AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Open Board Meeting

Wednesday, 23 May 2018

10:45am

Note:

- **Open Meeting from 10:45am**
- **Public Excluded to follow**

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

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Published 17 May 2018

Agenda
Meeting of the Board
23 May 2018

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

Time: 10:45am

Board Members	**Auckland DHB Executive Leadership**	
Gwen Tepania-Palmer (Board Chair)	Ailsa Claire	Chief Executive Officer
Jo Agnew	Karen Bartholomew	Acting Director of Health Outcomes – AHB/WDHB
Doug Armstrong	Margaret Dotchin	Chief Nursing Officer
Michelle Atkinson	Joanne Gibbs	Director Provider Services
Judith Bassett	Dame Naida Glavish	Chief Advisor Tikanga and General Manager Māori Health – ADHB/WDHB
Zoe Brownlie	Dr Debbie Holdsworth	Director of Funding – ADHB/WDHB
Dr Lee Mathias	Fiona Michel	Chief Human Resources Officer
Robyn Northey	Dr Andrew Old	Chief of Strategy, Participation and Improvement
Sharon Shea	Rosalie Percival	Chief Financial Officer
	Shayne Tong	Chief of Informatics
	Sue Waters	Chief Health Professions Officer
	Dr Margaret Wilsher	Chief Medical Officer
	Auckland DHB Senior Staff	
	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

10:45am **1. ATTENDANCE AND APOLOGIES**

Ailsa Claire, Margaret Dotchin

2. REGISTER OF INTEREST AND CONFLICTS OF INTEREST

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

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

3. CONFIRMATION OF MINUTES 11 APRIL 2018

4. ACTION POINTS

10.55am **5. EXECUTIVE REPORTS**

5.1 Chief Executives Report

11.10am	5.2	Health and Safety Report
11.20am	5.3	Human Resources Report
	6.	**PERFORMANCE REPORTS**
11.25am	6.1	Financial Performance Report
11.35am	6.2	Funder Report
	7.	**COMMITTEE REPORTS**
11:45am	7.1	Disability Support Advisory Committee Referral Report 14 March 2018
	7.2	Community and Public Health Advisory Committee Referral Report 4 April 2018
	8.	**DECISION REPORTS**
11.50am	8.1	Healing Environments
	8.2	Alice Nelson Charitable Trust
	8.3	2018/19 Annual Plan Approach
	8.4	Integrating Governance, Leadership and Planning Arrangements for Maori Health
	9.	**INFORMATION REPORTS**
12.15pm	9.1	Auckland DHB Engagement Survey Action Plan Update
12.25pm	9.2	Maori Health Development Update - Verbal Presentation – Auckland DHB Matāriki Events. [Dame Naida Glavish and Rikki Nia Nia] - What Matāriki stands for - awards and their categories - Release of the Ako application.
	10.	**GENERAL BUSINESS**
12.40pm	**11.**	**RESOLUTION TO EXCLUDE THE PUBLIC**
	12.	**SUPPLEMENTARY PAPERS (NEW)**
	12.1	Combined Regional Disability Support Advisory Committee – Update [to be treated as Item 8.5]
	12.2	Refers to Item 8.1 'Healing Environments' - to support the presentation and discussions.

Next Meeting:	Wednesday, 04 July 2018 at 10:00am A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton

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Attendance at Board Meetings

Members	09 Aug. 17	20 Sept 17	01 Nov. 17	13 Dec. 17	28 Feb. 18	11 Apr. 18	23 May. 18
Lester Levy (Chair) ***(resigned 1/2/18)***	1	1	1	x	r	r	r
Joanne Agnew	1	1	1	1	1	1	
Doug Armstrong	1	1	1	1	1	1	
Michelle Atkinson	1	1	1	1	1	1	
Judith Bassett	1	1	1	1	1	1	
Zoe Brownlie	1	1	1	1	1	1	
James Le Fevre (Deputy Chair) ***(resigned 16/4/18)***	x	1	1	1	1	1	r
Lee Mathias	1	1	1	1	1	1	
Robyn Northey	1	1	1	1	1	1	
Sharon Shea	1	x	1	1	x	1	
Gwen Tepania-Palmer, Chair ***(Board Chair from 2/2/18)***	1	1	1	1	1	1	
Key: 1 = present, x = absent, # = leave of absence, c = cancelled, resigned = r							

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
Gwen TEPANIA-PALMER	Board Member - Health Quality and Safety Commission Committee Member - Lottery Northland Community Committee Chair - Ngati Hine Health Trust Life member – National Council of Maori Nurses Alumnus – Massey University Director – Hauora Whanui Limited Northland	26.04.2018
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) Karma Food New Zealand LTD [50% shareholding, non-Director]	22.11.2017
Michelle ATKINSON	Evaluation Officer – Counties Manukau District Health Board Director – Stripey Limited Trustee - Starship Foundation Contracting in the sector	18.04.2018
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 Member – Trans-Tasman Occupations Tribunal Daughter – Partner Russell McVeagh Lawyers	16.01.2017
Judith BASSETT	Trustee - A+ Charitable Trust 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	17.05.2017
Zoe BROWNLIE	Community Health Worker – Auckland DHB Member – PSA Union Board member - RockEnrol Partner – Youth Connections, Auckland Council Partner – Aro Arataki Children's Centre Committee Son – Aro Arataki Childcare Centre	09.06.2017

Lee MATHIAS	Chair - Health Promotion Agency Chair - Unitec Chair - Health Innovation Hub (until the end of the Viclink contract in line with the director appointment) Chair – Medicines New Zealand Director - Health Alliance Limited (ex officio Auckland DHB) Director/shareholder - Pictor Limited Director – Pictor Diagnostics India Private Limited Director - Lee Mathias Limited Director - John Seabrook Holdings Limited Trustee - Lee Mathias Family Trust Trustee - Awamoana Family Trust Trustee - Mathias Martin Family Trust Member – New Zealand National Party	21.02.2018
Robyn NORTHEY	Shareholder of Fisher & Paykel Healthcare Shareholder of Oceania 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	05.07.2017
Sharon SHEA	Principal - Shea Pita Associates Ltd Provider - Maori Integrated contracts for Auckland and Waitemata DHBs Provider - multiple management consulting projects for Te Putahitanga o Te Waipounamu Whanau Ora Commissioning Agency Provider – Hapai Te Hauora for National SUDI project; supporting data design for regional provision (which includes potential reporting datasets for DHBs) Board member – Alliance Health Plus Iwi Affiliations: Ngati Ranginui, Ngati Hine, Ngati Hako and Ngati Haua Sub-contractor - Te Ha Oranga/Te Runanga o Ngati Whatua Contractor – New Zealand Social Investment Unit Director – Healthcare Applications Ltd Husband - Part owner Turuki Pharmacy Ltd, Auckland Husband - Board member - Waitemata DHB Husband – Director Healthcare Applications Ltd	27.04.2018

Minutes
Meeting of the Board
11 April 2018

Minutes of the Auckland District Health Board meeting held on Wednesday, 11 April 2018 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 10:00am

Board Members Present	**Auckland DHB Executive Leadership Team Present**	
Gwen Tepania-Palmer (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		
Dr Lee Mathias	Rosalie Percival	Chief Financial Officer
Robyn Northey	Shayne Tong	Chief of Informatics
Sharon Shea	Sue Waters	Chief Health Professions Officer
	Auckland DHB Senior Staff Present	
	Rachel Lorimer	Director Communications
	Gil Sewell	Human Resources Director, Organisational Development
	Marlene Skelton	Corporate Business Manager
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

The Board Chair, Gwen Tepania-Palmer welcomed Karen Webster, Tutor; Auckland University of Technology and six students of the Clinical Governance Course to the meeting.

Joanne Gibbs, Director Provider Services, introduced a recently made two and a half minute video highlighting staff from the Adult Emergency Department service talking about what a great place Auckland DHB and the Adult ED in particular, was to work.

The Board felt that this was a good innovation as the heart of any business was the people that work within it and it was good to be reminded of this.

1. ATTENDANCE AND APOLOGIES

That the apology of Dr Margaret Wilsher, Chief Medical Officer be received.

2. REGISTER AND CONFLICTS OF INTEREST (Pages 5-7)

Sharon Shea asked that the following new interest be added to her register:

Sub-contractor to Te Ha Oranga/Te Runanga o Ngati Whatua. New AOD programme to support women in Wiri Prison.

There were no conflicts of interest with any item appearing on the open agenda.

3. CONFIRMATION OF MINUTES 28 FEBRUARY 2018 (Pages 8-20)

Resolution: Moved Sharon Shea / Seconded Jo Agnew

That the minutes of the Board meeting held on 28 February 2018 be confirmed as a true and accurate record.

Carried

4. ACTION POINTS 28 FEBRUARY 2018 (Page 22)

There were no action points falling due to report on.

5. EXECUTIVE REPORTS

5.1 Chief Executive's Report (Pages 23-39)

Ailsa Claire, Chief Executive asked that the report be taken as read and highlighted points as follows:

- Auckland DHB is aspiring to be the first DHB to be Rainbow tick certified as a whole organisation
- Auckland DHB has been recognised for its effort in reducing its carbon footprint and was awarded three Silver Climate Champion Awards by Global Green and Healthy Hospitals.
- Ask HR is now one year old and have received 30,000 enquiries during that time.
- That the acute patient flow (ED 6 hrs) and improved access to elective surgery were challenged when meeting target. Reasons for this had been consistently reported since the middle of last year. Better Help for Smokers to Quit was below target for PHO enrolled patients and efforts to reach the Increased Immunisation 8 months target continued to fluctuate.
- The appointment of Associate Professor Dr Peter van der Weijer as acting Director of Women's Health. The advertising if this position had received 84 expressions of interest which was heartening.
- The opening of the Auckland Cancer Trials Centre which gives access to a wider range of drugs for patients as reported on page 39 of the agenda.

The following points were covered in discussion:

- Judith Bassett commented that the opening of the Auckland Cancer Trials Centre was a good initiative as it allowed the development of connections for Auckland DHB that it might not have been able to manage otherwise.
- Zoe Brownlie asked whether Auckland DHB was investigating, as part of the Rainbow Tick programme, provision of gender neutral bathrooms as Auckland Council had. Andrew Old confirmed that all publically accessible bathrooms were being audited

for suitability for conversion.

Gwen Tepania-Palmer acknowledged the work of the Chief Executive noting that she had had a very busy month, both on a regional and national basis.

Resolution: Moved Lee Mathias / Seconded Robyn Northey

That the Chief Executive report for April 2018 be received.

Carried

5.2 Health and Safety Report (Pages 40-102)

Sue Waters, Chief Health Professions Officer asked that the report be taken as read highlighting points made on pages 40 to 42 of the agenda.

The following points were covered in discussion:

- Advice was given that the Ernst and Young report would be provided to the next Board meeting.
- Jo Agnew was assured that in relation to patient handling and trips and falls additional training courses had been provided for staff and that the solution did not lie directly with the provision of additional staff.
- It was noted that in relation to asbestos management that the audit to be conducted as part of the health and safety maturity assessment had been deferred to early 2019. However, in the interim WorkSafe had been in and reviewed practise siting it as best practice and to be used as a benchmark.
- Advice was given that the role of "Health and Safety Representative" is taken on by a staff member over and above the role they are employed to carry out. Tension around this exists as environments have become busier. It is being monitored and efforts are being made to increase the level of representation and training.

  With regard to the situation with Contractors and NGO's – an update will be included in next report.
- James Le Fevre commented that other organisations had been surprisingly slow to respond to the requirement to manage workplace violence and that management were to be thanked for the proactive approach taken.

Gwen Tepania-Palmer acknowledged the work undertaken on behalf of the Board. Good progress continues to be made. The context is about achieving behaviour and cultural changes within the organisation and this work goes a long way to achieving that.

Resolution: Moved Lee Mathias / Seconded Sharon Shea

That the Board:

1. **Receives the Health and Safety Performance report for February 2018.**
2. **Endorses reporting of progress.**

Carried

5.3 Human Resources Report (Page 103-110)

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

- Human resources is 18 months into a programme of work aimed at delivering the Auckland DHB People Strategy objectives.
- Fiona Michel drew attention to page 108 of the agenda and item 4.3 where mention of the Thrive programme was made. This programme of work had now been approved and signed off. It is aimed at assisting lower paid staff move through to better paid positions within the Auckland DHB. Fiona believed that it would provide an enormous point of difference for Auckland DHB and the individuals working or seeking to work here.
- In relation to the Recruitment Strategy implementation Fiona advised that in the first three months of this year the Recruitment team had recruited for nearly 700 roles, the largest number ever. This could be attributed in part to the strategy of getting ready for winter early. The workload to recruit for that number of roles was significant.
- A tool that has been used to manage recruiting is Taleo which is currently undergoing an upgrade to improve further the recruiting experience this is due to go live on 1 May. Both Shayne Tong, Chief of Informatics and Fiona Michel are looking at the use of technology and at solutions that will assist and support the recruiting area.
- Fiona Michel alerted Board members that Friday, 18 May 2018 is "Pink Shirt" day where a national focus is placed on workplace bullying. As part of the "Speak Up" programme Auckland DHB would be taking part.

The following points were covered in discussion:

- Board members asked that management make them more aware of events that Board members could participate in. Members felt that they need to be proactive about being involved in openings and events to promote Board visibility.
- Sharon Shea was assured that the Maori cultural component of development was sitting under MALT and the Rangitahi programme. These aspects were reported on in depth at least twice a year to show progress made.
- Board members were assured that the Thrive programme would be showcased at the next board meeting. Gwen Tepania-Palmer thanked Human Resources staff for being innovative and being prepared to try new things.

Resolution: Moved Robyn Northey / Seconded Jo Agnew

That the Board:

1. **Receives the Auckland DHB Human Resources report.**
2. **Notes the Auckland DHB Human Resources progress.**

Carried

6. PERFORMANCE REPORTS

6.1 Financial Performance Report (Pages 111-119)

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

- The result for February 2018 shows that the budget is tracking as it should. The unfavourable variance is reducing and is on track to meet the budget at year end.
- Transplant numbers dipped in March but remain variable.
- All known risks have been provided for and the cash flow position is strong.

The following points were covered in discussion:

- Board members expressed their satisfaction with the financial situation.
- In relation to the balancing of the IDF budget members were advised that this was on track and of the nearly $600M budget the deviation currently sits within the 1% range.
- Accrued income had been well managed with a conservative approach being adopted.

Resolution: Moved Doug Armstrong / Seconded Lee Mathias

That the Board Receives the Financial Report for the 8 months to February 2018

Carried

6.2 Funder Update (Pages 120-136)

Debbie Holdsworth, Director Funding asked that the report be taken as read advising in brief as follows:

- The Letter of Expectation is still awaited from the Minister of Health but it is hoped to have it within the next two weeks.
- We have formally been advised the Better Public Service Targets have now been stopped. The DHBs have not been informed of any changes to health targets. System Level Measures data is beginning to allow more detailed reporting to be provided; for example, a view of diabetes can now be obtained at a practice level. More detailed reports on System Level Measures exist elsewhere in the agenda.
- Ernst and Young have the contract to review the ARC Funding Model; a final report with a proposed funding model is due in December 2018.
- Drawing attention to pay equity which had required a huge focus from the team, as reported for item 4.2 on page 124 of the agenda.
- A thorough update on mental health had been provided on pages 127 to 134 of the agenda. A submission is being prepared in response to the Government enquiry into

Mental Health and Addictions 2018.

- A good outcome had been reached in relation to residents living at Seaside Sanctuary on Waiheke Island as reported under 4.3 on page 125 of the agenda.

The following points were covered in discussion:

- Doug Armstrong raised a question in relation to whether the total figures reported for immunisation incorporated the Maori immunisation figures and whether the immunisation gap could be attributed to the low Maori figure. He was advised that the Maori figure was included in the total immunisation figure and contributed about a third of the gap to achieve the target, however this target is reported by ethnicity.
- Doug Armstrong also questioned what measures were employed to follow up new mothers in relation to required immunisation. Margaret Dotchin, Chief Nursing Officer advised that all women receive post-natal care for up to six weeks following a birth. In terms of after-care there is also Plunket and for those at risk there are nurses within general practises and the community following up on mothers and new born babies.
- Advice was given that it was believed that funding for SACAT would be captured within the budget envelope that was as yet to be released. Any issues this posed for the construction of an additional floor at Mission HomeGround would be raised in conversations had by the Auckland City Mission and the Ministry of Health. Judith Bassett asked that frequent updates on this issue be made to the appropriate Board meetings so members could maintain an overview on how this issue was progressing.
- Surprise was expressed that there was no regional or nationally consistent priorities and criteria for regional cardiology service demand. Assistance is being sought from the national cardiology network to facilitate development of these and when they are available they will be reported to the Board.
- Sharon Shea advised that the Community and Public Health Advisory Committee agenda had been reconfigured to allow members to contribute early on significant issues. The first deep dive was on equity in the SLM plan and this is presented later on the agenda for consideration by the Board.

Resolution: Moved Michelle Atkinson / Seconded Jo Agnew

That the Board note the key activities within the Planning, Funding and Outcomes Unit since the last update provided on 28 February 2018

Carried

7. COMMITTEE REPORTS

7.1 Hospital Advisory Committee (Pages 137-159)

Judith Bassett, Chair of the Hospital Advisory Committee introduced the report advising that the Directorate had been dealing with the constant challenges around acuity and increasing

demand along with the resource to effectively deal with this situation. Recruitment had become an issue for some services with hard to fill specialist roles.

Judith drew Board members attention to page 150 of the agenda and the comments made by Joanne Gibbs under item 5.2 saying that this succinctly summed up the current situation.

Resolution: Moved Lee Mathias / Seconded Michelle Atkinson

1. **That the Hospital Advisory Committee confirmed minutes of the meeting held on 7 February 2018 be received.**
2. **That the Hospital Advisory Committee draft unconfirmed minutes of the meeting held on 21 March 2018 be received.**

Carried

8. DECISION REPORTS - NIL

9. INFORMATION REPORTS

9.1 Recruitment Deep Dive (Pages 160-170)

Fiona Michel, Chief Human Resources Officer asked that the report be taken as read and introduced Gil Sewell, Human Resources Director, Organisational Development.

Fiona Michel advised that the report informed the Board about what was being done to improve recruitment processes and outcomes. There had not been much change in the way the Auckland DHB recruited up until one year ago. At that time the Recruitment Team was placed under the Organisational Development function and Gil Sewell's management.

Gil Sewell advised that there was a move toward a more modern service where the focus was on the development of partnership relationships rather than the historic reliance on merely being a processing service.

Demand is exceptionally high. The first three months of this year saw 700 appointments being made.

In the first year of the programme an interim step had been taken with the appointment of three additional recruitment consultants. This additional resource has had a positive impact on workload. The number of requisitions per recruitment consultant has come down from an average of 80 per month to an average of 67-75 per month. This has had a flow on effect and impact on reducing the time to hire. However, the number of requisitions per consultant was still higher than that managed by the other regional DHBs.

The focus now was on educating hiring managers, where capability and time available was mixed. Attention was being paid to those roles that were hard to fill or the most expensive to fill.

The following points were covered in discussion:

- Advice was given that the NRA were looking at their role in the recruitment of RMO's and had hired additional people at the right level and with the right skill mix to

address the issues experienced in this area.

- From the perspective of the Maori and Pacific workforce, which currently sits within the diversity strategy, a set of tools is being put together to improve this situation too. A report is due soon to the Executive Leadership Team. One of the strategies being looked at is that all eligible Maori and Pacific candidates be automatically interviewed as of right.

Resolution: Moved Judith Bassett / Seconded Zoe Brownlie

That the Board receives the Auckland DHB Recruitment – Deep Dive report.

Carried

9.2 Auckland DHB Statement of Performance Expectations Quarterly Report (Pages 171-178)

Debbie Holdsworth, Director of Funding – Auckland DHB/Waitemata DHB asked that the report be taken as read.

The following points were covered in discussion:

- It was advised that the impact of the removal of the Better Public Service targets would not be known until the Letter of Expectation was received from the Ministry of Health for the 2018/2019 year.
- It was noted that the report highlighted the importance of transparency as it provided an opportunity to focus on the more vulnerable areas.

Resolution: Moved Jo Agnew / Seconded Sharon Shea

That the Statement of Performance Expectations (SPE) Performance Report: Quarter two 2017/18 report be received.

Carried

9.3 System Level Measures Reporting (Pages 179-208)

Debbie Holdsworth, Director of Funding – Auckland DHB/Waitemata DHB asked that the report be taken as read advising that the report was in the nature of an update including the latest data for each SLM and their contributory measures and outlining progress of each working group against the improvement activities identified for each SLM in the SLM Improvement Plan.

There were no questions.

Resolution: Moved James Le Fevre / Seconded Zoe Brownlie

That the Board acknowledge the progress of the System Level Measures work programme against the indicator reporting for Quarter Two.

Carried

10. GENERAL BUSINESS

There was none.

11. RESOLUTION TO EXCLUDE THE PUBLIC (Pages 209-212)

Resolution: Moved Sharon Shea / Seconded Lee Mathias

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		
2. Register of Interest and Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 28 February 2018	**Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points	**Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Risk Management	**Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public**	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

	[Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	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 Chief Executives Confidential Report	**Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7 Performance Reports - Nil	N/A	N/A
8.1 Finance, Risk and Assurance Committee 22 March 2018	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)] **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]
8.2 Finance, Risk and Assurance Committee 5 April 2018	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)] **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	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]

	1982 s9(2)(ba)]	
8.3 Hospital Advisory Committee	**Commercial Activities** **Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)] **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]
9.1 Transplant Service Capacity Strategy	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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 Chief Executive at Risk Performance Pay Component	**Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.1 People Dashboard April 2018	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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 Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public	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

	[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)]	6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.2 HDC Final Report – Delayed Diagnosis of Ovarian Cancer	**Privacy of Persons** **Information relating to natural person(s) either living or deceased is enclosed in the report.** **Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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 General Business	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
13 Presentation - Equity Focus in System Level Measures Planning Process	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Carried

The meeting closed at 4.30pm.

Signed as a true and correct record of the Board meeting held on Wednesday, 11 April 2018

Chair: _____ Date: _____

Gwen Tepania-Palmer

Action Points from 11 April 2018 Open Board Meeting

As at Wednesday, 23 May 2018

Meeting and Item	Detail of Action	Designated to	Action by
20 September 2017 9.1	**Pedestrian Safety Grafton and Greenlane Clinical Centre Sites** At an appropriate time, a further update on the remaining pedestrian safety measures that are to be put in place on the Grafton and Greenlane Clinical Centre Sites be provided.	Allan Johns	TBA

Chief Executive's Report

Recommendation

That the April-May 2018 report of the Chief Executive be received.

Prepared by: Ailsa Claire (Chief Executive)

Glossary

1. Introduction

This report covers the period from 26 March to 6 May 2018. 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

A new Clinical Decision Unit for Auckland City Hospital

After a nine-month build, our new Clinical Decision Unit (CDU) was officially opened on 1 May 2018 and began admitting patients on 8 May. The CDU is an $8.45 million, 24-bed facility that sits alongside our busy Adult Emergency Department (AED) as part of the Level 2 Acute Hub, increasing our capacity to care for acute patients by 25%.

Many patients who enter the hospital through AED need more investigation before it can be decided whether to admit them as an inpatient or discharge them home with appropriate support. Now these patients can be transferred to the CDU for specialist assessment, freeing up AED beds for new acute patients. Some patients referred to the hospital by their GP will also be assessed in the CDU. The facility is designed to improve the experience of patients and whānau and to provide a better working environment for our staff.

Captions: (previous page) Chief Executive Ailsa Claire and Chair Gwen Tepania-Palmer officially open the CDU, *(right)* a look inside the new facility before it opened to patients.

Visit from the Acting Director General of Health

On 6 April, the Acting Director General of Health, Stephen McKernan spent the afternoon at Auckland DHB hosted by Chief Executive, Ailsa Claire and Chair Gwen Tepania-Palmer. He visited some of the new areas developed to improve patient care, including the Clinical Decision Unit, the Auckland Cancer Trials Centre and the Motutapu Ward.

He also visited the Oncology Day Stay and saw our MOS and Releasing Time to Care programmes in action in Radiology and Reablement. The Acting Director General also took the opportunity to get his flu vaccination during his visit.

Caption: Acting Director General of Health, Stephen McKernan (centre) with Chief Executive Ailsa Claire and members of our Nursing team.

Together – Let's make work better

In April, we kicked off an exciting new phase in our culture programme. It's our next step in helping make Auckland DHB a safe, healthy and supportive environment, where all our people have the opportunity to do their life's best work.

Called 'Together' the new programme builds on the work we've done in recent years developing and launching the Auckland DHB values and putting in place a People Strategy, and implementing new programmes such as Speak Up | Kaua ē patu wairua.

'Together' invites people from across the organisation to share their stories and experiences, and help us all understand what doing our life's best work looks like, right here, every day. The first phase saw a series of workshops held on 9 and 10 May, where staff shared information on what makes their day better, how they problem solve, and how they support each other and contribute to building a healthier community.

Focus on Sustainability

The Senior Leadership Team this month endorsed the development of an Auckland DHB Sustainability Strategy based on the UN Sustainable Development Goals (SDGs). With action to address Climate Change a key priority in the 2018/19 Letter of Expectations from the Minister, a comprehensive DHB approach is timely. As a first step we will undertake a materiality assessment to prioritise the 17 SDGs, under the guidance of a steering group reporting to the Executive Leadership Team. A formal update will be presented to the Board later this year.

Children's Emergency Department waiting room refurbishment

Starship Hospital's newly renovated children's emergency department (CED) assessment and waiting area opened on 3 May. Working with the Starship Foundation and supporter ASB, Starship CED staff identified an opportunity to use interactive technology to help distract children and prepare them for treatment, as well as create a more accommodating space for patient comfort and flow.

Caption: 'The Magical Forest' is part of the new Starship CED waiting area.

The space introduces interactive technology, created in consultation with young patients, to calm nervous patients and their whānau at what is often a difficult time. 'The Starship Animal Check-ups' space is a wall of frames featuring different characters to take children

through check-up experiences familiarising them with the processes they will soon undertake with the clinical team. 'The Magic Forest' is an avatar scene experience creating a calming space where virtual birds and flowers react to interaction.

Watch a video of some children exploring the new space here.

2.2 Health sector partnerships

New programmes to strengthen our communities

As part of our work to support healthy aging, Auckland and Waitemata DHBs are partnering with ACC to deliver new strength and balance programmes to help prevent falls in older members of our community. The evidence shows these types of programmes have a significant impact on the participant's quality of life, with research showing in-home strength and balance work can halve the risk of falls in people over 80 years or at risk of falls.

GPs assess their older patients' risk of falls and refer them to the appropriate strength and balance programme. Patients can be referred to community group strength and balance classes to participate as a group in exercises that reduce their risk of falling. For those who are more frail and unable to attend community programmes, in-home strength and balance programmes are available.

2018 Allied Health Conference

Auckland DHB and Canterbury DHB co-hosted the 2018 Allied Health, Scientific and Technical Conference at Te Papa in Wellington on 9-11 May. The conference theme was "Live Well, Stay Well, Get Well with Allied Health". It brought together 200 delegates from across the diverse and vital Allied Health, Scientific and Technical (AHS&T) workforce to share their knowledge and experience.

The AHS&T workforce makes up 16% of DHB employees, and has a significant footprint in the private sector, with more than 50 professional groups working across all health and disability services. AHS&T professionals are vital not only in the effective delivery of patient assessments, but also acute and rehabilitation treatment services and the delivery of necessary patient support services such as sterile supplies.

GoodSAM app for community first responders

The National Cardiac Network and Heart Foundation held an event on 24 May in the Clinical Education Centre to introduce interested staff to the GoodSAM (Good Smartphone Activated Medics) app.

GoodSAM is an international app that is being introduced in New Zealand through a collaboration between the National Cardiac Network, St John and Wellington Free Ambulance. People who have clinical or first aid training can sign up to be notified that someone suspected to be in cardiac arrest is near to them. The app is a way of helping patients receive bystander CPR and early defibrillation prior to emergency services arriving.

2.3 Patients and community

2.3.1 Email enquiries

Communications manages a generic communication email box, responding to all emails and connecting people to the correct departments. For this period, 206 emails were received. Of these emails, 24 were not communications-related and where appropriate, were referred to other departments and services at Auckland DHB.

2.3.2 Patient experience

Auckland Mayor, Phil Goff recently spent time in Auckland City Hospital for treatment; he shared some fantastic feedback about the care he received on his Facebook page:

"Spent the weekend involuntarily investigating Auckland's hospital system. My family has a history of clogged arteries which despite being a virtuous non smoker I have been unable to escape. So I ended up Saturday morning at Auckland Hospital for an angioplasty and a few stents. Procedure went well and I'm hassling the doctor to let me go home. Hopefully tomorrow and after a few days of working from home, I'll be back at work.

A big thanks first to doctors, nurses and staff. They been really great, both professional and caring. They are a wonderful cross section of multicultural Auckland. It's fantastic that in our country people get the urgent treatment they need and according to that need and not ability to pay. Thanks also for the kind messages from so many people. Heartfelt appreciation!"

2.4 External and internal communications

2.4.1 External

We received 90 requests for information, interviews or for access from media organisations between 26 March and 6 May 2018. Media queries included requests related to the Health Select Committee, maternity staffing levels, and the impact on infants of prenatal methamphetamine use by pregnant women.

Approximately 21 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 seven Official Information Act requests over this period.

2.4.2 Internal

- Two CE blog posts were published, they covered our plans for coping with the continued high demand for our services over winter; the acting Director General of health's visit and highlighted our annual flu vaccination campaign.
- Thirty eight news updates were published on Hippo, the DHB intranet.
- Six editions of 'Our News', the weekly email newsletter for all employees were distributed.
- Two 'In the Know' sessions were held on 13 April, with 80 people managers in attendance.
- The April/May edition of Nova magazine was published, highlights include: meeting our new HCAs, fighting flu together, tackling COPD with 600 years' experience, an interview with Professor Ed Mitchell and Pride Parade photos.

2.4.3 Events and campaigns

Influenza vaccination

Influenza is serious, highly contagious and largely preventable. Auckland DHB's goal this winter is to vaccinate more than 80% of our workforce, to protect our people and our patients.

We are part way through our annual vaccination and are tracking well. As at 14 May, 67% of Auckland DHB

employees, contractors, students and volunteers have been vaccinated against influenza, at drop-in vaccination clinics or by our in-team and roaming vaccinators.

In 2017, Auckland DHB vaccinated 74% of our workforce, and the national DHB health care worker influenza immunisation coverage rate was 66%. (These numbers exclude staff who are vaccinated elsewhere, e.g. by their personal GP.)

April Falls

Each April we highlight the important work done in preventing falls and fractures, which can have a significant impact on older people. Every year one in three people over 65, and one in two people aged 80 and over, will have a fall. This can lead to broken bones and other injuries, as well as a loss of confidence, social isolation, and for some, depression.

Caption: Staff visiting the April Falls stand pledge their commitment to preventing falls for our patients, listing some of the actions they take to put this into practise.

The theme for April Falls 2018 was Live Stronger for Longer. Our Falls Prevention team held an information stand on 11 April to promote community group strength and balance classes, raise awareness, and share resources for hospital staff.

#endPJparalysis

Launched on 17 April, end PJ paralysis is a 70-day campaign aimed at getting our patients moving as much as possible. Research shows that a week-long stay in hospital for older people can result in a 10% muscle loss, and can lead to a long term lack of confidence and independence. End PJ paralysis asks staff to get involved, get creative and help our patients get up, get dressed and get moving.

Earth Day

Auckland DHB celebrated Earth Day on 20 April, with information stands that showcased the exciting sustainability programmes we have in place to reduce energy and waste to landfill. The theme for this year was End Plastic Pollution. New Zealand has joined the United Nations-led CleanSeas campaign aimed at ridding our oceans of plastic. Plastic pollution has a significant effect on our environment, clogging our waterways, killing and injuring wildlife and endangering our health.

Caption: Some of our Sustainability Network team on Earth Day with our 2020 Healthcare Climate Challenge certificate.

Immunisation Week

Immunisation Week ran from 30 April to 6 May, and was a good opportunity to remind staff to check they and their whānau are up to date with immunisations.

This year's theme was 'immunisation throughout the lifespan'. Many vaccines are free, and being up to date is particularly important in Auckland with on-going outbreaks of mumps and pertussis (whooping cough), both diseases that are preventable through immunisation.

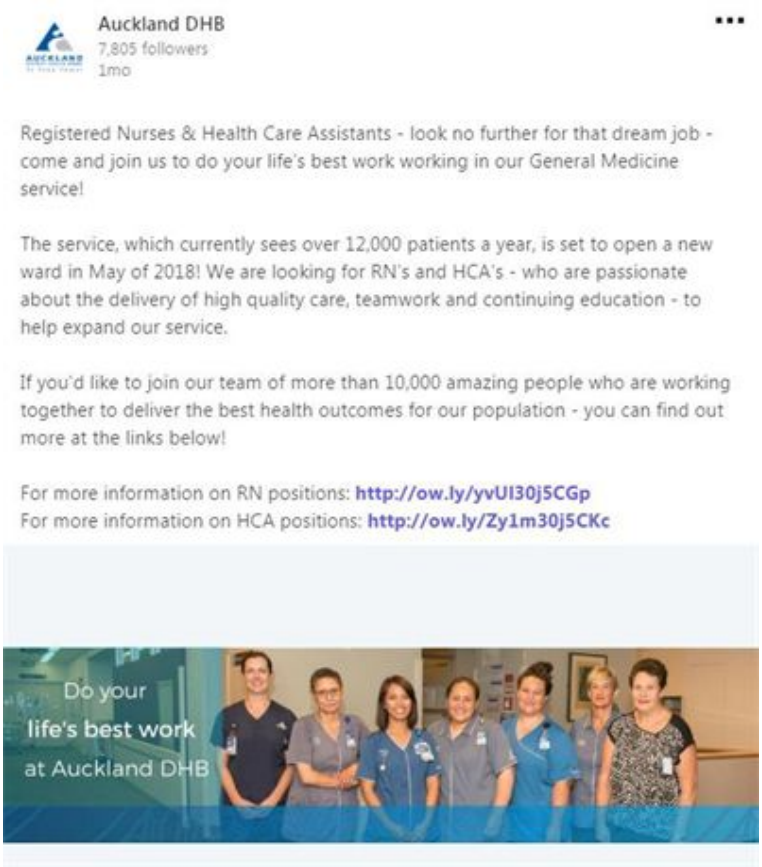
2.4.4 Social Media

Followers

LinkedIn: 7803
Facebook: 6222
Twitter: 3353
Instagram: 379

Top posts and statistics

Nurse and HCA recruitment



Update name	Date	Follows Acquired	Impressions	Clicks	Video views	CTR	Social Actions	Engagement
Registered Nurses & Health Care Assistants -... All followers	3/23/2018	-	6,078	114	-	1.88%	24	2.27%

Cleaning team recruitment

April Falls – Falls prevention

Meet our CSSD team

Update name	Date	Follows Acquired	Impressions	Clicks	Video views	CTR	Social Actions	Engagement
Meet the team - Central Sterile Services... All followers	4/10/2018	-	4,001	65	-	1.62%	33	2.45%

Post content summary

Our People

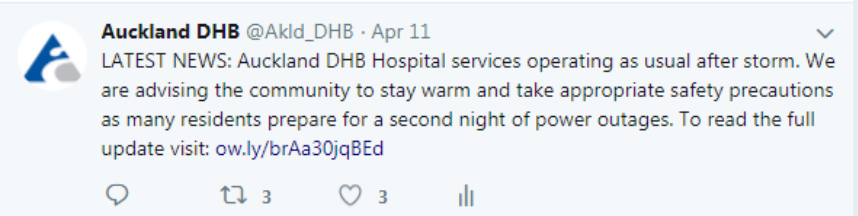
- Meet our CSSD team – World Sterile Sciences Day
- Administrative Professionals Day
- Local heroes
- House Officer of the month
- Starship nurse opens home to colleague in need
- New nurse welcome
- International Day of the Midwife

World-class healthcare

- FMHS 50th Anniversary Lecture: Training New Zealand's health workforce
- Starship heart screening

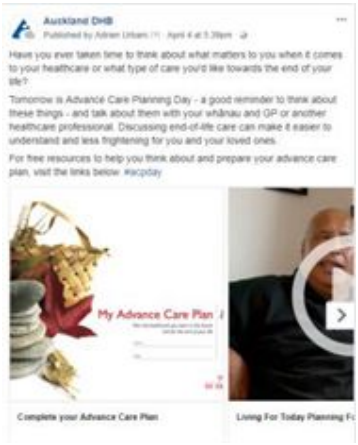
Patient Experience

- Service update following power outages
- New Starship Children's Emergency Department waiting area



Healthy communities

- Advance Care Planning Day
- Fight Flu
- Right Care For You over Easter
- April Falls – Falls prevention – live stronger for longer
- Preventing food: borne illness following power outages
- Immunisation Week
- Pacific travel warning – avoid dengue fever
- Scooter safety checks



Recruitment/organisational news

- Cleaner Recruitment
- Nurse & HCA recruitment
- New registrars welcome
- Celebrating Earth Day & Sustainability at Auckland DHB
- Matāriki Awards
- Anaesthetic Technician recruitment

2.5 Our People

2.5.1 Local Heroes

There were 23 people nominated as local heroes during March, and 9 during April.

Our joint April Local Heroes are Tracey Sadlier and Angie Sexton, Staff Nurses, Level 8 ORs.

The colleague who nominated them said: "I am nominating both Tracey and Angie who are in the same role and should receive this as a combined award. It would be inappropriate to nominate them separately as they both perform exceptionally. These two nurses skilfully mastermind the flow of acute and elective orthopaedic surgery through level 8 so that patients receive the care that they need in a timely manner. Tracey and Angie manage the constant overload of orthopaedic acute patients with ongoing session to session changes in schedules to accommodate both acute and elective cases.

They do this in an exemplary manner remaining calm and focussed on the patients' needs at all times. They also skilfully assist triaging the priority cases. I have often been impressed by the manner in which they have engaged with individual patients as they come through the pre-op area. They have really got to know and truly care about those patients who unfortunately have a number of returns to the OR. They maintain that personal touch in a technical environment which quickly puts the patient at ease.

The whole orthopaedic service respect and value the work that these nurses do firstly for their patients, and also for their colleagues and the departments. They are the unsung heroes, the worker bees; they are the Sunday night TV 'good sorts'."

Caption: Members of the OR team, with Tracey, Angie and Ailsa Claire at the presentation ceremony.

The May Local Hero is currently being chosen.

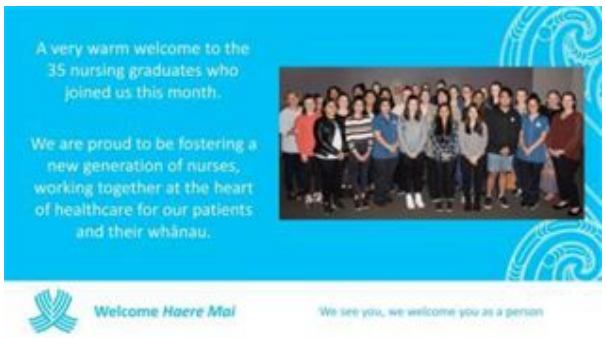
2.5.2 Welcoming our people

New registrars

We welcomed a new group of registrars. For the next few months they will consolidate their positions as valued members of our clinical teams and many will go on to become our future SMOs.

New NETP nurses

We also welcomed 35 new NETP nursing graduates who joined Auckland DHB this month.



2.5.3 Professional Recognition Days

World Sterile Sciences Day – 10 April

This was an opportunity to promote our Central Sterile Supplies Department, who play a critical role 'behind the scenes' in providing safe and effective surgical care for our patients. The work that they do is an important part of infection prevention and control in our hospitals, with the team processing around 5 million surgical instruments a year for sterilisation and decontamination. The team ran an information stand in the level 5 atrium, ACH, and we shared some of their stories across our communications channels.

International Day of the Midwife – 5 May

This year's theme for International Day of the Midwife focussed on quality, equity and leadership – **"Midwives leading the way with quality care"**. We took a moment to acknowledge our amazing midwifery team who work extremely hard to provide quality care for women, babies and their whānau, even during challenging times as our DHB works to bring more midwives into our service.

High quality midwifery care is essential for every mother and baby and provides the foundation for a lifetime of good health and wellbeing. Midwives play a vital role in working in partnership with women to ensure they navigate pregnancy, childbirth and the postnatal period safely.

2.5.4 Our People booklet published

We have recently published *'Celebrating Our People 2017',* the latest edition of our annual booklet, acknowledging and sharing some of the achievements of our people over the past year.

We've provided you with a personal copy at this Board meeting, and you can also find Celebrating Our People on Hippo.

2.5.5 Matāriki Awards

Applications for the first Matāriki Awards are now open. These Awards are aimed at anyone who works within Auckland DHB or provides a service on behalf of Auckland DHB to improve Māori health outcomes through values-based actions. The goal is to celebrate everything our people do to improve whānau experience, eliminate health inequities for Māori or develop the Māori workforce.

3. Performance of the Wider Health System

3.1 National Health Targets Performance Summary – Auckland DHB – March 2018

	Status	Comment
Acute patient flow (ED 6 hr)		Mar 88%, Target 95%
Improved access to elective surgery (YTD)		95% to plan for the year, Target 100%
Faster cancer treatment		Mar 91%, Target 90%
Better help for smokers to quit: • Hospital patients • PHO enrolled patients • Pregnant women registered with DHB-employed midwife or lead maternity	  	Mar 95%, Target 95% Mar Qtr 89%, Target 90% Mar Qtr 98%, Target 90%
Raising healthy kids		Mar 100%, Target 95%
Increased immunisation 8 months		Mar Qtr 94%, Target 95%

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

3.2 National Health Targets – YOY comparison Auckland Region DHBs

Please note the results for 2017/18 are not yet available.

	Auckland Region	2016/17				2017/18			
		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**	**95**	**95**	**95**	**93**				
	Waitemata DHB	97	97	97	97				
	Counties Manukau	96	96	95	92				
	All DHBs	93	94	94	93				
Improved Access to Elective Surgery The volume of elective surgery will be increased by an average of 4000 discharges per year.	**Auckland DHB**	**93**	**97**	**96**	**98**				
	Waitemata DHB	105	106	108	111				
	Counties Manukau	110	108	107	107				
	All DHBs	105	103	104	106				
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**	**79**	**88**	**87**	**81**				
	Waitemata DHB	86	90	92	90				
	Counties Manukau	75	74	76	78				
	All DHBs	78	82	82	81				
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**	**94**	**95**	**94**	**95**				
	Waitemata DHB	94	92	92	92				
	Counties Manukau	94	94	94	94				
	All DHBs	93	93	92	92				
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**	**87**	**88**	**88**	**92**				
	Waitemata DHB	87	88	88	90				
	Counties Manukau	89	89	89	92				
	All DHBs	87	86	86	89				
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**	**79**	**97**	**99**	**100**				
	Waitemata DHB	83	100	100	100				
	Counties Manukau	29	62	91	98				
	All DHBS	**49**	**72**	**86**	**91**				

Source: http://www.health.govt.nz/new-zealand-health-system/health-targets/how-my-dhb-performing

3.3 Financial Performance

The 2017/18 financial plan for a breakeven budget was approved at the 20 September 2017 Board meeting and has been approved by the Minister of Health. The breakeven budget is dependent on achieving savings of $19M and managing risks mainly relating to funding assumptions made (for instance revenue assumptions for Auckland Metro IDF pricing adjustors, national transplants revenue) and managing volume and cost pressures.

Year to date to March 2018, we are tracking unfavourable to the budget by $500k, having achieved a surplus of $9M against a surplus budget of $9.5M. Advice has been received from the Ministry of Health that there will be a wash-up of payment for heart, lung and liver transplant volumes and on this basis the DHB is now forecasting to meet budget at year end.

Distribution of the result across divisions shows the Funder and Governance arms (combined) with a result that was favourable to budget by $8.7M, which partially offset the $9.2M unfavourable result generated by the Provider Arm. The overall result is mostly revenue driven, with revenue below budget by $33.4M, mainly due to provisions for IDF wash-ups for volumes below budget, revenue not yet realised for the metro Auckland IDF price adjustor and additional transplant funding budgeted not yet realised. Unfavourable revenue was substantially offset by expenditure favourable to budget by $32.9M, mainly realised in Personnel/Outsourced staff (driven by FTE vacancies), outsourced services costs and Funder payments to providers.

4. Clinical Governance

4.1 School of Medicine Distinguished Clinical Teachers Awards 2017

In February, the University of Auckland's Faculty of Medical and Health Sciences, acknowledged eight recipients of the School of Medicine Distinguished Clinical Teachers Award for 2017. Among this year's awardees were three Auckland DHB clinical staff: Dr Tim Skinner, consultant anaesthetist; Dr Lynn Sadler, epidemiologist; and Dr Leah Andrews, child and adolescent psychiatrist.

The award acknowledges clinical staff working in the community and hospitals who have made substantial contributions to clinical teaching in the Faculty over many years and who have carried heavier teaching workloads than many of their peers - including assuming leadership positions in clinical teaching, delivery and participating in teaching development or new course establishment.

We congratulate these leaders in clinical teaching.

4.2 Senior Nurses achieve PhDs

Congratulations to Elaine McCall and Jackie Robinson for recently completing their PhDs.

Elaine is a Nurse Consultant and Leader, Safe Care Programme in Starship Child Health, and has been awarded a Doctor of Nursing (DN) from the University of Technology, Sydney. The title of her thesis is "Mayhem to Mindful: Improving Medication Administration Safety through Action Research."

Jackie is a Nurse Practitioner, Palliative Care and Service Clinical Lead, Adult Palliative Care, and has been awarded a PhD from the University of Auckland. The title of her thesis is "To explore the benefits and burdens of hospitalisation for people with palliative care needs and how these experiences influence a preference to return to hospital."

4.3 Director of Pre-Vocational Training

Dr Chris Lewis has been appointed to the role of Director, Pre-Vocational Training. He will transition to the role from 18 June 2018.

Chris is well known and respected at Auckland DHB where he has held the position of Consultant Respiratory Physician since October 2006. He has been a MCNZ pre-vocational educational supervisor since 2011. He also supervises RACP advanced trainees. Chris will bring his skills as a teacher and considerable experience in supporting pre-vocational trainees in their first year at Auckland DHB, to this reconfigured role.

Health and Safety Performance Report

Recommendation

That the Board:

1. **Receives the Health and Safety Performance report for April 2018.**
2. **Endorses reporting of progress.**
3. **Identifies any further format or reporting changes required to the performance report.**

Endorsed By: Sue Waters (Chief Health Professions Officer)

Glossary

BBFA	Blood and/or Body Fluid Accident
EY	Ernst and Young Limited
HSR	Health and Safety Representative
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
PCBU	Person Conducting a Business or Undertaking
PES	Pre-employment Health Screening
SMS	Safety Management System
SPEC	Safe Practice Effective Communication (SPEC)
SPIC	Safe Practice in the Community
YTD	Year to date
A/A	As Above

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 contains charts using data for the period up to the end of April 2018, the most recent month for which all data is available.

There were no Notifiable Events in March. Worksafe was notified of a non-work related incident on 12th April 2018 when an employee (residing in building 13) slipped on the stairwell on 10th April 2018. The injured staff member was taken to the hospital immediately (ankle injury). WorkSafe NZ has confirmed that they are not taking any further action and have closed the case.

Pre-Employment Screening rate was 99% for the month of March. The report is unavailable for the month of April.

There were 43 BBFA incidents in April; 28 of which were reported on SMS. All missing reports are being followed up by the Occupational Health Nurses.

There have been 14 Lost Time Injury Claims, against a target of 10 (Lagging Indicators Scorecard), with the frequency rate (events per million hours worked) of 14. The severity rate remains low, at 0.36. Note that claim figures include all work related injury claims lodged against Auckland DHB whether they were accepted, declined or are still pending a decision. This figure can vary slightly from month to month due to re-opening of historical claims to process late payment. This can also occur due to late claim reporting.

Health and Safety Representative (HSR) Training, is at 79% completed, against a target of 80%. This includes both the transitional training provided by WorkSafe and the two day training sourced from E.M.A. Currently there are 28 HSR roles vacant. In March 2018, 78% of HSRs had completed the training. In comparison there has been an increase of 1% of HSRs trained. Further to the E.M.A. Training, the NZQA Unit Standard (29315) which is an online assessment needs to be completed by HSRs.

All charts in this report include data from the Safety Management System (SMS - Datix). SMS reporting includes all workers, as required by the Health and Safety at Work Act. Changes to the configuration of the new Safety Management System have been made to enable the generation of reports, with effect from January 2018, on the progress of Health and Safety Incident Investigations. Number of Health and Safety Incidents investigated for the month of March (one month lag) is 24%. Quality Team is working with the Health and Safety Directorate Committee Chairs. A dashboard (at the Directorate Level) and Quick Cards will be developed to improve the compliance process.

At the end of each month, hiring managers and the Chairs of the Health and Safety Directorate Committees are sent reminder emails from Health and Safety Team identifying those that have not completed the Local Induction. A PowerPoint presentation has been extremely efficient in ensuring a high compliance rate (100%) in Perioperative Directorate. This has been circulated across other Directorates. The compliance process for the local inductions was mentioned in the Health and Safety Directions (newsletter that is circulated to HSRs and managers). A link has been placed on the Health and Safety webpage to simplify the reporting process. For the YTD (till April'18) there was a compliance rate of 81%. The **highest** it has been in over **12 months**.

6 Monthly Checklist Completions occurs in February and August of each year. Currently 47% of the checklists have been completed. Health and Safety Directorate Committee Chairs are sent reminder emails from Health and Safety identifying areas that have not completed the checklists. Perioperative Directorate has achieved 100% compliance rate.

This month 73% of new starters (excluding Registrars, House Officers and Locums) have completed the Health and Safety E-Learning training for the YTD (April). The compliance rate has gone down by 1% since the last report (74%).

Top three incident types that cause harm (Occurrences and Claims):

- Patient Handling: 6 incidents
- Slips/ Trips/ Falls: 7 incidents
- Workplace Violence and Aggression: 1 incident

Patient Handling Training was completed by 273 workers in April and refresher training was completed by 95 workers. There were 49 workshops in April. Whereas in March, Patient Handling Training was completed by 196 workers over 20 sessions. There has been an increase in the number of workshops in April, where staff members learn the physical skills needed for effective patient handling.

Workplace Violence and Aggression Prevention
Work underway to improve workplace violence prevention and responses with the clinical teams in Adults Emergency Department. An Advisor who will support the work of the Workplace Violence and Aggression Steering Committee has been hired and commenced in the month of May. Work has begun on the trial of the Management of Actual or Potential Aggression (MAPA) training customised for health and ADHB, as a replacement for the current Code Orange De-escalation and Restraint Training.

Hazardous Substances Regulations Review
In late November Regional Internal Audit engaged Deloitte to conduct an independent review to assist in identifying how Auckland DHB hazardous substances management programme will meet the requirements of the Health and Safety at Work (Hazardous Substances) Regulations taking effect from 1 December 2017, and identify any gaps that need to be addressed. A Draft Project Plan has been attached in the Health and Safety Updates, Section 10.

ACC Accredited Employer Partnership Programme Audit
Auckland DHB has maintained its Tertiary level rating in the ACC Accredited Employer Programme Audit. A new certificate has been issued for the period April 2018-March 2019 following the successful reaccreditation for the ACC Accredited Employers Programme. This audit took place on 6th November 2017. The next audit which is a full audit is planned for the 20th-23rd November 2018. The Project Plan is being completed and we will start with the Self-Assessment Process commencing mid-May.

Facilities and Development update: Section 11 of this report provides an overview of recent health and safety initiates within Facilities and Development Department. The report also includes graphs showing Health and Safety induction, incident reporting, safety inspections and meetings for the period.

Health and Safety Performance Report – April 2018

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3. Purpose of Report

This report is intended to provide information to the Board relating to the health and safety performance at Auckland District Health Board. Each Directorate receives a similar, focused report, containing data related to that part of the organisation. These are included in Section 12.

4. Health and Safety Scorecard for April 2018

The Leading and Lagging indicators in the scorecards are indicative of Health and Safety performance across the organisation using trends and traffic light indicators. This helps to highlight the areas where we are progressing towards our target and the ones where further improvement may be needed.

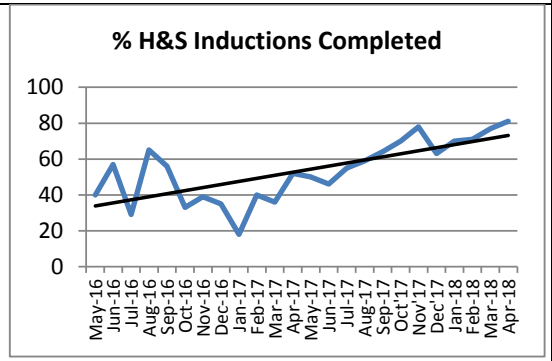
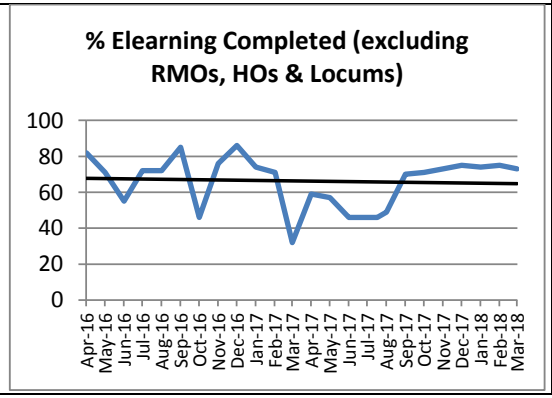
Lagging Indicators

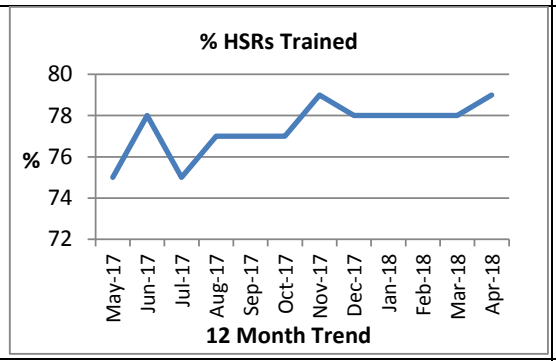
	Actual	Target	Trend
Lost Time Injury Frequency Rate	14	8	
Number of Injury Claims	29	35	
Lost Time Injury Severity Rate	0.36	2	
Lost Time Injury	14	10	
Cost of Injury Claims (000's)	52	80	
Excess Annual leave: % of workers with excess annual leave	9.89	6	
Number of Reported H&S Incidents			
Staff	202	200	
Contractors	2	50	
Students	RU	10	
Volunteers	RU	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			
Patient Handling	6	0	
Physical Environment (Slip/Trips/Falls)	7	0	
Workplace Violence and Aggression	1	0	
Lone/Off site worker safety; total recorded incidents and severity	RU	0	
Lone/Off site worker safety; total recorded claims	RU	0	

Leading Indicators

	Actual	Target	Trend
% Pre-employment screening before start date	RU	100	
% Significant Hazard Registers current	RU	80	
% completed hazard remediation	RU	80	
Management of Residual Risk action plans	RU	80	
% local H&S Induction completed (YTD)	81	100	
% Health & Safety e-learning completed (YTD - Excluding RMOs & HOs- one month lag)	73	100	
Number of H&S Representative Vacancies	28	25	
% H&S Representatives Trained	79	80	
% of reported H&S Incidents investigated- 14 days (one month lag)	24	80	
# of outstanding H&S Incident investigations	111	10	
Number of contractor audits completed	43	10	
Level of compliance contractor audits	100	90	
# of Hazardous Substance audits conducted	13	10	
% Hazardous Substance audits compliant	85	80	
Safety Secuity Audits conducted	RU	0	
% training completed in high risk WV areas	80	95	
Health and Wellbeing Programmes: new and underway	RU	0	
Number of staff Seasonal Influenza Vaccinations (YTD) 2018	5977	7923	
Contact Tracing (events)	9	N/A	
Number of Staff Assessed (For Contact Trace)	48	N/A	

5. Commentary on Health and Safety indicators exceptions

Indicator	Issue		Action
Local Health and Safety Inductions	Local Health and Safety Inductions are to be carried out within 7 days of the employee commencing work at Auckland DHB. Health and Safety Department is to be notified when this has been completed, using the link on its webpage.		Managers are responsible for the new starters' local inductions. The compliance process for the local inductions was mentioned in the Health and Safety Directions (newsletter that is circulated to HSRs and managers). A link has been placed on the Health and Safety webpage to simplify the reporting process. For the YTD (till April'18) there was a compliance rate of 81%. **The highest it has been in over 12 months.**
On-Line Health and Safety training (Ko Awatea LEARN) for all New Staff EXCEPT HO and RMO (see below for HO andRMO Stats)	All new workers should complete this assessment within one month of commencing work at Auckland DHB. Completion is reported directly by Ko Awatea.		Approximately 73% of new starters (excluding Registrars, House Officers and Locums) have completed the E-Learning training for the YTD (till April'18, one month lag).

