Open Board Meeting

Wednesday, 05 April 2017

10:15am

Note:

- **Open Meeting from 10:15am**
- **Public Excluded Session 12.45pm**

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

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Published 29 March 2017

Agenda
Meeting of the Board
05 April 2017

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

Time: 10:15am

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

Agenda

Please note that agenda times are estimates only

10.15am **1. ATTENDANCE AND APOLOGIES**

Sue Waters, Chief Health Professions Officer and Dr Andrew Old, Chief of Strategy, Participation and Improvement.

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?

10.20am **3. CONFIRMATION OF MINUTES 22 FEBRUARY 2017**

10.25am **4. ACTION POINTS 22 FEBRUARY 2017**

5. EXECUTIVE REPORTS

10.30am 5.1 Chief Executives Report

10.45am 5.2 Health and Safety Report

10.55am 5.3 Health and Safety mid-year review: July – December 2016

	6.	**PERFORMANCE REPORTS**
11.05am	6.1	Financial Performance Report
11.15am	6.2	Funder Update Report
	7.	**COMMITTEE REPORTS**
11.30am	7.1	Minutes of the Hospital Advisory Committee
	8.	**DECISION REPORTS**
11.35am	8.1	Auckland DHB Employee Metrics
	9.	**INFORMATION REPORTS**
11.45am	9.1	Human Resources Report
11.50am	9.2	Maori Health Workforce Development Alliance Leadership Team Update
11.55am	9.3	Auckland DHB EPMO and Strategic Programme update
12.05pm	**10.**	**GENERAL BUSINESS**
12.10pm	**11.**	**RESOLUTION TO EXCLUDE THE PUBLIC**
12.15pm		**LUNCH**

Next Meeting:	Wednesday, 17 May 2017 at 10:00am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

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

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

Register of Interests – Board

Member	Interest	Latest Disclosure
Lester LEVY	Chairman - Waitemata District Health Board (includes Trustee Well Foundation - ex-officio member as Waitemata DHB Chairman) Chairman – Counties Manukau District Health Board Chairman - Auckland Transport Chairman – Regional Governance Group – northern District Health Boards Chairman – Health Research Council Independent Chairman - Tonkin and Taylor Ltd (non-shareholder) Director and sole shareholder – Brilliant Solutions Ltd (private company) Director and shareholder – Mentum Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as a shareholder) Director and shareholder – LLC Ltd (private company, inactive, non-trading, holds no investments. Sole director, family trust as shareholder) Trustee – Levy Family Trust Trustee – Brilliant Street Trust	15.03.2017
Jo AGNEW	Professional Teaching Fellow – School of Nursing, Auckland University Casual Staff Nurse – Auckland District Health Board Director/Shareholder 99% of GJ Agnew & Assoc. LTD Trustee - Agnew Family Trust Shareholder – Karma Management NZ Ltd (non-Director, minority shareholder)	17.01.2017
Michelle ATKINSON	Evaluation Officer – Counties Manukau District Health Board Director – Stripey Limited	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 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	16.01.2017

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

Minutes
Meeting of the Board
22 February 2017

Minutes of the Auckland District Health Board meeting held on Wednesday, 22 February 2017 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 9:00am.

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Dr Lester Levy (Board 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 – ADHB/WDHB
Judith Bassett	Fiona Michel	Chief Human Resources Officer
Zoe Brownlie	Dr Andrew Old	Chief of Strategy, Participation and Improvement
James Le Fevre (Deputy Board Chair)		
Dr Lee Mathias	Rosalie Percival	Chief Financial Officer
Robyn Northey	Shayne Tong	Chief of Informatics
Sharon Shea	Sue Waters	Chief Health Professions Officer
Gwen Te Pania - Palmer	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff Present	
	Dr Karen Bartholomew	Clinical Director Health Gain
	Vanessa Beavis	Director of Perioperative
	Wendy Bennett	Planning and Health Intelligence Manager
	Judith Catherwood	Director Community and Long Term Conditions
	Allan Johns	Director Facilities and Development
	Margaret Hammond	Technical Head Haematology
	Rachel Lorimer	Director Communications
	Gil Sewell	Director Organisational Development
	Marlene Skelton	Corporate Business Manager
	Dr Edward Theakston	Laboratory Haematologist
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

Welcome to New Senior Staff Members

Lester Levy welcomed new staff members Rachel Lorimer, Director Communication and Shayne Tong, Chief of Informatics to their first Board meeting.

1. ATTENDANCE AND APOLOGIES

That apology of Bruce Levi, General Manager Pacific Health be received.

2. CONFLICTS OF INTEREST

While there were no conflicts of interest with any item on the open agenda, James Le Fevre wished his employment with Auckland DHB and role as Emergency Medicine Specialist - Adult Emergency Department noted.

Sharon Shea advised that she was now working with Alliance Health Plus PHO to provide strategic advice linked to their strategic planning project and this should be added to her interests.

3. CONFIRMATION OF MINUTES 7 DECEMBER 2016 *(Pages 8-27)*

Lee Mathias asked for a correction to be made to the minutes on page 10 of the agenda under, matters discussed, first bullet point; replace the words "immunisation target" with "Raising Healthy Kids target".

Resolution: Moved Gwen Tepania-Palmer / Seconded Judith Bassett

That the amended minutes of the Board meeting held on 7 December 2016 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS 7 DECEMBER 2016 (*Page 28)*

There were no current action points to report on.

5. CHAIRMAN'S REPORT

The Board Chair did not raise any matters at this point in the meeting.

[Secretarial Note: Lester Levy took item 8.2 next to allow Rosalie Percival to attend to other business immediately following its conclusion.]

6. CHIEF EXECUTIVE'S REPORT *(Pages 29--46)*

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

- That there had been a collection of events that had portrayed the hospital in a good light around the time of the Ministers visit to meet stroke treatment clinicians and patients in relation to stroke retrieval techniques. Simultaneously two complimentary articles in the Listener and North and South were published about the hospital.
  Lester Levy commented that the clot retrieval service was a very good example of collaboration. This instance carried some cost; any savings from the service longer term did not accrue to Auckland DHB but to the home DHB and services outside health. There needed to be a move toward paying for outcomes to address this situation. It was likely that as a result of this service that the whole stroke pathway for the region would significantly change.
  Ailsa Claire commented that as a result 24/7 interventional radiology would be required. In a hyper acute stroke service such as this these patients need to be returned to their home DHB as quickly as possible. That can be a challenge, particularly if the home DHB does not have a bed available. Auckland DHB is left managing this patient at further cost.
  Jo Agnew commented that a focus needed to be provided around reciprocal services. While Auckland DHB did Stroke well other regional DHBs may well do something else

better than Auckland DHB which should be taken advantage of. Ailsa Claire advised that Auckland DHB had already begun looking at what it was not doing well in order to have that very conversation on a regional basis.
Lester Levy commented that this was why every paper before the Board needed a metro Auckland lens applied to it in order to identify such opportunities. Real collaboration depends on properly working together to identify where a serious premium around service can be found.

- Sustainability in the health sector was the topic of this year's Sustainability Symposium held on 8 December 2016 at Auckland City Hospital. Auckland DHB had made a 13% reduction in carbon emissions over the previous year.
- As part of the Auckland City Mission Christmas Appeal nearly 11,000 food items were donated by staff. The hospital is also involved in some continuing work with the City Mission where support is being provided to their GP practise and advice given around the make-up of food parcels.
- The celebratory events and musical offerings in the weeks before Christmas under the banner of "Ka Pai Whanau" had made the hospital a nicer place for both staff and patients.
- 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. This will have a major impact on both staff and the organisation. It is a significant undertaking and as with all new ventures there is associated risk, but this is being managed. Lester Levy stressed that if Board Members were contacted directly by staff in relation to this or other staffing issues that they were to refer them directly to the Chief Executive or the Chief Human Resources Officer. By law all delegated employment functions rested with the Chief Executive.

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

Carried

7. COMMITTEE REPORTS - NIL

8. PERFORMANCE REPORTS

8.1 Health and Safety (*Pages 47-107)*

Sue Waters, Chief Health Professions Officer asked that the report be taken as read, highlighting points from the report summary on pages 47 and 48 of the agenda.

The following points were covered in discussion:

- Doug Armstrong noted that the proposal for a repeat deep dive review or audit of Auckland DHB Health and Safety systems is under development and was referred to

in draft Terms of Reference in appendix 7 on page 106 of the agenda. He wished to know who was carrying out this audit and when it was due. He strongly suggested that this information needed to be included in the resolution to be passed.
Sue Waters advised that an RFP process was required to be undertaken before contracting any firm or individual to undertake this work.

- Lee Mathias asked what was in place to target those areas and staff within the organisation that were not adhering to policy. Sue Waters advised that a period of grace was allowed for groups to improve their behaviour before action was taken. Behavioural and emotional change would not be able to be measured until the employee engagement survey was repeated in 18 months two years- time and this would highlight areas that still required a focus.
- Advice was given that at the time of being employed, individuals were asked what impairments they may have. However, many did not see themselves as impaired so a true record was not available. In relation to safety in the workplace Fiona Michel advised that the strategy around "three promises" was applied equally to staff as it was to patients.
- Sue Waters advised that in terms of the site security risk outlined on page 55 of the agenda that this was a part of the "Security for Safety" programme and a risk assessed approach had been employed for dealing with it. During the first year of the programme all high risk areas were being dealt with.
- Lester Levy again raised the issue around indicators and the fact that too much red was being reported. Leading indicators are those that can be influenced and he would like to see more progress with this.
- Sharon Shea commented on the 90% target employed in relation to mandatory e-learning reported on page 51, saying that mandatory meant all and therefore the target should be 100%.

Resolution: Moved Jo Agnew / Seconded Judith Bassett

That the Board:

1. **Receives the Health and Safety Performance report for December 2016.**
2. **Endorses reporting of progress.**
3. **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.**
4. **Notes that an external Health and Safety systems audit is to be completed and reported back to the Board by July 2017.**

Carried

[Secretarial Note: Rosalie Percival at 10.20am returned to the meeting during discussion of the above item.]

8.2 Financial Performance Report *(Pages 108-115)*

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

- The year to date trend has continued with the year to date expenditure favourable to budget by $3M. January has been a good month with the position not deteriorating any further.
- The level of delivery in IDF during January has shown a small recovery, with IDF Inflow revenue, $0.8M, favourable year to date.
- Electives continue to be unfavourable due to the orthopaedic numbers.
- The result has also been impacted overall by additional transplant activity that has been undertaken above the current funded levels. Key to controlling the budget is obtaining compensation for this and a pricing adjustment from the Ministry of Health. A budget bid has been made to Cabinet for additional resource for the next financial year.
- The 'Get on Track" initiatives have continued. The programme was ambitious so further initiatives around back of house functions have been sought and $7M has been found.

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

- Lee Mathias commented on the debt equity swap. Rosalie Percival replied that the focus had been on making sure that the DHB was not disadvantaged by the debt equity swap. Management had been successful in avoiding having to take the full impact of it at all at once. The key consideration now, is that when the DHB needs to invest in growth, how Treasury will view the consolidated balance sheet.
  Lester Levy reminded members that this was a public sector alignment and a mandatory approach.
- James Le Fevre commented that a $4.4M unfavourable spend in outsourced personnel was a big variance and wanted to know how it was made up. Rosalie Percival said that he was right to note this as an area of focus. The variance was mainly in the areas of Medical ($3.1M), Nursing ($1.4M) and Management and Administration ($1.1M) categories and related to covering key roles and gaps in service.
- In general, Rosalie Percival stated, that while delivery on IDF and electives had improved marginally, 20 additional transplants along with the effect of the RMO strikes had impacted negatively on the budget overall.

Resolution: Moved Lee Mathias / Seconded Jo Agnew

That the Board

1. **Receives this Financial Report for December 2016**
2. **Notes the change in Government policy reducing capital charge cost from 8% to 7% and the requirement of all DHB sector debt from the Crown to be converted to Crown Equity.**

Carried

[Secretarial Note: Item 6 was considered next. Rosalie Percival left the meeting.]

8.3 Funder Update Report *(Pages 116-132)*

Debbie Holdsworth, Director Funding asked that the report be taken as read.

The highlights in the report were:

- Health targets – "Raising Healthy Kids". Auckland DHB was sitting at number two nationally, and had received an "outstanding" acknowledgement from the Ministry. We have also recovered the Immunisation target for Q2 however the higher increase for Maori to close the equity gap was encouraging. A focus remains on ensuring the target for the eligible Maori population is met as there remains a gap to close.
- We are making progress with the PHO audit of non-financial reporting. Assuming no material issues are identified, we are on track to have this qualification on the accounts for non-financial reporting removed.
- Auckland DHB 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.

Areas of concern to draw attention to were:

- The planning process governing the setting of the 2017/2018 budget, page 117 of the agenda.
- The ESPI compliance around orthopaedics, page 118 of the agenda.
- The "Better Help for smokers to Quit" target which has not been achieved in the last two quarters and the drop in PHO performance in this area.

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

- Doug Armstrong asked about the equipment failure at a dental clinic in Pukekohe which led to contamination between the suction and compressed air lines. Debbie Holdsworth advised that all Auckland clinics had been inspected and that no risk existed outside of this one clinic. Debbie Holdsworth commented that as a result of the recall of patients it was found that a significant number of children had never been immunised for Hepatitis.

  Lee Mathias commented that it was unclear what level of immunity children have for Hepatitis B and wondered about the need for a catch-up immunisation campaign. Debbie Holdsworth was asked to investigate and report back via the next Funder Report.

  James Le Fevre commented that this raised a general question around the requirement to look more systematically at connection pipes and equipment across

the hospital. Sue Waters advised that the Water Quality Committee took a role in looking at this area and wider related issues.

- Judith Bassett asked whether, in relation to Pacific Health, the Board was maintaining its progress with churches as that appeared to be the main mechanism used to reach the Pacifica population. Debbie Holdsworth advised that while churches had a good reach with the older population and via them, children, there was another demographic that could be reached via sports clubs. Judith Bassett questioned whether this was a sustainable approach. Debbie Holdsworth was asked to investigate and report back via the next Funder Report.
- Lee Mathias commented that while from 1 July 2016 'More Heart and Diabetes Checks' is no longer a reportable national health target, she felt that this was a fundamental area of health care and would like to see measurement continue.
- Doug Armstrong asked whether looking at healthcare consumption by ethnicity might result in a change in approach to budgeting. Dr Karen Bartholomew replied that while health care utilisation is an important indicator, it wasn't the only factor and social determinants have a greater impact on overall health outcomes. Health need, access to care and quality of care are also important. We have invested more resources to address need and improve access in some programmes. For example, research by the Health Gain Team has looked at quantifying what further resource investment might be appropriate to reduce the life expectancy gap for Maori. There is likely to be a good case to invest more to reduce health inequalities.

Action

Debbie Holdsworth was asked to investigate Hepatitis immunisation and report back via the next Funder Report.

Debbie Holdsworth was asked to investigate the current approach for reaching the Pacifica population in relation to health initiatives and report back via the next Funder Report.

That the Funder Update Report for January 2017 be received.

Carried

[Secretarial Note: A 5 minute break was taken and then item 10.2 was considered next.]

9. DECISION REPORTS

9.1 Palliative Care Strategy Update *(Pages 133-137)*

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

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

- Advice given that Inter Rai data was not fully utilised across all of New Zealand as yet. The focus had been on provision of training in its use and implementation of the various tools. An increasing use would be seen in the future which would allow for benchmarking and for the tools to be used to support service planning. This meant that Inter-rai data have not been used to develop the strategy but would be used in the future once the data becomes more readily available.

Resolution: Moved Judith Bassett / Seconded Lee Mathias

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, is active to 2018.**

Carried

9.2 Integrated Palliative Care – Agreement with Mercy Hospice *(Pages 138-141)*

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

- 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 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.
- The role has two main functions, to provide strategic clinical leadership to both specialist providers of palliative care and the wider healthcare sector and to develop new community models of care.

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

- Judith Bassett commented that this was an important move forward as a big gap existed between institutional care and community care. The model proposed here may work in other areas too.
- James Le Fevre raised a question around what would happen in the event of the withdrawal of one of the parties. He was advised that individual employment responsibilities would then come into force. This person reports to Mercy Hospice and while Auckland DHB receives a service, it is not responsible for the employee.

Resolution: Moved Judith Bassett / Seconded Lee Mathias

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.**

Carried

9.3 Audit NZ Engagement Letter – PHO Audit *(Pages 142-145)*

Rosalie Percival, Chief Financial Officer asked that the report be taken as read advising that It had been agreed that it was 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.

Debbie Holdsworth commented, for the benefit of new members, that there had been a qualification on the accounts around accuracy of data received from PHOs. A defined position and agreement is now in place and it was hoped to have the qualification lifted.

Resolution: Moved Doug Armstrong / Seconded Jo Agnew

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 to 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 and appropriate assistance to Audit NZ**
4. **Approves that the Board Chair, on behalf of the Board, sign the attached Audit NZ letter on this audit.**

Carried

9.4 Auckland DHB Authorised Banking Signatories *(Pages 146-151)*

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

Resolution: Moved Doug Armstrong / Seconded Lee Mathias

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 sign:**
    1. **the updated Banking signatories Schedule 1 and 2**
    2. **any forms specific to Banks required to effect Board authorised signatories**

3. **future Schedules 1 and 2, only where there is no change in the Board approved positions but there are staff changes.**

Carried

9.5 Memorandum of Understanding between Child Youth and Family, Police and District Health Boards *(Pages 152-154)*

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

Resolution: Moved Gwen Tepania-Palmer / Seconded Michelle Atkinson

That the Board:
Approves the Chief Executive Officer signing the new schedules for the existing Memorandum of Understanding between Child Youth and Family, New Zealand Police and Auckland DHB.
Carried

9.6 Health and Safety Policies for Approval *(Pages 155-193)*

Sue Waters, Chief Health Professions Officer asked that the report be read, advising that she was seeking approval for 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.

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

- Doug Armstrong was advised that individuals at the time of signing an employment contract were required to divulge any significant health issues. Where the situation changes during their tenure they must advise management. Staff with issues would have their situation and the duties they performed looked at and could be redeployed if required. .

Resolution: Moved Jo Agnew / Seconded Judith Bassett

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**

Carried

10. EXPENDITURE APPROVALS AND RECOMMENDATIONS

10.1 Dispensation Request for Extension of Contract *(Pages 194-207)*

Margaret Hammond, Technical Head Haematology and Dr Edward Theakston, Laboratory Haematologist asked that the report be taken as read.

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

- Doug Armstrong commenting that the order of justification for the extension of the contract should appear at the beginning of the report and in the recommendations. Board members agreed to the amendment of recommendation two to incorporate the reason for the renewal.

Resolution: Moved Lee Mathias / Seconded James Le Fevre

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 for the reason that 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.**
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. The Dispensation notes the market has not changed since the open process for testing the market was undertaken in 2013. Note also the Stago coagulation instrument is the only approved coagulation instrument that can be integrated into the Roche Tracking System currently in use.**

Carried

[Secretarial Note: Item 10.3 was considered next.]

10.2 Perioperative Fleet Instruments 2016/2017 *(Pages 208-224)*

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

Resolution: Moved Lee Mathias / Seconded Jo Agnew

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.**

Carried

[Secretarial Note: Item 9.1 was considered next.]

10.3 Facilities Seeding Variation *(Pages 225-230)*

Allan Johns, Director Facilities and Development asked that the report be taken as read, highlighting as follows:

- The Beca Carter condition survey done last year had revealed significant issues with ageing infrastructure across Auckland DHB which had been exacerbated by under investment during the period 2000-2010. As well as renewing this aged plant there is a need to improve resiliency by adding additional redundancy to some critical systems.
- The business case timeline on page 227 of the agenda shows that the work required has been broken into tranches to better manage risk.
- The initial seed funding capex to initiate preparation of the business case for this project was $300,000. Preliminary work completed under that capex has indicated the need to significantly expand the scope of the renewals and upgrades required. This capex seeks additional seed funding of $1.575 million.
- This places Auckland DHB in a position to seriously step up its remediation programme and obtain the right underlying resources to build the required business cases.

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

- In response to a question in relation to the replacement of a metal roof at Greenlane Clinical Centre it was advised that this piece of work is on the regional capital plan and in general supported regionally.
  Treasury have not expressed surprise at the level of work required. Both Northland and Counties Manukau DHBs have also experienced significant growth. The difficulty will be in affordability of new work. This piece of work is required in order to keep an existing building functioning.
- Sharon Shea pointed out a discrepancy in the amount being asked for between pages 225 and 226 of the agenda. It was agreed that the figure was $1.575M. Rosalie Percival is to provide a breakdown of how the $1.575M is made up.

Action

Rosalie Percival is to provide a breakdown of how the $1.575M capex request for facilities seeding variation is made up.

Resolution: Moved Robyn Northey / Seconded Sharon Shea

That the Board approves

1. **Additional seed funding Capital Expenditure of $1.575 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.**

Carried

10.4 Workforce Central Upgrade *(Pages 231-237)*

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

- 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.
- The technical platform (hardware, operating system and database) that currently supports Workforce Central 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 being requested for a business case for investment in an upgrade 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 Auckland DHB over 5 years of $357,807.
- There are some risks associated with the project and these are outlined on page 234 of the agenda.

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

- James Le Fevre was advised that risk around resource referred to on page 234 of the agenda reflected that there are constraints existing around resource and these need to be mitigated by reprioritisation and reallocation of existing resource.

Resolution: Moved Lee Mathias / Seconded Judith Bassett

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.

Carried

11. DISCUSSION REPORTS - NIL

12. INFORMATION REPORTS

12.1 Human Resources Report *(Pages 238-241)*

Fiona Michel, Chief Human Resources Officer drew attention to the "A healthier community together" booklet that had been distributed to Board members which contained a strategy for the Board for the period 2016 to 2019.

Fiona advised that the key employment issues of concern to her were:

- Obtaining a strong future proof MECA. A good union relationship was needed to achieve this.
- A large volume of employee related issues that were being dealt with
- The extremely manual processes surrounding the payroll and Human Resources systems.

Also of note was:

- The level of collaboration that was occurring nationally; through the national GHR, regionally, with Healthforce New Zealand and with Maori and Waitemata DHB.
- An encouraging collective meeting of unions was held on Monday
- A nationally organised PSA protest in relation to health funding was to travel through 38 locations in New Zealand kicked off outside the Greenlane Clinical Centre this week with a rally and 200 cardboard cut-outs on show.

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

- Lee Mathias asked about overpayments of staff and the role of managers. Fiona Michel replied that training was provided and that the newly introduced managers practising certificate would ensure managers were aware of their personal responsibility. However, it should be noted that part of the payroll is still manual which involved signing of paper forms and the problem would not be totally addressed until an electronic solution was available.
- Doug Armstrong asked about MECCA negotiations Fiona Michel advised about current and potential arrangements. Ailsa Claire commented that she had recently been part of a Ministry sponsored conversation where Unions and employers were challenged to work collectively. This presents a challenge to Unions as they are not

used to working in this way and therefore it is incumbent on DHBs to foster a different relationship with them to make this work.

- Sharon Shea commented that' she would like to see Fiona Michel incorporate comment in the next report on some of the good work that had been undertaken around MALT (Maori Alliance Leadership Team).

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

Carried

12.2 Auckland DHB Employee Survey Results *(Pages 242-246)*

Gil Sewell, Director Organisational Development asked that the report be taken as read, highlighting as follows:

- This was the first organisation wide employee survey undertaken in 20 years
- The participation rate of 57% for the survey was very pleasing
- An analysis of the quantitative and qualitative responses to the survey provides us with a summary of Auckland DHB's strengths and opportunities. Strengths being our purpose, values and objectives are clear to people and individual teams work well together and colleagues are helpful, friendly and welcoming to each other. The areas of improvement are a more visible and supportive leadership and management, more positive behaviours between colleagues and more recognition of work undertaken. Action plans are being developed to deal with these issues.

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

- Lester Levy was advised that it was possible to interrogate the data to unit level to identify opportunities for improvement.
- Members were advised that a lot of organisations allow a two year timeframe to elapse so that action plans could be fully implemented before repeating the survey. There was the opportunity to carry out earlier "pulse" checks in particular areas as required.

Action

Lester Levy asked for a more complete report to be made available to members via Boardbooks resource centre. Those members with an interest in a specific area should let Marlene Skelton know.

Resolution: Moved Judith Bassett / Seconded Lee Mathias

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.**

Carried

12.3 Statement of Performance Expectations (SPE) Performance Report: Q2 2016/2017 *(Pages 247-255)*

Wendy Bennett, Planning and Health Intelligence Manager asked that the report be taken as read advising that since publication some indicators had been updated.

Feedback given that would improve the report:

- It is important to see the quarter by quarter improvements to provide a good picture
- Trend lines are not always useful and could be augmented by showing the last 4 quarters results
- It would be helpful to have a regional DHB comparative report.

That the Statement of Performance Expectations (SPE) Performance Report: Q2 2016/2017 be received.

Carried

12.4 Manawa Tahi Programme – ISSP Update *(Pages 256-265)*

Rosalie Percival, Chief Financial Officer asked that the report be taken as read, highlighting that the purpose of the paper is to update the Board on the progress of the Manawa Tahi (ISSP) Programme and key activities required to complete the ISSP strategy. Both are critical documents for the Board.

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.

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

- Advice that the programme is being led on a regional basis by Geraint Martin, Counties Manukau DHB as Lead CEO with a Steering Group consisting of Dr Andrew Brant, Chief Medical Officer Waitemata DHB, Neil Beney, General Manager Northland DHB, Sarah Thirlwell, Chief Information Officer Counties Manukau DHB, Myles Ward, CEO healthAlliance NZ, Rosalie Percival, Steve Boomert, CEO Procare, Dr Karl Cole, GP and Clinical Lead Integration Technology. The working group for the programme includes all of the Northern Region DHB CIOs.

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.

Carried

13 GENERAL BUSINESS

There was none.

14 ITEMS TRANSFERRED FROM CONFIDENTIAL AGENDA TO OPEN AGENDA

14.1 Committee Membership

(Item 7.1 on the Confidential Agenda)

The Board passed a resolution allowing the decision below and the attached report item 14.1 to be transferred to open agenda.

Resolution: Moved James Le Fevre / Seconded Lee Mathias

That the Board:

1. **Approve changes to the terms of reference for Board committees to make it clear that any number of Board members may be appointed to a committee and that the number of externals who can be appointed (where a number is stated) is a ceiling not a fixed requirement.**

2. **Approve the appointment of chairs, deputy chairs and members of committees and groups, as set out in this paper with one amendment that being the replacement of Robyn Northey for Sharon Shea on the Maori Health Gain Advisory Committee.**

3. **Note that external appointees will be required in most areas.**

4. **Approve the areas of special interest for each Board member, as set out in this paper.**

Carried

15 RESOLUTION TO EXCLUDE THE PUBLIC *(Pages 266-268)*

Resolution: Moved James Le Fevre / Seconded Jo Agnew

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	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage,	That the public conduct of the whole or the relevant part of the meeting would be likely to result in

the Board 7 December 2017	commercial activities [Official Information Act 1982 s9(2)(i)]	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]

The meeting closed at 2.00pm.

Signed as a true and correct record of the Board meeting held on 22 February 2017.

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
22 February 2017 Item 8.3	**Funder Report – Hepatitis Immunisation** Debbie Holdsworth was asked to investigate Hepatitis immunisation and report back via the next Funder Report.	Debbie Holdsworth	Refer to Item 6.2 Funder Report
22 February 2017 Item 8.3	**Funder Report – Pacifica Population** Debbie Holdsworth was asked to investigate the current approach for reaching the Pacifica population in relation to health initiatives and report back via the next Funder Report.	Debbie Holdsworth	Refer to Item 6.2 Funder Report
22 February 2017 Item 10.3	**Facilities Seeding Variation** Rosalie Percival is to provide a breakdown of how the $1.575M capex request for facilities seeding variation is made up.	Rosalie Percival	Completed
22 February 2017 Item 12.2	**Auckland DHB Employee Survey Results** That a more complete report to be made available to members via Boardbooks resource centre. Those members with an interest in a specific area should let Marlene Skelton know.	Fiona Michel Marlene Skelton	Completed

Chief Executive's Report

Recommendation

That the chief Executives Report for March 2017 be received.

Prepared by: Ailsa Claire (Chief Executive)

1. Introduction

This report covers the period from 4 February – 17 March 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 for Science and Innovation, Paul Goldsmith visited Auckland City Hospital on Friday 17 March to launch the 'Diabesity' symposium, held at the Clinical Education Centre. The event was organised by the Healthier Lives and A Better Start national science challenges and the Edgar Centre for Diabetes research at Otago University. The Minister was welcomed with a powhiri, led by Kaumatua David Hillman. Deputy CMO Dr Richard Sullivan represented Auckland DHB. A public forum 'The Cost of Sugar' was held the evening before the symposium, hosted by Kim Hill. Radio NZ intends to broadcast this at a later date.

2.1.2 Auckland Council Visits

Councillor Penny Hulse visited Auckland DHB on 24 February to open the first Sustainability in the Health Sector Symposium for 2017. Councillor Hulse is Chair of the Environment and Community Committee for Auckland Council. Her presentation focussed on the importance of collaboration between businesses, NGOs, health providers and public sector organisations to transform Auckland into a more sustainable city, in a way that best suits the need of the community.

2.2 DHB Board

Board members James Le Fevre, Michelle Atkinson, Judith Bassett, Lee Mathias, and Robyn Northey, were updated on Auckland DHB's Security for Safety programme during a visit to Auckland City Hospital on Wednesday 8 March. The Security for Safety programme was established to ensure the personal safety of all our staff, patients, whānau and visitors, and strengthen overall security across all DHB sites. Board members were shown the new CCTV coverage and occupational violence button in ED, the local lockdown capabilities at CFU, and the upgrade to security and new access control at the Co Gen Bike Park. They also visited the upgraded security control room, including a demonstration on the ability to lock down areas and the virtual guard capabilities.

2.3 Patient and Community

2.3.1 Acknowledgements

Human Rights Commission 2016 Good Employer Report

An analysis of 91 Crown entities across New Zealand saw Auckland DHB among those ranked equal-first for compliance with 'Good Employer' principles for the second year. All crown entities are required annually to outline their employment practices to the Commission, who reviews their performance across a range of benchmarks. The 100% result is testament to the dedication and achievement of our people, and the work we have done together to build a strong sense of purpose, values and objectives within the organisation.

Human Rights Commission
Te Kāhui Tika Tangata

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, 280 emails were received. Forty 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 82 requests for information, interviews or for access from media organisations between 4 February and 17 March 2017. Media queries included requests for information about hospital parking facilities, a request from The Listener to interview a clinician about

essential tremor, and a query about orthopaedic waiting times. We have also been working on a feature to highlight the quality and personality of our nurses in Paperboy magazine.

Approximately 29 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 27 Official Information Act requests over this period.

2.4.2 Internal

- Three CE blog posts were published, one on opportunities going forward in the New Year, one on our organisations sustainability goals, and one on our People Strategy.
- 30 news updates were published on Hippo the DHB intranet.
- Six eNova (weekly electronic newsletters) were published.
- An 'In the Know' session took place on 23 February, with approximately 110 managers attending. The next sessions will be held on 6 and 7 April.

2.4.3 Events and Campaigns

Certification audit

The 2017 certification audit for our inpatient services was undertaken between 28 February and 3 March. A team of 20 auditors visited our inpatient facilities and undertook 12 in-depth patient tracers, one on medication safety and one on infection prevention and control. The auditors gave some great feedback and singled out the areas they saw as us doing particularly well in. These included: MOS (our Management Operating System), Releasing Time to Care, our Values work, cellulitis, using the hospital wisely, our approach to quality improvement, rapid rounds, discharge planning, and communication. The patients and families/whānau who were interviewed made very positive comments to the auditors about the care that they or their family members were receiving. This feedback is well-deserved recognition of the efforts our people make every day to care of their patients. Final results from the auditors are expected at the end of March.

Cleaners Graduation

A graduation ceremony was held at Auckland City Hospital on 12 March to celebrate the achievement of almost 60 members of our Cleaning Services team who have completed the NZQA Certificate in Cleaning, a nationally recognised qualification. It was a great pleasure to attend and thank our cleaners for the essential contribution they make towards providing a safe and healthy environment for our patients, visitors, and staff. A second cohort is currently undertaking the training.







New Safety Management System (Datix)

More than 380 managers have been trained on our new Safety Management System (Datix), which is on track to go live in April. The new system centralises risk management and incident reporting across the DHB, and will make it easier for staff to report incidents and near misses. The new system also provides feedback once the investigation into a recorded incident has been completed, and proactively helps identify incident and risk hotspots.

Conversations that Count

Wednesday 5 April is Conversations that Count Day 2017, a national day that aims to raise awareness about advance care planning, and inspire people to think about, talk about and plan for their future and end-of-life care**.** We are planning events right across Auckland DHB in the weeks leading up to and after April 5 in residential care facilities, libraries, with community groups, and in Auckland City Hospital. We will be encouraging staff and visitors to take the time to think about what's important to them, talk about it and write a plan that can be used in the future if they are unable to tell their care team what they want.

2.4.4 Social Media

- Facebook likes: 4,375
- Twitter followers: 2,872
- LinkedIn followers: 5,676
- Instagram followers: 187

Featured post

The top social media post on any channel during this period was our Facebook post detailing the revolutionary stroke treatment clinicians are involved with at Auckland City Hospital. This single post reached a potential audience of more than 45,500 people with an engagement rate of 6 per cent.

(High engagement rate for corporate/organisational social media accounts is +2 per cent).

Our people

- CV ICU Open Day
- Prof Ed Gane, NZ Innovator of the Year
- Starship Palliative Care
- Local Hero
- Play Specialist Awareness

aucklanddhb

15 likes 6d

aucklanddhb We recently held an open day for all our staff to get a closer look at the amazing work our Cardiovascular Intensive Care Unit (CVICU) team do for patients after heart surgery. There was a CPR challenge and electrocardiogram (ECG) quiz. Our new simulation mannequin Lazarus (Laz for short) was on display as a 'typical' patient after heart surgery and our visitors were invited to check out some of his features including checking his pulses and listening to his 'lungs'. Laz is one of a kind in NZ! #ourpeople #CVICU

Add a comment...

Do you know about the wonderful qualified Play Specialists who work in our hospitals? Play is good medicine – our specialists help normalise the hospital experience, and give kids the chance to make sense of their world and their feelings. When tamariki are given time and space to play in hospital, they become more comfortable in their new environment. This week is Hospital Play Specialist Awareness week. #playspecialist #patientexperience

Organisational

- 100% rating in the 'Good Employer' review
- International Women's Day
- Service for the Queen Mother of Tonga
- Round the Bays – Starship Foundation
- Safekids win at NZ Direct Marketing Awards
- Research predicting premature births

We've received a 100% 'Good Employer' rating for the second year in a row from the New Zealand Human Rights Commission. Our Chief Exec Ailsa Claire is continually impressed with the dedication and achievement demonstrated by all our employees, "What's driven this achievement is each and every one of us breathing life into our values – each and every day." You can read the review here: http://ow.ly/S82G309XfMa #ourpeople #ourvalues

an Rights Commi
Te Kāhui Tika Tangata

Crown Entities and the Good Employer

The Human Rights Commission reviews and analyses the reporting of good employer obligations by Crown entities in their annual reports. It also...

GOOD-EMPLOYER.HRC.CO.NZ

Happy International Women's Day everyone! We'd like to say a huge thank you to each and every woman who works at Auckland DHB and contributes to growing the health and wellbeing of our communities. Women make an amazing contribution to our organisation, behind desks and documents, from our wards, labs and operating theatres, to our boardrooms and leadership team. We're immensely proud that women hold so many of the places on our Executive Leadership team and our Board. #InternationalWomensDay

Patient experience

- First kiwi mother and baby to undergo in-utero surgery for spina bifida
- #patientexperience letters
- Starship stars stories

Watch the amazing story of the first kiwi mum and baby to undergo surgery for spina bifida while still in the womb http://ow.ly/4ZNz309gEOG #kiwifirst #maternalfetalmedicine

Ground-breaking NZ first: Kiwi baby undergoes surgery for spina bifida...

Kiwi mum Catherine Harper and her husband faced a tough decision, for their unborn child with spina bifida, but a team in Aussie have given them an...

TVNZ.CO.NZ

"My mum has just had brain surgery on a ruptured aneurysm and what can I say. The doctors and nurses are amazing! Can't thank them enough. Just so happy she's getting better." - K. #patientexperience #familyexperience

Public health alert or education

- Flooding safety and weather warning
- World Kidney Day
- Healthy eating tips
- Healthpoint – Find a GP
- Auckland Walk Challenge
- Aki hauora – Māori language app

Want to find a Korean speaking GP in Kingsland? Did you know that with Healthpoint you can search for family doctors by opening hours, languages spoken, suburb, gender and more #healthinfo http://www.healthpoint.co.nz/doctors/

GPs (General Practitioners) • Healthpoint

A general practitioner (GP) provides medical care in the community and will usually be your first point of contact. Fees are lower if you are...

HEALTHPOINT.CO.NZ

Today is World Kidney Day! A healthy lifestyle will help keep your kidneys healthy. Your kidneys or tākihi are amazing vital organs which sit near the middle of your back. The main job of your kidneys is to remove toxins and excess water from your blood. Kidneys help control your blood pressure, produce red blood cells and keep your bones healthy http://ow.ly/CjSA309IZC2 #move4kidneys

Au
Bo

Campaigns

- Sit less, move more
- Rheumatic Fever
- SafeKids home safety #makeyourhomeasafetyzone
- Melanoma Awareness
- Immunisation
- 100% water
- Baby teeth matter - Child oral health
- Health star ratings

Recruitment

- Weekly round-up of new job postings
- RMO and Medical student career sessions

2.4.5 Our People

Local Heroes

24 people were nominated for Local Hero awards in February and March.

Robert Mustart, Project Manager was chosen as our February local hero.

A colleague who nominated **Robert** said: "Robert has been the project manager for the lino installation in the paediatric cardiac outpatients department. He has been fantastic, and has proficiently liaised with myself as ward manager and all other stakeholders. Nothing has been a problem and any arising issues have promptly and professionally dealt with. He has made what can be a potentially stressful process, smooth and efficient. He is always at the end of the phone and made himself fully available to us, despite having other projects running concurrently. The area has been transformed, and his hard work has made the area much more welcoming for our patients. He is a credit and asset to the Auckland DHB team, and is definitely our outpatient area local hero."

Our March local hero was **Desmond Frost,** Orderly.

The patient who nominated **Desmond** said: "I am a staff member and had never considered what role an orderly plays in patient care apart from wheeling them to and from procedures. Last week I ended up as a patient on one of the surgical wards. I had the absolute pleasure to meet Desmond. He came and introduced himself, explained where I was going and had a large smile. He was concerned about my comfort (ensuring I was warm enough) and my patient privacy (keeping my notes face down and asking if I would like the curtains pulled around me when I arrived at my imaging destination), especially since I was a staff member. His kindness was very touching. After the procedure he saw me waiting to be taken back to the ward and followed up to ensure an orderly had been arranged. I will never discount the importance of the kindness and compassion and the unsung role that our orderlies undertake in a patients care journey."

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary[1]

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

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

[1] 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
Shorter Stays in Emergency Departments 95% of patients will be admitted, discharged, or transferred from an emergency department within six hours.	**Auckland DHB**	**93**	**95**	**95**	**95**	**95**	**95**		
	Waitemata DHB	93	95	96	95	97	97		
	Counties Manukau	95	95	96	96	96	96		
	All DHBs	92	94	94	94	93	94		
Improved Access to Elective Surgery The volume of elective surgery will be increased by an average of 4000 discharges per year.	**Auckland DHB**	**93**	**98**	**98**	**101**	**93**	**97**		
	Waitemata DHB	101	101	102	106	105	106		
	Counties Manukau	99	103	105	109	110	108		
	All DHBs	104	105	106	108	105	103		
Faster Cancer Treatment 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks by July 2016, increasing to 90% by June 2017.	**Auckland DHB**	**66**	**70**	**75**	**77**	**79**	**88**		
	Waitemata DHB	74	68	70	75	86	90		
	Counties Manukau	70	72	70	74	75	74		
	All DHBs	69	75	75	74	78	82		
Increased Immunisation 95% of 8-months-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time.	**Auckland DHB**	**95**	**94**	**94**	**94**	**94**	**95**		
	Waitemata DHB	93	95	93	92	94	92		
	Counties Manukau	95	95	94	95	94	94		
	All DHBs	93	94	93	93	93	93		
Better Help for Smokers to Quit 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. (Other targets also exist)	**Auckland DHB**	**85**	**86**	**88**	**91**	**87**	**88**		
	Waitemata DHB	85	88	90	91	87	88		
	Counties Manukau	87	88	89	92	89	89		
	All DHBs	83	85	86	88	87	86		
Raising Healthy Kids 95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017.	**Auckland DHB**	Note: this target replaced ***More Heart and Diabetes Checks*** from July 2016				**79**	**97**		
	Waitemata DHB					83	100		
	Counties Manukau					29	62		
	All DHBS					**49**	**72**		

Source: http://www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing
Quarter 3 results not published as at 21 March 2017.

3.2 Financial Performance

The financial performance for the eight months to February 2017 was a surplus of $4.8M which was unfavourable to budget by $6.2M. This is attributed to an unfavourable result in the Provider arm ($14.8M adverse to budget), which was partially offset by the favourable performance to budget in the Funder arm of $9M and in the Governance Arm ($488K). The year to date result is mainly driven by revenue realised being $10.8M less than planned, with expenditure overall favourable to budget by $4.6M. Less than budgeted revenue is mainly due to under-delivery of additional electives volumes and inpatient services (subject to wash-ups at year end), less donation funding (due to timing) and less financial income (due to lower interest rates than assumed in the plan). Favourable expenditure is mainly in the Funder NGO payments ($15M favourable, primarily less demand driven pharmaceuticals and Aged Related Residential Care services costs), which fully offset unfavourable expenditure in outsourced personnel costs ($6M); clinical supplies costs ($4.5M) and infrastructure/ non-clinical supplies costs ($2M).

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

Work is underway to develop the financial and price volume schedules for 2017/18. However, this planning is being carried out in the absence of full Funding Advice from the Ministry. Funding advice will be provided in May 2017.

4. Clinical Governance

4.1 Development and recognition

4.1.1 National recognition for Professor Ed Gane

Ed is the Kiwi Bank New Zealand Innovator of the Year for 2017. Ed pioneered clinical trials in NZ which contributed to the development of an effective anti-viral treatment for people with hepatitis C. Almost anyone with hepatitis C can now be cured with a short course of medication thanks to this innovation. Effective treatment of hepatitis C means fewer deaths from liver disease, and fewer patients requiring liver transplants. As a result, the World Health Organisation has declared that the world-wide eradication of hepatitis C is possible within 30 years.

4.1.2 Professorship for Jon Skinner

Jon is a paediatric cardiologist and electrophysiologist at Starship Children's Health and has recently been promoted to professor at the University of Auckland. He leads a team unravelling the molecular basis of inherited cardiac disease, discovering genetic abnormalities that identify children and young people at risk of sudden cardiac death thus allowing for preventive treatment, and improved clinical outcomes. Jon also chairs the Cardiac Inherited Disease Group and runs the NZ-wide arrhythmia service for people with congenital heart disease.

Health and Safety Performance Report

Recommendation

That the Board:

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

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: Please note the score card has been reformatted to place similar lagging indicators together. This will give the reader an opportunity to evaluate associated KPIs for a specific Health and Safety system. Improvements to be noted: the percentage of local Health and Safety inductions registered has improved. This is related to reminders going to the areas regarding the non-registrations. There is still a huge opportunity for improvement. Also note that the target has been increased from 80% to 100% as requested by the Board. Welcome Day attendance has now been removed from the KPIs as all mandatory training has been removed from the new format and the KPI is no longer relevant to Health and Safety Induction compliance. Mandatory e-learning (Health and Safety Induction) is at 74% and the target has also been increased to 100%.

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. This plan has now been implemented and the Directorates are receiving con-compliance lists from Health and Safety to be discussed at the Directorate Health and Safety Committee. Improvement in the area will also be discussed with each of the Directorate management Teams as part of the Health and Safety Update Road show during March and April.

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

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

Staff Incidents (employees): 140 incidents were reported by staff in February 2017. This is 8% higher than the number reported in January. Please note the control chart added. The step change in May 2016 indicated where BBFA were added to the count. Twenty one of the February incidents resulted in injury requiring medical care. Eleven 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 rise in the rate is related to the increase in lost time injuries from the previous month. The main contributing factor to the lost time injuries is patient moving and handling. Additional incident investigations are underway to identify the key factors contributing to the increase.

