Open Board Meeting

Wednesday, 22 February 2017

09:00am

Note:

- **Open Meeting from 9:00 am to 11:30am**
- **Public Excluded Session 11:30am to 12:30pm**

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

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Published 16 February 2017

Agenda
Meeting of the Board
22 February 2017

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

Time: 9:00am

Board Members	**Auckland DHB Executive Leadership**	
Dr Lester Levy (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Simon Bowen	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	Linda Wakeling	Chief of Intelligence and 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
	Auxilia Nyangoni	Deputy Chief Financial Officer
	Marlene Skelton	Corporate Business Manager
	Suzanne Stephenson	Acting Director Communications
	(Other staff members who attend for a particular item are named at the start of the respective minute)	

Apologies Members:

Apologies Staff:

Agenda

Please note that agenda times are estimates only

9:00am **1.** **ATTENDANCE AND APOLOGIES**

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 7 DECEMBER 2016**

9.10am **4.** **ACTION POINTS 7 DECEMBER 2016**

9.15am **5.** **CHAIRMAN'S REPORT** - Verbal

9.25am	**6.**	**CHIEF EXECUTIVE'S REPORT**
	7.	**COMMITTEE REPORTS -** Nil
9.40am	**8.**	**PERFORMANCE REPORTS**
	8.1	Health and Safety
	8.2	Financial Performance Report
	8.3	Funder Update Report
10.15am	**9.**	**DECISION REPORTS**
	9.1	Palliative Care Strategy Update
	9.2	Integrated Palliative Care - Agreement with Mercy Hospice
	9.3	Audit NZ Engagement Letter - PHO Audit
	9.4	Auckland DHB Authorised Banking Signatories
	9.5	Memorandum of Understanding between Child Youth and Family, Police and District Health Boards
	9.6	Health and Safety Policies for Approval
10.45am	**10.**	**EXENDITURE APPROVALS AND RECOMMENDATIONS**
	10.1	Dispensation request for Extension of Contract
	10.2	Perioperative Fleet Instruments 16/17
	10.3	Facilities Seeding Variation
	10.4	Workforce Central Upgrade
	11.	**DISCUSSION REPORTS - NIL**
11.15am	**12.**	**INFORMATION REPORTS**
	12.1	Human Resources Report
	12.2	Auckland DHB Employee Survey Results
	12.3	Statement of Performance Expectations (SPE) Performance Report: Q2 2016/17
	12.4	Manawa Tahi Programme - ISSP Update
11.30am	**13.**	**GENERAL BUSINESS**
	14.	**ITEMS TRANSFERRED FROM CONFIDENTIAL AGENDA TO OPEN AGENDA**
11.30am	**15.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Next Meeting:	Wednesday, 05 April 2017 at 9:00AM A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

Members	17 Feb. 16	30 March.16	11 May. 16	22 Jun. 16	03 Aug. 16	07 Sep. 16	26 Oct. 16	07 Dec. 16
Lester Levy (Chair)	1	1	1	1	1	1	1	1
Joanne Agnew	1	1	1	1	1	1	1	1
Doug Armstrong	1	1	1	1	1	1	1	1
Michelle Atkinson	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1
Judith Bassett	1	1	1	x	1	1	1	1
Zoe Brownlie	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1
James Le Fevre (Deputy Chair)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1
Lee Mathias	x	1	1	1	1	1	1	1
Robyn Northey	1	1	1	1	1	1	1	1
Gwen Tepania-Palmer	1	1	1	x	1	1	1	1
Sharon Shea	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1
		Key: 1 = present, x = absent, # = leave of absence						

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – 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) Leader reviewer – State Services Commission Performance Improvement Framework (current review of Ministry of Business Innovation and Employment). 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	07.12.2016
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	17.01.2017
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	16.01.2017

	Member - Association of Salaried Medical Specialists Shareholder - Pacific Edge Diagnostics Ltd Trustee - Three Harbours Health Foundation Wife - Medicolegal advisor, Medical Protection Society Wife – Employee Waitemata DHB Department of Anaesthesia and Perioperative Medicine	
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 Director – New Zealand Health Partnerships Member – New Zealand National Party	20.01.2017
Robyn NORTHEY	Trustee - A+ Charitable Trust Shareholder of Fisher & Paykel Healthcare Chair – Community Housing Foundation Husband - member Waitemata Local Board Husband – shareholder of Fisher & Paykel Healthcare Husband – shareholder of Fletcher Building Husband – Chair, Problem Gambling Foundation	07.12.2016
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 Member - Children's Action Plan Directorate Advisory Group Safe Communities Foundation NZ – Work on pilot outcomes 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 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	14.02.2017
Gwen TEPANIA-PALMER	Board Member - Manaia PHO Chair - Ngati Hine Health Trust Committee Member - Te Taitokerau Whanau Ora Committee Member - Lottery Northland Community Committee Member - Health Quality and Safety Commission	01.12.2016

Minutes
Meeting of the Board
07 December 2016

Minutes of the Auckland District Health Board meeting held on Wednesday, 07 December 2016 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 9:45am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Dr Lester Levy (Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Margaret Dotchin	Chief Nursing Officer
Doug Armstrong	Joanne Gibbs	Director Provider Services
Michelle Atkinson	Dr Debbie Holdsworth	Director of Funding – Auckland DHB/Waitemata DHB
Judith Bassett	Fiona Michel	Chief Human Resources Officer
Zoe Brownlie	Auxilia Nyangoni	Acting Chief Financial Officer
James Le Fevre (Deputy Board Chair)	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Dr Lee Mathias	Sue Waters	Chief Health Professions Officer
Robyn Northey	Dr Margaret Wilsher	Chief Medical Officer
Sharon Shea		
Gwen Tepania-Palmer	**Auckland DHB Senior Staff Present**	
	Abbas Al-Murrant	Health Economist, Health Gain Team, Planning, Funding and Outcomes
	Dr Karen Bartholomew	Clinical Director Health Gain
	Samantha Bennett	Asian, Migrant and Refugee Health Gain Manager
	Wendy Bennett	Planning and Health Intelligence Manager
	Dr Lifeng Zhou	Senior Epidemiologist and Asian Health Advisor
	Riki Nai Nai	General Manager, Maori Health
	Julia Peters	Auckland Regional Public Health Service Clinical Director
	Marlene Skelton	Corporate Business Manager
	Suzanne Stephenson	Acting Director Communications
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

Karakia and Mihimihi

Patrick Taylor, Kaumatua, gave a welcome to returning and new members of the Board.

1. ATTENDANCE AND APOLOGIES

That the apology of Linda Wakeling, Chief of Intelligence and Informatics, and Joanne Gibbs for early departure be received.

2. CONFLICTS OF INTEREST

The following amendments to the interests register were advised:

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

James Le Fevre added his membership of the Waitemata District Health Board.

Robyn Northey – advised further interests pertaining to her husband:
Chair of the Community Housing Foundation
Member Waitemata Local Board

Sharon Shea added her membership to the Auckland DHB/Waitemata DHB Maori Workforce Development Project and her husband's interest as a director of Healthcare Applications Ltd.

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

Sharon Shea, item 8.1 - Youth Connection Pledge.

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

Resolution: Moved Gwen Tepania-Palmer / Seconded Lee Mathias

That the minutes of the Board meeting held on 26 October 2016 be confirmed as a true and accurate record.

Carried

4. HEALTH AND SAFETY - NIL

5. ACTION POINTS 26 OCTOBER 2016 - NIL

There were no current action points to report on.

6. CHIEF EXECUTIVE'S REPORT (Pages 19-33)

6.1 Chief Executive's Report

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

- The Thai Ministry of Public Health visited on 15 November. The visit, to study public health/medical curriculum development and delivery, was at the request of Crown agent, Education New Zealand.
- A range of communication cards have been produced featuring a set of icons patients can use if they are having difficulty communicating their immediate needs, wants or concerns. A third of the community are not New Zealand born. A large percentage of this group do not speak English. These cards have been translated into 11 languages in an attempt to ease communication difficulties.
- The paragraph in our patient letters about changing or cancelling appointments has been printed in six languages - Māori, Tongan, Samoan, Hindi, Chinese and Korean. This initiative was developed as part of a Greenbelt project this year aimed to reduce DNAs (patients who don't attend their appointments) within Gynaecology Services. It has now been rolled out across all patient letters with the exception of those services which are still requesting an appointment confirmation.

- The Tāmaki Mental Health and Wellbeing Team facilitated a pōwhiri and blessing of the name Awhi Ora at Ruapotaka marae. This was well received with the community expressing appreciation of the District Health Boards involvement. A full report on on Tamaki is to come to the February 2017 Board meeting.
- Starship celebrations continue throughout the year to mark the 25th anniversary. The Starship Foundation has launched a special website www.starshipbirthday.co.nz On 18 November a cake cutting celebration at Starship was held.
- As part of the commitment to alleviate food poverty in the Auckland neighbourhood, District Health Board staff are donating non-perishable food items to the Auckland City Mission at as part of the Ka pai whānau programme to support the Mission's Santa's Helpers Appeal.
- Good progress is being made within the organisation around sustainability. The project has struck a cord with staff as can be seen by the initiatives outlined on page 22 of the agenda.
- Social media is being used as effectively as possible in the area of recruitment where a weekly roundup of new job postings is being provided.
- Health Excellence Awards and Allied Health, Scientific and Technical Awards ceremonies were held late November early December. Both were well attended and successful events.
- Ka Pai Whānau – saying thank you to our people, and giving thanks Ka Pai Whānau opened with a performance by the Aisda Muscionaries, a Filipino ensemble of multi-instrumentalists on Saturday 26 November. Ailsa commented that there is a need to have more such events in order to thank people.
- Ailsa drew attention to the new national health target around "Better Help for Smokers to Quit" and PHO enrolled patients where the current September status is 87% of a 90% target.

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

- Lee Mathias drew attention to the immunisation target and the reported figure of 79%, querying how the immunisation figures were being reported. She felt that a quarter upon quarter increase should be shown rather than saying 79% of the target had already been obtained. James Le Fevre replied that the Ministry of Health ultimately reports what data has been supplied to them by the District Health Boards themselves. There appears to be a need to have the three regional District Health Boards look at their data definitions to ensure that reporting is carried out in the same manner. Debbie Holdsworth advised that a concerted effort early in the quarter had been made to pick up all rising four year olds due for immunisation within both the Auckland Waitemata DHBs. This was why the figure was high at this point in the reporting year.
- Lester Levy asked for clarification over what was audited and the frequency with which it was audited in relation to data used for reporting on national health targets.

Jo Gibbs advised that proportional reporting existed with some internal auditing applied to select services. She was not aware that an external audit had been commissioned. Debbie Holdsworth advised that Regional Internal Audit had completed some work in this area. Lester Levy said that it would be prudent to have a report to the next meeting on the nature and level of internal and external scrutiny of the National Health targets.

Action

That a report be presented to the next Board meeting detailing the nature and level of internal and external scrutiny of the National Health targets.

That the Chief Executives report for November 2016 be received.

Carried

7. PERFORMANCE REPORTS

7.1 Financial Performance Report (Pages 34-39)

Auxilia Nyangoni, Acting Chief Financial Officer asked that the report be taken as read, highlighting as follows:

- The District Health Board financial result for October 2016 was a surplus of $1.3M which was unfavourable to budget by $607K. For the Year to Date (YTD), a deficit of $465K was realised, unfavourable to budget by $4.9M. This reflects a $12M unfavourable Provider arm result, partially offset by a $7M favourable Funder arm result.
- The unfavourable YTD Provider Arm result is driven by less revenue than planned ($6.8M) mainly reflecting under-delivery of elective volumes, ACC volumes below plan and lower interest and donation income than planned. Expenditure was also unfavourable ($5.2M) primarily in outsourced personnel, clinical supplies and infrastructure and non-clinical supplies costs as detailed on page 35 of the agenda.
- The full year plan is a surplus of $4.5M and is forecast to be achieved. However, this is dependent on the District Health Board resolving the IDF pricing issues with the help of the Ministry of Health and other DHBs, resolution of transplant funding issues and stepping up the realisation of the full savings included in the plan.

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

- Lee Mathias commented that a $16K favourable year end variance was extremely tight and that the savings plan would have to be monitored very closely. Ailsa Claire replied that the “Get on Track” initiatives had been performing extremely well. The situation had been exacerbated by the worsening revenue situation.

- In answer to Doug Armstrong's question as to whether all 52 graduate nurses were required, Margaret Dotchin advised that there was funding for two intakes and with a nursing force of 3,500 these nurses were required to address attrition. Margaret Wilsher advised that the situation with medical graduates was more complex where District Health Boards were obliged under the Multi-Employer Collective Agreement, (Meca) to take medical graduates and absorb them into the workforce.
- Robyn Northey drew attention to the Capex budget and asked whether it was on track to be spent. Lester Levy reminded members that in the last financial year 95% of the Capex budget was expended, that this was a significant improvement on past years and put Auckland DHB in a positive position compared to many other DHBs. Auxilia Nyangoni explained that the Finance, Risk and Assurance Committee had utilised a different prioritisation process for this financial year which had only been approved in October providing a later than normal start for the 2016/2017 Capital Expenditure Plan. The expectation is that expenditure will now come back on track as there are a number of projects having just started or are programmed to start in the next two months.
- Sharon Shea referred to page 34 of the agenda asking how realisation of savings was to be stepped up to address the $8.3M unfavourable financial income position. She was advised that action is already in place with "Get on track" initiatives around realisation of savings and that a portion of the unfavourable position is also related to phasing of income. Additional proposals are also being developed.

That the Board receives the Financial Report for October 2016

Carried

7.2 Funder Update Report (Pages 40-55)

Debbie Holdsworth, Director Funding asked that the report be taken as read, highlighting that the Annual Plan approach for 2017/2018 and the Statement of Performance Expectations (SPE) Reporting were addressed later in the agenda. She drew attention to and expressed a concern that the Rheumatic Fever target (as reported on page 47 of the agenda) was not being met despite considerable effort.

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

- Lee Mathias referred to page 48 of the agenda, item 6.1 and whether Auckland DHB were aware of the programme, "Handle the Jandal", run by young people , mostly of Pasifika decent, about dealing with Family Violence and if so, was it being utilised. She also queried whether in relation to item 6.3 on page 49 of the agenda what the effect was on the current CAD service in terms of location and management; was it being looked at in terms of being offered as one cohesive service. Debbie Holdsworth replied that the current focus was around gaining a better understanding of the addictions clinical workforce, which was a vulnerable one, and the existing service itself. Consideration would be given to one cohesive service.

- Judith Bassett was advised that Auckland DHB was working toward and as prepared as any other District Health Board to roll out from 1 April 2017, guaranteed hours for the Home and Community Support Services workers. Lester Levy asked what the implications for the Board would be if the rollout out was not met or not successful. Debbie advised that she was not in a position to answer at this time and would provide a detailed report to the Community and Public Health Advisory committee (CPHAC).
- It was asked in relation to the Child Health Action Plan whether there was any connection to, or cross-over with "Vicky". Debbie Holdsworth undertook to investigate.
- James Le Fevre complimented staff in relation to the good result being achieved with the cancer target as reported in item 2.1 on page 41.
- Lee Mathias commented that the District Health Board appeared to be in a position of driving the registration of Asian migrants with PHO's. Lee felt that PHO's were incentivised through a payment to do this for themselves.

That the Funder Update Report for November 2016 be received.

Carried

8. COMMITTEE REPORTS

Manawa Ora

8.1 Youth Connection Pledge (Pages 56-64)

Aroha Haggie, Māori Health Gain Manager, Planning, Funding and Outcomes introduced Riki Nai Nai, General Manager Maori Health. Aroha asked that the report be taken as read highlighting as follows:

- That there is potential for a Youth Employment Pledge partnership between Youth Connections, Waitemata District Health Board, and Auckland District Health Boards, which would support the achievement of the Waitemata and Auckland DHBs existing Māori Health Workforce Development Strategy.
- Youth Connections is an initiative championed by the Mayor and the Deputy Mayor of Auckland Council and is supported by Auckland Council, Tindall Foundation, Hugh Green Foundation and Auckland Airport Community Trust. Youth Connections works across the public and private sectors to collapse the space between work-ready young people and youth-ready employers.
- Signing up to this pledge means Auckland and Waitemata DHBs will work with Auckland Council and other organisations along the health workforce pipeline to build a strategic alliance and engagement with local boards, their Youth Connections teams and Auckland Tourism, Events and Economic Development (ATEED) to unblock the existing youth recruitment channels and identify ways to improve the supply chain by providing business expertise and insight.

- The Youth Employment Pledge partnership augments the current Rangitahi and Youth Assistance programmes.

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

- Judith Bassett commented that she strongly supported this initiative. She however was slightly dismayed by the way the profile of the Pacifika work force waxed and waned throughout the report. She felt an equal emphasis should be applied. Fiona Michel advised that the Pasifika workforce were considered as equally important and specific hard targets for both Maori and Pacifika were being developed.
- Gwen Tepania – Palmer advised that Manawa Ora Committee totally supported this paper. These initiatives are having a major impact within the community.
- Lester Levy wished to know if the commitment to and momentum for the project would continue with Auckland Council given there was a change in Mayor and Deputy Mayor. Aroha advised that funding had been allocated and confirmed for the next three years

Resolution: Moved James Le Fevre / Seconded Gwen Tepania-Palmer

1. That the Auckland District Health Board receives the report and recommendation from the Manawa Ora Committee

2. That the Board endorses the District Health Board becoming a Youth Employment Pledge Partner with Youth Connections.

Carried

[Secretarial note: Sharon Shea did not vote on this item.]

9. DECISION REPORTS

9.1 2017/2018 Annual Plan Approach (Pages 65-68)

Wendy Bennett, Planning and Health Intelligence Manager asked that the report be taken as read, advising that the consultation draft indicates some significant changes in terms of content and format for 2017/18 Plan. These changes are as detailed on page 66 of the agenda.

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

- Lester Levy expressed concern around the potential for the removal of the requirement for a Maori Health Plan. Wendy advised that District Health Boards had not been provided with any guidance as yet in relation to how health equity should be managed if this were to occur.
- Riki Nai Nai advised that Maori Health Gain were not supportive of the removal and would recommend retention of the Maori Health Plan with the same status it currently enjoyed. If it was removed then an explicit section in the Annual Plan, standardised nationally, would be required so that focus could be maintained on

Maori Health. Gwen Tepania-Palmer advised that other current legislation existed that dictated what should occur and the requirement was for a plan to be in existence. It is important that a consistent approach across the region is in place governing Maori health.

- Lester Levy advised that the Board, should the obligation to produce a Maori health Plan be removed, continue as previously and produce one and submit it even though it has not been asked for. It should be done as a region and sent signed giving it appropriate status and endorsing the importance of addressing health inequalities.
- A discussion was had around which agency is responsible for providing what services within the disability sector. It was requested that information be provided to members clarifying this.

Resolution: Moved Judith Bassett / Seconded Lee Mathias

That the Board:

1. Approve the approach to annual planning for 2017/18, including the timetable.

2. Note the national planning guidance, including updates and changes.

Carried

9.2 Statement of Performance Expectations (SPE) Reporting (Pages 69-71)

Wendy Bennett, Planning and Health Intelligence Manager asked that the report be taken as read.

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

- Lester Levy noting that many indicators were lagging and easy to measure but difficult to influence. There was a need to measure both leading and lagging indicators.
- Comment provided that the Appendix 1 graphs were descriptive and contained no interpretative comment.

Resolution: Moved James Le Fevre / Seconded Lee Mathias

That the Board:

1. Approves the proposed reporting framework and frequency; subject to feedback provided.

Notes:

2. That management will continue to work on the draft SPE scorecard

3. That management will develop a report to enable reporting against variance within the SPE scorecard

Carried

9.3 2015/2016 Quality Account (Pages 72-132)

Sue Waters, Chief Health Professions Officer asked that the report be taken as read, advising that this was the fourth Quality Report produced by the Board and it was the first time that it had been produced in-house thanks to the expertise of Suzanne Stephenson, Acting Director Communications. It accompanies the Annual Report and balances the fiscal view with a quality perspective.

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

- Sue Waters advised that this document was not subject to the same rigour and scrutiny that the annual report was and therefore not subject to external audit.
- Gwen Tepania-Palmer advised that as a member of the Health Quality and Safety Commission she could add that the Commission valued the work Auckland DHB was doing and she urged that it continue.
- Andrew Old advised that there would be a limited hard copy run of this document for public use. Cost had to be balanced against accessibility. The document was publically available on the District Health Board website. Since the website was relaunched it was attracting increased traffic. Andrew was confident that documents published here were reaching a greater number of people than previously. The document had also been optimised for access via smart phones.
- Lester Levy asked that consideration be given to how to advertise or profile this document more effectively.

Resolution: Moved Gwen Tepania-Palmer / Seconded Robyn Northey

That the 2015/2016 Quality Account report be approved.

Carried

9.4 Conflict of Interest Policy Approval (Pages 133-151)

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

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

- Lester Levy commented that the policy should be accompanied by a communications plan showing how it was to be put into effect within the organisation. Fiona Michel advised that this would be addressed next year when behavioural expectations were rolled out as part of the People Management Plan which provided the platform for what it means to work in this organisation.
- Lee Mathias cautioned that staff undertaking multiple roles, while interpreting a potential conflict acceptable within one role but not another, needed to understand a conflict applied across the board.
- James Le Fevre commented that there was a staggering naiveté around conflicts and staff cannot always see what constituted a conflict for themselves and needed assistance.

Resolution: Moved Sharon Shea / Seconded James Le Fevre

That the Board:

1. Approves the updated Conflict of Interest Policy for staff.

2. Notes that:

2.1. The Auckland DHB Conflict of Interest Policy has been reviewed as per audit and accounting standard requirements.

2.2. This Policy has been reviewed and updated to reflect changes to ensure alignment where necessary with the Waitemata DHB (WDHB) Conflict of Interest Policy.

2.3. The policy has been considered and endorsed by the Executive Leadership Team.

Carried

9.5 Strategic Relationship between the District Health Boards and the Accident Compensation Corporation (Pages 152-165)

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

Resolution: Moved Doug Armstrong / Seconded James Le Fevre

That the Auckland District Health Board gives approval for the Auckland DHB Chief Executive Officer to sign the Memorandum of Understanding with the Accident Compensation Corporation.

Carried

9.6 Establishment of Executive Committee of the Board During the Holiday Recess (Page 166)

Lester Levy, Board Chair advised that as in recent years, it is proposed that a small Executive Committee be formed so that it can be convened at short notice, should this be necessary, to conduct urgent business during the holiday recess.

Resolution: Moved Doug Armstrong / Seconded Jo Agnew

1. That the Board approve the establishment of an Executive Committee (under schedule 3 clause 38 of the New Zealand Public Health and Disability Act 2000) to consider any matters that require the urgent attention of the Board during the Christmas/ New Year Board recess.

2. That membership of the Committee is to comprise the Board Chair, the Deputy Board Chair, Lee Mathias, Gwen Tepania-Palmer Jo Agnew and Judith Bassett, with a quorum of three members (the Chair needs to be one of the three members).

3. **That the Executive Committee be given delegated authority to make decisions on the Board's behalf relating to the urgent approval of business cases, leases and the awarding of contracts for facilities development, services and supplies and information services and on any other urgent recommendations from a Committee or the Chief Executive (same arrangements as last year).**

4. **That all decisions made by the Executive Committee be reported back to the Board at its meeting on 22 February 2017.**

5. **That the Executive Committee be dissolved as at 22 February 2017.**

Carried

9.7 Appointment of Chair for Hospital Advisory Committee and Finance, Risk and Assurance Committee

Lester Levy, Board Chair advised that for the purposes of the 7 December 2016, Hospital Advisory Committee meeting, all members of the Board be appointed as members of that committee and that Judith Bassett be appointed as the chair.

The committee structure and membership would be considered in the early new year.

Resolution: Moved Gwen Tepania-Palmer / Seconded James Le Fevre

That all members of the Board be appointed as members of the Hospital Advisory Committee and that Judith Bassett be appointed as the chair for the purposes of the 7 December 2016 meeting.

Carried

10. DISCUSSION PAPERS (Pages 167 - 183)

10.1 A Value of Care Approach to Auckland DHB (Pages 167-176)

Dr Karen Bartholomew, Clinical Director, Health Gain Team, Planning, Funding and Outcomes and Abbas Al-Murrant, Health Economist, Health Gain Team, Planning, Funding and Outcomes asked that the report be taken as read, outlining as follows:

A Value of Care approach is a systematic way to examine health outcomes and costs for population groups within services. It can be used for quality improvement, reducing costs and to more intentionally and transparently decide about the right mix of services and programmes for the population based on what they value and the benefit services can generate for them.

A Value of Care approach aligns with Auckland DHB vision, strategic themes (particularly intelligence, insight and patient and whānau centred care) and areas of focus, as well as articulated future direction. Using the Hospital Wisely, innovation and quality improvement,

the District Health Board values development (and valuing of our staff), care redesign, care coordination, patient self-management and whole-of-system management. There are also opportunities in this work for further development of academic partnerships and research, for example on the applicability of international tools for priority population groups such as Māori, Pacific, people with English as a second language and people with low health literacy.

This is a cost conscious data-driven approach that centres on outcomes that matter to patients. Currently health outcomes data is not collected in a systematic or accessible way. Investment in this approach would be required and further exploration is proposed in order to inform investment parameters and future direction.

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

- Lester Levy asked how the information provided here would be utilised should this path be followed. Ailsa Claire advised that it was a value proposition in relation to patients. At this point it was a proposal to get conversation started so that budgetary considerations could be raised in time for next year's budget.
- Abbas Al-Murrant advised that the approach was about using money that already exists more effectively and efficiently. Lester Levy concurred that there was a need to get better at this and using funding in the best possible manner. He cautioned against overlooking the Ministry of Health or the Boards own strategic themes when prioritising. The key was to unlocking funding that existed across the region in duplicated or triplicated services. Done correctly this could reduce GDP on expenditure and allow the board to gain more from what it was granted.
- Ailsa Claire advised that close consideration needed to be given to treating this like programme budgeting where an understanding of end to end expenditure was gained. If a shift in expenditure was promoted then it needed to be clearly understood what the total effect would be. There would be a need to be selective in what was done.

That the Board hold a workshop in February 2017 to discuss the value of care approach

Carried

10.2 Auckland DHB Programme Management Update on EPMO Development, Programme Identification and Definition (Pages 177-183)

Dr Andrew Old Chief of Strategy, Participation and Improvement asked that the report be taken as read, highlighting as follows:

- The development of programme management, and strategic programmes began in 2016 to address the recommendations arising from the Board and the Treasury's Investor Confidence Rating (ICR) assessment process.
- More rigour is being provided around discretionary project management. Work has commenced with an external assessor to ensure that the right things are being done.

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

- Lester Levy commented that it was necessary to gain real alignment between the three regional District Health Boards as an opportunity existed to save money collectively through this process.
- Ailsa Claire agreed saying that alignment was the aim otherwise District Health Boards would just end up having parallel conversations.

Resolution: Moved Gwen Tepania-Palmer / Seconded Jo Agnew

That the Board:

1. **Receives the Auckland DHB Programme Management Update on EPMO Development, Programme Identification and Definition report.**
2. **Notes the progress and status of the Portfolio, Programme and Project Management approach for Auckland DHB and takes steps to align this across metropolitan Auckland**

Carried

11 INFORMATION PAPERS

11.1 Auckland Water Supply – Update (Pages 184-190)

Julia Peters, Auckland Regional Public Health Service Clinical Director asked that the report be taken as read highlighting that the recent contamination of Havelock North's water supply has led to a central government inquiry into the incident. The level of risk inherent in Havelock North's drinking water supply does not exist in Auckland's reticulated drinking water system due to the treatment of all raw water (not just bore water), including chlorination.

Approximately 95% of the population of the region covered by the three Auckland DHBs are on a Watercare reticulated (piped) supply. This covers the majority of metropolitan Auckland, and all the satellite towns.

Only Waiheke and Great Barrier Island do not have a reticulated system. In New Zealand, statutory control of an individual water supply (i.e. self-supplier) falls under the Health Act 1956 and the Building Act 2004. The Building Act requires premises to be provided with potable water for consumption, oral hygiene, utensil washing and food preparation. Local authorities have obligations under the Building Act and Health Act to ensure that water being supplied to those buildings is potable.

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

- Doug Armstrong was advised that the public on non- reticulated water supply could access information about water quality from the Ministry of Health and Auckland Regional Public Health Services own websites.

Resolution: Moved Gwen Tepania-Palmer / Seconded Lee Mathias

That the Board:

1. **Receive the Auckland Water Supply report.**
2. **Note the nature of Auckland's reticulated drinking water supply (as delivered by Watercare Services Limited), including the infrastructure, the monitoring and treatment undertaken, and procedures developed to respond to a contamination incident.**
3. **Note that the level of risk inherent in Havelock North's drinking water supply does not exist in Auckland's reticulated drinking water supply due to the treatment of all raw water, including chlorination.**
4. **Note that if contamination of a water source occurs, Watercare has the ability to isolate the affected source(s) supplying the metropolitan area, and redistribute clean water from other parts of the network.**

Carried

11.2 International Benchmarking of Asian Health Outcomes for Waitemata and Auckland DHBs (Pages 191-328)

Dr Debbie Holdsworth, Director Funding, Samantha Bennett, Asian, Migrant and Refugee Health Gain Manager and Dr Lifeng Zhou, Senior Epidemiologist and Asian Health Advisor were in attendance to present the report, asking that it be taken as read.

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

- Lester Levy asked, in a practical applied sense, what the next steps would be in utilising this information. Debbie Holdsworth advised that the information would be considered by sub groups and a programme action plan would be reported back via the Community and Public Health Advisory committee and as part of the Funder update to the Board. However, a specific action plan could be supplied to the Board.
- Doug Armstrong asked whether the effort was worth it in terms of being equitable to other populations. Lee Mathias felt that it was important to have a better understanding of the different sub groups making up the Asian population. Within Auckland this group was one that posed many challenges in providing an efficient and effective healthcare service.

That the International Benchmarking of Asian Health Outcomes for Waitemata and Auckland DHBs report be received.

Carried

12 GENERAL BUSINESS

There was none.

13 RESOLUTION TO EXCLUDE THE PUBLIC

Resolution: Moved Robyn Northey / Seconded James Le Fevre

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. Confirmation of Confidential Minutes 26 October 2016	**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]
1.1 Confirmation of Circulated Resolution – Contract for the Provision of Specialist Paediatric and Adolescent Rehabilitation	**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]
2. Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Action Points 26 October 2016	**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]
3.1 Placement Orders – verbal update	**Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4.1 Health and Safety Performance Report	**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. **Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	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 Executive's Confidential Report	**Prevent improper gain** Information contained in this report could be used for improper gain or advantage if made public at this time. **Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	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 Auckland DHB Strategy – Next Steps – Presentation **[This item was withdrawn from the agenda]**	**Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	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 Capital Expenditure Budget for 2016/2017	**Prevent improper gain** Information contained in this report could be used for improper gain or advantage if made public at this time. **Prevent prejudice to commercial activities**	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

	Information contained in this report relates to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public. **Free and frank opinion** This paper contains free and frank expression of opinions by management to the board	[NZPH&D Act 2000]
7.2 Pre School Active Families and Green Prescription Procurement	**Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would prejudice or disadvantage Auckland DHB if made public at this time. **Prevent improper gain** Information contained in this report could be used for improper gain or advantage if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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 Auckland DHB Business Objects Upgrade Business Case	**Commercial information** A trade secret is incorporated in this report or publication and publication would unreasonably prejudice the commercial position of the external party **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would prejudice or disadvantage Auckland DHB if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.4 Variation Request for	**Commercial information** A trade secret is incorporated in	That the public conduct of the whole or the relevant part of the

the Child and Family Unit Project	this report or publication and publication would unreasonably prejudice the commercial position of the external party **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would prejudice or disadvantage Auckland DHB if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	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]
7.5 CSSD Single Instrument Tracking Project	**Commercial information** A trade secret is incorporated in this report or publication and publication would unreasonably prejudice the commercial position of the external party **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would n prejudice or disadvantage Auckland DHB if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.6 Auckland city Hospital New Substation	**Commercial information** A trade secret is incorporated in this report or publication and publication would unreasonably prejudice the commercial position of the external party **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would n prejudice or disadvantage Auckland DHB if made public at this time. **Prevent prejudice to commercial**	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]

	activities Information contained in this report relates to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	
8.1 Human Resources Update	**Privacy of persons** Information relating to natural person(s) either living or deceased is enclosed in this report. **Prevent improper gain** Information contained in this report could be used for improper gain or advantage if made public at this time. **Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	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 Voluntary Exit Policy	**Prevent improper gain** Information contained in this report could be used for improper gain or advantage if made public at this time. **Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	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 CT Scanner Upgrade for the National Forensic Pathology Service	**Commercial information** A trade secret is incorporated in this report or publication and publication would unreasonably prejudice the commercial position of the external party. **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and it would prejudice or disadvantage Auckland DHB if made public at this time. **Prevent prejudice to commercial activities** Information contained in this report relates to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

9.2 Approval for payments for C-Class Shares in healthAlliance	**Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.1 Collaboration Minutes Collaboration Committee dated 29 June 2016 Minutes Collaboration Committee dated 10 August 2016	**Free and frank opinion** This paper contains free and frank expression of opinions by management to the board.	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Carried

The meeting closed at 2.20pm.

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

Chair: _____ Date: _____

Lester Levy

Action Points from 22 February 2017 Open Board Meeting

As at Wednesday, 22 February 2017

Meeting and Item	Detail of Action	Designated to	Action by
7 December 2016 Item 6.1	**National Targets** That a report be presented to the February Board meeting detailing the nature and level of internal and external scrutiny	Ailsa Claire	This is included in the CEO report (item 5.1)

Chief Executive's Report

Recommendation

That the report of the Chief Executive for February 2017 be received.

Prepared by: Ailsa Claire (Chief Executive)

Glossary

1. Introduction

This report covers the period from 21 November 2016 to 3 February, 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

2.1.1 Ministerial Visits

Minister Coleman visited Auckland DHB on Friday 3 February to meet with stroke treatment clinicians Dr Stefan Brew (Neuroradiologist) and Dr Alan Barber (Neurologist), as well as stroke survivor Katrina Wheatley. Media were invited to join them for a short presentation and interview opportunity on the innovative stroke retrieval technique to remove clots from the brain as profiled recently in the NZ Listener.

Pictured: Stroke patients Kaumolangi Mausia and family, and Katrina Wheatley mid-TV interview.

2.2 DHB Board

During his visit on 3 February, Minister Coleman also met with the Auckland, Waitemata and Counties Manukau chair, Dr Lester Levy, as well as appointed and elected board members of the three Auckland region DHBs.

The following message from the chair was published for all staff of the three Auckland region DHBs:

2 February 2017

Dear colleagues

Being appointed as Chair of the three metro Auckland DHBs, is on the one hand, a very serious responsibility, but on the other hand is also a very significant opportunity. The simple reason I was willing to take on this responsibility is my assessment of the depth of the opportunity. I believe we can to do so much more for the population we have been entrusted to care for if we work together much more closely.

I would like to explain what I mean by doing more for our population and what working together much more closely actually means.

From my perspective, doing more for our population means significantly increasing the focus on health outcomes as well as the continuous drive for quality improvement, while providing much greater value for money. The latter is not simply to 'balance the books' but rather to create the essential capacity to further improve access to services, to better address health inequities and to ease our transition into the rapidly approaching digital world.

From the outset I would like to be clear that there is no intention to physically amalgamate the three metro Auckland DHBs. Rather, the three metro Auckland DHBs will work together much more closely as an integrated system as opposed to individually and in siloes. Each of the three metro Auckland DHBs will continue to operate with its own Board but there will be changes to both our approach and priorities as we develop an operating model that supports a more integrated system across metro Auckland. As an integrated system is being developed the underlying decisions will be based on evidence that is objective and robust.

The three metro Auckland DHBs are currently performing well but face a number of very significant challenges, including unprecedented population growth, rapidly changing demographics and accelerating technological change. The latter, some examples of which are genomic (personalised) medicine, mobile technology, nanotechnology, artificial intelligence, big data analytics, the cloud and social media, will inevitably (and much more quickly than we think) disrupt much of what we regard as conventional practice today. Parallels in other sectors are Uber and Airbnb and how they are revolutionising the global passenger-carrying and accommodation sectors.

The three metro Auckland DHBs have an experienced, highly skilled and very well-trained workforce. We have clever and capable partners in academia and the community, modern (or modernising) equipment and facilities and a developing focus on organisational purpose, culture and innovation. Purpose and culture are crucial – we must put patients and community much more explicitly at the heart of what we do and why we do it.

To ensure we take complete advantage of this new opportunity and extract the full potential from the positive elements we already have, we will need to collectively move away from silo thinking and working, from defensive attitudes and vested interests and from reluctance to change and unwillingness to collaborate.

Rather, we need to be open to new possibilities, to question how things can be improved and then actually change, not just plan to change. We need to share and adopt the best of each DHB and create the mindset, capacity and will for enduring change.

Making the metro Auckland DHBs the best funder and provider of healthcare possible for Aucklanders and New Zealanders will require a concerted, highly collaborative effort by all of us. My approach in leading this effort will be open and transparent and I will continue to regularly communicate on progress to all staff of our three DHBs.

While the period ahead will not be 'business as usual' as we currently know it, it will be an inspiring opportunity to further improve the care to our communities. Within our three DHBs, I believe we have the expertise and the courage to make positive change, even if this involves challenging ourselves to work in new and different ways.

With kind regards

Lester

Dr Lester Levy
Chair of Auckland DHB, Counties Manukau DHB and Waitemata DHB

2.3 Patient and Community

2.3.1 Acknowledgements

North & South editor Virginia Larson personally experienced Auckland City Hospital emergency department over the holiday period with her son. The magazine featured a full page editorial in the February 2017 issue:

Editorial

"In current affairs journalism, we often have to focus on what's *not* working in society. But the privilege of having a public forum like this means we get to toss some bouquets as well."

PEAK PRACTICE

Virginia Larson

I'm not a superstitious person, but there'll be no joking next December about who in the family is going to end up in a hospital emergency department over the Christmas-New Year holiday. We're really not an accident-prone bunch, and we're insured to the eyeballs, in part to avoid burdening the public health system when we can afford private care. And still, in the past five years we've enjoyed only one Accident and Emergency-free festive season. So far the Christmas Grinch has appeared as a meningitis scare, an abdominal hernia, a catheter-level urinary infection and, this recent summer holiday, a nose bleed of Hollywood splatter-movie proportions.

Our son's nose woes turned into a two-trip medical crisis, in fact – just before and after Christmas – the first being the most dramatic. A week earlier, he'd had scar tissue excised, at a private hospital, following a 2014 operation to straighten his nasal passages. What caused a blood vessel to burst remains a mystery, but at 6am we were on our way to Auckland Hospital with our son pouring blood into a towel. By the time we'd been whisked through triage, there was blood gurgling out his mouth and nostrils and coursing down his throat.

It was almost as alarming for his parents, watching as the ED doctor and nurses wrangled suction tubes and bleed-seeking scopes. After half an hour of partially successful padding and probing, the chief fixer turned up in the form of consulting otolaryngologist Dr Richard Douglas, dressed for action in shorts and cross-trainers, with specialised equipment and a patter of such positive reinforcement, everybody relaxed. Safely cauterised, though drained and achy, the patient was wheeled to a ward for 24-hour observation.

We were back at the ED a week later because our son was still tasting blood in the back of his throat and was just 48 hours out from a flight to China. It was a 6pm visit this time, probably too early for the drunks and brawlers, but again we didn't wait long to be seen by a cheerful Scottish-speaking ED doctor, then about an hour later, an otolaryngologist in blue scrubs, who introduced himself simply as "Ravi". Dr Ravi Jain, actually, because Google is a wonderful thing and I found his full name and accomplishments online after he led our son off for an examination.

Maybe young Dr Jain has been channelling one of my hero medico-writers, Atul Gawande; maybe he's a follower of Jainism, an ancient belief system which advocates that all living things be treated with the same respect and compassion, including worried middle-class parents. But he radiated a supreme calm and quiet confidence – "he's chill," as summed up by the patient.

He explained how he'd removed some residual tissue that had been causing the blood-specked mucous, said everything was otherwise healing nicely, answered all our questions and never acted as though we were wasting his precious time.

And honestly, I never heard an impatient word on the ED floor on either visit. That evening in the adjacent examination booths were two elderly women, one with advanced dementia, who kept wandering off; the other amiably confused.

"Just stay here, my darlin'," said the Scottish doctor to the Wanderer, by then fitted with non-slip hospital socks. "I'll get you a cup of tea." She was off again, so an orderly was brought in to sit with her. There was no conversation for him to follow, just unconnected ramblings, but he was unfailingly responsive and respectful.

Amiably Confused then piped up: "I had a fall, little stones... they've X-rayed my head, they've X-rayed my ears... I need to catch the bus to Waterview. Where are we?" It was patiently explained to her that she'd be staying in hospital overnight and told not to worry about the laundry bill after she expressed concerns about the extra sheets.

I know we all pay the public health bill – laundry included. I know our hospitals sometimes let people down. But overwhelmingly, the doctors, nurses and their helpers deliver skilled care and kindness, even to the demented, difficult and occasionally downright dangerous.

In current affairs journalism, we often have to focus on what's not working in society. But the privilege of having a public forum like this means we get to toss some bouquets as well. So thank you to the ED staff at Auckland Hospital who landed the holiday shift and helped the sick and wounded with such good grace. When I'm sure you'd have rather been home celebrating with your families – thank you for being, well, pretty darned chill.

NORTH&SOUTH

COVER CREDITS

The holiday season prompted a number of other patients to talk about their experiences, as received in this Christmas card:

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, 124 emails were received. Forty-three 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 125 requests for information, interviews or for access from media organisations between 21 November 2016 and 3 February, 2017. Media queries included requests for information about regional figures for organ donation, an interview request from TVNZ Sunday regarding women's health, requests to interview a spokesperson about the RMO strike, and a request to interview a spokesperson about the Tāmaki Mental Health & Wellbeing Initiative.

Approximately 38 per cent of the enquiries over this period sought the status of patients admitted following road accidents and other incidents or who were of interest because of their public profile.

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

2.4.2 Internal

- Two CE blog posts were published, one a celebratory end-of-year message, the other a welcome to 2017 message.
- 25 news updates were published on the DHB intranet.
- 9 eNova (weekly electronic newsletters) were published.
- An '*In the know*' session took place on 9 December, with approximately 85 managers attending.

2.4.3 Events and Campaigns

Sustainability in the Health Sector Symposium

Sustainability in the health sector was the topic of this year's Sustainability Symposium held on 8 December 2016 at Auckland City Hospital.

As a large energy user and generator of waste, Auckland DHB is actively working to improve its carbon footprint. With a sustainability programme that is growing from strength to strength, we saw a 13 per cent reduction in carbon emissions last year from that of the previous year.

This success was acknowledged by Ann Smith, CEO, Enviro-Mark Solutions, in her opening address at the Symposium. She said: "Climate change is going to be one of the biggest impacts on the health sector. The health sector itself has the largest footprint in the public service, and seeing the sector take leadership and encourage others to take action is really great."

The first Sustainability Symposium for the 2017 year is on 24 February, when Councillor Penny Hulse, Chair of the Environment and Community Committee will present.

Auckland City Mission Christmas Appeal

Late last year we set ourselves a target of an item per staff member for donations to the Auckland City Mission Appeal for those in need. 10,000 staff meant we suggested 10,000 items of household grocery items – tinned food and the like. We were delighted with the response with a total of 10,700 items. The Auckland DHB staff generosity moved the team at the Mission. The staff response was something we can all be immensely proud of.

A City Mission volunteer collects donations from ACH.

Ka Pai Whanau

We give thanks to the family that is our staff, patients and whanau with celebratory events and musical offerings each year in the weeks before Christmas. These are promoted under the banner of Ka Pai Whanau ("Thanks, family"). Our social media section below shows a selection of images. The numbers behind these are:

- 1 x ward-carolling night featuring nine community choirs
- 1 Royal NZ Navy Dixie Band performance
- 8 x separate choir performances for staff and visitors
- 500 Planet Espresso coffee gift cards for staff
- 1 x NZ Police Dog Squad visit to ACH
- 2 x MPI Border Protection Dog Squad visits to SSH
- 1 x Bollywood Dance Troupe Performance
- 1 x Filipino Traditional music ensemble performance from Aisda Muscionaries
- 1 x pop-duo performance from Bex and Michael
- Young Investigators Award
- Safekids child safety expo
- 2016 Health Excellence Awards (detail follows)
- A Festschrift for Emeritus Professor Bryan Parry

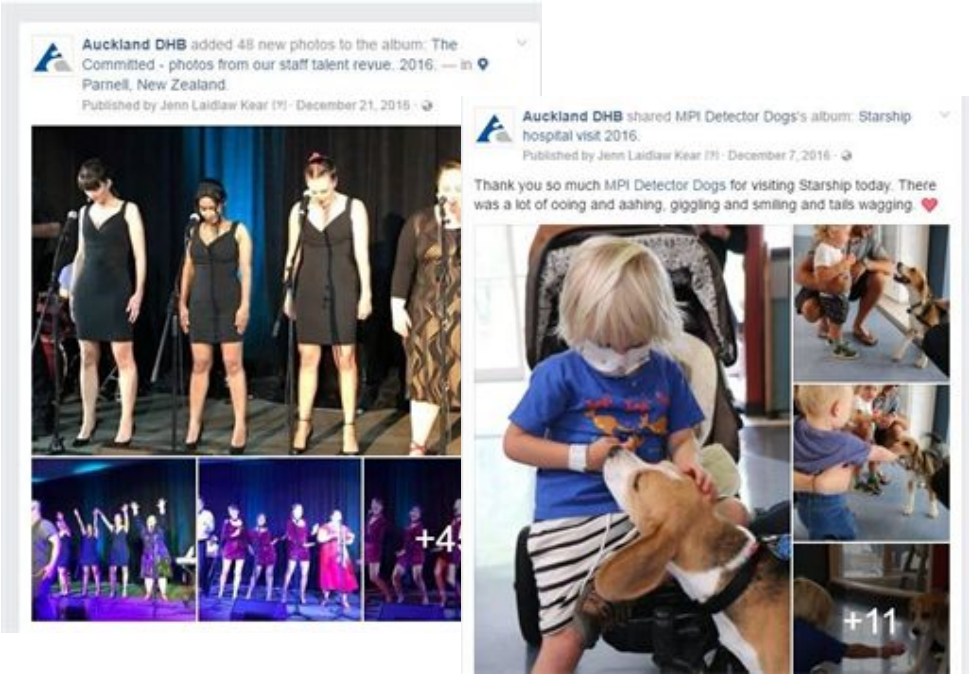
2.4.4 Social Media

Facebook likes: 4,170
Twitter followers: 2,804
LinkedIn followers: 5,538
Instagram followers: 166

Feature Campaign – Ka Pai Whanau

We had a number of events scheduled around our sites during the first two weeks of December for the third annual Ka Pai Whanau.

To date we reached a potential audience of more than 52,565 with an engagement rate of 5% for the campaign. (High engagement rate for corporate/organisational social media accounts is +2%).



Feature Post

The top social media post on any channel during this period was our Facebook album of photos from the ward Christmas decorating competition. This single post reached a potential audience of more than 18,000 people with an engagement rate of 14%.

Our people

- Rangatahi HR Award nomination
- Starship Stars
- RMO strike notice
- Tamaki

-

Organisational

- Bike Challenge
- Sustainability Symposium videos now online

Patient experience

- #patientexperience letters

Public health alert or education

- Green prescription
- Health ageing strategy

-

Campaigns

- Health star Rating
- Measles vaccinations
- Don't Drink While Pregnant
- Make your Home a Safety Zone
- #FizzFree
- #BeaBro
- Quitline
- Sun Tips
- Water Safety
- The Lowdown youth mental health messages

-

Recruitment

- Weekly round-up of new job postings

2.4.5 Our People

Local Heroes

25 people were nominated for Local Hero awards in December and January.

Godson Johnson was chosen as our December local hero.
Godson received three nominations:
"I have received a second compliment on the care that Godson has delivered in recent months. The most recent email showed that Godson most certainly demonstrates the values of Auckland DHB..." - *Colleague*
"Godson practices patient-first care. We are receiving very good feedback on the service that he provides from patients and their family. One patient even asked if Godson could come and see him back in the ward as he enjoyed the conversation that they shared. Godson made them feel important and that resulted in a positive patient experience while staying in Auckland City Hospital." - *Colleague*
"He is wonderful and always puts me at ease and smiles, hence I've nick-named him Smiley!! A very dedicated member of staff." – *Patient*

Two January local heroes were chosen: Nikki Mills and Helena Whyte.

The colleague who nominated **Helena** said: "Helena is a senior staff nurse in APU. She brought 120 appreciation gifts for the staff (from fundraising she organised throughout the year). She makes beautiful baskets for raffles; she supplies condiments and appliances for the staff tea room; she is part of the social committee and buys cards and thoughtful gifts for staff leaving, babies born, bereavements, weddings, and engagements. She does a tremendous amount (behind the scenes) that goes unnoticed and we would love her efforts to be acknowledged and to show her we really care."

Nikki was nominated by a staff member who said: "I was in a very difficult situation. Before I went home, I had to try to help a mother and baby who needed specialist help so that the staff over the weekend were not faced with a bigger challenge. Nikki answered the phone (on her day off) and without hesitation (even though it was now 6.30pm) she came to the ward. Her manner was empathetic, compassionate and above all highly skilled and professional. Nikki listened intently, explained everything, and with consent and discussion performed the procedure. The woman and her partner were thrilled and very grateful. The night staff were also grateful, as without intervention this would have made their job exceedingly challenging. This was an outstanding act of human kindness for a mother and baby in need."

Speak Up Kaua ē patu wairua

Speak Up launched to managers in November. It is a programme of work, led by Clinical Director Dr Arend Merrie, to encourage people to speak up if they see or experience harassment, discrimination or bullying. It puts in place support throughout the process when people do speak up and provides a strong endorsement of the value of respect in our culture. Above all it reinforces how respect flows through to positive patient outcomes.

24/7 Hospital Functioning Model of Care and Structure

The 24/7 Hospital Functioning Model of Care and Structure decision document was released on 13 February 2017. The new operating model will ensure the Auckland City Hospital site functions with optimal safety and effectiveness, seven days a week, 24 hours a day, 365 days a year.

The model was proposed in November 2016 and feedback was requested throughout a consultation period, where submissions were received from both internal and external stakeholders, including individual employees, employee teams, and the New Zealand Nurses Organisation. An email briefing regarding the consultation was circulated to the Hospital Advisory Committee in November and an update was provided at the December meeting.

As well as introducing a Patient at Risk model for timely identification and escalation of care for deteriorating patients, the new model will establish simpler bed management processes that are more integrated with the clinical frontline.

The new model will introduce Clinical Nurse Managers to strengthen clinical leadership and clinical support, as well as contribute to hospital management. The changes will make the hospital safer, give our staff better support, and enable more efficient bed management. They will also allow us to continue to successfully provide the right treatment, at the right time, in the right place, for our patients.

The new model is set to be in place by winter 2017 and will see an increase in total full-time equivalent employee numbers, in order to improve patient safety and provide more support, particularly after-hours. Those whose roles will be changing have been notified, and our aim is to find them alternative positions within the new model of care.

A steering group has been established to oversee the changes and ensure the transition is as smooth as possible for all involved.

Health Excellence Awards

The 2016 Health Excellence Awards took place on 1 December at Auckland War Memorial Museum. More than forty applications were received across five categories. The finalists and winners for the Awards can be viewed on our website here: http://www.adhb.health.nz/health-professionals/health-excellence-awards/2016-winners-gallery/








Inaugural Allied Health, Scientific and Technical Awards

Congratulations to all finalists and winners of Auckland DHB's inaugural Allied Health Scientific and Technical Awards which took place on 22 November 2016. It was a great night to celebrate the achievements that this significant workforce of 49 professions and approximately 1,800 people make to the organisation. The Awards were generously sponsored by A+ Trust.

Many commented on how much they appreciated the remarks made by executive and senior leaders on the night, whether receiving an award or not. Others reflected that they themselves didn't realise the diversity of professions in Allied Health, Scientific and Technical until the evening itself.

"A lovely experience"
"So proud to see colleagues getting awards and being recognised"
"Great to see the breadth of the professions in this grouping and learn about what they do when they are not in clinical service you work in…"
"Fantastic event for AHS&T to be brought together with academic partners – maybe we could provide an award next year…."
"Fabulous venue and celebration"

Health and Wellness

To continue to support the health and wellbeing of our employees, gym memberships are available all staff, free for those earning $55k or less, and available for all others at a highly subsidised rate of $100 per year.

There are also free Bootcamp sessions held twice weekly for all staff at the Domain and at Greenlane.

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary[1]

	Status	Comment
Acute patient flow (ED 6 hr)		Dec 94%, Target 95%
Improved access to elective surgery (YTD)		95% to plan for the year, Target 100%
Faster cancer treatment		Dec 87.8%, Target 85%
Better help for smokers to quit:		
• Hospital patients		Dec 95.64%, Target 95%
• PHO enrolled patients		Sep Qtr 87%, Target 90%
• Pregnant women registered with DHB-employed midwife or lead maternity		Sep Qtr 98%, Target 90%
Raising healthy kids		Dec 98%, Target 95%
Increased immunisation 8 months		Dec Qtr 95%, Target 95%

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

[1] 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**			
	Waitemata DHB	93	95	96	95	97			
	Counties Manukau	95	95	96	96	96			
	All DHBs	92	94	94	94	93			
 The volume of elective surgery will be increased by an average of 4000 discharges per year.	**Auckland DHB**	**93**	**98**	**98**	**101**	**93**			
	Waitemata DHB	101	101	102	106	105			
	Counties Manukau	99	103	105	109	110			
	All DHBs	104	105	106	108	105			
 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**			
	Waitemata DHB	74	68	70	75	86			
	Counties Manukau	70	72	70	74	75			
	All DHBs	69	75	75	74	78			
 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**			
	Waitemata DHB	93	95	93	92	94			
	Counties Manukau	95	95	94	95	94			
	All DHBs	93	94	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**			
	Waitemata DHB	85	88	90	91	87			
	Counties Manukau	87	88	89	92	89			
	All DHBs	83	85	86	88	87			
 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**			
	Waitemata DHB					83			
	Counties Manukau					29			
	All DHBS					**49**			

Source: http://www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing
Quarter 2 results not published as at 2 February 2017.

3.2 Financial Performance

The financial performance for the seven months to December 2016 was a surplus of $755k which was unfavourable to budget by $6M. This is attributed to an unfavourable result in the Provider arm ($14.2M adverse to budget), which was partially offset by the favourable performance to budget in the Funder arm of $8.3M. The year to date result is mainly driven by revenue realised being $9M less than planned, with expenditure overall favourable to budget by $3M. Less than budgeted revenue is mainly due to unrealised revenue for under-delivery of inpatient services subject to wash-ups and under-delivery of additional electives volumes (provision of $6.5M). Favourable expenditure is mainly driven by Funder NGO payments ($13.3M favourable, less pharmaceuticals costs and Aged Related Residential Care services costs), which fully offset unfavourable expenditure realised in outsourced personnel costs ($5.5M); clinical supplies ($4M) and infrastructure/ non-clinical supplies ($2.9M).

The full year plan is a surplus of $4.5M. Achieving this plan is dependent on the DHB increasing momentum to fully achieve the savings plan and subject to the DHB resolving the IDF pricing issues with the help of the Ministry of Health and other DHBs. A review of the IDF pricing issues and a proposal to resolve these has been completed for discussion with regional DHBs.

4. Clinical Governance

4.1 Development and recognition

4.1.1 Congratulations to Sir Richard Faull

ONZM BMedSc MBChB PhD DSc FRSNZ

Dr Richard Faull was recently knighted, recognising his four decades of service to brain research. In subsequent media interviews he said his love affair with the anatomy of the human brain has traversed almost forty years, and has made him a man "obsessed" and he was still just getting started.

In 2007, he was awarded the Rutherford Medal, the Royal Society of New Zealand's top honour, for his team's landmark finding that a diseased human brain can repair itself by creating new brain cells, something he had been taught as a med student was impossible. Highly regarded internationally, Sir Richard is the director of the Neurological Foundation Douglas Centre for Brain Research at the University of Auckland, where he teaches and oversees world-leading research on brain diseases.

5. Funding

5.1 Applications open

5.1.1 Starship Foundation funding

The Foundation's application process has been updated and funding for projects under $2,000 is now open year round. Funding for training and conferences is available quarterly.

Health and Safety Performance Report

Recommendation

That the Board:

a) Receives the Health and Safety Performance report for December 2016.
b) Endorses reporting of progress.
c) Supports the development of the indicators (from Safety to Health and Safety) as presented at the previous board meeting and used in this report for the 22 February 2017 Board meeting.
d) 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.

Please note that the report has been altered as per the request of the Board members. Definitions have been moved to an appendix (5) and duplication in commentary removed. Past history on risk and project management has also been removed to reflect as much as possible the most current action.

Health and Safety Score Card - Improvements to be noted: the percentage of staff incident reports followed up by manager within the time frame required continues to improve. 76% of staff incidents are now followed up by the manager within 14 days. Welcome Day attendance is now close to the target. Contractor audit outcomes continue to improve as do outcomes of Hazardous Substance audits. Mandatory e-learning (Health and Safety Induction) is close to target this month.

Note that control charts have been added where possible in the exception report.

Activities that require more focus continues to be local Health and Safety Inductions and further development of Directorate Hazard registers. A 30-60-90 day action plan has been developed to provide the Directorates with details on non-compliance with local Health and Safety induction.

From Safety to Health and Safety KPIs: numbers for the KPIs that are currently reportable have been included. Note that the format has changed to the same as the score card.

Health and Safety Risks: This table lists seven significant risks with six of them being amber. The risk calculation (consequence/likelihood) has been added. Updates for each of the action plans have been included in the report.

WorkSafe NZ Notifications: Health and Safety was not informed of any incidents (involving workers, patients or others) that required notification to WorkSafe in December 2016.

Staff Incidents (employees): 130 incidents were reported by staff in December 2016. This is 6% fewer than the number reported in October 2016. Please note the control chart added. The step change indicated where BBFA were added to the count. Twenty of the December incidents resulted in injury requiring medical care. Eight 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 Health and Safety department continues to be involved in many activities to improve the health and safety management within the organisation. Priority activities for December were preparation for working with the quality team to develop the Health and Safety modules in Datix (the replacement 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.

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 meeting 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.

Health and Safety Performance Report – December 2016

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 December 2016

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	8	8	
Number of Injury Claims	20	35	
Lost Time Injury	8	10	
Cost of Injury Claims (000's)	4	80	
Number of Reported H&S Incidents			
Staff	130	200	
Contractors	11	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	1	0	

Leading Indicators

Health Monitoring

	Actual	Target	Trend
Contact Tracing (events)	1	0	
Contact Trace (headcount exposed)	40	0	
Attendance at Welcome Day	84	88	
% local H&S Induction completed within 7 days	35	80	
Number of H&S Representative vacancies	19	25	
% H & S Representative Training	51	80	
% Pre-employment screening completed	90	90	
% Pre-employment screening before start date	99	100	
% Significant Hazard Registers current	58	80	
Number of staff Seasonal Influenza Vaccinations (YT	0	7923	

Ernst and Young recommended Indicators

% of reported H&S Incidents investigated- 14 days	75	80	
# of outstanding H&S Incident investigations	27	10	
% training completed in high risk WV areas	76	95	
Number of contractor audits completed	39	10	
Level of compliance contractor audits	100	90	
%Employee engagement satisfaction levels	70	0	
% completed hazard remediation	RU	80	
# of Hazardous Substance audits conducted	5	10	
% Hazardous Substance audits compliant	85	80	
% OH&S mandatory e learning completed	86	90	

8.1

5. From Safety to Health and Safety

In August 2016 Ailsa Claire, CEO made a presentation to the Board entitled "From Safety to Health and Safety". This new section of the Board Report will be further developed to monitor a number of indicators that will indicate improvements while the DHB works towards the goals outlined in the presentation. Initiatives that are designed to address the health and wellbeing of workers and patients were discussed including initiative to address Culture and Values.

WORKER INITIATIVES 12 MONTHS ROLLING

Lagging Indicators

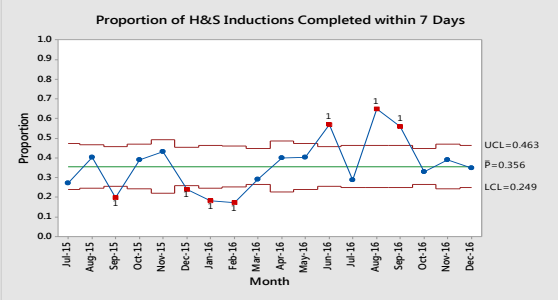
	Actual	Target	Trend
Excess Annual leave; % of workers with excess annual leave	9	6	
Lone/Off site workder safety; total recorded incidents and severity	0	10	
Lone/Off site workder safety; total recorded claims	0	0	
Internal worker safety; total recorded incident and severity	130	200	
Internal worker Safety: Total recorded Claims	22	35	
Violence and Aggression: total recorded incidents and the severity	27	50	
Violence and Aggression: total recorded Claims	4	0	

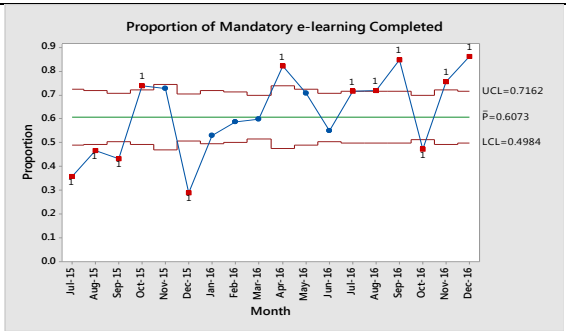
Leading Indicators

Health and Wellbring Programmes: new and underway	ru	0
Management of Reisidual Risk action plans	ru	0
Safety Secuity Audits conducted	ru	0

*Health and Safety data is not currently collected in relation to lone working. An information search of the October data did not indicate any incidents in relation to lone working.

6. 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.		Electronic form has been developed for easier return. E learning results indicate that local Health and Safety induction compliance is improving. A 30-60-90 day action plan has been developed. Detailed report will be provided to directorates from Feb. onwards.
% 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.
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 Safety Management System will assist.
Percentage training completed in high risk workplace violence areas	Some staff do not complete violence and aggression training within the required timeframes.		Appropriate training suppliers being considered with a view to providing new training options in early 2017. A tender process to commence in early 2017 managed by OD.

Indicator	Issue		Action
% 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.		86% of new starters completed the training in December 2016.
% 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) will be launched in early 2017. Health and Safety will work with Directorates to move Hazard registers to the new system. Tracking of compliance will be improved.
#of Hazardous Substance audits conducted	Monthly audits are requested by Health and Safety across the organisation. The number of audits depend on the availability of contacts within the units		Less opportunity to conduct audits in December due to the number of staff on annual leave.

7. 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	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. December 2016: The steering committee continues to meet monthly; Good progress is being made with the new ID cars for all workers and lock down	The risk remains high until the work to improve site and security systems is completed at Grafton, GCC and Point Chevalier. This work is expected to be ongoing for the next 12 months.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
	carry out all works on the systems upgrade and to carry out future R+M work on all security systems.	technology 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. A refreshed committee will be assembles and identify goals and objectives for the coming year. A specialist project manager will be recruited 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
ACH Atrium Walkway barriers	The glass barriers on some of the levels of the ACH atrium walkway are lower than others. The lower barriers allow for	Approval for part of the project was obtained in June 2016.	The risk will remain amber until the remediation is completed.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
563RR	people to climb over 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.	Handrails have been removed to prevent climbing points.	
Original Risk			Residual Risk (5x2) 10
Slips, Trips and Falls (related to hazards in grounds and buildings.) 478RR	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 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.	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.
Original Risk			Residual Risk (3x3) 9
Traffic Management (loading bays/ parking)	The level 5 loading bay at Grafton has been identified as a Health and Safety hazard by Auckland DHB.	A Pedestrian Safety steering group has been formed and monthly meeting are being held to agree priorities for remediation.	The risk remains moderate until the work to improve traffic safety is completed at Grafton and GCC and a Traffic management plan is established.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
388RR 465RR	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.	Projects are being progressed on a risk priority basis.	
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.	Asbestos in situ is safe. The risk remains moderate due to the unknowns in the asbestos register.
Original Risk			Residual Risk (4x2) 8
Facilities Lifts 502RR	Some 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 (4x5) 20

8. 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 2015/16 fiscal year.

