# Counties Manukau District Health Board
## Hospital Advisory Committee Meeting Agenda

**Wednesday, 8 March 2017 at 1.00pm – 4.30pm, Room 107, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
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<tr>
<td>1.00 – 1.30pm</td>
<td>1. Welcome</td>
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<td>1.30 – 1.45pm</td>
<td>2. Governance</td>
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<td></td>
<td>2.1 Attendance &amp; Apologies</td>
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<td>2.2 Disclosure of Interests/Specific Interests</td>
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<td>2.3 Confirmation of Public Minutes - 30 November 2016</td>
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<td>2.4 Action Items Register</td>
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<td>1.45 – 2.00pm</td>
<td>3. Information Papers</td>
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<td>2.00 – 2.15pm</td>
<td>3.1 Q2 Non-Financial Summary Report (Marianne Scott)</td>
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<td>3.2 Acute Spinal Service Report (Phillip Balmer)</td>
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<td>2.15 – 3.30pm</td>
<td>4. <strong>Provider Arm Performance Report</strong> (Phillip Balmer)</td>
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<td></td>
<td>4.1 Executive Summary/Responses to Action Items</td>
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<td>4.2 Balanced Scorecard</td>
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<td>4.4 Finance Report</td>
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<td>4.8 Adult Rehabilitation &amp; Health of Older People</td>
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<td>4.12 Facilities &amp; Asset Management</td>
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<td>4.13 Director Patient Care, Chief Nurse &amp; Allied Health Professions Officer</td>
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<td>3.45 – 3.50pm</td>
<td>5. <strong>Resolution to Exclude the Public</strong></td>
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<td>3.50 – 4.10pm</td>
<td>6. <strong>Confidential</strong></td>
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<td>6.1.1 National Inpatient Experience Survey November 2016</td>
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**Afternoon Tea Break**

**Next Meeting: 19 April 2017**
**Room 107, Ko Awatea, Middlemore Hospital, Otahuhu**
# BOARD MEMBER ATTENDANCE SCHEDULE – HAC 2017

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<tr>
<th>Name</th>
<th>Jan</th>
<th>Feb</th>
<th>8 Mar</th>
<th>19 April</th>
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<td>Catherine Abel-Pattinson (Deputy Chair HAC)</td>
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| Dr Lester Levy (Board Chair)               | • Chairman, Waitemata District Health Board (includes Trustee Well Foundation, ex-officio member).  
• Chairman, Auckland District Health Board  
• Chairman, Auckland Transport  
• Chairman, Health Research Council  
• Chairman, Regional Governance Group, Northern DHBs  
• Independent Chairman, Tonkin & Taylor  
• Adjunct Professor of Leadership, University of Auckland Business School  
• Head, New Zealand Leadership Institute, University of Auckland  
• Lead Reviewer, State Services Commission, Performance Improvement Framework  
• Director & Sole Shareholder, Brilliant Solutions Ltd  
• Director & Shareholder – Mentum Ltd  
• Director & Shareholder – LLC Ltd  
• Trustee, Levy Family Trust  
• Trustee, Brilliant Street Trust |
| Dr Ashraf Choudhary                        | • Board Member, Otara-Papatoetoe Local Board  
• Member, NZ Labour Party  
• Chairperson, Advisory Board Pearl of Island Foundation  
• Co-Patron, Bharatiya Samaj Charitable Trust |
| Catherine Abel-Pattinson (HAC Deputy Chair) | • Board Member, Health Promotion Agency  
• National Party Policy Committee Northern Region  
• Member, NZNO  
• Member, Directors Institute |
| Dianne Glenn                               | • Member, NZ Institute of Directors  
• Member, District Licensing Committee of Auckland Council  
• Life Member, Business and Professional Women Franklin  
• Member, UN Women Aotearoa/NZ  
• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust  
• Life Member, Ambury Park Centre for Riding Therapy Inc.  
• Vice President, National Council of Women of New Zealand |
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<tr>
<th><strong>Dr Lyn Murphy (HAC Chair)</strong></th>
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<th><strong>Rabin Rabindran</strong></th>
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<td>• Justice of the Peace</td>
<td>• Chairman, Primary ITO</td>
<td>• Chairman, Bank of India (NZ) Ltd</td>
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<td>• Member, Pacific Women’s Watch (NZ)</td>
<td>• Independent Director, Motor Trade Association</td>
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<td>• Member, Auckland Disabled Women’s Group</td>
<td>• Director, Dekra NZ Ltd (VTNZ)</td>
<td>• Director, Solid Energy NZ Ltd</td>
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<td>• Director, Swift Energy NZ Ltd</td>
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<td>• Chairman, Courier Solutions Ltd</td>
<td>• Director, Swift Energy NZ Holdings Ltd</td>
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<td>• Chairman, The Lines Company Ltd</td>
<td>• Director, Kowhai Operating Ltd</td>
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<td>• Chairman, Armstrong Motor Group (Advisory Board)</td>
<td>• Director, NZ Liaoning International Investment &amp; Development Co Ltd</td>
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<td>• Chairman, Signum Holdings Ltd (Trust Codes)</td>
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**HOSPITAL ADVISORY COMMITTEE MEMBERS' REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS**

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 8 March 2017

<table>
<thead>
<tr>
<th>Director having interest</th>
<th>Interest in</th>
<th>Particulars of interest</th>
<th>Disclosure date</th>
<th>Board Action</th>
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<tr>
<td>Dr Lyn Murphy</td>
<td>Allied Health Initiative for Education &amp; Development (AHIED)</td>
<td>Senior Lecturer, AUT School of Inter-Professional Health Studies</td>
<td>30 November 2016</td>
<td>That Dr Murphy’s specific interest be noted. The Committee agreed that she may remain in the room and participate in any discussion but be excluded from any voting, if applicable.</td>
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Minutes of Counties Manukau District Health Board Hospital Advisory Committee

Held on Wednesday, 30 November 2016 at 9.00 – 12.30pm, Room 107, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

Present: Dr Lee Mathias (Board Chair), Dr Lyn Murphy (Committee Chair), Ms Dianne Glenn, Ms Colleen Brown (Deputy Committee Chair) and Ms Kathy Maxwell.

In attendance: Mr Geraint Martin (Chief Executive), Ms Margaret White (Deputy Chief Financial Officer, Hospital Services), Mr Martin Chadwick (Director Allied Health), Mr Phillip Balmer (Director Hospital Services) and Ms Dinah Nicholas (Secretariat).

Apologies: Ms Sandra Alofivae, Apulu Reece Autagavaia, Mr David Collings, Mr George Ngatai, Ms Wendy Lai, Dr Gloria Johnson, Mr Brad Healey, Ms Denise Kivell and Ms Kerry Bakkerus.

1. **Welcome**

   The Chair welcomed everyone to the meeting.

2. **Governance**

   2.1 **Attendance & Apologies**

   Noted.

   2.2 **Disclosure of Interest/Specific Interests**

   The Disclosures of Interest were noted with no amendments.

   Dr Murphy noted a specific interest in relation to Item 3.2 on today’s agenda.

   2.3 **Confirmation of Public Minutes (19 October 2016)**

   **Resolution**

   That the Public Minutes of the Counties Manukau District Health Board Hospital Advisory Committee meeting held on Wednesday 19 October 2016 were taken as read and confirmed as a true and accurate record.

   **Moved:** Ms Colleen Brown  **Seconded:** Dr Lee Mathias  **Carried:** Unanimously

   2.4 **Action Item Register Public**

   Noted.
3. Reports


Overall we have performed well in meeting our commitments outlined in our Annual Plan for Q1.

- Diagnostic – all three of the colonoscopy wait time targets were met with MoH feedback acknowledging ‘exceptional recent achievement’.
- FCT – up 2.1% from Q4 15/16. The ‘patient choice’ factor is still not resolved however, MoH are actively paying attention to this and looking at an appropriate percentage.
- 8-month immunisation – while the target was almost achieved for the total population, the coverage target declined by 4% since 30 June 2016 for Maaori to 86%. It is estimated that 64 Maaori babies were not immunised on time. An analysis of the reasons behind the late immunisations was undertaken in order to eliminate equity gaps and better understand how we can assist Maaori whaanau with the immunisation decision and accessing services. This led to insights that we need to personalise our services to proactively engage Maaori mothers who we identify as being at high risk of late/missed immunisation to make them feel important and valued, as well as improve the communication between different service providers who have contact with these mothers pre and post-natal to build consistent relationships.

- Bowel screening – CM Health has been advised by MoH that we will begin screening in 2018 as one of the two DHBs to immediately follow the rollout at Hutt Valley and Wairarapa DHBs. This is excellent news for the Counties population.
- Acute coronary syndrome - % of high risk patients who receive an angiogram within 3 days of admission – it was noted that the Asian category is sitting at 59% for Q1 v target of 70%. It was felt that this would probably not be all Asian communities, it would likely be a particular sub-group (ie) Indian, as they seem to have a predisposition for CVD. A new Asian Health Gain Advisor has just been employed who will work alongside the services to support them in looking at any disparities for our Asian communities. Mr Balmer agreed to look into these numbers and report back with a break-down of them. Mr Andrew Kerr to attend a meeting in the New Year (date tbc) to give an overview of the cardiac network.

3.2 AHIED Initiative (Martin Chadwick)

The paper was noted and taken as read.

3.3 Inpatient Experience Survey (Dr David Hughes)

Survey No. 8 focussed on the organisation’s Values for the second year. They are an essential part of providing great care and a great experience at work and are directly linked to the quality of patient care and health outcomes.

Together - there has been a statistically significant five-point decrease in the percentage of patients who say that administrative staff always talk to them about their condition and treatment in ways that make it easy to understand. There has also been a three percentage point drop in patients who say administrative staff listen to what they had to say. Dr Hughes and Ms Kivell are picking up this piece of work and will look at whether there are things that we should be doing to turn this around.

Kind – a patient comment about the lack of pulling curtains when nurses or doctors examined her was noted. The pulling of curtains needs to be reinforced as basic good health care.
4. **Resolution to Exclude the Public**
   Individual reasons to exclude the public were noted.

**Resolution**
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 as detailed in the above paper.

**Moved:** Ms Kathy Maxwell   **Seconded:** Dr Lee Mathias   **Carried:** Unanimously

10.00am Public Excluded session.

10.09am Open meeting resumed.

5. **Hospital Services Directorate Report**

5.1 **Executive Summary/Health Targets** (Phillip Balmer)
   Mr Balmer to arrange a Board visit of the Discharge Lounge in the New Year.

5.2 **Balanced Scorecard**
The report was noted and taken as read.

5.3 **Human Resources**
The report was noted and taken as read.

5.4 **Responses to Action Items**
The report was noted and taken as read.

5.5 **Finance Report**
The report was noted and taken as read.

6.5.1 **Clinical Supplies**
   Ms White took the Committee through a deep dive presentation into Clinical Supplies.

5.6 **EC, Medicine & Integrated Care**

Breastscreen – the Mangere sub-site is operational again with a mammography machine being relocated from MSC with screening recommencing on 26 September. This is an excellent site for the screening of priority women for the BSA programme. A new machine has been installed at MSC. Mr Balmer to report back (21 June) with an update on the issues associated with why it is so difficult for Maaori & Pacific women to get their breast screening done – September results show Maaori (182 v target of 269), Pacific (298 v target of 370).

Dr Erica Whineray Kelly’s controversial new technology to treat cancer was discussed. This is a new way of giving radiation which studies have shown is cheaper, has fewer side effects and reduces recovery time. Intraoperative Radiation Therapy (IORT) is just one hit of radiation during surgery instead of a course of doses after surgery. It could be effective for a third of all breast cancers but it is fiercely controversial within the field of radiation oncology. The professional body which sets standards, the Royal Australian and New Zealand College of Radiologists, opposes it saying it needs more data before IORT can be
recommended but that is at odds with its own Breast Special Interest Group which supports IORT for selected patients. The MoH is currently investigating implementing it into the public system.

**Emerging Issues:**

**Sleep Service**
Pressure is rising in relation to equipment and consumables. The service has been managing the financial pressure through limited purchase of CPAP machines and associated consumables however, this is now causing issues for existing and new patients accessing equipment. The service is looking at new ways to meet rising demand and the high risk of budget overspend is being closely monitored.

**Creation of a General Medicine Floor (and separation of subspecialties)**
There is general agreement across Medicine to the creation of a dedicated General Medicine floor and the separation of subspecialties. It is anticipated that the GM floor will be implemented before the end of the 2016 calendar year.

5.7 **Surgery, Anaesthesia & Perioperative Services (Mary Burr)**

Acute WIES was 4.59% higher than contract for the month and 3.32% over YTD. Elective WIES was 1.79% higher than contract for the month and 3.18% YTD. Overall, outputs were 117 WIES over contract for the month and 324 WIES YTD. Compared to last year, overall WIES is 2.61% up YTD.

**Emerging Issues:**

**Anaesthetic Technician (AT) Shortage** – the AT shortage continued to bite in September however, we have improved the workforce and have more trainees now that have come out and are on the floor. Another group of trainees commence training in February. We have also included a new alternative workforce in this of RN Anaesthetic Assistants which will make us less vulnerable with this workforce.

**Ophthalmology**

**Workforce:**
- A new Ophthalmologist starts next week who will see FSAs 4-days a week which will create follow-up to be seen by the current Ophthalmologist.
- Two further Ophthalmologists are in the recruitment pathway.
- Two Optometrists with advanced practice are completing their training on 16 December and will then be on-boarded.
- Currently recruiting two clinical nurse specialists.
- Fully utilising our continued relationship with Auckland University and student placements in 2017.

**Facilities:**
- Fully utilising the Saturday clinics.
- New equipment is due to arrive in mid-January to go into the newly expanded L3 Galbraith training centre. The long term plan is the Module 6 expansion.

All follow-ups have been triaged and the urgent patients are being booked in immediately.
5.8 Women’s Health & Kidz First (Nettie Knetsch)

September continued with the very unusual winter pattern for children, both in presentations to ED and inpatient admissions - there were 341 few presentations to ED and 129 fewer inpatient admissions. Early analysis shows the greatest variance between 2015 and 2016 was children with viral infections and acute bronchiolitis but no major variation in WIES of LOS. Of particular interest was the decrease of 55 Pacific children with these diagnoses. This has also seen admissions in the <1-year olds decrease to 21% (from 23%) with Pacific babies dropping from 30% to 27% YTD.

(Mr Chadwick arrived at 11.55am)

5.9 Director of Midwifery (Nettie Knetsch)

The CM Health midwifery workforce is starting to wobble again due to retirements and being replaced with a younger workforce who have families. We will continue with our long term strategies and partnership with AUT with a focus on growing the midwifery pipeline for the Counties area. ADHB & WDHB are also experiencing an increase in vacancy rates.

The imminent closure of the community midwifery clinic at ETHC Otara was noted. Ms Knetsch was asked to look into the reasons behind the pending closure as a lot of work was undertaken to ensure that this population group had access to midwifery services.

5.10 Adult Rehabilitation & Health of Older People (Dana Ralph-Smith)

The Specialised Rehabilitation & Community Wellness Business Case has been approved by the Board and has commenced going through a northern regional approval process.

Spinal –Mr Balmer advised that a paper is being presented to the Regional Governance Group tomorrow in relation to funding. A national price is added on top of every spinal patient for spinal cord impairment ($27k) which Canterbury has been receiving for quite some time. With that, we are still incurring an annual loss of $2.4m. We are also seeing an increase in non-spinal cord impairment patients being referred just because we have the service. Mr Balmer will report back on this next year.

5.11 Mental Health & Addictions
The report was noted and taken as read.

5.12 Director of Nursing
The report was noted and taken as read.

5.13 Director of Allied Health
The report was noted and taken as read.

5.14 Facilities
The report was noted and taken as read.
6. **Presentation**

   **6.1 Winter 2016 Presentation**
   Dr Vanessa Thornton took the Committee through her presentation on Winter 2016.

**Resolution**
That the Hospital Advisory Committee receive the Hospital Services Directorate Report for May 2016.

**Moved:** Dr Lyn Murphy    **Seconded:** Dr Lee Mathias    **Carried:** Unanimously

**General Business**

The Chair acknowledged that this would be Mr Chadwick and Ms Kivell’s last HAC meeting and acknowledged their leadership, passion and commitment to the patient care domain and thanked them for their contributions to this committee.

The meeting closed at 12.50pm. The next meeting of the Hospital Advisory Committee will be **Wednesday, 8 March 2017** at Ko Awatea, Middlemore Hospital.

The Minutes of the meeting of the Counties Manukau District Health Board Hospital Advisory Committee held on **Wednesday, 30 November 2016** are approved.

Signed as a true and correct record on **Wednesday, 8 March 2017**.

(Moved: /Seconded: )

Chair ___________________________ 8 March 2017
Dr Lyn Murphy                    Date
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

### Hospital Advisory Committee Meeting – Action Items Register – 8 March 2017

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<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
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<td>30.11.16</td>
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<td>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.</td>
<td>8 March</td>
<td>Ms White/ Mr Balmer</td>
<td>Refer Item 6.4 on today’s agenda.</td>
<td>✔️</td>
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<td>7.9.2016</td>
<td>5.1</td>
<td>Certification – provide a quarterly report showing progress being made against each corrective action.</td>
<td>8 March</td>
<td>Dr Hughes</td>
<td>Refer Item 6.14 on today’s agenda.</td>
<td>✔️</td>
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<td>30.11.16</td>
<td>6.11</td>
<td>Medicine - Bowel Screening Programme regular update.</td>
<td>8 March</td>
<td>Mr Healey</td>
<td>Refer Item 6.6 on today’s agenda.</td>
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<td>30.11.16</td>
<td>6.1</td>
<td>Hospital Services 16/17 Project Plan - the services have identified 178 initiatives which have been broken down into 4 categories; Transformation, Service Improvement, Business As Usual and Revenue. Updated summaries, including specific bed day savings where applicable and benefits realisations to be reported back on a regular basis using the graph on page 108 as the baseline.</td>
<td>8 March</td>
<td>Mr Balmer</td>
<td>Refer Item 6.1 on today’s agenda.</td>
<td>✔️</td>
</tr>
<tr>
<td>19.10.2016</td>
<td>5.1</td>
<td>Director’s Report - SLM quarterly report</td>
<td>8 March</td>
<td>Mr Balmer</td>
<td>Refer Item 6.1 on today’s agenda.</td>
<td>✔️</td>
</tr>
<tr>
<td>23.3.2016</td>
<td>4.10</td>
<td>Medicine – Intragam – Dr Johnson to talk to the regional Clinical Practice Committee about them undertaking a cost benefit analysis on the efficacy and efficiency of Intragam v what was used before.</td>
<td>8 March</td>
<td>Dr Johnson</td>
<td>Refer Item 6.4 on today’s agenda.</td>
<td>✔️</td>
</tr>
<tr>
<td>27.7.2016</td>
<td>7.6</td>
<td>Director of Midwifery – report back on what the next steps will be on the primary birthing units (location and number) after the MQSP report is signed off by the Ministry.</td>
<td>19 April</td>
<td>Ms Knetsch</td>
<td>Refer Item 6.4 on today’s agenda.</td>
<td>✔️</td>
</tr>
</tbody>
</table>
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DUE DATE</th>
<th>RESPONSIBILITY</th>
<th>COMMENTS/UPDATES</th>
<th>COMPLETE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.10.2016</td>
<td>11.10.2016 (from ELT)</td>
<td>Zero Patient Harm Programme – submit a paper on the success of the Pressure Injury Prevention Programme.</td>
<td>19 April</td>
<td>Dr Hughes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.10.2016</td>
<td>5.12</td>
<td>HR – include a graph on Vacancy Rates by Professional Groups, Hospital &amp; Community.</td>
<td>8 March</td>
<td>Mr Balmer</td>
<td>Refer Item 6.4 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>30.11.2016</td>
<td>3.1</td>
<td>Q1 16/17 Non-Financial Report – report back with a breakdown of the Acute Coronary Syndrome Asian category (59% v target of 70%). Mr Andrew Kerr to give an overview of the cardiac network.</td>
<td>8 March</td>
<td>Mr Balmer</td>
<td>Refer Item 6.4 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>30.11.2016</td>
<td>6.1</td>
<td>Executive Summary – Arrange a Board visit to the Discharge Lounge in the New Year.</td>
<td>8 March</td>
<td>Mr Balmer</td>
<td>To be carried out during the Board induction visit to the hospital.</td>
<td>✓</td>
</tr>
<tr>
<td>30.11.2016</td>
<td>6.6</td>
<td>EC, Medicine &amp; Integrated Care – Report back with an update on the issues associated with why it is so difficult for Maori &amp; Pacific women to get their breast screening done - September result show Maori (182 v target of 269), Pacific (298 v target of 370).</td>
<td>12 July</td>
<td>Mr Balmer/Mr Healey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.11.2016</td>
<td>6.9</td>
<td>Director of Midwifery – Look into the reasons behind the pending closure of the community midwifery clinic at ETHC Otara as a lot of work was undertaken to ensure that this population group had access to midwifery services.</td>
<td>8 March</td>
<td>Mr Balmer/Ms Knetsch</td>
<td>Refer Item 6.4 on today’s agenda.</td>
<td>✓</td>
</tr>
<tr>
<td>30.11.2016</td>
<td>6.10</td>
<td>ARHoP – Spinal. Mr Balmer to report back on a paper that is being presented to the Regional Governance Group tomorrow (1 Dec) in relation to funding. A national price is added on top of every spinal patient for spinal cord impairment ($27k) which Canterbury has been receiving for quite some time. With that, we are still incurring an annual loss of $2.4m. We are also seeing an increase in non-spinal cord impairment patients being referred just because we have the service.</td>
<td>8 March</td>
<td>Mr Balmer/Ms Ralph-Smith</td>
<td>Refer Item 3.1 on today’s agenda.</td>
<td>✓</td>
</tr>
</tbody>
</table>
Recommendation

It is recommended that the Hospital Advisory Committee:

Note that this Q2 Summary Report was endorsed by ELT on 28 February 2017.

Note the results for Q2 progress against planned 2016/17 actions and performance expectations.

Review the identified issues and associated actions.

Note the companion Northern Region Health Plan Quarterly summary report provided by the Northern Regional Alliance for Quarter 2 2016/17.

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

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 Q2. In summary:

• Raising Healthy Kids Health Target – performance against this new health target improved from 29% in Q1 to 62% in Q2. In Counties Manukau Plunket is the B4SC provider, and referrals for clinical assessment and monitoring are being sent to Primary Care. An electronic referral process from B4SC to primary care has been set up and operational since 30 September 2016. With the electronic referral system now operational, we are confident that all referrals from 30 September will be acknowledged and therefore we are on track to achieve the health target. The health target is calculated on six months rolling data, therefore acknowledgement of 100% referrals will not be reflected in our reports until Q4 2016/17.

• National System Level Measures (SLM) and improving system integration – the significant level of integration work underway at CM Health was acknowledged by the MOH as well as CM Health’s progress towards meeting the 2016/17 SLM Improvement Plan milestones.

• Improving the health status of people with severe mental illness through improved access – CM Health has exceeded its 2016/17 access targets for both Maaori and total population groups aged 0 - 64 years.

Key Issues

Not all targets have been met due to differing factors:

• Ambulatory Sensitive Hospitalisations - The ambulatory sensitive hospitalisations (ASH) target for 45-64 year olds was not met in Q2 for our Maaori and Pacific population groups (Pacific: was 9,545/100,000 hospitalisations compared 6,424/100,000 target; Maaori 8,161/100,000 hospitalisations compared 6,029/100,000 target). The total population ASH rate for 45-64 year olds was 4,562/100,000
hospitalisations (compared 6,029/100,000 target). Both CM Health’s Maaori and Pacific ASH rates for 45-64 year olds are more than twice the national rates. Please refer to the 2016/17 Q2 Population Health Plans Covering Paper for further detail and discussion of the high Maaori and Pacific ASH rates and the actions proposed to reduce them.

- **Rheumatic Fever** – CM Health received a “not achieved” rating for the first episode rheumatic fever (RF) measure in Q2. The MOH has expressed concerns about what rapid response services CM Health has had in place from 30 September 2016 to ensure that 80 percent of our at-risk population (4-19 year old Maaori and Pacific and Quintile 5 children and young people) have access to fast and effective sore throat management. Currently approximately 72% of this group can access free care through their enrolled practice. Many of these practices have extended hours and are open on the weekends.

  The DHB has taken the stance of strengthening existing relationships in existing settings through establishing school based clinics and supporting the connection with the medical home rather than setting up separate services for sore throat management. The DHB submitted a refreshed RF plan that explicitly stated we would no longer be funding primary care to be delivering rapid response clinics due to the reduction in funding. This decision was made after consulting widely. Work is underway with ALT to explore opportunities for primary care to can increase access to young people. There is also going to be a focus quality improvement for sore throat management within primary care.

- **Stroke Services** – CM Health has received a “partially achieved” rating for stroke services in Q2. 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. The plan for this ward is to enable all acute stroke patients to be cared for in the one ward and for rehabilitation to commence at the earliest possible point. In the interim, as the capacity in this unit builds, a proportion of patients, when appropriate maybe cohort in general medical wards but receive medical care from dedicated stroke specialists. With this interim configuration there is the potential for performance in the stroke pathway KPI (80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway) and the transfer to inpatient rehabilitation services KPI (80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission) to be negatively affected for a short time.

- **Tobacco Maternity Health Target** – There have been ongoing issues with the MOH electronic records system being piloted at CMDHB in Q2 which appears to have affected the tobacco maternity data in a negative way. The MOH is aware of the issue and members of the smoking cessation (maternity) team are now obtaining the files for identified missing interventions to uncover where the data is being coded so the problem can be rectified.

- **Immunisation health target and immunisation by 5 years** – CM Health has received a “partially achieved” rating for both the immunisation health target (95% of all eligible children aged eight months are immunised) and for the five year immunisation target (95% of all eligible children aged five years are immunised). There continues to be a significant equity gap in Maaori immunisation coverage rates for both measures: 89% of Maaori babies aged eight months have been immunised on time compared with 94% total population, and 85% of Maaori infants aged five years have been immunised on time compared with 91% total population.
### CM Health 2016/17 Quarter 2 Health Target Snapshot

<table>
<thead>
<tr>
<th></th>
<th>Shorter stays in Emergency Departments</th>
<th>Improved access to Elective Surgery</th>
<th>Shorter waits for Cancer Treatment</th>
<th>Increased Initiation</th>
<th>Better help for Smokers to Quit</th>
<th>Better help for Smoking to Quit</th>
<th>Raising Healthy Kids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 3, 2015/16</td>
<td>95%</td>
<td>105%</td>
<td>70%</td>
<td>94%</td>
<td>89%</td>
<td>100%</td>
<td>-</td>
</tr>
<tr>
<td>Quarter 4, 2015/16</td>
<td>96%</td>
<td>109%</td>
<td>74%</td>
<td>95%</td>
<td>92%</td>
<td>100%</td>
<td>-</td>
</tr>
<tr>
<td>Quarter 1, 2016/17</td>
<td>96%</td>
<td>110%</td>
<td>76%</td>
<td>94%</td>
<td>89%</td>
<td>86%</td>
<td>29%</td>
</tr>
<tr>
<td>Quarter 2, 2016/17</td>
<td>96%</td>
<td>108%</td>
<td>74%</td>
<td>94%</td>
<td>89%</td>
<td>89%</td>
<td>62%</td>
</tr>
<tr>
<td>Achieved</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National goal</td>
<td>95%</td>
<td>100%</td>
<td>85%</td>
<td>95%</td>
<td>90%</td>
<td>90%</td>
<td>95%</td>
</tr>
</tbody>
</table>

* New health target for 2016/17 with data provided from the MOH quarterly (for previous six month period)

**Elective Surgery Health Target data follows a delayed timeframe and is therefore not yet available.
# National Health Targets

<table>
<thead>
<tr>
<th>AP Ref.</th>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2016/17 Quarter 2</th>
<th>Commentary / Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total, Maori, Pacific, Other, Asian</td>
<td></td>
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</tbody>
</table>

## 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)

<table>
<thead>
<tr>
<th></th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2016/17 Quarter 2</th>
<th>Commentary / Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>85%</td>
<td>74%</td>
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</tr>
</tbody>
</table>

The target has not been met in Q2 with a MOH result of 74% (target based on six month retrospective data for July - December 2016).