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 February were again 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.

The work plan to implement all of the system improvements required to meet the standards within the new Health and Safety legislation is now substantially complete. The one remaining item is the Lone Working Policy. The policy review has been through a more extended consultation with key

stakeholders and a number of systems will need to be developed to provide consistent risk management for lone workers. There is guidance and a number of tools on the Health and Safety intranet site to support local risk management for specific services. Auckland DHB is consulting with our regional colleagues to identify technology that may assist with monitoring of staff safety while working alone in the community. There is also discussion underway with Counties Manukau DHB in relation to training programmes that they are piloting.

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

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

Health and Safety Performance Report – February 2017

Contents

3. Purpose of Report

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

4. Health and Safety Scorecard for February 2017

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

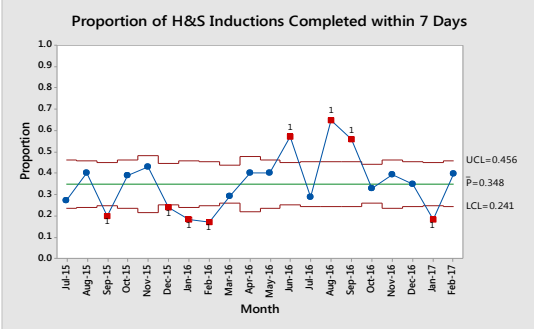
Lagging Indicators

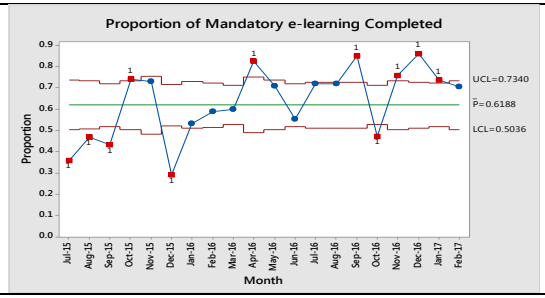
	Actual	Target	Trend
Lost Time Injury Frequency Rate	10	8	
Number of Injury Claims	24	35	
Lost Time Injury Severity Rate	0.44	2	
Lost Time Injury	11	10	
Cost of Injury Claims (000's)	43	80	
Excess Annual leave: % of workers with excess annual leave	9	6	
Number of Reported H&S Incidents			
Staff	140	200	
Contractors	21	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)	1	0	
Workplace Violence and Aggression	0	0	
Patient Handling	10	0	
Lone/Off site workder safety; total recorded incidents and severity	0	10	
Lone/Off site workder safety; total recorded claims	0	0	

Leading Indicators

	Actual	Target	Trend
% local H&S Induction completed	40	100	
% OH&S mandatory e learning completed	74	90	
Number of H&S Representative vacancies	19	25	
% H & S Representative Training	61	80	
% Pre-employment screening completed	90	90	
% Pre-employment screening before start date	98	100	
% Significant Hazard Registers current	75	80	
% completed hazard remediation	RU	80	
Management of Reisidual Risk action plans	RU	80	
% of reported H&S Incidents investigated- 14 days	73	80	
# of outstanding H&S Incident investigations	23	10	
Number of contractor audits completed	38	10	
Level of compliance contractor audits	100	90	
# of Hazardous Substance audits conducted	11	10	
% Hazardous Substance audits compliant	85	80	
Safety Secuity Audits conducted	RU	0	
% training completed in high risk WV areas	76	95	
Health and Wellbring Programmes: new and underway	0	0	
%Employee engagement satisfaction levels	70	0	
Number of staff Seasonal Influenza Vaccinations (YTD)	0	7923	
Contact Tracing (events)	1	0	
Contact Trace (headcount exposed)	4	0	

5. Commentary on Health and Safety indicators exceptions

Indicator	Issue		Action
Local Health and Safety Induction Completed within seven days. Mandatory Health and Safety training required for all new staff.	Some local Health and Safety inductions 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. 56 Health and Safety Reps have attended this training to date. 136 Health and Safety Reps completed Transitional Training for a total of 192 /317 Health and Safety Reps trained under the new Health and Safety legislation.
Number of outstanding Health and Safety incident investigations within 30 Days.	Some managers do not complete the required investigation before the incident is closed by Health and Safety (30 days).		Monthly reports sent to all Directorate Health and Safety Committee chair re: Occurrence reporting follow up non-compliance. Reminders generated with the new Safety Management System will

Indicator	Issue		Action
			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. Recruitment is underway for a Health and Safety Advisor to support this project. A work plan will identify any risks which cannot be controlled; these and any mitigating actions will be reported as a Health and Safety Risk on the organisational Risk Register.
% 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.		74% of new starters completed the training in February 2017. A data base has been developed and reminders sent to managers where Health and Safety Inductions are not recorded.
% Significant Hazard Registers Current	Some managers do not document identified hazards on the Hazard register. Many hazard registers still paper based.		The new risk/incident programme (Datix) 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.

6. Health and Safety Risks

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

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

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

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

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
	carry out all works on the systems upgrade and to carry out future R+M work on all security systems.	down 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
Auckland City Hospital Atrium Walkway	The glass barriers on some of the levels of the Auckland City Hospital atrium walkway are lower than others. The lower	Approval for part of the project was obtained in June 2016.	This risk could result in a death of a person attempting suicide. This is possible but rare. The risk will remain amber until

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
barriers 563RR	barriers allow for 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.	the remediation is completed.
Original Risk			Residual Risk (5x2) 10
Greenlane Clinical Centre Dental Clinic	The design of the glass balustrades allow for people (patients and children) to climb over them.	Facilities and Development have investigated possible solutions using the existing materials. Due to new building regulations a retro fit solution is not possible. New balustrades are required and being quoted. As an interim measure a security guard has been posted in the areas to ensure that no one is allowed to climb onto the balustrade.	This risk could result in a serious injury or death if someone was permitted to climb onto the balustrade. The security guard is in place to mitigate this from happening. This scenario is possible but rare. The risk will remain amber until new balustrades are installed.
Original Risk			Residual Risk (5x2) 10
Slips, Trips and Falls (related to hazards in	Making up almost 25% of our incidents, slips, trips and falls, continue to be one of the most significant hazards as they are	Continue to report trends and liaise regularly with Facilities when repairs are required. Liaise regularly with the	Risk remains at a medium level because of the unpredictable nature of this incident type. Many pieces of work are underway

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
grounds and buildings.) 478RR	with any other industry worldwide.	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.	to minimise physical environment risk.
Original Risk			Residual Risk (3x3) 9

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

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

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)

		height with 75mm full width
		• Building G17
		  ○ x1 close to bus stop on road to Claude Road.
		• Building G16 –
		  ○ x1 at a mid-point between Claude Road Entrance Gate and G15 pedestrian crossing.
		
		Install works anticipated commencement in 2 weeks.
		
		Works to be conducted is the Claude Road Entrance – Install new pedestrian crossing with footpath ramps just above vehicle gates/Gate House.	

Original Risk			Residual Risk (4x3) 12
Asbestos 524RR	There are a number of buildings utilised by Auckland DHB that contain asbestos. The Auckland DHB Facilities Asbestos register requires updating. Contractor compliance with asbestos hazard management is unclear.	Collaboration with Waitemata DHB is underway in relation to asbestos management plan and communication plan. The main Auckland DHB contractors likely to undertake work in areas where asbestos have been identified are required to undertake Asbestos Awareness Training. Building surveys are nearly complete and the Asbestos Management Plan has been	Asbestos in situ is safe if in good condition and not disturbed. The risk remains moderate due to the extent of asbestos in our buildings and the requirement to undertake planned and unplanned work on the structure of the buildings.

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

7. WorkSafe NZ Notifications

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

Staff Notifiable Events (1 July 2016- 28 Feb. 2017)

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

There was no Notifiable Events in February 2017.

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

Notifiable Events/ Incidents (Other Workers)

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

8. Staff Reported Incidents

The number of reported incidents by staff (occurrences) during the period 1-18 February 2017 amounted to 140, an increase of 8 % from last month. Please note that not all incidents result in harm to staff.

Directorate Abbreviations for Table 2:

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

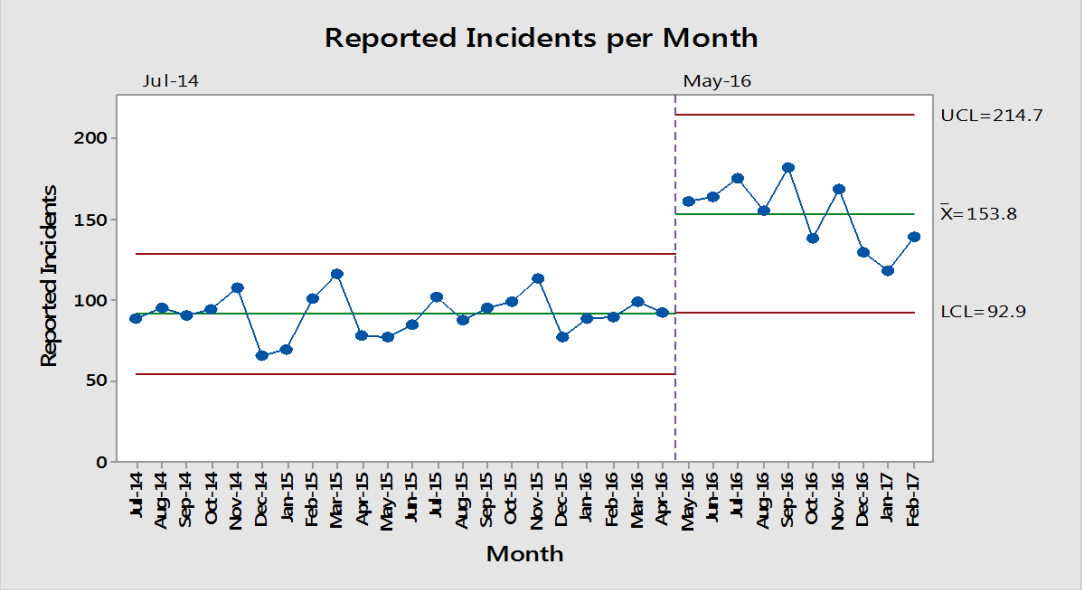


Table 1 – Total incidents reported by staff per month to February 2017.

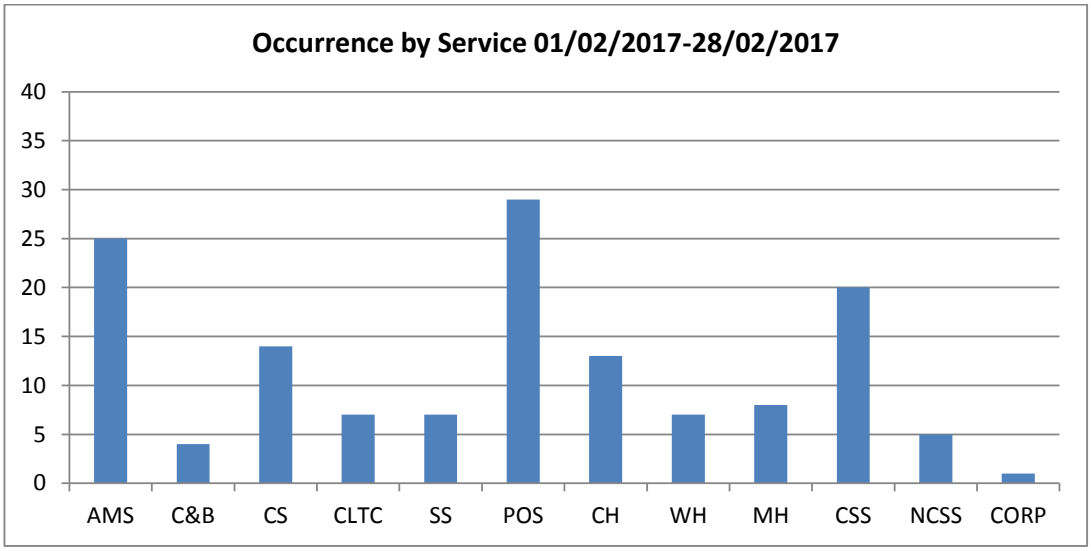


Table 2 – Incidents by Directorate – 1 – 28 February 2017

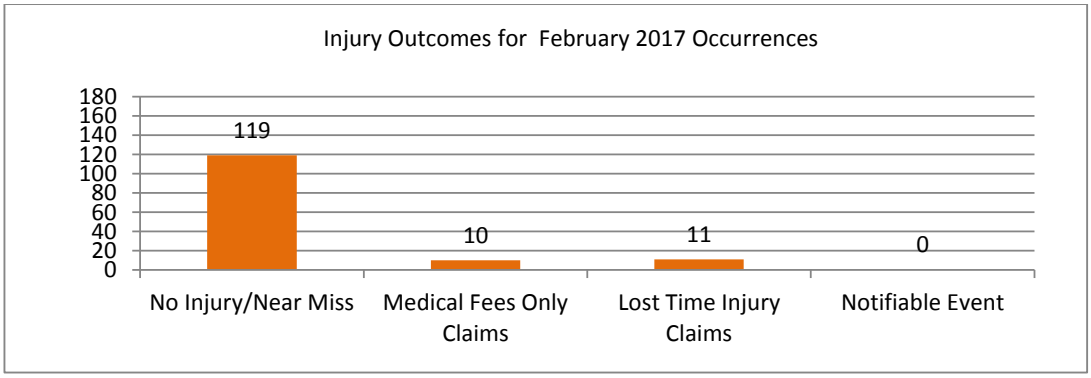


Table 3 – Incidents by Injury outcomes – 1 – 28 February 2017.

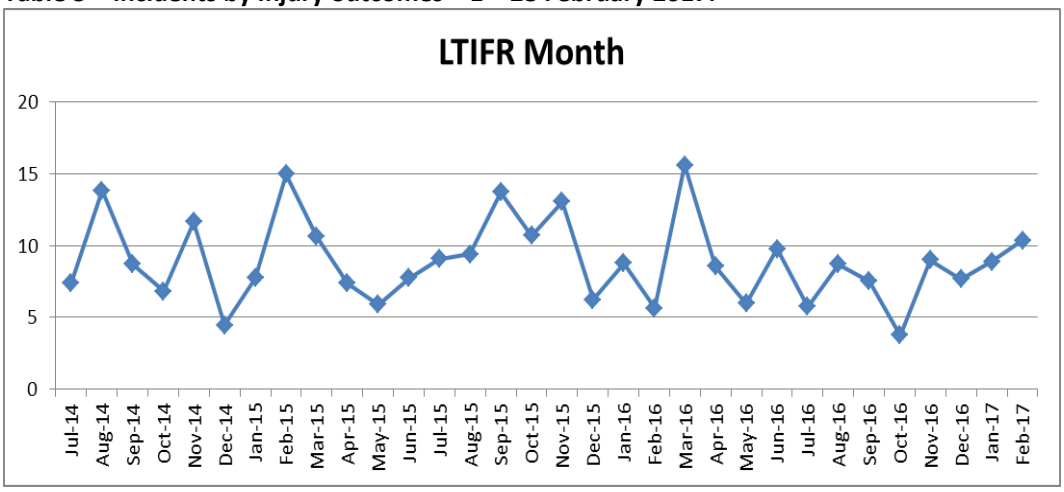


Table 4 – Lost Time Injury Frequency Rate by Month (July'14 – February'17)

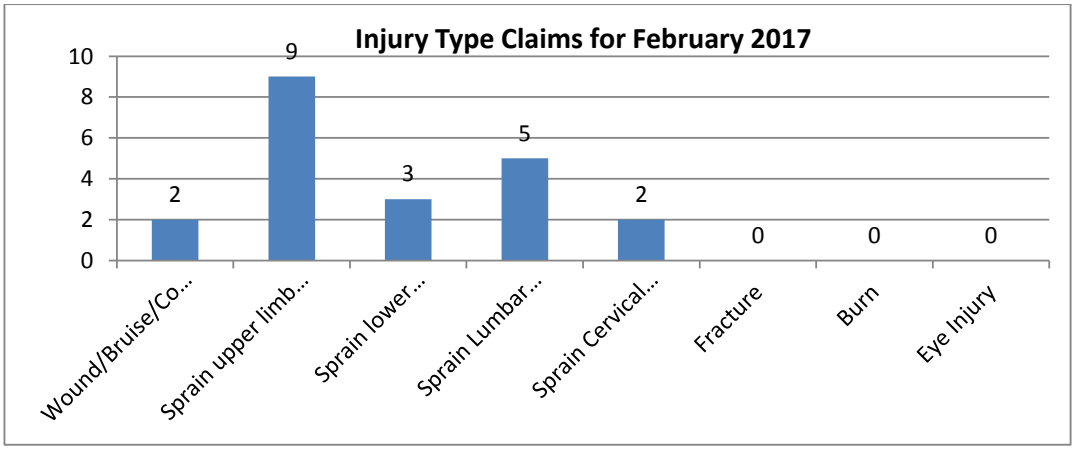


Table 5 - 21 claims by Injury type for February 2017

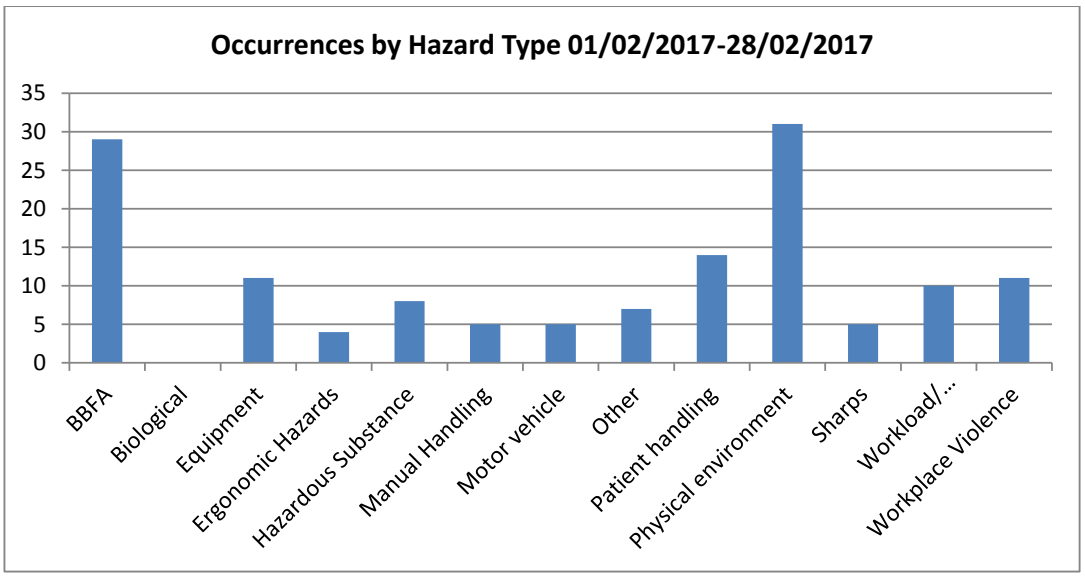


Table 6 – 140 Incidents (Ocurrences) By Hazard Type – February 2017.

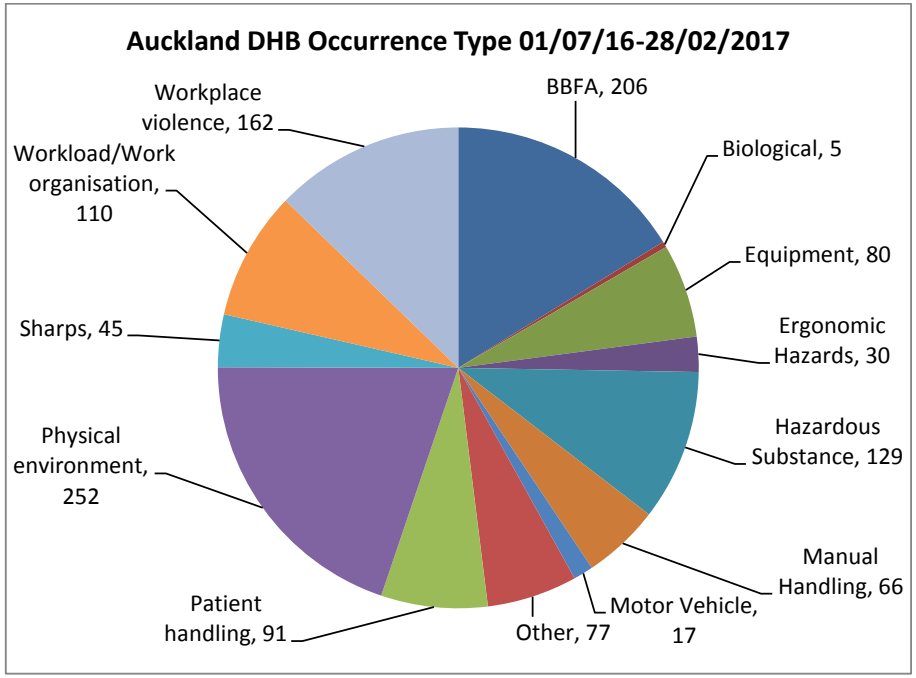


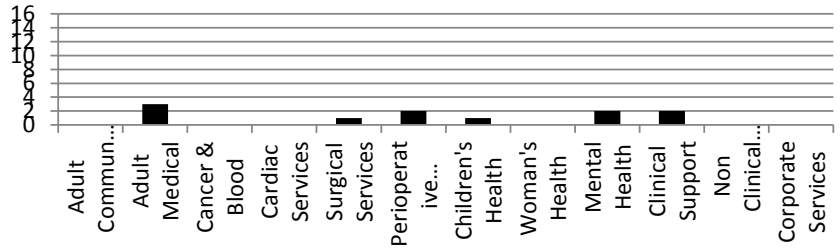
Table 7 – Fiscal Year to date Occurrences by Hazard type (YTD for 16/17 fiscal year).

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

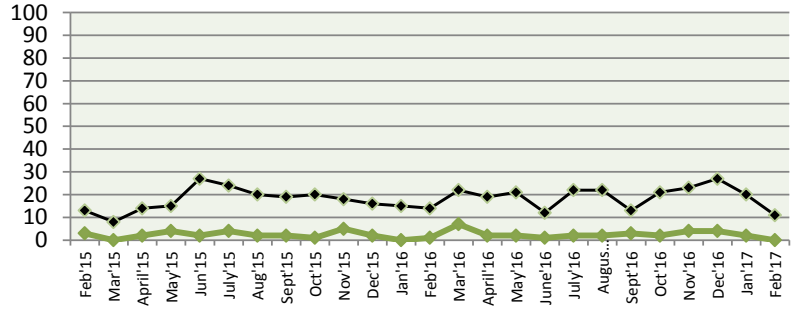
CLAIMS **OCCURANCE**

WORKPLACE VIOLENCE AND AGGRESSION:

Workplace Violence Injuries 01/02/2017 - 28/02/2017

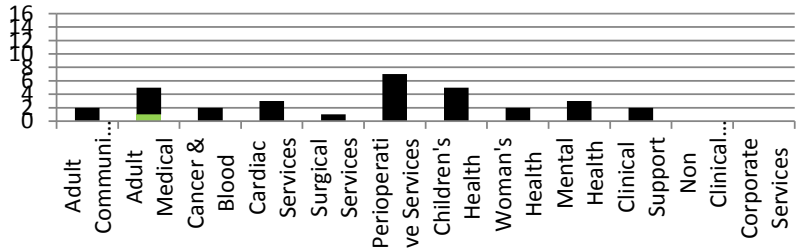


From 2 Year Rolling

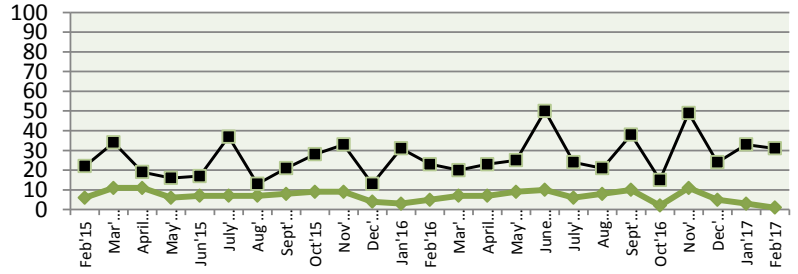


PHYSICAL ENVIRONMENT:

Physical Environment Injuries 01/02/2017 - 28/02/2017

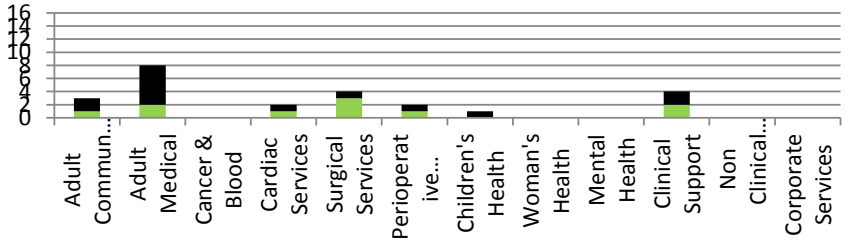


From 2 Year Rolling

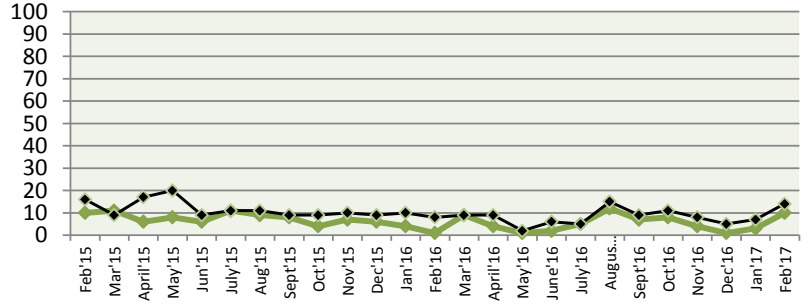


PATIENT HANDLING:

Patient Handling Injuries 01/02/2017 - 28/02/2017



From 2 Year Rolling



10. Health and Safety Activities

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

Health and Safety Rep Training
As per HSWA, external training is now required for Health and Safety Reps. A supplier has been selected and NZQA stage one training scheduled to June 2017. Eight courses are now in KIOSK (February to June 2017). Approx. 160/300 Health and Safety reps are now trained under the new legislation.

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

Managing Safely
The courses for 2017 have been set up in Kiosk. This has been promoted through the Directorate leadership team. Courses are well subscribed for early 2017. Approximately 200 managers have now completed this course.

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

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

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

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

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

Auckland DHB Health and Safety Committees
The Auckland DHB Health and Safety Governance Committee meets six-weekly, chaired by Sue Waters, and last met on 8 March 2017. All Directorate Health and Safety committees continue to meet regularly. Monthly Directorate Health and Safety Reports are provided to support the committees.

Safety Management System (Datix):
Health and Safety is working with the Quality team to implement 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 April.

Auckland DHB Moving and Handling Steering Committee
The Auckland DHB Moving and Handling steering committee chaired by Brenda McKay meets monthly. The Bariatric Bundle trial 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. The Chairperson is Anna Schofield. 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 two vacancies on the Health and Safety Team. Recruitment will continue for two Health and Safety Advisors. Health and Safety Advisor Team Leader position is on hold and current being filled by a contractor.

Deep Dive Audits
A proposal for a repeat deep dive review of Auckland DHB Health and Safety systems audit has now been agreed. See Terms of Reference in appendix 7. Preparation is now underway to undertake this audit in June 2017 with a report to the Board in July 2017.

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

Regional Collaboration:
There are a number of Regional Collaboration activities underway between the three Metro DHBs. Some examples are: Regional Employer Assistance Programme Supplier, Asbestos

Management, Hazardous Substances, the Employee Participation Regional Agreement with the Joint Unions, KoAwatea Learn courses as possible, Safe Practice training in Mental Health Services, Community Safety training, as well as Health and Safety report sharing and alignment as practical.

Auckland DHB 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.

11. Facilities and Development

Health and Safety

Contractor Management

The main contractor working on the Star Ship refurbishment project is Leigh's Construction Limited. They have engaged numerous contractors and sub-contractors to work on this project. Traditionally Facilities would provide an outline of the Auckland DHB Health and Safety expectations with the main contractor, get their key staff to undertake the PAE induction process and then the main contractor would be permitted to 'ring fence the site', engage, induct and manage these sub-contractors.

Given the current HSWA legislation and the fact that Auckland DHB are a PCBU and have a primary duty of care, Auckland DHB are now using the Contractor Management System to capture Health and Safety information on these contractors and sub-contractors and to provide us an oversight of their Health and Safety systems and processes.

The Auckland DHB contractor management process requires contractors to provide a list of sub-contractors they intend to use. Auckland DHB load the details of these contractors into the Auckland DHB Contractor Safety Management System, which sends an e mail link with electronic questionnaire requiring the companies to answer the questions and provide evidence to support their affirmative answers. Basically this system provides a repository for the information provided by contractors.

Another feature of the system is that the contractor's staff (workers) that will be required to work at Auckland DHB are sent a link to undertake the Auckland DHB Facilities on-line induction and quiz. This induction (PowerPoint presentation) provides an overview of the standards and expectations that are required from all people working on any Auckland DHB site.

The contractors will also undertake on-site inductions; in the case of Leigh's they use a combined PAE/ Leigh's induction which reinforces the key messages set out in the Auckland DHB Facilities on-line induction and also outlines the on-site requirements and rules that Leigh's have put in place.

As a quality check Facilities are sent a list of all workers that have signed into the Leigh's project and can compare these names to the list of workers that have completed the on-line induction process.

Auckland DHB Commercial Services are currently also looking at adopting the system so that they can better manage the contractors that they engage. They have been show how the system works and have arranged to meet the IT developer.

Facilities Safety Management System Due Diligence Review/ Audit

Implementing strategies based on the main conclusion's from the review undertaken on a range of the Auckland DHB key contractors will become a focus for continuous improvement in 2017. The report identified 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 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 or HR consultants, Site Safe information and often predominately focused on ticking the boxes to achieve the requirements of the ACC Workplace Safety Management System process. Some organisations had systems that were too large and complex for the size and activity of their activities and risk profile.

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 and/ or advice.

Current Initiatives

A focus for 2017 will be to have initiatives that provide focus, information, practical solutions and ways that the organisations could improve to meet Auckland DHB health and safety expectations and the requirements of the new legislation.

The initiatives that are currently a focus are:

- Facilities are working on an exemplar template to outline the procurement process and provide contractors with an outline and transparency of the Auckland DHB contractor/ contract requirements. The Health and Safety section has been updated to reflect legislation, PCBU duties and key Facilities and Development requirements that apply to all projects.

- Weekly meeting have been set up with the PAE Compliance Administration Manager to critique documentation, systems and vet compliance to required standards. These meetings are also used to ensure that we remain pro-active and focus on emerging or identified opportunities for improvement.

- Gaining a better understanding of the 'day to day' activities and how the contractors are managing any risk that these activities create will become a focal point, especially ensuring that the Auckland DHB/ PAE roles are clear.

- Updating the Permit to Work Process (PTW). Including the Lock out Tag out (LOTO) requirements.

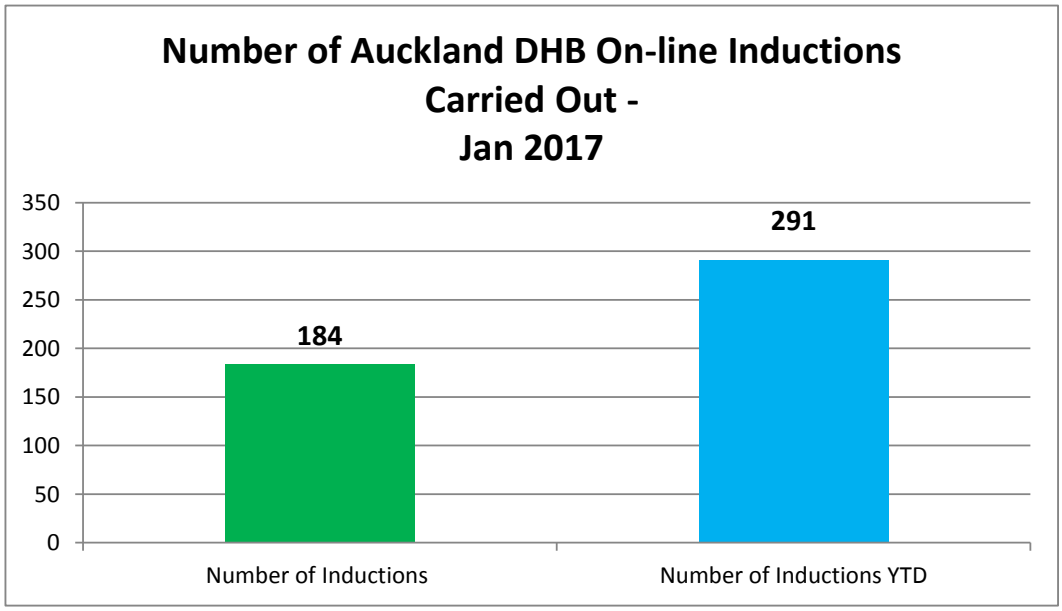
- Modifying the Take 5 process. This process has been well received by the incumbent contractors at Auckland DHB, so the intention now is to 'beef up' the process so that we

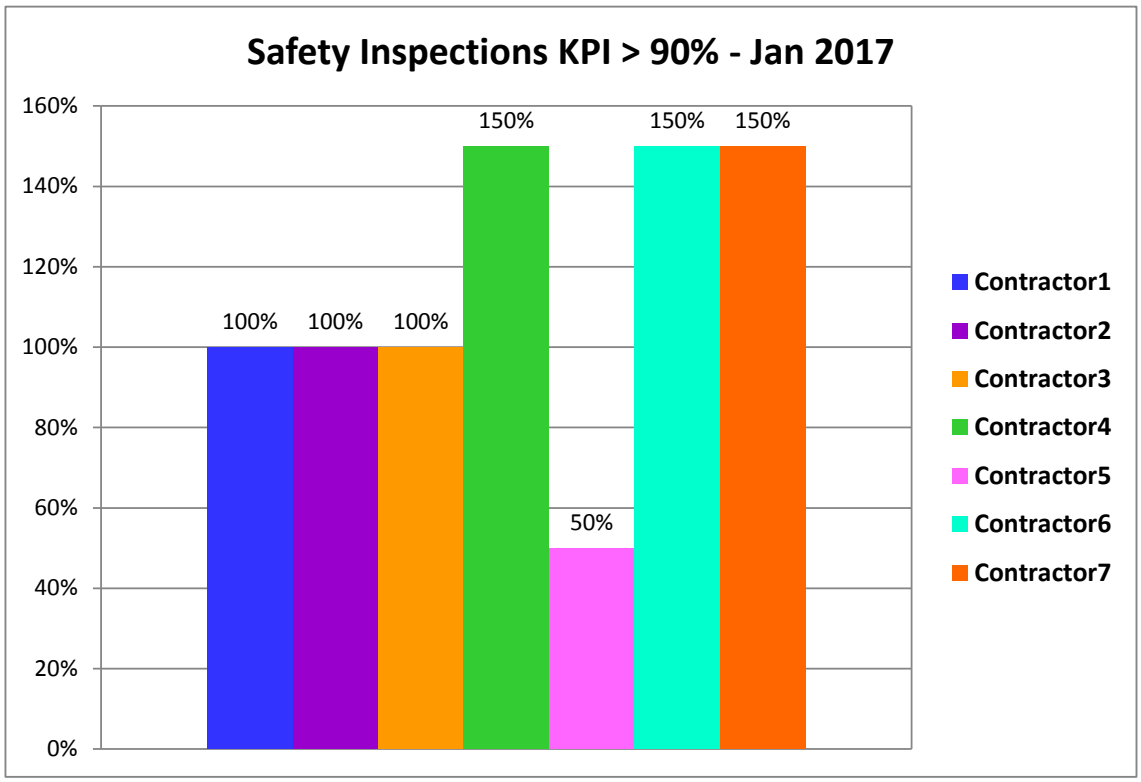
move from just a tick box check sheet to a process that will require the contractors to provide comments and additional information for some of the questions.

Currently Facilities is actively looking for opportunities to ensure that Facilities and Development contractors working at Auckland DHB have followed the appropriate (Facilities) induction process, especially as the Auckland DHB on-line induction and test is a relatively new process.

A meeting has been set up with the security team to see if they can act as a 'gate' when contractors go to apply for a security pass. Another area that is actively managing the status of contractors is the loading docks. Any requests for access to the docks are being vetted to ensure that the people wishing to gain access to the buildings have followed and completed the appropriate Health and Safety induction process

Facilities and Development Monthly Statistics
184 contractors have been inducted onto site during January and the yearly total is now standing at 291 inductions completed for workers physically working on site. This reflects the volume of projects that Facilities and Development are managing especially around Starship.





Contractor 5 have been questioned on their low level of compliance relating to inspections. They have had a change of key staff working at Auckland DHB and the handover process did not work as well as they expected.

There were no injuries reported during January.

12. Directorate Health and Safety Reports

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

Click on Directorate Title to access the report.

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

Adult Medical Services Health and Safety Report

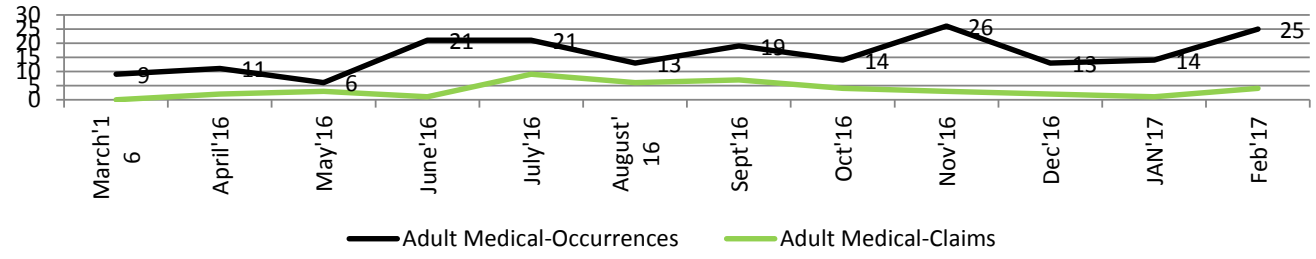
Lagging

	Actual	Target	Trend
H&S Incidents	25	20	
Work Injury Claims	4	0	
Lost Time Injuries	2	0	
Notifiable Events	0	0	

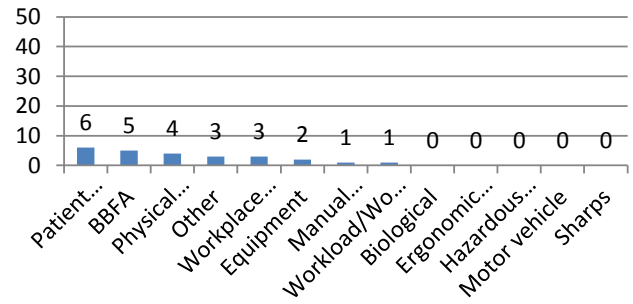
Leading

	Actual	Target	Trend
%H&S Inductions	58	80	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	41	80	
%6 Monthly Workplace Checklist	56	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	67	80	

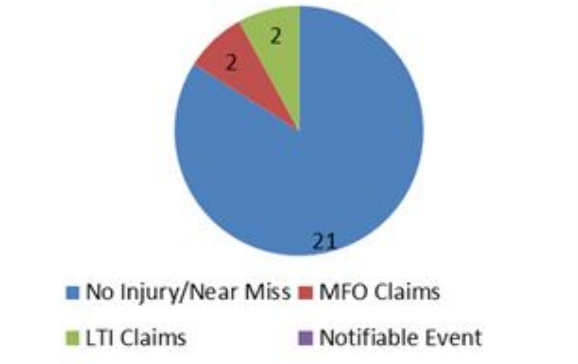
Health and Safety Incidents and Claims for 12 months



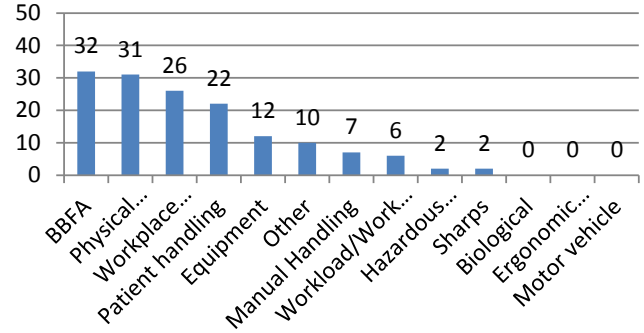
Health and Safety Incident by Hazard Type for February 2017



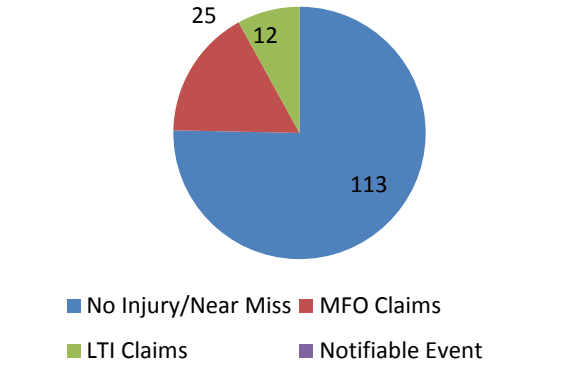
Work Injury by Outcome Type for February 2017



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



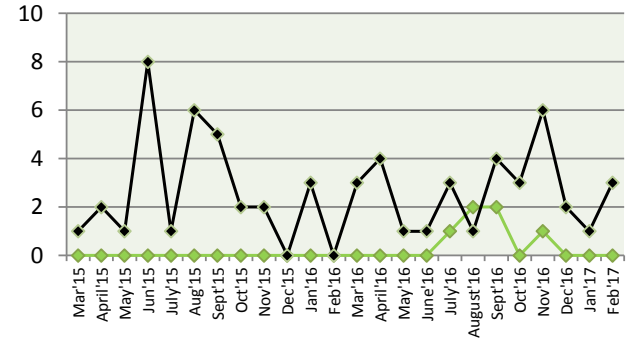
Work Injury by Outcome Type – YTD (2016-2017)



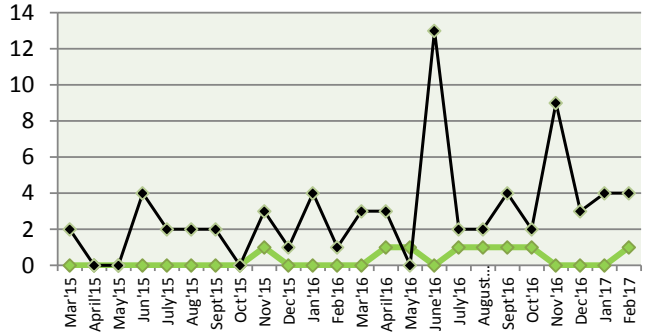
Adult Medical Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

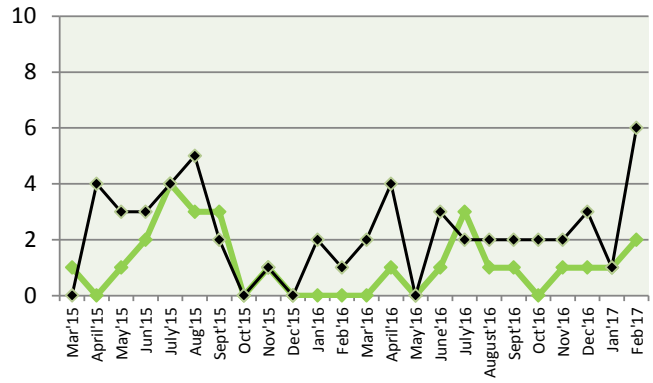
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



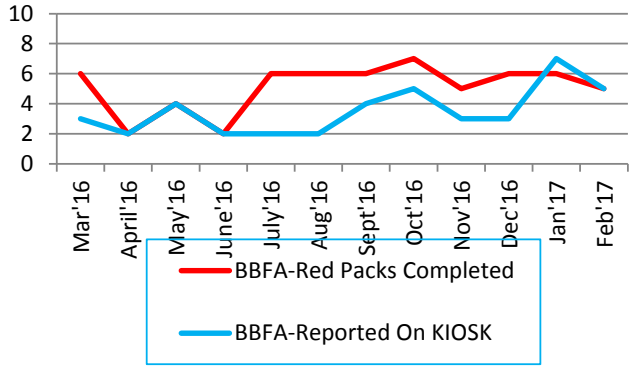
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