Staff Serious Harm and Notifiable Events (1 July 2015- 31 December 2016)

1)	20 August 2015	Fractured nose	staff member injured by service user
2)	1 October 2015	Fractured foot bone	staff member tripped on stairs
3)	12 December 2015	Laceration	stepped on needle on beach
4)	January 2016	Fracture	trip/fall
5)	13 April 2016	infectious disease	TB exposure
6)	12 May 2016	infectious disease	TB exposure
7)	28 August 2016	Severe Laceration	Dog Attack

There was no Notifiable Events in December 2016.

Notifiable Events/ Incidents (Patients and Visitors)
No Notifiable injury or illness to patients or visitors was reported in December 2016

Notifiable Events/ Incidents (Other Workers)

1)	25 February 2016	External Volunteer	trip/fall minor fracture
2)	10 February 2016	Compass Group	crushed finger
3)	11 March 2016	Volunteer	fracture/dislocation finger

No Notifiable Events to other workers reported to WorkSafe NZ in December 2016

9. Staff Reported Incidents

The number of reported incidents by staff (occurrences) during the period 1-31 December 2016 amounted to 130, a decrease of 6 % from last month. Please note that not all occurrences (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

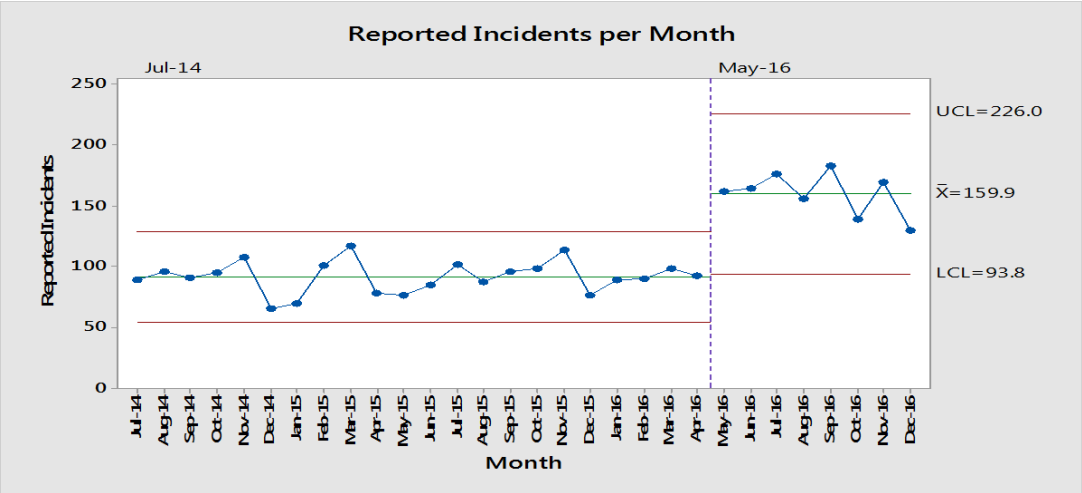


Table 1 – Total incidents reported by staff per month – January 2016 to December 2016.

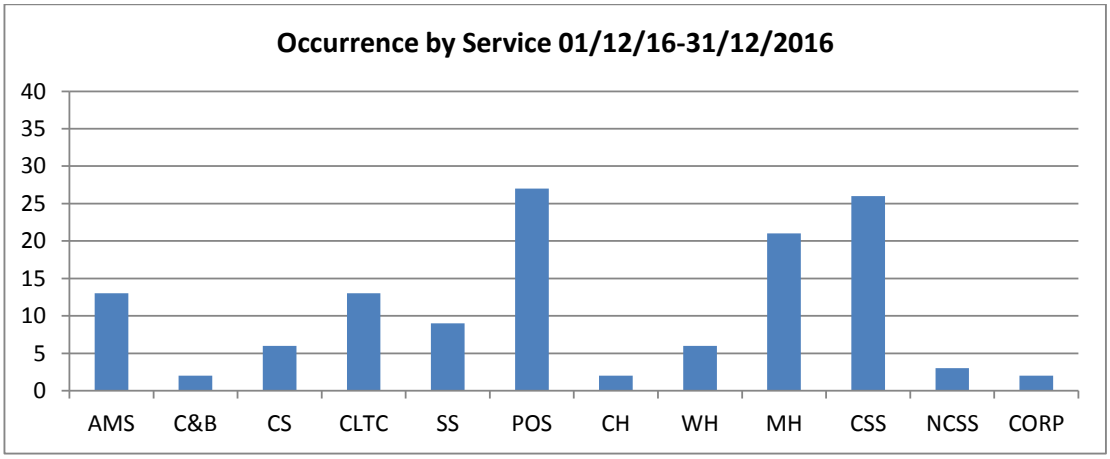


Table 2 – Incidents by Directorate – 1 – 31 December 2016

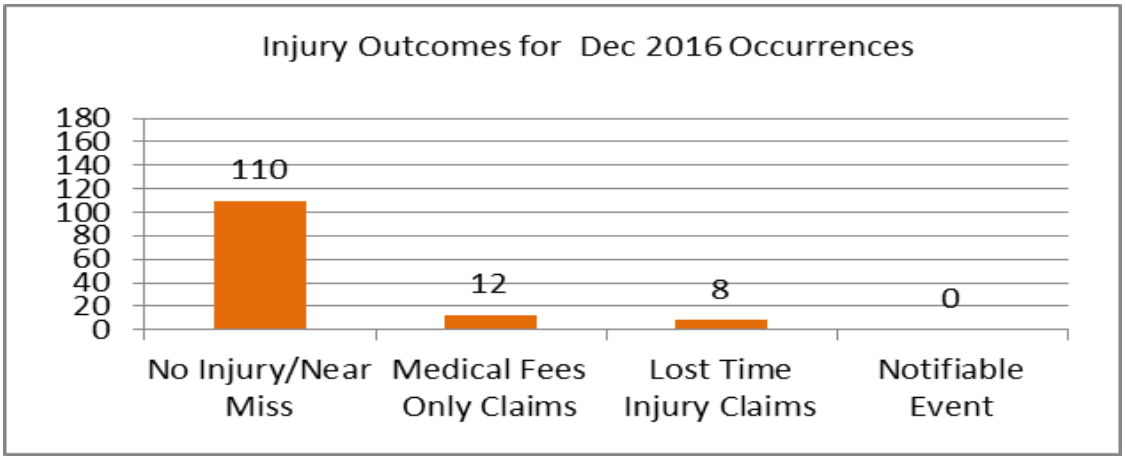


Table 3 – Incidents by Injury outcomes – 1– 31 December 2016.

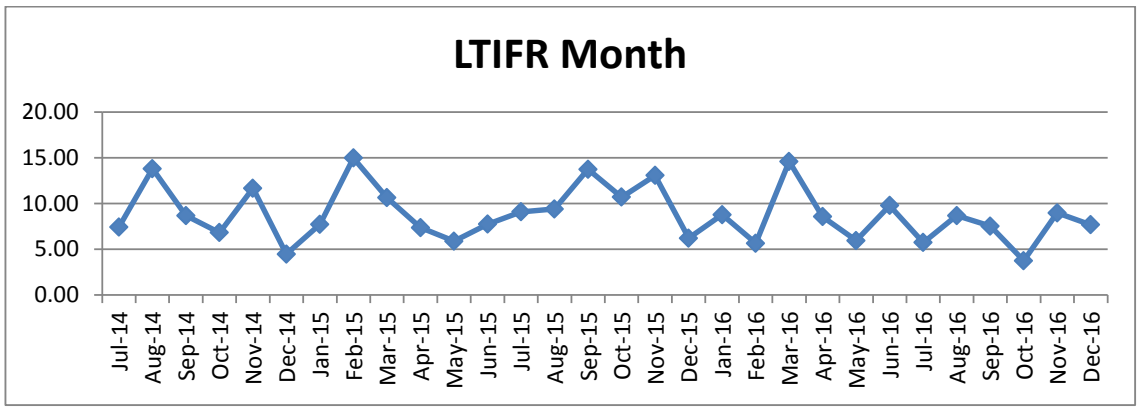


Table 4 – Lost Time Injury Frequency Rate by Month (July'14 – Dec'16)

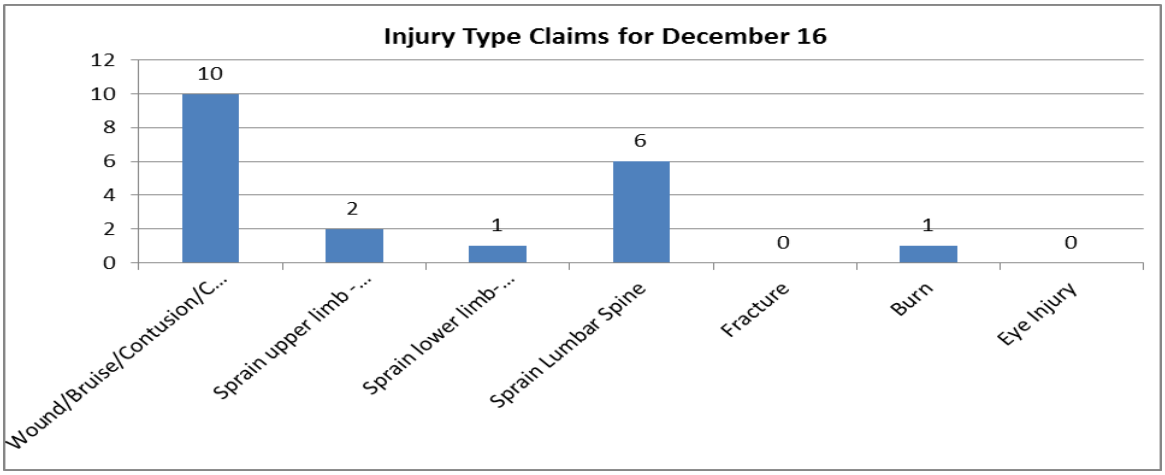


Table 5 - 20 claims by Injury type for December 2016

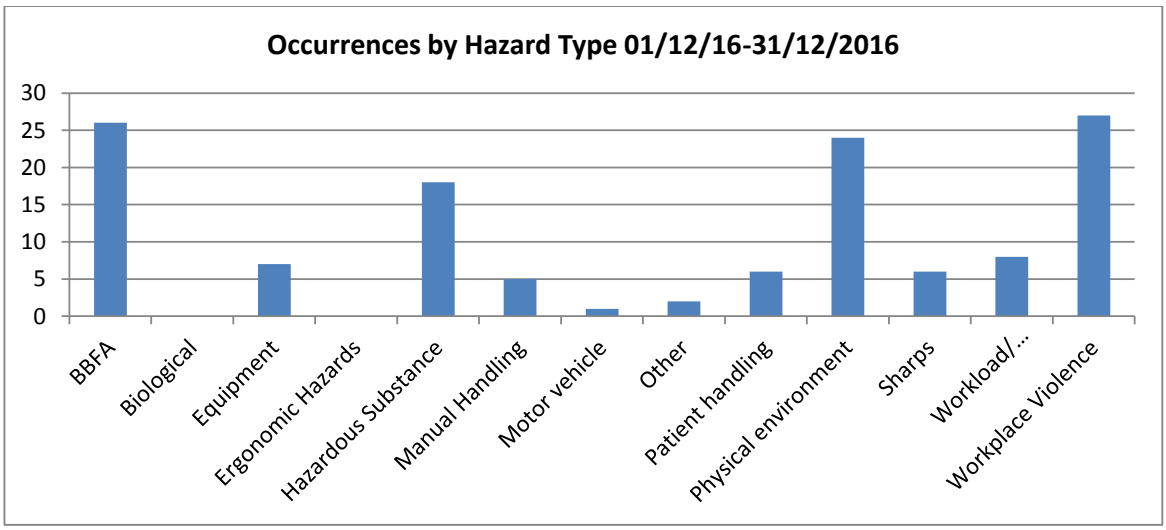


Table 6 – 130 Incidents (Ocurrences) By Hazard Type – December 2016.

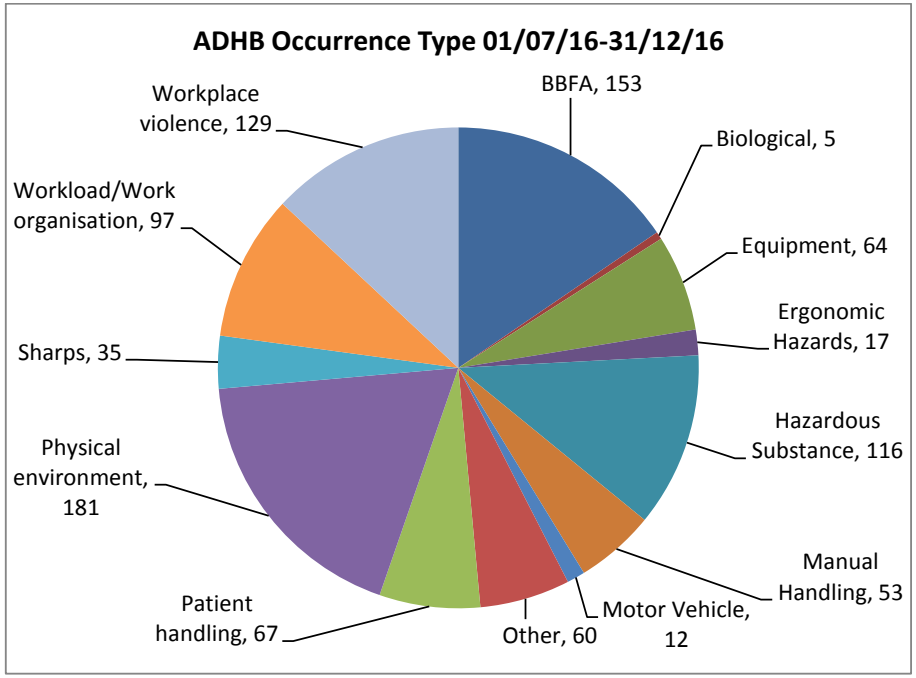


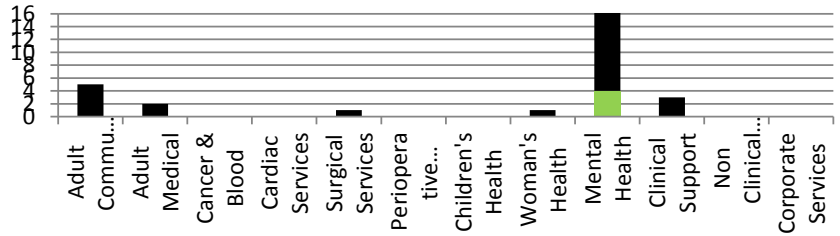
Table 7 – Fiscal Year to date Occurrences by Hazard type (YTD for 16/17 fiscal year).

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

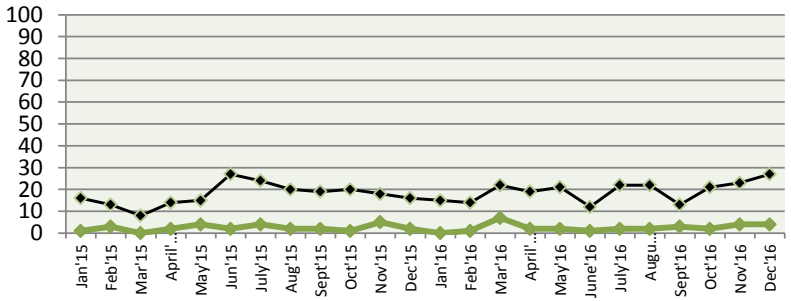
CLAIMS OCCURANCE

WORKPLACE VIOLENCE AND AGGRESSION:

Workplace Violence Injuries 01/12/2016 - 31/12/2016

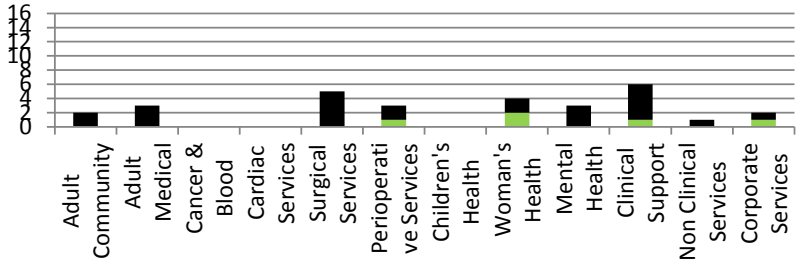


From 2 Year Rolling

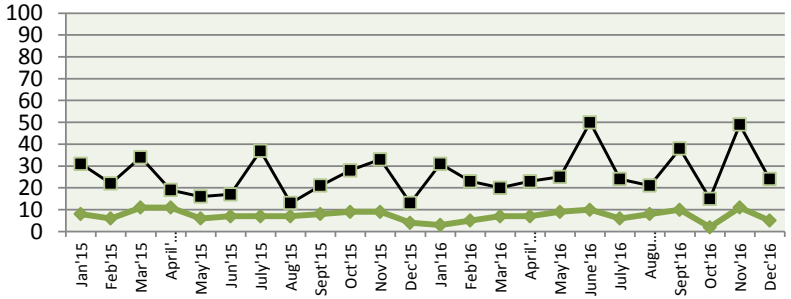


PHYSICAL ENVIRONMENT:

Physical Environment Injuries 01/12/2016 - 31/12/2016

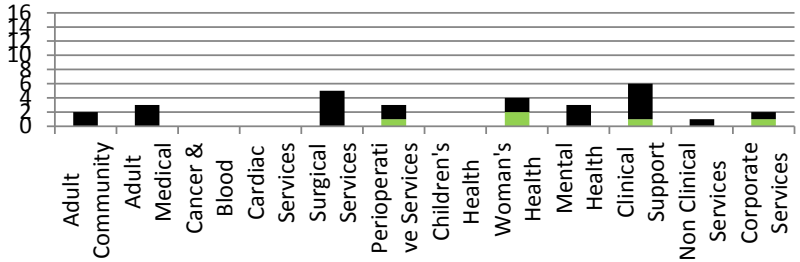


From 2 Year Rolling

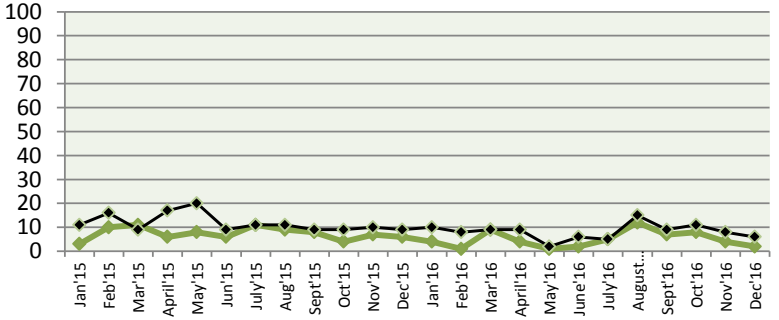


PATIENT HANDLING:

Patient Handling Injuries 01/12/2016 - 31/12/2016



From 2 Year Rolling



8.1

11. 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. See appendix 6 for report.

Health and Safety Rep Training
As per HSWA, external training is now required for Health and Safety Reps. A supplier has been selected and two initial training sessions scheduled. The course content has been reviewed and additional training for 2017 has been scheduled. Eight courses are now in KIOSK (February to June 2017).

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.

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 200 managers have now completed this course.

Board Health and Safety site visits
A new schedule for visits in 2017 is under development. Risk categories for all visits are yet to be agreed. The proposed dates of the visits will be 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 will focus on the Security for Safety Project.

Month	Day	Visit Date	Finance, Risk and Assurance Committee Meeting Date
March	Wednesday	**8 March 2017**	15 March
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

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 25 January 2017. The Health and Safety Committee Terms of Reference final review has been completed and will be submitted for Board sign off in February 2017. All Directorate Health and Safety committees continue to meet regularly.

Safety Management System (Datix):

Health and Safety is working with the Quality team to implement Datix. Health and Safety incident reporting and Hazard reporting is transitioning to Datix. The modules are developed. Data transfer is in progress, testing will be completed with a view to training and go live in early 2017. Health and Safety will participate in the manager training forums. Training for Health and Safety Reps will be provided in late March.

Auckland DHB Moving and Handling Steering Committee

The Auckland DHB Moving and Handling steering committee chaired by Brenda Clune meets monthly. The Bariatric Bundle trial is underway. Work has commenced on a fall retrieval bundle.

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. A Chairperson has been appointed by the Executive lead for health and Safety. A programme across the organisation will be developed including recommendations for changes in training content and frequency for physical health areas is under review and appropriate suppliers are being sought. A specialist project manager will be recruited to support this work.

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 three vacancies on the Health and Safety Team. Recruitment is underway for two Health and Safety Advisors. The Vocational Wellbeing Advisor commenced work in early 2017. 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 is under development. See draft Terms of Reference in appendix 7.

Waitemata DHB has been approached for feedback in relation to a joint audit as per the Ernst and Young Systems review conducted in 2015.

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. Auckland DHB will arrange for a regional meeting with Health and Safety Leads at the three metro DHBs to meet in the near future to further explore opportunities for Regional work.

12. Facilities and Development

Health and Safety

Facilities Safety Management System due Diligence Review/ Audit

The participant's that took part in the review process were all invited to a meeting to discuss the key findings of the review/ audit with the external auditor Gavin Johnson and John Casey (Facilities).

The report and findings from the external Auckland DHB due diligence review process/ audit were sent out to all the organisations prior to the meeting, with an invitation for all those involved in the review process to come to a meeting at Auckland DHB for an open discussion and feedback on the findings.

The final report provided an overview of key findings from all the reviews undertaken. Note: Auckland DHB did not provide each organisation with their own unique report as the purpose of the review was to provide Auckland DHB with a bench mark on the general level of understanding of health and safety and to determine the maturity of the contractor's safety management system and how well it has been implemented for the work undertaken at Auckland DHB.

The key findings were focused on the key **safety critical elements**

- Hazard and Risk Management
- Accident and incident management
- Emergency Planning, Preparedness and Response Management
- Contractor and Sub-Contractor Selection and Engagement
- Safe Work Practices/ Activities/ Methods- Safe Systems of Work

The conclusion that Auckland DHB came to as a result of the audit was that:-

Generally their knowledge of the significant chances and duties imposed by the Health and Safety at Work Act 2015, were not clear and not many organisations seem to still be seeking information on how to ensure they comply with this new legislation.

Generally the contractors own safety management systems are not very mature. Their Health and Safety management systems were often based on advice from external generalist (Health and Safety or Human Resources) consultants, Site Safe information and often predominately focused on the requirements of the ACC Workplace Safety Management System process and achieving these minimum requirements. Some organisations had systems that were too large and complex for the size and activity of the organisation.

As a result of their knowledge gap and lack of full understanding of the legislation, they have predominately adopted the Auckland DHB Facilities and Development Safety Management System tools and are looking to Auckland DHB to provide information and in some cases assistance.

During the audit there was strong evidence that the organisations had adopted and implemented the Auckland DHB systems and had a reasonable understanding and evidence

of implementation of the Facilities and Development Health and Safety processes and tools for the work they do on Auckland DHB sites.

At the meeting the key finding from the audit were discussed with a focus on practical solutions and ways that the organisations could improve to meet Auckland DHB health and safety expectations and the requirements of the new legislation.

The feedback from the reviews and meeting was that the contractors valued Auckland DHB's input and support and were happy to ensure that they complied with the Auckland DHB requirements.

From an Auckland DHB perspective, Facilities and Development intend to build on this review and are planning a range of future initiatives and actions to ensure continuous improvement:-

Contractor Forums will be arranged (possibility quarterly) that will allow the contractors an opportunity to discuss their initiatives and Health and Safety improvements since the audit. This will provide a platform for continuous improvement that contractors can use to learn from each other, share ideas and to discuss what works and what did not.

Auckland DHB will continue to work with contractors to assist them improve their Health and Safety management systems.

All the Facilities and Development unique rules and criteria required for working in a hospital and documentation are available to contractors so that they know what Facilities expectations are up front.

As part of this drive for continuous improvement Facilities and Development have developed a 'cheat Sheet' for developing a Site Specific Safety Plan (SSSP), all contractors required to complete a SSSP are provided with this tool, so that the contractors can see the requirements and standard of scrutiny that the Auckland DHB will be applying to their documentation.

The initiative already in place that was endorsed by the contractors- that any documentation or templates that are developed by organisations will be shared between all contractors, so that we can adopt the best documents for use at Auckland DHB.

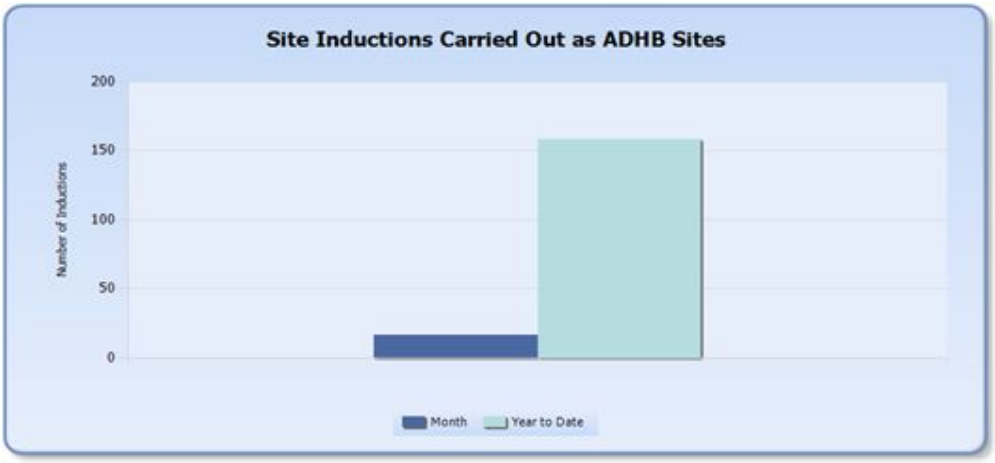
Contractors will ensure that the information they post into the Auckland DHB on-line contractor management database is relevant, fit for purpose and succinct as it was noted during the contractor audits that the contractor's safety systems are often based on SiteSafe templates or written to a similar basic standard. Reviews of the documentation by Facilities and Development have also found that the contractors Site Specific Safety Plans (SSSP's) are often just a cut and paste template, so often names of previous jobs or locations are found throughout the documentation that bears no relevance to the work they are engaged to undertake at Auckland DHB.

The Auckland DHB Health and Safety online contractor management system will also allow for the vetting of specific information to suit the often unique work required to be undertaken. The system is designed to be an evidence based system, when an organisation confirms that they have a process or procedure, they are asked to provide evidence to show and ensure that Health and Safety is an active part of the contractor's management program.

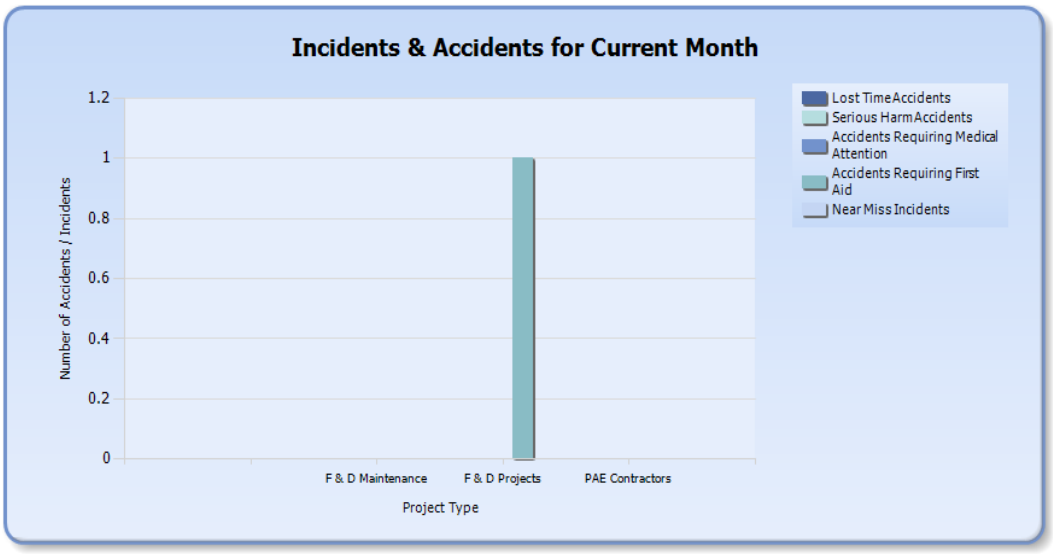
When a contractor has completed the survey and provided evidence they can submit their documentation for review by Facilities.

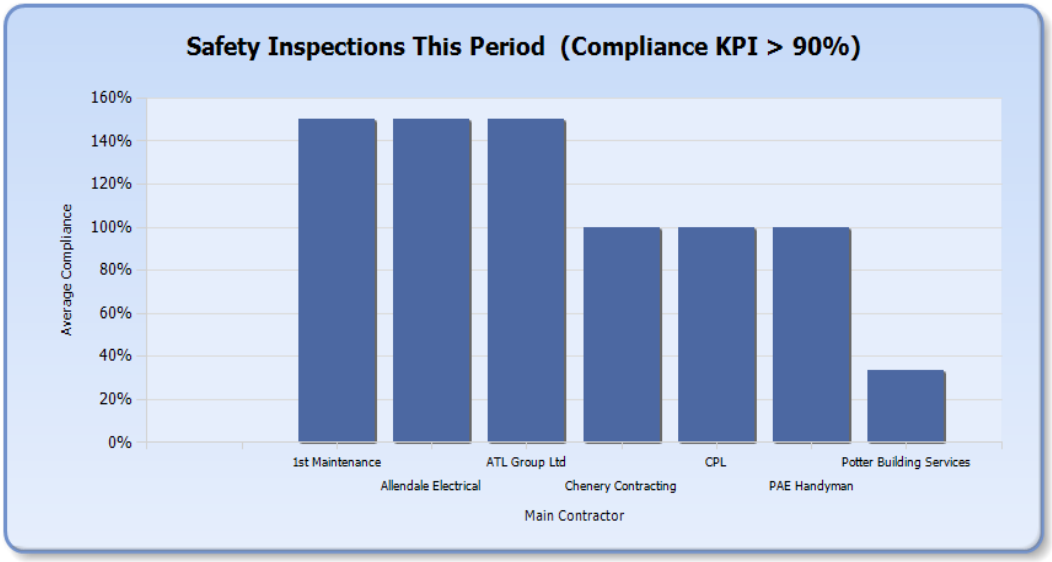
Facilities and Development Monthly Statistics

Sixteen contractors were inducted onto site and the yearly total is now standing at 158 inductions completed by PAE for workers physically working on site.

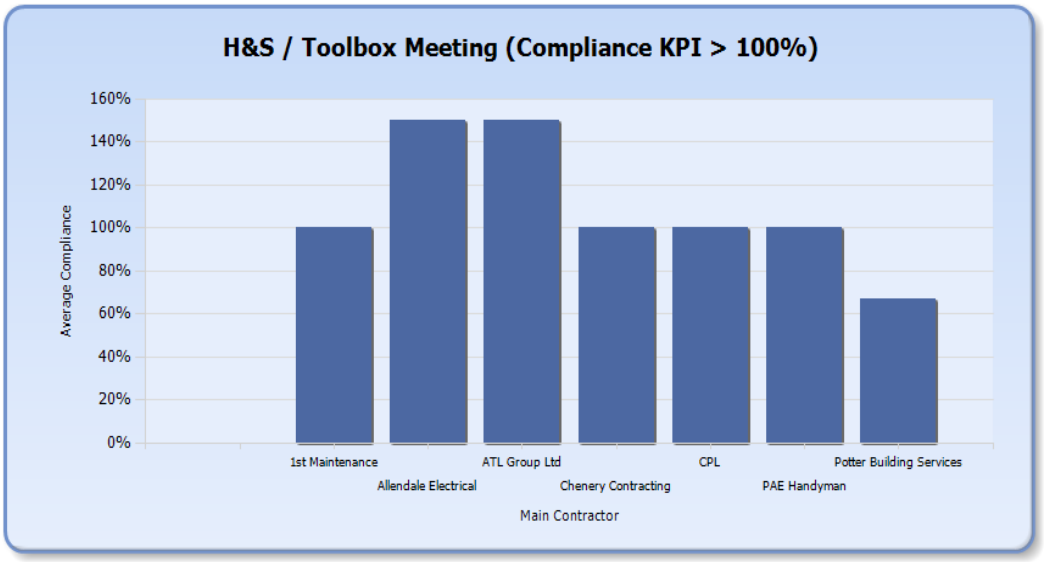


There was one first aid injury this month. The injury occurred when a contractor was loading three meter length metal struts into a lift cart to move them to a job. In the process of handling these struts he caught the inside of his arm causing a cut above his wrist, the wound was treated and he returned to work immediately.





Nineteen safety inspections were undertaken in November including two external audits.



13. 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

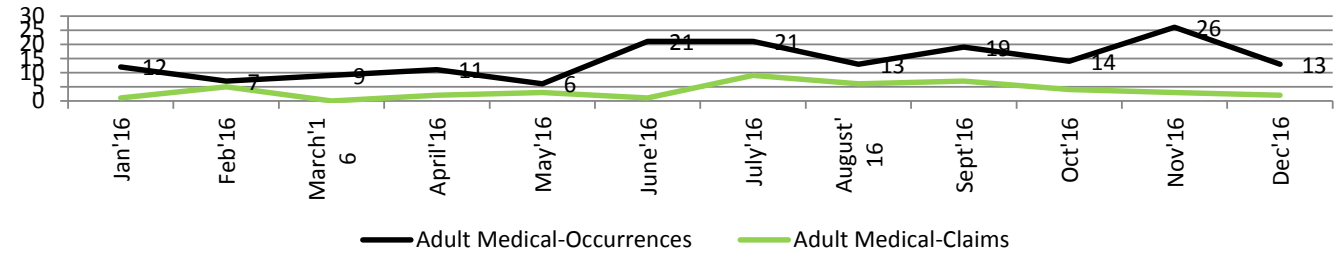
Lagging

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

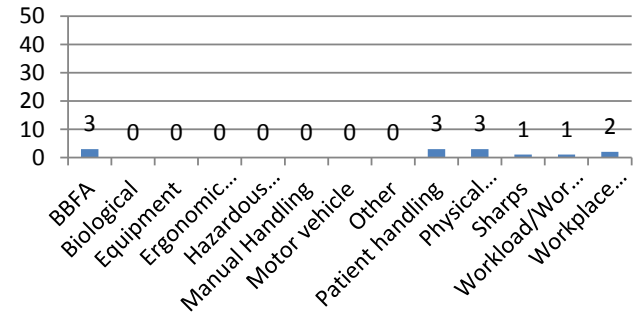
Leading

	Actual	Target	Trend
%H&S Inductions	20	80	
H&S Rep Vacancies No.	2	2	
%H&S Rep Training	29	80	
%6 Monthly Workplace Checklist	67	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	81	80	

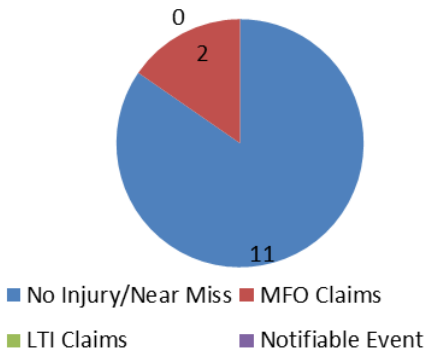
Health and Safety Incidents and Claims for 12 months



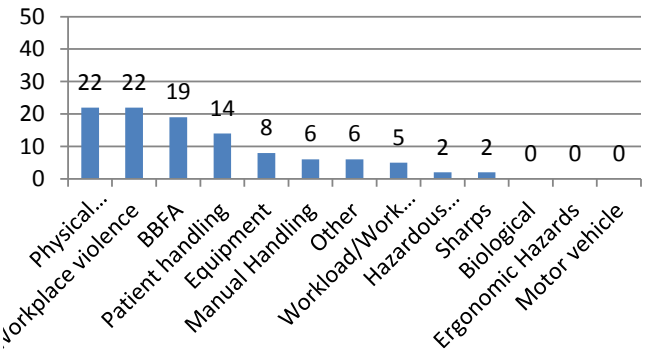
Health and Safety Incident by Hazard Type for December 2016



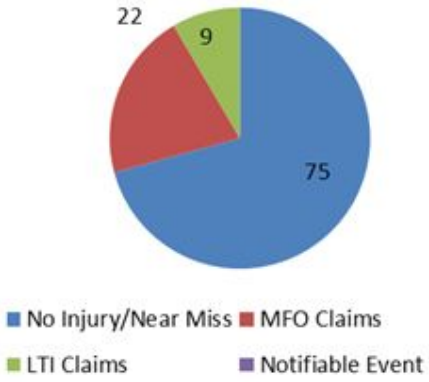
Work Injury by Outcome Type for December 2016



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



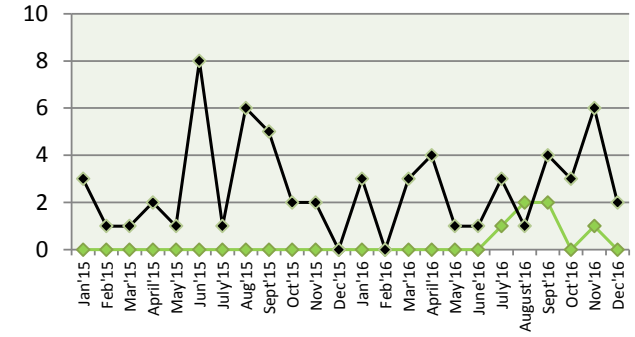
Work Injury by Outcome Type – YTD (2016-2017)



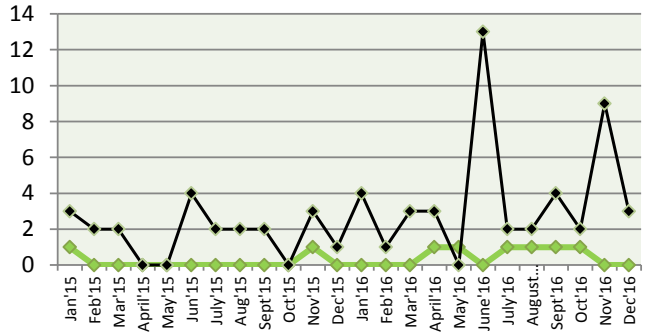
Adult Medical Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

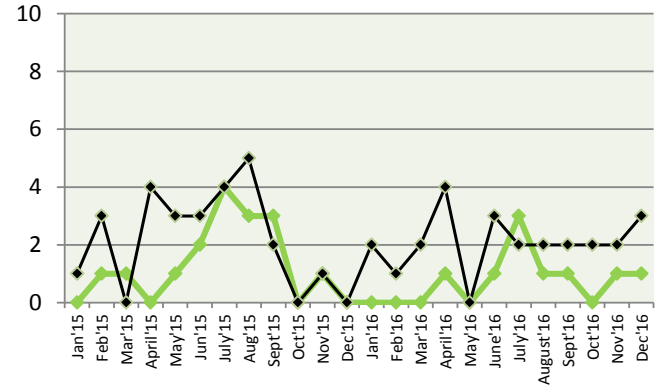
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



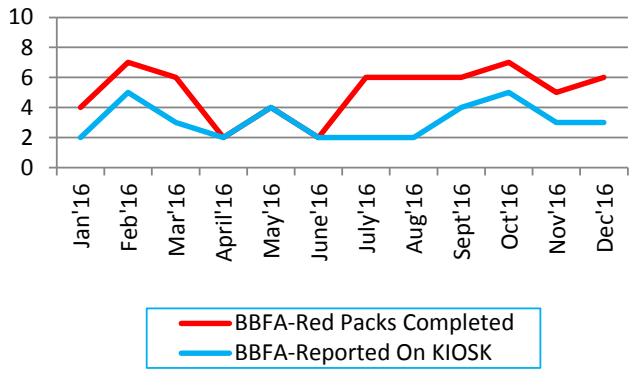
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

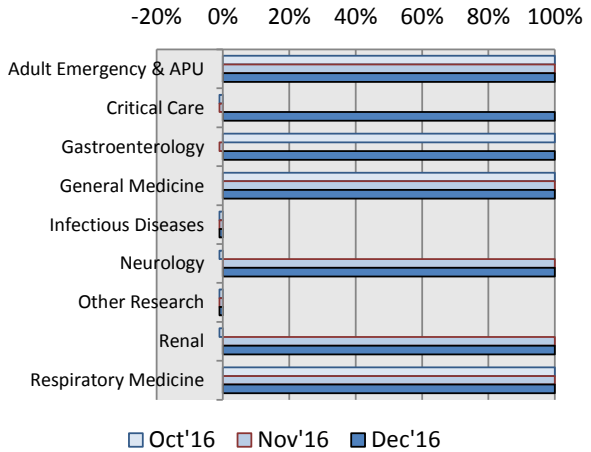


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



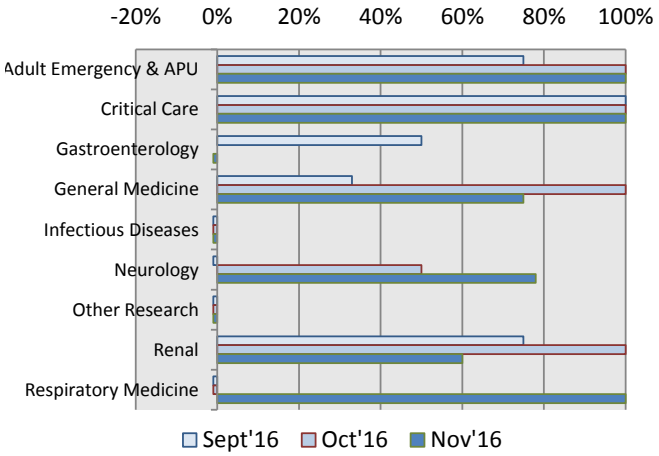
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	65%	80%	81%



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

Information data accurate as of 06/01/2017

Cancer and Blood Services Health and Safety Report

Lagging

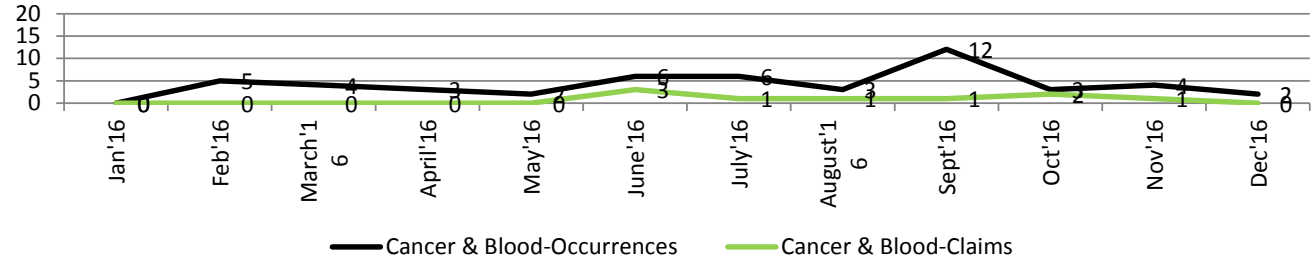
	Actual	Target	Trend
H&S Incidents	2	20	
Work Injury Claims	0	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

Leading

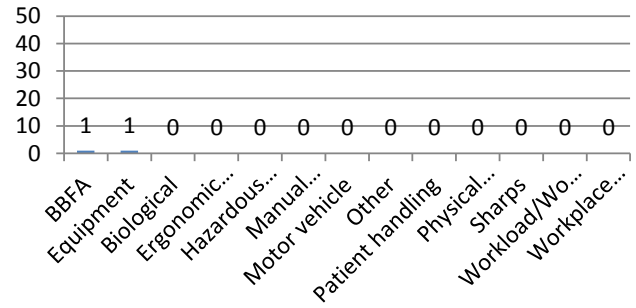
	Actual	Target	Trend
%H&S Inductions	14	80	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	10	80	
%H&S Rep Checklist	71	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	100	80	

8.1

Health and Safety Incidents and Claims for 12 months

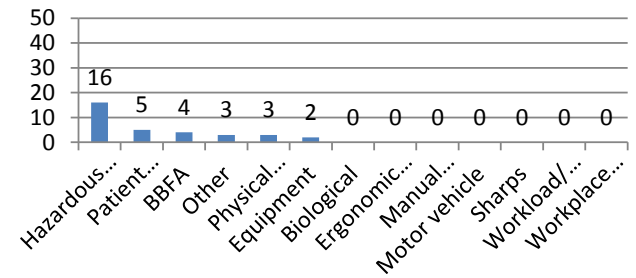


Health and Safety Incident by Hazard Type for December 2016



Work Injury by Outcome Type for December 2016

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

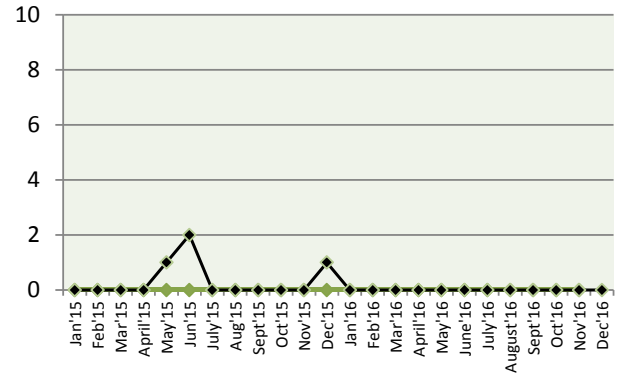


Work Injury by Outcome Type – YTD (2016-2017)

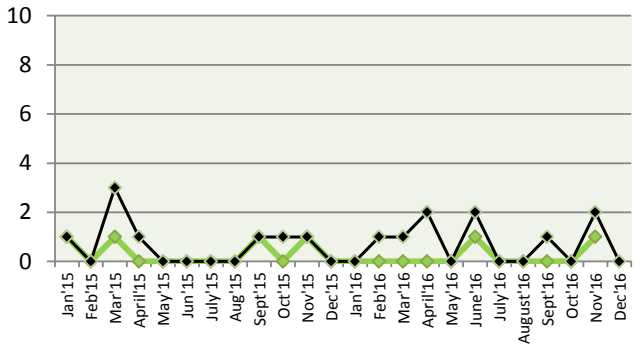
Cancer and Blood Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

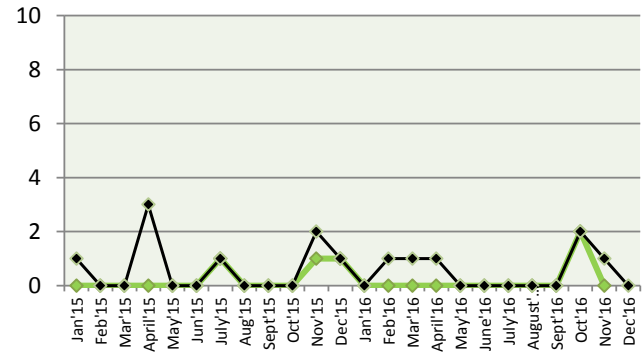
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



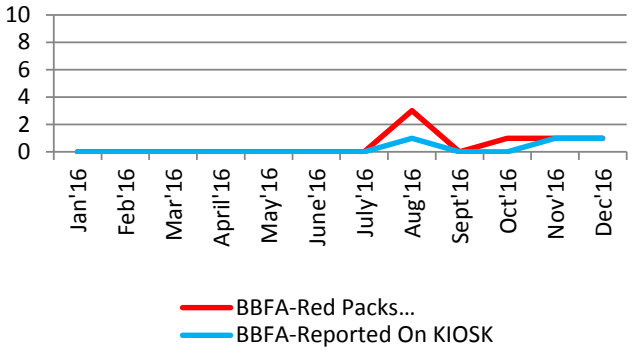
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

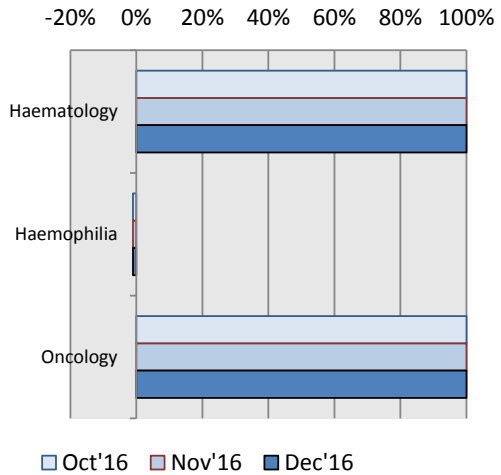


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



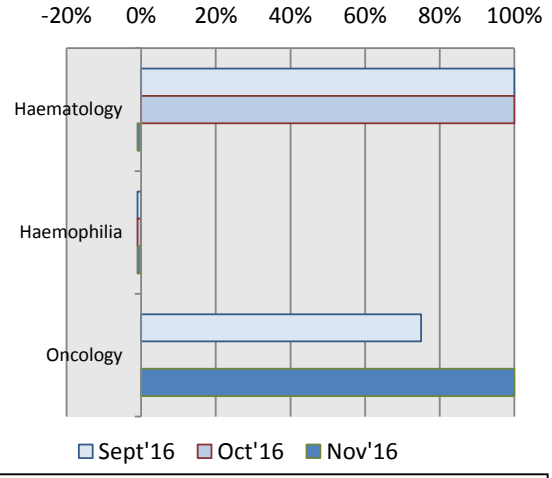
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	77%	50%	100%



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

Information data accurate as of 06/01/2017

Cardiac Services Health and Safety Report

Lagging

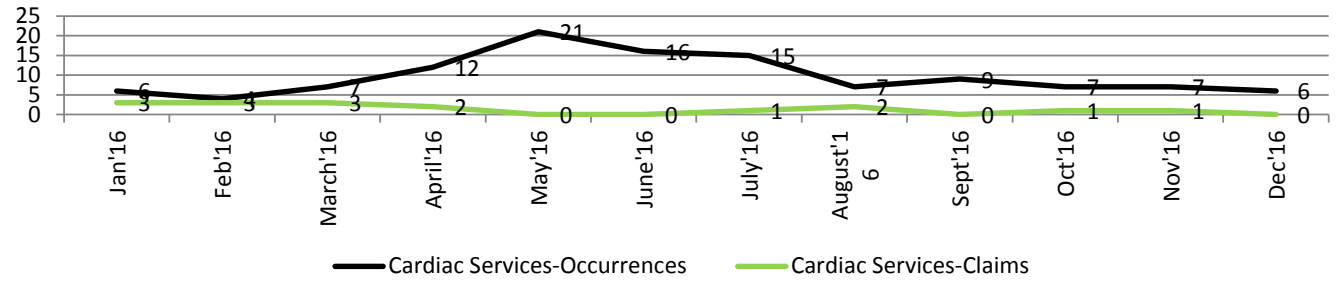
	Actual	Target	Trend
H&S Incidents	6	20	
Work Injury Claims	0	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

Leading

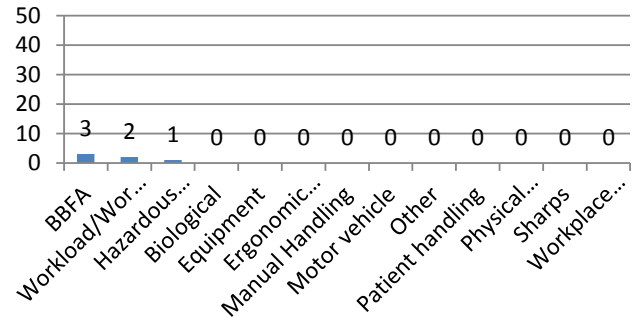
	Actual	Target	Trend
%H&S Inductions	32	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	56	80	
%6 Monthly Workplace Checklist	50	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	50	80	

8.1

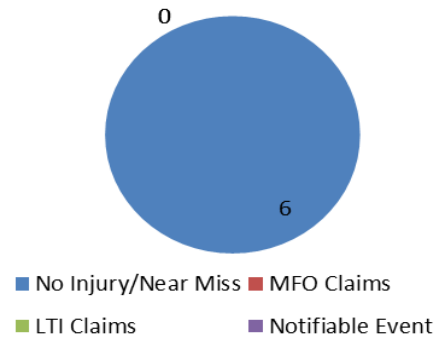
Health and Safety Incidents and Claims for 12 months



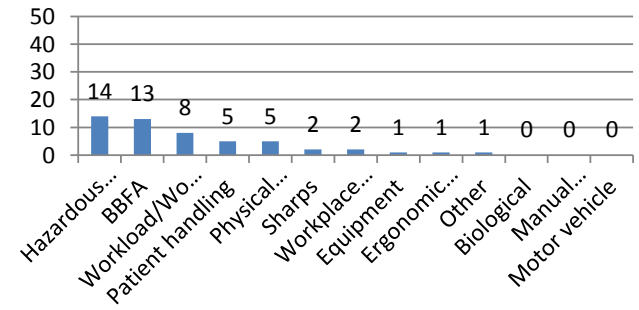
Health and Safety Incident by Hazard Type for December 2016



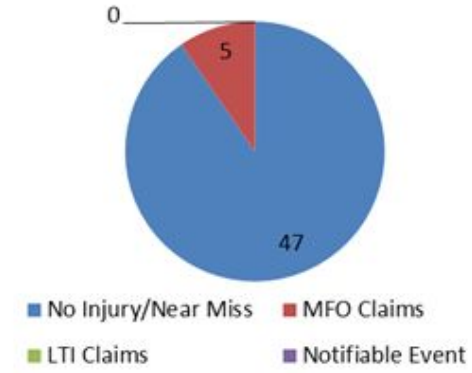
Work Injury by Outcome Type for December 2016



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



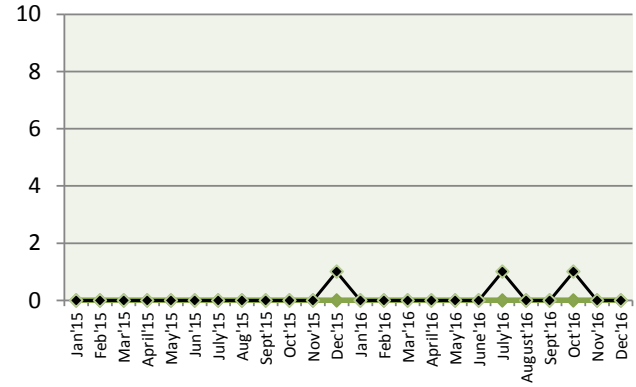
Work Injury by Outcome Type – YTD (2016-2017)



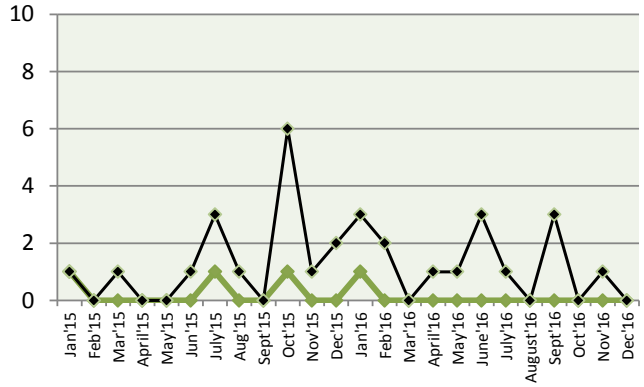
Cardiac Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

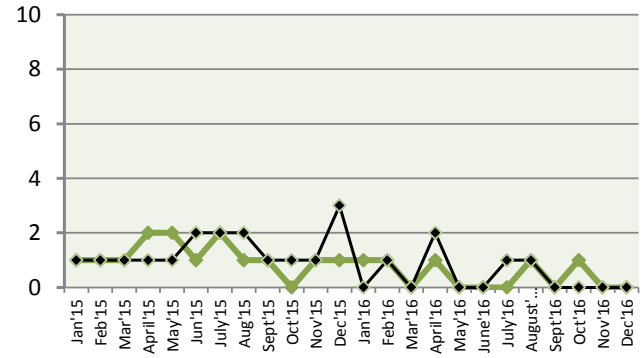
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



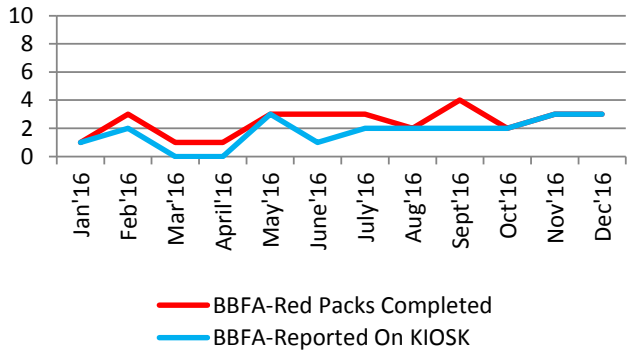
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

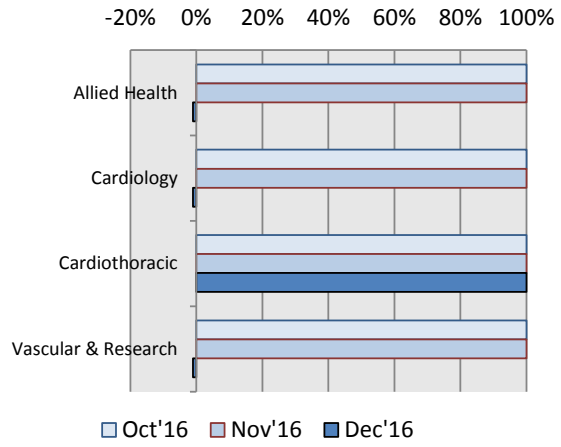


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



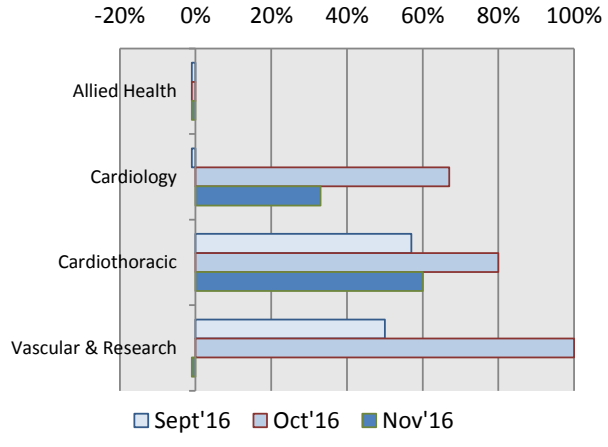
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	56%	78%	50%



Information data accurate as of 06/01/2017

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

Children's Services Health and Safety Report

Lagging

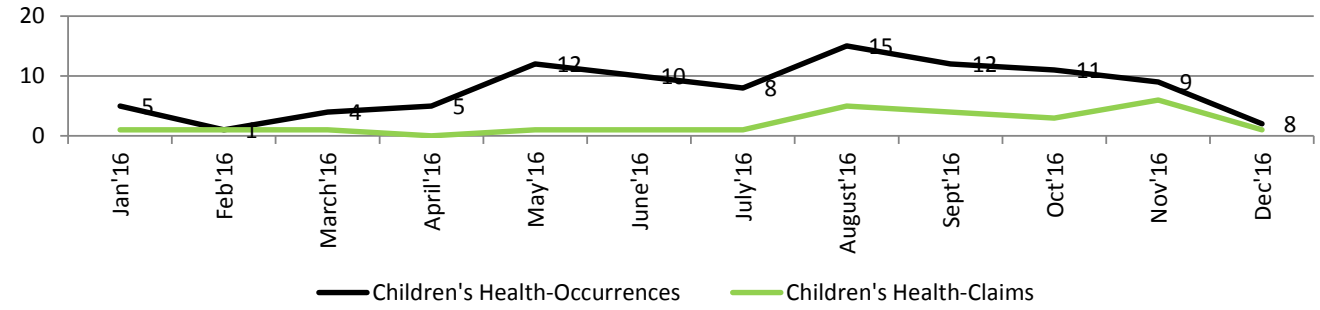
	Actual	Target	Trend
H&S Incidents	2	20	
Work Injury Claims	1	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

Leading

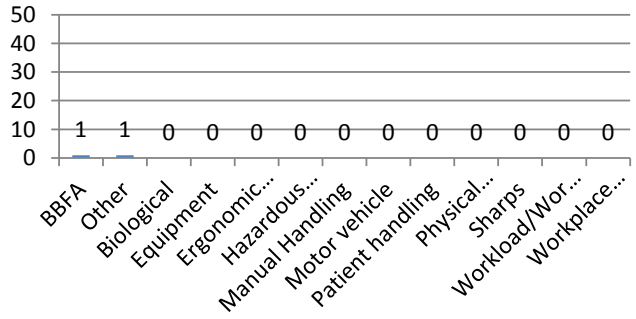
	Actual	Target	Trend
%H&S Inductions	100	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	52	80	
%6 Monthly Workplace Checklist	39	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	64	80	

8.1

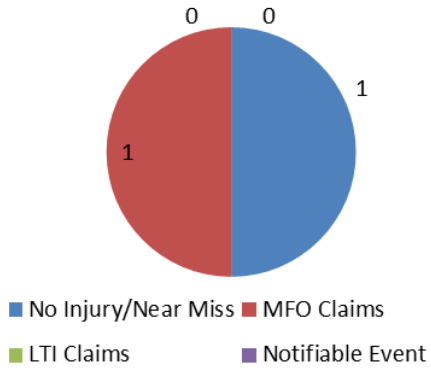
Health and Safety Incidents and Claims for 12 months



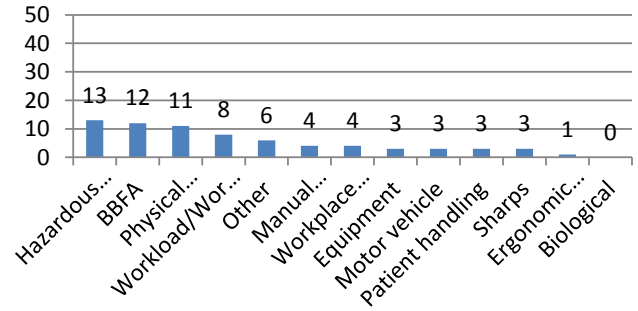
Health and Safety Incident by Hazard Type for December 2016



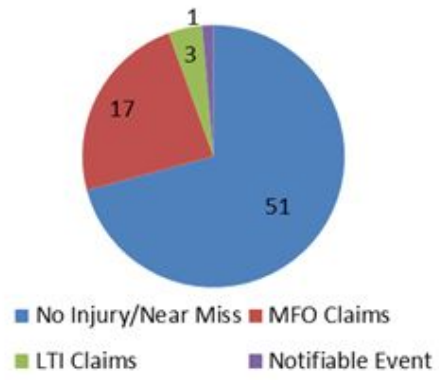
Work Injury by Outcome Type for December 2016



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



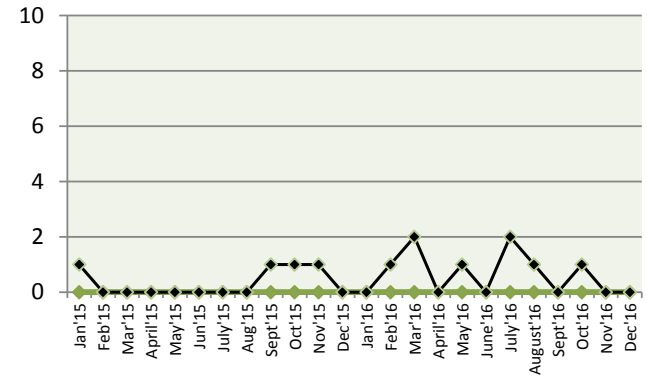
Work Injury by Outcome Type – YTD (2016-2017)



