HOSPITAL ADVISORY COMMITTEE (HAC) MEETING
23 August 2017

Venue: Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu Time: 1.30pm

Committee Members	CMDHB Management
Dr Lyn Murphy – Committee Chair Dr Ashraf Choudhary – CMDHB Board Member Catherine Abel-Pattinson – CMDHB Board Member Dianne Glenn – CMDHB Board Member Mark Darrow – CMDHB Board Member Rabin Rabindran – Deputy Chair	Gloria Johnson – acting Chief Executive Phillip Balmer – Director Hospital Services Vanessa Thornton – acting Chief Medical Officer Jenny Parr – Director of Patient Care, Chief Nurse & Allied Health Professions Officer Margaret White, acting Chief Financial Officer Dinah Nicholas - Secretariat

APOLOGIES

REGISTER OF INTERESTS

- 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?

PART 1 – Items to be considered in public meeting

AGENDA

1.30pm	**1.**	**AGENDA ORDER AND TIMING**
	2.	**CONFIRMATION OF MINUTES**
1.30pm	2.1	Confirmation of Minutes of the Hospital Advisory Committee Meeting – 12 July 2017
1.35pm	2.2	Action Items Register
	3.	**PROVIDER ARM PERFORMANCE REPORT**
1.40pm	3.1	Deep Dive into Demand Pressures for Medicine and Surgery (Brad Healey & Mary Burr)
2.00pm	3.2	Emergency Department, Medicine and Integrated Care (Brad Healey)
2.10pm	3.3	Surgery, Anaesthesia and Perioperative Services (Mary Burr)
2.20pm	3.4	Executive Summary/Performance Report (Phillip Balmer)
	3.5	Initiative Programme Update
	3.6	Balanced Scorecard
2.40pm	3.7	Finance Report (Margaret White)
2.50pm	3.8	Central Clinical Services (Ian Dodson)
3.00pm	3.9	KidzFirst and Women's Health (Nettie Knetsch)
3.20pm	3.10	Adult Rehabilitation and Health of Older People (Dana Ralph-Smith)
3.30pm	3.11	Mental Health and Addictions (Tess Ahern)
3.40pm	3.12	Facilities (Philip Healy)
3.50pm	3.13	Middlemore Central (Dot McKeen)
		Afternoon Tea Break (3.10 – 3.20pm)
	4.	**CORPORATE REPORTS**
4.00pm	4.1	Director Patient Care, Chief Nurse and Allied Health Professions Officer (Jenny Parr)
4.20pm	4.2	Human Resources Report (Phillip Balmer)
4.25pm	4.3	Q4 Non-Financial Summary Report 16/17

Next Meeting: Wednesday 4 October 2017, Room 101 Ko Awatea

Minutes of Counties Manukau District Health Board
Hospital Advisory Committee

Held on Wednesday, 12 July 2017 at 1.00pm
Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

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PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Lyn Murphy (Committee Chair)
Ashraf Choudary
Catherine Abel-Pattinson
Dianne Glenn
Mark Darrow
Rabin Rabindran

ALSO PRESENT

Phillip Balmer (Director Hospital Services)
Margaret White (acting Chief Financial Officer)
Gloria Johnson (acting Chief Executive)
Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer)
Janet Haley (Senior Communications Advisor)
Dinah Nicholas (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

Emily Ford, Manukau Courier attended the public section of this meeting.

APOLOGIES

An apology was received and accepted from Vanessa Thornton.

WELCOME

The Committee Chair welcomed all those present to the meeting.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted with no amendments.

There were no specific interests to note with regard to the agenda for this meeting.

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2. **AGENDA ORDER AND TIMING**

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

3. **COMMITTEE MINUTES**

Confirmation of the Minutes of the Hospital Advisory Committee meeting held on 31 May 2017

Resolution (Moved: Ashraf Choudhary/Seconded: Catherine Abel-Pattinson)

That the minutes of the Hospital Advisory Committee meeting held on 31 May 2017 be approved.

Carried

4. **FOR INFORMATION**

4.1 Whole of System, Health of Older People

Dr Shankar Sankaran, Consultant Geriatrician/Clinical Leader took the Committee through a presentation on Whole of System, Health of Older People highlighting the following:

Hip Fracture Registry- looks at improving outcomes for patients coming into the hospital with hip fractures. There are currently 12 DHBs participating in the Hip Fracture Registry with the other 8 DHBs due to come on board by the end of this year.

Fracture Liaison Service –This started 18-months ago and sees approximately 1000 patients each year. The Service identifies all men and women over the age of 50 years who present with fragility fractures and assesses them for risk factors for osteoporosis and future fractures. Those at risk will undergo BMD testing and fracture risk assessment. Where appropriate, osteoporosis treatment will be initiated and referral to Falls Prevention Services.

National Falls Programme – this programme will be launching on 1 September 2017. It is primary care led and is a population based screening programme for over 75-year olds and over 65-year old Maaori/Pacific who have a falls-related ACC claim within the previous year.

Acute Care for the Elderly –provides more coordinated care to the acutely unwell, non-specialised medical patients over 85-years old. By involving multidisciplinary team intervention earlier, this reduces deterioration during the acute phase. Other benefits include early discharge planning, improved linkages to inpatient rehab services in AT&R and coordinated ongoing care with community services. This service has been running for five years at CM Health.

Front Door Support (HOPE Service) this is a new service which reviews the frail older patients (with set criteria) in the ED short stay unit. The community is the best place for the frail older patient unless they are acutely unwell of course.

The Committee asked for some statistical data to be provided in the HoP reports to show how these programmes are improving patient outcomes.

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5. **PROVIDER ARM PERFORMANCE REPORT MAY 2017**

5.1 **Executive Summary/Responses to Action Items**

Phillip Balmer introduced the report. Matters highlighted or updated included:

Page 29, *Demand Growth Table* – despite the reorganisation and alignment of services to improve care across the continuum, we continue to be challenged by an increase in acute demand for adults, both in terms of volume and complexity. This acute demand has become more evident since winter has begun with a dramatic spike in presentations in both the adult and paediatric EDs. Combined, the adult and paediatric ED presentations during June have increased to record levels and much earlier than in previous years. During June, we had over 350 patients each day with presentations reaching a peak of 393 towards the end of June. Over one-third of those patients presenting required hospital admission. Medicine, for example, has been over 105% occupancy for 142 days in the last year and over 95% occupancy for over 220 days in the last three years.

A new ward was opened during the year (20 beds) and a further 40 beds were opened for the winter period.

The immediate contingency plan is to do as little elective surgery on the MMH site as possible and utilising the beds at MSC, Surgical Services are working through the options available. We can also use some of our other facilities (ie) Pukekohe Hospital (small numbers) but we are really looking to the long term regional investment plan to offer options. The suggestion, for us, is that this will mean substantial expansion at MSC to turn it into a much bigger elective surgical and ambulatory care centre. There will clearly need to be at least one additional major hospital in metro-Auckland, possibly two. If two, then there would certainly be one in the southern region.

5.2 Balanced Scorecard

The report was taken as read.

5.3 Finance Report

Margaret White (Chief Financial Officer) summarised this section of the report.

5.4 Emergency Department, Medicine and Integrated Care

Bowel Screening Programme – still in discussions with the Ministry in terms of what the Bowel Screening funding will be. No starting date has been received yet.

5.5 Surgery, Anaesthesia and Perioperative Services

Theatre Performance - the table on page 52 shows a significant improvement in 2017 in theatre session utilisation. One feature of the theatre utilisation improvement project has been in booking patients three weeks out which has seen a reduction in cancellation rates.

5.6 Central Clinical Supplies

Radiology – approval was received from the Board to replace the primary interventional radiology equipment in the department. This will result in more accurate imaging and will improve clinical outcomes for procedures.

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Reduced Radiologist FTE – this has been the highest risk for the department. We are working hard to recruit to fill the vacant positions and the service is being covered by running additional sessions and outsourcing some scans and reads to manage the volumes.

5.7 Women's Health and Kidz First

Food Service – we are seeing improvements in this area.

Births we have been relatively static in our birth rates but what has been more problematic is the increase in caesarean sections. May was sitting at 30%, YTD 26% against 23% last year. Obesity and older women having babies are both contributing to complex births and the increase in c-sections.

Neonatal Unit – the unit has continued with both higher acuity and admissions. Whilst the actual number of discharges from the unit is up 15% (41 babies), the WIES is up 53% (499) reflecting that increase in acuity. Occupancy for May was 98% with a few days more than 30 out of our 38 physical cots being occupied. We have therefore already needed to increase both the nursing ratios through the nursing bureau or nurses deployed from Kidz First Wards as well as increase the number of average resourced cots to 30. Recruitment for additional nursing staff is underway.

MCIS – the MCIS system will continue with ongoing support. Looking to the MoH for some clear indications of their level of investment will be. It will not be rolled out across the country until those who are currently using it say it is ready for that.

5.8 Adult Rehabilitation and Health of Older People

Community Support Workers - the quality of some of the standards of care being provided were discussed. How do we monitor and keep track of those standards, are our community support workers doing what they are contracted to do, how do we audit to ensure that what we pay for is what we get. Jenny Parr was asked to look into these questions and report back to the next meeting (23 August).

5.9 Mental Health and Addictions

Tiaho Mai New Build - Phase 1 due for completion early January 2018 and opening in March with additional capacity.

5.10 Facilities

Ko Awatea II – the KAII team and corporate finance functions are working jointly to provide the Board will a full summary of total project breakdown, including timeline, previously unaccounted for professional and fit-out costs and transaction arrangements. This review once completed will provide the Board with requested assurances around the project delivery framework. Discussions are ongoing about what the facility will be used for.

Masterplan for MMH Site – a site plan for the MMH site will be going to the Audit Risk & Finance meeting in August. We have to get clarification around some of our buildings on site, in particular the seismic issues of the Galbraith building.

Water Supply – Ms Glenn commented that if anything happened to the water supply to the MMH site, we only have 3-days water supply. Mr Balmer confirmed that Facilities are looking into options to either increase the current reservoir water storage capacity or look into a water bore option.

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Phillip Balmer also confirmed that the Emergency Plan is currently being reviewed to ensure we have all the key issues covered off covered (ie) power, water, technology, transport etc. The Committee asked for a copy of the updated Plan to come back to the next meeting (23 August).

5.11 Middlemore Central

The paper was taken as read.

6. **CORPORATE REPORTS**

6.1 Director of Patient Care, Chief Nurse and Allied Health Professions Officer

Jenny Parr introduced the report. Matters highlighted or updated included:

Allied Health – Ms Glenn noted that the Associate Director of Allied Health Speech Language Therapy recently attended the Australasian Society Study for Brain Impairment and expressed her interest in services provided to people with brain injuries. She was particularly interested to know what aphasia was and what exactly will be implemented in the Franklin locality mid-year in relation to group work in aphasia. Ms Parr confirmed that aphasia is difficulty with speech, it does happen in people who have had strokes and is a very big part of speech language therapy. She also confirmed she would come back to the Committee with some further information to what exactly will be happening in the Franklin locality.

Undergraduate Education Landscape- this appendix provided the Committee with an update on the way we manage aspects of education across the nursing and allied workforces. 1300 placements are provided per annum across nursing and allied health which is a large number and an important role that we take on. There are a number of institutions involved. We don't have a problem recruiting people into education for nursing and do our best to maximise our Maaori and Pacific workforce. Jenny Parr was asked to provide the gender split of the CM Health nursing and allied health workforce in her next report (23 August).

6.2 Human Resources

New Director - the new Director of Human Resources, Elizabeth Jeffs, starts on 31 July.

Voluntary Employee Turnover by reason of Leaving – Ms Glenn raised a concern about staff leaving and moving out of Auckland due to the high cost of living. The graph on page 92 shows that the vast majority of people leave for other reasons. Another question was raised in relation to the number of health professionals moving between New Zealand and Australia. Dr Johnson confirmed that this has always been variable between professions and is quite a lot less than now that it was a few years ago. Phillip Balmer agreed to look at a recent Ministry report and bring that back to the Committee (23 August) as they generally do track where people are going and why.

7. **RESOLUTION TO EXCLUDE THE PUBLIC**

Resolution (Moved: Mark Darrow/Seconded: Dianne Glenn)

That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ 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:

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General Subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
2.1 Public Excluded Minutes of 31 May 2017	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982). [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** For the reasons given in the previous meeting**.**
2.2. Action Items Register	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Action Items Register** For the reasons given in the previous meeting.
3.1 Patient Experience and Safety Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982). [NZPH&D Act 2000 Schedule 3, S32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S9(2)(a)]

Carried

The open session of the meeting concluded at 3.38pm

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD HOPSITAL ADVISORY COMMITTEE MEETING OF 31 MAY 2017.

Lyn Murphy, Committee Chair

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Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

Hospital Advisory Committee Meeting – Public Action Items Register – 23 August 2017

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
Standing Items						
12.7.17	2.4	Summary of Annual Leave Cash-Ups for Hospital Services Directorate – provide a **quarterly report** showing, for those staff that have had annual leave paid out, their current leave balance, leave accrual and leave taken. This report will not specifically identify particular individuals due to privacy issues.	4 October	Margaret White/ Phillip Balmer		
31.5.17	5.1	Certification – provide a **quarterly report** showing progress being made against each corrective action.	23 August	Jenny Parr	Refer Item 4.1 on today's agenda.	✓
12.7.2017	6.11	Medicine - Bowel Screening Programme **regular update** each meeting**.**	23 August	Brad Healey	Refer Item 3.5 on today's agenda.	
12.7.2017	2.	Patient Survey –**regular** update on the response rates to the patient survey and the complaints review process.	23 August	Jenny Parr	Refer Item 4.1 on today's agenda.	✓
12.7.2017	6.1	Hospital Services 2016/17 Project Initiatives ***Update*** (as part of the Executive Summary). ***Quarterly report*** including specific bed day savings and benefits realisations.	23 August 4 October	Phillip Balmer	Refer Item 3.2 on today's agenda.	✓
12.7.2017	5.1	System Level Measures ***Update*** (as part of the Executive Summary). ***Quarterly*** full report.	23 August 4 October	Phillip Balmer	Refer Item 3.1 on today's agenda.	✓
31.5.2017/ 12.7.2017	5.1	Acute Psychiatry – provide a regular report on how the DHB measures itself against the UK Mental Health Triage Scale model (ie) responses to triage times (how many people that were triaged E we did actually see within 4 weeks). The service is currently facing some technological issues in measuring some of this data accurately and is undertaking an audit to ensure the data is being	23 August	Phillip Balmer/ Tess Ahern	Refer Item 3.10 on today's agenda.	✓

Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
		measured correctly. Come back with a proposal based on the audit, when completed.				
12.7.2017	4.1	Health of Older People – provide statistical data on the programmes mentioned on 12 July by Shankar Sankaran in the HoP monthly report.	~~23 August~~/15 November	Phillip Balmer/ Dana Ralph-Smith	*Statistical data on the programmes discussed is limited at this stage for a number of reasons. A full complement of data will be reported to HAC following completion of Q1 2017/18.*	
12.7.2017	5.8	ARHoP – Community Support Workers – provide answers to the questions raised on 12 July.	23 August	Phillip Balmer/ Jenny Parr	Refer Item 3.9 on today's agenda.	✓
12.7.2017	5.10	Facilities – provide an updated copy of the Emergency Response plan.	23 August	Phillip Balmer	A verbal response will be provided at the meeting today.	✓
12.7.2017	6.1	Director of Patient Care – provide some further information in relation to what is happening in the Franklin locality with group work in aphasia. Provide the gender split of the CM Health nursing and allied health workforces.	23 August 23 August	Jenny Parr Jenny Parr	Refer Item 4.1 on today's agenda. Refer Item 4.1 on today's agenda.	✓ ✓
12.7.2017	6.2	HR – bring information back on the number of health professionals moving between NZ and Australia.	23 August	Phillip Balmer	A verbal response will be provided at the meeting today.	✓

Emergency Department, Medicine and Integrated Care

Glossary

APAC	Acute Post-Acute Care
CNM	Charge Nurse Manager
DNA	Did Not Attend
ED	Emergency Department
FCT	Faster Cancer Treatment
MA	Medical Assessment
MSC	Manukau SuperClinic
RMO	Resident Medical Officer
SMO	Senior Medical Officer
STEMI-PCI	ST-elevation Myocardial Infarction Percutaneous Coronary Intervention
YTD	Year to Date

Service Overview

The Emergency Department, Medicine and Integrated Care division is managed by Brad Healey (General Manager) with Clinical Directors/Heads Dr Carl Eagleton (Medicine), Dr Jeremy Dryden (Emergency Department), Dr Sally Urry (BreastScreen), and Clinical Nurse Directors To'a Fereti and Annie Fogarty.

Response to Action Item

HAC Meeting 12.7.2017 – National Bowel Screening Programme update
"Bowel Screening Programme regular update via the Medicine report each meeting"

There is potentially an issue with the funding to be provided for the National Bowel Screening Programme which is planned to be rolled out at CM Health in July 2018. We are meeting with the Ministry of Health in late-July 2017 to discuss the funding and potential service delivery issues. We plan to report back more fully after this meeting.

Highlights

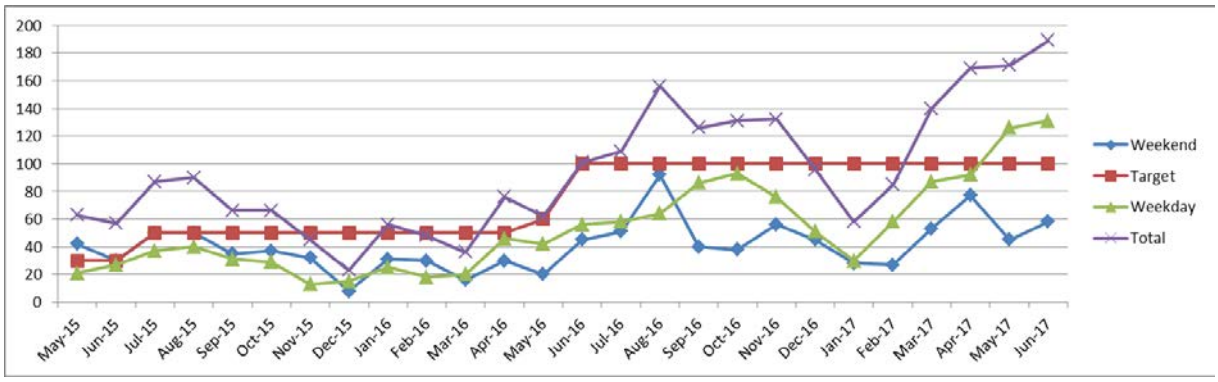
Nurse Facilitated Discharges in General Medicine

The number of Nurse Facilitated Discharges has been increasing over the last three months, with the highest number achieved since their introduction achieved in June. This improvement has resulted from better identification of suitable patients and improved engagement with medical teams. The weekday 3pm Rapid Round with the Nurse Manager, Clinical Head, APAC nurse, and Middlemore Central Duty Manager identifies potential patients for discharge the following day to ensure they are moved off the ward as early as possible.

During June, there were a total of 189 Nurse Facilitated Discharges in General Medicine, of which 30% were during the weekends (critical to ensuring the admission of new patients from the Emergency Department come Monday morning which is typically a very busy time). Nurse Facilitated Discharges have also been a significant contributor to improving rate of patient discharges before 11am (early discharges are also crucial in ensuring sufficient capacity throughout the hospital).

The purple line in the following graph highlights both the steady improvement in Nurse Facilitated Discharges since May 2015, and the recent step change in performance over the past few months.

General Medicine – Discharges since May 2015:



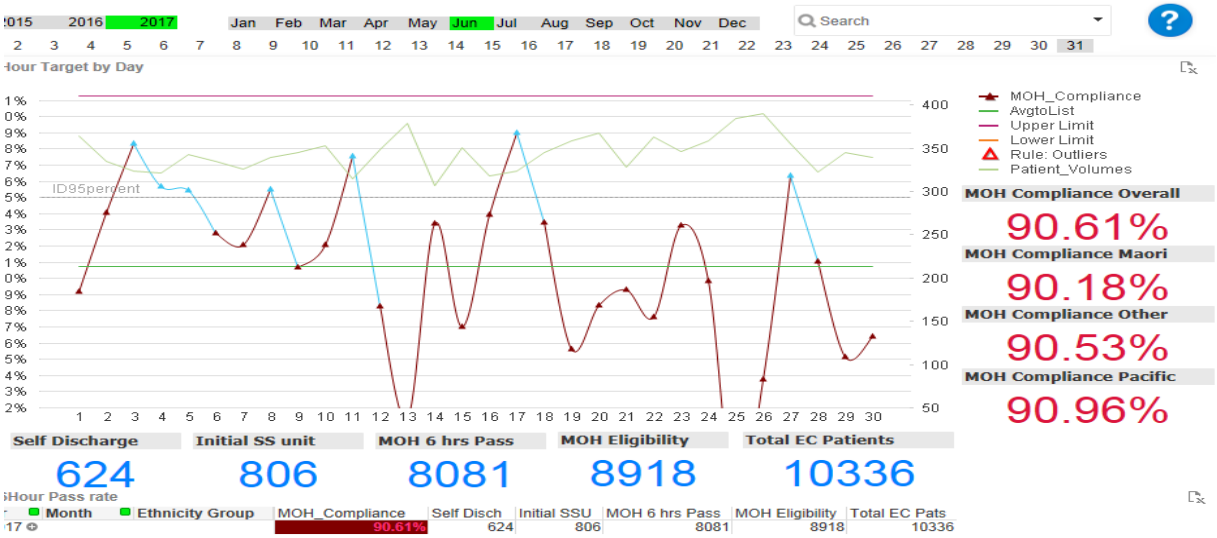
Winter Demand Update

Emergency Department

During June, ED presentations totalled 10,336 which is a 9.9% increase over last year's volumes for the same month. The daily average number of patients coming through the ED in June was 350, with a number of these patients being admitted to hospital. This has in turn resulted in a substantial increase in the number of "Dot Days" (hospital full days) which is being driven by unprecedented levels of acute demand.

The ED continues to hold high volumes of patients throughout the day, with a June average of 26 patients waiting for an inpatient bed at 7am which compares to between 2-4 patients in Auckland. The highest number of patients waiting at 7am recorded during the month was 49. This means that ED is holding approximately a ward full of patients every morning and throughout the day. As a result, the ED has again been unable to meet the national six hour target, achieving a 91% result for the month of June. The graph below shows daily performance against this target.

Daily ED performance against the six hour target – June 2017:



General Medicine

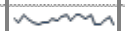
As noted above, patient volumes have been significantly higher than expected reflecting an early onset winter demand. Bed occupancy in General Medicine averaged 113% for the month, which presents significant challenges in managing patient flow throughout the hospital. We have continued to focus on improving discharge processes with a 3pm Rapid Round and Nurse Facilitated Discharges (as described in the highlights section of this report).

Update on previously reported issues

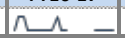
Issue	Date reported	Update
Gastroenterology – challenge of maintaining FCT and Ministry of Health targets	19 Oct 2016	We continue to experience high levels of demand which has been up to 33% increase per month from January. The demand has reduced for May and June, but there is still a 14% increase compared to this time last year. We are also experiencing increased "acute" procedures with hospital winter workload patients requiring a procedure prior to discharge. This has resulted in the cancellation of some elective procedures. Work continues to increase capacity within the Gastro department and to meet targets. Due to increased demand and previous SMO leave, the colonoscopy waiting list has now increased to 650; ideally the waiting list would be 350. Additionally, the gastroscopy waiting list has also increased to 981, which would ideally sit at around 400. To date, two more SMOs have been employed (commencing in March and May respectively). We continue to recruit for a Fellow, and have offered a position to a potential candidate to commence in December. All three SMOs on uncovered extended leave have now returned. In-house capacity has been increased through more SMOs agreeing to pick up additional lists. We continue to negotiate with SMOs to re-commence Saturday lists as several have expressed an interest in these. Another round of outsourcing to private providers has also been completed.
Lung Function Lab Accreditation	31 May 2017	Options are being explored for alternative testing space. Discussions held with Laboratory and Surgical Services staff around possible use of the laboratory space at MSC. The Laboratory service has presented a paper to the Anaesthetic team and is awaiting formal feedback.

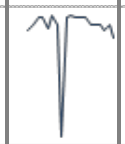
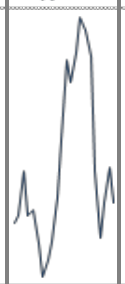
EMERGENCY DEPARTMENT, MEDICINE AND INTEGRATED CARE SCORECARD

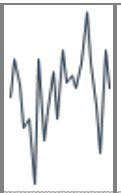
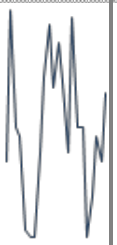
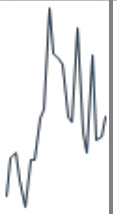
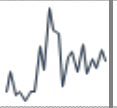
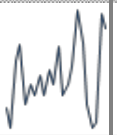
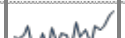
June 2017

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Total Caseweight		**2,505**	2,554	-1.9%	**29,212**	30,096	-2.9%		
	Elective Caseweight		**88**	80	10.0%	**647**	948	-31.8%		Mostly due to Cardiology & Gastro. Cardiology volumes are offset by corresponding over-performance in Acutes.
	Acute Caseweight (includes Intensive Care Unit)		**2,417**	2,473	-2.3%	**28,565**	29,148	-2.0%		Variance due to slightly lower volumes month to month than in previous years.
	Outpatient First Specialist Assessment (FSA) Volumes		**1,305**	1,308	-0.2%	**15,537**	15,563	-0.2%		
	Outpatient Follow Up Volumes		**3,646**	3,526	3.4%	**40,683**	41,002	-0.8%		
	Virtual First Specialist Assessments (FSAs)		**147**	151	-2.6%	**2,191**	1,805	21.4%		

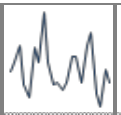
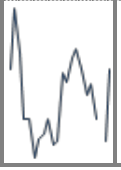
		Trend				12 month average			Rating	Commentary (by exception)
		FY16-17	May-17	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years		**8.9%**	5.0%	-3.9%	**7.5%**	5.0%	-2.5%		Continue to monitor annual leave > 2 years across all services.
	% Staff Turnover		**10.6%**	10.0%	-0.6%	**10.4%**	10.0%	-0.4%		
	% Sick Leave		**2.7%**	2.8%	0.1%	**3.0%**	2.8%	-0.2%		
	Workplace Injury per 1,000,000 hours		**0.0**	10.5	10.5	**12.7**	10.5	-2.2		

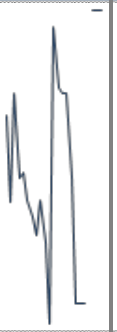
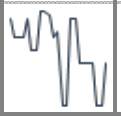
		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Safety	No. Falls causing major harm		**0**	0	0	**0**	0	0		No falls with harm for June

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Timely	% Radiotherapy commences in 4 weeks		**100%**	100%	0%	**100%**	100%	0%		
	% Chemotherapy commences in 4 weeks		**100%**	100%	0%	**100%**	100%	0%		
	% of patients admitted, discharged, transferred from ED within 6 hrs		**91%**	95%	-4%	**93%**	95%	-2%		High volume of Dot Days - unable to move patients through the hospital , an average of 26 patients waiting for beds daily with a high of 47 despite having opened additional inpatient bed capacity as part of winter planning.
	P1 (urgent) % diagnostic colonoscopy patients receive the procedure within 14 days		**97%**	85%	12%	**96%**	85%	11%		
	P2 (routine)% diagnostic colonoscopy patients receive the procedure within 42 days		**63%**	70%	-7%	**63%**	70%	-7%		P2 target continues to not be achieved due to a number of things experienced since December including, 3 SMOs going back to Gen Med cover, 3 SMOs in sabbatical and maternity leave, a senior fellow vacancy, RMO strike actions and an unprecedented increase in referrals (elective & acute) at approx. Up to 30% for the last 5 months, resulting in a backlog in the waiting list which will require an increase in capacity to clear. This has been rectified partially with 2 new SMOs, private outsourcing and re-commencing additional lists.
	% surveillance colonscopy patients receive their procedure within 84 days of planned date		**96%**	70%	26%	**96%**	70%	26%		

Timely (cont)	% cardiac STEMI - PCI (angiography) within 120 mins - Northern Region Target		**69%**	80%	-11%	**86%**	80%	6%		A high number of acute cases this month compared with previous 3 months. Many factors impact this target such as access to a Cath lab, ability to correctly diagnose a STEMI, ambulance time, time in ED, and time of day. Given the multi-factorial nature, and that the target was reached last month, it is difficult to ascertain the reason for failure to meet the target this month.
	% Coronary Angiography within 90days (1 month in arrears)		**91%**	95%	-4%	**91%**	95%	-4%		
	Medical Assessment – Triage 3-5 patients seen within 60 minutes		**97**	60	37	**85**	60	25		Reflects the increases length of time patient wait to be seen with increased patient numbers
	Door to Cathlab suspected Acute Coronary Syndrome < 3 days (median time)		**81%**	70%	11%	**78%**	70%	8%		
	General Medince - Seen By Time (minutes)									
	1st Time to be seen Triage 1 & 2 patients (median time in minutes)		**31**	30	-1	**31**	30	-1		
	1st Time to be seen Triage 3 - 5 patients (median time in minutes)		**93**	60	-33	**80**	60	-20		Significant gap between actual and target. This target is not being met for the majority of the time. The target for patients to be seen within 60 minutes is highly dependent on teams being in MA all the time. The model of care is proposing change to match resource availablity with demand by altering the roster. There is a MA project underway to review the processes and the performanace measures to understand what areas can be improved.This may enable closing the gap.
	2nd Time to be seen Triage 1 & 2 patients (median time in minutes)		**61**	30	-31	**56**	30	-26		Not meeting target and the performance for this metric is influenced by a number of factors including methods of patient handover that result in batching of patients referred. A review of the data will be done for this process to examine where are the points in the day that the timliness of the service is not met.Once this is established the cause of the delay will be expored. Project is underway.
	2nd Time to be seen Triage 3-5 patients (median time in minutes)		**80**	60	-20	**71**	60	-11		A similar approach as above to identifying the periods of the day that this process is not being timely will undertaken. This will provide insight into the reasons for non performance and help identify solutions.
	Faster Cancer Treatment - % high suspicion first cancer treatment within 62 days - MOH Faster Cancer Treatment		**88%**	85%	3%	**78%**	85%	-7%		Performance over the past 3 months has been steady at 83%. Patient and pathway micromanagement continue. The redeveloped tracker roles are mostly in place. This will provide greater drive to ensure all patients are managed in as timely manner as possible.
	Faster Cancer Treatment - %confirmed diagnosis first cancer treatment within 31 days - MOH Faster Cancer Treatment		**84%**	85%	-1%	**87%**	85%	2%		

		Trend	Year to date						Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
System Integration (Effective)	Average Length of Stay - Acute		**3.2**	3.5	0.3	**3.1**	3.5	0.4		
	Acute Readmissions within 28 days - Total		**1%**	10%	-9%	**13%**	10%	3%		This month acute 28 readmissions was 13% - It should be noted that 36 out of the 133 patients that were readmited were seen and sent home from ED/MA. Therefore while the rate is higher, some of these patients are not actually readmited to the ward but were re-presentations.

Effective (cont.)	Acute Readmissions within 28 days - 75+		**13%**	10%	3%	**14%**	10%	4%		Rate of readmission improved this month and is not significantly higher than expected. 8 out of 47 patients were seen and discharged from ED/MA so are not true readmissions.
	% of patients on home wards in General Medicine		**46%**	75%	-29%	**45%**	75%	-30%		May occupancy in home wards improved slightly. The overall occupancy for general medicine in May was 119%, significantly higher than previous months. With demand being greater than bed capacity, patients had to be placed in outlier wards . Additionally, to reduce the impact on MA and ED, patients had to be placed where beds were available. The SMO and RMO roster change proposal is underway to enable better operation of the home ward based system. Once the rosters are implemented, this is likely to improve provided the hospital occupancy enables the wards to handle additional capacity. However, with winter demand there will be need to outlie patients to meet capacity
	% of Outliers on non-medicine wards		**4.0%**	0.0%	-4.0%	**6.6%**	0.0%	-6.6%		The demand was greater than capacity this month for most days. Average occupancy was 119% this month which meant patients have had to be admitted to areas other than medicine to meet the demand. Capacity for this demand can only be managed through outying in areas where beds are available.

		Trend				Year			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Efficient	% Discharges from transit lounge or home by 1100hrs		**20%**	30%	10%	**17%**	30%	13%		The 11 am discharge rates have improved and been sustained over the last 3 months. Overall trend indicates a steady move towards the target with gradual improvement. 3 pm rapid rounds and nurse faciliatated discharges are strategies currently being used. Doctor roster changes will also result in timely decsion making to support early discharges. Work is also currently being done with CNMs and ward teams to increase the awareness of the need for early discharges as well as identifying reasons for why discharges are delayed. Note this data is for all medicine wards not just general medicine. General Medicine rates are higher.
	% Discharged from Medical Assessment Unit by 1100hrs		**43%**	40%	3%	**40%**	40%	0%		
	% of patients < 28 hrs discharged from inpatient wards		**10%**	10%	0%	**10%**	10%	0%		
	Implement Home First Renal policy - (increase Continuous Ambulatory Peritoneal & HD rate)		**44%**	50%	-6%	**44%**	50%	-6%		Ratio of Home:Incentre dialysis for June remains static at 44%:50%. There was 1 additional dialysis patient in June on pertioneal dialysis, raising the overall dialysis number to 624. There was only 1 transplant in June.

		Trend	Volumes Screened			% Screened in last 24 Months			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Equity	% Women with Breastscreen in last 24 months - total		**2518**	2255	263	**69%**	70%	-1%		We now have additional capacity, monthly targets are being exceeded, and coverage increasing. We continue to focus on strategies to increase Maaori coverage.
	% Women with Breastscreen in last 24 months - Maaori		**343**	269	74	**64%**	70%	-6%		
	% Women with Breastscreen in last 24 months - Pacific		**463**	370	93	**76%**	70%	6%		

Surgery, Anaesthesia and Perioperative Services

Glossary

CLAB	Central Line Associated Bacteraemia
CME	Continuing Medical Education
DNA	Did Not Attend
ESPI	Elective Services Patient Flow Indicator
FSA	First Specialist Assessment
GP	General Practitioner/General Practice
ICU	Intensive Care Unit
LOS	Length of Stay
MMH	Middlemore Hospital
MSC	Manukau SuperClinic
TBC	To be confirmed
VTE	Venous Thromboembolism
WIES	Weighted Inlier Equivalent Separations
YTD	Year to Date

Service Overview

Surgery, Anaesthesia, and Perioperative Services is managed by Mary Burr (General Manager), with Dr Mark Moores (Clinical Director – Surgery, Anaesthesia and Perioperative Services), Dr Tony Williams (Clinical Director - Critical Care Complex), Jacqui Wynne-Jones (Clinical Nurse Director – Surgery, Anaesthesia and Perioperative Services), and Annie Fogarty (Clinical Nurse Director – Acute and Critical Care Complex).

