HOSPITAL ADVISORY COMMITTEE (HAC) MEETING
18 July 2018

Venue: Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu Time: 1.00pm

Committee Members	CMDHB Management
Dr Lyn Murphy – Committee Chair Dr Ashraf Choudhary – CMDHB Board Member Catherine Abel-Pattinson – CMDHB Board Member Dianne Glenn – CMDHB Board Member	Gloria Johnson – acting Chief Executive Phillip Balmer – Director Hospital Services Vanessa Thornton – acting Chief Medical Officer Jenny Parr – Director of Patient Care, Chief Nurse & Allied Health Professions Officer Avinesh Anand, Deputy CFO Provider Vicky Tafau - Secretariat

APOLOGIES

REGISTER OF INTERESTS

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

PART I – Items to be considered in public meeting

			Page No.
1.00pm	**1.**	**AGENDA ORDER AND TIMING**	
	2.	**CONFIRMATION OF MINUTES**	
1.05pm	2.1	Confirmation of Minutes of the Hospital Advisory Committee Meeting – 6 June 2018	**005**
1.10pm	2.2	Action Items Register	**013**
	3.	**PROVIDER ARM PERFORMANCE REPORT**	
1.15pm	3.1	Executive Summary/SLM Update (Phillip Balmer)	**016**
		3.1.1 Car Park Improvement Options and Update	**029**
	3.2	2017/18 Hospital Services Workplan	**033**
	3.3	Balanced Scorecard	**038**
1.30pm	3.4	Finance Report (Avinesh Anand)	**041**
		3.4.1 Annual Leave Cash Up Summary	**045**
1.40pm	3.5	Emergency Department, Medicine and Integrated Care (Brad Healey)	**046**
		3.5.1 Maaori Breastscreen Coverage Update Paper/Presentation (Kathy Pritchard)	**054**
2.00pm	3.6	Surgery, Anaesthesia and Perioperative Services (Mary Burr)	**069**
		3.6.1 Response to Cataract Question	**077**
2.10pm	3.7	Central Clinical Services (Ian Dodson)	**078**
2.20pm	3.8	KidzFirst and Women's Health (Nettie Knetsch)	**084**
2.30pm	3.9	Adult Rehabilitation and Health of Older People/(Dana Ralph-Smith)	**095**
2.40pm	3.10	Mental Health and Addictions (Tess Ahern)	**098**
2.50pm	3.11	Middlemore Central (Dot McKeen)	**110**
		Afternoon Tea Break (3.00pm – 3.10pm)	
	4.	**CORPORATE REPORTS**	
3.10pm	4.1	Director Patient Care, Chief Nurse and Allied Health Professions Officer (Jenny Parr)	**112**
		4.1.1 Appendix 1: Care Compass Report /Appendix 2: Plan of Care Update/Appendix 3:HQSC Dashboard	**127**
3.25pm	4.2	Patient Experience & Safety Report (David Hughes)	**140**
		4.2.1 Dashboard & Variance Report	**141**
3.35pm	4.3	Human Resources Report (Phillip Balmer)	**149**
3.45pm	**5.**	**RESOLUTION TO EXCLUDE THE PUBLIC**	**153**

BOARD MEMBER ATTENDANCE SCHEDULE – HAC 2018

Name	31 Jan	Feb	14 Mar	23 Apr	May	6 June	18 July	29 Aug	Sept	10 Oct	21 Nov	Dec
Dr Lyn Murphy (Chair)	X	No Meeting	✓	✓	No Meeting	✓			No Meeting			No Meeting
Catherine Abel-Pattinson (Deputy Chair)	✓		✓	✓		✓						
Dr Ashraf Choudhary	✓		✓	✓		✓						
Dianne Glenn	✓		✓	✓		✓						
Mark Darrow	✓		✓	✓								
Rabin Rabindran	✓		✓	✓								

HAC MEMBERS
DISCLOSURE OF INTERESTS
18 July 2018

Member	Disclosure of Interest
Dr Lyn Murphy (HAC Chair)	• Member, ACT NZ • Director, Bizness Synergy Training Ltd • Director, Synergex Holdings Ltd • Trustee, Synergex Trust • Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ) • Member, New Zealand Association of Clinical Research (NZACRes) • Senior Lecturer, AUT University School of Inter professional Health Studies • Member, Public Health Association of New Zealand
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 • Husband (John Abel-Pattinson), Director, Blackstone Group Ltd • Husband, Director, Blackstone Partners Ltd • Husband, Director, Bspoke Ltd • Husband, Director, 540 Great South Ltd • Husband, Director, Barclay Suites • Husband, Chairman, Lifetime Design • Husband, Director, various single purpose property owning companies
Dianne Glenn	• Member, NZ Institute of Directors • 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. • Member, National Council of Women of New Zealand • Justice of the Peace • Member, Pacific Women's Watch (NZ) • Member, Auckland Disabled Women's Group • Life Member of Business and Professional Women NZ
External Appointee TBC	
External Appointee TBC	

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 18 July 2018

Director having interest	Interest in	Particulars of interest	Disclosure date	Board Action
Dr Lyn Murphy	Allied Health Initiative for Education & Development (AHIED)	Senior Lecturer, AUT School of Inter-Professional Health Studies	30 November 2016 8 March 2017	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.

Minutes of Counties Manukau District Health Board
Hospital Advisory Committee

Held on Wednesday, 6 June 2018 at 1.00pm
Room 101, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu, Auckland

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PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Dr Lyn Murphy (Chair)
Ms Catherine Abel-Pattinson (Deputy Chair)
Dr Ashraf Choudhary
Ms Dianne Glenn

ALSO PRESENT

Dr Gloria Johnson (acting Chief Executive)
Mr Avinesh Anand (Deputy CFO, Provider)
Mr Phillip Balmer (Director Hospital Services)
Ms Vanessa Thornton (acting Chief Medical Officer)
Ms Jenny Parr (Director of Patient Care, Chief Nurse & Allied Health Professions Officer)
Ms Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public or media representatives present for the public section of this meeting.

APOLOGIES

No apologies were received.

DISCLOSURE OF INTEREST/SPECIFIC INTERESTS

The Disclosures of Interest were noted.

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

1. AGENDA ORDER AND TIMING

The meeting commenced with a tour of the Adult Mental Health Unit.
Items were then taken in the same order as listed on the agenda.

2. **COMMITTEE MINUTES**

2.1 **Confirmation of the Minutes of the Hospital Advisory Committee meeting held on 23 April 2018.**

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

That the minutes of the Hospital Advisory Committee meeting held on 23 April 2018 be approved.

Carried

2.2 **Action Item Register**

It was noted that all actions are either on task or have been rescheduled.

3. **PROVIDER ARM PERFORMANCE REPORT**

Executive Summary

Phillip Balmer introduced the report highlighting:

Delivery of our 2017/18 initiatives work plan is continuing; across Hospital Services divisions and related programmes, there are now 102 total projects being monitored, which range from localised service improvements through to major transformational activities. There are 14 projects in initiation, which largely relate to new project commencing in line with the organisational Turnaround Plan. In total, 50 projects are now in execution phase, with 5 in Benefits Realisation. Further detail is provided in the 'Initiatives Programme' section of this month's report.

Projects are on track to deliver improved patient outcomes and reduced costs with savings YTD forecast to be $15M. Some of these savings will be ongoing for subsequent years. We are working on closing out the 17/18 projects.

We have also been working on our improvement program for 18/19 to achieve the triple aim of improving value and closing the equity gap by developing plans to deliver results in each of the turnaround focus areas. Our preliminary benefits for the provider arm equal $6.5M. We are working on project implementation plans to commence delivery of these improvements as soon as possible and will be providing regular reports back to ELT, ARF and HAC.

Work has been undertaken around the better management of chronic conditions including linking with Primary Care. One of the aims is to provide better support for End Of Life (EOL) care. Considerable thought and engagement has been invested into putting patients first and considering their wishes, providing advice, etc. Support is provided to the whaanau depending on requirements, when patients return home for the EOL journey. EOL and Chronic conditions are well supported by Community Central ensuring they have continued support at home.

A regular report in terms of metrics of how that will look will be provided.

Balanced Scorecard – Provider Arm

The report was taken as read.

The Scorecard shows significant improvements in many areas. Maaori BreastScreening was of particular note.

Action
Mr Balmer will ask Mr Brad Healy to provide an update for HAC highlighting what is being done differently in order to produce significant improvements for Maaori Breastscreening.

Finance Report – Provider Arm

The report was taken as read.

- Non-resident revenue: Mr Avinesh advised that CM Health don't write off bad debt. It is sent to Debt Collection agencies. A full report will be included in the Financial Year report – 18 July 2018.
- The last funding envelope saw CM Health's MoH contribution to non-resident revenue increased.
- Overspending in facilities is to be expected.

NZNO negotiations: to be discussed later in the meeting.

Emergency Department, Medicine and Integrated Care (Brad Healey)

The report was taken as read.

In regard to Breastfeeding, Mr Healy advised the results were reflective of the effort and focus of the leadership of the service. Mr Healy is confident that CM Health is doing well comparatively.

As at 31 February total coverage for women aged 50-69 years was 71.1%. Maaori coverage was 65.3%, and Pacific 83.3%. The national target of 70% has been achieved for the total population and Pacific. There has been a slight increase in Maaori coverage this month as the service has exceeded the Maaori screening volume target over the last 2 months.

- Readiness assessment: went well.
- Histopathology: case before board, endorsed. Submitted IANZ, successfully.
- Colonoscopy wait times: MOH is concerned due to the fact that CM Health is falling behind with wait times. Outsourcing is working well, however from Christmas 2017 to May, there has been a 30% increase in volume of those waiting. As such CM Health has fallen behind the P2 target. A recovery plan has been requested. Outsourcing is forming part of the recovery plan. Preliminary discussions are going live from end of June 2018.
- Bowel screening requires regular follow up.
- Winter Bed Capacity: effort is being put into what the needs of General Medicine are. Francis Group will undertake some diagnostics of the Patient Journey. This will challenge our thinking in a number of areas. Will give the process credibility. Many factors will feed into this study of the average length of stay. Average length of stay for 40% is currently 13 hours.
- Local delivery of oncology: Plan for next 12 to 24 months – Auckland looking to push some volume out our way. Longer term picture, post two years, will we continue to use level 5 of Galbraith. If not there Manukau Health Park seems to be the logical choice. Will require some thinking around this. Call centre, clerical tasks, these could potentially be done from home.

Surgery, Anaesthesia & Perioperative Services (Mary Burr)

The report was taken as read.

Highlights included:

- Acute WIES is 5.12% lower than contract for the month over contract by 2.22% YTD.
- We treated 70 Hip and Knee patients (YTD 709/685) against target of 65. For cataracts we treated 241 against a target of 103 patients (YTD 1473/1082).
- Theatre utilisation at MSC has increased to 78.8% for April 2018. Theatre Performance - Acute outputs returned to high volumes in April 2018 after a slight repreive in March 2018.
- 100% for discharges, YTD. Outputs are well over-phasing. Another positive.

Challenges include:

- Elective throughput.
- Workforce planning group: keeping an eye on anaesthesia.
- Population (worldwide) is aging and therefore an increase in aged related care in particular opthamology. Technology, recruitment (international shortage) and 'mega-clinics' will continue to assist CM Health in catching up by the end of the calendar year.

Action

Determine how many cataracts patients are being outsourced to ADHB and report back to the next HAC meeting.

Central Clinical Services (Phillip Balmer)

The report was taken as read.

Highlights included:

- The Laboratory has completed its surveillance audit (conducted by IANZ) during April. There were two CARs received. One was a continuation of the Histopathology accommodation CAR and requires progress to be made towards the reconstruction of the department. The second was related to the documentation currency in the department and requires us to make significant steps toward ensuring that our documents are reviewed in a timely manner. There was also a list of recommendations made by IANZ. The feedback from IANZ was generally very positive and stated that the lab continues to demonstrate high levels of performance.
- The updated Histopathology business case was approved again at ELT and is scheduled to go to the Board on the 16th of May.
- We have ceased routine laboratory testing at the Manukau Super Clinic retaining Point of Care urgent testing and Blood Bank Services. We have reduced the staffing at MSC from two to one and deployed the released resource to support the routine testing being performed at the Middlemore laboratory.
- The Patient Blood Management project is progressing well with good savings achieved in April although less than those in March. The new PBM nurse starts in May.
- Electronic Prescribing and Administration (Medchart) was rolled out successfully to two ARHOP wards in April. The uptake of MedChart in these wards has been excellent and there have been no significant clinical issues or risks identified. There have been some integration related issues highlighted and these have a plan for resolution. The planned roll out to the 5 Adult Rehabilitation and Health of Older Persons wards is expected to be completed on schedule in early June.
- MRT's and sonographer staffing much improved. Current vacant FTE – MRT – 4.00FTE and Sonography is .54FTE. Overseas advertising has resulted in a good response for MRT staff, however recruiting MRI trained staff remains challenging as the requirements of the MRTB are restrictive.
- The conversion rate to Radiology electronic orders is now close to 80% with excellent uptake across inpatient services. Some workflow issues with the new process are impacting the uptake in outpatient services.

Kidz First & Women's Health (Nettie Knetsch)

The report was taken as read.

Highlights included:

- Neonates continues to be a concern and CM Health are waiting on a sit down with the MoH.
- The Neonatal Unit has 4 fewer discharges YTD; WIES however are up by 119. In addition, the discharges under WH for Secondary Neonates (i.e. Neonates transferred from Neonatal Unit to maternity) is up by 161 discharges (61 WIES) YTD. Occupancy and acuity in April in the Neonatal Unit remain high.
- With the Unit reaching capacity frequently we have seen an increase in babies moving to the postnatal floor and being discharged from there. In addition, since March 2018 we have commenced using Kidz First Medical C-Pod for lower acuity level 2 Neonates. On average 4 babies and their mothers have been accommodated. Resource nurses on Kidz First Medical have developed a Resource Board on C Pod to provide education to the staff on caring for these neonates and provide support to the nurses when required.
- A public Health Registrar is to look at what is driving the need for increased neonatal care.
- The increasing acuity and complexity in maternity (YTD Caesarean Section rate up by 2% and Induction of Labour rate up by 1%) combined with the additional neonatal workload is resulting in more midwifery workforce being required than budgeted. Fortunately, the availability of bureau staff has been good over the past 3 months as well as the commencement of the new graduate midwives (20) and the very end of April but we still needed to allocate significant overtime hours as well to support the new graduate midwives during their orientation. Staff sickness in Women's Health continues to be higher than previous year reflecting the pressure on the workforce due to vacancies and increasing acuity particularly in the Birthing and Assessment area.
- Ineligibility, in Womens' health it is different from other departments. If baby's father is eligible, then the baby is and so is the mother until the baby is born.
- IDF: will be increased once the eligibility issues are resolved.
- Research: mostly ventilation and CPAP clinical trials, implementations. CM Health are leading experts in the country for CPAP.
- Gestational Diabetes: understanding the impact of comorbidities is an ongoing focus.