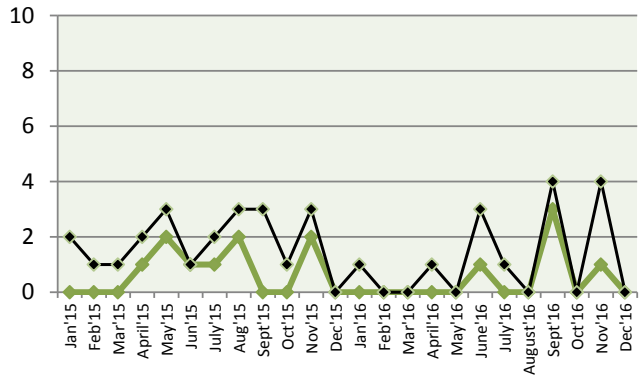
Children's Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

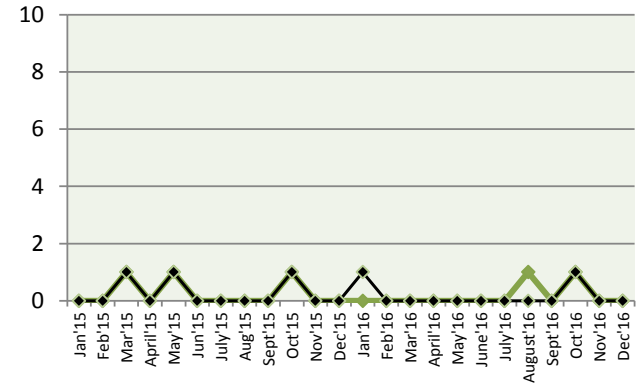
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



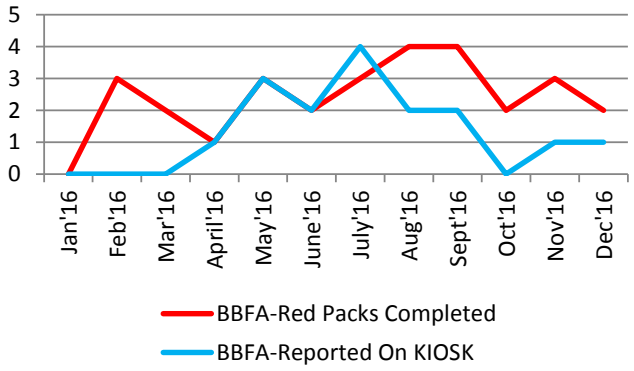
PHYSICAL ENVIRONMENT
((From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

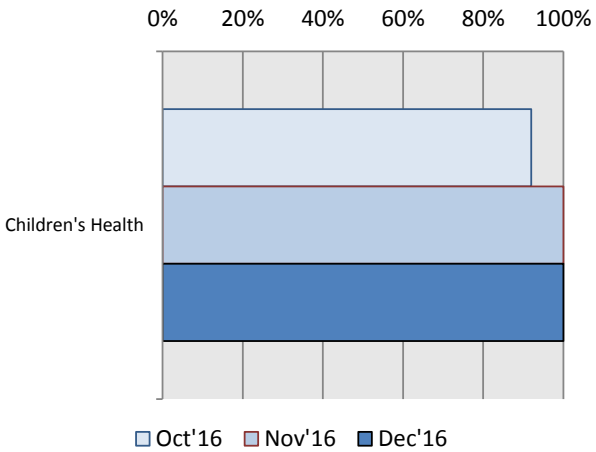


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



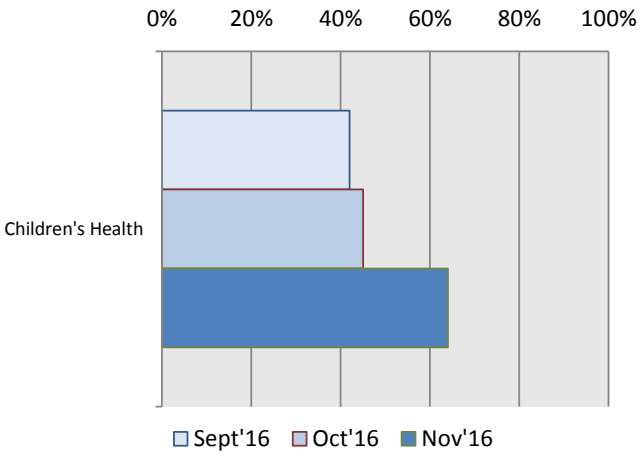
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	92%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	42%	45%	64%



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

Information data accurate as of 06/01/2017

Clinical Support Health and Safety Report

Lagging

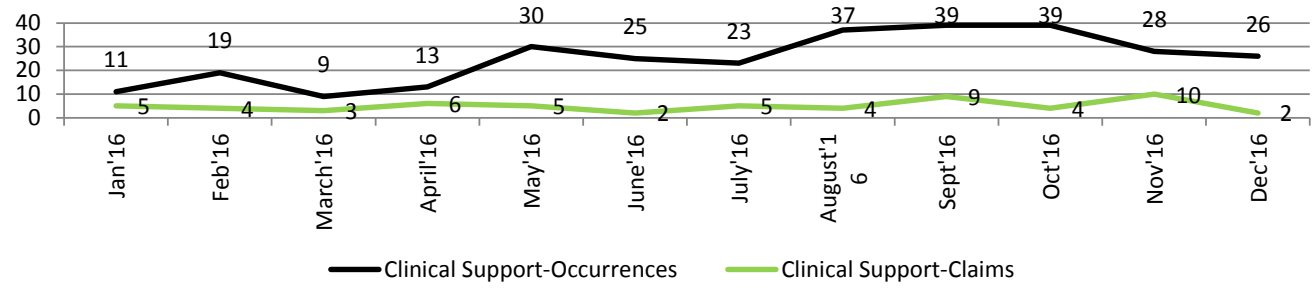
	Actual	Target	Trend
H&S Incidents	26	20	
Work Injury Claims	3	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

Leading

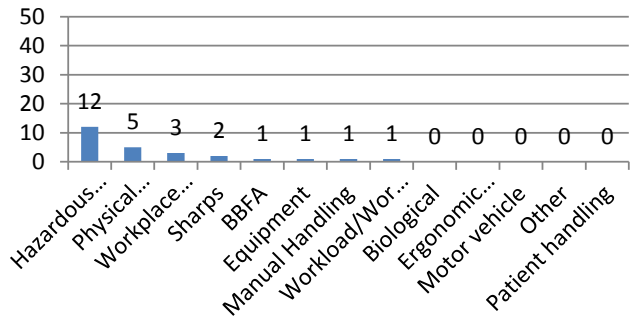
	Actual	Target	Trend
%H&S Inductions	57	80	
H&S Rep Vacancies No.	8	2	
%H&S Rep Training	86	80	
%6 Monthly Workplace Checklist	70	80	
%PES before start date	98	100	
%H&S Incidents Follow up 14 days	86	80	

8.1

Health and Safety Incidents and Claims for 12 months

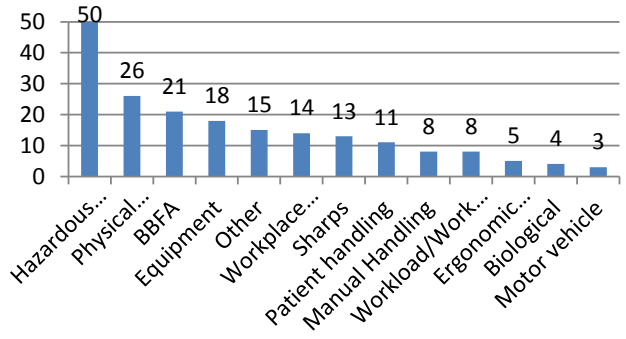


Health and Safety Incident by Hazard Type for December 2016

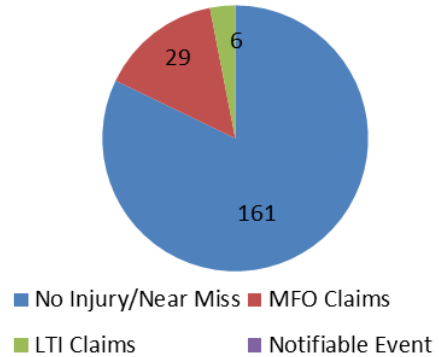


Work Injury by Outcome Type for December 2016

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



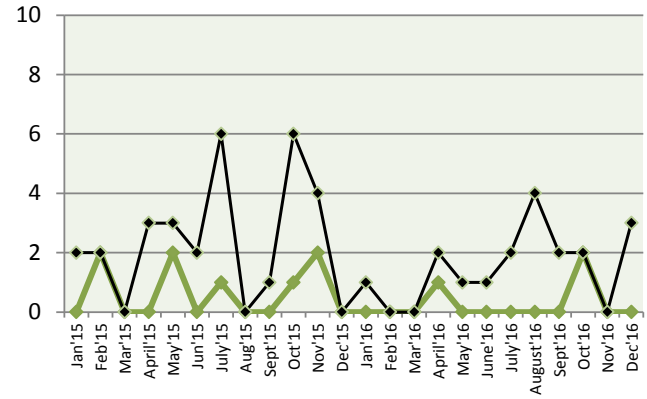
Work Injury by Outcome Type – YTD (2016-2017)



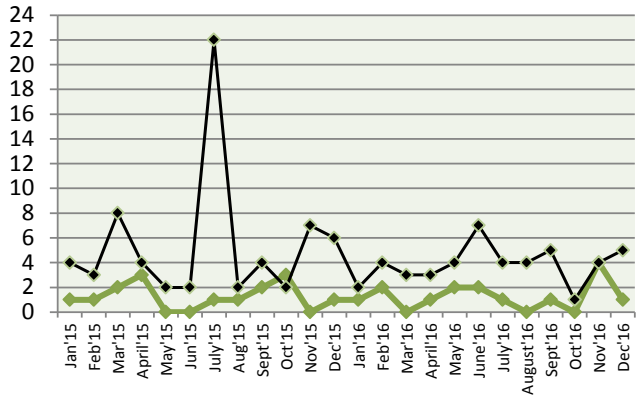
Clinical Support Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

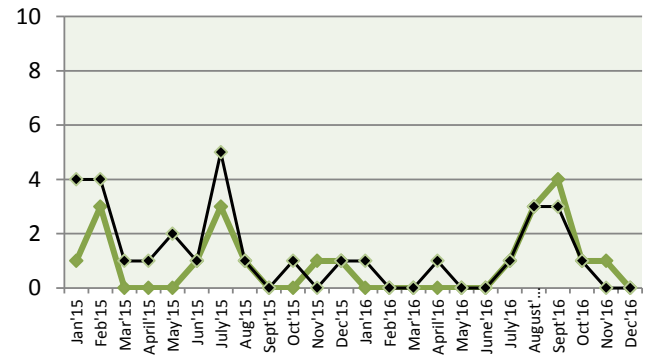
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



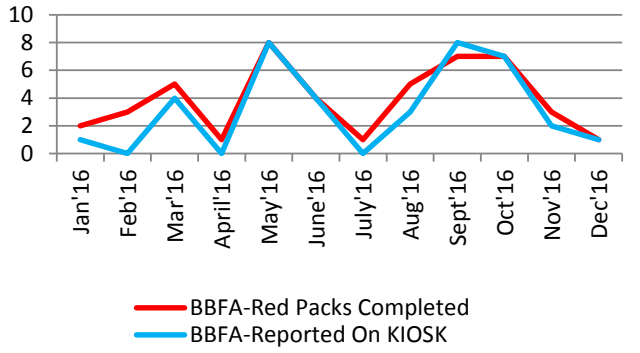
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

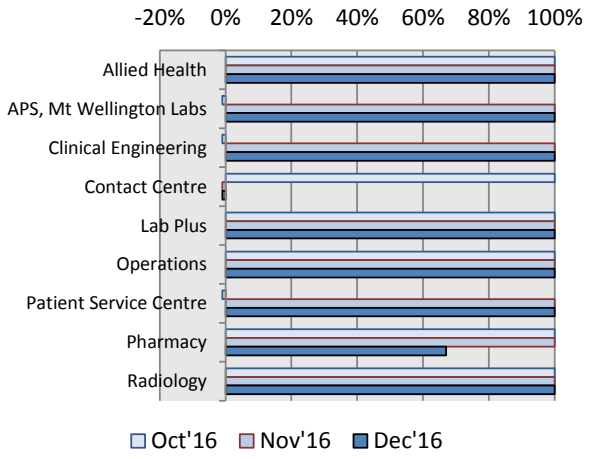


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



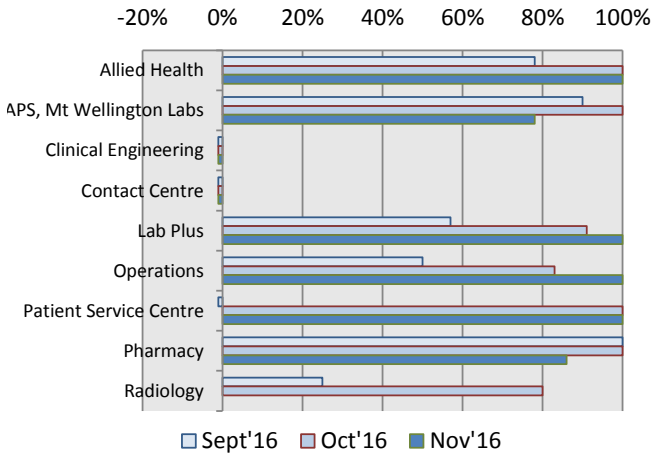
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	100%	100%	98%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	71%	92%	86%



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

Information data accurate as of 06/01/2017

Corporate Services Health and Safety Report

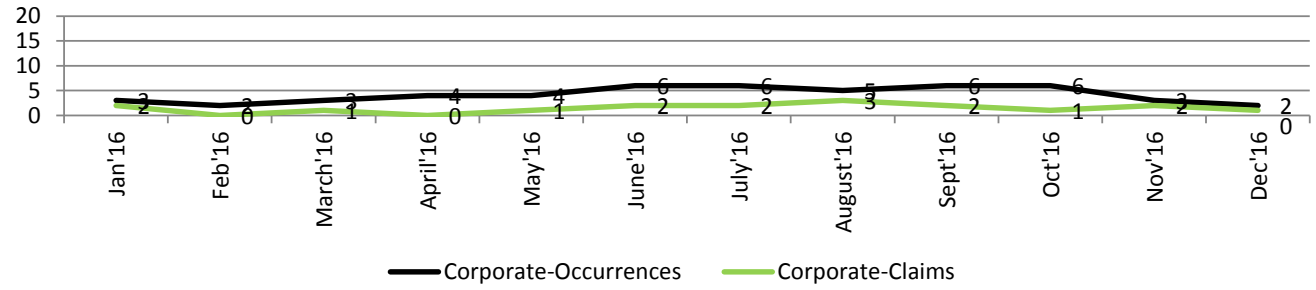
Lagging

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

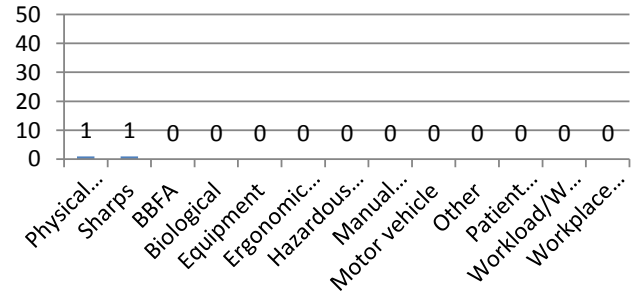
Leading

	Actual	Target	Trend
%H&S Inductions	25	80	
H&S Rep Vacancies No.	3	2	
%H&S Rep Training	69	80	
%6 Monthly Workplace Checklist	79	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	100	80	

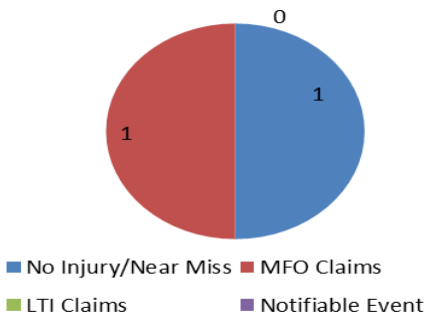
Health and Safety Incidents and Claims for 12 months



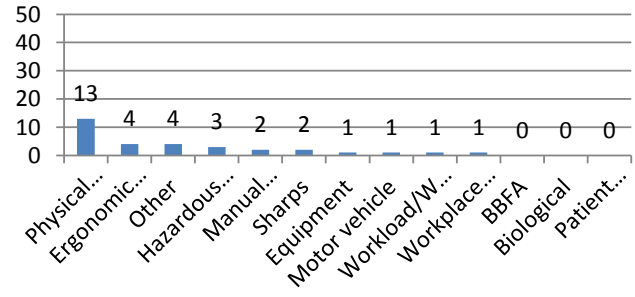
Health and Safety Incident by Hazard Type for December 2016



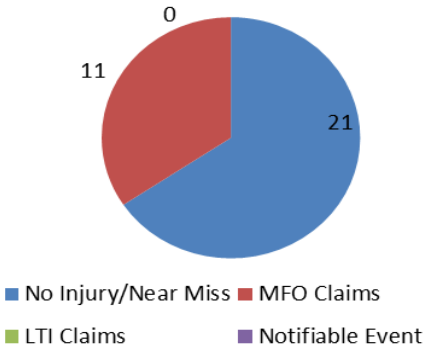
Work Injury by Outcome Type for December 2016



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



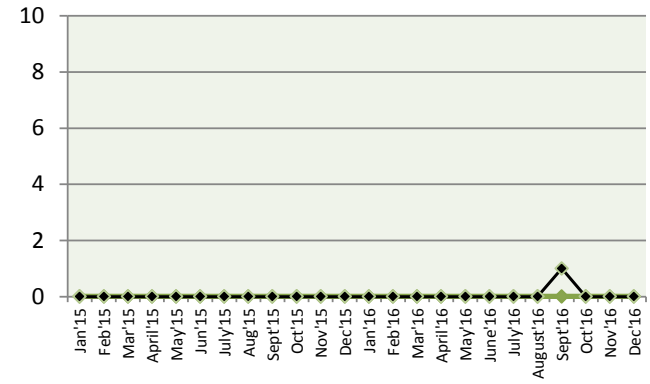
Work Injury by Outcome Type – YTD (2016-2017)



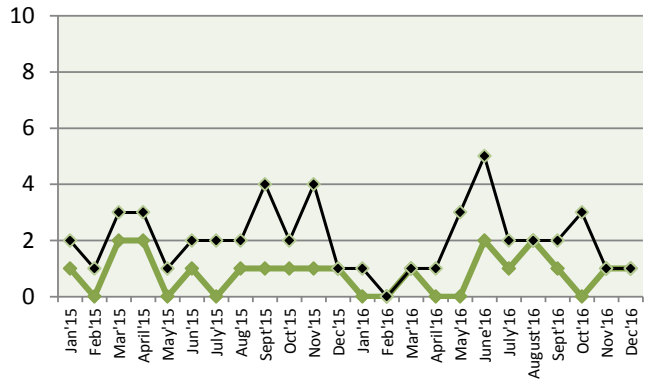
Corporate Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

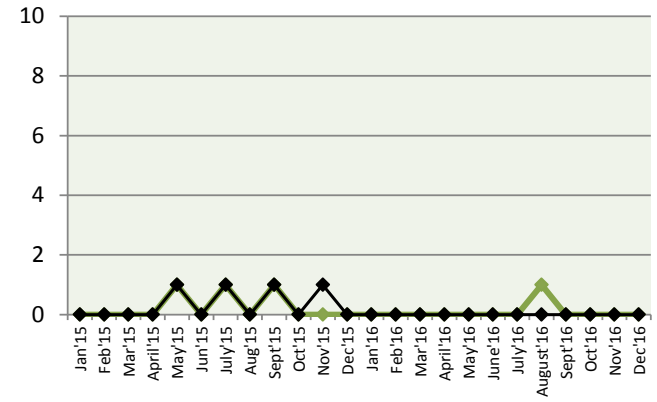
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



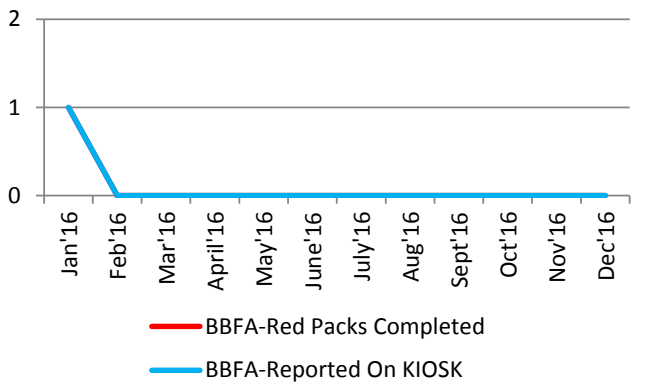
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



MANUAL HANDLING
(From 2 Years Rolling)

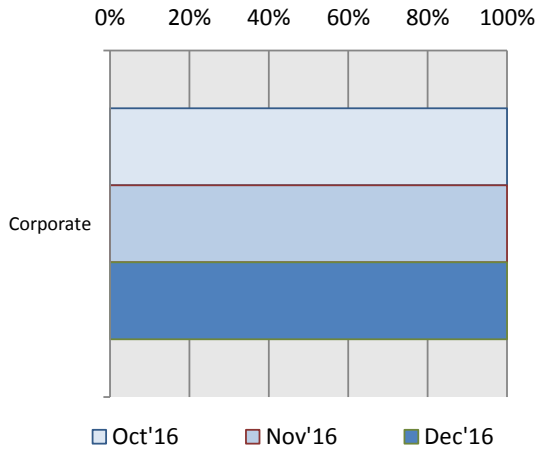


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



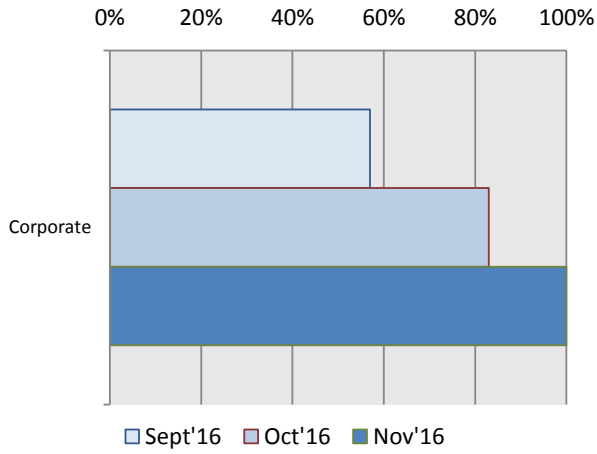
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	57%	83%	100%



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

Information data accurate as of 06/01/2017

Community and Long Term Conditions Health and Safety Report

Lagging

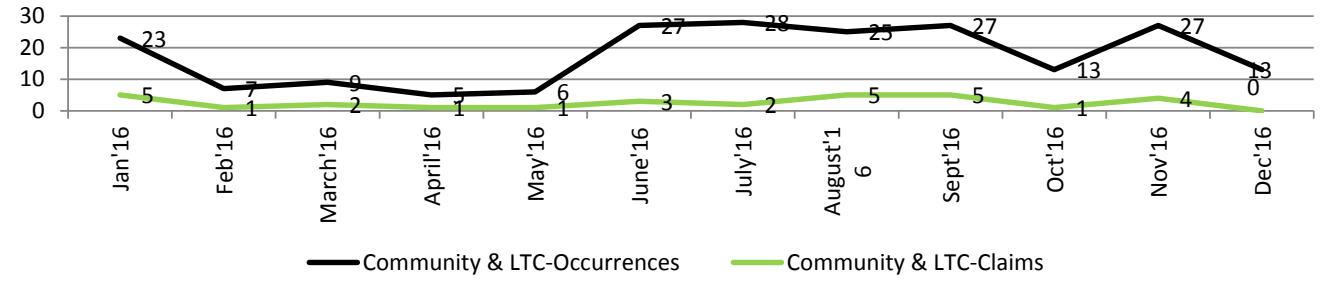
	Actual	Target	Trend
H&S Incidents	13	20	
Work Injury Claims	0	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

Leading

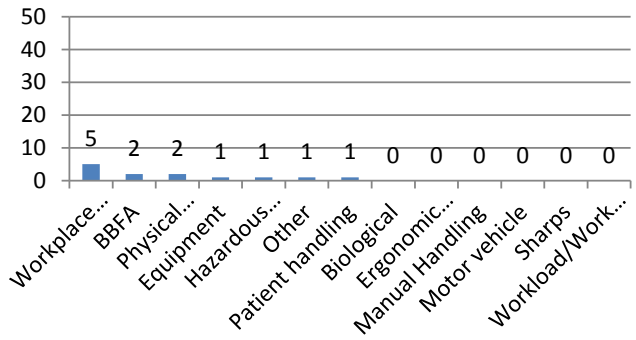
	Actual	Target	Trend
%H&S Inductions	67	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	68	80	
% 6 monthly Workplace Checklist	65	80	
%PES before start date	90	100	
%H&S Incidents Follow up 14 days	88	80	

8.1

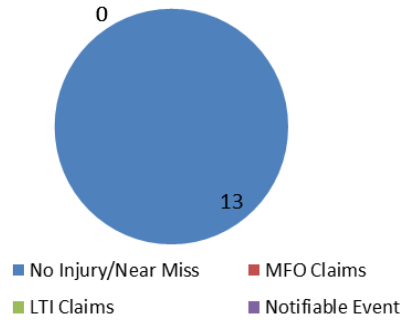
Health and Safety Incidents and Claims for 12 months



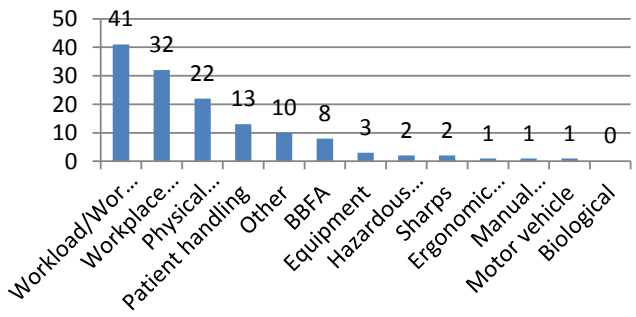
Health and Safety Incident by Hazard Type for December 2016



Work Injury by Outcome Type for December 2016

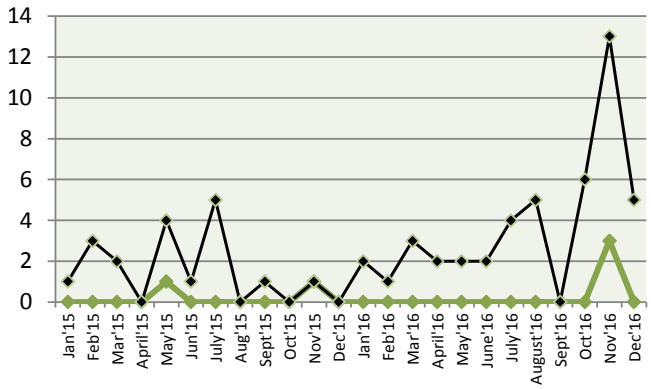


Health and Safety Incident by Hazard Type – Financial YTD (2016-2017)

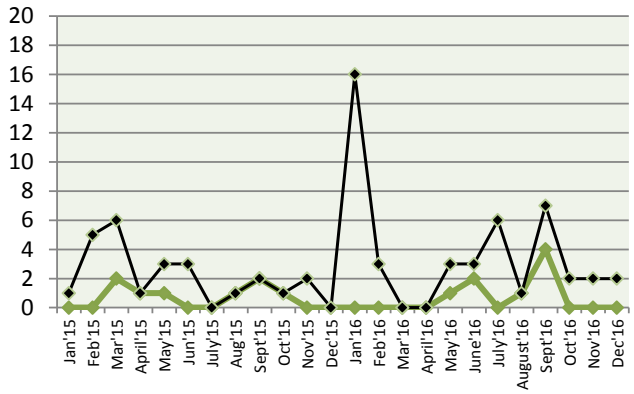


Work Injury by Outcome Type – YTD (2016-2017)

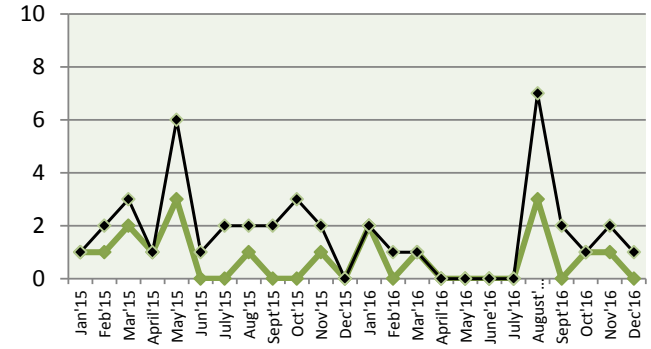
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



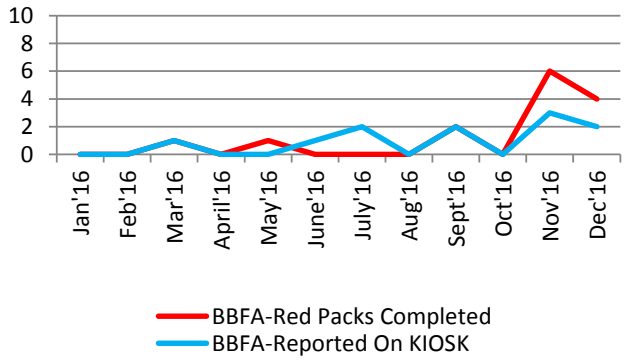
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

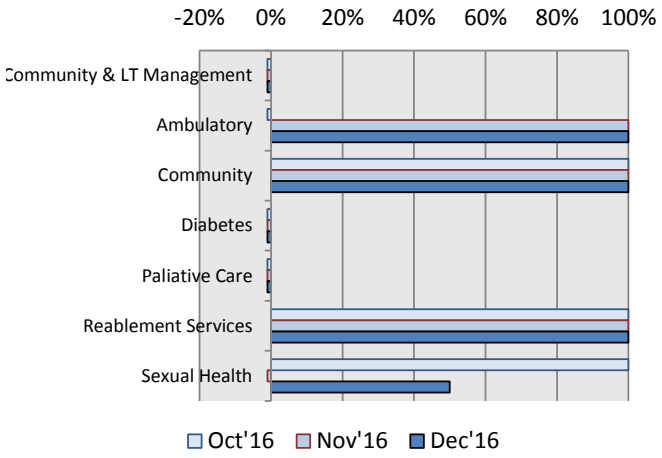


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



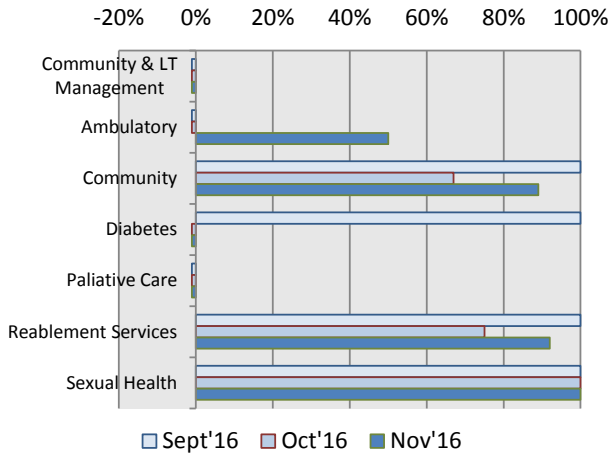
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	100%	100%	90%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	100%	77%	88%



Information data accurate as of 06/01/2017

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

Mental Health Services Health and Safety Report

Lagging

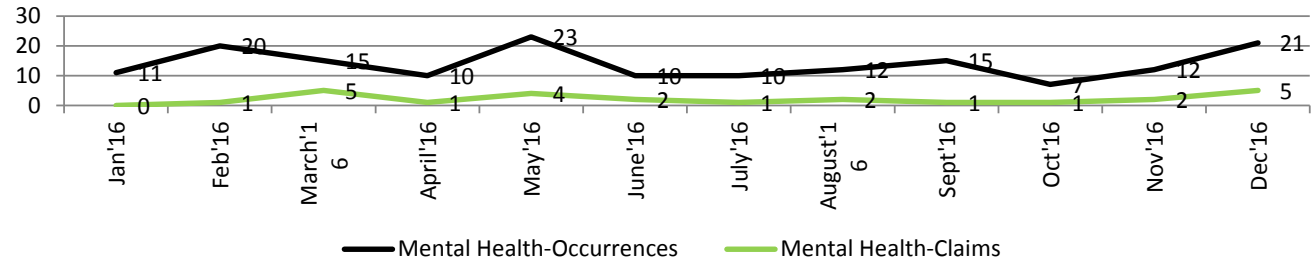
	Actual	Target	Trend
H&S Incidents	21	20	
Work Injury Claims	4	0	
Lost Time Injuries	3	0	
Notifiable Events	0	0	

Leading

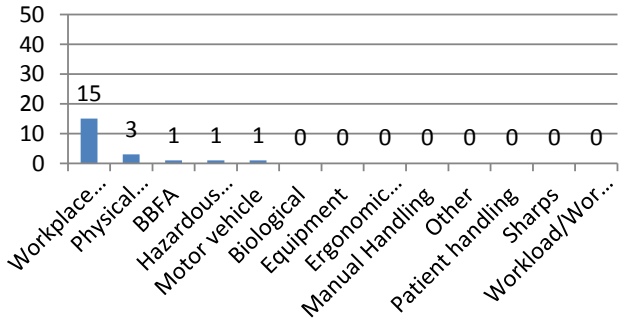
	Actual	Target	Trend
%H&S Inductions	67	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	56	80	
%6 Monthly Workplace Checklist	71	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	75	80	

8.1

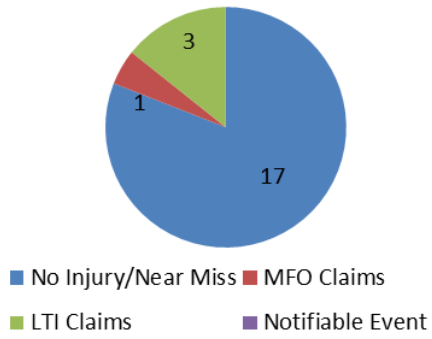
Health and Safety Incidents and Claims for 12 months



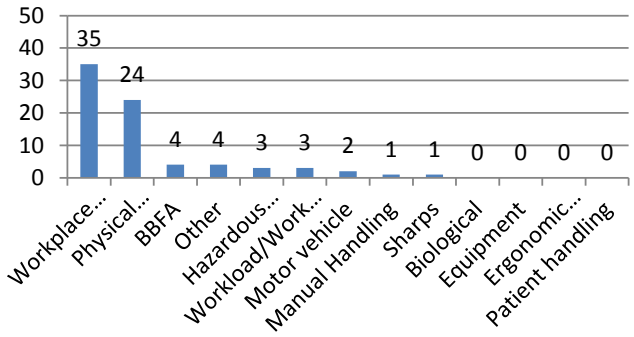
Health and Safety Incident by Hazard Type for December 2016



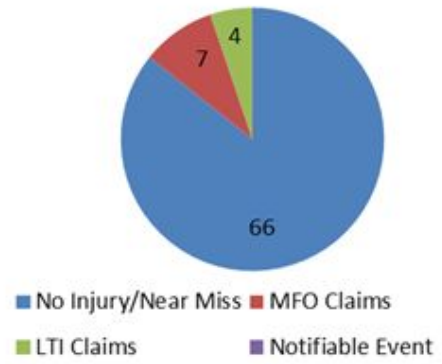
Work Injury by Outcome Type for December 2016



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

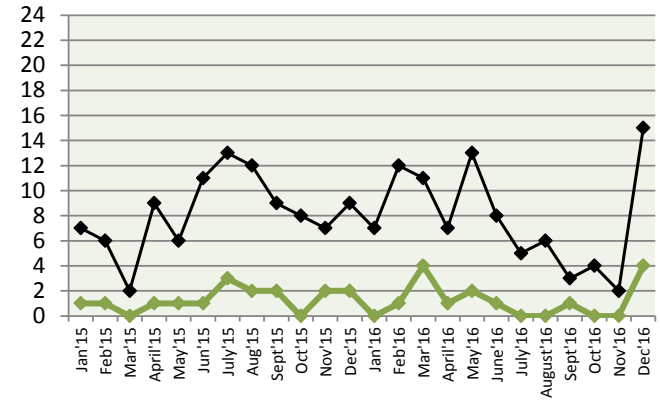


Work Injury by Outcome Type – YTD (2016-2017)

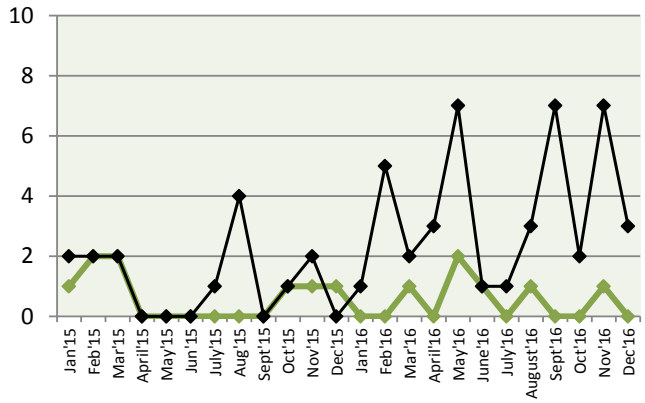


LEGEND: CLAIMS Health and Safety INCIDENT

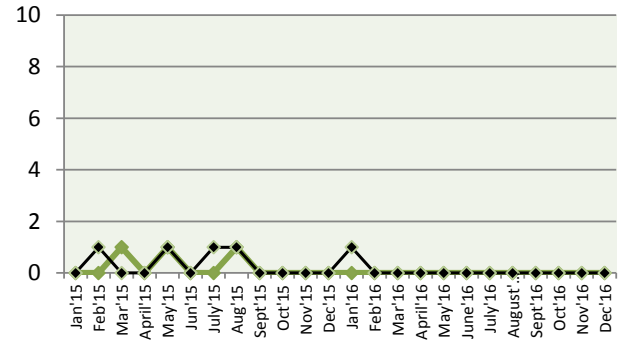
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



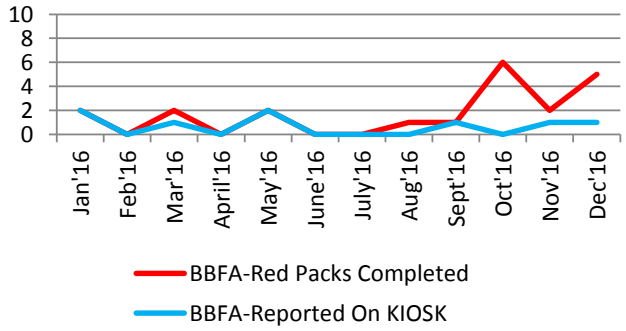
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

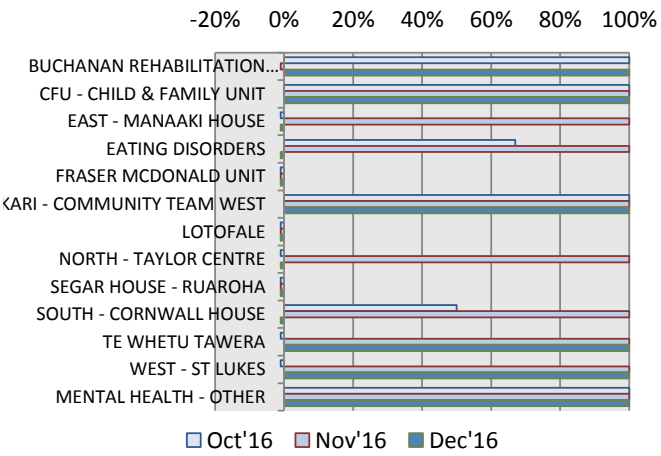


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



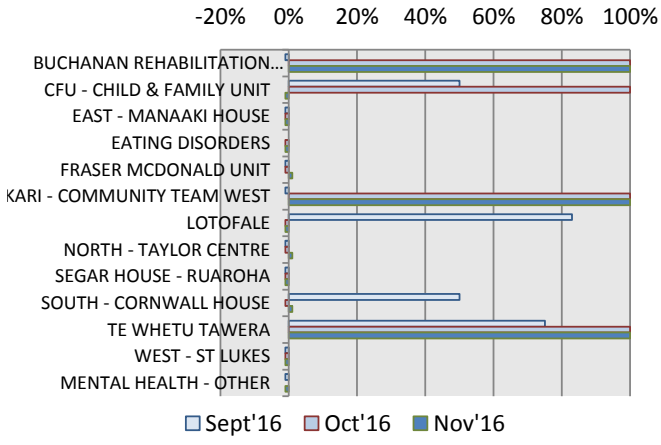
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	87%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	67%	86%	75%



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

Information data accurate as of 06/01/2017

Non Clinical Support Health and Safety Reports

Lagging

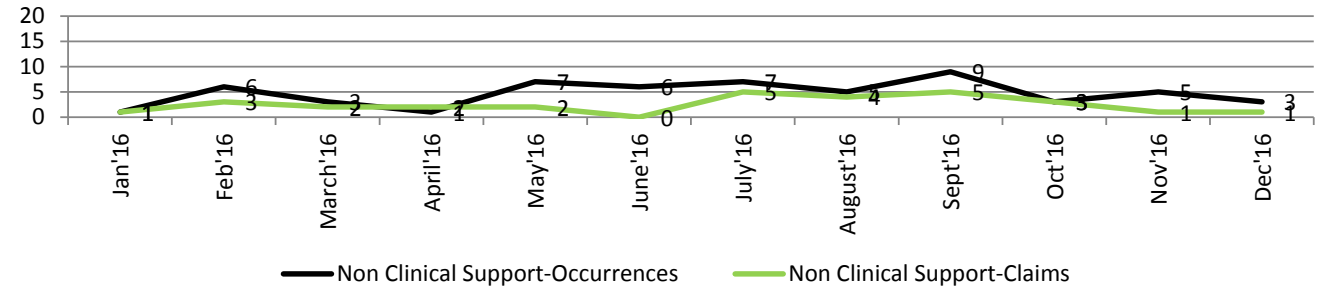
	Actual	Target	Trend
H&S Incidents	3	20	
Work Injury Claims	1	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

Leading

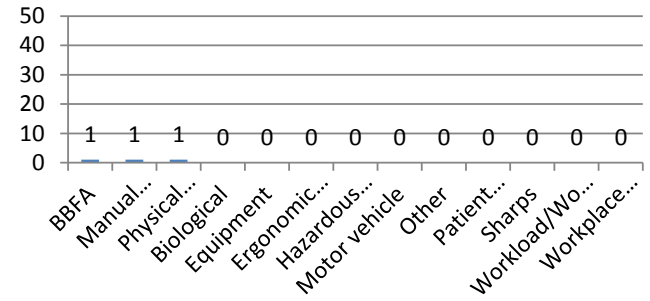
	Actual	Target	Trend
%H&S Inductions	0	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	8	80	
%6 Monthly Workplace Checklist	60	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	100	80	

8.1

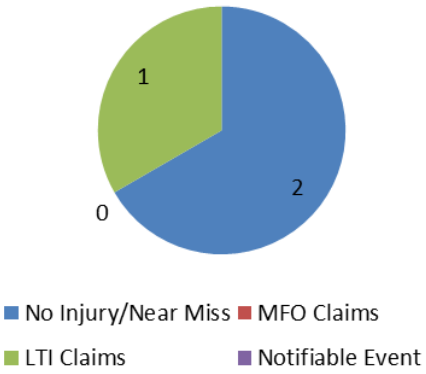
Health and Safety Incidents and Claims for 12 months



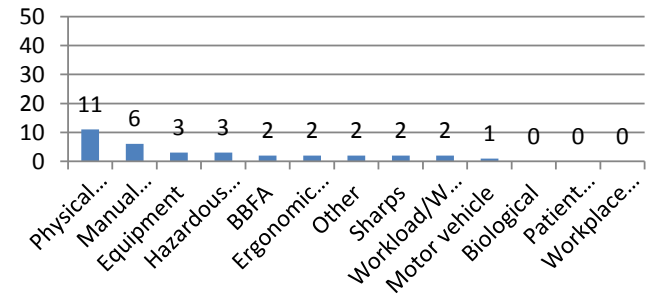
Health and Safety Incident by Hazard Type for December 2016



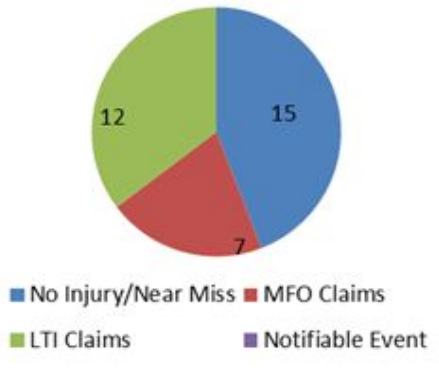
Work Injury by Outcome Type for December 2016



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



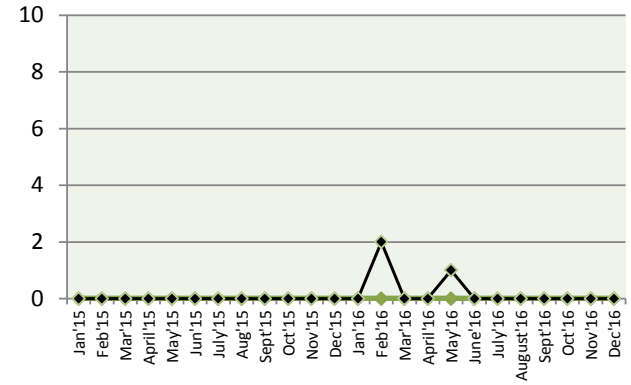
Work Injury by Outcome Type – YTD (2016-2017)



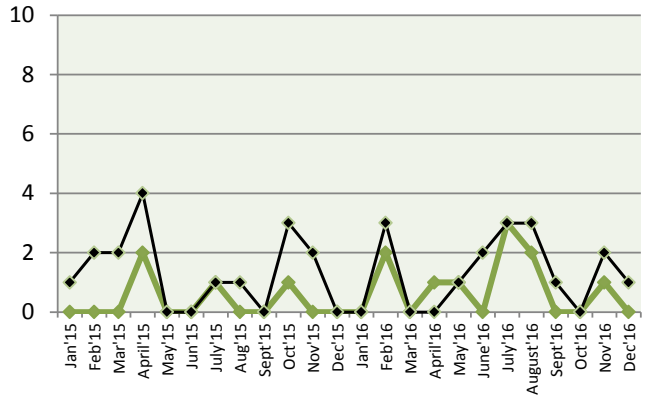
Non Clinical Support Health and Safety Reports (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

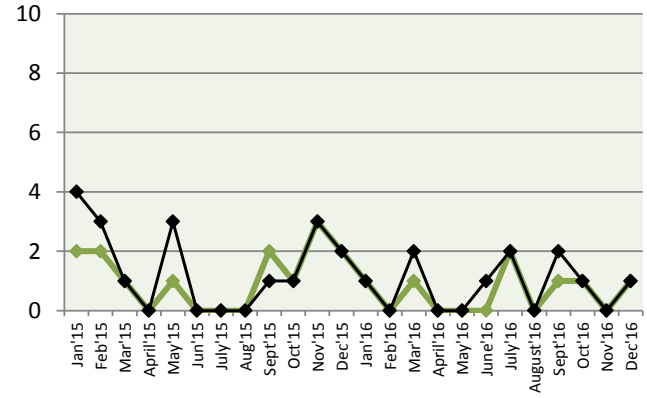
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



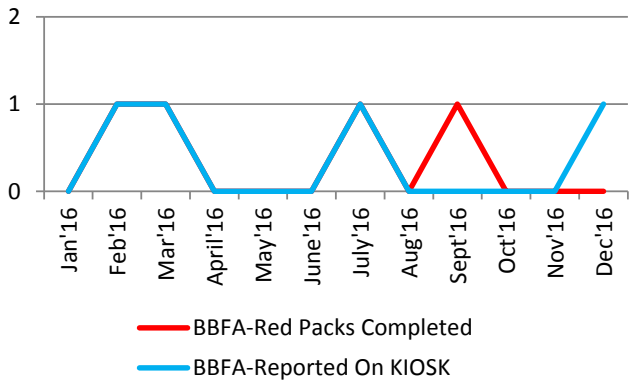
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



MANUAL HANDLING
(From 2 Years Rolling)

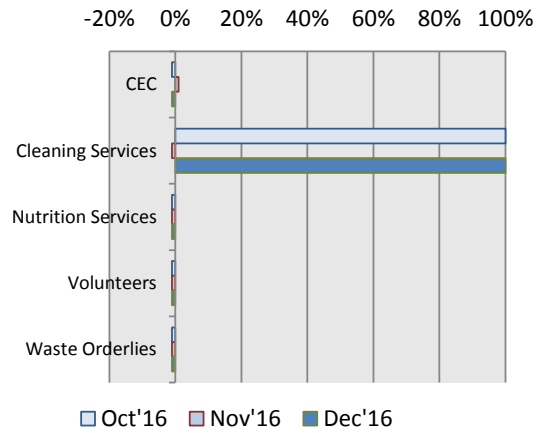


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



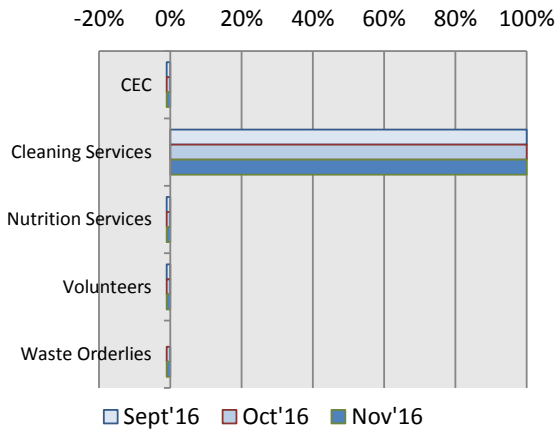
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	100%	0%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	89%	100%	100%



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

Information data accurate as of 06/01/2017

Perioperative Health and Safety Report

Lagging

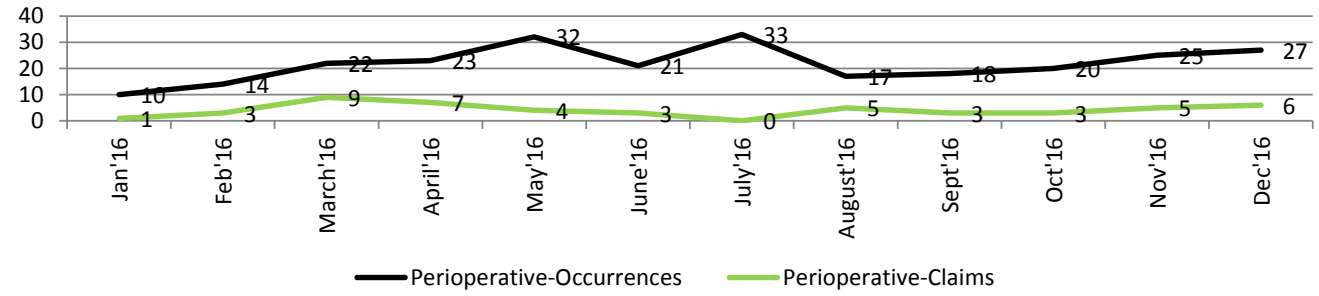
	Actual	Target	Trend
H&S Incidents	27	20	
Work Injury Claims	6	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

Leading

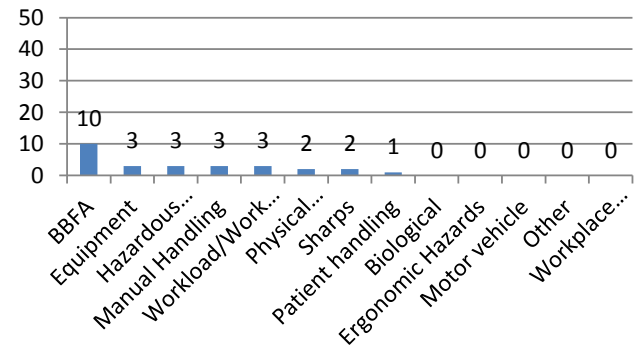
	Actual	Target	Trend
%H&S Inductions	100	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	70	80	
%6 Monthly Workplace Checklist	63	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	72	80	

8.1

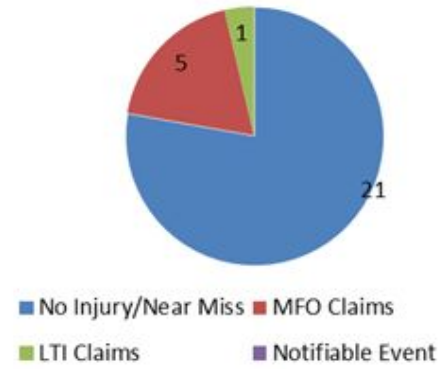
Health and Safety Incidents and Claims for 12 months



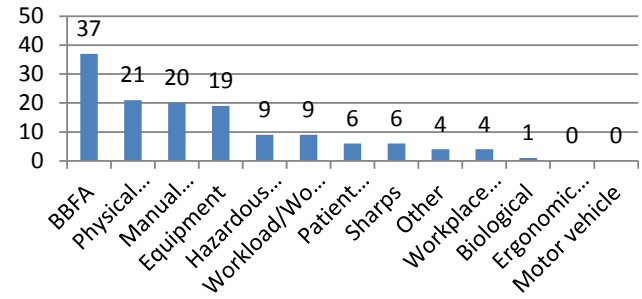
Health and Safety Incident by Hazard Type for December 2016



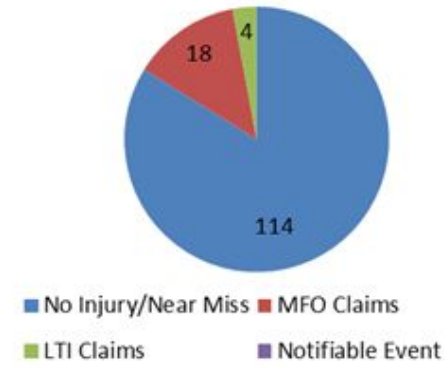
Work Injury by Outcome Type for December 2016



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



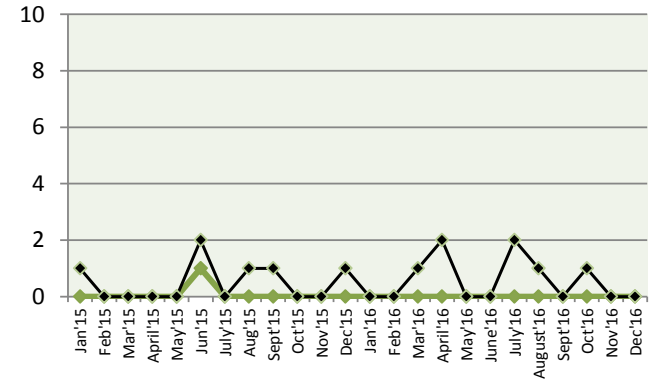
Work Injury by Outcome Type – YTD (2016-2017)



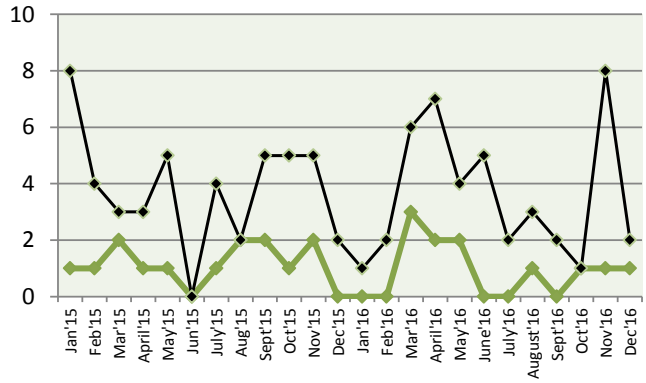
Perioperative Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

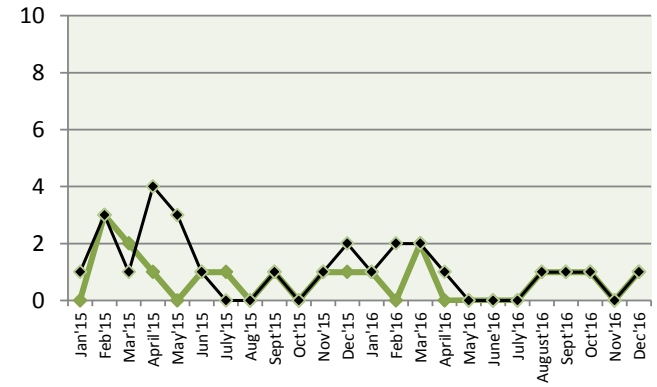
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



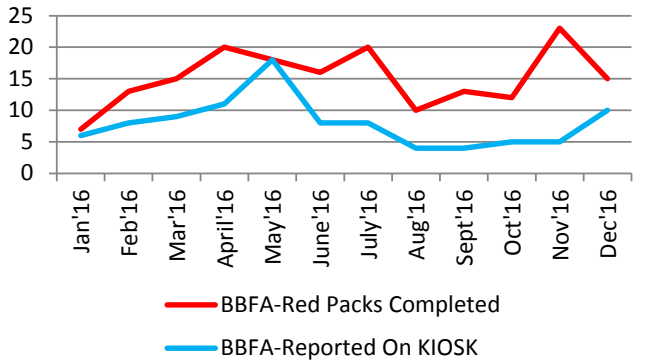
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

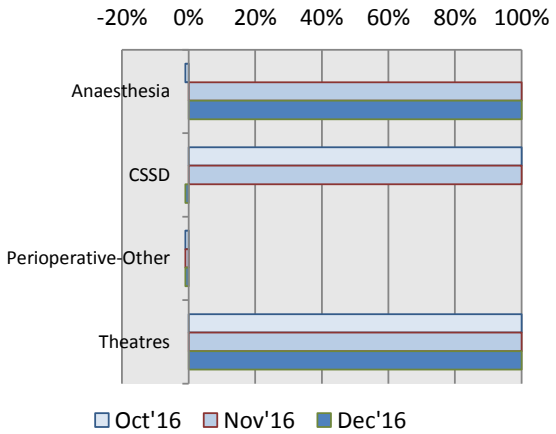


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



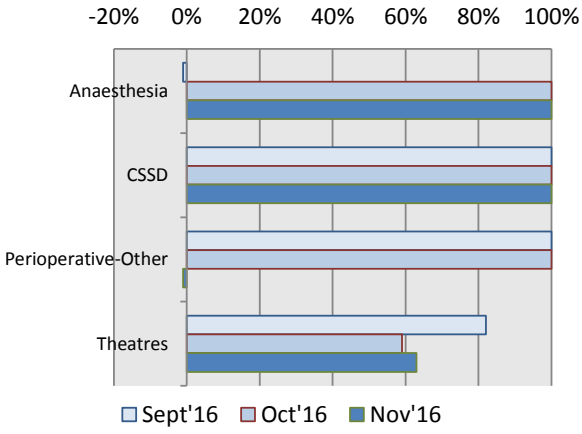
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	85%	68%	72%



Information data accurate as of 06/01/2017

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

Surgical Services Health and Safety Report

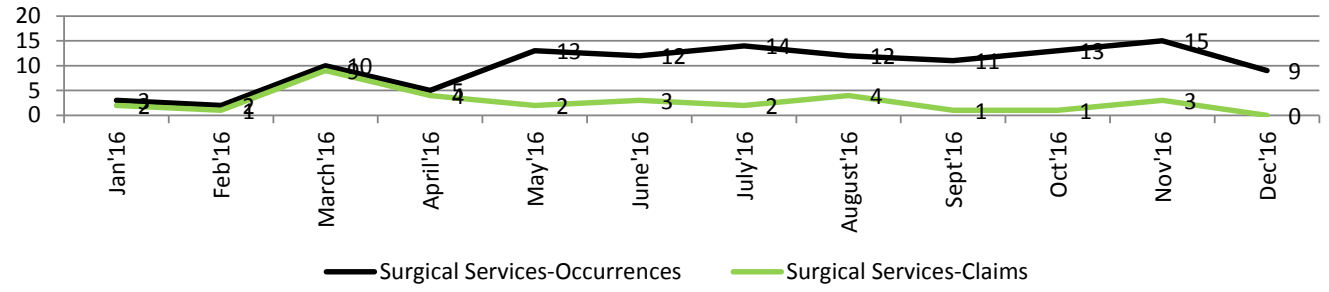
Lagging

	Actual	Target	Trend
H&S Incidents	9	20	
Work Injury Claims	0	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

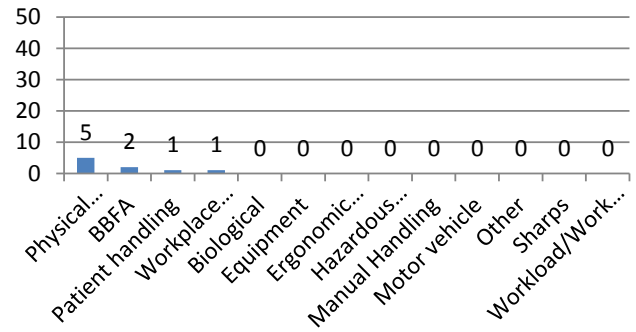
Leading

	Actual	Target	Trend
%H&S Inductions	3	80	
H&S Rep Vacancies No.	5	2	
%H&S Rep Training	35	80	
%6 Monthly Workplace Checklist	60	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	50	80	

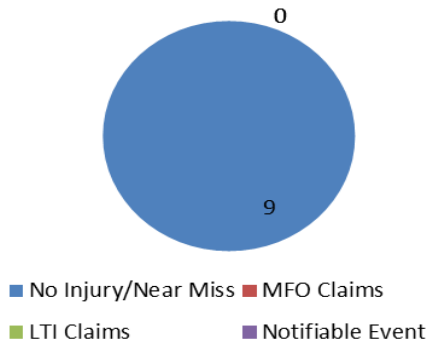
Health and Safety Incidents and Claims for 12 months



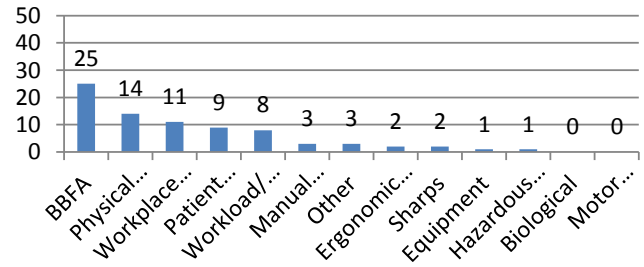
Health and Safety Incident by Hazard Type for December 2016



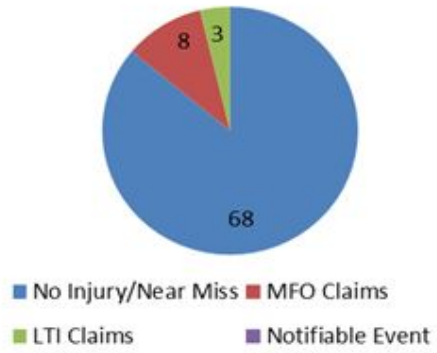
Work Injury by Outcome Type for December 2016



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



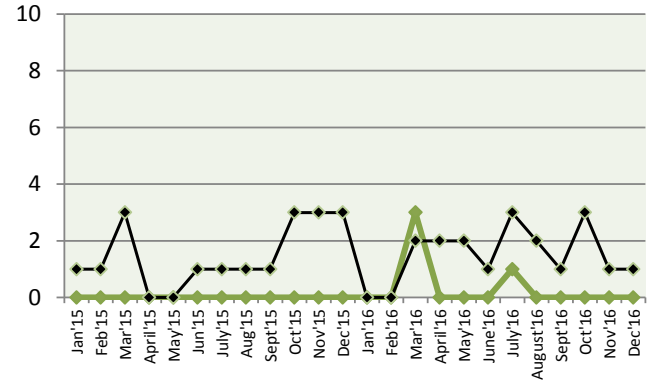
Work Injury by Outcome Type – YTD (2016-2017)