Highlights

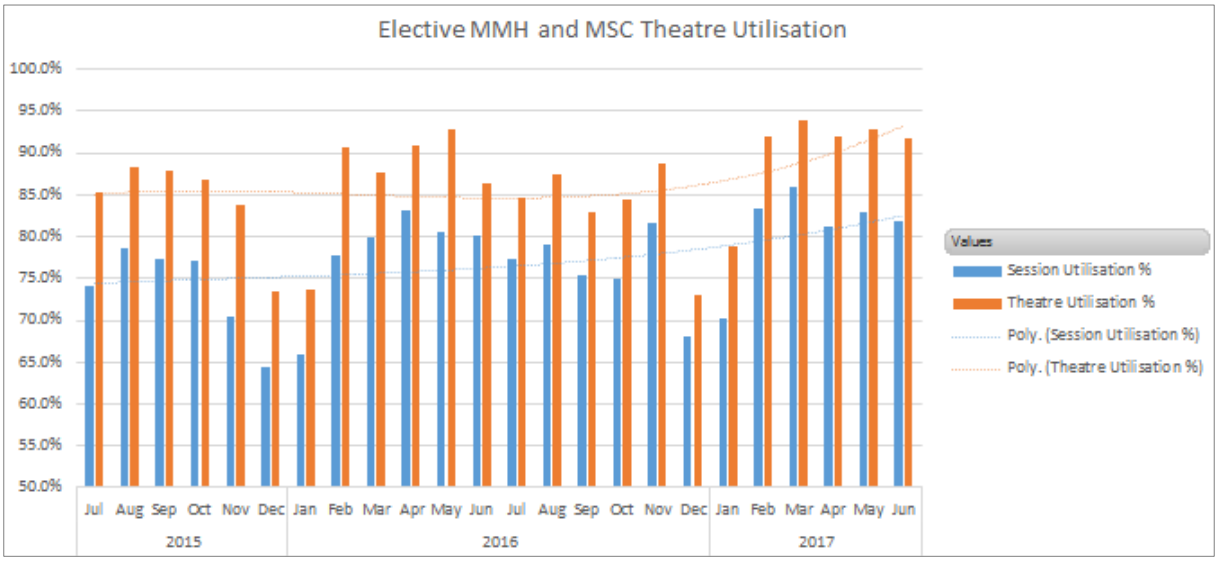
<u>Major achievements for the 2016/17 year</u>

The Surgery, Anaesthesia and Perioperative Services division has a number of achievements to highlight for the 2016/17 financial year:

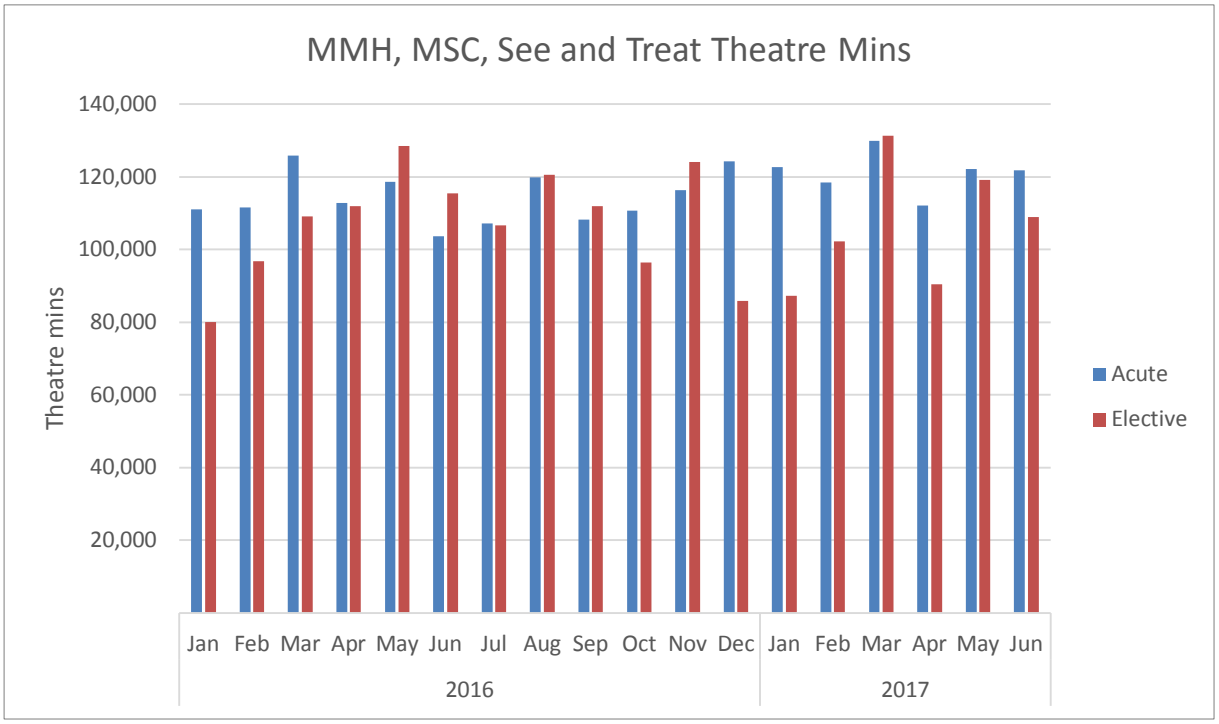
- Patient satisfaction has reached 90% by monthly average (satisfaction being those reporting their experience as good, very good, or excellent. N = 1162).
- The division met both the discharge and WIES targets for the year based on DHB of domicile.
- The total number of surgical patients (excluding gynaecology) that were treated and discharged from CM Health facilities was 34,305; an increase of 748 patients (or 2.23%) when compared to the previous financial year.
- The number of outsourced elective patients totalled 1,019 compared to 1,377 in the previous year – a reduction of 358 patients (or 26%).
- Internal elective productivity at CM Health facilities are 655 discharges (or 4.86%) higher than the outputs reported for the same period last year.
- The division achieved the Hip and Knee target of 892 operations, Bariatric target of 158 operations, and Cataract target of 1,319 operations. These three targets have considerable incentive funding attached.
- Inpatient discharges before 11am have been consistently at target of 30%.
- The Dedicated Education Units in General Surgery, Orthopaedics, and Theatre have enhanced the educational and training in the ward environment.
- Acute discharges are 188 cases higher than contract for June 2017, and 555 cases (or 2.83%) higher than contract for the year.

Theatre Performance

Elective theatre utilisation performance over both sites (Middlemore Hospital and Manukau SuperClinic) continues to exceed 85%.



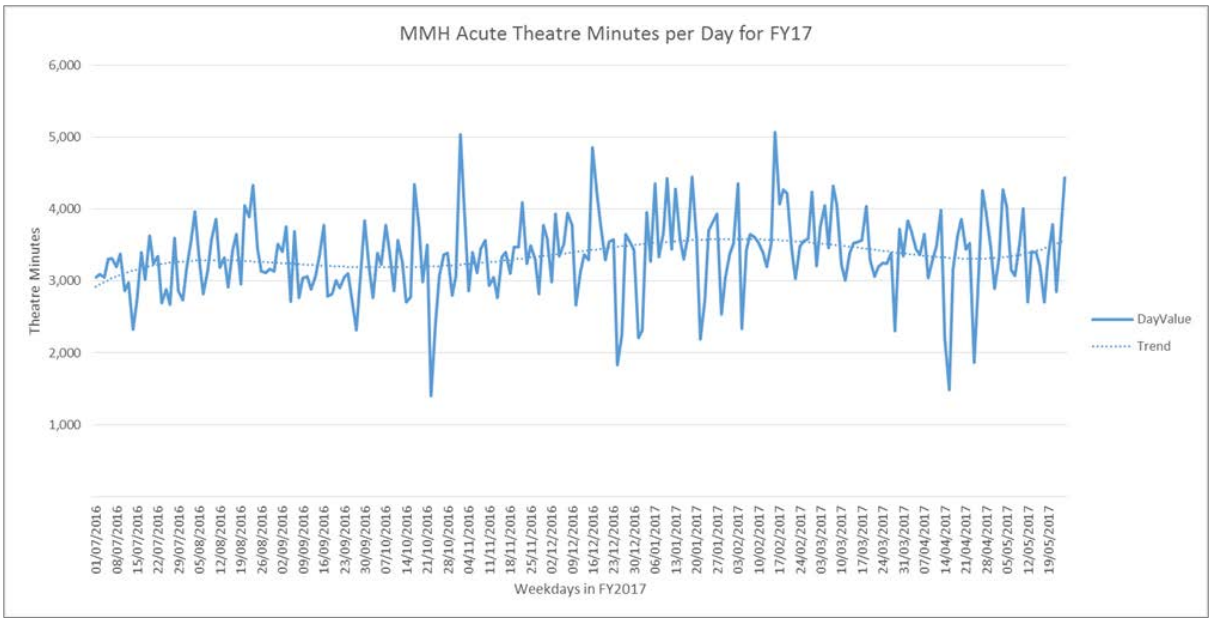
Overall theatre performance has delivered acute outputs of 122,000 minutes and elective outputs of 109,000 minutes.



Emerging Issues

High acute demand

Over the 2016/17 financial year, our acute demand has increased by around 15%, and is of a highly variable nature (see following graph). We are managing this demand through the short term reduction of elective lists and adjusting our production planning. While this strategy enabled us to meet elective targets for June 2017, the impact will be felt in July as the cases deferred are those that would have ensured we meet the July targets.



Update on previously reported issues

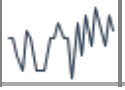
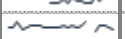
Issue	Date reported	Update
Critical Care beds under increasing demand	27 Jul 2016	Overall the total June admissions for Critical Care were 147; marginally higher than the start of winter 2015. 28 admissions were children. A plan is in place to manage elective bookings if acute volumes are high and beds are limited.
Demand on Ophthalmology and Otorhinolaryngology (ORL) services	27 Jul 2016	We are making steady progress through our overdue follow up appointments. We have a number of strategies in place and are working regionally and nationally to resolve the high volumes. Our new clinic facility is operational on Level 3, Galbraith.
Potential machinery failure in the MSC Sterile Supply Unit	8 Mar 2017	The MSC Sterile Supply Unit is at risk of failure due to ageing machinery. Remedial work is planned for January 2018. There is a plan in place to manage failures should they occur before the planned works.

SURGERY, ANAESTHESIA & PERIOPERATIVE SERVICES DIVISION — June 2017

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Total Caseweight (Provider view)		**3,552**	3,441	3.2%	**40,512**	41,036	-1.3%		Great result for June but slightly under for year.
	Elective Caseweight		**1,327**	1,456	-8.9%	**16,197**	16,378	-1.1%		Slightly under for 16-17.
	Acute Caseweight		**2,225**	1,985	12.1%	**24,315**	24,658	-1.4%		Contract not adjusted for WIES 16
	Acute discharges		**1,768**	1,580	11.9%	**20,181**	19,626	2.8%		Good result- a very busy year
	Elective Surgical Discharges		**1,235**	1,352	-8.6%	**15,143**	15,165	-0.1%		Shortfall of 22 Inpatient discharges (Overall discharge target achieved through counting procedural outpatients)
	Virtual FSAs/Follow ups -(GP consult and nonpatient appointments)		**335**	161	108.7%	**1,786**	1,756	1.7%		
	Personnel Costs ($000)		**$13,382**	$13,479	0.7%	**$153,788**	$155,365	1.0%		
	Financial Result Total ($m)		**$16,138**	$16,027	-0.7%	**$186,118**	$184,615	-0.8%		Impacted throughout the year by RMO strikes and anaesthetic tech shortages. Large amount of extra incentive funding will offset the majority of this deficit.
	Reduce clinical outsourcing ($000)		**$102**	$403	74.7%	**$5,323**	$4,032	-32.0%		

		Trend				12 month average			Rating	Commentary (by exception)
		FY16-17	May-17	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years		**15.6%**	5.0%	-10.6%	**15.3%**	5.0%	-10.3%		Work is in progress to manage high annual leave balances . These high balances sits mostly with SMOs who have CME leave and sabbaticals which impact.
	% Staff Turnover		**10.7%**	10.0%	-0.7%	**9.5%**	10.0%	0.5%		
	% Sick Leave		**2.3%**	2.8%	0.5%	**2.7%**	2.8%	0.1%		
	Workplace Injury per 1,000,000 hours		**0.0%**	10.5	10.5	**10.21**	10.5	0.3		

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)	Hand Hygiene compliance rate (based on Gold Audit) - Ward 11		**70%**	80%	-9.8%	**73%**	80%	-6.9%		New phase of work is beginning in 2017-18 to address hand hyigene - particularlyfocused on Ward 11.
	Pressure Injuries / 100 patients		**0.00**	0.00	0.00	**0.00**	0.00	0.00		
	Falls causing major harm / 1000 bed days		**0.00**	0.00	0.00	**2.00**	0.00	2.00		Month score is nil. Huge imrovement shown throughout the year.
	Severe Pressure Injury (ungradeable) per 1000 bed days		**0.00**	0.00	0.00	**0.00**	0.00	0.00		
	Surgical Site Surveillance for Major joints-									
	Antibiotics given 0-60mins before "knife to skin"		**91%**	95%	-4%	**89%**	95%	-6%		Timing on anaesthetic machines, theatre computers and theatre wall clock are not synchronised, one machine showing 8 mins difference. Will be followed up with biomedical engineering.
	2 grams or more Cefazolin given		**97%**	100%	-3%	**97%**	100%	-3%		Continuing with close monitoring
	Appropriate skin preparation		**98%**	100%	-2%	**99%**	100%	-1%		Continuing with close monitoring

Safety (cont.)	CLAB rate/ 1000 line days		**0.0**	0.0	0.0	**7.0**	0.0	-7.0		One patient in ICU with CLAB – no known cause of infection identified.
	VTE - Ortho (Acute and Elective)		**7.0**	2.0	-5.0	**83.0**	0.0	-83.0		Too early to say why there has been a rise in provoked VTE events. These will be reviewed by the VTE committee.
		Trend				**Year to date**			**Rating**	**Commentary (by exception)**
		FY16-17	**Jun-17**	**Target**	**Var**	**Actual**	**Target**	**Var**		
Timely	Pre-operative Length of Stay Days (from admit to surgery)		**1.3**	1.0	-0.3	**1.2**	1.0	-0.2		Improvement noted YTD. Is the focus of a new project to reduce preop LOS.
	ESPI 2 No. patients waiting >120 days for FSA - Elective (Surgical Services incl Gynae)		**0**	0	0.0	**0**	0	0.0		
	ESPI 5 No. patients waiting >120 days Treatment - Elective (Surgical Services incl Gynae)		**4**	0	-4.0	**4**	0	-4.0		Green ESPI (breaches within acceptable limits)
		Trend				**Year to date**			**Rating**	**Commentary (by exception)**
System Integration (Effective)		**FY16-17**	**Jun-17**	**Target**	**Var**	**Actual**	**Target**	**Var**		
	Average Length of Stay - Acute Inpatient incl Burns		**3.97**	3.8	-0.2	**3.75**	3.8	0.1		
	Average Length of Stay - Acute Inpatient excl: Burns		**3.93**	3.8	-0.1	**3.72**	3.8	0.1		
	Average Length of Stay - Acute Inpatient excl: Burns and Spinal Ortho		**3.91**	3.8	-0.1	**3.71**	3.8	0.1		
	Average Length of Stay - Electives		**1.00**	1.5	0.5	**1.19**	1.5	0.3		
		Trend				**Year to date**			**Rating**	**Commentary (by exception)**
Efficient		**FY16-17**	**Jun-17**	**Target**	**Var**	**Actual**	**Target**	**Var**		
	Theatre list utilisation - % used MMH/MSC		**84%**	85%	-1%	**91%**	85%	6%		
	Theatre session utilisation - % used MMH/MSC		**99%**	95%	4%	**94%**	95%	-0.6%		Excellent month result
	Elective Theatre turnaround times- Mins (MSC only)		**14**	15	1	**16**	15	-1		Acute pressures during June have resulted in an increase of elective DOS cancellations.
	Elective cancellations - Day of surgery as % of all Elective (all reasons)- SAPS only		**9%**	5%	-4%	**8%**	5%	-3%		
	Day of Surgery Admissions (DOSA)		**92%**	90%	2%	**89%**	90%	-1%		
	Day Case Rate (Elective/ Arranged) -Subspecialties in SAPS only Adults/kids		**72%**	65%	7%	**72%**	65%	7%		
	MMH % patients discharged to discharge lounge or home by 1100hrs		**30%**	30%	0%	**23%**	30%	-7%		Some extremely promising results as all services head towards 30%
	MMH % patients discharged to discharge lounge or home by 1100hrs -GEN SURG		**33%**	30%	3%	**26%**	30%	-4.4%		
	MMH % patients discharged to discharge lounge or home by 1100hrs- ORTHO		**24%**	30%	-7%	**17%**	30%	-13%		
	MMH % patients discharged to discharge lounge or home by 1100hrs- PLASTICS		**29%**	30%	-1%	**21%**	30%	-10%		
	Ratio FSA/FU clinic ratio		**30%**	31%	-1%	**37%**	31%	6%		
	Outpatient DNA rates - overall- Surgical Services only		**9%**	10%	1.2%	**8%**	10%	1.6%		
	Outpatient DNA rates - Maori (FSA) - Surgical Services only		**16%**	10%	-6.2%	**16%**	10%	-5.6%		Requires an organisational approach for best results.
	Outpatient DNA rates - Pacific (FSA)- Surgical Services only		**12%**	10%	-2.1%	**13%**	10%	-3.4%		
		Trend				**Year to date**			**Rating**	**Commentary (by exception)**
Equity		**FY16-17**	**Jun-17**	**Target**	**Var**	**Actual**	**Target**	**Var**		
	% of hospitalised smokers receiving smokefree advice & support -Total (Surgical)		**91%**	95%	-4%	**95%**	95%	0%		
		Trend				**Year to date**			**Rating**	**Commentary (by exception)**
P&WCC		**FY16-17**	**Jun-17**	**Target**	**Var**	**Actual**	**Target**	**Var**		
	Patient Experience Survey - month (n=93) and YTD (n=1162)		**92%**	90%	2%	**90%**	90%	0%		

Counties Manukau District Health Board
Hospital Advisory Committee
Hospital Directorate Services Report – June 2017

Recommendation

It is recommended that the Hospital Advisory Committee:

Receive the Hospital Directorate Services report covering activity in June 2017.

Prepared and submitted by Phillip Balmer, Director Hospital Services

Executive Summary

Glossary

ARHOP	Adult Rehabilitation and Health of Older People
ED	Emergency Department
LOS	Length of Stay
SLM	System Level Measures

Overview

It is always a surprise when the Annual Diversity Ball rolls around; it is hard to believe it has been a year since the last one, until that is, we stop and reflect on the year that has been and all that we have achieved. The Diversity Ball serves as a great opportunity to thank our staff and our business partners for their continued efforts in making CM Health a great place to work; a place where we are kind, value everyone, and work together to maintain our reputation of being excellent at what we do.

Almost a year ago we made some structural changes to the Hospital Services Directorate to better support the delivery of our organisation's "Healthy Together 2020" strategic direction. This included reorganising our existing divisions and establishing new ones. Our reporting to the Hospital Advisory Committee throughout the year has highlighted the triumphs and challenges each division has faced,

however, with the close of the financial year I'd like to take the opportunity to briefly recognise their efforts.

ED, Medicine and Integrated Care

Across the course of the year this newly reorganised division has been faced with responding to unprecedented demand at the front door and across the system. Despite this pressure, the division has implemented a number of successful service delivery changes (e.g. local oncology, general medicine floor), received international recognition for the work of the Toto Ora Dialysis Clinic team, and kicked off a review of ambulatory services to support the development of Community Hubs.

Surgery, Anaesthesia and Perioperative Services

As with our Medical sub-specialities, our Surgical services have also felt the pressure that has come with high and sustained levels of acute demand. The division responded through their Optimisation of Theatre Resources project, with their elective theatre utilisation consistently exceeding 85%. This work enabled the division to increase internal productivity by 5%, reduce outsourcing, meet their targets, respond to the surge in acute demand, and significantly raise overall patient satisfaction.

Central Clinical Services

In the short period Central Clinical Services has existed as a division, a high performing Pharmacy service has been established utilising state of the art robotics to improve efficiency and patient safety. The division has also had to respond to a number of challenges, including workforce shortages within the Radiology service, and the need to implement corrective action in order to maintain accreditation of our Histopathology lab.

Women's Health and Kidz First

As with our other services, the Women's Health and Kidz First division has experienced the impact of rising demand and acuity. Challenges for the division have been compounded by a midwifery workforce shortage, the roll-out of the Maternity Clinical Information System, and a recent spike in paediatric ED demand. In line with our strategic goal of reducing inequities and adding life years, the division's achievement in reducing Sudden Unexplained Death in Infants (SUDI) for Maaori babies through their implementation of the regional SUDI Safe Sleep programme of work is a standout success worth celebrating.

Adult Rehabilitation and Health of Older People

ARHOP has had a great deal of success leading and contributing to a range of local and regional initiatives with a whole-of-system lens, however, with the addition of Stroke care to the ARHOP portfolio as part of our divisional restructure, I'd like to highlight the work done in this area in particular. The team has been focussed on the stroke journey, from prevention through to treatment, and has considered how our local service delivery model across the continuum of care is aligned to wider regional planning. Additionally, a dedicated stroke unit was established in December as part of the acute stroke service redesign in order to improve outcomes for our patients by facilitating closer collaboration of the acute and rehabilitation teams in a single clinical unit.

Mental Health and Addictions

As with ARHOP, the Mental Health and Addictions division has been at the forefront of CM Health's transformative approach to integrating healthcare. Their performance throughout the year has been characterised by partnership with others to achieve the best possible outcomes for our patients; this has ranged from implementing new models of care within the ED environment (Awake Overnight Nurse and Department of Psychological Medicine), through to the development of integrated locality care teams.

A highlight for Hospital Services throughout the year has been watching the new Acute Mental Health Unit taking shape. The division's management team has been working hard to develop a plan for the facilitation and mobilisation of staff and service users to the new facility upon its completion.

Facilities and Asset Management

As part of the Hospital Services restructure, the Facilities division was reorganised to increase emphasis on strategic and operational support for facilities and assets across the organisation. Under the leadership of a new General Manager, the division has adopted a methodical and deliberate approach in the development and implementation of operational and management systems. Additionally, the division has been tasked with proactively identifying and addressing a number of facility and asset related risks.

Middlemore Central

Although Middlemore Central has been our organisation's operational hub for some time, it wasn't formally recognised as a division until the restructure. At that time, Middlemore Central assumed responsibility for the majority of our non-clinical support functions. Centralising our operational and support functions has enabled the division to drive a number of system-wide patient flow initiatives to support CM Health to operate more efficiently and effectively, and to respond to the recent step change in demand. A stand-out success has been the creation of the Discharge Lounge.

Reducing inequities and improving health outcomes – a success story

CM Health's strategic goal is that "together the CM Health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020". Given the significant challenges associated with reducing disparities and improving health outcomes for our population, we were proud of the success recognised in the recently released Ministry of Health report comparing one year lung cancer survival rates. The below table shows an overall improvement in the one year relative survival rate for lung cancer in all DHBs in the Northern region, with CM Health having the best survival rate of all four DHBs.

1 year relative survival rates by DHB region for selected sites - Calculated using the period method, and Ederer II								
DHB	**1998-99**	**2000-01**	**2002-03**	**2004-05**	**2006-07**	**2008-09**	**2010-11**	**2012-13**
Northland	0.239	0.254	0.259	0.301	0.281	0.262	0.265	0.278
Waitemata	0.309	0.294	0.236	0.335	0.329	0.356	0.335	0.414
Auckland	0.280	0.289	0.329	0.300	0.339	0.337	0.330	0.404
Counties	0.256	0.358	0.290	0.273	0.316	0.293	0.387	0.427

Summary of Financial Position

The Provider Arm has delivered a favourable financial result of $2.98M.

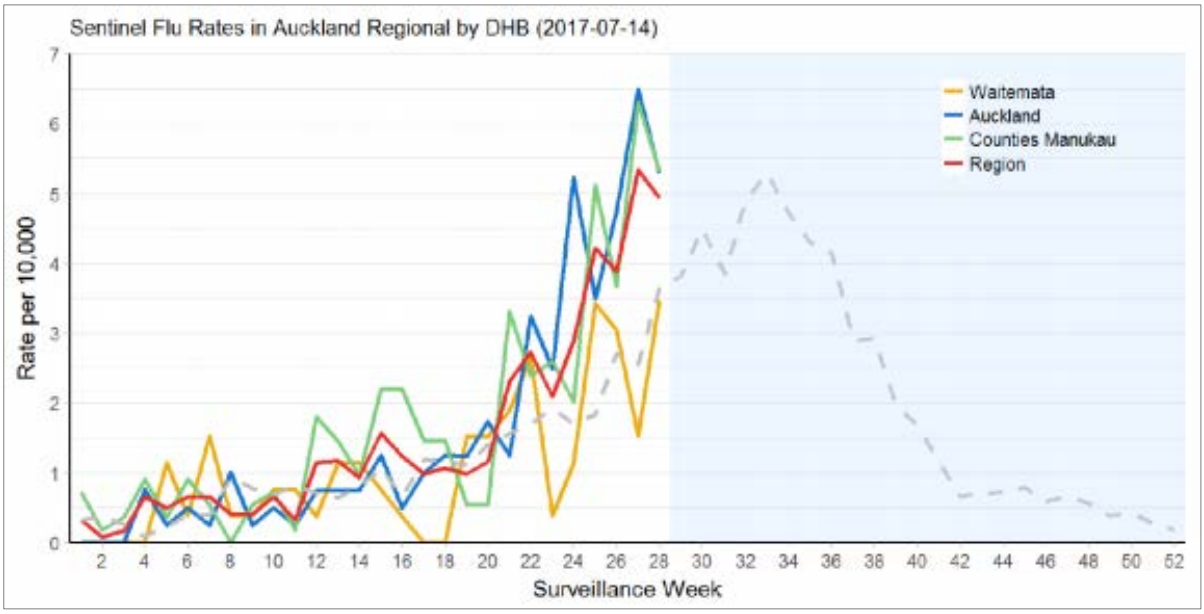
National Health Targets

Performance against the three health targets for which Hospital Services is responsible for is summarised in the table below.

Shorter Stays in Emergency Departments	**Description** 95% of patients will be admitted, discharged, or transferred from an emergency department within six hours		**June** Not Achieved ✖ 91%
Faster Cancer Treatment	**Description** 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 two weeks by July 2016, increasing to 90% by June 2017		**June (indicative)** Achieved ✓ 88%
Improved Access to Elective Surgery	**Description** The volume of elective surgery will be increased by an average of 4,000 discharges per year.	**May (confirmed)** Achieved ✓ 106.9%	**June (indicative)** Achieved ✓ 106.0%

It is disappointing, though not surprising, that we have again been unable to deliver the ED six hour target given our consistent performance for the last six years. The challenges have been predominantly due to acute bed pressures. Despite targeted efforts to improve patient flow throughout the system, bed occupancy remains very high, and accordingly our ED has been left with little choice but to hold high volumes of patients until beds become available.

Our medical services have been particularly impacted by a spike in influenza-like illness, as shown in a recent surveillance report produced by the Auckland Regional Public Health Service below. Our workforce is under high pressure to assess, treat, and move these patients on quickly without compromising their care. Our influenza vaccination rate was 67% which was the best result yet. Sick leave remained low at 2.5%.



Our surgical services have also continued to experience the impact of increasing acute demand, with acute theatre minutes increasing by 8% in the last six months. In order to accommodate increasing acute demand, a number of elective procedures have needed to be cancelled; however, the ongoing efforts of our surgical services to improve their productivity has meant that CM Health sustained its performance against the national elective surgery target for the month of June and achieved 106% YTD. We anticipate, however, that the flow on effects of this demand will likely impact our ability to meet the target in July. The service has, and will continue to, work to recover delayed elective procedures, and has a full recovery plan in place.

System Level Measures

Hospital Services continues to track performance against the contributory measures we have committed to as part of the overarching SLM programme of work. We continue to see significant increases in discharges by 11am as well as referrals to the Reablement service.

Performance against our LOS measure is symptomatic of both the increase in demand and the increase in acuity of our patients. Efforts to capture and measure the patient journey through a patient-flow dashboard are underway to enable us to identify and address pressure points and barriers within the system, and a targeted initiative to identify stranded patients and facilitate their return to community is also in flight; both workstreams are further discussed in the Middlemore Central section of this month's report.

KPI	Target	Target		Current		
	Target	Full Year	YTD	YTD%	YTD	By Month
ED Presentation	2.3%	111,473	12,391	4.9%	13,310	
ED Admit to Inpatient Ward	15.0%	31,009	3,417	3.5%	4,162	
Inpatient LOS > 10 Days	15.0%	4,371	445	29.4%	678	
Inpatient Readmission Within 28 Days	15.0%	6,501	667	19.0%	934	
Inpatient Discharge at Sunday	20.0%	8,744	1,018	5.3%	893	
Inpatient Discharge by 11AM (MMH)	25%	NA	2,055	30.6%	2,517	
Referrals to Reablement	20.0%	803	62	165.4%	138	

Legend of Indicator: Less than halfway to Target | Halfway to Target | Achieved Target

Legend of Sparkline: Current Year | Previous Year

Project Portfolio

The Initiatives Programme section of this month's report details performance against our 2016/17 plan. It is pleasing to note that through the implementation of our initiatives programme we have achieved 85% of our planned savings target for the year, totalling $12.4M. It is timely to pause and celebrate the significant effort and achievement of staff in realising this saving; at the beginning of the year we asked our teams to identify initiatives that they would lead and deliver in addition to executing their business-as-usual activity.

Despite experiencing unprecedented levels of demand across our system, individuals and teams have continued to drive their initiatives forward and realise the associated savings. This is a real testament to the capability and commitment of our people. We will continue to embed a more structured, disciplined, and centrally-supported approach to project delivery over the coming year, which will be fundamental to achieving our ambitious savings target of $30.24M.

Initiatives Programme

Glossary

ARHOP	Adult Rehabilitation and Health of Older People
CCS	Central Clinical Services
FY	Financial Year
MMC	Middlemore Central
YTD	Year To Date

Overview

As previously reported to the Committee, Hospital Services undertook an ambitious 2016/17 workplan consisting of a number of service-led transformation, improvement, and revenue initiatives. Each of these initiatives had identified benefits (financial and/or non-financial) which were tracked through a standardised process whereby all active initiatives were reported on each month by the responsible manager.

Delivery progress

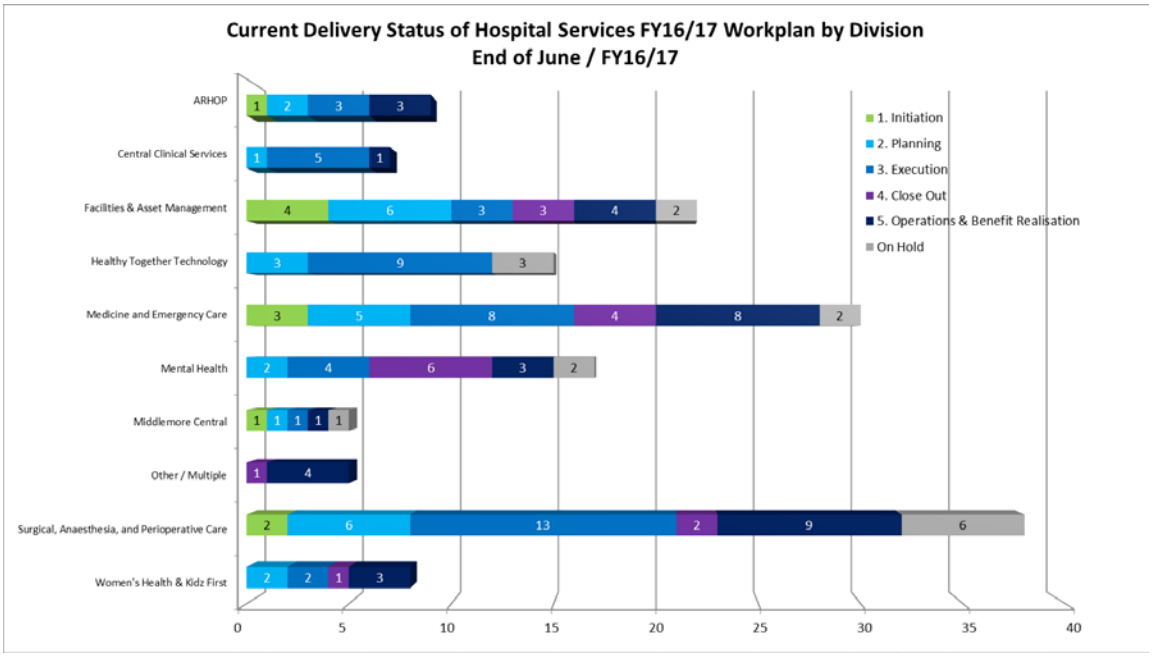
Since our last report, as part of the year end process across all Hospital Services divisions, an additional 14 projects have been completed and transitioned to either 'operations' or 'business as ususal'. A further three projects have moved from 'execution' to 'close out'.

Eleven initiatives remain in 'initiation', primarily as a result of reprioritisation due to operational demand. These initiatives continue to be monitored by General Managers, and will be reviewed as part of the 2017/18 strategy development process.

	Number of initiatives in phase				
Phase	Start of Q2	Start of Q3	End of April	End of Q4	Shift
Initiation	46	19	16	11	-5
Planning	58	38	34	28	-6
Execution	51	69	58	48	-10
Close Out	1	12	14	17	3
Operations	8	12	22	36	14
On hold	2	6	12	16	4
Total	166	156	156	156	0

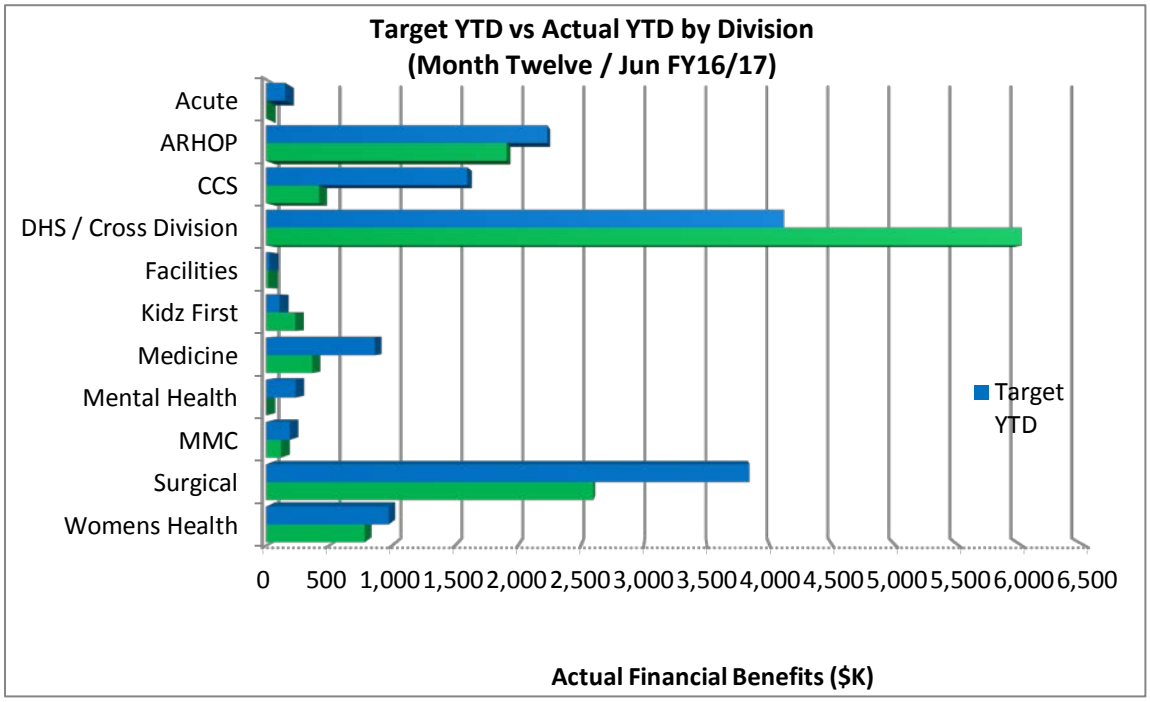
An additional four initiatives are noted as being 'on hold'; this is in part due to a divisional review of initiatives which have not progressed in line with their original plans. Strategies for these are being developed around how they will fit into the 2017/18 workplan – through reshaping or rescoping, or potentially abandoning as they no longer align with our strategic priorities.

The following graph shows the number and status of initiatives within each division.



Benefits Realisation

Savings achieved from planning 2016/17 initiatives totalled $12.4M against a target of $14.7M for the year; this represents a delivery result of 85% against target. This year end result has been confirmed by our Business Managers and is due to be reported through to the Audit Risk and Finance Committee in more detail.



Although a result of 85% is a great result, additional measures have been put in place moving into the 2017/18 year; this includes regular reporting on the progression of savings initiatives to the Investment and Change Steering Group, with early identification and intervention to get at risk initiatives back on track. Additionally, a three year pipeline of savings opportunities is being developed to provide a longer term picture of where benefits can be delivered.