Indicator	Issue		Action
Health and Safety Rep training	Training for new Health and Safety Rep is provided by EMA which includes the mandatory NZQA unit standard.		177 Health and Safety Representatives have attended the 2 day training provided by E.M.A., as of 30 April'18. However, we do not have the total numbers of the HSRs who have successfully completed the Unit Standard (passed the online assessment). Also 94 current HSRs have completed Transitional Training making it a total of 341 = 79%
Number of Health and Safety incidents investigated within 30 days.			Number of Health and Safety Incidents investigated for the month of April (one month lag) is 24%.
Percentage of training completed in high risk workplace violence areas	Workplace violence and aggression training is needed to manage the identified risks in these areas.	No data currently available.	The Workplace Violence and Aggression Steering Committee has identified that a multi-stream approach is needed to meet the needs of the various directorates and at varying levels within each directorate.
Hazard Registers are Current	No centralised system in place for the hazard registers (some directorates are using a paper or spreadsheet based system).		The Hazard Registers will be mapped to the new Safety Management System. This is a large piece of work and the Health and Safety Team is currently working with the Quality Team to achieve this.

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. There are eight risks on the table. One residual risk remains high, and seven are amber. No new risks have been added for this report. Update was provided by Heather Townend, Programme Manager and John Casey, Health and Safety, Risk and Compliance Manager, Facilities and Development (Auckland DHB).

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
Site Security 483RR	Access Control System and CCTV system experience on-going outage which occurs on a daily basis due to the age of both systems and lack of a preventative maintenance program over the past few years. Upgrade the maintenance protocols to reduce the down-time is required. Commercial Services now have operational control over both Access control and CCTV systems and are currently in the process of upgrading the access control system to a newer platform. The CCTV system is also being replaced by a new IP and VMS based CCTV system. Fortlock security systems have been selected as the preferred Contractor to carry out all works on the systems upgrade and to carry out future R+M work on all security systems.	A business case for an upgrade to the Access control and CCTV at both sites was accepted by the Board in December 2014. Steering group formed to oversee the management of this risk. Independent Consultant has reviewed plans and advised re the implementation model. There is an identified asbestos issue throughout Grafton and Greenlane sites but this is being carefully worked through by Facilities Management and close liaison with Commercial Services is underway in order to determine a safe pathway to accommodate the security systems upgrade.	The Honeywell replacement at Grafton site is now complete and scheduled for completion at Greenlane by end June 2018. This risk is lowering as more areas are cutover to the new Gallagher system; Access Control system is 89% and CCTV system upgrade is 49% completed. (Reported by Heather Townend for April 2018).
Original Risk			Residual Risk (2x2) 4

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
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 upon and training is ongoing. Discussion with a potential supplier for training for physical health area is underway and will be reported next month.	Remains a medium risk while incidents are occurring. However work is being done to close any gaps in security and safety in the community. We are not sure if all accidents/near misses are reported.
Original Risk			Residual Risk (4x3) 12
Auckland City Hospital Atrium Walkway barriers 563RR	The glass barriers on some of the levels of the Auckland City Hospital atrium walkway are lower than others. The lower barriers allow for people to climb over 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.	Approval for part of the project was obtained in June 2016. Handrails have been removed to prevent climbing points.	Facilities will monitor the area to see how effective these controls are. On-going monitoring indicates that the controls are effective as long as bins or chairs are not put against the balustrades. A request will be made to the Communications Team to communicate this to staff. Facilities have had the tri bins and seating in the atrium fixed so that it cannot be moved easily.
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	This project is complete. Currently the risk is eliminated due to the extended height of the new glass balustrades.

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
		solution is not possible. New balustrades are required and being quoted.	
Original Risk			Residual Risk
Slips, Trips and Falls (related to hazards in grounds and buildings.) 478RR	Making up almost 25% of our incidents, slips, trips and falls, continue to be one of the most significant hazards as they are with any other industry worldwide.	Continue to report trends and liaise regularly with Facilities when repairs are required. Liaise regularly with the cleaning service to ensure that best practice wet floor risk management is a continual focus. A Pedestrian Safety committee was established in late 2016 and meets monthly to drive priorities based on risk. July 2017 A review of the built in rubber matting in the entrances to some of the buildings is currently being undertaken by Facilities as water due to the inclement weather is being tracked into our buildings. A poster has also been developed and disseminated to the HSR's IN AN EFFORT to assist staff to take appropriate action in the event the flooring get wet	Risk remains at a medium level because of the unpredictable nature of this incident type. Posters have been designed to raise the awareness on what to do when a spill or leak occurs. These posters have been disseminated via the HSR's and managers asking them to put them on their Health and Safety notice boards or in prominent areas. Special matting has also been installed at the entrance to SSH (L2) and on the A08 L6 over bridge. This matting is designed to absorb water and therefore stop water being tracked into the building potentially creating a slip hazard. Further investigation into a cluster of slips, trips and fall incidents at GCC G04 by Jamaica Blue is also underway to see if the area can be further improved. Facilities engaged Vivian Naylor CCS Disability Action to help assess the area. The contrast in lighting levels and glare through the glass windows in conjunction with the different flooring surfaces, colours and surfaces were seen as potential issues in the area. A trial of a new LED lamp has been undertaken, the

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
			new lighting is brighter and provides a wider angle of light and has helped to reduce the contrast and even out the lighting. Additional lighting will be installed along the G04 to G08 corridor.
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 stairs,
		  ○ x1 at bottom end of A08 on exit road to Domain
			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. Speed bumps and additional signage have been put in place.
			
			The speed bumps are helping reduce the speed of vehicles on site. The Board have undertaken an engagement visit with Facilities during July 2017 to view this initiative.
			
			The pedestrian crossings (weather permitting) from car park A to A01, level 5 will be repainted using a non-slip coating.

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

		• 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
			When the hoardings by SSH are removed Facilities will re-paint the pedestrian crossings.

		The Junction at Carpark B and road down to Clinical records, building A21 has also been identified as requiring further review due to trucks needing to enter the A21 Carpark on the wrong side of the road.	This is still being reviewed and options being sought to improve the safety of this area.
		<u>Greenlane Clinical Centre Greenlane</u> • Building G04 main entrance	

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
		○ Upgrade current width 50mm 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 is a comprehensive on-going data base that is being actively managed. Contractor compliance with asbestos hazard management is being actively managed and any issues are being addressed on a case by case basis.	Collaboration with Waitemata and Counties DHB's is underway in relation to the asbestos meetings, the 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	WDHB have adopted the Auckland DHB on-line Contractor Management and Asbestos Register database. Representatives from CMDHB and WDHB are invited to the Auckland DHB asbestos management meeting. Asbestos in building is safe if in good condition and if not disturbed. The risk remains moderate due to the

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
		the Asbestos Management Plan has been reviewed by Health and Safety specialists at Meredith Connell. Recommended changes have been made and approved by SLT. Asbestos in the Workplace presentations (LearnHR) are being undertaken at GCC and ACH for staff. Further information sessions will be arranged to give staff on-going opportunity to understand more about asbestos and how pro-active Auckland DHB are at managing it.	extent of asbestos in our buildings and the requirement to undertake planned and unplanned work on the structure of the buildings. Especially Building Warrant of Fitness compliance work or emergency works The Asbestos Management Plan and Policy is due to be tabled at the next Board meeting for approval. RIA has an audit planned regarding the adequacy of the ADHB Asbestos Plan.
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. SSH lifts 21, 22 and 23 have been replaced. Enabling work has started on the main bank of service lifts in A01 behind the kitchen. The access hatch on level 15	The risk is reduced to moderate as the review of all lifts is now completed and remedial work is underway. All three of the new lifts are in service at SSH; work is still to be completed on the priority call system. The SSH link lift will no longer be used for patients (an alternate route is in place). Facilities have identified that 80% of lift break downs can be attributed to the lift doors being knocked or bumped. When this happens the lift will fail to safety and stop operating until it is reset by a lift engineer. An article in e Nova on this problem has been published it is the start of a campaign to educate staff on the importance of looking after our lifts and

Risk	Current status/Issues	Action	Residual Risk (consequence x likelihood)
			to help reduce the number of breakdowns.
Original Risk			Residual Risk (4x3) 12

7. WorkSafe NZ Notifications – no change from last report

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.
There were no Notifiable Events in April 2018.

8. Worker-Reported Incidents

Directorate Abbreviations for Chart 2:

AMS: Adult Medical Services Directorate
CandB: 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
PMS: Patient Management Services
POS: Perioperative Services Directorate
SS: Surgical Services Directorate
WH: Women's Health Services Directorate

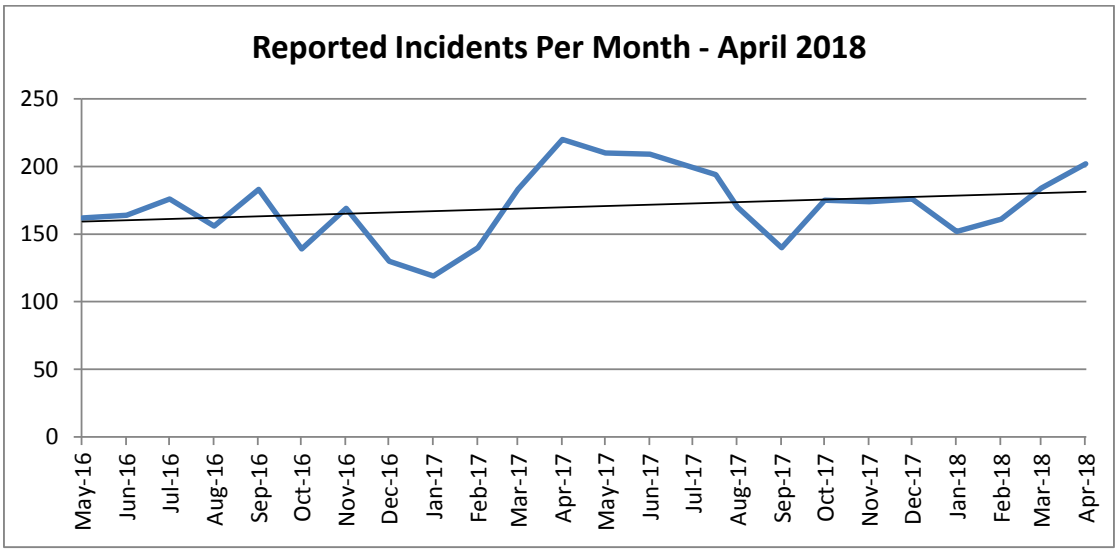


Chart 1 Total incidents reported by staff per month to April 2018.

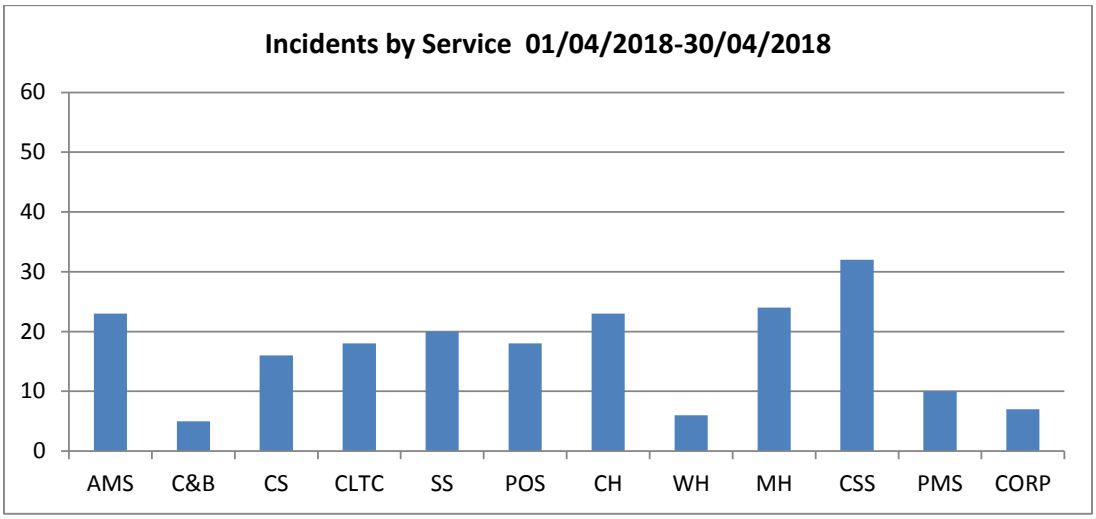


Chart 2 Incidents by Directorate: April 2018

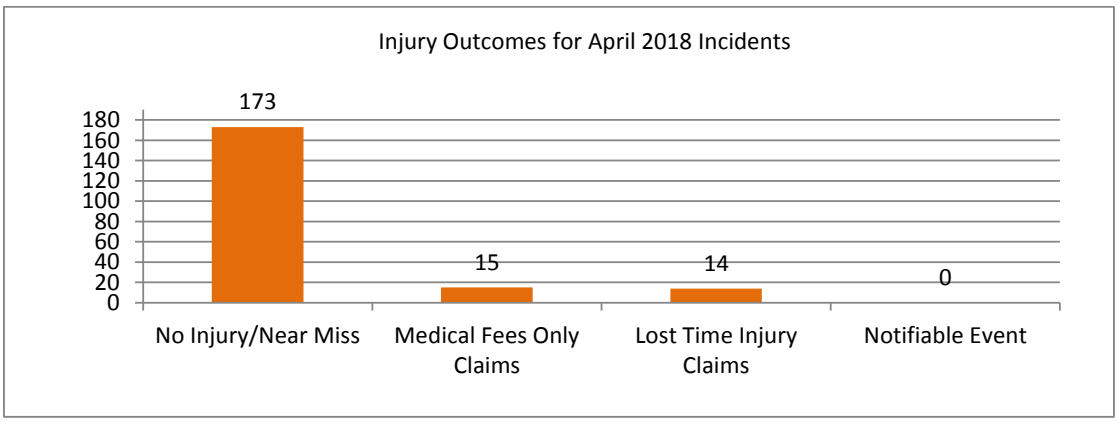


Chart 3 Incidents by Injury outcomes April 2018.

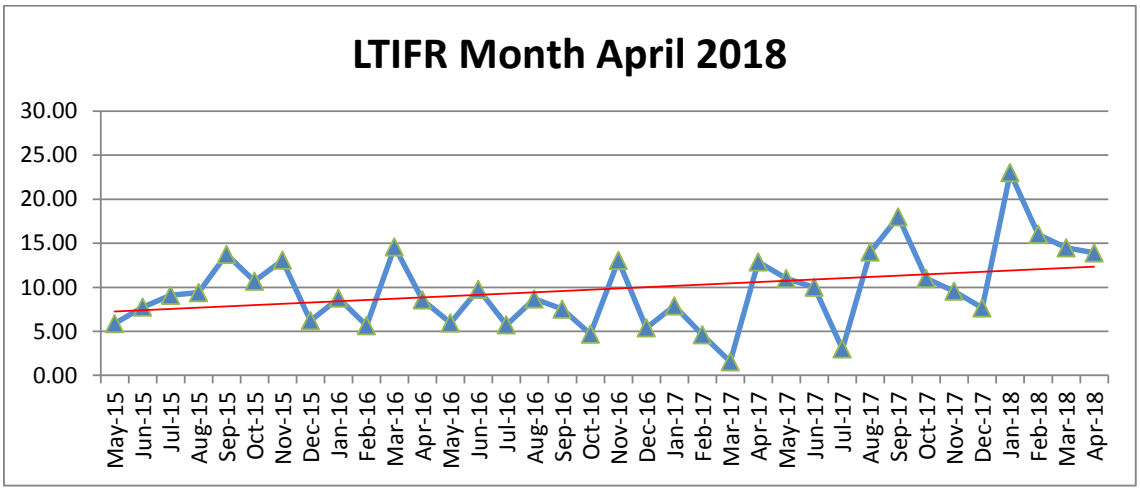


Chart 4 Lost Time Injury Frequency Rate by Month (May 2015 – April 2018)

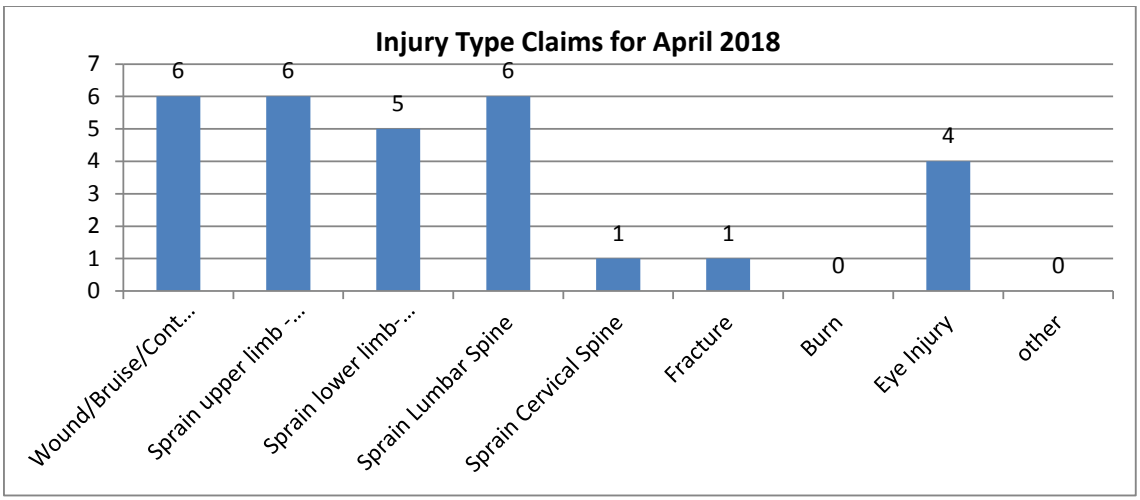


Chart 5 Claims by Injury type for April 2018

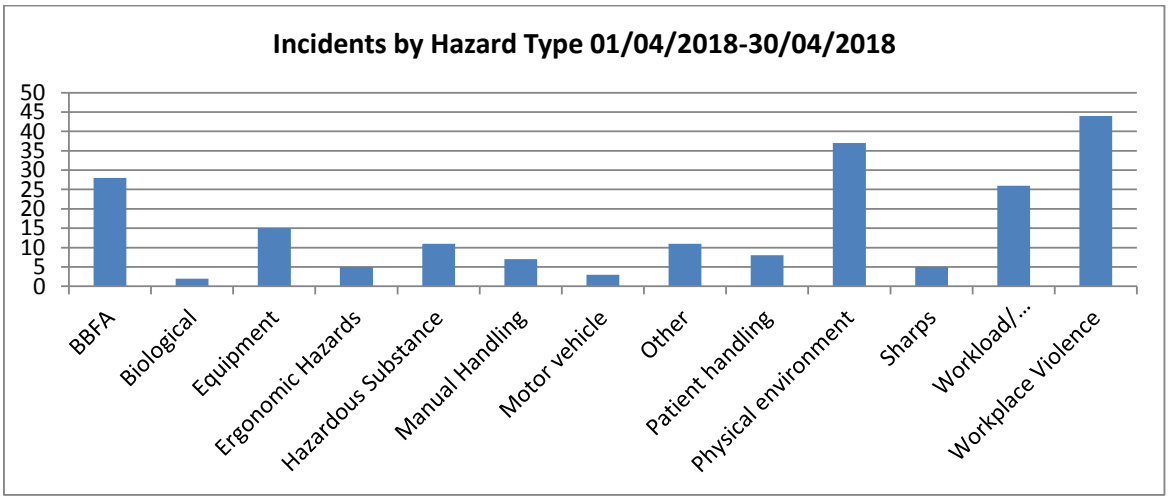


Chart 6 Incidents (Ocurrences) By Hazard Type April 2018 (202)

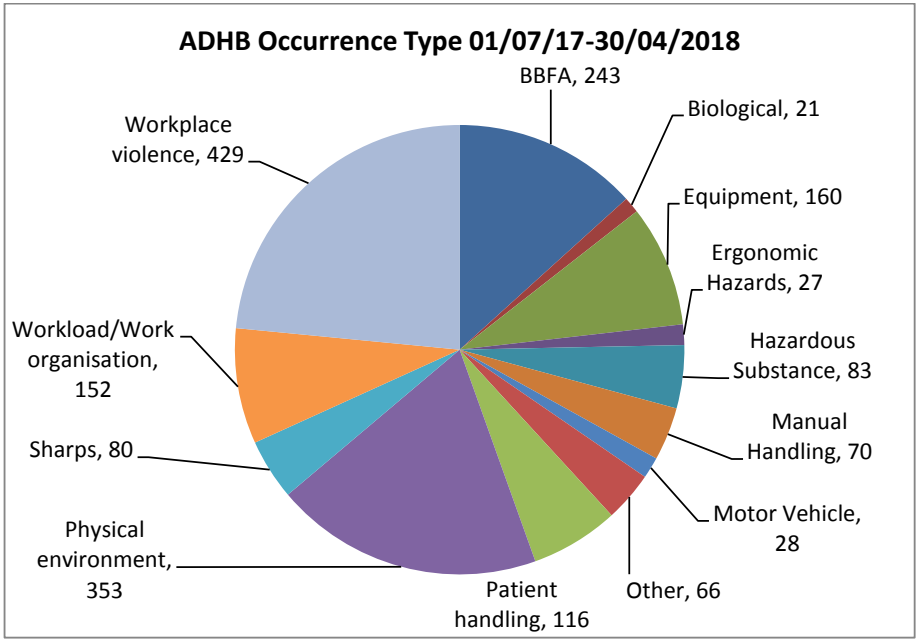
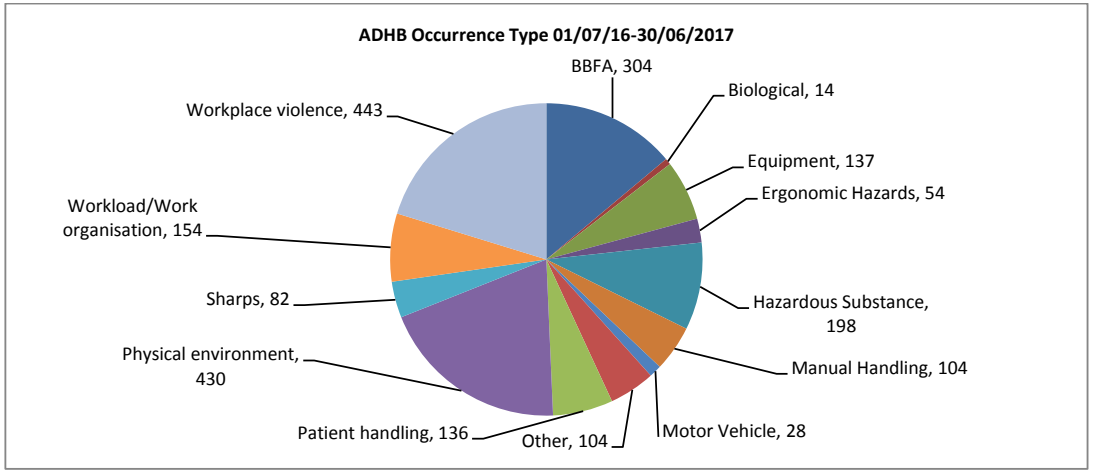


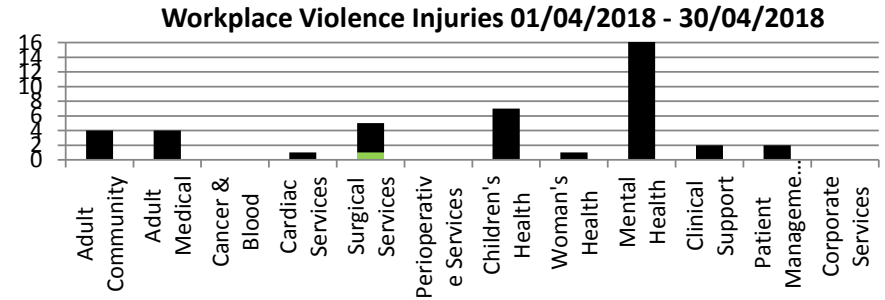
Chart 7 – Fiscal Year to Date - Occurrences by Hazard type (YTD for 17/18 fiscal year from SMS). Also YTD from last fiscal year for comparison (below)



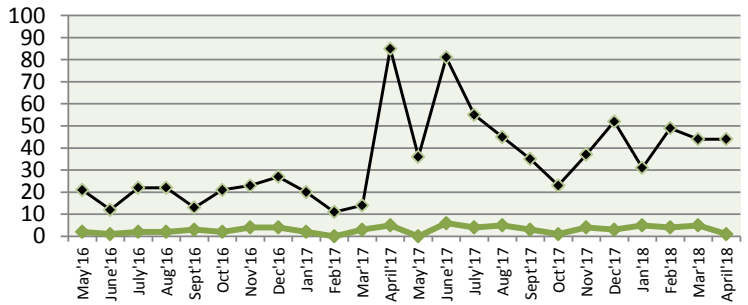
4. Top Three Incident Types Which Caused Harm (Occurrences and Claims)

CLAIMS OCCURANCES

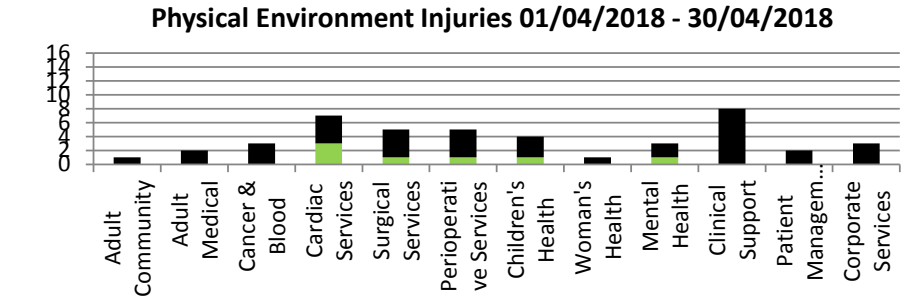
WORKPLACE VIOLENCE AND AGGRESSION:



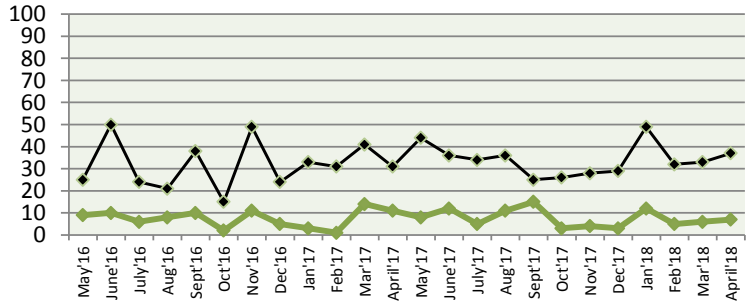
2 Year Rolling



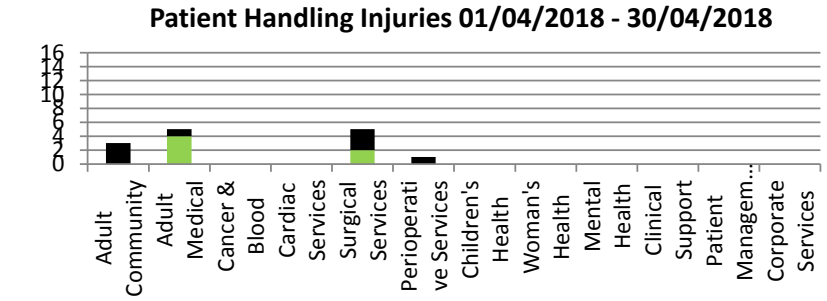
PHYSICAL ENVIRONMENT:



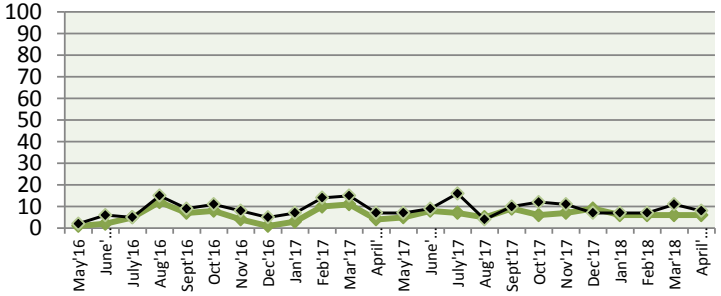
2 Year Rolling



PATIENT HANDLING:



2 Year Rolling



10. Health and Safety Activities

ACC Accredited Employer Partnership Programme Audit

A new certificate has been issued for the period April 2018-March 2019 following the successful reaccreditation for the ACC Accredited Employers Programme. This audit took place on 6th November 2017. The next audit which is a full audit will be held from the 20th-23rd November 2018. The Project Plan is being completed and will start with the Self-Assessment Process commencing mid-May.

Ernst and Young Follow-Up Health and Safety Review

Ernst and Young (EY) were engaged by Auckland and Waitemata DHBs to identify gaps in the current Health and Safety policy and practice. The Health and Safety at Work Act (2015) was sufficiently different to the Bill to warrant a further audit. This was identified in the EY report and a follow-up audit was conducted in June/ July 2017.

Key Findings:

- Locations of community workers not always adequately accounted for.
- Risk assessment process for community workers required improvement.
- Training matrices and records are not readily available and delivery methods require improvement.
- Improvements required to report near misses and hazards
- Transfer of knowledge between Directorates and areas could be improved.
- Quality of key H&S risk information provided to the Board requires improvement.
- Maintenance and CAPEX prioritisation requires more clarity

EY Recommendations and action update; High Risks (Orange), Moderate (Blue) and Improvement Idea (Black)

Risk area	EY Recommendations	ADHB Actions	Status
High			
Locations of community workers not always adequately accounted for.	ADHB to address this risk as high priority	Random checks/audits of areas would provide assurance that procedures to account for community workers were being followed. Lone Worker Pilot completed. Recommendations to Security for Safety Programme	Work in progress
Moderate			

Training matrices and records are not readily available and delivery methods require improvement	Ensure de-escalation training is available according to a schedule that accommodates workers' performance of responsibilities to clients in the community.	De-escalation Training is being finalized Workplace Violence and Aggression Adviser has been appointed. CALM Communication Training has been rolled out (mandatory for all staff). MAPA training underway for high risk areas	Work in progress
Improvements required to report near misses and hazards	Implement additional worker training to educate workers about situations, including near misses that may give rise to a harmful or damaging incident, as well as how to report those incidents	Improved awareness at every Health and Safety Directorate meeting. Health and Safety Directions (circulated to all HSRs and managers) highlights the importance of near miss reporting. Additional training has been provided on how to reports incidents on SMS (Datix).	Work in progress
Risk assessment process for community workers required improvement.	The draft Auckland DHB Lone and Community Worker policy should be revised to state that a risk assessment must, except in well-defined low risk circumstances, be performed for each	Being reviewed	Work in progress

	and every client a community worker visits.		
Transfer of knowledge between Directorates and areas could be improved.	Provide a platform where workers and area managers, such as charge nurses, can share H&S management information with each other.	All HSRs and managers have full access to the resources database where they get a list of all HSRs across ADHB. They can visit an area besides theirs, review its management of H&S, and share learnings. Monthly updates from all Directorates and successful approaches shared at Directorate and Organisation level H&S Committees	Work in progress
Quality of key H&S risk information provided to the Board requires improvement	Review and update risk reporting to the Board to better align reporting to Auckland DHB's material H&S risks	Being reviewed	Work in progress
Improvement Idea			
Maintenance and CAPEX prioritisation requires more clarity		Being reviewed	Work in progress

Hazardous Substances Regulations Review

In late November Regional Internal Audit engaged Deloitte to conduct an independent review to assist in identifying how Auckland DHB hazardous substances management programme will meet
the requirements of the Health and Safety at Work (Hazardous Substances) Regulations taking effect from 1 December 2017, and identify any gaps that need to be addressed.

A representative cross-section of 14 departments across Auckland City Hospital and Greenlane Clinical Centre were included in the review with four issues being identified as mentioned below:

- Hazardous substance inventories are not up to date and have missing information.
- Insufficient evidence of appropriately trained workers handling hazardous substances.
- Worksafe NZ has not been made aware of Sodium Fluoroacetate being held and in use on an

ADHB site.

- Missing and expired Safety Data Sheets, missing labels and incorrect signage.

A Draft Project Plan has been attached below:

PROJECT DETAILS			
Project title	Hazardous Substance Management		
Project Sponsor	Sue Waters		
Project Team Members	Nick Englemann		
Plan Compiled By	Sophia Tennyson		
Date	20/02/2018	**Version No.**	1

MAJOR MILESTONES		
Milestones	**When**	**Who**
Set up an Approved Handler Course and offer training to areas where an Approved Handler is required	24/04/2019	Sophia Tennyson
Update inventory of chemicals used within ADHB	24/10/2018	Sophia Tennyson and Occupational Hygienist Advisor
Review ADHB's requirements and processes for ensuring safety data sheets remain current.	Ongoing	Ongoing H&S Advisors with Directorate H&S leads

No	Task	When	Who
1	**Update inventory of chemicals used within ADHB**	24/04/2019 Underway	Sophia Tennyson and Occupational Hygienist Advisor
1.1	Identify and list buildings, areas and the managers responsible		a/a
1.2	Send out inventory forms with generic email giving instructions.		a/a
1.3	Review the process for monitoring and updating hazardous substance inventories		a/a
2	**Set up an Approved handler course and offer training to area where an approved handler is required**	24/04/2019 Underway	Sophia Tennyson
2.1	Identify areas that need approved handlers		a/a
2.2	Arrange for onsite training to occur		a/a
2.3	Arrange a training venue and date		a/a
2.4	Communicate with managers		a/a
2.5	Train the Trainer module		a/a
2.6	Identify processes required		a/a
2.7	Identify roles and responsibilities		a/a
2.8	Create information documentation		a/a
2.9	Train those responsible (initial training)		a/a
2.10	Consider centralised training matrix		a/a
3	**Notify Worksafe NZ that Sodium Fluoroacetate is being used onsite**	Complete 24/04/2018	Ross Hewett
4	**Safety Data Sheets**	24/10/2018 Underway	Sophia Tennyson and Directorate H&S Leads
4.1	Update master file of Safety data Sheets on Intranet		a/a
4.2	Mini SDS can be supplied from Chemwatch		a/a
4.3	Review the process for monitoring and updating Safety Data Sheets		a/a

Health and Safety Maturity Assessment

Following a recommendation at the February Finance Risk and Assurance Committee meeting, Auckland DHB has been engaging with Regional Internal Audit to complete a Health and Safety Maturity Assessment. Regional Internal Audit has agreed to fund the assessment with the aim of completing it by December 2018.

Health and Safety Audit Schedule

The table below is provisional and includes currently scheduled audits.

July 2017	**August 2017**	**September 2017**	**October 2017**
• Hazardous Substances Audits and inventory review • EY Audit	• Workplace Checklist compliance review	• Annual ACC AEP Self –Assessment	• Annual ACC AEP audit preparation
November 2017	**December 2017**	**January 2018**	**February 2018**
• Annual ACC AEP audit • Regional Internal Audit (Hazardous Substances)	• ACC AEP Audit report action plans developed	• Seasonal Flu Vaccination Report • Hazardous Substances Audit Report	• Workplace Checklist Compliance Review
March 2018	**April 2018**	**May 2018**	**June 2018**
• ACC AEP accreditation expires	• Start Self-Assessment for ACC AEP Audit (held in Nov)	• Annual ACC AEP Self-Assessment • Regional Internal Audit (Helipad) • Regional Internal Audit (Asbestos)	• Regional Internal Audit (Lone Workers) • Regional Internal Audit (Working at Heights)
July 2018	**August 2018**	**September 2018**	**October 2018**
• Hazardous Substances Audits and inventory review	• Workplace Checklist compliance review • Maturity Assessment (Regional Internal Audit)	• Annual ACC AEP Self-Assessment completion • Maturity Assessment (Regional Internal Audit)	• Annual ACC AEP Audit preparation
November 2018	**December 2018**	**January 2019**	**February 2019**
• Annual ACC AEP Audit			

Safe365
Currently in Auckland DHB a paper-based checklists or Excel spreadsheet is being used to monitor the induction process for contractors (all contractors other than Facilities and Development). Health and Safety Team, Facilities and Development, and Commercial Services will be trialling Safe365 to check if it would be able to support Auckland DHB's diverse needs. The trial is in progress and an update will be provided in the next Board Report.

Asbestos
The Asbestos Management Team meets fortnightly. The Asbestos Management Plan and Asbestos Policy documents have been completed and have been reviewed by independent legal experts. The documents are now finalised and awaiting endorsement by the board. A communication strategy is currently being developed by the Asbestos Management Team and will be endorsed by ELT prior to publication.

An educational presentation focusing on staff awareness of asbestos and how Auckland DHB is managing this historical substance has been prepared and presented to staff at various forums including the H.R. Learn sessions. Feedback has been very positive and Facilities and Development will continue to identify further opportunities to present this information to our staff.

Managing Safely
The courses for 2018 have been set up in Kiosk. This has been promoted throughout the Directorate leadership team. 284 managers have completed the Managing Safely course as of April 2018. New sessions have been scheduled for 2018 and this information is being notified to the Managers via the Health and Safety Directions and also individual emails to new managers coming on board.

Board Health and Safety Engagement visits
The Board Health and Safety Engagement visit dates for 2018 have been circulated. Areas to be visited are being shortlisted.

Month	Day	Visit Date	Venue	Time
May	Wednesday	16th May 2018	LabPlus	9am-12 pm
July	Wednesday	18th July 2018	TBC	9am-12 pm
September	Wednesday	19th September 2018	TBC	9am-12 pm
November	Wednesday	28th November 2018	TBC	9am-12 pm

Auckland DHB Health and Safety Committee
The Auckland DHB Health and Safety Committee meets six-weekly, chaired by Sue Waters, and last met on the 18th April. Minutes can be accessed on Hippo.

Safety Management System (Datix):
Health and Safety Team is working with the Quality Team to map the Hazard registers to the new Safety Management System. Health and Safety incident reporting has transitioned to the new system. Training was provided to the Health and Safety Reps (how to report an incident).

Auckland DHB Moving and Handling Steering Committee
The Auckland DHB Moving and Handling Steering Committee is chaired by Brenda McKay and they meet monthly. The Bariatric Bundle trial is now completed and a research paper will be presented to the ELT. Work has commenced on a fall retrieval bundle.

Auckland DHB Violence and Aggression Steering Committee
The Chairperson is Anna Schofield. Work underway to improve workplace violence prevention and responses with the clinical teams in Adults Emergency Department. An Advisor who will support the work of the Workplace Violence and Aggression Steering Committee has been hired and commenced in the month of May. Work has begun on the trial of the Management of Actual or Potential Aggression (MAPA) as a replacement for the current Code Orange De-escalation and Restraint Training. A Rollout Plan for Calm Communications and Security for Safety Training is being followed-up.

Health and Safety at Work Regulations 2016
See Appendix 4 for a detailed work plan with due dates and accountability.

Health and Safety Team
There is currently one vacancy in the Health and Safety Team. 3 new Advisers have commenced. A Health and Safety Manager started on the 14th May.

Seasonal Flu Vaccination Uptake:
The Seasonal Flu Vaccination Campaign completed the 1st Phase (Tuesday 3 April – Friday 13 April). The Second Phase started on 30th April and will continue till the 11th May. There will be drop in clinics, roaming vaccinators and off-site visits at the community centres. Communication is sent out via Enova, Health and Safety Directions and other channels to inform staff members of the times and dates these vaccinators are available.

6 Monthly Checklist Completions:
The HSRs do a 6 Monthly Checklist for their local areas. This occurs every February and August of each year. Currently 47% of the Auckland DHB Directorates have completed the checklists. Perioperative Directorates has achieved 100% compliance rate.

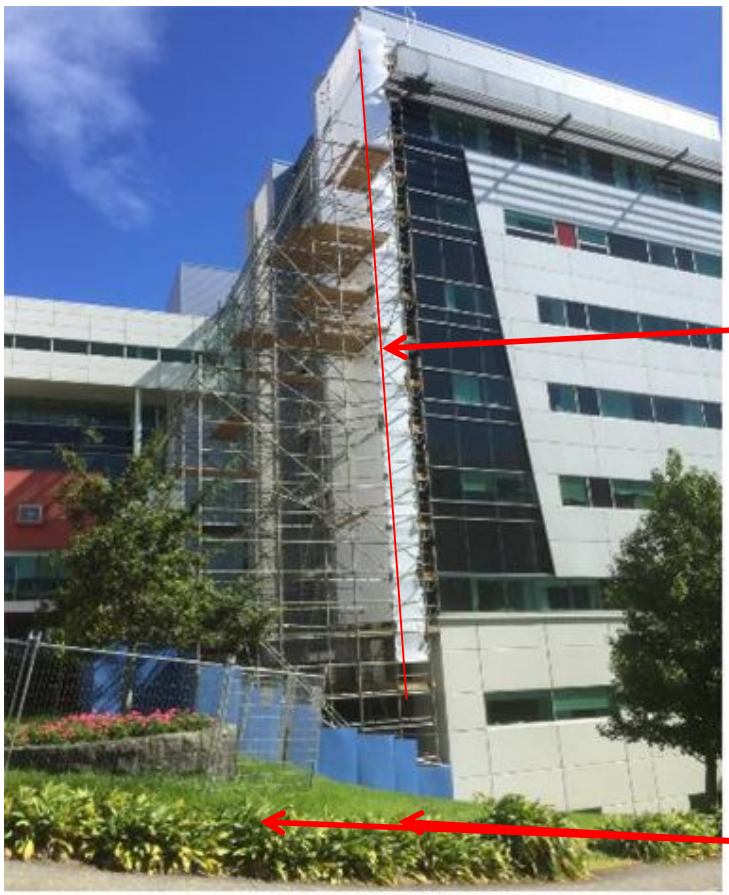
Regional Collaboration:
There are a number of Regional Collaboration activities underway between the three Metro DHBs. Some examples are: Regional Employer Assistance Programme Supplier, Asbestos Management, Hazardous Substances, the Employee Participation Regional Agreement with the Joint Unions, KoAwatea 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.

11. Facilities and Development Health and Safety

Current Initiatives

Facilities & Development are developing a Health and Safety Manual for the Facilities team and its contractors (PCBU's) the bases of the manual follows the present Auckland DHB H&S framework. The Health and Safety Manual will provide the cornerstone of the Facilities Safety Management system and will be a live document that will be amended and improved as part of the Facilities H&S continuous improvement and review program. The manual will outline the key requirements and processes that have already been developed within Facilities to ensure that Health and Safety is effectively implemented and actively managed. The document is predominately designed for use by contractors and Project Managers undertaking maintenance works and projects on the Auckland DHB sites. The manual will help make the H&S requirements and process more transparent and further support how risk is managed within the Facilities and Development activities in accordance with the Health and Safety at Work Act 2015.

The photograph below shows the scaffold that has been erected on the east side of building A32, to allow contractors to gain access to the exterior of the building.



Wrap (white area) provides weather tightness and also a defined 'work safety zone' around the area.

A solid hoarding has been erected around the perimeter of the scaffolding to prevent unauthorized access to the site.

The risk associated with security around the scaffolding has been solid hoarding around the perimeter of the site (blue hoarding and wire fence). The working

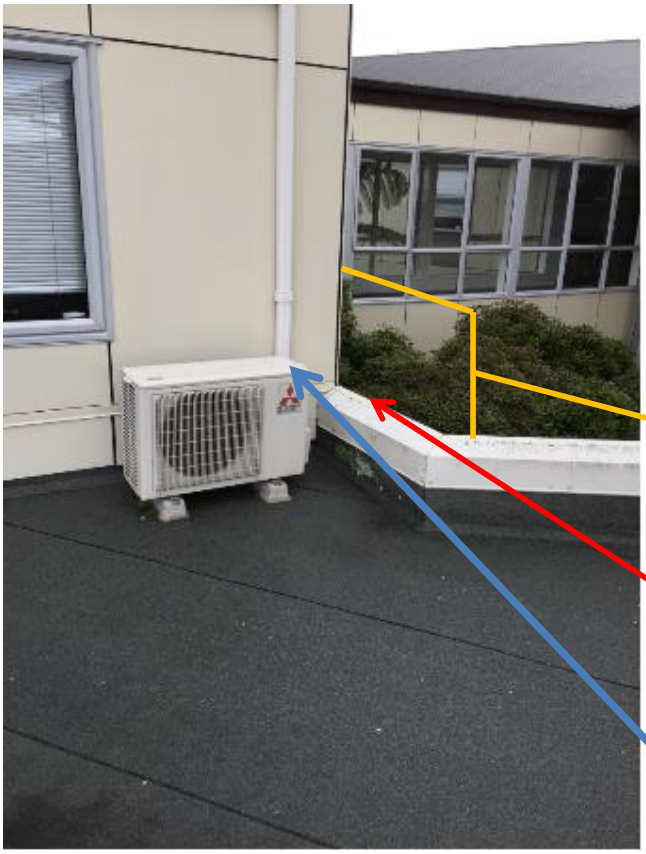
area from the bottom to the top of the building has also been wrapped to provide protection from the weather when the existing exterior panels are removed. This wrap also defines the working area and provides another layer of safety around the site.

A review of the processes used to manage high risk work activity is being undertaken. Facilities are working with PAE to streamline and implement a more standardised 'Permit to Work' process for activities such as Working at heights, Confined Space Entry and Lone Worker's. The Permit to Work process will help ensure that areas where high risk work activity is being undertaken are adequately managed and ADHB have the opportunity to undertake due diligence on the process and to ensure that the risks associated with the work are being managed adequately.

BECA have undertaken a Roof and Heights Safety Review at Auckland hospital. The findings in this report are being actioned based on the risk assessment score and activity. Facilities and are in the process of getting quotes to install fall prevention controls such as edge protection, anchor points or static life lines etc. to provide safe access and/ or recognised fall prevention controls for the contractors undertaking the work.

Currently Facilities have put a ban on any contractor working or walking within 2 meters of a roof edge without physical fall prevention controls in place. Any contractor required to work at height or on a roof top is required to complete a working at height permit; also outline and document the controls that they will take to prevent falls from height when undertaking their work.

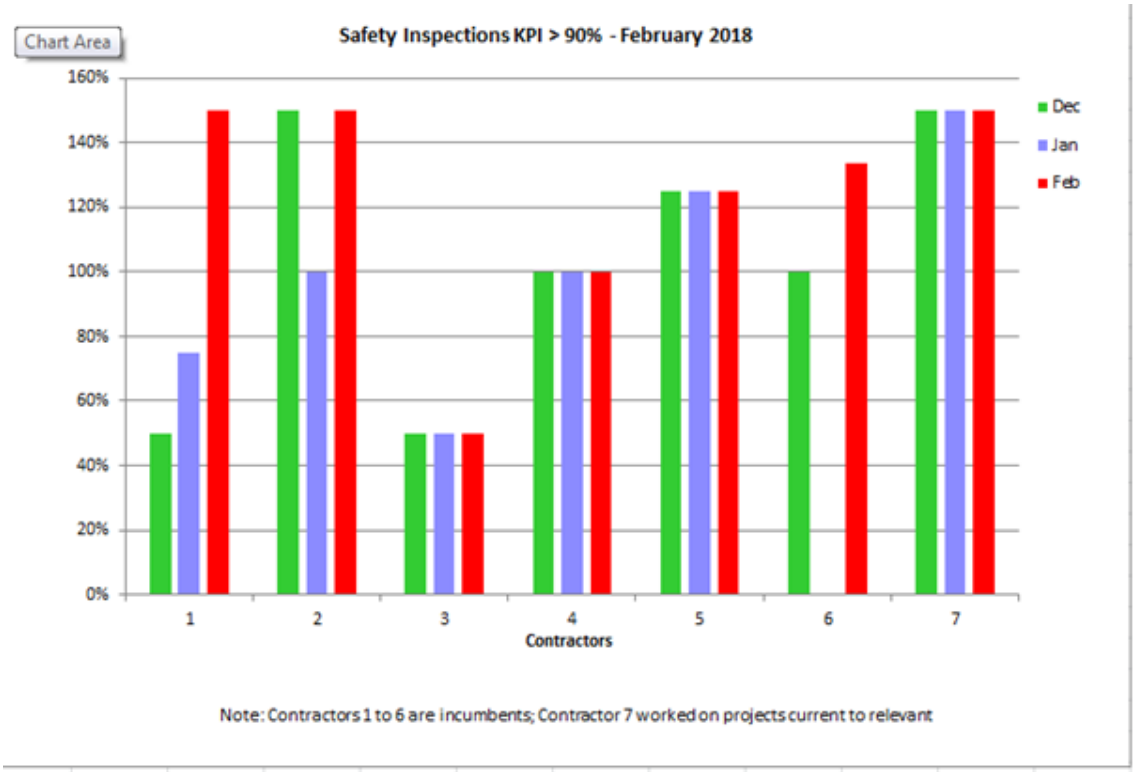
An example of the type of work that is undertaken on the roof tops is illustrated below. The photo shows an example of a heating and ventilation and air conditioning unit (HVAC unit) that is located on the edge of a roof one storey up from ground level. To service the unit the technician needs to gain access to the unit on the roof, unscrew the top cover from the unit to gain access to the internal components. Some of the screws that are required to be removed are located at the end of the unit nearest the roof edge. To do this job the person will need to be physically located by the edge of the roof, within 2 meters and therefore at risk of a fall from height. Facilities have currently stopped this work and postponed the routine maintenance (Planned Preventative Maintenance) until we can arrange to have edge protection installed on the edge of this part of the roof.



Actions from recent Hazardous Substances audit conducted by Deloitte have been completed by the Facilities and Development Health and Safety team in the last month. ADHB Occupational Health and Safety team has closed-out all actions after an onsite verification visit. This audit and the identified corrective actions has prompted Facilities to adopt a pro-active and on-going initiative to inspect the plant rooms with a focus on identifying any issues with regards to H&S, Hazardous Substances and housekeeping etc. Findings during these on-going inspections are raised with PAE so that they can manage any corrective preventative actions accordingly.

Facilities have established that the ACH level 7, Endoscopy, Scope sterilizing equipment waste discharge has an average pH value of 4.2. The Auckland hospital Trade Waste Agreement states that the lowest pH level of trade waste that we can discharge is to a pH value of 6. The low pH waste was causing a problem as the liquid waste is entering the sewerage system without being diluted by any other waste products. Currently Facilities are working with the equipment/ chemical suppliers trying to find a 'built in' solution using the wash cycle options on the Scope machines or an external dosing system. As an interim measure Facilities have diverted the run-off water from the RO plant and cooling towers on top of the A06 plant room to the drainage system linked to the testing point as a means to help reduce the pH of the waste water from the Scope machines. Currently the pH readings are being maintained within the limits of our Trade Waste Agreement.

Facilities acted on a Ministry of Health announcement that ground water from bore holes should be tested for Poly and Perfluorinated Alkyl Substances (PFAS) in water. This substance is associated with fire fighting foam that may have made its way into our underground water reservoirs. The testing was undertaken at Greenlane where bore water is taken for use on site. The testing was undertaken at an accredited laboratory and the results indicate that the water used at GCC is not contaminated with PSAF.



This month's reporting on the lead indicator for inspections is averaging over 100% across the seven main contractors that are undertaking work within Facilities. This indicates that the contractors are achieving above the targeted KPI requirements set by Facilities, in some cases fifty percent more than our minimum requirement. The lead indicators demonstrate a pro-active approach to health and safety management being undertaken by contractors Kelly engaged by facilities.

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.