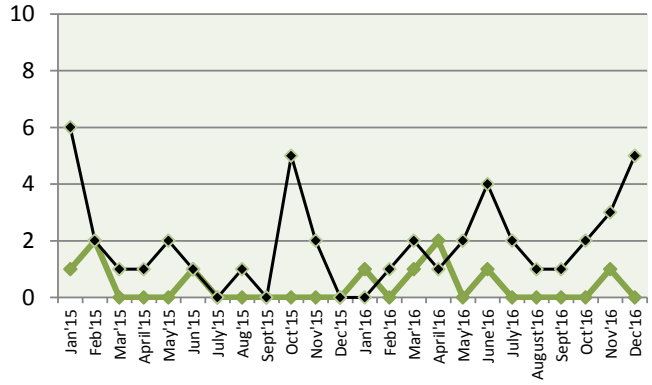
Surgical Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

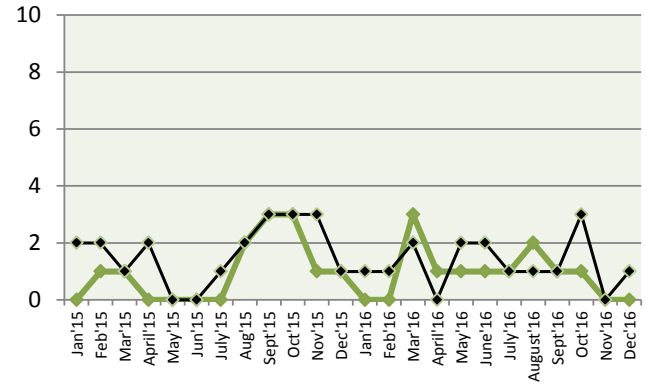
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



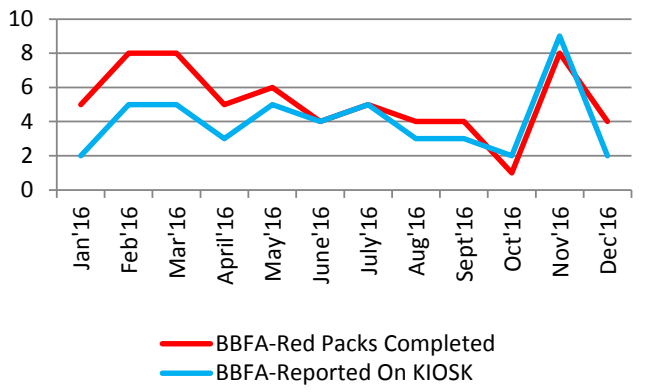
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

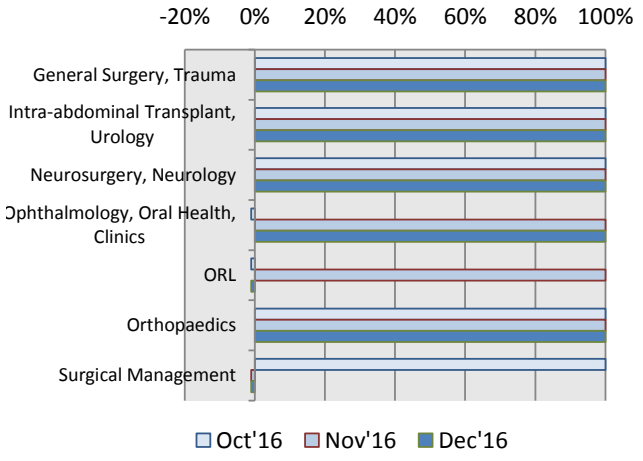


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



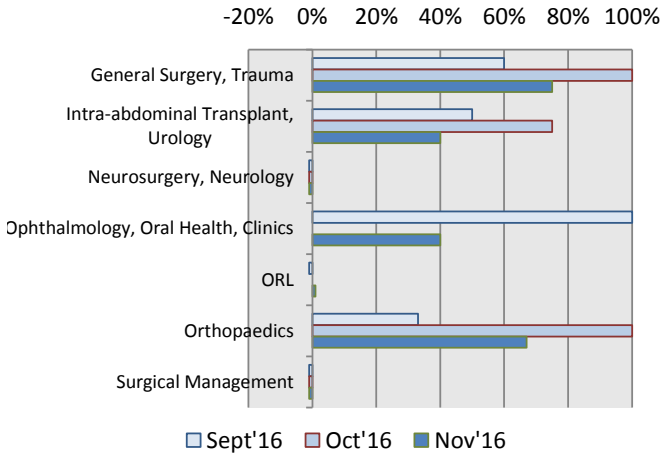
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	58%	75%	50%



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

Information data accurate as of 06/01/2017

Women's Health and Safety Report

Lagging

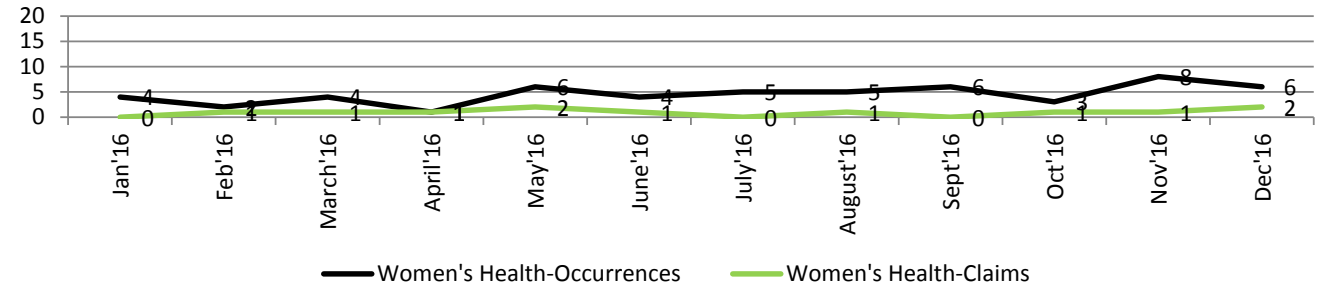
	Actual	Target	Trend
H&S Incidents	6	20	
Work Injury Claims	2	0	
Lost Time Injuries	2	0	
Notifiable Events	0	0	

Leading

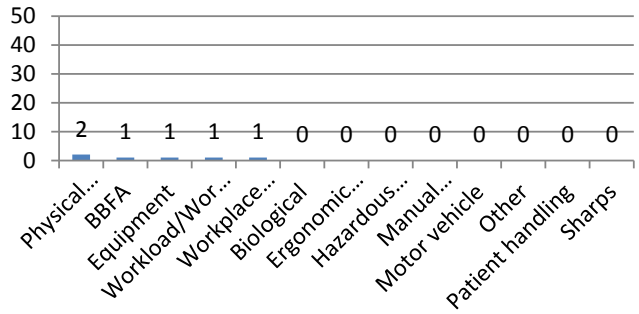
	Actual	Target	Trend
%H&S Inductions	57	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	21	80	
%6 Monthly Workplace Checklist	42	80	
%PES before start date	80	100	
%H&S Incidents Follow up 14 days	50	80	

8.1

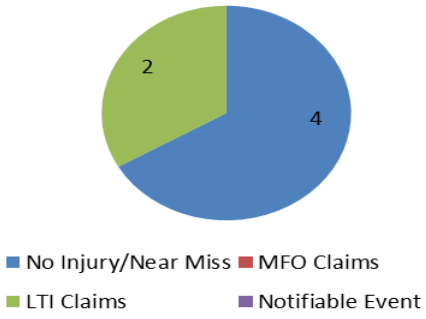
Health and Safety Incidents and Claims for 12 months



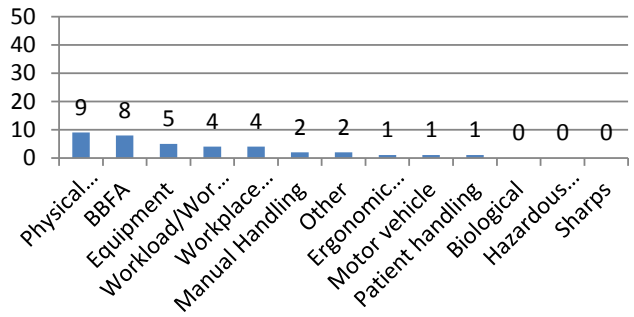
Health and Safety Incident by Hazard Type for December 2016



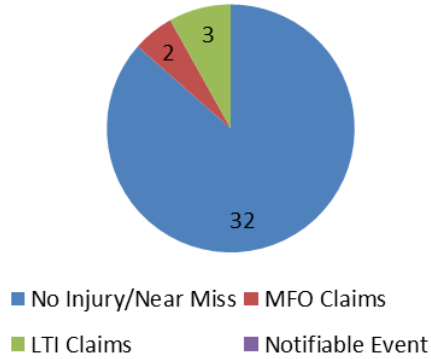
Work Injury by Outcome Type for December 2016



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



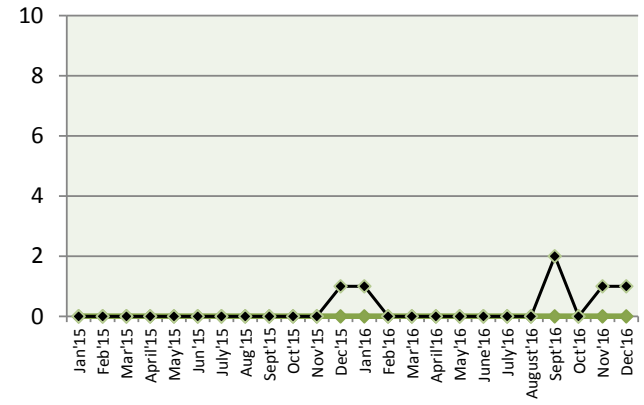
Work Injury by Outcome Type – YTD (2016-2017)



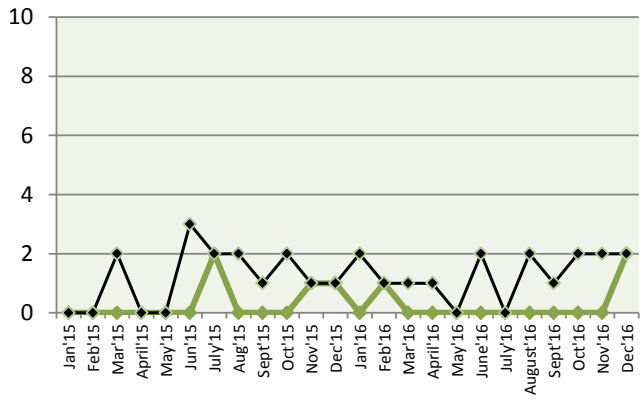
Women's Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

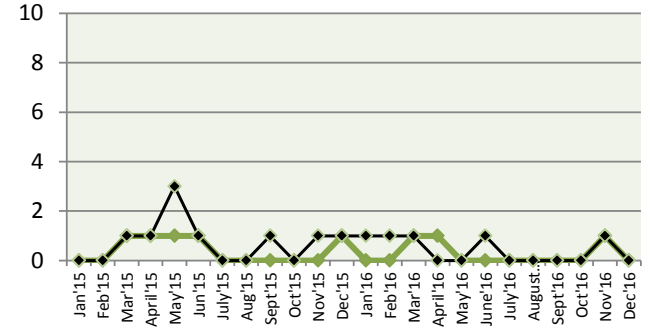
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



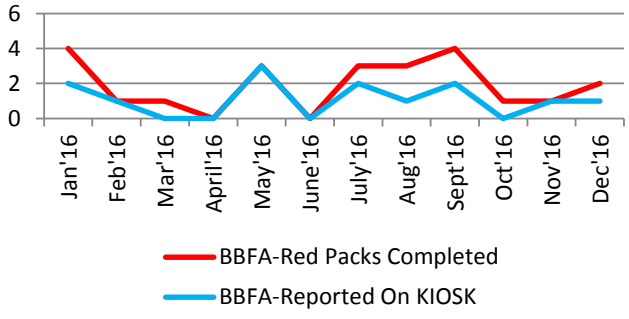
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

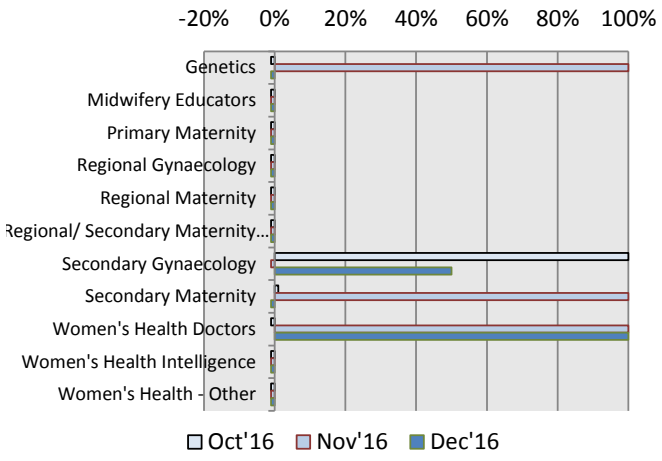


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



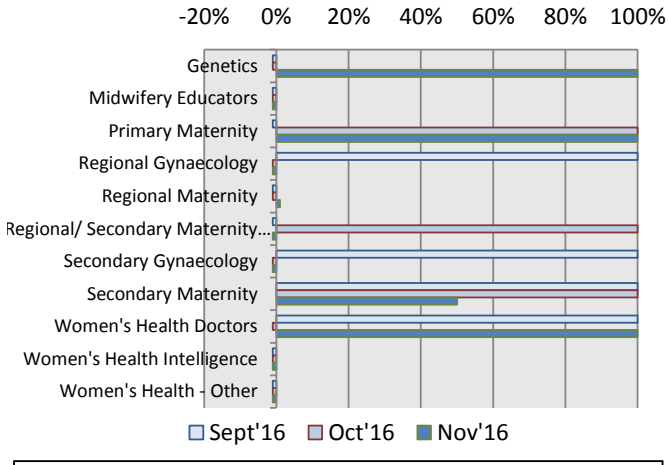
PRE-EMPLOYMENT SCREENING

TARGET	October'16	November'16	December'16
90%	50%	100%	80%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	September'16	October'16	November'16
80%	100%	100%	50%



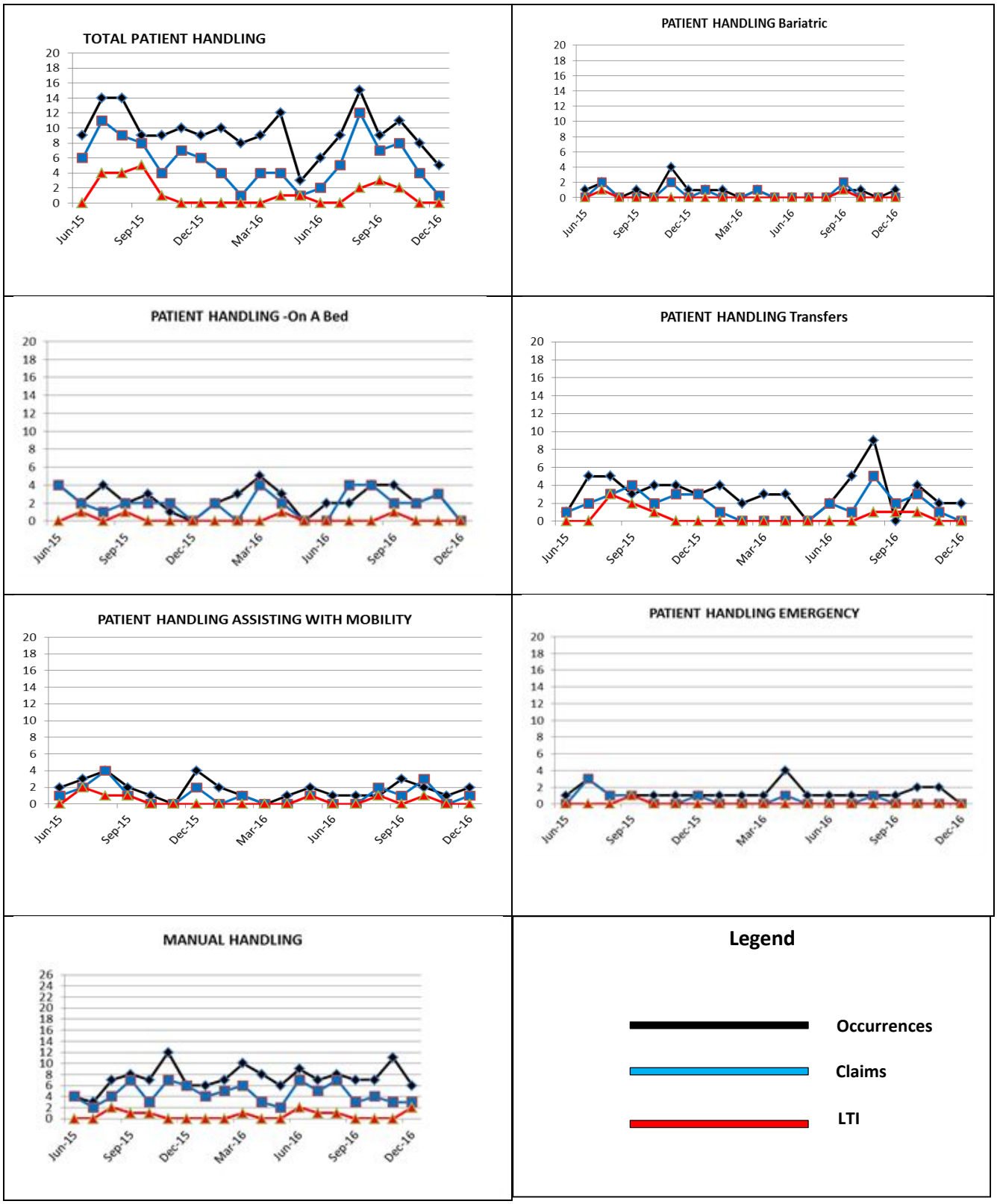
*Incident data 1 month lag to allow for Manager's investigations

Information data accurate as of 06/01/2017

Appendix 1 - Moving and Handling

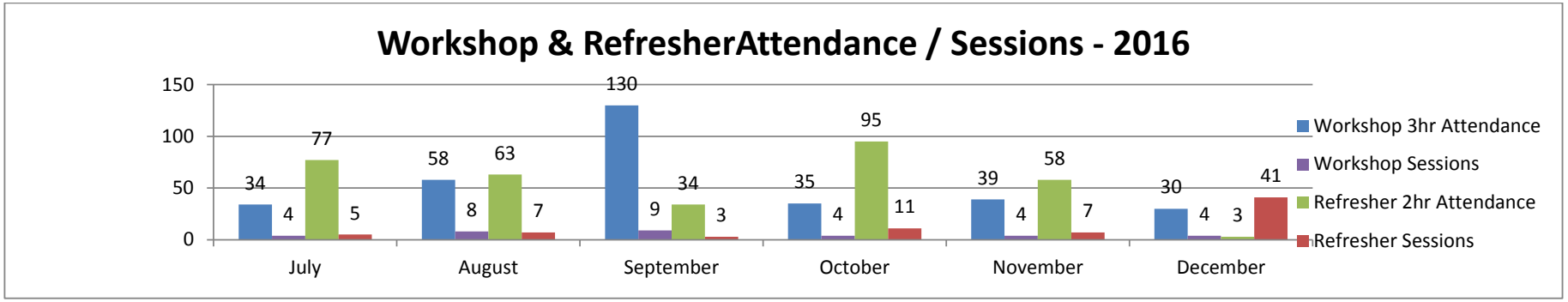
Please note; Occurrence and Claims and Training Data for December 2016

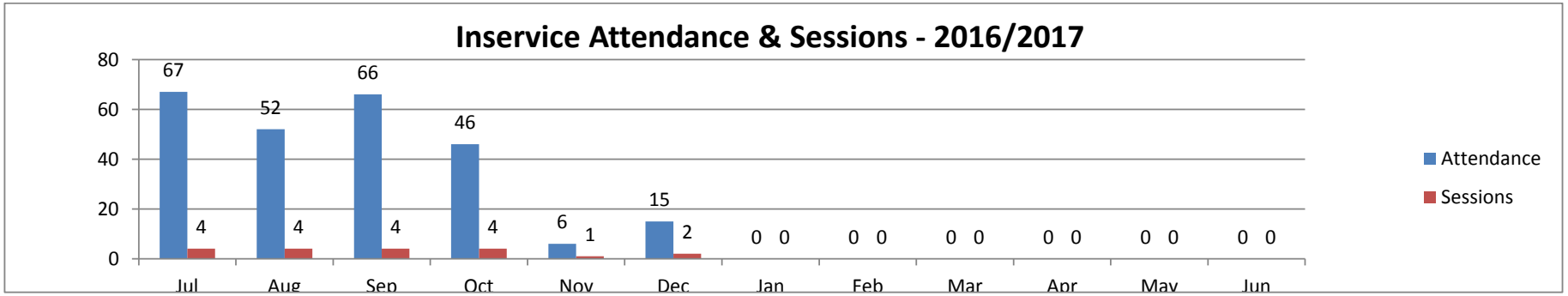
Table 5.1: Moving and Handling Injury causation

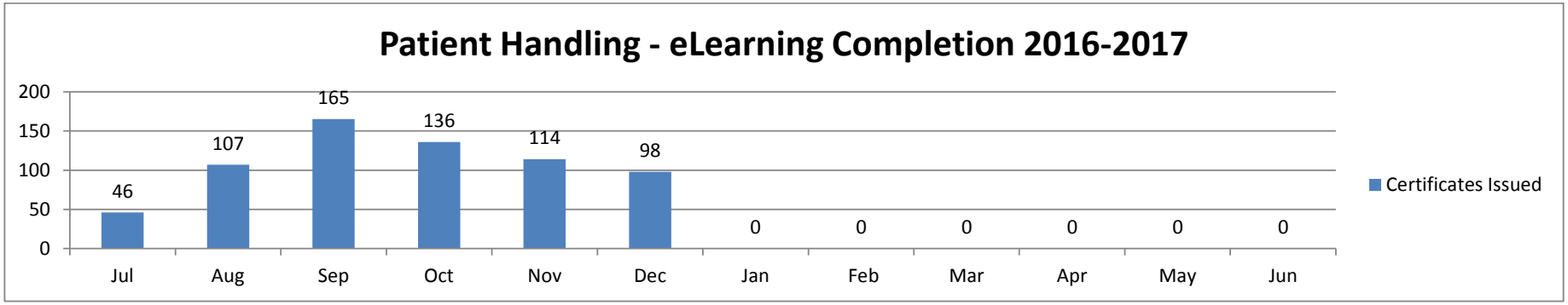


8.1

Appendix 2: Moving and Handling Workshops and Attendances from January 2016 – December 2016







Appendix 3 - Workplace Violence

1-31 December 2016

ADHB	Workplace Violence reported on RISKPRO				Workplace Violence reported on KIOSK				Workplace Violence CLAIMS
Directorate	December	% Reported		% Reported	December	% Reported		% Reported	
Community & LTC	5	8%	23	13%	5	19%	32	25%	0
Adult Medical	14	3%	48	9%	2	7%	22	17%	0
Cancer & Blood	0	0%	3	0%	0	0%	0	0%	0
Cardio-Vascular	0	0%	2	1%	0	0%	2	2%	0
Children's Health	2	0%	10	2%	0	0%	4	3%	0
Clinical Support	0	5%	4	6%	3	11%	14	11%	0
Corporate	0	0%	0	0%	0	0%	1	1%	0
Mental Health	40	24%	137	14%	15	56%	35	27%	4
Non Clinical Support	0	0%	2	0%	0	0%	0	0%	0
Perioperative	0	0%	3	2%	0	0%	4	3%	0
Surgery	0	2%	10	4%	1	4%	11	9%	0
Women's Health	1	2%	6	2%	1	4%	4	3%	0
Total ADHB	62		248		27		129		4

ADHB	Code Orange			
	December	% Reported	YTD	% Reported
ACH	90	80%	402	82%
Starship	14	13%	57	12%
Women's	0	0%	8	2%
GCC	1	1%	5	1%
Support Bldg	7	6%	21	4%
Total ADHB	112		493	

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	Substantially Completed	Policy is out for org wide consultation
		1.3	Hazard Identification and Risk Management	DJ/DL	30/03/16	**Completed**	This policy will be converted to a guideline published
		1.4	Health and Safety Occurrence reporting (Staff Incidents)	DJ/DL	30/03/16	On hold	This policy will be converted to a guideline , awaiting Datix system
		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**	simple review to align terminology
		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**	Has been aligned with the new Regulations via Asbestos Management committee. Published in June.
		1.10	Workplace Violence Prevention	DJ/DL	31/12/15	**Completed**	Policy published.
		1.11	Lone Worker Policy	DL	31/12/15	in progress	Policy has completed 30 day Auckland DHB wide consultation and will be aligned with Security project Lone Worker work stream. Additional consultation underway.
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

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	New course required. Content will be aligned will Health and Safety legislation and Regulations using the Institute of Directors Good Governance Health and Safety Guide as a core reference. Ko Awatea Learn course has been located and will be adapted for Auckland DHB.
		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. First course under the new law was held in May 2016. All course for 2016 now full, 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. And 2 training sessions scheduled for Dec. 2016 and Jan. 2017.
4	On Line Hazard	4.1	On Line Hazard Management	DJ/DL	31/12/2016	**Completed**	Focus of this project has moved to preparing the

NO.	Element	#	Detail Action	Assigned to	Due Date	Status	Remark
	Register		system: Install and train Directorates: • Sequential implementation (by Directorate) • One commenced per month throughout 2016 • Manager Training Health and Safety Rep training				services for transition to new Risk management software acquisition that is in final stages. 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	Substantially Competed	The Datix project is underway, consultation of design has occurred, testing will commence in November with a target go-live in February 2017.

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

8.1

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	Management Response
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.	**Management accepts this recommendation**
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.	**Management accepts this recommendation**
4.3.2 Training database	To increase the visibility of completed training and improve bring up reminders; work to centralise this system is supported.	**Management accepts this recommendation**
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.	**Management accepts this recommendation**
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.	**Management accepts this recommendation**

Appendix 7 Terms of reference for 2017 Health and Safety Review (Draft)

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.

Financial Performance Report

Recommendation

That the Board

(i) Receives this Financial Report for December 2016; and

(ii) Notes the change in Government policy reducing capital charge cost from 8% to 7% and requiring all DHB sector debt from the Crown to be converted to Crown Equity.

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

The DHB financial result for the month of December 2016 was a surplus of $1.2M which was unfavourable to budget by $0.4M. For the Year to Date (YTD), a surplus of $0.8M was realised, unfavourable to budget by $6M. This reflects a $14M unfavourable Provider arm result, partially offset by an $8.3M favourable Funder arm result. The overall DHB YTD result was driven by less revenue realised than planned.

YTD revenue was unfavourable to budget by $9M. Key drivers for this include under-delivery of additional electives volumes ($5.7M, reflected in MoH Devolved contracts revenue). Other unfavourable revenue variances include less than planned MoH non-devolved contracts revenue (mainly Public Health funding $1.1M les than planned but fully offset by favourable expenditure); unfavourable financial income ($1.6M mainly due to market interest rates below plan) and unfavourable donation income ($2M, associated with timing of implementing projects). Adverse variances were partially offset by $1.6M additional research income and $0.6M gain on the valuation of A+ Trust financial assets.

YTD expenditure is favourable to budget by $3M. This is primarily due to favourable Funder NGO expenditure ($13.3M, mainly pharmaceuticals, Age Related Residential Care and Mental Health services). This offsets adverse expenditure in net personnel and outsourced personnel costs ($4.4M); clinical supplies ($4M) and infrastructure/ non-clinical supplies ($2.9M).

The result has also been impacted overall by additional transplant activity that has been undertaken above the current funded levels. Compensation for this has been sought from the Ministry of Health.

The full year plan is a surplus of $4.5M and is forecast to be achieved. However, this is dependent on the DHB resolving the IDF pricing issues with the help of the Ministry of Health and other DHBs, and the planned savings or other offsets for unachievable savings being realised.

Summary Results as at 31December 2016

$000s	Month (December-16)			YTD (6 months ending 31 Dec-16)			Full Year (2016/17)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
MOH Sourced - PBFF	98,868	98,860	8 F	593,205	593,162	42 F	1,186,374	1,186,325	49F
MoH Contracts - Devolved	6,849	9,011	2,162 U	48,855	54,067	5,212 U	104,777	108,134	3,357U
	105,717	107,872	2,154 U	642,060	647,229	5,169 U	1,291,151	1,294,459	3,308U
MoH Contracts - Non-Devolved	4,551	4,894	343 U	27,495	29,702	2,207 U	58,367	59,538	1,171U
IDF Inflows	54,922	52,772	2,150 F	317,399	316,631	768 F	639,786	633,262	6,524F
Other Government (Non-MoH, Non-OtherDHBs)	4,020	3,249	772 F	19,071	18,909	162 F	40,349	37,738	2,611F
Patient and Consumer sourced	1,983	1,573	411 F	9,117	9,421	305 U	18,992	19,207	215U
Inter-DHB & Internal Revenue	1,121	1,258	137 U	6,814	7,878	1,064 U	14,544	15,791	1,247U
Other Income	4,563	4,157	406 F	27,498	25,111	2,387 F	51,673	48,721	2,952F
Donation Income	95	593	498 U	1,646	3,585	1,939 U	8,073	8,907	834U
Financial Income	372	678	306 U	2,238	3,865	1,627 U	4,921	7,606	2,685U
Total Income	**177,344**	**177,043**	**301 F**	**1,053,339**	**1,062,332**	**8,993 U**	**2,127,856**	**2,125,229**	**2,627F**
Expenditure									
Personnel	72,783	74,291	1,508 F	439,810	440,952	1,142 F	898,423	889,213	9,210U
Outsourced Personnel	2,128	1,115	1,014 U	12,234	6,738	5,496 U	20,265	13,402	6,863U
Outsourced Clinical Services	2,352	2,059	294 U	11,805	12,500	695 F	25,839	24,923	916U
Outsourced Other Services (incl. hA/funder Costs)	5,124	5,041	84 U	30,504	30,244	260 U	60,097	60,488	391F
Clinical Supplies	21,110	20,002	1,108 U	130,104	126,154	3,950 U	259,865	254,983	4,882U
Funder Payments - NGOs	46,509	47,642	1,134 F	272,570	285,853	13,283 F	549,843	571,707	21,864F
Funder Payments - IDF Outflows	9,669	9,567	102 U	57,264	57,400	136 F	115,557	114,800	757U
Infrastructure & Non-Clinical Supplies	12,057	11,097	959 U	70,854	68,001	2,853 U	137,962	135,452	2,510U
Finance Costs	1,050	1,052	2 F	6,239	6,311	72 F	12,538	12,621	83F
Capital Charge	3,359	3,568	209 F	21,199	21,408	209 F	42,931	43,140	209F
Total Expenditure	**176,141**	**175,433**	**708 U**	**1,052,584**	**1,055,560**	**2,976 F**	**2,123,320**	**2,120,729**	**2,591U**
Net Surplus / (Deficit)	**1,203**	**1,610**	**407 U**	**755**	**6,772**	**6,017 U**	**4,536**	**4,500**	**36 F**

2. Result by Arm

Result by Division	Month (December-16)			YTD (6 months ending 31 Dec-16)			Full Year (2016/17)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	421	375	46 F	10,575	2,250	8,325 F	21,100	4,500	16,600F
Provider	834	1,235	401 U	(9,663)	4,522	14,185 U	(16,506)	0	16,506U
Governance	(52)	0	52 U	(157)	0	157 U	(58)	0	58U
Net Surplus / (Deficit)	**1,203**	**1,610**	**407 U**	**755**	**6,772**	**6,017 U**	**4,536**	**4,500**	**36 F**

The favourable YTD Funder result reflects lower expenditure for Community Pharmacy as a result of 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 ($4M) mainly reflecting under-delivery of elective volumes, and lower interest and donation income than planned. Expenditure was also unfavourable ($10M) 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 December 2016

Month Result

Major Variances to budget on a line by line basis are described below.

Revenue was more than budget by $0.3M (0.2%), mainly driven by:

- MoH devolved contracts which are $2.1M unfavourable due to unrealised revenue for under-delivery of elective volumes.
- IDF Inflow revenue 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. The $2.1M

favourable variance mainly reflects the release of the "at risk" provisions for under-delivery of inpatient services.
- Other government revenue was $0.8M favourable mainly due to ACC revenue more than plan due to one off revenue for new contracts and additional volumes of elective surgery.
- Donation income $0.5M unfavourable due to the timing of key projects.

Expenditure was more than budget by $0.7M. Significant variances are described below:

- Favourable expenditure was realised mainly in Funder NGOs, $1.1M (2.4%) 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 lines not yet contracted for.
- Combined Personnel and Outsourced Personnel costs were $0.5M (0.7%) favourable, mainly in Medical, Allied Health and Management & Admin costs. Total FTEs at 8,661 are 123 above last month and 331 FTE above budget – the budget variance reflects a combination of FTE savings targets incorporated into the budget and a temporary spike in FTE for a) funded MRT students (33 above last month) and b) RMO FTE following rotation (39 above last month), both of which will reduce over the next month. After taking these temporary spikes into account, underlying total FTE are 45 above the calendar YTD average of 8,544 per month from January to November, with the increase predominantly in Nursing and Allied Health.
- Clinical Supplies $1.1M (5.5%) unfavourable, reflecting total volumes for the month 7.5% above contract.
- Infrastructure and Non Clinical Supplies $1M (8.6%) unfavourable, with the key variances being– high costs of bad/doubtful debts $0.3M unfavourable, in line with higher than budget non-resident revenue for the month, and facilities costs $0.3M unfavourable due to additional health and safety related expenditure.

Year to Date Result

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

Revenue was less than the budget by $9M. Significant movements underlying this included:

- MOH devolved contract revenue is $5.2M unfavourable YTD. The year to date adverse variance is mainly due to the creation of a revenue risk provision for the under delivered inpatient services that are subject to year-end wash-ups. To this effect $1.2M was accrued in July, $0.8M was accrued in September, $2.6M was accrued in October and $1.9M accrued in December. This totals $6.5M offset by a prior year upside for additional electives revenue of $0.8M accounted for in October. Included in the month and year to date result is also a net $0.2M decrease in Capital Charge revenue due to the cost of capital rate change from 8% to 7% (-$6.1M for 2016/17) offset by an increase 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, $0.8M 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 Income $1.6M favourable, offset by equivalent expenditure and bottom line neutral.
- ACC revenue $0.7M favourable – with the variance reflecting a combination of one off revenue for new contracts and a small number of high value elective cases.

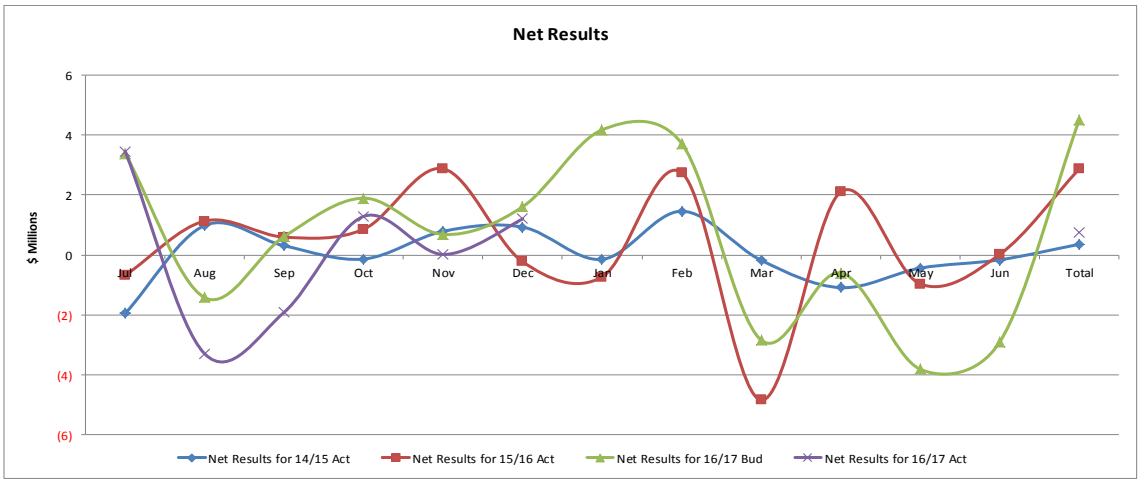
- Donations $2M unfavourable – revenue fluctuates from month to month, depending on timing of key projects, with the full year budget still expected to be achieved.
- Haemophilia funding $1.2M unfavourable for low blood product usage, bottom line neutral as offset by reduced expenditure.
- Other income includes a $0.6M gain on the valuation of A+ Trust financial assets.
- Financial Income $1.6M unfavourable driven by lower interest rates than assumed in the budget.

Expenditure was less than budget YTD by $3M, with significant underlying variances as follows:

- Combined Personnel and Outsourced Personnel Costs $4.4M (0.97%) unfavourable, mainly in Medical ($3.1M), Nursing ($1.4M) and Management & Admin ($1.1M) categories. YTD combined FTEs were 176 (2.1%) 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 $4M (3.1%) unfavourable comprising the following key variances:
    - Cardiovascular $1.1M 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.
    - Perioperative $0.7M reflecting theatre minutes 3.5% above YTD budget assumption.
    - One off costs for loss on disposal of assets $0.3M
    - Target savings not achieved $1.6M unfavourable.
- Outsourced Clinical Services $0.7M (5.6%) favourable, reflecting no Orthopaedic elective surgery outsourcing, and offset by an unfavourable revenue/volume position.
- Funder Payments to NGOs are YTD favourable $13.3M (4.6%) 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 $2.9M (4.2%) unfavourable reflecting Advance Care Planning project costs $0.6M unfavourable (bottom line neutral as offset by additional revenue), facilities costs $1.5M unfavourable driven by additional health and safety related expenditure and Patient Food $0.5M unfavourable due to additional costs of implementing new service model.

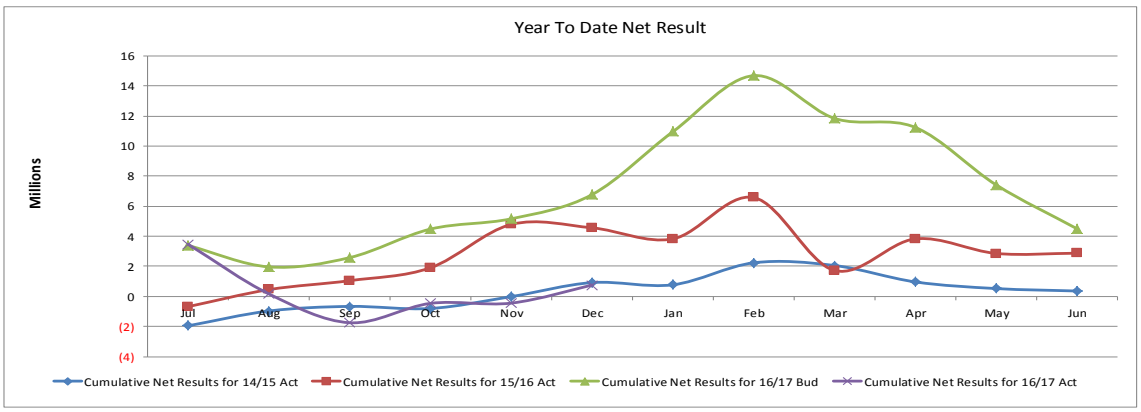
4. Performance Graphs

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							0.755

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						
Variance to Budget for 2016/17	0.076	(1.800)	(4.333)	(4.941)	(5.610)	(6.017)						

5. Efficiencies / Savings

Savings reported for the YTD to December 2016 of $10.2M were unfavourable to the budget of $21M by $10.8M. This is mainly attributed to timing factors as a number of initiatives are in implementation mode and have not come through yet. Savings achieved to date mainly relate to personnel/FTE/vacancy management, bed management, Laboratory/Radiology efficiencies and supply chain and Funder reported savings.

6. Financial Position

6.1 Statement of Financial Position as at 31 December 2016

$'000	31-Dec-16			30-Nov-16	Variance	30-Jun-16	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	576,798	576,798	0F	576,798	0F	576,798	0U
Reserves	-	-	0F	-	0F	-	0F
Revaluation Reserve	508,998	438,457	70,541F	508,998	0F	508,998	0F
Cashflow-hedge Reserve	(3,466)	(3,465)	1U	(3,512)	46F	(3,742)	276F
Accumulated Deficits from Prior Year's	(461,173)	(461,654)	481F	(461,173)	0F	(461,173)	0F
Current Surplus/(Deficit)	756	6,767	6,011U	(447)	1,203F	-	756F
	45,115	(19,895)	65,010F	43,866	1,249F	44,083	1,032F
Total Equity	**621,913**	**556,903**	**65,010F**	**620,664**	**1,249F**	**620,881**	**1,032F**
Non Current Assets							
Fixed Assets							
Land	282,803	249,006	33,797F	282,803	0F	282,803	0F
Buildings	614,900	586,895	28,005F	617,096	2,196U	619,402	4,502U
Plant & Equipment	82,025	88,764	6,739U	83,718	1,693U	92,164	10,139U
Work in Progress	50,159	55,751	5,592U	46,442	3,717F	45,236	4,923F
	1,029,887	980,416	49,471F	1,030,059	172U	1,039,605	9,718U
Derivative Financial Instruments	-	-	0F	-	0F	-	0F
Investments	-						
- Health Alliance	57,637	53,103	4,534F	56,578	1,059F	53,103	4,534F
- HBL	12,420	12,420	0U	12,420	0F	12,420	0F
- ADHB Term Deposits > 12 months	-	5,000	5,000U	-	0F	5,000	5,000U
- Other Investments	503	503	0F	503	0F	503	0F
	70,560	71,026	466U	69,501	1,059F	71,026	466U
Intangible Assets	534	1,115	581U	579	44U	762	228U
Trust Funds	15,553	14,494	1,059F	15,388	165F	14,495	1,058F
	86,648	86,635	13F	85,467	1,180F	86,283	365F
Total Non Current Assets	**1,116,535**	**1,067,051**	**49,484F**	**1,115,527**	**1,008F**	**1,125,888**	**9,353U**
Current Assets							
Cash & Short Term Deposits	76,497	41,388	35,108F	78,385	1,888U	34,461	42,035F
Trust Deposits > 3months	9,500	11,500	2,000U	10,000	500U	11,500	2,000U
ADHB Term Deposits > 3 months	10,000	5,000	5,000F	10,000	0F	15,000	5,000U
Debtors	22,359	29,872	7,512U	21,551	808F	29,869	7,510U
Accrued Income	39,389	32,179	7,210F	43,227	3,838U	32,179	7,210F
Prepayments	3,349	1,679	1,670F	2,536	813F	1,679	1,670F
Inventory	14,704	14,239	465F	14,433	272F	14,239	466F
Total Current Assets	**175,799**	**135,857**	**39,942F**	**180,132**	**4,333U**	**138,928**	**36,871F**
Current Liabilities							
Borrowing	(429)	(429)	0U	(429)	0F	(429)	0F
Trade & Other Creditors, Provisions	(212,994)	(183,796)	29,198U	(165,243)	47,751U	(133,316)	79,678U
Employee Benefits	(163,242)	(167,823)	4,581F	(165,533)	2,292F	(166,232)	2,990F
Funds Held in Trust	(1,252)	(1,239)	13U	(1,250)	2U	(1,239)	12U
Total Current Liabilities	**(377,917)**	**(353,287)**	**24,630U**	**(332,455)**	**45,462U**	**(301,217)**	**76,700U**
Working Capital	**(202,118)**	**(217,430)**	**15,312F**	**(152,324)**	**49,795U**	**(162,289)**	**39,829U**
Non Current Liabilities							
Borrowings	(254,851)	(255,065)	214F	(304,886)	50,036F	(305,065)	50,215F
Employee Entitlements	(37,653)	(37,653)	0F	(37,653)	0F	(37,653)	0F
Total Non Current Liabilities	**(292,504)**	**(292,718)**	**214F**	**(342,539)**	**50,036F**	**(342,718)**	**50,215F**
Net Assets	**621,913**	**556,903**	**65,010F**	**620,664**	**1,249F**	**620,881**	**1,031F**

Comments

Category	Comment
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 $17m 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	This is mainly favourable due Capex spend is $17m behind, due to delayed Board approval of 2016/17 capex budget. $13m favourable variance in payments to NGO funder providers. GST payable $10m favourable as no GST payments in Dec, but there will be 2 in Jan 17.
Creditors	Trade & Other Payables reflect timing differences for creditors accruals $6m and income in advance $8m and GST payable $10m (refer cash flow variance above).

6.2 Statement of Cash flows (Month and Year to Date December 2016)

$000's	Month (December-16)			YTD (6 months ending 31 Dec-16)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	182,400	176,365	6,035F	1,058,759	1,058,465	294F
Payments						
Personnel	(75,075)	(74,064)	1,011U	(442,800)	(439,362)	3,438U
Suppliers	(37,435)	(33,988)	3,447U	(222,343)	(217,785)	4,558U
Capital Charge	(21,199)	(21,408)	209F	(21,199)	(21,408)	209F
Funder payments	(56,177)	(57,209)	1,032F	(329,834)	(343,254)	13,420F
GST	11,925	0	11,925F	11,816	0	11,816F
	(177,962)	**(186,669)**	8,707F	**(1,004,361)**	**(1,021,809)**	17,448F
Net Operating Cash flows	**4,437**	**(10,304)**	**14,741F**	**54,398**	**36,656**	**17,742F**
Investing						
Interest Income	372	678	307U	2,238	3,863	1,625U
Sale of Assets	0	0	0F	0	0	0F
Purchase Fixed Assets	(3,808)	(5,906)	2,098F	(18,906)	(35,434)	16,528F
Investments and restricted trust funds	(559)	0	559U	10,440	10,000	440F
Net Investing Cash flows	**(3,996)**	**(5,228)**	**1,231F**	**(6,228)**	**(21,571)**	**15,343F**
Financing						
Other Equity Movement	0	1	1U	1	4	3U
Interest paid	(2,330)	(2,311)	19U	(6,135)	(6,013)	122U
Net Financing Cashflows	**(2,330)**	**(2,310)**	**20U**	**(6,134)**	**(6,009)**	**125U**
Total Net Cash flows	**(1,888)**	**(17,842)**	**15,953F**	**42,036**	**9,076**	**32,960F**
Opening Cash	78,385	59,232	19,154F	34,461	32,314	2,147F
Total Net Cash flows	(1,888)	(17,842)	15,953F	42,036	9,076	32,960F
Closing Cash	**76,497**	**41,390**	**35,107F**	**76,497**	**41,390**	**35,107F**

ADHB Cash	71,938	**38,855**	33,083F
A+ Trust Cash	2,987	**479**	2,508F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	1,571	**2,056**	485U
	76,497	**41,390**	**35,107F**
ADHB - Short Term > 3 months	10,000	**5,000**	5,000F
A+ Trust Deposits - Short Term > 3 months	9,500	**11,500**	2,000U
ADHB Deposits - Long Term	0	**5,000**	5,000U
A+ Trust Deposits - Long Term	15,553	**14,494**	1,059F
Total Cash & Deposits	**111,550**	**77,384**	**34,166F**

7.0 Government Policy Changes Impacting DHBs

There are 2 changes in government policy which will be effected during 2016/17 as follows:

7.1 Capital Charge Reduction

DHBs have been advised of a reduction in capital charge from 8% to 7% effective from 1 July 2016. This has a $6M impact on ADHB capital charge (i.e. reduction in the cost). However, MoH have already reduced the DHB's revenue in December by an equivalent amount so that the policy change is neutral to the Bottom-line.

We have been informally advised that there will be another reduction in capital charge from 7% to 6% effective from January 2017. We will update the Board when this is formally effected.

7.2 Crown Debt Swap into Crown Equity

There has been a change in government policy impacting how DHB capital is financed. Effective from 15 February 2017, all DHB sector Crown debt will be converted into Crown Equity. For ADHB, this is $304.5M debt. Currently this debt has a weighted average cost of capital of 4% but after conversion this will attract capital charge of 7% (formally advised) and potentially 6% (to be formally confirmed by the Ministry of Health). MoH will provide funding to fully offset the additional financing cost from this debt/equity swap.

The debt/equity swap also has implications for ADHB for the Cashflow Hedge Reserve (CFHR) put in place following closure of the Bond FRA in April 2015. The balance on the CFHR of $3.19M will need to be written off as there will no longer be any underlying debt to maintain this. MoH have indicated that they would provide funding to fully offset the write-off. However, they will be reducing the DHB's revenue over four years for the amount advanced and the following two options have been provided:

Option 1: Spread revenue reduction equally over four years ($'000s).

2016/17	2017/18	2018/19	2019/20	2020/21
+3,190	-797.5	-797.5	-797.5	-797.5

Option 2: Reduce revenue by amount equal to previously scheduled write off for 3 years and lump-sum balance reduction in 4th year ($'000s):

2016/17	2017/18	2018/19	2019/20	2020/21
+3,190	-552	-552	-552	-1,534

We opted for option 1 but note that this leaves us with stranded costs of approximately $437k per year (being $246k difference between $797.5k and the $552k we were writing off plus, $191k additional capital charge [6% on the $3.19M] as the write off of the CFHR increases the Crown Equity position). Therefore, we will need to find savings of $437k per year of $1.748M over four years to offset this stranded cost.

Funder Update

Recommendation

That the Funder Update Report for January 2017 be received:

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 Maori Health Gain); Lita Foliaki, (Manager Pacific Health Gain); Samantha Bennett, (Manager Asian Health Gain)
Endorsed by: Dr Debbie Holdsworth, (Director Funding)

Glossary

ACC	-	Accident Compensation Corporation
AH+	-	Alliance Health Plus
AOD	-	Alcohol and Other Drugs
ARC	-	Aged Residential Care
CPHAC	-	Community and Public Health Advisory Committee
CTO	-	Compulsory Treatment Order
CVD	-	Cardiovascular Disease
DHB	-	District Health Board
DSLA	-	Diabetes Service Level Alliance
HBHF	-	Healthy Babies Healthy Futures
HCHA	-	Home and Community Health Association
HCSS	-	Home and Community Support Services
HEEADDSSS	-	Home, Education/Employment, Eating, Activities, Drugs, Alcohol, Sexuality, Suicide and Depression, Safety
HVAZ	-	Healthy Village Action Zones
IPIF	-	Integrated Performance and Incentive Framework
LMC	-	Lead Maternity Carer
MBIE	-	Ministry of Business, Innovation and Employment
MHA	-	Mental Health and Addictions
MoH	-	Ministry of Health
NCHIP	-	National Child Health Information Platform
NRA	-	Northern Regional Alliance
NZCMHN	-	New Zealand College of Mental Health Nurses
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
RFP	-	Request For Proposal
PSA	-	Public Service Association
SACAT	-	Substance Addiction Compulsory Assessment and Treatment
SLM	-	System Level Measures

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 16 November 2016.

1. Planning

1.1 Annual Plans

The ADHB 2017/18 Annual Plan is currently being drafted based on Ministry guidance and advice. The 2017/18 funding envelope is still pending along with guidance for some priorities and measure definitions. Content for section 2: Our Goals and Priorities, is being refined and the Statement of Intent is being redrafted to incorporate System Level and contributory measures as well as responding to auditor feedback.

Any possible or definite service changes planned for 2017/18 will need to be included in the Service Coverage and Service Change section of the Annual Plan.

The first draft of the 2017/18 Annual Plan will be presented to the Finance Risk and Assurance Committee meeting on 15 March for review, with approval sought at the 29 March CPHAC meeting. The final first draft is due with the Ministry of Health by 31 March.

1.2 Annual Reports

Auckland DHB's 2015/16 Annual Report has now been published on the website.

2. Hospitals

2.1 Cancer target

The NRA reported result for November 2016 shows that ADHB achieved the 62-day FCT indicator and the interim ADHB reported result up to the end of December was 87.8%. This ongoing improvement is expected to continue.

2.2 Auckland DHB 2016/17 Surgical Health Target

2.2.1 2016/17 ADHB Surgical Health Target

The MOH Q2 reported position for the ADHB Surgical Health Target is 96.8%. This performance reflects an underlying improvement, however there will be some small data correction in Q3 associated with ACC, gynaecology and avastin which may moderate this level of achievement. DHB.

2.2.2 Year to Date Performance - December

As previously reported to the Board at the end of January, there is $6.4M funding from the MOH at risk for the DHB based on surgical discharge performance at December 2016. Approximately 50% of the elective discharge target shortfall is in Adult Orthopaedic services with the remaining shortfall across all other services except Urology and Adult General Surgery. All services have plans in place to achieve the full elective plan by June 2017 with the exception of Adult Orthopaedics. A plan for that service will be established once the outcome and recommendations of the Deloitte review are confirmed. The MOH elective policy requires ADHB to achieve the Adult Orthopaedic discharge target in order to meet the DHB's Surgical Health target and secure all the available funding to the DHB.

The provider recovery plans mean the DHB is expected to achieve 98% of the health target by the end of Q3. Previously the DHB has not expected to achieve 100% of the Health Target until the end

of Q4, however this level of achievement is now at risk due to the issues described above in Adult Orthopaedics.

The ADHB provider is on plan overall for other populations (IDF inflow) however there are areas of under-delivery that will require targeted action from the provider to achieve the health target plan, such as Ophthalmology services for the Waitemata DHB population. Under-delivery year to date for the Waitemata population is being offset by over delivery for Counties Manukau Health and Northland DHBs in key service areas such as Cardiothoracic, Cardiology and Urology. ADHB funder and provider have met with Counties Manukau Health to agree a plan to manage referrals to the clinically appropriate level.

2.2.3 Outsourcing Arrangements

Cataract outsourcing arrangements have continued as planned and the expected level of discharges by private providers was achieved in Q1 and 2. A decision was made in December to outsource the remaining Q3 and Q4 cataract outsourced volume requirement of 200 discharges in Q3, and to outsource a further 90 cataract discharges in January in response to other demand pressures within the service impacting on internal capacity. The outsourced volumes have been contracted with a single provider on the basis of best price.

2.2.4 ESPI Compliance

MOH reporting continues to show ADHB has been ESPI 5 non-compliant since July 2016 and this is driven by the ongoing capacity issues in both adult and paediatric Orthopaedics. At 15th December approximately 23% of patients on Orthopaedic waiting lists were waiting more than 120 days and this has deteriorated to 31% at the beginning of February. A plan to address the paediatric spinal capacity issues is in development but has yet to be agreed by all parties. In the absence of a recovery plan being agreed in the short term ADHB may need to consider changing the level of access to this service. As previously mentioned a plan has yet to be initiated to resolve the adult Orthopaedic issues associated with both ESPI 5 and the surgical discharge shortfall.

ADHB was moderately non-compliant (amber) for ESPI 2 (outpatient specialist appointments) and moderately non-compliant (amber) for ESPI 5 (booked for surgery) for all other services excluding Orthopaedics in December. The DHB is forecast to be fully non-compliant for all services in both ESPI 2 and ESPI 5 in January and February and expected to return to amber in March. The provider reports this is due to the effect of industrial action in mid-January. There is a weekly review process in place to ensure all services maintain recovery plans to achieve the required ESPI and surgical health target results.

2.3 IDF Arrangements

2.3.1 2015/16

The CMDHB/ADHB outpatient wash up has not been finalised due to a MOH data error ($200K unfavourable to ADHB) being identified and this is in the process of being reviewed and confirmed.

2.3.2 2016/17

The ADHB application to increase the payment for clot retrieval has been successful and will be applied retrospectively from July 2016. This will result in unbudgeted additional revenue of approximately $1m in 2016/17.

2.3.3 2017/18

Almost all IDF forecasts are finalised except arrangements for Counties Manukau Health, these are currently being reviewed with the expectation that an agreement will be finalised by 17 February. It is expected that all known IDF service changes for all populations will be implemented in time for the

February deadline with the expectation that no further changes will be made prior to the start of the new financial year.

2.4 Policy Priority areas

2.4.1 Colonoscopy Indicators

ADHB has continued to achieve all colonoscopy waiting time indicators in October and November as validated by MOH reporting. ADHB has commenced colonoscopy activity for the Waitemata population from February 2017 to reduce Waitemata DHB's reliance on outsourcing with the intention of continuing this commitment on a more sustainable basis beyond this financial year.

2.4.2 Radiology Indicators

As at the end of November, the ADHB provider achieved 94% outpatient CT completed within six weeks, with MRI performance deteriorating over the last month from 82% to 73%. 83% of outpatient ultrasounds were completed within six weeks against a DHB target of 95%. These results are not expected to materially improve in the December reported position. The deterioration in the reported MRI and US is mainly due to high numbers of staff vacancies with high numbers of new graduates being recruited to vacancies impacting on the rate at which we can expect improvement. Discussions are currently underway about options to address the capacity shortfall that is being forecast to continue over the next few months.

2.4.3 Bone Marrow Waiting Times

In December there was one patient who waited longer than the clinically recommended six weeks maximum waiting time guideline and up to four patients waited longer than recommended in January, however all this was resolved by late January.

2.5 National services

ADHB is regularly reporting to the MOH regarding progress against the planned increases in capacity of Paediatric Cardiac and Adult Congenital services, as a result of additional funding allocated in 2015/16 and 2016/17. While the increased funding in 2015/16 led to an improved position within the service of reduced elective cancellations and reduced elective operating outside of working hours, increased acute demand for non-Cardiac services in Q2 2016/17 has led to an increase in elective cancellations of Paediatric Cardiac Surgery. The provider is undertaking further work to assess ongoing and future requirements for non-Paediatric Cardiac PICU capacity.

ADHB developed a proposal for increased investment in National Metabolic Services in 2017/18 however feedback from the MoH indicated further information was needed before this could be considered further. This has not been able to be progressed within the time available to secure increased funding for 2017/18.

The DHB has been advised the funding for National Intestinal Failure (Coordination) Services is to be continued for a further year from 1 July 2017.

2.6 Regional Service Review Programme

The regional work plan is continuing with increased emphasis on the need for detailing planning for regionally consistent Urology services and improved coordination and consistency for Head and Neck and ORL services regionally.

A regionally agreed Hyperacute Stroke model has been developed and is in the final stages of consultation with stakeholders. Additional funding will need to be prioritised in 2017/18 by all funders, including the ADHB funder, for the new ADHB services, including the Clot Retrieval service,

and regional consultation on the funding approach is expected to occur throughout February and March.

3. Primary Care

3.1 Health Targets

3.1.1 Better Help for Smokers to Quit

The PHO target was not achieved in the first two Quarters, for some PHOs the performance has dropped considerably. We are working with each PHO to understand the reasons for the performance decline and measures to be able to rectify. One key element, unlike the More Heart and Diabetes Check, is that smoking brief advice has not become business as usual for General Practices. There remains significant reliance on PHOs to add resource and processes to enable the target to be achieved. Nationally performance against this target has declined.

3.1.2 More Heart and Diabetes Checks

All PHOs within Auckland DHB continue to meet the 90% target. Focus remains on ensuring we reach the target for the eligible Maori population, where there is a very small gap to close. From 1 July 2016 'More Heart and Diabetes Checks' is no longer a national health target. PHOs will continue to offer these checks to the eligible population and incorporate this activity as business as usual.

3.2 Audit Health Target Performance

Over the last several years DHB non-financial performance information, as reported in the Annual Report, has been qualified, as there was insufficient evidence that PHO performance against Health Targets could be independently verified. The DHB auditors are, along with the DHBs, wanting to remove this qualification. The four Northern DHBs along with their Auditors, Audit NZ, and DHBs Internal Auditors, are preparing an audit plan and protocol to undertake the abovementioned audit. The protocol will be tested with one PHO and a small sample of general practices before the full programme is put in place. The intent is to complete the audit programme prior to year end.

3.3 Auckland Waitemata Alliance

There are two key priorities within the work programme; improving diabetes care under Diabetes Service Level Alliance (DSLA), and development of an improvement plan for the new System Level Measures that have been introduced this year.

The DSLA has recently completed a review of podiatry services, recommendations on service improvements are to be presented to the Alliance in February. The review highlights a number of areas where improvements in access to podiatry, especially in the community, should be looked at.

A framework to improve the clinical management of Type 2 Diabetes has been approved by Metropolitan Auckland Clinical Governance Forum. This framework will be applied regionally and is now being presented to the Auckland Waitemata Alliance and the Counties Manukau Alliances for final approval. It is estimated that approximately 26% of people in Auckland and Waitemata have poor diabetes control. This framework will enable focus on the areas that matter clinically and measure how well we are doing.

The System Level Measures (SLM) are being introduced for 2016/17 to replace the Primary Care Integrated Performance and Incentive Framework (IPIF) with a Whole-of-System Outcomes-Focused Approach, aligning with District Health Board outcomes frameworks.

The improvement plan that was approved is to be reworked as the Ministry Of Health require plans for 2017/18 to have a stronger focus on specified improvement milestones. Work is underway for the regional plan to be updated accordingly. Additionally work is underway to put in place regional mechanisms for routine data capture and reporting so appropriate oversight of performance against the plan can occur.

3.4 Tamaki Primary Mental Health and Wellbeing Initiative

The Awhi Ora – Supporting Wellbeing programme expansion to 10 additional general practices outside of Tamaki is progressing to plan. We have other practices requesting to be included in the programme as a consequence of favourable feedback from those involved. So planning is to be progressed to enable further expansion. Further detail on this initiative is provided for information at the end of this report.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)

ADHB continues to participate in the Working Group progressing guaranteed hours, a component of a regularised HCSS workforce that was agreed as Part B of the In-between Travel Settlement Agreement. The implementation date for guaranteed hours is 1 April 2017.

The Ministry is currently working through a policy position and potential funding arrangements for guaranteed hours. A report from an independent party, informed by data from the virtual pilots in Auckland and Taranaki DHBs will inform the policy position and funding parameters of the costs of cancelled shifts.

A meeting is being held in Auckland on 8 February with all HCSS providers, DHBs, Ministry of Health, ACC and the Home and Community Health Association (HCHA) to provide consistent information and guidance on the implementation of guaranteed hours. A subsequent meeting is scheduled for 28 February when the Ministry will be able to communicate its policy position and funding arrangements for guaranteed hours.

Unions (PSA and Etu) and the HCHA are planning workshops for support workers and their employers to inform members of the changes that will happen to employment agreements from 1 April 2017 through introduction of guaranteed hours and Employment Standards Legislation requirements.

4.2 Aged Residential Care (ARC)

The other Northern Region DHBs and the NRA have agreed to a revised Deed of Assignment process, which includes due diligence and will be more timely and streamlined. The process has been reviewed by Legal and is ready for implementation.

4.3 Other Health of Older People Activity

A review of the DHB's day care service contracts has been completed including the evidence for these types of services. A paper will be prepared on the future of day care services based on the findings and recommendations.

The Partnering Agreement with ACC has been signed for the Falls Prevention Programme, which includes expansion of the Fracture Liaison Service, an In Home Strength and Balance Programme and a referral pathway that will also include community group strength and balance being led by ACC.

The New Zealand Healthy Ageing Strategy was launched in December.

5. Women, Children & Youth

5.1 Immunisation Health Target

The Q2 Immunisation Health Target was achieved. Of particular note, the increase on last quarter for Maori infants was 3.2%. The increase for the total infant cohort was 1.4%.

Target: 95%	**Total**	**Māori**	**Pacific**	**Dep 9-10**	**Change: Total**	**Change: Māori**
Q2 2016/17	95.4%	90.7%	94.5%	95.3%	1.4%	3.2%

5.2 Obesity Health Target – 'Raising Healthy Kids'

The Q2 result for Auckland for the Raising Healthy Kids Health Target received an "outstanding" acknowledgement from the Ministry of Health.