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

The report was taken as read.

Highlights included:

- The Indicative Business Case for the Specialised Rehabilitation Investment went to the Capital Investment Committee this month; a month earlier than previously expected in our previous report. We have subsequently commenced planning the next steps for the Detailed Business Case Development.
- E-prescribing began its rollout in April and has gone live in Wards 23 and 24. Throughout May the rollout will continue to go live in Wards 4, 5 and 31. Additionally, e-vitals has gone live in Ward 23 with implementation of e-vitals expected to occur early May for Ward 31 and the Spinal Rehabilitation Unit.
- Pyxis has been implemented at the Spinal Unit and training will commence early May.

Challenges included:

- The ARHOP services are working hard to plan for the increased service demand throughout the winter months.
- We are continuing in our efforts to encourage staff and patients to get their flu vaccinations that are available at Middlemore Hospital and in the community.

- The services are all developing contingency plans should a nursing strike occur in July.

Ms Ralph-Smith asked HAC to note the additional information paper re fractures.

Mental Health & Addictions (Tess Ahern)

The report was taken as read.
HAC had a tour of the new Adult Mental Health Unit at the start of the meeting.
Mental Health enquiry highlight: Mason Durie was impressed with the model of care that CM Health are working towards.
Reconfiguration of specialist services: underway, appointed most of the major roles. Maaori and Pacific roles being recruited for next week.
The overarching structure of Integrated Care North, Integrated Care South and District-wide services is confirmed (with Acute & Hospital Services being out of scope).

- Three Service Managers will oversee the Integrated Care North, Integrated Care South and District-wide services.
- IC North and IC South will each have a CAMHS Clinical Head and an Adult Clinical Head.
- There will be five locality Adult Community MH teams: two (Eastern and Otara-Mangere) in the IC North service and three (Manukau North, Papakura-Manurewa, Franklin) in the IC South service.
- There will be two CAMHS services: Whirinaki North in the IC North and Whirinaki South in the IC South
- Establishment of a new Franklin Adult Community Mental Health team based at Pukekohe hospital
- Realignment of administration FTE to support these services and teams following consideration of work done by the administration working group

Middlemore Central (Dot McKeen)

The report was taken as read.

Contingency planning for potential industrial action is well underway working with Service Managers and Clinical Nurse Directors should the industrial action by the NZNO go ahead.

An independent panel requested by the Prime Minister has been meeting with both parties, DHBs and NZNO, to find common ground in reaching an agreed outcome. The NZNO has advised that failing to reach an agreement could result in a total withdrawal of labour for 24 hours starting at 0700 hours on Thursday 5th July and finishing at 0700 hours on Friday 6th July. We are advised that similar action could take place again the following week on Thursday 12th July.

Draft plans have been prepared and sent to Anne Aitcheson, the National Contingency Planner, for review. Discussion will then take place around what constitutes Life Preserving Services.

Work has been undertaken over the last three months to prepare and agree on a Metro Winter Plan for the three Auckland region District Health Boards – Auckland, Waitemata and Counties Manukau Health.

The plans will cover daily regional reporting, Influenza preparation and agreed indicators of when escalation to Director of Hospital level may be required taking a regional operational stance.

4. CORPORATE REPORTS

4.1 *Director Patient Care, Chief Nurse and Allied Health Professions Officer* (Jenny Parr)

The paper was taken as read.

- Ms Parr advised that the Nursing Midwifery Awards were very much appreciated by staff.
- Certification: waiting for final confirmation of action plan from MoH. Gone from 19 corrective actions down to 12. Developing actions plans currently.
- Note: pictures of tables/graphs become difficult to read on Diligent.
- Parking: Esme Green machine doesn't produce a receipt. Philip to follow up with Parking Services. Intensive work is currently being undertaken around understanding car parking issues.
- ACC: compassionate parking and senior staff parking has been allocated. Looking at night staff parking at the hospital to alleviate any safety fears.
- Hoping to reinstate the payment machine in the main carpark.

4.2 *Patient Experience & Safety Report* (David Hughes)

Report taken as read.

- There has been a bounce back in the feedback on food. More positive results are being seen.
- There has been a significant increase on in-patient surveys completed in Women's Health due to tablets being used. The response rate has gone up brining us closer to the national average.
- Open book: continuation of excellent work being undertaken in falls prevention.
- Falls preventions most recent focus has been away from the hospital.

4.3 Patient & Whaanau Feedback on Parking (Jenny Parr)

The report was taken as read.

Resolution
The Hospital Advisory Committee:
Received the patient, family and Whaanau feedback on parking issues at the Middlemore Hospital site and recommendations for improvement.
Noted the recommendations which were considered by the Executive Leadership Team in conjunction with the *Car Parking Improvement Options* paper submitted by Phillip Balmer

Carried

Action
Mr Balmer to report further on car parking at the next meeting on 18 July 2018 and is to provide his Car Parking Improvement Options paper for HAC's information.

4.2 HR Report (Phillip Balmer)

The report was taken as read.

- A question was raised around whether or not bullying was an issues at CM Health and CM Health representatives at the table were asked if a survey been conducted? HAC were

advised that this issue is being looked at as a Health & Safety issue and a full report will be coming to the next Board meeting on 27 June 2018.

- CM Health is looking at better support for those teams under the most pressure, eg Neonatal.
- Voluntary turnover is currently remarkably low which is a pleasing result.

5. INFORMATION PAPER

The 2017/18 Non-Financial Summary Quarter 3 Report was taken as read.

6. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Dianne Glenn/Seconded: Catherine Abel-Pattinson)

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:

General Subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
2.1 Public Excluded Minutes of 14 March 2018	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982). [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** For the reasons given in the previous meeting**.**
3.1 Patient Experience and Safety Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982). [NZPH&D Act 2000 Schedule 3, S32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S9(2)(a)]

Carried

The open session of the meeting concluded at 3.45pm.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 6 JUNE 2018.

Dr Lyn Murphy
Chair

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

Hospital Advisory Committee Meeting – Public Action Items Register – 18 July 2018

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
Standing Items						
4.10.17	2.4	Summary of Annual Leave Cash-Ups for Hospital Services Directorate – provide a **quarterly report** showing, for those staff that have had annual leave paid out, their current leave balance, leave accrual and leave taken. This report will not specifically identify particular individuals due to privacy issues.	18 July	Avinesh Anand/ Phillip Balmer	Summary provided as part of agenda item 3.4.	
15.11.17	5.1	Certification – provide a **quarterly report** showing progress being made against each corrective action.	10 October	Jenny Parr		
31.1.18	6.11	Medicine - Bowel Screening Programme **regular update** each meeting**.**	18 July	Brad Healey	Refer agenda item 3.5.	
31.1.18	2.	Patient Survey –**regular** update on the response rates to the patient survey and the complaints review process.	18 July	Jenny Parr	Provided as part of agenda item 4.1.	
31.1.18	6.1	Hospital Services 2016/17 Project Initiatives ***Update*** (as part of the Executive Summary).	18 July	Phillip Balmer	Refer agenda item 3.2.	
15.11.17 31.1.18	5.1	System Level Measures ***Quarterly*** full report. ***Update*** (as part of the Executive Summary).	10 October 18 July	Phillip Balmer	Provided as part of agenda item 3.1.	
14.3.18	3	Finance – Bad Debt Summary – provide a **quarterly report** to HAC.	18 July	Avinesh Anand	Refer agenda item 3.2 – Public Excluded agenda.	
Monthly Action Items						
4.10.2017	3.4	Finance – update on supply chain management and clinical supplies, including what the region is doing on enhancing the supply chain generally and an update on the One-Link contract currently being renegotiated.	~~18 July~~/29 August	Avinesh Anand	HAC members that don't sit on ARF will be invited to attend a presentation by Pauline Hanna on 29 August 2018.	
14.3.18	4.1	Community Nursing - Cellulitis update is to be provided at an upcoming CPHAC meeting. Information is to be	18 July	Margie Apa, Karyn Sangster	During the summer of 2017-2018	✓

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

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
		provided in terms of staff losses and the increase in presentations at ED and with GPs. It was noted that the Social Investment Board does a lot of work in this area too. Ms Tafau to contact Margie Apa, Karyn Sangster and Wendy Walker to coordinate a response.			there were high levels of fleas in the community. Staff used flea bands to repel fleas, cars and offices were regularly flea bombed to reduce flea loads. There were two district nurses who reacted to the flea bands and flea bites they have chosen to seek alternative work in other parts of Auckland. Data linking increased fleas to increased rates of cellulitis is not available as insect bites classification includes other insects such as mosquitos and sand flies which were also flourishing in the summer conditions. Data from General Practices is not visible and classification would be generic and not specific to flea bites. With the change of season the fleas are decreasing in numbers and not impacting on nursing staff.	
14.3.18	5.1	Maaori Health Targets – HAC to follow up in terms of Maaori Men and Women Health Targets. HAC should make decisions regarding what targets we should focus on, where can we make the most gains. Mana Whenua i Tamakai Makaurau's Board have already signalled their willingness to work in conjunction with CM Health around these targets.	~~18 July~~/29 August	Phillip Balmer		
6.6.10	3	BreastScreening: Mr Balmer will ask Mr Healy to provide and update for HAC highlighting what is being done differently in order to produce significant improvements for Maaori BreastScreening.	18 July	Brad Healy	Update has been provided as part of agenda item 3.5.	

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

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
6.6.18	3	Cataract Patients: Provide an report to HAC determining how many cataract patients are being outsourced to ADHB.	18 July	Mary Burr	Report has been provided as part of agenda item 3.6.	
6.6.18	4.3	Car Parking at MMH: Mr Balmer to report further on car parking at the next meeting and is to provide his Car Parking Improvement Options paper for HAC's information.	18 July	Phillip Balmer	Refer agenda item 3.1.1.	

Counties Manukau District Health Board
Hospital Advisory Committee

Hospital Services Report – July 2018

Recommendation

It is recommended that the Hospital Advisory Committee:

Receive the Hospital Services Report covering activity in May 2018.

Prepared and submitted by Phillip Balmer, Director Hospital Services

Executive Summary

Glossary

COW	Computer on Wheels
CP	Clinical Portal
ERCP	Endoscopic Retrograde Cholangiopancreatography
EUS	Endoscopic Ultrasound
EWS	Early Warning Score
ESPI	Elective Service Productivity Indicator
FCT	Faster Cancer Treatment
FSA	First Specialist Appointment
MECA	Multi-Employer Collective Agreement
MERAS	Midwifery Employment Relations Advisory Service (union)
NHI	National Health Index
NZNO	New Zealand Nurse Organisation (union)
PSA	Public Service Association (union)
SMO	Senior Medical Officer

Overview

The hospital-wide balanced scorecard, finance, and human resources reports included in this report provide a consolidated view of organisational performance. We have also provided a high level overview of our 2017/18 project initiatives programme, and an update on the System Level Measure related to reduction in acute bed demand.

Financial Position

The Provider Arm produced a $1.48M favourable variance against budget for year to date May 2018, and a $241k unfavourable variance for the month.

Overall revenue is $5.4M favourable for the year to date, $287k favourable for the month attributable in part to increased revenue from the Tahitian burns contract, non resident revenue, bad debts recovery and additional funding for the capital charge.

Contract performance is on budget for acutes, and behind in Elective Wies with combined total Wies, 0.7% below budget. Total IDF Wies provided by other DHBs, are 9% below budget. Elective revenue is lower than expected YTD in part because we did not accurately predict for the 17/18 year, the impact of the move from Wies 16/17 to 17/18. The WIES impact of the change was 2.52% or 460 Wies (see below). We are 718 Elective WIES behind YTD. The gap has been narrowed by 379 WIES in May with elective outputs the highest for any one month during the financial year with Electives 26.2% above flexed contract for the month.

Conversion of Elective admit type Casemix events from Jul '16 - June '17 from WIES16 into WIES17 for CMH as provider & domiciled only

PUC	PUC Description	Total Wiesnz16	Total Wiesnz17	% change
D01.01	Inpatient Dental	40	39	-2.49%
S00.01	General Surgery Inpatients	4,545	4,415	-2.85%
S25.01	ORL Inpatients	1,257	1,243	-1.13%
S30.01	Gynaecology Inpatients	1,324	1,332	0.60%
S40.01	Ophthalmology Inpatients	1,124	1,068	-5.02%
S45.01	Orthopaedic Inpatients	5,199	5,269	1.36%
S60.01	Plastic & Burns - Inpatients	1,693	1,667	-1.49%
S70.01	Urology - Inpatients	354	327	-7.63%
Grand Total		15,535	15,360	

Personnel costs are slightly unfavourable due to increased demand pressures meaning we needed to resource additional capacity predominantly nursing and medical (784k for the month) which in part has been offset by the increased revenue. Nursing personnel costs are over budget as we have been responding to demand pressures consistent with CCDM in neonates, women's health, ED and Medicine. In 18/19 we have increased our budget for these areas.

We have outsourced more clinical services with a $1.1M unfavourable budget YTD. This has been in surgery, radiology, ophthalmology, and gastroenterology which has been necessary because of workforce gaps and growing wait times.