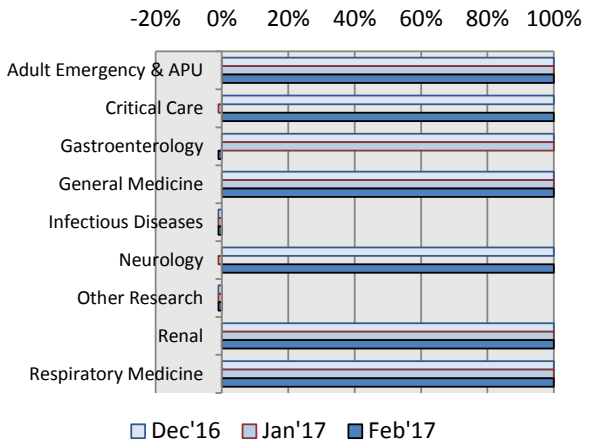


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



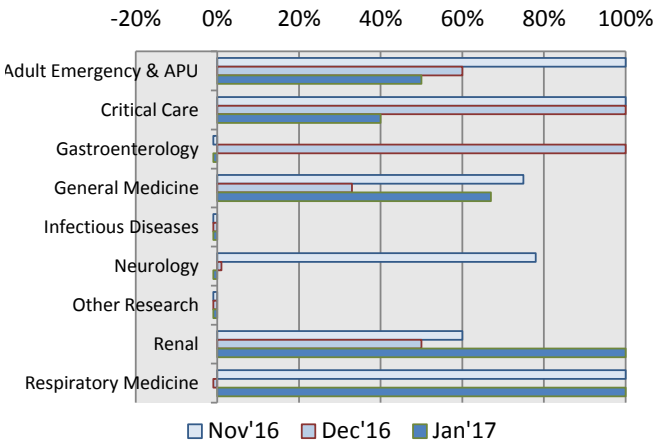
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	November'16	December'16	January'17
80%	80%	81%	67%



Information data accurate as of 6/3/2017

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

Cancer and Blood Services Health and Safety Report

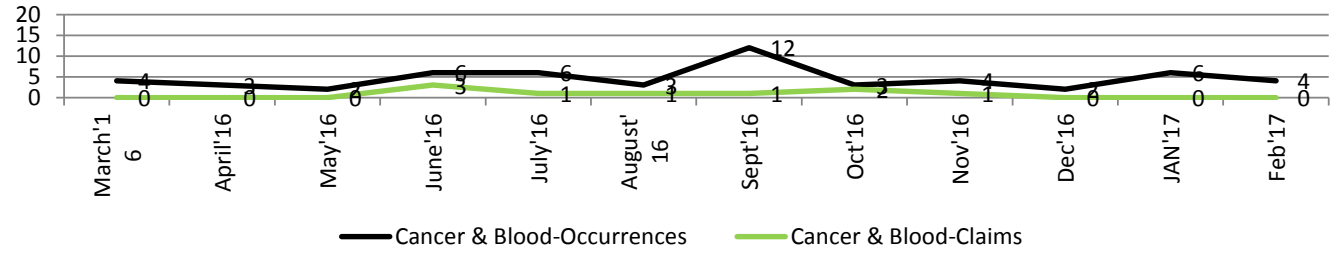
Lagging

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

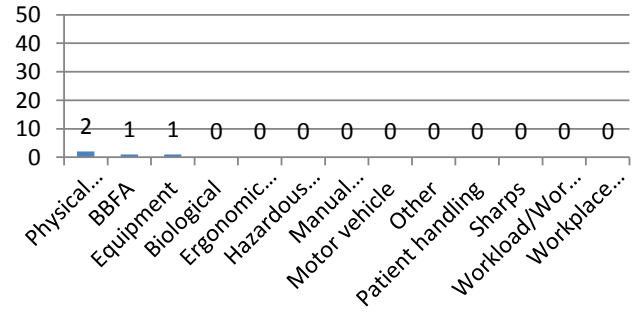
Leading

	Actual	Target	Trend
%H&S Inductions	20	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	20	80	
%H&S Rep Checklist	29	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	67	80	

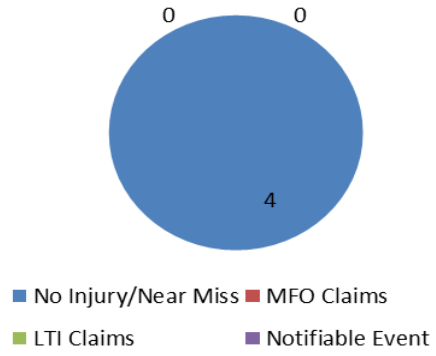
Health and Safety Incidents and Claims for 12 months



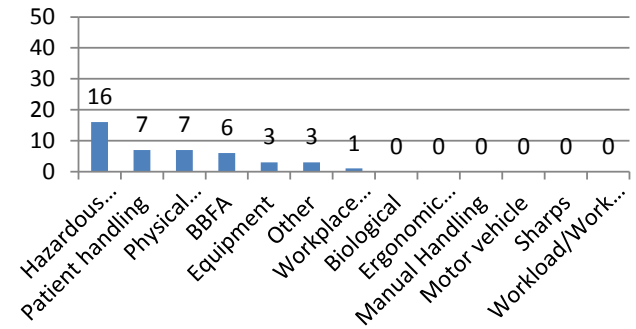
Health and Safety Incident by Hazard Type for February 2017



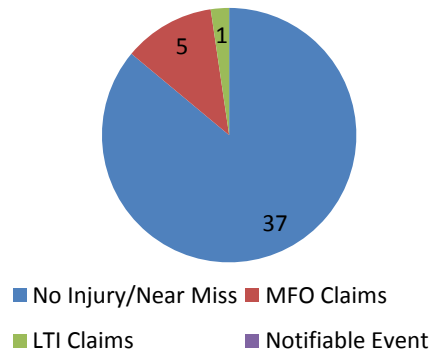
Work Injury by Outcome Type for February 2017



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



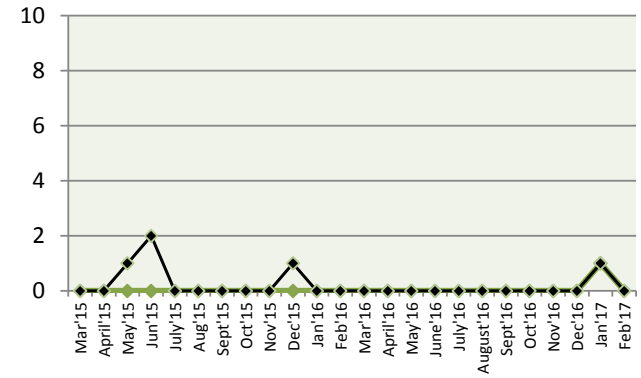
Work Injury by Outcome Type – YTD (2016-2017)



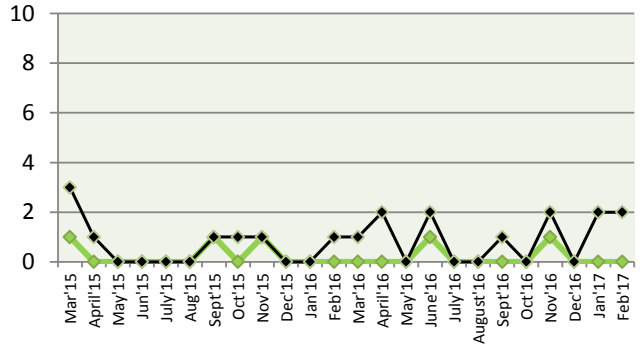
Cancer and Blood Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

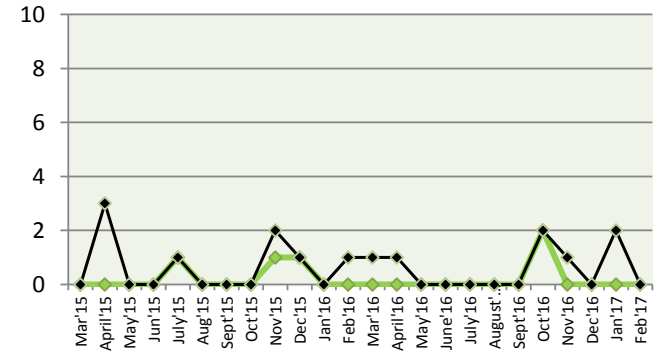
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



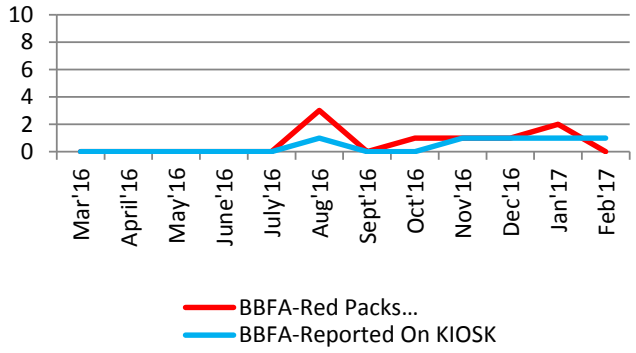
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

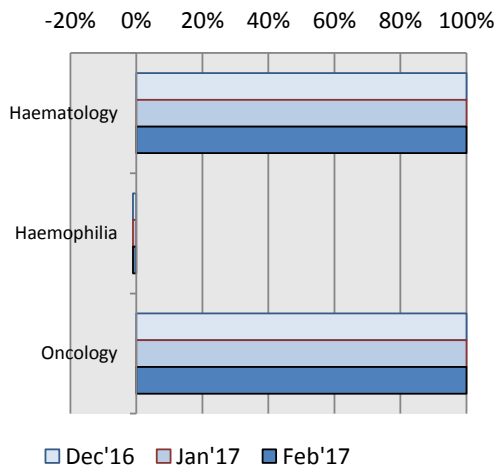


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



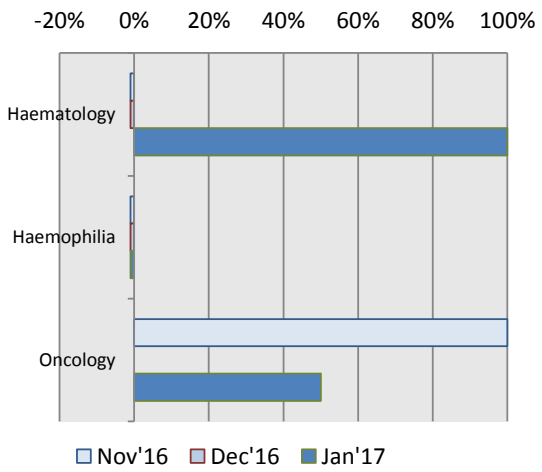
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

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



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

Information data accurate as of 6/3/2017

Cardiac Services Health and Safety Report

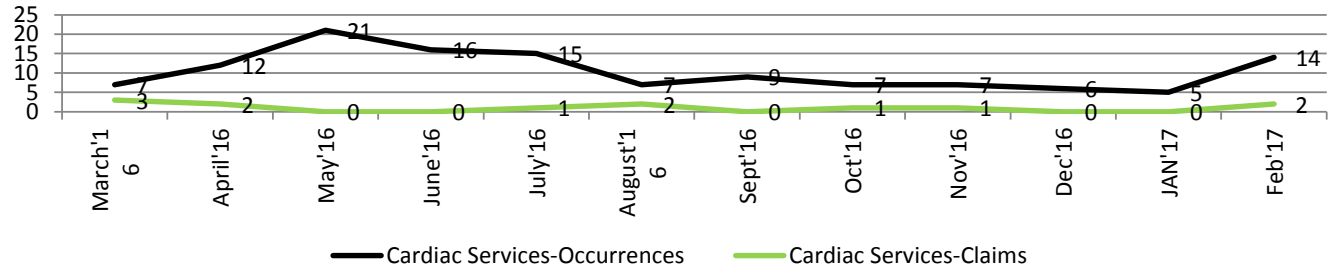
Lagging

	Actual	Target	Trend
H&S Incidents	14	20	
Work Injury Claims	2	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

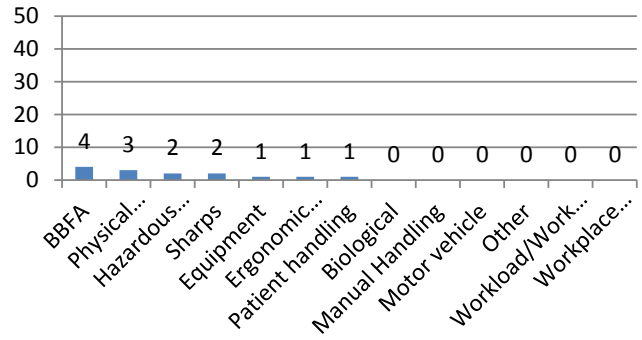
Leading

	Actual	Target	Trend
%H&S Inductions	19	80	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	59	80	
%6 Monthly Workplace Checklist	50	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	60	80	

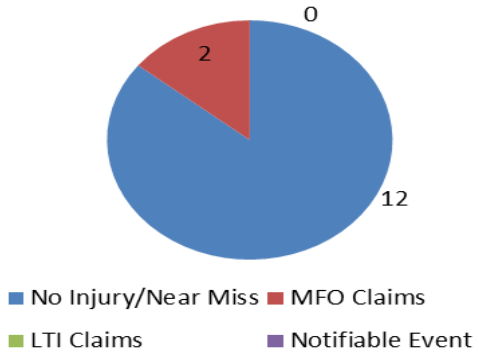
Health and Safety Incidents and Claims for 12 months



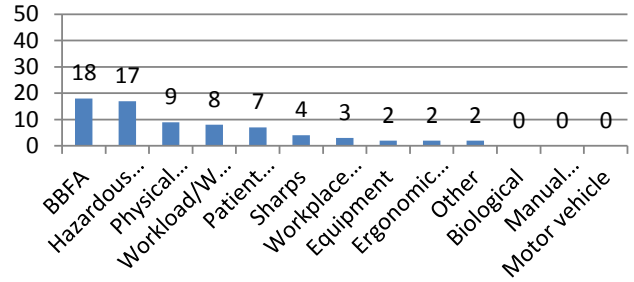
Health and Safety Incident by Hazard Type for February 2017



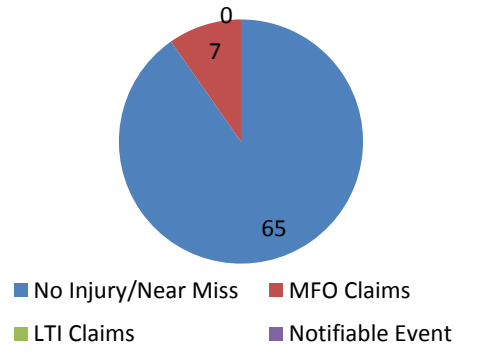
Work Injury by Outcome Type for February 2017



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



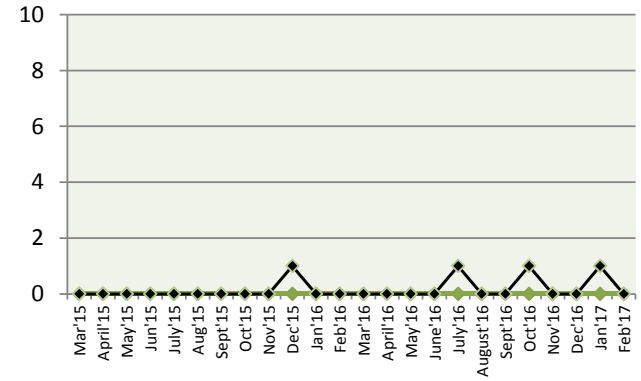
Work Injury by Outcome Type – YTD (2016-2017)



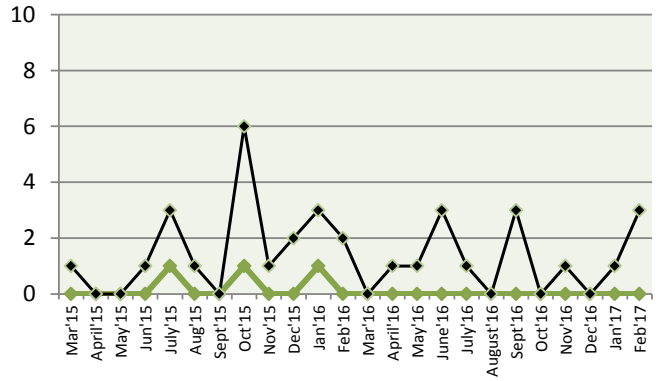
Cardiac Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

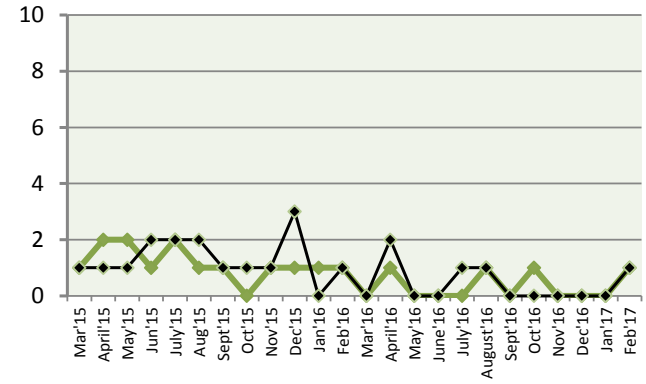
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



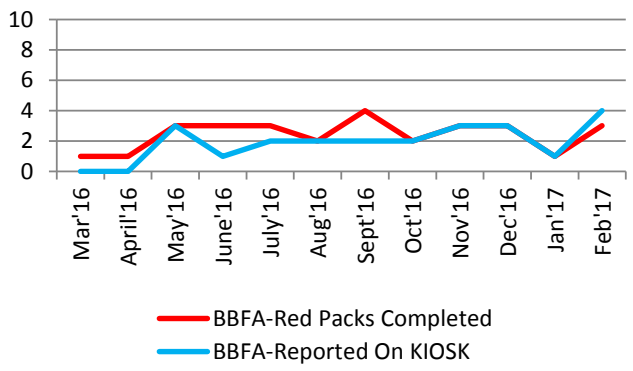
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

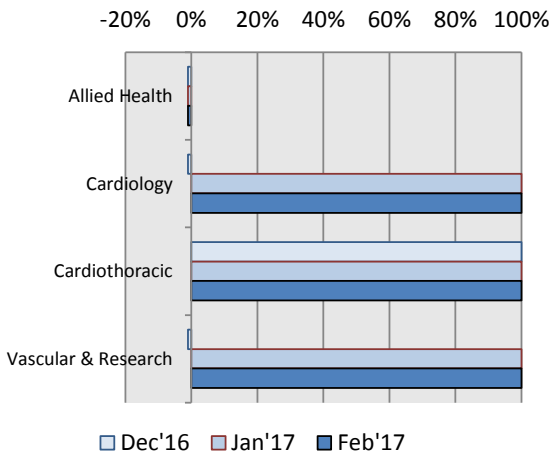


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



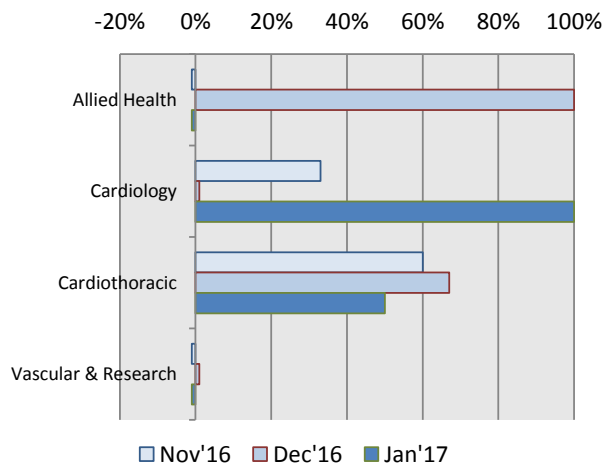
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	November'16	December'16	January'17
80%	78%	50%	60%



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

Information data accurate as of 6/3/2017

Children's Services Health and Safety Report

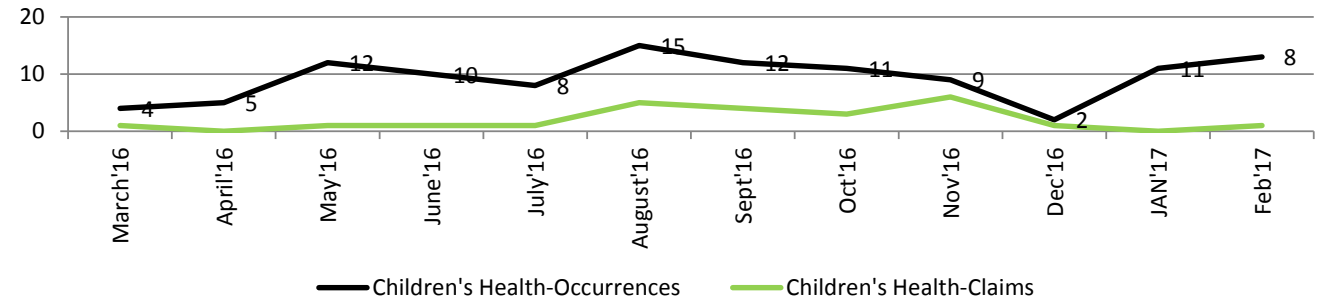
Lagging

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

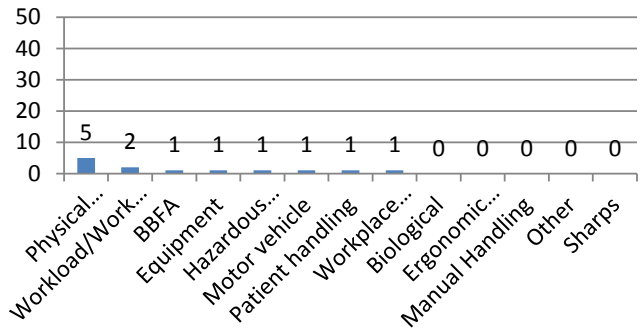
Leading

	Actual	Target	Trend
%H&S Inductions	23	80	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	48	80	
%6 Monthly Workplace Checklist	22	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	69	80	

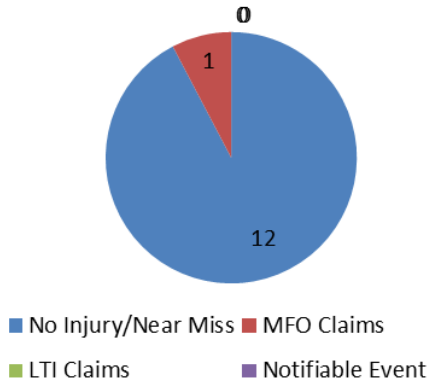
Health and Safety Incidents and Claims for 12 months



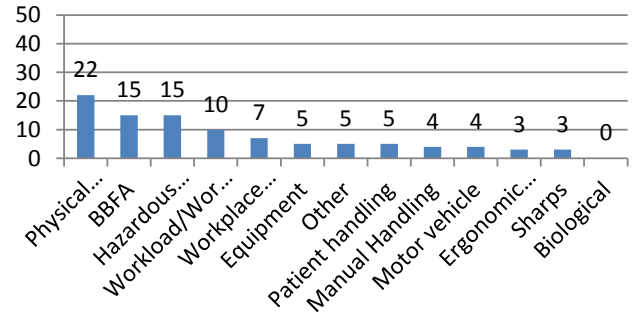
Health and Safety Incident by Hazard Type for February 2017



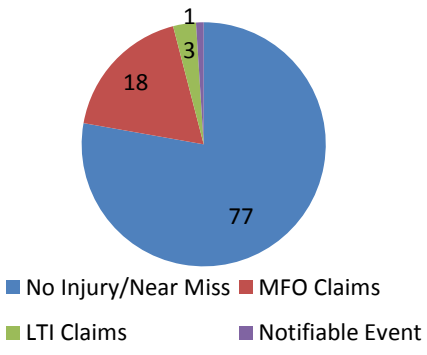
Work Injury by Outcome Type for February 2017



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



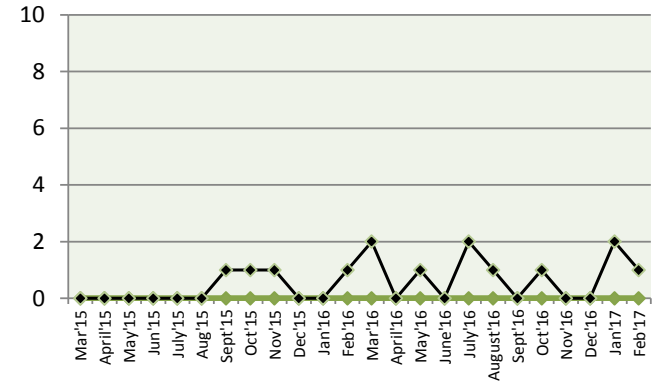
Work Injury by Outcome Type – YTD (2016-2017)



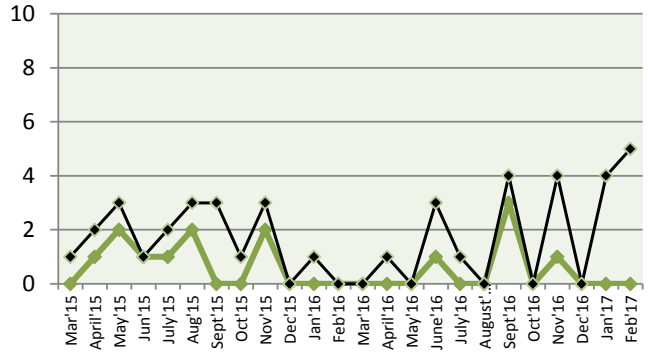
Children's Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

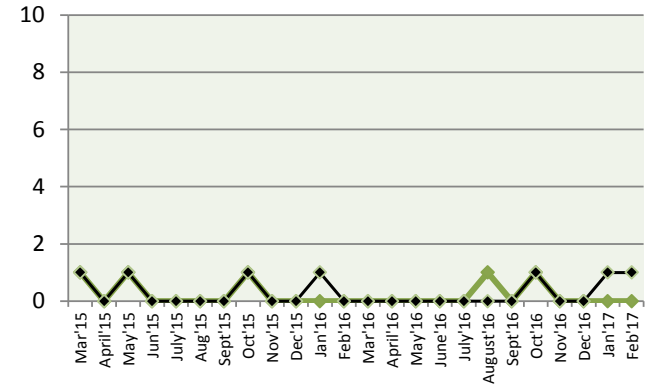
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



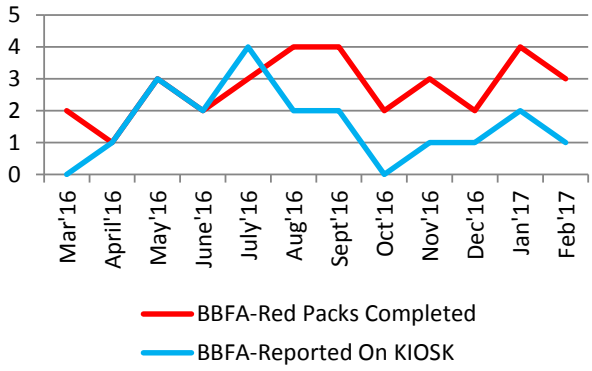
PHYSICAL ENVIRONMENT
((From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

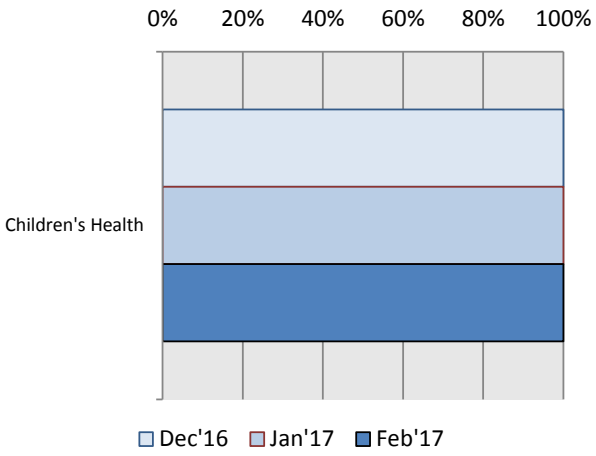


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



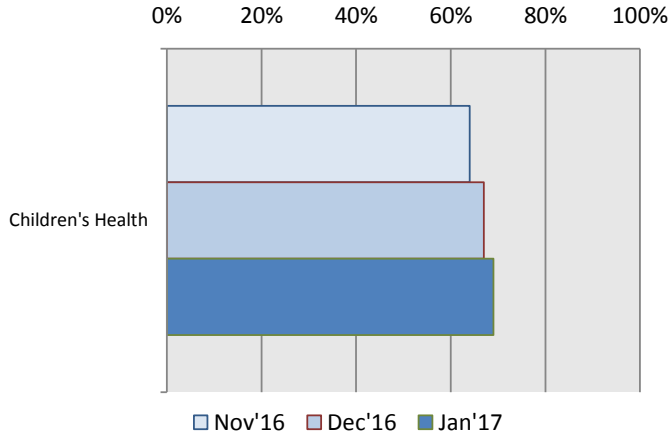
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	November'16	December'16	January'17
80%	45%	64%	69%



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

Information data accurate as of 6/3/2017

Clinical Support Health and Safety Report

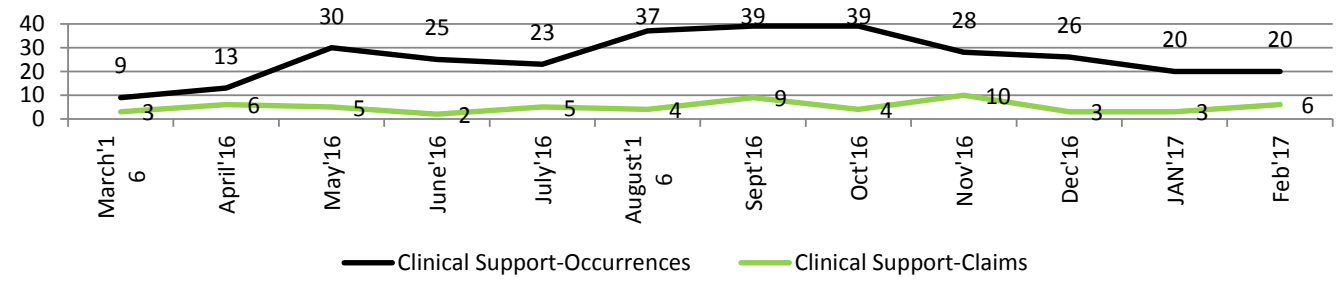
Lagging

	Actual	Target	Trend
H&S Incidents	20	20	
Work Injury Claims	6	0	
Lost Time Injuries	4	0	
Notifiable Events	0	0	

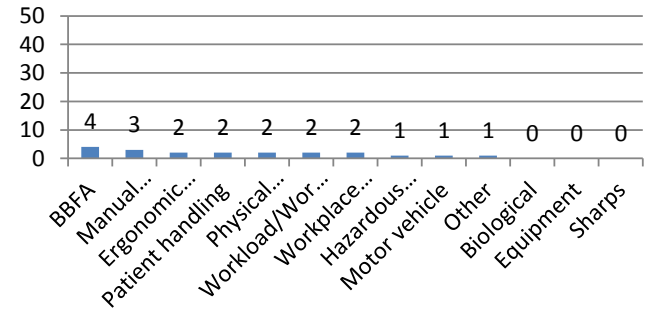
Leading

	Actual	Target	Trend
%H&S Inductions	46	80	
H&S Rep Vacancies No.	8	2	
%H&S Rep Training	67	80	
%6 Monthly Workplace Checklist	30	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	74	80	

Health and Safety Incidents and Claims for 12 months

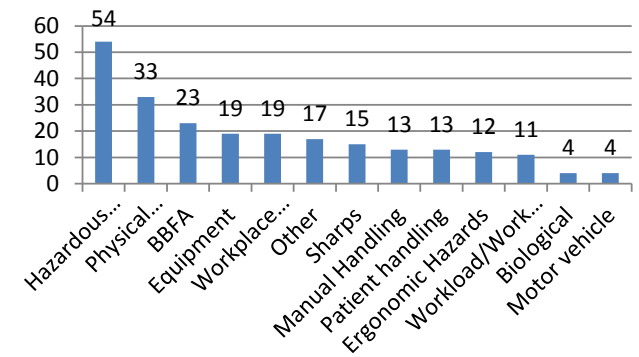


Health and Safety Incident by Hazard Type for February 2017

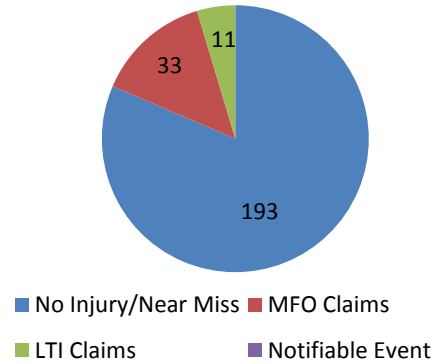


Work Injury by Outcome Type for February 2017

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



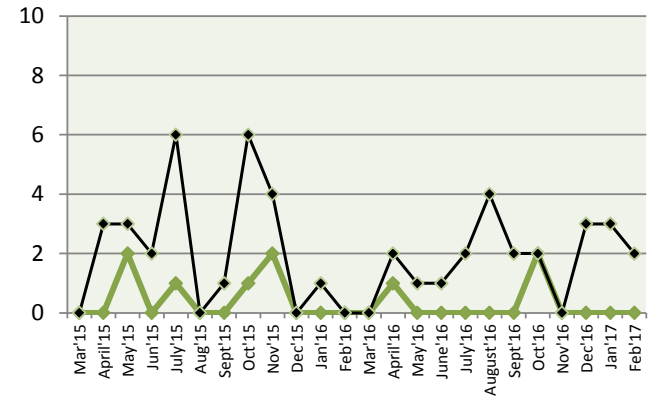
Work Injury by Outcome Type – YTD (2016-2017)



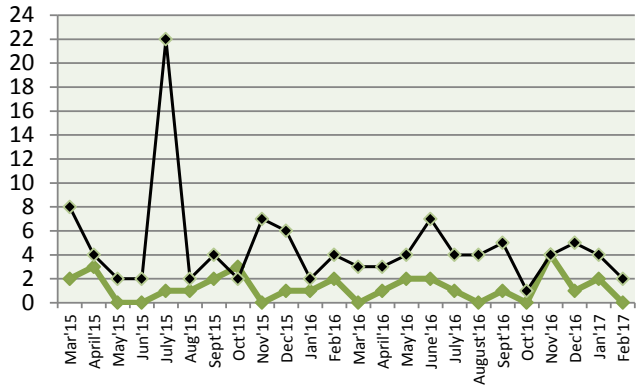
Clinical Support Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

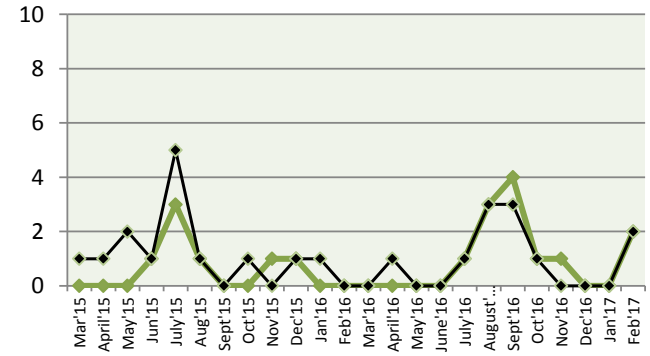
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



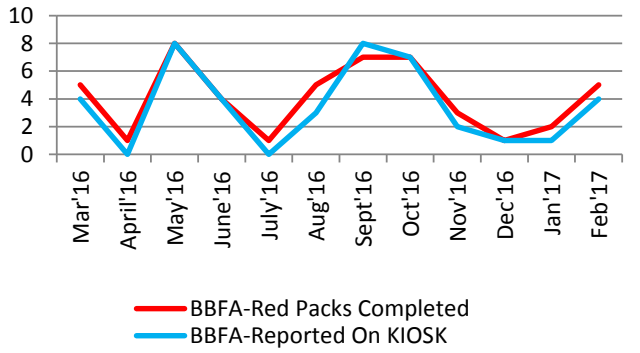
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

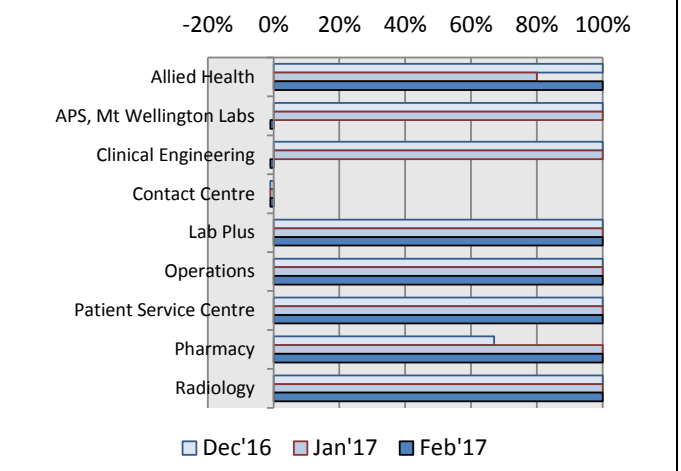


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



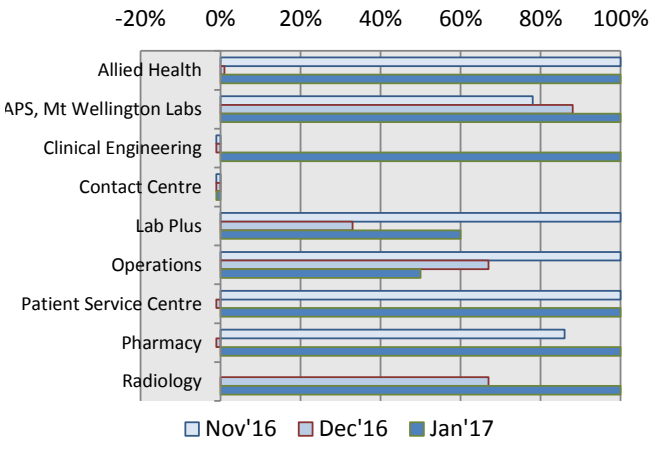
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	100%	98%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	November'16	December'16	January'17
80%	92%	86%	74%



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

Information data accurate as of 6/3/2017

Corporate Services Health and Safety Report

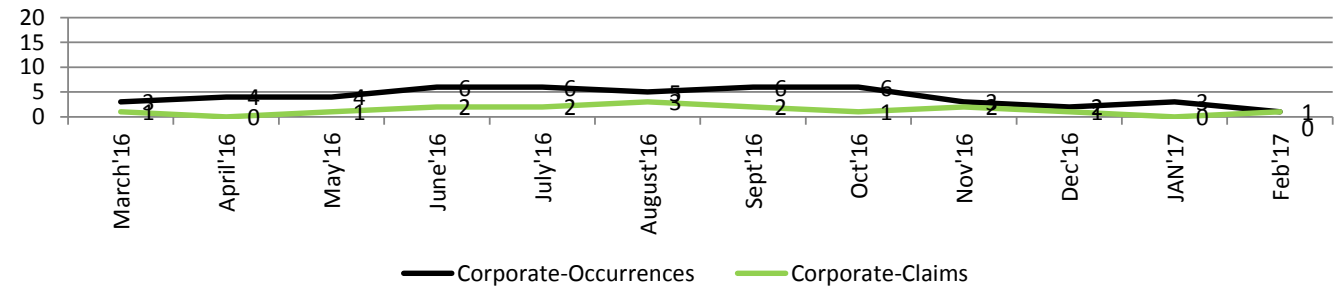
Lagging

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

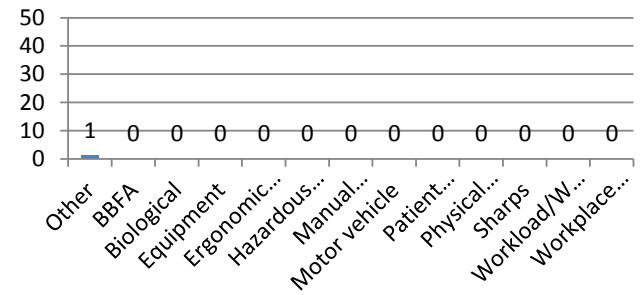
Leading

	Actual	Target	Trend
%H&S Inductions	50	80	
H&S Rep Vacancies No.	2	2	
%H&S Rep Training	63	80	
%6 Monthly Workplace Checklist	25	80	
%PES before start date	92	100	
%H&S Incidents Follow up 14 days	67	80	

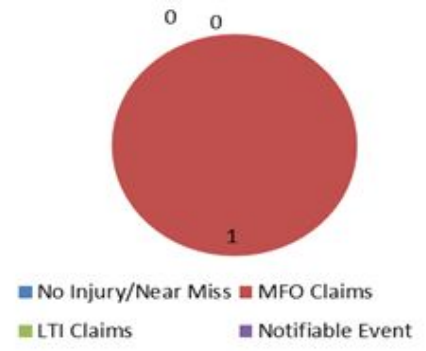
Health and Safety Incidents and Claims for 12 months



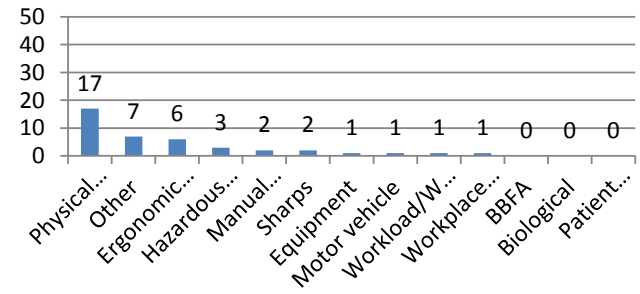
Health and Safety Incident by Hazard Type for February 2017



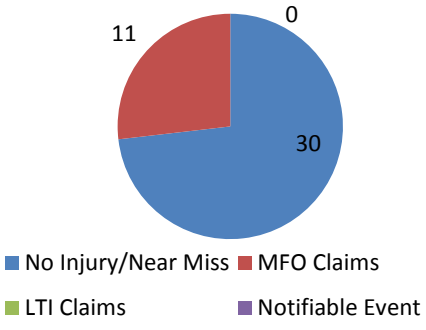
Work Injury by Outcome Type for February 2017



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



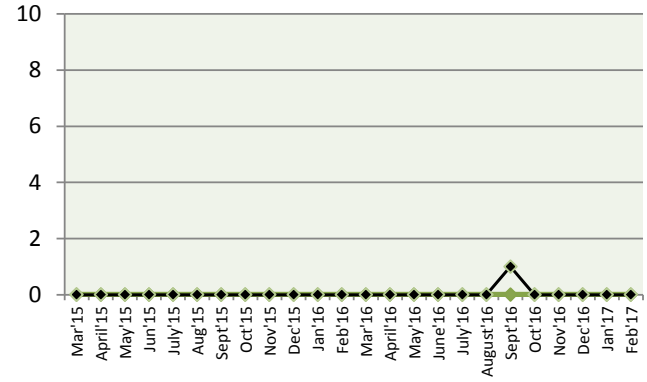
Work Injury by Outcome Type – YTD (2016-2017)



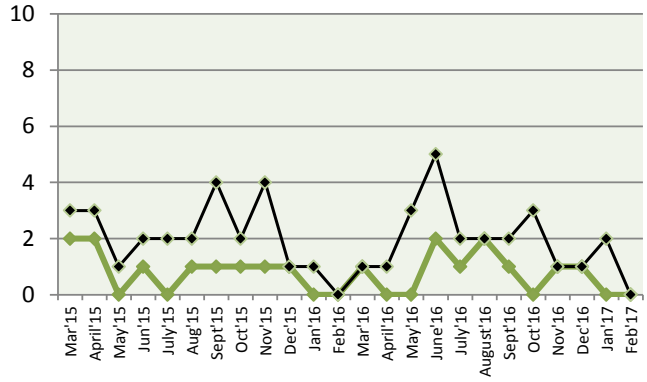
Corporate Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

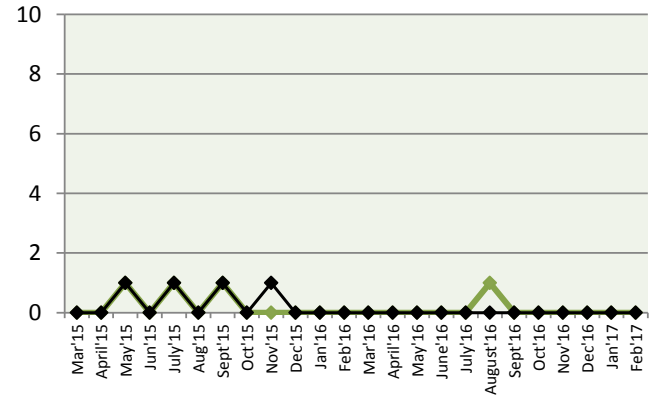
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