Note that a data discrepancy issue has been identified between internal CM Health data and MOH data, with MOH data not reflecting all patients on the FCT pathway due to a data capture issue. This appears to be negatively affecting our MOH performance results when compared with our internal performance results. Now that the data discrepancy issue has been identified steps are being taken to rectify it moving forward.

Internal CM Health data indicates a Q2 result of 76%. The internal 62-day performance data excluding patient choice indicates a result of 82%.

For Q2, actual performance improved in September and October, but then dropped in November and December. This was partly due to some longstanding breach patients and also significant clinical consideration issues that have led to unavoidable delays. Of the 12 patients that breached in December, 3 were due to patient choice and 5 were due to unavoidable complex clinical considerations.

In November each tumour stream developed an agreed action plan, aligned with the overall FCT programme. The focus of FCT improvement activity is to raise performance above 85% in a sustainable and patient centered manner. The work plan includes activity towards reaching 90% by July 2017.

## 2.3.5 Elective Surgery

- Volume of elective surgery will increase by at least 4000 discharges per year

<table>
<thead>
<tr>
<th></th>
<th>Frequency of reporting</th>
<th>Increase of 4,000 discharges per year</th>
<th>108%</th>
<th></th>
</tr>
</thead>
</table>

For Q2, actual performance improved in September and October, but then dropped in November and December. This was partly due to some longstanding breach patients and also significant clinical consideration issues that have led to unavoidable delays. Of the 12 patients that breached in December, 3 were due to patient choice and 5 were due to unavoidable complex clinical considerations.

In November each tumour stream developed an agreed action plan, aligned with the overall FCT programme. The focus of FCT improvement activity is to raise performance above 85% in a sustainable and patient centered manner. The work plan includes activity towards reaching 90% by July 2017.
<table>
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<tr>
<th>AP Ref.</th>
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<th>Indicator</th>
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<th>Current Target</th>
<th>Performance – 2016/17 Quarter 2</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>Maaori</td>
</tr>
<tr>
<td>2.3.4</td>
<td>Emergency Department Care</td>
<td>Percentage of patients admitted, discharged, or transferred from an ED within six hours</td>
<td>Quarterly</td>
<td>95%</td>
<td>96%</td>
<td>-</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Immunisation</td>
<td>Percentage of eight months olds who have had their primary course of immunisation on time</td>
<td>Quarterly</td>
<td>95%</td>
<td>94%</td>
<td>89%</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>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. While the 95% target was almost achieved for the total population (and was exceeded for our Pacific and Asian population groups), the coverage target was not met for Maaori (89%) and the target has therefore not been achieved. It was noted by the MOH that the CM Health equity gap is almost 2.5 times higher than the national equity gap. To note is that the coverage level for Maaori has risen by 3% since Q1 (86%).</td>
<td></td>
</tr>
<tr>
<td>2.2.5</td>
<td>Smoking (primary)</td>
<td>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</td>
<td>Quarterly</td>
<td>90%</td>
<td>89%</td>
<td>88%</td>
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<tr>
<td></td>
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<td></td>
<td>Small drop of 2.6% from Q4 2015/16. The greatest barrier to meeting the target is that PHOs struggle to reach transient patients. Mitigation strategies in place to address this include: using reminder/prompt tools, appointment scanning, involving reception in updating contact details and targeted smoking questionnaires, and ensuring smoking ABC is completed as part of enrolment.</td>
<td></td>
</tr>
<tr>
<td>2.2.5</td>
<td>Smoking (maternity)</td>
<td>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 and support to quit smoking</td>
<td>Quarterly</td>
<td>90%</td>
<td>82%</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Throughout quarters 1 and 2 data issues have been identified meaning that not all brief interventions undertaken have been recorded (resulting in potential underreporting of brief interventions). The CM Health maternity Smokefree service receives referrals from both DHB employed community midwives and independent Lead Maternity Carer (LMC) midwives. Feedback from the independent midwives is that the data recording forms they're using are only able to capture a woman’s smoking status, but not if the brief intervention has been offered. When these women are then passed to DHB community midwives it is therefore unclear whether they have had their brief intervention or not. To mitigate this issue, a list of NHIs of missing interventions going forward has been requested but</td>
<td></td>
</tr>
<tr>
<td>AP Ref.</td>
<td>Priority</td>
<td>Indicator</td>
<td>Frequency of reporting</td>
<td>Current Target</td>
<td>Performance – 2016/17 Quarter 2</td>
<td>Commentary / Interpretation</td>
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<td></td>
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<td></td>
<td></td>
<td>when this can be created has not been confirmed. This will make it then easier to filter out those that had not been seen by DHB employed midwives.</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>The Smokefree maternity advisor is working with maternity service manager on possible solutions. The MOH is aware of the data coding issue which is affecting DHBs nationally.</td>
</tr>
<tr>
<td>2.2.2</td>
<td></td>
<td>Raising healthy kids</td>
<td>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</td>
<td>Quarterly 95%</td>
<td>62% 65% 67% 44%</td>
<td>Plunket is the B4SC provider, and referrals for clinical assessment and monitoring are being sent to Primary Care. An electronic referral process from B4SC to primary care has been set up and operational since 30 September 2016. Note that the Q2 result is based on all completed B4SCs processed in the six-month period ending 31 November. With the electronic referral system operational we are confident that all referrals from 30 September will be acknowledged and therefore we will meet the health target. It should be noted however, that as achievement of the health target is calculated on six months rolling data, the acknowledgement of 100% referrals will not be reflected in the data until quarter four 2016/2017.</td>
</tr>
<tr>
<td>MOH Quarterly Reporting Performance Indicators</td>
<td>2.2.6</td>
<td>PP6: Improving the health status of people with severe mental illness through improved access</td>
<td>Age 0-19</td>
<td>Quarterly</td>
<td>Maaori: 4.45% Total: 3.15%</td>
<td>4.03% 5.87%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Age 20-64</td>
<td>Quarterly</td>
<td>Maaori: 7.70% Total: 3.15%</td>
<td>3.79% 8.55%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Age 65+</td>
<td>Quarterly</td>
<td>Maaori: 2.60% Total: 2.60%</td>
<td>2.45% 2.64%</td>
</tr>
</tbody>
</table>
## PP7: Improving mental health services using transition (discharge) planning and employment

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2016/17 Quarter 2</th>
<th>Commentary / Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long terms clients</td>
<td>Quarterly</td>
<td>95%</td>
<td>30%</td>
<td>The new MOH requirements to report on Employment and Education status have resulted in a change to the way this information is captured and has affected our performance result against the long term clients measure. This is a national issue of which the MOH are aware. The changes resulted in the need to re-enter values for service users. To date there are 30% entered and 70% yet to be entered. It is expected that the results will improve over the coming months as more records are updated.</td>
</tr>
<tr>
<td>Child and Youth</td>
<td>Quarterly</td>
<td>95%</td>
<td>93%</td>
<td></td>
</tr>
</tbody>
</table>

## PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds - Mental Health (Provider Arm)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2016/17 Quarter 2</th>
<th>Commentary / Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3 weeks</td>
<td>Quarterly</td>
<td>80%</td>
<td>72%</td>
<td>The percentage of 0-19 year olds who accessed services within three weeks is below target and has dropped 1.2% since Q1. Though the percentage is below target, it is still higher than both the regional (69.9%) and national (67.0%) results. Also to note is that the corresponding percentage for the 12-19 age group is 80.3%</td>
</tr>
<tr>
<td>&lt;8 weeks</td>
<td>Quarterly</td>
<td>95%</td>
<td>95%</td>
<td>Further, the number of unique CMDHB domiciled clients aged 0-19 seen during the year ended 30 September 2016 was 6600, an increase of 3% from the 6404 unique clients seen in the corresponding period last year. This increase has meant delays for some but overall far more young people are accessing specialist mental health services and almost all are being seen within the expected timeframes. Referrals are triaged and those with the highest need are prioritized and those needing urgent intervention are seen within 48 hours.</td>
</tr>
</tbody>
</table>

## PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds Addiction (NGOs)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2016/17 Quarter 2</th>
<th>Commentary / Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3 weeks</td>
<td>Quarterly</td>
<td>80%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>&lt;8 weeks</td>
<td>Quarterly</td>
<td>95%</td>
<td>99%</td>
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</tbody>
</table>

## 2.2.1 Long Term Conditions

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PP20: Long term conditions/DCIP</td>
<td>Quarterly</td>
<td></td>
</tr>
</tbody>
</table>

## 2.2.4 Diabetes - Improved management (HbA1c)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>AP Ref.</td>
<td>Priority</td>
<td>Indicator</td>
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<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2.2.3</td>
<td></td>
<td>PP20: Cardiovascular (CVD) health (CVD Risk Assessment – previous health target)</td>
</tr>
<tr>
<td>2.2.3</td>
<td></td>
<td>PP20 Acute Coronary Syndrome - Percentage of high-risk patients who receive an angiogram within 3 days of admission ('day of admission' being 'Day 0')</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PP20 Acute Coronary Syndrome - Percentage of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS Q1 ACS and Cath/PCI registry data collection within 30 days</td>
</tr>
<tr>
<td>2.3.2</td>
<td></td>
<td>PP20: Stroke - Percentage of potentially eligible stroke patients thrombolysed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PP20: Stroke - Percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway</td>
</tr>
</tbody>
</table>
### Counties Manukau District Health Board – Hospital Advisory Committee

#### 8 March 2017

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<tr>
<th>AP Ref.</th>
<th>Priority</th>
<th>Indicator</th>
<th>Frequency of reporting</th>
<th>Current Target</th>
<th>Performance – 2016/17 Quarter 2</th>
<th>Commentary / Interpretation</th>
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<tbody>
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<td></td>
<td>Total</td>
<td>Māori</td>
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**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% | 83.5% |

It is anticipated though that this negative result will reverse as the service is fully established.

As above. As the integrated stroke service is established the KPI for this area is impacted. The full establishment of the integrated stroke service will result in all stroke patients being admitted to this service at the acute stage and then either being transferred to longer term rehabilitation or receive short term rehabilitation on the integrated ward.

Over the next couple of months resources, competencies and capacity will be improved to ensure that achievement of this KPI is improved.

**2.1.1 Immunisation**

PP21: Percentage of two year olds who are fully immunised

| Quarterly | 95% | 94% | 91% | 96% | 92% | 98% |

The five year immunisation coverage rate for Māori has increased to 85% from 68% in Q2 last year. However there are still difficulties in locating four year old children to be immunised. Reminders for the free four year immunisation are sent out with B4 School Check reminder letters (90% of Māori children received their B4 School Check in 2015/16). There is focused activity for the most hard to reach families to bring them into a Saturday outreach clinic and complete the 4 year immunisation at the same time.

**2.3.7 Health of Older People**

PP23: Improving Wrap Around Services - Health of Older People

| Quarterly |           |

**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 |           |

**2.1.2 Rheumatic Fever**

PP28: Hospitalisation rates (per 100,000 total population) for acute rheumatic

| Quarterly | **6.1 per 100,000 (Total)** |

CM Health received a “not achieved” rating for the first episode rheumatic fever measure in Q2.

The MOH has expressed concerns about what rapid response services CM Health planned to have in place from 30 September 2016 to ensure that 80 percent of our at-risk population (4-19 year old...
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<td></td>
<td>Total</td>
<td>Maaori</td>
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<tr>
<td>2.1.2</td>
<td></td>
<td>PP28: Reducing rheumatic fever – facilitating the effective follow up of identified rheumatic fever cases</td>
<td>Quarterly</td>
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<tr>
<td>2.3.6</td>
<td>Improving waiting times for diagnostic services</td>
<td>PP29a: Coronary angiography – within 3 months (90 days)</td>
<td>Monthly</td>
<td>95%</td>
<td>99%</td>
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<tr>
<td></td>
<td></td>
<td>PP29b: CT – within 6 weeks (42 days)</td>
<td>Monthly</td>
<td>95%</td>
<td>97%</td>
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<tr>
<td></td>
<td></td>
<td>PP29c: MRI – within 6 weeks (42 days)</td>
<td>Monthly</td>
<td>85%</td>
<td>72%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>PP29d: Urgent diagnostic colonoscopy – within two weeks (14 days)</td>
<td>Monthly</td>
<td>75%</td>
<td>100%</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>PP29e: Diagnostic colonoscopy – within six weeks (42 days)</td>
<td>Monthly</td>
<td>65%</td>
<td>54%</td>
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</tbody>
</table>

Maaori and Pacific and Quintile5 children and youth have access to fast and effective sore throat management.

Currently approximately 72% of this group can access free care through their enrolled practice. Many of these practices have extended hours and are open on the weekends. The DHB has taken the stance of strengthening existing relationships in existing settings through establishing school based clinics and supporting the connection with the medical home rather than setting up separate services for sore throat management. The DHB submitted a refreshed RF plan that explicitly stated we would no longer be funding primary care to be delivering rapid response clinics due to the reduction in funding. This decision was made after consulting widely. Work is underway with ALT to explore opportunities for primary care to increase access to young people. There is also going to be a focus on quality improvement for sore throat management within primary care.

CM Health is in the process of planning for additional MRI capacity at the Middlemore site due on stream in first quarter 2018. In the meantime, outsourcing has been increased and additional weekend sessions worked to provide the additional capacity to meet the demand.

Performance for October and November exceeded the target with results of 88% and 81% respectively. However, performance dropped in December with a result of 54%.

There continues to be a significant growth rate in gastroenterology demand, with 20% increase in referrals for colonoscopies in 2016. There were also a number of events/issues in 2016 which impacted
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<tr>
<td>PP29f: Surveillance colonoscopy - within twelve weeks (84 days) beyond the planned date</td>
<td>Monthly</td>
<td>65%</td>
<td>78%</td>
<td></td>
<td>on ability to maintain targets at the end of the second quarter, and potentially will continue to impact into the beginning of the third quarter.</td>
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<tr>
<td>2.3.3</td>
<td>Faster Cancer Treatment</td>
<td>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)</td>
<td>Quarterly</td>
<td>85%</td>
<td>84%</td>
<td>292/350 31-day patients commenced treatment on time (84%) in Q2.</td>
</tr>
<tr>
<td></td>
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<td>PP30b: All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy from decision to treat</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td>A focus on data quality and completeness of the 31-day records continues, with the aim of ensuring all patients with cancer are included as per the eligibility criteria.</td>
</tr>
<tr>
<td>2.2.5</td>
<td>Better help for smokers to quit (previous health target)</td>
<td>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</td>
<td>Quarterly</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
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<tr>
<td>System Integration</td>
<td>SI1: Ambulatory sensitive (avoidable) hospital admissions</td>
<td>Six-Monthly</td>
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<td>Total</td>
<td>Maaori</td>
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<td>SI3</td>
<td></td>
<td>Ensuring delivery of service coverage</td>
<td>Six-Monthly</td>
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<td>2.3.5</td>
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<td>Inpatient length of stay</td>
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<td>3.3.3</td>
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<td>Acute LOS</td>
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<td>7.1.2</td>
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<td>2.2.6</td>
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<td>Quarterly</td>
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<td>2.7</td>
<td></td>
<td>Patient Experience</td>
<td>Quarterly</td>
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<tr>
<td>CFA</td>
<td></td>
<td>Appoint Cancer Nurse Coordinators</td>
<td>Six-monthly</td>
<td></td>
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<tr>
<td>CFA</td>
<td></td>
<td>Appoint Cancer Psychological and Social Support workers</td>
<td>Six-monthly</td>
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<tr>
<td>CFA</td>
<td></td>
<td>B4 School Check Funding</td>
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<tr>
<td>CFA</td>
<td></td>
<td>DSS Funding</td>
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<tr>
<td>CFA</td>
<td></td>
<td>Well Child Tamariki Ora Services</td>
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<td>Green Prescription</td>
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<td>Elective Variations</td>
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<tr>
<td>CFA</td>
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<td>Immunisation Coordination Service</td>
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<tr>
<td>CFA</td>
<td></td>
<td>National Immunisation Register (NIR) Ongoing Administrative Services</td>
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<tr>
<td>HS</td>
<td></td>
<td>Supporting delivery of the NZ Health Strategy</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td>New reporting requirement in 2016/17. The MOH requires brief explanation of one action being taken by CM Health each quarter per NZ health strategy theme.</td>
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</tbody>
</table>
Key achievements this quarter include:

- Good performance against the Minister’s Health Targets with regard to ‘Electives’, ‘ED Waits’ and ‘Increased immunisation’, signs of progress with regard to ‘Raising Healthy Kids’, reasonable performance with regard to the two ‘Quit Smoking’ indicators.
- A Northern Region Head Injury and Concussion pathway for children has been developed for primary care in partnership with ACC, Primary Care, Auckland Regional HealthPathways, Urgent Care, and Child Development representation. The purpose of the pathway is to enable identification and management of children following a head injury (not requiring hospital admission). ACC are piloting this pathway in primary care in the Northern Region with funding available to complete an assessment.
- The Regional HOP Planning and Funding Managers have worked with National interRAI representatives to resolve concerns re National interRAI data reporting and on-going staff training requirements for the Region.
- Waitemata DHB was the first in the country to achieve the FCT 62 day target as measured by the Ministry 6 month quarter and publicly reported. Three of the four DHBs in the region have achieved the target on one or multiple individual months.
- The Regional Catheter Lab model has been endorsed by the working group. It has been presented to the REF and SRG forums and endorsed subject to further options being modelled.
- The integrated mentorship program developed by the Diabetes Nurse Forum has been endorsed by the DHBs SLATs or equivalent. The group will reconvene next quarter to operationalise the programme with the intention to increase flexibility, review resourcing and develop a business case which can be personalised to the DHB requirements.
- Regional trauma symposium held with around 100 attendees, hosted by Ko Awatea.
- Evaluation of the acute continuum of Perinatal/infant mental health services has been completed, revealing a significant increase in intensity and access. Positive feedback from consumers in relation to their experience across the continuum.
- The 3 metro DHBs have agreed funding to progress Metro implementation of Predict.
- Stroke services in the Northern Region continue 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.
- Work continues on implementation of the Regional Standards for Quality Care for Adolescents and Young Adults in Secondary or Tertiary Care. Several services have expressed an interest in working with the network on this quality improvement initiative.
- Hepatitis C has been endorsed as one of the 5 Service Level Measures by the CEOs of the 3 Metro Auckland DHBs and the 7 PHOs for the 2017/18 financial year. This will see a focus on re-identification of patients lost to follow up, and education and awareness activity to identify new patients within the primary care environment.
- The Region has continued to identify areas of work that would benefit from more Māori representation. This includes the clinical network groups, enabler areas and working groups. The Region is currently working in partnership with the Māori Health teams to select appropriate people with the required skill sets to fill those gaps.
- The focus has remained on meeting ESP1 and service volume targets through close active management of processes and planning for the December/January holiday period.
- Both WDHB and ADHB Boards have agreed to become Youth Employment Pledge Partners with Youth Connections, an Auckland Council supported initiative that connects employers and young people for positive employment outcomes. The Pledge Partnership will position the DHBs as active agents in addressing the issue of youth unemployment for Māori and Pacific communities.
- Support to increase the Māori and Pacific participation in the health workforce is occurring through the setting and monitoring of hiring targets for specific professional occupations; with improved reporting on these targets. In addition, processes have been put in place to improve talent management, recruitment and selection processes within the DHBs that are more enabling for Māori and Pacific candidates. Auckland DHB has developed and is to pilot ‘unconscious bias’ training for managers.
- Continuation of the Northern Region Long Term Investment Plan project, with development of a current state view as part of the Phase 1 deliverables. The Plan will provide detail on regionally prioritised investments to deliver the optimal health gain for the Region’s population within the available resources.

### NZ Health Strategy – Regional highlights for the quarter

<table>
<thead>
<tr>
<th>People - powered</th>
<th>Closer to home</th>
<th>Value and high performance</th>
<th>One team</th>
<th>Smart system</th>
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</thead>
<tbody>
<tr>
<td>The Region is working with Māori Health team Representatives to</td>
<td>Plans approved for the delivery of Local Herceptin for some Breast patients at</td>
<td>Waitemata DHB was the first in the country to achieve the Faster Cancer Treatment 62</td>
<td>A primary care pathway for the identification and management of</td>
<td>Decision to use Predict as tool for metabolic screening. This will enable GP’s to access data for their clients;</td>
</tr>
</tbody>
</table>
develop a plan to improve outcomes for Maori with Dementia. This includes strengthening the roles of whānau as carers.

Counties Manukau DHB. Currently only delivered at the tertiary Regional Cancer & Blood Centre. The Northern region DHBs are providing training to support primary care to identify and manage children who are identified as overweight or obese.

Children following a head injury (not requiring hospital admission) was published in December 2016. ACC are piloting this pathway with funding for primary care to complete assessment.

The table below shows progress against the top 10 commitments

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Status</th>
<th>Notes</th>
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<tbody>
<tr>
<td>1 Achieve and maintain the National Health Targets</td>
<td>Some concerns regarding progress to target</td>
<td>Faster Cancer Treatment below the 85% target, at 79.3%, despite rising performance quarter on quarter</td>
</tr>
<tr>
<td>2 Child Health continue to reduce SUDI deaths to &lt; 0.4 SUDI Deaths per 1,000 Maori live births</td>
<td>On track</td>
<td>The Primary Care Pathway has been published and the Safe Sleep Calculator is being tested in primary care sites with evaluation</td>
</tr>
<tr>
<td>3 75% of clients receiving long term Home Based Support Services have an interRAI clinical assessment within the previous 24 months</td>
<td>On track</td>
<td>87% of LT HBSS clients have received an interRAI clinical assessment within the previous 24 months (as of June 2016)</td>
</tr>
<tr>
<td>4 85% of patients receive their first cancer treatment or other management within 31 days from decision to treat</td>
<td>On track</td>
<td>Note: 1 quarter data lag</td>
</tr>
<tr>
<td>5 Lift proportion such that 30% of bowel investigations are CTC; consistent with the Regional Colonoscopy Plan and Bowel investigations Programme Business Case</td>
<td>Some concerns regarding progress to target</td>
<td>Note: 1 quarter data lag</td>
</tr>
<tr>
<td>Note: In the July – Sept quarter CTC rates increased significantly, nearing the regional target. However this was primarily driven by a decrease in the absolute volume of colonoscopies rather than an increase in the absolute volume of CTC procedures.</td>
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<td>6 80% of patients presenting with ST elevation myocardial infarction (STEMI) referred for percutaneous coronary intervention (PCI) will be treated within 120 minutes</td>
<td>On track</td>
<td>The Northern Region has exceeded this target for Q2 84.5%</td>
</tr>
<tr>
<td>7 80% of diabetes patients to have good or acceptable glycaemic control (HbA1c&lt;64)</td>
<td>On track</td>
<td>Note that the KPI reports are issued every 6 months. The next report is due in Q3.</td>
</tr>
<tr>
<td>8 90% of discharges from adult mental health services receive post discharge</td>
<td>Some concerns regarding progress to target</td>
<td>72% of adult MH discharges were contacted within 7 days as of September 2016. This constitutes a 3% increase from previous</td>
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1 There may be some variation for patients from NDHB due to geographical isolation and dependence on emergency helicopter transport.
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<tbody>
<tr>
<td>community care (within 7 days)</td>
<td></td>
<td>quarter. For discussion at Mental Health and Addiction network meeting in January, 2017</td>
</tr>
<tr>
<td>9 80% of patients who have a stroke are treated in a stroke unit</td>
<td></td>
<td>The Northern Region achieved 78% for stroke patients treated in a dedicated stroke unit in the period Jul-Sep 2016. Overall, the region discharged the highest number of stroke patients on record. The slight decrease is largely attributed to availability of designated stroke beds to accommodate these additional cases.</td>
</tr>
<tr>
<td>10 Reduce unintended teen pregnancies</td>
<td></td>
<td>There is clear evidence of a reduction in termination rates and a reduction in the number of teen pregnancies across the region which indicates a drop in unintended teen pregnancies.</td>
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**Equity Priority**

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<th>Status</th>
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<tr>
<td>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.</td>
<td></td>
<td>The Region has begun identifying equity issues in all clinical network groups. This has been done in partnership with representatives from the DHB Planning and funding, Māori, Pacific and Asian/MELAA Health Teams.</td>
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Counties Manukau District Health Board
Hospital Advisory Committee
Acute Spinal Service

Recommendation

It is recommended that the Hospital Advisory Committee:

Receive the Acute Spinal Service report.

Prepared and submitted by: Dana Ralph-Smith, General Manager Adult Rehabilitation & Health of Older People

Purpose

The purpose of this paper is to provide an overview of the initial and current state of Acute Spinal Cord Impairment Service costs and funding state and to clarify service delivery quality improvements to date as a result of an action item from the 30 November HAC meeting:

“Mr Balmer advised that a paper is being presented to the Regional Governance Group tomorrow in relation to funding. A national price is added on top of every spinal patient for spinal cord impairment ($27k) which Canterbury has been receiving for quite some time. With that, we are still incurring an annual loss of $2.4m. Yes, the service is good, yes we are seeing improvement but the service is costing more than we are being funded. We are also seeing an increase in non-spinal cord impairment patients being referred just because we have the service. Mr Balmer will report back on this next year.”

Executive Summary

The Northern Supra-regional Acute Spinal Cord Impairment (SCI) service (aligned to the New Zealand Spinal Cord Action Plan 2014-2019) commenced delivery at Counties Manukau Health (CM Health) July 2014. Best practice guidelines recommend that patients receive decompression surgery within 24 hours, and dislocations needing a reduction should be performed within four hours. The overarching aims of the SCI Action Plan is to meet these guidelines and by so doing maximise opportunities for optimal function and reduce the risk of complications. The lifetime costs for major spinal injury are between $8-$16 million.

The new acute SCI service provided a number of challenges and opportunities for step change improvement.