(Control+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
- Patient Management Services
- Perioperative
- Surgical Services
- Women's Health

Adult Medical Services Health and Safety Report

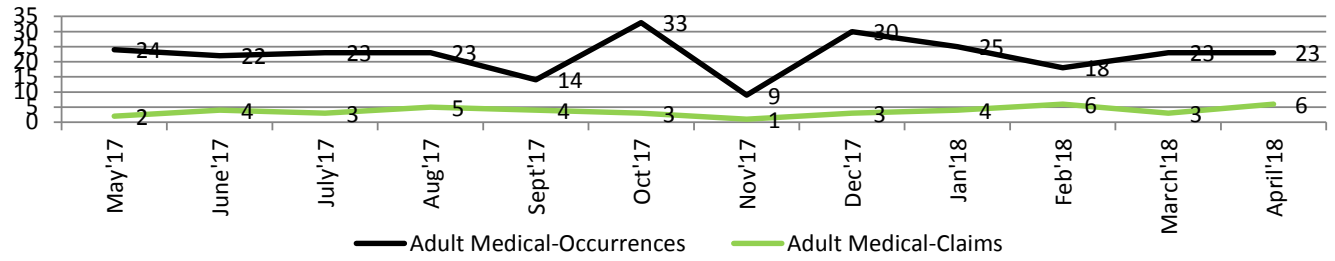
Lagging

	Actual	Target	Trend
H&S Incidents	23	20	
Work Injury Claims	6	0	
Lost Time Injuries	2	0	
Notifiable Events	0	0	

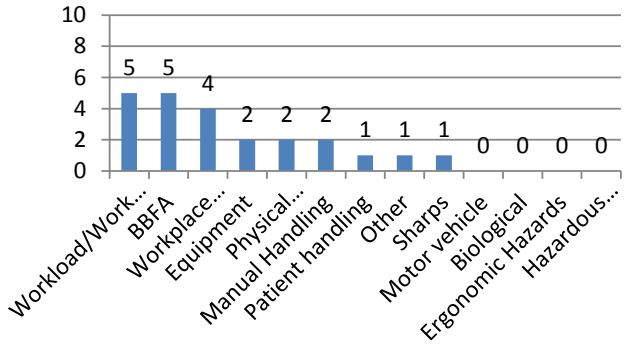
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	65	100	
H&S Rep Vacancies No.	4	2	
%H&S Rep Training	84	80	
%6 Monthly Workplace Checklist	37	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	4	80	

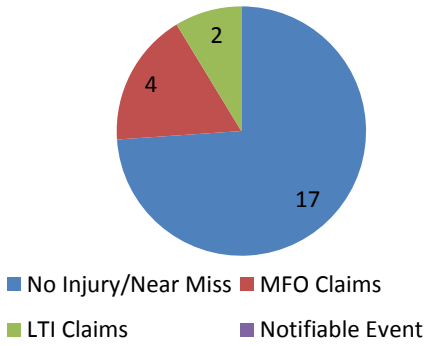
Health and Safety Incidents and Claims for 12 months



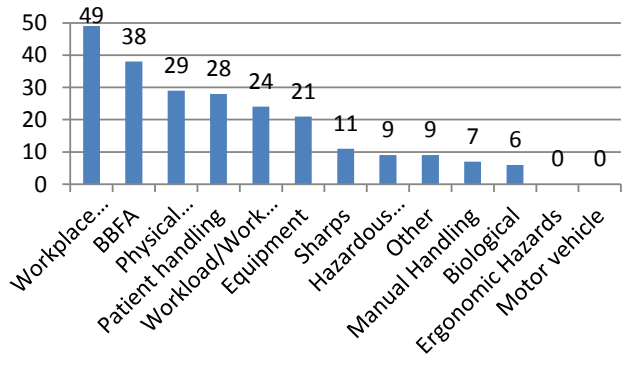
Health and Safety Incident by Hazard Type for April 2018



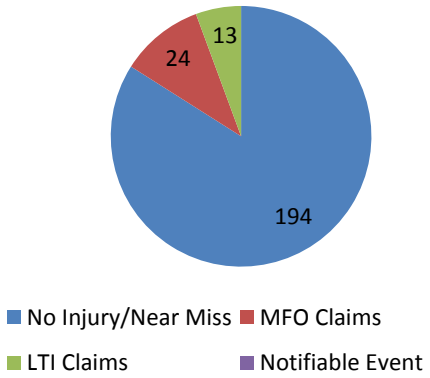
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



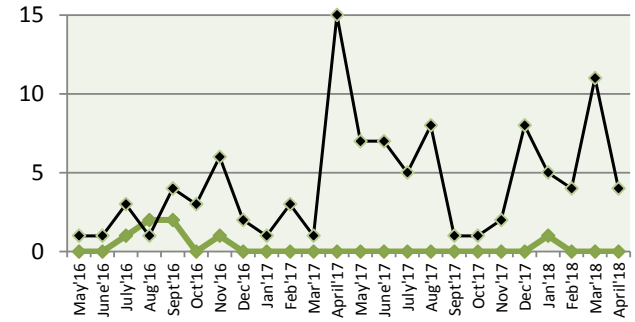
Work Injury by Outcome Type – YTD (2017-2018)



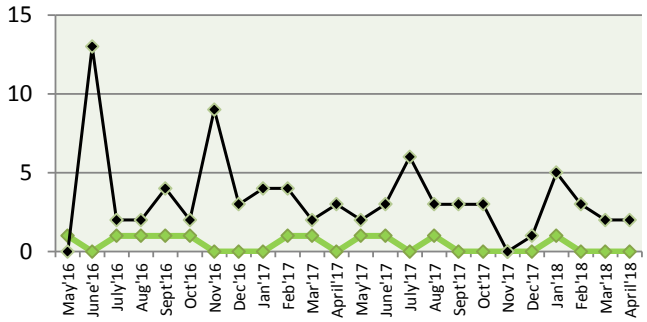
Adult Medical Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

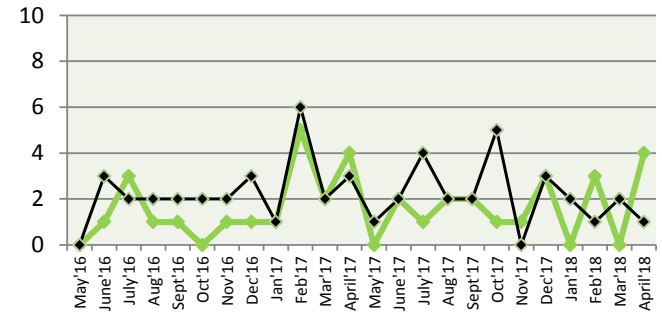
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



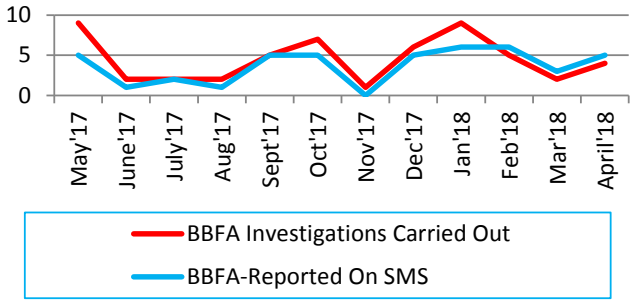
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

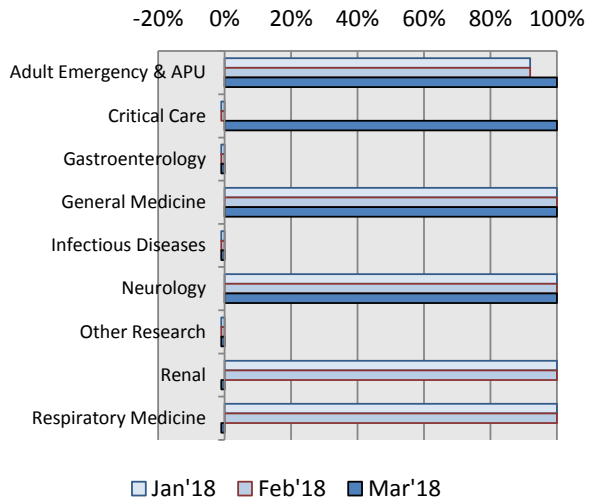


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



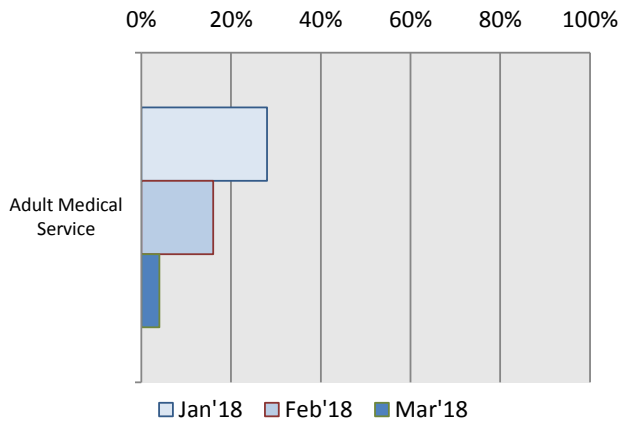
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	100%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	28%	16%	4%



Information data accurate as of 03/05/2018

Cancer and Blood Services Health and Safety Report

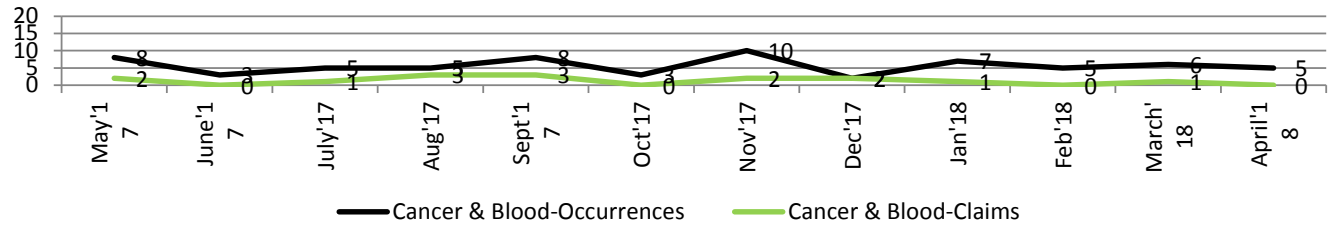
Lagging

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

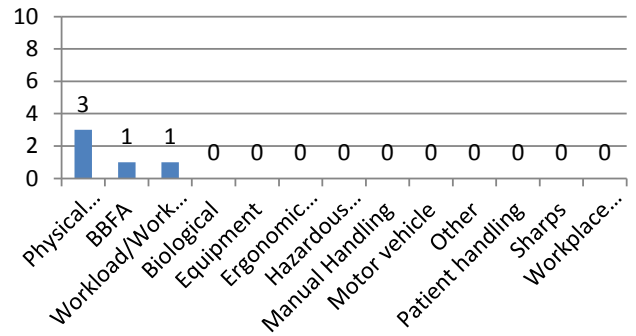
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	87	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	85	80	
%H&S Rep Checklist	88	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	29	80	

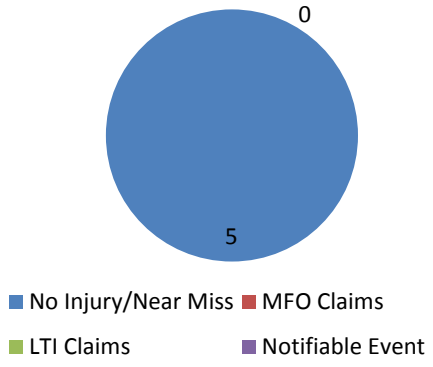
Health and Safety Incidents and Claims for 12 months



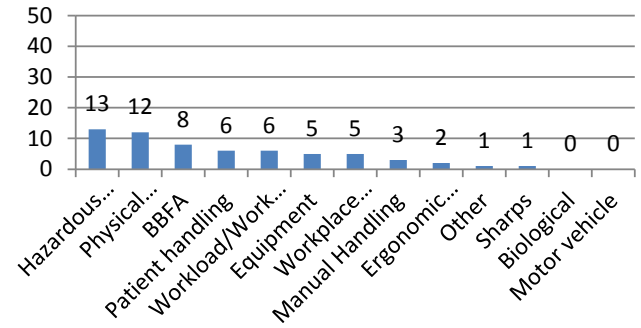
Health and Safety Incident by Hazard Type for April 2018



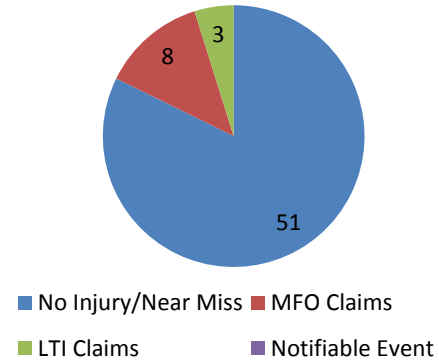
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



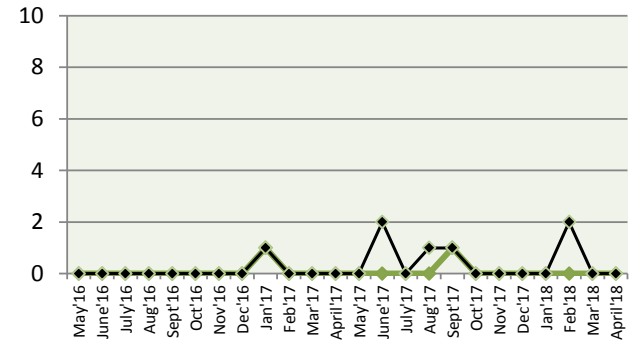
Work Injury by Outcome Type – YTD (2017-2018)



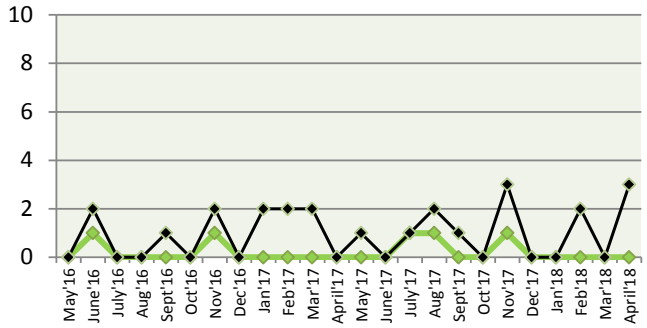
Cancer and Blood Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

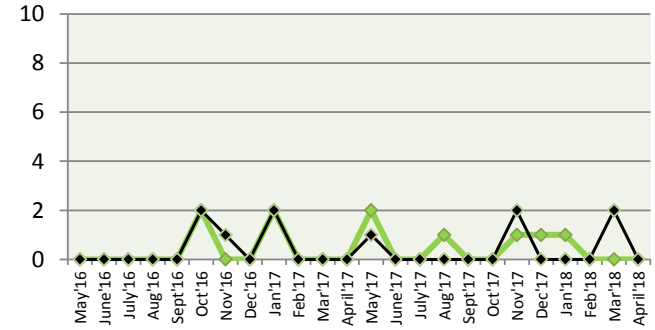
WORKPLACE VIOLENCE AND AGGRESSION (From 2 Years Rolling)



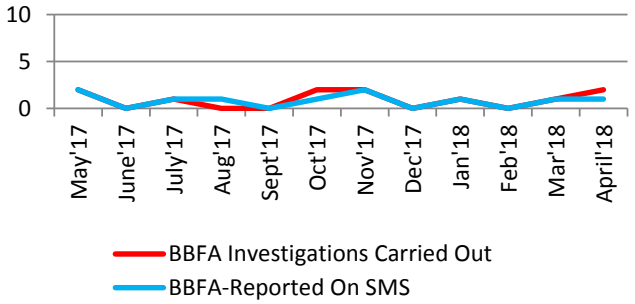
PHYSICAL ENVIRONMENT (From 2 Years Rolling)



PATIENT HANDLING (From 2 Years Rolling)

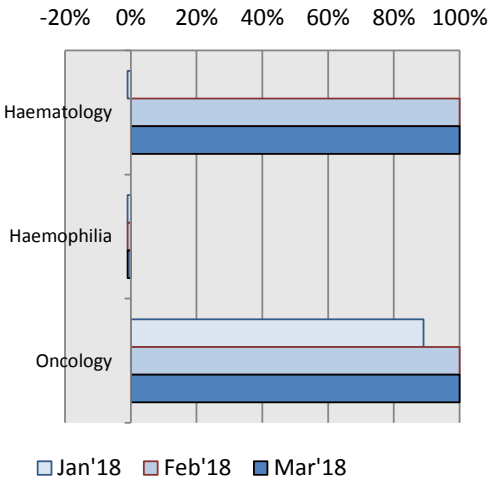


BLOOD AND BODY FLUID ACCIDENTS (From 1 Year Rolling)



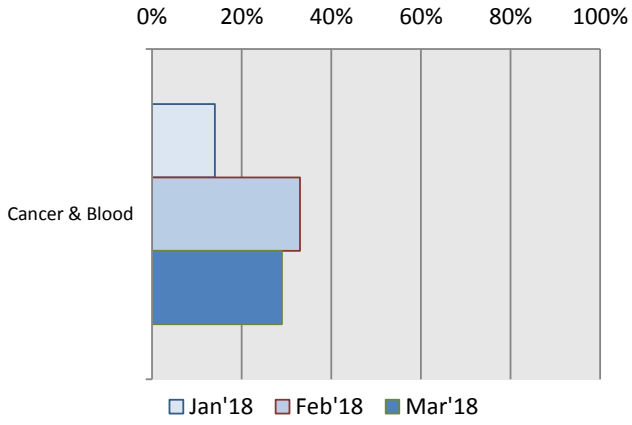
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	100%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	14%	33%	29%



Information data accurate as of 03/05/2018

Cardiac Services Health and Safety Report

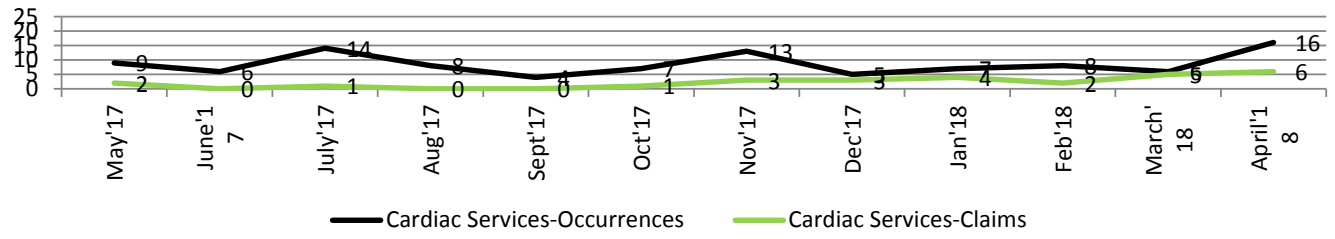
Lagging

	Actual	Target	Trend
H&S Incidents	16	20	
Work Injury Claims	6	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

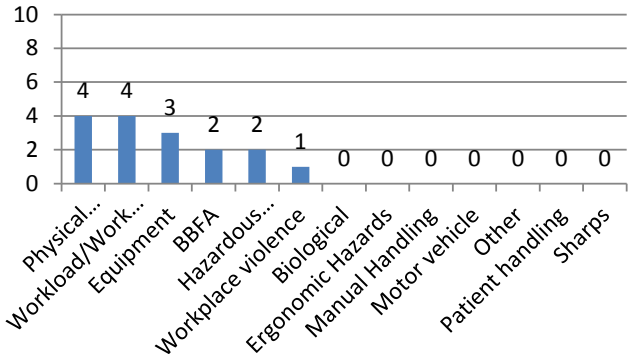
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	78	100	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	88	80	
%6 Monthly Workplace Checklist	55	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	0	80	

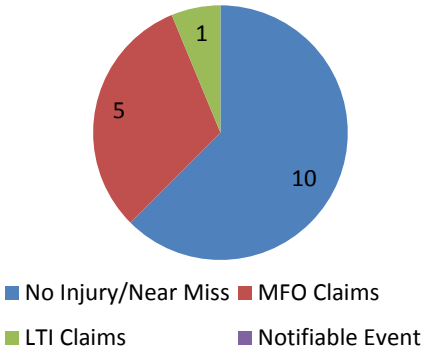
Health and Safety Incidents and Claims for 12 months



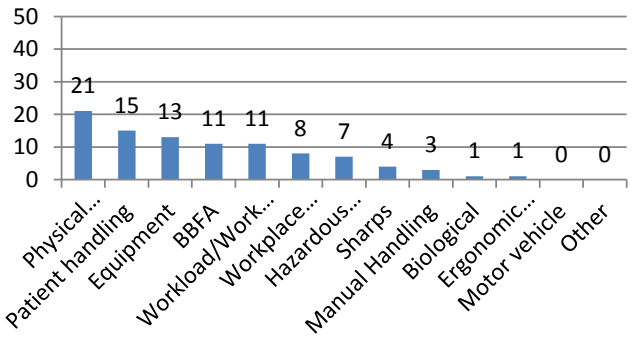
Health and Safety Incident by Hazard Type for April 2018



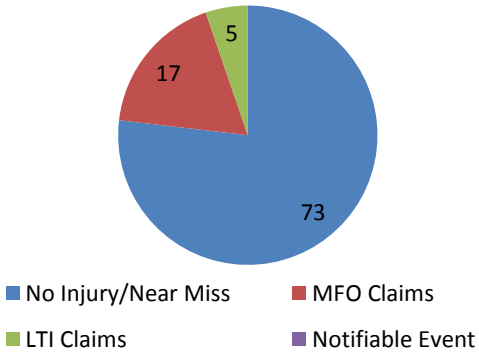
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



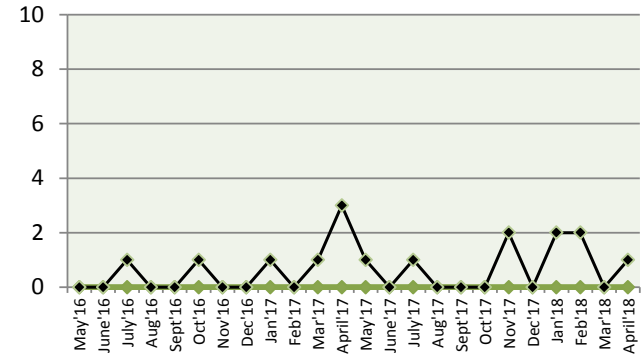
Work Injury by Outcome Type – YTD (2017-2018)



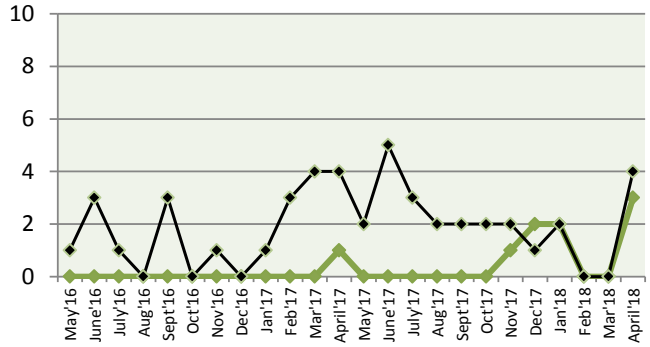
Cardiac Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

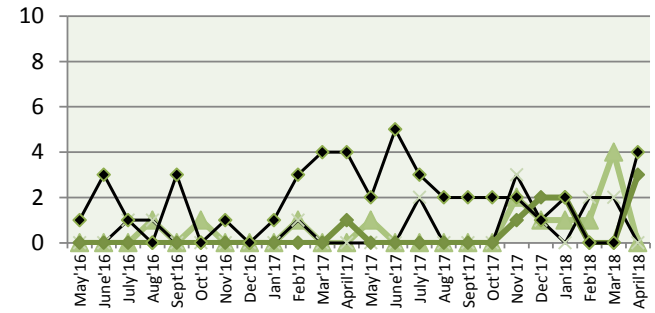
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



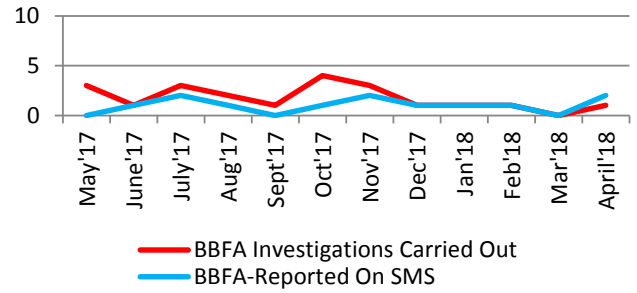
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

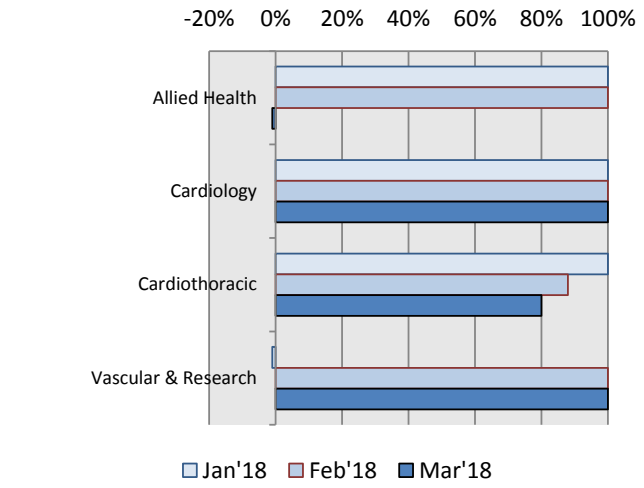


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



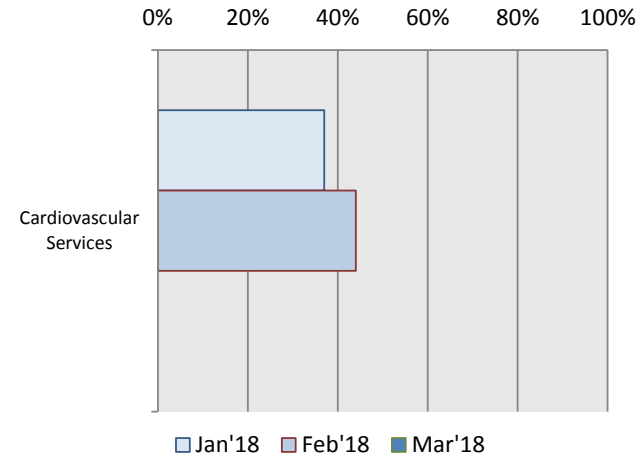
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	95%	88%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	38%	44%	0%



Information data accurate as of 03/05/2018

Children's Services Health and Safety Report

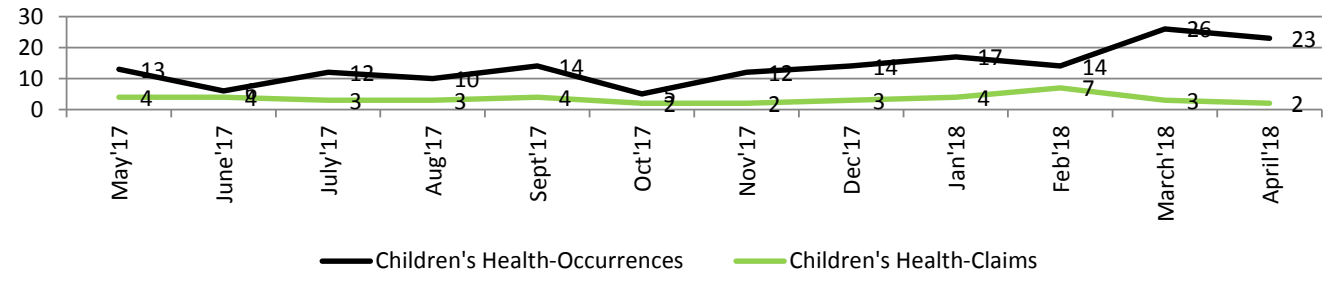
Lagging

	Actual	Target	Trend
H&S Incidents	23	20	
Work Injury Claims	2	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

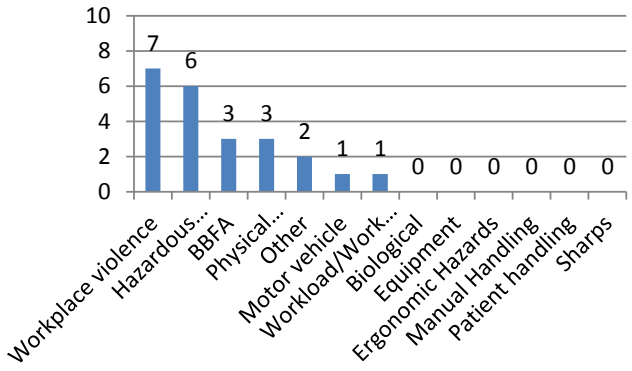
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	78	100	
H&S Rep Vacancies No.	7	2	
%H&S Rep Training	82	80	
%6 Monthly Workplace Checklist	20	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	19	80	

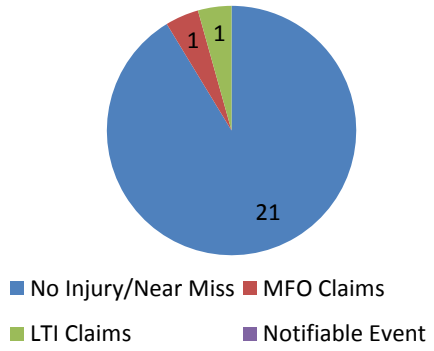
Health and Safety Incidents and Claims for 12 months



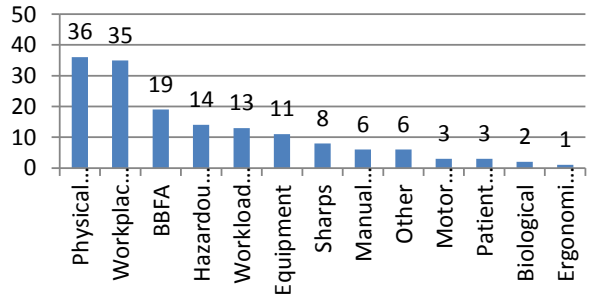
Health and Safety Incident by Hazard Type for April 2018



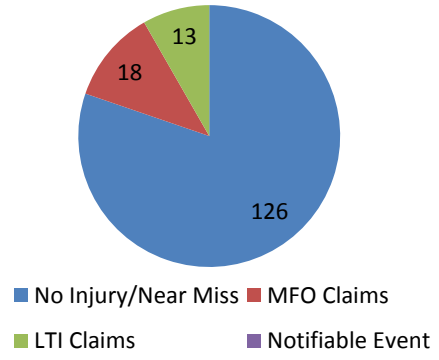
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



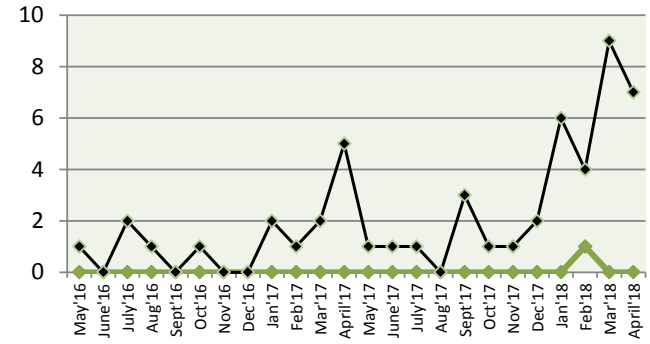
Work Injury by Outcome Type – YTD (2017-2018)



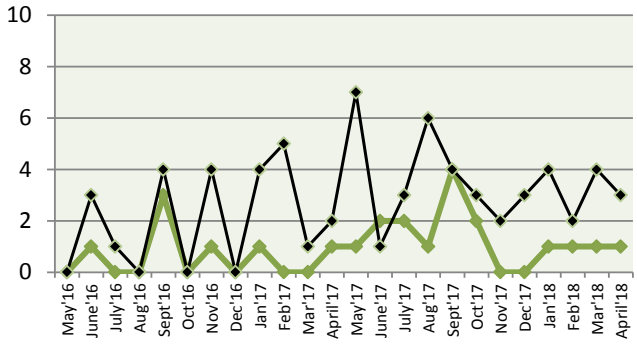
Children's Services Health and Safety Report (continued)

LEGEND: CLAIMS | Health and Safety INCIDENT

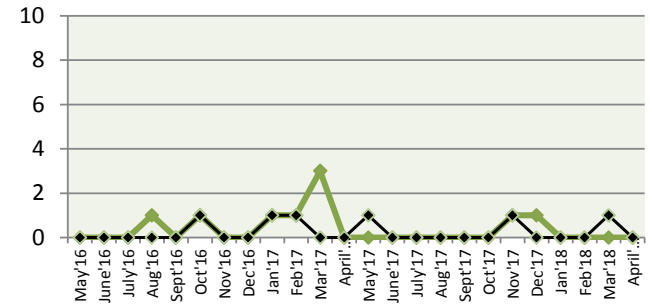
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



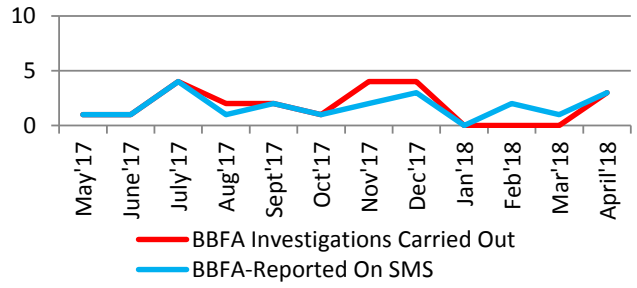
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

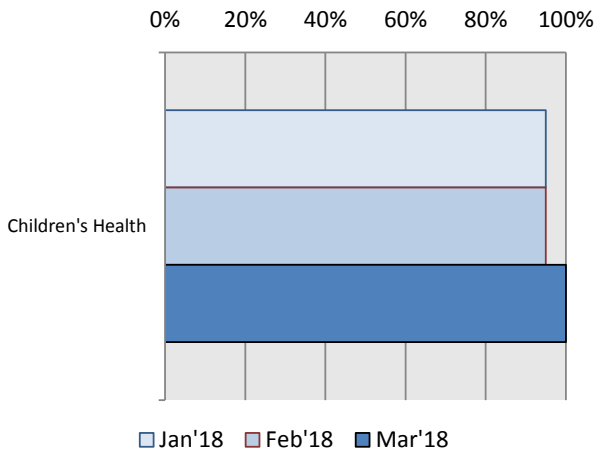


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



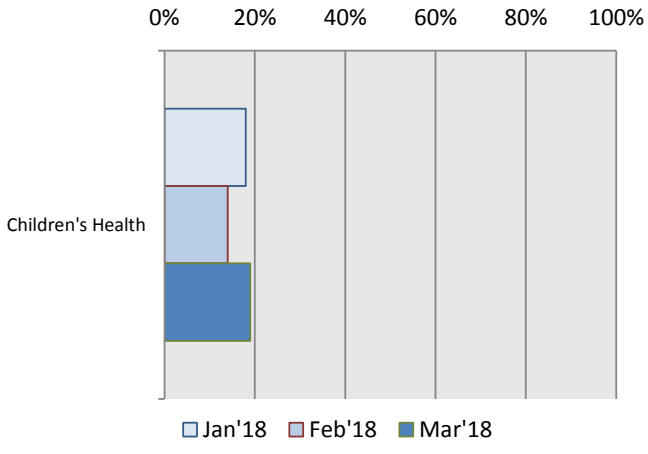
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	95%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	18%	14%	19%



Information data accurate as of 03/05/2018

Clinical Support Health and Safety Report

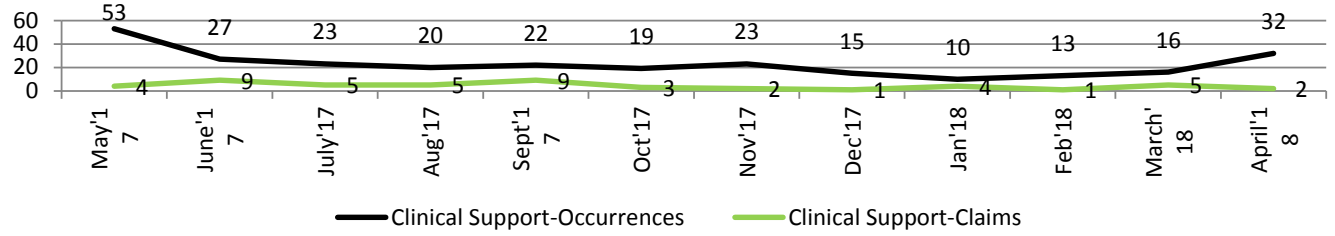
Lagging

	Actual	Target	Trend
H&S Incidents	32	20	
Work Injury Claims	2	0	
Lost Time Injuries	2	0	
Notifiable Events	0	0	

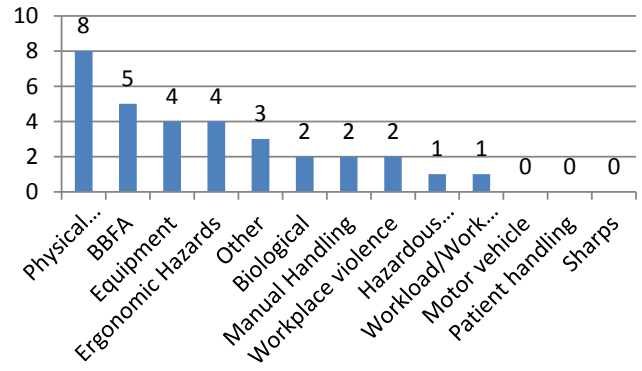
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	97	100	
H&S Rep Vacancies No.	4	2	
%H&S Rep Training	85	80	
%6 Monthly Workplace Checklist	68	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	29	80	

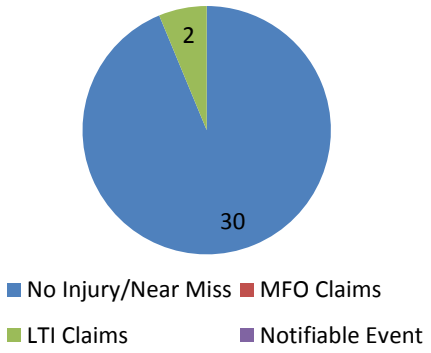
Health and Safety Incidents and Claims for 12 months



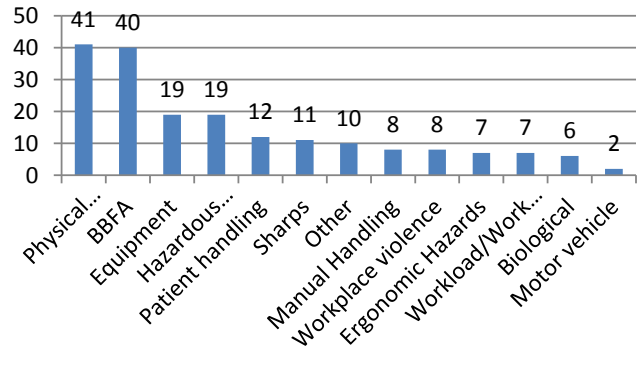
Health and Safety Incident by Hazard Type for April 2018



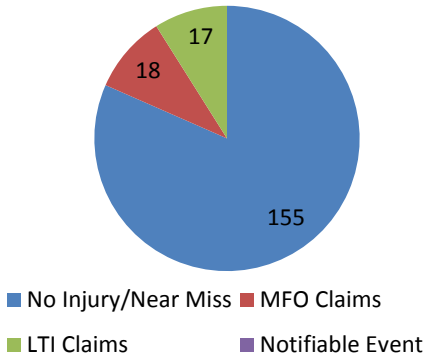
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



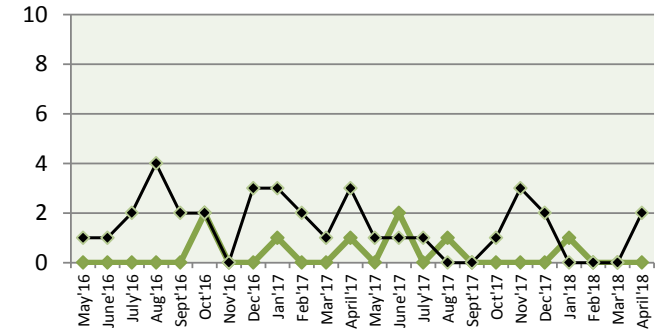
Work Injury by Outcome Type – YTD (2017-2018)



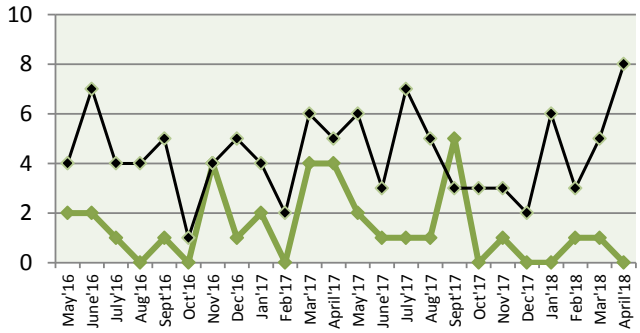
Clinical Support Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

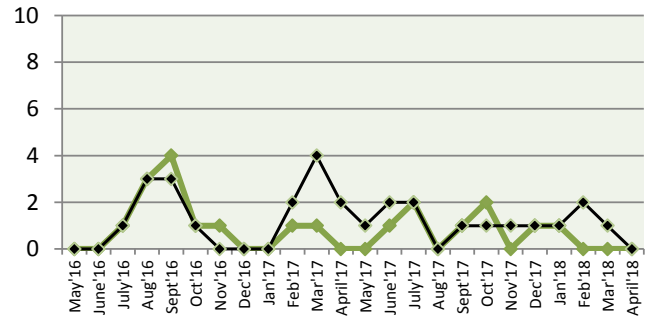
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



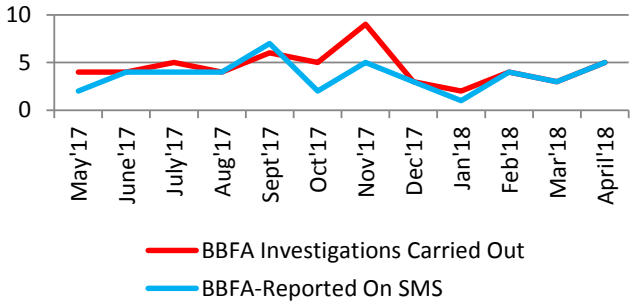
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

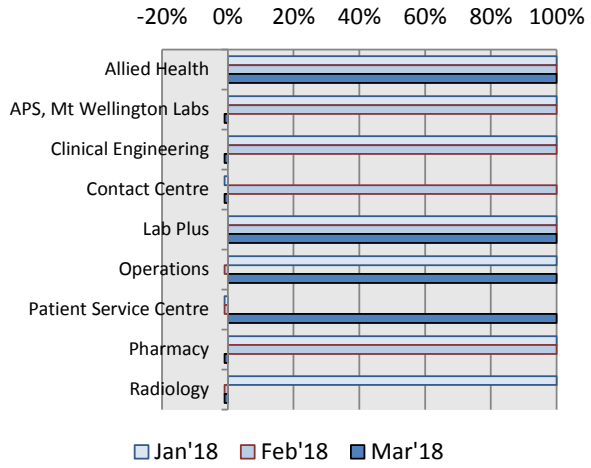


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



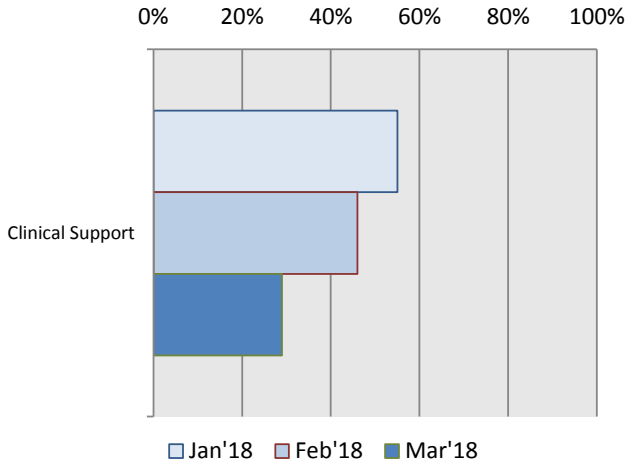
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	100%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	55%	46%	29%



Information data accurate as of 03/05/2018

Corporate Services Health and Safety Report

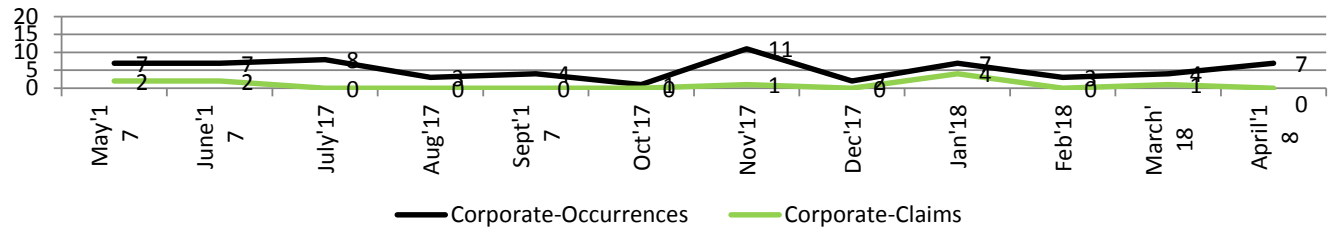
Lagging

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

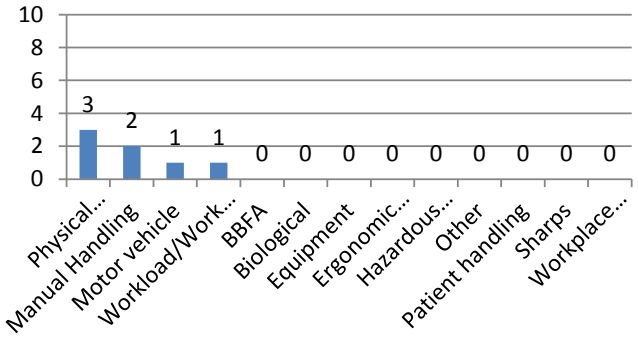
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	75	100	
H&S Rep Vacancies No.	6	2	
%H&S Rep Training	73	80	
%6 Monthly Workplace Checklist	44	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	29	80	

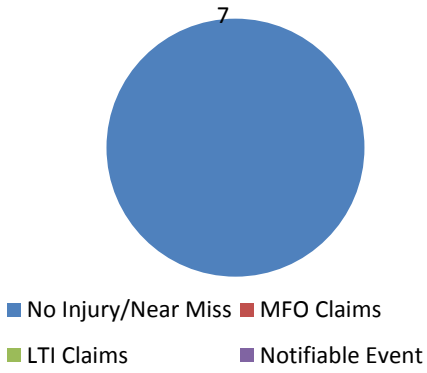
Health and Safety Incidents and Claims for 12 months



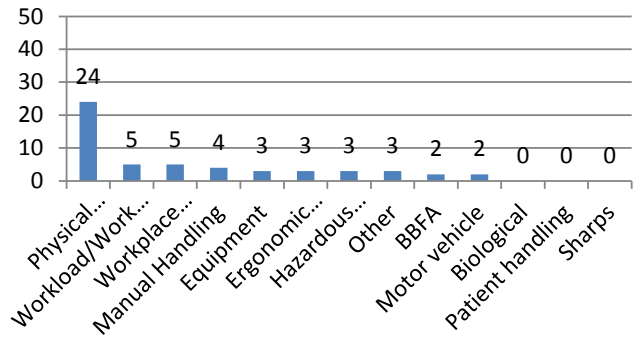
Health and Safety Incident by Hazard Type for April 2018



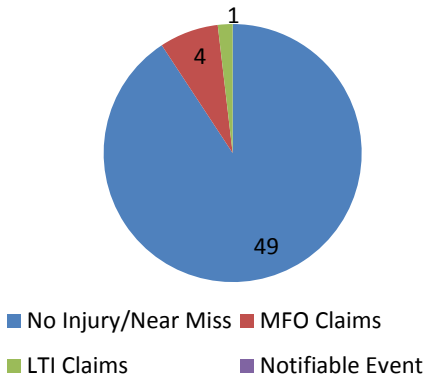
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



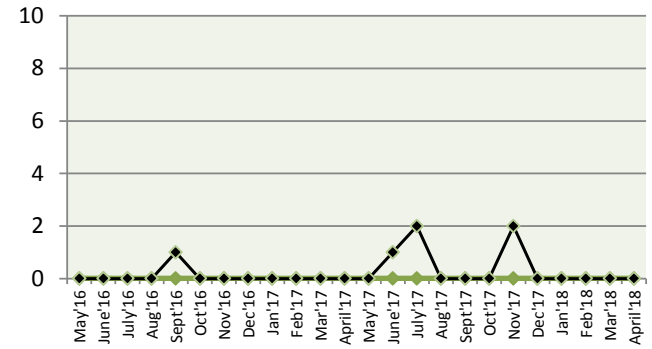
Work Injury by Outcome Type – YTD (2017-2018)



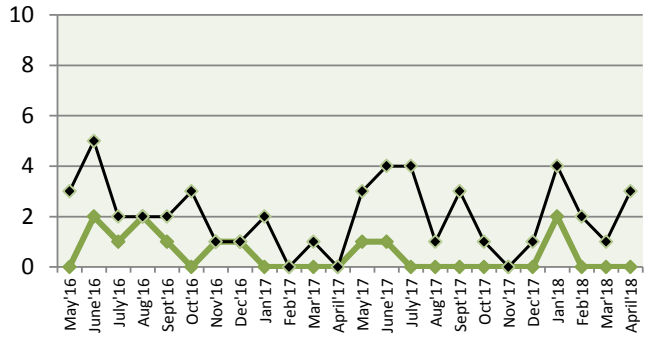
Corporate Services Health and Safety Report (continued)

LEGEND: CLAIMS | Health and Safety INCIDENT

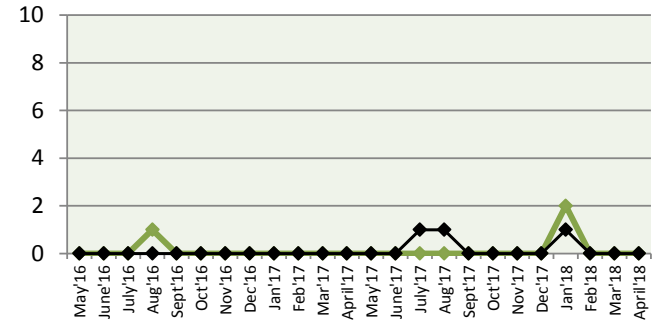
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



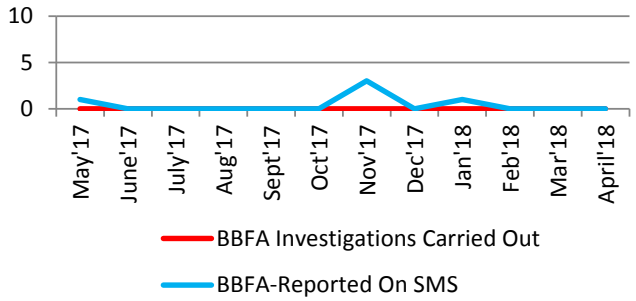
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



MANUAL HANDLING
(From 2 Years Rolling)

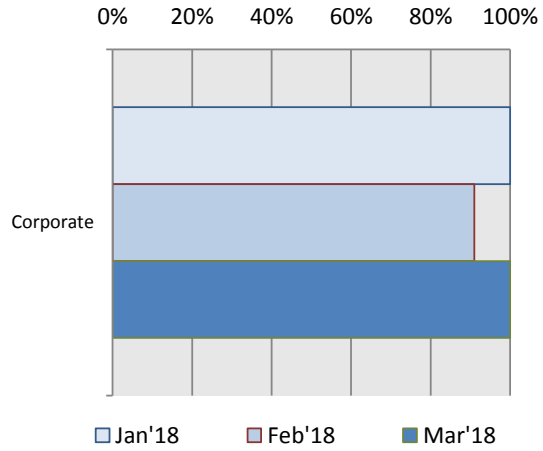


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



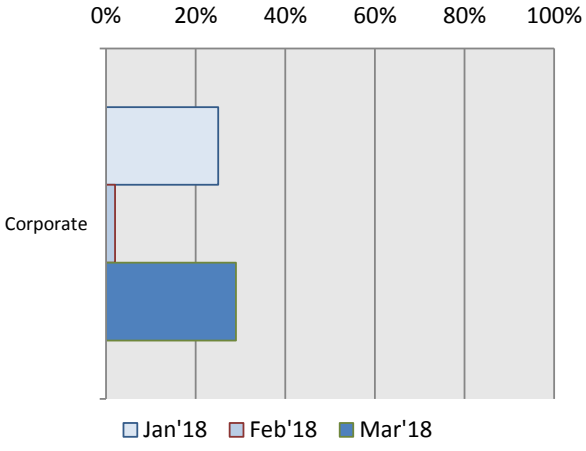
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	91%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	25%	2%	29%



Information data accurate as of 03/05/2018

Community and Long Term Conditions Health and Safety Report

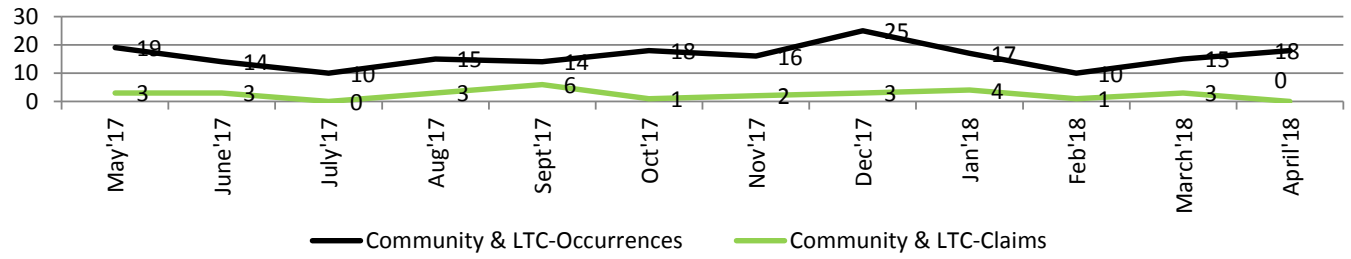
Lagging

	Actual	Target	Trend
H&S Incidents	18	20	
Work Injury Claims	0	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

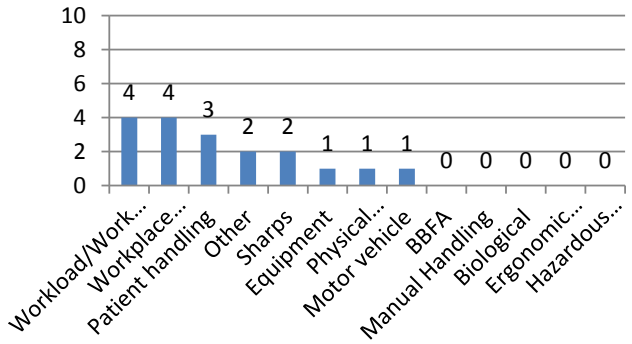
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	90	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	85	80	
% 6 monthly Workplace Checklist	65	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	63	80	

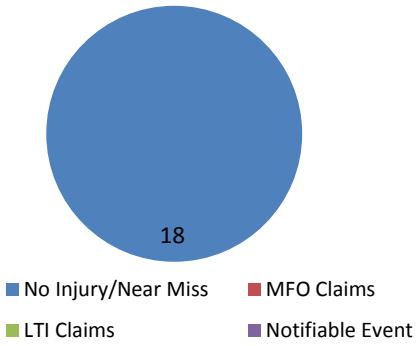
Health and Safety Incidents and Claims for 12 months



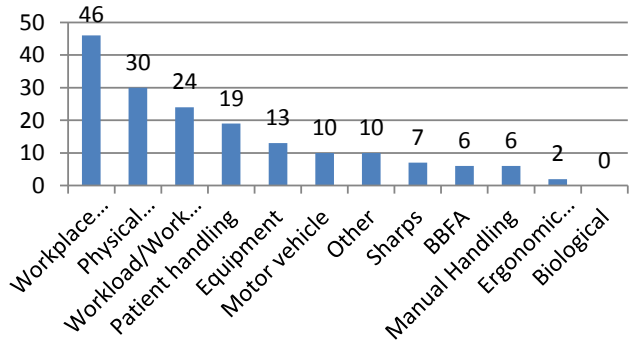
Health and Safety Incident by Hazard Type for April 2018



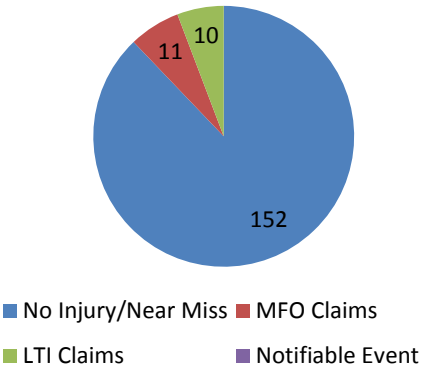
Work Injury by Outcome Type for April 2018



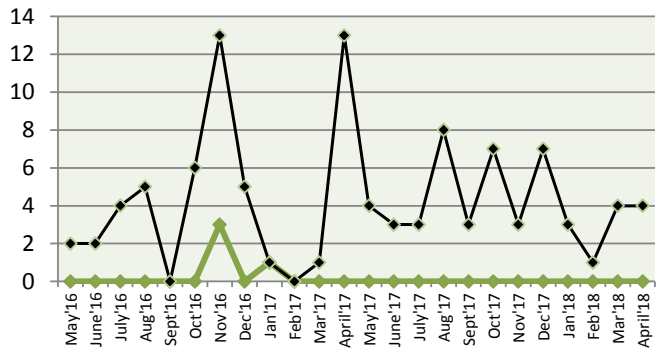
Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



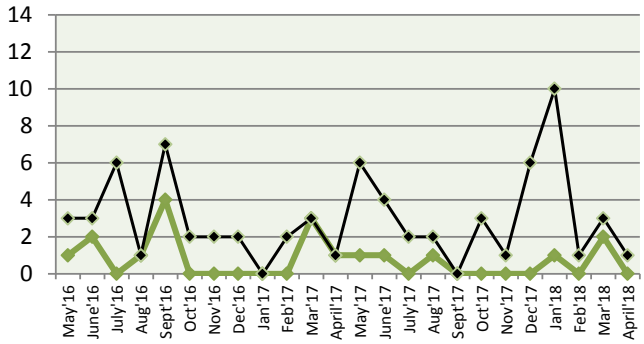
Work Injury by Outcome Type – YTD (2017-2018)



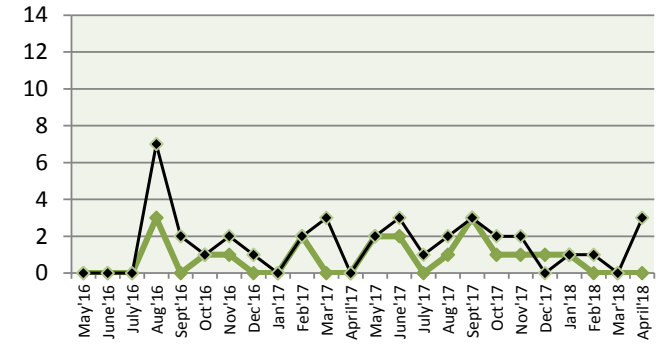
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



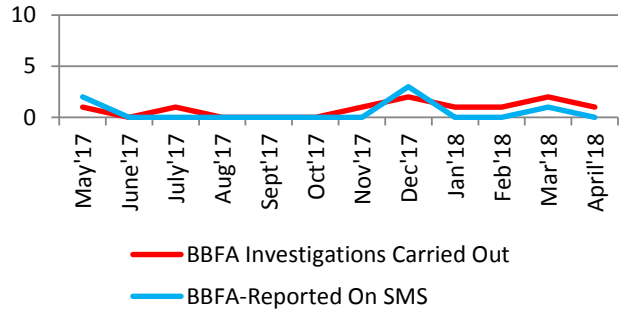
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

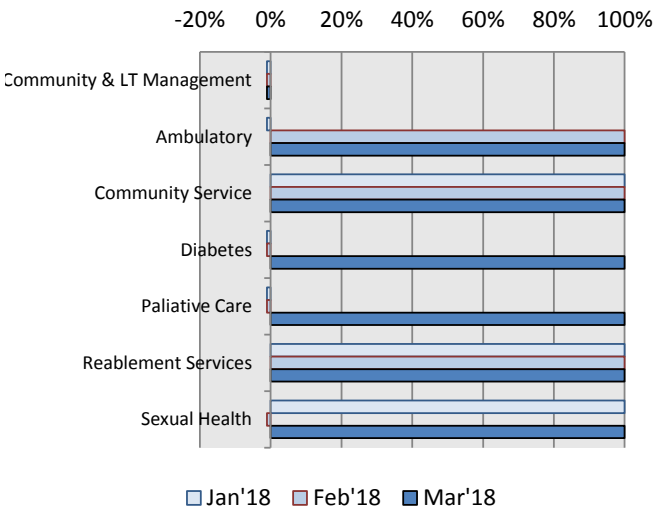


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



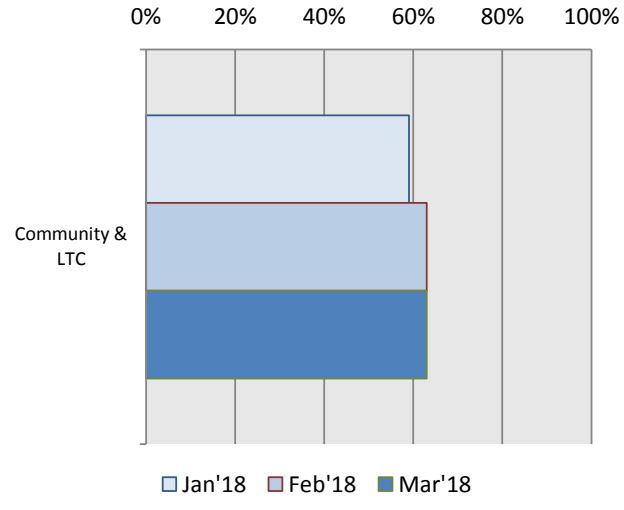
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	100%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	59%	63%	63%