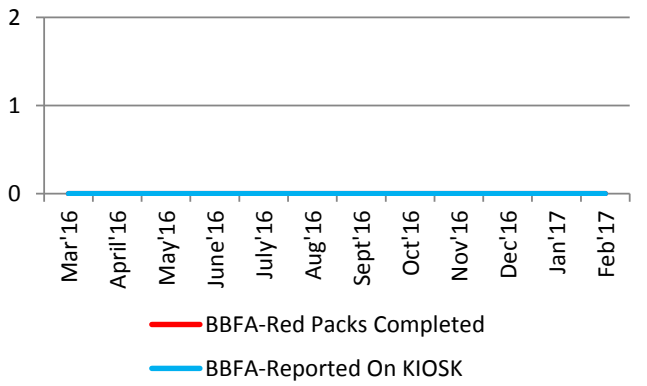
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



MANUAL HANDLING
(From 2 Years Rolling)

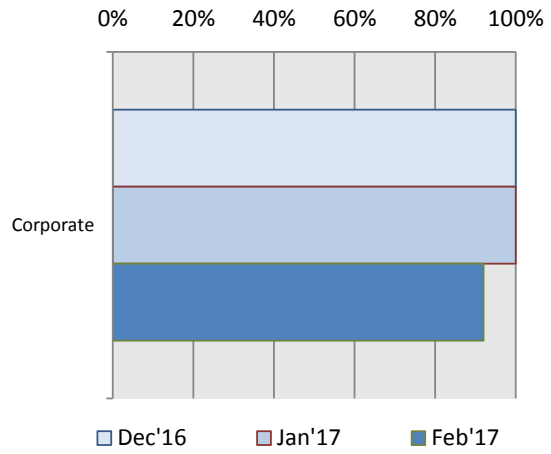


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



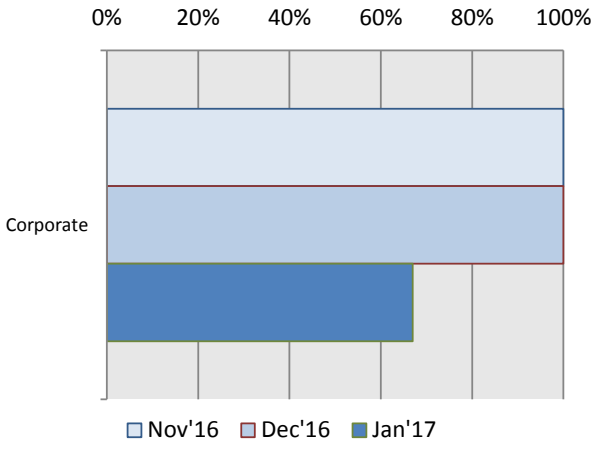
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	100%	100%	92%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	November'16	December'16	January'17
80%	83%	100%	67%



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

Information data accurate as of 6/3/2017

Community and Long Term Conditions Health and Safety Report

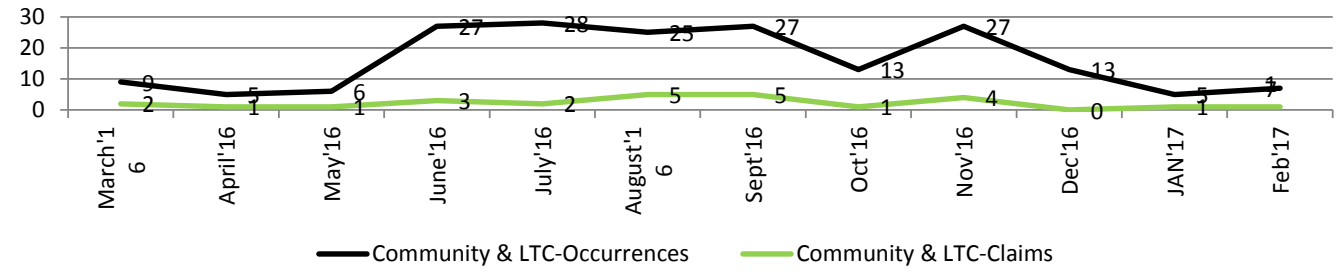
Lagging

	Actual	Target	Trend
H&S Incidents	7	20	
Work Injury Claims	1	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

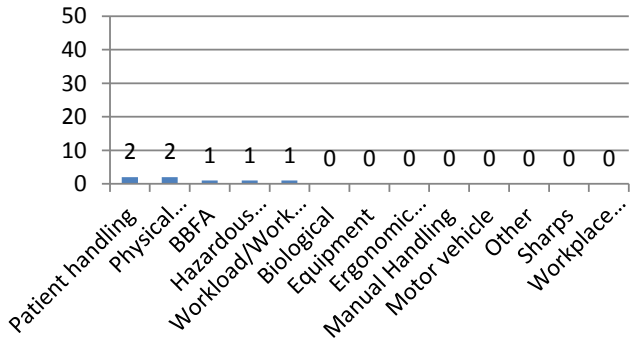
Leading

	Actual	Target	Trend
%H&S Inductions	57	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	68	80	
% 6 monthly Workplace Checklist	29	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	60	80	

Health and Safety Incidents and Claims for 12 months

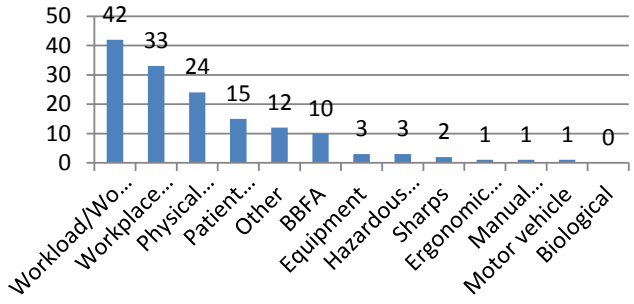


Health and Safety Incident by Hazard Type for February 2017

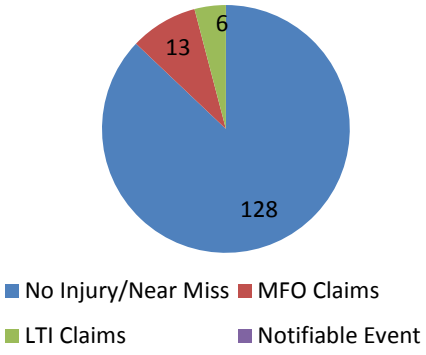


Work Injury by Outcome Type for February 2017

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

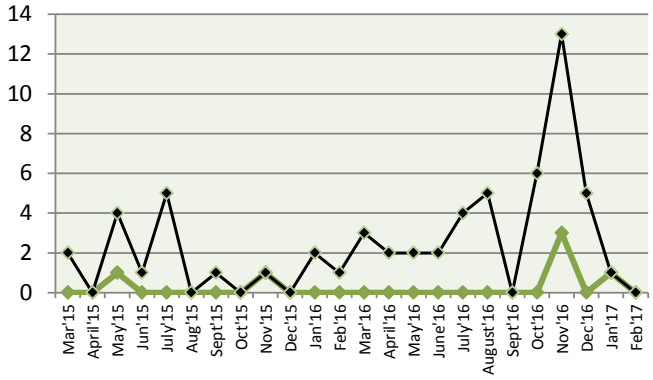


Work Injury by Outcome Type – YTD (2016-2017)

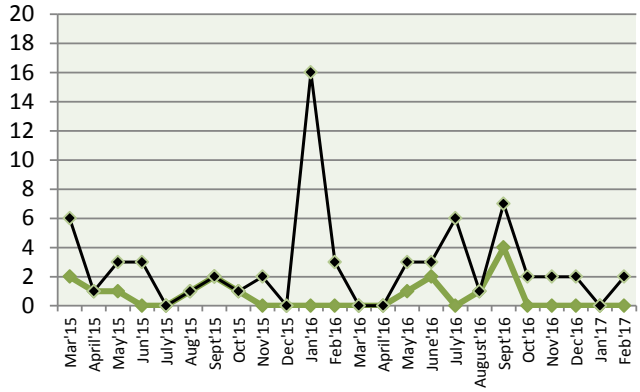


Community and Long Term Conditions Health and Safety Report (Continued)

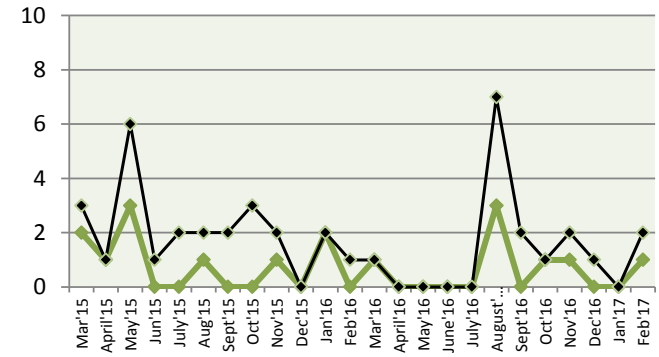
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



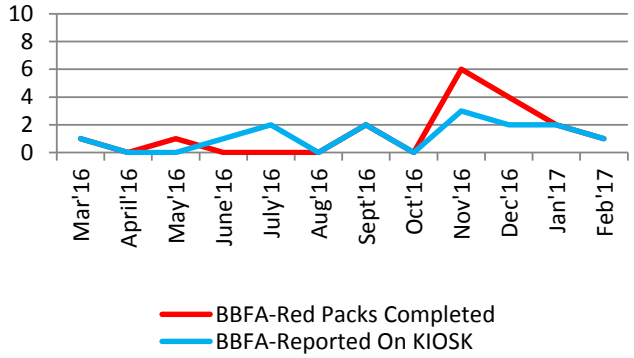
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

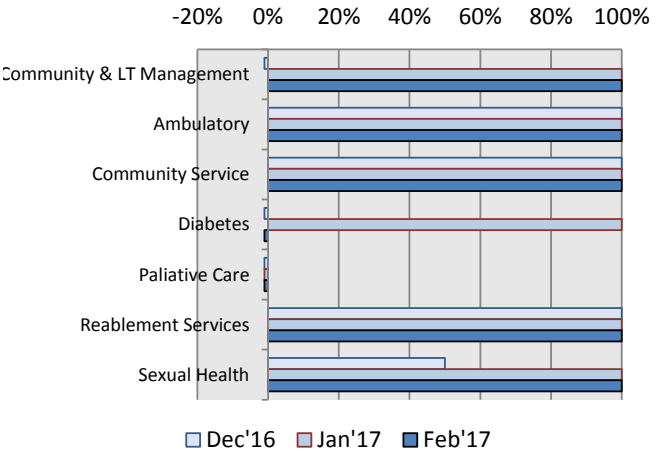


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



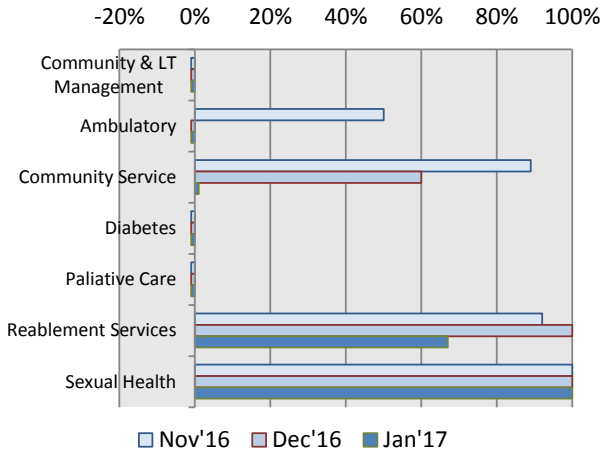
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	100%	90%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	November'16	December'16	January'17
80%	77%	88%	60%



Information data accurate as of 6/3/2017

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

Mental Health Services Health and Safety Report

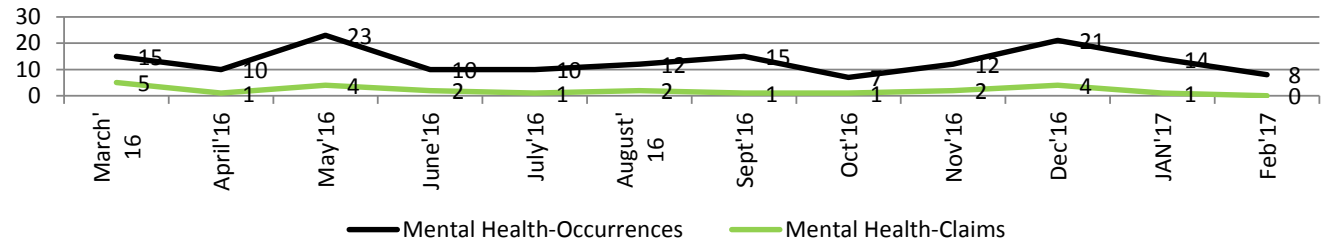
Lagging

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

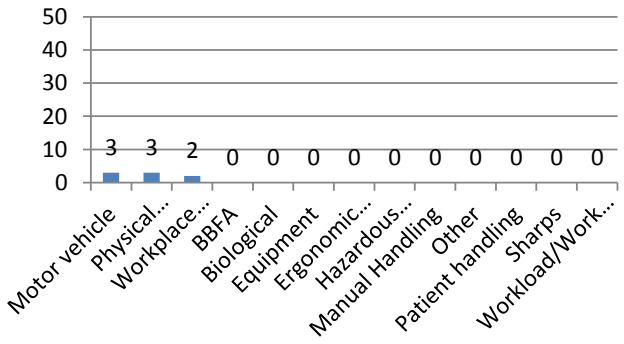
Leading

	Actual	Target	Trend
%H&S Inductions	38	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	53	80	
%6 Monthly Workplace Checklist	29	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	86	80	

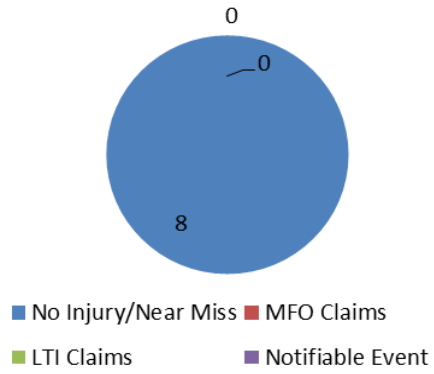
Health and Safety Incidents and Claims for 12 months



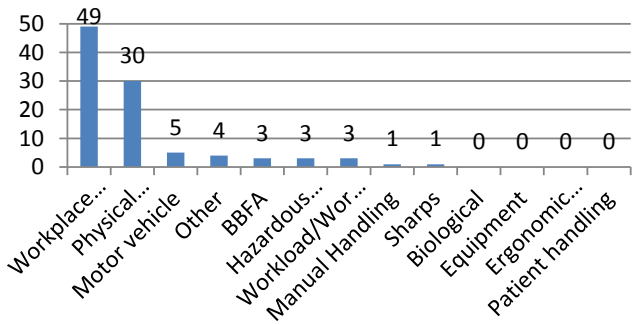
Health and Safety Incident by Hazard Type for February 2017



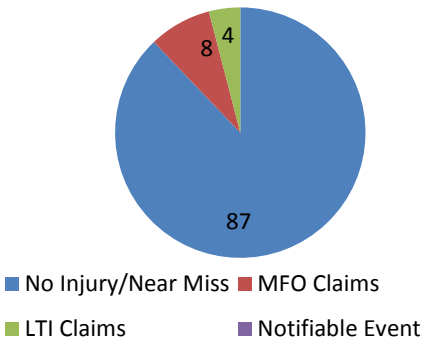
Work Injury by Outcome Type for February 2017



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

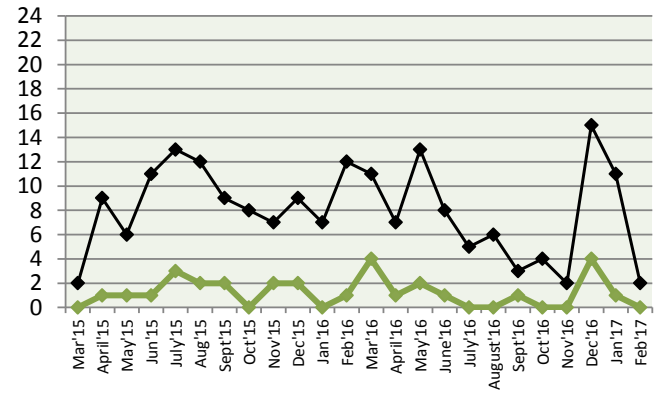


Work Injury by Outcome Type – YTD (2016-2017)

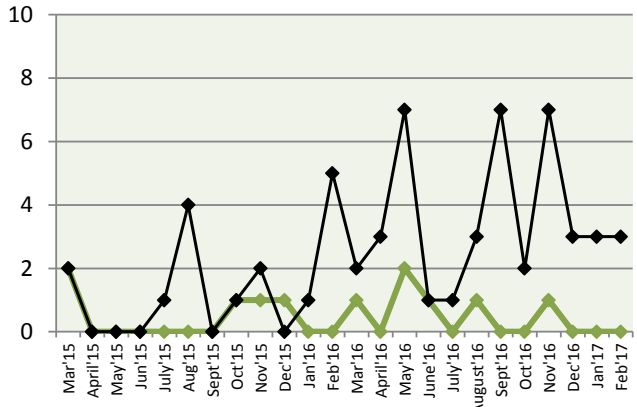


LEGEND: CLAIMS Health and Safety INCIDENT

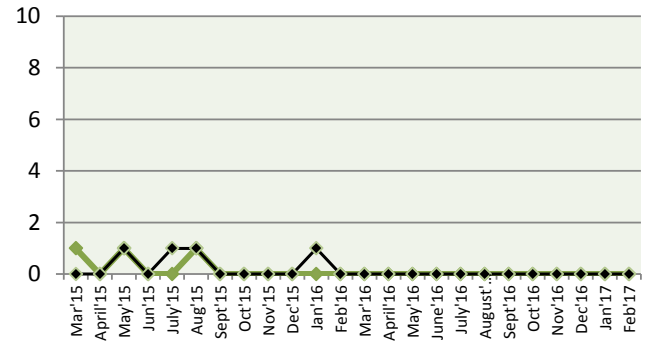
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



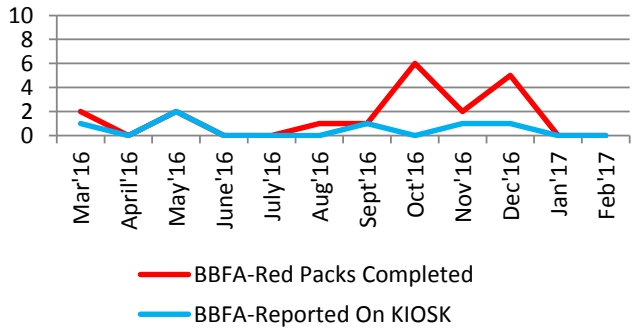
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

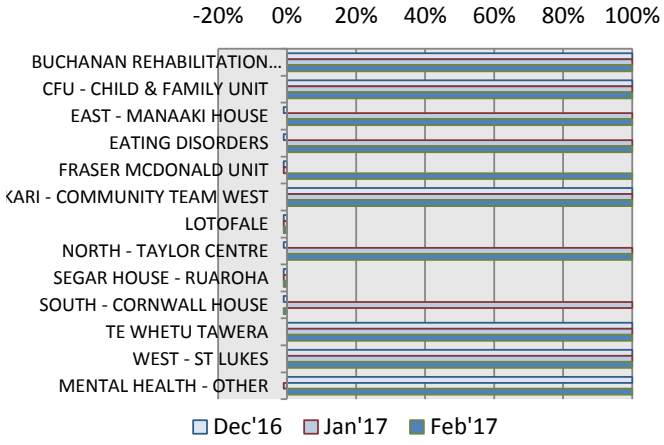


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



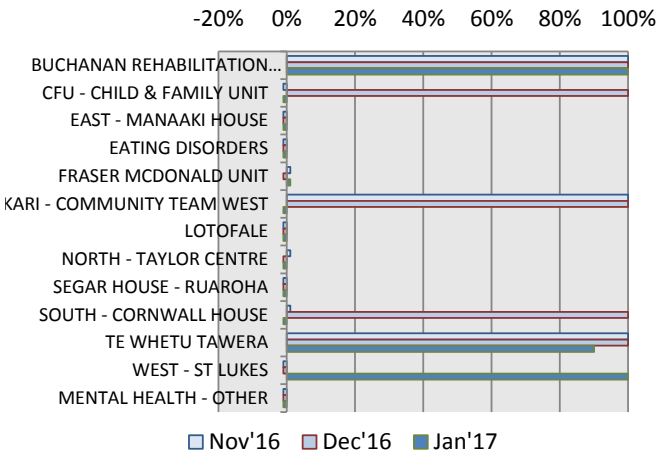
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	87%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	November'16	December'16	January'17
80%	86%	75%	86%



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

Information data accurate as of 6/3/2017

Non Clinical Support Health and Safety Reports

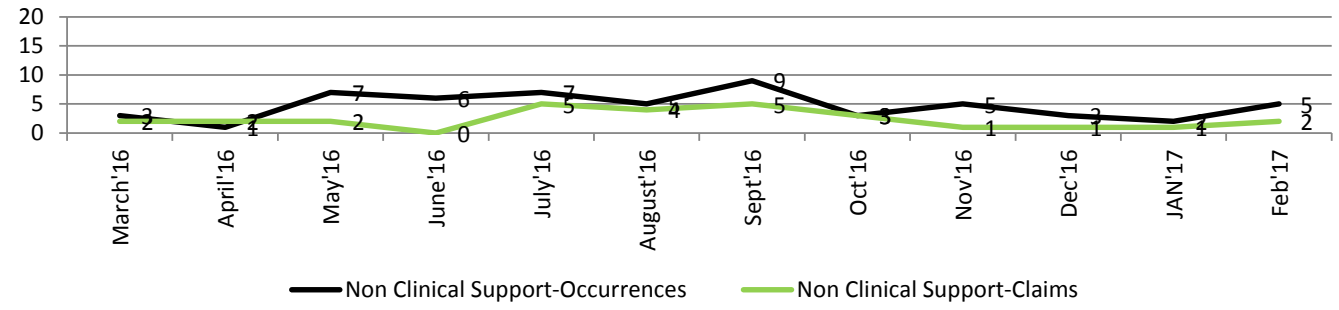
Lagging

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

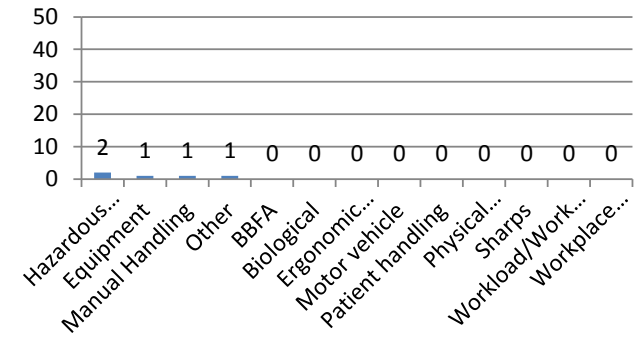
Leading

	Actual	Target	Trend
%H&S Inductions	50	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	17	80	
%6 Monthly Workplace Checklist	20	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

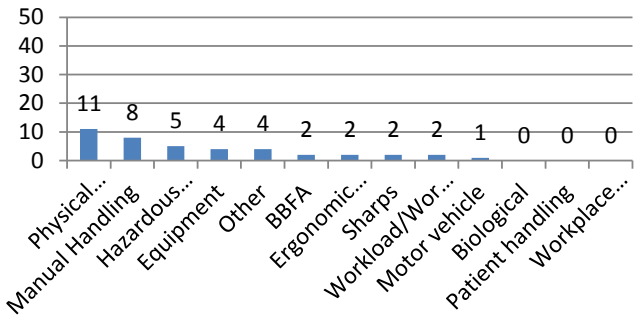


Health and Safety Incident by Hazard Type for February 2017

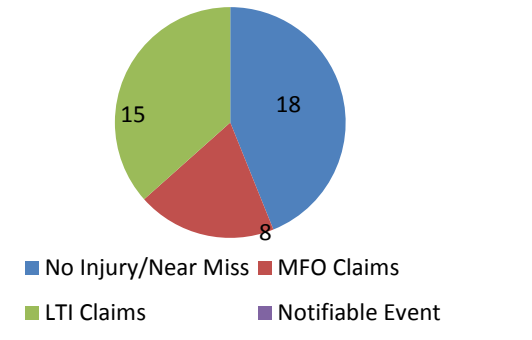


Work Injury by Outcome Type for February 2017

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



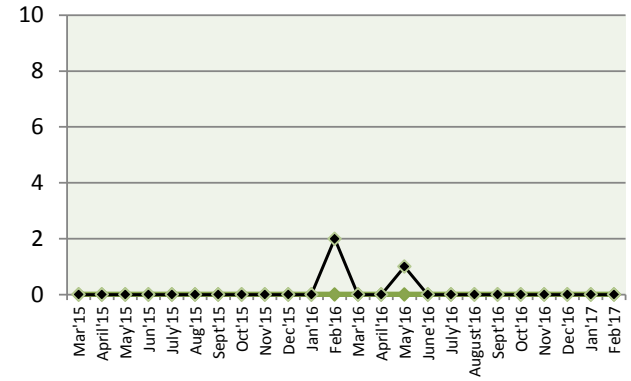
Work Injury by Outcome Type – YTD (2016-2017)



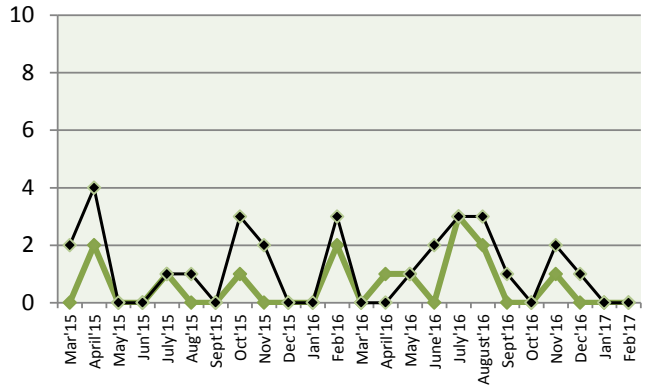
Non Clinical Support Health and Safety Reports (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

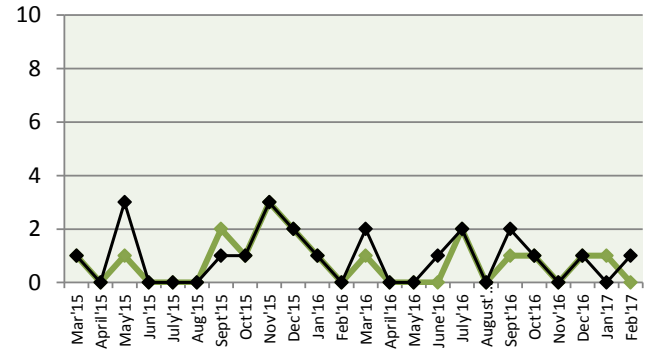
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



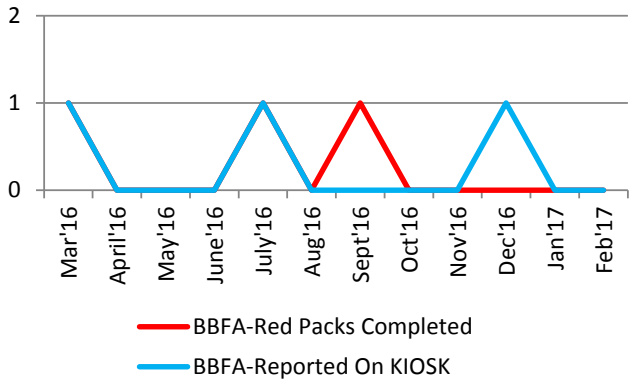
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



MANUAL HANDLING
(From 2 Years Rolling)

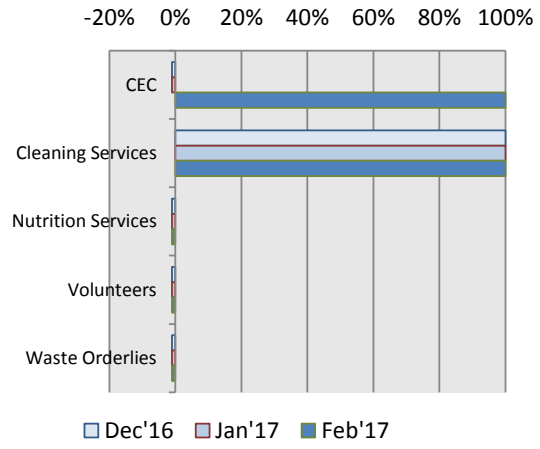


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



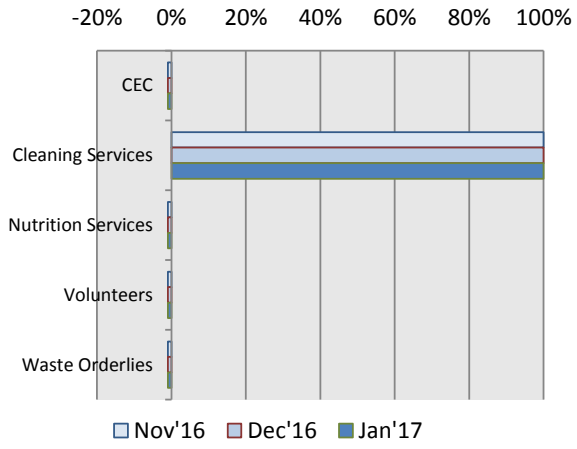
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	0%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

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



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

Information data accurate as of 6/3/2017

Perioperative Health and Safety Report

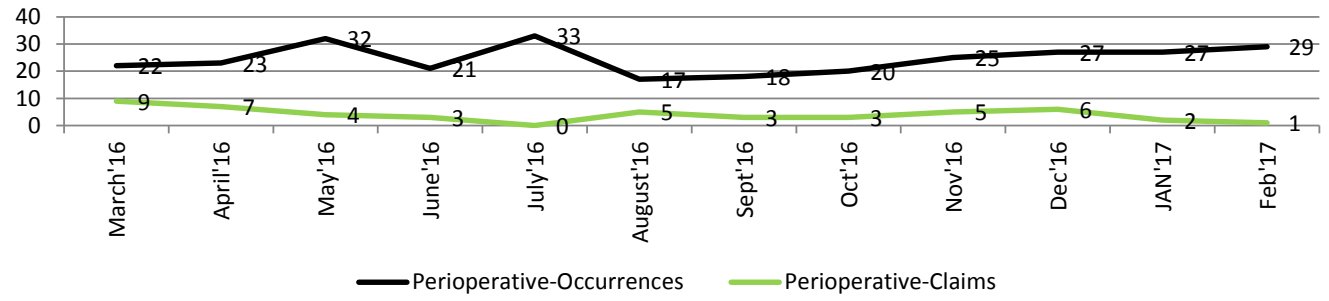
Lagging

	Actual	Target	Trend
H&S Incidents	29	20	
Work Injury Claims	1	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

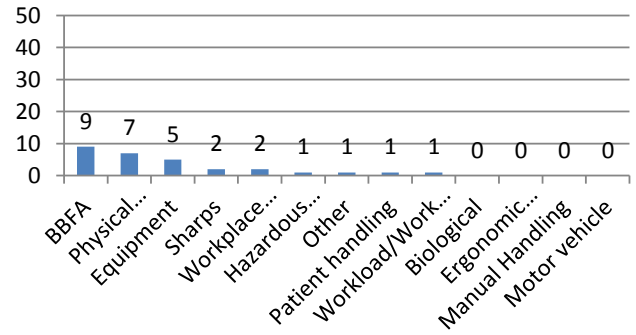
Leading

	Actual	Target	Trend
%H&S Inductions	79	80	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	78	80	
%6 Monthly Workplace Checklist	38	80	
%PES before start date	92	100	
%H&S Incidents Follow up 14 days	85	80	

Health and Safety Incidents and Claims for 12 months

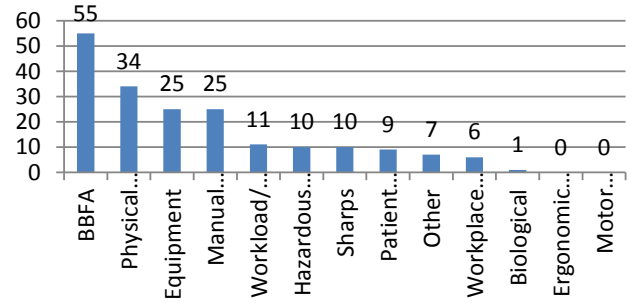


Health and Safety Incident by Hazard Type for February 2017

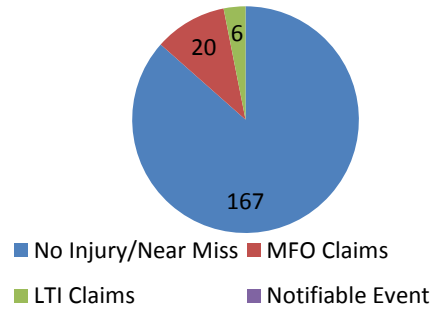


Work Injury by Outcome Type for February 2017

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



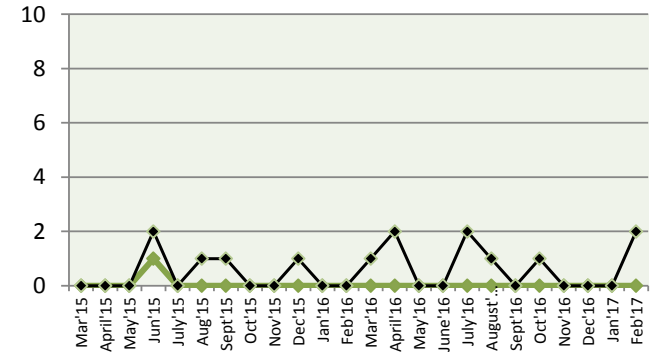
Work Injury by Outcome Type – YTD (2016-2017)



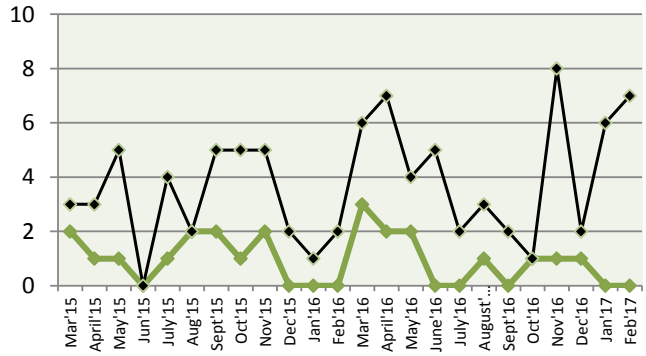
Perioperative Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

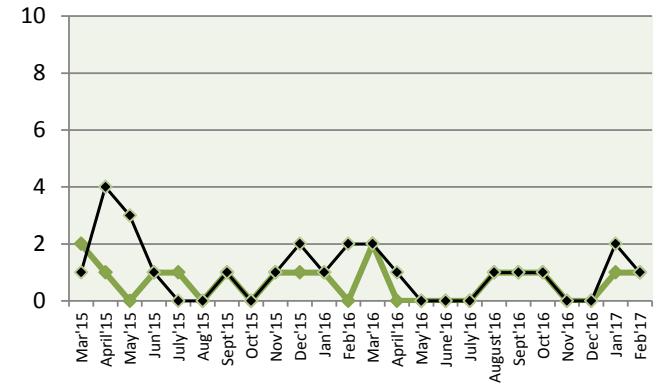
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



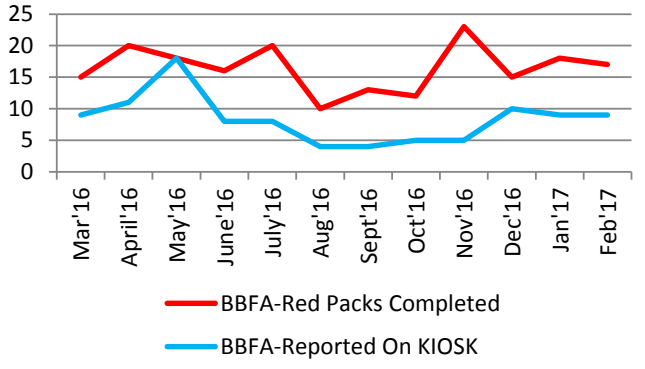
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

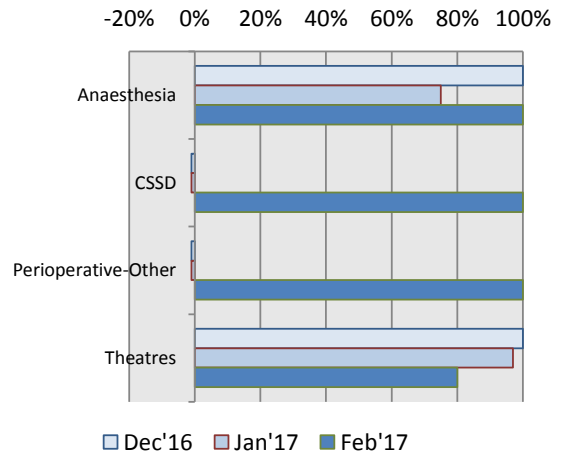


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



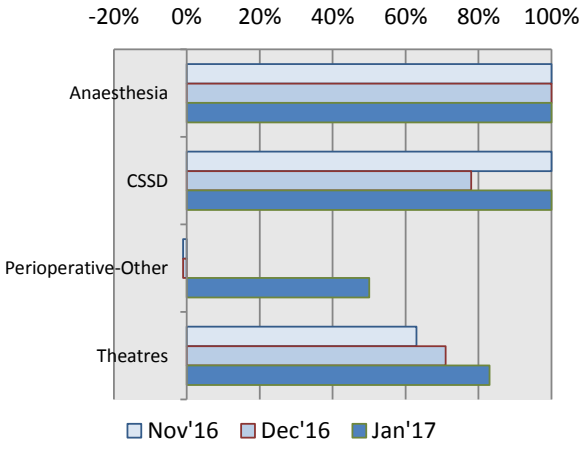
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	100%	100%	92%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	November'16	December'16	January'17
80%	68%	72%	85%



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

Information data accurate as of 6/3/2017

Surgical Services Health and Safety Report

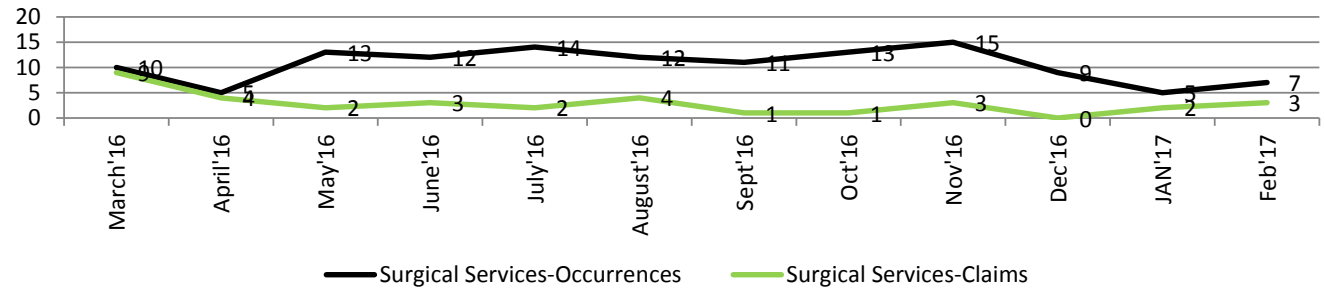
Lagging

	Actual	Target	Trend
H&S Incidents	7	20	
Work Injury Claims	3	0	
Lost Time Injuries	2	0	
Notifiable Events	0	0	

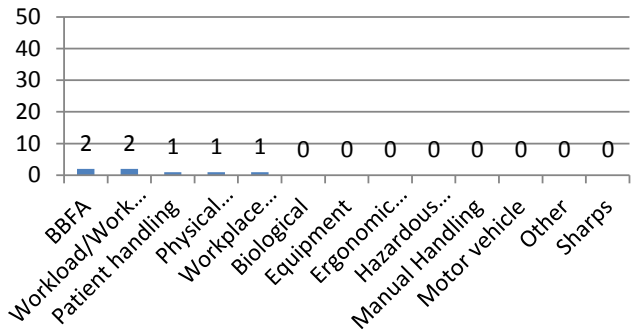
Leading

	Actual	Target	Trend
%H&S Inductions	14	80	
H&S Rep Vacancies No.	5	2	
%H&S Rep Training	47	80	
%6 Monthly Workplace Checklist	40	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	60	80	

Health and Safety Incidents and Claims for 12 months

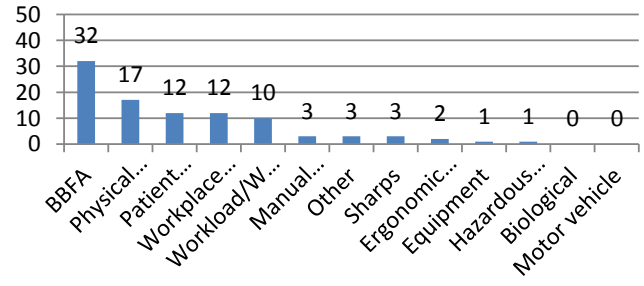


Health and Safety Incident by Hazard Type for February 2017

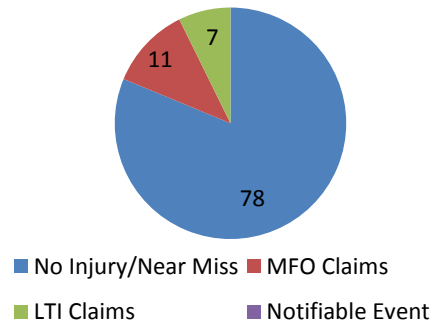


Work Injury by Outcome Type for February 2017

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



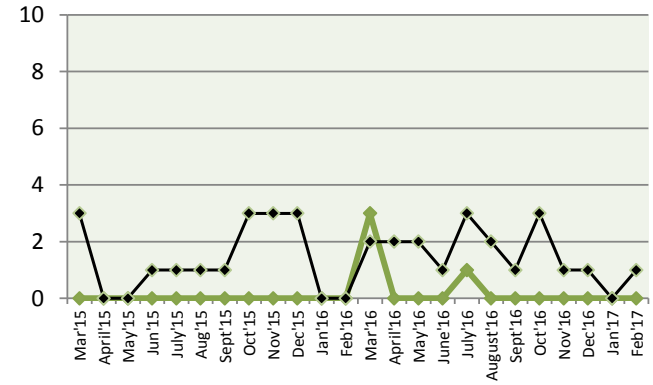
Work Injury by Outcome Type – YTD (2016-2017)



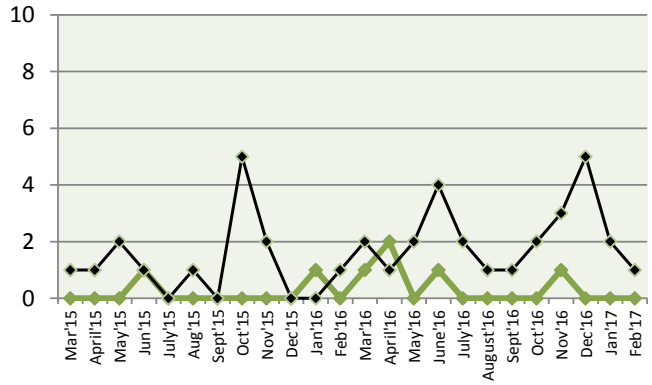
Surgical Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

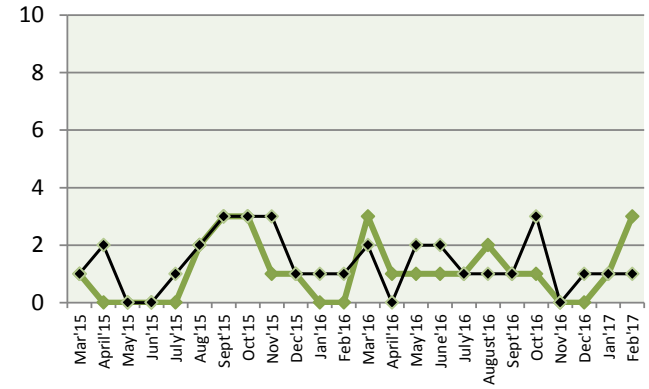
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