1. The acute services workforce capacity and capability underwent a significant step change improvement in efficiency and effectiveness, implementing a standardised regional referral and destination guideline and timely pathways of care from scene of accident to Emergency Care, Surgical Services, Intensive Care Unit, Acute Ward and Inpatient Auckland Spinal Rehabilitation Services. This service delivery improvement was supported through the investment in additional specialised trained allied health, nursing and medical resources into the critical care and acute environments and further clinical equipment and facilities refurbishments into the acute orthopaedic ward these changes have focussed on improving
acute service delivery, prevent avoidable complications and facilitating commencement of early rehabilitation as appropriate.

2. To offset the difference between the WIES based funding and the Actual cost of treatment associated with providing a higher quality of care for acute SCI (aligned with the Southern Supra Regional Acute Service funding model) the Ministry of Health agreed to an additional price adjuster for each acute SCI patient of $27K. This price adjuster meets the additional cost for the majority of SCI cases.

3. It has been previously highlighted that despite this adjuster PUC, the Acute SCI service was still incurring an overall annual $2.4m loss. Upon further analysis it has been clarified that this shortfall of $2.4m previously stated was the total shortfall over the 22 month period to November 2016.

4. The majority of this loss has occurred in small number of exceptional cases of patients with very long length of stay in ICU. Of these outlier patients 38% are CMDHB patients (as opposed to 24% for the Cost neutral group). As yet there are no discernible trends, numbers are small and highly variable over time (refer figure 1).

Figure 1: Outlier Acute SCI Patients (cost not met by revenue)

5. The average Loss per case is approximately $177k (refer Figure 2) with net loss falling into three main clusters:
   a. Those who stay under 20 days in ICU. Average loss is around $100k per case
   Those who stay between 40-80 days in ICU. Average loss is around $200k per case.
   Those who are around 100 days in ICU (two very high loss cases during the 22 month period reviewed).
6. In absence of a tertiary adjuster for Orthopaedic Services, we have sought assistance from the MOH National Casemix Group Lead Coordinator regarding the most appropriate mechanism to address the funding gap associated with these cases.

To improve the quality and efficiency of the SCI service, we have continued to focus on timeliness of transition from ICU to acute and acute to rehabilitation services. Rehabilitation services (funded by ACC rehab) as soon as the patient is able to participate in rehabilitation. A Rehabilitation SMO was recruited in 2016 to work alongside acute care teams to support holistic assessment, prevent avoidable complications and support the wider interdisciplinary team to commence rehabilitation without unnecessary delays.

7. It is also worthwhile to note that since the implementation of the new Acute Supra-Regional Service, a number of non-SCI acute spinal patients continue to be referred to CMH. This is allowed within the referral guidelines if the referring DHB feels patients could be at risk of neurologic impairment due to their spinal fracture complexity. These volumes have an impact on acute theatre and ward services and at times impact on our ability to manage elective services. Non SCI referral levels (incl the special cause variation that has occurred in Nov/Dec 2016) (refer Figure 3) will be monitored.
Summary

It is recommended that acute volumes, costs and funding (particularly of high cost exceptional cases) be reviewed by the interdisciplinary acute and rehabilitation teams to assess opportunity for quality improvement. It is also recommended that non-SCI cases from outside CMH be reviewed again at the end of the 2016-17 fiscal year to understand any special cause variation and to determine if further refinement of the referral criteria is appropriate.
Counties Manukau District Health Board  
Hospital Advisory Committee  
Hospital Services Report

Recommendation

It is recommended that the Hospital Advisory Committee:


Prepared and submitted by: Phillip Balmer, Director Hospital Services

Executive Summary

**Glossary**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALOS</td>
<td>Average Length of Stay</td>
</tr>
<tr>
<td>ARDS</td>
<td>Auckland Regional Dental Service</td>
</tr>
<tr>
<td>ASH</td>
<td>Ambulatory Sensitive Hospitalisations</td>
</tr>
<tr>
<td>BSC</td>
<td>Balanced Scorecard</td>
</tr>
<tr>
<td>DHS</td>
<td>Director Hospital Services</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>FCT</td>
<td>Faster Cancer Treatment</td>
</tr>
<tr>
<td>HRT</td>
<td>Health Roundtable</td>
</tr>
<tr>
<td>MMC</td>
<td>Middlemore Central</td>
</tr>
<tr>
<td>MMH</td>
<td>Middlemore Hospital</td>
</tr>
<tr>
<td>RMO</td>
<td>Resident Medical Officer</td>
</tr>
<tr>
<td>SLM</td>
<td>System Level Measure</td>
</tr>
<tr>
<td>STEEEP</td>
<td>Safe, Timely, Effective, Efficient, Equitable, Patient-Centered</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>

**Overview**

1. We remain on track with our improvement initiatives designed to achieve the triple aim and the aligned focus on the Institute of Medicines STEEEP framework as displayed in the BSC.
2. We are achieving all of the health targets except the FCT target. We have a great deal of focus on ensuring ongoing improvements are made to the FCT journey and that targets are met.
3. We have aligned our current whole of system agenda with the regional, national system level improvement efforts. Both the health targets and the SLMs are summarised below with greater detail provided in Appendix 2-4.
4. The RMO strike and increased acute demand described below has impacted on our elective service delivery for Counties and the region. We have a production plan for all services and have adjusted accordingly and are confident we will achieve all elective volumes for the 16/17 year.
5. We have had unprecedented growth in acute theatre demand shown below in table 1 over the last three months.
This growth in demand has predominantly been in orthopaedics as shown below. While the growth in the November, December, January quarter in Orthopaedic procedures has been only a 4% increase from 620 procedures to 645 procedures, (refer to the blue in table 2 below), the increase in acuity of these procedures has seen the number of theatre minutes increase from 65k minutes to almost 79k minutes, a 21% increase (refer to the red in table 2 below). As shown this growth in demand matches closely the additional capacity required.

Table 2: Change in Orthopaedic acute demand at MMH
## Health Targets

### Elective Surgery

Note: Performance against the Elective Surgery target is reported one month in arrears.

<table>
<thead>
<tr>
<th>Description</th>
<th>December (confirmed)</th>
<th>January (indicative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The volume of elective surgery will be increased by an average of 4,000 discharges per year.</td>
<td>Achieved</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>✓ 107.8%</td>
<td>✓ 106.0%</td>
</tr>
</tbody>
</table>

### Emergency Department

<table>
<thead>
<tr>
<th>Description</th>
<th>January</th>
</tr>
</thead>
<tbody>
<tr>
<td>95% of patients will be admitted, discharged, or transferred from an emergency department within six hours</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>✓ 95%</td>
</tr>
</tbody>
</table>

### Cancer Treatment

<table>
<thead>
<tr>
<th>Description</th>
<th>January</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Not Achieved</td>
</tr>
<tr>
<td></td>
<td>✗ 63%</td>
</tr>
</tbody>
</table>

### System level measures (see Appendix 1)

<table>
<thead>
<tr>
<th>Description: Maintain current performance against ASH rates for each DHB for 16/17.</th>
<th>January</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline ASH rates 16/17</td>
<td>On track</td>
</tr>
<tr>
<td>Number of ASH events</td>
<td>✓ 3.3%</td>
</tr>
<tr>
<td>Rates</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reduce ASH rates for 0-4 year olds by 2.5%</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Target ASH rates 17/18 decrease by 5%</td>
<td></td>
</tr>
<tr>
<td>Number of ASH events</td>
<td></td>
</tr>
<tr>
<td>Rates</td>
<td></td>
</tr>
</tbody>
</table>

MoH report January show a reduction in ASH rates for 0-4 year olds 12 months to Sept 2016

| Counts | % change |
| Counts | |
| Number of ASH events | 2,988 | 2.4% |
| Rates | 7,109 | 3.3% |

The largest reduction has been in Gastrointestinal and respiratory conditions
### Reduce ED presentations per 1000 domiciled using autoregressive integrated moving average (ARIMA)

**Description:** The number of ED events as a rate per 1000 patients domiciled in CMDHB will reduce by 1.9%. (N.B Goal is a 2.3% reduction in 16/17 against expected growth of 4.2% by June) 17.

<table>
<thead>
<tr>
<th>Historic ED Growth 14/15 to 15/16</th>
<th>4.90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>pop growth</td>
<td>2.40%</td>
</tr>
<tr>
<td>Exp w population growth 16/17</td>
<td>4.20%</td>
</tr>
<tr>
<td>Goal reduce expected ED</td>
<td></td>
</tr>
<tr>
<td>presentations 16/17 by 2.3%</td>
<td>-2.30%</td>
</tr>
<tr>
<td>Expected 16/17 ED vols with 4.2% growth</td>
<td>119631</td>
</tr>
<tr>
<td>Expected 16/17 ED vols with 2.3% reduction on expected growth 1.9%</td>
<td>116990</td>
</tr>
</tbody>
</table>

#### January
On track to achieve
✔️ 1.2%

### Reduce acute hospital bed day growth by 2% by June 2017 from 45.6 to 44.7

**Description**
As shown we have had a 2.8% increase in patient discharges in each calendar year and only a 0.8% increase in beds occupied
✔️ TBC

### Goal improve contributory measures on acute bed days: Reduce acute readmissions at 28 days to 7.7 days

**Description:** Standardised readmission rate (SRR) (NNPAC) (See Appendix 2 HRT latest report showing Counties has the lowest Readmission rate in the country). See table below SRR to March 31st 2016.

<table>
<thead>
<tr>
<th>DHB/Country</th>
<th>Rate 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHB</td>
<td>8.1%</td>
</tr>
<tr>
<td>CMDHB</td>
<td>7.7%</td>
</tr>
<tr>
<td>WDHB</td>
<td>8.0%</td>
</tr>
<tr>
<td>NZ</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

#### January
Achieved
✔️ 6.9% YTD
✔️ 7.6% January

### Goal improve contributory measures on acute bed days: Reduce ALOS

**Description:** Average length of stay for acute care episodes excluding MoH. (See Appendix 3 HRT latest report showing Counties has the second lowest ALOS in the country behind Canterbury).

#### January
Achieved
✔️ 2.7 days YTD
✔️ 2.7 days January
<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
<th>January</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve contributory</td>
<td>Percentage of bed days for medical surgical patients that were for long stay</td>
<td>Achieved</td>
</tr>
<tr>
<td>on acute bed days:</td>
<td>patients &gt; 21 days. (See Appendix 4 HRT latest report showing Counties has</td>
<td>✔️ 2.7 days YTD</td>
</tr>
<tr>
<td>Reduce % stranded</td>
<td>the second lowest % age of stranded patients in the country behind Canterbury).</td>
<td>✔️ 2.7days</td>
</tr>
<tr>
<td>patients</td>
<td></td>
<td>January</td>
</tr>
</tbody>
</table>

**Highlights**

**Facility Redevelopment**

1. **Bereavement Care Garage**

   The Counties Manukau Health Bereavement Care Centre is the only one of its kind in NZ. CM Health has developed this area because we know that for cultural reasons many of our bereaved families wish to remain with their departed loved ones. We have a facility akin to a departure lounge with private lounges, beverage facilities etc. One component of the bereavement care journey however was not in keeping with this supportive environment which was the garage where the departed loved one was picked up and transferred to their resting place. With the support of the Middlemore Foundation and more specifically the Hector Trust we have changed this environment. The change has been well received by families /whanau.

![Bereavement Care Garage](image)

**Paataka Place**

Middlemore Hospital has become the first New Zealand hospital to provide an organic food shop on its premises. We have completed a nearly $1million makeover of our retail precinct, Paataka Place, which officially opened on February 7. The anticipated return on this facility will be financial as well as an improved environment for staff, patients and whanaau. Staff had indicated they wanted to have choice with cafe food on offer. We have selected vendors based on alignment of CM Health values of providing healthy options (ie) Subway, Fuku Sushi, Columbus Coffee, Elixir Espresso, and Little Goodness. As well as food stores, the space is host to a florist and Haumanu Pharmacy, the first New Zealand pharmacy to use robotic technology to dispense medications with a consult space for staff teaching.

![Paataka Place](image)
Hospital Services 2016/17 Initiative Workplan

Project Delivery Overview

As previously reported to the Hospital Advisory Committee, Hospital Services is undertaking an ambitious workplan consisting of a number of service-led transformation, improvement, and revenue initiatives aligned with our Healthy Together strategy.

Each of these initiatives has identified benefits (either financial benefits, non-financial benefits, or both). We have in place a standardised improvement process combining improvement science and project management methodology to ensure these team led initiatives are successful and a reporting process to ensure progress against benefits and milestones are reported on each month.

Delivery Progress

We recognise that it is necessary to be disciplined about the number of projects any one team can complete. We have asked each team to identify 2-3 key projects for 16/17 and implement these projects through the year. Since the last report a further 18 projects have shifted from planning into execution, and 24 projects have been fully delivered and/or are undertaking close out activities. There are 19 initiatives still in initiation, with support now being provided by the General Managers to get these now into planning and execution.

Additionally, through rationalising and aligning initiatives we have 10 discrete initiatives less than reported previously, for example a number of initiatives working towards optimising theatre resources have been combined into one unified project.

The following figure shows the number of initiatives within each division, and the current status of these projects:
Benefits Realisation

Delivery of the financial benefits associated with a number of our projects is also progressing, with 68% of our target YTD benefits realised as of the end of December 2016.

Divisions are working hard to identify any roadblocks to delivery, and also on ways in which our stretch targets can be achieved. Further work on ensuring our phasing and reporting is accurate will also result in an improvement to reported performance going forward.

Additionally, a detailed review of benefits with the Finance team has identified some benefit upside which will move benefits closer to target during the early portion of Q3.
Responses to Action Items

Actions previously assigned by the Hospital Advisory Committee are reported back on in this section.

HAC Meeting 23.3.2016 – Intragram

“Dr Johnson to talk to the regional Clinical Practice Committee about them undertaking a cost benefit analysis on the efficacy and efficiency of Intragram v what was used before.”

The Clinical Practice Committee have now completed its evaluation/review of the research data and undertaken a cost-benefit analysis and the clinical recommendations on the use of Intragram have been circulated. A verbal update can be provided by Dr Johnson if required.

HAC Meeting 27.7.2016 – Primary Birthing Units

“Report back on what the next steps will be on the primary birthing units (location and number) after the MQSP report is signed off by the Ministry.”

This item is on the agenda for discussion at the next Maternity Strategic Forum and an update will come to HAC on 19 April.

HAC Meeting 19.10.2016 - HR

“Include a graph on Vacancy Rates by Professional Groups, Hospital & Community.”

![Total Current Open Vacancies as at 31 January 2017](image)
HAC Meeting 30.11.2016 - 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.”

Human Resources have an Annual Leave Management project underway within the Hospital Directorate with the direct aim to reduce our leave liability and decrease the number of those employees that currently have an annual leave balance the equivalent of 2 years or more in this area. This project will include supporting managers to not only reduce but maintain this reduced balance of annual leave.

<table>
<thead>
<tr>
<th>Employee Designation</th>
<th>AL Cash up Category</th>
<th>Ttl AL Cash Up (hrs)</th>
<th>Current AL Balance (hrs)</th>
<th>Ttl AL Taken in 12mths (hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Allied</td>
<td>Annual Leave Reduction Project</td>
<td>33.55</td>
<td>193.54</td>
<td>201.50</td>
</tr>
<tr>
<td>Allied Health - Outpatients</td>
<td>Annual Leave Reduction Project</td>
<td>69.96</td>
<td>128.58</td>
<td>120.00</td>
</tr>
<tr>
<td>Anaesthesiology</td>
<td>Annual Leave Reduction Project</td>
<td>22.00</td>
<td>347.69</td>
<td>185.00</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>413.61</td>
<td>474.30</td>
<td>255.00</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>62.16</td>
<td>18.39</td>
<td>130.32</td>
</tr>
<tr>
<td>Birth &amp; Assessment Unit</td>
<td>Annual Leave Reduction Project</td>
<td>249.70</td>
<td>224.40</td>
<td>52.00</td>
</tr>
<tr>
<td>Botany Maternity Hospital</td>
<td>Annual Leave Reduction Project</td>
<td>183.81</td>
<td>157.03</td>
<td>88.00</td>
</tr>
<tr>
<td>Child Health Services</td>
<td>Annual Leave Reduction Project</td>
<td>384.67</td>
<td>410.39</td>
<td>208.00</td>
</tr>
<tr>
<td>Cleaning Manukau/Botany</td>
<td>Annual Leave Reduction Project</td>
<td>69.57</td>
<td>331.76</td>
<td>57.00</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>69.57</td>
<td>331.76</td>
<td>57.00</td>
</tr>
<tr>
<td>Clinical Transcription</td>
<td>Other</td>
<td>72.71</td>
<td>307.24</td>
<td>61.50</td>
</tr>
<tr>
<td>Continuity of Care</td>
<td>Annual Leave Reduction Project</td>
<td>296.07</td>
<td>408.76</td>
<td>88.00</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Other</td>
<td>240.00</td>
<td>310.16</td>
<td>238.17</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Other</td>
<td>273.83</td>
<td>18.39</td>
<td>8.00</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>51.73</td>
<td>51.73</td>
<td>191.02</td>
</tr>
<tr>
<td>Hilary Ward 35 East, Koropiko</td>
<td>Annual Leave Reduction Project</td>
<td>51.78</td>
<td>421.64</td>
<td>280.00</td>
</tr>
<tr>
<td></td>
<td>Annual Leave Reduction Project</td>
<td>222.60</td>
<td>365.44</td>
<td>168.00</td>
</tr>
<tr>
<td>Home Care Nursing</td>
<td>Annual Leave Reduction Project</td>
<td>101.55</td>
<td>313.04</td>
<td>220.00</td>
</tr>
<tr>
<td>Intensive Care Unit (ICU)</td>
<td>Other</td>
<td>33.61</td>
<td>120.64</td>
<td>64.00</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>105.00</td>
<td>387.09</td>
<td>340.00</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1.64</td>
<td>232.74</td>
<td>270.00</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>115.08</td>
<td>445.98</td>
<td>-</td>
</tr>
<tr>
<td>Maternity Ward</td>
<td>Annual Leave Reduction Project</td>
<td>124.70</td>
<td>296.93</td>
<td>312.00</td>
</tr>
<tr>
<td></td>
<td>Annual Leave Reduction Project</td>
<td>177.99</td>
<td>260.34</td>
<td>288.00</td>
</tr>
<tr>
<td></td>
<td>Annual Leave Reduction Project</td>
<td>59.67</td>
<td>421.46</td>
<td>123.00</td>
</tr>
<tr>
<td>NICU</td>
<td>Annual Leave Reduction Project</td>
<td>179.15</td>
<td>272.19</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Annual Leave Reduction Project</td>
<td>293.00</td>
<td>291.59</td>
<td>144.00</td>
</tr>
<tr>
<td>Operating Theatre</td>
<td>Annual Leave Reduction Project</td>
<td>181.90</td>
<td>281.15</td>
<td>189.00</td>
</tr>
<tr>
<td></td>
<td>Annual Leave Reduction Project</td>
<td>94.93</td>
<td>375.15</td>
<td>233.00</td>
</tr>
<tr>
<td></td>
<td>Annual Leave Reduction Project</td>
<td>132.88</td>
<td>274.90</td>
<td>219.00</td>
</tr>
<tr>
<td>Patient at Risk Team</td>
<td>Annual Leave Reduction Project</td>
<td>67.46</td>
<td>318.37</td>
<td>131.00</td>
</tr>
<tr>
<td>Radiology</td>
<td>Other</td>
<td>97.67</td>
<td>18.39</td>
<td>144.00</td>
</tr>
<tr>
<td>Renal Services</td>
<td>Other</td>
<td>8.00</td>
<td>21.13</td>
<td>141.86</td>
</tr>
<tr>
<td>Security Services</td>
<td>Financial Hardship</td>
<td>37.91</td>
<td>441.73</td>
<td>280.00</td>
</tr>
<tr>
<td>Ward 9</td>
<td>Annual Leave Reduction Project</td>
<td>39.01</td>
<td>390.83</td>
<td>72.00</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>4,538.47</td>
<td>9,664.85</td>
<td>5,559.37</td>
</tr>
</tbody>
</table>

HAC Meeting 30.11.2016 - Q1 16/17 Non-Financial Report

“Report back with a breakdown of the Acute Coronary Syndrome Asian category (59% v target of 70%).”

During the Hospital Advisory Committee meeting of 30 November 2016, it was noted that the Asian category is sitting at 59% for Q1 v target of 70%. It was felt that this would probably not be all Asian communities, it would likely be a particular sub-group (ie) Indian, as they seem to have a predisposition for CVD. Coronary Care have reviewed the results and confirm that:

- The Asian category includes all Asian except Indian. Indian performance is captured and reported separately.
- The total number within the Asian category is very small (6/11 in most recent quarter) so this variance is unlikely to be as a result of a particular sub-group of the Asian category.
HAC Meeting 30.11.2016 – Closure of the Midwifery Clinic at ETHC

“Look into the reasons behind the pending closure of the community midwifery clinic at ETHC Otara as a lot of work was undertaken to ensure that this population group had access to midwifery services.”

The Dawson Road clinic is not closing. It has antenatal clinics there 5 days per week, both DHB and self-employed midwifery clinics.
Appendix 1: SLM framework “How well does your health system perform? Tracking progress toward the triple aim using system level measures” NZMJ 29 May 2015, Vol 128 No 1415
Appendix 2: HRT Benchmarks for SLMs: 28 day emergency readmission rates

4090 28 day emergency readmission rate

Comparison with peers (2015 Jul – 2016 Jun)

<table>
<thead>
<tr>
<th></th>
<th>Readmissions</th>
<th>Total episodes</th>
<th>25th Percentile</th>
<th>75th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panther</td>
<td>4,334</td>
<td>76,552</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tornado</td>
<td>2,854</td>
<td>47,120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CountiesMKNZ</td>
<td>6,252</td>
<td>95,095</td>
<td>6.6%</td>
<td></td>
</tr>
<tr>
<td>Cougar+</td>
<td>4,991</td>
<td>74,804</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artemis</td>
<td>4,320</td>
<td>61,557</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polaris</td>
<td>4,761</td>
<td>65,438</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sirius</td>
<td>4,483</td>
<td>61,419</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAH_QLD</td>
<td>5,487</td>
<td>72,643</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falcon</td>
<td>3,796</td>
<td>49,197</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Onion+</td>
<td>6,770</td>
<td>83,581</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demeter</td>
<td>7,000</td>
<td>86,013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC_SA</td>
<td>4,228</td>
<td>49,176</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orion</td>
<td>4,874</td>
<td>55,193</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CanterburyNZ</td>
<td>9,288</td>
<td>95,231</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AucklandNZ</td>
<td>9,480</td>
<td>87,867</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Formula: [readmissions] / [total episodes]

Source: Casemix

Description: % of episodes discharged in the reporting period, where the patient has an emergency readmission within 28 days of original discharge.

Index and readmission episode are acute or mental health care type only. Index is discharged home or to residential care. For the full list of inclusions and exclusions please see Appendix E.
## Appendix 3: HRT Benchmarks for SLMs: Relative stay index

### 2041 Acute care type Average Length of Stay (excluding mental health)

Comparison with peers (2015 Oct – 2016 Sep)

<table>
<thead>
<tr>
<th>Location</th>
<th>Bed days</th>
<th>Episodes</th>
<th>Relative Stay Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demeter</td>
<td>164,574</td>
<td>74,828</td>
<td>2.2</td>
</tr>
<tr>
<td>Orion+</td>
<td>228,177</td>
<td>94,990</td>
<td>2.4</td>
</tr>
<tr>
<td>CanterburyNZ</td>
<td>260,017</td>
<td>102,772</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>CountiesMKNZ</strong></td>
<td><strong>252,150</strong></td>
<td><strong>95,871</strong></td>
<td><strong>2.6</strong></td>
</tr>
<tr>
<td>Orion</td>
<td>170,365</td>
<td>62,298</td>
<td>2.7</td>
</tr>
<tr>
<td>Cougar+</td>
<td>199,510</td>
<td>72,450</td>
<td>2.8</td>
</tr>
<tr>
<td>Polaris</td>
<td>158,111</td>
<td>56,437</td>
<td>2.8</td>
</tr>
<tr>
<td>Artemis</td>
<td>187,136</td>
<td>64,249</td>
<td>2.9</td>
</tr>
<tr>
<td>AucklandNZ</td>
<td>272,233</td>
<td>93,231</td>
<td>2.9</td>
</tr>
<tr>
<td>PAH_QLD</td>
<td>176,511</td>
<td>58,583</td>
<td>3.0</td>
</tr>
<tr>
<td>Panther</td>
<td>222,771</td>
<td>70,541</td>
<td>3.2</td>
</tr>
<tr>
<td>FMC_SA</td>
<td>181,835</td>
<td>56,206</td>
<td>3.2</td>
</tr>
<tr>
<td>Sirius</td>
<td>214,337</td>
<td>61,413</td>
<td>3.5</td>
</tr>
<tr>
<td>Tornado</td>
<td>183,344</td>
<td>50,865</td>
<td>3.6</td>
</tr>
<tr>
<td>Falcon</td>
<td>210,270</td>
<td>53,175</td>
<td>4.0</td>
</tr>
</tbody>
</table>

**Formula:** \( \frac{\text{bed days}}{\text{episodes}} \)

**Source:** Casemix

**Description:** Average Length of Stay (days) for acute care type episodes excluding mental health

Only includes acute care type episodes. Excludes same day DRGs and error DRGs, episodes with HITH care and episodes in mental health (U) DRGs. Excludes episodes where the patient was discharged from ED.
Appendix 4: HRT Benchmarks for SLMs: Stranded patients with LOS > 21 days

2010 Long stay share of bed days for CountiesMKNZ in the latest period was 12.4%

Comparison with peers (2015 Oct – 2016 Sep)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Long stay bed days</th>
<th>Total bed days</th>
<th>% of Long stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demeter</td>
<td>12,554</td>
<td>119,616</td>
<td>10.5%</td>
</tr>
<tr>
<td>CanterburyNZ</td>
<td>19,851</td>
<td>187,161</td>
<td>10.6%</td>
</tr>
<tr>
<td>Artemis</td>
<td>16,848</td>
<td>147,362</td>
<td>11.4%</td>
</tr>
<tr>
<td>CountiesMKNZ</td>
<td>23,177</td>
<td>187,241</td>
<td>12.4%</td>
</tr>
<tr>
<td>Orion</td>
<td>23,796</td>
<td>180,888</td>
<td>13.2%</td>
</tr>
<tr>
<td>AucklandNZ</td>
<td>28,379</td>
<td>198,941</td>
<td>14.3%</td>
</tr>
<tr>
<td>Cougar</td>
<td>24,435</td>
<td>166,100</td>
<td>14.7%</td>
</tr>
<tr>
<td>Orion+</td>
<td>21,050</td>
<td>140,225</td>
<td>15.0%</td>
</tr>
<tr>
<td>FMC_SA</td>
<td>21,897</td>
<td>131,549</td>
<td>16.6%</td>
</tr>
<tr>
<td>Tornado</td>
<td>23,621</td>
<td>133,425</td>
<td>17.7%</td>
</tr>
<tr>
<td>PAH_QLD</td>
<td>28,905</td>
<td>154,206</td>
<td>18.7%</td>
</tr>
<tr>
<td>Panther</td>
<td>26,886</td>
<td>141,784</td>
<td>19.0%</td>
</tr>
<tr>
<td>Sirius</td>
<td>29,618</td>
<td>152,776</td>
<td>19.4%</td>
</tr>
<tr>
<td>Polaris</td>
<td>29,611</td>
<td>139,165</td>
<td>21.3%</td>
</tr>
<tr>
<td>Falcon</td>
<td>44,471</td>
<td>187,015</td>
<td>23.8%</td>
</tr>
</tbody>
</table>

Formula: [long stay bed days] / [total bed days]

Source: Casemix

Description: % of bed days in medical / surgical service lines that were for long stay patients

Acute care type only. Excludes U DRGs (Mental Health), same day DRGs and error DRGs and episodes with HITH care. Includes only medical & surgical DRGs. Excludes episodes where the patient was discharged from ED.

