the current legislation and that requirements to safely manage frozen expressed breast	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				for refrigeration and does not include freezing. In the Auckland City Hospital, food fridge monitoring is not occurring in three areas.	milk are documented and maintained.	
HDS(C)S.2008	Standard 1.4.8: Natural Light, Ventilation, And Heating	Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	PA Low			
HDS(C)S.2008	Criterion 1.4.8.1	Areas used by consumers and service providers are ventilated and heated appropriately.	PA Low	The ADHB smoke free policy complies with current legislation and legal decisions and is unequivocal that there is no smoking on ADHB premises. Despite this, smoking is occurring in Te Whetu Tawera and staff there report an inconsistent approach to supporting service users to be smoke free.	The ADHB meets its legal obligation to ensure that patients/consumers and service providers are not put at risk by exposure to environmental tobacco smoke by complying with current legislation (such as described in 21 Health Law Bulletin 424 [2013]) and providing a smoke free environment on all hospital property.	180
HDS(RMSP)S.2008	Standard 2.2.4: Evaluation	Services evaluate all episodes of restraint.	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.4.1	Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome	PA Low	Mental Health and Addiction Directorate: The charge nurse or service leader and the consumer representative did not conduct a use of force/personal restraint review as required by the Restraint Minimisation and Safe Practice in Mental Health policy.	Ensure that a review of each restraint event by the charge nurse and the consumer representative occurs.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers.				
HDS(RMSP)S.2008	Standard 2.2.5: Restraint Monitoring and Quality Review	Services demonstrate the monitoring and quality review of their use of restraint.	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.5.1	Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of	PA Low	Mental Health and Addictions Directorate: The Less Restrictive Practices governance group has only met a few times in 2016. The group has not carried out the required six monthly restraint audits during 2016 as required by the Restraint Minimisation and Safe Practice policy.	Implement the restraint audits as per policy.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.				

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 1.2.1.1	The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	Auckland DHB under took a major refresh of organisational values in early 2014. This involved working with staff and patients who spoke about their experiences of Auckland DHB, and helped to identify the factors that create a positive experience in the workplace. A survey was conducted in in 2014 to gauge staff awareness of the existing values and their attachment to them. From this data was collected and analysed to provide the basis to develop the new values. A set of four values was chosen for the organisation and after considerable engagement and testing of draft

Code	Name	Description	Attainment	Finding
				material, these were approved by the Board. Evidence of the values were seen all around the organisation. All communication has the values incorporated into it, from emails to the employee's signatures. The staff knew and mentioned the values when interviewed; they regarded it as part of the culture of the organisation and the 'rules' of the organisation. To measure the success of the introduction of the new values a staff engagement survey was conducted in 2016 which showed that against the question "knowing the values and expected behaviours of the organisation at work" the overall ADHB staff response was 88%. ADHB monitors the inpatient experience quarterly. This is linked to the values of the organisation, and used to measure improvement year on year. The last quarterly report viewed showed that since 2011 respect - Manaaki one of the key values has risen from 79 % to 84 %.
HDS(C)S.2008	Criterion 1.2.3.1	The organisation has a quality and risk management system which is understood and implemented by service providers.	CI	The management operating system (MOS) has established a framework to support decision making, and achieve the common direction and vision of the DHB. The MOS boards use a similar structure at each level of the organisation to clearly display quality objectives and key performance indicators (KPI) which are worked on at regular meetings. The structure also identifies and monitors emerging issues, risks and projects relevant to the ward, department, service, and directorate

Code	Name	Description	Attainment	Finding
				or at the Executive Leadership Team (ELT). The system includes escalation and updates to staff with improvement projects (e.g., Project Haumaru reducing violence in the acute mental health unit and increasing staff and patient safety flowing on from the escalation of the risk identified via the MOS). The ward level MOS boards have been adapted to ensure that the quality measures and drivers and metrics reflect their core business, but link directly to the overarching goals and priorities of the directorate. The quality, risk and improvements are celebrated in the annual published quality accounts. The inpatient experience survey is used to improve the service that patients receive. One example of this is following the 2014 data there has been hospital wide increase of 4% in patient's experience of discharge preparation and planning. Another example based on the 2014/2015 data almost 3% of patients commented they were given information whilst still groggy from anaesthetic. In the last twelve months only three patients (0.2%) have commented that this had happened.
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	There are many examples of using the data to improve service delivery. January 2014 and July 2015, 75% of patients referred to Auckland DHB with either a high suspicion of breast cancer or confirmed cancer waited longer than 14 days for First

Code	Name	Description	Attainment	Finding
				Specialist Assessment (FSA), and 29% of these waited longer than 62 days to receive treatment. A two phase programme designed and introduced a new care pathway, improving the triage system, ring fencing appointments for cancer patients to be seen in less than 14 days. The result was that from June 2016, 90% of women were receiving treatment within 62 days, an increase from 71%, and 88% of women waiting for their FSA were seen within 14 days, with an average waiting time of nine days – reduced from 22 days. Patients admitted with a cellulitis diagnosis are reviewed by a nurse practitioner and the data forms part of the utilisation and bed management project. The project aims to free up five to seven beds days per day. The cellulitis programme is now well underway with the next planned projects to improve the Chronic Obstructive Pulmonary Disease (COPD), and develop frail elderly pathways. The review of the management of fractured neck of femur data has driven a rethink of the pathway from ED to the rehabilitation ward. Patients are now transferred directly from the acute services to theatre for surgery and discharged from there directly to the rehabilitation wards. This has resulted in streamlining the patient's journey, providing a more timely intervention, and reducing the average length of stay through. This is in line with the early surgical

Code	Name	Description	Attainment	Finding
				intervention and supporting early rehabilitation after surgery (ERAS) providing better patient outcomes and reducing bed congestion in the orthopaedic ward. All 10 of the directorates have an improvement plan using data to measure the progress. One of the key indications that the executive and management are communicating the data in a meaningful way is indicated in the staff engagement survey where the leading strength of the organisation across all ADHB was that 97% of staff understand the work they perform makes a difference to other people.
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	CI	A review of the Ward 42 (Cardiothoracic) model of care identified that patients were turning up to the ward in an ad hoc manner to be seen for post-operative wound management, placing a burden on staff in a high acuity ward and this was not conducive to providing a good patient experience. Using a planned quality improvement approach, including evaluation of outcomes and ongoing refinement, a co-design piece of work was undertaken with patients to identify issues with the current process which revealed expected and unexpected issues for the patients, staff and the organisation. At completion of the project there are improved outcomes for patients, improved satisfaction for staff and the organisation now has data to assist with future planning

Code	Name	Description	Attainment	Finding
				plus financial gains which previously they did not receive. Other service areas have also utilised this model of care
HDS(IPC)S.2008	Criterion 3.5.7	Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	National reporting on SSI shows high degrees of continued compliance. The April to June 2016 results shows of 171 arthroplasty procedures (hips and knees) one infection reported, with eight in the last 12 months. Compliance with the correct timing of antibiotic prophylaxis occurred in 97 percent of the procedures. The administration of the recommended prophylaxis antibiotics occurred 95 percent of patients and discontinuation of the antibiotic occurred 100 percent of the time. The use of the nationally agreed skin preparations occurred in 96 percent of procedures. The graphs for the last two years show Auckland DHB's compliance to be in the high 90s for all areas. The national reporting for cardiac surgery shows 261 procedures with eight SSIs identified a 3.1 percent. Compliance with timing of prophylaxis antibiotic is 93 percent, dosage of antibiotic 98 percent and timing 100 percent, skin preparation use 99 percent. Hand hygiene compliance has a national target of 80 percent which was set in June 2015. The data for Auckland DHB shows for the fourth quarter of 2015 they had a rate of 81 percent. Figures for 2016 show 83 to 84 percent compliance overall and 88 percent compliance for Starship Children's hospital. Areas visited

Code	Name	Description	Attainment	Finding
				had hand hygiene trend data on show in corridors. The plans for world hand hygiene day 2016 are underway. The IPC service provide a detailed monthly report on hospital acquired blood stream infections (HABS). This show trends for HABS rising on the whole with reductions in children over the last two years. Central line associated bacteraemia rates show a rate of 1.09/1000 central line days. The reporting on water quality has shown that work to upgrade systems have been put in place and continual monitoring. The January 2017 monitoring shows all sites tested were within normal range. The IPC monthly report for February identifies water sampling occurring by an external company to national and international standards. The trigger point for reporting on Legionella levels have been identified

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

Attainment and Risk: FA

Evidence:

Staff interviewed across the services, including nursing, medical, allied health, understood their responsibilities in relation to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and could describe how this was implemented during practice. Staff were observed providing services in line with the Code, this included, maintaining privacy, speaking in a respectful manner, involving family / whānau, and information given to allow informed consent. Staff receive training in relation to the Code as part of the orientation programme and are guided by relevant policies. Patients/consumers and family members/whānau described care from staff around privacy being maintained, clear explanations being given, staff being open to their needs, being treated in a respectful manner and that their feedback was utilised and upheld by staff.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

Attainment and Risk: FA

Evidence:

Staff provide opportunities to inform patients and their families / whānau of their rights at the most appropriate time. A staff member was observed explaining the Code to a consumer within the mental health service. Brochures are given on the Code at preadmission clinics and on admission for those patients admitted directly into the hospitals. Information on the Code was widely displayed in all wards and clinical areas with brochures available, including information on accessing advocacy services. Brochures were displayed in multiple languages including sign language throughout all service areas. Patients/consumers and families/whānau interviewed were aware of the Code and felt able to seek further information as needed. They felt well informed, involved in decision making and that their privacy and individual needs were met.

The consumer auditors interviewed 20 consumers within the mental health services who reported being well informed of their rights and that these had been respected. Consumers gave examples of information provided re medication side- effects, aspects of their condition and reported they felt well cared for. Information on the advocacy services was available at the entrances of units, and Tupu Ora unit had a representative advocate visit which had been accessed as required.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

Attainment and Risk: FA

Evidence:

Auckland DHB's values which were made from a combination of patient and staff input are Welcome, Respect, Together, Aim high. Monthly on line patient experience surveys are analysed and reported on, with respect, dignity and privacy being closely monitored and results fed back to staff via a monthly report. Patients/consumers interviewed reported being treated with respect and that their privacy and dignity had been maintained. Screens and curtains were seen in all clinical areas being utilised to provide privacy. All wards/units have a lounge available and space for private discussions. Privacy is respected and this is supported by the layout of the wards and rooms. In the mental health areas consumers reported staff finding private spaces to hold conversations and that staff knock and request entry prior to entering rooms.

As part of the admission process, staff seek information from patients/consumers and their families/whanau, where appropriate, in relation to their individual cultural, religious and social needs and provide support to address these. This is documented in the assessment and planning documentation (A to D Planner). The hospital provides cultural support through the Maori Health team (He Kamaka Waiora) and the Tautai Fakataha service for Pacific island persons. Spiritual needs are also supported through the chaplaincy service.

Patients/consumers and families/whānau felt involved in decision making and that their wishes were respected. Independence is encouraged by staff and supported through use of allied health team members. In the Rehab Plus service a multidisciplinary team met with the patients and their families/whānau regularly and a strong emphasis was placed on enabling patient independence. In Te Whetu Tewera Unit (TE WHETU TAWERA) independence was promoted through links to the community and the development of well-being plans, and in the Buchanan Centre (BUCHNANAN REHABILITATION UNIT) and Fraser McDonald Unit independence is a primary focus and a strong commitment to ensuring life skills and activities of daily living are encouraged.

Family violence screening (FVS) is part of the assessment process in the women's health service, paediatric services and mental health services. Staff have been trained in the process and documentation reviewed demonstrated that this was completed where required. Policies and procedures support staff in this process. Within mental health services there are family safety facilitators trained in each service and the family advisor has been instrumental in the development of the programme.

All interviewed consumers/patients, staff and families/whānau report they had not witnessed or experienced abuse, neglect or discrimination.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

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Corrective Action:

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Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

Attainment and Risk: FA

Evidence:

Auckland DHB has a Maori Health Plan and a Kaumatua Action Plan in place and is strongly committed to accelerating Māori health gain to eliminate disparities in health status by improving the health outcomes of Māori. Progress is actively monitored by the joint Auckland DHB and Waitemata DHB Māori Health Board Advisory Committee, Manawa Ora. Auckland DHB have links with Te Rūnanga o Ngāti Whātua which are formalised through a memorandum of understanding (MOU).

Staff receive training in the Treaty of Waitangi and application of this within their work environment as part of the orientation process and on an ongoing basis. There is a Tikanga Best Practice policy in place which is the policy of ADHB to safeguard the wairua (spiritual), hinengaro (psychological) and tinana (physical) wellbeing of (Māori consumers/patients) and their whānau. Staff interviewed were familiar with how to access services available to support Māori patients/consumers.

A Māori Health Unit, He Kamaka Waiora provides support for patients/consumers and their whānau. Māori patients are identified as part of the assessment process and this is documented in the A to D planner. Within the maternity units there is a dedicated Māori midwifery team available for inpatients and for follow up in the community. Mental health services complete a comprehensive Māori assessment where applicable and there is a commitment to whānau involvement with whānau/family meetings, spaces and

education sessions. Evidence was sighted in TE WHETU TAWERA of Māori workers being involved with consumer's treatment plan and involvement in multidisciplinary team meetings where they were consulted on appropriate interventions. In BUCHNANAN REHABILITATION UNIT there is a strong link with a Kaupapa Māori service situated next door and the consumers can, on entry to the service attend a powhiri that is provided by the Māori service. Fraser McDonald unit have a shared care plan based on Whānau Tahi which covers lifestyle, daily life, social and mental wellbeing.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.4.7 (HDS(C)S.2008:1.1.4.7)

The service provides education and support for tangata whaiora, whānau, hupu, and iwi to promote Māori mental well-being.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.5: Recognition Of Pacific Values And Beliefs (HDS(C)S.2008:1.1.5)

Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

Attainment and Risk: FA

Evidence:

Pacifica tangata whaiora have their cultural needs met through the Tautai Fakataha service. The team of family support workers initiates contact and engages with pacific consumers offering social and cultural support to all pacific consumers and their families. Staff interviewed identified services they would link to if supporting a person who identified as a Pacifica. Referrals are made to Lotofale the Pacifica mental health team.

Criterion 1.1.5.1 (HDS(C)S.2008:1.1.5.1)

The service delivers and facilitates appropriate services for Pacific consumers and recognises the fundamental importance of the relationships between Pacific consumers, their families, and the community. This shall include, but is not limited to the service:
(a) Developing effective relationships with Pacific people to support active participation across all levels;
(b) Where appropriate, developing services that are based on Pacific frameworks/ models of health that promotes clinical and cultural competence;
(c) Ensuring access to services based on Pacific people's need and planning and delivering services accordingly;
(d) Developing a culturally enhanced workforce that will respond effectively to the needs of Pacific consumers.
This may include actively recruiting and employing service providers with links to Pacific people and providing suitable education/training/mentoring of service providers to respond to specific cultural requirements and preferences.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.5.2 (HDS(C)S.2008:1.1.5.2)

The service provides education, training, and support to Pacific people or other agencies to promote the well-being of Pacific people.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

Attainment and Risk: FA

Evidence:

Patients have their cultural, spiritual and ethnic values and beliefs identified through the assessment process on admission and on an ongoing basis. Documentation reviewed supported this, however within paediatric and medical services this was not consistently completed (refer1.3.5.2). Patients/consumers interviewed reported that their cultural and religious needs were being met. Staff at Fraser MacDonald reported that sometimes consumers are supported to attend outside churches, but mostly to visit the onsite hospital chapel. A chaplain interviewed reported he visited several units on a weekly basis as does a catholic priest. A consumer group session was observed where spirituality was discussed and consumer beliefs enquired about. Staff reported core training including cultural awareness.

Examples were seen of cultural sensitivity being shown (e.g., a Chinese patient within the mental health area was observed watching Chinese television with her daughter; following a complaint a patient had a family meeting where the family opened the meeting with a prayer, had an interpreter and a translator present, and when explanations were given it was checked that they made sense to the family).

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

Attainment and Risk: FA

Evidence:

A Code of Conduct describes staff behaviours that are not acceptable and actions that will be taken should these occur. All staff sign the Code of Conduct on employment and these were completed in the personnel files reviewed. Police vetting is undertaken for all staff prior to employment. Auckland DHB has harassment and bullying policy which guides staff should they encounter or observe such behaviours. Auckland DHB has a 'speak up' programme aimed at identifying and preventing harassment, discrimination and bullying and is a resource for managers. A patient interviewed within the surgical area commented she felt safe and well cared for. Patients spoken to with the medical area describe appropriate care with no crossing of boundaries identified. Staff described professional behaviour in relation to patient care and communication. Within the maternity unit women and their family/whānau reported staff were always professional in their communications and expressed satisfaction with their involvement and choices about their care.