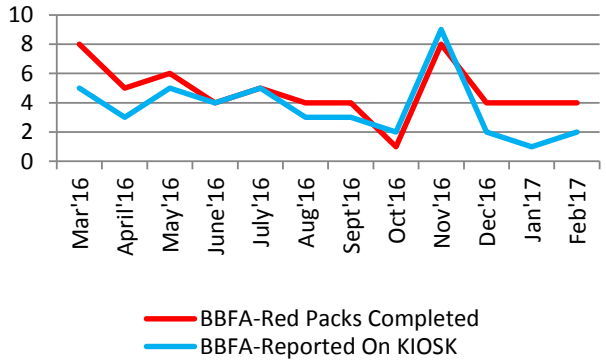
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

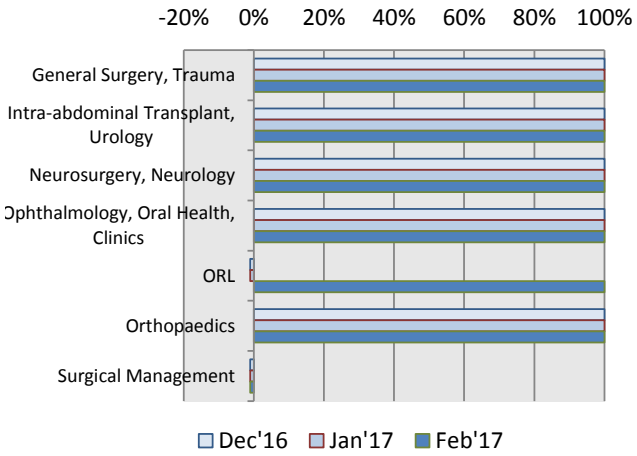


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



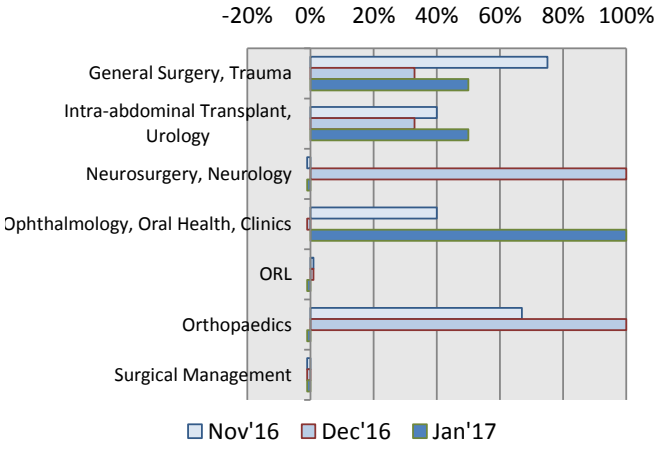
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	100%	100%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	November'16	December'16	January'17
80%	75%	50%	60%



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

Information data accurate as of 6/3/2017

Women's Health and Safety Report

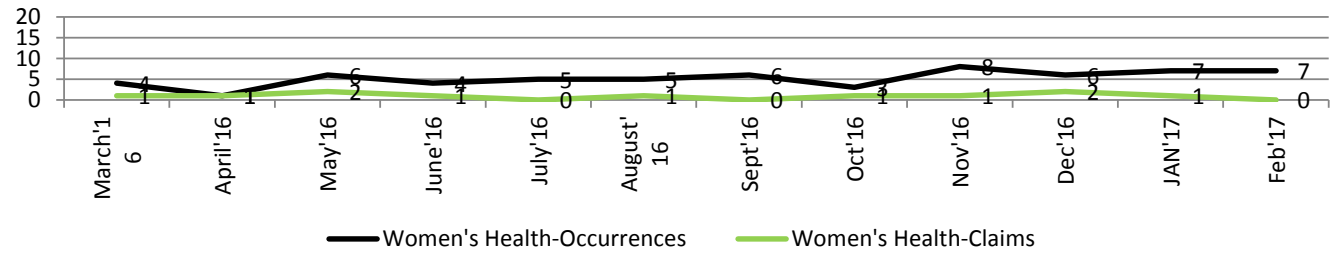
Lagging

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

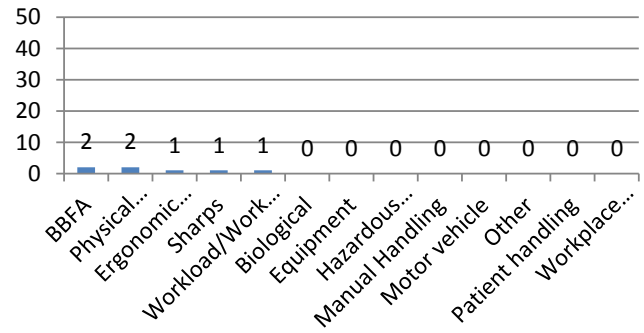
Leading

	Actual	Target	Trend
%H&S Inductions	50	80	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	33	80	
%6 Monthly Workplace Checklist	40	80	
%PES before start date	100	100	
%H&S Incidents Follow up 14 days	57	80	

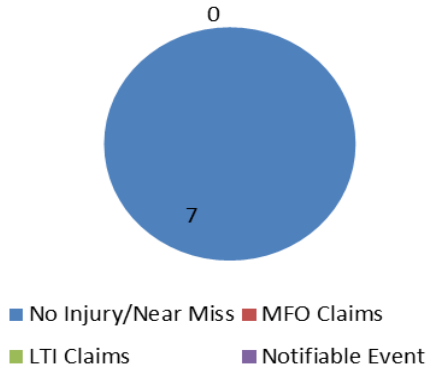
Health and Safety Incidents and Claims for 12 months



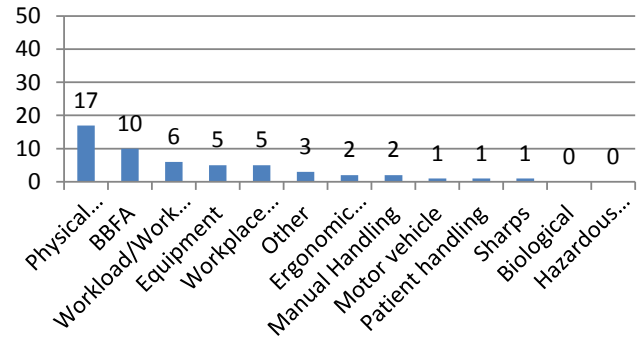
Health and Safety Incident by Hazard Type for February 2017



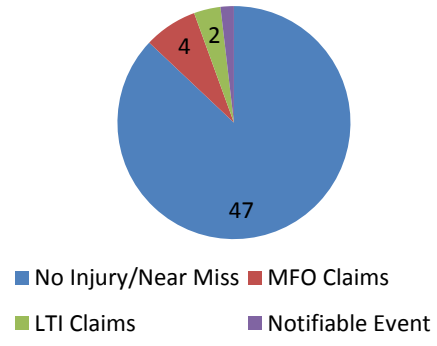
Work Injury by Outcome Type for February 2017



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



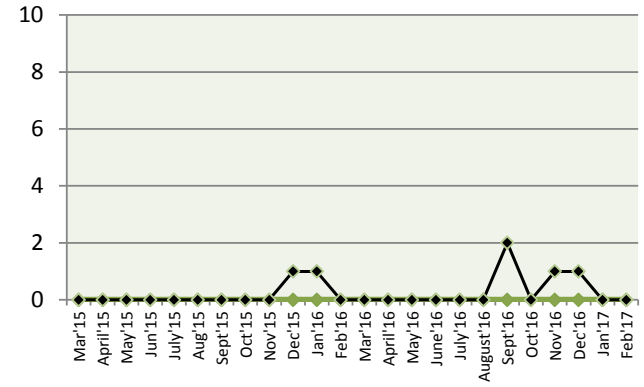
Work Injury by Outcome Type – YTD (2016-2017)



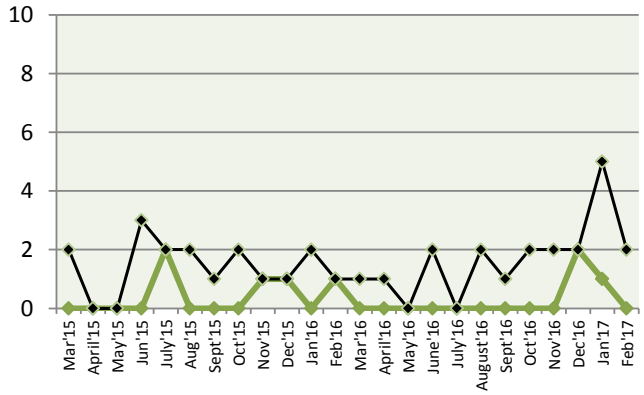
Women's Health and Safety Report (continued)

LEGEND: CLAIMS — Health and Safety INCIDENT

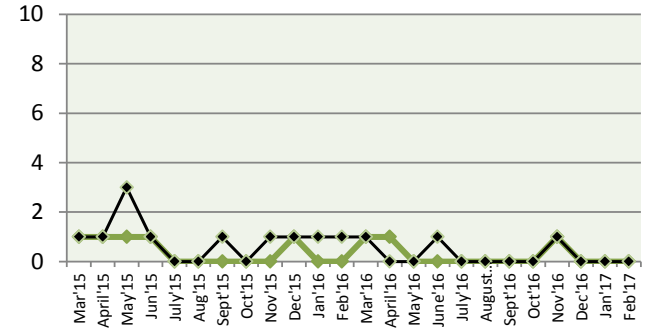
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



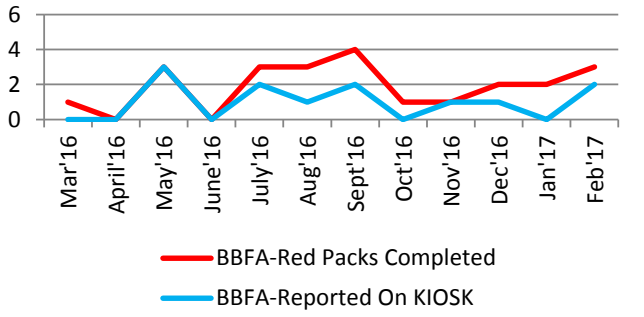
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

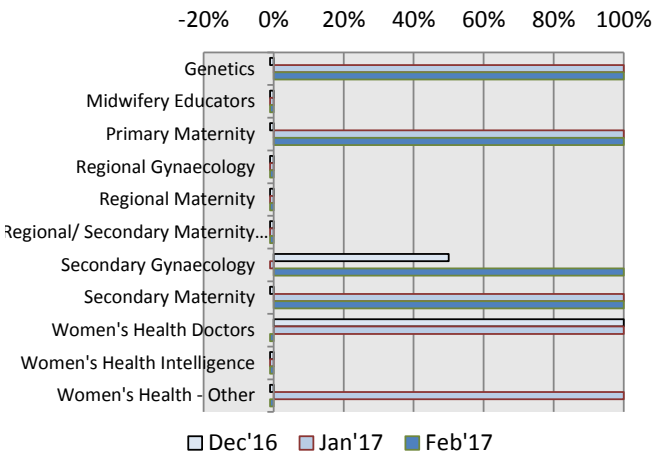


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



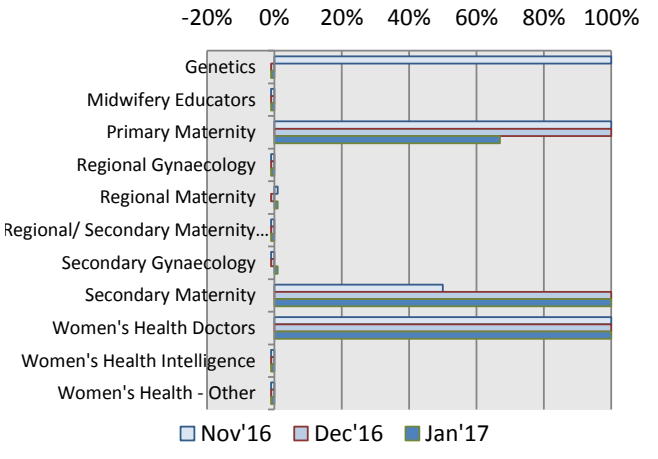
PRE-EMPLOYMENT SCREENING

TARGET	December'16	January'17	February'17
90%	100%	80%	100%



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	November'16	December'16	January'17
80%	100%	50%	57%



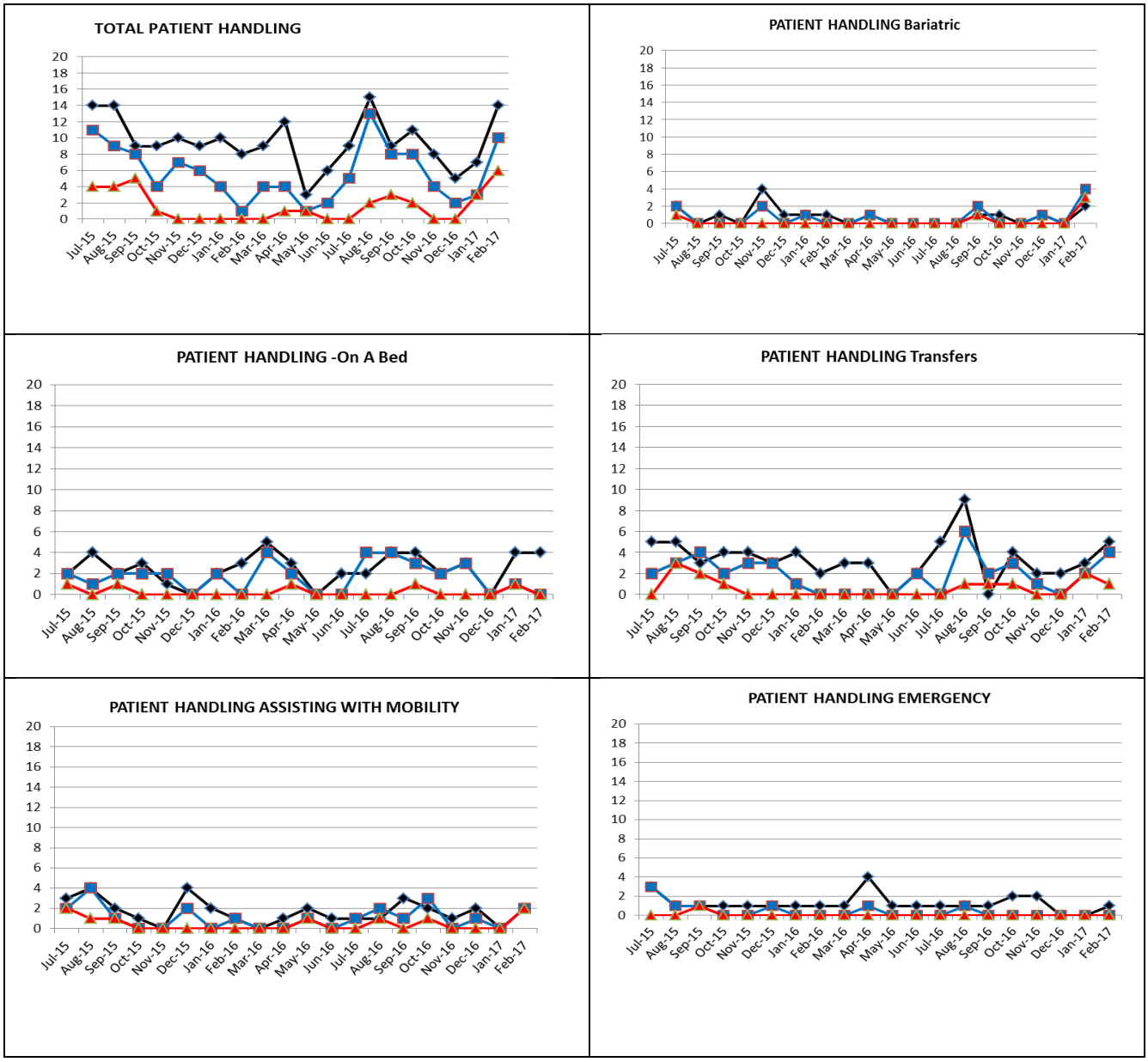
*Incident data 1 month lag to allow for Manager's investigations

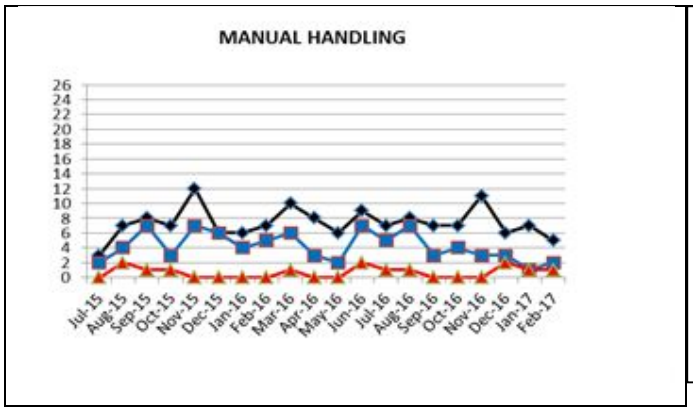
Information data accurate as of 6/3/2017

Appendix 1 - Moving and Handling

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

Table 5.1: Moving and Handling Injury causation




MANUAL HANDLING
26
24
22
20
18
16
14
12
10
8
6
4
2
0
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
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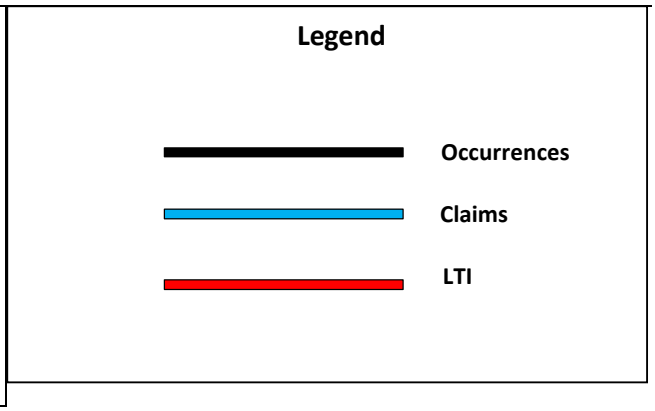
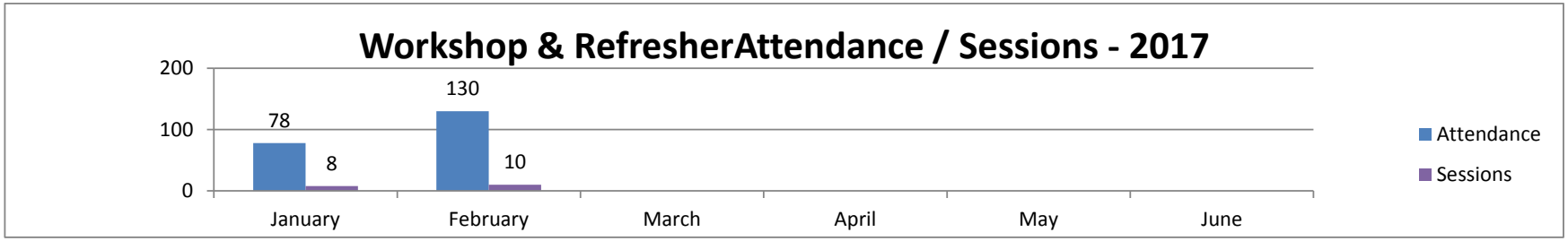
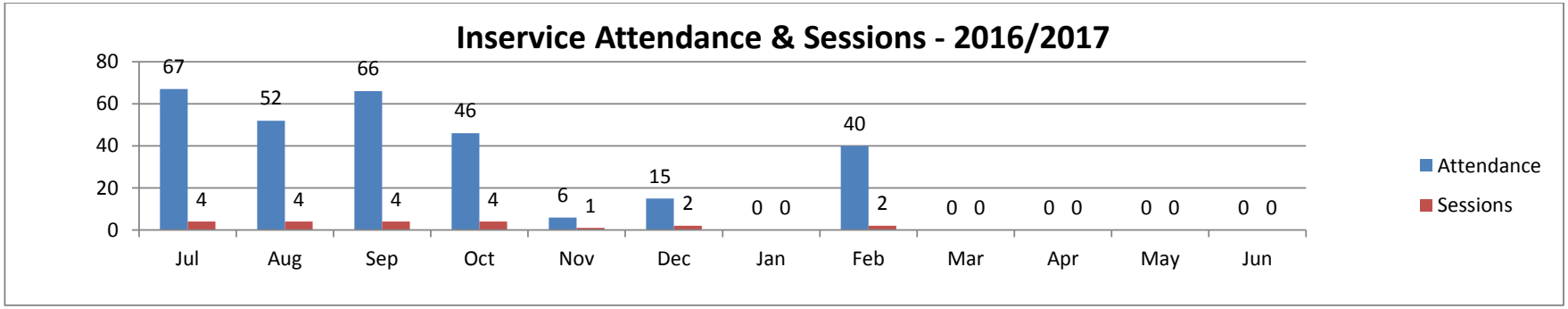
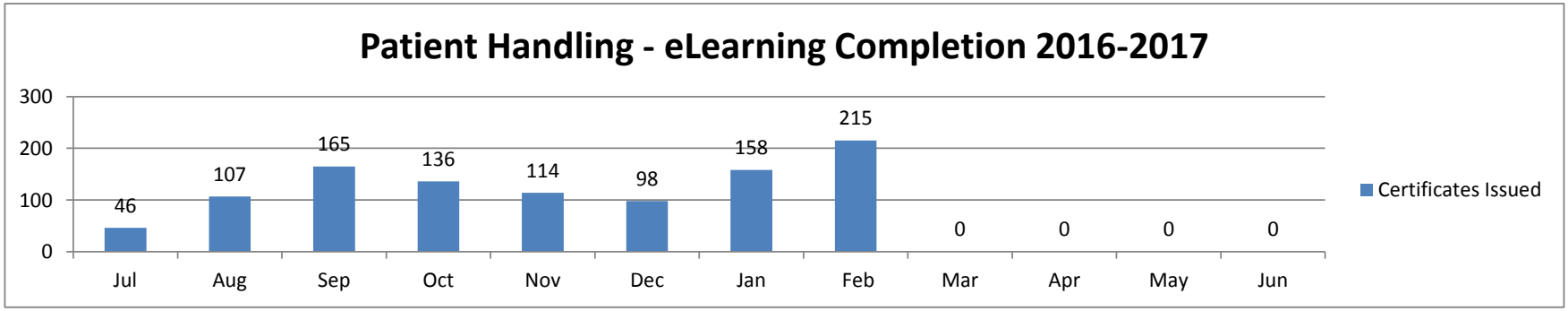
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17


Legend
Occurrences
Claims
LTI

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







Appendix 3 - Workplace Violence

1 – 28 February 2017

Auckland DHB	Workplace Violence reported on RISKPRO				Workplace Violence reported on KIOSK				Workplace Violence CLAIMS
Directorate	February	% Reported	YTD	% Reported	February	% Reported	YTD	% Reported	
Community & LTC	0	0%	23	11%	0	0%	33	20%	0
Adult Medical	4	20%	58	9%	3	27%	26	16%	0
Cancer & Blood	1	0%	5	0%	0	0%	1	1%	0
Cardio-Vascular	1	0%	3	1%	0	0%	3	2%	0
Children's Health	0	7%	10	2%	1	9%	7	4%	0
Clinical Support	2	13%	6	6%	2	18%	19	12%	0
Corporate	0	0%	0	0%	0	0%	1	1%	0
Mental Health	6	13%	166	17%	2	18%	49	30%	0
Non Clinical Support	0	0%	2	0%	0	0%	0	0%	0
Perioperative	0	13%	3	2%	2	18%	6	4%	0
Surgery	0	7%	13	4%	1	9%	12	7%	0
Women's Health	1	0%	7	2%	0	0%	5	3%	0
Total Auckland DHB	15		296		11		162		0

Auckland DHB	Code Orange			
	February	% Reported	YTD	% Reported
Auckland City Hospital	46	85%	509	80%
Starship	3	6%	64	10%
Women's	2	4%	11	2%
Greenlane Clinical Centre	0	0%	7	1%
Support Bldg	3	6%	48	8%
Total Auckland DHB	54		639	

A Code orange call is activated by staff whenever they feel that their safety or that of others is compromised and their own methods to resolve the issue have not worked. A Code Orange team

comprises of Duty Manager (Team Leader) Liaison Psychiatry, (Adult Services only), Clinical Nurse Advisor, and Security. Other personnel are utilised as required. This will be assessed and implemented by the Team Leader. All other team members and staff associated with the challenging behaviour/situation, follow the direction of the team leader to ensure management of the situation is effectively co-ordinated.

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

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

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

NO.	Element	#	Detail Action	Assigned to	Due Date	Status	Remark
			Directorates: • Sequential implementation (by Directorate) • One commenced per month throughout 2016 • Manager Training Health and Safety Rep training				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	**Competed**	The Datix project is underway, consultation of design has occurred, target go-live in late March 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

Appendix 6 Annual ACC Partnership Programme Audit

Background to the ACC Partnership Programme (ACCPP):

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

2016 ACCPP Audit

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

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

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

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

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

Five Recommendations were given: see table to follow below

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

Appendix 7 Terms of reference for 2017 Health and Safety Review

Purpose

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

Background

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

The 2014/15 audit consisted of:

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

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

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

Scope of work

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

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

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

Deliverables

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

Timeframes

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

Health and Safety mid-year review: July – December 2016

Recommendation

That the Board:

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

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

Glossary

LTIFR:	**Lost Time Injury Frequency Rate (work injury claim)**
LTISR:	**Lost time Injury Severity Rate**
WSNZ:	**Worksafe New Zealand**
ACCPP:	**ACC Partnership Programme**

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 Health and Safety mid- year review report is provided for the Auckland DHB Board for their information on the progress of the 16/17 Health and Safety annual Objectives for Auckland DHB.

An internal health and safety Governance audit was conducted in May 2016 by Deloitte on behalf of Health Alliance. One of the recommendations of the audit was that Auckland DHB should provide a mid-year health and Safety review report to the Board. This report is a mid- year review of the progress of the health and safety objectives for 2016/17.

The report includes a list of the Health and Safety Annual objectives for 2016/17. A progress note has been provided for each objective and where further detail is required, relevant graphs and tables have been provided following the Annual Objectives document.

The Annual Health and Safety objectives are developed under the guidance of the Health and Safety Governance Committee. They outline the work plan for the Health and Safety department for the fiscal year and include objectives for recurring operational functions and projects, policy reviews and development, continuous improvement action plans and development objectives.

At the mid-way point of the fiscal year 75% of the annual objectives are in progress and on track for completion by June 2017. Progress on each of these is noted.

Progress highlights include:

- ACCPP audit completed and Tertiary again achieved.

- Blood and Body Fluid policy review completed
- Asbestos management
- Security for Safety project
- Contractor Management
- Health and Safety Rep NZQA training commenced
- Mandatory e-learning Health and Safety Induction improved
- Percentage of managers completing investigations is improving
- Development of Health and Safety modules in Datix
- Regional collaboration on a number of initiatives

Focus over the next six months of the 16/17 fiscal year will be on reduction of moving and handling work injury claims, further development of the workplace violence action plan and improvement in the compliance for local Health and Safety induction for new employees.

The Health and Safety department will continue to advise and support the manager across Auckland DHB to understand their obligations under the Health and Safety at Work Act. Action plans will facilitate the implementation of all reasonably practical steps to reduce the risk of harm to workers and others in the Auckland DHB workplace.

3. Health and Safety Annual Plan 2016-2017 6 month update to December 2016

1. Goal

Goal		WHAT WILL BE DELIVERED	DUE DATE	6 month Update
		Recurring Operational Objectives	**status**	**To Dec. 2016**
1.1	Reduce harm to staff due to workplace accidents	• Auckland DHB LTIFR for June 2017 to be below 8.0 • Notifiable events (Worksafe) for 2016-17 to be below those in 2015-16 (7) • Add LTISR to Scorecard KPIs	June 2017	**In Progress:** • LTIFR Reported in each Board report. See Graph for Objective 1.1 below • One Notifiable event in the six month period • LTISR definition to be agreed
1.2	2016 ACC Audit	Completed Annual ACCPP audit for the organisation with tertiary status in the programme maintained. Part A and part B Audit (December 2016)	Dec. 2016	**Completed:** ACCPP audit completed in December 2016. Reported to the Finance Risk and Audit Committee in January 2017. Five minor recommendations, action plan underway. Next Audit late 2017
1.3	Flu Vaccine programme 2017	Project manage the 2017 Seasonal Flu Campaign for the organisation with the aim of increasing clinical staff uptake by 5% participated in the programme in 2017 and reach the aspirational target of 80% staff uptake. Facilitate the provision of pertussis vaccine to all staff vaccinated at the central venues.	June 2017	**In progress**: 74% vaccination uptake in 2016 Planning has commenced, for 2017 Steering committee chaired by Margaret Dotchin. Vaccinating to commence l29 March 2017. Communication plan developed. Staff vaccination Guideline to be reviewed to reflect Auckland DHBs approach to “duty of care” and mask wearing. Aspirational target of 80% staff uptake
1.4	Board Health and Safety Engagement Visits	Facilitate the Board Health and Safety Engagement Visit programme including planning and co-ordinating visits as per the schedule agreed for 2017.	June 2017	**In Progress:** Board safety engagement visit dates have been scheduled for 2017. March/April and May topics set. 8 March 2017 visit to look at the Security for Safety project. Three Board members attending.

Goal		WHAT WILL BE DELIVERED	DUE DATE	6 month Update
		Recurring Operational Objectives	**status**	**To Dec. 2016**
1.5	Health and Safety Systems Audits	• Ensure the completion of all Health and Safety systems audits as per the Health and Safety Audit Schedule. Including a Health and Safety system deep dive audit to review the Health and Safety systems management compliance in relation to HSWA. • Develop action plan for any recommendations provided by the auditors.	June 2017	**In Progress**: • Directorate consultation conducted in late 2016. Draft Terms of Reference written. Update on progress provided to Finance Risk and Audit Committee. • In contact with Health Alliance regarding obtaining a supplier to conduct this audit.

2. Health and Safety Policy Reviews

Health and Safety Policy Reviews		WHAT WILL BE DELIVERED	DUE DATE	6 month Update
		Recurring Operational Objectives	**status**	**To Dec. 2016**
2.1	Review	Blood and Body Fluid Accident (BBFA) Policy	June 2017	**Completed**
2.2	Review	Health and Safety Occurrence Policy (to align with Datix)	June 2017	**In Progress:** Policy will be aligned with new Safety Management System final development
2.3	Review	Staff Seasonal Influenza Vaccination Guideline	June 2017	**In Progress**: To be reviewed by Seasonal Influenza Steering Committee
2.4	Implementation	Facilitate the Implementation of the Health and Safety requirement s of the Medical Gas policy.	June 2017	**In Progress:** Health and Safety involved in the development of the policy. Health and Safety Requirement of the policy identified. Action plan for implementation underway.

3. Continuous Improvement

Continuous Improvement		WHAT WILL BE DELIVERED	DUE DATE	6 month Update
		Recurring Operational Objectives	**status**	**To Dec. 2016**
3.1	Moving and Handling	Reduction in the number of Patient Handling related claims by 5% from previous fiscal year; from 69 WR Injury claims to 65 or less. • Research and develop safer systems for Falls Retrieval in alignment with the Auckland DHB Fall Prevention protocols.	June 2017	**In Progress** Patient handling related claim for the first half of the fiscal year were 37. Seven of these were lost time injuries. See graph for objective 3.1 below Claims for the same period in the 15/16 fiscal year were 48 claims Falls Retrieval proposal presented to Auckland DHB Falls and Pressure Injury Working Group. Awaiting response
3.3	Workplace Violence Prevention	Reduction of the number of number of Workplace Violence and Aggression related worker claims by 25% previous fiscal year: from 29 Work Related Injury claims to 22 or less. • Review steering committee Terms of Reference • Provide training as per the requirements of the policy • audit practice against policy requirements	June 2017	**In Progress** Workplace Violence related work injury claims for the first half of the fiscal year were 17. See graph for objective 3.3 below Claims for the same period in the 15/16 fiscal year were 16 claims Steering committee Terms of Reference reviewed Chair appointed by ELT Training providers review plan underway To be included the June 2017 Health and Safety Systems audit
3.4	Facilities Safety	Facilitate the completion of key facilities projects: • Pedestrian Safety all campuses	June 2017	**In Progress**

Continuous Improvement		WHAT WILL BE DELIVERED	DUE DATE	6 month Update
		Recurring Operational Objectives	**status**	**To Dec. 2016**
		• Site security (Participate in steering group) • Asbestos management • Contractors Health and Safety Management		Project plans in place for risks See Table for objective 3.4 below
3.5	Auckland DHB Leading indicator improvement projects:	Develop and implement action plan to address all leading indicators that are below targeted values. • Attendance at Welcome Day • % local Health and Safety Induction completed within 7 days • Increase the number of Health and Safety Reps attending training • Increase number of hazard registers current • Increase % of staff incidents investigated by the manager • Increase % hazard remediation by managers • Increase % of mandatory Health and Safety induction e leaning completed	June 2017	**In Progress** Action plans in place for performance improvement in all KPIs See table for objective 3.5 below
3.6	WR Injury Claims Management	Reduce the number of time taken for decisions on claims, so that 80% of the claims decisions are made within 6 weeks of lodgement. (no more than one extension)	June 2017	**In Progress;** Action plan developed with Third Party administrator to reduce approval time frames. 75% of claims are decided with a maximum of one time extension. (6 weeks)
3.7	Staff Wellbeing	• Support the Auckland DHB Staff Wellbeing committee as per the work plan developed by the committee. • Deal with key health and safety and wellbeing risks promptly, using contemporary approaches in a way that sustains positive and progressive outcomes • Map all health and wellbeing Service available	June 2017	**In progress:** A number of initiatives are underway: • Speak up for Safety • Staff Satisfaction survey completed • Wellbeing information available on Intranet

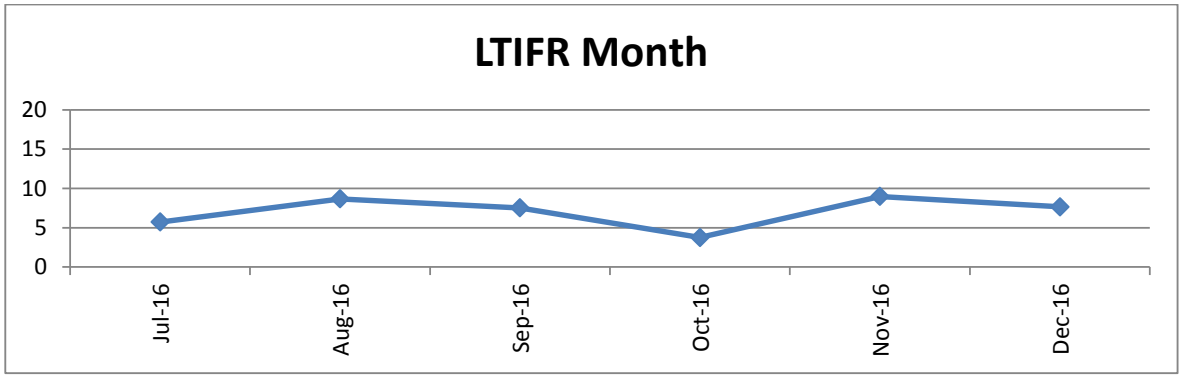
Continuous Improvement		WHAT WILL BE DELIVERED	DUE DATE	6 month Update
		Recurring Operational Objectives	status	To Dec. 2016
		to Auckland DHB staff		
3.8	Northern Regional DHB Health and Safety Collaboration	work collaboratively with the Northern region on appropriate regional Health and Safety risks, which will include procurement, public health promotion and employee strategies	June 2017	**In Progress** Monthly telephone conferences occurring. Metro Auckland alignment where possible on: Hazardous Substances Ko Awatea Learn Challenging Behaviours Training (Mental Health Services) Health Workforces Strategy Employee Participation Agreement Employee Assistance Programme Lone worker safety training

4. Developmental

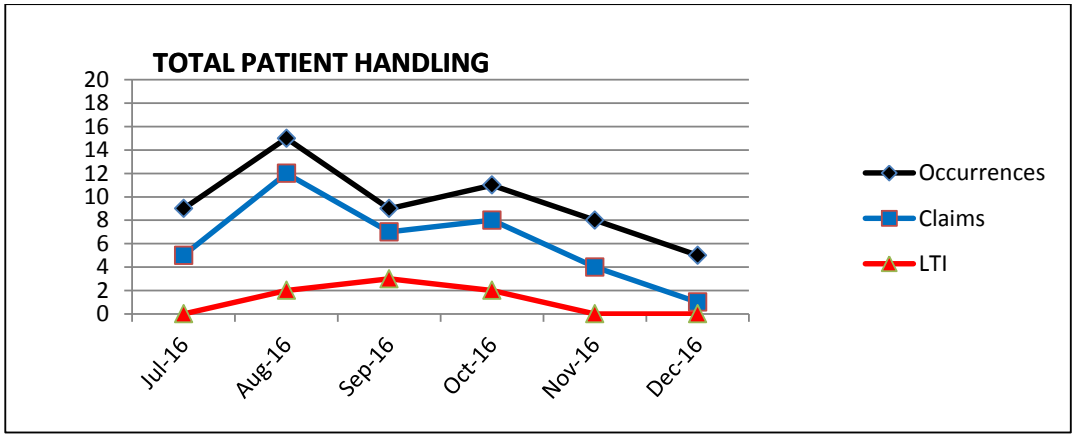
Developmental		WHAT WILL BE DELIVERED	DUE DATE	6 month Update
		Recurring Operational Objectives	status	To Dec. 2016
4.1	Datix	Design, test and facilitate the implementation of the Health and Safety modules of Datix. • Worker incident reporting • Hazard ID and Risk assessment Register • Risk Register Develop internal review and support systems to be provided by the Health and Safety Advisor team to assist managers to utilize the Health and Safety modules of Datix effectively.	June 2017	**In Progress:** Kiosk Incident reporting to transfer to new SMS in March 2017 Hazard Register to transfer to new SMS in March 2017 System customisation completed Training videos and quick cards underdevelopment Training manual under development Plan for all relevant Health and Safety documentation to be updated in place

Developmental		WHAT WILL BE DELIVERED	DUE DATE	6 month Update
		Recurring Operational Objectives	**status**	**To Dec. 2016**
4.2	ACCPP audit standards review	Review the ACCPP audit standards and ensure alignment of Health and Safety systems and injury management systems are aligned with the requirements of the new audit standards to be in effect 1/04/17.	June 2017	**To commence in April 2017** New ACCPP audit standards to be released in April 2017 Gap analysis and action plan to be developed in preparation for 2017 ACCPP audit.
4.2	Healthy Workplaces Strategy	Develop and release a healthy workplaces strategy	June 2017	**In Progress:** Development of People Strategy as reported by HR
4.3	Compliance Monitoring	Develop a process to track Auckland DHBs legal obligation in relation to NZ Safety legislation and codes of practice. Report results to Health and Safety Governance Committee and Finance Risk and Audit Committee every 6 Months.	June 2017	**To be developed** Project to be commenced in the second half of the 2016/17 fiscal year
4.4	Safety Culture Survey	Develop a proposal for a Safety Climate or Safety Culture Survey to inform the communication of Health and Safety systems within Auckland DHB	June 2017	**To be developed** Project to be commenced in the second half of the 2016/17 fiscal year
4.5	Auckland DHB staff position Descriptions	• Develop a proposal to include Health and Safety responsibilities in all Auckland DHB position Descriptions • Develop a proposal to ensure the all management staff are reviewed against their Health and Safety accountability	June 2017	**To be developed** Project to be commenced in the second half of the 2016/17 fiscal year

Objective: 1.1: Lost Time Injury Frequency Rate



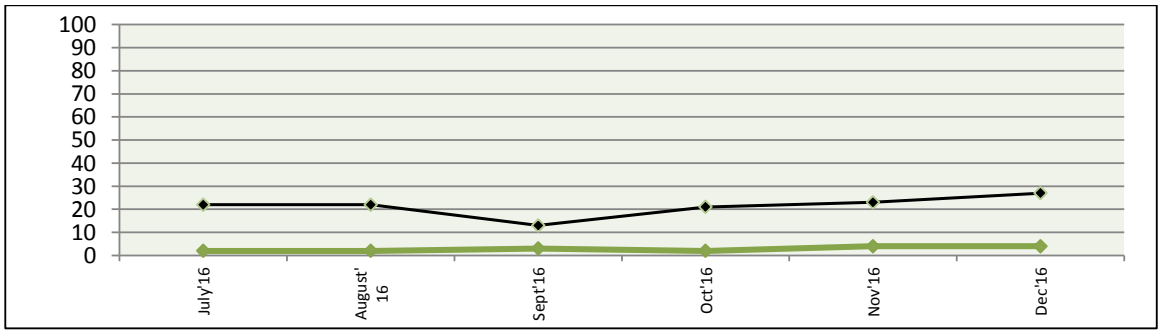
Objective 3.1: Moving and Handling



Objective: 3.3: Workplace Violence Prevention

LEGEND: Claims **Health & Safety Incidents:**

WORKPLACE VIOLENCE



Objective 3.4 Facilities Safety

Project/Initiative	Health and Safety Risk	Actions taken July16-Dec.16
Pedestrian Safety all campuses	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 risk remains moderate until the work to improve traffic safety is completed at Grafton and GCC and a Traffic management plan is established.	A Pedestrian Safety steering group has been formed and monthly meeting are being held to agree priorities for remediation. Additional traffic engineering and project feasibility reports completed for Grafton site. Projects are being progressed as funding allows. Projects completed: • Improved speed bumps at GCC • Pedestrian walkways car park B • Speed change both sites (10kph) • Re painted pedestrian crossings at ACH • Starship corner lane markings • Level 4 entrance emergency lane signage
Site security project	One of the key drivers for the Security for Safety Programme was as a result of an Independent Security Risk Assessment completed in June 2015. The objective of the report was to "undertake a full security assessment to ascertain the level of preparedness to lock-down Auckland DHB sites in the event of a critical incident – specifically armed offenders including an "active shooter". The Independent Security Assessment risk assessment and key findings highlighted four distinct areas that do not converge in a way that is essential in managing a safe and effective lock-down response which raises the level of safety risk and ability to respond to a critical incident. These four areas are personnel, procedures, equipment and premises. The 12 projects within the Security for Safety programme cover these four areas through	• Development of a draft Code Black policy and response procedures for a site lock-down during a critical event. • Development and approval of access plans for Starship Hospital and an access model for Auckland DHB to assist in the management and consistency for building access across the DHB. • Security Control Room upgrade completed and handed over to the Security team. • Issued over 13,000 Security ID cards. • Upgrade of over 150 door cards readers onto the new access control system and development of role based access model. • Commissioned the new Milestone CCTV system and installed over 100 new digital CCTV cameras. • Developed vision for future security staffing and services and completed the detailed definition of services. • Completion of needs analysis for security awareness / education and developed first e-learning module.

Project/Initiative	Health and Safety Risk	Actions taken July16-Dec.16
	implementation of new security systems, processes, training and awareness.	
Asbestos management	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. Asbestos in situ is safe. The risk remains moderate due to the unknowns in the asbestos register and the contractor management improvements required.	Bi weekly committee meetings Collaboration with WDHB is underway in relation to asbestos management plan and communication plan. Progress on Actions: • 90% Building surveys completed • Communication plan drafted • Asbestos Management plan drafted • Bespoke Asbestos register programme developed • Mandatory Contractor awareness training • Asbestos register contractor compliance audits underway • Asbestos removal in several areas as required
Contractors Health and Safety Management	Many types of contractors require access to Auckland DHB facilities to deliver agreed services. The new legislation increased the organisation accountability for Health and Safety requiresments. Contractor Health and Safety managmnet across the organisation has been inconsistant and posed a Health and Safety risk for Auckland DHBworkers and contractors. Risk reduction in this areas requires systems improvement from two key stakeholders ie Facilities and Commercial Sercice. A number of initiatives are underway to reduce this risk.	Facilities Actions: • Contractor Health and Safety management program implemented • Online Contractor worker induction • Take 5 added to BEIMs job work orders • Auckland DHB Contractor Policy reviewed and updated • External audit with 18 key contractors. • Contractor Panel agreements implemented • Safety in Design templates being developed • Ladder safety program and information to contractors • Lift SOP developed as 80% of lift defects originate from the lift doors being knocked/ bumped. Commercial Services actions: • Audit of Commercial Services contracts conducted, gap analysis completed • All audited companies have received audit results • Work on development of consistent Health and Safety systems compliance

Project/Initiative	Health and Safety Risk	Actions taken July16-Dec.16
		underway. • Contractor Safety management aligned with Security for Safety programme.