2017/18 Savings Plan

The savings plan for 2017/18 has been developed and validated, with a current target of $30.24M forecast from 38 initiatives across the organisation. Performance against this plan will be reported to the Committee at a summary level, and in more detail to both the Investment and Change Steering Group and the Audit Risk and Finance Committee.

Balanced Scorecard

NOTES
* performance is against previous year's actual
Δ ESPI interim results subject to change

HOSPITAL SERVICES BALANCED SCORECARD — June 2017

*Red variance figures: non-favourable result for the indicator

		Trend by month				Year to date		
		FY16-17	Jun-17	Target	Var	Actual	Target	Var
National Targets	Emergency Department - 6 hour Length of Stay target		**91%**	95%	-4%	**95%**	95%	0%
	FCT % of high suspicion first cancer treatment within 62 days (indicative result)		**88%**	85%	3%	**78%**	85%	-7%
	Elective surgery discharges		**1,235**	1,352	-8.7%	**15,143**	15,165	-0.1%

		Trend by month				Year to date		
		FY16-17	Jun-17	Target	Var	Actual	Target	Var
Ensuring Financial Sustainability	Total Caseweight		**7,581**	7,565	0.2%	**88,274**	89,048	-0.9%
	Acute Caseweight		**6,172**	5,896	4.7%	**70,103**	70,098	0.0%
	Elective Caseweight		**1,409**	1,669	-15.6%	**18,171**	18,950	-4.1%
	Total Discharges - performace compared to prior year.		**9,066**	8,788	3.2%	**104,234**	104,753	-0.5%
	Outpatient First Specialist Assessment Volumes		**4,039**	4,331	-6.7%	**50,470**	52,222	-3.4%
	Outpatient Follow Up Volumes		**10,916**	11,295	-3.4%	**125,523**	135,494	-7.4%
	Virtual First Specialist Assessments (GP consult and nonpatient appointments)		**534**	314	70.1%	**4,844**	3,789	27.8%
	Budgeted FTEs		**6,221**	6,049	-2.8%	**6,021**	6,038	0.3%
	Operating Costs ($000)		**$69,093**	$26,038	-165.4%	$296,608	$310,748	4.6%
	Personnel Costs ($000)		**$7,558**	$50,568	85.1%	$601,557	$596,551	-0.8%
	Financial Result Total ($000)		**-$107**	-$2,769	96.1%	-$16,923	-$19,905	15.0%
	Reduce clinical outsourcing ($000)		**$2,472**	$2,395	-3.2%	$28,287	$27,892	-1.4%

		Trend by month				Average last 12 months		
		FY16-17	May-17	Target	Var	Actual	Target	Var
Enabling High Performing People	Excess Annual Leave dollars ($000) - estimated cost for excess		**$3,877**	$1,213	-$2,664	**$3,563**	$1,215	-$2,348
	Adult Rehabilitation and Health of Older People		**$67**	$84	$17	**$71**	$81	$10
	Medicine, Acute Care and Clinical Support		**$507**	$285	-$222	**$496**	$331	-$165
	Surgical and Ambulatory Care		**$1,450**	$465	-$985	**$1,432**	$468	-$964
	Mental Health		**$342**	$204	-$139	**$305**	$168	-$137
	Women's Health and Kidz First		**$679**	$176	-$503	**$703**	$168	-$535
	% Staff Annual Leave >2 years		**11.8%**	5.0%	-6.8%	**11.6%**	5.0%	-6.6%
	Adult Rehabilitation and Health of Older People		**4.0%**	5.0%	1.0%	**4.4%**	5.0%	0.6%
	Medicine, Acute Care and Clinical Support		**8.9%**	5.0%	-3.9%	**7.5%**	5.0%	-2.5%
	Surgical and Ambulatory Care		**15.6%**	5.0%	-10.6%	**15.3%**	5.0%	-10.3%
	Mental Health		**8.4%**	5.0%	-3.4%	**9.1%**	5.0%	-4.1%
	Women's Health and Kidz First		**19.3%**	5.0%	-14.3%	**20.9%**	5.0%	-15.9%

		Trend by month				Average last 12 months		
		FY16-17	May-17	Target	Var	Actual	Target	Var
Enabling High Performing People (cont.)	% Staff Turnover (YTD no. voluntary turnovers by average headcount)		**10.6%**	10.0%	-0.6%	**10.9%**	10.0%	-0.9%
	% Sick Leave		**2.5%**	2.8%	0.3%	**3.0%**	2.8%	-0.2%
	Workplace Injury per 1,000,000 hours		**1.2**	10.5	9.3	**10.1**	10.5	0.4
	Workforce Diversity					Month to date		
			Jun-17	Target	Var	Jun-16	Target	Var
			Workforce	*Population*		*Workforce*	*Population*	
	Maaori		**7%**	16%	-9%	**7%**	16%	-9%
	Pacific		**13%**	23%	-10%	**12%**	23%	-11%
	Asian		**31%**	23%	8%	**29%**	23%	6%
	NZ European / non-specified/ other		**49%**	38%	11%	**52%**	38%	14%

		Trend by month				Year to date		
		FY16-17	May-17	Target	Var	Actual	Target	Var
First, Do No Harm (Safety)	% e-medication reconciliation - high risk patients within 48hrs (Jun-17)		**64%**	80%	-16%	**68%**	80%	-12%
	% Serious Pressure Injuries rate / 100 Patients		**0.0%**	3.5%	3.5%	**0.2%**	3.5%	3.3%
	Falls causing major harm rate / 1,000 bed days		**0.00**	0.00	0.00	**0.05**	0.00	-0.05
	Adverse Events: % of admissions affected by ≥4 triggers		**1.1%**	N/A	N/A	**1.3%**	N/A	N/A
	Central Line Associated Bacteraemia (CLAB) rate / 1,000 bed days in ICU		**0.00**	0.00	0.00	**0.03**	0.00	-0.03
	Rate of S. aureus bacteraemia rate / 1,000 bed days		**0.10**	0.00	-0.10	**0.07**	0.00	-0.07
			Quarterly reporting			Year		
			Q1 FY17	Target	Var	Actual	Target	Var
	% 75+years assessed for the risk of falling #		**93%**	90%	3.0%	N/A	N/A	N/A
	% 75+years assessed for falls risk with falls intervention plans #		**96%**	N/A	N/A	N/A	N/A	N/A

		Trend by month				Year to date		
		FY16-17	Jun-17	Target	Var	Actual	Target	Var
Timely	% Magnetic Resonance Image (MRI) scans completed within 6 weeks from referral		**80%**	85%	-5%	**80%**	85%	-5%
	% Computerised Tomography (CT) scans completed within 6 weeks from referral		**95%**	95%	0%	**96%**	95%	1%
	% urgent diagnostic colonoscopy within 14 days		**97%**	85%	12%	**96%**	85%	11%
	% diagnostic colonoscopy patients within 42 days		**63%**	70%	-7%	**63%**	70%	-7%
	% surveillance colonoscopy patients within 84 days		**96%**	70%	26%	**96%**	70%	26%
	% cardiac STEMI-PCI (angiography) <120mins - Northern Region		**69%**	80%	-11%	**86%**	80%	6%
	% Coronary Angiography within 90days (1mth arrears)		**91%**	95%	-4%	**91%**	95%	-4%
	ESPI 2: No. patients waiting >120 days for FSA - Elective Δ		**0.0**	0.0	0.0	**0.0**	0.0	0.0
	ESPI 5: No. patients waiting >120 days treatment - Elective Δ		**4.0**	0.0	-4.0	**4.0**	0.0	-4.0
	Radiology - Inpatient radiology completion times <24hrs		**93%**	95%	-2%	**94%**	95%	-1%
	Radiology- Emergency Care radiology completion times <2 hrs		**95%**	95%	0%	**94%**	95%	-1%
	FCT - % confirmed diagnosis first cancer treatment within 31 days		**84%**	85%	-1%	**87%**	85%	2%
	% Radiology results reported within 24 hours		**42%**	75%	-33%	**58%**	75%	-17%

		Trend by month				Year to date		
		FY16-17	Jun-17	Target	Var	Actual	Target	Var
System Integration (Effective)	Average Length of Stay - Acute Inpatient		**2.7**	3.0	0.3	**2.7**	3.0	0.3
	Average Length of Stay - Acute Arranged/ Elective		**1.7**	1.4	-0.3	**1.7**	1.4	-0.4
	Middlemore Hospital % patients to discharge lounge or home by 1100hrs		**21%**	30%	-9%	**18%**	30%	-12%
	Acute Readmissions within 7 days - Total		**3.0%**	2.7%	-0.3%	**2.6%**	2.9%	0.3%
	Acute Readmissions within 28 days - Total (1 month in arrear)		**7.1%**	6.9%	-0.2%	**6.9%**	7.1%	0.3%
	Acute Readmissions within 28 days - 75+ years (1 month in arrear)		**11%**	13%	1.7%	**11%**	12%	0.9%
	Emergency Department Presentations - 75+ year olds		**1,063**	807	-256	**1,028**	807	-221
	% clinical summaries (meddocs) authorised <7 days of creation		**71%**	95%	-24%	**72%**	95%	-23%
	% of patient outliers - not on home ward <5%		**6.1%**	5.0%	-1.1%	**4.0%**	5.4%	1.4%
			Quarterly Reporting			**Year to date**		
	% DHB Mental Health Services - children/ youth (0-19years) seen by 3 weeks for non-urgent		**74%**	80%	-6%	N/A	N/A	N/A
	Mental Health access rate - clients seen in last 12 months as % of population (0-19yrs)		**3.9%**	3.2%	0.8%	N/A	N/A	N/A
	Mental Health access rate - clients seen in last 12 months as % of population (20-64yrs)		**3.8%**	3.2%	0.7%	N/A	N/A	N/A
	Mental Health access rate - clients seen in last 12 months as % of population (64+yrs)		**2.4%**	2.6%	-0.2%	N/A	N/A	N/A

		Trend by month				Year to date		
		FY16-17	Jun-17	Target	Var	Actual	Target	Var
Efficient	Outpatient - First Specialist : Follow-up Clinic ratio		**37%**	38%	1%	**40%**	38%	-2%
	Outpatient - Did Not Attend rates - Maaori		**20%**	10%	-10%	**20%**	10%	-10%
	Outpatient - Did Not Attend rates - Pacific		**18%**	10%	-8%	**18%**	10%	-8%
	Theatre List Utilisation		**92%**	83%	9%	**92%**	83%	9%
	Day of Surgery Admissions (DOSA)		**92%**	90%	2%	**89%**	90%	-1%
	Day Case Rate (Elective/ Arranged)		**72%**	65%	7%	**72%**	65%	7%
	% Medical Assessment patients with Length of Stay < 28 hours		**81%**	65%	16%	**81%**	65%	16%
	No. Hospital bed days occupied (against forecast open beds)		**21,907**	21,712	-0.9%	**244,701**	257,988	5.4%
	No. Length of Stay outliers (LOS >10 days)*		**321**	311	-3%	**3,600**	3,340	-7%

		Trend by month				Year to date		
		FY16-17	Jun-17	Target	Var	Actual	Target	Var
Equity	% smokers receive smokefree advice / support -Total		**95%**	95%	0%	**96%**	95%	1%
	% smokers receive smokefree advice / support - Maaori		**95%**	95%	0%	**96%**	95%	1%
	% smokers receive smokefree advice / support - Pacific		**95%**	95%	0%	**96%**	95%	1%
	% smokers receive smokefree advice / support - Asian		**99%**	95%	4%	**96%**	95%	1%
			Volumes Screened			**% Screened in last 24 months**		
	% Women (45-60yrs) with Breastscreen in 24months - Total		**2518**	2255	263	**69%**	70%	-1%
	% Women (45-60yrs) with Breastscreen in 24months - Maaori		**343**	269	74	**64%**	70%	-6%
	% Women (45-60yrs) with Breastscreen in 24months - Pacific		**463**	370	93	**76%**	70%	6%

		Trend by month				Year to date		
		FY16-17	Jun-17	Target	Var	Actual	Target	Var
P&WCC	Patient experience Survey data - month (n=201) and YTD (n=2,606)		**77%**	90%	-13%	**79%**	90%	-11%

Financial Results – Provider Arm

Consolidated Statement of Financial Performance June 2017	Month				Year to Date			Full Year		
	Actual $(000)	Budget $(000)	Variance $(000)	Variance to Prev Mnth	Actual $(000)	Budget $(000)	Variance $(000)	Actual $(000)	Budget $(000)	Variance $(000)
Income										
Government Revenue	8,839	4,643	4,196 F	↑	65,030	56,744	8,287 F	65,030	56,744	8,287 F
Patient/Consumer Sourced	819	1,025	(206) U	↓	10,345	12,126	(1,781) U	10,345	12,126	(1,781) U
Other Income	1,689	2,570	(880) U	↓	22,442	31,339	(8,898) U	22,442	31,339	(8,898) U
Funder Payments	65,197	65,599	(402) U	↑	783,425	787,185	(3,761) U	783,425	787,185	(3,761) U
Total Income	**76,544**	**73,837**	**2,707 F**	↑	**881,242**	**887,394**	**(6,152) U**	**881,242**	**887,394**	**(6,152) U**
Expenditure										
Personnel	55,419	49,451	(5,967) U	↓	580,570	583,159	2,589 F	580,570	583,159	2,589 F
Outsourced Personnel	2,140	1,116	(1,024) U	↓	20,987	13,392	(7,595) U	20,987	13,392	(7,595) U
Outsourced Clinical	2,472	2,395	(77) U	↓	28,288	27,892	(396) U	28,288	27,892	(396) U
Outsourced Other	926	3,098	2,172 F	↑	34,423	37,178	2,755 F	34,423	37,178	2,755 F
Clinical Supplies (excluding Depreciation)	11,905	8,825	(3,080) U	↓	110,187	105,109	(5,079) U	110,187	105,109	(5,079) U
Other Expenses	(146)	6,087	6,233 F	↑	65,755	72,988	7,232 F	65,755	72,988	7,232 F
Total Expenditure (excl Depreciation, Interest and Capital Charge)	**72,716**	**70,974**	**(1,742) U**	↓	**840,210**	**839,717**	**(493) U**	**840,210**	**839,717**	**(493) U**
Earnings before Depreciation, Interest and Capital Charge	**3,828**	**2,863**	**964 F**	↑	**41,031**	**47,677**	**(6,646) U**	**41,031**	**47,677**	**(6,646) U**
Depreciation	1,345	2,894	1,549 F	↑	31,890	34,733	2,843 F	31,890	34,733	2,843 F
Interest	-	1,225	1,225 F	↔	7,865	14,700	6,835 F	7,865	14,700	6,835 F
Capital Charge	2,590	1,512	(1,077) U	↓	18,200	18,149	(51) U	18,200	18,149	(51) U
Total Depreciation, Interest and Capital Charge	**3,935**	**5,632**	**1,697 F**	↓	**57,955**	**67,582**	**9,627 F**	**57,955**	**67,582**	**9,627 F**
Net Surplus/(Deficit) Provider	**(107)**	**(2,769)**	**2,662 F**	↑	**(16,923)**	**(19,905)**	**2,982 F**	**(16,923)**	**(19,905)**	**2,982 F**

Personnel Costs By Professional Group June 2017	Month				Year to Date			Full Year		
	Actual $(000)	Budget $(000)	Variance $(000)	Variance to Prev Mnth	Actual $(000)	Budget $(000)	Variance $(000)	Actual $(000)	Budget $(000)	Variance $(000)
Medical Personnel	18,689	15,812	(2,876) U	↓	187,425	186,312	(1,113) U	187,425	186,312	(1,113) U
Nursing Personnel	20,778	18,515	(2,263) U	↓	221,040	218,131	(2,909) U	221,040	218,131	(2,909) U
Allied Health Personnel	6,786	7,134	348 F	↓	78,995	84,462	5,467 F	78,995	84,462	5,467 F
Support Personnel	2,396	2,265	(131) U	↓	26,979	26,267	(712) U	26,979	26,267	(712) U
Management/Administration Personnel	6,770	5,726	(1,045) U	↓	66,130	67,987	1,857 F	66,130	67,987	1,857 F
Total (before Outsourced Personnel)	**55,419**	**49,451**	**(5,967) U**	↓	**580,570**	**583,159**	**2,589 F**	**580,570**	**583,159**	**2,589 F**
Outsourced Medical	1,286	444	(842) U	↓	10,196	5,330	(4,866) U	10,196	5,330	(4,866) U
Outsourced Nursing	369	194	(175) U	↑	4,513	2,333	(2,179) U	4,513	2,333	(2,179) U
Outsourced Allied Health	59	11	(48) U	↑	562	133	(429) U	562	133	(429) U
Outsourced Support	60	1	(59) U	↓	408	12	(396) U	408	12	(396) U
Outsourced Management/Admin	366	465	100 F	↑	5,308	5,584	276 F	5,308	5,584	276 F
Total Outsourced Personnel	**2,140**	**1,116**	**(1,024) U**	↓	**20,987**	**13,392**	**(7,595) U**	**20,987**	**13,392**	**(7,595) U**
Total Personnel	**57,558**	**50,568**	**(6,991) U**	↓	**601,557**	**596,551**	**(5,006) U**	**601,557**	**596,551**	**(5,006) U**

Surplus / Deficit by Division June 2017	Month				Year to Date			Full Year		
	Actual $(000)	Budget $(000)	Variance $(000)	Variance to Prev Mnth	Actual $(000)	Budget $(000)	Variance $(000)	Actual $(000)	Budget $(000)	Variance $(000)
Central Clinical Services	(6,249)	(7,264)	1,015 F	↑	(85,024)	(86,842)	1,817 F	(85,024)	(86,842)	1,817 F
Emergency Medicine and Integration	(13,484)	(12,870)	(614) U	↓	(156,126)	(153,271)	(2,856) U	(156,126)	(153,271)	(2,856) U
Middlemore Central	(2,103)	(2,376)	273 F	↑	(29,118)	(27,905)	(1,213) U	(29,118)	(27,905)	(1,213) U
ARHOP	(3,325)	(3,432)	107 F	↑	(39,937)	(40,433)	496 F	(39,937)	(40,433)	496 F
Mental Health	(5,727)	(5,756)	30 F	↑	(68,165)	(68,486)	320 F	(68,165)	(68,486)	320 F
Surgical & Ambulatory	(15,686)	(15,542)	(145) U	↑	(180,714)	(179,042)	(1,672) U	(180,714)	(179,042)	(1,672) U
Women & Child Health	(5,641)	(5,627)	(14) U	↑	(67,639)	(66,832)	(807) U	(67,639)	(66,832)	(807) U
Facilities Services	(1,794)	(1,730)	(63) U	↑	(20,223)	(20,062)	(161) U	(20,223)	(20,062)	(161) U
Provider Management	60,029	57,088	2,941 F	↑	692,565	686,085	6,480 F	692,565	686,085	6,480 F
Innovations Hub & Ko Awatea	(2,550)	(1,630)	(921) U	↓	(19,142)	(19,557)	416 F	(19,142)	(19,557)	416 F
Integrated Care	(3,578)	(3,630)	52 F	↑	(43,400)	(43,562)	163 F	(43,400)	(43,562)	163 F
Total	**(107)**	**(2,769)**	**2,662 F**	↑	**(16,923)**	**(19,905)**	**2,982 F**	**(16,923)**	**(19,905)**	**2,982 F**

Volumes June 2017	Month				Year to Date			
	Actual Volume	Budget Volume	Variance Volume	Variance %	Actual Volume	Budget Volume	Variance Volume	Variance %
M00001 - General Medicine Inpatients	1,411	1,451	(39) U	-3%	16,507	16,992	(485) U	-3%
S00001 - General Surgery Inpatients	824	731	93 F	13%	9,626	9,081	545 F	6%
S45001 - Orthopaedic Inpatients	762	719	43 F	6%	8,527	8,926	(398) U	-4%
W10001 - Maternity Inpatients	594	537	58 F	11%	6,948	6,442	506 F	8%
S60001 - Plastic & Burns - Inpatients	513	469	43 F	9%	5,581	5,832	(251) U	-4%
M05001 - Emergency Medical Services Inpatients	379	422	(42) U	-10%	4,582	5,059	(476) U	-9%
M55001 - Paediatric Medicine Inpatients	304	357	(54) U	-15%	2,929	3,381	(452) U	-13%
W06003 - Secondary Neonatal	299	264	35 F	13%	3,444	3,169	275 F	9%
All Others	1,086	946	140 F	15%	11,959	11,217	742 F	7%
Total Acute WIES	**6,172**	**5,896**	**277 F**	5%	**70,103**	**70,098**	**5 F**	0%
S45001 - Orthopaedic Inpatients	314	481	(167) U	-35%	5,435	5,541	(106) U	-2%
S00001 - General Surgery Inpatients	363	401	(39) U	-10%	4,601	4,456	145 F	3%
S60001 - Plastic & Burns - Inpatients	212	246	(34) U	-14%	2,592	2,735	(143) U	-5%
S30001 - Gynaecology Inpatients	113	131	(18) U	-14%	1,364	1,572	(208) U	-13%
S25001 - ORL Inpatients	129	133	(4) U	-3%	1,300	1,475	(175) U	-12%
S40001 - Ophthalmology Inpatients	111	128	(18) U	-14%	1,159	1,425	(266) U	-19%
M10001 - Cardiology - Inpatients	49	46	3 F	6%	422	536	(114) U	-21%
S70001 - Urology - Inpatients	38	34	3 F	10%	392	383	9 F	2%
All Others	81	69	12 F	17%	824	827	(3) U	-0%
Total Elective WIES	**1,409**	**1,669**	**(261) U**	-16%	**18,089**	**18,950**	**(861) U**	-5%

Other Volumes June 2017 (compared to previous year)	Month				Year to Date			
	This Year	Last Year	Variance	Variance %	This Year	Last Year	Variance	Variance %
ED Presentations	10,329	9,422	907 F	10%	114,030	114,720	(690) U	-1%
Acute Discharges	7,660	7,201	459 F	6%	87,110	87,632	(522) U	-1%
Elective Discharges	1,406	1,588	(182) U	-11%	17,124	17,122	2 F	0%

Glossary

ACC	Accident Compensation Corporation
BOY	Balance of Year
CYF	Child, Youth and Family
DHB	District Health Board
FTE	Full Time Equivalent
MoH	Ministry of Health
F	Favourable
U	Unfavourable
WIES	Weighted Inlier Equivalent Separation (activity based measurement)
YTD	Year to Date

Activity

Despite a very busy end to the financial year, overall full year acute WIES volumes delivered to contract and ED presentations were 1% higher than previous year. This outcome reflects a balance between the effect of the milder 2016 winter (volumes presenting in quarter one 2016/17) and the early start to the 2017 winter which is evident in the June activity, with ED presentations and acute WIES being respectively 10% and 5% higher than plan for the month. A range of hospital and whole of system initiatives have helped to mitigate demand pressure. Lower than expected Plastics and Burns presentations under the Tahitian Burns contract have also contributed to this result.

Overall full year elective Provider Arm WIES is 5% below contract. Major contributors to this result are Cardiology electives displaced by acute workload in the CathLab as well as equipment failure (now resolved), and Ophthalmology inpatients lower than contract as a consequence of SMO vacancies and lower than expected outsourcing. Despite this, the DHB exceeded the Ministry of Health Elective Initiative discharge target for the year by 1,351 (107%) discharges.

Finance

The Provider Arm produced a $2.67M favourable result against budget for the month of June 2017, YTD $2.98M favourable. YTD variances are explained below.

Revenue

Overall revenue is $6.1M unfavourable for the year. A delay in the opening of the new retail pharmacy (opened 7 February 2017) and slower than anticipated retail sales to date has contributed $7.5m to the full year shortfall (but offset by an underspend in cost of goods sold, included in other expenses). Delayed Middlemore Foundation donation revenue ($1.2M) and fewer Tahitian burns presentations ($1.6M) contributed to the overall revenue shortfall. The on-going success of the ACC arrears initiative and ACC Treatment Injury has softened the impact, along with the Pharmac rebate for hospital pharmaceuticals ($1.4M) in Central Clinical Services. In the main, these specific revenue variances have little impact on operating cost.

A change to MoH DHB debt equity policy on 15th February 2017 has resulted in a $ 6.8M reduction in interest expense for the year, offset by a commensurate reduction in the MoH revenue. The change from Debt to Equity will start from 1 July 2017 with the DHB's being compensated for the difference in capital charge (6.0%) and the DHB average interest rate via way of increased revenue for the next two years only. This change is consistent across all DHB's.

Expenditure

Overall operational expenditure is $493k unfavourable for the year. Key expenditure variances are summarised below:

Personnel Costs $2.6M favourable YTD, Outsourced Personnel $7.6M unfavourable YTD

Personnel costs for the month are $5.9M unfavourable attributable to year end adjustments for actuarial costs, SMO annual leave and sabbatical, as well as a nursing payroll accrual as detailed below.

Variances in Personnel Cost categories (net of outsourcing) were as follows:

- Net Medical staff costs are $6M unfavourable YTD, reflecting;
    - Night cover for Women's Health as a result of a full year $500K budget error that is being managed through a number of initiatives, including the Maternity Ward Project (Living our Values) to mitigate the financial impact of unfavourable YTD costs.
    - Difficulty in attracting qualified psychiatrists to the DHB has led to a $2.1M underspend in Mental Health medical staff costs, offset by outsourced medical costs for locum cover, $3.5M (net $1.4M unfavourable).
    - SMO costs associated with the October and January RMO industrial action, YTD net cost $1.3M.
    - Non-Clinical year-end adjustments – Unbudgeted cost, $1.9M annual gratuity revaluation, provision for SMO leave to June 2017, $671k and ;
    - Existing medical staff vacancies (10.5 FTE) across the clinical services have reduced the impact of unplanned expenditure above.
- Net Nursing staff costs are $5.1M unfavourable YTD reflecting bureau use to cover high acute demand, particularly in the Neonatal unit, Medicine, Mental Health and ARHOP. This includes spend on the delirium project which will better facilitate management of patients and consolidation of watch capacity.

A number of non-clinical year-end adjustments ($2.2M) include a nursing payroll accrual $864k, annual gratuity revaluation $945k and unrealised target savings $251k.

- Net Allied Health staff costs are $5M favourable YTD; mainly reflecting continued vacancies across many areas of Allied Health and includes a shortage of anaesthetic technicians in the first half of the year and a shift of multidisciplinary Mental Health community work to nursing.

- Net Support personnel costs are $1.1M unfavourable YTD; predominantly reflecting overspends in cleaning, orderly and security services. This variance is driven by an understated budget for penals, increased demand for support services across the organisation and unrealised target savings due to the delayed implementation of the Video Remote Interpreting project. Notwithstanding this, the service has introduced a proactive performance management structure for these services encompassing performance management, management of sick leave, overtime and annual leave.

- Net Management and Administration staff, $2.1M favourable YTD; reflects existing vacancies across all services including the Community teams. High levels of annual leave taken over the Christmas/New Year period (including extended leave for non-essential staff) and a deliberate strategy for staff with leave balances >2 years to take annual leave, has had a positive impact on the YTD position. This strategy in planned to continue through 2017/18.

Non Staff Costs

- Clinical Outsourcing costs are $396k unfavourable YTD; driven mainly by Surgical services $1.8M unfavourable YTD. Despite surgical outsourced volumes decreasing by 26% year on year (Procedures FY16/17: 1,019, FY15/16: 1,377, FY14/15: 1,375), the mix of outsourced procedures included a higher level of high cost orthopaedic and general surgery procedures, reflecting volume pressures due to the two RMO strikes during the year.

  Other YTD unfavourable clinical outsourcing costs include ARHOP hire equipment $241k driven by an increase in new patients to support early discharge back into the community, and volume related increases in Labs and radiology $155k to support the early onset of winter acute volumes.

  Offsetting favourable variances include the Ko Awatea research fund balance of $936k that represents a lower than planned distribution of research funds during the year as well as, favourable variances in Integrated Care (Community Health Services Integration and Pacifc Group), $814k offset by revenue and personnel costs.

- Outsourced Corporate Services are $2.75M favourable mainly reflecting reduced Health Alliance IT depreciation.

- Clinical Supplies are $5m unfavourable YTD; reflecting continuing high demand in pharmaceuticals, $2.2M unfavourable, particularly in Immunosuppressant's. Bloods are $760k favourable reflecting a lower demand for blood transfusions. Unbudgeted operating lease costs associated with KAII of $1M have been offset by depreciation. YTD unrealised target savings, $1.9M and Community Team overspends, $701k has added to an already challenging clinical supplies budget.

- Other Expenses are $7.2m favourable for the year; reflecting reduced cost of goods sold associated with the delayed opening of retail pharmacy, $6.9M, together with non-clinical year-end adjustments.

- Interest, Depreciation and Capital Charge costs are $9.6M favourable for the year. As outlined above, the change from debt to equity funding has contributed $4.6M for the full year that will be offset by a reduction in MoH revenue. Depreciation is $2.8M favourable, reflecting a delay in the 2016/17 Capital programme.

Central Clinical Services

Glossary

CAR	Corrective Action Recommendation
CSF	Cerebrospinal Fluid
CT	Computed Tomography
ED	Emergency Department
ESBL	Extended-Spectrum Beta-Lactamases
eMR	Electronic Medication Reconciliation
FNA	Fine Needle Aspiration
FTE	Full Time Equivalent
IANZ	International Accreditation New Zealand
MRI	Magnetic Resonance Imaging
MRT	Medical Radiation Technologist
PT/INR	Prothrombin Time/International Normalised Ratio
SMO	Senior Medical Officer
SMOOTH	Safer Medicines on Transfer Home
YTD	Year to date

Service Overview

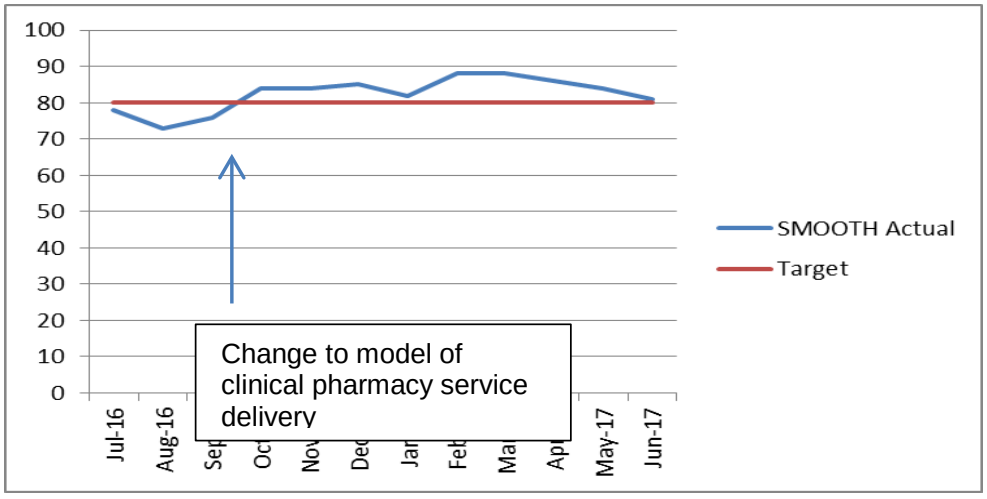
The Central Clinical Services division is managed by Ian Dodson (General Manager), with Clinical Directors/Heads Dr Ross Boswell (Laboratory), Dr Sally Urry (Radiology), Dr Mary Christie (Histopathology), and To'a Fereti (Clinical Nurse Director).

Highlights

SMOOTH - Pharmacy

High-risk patients who are discharged undergo a discharge medication management process (SMOOTH) which includes discharge medicines reconciliation, patient education, and the facilitation of access to medicines where appropriate. The performance of this programme has been excellent and sustained over the last six months. A change to the model of care provided by our Pharmacy service in October has led to the target being consistently achieved. The benefits include patients being better equipped for self-care, better informed about their medicines and medicine changes during their hospital stay, and improved patient safety at the time of transition. The graph below illustrates the consistently high performance of this service.

Percentage of high risk adult patients receiving SMOOTH services at discharge:



Radiology – appointment of MRT Team Leader

The new MRT Team Leader will commence during July; she is a previous employee who has been overseas for the last 18 months. This is the second of three leadership vacancies in Radiology that have been filled since the previous incumbents left in April and May of this year. The role of Ultrasound Team Leader is currently being advertised.

Laboratory

There are a number of highlights for the Laboratory service to report:

- For the first time in many years, the Laboratory service has experienced either minimal growth (Chemistry 0.9%) or a reduction in test numbers (Haematology -2.9%, Microbiology -6.3%, and Blood Bank -9.7%) for the overall year. This excludes Histology as test numbers are not comparable to previous years due to the introduction of Cerebro Tracking System.
- Compared to June 2016, the Microbiology workload increased by 15%, with other departments having similar workloads to the same period last year.
- Refinement of the automated Chemistry/Haematology system has resulted in further improvement in turn-around times for a range of analytes, not just those reported in the scorecard. Improvements to the system are ongoing.
- Responses to corrective actions identified during the April IANZ external audit have been send during June and the first week of July.

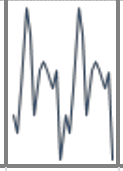
Update on previously reported issues

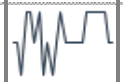
Issue	Date reported	Update
Reduced Radiologist FTE	7 Sep 2016	There has been an improvement in Radiologist vacancies and this continues to improve in July. There are now 6.1FTE vacancies which is a 16% shortfall. This continues to improve through until September with the vacancies forecast to reduce to 4.2FTE. We are working hard on recruiting to fill these positions.
General x-ray service	7 Sep 2016	The general x-ray service is significantly busier with IP/EC and GP patients. With the shortage of MRTs and Radiologists the team is working extremely hard to maintain services. Remote reporting at a Radiologist's home has started and another external Radiologist will commence remote reporting within two weeks (contracted to read 700 plain films per week). Opportunities are being explored to widen this capability. The backlog of unreported non-urgent general x-rays is at 4000. Existing staff are covering vacant shifts using overtime to ensure the service is maintained however this does put further strain on the existing workforce. The Radiology Service has been communicating with community and hospital referrers about the current capacity issues and is encouraging referrers to order imaging in a prudent manner.

Histopathology Lab	8 Mar 2017	The business case and ELT paper were finalised for presentation to ELT and onwards through the approvals pathway in July. CM Health continues to provide updates to IANZ with respect to the CAR in place for the Histopathology Lab. IANZ have indicated that they are comfortable that CM Health are progressing well to resolve the accommodation issue.
Rapid reduction in MRT workforce	31 May 2017	There has been a further reduction in MRT FTE due to resignations of MRTs moving out of Auckland in June. The current vacancies are at 11FTE with this expected to worsen in July with a further resignation. We have reviewed and refreshed advertising campaigns in the UK both in print and online and in Australia, however the lead in time is approximately three months from the UK and somewhat less from Australia. Our first choice would be local (or NZ based) MRTs, but the ability to attract MRTs locally is poor. The other Auckland-metro DHBs are experiencing similar issues with MRT shortages. Current services are being maintained through existing staff covering additional shifts.

CENTRAL CLINICAL SERVICES SCORECARD — June 2017

		Trend				12 month average			Rating	Commentary (by exception)
		FY16-17	May-17	Target	Var	Actual	Target	Var		
Enabling High Performing Peoole	% Staff with Annual Leave >2 years		**10.1%**	5.0%	-5.1%	**8.4%**	5.0%	-3.4%		Individual plans are being put in place in Radiology and Laboratory to reduce high leave balances. Staffing shortfalls in Radiology will continue to make it difficult to reduce these balances in the short-term.
	% Staff Turnover		**2.0%**	10.0%	8.0%	**1.8%**	10.0%	8.2%		

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Safety	% electronic medication reconciliation completed for high risk patients within 48hrs		**64%**	80%	-16%	**72%**	80%	-8%		This months eMR coverage for high risk patients was significantly lower. The volumes were significantly higher and LOS was lower on medical services. The opportunity window therefeore for eMR was small. Team Leaders have been asked to follow up this decline in performance on a weekly basis to see what the key issues are that have resulted in a decline. Weekly report to Service Manager on progress.