Staff within the mental health service reported adhering to professional boundaries and maintaining therapeutic relationships with their consumers ending upon discharge from the unit. Tupu Ora consumers are able to choose to be vegetarian or vegan despite the service being an eating disorder service. Food dislikes are registered with the chef and actioned. Language heard within the mental health units and sighted in the files was inclusive and non-discriminatory. Recovery principles were witnessed in the units, for example, displayed on posters. All consumers interviewed reported not having witnessed any discrimination and information regarding discrimination was sighted in all units.

Staff respect a consumers' right to refuse treatment, and reported the processes taken if a consumer did refuse treatment. Consumers interviewed reported varied responses to being asked what would happen if they refused treatment, some who were under the Mental Health Act reported they would be forced to take medication, however all said that staff would talk first with them about the reasons why they did not want to take it. Others reported that they had refused and staff had discussed their reasoning with them and that the consumers' felt heard. Consumers at Fraser MacDonald reported that they are allowed to choose the level of involvement in daily activity to meet their taste and preference. At Tupu Ora non-negotiable parts of the programme, are related to a red flag system and may result in review of treatment. The rationale behind the non-negotiable is explained fully in the admission pack.

Criterion 1.1.7.2 (HDS(C)S.2008:1.1.7.2)

Service providers should have an understanding of discrimination. Service providers shall demonstrate knowledge of the barriers to recovery posed by discrimination, which translates into provider systems that promote recovery.

Attainment and Risk: FA

Evidence:

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Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

9.3

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.7.4 (HDS(C)S.2008:1.1.7.4)

The service does not withdraw support or deny access to treatment and support programmes when or if the consumer refuses some aspects of treatment.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.7.5 (HDS(C)S.2008:1.1.7.5)

The service actively works to identify and address prejudicial attitudes and discriminatory practices and behaviours within its own service and any other service it has links with.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

Attainment and Risk: FA

Evidence:

Examples of good practice were observed and discussed throughout the course of the audit. Staff in each area provided examples of changes to practice and service developments based on evidence based practice. Examples included daily or three times a week medical officers' meetings within the medical and surgical areas giving opportunity to review the service in individual ward areas. The cardiothoracic area has redesigned processes within their area and have sought consumer participation and feedback continuously. Within maternity, regular multidisciplinary meetings (MDT) are occurring and staff report relationships are strong amongst the team and sharing of information and best practice scenarios. Sensory modulation is used at Fraser MacDonald and one patient was seen holding several cat comforters. At Tupu Ora there is pet therapy and activities that include creation of smell boxes and stress balls. Buchanan Centre and TE WHETU TAWERA have training in motivational interviewing and co-existing conditions. Sensory modulation was also evident.

Policies and procedures are referenced to best practice and are updated when current accepted best practice changes.

Staff (both clinical and non-clinical) are supported to develop skills and expertise through attending national and international conferences, belonging to professional and peer review groups and being involved in quality improvement activities using current accepted best practice tools and techniques. Nursing staff were encouraged to join a quality initiative group within their ward area as they progressed with their professional portfolio development.

All staff interviewed felt well supported in relation to professional development opportunities and access to evidence based resources, and the use of e-learning modules. Ward educators were visible in ward areas.

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

9.3

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

Attainment and Risk: FA

Evidence:

The open disclosure policy provides guidance for staff on open communication following adverse events. The hard copy information on a sample of incidents and complaints was reviewed along with the reviews of four serious events, and all demonstrated implementation of these principles. In all cases, the documentation showed that there had been sensitive communication with the affected patients or family, including in situations where there were significant barriers to easy communication. Letters sent to complainants are the responsibility of the directorate concerned but the members of the patient liaison team review them and offer support in communication. Staff managing complaints demonstrated competence in fostering open communication and there was feedback from complainants in appreciation of the individualised responses they received by phone or email in conjunction with the more formal letters of response.

Ward staff spoken to in clinical areas sampled were familiar with the principles of open disclosure and provided examples of how this occurred in practice. Patients interviewed by auditors reported that communication was open and effective and they felt well informed and their questions were answered. The 'Inpatient experience' survey June 2016 showed that communication is the most valued aspect of care, with about three quarters of the respondents positive about communication. This was a significant improvement compared with the survey three years previously.

There is a policy relating to the use of official interpreters and the cultural and ethnic diversity of the population of 510,000 in the catchment area means that this service is regularly required. A complaint was investigated in detail that included a complex family meeting with an interpreter and a written translation of the report of the meeting. Examples of the use of interpreters were seen or discussed in clinical areas. For example, in a multidisciplinary meeting in the Fraser McDonald Unit, an interpreter was being organised for a family meeting and there were many instances there where formal interpreters or staff members were used for a range of languages. In a neurosurgery ward, interpreters were used to discuss clinical care including restraint use, with family members.

There is a new website ("Our Open Book") which contains summaries of serious adverse events and a searching tool and this will eventually include SAC 1 and 2 and near miss reports. Some such events have been reported in user-friendly posters summarising the learning.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

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Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

Attainment and Risk: FA

Evidence:

Patients/Consumers, and where appropriate, their families/whānau, are provided with the information they need to make informed choices. Staff were knowledgeable about the organisation's policies and processes relating to informed consent, including consent for children, consent for those with diminished capacity, and consent in emergency situations. On interview, staff were able to describe various methods of consent (verbal and written) and when to use these appropriately. Patients' files reviewed showed evidence of relevant information being provided to facilitate informed consent, including information related to adverse effects, and completion of relevant consent documents. Evidence was sighted within the surgical area that body parts are able to be returned to the patient and that discussion occurs related to this prior to the patient going to theatre. All information provided complied with Right 7 of the Code. Written evidence of allied health staff gaining verbal consents prior to treatment was evident in all files reviewed within the surgical and medical areas.

Within maternity, all documentation audited had appropriate consent forms completed and evidence of consent obtained prior to specific procedures occurring. Women interviewed were happy with their care and felt fully informed from midwives and the MDT team.

In the mental health service examples of good practice related to consent were seen. All consumers interviewed who had been placed under the Compulsory Assessment and Treatment Act 1993 reported they had been given documentation and had explanations regarding their status and the mechanisms of the ACT. Two consumers reported they had spoken to the district inspector, who visits regularly, and staff were aware of how to access the inspectors. In BUCHNANAN REHABILITATION UNIT and TE WHETU TAWERA all consumers interviewed, reported that regardless of their status, nursing staff gained their consent, mostly verbally, to perform treatment such as administration of named medications, physical examinations and allied health staff gained consent for therapeutic interventions. In Tupu Ora and Fraser MacDonald admission packs for both services contained useful and informative information to enable the consumer to be fully informed. A staff member at Fraser MacDonald was sighted discussing the review stages under the Act for an elderly consumer, who could not recall meeting with the clinician who had signed off on one of the review stages.

Māori mental health service cultural advisors from Kai Atawhai are able to be accessed upon the death of Māori persons. They provide guidance on storage, return and disposal of body parts following death.

In line with national developments, the organisation has updated policies and processes in relation to advance directives, including 'resuscitation' directives. Staff were familiar with the concepts of advance directives, enduring power of attorney and living wills. Examples of fully completed and valid 'not for resuscitation' directives were sighted.

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

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Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.10.8 (HDS(C)S.2008:1.1.10.8)

The service has processes that give effect to consumers' requests on the storage, return or disposal of body parts, tissues, and bodily substances, taking into account the cultural practices of Māori and other cultures.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

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Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.10.9 (HDS(C)S.2008:1.1.10.9)

Where a service stores or uses body parts and/or bodily substances, there are processes and policies in place that meet Right 7(10) of the Code.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

Attainment and Risk: FA

Evidence:

Information about the Nationwide Health and Disability Advocacy Services was displayed throughout the areas visited in the form of posters and brochures. Patients interviewed understood their right to access independent advocacy services and felt able to have family and other support as desired. Within the paediatric area staff welcomed support people and provided facilities to support them.

Charge nurses interviewed spoke about informing complainants of their right to access advocacy services and how to do this as part of the complaints process.

Consumers interviewed in the mental health service knew their rights to have a support person, and staff supported them with this. Fraser MacDonald had a support person staying overnight. District inspectors had contact details displayed within units.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Attainment and Risk: FA

Evidence:

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Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

Attainment and Risk: FA

Evidence:

Staff are aware of the importance for patients to maintain links with family and visitors of their choice. This was particularly evident in the maternity service where women reported having visitors of their choice present and visiting hours being flexible. In areas where rest times were advocated, this was balanced on an individual basis to

ensure that the patients were also able to access relatives and friends. All wards/units have a family/whānau lounge. Within the paediatric unit one parent is encouraged to stay overnight. Accommodation can be provided close by for those family/whānau members who are from out of Auckland.

Within mental health services files reviewed showed that family and whānau involvement was actively pursued. Family are participating in assessments, reviews and discharge planning. Consumers maintained contact with their community key workers and non-governmental organisation (NGO) support workers. Māori and Pacifica community mental health services were involved in supporting those consumers who identified as Māori or Pacifica. Families reported feeling comfortable when visiting in BUCHNANAN REHABILITATION UNIT and TE WHETU TAWERA units and staff made them feel welcome.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

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Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when appropriate.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

Attainment and Risk: FA

Evidence:

There are about 900 complaints received by the DHB each year. The complaints management policy provides guidance on the complaint process and defines response times. This process, represented in a flow chart, is in accordance with the Health and Disability Commissioner's (HDC) Code of Patient Rights. There has been a recent review of the complaints process which ensures that accountability for the response process is with the directorate. Feedback Monitor Pro is the database used to record all complaints but in April this will be superseded by Datix, which will allow better access to information by a greater range of personnel. There are also physical files stored in the consumer liaison department, which is responsible for complaints management. The consumer liaison team leader and one of the coordinators provided information about the complaints process and examples of complaints reviewed were found to be comprehensive and sensitive to the complainants' issues. Interaction with complainants includes whatever format is most appropriate to their needs and examples were shown of phone calls, emails and face to face meetings along with the more formal letters of response (refer also to Standard 1.1.9).

Directorates have the responsibility for dealing with complaints and they are sent a weekly report with details of the status of their current complaints. All major complaints and HDC complaints are also overseen at a senior level with a fortnightly review meeting between the team leader and the Chief Nursing Office/Chief Professions Officer. Each month and quarter, each directorate is also provided with monthly data on complaints, including number of complaints, issues complained about and length of time to resolution.

Complaints referred from the HDC are all sent to the chief executive officer and coordinated by the consumer liaison team. Again, there is consistent tracking of progress of these complaints. Examples of concerns being addressed promptly and sensitively were seen during the audit, as were emails from complainants expressing their appreciation of the way they had been dealt with. Ward staff in three areas described the complaints process accurately when interviewed.

Information about how to make complaints is readily available along with other rights material throughout the hospital.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA

Evidence:

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Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

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Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

Attainment and Risk: FA

Evidence:

Interviews were held with several executive team members, professional leads and managers across the ten directorates which make up the hospital provider service. The Auckland DHB and the executive team have been developing short and long term strategies. The 2020 strategic plan is guided by a clear strategy vision, with three strategic goals and seven key strategic themes identified, all underpinned by the mandated strategies which have synergy with the values of the organisation. There is clear linkage and flow from local health service delivery up to the health sector goal of 'All New Zealanders live well, stay well, get well'. This was evidenced and seen in the linking of the strategies to three priorities for improvement across all the directorates. The priorities are supported by the three outcomes and impact measures of the strategic goals 'healthy communities, world class healthcare and achieved together'. This will form the progress reporting as long term indicators in the future annual plans. There is clear integration of the DHB's health service planning in conjunction with the Ministry health targets and health strategy.

The 2020 strategy is being used to inform the annual planning process. There are regional service development and alignment of plans, and the sub regional work is supported by a DHB chairman across the Auckland 'metro' area. This is evidenced with the merging of some teams to promote consistency across health services in the area and promote rational and regional service distribution. The aim is to strengthen the region overall, create the opportunity for certain services to be delivered locally, not destabilise any DHB.

Documents viewed were the Annual Plan 2016-2017, Clinical Service Plan, Draft Asset Management Plan 2015, Annual Report 2015, the Master Strategy August 2016 and the Provider Services Business Plan 2016-2017. The Quality Account 2015/16 was viewed and reflected both on the progress against the key priorities and the focus for the coming year.

The annual plan forecasts a surplus for the 16/17 period and the next three years and the recent investor confidence rate (ICR) reflects this with a rating of B. Recommendations from the ICR report were to improve project and programme delivery across Auckland DHB, and meet Treasury's ICR targets for improvements. This has been a springboard for transformational change in the way projects and programmes are established and monitored in a consistent and transparent way.

The DHB financial reports and risk management are overseen by the Finance Risk and Assurance Committee, a statutory committee of the board, and a range of minutes were viewed to provide context and validation of some of the key projects and risks being reviewed as part of the audit on site.

The 24 hour operation centre across the hospital determines staffing requirements and matches these to the clinical need. There is an efficient daily bed management coordinated by the duty managers. Midwife recruitment is an area of focus currently with a recruitment plan in place. The after hours service is managed by an on call executive and service manager.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: CI

Evidence:

Organisational values were refreshed in early 2014. A survey was conducted in 2014.

Throughout the audit the audit teams report that the staff knew and mentioned the values when interviewed; they regarded it as part of the culture of the organisation and the 'rules' of the organisation. The walls are decorated with 'soundbites' from patient and staff feedback linking to the values and reinforcing the message. The values were also communicated by the non-clinical support staff, one cleaner explaining how she felt valued and the commitment of the DHB to provide computer literacy programmes for her when she had no experience of technology, and that standard operating procedures were produced in seven languages to support a high percentage of non-English speaking workers. The increase in the incident reporting is testament that employees feel safe at ADHB to report incidents and concerns.

Auckland DHB now has a set of organisational values that were shaped by staff and patient conversations. These have been widely accepted and now form the foundation for staff and patient development work. The values are now integrated into a much larger piece of work so that they inform all their processes. They are now integral to the human resources processes from advertising, recruitment and staff development.

Finding:

Auckland DHB under took a major refresh of organisational values in early 2014. This involved working with staff and patients who spoke about their experiences of Auckland DHB, and helped to identify the factors that create a positive experience in the workplace. A survey was conducted in in 2014 to gauge staff awareness of the existing values and their attachment to them. From this data was collected and analysed to provide the basis to develop the new values. A set of four values was chosen for the organisation and after considerable engagement and testing of draft material, these were approved by the Board. Evidence of the values were seen all around the organisation. All communication has the values incorporated into it, from emails to the employee's signatures. The staff knew and mentioned the values when interviewed; they regarded it as part of the culture of the organisation and the 'rules' of the organisation.

To measure the success of the introduction of the new values a staff engagement survey was conducted in 2016 which showed that against the question "knowing the values and expected behaviours of the organisation at work" the overall ADHB staff response was 88%.

ADHB monitors the inpatient experience quarterly. This is linked to the values of the organisation, and used to measure improvement year on year. The last quarterly report viewed showed that since 2011 respect - Manaaki one of the key values has risen from 79 % to 84 %.

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

Attainment and Risk: FA

Evidence:

Interviews were held with several of the directorate leads, the professional leads, and chief strategic human resources officer to provide an overview of the running of the hospital and the challenges faced. ADHB has a structure focussed on ten directorates. The leadership of each directorate comprises of a director, a nurse director, allied health director, a primary care director, and general manager with the improvement team and quality and risk team working across all the directorates.

One of the programme streams 'using the hospital wisely' focusses on the utilisation and throughput of the hospital. A current project underway is to review and change the bed management policy and process. This is currently underway and is being supported by the data produced from the 24-hour operations centre. There is a senior manager and executive on call after-hours to support the safe running of the hospital. There has been increased focus and separating out of the elective and acute flow patients to be able to improve response and planning. The delegations' policy was sighted which clearly identified the level of authorities for staff with transfer of delegations in the event of absence.

The data collected and displayed on the dashboards and reported to the statutory committees provides evidence that the hospitals efficiency, effectiveness and safety is monitored and relayed to the Board. The management operating system (MOS) supports the day to day function of the hospital, communicating concerns and issues to the management team. This is further reinforced by the monthly walkabouts.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

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Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

Attainment and Risk: PA Low

Evidence:

Interviews were held with representatives from the quality and risk team, clinical effectiveness advisors, the interim quality manager, chief strategy participation and improvement, director of provider services, the internal auditor, and a variety of project and programme leads and charge nurse managers. A new quality and risk framework has been developed and is currently in draft it outlines how the 20 full time equivalent (FTE) team will support the ADHBs promise to its community to provide the best care for everyone, achieve the national health strategy, DHB strategic goals and support the values of the organisation in line with the 'Triple aim'. The quality department is currently managed by an interim manager and oversees five portfolios consisting of incident management, quality assurance, consumer feedback, serious adverse event reviews and clinical policy. Clinical risks are managed by the risk manager.

A review of the key documentation, including board papers, the Hospital Advisory Committee (HAC), Finance Risk and Assurance Committee, and Clinical Board documents provided evidence that quality and risk were on the agenda and being discussed to provide the Board with oversight to perform due diligence.

The quality framework links into the MOS and incorporates the escalation and cascade pathway to provide visibility of risk and improvements. Quality was evident at all levels of the organisation, embedded into the culture of the organisation and was evident in both clinical and non-clinical support services.