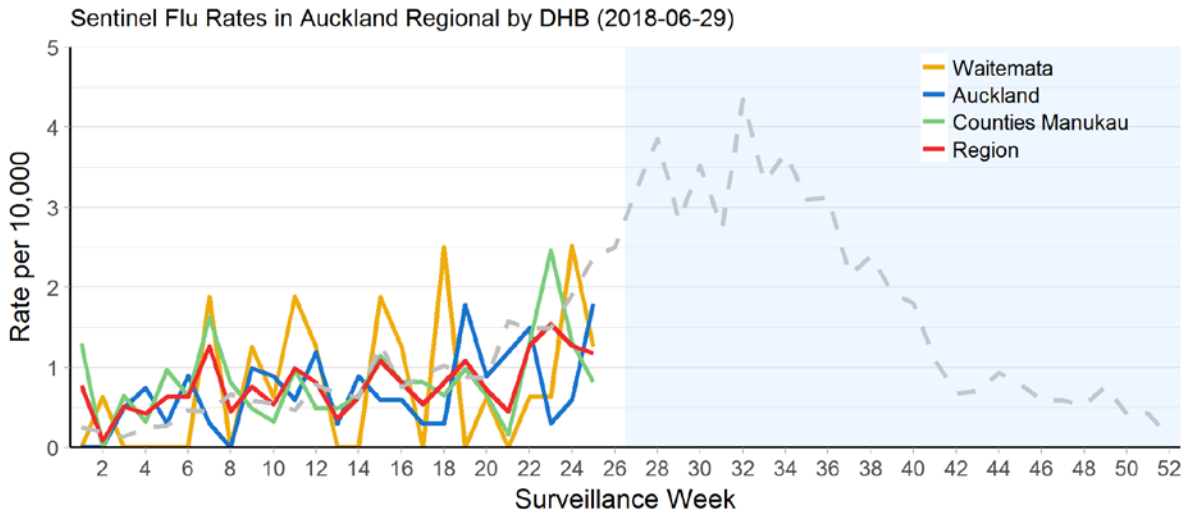
Initiatives Portfolio

Delivery of our 2017/18 initiatives work plan is continuing; across Hospital Services divisions and related programmes, there are now 84 total projects being monitored, which range from localised service improvements through to major transformational activities. We have achieved 81% of our $17M savings program with the largest savings from Surgery, ARHOP, nonclinical, and CCS. Medicine have not realised their savings program. We have been working to close out year-end projects with 18 projects now closed.

In total, 44 projects are now in execution phase, with 6 in Benefits Realisation. Further detail is provided in the 'Initiatives Programme' section of this month's report. 18 projects have been closed since the last report- this is due to both completion of existing projects, as well as rationalisation of projects to join them together with complementary activities within the portfolio in preparation for delivery of the Turnaround Plan.

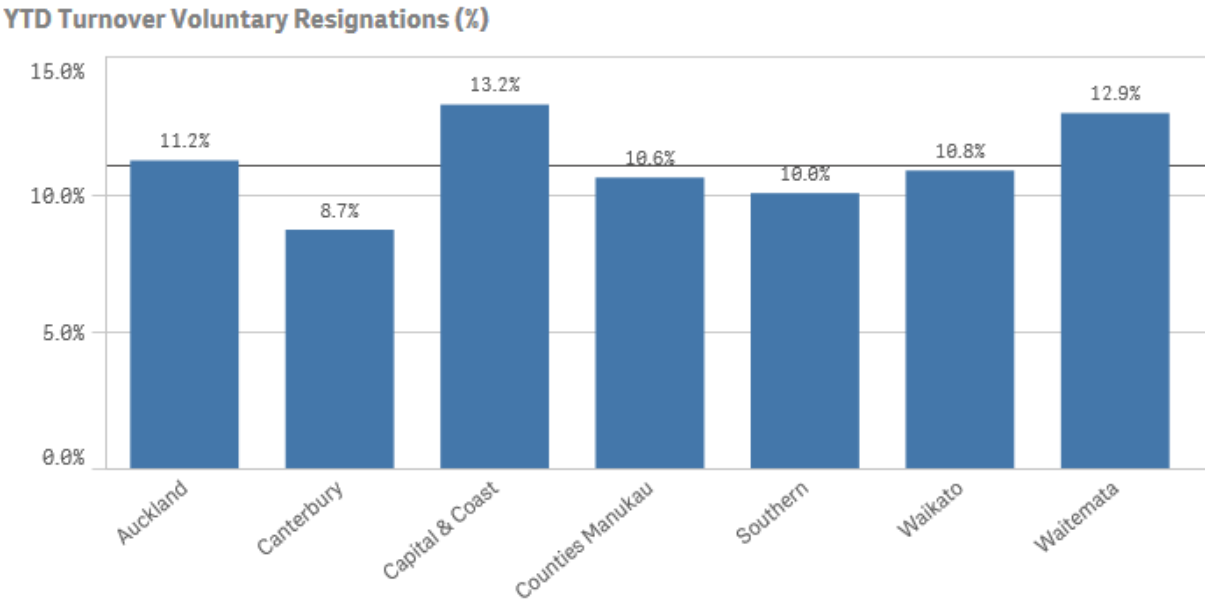
Winter focus

Our priority in May has been to prepare for winter to ensure our capacity is prepared for the escalating demand. We are very pleased that the approval has been given to open the additional ward. To date seasonal flu rates have been below that experience in May 2017. We remain optimistic that the forecast demand increase shown in grey below may be below that experienced in 2017 with the quadrivalent influenza vaccine more effective.



Divisional highlights

Workforce results reflect a low level of sick leave (2.9%), staff turnover which benchmarks well nationally and with the region.



Theatre acute demand showed a 10% reduction in May which meant we were able to deliver more elective volumes with a 5% increase in elective theatre minutes at MMH. MSC elective minutes were also at the highest volume for the year. General surgery, and orthopaedics combined acute and elective minutes were the highest for the last twelve months. Elective theatre patient cancellations were down to 6%.

We have seen reductions in wait times for ophthalmology for 50% overdue appointments by 414 appointments.

Acute flow metrics showed improvement for key conditions including Cardiac STEMI to PCI (94%), eligible stroke patients thrombolysed 15%, length of stay 2.6 days, ALOS > 10 days down by 5%. High numbers of presentations in Emergency Care continue with a 0.8% increase over last years volumes and a 3.7% increase YTD, with an average of 311 presentations per day. This has made it difficult to achieve the six hour target (see below).

Faster cancer treatment results were 100% for the month (see below).

We are pleased to see a reduction in our overdue appointments for ophthalmology and radiology (plain X-ray) with services increasing service hours in weekends and evenings to address the wait list backlog.

National Health Targets

Performance against the national health targets which will become one of a range of annual plan metrics for which the Hospital Services Directorate is responsible for are summarised below. We plan to have a greater focus in the 18/19 HAC report on areas of greatest concern that have been a challenge to realise improvements against. This will include MRI, Ophthalmology and Gastroenterology waiting times.

Elective Surgery

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

	Description The volume of elective surgery will be increased by an average of 4,000 discharges per year.	**April (actual)** Achieved ✓ 100.2%	**May (indicative)** Achieved ✓ 100%

Commentary

Due to high acute volumes and anaesthetists shortages over this year, there is continued pressure on both ESPI 2 (FSAs) and ESPI 5 (Treatment) in a number of services. We have received REDs in May 2018.

The Health Targets are also under threat. We have achieved 100% on our elective discharge target but despite our strong recovery plan, we have struggled to recover our elective WIES target which has financial implications for the organisation.

We continue the following for June 2018 and are working with the MOH to offset some of our good performance against this shortfall:

1. Continuing to providing hips and knees and cataract outputs well in excess of targets. If we provide more than these targets we achieve three objectives (A) better for patients- more are treated (B) increased WIES (C) gives the opportunity to offset in final wash up.
2. Maximising coding opportunities – we are reviewing the coding of elective cases in orthopaedics and general surgery to ensure coding is maximised for complexity and also reconciling that all cases operated on are on the patient management system. This involves data cleansing and matching.
3. Increased outsourcing overall until 30 June 2018.
4. Introducing outsourcing for some smaller cases e.g. therapeutic Botox so that we can increase discharges.
5. Increase through put of small cases to boost discharges.
6. Working with Anaesthesia to pick up extra lists by offering increased additional duty rates up to 30th June 2018 (yet to be picked up by Anaesthetics).
7. Continuing to fill theatre lists and ensuring we manage the start and finish times well.
8. Increasing output levels in the See and Treat unit and other out of theatre facilities that generate WIES or discharge numbers- example is Radio Frequency Ablation (RFA) in procedure rooms.
9. A theatre optimisation group has been established to review theatre processes including acute management, elective processes, and data management to ensure maximum use of resource.
10. Ongoing recruitment of anaesthetists with more expected to commence employment in

the next months.

11. Utilising alternative workforce e.g. Nurse Practitioners and Medical Officer (non- specialist) to contribute to outputs and release medical staff for other activities
12. A 'Lessons Learned' report is being prepared for the ELT.

Cancer Treatment

Faster Cancer Treatment	**Description** 90% 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.	**April (indicative)** Achieved ✓ **100%**

Commentary:

Urology, gynaecology and breast tumour streams are currently experiencing large referral volumes. This is creating capacity concerns for FSA and follow up slots in clinics. Cancer Tracking and Cancer Nurse Coordinators are working closely to ensure 62-day patients are not impacted by this as far as possible. Clear escalation processes are in place and are being followed.

The upcoming increase in acute theatres at MMH this will have a potential impact on availability of theatre for cancer patients. The General Surgical Service manager is negotiating to have FCT 62 day patients treated in acute theatre where possible.

We are aiming to have sustainability action plans completed by end June and a clear plan in place for maintenance and governance of FCT in a business as usual capacity from July onwards. This includes data and reporting / performance monitoring across each tumour stream.

There is a plan in place to develop a cancer steering group to replace some of the smaller more focused cancer working groups. Membership and Terms of Reference have been agreed and this will replace the current FCT governance group from July.

Contingency plans have been developed to minimise risk of patients breaching the FCT Health Target in the event of NZNO nurses strike.

Improved equity in access to timely cancer treatment

An audit of patients entering the Faster Cancer Treatment 62-day pathway over the 12-month period 1 Feb 2015 - 31 Jan 2016 found Maaori and Pacific patients, along with those living in the highest areas of socioeconomic deprivation were significantly less likely to meet the 62-day target than their counterparts. A more recent audit covering the 12 months between 1 November 2016 - 31 October 2017 has found ethnicity and level of deprivation is no longer associated with passing the target. This means that Maaori, Pacific, and those patients living in the most deprived areas are just as likely to meet the 62-day Faster Cancer Treatment Health Target as European/Other patients, and those living in the least deprived areas.

The findings from this recent audit have demonstrated that the efforts to achieve equity through developing standardised pathways for patients and improving care coordination these vulnerable patient groups has been working at CM Health.

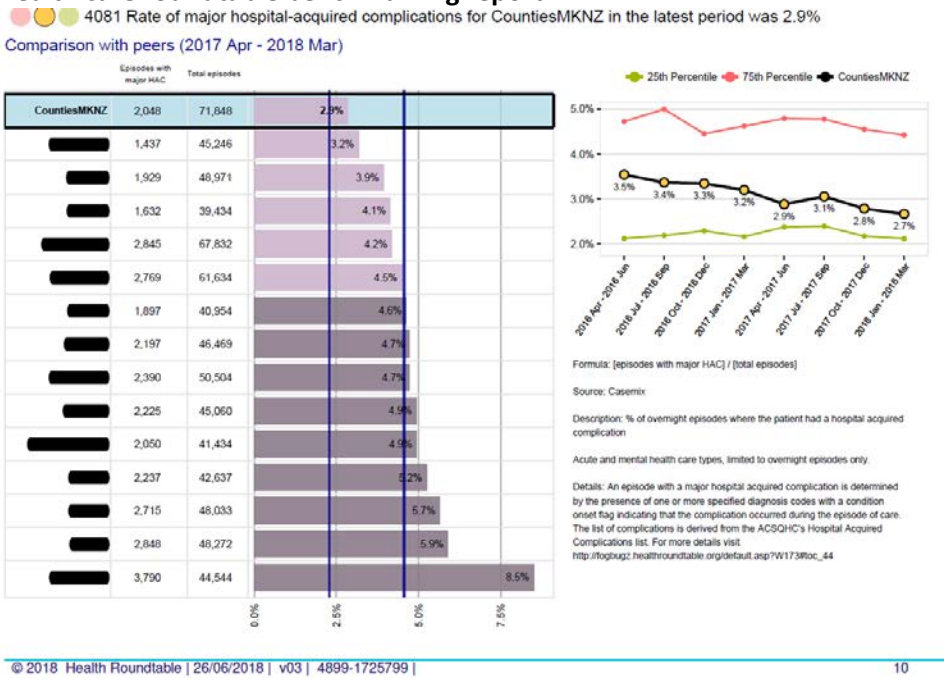
This outcome is significant. It indicates that the sustained focus on reducing disparities in health for more vulnerable groups referred with a high suspicion of cancer has made a tangible difference. The number of tumour streams less likely to meet the target has reduced from 6 in the original audit period to 2 tumour streams as noted.

Improved care coordination has been achieved by raising the profile and awareness of our population based Cancer Nurse Coordinators for Pacifica and Maaori patients ensuring that patients are referred to them early in the pathway and not when problems occur. In addition reporting has been developed that enable visibility of individual patients who identify as Maori and Pacific within 24 hours of them being graded as high suspicion for cancer. This allows for increased engagement in services, and better support for these high needs populations.

Performance data related to patients that go on to receive treatment is broken down by treatment type and ethnicity and is used to measure against the 62 day FCT Health Target and the 31 day priority indicator.

The most recent benchmarking from HRT from April 2017 to March 2018 shown below indicates we have the lowest level of hospital acquired complications across our Australasian benchmark counterparts and that we also have a consistent downward trend.