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Timely	% MRI scans completed within 6 weeks from acceptance of referral		**74%**	85%	-11%	**79%**	85%	-6%		Staffing vacancies and high demand continue to put pressure on this target. Maintaining current clinic resourcing and outsourcing some volumes.
	% CT scans completed within 6 weeks from acceptance of referral		**94%**	95%	-1%	**97%**	95%	2%		Lower performance this month but met target over the year
	Radiology - Inpatient radiology times < 24hours		**93%**	95%	-2%	**93%**	95%	-2%		Staffing vacancies and high demand continue to put pressure on this target. Maintaining current clinic resourcing and outsourcing some volumes.
	Radiology EC radiology times < 2 hours		**95%**	95%	0%	**94%**	95%	-1%		On target this month
	Laboratory -Test turnaround time (TAT) within 60mins									
	Potassium		**93%**	90%	3%	**95%**	90%	5%		
	Haemoglobin		**99%**	98%	1%	**99%**	98%	1%		
	PT/INR		**98%**	98%	0%	**98%**	98%	0%		
	Troponin 1 for ED		**94%**	90%	4%	**92%**	90%	2%		
	Histology - All - 5 working days		**86%**	90%	-4%	**85%**	90%	-5%		Maintaining TAT close to target
	Breast - 3 working days		**89%**	80%	9%	**90%**	80%	10%		
	Non gynae FNAs - 3 working days		**89%**	90%	-1%	**90%**	90%	0%		Very close to target, improved compared to earlier months
	Blood Bank - antibody screen within 4 hours		**94%**	90%	4%	**94%**	90%	4%		
	Microbiology									
	CSF cell count <30mins		**95%**	90%	5%	**95%**	90%	5%		
	ESBL screens <2days		**95%**	95%	0%	**95%**	95%	0%		
	CDT (C. diff Toxin) <25hrs		**96%**	90%	6%	**89%**	90%	-1%		
	UCHM (Urine Chemistry) <60mins		**93%**	90%	3%	**87%**	90%	-3%		Back on track now after a performance dip with the implemntation of the new urine analyser
	% radiology results reported within 24 hours		**42%**	75%	-33%	**59%**	75%	-16%		Significant backlog of reporting. SMOs FTE down by 8FTE wef end May '17. Improving. Remotre reporting contract set up (July) and plan in place to arrange further remote work stations.

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
System Integration (Effective)	% transcribed clinical summaries (meddocs) authorised <7 days of creation		**71%**	95%	-24%	**72%**	95%	-23%		Escalation to clinical leads and directors to push within their services. Slight delays in transcription currently.

Kidz First and Women's Health

Glossary

ALOS	Average Length of Stay
CD	Clinical Director
CLAB	Central Line Associated Bacteraemia
DNA	Did Not Attend
ED	Emergency Department
ESPI	Elective Services Patient Flow Indicator
FTE	Full Time Equivalent
FSA	First Specialist Assessment
GM	General Manager
HCA	Health Care Assistant
LMC	Lead Maternity Carer
MCIS	Maternity Clinical Information System
MoH	Ministry of Health
WIES	Weighted Inlier Equivalent Separations
YTD	Year to date

Service Overview

Kidz First and Women's Health is managed by Nettie Knetsch (General Manager) with Dr Wendy Walker (Clinical Director Kidz First), Dr Sarah Tout (Clinical Director Women's Health), Thelma Thompson (Director Midwifery), and Michelle Nicholson-Burr (Clinical Nurse Director).

Highlights

Activity summary

For June 2017, discharges in Kidz First Medical were up by 51 on the previous June, which was close to our usual pattern. ED presentations however were up by 497 for the month, the highest since the measurement of ED attendances was introduced in 2002. The 2,674 presentations for the month were close to volumes in the height of winter in August 2010. YTD ED attendances were lower (5.8%) due to the warmer weather and less viral illness during the 2016 winter months of July, August, and September.

Neonatal Unit

The Neonatal Unit has continued with both higher acuity and admissions. Whilst the actual number of discharges from the Unit is up 12% (39 babies), the WIES is up 37% (515) reflecting a significant increase in acuity. Occupancy for June was 98% (on average we resourced 29 cots in June) with a few days more than 30 out of our 38 physical cots being occupied. We have therefore already needed to increase both the nursing ratios through the nursing bureau or nurses redeployed from Kidz First Wards, as well as increase the number of average resourced cots to 28 or 30 (Depending on acuity and level of care). As a consequence of this increased in acuity the ALOS of babies in the Unit has increased from 18 days to 21 days. Recruitment for additional nursing staff continues.

Births

There were 527 births at Middlemore Hospital and 60 at the three community units; a total of 587 births for the month which is seven births more than June 2016. YTD, the overall birth numbers are 7,308 which is 15 births less than same period last year. The births at the three Community Units remained slightly behind, 43 down on last year hence the pressure remaining on maternity services at Middlemore Hospital. Although the overall number of births has remained stable, the WIES for secondary maternity has increased from 6,440 to 6,937 which is an increase of 7%.

This reflects the increased intervention rates (caesarean sections and inductions), as well as the co-morbidities of pregnant women and women in labour.

Outpatient services

Both Kidz First and Women's Health outpatient services maintained their focus on FSAs and Virtual FSAs. In addition, Gynaecology services introduced an extended outpatient Hysteroscopy service whereby the women can have small polyps removed in the outpatient setting rather than having to access Theatre. This has had an effect on the overall decrease in elective WIES, however offering the outpatient service is much better for the women as well as saving organisational theatre resources.

Annual reporting

The Women's Health Annual Report 2016/17 is currently in development in preparation for submitting to the Ministry of Health in August. This year the report has evolved from the Maternity Quality and Safety Programme Annual Report that was produced for the previous four years and will include a neonatal and a new gynaecology section. This Women's Health report describes practice, projects, and achievements which reflect the recommendations from the National Maternity Monitoring Group and the National Perinatal and Maternal Mortality Review Committee and aligns with CM Health's Annual and Maaori Health Plans and the New Zealand Maternity Standards. Information is also provided on other quality improvement projects underway or completed right across Women's Health in the 2016/17 fiscal year.

Update on MCIS

MoH (Jill Lane, Director Service Commissioning) communicated on 28 June 2017 to national maternity stakeholder groups that the MoH confirmed their commitment to progress with an electronic National Maternity Record (formerly MCIS). She expressed that the extensive work undertaken to confirm a level of confidence that an electronic maternity record is possible and ensures that women and babies receive the safest care. She acknowledges the challenging work and the continued work required to ensure a robust, user-friendly and both clinically intuitive and safe electronic National Maternity Record.

Ms Lane also mentioned that for now the National Maternity Record remains available only in the early-adopter DHBs and to community midwives through the Midwifery and Maternity Providers Organisation. An action plan based on the recommendation to achieve roll-out to the remaining DHBs will be communicated in July. The MoH programme team will also contact each DHB and relevant professional colleges about involvement in the journey forward.

In the meantime CM Health continues to use the MCIS with the existing paper forms (mostly charts) as well as with the standardisation work to make the system as user-friendly and information flow as consistent as possible within the limitations of the overall system. A month to month roll-over of the existing Letter of Agreement (contract) between CM Health and the Vendor remains in place in the absence of a national contract.

Update on previously reported issues

Issue	Date reported	Update
Neonatal Unit capacity	Apr 2016	Occupancy remains high after some easing over Christmas and New Year 2017. A project manager has been appointed for the regional capacity work. The first draft of this report was presented to the regional CD and GM forum in May 2017. Second draft will be ready for review at the end of July in time for the final draft to be presented to regional CEO/Planning and Funding Forum in September/October 2017. However, we have simultaneously commenced a nursing recruitment and model of care project to support more junior nursing staff to work in the neonatal specialty.
Caesarean Section Rate	8 Mar 2017	CS rate for June was 28%. YTD rate is 26% against 23% last year. The CS rate and processes are reviewed routinely with the clinical team. At the June regional Women's Health meeting significant increases in CS rates were also reported from Auckland and Waitemata and the region will continue with data analysis and clinical discussion to understand what is driving the significant spike across the region over the past five months. Midwifery (both LMC and self-employed) and junior medical staff shortages may well be a factor in this increase as well as the impact of new practice guidelines.
Midwifery workforce	8 Mar 2017	A further National Midwifery Advisory Group meeting was held on 3 July 2017 and provisional reports on the current midwifery workforce (national and by DHB) and projected midwifery workforce numbers required were shared. This provisional report will be shared at the national Chair and Chief Executive meeting on 13 July. The numbers projected are huge and are likely to require a new strategy for training and retaining midwifery workforce. In addition, the regional GMs, CDs, and Directors of Midwifery met again on 5 July 2017 to provide updates on the current regional midwifery shortages. Each DHB has different pressures, with Auckland DHB currently having the biggest employed midwifery shortfall and CM Health having shortages in the employed senior midwifery positions as well as LMC shortages. Robust discussion again took place on the sustainability of a midwifery workforce only in maternity services and how the region needs an interim plan developing the Registered Nurse and HCA workforce for maternity services as well. The Directors of Midwifery will be meeting later in July to develop an urgent retention strategy for senior employed midwives and the GMs, CDs and Directors of Midwifery will now meet monthly as well and develop an interim regional workforce plan (awaiting the national Midwifery Advisory Group data).

WOMEN'S HEALTH SCORECARD — June 2017

Ensuring Financial Sustainability

	Trend				Year to date			Rating	Commentary (by exception)
	FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
Acute Caseweight - Gynaecology Inpatients- acute		**143**	138	4%	**1635**	1655	-1%		Small variance on last year
Acute Caseweight - Secondary Neonatal Womens health		**154**	148	4%	**1539**	1779	-13%		More babies required to stay in Neonatal Unit, offset by increase in secondary WIES
Acute Caseweight - Inpatient maternity care primary maternity facility		**345**	379	-9%	**4392**	4545	-3%		offset by increase in Secondary WIES, small variances
Acute Caseweight - Women's Health secondary		**585**	537	9%	**6937**	6442	8%		Increase in C-section and acuity
Elective Caseweight - Gynaecology Inpatients - elective		**111**	131	-15%	**1342**	1572	-15%		YTD impacts of lower # of procedures / theatre list due to larger size patients as well as increase in hysteroscopies.
Hysteroscopy		**16**	N/A	N/A	**132**	N/A	N/A		New PUC from July 2016
Total Discharges - Gynaecology Inpatients- acute		**264**	250	6%	**3053**	3227	-5%		Small variance
Total Discharges - Secondary Neonatal Womens health		**208**	152	37%	**1946**	1876	4%		
Total Discharges - Inpatient maternity care primary maternity facility		**341**	296	15%	**3883**	3703	5%		Good utilisation of primary units for transfers from Middlemore
Total Discharges - Women's Health secondary		**1175**	1106	6%	**14370**	14154	2%		
Total Discharges - Gynaecology Inpatients - elective		**126**	130	-3%	**1429**	1600	-11%		As per the above
Gynaecology - 1st Attendance		**253**	233	9%	**2906**	2900	0%		On track
Non-Contact FSA Gynae Virtual		**66**	35	89%	**634**	421	51%		Increase as per outpatient strategy
First Obstetric Consults S/B Doctors		**257**	256	0%	**3000**	3075	-2%		Small variances, but increase in Virtual FSA
DHB non-specialist antenatal consults		**1130**	1603	-30%	**14149**	19238	-26%		MCIS / iPM data issues, volume understated
Gynaecology - Subsequent Attendance		**278**	217	28%	**3096**	2900	7%		Increase in more complex patients
Subsequent Obstetric Consults F/U S/B Doctors		**255**	305	-16%	**2721**	3661	-26%		Better coordination requiring less follow ups
DHB non-specialist postnatal consults		**1130**	1727	-35%	**14,149**	20720	-32%		MCIS / iPM data issues, volume understated
Budgeted FTEs		**352**	338	-4%	**347**	338	-3%		High over time and sick leave due to midwifery vacancies
Operating Costs ($000)		**$413**	$401	-3%	**$5,102**	$4,808	-6%		
Personnel Costs ($000)		**$2,833**	$2,767	-2%	**$33,937**	$32,799	-3%		
Financial Result Total ($000)		**-$3,146**	-$3,100	-1%	**-$37,920**	-$36,792	-3%		
Reduce Clinical Outsourcing ($000)		**$9**	$6	-50%	**$165**	$71	-132%		Offset against additional revenues

Enabling High Performing People

	Trend				12 month average			Rating	Commentary (by exception)
	FY16-17^	May-17	Target	Var	Actual	Target	Var		
% Staff with Annual Leave > 2 years - (one month in arrear)		**20.9%**	5.0%	-15.9%	**21.7%**	5.0%	-16.7%		Monitoring Trend
% Staff Turnover - (one month in arrear)		**12.7%**	10.0%	-2.7%	**12.5%**	10.0%	-2.5%		
% Sick leave - (one month in arrears)		**2.2%**	2.8%	0.6%	**3.2%**	2.8%	-0.4%		

First, Do No Harm (Safety)

	Trend				Year to date			Rating	Commentary (by exception)
	FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
Emergency trolley checks (days checked) per month		**84%**	100%	-16%	**N/A**	N/A	N/A		
Hand hygiene (compliance with checks) per month		**82%**	80%	2%	**N/A**	N/A	N/A		
Safe Sleep audits compliance		**100%**	100%	0%	**N/A**	N/A	N/A		No weekly data provided for Maternity North and South, and Papakura Primary Birthing Unit
Violence Intervention Programme (VIP) Screening		**57%**	80%	-23%	**N/A**	N/A	N/A		Rolling out new programme gradually. Rates improving

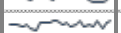
		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
Timely	ED 6 hour target - National Health target (Gynae)		**74%**	95%	-21%	**91%**	95%	-4%		Reviewing process in ED
	ESPI 2 - No. waiting >4 months for FSA - Elective		**0.0**	0.0	0.0	**0.0**	0.0	0.0		
	ESPI 5 - No. waiting > 4 months for treatment - Elective		**4.0**	0.0	4.0	**4.0**	0.0	4.0		
		Trend				Year			Rating	Commentary (by exception)
		FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
System Integration (Effective)	% transcribed clinic letters authorised <7 days created		**82%**	95%	-13%	**87%**	95%	-8%		
	ALOS Women's Health - babies (WNB and Neonates)		**3.20**	4.20	1.00	**3.30**	3.80	0.50		Shorter LOS as more babies required to stay longer in the Neonatal Unit
	Average Length of Stay Gynaecology - Middlemore		**1.55**	1.26	-0.29	**1.57**	1.60	0.03		
	Average Length of Stay Gynaecology - MSC Inpatients		**0.60**	0.70	0.10	**0.70**	0.76	0.06		
	Average Length of Stay Obstetric (DHB Mat) (1 month in arrear)		**2.99**	2.30	0.69	**2.37**	2.17	0.20		
	Average Length of Stay Obstetric (Ind. Mat) (1 month in arrear)		**2.90**	2.30	0.60	**2.27**	2.08	0.19		
	Average Length of Stay Vaginal Deliveries overall		**2.37**	2.16	0.21	**2.07**	2.10	-0.03		Small variance
	Maaori - 1st time mothers		**2.69**	2.50	1.21	**2.54**	2.62	-0.08		Small variance
	Pacific - 1st time mothers		**2.75**	2.85	-0.10	**2.75**	2.56	0.19		
		Trend				Year			Rating	Commentary (by exception)
		FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
Efficient	FSA / Follow up ratio - Gynae		1:1.1	1:1.1		1:1.07	1:1			
	DNA - Midwifery Antenatal clinics - First		**12%**	14%	2%	**14%**	13%	-1%		Small variances
	DNA - Midwifery Antenatal clinic - Follow up		**15%**	15%	0%	**13%**	15%	2%		
	DNA - Doctor Antenatal clinics- FSA		**11%**	12%	1%	**13%**	12%	-1%		Small variances
	DNA - Doctor Antenatal clinics - Follow up		**10%**	13%	3%	**11%**	18%	7%		Good improvement YTD
		Trend				Year			Rating	Commentary (by exception)
		FY16-17^	Jun-17	Target	Var	Actual	YTD*	Var		
	Outpatient DNA - Maaori (Gynae)		**12%**	9%	-3%	**13%**	10%	-3%		Improving on previous year actuals
	Outpatient DNA - Pacific (Gynae)		**11%**	7%	-4%	**10%**	10%	0%		
	Outpatient DNA - Maaori (Obst)		**25%**	25%	0%	**24%**	10%	-14%		
	Outpatient DNA - Pacific (Obst)		**15%**	14%	-1%	**17%**	10%	-7%		
		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
P&WCC	Patient experience survey - month (n=47) and YTD (n=643)		**70%**	76%	-6%	**77%**	76%	1%		Small sample over 12 months

NOTES

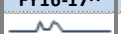
^FY16-17 - fiscal year 2016 and fiscal year 2017

KIDZ FIRST SCORECARD

June 2017

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Acute Caseweight - Paediatric Medicine Inpatients		**300**	356	-16%	**2917**	3362	-13%		Unusual winter and summer, busy June
	Acute Caseweight - Emergency Medicine - ED		**82**	75	9%	**832**	895	-7%		Unusual winter and summer, busy June
	Acute Caseweight - Inpatient Paediatric ICU		**9**	2	350%	**85**	32	166%		1 Burn Patient collected 54 WIES, also busy June
	Acute Caseweight -Secondary Neonatal Unit		**144**	116	24%	**1905**	1390	37%		High acuity and high volume
	Acute Caseweight - Paed Surg - accounted under Adult Surgery		**172**	164	5%	**1974**	2040	-3%		Slight decrease only
	Elective Caseweight - Paed Surg - accounted under Adult Surgery		**92**	74	24%	**981**	824	19%		Increasing trend and high acuity
	Total Discharges - Paediatric Medicine Inpatients		**545**	494	10%	**5197**	5571	-7%		Unusual winter and Summer, June 2017 discharges were higher
	Total Discharges - Emergency Medicine - ED		**290**	230	26%	**3052**	2966	3%		Discharges up on last year
	Total Discharges - Inpatient Paediatric ICU		**7**	4	75%	**30**	22	36%		On track, busier in June
	Total Discharges - Secondary Neonatal Unit		**29**	31	-6%	**369**	330	12%		High acuity and high volume
	Total Discharges- Acute Paed Surg - accounted under Adult Surgery		**187**	157	19%	**2005**	2167	-7%		Lower discharges but higher acuity YTD
	Total Discharges- Elective Paed Surg - accounted under Adult Surgery		**154**	168	-8%	**1496**	1728	-13%		Lower discharges but higher acuity YTD
	ED attendances		**2674**	2177	23%	**24587**	26106	-6%		Unusual winter and summer, however highest June 2017 figure since 2002
	Paed Medicine - 1st Attendance		**244**	180	36%	**2297**	2117	9%		Increase on last year as per strategy
	Non-Contact FSA - Any Medical specialty		**51**	42	21%	**604**	500	21%		Increase on last year as per strategy
	Paed Medicine - Subsequent Attendance		**344**	322	7%	**3563**	3700	-4%		Focus on FSAs
	Budgeted FTEs		**272**	278	2%	**274**	272	-1%		Additional positions offset against additional revenues (i.e. MM Clinical Trials).
	Operating Costs ($000)		**$352**	$256	-38%	**$4,123**	$3,036	-36%		Additional costs offset against additional revenues (i.e. Gateway, MM Clinical Trials).
	Personnel Costs ($000)		**$2,388**	$2,362	-1%	**$27,866**	$28,194	1%		Offset by additional revenue
	Financial Result Total ($000)		**-$2,422**	-$2,451	1%	**-$28,852**	-$29,166	1%		
	Reduce Clinical Outsourcing ($000)		**$6**	$4	-50%	**$74**	$53	-40%		Offset by additional revenue

		Trend				12 month average			Rating	Commentary (by exception)
		FY16-17^	May-17	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years - (one month in arrear)		**16.7%**	5.0%	-11.7%	**19.1%**	5.0%	-14.1%		Trend is decreasing
	% Staff Turnover - (one month in arrear)		**12.2%**	10.0%	-2.2%	**15.7%**	10.0%	-5.7%		Monitoring trend
	% Sick leave - (one month in arrears)		**2.5%**	2.8%	0.3%	**3.2%**	2.8%	-0.4%		Monitoring trend

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)	Neonatal Rate of medication errors/1000 bed days per month		**0.0%**	3.2%	3.2%	**3.2%**	3.2%	0.0%		On Track
	Neonatal Care CLAB rate per 1000 line days per month		**0.0**	0.0	0.0	**N/A**	N/A	N/A		
	CLAB insertion bundle compliance - Neonatal Unit		**100%**	100%	0%	**97%**	100%	-3%		Increasing compliance
	CLAB prevention maintenance bundle compliance- Neonatal Unit		**100%**	100%	0%	**88%**	100%	-12%		Process is followed 100% - documentation of the process not always completed.
	Emergency trolley checks (compliance with checking)		**91%**	100%	-9%	**N/A**	N/A	N/A		
	Hand hygiene (compliance with checking)		**92%**	80%	12%	**N/A**	N/A	N/A		
	Safe sleep - audits compliance		**75%**	100%	-25%	**N/A**	N/A	N/A		no weekly data provided for Kidz First Surgical
	Violence Intervention Programme (VIP) Screening		**80%**	80%	0%	**N/A**	N/A	N/A		New programme rolling out gradually. Rate steadily improving

		Trend				Year to date			Rating	Commentary (by exception)
Timely		FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
	ED 6 hour target - National Health target (Kidz First ED) - Initial speciality		**97%**	95%	2%	**98%**	95%	3%		
	ESPI 2 - No. waiting >4 months for FSA - Elective		**0.0**	0.0	0.0	**0.0**	0.0	0.0		
		Trend				Year to date			Rating	Commentary (by exception)
System Integration (Effective)		FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
	% transcribed clinic letters authorised >7 days of created		**78%**	75%	3%	**79%**	75%	4%		
		FY16-17^	Jun-17	LY Act	Var	Actual	YTD*	Var		
	Admission Rate Babies in the first year of life (Total)		**20%**	23%	3%	**21%**	23%	2%		
	Admission Rate Babies in the first year of life (Maaori)		**23%**	25%	2%	**25%**	27%	2%		Reflecting lower admissions
	Admission Rate Babies in the first year of life (Pacific)		**27%**	34%	7%	**28%**	30%	2%		
	ALOS - Kidz First - Surgical - Surgical Floor		**1.88**	1.81	-0.07	**2.10**	2.05	-0.05		Small variance
	ALOS - Kidz First Medicine - KF Wards		**2.55**	2.58	0.03	**2.66**	2.70	0.04		
	ALOS - Kidz First Medicine - ED Short Stay (hrs)		**4.07**	4.14	0.07	**4.26**	4.59	0.33		
	ALOS - Kidz First - Neonatal		**21.3**	17.0	-4.3	**21.1**	17.9	-3.2		High acuity
		Trend				Year			Rating	Commentary (by exception)
Efficient		FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
	Outpatient DNA - FSA		**9%**	11%	2%	**8%**	10%	2%		
	Outpatient DNA - Follow up		**12%**	11%	-1%	**12%**	12%	0%		
		Trend				Year to date			Rating	Commentary (by exception)
P&WCC		FY16-17^	Jun-17	Target	Var	Actual	Target	Var		
	Patient experience survey - month (n=5) and YTD (n=107)		**60%**	76%	-16%	**70%**	76%	-6%		Very small sample over the 12 months

NOTES

LY Act - Last year actuals

^FY16-17 - fiscal year 2016 and fiscal year 2017

Adult Rehabilitation and Health of Older People

Glossary

ACC	Accident Compensation Corporation
ARHOP	Adult Rehabilitation and Health of Older People
AROC	Australasian Outcomes Rehabilitation Centre
AT&R	Assessment, Treatment and Rehabilitation
CNM	Charge Nurse Manager
ED	Emergency Department
FTE	Full Time Equivalent
GP	General Practitioner/General Practice
HBSS	Home Based Support Services
LOS	Length of Stay
MMH	Middlemore Hospital
QA	Quality Assurance
YTD	Year to date

Service Overview

The Adult Rehabilitation and Health of Older People Division is managed by Dana Ralph-Smith (General Manager) with Dr Peter Gow (Clinical Director).

Responses to Action Item

HAC Meeting 12.7.2017 – Community Support Workers
"Provide answers to the questions raised at the 12 July HAC meeting".

The DHB contracts providers/organisations to provide home care. They are responsible for the quality of care provided by their staff. The DHB does not contract with individuals. If the DHB received a complaint about an individual it would rely on their employer to investigate and resolve the issue. There will be a clause in the contract that states the provider/organisation is to employ staff of a certain skill level. The providers/organisations are accountable to the HDC and other legislative frameworks as we all are.

Highlights

Stroke Service

Stroke Services have successfully recruited a new full-time Stroke Specialist Medical Officer who will commence in November 2017.

Specialised Rehabilitation Services

The Specialised Rehabilitation Services have commenced the International Certification of Accreditation of Rehabilitation Facilities Standards self-assessment process and will be using this audit tool to identify gaps and improve spinal rehabilitation services. The tool can be used across many specialised rehabilitation services, and we are planning to roll-out the self-assessment process across all specialised rehabilitation programmes over the next two years. A formal certification visit will then be arranged in three years' time.

Australasian Outcomes Rehabilitation Centre

AROC has launched ambulatory outcome measures for stroke, and our Community Stroke Rehabilitation services will be collecting this data from July 2017. This will enable us to nationally and internationally benchmark our community stroke service delivery.

Emerging issues

System-wide demand

ARHOP's hospital and community services have been challenged this month with the high volumes of Emergency Department presentations and inpatient admissions. This has an impact on the integrated stroke ward and on other rehabilitation services, with a requirement for these services to accommodate additional general medicine patients. The clinical and managerial leadership team have been working hard to continue to support high-quality care and appropriate staffing levels. There has also been significant staff illness during this same time.

Update on previously reported issues

Issue	Date reported	Update
Safe Moving and Manual Handling	12 July 2017	The Steering Group is exploring the use of an internationally validated pre-intervention safe moving and manual handling assessment tool in collaboration with the Waitemata DHB Moving and Handling coordinator called the Tool for Risks Outstanding in Patient Handling Interventions (TROPHI). International expert Mike Fray from the UK has agreed to support us to use this tool that he has jointly developed to identify a systematic and measurable approach to assessment and interventions of our Safe Moving and Manual Handling programme. Mike will be in New Zealand in November and there is an opportunity to consult with him further on sustainable and successful development and implementation of our CM Health programme.

ADULT REHABILITATION AND HEALTH OF OLDER PEOPLE SCORECARD

June 2017

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Spinal Inpatient ACC Revenue ('000s)		**$394**	$529	-25.5%	**$7,449**	$6,782	9.8%		
	Non-acute Rehabilitation ACC Revenue ('000s)		**$198**	$348	-43.2%	**$5,836**	$4,708	24.0%		
	Budgeted FTEs		**498**	478	-4.1%	**465**	475	2.1%		
	Operating Costs ($000)		**$3,725**	$4,052	8.1%	$47,333	$48,001	1.4%		
	Personnel Costs ($000)		**$2,835**	$3,232	12.3%	**$36,157**	$38,176	5.3%		
	Financial Result Total ($000)		**$3,325**	$3,432	3.1%	**$39,937**	$40,433	1.2%		
	Reduce clinical outsourcing ($000)		**$118**	$263	55.3%	**$3,399**	$3,159	-7.6%		There has been an increase of 83 clients from June '16 upto January '17 this increase has occurred to allow patients early supported discharge back into communities. Analysis being undertaken to identify opportunities to make further efficiencies

		Trend				12 month average			Rating	Commentary (by exception)
		FY16-17	May-17	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years		**4.0%**	5.0%	1.0%	**4.4%**	5.0%	0.6%		
	% Staff Turnover		**14.1%**	10.0%	-4.1%	**15.1%**	10.0%	-5.1%		Promotions and retirements
	% Sick Leave		**2.7%**	2.8%	0.1%	**3.0%**	2.8%	-0.2%		
	Workplace Injury per 1,000,000 hours		**14.0**	10.5	-3.5	**12.1**	10.5	-1.6		Safe Moving and Handling Programme planning underway. There has been an increase in verbal threats towards staff.

		Trend				12 month average			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)	Falls - % of falls assessments done in first 6 hours		**100%**	100%	0%	**96%**	100%	-4%		
	Falls - % of Interventions completed		**80%**	100%	-20%	**96%**	100%	-4%		This drop in performance attibuted to one ward - the Serivce Manager will discuss with CNM
	Pressure Injuries - % of assessments done in first 6 hours		**100%**	100%	0%	**97%**	100%	-3%		
	Pressure Injuries - % of interventions completed		**92%**	100%	-8%	**99%**	100%	-1%		Service Manager to discuss with CNMs and remind of importance
	Reduce over ride rate of Pyxis on AT&R wards decrease medication errors to 15%		**17%**	15%	-2%	**14%**	15%	1%		

		Trend				12 month average			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Timely	Access to specialist services -volumes of Geriatric AT&R Hotline Calls		**42**	36	6	**31**	36	-5		

		Trend				12 month average			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
System Integration (Effective)	Maintain number of patient 75's or older LOS > 10 days in AT&R wards		**53**	54	1	**50**	54	4		
	Maintain direct admissions from GPs to AT&R wards		**31**	23	-8	**24**	23	-1		
	Avoidable presentations to ED from Aged Residential Care Facilities (ARRC)		**16**	15	-1	**8**	15	6.8		
	MMH % patients discharged to discharge lounge or home by 1100hrs		**29%**	32%	-3%	**30%**	32%	-2%		Continuing to encourage discharges to discharge lounge
	Rehabilitation 7 day Readmissions rate		**4.3%**	2.9%	-1.4%	**3.8%**	2.9%	-0.9%		Reviewed each month by Geriatricians in QA meeting
	Acute Readmission within 28 days - Total for Rehabilitation beds (1mth in arrears)		**13%**	11%	-2%	**10%**	11%	1%		Reviewed each month by Geriatricians in QA meeting

		Trend	Quarterly reporting in arrears			Year			Rating	Commentary (by exception)
Efficient		FY16-17	Mar-17	Target	Var	Actual	Target	Var		
	% +65years with long term HBSS - comprehensive clinical assessment & care plan		**95%**	75%	20%	**94%**	75%	19%		

		Trend				Year to date			Rating	Commentary (by exception)
Equity		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
	Number of Spinal Rehabilitation Outreach Clinic days - (new measure 2014/15)		**6**	4	2	**56**	30	26		

		Trend				Year to date			Rating	Commentary (by exception)
P&WCC		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
	Patient Experience Survey		**79%**	90%	-11%	**78%**	90%	-12%		Poor response rates from ARHOP wards. Will be promoting collection of patient email addresses

Mental Health and Addictions

Glossary

AOD	Alcohol and Other Drugs
CAMHS	Child and Adolescent Mental Health Services
ED	Emergency Department
ILoC	Integrated Locality Care
LOS	Length of Stay
MH	Mental Health
MHSOP	Mental Health Services for Older People
MoH	Ministry of Health
NGO	Non Government Organisation
PRIMHD	Programme for the Integration of Mental Health Data

Service Overview

The Mental Health and Addictions division is managed by Tess Ahern (General Manager) with Dr Peter Watson (Clinical Director) and Anne Brebner (Clinical Nurse Director).

Response to Action Item

HAC Meeting 31.5.2017 – Mental Health Measures

"Provide a regular report on how the DHB measures itself against the UK Mental Health Triage Scale model (i.e.) responses to triage times (how many people that were triaged E we did actually see within 4 weeks). The service is currently facing some technological issues in measuring some of this data accurately and is undertaking an audit to ensure the data is being measured correctly. Come back with a proposal based on the audit, when completed".

The audit of wait times against the Triage scale has revealed a number of process issues that need to be rectified to ensure that a TRIAGE Wait Time Audit provides reliable data. The following recommendations/changes are proposed:

1. A change of process to facilitate the electronic extraction of data for future audits.
2. Consideration of different processes for the MMH Emergency Dept and the Community.
3. Determination of the ability to automate an auditable time stamp for when the triage form is completed.
4. Consider developing an automatic push of the triage code from the triage form to the Whiteboards.
5. Develop an automated report on TRIAGE wait times.

It is proposed that a further update be provided to the Committee in three months' time.

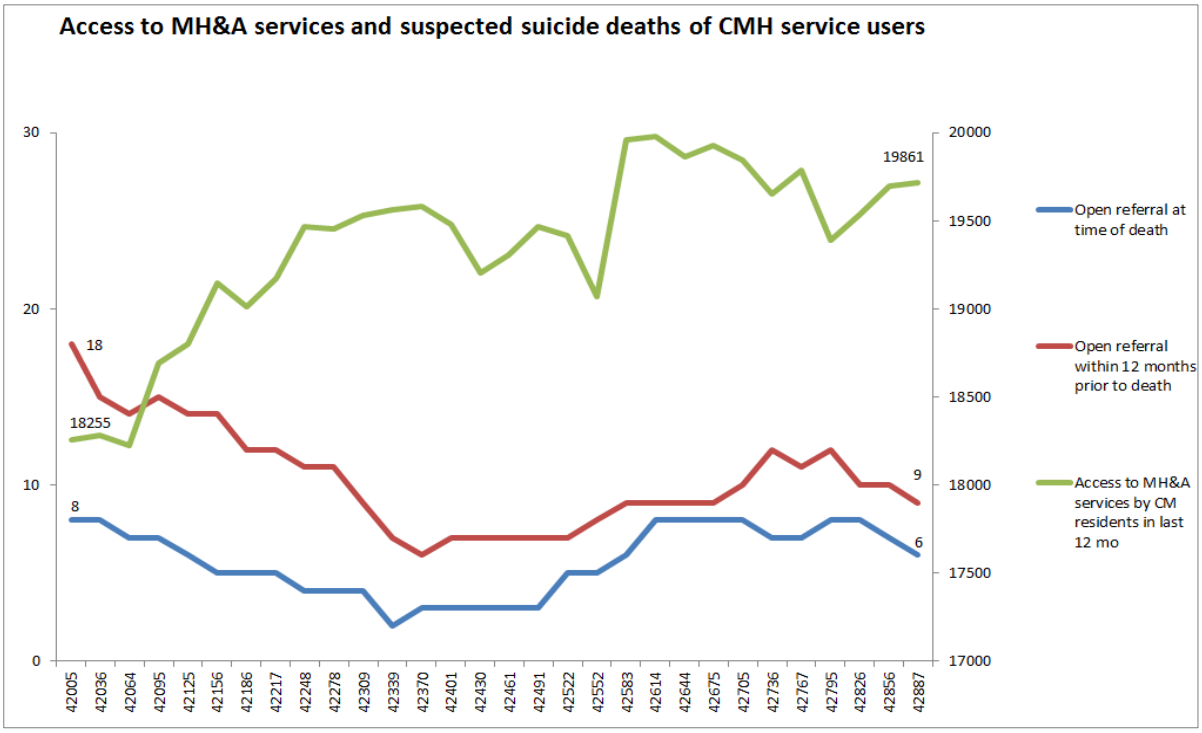
Highlights – year in review

<u>Suicide prevention</u>

Progress in the past year has included the development and agreement to a new CM Health Suicide Prevention plan, a Maori Community Suicide Prevention Plan, Workforce SP development, and community action initiatives. The work has been led by the appointment of a Suicide Prevention Coordinator that is funded and supported by the Mental Health Division.

In the last 12 month period there have been six suspected suicide deaths from people who had open referrals to Mental Health services. There were another nine suspected suicide deaths of people

who had had open referrals to our services within 12 months of their death. These 15 deaths comprise one third of all known suspected suicided deaths in Counties Manukau during this period. These numbers are similar to the numbers a year ago but continue a trend of reduction in the numbers of deaths of service users by suicide since the introduction of our targets for improvement.



Whole of System integration

Progress this year across the 'whole of system' integration agenda has been characterised by on-going engagement, consolidation of an agreed vision and approach, and a better understanding of the detail that underpins the new model of care and how services will be designed and delivered.