The ten directorates are responsible and take ownership for the setting and monitoring of the key performance indicators (KPIs) and quality metrics. Each directorate has a quality forum which monitors the key risks, the data sets, and any adverse events and improvements. A report was generated from these forums (as seen in several examples), and it was noted that there is a section to escalate issues to the Executive Leadership Team (ELT).

The data collection systems to support the quality and risk activities and reporting is currently fragmented and siloed, it operates using 'Chronus' for the improvement progress and 'Riskpro' for the capturing of the risk activities. The two systems do not interface or 'talk' to each other resulting in a very manual process. It is credit to the quality and risk

team that they manage to coordinate the quality and risk systems despite this. A launch of Datix in March 2017 is expected to remove some of the burden of double checking and provide more robust and joined up information. There has been an increase in the reporting of events from 8,000 in 2012 to 12,000 in 2016; this is attributed to better reporting and a just culture.

There has been a great deal of work to address the noncompliance in document control, to ensure the currency of ADHB policies and procedures, including risk assessing each controlled document to ensure that those with the highest risk are managed effectively. A set of 'frequently asked questions' (FAQ) sheets has been developed to help explain and guide staff in the requirements and processes of document control including expectations for document review. Currently there are 16.8% of controlled documents overdue for review.

The internal audit schedule for both the local ADHB audits, and the Northern regional audits was reviewed with 35 audits identified. There were a variety of audit projects, individual audits, regional audits and issues based audits which had been requested post incident or risk review. There is strong evidence of intentional data collection and utilisation, using data to inform service delivery and service development in line with the annual plan.

There are a range of improvement projects being undertaken across the district health board. Many have reached implementation stage; however have not yet had time to be evaluated. A new project team is being established to facilitate the control of improvement projects.

The health excellence awards support one of the ADHB values of aiming high, rewarding and recognising excellence within the organisation.

9.3

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: CI

Evidence:

Since the last audit there has been a maturing and embedding of the management operating system (MOS) to achieve the goal that every directorate and team has a MOS which is effective, aligned, visible and consistent. Throughout the organisation, and at all levels, staff interviewed spoke of the effectiveness of the MOS, and that it has provided a framework to support decision making, and achieve the common direction and vision of the DHB. The board room contains the executive MOS board, displaying the hospital status at a glance; this is a living system which changes in accordance to the cause/concerns raised to ensure there is clarity of the key issues. This is also reflected in the directorate rooms, where the directorate MOS boards and quality objectives and key performance indicators (KPI) A3 plans are shown and worked on at the regular meetings. Each of the clinical teams/wards has a service level MOS which is actively reviewed, a minimum of weekly, but more often daily with escalation and updates to staff of the current issues. The ward level MOS boards have been adapted to ensure that the quality measures and drivers and metrics reflect their core business, but link directly to the overarching goals and priorities of the directorate. There were many levels of examples of the MOS being used. The compliance is supported by monthly workarounds in the directorates. The MOS is used across 10 directorates, 49 services and 85 teams.

The P3M3 frameworks developed enable staff, through the tools and guidance, to undertake project/programme management appropriate to investment/risk. It also ensures that there is a consistent approach to P3M3 assessment, and a demonstrable action against the improvement roadmap. The P3M3 development project reports to the executive leadership team (ELT) and outputs will be authorised by ELT and the Audit and Finance Committee. These frameworks are now complete and will be presented to the Finance Risk and Assurance Committee, and ELT in March 2017.

There are three programmes planned, outpatients' model of care, incorporating the use of technology and telemedicine to make best use of resources, and using the hospital wisely with a current project around after-hour's hospital management, and faster cancer and treatment programme. The auditors reviewed examples of the 'using the hospital wisely' programme in both the cellulitis project and the bed/operational management project providing measured improvement with estimated discharge dates (EDD) and bed occupancy now at 98%, every clinical area can plan throughput, staff resources required, equipment/critical resource requirements, and service delivery with improved certainty.

Finding:

The management operating system (MOS) has established a framework to support decision making, and achieve the common direction and vision of the DHB. The MOS boards use a similar structure at each level of the organisation to clearly display quality objectives and key performance indicators (KPI) which are worked on at regular meetings. The structure also identifies and monitors emerging issues, risks and projects relevant to the ward, department, service, and directorate or at the Executive Leadership Team (ELT). The system includes escalation and updates to staff with improvement projects (e.g., Project Haumaru reducing violence in the acute mental health unit and increasing staff and patient safety flowing on from the escalation of the risk identified via the MOS). The ward level MOS boards have been adapted to ensure that the quality measures and drivers and metrics reflect their core business, but link directly to the overarching goals and priorities of the directorate.

The quality, risk and improvements are celebrated in the annual published quality accounts. The inpatient experience survey is used to improve the service that patients receive. One example of this is following the 2014 data there has been hospital wide increase of 4% in patient's experience of discharge preparation and planning. Another example based on the 2014/2015 data almost 3% of patients commented they were given information whilst still groggy from anaesthetic. In the last twelve months only three patients (0.2%) have commented that this had happened.

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: PA Low

Evidence:

There has been a great deal of work to address the noncompliance in document control, to ensure the currency of ADHB policies and procedures. Since the last audit, a two-stage joint plan has been developed between the corporate records management team and the quality team. Stage one of the plan was to risk assess of the 2272 controlled documents to ensure that those with the highest risk are managed effectively. Stage two was placing a process around the feedback from staff that the review and update system was not user friendly and difficult to navigate. To address this a set of eight FAQ sheets has been developed to help explain and guide staff in the requirements and processes of document control, transferring and reinforcing the responsibility of the document owner in the process. A business case and plan was developed to move from a paper system to an electronic workflow, with supporting information mapping templates. A new folder system in the drive forms a visual cue as to the status of the controlled documents. The new electronic workflow has been enabled by new processes making it easier for the document owners to review and rollover controlled documents where there no change in legislation or practice has occurred. Running alongside the plan is a current stocktake of the controlled documents to determine their currency and the archiving process has already commenced.

Finding:

Since the last audit, the work performed is evident; more so since January 2017 when the joint plan was commenced and the management of overdue documents has improved, however, at the time of audit 16.8% of controlled documents remain overdue for a review.

Corrective Action:

Policies and procedures are approved, up to date and reflect current legislation and regulations to guide practice in both the clinical and corporate support areas.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: CI

Evidence:

The 'at a glance boards' support the local data collection and communication along with the releasing time to care data which allows all staff to be part of the progress of the hospital. 'One more thing' was another project which was developed to address the variances in service delivery and identify areas for improvement. The project associated with the 'Using the hospital wisely' programme evolved from the data collected from this project, it reviewed the common barriers to discharging patients in a timely fashion, for example, patients held up by the protection of personal and property rights act (PPPR act) or patients awaiting referrals or further tests when they no longer meet the acute services criteria. The delayed discharge report was generated from the hospital dataset identifying the delays in the 'ready to go' (RTG) information. The DHB has made a concerted effort to capture meaningful data, which will add value to the organisation and have used it to drive service delivery and development as part of the annual plan. The clinical outcome measures are a blend of the mandatory reporting requirements but also the specific requirements of ADHB. The ADHB has invested in developing and acquiring tools to support data collection with systems, such as, SCAMP the new surgical tool to measure clinical outcomes, and MAP which provides the 'drill down' capability to focus on key issues and provide a reporting tool to the Hospital Advisory Committee (HAC). The performance improvement team and the quality team use the data from the hospital to target improvements in line with the key strategies, for example, the capacity/throughput and utilisation data has driven the development of contingency planning around the winter and summer plans to ensure the hospital is used wisely.

Effective utilisation of the health roundtable (HRT) information resulted in a focus on the data outliers within the ADHB service provision and bed utilisation. Cellulitis was one of the areas where it was recognised that ADHB was an outlier in the management of cellulitis. This was identified as the sixth highest priority areas for ADHB. A rapid improvement cycle project was established and for three days a group of doctors, nurses, allied health, finance staff, clinical effectiveness and the performance improvement team members worked through the causal factors and organisational barriers which impacted on the high incidence of cellulitis admissions which could have been managed elsewhere. Of the patients admitted with cellulitis only 4% required admission for treatment based on the matrix for best practice. A series of improvement plans were devised to address some of the barriers, for example, access to oral antibiotics after hours. The pharmacy team are developing packs of antibiotics to be available in ED to be given to the patients so they can be discharged home without admission. A care pathway has been developed as part of the project to provide clear guidance for clinicians based on best practice.

Finding:

There are many examples of using the data to improve service delivery.

January 2014 and July 2015, 75% of patients referred to Auckland DHB with either a high suspicion of breast cancer or confirmed cancer waited longer than 14 days for First Specialist Assessment (FSA), and 29% of these waited longer than 62 days to receive treatment. A two phase programme designed and introduced a new care pathway, improving the triage system, ring fencing appointments for cancer patients to be seen in less than 14 days. The result was that from June 2016, 90% of women were receiving treatment within 62 days, an increase from 71%, and 88% of women waiting for their FSA were seen within 14 days, with an average waiting time of nine days – reduced from 22 days.

Patients admitted with a cellulitis diagnosis are reviewed by a nurse practitioner and the data forms part of the utilisation and bed management project. The project aims to free up five to seven beds days per day. The cellulitis programme is now well underway with the next planned projects to improve the Chronic Obstructive Pulmonary Disease (COPD), and develop frail elderly pathways.

The review of the management of fractured neck of femur data has driven a rethink of the pathway from ED to the rehabilitation ward. Patients are now transferred directly from the acute services to theatre for surgery and discharged from there directly to the rehabilitation wards. This has resulted in streamlining the patient's journey, providing a more timely intervention, and reducing the average length of stay through. This is in line with the early surgical intervention and supporting early rehabilitation after surgery (ERAS) providing better patient outcomes and reducing bed congestion in the orthopaedic ward.

All 10 of the directorates have an improvement plan using data to measure the progress.

One of the key indications that the executive and management are communicating the data in a meaningful way is indicated in the staff engagement survey where the leading strength of the organisation across all ADHB was that 97% of staff understand the work they perform makes a difference to other people.

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: PA Low

Evidence:

Interviews were conducted with the quality manager, the emergency and risk manager and the executive chief health professions officer. There is a clear risk escalation process and evidence of the risk register being presented to the Board were sighted in the Finance Risk and Assurance Committee papers. The lack of interface between Chronus and RiskPro made the joining up of risks and improvements/mitigations a very manual task for the teams. The migration to Datix will address this. The auditors saw a correlation between the MOS and the risk process, for example, the safety risks identified in the mental health unit were mitigated through the commencement of the Project Haumaru 'Safer together at Te Whetu Tawera'

However, risks identified on the risk register had inconsistencies in the review timeframes, there was no clear review timeframe identified within the risk management policy to determine the frequency of review based on the risk classification.

Finding:

Risks on both the corporate register and service level registers were classified as major risks with spasmodic review timeframes, for example, some risks were being reviewed one, two, three or four monthly with no guidance behind the review timeframe explicit in the risk management policy.

Corrective Action:

Ensure that the risk management policy stipulates the review requirements of risk determined by the risk classification.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

Attainment and Risk: FA

Evidence:

The new Incident Management Policy outlines processes for the reporting and review of reportable events, including the statutory and regulatory obligations for essential notification reporting. The process is coordinated by the quality team and information was provided by the manager and four of the consumer experience advisors. The incident reporting system is 'on-line'. A series of alerts ensures that incidents are notified to the manager within 24 hours. There is a set process for reviewing these by the line manager of the reporter, who takes appropriate actions. Incidents scored as serious or major are escalated by online alert to the manager and senior management and clinical staff immediately they are reported. Automatically generated reports are sent to clinical managers and senior management. Incidents are rated for severity in accordance with Health Quality and Safety Commission (HQSC) protocols and the severity assessment code (SAC) one and two events are reported to the HQSC as

required. Serious and sentinel events are reviewed using the appropriate methodology (e.g., root cause analysis, or the London protocol for those in the Mental Health and Addictions Directorate).

The HQSC protocols require that reviews of SAC1 and 2 events occur within 70 days. This has proven a challenge for the organisation for some years. Stringent management and monitoring of these reviews has resulted in a steady decrease in the median completion time for these over the past three years, with the 2016 median being 104 days, down from 118 days in 2013. They have also greatly reduced the number of “legacy” cases which were over 240 days, from 14 to 3.

The Adverse Events Review Committee (AERC) is a high-level committee which meets fortnightly and reports to the Hospital Advisory Committee. 2016 minutes of these meetings show effective monitoring of adverse events and include individual review reports of serious events. These show that the processes undertaken are detailed, conducted by appropriately skilled and experienced staff and include recommendations which are reviewed by the Committee.

This whole process now incorporates continuous tracking of serious events and regular oversight of the review processes of the directorates. In addition, the quality team have undertaken analyses of adverse event information to identify recurrent issues or clustering of cases. Examples include the reporting of near misses and misidentification of patients.

The Quality Account 2015-2016 provides a summary of achievement against the national health targets, serious harm falls, pressure injuries and surgical site infections, all of which are reducing. SAC 2 falls and health care acquired pressure injuries are reviewed by a separate committee which is a subcommittee of the AERC.

Reports to the coroner, HDC and other statutory bodies are evidenced where required. At the clinical level, there were many examples of quality information, compliance checks and incident reporting. Ward staff meeting minutes showed discussion about medicine related errors.

9.3

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.5: Consumer Participation (HDS(C)S.2008:1.2.5)

Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.

Attainment and Risk: FA

Evidence:

There is a multi-level approach to consumer input to the ADHB. The ADHB Consumer Participation Policy details that there is to be a comprehensive partnership with consumers and consumer leaders. This partnership is described as happening at three levels, the clinical intervention level, the service development level and the organisational level. The responsibility of mental health workers, service mangers, general managers and clinical leaders is articulated in this document.

The ADHB contracts a non-government organisation to provide consumer participation across its mental health and addiction services. Four fulltime equivalents consumer leaders' positions are contracted. Role descriptions for these consumer leaders were reviewed and are consistent with the standard. The operational protocol between the two organisations was reviewed and it outlines expectations of both parties. The Consumer Leadership Plan for 2017/2018 was reviewed, which identifies the current position and targets for this year and a 12 month action plan. Evidence gathered through interviews, reviews of reports, meeting minutes and strategic plans evidence that both parties are fulfilling the requirements of the protocol and the participation policy.

At an organisational level, there is consumer input into core training sessions, strategic planning, clinical governance groups, quality improvement projects, recruitment and service/serious incident reviews. At a service delivery level, a consumer advisor visits weekly to engage with current service users and to provide systemic advocacy to staff and management.

Criterion 1.2.5.1 (HDS(C)S.2008:1.2.5.1)

The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.5.2 (HDS(C)S.2008:1.2.5.2)

Consumers and consumer groups involved in planning, implementation, and evaluation of services have clear terms of reference and position descriptions, and are appropriately reimbursed for expenses and/or paid for their time and expertise.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.5.3 (HDS(C)S.2008:1.2.5.3)

The service assists with training and support for consumers and service providers to maximise consumer participation in the service. This shall include:
(a) Education and/or training for service providers whose colleagues are consumers working in the services;
(b) Supervision; debriefing and peer support.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.5.4 (HDS(C)S.2008:1.2.5.4)

The service has policies and procedures related to consumer participation. The policies and procedures are used to maximise consumer involvement in the service and ensures their feedback is sought on the collective view. This shall include, but is not limited to:
(a) Employing consumers where practicable;
(b) The service assisting with education, training, and support for consumers to maximise their participation in the service;
(c) Training for service providers in working with consumers as advisors;
(d) Advisors liaising with consumer groups or networks.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.5.5 (HDS(C)S.2008:1.2.5.5)

The service implements processes that involve consumers at all levels of service delivery.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.6: Family/Whānau Participation (HDS(C)S.2008:1.2.6)

Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.

Attainment and Risk: FA

Evidence:

Mental Health Directorate has a fulltime family advisor position, whose role is directed by the family participation policy, a position description and supported by a Family Advisory Group. (Terms of reference were reviewed). The policy includes the expectation of working at an individual, service-wide and team level. The current involvement of the family advisor is extensive; examples of input include attending quality meetings, serious incident reviews, leading service implementation projects (for instance, the Family Violence Reduction Project) and delivery and development of training modules.

Family/whanau are regularly surveyed for their opinions of service quality, and the collated results were reviewed. Across the services visited, there was evidence through interviews and documentation that family/whanau involvement is occurring at a service delivery level.