Health care roundtable benchmarking report



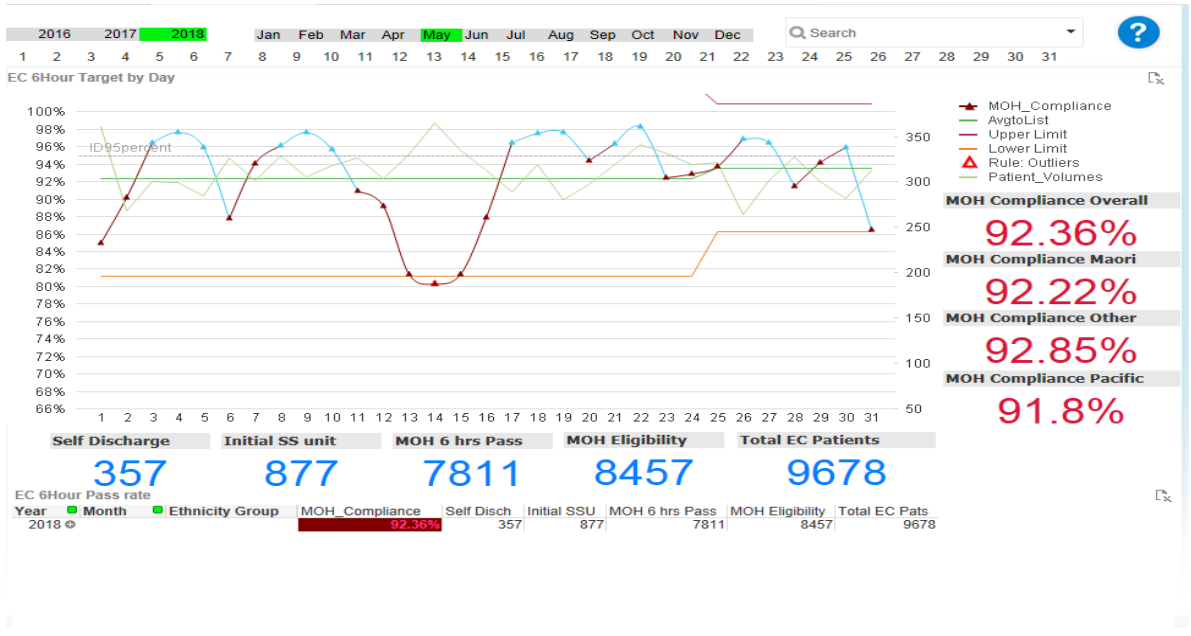
Emergency Department

Shorter Stays in Emergency Departments	**Description**	**April**
	95% of patients will be admitted, discharged, or transferred from an emergency department within six hours	Not Achieved ✖ 92%

Commentary:

Patent volume and bed demand mean the hospital has been unable to reach the six hour target achieving 92% for May against the target of 95%. This is for a variety of factors, high consistent surge presentation rates and consistent high hospital occupancy. Month % against the 6 hour target for April was 91%. Steps we are taking to improve our performance included preparation of a business case to establish additional bed capacity in winter.

The graph below shows daily performance against this target.



Colonoscopy

Colonoscopy Targets	**Description**	**May**
	• 90% urgent (P1) colonoscopies done within 14 days • 70% non-urgent (P2) colonoscopies done within 42 days • 70% of Surveillance colonoscopies done with 84 day	95% ↓ 65% ↑ 74% ↓

*arrows indicate trend compared to last month

Colonoscopy	2017								2018				
Period End	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb	Mar	April	May
P1 – % within 14 days (target 75%)	96%	98%	96%	100%	99%	99%	97%	98%	98%	99%	100%	98%	95%
P1 – % within 30 days (target 100%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
P2 – % within 42 days (target 70%)	58%	63%	59%	63%	70%	71%	77%	91%	65%	64%	68%	65%	65%
P2 – % within 120 days (target 100%)	98%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%
Surveillance – % within 84 days (target 70%)	93%	96%	98%	97%	81%	82%	84%	82%	72%	68%	78%	77%	74%
Surveillance - % within 120 days (target 100%)	99%	99%	100%	100%	100%	100%	100%	99%	94%	99%	100%	100%	97%
CT Colonography - % within 42 days (targt 65%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Gastroscopy

		May
Gastroscopy (CM Health Targets)	• 85% urgent (P1) gastroscopies done within 14 days • 70% non-urgent (P2) gastroscopies done within 42 days • 70% of Surveillance gastroscopies done with 84 days	**95%** ↑ **42%** ↑ **81%** ↓

*arrows indicate trend compared to last month

Gastroscopy	2017								2018				
Period End	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb	Mar	April	May
P1 – % within 14 days (target 75%)	98%	96%	95%	99%	97%	99%	98%	98%	89%	97%	97%	92%	95%
P1 – % within 30 days (target 100%)	99%	100%	93%	100%	100%	100%	100%	100%	98%	100%	98%	100%	100%
P2 – % within 42 days (target 70%)	29%	33%	32%	32%	32%	40%	44%	48%	38%	38%	42%	41%	42%
P2 – % within 120 days (target 100%)	55%	56%	88%	57%	55%	51%	58%	67%	63%	84%	82%	83%	83%
Surveillance – % within 84 days (target 70%)	54%	81%	90%	92%	83%	83%	85%	75%	68%	63%	66%	84%	81%
Surveillance - % within 120 days (target 100%)	75%	89%	93%	97%	95%	96%	93%	89%	80%	64%	64%	94%	100%

Commentary:

MoH targets for P2 and Surveillance colonoscopy and CM Health targets for P2 gastroscopy not met in May. This is due to ongoing issues with lack of capacity and the continued higher than forecast volume growth. The volume growth, though reduced from previous months, was 25% higher for 2018 than 2017.

Mitigation strategies for this include hiring another SMO, due to start in August, to cover for SMO leave. In addition, approval has been given to ensure we can achieve and maintain performance against our colonoscopy and gastroscopy targets and to outsource 560 procedures immediately and then another 500 throughout the 2018/19 year.

Diagnostic Access

The Radiology Service is responsible for Diagnostic Access Targets for CT and MRI Scan wait times.

Objective: sustain diagnostic access to	**Performance**	**Target**
CT – 95% within 42 days	MoH Indicator % (4wk rolling) 3rd June - 90%	Not achieved -5%
CTC – 95% within 42 days	Month of May 92%	Not achieved -3%
MRI – 85% within 42 days	MoH Indicator % (4wk rolling) 3rd June – 34%	Not achieved -51%

		May
CT Scans	CT – 95% scans completed within 6 weeks	**90%**↑
MRI Scans	MRI – 85% scans completed within 6 weeks	**34%**↓

Commentary

CT Scans (community referral):

- We have reinstated the 12-8 shift in an effort to reduce the waiting lists – whilst this keeps pace with demand it does mean that we need to be careful with rostering in order not to overload staff.

MRI Scans (community referral):

- Staffing- casual staff member who was here for 12 months has extended for a further 12. New trainee (quite experienced) probably in the recruitment pipeline, contract offered.
- We continue to advertise overseas for MRI staff; however the requirements of the NZ MRTB make it challenging for us to recruit overseas trained MRI techs to work in NZ.

*arrows indicate trend compared to last month

Other Issues

Industrial Action

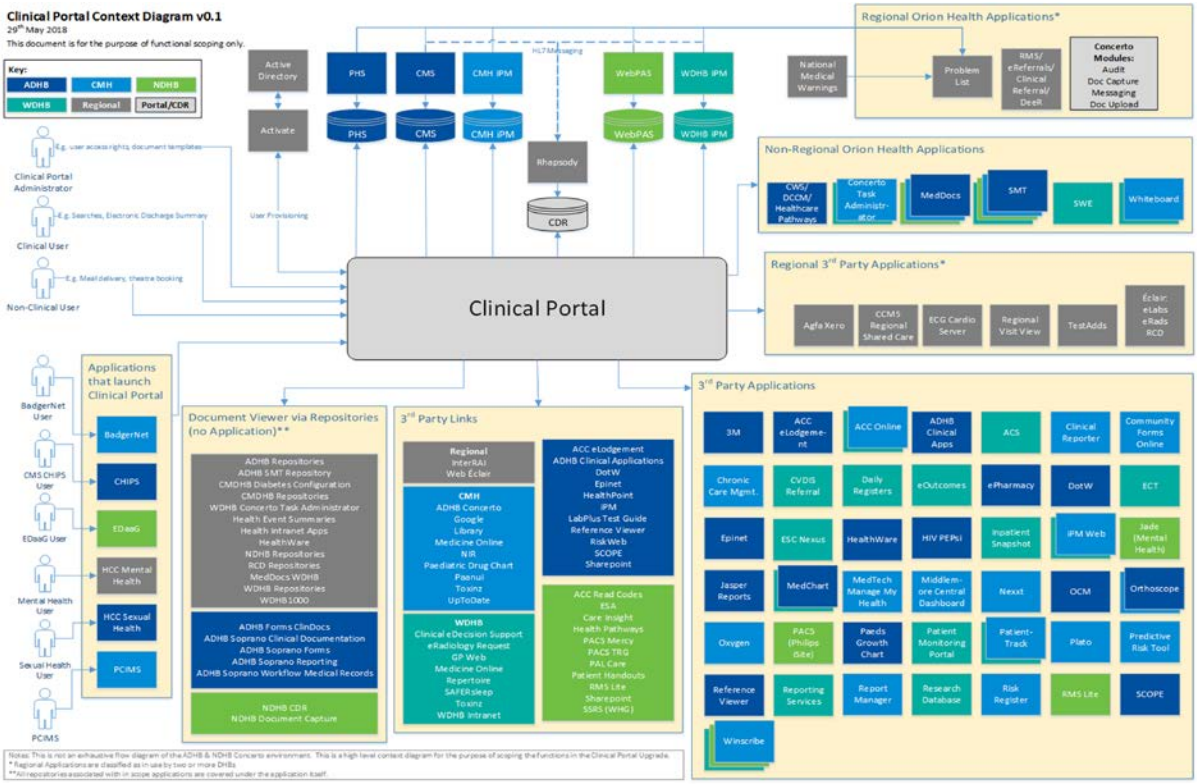
Contingency planning for potential industrial action is well underway working with Service Managers and Clinical Nurse Directors should the industrial action by the NZNO go ahead 5th and 12th July.

Service specific plans have been submitted to the National Coordinator as have plans for Life Preserving Services.

With a 98% membership rate for NZNO, we are taking the stance that all members will strike and basing our plans on that assumption when asking for LPS.

Health Together Technology (HTT) Updates: Technology enabling care

Clinical Portal (CP) was successfully upgraded in May 2018. CP is used by over 2700 clinicians on a daily basis to view all the details concerning their patients contained in the large number of applications we have in place (see diagram below). Consultant Dr Tommy Kee, clinical champion for HTT, says doctors are enjoying the new look and feel of Clinical Portal. Waitemata and CMH share the same portal and can search for patients across both DHBs. Discussions are underway to consider whether we will follow the rest of the country and move to a regional portal.



A new addition to Clinical portal is the Inpatient Snapshot shown below, which saves the house officer around 23 mouse clicks when viewing a patient's clinical information. Wards 34 east and north are currently trialling the use of large screens on computers on wheels (COWs). Clinical teams will have the opportunity to view the Inpatient Snapshot available in Clinical Portal on one large

screen.

This has been a real team effort between clinicians on the ground, the HTT project team, Health Alliance and Orion. Trainers from healthAlliance and the HTT team have spent many hours ensuring staff had assistance and training in using the new system which was key to its success.

ARHOP is the first service at CM Health to have **Clinical Portal, eVitals and ePrescribing** and **Administration** implemented and working together. We now have five ARHOP wards at Middlemore Hospital with all three systems implemented and working together. MedChart will now be implemented to Spinal Unit and Pukekohe to complete all ARHOP services.

ARHOP clinicians are able to view laboratory and radiology reports, any of the eVitals charts, medication and a number of other investigations in one screen.

CM Health joins six other DHBs in introducing MedChart to the clinical setting and is the only DHB with ePharmacy, Pyxis and MedChart – providing an opportunity in the future for a 'closed loop' medications system i.e. electronic recording of all parts of the prescribing, dispensing and administration processes for medications. Benefits include a reduction in medication errors as we now have a clear and easy to read medication chart and prompts for prescribing and dispensing medications. schedule tasks are some of the key benefits that staff have identified as making their lives easier. It is also more efficient as there is no need to rechart the medication required and we have the ability to access the chart when we are away from the ward".

The ARHOP team, Medication Safety Team (lead by Dhairesh Patel, Marie Lewis and Jane Farris) and Healthy Together Technology project team have been working closely on the delivery of the new system over the past 12 months. Marie Lewis has had a particularly long involvement with introducing MedChart to CM Health.

Complex Conditions Improvement Programme:
"Creating a more equitable health journey for our populations"

May 2018

Programme Name: Complex Conditions Programme: Creating a more equitable health journey for our populations. Note: This programme was previously known as "System Level Measures Acute Demand Improvement Programme: Better Management of Chronic Care".

Brief Description

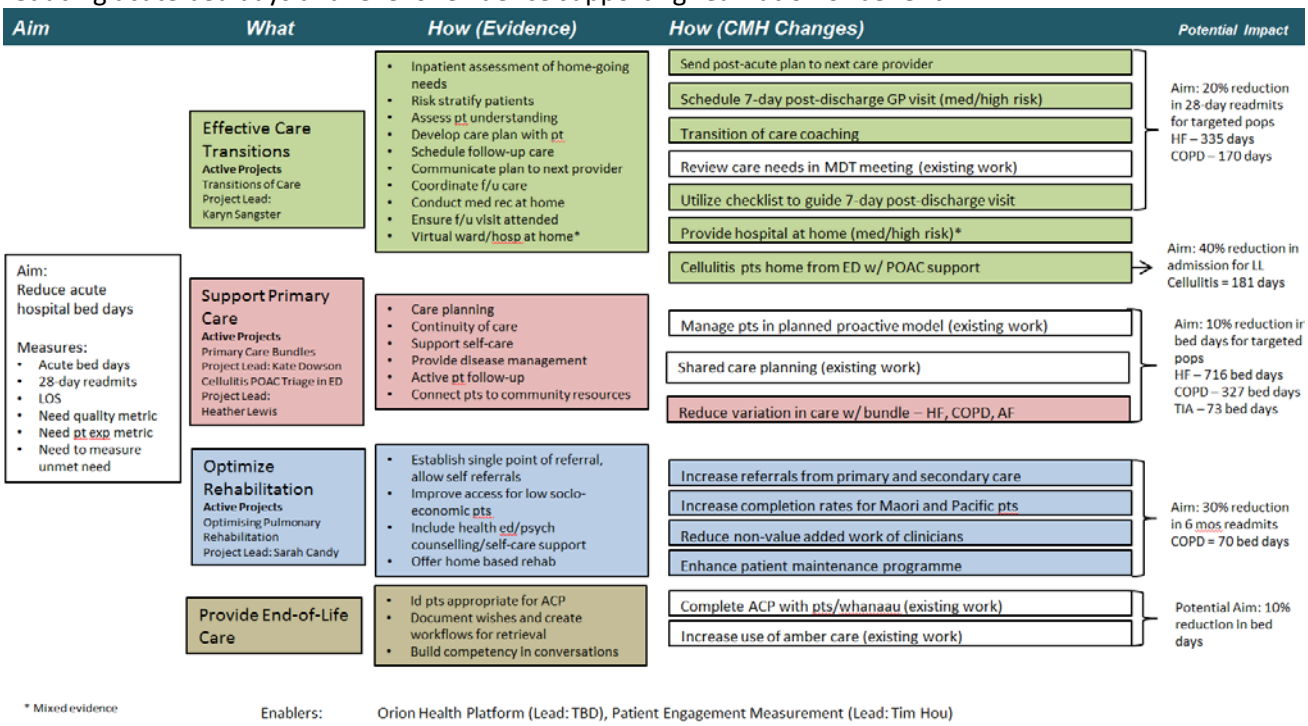
The Complex Conditions Improvement Programme is part of the Auckland metro SLM improvement plan and supports CM Health's Healthy Together strategy to improve health outcomes for our populations.