It has been encouraging to see the establishment of a new integrated locality care (ILoC) team in the Franklin locality and to receive positive feedback on the model. Of particular note regarding the ILoC development has been the positive response from primary care stakeholders and the success of bringing together a team with representation from CM Health mental health services, the Community Alcohol and Drugs Service, and NGO support workers. Early evidence indicates a 50% reduction in the number of referrals to the MHSOP specialist services from one of the practices with an enrolled population of 13,000 since the commencement of the new service.

Development of the ILoC in Franklin, together with the initial steps to establish ILoCs in the other localities, has further highlighted how key workforce readiness and workforce development is/will be to the success of this model, with this being a key area of focus for the coming year.

Development of Mental Health services in ED

The Psychiatric Liaison Service was discontinued in favour of the commencement of the Department of Psychological Medicine and a dedicated mental health clinical presence in the ED. The Mental Health service in ED became fully operational in July 2016 operating 24 hours a day.

Awake Overnight Nurse in ED

This project saw the introduction of experienced Registered Nurses from Intake and Acute Assessment working a night shift in the Emergency Department replacing the on call system.
The service was evaluated in September 2016 and the feedback was very positive. Key outcomes from the evaluation were:

- Faster response times to ED for mental health assessments
- Mental Health triage extended to 24 hours a day
- Increased support for the overnight Registrars (who previously worked largely in isolation).
- Increased satisfaction from Registrar group
- Improved access to Mental Health services
- Improved support for ED clinicians from Mental Health clinicians overnight

After Hours Phone and Triage Service

In April 2017 a new service was contracted from Home Healthcare Medical. The new service provides an out of hours call handling service and a triage service to Intake and Acute Assessment. There were a number of issues after the service commenced with some common themes. These were:

- Inaccurate triage rating of referrals
- Incorrect placement of triaged referrals in the electronic folders causing confusion and delay in processing
- Failures in handing over clinical information in a timely way
- Clinical risk issues resulting from a number of causes

A risk management strategy was put into place by Home Healthcare Medical and this included ensuring that there was an increase in senior staffing support on each shift for the call handlers. The risk strategy also included:

- Intake staff review the acute and non-acute folders daily
- Intake and Home Healthcare Medical staff maintain the issues log
- Two weekly interface meetings to problem solve collaboratively
- Intake staff participate in training and supervision sessions for Home Healthcare Medical staff
- Ongoing open communication between the services

The three month review of the service was completed on 29 June 2017. The review identified that there has been a distinct improvement since the commencement of the risk management strategy. The clinical service and Home Healthcare Medical continue to work collaboratively to address issues as they arise. A Clinical Governance group has been established to oversee the service.

Development and implementation of capacity planning tool

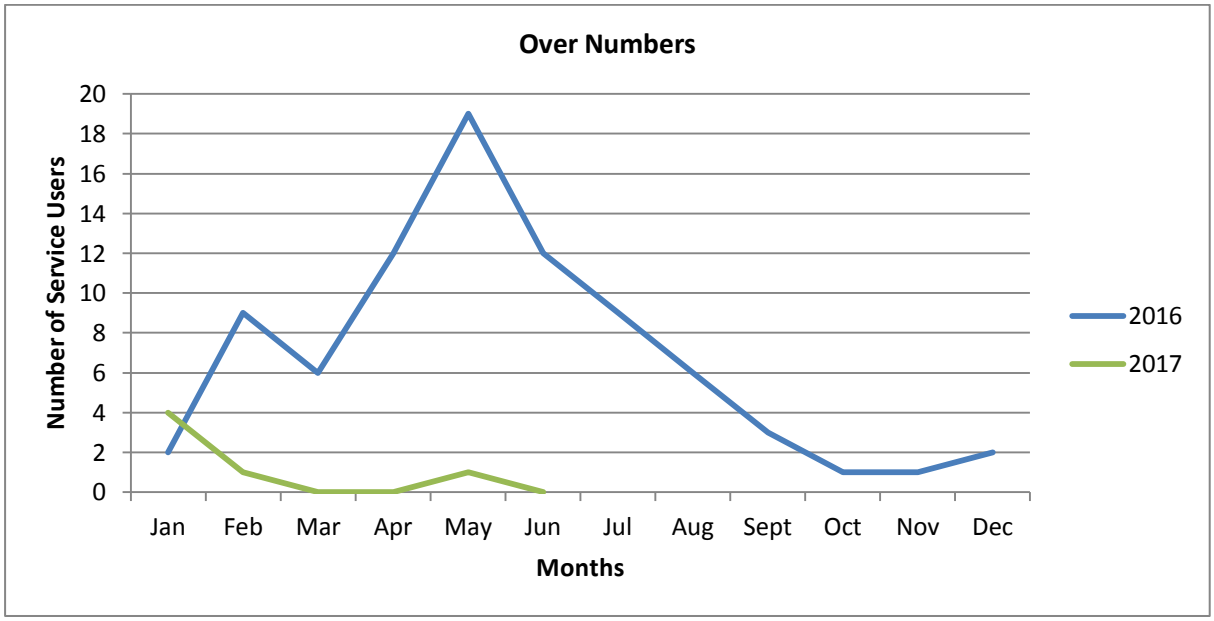
In July 2016 the Acute Mental Health Service implemented a capacity planning tool designed to ensure that there is always capacity across the service. This means capacity to:

- Assess and treat urgent referrals
- Offer a respite bed when it is clinically indicated
- Offer Home Based Treatment when required
- Offer an Inpatient admission when required

The service wanted to eliminate or reduce the number of times that the inpatient unit was "over numbers" by taking a pro-active approach to ensuring that there was always capacity across all parts of the service.
The capacity plan includes:

- Daily interface between acute services to plan for demand
- Daily 7.30am meeting between Nurse Unit Manager, Charge Nurse Manager and Associate Charge Nurse manager on Tiaho Mai
- Weekly LOS meeting that looks at both inpatient length of stay and respite length of stay and identifies barriers to discharge and then plans to overcome the barriers
- Improved documentation for Associate Charge nurse manager handover (Tiaho Mai)
- Three daily admission/pending admission lists distributed across all services each day
- Inclusion of NGO sector to assist with overcoming barriers that may prevent discharge/transition from occurring
- Weekly meeting between Intake/Home Based treatment/Tiaho Mai to plan to manage demand for each weekend – including management and medical teams
- Clear escalation strategy if entering the "red zone" (i.e. no capacity in one or all parts of the acute service)

The success of this plan can be seen most clearly in the reduction of times that Tiaho Mai has service users on the unit "over numbers" as seen in the graph below.



Access to CAMHS

Performance against the Ministry of Health's 'Policy Priority 6: improving the health status of people with severe mental illness through improved access' is shown in the trend charts below. These indicate the increasing demand for access to CAMHS.

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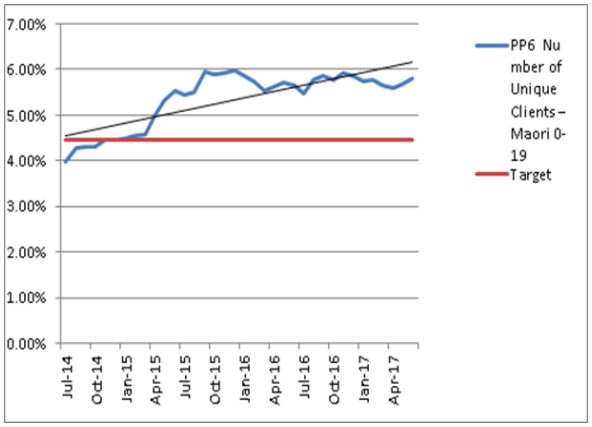


To manage this demand Whirinaki CAMHS have undertaken to align the Leadership and Team structure to integrate more effectively with the Mental Health and Addiction roll out of ILoC. It is envisaged that improved integration will ultimately minimize the increase on demand for CAMHS by intervening earlier, closer to home, and from within primary care whilst enabling easier access for those who need integrated specialist episodic (ISpEC) CAMHS care.

Youth Forensic team recruitment

For a range of reasons the Youth Forensic team had a period where all the positions were vacant. This meant the work and functions of this service were picked by other members of the Child and Adolescent service. We are pleased to report the team is nearly fully recruited with 4.6FTE out of the five funded FTE positions now in place. Training and development for the new team is being supported by the Regional Forensic Service.

Maternal Mental Health Model of Care

The Maternal Mental Health team received the Mental Health Nursing Service Award for the work the team have completed to develop a clear and contemporary model of care. The team has worked in collaboration with their NGO partner and there is now improved access to Maternal Mental Health support for women when pregnant or with a new baby. The work was undertaken as a result of the Counties Manukau Maternal Mental Health service review which was completed in 2015.

This service development has taken enormous time and effort from across the organisation and this award is in recognition that this team made strenuous efforts to ensure that this service is now fit for purpose.

NZ HR Award to Mental Health Nursing Education Team

The Mental Health Nurse Education Team were awarded the NZ HR Award for "Learning and development capability in the public Sector" for the development of the National Safe Practice Effective Communication training package.

Opening of three additional beds in Koropiko – Ward 35 East

An additional three beds were opened in Ward 35E and these have been fully utilised. At the same time as the structural work was undertaken to accommodate the beds some minor modifications to the ward has enabled a 'flexible care area' to be operationalised. This means that there is now the option to separate service users who present with intrusive or challenging behaviour that put either themselves at risk or others from the more vulnerable service users.

South Auckland Special Interest Group (SASI)

SASI was established in 2012. The core organisers for the group are a Clinical Nurse Specialist from CM Health's Mental Health Service and the Mental Health Coordinators from Primary Health Organisations. SASI has organised bi-monthly education sessions for both primary and secondary service staff over the past five years.

The core group of organisers normally have a monthly meeting to plan for SASI sessions. The involvement of the primary and secondary mental health clinicians in the planning and organising of these sessions has helped to bring these groups closer together. SASI planning and organising sessions have not only enhanced the working relationship between the two groups of core organisers but also provide great bridging opportunities to update everyone about new projects/developments.

In the past 12 months, many specialist services have been invited to SASI education sessions and have presented their speciality of knowledge including:

- July 2016 - Anxiety/Panic and Brief Interventions
- September 2016 - Mood Disorders
- November 2016 - Alcohol and other drugs
- March 2017 - Maternal Mental Health
- May 2017 - Delirium/Dementia

More than 50 staff attended each session. These staff represent a variety of different roles such as GPs, practice nurses, psychologists and counsellors. They also represent a wide range of services including Primary Health, DHB, NGO, and private.
Feedback from SASI sessions has always been overwhelmingly positive. Many people reported that SASI sessions provide great networking opportunities across the different roles and services, allowing them to get to know staff across the primary and secondary services. Staff also reported that they learnt more about how their role fits into the bigger picture, such as learning more about their roles and services.

Overall, SASI has been a great forum to bring staff from different services in the Counties Manukau area together and strengthen the collaboration between services. In addition, it has also encouraged and supported staff professional development.

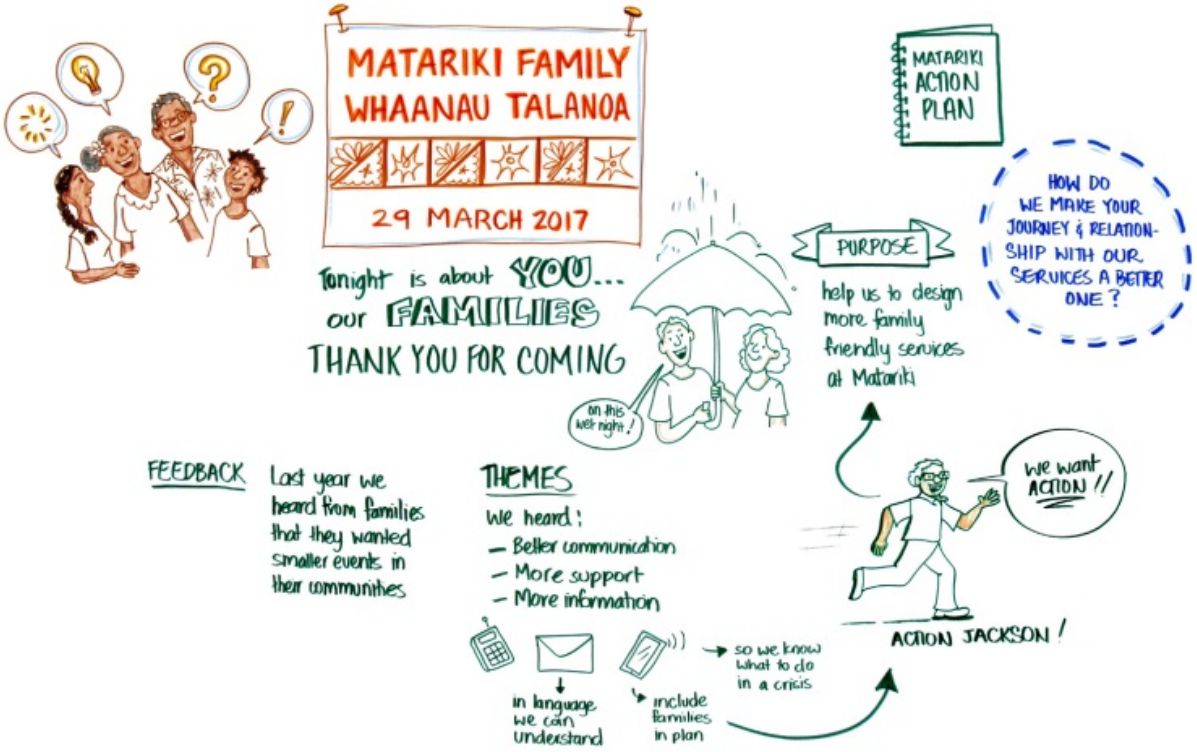
The Consumer and Family Whaanau Centred Care Team (CFWCC)

CFWCC is a small and energetic group that provides consumer and family whaanau engagement, evaluation and research support and advice to the Mental Health & Addictions division of CM Health. The team is made up of professionals with either personal or family experience of recovery from mental health issues (some with both).

Ruth Cheeseman and Moko Kairua are our Consumer Engagement Advisors. They facilitate inpatient ward forums both at Tiaho Mai the inpatient acute mental health facility and Ward 35 East, an acute inpatient ward for older persons with mental health needs. Ruth and Moko also support community teams with co-design activity, feedback to services users and their whaanau and they are both skilled at advising consumers on the methods of providing feedback to services that the consumer is most comfortable with. Moko and Ruth have worked with empathy and skill to maintain collaborative partnerships with Charge Nurses and community Team Managers – their non-confrontational approach has been key to finding effective solutions in often challenging and complex circumstances.

Sue Cotton is the division's Family Advisor. She brings her extensive mental health service knowledge, passion and experience to her this role. Sue has been instrumental in bringing 'family inclusive practice' to a reality in mental health services. She has tirelessly sat with teams and explained the importance of this work and the value of acknowledging and engaging family members, whoever they may be, as partners in care. Sue has worked in collaboration with Supporting Parents in Mental Illness a local NGO partner, to establish support groups for families in the Takanini district. Sue also sits on the CM Health Patient and Whaanau Centred Care Programme Board. Sue recently supported a cultural family whaanau Talanoa (community sharing of ideas, discussion, talking about experiences) at Matariki, one of our community sites.

Refer over the page for a graphic of the feedback from participants of the Talanoa.



Maryanne Richardson and Simon Bush are the Partnership, Evaluation, Recovery (PER) team; they evaluate mental health services, on a team by team basis. The PER team use a person-centred, qualitative-narrative methodology for evaluation; incorporating the views of service users, family and whaanau, staff, NGOs and other providers. The principles of the PER team's methodology are based on the values of equality, equity, respect, partnership and a recovery approach and are aligned to the Counties Manukau Health vision and values. The PER team adopts an inductive approach to evaluation, where themes are identified based on issues identified at the time of the evaluation. The aim of the evaluation process is to provide information that identifies strengths as well as opportunities for improvement, to enable service improvement that supports service user recovery and enhances wellness.

The CFWCC team is also fortunate to be supported by the knowledge and expertise of Liz Stewart, Mental Health Researcher. Liz provides advice and guidance on evaluation planning, methodology and reporting. She also supports the Mental Health division with research-based administrative activity within their research and evaluation programme.

The team is led by Cassandra Laskey who is thrilled with the team's productivity; their diversity, passion, relentless optimism and 'can-do' attitude towards improving consumer and family outcomes and experience of mental health services. They do their 'work' with a great deal of heart.

MENTAL HEALTH SCORECARD

June 2017

		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Overtime costs ($000)		**$186**	$149	-24.9%	**$2,093**	$1,787	-17.1%		High acute demand off-set by community vacancies
	Budgeted FTEs		**659**	689	4.3%	**650**	689	5.6%		Does not include locum FTEs
	Operating Costs ($000)		**$5,769**	$5,776	0.1%	**$68,781**	$68,718	-0.1%		
	Personnel Costs ($000)		**$5,109**	$5,469	6.6%	**$61,303**	$65,027	5.7%		
	Financial Result Total ($000)		**$5,727**	$5,756	0.5%	**$68,165**	$68,486	0.5%		
		Trend				12 month average			Rating	Commentary (by exception)
		FY16-17	May-17	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years		**8.4%**	5.0%	-3.4%	**9.1%**	5.0%	-4.1%		Managers are working with staff on individual plans to reduce annual leave 2years
	% Staff Turnover		**10.1%**	10.0%	-0.1%	**10.4%**	10.0%	-0.4%		
	% Sick Leave		**2.5%**	2.8%	0.3%	**3.5%**	2.8%	-0.7%		Sick leave reviews undertaken with staff with high sick leave
	Workplace Injury Per 1,000,000 hours		**0.0**	10.5	10.5	**10.5**	10.5	0.0		
		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)	Number of Seclusion events/100,000		**3.2**	5.0	1.8	**N/A**	N/A	N/A		
	Seclusion hours/100,000		**33**	50	17	**N/A**	N/A	N/A		
	Number of Clients Secluded/100,000		**3.2**	3.0	-0.2	**N/A**	N/A	N/A		
		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Timely	Shorter wait times for non urgent mental health and addiction Services (%<3 week wait) - 12 months rolling									
	0-19 years		**74%**	80%	-5.7%	**N/A**	N/A	N/A		Unique Clients seen has exceeded MOH Target by 1105
	20-64 years		**86%**	80%	5.6%	**N/A**	N/A	N/A		
	65+ years		**92%**	80%	11.8%	**N/A**	N/A	N/A		
	Shorter wait times for non urgent mental health and addiction Services (%<8 week wait)- 12 months rolling									
	0-19 years		**95%**	95%	-0.1%	**N/A**	N/A	N/A		Unique Clients seen has exceeded MOH Target by 1105
	20-64 years		**96%**	95%	1.1%	**N/A**	N/A	N/A		
	65+ years		**98%**	95%	2.5%	**N/A**	N/A	N/A		
		Trend				Year to date			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
System Integration (Effective)	Access rate - Number of CM domiciled unique clients seen by all MH services ((PRIMHD reporting services include AoD and NGO services) 12 months as a % of population) - Total									
	0-19 years		**3.9%**	3.2%	0.7%	**N/A**	N/A	N/A		
	20-64 years		**3.8%**	3.2%	0.6%	**N/A**	N/A	N/A		
	65+ years		**2.4%**	2.6%	-0.2%	**N/A**	N/A	N/A		Meeting the wait time targets - no build-up of a waitlist
	Readmissions to Tiaho Mai within 28 days - Total (1 month in arrears)		**10.3%**	12.0%	1.7%	**9.0%**	12.0%	3.0%		

		Trend				Year			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Efficient	Inpatient Occupancy - Tiaho Mai Acute Mental Health Unit		**93%**	85%	-7.6%	**93%**	85%	-7.6%		Signifies overcrowding
	Number of Tiaho Mai Inpatient LOS >35 days		**9**	10	1.0	**9**	10	0.6		

		Trend				Year			Rating	Commentary (by exception)
		FY16-17	Jun-17	Target	Var	Actual	Target	Var		
Equity	Access rate - Number of CM domiciled unique clients seen by MH services (PRIMHD) 12 months as a % of population - Maori									
	0-19 years		**5.8%**	4.5%	1.4%	**N/A**	N/A	N/A		
	20-64 years		**8.6%**	7.7%	0.9%	**N/A**	N/A	N/A		
	65+ years		**2.9%**	2.6%	0.3%	**N/A**	N/A	N/A		

Facilities and Asset Management

Glossary

ARF	Audit Risk and Finance
CMDHB	Counties Manukau District Health Board
CFO	Chief Financial Officer
DHS	Director Hospital Services
hA	healthAlliance
HAC	Hospital Advisory Committee
H&S	Health and Safety
HSWA	Health and Safety at Work Act
IL	Importance Level
LTIP	Long Term Investment Planning Process
MMH	Middlemore Hospital
MSC	Manukau SuperClinic
OHSS	Occupational Health and Safety Service
ToR	Terms of Reference

Service Overview

The Facilities and Asset Management division is led by Philip Healy (General Manager). The division is responsible for Engineering and Facilities, Property Management, Capital Planning, Development and Construction, Clinical Engineering, Transportation and Fleet Management, Infrastructure Services, Enterprise Asset Management, Procurement and Contract Management, Energy Management, Environmental Sustainability, Infrastructure/Facilities, IS Systems, Hazardous Substance, and Safety Compliance/Management.

Highlights

MMH & MSC Cladding Investigations

Further to the progression Scott Building recladding settlement with Hawkins and the associated construction proposal. Facilities have '*based on the Scott Building costs analyse'* provided a preliminary estimate to reclad the following facilities (*Scott Building, Kidz First, McIndoe and the Manukau Super Clinic*) which appear to have potential weather seal, build and passive fire protection issues.

Magnitude of cost estimates has been disclosed to CMDHB Audit Risk and Finance subcommittee and endorsement received from CMDHB's Executive Leadership Team to engage professional Chartered Building Surveyors Alexander & Company (*previously involved*) to formally appraise and evaluate the remediate works and timeframes required to rectify building cladding issues.

Asset Risk and Condition Survey – BECA Consulting

Further to the previously reported 2016 +$40m deferred facilities maintenance and associated accrued infrastructure and asset failure risk. The deferred maintenance being reported in December/May Facilities service report for inclusion within the HAC report. The need for an assets risk review has been further accentuated with the current Galbraith seismic review. This highlighted the need for expediting Galbraith critical infrastructure services relocations and diversions.

The executive leadership team endorsed the previously proposed engagement of BECA consulting to undertake the proposed bottom up infrastructure review to professionally identify and prioritise critical infrastructure investment requirements and/or any fit for purpose infrastructure issue which require resolution.

The Galbraith critical infrastructure review will be incorporated into the wider BECA critical assets condition and risk identification commission. This investigation is aligned to the work undertaken by ADHB to establish its ten year remediation works program. The survey will further inform CMDHB's long term investment planning process (LTIP). The asset risk and condition survey will be utilised in-conjunction with CMDHB's the investor confidence rating.

Emerging Issues

Holmes Consulting Galbraith Seismic Recommendations

Holmes Consulting under the dispensation granted to CMDHB to operate Galbraith as an IL3 service through to 2021 were required to undertake a seismic review March 2017. In light of, 'The Building (Earthquake –prone Building) Amendment Act 2016' enactment as of July 2017. Further to the above, Facilities working with the Director of Hospital Services has developed an action plan and terms of reference (ToR) for its professional consultants to expedite the formal seismic review, evaluate options and develop a cost plan for the required undertakings.

Update on previously reported issues

Issues	Date reported	Update
MSC Power Supply Failure	May 2017	Mains power has now been resorted to the MSC. New mains power cables (300 dia) have been installed as the cables installed by the contractor (16 dia) under the original Clinics Design and Build contract proved to be inadequate and failed.
Facilities Audits/Compliance with the HSWA 2015 enhanced Board Reporting obligations	April 2017	Facilities and OHSS with the assistance of external experts/moderators have been working collaboratively together to develop, audit and systematically rollout a phased improvement plan to achieve a fully complaint integrated H&S management and reporting regime for the Facilities functions. The programme of work has been initiated to achieve full compliance with the HSWA 2015. Compliant systems of work and a comprehensive assurance regime require a step change in elements of Facilities safety management systems and/or safety culture. This is currently being actively led with extensive training being undertaken and systems of work audits ongoing.
Galbraith Asbestos Identification	April 2017	Asbestos has been identified within the Galbraith Theatres, reports has been confirmed asbestos contamination in the basement and areas of level one. Testing has been undertaken in these areas and contaminated areas cordoned off. Expert containment and removal services have

		been procured as well as hazard management software required for CMDHB to implement a compliant HSWA 2015 management plan. A rolling asbestos identification and safety management plan is being rolled out. The operational, economic and commercial impact of the programme is being evaluated. Where asbestos has been identified this is being estimated within Galbraith Business Cases as between $100 to S150 cost impact per square metre of Floor/ceiling area. Environmental isolation controls and air monitoring protocol have been initiated. Focus areas for remediation are being targeted. (*Currently Galbraith basement and first floor*).
Regional Water Supply – Potential for Contamination	April 2017	Facilities have previously recommended that water supply is a business continuity risk and proposed secondary supply options. Under the Galbraith seismic review water supply is a critical service or seismic importance level four requirements. In accordance with the review requirements, Facilities have requested that BECA assess the provision of the secondary supply of water and associated costs within the scope of its asset condition and risk survey.
Engineering Staff Retention	March 2017	The retention and attraction of Engineering staff in the current economic environment is proving challenging. Some advertisements for staff are attracting no responses due to the disparity in CMDHB pay scales and market rates. To engage external contractors involves a cost factor of approximately 2.5 times the internal pay rate. Facilities are working with HR to undertake a job scaling exercise and/or look at dispensations for short fixed term contracts to cover the current period of hyperinflation in the construction and engineering sectors (*70 -100 year works high point*)
Clinical Engineering Resourcing key issues (retaining resource/ adequacy of resources	February 2017	Clinical Engineering WoF non-compliance rates are currently breaching 14%, which is beyond the 8% acceptable risk level. This is due primarily to an increased portfolio and resourcing levels. Clinical Engineering have and are currently

		recruiting resources and working with HR on a retention strategy. As with general engineering market rate are considerably higher than CMDHB rates and staff retention and attraction is challenging for the function. The insourced Clinical Engineering approach CMDHB have undertaken has proved to be an efficient and effective approach with good internal cost and operational controls.
CMDHB Devolved Property Management and Leasing	February 2017	In the past the CMDHB Executive devolved the negotiation of leases and maintenance of community based properties directly to service managers or their executive assistants. The space planning function was also devolved into the respective Hospital Services. Facilities are engaging in centralising the control of the property assurance and negotiation process and engaging in space planning facilitation and moderations with the respective services. Facilities has further sort to allocate in the near future 0.5 fte of one of its project managers to the space planning function.
IT Infrastructure Interface Management	January 2017	Currently hA is CMDHB IT infrastructure provider does not fall under the same operational governance as the Facilities and Engineering and Asset Management Department. Facilities work is ongoing to define Facilities Assets and Facilities has instructed hA that their site based works are required to fall under standard Engineering sub-contractor control of work permits and/or work systems. This is specifically relevant in respect of permitted area where asbestos has been identified.

Middlemore Central

Glossary

ARHOP	Adult Rehabilitation and Health of Older People
AT&R	Assessment, Treatment and Rehabilitation
NASC	Needs Assessment and Coordination Service

Service Overview

Middlemore Central is managed by Dot McKeen (General Manager) with Dr David Hughes (Clinical Director).

Highlights

Bed cleaning

A bed cleaning working party is working on ensuring that all beds meet a uniform standard of cleaning and that patient flow is not impeded by the beds not being ready.

A flowchart defining specific responsibilities and cleaning materials required for a routine discharge bed clean was presented to Clinical Governance Group and will be rolled out through the organisation. This allows for role clarity for cleaners and Health Care Assistants with an on line teaching programme to ensure standardised approach.

Stranded patients

Initially a stranded patient work-stream was assembled with membership from Primary Care, Localities, and the hospital to identify the blockages of getting these sometimes complex patients back into the community. With time this work-stream has evolved to become a steering group supported by an operational group to ensure focus and activity remains targeted and deliberate. The steering group is focussing on the following:

- Identification of barriers to discharge
- The admission processes to ARHOP/AT&R and Rehabilitation services – to improve efficiencies and timeliness of transfers
- Ambulance transfers and subsequent hold-ups
- Rest homes and when they can accept patients
- Increase knowledge for clinical staff of community initiatives and increase access to community
- Progress Community Forms on line to be more user friendly and accessible for the CNMs
- Improving efficiencies through increased access to NASC, occupational therapy, physiotherapy, and social work supports through matching hours of work with clinical requirements.
- Support service to run 24/7 through clinical leadership with processes to support weekend discharges

Acute Flow Dashboard

A working group with representatives from the Emergency Department, nursing, clerical, orderlies, cleaning, Middlemore Central, and Health Intelligence and Informatics are working to create a dashboard that maps the patient journey throughout the organisation. It is then planned that each “leg” of the journey which can be measured and recorded will give the basis for improvement initiatives.

Winter Lessons Learned Report

Since Middlemore Central opened in 2011, a Winter Plan has been prepared annually using the information from Cap Plan, and with input from General Managers, Service Managers, and their clinical partners. At the end of each winter, a "Lessons Learned" report is presented to the organisation looking at our patient workload, their link with Primary Care and localities, what they presented with, their length of stay, Readmission rates etc. Each year this report grows as clinicians seek more information to allow for better planning the following year. Staff from Middlemore Central and the Health Intelligence and Informatics team work closely to collect and prepare this report which grows in popularity each year.

Emerging Issues

Winter demand

Large volumes of patients presenting with Influenza-like illness have been challenging for Middlemore Central in trying to facilitate patient flow. The larger than usual number of admissions, particularly medical admissions, present problems resulting in a larger number of outliers – that is patients who are not in their home ward. This in turn lengthens the ward rounds the following day which again slows down the discharge process. There are several working groups meeting to track and time the admission and discharge process to identify "road blocks" and address them.

Additional beds have been staffed and resourced in both wards 2 and 31, with an additional bed added on wards 6, 7, 31 East, and 33 West.

Director of Patient Care, Chief Nurse & Allied Health Professions Officer

Prepared and submitted by Jenny Parr, Director of Patient Care, Chief Nurse & Allied Health Professions Officer, with updates provided by the Directorate of Patient Care including Nursing, Midwifery and Allied Health in the hospital, and Primary and Integrated Care.

Highlights

Hospital services continue to experience early arrival of winter, with very full wards and complexity of patients in all services. Action on a number of fronts with clinical staff and support services continues to focus on frontline staff support and standards, ensuring efficient patient journeys, timely discharges, lower re-admissions, and co-ordination with community services and colleagues.

The report has an expanded section on Allied Health Scientific and Technical. Of note, there are several smaller workforces where difficulty recruiting or small increases in staffing have a notable impact. Although these are not new problems and there is local, regional and in some cases national action, they have been included for the Committee's information.

As at 7 July 69% (close to 2,000) Nurses and Health Care Assistant's (HCAs) had received their annual influenza vaccination. The 131 peer vaccinator nurses, who all completed training and used standing orders to provide vaccinations in clinical areas, significantly supported this year's effort. Special recognition to medicine wards 6 and 33E who achieved 100% vaccination of the ward nurse teams. The Speech Language Therapy team were the Allied Health Flu Fighter champions with 84% of staff immunised against flu.

The annual Diversity Ball on 5 August was a fabulous opportunity to celebrate CM Health values, our diverse workforce and acknowledge the hard work occurring across the organisation in winter. This year's theme, "Bollywood meets Hollywood", gave a particular focus on the contribution of our Indian staff to the organisation.

Congratulations to Akshat Shah, a Middlemore-based Speech Language Therapist, who has won the University of Auckland (UoA) 3-minute Thesis Masters Final. Akshat spoke on the effectiveness of a workshop to improve community speech language therapists' ability to assess and provide appropriate intervention for children with cleft palate speech disorders. Akshat will now represent the UoA at the Masters 3MT Inter-University Challenge, to be hosted by Victoria University on 24 August.

Actions from the Last Meeting

Appendix 1 has been provided by the Undergraduate and Entry to Practice Development Lead, Ko Awatea and Business Support to Director of Nursing. It is in response to a request made at the July HAC meeting for further demographic information on the Nursing, Allied Health and Technical/Scientific workforce and student populations.

The Speech Language Therapist at Pukekohe Hospital is working with Aphasia New Zealand, to deliver evidence-based group work for people with aphasia in Franklin. This will replicate a similar model from the Centre for Brain Research at The University of Auckland (UoA), and will be a Gavel Club; a modified version of Toastmasters, for people who have language problems post-stroke. The group will be led by a service user, who has aphasia. Toastmasters New Zealand will provide governance for this and relationships with UoA will assist with the implementation.

Workforce

Timeframes for recruitment with approval, advertising and then screening/police vetting of applications (20-45 working days) can create additional re-working and delays for new external applicants to vacancies. The recruitment team have reduced the time from approval to recruit to offer from 120 days to 52 days for Nursing since January 2017 and from 91 days to 47 days for Allied Health staff over the same period.

The Vulnerable Children Act (VCA) stipulates that all staff in contact with children need to complete the NZ Police vetting process by June 2018. Employees will be vetted under two categories, core, and non-core workers. The HR Team is co-ordinating the vetting programme for our existing staff, starting with Kidz First and Women's Health as pilot services. Employees began receiving an information letter and police vetting forms to complete from early June.

Nursing

For June, there were 153 FTE[1] Nursing/Midwifery recruitable[2] vacancies active with the Recruitment team. This reflects a 5% vacancy across the total workforce (Nursing, Midwifery, and Health Care Assistant). Of the open recruitments initiated, 38 FTE occurred in June.

Of this total, across all CM Health services there are 13.6 FTE of Senior Nursing roles, 6.8 FTE of Enrolled Nurse roles, along with 97 FTE of Registered Nurse (RN) vacancies (40 in community settings). There are 5.9 FTE Midwifery vacancies (inpatient and community). HCA recruitment is also high at 21.4 FTE HCA being recruited, 8.0 FTE to support community teams.

(a) Nursing Workforce Hotspots

New graduate nurses are a key part of our future workforce, and the recruitment and retention of these nurses needs to be efficient and streamlined. It is also valuable to retain staff known to, and well orientated to CM Health for safe clinical service.

Work is underway to transition from employing new graduate nurses on a permanent rather than fixed term contract in the 12-month New Entrant to Practice [NETP] and the New Entrant to Specialist Practice [NESP] programmes. Currently, over 95% of participants transfer to a permanent role at CM Health at the end of the NETP programme. Discussions between clinical services, recruitment, and the NETP coordinators intend to ensure current NETP participants (completing in September on fixed term contracts) have an early opportunity to apply for vacant permanent roles.

In Mental Health and Addictions, there is a commitment towards intentional 'growth of our own' nursing workforce. External recruitment is no longer yielding many new to CM Health registered nurses for Mental Health. This is part of a wider national challenge for mental health nursing. Therefore, the service will be intentionally taking on greater numbers of new graduate nurses this year, and supporting the clinical areas doing so with a 0.4 FTE of Clinical Coach. Service specifications for registered nurses on New Entry to Specialty Practice (NESP) pathway require provision of a preceptor and coaching component. In teams where there are low numbers of experienced RNs, the Clinical Coach will support the practice areas.

Capacity for District Nursing is also under pressure. Community Central is processing up to 100 requests for community services each day.

[1] *131 FTE as of 10 August 2017*

[2] *Positions becoming or currently vacant, which have been reviewed, and are advertised. This activity includes ongoing recruitment campaigns for 'hard to fill' areas, including attracting experienced nurses in Women's Health, Mental Health (especially Child and Youth) and Emergency Department.*

(b) Key Events

Research Week 2017, hosted by the Ko Awatea Research and Evaluation Office in June, was a celebration of the great variety of health research taking place at CM Health and across the sector. The event included seven research workshops, 25 research presentations, and 22 research posters. There were also another 20 posters from second-year nursing students and 6 representing summer studentships. Topics covered a range of clinical and health topics, including diet and obesity, surgical, medical and acute care, child health, respiratory health, mental health, and patient experience. The award for Best Nurse Research went to Shirley Lawrence – "Comparing respiratory virus burden among infants <1 year of age across emergency care and inpatient settings in Auckland, New Zealand."