Criterion 1.2.6.1 (HDS(C)S.2008:1.2.6.1)

The service demonstrates family/whānau and community participation where relevant, in the planning, implementation, monitoring, and evaluation of service delivery.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.6.2 (HDS(C)S.2008:1.2.6.2)

Family/whānau who participate in an advisory capacity have clear terms of reference. This shall include, but is not limited to:
(a) Advice sought from the family/whānau advisory groups when developing a terms of reference;
(b) Roles and responsibilities shall be clearly outlined and include accountabilities, confidentiality and conflicts of interest.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.6.3 (HDS(C)S.2008:1.2.6.3)

The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view. This shall include, but is not limited to:
(a) Employing family/whānau where practicable;
(b) The service assisting with education, training, and support for families/whānau to maximise their participation in the service;
(c) Training for service providers in working with families/whānau as advisors;
(d) Advisors liaising with family/whānau groups or networks.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

Attainment and Risk: PA Low

Evidence:

The recruitment process was reviewed with the chief human resources officer and members of the human resources team. There are well defined processes for "on boarding" new staff and a review of 30 hard copy personnel files showed that these processes are consistently implemented. Qualifications, the right to work in New Zealand, practising certificates and referees are all checked.

The extra police vetting requirements incorporated in the Vulnerable Children Act (VCA) 2014 have been consistently applied to both new staff and existing staff. Although there is provision to fast track this vetting process, five clinical areas reported delays in being able to appoint staff and attributed this to the VCA process. Otherwise, the recruitment process has been refined and developed and won a Health Excellence Award for nursing bureau recruitment.

Orientation and induction are another area that the human resources team continue to refine. Increasing parts of the initial orientation have become on line and all staff have been given access to computers for this. Improved e-learning for appropriate mandatory training via Ko Awatea LEARN was implemented in July 2016 with additional personnel records review confirming this. This has improved the information available about staff completion of these requirements although a full IT solution is not yet available. Much work is undertaken to identify and rectify any barriers to learning, such as for new staff for which English is a second language. For example, a literacy programme has been implemented for members of the cleaning staff.

There is a documented process for the credentialing of medical staff, as part of their employment process and on an annual basis. The process was confirmed by the clinical directors of general paediatrics, and renal services, the director of surgical services and the director of women's health. A credentialing committee reviews the documentation and signs off the individual's credentialing completed documentation.

The clinical directors of general paediatrics, and renal services, the director of surgical services and the director of women's health stated the recruitment process was supported by the human resources department and were able to show good recruitment practices were in place. This included evidence being provided of qualifications and education. They stated there are some difficulties in recruitment to some very specialised posts and they have to seek recruits from overseas. There are processes in place to ensure where the specialist requires professional supervision that this can be provided. They discussed the registered medical officer (RMO) regional process of training in line with the College processes. The five-year process for review of training requirements for RMOs was confirmed.

The on-line learning is well monitored and results in effective processes being implemented to ensure that all staff complete the mandatory training. Area or role-specific orientation is determined within each service or discipline and examples were provided from a range of directorates to show the extent of this. Nurse educators in services or units keep their own records of staff training, which requires cumbersome double entry of information as there is no automation of training records. These spreadsheets were reviewed in services sampled at this audit and all showed effective completion and monitoring of training.

Figures provided show, in July 2016, 60 percent of nursing staff are involved in the professional development and recognition programme (PDRP).

Annual practising certificates are monitored and scopes of practice are recorded. The director clinical support services, allied health and other areas and the allied health – clinical support manager identified that they have 98 percent of staff with a current APC which is being actively managed, as the data was not seen as reliable.

Services also keep information about performance appraisals and the completion of these was variable.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: PA Low

Evidence:

The ADHB policy requires that all staff undergo a performance appraisal annually. This is managed at service level with the responsibility sitting with managers. Service manager's carryout appraisals after three months then annually. The human resources team reported that there is no specific mechanism in place for compliance with this to be reported so there is minimal monitoring occurring. Some services and units sampled had consistently high levels of up to date performance appraisals but this was highly variable across the DHB as a whole.

The human resources team reported that they are undertaking a review of the performance appraisal process and streamlining it so that the requirements are more pertinent. The HR team reported being aware that there was incomplete information about performance appraisals

Finding:

ADHB requires that all employees have a performance appraisal annually. The responsibility for this sits with managers. Some service managers provided evidence of having completed appraisals within this period but this is inconsistent across the organisation. There is no process in place for the organisation to measure achievement of this requirement.

Corrective Action:

There is a process in place to monitor and ensure that all employees of the ADHB have a performance appraisal annually as required by Board policy.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

Attainment and Risk: FA

Evidence:

Auckland DHB have a 24-hour bed management centre that is managed by duty and bed managers, who are registered nurses. Oversight of the centre is by a patient flow manager who reports to the director patient services, clinical support directorate. The objectives of the centre is to accommodate all patients and allow patient flow through the appropriate areas. The centre uses the data available from area specific information screens to allow them an up to date overview of the patients and staff status of the hospital by area.

Regular data on the hospital occupancy and staff status is available to senior staff and management. Meetings of senior area staff are held regularly, throughout the day and weekly to ensure staffing needs are met and plan for known capacity issues, to review and update the hospital status. There are processes to manage high patient numbers and the hospital can flex up if required. Additional staff are available from the Auckland hospital bureau and external contracted bureaus. If required senior staff take on clinical roles. In the event of areas being identified as being' traffic light – red', there are escalation plans at all levels, beginning with ward level up to executive level. The occurrence of this status was discussed with clinical charge nurses on the wards and it was confirmed that this occurs, the last event identified being during the January peak. The activation of the escalation processes was confirmed in the wards visited and by senior management interviewed.

All areas visited were asked about staffing, with maternity and orthopaedics identifying pressure on staff Rosters were reviewed and clinical charge nurses interviewed in four areas, including orthopaedics. These showed staffing level guidelines being in-place and implemented and staffing against budget reviewed. Where vacancies existed, processes were underway for recruitment to fill the spaces. Escalation plans are in place and can be activated. Maternity service staffing continues to be identified on the organisation's risk register and a meeting with the midwifery director, director of child health and chief nursing officer provided evidence of a management strategy that is being implemented to ensure safe staffing levels. This includes the employment of additional clinical charge midwife managers, increasing the budget for full time equivalents, use of internal maternity bureau, a discussion document out for consultation of a new model of care, working closely with the local university to try to ensure increases in the intake of newly qualified midwives and Maori midwives. Indications that the plan has had an impact is the reduction in staff leaving this year and staff stating that they feel supported in the areas where the additional charge midwife managers have been employed.

A meeting with senior medical staff provided evidence of staffing levels meeting requirements of the services being provided.

Mental health services were observed to have moved to a new multidisciplinary team model and the employment of staff to new posts has created cohesive teams with a patient centred focus.

Allied health staffing level demands were discussed with the director clinical support allied health, radiology, laboratory and other areas and the allied health clinical support manager. Staffing levels within their services were at budget level, with the exception of radiology and physiotherapy. These areas were identified as areas of high staff turn-over; vacancies in these areas have active recruitment processes occurring. Physiotherapy have a patient prioritisation process in place to ensure high priority patients are seen, and the director receives reports on this process. Staff spoke of extended roles for physiotherapists and pharmacists, being undertaken with the development of a scope of practice for these roles.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

Attainment and Risk: PA Low

Evidence:

Interviews were conducted with the director information management operations and a teleconference earlier involving the chief health professions officer. There is a DHB wide policy governing the privacy of information systems, access and management in line with the Privacy Act and Privacy Code and the document standards for the hard copy files.

The DHB has a no destruction policy and there is a programme to transfer all hard copy clinical files into the electronic format and accessible to users via the ADHB clinical record 3M Chartview. The scanning of clinical records is facilitated by the DHB forms development process to ensure all clinical forms have a barcode and a patient label which allows for automatic indexing to the clinical record 3M Chartview. The scanning process is managed by the scan centre team. The information management is overseen by the director information management operations and there is a large support team of scan centre, clinical records, and data quality and transcription staff.

There is a dedicated document control audit position to audit all staff access, this is a rolling process and ensures that the access to clinical systems, This is a process that ensures all users are audited at least once a year for access to the clinical records (3M Chartview, Concerto and éclair. There is a plan to increase auditing to quarterly with the enhancement of the audit exception reporting. The plan is for auditing six monthly. Any red flags raised are investigated and if there remains a question regarding the appropriateness of access a 'please explain' letter is sent to allow the employee a chance to explain the access. There is DHB wide training on the Privacy Act and its implications within the DHB. There are staff identified to manage and authorise the release of information and on average they respond to 1200 requests per month. The electronic foot printing allows incidents or potential breaches to be followed up and dealt with, this process was seen on site.

The patients reviewed using tracer methodology and reviews of other clinical file demonstrated that document standards in terms of legibility and signatures was generally of an acceptable standard in the 139 files reviewed.

Starship Hospital has patient information that was visible and accessible in the ward areas including names, addresses and clinical information.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Attainment and Risk: PA Moderate

Evidence:

Privacy training is provided at orientation for all staff and the national privacy week was advertised last year using 'Privacy -in your hands' as a campaign to raise awareness. There is a robust investigation process for any suspected breaches. A report on the inpatient experience noted that whilst 3% constituted a small percentage, these patients felt that their privacy was not protected. Staff spoken to during the audit were aware of the need for privacy and could identify ways in which they maintained it. Staff spoke of the challenges at bedside handover when in four bedded rooms and the ways they tried to manage this. Patient information was visible at the reception of the Starship hospital as employees were putting together clinical information for clinics with the names of the children clearly visible. The clipboards in the Starship hospital had the admission to discharge planner located outside the bed space with detailed information accessible to all.

Finding:

Patient information including names, addresses and clinical information is visible and accessible to the public in ward areas of Starship hospital.

Corrective Action:

Ensure that all patient information is maintained in a secure manner and is not publicly accessible.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

Attainment and Risk: FA

Evidence:

Patients access services either as an arranged admission or acute admission based on their needs. Relevant criteria, procedures and protocols are in place.

Acute admissions occur through the emergency department (ED) based around a standardised triage category and process. Waiting times based on triage scores are monitored. The DHB monitors the national target of less than six hours in the ED. In the last quarter at Auckland, 95% of the patients achieved this target which is in line with the national target. Patients interviewed expressed satisfaction with the timeliness of their entry to services via the ED. All acute paediatric patients travel through ED, and frequent attenders with chronic conditions have individualised plans maintained for future admissions. A range of care pathways are also utilised by Starship children's hospital to fast track treatment. Oncology patients who are currently under the care of Auckland oncology services enter via ED and once triaged are seen by the oncology team and appropriate treatment options are chosen.

Auckland DHB accepts admissions both locally and from other regions depending on the services required. Arranged admissions are referred to Auckland DHB with these referrals being assessed by a specialist relevant to the patient's presenting complaint. Once assessed in an outpatient setting, the patients are either discharged, asked to re-attend for follow up appointment or 'scored' against a prioritisation tool, some of which are agreed nationally, to determine whether they will be eligible for surgery in the public sector.

The process around a First Specialist Assessment (FSA) is defined, monitored and reported on nationally. National guidelines are used. Auckland DHB in the last reporting quarter have 97% increased access to elective surgery, this is reduced from 98% in the previous quarter.

Auckland City Hospital has a large number of Pacific Island women in particular who do not attend gynaecology clinic appointments; this has led to a quality improvement process with the aim of increasing attendance. The appointment letter has been translated into multiple languages now and simplified; the project is yet to be evaluated. Auckland City Hospital has a fast track fractured neck of femur pathway which enables patients within five days of injury to be admitted to the 'Reablement' ward. The ward is set up to manage post-operative monitoring and to manage any post operation delirium as well as early rehabilitation.

Mental health service has a single point of entry to services. Patients are able to self-refer, be referred by other service providers or transfer from other services. The acute mental health service has developed an admission system that is proactive and was developed alongside the community mental health services. Decisions to admit into a vacant bed are made collaboratively involving inpatient and community mental health multidisciplinary team members. The coordinator of the service conveyed that every person who requires an inpatient bed was admitted. The system not only focussed on providing service entry for people requiring such a treatment setting, but to ensure that the least restrictive treatment setting is provided for the consumer. In the Buchanan Rehabilitation Unit in the files reviewed it was clearly documented that discussions had occurred prior to admission regarding meeting the criteria for admission. The child and family unit have a clear criteria and process for acute and arranged admission.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.1.5 (HDS(C)S.2008:1.3.1.5)

To facilitate appropriate and timely entry to the service, a system is implemented to prioritise referrals and identify potential risks for each consumer, including considering previous risk management plans.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

Attainment and Risk: FA

Evidence:

Entry is only declined if the referral criteria are not met, in which case the referrer is informed of the reasons why and any alternatives available. Reasons are discussed with patients and their family, where appropriate. Where any arranged surgical admission is cancelled, either due to the person being unwell, inadequate preparation or due to acute work demands), this is discussed with the patients and another date is arranged. A patient file reviewed within the cardiothoracic ward documented the process of notifying the patient of theatre cancellation and the re-scheduling for the next day. In cardiology, work has been undertaken to coordinate cardiac services and prevent operations being cancelled. A daily meeting is held between all cardiology services and various operational issues are reviewed. Staff report that it is now rare for a procedure to be cancelled and if it is necessary it is known early in the day and thus prevents having a negative impact on the patient due to fasting. Patients are informed that this may occur and that if possible they can return home until the next day

Within the paediatric services an efficient process for preventing cancellations was observed. Daily meetings are held and proactive staffing mixes are initiated and various bed management processes are activated to prevent cancellations occurring.

Medical wards appropriately track outliers and they are managed by their home team, moving when possible to the appropriate specialty ward.

Entry to Te Whetu Tawera was only declined when the consumer did not require such an intensive treatment setting. Treatment alternatives in the community were arranged that were less restrictive, for example intensive community based treatment or respite. This was supported by consumer files reviewed and discussion with the entry coordinator. Buchanan Rehabilitation Unit also explored alternative treatment options if intensive treatment was not required.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

Attainment and Risk: FA

Evidence:

The twelve patients reviewed using tracer methodology were selected in collaboration with staff in the clinical areas based around criteria defined by the Ministry. Tracer patients' journeys covered medical, surgical, older persons' health, paediatric, maternity and mental health departments and wards. Visits occurred to the emergency department, cardiovascular intensive care and the operating theatre suite as part of the tracer patients' journeys. Other wards and departments were also visited during incidental sampling. In addition, two system tracers were undertaken on an aspect of medicines management, and infection prevention and control. Auditors and technical expert assessors worked collaboratively reviewing the relevant documentation and interviewing medical, nursing and allied health team members, the patients, and where possible, their family/whānau members. This information, plus supplementary sampling forms the basis of the comments within the Continuum of Service Delivery Standards below.

Processes are implemented to schedule patients requiring acute surgery. This occurred in a timely manner for the surgical patient audited using tracer methodology and other patients whose files were reviewed.

A multidisciplinary team (MDT) provides services to the patients, all of whom are qualified and skilled for their roles. Enrolled nurses and health care assistants support registered nursing staff with adequate guidance and supervision provided. Health care assistants are regularly used when a "patient watch" is required. Nursing entry to practice (NETP) registered nurses (RNs) are working with designated preceptors who are providing ongoing support alongside clinical coaches who were visible in many of the wards visited. A NETP nurse interviewed felt well supported and felt their confidence and skill development growing. Ward staff interviewed reported adequate orientation period and content provided. In the mental health service staff reported that they felt happy to take on a case load following their orientation period. Nursing students were evident in most areas and those spoken to felt they were well supported by their preceptor and were having their learning needs met and were enjoying the experience.

Medical and nursing staff reported that there is access to on call junior and senior medical staff 24hours a day, seven days a week. Nursing staff access after-hours duty managers for support with problem solving and decision making. A review of the 24hour management of Auckland hospital has been undertaken and feedback is currently being reviewed.

Timely access to allied health services was evident in the files reviewed across all service areas. Examples of patients accessing specialist services as and when appropriate were noted. The pain service covered all surgical areas, and patients were reviewed daily by the team until the patient was on maintenance analgesia. 'Rapid rounds' occur most days on the surgical, medical and older persons' health wards and this worked well for allied health staff to support timely discharge planning. The rapid rounds have improved communication between the MDT and improved care planning and evaluation according to staff interviewed.

Formal MDT meetings occur on at least a weekly basis and staff reported an integrated approach to care with good communication between team members. Referrals to allied health were documented on the office electronic whiteboard and progress captured. At Rehab plus where rehabilitation occurs for patients under 65, daily MDT communication was observed occurring throughout the morning with active listening demonstrated followed by discussion between team members and including the patient as appropriate. Weekly MDT education and MOS meetings were undertaken in most areas. Within the theatre suite daily briefings were held and covered what the day involved, equipment required and anything else pertinent for the day. The theatre team reported that these meetings had improved communication between the team and had a positive impact of the daily functioning of the theatre suite.

Nurses' handover between shifts was observed, in most areas and covered relevant information. Handover occurred by the bedside in most areas and staff reported this as working well and involvement by the patient and their family / whānau was valuable and appreciated by the majority of patients interviewed. Transfer between wards, departments follows a standardised transfer of care process supported by the communication tool 'ISOBAR' (identify–situation–observations–background–agreed plan–read back). Documentation reviewed, staff interviewed and observations demonstrates this was effective.