Together with our PHO partners we are working to reduce the days our patients spend in acute care by improving the delivery of care for patients with COPD, HF, stroke and cellulitis. The changes will improve the value of the care we deliver across the whole of system by reducing hospital activity, improving quality and patient experience.

What's the theory?

This programme aims to contribute to the Auckland DHBs target of a 2% reduction of acute bed days through the improvement of care delivery as prioritied by our cross-continuum clinical leadership. Below is a driver diagram depicting the improvement work to be commissioned through this programme.

The areas of improvement below have been prioritized based upon potential contribution to the aim of reducing acute bed days and level of evidence supporting realization of benefit.



What's the project/programme design?

Overall programme governance and accountability is provided by the Alliance Leadership Team (ALT). An action group comprised of Sponsors, Project Leads of commissioned work, and Ko Awatea Programme Leadership meet fortnightly to review progress, discuss risks, and make decisions to accelerate work.

Ideas for change have been generated by population-specific workgroups with representation from across the continuum of care. They convened from July to December 2017, to conduct diagnostic work and prioritize areas of improvement work. On a monthly basis, the primary and secondary care Clinical Leads for this programme of work come together with Sponsors and other Key Stakeholders to ensure learning and collaboration across projects and populations.

In addition, the *Community and Hospital Management Integration Team* and *Hospital Management Team* meetings serve as forums for shared learning. The Better Management of Chronic Care Improvement Programme progress is presented to these groups on a regular basis for discussion and feedback.

What's the aspirational goal?

This programme of work aims to contribute to the Auckland DHBs target of a 2% reduction of acute bed days through the improvement of care delivery as prioritied by our cross-continuum clinical leadership.

What results will the project achieve over time?

Each project will track reductions in acute bed days, admissions, length of stay, and 28-day readmissions for the population of focus. These measures are currently being tracked on a monthly basis, and are expected to trend toward the goal. In addition, we are actively working to identify measures of quality and patient experience given the "triple aim" nature of this work.

Process measures have been developed for each of the commissioned projects. For example, we aim to measure occurance fo a 7 day follow-up visit with primary care.

Progress To Date:

During the month of May, the following project level activities occurred:

- **Transitions of Care** – A care transitions pathway for patients with complex conditions was validated with a multi-disciplinary team representing hospital, community and primary care. The specific responsibilities of the transitions coordinator were defined. The transitions coordinator will be utilizing a checklist to ensure key post-acute planning tasks are conducted and to ensure patient and whanau understanding of the post-acute plan. A decision support tool has been drafted to guide decision-making about the appropriate level of post-acute support.

- Next steps are to develop the transition coordinator checklist, obtain input and refine the decision support tool, develop a health literacy training plan, and develop measure set to evaluate impact. Plans are to test the pathway with a small set of patients; beginning with HF and COPD.

- **Primary Care Bundles** – Checklists to guide primary care for patients with complex conditions have been drafted. A general checklist for all patients and condition-specific checklists for patients with stroke/TIA, heart failure, and COPD are defined and include input from secondary and primary care clinical leads. Next steps are the define process and outcome measures that align with the bundles. Measurement is dependent on data received via PHOs and so data requests must be negotiated with those entities.

- **ED Triage for Patients with Cellulitis** – The Cellulitis Workgroup has developed an assessment form for use in ED. The form will act as a screening tool to identify which patients with lower limb cellulitis are appropriate for referral to POAC for treatment of their cellulitis in the community rather than admission to hospital. The form will be tested with various clinicians to ensure it is user friendly before being implemented in ED. Work is also underway to understand the current process for cellulitis patients attending ED and to map how the new process including referral to POAC will look. The team plans to begin testing the process with patients in July.

- **Rehab Optimization –** Work continues with a focus on patient referrals and programme completion. Our internal referral practices are currently being reviewed. Updated CM Health pulmonary rehabilitation articles have been accepted and are now live on Auckland regional health pathways. Healthpoint articles are currently being reviewed. A meeting was held with Papakura Marae to understand more about the needs of our Maori population, and to explore any potential new opportunities of working. The planning of a Maori patient focus group has started and is anticipated to be held in July.

- **Measurement** – An outcome dashboard that includes measures of bed day utilization was distributed to clinical leads. It is too early in the improvement work to expect an impact from the changes being made. During the month of May, the Measurement Team began continued investigation into a mortality measure and discussed how best to measure health inequities. Work on process measures continues. In addition, conversations have started with Population Health to determine measurement that may be in place to understand population growth, unmet need, and increasing disease burden within the community.

Other key work that may report into this Programme in the future include Hospital in the Home, Early Supported Discharge for Cellulitis Patients, and Planned Proactive Care.

Counties Manukau District Health Board
Hospital Advisory Committee
Car Park Improvement options and update

Recommendation

It is recommended that the Hospital Advisory Committee:

Receive this paper as informational.

Note that an additional 55 car parks will be created on the main hospital campus to accommodate patient and visitor parking.

Note the paper presents actions developed in consultation with ACC, who currently own the car parking concession, to address the issues associated with public parking capacity and public and staff security.

Note ACC are supportive of changes to improve parking options for visitors and staff and to address security concerns.

Note CM Health have reviewed current security arrangements and to ensure staff safety in attending or leaving work at MMH.

Prepared and submitted by: Phillip Balmer (DHS)

This paper has been through HMT/P&CLT/CGG/ISGG			No
Financial Implications	Yes	Finance have been consulted	Yes
HR Implications	Yes	HR have been consulted	No

Purpose

The purpose of this paper is to:

- note the additional car parks, previously identified, that will be provided on the main hospital campus over the next several months
- inform Hospital Advisory Committee of actions underway, or to be implemented, to improve car parking options and security of staff and public

Executive Summary

A previous ELT paper (May 18) noted the parking constraints and identified a number of options which have been, or are to be implemented, to improve parking at the MMH site with **55 additional car parks** provided. In addition, with the construction underway on both Tiaho Mai and KA2 we have attempted to mitigate the reduction in the number of car parks available to visitors and staff on the main campus as follows:

- To address the loss of car parks for the new AMHU we moved 17 fleet cars across to Western Campus, and moved SMOs to the car park outside the Poutasi Link. Once AMHU is completed in December 2018, a further 10 car parks will be added adjacent to this building.
- The loss of 26 car parks with the KA2 build has been offset with the expanded Creche parking area which once the contractors have moved will add a net increase of 43 additional car parks.
- We also reviewed options on the Western Campus with a parking engineer funded by ACC and added 12 more car parks.

- The option of moving gas and power from Gate 1, will be included as part of the review by BECA looking at Galbraith remediation of critical infrastructure. If they were to be moved this would create an option for expanding an additional 50 parks at the MMH entrance.

More recently, in discussions with ACC, they have agreed that due to a reduction in occupancy rates on the main campus overnight, for staff to use these car parks. This would mean they are parked closer to the main hospital and will be more visible addressing security concerns.

Our security coverage during staff change of shift is also under review. We are considering options for better security camera coverage of hospital road and the wider CM Health campus to enable the development of a final options appraisal for submission and approval.

Background

Due to increasing parking constraints across the main hospital campus, CM Health has hosted a number of meetings with ACC (owners of the car parking concession) to discuss actions to address both capacity and safety issues. As a result ACC and CM Health have agreed to a number of actions that will be implemented to improve public parking, inform staff of available car parks within designated areas and improve safety and accessibility for both public and staff (see appendix A).

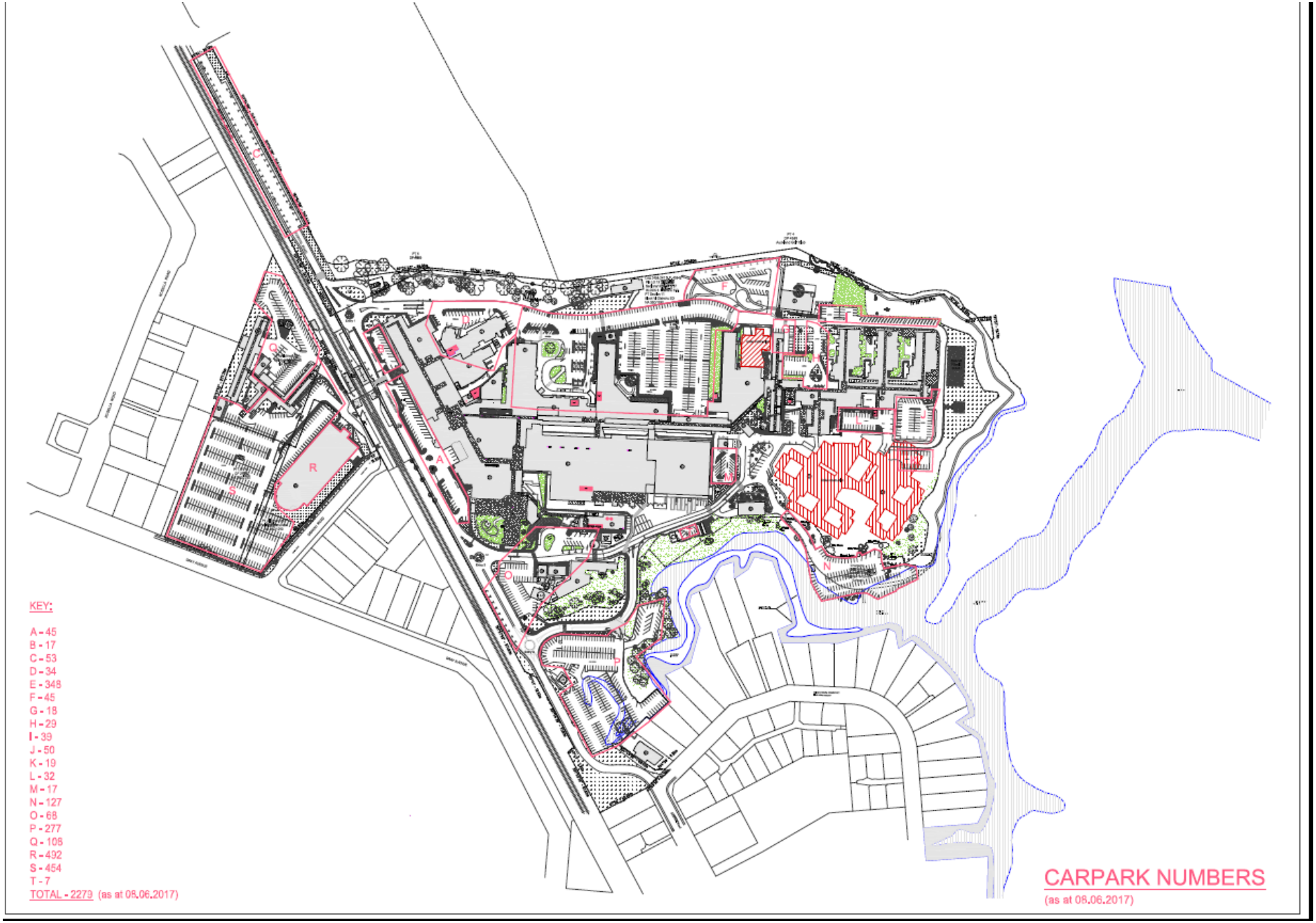
Public parking actions

In addition to the 59 extra car parks to be created, CM Health has identified the following with the intention to improve parking access for patients and visitors:

- An additional 18-20 on grade parks will become available at the north/east end of the campus (adjacent to the helipad), on completion of the AMHU. This is currently being used by contractors.
- We intend to increase the number of mobility car parks on the main campus from 14 to 20.

Appendix A – ACC/CM Health actions to improve car park access and safety (June 2018)

Action	Cost	Owner	Date
1. ACC have agreed to provide access for staff on the main hospital campus between the hours of 8pm and 8am, without penalties. This means they are parked closer to the main hospital and will be more visible addressing security concerns (Car park E).	No	ACC	June 18
2. Review and proposal to install electronic sign boards on the western campus notifying staff of available car parks within the multstorey building.	TBA	ACC	July 18
3. Installation of CCTV's in areas of high risk to provide better security and safety of staff and public with full 24/7 monitoring and signage associated.		CM Health	June 18
4. Implement recommendations from police	No	CM Health	June 18
5. Increase the number of mobility car parks for visitors/patients at the main hospital entrance from 14 to 20 to provide easier access for those requiring mobility parking	TBA	CM Health	June 18
6. Create online information of available car parks across the campus for staff (and in particular for SMO parking).	TBA	ACC/CM Health	September 18
7. Develop and implement a communication campaign on car parking initiatives for both staff and patients including transport plan, designated car parking, infringement actions and changes to car parks.		CM Health	July/August 18
8. Introduce a system whereby staff parked in public car parking spaces after the hours of 8.30am and before 8.00pm will be issued an initial warning letter. Ongoing infringements from recidivists will result in a breach notice.	No	ACC/CM Health	July 18
9. Communication plan organisation wide to inform and encourage safety behaviour: a. Safety awareness of dangers and personal awareness to keep yourself safe; b. Safety culture development to ensure if all staff see something that does not look right within the hospital sites or grounds they report – 'Speak up' campaign expand to include safety. **c.** Video's for induction, specific topics relating to safety – Police happy to help and also Leadership involvement to highlight personal safety, 'walking bus' and other initiatives.			June 18


KEY:
A - 45
B - 17
C - 53
D - 34
E - 348
F - 45
G - 18
H - 29
I - 39
J - 50
K - 19
L - 32
M - 17
N - 127
O - 68
P - 277
Q - 108
R - 492
S - 454
T - 7
TOTAL - 2279 (as at 08.06.2017)
CARPARK NUMBERS
(as at 08.06.2017)

Hospital Services 2017/18

June Workplan Report

Project Delivery Overview

Throughout FY17/18, Hospital Services has been undertaking an ambitious workplan consisting of a number of service-led transformation, improvement, and revenue initiatives aligned with our Healthy Together strategy.