Information data accurate as of 03/05/2018

Mental Health Services Health and Safety Report

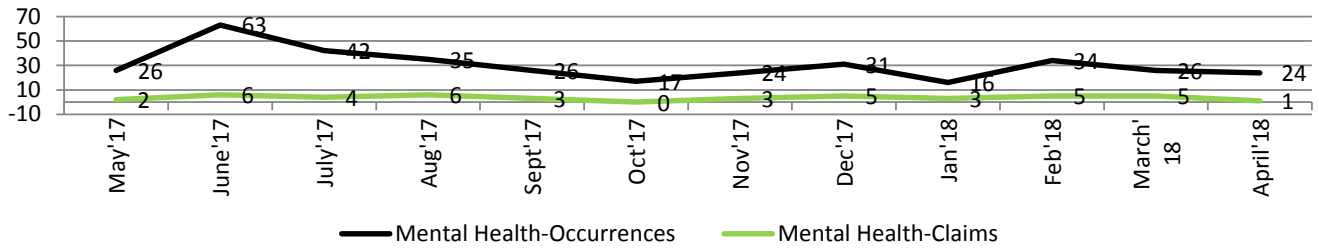
Lagging

	Actual	Target	Trend
H&S Incidents	24	20	
Work Injury Claims	1	0	
Lost Time Injuries	0	0	
Notifiable Events	0	0	

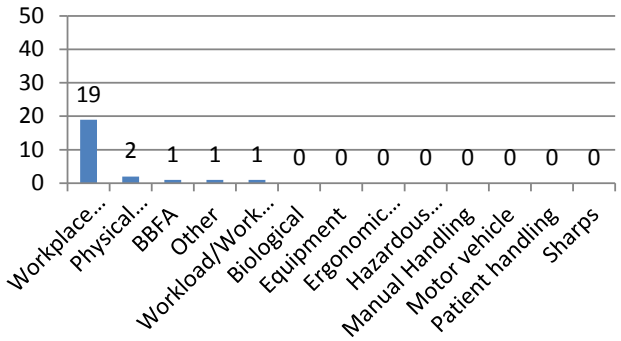
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	87	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	63	80	
% 6 monthly Workplace Checklist	19	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	15	80	

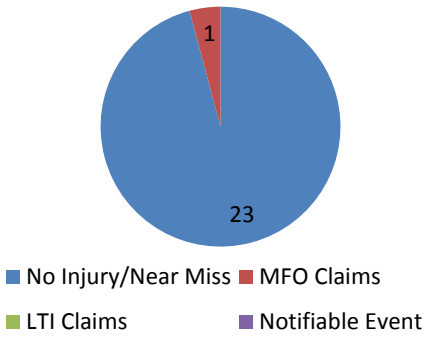
Health and Safety Incidents and Claims for 12 months



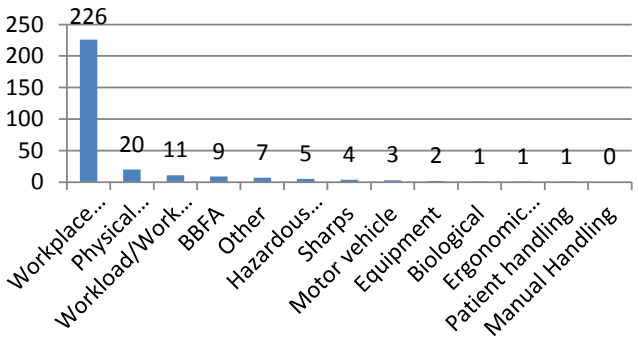
Health and Safety Incident by Hazard Type for April 2018



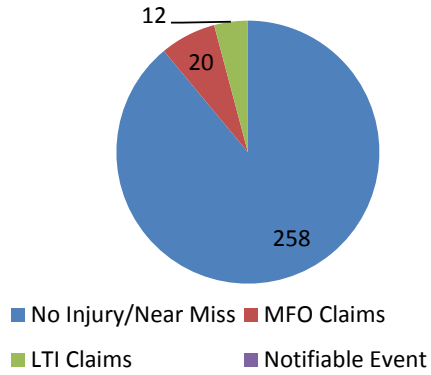
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)

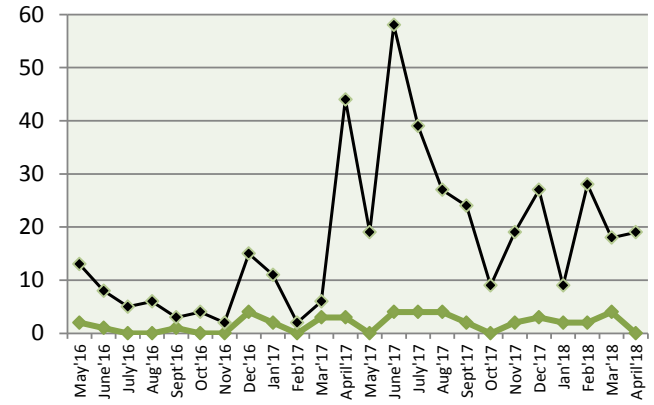


Work Injury by Outcome Type – YTD (2017-2018)

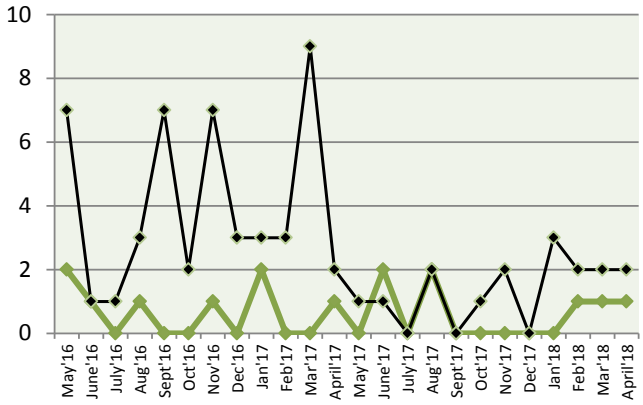


LEGEND: CLAIMS Health and Safety INCIDENT

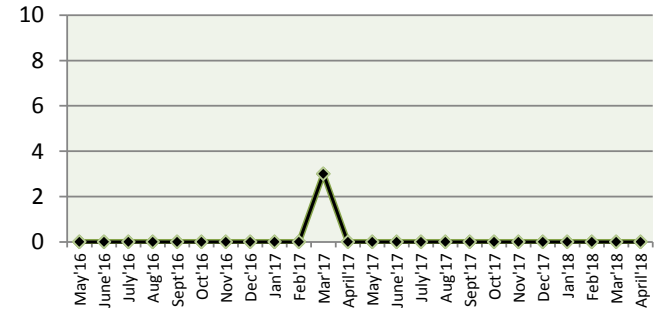
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



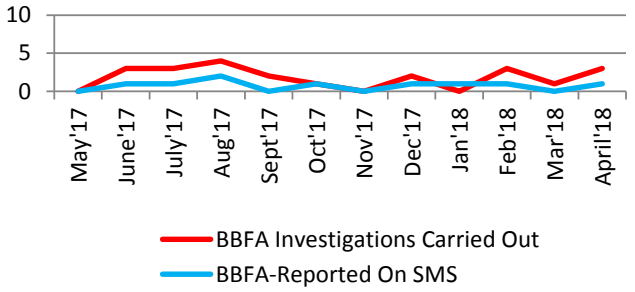
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

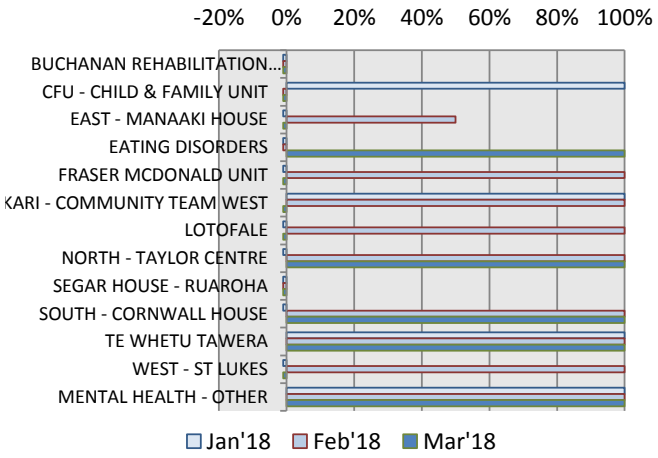


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



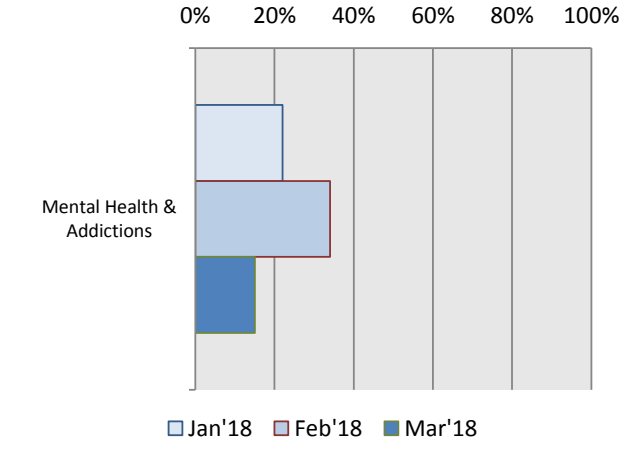
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	95%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	22%	34%	15%



Information data accurate as of 03/05/2018

Patient Management Service Health and Safety Reports

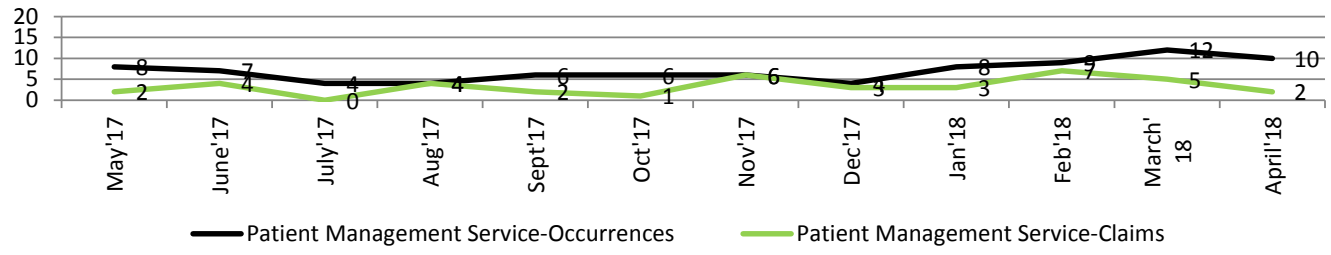
Lagging

	Actual	Target	Trend
H&S Incidents	10	20	
Work Injury Claims	2	0	
Lost Time Injuries	1	0	
Notifiable Events	0	0	

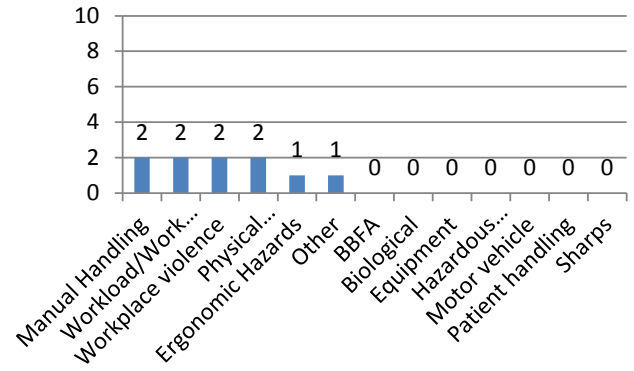
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	81	100	
H&S Rep Vacancies No.	2	2	
%H&S Rep Training	81	80	
%6 Monthly Workplace Checklist	33	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	50	80	

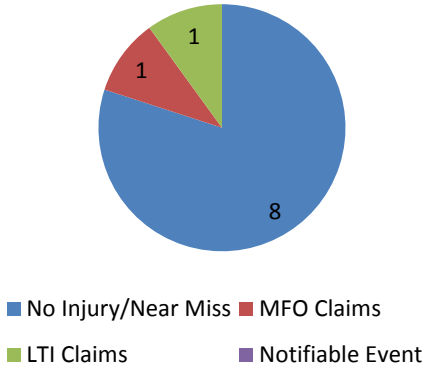
Health and Safety Incidents and Claims for 12 months



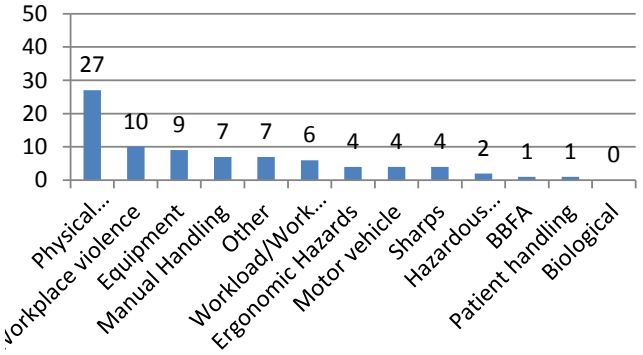
Health and Safety Incident by Hazard Type for April 2018



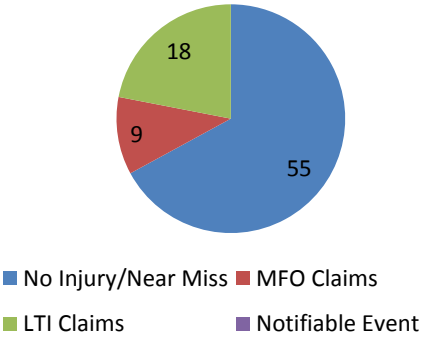
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



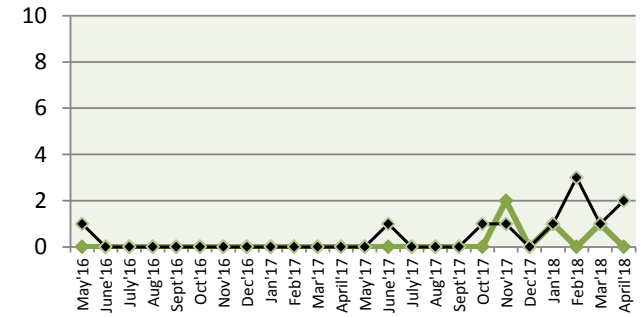
Work Injury by Outcome Type – YTD (2017-2018)



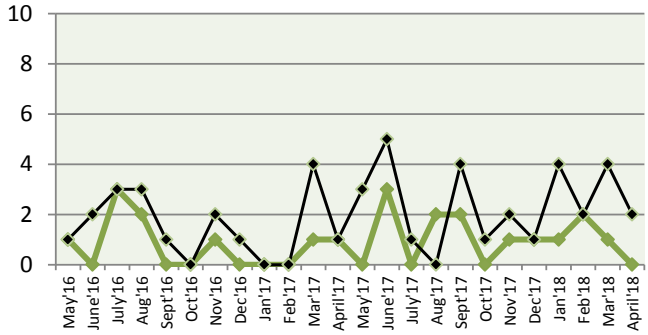
Patient Management Service Health and Safety Reports (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

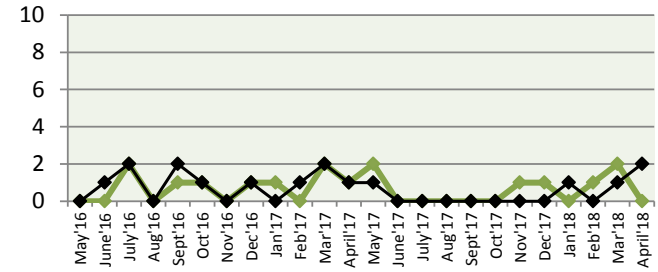
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



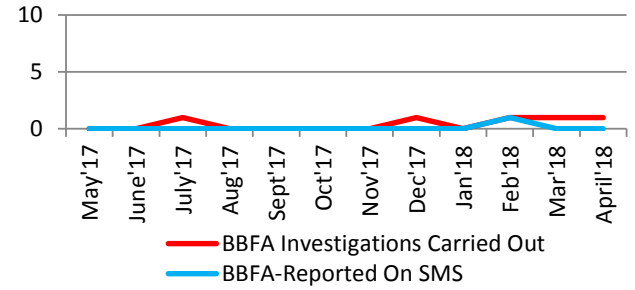
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



MANUAL HANDLING
(From 2 Years Rolling)

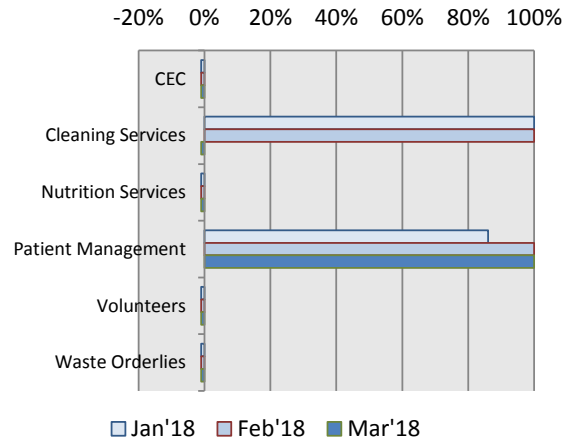


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



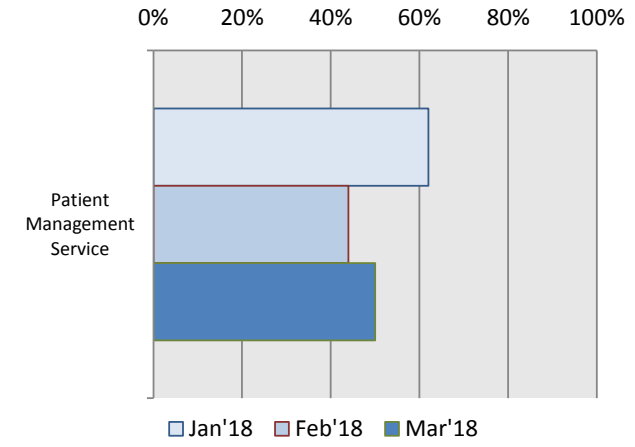
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	100%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	63%	44%	50%



Information data accurate as of 03/05/2018

Perioperative Health and Safety Report

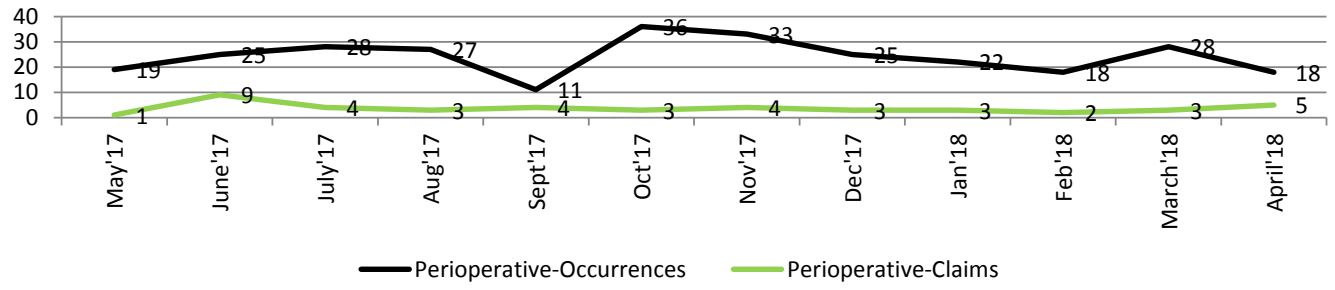
Lagging

	Actual	Target	Trend
H&S Incidents	18	20	
Work Injury Claims	5	0	
Lost Time Injuries	2	0	
Notifiable Events	0	0	

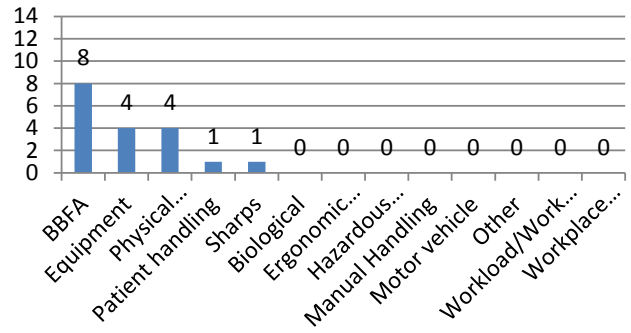
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	95	100	
H&S Rep Vacancies No.	1	2	
%H&S Rep Training	93	80	
%6 Monthly Workplace Checklist	100	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	10	80	

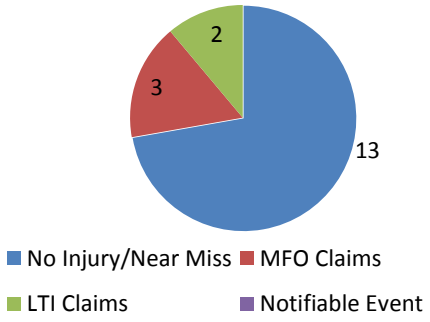
Health and Safety Incidents and Claims for 12 months



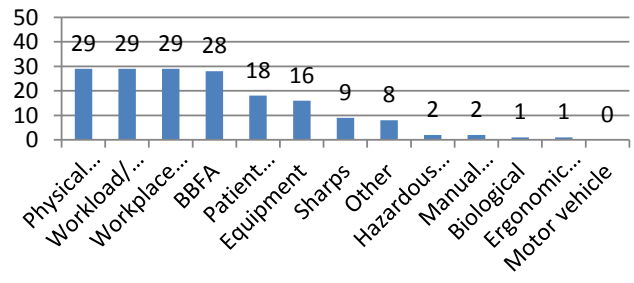
Health and Safety Incident by Hazard Type for April 2018



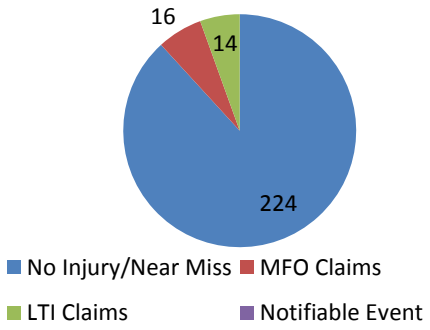
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



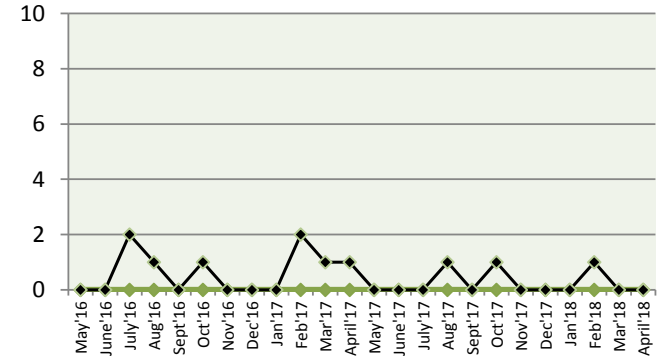
Work Injury by Outcome Type – YTD (2017-2018)



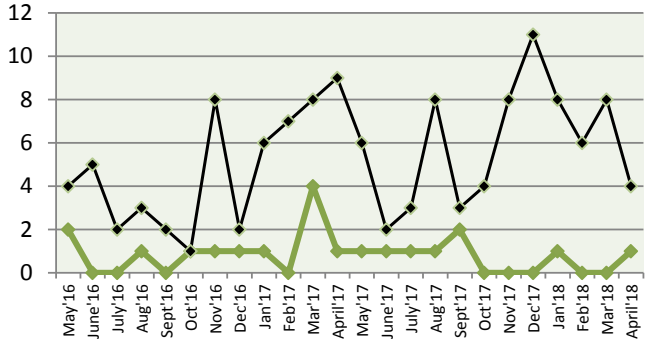
Perioperative Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

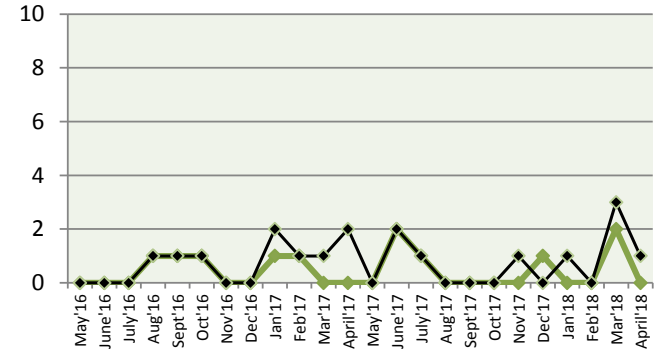
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



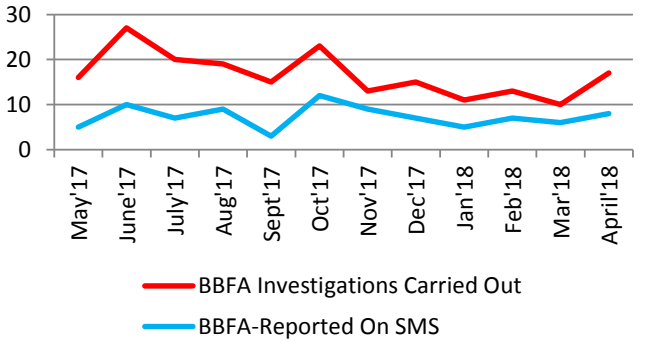
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

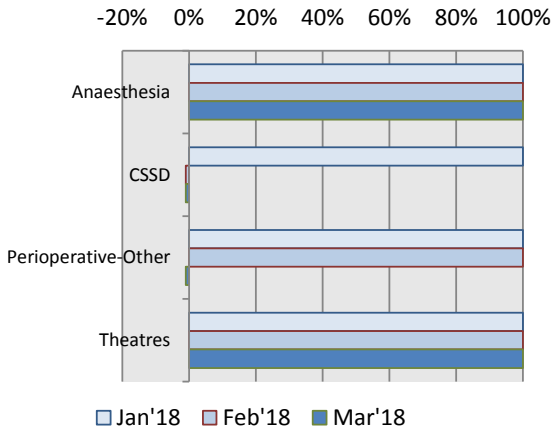


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



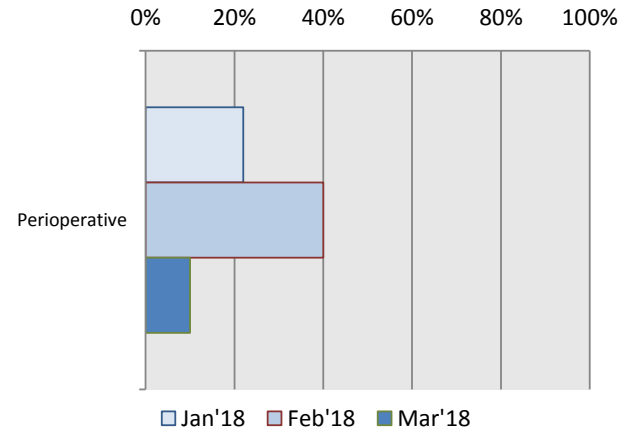
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	100%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	22%	40%	10%



Information data accurate as of 03/05/2018

Surgical Services Health and Safety Report

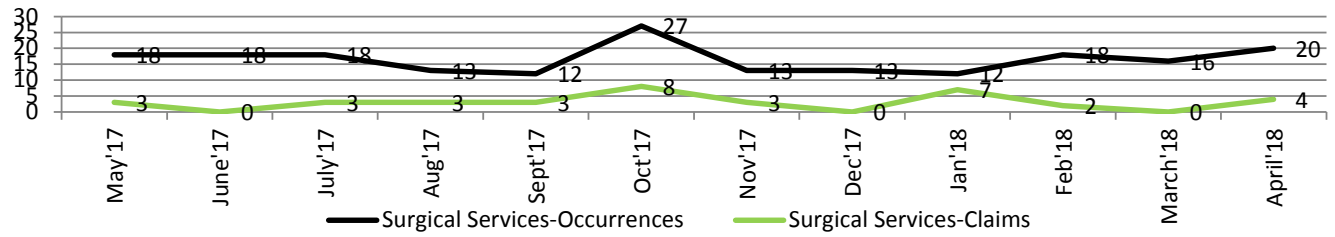
Lagging

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

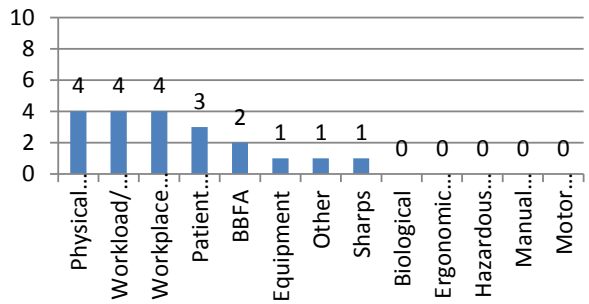
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	80	100	
H&S Rep Vacancies No.	3	2	
%H&S Rep Training	71	80	
%6 Monthly Workplace Checklist	35	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	24	80	

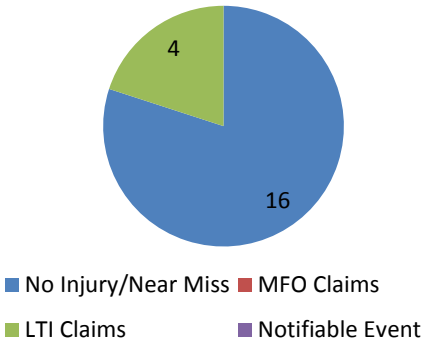
Health and Safety Incidents and Claims for 12 months



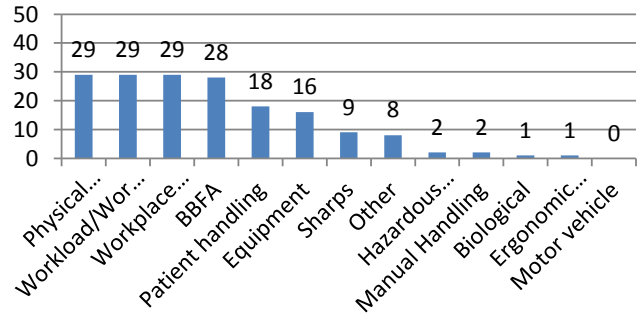
Health and Safety Incident by Hazard Type for April 2018



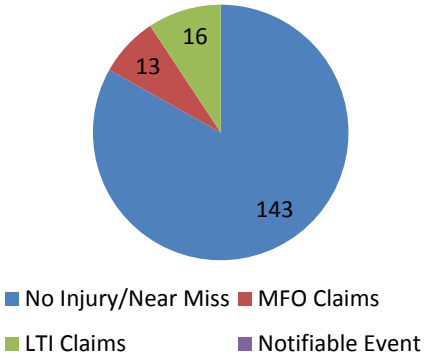
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



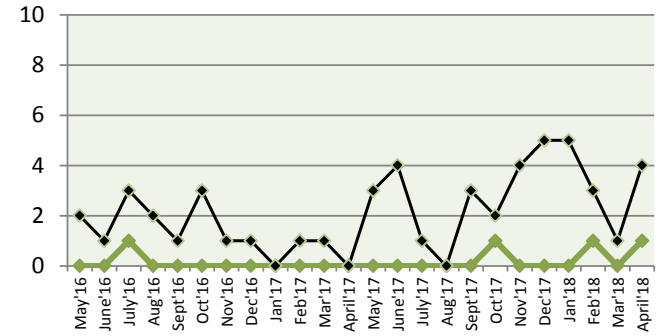
Work Injury by Outcome Type – YTD (2017-2018)



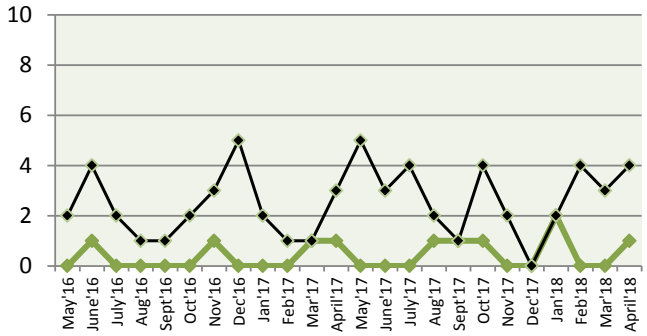
Surgical Services Health and Safety Report (continued)

LEGEND: CLAIMS Health and Safety INCIDENT

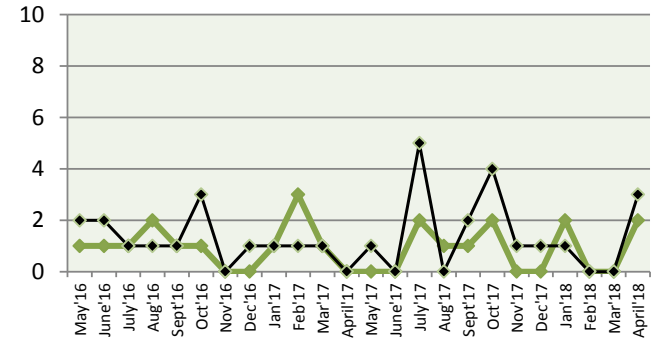
WORKPLACE VIOLENCE AND AGGRESSION (From 2 Years Rolling)



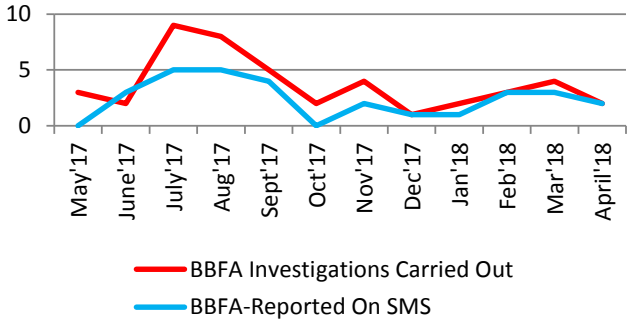
PHYSICAL ENVIRONMENT (From 2 Years Rolling)



PATIENT HANDLING (From 2 Years Rolling)

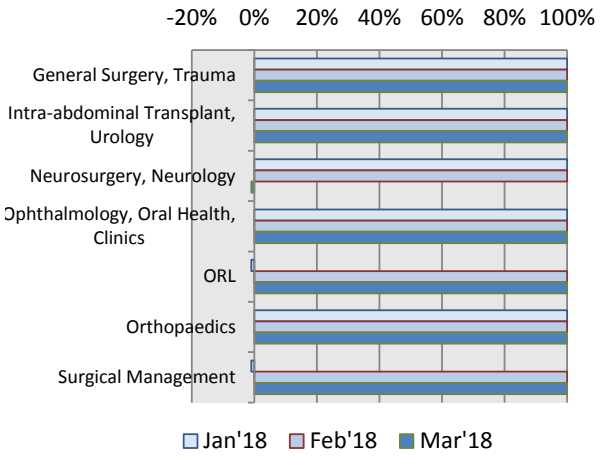


BLOOD AND BODY FLUID ACCIDENTS (From 1 Year Rolling)



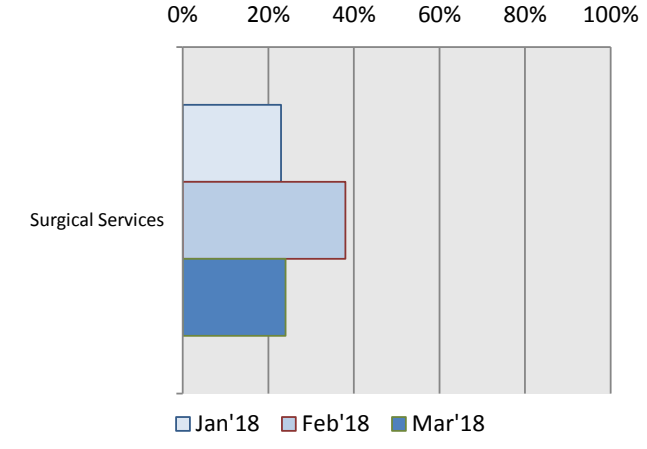
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	100%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	23%	38%	24%



Information data accurate as of 03/05/2018

Women's Health and Safety Report

5.2

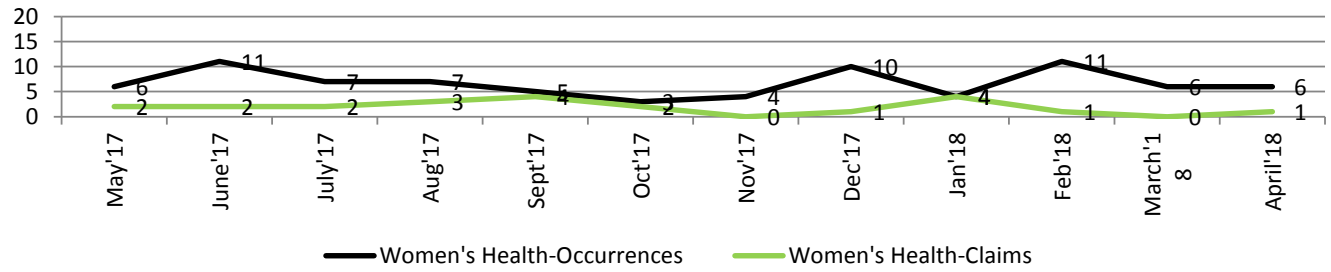
Lagging

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

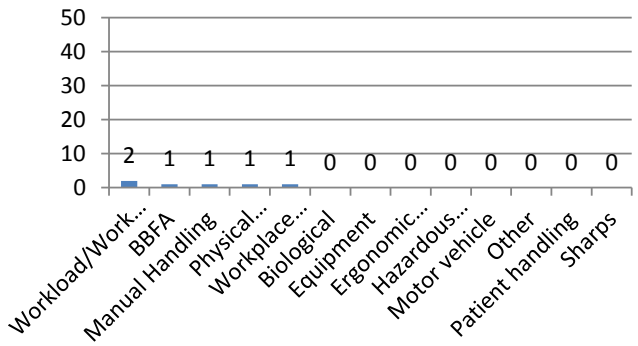
Leading

	Actual	Target	Trend
%H&S Inductions (YTD)	62	100	
H&S Rep Vacancies No.	0	2	
%H&S Rep Training	68	80	
%6 Monthly Workplace Checklist	42	80	
%PES before start date	RU	100	
%H&S Incidents Follow up 14 days	80	80	

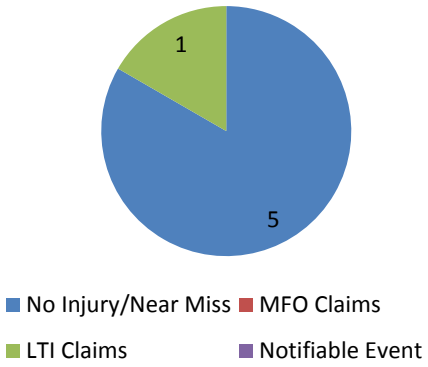
Health and Safety Incidents and Claims for 12 months



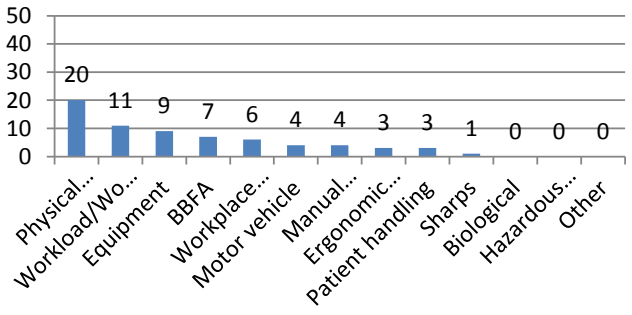
Health and Safety Incident by Hazard Type for April 2018



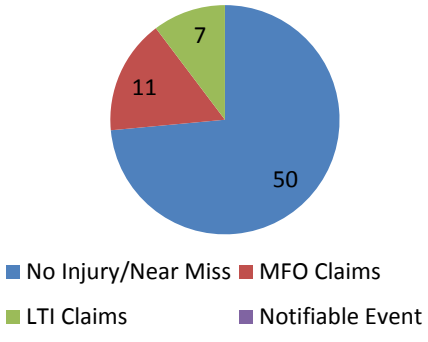
Work Injury by Outcome Type for April 2018



Health and Safety Incident by Hazard Type – Financial YTD (2017-2018)



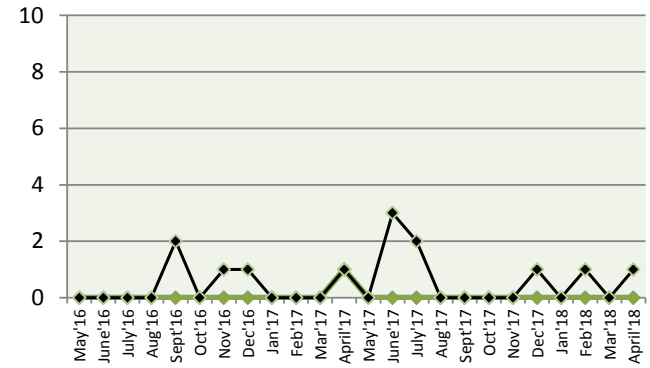
Work Injury by Outcome Type – YTD (2017-2018)



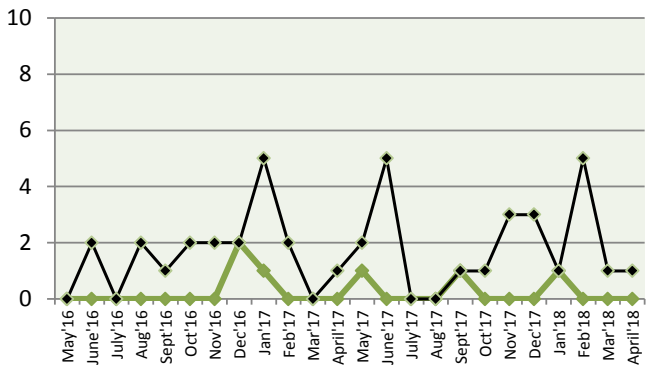
Women's Health and Safety Report (continued)

LEGEND: CLAIMS | Health and Safety INCIDENT

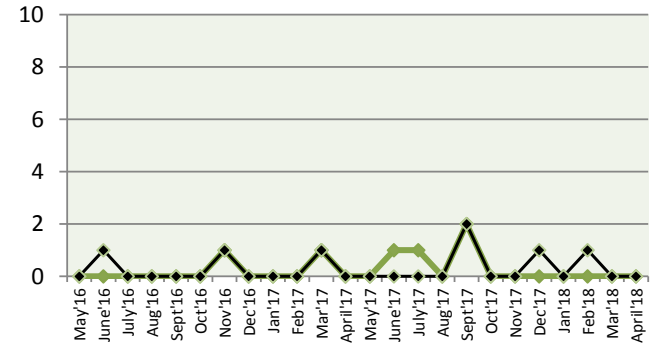
WORKPLACE VIOLENCE AND AGGRESSION
(From 2 Years Rolling)



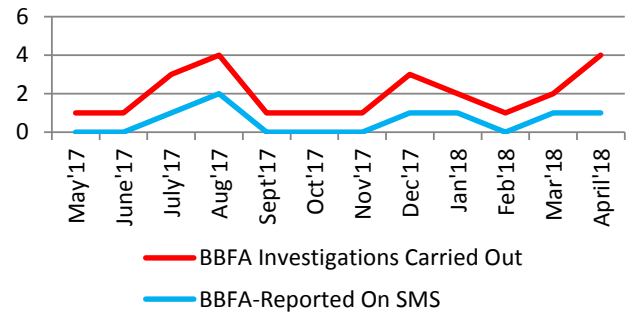
PHYSICAL ENVIRONMENT
(From 2 Years Rolling)



PATIENT HANDLING
(From 2 Years Rolling)

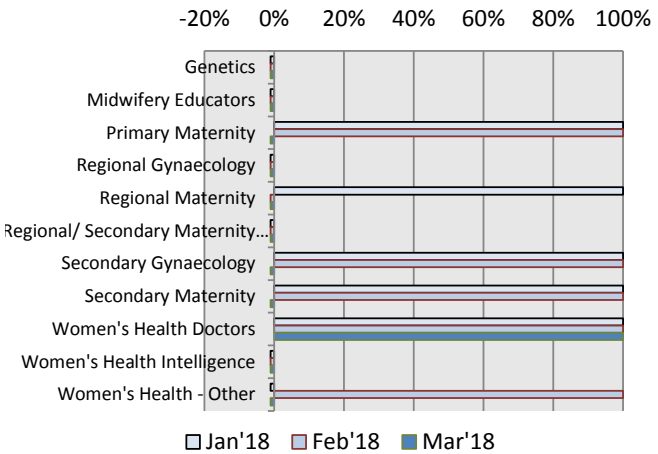


BLOOD AND BODY FLUID ACCIDENTS
(From 1 Year Rolling)



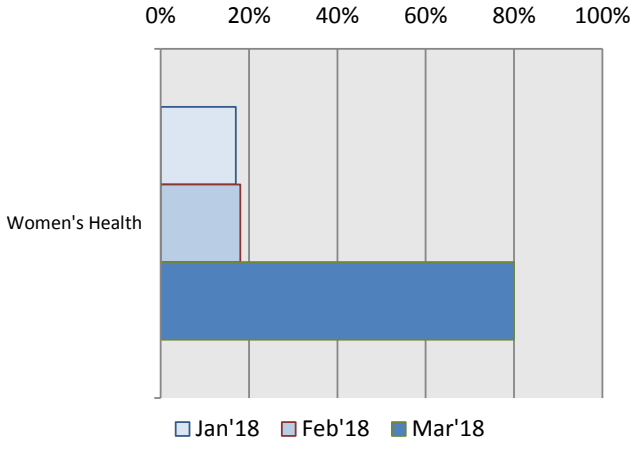
PRE-EMPLOYMENT SCREENING

TARGET	February'18	March'18	April'18
100%	100%	100%	RU



Health and Safety INCIDENTS INVESTIGATIONS *

TARGET	January'18	February'18	March'18
80%	17%	18%	80%

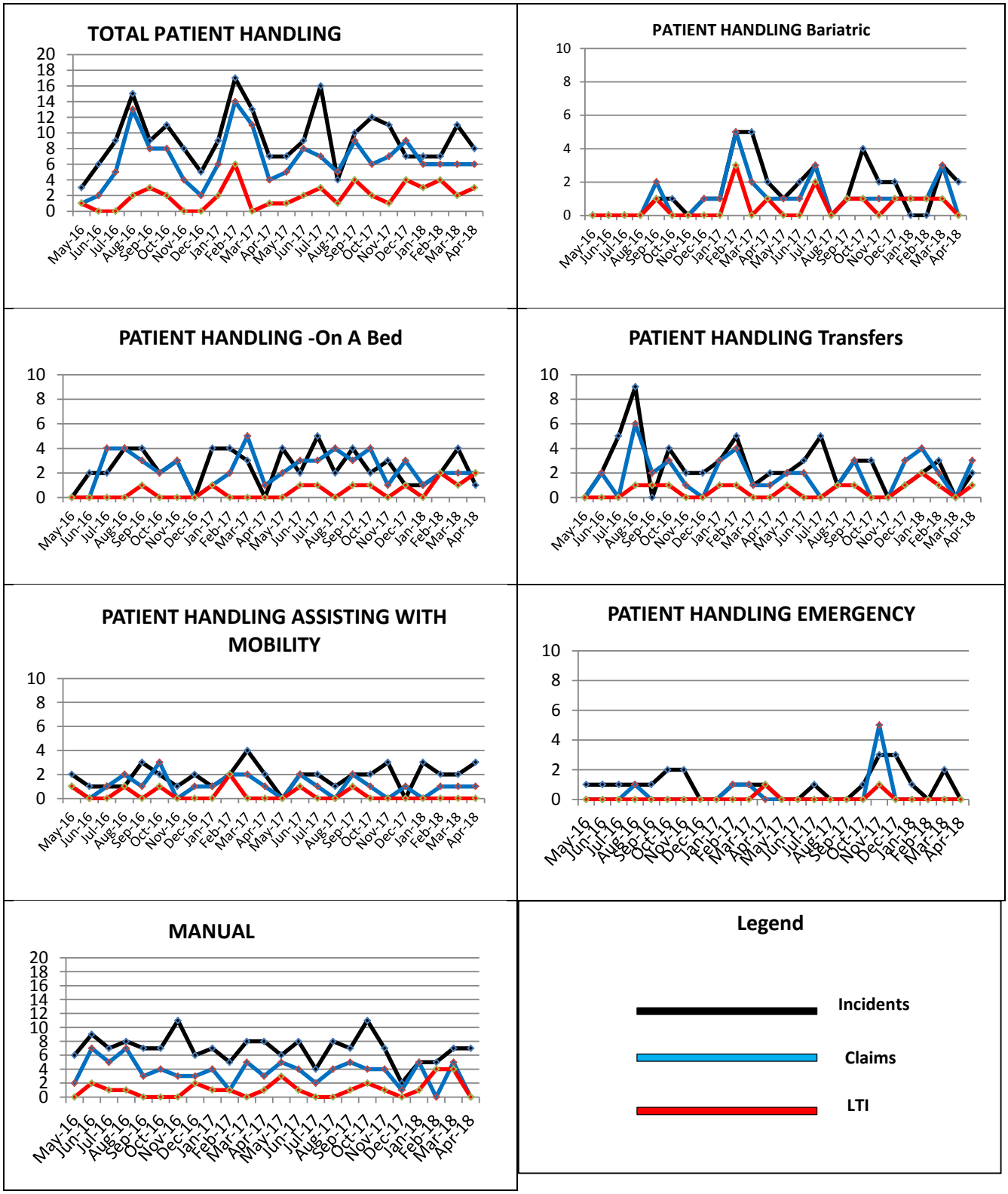


Information data accurate as of 03/05/2018

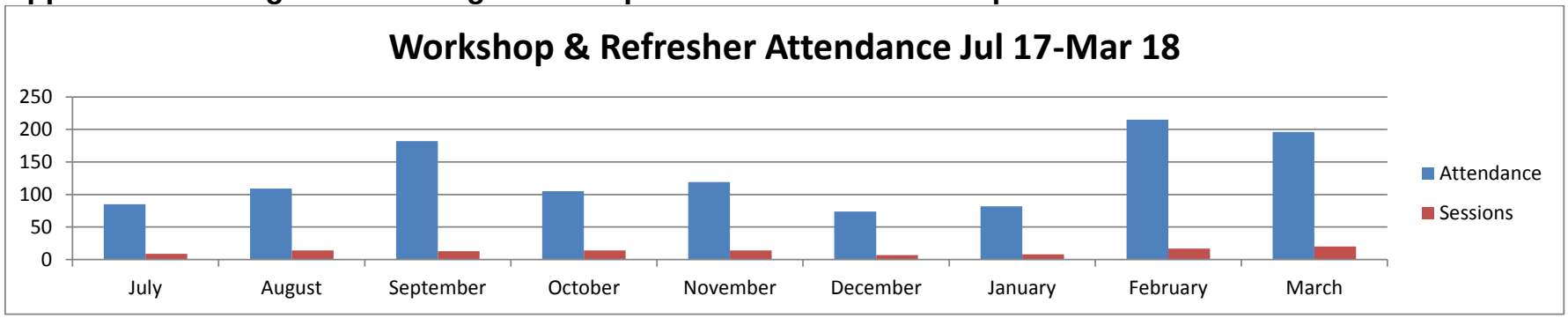
Appendix 1 Moving and Handling

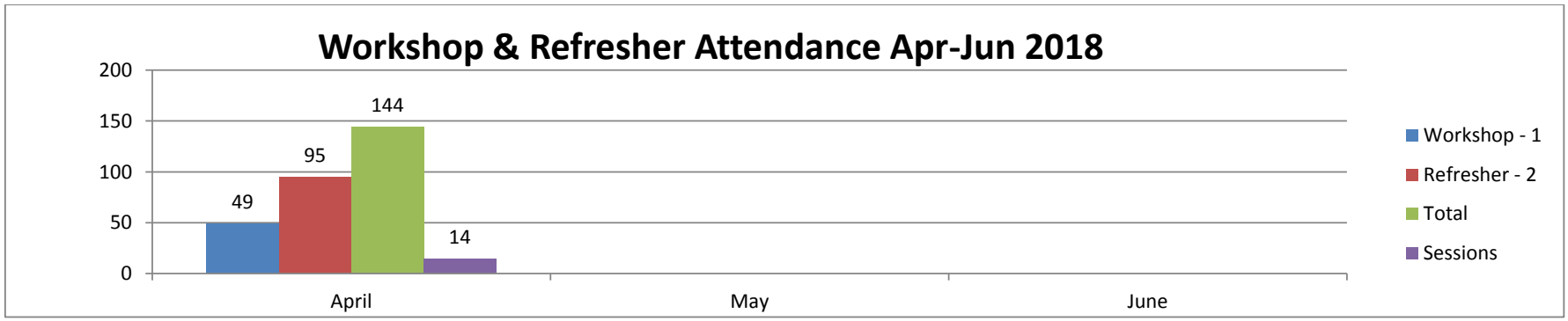
Please note; Incidents and Claims and Training Data for April 2018

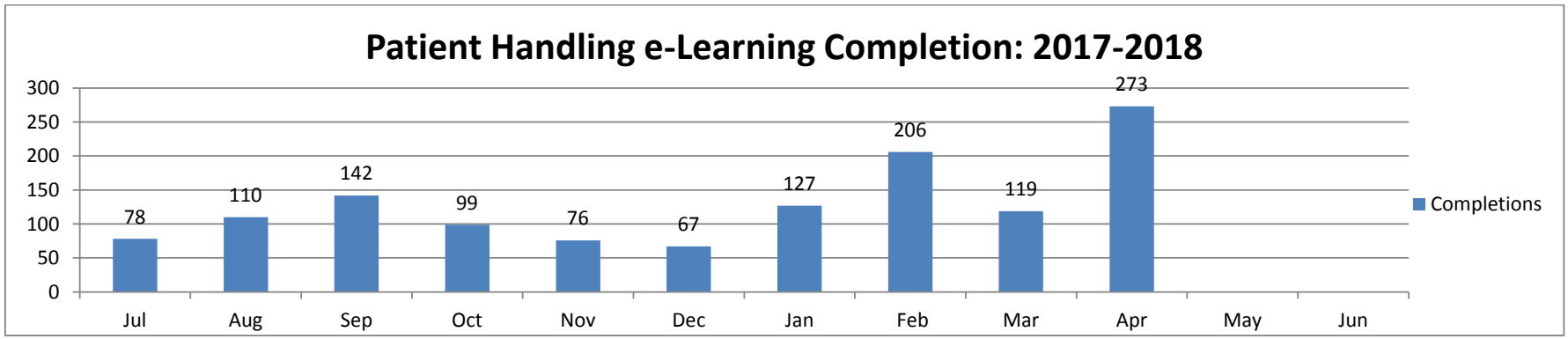
Table 5.1: Moving and Handling Injury causation



Appendix 2 Moving and Handling Workshops and Attendances for April 2018







Appendix 3 Workplace Violence April 2018

ADHB	Workplace Violence reported on Safety Management System (RISKPRO)				Workplace Violence reported on New Safety Management System				Workplace Violence CLAIMS
Directorate	April	%	YTD	%	April	%	YTD	%	April
Community & LTC	7	22%	32	8%	4	9%	46	11%	0
Adult Medical	5	16%	49	12%	4	9%	49	11%	0
Cancer & Blood	0	0%	6	2%	0	0%	5	1%	0
Cardio-Vascular	3	9%	9	2%	1	2%	8	2%	0
Children's Health	7	22%	21	5%	7	16%	35	8%	0
Clinical Support	0	0%	0	0%	2	5%	8	2%	0
Corporate	0	0%	0	0%	0	0%	5	1%	0
Mental Health	2	6%	224	56%	19	43%	226	53%	0
Patient Management Services	5	16%	7	2%	2	5%	10	2%	0
Perioperative	0	0%	5	1%	0	0%	2	0%	0
Surgery	3	9%	46	12%	4	9%	29	7%	1
Women's Health	0	0%	1	0%	1	2%	6	1%	0
Total ADHB	32		400		44		429		1

ADHB	Code Orange			
	April	%	YTD	%
ACH	88	74%	964	78%
Starship	21	18%	185	15%
Women's	2	2%	22	2%
GCC	4	3%	7	1%
Support Bldg	4	3%	59	5%
Total ADHB	119		1237	

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 Clinical Nurse Manager, Psychiatry Liaison and Security. Other personnel are utilised as required. All other team members and staff associated with the challenging behaviour/situation, follow the direction of the CNM to ensure management of the situation is effectively co-ordinated.