Tracer patients' files and additional files reviewed show that assessments and subsequent plans and interventions are thorough and timely. Diagnostic tests are completed in a timely manner in the emergency department, and elsewhere, with results reviewed, discussed and actioned as appropriate. Medical staff are able to access results via the computer from anywhere in the hospital. A house officer was observed giving a verbal order to nursing staff via the telephone following results of a blood test being reviewed.

The early warning score is in use (EWS) and completed as required, and where action is required this is sought. The EWS score is commenced in ED for acute admissions. A modified EWS is to be implemented by May 2017 within the maternity unit. The escalation system is currently being reviewed alongside the 24hour coverage of the hospital and in line with the changes being made nationally. Auckland is one of five DHBs to trial the new national EWS chart as part of the deteriorating patient programme. 'Rapid rounding' was occurring in some ward areas visited and the implementation of 'Releasing time to care' has increased patient time markedly in some wards, with one ward seeing an increase from 37% patient time to 61%.

Mental health services are well staffed in terms of a multidisciplinary team who all contribute to clinical management and planning. Tupu Ora, a residential unit for people with an eating disorder, has a GP two days a week, a psychiatrist two days a week, a dedicated dietician, psychologist, psychotherapist, occupational therapist as well as registered nurses. Te Whetu Tawera unit includes access to occupational therapists, clinical psychologists and social workers and has a volunteer coordinator who has engaged volunteers that offer entertainment and activities including after hours, for example pet therapy and music. Within mental health services the community mental health service participate in MDT meetings alongside the Māori cultural team and they are seen as an integral part of the MDT. Staff interviewed confirmed that

communication between team members and external service providers was effective and of benefit to the consumers. Referrals to other specialist services were initiated and responded to promptly (e.g., neurology, dermatology, cardiology and orthopaedics). Consumers reported they are provided with physical support and are informed of necessary treatments and outcomes.

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.3.5 (HDS(C)S.2008:1.3.3.5)

The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.3.6 (HDS(C)S.2008:1.3.3.6)

The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

Attainment and Risk: FA

Evidence:

Assessments are occurring at the first point of contact, at the time of admission and on an ongoing basis depending on the needs of the patients. Assessments were documented for all members of the MDT either using the admission to discharge planner (A to D) assessment tools or included in the progress notes section of the clinical record. Specific nursing assessments have been completed. A range of specific assessment tools, based on good practice were in use across the clinical areas visited, these include falls risk, pressure injury prevention, smoking cessation, and nutritional assessments. A review of each patient's ability to complete activities of daily living and identify any social/cultural needs is also included. Functional independence measures (FIMS) and Australian Rehabilitation Outcome Centre (AROC) assessments are completed in rehabilitation services. Other allied health specific tools and interRAI are also used. In some areas, such as the respiratory and stroke units, the ward have excellent auditing of falls, pressure area and smoking assessment data along with infection control (hand hygiene) compliance which is reflected with completely up to date information displayed.

Paediatrics have age appropriate risk assessment tools completed and collection of immunisation status.

Patient records sampled demonstrated the assessments have been completed in a timely manner with occasional exceptions. Patients interviewed reported their involvement in the assessment process and felt this process was thorough and timely. One of the surgical tracer patients really appreciated having the assessment data and outcomes readily accessible for all staff to read as she did not have to keep repeating herself.

The assessment findings and the needs of the patient are used to develop a planned approach to care. This was reflected in documentation reviewed. Patients who smoked were routinely offered nicotine replacement therapy and one of the tracer patients was very thankful for this as they were unable to mobilise outside for a week. Patient goals were not always identified in a number of services visited. This is included in the area for improvement raised in criterion 1.3.5.2. However, in the older persons' ward and rehab plus, patient goals were recorded along with time frames and ongoing plans especially for over the weekends.

The ward whiteboards were used to indicate specific patient risks, for example falls and allergies, and in many areas they were also displayed on the 'patient at a glance' board at the bedside with consent having been obtained for this to occur.

In the mental health services, comprehensive assessments are in place and are carried out on all patients. Physical assessment occurs as required and this includes on admission. A consumer was observed having their blood pressure monitored and this occurred three times a week. Cultural assessments were documented for the tracer consumers. Family violence screening occurred. Te Whetu Tawera has a dedicated family violence coordinator role. If the family violence screens indicate that abuse or neglect occurs in the patients' environment a thorough assessment is completed. One such assessment showed that reporting was in line with the Vulnerable Children Act. The Buchanan Rehabilitation Unit has a GP on its premises several days each week to ensure the consumers' physical well-being. The GP does the metabolic screening.

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.4.5 (HDS(C)S.2008:1.3.4.5)

Where appropriate, cultural assessments are facilitated in collaboration with tohunga or traditional healers.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

Attainment and Risk: PA Low

Evidence:

Various treatment and care planning tools are in use across the services; these include the A to D Planner and clinical pathways. In most areas, the plans are individualised based on initial and ongoing assessments when completed. Some exceptions were noted in medical, paediatric and surgical areas. Care plans were reviewed each shift and updated if the care needs of the patient changed, however did not always reflect that patients' goals had been identified.

All health professionals involved in the care of the patient make entries in the record in relation to ongoing assessments, progress and updating of the plan. This is supported by multidisciplinary reviews, rapid rounds and planning meetings, either daily in some areas or weekly in others. Meetings observed provided evidence of a thorough and focussed process however; these plans were not consistently documented in the clinical files reviewed. The shift bedside handover in some areas allows for the patient and in some cases their families/ whānau to be involved in the process and contribute to a patient focussed approach. This was confirmed by tracer patients interviewed.

The whiteboards in the ward offices are a quick reference to track and plan progress, including referrals, the expected day of discharge and specific risks.

Plans of care were noted by the surgeons for the immediate post-operative periods in theatre records. ISOBAR forms from ED and the doctor summary from ED detail the initial plan of care at admission for patients admitted acutely.

Evidence of disciplines and services working together to ensure an integrated approach to planning were observed. An example of this was the pain team who visit daily those patients who require pain management and an ongoing plan of care was clearly documented in the patient's notes. The cardiothoracic ward demonstrated team involvement in care planning as did Rehab Plus.

Within the mental health service, individualised care plans are developed by the MDT based on the consumers' goals and identified care needs. Consumers reported attending treatment planning meetings. Consumers and families were able to articulate achievements that needed to happen before discharge. Te Whetu Tawera and Buchanan Rehabilitation Unit has a documented service delivery pathway that include time frames. Files reviewed showed that implementation of the pathways occurred with flexibility to accommodate the consumers unanticipated needs. The early warning signs and a relapse prevention plan were included in the risk management plan. Consumers were aware of their triggers, early warning signs and how to manage these in order to prevent relapses.

At Buchanan Rehabilitation Unit changes were made to the morning MDT meeting, focussing the meeting on the goals the consumers wanted to achieve. Staff reported that the changes had been positive. The national shared care plan (Whanau Tahi) is well used to incorporate assessment information into plans at the Fraser MacDonald unit.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: PA Low

Evidence:

Assessments are completed in all service streams; however, these assessments did not always translate into a documented care plan. In areas where care plans were utilised they were not always updated as needs changed. Outcomes and goals were inconsistently documented throughout service streams. Evidence of care planning occurring either at rapid rounds or MDT meetings was observed, however the documentation of these discussions was not evident. In some areas, the outcome of rapid rounds was entered onto the office whiteboard, where it was clearly visible for that day but was not captured in the clinical file. .Lack of documentation did not lead to lack of

care, care was delivered according to tracer patients and other patients/ family interviewed. When interviewed staff were able to articulate the plan of care given to patients and how this had been delivered.

In oncology, there were no specific care plans or clinical pathways sighted. The clinical notes have entries in response to assessment and proposed care. However, it was difficult to identify that the proposed care had been carried out and what the outcomes of care were.

In the renal/liver area, generic plans are in use; these do not contain goals. There is nowhere on this care plan to document that the care has occurred and the response to care, except in the clinical notes and this was not always clear.

Within maternity, six out of six clinical files reviewed demonstrated some planning in the clinical notes, however there is no care plan for assessing needs, goals, progress towards goals, participation of appropriate multidisciplinary staff or individual care planning for mothers or babies. The maternity tracer patient's clinical notes did not reflect a delivery plan for a caesarean section prior to going to surgery.

In paediatrics the families/whānau goals for the child were not recorded in most instances as a basis for care with most plans being based on clinical assessment without reference to the child or families desired outcome. Minimal information is recorded in all notes reviewed in relation to cultural / spiritual requirements with only ethnicity or religion recorded in the assessment rather than the families stated wishes. Allied health plans were detailed; however they are not always included into the nursing care plan.an example being the dietician and speech language therapist plans regarding method of infant feeding and feeding position were not integrated into the care plan.

The medical tracer nursing care plan did not record all aspects of care. The surgical tracer has minimal detail regarding psychosocial care with no record of housing situation and cultural requirements documented. The medical and orthopaedic wards had rapid rounds with ward based teams, with care planning discussed, including discharge planning, but this is not reflected in the patient's file, but rather the information was captured on the whiteboard. Nursing plans in clinical notes are not always present, or are very brief for example "see reg note, emotional support." In medical wards 11 out of 22 clinical files do not have part B of the A to D planner completed, patient goals are not recorded. Part B was not consistently completed in orthopaedic areas reviewed with eight out of 10 files not having part B completed in the files.

Finding:

Individual assessment needs, desired outcomes and goals are not consistently documented throughout most service streams as a basis for informing care plans and service delivery.

Corrective Action:

Interventions required to achieve the desired outcomes and goals are documented in a service delivery plan.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.5.4 (HDS(C)S.2008:1.3.5.4)

The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/ whānau if appropriate.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

Attainment and Risk: FA

Evidence:

Interventions required to meet the patients' needs are based on the initial assessment and ongoing re-assessment. Clinical files reviewed showed examples of interventions carried out as planned and prescribed for example daily weighs, glucose monitoring, falls prevention strategies. Members of the MDT discuss progress for each patient, and the best interventions to respond to changing needs. Decisions around the most appropriate interventions are based on results of diagnostic tests, recordings and other relevant clinical information. Specialist input is sought as was evident in files reviewed, for example in orthopaedic wards advice from the infectious disease team was clearly documented and followed up.

In Rehab plus and older persons' health, patient goals were consistently recorded including time frames and plans for the weekend. In maternity interviews with women and their family / whānau stated that they were consulted and collaborated with when midwives and the MDT assessed and planned their care, and were aware when changes occurred. High patient satisfaction was expressed with their standard of care.

In mental health areas staff communicated positively with consumers and included them in decision making related to planning and interventions. There is written information regarding mental illness in all units visited. In Te Whetu Tawera consumers report they have wellbeing plans that are developed together. Buchanan Rehabilitation Unit facilitated and coordinated consumers' participation in activities within the community such as obtaining work and attending university. The discharge coordinator specifically

worked with accommodation providers and landlords on non–discriminatory practices. Information about mental health conditions and medication was provided through monthly family groups facilitated by the services social workers. A consumer consultant / advisor provided 'hearing voices' workshops to consumers, families and the general public in order to address the stigma voice hearers are exposed to. Evidence suggests that those workshops promote acceptance by the patients themselves.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: CI

Evidence:

Routine practice at Auckland City Hospital was for post-operative cardiothoracic patients to return to ward 42 for wound checking and management. Patients would arrive and wait for up to two hours to be seen, queue in corridors, and sit in inpatient waiting rooms which contributed to a chaotic ward environment. The burden on staff to attend to wound review, dressings and other clinical care was unsustainable in the long term. No identification of patient volumes had been captured to inform any long-term planning for growth in this patient group and there was no linking back to funding. A project team was developed ensuring representation from cardiology and cardiothoracic to identify the feasibility for utilising a new area that sat within the cardiology floor space. A co-design piece of work was undertaken with patients to identify issues with current process which revealed known issues around environment, wait times plus parking and expense issues. Work streams were identified and a process map completed and identification of areas for improvement. Various reviews of area and resources were undertaken. Wider organisation communication needed to be considered due to the area under consideration being used for winter overflow. Financial implications and FTE were considered. Agreement with the cardiothoracic team to allocate a registrar to the clinic to avoid delays for patients needed to be negotiated. Development of a booking schedule was required that could link to financial management systems. Standard operating procedures developed and an appointment card. Evaluation of improvements required a co-design survey to be completed. Results were analysed and further changes made where required.

The change has given patients structured appointment times, they are now able to organise lives around post-operative appointments, patients can allocate time and cost of parking, there is a less chaotic environment to be seen in, patients are welcomed into the area as they are expected which has made them feel valued. Staff no longer have to apologise and excuse long wait times plus they are now proud of the service provided to patients. The work is now visible and the service can collect data regarding volumes and growth of service. Other specialties now use the space. Volumes and funding accuracy has been captured. Funding has been allocated correctly to specialist or nurse led clinics, the organisation is able to review previous volumes to assist in setting of price volume schedule, and the use of rooms is maximised so space is well utilised. Key metrics have been established and shared with the directorate and wider organisation to show the difference this project has made to the patients, staff and organisation.

Finding:

A review of the Ward 42 (Cardiothoracic) model of care identified that patients were turning up to the ward in an ad hoc manner to be seen for post-operative wound management, placing a burden on staff in a high acuity ward and this was not conducive to providing a good patient experience. Using a planned quality improvement approach, including evaluation of outcomes and ongoing refinement, a co-design piece of work was undertaken with patients to identify issues with the current process which revealed expected and unexpected issues for the patients, staff and the organisation. At completion of the project there are improved outcomes for patients, improved satisfaction for staff and the organisation now has data to assist with future planning plus financial gains which previously they did not receive. Other service areas have also utilised this model of care

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.6.3 (HDS(C)S.2008:1.3.6.3)

The consumer receives the least restrictive and intrusive treatment and/or support possible.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.6.5 (HDS(C)S.2008:1.3.6.5)

The consumer receives services which:
(a) Promote mental health and well-being;
(b) Limit as far as possible the onset of mental illness or mental health issues;
(c) Provide information about mental illness and mental health issues, including prevention of these;
(d) Promote acceptance and inclusion;
(e) Reduce stigma and discrimination.
This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

Attainment and Risk: FA

Evidence:

Activities meet the requirements of the individual patients; these are particular to the various speciality settings. Allied health staff are part of the MDT and examples of referrals to physiotherapists and occupational therapists were seen. Patients in medical and surgical services are supported with activities to promote rehabilitation and timely discharge. Cultural and spiritual support is available through the Māori health team, Pacifica team, chaplains and is easily accessible. Older persons' health has a breakfast club in place as part of the rehabilitation process. Rehab plus hold a weekly bar-b-que that the patients prepare and cook. Patients prepare their own breakfast as able and the dining room is set up to enable patients with various disabilities to participate, for example, tables at various heights to allow for wheelchairs or standing. There is an outdoor area for patient enjoyment, all at ground level to enable easy patient access. A swimming pool is also available, however on the day of audit this was temporarily out of action.

In the paediatric service there is an extensive play therapy programme including adolescent specific options run by skilled and qualified play and education therapists. Staff are able to access some resources for new admissions.

Occupational therapy and social worker input within the mental health services is evident and provides a basis for planned and meaningful activities. All units have planned activities. In Te Whetu Tawera where there are two occupational therapists and a part time physiotherapist employed, individual and group based activities are available. An activity plan was displayed within the wards and included the intensive care unit. A group of volunteers engage consumers in a variety of activities including playing games, making music and pet therapy. The clinical psychologist also provided group activities such as mindfulness. The Māori cultural service visits the inpatient units in the morning to lead karakia and waiata for consumers to join in if they wish. In Buchanan Rehabilitation Unit activities are mainly individualised and are geared towards consumers being able to live in the community. Both services engaged the community drug and alcohol co-existing disorder services to hold groups on substance use issues. Fraser MacDonald unit also has access to part time physiotherapist.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

Attainment and Risk: PA Low

Evidence:

Care and treatment was evaluated on an ongoing basis in all services visited. Files reviewed had evidence of evaluation occurring by those health professionals involved in patients' care. This was however inconsistently documented as part of the care plan or in the progress notes on a shift by shift basis. The frequency of evaluation and reassessment is based on the acuity and progress of the patient. This varies between continual monitoring in the intensive care unit, high dependency unit, emergency department and post-operative care unit (PACU), to daily review of patients in the older persons' health re-enablement unit and the rehab plus unit.

Access to specialist advice and support is available 24 hours a day, seven days a week to support ward staff with timely evaluation, for example the pain service. On call house surgeons can access advice from more senior doctors if required after hours. Appropriate tools to evaluate progress are used. Early warning score system (EWS) informs evaluation of observations and vital signs with children and adults specific vital signs recording documents being available and in use. Escalation was noted to occur, however this was inconsistent in some areas. Within the paediatric area there is a clear escalation process documented commencing at a Patient at risk (PAR) nurse call out for stable children with a higher paediatric early warning (PEW) score, to a code pink for those children who are unstable and a higher PEW score and then a code blue for those with respiratory / cardiac arrest or medical emergency.

Fluid balance charts are an informative evaluation tool; however these are not consistently documented in most areas.