The 2017 Arthur D Bronlund Trust Fund Award is to assist health professionals (other than doctors) to travel overseas for further education and training, gain experience, skills or knowledge, or undertake research. This year it is awarded to Linda Legge, Clinical Nurse Specialist, Kidz First. She will use the award to attend and present a research study at the Lancefield Symposium on Streptococci and Streptococcal Infections in Fiji. Linda was an integral part of a research study to help children have a reduced pain option with their monthly rheumatic fever treatments. This research study led to all NZ DHB's changing how intra-muscular penicillin is administered to children for rheumatic fever management, and there is international interest on its findings.

(c) Nursing Pipeline and Education

Selection and recruitment for the September New Entry to Practice (NETP) intake is nearing completion, with State Exams in late July. Planning is concurrently occurring for potential numbers for the January intake. Building on the successful pilot last summer in Emergency Care of scholarship roles for new nurses between State Exams and NETP commencing, Kidz First will test this model in August. Emergency Care are also considering how to resource this model again in 2017/18.

The National Framework for Professional Development and Recognition Programme (PDRP) Levels of Practice Criteria has recently been review and updated. There are some changes made to the criteria and wording for the levels of practice with most changes to the expert (level 4). Other changes are, greater definition of senior nurse level, a new section on privacy and confidentiality and information about the new e-Portfolios. CM Health documents now reflect the changes, and are available via the intranet for staff. The e-Portfolios site went live on 18 July 2017 for all nursing staff to use via KA Learn. There will be a transition period where nurses will be able to submit either a paper-based portfolio or an e-Portfolio. From 1 January 2018, nurses are expected to submit electronically only. All PDRP assessors are receiving education to help nurses learn the new system and will be available as required. Roadshows across CM Health will provide support to use the e-Portfolio system.

As part of sustaining unprecedented winter workloads, a contingency to temporarily reduce internal education sessions for July/August was instituted. This has also occurred in previous years, however the challenge being to balance this response with enabling each service to roster-smooth and sustain access to annual patient safety training and other ongoing education sessions.

"Leading Quality Care" Expressions of interest and selection for the second cohort is underway. This 6-month programme for existing leaders is designed to influence and strengthen performance with a focus on frontline quality care, and patient outcomes in the hospital. There is a deliberate emphasis on practical application, with tools and strategies to assist leadership. The participants work with peers to help develop ideas, improve, and influence a team's experience and thereby patient experience.

Medication Management has changed significantly at CM Health over time. The introduction of Pyxis (electronic dispensing at ward level) occurred in 2011. However the main form of communication between ward and pharmacies continues to be faxing. This method does consume time with charts (3-7 pages) needing faxing, reliance on an available phone system and pages received on different fax machines in pharmacy. A project developing email scanning was due for completion in May however this is now moved to December following several meetings with Health Alliance on workstream flow issues.

Midwifery

The Ministry of Health (MoH) Chief Nurse arranged a meeting on 26 April with the New Zealand College of Midwives, MoH Maternity Advisor and representation from 10 District Health Boards (DHB) to discuss vacancies in tertiary maternity units. The actions agreed from this meeting were: a paper on the current midwifery workforce and projections into the future will be finalised by Health Workforce New Zealand and circulated to all participants and DHBs not represented; further discussion at the Directors of Nursing meeting to be held on 1 June; a presentation to the Chairs and Chief Executives meeting on 13 July 2017 by the National Maternity Monitoring Group, Midwifery Strategic Advisory Group (MSAG) and the Ministry of Health.

MSAG is part of Health Work New Zealand's strategic approach to provide leadership in a partnership approach between Health Workforce New Zealand (HWNZ) and representatives from the midwifery profession, midwifery education sector and the wider health workforce. The purpose of the MSAG is to provide strategic advice and guidance to the Ministry of Health and the sector to ensure a sustainable and supported midwifery workforce.

MSAG presented the draft National Work Programme to the HWNZ Board in June and was given support to progress to the next stage and finalise the plan which will occur in September 2017. The Work programme focuses on the following five work streams: Development of the midwifery pipeline; Leadership; Stabilise the workforce by encouraging recruitment and retention; Support for the Midwifery Advisory Groups work programme. Although the Work Programme will not be finalised till September, work has commenced.

An Analytics Manager from HWNZ presented midwifery workforce data at the meeting held on 3 July 2017 with the DHB Midwifery Leaders, Chair of MSAG and MoH, which assists in projections of workforce requirements, taking into consideration the population, fertility rate and midwifery workforce variables. The draft work programme was also discussed and feedback sort.

At a regional level, the Midwifery workforce shortage is included on the agenda of the Auckland Regional DHBs Women's Health General Managers, Service Managers and Clinical Lead's monthly meetings, updating and working together on a Regional Strategy to improve the midwifery workforce. The HWNZ Analytics Manager and Chair of MSAG will be coming to a meeting with the four Northern DHBs on 18 August 2017 to present the data and discuss the work programme.

Allied Health, Scientific and Technical

The Allied Health Scientific and Technical workforces include 26 groupings (see Appendix 1). There are 1,167 FTE in these groups. Scientific and Technical have the highest representation of males (24%), followed by Allied Health (15%). The ethnicity profile is also provided in Appendix 1. Of interest is the varying profile of ethnicities across the Allied Health Scientific and Technical workforces. There are currently 46 FTE being recruited, 3.9% of the workforce.

(a) Psychology

A new Clinical Access Arrangement has been signed with Canterbury University, to accommodate psychology students as interns from the Child and Family Psychology programme.

This year 12 new psychology graduates have been employed across 80 staff (across the 5 divisions), which is a high percentage. Some issues with supervision arrangements and output expectations arose, but it was managed well and safe practice was ensured.

(b) Dietetics

Forty bariatric surgeries were performed in June in an effort to try and meet agreed targets. This has a flow-on effect for the dietician post-op clinics and trying to get these patients seen 3-weeks post-op (as per guidelines). Custom clinics have been employed to manage this as a temporary solution, but will not be able to be continued as a longer-term solution should numbers continue to surge. A group session for those who are 18-months post-surgery has started. The aim is to evaluate this; however this is a large project so may be a possible student research project for next year.

(c) For cardiac roles (based in the Cardiac Investigation unit) there is a national workforce shortage:

i. Cardiac Sonographers

There is a longstanding 1.0 vacancy requiring targeted overseas recruitment. A 12-month parental vacancy has remained unfilled since December 2016. A Clinical Tutor role is under development to improve on-site training. Potential for an advanced practice role is being investigated to improve workflow and quality activities.

ii. Cardiac Physiologists

There are skill-set limitations for advanced technologies within the current team, which are being managed by up-skilling of junior team members, requiring on-going training. This has limited the on-call team size. An additional on-call physiologist will be available in September to make the on-call rotation more robust. An assistant role is being developed to enable the highly skilled team to target key patient focussed areas and reduce the administration burden of the role.

iii. Cardiac Technicians

There is a current vacancy which is currently being recruited, but this will not be filled with a qualified staff. This will reduce the skill mix of the small team.

(d) Occupational Therapy

The current workforce hotspots remain in mental health, however there has been some improvement since last month's report with 6 out of 9 vacancies successfully recruited. Work is being undertaken with Talent Acquisition and HR to advertise internationally and on association websites.

(e) Health Equity Campaign: Maaori and Pacifica Workforce Development

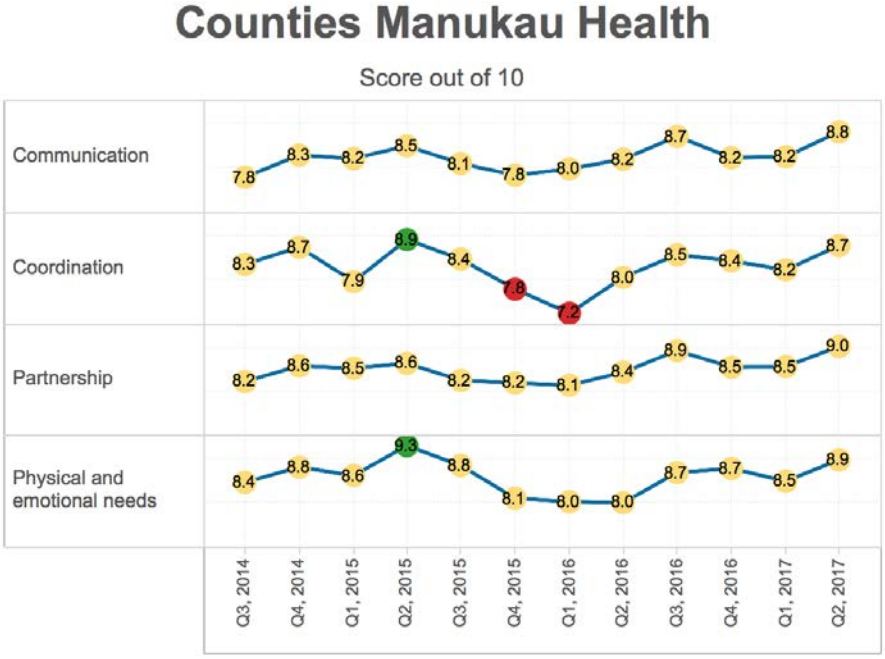
A Careers Advisers 'Myth Busting Day' 101 was held on Monday 17 July, as part of the Health Equity Campaign project: *Diversifying the Allied Health Workforce*. Key objectives focused around up-skilling careers advisors of South Auckland Secondary Schools, on Allied Health careers and how the advisors could specifically support Maaori and Pacific students into an Allied Health career. Of the 20 people invited, seven participants attended from the following schools: Tangaroa College (3), Alfriston College (1), Auckland Girls Grammar School (2) and Manurewa High School (1). Both Tangaroa College and Alfriston College are current Health Science Academy schools and Manurewa High School runs an independent academy model. With a smaller group the level of discussion and engagement was high. Pre and post surveys were completed in order to collect data and for quality control.

Feedback has been analysed and discussed and informs the following planned activities:

- Allied Health Workforce Expo (8 September) – is an annual event which will be further strengthened in 2017 through improved evaluation approaches and data collection
- Development of an e-learning package to assist Careers Advisers and students with improving knowledge of Allied Health careers and pathways
- Focus groups with Maaori and Pacific students in Occupational Therapy and Physiotherapy at AUT, to better understand barriers to successful completion of study and choosing employment at CM Health.
- Focus groups with family/whaanau to understand their perspective and use this dialogue to encourage more Maaori and Pacific students into Allied Health

Patient Experience

Patients receiving care in our hospitals between 31 July and 13 August 2017 may be contacted to respond to the quarterly national patient experience survey. Posters promoting the survey to in-patients will be distributed, asking that they provide their email address for the survey. The patient experience of care *system level measures* work stream has set a target for 2017-18 to achieve an aggregate of 8.5 for the 4 domains.



'Hello my name is …' international day was held on 25 July. In September, the region is hosting Chris Pointon, husband of Dr Kate Granger who died last year and spent her last 5 years of life challenging public attitudes to death and medical staff approaches to patients. She led the campaign, 'Hello my name is …'.

The April-June Gold Standard National Hand Hygiene Audit achieved 80% compliance. Of the areas audited, Critical Care, Emergency Department, National Burns Centre, Scott and Rito Dialysis units, Kidz First medical and surgical, and Ward 1 and Ward 24 achieved over 80%. The rollout of the audit and training of more auditors across the hospital continues.

The Mental Health 'Supporting Parents, Healthy Children' programme is a Ministry of Health-directed action, that we are embedding into everyday practice. The focus for this work is recognising that a large number of users of our secondary mental health services are also parents. Supporting them to maintain a parenting role; whilst also recovering from mental health issues is vital to supporting wellness.

A senior nurse is working closely with the Family and Whaanau advisor, and has presented this programme to every clinical team as an introduction and explanation. New accountability measures have been added into reporting and electronic clinical notes.

Inpatient Experience Report

The Divisional analysis of 'communication' for the Patient Experience Survey results has been well received as it has provided in-depth service specific details to support development of divisional level action plans. Efforts to boost participation and email collection for both the National Survey and Inpatient survey continue, with email collection by area being monitored.

Volunteer Services

A Volunteer Coordinator has been successfully recruited to replace Neshanee Naidoo, with an expected start date of 30 August. The successful applicant has valuable experience in managing and recruiting volunteers.

The Manukau Super Clinic (MSC) Northern Shuttle Service route was resumed on 10 July. Staffed by volunteers, it is providing a reliable service thus far. The Southern Shuttle Service will resume as volunteer numbers permit.

Allied Health

Ko Awatea has published the Folau I Lagi-Ma improvement guide describing how an innovative self-management support model has improved quality of life for people with long-term conditions.

The model was created by Folau I Lagi-Ma project team as part of the Manaaki Hauora – Supporting Wellness campaign, which aimed to provide self-management support for people living with long-term conditions in the Counties Manukau area.

Folau I Lagi-Ma integrates occupational therapy with peer support in a primary care setting to deliver better, more holistic care for people who experience both physical and mental health symptoms as a result of long-term conditions.

Quality and Improvement

Technology Enabled Care

(a) Clinical Documentation programme - eVitals
A decision was taken to delay the rollout by one month. User Acceptance Testing (UAT) of the system has commenced, initially with the programme clinical coaches, and there are ongoing briefings on progress to clinical teams and leaders. Members of the Patient Safety team have been closely involved in the eVitals project, lately participating in user acceptance testing of the nursing assessment, falls, pressure injuries and fluid balance components and providing testing feedback. Dieticians have been supporting the project by integrating the Malnutrition Screening Tool (MST) into the Pressure Injury Risk assessment Tool (Waterlow) and interventions into the Pressure Injury Bundles of Care. The final version includes the MST and bundles of care included in the Pressure Injury Risk Assessment Tool. The use of the electronic weight chart and fluid balance chart will provide essential information about service demand for both Acute Dieticians and consequent flow on to the Community Dieticians.

(b) Care Capacity Demand Management (CCDM)
The Steering Group hosted a visit by the national Safe Staffing/Healthy Workplace Unit in late July, as part of system validation. The CCDM coordinator is continuing to work closely with ward staff on process expectations and data compliance.

(c) iPM Upgrade
The upgrade of iPM will give access to the latest version of the patient management software. The upgrade will provide improvements including enhanced capture of information for patient registration, more efficient matching of referrals to our services and more reliable data reporting. CM Health and healthAlliance jointly decided to delay the scheduled upgrade (initially to be on 7 July), to enable testing, remediation of technical issues and further preparation time. During the iPM system upgrade, a 12-hour outage will mean that all services will need to capture patient information using 'manual' processes. We are using the delay as an opportunity to fine-tune service continuity plans, continue with staff training and access the eLearning modules.

Midwifery

(a) Living Our Values Maternity North & South Project
This project was initiated in December 2016 and the goals are to improve inpatient care experience, decrease maternity process variation, standardise clinical pathways of care and improve staff satisfaction. A solution proposal document was presented to sponsors and the steering committee on 16 May 2017. Following this, a work plan has commenced within the following five work streams:

i. Ward split: The ward will be physically and financially divided so that a clear leadership model for staff is created with increased sense of team and accountability, reduced congestion in the central hub, ownership of equipment to name a few. North and South wards will have their own hub and handover procedures.

ii. Model of care and people: This work stream will focus on communication and collaboration between allied health teams, establishment of standardised pathways of care, admission and discharge criteria to name a few.

iii. Equipment and resources work stream: This team will focus on the physical separation of the wards and improving the efficiency of space and equipment. An example of this is; the increased floor space in the North Hub by the narrowing of the workbench.

iv. Communication: The key focus will be improving opportunities and process for inpatient and staff feedback, introduction of safety huddles and establishing a clear and consistent meet and greet process for inpatients.

v. Measurement and reporting: This group will work with Middlemore Central and Health Intelligence and Informatics to enable accurate capturing and use of ward data.

(b) Women's Health Annual Report 2016/17
This is currently in development in preparation to submit to the MoH National Maternity Monitoring Group by the end of August 2017. This report includes the Maternity Quality and Safety Programme, a neonatal section and this year will also include a gynaecology section. The public presentation of the report is scheduled for 20 September 2017.

(c) World Breastfeeding Week 1-7 August 2017
CM Health celebrated World Breastfeeding Week, with the Lactation Service putting up displays around Middlemore Hospital. The theme this year was 'Sustaining Breastfeeding Together' which highlighted how we all need to work together so mothers can breastfeed. An event during

the week was 'The Big Latch On', where mothers breastfed together at the same time. Venues for this in Counties Manukau region were: Turuki Healthcare Mangere, All Saints Church Howick, Pukekohe Town Hall, Friend of the Farmer Cafe Takanini. More information: www.biglatchon.org.nz

Allied Health

(a) Psychology
By using the Psychology Pathways and careful review of the waitlist, Te Rawhiti team has reduced their waitlist to three, and waiting time is within an acceptable range.

(b) Dietetics
There is ongoing work to commence a national accreditation portfolio process for Specialist Diabetes Dieticians, in addition to progressing work with WINTEC in order to create a post graduate opportunity for additional training in diabetes.

(c) Speech and Language Therapy
Home health care speech and language therapists have implemented a training package for GP registrars to help them work with patients with communication disabilities such as aphasia. They have partnered with two service users to deliver this. Evaluation pre and post training suggested that the GP experience of the training was highly relevant, expertly and meaningfully delivered, and will make a tangible change to our patients' experience of seeing their GP. Communication strategies modelled included creating communication "ramps", using pen and paper for key words, regularly checking in that patients understand their message, and giving appointments longer slots if patients need it.

The speech language therapy spinal research project, examining the impact of dysphagia rehabilitation for patients following spinal injury, is underway at the Spinal Unit. Currently speech language therapists are able to assess the dysphagia of individuals post-stroke and assist with aspects of care such as tracheostomy weaning whilst the patient is in the intensive care unit. However, there is little resource for speech language therapy to continue during the rehabilitative process in the spinal unit.

Speech Language Therapy is experiencing challenges associated with reconciling our existing resources for patients requiring video fluoroscopies to objectively assess swallowing. Across the 26 FTE speech language therapists working in Counties Manukau Health (CM Health), there are only three who are video-fluoroscopy competent and therefore able to conduct the procedure and complete the complex reporting arrangements associated with this. The Associate Director is working collaboratively with General Managers to generate solutions to this issue. Within speech language therapy, the training of further speech language therapists within the service to be video-fluoroscopy competent is being accelerated. This will not create further video-fluoroscopy slots in the radiology suite, but will create greater flexibility within the service to respond to demand, help with absences and assist with succession planning.

Further to the workforce issue for video-fluoroscopy, demands for this service have grown considerably. This is a reflection of population growth within localities. There is an increase in individuals being discharged from Middlemore requiring follow up instrumental assessments, and therefore having marked an increase in referrals for follow-up and video-fluoroscopy for swallowing impairments.

(d) Social Work
CM Health Family Violence Policy and Procedure has been updated to align with the Ministry of Health Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence. Violence Intervention Programme training has been updated to align with the new guideline.

i. High Risk Pregnant Maaori Women

A new initiative has commenced with community Midwifery Services, Te Kaahui Ora, Maaori Health and Social Work to improve the process of risk assessment, intervention and safety planning for vulnerable pregnant Maaori women and their unborn babies. This initiative follows the realisation that almost 90 % of women on the CM Health high risk unborn register are Maaori. Pregnant women are placed on the high risk unborn register if CM Health staff have serious concerns for the wellbeing of an unborn baby and that these concerns are likely to place a new-born infant at risk, eg: substance misuse, family violence, expectant mothers non-participation in antenatal care, and previous Oranga Tamariki involvement.

The inaugural meeting was held on 25 July 2017. The following steps will be taken initially:

- A focus on training on Family Violence and Child Abuse and Neglect for community Midwives and social workers. This is provided to staff by the Violence Intervention Programme Team.
- The building of meaningful and respectful relationships with Community Maaori services.
- Develop a more streamlined approach for Maaori Health, midwifery, social work and external community services to work together to with pregnant Maaori women and their whaanau.

A wider meeting will be called with internal and external stakeholders to build strong partnerships and to develop strategies to work together prior to the birth of a child so as to enable effective planning, support and intervention to ensure a new born child's safety and healthy development after they are born.

ii. Police Safety Assessment Meetings (SAM)

Counties Manukau Police have initiated daily Police SAMs as part of their initiative to provide an improved response to family violence. CM Health staff (Social Workers from Maaori and Pacific health teams) attend these meetings daily to support this practice.

This process albeit necessary, is also considered to be very time consume reviewing and needs reviewing. The Director of Allied Health (DAH) and Associate Director of Allied Health (ADAH) – Social Work are meeting with the necessary stakeholders to resolve this.

iii. Social Work Alert Committee (SWAC)

The ADAH Social Work, together with the Social Work Alert Committee, is in the process of reviewing the processes of approving and loading of social work alerts. The following steps have been undertaken:

- Review of policies, procedures and forms
- Recruiting of new members from other disciplines
- Mapping and analysing of the social work alert committee process with the aim of making it more streamlined and efficient

(e) Dietetics

A 0.5 FTE Dietician has commenced who will cover the acute teams outpatient clinics. Her role will include exploring the increasing gastro outpatient waitlist and develop strategies to ensure the right patients are seen in a timely manner. Custom clinics have been required to help meet waitlist targets during the past few months, and ongoing meetings are planned to evaluate clinics and look at new models of care.

The Paediatric obesity support package has been reviewed in light of ongoing non-attendance and the provision of this type of nutrition support by other community providers. Treatment goals, time required to meet goals, content of education and ongoing community support are being modified.

(f) Occupational Therapy

A senior Occupational Therapist presented a report on suicide prevention and post-vention to the Mental Health Clinical Governance Group. A number of new initiatives including *Link4life* project, Facebook back, Kaitaiaki Roopu (for Maaori suicide prevention) and improved messaging and data collection have been initiated over the last year. Statistics show little change in the numbers of suicides, however due to population increase, this actually represents a proportional decline in numbers. It is interesting to note for the Counties Manukau area, under 25-years suicide rates represent 18% of the numbers, whereas 25–64-years represents 78%. A total of 33% of those suicides were known to mental health services.

Patient Safety

(a) Falls Prevention

Two plan-do-study-act (PDSA) tests continue in Adult Rehabilitation & Health of Older People (ARHOP) to look at improving post falls review and documentation.

i. A multidisciplinary post-fall huddle analysis template and process was tested on Ward 24 (geriatric rehabilitation) during May/June. The intention of the huddle is to review the circumstances of the fall as soon as possible, what falls prevention interventions were (or were not) in place at the time of the fall, any contributing factors and the post fall follow-up/action plan. Numbers have not been sufficient to make any recommendations from the test period so Ward 23 is considering taking part in the test as well.

ii. A Post-Fall Checklist is being tested on Ward 4 (assessment, treatment and rehabilitation) in July/August. This PDSA is to test whether completing the Post-Fall Checklist assists with decision making and prompts action immediately after the fall and provides clearer documentation about the fall for the purpose of incident reporting and case review.

Certification Update

The recent establishment of the Corrective Action Group Monitoring (Chaired by the Director of Patient Care, Chief Nurse and Allied Health Professions Officer) has improved traction on several corrective actions that were slow to resolve. The next Ministry of Health review of our Corrective Actions will occur on 15 September. The next Certification visit will be in November 2017 with a self-assessment completed in the six weeks prior.

(a) Complaint Review Update

Two of the corrective actions from the last Certification audit were to (a) improve our complaint process and (b) develop a Corrective Action Database for Complaints and Serious and Sentinel Events (SSE). The complaint review is complete and options have been developed. It is likely that further (staff) consultation will be needed on the options.

(b) Women's Health Controlled Documents

Women's Health has set up an Obstetric and Midwifery Controlled Document Coordination Group which meets monthly and is making positive progress. Each out of date document is allocated to a staff member with expertise in that area; who then reviews and sends the document out for the required consultation, prior to the document returning to the Group for

final sign off. Several documents have been completed and Women's Health is considering removing this risk from the Risk Register.

(c) The Patient Safety team have commenced a small-scale plan-do-study- act (PDSA) testing of the Plan of Care documentation on one surgical and one medical ward on 10 July. Initial tests have been successful with minor modifications made to the documents following feedback from testers. So far all testers think this documentation is an improvement from the current version. Auditing of completed documentation using the gold audit tool has found this would pass certification requirements. The mnemonic AIE (ie: Assessment, Implementation and Evaluation) for documentation in the clinical notes is also being tested and has been successful with both wards writing in this format and improvement noted in the content of the clinical notes. A guide sheet is being developed to aid users. Testing will continue with the intention of increasing the number of patients and wards over time. The Plan of Care project also assists us with meeting our Certification requirements as the lack of care planning was a corrective action from the April 2016 audit.

(d) Corrective Action Database
An excel database is being trialled using SSE actions. Further work is required on developing the supporting process of updating and contacting the 'owners' of corrective actions.

(e) Unresolved Corrective Actions
The corrective actions that remain open since the Certification audit in April 2016 are making steady progress with traction gained through the oversight of the Corrective Action Monitoring Group. The Ministry is satisfied with the progress being made and deferred the scheduled August update report until later this year.

Attached for interest as Appendix 2 is a Certification Maturity Matrix which provides a perspective on how the organisation can benchmark its performance against the achievement of Certification Standards. Traditionally organisations focus on 'passing' and/or getting 'few' corrective actions. However as this matrix demonstrates, it is appropriate to aspire to exceed the standards by achieving Continuous Improvement ratings (the highest). The Matrix (adapted from Philip Crosby's Maturity Grid and published in his 1979 book 'Quality if Free') also correlates the Core Certification standards with the STEEEP Quality framework, further demonstrating how the achievement of Certification aligns with this fundamental quality framework.

Leadership

National

(a) Nurse Executives New Zealand
The Director of Nursing completed her four year tenure as Chairperson for Nurse Executives NZ. The incoming chair is Karyn Sangster, Chief Nurse Advisor Primary & Integrated care CM Health. This nomination was elected non-opposed. Key meeting themes included Health and Disability complaint review and recommendations. Whilst 7% were noted about nursing care, discussions included aspects of improved communication and coordination.

(b) Growing Nursing Leaders: the Doctoral Internship Programme:
A group of North Island DHBs (Waikato, Counties Manukau, Bay of Plenty, Auckland, Northland and Waitemata) are working in partnership with the UoA to run a Bachelor of Nursing (Honours) Leadership programme, which enrols up to twenty new graduate nurses each year. The programme began in Waikato DHB in 2013 and CM Health in 2014. Currently three of our initial graduates have met the criteria for a PhD scholarship worth $45,000.

(c) Nurse Prescribing
Final approval of the Registered Nurse Designated Prescribing in Community Health trial and evaluation has been received, with all aspects of the programme having been met. Evaluation of the programme will commence this month with a completion date of 30 March 2018. Training days for Family Planning certificate in contraception and sexual health has been held to support 6 nurses to prescribe in this scope.

Regional

The Chief Nurse Advisor Primary and Integrated Care is working with the Nursing Director Auckland District Health Board (ADHB) and Waitemata District Health Board (WDHB) to initiate a regional primary health care nurse's reference group. Each DHB currently has local groups and will combine the two groups to provide a regional approach. The group will meet every two months. On the alternate month, Primary Health Organisation Nurse Leaders will hold a workshop to progress development of the primary care nursing workforce.

Allied Health

(a) Dietetic Quality Group Meeting
ADAH Dietetics set up the. first meeting for the Dietetic department, with representatives from each of the services to come together to set up a Quality Based group, to start looking at our services including development of standards for patient information sheets and Standards of Care, and proposal of outcome measures across dietetics.

(b) Auckland Regional Diabetes Dietician Meeting
The Associate Director Allied Health Dietetics and Nutrition, attended the monthly regional diabetes dietician meeting to present back the work being done on the regional diabetes dietician referral criteria between primary and secondary care. Next step is to present this back to the CM Health Local Diabetes Team meeting, to get these adopted by the group.

(c) Occupational Therapy
The Leadership Group Occupational Therapy recognise the pressure currently on staff and want to recognise a variety of staff, experienced and new, for going the extra mile for the people they serve and the organisation. They have proposed a monthly award from each of the four values which is across the whole District Health Board occupational therapy. Award winners would have their name in the Daily Dose; receive a certificate and a coffee voucher. The purpose of this is to recognise excellence in staff, not necessarily via the academic pathway which so many of the awards currently support, but rather the core values of CM Health.

Appendix 1 - Summary of Undergraduate Education and Placements

Table 1: CM Health Workforce – Source: Human Resources (Leadr data at 19 July 2017)

Occupational Group	Headcount	Sum of FTE
Allied Health		
Audiologists	11	6.5
Child Therapists	22	17.2
Community Support Workers	77	70.8
Cultural Workers	5	4.8
Dieticians	47	35.2
Health Promotion Officers	70	59.7
Hearing/Vision Testers	31	26.8
Occupational Therapists	128	112.9
Other Allied Health Staff	1	0.0
Pharmacist Interns	2	2.0
Pharmacists	68	58.5
Physiotherapists	155	102.6
Podiatrist	2	1.0
Psychologists	82	67.9
Social Workers	143	131.7
Speech Therapists	26	20.1
Therapist Aids/Assistants	53	44.5
Youth Workers	2	2.0
Allied Health Total	925	764.1
Midwifery		
Registered Midwives	179	127.9
Midwifery Total	179	127.9
Nursing		
Enrolled Nurses	83	65.5
Health Service Assistants	408	323.6
Internal Bureau Nurses/HCA	*441*	*12.2*
Nurse Practitioner	10	8.8
Registered Nurses	2030	1697.8
Senior Nurses	594	496.5
Nursing Total	3566	2604.4
Technical & Scientific		
Laboratory Assistants	57	50.3
Laboratory Technologists	81	76.4
MRTs & Sonographer Students	28	3.0
MRT's & Sonographers	119	89.6
Pharmacist Technicians	23	18.8
Phlebotomists	38	30.9
Scientific Officers & Researchers	7	6.6
Technicians	152	128.3
Technical & Scientific Total	505	403.8
Grand Total	**5175**	**3900.2**

Table 2: Gender Profile

Occupational Group	Gender		
Headcount	Female	Male	Grand Total
Allied Health			
Audiologists	73%	27%	100%
Child Therapists	95%	5%	100%
Community Support Workers	68%	32%	100%
Cultural Workers	20%	80%	100%
Dieticians	94%	6%	100%
Health Promotion Officers	94%	6%	100%
Hearing/Vision Testers	90%	10%	100%
Occupational Therapists	94%	6%	100%
Other Allied Health Staff	100%	0%	100%
Pharmacist Interns	100%	0%	100%
Pharmacists	78%	22%	100%
Physiotherapists	90%	10%	100%
Podiatrist	0%	100%	100%
Psychologists	80%	20%	100%
Social Workers	81%	19%	100%
Speech Therapists	96%	4%	100%
Therapist Aids/Assistants	81%	19%	100%
Youth Workers	0%	100%	100%
Allied Health Total	85%	15%	100%
Midwifery			
Registered Midwives	100%	0%	100%
Midwifery Total	100%	0%	100%
Nursing			
Enrolled Nurses	95%	5%	100%
Health Service Assistants	77%	23%	100%
Internal Bureau Nurses	94%	6%	100%
Nurse Practitioner	90%	10%	100%
Registered Nurses	87%	13%	100%
Senior Nurses	93%	7%	100%
Nursing Total	88%	12%	100%
Technical & Scientific			
Laboratory Assistants	88%	12%	100%
Laboratory Technologists	77%	23%	100%
MRT's & Sonographer Students	89%	11%	100%
MRT's & Sonographers	79%	21%	100%
Pharmacist Technicians	96%	4%	100%
Phlebotomists	79%	21%	100%
Scientific Officers & Researchers	86%	14%	100%
Technicians	63%	38%	100%
Technical & Scientific Total	76%	24%	100%
Grand Total	**87%**	**13%**	**100%**

Table 3: Ethnicity Profile

Occupational Group	Ethnicity						
Headcount	Asian	European	Maaori	Pacific Island	Other	#N/A	Grand Total
Allied Health							
Audiologists	64%	27%		9%			100%
Child Therapists	14%	77%		5%	5%		100%
Community Support Workers	17%	30%	25%	23%	3%	3%	100%
Cultural Workers		20%	60%	20%			100%
Dieticians	17%	77%	2%		4%		100%
Health Promotion Officers	26%	40%	10%	21%	1%	1%	100%
Hearing/Vision Testers	10%	52%	16%	16%		6%	100%
Occupational Therapists	9%	76%	4%	5%	4%	2%	100%
Other Allied Health Staff		100%					100%
Pharmacist Interns	50%	50%					100%
Pharmacists	44%	46%		3%	7%		100%
Physiotherapists	10%	86%		2%		3%	100%
Podiatrist	50%			50%			100%
Psychologists	9%	80%	4%	4%	2%	1%	100%
Social Workers	13%	43%	17%	21%	3%	3%	100%
Speech Therapists	12%	77%	8%	4%			100%
Therapist Aids/Assistants	32%	51%	2%	13%	2%		100%
Youth Workers			50%	50%			100%
Allied Health Total	17%	61%	8%	10%	2%	2%	100%
Midwifery							
Registered Midwives	7%	84%	5%	1%	2%	1%	100%
Midwifery Total	7%	84%	5%	1%	2%	1%	100%
Nursing							
Enrolled Nurses	19%	52%	7%	12%	6%	4%	100%
Health Service Assistants	45%	20%	9%	19%	1%	5%	100%
Internal Bureau Nurses	47%	30%	3%	16%	2%	2%	100%
Nurse Practitioner	10%	80%		10%			100%
Registered Nurses	47%	34%	3%	11%	3%	3%	100%
Senior Nurses	16%	69%	4%	5%	2%	4%	100%
Nursing Total	41%	38%	4%	11%	3%	3%	100%
Technical & Scientific							
Laboratory Assistants	49%	26%	2%	14%	4%	5%	100%
Laboratory Technologists	43%	48%		2%	4%	2%	100%
MRTs & Sonographer Students	29%	50%		7%	14%		100%
MRT's & Sonographers	19%	66%	3%	1%	3%	8%	100%
Pharmacist Technicians	57%	30%		13%			100%
Phlebotomists	61%	18%	3%	5%	8%	5%	100%
Scientific Officers & Researchers	14%	71%		14%			100%
Technicians	30%	47%	5%	10%	2%	6%	100%
Technical & Scientific Total	35%	47%	3%	7%	4%	5%	100%
Grand Total	**35%**	**45%**	**5%**	**10%**	**3%**	**3%**	**100%**

Student Demographics

We do not routinely capture the demographic profile of students coming to CM Health services for placements; Tertiary institutes are responsible for the selection and enrolment of students, and may have targets to increase Maaori/ Pacific participation in tertiary study. They will report demographic detail data to the Tertiary Education Commission, and via NZQA evaluations.

Further, the allocation of undergraduate students to clinical placement sites is carried out by the tertiary providers, and will create variation in student demographics between cohorts. This allocation process is based on providing a variety of clinical experiences to all students, within the available placements offered.

Table 4: Snapshot for the Largest Undergraduate Student Cohorts Coming to CM Health, Reflecting Indicative Overall Profile of Placements

Institute	Female	Male	Maaori	Pacific	Asian	Other
MIT - Nursing (BN, BPN, EN) *Data on MIT 2017 intakes*	95%	5%	12%	37%	49%	
University of Auckland – Nursing *24 students on placements 2016* *Total UoA 2017 intake 117*	87%	13%	0%* See note	4.2%* See note	54.2%	41.6%
AUT – Physiotherapy *87 students on placements 2016*	52%	48%	13.8%	17.2%	10.3%	58.6%
AUT – Occupational Therapy *50 students on placements 2016*	78%	22%	12%	4%	18%	66%
Social work – variety of institutions *23 students on placements 2017*	87%	13%	0%	30.4%	21.8%	47.8%

Notes on 2017 Enrolments for Nursing – Nursing Review 2017

The UoA's nursing school took on 117 students this year (slightly above its 110 planned places), with school-leavers making up 58% of the intake. The UoA has noted a steady trend towards more males and more mature students in recent years. The outgoing head of school, Associate Professor Judy Kilpatrick, said it had 23 males (19 per cent) – up on previous years – enrolled in its 2017 intake.