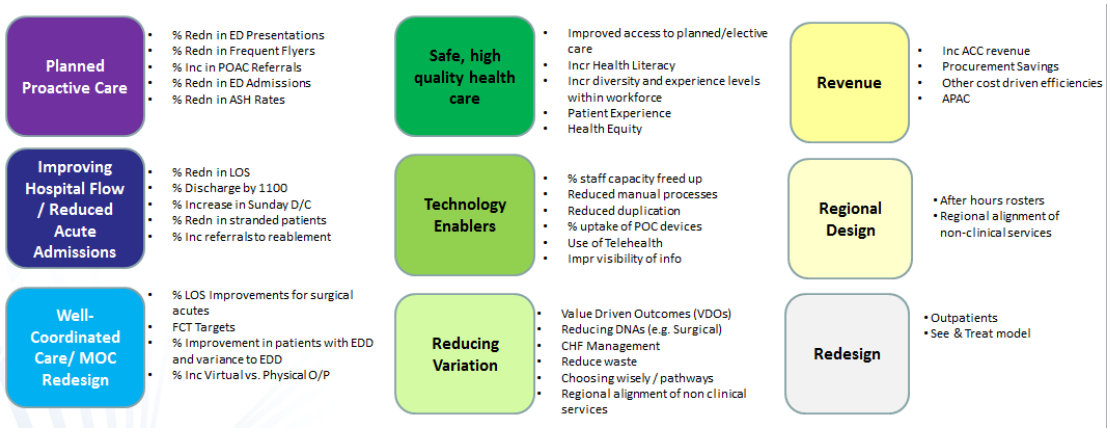
A number of these are building and continuing with projects already underway, while others have been established to drive our strategic goals around improving services for patients, and maintaining financial sustainability.

Each of these initiatives has identified benefits (either financial benefits, non-financial benefits, or both) which are being tracked, and a standardised process whereby all active Hospital Services initiatives are reported on each month by the respective managers is in place.

Plan for FY17/18

Nine key outcome areas have been identified which work will align to; these cover the improvement of System Level Measures (SLMs), as well as providing safe, high quality healthcare, technology enablement to improved systems and processes, regional design for services, and improving revenue.

Figure 1: Key Outcome Areas FY17/18:



Delivery Progress

Across Hospital Services Divisions and related programmes, there are currently 84 total projects being monitored, which range from localised service improvements through to major transformational activities.

There are 11 currently in initiation, which largely relate to new projects which are commencing in line with the Turnaround Plan

In total 44 projects are now in Execution, with 6 progressing through Benefits Realisation.

18 projects have been closed since the last report- this is due to both completion of existing projects, as well as rationalisation of projects to join them together with complementary activities within the portfolio in preparation for delivery of the Turnaround Plan.

Figure 2: Breakdown of project delivery by Division, June '18:

Project Divisions:	1. Initiation	2. Planning	3. Execution	4. Close Out	5. Operations & Benefits Realisation	On Hold	Grand Total
ARHOP		1	4	1			6
Central Clinical Services	2		4		1		7
Facilities & Asset Management		2	3				5
Healthy Together Technology	2	1	4	4		1	12
Medicine and Emergency Care	3	2	4	1	1	1	12
Mental Health		5	8			2	15
Middlemore Central			2				2
Surgical, Anaesthesia, and Perioperative Care	4	2	14		4		24
Women's Health			1				1
Grand Total	11	13	44	6	6	4	84

Figure 3: Project Portfolio Movements by Phase

	Number of initiatives in phase							
Delivery Phase	**Aug '17**	**Sep '17**	**Dec '17**	**Feb '18**	**Apr '18**	**May '18**	**June '18**	**Shift since last report**
1. Initiation	31	24	22	13	10	14	11	-3
2. Planning	26	30	32	27	23	19	13	-6
3. Execution	47	49	43	55	47	50	44	-6
4. Close Out	11	7	11	7	4	3	6	3
5. Operations	4	9	11	7	10	5	6	1
On Hold	14	11	11	17	17	11	4	-7

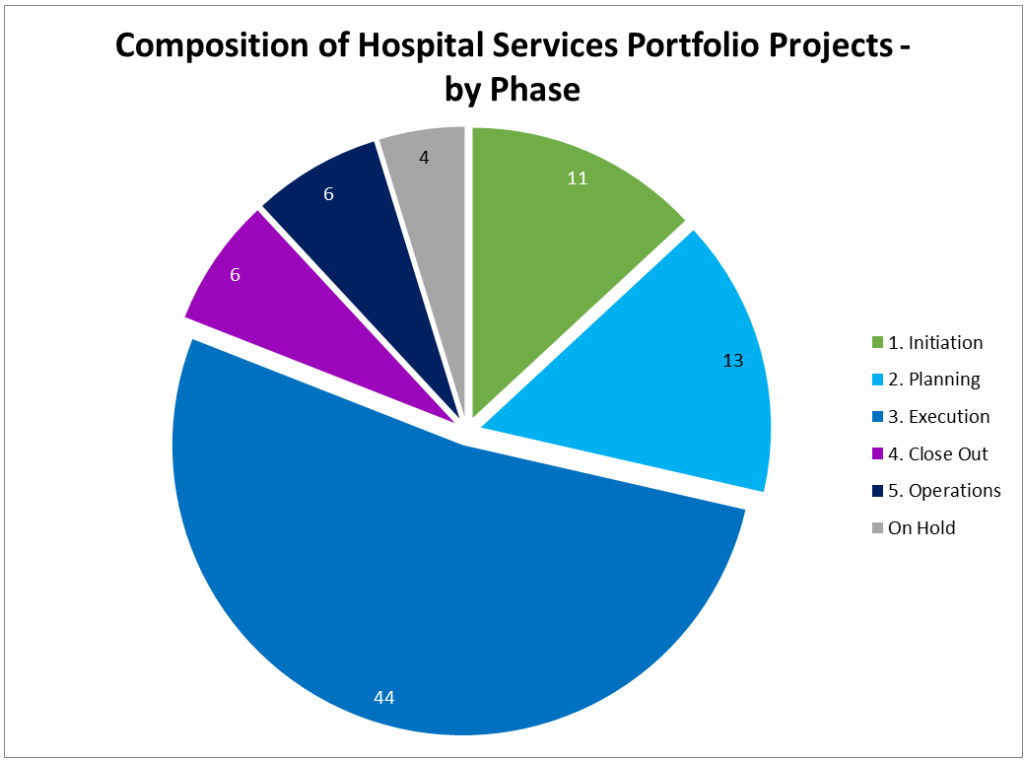
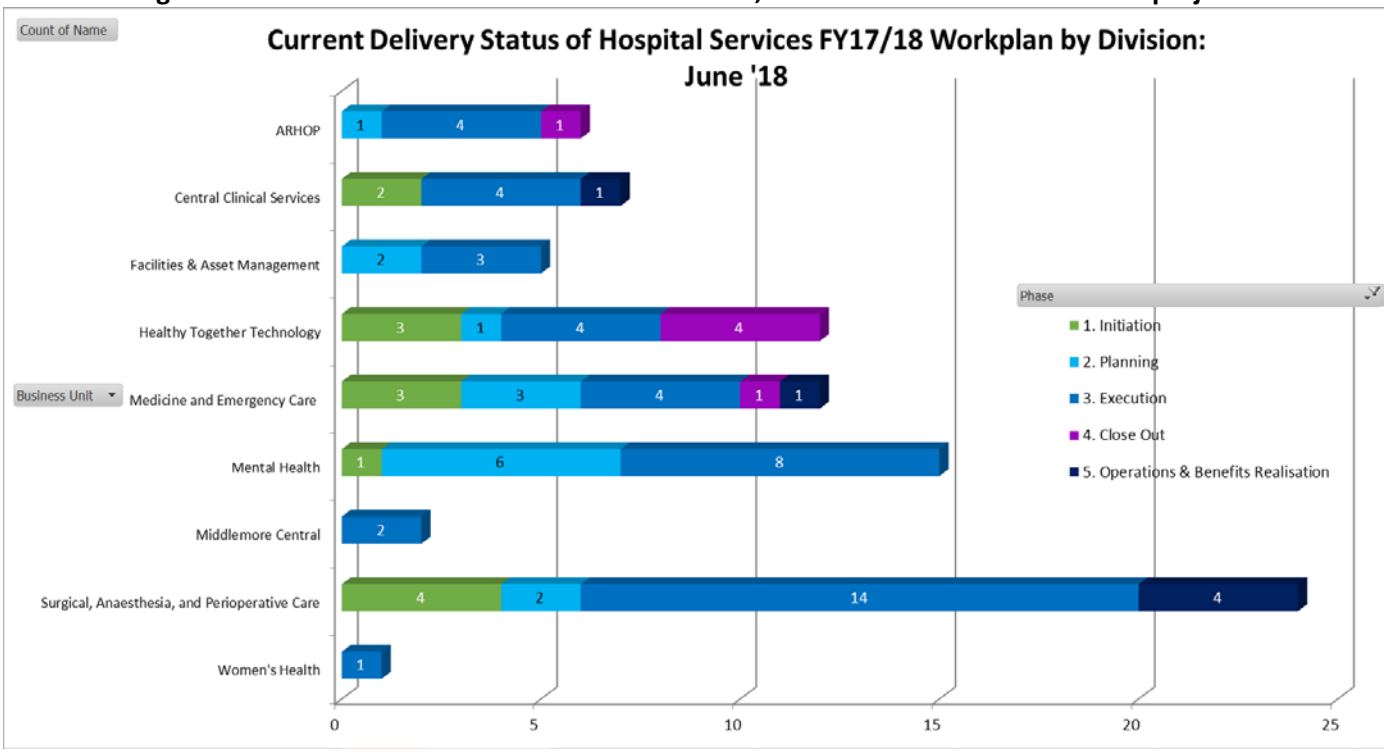


Figure 4: Number of initiatives within each division, and the current status of these projects:



Benefits Realisation

The full year financial benefit target for CMH is **$30.37M** across all areas of the organisation.

In total, **$17.67M** of this target is directly attributable from Hospital Services initiatives (excluding cross-directorate & whole of system benefits)

Overall CMH FY17/18 Financial Benefit Targets:

Division / Directorate delivering saving:	Budgeted Full Year Target ($M)
ARHOP	$1.004
Central Clinical Services	$0.110
Corporate	$4.022
Emergency, Medicine, Integration	$0.869
Facilities Management	$2.170
Funder Governance Integrated Care	$3.133
Governance	$2.268
Hospital Services	$0.986
Human Resources	$0.197
Kidz First	$0.547
Ko Awatea	$2.100
Mental Health and Addictions	$0.890
Middlemore Central	$0.238
Non-Clinical	$6.100
Surgery, Anaesthetic and Perioperative Services	$3.986
Whole of System	$0.970
Women's Health	$0.777
Grand Total	**$30.367**

Monthly tracking and reporting is in place across all of these initiatives, with regular reporting to ELT now in place identifying any issues around benefit realisation, and how these are being mitigated

Of the **$17.677M** of benefits being delivered directly through Hospital Service initiatives, a performance breakdown is presented below.

Figure 5: Hospital Services Benefits Delivery at end of May '18 (Month Eleven / Q4)

Division	Budgeted Target FY17/18 ($K)	Current Forecast FY17/18 ($K)	Variance Full Year ($K)	YTD Target ($K)	YTD Actual ($K)	Variance YTD ($K)	% of Target Delivered YTD
ARHOP	1,004	1,305	301	920	1,424	504	155%
Central Clinical Services	110	688	578	101	678	578	673%
Emergency, Medicine, Integration	869	0	-869	797	0	-797	0%
Facilities Management	2,170	580	-1,590	1,741	545	-1,196	31%
Hospital Services	986	0	-986	821	0	-821	0%
Kidz First	547	547	0	501	501	0	100%
Mental Health and Addictions	890	858	-32	816	858	42	105%
Middlemore Central	238	0	-238	218	0	-218	0%
Non-Clinical	6,100	5,159	-941	5,592	5,065	-527	91%
Surgery, Anaesthetic and Perioperative Services	3,986	3,986	0	3,654	3,099	-555	85%
Women's Health	777	777	0	712	712	0	100%
Grand Total	17,677	13,900	-3,777	15,872	12,883	-2,990	81%

Across the whole Hospital Services directorate, **81%** of the YTD target benefit for the eleven months of the FY has been delivered, tracking close to target.

Benefits exceeding target for ACC (within 'Non-Clinical') and ARHOP savings have contributed to delivering a favourable variance to target, and Central Clinical Services have been able to deliver additional benefits not originally budgeted.

However, the full year forecast for all benefits is reviewed monthly, which has currently identified an overall unfavourable variance of **$2.99M** across all Divisions. This is primarily due to demand driven pressures eroding planned benefits in some areas.

Overall, the CMH organisational benefits plan is tracking at **$16.98 YTD** Actual Benefit vs. **$27.43 YTD** Budgeted target, an unfavourable variance of **$10.48M**

Mitigations are in place across all intiatives to ensure that benefits are delivered as per plan, and where this is not possible, alternative benefit avenues are considered.

Additionally, a pipeline of savings opportunities is being developed via the Turnaround Plan, to provide a longer term picture of where benefits can be delivered.