Laboratory and radiology investigations are requested when clinically indicated.

Where progress was not as expected, there were examples of timely changes made in response to early warning scores, increased pain levels or decreased fluid output. Staff reported that the use of the communication tool ISOBAR supported a thorough and objective way to pass on evaluation information. An example of a good experience of escalation of issues was observed in the renal and liver ward where a patient's renal output was poor, this was escalated and followed through by medical and nursing staff and the patients' status reversed.

In mental health services the effectiveness of service delivery was assessed at the regular MDT meetings. Changes to treatment plans were seen to be implemented based on progress. Consumers' report the staff explained changes to medication and referrals that they make on behalf of the consumer. Family spoken to report they feel involved with their loved one's care. The Health of the Nation Outcome Scale (HoNOS) is used as part of the national data requirement and as a broad measure to signal clinical issues, however this does not produce reliable data currently.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: PA Low

Evidence:

Care and treatment was evaluated throughout all service streams. Staff interviewed are able to articulate how this occurred and were observed at evaluating patient response to cares during rapid rounds and MDT meetings.

Paediatric early warning scores are in use and are completed and totalled on most occasions. However, variance is not documented to indicate to staff the expected parameters for observations, an example seen was for the cardiac surgery tracer whose 'normal range' sits outside the standard score expectation.

Within medical and surgical areas nine out of 15 files reviewed showed EWS scores were consistently totalled however the escalation process was inconsistently activated when the score directed that further action was required. Fluid balances were inconsistently totalled throughout surgical and medical areas.

In a surgical area evaluation responses, such as action taken in response to an abnormal recording was not always documented in the clinical notes, for example an elevated temperature required cooling cares to be given, which reduced the temperature down to within normal parameters within two hours, this was observed happening but no evidence was written to support it.

Finding:

Evaluation of interventions and the responses to treatment are inconsistently documented throughout most service streams.

Corrective Action:

Ensure evaluation tools are completed and inform the care planning process

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

9.3

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.8.4 (HDS(C)S.2008:1.3.8.4)

Evaluation includes the use of a range of outcome measurement tools, and input from a range of stakeholders, including consumers, clinicians, and family/whānau if appropriate.

Attainment and Risk: PA Low

Evidence:

It was not possible to extract reliable HoNOS (health of the nation outcome scale) data for Te Whetu Tawera and Buchanan Rehabilitation unit. The service was aware that there had been issues with entering the HoNOS at the required service delivery points. Only matched pair data was available. The percentage of matched HoNOS data during 2016 was between 51% and 62.1%.

A plan has been put in place to improve HoNOS compliance. The part of the plan that included training HoNos trainers was implemented in November 2016. A project to inform clinical processes by HoNOS scores is in the process of being developed.

Finding:

The service has not achieved the HoNOS targets during 2016.

Corrective Action:

Develop and implement a plan to ensure HoNos compliance.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

Attainment and Risk: FA

Evidence:

Medical and nursing staff interviewed discussed examples of referrals to other health services and how these were facilitated. This was supported in clinical files reviewed. Staff from other services are included in MDT reviews and can visit the patient to provide an assessment, advice and support when indicated. A file reviewed in the cardiothoracic area showed evidence of a diabetes nurse specialist having input into the management of a patient's care.

Patients interviewed as part of the tracer methodology process felt involved in decisions about their care and discussed examples of where referrals had been made with their involvement. In older persons' health evidence of this was seen when an occupational therapist accessed equipment on the same day as ordered to enable an early discharge.

In older persons' health a project for transitioning patients home from hospital and supporting them in the community (new immediate care services) is making a noticeable difference to discharge planning. This includes the rapid response service, early supported discharge service and supported discharge service. A one page description outlining the purpose of each service which includes a single point of access phone number and e-referral process makes this service accessible for referral.

Where patients are being discharged to an aged care facility, the social worker works with the patient and their family / whanau to discuss options and facilitate an appropriate assessment.

Within maternity, women and their family / whānau interviewed felt they were given choices to access other service providers, and were provided with information and brochures should they require these services post discharge.

All files reviewed had evidence of appropriate and timely input from allied health staff and evidence of referrals to other specialities and these were actioned in a timely way.

In mental health services, families report they were offered support and Supporting Families brochures were available in the units. Pacifica, Maori and other minority culture patients are referred to the specific cultural support services. Referral to support services run by non-government organisations are utilised as needs dictate. Consumers at Buchanan Rehabilitation Unit are referred to activity programmes run by peers and or NGOs. The service will refer to any service that supports the goals of the consumers.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

Attainment and Risk: PA Low

Evidence:

Discharge is a planned process, in collaboration with the patients and their families. For those with a planned admission, discharge arrangements are discussed as part of the pre-assessment process and any particular needs catered for. For acute admissions, an estimated date of discharge (EDD) is documented as soon as possible and any barriers to discharge identified and planned for, however in many areas these were inconsistently documented. For patients with more complex needs, the MDT works together to progress discharge. Medical and older persons' health service have a rapid round focus on discharge planning which is updated on the whiteboard

Transfer from ED to the wards and from PACU to the wards was reported by staff to be a consistent and reliable process and this was supported in documentation reviewed in most cases.

At Te Whetu Tawera and Buchanan Rehabilitation Unit discharge planning is discussed at service entry. The focus on a successful discharge was shown throughout the records and confirmed through interviews. Both services work closely with community mental and other support services. At the discharge or transfer time the consumer will be familiar with the new service providers, the accommodation situation and any other supporting arrangements. Each of the services had a dedicated role that monitored the journey toward discharge and or transition. The discharge planning meetings attended by the MDT included the community services the consumer was referred to. Staff interviewed were cognisant of the impact of failed discharges can have on consumers. One important aspect, namely to support consumers to have confidence in themselves that they can live in the community was reflected in the records. The national shared care plan (Whanau Tahi) is well used to incorporate assessment information into plans at the Fraser MacDonald unit. At ward handover, discharge planning was incorporated into patient reviews and clinical staff were able to provide good information about consumers discharge needs, however documentation in patients' files did not readily show planning for discharge.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: PA Low

Evidence:

Discharge planning was heard when observing rapid rounds, MDT meetings and on the whiteboards in the offices, however it was inconsistently documented in the clinical notes.

In maternity area six out of six files reviewed had no evidence of discharge planning and no discharge plan pathway.

Medical and surgical wards have an EDD documented on the whiteboard, which is discussed daily at rapid round and during MDT meetings; however it is not always reflected in the clinical file.

The tracer patient in the orthopaedic ward was expected to be discharged the following day but was anxious about discharge and felt that more planning and family input was required.

Within Fraser MacDonald unit staff were able to articulate the plans for a consumers discharge however this was not documented easily in the patient clinical notes.

Finding:

Discharge planning is not consistently being documented throughout most service streams.

Corrective Action:

Ensure discharge and transfer planning is documented, timely and minimises the risks associated with discharge and/or transfer.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.11: Use Of Electroconvulsive Therapy (Ect) (HDS(C)S.2008:1.3.11)

Consumers who are administered electroconvulsive therapy are well informed and receive it in a safe manner.
(Only mental health services that provide ECT need to comply with Standard 3.11)

Attainment and Risk: FA

Evidence:

Auckland mental health service operates an electroconvulsive therapy (ECT) programme that is delivered in accordance with legislative requirements and best practice guidelines. The service operates under the direction of the lead ECT consultant. Consumer files reviewed show consumers are fully informed on risks/side effects. They undergo relevant physical examinations and receive specialist consultations for existing health conditions. Each staff member who is involved in providing ECT practices has a comprehensive role description. The service establishes a team to ensure that ECT trained and experienced staff are available at all times to provide this treatment. A new state of the art ECT machine has recently been purchased. The machine is easier to manage than the one previously used.

Criterion 1.3.11.1 (HDS(C)S.2008:1.3.11.1)

ECT is provided according to legislation and currently accepted best practice guidelines.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.11.2 (HDS(C)S.2008:1.3.11.2)

There are monitoring processes in place to ensure all assessments, consents, and application of ECT comply with the currently accepted best practice guidelines, legislation, and the organisation's policies and procedures.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.11.3 (HDS(C)S.2008:1.3.11.3)

Consumers are given specific information on the risks and known side effects of ECT.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.11.4 (HDS(C)S.2008:1.3.11.4)

The consumer shall be fully informed.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

Attainment and Risk: PA Moderate

Evidence:

Staff interviewed discussed a range of quality improvement initiatives completed or underway across the organisation to improve medication safety. These include the medicine governance walk arounds, the purpose of which is to identify issues, provide feedback to the areas and assist with a solution, as well as listen to staff in the area for their concerns around medication safety. Recent service improvements undertaken are reduction in pharmacy dispensing errors, real time centralised temperature monitoring and automated dispensing machines for out of hour's medication storage.

The Auckland DHB wide medicine governance committee meets monthly. The committee have documented terms of reference and clear lines of communication. Minutes reviewed and members interviewed demonstrate involvement in emerging issues, projects, audit results, review and monitoring of errors, changes to practice and a general gathering of all medication relation activities. Key priorities are agreed and worked upon. Various projects have been undertaken. E-prescribing is currently being trialled in two areas of the hospital. The charge nurse of one ward has instigated one at a time administration with the computer on wheels (COW) and reports that the roll out has been well supported with zero medication errors for the past month which is a first time ever.

The national medication chart is in use. Prescribing practices meet the standard required with the exception of indications and dose limits for use of pro re nata (PRN) medication, completing the VTE risk assessments and the discontinuation of medicine not being end dated and signed and the handwritten documentation of the patient's name and NHI. Administration practices observed and supporting documentation reviewed demonstrated compliance with policies, with the exception of insulin vials not consistently being discarded, inconsistent fridge monitoring and medicine reconciliation not being completed in all areas of the hospital. Plans are already in place to upgrade all medication refrigerators to real time centralised monitoring and a commitment to increase pharmacist's numbers to commence further reconciliation is also underway.

Medicines are stored in dedicated medicines areas, which are clean and well organised with stock controlled. Many of the areas have undergone a recent upgrade and reconfigure in line with 'Releasing time to care' work and utilising lean processes. Staff interviewed were very positive about this change and spoke about the rooms not being so crowded, and medications easier to reach. Medicines on the resuscitation trolleys were also organised and easy to view.

Staff involved in medicines management are assessed as being competent to do so through education packages, and ward based education. Records are maintained by the clinical educators on spreadsheets. Medicine competency commences at orientation. There are additional competency processes for advanced analgesia and epidural medicines. E-learning packages are available on Ko Awatea.

Consumers interviewed within mental health areas were familiar with their medications and possible side effects and treatment plan. They felt involved in related decision making. In Te Whetu Tawera, Buchanan Rehabilitation Unit and Fraser Macdonald Unit a pharmacist is allocated to each of the services to ensure that medication charts are correctly completed and to provide consultation to staff. Additionally, they also provide education and training for patients. Buchanan Rehabilitation Unit has seen a significant reduction in medication errors.

Medication tracer: The systems and processes related to insulin administration and storage was reviewed, as this area had arisen daily by each auditor working in the clinical areas as an issue. Insulin that is not in use should be stored in the refrigerator. If refrigeration is not possible, it can be kept at room temperature [15-25 degrees C] for 28 days. Once a vial has been opened for the first time, a label is adhered to the vial with the date opened documented clearly. This vial is then able to be used for 28 days before it is discarded. However, vials are not currently being routinely discarded once the 28 days has passed. On interview, staff did acknowledge that they presumed that due to the vial remaining in the refrigerator they could administer the insulin without always checking that it was within the expiry date. This was not consistent in all areas, with some staff clear that the label would be checked prior to administration. Staff in most service areas interviewed had received education regarding insulin administration and storage was a component of this training. When teaching patients' about self administration of insulin, the registered nurse's articulated that the storage of insulin was included. Insulin prescriptions reviewed were correctly prescribed, evidence that the insulin had been administered was documented and the prescription regimen followed correctly. On reviewing blood glucose monitoring charts these were all correctly documented.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: PA Moderate

Evidence:

Medicine Reconciliation is occurring in some areas with 39% of adult patients having medicine reconciliation completed however there remains areas where this is not occurring. A plan is underway to employ more pharmacists over the next eighteen months. The surgical tracer patient in orthopaedics was admitted on an antidepressant. They were five days post admission and this medication was still not prescribed or given. In areas where reconciliation did occur, it was evident that pharmacists not only reconciled medicines, but also corrected the prescribing of medications and added instruction to prescribed medications in particular pro re nata (PRN) medication.

Refrigerator temperature was inconsistently being monitored throughout the hospital, however the DHB have selected a centralised monitoring system and a business case has been approved to proceed with this in the near future. In some areas where there has been a variance it has been logged on the chart but no action taken. Other incidents were seen where it had been reported but no consequent action was documented. Some staff spoken to were not aware of what action to take should a variance be seen especially at the weekend. In Ward 64 there was a temperature over the requirement for 13 days in February, however no action had been agreed upon at the time of audit. In the paediatric area there was uncertainty regarding the monitoring of vaccination refrigerators with variances.

Insulin vials were seen throughout all service streams with labels identifying that the vials were past the standard 28 days from opening. The insulin was not expired on the manufacturers date but from opening date. Staff interviewed did not always check this date prior to administration. Within the paediatric area vials were found past the documented expiry date. On an Orthopaedic ward two vials of four were expired, one being eleven days past its expiry date. Ward 64 two out of four were past the labelled expiry date. On medical wards and the older persons health ward vials were found either opened and not labelled, or had been opened for more than 28 days. At Greenlane four vials out of six were past the documented expiry date.

Finding:

Medicine reconciliation, fridge temperature monitoring, expired insulin remaining in the fridge are areas that were inconsistently evidenced throughout service streams.

Corrective Action:

All aspects of medicines management comply with legislation and best practice requirements.

Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: PA Low

Evidence:

Venous thromboembolism (VTE) assessments are rarely completed in the medicine charts sampled (all areas), an exception to this was within the cardiothoracic ward where it was completed in all patients' charts, this was recorded on a separate sheet of paper and not on the medication chart. The decision regarding length of enoxaparin prophylaxis is also not documented in patient prescribed enoxaparin. Staff state there is the assumption that it will cease on discharge but there was no formal process around this.

Within the medical area, VTE assessment was not completed on 24 of 27 medication charts, within surgical area VTE assessment was not completed in 19 of 20 medication charts

Throughout all service streams discontinuation of medications was not always dated and signed. A line was evident within the chart depicting that the medication was to stop, however this was often seen to be through all days of the prescription and not just from the required end date.

Dose limits and indications for PRN medicines are not consistently documented in medicine charts sampled in all wards/units, although there are individual prescribers who document these aspects (e.g., all medication charts at Rehab Plus had these documented). In areas that receive a medicine reconciliation service these are recorded.

Both tracer patients within medical and older person's health areas had two medications administered with no prescriber signature evident.

The medication chart directs the prescriber to hand write the patients name and NHI clearly on the medication chart, however this was rarely written, with one out of 45 charts sampled throughout all service streams having this. Often the label had been placed over this area.

Finding:

Medication management information was inconsistently recorded, for example, completing VTE assessments, indications for use of pro re nata (PRN) medications, prescriber's signature not evident, and the handwritten recording of the patient's name and NHI.

Corrective Action:

All aspects of prescribing, assessment and documentation comply with legislation.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.7 (HDS(C)S.2008:1.3.12.7)

Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

Attainment and Risk: PA Low

Evidence:

Interviews were held with the Compass provider manager a Compass dietitian, the ADHB professional leader for dieticians and nutritionists and the ADHB contracts manager. The IANZ accreditation audit for compliance to the Hazard Analysis and Critical Control Point (HACCP) NZ programme was conducted February 2017 by Telarc and the resulting corrective actions were viewed. None of the recommendations were high risk, although there was no corrective action plan yet developed as the report was only received the week prior to the audit.

A review of the food provision was carried out in 2016 which resulted in a change from tray line service to the 'Steamplicity' system. This has changed the way meals are delivered in some of the wards. The new steam system for meal service has been introduced into most clinical areas. The new system only requires three catering assistants to prepare, and the remainder of the assistants have been relocated (two per ward), to heat and serve the food. The staff spoken to are pleased with this change and that the visibility of the catering assistants has proved popular with the patients.

There are patient satisfaction KPIs included in the Compass/ADHB contract. Compass conducts food satisfaction surveys which include tray accuracy and meal substitution and the feedback trend indicates an increase in patient satisfaction from 69% response rate responses, the January 2017 audit results showing 80% satisfaction, however 50% of the patients when asked on site during the audit stated they did not enjoy the food.

The food is well designed to meet most of the patients' dietary needs and this is clearly identified on the menu. Trendcare is used to communicate dietary requirements and any allergies are highlighted, this system then feeds into 'Saffron' the Compass electronic system which generates the menus for the day. The food service provides access to food after hours. Where there is a complex dietary need, then a tray line meal is created in consultation with the dietitians.

Compass have a range of specific standard operating procedures and works in accordance with the DHB policies, for example, health and safety and infection prevention and control. There are fortnightly dietitian and Compass meetings where issues are raised and risks and incidents are reviewed.