Details: [long stay bed days] are bed days for episodes with a LOS > 21.0 days.
### Balanced Scorecard

**HOSPITAL SERVICES BALANCED SCORECARD**

January 2017

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

#### National Targets

<table>
<thead>
<tr>
<th>Indicator</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department - 6 hour Length of Stay target</td>
<td>95%</td>
<td>95%</td>
<td>10%</td>
<td>96%</td>
<td>95%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faster Cancer Treatment - % of high suspicion first cancer treatment within 62 days (indicative result)</td>
<td>63%</td>
<td>63%</td>
<td>3%</td>
<td>75%</td>
<td>65%</td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective surgery discharges</td>
<td>991</td>
<td>1,099</td>
<td>-10%</td>
<td>8,658</td>
<td>7,509</td>
<td>15.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% smokers receive smokefree advice - Total</td>
<td>96%</td>
<td>95%</td>
<td>1%</td>
<td>96%</td>
<td>95%</td>
<td>1%</td>
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<td></td>
</tr>
</tbody>
</table>

#### Trend by month

<table>
<thead>
<tr>
<th>Month</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Caseweight</td>
<td>6,155</td>
<td>6,938</td>
<td>-11.3%</td>
<td>50,898</td>
<td>51,756</td>
<td>-1.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Caseweight</td>
<td>5,208</td>
<td>5,618</td>
<td>-7.3%</td>
<td>40,683</td>
<td>41,030</td>
<td>-0.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective Caseweight</td>
<td>2,676</td>
<td>3,072</td>
<td>-12.9%</td>
<td>24,214</td>
<td>24,355</td>
<td>-0.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Discharges</td>
<td>7,021</td>
<td>7,775</td>
<td>20.0%</td>
<td>64,854</td>
<td>66,739</td>
<td>5.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient First Specialist Assessment Volumes</td>
<td>213</td>
<td>295</td>
<td>-27.8%</td>
<td>2,297</td>
<td>2,205</td>
<td>4.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Follow Up Volumes</td>
<td>5,590</td>
<td>6,028</td>
<td>7.3%</td>
<td>5,431</td>
<td>5,331</td>
<td>11.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virtual First Specialist Assessments (GP consult and nonpatient appointments)</td>
<td>213</td>
<td>295</td>
<td>-27.8%</td>
<td>2,297</td>
<td>2,205</td>
<td>4.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budgeted FTEs</td>
<td>$21,676</td>
<td>$20,938</td>
<td>-3.5%</td>
<td>$154,236</td>
<td>$148,725</td>
<td>-3.7%</td>
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</tr>
<tr>
<td>Operating Costs ($000)</td>
<td>$48,418</td>
<td>$48,867</td>
<td>0.9%</td>
<td>$332,165</td>
<td>$339,959</td>
<td>2.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel Costs ($000)</td>
<td>$5,415</td>
<td>$5,164</td>
<td>-5.0%</td>
<td>$44,246</td>
<td>$44,044</td>
<td>-0.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Result Total ($000)</td>
<td>-1,555</td>
<td>-1,563</td>
<td>0.5%</td>
<td>-9,998</td>
<td>-10,098</td>
<td>1.0%</td>
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<td></td>
</tr>
<tr>
<td>Reduce clinical outsourcing ($000)</td>
<td>$2,534</td>
<td>$2,188</td>
<td>-15.8%</td>
<td>$16,333</td>
<td>$15,885</td>
<td>-2.8%</td>
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#### Enabling High Performing People

<table>
<thead>
<tr>
<th>Indicator</th>
<th>FY16-17</th>
<th>Dec-16</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
<th>Target</th>
<th>Var</th>
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</thead>
<tbody>
<tr>
<td>Excess Annual Leave dollars ($000) - estimated cost for excess</td>
<td>$3,355</td>
<td>$3,129</td>
<td>-$2,226</td>
<td>$3,423</td>
<td>$1,192</td>
<td>-$2,231</td>
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</tr>
<tr>
<td>Adult Rehabilitation and Health of Older People</td>
<td>$584</td>
<td>$514</td>
<td>-$70</td>
<td>$66</td>
<td>$73</td>
<td>7%</td>
<td></td>
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</tr>
<tr>
<td>Medicine, Acute Care and Clinical Support</td>
<td>$718</td>
<td>$642</td>
<td>-$76</td>
<td>$73</td>
<td>$95</td>
<td>22%</td>
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</tr>
<tr>
<td>Surgical and Ambulatory Care</td>
<td>$3,342</td>
<td>$3,454</td>
<td>-3%</td>
<td>$1,401</td>
<td>$1,446</td>
<td>3%</td>
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<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>$296</td>
<td>$314</td>
<td>-26%</td>
<td>$261</td>
<td>$314</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women’s Health and Kidz First</td>
<td>$601</td>
<td>$515</td>
<td>-$186</td>
<td>$246</td>
<td>$162</td>
<td>-$559</td>
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</tr>
<tr>
<td>% Staff Annual Leave &gt;2 years</td>
<td>11.0%</td>
<td>5.0%</td>
<td>-6.0%</td>
<td>11.9%</td>
<td>5.0%</td>
<td>-6.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Rehabilitation and Health of Older People</td>
<td>11.0%</td>
<td>5.0%</td>
<td>-6.0%</td>
<td>11.9%</td>
<td>5.0%</td>
<td>-6.9%</td>
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<td></td>
</tr>
<tr>
<td>Medicine, Acute Care and Clinical Support</td>
<td>11.0%</td>
<td>5.0%</td>
<td>-6.0%</td>
<td>11.9%</td>
<td>5.0%</td>
<td>-6.9%</td>
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<td></td>
</tr>
<tr>
<td>Surgical and Ambulatory Care</td>
<td>11.0%</td>
<td>5.0%</td>
<td>-6.0%</td>
<td>11.9%</td>
<td>5.0%</td>
<td>-6.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>11.0%</td>
<td>5.0%</td>
<td>-6.0%</td>
<td>11.9%</td>
<td>5.0%</td>
<td>-6.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Staff Turnover (YTD no. voluntary turnovers by average headcount)</td>
<td>11.3%</td>
<td>10.0%</td>
<td>-1.3%</td>
<td>10.4%</td>
<td>10.0%</td>
<td>-0.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace Injury per 1,000,000 hours</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
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<td></td>
</tr>
<tr>
<td>% Sick Leave</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
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</tbody>
</table>

#### Workforce Diversity

<table>
<thead>
<tr>
<th>Category</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>7%</td>
<td>7%</td>
<td>0%</td>
<td>7%</td>
<td>6%</td>
<td>-1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific</td>
<td>12%</td>
<td>12%</td>
<td>0%</td>
<td>12%</td>
<td>12%</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>31%</td>
<td>31%</td>
<td>0%</td>
<td>31%</td>
<td>31%</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ European / non-specified/ other</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Countsies Manukau District Health Board – Hospital Advisory Committee

8 March 2017
<table>
<thead>
<tr>
<th>Timely</th>
<th>Trend by month FY16-17</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>% e-medication reconciliation - high risk patients within 48hrs</td>
<td>75% 80% -5% 68% 80% -12%</td>
<td></td>
</tr>
<tr>
<td>% Serious Pressure Injuries rate / 100 Patients</td>
<td>0.0% 3.5% 3.5% 3.5% 3.5%</td>
<td></td>
</tr>
<tr>
<td>Falls causing major harm rate / 1,000 bed days</td>
<td>0.00 0.00 0.00 0.00 0.00</td>
<td></td>
</tr>
<tr>
<td>Rate of adverse events / 1,000 bed days</td>
<td>N/A N/A N/A N/A N/A</td>
<td></td>
</tr>
<tr>
<td>Central Line Associated Bacteraemia (CLAB) rate / 1,000 bed days</td>
<td>0.00 0.00 0.00 0.04 0.00</td>
<td>-0.04</td>
</tr>
<tr>
<td>Rate of S. aureus bacteraemia rate / 1,000 bed days</td>
<td>0.04 0.00 -0.04 0.08 0.00</td>
<td>-0.08</td>
</tr>
<tr>
<td>% 75+ years assessed for the risk of falling #</td>
<td>95% 90% 5.0% N/A N/A</td>
<td></td>
</tr>
<tr>
<td>% 75+ years assessed for falls risk with falls intervention plans.#</td>
<td>91% N/A N/A N/A N/A</td>
<td></td>
</tr>
<tr>
<td>% Magnetic Resonance Image (MRI) scans completed within 6 weeks from referral - MOH IDP</td>
<td>59% 85% -26% 81% 85% 1%</td>
<td></td>
</tr>
<tr>
<td>% Computerised Tomography (CT) scans completed within 6 weeks from referral - MOH IDP</td>
<td>95% 95% 0% 97% 95% 2%</td>
<td></td>
</tr>
<tr>
<td>% urgent diagnostic colonoscopy within 14 days - MOH IDP</td>
<td>94% 85% 9% 96% 85% 11%</td>
<td></td>
</tr>
<tr>
<td>% diagnostic colonoscopy patients within 42 days - MOH IDP</td>
<td>40% 70% -30% 73% 70% 3%</td>
<td></td>
</tr>
<tr>
<td>% surveillance colonoscopy patients within 84 days - MOH IDP</td>
<td>60% 70% -10% 85% 70% 15%</td>
<td></td>
</tr>
<tr>
<td>% cardiac STEMI-PCI (angiography) &lt;120mins - Northern Region</td>
<td>78% 80% -2% 87% 80% 7%</td>
<td></td>
</tr>
<tr>
<td>% Coronary Angiography within 90days - MOH IDP (11th arrears)</td>
<td>91% 95% -4% 98% 95% 3%</td>
<td></td>
</tr>
<tr>
<td>ESPI 2: No. patients waiting &gt;120 days for FSA - Elective Δ</td>
<td>0.0 0.0 0.0 0.0 0.0 0.0</td>
<td></td>
</tr>
<tr>
<td>ESPI 5: No. patients waiting &gt;120 days treatment - Elective Δ</td>
<td>31.0 0.0 -31.0 31.0 0.0 -31.0</td>
<td></td>
</tr>
<tr>
<td>Radiology - Inpatient radiology completion times &lt;24hrs</td>
<td>94% 95% -1% 94% 95% -1%</td>
<td></td>
</tr>
<tr>
<td>Radiology- Emergency Care radiology completion times &lt;2hrs</td>
<td>95% 95% 0% 93% 95% -2%</td>
<td></td>
</tr>
<tr>
<td>% Faster Cancer Treatment - % high suspicion first cancer treatment within 62 days - MOH FCT Target</td>
<td>63% 85% -22% 75% 85% 16%</td>
<td></td>
</tr>
<tr>
<td>% Faster Cancer Treatment - % confirmed diagnosis first cancer treatment within 31 days</td>
<td>89% N/A N/A 85% N/A 5%</td>
<td></td>
</tr>
<tr>
<td>% Radiology results reported within 24 hours</td>
<td>60% 75% -15% 59% 75% -16%</td>
<td></td>
</tr>
</tbody>
</table>
### Average Length of Stay - Acute Inpatient - MOH IDP

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.7</td>
<td>3.0</td>
<td>0.3</td>
<td>2.7</td>
<td>3.0</td>
</tr>
</tbody>
</table>

### Average Length of Stay - Acute Arranged/ Elective - MOH IDP

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.8</td>
<td>1.4</td>
<td>0.4</td>
<td>1.8</td>
<td>1.4</td>
</tr>
</tbody>
</table>

### Middlemore Hospital % patients to discharge lounge or home by 1100hrs

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27%</td>
<td>30%</td>
<td>-3%</td>
<td>17%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Acute Readmissions within 7 days - Total

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.5%</td>
<td>2.9%</td>
<td>-0.4</td>
<td>2.6%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

### Acute Readmissions within 28 days - Total - MOH IDP (1 month in arrear)

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7.3%</td>
<td>7.6%</td>
<td>-0.3</td>
<td>6.9%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

### Acute Readmissions within 28 days - 75+ years - MOH IDP (1 month in arrear)

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12%</td>
<td>12%</td>
<td>0.2%</td>
<td>11%</td>
<td>12%</td>
</tr>
</tbody>
</table>

### Emergency Department Presentations - 75+ year olds

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>947</td>
<td>807</td>
<td>-140</td>
<td>1,033</td>
<td>807</td>
</tr>
</tbody>
</table>

### % clinical summaries (meddocs) authorised <7 days of creation

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>72%</td>
<td>95%</td>
<td>-23%</td>
<td>73%</td>
<td>95%</td>
</tr>
</tbody>
</table>

### % of patient outliers - not on home ward <5%

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.6%</td>
<td>5.0%</td>
<td>2.4%</td>
<td>4.2%</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

### Outpatient - First Specialist : Follow-up Clinic ratio

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>38%</td>
<td>35%</td>
<td>-3%</td>
<td>37%</td>
<td>37%</td>
</tr>
</tbody>
</table>

### Outpatient - Did Not Attend rates - Maori

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21%</td>
<td>10%</td>
<td>-11%</td>
<td>20%</td>
<td>10%</td>
</tr>
</tbody>
</table>

### Outpatient - Did Not Attend rates - Pacific

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19%</td>
<td>10%</td>
<td>-9%</td>
<td>18%</td>
<td>10%</td>
</tr>
</tbody>
</table>

### Theatre List Utilisation

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>93%</td>
<td>83%</td>
<td>10%</td>
<td>91%</td>
<td>83%</td>
</tr>
</tbody>
</table>

### Day of Surgery Admissions (DOSA)

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>92%</td>
<td>90%</td>
<td>2%</td>
<td>89%</td>
<td>90%</td>
</tr>
</tbody>
</table>

### Day Case Rate (Elective/ Arranged)

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>76%</td>
<td>65%</td>
<td>11%</td>
<td>72%</td>
<td>65%</td>
</tr>
</tbody>
</table>

### % Medical Assessment patients with Length of Stay < 28 hours

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>78%</td>
<td>65%</td>
<td>13%</td>
<td>80%</td>
<td>65%</td>
</tr>
</tbody>
</table>

### No. Hospital bed days occupied (against forecast open beds)

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19,867</td>
<td>20,934</td>
<td>5.4%</td>
<td>140,885</td>
<td>150,891</td>
</tr>
</tbody>
</table>

### No. Length of Stay outliers (LOS >10 days)*

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>263</td>
<td>200</td>
<td>-24%</td>
<td>2,038</td>
<td>1,830</td>
</tr>
</tbody>
</table>

### % smokers receive smokefree advice - Maori

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97%</td>
<td>95%</td>
<td>2%</td>
<td>96%</td>
<td>95%</td>
</tr>
</tbody>
</table>

### % smokers receive smokefree advice - Pacific

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>97%</td>
<td>95%</td>
<td>2%</td>
<td>96%</td>
<td>95%</td>
</tr>
</tbody>
</table>

### % smokers receive smokefree advice - Asian

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>96%</td>
<td>95%</td>
<td>1%</td>
<td>97%</td>
<td>95%</td>
</tr>
</tbody>
</table>

### Volumes Screened

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2261</td>
<td>2255</td>
<td>6</td>
<td>68%</td>
<td>70%</td>
</tr>
</tbody>
</table>

### No. Women (45-60yrs) with Breastscreen in 24 months - Maaori

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>278</td>
<td>269</td>
<td>9</td>
<td>64%</td>
<td>70%</td>
</tr>
</tbody>
</table>

### No. Women (45-60yrs) with Breastscreen in 24 months - Pacific

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>399</td>
<td>370</td>
<td>29</td>
<td>75%</td>
<td>70%</td>
</tr>
</tbody>
</table>

### Patient experience Survey data - month (n=173) and YTD (n=1479)

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>76%</td>
<td>90%</td>
<td>-14%</td>
<td>80%</td>
<td>90%</td>
</tr>
</tbody>
</table>

### NOTES

* performance is against previous year’s actual
Δ ESPI interim results subject to change
**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 December 2016.

**Sick leave as percentage of total paid hours**

![Sick Leave as Percentage of Total Paid Hours](image)

**Annualised CMDHB voluntary turnover**

![Annualised CMDHB Voluntary Turnover](image)
Percentage of CMDHB workforce with annual leave balances > 2 yrs

![Graph showing percentage of CMDHB workforce with annual leave balances > 2 years' equivalent (Hospital Directorate Only).](image)

Annual leave paid as percentage of total paid hours

![Graph showing annual leave paid as a percentage of total paid hours from January 2016 to December 2016.](image)
Voluntary Employee Turnover by Reason for Leaving (January 2016 to December 2016)

- Personal
- Resigned
- To go overseas
- Another job in public health
- Job in Private health
- Job outside of health
- Job dissatisfaction
- Left district
- Unpaid work
- Education
## Finance Report Provider Arm

### Consolidated Statement of Financial Performance
**CMDHB Provider January 2017**

<table>
<thead>
<tr>
<th>Performance</th>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government Revenue</td>
<td>$4,696</td>
<td>$769 F</td>
<td>$2,181 F</td>
</tr>
<tr>
<td>Patient/Consumer Sourced</td>
<td>$769</td>
<td>$F</td>
<td>$1,218 F</td>
</tr>
<tr>
<td>Other Income</td>
<td>$2,181</td>
<td>$F</td>
<td>$3,150 F</td>
</tr>
<tr>
<td>Total Income</td>
<td>$7,658</td>
<td>$1,486 F</td>
<td>$5,499 F</td>
</tr>
</tbody>
</table>

| **Expenditure** |       |              |           |
| Personnel |       |              |           |
| Outsourced Personnel | $48,867 | $450 F | $429 F |
| Outsourced Clinical | $769 | $F | $670 F |
| Outsourced Other | $769 | $F | $769 F |
| Total Personnel | $51,467 | $878 F | $5,867 F |

| **Net Surplus/(Deficit) Provider** |       |              |           |
| Net Surplus/(Deficit) Provider | $(1,555) | $(1,563) | $8 F |

### Personnel Costs By Professional Group
**January 2017**

<table>
<thead>
<tr>
<th>Professional Group</th>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allied Health Personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support Personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management/Administration Personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (before Outsourced Personnel)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Outsourced Personnel |       |              |           |
| Outsourced Nursing |       |              |           |
| Outsourced Allied Health |       |              |           |
| Outsourced Support |       |              |           |
| Outsourced Management/Admin |       |              |           |
| Total Outsourced Personnel |       |              |           |

### Surplus / Deficit by Division
**January 2017**

<table>
<thead>
<tr>
<th>Division</th>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Clinical Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine and Integration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middlemore Central</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARHOP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical &amp; Ambulatory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women &amp; Child Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilities Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Innovations Hub &amp; Ko Awatea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Consolidated Statement of Financial Performance
**January 2017**

<table>
<thead>
<tr>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>$3,481</td>
<td>$1,453</td>
</tr>
<tr>
<td>Expenditure</td>
<td>$73,757</td>
<td>$14,502</td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>$(1,555)</td>
<td>$(1,563)</td>
</tr>
</tbody>
</table>

### Consolidated Statement of Financial Performance
**January 2017**

<table>
<thead>
<tr>
<th>Month</th>
<th>Year to Date</th>
<th>Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>$3,481</td>
<td>$1,453</td>
</tr>
<tr>
<td>Expenditure</td>
<td>$73,757</td>
<td>$14,502</td>
</tr>
<tr>
<td>Net Surplus/(Deficit)</td>
<td>$(1,555)</td>
<td>$(1,563)</td>
</tr>
</tbody>
</table>
Month in review

The Provider Arm produced an $8K favourable result against budget for January 2017 (YTD $100k favourable).

Emergency Department presentations YTD to January are 1.2% below the same period last year, reflecting a milder climate and the positive impact of integration work currently underway in the community.

RMO Industrial action for the three days 17th to 20th January has significantly disrupted inpatient activity, particularly surgery. YTD WIES activity is now running 1.7% below contract (acute -0.8% and elective -4.8%), reflecting the cumulative impact of industrial action. Acute surgical demand is also continuing to place pressure on elective lists. Recovery plans are in place to deliver to targets for the balance of year with specific focus on the MOH Elective discharge target.

The “Summer Bed Plan” was implemented over the Christmas and New Year Break with a nominated number of beds closing through to early January, in some cases extended closures. Non-essential staff were also encouraged to take extended leave during the holiday period resulting in realised benefits for the month.

Revenue

Overall revenue is $298k unfavourable for the month and $3.8M unfavourable year to date. Delay for the opening of the new retail pharmacy (open 7 February 2017) has contributed $4.5M to this YTD shortfall ($1M unfavourable for the month), but this is offset by YTD underspend in cost of goods sold (other expenses). Lower non-resident volumes ($340k), delayed Middlemore Foundation donation revenue ($359k) and fewer Tahitian burns presentations ($780k) have also presented a challenge YTD. The on-going success of the ACC arrears initiative and ACC Treatment Injury have softened this impact YTD.

Expenditure

Overall operational expenditure is $290k unfavourable for the month and favourable $2.3M YTD.

Key expenditure variances are summarised below:

Personnel Costs ($7.8M favourable YTD, Outsourced Personnel $3.5M unfavourable)"}

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

- Net Medical staff costs are $170k unfavourable YTD; difficulty in attracting salaried psychiatrists to the DHB has led to a $1.4M underspend in Mental Health staff costs, offset by outsourced medical costs for locum cover, $1.8M.
SMO costs associated with the January RMO industrial action ($670k net of RMO pay offset) have been fortuitously covered by existing medical vacancies, including SMO’s in urology and ophthalmology.

Over allocation of house officers is particularly challenging for medical services. This is a common theme across the region and is being managed carefully to reduce the financial impact.

- Net Nursing staff costs are $565k unfavourable YTD; reflecting bureau use to cover high acute demand, particularly in the Neonatal unit and Mental Health service. Bureau use is elevated to cover for approved nursing vacancies.

- Net Allied Health staff costs are $3.2M favourable YTD; driven by a shortage of anaesthetic technicians in the first half of the year $600K, together with a shift of multidisciplinary Mental Health community work to nursing. Continued vacancies across many areas of Allied Health and extended leave over the holiday period makes up the balance.

- Net Support Personnel costs are $608k unfavourable YTD; an analysis of all current service provision is underway to identify opportunities to minimise future exposure predominantly within cleaning, orderly and security services. Work is also underway with Human Resources to implement a proactive performance management structure for these services encompassing performance management, management of sick leave, overtime and annual leave.

- Net Management and Admin staff $2.4M favourable YTD; reflects vacancies in the Community teams $884k and Ko Awatea $600k together with other vacancies spread across all other services. Planned annual leave taken over the holiday period have also had a positive impact.

Non Staff Costs

- Clinical Supplies are $1.55M unfavourable YTD; driven by increased use of cancer drugs in Haematology and high cost drugs in Renal (Rituximab) and Gastro (Infliximab - treatment of Crohns Disease). Trends reflect regional alignment and clinical best practice. The January month favourable variance of $744k reflects a decreased workload due to high levels of annual leave over the holiday period and lower purchases as services consume clinical supplies carried over from December.

- Other Expenses are $180k unfavourable YTD; reflecting reduced cost of goods sold associated with the delay to open the retail pharmacy, offset by investment in Community Health Services Integration, on-going exposure relating to the national food contract and repairs and maintenance.

- Interest Depreciation and Capital Charge costs are $1.6M favourable YTD due to favourable interest rates and delay for capital investment.

Looking Ahead

System level measures have been introduced across Counties Manukau Health, ensuring aligned focus on the areas of our business most amendable to improvement.

Services will continue to work together to reduce ED demand through community focused staff at the front door and targeting repeat attendances from specific patient groups. Targeted extension of community based care (ASH focus) will assist stranded patients and at risk individuals. Discharging
efforts will focus on achieving 25% by 11 am and increasing Sunday discharges by 20%. This combination of interventions will reduce our bed demand going into autumn and winter enabling us to continue to run with YTD staffing resource.

The YTD cost of two periods of RMO industrial action has amounted to just over $2M. These costs add additional pressure to an already challenging Hospital Provider position.

Provider services are working closely with the Funder to deliver to the overall organisation target surplus of $4.5M. The above measures, combined with continued delivery against our target benefit plan will enable the Provider contribution to increase by $4.3M (favourable to budget), offsetting the unplanned cost exposure in the Funder Arm.
Emergency Department, Medicine & Integrated Care

Glossary
DAASH - Documentation Analgesia Airway Sepsis Heart
FCT – Faster Cancer Treatment
MoH – Ministry of Health
PCI – Percutaneous Coronary Intervention

Service Overview
The Division of Medicine, Acute Care and Clinical Support service is managed by Brad Healey General Manager, with Clinical Directors/Heads Dr Carl Eagleton (Medicine), Dr Vanessa Thornton (Emergency Care), Dr Sally Urry (Breastscreen), Dr Mary Christie (Histopathology), and Clinical Nurse Directors To’a Fereti and Annie Fogarty.

Volumes

Activity (Overall trends positive with reduced acute volumes)

ED presentations
In January were 9,080, down 2.6% on last years actuals of 9,323. YTD presentations are 66,743 vs 67,535 this time last year, down 1.2% following the mild winter. Against forecast, ED discharges in January were 9,024 vs 9,839 contract, down 8% for the month and 66,696 vs 70,323 forecast YTD, down 5%. The forecast growth of 3.5% on last year’s volumes has not occurred with a milder winter and enhanced capacity in the community and a range of inpatient initiatives including the front door initiative.

Acute Wies YTD, is 2.9% down on contract, a total of 426 WIES YTD.

In-centre dialysis treatments are down 2.7% against contract which is positive as we are focussing on more patients having home dialysis as opposed to incentre. Home dialysis volumes are on contract and are expected to exceed contract in the next few months with the addition of the third community house.
Emerging Opportunities

Medical Oncology

Outpatient clinics commenced in the new Galbraith Infusion Centre from 24/1/17, ahead of the first infusions (Herceptin) commencing 14/2/17 as part of the new model of care for the Auckland Regional Cancer service.

Bowel Screening Programme (BSP)

In November 2016 the MoH informed us that the BSP would be implemented at Counties Health in April 2018 rather than the initially proposed date of 2019. We have established a plan to deliver the BSP within these timeframes and believe it will contribute greatly to achieving our goal of adding 500,000 life years by 2020.

Improving the discharge process

We are working to improve patient discharges so that the clinical teams and patient and whanau are working in a coordinated way to prepare the patient for discharge. The improved process includes ensuring all patients have an expected date of discharge known and visible to all care providers. This includes increased use of the discharge lounge so that patient teaching and pharmacy counselling can be provided. It also includes use of criteria specific discharge enhancing the role of nurses in the discharge process and ensuring more timely discharge (see graph below).