Auckland DHB achieved a referral rate of 97%, up from 79% in Quarter 1. As such, the DHB achieved the health target a year ahead of the target date. The Ministry also noted that it is pleasing to see that the 'rate of referrals declined' has decreased, and is now sitting at 28%. The DHB has plans to undertake an evaluation of declines.

Specifically the Ministry commented that "the Auckland region DHBs are to be congratulated on their collaborative approach in both health pathways and the support that they provide families with children who are obese."

5.3 Rheumatic Fever Prevention Programme

As previously reported, the DHB has not achieved the MoH target for Rheumatic Fever and was required to provide a resolution plan. This plan has been approved by the Ministry. Much of the focus of the Plan relates to improving the response for Pacific families. This includes community awareness, primary care services as well as housing initiatives. The opportunity to engage proactively in improving living conditions through the Healthy Housing Initiative is welcomed by the DHB and is supported by additional funding from the MoH.

5.4 Healthy Housing Initiative

The extension of the Rheumatic Fever Auckland Wide Housing Initiative now includes vulnerable pregnant women and children hospitalised with a range of other housing related medical conditions. The new programme is being established rapidly in ADHB.

- A procurement process has been run and HealthWEST engaged as the community provider of social work services
- A Service Level Agreement (SLA) has been entered into with the provider arm for housing related social work services
- Two staff members have been engaged to co-ordinate services
- Additional philanthropic services (a gift pack including warm children's pyjamas, blankets and cleaning products) have been proposed to the Starship Foundation for funding.

5.5 2016 Health and Well-being (HEEADDSSS) Assessments

The number of young people in school Year 9 who received a comprehensive health and well-being assessment increased during 2016, though the percentage decreased from 2015. A total of 1,974 Year 9 students or 92.5% had an assessment during 2016. The percentage reduction is due to the addition of Auckland Girls Grammar to the programme. Auckland Girls was not expected to and did not achieve the 95% target in 2016. It is expected the target will be achieved again in 2017.

With the addition of Auckland Girls as the tenth school to the DHB funded school based health service, 9,272 young people now have access to a nurse-led primary health care service, supported by general practitioners and clinical psychologists in their school. Evidence shows that school based health services improve access to primary healthcare.

5.6 National Child Health Information Platform

The business case for a National Child Health Information Platform (NCHIP), for the Northern Region, has been going through a number of sign off processes. We expect to bring the final case to the Finance Risk and Assurance Committee early this year. As previously reported, NCHIP has the potential to better identify children who are missing out on the health services they are entitled to, and to drive system and service design around meeting the health needs of vulnerable children.

5.7 Oral Health

As has been reported by the media, there was an equipment failure at a dental clinic in Pukekohe leading to contamination between the suction and compressed air lines. As a result, children who attended the clinic may have been exposed to the blood of other children attending the clinic. There is a small risk that they may have been exposed to a range of blood-borne illnesses such as Hepatitis.

Checks have been undertaken in all Auckland school dental clinics. No similar equipment installation errors have been identified.

6. Mental Health and Addictions

6.1 Equally Well

The associations between mental health and/or addiction problems and relatively poor physical health outcomes have been well-established over many decades. Equally Well[1] attempts to address this longstanding and unacceptable inequity through a programme of collaborative action. ADHB as one of the signatories to the consensus statement recognise the need for coordinated action that will contribute to improved physical health and increased life expectancy. The Planning, Funding and Outcomes Team, in consultation with service providers, have drafted a proposal to do a baseline health needs assessment, documenting what we know about the physical health of people with chronic mental health illnesses and greater than one year engagement with Specialist Mental Health Services. In addition a piece of work is currently being scoped to identify the population on antipsychotics within our community that should be having yearly health checks. The aim is to identify baselines from each project by June 2017, in order to evaluate any improvements in response to new initiatives and programmes of work aimed at improving physical and medical wellbeing of service users.

6.2 Metro Auckland Collaborative, Training Primary Care Nurses in Mental Health Addictions

Metro Auckland DHBs and PHOs have formed a Collaborative to provide a regional Mental Health and addictions credentialing programme for Primary Health Care nurses based on Te Ao Māramatanga, New Zealand College of Mental Health Nurses (NZCMHN), Primary Care Nursing Mental Health and Addiction Credentialing Framework.

An initial pilot credentialing programme for Primary Healthcare Nurses was completed in February 2016, this was evaluated and found to be valuable. Auckland DHB, Waitemata DHB and Counties

[1] Te Pou, 2015, "Equally Well Framework for Collaboration". Download from *http://www.tepou.co.nz/initiatives/organisations-supporting-equally-well/45*.

Manukau Health have agreed to fund the programme for 2016/17, with up to 60 Practice Nurses to be enrolled over two intakes throughout the year. Waitemata PHO has agreed to be the provider of this initiative which started on 1 July 2016.

The first intake for 2016/17 began in September 2016 with 25 practice nurses. Two nurses have retired from the first intake, of the remaining 23, 10 are from ADHB practices. The second intake begins in late February. There are currently 27 nurses enrolled, 12 of which are from ADHB practices.

6.3 Fit for the Future

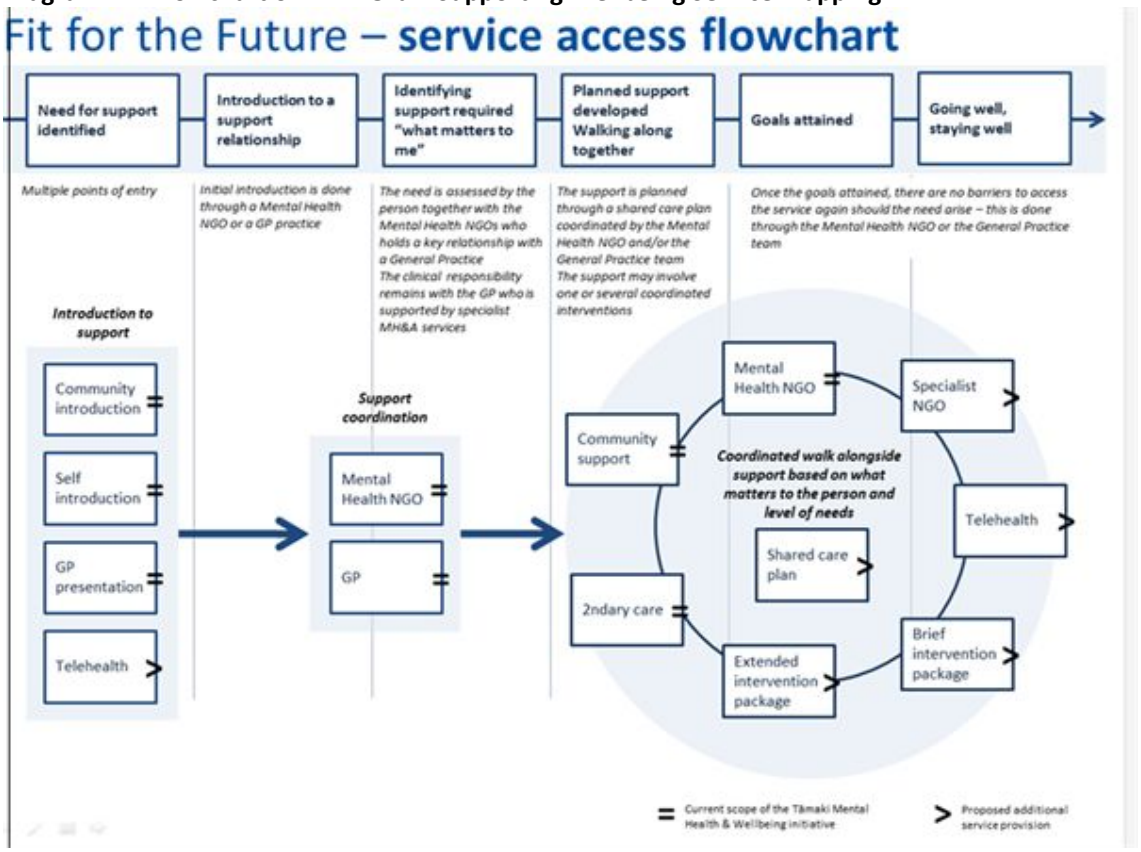
Ministry of Health are keen to identify innovative, sustainable solutions to help address the increasing demand on specialist MHA services. The *Fit for the Future* programme of work is about improving responses and outcomes for people whose mental health and addiction needs are not easily met in primary care, but who do not meet the threshold for specialist MH care. The *Fit for the Future* proposition is that increased support through primary and community care will enable this group to experience improved outcomes and will help to rebalance demand pressures across the continuum of care.

ADHB has been selected to progress through to the next stage (a closed RFP) in the Ministry of Health: Existing Initiatives for Investment in Building an Evidence Base (People with moderate mental health issues). An application to meet the RFP closing date of 9 February 2017 is being developed to seek funding to upscale, to 30 or more General Practices in Auckland DHB, and evaluate Awhi Ora – Supporting Wellbeing project (as diagrammed below as service access flowchart) it also includes providing the following service delivery model:

- providing access to community support options without having to refer to secondary/specialist MH services and care
- developing integrated service navigators
- increasing the range and depth of support available at primary and community level
- developing wrap-around services (co-ordinated approaches) for those with complex (or multiple) needs
- integrating mental health and addiction professionals into primary care and community settings
- ensuring the workforce is well equipped and supported to design and deliver integrated responses

Further detail on the Awhi Ora, which has been developed and piloted in Tamaki, is provided for information at the end of this report.

Diagram 1: A flowchart of Awhi Ora – Supporting Wellbeing Service Mapping



6.4 Annual Planning Stakeholder Workshops Held

ADHB Funded MHA Service providers were invited to an annual planning workshop on 23 January 2017, with 25 people attending the session. The participants identified a range of priorities to base a MH programme plan of actions around for 2017/18:

- Improve Youth health outcomes through integrated and shared care plan pathways when multiple agencies and services are involved.
- Increase mental health awareness among Asian, new migrant and refugee youth and their parents/families
- Collaborate in the development of tools and pathways for identifying and supporting vulnerable pregnant women and infants, including developing a consistent risk assessment tool and referral pathways for maternal depression, alcohol and other drug issues, housing issues and social work services
- Collaborate to meet the needs of the patient and health providers to deliver the right services in the right place and by the best person, to get outcomes that matter to the patient/service users. Beginning with a service mapping project to identify opportunities to enhance what is working well, any gaps and to test out new evidence based services. As well as stopping services which do not make a difference to health gains or outcomes
- Increase CADS Pregnancy and Parenting Service provided in community and Primary Care settings for pregnant women and women with young infants (<12 months) with AOD addition issues
- All service users prescribed anti-psychotic medication have regular physical health screening and are referred to appropriate services for follow-up
- Provide Suicide prevention training to Maori community groups

- Develop a business case for the Tamaki Primary Mental Health programme expansion to General Practices outside Tamaki with the aim of integrating care between General Practice and Mental Health NGOs to reduce referral to secondary care services
- Reduce the rate of Maori under Compulsory Treatment Orders (CTOs) by 10% through:
    - Working collaboratively with the MoH to agree and document a robust definition for the CTO indicator
    - Undertake analysis of underlying data to understand pathways, gaps and opportunities for improvement
    - Develop recommendations for evidenced based interventions to address the disease and health burden

6.5 Substance Addiction Compulsory Assessment and Treatment (SACAT) Legislation

The third and final reading of this legislation is expected to take place during February 2017 with the legislation being enacted at the end of March 2017. The Act will come into effect 12 months later, in March 2018.

Running alongside this Bill's parliamentary process is a project to draft a Northern Region SACAT model of care for Northland, Waitemata, Auckland and Counties Manukau DHBs, which was developed in November 2016 along with an estimated additional funding framework, which has been tabled at the Northern Region MHA Clinical Network and approved as a working draft. The model and the budget will continue to be refined over the course of 2017.

A national workshop hosted by the Ministry of Health will take place on 8 March 2017. The purpose of this workshop is to develop a nationwide service specification for the model of care, to discuss workforce development opportunities and to discuss the appointment of Statutory Officers. The 12 month timeline for implementation and commencement of the legislation will be challenging and additional new MoH funding will be required to fund DHB and NGO AOD Service Providers, to develop new and expanded services.

7. Maori Health Gain

7.1 Annual Planning

Ministry of Health planning expectations have evolved over the last five years. In 2013/14, the planning guidance was updated to include a prescribed template for DHB Māori health plans as a standalone but companion document to the Annual Plan. The purpose of the Annual Māori Health Plans was to accelerate Māori health gain within our respective districts. It provided each District Health Board and their local health services with priority areas for action for the financial year and specified accountabilities for the activities.

In 2017/18 the Ministry of Health planning guidance amended this requirement to no longer require a separate DHB Māori health plan by integrating Māori health planning into the Annual Plan. However, in December 2016 the Board Chair communicated his intention at the Auckland and Waitemata DHB Board meetings to continue with Māori health plans and to align these across the three metro Auckland DHBs in 2017/18. Respective DHB Māori health, planning and funding teams met over December-January to explore opportunities to realise that objective.

Through these meetings the Metro Auckland District Health Boards are proposing to our respective Māori Health Gain Advisory Committees that we:

- Continue with a common flow to the Māori health planning documents. This will make it easier for community, clinical, operational and executive leaders working across the region to review and engage with the respective plans
- Adopt a "life course" approach to the presentation of activities and indicators. This will better reflect the NZ Health Strategy and local DHB strategy focus on health equity and Māori world view of collective well-being than the current "indicator" list method of the current Ministry of Health template
- Maintain the nationally determined priority areas and indicators from the 2016/17 Māori Health Plan, with the incorporation of System Level Measure (SLM) actions
- Continue to have a limited number of local priorities for each District Health Board to support the needs and opportunities for their respective Māori communities
- Provide a list of potential priority areas where regional collaboration could be beneficial. Further discussion will be required to determine which of these are included in the 2017/18 Māori Health Plans as regional priorities.

As with previous years, we will continue to consult with the relevant internal and external partners throughout the development of the Māori health plans including our Memoranda of Understanding partners.

8. Pacific Health Gain

8.1 Renewing Pacific Health Action Plan (PHAP)

The new Pacific Health Action Plan will be submitted to CPHAC in March 2017. This is later than intended, but work on each of the priorities has been ongoing.

With the appointment of a single Chair for the three metro Auckland DHBs, consideration has been given to ways of better aligning the Pacific work across these DHBs, agreement has been reached to start with the development a joint Pacific Child Health Plan. A joint Pacific Plan will be considered in the future. Currently there is also an aligned process in the development and implementation of the Pacific Workforce Strategy across the three DHBs.

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

In terms of parenting education, feedback from churches/groups which have completed the Incredible Years programme, run over 14 weeks, is that it is too long, attendance has been shown to decrease after six weeks.

Te Whanau o Waipareira is the provider of the Triple P programme, which is run over five weeks, in the West Auckland area. They have trained Pacific facilitators, who will deliver in West Auckland, the North Shore and in the ADHB area. Nine programs will be delivered by the end of this financial year.

The Living without Violence programme will be delivered to eight churches/groups before the end of this financial year. Three more churches have expressed interest but are unable to be catered to this year as funding has only been received for up to eight.

In relation to rheumatic fever, the Pacific team continues to participate in the implementation of the Rheumatic Fever Resolution Plan.
Within the Healthy Babies and Healthy Futures (HBHF) programme, in the last two quarters

- 142 Pacific mothers were engaged in conversation about nutrition and physical activity using Healthy Conversation Skills s and motivational interviewing out of a target of 150

- 87 Pacific mothers were enrolled in the TextMATCH component of the programme out of a target of 125
- 81 Pacific mothers enrolled in the 6-week community learning programme, 30 completed the programme out of a target of 45

Receiving referrals from LMCs and other providers to the service continues to be a challenge. This is not unique to this service and we continue to work on strengthening relationships with providers who can make referrals.

8.3 PHAP Priority 2 –Pacific People are smoke-free

The report from the consultation with Tongan male smokers about better engagement with smoking cessation services has been received from the West Fono Health Trust. The consultation was undertaken with four kava drinking groups, as drinking kava and smoking are very much linked. The report made the following recommendations:

- Undertake a group quit smoking competition specifically for Tongan men
- Provide group therapy for the competitors
- Use Fanau Ola (family) framework for intervention
- Deliver community health promotion as part of the process of recruitment of men to participate in the competition
- Create smokefree environments

We are currently working with West Fono to identify which of the above can be provided within their current contract with the Ministry of Health for smoking cessation services and which are extra. We will present a business case to the DHB Primary Care team, to pilot an intervention, specifically for Tongan men, based on the above elements.

8.4 Priority 3 – Pacific people are active and eat healthy

A total of 2499 people from the Enua Ola and HVAZ programmes participated in the Aiga Weight Loss Challenge in 2016, 2119 (84%) completed the eight week competition. In the HVAZ churches, 69% of those that completed the programme lost weight. Results over the four years that the Aiga Challenge has been held are still being analysed.

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

In terms of the *Fanau Ola* integrated service contract that ADHB has with AH+ PHO, we have had discussions with the Social Services Team in MBIE as part of our attempt to further develop an outcomes based payment component of the contract. MBIE has forwarded a number of papers that have been useful and informative. Some components of the packages of care that we purchase/fund can be more easily purchased on an outcome basis, specifically those components relating to behaviour change. MBIE has offered to involve us in forums that they will facilitate with other government funders to continue to work on outcomes based pricing. This will contribute towards a review of the *Fanau Ola* service.

8.6 PHAP Priority 6 – That Pacific people live in houses that are warm and are not over crowded

The recent consultation undertaken for renewing PHAP strongly supported the need to continue to focus on housing. We have made contact with Housing NZ and will work towards using the HVAZ networks as a mechanism for linking Housing NZ to the community.

9. Asian, Migrant and Refugee Health Gain

9.1 International Benchmarking of Asian Health Outcomes Waitemata and Auckland DHBs report

This report was presented to the November Board meeting and tells us how we are performing internationally. When we aggregate Asian as one homogenous group the findings showcase we are leaders in health status and health outcomes.

Though, this hides subgroup inequalities. There are disparities for areas such as CVD, diabetes, youth mental health, and childhood obesity which are identified in the report.

The report has a number of recommendations and our top three areas for action are:

1. Access to healthcare services, e.g. PHO enrolment and access to youth mental health, cervical screening
2. Prevention, tailored or targeted preventive healthy lifestyle activities
3. Granular data monitoring to level 4, making sure our data tells us about the subgroups we are interested in. We are working on a national level to get systems solutions.

10. Tamaki Mental Health & Wellbeing Deep Dive

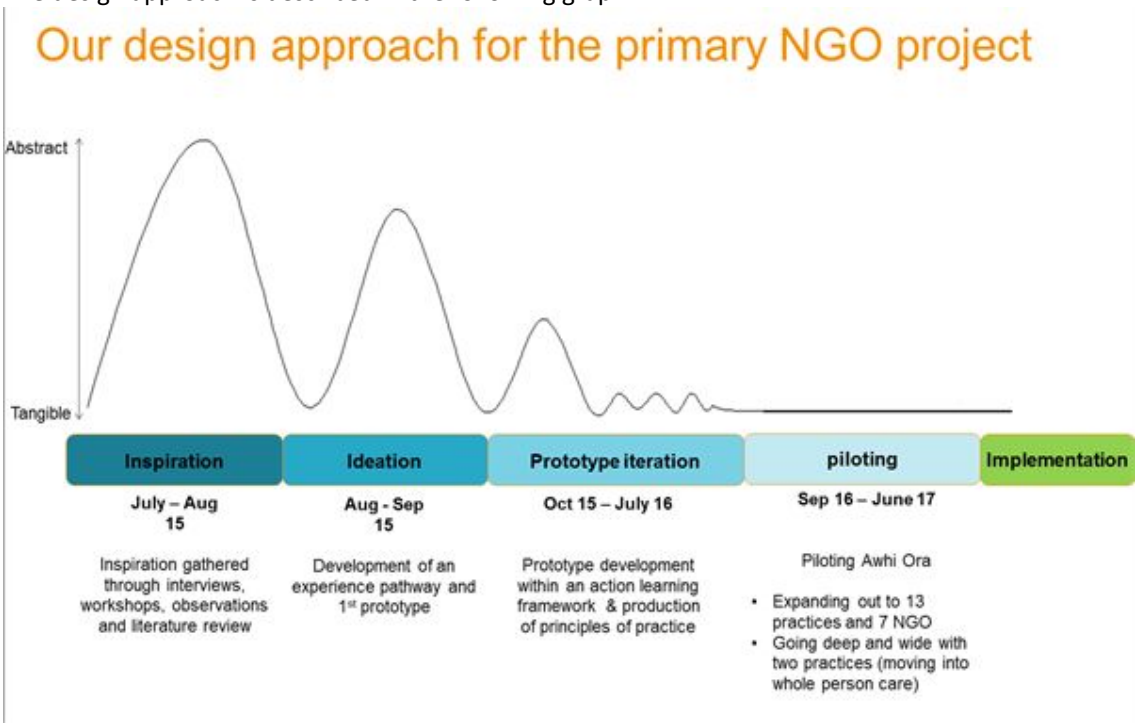
The Tamaki Locality work programme has two distinct components. The first, Awhi Ora, is a service development approach using co-design principles to put in place an improved response to the management of primary mental health in the community. The second is the cross sectorial approach working with the community and other agencies to develop a broader range of responses to improved wellbeing. Both components are in response to the community request for a focus on improving wellbeing.

10.1 Our process

10.1.1 Co-design

The Tāmaki Mental Health & Wellbeing Initiative commenced in 2013 and has taken a co-design approach, both in terms of responding to what the community identified as their top priority and also in the development of the service design. Co-design is based on principles of shared leaderships between patients and professionals. It begins with people- their experiences, perspectives, values, challenges and understandings. The programme involves working with vulnerable people to create interventions, services and programmes which work in the context of their lives, and reflect their own values and goals. To make co-design work, power and decision making has to be shared from the beginning with those who are impacted by health and social issues. This approach has resulted in the community, service providers and funders owning the design development of the service, ensuring sustainable change management

The design approach is described in the following graph.



The following 3 principles emerged from the data gathered during the prototype phase. At its heart, the support should be:

- person-centred: based on what matters to the person
- relational: building on trusting relationships between the person and the health professionals who provide the support
- collaborative: where health professionals work together beyond organisational boundaries or professional status

10.1.2 Programme definition

The Tāmaki Mental Health & Wellbeing Initiative vision is to create an experience of mental health and wellbeing focused on the whole person in their family, whānau and community, over the whole of their life supported by integrated services that are relevant for Tāmaki. It focuses on creating a seamless continuum of care and support across community, NGOs, primary and secondary care, to enable people to be likely to remain or go back quickly to the "softer" end of that continuum. This involves addressing the prevention and early intervention dimensions within the continuum of care and support.

The programme of work is made up of five projects:

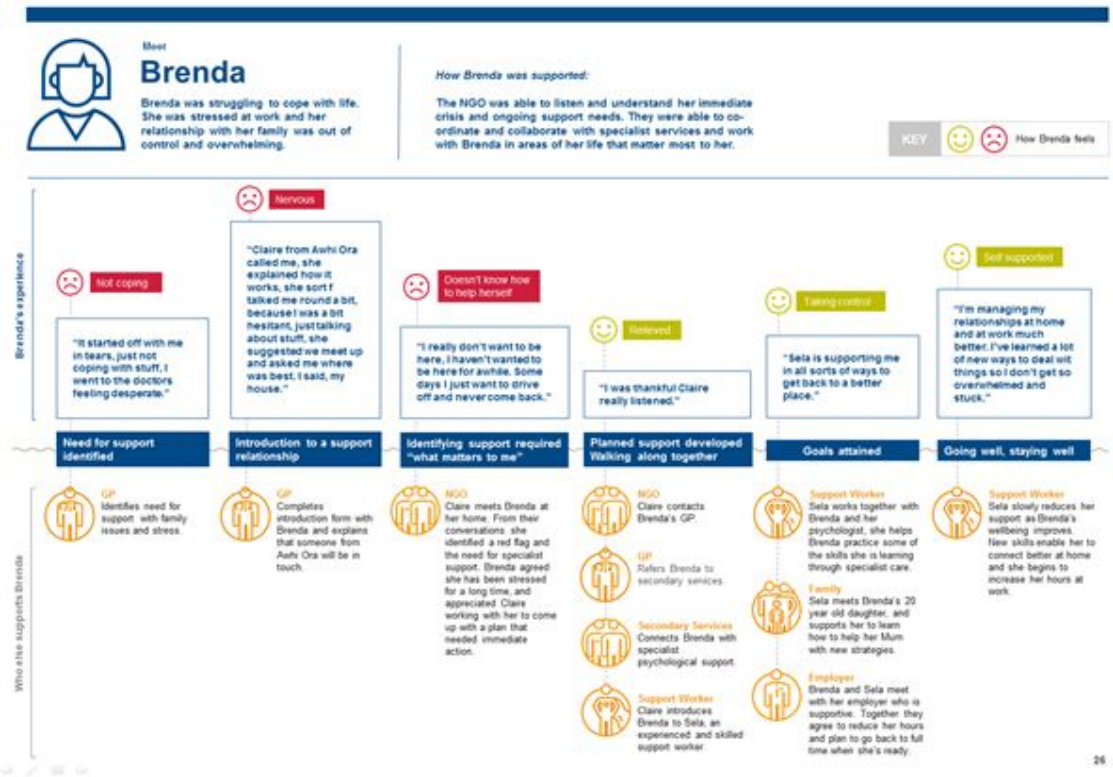
- The **Awhi Ora – Supporting Wellbeing** project is about enabling access to the mental health NGOs from community or primary care, with a strong focus on removing barriers to access, for example, allowing people to self-introduce to NGO support, rather than accessing through their GP
- The **Whole person – whole of life support**, looks at expanding the network of support to other types of NGOs and organisations
- **Linkage services** is about providing the knowledge of providers/organisations/networks that exist in the community so any door can become the right door for people who look for support. The navigation element of support may be explored further in this work

- The **Primary – Secondary integration** aims to support peoples' mental health concerns in primary care with secondary care supporting, rather than people being referred to secondary care. This will also increase the likelihood of people also being supported for their physical health needs
- The **Local Wellbeing** project moves towards even earlier intervention and prevention within the continuum of care we are creating across community, NGOs, primary and secondary care. For example, identifying bright spots in the community who are doing good work around wellbeing, in order to launch potential new activities where there are gaps as well as promoting and connecting the existing ones.

10.2 Programme Status

10.2.1 Awhi Ora

The Awhi Ora – Supporting Wellbeing support service is now in place as a pilot in 13 practices, chosen as having high needs enrolled populations. Qualitative data is showing the difference this service has made by making use of the complementarity between the GP and NGO, removing barriers to access and providing a channel for early intervention. This has been illustrated by Brenda's story.



An evaluation framework is being developed for this pilot, which will provide qualitative and quantitative data to continue to build on the current evidence base by the end of the pilot phase (end of June 2017). The next phase of deployment from June 2017 will include Waitemata DHB practices.

10.2.2 Overall

Within the **Whole person – whole of life support** project, the development of a prototype will take place in three practices and a community group during Q1 2017. We will be working to formalise the commitment of these groups and forming the design team.

In **Linkage Service**, there has been a contribution to the GP resource kit through the Tāmaki service mapping and Healthpoint update.

For the **Primary – secondary integration** project, the design cycle has been completed, next steps involve agreeing on the implementation with Mental Health directorate.

Within the **Local Wellbeing** project, community activation eventuated in initial bright spots convergence meeting, shared vision and activities to be agreed.

10.3 Risks

The developmental evaluation carried out as part of the prototype provides great feedback about people and service provider experience. However it doesn't form an evidence base around outcomes compared to other interventions. Quantitative data is being collected in the correct pilot. A full evaluation needs to be resourced as part of the next wave of deployment from June 2017.

The 10% of NGO capacity that is ring-fenced for supporting people in primary care is being fully used in the current pilot where the service is available to an enrolled population of 85,000. Further expansion requires additional NGO capacity.

10.4 Conclusion

There are exciting service developments around early intervention and primary care support for Mental Health.

The principles established in the Awhi Ora – Supporting Wellbeing service, lay the foundations for the ADHB ways of working in the localities approach, informing the development of any community based service. The relationships built across General Practices, NGOs, ADHB services can be leveraged to develop services around any long term condition (or set of conditions).

ADHB Palliative Care Strategy – Implementation Progress Report

Recommendation

That the Board:

1. **Receives the ADHB Palliative Care Strategy Implementation Progress report for February 2017.**
2. **Notes that status and progress of the strategy, approved by the Board in February 2016, which is active to 2018.**

Prepared by: Judith Catherwood (Director Community and Long Term Conditions)
Endorsed by: Joanne Gibbs (Director Provider Services)
Endorsed by Executive Leadership Team: Date: Tuesday, 14 February 2017

Glossary

Acronym/term	Definition
ADHB	Auckland District Health Board
APCGG	Adult Palliative Care Governance Group
HQSC	Health Quality and Safety Commission
SHARE	Supportive Hospice and Aged Residential Exchange
MoH	Ministry of Health
NGO	Non-governmental organisation
NRA	Northern Regional Alliance
WDHB	Waitemata District Health Board

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	The strategy specifically supports an integrated patient/whanau centred model of care with the roots in the community. Specific work within the strategy engages communities we serve in the design of the service.
Emphasis/investment on both treatment and keeping people healthy	The strategy has a focus on end of life and palliative care. It delivers on all aspects of palliative care, physical, psychosocial, spiritual and emotional.
Service integration and/or consolidation	The strategy has a specific focus on service integration across specialist palliative care providers and generalist providers including hospital, general practice and aged residential care services.
Outward focus and flexible service orientation	The strategy supports person centred care. Palliative care service development has included patients and families in its design. It also involves benchmarking and evidence where available to inform decision making.

Operational and financial sustainability	Palliative Care services will become increasingly stretched as the population ages and as complex chronic disease becomes more prevalent. The specialist workforce is under pressure and this strategy supports the integration of services and education to support palliative care delivered by others.

2. Executive Summary

The ADHB Board approved the ADHB Adult Palliative Care Strategy in February 2016. This report is prepared at ADHB Board request in 2016, to provide information on progress, one year on, from publication of the strategy. The strategy is live and implementation continues until end of 2018 when the strategy will be reviewed.

3. Introduction/Background

The ADHB Board approved the strategy in 2016. The strategy was developed by a wide range of stakeholders and service providers over the course of 12 months. The strategy was consulted on widely, across the health community, prior to being approved. The strategy aims to implement integrated services delivered by wide ranging service providers using a tiered model of care focussed on complexity and allowing patients and families/whanau to be cared for within each stage of the complexity model, based on individual need.

The strategy embraces the important role of both specialist and primary palliative care providers. It specifically aims to ensure the model provides "palliative care without walls" supporting the individual wherever their specific care requirement may best be provided within available capability, capacity and resources. It also focussed on all life limiting disease (not just cancer) and broadens the traditional practice of palliative care in order to increase effectiveness and equity.

The strategy has four specific goals:

1. To provide integrated and seamless patient, family and whanau focussed care for all people with a life limiting illness regardless of diagnosis, prognosis or care setting.
2. To empower our community to care in the best way possible for those affected by life limiting illness and death.
3. To develop a sustainable palliative care workforce inclusive of all care providers that is responsive to the needs of patients and their families.
4. To influence the development of palliative care at national and regional level.

4. Progress/Achievements/Activity

Progress has been progressive and developmental over the course of the first year. Progress will be reported under each of the four goals above.

Goal 1:

- A new integrated clinician leadership model and the development of the concept of a palliative care lead provider model is being developed and continues to be consulted on. The model once approved will be implemented in early 2017. The new model will result in

integrated clinical leadership and clinical governance of specialist palliative care services in Auckland District and the new leader will be accountable for the delivery of new models of care aligned to the strategy.

- A working group has reviewed the available clinical systems to support integrated clinical records in the current environment. A preferred option is being tested through due diligence by staff in a range of providers prior to a recommendation being made.
- Community services and Mercy Hospice teams have engaged in the locality model of care and are configured to enable further integration in service delivery for our population.
- Workshops to support improved palliative care under the Using the Hospital Wisely Programme have been held. An action plan is in development to support change and service improvement.
- A Goals of Care initiative has commenced with General Medicine to help identify treatment goals relevant to individuals with specific illnesses in the context of their values and goals. This will align with HQSC work being developed.
- MoH has released new palliative care Innovation Funding. A regional approach has been adopted in the plans for use of this funding and the MoH have just approved the regional bid for their allocation. This funding will be channelled through the Hospices on a regional basis and will be available to support new models of integrated care with the aged residential care sector and with Primary Care. After a short pre planning period the new resources will be deployed from September 2017 onwards.
- A project to support aged residential care (SHARE) is included in the Innovation funding for Auckland. This will commence in partnership with the University of Auckland in September 2017.
- Specialist Palliative after hours services have been reviewed and alternative models identified. The new clinician leader will be tasked with finalising a sustainable and affordable plan for 24/7 support in specialist palliative care during 2017.
- A core data set has been identified. Work is progressing with Business Intelligence support to implement the data set which will include a system wide palliative care dashboard when fully developed.

During Phase 2 and 3 of the strategy, implementation work in the areas of allied health and psychosocial supports, urgent palliative care options for primary care and community services and cultural supports will be developed more fully. In part, this will be delivered through the new MoH Innovation Funding.

Goal 2:

- The Palliative Care Education Group has been reformed. Work is progressing on developing competencies and on the delivery of education to all workforce groups. This will be a continuous process across all phases of the strategy.
- Several new research projects have been commenced or have secured funding. These include the SHARE Project, The VOICES Project and the use of a summer student to progress a review of service use for patients who died in the 2015 calendar year. A palliative care research group led by Professor Merryn Gott under the School of Nursing, University of Auckland involves a number of our palliative care specialists, and builds effective integrated research in the field.

- A business case to support the transition of the leadership of Advance Care Planning across Auckland District into the Community and Long Term Conditions Directorate has been advanced and will be considered in early 2017 by the Senior Leadership Team.
- A co-design project involving specialists in palliative care and the specialist liver team at ADHB has been initiated. This has been successful and a revised patient and family led model of care for this patient group will be developed. The approach to co-design in palliative care in the future will be reviewed along with other long term conditions in 2017.
- A consumer representative role has been formally recruited to the APCGG. The consumer has personal experience of supporting end of life care in a range of settings within ADHB in her family.
- A NGO representative has also been recruited to within the APCGG. They have specific experience of supporting those dying from motor neurone disease.
- Through the deployment of the VOICES Project, we will receive feedback from bereaved families regarding their experience of services at the end of life. If successful, opportunities for VOICES to be integrated as part of the DHB consumer feedback program will be explored.

During Phase 2 and 3, implementation work will be progressed in an approach to community awareness of end of life issues and the development of greater community resilience. Through the deployment of the new innovation funding, new approaches to support services for Pacific and Asian cultures and their palliative care needs will be explored at regional level.

Goal 3:

- The MoH Innovation Funding and SHARE Project, will specifically support workforce development once deployed across the primary palliative care workforce in primary care, community services and aged residential care sectors.
- The new clinician leadership model will have a specific focus on the strategic development of the specialist and generalist palliative care workforce in ADHB.
- A regional project supported by the NRA, to support workforce planning in palliative care services is about to commence.
- The Maanakatia rounds have been a success within ADHB and support staff in a range of services to debrief and seek support in specific cases. These rounds now have recurrent funding.

During Phase 2 and 3, the focus will continue on workforce and succession planning.

Goal 4:

- The regional approach has supported the development of a consistent plan for the new MoH Innovation Funding for Palliative Care Services.
- The National Palliative Care Review received a full consultation response from ADHB and WDHB. An Action Plan to support this review is currently being consulted on at present. We expect release of this final document in February or March 2017.

During Phase 2 and 3, we expect to focus more fully on the cultural aspects of palliative care, on the development of the regional governance and collaboration between Hospice Providers and others through the use of the Innovation Funding, and on implementation of the MoH National Palliative Care Review recommendations.

5. Costs/Resources/Funding

Currently the strategy is being implemented in a cost neutral manner. No additional costs have been incurred outside of existing budgets. The new MoH Innovation Funding which has just been approved will be used to augment existing resources and coordinated on a regional basis.

Areas of constraint in terms of implementation speed include the work on integrated clinical system/records to support integrated palliative care services. These depend on adaptation of existing clinical systems and this may incur capital and planning costs. In addition the work on palliative care data sets/dashboards are limited by Business Intelligence capacity. This includes both available data (much of which is manual or available from multiple providers and systems) and implementation capacity in terms of workforce availability given other multiple priorities.

Educational resources and capacity are stretched but not yet at capacity. As a group we aim to work within existing budgets and FTE capacity in the delivery of this strategy.

All aspects of the strategy are using the capabilities and enthusiasm of a wide range of staff, from across all providers, corporate services, funding and planning etc. Their contribution and their commitment to improving patient care should be acknowledged, as without it, none of the above could have been achieved.

6. Risks/Issues

There are currently no major risks or issues.

7. Conclusion

The Board is asked to note this report and progress on the ADHB Palliative Care Strategy Implementation.

Integrated Palliative Care - Agreement with Mercy Hospice

Recommendation

That the Board:

1. **Receives the Agreement with Mercy Hospice –Integrated Palliative Care report for February 2017.**
2. **Approves the Agreement between Mercy Hospice and Auckland DHB.**
3. **If approved, authorise the CEO to sign the document on behalf of Auckland DHB.**

Prepared by: Judith Catherwood (Director Community and Long Term Conditions)
Endorsed by: Ailsa Claire (CEO)
Endorsed by Executive Leadership Team: Yes

1. Executive Summary

Auckland District Health Board approved an Adult Palliative Care Strategy for implementation at the Board meeting in March 2016. The strategy indicates the plan to develop integrated clinical leadership of adult palliative care services through the development of a lead provider model.

The first step in this process has been developed by the two specialist providers (Mercy Hospice, through its governing body of Mercy Healthcare and Auckland DHB Directorate of Community and Long Term Conditions) in collaboration and with guidance from the Deputy Director of Funding and Planning, Director of Provider Services and CEO.

The first step involves the establishment of a new clinical leadership position of Strategic Clinical Director – Integrated Palliative Care. This role will be employed by Mercy Hospice and report to the CEO of Mercy Healthcare for an initial transitional period. Over the next 12 months, it is anticipated the direct reporting arrangements will be devolved to the CEO of Mercy Hospice. The role will report indirectly to the Director of Community and Long Term Conditions. The role will provide strategic clinical leadership to both specialist providers of palliative care and the wider healthcare sector, working in collaboration and under the direction of the CEO Mercy Healthcare and the Director Community and Long Term Conditions.

The role will be jointly funded by both specialist providers through existing funding and budgets.

The Agreement outlines the proposed terms of working between the two parties and new role. An addendum to the agreement will be put in place to clarify the detail of the payments between the organisations for the new position.

The position and the new working arrangements have been subject to extensive consultation between the two specialist providers, and the wider healthcare sector.

2. Conclusion

The Auckland DHB Board is asked to approve this Agreement to be signed by the CEO on behalf of the Board.

AGREEMENT TO SUPPORT THE PROVISION OF INTEGRATED SPECIALIST PALLIATIVE CARE SERVICES

Between Mercy Hospice Auckland Limited (MHA)

and the

Auckland District Health Board (ADHB)

1. Background

1.1 Mercy Hospice Auckland (MHA) provides specialist inpatient and community palliative care services for patients, family/whanau within the Auckland District Health Board (ADHB) region and works in close collaboration with Primary Care providers, Residential Care Facilities and secondary service providers. In addition MHA provides on-site and off-site palliative care education and multi-disciplinary training opportunities for clinicians within the ADHB region.

1.2 Auckland District Health Board (ADHB) provides a specialist consultative palliative care service (Hospital Palliative Care Team - HPCT) that works across all adult services within ADHB region. The HPCT also supports transition from the hospital to the hospice based specialist services and community based providers (locally and regionally), and provides education and support to clinical teams throughout the hospital.

1.3 MHA will appoint a Strategic Clinical Director – Integrated Palliative Care (SCD-IPC) who will lead and guide the development of a seamless palliative care service across the ADHB region through close collaboration, alliances and integration of services where needed and appropriate.

The role is a strategic leadership and planning role and will not have operational service delivery responsibilities or management accountabilities or workforce leadership for either MHA or ADHB services but will work closely with the clinical leaders and all clinical teams delivering palliative care service.

The SCD-IPC role will incorporate the appropriate use of clinical governance concepts.

1.4 A core premise in the relationship between MHA and ADHB is to support integration of services and improved care for our population. It is important for each party to maintain their individual clinical, philosophical and operational autonomy. Specifically MHA's heritage, mission, values and ethics are to be acknowledged and respected, and these will remain integrated within any service provided.

2. Purpose

2.1 The purpose of this Agreement is to specify the principles and objectives that will underpin and support the working arrangement between the SCD-IPC, MHA and the ADHB Specialist Palliative Care service.

2.2 It is anticipated that the SCD-IPC will develop a strong collaborative and effective working relationship with all stakeholders providing palliative care services for ADHB patients. The stakeholders would primarily include Mercy Hospice Auckland, other providers of community palliative care within the ADHB area including the residential care sector and primary care as well as the ADHB Community Services and Hospital Clinical Teams. As ADHB patients may receive care from other DHBs there would be an expectation of a strong collaborative relationship with the Northern Region specialist palliative care services, particularly Waitemata and Counties Manukau DHBs, as well as other DHBs nationally.

2.3 The SCD-IPC is a strategic role designed to ensure that the direction, alignment and commitment from the two specialist providers and their respective employers is consistent with the development of an integrated multi-disciplinary palliative care service across the ADHB region. The SCD-IPC, in collaboration with MHA, ADHB Specialist Palliative Care service, ADHB Palliative Care Governance Group and other regional DHBs will contribute to regional service development strategy, clinical standards and models of care as well as workforce development and planning.

2.4 The SCD-IPC role will provide strategic leadership to deliver a seamless palliative care service across the ADHB region. In doing so the role will promote and support integration of clinical practice and influence how specialist palliative care services are practiced, organised and delivered across ADHB.

The role will not have a management or operational role within MHA or ADHB. Day-to-day management of the two specialist services will remain the responsibility of the clinical leaders of the respective organisations, their support structures and their employers.

2.5 The SCD-IPC role will incorporate the appropriate use of clinical governance elements to assist providers to deliver the highest quality palliative care with reference to the ADHB Adult Palliative Care Strategy, sound evidence-based medicine and established palliative care principles

Clinical Governance may be defined as “a framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.” *1.Scally et al*

The commonly suggested clinical governance elements include; clinical safety and effectiveness, quality assurance, provider education and development, patient and service user experience, clinical audit, risk management, and research and development. *2.bpac NZ*

Development of clinical governance elements within specialist palliative care services would have clinicians’ central to any discussions and the process would be open and transparent. Collaborative working with clinicians, patients, families/whanau and other key stakeholders is essential.

2.6 MHA, the SCD-IPC and ADHB will work collaboratively to develop and implement integrated multi-disciplinary palliative care services across ADHB region.

2.7 It is a requirement that the SCD-IPC will have some clinical time in both specialist teams on a regular basis.

2.8 It is anticipated that the SCD-IPC recruitment process will aim to attract a broad range of applicants from palliative care backgrounds with strong clinical experience and professional and personal leadership skills.

1. Scally G et al, Clinical governance and the drive for quality improvement in the new NHS England. BMJ 1998;317:61-65
2. bpac NZ. Clinical Governance, September 2005

3. Reporting

The SCD-IPC will report operationally and professionally to the CEO of Mercy Healthcare Auckland (being the governing body of Mercy Hospice) for a transitional period and work collaboratively with the Director-ADHB Community and Long Term Conditions. The three will meet monthly or more regularly as required to facilitate the implementation of this Agreement. The CEO of Mercy Healthcare and Director-ADHB CLTC are responsible for receiving and deciding on any recommendations of the SCD-IPC. In the event the CEO of Mercy Healthcare and Director-ADHB CLTC cannot agree, they will refer the matter to their respective governing bodies for resolution.

The SCD-IPC will inform the CEO of Mercy Healthcare and Director-ADHB CLTC on the ongoing progress of the delivery of integrated, high quality, patient-centred, evidence-based palliative care, to meet the palliative care needs of people in the ADHB region.

The CEO of Mercy Healthcare and Director-ADHB CLTC would then be enabled to appraise their respective governing bodies; the MHA Board of Directors and ADHB Board and CEO

4. Funding the SCD – IPC position

Mercy Hospice Auckland Limited agrees to engage the SCD – IPC as its employee and Auckland District Health Board agrees to contribute 50% of the SCD's annual remuneration package and expenses.

5. Term

5.1 This MOU is effective from the date of the SCD-IPC appointment and reviewed every 12 months thereafter. Any changes to the terms of the MOU will be in writing and signed by both parties before taking effect.

5.2 Either party may withdraw from the MOU by giving 3 months written notice to the other party.

The agreement is signed on …….

Signed by	Signed by
……	…….
……	…….. ..
On behalf of Mercy Hospice Auckland Limited And Mercy Healthcare Auckland Limited	On behalf of Auckland District Health Board

Audit NZ Letter for PHO Audits

Recommendation

That the Board:

1. **Notes the need for Audit NZ to audit DHB non-financial performance measures that rely on information from third party health providers, which will enable them determine if the qualification on non-financial performance information should remain or be removed for 2016/17;**
2. **Notes that the audits will be completed jointly for all three metro-Auckland DHBs;**
3. **Approves that Regional Internal Audit provides direct but not excessive assistance to Audit NZ; and**
4. **Approves that the Board Chair, on behalf of the Board, signs the attached Audit NZ letter on this audit.**

Prepared by: Auxilia Nyangoni (Deputy Chief Financial Officer)
Endorsed by: Rosalie Percival (Chief Financial Officer)
Date: 10 February 2017

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	The DHB has a statutory requirement to report financial and non-financial performance information in its Annual Report which is presented Parliament. Audit NZ has qualified the non-financial performance information and completing an audit of PHOs will enable Audit NZ to decide whether to remove the qualification or not.
Emphasis/investment on both treatment and keeping people healthy	
Service integration and/or consolidation	
Intelligence and insight	
Evidence informed decision making and practice	
Outward focus and flexible service orientation	
Operational and financial sustainability	

2. Purpose

The Board is being asked to approve the Audit NZ letter attached, which will enable audit non-financial performance information provided by third parties that is used in the DHB's Annual Reports.

3. Overview

Auckland DHB's non-financial performance information has been qualified by Audit NZ (per below):

Qualified opinion on the performance information because of limited controls on information from third-party health providers

Some significant performance measures of the Health Board and group, (including some of the national health targets, and the corresponding district health board sector averages used as comparators), rely on information from third-party health providers, such as primary health organisations. The Health Board and group's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

It has been agreed that it is more efficient and cost effective for Audit NZ to complete the audit for the three Auckland Metro DHBs at the same time and with assistance from Regional Internal Audit. An overview of the audit is provided in the Audit NZ letter attached. The Board is asked to approve the letter which should be signed by the Board Chair. A similar letter has been sent to the ADHB CE.

9 February 2017

Level 6
280 Queen Street
PO Box 1165, Auckland 1140
www.auditnz.govt.nz
Fax: 09 366 0215

Dr Lester Levy
Chairman
Auckland District Health Board
Private Bag 92189
Auckland Mail Centre
Auckland 1142

Dear Lester

Audit of performance data provided by primary health organisations to Auckland District Health Board for the year ended 30 June 2017

This letter is to advise that we intend to use resources provided by Regional Internal Audit (RIA) to undertake some audit work on our behalf, as described below.

Requirements of Auditing Standard

When using internal auditors to provide direct assistance with our audit of Auckland District Health Board's (ADHB's) financial statements and/or performance information, we are required to follow the requirements of International Standard on Auditing (New Zealand) 610: Using the Work of Internal Auditors (ISA (NZ) 610).

Direct assistance is described in the standard as being the use of internal auditors to perform audit procedures under the direction, supervision and review of the external auditor.

Paragraph 31 of ISA (NZ) 610 requires us to:

- communicate the nature and extent of our planned use of internal auditors with the Board, and
- reach a mutual understanding that such use is not excessive in the circumstances of the ADHB audit.

As required by paragraph 33 of ISA (NZ) 610, we are also writing to the DHB's Chief Executive Officer to seek agreement, prior to the work being undertaken, that RIA will be allowed to follow our instructions, and that ADHB will not intervene in the work RIA performs on our behalf.

Scope of work to be performed by RIA

RIA will provide direct assistance to Audit New Zealand and perform the following work in respect of the audit of performance information for the year ended 30 June 2017:

- Reviews of the control environment at ProCare Networks Limited and Auckland PHO Limited in respect of the collection, processing and analysis of data used for monitoring performance against the National Health Targets for:

- Increased immunisation.
- Better help for smokers to quit.

- Confirming that data submitted to the DHB by Primary Health Organisations (PHOs) is accurate and complete for a randomly selected sample of GP practices.

Tim Wood, Deputy Director Funding, Auckland and Waitemata District Health Boards is liaising with the PHOs to arrange the timing of RIA's visit to each location selected for review. We require RIA to complete their work by Wednesday 5 April 2017.

We do not anticipate using RIA to provide direct assistance for any other aspect of this year's audit.

9.3

Audit Zealand's responsibilities in respect of work to be performed

Audit New Zealand will be responsible for determining the scope of work to be performed, providing direction to RIA staff performing that work, and reviewing all work completed by RIA staff.

We expect RIA to draw initial conclusions from the work performed. However Audit New Zealand will be responsible for assessing:

(a) whether sufficient and appropriate audit evidence has been obtained to support those conclusions, and

(b) how that work impacts upon the audit opinion we intend to issue in respect of ADHB's performance information.

Regional approach for the audit

We are planning to use RIA to provide direct assistance for the audit of third party performance information for the four northern region DHBs. This will help ensure that, wherever possible, we can achieve efficiencies in our audit approach. In particular:

- Where a PHO is responsible for GP practices across more than one DHB, we will only need to review its systems once. (The random sample of GP practices will still be selected separately for each DHB.)
- The same staff from RIA and Audit New Zealand will be completing the work for all four DHBs.

Our audit opinion on performance information

We are completing work at the PHOs and GP practices with the intention of obtaining sufficient audit assurance to enable us to remove the qualification of our audit opinion on the DHB's performance information. This assumes that no other matters come to our attention that result in performance and/or financial information being materially misstated and that we are able to obtain the necessary level of assurance to issue an unqualified opinion.

However, there is no practical means of verifying the performance information for the 2015/16 financial year (the comparative information). We will therefore need to issue a qualified opinion on the comparative performance information because of limited controls on information from third-party health providers in the prior year.

This is consistent with last year where the eight DHBs who were issued with an unqualified opinion in respect of their 2015/16 performance information were still qualified in respect of the 2014/15 comparatives.

Conclusion

If you have any questions please contact me directly on 021 222 8603.

Please return the signed copy of this letter to suzanne.merriott@auditnz.govt.nz by Wednesday 22 February 2017.

Yours sincerely

Karen MacKenzie
Director

Cc Ailsa Claire, Chief Executive Officer

I confirm my agreement (on behalf of the Board) to RIA providing direct assistance to Audit New Zealand for the 2016/17 audit of performance information provided to the DHB by third parties.

I also confirm my understanding that the level of direct assistance provided by RIA is not excessive having regard to the overall size and complexity of your audit of ADHB's financial and performance statements.

Signed:

Name: Dr Lester Levy

Position: Chairman

Date:

Auckland District Health Board Authorised Banking Signatories

Recommendation

That the Board:

1. **Notes the need for updated Auckland DHB Banking Signatories following changes in Government policy and staff movements as outlined in this report**
2. **Approves the positions listed in Schedules 1 and 2 as the full list of Auckland DHB Authorised Banking Signatories to replace all previously approved lists**
3. **Approves the closure of the Westpac Mental Health Patient Trust Account**
4. **Approves removal of the Auckland DHB Authorised Signatories for Loan Facilities with the Ministry of Health**
5. **Authorises the Board Chair and Chair of the Finance, Risk and Assurance Committee to:**
   a. **sign the updated Banking signatories Schedule 1 and 2;**
   b. **sign any forms specific to Banks required to effect Board authorised signatories; and**
   c. **sign future Schedules 1 and 2 only where there is no change in the Board approved positions but there are staff changes.**

Prepared by: Auxilia Nyangoni (Deputy Chief Financial Officer)
Endorsed by: Rosalie Percival (Chief Financial Officer)
Date: 9 February 2017

1. Board Strategic Alignment

Operational and financial sustainability	Maintenance of the relevant Auckland DHB authorised banking signatories is important to maintain operational and financial efficiency of the Auckland DHB finances.

2. Purpose

This report is to request Board approval of an updated list of Auckland DHB authorised banking signatories, to close the Westpac Mental Health Patient Trust account which is no longer required by the service and to remove the Authorised Signatories for loan facilities with the Ministry of Health as we will no longer have any loans with the Ministry following the Debt / Equity Swap policy, the change effective from 15 February 2017.

3. Overview

The following changes are noted:

- As a result of recent organisational structure changes at healthAlliance (hA), there have been two changes in position titles. The General Manager Finance and Strategy (hA) (previously Ross Chirnside) has been replaced by the new Chief Financial Officer (hA) - Fiona Harnett. The position of Manager Finance Service Delivery (hA), which was previously vacant, has been replaced by the Finance Services Manager - Diane Barcelli.
- At Auckland DHB, the role of HR Information and Systems Improvement Manager (previously occupied by Pat Butcher who has since retired) has been replaced by the HR Director Services – Anna Sefuiva.
- The title of Chair, Audit and Finance Committee has been changed to Chair, Finance Risk and Assurance Committee.

- The Westpac Mental Health Patient Trust Account (number 02-0252-0453671-0002) was previously used to manage monies on behalf of Mental Health patients. These activities ceased and the account was only being used to fund petty cash reimbursements. Alternative standard petty cash procedures are now being applied by the Mental Health service and therefore this account is no longer required. It has been requested by the Mental Health service to close this account. It is recommended to close this account as it shares the same core bank account number as the main Auckland DHB Sweep account, but with a different suffix.
- On 15 February 2017 Auckland DHB will repay all National Health Board Loans to the Ministry of Health totalling $304,500,000 per the Government change in policy for capital financing for the DHB Sector. Therefore, Auckland DHB will no longer require Authorised Banking Signatories for loan facilities with the Ministry of Health. We have therefore removed this schedule (previously Schedule 2) from the updated list of Authorised Banking Signatories.

4. Attachments

Schedule 1:	Authorised Signatories for Private Sector Banking Arrangements including Bonds, Derivatives and Investments
Schedule 2:	Authorised Signatories for Shared Commercial Banking arrangements with NZ Health Partnerships , Westpac NZ Limited, Other DHBs and DHB entities

10. Conclusion

We recommend that the Board approves the changes to the Auckland DHB authorised banking signatories, closure of the Westpac Mental Health Patient Trust account and removal of the “Auckland DHB Authorised Signatories for Loan Facilities with the Ministry of Health”.

Schedule 1

Auckland DHB Authorised Signatories for Private Sector Banking Arrangements including Bonds, Derivatives and Investments

The Auckland DHB (ADHB) Board approves the following staff positions as authorised banking signatories effective immediately. This list replaces any previously advised signatories.

Signing Rules:	
Transactional Banking (including payroll payments) and Money Market Dealing Authorities	Any two signatories acting together.
Derivatives Dealing Authorities	Chief Financial Officer and any other authorised signatory acting together.
Private Bonds	Chief Financial Officer and any other authorised signatory acting together.
Investments	Chief Financial Officer / Deputy Chief Financial Officer and any other ADHB authorised signatory.

Position	**Name**	**Specimen Signature**
A. Signatories for all private sector banking arrangements including payroll		
Chief Executive Officer (ADHB)	Ailsa Claire	
Chief Financial Officer (ADHB)	Rosalie Percival	
Deputy Chief Financial Officer (ADHB)	Auxilia Nyangoni	
Corporate Finance Manager Strategy & Reporting (ADHB)	Timneen Taljard	
General Counsel (ADHB)	Bruce Northey	
Asset Planning Manager (ADHB)	Janet Latimer	
Chief Financial Officer (hA)	Fiona Harnett	

Position	Name	Specimen Signature
Finance Services Manager (hA)	Diane Barcelli	
Manager Financial Control (hA)	Gordon Herdman	
Financial Accountant (hA)	Jenny Tiong	
Financial Accountant (hA)	Charles Pollock	
Financial Accountant (hA)	Shamal Silva	
Financial Accountant (hA)	Michael Lee	
B. Signatories for Payroll Payments only		
HR Director Services (ADHB)	Anna Sefuiva	
Payroll Systems Accountant (ADHB)	Gary Grant Alpaugh	
Team Leader (ADHB)	Tania Parsons	
Payroll Systems Improvement Specialist (ADHB)	Mike Grattan	
C. Signatories for Dommett Avenue Account		
Chief Financial Officer (ADHB)	Rosalie Percival	
Deputy Chief Financial Officer (ADHB)	Auxilia Nyangoni	
Asset Planning Manager (ADHB)	Janet Latimer	

D. Signatories for Tenancy Bond Accounts		
Business Manager (ADHB)	Ewen McQueen	
Property and Project Manager (ADHB)	Reg Prasad	
Asset Planning Manager (ADHB)	Janet Latimer	
General Counsel (ADHB)	Bruce Northey	
Finance Manager, Clinical and Non-Clinical Support Services	Leanne Gatman	

Signed on behalf of the Board by:

Dr Lester Levy	tbc
Board Chair	**Chair, Finance, Risk and Assurance Committee**

Dated this _____ day of _____ 2017

Schedule 2

Auckland DHB Authorised Signatories for Shared Commercial Banking arrangements with New Zealand Health Partnerships, Westpac New Zealand Limited, Other DHBs and DHB entities

The following are the positions, names and true signatures of persons who have been authorised by the Acceding Party to give any notices and other communications under, or in connection with, the Master Agreement on behalf of the Acceding Party.

Signing Rule:
Any two signatories acting together.

Position	Name	Specimen Signature
Board Chair (ADHB)	Lester Levy	
Chair, Finance, Risk and Assurance Committee (ADHB)	tbc	
Chief Executive Officer (ADHB)	Ailsa Claire	
Chief Financial Officer (ADHB)	Rosalie Percival	
Deputy Chief Financial Officer (ADHB)	Auxilia Nyangoni	
Corporate Finance Manager Strategy & Reporting (ADHB)	Timneen Taljard	

Signed on behalf of the Board by:

Dr Lester Levy	tbc
Board Chair	**Chair, Finance, Risk and Assurance Committee**

Dated this _____ day of _____ 2017

Memorandum of Understanding between Child Youth and Family, Police and District Health Boards

Recommendation

That the Board:

1. **Approves the Chief Executive Officer to sign the new schedules for the existing Memorandum of Understanding between Child Youth and Family, New Zealand Police and Auckland DHB**

Prepared by: Sharon McCook (Executive Business Manager)
Endorsed by: Ailsa Claire (Chief Executive Officer)

Glossary

MOU Memorandum of Understanding

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	Collaboration between the parties can positively influence the health of children, young people and their families/whānau.
Emphasis/investment on both treatment and keeping people healthy	The welfare, interests and safety of children and young people are the first and paramount considerations of the parties to the MOU.
Service integration and/or consolidation	The MOU provides formal procedures, particularly around effective communication, sharing information and developing the positive working relationship necessary to support working collaboratively together.
Intelligence and insight	The parties agree to communicate regularly and share information that could help to keep a child or young person safe and well in a manner that is consistent with the law.
Evidence informed decision making and practice	The MOU provides agreed joint standard operating procedures for the parties that are based on expert advice.
Outward focus and flexible service orientation	The engagement will prioritise activities that reduce inequalities amongst children, young people and their families.
Operational and financial sustainability	The MOU builds on existing practices at Auckland DHB and is implementable within current resources.

2. Executive Summary

This paper provides an update on two amendments to an existing Memorandum of Understanding (MOU) between the District Health Boards, Child Youth and Family and the New Zealand Police. The purpose of the MOU is to provide guidance for interagency management and safety of children and young people identified as experiencing abuse and neglect.

The MOU has recently been revised to include new third and fourth Schedules. Schedule 3 provides a Guideline for the management of children with neglect of medical care. Schedule 4 outlines joint operating procedures for children and young people at risk from exposure to the illicit drug manufacturing process. Current feedback has indicated that the parties can now endorse the third and fourth schedules by signing the revised MOU. It should be noted that the MOU is a relationship agreement and is not intended to be legally binding.

It is recommended that the Auckland DHB Board approves the Chief Executive to sign the new schedules for the MOU.

3. Background to the MOU and the current revisions

In 2011, all DHBs signed a MOU between Child, Youth and Family, the New Zealand Police and individual DHB Chief Executives.

In 2012, the parties revised the MOU with the addition of Schedule Two which outlines the role of the Child Youth and Family Hospital Liaison Social Worker in DHBs.

In 2015/16 a Guideline for the Management of Children with Neglect of Medical Care was developed and is now presented as Schedule Three to the MOU. A fourth schedule to the MOU is a Joint Standard Operating Procedures for Children and Young People in Clandestine Laboratories. This includes a detailed guideline for the medical examination of children/young people who require an assessment including ascertaining the level of exposure to illicit drugs and toxic chemicals and determining their health, wellbeing, cares and protection needs.

As with the MOU and the first two schedules, frontline clinicians, including paediatricians and Violence Intervention Programme coordinators in all DHBs, were included in the consultation process for the third and fourth documents to the MOU.

4. Implementation at Auckland DHB

The parties to this MOU, including Auckland DHB, currently work together and offer advice to each other in the management and safety of children and young people with suspected or confirmed abuse or neglect. In particular the MOU ensures that health and safety outcomes for children and young people are met within each party's legislative and funding responsibilities.

Both the new schedules are already in practice in Auckland DHB as they build on current practice in Te Puaruruhau (the Auckland DHB health service for children and young people who have experienced abuse or neglect).

The revised schedules provide an agreed protocol for acquiring samples (usually hair samples) for the New Zealand Police from children uplifted from, or discovered in, methamphetamine laboratories, and for activities Police and Child, Youth and Family must undertake in the community before children come to the DHB.

5. Risk assessment

The MOU clearly outlines the commitment of the parties to appropriate management of suspected child abuse and neglect including prevention and child protection.

Staff at Te Puaruruhau note that the revised MOU formalises existing processes for Auckland DHB and the relevant service is able to cope with the existing workload within current resources. It is not anticipated that the revised Schedules will impact demand in the Auckland DHB region. In light of this, it does not appear that revised MOU will place an undue burden on Auckland DHB.

Health and Safety Policy update approval request: 3 Health and Safety Policies

Recommendation

That the Board:

1. **Approve the publication of the Rehabilitation of Staff policy review following re-formatting as requested October 2016**
2. **Approve the publication of the Blood and Body Fluid Accident policy review**
3. **Approve the publication of the N95 Fit Testing policy review**

Prepared by: Denise Johnson (Manager OH&S)
Endorsed by: Sue Waters (Chief Health Professions Officer)
Endorsed by Executive Leadership Team: yes: Date: 14 February 2017

Glossary

Acronym/term	Definition
ACCPP:	**ACC Partnership Programme**
BBFA:	**Blood and Body Fluid Accident**
N95:	**N95 Particulate Respirator**

1. Executive Summary

This report is seeking the approval of the re-publication of three Health and Safety policies. Each of the policies has been reviewed in relation to current practice and changes were made as required.

The Rehabilitation of staff policy has been previously reviewed by the Board and a request was made to simplify the formatting, this has been done.

It is recommended that the Board approve the three policies for re-publication under the Chief Health Professions Officer.

2. Introduction/Background

The purpose of each of these policies is as follows:

The purpose of the Rehabilitation of Staff policy is to provide information to managers and staff on the processes in place to enable the organisation to support the return to full duties following an injury to a staff member. This policy was presented to the Board for approval in October 2016. Board members requested that the policy be simplified. Following this request the policy was reformatted and simplified. The content of the policy instructions and statements were unchanged.