HOSPITAL SERVICES BALANCED SCORECARD — May 2018

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

		Trend by month				Year to date		
		FY1617-1718	May-18	Target	Var	Actual	Target	Var
National Targets	Emergency Department - 6 hour Length of Stay target		**92%**	95%	-3%	**90%**	95%	-5%
	FCT % of high suspicion first cancer treatment within 62 days (indicative result)		**100%**	90%	10%	**95%**	90%	5%
	Elective surgery discharges		**1,622**	1,414	14.7%	**13,353**	14,153	-5.7%
		Trend by month				Year to date		
		FY1617-1718	May-18	Target	Var	Actual	Target	Var
Ensuring Financial Sustainability	Total Caseweight		**7,260**	7,743	-6.2%	**80,291**	80,840	-0.7%
	Acute Caseweight		**5,516**	6,078	-9.2%	**64,486**	64,172	0.5%
	Elective Caseweight		**1,744**	1,665	4.7%	**15,805**	16,669	-5.2%
	Total Discharges - performace compared to prior year.		**8,805**	9,287	-5.2%	**95,055**	95,361	-0.3%
	Outpatient First Specialist Assessment Volumes		**4,436**	4,714	-5.9%	**44,462**	49,233	-9.7%
	Outpatient Follow Up Volumes		**11,284**	11,048	2.1%	**111,977**	116,964	-4.3%
	Virtual First Specialist Assessments (GP consult and nonpatient appointments)		**482**	391	23.3%	**5,663**	3,961	43.0%
	Budgeted FTEs		**6,370**	6,280	-1%	**6,289**	6,260	0%
	Operating Costs ($000)		**$75,932**	$75,184	-1%	**$806,215**	$804,615	0%
	Personnel Costs ($000)		**$54,348**	$53,565	-1%	**$571,082**	$568,454	0%
	Financial Result Total ($000)		**-$4,619**	-$4,378	-6%	**-$20,457**	-$21,933	7%
	Reduce clinical outsourcing ($000)		**$2,581**	$2,240	-15%	**$26,315**	$25,179	-5%
		Trend by month				Average last 12 months		
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var
Enabling High Performing People	Excess Annual Leave dollars ($000) - estimated cost for excess		**$4,042**	$1,239	-$2,803	**$3,851**	$1,195	-$2,656
	Adult Rehabilitation and Health of Older People		**$87**	$82	-$5	**$74**	$79	$5
	Medicine, Acute Care and Clinical Support		**$510**	$268	-$242	**$441**	$259	-$182
	Surgical and Ambulatory Care		**$1,586**	$518	-$1,068	**$1,509**	$490	-$1,019
	Mental Health		**$376**	$192	-$184	**$350**	$192	-$158
	Women's Health and Kidz First		**$657**	$179	-$478	**$651**	$175	-$476
	% Staff Annual Leave >2 years		**12.1%**	5.0%	-7.1%	**11.7%**	5.0%	-6.7%
	Adult Rehabilitation and Health of Older People		**5.3%**	5.0%	-0.3%	**4.7%**	5.0%	0.3%
	Medicine, Acute Care and Clinical Support		**9.5%**	5.0%	-4.5%	**8.5%**	5.0%	-3.5%
	Surgical and Ambulatory Care		**15.3%**	5.0%	-10.3%	**15.4%**	5.0%	-10.4%
	Mental Health		**9.8%**	5.0%	-4.8%	**9.1%**	5.0%	-4.1%
	Women's Health and Kidz First		**18.4%**	5.0%	-13.4%	**18.6%**	5.0%	-13.6%

		Trend by month				Average last 12 months		
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var
Enabling High Performing People (cont.)	% Staff Turnover (YTD no. voluntary turnovers by average headcount)		**7.6%**	10.0%	2.4%	**8.7%**	10.0%	1.3%
	% Sick Leave		**2.9%**	2.8%	-0.1%	**3.0%**	2.8%	-0.2%
	Workplace Injury per 1,000,000 hours		**2.7**	10.5	7.8	**13.4**	10.5	-2.9
	Workforce Diversity					Month to date		
			May-18	Target	Var	May-17	Target	Var
			Workforce	*Population*		*Workforce*	*Population*	
	Maaori		**7%**	16%	-10%	**7%**	16%	-10%
	Pacific		**13%**	23%	-10%	**13%**	23%	-10%
	Asian		**33%**	23%	10%	**30%**	23%	7%
	NZ European / non-specified/ other		**46%**	38%	9%	**49%**	38%	12%

		Trend by month				Year to date		
		FY1617-1718	May-18	Target	Var	Actual	Target	Var
First, Do No Harm (Safety)	% e-medication reconciliation - high risk patients within 48hrs		**79%**	80%	-1%	**78%**	80%	-2%
	% Serious Pressure Injuries rate / 100 Patients (Apr-18)		**0.0%**	3.5%	3.5%	**0.2%**	3.5%	3.3%
	Falls causing major harm rate / 1,000 bed days		**0.04**	0.00	0.04	**0.05**	0.00	-0.05
	Adverse Events: % of admissions affected by ≥4 triggers (Mar-18)		**1.1%**	N/A	N/A	**1.2%**	N/A	N/A
	Central Line Associated Bacteraemia (CLAB) rate / 1,000 bed days in ICU		**0.00**	0.00	0.00	**3.90**	0.00	-3.90
	Rate of S. aureus bacteraemia rate / 1,000 bed days		**0.07**	0.00	-0.07	**0.06**	0.00	-0.06
			Quarterly reporting			Year		
			Q3 FY1718	Target	Var	Actual	Target	Var
	% 75+ years assessed for the risk of falling #		**94%**	90%	4%	N/A	N/A	N/A
	% 75+ years assessed for falls risk with falls intervention plans #		**100%**	N/A	N/A	N/A	N/A	N/A

		Trend by month				Year to date		
		FY1617-1718	May-18	Target	Var	Actual	Target	Var
Timely	% Magnetic Resonance Image (MRI) scans completed within 6 weeks from referral		**34%**	85%	-51%	**44%**	85%	-41%
	% Computerised Tomography (CT) scans completed within 6 weeks from referral		**90%**	95%	-5%	**90%**	95%	-5%
	% urgent diagnostic colonoscopy within 14 days		**95%**	85%	10%	**98%**	85%	13%
	% diagnostic colonoscopy patients within 42 days		**65%**	70%	-5%	**69%**	70%	-1%
	% surveillance colonoscopy patients within 84 days		**74%**	70%	4%	**81%**	70%	11%
	% cardiac STEMI-PCI (angiography) <120mins - Northern Region		**94%**	80%	14%	**81%**	80%	1%
	% Coronary Angiography within 90days (1mth arrears)		**95%**	95%	0%	**93%**	95%	-2%
	ESPI 2: No. patients waiting >120 days for FSA - Elective Δ		**31**	0	-31	**31**	0	-31
	ESPI 5: No. patients waiting >120 days treatment - Elective Δ		**82**	0	-82	**82**	0	-82
	Radiology - Inpatient radiology completion times <24hrs		**88%**	95%	-7%	**89%**	95%	-6%
	Radiology- Emergency Care radiology completion times <2 hrs		**90%**	95%	-5%	**92%**	95%	-3%
	FCT - % confirmed diagnosis first cancer treatment within 31 days		**97%**	85%	12%	**94%**	85%	9%
	% Radiology results reported within 24 hours		**50%**	75%	-25%	**50%**	75%	-25%

		Trend by month				Year to date		
		FY1617-1718	May-18	Target	Var	Actual	Target	Var
System Integration (Effective)	Average Length of Stay - Acute Inpatient		**2.9**	3.0	0.1	**2.8**	3.0	0.1
	Average Length of Stay - Acute Arranged/ Elective		**1.6**	1.4	-0.2	**1.7**	1.4	-0.3
	Middlemore Hospital % patients to discharge lounge or home by 1100hrs		**17%**	30%	-13%	**18%**	30%	-12%
	Acute Readmissions within 7 days - Total		**3.2%**	2.5%	-0.8%	**2.6%**	2.6%	0.0%
	Acute Readmissions within 28 days - Total (1 month in arrear)		**6.7%**	6.8%	0.1%	**6.7%**	6.9%	0.2%
	Acute Readmissions within 28 days - 75+ years (1 month in arrear)		**10%**	13%	3.2%	**10%**	12%	1.7%
	Emergency Department Presentations - 75+ year olds		**1,041**	807	-234	11,413	8,877	-2536
	% clinical summaries (meddocs) authorised <7 days of creation		**65%**	95%	-30%	**66%**	95%	-29%
	% of patient outliers - not on home ward <5%		**4.2%**	5.0%	0.8%	**5.6%**	5.0%	-0.6%
			Quarterly Reporting			**Year to date**		
	% DHB Mental Health Services - children/ youth (0-19years) seen by 3 weeks for non-urgent		**70%**	80%	-10%	N/A	N/A	N/A
	Mental Health access rate - clients seen in last 12 months as % of population (0-19yrs)		**4.1%**	3.2%	1.0%	N/A	N/A	N/A
	Mental Health access rate - clients seen in last 12 months as % of population (20-64yrs)		**3.9%**	3.2%	0.7%	N/A	N/A	N/A
	Mental Health access rate - clients seen in last 12 months as % of population (65+yrs)		**2.3%**	2.6%	-0.3%	N/A	N/A	N/A
		Trend by month				Year to date		
		FY1617-1718	May-18	Target	Var	Actual	Target	Var
Efficient	Outpatient - First Specialist : Follow-up Clinic ratio		**39%**	43%	4%	**40%**	42%	2%
	Outpatient - Did Not Attend rates - Maaori		**20%**	10%	-10%	**19%**	10%	-9%
	Outpatient - Did Not Attend rates - Pacific		**18%**	10%	-8%	**18%**	10%	-8%
	Theatre List Utilisation		**90%**	83%	7%	**92%**	83%	8%
	Day of Surgery Admissions (DOSA)		**N/A**	90%	-	**90%**	90%	0%
	Day Case Rate (Elective/ Arranged)		**N/A**	65%	-	**66%**	65%	1%
	% Medical Assessment patients with Length of Stay < 28 hours		**83%**	65%	18%	**81%**	65%	16%
	No. Hospital bed days occupied (against forecast open beds)		**19,852**	20,845	5.0%	**206,288**	216,603	5.0%
	No. Length of Stay outliers (LOS >10 days)*		**145**	152	5%	**1,604**	1,560	-3%
		Trend by month				Year to date		
		FY1617-1718	May-18	Target	Var	Actual	Target	Var
Equity	% smokers receive smokefree advice / support -Total		**95%**	95%	0%	**96%**	95%	1%
	% smokers receive smokefree advice / support - Maaori		**95%**	95%	0%	**96%**	95%	1%
	% smokers receive smokefree advice / support - Pacific		**94%**	95%	-1%	**96%**	95%	1%
	% smokers receive smokefree advice / support - Asian		**90%**	95%	-5%	**95%**	95%	0%
			Volumes Screened			**% Screened in last 24 months**		
	% Women (45-60yrs) with Breastscreen in 24months - Total		**2287**	2400	-113	**71%**	70%	1%
	% Women (45-60yrs) with Breastscreen in 24months - Maaori		**331**	289	42	**65%**	70%	-5%
	% Women (45-60yrs) with Breastscreen in 24months - Pacific		**552**	377	175	**83%**	70%	13%
		Trend by month				Year to date		
		FY1617-1718	May-18	Target	Var	Actual	Target	Var
P&WCC	Patient experience Survey data very good/excellent - month (n=243) and YTD (n=3045)		**81%**	90%	-9%	**80%**	90%	-10%

Financial Results – CMDHB Provider Arm: May 2018*

Glossary

ACC	Accident Compensation Corporation
ED	Emergency Department
FSA	First Specialist Assessment
FTE	Full Time Equivalent
FU	Follow Up Appointment
LTIP	Long Term Investment Plan
MoH	Ministry of Health
WIES	Weighted Inlier Equivalent Separation (activity based measurement)
YTD	Year to Date

Consolidated Statement of Financial Performance CMDHB Provider	Month				Year to Date			Full Year		
	Actual $(000)	Budget $(000)	Variance $(000)	Variance Prior	Actual $(000)	Budget $(000)	Variance $(000)	Forecast $(000)	Budget $(000)	Variance $(000)
Income										
Government Revenue	72,818	73,400	(582) U	↓	814,459	811,079	3,380 F	889,057	884,559	4,499 F
Patient/Consumer Sourced	968	988	(20) U	↓	13,357	10,847	2,510 F	14,414	11,846	2,568 F
Other Income	2,988	2,100	888 F	↑	22,812	23,255	(443) U	25,085	25,548	(464) U
Funder Payments	-	-	0 F	⇔	-	-	0 F	-	-	0 F
Total Income	**76,775**	**76,488**	**287 F**	↑	**850,628**	**845,181**	**5,447 F**	**928,555**	**921,953**	**6,602 F**
Expenditure										
Personnel	52,785	52,630	(155) U	↓	553,823	558,205	4,382 F	604,941	609,227	4,286 F
Outsourced Personnel	1,563	934	(629) U	↑	17,258	10,248	(7,010) U	18,525	11,174	(7,351) U
Outsourced Clinical	2,581	2,240	(342) U	↓	26,315	25,179	(1,136) U	28,935	27,352	(1,584) U
Outsourced Other	2,616	3,254	638 F	↑	34,990	35,794	803 F	38,998	39,048	50 F
Clinical Supplies (excluding Depreciation)	10,114	10,006	(107) U	↓	109,487	107,458	(2,028) U	119,573	117,412	(2,161) U
Other Expenses	6,273	6,119	(154) U	↓	64,342	67,730	3,388 F	71,242	73,864	2,623 F
Total Operating Expenditure	**75,932**	**75,184**	**(749) U**	↓	**806,215**	**804,615**	**(1,600) U**	**882,214**	**878,076**	**(4,137) U**
Total Operating Surplus/(Deficit)	**842**	**1,304**	**(462) U**	↓	**44,414**	**40,567**	**3,847 F**	**46,342**	**43,877**	**2,465 F**
Depreciation	2,724	2,661	(63) U	↓	30,179	29,271	(908) U	32,670	31,932	(738) U
Interest	-	27	27 F	⇔	7	295	288 F	53	322	269 F
Capital Charge	2,737	2,994	257 F	↑	34,685	32,934	(1,751) U	37,421	35,928	(1,493) U
Total Depreciation, Interest and Capital	**5,461**	**5,682**	**221 F**	↑	**64,870**	**62,500**	**(2,370) U**	**70,144**	**68,182**	**(1,962) U**
Net Surplus/(Deficit)	**(4,619)**	**(4,379)**	**(240) U**	↑	**(20,456)**	**(21,933)**	**1,477 F**	**(23,801)**	**(24,305)**	**504 F**