Renal dialysis technology enhancement

Work continues with Fresenius to change all of the incentre dialysis units to High Flux dialysis at no additional cost. This means patient’s dialysis sessions will be reduced from 4-5 hours to 2-3 hours reducing the burden of disease and improving clinical outcomes with better clearance of middle molecules that can give rise to arthritis and joint pain amongst other benefits.

Team based wards

Ward configuration to strengthen specialty alignment e.g. cardiology, respiratory, medicine etc has now occurred. Apart from a few initial adjustment challenges the change has progressed well. We expect to see that the the closer alignment of the multidisciplinary teams with the medical teams will improve patient care, clinical outcomes and patient experience.
## EMERGENCY CARE, MEDICINE AND INTEGRATED CARE SCORECARD

### January 2017

#### Ensuring Financial Sustainability

<table>
<thead>
<tr>
<th></th>
<th>Trend FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Caseweight</td>
<td></td>
<td>2,262</td>
<td>2,358</td>
<td>-4.1%</td>
<td>17,962</td>
<td>18,404</td>
<td>-2.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective Caseweight</td>
<td></td>
<td>35</td>
<td>72</td>
<td>-51.4%</td>
<td>354</td>
<td>564</td>
<td>-37.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Caseweight (includes ICU)</td>
<td></td>
<td>2,227</td>
<td>2,286</td>
<td>-2.6%</td>
<td>17,608</td>
<td>17,840</td>
<td>-1.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient FSA Volumes</td>
<td></td>
<td>993</td>
<td>1,178</td>
<td>-15.7%</td>
<td>9,548</td>
<td>9,450</td>
<td>1.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Follow Up Volumes</td>
<td></td>
<td>2,376</td>
<td>3,002</td>
<td>-20.9%</td>
<td>22,860</td>
<td>23,551</td>
<td>-2.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virtual FSAs</td>
<td></td>
<td>109</td>
<td>146</td>
<td>-25.3%</td>
<td>1,208</td>
<td>1,050</td>
<td>15.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Enabling High Performing People

<table>
<thead>
<tr>
<th></th>
<th>Trend FY16-17</th>
<th>Dec-16</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
<th>12 month average</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Staff with Annual Leave &gt; 2 years</td>
<td></td>
<td>6.6%</td>
<td>5.0%</td>
<td>-1.6%</td>
<td>8.0%</td>
<td>5.0%</td>
<td>-3.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Staff Turnover</td>
<td></td>
<td>10.5%</td>
<td>10.0%</td>
<td>-0.5%</td>
<td>9.3%</td>
<td>10.0%</td>
<td>0.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Sick Leave</td>
<td></td>
<td>0.0%</td>
<td>2.8%</td>
<td>2.8%</td>
<td>2.9%</td>
<td>2.8%</td>
<td>-0.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace Injury per 1,000,000 hours</td>
<td></td>
<td>10.5</td>
<td>10.5</td>
<td>10.5</td>
<td>10.5</td>
<td>10.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Safety

<table>
<thead>
<tr>
<th></th>
<th>Trend FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Falls causing major harm</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>No falls.</td>
</tr>
</tbody>
</table>

Counties Manukau District Health Board – Hospital Advisory Committee 8 March 2017
<table>
<thead>
<tr>
<th>Time</th>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Target</th>
<th>Var</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Radiotherapy commences in 4 weeks</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Green</td>
<td>Target not achieved due to SMO vacancies x 2, 3 SMOs on extended leave without cover, 1 fellow vacancy and the RMO strike action. Outsourcing and recruitment of SMO has been undertaken to mitigate the failure to achieve targets.</td>
</tr>
<tr>
<td>% Chemotherapy commences in 4 weeks</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Green</td>
<td>Target not achieved due to SMO vacancies x 2, 3 SMOs on extended leave without cover, 1 fellow vacancy and the RMO strike action. Outsourcing and recruitment of SMO has been undertaken to mitigate the failure to achieve targets.</td>
</tr>
<tr>
<td>% of patients admitted, discharged, transferred from ED within 6 hrs</td>
<td>95%</td>
<td>95%</td>
<td>0%</td>
<td>96%</td>
<td>95%</td>
<td>1%</td>
<td>95%</td>
<td>1%</td>
<td>Red</td>
<td>Lengthening wait for elective angiograms due to combination of acute demand competing with elective slots, machine breakdowns and public holidays. Additional capacity in theatre will assist in helping meet the target.</td>
</tr>
<tr>
<td>P1 (urgent) % diagnostic colonoscopy patients receive the procedure within 14 days</td>
<td>94%</td>
<td>85%</td>
<td>15%</td>
<td>96%</td>
<td>85%</td>
<td>10%</td>
<td>96%</td>
<td>10%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>P2 (routine) % diagnostic colonoscopy patients receive the procedure within 42 days</td>
<td>40%</td>
<td>70%</td>
<td>-15%</td>
<td>73%</td>
<td>70%</td>
<td>13%</td>
<td>73%</td>
<td>13%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>% surveillance colonoscopy patients receive their procedure within 84 days of planned date</td>
<td>60%</td>
<td>70%</td>
<td>-10%</td>
<td>85%</td>
<td>70%</td>
<td>15%</td>
<td>85%</td>
<td>15%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>% cardiac STEMI - PCI (angiography) within 120 mins - Northern Region Target</td>
<td>78%</td>
<td>80%</td>
<td>8%</td>
<td>87%</td>
<td>80%</td>
<td>8%</td>
<td>87%</td>
<td>8%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>% Coronary Angiography within 90days - MOH IDP (1 month in arrears)</td>
<td>91%</td>
<td>95%</td>
<td>1%</td>
<td>98%</td>
<td>95%</td>
<td>3%</td>
<td>98%</td>
<td>3%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>Medical Assessment – Triage 3-5 patients seen within 60 minutes</td>
<td>87%</td>
<td>60%</td>
<td>17%</td>
<td>76</td>
<td>60</td>
<td>16%</td>
<td>76</td>
<td>16%</td>
<td>Red</td>
<td>High volumes in medicine made this difficult to achieve</td>
</tr>
<tr>
<td>Door to Cathlab suspected Acute Coronary Syndrome &lt; 3 days (median time)</td>
<td>78%</td>
<td>70%</td>
<td>8%</td>
<td>80%</td>
<td>70%</td>
<td>10%</td>
<td>80%</td>
<td>10%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>1st Time to be seen Triage 1 &amp; 2 patients (median time in minutes)</td>
<td>28</td>
<td>30</td>
<td>2%</td>
<td>30</td>
<td>30</td>
<td>0%</td>
<td>30</td>
<td>0%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>1st Time to be seen Triage 3 - 5 patients (median time in minutes)</td>
<td>77</td>
<td>60</td>
<td>16%</td>
<td>76</td>
<td>60</td>
<td>16%</td>
<td>76</td>
<td>16%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>2nd Time to be seen Triage 1 &amp; 2 patients (median time in minutes)</td>
<td>77</td>
<td>60</td>
<td>16%</td>
<td>76</td>
<td>60</td>
<td>16%</td>
<td>76</td>
<td>16%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>2nd Time to be seen Triage 3 - 5 patients (median time in minutes)</td>
<td>71</td>
<td>60</td>
<td>11%</td>
<td>68</td>
<td>60</td>
<td>8%</td>
<td>68</td>
<td>8%</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>Faster Cancer Treatment - % high suspicion first cancer treatment within 62 days - MOH FCT</td>
<td>63%</td>
<td>85%</td>
<td>-17%</td>
<td>75%</td>
<td>85%</td>
<td>-9%</td>
<td>75%</td>
<td>-9%</td>
<td>Yellow</td>
<td></td>
</tr>
<tr>
<td>Faster Cancer Treatment - %confirmed diagnosis first cancer treatment within 31 days - MOH FCT</td>
<td>89%</td>
<td>85%</td>
<td>14%</td>
<td>85%</td>
<td>85%</td>
<td>-1.0%</td>
<td>85%</td>
<td>-1.0%</td>
<td>Green</td>
<td></td>
</tr>
</tbody>
</table>
### Average Length of Stay - Acute

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>3.1</td>
<td>3.5</td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3.2</td>
<td>3.5</td>
<td>0.3</td>
</tr>
</tbody>
</table>

**Commentary (by exception):**

The general medicine floor change occurred on the 5th of Dec. Despite the change there are still a high level of patients not on home wards. This is being assessed.

### Acute Readmissions within 28 days - Total

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>11%</td>
<td>10%</td>
<td>-1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>14%</td>
<td>10%</td>
<td>-4%</td>
</tr>
</tbody>
</table>

### Acute Readmissions within 28 days - 75+

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>45%</td>
<td>75%</td>
<td>-30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>45%</td>
<td>75%</td>
<td>-30%</td>
</tr>
</tbody>
</table>

### % of patients on home wards in General Medicine

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>45%</td>
<td>75%</td>
<td>-30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>45%</td>
<td>75%</td>
<td>-30%</td>
</tr>
</tbody>
</table>

### % of Outliers on non-medicine wards

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>4.8%</td>
<td>0.0%</td>
<td>-4.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7.6%</td>
<td>0.0%</td>
<td>-7.6%</td>
</tr>
</tbody>
</table>

**Commentary (by exception):**

The general medicine floor change occurred on the 5th of Dec. Despite the change there are still a high level of patients not on home wards. This is being assessed.

### % Discharges from transit lounge or home by 1100hrs

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>13%</td>
<td>30%</td>
<td>-17%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15%</td>
<td>30%</td>
<td>-15%</td>
</tr>
</tbody>
</table>

**Commentary (by exception):**

Improved patient discharge process underway.

### % MA short stay patients discharged home from Medical Assessment

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>83%</td>
<td>80%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>82%</td>
<td>80%</td>
<td>2%</td>
</tr>
</tbody>
</table>

### % Discharged from Medical Assessment Unit by 1100hrs

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>36%</td>
<td>40.0%</td>
<td>-4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>39%</td>
<td>40%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

### % of patients <28 hrs discharged from inpatient wards

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>9%</td>
<td>10%</td>
<td>-1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Implement Home First Renal policy - (increase CAPD & HD rate)

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>44%</td>
<td>50%</td>
<td>-6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>44%</td>
<td>50%</td>
<td>-6%</td>
</tr>
</tbody>
</table>

**Commentary (by exception):**

Volumes for home therapies have increased overall by 1 from January. However, this actually includes 3 new patient to PD, but 2 patients died & 1 patient transferred to another DHB, there were also 2 new home haemodialysis patients. The total number of patients on dialysis has increased by 9, with 8 being incentre dialysis. So the incentre:home therapies is 44%:56%.

### % Women with Breastscreen in last 24 months - total

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2261</td>
<td>2255</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>68%</td>
<td>70%</td>
<td>-2%</td>
</tr>
</tbody>
</table>

### % Women with Breastscreen in last 24 months - Maaori

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>278</td>
<td>269</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>64%</td>
<td>70%</td>
<td>-6%</td>
</tr>
</tbody>
</table>

### % Women with Breastscreen in last 24 months - Pacific

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>399</td>
<td>370</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>75%</td>
<td>70%</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Successful Recruitment of MRTs has resulted in additional screening slots. Business case underway for additional mammography machine to further increase capacity.

### % Women with Breastscreen in last 24 months - total

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target Var</th>
<th>Actual</th>
<th>Target Var</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>85%</td>
<td>90%</td>
<td>-5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>82%</td>
<td>90%</td>
<td>-8%</td>
</tr>
</tbody>
</table>

**Commentary (by exception):**

Successful Recruitment of MRTs has resulted in additional screening slots. Business case underway for additional mammography machine to further increase capacity.
Surgery, Anaesthesia & Perioperative Services

Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AT</td>
<td>Anaesthetic Technician</td>
</tr>
<tr>
<td>CLAB</td>
<td>Central Line Associated Bacteraemia</td>
</tr>
<tr>
<td>CCC</td>
<td>Critical Care Complex</td>
</tr>
<tr>
<td>DNA</td>
<td>Did Not Attend</td>
</tr>
<tr>
<td>DOSA</td>
<td>Day of Surgery Admissions</td>
</tr>
<tr>
<td>ESPI</td>
<td>Elective Services Patient Flow Indicator</td>
</tr>
<tr>
<td>FSA</td>
<td>First Specialist Assessment</td>
</tr>
<tr>
<td>HoD</td>
<td>Head of Department</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>MSC</td>
<td>Manukau SuperClinic</td>
</tr>
<tr>
<td>ORL</td>
<td>Otorhinolaryngology</td>
</tr>
<tr>
<td>PAR</td>
<td>Patient at Risk</td>
</tr>
<tr>
<td>PCIMS</td>
<td>Perioperative Clinical Information Management System</td>
</tr>
<tr>
<td>SAPS</td>
<td>Surgery, Anaesthesia and Perioperative Services</td>
</tr>
<tr>
<td>VTE</td>
<td>Venous Thrombosis</td>
</tr>
</tbody>
</table>

Service Overview

Surgical, Anaesthesia and Perioperative Services is managed by Mary Burr General Manager with Dr Mark Moores Clinical Director - Surgery, Catherine Simpson Clinical Director - Critical Care, Jacqui Wynne-Jones Clinical Nurse Director - Surgery, and Annie Fogerty Clinical Nurse Director - Acute & Critical Care.

Highlights

WIES

Electives WIES are 14.70% under contract for the month as a result of the strike but are only 0.09% below contract year to date despite the significant impact of the two RDA strikes.

Elective WIES are 402 WIES or 4.56% higher than the corresponding period of the last financial year. Overall we are 155 WIES or 0.68% over the WIES achieved last year.

Discharges

Acute discharges are 80 cases lower than contract for the month but 360 cases or 3.12% higher than contract year to date.

Elective discharges were lower than anticipated contracted levels by 46 patients or 4.51% but 112 patients (1.3%) higher compared with contract year to date.

Overall patient discharges are 127 lower than contract for month but 472 patients higher year to date so our goal to maintain a YTD buffer rather than chase volumes in the last quarter because of unforeseen events has proved effective.

In comparison with that of last financial year acute discharges are higher by 214 patients and electives are over by 430. Overall therefore we have provided surgery for 644 more patients compared with the corresponding seven month period of the last financial year.
Emerging Issues

- The month’s Elective target has been adversely impacted by RMO strike action which resulted in 35 elective lists being postponed. In total 85 elective cases had to be deferred which in turn has caused a number of breaches in ESPi5. We have in place our recovery plan which means we have adjusted our production plan but we are on track to deliver Counties and IDF volumes for 16/17.

- We have a potential machinery failure in the sterilising unit at MSC which will have a major impact upon the delivery of elective surgery if it occurs. Several pieces of equipment are due for replacement in the Sterilising Unit and one major item has developed a crack. We have an action plan in place for a control refit and an emergency plan in case for a catastrophic failure.

Update on previously reported issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Date reported</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic Demand</td>
<td>Dec 2017</td>
<td>Increased acute demand has impacted upon orthopaedic elective outputs resulting in a RED ESPi for the service. We have resourced extra acute theatre time to manage the volumes and reduce the impact on elective throughput. We are meeting our elective discharge targets.</td>
</tr>
<tr>
<td>Demand on Ophthalmology and ORL Services</td>
<td>July 2016</td>
<td>The interim solution, the ophthalmology training facility in the Galbraith building will open in March. The new training facility will have three clinic rooms, two technical rooms, and a patient waiting area in close proximity. The expanded training facilities will coincide with the arrival of the two new ophthalmologist appointments commencing in early 2017 and with the Auckland University academic year starting in February. In the longer term it is envisioned that the Ophthalmology training facility will occur as an extension of Module 6 at MSC as part of the UoO dental facility.</td>
</tr>
</tbody>
</table>
| Critical Care beds under increasing demand | July 2016 | 1. PAR team data still being collected. Monitoring upgrade of electronic system.  
2. Booking system in place for elective surgery.  
3. Workgroup established with Surgery and Medicine around patient flow to ensure discharges are made in a timely manner. |
### SURGICAL AND AMBULATORY SCORECARD

**January 2017**

#### Trend Rating Commentary (by exception)

<table>
<thead>
<tr>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Caseweight (Provider view)</strong></td>
<td>2,861</td>
<td>3,274</td>
<td>-12.0%</td>
<td>22,973</td>
<td>23,279</td>
<td>-1.3%</td>
</tr>
<tr>
<td><strong>Elective Caseweight</strong></td>
<td>948</td>
<td>1,112</td>
<td>-14.7%</td>
<td>9,204</td>
<td>9,212</td>
<td>-0.1%</td>
</tr>
<tr>
<td><strong>Acute Caseweight</strong></td>
<td>1,912</td>
<td>2,163</td>
<td>-11.6%</td>
<td>13,770</td>
<td>14,067</td>
<td>-2.1%</td>
</tr>
<tr>
<td><strong>Acute discharges</strong></td>
<td>1,641</td>
<td>1,721</td>
<td>-4.7%</td>
<td>11,556</td>
<td>11,196</td>
<td>3.2%</td>
</tr>
<tr>
<td><strong>Elective Surgical Discharges</strong></td>
<td>983</td>
<td>1,029</td>
<td>-4.5%</td>
<td>8,650</td>
<td>8,538</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Virtual FSAs/Follow ups -(GP consult and nonpatient appointments)</strong></td>
<td>108</td>
<td>128</td>
<td>-15.5%</td>
<td>940</td>
<td>1,021</td>
<td>-7.9%</td>
</tr>
<tr>
<td><strong>Personnel Costs ($000)</strong></td>
<td>$12,882</td>
<td>$12,322</td>
<td>-4.5%</td>
<td>$88,427</td>
<td>$89,439</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Financial Result Total ($m)</strong></td>
<td>$14,851</td>
<td>$14,502</td>
<td>-2.4%</td>
<td>$105,831</td>
<td>$105,350</td>
<td>-0.46%</td>
</tr>
<tr>
<td><strong>Reduce clinical outsourcing ($000)</strong></td>
<td>$221</td>
<td>$202</td>
<td>-9.8%</td>
<td>$3,033</td>
<td>$1,996</td>
<td>-52.0%</td>
</tr>
</tbody>
</table>

#### Ensuring Financial Sustainability

<table>
<thead>
<tr>
<th>Trend FY16-17</th>
<th>Dec-16</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% Staff with Annual Leave &gt; 2 years</strong></td>
<td>14.8%</td>
<td>5.0%</td>
<td>-9.8%</td>
<td>15.7%</td>
<td>5.0%</td>
<td>-10.7%</td>
</tr>
<tr>
<td><strong>% Staff Turnover</strong></td>
<td>9.7%</td>
<td>10.0%</td>
<td>0.3%</td>
<td>8.7%</td>
<td>10.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>% Sick Leave</strong></td>
<td>2.5%</td>
<td>2.8%</td>
<td>0.3%</td>
<td>2.7%</td>
<td>2.8%</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Workplace Injury per 1,000,000 hours</strong></td>
<td>10.5</td>
<td>10.5</td>
<td>0.0</td>
<td>10.5</td>
<td>10.5</td>
<td>0.0</td>
</tr>
</tbody>
</table>

#### Enabling High Performing People

<table>
<thead>
<tr>
<th>Trend FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hand Hygiene compliance rate (based on Gold Audit) - Ward 11</strong></td>
<td>73%</td>
<td>80%</td>
<td>-7.0%</td>
<td>74%</td>
<td>80%</td>
<td>-6.1%</td>
</tr>
<tr>
<td><strong>Pressure Injuries / 100 patients</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Falls causing major harm / 1000 bed days</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Severe Pressure Injury (ungradeable) per 1000 bed days</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Surgical Site Surveillance for Major joints</strong></td>
<td>93%</td>
<td>95%</td>
<td>-2%</td>
<td>89%</td>
<td>95%</td>
<td>-6%</td>
</tr>
</tbody>
</table>

#### First, Do No Harm (Safety)

<table>
<thead>
<tr>
<th>Trend FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibiotics given 0-60mins before &quot;knife to skin&quot;</strong></td>
<td>90%</td>
<td>100%</td>
<td>0%</td>
<td>97%</td>
<td>100%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>2 grams or more Cefazolin given</strong></td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>99%</td>
<td>100%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Appropriate skin preparation</strong></td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>99%</td>
<td>100%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>CLAB rate/ 1000 line days</strong></td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.4</td>
<td>0.0</td>
<td>-0.4%</td>
</tr>
<tr>
<td><strong>Rate of S. aureus bacteraemia per 1000 bed days</strong></td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>VTE - Ortho (Acute and Elective)</strong></td>
<td>5.0</td>
<td>2.0</td>
<td>-3.0</td>
<td>44.0</td>
<td>0.0</td>
<td>-44.0</td>
</tr>
</tbody>
</table>

#### Timeliness

<table>
<thead>
<tr>
<th>Trend FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-operative Length of Stay Days (from admit to surgery)</strong></td>
<td>1.3</td>
<td>1.0</td>
<td>-0.3</td>
<td>1.2</td>
<td>1.0</td>
<td>-0.2</td>
</tr>
<tr>
<td><strong>ESPI 2 No. patients waiting &gt;120 days for FSA - Elective (Surgical Services incl Gynae)</strong></td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>ESPI 5 No. patients waiting &gt;120 days Treatment - Elective (Surgical Services incl Gynae)</strong></td>
<td>31</td>
<td>31</td>
<td>-31.0</td>
<td>31</td>
<td>0</td>
<td>-31.0</td>
</tr>
</tbody>
</table>

**Commentary (by exception)**

- **Month impacted by strike. Recovery plan in place.**
- **Month impacted by strike. Recovery plan in place.**
- **High contract not adjusted for change in WIES.**
- **Improvement in month % over previous months. Monitoring weekly.**
- **Relates to increased out sourcing in respect of strike losses and previous Anaesthetic Tech shortage.**
- **Working consistently with staff with high leave balances. Service Managers reporting back monthly.**
- **Next audit results March 17. 17/18 plan to have 2 gold auditors in each area.**
- **Prolonged set up time can impact on knife to skin result. Monitoring continues. Communications to all staff to improve documentation.**
- **Education packages continue.**
- **Pre OP LOS being impacted by delays in treatment of Acutes. More resource put into acute theatres.**
- **Relates to strike losses. Recovery plans in place.**
### System Integration (Effective)

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of Stay - Acute Inpatient incl Burns</td>
<td>3.69</td>
<td>3.8</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay - Acute Inpatient excl: Burns</td>
<td>3.65</td>
<td>3.8</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay - Acute Inpatient excl: Burns and Spinal Ortho</td>
<td>3.64</td>
<td>3.8</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay - Electives</td>
<td>0.84</td>
<td>1.5</td>
<td>0.7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theatre list utilisation - % used MMH/MSC (MOH OSS)</td>
<td>93%</td>
<td>85%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Theatre session utilisation - % used MMH/MSC</td>
<td>98%</td>
<td>95%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Elective Theatre turnaround times - Mins (MSC only)</td>
<td>15</td>
<td>15</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Elective cancellations - Day of surgery as % of all Elective (all reasons)- SACS only</td>
<td>7.7%</td>
<td>5.0%</td>
<td>-2.7%</td>
<td></td>
</tr>
<tr>
<td>Day of Surgery Admissions (DOSA)</td>
<td>92%</td>
<td>90%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Day Case Rate (Elective/ Arranged)- Subspecialties in SACS only Adults/kids</td>
<td>76%</td>
<td>65%</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>MMH % patients discharged to discharge lounge or home by 1100hrs</td>
<td>19%</td>
<td>30%</td>
<td>-11%</td>
<td></td>
</tr>
<tr>
<td>MMH % patients discharged to discharge lounge or home by 1100hrs - GEN SURG</td>
<td>16%</td>
<td>30%</td>
<td>-14%</td>
<td></td>
</tr>
<tr>
<td>MMH % patients discharged to discharge lounge or home by 1100hrs- ORTHO</td>
<td>11%</td>
<td>30%</td>
<td>-19%</td>
<td></td>
</tr>
<tr>
<td>Ratio FSA/FU clinic ratio</td>
<td>36%</td>
<td>31%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Outpatient DNA rates - overall- Surgical Services only</td>
<td>9%</td>
<td>10%</td>
<td>0.7%</td>
<td></td>
</tr>
<tr>
<td>Outpatient DNA rates - Maori (FSA) - Surgical Services only</td>
<td>15%</td>
<td>10%</td>
<td>-5.1%</td>
<td></td>
</tr>
<tr>
<td>Outpatient DNA rates - Pacific (FSA)- Surgical Services only</td>
<td>16%</td>
<td>10%</td>
<td>-5.5%</td>
<td></td>
</tr>
</tbody>
</table>

### Efficient

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of hospitalised smokers receiving smokefree advice &amp; support -Total (Surgical)</td>
<td>97%</td>
<td>95%</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>

### Equity

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience Survey - month (n=61) and YTD (n=472)</td>
<td>83%</td>
<td>90%</td>
<td>-7%</td>
<td></td>
</tr>
</tbody>
</table>

### Commentary (by exception)

- Still work to do - monitoring closely. Monitored and discussed at fortnightly meeting.
- Disappointing month’s result - impact by high acute load in hospital. Close monitoring continues by CNM Patient Flow.
- Organisational approach required.
Women’s Health & Kidz First

Glossary
HCA Health Care Assistant
KF Kidz First
LMC Lead Maternity Carer
MQSP Maternity Quality and Safety Programme
NHPPD Nursing Hours Per Patient Day
SUDI Sudden Unexplained Death of Infant
VIP Violence Intervention Programme

Service Overview

Kidz First and Women’s Health is managed by General Manager Nettie Knetsch 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

For January 2017, admissions in Kidz First Medical were down by 88 and ED presentations were lower by 252 for the month. This pattern was also seen by the two other DHBs. The pattern presented below showing non-standardised ASH rates for 0-4 years for the last 12 months shows declining numbers for Maori and Pacific. We have seen declining Emergency Department presentations and inpatient admissions for all children in January, and YTD which has resulted in 1458 fewer presentations to ED and 402 fewer admissions YTD. The greatest variance between 2015 and 2016 was in children with viral infections and acute bronchiolitis but no major variations in WIES or LOS. Of interest is the decrease of 5% in Pacific children in these diagnoses.
The lower patient volumes provided the opportunity to amalgamate Kidz First Medical and Surgical Floors over the Christmas and New Year period as a trial for a month for the first time ever. This enabled more staff to take annual leave and those remaining to be redeployed to cover the very busy Neonatal Unit or Maternity. The overall saving for the 4 weeks of amalgamation was $176k. The Neonatal Unit became incredibly busy again in January.

Emerging Issues

- Despite the overall birth numbers remaining stable, we are seeing a slow increase in Caesarean Section rate. YTD December this is 26% vs 22% for the same period last year.
- Over the past 3 months we have seen our midwifery FTE going down rapidly. This is due to retirements, parental leave and younger midwives now also moving out of Auckland to provincial centres (housing affordability impact). Senior midwives and clinical charge midwives worked effectively to cover the vacancies often working themselves. We have set up a midwifery workforce action group in early January involving all senior midwifery leaders, HR, both unions (MERAS and NZNO) to manage the immediate shortage as well as plan for maximising the recruitment and employment of the upcoming new graduate cohort of 30 midwives in May 2017.