The Blood and Body Fluid Accident (BBFA) policy has been in place since October 2000, it provides a follow up process for workers who have an unprotected exposure to blood and or body fluids and could be at risk of exposure to serious blood borne infections such as HIV, Hep B or Hep C. The process includes a risk assessment, blood testing, provision of prophylactic treatment (if required)

and on-going health monitoring. The review was conducted by the Occupational Health Doctor and included updates from ADHB subject matter experts in relation to HIV, Hep B and Hep C exposure.

The N95 Fit Testing policy has been in place since 2012. The purpose of the policy is to provide a process for fit testing N95 particulate respirators that are used by workers who are in close contact with patients with active TB. ADHB uses a quantitative fit test method by using a piece of equipment called a Portacount machine. The policy outlines the workers who require fit testing based on the risk of exposure to TB in relation to the degree of contact with patients with active TB. The policy also outlines an annual health monitoring programme.

3. Risks/Issues

There are no known issues with the re-publication of any of these policies.

The policies are required to manage the health and safety risks related to exposure to blood and body fluids and TB, without these two policies the risk to workers from these exposures would be significant.

4. Approach/Methodology/Analysis/Justification

All health and Safety policies are reviewed as per the document control requirements. The key change in the document is a change from Human Resource Portfolio to Chief Health Professions portfolio. This occurred because the reporting lines for Health and Safety have been re-assigned.

5. Consultation/Engagement

Consultation as per the requirements of Document control was undertaken. As none of the three are new policies they has been reviewed to meet current practice and re published without additional organisation wide consultation.

6. Conclusion

A routine review of the three policies was conducted to ensure it still met the requirements of the needs of the organisation. Minor changes were made and it was submitted to document control for publication.

It is recommended that the Board approve the re-publication of this policy under the Chief Health Professions Officer.

N95 Particulate Respirator Fit Testing for Infectious Tuberculosis

Document Type	Policy
Function	Workforce Services
Healthcare Service Group (HSG)	Multiple HSGs
Departments affected	Respiratory including Respiratory Physiotherapy Bronchoscopy Infectious Diseases Public Health Radiology Allied Health Cleaning Service Interpreter Service Phlebotomy Service Paediatric Respiratory and ID Services
Patients affected (if applicable)	n/a
Staff members affected	**Fit Test Required**: Respiratory Nurses, Doctors and Healthcare Assistants, Infectious Diseases Nurses and Doctors, Respiratory Physiotherapists, Cytologist (when attending bronchoscopy), Bronchoscopy Nurse Assists, Nursing students when specifically assigned to work with infectious TB patient, TB Public Health Nurses, Interpreters with MDR TB patients, Paediatric Respiratory and ID staff if assigned to an infectious TB patient **Secure Fit Required**: Interventional Radiologists, Clinical Nurse Advisors, Allied Health, Cleaners, Interpreters, Phlebotomists, Family/visitors **Occupied AIIR access prohibited**: Nursing Bureau, Technicians, Orderlies, Kitchen staff
Key words (not part of title)	Surveillance
Author – role only	Manager Occupational Health and Safety
Owner (see ownership structure)	Chief Health Professions Officer
Edited by	Document Controller
Date first published	October 2012
Date this version published	October 2012
Date of next scheduled review	October 2015
Unique Identifier	HS01/ASD/011

Contents

9. Corrections and amendments (office use only)

1. Purpose of policy

Health care staff are at an increased risk of contracting TB and continue to require protection controls in place to minimise exposure, (McNaughton ET AL, 1994 and Meredith ET AL 1996).

To provide a policy for managing and minimising the biological hazard of exposure to Pulmonary Tuberculosis (TB) by fit testing or secure fitting the N95 Particulate Respirator. The policy will ensure that the appropriate tests and follow up are given to the employee.

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2. Policy statements

2.1 Exposure to infectious TB Patients: Staff required to enter the **Airborne Infection Isolation Room (AIIR)** should be restricted to those performing vital roles only.

All staff who are identified to work in AIIR or carry out aerosolising procedures are required to wear an N95 particulate respirator that has been quantitatively fit-tested or securely fitted depended on this policy. The N95 particulate respirator is worn as a means of protecting staff from airborne mycobacterium tuberculosis. (www.viha.ca).

2.2 Annual Retraining and Health Surveillance: Following the initial N95 respirator fitting by quantitative fit-test or secure fit training all staff must undergo annual secure fit re-training and education. Education includes a reminder of the important TB symptoms to be aware of and the requirement to report symptoms of concern promptly.
Close contact staff, who are required to wear a quantitatively fit-tested respirator, will also undergo annual health surveillance by way of symptom questionnaire.

2.3 Periodic Quantitative Fit- testing: Repeat quantitative fit- testing is required when there has been: 1) a significant change in body weight including during pregnancy, 2) a new medical condition that increases the risk to the staff member of acquiring active TB such as immune compromise, 3) failure to obtain a secure fit, and 4) a change in the characteristics of the mask and/or mask supplier (MMWR, CDC, 2005).

2.4 Failed Quantitative Fit-test and Secure Fit: Where this failure affects the individual's ability to perform his/her duty (providing care to a patient with TB) the individual may be asked to:

- Re-deploy to other duties and / or another work area, or
- Wear a different class/ style / size of respiratory protection (It will be the employer's responsibility to provide this equipment and to fit test, educate and train the individual prior to asking him / her to utilise the equipment (www.viha.ca).

2.5 Training: Staff will receive education / training at the time of their initial respirator fitting and refresher training annually. Additional training will be performed if inadequacies in the employee's knowledge or use of the respirator are identified (www.viha.ca).

The following topics will be covered:

.

- Why a respirator is necessary and why quantitative fit-test or secure fit training is being recommended.
- Donning, doffing and disposal of N95 particulate respirators-Click here for Infection Control Patient Isolation Policy and go to Airborne Precautions
- Signs and symbols used to demonstrate that particulate respirators are required in an area
- Seal test
- Storage of the N95 particulate respirators
- Limitations of the N95 particulate respirators
- Important TB symptoms to be aware of and to report symptoms promptly

2.6 Staff who should not wear an N95 Particulate Respirator: Those staff who have a physical or psychological reason assessed and documented by an OH&S Doctor. It also includes staff that cannot pass a fit-test or secure fit because of the presence of facial hair or other condition that interferes with the seal of the mask to the face, (MMWR, CDC).

2.7 Initial mask fitting upon hire:

- Staff will be assessed for their medical fitness to safely wear an N95 particulate respirator prior to exposure to infectious TB patients. This will be by way of health questionnaire, then assessment by the OH&S doctor if required.
- Medically fit staff will undergo quantitative fit-testing for the N95 respirator or secure fit training in accordance with this policy.
- Staff who are medically not able to wear an N95 respirator or who do not pass the fit-test will be restricted from duties involving the care of infectious TB patients.

2.8 Failure to Comply: Refusal of a staff member to be fit tested or comply with the requirements (as required within the scope of their work) may be subject to disciplinary action.

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3. Definitions

Pulmonary Tuberculosis
Pulmonary Tuberculosis is caused by the bacteria *Mycobacterium tuberculosis.* Infection occurs when a person inhales the bacteria which traverse the respiratory tract to reach the alveoli of the lungs. This is termed the airborne route of transmission (www.cdc.gov).

Infectious Tuberculosis

TB is infectious to other people when it occurs in the lungs or larynx. In general, a person diagnosed with TB of the lungs or larynx should be considered infectious until the person has:

- completed at least two weeks of appropriate anti-TB therapy based on susceptibility results; and
- shown to have clinical improvement in symptoms and signs of TB; and
- had two consecutive negative acid-fast bacilli (AFB) sputum smear results, or been determined to be non-infectious by a physician experienced in managing TB disease.

Patients infected with multidrug-resistant strains of tuberculosis (MDR TB) must be on treatment guided by susceptibility testing and a case-by-case decision should be made as to when they are no longer considered to be infectious by a physician experienced in managing MDR TB disease.

Close Contact

- Staff carrying out general care duties whose cumulative contact with the infectious TB patient is likely to be 8 hours or more annually.
- Staff who perform aerosolising procedures (bronchoscopy, intubation, open suctioning, sputum induction) on an infectious TB patient.

Casual Contact

Staff who carry out general care duties with an infectious TB patient whose cumulative contact is less than 8 hours annually.

Facial Hair

Staff with facial hair are at increased risk of exposure to TB, and other respiratory pathogens, as the N95 respirator does not form a tight seal. Staff working within the scope of this policy must be clean shaven at all times when required to wear an N95 respirator. There is currently no alternative respiratory protection available in ADHB for this group.

N95 Particulate Respirator

N95 masks are commonly called “particulate respirators“. N means ‘not resistant to oil’ and ‘95’ refers to 95% filter efficiency. They offer protection by filtering the air before it enters the respiratory tract. N95 particulate respirators are designed to filter 95 % of particles (particulate aerosols free of oil) that are 0.3 microns in size or larger. They effectively provide protection from airborne contaminants and pathogens that are transmitted by the airborne route, such as TB, chickenpox and measles. The mask is fluid resistant and is disposable (www.osha.gov and Infection Control Patient Policy).

When the respirator is tight fitting and forms a complete seal with the face, airborne hazards/droplets are prevented from entering into the breathing zone by the face piece seal.

N95 Particulate Respirator Secure Fit (may also be termed ‘best fit’**)**

The N95 particulate respirator forms a complete seal with the face as determined by a seal-test with training provided by a qualified health professional including instruction on the correct donning, doffing and disposal of the mask. This process is outlined in the Infection Control Patient Isolation policy.

Personal Protective Equipment (PPE)
Disposable N95 particulate respirators are an item of personal protective equipment (PPE) worn by health care staff who are exposed to patients with Pulmonary TB.

Fit-Test
This is a qualitative or quantitative test to evaluate the fit and, therefore, adequacy of a respirator on an individual.

Qualitative fit-test: A pass/fail fit-test to assess the adequacy of the respirator that relies on the individual's response to a test agent.

Quantitative fit-test: An assessment of the adequacy of the respirator by numerically measuring the amount of leakage into the respirator. The Auckland DHB is undertaking quantitative fit-tests using a PortaCount machine.

4. Roles and Responsibilities

Occupational Health & Safety

OH&S is responsible for providing the ADHB respiratory protection program.

OH&S staff will perform quantitative fit-tests upon hire and periodic quantitative fit-tests, as indicated. Qualified health professionals, from within the participating services, will provide quantitative fit-tests for their staff when required at **short notice**. In an urgent situation after-hours a secure-fit can be used.

OH&S will design and manage the secure-fit training programme for staff requiring this upon hire and also the annual training and health surveillance programme. Delivery of the secure-fit training programmes will be carried out by Nurse Educators within the participating service and OH&S will provide advice and assistance, as needed.

OH&S will report the pass/fail test results to all Managers so that the TB exposure risk to their staff can be managed appropriately.

Nurse Educators

Nurse Educators will deliver the secure-fit training to those staff who require secure-fit upon hire and for all staff on the annual secure-fit retraining and education programme. They will work with OH&S who will manage these programmes.

The Nurse Educator should use the provided pass/fail forms and pass these to OH&S for record keeping. OH&S will advise the Manager about the pass/fail results so they can make any necessary work accommodations for their employee. If a staff member is not achieving a secure fit then OH&S may look at additional training for the staff member and quantitative fit testing.

Managers

Managers are responsible for the health and safety of their staff at work, and as such, they must ensure that their staff are given time to attend the initial respirator fit testing and the annual secure fit training programme.

The Manager must inform OH&S when they have a new staff member requiring a quantitative fit-test upon hire. OH&S will then arrange an appointment with the staff member. The manager must inform their Nurse Educator when they have a new staff member requiring a secure-fit upon hire.

The Manager should liaise with OH&S when a staff member may require a periodic quantitative fit test, for example if there are concerns about a change in body weight or the staff member has indicated they have a medical condition that may increase their risk of acquiring active TB disease. The Manager should inform OH&S if they become aware of a change in N95 mask supplier or appearance.

The Manager should make a record of the N95 fit-test and secure fit pass/fail results for their staff and where a staff member has failed the required fit test they must ensure the staff member is not assigned to care for an infectious TB patient.

5. Identification of requirement for use of N95 Particulate Respirator

Respiratory Protection Controls
Wearing of an N95 Particulate Respirator is the third level of control in a TB infection control program. The use of protective equipment is used in situations that pose a risk of exposure to TB, despite engineering and administrative controls being in place. Use of respiratory protection can further reduce staff risk of exposure to droplet nuclei that are expelled into the air, (Chapter 7-Tuberculosis Infection Control, CDC).

Use of N95 Particulate Respirator is required for:

- Staff whose cumulative contact with an infectious TB patient is likely to be 8 hours or more annually. These staff must wear a fit- tested N95 particulate respirator. We are using a Portacount machine for a quantitative fit-test.
- Staff required to enter the AIIR occupied by an infectious TB patient should be restricted to those performing vital roles only.
- Staff who perform aerosolising procedures on an infectious TB patient, or who are in the room during the procedure, must wear a fit-tested N95 particulate

respirator. Aerosolising procedures include bronchoscopy, intubation, open suctioning and sputum induction.

- Nursing students on rotation in the Respiratory Service must wear a fit-tested particulate respirator before entering an AIIR occupied by an infectious TB patient. They are not to enter rooms with MDR TB patients.
- All others entering the room of a patient with known or suspected infectious pulmonary tuberculosis must wear an N95 particulate respirator which has been securely fitted. A qualified health professional will explain the seal-test, donning, doffing and disposal process as per **Infection Control Patient Isolation Policy** – **Click Here and go to Airborne Precautions.**

Staff Personal Health

Staff who have the highest risk of contracting active TB **should not** routinely care for patients with infective pulmonary TB. If patient care is unavoidable these staff should wear a quantitatively fit-tested N95 particulate respirator.

Highest risk groups are:

- Staff infected with HIV with a CD4 count < 200
- Staff taking anti-Tumour Necrosis Factor drugs to treat inflammatory conditions such as rheumatoid arthritis, ankylosing spondylitis and inflammatory bowel disease
- Staff with an organ transplant

Other staff with immune compromise or certain medical conditions are at increased risk of developing active TB to varying degree and should be assessed for possible work restriction on a case by case basis upon hire, or if referred to OH&S for assessment once employed. If in contact with an infectious TB patient they should wear a quantitatively fit-tested N95 particulate respirator.

Other conditions associated with increased risk of progression to active TB are:

- Diabetes (especially insulin dependent or poorly controlled)
- Chronic renal failure/dialysis
- Some cancers - leukaemia, lymphoma, head and neck cancer
- Gastrectomy
- Jejuno-ileal bypass
- Immunosuppressive therapy *(including prolonged prednisone)*

Pregnant staff are not at any increased risk of becoming infected with *Mycobacterium tuberculosis* or progressing from LTBi to active TB compared to the general population. Treatment for active TB is not contra-indicated in pregnancy, however, there are additional considerations regarding medication side effects in the mother and her foetus.

For this reason pregnant staff should be considered for work restriction. If pregnant staff are in contact with an infectious TB patient they should wear a quantitatively fit-tested N95 particulate respirator. Re-fitting maybe required during the pregnancy if there are significant weight changes.

Risk assessment Matrix: Applies to those entering AIIR occupied by an infectious TB patient

Criteria	**Low to Medium Risk** **Secure fit-test required**	**High Risk** **Quantitative fit-test required**
Contact during daily patient care	Casual < 8 hours cumulative care annually	Close contact > 8 hours cumulative care annually
Aerosol Generating Procedures	None	Intubation Open suctioning Sputum induction Bronchoscopy
Role	Interventional Radiologists Paediatric Respiratory and ID Doctors, Nurses and HCAs <u>Essential duties only</u> Allied Health Cleaners Clinical Nurse Advisor Interpreters	Bronchoscopy Nurse Assists Cytologists in Bronchoscopy room ID Doctors and Nurses Public Health TB Nurses Adult Respiratory Doctors, Nurses and HCAs Respiratory Physiotherapists Nursing students if assigned to an infectious TB patient *Interpreters for MDR TB patients *Paediatric Respiratory and ID Doctors, Nurses and HCAs for higher risk patients

Note

*****Paediatric TB patient presentation to SSH is rare and small children tend to be less infective due to a weaker cough. If an older child is deemed to be infective (can generate aerosols through coughing) then a Short Notice quantitative fit-testing programme is to be used for affected staff – this will be managed by OH&S. Secure-fit can be used initially until the fit testing programme is underway. Secure fit may also be used for low infectivity paediatric patients.

*****Interpreters are to use secure-fit unless they are assigned to a MDR TB patient and then the ward based Short Notice quantitative fit-test programme is to be used.

N95 Particulate Respirator Initial Fit Test Requirements for Staff

ROLE	FIT TEST	SECURE FIT	OTHER (Hazard Control)
Allied Health (Occupational Therapist, Speech Language Therapist and Social Worker)		Yes	
Bronchoscopy Nurse Assists	Yes		
Cleaner		Yes	
Clinical Nurse Advisor		Yes	
Contractor (Room maintenance)	No	No	*The patient is removed from the room and the contractor enters after 20 minutes*
Cytologist (working in Bronchoscopy)	Yes		
Infectious Diseases Doctor	Yes		
Infectious Diseases Nurse	Yes		
Interpreter	Yes for MDR TB patient	Yes for all other patients	*For MDR TB patient short notice fit-test on ward*
Interventional Radiologists		Yes	
Kitchen Staff	No	No	*Not to enter AIIR* *Nursing staff to assist with the delivery of meals*
Microbiology Laboratory, TB Section	No	No	*Work within a biological safety cabinet*
Nursing Bureau	No	No	*Not to enter AIIR occupied by an infective TB patient*
Orderly	No	No	*Not to enter AIIR* *Nursing staff can assist patient transfer out of the room. Patient to wear a surgical mask for transfers*
Phlebotomy	No	Yes	*Not to enter AIIR occupied by a MDR TB patient. Secure-fit for other TB patients*
Public Health TB Nurses	Yes		
Radiographers (General)	No	No	*Patient is to wear a surgical mask*
Adult Respiratory Doctor	Yes		
Adult Respiratory HCA	Yes		
Adult Respiratory Nurse	Yes		
Respiratory Physiotherapist	Yes		
Nursing student	Yes		*Fit test to be provided on ward*

	only if essential		*Annual training not indicated* *Not to enter AIIR with MDR TB patient*
Technician (Anaesthetic and Renal)	No	No	*Not to enter AIIR occupied by an infective TB patient*
Paediatric Respiratory and ID staff involved with care of TB patient	Yes	Yes	*Short notice fit-testing for staff assigned to older patients deemed infective. Secure-fit to be used until fit-test carried out and for other significantly less infective paediatric patients*
**Urgent essential entry to AIIR for staff not on N95 fit programme*			*Seal-test before entry* *Patient to wear surgical mask*

Legislation

Health and Safety in Employment Act 1992
Privacy Act 1993
New Zealand Public Health and Disability Act 2000
Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
Schedule of notifiable diseases - updated May 2009

6. Supporting evidence

1. Retrieved from http//:www.viha.ca-Vancouver Island Health Authority Respiratory Protection Program, September 2009
2. Retrieved from http//:www.cdc.gov-MMWR,December 30,2005/Vol.54/No.RR-17. Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005
3. Retrieved from http//:www.cdc.gov-Chapter 7-Tuberculosis Infection Control
4. Retrieved from http//:www.osha.gov-OSHA Technical Manual (OTM) Section viii : Chapter 2
5. Guidelines for Tuberculosis Control in New Zealand 2010
6. Retrieved from http//:www.ucsf.health.org
7. McNaughton ET AL, (1994). The risk of tuberculous infection in hospital medical staff. Aust NZ J Med ; 24
8. Meredith, S, ET AL, (1996). Are healthcare workers in England and Wales at increased risk of tuberculosis? British Medical Journal; Aug 31, 1996; 313, 7056.

9. Associated ADHB documents

Health & Safety
Human Resource Principles
Pre-Employment Health Screening
Discipline & Dismissal
Hand Hygiene

Patient Isolation
Staff with Communicable Diseases
Standard Precautions
Hazard Management

An N95 Particulate Respirator Fit Testing Guideline to support this policy is under development and should be available in early 2013.

10. Corrections and amendments (office use only)

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or the Document Controller without delay.

Blood & Body Fluid Accidents

Document Type	Policy
Function	Workforce Services
Directorate	ADHB Generic
Department(s) affected	All ADHB HSGs, Services and Departments
Patients affected (if applicable)	n/a
Staff members affected	All ADHB employees, contractors, students and volunteers
Key words (not part of title)	needle stick, Hep B, Hep C, HIV, Event Lead
Author – role only	Manager OH&S
Owner (see ownership structure)	Owner: Chief Executive & Endorsed by The Board Issuer: Chief Health Professions Officer
Issuer	Chief Health Professions Officer
Edited by	Document Controller
Date first published	October 2000
Date this version published	May 2013
Date of next scheduled review	May 2016
Unique Identifier	HS01/ASD/005

Contents

1. Purpose of policy

To provide a procedure for reporting and managing blood & body fluid accidents (BBFA) and to ensure that the appropriate follow up and any necessary treatment is given to the employee.

2. Scope

This policy applies to all ADHB employees, contractors, students and volunteers

3. Definitions

An exposure that might place a Health Care Worker at risk for Hepatitis B, Hepatitis C, or HIV infection is defined as a percutaneous injury (e.g., a needle-stick or cut with a sharp object) or contact of mucous membrane or non- intact skin (e.g., exposed skin that is chapped, abraded, or afflicted with dermatitis) with blood, tissue, or other body fluids that are potentially infectious (Center for Disease Control and Prevention, USA).

4. Blood & Body Fluid Accidents

Blood & Body Fluid Accidents Types

Types:

- Needle-stick or sharps injury
- Splash / bite/ scrape

Exposure Prone Procedures

In the vast majority of BBFAs the Health Care Worker (HCW) is the person at risk of potential infection and is considered the 'recipient' in these accidents. Very rarely a patient may be at risk if an accident occurs where a Health Care Worker (who is infected with Hepatitis B, Hepatitis C or HIV) is performing an exposure prone procedure.

An exposure prone procedure (EPP) is defined as "…. where the worker's gloved hands may be in contact with sharp instruments, needle tips, or sharp tissues (spicules of bone or teeth) while inside a patient's open body cavity, wound or confined anatomical space, where the hands or fingertips may not be completely visible at all times …" (UK DoH 2001).

The ADHB has a process to manage staff who perform exposure prone procedures to reduce risk of infection to patients undergoing these procedures. This is managed under the risk assessment process. An exposure prone procedure policy (Transmissible Major Viral Infection policy) is currently under development.

Location of Worker When Accident Occurs
The majority of ADHB staff work on either the ACH site or the GCC site where there is ready access to Lab Plus for blood tests. Workers located or working at sites away from these main sites must come into Lab Plus at ACH or GCC to provide blood samples.

Workers who are located at CMDHB or WDHB should use the BBFA response system within their host DHB. Blood results will be accessed by ADHB Occupational Health Service (OHS) via the respective OHS departments.

Risk to Health Care Workers
The published rates of non-immune persons found positive after percutaneous exposure to HBV is 30%, HCV 1.8% and HIV 0.3%.

HIV Risk Assessment
- An assessment of the risk of HIV transmission is necessary to determine appropriate follow-up. Prophylaxis is available for those staff who have had a high risk exposure.
- The Infectious Disease (ID) Registrar on-call is responsible for this HIV risk assessment and administration of prophylaxis, if required. They should be contacted immediately following a BBFA where the patient source is known to be infected with HIV, or when the subsequent blood test comes back positive for HIV.

Management of BBFAs
The Process consists of:
- Stage One (immediate response and blood collection). See BBFA Process
- Stage Two (post exposure follow up). See HepC, HepB and HIV protocols.

An Event Lead will be identified to assist the injured HCW through Stage One of the process. The OHS Nurse will oversee Stage Two.

All aspects of completing this process must be carried out as soon as possible to action any treatment that may be required for the injured staff member.

Failure to Report
All staff are obliged under the Health and Safety at Work Act to protect themselves and others while at work. Failure to report a Blood & Body Fluid Accident may result in a disciplinary action.

5. Roles & Responsibilities

Injured Person
All staff who have had a Blood & Body Fluid Accident at work must:

- Carry out first aid as soon as possible on the affected area
- Report all BBFAs to their manager immediately
- Identify a BBFA Event Lead for their work area. The Event Lead will access the BBFA Response Pack
- Complete a BBFA Staff Management form, CC406, found in the Response Pack and fax to OHS (27084)
- Complete all necessary blood tests (lab forms are included on the CC406 form)
- Employees must also report the incident as an OH&S Occurrence on the ADHB Incident Management reporting system
- Students, Volunteers and Contractors report the incident using an alternative staff incident report form.

Manager
Managers (or managers with delegated authority) must:

- Follow up all staff incident reports
- Investigate all reported accidents to ensure accurate report taking and appropriate action to try and prevent similar accidents from occurring

Event Lead

- Any supervisor, shift coordinator or manager may be an Event Lead
- The role of the Event Lead is to follow the process and assist the injured person to complete the CC406 form and provide blood samples
- The Event Lead can also act as the Third Party to obtain the patient's consent and blood samples

Responsibility of Third Party
Third party person is responsible for approaching the patient or patient's guardian to explain the process and requirement for blood testing of the patient (or source) and obtaining written consent prior to these tests.

Assignment of this position can be delegated to a team leader, charge nurse, doctor or colleague and must not be the staff member who has experienced the BBFA.

A signature is required on the BBFA CC406 form by the person acting as the Third Party.

The HCW who has had the BBFA **must not** approach the patient to obtain consent or take a patient blood sample as this is a breach of both the Privacy Act of 1993 & The Health & Disability Code of Consumers Rights 1996.

Surgical Patient Consent
Pre-operative patient consent to screening is included in the 'Agreement to Treatment – Surgery/Other Procedure' (CR0111). Please note that some surgical patients may not have completed the CR0111 due to level of emergency at the time of admission to hospital. Patients must be informed post-operatively that a BBFA and subsequent blood screening has occurred.

In all other instances, a third party person (team leader or colleague) must obtain written consent before a specimen can be taken for screening.

6. Procedure

Steps to Follow:

Who	What	How (Steps required)
Injured Person Working at ACH or GCC site	Commence the response process immediately	• Clean / irrigate affected area thoroughly with running water and then wash area with soap and water (excluding eyes) and dry • Apply aqueous betadine to site; cover area with plaster, if still bleeding • Inform the manager or shift supervisor for this work area as quickly as possible (they can become the Event Lead) • Event Lead will access a BBFA Response Pack and start the process as per the flow chart • The BBFA form (CC406) is obtained from the Response Pack. Complete all fields of the form clearly • Contact OHS Nurse on 26946/26997 for your Hep B status if unknown • Provide blood sample for baseline tests indicated on the BBFA form. Do **NOT** circle tests as all tests will be carried out by the lab • Blood samples from patient source to be arranged by another member of the service team acting as Third Party • Report accident on the ADHB Incident reporting system • Contact EAP if you would like supportive counselling – see EAP contact details under "H" for Health and Safety on the ADHB Intranet
Injured Person Working at Communi-ty site	Commence the response process immediately	• Clean / irrigate affected area thoroughly with running water and then wash area with soap and water (excluding eyes) and dry • Apply aqueous betadine to site; cover area with plaster, if still bleeding • Inform the manager or shift supervisor for your work area as quickly as possible (they can become the Event Lead) • Event Lead will access a BBFA Response Pack and start the process as per the flow chart • The BBFA form (CC406) is obtained from the Response Pack. Complete all fields of the form clearly • Contact ADHB OHS Nurse (630-9943

		ext.26946/26997) for your Hep B status if unknown • Provide blood sample (at **Lab Plus**) for baseline tests indicated on the BBFA form. Do **NOT** circle tests as all tests will be carried out by the lab • Blood samples from patient source to be obtained by another member of the service team acting as Third Party and sent to **Lab Plus** for analysis. Patient may come to LabPlus phlebotomy by taxi if needed • Report accident on the ADHB Incident reporting system • Contact EAP if you would like supportive counselling – see EAP contact details under "H" for Health and Safety on the ADHB Intranet
Injured Person Working at Another DHB site	Commence the response process immediately	• Clean / irrigate affected area thoroughly with running water and then wash area with soap and water (excluding eyes) and dry • Apply aqueous betadine to site; cover area with plaster, if still bleeding • Follow BBFA response process of the DHB you are at. Provide baseline blood tests and patient source tests at the lab within that DHB. • Inform OHS nurse at ADHB (630-9943 ext.26946/26997) and obtain your Hep B status if unknown • OHS at ADHB will liaise with host DHB OHS department • Report accident on the ADHB Incident reporting system as soon as you are able • Contact EAP if you would like supportive counselling – see EAP contact details under "H" for Health and Safety on the ADHB Intranet
Event Lead	Manage the process for the injured person and act as Third Party person if possible	• Access a BBFA Response Pack and start the process as per the flow chart • Do initial risk assessment of BBFA in conjunction with the injured staff member • Contact Infectious Disease Registrar immediately if patient source is known to be infected with HIV • Contact Infectious Diseases Registrar if patient source blood unobtainable for testing • Ensure the CC406 form is completed accurately and clearly • Ensure bloods are taken from injured staff member and patient source • Act as Third Party person if possible • If this is not appropriate identify appropriate person • **Injured staff member cannot approach patient**

		for consent or blood taking • Support the injured worker and remind them about EAP if required – see EAP contact details under "H" for Health and Safety on the ADHB Intranet • Fax page 1 of CC406 form to OHS department 27084
Third Party Person	Obtain consent and arrange for blood draw for patient	• Only the Third Party person may approach the patient with an explanation of ADHB's BBFA policy and what has occurred • Complete Third Party section of CC406 form on page one or affix a patient identification label to this area • Check patient records for a set of Hepatitis B, C, and HIV serology results from **this** admission. If available the patient source will not require re-testing following this BBFA. If all three results are not available the patient will require blood samples. • Obtain patient consent for the indicated tests – Hep B, Hep C and HIV. Do **NOT** circle tests required on the lab form as all tests will be carried out by the lab • Arrange for blood draw from patient source
Manager/ Charge Nurse	Oversees whole BBFA process	• Ensure BBFA process supported by an Event Lead and that injured staff member is followed up • Initiate critical response process if required • Incident report investigated and hazard management process followed to avoid repetition of this type of accident
OH&S Nurse	Post event follow up and health monitoring	• Receives and reviews both patient source and injured staff member's blood results for BBFA risk assessment • Contacts staff member for accident information, results of blood tests and provides advice on next steps. • Coordinates any follow up appointments, vaccinations or blood test recalls that are required for the injured staff member • Administers HBIG during normal work hours to non-immune HCWs who have had a high risk Hep B exposure • **NOTE: it is the responsibility of the patient's treatment team to review the patient's HBV, HCV and HIV serology results, inform the patient and follow-up on any abnormal results.**
Clinical	Ensure BBFA	• Follow process for Event Lead

Nurse Advisor in 24 Hour Centre (After hours only)	process is followed when Event Lead and/or OH&S Nurse is not available	• If patient source is known to be infected with HIV the Infectious Diseases Registrar must be contacted immediately for risk assessment and possible prophylaxis for injured staff member • Contact Infectious Diseases Registrar if patient/source blood unobtainable for testing • Chase up all patient source and staff blood test results. Discuss with ID Registrar if needed • If the patient source is known, or found to be, infected with Hepatitis B and the HCW is non-immune contact the ID Registrar for consideration of HBIG during the weekend or public holidays. HBIG can be given in Adult Emergency Department under the direction of the ID Registrar. • Initiate critical response process if required • Act as liaison person between injured staff member and ID Registrar
Lab Plus	Receives blood samples and carries out virology testing	• Ensures blood samples from BBFAs are processed within the service level agreement timeframes with OH&S. All BBFA blood tests to be processed as a priority by Lab Plus • Contacts ID Registrar immediately if patient source is found to have HIV infection • Contacts OHS department by phone with early results if patient source bloods are abnormal

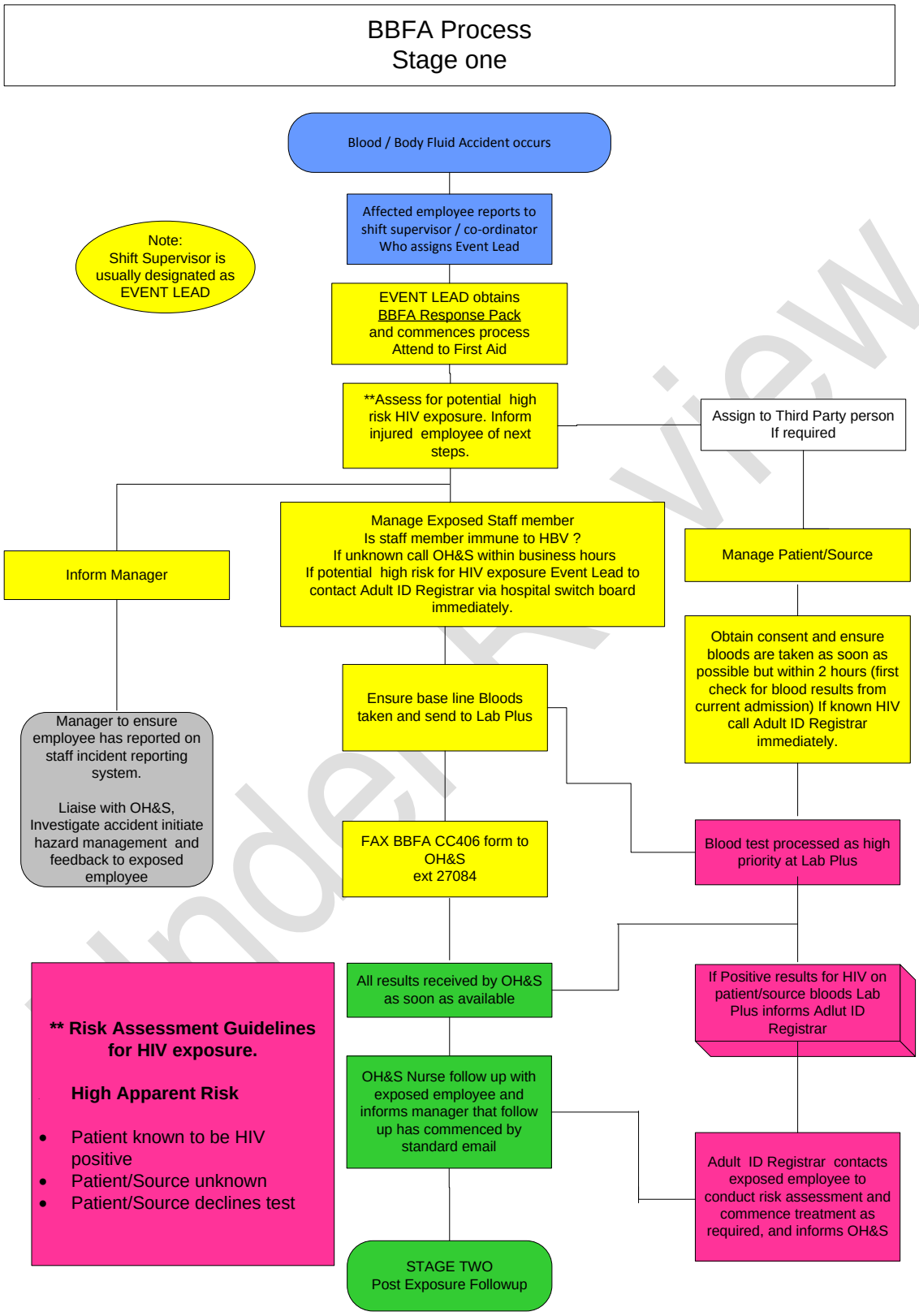
7. Additional Actions in High Risk BBFA Situations

Who	What	How (Steps required)

Infectious Disease Registrar	HIV exposure risk assessment	• ID Registrar will be advised by the Event Lead, or the CNA after hours, if patient source is:
		  • Known to have HIV infection
		  • Blood is unobtainable
		• ID Registrar will be advised directly by the laboratory if the patient source blood test is positive for HIV
		• The ID Registrar will then inform the affected staff member
		• An exposure risk assessment is required in all cases

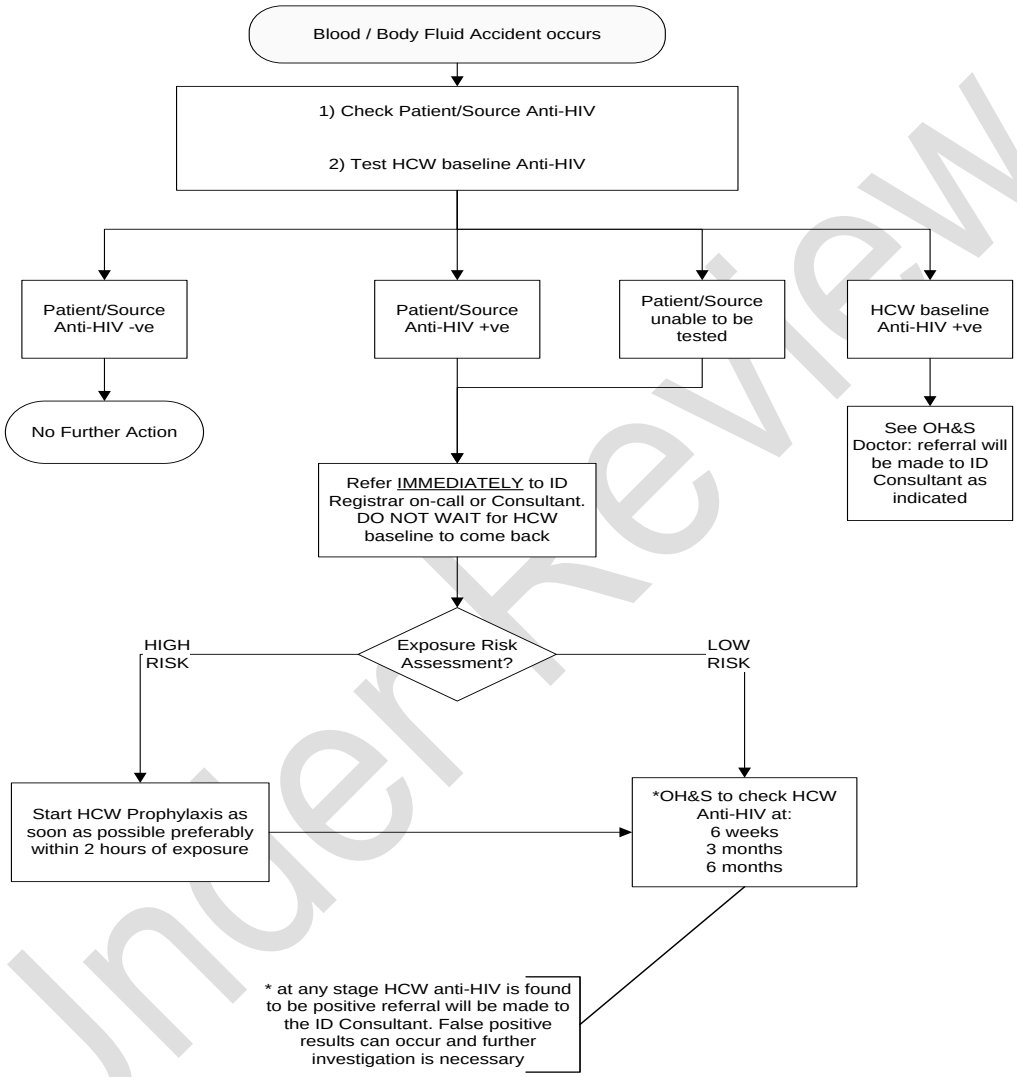
	Administration of HIV prophylaxis	• If the BBFA exposure is considered high risk for HIV transmission the ID Registrar will offer and administer prophylaxis treatment to the HCW • ID Registrar to inform OHS Nurse via email of risk assessment status and whether or not prophylaxis has been given
	Administration of HBIG during weekends and holidays	• ID Registrar will be notified by CNA after hours if the HCW is at risk of Hepatitis B from this exposure. HBIG can be given in Adult Emergency Department. • ID Registrar to provide BBFA management advice to Event Lead and/or CNA after hours and to OHS Nurse if OHS Doctor is not available
OH&S Physician	Advisory	• BBFA management guidance and provides advice to OHS Nurse and affected staff as required
EAP Services	Counselling	• Provides counselling services to staff concerned about their BBFA – see OH&S web site for information

8. BBFA Process Stage One

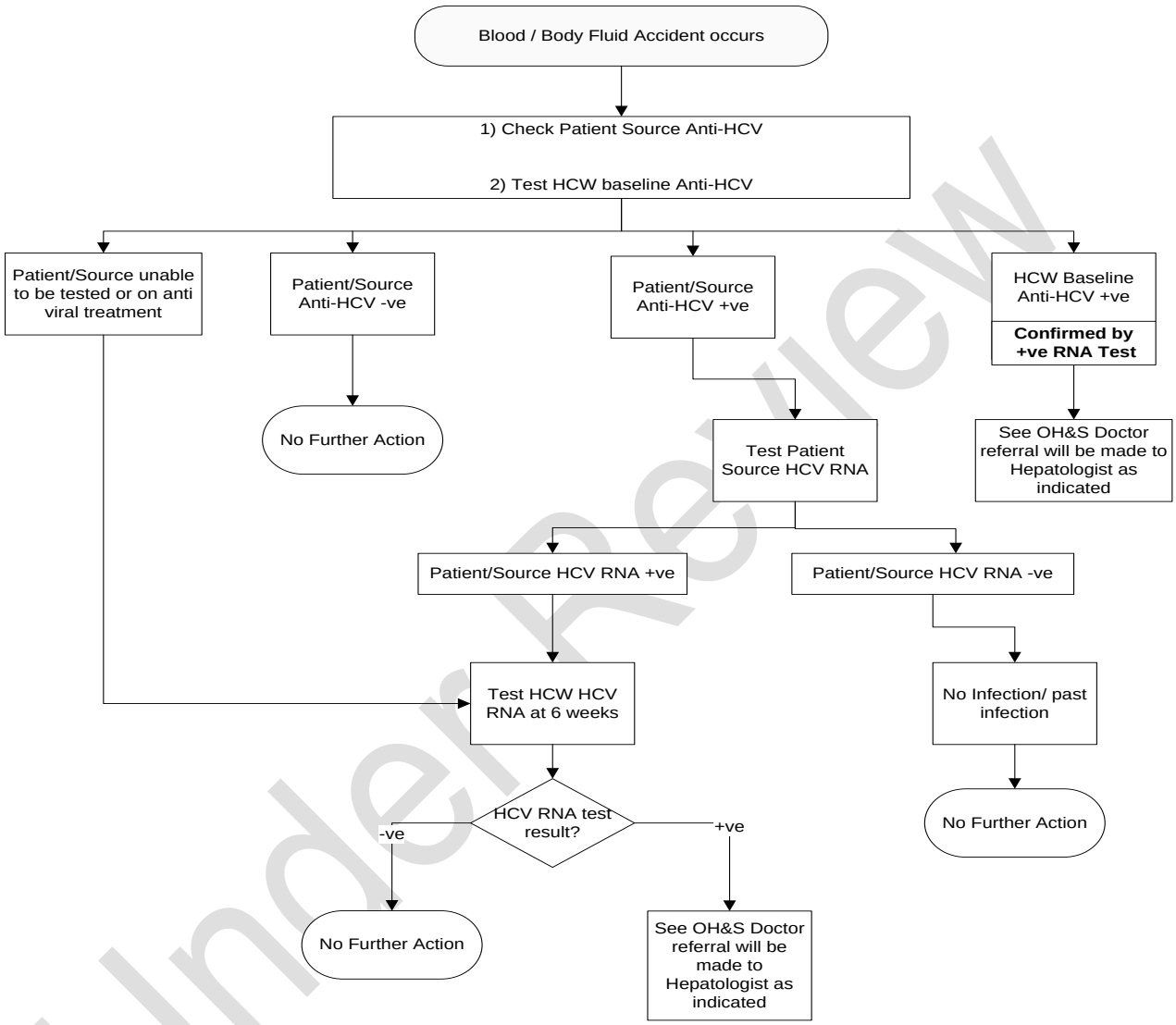


9. Treatment, Exposure and Follow-up Protocol

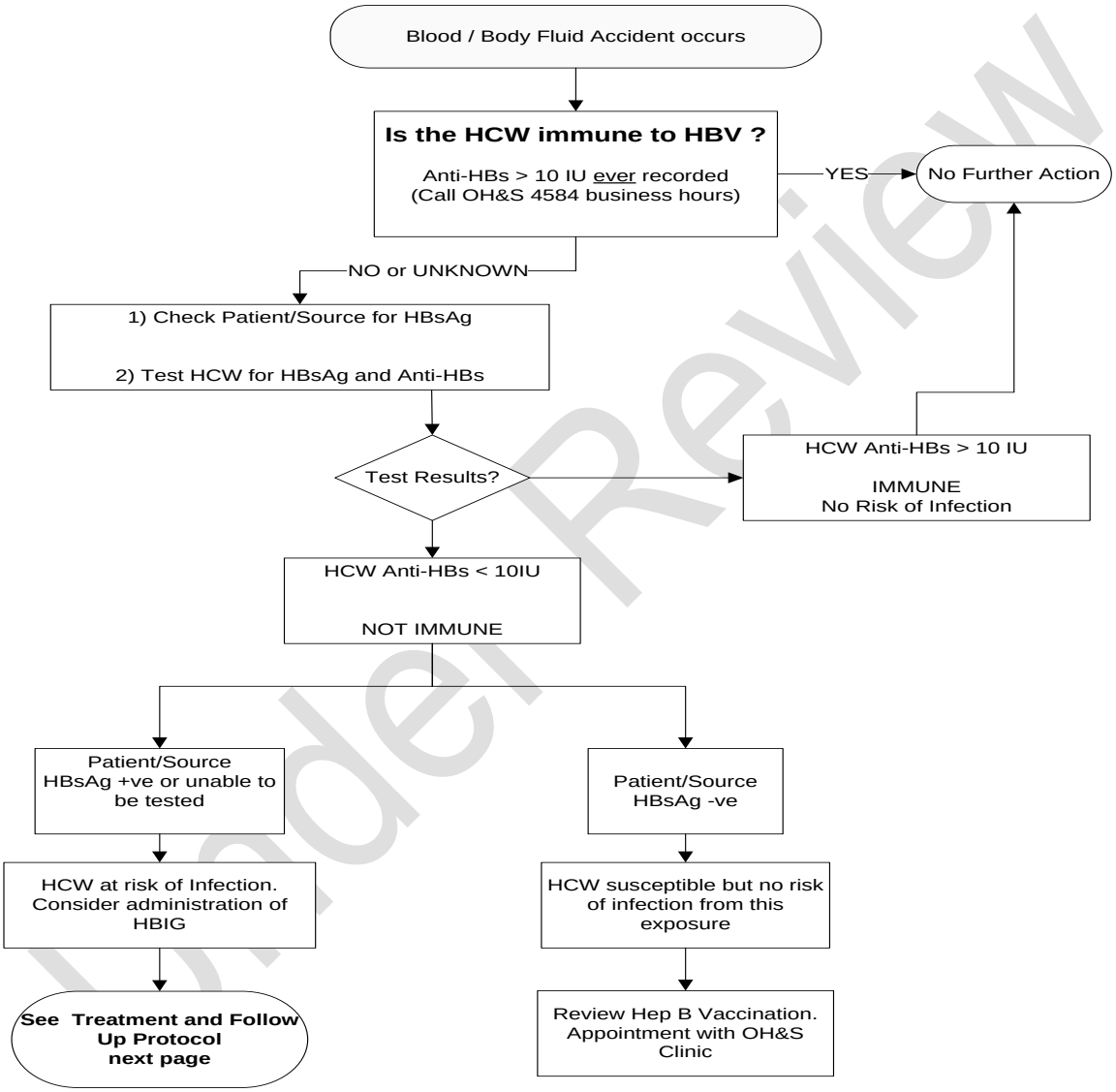
Flow Chart: Stage Two – HIV Post Exposure Protocol



Flow Chart Stage Two – Hepatitis C Post Exposure Protocol



Flow Chart: Stage Two - Hepatitis B Post Exposure Protocol



Appendix 1: Treatment and Follow-up Protocol for Hepatitis B

HBV POST EXPOSURE TREATMENT AND FOLLOW UP PROTOCOL FOR NON IMMUNE HCW'S AT RISK OF INFECTION

HCW VACCINATION HISTORY	TREATMENT	FOLLOW-UP INFECTION TESTS	FOLLOW-UP IMMUNITY TESTS
NEVER VACCINATED OR INCOMPLETE COURSE	HBIG within 72 hours and Accelerated course of Engerix (0,1,2 months)	6 weeks: HBsAg 3 months: HBsAg 6 months: HBsAg	Test Anti-HBs at 3 months: Anti-HBs<10IU indicates HCW not protected. Double-dose Twinrix will be offered. Otherwise confirm immunity status at 6 months: If Anti-HBs>10IU IMMUNE If Anti-HBs<10IU not immune. OH&S will manage poor-responder alternative vaccination process.
PREVIOUS VACCINATION COURSE AND THIS IS FIRST IMMUNITY TEST	HBIG within 72 hours and Engerix Booster	6 weeks: HBsAg 3 months: HBsAg 6 months: HBsAg	
KNOWN POOR-RESPONDER TO STANDARD VACCINE COURSE(S) Previous Anti-HBs<10IU at post vaccination check	HBIG within 72 hours and Double-dose Twinrix (0,1 months)	6 weeks: HBsAg 3 months: HBsAg 6 months: HBsAg	Test Anti-HBs at 3 months: Anti-HBs<10 IU indicates HCW not protected. A third dose of Twinrix will be offered. Otherwise confirm immunity status at 6 months: If Anti-HBs>10IU IMMUNE If Anti-HBs< 10IU after 2 doses of Twinrix, give 3rd dose and recheck immunity in a month. If Anti-HBs< 10IU, after 3 doses Twinrix, PERSISTENT NON-RESPONDER
PERSISTENT VACCINE NON-RESPONDER Documented in OH&S records and alternative vaccination has been tried and is unsuccessful	HBIG within 72 hours	6 weeks: HBsAg 3 months: HBsAg 6 months: HBsAg	No testing required

*** At any stage HBsAg is positive, or symptoms of hepatitis occur, OHS will refer the HCW directly to a Hepatologist, as indicated**

10. Associated Documents

Board Policies

- Health & Safety
- Human Resource Principles
- Pre-Employment Health Screening
- Discipline & Dismissal
- Employee Assistance Program
- Standard Precautions - Infection Control

Health & Safety Policies

- OH&S Occurrence
- Hazard Identification and Risk Assessment Guideline

Infection Prevention and Control

- Major Viral Transmission Committee
- Major Viral Transmission Policy (TBA)

Legislation

- Health & Safety at Work Act (2015)
- Privacy Act (1993)
- Health & Disability code of Consumers Rights (1996)

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11. Corrections and amendments (office use only)

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Rehabilitation of Staff

Document Type	Policy
Function	Corporate Services
Directorate(s)	All
Department(s) affected	All
Applicable for which patients, clients or residents?	No
Applicable for which staff members?	All employees of ADHB
Key words (not part of title)	n/a
Author – role only	Manager OH&S
Owner (see ownership structure)	Chief Health Professions Officer
Edited by	Document Controller
Date first published	TBA – office use only
Date this version published	TBA – office use only
Review frequency	TBA – office use only
Unique Identifier	TBA – office use only

Contents

1. Purpose of policy

The purpose of this policy is to:

- Reduce the duration and extent of work incapacity associated with work or non-work related injuries and illness
- Ensure vocational rehabilitation is available to those who need it
- Establish processes for prompt recovery and safe return to work
- Ensure that ADHB is compliant with the current legislation.

2. Policy statements

ADHB will:

- Meet it's obligations in accordance with all work related legislation and the standards of the ACC Partnership Programme including an annual audit conducted by an external auditor.
- Monitor the rehabilitation process and provide advice on procedures to ensure that employees receive meaningful involvement.
- Promote the expectation that a return to work as soon as is possible after the injury or illness is normal practice.
- Provide clear accountabilities and responsibilities for all parties involved including ADHB third party administrator (TPA) and all other stakeholders.
- Keep all personal medical information confidential with only appropriate information provided to ADHB management.
- Provide suitable and safe alternative duties/hours for employees when recommended by health provider as reasonably possible.
- Reserve the right to request a second opinion from specialist health professionals.
- Ensure employees receive their legal rights and entitlements including adherence to the ACC Code of Claimants Rights.
- Staff incident report will be required to confirm injury details provided by the employee in relation to work related injury ACC claims.
- a claim decision (accept/decline) of the work related ACC claim may be declined on the basis of lack of documentation in the absence of a completed staff incident report.
- Regularly review rehabilitation outcomes and service provision to ensure effectiveness of the programme and identify opportunities for improvement.

3. Definitions

Term	Definition
ACC45 (Medical Certificate)	Initial medical treatment form, completed by a registered medical practitioner (i.e. GP, Physiotherapist). This form is required by ACC (non-work related cases), TPA (work related cases)
ACC18 (Medical Certificate)	Subsequent medical treatment forms, completed by a registered medical practitioner (i.e. GP, Physiotherapist). This form is required by ACC (non-work related cases), TPA (work related cases)

Code of ACC Claimant's Rights	The code encourages positive relationships between ACC, ADHB,TPA and the employee
Cover Decision	A written decision that accepts or declines the employer's liability for a work related ACC claim.
Gradual Process Injury	An injury resulting from the prolonged or multiple exposures to a task or hazardous environmental factor. For example: Noise induced hearing loss, muscle pain and swelling.
ACC Act or Legislation	Accident Compensation Act 2001
Lost time Injury	Any injury that involves a staff member losing one full shift of work and there is an ACC45/ACC18 medical certificate provided by the medical practitioner confirming the need for time off work.
Medical Certificate of Work Capability	A form for the employee to take to the Doctor so that appropriate alternative or selected duties can be provided at their work place.
Non Work Injury	A personal injury which occurs as a result of activity which is not related to work tasks or the work environment this may be related to a non-work ACC claim. • ADHB facilitates return to work for employees who have had a non work accident covered by ACC. • ACC provides all entitlements and will liaise with ADHB to co-ordinate elements of vocational rehabilitation. • OH&S will support managers in management of non progressive cases as required. (refer to Rehabilitation Type Summary)
Manager	The person with management responsibilities for the injured or ill employee to which the costs of any cost related to leave will be allocated.
PICBA Injury	Personal Injury Caused by Accident – otherwise known as a sudden onset injury
Rehabilitation Plan	Is a structured, written process to facilitate active change and support the goal of restoring the employee's health and independence
Return to Work Programme	A programme instituted by the employer and medical providers to return an injured employee safely to work as quickly as possible. This is often a gradual process that includes transitional duties and hours of work.
Review – Formal	An employee may review any decision made by ADHB in relation to the work related injury management process. Application to review must be completed on a prescribed form available from the TPA.
Support Person	A person selected by the employee to attend meetings with them. The nominated support person could be a colleague, friend, family member H&S Rep or a union representative
TPA Third Party Administrator	This is the company that is contracted to provide the ADHB with injury and claims management expertise. May also be referred to as Third Party Provider (TPP)
Treatment or Medical Provider	A treatment provider may include (but is not limited to) a general practitioner, physiotherapist, dentist, orthopaedic surgeon, occupational physician, osteopath and the like.

Work related Injury	A personal injury which occurs within ADHB facilities and/or as a direct result of specific work tasks. • The work related injury management and rehabilitation process is governed by the requirements of the ACC Partnership programme which in turn are governed by the ACC Act.

4. Roles and Responsibilities

Who	Action	When
Effected person	Inform their manager/team leader of injury or illness as soon as practicable.	Within 24 hours or ASAP
	Provide copy of all medical certificates to manager	ASAP
	Complete staff incident report	Within 24 hours or ASAP
	Invite a nominated support person to attend rehabilitation meetings if desired	As required
	Participate in rehabilitation programme and prompt return to work	As required
Manager	The manager is responsible for all management of employees who report directly to them. Therefore the manager maintains their normal relationship with the injured/ill employee and is the key driver of the rehabilitation process for an individual episode of rehabilitation for that employee.	always
	Contact employee for initial needs assessment	Within 48 hours of injury report
	Investigate staff incident that resulted in the work related injury/illness and complete the process required by the ADHB policy.	Within 7 days of report
	Attend meetings and cooperate with the composition of a rehabilitation plan, acknowledging operational priorities and any limitations stipulated on the medical certificate.	As required
	Liaise with Employee whilst off work to update and document action plan.	Weekly
	Liaise with case manager & OH&S.	As required
	Provide suitable and safe alternative duties within the capabilities of the employee's rehabilitation.	On-going
	Monitor and support the employee when at work.	As required
	Promote a clear understanding of the objectives and principles of the rehabilitation policy to all staff.	As required
	Identify and implement strategies to prevent injuries to other employees.	On-going

OH&S	Provide support and advice to manager regarding injury management of a claimant and obligation under the ACCPP.	As required
	Maintain work related claim data base	Monthly
	Provide monthly statistical data and trends to ADHB	as requested
	Facilitate communications between ACC, TPA and the ADHB	as required
	Ensure external providers (TPA, health providers) maintain standards as per the service level agreement requirements	Annually
Case Manager	Co-ordinate the process of the employee returning to his/her duties in a gradual, safe manner.	
	Consult with the work area to identify safe alternative duties according to the employee's job description.	
	Provide a written & signed rehabilitation plan for the Employee, supervisor/manager to follow.	
	Monitor the effectiveness of the programme with agreed objectives and timeframes with the employee and manager.	
	Ensure the employee is aware of their obligations and entitlements under the ACC Act 2001.	
	Involve other 'support professionals' or agencies where necessary to aid the early return to work.	
	Give appropriate information with regard to the dispute resolution process	
GP	Remains the person's primary health care provider. Issue Medical certificate to appropriate party (ACC non-work related, TPA work related injury/illness)	Immediately
	Assess person's fitness for work, and outlines capability limitations including time constraints	Immediately and as required
Support person	Attend meetings with the injured person if requested	As required
	Take notes at the meetings if requested by the injured person	As required

5. Disputes regarding work related ACC Claims Decisions

ADHB encourages an open and consultative approach to rehabilitation, workplace injury management and safety. This includes a willingness to work co-operatively with complaints or dissatisfaction about the services provided to our employees.

In most cases, managers are directly responsible for dispute resolution. ADHB Disputes Manager is the Chief Health Professions Officer. The ADHB Disputes Manager is formally informed about any dispute and asked to intervene directly when an employee is not satisfied with an action proposed by the manager.

Please note that the ADHB uses a Third Party Administrator (TPA), to provide services in the processing of work accident claims.

Note: This section is related to complaints and disputes for work related ACC claims only. Complaints and disputes resulting from illness rehabilitation interventions to be managed in accordance with the Human Resource Principles policy.

In the case of disagreement about work injury claims, the following three step process is to be followed.

Stage	Process description
One: **Initial Discussion**	• Formal discussion of the problem or dispute with the employee, manager, case manager or service provider concerned. The aim of the discussion is to jointly agree a resolution. ADHB Disputes Manager is able to facilitate this meeting if required. • If agreement reached, it should be recorded, in brief, in writing. • If the problem is not resolved by discussion, then the issue is formally referred to the ADHB Disputes Manager. The ADHB Disputes Manager is then responsible for seeking an agreed resolution in the most appropriate manner. • Where the dispute or complaint is about a work injury claim decision made by a case manager, the employee should go directly to the formal review process outlined in the Review Process stage
Two: **Review Process – Internal & Administrative**	• The case manager will provide the prescribed form required to lodge a formal request for review of case decisions made. If desired, the employee may request that the review be conducted by an independent party. • The employee will also receive from the TPA written information about what to do throughout the review process. The information will include details of all work injury decisions made, the employee's entitlements to ACC cover and benefits, and all relevant legislation will be cited. • Written decision letters must always explain to the employee their rights to formally review any decision and the process involved.

	• An administrative review will be undertaken by a TPA manager to take a fresh look at all the facts and decide whether the decision made was the correct one. • All relevant people will be consulted, including those at the workplace. The TPA will notify the ADHB Disputes Manager of the outcome. If an employee is still not satisfied then they may proceed to the External Review stage
Three: **External Review**	• If the decision made by the TPA is not changed following the administrative review, the next step is to proceed to an external review, conducted by an independent professional. Reviews are undertaken by an external dispute resolution service. All relevant parties (including employee support people or nominated representatives) must be consulted to make sure the selected reviewer is acceptable. • Following the hearing, the reviewer has 28 days to issue a Review Decision (unless further information such more detailed medical information is required or information is presented by one of the parties that has not been reviewed by the other party prior to the meeting). • Once the decision is issued, the claimant has 28 days to appeal to the District Court if they wish to do so.

6. Complaints regarding work related ACC Claims

The ACC Code of Claimants Rights encourages positive relationships between ACC, the Accredited Employer, the Third Party Administrator and claimants.

For ACC, the Accredited Employer and Third Party Administrator to assist claimants a partnership based on mutual trust, respect, understanding and participation is critical.

Claimants and ACC, Accredited Employer, and Third Party Administrator need to work together, especially in the rehabilitation process.

This code is about how ACC, Accredited Employer, and the Third Party Administrator will work with claimants to make sure they receive the highest practicable standard of service and fairness.

Claimants have the right to:

- Be treated with dignity and respect
- Be treated fairly, and to have views considered
- Have their culture, values and beliefs respected
- A support person or persons present at meetings
- Effective communication
- Be fully informed
- Have their privacy respected

- Complain

Accredited employers, and persons acting as agents of ACC or on behalf of ACC, must also comply with this Code in their dealings with claimants.

Follow the stages below to process ACC work related complaints.

Step	Action
1.	Claimant lodges a complaint either in writing or by phone to ACC's complaints service.
2.	ACC Complaints Service obtains the necessary complaint detail and confirms whether or not the complaint does relate to matters dealt with under the ACC Code.
3.	Impartial investigation conducted, seeking information from the different parties involved.
4.	The complaints service provides a list of facts to check.
5.	ACC complaints service makes a formal decision.

7. Process summary table

	Work related Injury/Illness	Non work ACC Injury	Personal Health Impairment
Work incapacity/Absence	due to work related accident	due to non- work ACC injury	due to personal health.
Managers Action	Call OH&S case manager Complete initial needs assessment if time off work taken	Call OH&S Vocational Wellbeing Advisor for advice if needed	Discuss with HRC Complete request for Occupational Health assessment. (OH&S Forms)
Case manager	OH&S in house case manager	ACC case manager	Employee's manager
Case manager assigned	If 4 or more days off work or if considered high risk	Variable as per ACC protocol	Manager initiated
OH&S support	OH&S in house case manager	OH&S Vocational Wellbeing Advisor	OH&S Vocational Wellbeing Advisor
HRC	Involved if non progressive injury more than 6 months	Involved if long absence	Always involved
Staff incident report	Required to support workplace accident claim	Not required	may be used to report pain and discomfort at work by nit caused by work
Medical Certificates	ACC 45 , ACC 18	ACC45 , ACC 18	Medical certificate from doctor may be provided in some cases if requested
OH&S Referral documents	Not required	Not required unless OH&S referral for non- progressive case is requested by manager	Referral from manager required (OH&S forms)
Consent document	Obtained by TPA (WorkAon)	Not Required unless OH&S referral is requested by manager	Required as part of referral to OH&S
Case managers Action	OH&S: Liaise with injured employee and manager Develop Individual Rehabilitation Plan and regular review of same	ACC case manager: Liaises with injured employee Develop Individual Rehabilitation Plan and regular review of same	Manager: obtain advice from OH&S Vocational Wellbeing advisor and coordinate action plan as required.