In the mental health facilities Staff stated that specific diets are easily ordered and provided. The Buchanan Clinic no longer employs their own cook, and they are now part of the hospital food system. Staff spoken to reported that this arrangement has worked for them. All consumers reported the food was edible, portion size was adequate and meals arrived on time. In the Buchanan Centre consumers in the flats cook for themselves they receive $70 per week for groceries and are assisted to keep within the budget. Healthy eating is encouraged and consumers detailed the support staff give to preparing menus and the education sessions which are provided.

There is a lack of documented guidelines and clarity around the requirements for expressed breast milk storage in the paediatric and maternity wards. The fridge and freezers being used for food storage on the wards are not consistently being monitored in all areas.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: PA Low

Evidence:

The introduction of the 'steamplicity' on the wards has had a positive effect on the monitoring of the food fridges which is now performed by the catering assistants. The temperatures were recorded daily and there was a sticker system in place noting the date of opening and expiry dates. The reheating of the food is also performed by the catering assistants with documentation of the temperature prior to serving. Some of the wards had two patient food fridges and in three of the clinical areas visited by technical expert advisors and auditors the second fridge had no record of temperature monitoring. In Starship, while food fridges are monitored, the expressed breast milk (EMB) freezers are not. The policy does not include the freezer requirements and is not definitive regarding EBM fridge storage periods (i.e., states both 48 hours and 72 hours).

Finding:

Freezers that store expressed breastmilk in Starship Hospital are not monitored. The policy for safe storage of expressed breast milk has conflicting timeframes for refrigeration and does not include freezing. In the Auckland City Hospital, food fridge monitoring is not occurring in three areas.

Corrective Action:

Ensure that food storage and monitoring processes comply with the current legislation and that requirements to safely manage frozen expressed breast milk are documented and maintained.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

Attainment and Risk: FA

Evidence:

Waste management policies are current and guide staff in the appropriate segregation of waste. The last review of the waste policy shows the organisation's commitment to minimising harm to the environment, including the recycling of 'PVC' generated by medical packaging. Staff spoken with were aware of waste management policies.

Waste is collected from areas by cleaners and put into collections points, and waste orderlies collect from these points at regular times. Waste was seen as being stored appropriately in all areas visited. Hard shell sharps containers are available in all areas. Contracted organisations remove waste from designated dock ways and this was observed. Staff in these areas spoke of education on personnel protective equipment (PPE). PPE was sighted as available in all areas visited and being used appropriately.

Chemical storage was sighted as appropriate to the areas, including kitchen, sterile services, boiler room and laundry. Staff in these areas report training on the handling of chemicals. There is a list of approved hazardous substance handlers and periodic audits are undertaken on safe handling of chemicals. External storage of hazardous substances was observed as being clearly signposted with HAZCHEM signage.

9.3

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

Attainment and Risk: FA

Evidence:

All buildings have a current Building Warrant of Fitness. In discussions with the operations manager - facilities management and the director - facilities & development it was established that the upgrade work in Starship Hospital is being managed by the project planning office and not at the stage of requiring a Certificate of Public Use. The ADHB Asset Management Plan 2015 details the forward planning for replacement of all major buildings and plant.

There is a planned and reactive maintenance programme, tracked on the Building and Engineering Information Management System (BEIMS). Both planned and reactive maintenance is carried out by daily and monthly work plans, which when completed, are entered onto the BEIMS. Review of the Clinical Engineering Status list for February 2017 and biomedical equipment lists shows less than 5 percent of equipment being overdue. There are processes in place to ensure equipment identified as high priority items are not overdue, with one percent being identified for biomedical equipment. No equipment sighted was seen to be over their review date. Staff interviewed reported that the service is responsive and that any urgent matter are attended to in a timely manner. There were no concerns raised by staff in clinical areas in relation to the environment and equipment. Reporting on maintenance meeting targets is sent to senior staff. Hot water temperature monitoring is occurring and shows regulatory requirements are being met. An issue with the storage of hot water has been identified and is now being monitored online two hourly (See IPC surveillance).

Facilities visited, including mental health and eating disorders area which are fit for purpose, safe and comfortable. The work already carried out in Starship Hospital shows improvement since the last audit.

There is limited external access to seating areas for patients to access quiet spaces, around Auckland hospital. However, there are corridors within the main hospital that are wide with high windows to allow for natural lighting and it was observed that patients and families interviewed were happy with the facilities provided.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

Attainment and Risk: FA

Evidence:

There are adequate toilets and shower facilities in all areas visited. These have suitable privacy/locking devices and access to call bells. They were noted to be clean and well organised with enough space for patients, equipment and staff, as needed. Toilet facilities are also available for visitors and staff. Patients and staff across the services were satisfied with the toilets, bathing and personal hygiene facilities.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

Attainment and Risk: FA

Evidence:

All clinical areas have sufficient space around the beds, to allow patients with aids and an assistant to move freely, even in shared rooms. Single and four bedded rooms were observed in most general clinical wards. Mental health facilities have single and double rooms which have adequate space and were seen to be personalised. Patients commented positively about the environment.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

Attainment and Risk: FA

Evidence:

The Co-Design process is addressing facilities, furniture and furnishings to provide an appropriate and safe patient environment. Inpatient wards have access to whanau rooms with adjacent pantries. Mental health services provide areas which are commensurate with their immediate needs. The renovation of Buchanan Clinic since the last audit has improved the environment.

All units have areas for play, to meet with family, exercise, for sensory modulation and dining rooms. Starship hospital have play areas on each floor as well as family rooms. There are also McDonald House options for patients and families.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

Attainment and Risk: FA

Evidence:

Cleaning services have changed, in recent years, and is now being provided 'in house'. The changes include a new seven step cleaning practices and the provision of a 24 hour cleaning service. The Victorian cleaning standards are being used and audits occurring against these standards. Cleaning staff receive orientation and ongoing training, to the cleaning system requirements. This includes the use of a traffic light process to identify the type of cleaning to be undertaken, using which products. Five cleaners spoken with confirmed training has occurred and report that they are well supported with sufficient equipment required to provide a safe and quality service. Cleaning trollies

have a locked cupboard for chemicals and material safety datasheets are attached to the trolley. Locked cupboards are used for storage of the trolleys when not in use and chemicals. All areas visited were observed to be clean, and patient's spoken to be happy with their environment.

Laundry services, for hospital linen, are provided by an external contracted provider, who service all three of Auckland DHBs. Mental health services provide clean and safe laundry services for patients, to undertake their personnel laundry, with hospital linen being sent to the external provider. The service is certified under the laundry standard and an annual audit occurs by representatives from infection control and occupational health and safety. A quality improvement activity, jointly between the laundry and the DHBs, called the orange sticker system is a process to identify any laundry bag filled to over 16kg. If over an orange stickered is attached and be left at the DHB to redistributed to reduce the weight in the bags. Staff in areas visited were aware of the orange sticker process and raised no concerns related to the linen service.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

Attainment and Risk: FA

Evidence:

Policies and procedures guide staff on the management of emergencies and training is undertaken during orientation, and ongoing when requested.

There are Fire Service approved evacuation plans for all areas and six monthly checking occurs.

The organisation has a Health Emergency Plan (2014-2017). The manager of emergency services is part of a regular meeting with civil defence, regional and national emergency management groups. Desk top exercises have occurred to test systems in place, and learnings from these are used to improve processes.

Utilities are provided by external companies, with generator back up and co-generation available. Two emergency independent water supplies are available.

Call bells for patients to alert nursing staff and emergency call systems are in place in all areas visited. Emergency trollies were sighted in all areas and are checked on a regular basis.

An external company is used to provide security services. This is overseen by the ADHB security manager, who provides a monthly report to senior management, on contracted key performance indicators. Standing operation procedures describe the process for locking doors to ensure a safe environment at night. The security guards have had training to provide safe holding practices for 'code orange' situations. There are over 600 closed circuit televisions (CCTV) being monitored from a central control centre. An external independent security assessment was carried out in 2014 which has been developed into a security project and it is hoped to have this completed in the next two years.

Vulnerable areas have specific security processes in place. The Starship hospital was observed to be open and a meeting with senior manager and the project team provided evidence of the security measures in place while also promoting a family friendly environment. The renovation works in this area will see an enhanced security system in place once completed. Mental health services provided at Te Whetu Tawera have a dedicated wing for vulnerable patients that was secured via alarm over night. This was reflecting an acknowledgement that some patients are at risk of exploitation and a commitment to protect such patients.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

Attainment and Risk: PA Low

Evidence:

There are three areas that have rooms with no natural lighting; CCU, PICU and 23B. These areas are not able to be structurally modified and staff ensure that patients spend the minimum amount of time in these rooms. All other areas have access to natural lighting. Central heating and air conditioning ensures temperatures meet the needs of the individual areas. No reports of issues related to heating or ventilation were identified during audit.

The hospital has a smoke free environment policy for the hospital property and grounds. However, it was observed that patients were smoking inside and out in one of the mental health service facilities.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

9.3

Attainment and Risk: PA Low

Evidence:

On the whole, it was observed that there is good signage in and outside the hospital buildings on the organisations smoke free policy. However, in Te Whetu Tawera (TE WHETU TAWERA) patients were observed smoking inside and outside the facility. Staff report, the initial drive for a smoke free environment has not been sustained. Smoking is not being consistently discouraged by staff and staff state they are powerless to prevent this occurring.

Finding:

The ADHB smoke free policy complies with current legislation and legal decisions and is unequivocal that there is no smoking on ADHB premises. Despite this, smoking is occurring in Te Whetu Tawera and staff there report an inconsistent approach to supporting service users to be smoke free.

Corrective Action:

The ADHB meets its legal obligation to ensure that patients/consumers and service providers are not put at risk by exposure to environmental tobacco smoke by complying with current legislation (such as described in 21 Health Law Bulletin 424 [2013]) and providing a smoke free environment on all hospital property.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

Attainment and Risk: FA

Evidence:

The Restraint Minimisation and Safe Practice (RMSP) committee oversees enabler processes throughout the Auckland District Health Board. This was confirmed by the group members at interview. Approved enablers are listed in the appendix of the Restraint Minimisation and Safe Practice policy. Each approved enabler included detailed requirements on type of equipment, usage, application, assessment, monitoring and documentation.

Observations at all wards visited showed that enablers had not been used on the day of the audit. Staff interviewed knew the enablers that are approved and the processes required to apply them. An attitude of minimising the use of enablers and restraint was a theme throughout discussions with staff including those in leadership positions. The systems reviewed support the organisational drive of using enablers only if such interventions are evidence based.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

Attainment and Risk: FA

Evidence:

The three restraint minimisation and safe practice policies and procedures (mental health, medical departments and department of critical care medicine) and the terms of reference identify that the Restraint Minimisation Steering Group is responsible for oversight of the approval and monitoring of restraints as well as restraint training. All forms of restraint used within the Mental Health and Addictions Directorate also require approval from the Less Restrictive Practices Governance Group.

Members of both groups described their responsibilities. Six steering group meeting minutes held during 2016 showed that restraint approvals and restraint training had been discussed. The restraints that have been approved are listed in the appendix of the policies.

Each approved restraint included detailed requirements on type of equipment mandated, usage, application, assessment, monitoring and documentation.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

Attainment and Risk: FA

Evidence:

The restraint minimisation and safe practice policies and procedures identify the assessment requirements. Those were consistent with best practice, the standard and a patient centred approach.

Fourteen assessments have been reviewed. They were from Te Whetu Tawera, Frazer McDonald Unit, neurosurgical ward and critical care medicine ward. All assessments had been completed by regulated health professionals. Assessment information was noted in the clinical records, care plans and early warning sign charts. All mental health services completed a 'use of force' and, where seclusion is used each episode has a "seclusion form" completed.

Six staff interviewed had knowledge about how to apply the approved restraints and the documentation required. They explained how they discerned whether the restraint was in the best interest of the patient, was safe, other interventions had been tried and that restraint was needed to provide the patient with necessary treatments or to avoid that people are getting hurt. The processes implemented were in line with the policies and procedures. The information obtained indicated a staff culture that made an effort to minimise restraint episodes.

An example of identifying situations that could prevent restraint is the Behaviour of Concern Pathway that identifies patients at risk for agitation and aggression and provides guidance on early detection and options of alternative interventions.

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:
(a) Any risks related to the use of restraint;
(b) Any underlying causes for the relevant behaviour or condition if known;
(c) Existing advance directives the consumer may have made;
(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
(f) Maintaining culturally safe practice;
(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
(h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

Attainment and Risk: FA

Evidence:

The 14 restraint records from Te Whetu Tawera, Frazer McDonald Unit, neurosurgical ward and critical care medicine ward showed that restraint was initiated by a regulated health professional as per policies. Staff explained that only those trained in restraint practices applied the restraints used. Examples provided by staff or observed included personal restraints, seclusion, directed support to return to the ward and wrist straps. At the medical and older persons wards the registered nurses described that the use of bedrails were actively discouraged. Clinical records, incident reports, use of force records, seclusion form, early warning sign charts and care plans showed that staff had tried a variety of interventions unsuccessfully before applying the restraints. The records showed that the justification for the restraint was to ensure the safety of the patient, staff or visitors present at the ward. Some of the restraints were needed to provide the patient with necessary treatments. On-going monitoring during the restraints was noted in the clinical records. It was observed that wrist straps had been regularly monitored.

For seclusion episodes in Te Whetu Tawera the processes determined by the Mental Health Act 1992 had been followed and documentation on the specific templates occurred. Monitoring followed the Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (2010) guidelines.

Staff stated that restraints were removed as soon as this was safe. Transition processes from restraints to non-restraint conditions were noted in the patients' care plans that were reviewed.

Four staff interviewed described restraint practices that reflected the organisation's policies and procedures. Staff conveyed that restraint coordinators, charge nurses or clinical leaders present on the ward during restraint informed decision making before, during and after the restraints.

The records maintained on restraint were in line with the policies and procedures. The service maintained a restraint register with sufficient detail to assess the implementation of the required processes, patterns of restraint use and injuries during restraint.

Patient records and staff interviews demonstrated that staff communicated with the patients' family when this was appropriate.

The review of the restraint processes indicated that staff involved take due care when restraining a patient. They are supported by systems that guide their restraint practice. The interviews, records and observations showed that patients' dignity was maintained during the restraint processes.

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:
(a) Only as a last resort to maintain the safety of consumers, service providers or others;
(b) Following appropriate planning and preparation;
(c) By the most appropriate health professional;
(d) When the environment is appropriate and safe for successful initiation;
(e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:
(a) Details of the reasons for initiating the restraint, including the desired outcome;
(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
(c) Details of any advocacy/support offered, provided or facilitated;
(d) The outcome of the restraint;
(e) Any injury to any person as a result of the use of restraint;
(f) Observations and monitoring of the consumer during the restraint;
(g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

Attainment and Risk: PA Low

Evidence:

The restraint policies and procedures identify the evaluation requirements that include the items (a) to (j) required by this standard.

Processes are in place to review all restraint episodes with the purpose of evaluating that the practices used are in line with the organisations policies and procedures and current best practices. Interview with staff, including committee and workshop members and chair persons stated that reviews of each restraint episode was done in a variety of ways; discussion at multidisciplinary team reviews, audits of restraint documentation by restraint coordinators and analysis of data in a variety of committees and working groups.

A shortfall has been identified at the Mental Health and Addiction Directorate related to the reviews of individual restraints.

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:
(a) Future options to avoid the use of restraint;

(b) Whether the consumer's service delivery plan (or crisis plan) was followed;
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
(d) Whether the desired outcome was achieved;
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;
(f) The duration of the restraint episode and whether this was for the least amount of time required;
(g) The impact the restraint had on the consumer;
(h) Whether appropriate advocacy/support was provided or facilitated;
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
(j) Whether the service's policies and procedures were followed;
(k) Any suggested changes or additions required to the restraint education for service providers.

Attainment and Risk: PA Low

Evidence:

Systems have been put in place to ensure evaluation of each restraint. Restraint Minimisation Steering Group Committee members stated that restraint co-ordinators are in each area of the hospital. Their role is to evaluate each restraint use in their area and interviews and records showed that this is happening.

Three members of the Least Restrictive Practice Group convey that at the mental health units restraint evaluations are the responsibility of charge nurses and the consumer advisor. This process is also noted in the mental health restraint minimisation policy and procedure.

Examples of the implementation of the prescribed processes had been observed at the neurosurgery and critical care medicine wards were wrist straps were released 2 hourly. Seclusion in Mental Health has compulsory monitoring requirements that were noted and implemented on specific templates and in the clinical notes.

Review of fourteen clinical records showed that relevant aspects of the restraint event had been discussed with multidisciplinary team members, patients and in some cases family members. Care plans had been amended if alternative or preventative interventions to restraints had been identified.

Systems to evaluate and monitor each restraint episode are in place, known to staff and implemented at the general hospital. Reviews of records, documentation and interviews indicated that the organisational focus is on the reduction of restraining patients.