Update on previously reported issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Date reported</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal Unit capacity</td>
<td>April 2016</td>
<td>Occupancy remains high after some easing over Christmas and New Year 2017. Whilst regional capacity work is underway we have simultaneously commenced a nursing recruitment and model of care project to support more junior nursing staff to work in the neonatal specialty.</td>
</tr>
</tbody>
</table>
### KIDZ FIRST SCORECARD

#### January 2017

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Caseweight</td>
<td>248</td>
<td>290</td>
<td>-14%</td>
<td>2826</td>
<td>2901</td>
<td>-3%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Acute Caseweight - Paed Surg - accounted under Adult Surgery</td>
<td>125</td>
<td>179</td>
<td>-30%</td>
<td>1177</td>
<td>1164</td>
<td>1%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Acute Caseweight - Emergency medicine - accounted under Adult Acute Care</td>
<td>60</td>
<td>75</td>
<td>-20%</td>
<td>463</td>
<td>522</td>
<td>-11%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Acute Caseweight - Intensivist Medicine ICU - accounted under ICU</td>
<td>2</td>
<td>0</td>
<td>#DIV/0!</td>
<td>79</td>
<td>15</td>
<td>427%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Elective Caseweight - Paed Surg - accounted under Adult Surgery</td>
<td>48</td>
<td>56</td>
<td>-14%</td>
<td>509</td>
<td>467</td>
<td>9%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Total Discharges</td>
<td>290</td>
<td>376</td>
<td>-23%</td>
<td>3278</td>
<td>3657</td>
<td>-10%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Outpatient First Specialist Assessment volumes</td>
<td>202</td>
<td>189</td>
<td>7%</td>
<td>1726</td>
<td>1547</td>
<td>12%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Budgeted FTEs</td>
<td>238</td>
<td>271</td>
<td>12%</td>
<td>266</td>
<td>277</td>
<td>4%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Operating Costs ($000)</td>
<td>$2,210</td>
<td>$2,400</td>
<td>8%</td>
<td>$16,024</td>
<td>$16,590</td>
<td>3%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Financial Result Total ($000)</td>
<td>$2,322</td>
<td>$2,468</td>
<td>6%</td>
<td>$16,848</td>
<td>$17,156</td>
<td>2%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Reduce Clinical Outsourcing ($000)</td>
<td>$3</td>
<td>$4</td>
<td>25%</td>
<td>$40</td>
<td>$35</td>
<td>-14%</td>
<td><img src="Reasons" alt="Commentary" /></td>
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</table>

### Enabling High Performing People

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Dec-16</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Staff with Annual Leave &gt; 2 years - (one month in arrear)</td>
<td>18.5%</td>
<td>5.0%</td>
<td>-13.5%</td>
<td>20.6%</td>
<td>5.0%</td>
<td>-15.6%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>% Staff Turnover - (one month in arrear)</td>
<td>16.1%</td>
<td>10.0%</td>
<td>-6.1%</td>
<td>16.1%</td>
<td>10.0%</td>
<td>-6.1%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>% Sick leave - (one month in arrears)</td>
<td>3.1%</td>
<td>2.8%</td>
<td>-0.3%</td>
<td>3.4%</td>
<td>2.8%</td>
<td>-0.6%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Workplace injuries recorded per 1,000,000 hours - (one months in arrears)</td>
<td>10.5</td>
<td>10.5</td>
<td>10.5</td>
<td>10.5</td>
<td>10.5</td>
<td><img src="Reasons" alt="Commentary" /></td>
<td></td>
</tr>
</tbody>
</table>

### First, Do No Harm (Safety)

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal Rate of medication errors/1000 bed days per month</td>
<td>1.3%</td>
<td>3.2%</td>
<td>2.0%</td>
<td>3.9%</td>
<td>3.2%</td>
<td>-0.7%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Neonatal Care CLAB rate per 1000 line days per month</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td><img src="Reasons" alt="Commentary" /></td>
<td></td>
</tr>
<tr>
<td>CLAB insertion bundle compliance - NNU</td>
<td>96%</td>
<td>100%</td>
<td>-4%</td>
<td>98%</td>
<td>100%</td>
<td>-2%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>CLAB prevention maintenance bundle compliance- NNU</td>
<td>92%</td>
<td>100%</td>
<td>-8%</td>
<td>88%</td>
<td>100%</td>
<td>-13%</td>
<td><img src="Reasons" alt="Commentary" /></td>
</tr>
<tr>
<td>Emergency trolley checks (compliance with checking)</td>
<td>94%</td>
<td>100%</td>
<td>-6%</td>
<td>N/A</td>
<td>N/A</td>
<td><img src="Reasons" alt="Commentary" /></td>
<td>Continued progress</td>
</tr>
<tr>
<td>Hand hygiene (compliance with checking)</td>
<td>98%</td>
<td>80%</td>
<td>-18%</td>
<td>N/A</td>
<td>N/A</td>
<td><img src="Reasons" alt="Commentary" /></td>
<td></td>
</tr>
<tr>
<td>Safe sleep - audits completed</td>
<td>84%</td>
<td>100%</td>
<td>-16%</td>
<td>N/A</td>
<td>N/A</td>
<td><img src="Reasons" alt="Commentary" /></td>
<td>Neonatal unit struggling with documentation due to acuity and high use of bureau nurses.</td>
</tr>
<tr>
<td>Occupational Health and Safety (OHS) Audit (Bi-Monthly)</td>
<td>NA</td>
<td>100%</td>
<td>#VALUE!</td>
<td>N/A</td>
<td>N/A</td>
<td><img src="Reasons" alt="Commentary" /></td>
<td>Next report due in Feb 2017</td>
</tr>
<tr>
<td>Violence Intervention Programme (VIP) Screening</td>
<td>68%</td>
<td>80%</td>
<td>-12%</td>
<td>56%</td>
<td>80%</td>
<td>-24%</td>
<td><img src="Reasons" alt="Commentary" /></td>
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**Counties Manukau District Health Board – Hospital Advisory Committee**

8 March 2017
### Timely

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED 6 hour target - National Health target (Kidz First EC) - Initial speciality</td>
<td>98%</td>
<td>95%</td>
<td>3%</td>
<td>98%</td>
<td>95%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>ESPI 2 - No. waiting &gt;4 months for FSA - Elective</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
</tbody>
</table>

### System Integration (Effective)

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% transcribed clinic letters authorised &gt;7 days of created</td>
<td>81%</td>
<td>75%</td>
<td>6%</td>
<td>79%</td>
<td>75%</td>
<td>4%</td>
<td></td>
</tr>
</tbody>
</table>

### Efficient

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Rate Babies in the first year of life (Total)</td>
<td>21%</td>
<td>19%</td>
<td>-2%</td>
<td>21%</td>
<td>23%</td>
<td>2%</td>
<td>Due to low winter admissions</td>
</tr>
<tr>
<td>Admission Rate Babies in the first year of life (Maori)</td>
<td>22%</td>
<td>22%</td>
<td>0%</td>
<td>24%</td>
<td>27%</td>
<td>3%</td>
<td>Due to low winter admissions</td>
</tr>
<tr>
<td>Admission Rate Babies in the first year of life (Pacific)</td>
<td>30%</td>
<td>26%</td>
<td>-4%</td>
<td>27%</td>
<td>30%</td>
<td>3%</td>
<td>Due to low winter admissions</td>
</tr>
<tr>
<td>ALOS (raw) - Kidz First - Surgical - Surgical Floor</td>
<td>2.14</td>
<td>1.85</td>
<td>-0.29</td>
<td>2.08</td>
<td>2.05</td>
<td>-0.03</td>
<td>Very small variance</td>
</tr>
<tr>
<td>ALOS (raw) - Kidz First Medicine - KF Wards</td>
<td>2.54</td>
<td>2.48</td>
<td>-0.06</td>
<td>2.63</td>
<td>2.69</td>
<td>0.06</td>
<td>Very small variance</td>
</tr>
<tr>
<td>ALOS (raw) - Kidz First Medicine - EC Short Stay (hrs)</td>
<td>4.61</td>
<td>4.22</td>
<td>-0.39</td>
<td>4.32</td>
<td>4.59</td>
<td>0.27</td>
<td>Very small variance</td>
</tr>
<tr>
<td>ALOS (raw) - Kidz First - Neonatal Unit discharge only</td>
<td>13.7</td>
<td>12.8</td>
<td>-0.9</td>
<td>12.9</td>
<td>12.7</td>
<td>-0.2</td>
<td>Very small variance YTD</td>
</tr>
<tr>
<td>ALOS (raw) - Kidz First - Neonates including WH</td>
<td>5.57</td>
<td>5.55</td>
<td>-0.02</td>
<td>6.09</td>
<td>5.93</td>
<td>-0.16</td>
<td>Very small variance</td>
</tr>
</tbody>
</table>

### P&WC

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient DNA - FSA</td>
<td>8%</td>
<td>5%</td>
<td>-3%</td>
<td>8%</td>
<td>10%</td>
<td>2%</td>
<td>On track</td>
</tr>
<tr>
<td>Outpatient DNA - Follow up</td>
<td>13%</td>
<td>15%</td>
<td>2%</td>
<td>12%</td>
<td>12%</td>
<td>0%</td>
<td>On track</td>
</tr>
</tbody>
</table>

### Patient experience survey - month (n=3) and YTD (n=53)

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>67%</td>
<td>76%</td>
<td>-9%</td>
<td>66%</td>
<td>76%</td>
<td>-10%</td>
<td>Small variance</td>
<td></td>
</tr>
</tbody>
</table>

---

**NOTES**

LY Act - Last year actuals

*FY16-17 - fiscal year 2016 and fiscal year 2017*
## WOMEN’S HEALTH SCORECARD

**January 2017**

<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Target</th>
<th>Var</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Caseweight</td>
<td>878</td>
<td>954</td>
<td>-8%</td>
<td>6629</td>
<td>6677</td>
<td>-1%</td>
<td></td>
<td></td>
<td>Reflecting higher acuity as discharge volumes lower</td>
</tr>
<tr>
<td>Acute Caseweight</td>
<td>792</td>
<td>823</td>
<td>-4%</td>
<td>5874</td>
<td>5760</td>
<td>2%</td>
<td></td>
<td></td>
<td>Reflecting higher acuity as discharge volumes lower</td>
</tr>
<tr>
<td>Elective Caseweight</td>
<td>86</td>
<td>131</td>
<td>-34%</td>
<td>755</td>
<td>917</td>
<td>-18%</td>
<td></td>
<td></td>
<td>Use of surgical bus - count Discharges but not WIES</td>
</tr>
<tr>
<td>Total Discharges</td>
<td>1738</td>
<td>1744</td>
<td>0%</td>
<td>12111</td>
<td>12254</td>
<td>-1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient First Specialist Assessment volumes</td>
<td>210</td>
<td>208</td>
<td>1%</td>
<td>1997</td>
<td>1685</td>
<td>19%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Follow up Volumes</td>
<td>291</td>
<td>396</td>
<td>-27%</td>
<td>3001</td>
<td>2347</td>
<td>28%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budgeted FTEs</td>
<td>$422</td>
<td>$400</td>
<td>-6%</td>
<td>$2,941</td>
<td>$2,805</td>
<td>-5%</td>
<td></td>
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</tr>
<tr>
<td>Operating Costs ($000)</td>
<td>$3,064</td>
<td>$2,849</td>
<td>-8%</td>
<td>$19,658</td>
<td>$19,100</td>
<td>-3%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Financial Result Total ($000)</td>
<td>$4,066</td>
<td>$3,182</td>
<td>-7%</td>
<td>$21,926</td>
<td>$21,430</td>
<td>-2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce Clinical Outsourcing ($000)</td>
<td>$14</td>
<td>$6</td>
<td>-133%</td>
<td>$115</td>
<td>$42</td>
<td>-174%</td>
<td></td>
<td></td>
<td>Offset against additional revenues</td>
</tr>
<tr>
<td>% Staff with Annual Leave &gt; 2 years - (one month in arrear)</td>
<td>19.9%</td>
<td>10.0%</td>
<td>-14.9%</td>
<td>23.3%</td>
<td>5.0%</td>
<td>-18.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Staff Turnover - (one month in arrear)</td>
<td>12.6%</td>
<td>10.0%</td>
<td>-2.6%</td>
<td>11.4%</td>
<td>10.0%</td>
<td>-1.4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Sick leave - (one month in arrears)</td>
<td>3.8%</td>
<td>2.8%</td>
<td>-1.0%</td>
<td>3.3%</td>
<td>2.8%</td>
<td>-0.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workplace injuries recorded per 1,000,000 hours - (one months in arrears)</td>
<td>10.5</td>
<td>10.5</td>
<td></td>
<td>10.5</td>
<td>10.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency trolley checks (days checked) per month</td>
<td>94%</td>
<td>100%</td>
<td>-6%</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td>Monitoring trends. Weekend checks not consistent</td>
</tr>
<tr>
<td>Hand hygiene (compliance with checks) per month</td>
<td>92%</td>
<td>80%</td>
<td>12%</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe Sleep audits completed</td>
<td>90%</td>
<td>100%</td>
<td>-10%</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Health and Safety (OHS) Audit (Bi-Monthly)</td>
<td>N/A</td>
<td>100%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td>Next report in Feb 2017</td>
</tr>
<tr>
<td>Violence Intervention Programme (VIP) Screening</td>
<td>58%</td>
<td>80%</td>
<td>-22%</td>
<td>52%</td>
<td>80%</td>
<td>-28%</td>
<td></td>
<td></td>
<td>Rolling out new programme gradually. Rates improving</td>
</tr>
<tr>
<td>% transcribed clinic letters authorised &lt;7 days created</td>
<td>84%</td>
<td>95%</td>
<td>-11%</td>
<td>88%</td>
<td>95%</td>
<td>-7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay Gynaecology - MMH</td>
<td>1.50</td>
<td>1.58</td>
<td>0.08</td>
<td>1.53</td>
<td>1.60</td>
<td>0.07</td>
<td></td>
<td></td>
<td>Small variances</td>
</tr>
<tr>
<td>Average Length of Stay Gynaecology - MSC Inpatients</td>
<td>0.41</td>
<td>0.48</td>
<td>0.07</td>
<td>0.66</td>
<td>0.76</td>
<td>0.10</td>
<td></td>
<td></td>
<td>Small variances</td>
</tr>
<tr>
<td>Average Length of Stay Obstetric (DHB Mat) (1 month in arrear)</td>
<td>2.28</td>
<td>2.02</td>
<td>0.26</td>
<td>2.33</td>
<td>2.17</td>
<td>0.16</td>
<td></td>
<td></td>
<td>Small variances</td>
</tr>
<tr>
<td>Average Length of Stay Obstetric (Ind. Mat) (1 month in arrear)</td>
<td>2.15</td>
<td>2.02</td>
<td>0.13</td>
<td>2.21</td>
<td>2.08</td>
<td>0.13</td>
<td></td>
<td></td>
<td>Small variances</td>
</tr>
<tr>
<td>Average Length of Stay Vaginal Deliveries overall</td>
<td>1.52</td>
<td>2.15</td>
<td>-0.63</td>
<td>1.96</td>
<td>2.10</td>
<td>-0.14</td>
<td></td>
<td></td>
<td>Small variances</td>
</tr>
<tr>
<td>Māori - 1st time mothers</td>
<td>1.80</td>
<td>1.91</td>
<td>1.21</td>
<td>2.47</td>
<td>2.62</td>
<td>-0.15</td>
<td></td>
<td></td>
<td>Small variances</td>
</tr>
<tr>
<td>Pacific - 1st time mothers</td>
<td>2.04</td>
<td>2.64</td>
<td>-0.60</td>
<td>2.56</td>
<td>2.56</td>
<td>0.00</td>
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</tr>
</tbody>
</table>

Counties Manukau District Health Board – Hospital Advisory Committee 8 March 2017
<table>
<thead>
<tr>
<th>Trend</th>
<th>FY16-17^</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>YTD*</th>
<th>Var</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSA / FUP ratio - Gynae</td>
<td>1.37 : 1</td>
<td>1:1.1</td>
<td>1.02 : 1</td>
<td>1:1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNA - Midwifery Antenatal clinics - First</td>
<td>16%</td>
<td>9%</td>
<td>-7%</td>
<td>14%</td>
<td>13%</td>
<td>-1%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNA - Midwifery Antenatal clinic - Follow up</td>
<td>14%</td>
<td>14%</td>
<td>0%</td>
<td>13%</td>
<td>15%</td>
<td>2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNA - Doctor Antenatal clinics - FSA</td>
<td>10%</td>
<td>10%</td>
<td>0%</td>
<td>14%</td>
<td>12%</td>
<td>-2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNA - Doctor Antenatal clinics - Follow up</td>
<td>8%</td>
<td>18%</td>
<td>10%</td>
<td>11%</td>
<td>14%</td>
<td>3%</td>
<td>Improving trend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient DNA - Maaori (Gynae)</td>
<td>13%</td>
<td>12%</td>
<td>-1%</td>
<td>14%</td>
<td>10%</td>
<td>-4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient DNA - Pacific (Gynae)</td>
<td>10%</td>
<td>11%</td>
<td>1%</td>
<td>8%</td>
<td>10%</td>
<td>2%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient DNA - Maaori (Obst)</td>
<td>22%</td>
<td>29%</td>
<td>7%</td>
<td>24%</td>
<td>10%</td>
<td>-14%</td>
<td>Improvement on last year's rates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient DNA - Pacific (Obst)</td>
<td>17%</td>
<td>20%</td>
<td>3%</td>
<td>18%</td>
<td>10%</td>
<td>-8%</td>
<td>Improvement on last year's rates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient experience survey - month (n=58) and YTD (n=377)</td>
<td>81%</td>
<td>76%</td>
<td>5%</td>
<td>77%</td>
<td>76%</td>
<td>1%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTES

^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  
ASRU  Auckland Spinal Rehabilitation Unit  
AT&R  Assessment, Treatment and Rehabilitation Services  
HBSS  Home Based Support Services  
IBC  Indicative Business Case  
LOS  Length of Stay

Service Overview

Adult Rehabilitation and Health of Older People (ARHOP) is managed by Dana Ralph-Smith General Manager, with Dr Peter Gow Clinical Director, and Lyn Cooper Clinical Nurse Director (ARHOP). In addition, to support the Health of Older People contracted services, Dr Kathy Peri is Clinical Nurse Director.

Highlights

The implementation of the Cognitive Impairment pathway with the Eastern Locality, Auckland University, Dementia Auckland and Counties Manukau Health has commenced.

A dedicated stroke unit was established in December as part of the acute stroke service redesign to improve outcomes for stroke patients by closer collaboration of the acute and rehabilitation teams in a single clinical unit. Stroke numbers continue to grow with currently on average 18 stroke inpatients per day in MMH. This links to the previous work done on improving the stroke journey through early supported discharge with an enhanced community based stroke team already in place. We have a PDSA improvement project underway to improve the patient journey in conjunction with Ko Awatea. Focusing on stroke prevention through to treatment and rehabilitation is one of our priorities to realise our Healthy Together goals of adding 500k healthy life years and improving equity of outcomes for our community.

N.B. ASH rates shown below reflect a disparity and recent increase in stroke admissions for Pacific and Maori patients.

![Standardised ASH Rate, Counties Manukau DHB, 45 to 64 age group, Stroke, 5 years to end](image-url)
Emerging Issues
Nil to report

Update on previously reported issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Date reported</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Hyper-acute Stroke services</td>
<td>November 2016</td>
<td>Planning work has commenced in preparation for the Phase 1 Rollout at the beginning of July. Overview of the implementation, combined pathway for thrombectomy (all hours) &amp; hyper-acute stroke (after hours), and a list of key performance indicator measures for evaluating the initial rollout developed. Quarterly updates on progression of regional project plan can be provided. This issue can be closed.</td>
</tr>
<tr>
<td>Increase in Auckland Spinal Rehabilitation Unit (ASRU) Occupancy</td>
<td>July 2016</td>
<td>Acute Orthopaedics and Rehabilitation Medicine Services have implemented improved assessment and transfer and discharge planning processes to manage flow and occupancy constraints into the ASRU site by commencing rehabilitation sooner while on the acute site and improved communication around estimated discharges and transfers. This issue can be closed.</td>
</tr>
<tr>
<td>NZRDA Industrial Action notice was received on 30 December 2017 and planning is under way for strike action effective for 73 hours between 7am Tuesday 17 January to 8am Friday 20 January.</td>
<td>December 2016</td>
<td>ARHOP prepared for the RMO strike, with the cover falling to the Senior Medical Staff and Senior Nurses. Rosters and contingency plans worked well. This issue can be closed.</td>
</tr>
<tr>
<td>Category</td>
<td>FY16-17</td>
<td>Jan-17</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>Spinal Inpatient ACC Revenue ('000s)</td>
<td>$802</td>
<td>$560</td>
</tr>
<tr>
<td>Non-acute Rehabilitation ACC Revenue ('000s)</td>
<td>$409</td>
<td>$392</td>
</tr>
<tr>
<td>Budgeted FTEs</td>
<td>431</td>
<td>469</td>
</tr>
<tr>
<td>Operating Costs ($000)</td>
<td>$3,923</td>
<td>$3,982</td>
</tr>
<tr>
<td>Personnel Costs ($000)</td>
<td>$3,080</td>
<td>$3,170</td>
</tr>
<tr>
<td>Financial Result Total ($000)</td>
<td>$3,297</td>
<td>$3,352</td>
</tr>
<tr>
<td>Reduce clinical outsourcing ($000)</td>
<td>$317</td>
<td>$263</td>
</tr>
<tr>
<td>% Staff with Annual Leave &gt; 2 years (1)</td>
<td>3.7%</td>
<td>5.0%</td>
</tr>
<tr>
<td>% Staff Turnover (2)</td>
<td>15.9%</td>
<td>10.0%</td>
</tr>
<tr>
<td>% Sick Leave (3)</td>
<td>2.7%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Workplace Injury per 1,000,000 hours (4)</td>
<td>10.5</td>
<td>10.5</td>
</tr>
<tr>
<td>Falls - % of falls assessments done in first 6 hours (5)</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Falls - % of interventions completed</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Pressure Injuries - % of assessments done in first 6 hours</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Pressure Injuries - % of interventions completed</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Reduce over ride rate of Pyxis on ATR wards decrease medication errors to 15%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Proportion of referrals managed via e-referrals across Services (ARHOP)</td>
<td>62%</td>
<td>50%</td>
</tr>
<tr>
<td>Access to specialist services - volumes of Geriatric A&amp;R Hotline Calls</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>Maintain number of patient 75’s or older LOS &gt; 10 days in AT&amp;R wards</td>
<td>43</td>
<td>54</td>
</tr>
<tr>
<td>Maintain direct admissions from GPs to ATR wards</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Avoidable presentations to EC from Aged Residential Care Facilities (ARCC)</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>MMH % patients discharged to discharge lounge or home by 1100hrs</td>
<td>25%</td>
<td>32%</td>
</tr>
<tr>
<td>Rehabilitation 7 day Readmissions rate</td>
<td>5.1%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Acute Readmission within 28 days - Total for Rehabilitation beds (1 month in arrears)</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td>Efficient</td>
<td>Trend</td>
<td>Quarterly reporting in arrears</td>
</tr>
<tr>
<td>-----------</td>
<td>-------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>FY16-17</td>
<td>Dec-16</td>
<td>Target Var</td>
</tr>
<tr>
<td></td>
<td></td>
<td>95% 75% 20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>95% 75% 20%</td>
</tr>
</tbody>
</table>

**Rating Commentary (by exception)**

% +65 years with long term HBSS - comprehensive clinical assessment & care plan

<table>
<thead>
<tr>
<th>Equity</th>
<th>Trend</th>
<th>Year to date</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY16-17</td>
<td>Jan-17</td>
<td>Target Var</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 4 -1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>31 30 1</td>
<td></td>
</tr>
</tbody>
</table>

**Rating Commentary (by exception)**

Number of Spinal Rehabilitation Outreach Clinic days - (new measure 2014/15)

<table>
<thead>
<tr>
<th>PRWCC</th>
<th>Trend</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY16-17</td>
<td>Jan-17</td>
<td>Target Var</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>80% 90% -10%</td>
<td></td>
<td>Staff away for first two weeks in January</td>
</tr>
</tbody>
</table>
Mental Health & Addictions

Glossary

ICLT               Integrated Care Locality Team
CAMHS         Child & Adolescent Mental Health Service
NGO               Non-Government Organisation
CADS         Community Alcohol & Drug Service

Service Overview

Mental Health is managed by Tess Ahern, General Manager, with Peter Watson Clinical Director and Anne Brebner Clinical Nurse Director.

Highlights

Fiona Ross (Treasury’s Chief Operating Officer and Deputy Secretary, Strategy, Performance and Engagement) and Tom Byrne (Treasury, State Services Commission and Department of Prime Minister and Cabinet’s Chief Information Officer) visited Counties Manukau DHB in December. They took a particular interest in the rebuild of the acute adult inpatient unit (Tiaho Mai) and were able to view the building site from an adjacent building’s balcony. They seemed interested in the design (courtyard model, first of its type in New Zealand although many examples in Australia) and took the opportunity to visit the demonstration rooms. Information was provided about the rationale for the design, including the detailed design. They took an interest in the budget and budget priorities for the building project. We explained the process – (experienced based design followed by consultation groups) that informed the building design and they appeared to be interested in how the service engaged the stakeholder groups, especially service users and their family/whanau.

Awake Overnight Nurse Pilot becomes Business as Usual

The evaluation of the six month trial of an awake overnight nurse based in the Emergency Department demonstrated:

- that the demand consistently exceeded the capacity of one mental health registrar
- an increase in responsiveness and decreased waiting times
- improved clinical safety and effectiveness of service delivery
- eliminated the backlog of work at 8am waiting for MHS
- minimal requirement for the back up on call Duly Authorised Officers
- Increased support and satisfaction from the mental health registrars who were previously working in relative isolation

A business case was submitted and approved in November for 3.6 additional Registered Nurses FTE to ensure the sustainability of this service. These roles are currently being advertised. This new component of Acute Mental Health Services ensures that the service is fully operational 24 hours a day. The service is developing KPI’s (in collaboration with the Emergency Department) to ensure ongoing monitoring of areas such as demand, waiting times, short stay LoS, admission rates, and S109 (via Police) presentations.

WOS Integration Update

Progress continues with the whole of system transformation agenda for mental health and addictions. The focus remains on improving health outcomes and service user experience within the existing funding provisions. The programme of work continues to be aligned with the broader DHB’s community integration and localities approach, developing our teams to work alongside other healthcare teams and general practices to respond to and enhance the overall wellbeing of the community.
Counties Manukau population.

Central to the delivery of the transformation agenda is the creation of new integrated care locality teams (ICLTs) that will include specialist mental health and addiction services and NGO providers working in collaboration with primary care to meet the physical and mental health needs of our communities. ICLTs will complement the services provided by our specialist community mental health teams, providing consult liaison support and advice in relation to early intervention, developing the confidence and capability of the primary care workforce to respond to people’s mental health and addiction needs. The first ICLT has been established in the Franklin locality and continues to develop its links with primary care and other locality-based specialist healthcare teams. The initial response from primary care partners has been positive and the team is committed to working hard to foster strong relationships across the locality.