Appendix 4 Work plan to align Health and Safety systems and policies to Health and Safety at Work Regulations 2016

NO.	Element	#	Detail Action	Assigned to	Due Date	Status	Remark
1	Health and Safety Policy Reviews	1.1	Health and Safety Policy (Board policy)	MI	30/03/16	**Completed**	Policy published
		1.2	Health and Safety Committee Terms of Reference	MI	30/03/16	**Completed**	Policy published
		1.3	Hazard Identification and Risk Management	MI	30/03/16	**Completed**	Guideline published
		1.4	Health and Safety Occurrence reporting (Staff Incidents)	MI	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	MI/ BG	30/11/15	**Completed**	Policy now published
		1.6	Pre-Employment Health Screening	MI/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	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	MI	31/12/15	In progress	Consultation with all Directorate Health and Safety Committees now completed. The policy will now advance to organisation wide consultation vie document control and be tabled to the Board.
2	Health and Safety Information	2.1	Health and Safety intranet resign and content review to	DJ/DL	30/03/16	**Completed**	This review will include all Health and Safety advice sheets, forms, processes etc. on the

NO.	Element	#	Detail Action	Assigned to	Due Date	Status	Remark
			ensure all content is updated to reflect requirements of the new Health and Safety legislation and codes of practice released by WorkSafe NZ.				Health and Safety intranet site. New site how now been published in HIPPO
3	Training	3.1	Directing Safely: • Board, ELT and Directors • Apply legal requirements to operational environment • 2-3 hours	MI	30/03/16	Substantially Completed	Ko Awatea Learn course has been adapted and will be piloted in May.
		3.2	Managers: Managing Safely • Line managers • Full day • Pre-reading/assessment • Post course assignment	DJ/DL	30/03/16	**Completed**	Redesign of current managers course. Based on content of new Health and Safety legislation and Regulations and Health and Safety document reviews. Course schedule for 2017 published.
		3.3	Staff: Working Safely • Welcome Day • Health and Safety handbook/Ko Awatea Learn • Local Health and Safety Induction • Hazard specific training	DJ/DL	30/03/16	**Completed**	Review of current tools required to update and align to new legislation. Hazard specific training includes aggression relation safety training, and hazardous substance training
		3.4	Health and Safety Reps: • Health and Safety Rep Orientation • Core Training (NZQA) • Topic Training (CPD)	DJ/DL	30/03/16	**Completed**	Health and Safety Rep elections held in June 2016. External "Core" Training will be required. Supplier engaged. Courses for 2017 in KIOSK.

NO.	Element	#	Detail Action	Assigned to	Due Date	Status	Remark
4	On Line Hazard Register	4.1	On Line Hazard Management system: Install and train Directorates: • Sequential implementation (by Directorate) • One commenced per month throughout 2016 • Manager Training Health and Safety Rep training	DJ/DL	31/12/2016	**Completed**	Focus of this project has moved to preparing the services for transition to new Risk management software acquisition that is in final stages. Health and Safety is working with the Directorates to prepare for transition to Datix Hazard Register. Six 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)	MI	31/12/2017	**Competed**	New Safety management system went live in March. Health and Safety will support the transition to the new system.

Appendix 5 Definitions

Definitions for Monthly Performance Scorecard

Lost Time Injury Frequency Rate	LTIFR refers to the number of lost time injuries occurring in a workplace per one million man-hours worked. An LTIFR of seven, for example, shows that seven lost time injuries occur on a jobsite every one million man-hours worked. The formula gives a picture of how safe a workplace is for its workers. Lost time injuries (LTI) include all on-the-job injuries that require a person to stay away from work more than 24 hours, or which result in death or permanent disability. This definition comes from the Australian standard 1885.1– 1990 Workplace Injury and Disease Recording Standard.[1][2]
Lost Time Injuries	Any injury claim resulting in ONE or more full days lost time on an ACC45
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**
  An unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person's health or safety.

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

Auckland DHB Human Resources Report for Open Board

Recommendation

That the Board:

1. **Receives the Auckland DHB Human Resources report.**
2. **Notes the Auckland DHB Human Resources progress.**

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

Glossary

Acronym/term	Definition
HR	Human Resources
MALT	Māori Alliance Leadership Team
OD	Organisational Development
SMO	Senior Medical Officer

1. Board Strategic Alignment

Community, whānau 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 Human Resources policies, processes and forms. • Provide easily-accessed, consistent, quality support from Human Resources. • 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 Human Resources Operating Model to optimise funding, workflow and to enable us to move quickly on workforce opportunities.
Operational and financial sustainability	• Reduce time spent on Human Resources 'bureaucracy' to replace with value-add employment activity that enhances both the employee experience and patient care through effective individual, team and system development. • Creatively share resources and solutions with partner organisations. • Ensure employment terms and conditions are accurately implemented, mutually beneficial, affordable and fit for the future. • Evolve the workforce to ensure we have the right people, in the right place, in the right roles, at the right times, with the right skills.

2. Executive Summary

The purpose of this report is to provide the Board an update on the progress made towards delivering the Auckland DHB People Strategy objectives, in particular the five big actions/workstreams that sit within this.

3. Introduction/Background

At Auckland DHB, we strive to be a healthy community in all senses of the word: looking after each other so we can look after New Zealanders. Our People Strategy provides a pathway for working together over the next three years so that we can all continue to do our life's best work for our patients, our whānau and our communities.

Our people have a commitment to making a difference to patients and the community, achieving things we can all be proud of and satisfied with, fostering respect and belonging and continuing developing their skills and experience. In return, so that our staff can do their life's best work at Auckland DHB, we promise:

- Outstanding professional and personal development opportunities for everyone.
- To champion and support your physical and mental wellbeing, just as you do for those we serve.

- Transparency and fairness to ensure we can all live our values and commitments.

Over the next three years the Auckland DHB People Strategy will focus on five big actions to help us all role model a happy, healthy, high-performing community by:

1. Accelerating capability and skills
2. Making it easier to work here
3. Building constructive relationships
4. Delivering on our promises
5. Ensuring a quality start

These five big actions are summarised below with their Key Performance Indicators for 2017/2018:

Five Big Actions	Key Performance Indicator	Indicative measures
Accelerating capability and skills	1.1 Implementation of State Services Commission Talent and Leadership programme	Tiers 1/2 mapped, development plans implemented and profiling underway at the Career Board.
	1.2 Implementation of Auckland DHB Education Strategy/Plan	Strategy approved and action plan completed.
	1.3 Delivery of learnHR programme: online and face-to-face	learnHR utilisation/attendance achieves targets.
	1.4 Implementation of Change Framework	Change framework being used in organisational change plans.
Making it easier to work here	2.1 Workforce Central used by all employees	Elimination of manual/paper-based 'exceptions', where an online solution is available.
	2.2 Leader Upgrade	Successful implementation of Leader upgrade with no impact on employees or services through this process.
	2.3 Employment system/administration process improvements	Auckland DHB Manager Satisfaction with Human Resources (HR), achievement of askHR Service Standards, myHR accuracy.
	2.4 Values-based employment processes	Standard templates and resources for change and dispute management.
	2.5 Performance conversations recording and tracking	Delivery of Hospital Certification Action Item.
Building constructive relationships	3.1 Culture programme ('Values Part 2')	Completion of focus groups, and a draft co-designed solution for communicating who we are and how we behave when we're at our best.
	3.2 Employee engagement action plans	Quarterly reporting provided to Board, actions completed and employee engagement results increased.
	3.3 Complete Request for Proposal for 2018 Engagement Survey	Plan for re-survey in 2018 is complete.
	3.4 Complete Values Workshops	95% of Auckland DHB teams have

	across all teams	completed a Values workshop.
	3.5 Implement the People Strategy Communications Plan	Auckland DHB people understand and are involved in People Strategy deliverables.
Delivering on our promises	4.1 Embedding the 'Speak Up' programme	Awareness and use of 'Speak Up'.
	4.2 Effective Wellbeing Committee and Wellbeing Action Plan	Positive employee feedback about commitment to wellbeing.
	4.3 Remuneration Strategy implementation	Rem Strategy commitments met.
	4.4 Quality People Metrics dashboards and insights	Accurate and informative People Dashboards prepared in line with Board Reporting timelines.
	4.5 Scoping Early Intervention software/data analysis	Business case for Early Intervention programme approved.
Ensuring a quality start	5.1 Management Development Programme rollout	Management Development Programme uptake targets achieved.
	5.2 Recruitment strategy implementation	Reduced time to hire and effective hiring for values-fit.
	5.3 Māori Alliance Leadership Team action plans	Māori/Pacific Recruitment and Action Plan Targets on-track.
	5.4 Taleo transition and onboarding internal roles	Reduced time and improved onboarding experience.
	5.5 Rangatahi Programme	Contractual commitments met and conversion of participants into Health roles.

4. Progress/Achievements/Activity

Progress on the Key Performance Indicators for the five big actions within the Auckland DHB People Strategy are as follows:

Accelerating Capability and Skills

1.1 Implementation of State Services Commission Talent and Leadership programme

- Facilitated session with the Executive Leadership Team to agree on a high level approach and their role in it. First development conversations have been set up for Chief Executive's direct reports.
- The Leadership Success Profile which describes what good leadership looks like is being used to revise the 360 in use on the Auckland DHB's Leadership Development Programme.
- Starting to use the tools in other leadership development conversations.
- Chief Executive to present first Auckland DHB opportunity at Auckland Career Board 20 April 2018.

1.2 Implementation of Auckland DHB Education Strategy/Plan

- Senior Leadership Team endorsed the Education Strategy. Detailed plans and timelines for the streams of work are now being set up.

1.3 Delivery of learnHR programme – online and face-to-face

- The calendar for this voluntary lunchtime seminar programme for management and employee development is set for 2018 and is available via myHR on Hippo. The March 2018 Workshops addressed Recruitment and Reputation, jointly led by General Manager Jennie Montague and Recruitment Manager Don Fulford.
- The April 2018 topic is having Good Performance Conversations. A panel consisting of Senior Medical Officers (SMOs), Directors of Nursing and HR will talk about their experiences and take questions.

1.4 Implementation of Change Framework

- Due to the personal circumstances of the Practice Lead, this work has not progressed since the last report (she is supporting her terminally ill mother overseas).

Making it easier to work here

2.1 Workforce Central used by all employees

- Workforce Central went live as planned on 16 April 2018, with positive feedback. There are currently approx 1,300 employees still to be implemented. The restart for implementation to resume is being planned.

2.2 Leader Upgrade

Kiosk was moved onto the new infrastructure in April 2018. There has been a delay in moving Leader as we continue to identify and resolve issues with the interfaces. This has not yet impacted on the overall go-live date.

2.3 Employment systems/administration process improvements

- We are awaiting our resource for online forms to start in May 2018 in order to resume this work.

2.4 Values-based employment processes

- The redesign and rationalisation of employment templates and review of processes is underway to ensure the language and approach reflects our values no matter how challenging the employment intervention. A first tranche of letter templates is almost complete, together with a process outline for dealing with employment matters.

2.5 Performance conversations recording and tracking

- The system went live on 9 October 2017, resolving the Hospital Certification Improvement Action Item.
- Broad training for people leaders commences in May 2018, after the learnHR Workshops (see previous page). They consist of Conversation Skills Workshops and clinics for issues while using Kiosk for recording purposes.

Building Constructive Relationships

3.1 Culture programme

- Discovery meetings held with Southern Cross and Loma Linda University Medical Centre, California. Interesting lessons learned by both organisations regarding the inter-connectedness of culture with leadership, strategy and systems.
- Communications have gone out inviting our people to have their say by sharing real situations and helpful solutions from their own experiences working here.
- There are a number of accessible, different ways for people to be involved and share their stories that will run throughout May 2018. These include:
  - Small group workshops: 9 May 2018: Focus Groups 1, 2 and 3 Auckland City Hospital; 10 May 2018: Focus Groups 4, 5 and 6 Greenlane Clinical Centre
  - One-to-one interviews with people from deliberately selected demographic groups between 2-11 May 2018
  - Walk-through sessions and Drop-in sessions across our sites from 21 May-8 June 2018
  - Organisation wide survey early June 2018

3.2 Employee engagement action plans

- Quarterly reporting on Engagement Action Plans continues across Directorates. Some case studies of good practice are emerging (e.g. Clinical Transcription team).

3.3 Complete Request for Proposal for 2018 Engagement Survey

- The Request for Proposal for our Employee Survey is now loaded onto the Government Electronic Tenders Service site. We expect to run the next Employee Survey in late 2018 - two years on from the last survey.

3.4 Complete Values Workshops across all teams

- During March and April 2018, a significant number of Values Workshops were facilitated by HR across Non Clinical Support (Orderlies and Cleaners) and in Clinical Support Services.
- We are working towards a clear understanding of the baseline level of completed Values Workshops. There is clearly a big variation between Directorates which will mean targeted work to achieve the required outcomes.
- A number of methods for employees to access refresher values discussions have been established, from selected external facilitators who can run Values Workshops to 'bite-sized' conversation guides for team leaders. Uptake will be monitored quarterly.

3.5 Implement the People Strategy Communications Plan

- Dedicated Communications resource has been budgeted for, but has still not been filled. The communications plan and events calendar agreed with the Communications Team is now a standing agenda item at HR Leadership Team's monthly Strategy Review Meeting.

Delivering on our Promises

4.1 Embedding the 'Speak Up' programme

- We have started the second phase of embedding the 'Speak Up' programme within Auckland DHB with work continuing on the development of a manager's coaching framework on how to effectively respond to 'Speak Up' submissions.
- Preparations for Pink Shirt Day, with the emphasis on kindness to each other, are underway. Pink Shirt Day is on 18 May 2018.

4.2 Effective Wellbeing Committee and Wellbeing Action Plan

- The first draft of the Wellbeing Strategy and Plan is due to be presented to the Executive Leadership Team in May 2018. It is based on the World Health Organisation's Wellbeing Framework.
- The Schwartz Rounds now sit with this work and will be run by the Organisational Development (OD) Team, rather than Palliative Care. We would like to acknowledge the significant work by Dr Anne O'Callaghan and Dr Sham Shah to get the Schwartz relationship up and running. The Schwartz Center for Compassionate Healthcare's mission is simple but compelling: to promote compassionate care so that patients and their caregivers relate to one another in a way that provides hope to the patient, support to caregivers and sustenance to the healing process. We are the first Schwartz hospital in Australasia.

4.3 Remuneration Strategy implementation

- The Thrive programme (lower income workers) strategy has been endorsed by the Executive Leadership team with implementation planning now underway. An offer and acceptance for the Supportive Employment fixed term position has taken place. This role will commence on 30 April 2018 to support the programme around providing a stronger employment proposition for potential employees from the youth market and for those with disabilities or mental health needs.

4.4 Quality People Metrics dashboards and insights

- Revised dashboard and reporting has been developed and is in testing, before being presented to the HR Subcommittee in June 2018.

4.5 Scoping Early Intervention software/data analysis

- There is no existing healthcare focused software available. A teleconference took place with a company in the USA who provided the software to New Zealand Police. This will be a long-term programme.

Ensuring a Quality Start

5.1 Management Development Programme rollout

- With 90 views, 22 expressions of interest and 10 final applications, the shortlisting meeting to bring down to 3 or 4 providers to present to the selection panel takes place 23 April 2018. The presentations are set for 17-21 May 2018. The panel includes SMO, Allied Health, Nursing and HR representatives.

5.2 Recruitment strategy implementation

- Recrutiment Strategy has been endorsed by the Executive Leadership Team. The first phase is underway - a formal review of the Recruitment Function. Feedback has been solicited from a wide range of hiring managers and HR. We are working through the feedback with the support of externals (led by Fiona Barrington) and will be in a position to design an appropriate Model of Service by early May 2018.

5.3 Māori Alliance Leadership Team action plans

- Māori Alliance Leadership Team (MALT) action plans are progressing in line with milestones, expedited by the separation of the MALT Strategy and Working Groups. There is a great deal of work taking place in the fields of recruitment and development, as well as significant data analytics and reporting.

5.4 Taleo transition and onboarding internal roles

- Go-live set for 1 May 2018. We are on track to meet this. The Senior Leadership Team appreciated the benefits the automation will bring.

5.5 Rangatahi Programme

- We are working with the new Te Rūnanga o Ngāti Whātua to create a refreshed Rangatahi Progarmme for Auckland and Waitemata DHBs, formalising a more regional approach for the first time.

In addition:

- Rachel Masters joined us from Rusell McVeigh Auckland, at the end of March 2018. She takes over the Quality Start portfolio previously held by Natasha Cherrie.
- We have made an offer of employment for the OD Practice Leader - Supportive Employment role. The role commences 30 April 2018.

Regional Collaboration

- The metro-Auckland OD group met on 19 April 2018 to share thinking, tools and materials and to continue to ensure alignment and reduce duplication of effort and resources across the region.

5. Conclusion

This report has provided the Board an update on the progress made towards delivering the Auckland DHB People Strategy objectives, in particular the five big actions/workstreams that sit within this.

Financial Performance Report for the 9 Months ending 31 March 2018

Recommendation

That the Board receive this Financial Report for the 9 months ending 31 March 2018

6.1

Prepared by: Rosalie Percival, Chief Financial Officer
Date: 5 May 2018

1. Executive Summary

The 2017/18 year financial plan is for a breakeven result. Underlying assumptions with inherent risk for achieving the planned result include additional funding assumed for IDF price adjustors for the Auckland metro DHBs for 2016/17 ($6.5M) and 2017/18 ($3.3M), funding for transplants ($3.5M) and the $19M savings plan.

Performance for the month of March 2018 against the 2017/18 Annual Plan shows a net deficit of $3.7M which was favourable by $0.09M to the budget of $3.8M.

Performance for the year to date (YTD) shows a net surplus of $9M which was unfavourable by $0.5M to the budget of $9.5M. The overall YTD net surplus unfavourable variance of $0.5M is made up as follows:

Result by Division	**YTD (9 months ending 31 Mar-18)**		
	Actual	**Budget**	**Variance**
Funder	12,718	5,427	7,291 F
Provider	(5,117)	4,048	9,165 U
Governance	1,371	0	1,371 F
Net Surplus / (Deficit)	**8,972**	**9,474**	**503 U**

- The favourable Funder arm result is primarily due to favourable demand driven expenditure across pharmaceuticals, laboratories, disability services and also in IDF outflows.
- The unfavourable Provider arm result is primarily revenue driven, with revenue less than budget by $17M mainly reflecting Auckland metro IDF pricing revenue not yet realised, provisions for IDF wash-ups and various other movements across revenue categories.
- The favourable Governance result is mainly due to less expenditure than budgeted for outsourced funder services and infrastructure costs (mainly IT).

2. Summary Result and Financial Commentary for March 2018

$000s	Month (Mar-18)			YTD (9 months ending 31 Mar-18)			Full Year (2017/18)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Income									
Government and Crown Agency	121,685	122,303	618 U	1,091,362	1,100,361	8,999 U	1,463,504	1,467,414	3,910U
Non-Government and Crown Agency	8,610	7,594	1,016 F	64,973	68,109	3,136 U	88,987	90,962	1,975U
Inter- District Flows	53,240	51,406	1,835 F	452,604	462,651	10,046 U	610,926	616,867	5,941U
Inter-Provider and Internal Revenue	1,145	1,903	758 U	5,735	16,907	11,172 U	16,252	22,715	6,463U
Total Income	**184,680**	**183,205**	**1,474 F**	**1,614,674**	**1,648,028**	**33,353 U**	**2,179,669**	**2,197,958**	**18,289U**
Expenditure									
Personnel	80,705	81,740	1,035 F	692,886	706,565	13,678 F	946,149	951,733	5,584F
Outsourced Personnel	2,534	1,204	1,330 U	20,413	10,837	9,576 U	23,010	14,450	8,560U
Outsourced Clinical Services	2,745	3,259	514 F	22,635	27,680	5,045 F	36,700	37,209	509F
Outsourced Other Services	5,597	5,766	169 F	50,558	51,892	1,334 F	68,695	69,189	494F
Clinical Supplies	23,445	23,900	455 F	203,757	203,913	157 F	274,196	274,138	58U
Funder Payments - NGOs and IDF Outflows	56,374	54,423	1,950 U	466,644	489,810	23,165 F	621,510	653,079	31,569F
Infrastructure & Non-Clinical Supplies	17,019	16,741	278 U	148,808	147,856	953 U	209,409	198,160	11,249U
Total Expenditure	**188,419**	**187,034**	**1,385 U**	**1,605,702**	**1,638,553**	**32,850 F**	**2,179,669**	**2,197,958**	18,289F
Net Surplus / (Deficit)	**(3,739)**	**(3,828)**	**89 F**	**8,973**	**9,474**	**503 U**	**0**	**(0)**	**0 F**

Result by Division	Month (Mar-18)			YTD (9 months ending 31 Mar-18)			Full Year (2017/18)		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funder	616	603	13 F	12,718	5,427	7,291 F	28,566	7,236	21,329 F
Provider	(4,447)	(4,431)	16 U	(5,117)	4,048	9,165 U	(28,736)	(7,236)	21,500 U
Governance	92	0	92 F	1,371	0	1,371 F	171	0	171 F
Net Surplus / (Deficit)	**(3,739)**	**(3,828)**	**89 F**	**8,972**	**9,474**	**503 U**	**0**	**0**	**0 F**

Commentary on DHB Consolidated Financial Performance

Month Result - Major variances to budget on a line by line basis are described below:

Revenue is favourable to budget by $1.5M (0.8%) and mainly driven by:

- $1M (13.4%) favourable Non-Government and Crown Agency revenue, largely due to Non-Resident patients' income higher than anticipated this month.
- $1.8M (3.6%) favourable Inter-District Flows, reflecting favourable PHO wash-ups and a prior year IDF inflow wash-up related to Community Pharmacy.

Expenditure is unfavourable to budget by $1.4M (-0.7%) mainly driven by:

- $2M (-3.6%) unfavourable in Funder Payments to NGOs and IDF Outflows, which is largely from unfavourable movements in Health of Older People expenditure, mostly due to pay equity costs, and in Mental Health services, due to back dated cost provisions for increased levels of residential care and additional services provided.

The unfavourable variances in expenditure above are offset by various minor favourable and unfavourable movements across other expense categories.

Year to Date Result - Major variances to budget on a line by line basis are described below.

Total Revenue is unfavourable to budget by $33M (-2.0%), mainly driven by:

- $9M (-0.8%) unfavourable variance in Government and Crown Agency revenue, due to unfavourable movement in the MOH side contract income for both the Funder ($5M) and Provider ($4M). These are mostly in line with services delivered.
- $3M (-4.6%) unfavourable variance in Non-Government and Crown Agency revenue is mainly in Patient income ($1M) and Other Income ($2.2M) due to revenue targets yet to be achieved.
- $10M (-2.2%) unfavourable IDF inflow revenue variance includes: Funder IDF wash-up provisions for under delivered services and funding initiatives not yet realised.

- $11M (-66.1%) unfavourable Inter-Provider and Internal revenue variance includes: Additional revenue assumed for budget initiatives (including IDF pricing adjustor for metro Auckland DHBs) not yet realised and Provider provision for IDF wash-ups for inpatient services that are below contract.

Total expenditure is $33M (2.0%) favourable, mainly driven by:

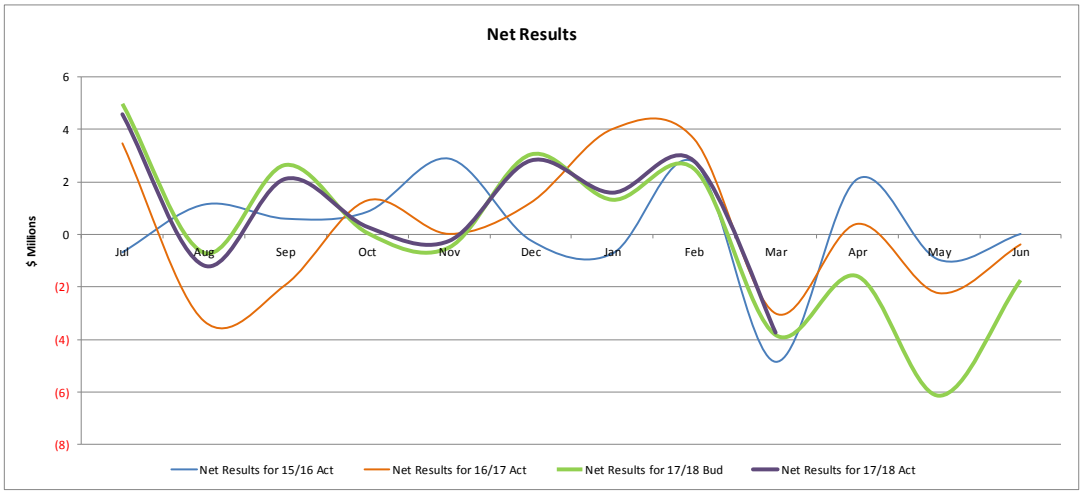
- $4.1M (0.6%) favourable variance in Personnel/Outsourced Personnel costs - this movement primarily reflects personnel being 93 FTE (1.0%) below budget. This favourable variance includes an offset of $2.6M reflecting the increase in the estimated costs for expired MECAs.
- $5M (18.2%) favourable variance in Outsourced Clinical Services from outsourced volumes for Orthopaedics and Ophthalmology elective surgery being below the phased contract.
- $23M (4.7%) favourable variance in NGO costs and IDF Outflows reflecting: expected variations across Funder services which mostly arise out of monthly demand/utilisation variances in Community Pharmacy, Age Related Residential Care and Primary Health Organisations, and it includes an offsetting Pay Equity costs being higher than budget to date. The YTD variance also includes upsides in IDF outflow wash-up and service change for decrease in dental volumes.

Forecast Result

The year end forecast is now a breakeven result as planned reflecting updated transplant revenue expectations for 2017/18, review of current performance and risks relating to IDF wash-ups, cancer treatment costs, and IDF pricing issues.

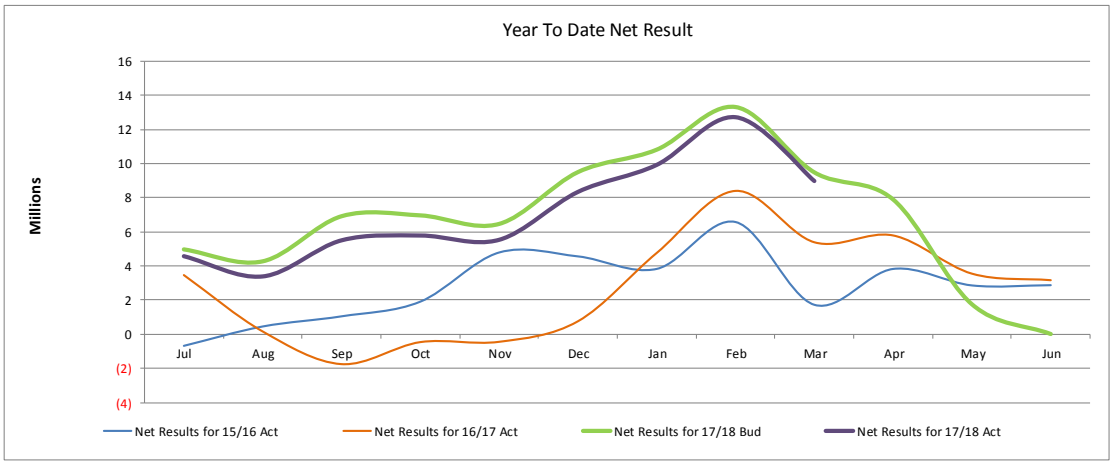
3. Performance Graphs

Figure 1: Consolidated Net Result (Month)



$ millions	July	August	Spetember	October	November	December	January	February	March	April	May	June	Total
Net Results 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 Results for 16/17 Act	3.462	(3.302)	(1.914)	1.290	0.017	1.203	4.004	3.636	(3.010)	0.398	(2.238)	(0.384)	3.162
Net Results for 17/18 Bud	4.968	(0.700)	2.641	0.052	(0.501)	3.036	1.316	2.498	(3.828)	(1.590)	(6.139)	(1.743)	0.008
Net Results for 17/18 Act	4.569	(1.187)	2.114	0.283	(0.252)	2.806	1.585	2.793	(3.739)				8.972

Figure 2: Consolidated Net Result (Cumulative YTD)



$'millions	July	August	September	October	November	December	January	February	March	April	May	June
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
Net Results for 16/17 Act	3.462	0.159	(1.755)	(0.465)	(0.448)	0.755	4.759	8.394	5.385	5.783	3.545	3.162
Net Results for 17/18 Bud	4.968	4.267	6.908	6.960	6.459	9.495	10.810	13.308	9.480	7.890	1.751	0.008
Net Results for 17/18 Act	4.569	3.382	5.497	5.779	5.527	8.333	9.919	12.712	8.972			
Variance to Budget 17/18	(0.399)	0.885	1.411	1.180	0.931	1.161	0.891	0.597	0.508			

4. Efficiencies/Savings

The savings target for 2017/18 in the financial plan is $19M, with all of the savings planned to be generated within the Provider Arm.

Auckland DHB has generated significant savings over the past few years, in excess of $211M. However, the savings are becoming more difficult to find and deliver. To improve savings delivery capability, the DHB has implemented a Financial Sustainability Program to ensure continuous identification, assessment (risk and achievability), implementation and monitoring of savings initiatives.

Savings of $8.3M have been achieved against a target of $12.6M YTD as summarised in the table below. The forecast is to deliver the full year savings in line with the total agreed budget.

March 2018 Year to Date Position

2017/18 Savings Programme	Ytd Actual	Ytd Target	Ytd Variance	Traffic Light	Full Year Forecast	Full Year Target	Full Year Variance
Bring Outsourcing In-House	451	630	-179	🔴	772	1,068	-296
Capex - Invest to Save	567	753	-186	🔴	1023	1,209	-186
Clinical Pathway	467	699	-232	🔴	883	1,209	-326
Cost Containment	1278	2,820	-1,542	🔴	1886	3,984	-2,098
Procurement & Supply Chain	2163	2,949	-786	🔴	3345	4,478	-1,133
Revenue Growth	2362	3,996	-1,634	🔴	5570	5,333	237
Using the Hospital Wisely	1054	780	274	🟢	1800	1,560	240
Total	8,342	12,627	-4,285	🔴	15,279	18,841	-3,562

Commentary on YTD Performance

- **Bring Outsourcing In-House [YTD $179k U] -** The small unfavourable variance YTD reflects delayed savings in the Outpatients workstream.

- **Capex - Invest to Save [YTD $186k U] -** The unfavourable variance YTD is due to the delayed savings for the Interpreter initiatives which are now forecast to start from May 2018.

- **Clinical Pathways [YTD $232k U] -** The unfavourable variance YTD is due to the delayed review of clinical pathways in Child Health and Women's. This is being progressed, with work underway to scope the areas and associated cost containment.

- **Cost Containment [YTD $1,542k U] -** We continue to monitor cost against volumes and manage discretionary spend.

- **Procurement & Supply Chain [YTD $786k U] -** HealthAlliance savings of $857k are reported against a budget of $1,295k.

- **Revenue Growth [YTD $1,634k U] -** The key driver of the unfavourable variance is additional IDF volumes below plan which has been significantly influenced by high acute volumes. Further revenue opportunities have been identified, meaning an overall forecast of $240k F position at year end.

- **Using the Hospital Wisely [YTD $274k F] -** High level projects include: Cellulitis Pathways, Palliative Care, Day of Surgery Admission (DOSA), and Discharge Planning. Although savings were phased from January 2018, savings have been realised since July 2017 and are tracking on budget for the full year.

Pipeline for further service improvement

The program has identified the following initiatives with potential to generate further savings and work is underway to refine and inform the savings and timing.

Project	Project Status
Loss Making Services	• Bone Marrow Transplant review is complete, key findings indicated that the service will be overall profitable for 17-18, and cost neutral in 2018-19. Opportunities have been identified for possible cost containment, which have been passed to the service. • Vascular review is complete. Key findings have identified potential opportunities and areas for further investigation by the service. • Neurosurgery review is complete. Key findings have identified potential opportunities and areas for further investigation by the service. • ORL and Orthopaedics are underway. • In total, eleven services have been identified and prioritised for review.
Outpatients	Benefit scoping underway
Our People	Scoping

5. Financial Position

5.1 Statement of Financial Position as at 31 March 2018

$'000	31-Mar-18			28-Feb-18	Variance	30-Jun-17	Variance
	Actual	Budget	Variance	Actual	Last Month	Actual	Last Year
Public Equity	881,298	881,298	0F	881,298	0F	881,298	0F
Reserves							
Revaluation Reserve	515,639	515,639	0U	515,639	0F	515,639	0U
Accumulated Deficits from Prior Year's	(458,009)	(458,009)	0U	(458,009)	0F	(461,173)	3,164F
Current Surplus/(Deficit)	8,974	9,476	502U	12,713	3,739U	3,164	5,810F
	66,604	67,106	502U	70,343	3,739U	57,630	8,974F
Total Equity	**947,902**	**948,404**	**502U**	**951,641**	**3,739U**	**938,928**	**8,974F**
Non Current Assets							
Fixed Assets							
Land	321,582	321,582	0F	321,582	0F	321,582	0F
Buildings	560,946	562,090	1,144U	562,906	1,960U	576,044	15,098U
Plant & Equipment	82,470	86,249	3,779U	82,486	16U	90,502	8,031U
Work in Progress	60,320	105,757	45,437U	54,092	6,228F	35,892	24,428F
Total PPE	1,025,319	1,075,678	50,359U	1,021,067	4,252F	1,024,020	1,299F
Investments							
- Health Alliance	63,243	60,512	2,731F	63,243	0F	57,936	5,308F
- HZHPL	12,420	12,420	0U	12,420	0F	12,420	0F
- ADHB Term Deposits > 12 months	3,326	-	3,326F	2,337	989F	-	3,326F
- Other Investments	685	684	1F	685	0F	685	0F
	79,674	73,616	6,058F	78,685	989F	71,041	8,634F
Intangible Assets	540	1,205	666U	596	57U	995	456U
Trust Funds	12,954	14,625	1,671U	13,128	175U	14,625	1,671U
	93,168	89,446	3,722F	92,410	758F	86,660	6,507F
Total Non Current Assets	**1,118,486**	**1,165,124**	**46,638U**	**1,113,476**	**5,010F**	**1,110,680**	**7,806F**
Current Assets							
Cash & Short Term Deposits	134,829	67,303	67,526F	112,146	22,682F	72,178	62,650F
Trust Deposits > 3months	13,783	13,000	783F	13,785	3U	13,000	783F
ADHB Term Deposits > 3 months	30,000	-	30,000F	30,000	0F	11,000	19,000F
Debtors	26,671	23,990	2,681F	27,995	1,324U	30,990	4,319U
Accrued Income	38,668	63,432	24,764U	38,490	178F	56,432	17,764U
Prepayments	2,143	5,027	2,884U	2,802	659U	5,027	2,884U
Inventory	14,238	13,882	356F	13,793	445F	13,882	356F
Total Current Assets	**260,331**	**186,634**	**73,697F**	**239,011**	**21,320F**	**202,509**	**57,821F**
Current Liabilities							
Borrowing	(780)	(2,094)	1,314F	(494)	286U	(494)	286U
Trade & Other Creditors, Provisions	(187,836)	(162,696)	25,140U	(170,557)	17,278U	(144,178)	43,657U
Employee Entitlements	(196,644)	(188,754)	7,890U	(186,703)	9,941U	(186,179)	10,465U
Funds Held in Trust	(1,275)	(1,263)	12U	(1,275)	0U	(1,263)	12U
Total Current Liabilities	**(386,534)**	**(354,807)**	**31,727U**	**(359,029)**	**27,505U**	**(332,114)**	**54,419U**
Working Capital	**(126,204)**	**(168,173)**	**41,969F**	**(120,018)**	**6,185U**	**(129,605)**	**3,402F**
Non Current Liabilities							
Borrowings	(2,607)	(6,773)	4,166F	(44)	2,563U	(373)	2,234U
Employee Entitlements	(41,774)	(41,774)	0F	(41,774)	0F	(41,774)	0F
Total Non Current Liabilities	**(44,381)**	**(48,547)**	**4,166F**	**(41,818)**	**2,563U**	**(42,147)**	**2,234U**
Net Assets	**947,902**	**948,404**	**502U**	**951,641**	**3,739U**	**938,928**	**8,974F**

Commentary

The major variances to budget are summariesed as:

Property, Plant and Equipment:
The variance reflects capital expenditure tracking below budget YTD. Budgeted capital spend is based on timing of implementation of capital projects as advised by services which may vary due to timing of capital approval, procurement and implementation timeframes.

Cash and Short Term Deposits:
The higher than budgeted balance reflects impact of the delay in the capital program on cash, lower than budgeted payments to providers / suppliers and favourable timing of MoH budgeted revenue received.

Debtors and Accrued Income:
Accrued income is $25M below budgeted levels due to the timing of receipts from the Ministry of Health, the favourable timing is reflected in the higher than budgeted cash on hand balance.

Trade and Other Creditors, Provisions:
Is made up of:

	$000's
Trade Creditors (including accruals)	165,938
Income in Advance	21,798
Provisions (Litigation)	100
Total	187,836

5.2 Statement of Cash flows (Month March 2018)

$000's	Month (Mar-18)			YTD (9 months ending 31 Mar-18)		
	Actual	Budget	Variance	Actual	Budget	Variance
Operations						
Cash Received	188,147	182,742	5,405F	1,639,553	1,643,979	4,426U
Payments						
Personnel	(70,764)	(81,740)	10,976F	(682,422)	(703,988)	21,566F
Suppliers	(33,887)	(42,209)	8,322F	(348,341)	(359,959)	11,618F
Capital Charge	0	0	0F	(27,561)	(27,411)	150U
Payments to other DHBs and Providers	(56,374)	(54,423)	1,951U	(466,644)	(489,807)	23,163F
GST	1,678	0	1,678F	1,672	0	1,672F
	(159,346)	**(178,372)**	19,026F	**(1,523,296)**	**(1,581,165)**	57,869F
Net Operating Cash flows	**28,801**	**4,370**	**24,431F**	**116,257**	**62,814**	**53,443F**
Investing						
Interest Income	528	463	65F	4,103	4,049	54F
Sale of Assets	26	0	26F	32	0	32F
Purchase Fixed Assets	(8,521)	(9,757)	1,236F	(34,183)	(79,809)	45,627F
Investments and restricted trust funds	(1,000)	0	1,000U	(26,079)	8,425	34,504U
Net Investing Cash flows	**(8,967)**	**(9,294)**	**327F**	**(56,127)**	**(67,335)**	**11,209F**
Financing						
Interest paid	2,849	(40)	2,889F	2,520	(360)	2,880F
New loans raised	0	0	0F	0	0	0F
Loans repaid	0	0	0F	0	0	0F
Other Equity Movement	0	1	1U	0	6	6U
Net Financing Cashflows	**2,849**	**(39)**	**2,888F**	**2,520**	**(354)**	**2,874F**
Total Net Cash flows	**22,682**	**(4,963)**	**27,645F**	**62,650**	**(4,875)**	**67,526F**
Opening Cash	112,146	72,266	39,880F	72,179	72,178	0F
Total Net Cash flows	22,682	(4,963)	27,645F	62,650	(4,875)	67,526F
Closing Cash	**134,829**	**67,303**	**67,525F**	**134,829**	**67,303**	**67,526F**

ADHB Cash	133,034	64,802	68,232F
A+ Trust Cash	1,464	916	548F
A+ Trust Deposits - Short Term < 3 months & restricted fund deposits	331	1,585	1,254U
	134,829	**67,303**	**67,526F**
ADHB - Short Term > 3 months	30,000	0	30,000F
A+ Trust Deposits - Short Term > 3 months	13,783	13,000	783F
ADHB Deposits - Long Term	0	0	0F
A+ Trust Deposits - Long Term	16,280	14,625	1,655F
Total Cash & Deposits	**194,891**	**94,928**	**99,963F**

Planning Funding and Outcomes Update

Recommendation

That the Board note the key activities within the Planning, Funding and Outcomes Unit since the last update provided on 11 April 2018.

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), Dr Karen Bartholomew (Acting Director, Health Outcomes)

Glossary

AAA	-	Abdominal Aortic Aneurysm
ACC	-	Accident Compensation Corporation
ARC	-	Aged Residential Care
ARDS	-	Auckland Regional Dental Service
ARPHS	-	Auckland Regional Public Health Service
ARRC	-	Age Related Residential Care
CPHAC	-	Community and Public Health Advisory Committee
DHB	-	District Health Board
DMFT	-	Decayed, Missing or Filled Teeth
EP	-	Electrophysiology
ESPI	-	Elective Services Performance Indicators
HCSS	-	Home and Community Support Services
HNA	-	Health Needs Assessment
HPV	-	Human Papilloma Virus
HVAZ	-	Healthy Village Action Zones
ICD	-	International Classification of Diseases
IDF	-	Inter District Flows
MMR	-	Mumps Measles and Rubella
MoH	-	Ministry of Health
NASC	-	Needs Assessment Service Coordination
NHI	-	National Health Index
NCSP	-	National Cervical Screening Programme
NSU	-	National Screening Unit
NGO	-	Non-Governmental Organisation
NZIS	-	New Zealand Institute of Sport
PHAP	-	Pacific Health Action Plan
PHO	-	Primary Health Organisation
SACAT	-	Substance Addiction Compulsory Assessment and Treatment Act
SUDI	-	Sudden Unexplained Death of an Infant

1 Summary

This report updates the Auckland District Health Board (DHB) Board on planning and funding and health gain activities and areas of priority, since its last meeting on 11 April 2018.

2 Planning

2.1 Annual Plan

At the time of writing this report, we are still yet to receive the Ministers Letter of Expectations and the Funding Envelope for 2018/19. However, the Ministry of Health (MoH) recently informed us because the Crown Entities Act includes legislative timeframes for the preparation, and Ministerial review, of Statements of Intent and Statements of Performance Expectations we are required to provide a draft Statement of Performance Expectations (and new Statements of Intent if these are produced) to the Minister for his review no later than two months before the start of the financial year to which they apply. These are challenging to produce without corresponding planning advice, or finalisation of those measures and indicators which inform this part of the Annual Plan e.g. the System Level Measures Action Plan. Therefore, as advised by the MoH, the 2017/18 current measures were retained alongside updated baseline data. The document notes the need for updates once planning advice and other relevant information becomes available. This was provided to the Board for their review and approval on 26 April 2018 and submitted to the MoH on 30 April.

2.2 Annual Report

Initial drafting of reports commenced, timetables agreed with auditors. We are working on developing a library of suitable photographic material for this and future editions.

2.3 System Level Measure Improvement Plans

Consultation with key stakeholders has commenced to inform the development of the 2018/19 System Level Measure Improvement Plan: some primary care consultation, Māori and mana whenua consultation, we have started consumer consultation and have Pacific and other key stakeholder consultation planned. Consultation will broadly represent the general principles of the planning advice from last year as 2018/19 planning advice has not yet been received.

3 Primary Care

3.1 Auckland Waitemata Alliance

The Auckland Waitemata Alliance continues to have a primary focus on diabetes care and implementation of the System Level Measures Plan.

The Alliance Leadership Team recently, endorsed a plan to undertake a co-design process for general practice. This proposal, based on patient perspectives, aims to transform care for a group of high risk/need people with type 2 diabetes. The initial implementation involves up to six general practices in each DHB. This transformed care will:

1. Improve relationships between people with diabetes and health providers
2. Change the culture both within general practice and specialist care to support and empower a partnership and coordinated team approach to care in a way that meets the needs of people with diabetes
3. Improve relationships between health providers (general practice, PHO, secondary services, NGOs etc. to better support people with diabetes
4. Improve integration across sectors i.e. health and social services

5. Improve outcomes for people with diabetes as measured by the Metro Auckland Clinical Governance Forum diabetes clinical indicators.

Further the initial co-design work identified that people newly diagnosed with type 2 diabetes or struggling to control their diabetes would benefit from a support worker to help them navigate their diabetes care and this navigation could include:

- Development of care plans
- Support to attend appointments and engage with health providers
- Support to access social and health supports
- Motivation support.

The use of Health Coaches, which have been shown to be beneficial in other areas, is to be trialled as the patient support worker during the co-design process.

The Alliance GP Transparency Programme has been looking at mechanisms to provide the general public with more information on general practice – by providing prospective patients with appropriate, accessible and user-friendly information on general practices in the metro Auckland area to help them make an informed choice around their providers of primary health care. Further the programme hopes to encourage transparency and promote quality improvement – by publishing information and other clinical indicators for general practices within the metro Auckland area. To date the following has occurred:

- Literature review
- Consultation with patients and community groups on what they would see as valuable and how this could be presented
- Teleconferenced with the UKs National Health Service to discuss their experience
- Discussed possible linkages with Royal New Zealand College of General Practitioners Cornerstone accreditation programme

The Alliance Leadership Team has agreed to undertake a test of the proposed indicators and an evaluation to confirm if the programme should be further developed.

3.2 Community Pharmacy

Consultation on the proposed new direction has concluded. The DHBs are now considering the 1600+ responses and how the responses should be considered within the direction. The level of interest in the new direction and agreement has been very high. Over 200 people attended the consultation evening for the Auckland region. Additionally, a number of smaller face to face meetings were requested to discuss the proposal in detail.

4 Health of Older People

4.1 Age Residential Care (ARC)

Eight ARC facilities in Auckland DHB were affected by the recent power outage, the longest outage lasted six nights. Overall facilities responded well to this event, however, debriefing sessions are being set up for all ARC providers to share lessons learnt and identify improvements that can be made to their emergency planning. Currently all facilities are audited on their emergency planning during certification and surveillance audits.

Work is continuing on the mechanism for incorporating pay equity funding into the 2018/19 ARC bed day rates and minimising the 'overs' and 'unders' that occurred this year leading to some providers being in pay equity deficit. However, there has been discussion around the need for continuing

transitional support funding and how this could be managed within the allocated pay equity funding as there are still likely to be some cases of material pay equity deficit in 2018/19.

4.2 Home and Community Support Services (HCSS)

Planning and Funding supported the Ministry with hosting a Future Models of Care workshop for the Northern Region in April and is also actively involved in the Future Models of Care Management Group and the Working Group developing an outcome measures framework for HCSS.

A cultural responsiveness workshop was held with Auckland DHB HCSS providers focusing on the Meihana Model. A project group has been formed to further develop outcomes from this workshop.

The complexities of incorporating pay equity funding and guaranteed hours funding into DHB contracts are yet to be fully understood. A national Working Group has been set up and it is intended this funding will be incorporated into DHB contracts by 1 July 2019.

4.3 Other Health of Older People Activity

E-referrals have been set up to enable GPs to more easily refer patients, at risk of falls, to either the In Home Strength and Balance Programme or the community group exercise sessions approved by ACC. The in-home programme is for people who are too frail to access the community easily while the group exercise sessions are for those people who are able to get out and about in their neighbourhoods.

5 Women, Children & Youth

5.1 Immunisation

5.1.1 Immunisation Health Target

As previously reported, the Immunisation Health Target was not achieved in quarter 3 (Q3). By eight months of age, 94% of babies living in Auckland DHB were fully immunised, up from 92% in the previous quarter. The detail, including ethnicity breakdown, is shown in Table 1 below.

Table 1: IMMUNISATION COVERAGE BY PRIORITISED ETHNICITY

Change in Immunisation Coverage at Milestone Age (eight months of age) - Current Year (Q3 17/18) versus Previous year (Q3 16/17)

	Total			NZE			Māori			Pacific			Asian			Other		
	Q3 17/18	Q3 16/17	% ^	Q3 17/18	Q3 16/17	% ^	Q3 17/18	Q3 16/17	% ^	Q3 17/18	Q3 16/17	% ^	Q3 17/18	Q3 16/17	% ^	Q3 17/18	Q3 16/17	% ^
ADHB	94%	94%	0	96%	95%	+1	86%	89%	-3	92%	93%	-1	98%	98%	0	89%	90%	-1
NZ	92%	92%	0	93%	93%	0	87%	89%	-2	93%	95%	-2	98%	97%	+1	85%	88%	-3

Efforts to achieve equity for Māori infants continue. An intensive work programme is underway to enhance outreach immunisation services. The funding team are actively tracking progress baby by baby.

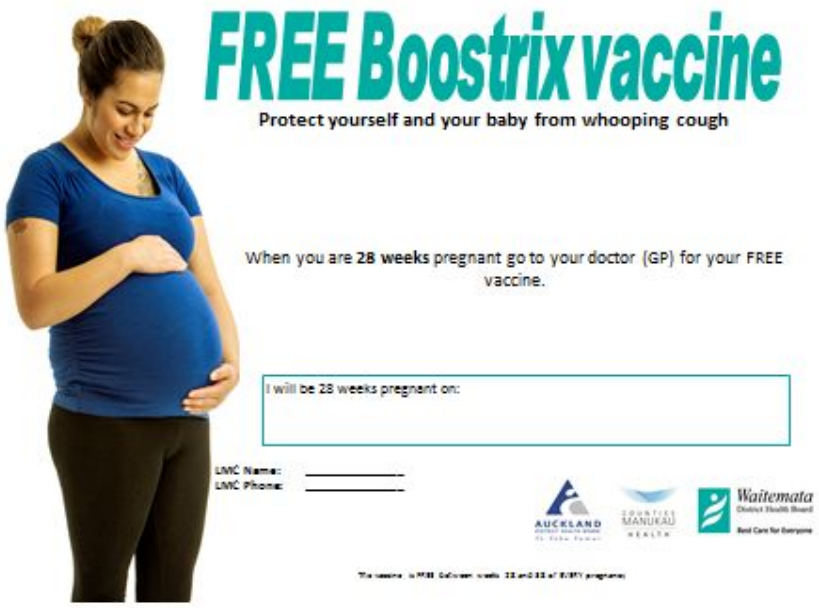
The power outage affected a number of practices, with some disruption to vaccine cold chain. The PHOs are managing and directly supporting affected practices. Funding of Zoster vaccine started 1

April for those 65-88 years of age. The influenza vaccine is now available in practices and the DHB communications campaign has started. Immunisation week is 30 April to 4 May and will be an opportunity for both primary care and the DHB to promote immunisation. These factors combine to create a significant increase in work for practices which can affect achievement of the health target.

5.1.2 Antenatal immunisations

In addition to the health target, the Metro Auckland Alliance Leadership Team has committed to a focus on antenatal immunisation. This work is aligned to the System Level Measures Activity.

Reminder cards for antenatal Boostrix have been distributed to primary care, pharmacies and Lead Maternity Carers and a parallel antenatal Influenza reminder card is in development. The cards developed by the Funder have also been adopted by Counties Manukau Health. This regional approach works well for women and practices particularly as maternity care is not restricted by DHB boundaries.



The first PHO/practice level analysis of pregnancy immunisation coverage to the end of Dec 2017 went out to PHOs on Monday. An analyst is currently exploring the feasibility of a pregnancy notification to general practice from a DHB dataset.

An analysis of Auckland DHB antenatal clinic attendances and immunisation status for 2017, demonstrates an opportunity to vaccinate over 1,000 pregnant women this winter, who would not be otherwise vaccinated. Almost half of the Pacific and one third of Māori women who birth at Auckland DHB attend a DHB antenatal clinic. This group of women are least likely to be vaccinated in primary care. Funding to provide vaccinations alongside antenatal clinics has been approved by the Chief Executive.

5.1.3 Mumps catch up

Since early 2017, metro Auckland has been experiencing an outbreak of Mumps, with over 1,240 cases as at 19 April 2018. Auckland DHB CEO approved allocation of up to $500k for a school based MMR vaccine catch up programme in 10 Auckland high schools. The schools include nine low decile

schools with existing Enhanced School Based Health Services and Avondale College, which has a large Pacific population.

The MoH have endorsed a local school based response and contributed $100k to each of the metro Auckland DHBs in support of this. Principals have endorsed the school-based programme, and a dedicated project team has now been established. Vaccinations will occur during school terms two and three.

The Auckland Regional Public Health Service (ARPHS) continues to lead the communications across the region.

5.1.4 Obesity Health Target – 'Raising Healthy Kids'

Auckland DHB continues to exceed the Raising Healthy Kids target for all ethnicities with 100% of children having their referrals acknowledged within 30 days. A procurement process has been undertaken for a Positive Parenting and Active Lifestyle service for pre-school children, pregnant women and their whānau. The preferred providers have been selected and contract negotiations are nearly complete. This will add a comprehensive referral option.

5.2 Oral Health – including maternal oral health

The Ministry of Health annual reporting for 2017 has just been completed and is provided in the table below.

Ministry of Health annual reporting for 2017

Indicator	Target	Total	Māori	Pacific	Other
Children Caries free at five years of age	65%	61%	50%	31%	70%
Mean DMFT score at year 8 (decayed, missing and filled teeth) (high scores indicate worse state of teeth)	0.72	0.65	0.94	1.04	0.49
Preschool children enrolled in DHB funded Oral Health Services	95%	91.5%	69.1%	91.8%	95.8%
Pre-school and Primary School Children overdue for their scheduled examinations (Arrears)	< 10%	Preschool:10% Primary school: 19% Total: 16%	Preschool:10% Primary school: 19% Total: 16%	Preschool:8% Primary School: 19% Total: 16%	Preschool:10% Primary school: 19% Total: 16%

In 2017 the Metro Auckland Preschool Oral Health Strategy was developed to support improving the oral health of Māori and Pacific pre-schoolers. There is a significant equity gap between Māori, Pacific and Other children. Eliminating this gap is the focus of the Preschool Oral Health Strategy, this strategy was endorsed by CPHAC. Some improvements in service delivery are evident as a result of this change in focus (such as provision of Saturday clinics and more frequent recall for Māori and Pacific children).

The preschool enrolment target was not met however there has been an increase for all ethnicities from last year. Work is currently being undertaken to ensure babies born in facilities outside Auckland DHB are enrolled at birth. Approximately 340 Auckland DHB domiciled babies were born in Counties Manukau Health facilities in 2016/17. There is also work occurring to ensure that ethnicity is being recorded correctly in the Titanium system.

The DMFT target for year 8 children was met and improvements were seen for Pacific and Other children, there was a small drop in the Māori rate and there is still a significant gap between Other and Māori and Pacific children. The implementation of the Supportive Treatment Pathway and opening of Saturday clinics will support children to be seen more regularly and enable preventative treatments such as fissure sealants.

The arrears target was met for preschool children. There has been a reduction of arrears of 3% for Māori and 5% for Pacific compared to 2016. However, the primary school and total arrears were not met. Increased productivity is being driven to reduce arrears.

The Chief Executive has approved funding for a pilot based in Tamaki to improve oral health in pregnant women. Oral health deteriorates as a consequence of pregnancy, and poor oral health contributes to poor birth outcomes including low birth weight and prematurity. The new service will be located in Tamaki and be available to pregnant women who have a community service card and are in need of dental services.

5.3 National Sudden Unexplained Death of an Infant (SUDI) Prevention Programme

A draft Northern Region Plan for SUDI prevention was submitted to the MoH in November 2017. Positive feedback was received from the Ministry of Health and the national SUDI prevention programme coordinator, Hapai te Hauora Tapui, including from their Expert Advisory Group for SUDI prevention in April 2018. Further development of the priorities for regional collaboration will be identified and discussed with the SUDI implementation group in preparation of the Northern Region Plan for SUDI prevention 2018 – 2019.

5.4 Healthy Housing

The service has now been in place for over a year. Referrals are steady and the service has become well known amongst relevant referrers. In Auckland DHB, to date there have been

- 337 eligible referrals including 1,496 individual family members. Of these, 96 referrals were for pregnant women/new mothers (pregnant women are a particular focus as the programme aims to intervene early, before respiratory illnesses become a chronic condition)
- 507 interventions have been delivered including 36 families moving into new social housing.

The focus for the next quarter will be ensuring Kainga Ora is receiving all eligible referrals. To support this, discharge lists for each of the MoH eligibility groups will be analysed. The intent is to obtain all Auckland DHB and Waitemata DHB discharges with the relevant discharge International Classification of Diseases (ICD) codes and geocoding for 0-5 year olds, maternity admissions, neonate discharges and high risk maternity clinic lists. This work is being undertaken in partnership with public health physicians and paediatricians.

Kainga Ora continues to work on improving feedback loops and communication with referrers. Ministry for Social Development and Kainga Ora have worked together to develop a robust reporting process that meets both organisations needs and ensures that no whanau falls through the gaps. Housing New Zealand and Kainga Ora are in the process of improving reporting mechanisms so they are fit for purpose while ensuring whanau needs are addressed.