*Maaori and Pasifika students were also up on previous years, with 15 (13%) Maaori and 12 (10%) Pasifika students in this year's intake. For the first time, many of these were enrolling through the medical and health science faculty's Maaori and Pacific Admission Scheme.

MIT nursing school head of school Dr. Willem Fourie, said application numbers were on par with recent years, but it had improved the conversion rate from application to actual enrolments, including some targeted work on improving Maaori enrolments.

Maaori make up about 12% and Pacific students 37% of the main BN programme intake. Pacific students make up about 90% of the BN Pacific with the remaining 10% mostly Maaori students.

New Graduate Nurse Recruitment

Advanced Choice of Employment (ACE) National Recruitment Process for Nursing
The national Advanced Choice of Employment (ACE) Nursing programme facilitates the application, recruitment, and matching process for new graduate nurses applying for a position on the Nurse Entry to Practice (NETP) or New Entry to Specialty Practice (NESP) Mental Health & Addiction Nursing Programmes.

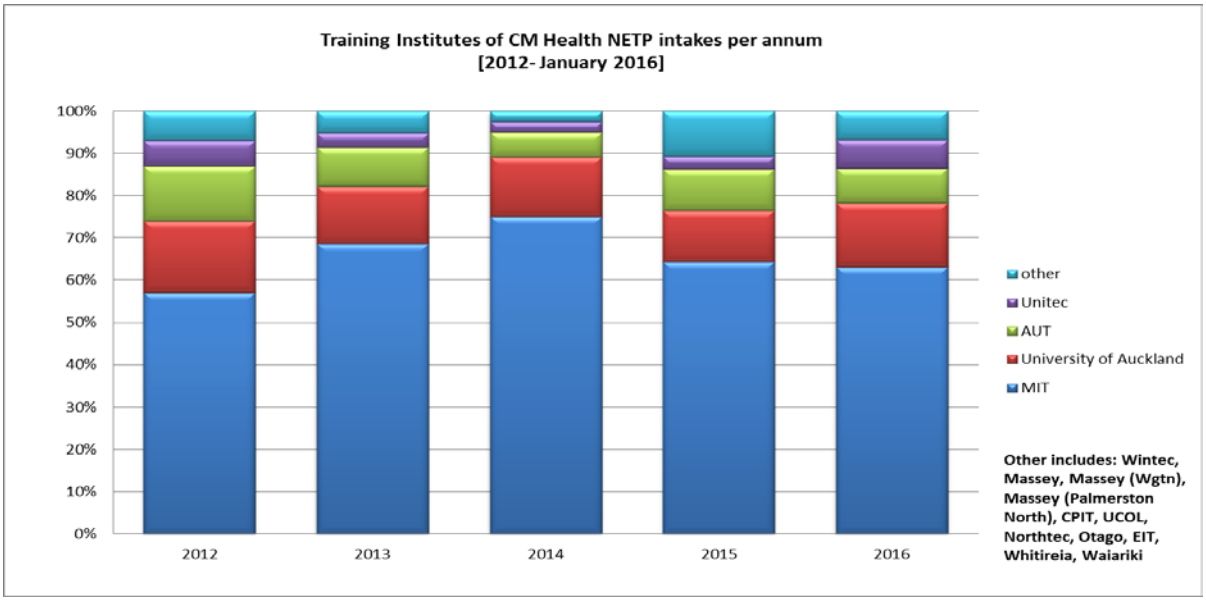
As the nationally agreed process, obtaining a funded NETP or NESP position in New Zealand can only occur via the ACE Nursing system. Graduates apply and provide their application documents through a centralised portal, the ACE website. Applicants can apply to up to three employers they are interested in working for. This information forms the 'talent pool'.

Employers (DHB and other health employers) review applications, interview applicants that align with their criteria and shortlist applicants they would like to employ. Employers provide ACE with details of NETP/NESP vacancies, and a list of their preferred applicants.

Finally, ACE uses an iterative algorithm process to 'best match' applicant's preference of employer with the employer's preference of applicant. This is intended to ensure graduates receive the best possible job offer, and maximise the number of graduates who receive job offers.

Full details of the ACE Nursing programme process can be found here https://nursing.acenz.net.nz/
Currently, at CM Health there are two main intakes processes per year (January and September), with a smaller May intake also used to capture applicants still seeking employment. Total intake numbers at CM Health have been gradually increasing, with the largest intake in January. Graduates come from a variety of tertiary institutes; however, the majority are consistently from MIT, followed by University of Auckland.

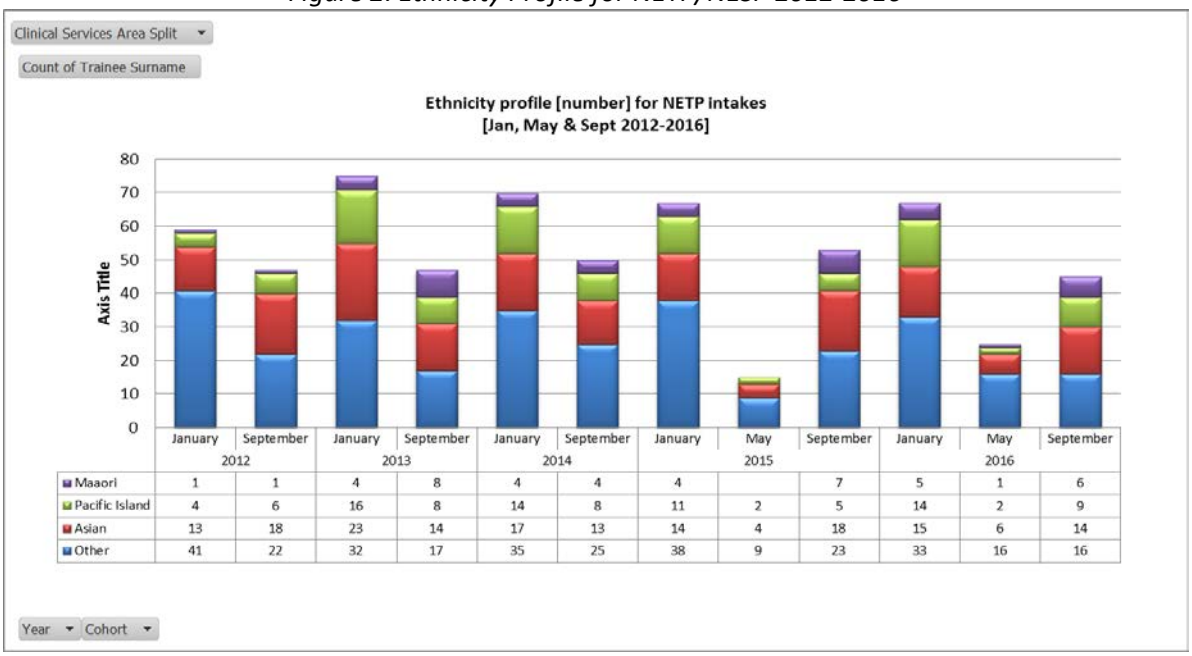
Figure 1: CM Health NETP Intakes by Tertiary Institute (2012-16)



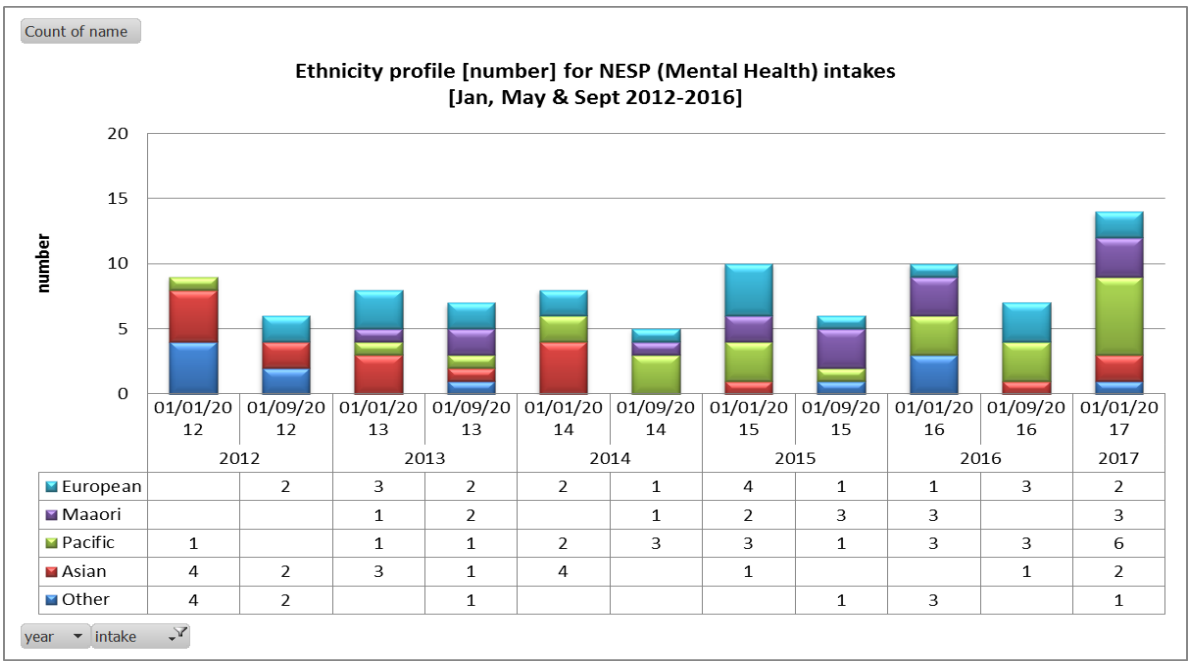
In February 2016, the HWNZ Workforce report noted "In recent years not all nursing graduates have found employment immediately, but workforce planning indicates New Zealand will need to train more nurses by 2017, when retirement among the ageing workforce will become a critical factor."

Ethnic Profile for CM Health NETP Intakes

Figure 2: Ethnicity Profile for NETP/NESP 2012-2016



	January 2012	September 2012	January 2013	September 2013	January 2014	September 2014	January 2015	May 2015	September 2015	January 2016	May 2016	September 2016
Maaori	1	1	4	8	4	4	4		7	5	1	6
Pacific Island	4	6	16	8	14	8	11	2	5	14	2	9
Asian	13	18	23	14	17	13	14	4	18	15	6	14
Other	41	22	32	17	35	25	38	9	23	33	16	16



	01/01/2012	01/09/2012	01/01/2013	01/09/2013	01/01/2014	01/09/2014	01/01/2015	01/09/2015	01/01/2016	01/09/2016	01/01/2017
European		2	3	2	2	1	4	1	1	3	2
Maaori			1	2		1	2	3	3		3
Pacific	1		1	1	2	3	3	1	3	3	6
Asian	4	2	3	1	4		1			1	2
Other	4	2		1				1	3		1

Attracting and appointing graduate nurses who identify as Maaori and Pacific is a priority during any recruitment round for NETP positions.

Total numbers and proportion in the intakes remain relatively small for these for a number of reasons:

(a) New Graduate Candidate and Clinical Area Preferences Prior to Matching:
Areas may give preference to a candidate who had their clinical 'transition' (final) undergraduate placement in the area, after having invested in their work readiness, *OR* candidates may give their preference to the area of their 'transition' (final) placement, meaning priority is given to that area and employer during the 'matching' process.

(b) Availability of Maaori and Pacific Applicants and Candidates
There are much smaller numbers of Maaori students, compared to Pacific and other students enrolled in undergraduate training programmes. Consequently, there are only small numbers of Maaori candidates applying for each graduate intake.

CM Health is 'competing' within greater Auckland region for the same candidates. With region-wide workforce strategies in regards to increasing Maaori and Pacific workforce numbers, these graduate nurses are in demand.

Additional Work to Increase Maaori and Pacific Graduate Nurse Numbers

A Health Equity Campaign-supported project – called 'P.L.U.S.' (Pacific Lagolago U'u lima Savali Faatasi) is currently underway. A Pacific CMN leads the project; with support from other senior Pacific Nurses and the current ward Dedicated Education Units (DEU). This intends to facilitate successful recruitment into NETP at CM Health for these students.

- The project establishes a clinical placement for Pacific nursing students from Year 2 through to transition. The project aims to increase the representation of Pacific nurses in the current workforce by increasing the success rates of Pacific NETP graduates.
- The project also aims to increase the Nursing undergraduate student intake for 2017 from MIT, increase the Pacific Nursing students participation and acceptance of clinical placements, and provide specific coaching and mentoring for these students – Pacific for Pacific.

CM Health is continuously exploring further cultural support and mentorship needs to support Maaori and Pacific graduate nurses throughout their first year of practice, including support from the newly appointed Maaori Nurse Educator appointed to in May 2017, and links to Maaori and Pacific nurse groups and networks within CM Health.

The Nurse Co-ordinator/Educator NETP work closely with Nurse Leaders in Primary Care to recruit Maaori graduate nurses to Primary Care providers.

Additional funding via the Maaori Health team at CM Health is used to support primary care practices to employ Maaori graduate nurses. In 2016/17, funding for 10 Maaori graduate nurses occurred. Sustainability of this additional funding and ongoing employment for these nurses in primary care at completion remains challenging.

Graduate Midwifery Recruitment

The midwifery new graduate programme is highly sought after by new graduates, and is aimed at consolidating the practice of new graduate midwifery specific to the hospital environment. This is a 15-month programme to support the practitioner as they rotate through an antenatal, postnatal and delivery suite setting.

A Midwife Co-ordinator manages the programme and ensures each graduate midwife is supported by a designated preceptor. The programme includes four extra study days, which are pertinent to working in a busy, hospital department. There are usually two intakes (one commencing in January and another in May). There is a Voluntary Bonding Scheme incentive payment scheme that has been introduced by the Government to reward midwifery graduates who agree to work in hard-to-staff areas.

Graduate Allied Health and Scientific Recruitment

Allied Health graduates are recruited to existing suitable vacancies within each service, with the number of graduates employed each year reflecting the current vacancies in the organisation.

Physiotherapy, Occupational Therapy and Speech Language therapy all provide permanent new graduate rotational positions for new graduate staff. These programmes are for up to 2 years, and staff move through various services for 4-6 months each and are provided with additional support and development. This enables graduates to gain a range of experience in their first 1-2 years of practice prior to specialising.

Occupational Therapy and Social Work in Mental Health provides a new graduate programme that includes support to complete a Postgraduate Certificate in Health (Allied Mental Health) through Victoria University - Wellington.

Occupational Therapy, Pharmacy, and Physiotherapy also provide advanced rotations for more experienced staff. Dieticians are in the process of developing rotational positions. All staff has regular professional supervision, and there is a commitment to on-going education. Strong links with professional bodies are maintained through the professional leaders. Links with tertiary providers are strengthened by a robust student placement scheme for these professions.

Maaori and Pacific applicants are prioritised for recruitment; however, the available graduate numbers applying for positions remain low (refer workforce data at the start of report).

A particular challenge facing this workforce is that school students are typically unaware of the wide range of health careers. The majority think only of medicine or nursing, or of well-known allied health professions such as Physiotherapy or Social Work. For some professions, such as Physiotherapy, the private sector and particularly sports physiotherapy are appealing for many Maaori and Pacific students, who wish to pursue a career in this field rather than work in a DHB.

A number of allied health professions appear on Immigration New Zealand's long-term skill shortage list. Because there are fewer home-grown professionals to fill vacancies in specific professions at present, the percentage of overseas-trained practitioners tends to be high.

Additional Work to Increase our Maaori and Pacific Allied Health Numbers

(a) Diversifying Allied Health Workforce
A Health Equity Campaign project; with a focus on four priority professions who are under-represented for Maaori and Pacific staff (Physiotherapy, Occupational Therapy, Dietetics, and Pharmacy). The aim is to engage better with Maaori and Pacific secondary school students, their whaanau /family groups, and career advisors to encourage them to pursue Allied Health training and careers.

Activities planned for 2017 include: a Careers Advisers Day (July), an Allied Health workforce expo (September 2017), and focus groups with AUT Physiotherapy and Occupational Therapy undergraduates.

(b) Mentoring Pacific and Maaori Physiotherapy Students
A pilot is underway, led by a Pacific Physiotherapist. It involves a mentoring group consisting of four "Fono" (meetings) will take place throughout 2017. The pilot is for 4th year Pacific and Maaori physiotherapy students on clinical placements at CM Health. Students are provided with additional support for placements, mentoring around CV writing and interviewing skills, links to ongoing training, and guidance to the recruitment process.

Strategic Action for a Diverse Workforce to Reflect the Counties Community:

In addition to the profession specific initiatives outlined above, CM Health has a clear strategic direction that includes a diverse workforce, and this is outlined in our People Strategy and action plan documents.

A number of broader organisational, regional and national programmes support this intent, including:

(a) Regional initiatives to support the future health workforce pipeline include the CM health secondary school Health Science Academies (Tangaroa College, De la Salle College, Alfriston College), Pacific Healthcare heroes, Kia Ora Hauora (also a national programme).

(b) Programme W&AT! -the "Working & Achieving Together" Programme (programme W&AT) is a regional collaboration to pathway Pacific students into the health workforce. This initiative is to assist Students to be more "employment ready" for the DHBs and PHOs and to be strong candidates for employment. An important part of this support is 1:1 mentoring for students, specifically final year Pacific Health Students from AUT University, University of Auckland, Manukau Institute of Technology, Massey University, and Unitec.

(c) Financial Scholarships: There is also a variety of national scholarships to provide financial assistance for Maaori and Pacific students via HWNZ, Te Pou, Le Va and other organisations.

Further information, targeted initiatives and measures can be provided by the Recruitment, Building Capability team, the Maaori and Pacific Health teams and are captured in the CM Health Annual Plan documents. National workforce information and plans are available via the Ministry of Health website – including links to the HWNZ taskforces, regional training hubs and workforce forecasts and modelling.

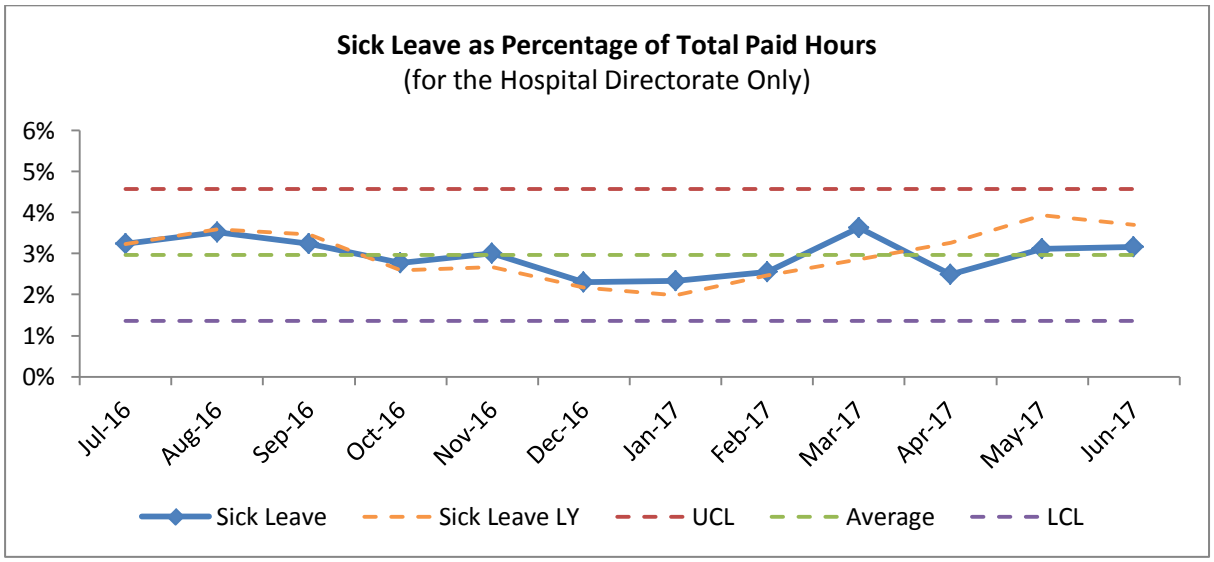
http://www.health.govt.nz/publication/health-health-workforce-report-2015

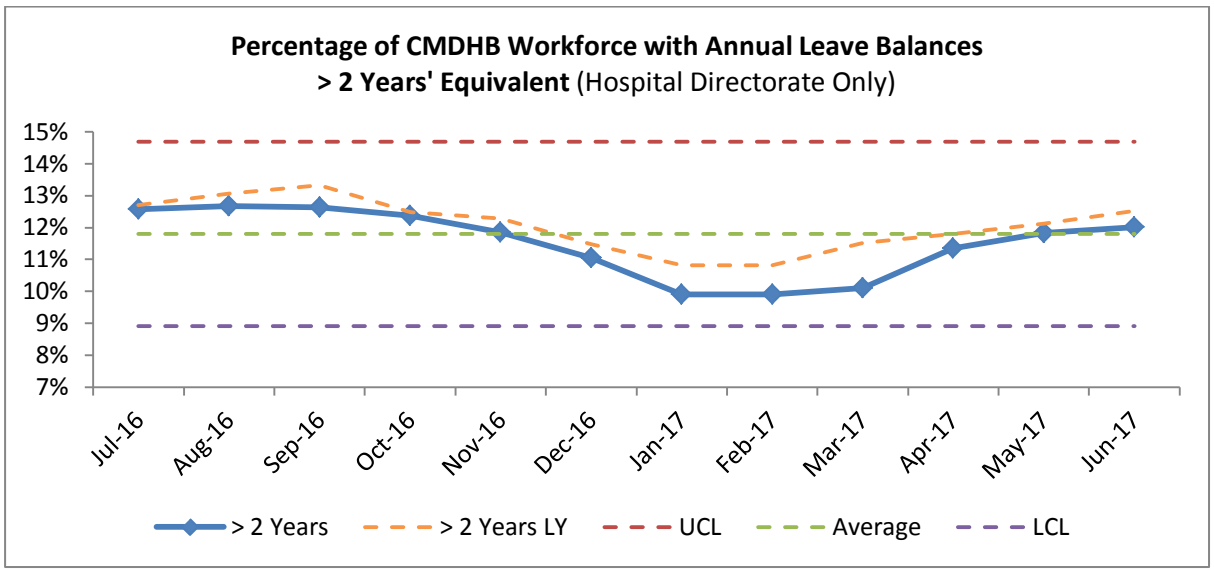
Appendix 2 - Certification Maturity Matrix

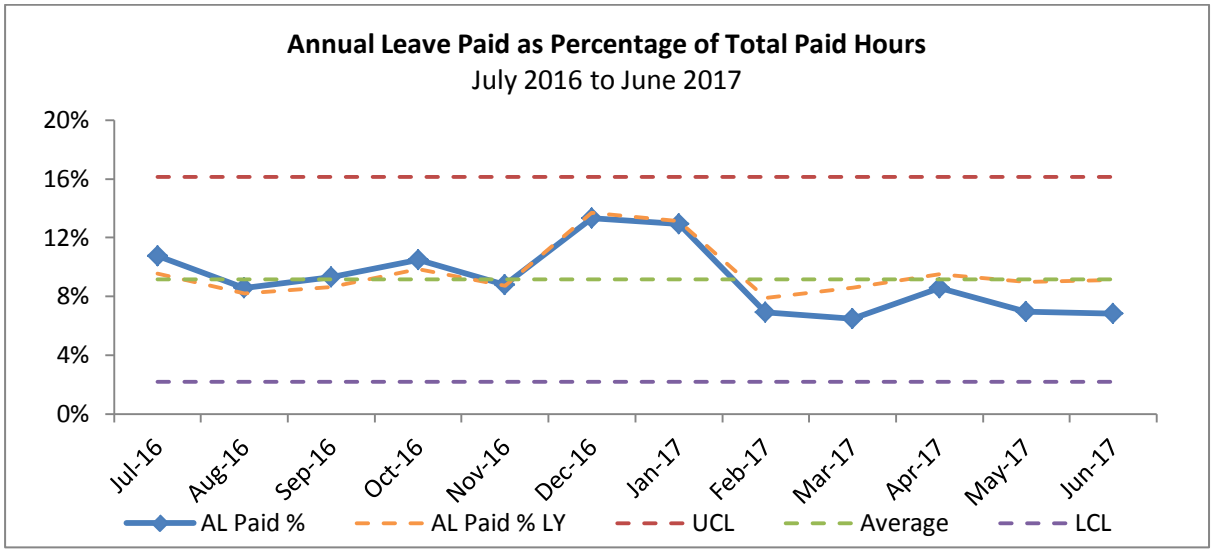
HDSS Certification Standards (Correlated with the IOM Quality Dimensions)	Environment				
	Chaos (Non- compliant)	**Repeatable (Partial compliance)**	**Defined (80% Compliant)**	**Managing (Fully Compliant)**	**Optimising (Continuous Improvement)**
Consumer rights (*Equitable, Safe, Effective, People Centred)	The consumer is incidental to processes and purpose. Lots of complaints and incidents. Lots of external inquiries	Recognition of the importance of consumer feedback but bad apple approach to solutions.	Consumer feedback actively responded to and sought and beginning use for service/system improvement.	Consumer feedback used strategically to inform service quality and delivery. Solutions target the system.	Co design and patient/whaanau partnership. Consumer expectations exceeded – voted best health care system in Australasia
Organisational Management (*Safe, Efficient, Effective, People Centred)	Ad hoc and reactive. Lots of variation in practice. No organisational focus on quality or structure	Beginning to organise for quality service delivery. Compliance culture developing.	Robust policies and procedures guide practice. Some move made to continuous improvement culture. Benefits of Certification as a quality tool recognised	Performance aligned to strategy and best practice with striving to achieve more. Certification is used as a quality improvement framework	Judged a High Performing and High Reliability Organisation by consumers and peers.
Continuous Service Delivery (*Timely, Safe, Efficient, Effective, People Centred)	No visibility of performance or management of end to end processes. Hit and miss access for consumers	Some use of data and plans to inform and guide performance. Some system improvement occurring. Limited understanding of causes of variation.	Routine capture and utilisation of data for performance improvement. Causes of variation better understood. Access for consumers improved.	Comprehensive use of outcome data for CI. Preventative action taken. Access less of a problem. More drive for quality improvement at a system level	All care is measured and delivered according to the 3 R's. Consumers have seamless access to care. Inequality of outcome continuously reduced. 0 waste.
Safe and Appropriate Environment (*Accessible, Safe)	Culture of acceptance/tolerance of patient harm as part of care. When mistakes happen we either hide them or blame others	We realise some harm is occurring and punish the person responsible. Little understanding of systems theory	Recognition of the role of systems theory. Some preventative action applied to known hazards.	Greater focus on prevention. Routine use of system thinking and RCA. Strong focus on patient safety. Reduced clinical variation	'0 patient harm'. Culture of inquiry and systems thinking. Activity is preventative rather than fixing problems that occur.
Summation of quality position **STEEEP**	Fails to meet certification and other Best Practice Standards. Tolerance for poor quality. We don't really have a problem with quality	Partial compliance and plan developed to improve on known problems. We are beginning to understand why we have a quality problem	Some regular audit occurring and remedial activity. Largely compliant with standards. We understand why we have quality problems and are on to it	Fully compliant with standards. Robust self-audit feeding into service improvement. Lots of preventative activity. Low tolerance for poor quality.	Consistently achieves Continuous Improvement ratings. We don't have a quality problem. We anticipate and prevent poor quality from occurring.

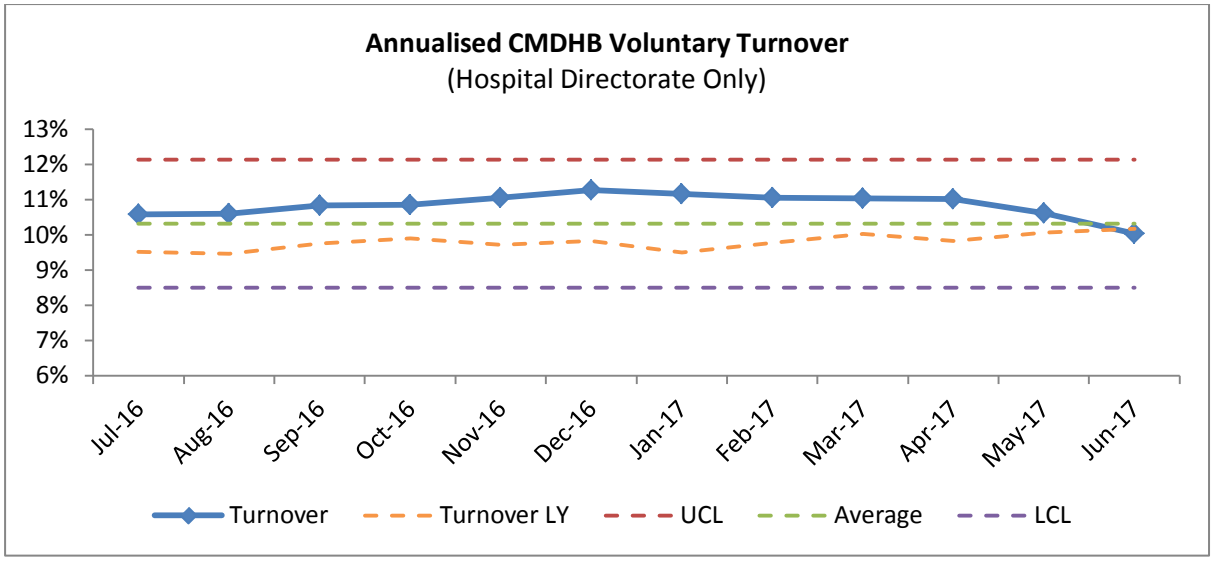
Human Resources (HR)

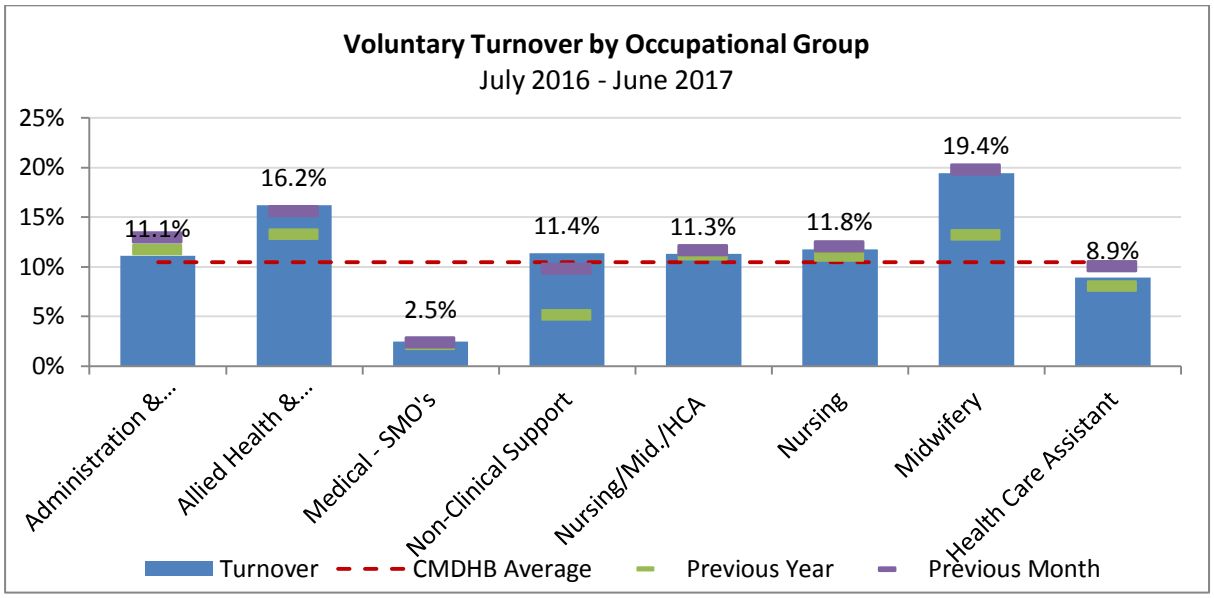
HR metrics are provided to outline performance for Annual Leave Balances, Sick Leave and Turnover rates. Below are the 12 month trend graphs to June 2017.

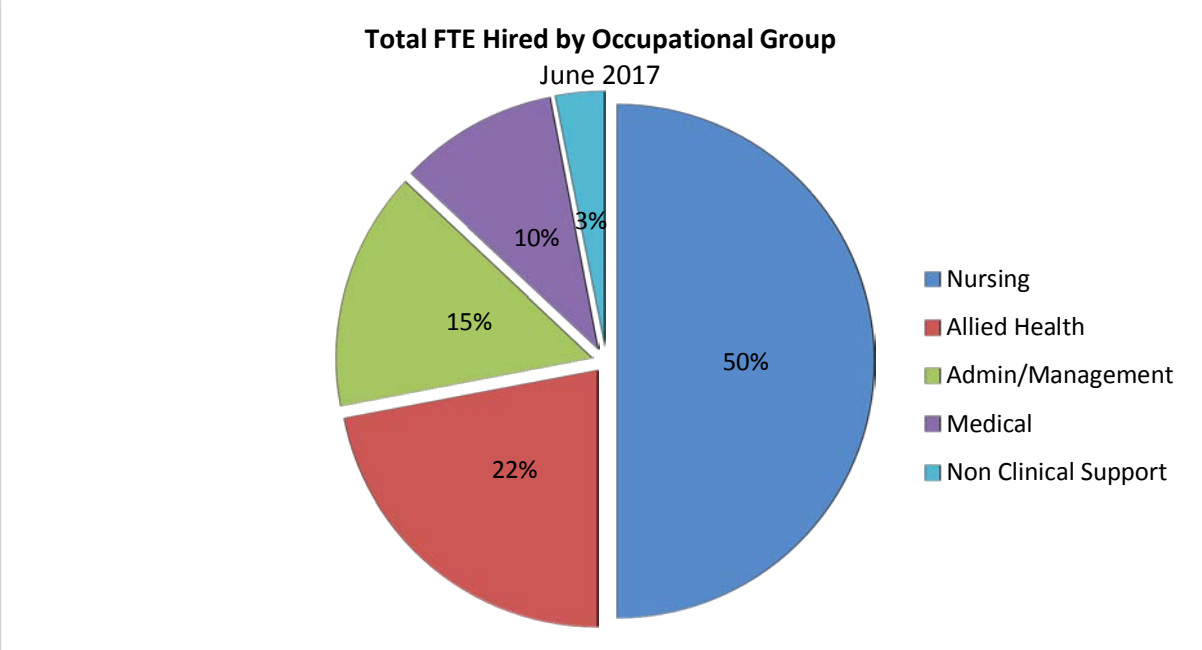


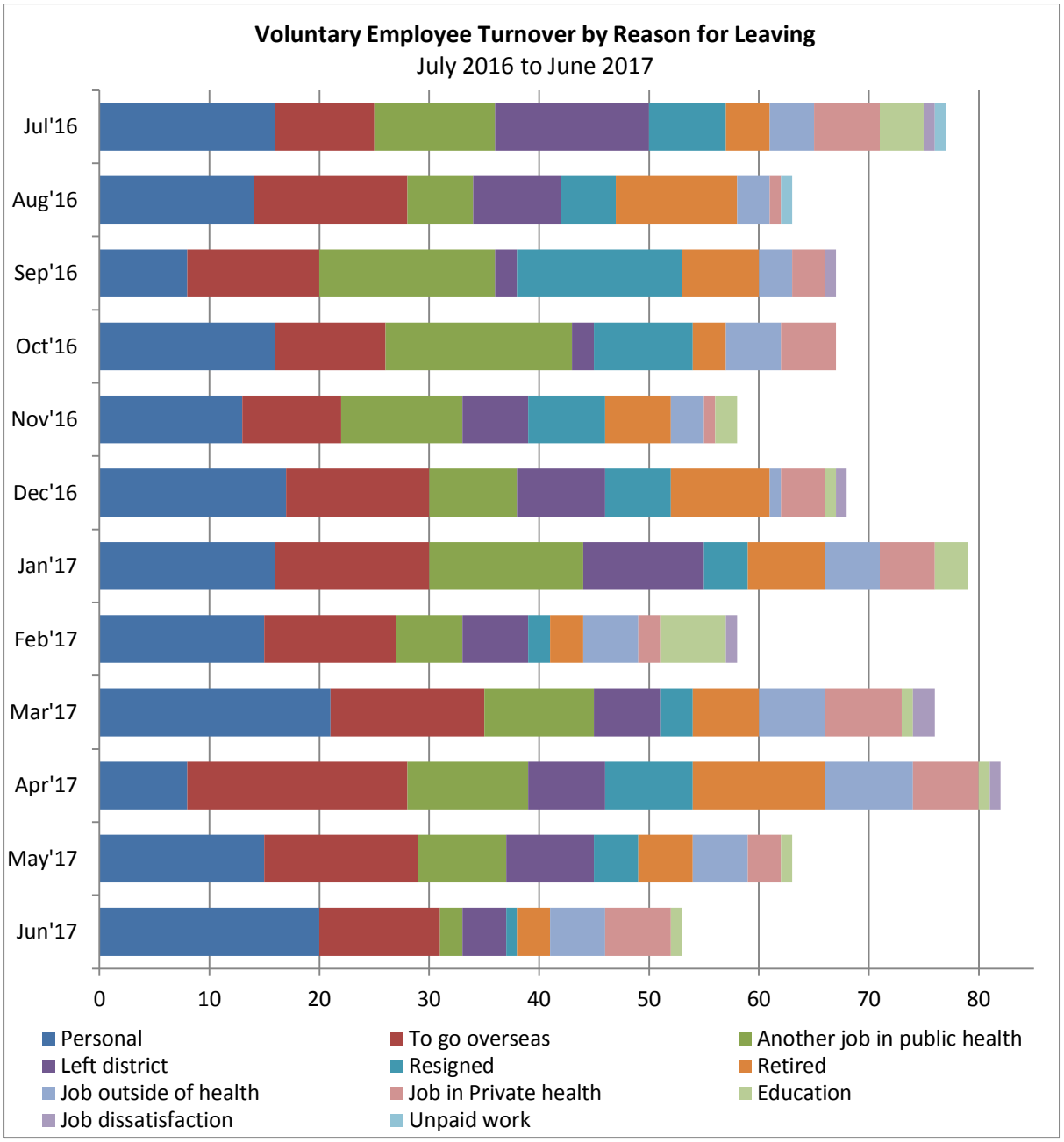





Annualised CMDHB Voluntary Turnover
(Hospital Directorate Only)
13%
12%
11%
10%
9%
8%
7%
6%
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Turnover
Turnover LY
UCL
Average
LCL


Voluntary Turnover by Occupational Group
July 2016 - June 2017
25%
20%
15%
10%
5%
0%
11.1%
16.2%
2.5%
11.4%
11.3%
11.8%
19.4%
8.9%
Administration &...
Allied Health &...
Medical - SMO's
Non-Clinical Support
Nursing/Mid./HCA
Nursing
Midwifery
Health Care Assistant
Turnover
CMDHB Average
Previous Year
Previous Month


Total FTE Hired by Occupational Group
June 2017
50%
22%
15%
10%
3%
Nursing
Allied Health
Admin/Management
Medical
Non Clinical Support


Voluntary Employee Turnover by Reason for Leaving
July 2016 to June 2017
Jul'16
Aug'16
Sep'16
Oct'16
Nov'16
Dec'16
Jan'17
Feb'17
Mar'17
Apr'17
May'17
Jun'17
0
10
20
30
40
50
60
70
80
Personal
To go overseas
Another job in public health
Left district
Resigned
Retired
Job outside of health
Job in Private health
Education
Job dissatisfaction
Unpaid work

Counties Manukau District Health Board
Hospital Advisory Committee
2016/17 Non-Financial Summary Q4 Report

Recommendation

It is recommended that the Hospital Advisory Committee:

Note that this Q4 Summary Report was approved by ELT on 22 August 2017.