With the development of ICLTs, consideration will be given to changes needed across specialist community mental health teams to ensure a comprehensive and effective approach to the delivery of care across the spectrum of need.

In addition to the development of ICLTs, the other major strands of the transformation agenda are (1) the development of a comprehensive suite of NGO services in each locality, ensuring that service provision reflects the demographics within each locality and (2) integration of specialist AOD services within ICLTs and across the wider system.

Underpinning this work will be the continued commitment to co-design, using it to inform the ongoing development of ideas and to test progress, involving a range of stakeholders from consumers/whaanau through to service providers.

Next steps:
Subject to the Board’s feedback on the implementation plan endorsed by ELT in November 2016, key next steps for progressing the agenda over the first half of 2017 will be:

- continued development of the Franklin ICLT, including expanding the team to include specialist AOD and NGO support services
- establishing an ICLT presence in each locality by July 2017
- determining the appropriate allocation of the CM Health mental health workforce across the ICLTs and specialist community teams, including the development of a life-course approach across the specialist Maori and Pacific child, adolescent and adult services
- working with the Community Alcohol and Drugs Service (CADS) to integrate specialist AOD clinicians and services within an integrated model of care
- working with MBIE to develop a robust procurement process for the development of a comprehensive suite of NGO support services within each locality.

Visit from Ombudsman under the Crimes of Torture Act 1989 MHSOP and Tiaho Mai

A short unannounced visit by the office of the Ombudsman was made to Ward 35E under the Crimes of Torture Act 1989. A draft copy of their report has been received by the service. In brief their findings were:
- There was no evidence that clients had been subject to anything that could be construed as torture, or cruel, inhuman or degrading treatment
- The DHB complaints process was visible in the ward
- Clients had the necessary paperwork to detain and treat them
- Generally clients were complementary about staff in the ward and felt there was someone they could turn to if they had concerns
Inspectors observed positive client / staff relationships with respectful interactions
The ward was clean tidy and well presented
Clients had access to clean clothing and bedding
No complaints about the food, access to the telephone or access to family and friends
Information on a wide range of topics was easily available
Leadership was visible supportive and positive

Tiaho Mai (Adult Inpatient Unit) was also visited by the office of the Ombudsman under the Crimes of Torture Act. The service was commended for the efforts made to achieve and maintain an open unit and with the plans to carry this into the new facility. The Inspectors reported observing positive interactions between staff and service users in a relaxed therapeutic environment

Update on previously reported issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Date reported</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Forensic recruitment issues</td>
<td>19/10/16</td>
<td>1.6 of the 5 vacant FTE in place, the service will maintain current interim service plan which will support the orientation of new recruits and continuation of recruitment activity.</td>
</tr>
</tbody>
</table>

**Interim plan to maintain service – update**

- Whirinaki CAMHS clinicians are continuing to cover courts, completing indicative assessments and assessing young people engaged with the justice system.
- Youth Crime Action Plan (YCAP) community meetings are being attended by a Team Manager and Team Clinical Co-ordinator.
- Whirinaki clinicians are continuing to see open clients in residences.
- Whirinaki continue liaise with RYFs and a RYFS delegate continues to attend multi agency meetings and provides feedback to Whirinaki regarding Counties youth requirements.
## MENTAL HEALTH SCORECARD

### Ensuring Financial Sustainability

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overtime costs ($000)</td>
<td>$434</td>
<td>591</td>
<td>689</td>
<td>14.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budgeted FTEs</td>
<td></td>
<td>$5,846</td>
<td>$5,874</td>
<td>0.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Costs ($000)</td>
<td></td>
<td>$5,129</td>
<td>$5,564</td>
<td>7.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel Costs ($000)</td>
<td></td>
<td>$5,808</td>
<td>$5,855</td>
<td>0.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Commentary (by exception)**
- High acute demand off-set by community vacancies
- Does not include locum FTEs

### Enabling High Performing People

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY16-17</th>
<th>Dec-16</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Staff with Annual Leave &gt; 2 years</td>
<td>9.0%</td>
<td>5.0%</td>
<td>4.0%</td>
<td></td>
<td>8.8%</td>
<td>5.0%</td>
<td>-3.8%</td>
</tr>
<tr>
<td>% Staff Turnover</td>
<td>10.3%</td>
<td>10.0%</td>
<td>0.3%</td>
<td></td>
<td>11.2%</td>
<td>10.0%</td>
<td>-1.2%</td>
</tr>
<tr>
<td>% Sick Leave</td>
<td>3.5%</td>
<td>2.8%</td>
<td>-0.7%</td>
<td></td>
<td>3.7%</td>
<td>2.8%</td>
<td>-0.9%</td>
</tr>
<tr>
<td>Workplace Injury Per 1,000,000 hours</td>
<td>10.5</td>
<td>10.5</td>
<td>10.5</td>
<td></td>
<td>10.5</td>
<td>10.5</td>
<td></td>
</tr>
</tbody>
</table>

**Commentary (by exception)**
- Each episode of seclusion is reviewed at the weekly risk meeting against the standards

### Ensuring Safer Care by Minimising Harm (SaCW)

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Seclusion events/100,000</td>
<td>7.4</td>
<td>5.0</td>
<td>-2.4%</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Seclusion hours/100,000</td>
<td>55</td>
<td>50</td>
<td>-5%</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Number of Clients Secluded/100,000</td>
<td>2.9</td>
<td>3.0</td>
<td>0.1%</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

**Commentary (by exception)**
- Unique Clients seen has exceeded MOH Target by 1238

### Ensuring Timeliness

#### Shorter wait times for non urgent mental health and addiction Services (%< 3 week wait) - 12 months rolling

<table>
<thead>
<tr>
<th>Age Group</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19 years</td>
<td>73%</td>
<td>80%</td>
<td>-6.6%</td>
<td>N/A</td>
<td>Unique Clients seen has exceeded MOH Target by 1238</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-64 years</td>
<td>86%</td>
<td>80%</td>
<td>6.4%</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65+ years</td>
<td>91%</td>
<td>80%</td>
<td>11.5%</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Shorter wait times for non urgent mental health and addiction Services (%< 8 week wait) - 12 months rolling

<table>
<thead>
<tr>
<th>Age Group</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19 years</td>
<td>95%</td>
<td>95%</td>
<td>-0.4%</td>
<td>N/A</td>
<td>Unique Clients seen has exceeded MOH Target by 1238</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-64 years</td>
<td>97%</td>
<td>95%</td>
<td>2.2%</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65+ years</td>
<td>98%</td>
<td>95%</td>
<td>3.2%</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Ensuring System Integration (Effective)

#### Access rate - Number of CM domiciled unique clients seen by all MH services ([PRIMH](https://www.primehealth.org.nz) reporting services include AoD and NGO services) 12 months as a % of population - Total

<table>
<thead>
<tr>
<th>Age Group</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-19 years</td>
<td>3.9%</td>
<td>3.2%</td>
<td>0.8%</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-64 years</td>
<td>3.7%</td>
<td>3.2%</td>
<td>0.6%</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65+ years</td>
<td>2.4%</td>
<td>2.6%</td>
<td>-0.2%</td>
<td>N/A</td>
<td>Meeting the wait time targets - no build-up of a waitlist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Readmissions to Tiaho Mai within 28 days - Total (1 month in arrears)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Target</th>
<th>Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>5.3%</td>
<td>12.0%</td>
<td>6.7%</td>
<td>12.0%</td>
<td>12.0%</td>
<td>12.0%</td>
<td></td>
</tr>
<tr>
<td>Efficient</td>
<td>Trend</td>
<td>FY16-17</td>
<td>Jan-17</td>
<td>Target</td>
<td>Var</td>
<td>Actual</td>
<td>Year</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------</td>
<td>---------</td>
<td>--------</td>
<td>--------</td>
<td>-----</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>Inpatient Occupancy - Tiaho Mai Acute Mental Health Unit</td>
<td></td>
<td>84%</td>
<td>85%</td>
<td>0.6%</td>
<td></td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Number of Tiaho Mai Inpatient LOS &gt;35 days</td>
<td></td>
<td></td>
<td>8</td>
<td>10</td>
<td>2.0</td>
<td>40</td>
<td>40.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equity</th>
<th>Trend</th>
<th>FY16-17</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Actual</th>
<th>Year</th>
<th>Target</th>
<th>Var</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access rate - Number of CM domiciled unique clients seen by MH services (PRIMHD) 12 months as a % of population - Maori</td>
<td></td>
<td></td>
<td>5.8%</td>
<td>4.5%</td>
<td>1.3%</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-19 years</td>
<td></td>
<td></td>
<td>8.4%</td>
<td>7.7%</td>
<td>0.7%</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65+ years</td>
<td></td>
<td></td>
<td>2.7%</td>
<td>2.6%</td>
<td>0.1%</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Middlemore Central

Glossary

CapPlan – Capacity Planning tool
NZRDA – New Zealand Resident Doctor Association

Service Overview

Middlemore Central is managed by Dot McKeen, General Manager, with David Hughes Clinical Director.

Highlights

Summer Plan

The Summer plan was in place for the 2 weeks over the Christmas / New Year period with beds being closed using the forecast from CapPlan. As shown below we closed 2505 beds over the summer period as compared to the 2169 beds we planned to close. The planning is done each year with the Service Managers and Charge Nurse Managers with a focus on additional nursing staff being allocated annual leave over this period and to ensure demand meets capacity.

<table>
<thead>
<tr>
<th>28 Days Xmas Period</th>
<th>19/12/2016 to 15/01/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>Medical</td>
</tr>
<tr>
<td>Beds we planned to close</td>
<td>235</td>
</tr>
<tr>
<td>Beds we actually closed</td>
<td>408</td>
</tr>
<tr>
<td>Difference</td>
<td>173</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>28 Days Holiday Period</th>
<th>21/12/2015 to 17/01/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward</td>
<td>Medical</td>
</tr>
<tr>
<td>Beds we planned to close</td>
<td>635</td>
</tr>
<tr>
<td>Beds we actually closed</td>
<td>491</td>
</tr>
<tr>
<td>Difference</td>
<td>-144</td>
</tr>
</tbody>
</table>
Emerging Issues

Industrial Action

Industrial action by the NZRDA for three days from 0800 hours Tuesday 17th to 0800 hours Friday 20th January was successfully planned and managed with cover being provided by the Senior Medical staff.
Central Clinical Services

Glossary
- CAR: Corrective Action Recommendation
- CT: Computed Tomography
- eMR: Electronic Medicine Reconciliation
- IANZ: International Accreditation New Zealand
- iPM: i.Patient Manager
- MOW: Meals on Wheels
- MRI: Magnetic Resonance Imaging
- MRT: Medical Radiation Technologist
- MSC: Manukau SuperClinic
- NHI: National Health Index
- NPF: National Patient Flow

Service Review
The Division of Central Clinical Services is managed by Ian Dodson General Manager, with Clinical Directors/Heads Dr Vanessa Thornton (Emergency Care), Dr Ross Boswell (Laboratory), Dr Sally Urry (Radiology), Dr Mary Christie (Histopathology), and Clinical Nurse Director To’a Fereti.

Highlights
Retail Pharmacy
The licence to operate the retail pharmacy (Haumanu Pharmacy) was obtained in January and installation of robotics and IT infrastructure to support the retail pharmacy operations was completed. The retail pharmacy uses two types of automation making processes efficient and safer and potentially adding future capacity to the pharmacy operations. The robotics were installed and tested in January. The use of automation in pharmacy in New Zealand is a new concept and Haumanu Pharmacy is the first in New Zealand to bring this level of automation in pharmacy. Retail pharmacy staff were also onboarded in January as well. The Pharmacy opened on 7th February.

Laboratory Services
The new laboratory equipment is now being well utilised as the team are becoming more familiar with the equipment. There are still some ongoing adjustments to be made to maximise the efficiencies of the new laboratory. Workload for the month of January was only marginally increased on previous January 2016 with 2% growth in specimens overall.

Emerging Issues
Laboratory Services
International Accreditation New Zealand (IANZ) audit in December resulted in a number of recommendations and 4 Corrective Action Requests across the Laboratory Service. The most significant being in relation to the inadequacy of Histology accommodation and environmental conditions. CMH has provided several responses already to IANZ in relation to all corrective actions. Work in underway on developing the budget and business case for the relocation of Histology to meet the certification requirements. A schedule of accommodation has been provided to the Architects and preliminary work has been undertaken to prioritise the allocation of capital which is currently estimated at $4.9M.

A serious incident was discovered at the Auckland Regional Dental Service during January that has resulted in the laboratory becoming involved in the testing of 2,100 patients of the dental service. A plan was rapidly put in place to collect and process these samples. To date 1500 patients have had...
blood collected and have been tested for significant blood borne viral pathogens (7,500 tests performed and reported so far.

**Update on previously reported issues**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Date reported</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduced Radiologist FTE</strong></td>
<td>7 Sept 2016</td>
<td>The SMO team have performed a significant amount of additional reporting over the holiday periods and this is reflected in the slightly better Report Turnaround achieved this month. Remote reporting workstations were successfully trialled in December and early January and these now require purchase of high luminance monitors.</td>
</tr>
<tr>
<td><strong>General x-ray service</strong> (update to the above)</td>
<td>7 Sept 2016</td>
<td>Capacity to meet demand has improved through January such that production has matched demand more closely. However, effort is now required to overcome the waiting list backlog and a weekend session will be held. This usually results in 250 patients receiving their x-rays.</td>
</tr>
</tbody>
</table>
## CLINICAL SUPPORT SCORECARD

### January 2017

<table>
<thead>
<tr>
<th>Enabling Essential Sustainability</th>
<th>FY16-17</th>
<th>Trend</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Target</th>
<th>Var</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Caseweight</td>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Elective Caseweight</td>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Acute Caseweight (includes ICU)</td>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Outpatient FSA Volumes</td>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Outpatient Follow-Up Volumes</td>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Virtual FSAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Treatments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Enabling High Performing

<table>
<thead>
<tr>
<th>% Staff with Annual Leave &gt; 2 years</th>
<th>FY16-17</th>
<th>Trend</th>
<th>Dec-16</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Target</th>
<th>Var</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Staff Turnover</td>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>% Sick Leave</td>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Workplace Injury per 1,000,000 hours</td>
<td>FY16-17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Safety

<table>
<thead>
<tr>
<th>% electronic medication reconciliation completed for high risk patients within 48hrs</th>
<th>FY16-17</th>
<th>Trend</th>
<th>Jan-17</th>
<th>Target</th>
<th>Var</th>
<th>Year to date</th>
<th>Target</th>
<th>Var</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
</table>

Improvement in eMR rates in January. Rates were closer to target this month.
Team Leasers have been briefed to keep a weekly watch on this KPI and identify barriers to reaching the 80% target
<table>
<thead>
<tr>
<th>Trend FY16-17</th>
<th>Year to date</th>
<th>Rating</th>
<th>Commentary (by exception)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% MRI scans completed within 6 weeks from acceptance of referral</td>
<td>Jan-17</td>
<td>Target</td>
<td>Var</td>
</tr>
<tr>
<td>59%</td>
<td>85%</td>
<td>-13%</td>
<td>81%</td>
</tr>
<tr>
<td>% CT scans completed within 6 weeks from acceptance of referral</td>
<td>95%</td>
<td>95%</td>
<td>2%</td>
</tr>
<tr>
<td>Radiology - Inpatient radiology times &lt; 24 hours</td>
<td>94%</td>
<td>95%</td>
<td>-1%</td>
</tr>
<tr>
<td>Radiology Ec radiology times &lt; 2 hours</td>
<td>95%</td>
<td>95%</td>
<td>2%</td>
</tr>
<tr>
<td>Laboratory - Test turnaround time (TAT) within 60 mins</td>
<td>92%</td>
<td>90%</td>
<td>2%</td>
</tr>
<tr>
<td>Potassium</td>
<td>99%</td>
<td>98%</td>
<td>0%</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>98%</td>
<td>98%</td>
<td>0%</td>
</tr>
<tr>
<td>Troponin I</td>
<td>93%</td>
<td>90%</td>
<td>-1%</td>
</tr>
<tr>
<td>Histology - All - 3 working days</td>
<td>85%</td>
<td>90%</td>
<td>-2%</td>
</tr>
<tr>
<td>Breast - 3 working days</td>
<td>91%</td>
<td>80%</td>
<td>16%</td>
</tr>
<tr>
<td>Non gynaecologic FNA - 3 working days</td>
<td>86%</td>
<td>90%</td>
<td>0%</td>
</tr>
<tr>
<td>Blood Bank - antibody screen within 4 hours</td>
<td>94%</td>
<td>90%</td>
<td>4%</td>
</tr>
<tr>
<td>Microbiology</td>
<td>97%</td>
<td>90%</td>
<td>2%</td>
</tr>
<tr>
<td>CSF cell count &lt;30 mins</td>
<td>96%</td>
<td>95%</td>
<td>1%</td>
</tr>
<tr>
<td>ESBL screens &lt;2 days</td>
<td>92%</td>
<td>90%</td>
<td>-1%</td>
</tr>
<tr>
<td>UCHM (Urinary Chemistry) &lt;60 mins</td>
<td>88%</td>
<td>90%</td>
<td>0%</td>
</tr>
<tr>
<td>% radiology results reported within 24 hours</td>
<td>Jan-17</td>
<td>Target</td>
<td>Var</td>
</tr>
<tr>
<td>60%</td>
<td>75%</td>
<td>-18%</td>
<td>59%</td>
</tr>
<tr>
<td>% transcribed clinical summaries (meddocs) authorised &lt;7 days of creation</td>
<td>Trend FY16-17</td>
<td>Jan-17</td>
<td>Target</td>
</tr>
<tr>
<td>72%</td>
<td>95%</td>
<td>-23%</td>
<td>73%</td>
</tr>
</tbody>
</table>

As reported previously demand in Nov and Dec was ahead of our capacity and the holiday period has reduced the number of normal working days, in turn reducing our capacity to deliver. Outsourcing, full running of evening sessions and planned weekend sessions over the next few months will assist in bringing us back to the target.

Histologist levels back to normal levels and will expect turnaround times to return to target next month.

A slight improvement on December result. We continue to struggle to better perform due to reduced SMD FTE. The testing of remote workstations which will enhance our ability to enhance external reporting has been successful. Funding for workstations is being sought.

Working with the quality facilitators in each division to further focus on improving the turnaround time for transcription.
Facilities and Asset Management

ARDS Auckland Regional Dental Service
MIT Manukau Institute of Technology
WDHB Waitemata District Health Board

Service Overview

The Facilities division includes Clinical Engineering, Equipment and Assets Services, Non-Clinical Support Services, Engineering, and Facilities. The General Manager is Philip Healy.

Emerging Issues January 2017 Report

<table>
<thead>
<tr>
<th>Issue</th>
<th>Date reported</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contamination issue with the ARDS/WDHB Dental Equipment at Pukekohe Intermediate Dental School. Potentially serious health incident health occurred equipment, vendor contract and staff management interfaces WMDHB/CMDHB</td>
<td>January 2017 report</td>
<td>Major incident ARDS/WDHB highlighting concerns around WDHB &amp; CMDHB Contract Management, Facilities access/operational controls and responsibility interfaces. Independent incident report commissioned but is expected to highlight areas for improvement in respect of contract and vendor management procedures in jointly owned and operated facilities.</td>
</tr>
</tbody>
</table>

Update on previously reported issues

<table>
<thead>
<tr>
<th>Issue</th>
<th>Date reported</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fleet Replacement Programme CMDHB has reviewed the condition and age of its vehicle fleet.</td>
<td>8/3/17</td>
<td>Although generally in good condition, due to age and high km’s the decision has been made to dispose of the owned CMDHB Fleet and lease new vehicles on a rolling basis. A rolling replacement programme commenced in 2017 for the aged component of the fleet. An electric vehicle pilot is under consideration.</td>
</tr>
<tr>
<td>Draeger Equipment Procurement Concerns raised with MedSafe upon potential risks associated with faulty Draeger equipment</td>
<td>8/3/17</td>
<td>Meeting conducted with Draeger’s regional management and referred to Draeger Board to resolve on-going equipment concerns. Draeger have agreed to a series of corrective actions and a swap out of the affected equipment line (M300). Equipment replacement and diagnostic input represents a $300-$500k budget upside for MMH.</td>
</tr>
<tr>
<td>Clinical Engineering workforce shortage</td>
<td>4/5/16</td>
<td>Demand based on compliance testing and certification continues to exceed the capacity to deliver. Recruitment drives increasing, national training now commenced through MIT and an increased effort in recruiting trainees is assisting the situation but not solving the basic resource problem. Financial pressures are underscoring churn both to other organisations and to other</td>
</tr>
</tbody>
</table>
centres away from Auckland. (This has been raised on the risk Register). A similar shortfall in other trades is being experienced across Auckland. As previously reported, the northern region needs to combine resources for this service if we are to manage the increasing incidence of non-compliance in this sector.

<table>
<thead>
<tr>
<th>Maternity Security system</th>
<th>8/3/17</th>
<th>Maternity Security system has been awarded to CMS and rollout of this leading edge system for Maternity Level 4 MMH is now complete and functional.</th>
</tr>
</thead>
</table>
| **Acute Mental Health Inpatient**  
Construction schedule recovery review | 8/3/17 | Acute Mental Health Inpatient Unit - Although commencing well is currently a month behind schedule. The services of leading NZ build –ability expert (Warren Hollings) have been engaged to independently conduct a programme review and provide assurance on delivery. |
| **Kiwirail – third rail line**  | 15/6/16 | Met with Kiwirail approximately 6-months ago to outline key considerations for CM Health. Kiwirail have capital cost constraints and although there is some background development work ongoing, we are not expecting any progression of the third/fourth rail scheme within the next 12-month period. |
**Director of Patient Care, Chief Nurse and Allied Health Professions Officer**

**Glossary**

- AWM: Acuity Workload Management
- DEU: Dedicated Education Unit
- DoN: Director of Nursing
- HWNZ: Health Workforce New Zealand
- MHSOP: Mental Health Services for Older People
- RN/RM: Registered Nurse/Registered Midwife

**Summary**

The Director of Patient Care, Chief Nurse and Allied Health Professions Officer commenced at Counties Manukau Health on the 16th January 2017. This role has professional leadership responsibility for nursing, midwifery, allied health, scientific and technical and includes nursing in primary and integrated care. She also holds responsibility and oversight for Experience, Measurement and Compliance, Safety, and Standards. This report provides an update from each of the professional leaders with hospital responsibilities and reports from Experience, Measurement and Compliance and Standards. The separate Patient Safety and Experience report provides a specific focus on these areas.

Particular areas of the report to note are the challenges faced by specific workforce groups (neonatal and midwifery) and associated actions, and the priority to gain further traction on the certification action plan which are more complex and need greater support.

**Professional Updates**

**Director of Nursing**

**Summary**

This report provides updates on work the Director of Nursing is undertaking, and aligns this work to the organisational strategy of Healthy Together 2020. The regular report will note highlights and successes from Clinical Nurse Directors (CNDs), as well as any other risks or issues within the organisation relating to nursing.

**Key Events**

**Summer Bed and Roster Planning**

Services agreed summer bed and roster schedules over the Christmas holiday period, and the plans overseen and centrally adjusted from Middlemore Central to respond to daily fluctuations in demand. At times, getting the ‘right solution’ required careful consideration to manage patient safety, flow and sustain/support staff morale.

In the lead up to Christmas, wards and services took time to decorate and share celebrations. The staff choir performed at the last Staff Forum, with the ‘CM Health 12 days of Wellness’ carol a special highlight.
New Entry to Practice (NETP) and New Entry to Specialist Practice (NESP) Intakes

There were 57 NETP and 14 NESP RNs (working 0.8 FTE) commencing in January 2017 across the hospital services, and a further 10 NETP RNs in Primary care settings. Five of these are supported with Māori workforce funding, and one by Ministry of Justice, at Wiri Women’s Prison.

Procare PHO and CM Health are working together to increase the numbers of Māori new graduate nurses working in primary care. Procare and CM Health have worked closely with Manukau Institute of Technology School of Nursing to identify both Māori undergraduate nurses who are interested in working in primary care and practices that are interested in employing a new graduate or having a student on placement.

The pilot includes a financial incentive for practices to support a Māori new graduate and cultural support, including identifying emerging leaders and providing opportunities for new nurses to participate in wānanga based programmes. Procare and CM Health work on the principle that employment of Māori nurses is an investment approach because they can effectively engage with Māori whānau and influence positive lifestyle changes. There have been two intakes; five Māori new graduates in September 2016 and a further five in January 2017.

NZ Nursing Council – Workforce Atlas


Data indicators include:

- Nurse demographics; (number, gender, age, ethnicity)
- Hours worked, Main employment, Main practice, Status
- Qualification received and Country of nursing qualification received

Resident Doctors Association (RDA) Action

Nursing teams across the organisation supported preparations for contingency plans for the recent RDA Industrial Action, particularly to maintain safe care and patient flow.
Healthy Services

National DHB DoN, HWNZ, and Nurse Executives and Health Roundtable meetings have had senior nurse attendance. These meetings and workshops continue to provide networking and strategic planning opportunities.

The Health Equity Campaign

Kidz First will be engaged in a joint Medical/ Nursing Health Equity project for children with Chronic Lung Disease. This will develop a criteria led process, and Dr Adrian Trenholm will lead, with two Nurses contributing to the project. Michele Nicholson-Burr CND Kidz First & Women’s Health is seconded 0.2 FTE to the organisational Health Equity Campaign.

Patient Safety Leadership walk rounds

These are settling into part of ‘usual business’ – recent visits included Koropiko [MHSOP], the Neonatal unit, and ward 9 Surgical. Managers now attend the post-visit feedback sessions to hear themes and discuss potential support for changes. Formal evaluation is in progress.

Technology Enabled Care

The DoN is the project sponsor for the Clinical Documentation programme of work, which includes the recording of vital signs on a mobile device (e-Vitals). There has been strong relationship built with Canterbury DHB and Waitemata DHB to share experience and tools. Sally Dennis, Clinical Nurse Lead for the programme is appointed and recruitment processes for the eVital Coaches is in progress. The initial rollout will begin June 2017 after comprehensive system testing processes are completed. The organisation roll out is due for completion within 52 weeks of the start date.

Handover of Care

The Certification Corrective Action relating to handover of care is continuing with seven identified work streams. A CND has been appointed as Champion for the e-Whiteboard component of Bed management technology.

Care Capacity Demand Management (CCDM)

The AWM modules and Web Scheduler need roll out completion. Web Scheduler is now in Emergency Department; Women’s Health and Mental Health will not progress at this time while addressing other priorities for capacity management. A CCDM Coordinator role is being recruited, to support Middlemore Central overview of data compliance, validation and analysis. The application for inclusion in the national CCDM programme is awaiting a response.

Nursing Workforce Sustainability

A number of nursing workforce metrics continue to be analysed and reported monthly.