	Work related Injury/Illness	Non work ACC Injury	Personal Health Impairment
	Co-ordinates treatments required	Co-ordinates treatments required	
Funding for care	ADHB administered by TPA	ACC	Funded by employee (public health or private insurance) and in some cases by ADHB
Salary (Leave)	First week paid by ADHB (ACWK) On-going: Entitled to 80% Earning related compensation paid by ADHB	First week paid by ADHB (Sick leave) On-going: Entitled to 80% Earning related compensation paid by ACC	Sick time, annual leave taken as sick, special leave
Primary Health care provider	Employee's GP	Employee's GP	Employee's GP
OH&S Occupational Medicine Physician	referred to external providers only	Not used, ACC to provide all care and assessment	Referral through OH&S Occupational Health Doctor will liaise with employee's GP
Workplace accommodation (Facilitate requirements of the Rehab Plan)	Required under the ACC Partnership Programme. Alternative duties may be required	ADHB as a good employer and guided by operational needs	ADHB as a good employer and guided by operational needs
Alternative duties (light duties)	May be outside of normal work unit and duties, but salary will still be paid by the unit paying the employee at the time of the injury.	Within normal unit and duties, but there are some exceptions.	Within normal unit and duties
Rehabilitation meetings	Monthly to update IRP	As required by ACC	As required by Manager

8. Legislation (sometimes required for a policy)

- Health & Safety at Work Act 2015
- Injury Prevention, Rehabilitation and Compensation Act (2001)
- Human Rights Act (1993)
- Privacy Act (1993)
- Health Information Privacy Code (1994)
- Code of Health & Disability Services Consumers' Rights (1996)

9. Associated Auckland DHB documents (always required)

- Leave
- Human Resource Principles
- OH&S Occurrence
- Hazard Identification and risk Management

10. Disclaimer (always required for a guideline - we will add the text for you)

11. Corrections and amendments (we will add the text for you)

Dispensation Request for Coagulation Contract Extension

Recommendation

That the Board:

1. **Receives the Dispensation Request for Coagulation Contract Extension report for February 2017**
2. **Approve the extension of the current contract for a further 1 year with a right of renewal of 1 year with the provision of an additional upgraded instrument for LabPLUS at no additional cost**
3. **Note that the current Diagnostica Stago Pty Limited contract for the supply of coagulation instrument with associated reagents and maintenance services has been in place for the past 3 years and it has a remaining 2 year term**
4. **Note the Dispensation (MBIE Government Rule of Sourcing: under Rule 15.9.c – Only one supplier) from Open Tender approved by healthAlliance (FPSC) on the 5th Dec 2016 to directly negotiate with Diagnostica Stago Pty Limited for an Auckland DHB LabPLUS contract extension of more than 5 years.**

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ELT Endorsed: Date 14 February 2017

Glossary

Acronym/term	Definition
Stago	Diagnostica Stago Pty Limited
MAX	Stago Coagulation instrument STAR MAX
LIS	Laboratory Information System
Sysmex	Sysmex New Zealand Limited
Beckman Coulter	Beckman Coulter New Zealand Limited
Siemens	Siemens (N.Z.) Limited

1. Board Strategic Alignment

Service integration and/or consolidation	The new Stago MAX instrument will be integrated to the new Blood Services Work Area Technology Upgraded Tracking System at LabPLUS ADHB.

2. Executive Summary

The purpose of this paper is to seek approval to extend the current Stago coagulation arrangement for a further 1 year with a right of renewal of 1 year term with the provision of an additional upgraded coagulation instrument to LabPLUS ADHB at no additional costs as part of the Blood Services Work Area Technology Upgrade Project.

3. Introduction/Background

LabPLUS Auckand DHB offers a comprehensive haematology testing services to the out-patients of Auckland City Hospital. Coagulation testing is an essential testing form the Haematology area for screening the haemostasis system of patients for the diagnosis and treatment of bleeding disorders, and for anticoagulant monitoring.

In March 2013, Auckland DHB (ADHB), Counties Manukau DHB (CMDHB), Northland DHB (NDHB), Waitemata DHB (WDHB) and Waikato DHB (WADHB) entered into a 5 year arrangement for the provision of loan coagulation instruments with associated consumables and services with Diagnostica Stago Pty Limited (Stago) through an open tender process. In April 2016, Canterbury DHB (CDHB), West Coast DHB (WCDHB) and Taranaki DHB (TDHB) received the Dispensation approval and changed to Stago technology as the Stago solution was the most technology suitable and cost effective solution for the various DHBs.

In 2016, Stago released a newer model Coagulation instrument, the MAX which offers substantial technical advantages over the old model. The MAX enables LabPLUS to comply with best practice for coagulation factor assays, improved functionality of quality control monitoring and improved audit and traceability capability. The MAX also enables statistical processes such as comparing reagent Lot Numbers or establishing reference ranges to be done on board rather that off-line using manual entry thus saving time and reducing potential errors.

While Counties Manukau DHB went through the new automation laboratory build (gone-live 27th Sep 2016), a backup instrument was required for Counties Manukau DHB to continuously perform routine tests. Stago offered LabPLUS ADHB an upgrade of one MAX at no additional cost and transferred one of the old instruments from Auckland DHB to Counties Manukau DHB. It is an approximately $110K CAPEX avoidance of a new instrument to LabPLUS Auckland DHB.

On the 3rd Aug 2016, LabPLUS received the Board approval to commence the Blood Services Work Area Technology Upgrade. Part of the upgrade involves the integration of the Stago coagulation instrument with the Roche Automated Tracking Systems. It is worth noting that the Stago coagulation instrument is the ONLY approved coagulation instrument to be integrated onto the Roche automated tracking system, there is no alternative coagulation instrument which can be connected to the Roche tracking systems.

4. Costs/Resources/Funding

During the 2013 coagulation tender process for Auckland DHB, Counties Manukau DHB, Northland DHB, Waitemata DHB and Waikato DHB, it was confirmed that Stago offered all instruments to the various DHBs at no cost, i.e. no instrument costs had been loaded onto the consumable costs. The

estimated OPEX reduction to Auckland DHB was **$160K** per annum based on Jan-Dec 2012 Oracle usage.

The other 2 suppliers who can potentially provide the Coagulation technologies were Beckman Coulter and Siemens. The 5 DHBs eliminated both suppliers because Beckman Coulter and Siemens provide a less preferred technology compare to Stago's solution. Commercially it would also cost the 5 DHBs significantly more compare to the Stago's solution. For example, the Siemens' solution would cost approximately $255K p.a. extra to ADHB; and the Beckman Coulter's solution would cost approximately $40K p.a. extra to ADHB.

The actual OPEX reductions achieved for the past three years are presented in the table below by comparing old and new pricing based on LabPLUS' actual Oracle usage from 2014 to 2016.

Year	**Jan to Dec 2014**	**Jan to Dec 2015**	**Jan to Dec 2016**
OPEX Reduction	$154,798	$131,280	$182,889

By extending the current Stago arrangement for a further 2 years, Auckland DHB will not only be able to keep the most technical suitable technology as part of the upgrade tracking system but also to continue realizing OPEX savings.

LabPLUS has the requirement to install a 2nd MAX instrument as part of the automated tracking system, the supplier has agreed to offer the 2nd MAX at no additional cost to LabPLUS Auckland DHB by extending Auckland DHB's arrangement for a further 1 year with a right of renewal of 1 year.

- No CAPEX requirement;
- No additional IS or Facility CAPEX requirement, the CAPEX for the coagulation instruments to be interfaced to the IT3000 middleware/infrastructure has been included in the overall deal for the Blood Services Work Area Technologies Upgrade project. The CAPEX funding for IS requirement is limited. It would occur more costs from the 3rd Party LIS vendor Sysmex as well as healthAlliance IS if LabPLUS does not upgrade the 2nd instrument to the newer model due to different interfacing requirement.
- No additional OPEX requirement;
- One-off CAPEX avoidance for the 2nd new MAX with the tracking integration parts; estimated value of $235K;
- 2 year maintenance service charges included; estimated value of $64K ($16K per instrument per annum) in total.

5. Risks/Issues

Technical

The Haematology department requested an upgrade for 2nd Stago instrument to the latest model for the following technical reasons:

- LabPLUS currently have 2 coagulation instruments to perform routine and special coagulation tests. To have the 2nd MAX instrument available will allow LabPLUS to

continuously perform these tests during the integration process as the old instrument will become the backup/contingency instrument.

- The Stago instruments will be interfaced to Roche middleware IT3000 which is a monopoly middleware/infrastructure for the automated tracking systems from Roche. Two instruments the same is required for the interface, only one set of rules to write and maintain rather than two.
- It worth noting Counties Manukau DHB laboratory also has the Stago instruments for coagulation testing. The 2 DHBs have the agreement that Counties Manukau DHB will become Auckland DHB's contingent site for urgent sample testing if it is required for Auckland DHB to temporarily switch off their instruments during installation/upgrade process for the Blood Services Work Areas. This would cause minimum disruption as the reference ranges are the same because the technology is the same.
- The risk of changing technology is very high, as well as with change having a significant implementation cost, and a deleterious effect on service provision and patient disruption due to the re-validation process. There will also be significant loss of institutional knowledge and expertise.

Procurement

The risk of procurement challenge is considered low following healthAlliance and legal assessment as:

- ADHB is still under contract with the current supplier for another 2 years, the current contract cannot be terminated early.
- The risk of other companies complaining about not being given an opportunity to tender is low because there is only one supplier who can provide the coagulation instruments to be integrated to the Roche Automated tracking systems.

Dispensation from open tender was granted on the 5th December 2016 for hA Procurement to negotiate with Stago to extend the current ADHB Stago coagulation arrangement for 1 year with a right of renewal of 1 year (1+1).

10. Conclusion

It is recommended that Auckland DHB extend the current Stago coagulation arrangement for a further 1 year with a right of renewal of 1 year with the provision of an additional upgraded instrument for LabPLUS at no additional costs.

ADHB Last 12 Month Order History (Jan 1

		Last 12 Months Spend			Stago RFP		2014			2015			2016		
Supplier Code	Description	Agreed Volume to use in RFP	Current Price	Agreed Volume X Current Pricing	RFP Pricing	Agreed Volume X RFP Pricing	2014 QTY	2014 Spend	Spend on old prices	2015 QTY	2015 Spend	Spend on old prices	2016 QTY	2016 Spend	Spend on old prices
354	STA -Apixaban Calibrator						0	0	0	0	0	0	3	628.24	628.24
355	00355 - STA FONDAPARINUX CONTROL						0	0	0	0	0	0	3	824.46	824.46
88349	STA-R Evolution paediatric rack- 2 per pack						0	0	0	0	0	0	3	550	550
662	STA D-DIMER PLUS				1360.41		10	13604.1	13604.1	25	34010.25	34010.25	30	28568.61	28568.61
673	STA LIQUID FIB				203.14		46	9344.44	9344.44	102	20720.28	20720.28	92	15438.64	15438.64
797	STA Mini Reducer				120		5	600	600	9	1080	1080	12	960	960
1074	01074 - STA Apixaban control				200		3	600	600	0	0	0	4	600	600
1075	01075 - STA Apixaban calibrator				332		2	664	664	1	332	332	2	664	664
310	APTT CEPHASCREEN	0	$268.82	$12,634.54	247.47	0	64	12670.72	$17,204.48	54	10690.92	$14,516.28	67	9701.02	$18,010.94
T1203	Triniclot HS APTT (to replace 310)	47			160	7520	0	0	$0.00	0	0	$0.00	0	0	$0.00
665	NEOPLASTINE R15	37	$170.00	$6,290.00	144	5328	69	7948.8	$11,730.00	74	8524.8	$12,580.00	73	7603.2	$12,410.00
667	STA Neoplastine CI+10	0	$100.15	$0.00	96	0	0	0	$0.00	0	0	$0.00	0	0	$0.00
674	FIBRINOGEN THROMBIN	63	$341.18	$21,494.34	317.41	19996.83	37	9021.16	$12,623.66	0	0	$0.00	0	0	$0.00
596	ANTITHROMBIN III	26	$385.00	$10,010.00	332.78	8652.28	32	8519.04	$12,320.00	27	7187.94	$10,395.00	36	8785.26	$13,860.00
671	PROTEIN C CHROMOGENIC	16	$1,257.31	$20,116.96	1086.77	17388.32	13	11302.46	$16,345.03	14	12171.88	$17,602.34	15	11302.46	$18,859.65
516	STA Liatest Free Protein S	0	$2,423.14	$0.00	2037.5	0	0	0	$0.00	0	0	$0.00	0	0	$0.00
721	STA Staclot APCR	10	$458.82	$0.00	358	3580	0	0	$0.00	0	0	$0.00	0	0	$0.00
612	HEPARIN ASSAY ROTACHROM	0	$323.53	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
615	Asserachrom HPIA	0	$1,287.50	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
725	FACTOR VIII DEFICIENT 6 X 1ML	0	$152.94	$0.00		0	65	9941.1	$9,941.10	56	8564.64	$8,564.64	75	9023.46	$11,470.50
724	FACTOR IX DEFICIENT 6 X 1ML	0	$152.94	$0.00		0	24	3670.56	$3,670.56	16	2447.04	$2,447.04	21	2752.92	$3,211.74
515	D DIMERS LIATEST	20	$1,967.40	$39,348.00	1700.51	34010.2	25	34010.25	$49,185.00	0	0	$0.00	0	0	$0.00
543	STA Liatest FM	0	$770.00	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
518	VWF LIA	14	$729.41	$10,211.74	630.48	8826.72	15	7565.7	$10,941.15	13	6556.94	$9,482.33	15	6556.94	$10,941.15
239	ASSERACHROM VEF:CB	15	$780.00	$11,700.00	861	12915	16	11020.8	$12,480.00	13	8954.4	$10,140.00	15	8265.6	$11,700.00
851	Stachrom HCII	0	$870.59	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
658	STA Stachrom Plasminogen	0	$647.06	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
599	PTT LA	0	$110.00	$0.00	80	0	0	0	$0.00	0	0	$0.00	0	0	$0.00
333	RVV SCREEN	4	$620.00	$2,480.00	535.9	2143.6	4	1714.88	$2,480.00	3	1286.16	$1,860.00	8	3429.76	$4,960.00
334	RVV CONFIRM	4	$460.00	$1,840.00	397.61	1590.44	5	1590.45	$2,300.00	2	636.18	$920.00	6	1908.54	$2,760.00
669	THROMBIN CLOTTING TIME	31	$352.95	$10,941.45	305.08	9457.48	37	8298.04	$13,059.15	39	9518.34	$13,765.05	47	9762.4	$16,588.65
367	CACL2	20	$76.47	$1,529.40	66	1320	28	1214.4	$2,141.16	17	897.6	$1,299.99	26	1214.4	$1,988.22
360	OWRENS BUFFER	28	$88.24	$2,470.72	77	2156	45	2772	$3,970.80	48	2956.8	$4,235.52	43	2340.8	$3,794.32
745	FACTOR II DEFICIENT 6 X 1ML	3	$47.06	$141.18	40.68	122.04	5	162.7	$235.30	3	86.77	$141.18	6	162.7	$282.36
744	FACTOR V DEFICIENT 6 X 1ML	6	$47.06	$282.36	40.68	244.08	12	390.48	$564.72	9	260.32	$423.54	11	292.86	$517.66
743	FACTOR VII DEFICIENT 6 X 1ML	6	$300.00	$1,800.00	259.31	1555.86	6	1244.7	$1,800.00	4	829.8	$1,200.00	8	1244.7	$2,400.00
738	FACTOR X DEFICIENT 6 X 1ML	2	$108.24	$216.48	93.55	187.1	6	449.04	$649.44	3	224.52	$324.72	8	523.88	$865.92
723	STA DEFICIENT XI	2	$360.00	$720.00	311.17	622.34	8	1991.52	$2,880.00	5	1244.7	$1,800.00	7	1742.58	$2,520.00
722	STA Deficient XII	0	$360.00	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
746	FREE PROTEIN S CLOTTING ASSAY	38	$527.43	$20,042.34	455.89	17323.82	39	14223.69	$20,569.77	41	14953.11	$21,624.63	45	14953.11	$23,734.35
38669	STA CUVETTES	48	$1,453.32	$69,759.36	1257	60336	51	51285.6	$74,119.32	62	62347.2	$90,105.84	56	46257.6	$81,385.92
975	STA DESORB U 360 ML	156	$134.12	$20,922.72	116	18096	186	17260.8	$24,946.32	204	18745.6	$27,360.48	194	16425.6	$26,019.28
973	STA CLEANER SOLUTION 15 LITRES	90	$144.92	$13,042.80	126	11340	114	11491.2	$16,520.88	124	12499.2	$17,970.08	134	11188.8	$19,419.28
802	STA MICROCUPS	6	$125.00	$750.00	150	900	3	360	$375.00	2	240	$250.00	4	480	$500.00
801	STA MAXI REDUCER 10mL & 15mL VIALS (BOX100)	2	$168.00	$336.00	150	300	7	840	$1,176.00	4	480	$672.00	6	600	$1,008.00
675	UNICALIBRATOR 6 X 1ML	18	$111.76	$2,011.68	97	1746	44	2328	$4,917.44	17	1319.2	$1,899.92	17	1086.4	$1,899.92
520	VWF CALIBRATOR 6 X 1ML	1	$117.65	$117.65	117.65	117.65	6	564.72	$705.90	3	282.36	$352.95	0	0	$0.00
685	STA CALIBRATOR HPBM/LMWH (3x4x1mL)	0	$147.06	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
544	STA FM Calibrator	0	$385.00	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
684	UFH CALIBRATOR 4 X 3 X 1ML	0	$148.00	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
678	STA SYSTEM CONTROL 2 X 12 X 1ML	21	$352.94	$7,411.74	305	6405	36	8784	$12,705.84	26	6344	$9,176.44	36	7076	$12,705.84
526	LIATEST CONTROL N + P 2 X 12 X 1ML	28	$329.41	$9,223.48	285	7980	14	3192	$4,611.74	23	5244	$7,576.43	14	2736	$4,611.74
686	STA QUALITY HPBM/LMWH (2x6x1mL)	10	$105.88	$1,058.80	92	920	13	956.8	$1,376.44	8	588.8	$847.04	18	1030.4	$1,905.84
679	STA COAG N + P 2 X 12 X 1ML	130	$188.24	$24,471.20	163	21190	80	10432	$15,059.20	0	0	$0.00	0	0	$0.00
522	STA COAG NORM 1mL BX/100	23	$588.24	$13,529.52	509	11707	40	16288	$23,529.60	49	18324	$28,823.76	56	18731.2	$32,941.44
523	Coag Path	0	$605.89	$0.00	509	0	16	6515.2	$9,694.24	9	3664.8	$5,453.01	22	7736.8	$13,329.58
201	STA CONTROL LA 1 + 2 3 X 2 X 1ML	13	$100.00	$1,300.00	87	1131	12	835.2	$1,200.00	13	904.8	$1,300.00	17	904.8	$1,700.00
539	POOL NORM (BOX12 x 1mL)	23	$162.00	$3,726.00	140	3220	29	3248	$4,698.00	32	3584	$5,184.00	35	3248	$5,670.00
683	UFH CONTROL 6 X 2 X 1ML	0	$98.90	$0.00		0	14	1384.6	$1,384.60	0	0	$0.00	0	0	$0.00
39164	NEEDLE 1 (CAP PIERCING STAR)	4	$2,173.32	$8,693.28	1880	7520	4	6016	$8,693.28	3	4512	$6,519.96	2	1504	$4,346.64
27354	Needle 2 STA Compact	0	$375.78	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
27307	NEEDLE ARM N 3 WITH NUT B	3	$352.70	$1,058.10	440	1320	1	352	$352.70	0	0	$0.00	0	0	$0.00
27538	SYRINGE AND O RINGS	2	$551.80	$1,103.60	465	930	3	1116	$1,655.40	3	1116	$1,655.40	8	2976	$4,414.40
27530	TEFLON TIPS FOR SYRINGE AND O RINGS	10	$153.85	$1,538.50	217	2170	11	1909.6	$1,692.35	2	347.2	$307.70	7	1736	$1,076.95
87063	SUCTION TIP V5	2	$104.10	$208.20	116	232	0	0	$0.00	0	0	$0.00	0	0	$0.00
315	STA ImmunoDef XII	2	$311.17		311.17	622.34	0	0	$0.00	0	0	$0.00	0	0	$0.00
614	STA Reptilase	1	$326.47	$326.47	312.5	312.5	1	250	$326.47	0	0	$0.00	0	0	$0.00
734	STA ImmunoDef IX	17	$152.94	$2,599.98	132.19	2247.23	0	0	$0.00	0	0	$0.00	0	0	$0.00
728	STA ImmunoDef VIII	49	$152.94	$7,494.06	132.2	6477.8	0	0	$0.00	0	0	$0.00	0	0	$0.00
1058	STic Expert HIT	6	$384.00		375	2250	0	0	$0.00	0	0	$0.00	0	0	$0.00
348	STA Multi Hep Calibrator	2	$179.85	$359.70	270	540	4	864	$719.40	2	432	$359.70	4	864	$719.40
381	STA Quality HNF/UFH	5	$135.00	$675.00	122	610	4	390.4	$540.00	10	976	$1,350.00	13	976	$1,755.00
26699	Halogen Lamp	1	$93.01	$93.01	112	112	0	0	$0.00	0	0	$0.00	0	0	$0.00
39163	Suction Head (v4)	0		$0.00	116	0	0	0	$0.00	0	0	$0.00	0	0	$0.00
311	STA Liquid Anti-Xa	20	$492.68	$9,853.60	354.88	7097.6	22	6245.8	$10,838.96	10	2839	$4,926.80	22	5110.2	$10,838.96
704	STA RIVAROXABAN CALIBRATOR	1	$430.37	$430.37	415	415	0	0	$0.00	2	664	$860.74	0	0	$0.00
706	STA RIVAROXABAN CONTROLS	1	$250.27	$250.27	250	250	5	1000	$1,251.35	9	1800	$2,252.43	0	0	$0.00
27543	MICROCUP ADAPTORS	5	$27.00	$135.00	26.5	132.5	1	21.2	$27.00	0	0	$0.00	0	0	$0.00
39250	NEEDLE 2	1	$787.29	$787.29	680	680	1	544	$787.29	0	0	$0.00	0	0	$0.00
80785	LLD CABLE	0	$200.90	$0.00		0	0	0	$0.00	0	0	$0.00	0	0	$0.00
			Current Spend	$377,536.89	IF no Discount	$334,248		$329,010	$455,809		$301,390	$404,669		$280,468	$435,358
					IF 8% Discount	$307,507.9									
					If 17% Discount	$277,425.6									
					If 20% Discount	$267,398.2									
Annual Service Charge		Annual Service Charge													
		STA-R Evolution 1		14000	Expert 1	0									
		STA-R Evolution 2		14000	Expert 2	0									
				28000		0		Saving each year	$154,798			$131,280			$182,889
Annual Leasing Charge		Annual Leasing Charge													
		STA-R Evolution 1		0	Expert 1	0									
		STA-R Evolution 2		0	Expert 2	0									
				0		0									
		Current buying from elsewhere			IF Stago										
Siemens Product (Factor 12)															
10446318	Factor XII (12)	2	83.96	167.92	Stago 315 Factor 12	included in RFP									
10487040	Innovance VWF Activity	24	1219.2	29260.8	emens Innovance VWF Activity	34427.28									
10446652	Factor XIII (13)	2	1343.39	2686.78	Siemens Factor XIII	1445.88									
Other Reagents buying from Elsewhere															
	Abacus APC	50	$ 505.00	25250	Stago 721 APCR	included in RFP									
	Diamed HIT	5	$ 345.00	1725	Stago 1058 HIT	included in RFP									
					Stago 539 Pool Norm	included in RFP									
					Collagen Binding	included in RFP									
				$ 59,090.50		35873.16									
			Current Spend	$464,627	RFP Spend	$370,121									
					IF No Discount	$370,120.89									
					Compare to Current Spend	-$94,506									
					IF 8% Discount	$343,381.07									
					Compare to Current Spend	-$121,246									
					If 17% Discount	$313,298.78									
					Compare to Current Spend	-$151,329									
					IF 20% Discount	$303,271.34									
					Compare to Current Spend	-$161,356									
					Sysmex Interfacing	not required									
					UPS	Free									
					Middleware	not required									

10.1

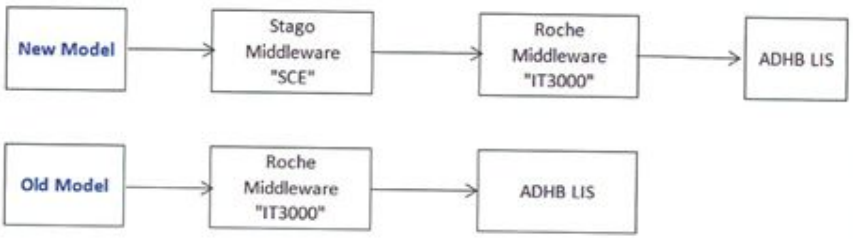
REQUEST FOR RULES* COMPLIANCE APPROVAL NUMBER

**Rules refers to the Government Rules of Sourcing 3rd Edition*
This form is used to gain Rules Compliance Approval, specifically when seeking not to openly advertise as set out in Rule 14 of the Government Rules of Sourcing 3rd Edition.

1. PROJECT NAME & NUMBER	ADHB Diagnostica Stago Pty Limited New Contract Setup
2. PROCUREMENT SPECIALIST	Yaping Gong, Senior Procurement Specialist
3. OPT-OUT or EXEMPTION RULE	**Rule 15.9.c.i – Only one supplier for technical reasons.**
4. WHY ARE YOU APPLYING FOR COMPLIANCE APPROVAL?	**Background:** • Coagulation testing is essential for screening the haemostasis system of patients for the diagnosis and treatment of bleeding disorders, and for anticoagulant monitoring. • hA Procurement conducted an open RFP process in 2012 on behalf of the Northern 4 DHBs and Waikato DHB for the provision of loan coagulation analysers with associated consumables and services. As an outcome of the RFP process, Diagnostica Stago Pty Limited (Stago) was the successful party as their solution represented the most technical suitable and cost effective option. • The 5 DHBs including ADHB entered into a joint agreement hA13-1246 in March 2013. The current contract is still valid for another 2 years and expires in Feb 2019. • In 2016, Stago released a newer model Coagulation analyser, the STAR MAX (MAX) which offers substantial technical advantages over the old model. The MAX enables LabPLUS to comply with best practice for coagulation factor assays, improved functionality of quality control monitoring and improved audit and traceability capability. Stago has offered an upgrade for one of the analysers at LabPLUS ADHB at no additional cost. • LabPLUS ADHB in August 2016 received Board Approval to proceed with the technologies upgrade for the Blood Services Work Areas. Part of the upgrade is to install the Stago Coagulation analysers onto the Roche Diagnostic New Zealand Limited's (Roche) Automated Tracking Systems. • LabPLUS ADHB has requested to upgrade the 2nd Stago analyser to the latest model MAX. The supplier has agreed to offer the 2nd MAX at no cost to ADHB by extending ADHB's arrangement for a further 1+1 years, i.e. expiry of Feb 2020 with a one year right of renewal. As this requirement is unique to ADHB, it is recommended that ADHB to setup a new contract with Stago with an extension of the term. • Since the overall expenditure has exceeded $100K and total arrangement exceeds 5 years term, CAN approval is required prior to the contract extension following MBIE Government Rules of Sourcing.

Technical Risks:

- The market has not changed since 2013. It worth noting that in April 2016, Canterbury DHB (CDHB), West Coast DHB (WCDHB) and Taranaki DHB (TDHB) received the Dispensation approval and changed to Stago technology as the Stago solution was the most technology suitable and cost effective solution for the various DHBs.
- Roche has confirmed that the Stago Coagulation analysers are the only approved analysers to be installed onto the Roche automated tracking system. The hardware component to connect the Roche track and the Stago analyser is called the "Reformatter", this hardware is supplied by Roche and it is designed speciafically for the Stago analyser, i.e. no other coagulation analysers can be connected to the tracking system via this Reformatter.
- The Stago analysers will be interfaced to IT3000 which is a monopoly middleware/infrastructure for the automated tracking systems from Roche. Two analysers the same is preferable for the interface, i.e. only one set of rules to write and maintain rather than two. The diagram below illustrates the interfacing difference for the old and new models.



- LabPLUS currently have 2 coagulation instruments to perform routine and special coagulation tests. To have the 2nd MAX instrument available will allow LabPLUS to continuously perform these tests during the integration process as the old instrument will become the backup/contingency instrument.
- It worth noting that CMDHB laboratory also has the Stago analysers for coagulation testing. The 2 DHBs have the agreement that CMDHB will become ADHB's contingent site for urgent sample testing if it is required for ADHB to temporary switch off their analysers during installation/upgrade process for the Blood Services Work Areas. This would cause minimum disruption as the reference ranges are the same because the technology is the same.
- The risk of changing technology is very high, with change having a significant implementation cost, and a deleterious effect on service provision and patient disruption due to the re-validation process. There will also be significant loss of institutional knowledge and expertise.
- Having two analysers the same will make it easier for staff operationally with only one set of Standard Operating Procedures to be familiar with. Lessens the risk of errors.

10.1

REQUEST FOR RULES* COMPLIANCE APPROVAL NUMBER

	Financial Risk: • There is no CAPEX available to procure alternative systems. The two new MAX worth approximately $235K, this is a one-off CAPEX avoidance to ADHB. • hA Procurement has negotiated the maintenance service to be included in the extended term at no additional cost to ADHB, worth $64K ($16K per instrument per annum) • The CAPEX for the coagulation analysers to be interfaced to the IT3000 middleware/infrastructure has been included in the overall deal for the Blood Services Work Area Technologies Upgrade project. It would occur more costs from the 3rd Party LIS vendor Sysmex as well as healthAlliance IS if LabPLUS does not upgrade the 2nd analyser to the newer model due to different interfacing requirement. • Any potential cost savings envisaged by working with a new provider would be lost in significant implementation costs, service disruption and unknown reliability, surety of service and huge loss of institutional knowledge and significant clinical risk.
5. OVERVIEW OF RISK AND MITIGATION ACTIONS IF APPROVAL GRANTED	**Procurement Risks are low:** • ADHB is still under contract with the current supplier for another 2 years, the current contract cannot be terminated early. • The risk of other companies complaining about not being given an opportunity to tender is low because of the technical and financial reasons set out above. **Government Rule of Sourcing** • **Rule 15.9.c.i – Only one supplier for technical reasons**
6. PARTICIPATING DHB(S)	Auckland DHB
7. SUPPLIER (s)	Diagnostica Stago Pty Limited
8. TYPE OF CONTRACT	New
9. ESTIMATED CONTRACT VALUE	Approximately $330K per annum
10. ESTIMATED BENEFITS	CAPEX Avoidance of $235K OPEX Avoidance of $64K
11. TERM OF CONTRACT	A new contract of 3 years with a right of renewal of 1 year (2 years remaining term, with an extension of a further 1 years) Yaping
12. LAST COMPETITIVE PROCESS	2013
13. NEXT PLANNED COMPETITIVE PROCESS	2021

REQUEST FOR RULES* COMPLIANCE APPROVAL NUMBER

14. ATTACHMENTS		
Sign Off		
CM Comments		
hA Category Manager	Name Alberto Areias Signature	Date 21/11/2016
[An attached email approval is sufficient in lieu of a signature and should be attached as proof] *Legal comment (i.e. email) should be included as essential documentation for the category manager review and sign-off, plus any appropriate DHB documentation outlining urgency of request etc*		

10.1

DHB ENDORSEMENT		
Laboratory Manager	Name Ross Hewett Signature email endorsement (1)	Date 21/11/2016

For DHB specific procurement activity, the DHB nominated Procurement Lead to sign as acknowledgement that they have been consulted in the procurement project and approve the proposed contract.		
DHB Procurement Lead	Name Jane Woolford Signature email endorsement (2)	Date 23/11/2016

CEO Approval		
This Rule compliance is approved/not approved		
CEO	Signature	Date 2/12/16.
[An attached email approval is sufficient in lieu of a signature and should be attached as proof]		

CHAIRPERSON Approval		
This Rule compliance is approved/not approved		
CHAIRMAN	Paul Harper Signature	Date 5/12/16

REQUEST FOR RULES* COMPLIANCE APPROVAL NUMBER

[An attached email approval is sufficient in lieu of a signature and should be attached as proof]

FOR OFFICE USE ONLY

DAPTIV PROJECT NUMBER	To be completed by Procurement Support
COMPLIANCE APPROVAL NUMBER	To be completed by Procurement Support
COMPLIANCE APPROVAL DATE	To be completed by Procurement Support

HA legal

Yaping Gong (healthAlliance)

From: Theresa Dabuli (healthAlliance)
Sent: Monday, 07 November 2016 16:15
To: Yaping Gong (healthAlliance)
Subject: RE: Stago - CAN Request

Ok I would include the additional wording you have in your email.

Theresa Dabuli / Lawyer
Mobile +64 21 043 3313
healthAlliance
www.healthalliance.co.nz

From: Yaping Gong (healthAlliance)
Sent: Monday, 07 November 2016 4:05 p.m.
To: Theresa Dabuli (healthAlliance)
Subject: RE: Stago - CAN Request

10.1

Hi Theresa,

Thanks for your help, my comments as below, also attached the revised CAN request.

From the information set out in your request, it appears that this request comes within an exemption under the Government Rules of Sourcing for the reasons you have set out in the CAN request. I note you have stated that Roche has confirmed that Stago Coagulation analysers are the only approved analysers to be installed onto the Roche automated tracking system. Does this mean that this is the only system that CAN be installed onto the Roche tracking system or the only system that HAS been installed onto the Roche tracking system? As if it's the only one that has been installed – then it is arguable that other systems can be installed on that system. Could you please confirm? Roche has confirmed that the Stago's coagulation analyser is the ONLY analyser approved by Roche to be connect onto their tracking system. Even though there are other Coagulation analysers, i.e. from Beckman Coulter or Siemens. But Roche confirmed that they only allow the Stago analyser to go onto their tracks as the reformatter only works for the Stago analyser.

- Roche has confirmed that the Stago Coagulation analysers are the only approved analysers to be installed onto the Roche Automated tracking system. The hardware component to connect the Roche track and the Stago analyser called the "Reformatter", this hardware is supplied by Roche and it is designed speciafically for the Stago analyser, i.e. no other coagulation analysers can be connect to the tracking system via this Reformatter.

In addition, I recommend that you expand the rule in Section 3 – i.e. that there is only one supplier for technical reasons. Thanks, have amended.

I recommend that the changes I have suggested are made prior to the request being reviewed by the procurement board. Will do, thanks

Many thanks,
Yaping Gong
Senior Procurement Specialist LABS
Procurement & Supply Chain
Mobile: +64 21 942 756
Email: yaping.gong@healthalliance.co.nz
healthAlliance FPSC
Connect Business Park
581-585 Great South Road,
Penrose, Auckland

ADHB Legal

Yaping Gong (healthAlliance)

From: Bruce Northey (ADHB)
Sent: Monday, 21 November 2016 16:19
To: Yaping Gong (healthAlliance); Jane Woolford (ADHB); Ross Hewett (ADHB)
Cc: Alberto Areias (healthAlliance)
Subject: RE: Dispensation endrosement required!

I note my hA colleagues' comments and endorse both requests.

Bruce Northey
General Counsel | Legal Services
Ph: 09 307 4949 Ext: 26876 | Mob: 021 938104 | bnorthey@adhb.govt.nz
Auckland District Health Board | Level 2 | Building 16 | Greenlane Clinical Centre

Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua*

From: Yaping Gong (healthAlliance)
Sent: Monday, 21 November 2016 2:03 p.m.
To: Bruce Northey (ADHB); Jane Woolford (ADHB); Ross Hewett (ADHB)
Cc: Alberto Areias (healthAlliance)
Subject: Dispensation endrosement required!

Hi Bruce, Jane and Ross,

LabPLUS has 2 dispensation requests ready for execution, both are in monopoly arrangement.
Your endorsement is required, can you please confirm by email?

Bruce, they have been reviewed by hA legal, however ADHB Legal endorsement is also required as part of the process...

Please feel free to ask me if you have any questions.

Kindest regards,
Yaping Gong
Senior Procurement Specialist LABS
Procurement & Supply Chain
Mobile: +64 21 942 756
Email: yaping.gong@healthalliance.co.nz
healthAlliance FPSC
Connect Business Park
581-585 Great South Road,
Penrose, Auckland
"COMMUNICATE COMMUNICATE COMMUNICATE !!"

(1)

Yaping Gong (healthAlliance)

From: Ross Hewett (ADHB)
Sent: Monday, 21 November 2016 16:25
To: Bruce Northey (ADHB)
Cc: Yaping Gong (healthAlliance); Jane Woolford (ADHB); Alberto Areias (healthAlliance)
Subject: Re: Dispensation endrosement required!

Endorsed.

Sent from my iPhone

On 21/11/2016, at 4:18 PM, Bruce Northey (ADHB) <BNorthey@adhb.govt.nz> wrote:

> I note my hA colleagues' comments and endorse both requests.
>
> **Bruce Northey**
> General Counsel | Legal Services
> Ph: 09 307 4949 Ext: 26876 | Mob: 021 938104 | bnorthey@adhb.govt.nz
> **Auckland District Health Board** | Level 2 | Building 16 | Greenlane Clinical Centre
>
> Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua*
>
>
>
> ---
>
> **From:** Yaping Gong (healthAlliance)
> **Sent:** Monday, 21 November 2016 2:03 p.m.
> **To:** Bruce Northey (ADHB); Jane Woolford (ADHB); Ross Hewett (ADHB)
> **Cc:** Alberto Areias (healthAlliance)
> **Subject:** Dispensation endrosement required!
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>
> Please feel free to ask me if you have any questions.
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> Kindest regards,
> Yaping Gong
> Senior Procurement Specialist LABS
> Procurement & Supply Chain
> Mobile: +64 21 942 756
> Email: yaping.gong@healthalliance.co.nz
> healthAlliance FPSC
> Connect Business Park
> 581-585 Great South Road,
> Penrose, Auckland
> *"COMMUNICATE COMMUNICATE COMMUNICATE !!"*

Yaping Gong (healthAlliance)

2

From: Jane Woolford (ADHB)
Sent: Wednesday, 23 November 2016 11:37
To: Yaping Gong (healthAlliance); Bruce Northey (ADHB); Ross Hewett (ADHB)
Cc: Alberto Areias (healthAlliance)
Subject: RE: Dispensation endrosement required!

Hi Yaping,

I have noticed that I didn't respond to this. Yes I am happy to endorse,

thanks

Jane Woolford
Operations Manager Supply Chain and Procurement
Auckland City Hospital
093670000 x 21903 or ph 021942938

From: Yaping Gong (healthAlliance)
Sent: Monday, 21 November 2016 2:03 p.m.
To: Bruce Northey (ADHB); Jane Woolford (ADHB); Ross Hewett (ADHB)
Cc: Alberto Areias (healthAlliance)
Subject: Dispensation endrosement required!

Hi Bruce, Jane and Ross,

LabPLUS has 2 dispensation requests ready for execution, both are in monopoly arrangement.
Your endorsement is required, can you please confirm by email?

Bruce, they have been reviewed by hA legal, however ADHB Legal endorsement is also required as part of the process...

Please feel free to ask me if you have any questions.

Kindest regards,
Yaping Gong
Senior Procurement Specialist LABS
Procurement & Supply Chain
Mobile: +64 21 942 756
Email: yaping.gong@healthalliance.co.nz
healthAlliance FPSC
Connect Business Park
581-585 Great South Road,
Penrose, Auckland
"COMMUNICATE COMMUNICATE COMMUNICATE !!"

Perioperative Fleet Instruments Capex request

Recommendation

That the Board:

1. **Approves $950,000 Capital Expenditure for replacement and replenishment of fleet instruments for Perioperative Services as per the attached Business Case.**
2. **Notes that $950,000 has been prioritised and provisioned in the 2016/17 Capital Budget which was approved by Board in 2016.**

Prepared by: Deb Sucich: Theatre Manager, Cardiac and ORL
Endorsed by: Vanessa Beavis: Director of Perioperative
Endorsed by Executive Leadership Team: Yes: Date: Tuesday, 14 February 2017

Glossary

Acronym/term Definition

1. Board Strategic Alignment

Operational and financial sustainability	Supports the current level of operating room throughput through the replacement and replenishment of fleet instruments.

2. Executive Summary

The purpose of this fleet purchase is to **meet the current surgical volume demand for all theatres**. This will be attained by the:

- Replenishment of existing single instruments and sets
- Replacement of existing single instruments and sets
- Purchase of additional single instruments and instrument sets

3. Introduction/Background

The key objectives and benefits of this project are:

- Support the current level of surgical throughput required to meet MOH targets.
- Meet CSSD sterilisation Key Performance Indicator's (KPI's).
- Maintain fast track sterilisation through CSSD.
- Reduce risks in processing delays at CSSD.
- Reduce maintenance costs by $30,000 for 2015/16 financial year

4. Costs/Resources/Funding

The impact on operational costs for 2016/17:

- Project will be completed in Feb 2018, no impact on depreciation for 2016/17.
- Reduce budgeted maintenance costs by $30,000 per annum after project completion.
- An increase in theatre productivity which cannot be quantified.

5. Risks/Issues

Risks and constraints include:

- Quotes out of date once the approval process is complete.
- Subject to foreign exchange rate.
- Supplier availability.
- Funds not available

6. Conclusion

That Board approves Perioperative Services bulk instrument purchases to the value of $950,000.

Perioperative Fleet Instruments 2016/17

Perioperative Fleet Instruments
Perioperative Health Service Group
ADHB

Perioperative Fleet Instruments 2016/17

Document Date:	December 2016
Prepared By:	Tara Argent - General Manager Roopa Reddy - CSSD Manager (Acting)
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	ADHB Capital and Asset Management Planning Date: 10 January 2017
	ADHB Executive Leadership Team Date: TBA
	Northern Region Capital Group - NA
Next Steps:	ADHB Audit & Finance Committee consideration
	ADHB Board consideration
	National Capital Committee consideration -NA

Perioperative Fleet Instruments 2016/17

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1. Executive Summary

1.1 Purpose of the Business Case

To obtain approval for Perioperative Services to purchase bulk instruments as provided for in the 2016/17 capital plan.

1.2 Business Case/Project Proposal

That CAMP approves the Central Sterile Supply Department (CSSD) to purchase fleet instruments up to a value of $950,000.

1.3 Key Drivers for the Project

The purpose of this fleet purchase is to **meet the current surgical volume demand for all theatres**. This will be attained by the:

- Replenishment of existing single instruments and sets
- Replacement of existing single instruments and sets
- Purchase of additional single instruments and instrument sets

1.4 Key Objectives and Benefits of Implementing the Project

The key objectives and benefits of this project are:

- Support the current level of surgical throughput required to meet MOH targets.
- Meet CSSD sterilisation Key Performance Indicator's (KPI's).
- Maintain fast track sterilisation through CSSD.
- Reduce risks in processing delays at CSSD.
- Reduce maintenance costs by $30,000 for 2017/18 financial year.

1.5 Summary Options Analysis

Three options have been considered:

- Status Quo (no spend in 2016/17)
- Replenish half the requirement in 2016/17 and half in 2017/18
- Purchase $950,000 as per capital plan in 2016/17.

To achieve the listed objectives, the full purchase in 2016/17 is the recommended path.

1.6 Summary Total Project Costs and Proposed Project Financing

Perioperative Fleet Instruments	Total Capital Cost	ADHB Capital Plan 2016/17
Project –TBA	$950,000	$950,000

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1.7 Summary Financial Analysis

The impact on operational costs for 2016/17:

- Project will be completed in Feb 2018, no impact on depreciation for 2016/17.
- Reduce budgeted maintenance costs by $30,000 per annum after project completion.
- An increase in theatre productivity which cannot be quantified.

1.8 Summary Risk and Constraints Analysis

Risks and constraints include:

- Quotes out of date once the approval process is complete.
- Subject to foreign exchange rate.
- Supplier availability.
- Funds not available.

1.9 Summary Project Implementation Timeframes

CAMP Approval	18 Jan 2017
Board Approval	Feb 2017
Purchase Order Number	Mar 2017
Final Order	Mar 2017
Final invoicing and checking	Mar 2017
Completed project - capitalisation	Feb 2018
Post Implementation Review	Aug 2018

1.10 Conclusion and Recommendation

That CAMP approves Perioperative Services bulk instrument purchases to the value of $950,000.

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2. Project Proposal

The proposal is to replace, replenish and purchase additional sets and single instruments that have been prioritised on the basis of:

- Breakdown
- Cost to repair
- Poor condition
- Poses a risk of failure.

It will comprise the most common items regularly required by theatre as 'priority processing' (i.e. 'fast track') and new sets for increased volumes of cases.

As with the 2015/16, CSSD fleet instrument purchase, this purchase will reduce processing delays and maintain KPI's for fast track sterilisation.

3. Project Drivers

3.1 Current State

CSSD provides a service of decontaminating and sterilising instrument sets for all surgical procedures.

CSSD is required to provide a **fast and efficient service** with minimal downtime twenty four hours per day, seven days per week.

Operating Rooms have in the last 3 years increased theatre space by adding a Hybrid OR in Level 4 and a procedure room in Starship theatres allowing an increase in through put of a mix of elective and acute cases.

The casemix for delivery of surgery has become more complex, resulting in requests for new equipment for different procedures. In recent years volumes of cases have also increased requiring more instrument sets that need to be turned around by CSSD in a 12 hour timeframe. This has resulted in some instruments being sterilised more frequently than in previous years and therefore these instruments need to be replaced earlier than the expected manufacturer's life.

The SCRUM process to recycle theatre sessions has improved the use for elective sessions with more hours being recycled. Allocation of theatre time has increased year on year for the last 4 years. With standard hours occupied Jul – Dec going from 24,728 in 2013-14 to 25,683 in 2014-15 to 25,489 in 2015-16 and with the 2016-17 achieving 26,595 resulting in an increase year on year, with a total of an extra 1867 hrs extra allocated this year. This has also impacted on CSSD by increasing year on year the amount of single instruments and sets sterilised.

To achieve sterility for surgical equipment, CSSD must follow Standard Operating Procedures (SOPs) for processing of the finished 'product'. Daily sterile equipment requests must be received, processed and delivered back to the theatres within the agreed time frame.

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The six processing stages for processing sterile equipment are:

- Washing → Checking → Packing → Sterilising → Storage → Dispatch

The current turnaround time as agreed on KPI's are:

- 12 hours for all operating theatres with the exception of Neurology.
- 8 hours Neurosurgical (expensive small fleet equipment)
- 24 hour standby for items available for acute cases

Additional KPIs demonstrating increasing items being processed, Efficiency gains (instruments processed per FTE) and Complexity increases (instruments used per case) are summarised below.

KPIs	2012	2013	2014	2015	2016
Number of items processed	4,300,000	4,773,000	5,345,760	5,848,294	6,082,226
Additional items vs. 2012		473,000	1,045,760	1,548,294	1,782,226
Increased items processed % from 2012		11%	24%	36%	41%
Theatre cases including OR and virtual	41,467	42,129	44,356	45,421	46,828
Additional cases vs. 2012		662	2,889	3,954	5,361
Increased cases % from 2012		2%	7%	10%	13%
CSSD FTE	108.1	108.4	109.3	111.7	112.9
Items processed per FTE	39,778	44,031	48,909	52,357	53,873
Additional items processed per FTE vs. 2012		4,253	9,131	12,579	14,095
EFFICIENCY GAINS		11%	23%	32%	35%
Items per Case	103.7	113.3	120.5	128.8	129.9
additional items per case		9.6	16.8	25.1	26.2
COMPLEXITY INCREASE		9%	16%	24%	25%

3.2 Future State (Investment Objectives)

The current value of instrumentation is still difficult to establish with accuracy. Unfortunately ADHB's current instrument tracking system (TDOC) does not record the purchase cost of instruments, their associated depreciation or repair cost. In many cases instruments are purchased as part of a larger capex and are often not itemised in the fixed asset register. This has been raised as a clinical and management risk for a number of years.

The TDOC system is currently under review. A solution to the tracking problem is yet to be decided.

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4. Project Benefits

4.1 Project Deliverables

Maintaining quality of clinical care and good patient outcomes:

- Providing patient safe and timely surgery within the timeframes identified by the requirements of the surgical specialty best practice.
- Providing surgeons and theatre staff with the appropriate sterile equipment when required without delay.
- Reducing the risk of additional expenditure on prolonged admissions because of delays in surgery due to lack of sterile equipment available.

Improved operational efficiency:

- Assuming patients have had timely surgery, there should be fewer complications and more predictable (shorter) lengths of stay. CSSD efficiency supports timely discharge planning and better bed management.
- Improved productivity and effective utilisation of clinical staff. The number of cases being extended or cancelled due to unavailability of instrument sets and/or sourcing suitable alternatives, has reduced.

4.2 Quantifying Benefits

Maintenance savings are estimated to be $30,000 p.a. after project completion.

5. Strategic Fit

5.1 Local Strategic Fit

The proposed instrumentation purchase is detailed in Appendix 3.

Dispensation not to go to a contestable process has been sought on the following grounds:

1. **Disproportionate Procurement Cost**
   - As experienced during the 2015/16 CAPEX of the same nature, ADHB will spend $950k across 552+ line items across 23 suppliers.
   - Top 3 suppliers (Medipak, Downs and Medtronics) comprise 67% of the total purchase.
   - Top Supplier Medipak with 18 Equipment sets (trade-in plus new sets) making up 42% of the total purchase.
   - Replacement of part sets from the same supplier.
   - Adding matching new sets: e.g. CSSD has two sets and is adding a third set. The third set will be purchased from the supplier of the first two sets.
   - Adding a new piece where CSSD has one unit and is looking to increase this to two units. Like the point above the second unit would be sourced from the supplier of the first unit.
   - Adding new sets where there are two or more suppliers.
   - In all instances the objective is to ensure that instrument recipes are not compromised and that continuity in instrument requirements is maintained across the OR's.

2. **Contract (Privity) Act 1982**
   - Three of the top five suppliers from the previous purchase have current price agreement with CMDHB & WDHB. ADHB will leverage on the existing agreed pricing and service levels.

3. **Aggregation of Volume**
   - ADHB will have greater benefit by aggregating the volume of all surgical instruments within the organisation.
   - ADHB will also benefit by leveraging on the same instrumentation project being done by CMDHB at the same time.

5.2 Regional Strategic Fit

This purchase will have regional implications on aspects of Contract Privity and aggregation of volume. Price agreements are in place for three major surgical instrument suppliers with CMDHB & WDHB in which ADHB can take privity.

Health Alliance are also working on panel contracts with the main suppliers who fit the key description of ADHB requirements in terms of quality and fit.

5.3 National Strategic Fit

National Strategic fit is not a key driver of this project. No national strategy currently in place.

6. Critical Success Factors

Critical success factors:

- Timeliness of order
- Communication with OR Managers.
- Communication with hA.

7. Options Analysis

Option 1: status quo

- Further delay for purchase of additional CSSD fleet instrumentation will cause substantial risk to surgical flow. The current reliance on CSSD fast tracking is not sustainable.

Option 2: replenish half in 2016/17 and half in 2017/18

- The instrumentation requested reflects requirements to support current and planned activity for 2016/2017. Delay for purchase of instrumentation risks on-going emergency spends, reducing our ability to negotiate best prices.

Option 3: Recommended option – purchase of additional instrumentation to the value of $950,000.

- The recommended set of instrumentation will efficiently support surgical flow through at ACH.

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8. Project Costs

Item	Cost
See Appendix C pre-procurement negotiation. Final value to be $950,000	$950,000

9. Project Financing

Source of Funding	Amount
Budget Capex Plan Approval - Project – TBA	$950,000

10. Financial Analysis and Affordability

10.1 Financial Analysis Overview

The bulk purchase will be completed in Feb 2018. Because of the nature of the purchase, supplies will be sought from a number of suppliers over a period of time. We are estimating an outward cashflow of varying amounts to occur between Feb – Dec 2017.

The project is estimated to close in Feb 2018 so there will be no depreciation for the current financial year.

There is an estimated quantifiable savings of $30,000 in reduced maintenance costs on instruments which will only be realised at completion of the project.

Any other savings or efficiencies gained in CSSD or the operating theatres cannot be quantified at this point in time.

10.2 Key Assumptions

- Maintenance cost savings $30k per annum.
- Cash flow discount rate to calculate NPV of 8%
- Cost of capital of 8%
- Project life of 10 years
- Depreciation rate of 10%

10.3 Financial Projections

The financial projections show a negative impact on the ADHB result of $950k over 10 years. This is offset by improved theatre productivity/optimisation of service revenue, which is not reflected in the business case profit and loss forecast. Similarly the capital investment evaluation which shows an NPV of -$650k does not make any provision for incremental revenue received by services from improved theatre productivity. Base-line funding also includes provision for capital replacement which is not included in the financial projections.

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Financial Measure	Impact
Net Profit and Loss	($650,000)
NPV	($650,000)
IRR	N/A
Non-discounted cash payback	➢ 15 years

11. Project Constraints

The main constraint is time and funds. The process in approving funds will delay the ordering time. However, due to the planned maintenance funding in the last few years, this has reduced pressure on the organisation and allowed for breathing space in terms of resources.

12. Risk Analysis and Management

Risk	Likelihood	Impact	Management strategy
Not placing a purchase order in a suitable timescale.	High	High	▪ Procurement to negotiate with suppliers immediately after the November CAMP meeting ▪ Early discussion with suppliers to identify and plan deliveries.
Quoted price is in excess of the market	Low	Medium	▪ Controlled with hA contracts/processes.
Supplier Availability	Low	High	▪ On-going discussion to understand supplier capability and manufacturing strategy.
Currency	Low	High	▪ Understand the impact in currency movements and ensure hA maximises the budgeted spend. ▪
Unable to obtain Funding	Medium	High	▪ Has been reduced by annual bulk funding for planned maintenance.

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13. Project Implementation

13.1 Implementation Plan

CAMP Approval	18 Jan 2017
Board Approval	Feb 2017
Purchase Order Number	Mar 2017
Final Order	Mar 2017
Final invoicing and checking	Mar 2017
Completed project - capitalisation	Feb 2018
Post Implementation Review	Aug 2018

13.2 Implementation Timeline

See 13.1

13.3 Change Management

CSSD will manage the ordering of the equipment and communicate with both service users and health alliance in this process.

13.4 Benefits Management Plan

This will be monitored through the 2016/17 and on-going savings reporting programme to the Board.

13.5 Project Structure, Monitoring and Reporting

To be incorporated into the Implementation Plan coordinated by CSSD with service users and Health Alliance.

13.6 Post Implementation Evaluation

The post audit will occur 6 months after final equipment purchase order.

14. Completeness and Consultation

Engagement has already progressed with service users and health alliance procurement.

15. Recommendation

That approval is given to Perioperative Service for the use of $950,000 provided in the 2016/17 ADHB capital plan for the purchase of bulk instruments.

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Appendix 1: Profit and loss

Forecast Profit and Loss

Project Name: Bulk Instruments 2016/17

(Enter costs as negative numbers and revenue as positive numbers)

Cost of Capital 8%	Initial	Years										
Project Life Years	**Investment**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**TOTAL**
Corresponding Financial Year												
Investment												
Land												0
Buildings & Plant												0
Clinical Equipment	-950,000											-950,000
Other Equipment												0
Information Technology												0
Intangible Assets (Software)												0
Motor Vehicles												0
												0
Total Investment Outflow	**-950,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**-950,000**
Revenue / Benefits												
												0
												0
												0
												0
Total Revenue	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Expenditure												
Personnel												0
~ Medical												0
~ Nursing												0
~ Allied Health												0
~ Support												0
~ Management & Admin												0
Outsourced												0
Clinical Supplies		30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	300,000
Infrastructure & Non-Clinical Supplies												0
												0
Depreciation		-95,000	-95,000	-95,000	-95,000	-95,000	-95,000	-95,000	-95,000	-95,000	-95,000	-950,000
Total Expenditure	**0**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-650,000**
Net Profit / (Loss)	**0**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-65,000**	**-650,000**

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Appendix 2: NPV

Capital investment Evaluation Model

Project Name: Bulk Instruments 2016/17

(Enter cash outflows as negative numbers and cash inflows as positive numbers)

DISCOUNT RATE 8%	Initial Investment	Years 1	2	3	4	5	6	7	8	9	10	TOTAL
1) Investment:												
Land												0
Buildings & Plant												0
Clinical Equipment	(950,000)											(950,000)
Other Equipment												0
Information Technology												0
Intangible Assets (Software)												0
Motor Vehicles												0
Total Investment Outflow	**(950,000)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(950,000)**
2) Revenue / Benefits												
												0
												0
												0
												0
												0
												0
												0
Total Revenue / Benefits	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
3) Costs												
Personnel												0
~ Medical												0
~ Nursing												0
~ Allied Health												0
~ Support												0
~ Management & Admin												0
Outsourced												0
Clinical Supplies		30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	30,000	300,000
Infrastructure & Non-Clinical Supplies												0
												0
												0
												0
												0
Total expenditure	**0**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**300,000**
Operating Cash Inflows/-Outflows	**0**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**300,000**
Total Net Cashflow Inflows/-Outflows	**(950,000)**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	**(650,000)**
Cumulative Cashflow	**(950,000)**	**(920,000)**	**(890,000)**	**(860,000)**	**(830,000)**	**(800,000)**	**(770,000)**	**(740,000)**	**(710,000)**	**(680,000)**	**(650,000)**	

Investment Evaluation

Net Present Value	**-748,698**	**Non-discounted Cash Payback**	**>15 Years**
Internal Rate of Return	**-16.86%**		

Facilities Infrastructure Renewal and Upgrade Programme – Additional Seed Funding to progress Business Case

Recommendation

That the Board approves

1. **Additional seed funding Capital Expenditure of $1.525 million to undertake necessary investigations to progress preparation of the business case for the Facilities Infrastructure Renewal and Upgrade Programme.** [It should be noted that this is in addition to the $300,000 seed funding capex already approved for this project by the Finance, Risk and Assurance Committee in August 2016). The funding is required to procure consultancy works ($1million) and additional staff to work on the programme for the next eighteen months ($575,000).]
2. **The funding sources being substitution of $1m Capital allocated to the Facilities budget in 2016/17 and a top slice of $525,000 from the 2017/18 Capital budget.**
3. **The $1m substitution coming from deferring the project for of replacement of the roof for Building 17 at Greenlane Clinical Centre, $900,000, and $100,000 underspend on the Pathology Lab chilled water upgrade.**

Prepared by: Allan Johns (Director Facilities and Development)
Endorsed by: Rosalie Percival (Chief Financial Officer)
Endorsed by Executive Leadership Team: Yes: Date: Tuesday, 14 February 2017

1. Board Strategic Alignment

Operational and financial sustainability	The Facilities Infrastructure Renewal & Upgrade Programme is critical to maintaining the DHB's buildings and engineering plant in a safe, operational and resilient state

2. Executive Summary

As part of the Auckland DHB Long Term Investment Plan (LTIP) a major programme is scheduled over the next ten years to renew and upgrade key building services and engineering infrastructure. This includes lifts, fire systems, hydraulic services, HVAC plant and electrical network and switchgear, underground services tunnels and plant buildings.

A condition survey done by engineering consultants Beca Carter last year indicates much of this infrastructure is near the end of its expected life. As well as renewing this aged plant there is a need to improve resiliency by adding additional redundancy to some critical systems.

Further background on the infrastructure renewal programme is contained in the LTIP Project Brief attached to this paper.

In August 2016 the Finance, Risk and Assurance Committee approved a seed funding capex of $300,000 to initiate preparation of the business case for this project. Preliminary work completed under that capex has indicated the need to significantly expand the scope of the renewals and upgrades required. The overall programme has now been indicatively costed at $300 million. Part of $300,000 was to cover the cost of a Project Director to drive the renewal programme. To date this position has been difficult to fill due to the current market conditions and the need recruit a person with the necessary technical and programme management skills. The recruitment process is still continuing.

This capex seeks additional seed funding of $1.575 million.

As with the previous approval this is not intended to cover all the costs of completing the full BBC business cases. Rather it is to enable the significant investigation, planning and analysis work required as part of the preparation for the Strategic Business Case and Programme Business Case. There are over 615 items of major plant, equipment and facilities to upgrade, a number of them over 40 years old, near end-of-life and many with complex interconnections. A large number of investigations need to be undertaken by expert engineers and other specialist consultants.

The additional seed funding will allow procurement of these consultancy works and services for the areas detailed below:

- Electrical engineers
- Building services engineers
- Quantity Surveyors
- Structural engineers
- Hydraulic engineers
- Lift Consultants
- Fire engineering and fire protection
- Acoustic engineers
- Seismic reviews of existing underground services tunnels
- Preparation of site master plans for building services infrastructure on both the ACH and GCC campuses
- Services integration specialists
- BMS Consultants
- Architects/BIM Consultants/Site Master Planning
- Geotechnical surveys of sites where new plant buildings may be established and routes for underground services
- Peer reviewers

In addition a number of new staff positions will be needed for this major programme of work. A number of the current staff will spend part of their time on the projects and part on the business as usual activities. This is important for two reasons; firstly to transfer knowledge of the site, the equipment and maintenance systems to the programme team and secondly to understand what the programme delivers so it can be integrated back into business as usual as projects are handed back to the operations team. This is essential to minimise the inherent risks that this programme has across the organisation. The time spent on project activities will be capitalised against the renewal project.

An independent review of the Facilities Management Function has been conducted by Price Waterhouse Coopers. The objective of the review was to consider the Facilities' functions current

and future needs and in doing so determine whether its operations and structure are both fit for purpose and fit for future. This review recommends reorganising and enhancing the resources within the Facilities Management Department to enable the Department to carry out the work required in future. A number of the new and existing staff will have roles that span operational Facilities activities and will also play a significant role in the renewal project. On approval of this additional seed funding the recommendations from the Price Waterhouse Coopers review with respect to reorganisation of staffing will be implemented. The first phase of this implementation is consultation on proposed changes.

3. Business Case Timeline

Strategic paper to Capital Investment Committee	February 2017
Risk Profile Assessment to MOH/Treasury	February 2017
Strategic Programme Business Case	June 2017
Tranche 1 Business Case	September 2017

Budget

Funding for this additional seed funding capex will be come from two sources.

1. Via substitution from the following projects in the Facilities approved 16/17 capital plan.

Project	Available for Substitution	Comment
GCC Main Bldg - replace metal roof AK-17-C-76	$900,000	Project deferred to next summer due to late 16/17 Plan approval
ACH Pathlab Bldg - upgrade chilled water AK-17-C-63	$100,000	Expected underspend on project
	$1,000,000	

2. $575,000 from the 2017/18 Capital Budget

Attached

- Strategic Paper submitted to the Ministry of Health and Treasury via the Capital Investment Committee.

Auckland District Health Board: Infrastructure Remediation Programme

1. Executive Summary

The Auckland District Health Board has identified a significant programme of remediation works required to ensure the safe ongoing operation of its facilities. This is informed by the Asset Management Plan, the Long Term Investment Plan (underway), the Clinical Services Plan and the assessment of asset management maturity level undertaken as part of the Investor Confidence Rating process.

The estimated capital cost of the programme is $250-350m, with the estimated whole of life cost exceeding $500m. The timeline for programme delivery is 8-10 years.

Auckland DHB is seeking to commence the development of a Programme Strategic Assessment and Programme business case, to support investment in remediation of the critical infrastructure. The indicative timeline for the completion of the Programme Business Case is mid-2017, with the first tranche/project business case to be completed by the end of 2017. The approach and dates are to be confirmed with the Corporate Centre.

2. Introduction/Background

The facilities at both the Green Lane and Auckland City Hospital campuses have been developed over a long period. With time and use, the buildings and infrastructure are deteriorating and ongoing investment is required to ensure that the facilities and infrastructure continue to be safe and functional into the future.

Auckland DHB has a programme of ongoing asset management improvement projects, to maintain the current asset base by implementing appropriate upgrades, refurbishments, replacements and maintenance programmes, using free cash flow from depreciation. There has been little change in the maintenance budget, with spending remaining relatively constant at approximately $8m per annum over the past 4 years. This is inadequate for the age of the buildings and the extent of the remediation work required to ensure that critical assets are maintained and ongoing operation can be assured.