Objective: 3.5: Leading and Lagging Indicators

Board KPI	Target	July 2016	Actions Taken	Dec. 2016
Attendance at Welcome Day	88%	79%	Welcome Day has been re-designed and the Health and Safety Induction componenet has been reviewed.	84%
% local Health and Safety Induction completed within 7 days	80%	29%	Electronic reporting has been introduced Data base to track compliance has been developed Monthly reminders will be sent to managers Non-Compliance will be reported to Directorate from Feb. 2017	35%
Increase the number of Health and Safety Reps attending training	80%	47%	120 Health and Safety Reps completed WorkSafe approved Transition Training in June 2016 Plan to provide Health and Safety Rep NZQA training as required by HSWA developed A supplier to deliver NZQA training to Health and Safety Reps has been engaged. Training commenced in December 2016 Training dates for 2017 published	51%
Increase number of hazard registers current	80%	25%	A transitional on line Hazrad Register developed Directorates supported with populating their directoate register. Hazard Register within the new Safety Management System developed (Datix)	58%
Increase % of staff incidents investigated by the manager	80%	74%	Manager receive regular communication for Health and Safety regarding completion of incident reports Reminders sent monthly Monthly non compliance report provided to Diretorate Health and Safety committees Compliance KPI included in Directorate Health and Safety score card.	75%
Increase % hazard remediation by managers	80%	RU	Awaiting implementaion of Datix system	RU
Increase % of mandatory Health and Safety induction e leaning completed	90%	57%	Electronic reporting has been introduced Data base to track compliance has been developed Monthly reminders will be sent to	86%

Board KPI	Target	July 2016	Actions Taken	Dec. 2016
			managers Non-Compliance will be reported to Directorate from Feb. 2017	

Financial Performance Report

Recommendation

That the Board

(i) Receives this Financial Report for February 2017.

Prepared by: Rosalie Percival, Chief Financial Officer

1. Executive Summary

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

YTD revenue was unfavourable to budget by $10.2M. Key contributors to unfavourable revenue include: under delivery of inpatient and additional electives volumes (net $5.7M adverse wash-up provision); less than planned Public Health revenue ($1.2M, timing only); Haemophilia funding ($1.6M, due to lower blood product usage); donation income ($1.7M, timing only); and interest income ($2M, lower interest rates). These are offset by favourable IDF Inflows ($1.3M, service changes) and other income ($2.5M, mainly research grants and drug trial revenue, with corresponding costs).

YTD expenditure is favourable to budget by $3.9M. This is primarily due to favourable Funder NGO expenditure ($15.7M, mainly pharmaceuticals, Age Related Residential Care and Mental Health services). This offsets adverse expenditure in net personnel and outsourced personnel costs ($7.2M); clinical supplies ($4.4M) and infrastructure/ non-clinical supplies ($2.5M).

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

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

Summary Results as at 28 February 2017

$000s	Month (February-17)			YTD (8 months ending 28 Feb-17)			Full Year (2016/17)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
MOH Sourced - PBFF	98,866	98,860	5 F	790,936	790,883	53 F	1,186,378	1,186,325	53F
MoH Contracts - Devolved	9,299	9,011	288 F	67,191	72,089	4,898 U	104,966	108,134	3,168U
	108,165	107,872	294 F	858,127	862,972	4,845 U	1,291,344	1,294,459	3,115U
MoH Contracts - Non-Devolved	4,710	4,834	123 U	36,330	39,376	3,046 U	57,787	59,538	1,751U
IDF Inflows	53,355	52,772	583 F	423,481	422,174	1,307 F	639,776	633,262	6,514F
Other Government (Non-MoH, Non-OtherDHBs)	3,200	3,169	31 F	25,306	25,190	116 F	37,796	37,738	58F
Patient and Consumer sourced	1,334	1,631	297 U	11,804	12,683	879 U	18,573	19,207	634U
Inter-DHB & Internal Revenue	895	1,280	385 U	8,781	10,389	1,607 U	14,040	15,791	1,751U
Other Income	4,706	4,157	549 F	35,990	33,412	2,578 F	50,944	48,721	2,223F
Donation Income	768	593	175 F	3,072	4,785	1,714 U	8,272	8,907	635U
Financial Income	481	660	178 U	3,087	5,174	2,087 U	4,839	7,606	2,767U
Total Income	**177,614**	**176,965**	**649 F**	**1,405,979**	**1,416,155**	**10,176 U**	**2,123,371**	**2,125,229**	**1,858U**
Expenditure									
Personnel	72,099	71,236	863 U	586,336	585,834	501 U	894,817	889,213	5,604U
Outsourced Personnel	1,828	1,111	717 U	15,699	8,959	6,740 U	22,802	13,402	9,400U
Outsourced Clinical Services	1,875	2,057	182 F	15,004	16,694	1,689 F	26,800	24,923	1,877U
Outsourced Other Services (incl. hA/funder Costs)	5,456	5,041	415 U	41,068	40,325	743 U	60,263	60,488	225F
Clinical Supplies	20,699	20,739	39 F	169,058	164,617	4,441 U	259,471	254,983	4,488U
Funder Payments - NGOs	47,109	47,642	533 F	365,458	381,138	15,680 F	547,118	571,707	24,589F
Funder Payments - IDF Outflows	9,289	9,567	277 F	76,140	76,533	393 F	115,557	114,800	757U
Infrastructure & Non-Clinical Supplies	11,577	11,173	404 U	92,755	90,309	2,446 U	137,957	135,452	2,505U
Finance Costs	513	1,052	539 F	7,801	8,414	613 F	12,537	12,621	84F
Capital Charge	3,534	3,622	88 F	28,266	28,652	386 F	42,842	43,140	298F
Total Expenditure	**173,979**	**173,238**	**740 U**	**1,397,585**	**1,401,475**	**3,890 F**	**2,120,164**	**2,120,729**	565F
Net Surplus / (Deficit)	**3,636**	**3,727**	**91 U**	**8,394**	**14,681**	**6,286 U**	**3,207**	**4,500**	**1,293 U**

2. Result by Arm

Result by Division	Month (February-17)			YTD (8 months ending 28 Feb-17)			Full Year (2016/17)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	1,952	375	1,577 F	13,623	3,000	10,623 F	(18,889)	4,500	23,389U
Provider	1,700	3,352	1,652 U	(4,725)	11,681	16,405 U	22,500	0	22,500F
Governance	(16)	0	16 U	(504)	0	504 U	(404)	0	404U
Net Surplus / (Deficit)	**3,636**	**3,727**	**91 U**	**8,394**	**14,681**	**6,286 U**	**3,207**	**4,500**	**1,293 U**

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

The unfavourable YTD Provider Arm result is driven by less revenue than planned ($4.8M) mainly reflecting under-delivery of elective volumes, and lower interest and donation income than planned. Expenditure was also unfavourable ($11.6M) 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 February 2017

Month Result

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

Revenue was more than budget by $0.7M (0.4%), mainly driven by:

- IDF Inflow revenue is favourable by $0.6M (1.1%) mainly from the favourable impact of PHO quarterly wash-ups and the PHO Fee for service half yearly wash-up.
- Other income $0.5M (13.2%) favourable mainly due to Research grant income.

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

Expenditure was adverse to budget by $0.7M with significant variances in:

- Funder NGOs favourable by $0.5 M (1.1%), 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 $1.5M (2.2%) unfavourable, mainly in Medical, Allied Health and Management & Admin costs. Total FTEs at 8,616 are 272 FTE above budget – the unfavourable FTE variance is primarily due to savings targets incorporated into the budget but also reflects a temporary spike in Nursing FTE following the main intake of new graduates in February (this should reduce over the next two months). The cost impact of FTE above budget is partially offset by lower cost per FTE due to reductions in overtime and other premium payments.
- Finance costs were $0.5M favourable due to the Crown Debt Equity swap effected on 15 February which has removed interest expense for the rest of the year, although this is bottom-line neutral as matched by revenue reduction.

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

Revenue was less than the budget by $10M. Significant movements underlying this included:

- MOH devolved contract revenue is $4.9M unfavourable YTD. The YTD adverse variance is mainly due to the creation of a revenue risk provision for the under delivered inpatient services and additional electives (net $5.7M). Also included in the month and YTD result is a net $0.3M decrease in Capital Charge revenue due to the cost of capital rate change from 8% to 7% (full year impact is$6.1M) offset by an increase in revenue to compensate for the asset revaluation impact at June 2016 ($5.6M). To a much lesser extent there is also an element of Funded Initiatives influencing the YTD position. These are offset by equivalent expenditure variances and have a nil effect on the overall result.
- IDF Inflow revenue, $1.3M favourable YTD, is funding received from other DHBs and much of this revenue is variable according to service delivery and therefore at risk if under delivered. IDF Inflow revenue is also influenced by post budget service changes against budget but this is usually marginal. Also affecting variances are service changes and wash ups. Services changes include lower than budgeted inflows for Paediatric and Adult Congenital Cardiac starting from November offset by higher than budgeted inflows for PCT Melanoma starting from December. Wash ups include the favourable impact of the Ministry's PHO quarterly wash-ups settled in August and November as well as a favourable last quarter 2015/16 adjustment for Paediatric and Adult Congenital Cardiac inflow.
- Research and drug trial Income $2.4M favourable, offset by equivalent expenditure and bottom line neutral.
- ACC revenue $1.2M favourable – with the variance reflecting a combination of one off revenue for new contracts and a small number of high value elective cases.
- Donations $1.7M 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 $1.6M unfavourable for low blood product usage, bottom line neutral as offset by reduced expenditure.
- Other income includes a $0.5M gain on the valuation of A+ Trust financial assets.
- Financial Income $2M unfavourable driven by lower interest rates than assumed in the budget.

Expenditure was less than budget YTD by $3.9M, with significant underlying variances as follows:

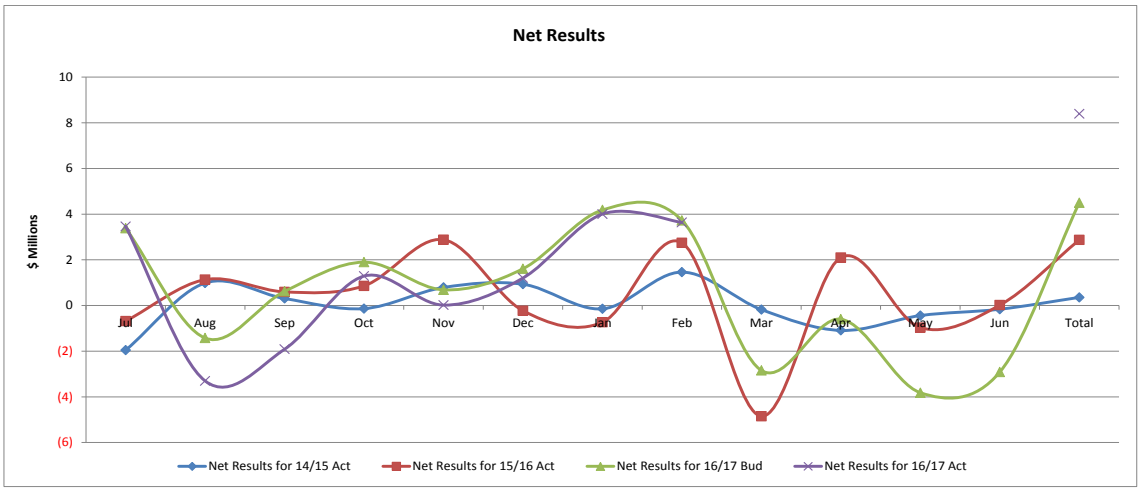
- Combined Personnel and Outsourced Personnel Costs $7.2M (1.2%) unfavourable, mainly in Medical ($5.1M), Nursing ($2.6M) and Management & Admin ($1M) categories. YTD combined

FTEs were 196 (2.3%) 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 $4.4M (2.7%) unfavourable comprising the following key variances:
  - Haemophilia blood products $1.4M favourable due to low product usage year to date (highly variable), but offset by reduced income.
  - PCT (cancer) drugs $2.2M unfavourable due to increased volumes of Herceptin and melanoma drugs combined with unbudgeted new high cost drug Pertuzumab (note partially offset by additional revenue of $1.1M year to date, and will be subject to full IDF washup at year end).
  - Cardiovascular $0.9M 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.
  - One off costs for loss on disposal of assets $0.4M.
- Outsourced Clinical Services $1.7M (10.1%) favourable, reflecting no Orthopaedic elective surgery outsourcing YTD ($3.3M favourable but this is offset by an unfavourable Orthopaedics elective revenue position), and this is offset by costs of additional outsourcing in Ophthalmology to address waitlist and meet MOH targets.
- Funder Payments to NGOs are YTD favourable $15.7M (4.1%) 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 $2.4M (2.7%) unfavourable primarily reflecting unfavourable facilities costs due to additional health and safety related expenditure.

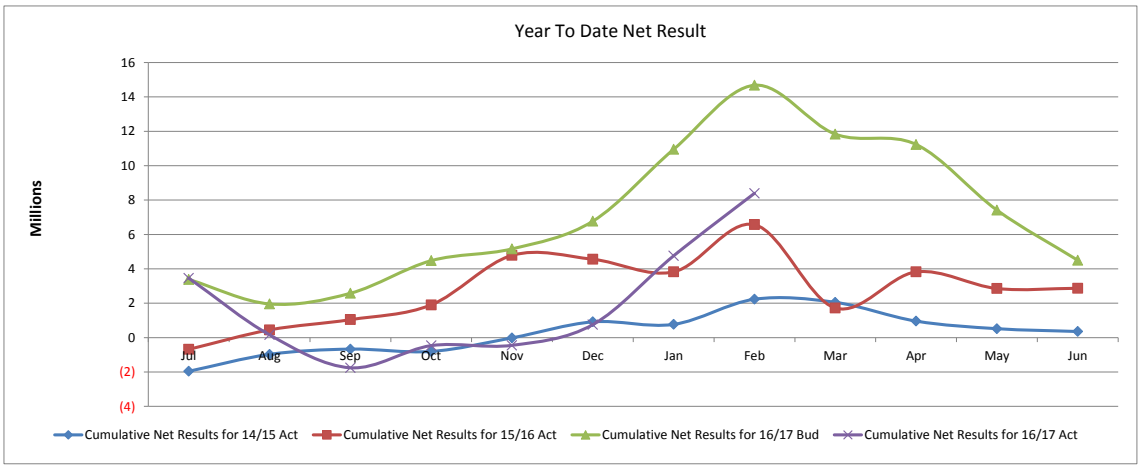
4. Performance Graphs

Figure 1: Consolidated Net Result (Month)



$ millions	July	August	Spetember	October	November	December	January	February	March	April	May	June	Total
Net Result for 14/15 Act	(1.957)	0.984	0.306	(0.137)	0.790	0.931	(0.147)	1.462	(0.179)	(1.093)	(0.441)	(0.164)	0.355
Net Result for 15/16 Act	(0.683)	1.133	0.595	0.859	2.881	(0.227)	(0.734)	2.747	(4.850)	2.101	(0.967)	0.015	2.871
Net Result for 16/17 Bud	3.385	(1.426)	0.619	1.897	0.686	1.610	4.182	3.727	(2.844)	(0.600)	(3.819)	(2.916)	4.500
Net Result for 16/17 Act	3.462	(3.302)	(1.914)	1.290	0.017	1.203	4.004	3.636					8.394

Figure 2: Consolidated Net Result (Cumulative YTD)



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

5. Efficiencies / Savings

Savings reported for the YTD to January 2017 of $15M were unfavourable to the budget of $28M by $13M. Savings achieved to date mainly relate to personnel/FTE/vacancy management, bed management, Laboratory/Radiology efficiencies and supply chain and Funder reported savings. Initiatives being implemented take time for the savings to start coming through. A financial sustainability programme has been established to oversee identification, implementation and realisation of savings from the Get on Track and Think Tank initiatives.

6. Financial Position

6.1 Statement of Financial Position as at 28 February 2017

$'000	28-Feb-17			31-Jan-16	Variance	30-Jun-16	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	881,298	576,798	304,500F	576,798	304,500F	576,798	304,500F
Reserves	-	-	0F	-	0F	-	0F
Revaluation Reserve	508,998	438,457	70,541F	508,998	0F	508,998	0F
Cashflow-hedge Reserve	(3,374)	(3,373)	1U	(3,420)	46F	(3,742)	368F
Accumulated Deficits from Prior Year's	(461,173)	(461,652)	479F	(461,173)	0F	(461,173)	0F
Current Surplus/(Deficit)	8,396	14,676	6,280U	4,760	3,636F	-	8,396F
	52,847	(11,892)	64,739F	49,165	3,682F	44,083	8,764F
Total Equity	**934,145**	**564,906**	**369,239F**	**625,963**	**308,182F**	**620,881**	**313,264F**
Non Current Assets							
Fixed Assets							
Land	282,803	249,006	33,797F	282,803	0F	282,803	0F
Buildings	610,790	586,349	24,441F	612,756	1,966U	619,402	8,612U
Plant & Equipment	84,108	89,504	5,396U	82,075	2,033F	92,164	8,056U
Work in Progress	48,773	59,257	10,484U	49,994	1,221U	45,236	3,537F
	1,026,474	984,116	42,358F	1,027,628	1,154U	1,039,605	13,131U
Derivative Financial Instruments	-	-	0F	-	0F	-	0F
Investments	-						
- Health Alliance	57,637	53,103	4,534F	57,637	0F	53,103	4,534F
- HBL	12,420	12,420	0U	12,420	0F	12,420	0F
- ADHB Term Deposits > 12 months	-	-	0F	-	0F	5,000	5,000U
- Other Investments	505	503	2F	503	2F	503	2F
	70,562	66,026	4,536F	70,560	2F	71,026	464U
Intangible Assets	542	1,223	681U	589	47U	762	220U
Trust Funds	15,690	14,494	1,196F	15,531	158F	14,495	1,195F
	86,793	81,743	5,050F	86,680	113F	86,283	510F
Total Non Current Assets	**1,113,267**	**1,065,859**	**47,408F**	**1,114,308**	**1,041U**	**1,125,888**	**12,621U**
Current Assets							
Cash & Short Term Deposits	85,892	58,416	27,475F	85,154	738F	34,461	51,431F
Trust Deposits > 3months	9,000	11,500	2,500U	8,000	1,000F	11,500	2,500U
ADHB Term Deposits > 3 months	11,000	5,000	6,000F	10,000	1,000F	15,000	4,000U
Debtors	21,234	29,872	8,637U	20,609	625F	29,869	8,635U
Accrued Income	42,778	32,179	10,599F	37,396	5,382F	32,179	10,599F
Prepayments	2,005	1,679	326F	2,521	516U	1,679	326F
Inventory	14,545	14,239	306F	14,585	40U	14,239	306F
Total Current Assets	**186,455**	**152,885**	**33,570F**	**178,265**	**8,190F**	**138,928**	**47,527F**
Current Liabilities							
Borrowing	(429)	(429)	0U	(429)	0F	(429)	0F
Trade & Other Creditors, Provisions	(156,027)	(191,037)	35,010F	(203,676)	47,649F	(133,316)	22,711U
Employee Benefits	(169,932)	(168,415)	1,517U	(168,783)	1,149U	(166,232)	3,701U
Funds Held in Trust	(1,255)	(1,239)	16U	(1,254)	2U	(1,239)	16U
Total Current Liabilities	**(327,644)**	**(361,120)**	**33,476F**	**(374,143)**	**46,498F**	**(301,217)**	**26,428U**
Working Capital	**(141,190)**	**(208,235)**	**67,045F**	**(195,878)**	**54,688F**	**(162,289)**	**21,099F**
Non Current Liabilities							
Borrowings	(279)	(255,065)	254,786F	(254,815)	254,536F	(305,065)	304,786F
Employee Entitlements	(37,653)	(37,653)	0F	(37,653)	0F	(37,653)	0F
Total Non Current Liabilities	**(37,932)**	**(292,718)**	**254,786F**	**(292,468)**	**254,536F**	**(342,718)**	**304,786F**
Net Assets	**934,145**	**564,906**	**369,239F**	**625,963**	**308,181F**	**620,881**	**313,263F**

Comments

Category	Comment
Public Equity and Borrowings	In February 2017 $304,500m of the ADHB debt was converted in Public Equity. This was in terms of a change in government policy impacting how DHB capital is financed.
Fixed Assets	The full revaluation of land and buildings completed at 30 June 2016 resulted in an increase in revaluation reserve of $70.5M ($33.8M for land and $36.7M for buildings), these revaluation adjustments were not accounted for in the 2016/17 budget. This is offset by less spend of capital expenditure against budget of $22m due to the delayed approval of the Capex Budget by the Board as a result of an extensive Capex prioritisation process for the 2016/17 Capex Budget.
Cash & short term deposits	Capex spend is $22m behind, due to delayed Board approval of 2016/17 capex budget. $16m favourable variance in payments to NGO funder providers. These are offset by $4.5m investment in healthAlliance for the transfer of IT assets C class shares which was not in the budget.
Creditors	Trade & Other Payables: $50m favourable is as a result of the conversion of Crown Debt to equity in February; and other differences reflect timing differences for creditors accruals $13m and income in advance $3m.

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

$000's	Month (February-17)			YTD (8 months ending 28 Feb-17)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	166,836	176,306	9,470U	1,402,905	1,410,978	8,073U
Payments						
Personnel	(70,950)	(70,963)	13F	(582,635)	(583,653)	1,018F
Suppliers	(29,814)	(37,101)	7,287F	(286,286)	(289,027)	2,741F
Capital Charge	0	0	0F	(21,199)	(21,408)	209F
Funder payments	(56,397)	(57,209)	812F	(441,596)	(457,672)	16,076F
GST	(921)	0	921U	1,123	0	1,123F
	(158,081)	**(165,273)**	7,192F	**(1,330,594)**	**(1,351,760)**	21,166F
Net Operating Cash flows	**8,755**	**11,033**	**2,278U**	**72,311**	**59,218**	**13,093F**
Investing						
Interest Income	481	660	180U	3,087	5,173	2,086U
Sale of Assets	0	0	0F	0	0	0F
Purchase Fixed Assets	(3,182)	(5,905)	2,723F	(24,421)	(47,244)	22,823F
Investments and restricted trust funds	(2,120)	0	2,120U	9,820	15,000	5,180U
Net Investing Cash flows	**(4,821)**	**(5,245)**	**423F**	**(11,514)**	**(27,071)**	**15,557F**
Financing						
Other Equity Movement	0	(1)	1F	1	4	3U
Interest paid	(3,194)	(17)	3,177U	(9,365)	(6,047)	3,318U
Net Financing Cashflows	**(3,194)**	**(18)**	**3,176U**	**(9,364)**	**(6,043)**	**3,321U**
Total Net Cash flows	**740**	**5,770**	**5,031U**	**51,433**	**26,104**	**25,329F**
Opening Cash	85,154	47,648	37,507F	34,461	32,314	2,147F
Total Net Cash flows	740	5,770	5,031U	51,433	26,104	25,329F
Closing Cash	**85,894**	**53,418**	**32,476F**	**85,894**	**58,418**	**27,476F**

ADHB Cash	81,289	**55,883**	25,406F
A+ Trust Cash	1,029	**479**	550F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	3,576	**2,056**	1,520F
	85,894	**58,418**	**27,476F**
ADHB - Short Term > 3 months	11,000	**5,000**	6,000F
A+ Trust Deposits - Short Term > 3 months	9,000	**11,500**	2,500U
ADHB Deposits - Long Term	0	**0**	0F
A+ Trust Deposits - Long Term	15,689	**14,494**	1,195F
Total Cash & Deposits	**121,583**	**89,412**	**32,171F**

Funder Update

Recommendation

That the Funder Update Report for March 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 Māori Health Gain); Lita Foliaki, (Manager Pacific Health Gain); Samantha Bennett, (Manager Asian Health Gain)
Endorsed by: Dr Debbie Holdsworth, (Director Funding)

Glossary

AH+	-	Alliance Health Plus
AOD	-	Alcohol and Other Drugs
ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
ASH	-	Ambulatory Sensitive Hospitalisation
DHB	-	District Health Board
DSLA	-	Diabetes Service Level Alliance
HBHF	-	Healthy Babies Healthy Futures
HCSS	-	Home and Community Support Services
HEEADDSSS	-	Home, Education/Employment, Eating, Activities, Drugs, Alcohol, Sexuality, Suicide and Depression, Safety
HepB	-	Hepatitis B
HNA	-	Health Needs Assessment
HVAZ	-	Healthy Village Action Zones
ICS	-	Interim Care Scheme
IDAT	-	Involuntary Drug and Alcohol Treatment Programme
IPIF	-	Integrated Performance and Incentive Framework
LCS	-	Local Coordination Service
LMC	-	Lead Maternity Carer
MBIE	-	Ministry of Business, Innovation and Employment
MELAA	-	Middle Eastern, Latin American and African
MHA	-	Mental Health and Addictions
MoH	-	Ministry of Health
NGO	-	Non-Governmental Organisation
NRA	-	Northern Regional Alliance
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
RFP	-	Request For Proposal
SACAT	-	Substance Addiction Compulsory Assessment and Treatment
SLM	-	System Level Measures
TAG	-	Technical Advisory Group

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 22 February 2017.

1. Planning

1.1 Annual Plans

The first draft of the 2017/18 Annual Plan was presented to the Finance Risk and Assurance Committee meeting on 15 March for review. The final first draft will incorporate changes made as a result of feedback received at this meeting and final approval sought via circular resolution. The final first draft will be submitted to the Ministry of Health (MoH) by 31 March.

The 2017/18 funding envelope is still pending, therefore MoH due dates for the second draft have been extended into June. Further MoH guidance has been released for some priorities and measure definitions. The MoH is not expecting to see changes as a result of this late guidance until the second draft. The Statement of Intent has been redrafted to incorporate System Level and contributory measures and this will be updated once the 2017/18 System Level Measure Improvement Plan has been finalised.

1.2 Annual Reports

Audit New Zealand will commence some of the Statement of Service Performance (2016/17 Annual Plan) testing during their interim audit visit starting 8 May 2017.

1.3 System Level Measure Reporting

The 2017/18 System Level Measures (SLM) Improvement Plan is currently being drafted under the Auckland and Waitemata Primary Care Alliance Leadership Team and Counties Manukau Health Alliance. The SLM Steering Group oversees six working groups related to the six SLM measures. The SLM from July 2016 are:

1. Ambulatory Sensitive Hospitalisations rates for 0-4 year olds
2. Acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality

Two new developmental measures for 2017/18 (not yet finalised by the MoH):

1. Youth access to and utilisation of youth-appropriate health services
2. Proportion of babies who live in a smoke free household at six weeks post birth

We are working with Counties Manukau Health to develop a tool to report SLM head measures and the selected contributory measures developed in the Improvement Plans on a quarterly basis along with progress to date on planned activities to improve performance.

2. Hospitals

2.1 Cancer target

The Auckland DHB provider reported achievement of the 62-day FCT indicator for January 2017 at 89.3%. A range of Auckland DHB provider led improvement initiatives has the DHB on track to achieve the 90% achievement required by 30 June 2017.

2.2 Auckland DHB 2016/17 Surgical Health Target

2016/17 ADHB Surgical Health Target

For the period ending year to date February, the Auckland DHB Surgical Health Target is 95.7% overall with the provider surgical discharges tracking at 94.1% of planned volumes.

Year to Date Performance - February

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. Each service has plans in place to address the discharge shortfall currently being reported, including a plan to outsource small volumes of adult and paediatric ENT services in the next month. Additional alternative capacity for Adult Orthopaedic procedures is currently being explored. However, there is no capacity available with both Waitemata DHB and Counties Manukau Health currently outsourcing Orthopaedic services to private providers. Counties Manukau Health is currently considering a request to do 10 elective spinal procedures for the Auckland DHB population prior to 30 June 2017. At this stage two private providers have indicated they have capacity available to undertake up to 300 Adult Orthopaedic procedures, negotiations are underway regarding the casemix of procedures and contract prices.

The 2016/17 adult Orthopaedic discharge target for the Auckland DHB provider is 1625 discharges and the provider is forecasting to achieve 1070 discharges by 30 June 2017. This is approximately 150-200 discharges less than the volumes delivered internally for the Auckland DHB population in 2014/15 and 2015/16. It is unlikely the level of outsourced capacity available to 30 June will offset an expected shortfall of 250 Orthopaedic discharges. There is also insufficient demand and capacity to address this Orthopaedic shortfall in other clinical services for the Auckland DHB population notwithstanding the particular requirement of the Minister to increase Orthopaedic services in 2016/17 which we will not achieve.

As previously reported to the Board, the Auckland DHB provider continues to over deliver elective procedures for the Counties Manukau population in Urology and Cardiology services. Counties Manukau Health has previously advised of their intention to increase internal production in these service areas during 2016/17 however this does not appear to be occurring as previously intended.

Outsourcing Arrangements

Cataract outsourcing arrangements have continued as planned, with the total expected level of discharges by the contracted private provider being achieved. The RFP for a panel of suppliers for Ophthalmology procedures going forward has now been completed, this will allow future outsourcing to occur as needed on an ongoing basis throughout the year at the best price.

The current Orthopaedic outsourcing discussions that are needed to meet 2016/17 population needs, the discharge target and ESPI compliance, has led to a range of discussions with both DHB and private providers regarding indicative 2017/18 Orthopaedic capacity. As a result of these discussions a provisional plan has been established with volume commitments made to both Waitemata DHB and Counties Manukau Health, and private providers. The intention is to avoid the need to source new capacity throughout the year and to provide sufficient notice to providers to establish capacity in a coherent and cost effective manner.

ESPI Compliance

MoH reporting continues to show Auckland DHB has been ESPI 5 non-compliant since July 2016 and this is driven by the ongoing capacity issues in both adult and paediatric Orthopaedics. Based on provider reporting to the week ending 17 March 2017, 34% of patients waiting for Adult Orthopaedic surgery were waiting in excess of 120 days. This position will not materially improve unless we are successful in securing 300 discharges through private providers by 30 June. Assuming we do achieve

300 discharges in the private sector, to achieve full ESPI compliance in Adult Orthopaedics by 30 June, the Auckland DHB provider will need to ensure patients are booked for surgery in order of highest clinical priority, then longest time waiting for lower priority patients.

There are ongoing issues with insufficient internal capacity to meet the demand for Paediatric spinal surgery resulting in children and young people waiting up to 12 months for P2 surgery. Progress is being made within the service however it is not yet clear whether the ESPI compliance issues in this service will be resolved by 30 June.

The DHB is expected to be moderately non-compliant in ESPI 2 for March.

2.3 IDF Arrangements

2015/16

The Counties Manukau Health/Auckland DHB outpatient wash up has not been finalised due to a delay in getting the MoH data error corrected however both parties agree with the volume of services provided and this enables the wash-up to be settled within the next month.

2016/17

Wash-up forecasts are routinely monitored and changing trends reviewed by the funder. There is a marked change in the use of Pharmaceutical Cancer Treatments for breast cancer and this is expected to increase further with the addition of a new breast cancer funded treatment that commenced in later 2016. All costs associated with these changes are subject to full wash-up.

2017/18

IDF forecasts were finalised in time for the February deadline and no change was made to the IDF arrangements for the Counties population. A new funding agreement for the Hyper acute Stroke and Clot Retrieval services is currently being negotiated and will be implemented in time for the new services to start July 2017.

2.4 Policy Priority areas

Colonoscopy Indicators

Auckland DHB has continued to achieve all colonoscopy waiting time indicators in December and January as validated by MOH reporting. Auckland DHB has commenced colonoscopy activity for the Waitemata population from February 2017 to reduce Waitemata DHB's reliance on outsourcing and discussions are underway presently to increase this volume from July 2017.

Radiology Indicators

As at the end of December, the Auckland DHB provider achieved 97.5% outpatient CT completed within six weeks, with MRI performance deteriorating further over the last month to 67%. 86% of outpatient ultrasounds were completed within six weeks against a DHB target of 95%. The deterioration in the reported MRI and US position is mainly due to high numbers of staff vacancies and the Auckland DHB provider is making good progress across a range of initiatives to address these workforce issues, with performance expected to be seen in the next few months.

Bone Marrow Waiting Times

Four patients waited longer than the clinically recommended six weeks maximum waiting time guideline in January and one in February, however the service is expected to maintain compliance with the guidelines going forward.

2.5 National services

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 and the MoH has signalled an intention to renew a

three year arrangement. Further discussion is needed as to whether the current coordination service and governance arrangements are sustainable.

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

2.6 Regional Service Review Programme

Regional clinical discussions have commenced in support of the Regional review of Head and Neck services. Further work is to occur regionally to agree the long term configuration and financial sustainability of regional Urology services in light of the impact of the Counties Manukau Health local delivery arrangements. A review of regional Oral Health service delivery arrangements, including the configuration of primary and specialist dental services, has been initiated in response to the opportunities arising for the Counties population from the CMDHB alliance with the University of Otago Dental School.

As previously advised to the Board, 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 Auckland DHB funder, for the new Auckland DHB services, including the Clot Retrieval service, and regional consultation on the funding approach is continuing throughout February and March.

3. Primary Care

3.1 Health Targets

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. Several PHOs are now edging closer to the target being approximately two percentage points off. 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.

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 Māori 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 audit protocol has been tested with ProCare and three of its general practices. A full audit schedule has now been agreed with completion in May 2017.

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 SLM that have been introduced this year.

The SLM were 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 DHB outcomes frameworks.

The 2016/17 improvement plan has been reworked to meet the MoH requirements for a stronger focus on specified improvement milestones. The draft plan has been submitted to the MoH for comment with a finalised plan due for submission in May.

The DSLA has recently completed a 'Co-design' process with people who have diabetes. Co-design is underpinned by the mindset that people are experts in their own lives and deserve to play an active role in the decisions that shape their lives. Of the 22 people involved Māori, Pacific (Tongan and Samoan), and Indian people were engaged. Across these groups we spoke to people newly diagnosed (ranging from one to six months ago); those who have struggled to manage their diabetes for many years (10-20 years); those who have experienced serious complications from their diabetes (lower limb amputation); people of various ages, genders, and places of residence (across Auckland and Waitemata). The Co-Design report provides insights into the patients' perceptions of current state of the diabetes services. It has also identified a number of issues/barriers experienced by patients in engaging with the diabetes services. 11 key insights have been identified and the DSLA is now considering how these are incorporated in to the re-design of diabetes services.

3.4 Green Prescription and Active Families

The Funder has been undertaking a Request for Proposal for the Green Prescription and Active Families programmes. Preferred providers have been identified and agreements are being negotiated. The new agreements will have a focus on supporting innovation and increasing engagement for Māori and Pacific people.

4. Health of Older People

4.1 Home and Community Support Services (HCSS)

As part of the Settlement Agreement for Inbetween Travel, guaranteed hours for support workers will be implemented on 1 April 2017. During February meetings were held with regional HCSS providers to discuss the planning and implementation process. Providers and unions have been hosting workshops for employees.

Guaranteed hours are defined as the greater of either:

- 80% of the employee's average total hours (including any paid leave) over the 3 months prior to 1 December 2016; or
- The regular client hours as agreed by the employer and the employee.

Genuine casual workers are excluded from guaranteed hours.

The MoH will vary the Crown Funding Agreement to pass funding onto DHBs but this will be fiscally neutral to DHBs. There will be a wash up mechanism at 30 June 2017 and 30 June 2018.

Current contracts with HCSS providers will be varied by 31 March 2017. Providers will claim for cancelled clients visits (according to an Operational Policy Document) using the same system as currently used for Inbetween Travel claims. This will enable the workforce to be paid a wage as opposed to the current workforce which is paid on piecemeal basis as assignment workers.

4.2 Aged Residential Care (ARC)

An aged residential care (ARC) Funding Model Review project is underway. The Review will consider the issues identified with the current funding model and attempt to address them in a manner, which is both fair and equitable. Terms of Reference have been finalised for the Review, which will actively consider the relationship with other parts of the system such as primary and acute hospital care. A Steering Group will manage the project on behalf of consumers, DHBs and providers. The Review will be completed by December 2017.

All ARC providers are now able to access interRAI (standardised clinical assessment) reports for their facility. These reports are at an aggregated level and enable providers to compare their residents' health status with other similar facilities and against the DHB, other DHBs and all New Zealand.

4.3 Other Health of Older People Activity

The Health of Older People team is reviewing the Interim Care Scheme (ICS) to identify improvements and inform a future procurement process. ICS is short term admissions of inpatients into residential care (hospital level certified) when a patient does not have an acute medical condition that requires an acute hospital bed but are unable to be managed safely and appropriately at home e.g. a patient who is non-weight bearing for a period of time. Other areas currently being reviewed are day service contracts and respite care.

5. Women, Children & Youth

5.1 Immunisation Health Target

The immunisation health target is a continuing challenge as new cohorts of infants enter the health system and require a series of three vaccinations at six weeks, three months and five months of age. In spite of this, the immunisation health target was achieved in Q2, with 95% of infants fully immunised at eight months of age. Only one DHB achieved a higher result. Results for Pacific and Asian exceed the target, however results for Māori (91%) are not yet achieving target.

Questions have been raised on the level of childhood immunity for Hepatitis B (HepB), following the equipment failure, leading to contamination, at a dental clinic in Pukekohe. The HepB vaccine was introduced in 1998 (people vaccinated would now be aged 29 years). Three doses of the vaccine are given in the first year of life, New Zealand has had high immunisation coverage rates at 24 months of age for many years now. Almost everyone born since 2005 (people who are now aged 11 years) is now on the NIR, so almost all of the Pukekohe children would have an electronic Immunisation record.

All children were recalled as part of the Pukekohe incident and offered HepB serology. However, if they had already had a full course of HepB vaccinations (three doses) they would not need any additional doses (regardless of their serology) as HepB has been demonstrated to be highly effective (lasting over 20 years).

Counties Manukau Health looked at each child's immunisation record on the NIR to determine their Hepatitis B status. They have informed us, from their manual count, it is estimated that between 93% and 95% of the children were up to date for their course of HepB. This count is currently being confirmed.

5.2 Obesity Health Target – 'Raising Healthy Kids'

Auckland DHB was second to top in the country for the Raising Healthy Kids (obesity) health target, with the MoH noting this was an "outstanding" result. Auckland DHB achieved 97% of obese children identified had their referral acknowledged.

The target is, by December 2017, 95% of obese children identified in the Before School check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. Data is based on all acknowledged referrals for obese children up to the end of the quarter from Before School checks occurring in the six months between 1 June and 30 November 2016.

The processes and additional resources that the DHBs have put into this programme of work have meant this health target has been achieved a year ahead of the required timeframe. Efforts over 2017 will focus on maintaining these excellent results as well as exploring and evaluating issues around referrals being declined by families. Declines are nearly 20% and at this time are excluded from the target, unlike the immunisation target. This may change over time as other DHBs get closer to achieving the Raising Healthy Kids' target. In Q3 we are undertaking further work on declines, including investigating which referral pathways families prefer and developing an understanding of their experience of interacting with a health professional.

5.3 Rheumatic Fever

We have not achieved a reduction in reported first hospitalisations for first episodes of Rheumatic Fever, with a rate of 5.4 per 100,000 in the 2016 calendar year. This is in spite of a range of activities designed to deliver improvements and health gain from prevention through to on-going management. This programme is being discussed with the Community and Public Health Advisory Committee and any recommendations from the Committee should be considered as superseding this brief update.

5.4 Child Health

The focus continues to build on multiple enrolments for newborn infants, which is also part of the Ambulatory Sensitive Hospitalisation (ASH) SLM Improvement Plan. In 2016, Auckland DHB implemented communications to better inform new parents about free health services for their baby. Building on this success, Auckland DHB has started a one year pilot New Born Enrolment Coordination role. This is a midwife led service based in the Community Midwifery team, with the aim of improving early connections with Well Child and General Practices. The priority focus is for Māori, Pacific babies and those living in lower socio-economic areas.

In 2016 the new-born enrolment process with oral health was streamlined. This new process was rolled out in Auckland DHB from November 2016 and has shown a dramatic increase in enrolment by one year of age. It will take a full year to show the full effect in the data reported. It is expected that 95% of one year olds will be enrolled by December 2017, which is the measure reflected for oral health in the ASH SLM Improvement Plan. There are marked inequalities in enrolment so further strategies are being developed for Māori and Pacific babies. Further analysis is also being undertaken to ensure ethnicity is captured accurately. Work is also occurring with Well Child Tamariki Ora providers to ensure the Auckland Regional Dental Service (ARDS) are notified of babies who are not enrolled, for example babies who are new to the area. Early enrolment is the first step towards improving utilisation by one year of age.

To improve the oral health status of pre-schoolers in the metro Auckland region an oral health preschool strategy is being developed. This has a strong focus on Pacific children, reducing inequalities and ensuring earlier access to the oral health service. Components of the strategy are

included in the ASH SLM Improvement Plan In addition a new Professional Lead has been employed who is reviewing the model of care for ARDS.

5.5 Youth Health

The Youth Health Alliance established between Auckland DHB and Auckland PHOs continues to work well. An evaluation commissioned by the Youth Health Alliance, produced by Malatest International demonstrated extremely positive results in relation to the psychologist in schools service, including increased access and utilisation for males, Māori, Pacific and Asian young people.

In 2016, 1,974 young people in Auckland had a comprehensive wellness check or HEADSSS assessment. Of Year 9 students, this represents 93% of the students in the 10 Auckland DHB funded school based health service schools. Results, while below the 95% achieved last year, were very pleasing as they now include Auckland Girls Grammar School, which has taken some time to establish.

5.6 Women's Health

There are changes to the cervical screening programme being planned for introduction in 2018. Māori women in particular are not screened at the same levels as other ethnicities.

The Pregnancy and First Year of Life Alliance focuses on what we need to do to improve health outcomes during the first 1000 days (pregnancy and the first two years of life). The group, comprised of DHB and community managers and clinicians has received a range of evidence based information and is in the process of agreeing a number of priority projects. These currently include:

1. Working to improve information flows between Lead Maternity Carer (LMC)/GP/Well Child Tamariki Ora/DHB
2. Further developing the pregnancy and parenting information website and app, including modules for pre-conception and the first 1000 days
3. Improving access to free Long Acting Reversible Contraction (LARC)
4. Identifying anxiety and depression and increasing services for women (and partners) experiencing mild to moderate anxiety and/or depression during pregnancy and the first 12 months post-partum
5. Progress a Maternal Oral Health business case
6. Reviewing coverage and volume of services provided for Family Violence
7. Developing a 'whole of whānau' attachment and perinatal Mental Health service
8. Developing hands on delivery of parenting skills for teen mums/at risk women and families.

6. Mental Health and Addictions

6.1 Auckland DHB Review of Residential Rehabilitation

The review of Auckland DHB Residential Rehabilitation services began in early 2016/17. The rationale for this review was the large aging cohort of people with high support needs who are expected to gradually exit Residential Rehabilitation services. As this cohort of people exit residential services an approach will be taken to reduce the number of beds with the reallocation of this funding to Support Hours based services.

The purposes of this review, led by the DHB Mental Health Local Coordination Service (LCS), are to identify:

- The number of Residential Rehabilitation beds required once the identified cohort has exited
- Existing Residential Rehabilitation services that could be reconfigured to Support Hours based services as the identified cohort exits services.

To date the following actions have occurred:

- Ten beds with Framework Services Ltd were identified by LCS as suitable to be reconfigured. These beds were transitioned to Support Hours in August 2016, with Board approval
- Five beds with Affinity Services Ltd have been identified by LCS as suitable to be reconfigured pending Board approval
- Six beds with Emerge Aotearoa Ltd been identified by LCS as suitable to be reconfigured, Auckland DHB Board approval will be sought for this transition.

The review process will continue until all NGO Residential Rehabilitation services have been reviewed. The review will be repeated in future years to inform future transitions.

6.2 Health Needs Assessment Project

To support planning across both Auckland DHB primary and specialist care in the Mental Health and Addiction Services, the Health Gain Team is undertaking a focused physical Health Needs Assessment (HNA) for all Mental Health specialist service users engaged with services for greater than one year.