The MoH have conducted a national evaluation of the healthy homes initiative services which indicates positive outcomes for whanau. The final report is not yet available. Further evaluation is required to support the development of a service improvement framework locally and nationally. Kainga Ora have developed a service evaluation framework with the support of Dr Tom Robinson. A survey with whanau who have had all identified interventions closed will form part of the evaluation.

5.5 Cervical Screening

The target for the National Cervical Screening Programme (NCSP) coverage is 80% of women. Nationally, this coverage target has been met for European/other women, however, Māori and Asian women are below 70% coverage nationally.

The table below shows the three year coverage rate (%) of eligible women broken down by ethnicity for all metro Auckland DHBs and New Zealand total.

The % NCSP coverage of women aged 25-69 in the three years ending 31 December 2017					
	Māori	Pacific	Asian	Other	Total
ADHB	54.4%	69.8%	54.3%	77.2%	67.1%
WDHB	59.4%	71.6%	69.5%	77.4%	73.6%
CMDHB	65.0%	80.2%	68.5%	75.0%	72.8%
Total NZ	65.7%	74.9%	63.8%	79.3%	74.7%

Data: MoH NCSP New Zealand Auckland District Health Board Coverage Report for the period ending 31 December 2017

Auckland DHB currently has the lowest coverage for Māori women and the lowest overall coverage of any DHB in the country.

Coverage nationally has reduced a little for Māori, Pacific and other women over the past three years. Coverage for Asian women is steady.

The % NCSP coverage of women aged 25-69 in the three years ending 31 December 2015, 2016, 2017					
Location	Year	Māori	Pacific	Asian	Other
ADHB	2015	55.8 %	71.5 %	57.2 %	77.3 %
	2016	56.1 %	71.3 %	56.2 %	77.5 %
	2017	54.4 %	69.8 %	54.3 %	77.2 %
WDHB	2015	61.5 %	75.3 %	70.8 %	80.1 %
	2016	61.0 %	74.3 %	70.2 %	79.0 %
	2017	59.4 %	71.6 %	69.5 %	77.4 %
CMDHB	2015	65.1 %	82.4 %	68.5 %	76.8 %
	2016	66.8 %	83.6 %	68.5 %	76.4 %
	2017	65.0 %	80.2 %	68.5 %	75.0 %
Total NZ	2015	67.0 %	76.5 %	63.9 %	81.0 %
	2016	66.9 %	76.9 %	63.9 %	80.2 %
	2017	65.7 %	74.9 %	63.8 %	79.3 %

Data: MoH NCSP New Zealand Auckland District Health Board Coverage Report for the period ending 31 December 2017

Factors contributing to low coverage in Auckland include:

- Strong population growth
- Enrolment of new residents in the DHB area into the NCSP programme may take some time and is somewhat dependent on enrolment with PHOs as the programme is predominantly delivered through primary care practices
- Some confusion amongst primary care practices around the intended shift in the next few years to HPV primary testing. This intended change to the NCSP programme has been signalled by NSU, but the intended rollout date and communication regarding the implementation of the new programme has been limited. In particular, until the NSU have

contracted for required upgrades to the register infrastructure, they have not been willing to name an implementation date. Previous advice indicated implementation in 2018 but this seems unlikely. In the absence of this updated advice, there has been a lack of direction as to what the new programme will mean for current screening. Feedback suggests that advice from the NSU to the effect that usual care, including three year recall until the first screen under the new HPV primary testing protocol is completed may be helpful

- Cervical Screening was previously an IPIFF target. It is not currently an System Level Measure activity. This may have contributed to a lack of focus on cervical screening in the face of many competing demands on primary care
- Promotion of the programme to the public has been very limited, although NSU have re-branded their website and materials, this has largely been passively launched
- Change in Independent Service Providers may have had an impact on reach – these contracts are held directly with MoH so we do not have visibility on the impact directly
- Reduction in total screen volumes.

The rolling three year total of NCSP screens completed in Auckland DHB appears to trending downward. This is not the case in other metro Auckland DHBs or in the country as a whole.

The number of NSCP screens completed for women aged 25-69 in the three years ending 31 December 2015, 2016, 2017						
Location	Year	Māori	Pacific	Asian	Other	Total
ADHB	2015	5,602	10,053	27,327	62,555	105,537
	2016	5,668	9,371	27,651	58,437	101,127
	2017	5,684	9,176	28,062	57,431	100,353
WDHB	2015	7,155	6,745	22,293	81,371	117,564
	2016	7,786	7,163	25,510	79,378	119,837
	2017	7,969	7,074	27,375	77,715	120,133
CMDHB	2015	11,411	19,013	23,123	43,633	97,180
	2016	12,710	20,973	25,775	42,645	102,103
	2017	12,810	21,069	27,311	41,181	102,371
Total NZ	2015	99,703	49,248	109,830	649,614	908,395
	2016	107,038	51,831	119,385	642,903	921,157
	2017	109,986	51,983	126,886	638,756	927,611

Data: MOH NCSP New Zealand Auckland District Health Board Coverage Report for the period ending 31 December 2017; MoH NCSP New Zealand Auckland District Health Board Coverage Report for the period ending 31 December 2016; MOH NCSP New Zealand Auckland District Health Board Coverage Report for the period ending 31 December 2015.

Current actions to increase cervical screening include:

- Working with the ISP Well Women and Family Trust, to support the development of stronger relationships within Māori organisations and communities
- Supporting PHOs and practices to undertake targeted invitation and recall
- Regular bi-monthly Metro Auckland Cervical Screening Operations group meetings to share strategies and initiatives for improving cervical screening programme delivery and reach
- Regular 'update' education provision for smear takers including GPs and practice nurses
- Provision of funding for PHOs to provide 'free screens' for priority women including Māori, Pacific and Asian women and Other women who are five years or more overdue, or have never been screened
- Supporting HPV-Self Sampling study.

Next steps:

- Further support for Māori Provider Organisations and communities to promote cervical screening along with practical supports for screening provision (such as providing screening nurses to events) in collaboration with Well Women and Family Trust
- Investigate the apparent decline in number of screens to understand where this is occurring and implement remedial actions
- Continue with existing supports.

5.6 Transgender

Transgender Health Services continue to be well utilised, with strong demand and referral numbers continuing to increase year on year for both the adult service (Auckland Regional Sexual Health Service) and youth service (Centre for Youth Health).

Number of first appointments:

		2015/16	2016/17	2017/18 (Q3 YTD)
Adult	**ADHB**	20	38	67
	WDHB	11	33	48
Youth	**ADHB**	9	31	14
	WDHB	-	29	26
Total		**40**	**131**	**155 (Q3 YTD)**

Upcoming work in Q4 includes:

- Improved referral process for Auckland with a dedicated e-Referral for transgender health services being completed
- Proposal for funding of a transgender peer support service
- Development of regional clinical guidelines for transgender healthcare.

These developments are expected to improve the care that transgender people are able to receive in primary care.

6 Mental Health and Addictions

6.1 Government Inquiry into Mental Health and Addiction 2018

The Mental Health and Addictions Inquiry team visited Auckland DHB services and groups on Monday May 7 and Tuesday May 8 2018. DHBs were provided with a guidance note for information they provide to the Inquiry Team prior to site visits, due three working days prior to the site visit, this included:

1. the population DHBs serve, including priority populations
2. pressures DHBs face now and predictions of what DHBs will face in the future
3. model of care (including how this has changed over time and how DHBs anticipate it will change in the future)
4. system, organisational and funding arrangements now and how they could change in the future
5. partnerships and relationships with key organisations and groups
6. what is working well, including the most promising initiatives and approaches
7. what is not working well, including gaps and the groups that are missing out
8. regional information and data (not likely to be available from national sources)
9. strategic oversight of DHB's approach to meeting their population's needs and
10. deeper understanding of the programmes, initiatives, services and supports DHB's fund and provide.

As well as providing Auckland DHB information and advice sought by the Inquiry, feedback from consultations with internal and external stakeholders is included throughout the report.

Auckland DHB consulted with a range of stakeholders, using information provided by the Inquiry Panel to structure online and face-to-face discussions, as follows:

1. Current situation
2. What is working well in mental health and addiction (and suicide prevention)
3. Gaps, unmet needs, and challenges
4. Solutions

Engagement mechanisms included workshops and discussions with the following groups and individuals:

- Mental health directorate leadership group
- Auckland DHB Mental Health and Addictions Programme Board
- Service clinical director, nurse unit managers, portfolio performance managers
- Clinical team leaders, charge nurses, lead clinicians
- Pacific general manager and nurse director
- Māori general manager
- Tūhono (forum of Mental Health and Addictions DHB and NGOs services and consumer representatives)
- Oranga Tamariki Mental Health Steering Group
- Consumer leadership
- Mental health and addiction service users (via workshop participation and online survey)
- Family/whānau advisor
- Nursing workforce (frontline clinicians)
- Allied heath workforce (frontline staff)
- Medical workforce (frontline psychiatrists) and
- Representatives from MSD, Housing, Probation, Police, Corrections, Education, and Youth Justice, together with tāngata whaiora and their whanau (to discuss addiction services).

The process has required a commitment of time within a short timeframe across whole of sector to write up the submission documents to the Inquiry team, and will continue to demand additional time from the team and services with written submissions being accepted right until the end of June 2018.

7 Māori Health Gain

7.1 Māori Health Services Design

As part of the ongoing development of outcomes contracting the Māori Health gain team are working on a project to determine the future design and focus of Māori health services across Auckland and Waitemata DHBs. As part of this project a literature review has been completed looking at indigenous models of health, current strategic directions and characteristics of effective health systems for indigenous peoples. Further to this a range of Māori health experts will be engaged as well as a series of meeting with local Māori health providers. These engagements along evidence and literature will help inform future Māori health service design and priorities. It is expected that a report on the project will be presented to the respective Boards in the first quarter of 2018/19.

7.2 Workforce Development

The Māori health gains team have established a PHO working group to develop and implement a workforce ethnicity reporting tool and process to report primary care workforce date by ethnicity. The project will assist the establishment of a baseline which will then inform strategies to increase the number of Māori in the health workforce. This project is aligned to the Māori workforce Alliance Leadership Team work programme priorities, is supported by the Auckland and Waitemata Alliance Leadership Team and is part of the current Auckland and Waitemata DHBs Māori health plan 2017/18.

7.3 Abdominal Aortic Aneurysm (AAA) update

The AAA and Arterial Fibrillation screening extension programme for Māori is now complete. The data is currently being analysed and the evaluation is underway, including a range of quantitative measures and health professional and whānau interviews. The results will be reported to the Board. The outcome of a Health Research Council application for a larger study across Auckland and Waikato are currently awaited. The Māori coordinator for AAA has been secured to support the roll-out of the larger HPV self-sampling project aimed at improving equity in cervical screening.

8 Pacific Health Gain

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

Alliance Health Plus PHO has been chosen as the provider of Positive Parenting and Active Lifestyle programme in the Auckland DHB area, for children identified as overweight or obese in the Before Schools programme. We continue to work with the Child Health Team and Alliance Health Plus to implement the programme.

We met with Ministry of Social Development and agreed to meet with the Ministry of Education, as departments who do fund parenting programmes, to explore the option of providing parenting education at the population level and not just as a response to children/families who are identified by Oranga Tamariki and schools as having behavioural problems.

We believe that parenting education is fundamental to support Pacific parents not to abuse their children, especially if they themselves experienced abuse as a form of discipline when they were children. Anecdotal evidence suggests that physical abuse is still common, both by parents who believe that this is right and those that don't but default to it under pressure and not knowing other alternatives. We will continue to search for resources to further implement the parenting education programme that we and the Healthy Village Action Zones (HVAZ) churches had initiated.

8.2 PHAP Priority 2 – Pacific People are smoke-free

The primary care team is funding training for smoke-free champions from the HVAZ churches and other groups, to be able to engage people who smoke in a supportive and motivational discussion about stopping smoking. They will also be trained to refer willing smokers to West Fono and Procare for quit smoke support.

8.3 Priority 3 – Pacific people are active and eat healthy

The NZ Institute of Sport (NZIS) offered to provide NZQA Level 4 training for members of HVAZ and Enua Ola who wish to qualify as personal trainers free of charge, tuition fees are usually $5,500 per student. 17 people have taken up the training, 10 from HVAZ, seven from Enua Ola.

NZIS requested that Waitemata/Auckland DHBs work in partnership with them to provide:

- Additional mentoring/tutoring as required for the students
- Wellness sessions
- Health education for all NZIS students, specifically sexual health education
- Health screening
- Promotion of NZIS courses in the Pacific community
- Pacific communities to give advice to NZIS as to how to better support Pacific students.

The Pacific Team has agreed to the above requests. The two personnel at the Pacific Science Academy and members of the Pacific Planning and Funding Team will provide mentoring/tutoring as well as facilitate access to sexual health educators from the DHBs, parish community nurses will provide health screening, HVAZ and Enua Ola co-ordinators will promote NZIS courses in the community as well as facilitate access to advice from the community to the support Pacific students' needs.

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

Actions are being rolled out from the Asian, migrant and refugee health plan 2017-2019, recently signed off by CPHAC.

9.2 Increase Access and Utilisation to Health Services

Indicators:

- Increase by 2% the proportion of Asians who enrol with a PHO to meet 71% target by 30 June, 2018 (current rate 70% as at Q4 2017/18)
- 80% of eligible Asian women will have completed a cervical sample by 2020 (current rate 54.3% as at Dec 2017).

The Auckland DHB Asian PHO enrolment rate has finally increased 1% between Q3 and Q4, to reach 70%, with 1,530 new enrolees. This is a good sign given the PHO enrolment rate was stagnant at 69% for three previous quarters this Financial Year.

Current activities:

- Presenting information about the NZ health & disability system and health services at the ANZ Migrant Expo (16 June). Over 10,000 new migrants expected to attend
- Promoting influenza immunisation messaging in translated languages (Chinese and Korean) to ethnic communities; Asian, migrant, student, former refugee and asylum seeker partners; and institutes via their online, social media and hardcopy information platforms
- Presenting health literacy information about improving access to - and patient experience of - breast and cervical screening to Asian general practitioners at the Auckland Chinese Medical Association Conference (5 May)
- We have populated the Auckland Regional Health Pathway for Asian, migrant and refugee targeted support services for the two following pathways -Mental Health Community Support, and Migrant and Refugee Services
- Supporting the Mental Health Inquiry for Asian and former refugee mental health.

Indicator: Increase opportunities for participation of eligible refugees enrolled in participating general practices as part of the Refugee Primary Care Wrap Around Service funding

Activities include:

- Reviewing the Service Specifications of the Refugee Primary Care Wrap Around Service Agreements
- Delivered an asylum seeker health forum to 36 primary health professionals (10 April)
- Planning to deliver a frontline receptionist cross cultural professional development training to primary care staff (11 May)
- Promoting NZ health & disability system and information about the Refugee Primary Care Wrap Around Service to asylum seeker and mainstream support agencies at the National Asylum Seeker Forum (6 June).

10 Hospitals

10.1 Cancer target

Auckland DHB's reported achievement of the 62-day FCT indicator for the YTD period as at end of Q3 was 91.4%. Significantly high referral rates in December 2017 and ongoing reduced SMO capacity are impacting Radiation Oncology waiting times, with constraints across multiple tumour streams. A recovery plan is being developed to address the issues.

10.2 Auckland DHB Surgical Health Target

For February year to date, the Auckland DHB Surgical Health Target performance as reported by the MoH is 94.2%. The year to date surgical elective discharge gap is mainly due to a shortfall of Adult Orthopaedic activity with a year-end forecast gap of 600 discharges. There are plans in place to achieve the discharge plan in most services however there is likely to be a discharge shortfall in General Surgery in addition to Adult Orthopaedics, and this will impact on additional elective revenue paid to the DHB by the Ministry of Health in 2017/18. Work is continuing to make use of available capacity within private suppliers to mitigate the forecast discharge shortfall in all services.

10.3 ESPI Compliance

Auckland DHB was moderately non-compliant for ESPI2 in February with both Adult Orthopaedics and General Surgery non-compliant. The DHB is likely to be ESPI2 moderately non-compliant in Adult and Paediatric Orthopaedics, Neurology, Otorhinolaryngology, Ophthalmology and Paediatric Dermatology in March. ESPI5 is expected to be non-compliant in March, the third consecutive month of non-compliance. The provider has established a range of initiatives to mitigate the forecast level of non-compliance.

10.4 Regional Cardiology service demand

The Auckland DHB Cardiology service provides acute and elective services for the Auckland DHB population and is the regional provider of a range of complex cardiology procedures including Electrophysiology (EP) services for the Northern region population. Demand for regional EP services has increased over the last three years and work is underway regionally to develop a plan to respond to this demand including the development of a proposal for additional investment for the Northern region populations. The Auckland DHB population elective service delivery is 32% more than funded in 2017/18 for the March YTD period, and work has commenced to understand the drivers of the change in 2017/18.

10.5 2018/19 Auckland DHB Provider Planning

The final draft of the 2018/19 Price Volume Schedule for Auckland DHB provider services for the Auckland DHB population is complete pending confirmation of final prices which will not be available until the Funding Envelope advice is received. The draft elective services discharge plan for the Auckland DHB population is in development and will be established based on known demand and unmet need rather than an assumed level of discharge target increase yet to be advised by the MoH in 2018/19.

10.6 IDF Arrangements

2017/18

The Auckland DHB provider has delivered more acute WIES than planned in the February year to date period and less elective WIES than planned for other populations with the overall position being generally on budget. There is expected to be an increase in elective Urology discharges for the Counties Manukau Health population over the last two months of the financial year to address waiting list issues that have arisen.

2018/19

The funder has provided updated 2017/18 year end forecast analysis to IDF funders to enable the DHBs to confirm 2018/19 IDF funding arrangements. Whilst the affordability of 2018/19 IDF volumes is uncertain for funders in the absence of final prices, funder analysis shows the total volume levels have been set appropriately for the expected level of demand excluding any as yet unknown service changes. The IDF forecasts exclude any uplifts for increased renal transplants, increased clot retrieval services and further service change relating to the Auckland metro after hours hyper- acute stroke service.

10.7 Policy Priority areas

Colonoscopy Indicators

Auckland DHB achieved the waiting time targets for urgent and colonoscopy in February, but did not achieve the colonoscopy surveillance waiting time indicator. The service has implemented a range of measures to recover these indicators and is expected to achieve compliance with the surveillance indicator by the end of April.

Radiology Indicators

Auckland DHB performance in outpatient MR and CT has improved since last month from 58% and 80%, to 70% and 90% respectively, with ongoing improvement expected to continue.

10.8 National Services

Auckland DHB is finalising detailed work to inform discussions with the MoH about the service specification, purchasing framework and pricing arrangements to support sustainable funding of nationally funded and IDF funded transplant services.

10.9 Regional Service Review Programme

Cardiac Catheter Laboratory services – Northern region DHB Chief Financial Officers' have developed draft regional principles for the management of stranded costs associated with service change and will be considering the application of the Cardiology stranded cost impact analysis that has been completed by Auckland DHB. The impact analysis assumed Northland DHB would be establishing a new service in 2019/20 and Counties Manukau in 2020/21 but there has been no further progress of these business cases at this time.

Head and Neck services – work has yet to be completed to quantify any increased cost likely in 2018/19 associated with addressing regional inconsistencies identified by the Regional Head and Neck service review.

Disability Support Advisory Committee Meeting Minutes 14 March 2018 – Draft Unconfirmed Minutes

Prepared by: Michelle Webb (Corporate Committee Secretary)

Recommendation

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

Minutes
Disability Support Advisory Committee Special Meeting
14 March 2018

Minutes of the Disability Support Advisory Committee Special Meeting held on Wednesday, 14 March 2018 in the A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton commencing at 3:00pm

Committee Members present	**Auckland DHB and Waitemata DHB Staff present**	
Jo Agnew (Chair)	Ailsa Claire	Chief Executive Officer Auckland DHB [arrived at 3.29pm]
Michelle Atkinson	Dr Debbie Holdsworth	Director of Funding Auckland and Waitemata DHBs [arrived at 3.24pm]
Edward Benson-Cooper [arrived at 3.15pm]	Sue Waters	Chief Health Professions Officer
Allison Roe	Michelle Webb	Committee Secretary
Gwen Tepania-Palmer (Board Chair, Auckland DHB, ex officio)		
	(Other staff members who attend for a particular item are named at the start of the minute for that item)	

1. ATTENDANCE AND APOLOGIES

The apologies of committee members Matire Harwood (Deputy Chair) and Robyn Northey, and of senior staff members Dale Bramley were received.

The apologies of Ailsa Claire, Chief Executive Officer Auckland DHB and Dr Debbie Holdsworth, Director of Funding Auckland and Waitemata DHBs for lateness were also received.

[Secretarial Note: As this was a special meeting of the committee supporting officers were not required to be in attendance].

2. CONFIRMATION OF MINUTES 6 DECEMBER 2017 (Pages 5-11)

Resolution: Moved Michelle Atkinson / Seconded Edward Benson-Cooper

That the minutes of the Disability Support Advisory Committee meeting held on 6 December 2017 be confirmed as a true and accurate record.

Carried

3. RESOLUTION TO EXCLUDE THE PUBLIC (Page 12)

Resolution: Moved Michelle Atkinson / Seconded Edward Benson-Cooper

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. Attendance and Apologies	As per 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]
2. Integrating Governance Arrangements for Disability Issues	**Commercial Activities Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public** [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Carried

The meeting closed at 3.57pm.

Signed as a true and correct record of the Disability Support Advisory Committee meeting held on Wednesday, 14 March 2018

Chair: _____ Date: _____

Jo Agnew

Minutes of the meeting of the Auckland DHB and Waitemata DHB

Community and Public Health Advisory Committees

Wednesday 04 April 2018

held at Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna,
commencing at 10.01am

Part I - Items considered in Public Meeting

COMMITTEE MEMBERS:

Sharon Shea (Committee Chair - ADHB Board member)
Max Abbott (WDHB Board member)
Judith Bassett (ADHB Board member)
Edward Benson-Cooper (WDHB Board member) (until 12 noon, item 4.1)
Zoe Brownlie (ADHB Board member)
Sandra Coney (WDHB Board member) (until 12 noon, item 4.1)
Warren Flaunty (Committee Deputy Chair - WDHB Board member)
Matire Harwood (WDHB Board member)
Lee Mathias (ADHB Board member)
Robyn Northey (ADHB Board member)

ALSO PRESENT:

Dale Bramley (WDHB Chief Executive Officer)
Ailsa Claire (ADHB Chief Executive Officer
Debbie Holdsworth (ADHB and WDHB, Director Funding)
Karen Bartholomew (ADHB and WDHB Acting Director Health Outcomes)
Andrew Old (ADHB Chief Strategy/Participation and Improvement)
Peta Molloy (Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES:

Bill Grieve (Chair, Hibiscus Hospice)
Nicolette Bodewes (Chair, North Shore Hospice)
Jan Nichols (Chief Executive, North Shore Hospice)

KARAKIA:

The Committee Chair invited Bruce Levi to open the meeting with a prayer.

WELCOME:

The Committee Chair welcomed those in attendance at the meeting.

APOLOGIES:

An apology was received and accepted from Allison Roe and for early departure from Edward Benson-Cooper.

DISCLOSURE OF INTERESTS

There were no declarations of interests relating to the agenda.

Sharon Shea advised that she is working with Te Ha Oranga, the provider arm of Te Runanga o Ngati Whatua who is delivering a new programme within the Auckland Women's Prison in Wiri.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed on the agenda.

2. COMMITTEE MINUTES

2.1 Confirmation of Minutes of the Auckland and Waitemata DHBs' Community and Public Health Advisory Committees Meeting held on 06/12/17 (agenda pages 7 to 11)

Judith Bassett corrected Dame Sister Pauline Engel's (not Francis) name in the minutes of 06 December 2017; Dame Sister Pauline Engel sadly passed away late 2017.

Resolution (Moved Judith Bassett/Seconded Warren Flaunty)

That the Minutes of the Auckland and Waitemata District Health Boards' Community and Public Health Advisory Committees Meeting held on 06 December 2017 be approved.

Carried

The Committee Chair acknowledged Warren Flaunty and his recent retirement from the pharmacy profession.

Matters Arising (agenda pages 12)

Debbie Holdsworth summarised the matters arising reported.

In response to a question about the recent mumps outbreak Ruth Bijl said that there has been a slight decrease in the number of cases. With regard to immunisation, Waitemata DHB has undertaken a 'catch-up' programme in five low decile primary schools. Auckland DHB has also taken the opportunity to engage with the Pacific community through PHOs and tertiary institutes. In response to a question about the age of patients being diagnosed with mumps and whether there was an issue with the vaccine still being effective, Catherine Jackson noted that the primary reason for those diagnoses is that people have not been immunised. In 2001 when the vaccine age was adjusted from 11 years to 4 years of age, this resulted in a cohort that was not vaccinated. The majority of patients diagnosed were not fully immunised due to changes in the health system.

3. STANDARD REPORT

3.1 Planning, Funding and Outcomes Update (agenda pages 13 to 104)

One of the key highlights identified in the update report was the strengthened strategic partnership established between Hibiscus Hospice and the North Shore Hospice Trust. In attendance to present to the Committee were Bill Grieve (Chair, Hibiscus Hospice), Nicolette

Bodewes (Chair, North Shore Hospice) and Jan Nichols (Chief Executive, North Shore Hospice).

The Committee Chair invited the hospice representatives to open the discussion and highlight the work undertaken to form an alliance. The following was noted:

- Bill Grieve noted his background as a retired engineer, his role as Chair of Hibiscus Hospice for the past nine years and for a period as Chief Executive of the Hospice. He spoke about the focus of retaining costs and maximising revenue for the hospice as well as the support given and steps taken with Pat Alley as previous Chair of the northern region hospices. Following that, over a three year period a lack of clinical leadership was identified and at the hospice Board's discretion, Simon Allan came on board and was instrumental in getting things back on track. Bill noted that in stepping into the role of Chief Executive the clear need for a change in style and culture was identified, as well as recognising the needs of a growing population. Radical change was needed and an alliance with North Shore Hospice was developed. A good relationship has been formed and a common Chief Executive, Jan Nichols, appointed.
- Jan Nichols spoke about the changes that have taken place to-date, noting the motivation from both Trusts to provide the best service. She said that funding is an issue from all sources, with equity issues in the district. Population growth is a significant issue, with a large number of people expected to die over the next 50 year period. In addition Jan noted that since being appointed as Chief Executive across the North Shore and Hibiscus Hospices, a HR hub has been developed. It is a small team that deserves much credit as no external consultants or resource was utilised in effecting the required changes and setting a single set of values, a single voice for the DHB, a single contract across both Hospices and an attractive employment plan. All clinical services were looked at with restrictions put in place, duplication in clinical management and administration has been streamlined; in particular a staff member, Ree, was noted for the exceptional role in working across services with a focus on supporting the clinical team. Areas of restructure have taken place with others in process or being finalised. Feedback on the proposed changes and those now in place was invited. It was also noted that as these are community hospices, there are also a lot of volunteers helping.
- Nicolette Bodewes noted her profession as a lawyer and that she had been on the Board of North Shore Hospice for five years. She advised that consideration is being given to forming a Foundation Trust, this depends on a legal technicality and ensuring that with regards to bequests, those willed to Hibiscus Hospice are used for that Hospice alone (this will also apply to fundraising). In addition it was noted that there is engagement with a PR company to present the Hospices' story to the community.
- As at 1 July 2018, it is hoped both Hospices will be one entity, making required savings and providing a better service to patients and their families.
- In response to a question about lessons learnt, it was noted that: it can be done and where there is a will there is a way. There was a strong willingness of both boards to cooperate and work towards one goal, all Board members recognised one goal which was for the best service for patients. The transition has gone smoothly with there now being a combined Board. There is a motivated team to achieve the same goals.
- Bill Grieve also noted that often when a merger occurs there often is a dominate player, this has not occurred for the Hospices and both are seen as absolute equals. He acknowledged both Hospice Boards for their support in achieving this.

Warren Flaunty acknowledged the work undertaken and queried if there was any involvement from the West Auckland Hospice; in response Nicolette advised that there was

no involvement at this stage, but suggestions are welcome. She noted that there is room for growth and reiterated Bill's comments that there is not a dominant party involved in the new alliance. Bill further noted that the key is common values and purpose.

The Committee Chair thanked Bill, Nicolette and Jan for attending and speaking at the meeting.

Debbie Holdsworth noted the key highlights in the Funding and Planning report. The following matters were discussed and response to questions included:

- Samantha Bennett noted the Asian, Migrant and Refugee Plan and that high level findings show that the Auckland DHB and Waitemata DHB are national leaders in Asian health. However, there were also disparities identified in high risk Asian groups, such as high numbers of Chinese smoking as well as obesity and diabetes for South Asian groups. The Plan is a high level summary and provides an understanding of cultural needs for the high risk groups.
- Lee Mathias noted a potential impact for the way in which data is collected, a third of our population is Asian and there is an opportunity to formally request changes via the DHB Boards in time for the next Census to allow better data outcomes. Samantha Bennett advised that Lifeng Zhou works closely with Statistics NZ and there is dialogue about the MELAA (Middle Eastern, Latin American and African populations) category and whether a broader category is needed. The Chair agreed and Samantha should report back to the Committee Lifeng's progress with Statistics NZ.
- Tim Wood advised that the diabetes clinical indicators can now be reported at a more granular level. An understanding is being gained about what is being prescribed and what is being dispensed; however, whilst prescribing data shows an improvement in what is being prescribed, an equivalent improvement is not being show with respect to patients collecting their scripts from the pharmacy. Tim acknowledged the PHOs work in producing the data and starting to use it in a meaningful way to address disparity. In response to a question from Lee Mathias, Tim said that the data was stored by the DHBs and that there is a process across the three metro Auckland DHBs about having a repository in the Cloud on an ongoing basis.
- With regard to the diabetes clinical indicator data now available, the Committee Chair queried whether there is work on identifying any ethnic differences when collecting a prescription. Tim advised that the data collection is providing an opportunity to ask questions such as ethnicity differences; the Diabetes Service Level Alliance will start to look at the data and develop a work plan. The work plan will include areas like co-design with general practices, a programme of activity over the next two years and co-design of patients and general practice teams. A piece of work has been undertaken previously around high needs patients with general practices. He also noted two key areas of work that have a strong equity lens, being: a programme around improving podiatry care with GP practice teams and the way community podiatrists provide care; and there is work on improving the retinal screening programme. It is known that there is a high level of DNA rates and not enough screening capacity within the system.

The remainder of the report was taken as read. Additional matters raised and response to questions included:

- Warren Flaunty noted the update provided on aged residential care audits (page 31 of the agenda) and that it was not clear whether any spot audits had identified irregularities in the system; he also asked that a breakdown of corrective actions

between spot audits and normal certification be identified. Debbie Holdsworth advised that this will be responded to.

- Matire Harwood noted the ethnicity and inequity data reported in areas such as cervical smears and queried what is being done to change this. Debbie Holdsworth advised that this could be presented to the Committee as a deep dive and this would include cervical screening and breast screening. It was requested that the deep dive also include information on the cost for cervical screening (as it is not a free service) as well as the self-sampling programme and whether that will suit Maori women.
- In areas such as dental care and inequity, Ruth Bijl advised that oral health identified that clinic opening hours were not favourable and that Saturday clinics were introduced and are working well.
- Warren Flaunty noted the Zero Suicide Framework reported (page 35 of the agenda) and queried whether people who commit suicide are known to the DHBs services. Trish Palmer advised that they may have been known to the DHBs services, but might not be an active client. She also advised that a National Suicide Mortality Group had been established. It was also noted that a programme was in place across hospital presentations to address suicidal thoughts with targeted interventions; this is in the early stages with positive results being seen.
- In response to a question from Sandra Coney about programmes in schools to help prevent suicide, Trish Palmer advised that there is investment from the Ministry of Health and a call for resilience and mental health wellbeing programmes funded by the Ministry of Health from within school based programmes. Trish Palmer noted that Tamaki College are piloting a 'peered up' programme which is peer youth support; this is a 12 month programme that commenced in January 2018.

Dale Bramley noted that he and Ailsa Claire had recently met with the Alliance Chairs. He acknowledged the practice level data now being provided and the challenge in best utilising that data.

4. DEEP DIVE REPORT

4.1 Equity Focus in System Level Measures Planning Process (agenda pages 105 to 159)

The Chair opened this part of the meeting noting that the two DHB Boards had agreed to focus on Equity, and in particular, improving Equity for Maori, Pacific Peoples' and other high need groups as an important strategic priority.

The purpose of this part of the CPHAC meeting is to give committee members an opportunity to guide DHB management about its expectations for equitable outcomes. Members are also encouraged to offer a future-focused view about 'what works', for management consideration.

Dr Catherine Jackson presented to the Committee on equity and system level measures.

Matters covered in discussion and response to questions included:

- Noting that there have been discussions around targeting specific populations to communicate health messages, including digitally targeting those groups.
- That there is room for improvement in learning from programmes that have been successfully communicated. The metro-Auckland DHBs could work together to understand what social marketing looks like and utilise that data.

- Noting that PHO data collected is reported back to general practices, but it is anonymised.
- In response to a comment and question from Matire Harwood about how workforce development and employment is a determinant of health outcomes and wellbeing, Ailsa Claire noted that it is recognised that the ADHB is the largest employer in the community. The ADHB is looking at how it can support and encourage its low paid workers in career pathways. She spoke about the ADHB programme 'Thrive' (which provides a framework of initiatives that may be replicated for employee groups); it was noted that ADHB has had 60 cleaning staff move to a level 3 grading and are now moving to healthcare assistant roles.
- In response to a question from Max Abbot about the graph presented for 'acute bed days – equity,' it was noted that the data is adjusted for age and not deprivation.

The Committee Chair acknowledged the presentation given and encouraged Committee members to provide feedback directly to Karen Bartholomew on the deep dive.

In response to a question about the reporting of system level measures, Karen Bartholomew noted that a quarterly report is submitted to both the Auckland DHB and the Waitemata DHB Boards. There is also reporting to each of the Boards Committees that focus on the each specific Committees purpose.

5. GENERAL BUSINESS

There were no items of general business.

The meeting concluded at 12.08pm

SIGNED AS A CORRECT RECORD OF A MEETING OF THE AUCKLAND AND WAITEMATA DISTRICT HEALTH BOARDS' COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEES HELD ON 04 April 2018

_____CHAIR

Healing Environments for Auckland DHB

Recommendations

That the Board:

1. **Is Informed** of the work to improve the experience of our physical environments at Auckland DHB
2. **Approves** a 'Look and Feel' guideline for Auckland DHB and its on-going development into an Auckland DHB Design Manual to establish a standard for environment design at Auckland DHB.

Prepared by: Justin Kennedy-Good (Programme Director Performance Improvement)
Endorsed by: Allan Johns (Director, Facilities and Development)
Dr Andrew Old (Chief of Strategy, Participation and Improvement)
Endorsed by Executive Leadership Team: Yes: Date: Tuesday, 15 May 2018

Attachments: **Auckland DHB Look and Feel Guideline**
Process draft document
Examples:
Building 32, Level 8 Wait Area

Strategic Alignment

Strategic Theme	Comments
Community family/whānau and patient-centric model of healthcare	Physical environments influence the patient experience and may influence clinical outcomes. The way our system develops and maintains environments is (or is not) a visible demonstration of our commitment to being more patient-centric, an ability to adapt to changing models of care and new technologies.
Service integration and / or consolidation	How care is delivered and experienced is inextricably linked to the design of the environment which care is delivered in. Facility refurbishments provide an ideal time to learn from previous investments and design-in new ways of working.
Consistent evidence informed decision making practice	There is a solid evidence to support the role that Healing Environments has in enhancing the experience and outcomes for patients their whānau. How a facility is designed has a direct effect on the efficiency, effectiveness and wellbeing of staff.
Emphasis on operational and financial sustainability	Healing environments that encompass objectives for improved outcomes, efficiency and experience will return year on year savings as they enable improved service performance.

1. Executive Summary

In 2014 Auckland DHB gathered insights from over 1,000 patients, visitors and staff on their experiences of our public spaces on the Grafton site.

The insights led to the Public Spaces Programme, consisting of three large work streams:

(1) Sustainable Transport
(2) Wayfinding
(3) Healing Environments

This paper relates to the Healing Environments work stream.

Healthcare facilities exist to deliver care and promote health and wellbeing. While the services provided are critical, there is a strong body of evidence that the physical environment plays a significant role in supporting and improving health and wellbeing. Healing environments, for healthcare buildings, describes a physical setting that supports patients and families through the stresses imposed by illness, hospitalisation, medical visits, the process of healing, and sometimes, bereavement.

For our patients a healing environment provides for recovery, connection with friends and family and the ability manage their daily lives. For our visitors this means they can spend quality time with loved ones and be supported through moments of joy, uncertainty or sadness. For our staff a healing environment should enable them to spend time delivering the best care possible and working in the most effective way. A healing environment should also provide refuge and calm.

The Healing Environments work stream was launched under the Public Spaces programme with a focus on refurbishment of our entry from Carpark A to the Grafton site.

What we learned has been summarised into a Look and Feel guideline (attached). This was developed in partnership with multiple stakeholder groups, in particular, those with low mobility and mild visual and/or cognitive impairment. It provides a starting point for redesigning future public spaces.

This paper seeks approval to the Look and Feel guideline and its ongoing development into an Auckland DHB Design Manual to support the DHB to create and maintain Healing Environments for our patients, whānau and staff.

2. Background

In 2014 Auckland DHB gathered insights from over a thousand users on their experience of public spaces at the Grafton site. The work used a human centred design approach as part of the Public Spaces programme. Data gathering focused on entry to Building 32 and Building 01 from Carparks A and B, and street level entry from Park road.

The insights generated may be simply understood as:

- Getting to hospital, in particular getting a carpark and pick up/drop off, is difficult and stressful.
- Navigating the hospital once here is difficult and also stressful.
- We also heard that the physical environment isn't supportive, in particular for those with functional or cognitive impairment.

In response the Public Spaces programme initiated three large work streams, (1) the Sustainable Transport Programme, (2) Wayfinding programme and (3) Healing Environments. This paper relates predominantly to the Healing Environments work stream.

3. Healing Environments Overview

Each year Auckland DHB invests significant capital into facility refurbishments and new builds.

Every new project requires services to describe why they want to change, and what they hope to achieve. Typically those objectives are transcribed into a business case before costing, approval and eventual handover to architects. Those architects then design a solution to meet the described requirements. Historically this has been done with a user group made up of clinicians and other staff.

Through the Healing Environments work we found that the lack of a patient and whānau voice was a gap in our planning:

"My little boy had a karakia [prayer] that he wanted to give her [grandma] before she went in, but he was shy to do it in front of everyone and he didn't know where to do it, and it was beautiful, he'd just learned it. He ended up doing it in the elevator."- Visitor

"I was in shock when diagnosed, where do I go, where do I sit, what do I do?" - Patient

"Sad things happen here; we need a place to get away, to cry" - Staff

In addition to the missing patient and whānau voice, it can be confusing for DHB staff to know who to engage with and which tools to use when going through a design process.

Currently there is no Auckland DHB standard to ensure a consistent approach. This risks us continuing to design-in old ways of working, missing opportunities to improve how we work, and improve the experiences of patients and whānau.

Our Healing Environments approach was predicated on the principle of co-design which brings together experts (e.g. architects, designers and others) and users of the space (e.g. patients, whānau, visitors and other staff).

4. Healing Environments Approach

4.1 Objectives

Project objectives for Healing Environments in our Public Spaces included:

- Refurbished Level 5 Entry and Retail for improved user experience
- Refurbished retail offering that meets the needs of our many users
- Endorsed ADHB Public Spaces Look and Feel Guideline

These have almost been completed through a cross functional team including Facilities, Performance Improvement and a specially formed accessibility group that included clinicians and people with lived experience of a range of disabilities. The learning from this work has been summarised into a Look and Feel Guideline (attached).

4.2 Approach

The Healing Environments approach has been about providing 'how' we bring together various experts with users to arrive at the best design for patients, whānau and staff.

The current working approach is outlined below. It follows a human centred design format. This enables us to set clinical outcome, efficiency and experience goals:

Discover	Define	Develop	Deliver
How are we performing?	What are our goals for the new environment?	What are the solutions to identified opportunities?	Build the new facility and troubleshoot with users any unforeseen issues
- Interviews with patients and key stakeholders - Literature review - 'Go see' best practice (NZ or internationally) - Observe patients to understand entire journey - Review of current facilities (what works, what doesn't) - Map Seven types of flow (clinicians, patients/ whānau, medication, etc) - Establish baseline performance in outcomes, efficiency and experience - New site review to establish potential constraints	- Theming and synthesising outputs from discover phase - Vision and design principles agreed - Quantifiable outcome, efficiency and experience goals created - Key problems to solve/opportunities to explore agreed	- Workshops to solve problems/opportunities with patients/staff (i.e. rapid improvement event format) - Design effort to align to agreed opportunity areas (i.e. if best practice can be adopted, do no re-work those areas) - Demonstrate how performance goals will be achieved (i.e. new flows, new patient experience, improved outcomes)	- Commence change management activities to introduce new service delivery processes or expectations. - Project group engaged in build programme in the event of unforeseen issues

This is a process that we are refining. Further detail and it's alignment to traditional programme management methods can be seen in the attached process draft document.

Further work remains to embed these approaches into how we design and build facilities. The intent of the Look and Feel guideline is to establish a standard, using a thorough approach to then allow fast replication. This approach to establishing standards can be applied to any common area, such as Whānau Rooms.

4.3. The approach in Public Spaces

4.3.1 Design approach

Emphasis in Public Spaces was placed on patient experience:

I. Providing a welcoming entry at Carpark A. The retail configuration at this location had not been changed since opening Carpark A and it historically served a mostly staff customer group. (Approximately 20,000 people enter through that door each week, most of them are not staff).
II. Addressing accessibility and cognitive impairment concerns at that entry point.
III. Enabling a new Wayfinding system (covered by previous presentation May 2017)
IV. Introducing new retailers in the area (covered previously by Commercial Services processes)

The design principles were to create a simple, discernible, purposeful and accessible environment.

4.3.1. User types and considerations

The following user types and considerations were applied in the Healing Environments approach for Carpark A:

- **Patients and visitors**: This user group spends much of their hospital experience waiting in public environments. Easy movement, line-of-sight, natural light, noise management, privacy, seating and social areas all have a direct impact on their experience.
- **Mobility Impaired Users:** Accessibility should never be an afterthought at our hospital. There should be clear paths for wheelchair users to navigate through a space or reside comfortably in public spaces.
- **Cleaners:** Hospital cleaners are responsible for the up-keep and cleanliness of all public spaces. Any design decisions around materials should be considered in relation to their work.
- **Clinicians:** Clinicians operate within hospital spaces every day, during work and break times. They require quick access to public resources during busy periods as well as privacy, refuge and calm to deal with the challenges posed by demanding shift work.
- **Elderly & Cognitively Impaired:** Elderly or cognitively impaired users can be either patients or visitors. Sufficient lighting, simple colours and patterns, consistent evenly-surfaced flooring, appropriate seating all help create a safe and comfortable environment for them.

4.3.3. Design emphasis

I. Providing a welcoming entry

- **Moving the volunteers closer to the entry way –** feedback regarding reception from patients and visitors highlighted an opportunity to bring our volunteers closer to the entry point and a desire for them to perform a floating concierge type service. Whilst we were unable to have a small kiosk as originally intended, the new location enables visitors and patients to be greeted by a smiling face as soon as they enter. This location also has the benefit of being visible when patients leave, so we can assist them with anything they require on the way out.
- **Moving Planet Espresso –** the direct line for movement through the Carpark A entry conflicted with the location and operational function of Planet Espresso.
- **Replacing flooring and repainting walls and ceiling –** To remove colour contrast in the floor and to create a simple, neutral aesthetic that highlighted the new wayfinding system.
- **Allowing more natural light –** removing frosting from external windows and ensuring retailers allow a view through their stores allows visitors to orient themselves in the space.

A significant change was opening the Graftons café to the public and putting tables and chairs on the level five over-bridge. It reinforces the transition of the Carpark A area from a predominantly staff space, to a mixed setting.

II. Addressing accessibility and cognitive impairment concerns

- **Inappropriate seating –** seats that do not provide sufficient stability to ease in or push out of. Or seats that are not of an iconic design (they don't look like seats).
- **Inconsistent lighting –** Lighting that is appropriate for an area and of sufficient strength to be useful.

- **Obstructions –** removing all obstructions from the floor and that obstruct the natural flow of people movement.
- **Lack of differentiation between steps and on glass –** for safety, ensuring steps and glass panes are highly visible
- **Variation in flooring –** for safety, removing different shades of flooring as high contrast changes in surface colouring can appear as a step to visually or cognitively impaired people.

5. Recommendations

The Auckland DHB Look and Feel Guideline contains principles for the design of public spaces. It also includes an accessibility checklist based on our learning. The intent of this Guideline is that it is a 'living document' updated with new areas as we establish an Auckland DHB standard for those areas. It should also be updated as we review the performance of refurbished areas.

There are components that require further development and expression, in particular our connection with local iwi.

Our intent is to develop an Auckland DHB Design manual to encompass the Look and Feel Guideline. Additional sections be added over time under the governance of appropriate programmes (e.g. Whānau rooms under the governance of the Patient and Whānau Centred Care programme) while design methodology refinement continues between Facilities, Performance Improvement and the Patient Experience teams.

5.4 Regional and wider DHB collaboration

The development of this Look and Feel Guideline has included conversations with several DHBs. Waitemata have created useful literature summaries for a range of clinical areas as part of project Leap Frog. Southern DHB have received a copy of the Public Spaces Concept Brief pre work to help with their design processes and visited Auckland DHB to see our design work. The approach to facility design was presented by Justin Kennedy-Good at the Health Design Conference in 2017. This included several DHBs in the audience, along with architecture, engineering and supplier firms.

The concept brief has also been shared internationally with the Health Design Lab, Emily Carr University of Art + Design, Toronto, Canada to assist with their design processes in developing a new large hospital and its public spaces.

6. Conclusion

There are good links between physical environments and health and wellbeing.

We know that many of our spaces can be improved and if we aspire to truly 'Healing Environments' then we require new design processes that include the appropriate engagement of users (patients and staff), earlier in the process.

The establishment of design standards for Auckland DHB is a start on this path. Using insights gathered through The Public Spaces programme we have developed the beginnings of those standards and a different way to design. This was done with in partnership with our Accessibility group, passionate clinicians, and the Facilities team and is a great base to build from.

Approval of the Alice Nelson Charitable Trust

Recommendation

That the Board:

1. **Note the establishment of the Alice Nelson Charitable Trust by Counties Manukau DHB, with the assets as described in the background section of this paper.**
2. **Approve the appointment of the Chief Nursing Officer, Margaret Dotchin, as a trustee of the Alice Nelson Charitable Trust.**
3. **Note that the approval above is subject to final approval by the Minister of Health as required by s28(1)(b) of the NZ Public Health and Disability Act. This will be sought by Counties Manukau DHB.**

Prepared by: Bruce Northey General Counsel
Endorsed by: Alisa Claire Chief Executive
Endorsed by Executive Leadership Team: No:

1. Executive Summary

The purpose of this paper is to seek Board approval for the appointment of the Chief Nursing Officer as a trustee of the Alice Nelson Charitable Trust.

2. Introduction

Counties Manukau DHB is to establish a charitable trust in the name of Alice Nelson, the late Edward Nelson's mother, for charitable purposes that include providing financial assistance to nurses, midwives and their families in Auckland in financial need. Given that the scope of the trust is regional, Counties Manukau DHB has consulted with Auckland DHB and Waitemata DHB on the terms of the trust and has determined that each DHB will appoint a trustee.

Once the Alice Nelson Charitable Trust (the Trust) is established, Counties Manukau DHB will transfer approximately $1,950,000, representing the proceeds of the sale of 18 The Parade, Bucklands Beach, Auckland (the Property) which was bequeathed to one of the DHBs predecessor organisations under the will of Edward Nelson dated 197;, less agreed costs (the net amount being the Funds). The trustees will then be responsible for the management and distribution of the Funds in accordance with the terms of the Trust Deed.

3. Background

By will dated 5 December 1973 (the Will), Mr Edward Victor Nelson bequeathed the Property to the Auckland Hospital Board (the AHB) to be used as a convalescent or rest home for nurses in the Auckland region. The Property was transferred to the AHB in accordance with the Will in 1982.

In 1982, the AHB transferred the Property to the Auckland Nurses and Midwives Rest and Recreation Society Incorporated (the Society), then known as the Auckland School of Nursing Rest and Recreation Society Incorporated for the purpose of providing convalescent and rest home services for members of the nursing staff of the AHB, pursuant to the AHB's obligation under the Will. The Property transfer was made pursuant to an agreement dated 25 June 1982 (the Transfer Deed). The Transfer Deed specified that:

- The Society was to use the Property to provide convalescent and rest home services for nursing staff of the AHB
- If, at any stage, the Society was unable or unwilling to provide these services, the Property was to be transferred back to the AHB
- The AHB was to pay the maintenance costs of the Property.

In 2014, the Society decided that it could no longer effectively use the Property to provide convalescent and rest home services and, accordingly, wished to divest itself of the Property. Counties Manukau DHB then obtained approval from Auckland DHB and the Waitemata DHB to:

- sell the Property and apply the proceeds for an appropriate purpose close in nature to the terms of the original bequest, as approved by the Attorney-General
- seek reimbursement from the proceeds of sale of all costs directly incurred by Counties Manukau DHB in obtaining the appropriate approvals, disposing of the Property and establishing a subsequent trust mechanism to give effect to the testator's wishes
- pay the Society compensation for all improvements of a permanent nature made to the Property (as per Counties Manukau DHB's obligation to do so under clause 4 of the Transfer Deed).

Approval in principle was received in June 2014 by the then Minister of Health that the Property could be sold by Counties Manukau DHB pursuant to section 11A of the Health Sector (Transfers) Act and the proceeds of sale held to further the intent of the original bequest. The Property was sold in August 2015 and the sale proceeds are currently held in a solicitor's trust account on behalf of Counties Manukau DHB.

Counties Manukau DHB consulted with the Society and determined that the Funds would be more prudently managed and Mr Nelson's original wishes served if the Funds were held in a charitable vehicle with a more representative board of trustees. There was a concern that the membership base of the Society narrowed the number and class of persons who may potentially benefit from the Funds. Accordingly, the three DHBs agreed that the Trust should have charitable purposes that include providing financial assistance to nurses, midwives, and their families in Auckland in financial need.

In order to establish the Trust, approval was required from the Attorney-General and the Minster of Health. Chapman Tripp prepared the Trust Deed, which was copied to the Attorney-General. The Attorney-General approved Counties Manukau DHB's proposal to establish the Trust, along with the draft Trust Deed on 3 December 2017.

The Ministry of Health has advised Counties Manukau DHB to gain Board approval from Counties Manukau DHB, Auckland DHB and Waitemata DHB before requesting final approval from the Minister of Health.

2018/19 Annual Plan Approach

Recommendation:

That the Board:

1 **Note the compressed timetable to deliver a first draft of the 2018/19 Annual Plan to the Ministry of Health by 16 July**

2 **Approve the approach to annual planning for 2018/19 which will require a compressed process to develop and collate the first draft to be presented to the 4 July Board meeting to review and also to gain approval to submit to the Ministry of Health.**

3 **Note the recently released national planning guidance, including updates and changes**
   a. **The Ministry is exploring life course approaches to understand population performance**
   b. **Increased focus on equity**
   c. **Additional priority sections: Public delivery of health services, Climate change, Waste disposal, Budget 18 initiatives (once confirmed), Cross-government targets (once confirmed)**
   d. **All of the Health Targets are under review and information as to which will continue in 2018/19 is still to be confirmed**

Prepared by: Wendy Bennett (Planning and Health Intelligence Manager)
Endorsed by: Dr Karen Bartholomew (Acting Director of Health Outcomes)

Glossary:

DHB - District Health Board
MoH - Ministry of Health
SOI - Statement of Intent
SPE - Statement of Performance Expectations

1. Strategic Alignment

Community, whanau and patient centred model of care	Our Annual Plan demonstrates our commitment to our communities, patients and families through providing information on the priorities for the coming year and the associated activities to achieve these through improving health outcomes and enhancing patient experience.
Emphasis and investment on both treatment and keeping people healthy	Activities focused on both treatment and keeping people healthy are identified within the Annual Plan.
Consistent evidence informed decision making and practice	A range of indicators associated with the services and activities the DHB leads or is involved in are captured in the SPE and the MoH's reporting indicator section – along with targets for the coming year. Our Annual Plan demonstrates our commitment to achieving these.
Intelligence and insight	

Operational and financial sustainability	The Financial section of the Annual Plan lays out in detail the budget for the coming financial year. The Annual Plan also contains a variety of operational measures and targets we have committed to which will help us understand if we are delivering value and operating sustainably.

2. Executive Summary

DHBs are required to develop an Annual Plan each year.

This yea however, the Planning Advice and Funding Envelope have been significantly delayed.

The Ministry of Health has only recently released the 2018/19 DHB Annual Planning Package, along with the Minister's Letter of Expectations on 10 May 2018 – this is usually received in December of the preceding year. The Planning Package indicates some changes in terms of content for 2018/19.

A proposed approach and timeframes are included.

3. The Minister's Letter of Expectations

The Minister's Letter of Expectations was released alongside the 2018/19 Annual Planning Package on 10 May 2018. The Government has committed to an $8 billion investment to meet cost pressures and deliver new initiatives over the next 4 years, signalling an increased focus on these priority areas:

1. Primary Care
2. Mental health
3. Public delivery of health services
4. Improving equity in health outcomes

DHBs are expected to continue to focus on long term capital planning, including service planning and asset investment.

DHB Chairs, Chief Executives and management will be held tightly accountable for lifting DHB performance, particularly in relation to equity of access to health services and equity of health outcomes. There is an expectation of strong regional accountability and responsibility where appropriate. The Ministry Advisory Group will work with the Ministry of Health to strengthen relationships across the health sector.

Sharing of best practice innovation, clinical leadership and strong and proactive relationships with the Ministry, other DHBs and the wider sector are required to increase collaboration and improve equity of access, quality and health outcomes.

An increased emphasis on workforce development, including:

- Increased emphasis on the use of generalist workforces for less specialised tasks
- Allied health staff, nursing, medical and related fields need to operate at the top of their scope of practice
- Full implementation of Care Capacity Demand Management by 2021
- All DHBs to adhere to the Medical Council's requirement for Community Based Attachments for interns

Other points to note:

- From 2018/19 the full budget management responsibility for all remaining hospital medicines will move from DHBs to PHARMAC
- Expectation that DHBs continue working in partnership with the Ministry to improve data submission and quality for the National Patient Flow collection during 2018/19
- DHBs need to work towards increasing the rate of organ donations
- The annual plan needs to identify how the DHB will
    - improve the health and wellbeing of infants, children and youth, with a particular focus on Māori, Pacific and highly deprived
    - reduce the burden of long term conditions, particularly diabetes, in partnership with primary care
    - implement a strong response to climate change

4. Planning guidance – updates and changes

The Ministry of Health released the 2018/19 DHB Annual Planning Package on 11 May 2018. While the package largely adheres to the format requirements established in 2017/18, there are some changes in content requirements. These include:

- The Ministry is exploring life course approaches as a way of understanding DHB population performance challenges. Therefore, DHBs are expected to identify within their Annual Plan (AP) the most significant actions they expect to deliver in the 2018/19 year to address local population challenges for the following life course groupings:
    - Pregnancy
    - Early years and childhood
    - Adolescence and young adulthood
    - Adulthood
    - Older people.
- There is an increased emphasis on reflecting health equity in Annual Plans, though following last year's format, to include at least one – specifically identified – equity action within each planning priority. There is again no requirement for a stand-alone Māori Health Plan
- All of the Health Targets are under review and information as to which will continue in 2018/19 is still to be confirmed
- The Minister is not requiring DHBs to refresh Statements of Intent in 2018/19. We have signalled to the Ministry that we will incorporate some minor updates
- Additional priority sections: Public delivery of health services, Climate change, Waste disposal, Budget 18 initiatives (once confirmed), Cross-government targets (once confirmed)
- Priority sections that have changed:
    - Now a specific Child Health section, incorporating Child Wellbeing, Maternal Mental Health Services, Supporting Health in Schools, School Based Health Services and Immunisation
    - Mental Health – removal of the Prime Minister's Youth Mental Health Project. This section now incorporates Population Mental Health, Mental Health and Addictions Improvement Activities and Addictions

- Primary Health Care section now incorporates Access and Integration, as well as CVD diabetes risk assessment. System Level Measures and Pharmacy Action Plan focus areas retained.