Note the results for Q4 progress against planned 2016/17 actions and performance expectations.

Review the identified issues and associated actions.

Note that the companion Northern Region Health Plan Quarterly summary report provided by the Northern Regional Alliance for Quarter 4 2016/17.

Prepared and submitted by Kitty Neill, Planning Advisor on behalf of Margie Apa, Director Population Health, Strategy and Investments.

Glossary
CVDRA –Cardiovascular Risk Assessment
ED – Emergency Department
FCT – Faster Cancer Treatment
MOH – Ministry of Health
WCTO – Well Child Tamariki Ora

Purpose

To provide a summary picture of how we are progressing against our planned commitments outlined in the 2016/17 CM Health Annual Plan.

Significant Achievements

Overall, we have performed well in meeting our commitments outlined in our 2016/17 Annual Plan for Q4. In summary:

- Raising Healthy Kids Health Target – as a result of the referral system now being fully implemented, performance against this new health target improved from 29% in Q1 to 98% in Q4, with equity across all ethnicity groups. This means that 98% of children in Counties Manukau who are identified as obese in their Before School Check (B4 School Check) are being referred to a health professional for a clinical assessment and family based nutrition, activity and lifestyle interventions.
- Smokefree- both the Better Help for Smokers to Quit Primary and Maternity Health Targets have been met equitably for all ethnicity groups.
- Faster Cancer Treatment (FCT)- Although the 85% June 2017 target has not been met (final MOH data shows a result of 78% for the period January to June), actual performance has shown an improvement since March, with results in March, April and June being at or above 85% (performance in May was at 78%).

  To note is that as of 1 July 2017, the FCT target will increase from 85% to 90%; however, the target definition at this time will also change. Currently, breaches can be attributed to patient choice, clinical consideration, or capacity constraints. When the new target takes effect, only those relating to capacity constraints will be counted as breaches. Accordingly we expect our performance against the target to improve in 2017/18, despite the increase to 90%.

Key Issues

Not all targets have been met due to differing factors:

- Emergency Department (ED) 6 hour Health Target - Volumes over the winter quarter have presented a significant challenge and the 6 hour Health Target has not been achieved for the first time since the target was introduced in 2009. During June, ED presentations totaled 10,336, a 9.9% increase over June 2016 volumes. Higher patient volumes across the system have impeded patient flow throughout the hospital, which in turn has meant our ED has been unable to process patients within the target timeframe.

  A range of initiatives are underway to address underlying system challenges and manage demand including: increasing staff to optimize capacity at the Manukau Super Clinic, cancelling outpatient appointments, utilising areas that can accommodate additional beds, and many staff providing additional cover out of hours. Long term, consideration is being given to ensuring there is sufficient capacity available next winter.

- Immunisation Health Target – the immunisation at 8 month Health Target has not been met with an end of year result of 94% for the total population and 89% for Maaori. A further 24 babies were required to be immunised on time by 30 June 2017 in order to have met this end of year target.

  To try and address low Maaori coverage rates, in Q1 2017/18 a targeted strategy "Awhi mai" is being piloted. This aims to educate and support mothers/ caregivers on immunisations from 6 weeks to 4 years through Well Child Tamariki Ora (WCTO) and is supported by referral into Whanau Ora services. The aim is to increase engagement with a "health home" and that that babies are immunised on time at GP practice or in the home.

- Stroke services – As anticipated, there has been a drop in performance against the stroke service KPIs while the integrated acute stroke and rehab ward is established. As previously reported, in early December, the Acute Stroke Unit moved to a new 12-bedded ward which will eventually become an integrated acute and rehab stroke ward. As forecasted in earlier reporting, the current configuration has caused performance against key stroke indicators to deteriorate as stroke unit capacity is reduced. It is anticipated that bed capacity will increase to 20 beds by end of Q2 2017/18 and performance against the indicators will therefore improve.

CM Health 2016/17 Quarter 4 Health Target Snapshot

COUNTIES MANUKAU HEALTH	Shorter stays in Emergency Departments	Improved access to Elective Surgery	Shorter waits for Cancer Treatment	Increased Immunisation	Better help for Smokers to Quit Primary	Better help for Smokers to Quit Maternity	Raising Healthy Kids *
Quarter 1, 2016/17	96%	110%	76%	94%	89%	86%	29%
Quarter 2, 2016/17	96%	108%	74%	94%	89%	89%	62%
Quarter 3, 2016/17	95%	107%	75%	94%	89%	Not available**	91%
Quarter 4, 2016/17		107%	78%	94%	92%	90%	98%
Achieved		✓			✓	✓	✓
National goal	95%	100%	85%	95%	90%	90%	95%

* New health target for 2016/17 with data provided from the MOH quarterly (for previous six month period)
** Due to ongoing issues with the Maternity Clinical Information System (MCIS), results for the maternity smokefree target were not available in Q3. The issue has now been resolved.

CM Health 2016/17 Quarter 4 Summary Progress Report

Dashboard Key			
Yellow = Outstanding	Green = Target Achieved	Orange = Partially Achieved	Red = Not Achieved

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2016/17 Quarter 3					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
National Health Targets										
2.3.3	**Cancer**	Percentage of patients receiving 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 two weeks	Quarterly	**85%**	78%					The target has not been met in Q4 with a MOH result of 78% (result based on six month retrospective data for January - June 2017). Performance has improved by 3% since last quarter. Actual performance has shown an improvement since March, with results in March, April and June being at or above 85% (performance in May was at 78%).
2.3.5	**Elective Surgery**	Volume of elective surgery will increase by at least 4000 discharges per year	Quarterly	**Increase of 4,000 discharges per year**	107%					
2.3.4	**Emergency Department Care**	Percentage of patients admitted, discharged, or transferred from an ED within six hours	Quarterly	**95%**	92%					Performance has dropped 3% since last quarter with a final result of 92%. Volumes over the winter quarter have presented a significant challenge and the 6 hour Health Target has not been achieved for the first time since the target was introduced in 2009. During June, ED presentations totaled 10,336, a 9.9% increase over June 2016 volumes. Higher patient volumes across the system have impeded patient flow throughout the hospital, which in turn has meant our ED has been unable to process patients within the target timeframe. A range of initiatives are underway to address underlying system challenges and manage demand including increasing staff to optimize capacity at the Manukau Super Clinic, cancelling outpatient appointments, utilizing areas that can accommodate additional beds, and many staff providing additional cover out of hours. Long term, consideration is being given to ensuring there is sufficient capacity available next winter.

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2016/17 Quarter 3					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
2.1.1	**Immunisation**	Percentage of eight months olds who have had their primary course of immunisation on time	Quarterly	**95%**	94%	89%	96%	92%	98%	The definition of the eight month immunisation health target requires that 95% of all eligible children aged eight months are immunised and that significant progress for the Maaori population group and, where relevant, the Pacific population group has been achieved. The 95% target was almost achieved for the total population (and was exceeded for our Pacific and Asian population groups). A further 24 babies were required to be immunised on time by 30 June 2017 in order to have met this end of year target. The coverage target was not met for Maaori (89%). Performance for Maaori has improved since Q1, but has dropped slightly between Q3 and Q4 (Maaori coverage rates Q1:86%, Q2:89%, Q3: 91%, Q4:89%). At the end of Q4, a further 31 Maaori babies needed to be immunised on time to meet the 95% health target. In Q1 2017/18 a targeted strategy "Awhi mai" is being piloted. This aims to educate and support mothers/ caregivers on immunisations from 6 weeks to 4 years through WCTO and is supported by referral into Whanau Ora services. The aim is to increase engagement with a "health home" and that that babies are immunised on time at GP practice or in the home.
2.2.5	**Smoking (primary)**	Percentage of enrolled patients who smoke and were seen by a health practitioner in general practice and were offered brief advice and support to quit smoking	Quarterly	**90%**	92%	91%	92%	94%	93%	The Better Help for Smokers to Quit Primary Care Health Target has been met equitably for all ethnicity groups. Performance improvements reflect PHOs' sustained focus on this target and PHOs have continued to work with their low performing practices and to provide additional resources to support these practices. In line with the 2017/18 Regional SLM Improvement Plan, a key focus for the Smokefree team is now on increasing the cessation support rates (CM Health currently had the lowest total population cessation support rate in Metro Auckland in Q1 2016/17. Auckland DHB: 24.7%, Waitemata DHB: 32.9%, CM Health 24.4%).
2.2.5	**Smoking (maternity)**	Percentage of pregnant women who identify as smokers, at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer, being offered advice	Quarterly	**90%**	90%	92%				The Better Help for Smokers to Quit Maternity Health Target has been met equitably for total and Maaori population groups (other ethnicities not reported). Issues with the Maternity Clinical Information System have now been resolved.

AP Ref.	Priority	Indicator		Frequency of reporting	Current Target	Performance – 2016/17 Quarter 3					Commentary / Interpretation
						Total	Maaori	Pacific	Other	Asian	
		and support to quit smoking									
2.2.2	**Raising healthy kids**	Percentage of obese children identified in the Before School Check (B4 School Check) programme will be referred to a health professional for a clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017		Quarterly	**95%**	98%	99%	99%	95%		CM Health has met the Raising Healthy Kids health target in Q4, with equity across all ethnicity groups. The focus is now on the proportion of whaanau who are declining the offer of a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions. The overall rate of referrals being declined in CM Health in Q4 was 24% (national average 29%). There has been a decrease in the proportion of Maaori families declining referrals (Q4:33%, down from 40% in Q3). Pacific declines are the lowest at 18%. Activity aimed to reduce the number of declines includes decline notification letters being sent to GPs to notify them with a child has been identified as being >98th centile and the parent/caregiver has declined a referral, quarterly audit of declines, and focus groups to investigate reasons for declines.
MOH Quarterly Reporting Performance Indicators											
2.2.6	**Mental health and addictions**	PP6: Improving the health status of people with severe mental illness through improved access		Six-monthly							
		PP7: Improving mental health services using transition (discharge) planning and employment	Child and Youth	Quarterly	**95%**	95%					The child and youth target has been achieved this quarter which illustrates substantial improvement since Q4 2015/16 (84.4%).
		PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds - Mental Health (Provider Arm)	<3 weeks	Quarterly	**80%**	74.3%					The percentage of 0-19 year olds who accessed services within three weeks is below target, but has improved 2.1% since Q2. Though the percentage is below target, it is still higher than both the regional (72.8%) and national (69.0%) results. Also to note is that the corresponding percentage for the 12-19 age group is 81.1% Further, the number of unique CMDHB domiciled clients aged 0-19 seen during the year ended 30 September 2016 was 6,335, an increase of 2% from the 6,292 unique clients seen in the corresponding
			<8 weeks	Quarterly	**95%**	94.8%					

AP Ref.	Priority	Indicator		Frequency of reporting	Current Target	Performance – 2016/17 Quarter 3					Commentary / Interpretation
						Total	Maaori	Pacific	Other	Asian	
											period last year. Actions to improve performance include: i. Detailed NHI linked review of referrals not meeting the wait time targets in the 0-29 age group. This has revealed a number of instances where there are discharge coding issues that have contributed to the performance outcome. This will be reviewed in more detail and support given to the service to improve the accuracy of their discharge coding. ii. CM Health is participating in the national Child Adolescent Mental Health Service discussions regarding the review of this performance measure.
		PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds Addiction (NGOs)	<3 weeks	Quarterly	**80%**	94.4%					
			<8 weeks	Quarterly	**95%**	99.3%					
2.3.8	**Oral Health**	PP12: Utilisation of DHB-funded dental services by adolescents from School Year 9 up to and including age 17 years		Annual	**85%**	72%					Note result is as at December 2016. This target has not been achieved and there has been no improvement in utilisation rates since December 2015 (73%). Note that 72% is above both the national performance result (70%) and the Northern Region result (69%). Identified barriers to achieving this target include: resistance by some schools in the Counties Manukau to host Mobile Dental Clinics and that an estimated 2,500 people in the 9-17 age bracket (predominately aged 16-17) are outside of the secondary education system and therefore are not engaged by school-based engagement programmes. Actions being taken to improve performance moving forward include: CM Health continues to advocate for increased numbers of schools hosting Mobile Dental Clinics, the Auckland Regional Dental Service (ARDS) will meet with the MOH Oral Health team in September 2017 to devise engagement strategies for reaching out to young people who are classified as NEET (Not in Education, Employment or Training).
2.2.1	**Long Term Conditions**	PP20: Long term conditions/DCIP		Quarterly							

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2016/17 Quarter 3					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
2.2.4		PP20: Diabetes - Improved management (HbA1c)	Quarterly							
2.2.3		PP20: Cardiovascular (CVD) health (CVD Risk Assessment – previous health target)	Quarterly	**90%**	92%	89%	91%	93%		There was a 1.9% increase in CVDRA rate for Maaori since Q3 however there remain ongoing differences in performance between Maaori and other ethnicities. The CVDRA rate for Maaori men aged 35-44 for Q4 is 73%. There has been very little movement in the assessment rate for this population group over the last year, with results ranging between 72.1% and 73.3%. Given that equity of coverage has not been achieved yet, our DHB and PHOs have committed to a number of actions regarding this measure under the 2017/18 Maaori Health Plan. For example, all of our PHOs provide monthly reporting to their practices regarding this measure. We use prioritised ethnicity reporting for this; with Maaori and Pacific coverage reported at the top of the page. We believe regular feedback and the use of good quality data is integral to meeting this target. PHOs also continue to share innovative ways of thinking in order to reach high risk populations. For example, practices with high numbers of Maaori men aged 35-44 were identified by PHOs and have together discussed strategies to improve coverage. For example, appointment scanning (if these men are attending with family members), using Test Safe data, and opportunistic screening at urgent care appointments. Work in this area is also supported by the inclusion of CVDRA for Maaori and CVD management as contributory measures under the Amenable Mortality SLM for 2017/18.
2.2.3		PP20 Acute Coronary Syndrome - Percentage of high-risk patients who receive an angiogram within 3 days of admission ('day of admission' being 'Day 0')	Quarterly	**70%**	74%	66%	60.%	77%	84%	Performance has dropped since Q1 (Q1 results - Total: 76%, Maaori: 86%, Pacific: 78%) and Maaori and Pacific are now below target. Feedback from the cardiology service is that this is most likely as a result of Maaori and Pacific patients being more likely to present later (for example after having had three bouts of chest pain rather than one) and with higher rates of co-morbidities and clinical complexity. Plans for a second catheter laboratory (discussed further in relation to intervention rates (SI4) below) remain in progress, which would help to increase

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2016/17 Quarter 3					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
										capacity and timeliness of angiograms.
		PP20 Acute Coronary Syndrome - Percentage of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days	Quarterly	**95%**	99%	100%	98%	99%	100%	
2.3.2		PP20: Stroke - Percentage of potentially eligible stroke patients thrombolysed	Quarterly	**6%**	11%					
		PP20: Stroke - Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	Quarterly	**80%**	68%					Performance against this measure dropped (Q1:83%. Q2:79%, Q3:81%). As previously reported, in Early December, the Acute Stroke Unit moved to a new 12-bedded ward which will eventually become an integrated acute and rehab stroke ward. As forecasted in earlier reporting, the current configuration has caused performance in this KPI to deteriorate as there in no ability to accommodate more patients in this unit. Therefore, patients are required to outlie in a medical ward. However, we anticipate bed capacity to increase to 20 beds by end of Q2 2017/18.
		PP20: Stroke – Percentage of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission (also report % of acute stroke patients transferred to inpatient rehab)	Quarterly	80%	63%					Performance against this measure has dropped 5% since Q3. In addition to the above comments, it has been identified that there were a high number of patients under the age of 65 with severe strokes and high levels of impairment. Some of these patients were staying in excess of 40 days at the inpatient stroke rehab ward. This has impeded flow of acute patients to the rehabilitation ward; thus, impacting this timeliness measure. Work continues with clinical teams to identify inpatient rehabilitation options to increase capacity. Further to this, the unprecedented acute load experienced in May and June may have impacted on the stroke service's ability to achieve this target for transfer patients to inpatient rehabilitation in a timely manner.
2.1.1	**Immunisation**	PP21: Percentage of two year olds who are fully immunised	Quarterly	**95%**	95%	90%	97%	93%	98%	Note that Maaori immunisation coverage for this age group has remained relatively stable over 2016/17

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2016/17 Quarter 3					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
										ranging between 89% and 92%. See comments under the Increased Immunisation Health Target for strategies targeted to increasing Maaori coverage.
		PP21: Percentage of five year olds who are fully immunised	Quarterly	**95% by June 2017**	92%	89%	94%	91%	92%	The five year immunisation coverage rate for all ethnicities have improved over 2016/17 (Q4 2015/16 results: total: 88%, Maaori: 83%, Pacific: 88%, Other: 88%) although disparities by ethnicity are still present. The gap to meet the target of 95% is 74 children of which 9 are European, 36 are Maaori, 5 are Pacific and 13 are "Other".
2.3.1	**System integration**	PP22: Improving system integration	Quarterly							
2.3.7	**Health of Older People**	PP23: Improving Wrap Around Services - Health of Older People	Quarterly							Note that all Health of Older People targets were achieved, with the exception of the two interRAI measures. In Q4, only 26% of complex patients were seen within 5 working days of referral for a home care assessment (target 65%) and 67% of non-complex patients were seen within 15 working days of referral for a contact assessment (target 70%). The Locality team has recently mapped the patient journey for complex patients and identified a number of administrative blockages in the referral pathway which have led to delays in the provision of timely home care assessment. Next steps identified to address these blockages include: increasing resources to remove service co-ordination and administration tasks from the assessors to improve capacity; monitor work practices to ensure assessments are closed off as completed in a more timely manner; and continue to monitor intake and triage to ensure minimal delay in getting referrals to the assessors.
2.1.8	**Mental Health**	PP25: Prime Minister's Youth Mental Health Project	Quarterly							
2.2.6		PP26: The Mental Health and Addiction Service Development Plan	Quarterly							
2.1.3	**Child Health**	PP27: Delivery of the Children's Action Plan	Quarterly							

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2016/17 Quarter 3					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
2.1.2	**Rheumatic Fever**	PP28: Hospitalisation rates (per 100,000 total population) for acute rheumatic	Quarterly	**6.1 per 100,000 (Total)**						
2.1.2		PP28: Reducing rheumatic fever – facilitating the effective follow up of identified rheumatic fever cases	Quarterly							
2.3.6	**Improving waiting times for diagnostic services**	PP29a: Coronary angiography – within 3 months (90 days)	Monthly	**95%**	96%					
		PP29b: CT –within than 6 weeks (42 days)	Monthly	**95%**	95%					
		PP29c: MRI – within 6 weeks (42 days)	Monthly	**85%**	80%					Performance has improved 8% since Q2 (72%). CM Heath is in the process of planning for additional MRI capacity at the Middlemore site due on stream in Q2 2018. Demand continues at a high level and a combination of outsourcing and additional weekend sessions is assisting in addressing the difference between demand and the current capacity to produce. The Radiology service has recently had 2 MRI technicians return from long leave and the team is working to capacity.
		PP29d: Urgent diagnostic colonoscopy – within two weeks (14 days)	Monthly	**75%**	97%					
		PP29e: Diagnostic colonoscopy – within six weeks (42 days)	Monthly	**65%**	63%					Performance has improved from 56% in Q3. There continues to be a significant growth rate in gastroenterology demand, with 20% increase in referrals for colonoscopies in 2016 and an unprecedented 33% growth from January to March 2017. There were also a number of events/issues in 2016/17 which impacted on CMH's ability to maintain targets. Events impacting on productivity include a number of SMO vacancies and SMO maternity, sabbatical and annual leave resulting in a loss of capacity. Further, the recent increase in demand for acute procedures, due to the increased inpatient occupancy over winter, has reduced the ability to do elective procedures. Mitigation plans to deal with reduced capacity and increased demand include: the recruitment to two

AP Ref.	Priority	Indicator		Frequency of reporting	Current Target	Performance – 2016/17 Quarter 3					Commentary / Interpretation
						Total	Maaori	Pacific	Other	Asian	
											SMO positions, instigating new contracts with new SMOs allowing for additional payment for increased availability to cover vacant lists, give short-term/casual contracts whenever possible to additional endoscopists, and setting up additional lists in vacant capacity whenever possible in-house including weekend lists if possible. Outsourcing to private providers has now been completed, with 550 colonoscopies being outsourced.
		PP29f: Surveillance colonoscopy - within twelve weeks (84 days) beyond the planned date		Monthly	**65%**	96%					Performance has improved significantly since Q3 (61%). This can be attributed to increased capacity through the recruitment of the two new SMOs and a further SMO returning from sabbatical leave.
2.3.3	**Faster Cancer Treatment**	PP30a: FCT - Length of time taken for patients to receive their first treatment (or other management) for cancer from date to decision-to-treat (31 day indicator)		Quarterly	**85%**	88%					Performance has remained steady from Q3 at 88%.
		PP30b: All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy from decision to treat		Quarterly							
2.2.5	**Better help for smokers to quit (previous health target)**	PP31: Percentage of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking		Quarterly	**95%**	96%	96%	97%	96%		
2.3.5	**Inpatient length of stay**	OS3: Inpatient length of stay	Elective LOS	Quarterly	**1.59 days**	1.61 days					Performance sustained since Q3 (improved since Q1 and Q2, 1.64 days). Work continues to address outliers in General surgery and Orthopaedics.
3.3.3			Acute LOS	Quarterly	**2.60 days**	2.64 days					Acute length of stay has increased in Q4 (Q1:2.58, Q2:2.60, Q3:2.60).
7.1.2	**Data Quality**	OS10: NHI and data submitted to National Collections		Quarterly							
		National Collections		Quarterly							
		PRIMHD:		Quarterly							
7.1.3 2.3.5	**Ambulatory sensitive (avoidable) hospital admissions**	SI1: Ambulatory sensitive (avoidable) hospital admissions		Six-monthly	**3,600 per 100,000 population**						

AP Ref.	Priority	Indicator	Frequency of reporting	Current Target	Performance – 2016/17 Quarter 3					Commentary / Interpretation
					Total	Maaori	Pacific	Other	Asian	
	Service Coverage	SI3: Ensuring delivery of Service Coverage	Six-monthly							
	Electives	SI4: Elective services standardised intervention rates *(major joints, cataracts, cardiac surgery, percutaneous revascularisation & coronary angiography)*	Quarterly							Performance has improved since Q3 in the angiography and angioplasty categories as a result of heightened activity and no equipment issues. The business case for a second catheter laboratory is being considered at the regional Service Review Group forum after presentation by Northern Regional Alliance and the Cardiac Network regarding regional Catheter Laboratory capacity and future investment. The funding decision for the second Catheter Laboratory remains in progress.
	Whaanau Ora	SI5: Delivery of Whānau ora	Annually							
2.2.6	**Mental Health**	OP1: Mental health output delivery against plan	Quarterly							
2.7	**Patient Experience**	DV4: Improving patient experience - Proportion of patients who have rated CMH overall experience of care and treatment as 'Very Good' or 'Excellent'	Quarterly							
	CFA	**B4 School Check Funding**	Quarterly							
	CFA	**DSS Funding**	Quarterly							
	CFA	**Well Child Tamariki Ora Services**	Quarterly							
	CFA	**Green Prescription**	Quarterly							
	CFA	**Electives Initiative and Ambulatory Initiative**	Quarterly							
	CFA	**Appoint Cancer Nurse Coordinators**	Annual							
	CFA	**Appoint cancer psychological and social support workers**	Annual							
	CFA	**Immunisation coordination service**	Annual							
	CFA	**National Immunisation Register (NIR) Ongoing Administration Services**	Quarterly							
	HS	**Supporting delivery of the NZ Health Strategy**	Quarterly							

Northern Regional Health Plan Quarter 4 Summary Report

Key achievements this quarter include:

- **Child Health** - The Skin Infection Prevention Primary Care Pathway has been published, key messages agreed and resources tested in primary care sites with evaluation.
- **Health of Older People** –The Northern Region led the development and production of a suite of national dementia education and training resources for primary health care professionals (in partnership with the other three regions). The Dementia E-Learning Toolkit is the first of its kind in New Zealand and provides clinical education points for Doctors and Nurses. Officially Launched in March 2017 the toolkit has been well received with a total of 393 users during Q4 April to June including 141 Doctors, 187 Nurses and 65 Other health workforce.
- **Cancer -** Local delivery of Herceptin volumes at CMH have now reached expected volumes and planning for local delivery of Herceptin at WDHB is well advanced, with a mid-July commencement planned
- **CVD**
    - Regional Catheter Lab planning continues to progress with interim plans to manage service requirements at both NDHB and CMH being developed, whilst long term plan options are reviewed.
    - The implementation of the GoodSAM app is progressing along with national initiatives to increase awareness and training for CPR across the country and increase access to AEDs
- **Diabetes**
    - The West Auckland QI co-ordinator role and initiative presented by Janine Strickland was awarded a Prize for Innovation at the recent New Zealand Society for the Study of Diabetes meeting (NZSSD). This project was initially undertaken by the Diabetes network.
    - A mental health pilot project, undertaken in conjunction with the MOH, supporting people with poorly controlled diabetes to access mental health services is delivering positive results in Northland. A full evaluation will be published in September.
    - Two healthy lifestyle manuals, 'Tackle Diabetes' and 'Tackle Pre-Diabetes', written by Dr Catherine McNamara have recently been published. These manuals, providing a six part action plan for managing Type 2 Diabetes and Pre-Diabetes, have been well received by the network. The primary care liaison members are particularly keen to see these made widely available to GP practices across the region.
- **Mental Health and Addictions**
    - Proposed SACAT Model of Care for the Northern Region completed and forwarded to Ministry as requested.
    - 120 people attended a Clinical network day for PIMH Services.
    - Stocktake completed of Mental Health and Addiction uptake of e-referrals and workplan identified for 2017/18 to progress web-based referrals and intra-referrals.
- **Stroke**
    - Implementation of the Centralised Stroke Hyperacute After Hours Model of Care, is on track to commence 24 July 2017, commencing with the West Auckland population.
    - Stroke services in the Northern Region continues to exceed the KPI target of 80% patients admitted to a dedicated stroke bed which is now over four consecutive quarters, indicating a sustainable trend
- **Youth -** The surveys which are part of the Regional Standards for Quality Care for Adolescents and Young Adults in Secondary or Tertiary Care tool kit are now available electronically. Engagement continues with the DHBs, the renal service at CMDHB has picked up the standards along with the sexual health service at ADHB. The standards have also been added to the Centre for Youth Health Point page.
- **Hepatitis C** –
    - From Jan to June 2017, 281 patients were diagnosed as being Hep C positive through RNA/PCR testing from a total of 824 tests performed and represent a positive rate of 34.1%. This gives confidence that the vulnerable populations are being targeted as the positive rate for the general population is only 1.1%.
    - New cases scanned from January to June 2017 has increased to 283 from 94 cases in the previous six months
- **Health Equity -** Work is progressing with Dementia Auckland, the Maori Health teams and Researchers at the University of Auckland to work to develop a Northern Regional Maori Dementia Plan. This will support the development of the national Dementia resources for Maori and the delivery of culturally appropriate dementia training at local marae. The Region intends to extend this joint project to Pacific carers and families in the 2017-2018 year.
- **Health Quality & Safety** - HQSC led a regional workshop for the medication safety leads in May which provided opportunities for DHBs to share and learn from each other and to understand what priorities were being worked on at each DHB.

- **Workforce**
  - The regional psychiatry registrar project "Improving Recruitment of New Zealand Trainees to the Psychiatry Registrar Training Programme - Auckland Metro Region" is now completed. The report and findings have been accepted and focus has now shifted to implementing the recommendations.
  - CMH was the principle sponsor for Te Kahu Korako: Maori Health Leadership Summit which was hosted by Te Rau Matatini, over three days in May. Around 1,000 Maaori leaders attended the event which focused on; growing and sustaining Maori Health Leadership, Rangatahi Leadership and Practice Development Addictions Sector. Around 1000 Maaori leaders attended the event.
- **Information Systems**
  - The Executive Overview of ISSP" has been completed with the RGG approving the contents on the 1 June. The Programme has subsequently refocused upon updating and finalising the ISSP and ISSP Annex.
  - The Northern Region continues to increase use of the eReferrals solution. Across the metro DHBs over 1,100,000 eReferrals have now been received since go live. 100% of GP practices are eligible to send eReferrals using the regional solution.
- **Capital** - Continuation of the Northern Region Long Term Investment Plan. The region has agreed a high level 'regional network' model to inform a proposed future state. This model is being used to develop counterfactuals and financial models to inform decisions about a preferred regional investment path.

NZ Health Strategy – Regional highlights for the quarter				
People - powered	**Closer to home**	**Value and high performance**	**One team**	**Smart system**
The Region has begun work with Dementia Auckland, the Maori Health teams and Researchers at the University of Auckland to develop a Northern Region Maori Dementia Plan, supporting the development of the national Dementia resources for Maori and the delivery of culturally appropriate dementia training at local marae. The Region intends to extend this joint project to Pacific carers and families in the 2017-2018 year.	Service redesign work continues with the aim of ensuring Primary Care and Retinal Screening/Podiatry Services have the capability and capacity to provide quality services to people living with diabetes, especially high risk and vulnerable populations.	There has been a significant change in the mix of patients that Auckland DHB's Liver Transplant Unit manages. This is a direct result the increasing role of primary care in the treatment and ongoing management of patients with Hepatitis C. This has been mirrored in the utilisation of liver elastography scanning which continues to increase in referrals from primary care directly. The unnecessary burden on First Specialist Appointments for the non-complex liver cases is reducing freeing capacity to deal with complex patients.	The primary care pathway for the identification and management of children following head injury (not requiring hospital admission) has been piloted with ACC funding attached to the primary care SCAT 3 assessment. ACC is determining whether it will provide funding for the SCAT3/5 assessment to be implemented nationally, alongside the pathway	Shared electronic records, data repository and central diabetes register are all being worked towards as part of the Diabetes SLAT activity occurring in the three metro Auckland DHBs.

The table below shows progress against the top 10 commitments

On track	Some concerns regarding progress to target	Not achieved or declining performance

	Commitment	Status	Notes
1	Achieve and maintain the National		National targets were achieved with regard to 'Improved

	Commitment	Status	Notes
	Health Targets		access to elective surgery'; and 'Raising healthy kids' and 'Better help for smokers to quit – maternity'. National targets substantially achieved with regard to: • 'Shorter stays in ED' (94% on target of 95%) • 'Better help for smokers to quit - primary' (achieved 87.7% against a target of 90%) • 'Increased Immunisation' (achieved 92.8% against a target of 95%) • 'Faster Cancer Treatment' (achieved 84.8% against a target of 85%).
2	Child Health continue to reduce SUDI deaths to ≤ 0.4 SUDI Deaths per 1,000 Maori live births		The Primary Care Pathway has been published and the Safe Sleep Calculator is being tested in primary care sites with evaluation
3	75% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 24 months		83% of LT HBSS clients have received an interRAI clinical assessment within the previous 24 months (as of Mar 2017)
4	85% of patients receive their first cancer treatment or other management within 31 days from decision to treat		Note: 1 quarter data lag Achieved 88.7%
5	Lift proportion such that 30% of bowel investigations are CTC; consistent with the Regional Colonoscopy Plan and Bowel investigations Programme Business Case		Note: 1 quarter data lag In the Jan to Mar quarter, CTC rates remained at or around 20% for the region.
6	80% of patients presenting with ST elevation myocardial infarction (STEMI) referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes[1]		The Northern Region is slightly below the target this quarter at 76.4%. This is largely due to NDHB and WDHB results for this quarter.
7	80% of diabetes patients to have good or acceptable glycaemic control (HbA1c≤64)		Reports from Jan 2017 indicated 71% of patients have good or acceptable glycaemic control, which is similar to the previous 6 months. The latest report, due end of July; will confirm any improvement in this target.
8	90% of discharges from adult mental health services receive post discharge community care (within 7 days)		68.2% for last 3 months: 69.2% YTD National average 65% YTD
9	80% of patients who have a stroke are treated in a stroke unit		The Northern Region achieved 79% for stroke patients treated in a dedicated stroke unit for the period Jan-Mar 2017.
10	Reduce unintended teen pregnancies		There is evidence of an ongoing reduction in termination rates and a reduction in the number of teen pregnancies.
Equity Priority			
EP	Equity (which will be an emphasis across each clinical network area of work) involving identification of equity issues in the areas of priority regional focus, and developing plans to address the gaps identified.		The Region has identified equity issues in all clinical network groups and has developed actions that aim to address these issues in the 2017/28 Regional Plan

[1] There may be some variation for patients from NDHB due to geographical isolation and dependence on emergency helicopter transport.