This project responds to the fact that people with serious mental illness typically live between 10 and 32 years less than the general population. Around 80% of this higher mortality rate is attributed to the much higher rates of physical illnesses, such as cardiovascular and respiratory diseases and cancer experienced by people with serious mental illness. This is a global phenomenon, it is increasingly recognised that much more needs to be done to address the gap in physical health and life expectancy between those who live with a mental illness and those who don't. Overall prevalence of mental illness and addictions is 20.7% of adults, but is much higher for Māori (30%) and Pacific peoples (24%). Enabling good data on ethnicity and age groups of people will support funding bids for future targeted programme delivery.

The project is focused on the physical health status of people with chronic serious mental health conditions (that is greater than one year) to:

- Establish a baseline of what we know and can measure now in Auckland DHB
- Quantify areas of need and service gaps
- Allow the estimation of cohort population numbers e.g. by ethnicity, age group or setting, to inform targeting of future activity
- Support primary care delivery of services
- Inform a monitoring and evaluation strategy to measure the impact of Equally Well interventions

6.3 Substance Addiction Compulsory Assessment and Treatment (SACAT) Legislation

The SACAT legislation provides for the compulsory treatment of individuals who are considered to have severe substance addiction, are at risk of severe harm and; their decision making capacity is severely compromised to the extent that they are unable to make decisions about their health. The Act was enacted on 8 February 2017 and will come into effect on 21 February 2018. The Northern Region SACAT Technical Advisory Group (TAG) have developed a model of care on the basis of contributions and engagement from a range of Alcohol and Other Drug (AOD) stakeholders, who participated in Regional Workshops held from September to November 2016.

Through this process, the gaps in the current continuum of care were identified and the best practice model developed and costed. Indicative costs to implement the Model of Care have been revised based on the New South Wales (Australia) Involuntary Drug and Alcohol Treatment Programme (IDAT) draft evaluation. IDAT data provided a methodology to identify more accurately future service demand, rates of access and entry into involuntary treatment, the NSW figures were adjusted to

allow for differences in admission criteria, including exclusions and treatment population, using Northern Region population data.

The purpose of the Model of Care is to:

- Describe the principles, aims and overall components of the SACAT pathway in the Northern Region
- Describe the interventions to be delivered, who will deliver them, timeframes and locations
- Describe the skills, knowledge and behaviour required to deliver each stage of the service user journey
- Provide a consistent SACAT response in the Northern Region
- Assist clinicians and other stakeholders to interpret the legislation as it relates to alcohol and other drug assessment and treatment

The draft model describes the key stages of the SACAT response, from the point of referral to the point at which a person successfully exits from the Act. It also provides details on continuing care treatment and support options post discharge.

The draft Model of Care, along with an estimated additional funding framework, was tabled at the Northern Region MHA Clinical Network meeting in December 2016 and approved as a working draft. A teleconference was subsequently held with representatives from the IDAT Programme from New South Wales Health to further improve the SACAT Model of Care, including refining predicted treatment volumes. The rate of referrals, assessments and treatment episodes in New South Wales based on four years of evaluation data, are significantly lower than Northern Region DHBs original estimates. The Northern Region estimated volumes and budget has been revised accordingly.

The 12-month timeline for implementation and commencement of the legislation was already challenging, particularly the commissioning, design and development of a new Regional facility and; additional new MoH funding will be required to fund DHB and NGO AOD Service Providers, to develop new and expanded harm reduction aftercare services to fill identified gaps in the service continuum.

The introduction of this legislation will have a significant impact on the AOD sector. Auckland metropolitan AOD services are experiencing significant demand for treatment, with long wait lists and an increased degree of complexity and acuity. These services in comparison to mental health services which have similar compliance requirements are significantly underfunded both in terms of the bed day rate and the staffing complement. In this context the new Model of Care for compulsory treatment and the need for gazetted treatment facilities has significant logistical, service design and financial implications.

A national meeting led by the MoH was held on 8 March 2017. The purpose of this workshop was to develop a nationwide service specification for the Model of Care, to discuss workforce development opportunities and what a treatment programme for this cohort of people will include. At this meeting the MoH indicated that they had not submitted a funding bid to cover the costs associated with implementing the legislation. In the interim, they plan to conduct a procurement process for approximately four short-term regional services, the results of which will be decided in November, with services expected to be operational by 21 February 2018. There are substantial risks if no new funding is made available to implement this legislation. A risk management plan is in the process of being developed.

7. Māori Health Gain

7.1 Māori Health Plan

The draft Auckland 2017/18 Māori Health Plan was endorsed by the Community and Public Health Advisory Committee to be submitted to the MoH. There is no longer a MoH requirement for DHBs to produce standalone Annual Māori Health Plans. However, through the request and support of the Board to keep a focus on equitable Māori health outcomes we are continuing to develop and present one. The Auckland DHB Annual Māori Health Plan will continue to be aligned with the Waitemata DHB Annual Māori Health Plan. We are also working with Counties Manukau Health to align our Māori Health Plans and identify priority areas for regional collaboration. Engagement with key internal and external stakeholders has been undertaken and will continue to occur throughout the development process.

7.2 HPV Self-sampling studies

HPV self-sampling is a novel technology for cervical screening, designed to improve participation and health outcomes for women who are currently never, or under-screened. Two studies on self-sampling are underway across Waitemata DHB and Auckland DHB. The HPV self-sampling feasibility study has completed three focus groups with 20 Māori women from West Auckland. The focus groups were facilitated by Health Literacy NZ and the Māori smear taker study nurse. These groups examined barriers to routine screening, provided feedback on the study materials and test kit, examined knowledge about HPV and the acceptability of HPV testing, and offered HPV self-sampling and routine screening to the participants. The response was very positive, with 18 women choosing to complete self-sampling. The participants were across the age range and many had never been screened before.

The focus groups have resulted in several changes to the information sheets and test kit instructions for women, which have been notified to ethics, the National Cervical Screening Programme and National Kaitiaki Group. The Auckland Pathology Service laboratory has conducted a validation panel of HPV samples as this is the first time self-sampling tests have been used in New Zealand. The focus group samples will be processed shortly. Recruitment of 200 Māori women will begin after the three participating West Auckland general practices have been through the study education session. Planning is underway for the larger Health Research Council study in partnership with Massey University for Māori, Pacific and Asian women. A research nurse coordinator has been appointed and is developing a similar focus group process for Pacific and Asian women. It is likely that this study will begin recruiting women from September 2017, after the necessary approvals are in place.

7.3 Māori Women's Colposcopy Experience Survey

A telephone survey of 101 Māori women who attended colposcopy service across Waitemata DHB and Auckland DHB was conducted as part of the Māori Health Plan requirements related to cervical screening, looking at quality of care. The survey was conducted by an experienced Māori telephone interviewer. The results are encouraging with 97.1% of patients being 'extremely likely' or 'likely' to recommend the service to their friends and family who needed a similar service.

Qualitative analysis of free text comments suggests many patients felt that they were cared for and respected, the staff were professional and friendly and that the service was efficient. Women were highly supportive of the offer of support-to-services by women's health social workers and nurses, even if they did not take up the offer. Suggested improvements were often focused around communication pre, during and post colposcopy clinic.

8. Pacific Health Gain

8.1 Renewing Pacific Health Action Plan (PHAP)

The updated Pacific Health Action Plan will be submitted to the Community and Public Health Advisory Committee in March 2017. This is later than intended, but work on each of the priorities has been ongoing.

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

Four Triple P parenting programmes are being delivered in the Auckland DHB area and will be completed by the end of this financial year. Triple P facilitators, who are bilingual in Tongan/Samoan and English, are delivering the programmes.

Three *Living without* Violence programmes will also be delivered before the end of this financial year. Facilitators will be trained in June 2017, with training funded by the Todd Foundation and delivered by the Catholic Social Services.

In relation to rheumatic fever, the Pacific team continues to participate in the implementation of the Rheumatic Fever Resolution Plan.

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. Feedback was also provided to those who took part in the consultation.

We continue to work with West Fono to identify which of the recommendations can be provided within their current contract with the MoH 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.

8.4 Priority 3 – Pacific people are active and eat healthy

A total of 2499 people from the Enua Ola and Healthy Village Action Zones (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 Alliance Health Plus (AH+), we have had discussions with the Social Services Team at the Ministry of Business, Innovation and Employment (MBIE) as part of our attempt to further develop an outcomes based payment component of the contract. MBIE has offered to involve us in forums they will facilitate with other government funders to continue to work on outcomes based pricing. We have invited the manager of the Social Services Team to participate jointly with us and AH+ in the review of the service and the development of a new contract from 1 July 2017 onwards.

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 participated in the development of the Kainga Ora Healthy Homes Initiative and we will support dissemination of information about the Initiative to Pacific providers and communities.

8.7 Pacific population engagement

Churches have been one of the main mechanisms used to engage with the Pacific population. We are currently also using the following:

- Community trusts
- Reo Ora Health Voice, with Pacific making up 21% of people currently with Reo Ora
- Text Messaging, specifically with the Healthy Babies Healthy Futures programme
- Kava drinking groups, specifically regarding smoking in Tongan male community
- Facebook, specifically with the Enua Ola programme
- Health Link

Sports clubs/organisations have also been considered as an option for engaging people. We have had some success with this in the past through the Healthy Eating Healthy Action policy, however we have not had the capacity to retain those links.

For future engagement, we believe that we should use the internet more and more as the Pacific population is largely NZ born and English speaking.

9. Asian, Migrant and Refugee Health Gain

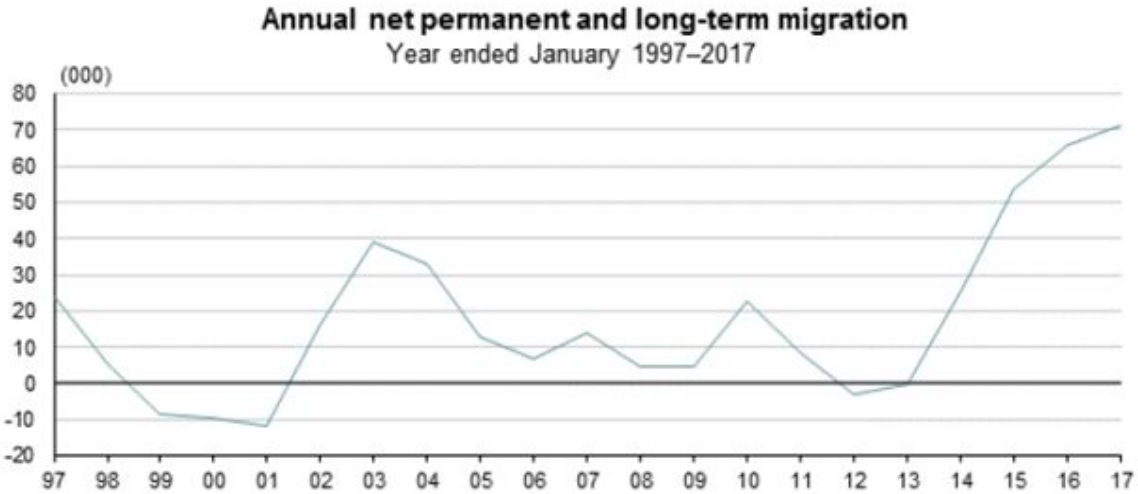
9.1 Increase the DHBs' capability and capacity to deliver responsive systems and strategies to targeted Asian, migrant and refugee populations

Recommendations from the findings of the International Benchmarking of Asian Health Outcomes Waitemata and Auckland DHBs report are rolling out as part of the Asian and Middle Eastern, Latin American and African (MELAA) Health Action Plan 2017-2020 (Auckland and Waitemata DHBs).

9.2 Increase Access and Utilisation to Health Services

Indicator: Increase by 2% the proportion of Asians who enrol with a PHO to meet 75% target by 30 June, 2017 (current rate 69% as at Q1 2017)

The Statistics New Zealand population projections have substantially underestimated the migration for Asian populations, particularly impacting Auckland DHB. The 2016 updates resulted in what appears to be an addition of more than 10,000 Asian people in Auckland DHB in one quarter. We have analysed this further, the results of which are summarised below.



Source: Statistics NZ, Updated 27 February 2017.

The figure above shows the most recent migration figures, demonstrating very high and sustained migration numbers from 2014-2017, substantially higher than the assumptions built in to the Statistics NZ and MoH population projection numbers. The 2016 projection update has corrected this substantial underestimate, however a result of this correction has impacted Auckland DHB and the Asian population. Further analyses have demonstrated that the growth is in the younger population. Table 1 below shows the difference between projections in one quarter.

Table 1 Change of projected Asian populations from Q4 2016 to Q1 2017, Auckland DHB (based on two projections/updates).

Year and quarter	Auckland Asian	
	PHO enrolees	Population
2016 Q4*	114,480	156,285
2017 Q1**	115,651	166,450
Absolute increase	1,171	10,165
Increase ratio	1%	7%

** Based on '2015 Update'; ** based on '2016 Update'*

The impact of the change of the Statistics New Zealand's population projections update from 2015 to 2016 for Asians of Auckland DHB has resulted in a drop of the Asian PHO rate from 73% as at Q4 2016 (based on '2015 Update' population projection by Statistics New Zealand) to 69% as at Q1 2017 (based on '2016 Update' population projection by Statistics New Zealand).

Cervical Screening:
The impact of the large population denominator change for Auckland DHB is also seen on other indicators, including cervical screening. December 2016 cervical screening coverage is now at 59.2% for Auckland DHB with 9,740 Asian women requiring a cervical screen to reach 80% coverage. This is an increase of 3,728 women requiring a cervical screen to reach the 80% target since December 2015 (when 6,012 women were required to be screened and coverage was 66%).

Pregnancy, Parenting and Lifestyle:
A workshop in March was delivered to Auckland DHB services providers in the areas of pregnancy, parenting and lifestyle with a lens on Asian and former refugee populations. The intent was to network, and strengthen engagement and referral pathways for providers across mainstream and ethnic specific touch points for these groups.

Next steps:

- A multilingual Healthcare – where should I go? social media campaign to the broader Asian migrant and student populations domiciled in the Auckland DHB will roll out for eight weeks from April-June 2017
- Leverage on the Healthcare campaign to promote targeted messaging about cervical screening to women aged 20-29yrs in the Auckland DHB
- Deliver NZ Health & Disability System presentations to universities, Private Training Establishments, settlement partners, ethnic associations and libraries (ongoing, approx. four per month)
- Continue involvement in the Auckland Agency Group to develop the New Zealand International Student Wellbeing Strategy with focus on the Health and Wellbeing pillar priority areas/settings - mental health, sexual health and primary care
- Work with Statistics NZ to extricate the international student population from the Asian figures.

7.1

Hospital Advisory Committee Meeting 15 March 2017 - Draft Minutes

Prepared by: Michelle Webb (Corporate Committee Secretary)

Recommendations

That the Hospital Advisory Committee draft minutes be received.

Minutes
Hospital Advisory Committee Meeting
15 March 2017

Minutes of the Hospital Advisory Committee meeting held on Wednesday, 15 March 2017 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 1.30pm

Committee Members Present		**Auckland DHB Executive Leadership Team Present**	
Judith Bassett (Chair)		Ailsa Claire	Chief Executive Officer
James Le Fevre (Deputy Chair)		Margaret Dotchin	Chief Nursing Officer
Jo Agnew		Joanne Gibbs	Director Provider Services
Michelle Atkinson		Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Dr Lee Mathias		Fiona Michel	Chief Human Resources Officer
Gwen Tepania-Palmer		Rosalie Percival	Chief Financial Officer
		Shayne Tong	Chief of Informatics
		Sue Waters	Chief Health Professions Officer
		Auckland DHB Senior Staff Present	
		Dr John Beca	Director Surgical, Child Health
		Duncan Bliss	General Manager Surgical and Perioperative Services
		Jo Brown	Funding and Development Manager Hospitals
		Judith Catherwood	Director Long Term Conditions
		Ian Costello	Director of Clinical Support Services
		Dr Mark Edwards	Director Cardiovascular Services
		Dr Sue Fleming	Director Women's Health
		Anna Schofield	Acting Director Mental Health and Addictions
		Dr Michael Shepherd	Director Medical, Children's Health
		Dr Barry Snow	Director Adult Medical
		Dr Richard Sullivan	Director Cancer and Blood and Deputy Chief Medical Officer
		Michelle Webb	Committee Secretary
		(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. APOLOGIES

The apology of member Doug Armstrong was received. The further apologies of senior staff members Naida Glavish, Chief Advisor Tikanga, Arend Merrie, Director Surgical Services and Vanessa Beavis, Director Perioperative were also received.

The Chair introduced Shayne Tong, Chief of Informatics to the Committee and welcomed him to the meeting.

2. REGISTER AND CONFLICTS OF INTEREST

Lee Mathias advised that she was no longer a Director of New Zealand Health Partnerships.

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

3. CONFIRMATION OF MINUTES 07 December 2016 (Pages 8 to 19)

Resolution: Moved Jo Agnew / Seconded Gwen Tepania-Palmer

That the minutes of the Hospital Advisory Committee meeting held 07 December 2016 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS (Page 20)

People Metrics Report: Fiona Michel, Chief Human Resources Officer confirmed that the People Metrics report required discussion with the Human Resources Sub-committee prior to finalisation and therefore presentation of this report to the Hospital Advisory Committee has been deferred to April 2017.

Auckland Integrated Cancer Centre: Due to regional discussions about the business case still being in progress, the update report has been deferred until June 2017.

All other action items were complete.

5. PROVIDER ARM OPERATIONAL PERFORMANCE REPORT (Pages 21 to 151)

5.1 Provider Arm Operational Performance Report – Executive Summary (Pages 21 to 26)

[Secretarial note: Items 5.1 and 5.2 were taken as one item. Where there was comment it is recorded under the item it pertained to.]

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

- There has been a significant increase in volume of presentations and acuity to the Adult Emergency Department and as a result the 6 hour target for Quarter 3 is at risk.
- Electives discharge performance recovered during Quarter 2, however full recovery is dependent on orthopaedic outsourcing for the remainder of the year.
- Consultation on the 24/7 Hospital Functioning Model of Care and Structure proposal has closed. Feedback received supported the proposed model of care. Recruitment to new roles is in progress.
- A new vital signs chart and early warning score is being trialled as part of the Deteriorating Patients Programme. A peer review of the pilot by the Health and Quality Safety Commission is scheduled to take place in late March 2017.
- Management are developing the next Provider Services Business Plan in collaboration with the Funder. Particular attention is being given to the current challenges in financial sustainability and ongoing issues with transplant and orthopaedic services.

The following matters were covered in response to questions:

- Lee Mathias drew attention to the triage trends 2016 graph on page 22 of the agenda. The volume of Triage 1 presentations for the last quarter of 2015 was showing as 16%. It was clarified that the volumes experienced during the last

quarter of 2016 hadn't been laid over the top, which would have provided context of how the patient volumes had increased in that period of time.

- Gwen Tepania-Palmer asked whether there were penalties associated with non-compliance to the 6 hour Emergency Department target and was advised that there were none. The issues had been discussed with the Ministry of Health and the Auckland DHB performance is deemed good considering the significant volume increases.
- James Le Fevre observed that interpretation of the targets and measures achieved needed to be considered in context. The approach of Auckland DHB to the clinical pathway is to meet patient needs and outcomes rather than to focus solely on achieving outputs against targets.
- Advice was given that work is in progress on the new facility for safe treatment of mental health patients presenting to the Emergency Department which will improve the flow and experience for Mental Health patients entering the hospital environment.

5.2 Scorecard (Pages 27 to 30)

The Chair commented on the pleasing improvement in the elective day of surgery rate. Jo Gibbs advised that the improvement changes made to the transition lounge to enable pre and post-operative patients to be accommodated had assisted with this.

There was discussion regarding the current format of the scorecard. Ailsa Claire reiterated that the scorecard required review. The targets currently used are stretch targets and do not allow progress to be plotted. There was agreement that the scorecard would be more informative if it reflected both a stretch and a benchmark target, and that a revised Auckland DHB Provider Scorecard should be trialled at the next Hospital Advisory Committee meeting.

Action:

That a revised Auckland DHB Provider Scorecard be trialled for reporting at the next Hospital Advisory Committee meeting.

5.3 Clinical Support Services (Pages 31 to 39)

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

- The MRI capacity challenges as detailed in the report on page 35 of the agenda. Recovery plans are in place and as a result performance has returned to 80%.
- Focus is being placed on succession planning and discussions are in progress with training organisations to develop workforce planning strategies.
- The Medicines Academic Practice Unit which has been formed with the Schools of Pharmacy and Nursing as a collaborative initiative.

The Chair commended the directorate on being alert to collaborative opportunities.

A general discussion was had regarding challenges in the area of MRI. Of note was that MRTs training received overseas is not recognised in New Zealand.

New Zealand is unique in that it has a registered scope of practice for MRI. Other countries don't have the same scope so comparison of qualifications achieved internationally against the New Zealand standard is not possible. Discussion is occurring with regulatory bodies to explore the potential for past experience to be recognised during accreditation.

Action
That the Hospital Advisory Committee be kept informed of the progress of the MRI accreditation initiative.

5.4 Women's Health Directorate (Pages 40 to 48)

Sue Fleming, Director Women's Health spoke to the report highlighting the following:

- Workforce issues, particularly the ability to fill vacancies and a critical shortage of Maternal Fetal Medicine Specialists were proving to be a challenge. Recommendations to enable development of a sustainable workforce will be presented to the Board in the coming months.

The following matters were covered in response to questions:

- Lee Mathias commented that she had observed that an "Expression of Interest" tender regarding primary nursing had been recently notified. Sue Fleming advised that this was a Request for Information process being led by the Funder to inform development of options for delivery of a primary birthing facility in the Auckland DHB district.
- James Le Fevre asked what was involved around content for the Team Resilience workshops recently undertaken by the Women's Health staff. It was advised that these workshops were tailored to specific challenges experienced by the service with support from Human Resources management. It was noted that resilience is important throughout all services and the training approach needs to be consistent across the organisation. Other departments could benefit from the sharing of information on what aspects of the training worked well.

The Committee expressed interest in receiving a summary of the most effective key themes of the resilience workshops undertaken by Women's Health staff.

The Chair commented that the Wahine Ora programme of work was progressing well and producing positive outcomes.

Action:
That an information report summarising the most effective key themes of the resilience training delivered within Women's Health be provided to the next Hospital Advisory Committee meeting.

5.5 Child Health Directorate (Pages 49 to 61)

John Beca, Director Surgical Child Health asked that the report be taken as read, highlighting the following:

- Significant effort is being applied to maintain safety and reduce risk during the current refurbishment work in progress at Starship Hospital to ensure the efficient running of the service.
- The framework for the measures for the Starship Clinical Excellence Programme report and dashboard on page 52 of the agenda has been based on that of the Institute of Medicine. There has been interest from other hospitals to be involved in the work to develop international benchmark data.
- There has been variable performance against the Child Surgical target in paediatrics. Mitigation plans were activated to manage risk around not meeting the target.

Gwen Tepania-Palmer acknowledged the good work completed on Maori Did Not Attends and encouraged a continued focus on Pacific Did Not Attends. Gwen also noted that the intended focus of the proposed Pacific Navigator role on addressing Pacific Was Not Brought was positive.

The Chair commented that the intended collaboration with Waitemata and Counties Manukau DHBs to address the Was Not Brought rates was also positive.

5.6 Perioperative Services Directorate (Pages 62 to 70)

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

- The good performance in January, despite industrial action, which could be attributed to excellent management of the acute workload by staff.
- Delays in the single instrument tracking project have been reported to the Board and the contractual issues are being worked through.

The Chair noted the key achievements for the directorate, in particular the Local Heroes nomination for the staff member from Greenlane Surgical Unit – PACU, and the award received by the Greenlane Surgical Unit Technician at the Allied Health Awards.

Gwen Tepania-Palmer enquired about the timeframe for the risk review on the impact of transplants. Advice was given that the service was currently over delivering against contract but still meeting patient needs. There has been a 40% increase in volumes in the last two years. It was acknowledged that undertaking transplants beyond funded volumes impacts negatively on budgets. Information on the investment required to meet volumes has been presented to the Finance Risk and Assurance Committee for consideration.

5.7 Cancer and Blood Directorate (Pages 71 to 77)

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

- An options paper is being submitted to the Board regarding the planned replacement of one of the six Linear Accelerators in Radiation Oncology
- Auckland DHB are working closely with Counties Manukau DHB to establish a pilot of Adjuvant Herceptin delivery within the Counties Manukau region.

- Phase 1 of the Alignment Project to realign Cancer and Blood services prior to any moves into new facilities. There will be improvements in patient experience resulting from co-location of clinics and tumour streaming.

James Le Fevre commended the team on the good work done in a complex environment.

5.8 Mental Health Directorate (Pages 78 to 91)

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

- The successful appointment of a new Director of Nursing Mental Health and a new Medical Director for the service.
- The development of the Mental Health Facilities plan and relocation of Assertive Community Outreach Services from St Lukes to the Rehab Plus Building at Point Chevalier.
- The Escalation plan which is functioning well and is proving to be effective in managing acute demand.

The following matters were covered in response to questions:

- Gwen Tepania-Palmer queried the number of detox units available in Auckland and was advised that Waitemata DHB Community Alcohol and Drug Services held 10 beds and the City Mission held 4 beds. Lee Mathias added that there was also capacity at The Retreat in Mangere and that Capri was now closed. Anna Schofield advised that national work on Mental Health and Addictions relating to the need for detox management followed by locked care treatment was occurring and that the Funder would be presenting information about this to the Board in the future. Changes in legislation are pending, with a new Bill to be enacted in February 2018.
- Lee Mathias asked how well prepared Auckland DHB was for changes in the Addiction Act. It was advised that a key challenge was management of 'legal highs', which can still be purchased in some retail outlets, being brought back to the wards which can put other patients at risk.

5.9 Adult Medical Directorate (Pages 92 to 98)

Barry Snow, Director Adult Medical spoke to the report and provided an update highlighting the following:

- The significant and continuing growth in presentations to the Emergency Department which is averaging 199 presentations per day; more than this time last year. The patient profile is also becoming more acute. The directorate has continued to build capacity but demand continues to grow. Mitigation actions implemented include rostering of an additional patient flow nurse during the peak shift and opening further bed flex space.
- The success of the Rapid Improvement event for management of cellulitis held in December

- Delivery of a strategic business case for delivery of a Regional Hyperacute Stroke Service
- The strong focus being placed on Early Supported Discharge and Rapid Response services

Lee Mathias expressed interest in the cellulitis patient's pathway and what recommendations from the rapid improvement event were being implemented. Advice was given that these were specifically related to enhancing the POAC/Community response, use of a screening and assessment tool, and introducing new tools into the Emergency Department such as i.e. antibiotics packs to go. Lee also enquired whether primary care were utilising the iMoko app. Barry Snow undertook to review the tool to see if it could be used in the Auckland region.

Action: That a review of the iMoko application tool be undertaken to determine its suitability for use within the Auckland region.

5.10 Community and Long Term Conditions Directorate (Pages 99 to 109)

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

- The commencement of the Early Supported Discharge Service in July 2016.
- The improvements in performance against the 62 day target for Faster Cancer Treatment for high suspicion of melanoma patients.
- The good progress in recruitment to senior leadership roles within the directorate with most of the team now in place.
- The Community Services and Sexual Health Service new business rules and reporting arrangements which are now complete and implemented.

There were no questions.

5.11 Surgical Services Directorate (Pages 110 to 119)

Duncan Bliss, General Manager Surgical Services asked that the report be taken as read, noting formal thanks to the outgoing Director Surgical Services, Mr Wayne Jones and the welcoming of the new Director Mr Arend Merrie.

Duncan highlighted the following:

- Despite the impact of industrial action in January, effective summer plans led to service over performance.
- The significant improvement in the Electives Day of Stay Admission rate, which could be attributed to a large amount of targeted day stay work to counter the impacts of the industrial action
- The Adult ESPI 2 position which was non-compliant for Auckland DHB at 1.15% will also be moderately non-compliant in March.
- Progress in the use of the Greenlane Surgical Unit. Previously unallocated all day OR sessions are being utilised for additional Ocular Plastic sessions.

There were no questions.

5.12 Cardiovascular Directorate (Pages 120 to 127)

Mark Edwards, Director Cardiovascular asked that the report be taken as read highlighting the following:

- The high levels of activity within the service, in particular the increase in cardiac bypasses being performed. There have been 77 more bypasses performed this year than in the same period last year.
- The positive comments made regarding the work of cardiac surgery as part of the Certification Audit.
- The Cardiovascular Intensive Care Unit (CVICU) open day held for all staff to showcase the work the CVICU team do for patients after heart surgery. It was noted that a short article about this event in eNova would highlight the success of this event.
- The review of the model of Nursing Education delivery to strengthen and streamline the way that nursing education is delivered across the Directorate.

The Committee expressed interest in staying informed on the progress of the nursing education model review.

Action:

That regular updates on the progress of the review of the Nursing Education model within Cardiovascular Services be made within the Cardiovascular Directorate report.

5.13 Non-Clinical Support Services (Pages 128 to 136)

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

- 59 cleaning services staff have achieved NZQA Level 3 and subsequently graduated
- The good feedback received from the public about the quality of service provided by cleaning staff.
- Work progressing on the Supply Chain Regional Review which presents opportunities for improvements and savings.
- The commencement of a further Workplace Literacy course for staff.

Michelle Atkinson acknowledged the excellent achievements of the cleaning services staff.

Action:

That formal congratulations and thanks for the excellent work and achievements of the cleaning services staff be extended.

5.14 Provider Arm Financial and Operational Performance Report (Pages 137 to 151)

Rosalie Percival, Chief Financial Officer spoke to the report.

The overall result for February is $0.6M unfavourable.

Challenges in elective delivery have impacted the budget with acute surgical discharges and IDF patients (not currently charged) being over budget. Obtaining funding for an increased volume of transplants is being negotiated as current volumes pose a key risk to the budget.It was noted that recent publicity regarding organ donation had contributed to an increase in transplant activity. A draft national Organ Donation strategy is being finalised and submitted to Cabinet. If adopted, careful consideration when planning for future transplants service delivery will be required.

There were no questions.

Resolution: Moved Gwen Tepania-Palmer / Seconded Jo Agnew

That the Performance Reports for March 2017 be received.

Carried

6. INFORMATION PAPERS

6.1 Patient Experience Report (Pages 152 to 159)

Margaret Dotchin, Chief Nursing Officer asked that the reports be taken as read highlighting that the Partners in Care programme is focused on sharing information with staff on the wards. Historically space limitations had challenged the ability to enable increased family and whanau support. Facilities improvements are now being incorporated into the Patient and Family Care Programme to further support the inclusion of family and whanau and enhance the patient experience.

Resolution: Moved Michelle Atkinson / Seconded Lee Mathias

That the patient experience reports for December 2016 be received.

Carried

7. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 160 to 163)

Resolution: Moved Gwen Tepania-Palmer / Seconded Lee Mathias

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

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

2. Register and Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 07 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]
4. Confidential Action Points 07 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 Hospital Advisory Committee Forward Programme for 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]
5.2 Hyperacute Stroke Service – Progress Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

5.3 Auckland DHB Organisation Wide Certification Audit – Draft Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.1 Faster Cancer Treatment	**Commercial Activities** Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.2 Security for Safety	**Prejudice to Health or Safety** Information about measures protecting the health and safety of members of the public is enclosed in this report and those measures would be prejudiced by publication at this time [Official Information Act 1982 s9(2)(c)] **Commercial Activities** Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
6.3 Food Services	**Commercial Activities** Information contained in this report related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of

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

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

Carried

The meeting closed at 4.15pm.

Signed as a true and correct record of the Hospital Advisory Committee meeting held on Wednesday, 15 March 2017

Chair: _____ Date: _____

Judith Bassett

Auckland DHB Employee Metrics

Recommendation

That the Board:

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

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

1. Board Strategic Alignment

Service integration and/or consolidation	Effective employee metrics will ensure timely and targeted decision making, and will enable accurate forecasting of issues and opportunities to improve both the employee and patient experience.
Intelligence and insight	
Evidence informed decision making and practice	
Operational and financial sustainability	

2. Introduction/Background

Employee metrics are reported to the Board through Directorate Scorecards in reports to the Hospital Advisory Committee (HAC) and from time to time through 'deep dive' papers provided to the HR Subcommittee.

The HAC scorecard is comprised of over 30 metrics spanning across the areas of Patient Safety, Quality Care, Improved Health Status and Engaged Workforce. The metrics vary between directorates, and have focussed on 'hot spot' issues rather than looking holistically at measures that monitor overall cultural health. There are no reports provided regularly to the Board for non-directorate employee groups, such as Corporate or Public Health. Targets have been set at an 'ideal' state, making it difficult to see, monitor or govern incremental progress.

With the introduction of the Auckland DHB People Strategy, it is a good opportunity to review our employee metrics to ensure the effective assessment and monitoring of progress, and to enable the Board to govern workforce issues more effectively.

3. Current Employee Metrics

		Organisation Interest Does the metric reflect the organisation wide priorities and Directorate interests?	Responsibility Does Provider Directorate own the primary responsibility of delivering the positive metric outcomes	Data Integrity Is the metric supported by a robust data capturing and reporting system to ensure integrity?	# of Directorates tracking it in HAC	Recommendation
Engaged Workforce	Excess annual leave dollars ($M)	√	√	√	ALL	Recommend to stay in HAC
	% Employee with excess annual leave > 2 years	√	√	√	ALL	Recommend to stay in HAC
	% Voluntary turnover (annually)	√	√	√	ALL	Recommend to stay in HAC
	% Voluntary turnover < 1 year tenure	√	√	√	ALL	Recommend to stay in HAC
	Sick leave hours taken as a percentage of total hours worked	√	√	√	ALL	Recommend to stay in HAC
	# of Pre-employment Screenings (PES) cleared after the start date	√	Unclear	√	10 (out of 11)	Recommend to remove. Target of '0"was met 99% of the time, unnecessary to report to the Board every month. The screening is health-related, co-ordinated by OH&S, it does not include other screenings (i.e., police vetting) co-ordinated by HR.
	% Employee with excess annual leave > 1 years			√	10 (out of 11)	Recommend to remove, not one of the priorities
	% Employee with excess annual leave and insufficient plan to clear excess by the end of FY		√		ALL	Recommend to remove for now, not a workable measure
	% of employee with		√		2 (out of 11)	Recommend to

		Organisation Interest Does the metric reflect the organisation wide priorities and Directorate interests?	Responsibility Does Provider Directorate own the primary responsibility of delivering the positive metric outcomes	Data Integrity Is the metric supported by a robust data capturing and reporting system to ensure integrity?	# of Directorates tracking it in HAC	Recommendation
	leave planned for the current 12 months					remove, not a workable measure on a monthly basis
	% leave taken to date for the current 12 month		√	√	2 (out of 11)	Recommend to remove, not a workable measure on a monthly basis
	# of Employees who have taken greater than 80 hours sick leave in the past 12 months	√	√	√	1 (out of 11)	Recommend to remove, available in push report

4. Proposed additions to our Employee Metrics

	Lead/Lag Indicators	Outcomes
Employee Engagement (focus on acting on survey results and driving positive team culture and behaviours)	% of managers/teams with action plans developed following the engagement survey % of managers/teams with action plans completed following the engagement survey	• Reduced turnover of performing employees • Improved engagement scores • Improved levels of patient satisfaction.
Annual Reviews	# of employees with a current-year performance rating	• Compliance with Certification Audit standards
Māori/Pacific Workforce	Performance against targeted increases of Māori/Pacific employees in key healthcare roles	• Increased matching with our community demographic
Welcome Day attendance	% new starters who have not attended Welcome Day within 2 months of joining.	• Core compliance needs met • Early employee engagement
Leadership Development	% leaders who have completed the Auckland DHB Leadership Development Programme % managers who have completed the Management Practicing Certificate (to be introduced in late 2017)	• Increased capability and competence of leaders and managers

	Lead/Lag Indicators	Outcomes
Time to Recruit	Average number of days to recruit	• Highlighting hard to fill roles
Employment Investigations	# of open employment investigations # of open employment investigations relating to bullying, harassment & discrimination	• Clarity of management/cultural issues and 'hot spots'
Personal Grievances	# of open personal grievances Cost of external legal advice for employment related issues	• Clarity of management/cultural issues and 'hot spots'
Annual Practicing Certificates	# of people who require, but do not hold, a current Annual Practicing Certificate	• Compliance
Payroll errors	$ of over/underpayments made	• Improved accuracy of payroll

Note that Health & Safety Metrics, often captured in Employee Dashboards, are provided independently to the Board in the standing Health & Safety Report, and will not be replicated in this report.

5. Targets and Benchmarks

It is proposed that a new dashboard format is prepared with the following detail:

Measure	Frequency	In Year Target	Stretch Target	Trend	Insight
Name and short description	Monthly/ Quarterly/ Annually	Improvement objective (Self benchmarked)	Ideal objective (Externally benchmarked)	Better, worse or same than last report	Commentary on actions and mitigations

Where benchmarks do not currently exist, we will work regionally and nationally with other DHBs and central support agencies (NRA, TAS) to determine appropriate benchmarking measures for future reporting.

6. Data Integrity

Employee data is held in several online systems, some is manually recorded, some held in paper-based personnel files and some is not held centrally at all and has to be requested from managers each time it is required. Employee data definitions are not always consistent, and may result in different reporting outcomes between DHBs, and between in-house teams such as HR, Business Intelligence and Finance. This impacts the reliability, integrity and credibility of some employee data reporting. A future project to review improvement opportunities will be considered in 2018.

7. Next Steps

It is proposed that a new standard dashboard format including the updated list of current and additional metrics is implemented consistently for Auckland DHB as a whole, and by Directorate/Service/Function, from the next Board meeting.

Auckland DHB Human Resources Report

Recommendation

That the Board:

1. **Receives the Auckland DHB Human Resources report for April 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. Key Employment Issues/Opportunities

Key employment issues and opportunities are monitored and mitigated by Auckland DHB. The Board will be updated quarterly (next due May 2017), or whenever a significant change arises, along with detailing progress and outcome reporting.

2. Delivering the Auckland DHB People Strategy

HR Operating Model

On 1 March, Auckland DHB launched the new HR Operating Model, providing a tiered support service to our managers and employees with HR questions. The askHR function (telephone and email support) had over 1000 contacts in the first two weeks. Anecdotal feedback has been prolific and positive about the quality and timeliness of the support provided by the new askHR team. The model has been designed to free-up capacity in our HR Management and Specialist teams, to enable them to work on proactive deliverables in the Auckland DHB People Strategy, and improve the employee employment experience.

Auckland DHB People Strategy

In March, the Auckland DHB People Strategy was communicated to our people via a series of face to face communication channels such as our regular In the Know forum (managers) and our new education lecture series called learnHR. The Chief Executive's March Blog to all employees was dedicated to the Auckland DHB People Strategy.

3. Human Rights Commission Good Employer Report

Auckland DHB has been ranked first-equal for compliance with 'Good Employer' principles for the second year in a row, with a result of 100%. http://good-employer.hrc.co.nz/#2016/report/entity-4

The review by the Human Rights Commission factors-in performance across a range of benchmarks, such as:

- Safe and healthy environment
- Leadership, accountability and culture
- Recruitment, selection and induction
- Employee development, promotion and exit
- Flexibility and work design
- Harassment and bullying prevention
- Employee recognition and working conditions
- Equal Employment Opportunity initiatives

4. Navigate (Welcome Day)

A key priority of our People Strategy is ensuring our new people get a quality start. Critical to this is a new employee's onboarding process. The term 'Onboarding' describes the process of bringing a new employee into the organisation. Onboarding is an ongoing process, not a one off event and can be broken down into 3 phases:

- Pre-boarding (joining to first day)
- Orientation (first weeks)
- Induction (first 100 days with focus on understanding the organisation, their service and role)

As part of this work, Welcome Day has been overhauled and we will be piloting a replacement event *Navigate Auckland DHB* on 3 April. This onboarding event is a component of all new employees' induction.

The event will welcome new people to our organisation, inspire them with Auckland DHB's purpose and direction and the difference we make to our community. We will highlight what makes our organisation a great place to work. The occasion will include a new employee "expo" and bite sized sessions which will provide an opportunity for new people to explore and learn more about working here.

The bite sized sessions for the pilot include our Values, Speak Up, Family Violence Intervention and an inspiring story on something we are proud of at Auckland DHB.

The expo will include our teams from Health & Safety, Quality, Legal Services, HR, Health Alliance and Smokefree Services to build awareness of their services and how they are accessed including any training new employees should complete.

In addition a range of stands providing health and wellbeing, employee benefit and 'working here' information such as Domain Fitness, our insurance and financial advice partners Southern Cross, Advice First (Accuro), Auckland Transport and Wilsons Parking, Employee Assistance Programme will be present.

It is intended that Navigate Auckland DHB will run bi-monthly, and is visibly lead by our Chief Executive, Executive and Senior Leadership teams.

5. Auckland DHB Leadership Development

The first cohort of leaders to undertake the Auckland DHB Leadership Development programme in 2017, commenced in mid-March. A deep-dive report on overall leadership development progress, and the impacts of the programme on organisational effectiveness will be presented to the Board in May 2017.

6. Lower-Paid Workers

Recently almost 60 of the cleaning team graduated with a nationally recognised qualification. This achievement contributes to their pride, and that of their family and whānau, provides a merit increase in salary and increases their sense of connection with Auckland DHB. A project has commenced to assess how we better support Lower Paid Workers. We are partnering with the Ministry of Social Development (MSD) to ensure our people have access to all relevant services MSD offer, and we are exploring how that partnership may enable us to offer first-level jobs to ready-to-work New Zealanders working with MSD (through Work and Income New Zealand).

7. Doing our Life's Best Work

Our inaugural learnHR lecture series session was held at the Ernest Davis Room on 8 March. learnHR has been developed, as part of a suite of management and leadership development opportunities for our people to upskill on employment and people-related topics.

The learnHR sessions are an hour long will run on both Auckland City and Greenlane sites each month. The content will be focussed around topics that will be mandatory in the Management Practicing Certificate – a training and assessment tool that all managers will need to complete bi-annually to ensure they can demonstrate the core skills required of an Auckland DHB people manager.

Our speaker at the inaugural event in March was Angela Atkins. Angela has worked in HR for 20 years and has written a number of well-regarded books, including the bestselling *Management Bites*.

Feedback from this first session, and about the learnHR series included:

"It was especially useful in line with plans that are currently being developed for a local frontline leaders programme."

"As a new manager I'm keen to get my hands on any tips I can"

"It was easy to assimilate with good ideas. The person I sat next to had some great ideas as well, so the chat to neighbour was worthwhile. Some of content reaffirmed that I was on the right track".

"It was an excellent session and more sessions like this would be helpful for us to have professional growth in ADHB. Thanks."

"I have heard anecdotally that many senior nurses are looking for ways to develop themselves but don't yet know how to do this or access help. I have been pointing them in your direction, but I think there is a real need for this sort of development for our teams"

Māori Health Workforce Development Alliance Leadership Team Update

Recommendation

That the Board:

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

Prepared by: Gil Sewell – Director, Organisational Development Auckland DHB, Vanessa Duthie – Māori Workforce Development Consultant and Kim Herrick – Organisational Development Practice Lead at Auckland DHB
Endorsed by: Fiona Michel - Chief HR Officer

Glossary

DHB	District Health Board
MALT	Māori Health Workforce Development Alliance Leadership Team

1. Board Strategic Alignment

Community, whānau and patient-centred model of care	The MALT programme will accelerate Māori health gains through a workforce who reflect the makeup of our communities.
Emphasis/investment on both treatment and keeping people healthy	It ensures our resources are directed to the areas and communities of high need.
Service integration and/or consolidation	MALT Programme supports delivery of the right services in the right place and by the best person to get outcomes that matter to the patient.
Consistent evidence informed decision making and practice	The MALT programme of work is informed by long-standing evidence that outcomes are improved by culturally appropriate care.
Outward focus and flexible service orientation	The MALT programme is focused on reducing inequalities in health status for our Māori population.
Operational and financial sustainability	There is evidence to suggest ethnic diversity is positively related to above average financial returns and better health outcomes.

2. Executive Summary

This paper provides an overview and update to the Board on MALT activities. MALT was established in 2014 to focus on initiatives and actions to achieve scale – or 'more Māori health workers, everywhere' by 2020. The strategy is designed to maximise the contribution of all health care providers in achieving health equity for Māori.

3. Background

Both the Auckland and Waitemata District Health Boards have strategic statements and plans related to Māori health workforce development that have been in place for some time. Workforce data suggests that all activity designed to increase the number of Māori in the health and disability workforce has had little impact on Māori workforce participation rates. This is not unique, as national workforce data is also relatively static.