Vacancy and Recruitment

At the end of December, across CM Health, there were 176 FTE ‘recruitable’ vacancies. Recruitable vacancies are those confirmed vacancy positions which have been reviewed and are able to be advertised. This reflects a 6% vacancy across Nursing, Midwifery and Health Care Assistant (HCA) total workforce. Of these:

- There are 40.4 FTE of Senior Nursing roles, 4.0 FTE of Enrolled Nurse roles, along with 107 FTE of RN vacancies. There are 8.5 FTE midwifery recruitable vacancies, and 16 FTE Health
Care Assistants vacancies. The Neonatal unit continue to be challenged with staffing cover issues and are being supported adjust staff resource models, recruit additional staff and will to have three New Graduates in January.

- 83.1 FTE are community-based/integrated or ambulatory roles; of that, 53.7 are for RN/ RM roles, and the residual are at Senior Nurse grades or Assistants roles.
- There are 93.1 FTE roles vacant in acute/ inpatient areas – 62 FTE are for RN/ RM grade roles.

The Recruitment Team have recently employed new and additional staff. There has been joint work with the services to streamline processes and formulated plans to address shortages.

Leave

Nursing leave use is following anticipated seasonal patterns for November, December 2016 and January:

- Services managed the balance of the seasonal clinical demands and school holiday leave requests for staff. As anticipated, annual leave use increased in December, partly due to school holidays. Annual leave was higher than November and December last year.
- Education leave hours were lower in many areas, reflecting holiday time for postgraduate study, as well as less internal training activity.
- Sick Leave is beginning to trend downwards following winter, although overall was higher this December than last year, along with overtime in Mental Health and Women’s Health.

Bureau hours and FTE used

Overall, the reducing trend to November did not sustain into December, there was a small increase in total Bureau FTE (at 171 FTE), with stable use of RNs and more HCA use. Encouragingly, most of HCA increase was addressed from internal bureau use.

- Continue to fill over 90% of HCA requests and 50% of RN requests
- RN external use is small – at 6.5 FTE for the month, continuing the reducing trend.
- Bureau RN/RM hours reflect a seasonal pattern; Bureau RN use is comparable with 2015. The high RN users reflect areas of vacancy (ward 11), which is now largely filled and the routine use of bureau as part of rosters in Women’s Health.
- Bureau HCA hours is reducing after winter, though the total continues to be higher than 12 months ago. Less external agency was HCA FTE used. The HCA use remains largely driven by continued growth in assessed needs for 1:1 watches, but this use renewed in December for both medical and surgical wards with a total of 72 FTE were used.

Service Highlights

Innovative Models of Care and Integration

- A CMH and University of Auckland joint role provided clinical and academic support for a Nurse Practitioner intern post. The result is that we now have our 16th Nurse Practitioner with an Emergency care focus.
- The Counties Manukau lead for the national Nurse Prescribing pilot continues, with 45 Nurses from Primary and community services involved. The original plan was for 20, so this additional uptake is very encouraging. There are five Kidz First Public Health Nurses participating.
- Kidz First is trialling a Team Nursing model for the two inpatient wards, to evaluate if this provides better support for the new graduate and step 2-4 registered nurses, and enables
amalgamation of the two wards at certain times. The evaluation includes the introduction of ‘safety huddle’ at shift handover. Initial feedback was very positive.

- The Kidz First Home Care Nursing team has reviewed their case management model, with the aim of moving to a more locality/ geographically aligned caseload allocation. Following some initial challenges, this is now seeing positive benefits for families and staff, with good communication between the team to support ongoing improvement.
- The Public Health Nurse team is now integrated with the School Health Network, to support integration and shared workforce development. The successes of the wider integration was obvious in the highly complex management of the Pukekohe Dental Health Incident
- The Mental Health Integrated Care Locality Teams are now fully staffed for CNS positions, to fully support the acceleration of integration. An integration team has begun in the Franklin locality with 3 FTE allocated to the integrated mental health pathway work.
- The Manukau Rehabilitation Service and Wellness Centre preparation for the Indicative Business Case to Treasury is almost complete. Fortnightly workshops are happening in developing the new Model of Care.
- The Acute Care Clinical Coach pilot has ended, with positive outcomes. Discussions are ongoing as to how to sustain this model, and the pilot Nurses are to be commended for their enthusiasm in developing this new way to support workloads.

**Education**

- The Kidz First service DEU will have a ‘soft rollout’ during 2017, with a view to embracing a fully inter professional DEU with University of Auckland from 2018. In the interim, Paediatricians and Clinical Liaison Nurses will create combined teaching opportunities wherever possible.
- The inaugural acute Summer Scholarship for graduates (4), based in Emergency Care had positive feedback, and more formal evaluation is underway. The programme supported Nurses to continue consolidating skills, and it is expected this will smooth their initial orientation time period.
- Intravenous cannulation and phlebotomy training schedule planned for February March has a 75% uptake of external applicants

**Service Reconfiguration**

- The Medicine ward reconfiguration was complete in December, with adjustment to speciality allocations. This is requiring sharing of expertise and enabling nurse skill development, and staff are to be commended for taking up the early challenges.
- The new integrated Stroke Service Ward is open, with 12 beds transferred from Ward 6 to Ward 31 on 5th December. ARHOP will oversee this new service. Ward 31 was ‘transformed’ from the discharge lounge to an acute ward in two days. Staff from the rehab wards, ward 23, and some bureau was used initially and recruitment to the ward FTE is ongoing. In the first 3 weeks, the occupancy was at 10-12 patients.

**National leadership**

- The DoN continues as a member of the NZ advisory group for Safer 24/7 nursing joint research with Worksafe, Massey, NZ Nurses Organisation and Chief Nurses Office.
Midwifery Workforce

As previously highlighted to HAC the midwifery vacancy rate is increasing. In October 2016, Women’s Health was 9.87 full time equivalent (FTE) down against the midwifery staffing budget, however the actual worked FTE was a positive 0.53 over budget with the usage of bureau. In January 2017 the FTE down was 17.17 and the true shortage was 8.83FTE as bureau midwife availability over the summer holiday period also declined. This increase in vacancies in addition to a heavy workload over December-January is putting additional pressure on the committed midwifery staff, particularly at Middlemore Hospital with this sustained pace and workload.

11 Resignations are balanced between retirement, pursuing other jobs such as research, moving to LMC practice within Counties Manukau area, moving out of the area to be able to purchase a house and leaving due to the workload. In addition to the resignations there has been a need to cover annual leave, sickness and an approximate 7 FTE of maternity leave.

Midwifery staffing profile

The Midwifery workforce demographics have changed over the last few years. The recruitment profile into training previously was a woman making a mid-career choice. Currently the largest number of student midwives are entering their training during their twenties, this leading to a younger workforce. Younger women in general will take breaks in their careers for travel and families. This combined with the older workforce closer to retirement who are choosing to work less hours per week, adds to an inconsistently available workforce until CM Health has grown enough through the pipeline.

Mitigating actions

The Women’s Health initial response in November 2016 included reviewing recruitment processes and strategies with the Talent Acquisition Team; as well as informing the unions and the Auckland Region New Zealand College of Midwives and to work with these organisations towards solutions. Auckland District Health Board and Waikato District Health Board are in similar situations although they do have a greater percentage of Lead Maternity Carers (LMC) providing care for the women. The Christmas period plan to assist the staffing over the holiday period included senior midwifery staff going on call when there were shortfalls in the roster, requesting SMO and RMO assistance when acuity high, all staff working at the top of their scope including Health Care Assistants; transferring women over to LMCs with informed consent of women and LMCs, communicating clearly to LMCs and staff and communicating the criteria for women being admitted to Birthing and Assessment.

Women’s Health Management continues to work closely with the Talent Acquisition Team for recruitment and the Unions on short term solutions. As well as reviewing workforce data, both employed and self-employed to enable fresh projections of workforce requirements. Long term strategies and partnership with Auckland University of Technology will continue with a focus of growing the midwifery pipeline for the Counties area. See Appendix A: Midwifery Workforce Plan 2017.

The Midwifery Council of New Zealand, NZCoM National office, Ministry of Health Maternity Advisor and Health Workforce New Zealand Midwifery Strategic Advisory Group (MSAG) will be informed due to the wider impacts our shortages and strategies have on the entire maternity workforce and to seek support for additional system-wide actions.
Midwifery Graduates

Five graduates commenced in January 2017 as the small intake for this period of the year. The main intake will occur in May 2017. Recruitment will commence for this shortly. In January 2017 CM Health updated the Graduate Programme information booklet and spent time discussing our programme with the third year students, including the benefits, challenges and privileges of working in this community.

CM Health continues to have an excellent record with the New Graduate Midwifery Programme we offer and we are working on recruiting as many suitable midwifery graduates as possible for the May intake. This includes graduates who want to work as a self-employed midwife in the Counties Manukau area. We have already set up a planning group working on new models of orientation and support for the planned increase of new graduates for 2017 and 2018.

Director of Allied Health
Prepared and submitted by Annelize de Wet Acting Director Allied Health

Allied Health Initiative for Education and Development (AHIED)

The Allied Health Grand Rounds continue. A specific focus has been on including the Scientific and Technical workforces with a possible patient experience focus. Supervision audit has been done by Occupational Therapy. Supervision training and support to technical and scientific workforce is underway. A National network of AH Scientific and Technical professional development leaders have been established and are working on finalising Terms of Reference. A specific regional focus will be selected. Planning is underway for the Allied Health Celebration day 19 October with a focus on Patient experience.

Model of Care (MOC) fit for purpose

Implementation of an AH Career pathway continues. This has been implemented for staff on step 9-15 on a 15 step scale using the titles of:

- Core Clinical
- Specialty Role
- Advanced Clinician
- Advanced Practitioner

Discussions and follow up with HR are occurring this month for progressing the programme of work.

Allied Health Workforce Diversity

Taking the lessons learnt from the Diversity Hui and the Allied Health Workforce expo, a submission has been accepted as a part of the Health Equity campaign to look to take the key concepts and package them in a way to be sustainable ongoing, and to bring in parent/carer education into the package. An Allied Health Career expo for local college students, and parents evening to promote Maori and Pacifica students is being planned for September 2017 to encourage students to consider careers in Allied Health.

Transition to practice: A programme to support allied health new graduates into the workforce

The transition from student to allied health professional can be stressful and it has been suggested that this experience may contribute to decreased staff retention. New graduates are an increasing
proportion of the Counties Manukau Health allied health workforce and it was agreed that more needed to be known about their experience. In early 2016 a new cohort of physiotherapy, occupational therapy and social work allied health new graduates participated in focus groups and many expressed a lack of support with their orientation and clinical practice. They often felt overwhelmed and at times confused. Investigation with allied health managers and clinical leaders further identified that many of the orientation challenges were due to the organisational systems and processes (full report is attached).

In response to the challenges what were identified in 2016, a range of inter-professional initiatives were introduced from December 2016 to support facilitation of a safe and effective transition from student to novice practitioner.

These include:
1) Introduction of best practice guidelines to support new graduates
2) Allied health preceptor training and support (model adapted from nursing preceptor training, 32 staff have attended training to date)
3) Monthly new graduate supervision group (14 in the group – PT, OT, SW from physical and mental health)
4) Allied health “OnBoarding programme”. This is a 2 day organisational orientation occurring fortnightly, alongside nursing (this extends beyond new graduates to AH staff new to the CM Health, at present open to PT, OT, SW, SLT, DT) [http://southnet/building-capability/Courses/On_Boarding_Nursing_Allied_Health.htm](http://southnet/building-capability/Courses/On_Boarding_Nursing_Allied_Health.htm)

An evaluation of these initiatives is planned for later in the year, and there maybe scope to scale these initiatives up to include further professional groups.

**Patient Experience - Improving Experience everyday everywhere for everyone**

In 2017, the focus is on an annual programme of activities to raise awareness of everyone’s contribution to *Improving Experience everyday everywhere for everyone*. This incorporates activities around the International Patient Experience Week 24-28 April 2017 but extends activity and focus across the year. A regional oncology workshop will be conducted during this week and all regional DHBs are focusing local on their values. It is planned that 2018 will see a return to greater emphasis on more regional activities.

**National inpatient survey**

During 30 January and 12 February a random selection of discharged inpatients were sent a link to the survey either by email or text. A core focus in 2017 is to increase the response rate and diversity of respondents. For this initial survey period, posters were placed on wards to promote it. The posters will also prompt patients to provide the DHB with their email address if they are not already in the electronic system. Participation in the survey is voluntary.

**Grand Round presentation**

On the 23 February 2017, Peter Gow, Clinical Director of Patient and Whanau Centred Care will Chair a Grand Round on Patient and Whanau Centred Care. Three presentations will be given:
1) Creating a vision for Safety, Experience and Standards throughout our system, Jenny Parr, Director of Patient Care, Chief Nurse and Allied Health Professions Officer I Patient Care Directorate
2) Experiences affect all of us, Dr Lynne Maher, Director of Innovation Ko Awatea I Health System Innovation and Improvement
3) Mapping Patient Journeys: Understanding and improving patient experience through research and co-design, Olivia Anstis, Improvement Advisor – Strategic Projects and Dr Jodie Main, Clinical Lead, Atlantis Healthcare.

**Empathy Zone and listening events**

As part of the patient experience programme of activities for the year, this event on 20th March 2017 will be the first of many listening events held to help understand the experiences of our staff, students, patients and whaanau. Approximately 40 students will attend, and we consumers are being contacted to participate. The aim is for groups of 5 students to be partnered with a consumer.

- Empathy zone 12.00-2.00pm
- Student listening events 2-30pm-4.30pm.

**Health literacy strategy**

Counties Manukau Health has developed a health literacy strategy and approach document entitled “Building Understanding: Advance on being a health literate organisation” which is now available on the internet at [http://countiesmanukau.health.nz/about-us/performance-and-planning/planning-documents/#health_literacy](http://countiesmanukau.health.nz/about-us/performance-and-planning/planning-documents/#health_literacy). This outlines a range of capability building actions aimed at progressing the three components of a health literate organisation and system (one which builds understanding between patients, whaanau and staff):

- Health literate, culturally competent staff
- Health literate, culturally competent health education resources, and
- Supportive systems and processes

A course based on the Ministry of Health document “Rauemi Atawhai: A guide to developing health education resources in New Zealand” which aims to address (mainly) the second and third of these components will be delivered by Health Literacy NZ in March-April. Fifteen participants from seven services will explore the systems and processes for managing health education resources within their services and contribute towards a template for processes which can be shared across the organisation, while using the Rauemi Atawhai framework to inform the development of a case study resource from each service. Evaluation by the Ko Awatea evaluation team will document changes in understanding, behaviour and systems around health education resources in course participants over the period from before to three months following the course.

**Volunteers**

The number of volunteers has grown in 2016 with increased usage of the volunteer service in pockets of the hospital. Volunteers contributed 9357.20 hours for 2016. Specific activities in 2016 included:

- Winners of the MOH Volunteer award – Healthcare Provider Service Volunteers Team Award.
- Support of Patient Experience week and Patient Safety Week 2016
- Increased the number of schools partnerships to join our volunteer programme 2016
- Increasing the engagement with schools, both local and further afield.
- A service is being offered to the organisation (was not available in the past) to support return to work, light duties opportunities to our staff who are injured while at work.
The profile of the Volunteer service is:

![Pie Chart]

- 34.14% School students
- 36.58% University Students
- 25.20% Job seekers
- 4.87% Retired

School students that made up 34.14% were on the volunteer programme for 2016, will not be returning 2017. We will be recruiting a new set of school students to our volunteer work force in 2017.

The volunteer service expects to see a large volume of joiners and leavers. Volunteers leaving in 2016 included:

- 50 school student volunteers
- 79 in total from job seeker, university and retired categories. Based on the feedback, evidence shows that majority of the volunteers left to find paid work or had been offered paid work.
- Supported 16 internal staff 2016 (HCA, Orderly, cleaning, Security, RN) with light duties while recovering from work place injury.

79 volunteers exited the programme last year for various reasons.

**Challenges: Retention of volunteers**

A review of the database of active volunteers has been conducted to remove volunteers that have not done a volunteer shift in the last 3 months and that could not be contacted. There are currently 67 Active Rainbow volunteers on our data base and more are being recruited to replace the exited volunteers. This total excludes the anticipated 50 school students we will be recruiting in 2017.

**Measurement and Compliance**

**HDSS Certification Corrective Action Update**

All providers of healthcare services in New Zealand are required to be certified by the Ministry of Health under the Health and Disability Services (Safety) Act 2001 and meet the NZS8134:2008 Health and Disability Services Standard (HDSS). There are 6 core standards assessed: Consumer Rights, Organisational Management, Continuum of Service Delivery, Safe and Appropriate Environment, Restraint Minimisation and Safe Practice (including seclusion use) and Infection Prevention and Control.

Certification can be likened to a warrant of fitness that aims to ensure the hospital is providing safe, effective and appropriate care. Achieving and maintaining certification is essential to operating as a hospital and one of the important measures of service quality. Certification is usually awarded for a 3 year period however there is a mid-cycle progress visit (called a surveillance audit) which checks on progress with corrective actions. We expect a surveillance audit to occur in November 2017.
April 2016 results

Our last full Certification audit was in April 2016 and we were awarded a 3 year certification period\(^1\). For the first time we achieved a Continuous Improvement (CI) rating which is the highest rating that can be awarded and is reserved for exceptional performance. CI ratings are rarely awarded and was given to acknowledge Tamaki Oranga’s work in eradicating seclusion use in what is acknowledged to be a challenging population. We also received 19 corrective actions – 4 of which were rated as moderate risk. Table 1 demonstrates there has been an improvement in our Certification performance over time.

Table 1: Corrective action and continuous improvements since 2012

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>Surveillance</td>
<td>Certification</td>
<td>Surveillance</td>
<td>Certification</td>
</tr>
<tr>
<td>No. of CI rating</td>
<td>0 CI rating</td>
<td>0 CI rating</td>
<td>0 CI rating</td>
<td>1 CI rating</td>
</tr>
<tr>
<td>No. of corrective actions</td>
<td>31 corrective actions</td>
<td>24 corrective actions</td>
<td>22 corrective actions</td>
<td>19 Corrective actions</td>
</tr>
<tr>
<td></td>
<td>13 moderate risk</td>
<td>10 moderate risk</td>
<td>9 moderate risk</td>
<td>4 moderate risk</td>
</tr>
</tbody>
</table>

The corrective actions with moderate risk rating were: medication management, skill mix and recruitment delays, physical environment and discharge planning. Five of the 19 corrective actions relate to the quality of documentation which is also not uncommon in other DHB’s. However this result demonstrates improvement when compared with the 2014 HDSS Surveillance audit in which poor documentation featured in 11 corrective actions.

Corrective Action Plan update

Following the April 2016 audit the organisation developed a Corrective Action Plan through which we track our progress. The DHB is required to report to the Ministry on progress at 3 monthly internals (for moderate risk actions) and 6 monthly for low risk actions. The last report was provided on 5\(^{th}\) February 2017. Some positive feedback has been received from the Ministry on 4 corrective actions that were reported on with two of them being closed as a result of our action taken. Despite the closure of these corrective actions by the HDSS, the DHB will continue to monitor progress in these areas.

The Director of Patient Care has overall responsibility for certification standards. Following a review of the action plan, the nine corrective actions with progress which has been noted as ‘slow’ or ‘some’, will be monitored through a delivery group which will be established in March 2017. With respect to the three corrective actions judged as having ‘slow’ progress, the following actions are underway:

- A review of the complaints and compliments feedback is being consulted on to commence March/April 2017.
- Further investigation is underway into the Service Provision Requirements 1.3.3.3. Actions in relation to maternity staffing are highlighted in the Director of Midwifery report.
- A stocktake of patient fridge temperature monitoring is underway (Feb 2017).

Appendix 1 details the corrective action, executive and operational leads.

<table>
<thead>
<tr>
<th>HDSS Standard</th>
<th>MoH Corrective Action</th>
<th>Executive Owner</th>
<th>Operational Lead</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Provider Availability 1.2.8.1 Moderate</strong></td>
<td>Ensure staffing levels and skill mix meet requirements for patient safety, including for patients with spinal injuries being transferred from ICU to the ward. The current recruitment process is reviewed to ensure all possible delays are reduced.</td>
<td>Director Hospital Services</td>
<td>MMC Governance Group Talent Acquisition Manager</td>
<td>Complete</td>
</tr>
<tr>
<td><strong>Transition, Exit, Discharge, Or Transfer 1.3.10.2 Moderate</strong></td>
<td>Ensure discharge and transfer planning is documented, timely and minimises the risks associated with discharge and/or transfer.</td>
<td>Director Hospital Services</td>
<td>MMC Governance Group</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Medicine Management 1.3.12.1 Moderate</strong></td>
<td>Ensure that medicine records are sufficiently detailed to consistently include dose limits, indications for prn medicines, dating and signing when medications are discontinued, individual dating of medications when prescribed. Ensure that sample signatures and prescriber numbers as well as venous thromboembolism risk assessments are documented. Franklin Hospital - Ensure an indication for use for all PRN medications is documented in the residents medication chart.</td>
<td>Chief Medical Officer</td>
<td>Clinical Head Medication Safety Group DT TG Medical Education Fellow SM ARHOP / Franklin Locality QA Manager / CND’s Medication Safety Group</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Facility Specifications 1.4.2.4 Moderate</strong></td>
<td>Implement consistent processes which ensure the physical environment minimises the risk of harm to patients.</td>
<td>Director Hospital Services</td>
<td>GM’s OHSS Manager</td>
<td>Complete</td>
</tr>
<tr>
<td><strong>Independence, Personal Privacy, Dignity, And Respect 1.1.3.6 Low</strong></td>
<td>Ensure Tiaho Mai does not restrict the movement of informal patients.</td>
<td>Director Hospital Services</td>
<td>GM / CD Mental Health</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Complaints Management 1.1.13.1 Low</strong></td>
<td>Ensure the complaints management system includes all complaints and demonstrate the management of complaints within expected timeframes.</td>
<td>Director of Patient Care</td>
<td>Quality Assurance Manager</td>
<td>Slow</td>
</tr>
<tr>
<td><strong>Quality And Risk Management Systems 1.2.3.3 Low</strong></td>
<td>Policies and procedures are current and reviewed at regular intervals as defined in policy.</td>
<td>Director of Patient Care</td>
<td>Controlled Document Committee</td>
<td>Some</td>
</tr>
<tr>
<td><strong>Quality And Risk Management Systems 1.2.3.8 Low</strong></td>
<td>All corrective actions as a result of events and complaints are implemented as and when required and there is a systematic approach to ensure completion and that the recommendations have in fact addressed the issues raised.</td>
<td>Director of Patient Care</td>
<td>Quality Assurance Manager</td>
<td>Some</td>
</tr>
<tr>
<td><strong>Quality And Risk Management Systems 1.2.3.9 Low</strong></td>
<td>Work to address the current deficiencies in the risk management system is implemented as planned to ensure a robust system is in place and understood by those staff involved.</td>
<td>Director of Strategy</td>
<td>Risk Manager</td>
<td>Some</td>
</tr>
<tr>
<td><strong>Human Resource Management 1.2.7.2 Low</strong></td>
<td>Complete credentialing and maintain currency in accordance with organisational requirements.</td>
<td>Chief Medical Officer</td>
<td>Chief Medical Officer Deputy CMO, CD Medicine</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Human Resource Management 1.2.7.5 Low</strong></td>
<td>Implement a comprehensive system to identify, plan, manage, and record ongoing staff education. Franklin Hospital - Ensure a system is in place to accurately capture compliance with mandatory</td>
<td>Director Hospital Services</td>
<td>Building Capability Lead Organisational Development Manager</td>
<td>Good</td>
</tr>
<tr>
<td>HDSS Standard</td>
<td>MoH Corrective Action</td>
<td>Executive Owner</td>
<td>Operational Lead</td>
<td>Progress</td>
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<tr>
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</tr>
<tr>
<td><strong>Service Provision Requirements 1.3.3.3</strong></td>
<td>Ensure patients’ needs are identified and provided for in a timely manner.</td>
<td>Director of Hospital Services</td>
<td>MMC Governance Group</td>
<td>Slow</td>
</tr>
<tr>
<td><strong>Assessment 1.3.4.2 Low</strong></td>
<td>Individualised goals/needs/desired outcomes are sought and documented as a basis for care planning and delivery. Franklin Hospital – Ensure all interRAI assessments and reviews are completed within required timeframes.</td>
<td>Director of Patient Care</td>
<td>DoN / CND’s SM ARHOP / Franklin Locality</td>
<td>Some</td>
</tr>
<tr>
<td><strong>Planning 1.3.5.2 Low</strong></td>
<td>Ensure the information from all relevant assessment sources is documented in detail to support an ongoing plan of care to meet the patients’ needs and goals. Care plans are developed that guide practice and support the patient, with the involvement of the patient. Early warning signs and relapse prevention is part of the care plan for patients in the mental health service.</td>
<td>Director of Patient Care</td>
<td>DoN / CND’s GM / CD Mental Health</td>
<td>Some</td>
</tr>
<tr>
<td><strong>Planned Activities 1.3.7.1 Low</strong></td>
<td>Resource and develop the activity programme that has been developed. Individual care plans reflect the inclusion of activities meaningful for the patient.</td>
<td>Director of Patient Care</td>
<td>GM / CD Mental Health</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Evaluation 1.3.8.2 Low</strong></td>
<td>Ensure evaluation tools are completed and inform the care planning process</td>
<td>Director of Patient Care</td>
<td>DoN CND’s</td>
<td>Some</td>
</tr>
<tr>
<td><strong>Nutrition, Safe Food, And Fluid Management 1.3.13.2 Low</strong></td>
<td>Patients with special dietary needs have these consistently identified and met.</td>
<td>Director of Hospital Services</td>
<td>Manager Food Service and Fleet GM MHS</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Nutrition, Safe Food, And Fluid Management 1.3.13.5 Low</strong></td>
<td>All patient food is stored safely within fridges in patient ward areas, at the correct temperature, correctly labelled and dated.</td>
<td>Director of Patient Care</td>
<td>DoN CND’s OSHH</td>
<td>Slow</td>
</tr>
<tr>
<td><strong>Facility Specifications 1.4.2.6 Low</strong></td>
<td>Ensure patients can access a safe outdoor courtyard area.</td>
<td>Director of Hospital Services</td>
<td>GM / CD Mental Health</td>
<td>Good</td>
</tr>
</tbody>
</table>
## Counties Manukau District Health Board

### Resolution to Exclude the Public

**Resolution:**
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:

<table>
<thead>
<tr>
<th>General Subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Patient Experience &amp; Safety Report</td>
<td>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.</td>
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<td></td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32 (a)]</td>
<td>Privacy</td>
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<td>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.</td>
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<td>[Official Information Act 1982 S9(2)(a)]</td>
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<tr>
<td>6.2 Minutes of HAC meeting 30 November 2016 with public excluded</td>
<td>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.</td>
<td></td>
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<tr>
<td></td>
<td>[NZPH&amp;D Act 2000 Schedule 3, S32(a)]</td>
<td>Confirmation of Minutes</td>
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<td></td>
<td></td>
<td>For the reasons given in the previous meeting.</td>
</tr>
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