In order to inform the investment required, over the past two years, the DHB has:

- Developed its Asset Management Plan (AMP), outlining the physical asset base, condition of the assets and the refurbishment, upgrade and replacement requirements over the long term;
- Developed the Clinical Services Plan (CSP), which includes asset impacts of the projected demand to assist in prioritisation of projects;
- Development of the Long Term Investment Plan (LTIP). This describes the investment journey and shows how investment will occur to support the delivery of DHB strategy;
- Commenced Site Master Planning on key strategic capital projects, with timing in the medium to long term. The CSP will inform the scope, timing and cost of the long-term facilities renewals, upgrades and new builds;
- Assessed its asset management maturity level as part of the Investor Confidence Rating process and achieved a B rating. A number of work streams are in place to improve the ICR;

- Commissioned reviews of critical infrastructure services at Auckland Hospital (Grafton) and the Greenlane Clinical Centre, to support prioritisation of investment in critical infrastructure.

3. Major capital investment projects (>$10M and Unapproved)

In addition to baseline replacements across all asset classes, the following major projects are planned for the ten year planning horizon.

- Integrated Cancer Service with Centre at Grafton site
- Renal service developments at Greenlane Clinical Centre and in the Community
- Integrated Stroke Service
- Information Technology Infrastructure and applications
- Major ward and theatre refurbishments across all sites and some development for tertiary and local population growth

4. Review of Critical Infrastructure Services

In 2016, Auckland DHB engaged BECA to complete reviews of critical infrastructure services at Auckland Hospital (Grafton) and Greenlane Clinical Centre. The objectives of the review were to identify the critical assets, to identify those assets at increased risk of failure due to condition, reliability issues or seismic events, and to identify assets posing the greatest operational risk to the DHB, based on the combination of criticality and likelihood of failure. The risk scores assigned to each asset are being used to prioritise the asset list, for the purpose of developing risk management strategies.

The reviews identified more than 615 assets across the two sites deemed to be of Major or Significant criticality, and assessed as either Likely or Very Likely to fail. In conjunction with the other asset planning work undertaken, the anticipated capital cost of the Programme is estimated at between $250 million and $350 million. The whole of life cost for the Programme would exceed $500 million.

Without investment in this critical infrastructure, there is significant risk of asset failure impacting on ongoing operational viability. Failure of critical assets would have significant implications for the delivery of key public services, as well as internal operation of the DHB. Health care delivery in the affected area would be compromised or would cease, resulting in an inability to provide appropriate care in a safe environment.

5. Next Steps

The DHB is embarking on the development of a Programme Business Case, to describe the current issues with facilities and infrastructure, consider options for addressing the issues and to propose a preferred programme approach and timeline for remediating the critical infrastructure.

This proposed Programme has been flagged in the 2016/17 Annual Plan, and has been raised with the Corporate Centre as an early indicator of the anticipated need for investment.

At this stage, it is proposed that a Programme Business Case is developed, commencing with the Programme Strategic Assessment. The indicative timeline for the Programme Business Case is for completion mid-2017. This would be followed by a series of tranche/project business cases. It is envisaged that the Programme duration would be 8-10 years, and therefore the tranche/project

business cases would fall over a number of financial years and link to the regional capital planning process.

The first tranche of the project business cases will cover works required to maintain the site from plant failure, works required to mitigate high risk areas and increase resilience and investigations required to produce a detailed programme of works that minimises clinical risk during the installation of new plant. This includes:

- Upgrade of the lift fleet, which is continually failing with a large number of entrapments including critical patients, members of the public and staff;
- A new substation project to provide a second incoming power supply to the Grafton site and further work on the electrical infrastructure including ring mains, replacement of transformers and replacement of aged electrical switchboards;
- Replacement of ageing and failing fire protection services.

High Level Indicative Estimates of costs for the next three years (further refinement required)

Year	ADHB	External Financing required
2017/2018	$30m	$25m
2018/2019	$66m	$56m
2019/2020	$70m	$55m

This process is due to commence in February 2017, with the submission of the Risk Profile Assessment, and discussions with the Corporate Centre on the proposed approach and timeline.

ADHB/WDHB Workforce Central Upgrade Business Case

Reason for Confidentiality: Confidence Embargoed until: 22 February 2017

Recommendation

That the Board:

1. **Receives the Auckland DHB/Waitemata DHB Workforce Central Upgrade Business Case.**
2. **Approves the business case for investment in an upgrade of the Kronos Workforce Central Rostering and Timesheet management application used by Auckland and Waitemata DHBs to the latest available version and migration of the hosting model for Workforce Central to Software as a Service to deliver savings to Auckland DHB over 5 years of $357,807. The total investment requested is:**
   - **Capital expenditure of $519,000 (ADHB share).**
   - **Annual additional operating costs of $239,284 per annum (Auckland DHB share).**
3. **Notes that this business case has been approved by the Northern Regional Capital Committee, the Waitemata DHB and the healthAlliance Board.**

Prepared by: Joanne Bos Project Director, Anna Sefuiva Director, HR Services
Endorsed by: Fiona Michel (Chief HR Officer)
Endorsed by: Rosalie Percival (Chief Financial Officer)
Endorsed by Executive Leadership Team: Yes: Date: Thursday, 09 February 2017

Glossary

Acronym/term	Definition
DR	Disaster Recovery
Disaster Recovery	Capability to enable systems to continue to operate when a component failure occurs
FY	Financial Year
Kronos	Workforce Central system vendor
SaaS	Software as a Service
Software as a Service	A software licensing and delivery model in which software is licensed on a subscription basis and is externally hosted
WDHB	Waitemata District Health Board
WFC	Workforce Central

1. Board Strategic Alignment

Operational and financial sustainability	This project will deliver an upgrade to Workforce Central, which will mitigate risks associated with the current aging and unsupported platform and deliver cost savings

2. Executive Summary

The Kronos Workforce Central (WFC) application is extensively used for Safe Staffing Level Coverage and Workload Planning, Rostering and Scheduling, Time Off Request (Leave) Management and Employee Timecard approval for both Auckland DHB and Waitemata DHB employees, inclusive of Internal and External Bureau Nursing. The application is running on an outdated and unsupported version.

The technical platform (hardware, Operating System and database) that currently supports WFC is out of date and unsupported and the system is at increasing risk of failure and performance degradation. A system and technical platform upgrade is required to mitigate this risk.

Approval is requested for a business case for investment in an upgrade of the Kronos Workforce Central Rostering and Timesheet management application used by Auckland and Waitemata DHBs to the latest available version and migration of the hosting model for Workforce Central to Software as a Service. This approach will deliver a system and platform upgrade with the least capital investment, will eliminate the need for future capital investment to maintain system currency and will deliver savings to ADHB over 5 years of $357,807.

The total capital investment required is $519,000. This will be funded via a reprioritisation of the approved 16/17 capital plan. Additional operating costs are $238,284 per annum.

While we could continue to operate on an unsupported version, should the system fail, this would result in the loss of rosters, any pre booked leave and employees not being paid correctly for time worked. We acknowledge that some users do not like WFC and that it is viewed as a system which is not intuitive nor user friendly, however, undertaking the upgrade will deliver some new functionality and an improvement in the user experience.

To ensure a seamless transition to the new version of WFC, a change management and training plan will run parallel to the upgrade project.

The investment to upgrade has been approved by Waitemata DHB.

3. Introduction/Background

The Kronos Workforce Central (WFC) application is extensively used for Safe Staffing Level Coverage and Workload Planning, Rostering and Scheduling, Time Off Request (Leave) Management and Employee Timecard approval for both Auckland DHB and Waitemata DHB employees, inclusive of Internal and External Bureau Nursing. The application is running on an outdated and unsupported version.

The technical platform (hardware, Operating System and database) that currently supports WFC is out of date and unsupported and the system is at increasing risk of failure and performance degradation.

The Department of Internal Affairs has provided a directive that government agencies should, wherever possible consider Software as a Service as an alternative to hosting systems internally.

This ensures that applications and their underlying technical platform are maintained at current levels and eliminates the need for capital investment to upgrade and maintain them.

It is proposed that the Auckland DHB and Waitemata DHB Kronos Workforce Central Rostering and Timesheet management application be upgraded to the latest available version (Version 8.0) and that the hosting model for Workforce Central is migrated to Software as a Service. This means the system will be hosted and managed by the Workforce Central vendor Kronos

4. Costs/Resources/Funding

Capital Costs

Total Capital Expenditure (as advised by healthAlliance)	$1,262,000
hA funding already approved	$223,000
Total additional funding required	$1,039,000
ADHB Share (50%)	**$519,000**

Source of Capital Financing	**Amount**
hA ICT Capital Plan FY 15/16 (approved)	$223,000
WDHB Capital Plan FY 16/17 (approved)	$519,500
ADHB Capital Plan FY 16/17 (substitution)	$519,500
TOTAL	**$1,262,000**

The total cost of the project was expected to be funded from the healthAlliance ICT capital budget but this is no longer feasible. Funding for this project has been prioritised from the FY16/17 capital plan

Operating Costs

The following operating costs have been provided by healthAlliance:

Software as a Service Fee + healthAlliance costs	$924,068
Current Costs	$445,500
Increase in Operating Costs	$478,568
Auckland DHB Share (50%)	**$239,284**

This has been accommodated for in operating budgets

Financial Analysis

The total capital cost to Auckland DHB and Waitemata DHB for this project is estimated at $1.262m. Financial benefits will be accrued from this project over 5 years.

Hosting Model	CAPEX	OPEX (5 yrs)	Total
SaaS	$1,262,000	$4,620,340	$5,882,340
Current Model	$5,261,453	$1,336,500	$6,597,953
	Savings		**$715,613**
	ADHB Share (50%)		**$357,807**

5. Risks/Issues

The project is constrained by the following factors:

- Timely availability of funding from both Auckland DHB and Waitemata DHB is required to ensure the project can start and be delivered on schedule
- Dependency on healthAlliance and vendor resources and their respective lead times for resource availability
- The availability of appropriate Auckland DHB and DHB testing resources to meet project timelines.

The following risks have been identified for this project:

Risk	Probability	Impact	Risk management strategy
Auckland DHB and/or Waitemata DHB resources are not available to assist with implementation.	High	High	Recognise lead time for some resources. Request commitment to project timeframes.
Vendor or hA resources not available as required	Medium	High	Commence activities early where possible. Organise project activities in order to accommodate necessary lead-times.
Technical solutions (e.g. interfaces) fail to deliver expected functionality or performance	Medium	High	Early design and testing. Conduct testing early to determine acceptability.
Insufficient time and or budget is available to implement the solution	Low	High	Prepare detailed timing and costs at a project level. Project managers to ensure cost/timeframes are adhered to. Factor a contingency into budget and schedule.
Change management initiatives fail to successfully engage and motivate stakeholders to adopt changes	Low	High	Dedicate resources to change management activities. Identify and involve stakeholders early. Clear and consistent communication.

6. Key Objectives

The key objectives for this project are as follows:

- To upgrade to the latest supported version of the application
- To replace the current out of support and aging technical platform
- To implement a highly resilient technical architecture for Workforce Central including Disaster Recovery capability
- To change the current system hosting model to Software as a Service to provide assurance that the application and the underlying technical platform are maintained on supported versions and meet capacity requirements without the need for future capital investment.
- Mitigate the risks of the system failing which could result in the loss of rosters, pre-booked leave and incorrect employee pays

7. Key Benefits

The key benefits of this project are as follows:

- Mitigation of the current system failure and performance degradation risks due to the current unsupported and aging application version and technical platform.
- Highly resilient infrastructure with disaster recovery capability to ensure minimal impacts to system availability.
- Resolution of current system faults.
- Access to system enhancements available in the latest version including mobile capability and improved reporting and analytics.
- Reduction in cash required for upgrade in FY 16/17 of $1.162M for the northern region by moving the hosting model to Software as a Service.
- Contractual assurance that the application and the underlying technical platform will be maintained on supported versions and meet increasing capacity requirements without the need for further capital investment.
- Operating savings of $357,807 for ADHB over 5 years

8. Options Analysis

Option 1: Do Nothing. Do not upgrade Workforce central or the underlying technical platform. Retain the current in-house hosting model.

Option 2: Upgrade Workforce Central and continue with the healthAlliance managed service.

Option 3: Preferred option. Upgrade Workforce Central and move to a vendor managed software as a service model.

Assessment Criteria for Options	**Option 1** Do Nothing	**Option 2** healthAlliance Managed	**Option 3** Vendor Managed (Preferred Option)
Updates Technical Platform to latest versions	No	Yes	Yes

Assessment Criteria for Options	Option 1 Do Nothing	Option 2 healthAlliance Managed	Option 3 Vendor Managed (Preferred Option)
Implements Disaster Recovery capability	No	Yes	Yes
Updates Workforce Central to the latest version and delivers new functionality	No	Yes	Yes
Enables future upgrades to be undertaken without the need for capital investment	No	No	Yes
Meets Department of Internal Affairs directives for Cloud Hosting	No	No	Yes
Capital Cost	N/A	$2,423,950	$1,262,000
Per Annum Operational Cost (Auckland DHB Share – 50%)	$222,750	$222,750	$462,034 (Maintenance + Managed Service)
Total Capex and Opex Cost over 5 years	$6,597,953 (assumes upgrade is deferred but still done)	$6,597,953	$5,882,340

Option 3, upgrade Workforce Central and move to a vendor managed software as a service model, is preferred because it will deliver a system and platform upgrade with the least capital investment and eliminates the need for future capital investment to maintain system currency.

9. Implementation Timelines

Implementation is expected to commence in February 2017 with duration of 3-4 months

10. Conclusion

It is recommended that the Board approves the Auckland DHB-Waitemata DHB Workforce Central Upgrade business case. This includes:

- Upgrade of the Workforce Central system to the latest version
- Upgrade of the Workforce Central underlying technical platform to supported versions
- Implement Disaster Recovery Capability for the Workforce Central system
- Migration of the hosting model for Workforce Central to Software as a Service
- Related integration, reporting and change management activities

- Commitment of capital funds of $519,500 from the ADHB FY 16/17 Capital Plan
- Increased annual operational costs for the affected responsibility centres of $239,284.

Auckland DHB HR Report (Open)

Recommendation

That the Board:

1. **Receives the Auckland DHB HR report for January 2017.**

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

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.

1. Delivering the Auckland DHB People Strategy

2016 Summary

In addition to 'business-as-usual' eg: Fortnightly payroll for over 10,000 employees, recruiting more than 1,200 new employees, challenging employment issues, restructures, MECA negotiations and implementations, IEA reviews, Welcome Days:

January – April 2016

Gathered feedback on our current HR service: Deloitte review, Values co-design, interviews with Board/ELT/SLT, analysis of patient feedback (compliments, complaints, Design Lab), Auckland DHB Strategy Forum input, service visits, Union meetings, Regional and National DHB HR forums, Auckland DHB HR team workshops.

May – August 2016

Proposed a way forward with an Auckland DHB People Strategy paper – signed off by SLT, ELT and the Auckland DHB Board, with an annual review and reset, and quarterly performance review conversations. Replaced the Learning & Development function with a new Organisational Development team. Integrated Payroll and Workforce Central into the HR function. Transitioned Auckland DHB away from Moodle, to Ko Awatea LEARN.

September – December 2016

Prepared and consulted on a new HR Operating Model. Supported the organisation through 'Get on Track' and the Junior Doctors' strike. Launched new and improved online forms and information for employees via HIPPO (myHR). Delivered an Engagement survey and results to 10,000 employees. Relocated 65 HR employees and thousands of personnel files to a new site at GCC. . Co-design and 'soft' launch of Speak Up to tackle bullying, harassment & discrimination.

2017 People Strategy Work Programme

Progress against our People Strategy 'Big 5' themes will be reported quarterly.

Delivery Milestones	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
Delivering on our promises				
• Awareness/use of Speak Up				
• Awareness/visibility of our Values				
• Auckland DHB employee engagement action planning				
• Deliver a Code of Conduct				
Accelerating capability and skill				
• Deliver our Management Practicing Certificate				
• Deliver our Leadership Development Programmes				
Ensuring a quality start				
• Deliver the new Auckland DHB Orientation Programme				
• Māori/Pacific Recruitment Targets achieved				
Building constructive relationships				
• Initiatives to enhance opportunities for our Low-Paid workforce				
Making it easier to work here				
• Simplification and consistent look & feel of all HR forms, guidelines, policies and processes				

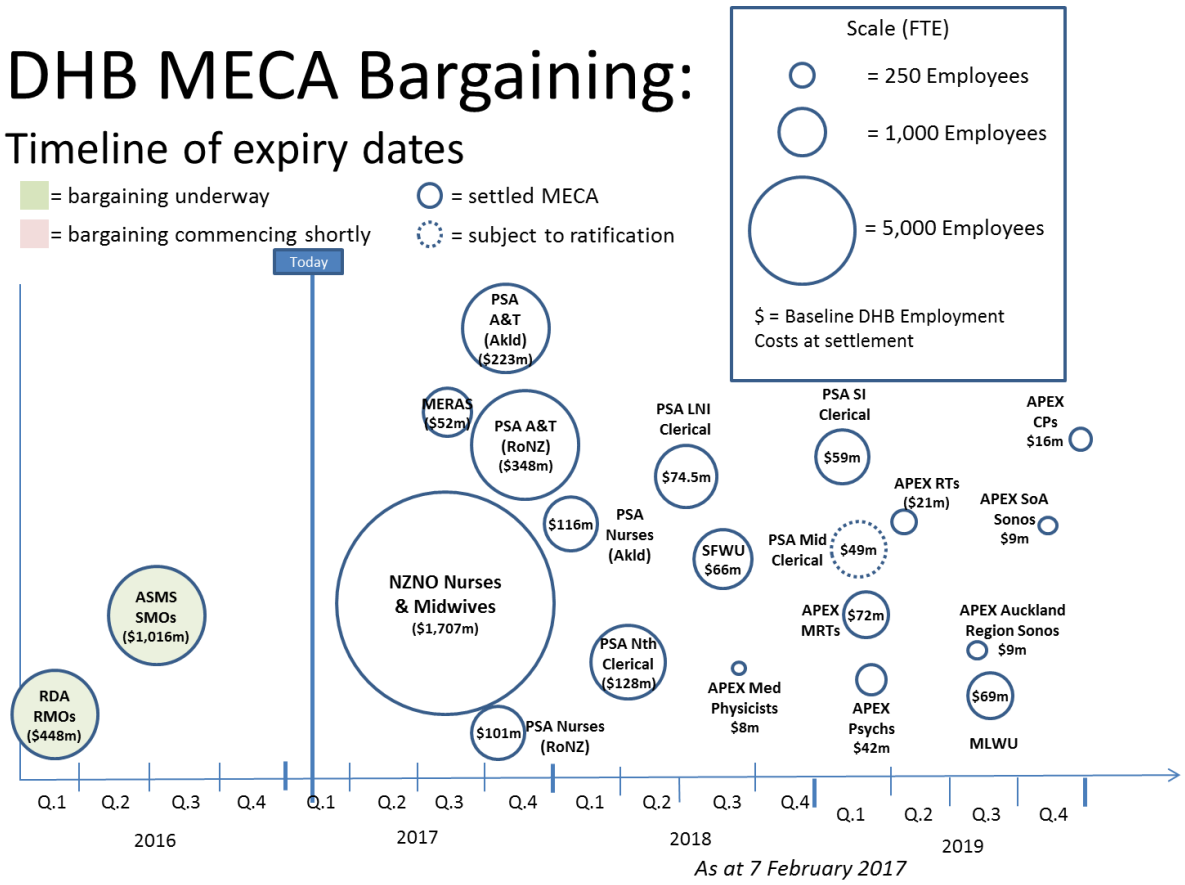
2. Key Employment Issues/Opportunities

The Board will be interested in key employment issues and opportunities being monitored and mitigated by Auckland DHB. This list will be updated quarterly, or whenever a significant change arises, along with detailing progress and outcome reporting.

	Issues/Opportunities	Current People Strategy Response
ADHB	• Confidence and competence of leaders to effectively lead/manage our workforce	• JumpShift Leadership Development Programme, and Management Practicing Certificate
	• Ability to reduce leave balances while maintaining service levels	• Focus on high-balance individuals in each service. Maximising leave in 'quiet' times.
	• Managing the operational flexibility and financial implications of MECA terms and conditions	• Employment of ER/IR Practice Leader
	• Impact of bullying, harassment & discrimination on wellbeing and productivity	• Introduction of the Values and Speak Up programmes.
	• Manual HR/Payroll processes and systems risk	• Change to HR Operating Model, introduction of myHR and askHR. • Review of Payroll function. • HR technology upgrades.
	• Employee Survey feedback	• Organisational, directorate/service action planning and regular progress reporting
	• Vulnerable workforces (Māori, Pacific and Low-Paid workers)	• Active partner with Waitematā on the Māori Alliance Leadership Team. • Initial discussions with MSD to explore options for Low Paid workers
Region	• Northern Regional Alliance effectiveness • Securing suitable community-based attachments • Auckland house price impact on talent attraction and retention	• Auckland Metro Region GMHR working group, meeting monthly to progress actions and opportunities for improvement on all regional issues.
Sector	• Implications of RMO (and other) bargaining outcomes • Alignment to SSC/Public Service Leadership Success Profile & Framework • HWNZ funding model proposal • 'High Performance – High Engagement' (HPHE) union partnership model	• Auckland DHB participation in Sector Workforce Strategy Group, National GMHR forums, HWNZ workshops, HPHE workshop and early adoption of SSC Leadership Success Profile & Framework.

3. Industrial Relations

The long-time ER/IR Practice leader vacancy in HR has recently been filled by employment lawyer Armin Naghizadeh. Armin will take responsibility for strengthening our employment and industrial relations participation, practices and outcomes. The timetable for upcoming bargaining is as follows:



4. Employment Metrics

A paper outlining proposed employment metrics for ongoing reporting to the Hospital Advisory Committee (HAC) and Board will be tabled for discussion and endorsement at the next HAC and HR Subcommittee meetings.

5. Doing our Life's Best Work

We have recently welcomed the largest intake of Māori and Pacific Nursing Graduates, with 18 joining Auckland ADHB in the current cohort of 80 new employees, supporting our goal to better match our healthcare workforce diversity with the community we serve.

Auckland DHB Employee Survey 2016

Recommendation

That the Board:

1. **Receives the Auckland DHB Employee Survey 2016 report for January 2017.**
2. **Endorses quarterly reporting on Employee Survey action planning to the Hospital Advisory Committee and Auckland DHB Board.**

Prepared by: Gil Sewell (Director, Organisational Development)
Endorsed by: Fiona Michel (Chief HR Officer)
Endorsed by: Ailsa Claire (Chief Executive)

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	Employee Survey is an enabler of our aspiration to be renowned for our people-centred approaches, starting with our employees.
Emphasis/investment on both treatment and keeping people healthy	Employee Survey allows us to identify where we can provide support for the safety and wellbeing of our people, to support them in their efforts to increase wellness in patients.
Service integration and/or consolidation	Employee Survey provides insight from our people into how we can better provide an integrated and seamless service.
Intelligence and insight	Employee Survey is an early step in obtaining a wider range of data to support planning processes and quality improvement work.
Evidence informed decision making and practice	Employee Survey provides evidence to drive decisions about how we provide our services by identifying what our people deem to be priority areas for attention.
Outward focus and flexible service orientation	Employee alerts the organisation to areas where the balance between bureaucracy and service delivered are perceived to be out of kilter.
Operational and financial sustainability	Employee Survey helps identify areas for development and strengthening of our people and our leaders.

2. Executive Summary

This report is submitted to provide information to the Board on the results of the 2016 Auckland DHB Employee Survey.

The participation rates for the survey were very pleasing. 57% of staff completed the survey, across all professional groups. Anecdotally, other Auckland Metro DHBs report participation rates for past Employee Surveys between 40-45%.

The results of the survey provide us with insight into what is working well at Auckland DHB and where there are opportunities for improvement to ensure we live up to the employee value proposition.

An analysis of the quantitative and qualitative responses to the survey provides us with a summary of Auckland DHB's strengths and opportunities:

Strengths

- Our purpose, values and objectives are clear to people – there is a clear sense of direction and people are clear about their individual roles.
- Teamwork is the cornerstone of safe healthcare: people report that individual teams work well together and colleagues are helpful, friendly and welcoming to each other.
- 78% of people feel safe to speak up when there is an error or an issue – this indicates a strong safety culture, with some room for improvement.

Opportunities

The survey indicated that there are five areas of opportunity for listening to our employees and acting on their views and suggestions to improve their experience of working at Auckland DHB.

1. Review workload and its impact on employees' health and wellbeing and on quality of patient care.
2. More positive behaviours between colleagues.
3. People want more visible and supportive leadership and management.
4. An improvement in team-working and working between teams and services.
5. Car parking.

Over the course of the next year, action plans will be put in place both at an organisational level and service/directorate/function level to strengthen the good things already happening for our employees and make improvements where required.

Progress against plans will be reported at the Hospital Advisory Committee and at the main Board each quarter.

3. Introduction/Background

This report is designed to provide the results of the Auckland DHB Employee survey which was conducted between October - November 2016.

The results of the survey help inform us as an organisation where we need to focus our efforts to achieve the Auckland DHB strategy and goals, through a better experience at work for our employees.

4. Participation

5654 people (57% of our workforce), took part in the survey. Response rates were high across all services and professions. We can therefore be confident that the survey responses and the themes coming from the open-ended questions are representative of our employees' views.

	Responded	Participation rate
Overall	**5654**	**57%**
Allied, Scientific & Technical	1415	63%
Hospitality Staff *	99	32%
Medical	735	43%
Nursing and Midwifery	2389	56%
Other support staff	658	71%
Corporate (professional) staff	356	76%

*We have learned lessons on how to increase participation amongst hospitality staff, many of whom do not have dedicated computer access, when we next test engagement.

4. Engagement Scores

Employee engagement is defined as "a set of positive attitudes and behaviours enabling high performance of a kind which are in tune with the organisation's mission." (Storey, 2008). Importantly, "there is a clear relationship between the wellbeing of employee and patients' wellbeing" according to a major Kings Fund study in 2012.

The overall engagement score is calculated from a combination of three factors, which research has shown describe the extent to which employees emotionally and physically apply themselves at work; satisfaction, advocacy and motivation. This is an outcome measure enabling us to track engagement levels over time, and to identify differences between groups.

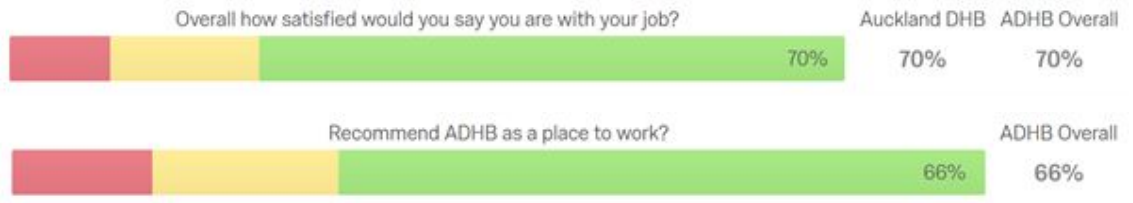
Results of the 2016 survey show slight variations between employee groups:

Group	Engagement Score
Overall	77%
Allied, Scientific and Technical	76%
Hospitality Staff	77%
Medical	73%
Nursing & Midwifery	78%
Other support	78%
Corporate (professional) staff	80%

5. Drivers of Advocacy and Satisfaction

The survey asked people to provide reasons for their answers to questions about whether they would recommend Auckland DHB as a place to work, and their level of job satisfaction.

The organisational results for these questions are:



The reasonably high levels of work satisfaction can be attributed to the following:

- Supportive, respectful, happy colleagues
- The quality and professionalism of the care the DHB provides
- Opportunities to grow at work

Where staff described they were not satisfied with their job, or would not recommend the DHB as a place to work, they indicated they are experiencing:

- A lack of support from management and from colleagues
- Lack of resources and staffing resulting in pressure and stress
- A culture of lack of respect and bullying

When we asked our people whether they would recommend the DHB as a place to be treated – 88% said they would, because of the high standards and quality of care provided by our employees.

Where there were concerns expressed, the themes revolve around patient waiting times, lack of resources and staffing levels, with some employees expressing worries about patient experience, and unprofessional or disrespectful behaviour from some colleagues.

6. Factors that influence engagement

The research shows there are five things that for employees to be fully engaged in their work:

- Employees are enabled to work towards a clear **direction and purpose** that resonates with them.
- Employees can use their skills and ideas to **contribute** to success and improvement.
- Employee efforts are **recognised and valued** by colleagues, managers and patients.
- Employees experience **connection and support** not only within teams but across boundaries/ silos, and in multidisciplinary teams.
- There is an absence of what the literature calls 'psychosocial hazards' (or put more positively – work contributes to employee **safety and wellbeing**).
- Employees experience each other living up to a set of **shared values.**

Our survey asked a series of questions to identify the extent to which respondents believe these factors are in place.

There were a range of opportunities for improvement, but the results suggest our key focus for improvement should be on the following four areas:

- **Ensuring people are recognised and valued at work**
- **Better connections between teams**
- **Protecting people's safety and wellbeing at work**
- **Continuing to embed our shared values and behaviours**

7. Benchmarking

Benchmarking has been undertaken across a number of key questions.

The benchmarks are made against:

- NHS 2016
- April Strategy client average

The areas/ questions that we have benchmarked against are:

- Recommend as a place to work /place for treatment
- Drivers of engagement – overall domains
- Bullying and discrimination
- Recognition and praise
- Emotions

Comparisons to these benchmarks show us that:

- Compared to other healthcare providers, we are happy with the quality of care delivered at our place of work.
- The overall employment experience at Auckland DHB is no better or worse than at similar healthcare organisations.
- Bullying and discrimination are more common at Auckland DHB than at other healthcare organisations.
- Lack of leadership visibility is an issue for Auckland DHB when compared to other healthcare organisations.

8. Summary

Despite the pressures people are under, our employees display high levels of engagement: 70% of employees are satisfied with their jobs and 88% would recommend the DHB as a place to be treated.

Teamwork – the foundation of safe care – is strong in the DHB, with 84% saying that their team works well together to provide a great service. Most people are happy to speak up if they notice and error. Our amazing people remain our greatest asset, and we see each other as friendly, welcoming and helpful.

We also have some clear areas for action to keep improving the work experience of our people.

9. Next steps

In mid-December, all managers across the organisation were provided with access to the results for their area.

The expectation is that all teams will discuss their results and develop an action plan to be implemented by the end of this financial year. Directorates will be required to submit a quarterly report to the HAC and Auckland DHB overall to the Board, showing the 1-2 opportunities they have identified, key actions taken and the plan for the following quarter in order to realise those changes.

Statement of Performance Expectations (SPE) Performance Report: Q2 2016/17

Recommendation:

That the report be received.

Prepared by: Wendy Bennett (Planning & Health Intelligence Manager – Auckland and Waitemata DHBs)
Endorsed by: Karen Bartholemew (Acting Director Health Outcomes – Auckland and Waitemata DHBs), Simon Bowen (Director of Health Outcomes – Auckland and Waitemata DHBs)

Glossary

ARPHS	Auckland Regional Public Health Service
CEO	Chief Executive Officer
CVD	Cardiovascular disease
DHB	District Health Board
HAC	Hospital Advisory Committee
HT	Health Target
POAC	Primary Options for Acute Care
SIR	Surgical intervention rate
SPE	Statement of Performance Expectations
TB	Tuberculosis
WIES	Weighted Inlier Equivalent Separation
YTD	Year-to-date

Introduction

The Board has requested regular reporting of the indicators in the Statement of Performance Expectations (SPE) that makes up a key component of the Annual Plan. Measures within the SPE (Module 3 of the Annual Plan) represent the outputs/activities we deliver to meet our goals and objectives in the first two modules of the Annual Plan, and also provide a reasonable representation of the vast scope of business-as-usual services provided, using a small number of cornerstone indicators. Performance measures are concerned with the quantity, quality and the timeliness of service delivery. Actual performance against these measures is reported in the DHB's Annual Report, and audited at year end by the DHB's auditors, AuditNZ.

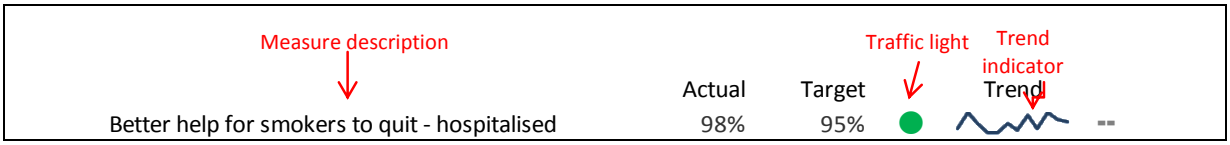
Many of the indicators included in the SPE are currently reported via other scorecards/reports to Board and Board Committees. Therefore, this report excludes variance reported elsewhere for indicators included in other reports. This report also excludes indicators for which data is only available annually.

This report represents the first SPE report to the Board and and summarises the performance for Quarter 2 2016/17. Auckland DHB has met the majority of SPE indicator targets in Prevention Services (Output Class 1) and Rehabilitation and Support Services (Output Class 4). We continue to focus on our performance in Early Detection and Management (Output Class 2) by working with our Primary Care partners to improve service. In the Intensive Assessment and Treatment (Output Class 3) indicators, we note that all of our quality and patient safety indicators are on track; our key area of focus is orthopaedic waiting times.

HOW TO INTERPRET THE SCORECARDS

Traffic lights

For each measure, the traffic light indicates whether the actual performance is on target or not for the reporting period (or previous reporting period if data are not available as indicated by the *grey bold italic* font).



The colour of the traffic lights aligns with the Annual Plan:

Traffic light	Criteria: Relative variance actual vs. target		Interpretation
●	On target or better		Achieved
●	95-99.9% achieved	0.1–5% away from target	Substantially Achieved
●	90-94.9%*achieved	5.1–10% away from target AND improvement from last month	Not achieved, but progress made
●	<94.9% achieved	5.1–10% away from target, AND no improvement, OR >10% away from target	Not Achieved

Exception: Cardiac arrest calls is Green if number ≤1, Blue if =2, Amber if =3 and Red if ≥4

Trend indicators

A trend line and a trend indicator is reported against each measure. Trend lines represent the actual data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. The small data range may result in small variations appearing to be large.

Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance trend, use the trend indicator as described below.

The trend indicator criteria and interpretation rules:

Trend indicator	Rules	Interpretation
▲	**Current > Previous** month (or reporting period) **performance**	Improvement
▼	**Current < Previous** month (or reporting period) **performance**	Decline
--	**Current = Previous** month (or reporting period) **performance**	Stable

By default, the performance criteria is the actual:target ratio. However, in some exceptions (e.g., when target is 0 and when performance can be negative (e.g., net result) the performance reflects the actual.

Look up for scorecard-specific guidelines are available at the bottom of each scorecard:

SPE scorecard: Q2 2016/17

Auckland DHB Performance Scorecard

Statement of Performance Expectations

Quarter 2

2016/17

Output Class 1: Prevention Services

	Actual	Target		Trend	
Health Promotion					
Better help for smokers to quit - hospitalised	96%	95%	●		--
Better help for smokers - Primary Care	88%	90%	●		▲
Better help for smokers - Maternity	*98%*	*90%*	●		▼
Raising Healthy kids	97%	95%	●		▲
Green Prescriptions - adults	2,586	3,076	●		▼
Health Protection (ARPHS - all northern region DHB results)					
Tobacco retailer compliance checks conducted (YTD)	73	30	●		▲
% of TB treatments with start date	100%	85%	●		--
Population based screening					
Breast screening coverage	63%	70%	●		▼
Newborn hearing - % babies offered screening within 1 month	100%	90%	●		--
Referral rate to audiology	0.6%	≤4%	●		▲
Audiology services by 6 month of age	100%	≥95%	●		--
Percentage of B4 School Checks completed (YTD)	47%	45%	●		▼

Output Class 2: Early Detection and Management

	Actual	Target		Trend	
Primary health care					
Primary care enrolment	84%	95%	●		▼
POAC Referrals YTD	2258	3500	●		▲
Increased immunisation (8-month old)	96%	95%	●		▲
Cervical Screening	*72%*	*80%*	●		
Diabetes management	*69%*	*61%*	●		▲
CVD on Triple therapy	*53%*	*55%*	●		
% CVD risk assessed in last 5 years	92%	90%	●		▼
Community referred testing and diagnostics					
GP referred radiological tests (YTD)	13,257				▲
% CTs completed within 6 weeks	98%	95%	●		▲
% MRIs completed within 6 weeks	67%	85%	●		▼

Output Class 4: Rehabilitation and Support Services

	Actual	Target		Trend	
Home-based support					
Long term support 65+ who have had interRAI	98%	95%	●		▲
% urgent InterRAI assessed in 5 working days	80%	90%	●		▲
% non-urgent InterRAI assessed in 15 working days	93%	90%	●		▲
Palliative Care					
Number of contacts (YTD)	4,801				
Proportion of hospice patient deaths that occur at home	28%	↑	●		▲
Proportion of referrals that wait >48 hours for a hospice bed	0%	↓	●		▲
Residential Care					
ARC providers with 4 year audit certification	32%	↑	●		▲

Output Class 3: Intensive Assessment and Treatment

	Actual	Target		Trend	
Acute services					
Number of ED attendances (YTD)	36,983				
Total acute WIES (DHB Provider - YTD)	51,349	50,577	●		▼
Shorter Waits in ED	95%	95%	●		--
Faster cancer treatment - within 62 days	88%	85%	●		▲
% of eligible stroke patients thrombolysed	*10%*	*10%*	●		▼
% of stroke patients admitted to stroke unit	*75%*	*80%*	●		▼
Coronary angiography in 3 days (ACS patients)	87%	70%	●		▲
Maternity					
Number of births in Auckland DHB hospitals (YTD)	*1,872*				
% primiparous vaginal births with 3rd/4th degree tears	5.1%	↓	●		▼
Elective (inpatient/outpatient)					
HT: elective surgical discharges	*93%*	*100%*	●		▼
Surgical intervention rates (SIR) - joints	*17.1*	*21*	●		▼
SIR - cataracts	*44.8*	*27*	●		▲
SIR - cardiac	*5.8*	*6.5*	●		▲
SIR - PCR	*11.4*	*12.5*	●		▲
SIR - angiogram	*31.6*	*34.7*	●		▲
% urgent diagnostic colonoscopy in 14 days	96%	98%	●		▲
% non-urgent diagnostic colonoscopy in 42 days	95%	56%	●		--
% waiting > 4 months for their FSA (ESPI 2)	0.31%	0.00%	●		▼
% waiting > 4 months for their treatment (ESPI 5)	3.73%	0.00%	●		▼
Quality and patient safety (HQSC)					
Percentage of opportunities for hand hygiene taken	*84%*	*81%*	●		--
Older patients assessed for risk of falling	*92%*	*90%*	●		▼
Hip & Knee operations with prophylactic antibiotic given	*97%*	*100%*	●		▲
Staph bacteraemia rate per 1,000 inpatient bed days	0.0008	↓	●		▲
% of inpatients who rate care very good or excellent	*86%*	↑	●		▼
Mental health					
Mental health service access 0-19	3.3%	3.0%	●		▲
Mental health service access 20-64	3.6%	3.7%	●		▼
Mental health service access 65+	3.1%	3.1%	●		▼
0-19 Mental Health waiting within 3 weeks	*74%*	*80%*	●		▼
0-19 Mental Health waiting within 8 weeks	*90%*	*95%*	●		▲
0-19 Addictions waiting within 3 weeks	*94%*	*80%*	●		▼
0-19 Addictions waiting within 8 weeks	*99%*	*95%*	●		▼

How to read

Performance indicators:

- ● Achieved/ On track
- ● Substantially Achieved but off target
- ● Not Achieved but progress made
- ● Not Achieved/ Off track

Trend indicators:

- ▲ Performance ***improved*** compared with previous quarter
- ▼ Performance ***declined*** compared with previous quarter
- -- Performance was ***maintained***

Key notes

ESPI traffic lights follow MoH criteria:

ESPI 2	ESPI 5
● 0	● 0
● < 0.4%	● < 1%
● ≥ 0.4%	● ≥ 1%

The triple therapy target published in the 2016/17 Annual Plan (70%) has been superceded by the SLM Plan target

A Question?

12.3

OUTPUT CLASS 1: PREVENTION SERVICES

SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
Health promotion		
1. Better help for smokers to quit – hospitalised	✓	*In CEO, HAC reports*
2. Better help for smokers to quit – Primary Care	✓	*In CEO, Primary Care reports*
3. Better help for smokers to quit – maternity	✓	*In CEO report*
4. Raising Healthy Kids	✓	*In CEO report*
5. Green Prescription – adults	✖	Referral numbers are historically slow during December. Sport Auckland is in a good position to reach target referral by the end of the year, as they are currently 84% of the target. They will be delivering some new evening services with an expected outcome of increased referrals and engagement. (from MoH report – Leanne Catchpole)
Health protection (ARPHS – all northern region DHB results)		
6. Tobacco retailer compliance checks conducted (YTD)	✓	
7. % of TB treatments with start date	✓	
Population-based screening		
8. Breast screening coverage	✖	A change in NSU coding and data processes in June 2016 has resulted in variances with coverage reports that are unrelated to actual screening activity. The identification of unscreened and under screened women through a national NHI data matching process remains the key strategy to increase coverage. To support this activity and the associated increase in coverage it has been proposed that breast screening be recognised as a contributory measure under the new System Level Measure of amenable mortality. This will support renewed focus and activity on breast screening by Primary Care. Collaborative activity to provide joint health promotion for cervical and breast screening has also been pursued, this activity also incorporates smoking cessation messaging and Green Prescription activity. (from CPHAC report – Pam Hewlett)
9. Newborn hearing - % babies offered screening within 1 month	✓	
10. Referral rate to audiology	✓	
11. Audiology services by 6 months of age	✓	

Indicator	On target	Variance commentary
12. % of Before School Checks completed (YTD)	✓	

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT

SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
Primary health care		
13. Primary care enrolment	✗	*In Primary Care report*
14. POAC referrals YTD	✗	Utilisation of POAC in Auckland DHB has regularly been below target. We have just undertaken a review of POAC, including a review of utilisation variability. The review report was finalised the week prior to Christmas. We are now considering interventions to improve utilisation in the Auckland DHB area. (from Tim Wood)
15. Increased immunisation (8-month old)	✓	*In CEO report*
16. Cervical screening	✗	The Auckland and Waitemata Coordination service continues to focus on supporting PHOs in interpreting monthly NSU data match lists to facilitate prioritising invitation and recall of unscreened women. The invitation and recall letters are now available in 11 languages. Opportunistic screening also remains a key focus and cervical screening is regularly offered in conjunction with the Breast Screen mobile vans. (from CPHAC report – Pam Hewlett)
17. Diabetes management	✓	*In Primary Care report*
18. CVD on triple therapy	✓	
19. % CVD risk assessed in the last 5 years	✓	
Community-referred testing and diagnostics		
20. GP-referred radiological tests	✓	
21. % CTs completed within 6 weeks	✓	*In HAC report*
22. % MRIs completed within 6 weeks	✗	*In HAC report*

12.3

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT

SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
Acute services		
23. Number of ED attendances (YTD)	No set target	
24. Total acute WIES (DHB Provider – YTD)	✓	
25. Shorter Waits in ED	✓	*In CEO report*
26. Faster Cancer Treatment – within 62 days	✓	*In CEO report*
27. % of eligible stroke patients thrombolysed	✓	
28. % of stroke patients admitted to stroke unit	✗	Auckland DHB has historically performed well on this target and we expect to meet this going forward. There may be data quality issues relating to Q1 and we are currently investigating this (from MoH report – Dee Hackett, Alan Barber)
29. Coronary angiography in 3 days (ACS patients)	✓	
Maternity		
30. Number of births in Auckland DHB hospitals (YTD)	No set target	
31. % primiparous vaginal births with third/fourth degree tears	✓	
Elective (inpatient/outpatient)		
32. HT: elective surgical discharges	✗	*In CEO, HAC reports*
33. Surgical intervention rates (SIR) – joints	✗	This result is a decrease of 1.78 per 10,000 population from the 12 months ending 03/03/2016, and a decrease of 1.72 per 10,000 population from the 12 months ending 30/09/2015. Orthopaedic volumes this year are tracking at lower levels than planned. Intervention rates are expected to improve with the confirmation of additional capacity following the recent review.
34. SIR – cataracts	✓	

Indicator	On target	Variance commentary
35. SIR – cardiac	✖	The quarter saw sustained higher than planned inflows onto the waitlist. This placed pressure on the waitlist target times and contributed to the increase in elective patients waiting for surgery. We continue fortnightly teleconferences with the Ministry of Health to review and discuss the waitlist target times. Rigorous monitoring of the waitlist continues. ADHB maintains good relationships with referrers to the service and there are no real or perceived barriers to referral. (from Sam Titchner)
36. SIR – PCR	✖	All patients undergoing PCR intervention must first undergo diagnostic angiography. As we are achieving waiting list time frames for angiography, and have a good relationship with primary care, there are no barriers to referral for PCR (from Sam Titchner)
37. SIR – angiogram	✖	This result is an increase of 0.48 per 10,000 population from the 12 months ending 03/03/2016, and an increase of 2.14 per 10,000 population from the 12 months ending 30/09/2015. This result has improved from that reported in the last quarter. ADHB is meeting waitlist demand and time frames for angiography, there are no real or perceived barriers to referral and we continue to ensure that we maintain relationships with the primary sector. The increase in CT non-invasive angiography may be a contributing factor. We ensure all angiography cases undertaken are clinically appropriate and as far as we are aware, there are no real or perceived access issues for angiography. (from MoH report – Sam Titchener)
38. % urgent diagnostic colonoscopy in 14 days	✓	*In HAC report*
39. % non-urgent diagnostic colonoscopy in 42 days	✓	*In HAC report*
40. % waiting >4 months for their FSA (ESPI 2)	✖	*In HAC report*

12.3

Indicator	On target	Variance commentary
41. % waiting >4 months for their treatment (ESPI 5)	✖	*In HAC report*
Quality and patient safety (HQSC)		
42. % of opportunities for hand hygiene taken	✓	*In HAC report*
43. Older patients assessed for risk of falling	✓	
44. Hip and knee operations with prophylactic antibiotic given	✓	
45. Staph bacteraemia rate per 1,000 inpatient bed days	✓	*In HAC report*
46. % inpatients who rate care very good or excellent	✓	*In HAC report*
Mental health		
47. Mental Health service access 0-19	✓	*In HAC report*
48. Mental Health service access 20-64	✓	*In HAC report*
49. Mental Health services access 65+	✓	*In HAC report*
50. 0-19 Mental Health waiting within 3 weeks	✖	*In HAC report*
51. 0-19 Mental Health waiting within 8 weeks	✖	*In HAC report*
52. 0-19 Addiction waiting within 3 weeks	✓	
53. 0-19 Addiction waiting within 8 weeks	✓	

OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

SCORECARD VARIANCE REPORT

Indicator	On target	Variance commentary
Home-based support		
54. Long-term support 65+ who have had InterRAI	✓	
55. % urgent InterRAI assessed in 5 working days	✖	The Service has improved from 70% urgent referrals completed within 5 days in Q1 to 80% in Q2. The main reason for not meeting this target is patient and family choice. When the patient or family decline an earlier assessment date and request a later date, we will honour that request if it does not create clinical risk for the patient. We are working on a system to define those who choose a later appointment so we can report on any other breaches which are service related. This is a manual data collection process at present. (from Judith Catherwood)
56. % non-urgent InterRAI assessed in 15 working days	✓	

Palliative care		
57. Number of contacts (YTD) 58. Proportion of hospice patient deaths that occur at home 59. Proportion of referrals that wait >48 hours for a hospice bed	No set target ✓ ✓	
Residential care		
60. ARC providers with 4-year audit certification	No set target	

Information Paper

Manawa Tahi (ISSP) Programme

Recommendation

That the Board:

1. **Receives the Manawa Tahi ISSP Programme report for February.**
2. **Notes that status and progress of the Manawa Tahi ISSP Programme**

Prepared by: Name James McGeorge
Endorsed by: Name Wayne Pohe, Manawa Tahi Programme Sponsor
Endorsed by Executive Leadership Team: Yes

Glossary

Acronym/term	Definition
ISSP	Information Systems Strategic Plan
APM	Application Portfolio Management

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	The ISSP has developed as set of regional problem statements, strategic objectives and investment objectives that collectively define the high level business outcomes for regional IS investment. This "Investment Logic Map" has been developed in conjunction with key senior regional stakeholders and leverages the DHB LTIPs and other supporting strategic documents. As a result it will align the listed ADHB strategic imperatives.
Emphasis/investment on both treatment and keeping people healthy	
Service integration and/or consolidation	
Intelligence and insight	
Evidence informed decision making and practice	
Outward focus and flexible service orientation	
Operational and financial sustainability	

2. Executive Summary

The purpose of this paper is to update the Board on the progress of the Manawa Tahi (ISSP) Programme and key activities required to complete the ISSP strategy.

The Manawa Tahi Programme commenced last year and its objectives are to determine Regional Information Systems Business Drivers and to deliver a Regional Information Systems Strategic Plan. The target for the programme is that the Information Systems Plan will be completed by May 2017. There will be further engagement with the programme representatives in attendance at future Board meetings.

This is an interim programme update to Boards and outlines the

- High level approach of the programme and progress to date
- Key IS Business Drivers and supporting problem statements
- Agreed Regional Strategic Objectives

- Future activities required to complete the ISSP

3. Supporting Document

Please see the document "Manawa Tahi (ISSP) ADHB Board Update 10 02 2017 v1.0.ppt" for more details.

Northern Region Information Systems Strategic Plan

12.4

Manawa Tahi (ISSP) Programme – ADHB Board Update

10/02/17

Programme Scope and Objectives

The Manawa Tahi (ISSP) Programme has two key objectives:

- **Regional IS Business Drivers**
- **Information Systems Strategic Plan (ISSP)**

A secondary objective is the set up and population of an **Application Portfolio Management (APM)** solution (tactical and strategic) with information on regional Applications and associated qualitative and quantitative metrics. This will be used to develop "Heat Maps" on as-is application suitability from financial, risk, functional and strategic perspectives that will consequently be used to inform the ISSP.

The Regional IS Business Drivers contain the high level regional business requirements for IS investment. This artefact was approved in December 2016 (by the PSG and RGG). A summary of the agreed problem statements, strategic objectives and investment logic map is included for information in slides 5 - 8

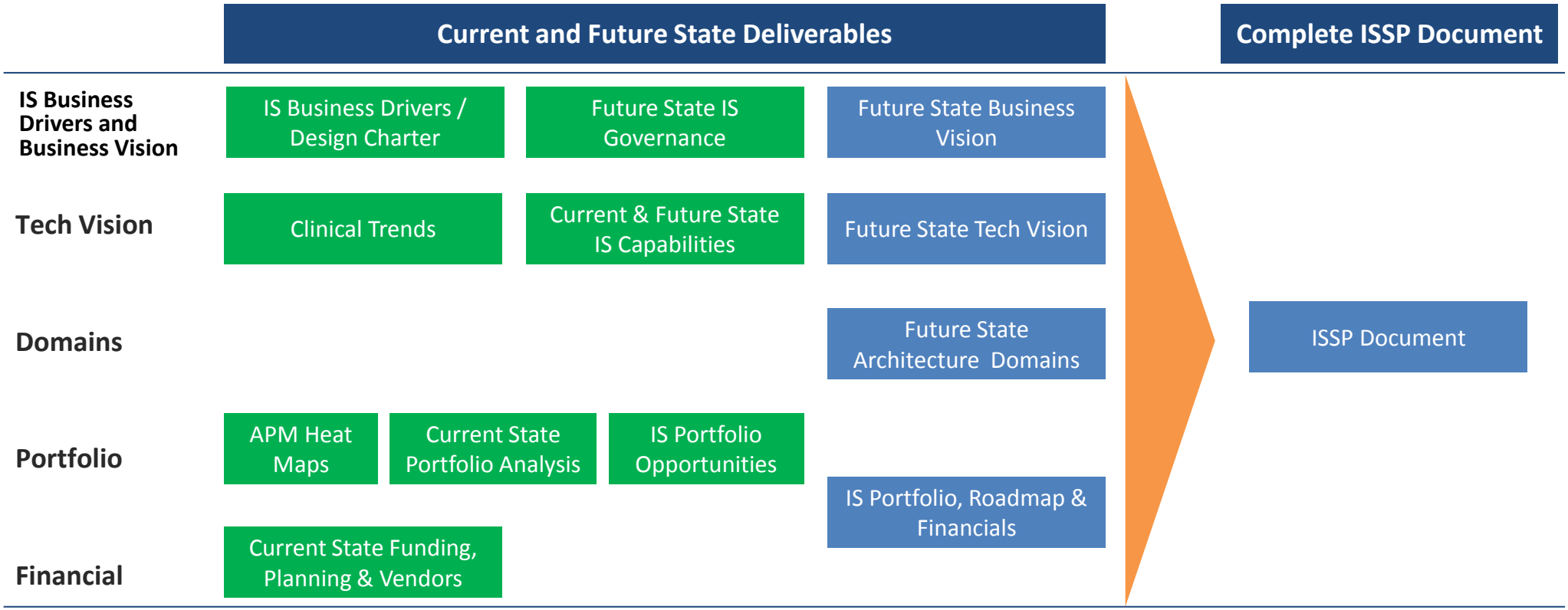
The Information Systems Plan is a document to be completed and approved by May 2017 will contain the following key sections:

- **Exec Summary** (Strategic context & drivers, Scope / Objectives, ILM)
- **Current State Assessment** (Summary of APM, ICT Capability etc)
- **Future State Vision** (Sliders, Business Drivers, Summary to be ICT)
- **Roadmap** (Bringing our vision to life, Implementation strategy & 5 yr work programme / roadmap, Risk, issues, constraints and assumptions, Investment Model
- **Next Steps**
- **Appendices**

To support the above a range of As-Is and supporting assessments have been undertaken including Tech Trends, Portfolio & Portfolio Opportunities, Funding and Planning, Governance, ICT Capability and Supplier. This work is complete.

ISSP High level Approach and Progress

Each current state deliverable forms a chapter in the wider ISSP. Data drawn from each deliverable and analysis linking findings across the deliverables will form the insights contained within the ISSP document.



Key: Complete | Future

Notes
- In parallel work progressing on Strategic APM and EA Tools

12.4

Page No. 3

IS Business Drivers – Problem Statements

High-level Primary Regional Problem Statements

1. **The clinical sustainability and patient outcomes are not optimal**
2. **Information systems need enhancement and improvement**
3. **Regional ways of working are not fit for purpose**

1. Clinical sustainability and patient outcomes are not optimal

Population demographics	• There is net migration into the region, driving general population and volume growth. • Population is ageing and presenting with increased chronic conditions and comorbidities. • There are significant health inequalities across the region.*
Clinical sustainability	• The current delivery models for healthcare are not sustainable to support future demand in terms of quality, access or equity.* • The NZ Health Strategy challenges the Northern Region's models of care to rotate towards new models. • There are unmet needs in the community which the DHBs cannot fund and this gap is expected to widen.
Financial sustainability	• The current operational and financial sustainability of DHBs is under threat.* • There is competition for limited funds, driving tactical investment decisions. • There is a looming risk balloon from poor investments - particularly in IS and facilities.
Social objectives	• There is a lack of understanding of what customers/patients/whanau want, and how they interact with the healthcare system. • Social investment objectives are at an early stage and thinking is still evolving.
Consumer interaction	• There is limited understanding of an 'active' consumer and no systematic capability to drive participatory health. • There is a lack of capability to analyse population health and to understand consumer preferences or behavioural segments. • The lack of mobility reinforces a focus on hospital-based care and existing service delivery settings. • There is no strategy or 'omni-channel' capability that seamlessly tracks interactions across different engagement channels.

Reference Appendix C for the detail behind each problem statement.
* Aligns to the Northern Region Health Plan drivers for change

IS Business Drivers –Problem Statements

2. Information systems need enhancement and improvement

Information management	• There is a need to join information and capabilities across a fragmented system landscape in the form of shared records.* • There are no formally identified 'sources of truth' (systems of record) to inform clinical decision making or prioritise integration across the region • There is low capability to leverage available data for evidence-based decision making (both financially and clinically) and to drive analytical insights • Information governance, data definitions, standards and information ownership and stewardship are immature
Cyber security and protection	• The cyber security risks faced by the region are only partially understood and not well governed. There is no explicit acknowledgement of the risk appetite that DHB Boards are prepared to tolerate and the consequences of making particular investment decisions – or not – with regard to IT. • There are risks around data loss (lack of back-up), confidentiality breaches (ability to pick up data on USB sticks) as well as data corruption across the existing system landscape. As more information becomes digitized, the impact of these risks increases. • External security (hacking, ransom software, etc.) needs to be strengthened and supported by stronger governance
Information Systems	• There has been poor investment in IS which has created a wall of obsolescence • The bulk of IS investment is towards status quo, rather than new capabilities or innovation. • The IS funding model and governance is neither sustainable nor sufficient. • The existing IS landscape is poorly understood and there is uncertainty around the impact of technology trends.

3. Regional ways of working are not fit for purpose

Regional ways of working	• Decision making is slow and cumbersome. • Developing regional business cases (e.g. NEHR) or implementing projects (e.g. CareConnect) is difficult and expensive, due to multiple and duplicative governance forums with unclear decision-rights / accountabilities.

12.4

Reference Appendix C for the detail behind each problem statement.
* Aligns to the Northern Region Health Plan drivers for change

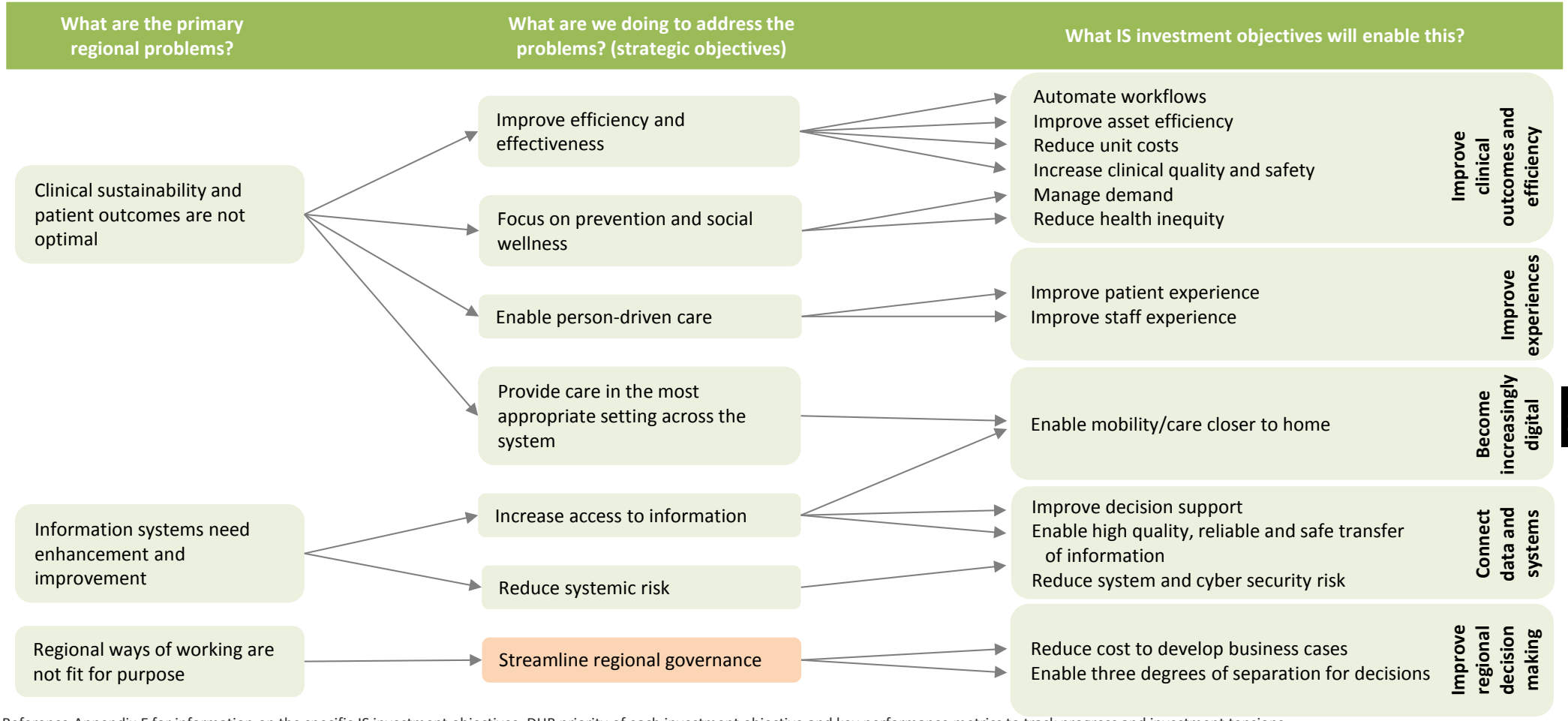
IS Business Drivers: Strategic Objectives

Regional Strategic Objectives	To Achieve…
1. Reduce systemic risk	…a trusted and reliable infrastructure as a foundation for decision making
2. Increase access to information	…informed clinical decision making …a more consistent patient experience
3. Improve efficiency and effectiveness	…better clinical and safety outcomes …effective utilisation of available resources (facilities, staff, equipment, etc.) …more capacity to address the unmet need in the community and increase access to care
4. Provide care in the most appropriate setting across the system	…improved clinical sustainability and patient outcomes …care provided in settings which best serve the patient's clinical and social needs
5. Streamline regional governance	…defined accountabilities …effective decision making processes
6. Focus on prevention and social wellness	…equality in access to care and health outcomes …health across all social environments (schools, workplaces, neighbourhoods)
7. Enable person-driven care	…better understand what people want from their health system …increased access, choice and information about their own care

Reference Appendix D for detail on the alignment to the New Zealand Health Strategy as well as the projects/strategies by DHB which support the regional strategic objectives.

IS Business Drivers: Investment Logic Map

To make the strategic objectives tangible, an IS investment framework was developed. This investment framework will ensure that the funded IS initiatives will address the regional strategies and current problem statements. This provides transparency across the region, as well as optimal value for each dollar spent.



Reference Appendix E for information on the specific IS investment objectives, DHB priority of each investment objective and key performance metrics to track progress and investment tensions

This strategic objective was not provided in the DHB LTIPs or annual plans because this is not a responsibility of a single DHB. However, this is necessary to address the regional problem statements and enable the future success of the ISSP. This subject will be addressed in more detail within the governance work stream of the ISSP to identify efficient organisation structures and decision making processes which could be adopted within the region.

Next Steps

- With the completion of the IS Business Drivers and As-Is Analysis work the programme is moving focus to defining the “To-Be”
- Key focus areas
  - Business Vision
  - Technical Vision
  - Technical Domain Strategies
  - To Be Portfolio Design
  - Financial Model
- These components along with the historic work around IS Business Drivers will be merged into the ISSP document
- Programme expanding the engagement approach instituting a Programme Working Group with a range of regional stakeholders. Additionally proactively informing and consulting with a range of regional forums and stakeholders (DHB IS Governance forums, DHB Exec teams etc)
- Working closely with Northern Region LTIP initiative to ensure alignment

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]
2.1 Confirmation of Confidential Minutes of the Board 7 December 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]
2.2 Confirmation of Confidential Minutes of the Executive Committee of the Board 31 January 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]
3. 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]
4. Confidential Action Points 7 December 2016	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for

		withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Chief Executive's Report	**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]
6. Information and Technology Reports - Nil	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]
7.1 Committee Membership	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **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]
8. Expenditure Approval and Recommendations - Nil	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. Financial Planning Updates - Nil	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]

10. Discussion Reports - Nil	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]
11.1 Human Resources Update	**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]
12.1 Northern Region Long Term Investment Plan	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **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]
12.2 Orthopaedics Update	**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]