The mental Health and Addiction Directorate required that the consumer representative with the charge nurse reviews each personal restraint. The shortfall identified was that this requirement had not been implemented in the past six months.

Finding:

Mental Health and Addiction Directorate: The charge nurse or service leader and the consumer representative did not conduct a use of force/personal restraint review as required by the Restraint Minimisation and Safe Practice in Mental Health policy.

Corrective Action:

Ensure that a review of each restraint event by the charge nurse and the consumer representative occurs.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

9.3

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

Attainment and Risk: PA Low

Evidence:

Restraint Minimisation Steering Group members stated that evaluation reports completed by the restraint coordinators and restraint process audits are submitted to the quality department to co-ordinate the development of practice improvement measures. Examples of reviews and audits were provided.

The restraint audit report from December 2016 provided information on restraint use over time. Patterns of restraint use in each area can be identified on a spreadsheet.

The six Restraint Minimisation Steering Group meetings and the two restraint coordinator meetings show that results of audits and trends of restraint use are reviewed.

An initiative (as part work place safety strategies - a reduction of aggression) by the organisation in response to staff injuries during restraints was explained by the chair of the Workplace Violence and Aggression Steering Committee. The Auckland District Health Board has developed a safe environment programme for staff in relation to potential verbal and physical aggression from patients and visitors. This programme is sought to prevent the use of restraint and therefore injuries to personnel involved in personal restraints.

Other responses to some of the restraint reviews showed, for example, changes in training and the elimination of mechanical restraints. Several training initiatives had commenced during the time of the audit. Patterns of restraint use at Te Whetu Tawera showed restraints had been reduced by half during the July 2015 to December 2016 period. Training changes, clinical leadership support and a change in team culture are sought to have contributed to this positive outcome.

Although restraint practices and frequencies had significantly improved at the Mental Health and Addictions Directorate a shortfall in regards to restraint audits has been identified.

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:
(a) The extent of restraint use and any trends;
(b) The organisation's progress in reducing restraint;
(c) Adverse outcomes;
(d) Service provider compliance with policies and procedures;
(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
(g) Whether changes to policy, procedures, or guidelines are required; and
(h) Whether there are additional education or training needs or changes required to existing education.

Attainment and Risk: PA Low

Evidence:

All departments except the Mental Health and Addictions Directorate implemented audits at the required frequencies. The audit results are reviewed and analysed firstly by the restraint coordinators. The information is then processed to the quality department who coordinates service improvement processes that are presented to the Restraint Minimisation Steering group for sanction and monitoring whether the measures having been put in place have the anticipated outcomes.

The Mental Health and Addictions Directorate has established a Least Restrictive Practice Group that met twice in 2016. This group has working groups that respond to trends, such as the high rates of Maori on compulsory treatment orders, restrictive and coercive practices, assault reductions and workplace violence prevention. Another responsibility of this group is to reconcile the electronic restraint records against registers held on the wards.

Finding:

Mental Health and Addictions Directorate: The Less Restrictive Practices governance group has only met a few times in 2016. The group has not carried out the required six monthly restraint audits during 2016 as required by the Restraint Minimisation and Safe Practice policy.

Corrective Action:

Implement the restraint audits as per policy.

Timeframe (days): 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 2.3: Seclusion

Consumers receive services in the least restrictive manner.

Standard 2.3.1: Safe Seclusion Use (HDS(RMSP)S.2008:2.3.1)

Services demonstrate that all use of seclusion is for safety reasons only.

Attainment and Risk: FA

Evidence:

The seclusion policy and procedure is current, in line with the Ministry of Health guideline, best practice and legislation. Two clinical and seclusion records showed that seclusion occurred, for example, during an assault of a staff member and when patients' behaviour compromised other patients' safety. Practices reviewed through interviews with three staff and two patient records showed that seclusion was the last resort after all attempts to de-escalate had failed. The staff were aware that only patients under the Mental Health Act 1992 can be secluded. This requirement is documented in the seclusion policy and on the Guidance for the Seclusion Form.

The clinical notes and interviews showed that staff in collaboration with the patients explored triggers that set off behaviours that become unsafe. Either avoidance of the triggers or therapeutic interventions occurred. Sensory triggers and substance misuse after leave are two examples that had been identified as contributing to the patients' unsafe behaviours. In response, sensory considerations and alcohol and other drug interventions were offered to the patient.

The impact of seclusion on the patients was noted in the clinical records.

The latest national seclusion rates showed that Te Whetu Tawera has the lowest rates nationally.

Criterion 2.3.1.1 (HDS(RMSP)S.2008:2.3.1.1)

The service has policies and procedures on seclusion that meet the requirements contained in 'Seclusion under the Mental Health (Compulsory Assessment and Treatment Act 1992' (MoH).

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.1.2 (HDS(RMSP)S.2008:2.3.1.2)

Consumers are subject to the use of seclusion when there is an assessed risk to the safety of the consumer, to other consumers, service providers, or others.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.1.3 (HDS(RMSP)S.2008:2.3.1.3)

There exists a legal basis for each episode of seclusion.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.1.4 (HDS(RMSP)S.2008:2.3.1.4)

Any factors that may require caution must be assessed for each episode.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.1.5 (HDS(RMSP)S.2008:2.3.1.5)

The likely impact the use of seclusion will have on the consumer's recovery and therapeutic relationships is considered and documented.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 2.3.2: Approved Seclusion Rooms (HDS(RMSP)S.2008:2.3.2)

Seclusion only occurs in an approved and designated seclusion room.

Attainment and Risk: FA

Evidence:

One of the three seclusion rooms at Te Whetu Tawera has been de-commissioned. Patients at the Frazer McDonald unit are no longer secluded as the seclusion room there has been de-commissioned. The seclusion rooms at Te Whetu Tawera had windows to the outside. The rooms are part of the central heating, ventilation and air conditioning system of the unit.

A window to the staff area was of a dimension that allowed the patient to fully view the staff member observing. Seclusion rooms had a functioning call bell. The furnishing was safe and appropriate for seclusion rooms. The service had placed clocks in front of the seclusion windows so the patient was able to be oriented in time. This was indicating consideration and thoughtfulness as patients in seclusion often lose their sense of orientation.

Criterion 2.3.2.1 (HDS(RMSP)S.2008:2.3.2.1)

The seclusion room provides adequate lighting, room temperature, and ventilation.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.2.2 (HDS(RMSP)S.2008:2.3.2.2)

The seclusion room allows the observation of the consumer and allows the consumer to see the head and shoulders of the service provider.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.2.3 (HDS(RMSP)S.2008:2.3.2.3)

The seclusion room provides a means for the consumer to effectively call for attention.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 2.3.2.4 (HDS(RMSP)S.2008:2.3.2.4)

The seclusion room contains only furniture and fittings chosen to avoid the potential for harm.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

Attainment and Risk: FA

Evidence:

The Infection Prevention and Control Executive Committee (IPCEC) terms of reference, detail clear lines of accountability for infection control management. The monthly meetings of this committee are chaired by the chief nurse who will take issues to senior management and the board. The position descriptions for the infection prevention and control manager (IPCM) and the infection prevention and control nurse specialists (IPC CNS) details their responsibilities and accountabilities. The Infection Prevention Operational Plan outlines how the organisation plans to meet the requirements of the standard and is reviewed annually.

There are processes in place to ensure patients with infectious diseases are identified on admission. This is via the assessment process and alerts both on the national and the organisation's alert system. There are policies and procedures to manage patients with suspected and known infections. Both positive and negative pressure rooms are available and all areas have single rooms. Where patients are flagged on the system as having non-infectious multi-resistant organisms (MRO) there are policies on their management, including shared rooms. Signage is available to advice visitors with infectious diseases not to visit. Brochures are available on coughing etiquette, and on other infections such as MRO, extended spectrum beta-lactamases (ESBL) and clostridium difficile.

Infection control systems tracer: The identification and management of patients with multi resistant organisms (MRO) was reviewed in detail using systems tracer methodology. Visits to the neurosurgical area, general medical ward, and emergency department were undertaken. Two IPC CNSs, two clinical charge nurses, three RNs, and two cleaners were interviewed and observations made related to management of isolation, including the use of personal protective equipment and signage.

There are assessment processes in place for the identification of patients with possible MROs commencing in the emergency department. Patients with known infection risks have an alert on the patient management system, and the IPC CNSs stated they also have access to the national alert system. Confirmation by swabs occurs and patients are kept isolated until the results are known.

Practice was observed to be of a consistently good standard with contact precautions implemented and well understood by all staff. Good communication was evident between the nursing, IPC team and cleaning staff. Education, information brochures are available for staff and patients. Two patients in contact isolation were interviewed and they were aware of the reasons for isolation and stated relatives were also informed. Three additional isolation patients' records were reviewed and isolation practices found to be appropriately documented. Staff were very complimentary of the infection prevention teams prompt responsiveness and support

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

Attainment and Risk: FA

Evidence:

The IPCEC terms of reference, states the membership includes; a clinical microbiologist, infectious disease physician, public health, pharmacy, occupational health, directorate members and facilities staff such as cleaning services. This was confirmed by the lead microbiologist and IPCM. The infection prevention and control committee meet monthly. Surveillance data and audit results are discussed with monthly reports generated and providing analysis of any trends. An annual collated report of all activity, analysis, trends and recommendations is produced.

The infection prevention and control team is made up of experienced nurses of which three have a master's degree and all have held positions in infection control for some time. The IPCM oversees six IPC CNSs who have delegated responsibility for certain areas. The IPCM and IPC CNSs have access to laboratory staff and receive electronic test results on a daily basis. The IPC CNS work closely with the area specific RNs who have an infection control role, such as the hand hygiene champion. The IPC CNS visit the areas where infection cases are identified and provide support as well as monitor the activity occurring. This allows for ongoing education of staff and patients. Stickers were sighted in patient's notes identifying the type of precautions in place.

9.3

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

Attainment and Risk: FA

Evidence:

There is a wide range of policies, procedures and information documents, that are the responsibility of the IPC team and overseen by the IPCEC. The policies and procedures are reviewed every three years and reflected current good practice. Staff access the policies and procedures via the intranet which has an infection prevention and control specific site and is continually being updated to provide guidance on changes and advise on latest trends.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

Attainment and Risk: FA

Evidence:

All staff undertakes education at orientation. The online education was reviewed last year. Hand hygiene champions attend training regularly. The hand hygiene champions monitor levels of infection control compliance. IPC CNSs provide training to staff in an area when agreed with the clinical charge nurse and/or nurse educators. This was

confirmed by one clinical charge nurse who provided evidence of the recording of the infection control training. Education study days and sessions are offered to primary and community care services.

Two IPC CNSs described meeting with patients and providing information on their infection and precautions being taken and this was documented in the patients' notes. However, the patient, when spoken too, could not remember have received this information. Patient and staff information booklets were sighted for contact precautions.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA

Evidence:

A comprehensive surveillance programme is well established. Surveillance data is collected continuously. The IPC CNSs receive and follow up laboratory results of isolates of concern to facilitate a prompt and early response to possible outbreaks or change in prevalence. An electronic daily patient list contains alerts to the IPC team of patients with known organisms of concern and those in isolation. The IPC CNSs visit the clinical areas confirming correct isolation practice has been implemented and supporting staff to safely manage care.

Activities include surgical site infection reporting in accordance with the Health Quality and Safety Commission (HQSC) priorities, continually meeting the set targets. Hand hygiene is practised, with all areas having at least one gold hand hygiene co-ordinator carrying out ongoing audits. Hospital acquired blood stream infections (HABSI), including central line associated bacteraemia bundle (CLAB) are monitored. A project on water surveillance, following two cases of Legionella has seen an identification of water issues and continuous monitoring of water temperatures. No further cases of Legionella have been identified since the activities were commenced.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: CI

Evidence:

Discussions with the microbiologist, IPCM and two IPC CNS provided evidence of ongoing surveillance activity which is agreed annually by the IPCEG. The organisation has been proactive in its surveillance programme for many years.

Auckland DHB was the lead agency for the Minstry of Health National Quality Improvement Committee Infection Prevention and Control Programme and developed a set of recommendations for a National Surgical Site Infection Surveillance Programme. The SSI programme report in accordance with the Health Quality and Safety Commission (HCSC) priorities, continually exceeding the national targets. They have combined a focus on surgical site infections and the achievements of the Surgical Site Infection Improvement Programme with the promotion of its pilot project, 'Take a Moment' which is part of the hand hygiene quality improvement initiative.

Hand hygiene surveillance, is well established, with at least one gold hand hygiene champion/auditor in all areas. Surveillance activities show a high degree of compliance with the five moments of hand hygiene practice which is above the national target.

Monthly reports on healthcare associated bloodstream infections (HABSI), show trending down. The IPCM spoke of the changes they have put in place over time to achieve this. This included, the IPC CNS activities related to early identification of possible patients with or with suspected infections, managing these patients as an outreach team, supporting ward staff in the management of such patients, and providing education for staff, patients and families. Cleaning practice changes with a traffic light system of cleaning being undertaken based on infection risk.

A Water Quality Committee has been set up with an expanded terms of reference from the Legionella Technical Advisory Group (2014-15). This followed two patients identified as contacting Legionella as inpatients, one of whom died. The objective of the committee is to provide assurance that the quality of the water is appropriate for the environment, identify and instigate monitoring regimes and to link with the IPCEG. Reports show that the identification of elements in the water which are being monitored and that the sampling of Legionella levels meet national and international standards.

Finding:

National reporting on SSI shows high degrees of continued compliance. The April to June 2016 results shows of 171 arthroplasty procedures (hips and knees) one infection reported, with eight in the last 12 months. Compliance with the correct timing of antibiotic prophylaxis occurred in 97 percent of the procedures. The administration of the recommended prophylaxis antibiotics occurred 95 percent of patients and discontinuation of the antibiotic occurred 100 percent of the time. The use of the nationally agreed skin preparations occurred in 96 percent of procedures. The graphs for the last two years show Auckland DHB's compliance to be in the high 90s for all areas. The national reporting for cardiac surgery shows 261 procedures with eight SSIs identified a 3.1 percent. Compliance with timing of prophylaxis antibiotic is 93 percent, dosage of antibiotic 98 percent and timing 100 percent, skin preparation use 99 percent.

Hand hygiene compliance has a national target of 80 percent which was set in June 2015. The data for Auckland DHB shows for the fourth quarter of 2015 they had a rate of 81 percent. Figures for 2016 show 83 to 84 percent compliance overall and 88 percent compliance for Starship Children's hospital. Areas visited had hand hygiene trend data on show in corridors. The plans for world hand hygiene day 2016 are underway.

The IPC service provide a detailed monthly report on hospital acquired blood stream infections (HABS). This show trends for HABS rising on the whole with reductions in children over the last two years. Central line associated bacteraemia rates show a rate of 1.09/1000 central line days.

The reporting on water quality has shown that work to upgrade systems have been put in place and continual monitoring. The January 2017 monitoring shows all sites tested were within normal range. The IPC monthly report for February identifies water sampling occurring by an external company to national and international standards. The trigger point for reporting on Legionella levels have been identified

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 3.6: Antimicrobial usage (HDS(IPC)S.2008:3.6)

Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians.

Attainment and Risk: FA

Evidence:

An antimicrobial stewardship committee reports to the IPCEC. Medical staff are guided by policy and guideline to use appropriate and prudent prescribing. This includes online information and a smart phone application. An antimicrobial restricted list identifies a range of antimicrobials which need to be discussed with the infectious disease microbiologist prior to prescribing. All clinical pharmacists monitor the appropriateness of antimicrobial prescribing practices and regular auditing is occurring. An annual antibiogram is produced by the laboratory on an annual basis.

Criterion 3.6.1 (HDS(IPC)S.2008:3.6.1)

The organisation, medical practitioner or other prescriber has an antimicrobial policy which is consistent with the current accepted practice of prudent use in the treatment of infections.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.6.4 (HDS(IPC)S.2008:3.6.4)

Regular auditing and monitoring of compliance with prophylactic and therapeutic antimicrobial policies shall be a component of the facility's infection control programme.

Attainment and Risk: FA

Evidence:

Click here to enter text

Finding:

Click here to enter text

Corrective Action:

Click here to enter text

Timeframe (days): Choose an item *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

9.3

Resolution to exclude the public from the meeting

Recommendation

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies		That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. Register of Interest and Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 5 April 2017	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Circulated Resolution – Level 2 Clinical Decision Unit and Blood Bank Extension	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Action Points 5 April 2017	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

		withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Chief Executives Confidential Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Funder Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.1 Finance Risk and Assurance Committee Reports	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

7.2 Hospital Advisory Committee Reports	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.3 Community and Public Health Advisory Committee Reports	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.1 EPMO Development Proposal	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Change in Shared Commercial Banking Supplier	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.3 New Zealand Health Innovation Hub – Update Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act	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

	1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] **Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]	sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.3.1 New Zealand Health Innovation Hub – Directors Fees	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] **Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9. Discussion Reports – Nil	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.1 Northern Region Long Term Investment Plan Update	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

	and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	
10.2 Northern Region Health Plan 2017-2018	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]