Regional service plans will need to be focused on the following regional enablers:

- Equitable Access and Outcomes
- Child Health
- Workforce
- Technology and Digital Services
- Quality
- Clinical Leadership
- Pathways

The regional priority is identified as Hepatitis C.

Some of the guidance is still under development and health targets, some performance measures and targets are still to be released.

5. Proposed approach to Auckland Annual Planning

The 2018/19 DHB Annual Planning Package has been disseminated to staff and other stakeholders. The Planning Team will work with authors/contributors to begin the process of developing and collating the required material to prepare the Annual Plan.

New requirements, particularly around the increased emphasis on equity and the life course approach to population performance will be considered and format and content adapted and updated as appropriate.

There appears to be quite limited scope for feedback within this planning round, given the very tight timeframes, but where necessary we will be providing some feedback to the Ministry of Health.

Changes to the Operating Policy Framework and the Service Coverage Schedule for 2018/19 will be reviewed and those accountable informed. Liaison with Ministry as required.

The Planning Team will engage other key stakeholders as required to ensure alignment with other Plans, current activity and existing collaborative work while undertaking the Annual Plan development.

The timetable of key activities required to complete the plan is extensive and the Ministry of Health timeframes very tight. There will therefore be reduced opportunity for wider consultation on the content of the first draft of the Annual Plan.

6. Financial Information

2018/19 Financial Budgets have been developed to date in the absence of the Ministry of Health Funding Envelope which is expected to be received on 18 May 2018. Budgets and assumptions made to date will be reviewed and finalised following the allocation of funding and assessment of any funding gaps. A detailed update on financial budgets will be provided to the Finance Risk and Assurance Committee at its 14 June 2018 meeting.

7. Sign Off Process and Timelines

Draft 1 of the Annual Plan will be presented to the July Board for review and approval sought to submit to the Ministry of Health on 16 July 2018 as required. The final draft will be presented for consideration at September Board/Committee meetings, to be confirmed once final dates for submission are released by the Ministry of Health. Endorsement of the Annual Plan will also be sought at these critical stages from our MoU and other partners.

The final Annual Plan will require the signatures of the following:

- Board Chair
- Deputy Chair
- CEO
- MoU Partner

As in past years, it is proposed that any amendment or last minute changes to the Annual Plan, Statement of Performance Expectations and Statement of Intent be delegated to the Board Chair and the CEO. This provision allows flexibility to accommodate late information.

Regular oversight of the Annual Plan, the Statement of Performance Expectations and Statement of Intent while under development is the responsibility of the Director – Health Outcomes and the Director - Funding.

Timeframe

Note this timetable focuses on the non-financial elements of the planning process and does not include the budgeting process deadlines and milestones. Dates for submission of the finalised Annual Plan (draft 2) have not yet been released by the Ministry of Health.

10 May	Minister's Letter of Expectations released
11 May	2018/19 Annual Planning Package released - MoH
18 May	Funding Envelope advice due for release
June	Annual Plan content development and review
29 June	DHBs to provide the final Statement of Performance Expectations
2 July	Submit final System Level Measure Improvement Plan
4 July*	Auckland DHB Board meeting to review and approval sought to submit to the Ministry of Health the Auckland DHB 2018/19 Annual Plan – draft 1
16 July	**2018/19 Annual Plans (including minor updates to Statements of Intent) and Northern Region Health Plan submitted to the Ministry of Health as a draft for review**
31 July	System Level Measure Improvement Plan approved
Week beginning 13 August	Ministry of Health provides informal feedback on draft Annual Plans
Week beginning 3 September	Ministry expects to facilitate formal feedback on DHBs draft Annual Plans, Regional Service Plans and, Public Health Unit Annual Plans.
September - *TBC*	Board/Committee review of second draft and approval sought to submit to MoH
TBC	**Board-approved 2017/18 Annual Plans (including any updates to Statements of Intent) and Northern Region Health Plan submitted to the Ministry of Health**

* extra time may be provided for full consideration and review of Annual Plan content

8. Risks, Opportunities and Mitigations

Risk area	Specifically	Mitigation
Very tight timeframes may impact on quality of content	Ensuring the right balance of government and local priority setting will be challenging, within a restricted timeframe for development.	Early engagement with authors and contributors, assistance as required. Timely liaison with MoH.
Active leadership of priority area content development. Adequately engaging with a wide range of stakeholders.	While the restricted timeframes allow for limited scope for input from stakeholders, there is still an expectation for DHBs to engage with relevant stakeholders, including their primary care partners, when developing their 2018/19 APs.	Early advice to staff and regular communication that keeps everyone up to date with planning expectations for 2018/19 throughout the process. Clear roles and responsibilities identified early in the process. Responsible authors identified at the start of the process. Active support and facilitation of engagement opportunities.

9. Conclusion

2018/19 will present some challenges as we develop Annual Plans, update the Statements of Intent and Statements of Performance Expectations in line with the Ministry's significant condensed timelines. Key to our success is gaining endorsement from the Board for the proposed planning process. We will also need to make sure content development is appropriately assigned and led and that key stakeholders are informed about the approach and, where practicable, have an opportunity to provide input into the planning process.

Integrating Governance, Leadership and Planning Arrangements for Maori Health

Recommendations

It is recommended that the Board:

1. **Note that because of changes in Board leadership, there have been delays in implementing decisions taken by the Boards of the Auckland, Counties Manukau and Waitemata DHBs at their meetings on 1 November 2017, 6 December 2017 and 8 November 2017 respectively in respect of the governance, leadership and planning arrangements for Maori health across the metro Auckland DHBs**

2. **Note that the interim Chairs of Auckland and Waitemata DHBs, together with the Chief Executives of the metro Auckland DHBs, recently met to discuss best ways forward in the light of Recommendation 1 above and agreed that:**

    a) **As soon as all three new Board Chairs are in place (by 10 June), the Chairs will be asked to appoint members of the new Maori Health Advisory Committee, in accordance with decisions 2-3 made at their earlier Board meeting. A first meeting of the Maori Health Advisory Committee will then be able to be scheduled**
    b) **The extension of the role of the Chief Advisor Tikanga for both Auckland and Waitemata DHBs to include Counties Manukau DHB should be placed on hold for the time-being until Counties Manukau DHB and Manawhenua signal they are ready for this extension**
    c) **Dr. Bramley, as lead CEO for Maori health across the metro Auckland DHBs, will consult with the Maori Health Advisory Committee, once established, on a suitable process for the recruitment and appointment of a Director, Maori Health Services. Assuming the Maori Health Advisory Committee favours a single Director of Maori Health Services across the metro Auckland DHBs, Dr. Bramley will lead the appointment panel for the position and invite the other metro Auckland Chief Executives to join the panel, should they wish to do so**
    d) **As an interim measure, and recognising that the process contemplated in 2 (c) above may take a number of months, Counties Manukau DHB should immediately move to fill its vacant position of General Manager Maori Health on a fixed term basis of 12-18 months**
    e) **A further update should be provided to all three metro Auckland DHB Boards once tangible progress has been made with steps 2 (a) through 2 (d) above.**

3. **Note that as provided for by the New Zealand Public Health and Disability Act 2000, appointments to staff positions, as contemplated in Recommendation 2 (c) above, are the preserve of a Chief Executive not a Board or Board Committee**

4. **Endorse the actions set out in Recommendation 2 above, subject to the endorsement of the Minister of Health.**

Prepared by: Gwen Tepania-Palmer, Chair Auckland DHB
Vui Mark Gosche, Chair, Counties Manukau DHB
Kylie Clegg, Chair Waitemata DHB

Purpose

This paper provides an update on the implementation of decisions of the Boards of the Auckland, Counties Manukau and Waitemata DHBs (metro Auckland DHBs) in respect of the above subject on 1 November 2017, 6 December 2017 and 8 November 2017 respectively.

Background

Late last year, the Boards of the metro Auckland DHBs considered proposals for changing governance, leadership and planning arrangements for Maori health across the metro Auckland DHBs.

In separate meetings, the Boards of Auckland, Counties Manukau and Waitemata DHBs each:

1. **Agreed** to the creation of a combined Maori Health Advisory Committee (MHAC) across the metro Auckland DHBs with the terms of reference set out in an attached paper
2. **Invited** the Chairman of the metro Auckland DHBs, in consultation with the current Chairs of the Maori Health Advisory Committees, to make initial appointments to MHAC and designate its Chair
3. **Noted** that, in respect of external appointments, the Chairman will first consult in accordance with memorandum of understanding (MoU) between the metro Auckland DHBs and Manawhenua or Maori organisations
4. **Invited** MHAC to recommend to the Boards of the metro Auckland DHBs terms of reference for, and composition of, a Kaumatua Council to provide advice and guidance on efforts to improve health outcomes for Maori across metropolitan Auckland
5. **Invited** Dr. Dale Bramley, Chief Executive of Waitemata DHB, to assume a leadership role, including full managerial oversight and delegated authority, for Maori health for the metro Auckland DHBs
6. **Invited** Dr. Bramley to develop options for improving the leadership, management and planning of Maori health issues across the metro Auckland DHBs, including the:

    a) creation of a single Maori health team across the metro Auckland DHBs, with one or more senior executive positions to lead and manage the team and clear definition of what functions should be regionalised as opposed to operated locally
    b) extension of the role of the Chief Advisor Tikanga for both Auckland and Waitemata DHBs to include Counties Manukau, subject to consultation with Manawhenua by Counties Manukua DHB
    c) rationalisation of existing plans and approaches for Maori health across the metro Auckland DHBs
    d) alignment of processes across the metro Auckland DHBs for the review of research proposals from the perspective of Maori ethics and tikanga

7. **Noted** that Dr. Bramley will engage with MHAC on the proposed plan to give effect to the above recommendation and that he will also liaise with the Chief Executives of Auckland and Counties Manukau DHBs, as well as other stakeholders as appropriate, before finalising his proposed plan.

Comment

Since these decisions were taken, a number of changes have occurred, the most significant of which has been the retirement of Dr. Lester Levy as Chair of the metro Auckland DHBs and his replacement by separate Chairs for each DHB.

Deputy Board Chairs have served or are serving as Chairs on an interim basis. New Chairs to lead the metro Auckland DHBs on an ongoing basis have recently been announced by the Minister of Health and either have or will shortly commence their terms.

The effect of these changes has been to delay the formation of the Maori Health Advisory Committee, the extension of the role of the Chief Advisor Tikanga for both Auckland and Waitemata DHBs to include Counties Manukau DHB and an appointments process for a Director of Maori Health Services to lead a single Maori health team across the metro Auckland DHBs.

This delay has particularly affected Counties Manukau DHB which, unlike Auckland and Waitemata DHBs, has not already had a General Manager for Maori Health Services in place.

The interim Chairs of Auckland and Waitemata DHBs, together with the Chief Executives of the metro Auckland DHBs, recently met to discuss best ways forward.

Recognising the previous decisions taken by the Boards of the metro Auckland DHBs, and the distinction between governance and management roles and responsibilities, as reflected in the New Zealand Public Health and Disability Act 2000, they agreed that:

1. As soon as all three new Board Chairs are in place (by 10 June), the Chairs will be asked to appoint members of the new Maori Health Advisory Committee, in accordance with decisions 2-3 made at their earlier Board meeting. A first meeting of the Maori Health Advisory Committee will then be able to be scheduled
2. The extension of the role of the Chief Advisor Tikanga for both Auckland and Waitemata DHBs to include Counties Manukau DHB should be placed on hold for the time-being until Counties Manukau DHB and Manawhenua signal they are ready for this extension
3. Dr. Bramley, as lead CEO for Maori health across the metro Auckland DHBs, will consult with the Maori Health Advisory Committee, once established, on a suitable process for the recruitment and appointment of a Director, Maori Health Services. Assuming the Maori Health Advisory Committee favours a single Director of Maori Health Services across the metro Auckland DHBs, Dr. Bramley will lead the appointment panel for the position and invite the other metro Auckland Chief Executives to join the panel, should they wish to do so
4. As an interim measure, and recognising that the process contemplated in 3 above may take a number of months, Counties Manukau DHB should immediately move to fill its vacant position of General Manager Maori Health on a fixed term basis of 12-18 months
5. A further update should be provided to all three metro Auckland DHB Boards once tangible progress has been made with steps 1-4 above.

It is recommended that before proceeding to implement the above decisions, the Minister of Health be informed of the intention to create a single MHAC and be invited to give any feedback that he may have. Any such feedback would need to be considered by the Boards of the metro Auckland DHBs.

Auckland DHB Engagement Survey Action Plan Update Report

Recommendation

That the Board:

1. **Receives the Auckland DHB Engagement Survey Action Plan Update report.**
2. **Notes the Auckland DHB Engagement Survey Action Plan Update progress.**

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

Glossary

Acronym/term	Definition
FTE	Full-time Equivalent
HR	Human Resources
MOS	Management Operating System
SMO	Senior Medical Officer

1. Introduction/Background

The purpose of this report is to provide the Board a Directorate update on the Auckland DHB Engagement Survey action planning for the last quarter. Actions over the last quarter focus on the continued embedding of 'Speak Up' and also the continued roll out of values workshops across the Directorates. Many of the Directorates are reporting that issues with vacancies are hindering their ability to focus fully on workforce engagement work. It is positive to see that there is a focus on values based behaviours, and timely dealing with instances of challenging behaviours identified in this report.

2. Progress/Achievements/Activity

Directorate: Clinical Support

Our top three action planning priorities	What needs to change	What we are doing	Our success measures
Safety and Wellbeing. Health and Wellbeing has not suffered because of my work. Bullying and Harassment.	All employees feeling happy, well and safe at work. Level of bullying or harassment in the workplace dropping.	Some areas have been experiencing delays in either finding suitable candidates or recruitment delays which are increasing employee stress levels. Areas of concern are being raised in Directorate monthly Quality and Care Forum. Additional recruitment	Lower attrition and sick leave rates. Lower instances of bullying and harassment being recorded within the Directorate. Increased positive feedback from staff.

		resource has been obtained. Proposals being prepared to address where services require additional Full-time Equivalent (FTE). We are seeing a shift in managers addressing unacceptable behaviour in a timelier manner. Values Workshops will be delivered to all staff by June 2018 and should create a better sense of behaviours which are in line with our values.	
Emotions at Work Drained, Cynical and Frustrated.	Workforce and Capacity Planning. Not relying on overtime for extended hours.	Where immediate workforce concerns are identified actions are being put in place to address. Longer term workforce planning is being identified which will allow better lead in with affected employees.	Properly resourced on call services. Improved morale and productivity.
Recognition and Value. Feeling Valued and Appreciated. Being recognised for doing a great job.	Staff recognised for their great work. Provide more feedback within services, from Directorate and wider organisation. Ensure staff feel engaged in the wider organisation. Celebrating good things and successes. Management to acknowledge great work and thank staff. Acknowledge staff in staff meetings.	The Directorate continue to look at ways of recognising great work. Senior Leadership Team meets with those who have been nominated or won awards. Newsletter is being introduced to communicate more widely and will recognise achievements and celebrate success. Looking to introduce Engagement Champions from each service.	Staff contribution to the service, service improvement and organisational strategies. Higher levels of engagement.
• We are continuing to engage with staff more around information sharing, with values workshops/team charters continuing to be done. • Management are starting to attend Management Operating System (MOS) and Staff Meetings			

with more walk-arounds.

Directorate: Perioperative

Our top three action planning priorities	What needs to change	What we are doing	Our success measures
Reduce the incidence of bullying, harassment and discrimination, either experienced or observed.	The structural changes to the Perioperative Directorate have been implemented. The Human Resources (HR) team will now look at implementing a behavioural coaching programme to assist line managers to: • role model the organisation's values in a way that is apparent to all • that staff feel safe to say "It's not ok to…."	A new Nurse Director has recently been appointed to the role. HR is working with her to help her embed herself in the role operationally and will coach her on appropriate behaviours. The next step will be to work with her on ensuring that engagement action plans are in place under the new structure. The 'Speak Up' programme is a well-publicised brand but not many complaints are received through this channel.	Reduction in complaints about poor behaviour. Improved results in the next survey. An understanding by management of how positive behaviours can influence performance and job satisfaction.
Improve the level of health and wellbeing amongst staff in the Directorate.	Reduce the amount of accrued annual leave. Reduce the amount of sick leave taken.	Two significant initiatives have taken place, as follows: • the first is the implementation of the new clinician led structure • the second is the effort that has gone into trying to resolve the shortage of Anaesthetic Technicians Both of the above are contributing to working towards a more even distribution of the workload and therefore, the ability to take annual	Reduction in annual leave accumulations and amount of sick leave taken. Reduction in overtime costs. Improved results in the next survey.

		leave. The new leadership, particularly in the nursing group and in Central Sterile Supply Department, are endeavouring to address annual and sick leave issues.	
Increase the level of personal and team recognition for actions taken and work well done.	Immediate appreciation needs to be expressed to team or employee for a job well done. Leadership teams need to share improvement ideas and listen to proposals. Survey action plans need to be monitored.	The Performance and Development process in Kiosk has been circulated to the Directorate. HR will be working with management to ensure that every employee has had a performance review and through this process will coach managers on how to give positive feedback. Monitoring action plans as an agenda item in Lead Team meetings need to be dealt with more robustly.	Actions taken from meetings and by whom. Improved results in the next survey.

Directorate: Surgical Services

Our top three action planning priorities	What needs to change	What we are doing	Our success measures
Increase the visibility and approachability of the Directorate leadership.	Amount and type of physical, verbal and written interaction.	Individual service plans have been developed which include KPIs on engagement action plans. The service plans are now being used to monitor progress in the services against the wider Directorate plan. Several members of the Lead Team are now attending meetings across the Directorate on an ad hoc basis, which is being received	Effective cascading of information across the Directorate and resultant actions. Successful actions coming from meetings and interactions. Actions taken from meetings and by whom. Improved results in the pulse survey.

		positively.	
Reduce the incidence of experienced or observed bullying, harassment and discrimination.	Acknowledgement of impact of negative behaviour on staff including from staff in other Directorates. Role modelling of organisational values needs to be visible.	A concerted effort is being made to re-energise the focus on Values' training and HR is currently conducting sessions with groups across the Directorate. The Performance and Development process in Kiosk has been distributed and managers are being encouraged to utilise this tool before it becomes mandatory in the new year. This will mean managers start having conversations with their staff about both objectives and behaviours.	Reduction in complaints about poor behaviour. Improved results in the next pulse survey.
Improve the level of health and wellbeing amongst staff in the Directorate.	Recruitment to and maintaining agreed Models of Care. Internal communication needs to improve. Opportunity to take annual leave. Staff resilience.	The recruitment process is working effectively and a number of new employees have been appointed. The goal is to stem the tide of resignations from experienced staff resulting from the constant work load pressures. Work is currently in progress to identify where the pressure points are and to try and find solutions to these. The regular meetings structure which has been established is proving positive in keeping everyone aligned and focused on the priorities for the Directorate. A Directorate picnic has been held for all staff on 2 March 2018.	Feedback received from staff on internal communications. Increase in annual leave taken. Decrease in sick leave taken and overtime. Improved results in the next pulse survey.

Directorate: Cardiovascular Services

Our top three action planning priorities	What needs to change	What we are doing	Our success measures
A significant percentage of our workforce responded that they had personally observed bullying or unacceptable behaviour in the workplace in the last six months.	We need our people to feel comfortable, capable and supported to report or challenge that observed behaviour. We need our people to feel safe in the workplace, and to value and respect one another.	We have promoted the 'Speak Up' program across the Directorate. Most teams have acted according to their individual action plans except the Senior Medical Officers (SMOs). Several of the SMOs have responded as individuals via their performance plans and courses offered by the College of Surgeons.	Real measurement for success is likely from the next Engagement Survey. There is increasing evidence in most areas that we are maturing as a Directorate as a result of the 'Speak Up' programme and that has led to positive outcomes from known events.
A significant proportion of our workforce responded negatively to the statement that my health and wellbeing has not suffered because of my work.	We need to ensure our staff feel more valued. We need to ensure staff aren't coming to work fatigued because of rostering and overtime calls. Work flows and processes need to be more streamlined.	The change process in Ward 42 was designed to respond to streamlining workflow. There has been real progress in this area. Knowledge and understanding of the importance of Trendcare is growing in terms of working towards a more appropriate Model of Care. While the leave rosters are reviewed regularly to support staff rest and relaxation, there is still challenge in allowing more leave.	Improvement on scoring in next survey. Annual leave balances/ liability should decrease. Staff turnover and sick leave balances should be within expected range. Staff are engaged in projects to improve work flows and processes. There are still challenges in this area.
In some areas of this Directorate about half of our people responded negatively to the view that they are praised and recognised when they do a good job.	While our people feel engaged, they will feel more engaged if they feel valued. In addition, leaders acknowledging and celebrating good work should be a natural response.	The Leadership and the coaching conversations for people leader programmes have attracted more leaders – it appears though that many are missing out because of demand. The value of performance conversations is being strongly promoted	People should report improved job satisfaction, and better levels of connection in the workplace.

		across the Directorate. Immediate supervisors are recognising when their people do a good job and the Directors are advised of positive events so that they too can respond.	

Directorate: Mental Health and Addictions

Our top action planning priorities	What needs to change	What we are doing	Our success measures
Safety and Wellbeing. Health and Wellbeing has not suffered because of my work. Bullying and Harassment.	All employees feeling happy, well and safe at work. Level of bullying or harassment in the workplace continues to reduce.	Values Workshops completed in 2016 and continued in 2017. 'Speak Up' Launched in May 2017 – Teams are aware of the 'Speak Up' pathway. Directorate Leadership Team role modelling the behaviours we want to see in the Directorate from the Top.	Reduce number of informal and formal complaints from employees experiencing inappropriate behaviour in their workplace Directorate. 'Speak Up' submissions are acknowledged and responded to ensuring parties have a resolution that everyone has agreed on and happy with. Directorate Leadership Team developed a Team Charter which includes behaviours that promote a work environment and leadership behaviours which are aligned to Auckland DHB Values.
Different Teams and Services work well together. Directorate Leadership Team are visible and approachable. Strategic	Increase across and within team communications and connections, creating 'One Team'. Directorate Leadership Team role model Auckland DHB Values and are visible and approachable to all Mental Health and	Directorate Leadership Team and Service Clinical Directors now have an integrated fortnightly meeting so that Key Leadership roles are aligned to strategy and operational Key Results Area and cascaded to Service Clinical Director	Meetings are embedded; all teams within Mental Health and Addictions Services are working together as 'One Team' being collaborative and supportive. Director meetings are embedded and began in

Direction. Connecting new staff to the Directorates A3s and business plans.	Addictions Teams.	respective Services/Teams. Director established quarterly sessions with teams. Nurse Director and Medical Director established Nursing and Medical session with Teams focus on all A3s. Designed, developed and implemented a newbies 'orientation hour' for all new staff following the Navigate session – this Mental Health and Addictions orientation is called *Discovery Hour.* Newsletter "Touching Base" implemented in 2015 by Directorate Leadership Team.	January 2018. Nurse Director and Multi-Disciplinary Meetings are embedded and began in January 2018. First Discovery Hour took place Feb 2018. Continue to publish the "Touching Base" on a quarterly basis.

Directorate: Adult Medical

Our top three action planning priorities	What needs to change	What we are doing	Our success measures
Each service within the Adult Medical Directorate has its own set of action plans and priorities that broadly reflect the action priorities listed below. Not all of the issues below are reflected in the plans of each individual service. Within each service the action planning should be cascaded to the front line employees and their leaders (mostly Clinical Charge Nurse, Charge Nurse and Team Leader). This has still not been completed successfully for all teams in each service. Work has taken place opportunistically and when time has allowed in Wards and the Adult Emergency Department, and work to support employees following on from the outcomes of the Employee Engagement Survey are taking place in all teams.			
Improved employee wellbeing through improved resilience and through support for the 'Speak Up' campaign and processes.	Staff need to feel able to 'Speak Up'. Awareness and use of values to be clear on appropriate and inappropriate behaviour. Values to be used as part of annual performance review.	Use of 'Speak Up' materials. Hold 'Speak Up' awareness sessions with teams. Identify and recruit Directorate-wide 'Speak Up' supporters. Undertaking values and	Record of events: several events have taken place within the Directorate. Record of issues raised. Employee Assistance Programme information (increased access) not accessed to date.

	This needs to be discussed at team meetings. Employees encouraged to 'Speak Up'. Staff provided with support and tools to improve resilience.	behaviour sessions within teams. Work with Employee Assistance Programme and others on improved resilience.	Anecdotal decrease in tolerance for inappropriate behaviour but reporting on incidents has not increased. 'Speak Up' supporters in place in all services.
Improve employee satisfaction following the outcomes of the Employee Engagement Survey.	Develop service plans and team plans. Improved support to be provided to clinical graduate employees. Focus needs to be on positivity. Improve the physical environment, if unsafe or contributing to large scale employee concern.	Share and discuss Engagement Survey results and develop individual team action plans. Undertake specific induction and engagement planning for new graduates. Develop and reinforce a 'thank you' culture and other behaviours that relate to the Auckland DHB values. Seeking funding, particularly to make improvements where environment is considered unsafe.	Team plans at all levels of team are in place and the action plans are being implemented and monitored. Specific support for new graduates is developed and provided. Undertake action to support development and delivery of the 'focus on positivity'. Formalise cascade of senior and organisational meetings to staff and provide an opportunity to feedback is still in its infancy, but improving. Appropriate resources are sought and support for these requests is given.
Investigate and take action on the issues raised by employees feeling that there is insufficient time to complete their work.	Improve recruitment turn-around times and processes. Improve leave planning. Ensure sick leave is effectively monitored and managed. Investigate the legitimacy of any requests for additional staffing and complete the business planning for this.	Working more closely with recruitment to improve our recruitment success. Make use of the HR information available. Get access to staff support that will allow effective business planning and access to more resources.	Time to recruit reduces. Reduction in Sickness/ Bradford factor: seeking to understand any correlation. Considerable activity to improve effectiveness to reduce risk to staff (work smarter not harder).

Directorate: Cancer and Blood

Our top three action planning priorities	What needs to change	What we are doing	Our success measures
Each Service within the Cancer and Blood Directorate has its own set of action plans and priorities that broadly reflect the action priorities listed below. Not all of the issues below are reflected in the plans of each individual service. Within each service the action planning should be cascaded to the front line employees and their leaders (mostly Clinical Charge Nurse, Charge Nurse and Team Leader). This has still not been completed successfully for all teams in each service. Work has taken place opportunistically and when time has allowed in Wards and the Adult Emergency Department, and work to support employees following on from the outcomes of the Employee Engagement Survey are taking place in all teams.			
Support improved Health and Wellbeing.	Implementation of a continuous cycle of burn-out assessment and systems improvement. Support individual action plans for burn-out prevention. Staff able to get support to manage issues.	Conferences and learning opportunities. Use of available support mechanisms. Investigate better ways of working to reduce risks to staff.	Record of events: several events have taken place within the Directorate, including burnout conference in May 2017. Employee Assistance Programme information (increased access) not accessed to date. Reduction in Sickness/ Bradford factor: seeking to understand any correlation. Appropriate support provided to employees exhibiting burnout. Considerable activity to improve effectiveness to reduce risk to staff (work smarter not harder).
Improve the situation in relation to inappropriate behaviour including bullying and harassment.	Staff need to feel able to 'Speak Up'. Code of behaviour for Cancer and Blood needs to be developed.	Use of 'Speak Up' materials. Identify and recruit directorate-wide 'Speak Up' champions. Develop a Code of Behaviour for Cancer and Blood.	Anecdotal decrease in tolerance for inappropriate behaviour but reporting on incidents has not increased. 'Speak Up' supporters in place in all services. Code of Behaviour not yet in place for all services.
Improve the way in which we interact	Improve leadership visibility and communication within	State of the Nation and other events. Greater visibility of	Events have happened. Formalise cascade of senior and

"Together".	and across teams. Improve multi-disciplinary working across professions within each service	Service Clinical Directors and Executive Leadership Team. Ensure commitment to multi-disciplinary working in services. Leaders to ask their teams "Is there anything I could do better?".	organisational meetings to staff with an opportunity to feedback is still in its infancy, but improving. Leader rounding to check on effectiveness of communication cascade and multi-disciplinary team function is improving slowly.

Directorate: Child Health

Our top three action planning priorities	What needs to change	What we are doing	Our success measures
Recognition and Value. Efforts are recognised and valued. Staff feel valued and appreciated.	Increase positive feedback from managers and amongst team members. Staff feel recognised for good work.	We have introduced a fortnightly newsletter, including recognition of achievements and long service. Staff put each other forward for recognition. Education on why appreciation matters and giving effective feedback. Incorporate recognition into business as usual - MOS, Clinical Excellence, Directorate, Service Review etc.	Improved results at next survey. Improved Patient Safety Culture survey results. Lower sick leave and attrition rates. Increased staff participation in Clinical Excellence.
Safety and Wellbeing. Reduce the prevalence of bullying in our workplace. Staff feel safe to 'Speak Up'.	All employees are happy, healthy and safe, and able to work to their potential. Managers are able to identify and eliminate unhealthy behaviours.	Strengthen, embed and spread psychological safety work. Further survey imminent. Leaders actively support 'Speak Up'. Education and support for managers to create a safe work environment. Staff wellbeing is an agenda item at HandS meetings.	
Contribution	We encourage and	Promote staff	

and Control. My views and ideas are welcomed and encouraged.	respond to staff ideas. Strengthen/ increase channels for staff feedback. Staff understand why decisions are made.	involvement in clinical excellence and other forums where ideas can be shared. Continue "Good Catch" programme.	
• We have incorporated engagement and action plans into business as usual- Directorate, MOS, service meetings. • We connect with employees to identify issues, find solutions and share ideas.			

Directorate: Women's Health

Our top action planning priorities	What needs to change	What we are doing	Our success measures
No significant progress on action planning in January-February 2018 due to a number of factors including vacant leadership roles requiring some employees to operate in multiple roles to ensure patient safety and wellbeing. New Women's Health Director commences 1 March 2018.			
Fill vacancies.	Convert more expressions of interest/ applications to job acceptance. Auckland DHB/ Women's Health profile and recruitment approach to effectively source scarce skillsets, be proactive, and build a pipeline for the future workforce.	Securing external recruitment expertise to boost capacity and impact of communications. Articulate the "why" beyond clinical attraction. Strengthen what we offer (individualised development plans/ "package").	Modernised recruitment campaign underway supported by new channels and media; Auckland DHB stand at International Midwifery Conference in Adelaide to attract experienced midwives. Vacant Midwifery FTE 26.8, of which 14.4FTE is hired (16 midwives) to start by end January 2018. Average Time to Hire (Authority to Recruit approval to offer acceptance) = 68.25 days. Filled critical positions: All SMO vacancies hired to; however 2 on or going on Parental Leave; 1 subject to passing Medical Council of New Zealand requirements. Operations Manager Gynaecology started;

			Operations Manager Maternity appointed to start mid-January 2018. Unfilled critical positions: 2 Service Clinical Director (1 filled, starting mid-January 2018); second interviewing late November 2018. Churn within midwifery leaders, some desired, 2 retirements and 3 internal transfers being filled with internal appointments. Turnover < 12 months = 2 individuals.
Address unacceptable levels of bullying and harassment.	Increased understanding of what harassment and bullying is and isn't; and willingness by individuals to 'Speak Up' informally. Consistent will across people managers to address inappropriate behaviour so that owning of behaviour and appropriate outcomes occur. Interactions, even when giving feedback around areas that need to change are conducted in a supportive manner.	Implement 'Speak Up' processes and guides. Up skill use of feedback models – talk to you not about you. Teams develop Charters.	Team culture development programme underway in one service in response to multiple complaints regarding behaviour, with good effect. 1 individual resigned rather than engage in behaviour modification following bullying complaints. Feedback clarified that employees have labelled behaviour as bullying that do not meet the definition; education continues informally via people leaders. Team Charter for each team. Team use of "above and below the line" feedback. Number of bullying/ harassment issues raised formally and time taken to resolve.

			Graduate midwife hire rate: 2 of 3 New Zealand trained graduate midwives declined offers in October 2017; 7 of 10 Australian trained graduate midwives accepted. Turnover < 12 months = 2 and exit interviews.
Take care of our people's wellbeing and safety.	Increase focus and communication on the positive contribution and effort of employees. Managers acting to address the wellbeing of their team members when individual issues arise (demonstrating care and efficacy, not hopelessness).	Resilience training. Strengthen support and training to deal with critical incidents and processes. Individual performance reviews and development plans. Take action to support personal/ health status and promote the wellbeing of our people (*I see you*).	Annual Performance review or individual feedback completion rate. Individual development plans in place. Wellbeing actions for leaders, individuals and team. Enhanced Employee Assistance Programme supporting 13 people leaders with good effect; themes dominated by impact of on-going workforce shortages and no end in sight. Retention tactics underway for identified key talent (discretionary leave; fixed/flexible work pattern for defined period; individual development plans defining promotion or valued professional up skilling). Witness 'Speak Up' action to support and care for colleagues.
Manager focus on working with employee strengths more than the gap.	More affirming of the positive than focusing on the areas of gap. More celebration of success. Awareness and ability to work with insight into own and others strengths in the	Strengths based leadership workshop. People managers use team profiling tool to raise awareness of own and others styles and strengths. Individual performance reviews/feedback	Objectives set and achieved. Team-developed short term team or service goals that are achieved. Team effectiveness. Awareness of leadership impact. One-on-one

	workplace.	conducted in a way that leaves people feeling valued and appreciated. Leadership coaching.	coaching at L2 underway addressing performance and leadership behaviour issues.

3. Conclusion

This report has provided the Board a Directorate update on the Auckland DHB Engagement Survey action planning for the last quarter. A further Directorate update will be provided at the September 2018 Board Meeting.

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		
2. Register of Interest and Conflicts of Interest	As per that stated in the open agenda	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3. Confirmation of Confidential Minutes 11 April 2018	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
3.1 Circulated Resolution – Draft 2018/2019 Statement of Performance Expectations	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
4. Confidential Action Points	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
5.1 Risk Management –	**Commercial Activities** Information contained in this report is related to commercial activities and	That the public conduct of the whole or the relevant part of the meeting would

Board Update	Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	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 Chief Executives Confidential Report	**Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
7 Performance Reports - Nil	N/A	N/A
8.1 Finance, Risk and Assurance Committee Referral Report 2 May 2018	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
8.2 Disability Support Advisory Committee Referral Report 14 May 2018	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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 healthAlliance NZ Ltd – Shareholder Issues	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

9.2 Contract Renewals and Value Increases – Primary Care, Community Care and Aged Residential Care	**Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)] **Prevent Improper Gain** Information contained in this report could be used for improper gain or advantage if it is made public at this time [Official Information Act 1982 s9(2)(k)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
10.1 Draft Auckland DHB Business Plan 2018/2019	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.1 Human Resources Report	**Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)] **Negotiations** Information relating to commercial and/or industrial negotiations in progress is incorporated in this report and would prejudice or disadvantage if made public at this time [Official Information Act 1982 s9(2)(j)]	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]
11.2 THRIVE Deep Dive	**Privacy of Persons** Information relating to natural person(s) either living or deceased is enclosed in the report. **Commercial Activities** Information contained in this report is related to commercial activities and Auckland DHB would be prejudiced or disadvantaged if that information was made public [Official Information Act 1982 s9(2)(i)]	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 General Business	N/A	That the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information which good reason for withholding would exist under any of

		sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982 [NZPH&D Act 2000]

Combined Regional Disability Support Advisory Committee - Update

Recommendation

That the Board:

1. **Notes the update provided around the establishment of a Combined Regional Disability Support Advisory Committee, metro Auckland.**

That the Board; subject to ministerial approval:

2. **Endorses the interim arrangement of co-chairs for the Committee being from Auckland and Counties Manukau DHBs.**
3. **Notes that the first meeting of the new joint Regional Disability Support Advisory Committee subject to ministerial approval will occur on 6 June 2018.**
4. **Endorses the Auckland DHB Committee membership as follows:**

Jo Agnew	**Co Chair**
Michelle Atkinson	**Member**
Robyn Northey	**Member**

Prepared by: Jo Agnew (Chair, Auckland and Waitemata DHBs joint Disability Support Advisory Committee)
Endorsed by: Gwen Tepania-Palmer (Board Chair Auckland, Waitemata and Counties Manukau DHBs)

1. Board Strategic Alignment

Community, whanau and patient-centred model of care	The commitment made by Auckland, Waitemata and Counties Manukau DHBs to its communities, patients and families aligned to the specific outcomes of the New Zealand Disability Strategy 2016 to 2026 will be reviewed and monitored in an aligned and collaborative way, and consistent advice will be given to all three Boards on how they can effectively meet their responsibilities towards the government's vision and strategies for people with disabilities.
Intelligence and insight	The focus and work programme of the Disability Support Advisory Committee will be based on the disability support needs of the resident populations of Auckland, Waitemata and Counties Manukau DHBs and on the strategic priorities for giving action to the outcome areas of the New Zealand Disability Support Strategy 2016 to 2026. Work programmes will be aligned across the metro-Auckland DHBs.
Outward focus and flexible service orientation	The Committee will focus on strategies and provision of advice that will reduce inequalities in health outcomes for disabled people. It will develop and maintain stakeholder relationships to promote an inclusive healthcare environment that maximises health outcomes for disabled people in the metro-Auckland region. This will create consistency for service users with a disability in the Auckland, Waitemata and Counties Manukau districts and a common patient experience across all three DHBs.

2. Executive Summary

This report seeks Board endorsement of an interim arrangement of co-chairs for the regional Disability Support Advisory Committee for the metro-Auckland region, those co-chairs being from Auckland and Counties Manukau DHBs.

3. Background

The previous Board Chair had signalled the intention to establish a regional combined Disability Support Advisory Committee.

In separate meetings, the Boards of Auckland, Counties Manukau and Waitemata DHBs each agreed as follows:

"That the Board:

1. Agree that a single Disability Support Advisory Committee (DiSAC) with the terms of reference set out in Appendix 1 to this paper be established to advise them on disability issues, as required by the New Zealand Public Health and Disability Act 2000.
2. Note that, subject to Recommendation 1 being agreed, the CEOs of the metro Auckland DHBs have agreed that, to support the work of a single DiSAC, the Chief Executive of Counties Manukau DHB will assume a strategic leadership role for disability issues for the metro Auckland DHBs.
3. Invite the chairpersons of the Boards of Auckland, Counties Manukau and Waitemata DHBs to make appointments to the proposed DiSAC in accordance with the process set out in this paper."

The appointment process referred to in (3) above was:

"The following process will be used to establish the proposed DiSAC:

- The chairpersons of the metro Auckland DHB Boards will discuss and decide on a chairperson for DiSAC
- Together with the chairperson-designate for DiSAC, the chairpersons of the metro Auckland DHB Boards will discuss and decide on the appointment of Board members to DiSAC, as outlined in the terms of reference outlined above, taking into account the balance of skills, experience, knowledge and diversity to enable DiSAC to carry out its functions
- The chairperson-designate, together with the Chief Executives of the metro Auckland DHBs, will consider what appointed members are needed to complement the skills and experience of Board members and make recommendations to the chairpersons of the metro Auckland DHB Boards who will discuss and decide on what appointments will be made, if any. This consideration should include appropriate consultation with mana whenua
- Upon all appointments being made, the two current DiSACs will be disestablished."

4. Current Situation

Since these decisions were taken, a number of changes have occurred, the most significant of which has been the retirement of Dr. Lester Levy as Chair of the metro Auckland DHBs and his replacement by separate Chairs for each DHB.

Deputy Board Chairs have served or are serving as Chairs on an interim basis. New Chairs to lead the metro Auckland DHBs on an ongoing basis have recently been announced by the Minister of Health and either have or will shortly commence their terms.

In light of that a decision has been made to enter into an interim arrangement of co-chairs for the Committee and allow the new Chairs to revisit this decision at a time mutually convenient to them.

5. Conclusion

It is recommended that the Boards of Auckland, Counties Manukau and Waitemata DHBs:

1. Note the update provided around the establishment of a Combined Regional Disability Support Advisory Committee.

That the Board subject to ministerial approval being obtained:

2. Endorse the interim arrangement of co-chairs for the Committee being from Auckland and Counties Manukau DHBs.
3. Note that the first meeting of the new joint Regional Disability Support Advisory Committee will occur on 6 June 2018.
4. Endorses the Auckland DHB Committee membership as follows:

Jo Agnew	Co Chair
Michelle Atkinson	Member
Robyn Northey	Member

Draft Disability Support Advisory Committee Terms of Reference

Establishment

Section 35 of the New Zealand Public Health and Disability Act 2000 (the Act) requires the Board of a DHB to have a committee to advise on disability issues called the disability support advisory committee. The committee must provide for Māori representation.

These terms of reference provide for the establishment of a single disability support advisory committee (DiSAC) to advise the Boards of Auckland, Counties Manukau and Waitemata DHBs (metro Auckland DHBs) on disability issues, as required by the Act.

This committee replaces Auckland and Waitemata DHBs' current joint DiSAC and Counties Manukau DHB's current DiSAC.

Purpose

As provided by section 35 of the Act, DiSAC's purpose is to advise the Boards of the metro Auckland DHBs on disability issues.

Functions

As provided by clause 3 of Schedule 4 of the Act, DiSAC's functions are as follows:

1. To provide advice on:
   (a) the disability support needs of the resident population of the metro Auckland DHBs; and
   (b) priorities for use of the disability support funding provided.
2. To ensure that the following promote the inclusion and participation in society, and maximise the independence, of the people with disabilities within the DHB's resident population:
   (a) the kinds of disability support services the metro Auckland DHBs have provided or funded or could provide or fund for those people:
   (b) all policies the metro Auckland DHBs have adopted or could adopt for those people.
3. To ensure that its advice this is not inconsistent with the New Zealand disability strategy.

Responsibilities

To carry out its functions, DiSAC will develop and operate under an explicit philosophy that values diversity and self-determination for people with disabilities.

In particular, DiSAC will provide advice on:

1. The overall performance of disability support services delivered by, or through, the metro Auckland DHBs
2. The development of strategies and policies related to disability support services,

disability issues and health service provision for people with disabilities in metropolitan Auckland, having regard to, as appropriate:

(a) the United National Convention on the Rights of Persons with Disabilities

(b) The New Zealand Disability Strategy

(c) the Health of Older People Strategy and the New Zealand Positive Ageing Strategy

(d) the strategic planning processes of the metro Auckland DHBs, including the Northern Region's Long-Term Investment Plan (LTIP), Information Systems Strategic Plan (ISSP) and Health Plan, and related consultation processes

3. The performance of disability support services against expectations as set out in Annual Plans and other relevant accountability documents, documented standards and legislation
4. The delivery of mainstream health services for disabled people
5. Contributions that can be made by the metro Auckland DHBs to the development and implementation of regional and national policies related to disability issues
6. The development and maintenance of relationships with disability stakeholders to support regional collaboration and co-ordination
7. The extent to which Annual Plans demonstrate how disabled people will access health services and how metro Auckland DHB will ensure that the disability support services they provide are coordinated across the DHBs and with services of other providers to meet the needs of disabled people
8. How the metro Auckland DHBs can meet their responsibilities to deliver the Government's vision and strategies for people with disabilities
9. How to build capacity for Māori and Pasifika to participate in the health and disability sector and for the sector to meet the needs of Māori and Pasifika
10. The criteria, priorities and systems to be used in providing, auditing and monitoring disability support services
11. The management of risks relevant to the provision of disability support services
12. The implications of strategic planning, prioritisation and funding decisions.

Accountabilities

DiSAC is accountable to the Boards of the metro Auckland DHBs.

While DiSAC's role is advisory only, the Boards of the metro Auckland DHBs may delegate to DiSAC the authority to make decisions and take actions on their behalf in relation to certain matters. In this event, the Boards of the metro Auckland DHBs may need to amend their delegation policies and seek the approval of the Minister of Health pursuant to clause 39 of Schedule 3 of the Act.

Any recommendations or decisions of DiSAC must be ratified by the Boards of the metro Auckland DHBs (unless authority has already been delegated to DiSAC).

DiSAC may only give advice or release information to other parties under authority from the Boards of the metro Auckland DHBs.

DISAC must comply with all relevant provisions of the Act, including requirements relating to committee meetings.

Members of DiSAC must comply with processes and requirements of the Boards of the metro Auckland DHBs, whether or not they are Board members or external appointees.

Membership

DiSAC shall comprise:

- Up to four Board members from each of the three metro Auckland DHBs
- Appointed members as may be required to complement the skills and experience of Board members.

At least three members of DiSAC shall be Māori.

Quorum

A majority of DiSAC's Board members must be present before DiSAC can be convened.

DiSAC decisions can be reached by a simple majority of members present (whether Board members or external appointees).

Conduct and frequency of meetings

It is envisaged that DiSAC will meet quarterly, although the frequency of meetings will be a matter for the chairperson to decide. The chairperson will also decide the venue for meetings.

Conflicts of interest

As required by clause 6(3) of Schedule 3 of the Act, prospective appointees to committees are required to disclose existing and potential conflicts before they are appointed. Any subsequent conflicts must also be declared, especially when funding matters are being considered.

Review

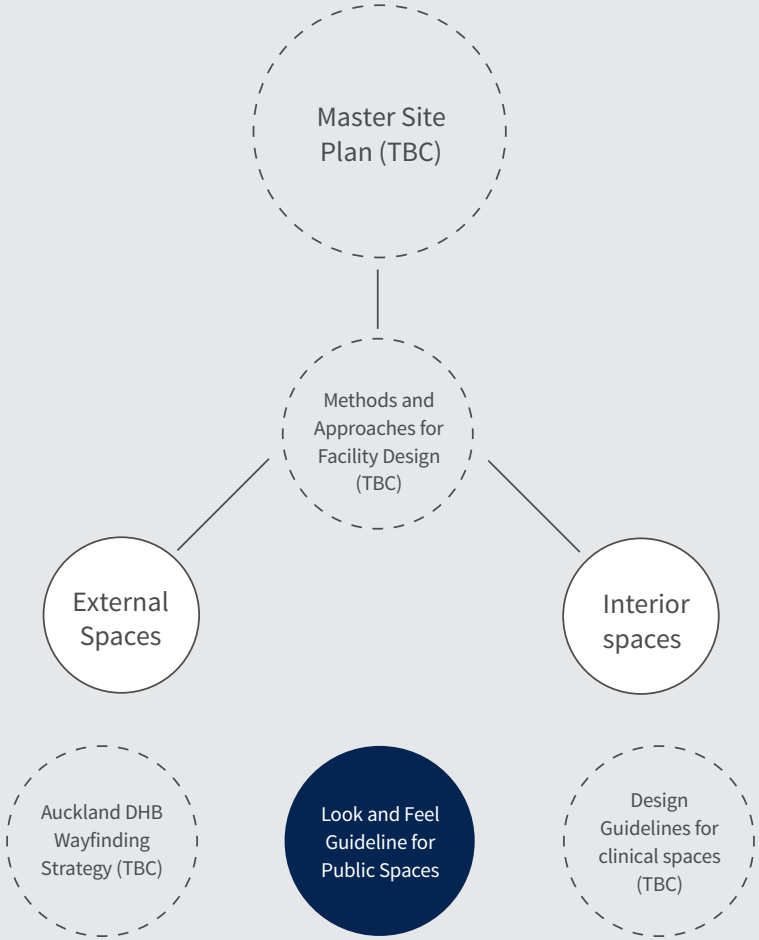
These terms of reference will be reviewed by DiSAC and the Boards of the metro Auckland DHBs after one year of operation and subsequently at least every three years.

AUCKLAND DHB

VERSION 1.0

Look and Feel Guideline for Public Spaces

Other Reference Documents



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Section A

How to Use this Guideline
Project Brief Considerations
User Types
Types of Space
Our Pepeha
Cultural Considerations

How to use this Guide

This document has been put together to help improve the experience of public spaces at Auckland City Hospital.

The seven roles of our public spaces are:

- Enable safe arrival, entry and exit
- Be welcoming, inviting and comfortable
- Enable safe, comfortable movement
- Enable better life management
- Enable calm, privacy and refuge
- Enable recreation and social connection
- Build and promote community partnership

This document:

- Provides practical guidance in the areas of flooring, lighting, planting, furniture and colour usage.
- Describes a concept for identifying types of public space and interpreting our natural landscape.

This document does not:

- Replace the role of a spatial designer or architect and should be seen as an input to the design process.

Project Brief Considerations

What problem are you trying to solve and who are you designing for?

Before diving into detail design, stop and consider what the purpose of refurbishing or redesigning a space might be. Who are the users of the space and what are their needs?

What type of space is it?

Is the space an entrance, a thoroughfare or a resting place for privacy? The type of space should strongly dictate core design decisions, particularly around flooring, furniture and lighting and encourage appropriate behaviour.

Is the space safe & accessible?

As a hospital, it's important to design for extreme users to help prevent the likelihood of further injury or distress. This could include anything from non-slip surfaces and consistent flooring, to reception desks and retail areas that allow for wheelchair access. Design decisions should also consider people with cognitive impairment who are navigating public spaces.

Wayfinding is more than just signage. What visual or structural cues are there to support wayfinding?

Design elements such as structure, line of sight, layout and colour all affect a user's ability to navigate confidently and accurately through a space. The most effective examples of wayfinding co-ordinate these elements together to create a coherent, harmonious system.

What flows/services operate within the space?

Taking a 'Lean' perspective, each space has its own unique set of users, services and flows. Are there competing flows in an environment that need to be dealt with? For example a clinician thoroughfare and a patient/whānau rest area.

Some users' needs may conflict with others, so it is important to understand which groups or services are prioritised. This consideration also has implications for the type of maintenance required and how hard-wearing the space should be.*

Which aspects of the space are welcoming?

Spaces should communicate 'welcome' to people. Layout, transparency of services, colour, light and nature are all design elements that can dramatically affect a person's first impressions and confidence in a hospital environment.

What cultural considerations are there—what's the story behind the space?

Cultural design considerations both honour the past and create an identity that people can relate to and engage with. The connection with the local iwi and the history of the domain are two examples of strong cultural ties that should be embedded in the design of hospital spaces. Refer to section (A:6) for guidance in this area.

What are the security considerations of the space?

The layout of a space should minimise security risks. For example, there should not be areas for people to fully conceal themselves from security guards or other hospital users.

**The Toyota Way to Healthcare Excellence: Increase Efficiency and Improve Quality with Lean.*

User Types

Patients & Visitors

- This user group spends much of their hospital experience waiting in public environments. Easy movement, line-of-sight, natural light, noise management, privacy, seating and social areas all have a direct impact on their experience.

Mobility Impaired Users

- Accessibility should never be an afterthought at our hospital. There should be clear paths for wheelchair users to navigate through a space or reside comfortably in public spaces.

Cleaners

- Hospital cleaners are responsible for the up-keep and cleanliness of all public spaces. Any design decisions around materials should be considered in relation to their work.

Clinicians

- Clinicians operate within hospital spaces every day, during work and break times. They require quick access to public resources during busy periods as well as privacy, refuge and calm to deal with the challenges posed by demanding shift work.

Elderly & Cognitively Impaired

- Elderly or cognitively impaired users can be either patients or visitors. Sufficient lighting, simple colours and patterns, consistent evenly-surfaced flooring, appropriate seating all help create a safe and comfortable environment for them.

Children

- Children will often spend long periods of time in the hospital with other family members so it is important to cater to their needs wherever possible. Design elements such as playful colours and areas help create spaces that are fun and engaging.

Types of Space

Building on research from other international healthcare facilities, there are four types of public space at Auckland City Hospital that are referred to in this document:

1. Thoroughfare

- These spaces are high foot-traffic, dynamic environments where user volumes fluctuate. They should be spacious, well-lit and capitalise on available natural light. Wayfinding and clear line of sight is a priority in thoroughfares, facilitating the efficient movement of patients, visitors and staff to key destinations in the hospital.

2. Entrance / Exit

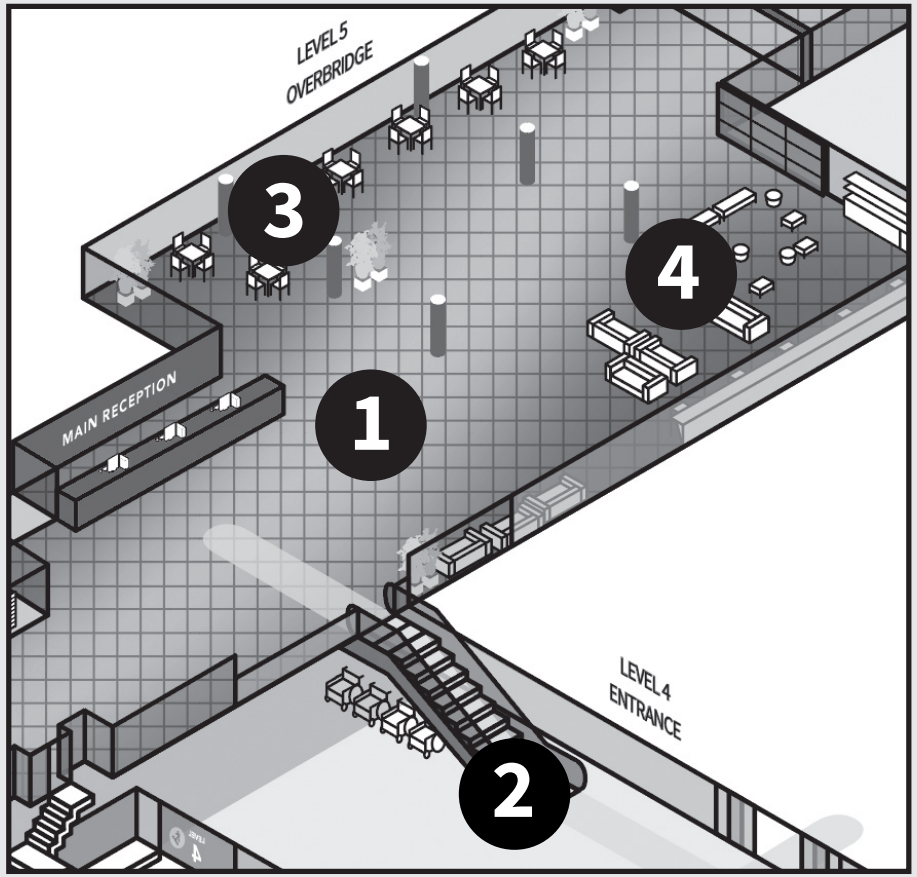
- Entrance and Exit spaces include atrium/foyer and transitions between environments (such as moving from the bridge into the retail space). Entrances / Exits should be highly accessible, uncluttered, memorable, well lit and have clear wayfinding cues, as they often host large volumes of people navigating to key destinations.

3. Short Stay

- Places for meeting others, or taking short breaks, often with high volumes of people and noise levels. Breakout furniture such as stools, benches and un-upholstered chairs should be used to encourage short stays. Purposeful manipulation of natural light should be used to enhance the welcoming nature of the space.

4. Long Stay

- Calming spaces that often accommodate high volumes but are much more personal and quiet in tone. Comfortable furniture such as modular couches and ottomans should be used to accommodate longer stays. Larger installations of plants can be used such as green walls or planter boxes to connect with nature.



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Our Pepeha

A Pepeha is a way of introducing ourselves, acknowledging our identity, our relationship to the land, and those who have gone before us. These photographs represent our Pepeha—they can be seen as a story for our four types of public space.

Ko Pukekawa te Maunga

Pukekawa is the Mountain

Ko Waitematā te Moana

Waitematā is the sea

Ko Horotiu me Waipapa nga Puna Wai

Horotiu and Waipapa are the fresh water springs

Ko Waikāhanga te Pā

Waikahanga is the Fort

1. Thoroughfare

Ko Horotiu me Waipapa nga Puna Wai
The river currents flowing through the domain site are like thoroughfares moving people through space.

2. Entrance / Exit

Ko Waitematā te Moana
Where the sea meets the land--inspiration for our entrances and exits.

3. Short Stay

Ko Pukekawa te Maunga
Our short stay spaces are likened to the mountains dotted throughout our landscape.

4. Long Stay

Ko Waikāhanga te Pā
The forts of this landscape are the zones where people are able to take refuge and feel safe.

Cultural Considerations

Iwi Gifted Site

1860 Auckland Domain. View across flax, ponds and trees to the harbour.*

The Auckland hospital site was gifted Ngati Whatua land. The origins of this hospital site are important to us and should be honoured as part of our relationship with the local iwi.

Manea Stone

In Maori tradition, the Manea stone is connected to the Mauri stone that is buried deep within the foundation of a building. People can touch the Manea stone, 'releasing negative energy and sending it to the centre of the earth.' The Mauri and Manea stones are from various locations around the Ngati Whatua region. They are incised with designs unique to the Ngati Whatua iwi.

Tupapaku Lift

The Tupapaku lift is used to transport the deceased to the mortuary on level 1. This specific pathway was designated to ensure those who have passed away are treated with respect and are transported carefully to the mortuary and into the care of the family members.