This finding suggests that structural and institutional barriers persist in the health and education systems and that the current approach to Māori health workforce development and planning requires change. It is in this context that the establishment of an 'alliance leadership team' modelled on the DHB-PHO alliancing model was proposed.

It is clear that Māori have poorer health status than other New Zealanders and that better health outcomes can be achieved through improved access to primary health care. Few DHB workforce development strategies have had a clear focus on increasing the capacity of the Māori primary health care/ community workforce. New models of care and expansion of Whānau Ora initiatives create opportunities for workforce innovation.

Improvement in workforce disparities takes time, a realistic funding commitment and leadership particularly from boards and senior executives through to Hiring Managers. The latter point is critical if any initiatives are to be sustainable. Māori health leadership is essential to changing the traditional DHB-driven model of workforce planning enabling new models and frameworks to develop.

This strategy includes 10 areas for action grouped under four broad categories:

Getting ready
- Strategic Leadership

Getting graduates
- Expand the Rangatahi programme
- Align Kia Ora Hauora
- Work with tertiary education

Getting jobs
- Human Resource Management Framework
- Recruitment/ Employment Agency

Getting results
- Develop clinical leaders
- Primary health care
- Education and training
- Measure performance

4. Activity

A MALT Workforce Action Team has been established, reporting to MALT and responsible for implementation of the Action Plan. The Action Plan has 12 projects designed to achieve these three aims.

The MALT Action Plan for this financial year lists three priority areas of activity:

Aim 1: Recruitment and retention

Aim 2: Pipeline development

Aim 3: Leadership development

Aim 1: **Recruitment and retention**

- Māori Health Workforce Development Quarterly scorecard developed to track impact of recruitment and retention activities for defined, prioritised workforce groups in the Action Plan.
- Defined and prioritised occupations are junior medical, nursing (including assistants), midwifery, occupational therapy, physiotherapy, dental therapy and dietetics.
- The scorecard records progress using census standard workforce ethnicity data protocols.
- Both DHBs have improved their employee ethnicity data. Auckland has surveyed all employees resulting in 9,750 or 93% of employees identifying their ethnicity. At Waitemata the figures are 6,425 and 95%.
- Key recommendations defined for recruitment and retention practices:
    - Improved recruitment practices including prioritisation of Māori applicants to leverage the limited pipeline of Māori job candidates.
    - Culturally competent panellists at interview provide Māori with a more welcoming environment, enabling optimal candidate interview performance.
    - Mentoring as an effective staff retention strategy for Māori, helping new starters feel safer and more confident to navigate any challenges.
    - Culturally safe networking forums provide valuable opportunities for Māori to feel connected to their culture at work, to have leaders communicate directly with them on key items, to engage in professional development and to be consulted with on key Kaupapa.

These improved attraction and recruitment strategies will develop a more inclusive culture to improve attraction of Māori and Pacific people to become health care professionals.

Aim 2: Pipeline development

- Targets have been set for the prioritised occupations and translated into headcount required by 2025:
    - Auckland DHB:
        - From 3.5 % to 7.4% Māori employees, an increase of 193 individuals
    - Waitemata DHB
        - From 2.6% to 8.8% Māori employees, an increase of 209 individuals
- Contributing to candidate pipeline development are:
    - Rangatahi Programme across both Auckland and Waitemata DHBs
    - Formalised partnership with Work & Income for the supply of candidates in to mostly admin/non-clinical type positions

Aim 3: Leadership development

- Specific activity under Auckland DHB People Strategy activity for 2017 to work with GMs of Māori and Pacific Health to identify specific Māori and Pacific cohorts to attend Leadership Development programmes.

5. Resources

MALT members:

Working Group members:

The Māori Health Workforce Development Consultant 0.5 FTE is the only dedicated resource. Other resources supporting the implementation of the Action Plan are:

1.1 FTE redirected from other roles until June 2017

70K project manager resource until August 2017

6. Achievements

- Led the acceleration of work to improve workforce ethnicity data across Metro Auckland DHBs.
- Developed an aligned overarching plan, annual work programme and targets including a scorecard and recruitment metrics.
- Established a Māori Health Workforce Action team.
- Applied a Metro Auckland approach to the Rangatahi Programme including programme design, remuneration and delivery of activities.
- Identified improvements for the Rangatahi Programme across Metro DHBs to enhance the cadets experience e.g. Metro Auckland DHB hui
- Coordinated a proactive approach to attraction and recruitment of Māori and/or Pacific New Graduate nurses.
- Updated recruitment systems to identify Māori and/or Pacific candidates.
- Bringing MALT strategy to life with clinical leaders, sharing with stakeholders across Directorates.
- Obtained endorsement of Youth Employment Pledge.
- Finalist in Human Resources Institute of New Zealand Awards for Rangatahi Programme in the Diversity and Inclusion category.

7. Risks

Risk	Description	Mitigation
Lack of robust employee ethnicity data for target setting and effective reporting.	Collection, storage and reporting of workforce ethnicity data differs across DHBs, impacting on target setting and reliable monitoring of progress against the strategy.	• Regularly audit the ethnicity data capture process for deviation from census standards. • Establish clear data definitions, align standard

		role definitions and agree on reporting requirements across both DHBs.
Inadequate resources to deliver the 2017/18 Action Plan.	The achievements realised in the 2016/17 Action Plan relied heavily on short term extra resources. There is no formalised budget for this activity.	• Build upon the momentum created in 2016/17 by investing in a Māori Health Workforce Development Team for the 2017/18 year. Options are being explored for sustainable investment.

8. Planning for 2017/18

We are reviewing the MALT strategy to identify which activities will build upon the work done in 2016/17 and provide the greatest impact in 2017/18.
While the 2016/17 Action Plan looked across the employee life cycle, the 2017/18 approach will focus on the recruitment and retention of Māori employees across DHBs.

9. Conclusion

The Programme is an excellent example of collaboration across DHBs

- Mitigate risks associated with adequate and appropriate reporting.
- Mitigate risks associated with resources to continue delivering against plans and targets.
- Decide what activities should be prioritised for delivery in 2017/18 that will give the greatest impact.

Māori Alliance Leadership Team (MALT) Terms of Reference

9.2

Governing Waitemata – Auckland DHB's Māori Health Workforce Development

1. Purpose

The purpose of the Māori Alliance Leadership Team (MALT) of Auckland and Waitemata is to:

a) **Oversee and advise** on activity aimed at achieving the overarching objective of the Strategy - to increase the number of Māori working in the health and disability workforce (in Auckland and Waitemata DHBs' catchment areas) from 3 – 5% in 2014 to reflect the percentage of working age Māori (20-64 years) in the district's populations by 2025 (7.4% Auckland DHB, 88% Waitemata DHB).

b) **Make decisions** that lead to the implementation of the Waitemata - Auckland DHB Māori Health Workforce Development Strategy 2014-2017 (the Strategy)

2. Guiding principles

2.1 Open, inclusive and collaborative

We will work collaboratively towards the achievement of increasing the Māori health and disability workforce, and involve all necessary parties from across the workforce development pipeline[1] in whatever capacity they are able to contribute. The strength of this group will be the collective knowledge of our members, and, therefore the broader that knowledge base is, the greater the depth of knowledge and learning we can draw on to achieve our aim.

2.2 Innovative and courageous

We will provide a forum where new initiatives can be explored and developed, and where existing initiatives can be tested, that provides a knowledge base upon which system change can occur.

2.3 Leadership

We will provide leadership for the entire Auckland and Waitemata health and disability sector towards the achievement of increasing the Māori health and disability workforce.

2.4 Equity

We acknowledge that across the entire pipeline Māori experience unfair and unjust inequities, and are therefore Māori are the primary focus of our group and all activity we undertake in support of it.

3. Role and functions

3.1 Leadership

Provide leadership across Auckland and Waitemata districts for all activity aligned to increasing and developing the Māori health and disability workforce

3.2 Resource allocation

Allocate resources to current and proposed activity that will achieve the stated purpose of the

3.3 Sustain relationships

Sustain relationships across the membership of the Governance Group, and build relationships across the pipeline as necessary, that will strengthen the Māori Alliance Leadership Team and its activities

3.4 Monitoring progress

Receive regular progress reports from various groups, entities and initiatives within the remit of the Māori Alliance Leadership Team in order to measure what impact they are having on the achievement of the aim of the Strategy.

3.5 Reporting progress

Provide regular reports to the Boards of Auckland and Waitemata District Health Boards via Manawa Ora.

[1] For pipeline details see the actual Māori Health Workforce Development Strategy.

4. Annual work plan

MALT will develop and oversee an annual work plan which is designed to implement the Strategy. The annual work plan is a separate document agreed by MALT at the beginning of each financial year.

5. Membership

5.1 Chair

MALT will be chaired by the lead CEO Māori health for Auckland and Waitemata DHBs.

5.2 Representatives

Core representatives are both DHBs and Iwi. Other stakeholders or organisations may be invited to participate based on the agreement of MALT. Wherever possible, representatives will be CEOs or senior managers who have significant influence within their organisation and/or across the sector.

5.3 Review of membership

As agreed, MALT may review membership as required. All existing members are welcome to recommend new members, with a brief justification, for MALT to discuss. If agreed to by the other members, the Secretariat will make a formal invitation on behalf of the Māori Alliance Leadership Team.

6. Operational procedures

6.1 Meetings

Meetings will occur at least quarterly and be hosted by Waitemata DHB. The agenda for the meetings will be set by the Chair and circulated, with relevant documentation, at least one week before the meeting date for review by the representatives.

6.2 Secretariat

Secretariat support will be provided by Waitemata DHB. The secretariat will be responsible for taking minutes at the meeting, following up on actions, and circulating minutes following meetings.

6.3 Quorum

At least half of the members must be present, including the Chair, in order for the meetings to take place.

6.4 Decision making

There is an expectation that once a decision has been made all members will unify behind this decision. If a group decision cannot be reached the Chair may call for further discussion, seek further information or defer a decision to a future meeting.

6.5 Review of Terms of Reference

These Terms of Reference will be reviewed every 12 months, or as matters arise requiring amendments to the document following agreement by the current members.

7. Reporting

7.1 Quarterly reporting

The Māori Alliance Leadership Team will report quarterly to Manawa Ora on progress against the work plan and achievement of the overall aim of the Strategy.

Auckland DHB EPMO and Strategic Programme update

Recommendation

That the Board:

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

Prepared by:	Jeremy Muirhead (EPMO Manager)
Endorsed by:	Andrew Old (Chief of Strategy, Participation and Improvement), Ailsa Claire (Chief Executive)

Attachments: Appendix A: Strategic Programme Overview

Glossary

P3M3	Portfolio, Programme, Project Management Maturity Model
ICR	Investor Confidence Rating
EPMO	Enterprise Portfolio Management Office

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	Establishment of a clear Portfolio, Programme and Project management framework, with associated systems, processes and assurance, will allow us to prioritise, monitor and evaluate our activity ensuring alignment with relevant objectives and strategic themes. Development of the strategic portfolio and the strategic programmes are a key mechanism to deliver our strategy
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	

1. Executive Summary

This paper provides an update on the development of our strategic portfolio and an Enterprise Portfolio Management Office (EPMO), and the wider project, programme and portfolio capability development work.

The status of the strategic programmes is discussed in Section 3, including the concept of a strategic portfolio. A clear approach to the collective management of these programmes, and decisions around operational resource and prioritisation for these programmes is particularly important due to the number of interdependencies and is central to delivery of the Board's strategy for the organisation.

Section 4 discusses the development of the EPMO and how this relates to the Strategic Portfolio. The next major milestone for the EPMO is confirmation of the operating model and the EPMO Charter. These are due to be considered at the next Finance Risk and Assurance Committee meeting.

The final section of this paper provides an overview of regional collaboration between the Northern region District Health Boards in relation to this work.

2. Introduction

The development of programme management, and a portfolio of strategic programmes began in 2016 to address recommendations arising from the Board and the Treasury's Investor Confidence Rating (ICR) assessment process.

The selection of strategic programmes, and the development of the programme and portfolio management approaches discussed in this paper, are part of a larger piece of work to improve our project, programme and portfolio management and capability, through the creation of integrated frameworks. These frameworks are being designed to work together to ensure consistency in application, and to ensure we meet the requirements of the ICR, as well as enhance our ability to deliver the objectives of each programme.

The Auckland DHB EPMO is being developed to support these new ways of working and the practical application of the frameworks.

i. Definition of a programme

A programme is a temporary undertaking, created to deliver defined outcomes and benefits, via a group of **related projects**, managed in a coordinated way[1].

This paper refers to 'strategic programmes'. These are the programmes selected by the Senior Leadership Team as the highest priority to deliver the Auckland DHB Strategy. They are the key delivery mechanism for the Strategy and the Board will be actively engaged in selecting and approving programmes for inclusion. Collectively, the strategic programmes

[1] The Managing Successful Programmes (MSP) methodology defines a programme as a *'temporary, flexible organisation, create to coordinate, direct and oversee the implementation of a set of related projects and activities to deliver outcomes and benefits related to the organisation's strategic objectives.'*

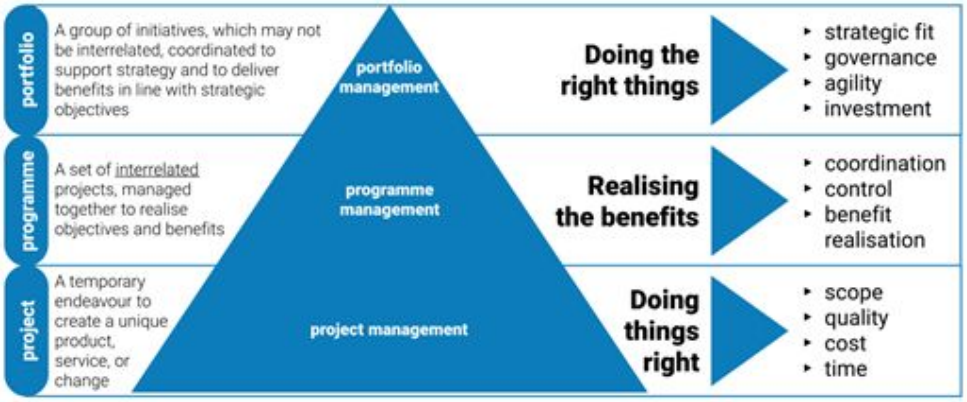
(along with any other strategic projects) form the strategic portfolio. The proposed programme management framework will apply to any future Auckland DHB programme.

ii. Definition of a portfolio

A *portfolio* is a group of initiatives[2] that, unlike a programme, **may not be related to each other,** but which are coordinated and controlled, to deliver strategic objectives and optimise investment. Auckland DHB has several portfolios in which various projects are undertaken – which are subsets of the organisation's collective investment. An example would be our Facilities & Development portfolio.

Portfolio management is concerned with *doing the right things* through effective planning, coordination and prioritisation processes. These processes aim to achieve optimum value through alignment of investment with business investment strategies. An individual portfolio area, for example, may include various 'major' projects, ongoing work programmes (such as remediation) and programmes of projects.

Fig 1 Comparison of project, prgoramme and portfolio management



3. Strategic programmes and portfolio management

This section discusses the two primary areas of focus for the *strategic portfolio:*

1. the delivery of the strategic programmes (programme management); and
2. the collective management of the strategic programmes (portfolio management).

Table 2 Programme vs portfolio management

	PROGRAMME MANAGEMENT	PORTFOLIO MANAGMENT
AIM	Deliver planned outcomes & realise benefits	Optimise scare resources
FOCUS	Coordination of related projects and activities, dependency management, project/programme governance	Investment optimisation
SCOPE	Multi-project coordination	Investment/disinvestment decision making Resource utilisation and management across multi-project/programmes

[2] Initiatives can be either projects or programmes

1. *Update on the development of the Strategic Programmes*

Since the last Board update in December 2016, work has continued on the development of the *strategic programmes.* Eight of the planned 16 programmes are now in the *delivery phase*. An overview of the strategic programmes is included as Appendix A.

The nature of these programmes and their many interdependencies increase both the complexity of their delivery, and the management of resources and interdependencies between them – and particularly for those programmes involving significant change.

The next stage of development of these programmes will focus on mapping all the individual projects to understand their interdependencies and points of integration. The Auckland DHB project management framework (Finance Risk and Assurance Committee, March 2017), will now be updated to include the relevant application of the framework to the strategic programmes.

2. *The strategic portfolio*

A portfolio approach is planned for the governance and coordination of the collective of strategic programmes. The management of the *strategic portfolio* considers a structured approach to answering the following questions:

- *Are we doing the right things?*
- *How do we prioritise between programmes competing for limited organisation resource (particularly operational resource where capital planning and expenditure processes do not apply)?*
- *How do we manage operational resources between programmes, allowing for forecasting and utilisation planning?*
- *How do we make decisions to stop or deprioritise a programme?*

Functioning as the *executive governance group* for the collective of strategic programmes, the Executive Leadership Team is tasked to make these portfolio level decisions, enabled by the development of the EPMO. The Executive Leadership Team will make recommendations to the Board about prioritising across the portfolio, and in future we will look for endorsement of the *Strategic Portfolio* in its entirety, as part of an enhanced annual planning cycle.

The first phase of development is the creation of the reporting framework for the strategic portfolio, and the provision of a strategic programmes dashboard – showing collective risks, issues, progress and performance indicators. The first round of reporting to ELT occurred in March 2017, and will be continuously improved as development progresses. We will include a *Strategic Portfolio* report as part of the standard suite of Board reporting on a quarterly basis, with ad hoc decisions on changes to the portfolio brought forward on an as-required basis.

4. Enterprise PMO Development

i. Development of the EPMO

The development of the EPMO is continuing to take a staged approach to the delivery of its three central objectives, as agreed by the Executive Leadership Team:

- **Ensure visibility and transparency** of the enterprise portfolio through analysis and reporting;
- **Enable decision making**, planning and strategy deployment; and
- **Support P3M capability development**

The first major milestone of the wider P3M3 development work, the Project Management Framework, was met in March 2017, and the focus of the next phase is the definition and approval of the EPMO's operating model and relationship to existing portfolios.

Table 3 Milestones for March 2017

Description	Target	Status
Strategic programme reporting (MOS & dashboard) (first iteration)	28/3/2017	*Complete*
Draft EPMO Charter & Options paper	26/4/2017	*In progress*
EPMO Intranet presence and repository (PMF)	21/3/2017	*In progress*

ii. EPMO & strategic programme management

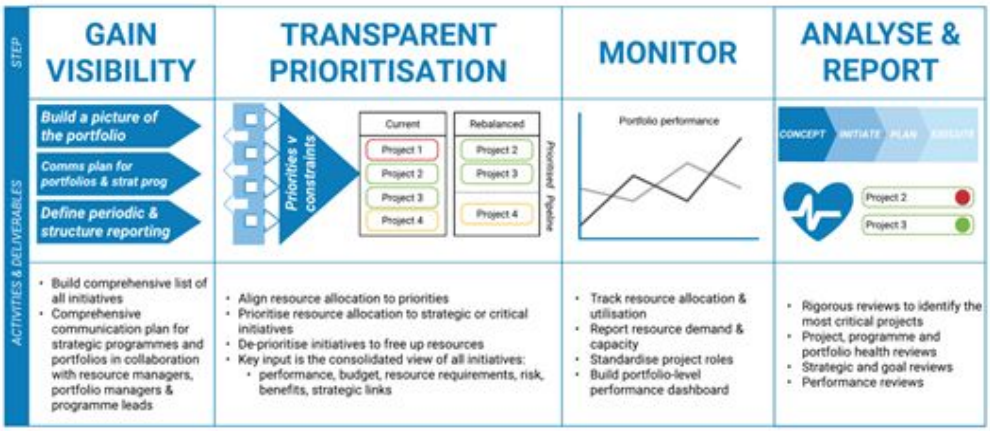
The strategic programmes are largely delivering outside existing 'project portfolios' such as Information Management (IM), or Facilities and Development.

These programmes do not all fit a traditional capital investment and control process, and so a logical and enabling approach must be developed. It is a priority of the EPMO to enable the consistent management of these programmes through the development and application of a consistent programme framework although programme management support functions are limited within the current resources of the EPMO. A strategic programme management office/support function will be considered in the EPMO Options paper.

iii. Strategic portfolio management

As discussed in Section 3, there is a need not only for consistent programme management *within* programmes, but also for a coordinated management of the *strategic portfolio* (that is, *across* all of the individual programmes). The EPMO options will consider what functions are required to enable these portfolio management processes, and in particular those outlined in Fig 4

Fig 4 High level portfolio management priorities



iv. Enterprise portfolio management

The EPMO will provide the organisation with a true picture of the entire *'enterprise portfolio'* and a consistent approach to portfolio management through the development of the portfolio management framework. While elements of portfolio management will be developed as required, substantive work on the framework is planned to begin in Phase II of the P3M maturity development roadmap.

This approach will be coordinated between the existing portfolios with clear accountabilities agreed between the accountable executives.

Table 5 Phased approach to Auckland DHB P3M framework and maturity development

	Phase I (Jan – June 17)	*Phase II (July – Dec)*	*Phase III (Jan – Jun 18)*
Portfolio			
Programme			
Project			

5. Regional DHB collaboration

Auckland DHB is engaging with our Northern region DHBs colleagues as part of the P3M3 capability development, and has taken steps to both learn from, and identify where we can collaborate on aligned approaches and processes.

Following an initial meeting in February between ADHB and WDHB, the first regional P3M3 meeting was held between CMDHB, WDHB, Auckland DHB and NDHB in March 2017.

This meeting considered the following areas for collaboration in regards to P3M3 and other areas of the ICR

- Project portfolio management software tools: options for shared learning, experience, and requirement gathering
- Joint *Investment Logic Mapping* training opportunity
- Establishing a P3M Community of Practice

5. Conclusion

Development of the strategic portfolio, EPMO, and P3M3 capability roadmap continues in a coordinated way, with the following areas:

- the creation of standardised and consistent portfolio management framework for the strategic portfolio;
- the continuing development of the strategic programmes in the *definition and identification phases*; and
- an EPMO options paper and Charter

An options paper to agree an operating model for the EPMO will be presented to the next Finance, Risk and Assurance Committee, and we will keep the Board close to the *Strategic Portfolio* through both scheduled and ad hoc reporting.

Appendix A: Auckland DHB Strategic Programme Overview

The current Strategic Portfolio is summarised below. The portfolio is in transition as we manage a number of existing inflight programmes alongside newer initiatives, and start to bring them together in a coordinated and consistent framework. Each programme has been mapped to the Board's strategic themes and in future, the alignment to strategy will be made even more explicit through the programme development and approval process through the Board.

KEY	In Delivery phase	In Definition phase	In Identification phase

Programme	Background	Strategic links	Objectives	Measures	Current work-streams / projects
USING THE HOSPTIAL WISELY	The Auckland DHB population is growing and will place increasing pressure on our hospital services unless the demand is managed. Our Emergency Department continues to see a trend of increasing attendances which is unsustainable in the long-term. As recommended in the Clinical Services Plan, we need to address this increasing demand to provide a high standard of care to both our acute and elective patients. Previous analysis has shown there are inconsistent processes in place across the provider arm for effectively managing inpatient demand. There is an opportunity to utilise a range of hospital and community services to reduce pressure on our limited hospital resources. Using the hospital wisely ensures the best use of resources to meet the needs of the population. This work programme aims to reduce pressure on our hospital services through improvement to processes, pathways and use of services. This work programme aims to achieve this over the next three years		**Reducing patient length of stay** **Reduction in avoidable admissions and readmissions** **Maximising the use of ambulatory service models**	Reduced ALOS Increase DOSA Palliative Patients spend fewer days in hospital final year of life Reduced readmission rates Improved Discharge Planning	**Discharge planning** **Palliative Care** **End to end pathways** **DOSA** **Intermediate Care** **Bed Modelling and Ward Realignment**
OUTPATIENTS MODEL OF CARE	The Provider Arm currently cares for 1.03 million outpatient visits across all our facilities. As outlined in the Provider Clinical Services Plan, if the population continues to grow and there is no change in the current model of care, we could be facing a 9.8% increase in outpatient face-to-face visits by 2020. For the most part we only have one traditional outpatient model of care. • Outpatient experience and communication is less than ideal, and can be variable and inconsistent. • Clinics are not co-ordinated within specialities and across pathways. • Patients often experience long waiting times for access to appointments as well as on the day of the clinic. • Appointments are frequently rescheduled due to capacity planning issues. • Planned outpatient clinic capacity is currently underutilised. • Patients are booked for unnecessary simple outpatient appointments. • Patients often have to travel long distances for appointments. • Patients find rescheduling of appointments difficult due to processes and hours of availability. • The current structure and skill mix of staff results in delays and inconsistency when staff are absent.		**A clear governance and management framework for Patient Access Booking and Choice to deliver agreed outcomes with each Directorate.** **Existing clinics operate with greater utilisation, less rework and wasted activity.** **Dynamic outpatient models that cater for our different patient groups and the specialties that deliver their care are defined and implemented.** **Resources and funding are matched to dynamic outpatient models.** **Virtual consults, tele-health, community clinics and many other offerings (based on best practice) are adopted where feasible.** **Encompasses a more integrated approach with primary care.** **Outpatient services are operationally and financially sustainable.**	The consistency of how we engage with patients in outpatient settings and meet our basic standards is Improved The proportion of outpatient encounters delivered "closer to patients' home" is Increased The time "wasted" by our patients and clinicians as a part outpatient care is Decreased The patient experience of how we provide outpatient care is Improved Access rates to our outpatient services are Maintained / Increased The clinical outcomes that are delivered through outpatient care are Maintained	**Access Booking and Choice (ABC) Policy - Business rules** **Performance visibility** **Tele-interpreters (TINT) project** **Letters management** **PAS skill mix and structure review** **Review of clinic working hours** **Reduction of DNA rates (regional focus and localised initiatives)** **Transformation programme**

DAILY HOSPITAL FUNCTIONING

Over the last several years, Auckland DHB has not consistently met elective and acute organisational goals as well as our patients' needs at the right time and the right place. The growing patient demand on Auckland DHB requires a higher and higher utilisation of resources (supply: staff, beds, theatres, materials, etc.).

To meet this demand, Auckland DHB must strive toward best-in-class operations with respect to:

- Planning and Forecasting (Patient & Operations Planning to predict patient demand)
- Booking, Scheduling and Rostering (To plan resourced 'supply')
- **Daily Hospital Functioning** to Monitor, Escalate and Respond to daily variation in demand (# of patients, acuity and needs) and supply (bed capacity, theatre, facilities, staffing levels, incidents, etc.)

The capability of Daily Hospital Functioning must continue to improve to meet these growing demands and provide safe clinical capacity for all our patients.

Best practice evidence supports the creation of an integrated operations centre that co-locates key operational staff and provides them with a timely view of past and predicted operational performance with agreed escalation plans.

To oversee the development of an integrated operations centre and supporting functions that will

- **improve coordination of resources across services to deliver improved patient flow,**
- **reduced cancelled surgery,**
- **improve patient safety (with the right staff in the right place), and**
- **enable flexing bed capacity and resource up and down to meet on-the-day patient needs.**

Shorter Emergency Department stays

Reduced cancellations of elective surgery

Integrated Operations Centre

Variance Response Management

Operational Intelligence & Forecasting

Transition Hub

PRIMARY & COMMUNITY

The Primary and Community programme is a response to three key reflections on the impact of our current healthcare system on people's health and wellbeing:

1. Long term conditions are one of the biggest challenges facing heath systems. But existing systems were primarily designed to deliver hospital based cures. Whilst important, this is becoming less relevant as the day to day management of chronic conditions has to happen continuously in homes, communities and workplaces rather than episodically in medical settings.
2. It is estimated that only 20% of an individual's health outcomes result from clinical treatment. The remaining 80% are determined by wider factors such as lifestyle choices, the physical environment and social networks. Only by addressing these factors can we create a healthier population and address challenges such as health inequality.

There is widespread consensus that our health system is not sustainable in its current form. Demand pressures are growing and funding is unable to keep pace. System focus must shift away from treatment in expensive institutional settings towards keeping people well, early intervention to prevent hospital admission and supporting people to manage their conditions in the community.

To improve the following outcomes for the communities targeted by the programme:

Health and wellbeing

Health equity

Health system sustainability

This will be achieved through a focus on:

Prevention

Early intervention

Person activation

Whanau activation

Community activation

Service access

Measures will be determined after the project inclusion list has been prioritised and new projects scoped. There are a myriad of health, wellbeing, equity and sustainability measures that may be used. The chosen measures will be highly intervention specific and will include a mix of quantitative and qualitative measures

The Primary and Community board is at an early stage and is currently evaluating several existing and proposed projects for inclusion under its remit. This draft list includes:

Tamaki mental health and wellbeing

Care navigation

Mt Roskill CVD and COPD initiative

Locality planning tea

Tamaki health hub

Early years hub

Postnatal care re-design

CLTC Locality model

Diabetes locality support

Single point of access to community service

Community palliative car

Intermediate care services

AFTERHOURS INPATIENT SAFETY

An increased focus on patient safety across the globe has identified afterhours safety as an area of particular risk. Afterhours is defined as 5pm to 8am weekdays and throughout the weekend.

Auckland DHB is a large and complex inpatient hospital offering a full range of services across 24 hours of operation. There is a growing concern that the model of care offered afterhours may not be optimally configured to ensure patient safety.

We need to develop and implement a robust and reliable afterhours inpatient safety function across the Auckland DHB inpatient settings. This is a cross directorate issue that is of significant importance.

Afterhours safety for our patients is equivalent to daytime safety

A sustainable afterhours staffing model

Appropriate resources effectively shared across the inpatient settings

Consistent and reliable access to and sharing of information to ensure patient safety

Agreed process and measures for monitoring afterhours patient safety

Improved access to information that staff need to deliver care afterhours	**Information for afterhours staff**
Enhanced capacity and improved access to theatres afterhours	**Handover**
Increased understanding of the way we deliver care afterhours and identification of opportunities for improvement	**Out of hours theatre access and anaesthetic cover**
Consistent and reliable handover processes	**Future oversight of Afterhours Inpatient Safety**
Enhanced senior nursing leadership and decision making afterhours	**24/7 Hospital Functioning**
Patient experience of afterhours care is improved	

SECURITY FOR SAFETY

In February 2015, the Hospital Advisory Committee (HAC) requested that ADHB undertake a full security assessment to ascertain the level of preparedness to lock down the sites in the event of a critical incident. In June 2015, an Independent Security Risk Assessment was completed and presented to the Hospital Advisory Committee (HAC). In context of the recent MSD Phase 2 Report and Recommendations that the DHB undertook an external review the organisation's security protocol.

The recommendation for a Safety-for-Security programme of work to be initiated to strengthen the security framework and raise the level of response in line with new IT systems, procedures and staff training was approved. In August 2015, it was reported that the Quality and Standards Review Committee would have overall accountability in directing implementation of Safety-for-Security Improvement Programme under the

On 4 August 2016 the Board approved the business case for the Security for Safety Programme at a total cost not exceeding 8.56M. The Board noted the existing capital approval of $2.43m to cover the Access Control and CCTV upgrade and that an additional $6.13M was being sought to complete the programme over 3 years.

The Security-for-Safety programme encompasses several interdependent projects aimed at strengthening security across all ADHB sites in order to improve the safety of our staff, patients and visitors.

The development of processes and procedures to support a site, building or partial building lock-down

Configuration of our security systems to enable:

- **appropriate access to buildings by authorised personnel and to prevent unauthorised access**
- **a swift and reliable lock-down**
- **effective alarm monitoring and response to security alarms and calls for assistance**
- **the integration of CCTV to door alarms, to enable remote monitoring and timely response to security alarms**

The development of a security conscious culture, where security-for-safety becomes everyone's responsibility

The development of appropriate security training and awareness for all ADHB staff, contractors and volunteers

The development of a security model that ensures we meet our obligations under the Health and Safety at Work Act 2015 and

Meets the relevant recommendations made in the Phase II report following the Ministry of Social Development fatalities.

Security Access Plans	**Lockdown and code black**
Fit-for-purpose Security Control Rooms	**Culture and performance**
SCR interoperability	**Access plans**
Ability to perform swift and reliable lock-down	**Access control and CCTV**
Code Black response in place	**Security / ID Card**
CCTV system upgraded	**Security Control Room**
Access Control system upgraded	**Security Staffing and Services**
Security system enhancements identified	**Security Alarm Monitoring**
Security system enhancements implemented	**Lone worker**
Established Security staffing and services	**Contractor training**
Security staffing and services aligned to Protective Security Requirements	**Keeping weapons out of hospital**
Security personnel trained in healthcare security	**Security in hospital sites**
Security awareness and education – ADHB employees	**Visitor management**

PEOPLE	Every day of the year, Auckland District Health Board (DHB) brings together thousands of people to deliver world-class healthcare and drive for healthy communities. More than 10,000 people are directly employed by the Auckland DHB and many others work in collaboration with us as volunteers, contractors, suppliers and professional partners. As employer and employees, we have legal and ethical obligations to fulfil the employment commitments we make to each other when we decide to work together. With mutual commitment, the whole for our people, patients, whānau and communities can be greater than the sum of the parts.		**Accelerate capability and skill** **Make it easy to work here** **Ensure a quality start** **Build constructive relationships** **Deliver on our promises**	**Accelerate capability and skill –** becoming a learning organisation at all levels, and ensuring our leaders and managers understand and consistently demonstrate the expectations of their role as the employer, embedding our values and a safety culture within their teams	**Management Practicing Certificate** **Leadership, coaching & communication** **Management of bullying & violence**
				Make it easy to work here – minimising the time and effort required to complete Human Resources administration and bringing clarity and simplicity to Human Resources policies and processes	**Access to HR services, info & tools** **Career pathways & benefits**
				Ensure a quality start – creating an inspiring and engaging 'first 100 days' welcome to ADHB and a strong pipeline of diverse candidates for the long term	**Orientation process** **Workplace behaviours**
				Build constructive relationships – connecting with our people to design and evolve how we work together	**Speak up**
				Deliver on our promises – ensuring we are trusted to fulfil our commitments as an employer, and build a plan to identify and shape the workforce we need for the future of health in Auckland	**Maori and Pacific Island employee recruitment and development** **Future workforce planning**
DETERIORATING PATIENTS	Auckland DHB currently has diverse mechanisms for the management of deteriorating patients which are no in keeping with current best practice. The diversity of management is dependent on several factors including the geographic location of patients within the organisation. A consistent approach would improve the care of medically unstable patients throughout the hospital, intezgrate the current separate structures and systems for these patients, and align Auckland DHB with current best practice for the care of deteriorating patients.		**Timely recognition and appropriate escalation of deteriorating patients** **Regularly reported measures to the appropriate people and places** **Proactively review potentially unstable patients** **Integrated system that is reliable, easy to use and adaptable** **Align with national deteriorating patient**	The use of EWS / PEWS scoring systems is improved throughout the organisation The response to patients at risk of deterioration is enhance	**Introduction of a Patient at Risk service involving:** • **Prevention and early identification of deteriorating patient** • **Response to deteriorating patient** • **Governance of deteriorating patient management** **Review of High dependency care areas outside formal HDU settings** **24/7 Hospital Functioning**

PROVIDER FINANCIAL SUSTAINABILITY	Significant steps have been taken to reduce costs at ADHB over the past four years, underpinned by a comprehensive savings programme which has delivered savings in excess of $200M between 2012/13 and 2015/16. However, It is clear that in order to provide assurance of delivery of the 3 year financial savings plan a more formalised programme approach is necessary. Consistent with the programme approach being adopted within the DHB, a Programme Board is proposed to manage the delivery of the savings plan and the development of financial, benefits and performance management frameworks and systems. Endorsed by the Finance Risk and Assurance Committee this Board replaces the Get on Track and Think Tank groups. The Financial Sustainability programme will deliver these objectives will adhering to our governing principles: • Initiatives should improve quality, safety and patient experience. • Initiatives should change current process, rather than top slice budgets or implement short term "workarounds" • The Board, FRAC and ELT must have assurance that potential initiatives have been assessed for impact • Accountability for delivery is maintained at a Directorate level • Enable our staff to deliver through removing unnecessary bureaucracy whilst adhering to a risk based approach to reporting and monitoring. • Our primary focus should always be to improve clinical outcomes	 	**Support the savings plan and the provider directorates in meeting these objectives** **Provide a clear framework of the consistent identification, impact assessment, prioritisation and delivery of initiatives** **Support the achievement of benchmarked performance consistently in the upper quartile across all measures** **Provide a clear risk assessment framework for programme risks** **Develop effective integrated reporting framework**	TBC	**Systems, frameworks & integration** **Productivity** **Procurement & logistics** **Corporate** **Revenue** **Reporting & monitoring**
ASSET MANAGEMENT IMPROVEMNT	The Government's maiden Investment Statement (published in December 2010) and subsequent statements including by the Treasury in its 2014 Investment Statement (published 26 March 2014) states the theme that if Government is to realise its economic goals and deliver better public services it is important to have effective management of Crown assets, and to make the best possible future investment decisions. In April 2015, Cabinet issued a new Cabinet Office circular CO(15)5 entitled Investment Management and Asset Performance in the State Services. Cabinet agreed to reinforce the objectives of the system by using performance indicators and information to determine the Investor Confidence Rating (ICR) for key Investment Intensive agencies operating in the State services. The ICR is an indicator of the confidence that investors have in an agency's capacity and capability to realise a promised investment result. The Treasury has been working with these agencies since 2008 to lift the level of maturity of asset management practices. One element of the ICR requires that individual investment intensive agencies determine and demonstrate a level of Asset Management Maturity (AMM) that is appropriate to the scale of assets under management and the criticality of those assets to the delivery of key public services. The appropriate standard is to be determined with reference to a Treasury-endorsed asset management maturity matrix. The rationale is that sustainable, cost effective asset or investment performance is likely to be a function of the quality of underlying asset management practices, systems and culture in those agencies.	 	**Effective, integrated and complete Long Term Investment Plan** **Asset management framework** **Investment governance and decision making framework for major capital works** **Oversight of Facilities remediation**	**Improved Asset Management Maturity** **High quality Long Term Investment Plan** **Asset performance** **System performance**	**Asset management:** *Policies, process & strategy improvement* **Asset management:** *Asset data and systems* **Asset management:** *Asset performance* **Asset management:** *Plan integration and process* **Long Term Investment Plan** **Programme design**

PATIENT SAFETY	Patient safety has points of integration and interrelation across several programmes.
	
	• In addition to the specific work streams the following activities are conducted at service, directorate or organisational level
	  • Serious adverse event/critical incident reporting, review and learning
	  • Mortality and morbidity review, benchmarking with HRT
	  • Key organisation wide surveillance and audit activities
	• Patient safety metrics are embedded in the management operating system at service and directorate level
	• Training opportunities provided to build capability in quality and safety
			**A culture of quality and safety where the patient is at the centre, and where staff speak out for safety**
			
			An environment where high performing teams deliver safe and reliable care
			
			Where real time data informs continual practice improvement, variation is minimal and evidence underpins decision making
			
			Feedback is open and transparent and results are shared
			
			All underpinned by robust safety systems and processes, an enabling structure, leadership and capability in quality improvement and safety
					Hand hygiene
					
					Handover
					
					Health care acquired infection
					
					Medication safety
					
					Pressure injuries
					
					Perioperative safety
					
					Deteriorating patient
					
					Frail elderly
					
					Minimising variation

PATIENT AND WHANAU CENTRED CARE	Community, family/whānau and patient-centric model of healthcare' is one of the seven strategic themes for Auckland DHB. This Programme Board is planned to bring together a range of projects that have improving patient and whanau experience as their key aim. As well as delivering against one of our Board mandated strategic themes, this programme is also underpinned by our, people, patient safety and nursing / midwifery strategies; and directly supports actions to embed our values of Welcome | Haere Mai, Respect | Manaaki, and Together | Tūhono. Every person and family has different support and health care service needs and aspirations. The ADHB Board is committed to reorienting our system around the needs of our patients, whānau and communities. The quality of the patient and whānau experience, and their outcomes, should be the starting point for the way we think, act and invest. Building service models centred on the world of the patient and their family and whānau (versus requiring patients to fit their lives around services we happen to offer) will minimise the work of being a patient and deliver on the goals important to the patient and their whānau/family. Patient and whānau/family-centred care recognises that patients and whānau/families are experts on what matters to them. Evidence shows that improving patient experience is positively associated with higher levels of adherence to recommended prevention and treatment processes, better clinical outcomes, better patient safety within hospitals, less health care utilization, and lower costs. In 2014 the Auckland DHB executive engaged over 1000 users asked to identify a range of opportunities to improve ADHBs Public Spaces. From there three major streams of work were launched; Wayfinding, Sustainable Transport and Healing Environments. Healing environment, for healthcare buildings describes a physical setting and organisational culture that supports patients and families through the stresses imposed by illness, hospitalisation, medical visits, the process of healing, and sometimes bereavement.	  	**All people, family/whānau experience our values of Welcome, Respect, Together and Aim High.** **Patients determine the supports they want for their health care and for their whānau/family. People control their health care and have services tailored to their needs.** **Auckland DHB are renowned for our people-centred approaches, through our personal interactions and enabling self-determined care.** **First impressions of our services are exemplary, everyone is treated with dignity, cultural sensitivity, and respect.** **Patient and whānau/family determined care plans at ADHB are the norm with care plans tailored to reflect patient and whānau/family priorities and goals** **Pathways of care and services are designed around what matters to patients.** **Auckland DHB public spaces are designed for improved user experience.** **Build knowledge and awareness around Healing Environments, the benefits and how to achieve them**	TBC	**Establish programme board** **Releasing Time to Care including Partners in Care** **Patient Experience Insights** **Public Spaces** **Healing Environments**
MENTAL HEALTH	This programme is currently in the identification stage, and working towards the formation of a Programme Board. Expressions of Interest were invited for Board membership: to lead and manage the process of strategic change to transform mental health and addiction services by setting a clear direction (shared goals and outcomes); developing and engaging people and their whanau/family and piloting innovation to ensure transformations continue to be tailored to the needs of the population and rolled out and sustained over time. MHA Programme Board will be a key leadership, strategic oversight and advisory group reporting to the ADHB Board (via the Executive Sponsor Group). Its purpose will be to take overall responsibility for the effective running of the Mental Health and Addictions strategic programme of work.				

NORTHERN REGION CANCER BOARD	In 2013 the Northern Region Governance Group (comprising Board Chairs and CEOs) sanctioned the formation of a Northern Region Cancer Board to oversee the region's response to the challenges provided within the cancer arena. The Cancer Board is the meeting place where decisions are taken regarding the best approaches for cancer. A Strategic Plan was developed to articulate our strategic intent, values and 5 year goals over 2014/15 – 2019/20. This Plan is currently under review to explicitly reference an increased focus on research-enabled cancer care. **Please note that this work programme may need to be viewed in light of new regional governance arrangements, as it may be subject to change**	**The following are the priorities for cancer care in the Northern Region.** **Progress Regional Tumour Stream outcomes (lung, upper-gastrointestinal, bowel, haematology, gynaecology, sarcoma, breast)** **Complete a Regional MDM stocktake and gap analysis project** **Provide regional visibility of the Ministry of Health Faster Cancer Treatment, and Psycho-social Supportive Care initiative** **Progress the Local Delivery of Oncology project** **Integrate a comprehensive research approach across all aspects of regional cancer care delivery**		Current work focusses on greater local provision of chemotherapy for specific cohorts of patients who experience breast and bowel cancer.
IS APPLICATION STABILISATION	To be developed	**To be developed**		
VALUE-BASED COMMISSIONING	To be developed	**To be developed**		

Resolution to exclude the public from the meeting

Recommendation

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

General subject of item to be considered	Reason for passing this resolution in relation to the item	Grounds under Clause 32 for the passing of this resolution
1. Apologies		That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
2. Register and Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 22 February 2017	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points 22 February 2017	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Chief Executives Confidential Report	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)]	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

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

	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)]	be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7.3 Westpac Banking Arrangement Extension Letter	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8. Discussion Reports - NIL		That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.1 NRLTIP Board Update	**Commercial Activities** To enable the Board to carry out, without prejudice or disadvantage, commercial activities [Official Information Act 1982 s9(2)(i)] **Confidence** Information which is subject to an express obligation of confidence or which was supplied under compulsion is enclosed in this report [Official Information Act 1982 s9(2)(ba)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
9.2 Human Resources Report	**Privacy of Persons** Information relating to natural person(s) either living or deceased is enclosed in this report [Official Information Act s9(2)(a)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of

		sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]