For more information of the cultural significance of this pathway, contact:

Naida Glavish
Naida.Glavish@waitematadhb.govt.nz

Maori Artwork and Carvings

Situated around the hospital are Maori carvings and artwork. For advice on how these are displayed Contact the art director:

Annemarie Hay
annemarie.hay@xtra.co.nz

For the meanings of these artefacts, contact:

Naida Glavish:
Naida.Glavish@waitematadhb.govt.nz

**www.aucklandmuseum.com/collection/object/am_library-photography-58414*

Guidelines in Practice

B

Section B

Flooring

Lighting

Planting

Furniture

Colour

Summary Matrix

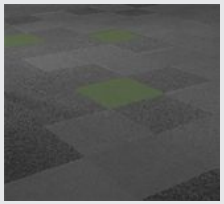
Flooring Decisions

Key Principles:

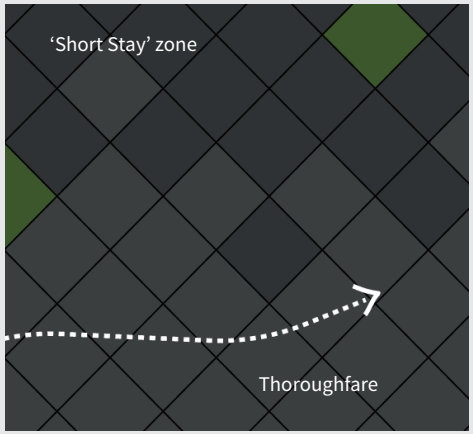
- 'Carpet' means carpet tiles, 500x500mm, with extra stock ordered and kept on site to accommodate replacement.
- The benefit of carpet tiles extends beyond replacement for maintenance—carpet tiles could be used to indicate other zones in the public space.

- 'Vinyl' means homogeneous sheet (not tiled) vinyl; matte as opposed to glossy finish; colour is subtle, low contrast. Non-slip vinyl should be used around wet areas.
- Colours:
  At transitions between floor finishes there should be as little tonal contrast as possible—i.e. lightness as opposed to sharp changes in colour.
- NB: This may be an issue specifically with retailers.

Best Practice: ✓



Low contrast, simple tones. Mosaic patterns should be uncomplicated and are used to indicate zones in a space.



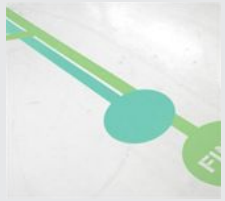
Transitions in flooring colour should be gradual and not 'jarring.'

There should be strong contrast between wall and floor treatments so visually and cognitively impaired users can navigate the space.

In a thoroughfare, the wood grain direction should flow with space. Wood grain vinyl should not be 'coved' where it meets the wall.

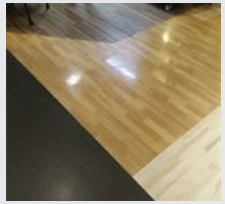
What to Avoid: ×

Avoid bright, high contrast patterns, as they cause confusion for visual/cognitively impaired users.



Any wayfinding on the ground should not cover areas where there is high foot traffic.

High gloss vinyl can produce reflections and can appear as water on the floor.



Avoid intersections of multiple flooring types as they can cause confusion.

12.2

Lighting Decisions

Key Principles:

- Celebrate natural lighting conditions wherever possible and establish whether the space receives direct sunlight.
- Because the hospital is a 24 hour facility, day lighting and night lighting of a space should always be considered.
- Building code requirements for emergency exit pathways should be a part of the lighting discussion from the outset.
- Colour rendering of LED's can vary in quality dramatically. Cheap LED lighting solutions can result in a washed out environment.
- Avoid intense back lighting behind serving staff as this makes lip reading difficult for hearing impaired.
- Avoid glare and reflective surfaces on wayfinding and information displays.

1. Thoroughfare

Bright, even light illuminating pathways through public spaces. Wayfinding spotlights to identify signage easily, especially low-light areas. At night these areas should still be clearly illuminated.

2. Entrance / Exit

Bright, welcoming natural light. Pendant lighting and wall wash lighting can be used to create landmarks at entrance/exit points. Key areas such as receptions should be spot lit, especially at night.

3. Short Stay

Warm, ambient lighting that capitalises on natural light wherever possible. Areas of planting can be spot lit (or shadow lit by hiding the light source) to create calming green environments. At night these areas should still be clearly illuminated.

4. Long Stay

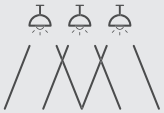
Dimmable, diffused lighting, and purposeful manipulation of natural light to enhance the intimate qualities of the space. At night these zones should have a warm, quiet feel with the potential to create softly lit areas for resting.

1. Panel Lighting

- LED panels which are sized to fit with the existing ceiling grid - 1200mm x 300mm is fairly standard.

2. Ambient Lighting

- Lux and colour temperature of light should suit the task. Higher (whiter) colour temperatures that more closely resemble daylight work better in areas of planting. Warmer lighting is suitable for more intimate situations (Ideally these areas would be locally dimmable).



3. Spot Lighting

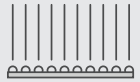
- Direct spotlighting for illuminating wayfinding elements, artwork or landmarks in a space. These can also be used to highlight areas such as reception desks or entries/exits to stair wells etc.

4. Lighting Installations/ Pendants

- Feature lighting installations are ideal for double-height areas or welcoming spaces such as entries and exits. They can also act as subtle landmarks in the busy hospital environment.

5. Wall Wash / Shadow Lighting

- Used to draw attention to details in the built environment or features such as green walls or planters. This type of lighting can also be used to create ambient environments.



	Best Practice: ✓		What to Avoid: ×	
2. Ambient Lighting 		> Reinforcing daylight.		> Calmer, restful environments.
		> Bland and office-like.		
4. Lighting Installations/ Pendants 		> Simple forms. Landmarking.		> Attractive both lit and unlit.
		> Bland and dated.		

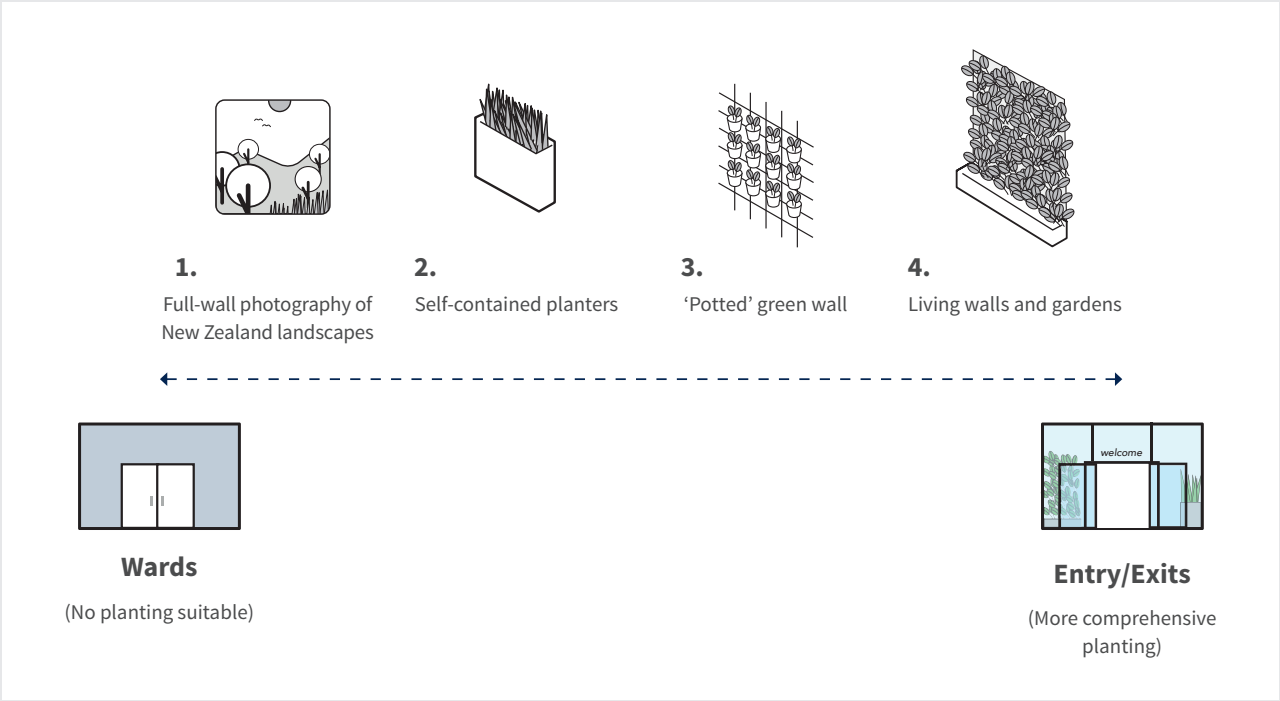
12.2

Planting Considerations

Key Principles:

- Planting should be used wherever possible to connect with the outdoors. This is especially important for patients who are not able to leave the hospital.
- The cost associated with planting is twofold: the upfront cost of buying the plants; and the upkeep and maintenance involved to keep them alive and fresh.
- The intensity of planting and its placement in the hospital depends on where it is in relation to ward areas.
- Wherever possible, suitable native specimens should be chosen to celebrate New Zealand flora.
- Auckland DHB Infection Control are very conscious of exposed soil producing airborne spores. Covering the soil properly with pebbles or mesh is vital.
- When selecting planting for an area, take note of the surrounding wards and the type of patients staying there.
- Where no planting is suitable, full-bleed (floor to ceiling) landscape photographs can be used to connect the hospital environment with nature.
- Ensure planters and potted walls are at a height that a small child cannot climb.
- Plants should not be flowering (producing pollen) or have a strong odour.
- Any deviation from this guideline needs to be approved by infection control.

Planting in Proximity to Entry/Exits:



	Best Practice: ✓		What to avoid: ×
2. Self Contained Planters 	 > Simple forms. One material.	 > Rectangular forms for breaking up space.	 > Quirky designs that date fast.
4. Living Walls and Gardens 	 > Simple forms. Landmarks.	 > Attractive both lit and unlit. Landmarks in the space.	 > Full gardens located in high risk areas.

12.2

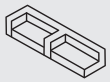
Furniture Types

Key Principles:

- Regardless of location, there should be a variety of heights with and without backrest and armrests to accommodate mobility issues.
- Armchairs should be provided with a minimum seat height of 450mm, arms that extend all the way to the front face and that are positioned over the chair legs.
- Furniture should contrast well with surroundings (floor and walls)
- Furniture should be simple in form, and easy to reupholster.
- Fine profile furniture can be too hard to see for some users.
- Crevices harbour bacteria and should be minimised where possible in the furniture design. For the sake of cleaning and replaceability, furniture should have removable elements (squabs etc).
- 'Mix and Match': establish a family of furniture, colours and fabrics so the overall look and feel is not compromised by a certain product going out of stock.
- For those with cognitive impairment, such as dementia, it is vital that furniture is 'archetypal' e.g. it is easily identifiable as a chair. Avoid large bold patterns that could be confusing.

Furniture Types:

1. Modular Couch



- Minimal couch module allows the design to be extended to create longer stretches of seating. This would need to be paired with a more conventional option with armrests.

2. Tall Seating

- There should be mix of lower profile and taller seating options available. The elderly, or those with mobility issues, need seating at an appropriate height. Arm rests are also important to support these users.

3. Single Seat/Chair

- Single chairs are especially important for individuals who wish to sit by themselves in a public space. They should compliment the shape and proportion of the couch design.

4. Small Tables

- Couch height tables are great for people who choose to eat in the seating/breakout area, or don't have a full-height table to eat at. They are also useful for people using laptops/tablets in seated areas.

5. High-back Seating

- High-back seating will help to create areas of privacy. This type of furniture should not be overused as there is a risk of creating awkward, inaccessible zones in the space.

6. Breakout Ottomans

- Low-profile, breakout ottomans are great to contrast with conventional chairs and couches. They are suitable for furnishing areas where children will be waiting with families.

7. Tables

- Small cafe-style table are suitable for bridge areas. Folding functionality allows for tables to be cleared away efficiently and quickly.

8. Chairs

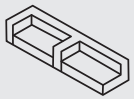
- Simple dining chairs for the bridge areas for groups of up to 4 or 5 per table.

9. Stools

- Perching furniture for counters along windows etc.

Best Practice: ✓

1. Modular Couch



2. Tall Seating

3. Single Seat/Chair

4. Small Tables

5. High-Back Seating

6. Breakout Ottomans

7. Tables

8. Chairs

9. Stools

12.2

Colours

Key Principles:

- The use of colour in the hospital environment must be treated with care. There are a core set of colours that are backbone of our wayfinding system which means they can't be used anywhere else:
- Our main navigation and emergency colours are:

Navigation Blue

Primary directional colour

Pantone 281 C / Resene 'Surfs Up'

Emergency Red

Only to indicate emergency.

Pantone 485 C / Resene 'Havoc'

- The colour blocking on our lift banks in order of lift A, B and C:

Blue

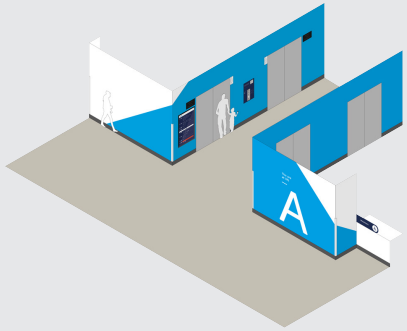
Pantone 299 C / Resene 'Curious Blue'

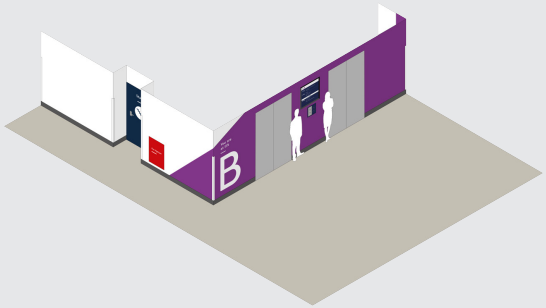
Purple

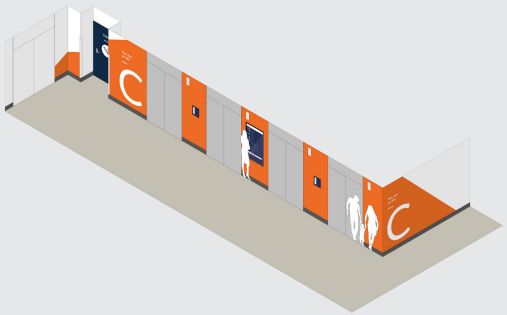
Pantone 2593 C / Resene 'Daisy Bush'

Orange

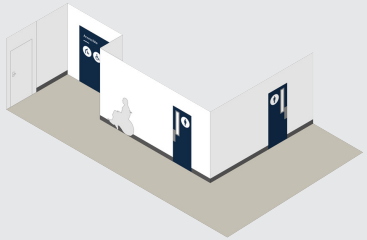
Pantone 1585 C / Resene 'Hyperactive'







- Door treatment varies depending on whether it concerns the public or staff. Doors to staff only areas should be painted in the same colour as surrounding walls.
- Doors to public areas/ amenities e.g. stairs, toilets etc. Should be painted in the 'Navigational Blue:'

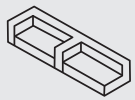


- Colours chosen for painting walls in public spaces should never compete with the lift colour blocking.
- More neutral calming tones allow wayfinding elements to contrast strongly with the environment.
- Timber treatment in public areas in a good option for highlighting wayfinding elements, whilst creating a bright, natural feel to a space:

Lady Cilento Children's Hospital

Example Decision Matrix

This matrix is a good starting point when beginning to look at refurbishing a new public space at Auckland City Hospital. Refer back to the sections in this guide for more detailed information on each category.

	 Food/Retail?	 Flooring	 Furniture	 Lighting	 Planting
Thoroughfare 	Yes / No	Vinyl Flooring / Carpet	Not applicable because of high foot traffic.	Bright, even light, illuminating pathways through public spaces.	The occasional pot plant, suitable in higher traffic areas. Planter boxes can also be used to separate thoroughfares from short or long stay spaces.
Entrance / Exit 	Yes / No	Vinyl Flooring / Carpet	Some seating appropriate for people to rest once they arrive at the hospital.	Bright, welcoming, natural light. Pendant lighting and wall wash lighting can be used to create landmarks.	More comprehensive planting (such as gardens or green walls) are suitable at entry/ exits to hospital. Internal entry/ exits should not be cluttered with planters.
Short Stay 	Yes / No	Vinyl Flooring / Carpet	Breakout furniture that encourages short stays, such as stools, benches and ottomans. Minimal use of upholstered furniture.	Warm, ambient lighting that capitalises on natural light wherever possible.	Potted green walls or planter boxes to create green, calming environments.
Long Stay 	Yes / No	Vinyl Flooring / Carpet	More comfortable, upholstered furniture and ottomans with low side/coffee tables for eating and storing belongings.	Dimmable, diffused light and purposeful manipulation of natural light to enhance the intimate qualities of the space.	Larger installations of plants such as green walls or planter boxes to create a greater sense of calm and refuge.

12.2

Appendices

C

Section C

Art Curation & Patient Stories

Accessibility Checklist

Art Curation & Patient Stories

Art Curation

- The Auckland DHB has an Art Committee. It's aim is to provide an environment that enhances and promotes the health and wellbeing of patients and visitors.
- The priority is for the display of art works to be in patient and public areas and the Art Committee supports and encourages the work of New Zealand artists.
- All proposed donations of art work must first be approved for suitability of subject-matter, style and size, by the art adviser to the Art Committee

Contact:

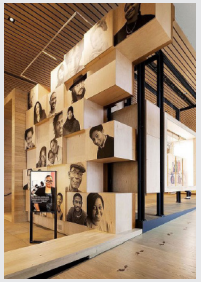
Annemarie Hay
annemarie.hay@xtra.co.nz

Patient Stories

There is an opportunity to incorporate patient stories into our public environments to celebrate the faces of our multicultural community.

This is a chance to encourage people to consider those who have been in the hospital before them and instil a sense of community in our physical environment.

Designers could present the patient images in creative ways as displayed in the example below:



Accessibility Checklist

What have we learnt about accessibility?

Flooring

- Avoid strong contrasts in flooring colour ☐
- Vinyl is better for wheelchair users ☐
- Carpet is better for those on crutches or using a walking frame ☐

Colour Selection

- Minimise colour variation and visual noise ☐
- Do a black/white photocopy of the materials selection to assess contrasts ☐

Fabric Selection

- Avoid large bold patterns that could be confusing to those with cognitive impairment ☐

Lighting

- Avoid glare—harsh light is hard for users with visual impairment ☐
- Avoid reflective surfaces—especially on wayfinding and information displays ☐

Furniture

- Provide a range of furniture to meet a range of needs ☐
- Armchairs provided with a minimum seat height of 450mm, arms extending all the way to the front face, arms vertical and positioned over the legs ☐

Counters

- When no activity needs to be completed a 900mm height counter is sufficient ☐
- When activity is required such as filling in paperwork there needs to be a 750mm height counter option ☐
- The counter top should be a different colour to the sides or have an edge trim to distinguish the top ☐
- Counters should contrast with the flooring ☐

Electronic Devices

- Avoid solely supplying touch screen devices including EFTPOS to enable access for sight impaired users ☐
- EFTPOS devices to be on long cable or wireless to allow easy access for wheelchair users ☐

Walkways / Corridors

- Main access walkways and corridors need to be wide enough to allow turning for wheelchair users ☐
- 1.5m turning circle ☐

Overall Layout

- Visually impaired people navigate using straight lines, following walls and other features ☐
- Utilise subtle junction markers where possible (similar to footpaths at intersections) ☐

Information

- Menus and other information should be in large font using contrasting colours ☐
- Sight impaired customers/users should be able to get up close to the menus to read the content ☐

Other

- No signs or display items should stick out from the wall at a height that could obstruct a visually impaired person ☐

12.2


AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai


LAB
DHW

12.2

Auckland City Hospital:
Building 8 Waitroom Refurbishment

Workshops / User Engagement / Concept Design

Disclaimer

Through workshops, user engagement exercises and internal design activity, the *Design for Health and Wellbeing Lab* have provided guidance and recommendations on how best the Facilities team could refurbish the environment to accommodate patients, family and staff.

This document does not contain technical drawings for refurbishing the Cancer & Blood waiting room at Auckland DHB.

Brief

Project Purpose:

To improve the public waiting room for Cancer and Blood service patients and their families. The role of the DHW Lab was to facilitate design workshops with clinical stakeholders and Facilities, with a view to develop refurbishment options. Building on existing patient research (carried out by the DHW Lab and Performance Improvement) at Auckland DHB, patients and families will have the opportunity to vote and provide feedback on design concepts.

In Scope

- Preparation and facilitation of 3 stakeholder workshops and the supporting design work to visualise concepts etc.

Out of Scope

- Detail design (e.g. architectural drawings etc.) will not be provided by the DHW Lab. The detailed design and implementation phases will be managed by Facilities.
- Flooring replacement (too costly in light of the initial indicated budget of $120,000).

Key Considerations:

- The DHW Lab will work alongside Facilities at Auckland DHB, who are experts in refurbishments, to recommend decisions around layout, lighting, materials, colours, fixtures and furnishings, etc.
- Design work will be required from DHW Lab between workshops to synthesise and develop workshop outcomes, which may include: illustrations/sketches, small scale models, inspiration imagery.
- Existing knowledge and principles from the Public Spaces Look & Feel Guidelines will be utilised.

Deliverables:

- Guiding principles that describe what the new environment should be.
- Recommendations for refurbishment priorities within the scope of the waiting space.
- Visualisations of how a refurbished waiting room could look and feel.
- Colour/material palette that explores suitable colours, furniture, and materials for the space.
- A document summarising the design workshop process and outcomes.


CanTeen
MELANIE
CHASER
What is singer Mike Rosenberg's stage name?
A Passenger
B Traveller
C Commuter
TAXI
FREE PHONE
Female

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Workshop 3 summary	13
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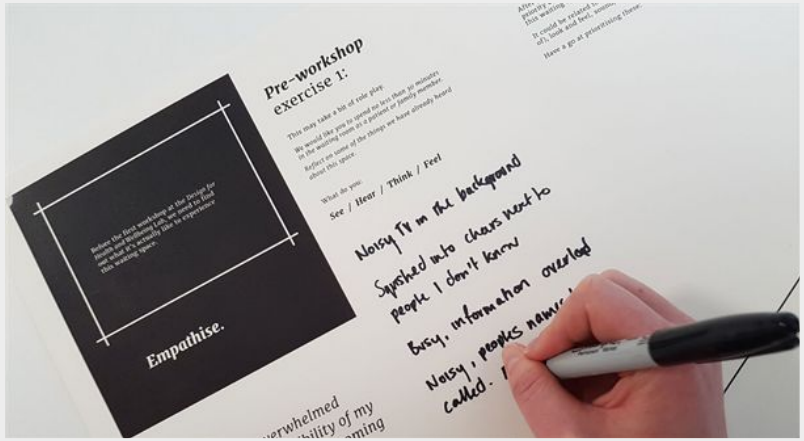
Workshop 1 Summary

26_5_17

We established a collaborative approach between Facilities, Cancer & Blood staff and the Design for Health & Wellbeing Lab. A series of interactive workshops consisted of 3 designers from the DHW Lab, a receptionist, two nurses and a Facilities project manager.



Pre-workshop exercises:

Before the first workshop at the DHW Lab, we asked all participants to experience this waiting space first hand. These exercises framed the basis of the first collaborative workshop.

- The first exercise encouraged participants to spend no less than 30 minutes in the waiting room, as a patient or family member typically would. Reflecting on some of the existing research about the environment, participants were ask to record what they 'Think / See / Hear / Feel.'

- After this roleplay exercise, participants noted some of the priority areas they thought needed improving in the waiting space relating to layout, privacy (or the lack of), look and feel, acoustics, comfort etc.

"I was so overwhelmed about the possibility of my mortality and then coming to the building, seeing how full the building was, and then being lined up like sheep—

that was such a struggle…."

– Patient

The focus of the workshop was to establish a shared understanding of the current waiting room experience, in order to distil a set of guiding design principles for the refurbishment.

We Saw:
- **Clutter** especially in relation to the posters and health information across the walls.
- Issues with the **desk**, including its placement and how patients interacted with staff.
- **Seating** that was 'impersonal;' It did not accommodate a variety of user types.
- Lack of appropriate **distractions / activities**, for both adults and children.
- The **hot drink** station well used.

We Heard:
- **TV**. Other than key times of the day, the TV was generally considered to be obnoxious.
- **Private conversations** including patients giving personal details.
- **Ambient noises** that are amplified by the lack of sound absorbing material.
- **Phone conversations** are not private at all.
- **Doctors calling** out for patients.

We Thought:
- 'The tall desk is a blunt welcome experience'
- 'The place is not inviting!'
- 'I would not want to spend time here'
- 'Seating is not welcoming - It could be in huddles'
- 'Seating lined up like an assembly'
- 'Nothing to do other than read magazines'
- 'Not being able to see the time is disempowering'

We Felt:
- 'Like I'm in a fish bowl with no privacy'
- 'It's like a bus terminal'
- 'People are nervous here'
- 'Dis-empowered—nothing to do with my time'
- The place feels 'soulless,' 'rigid', 'bland,' 'cold'

The group shared ideas for how best the space could be improved. Together with the patient feedback already gathered, we compiled a set of 'how might we' statements.
These are provocations that acted as a 'design brief' for guiding the concept design.

How might we...
- *Create a welcoming reception experience for patients and family?*
- *Accommodate different cultures and families through appropriate furniture/layout?*
- *Improve the acoustics of the space and allow for moments of privacy?*
- *Allow for social interaction between patients who are going through similar experiences?*
- *Create suitable activities/distractions for both children and adults?*
- *Celebrate natural light and the connection to the outdoors?*
- *Contain health information and collateral and make better use of wall space?*
- *Create a calming ambience through lighting and colour palette?*
- *Make the space more personable and comfortable?*

Key considerations/questions:
- *There are currently 48 chairs and at busy times the room is full.*
- *How many children would use this space with parents?*
- *Although it is out of scope of this project - a refurbishment should keep in mind potential changes to patient check in, or how doctors call for patients.*
- *Are there limitations to what the available 'Dry July' funding can be spent on for the refurbishment?*

Workshop 2 Summary

15_6_17

Using scale models and representative furniture blocks, this workshop began to bring form to the design principles established in workshop 1.

Exercise 1.

Experimenting with furniture layouts using a scale model and discussing how they would improve the room's function and the patient experience. Some of the key points of the discussion during the model making included the following:

Furniture:

- **Capacity** is very important – currently 48 seats, sometimes 10 more are needed.
- Range of flexible and fixed furniture.
- Chairs are reconfigured by patients into rows **to face where doctors call from.**
- Preserve the potential for patients to move and **configure** furniture themselves.
- Some patients need **armrests** to help themselves out of seats.
- Space-saving **tables**, such as side tables that fit next to chairs would be suitable.
- Higher table/bench with bar stools or café style seating potentially against the window.

Reception:

- **Line of sight** from all areas of the room to doctors and reception desk is important.
- Line of sight from desk to atrium to assist patients if necessary.
- People are often **tired/exhausted** when arriving (esp. from carpark); they have to stand to check-in so they lean on/over desk.
- "The desk is like a **leaning pole.**"
- "Take a seat" system not often trusted by patients - they worry about missing out on being called.
- Check-in option: bench **leaner** to check paperwork details, adjacent to the reception.
- There are 'zones' at the reception desk: visitor check-in, doctor/receptionist discussion and quick enquiry.
- The desk needs to be bigger to accommodate up to 3 staff working at a time.

Privacy:

- Window treatment could soften the atmosphere e.g. frosting.
- Privacy could be achieved via **plants**, dividers, trellis + planter boxes.
- Shadow lighting could help to create depth in the space.

Amenities:

- Privacy needed at entrance of toilet corridor.
- Privacy needed where patients take their weight (currently exposed).
- Consider access to toilets for wheelchairs/less able users.
- Health information wall space moving to corridor by toilets.

Waiting:

- Treatment wait times are fairly quick—mostly 10-15 mins.
- If a patient arrives early they can wait for up to 30 mins.
- Patients can also be waiting for blood test results.
- Childrens' play space is not a priority as there are not many children (8 children over a 1-week sample) and they have short wait times (10-15 mins). A good option available is to provide some simple activities such as books, arts and crafts, and to invite children to the downstairs play area.
- Placement of beverage station could be moved to a more 'still' area in the space.

Examples of the concept models created during the workshops.

Exercise 2.

In a subsequent activity, the DHW Lab team sourced a range of inspiration images around the themes of: privacy, nature, furniture, and activities/interactions. We asked each other, which of these examples might be suitable references for this environment and why. Using the models as a basis, the two groups annotated their concepts with visuals and notes.

Post Workshop 2

At the conclusion of workshop 2, the DHW Lab developed two concept directions based on the project scope and identified opportunities for functional layout improvements.

Feedback station:

The DHW Lab built a feedback station, produced feedback forms and collateral that communicated two layout ideas from workshop 2. The station was located in the waiting space and invited patients, families and staff to provide input. They could give written feedback on the concepts presented to them and also had the chance to vote for the concept they liked best. The concepts were intentionally presented without detail and colour, to focus feedback around layout, capacity and flow.

Presenting to sponsors and doctors:

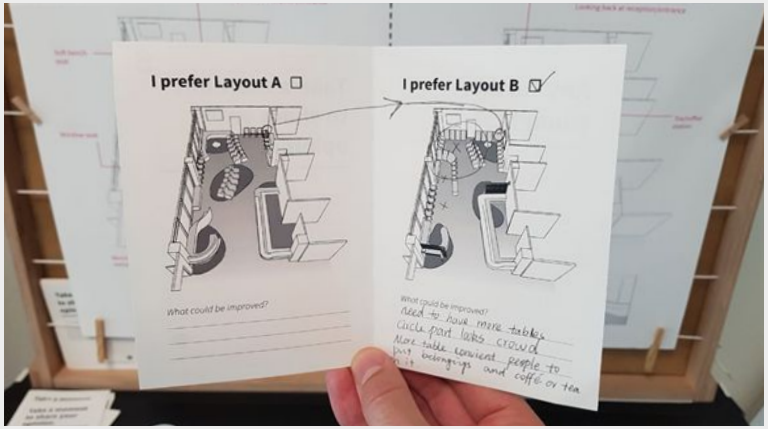
A DHW Lab designer brought the layout ideas to the project sponsors and doctors, providing an opportunity for them to share their opinion about how the space should be configured.

Collating feedback:

The concepts generated a lot of feedback—69 people participated in the survey:
Some of the written feedback included:

- *'Is there a need for a longer reception?'*
- *'More soft bench seats.'*
- *'Some seating where you can place a wheelchair next to could be handy.'*
- *'Need to have more tables.'*
- *'[Leave] TV where it is; kids play area? Soft seating needs to be cleanable; Wheelchair accessible? Self-opening doors?'*
- *'I like this idea as there is more room and it looks spacious.'*
- *'Looks nicer with screening, better seating too…'*
- *'I don't like not seeing reception - as when the wait is long you may feel forgotten.'*

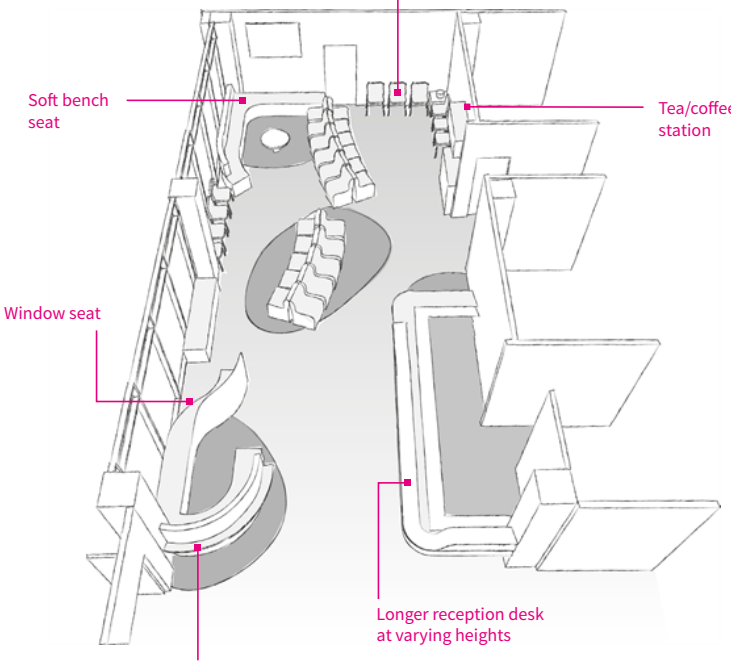
As well as anecdotal responses, the meeting with the project sponsors broadened the project scope to consider shifting the entrance and reception desk to the opposite end of the space (originally this had been deemed out of scope based on the original budget indication). This suggestion was consistent with other patient and staff feedback we heard about the clash of doctor and patient flows at the existing reception desk location.



Take a moment to share which option you like and why.

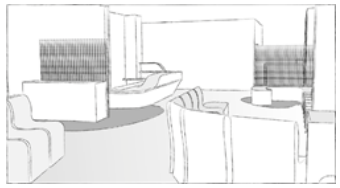
A.

Looking back at reception/entrance

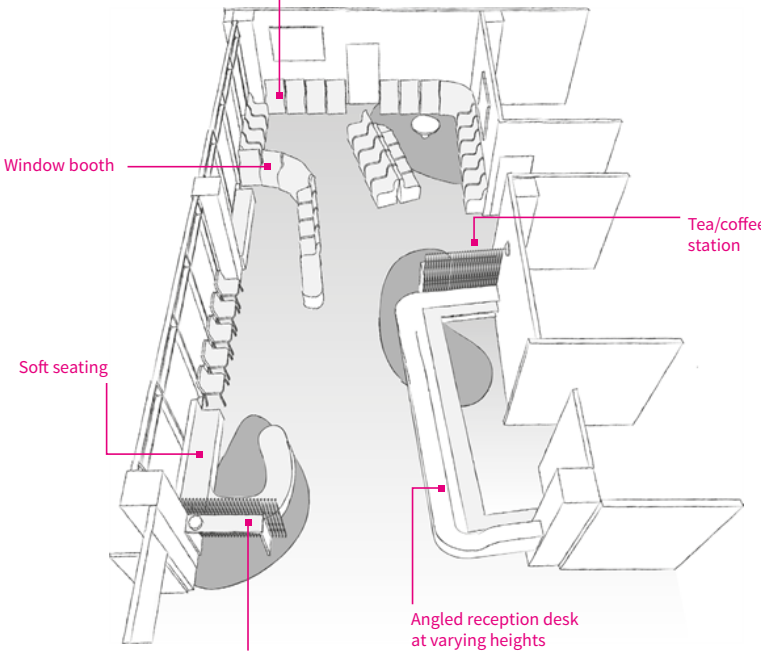


Arriving at reception

B.



Looking back at reception/entrance



Arriving at reception

12.2

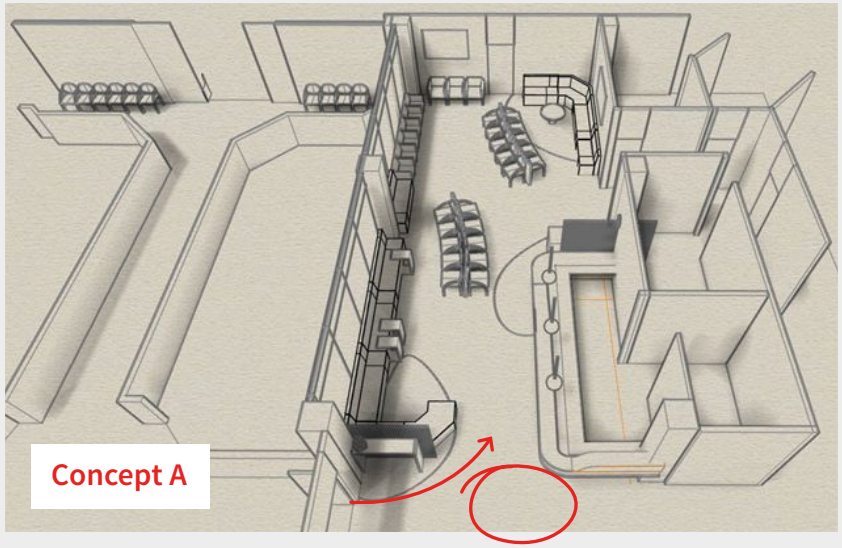
Workshop 3 - Preparation

After the user engagement process the DHW Lab team refined the concepts based on feedback.

Concept A: Existing entrance and desk location.

This layout makes incremental improvements to how the current space functions:

- On arrival, a bar leaner provides a resting point for patients tired from their journey.
- The reception desk is more welcoming with varied heights.
- The reception desk could potentially accommodate a third staff member.
- Partitioning could be used to help make the environment feel less exposed.
- Soft seating is incorporated around the perimeter of the space.
- Flexible furniture arrangements could be configured in the centre of the space.
- Tea and coffee station backs onto the reception desk.

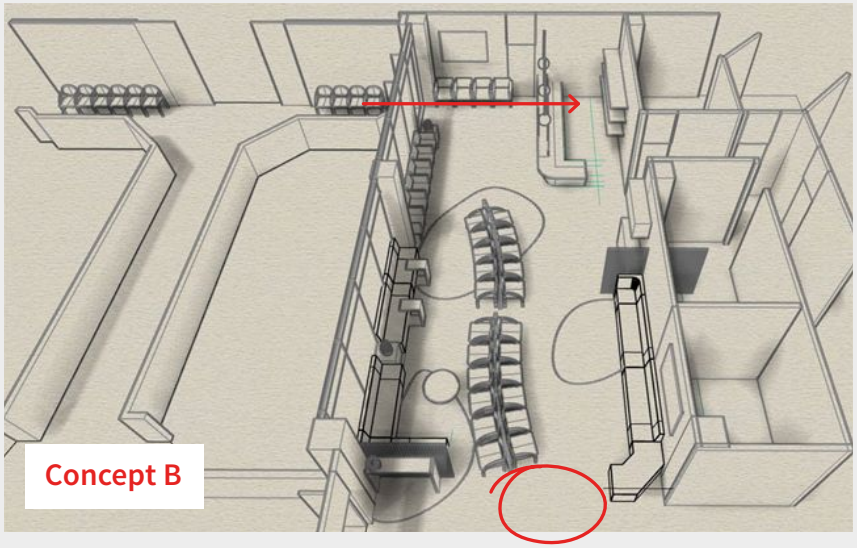


It was identified that a decision to shift the entrance and reception desk was a trade-off that the project sponsors and Facilities team would work through based on the costings from a Quantity Surveyor. The DHW Lab resolved two layouts that could be taken and costed, enabling informed trade-offs once the project is progressed by Facilities.

Concept B: New entrance and desk location.

This layout has significant implications for how the current space functions and flows:

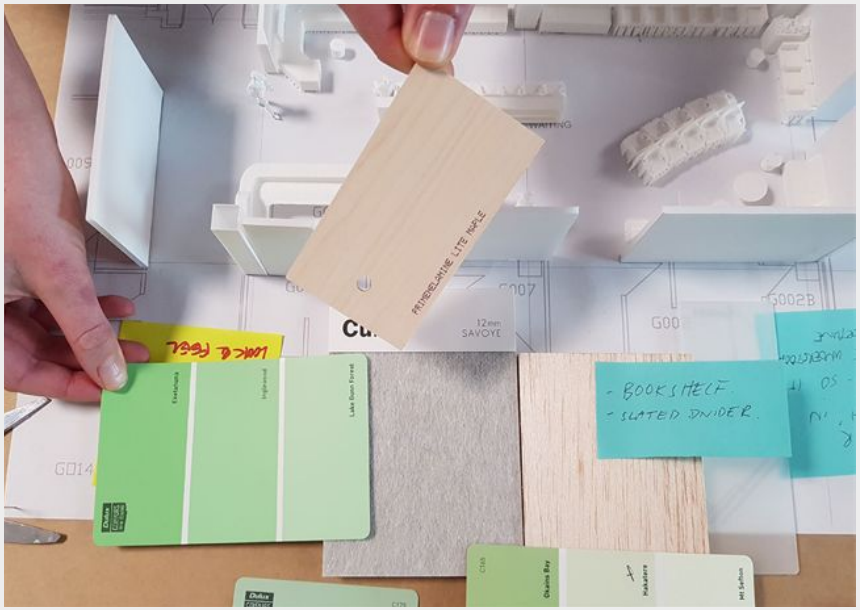
- On arrival, patients walk directly to the new reception desk location.
- There is a more logical circulation established through the space: Patients check in, take a seat, and wait to be called by the doctor. This would eliminate the clash of flows in the existing layout.
- The reception desk is more welcoming with varied heights.
- Partitioning could be used to help make the environment feel less exposed.
- Soft seating is incorporated around the perimeter of the space.



Workshop 3 Summary

The final workshop moved beyond function and layout to explore how the space should look and feel.

As a group we explored how the space might be treated as a calming, natural environment. Looking down on the atrium garden space, we likened the waiting area to being on top of a mountain.



DHW Lab designers built two scale models of concept A and B for the workshop. This facilitated discussion and debate about what types of furnishings would be appropriate in different aspects of the design. This was a hands-on creative session, inviting participants to re-imagine the environment.

We asked ourselves, How might we:

- *Create a welcoming reception experience for patients and family?*
- *Celebrate natural light and the connection to the outdoors?*
- *Create a calming ambience using lighting and colour palette?*
- *Make the space more personable and comfortable?*

In two groups, we used inspiration imagery, colour and material swatches to create 'mood boards' that captured what might be a suitable look and feel for the environment. These decisions directly impacted on the final recommendations presented in this document.

12.2

Recommendations

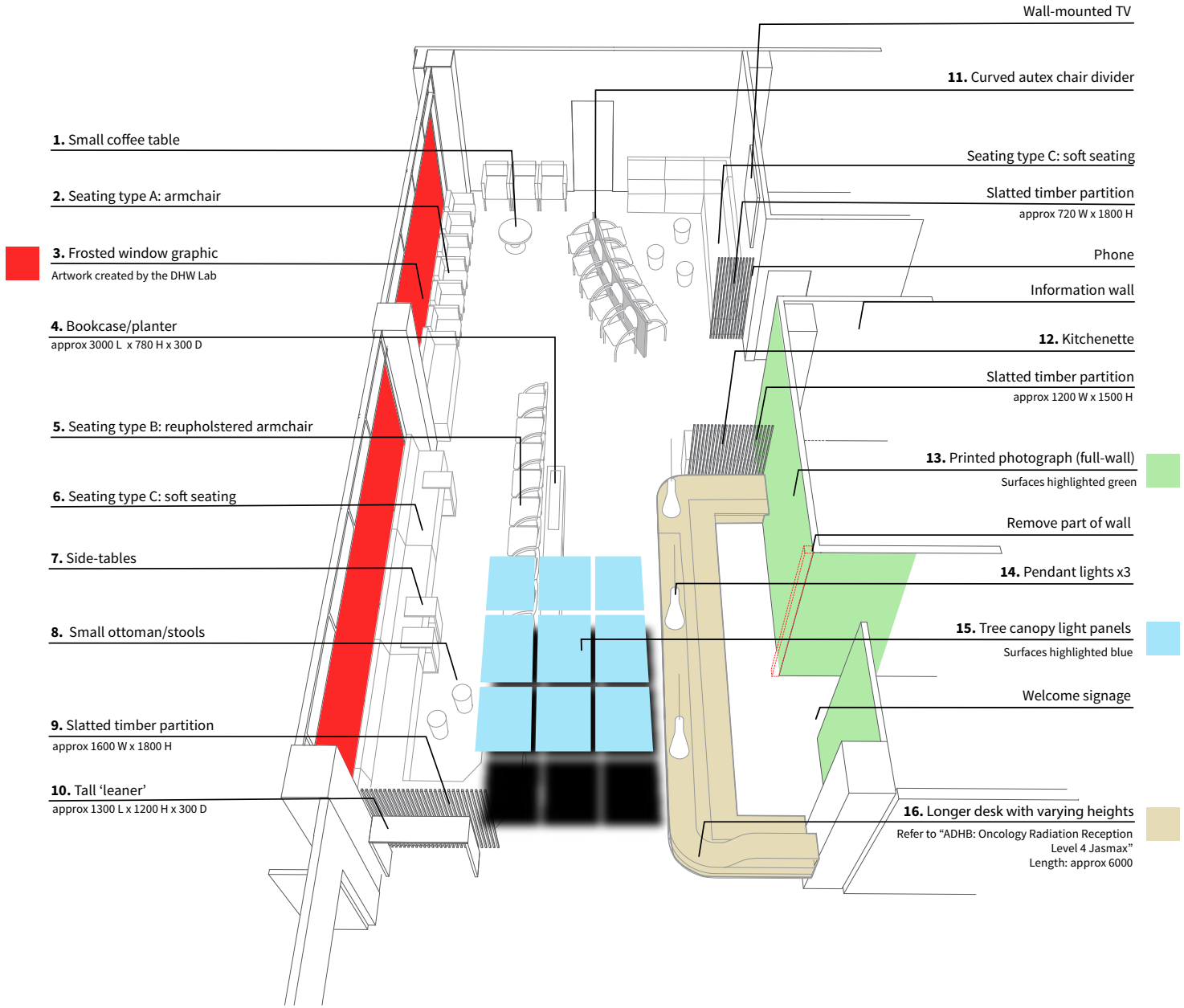
Concept A Description:
Based on an understanding of the available budget, this layout makes incremental improvements to the existing function of the waiting room (the desk location and entrance remain where they are).

Privacy:
This design creates a less-exposed waiting environment, whilst retaining a degree of transparency through slated timber partitions.

Furniture variation:
A mix of furniture types to offer patients choices—such as a resting leaner on entry to the space or soft seating zones for longer stays. Small ottomans are an easy, portable solution for kids who might accompany parents in the space.

Natural, calming aesthetic:
Conceptually, the space is likened to being on a mountainside, looking down on the atrium of trees. A natural and calming colour/material palette is drawn from a stunning vista behind the reception desk and a tree canopy above.

Artistic Impression.



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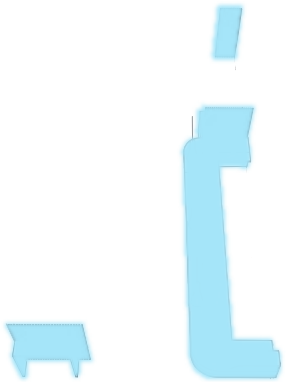
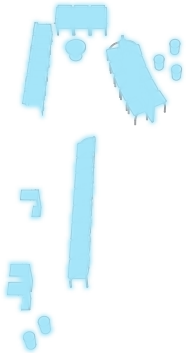


Fixed

These elements are fixed in the Waiting room design.

Semi-flexible

These elements can be reconfigured if nessessary.



Flexible

These elements are easily recongfigurable and more armchairs could be added for increased capacity.

12.2

This page is a diagram only

Specifications

1. Small coffee table

Example:
Kada Furniture
'Blom Cafe table'

2. Seating type A: armchair

Example:
Kada Furniture
'Orlassi'

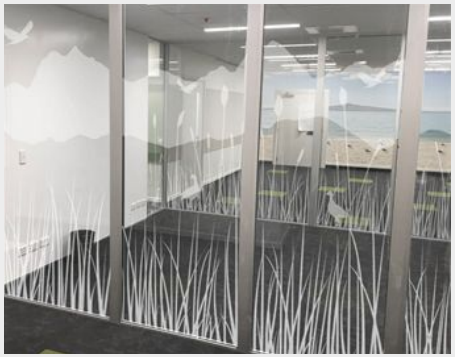
Material from: Crypton.

Suggested Colours

3. Frosted window graphic

Example:
DHW Lab – 'Wetlands graphic'

This artwork is available to be used and the design files are with the DHW Lab.



4. Bookcase/planter

Description:
A semi-fixed bookcase, incorporating a planter box into part of its top surface. Set parallel to the reception desk, the bookcase could also act as perch for waiting patients.

5. Seating type B: reupholstered armchair

Material from: 'Textilia/at work'
Fresco Plus

Iceberg Grasshopper

6. Seating type C: soft seating

Example:
Kada Furniture
'Modulo'

Material from: Crypton.

Suggested Colours

7. Side-tables

Example:
Kada Furniture
'Fold'

8. Small ottoman/stools

Example:
Kada Furniture
'Cart Stool'

Suggested Colours

9. Slatted timber partition

Suggested 'Ash' timber

10. Tall leaner

Example:
Simple form, in either white or timber.

11. Curved autex chair divider

Example:
A curved acoustic panel used to divide seating and create zones in the space.

Material from: 'Autex'

Range: Cube
Suggested colour: Savoye
Thickness 24mm

12. Kitchenette

Example:
Cabinetry and bench top, potentially plumbed in, allowing for water supply and sink.

13. Printed photograph (full-wall)

Description:
Full-wall photograph looking down on a local New Zealland landscape (i.e. be taken from a mountain/hilltop).

Supplier: Juggernaut Graphics

Example Image

14. Pendant lights

Description:
Slatted timber aesthetic, reflecting the slatted timber partitions. Simple in form.

Example:
4201 & 4200 BY SECTO

15. Tree canopy light panels

Description:
Using the ceiling grid to display a tree canopy. Ideally, incorporated with lighting panels.

16. Longer desk with varying heights.

Description:
The desk design used in the Oncology Radiation reception can be adjusted to suit the Cancer & Blood waiting room.

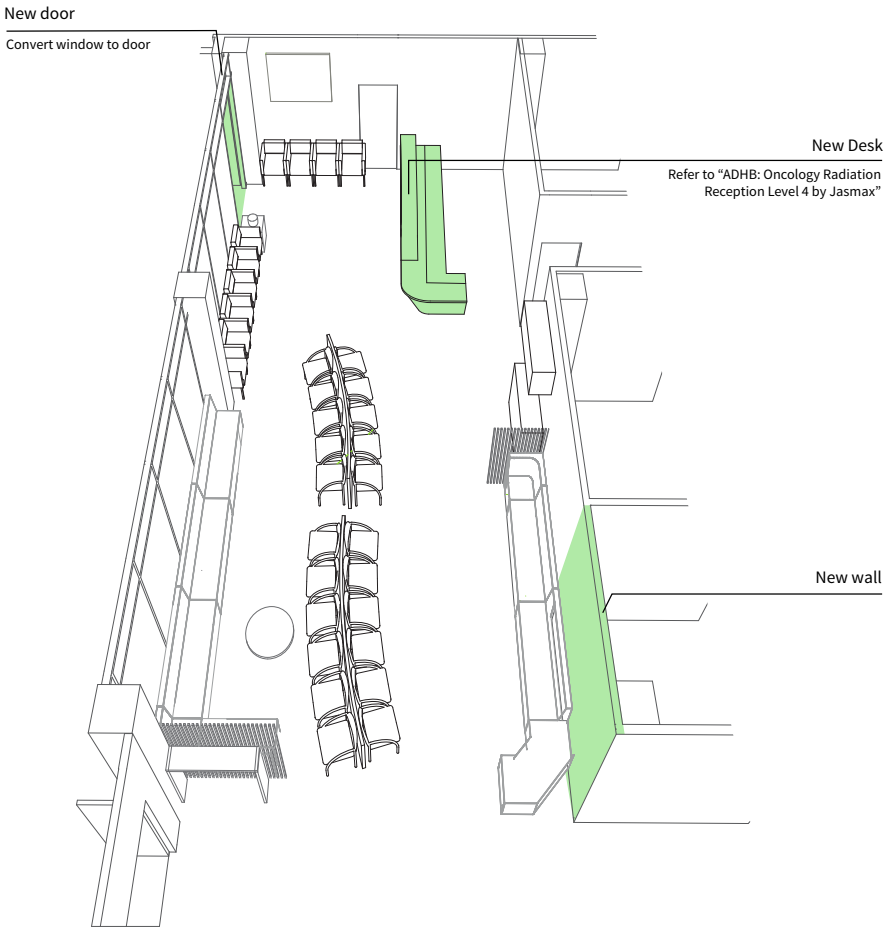
Refer to “ADHB: Oncology Radiation Reception Level 4 Jasmax”
Length: approx 6000

Colour/material palette

Entrance Variation

Concept B Description:
Based on the input from project sponsors, the DHW Lab were asked to explore the possibility of a relocated entrance and desk location (refer to page 12 for justification). This design would require behavioural change from patients and families accustomed to using the existing entrance. Signage at the entrance to the building would need to direct people inside through the new door.

Artistic Impression.



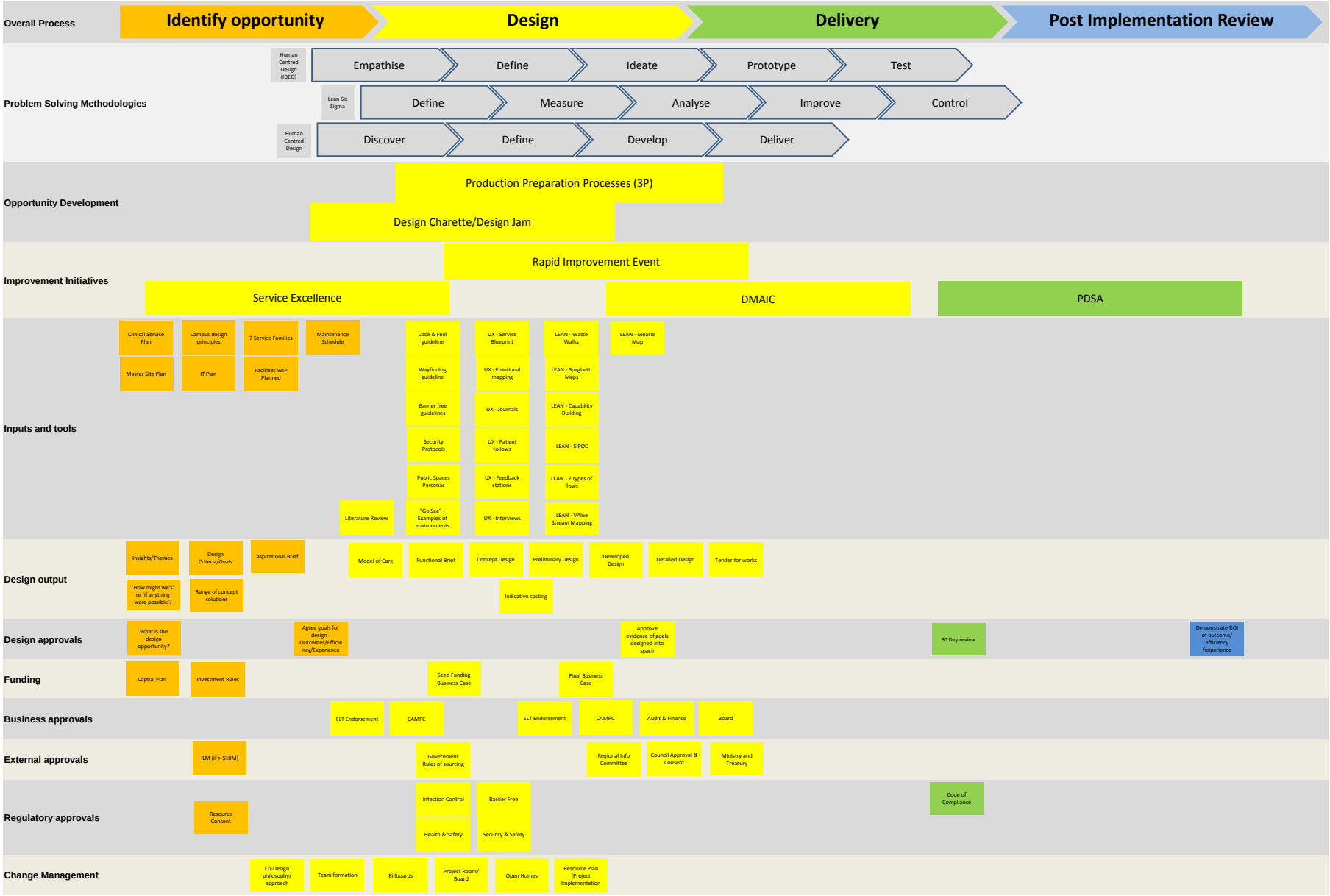
12.2

This document marks the formal handover of design recommendations from the DHW Lab to be taken foward by the Facilites team.

Thank you to all staff and public involved in this process facilited by the DHW Lab. Specifically, thank you to workshop particpants:

Cancer and Blood staff – Pam Cham, Margaret Edmunds, Marina Stander
Facilites – Tania Cottew

Auckland District Health Board Design Guide (Draft)



12.2