Personnel Costs By Professional Group	Month				Year to Date			Full Year		
	Actual $(000)	Budget $(000)	Variance $(000)	Variance Prior	Actual $(000)	Budget $(000)	Variance $(000)	Forecast $(000)	Budget $(000)	Variance $(000)
Medical Personnel	17,588	17,141	(447) U	↓	177,122	181,038	3,916 F	190,726	197,785	7,058 F
Nursing Personnel	19,920	19,782	(137) U	↑	217,200	211,245	(5,955) U	238,476	230,547	(7,928) U
Allied Health Personnel	7,198	7,236	38 F	↓	75,025	77,072	2,047 F	81,845	84,056	2,211 F
Support Personnel	2,354	2,552	198 F	↑	25,331	26,389	1,057 F	27,749	28,776	1,026 F
Management/Administration Personnel	5,726	5,920	194 F	↓	59,145	62,461	3,316 F	66,145	68,063	1,918 F
Total (before Outsourced Personnel)	**52,785**	**52,630**	**(155) U**	↓	**553,823**	**558,205**	**4,382 F**	**604,941**	**609,227**	**4,286 F**
Outsourced Medical	974	471	(502) U	↓	9,317	5,155	(4,162) U	10,065	5,618	(4,447) U
Outsourced Nursing	119	52	(68) U	↑	2,573	571	(2,003) U	2,650	623	(2,028) U
Outsourced Allied Health	44	2	(42) U	↓	309	18	(290) U	320	20	(300) U
Outsourced Support	19	0	(19) U	↓	327	3	(323) U	327	4	(323) U
Outsourced Management/Admin	407	409	2 F	↑	4,732	4,501	(231) U	5,162	4,910	(252) U
Total Outsourced Personnel	**1,563**	**934**	**(629) U**	↑	**17,258**	**10,248**	**(7,010) U**	**18,525**	**11,174**	**(7,351) U**
Total Personnel	**54,348**	**53,565**	**(784) U**	↓	**571,082**	**568,454**	**(2,628) U**	**623,466**	**620,401**	**(3,065) U**

Surplus / (Deficit) by Division	Month				Year to Date			Full Year		
	Actual $(000)	Budget $(000)	Variance $(000)	Variance Prior	Actual $(000)	Budget $(000)	Variance $(000)	Forecast $(000)	Budget $(000)	Variance $(000)
Central Clinical Services	(7,127)	(7,701)	574 F	↑	(80,270)	(82,188)	1,917 F	(87,344)	(89,461)	2,117 F
Emergency Medicine and Integration	(14,109)	(14,143)	34 F	↑	(153,771)	(151,797)	(1,974) U	(167,926)	(165,188)	(2,738) U
Middlemore Central	(2,455)	(2,647)	192 F	↑	(27,049)	(27,598)	549 F	(29,534)	(30,061)	527 F
ARHOP	(3,681)	(3,587)	(94) U	↓	(38,825)	(38,911)	86 F	(42,489)	(42,489)	0 F
Mental Health	(6,059)	(5,928)	(131) U	↓	(65,370)	(65,414)	44 F	(71,441)	(71,441)	0 F
Surgical & Ambulatory	(16,890)	(16,666)	(224) U	↓	(169,340)	(170,792)	1,452 F	(186,735)	(187,635)	900 F
Women & Child Health	(6,135)	(6,331)	197 F	↑	(65,739)	(66,577)	837 F	(71,948)	(72,481)	533 F
Facilities Services	(2,172)	(1,830)	(342) U	↓	(21,372)	(19,732)	(1,640) U	(23,380)	(21,540)	(1,840) U
Provider Management	59,107	59,552	(445) U	↑	654,072	656,205	(2,133) U	714,932	716,071	(1,139) U
Innovations Hub & Ko Awatea	(1,200)	(1,366)	166 F	↑	(12,380)	(14,122)	1,742 F	(13,852)	(15,347)	1,496 F
Integrated Care	(3,898)	(3,731)	(167) U	↓	(40,411)	(41,006)	596 F	(44,084)	(44,733)	649 F
Net Surplus/(Deficit)	**(4,619)**	**(4,379)**	**(240) U**	↑	**(20,456)**	**(21,933)**	**1,477 F**	**(23,801)**	**(24,305)**	**504 F**

***Due to rounding, numbers presented throughout this document may not add up precisely to the totals provided.**

Contract Performance	Month				Year to Date			
	Actual Volume	Contract Volume	Variance Volume	Variance %	Actual Volume	Contract Volume	Variance Volume	Variance %
M00001 - General Medicine Inpatients	1,414	1,338	75 F	5.6%	15,894	15,199	694 F	4.6%
S00001 - General Surgery Inpatients	774	845	(71) U	-8.4%	9,141	8,277	864 F	10.4%
S45001 - Orthopaedic Inpatients	608	788	(179) U	-22.7%	7,383	7,716	(333) U	-4.3%
W10001 - Maternity Inpatients	420	640	(220) U	-34.3%	5,722	6,397	(675) U	-10.5%
S60001 - Plastic & Burns - Inpatients	431	543	(112) U	-20.6%	4,996	5,324	(327) U	-6.1%
M05001 - Emergency Medical Services Inpatients	417	396	21 F	5.2%	4,291	4,257	34 F	0.8%
M55001 - Paediatric Medicine Inpatients	202	247	(45) U	-18.1%	2,607	2,990	(384) U	-12.8%
W06003 - Secondary Neonatal	333	293	40 F	13.7%	3,383	3,170	214 F	6.7%
All Others	916	988	(72) U	-7.3%	11,070	10,842	228 F	2.1%
Total Acute WIES	**5,516**	**6,078**	**(562) U**	-9.2%	**64,486**	**64,172**	**314 F**	0.5%
S45001 - Orthopaedic Inpatients	534	453	81 F	17.9%	4,574	4,529	45 F	1.0%
S00001 - General Surgery Inpatients	399	408	(9) U	-2.1%	3,784	4,078	(294) U	-7.2%
S60001 - Plastic & Burns - Inpatients	265	244	21 F	8.5%	2,297	2,443	(146) U	-6.0%
S30001 - Gynaecology Inpatients	104	148	(43) U	-29.3%	1,173	1,424	(251) U	-17.6%
S25001 - ORL Inpatients	122	134	(12) U	-9.0%	1,109	1,336	(227) U	-17.0%
S40001 - Ophthalmology Inpatients	134	131	2 F	0.0%	1,076	1,311	(235) U	0.0%
M10001 - Cardiology - Inpatients	45	48	(3) U	-5.9%	436	532	(95) U	-17.9%
S70001 - Urology - Inpatients	26	42	(16) U	-37.1%	317	419	(103) U	-24.5%
All Others	115	58	57 F	99.9%	1,039	596	443 F	74.3%
Total Elective WIES	**1,744**	**1,665**	**79 F**	4.8%	**15,805**	**16,669**	**(863) U**	-5.2%
Total WIES	**7,260**	**7,743**	**(483) U**	**-6.2%**	**80,291**	**80,840**	**(549) U**	**-0.7%**
Total IDF WIES	**861**	**945**	**(85) U**	**-8.9%**	**8,753**	**9,620**	**(867) U**	**-9.0%**

Prior Period Comparisons	Month				Year to Date			
	This Year	Last Year	Variance	Variance %	This Year	Last Year	Variance	Variance %
Acute Discharges	7,080	7,640	(560) U	-7.9%	79,699	79,586	113 F	0.1%
Elective Discharges	1,724	1,647	77 F	4.5%	15,361	15,775	(414) U	-2.7%
Births	617	591	26 F	4.2%	6,866	6,720	146 F	2.1%
ED Discharges	9,665	9,553	112 F	1.2%	107,767	103,701	4,066 F	3.8%
FSA Volumes	4,437	4,893	(456) U	-10.3%	44,464	46,730	(2,266) U	-5.1%
FU Volumes	11,089	12,538	(1,449) U	-13.1%	110,188	114,940	(4,752) U	-4.3%
Length of Stay (days)	20,195	20,212	(17) U	-0.1%	208,494	200,027	8,467 F	4.1%

Case weight Activity

Year to date acute volumes are 0.5% ahead of contract. Although the overall rate of growth continues to slow – main growth areas continue to be in General Medicine, General Surgery and secondary neonates (increasing acuity).

Electives continue to track under contract, with year to date volumes being 5.2% behind contract. However, the rate of elective activity increased in May, with discharges of 1,744 being the highest monthly total so far this year. It is still unclear if the full elective contract will be achieved. The Recovery Plan to attempt to mitigate the under delivery of elective volumes includes scheduled additional theatre sessions, extra clinics and increased subcontracted procedures to private providers.

The shortfall in elective volumes stems from the shortage of theatre space due to acute demand and anaesthetist vacancies. Outsourced discharges account for almost 10% of the total year to date elective activity.

Finance Overview

The Provider Arm produced a $1.48M favourable variance against budget for year to date May 2018, and a $241k unfavourable variance for the month.

Major Year to Date variances are explained below.

Revenue

Overall revenue is $5.4M favourable for the year to date, ($287k favourable for the month) reflecting the following major movements:

- ACC arrears initiative - $7.2m favourable.
- Tahitian burns contract - $878k favourable

- Non-residents - 1.3m favourable; A combination of increased resource within the eligibility team over the last few years and use of the costing system data from COSTPRO (implemented this year) has significantly improved the accuracy of invoicing of services provided to Non-Residents.
- Bad debts recovered - $423k favourable due to improved internal and external processes including ongoing routine transfer of debt to our agent (Baycorp) and better assessment of a patients' ability to pay.
- Additional funding for the Capital Charge of $3.54m offsetting expenses in previous months
- Under delivery of the YTD elective programme, partly due to higher than contracted acute volumes through the winter months - $6.75m unfavourable.
- Reversal of a MoH revenue adjustment at 30 June 2017 - $620k unfavourable (offset by favourable personnel costs)
- Lower than anticipated sales in the Retail Pharmacy - $1.0m, offset by a reduction in cost of goods sold (included in Other Expenses).
- Reduction in donation revenue of $1.2m.

Expenditure

Overall operational expenditure is $1.6M unfavourable year to date ($749k unfavourable for the month).

Net Personnel Costs - unfavourable $2.6M YTD ($784k unfavourable for the month)

Net personnel costs are $2.6M unfavourable year to date, driven by the unfavourable growth in nursing costs. Overall FTEs are 69 unfavourable to budget (including outsourced personnel).

Personnel by Professional Group - Permanent and Outsourced	Month $$$			Year to Date $$$			Year to Date FTE		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	18,562	17,612	(950) U	186,439	186,193	(246) U	879	858	(22) U
Nursing Personnel	20,039	19,834	(205) U	219,773	211,816	(7,957) U	2,973	2,801	(172) U
Allied Health Personnel	7,242	7,238	(4) U	75,334	77,091	1,757 F	1,139	1,176	37 F
Support Personnel	2,373	2,552	179 F	25,658	26,392	734 F	514	531	16 F
Management Personnel	6,132	6,329	196 F	63,878	66,962	3,085 F	895	967	72 F
Totals	**54,348**	**53,565**	**(784) U**	**571,082**	**568,454**	**(2,628) U**	**6,401**	**6,332**	**(69) U**

- Net Medical costs are $246k unfavourable YTD ($950k unfavourable for the month) reflecting increased costs for the month in Orthopaedics' and the Emergency Department, driven by volume. Year to date vacancies across the services in difficult to recruit to positions mainly in Anaesthesiology, Radiology and Mental Health have subsidised the impact of the schedule 10 implementation in November, volume growth as well as a level of unrealised target savings.

- Net Nursing costs are $7.96M unfavourable YTD ($205k unfavourable for the month) reflecting the significant increase in clinical demand, the cost of internal bureau staff, the cost of outsourcing and unrealised target savings.

- Net Allied Health costs are $1.75M favourable YTD ($4k unfavourable for the month) representing vacancies across the services that are being actively recruited, mainly Psychologists, Anaesthetic Technicians, Social Workers and Occupational Therapists.

- Net Support Personnel are $734k favourable YTD ($179k favourable for the month) reflecting vacancies in Engineering, Facilities Management and Sterile Supplies partially offset by overspends in Security Services and Interpreters.

- Net Management and Administration Personnel are $3.1M favourable YTD ($196k favourable for the month) reflecting vacancies across all services.

Non Staff Costs

- Clinical Outsourcing costs are $1.1M unfavourable YTD ($342k unfavourable for the month) representing outsourced MRI volumes and an increase in the volume of elective work outsourced to

private hospitals to mitigate the impact of increased acute demand, primarily in Orthopaedics, General Surgery, ORL and Ophthalmology.

- Clinical Supplies costs are $2M unfavourable YTD ($107k unfavourable for the month) reflecting high clinical demand, with significant increased costs in 'Instruments and Equipment' and Pharmaceuticals. Unrealised YTD target savings has been offset by underspends in implants and prostheses and a one off favourable movement in creditors (relating to June 2017 year-end accruals).

- Other expenses are $3.4M favourable YTD ($154k unfavourable for the month) reflecting the following major movements:
    - Favourable Retail Pharmacy costs (compensating for lower than budgeted Pharmacy revenue).
    - A positive one-off adjustment to the Bad Debt provision due to regional alignment of the Bad Debt process.
    - Favourable Information Technology and Communications and Insurance costs.
    - Overspends in Hotel Services driven by patient meals and laundry costs due to patient volumes.
    - Additional costs as part of the Facilities Remediation Programme including Seismic and Cladding assessments.
    - Additional repairs and maintenance costs.

- Interest, Depreciation and Capital Charge costs are $2.4M unfavourable YTD ($221k favourable for the month) driven by a revision to the Capital Charge (offset by additional funding) and additional year to date depreciation associated with the revaluation of buildings.

Forecast to Year End

The year-end forecast currently stands at a deficit of $23.8m (budget deficit $24.3m), a $500k favourable variance against budget.

Looking Ahead

Planning within the Provider Arm includes:

- Winter planning to ensure we have capacity to meet demand pressures and provide quality of care throughout the year.
- Facilities Master Planning - Immediate Demand and Facilities Remediation Programmes, to confirm capacity requirements over the next 3-5 years and align facility investments.
- Turn-around-Programme – Planning of the 2018/19 Savings Programme to deliver budget targets.

Summary of Annual Leave Cashups within the Hospital Services Directorate

for the period 1st January to 31st May 2018

RC Name	Category	Ttl AL Cash Up (hrs)	Current AL Balance (hrs)	Ttl AL Taken in 12 Months (hrs)
Birthing & Assessment Unit	Financial Hardship	237.65	26.13	124.60
Maternity Ward North	Financial Hardship	69.13	32.76	381.61
Maternity Ward	Financial Hardship	97.04	25.71	515.62
Orthopaedic Surgery	Financial Hardship	172.78	-	-
Grand Total		**576.60**	**84.60**	**1,021.83**

Summary of Annual Leave Cashups within the Hospital Services Directorate

for the period 1st January to 31st May 2018

Employee Designation	Category	Ttl AL Cash Up (hrs)	Current AL Balance (hrs)	Ttl AL Taken in 12 Months (hrs)
HEALTH CARE ASSISTANT	Financial Hardship	334.69	51.84	640.22
REGISTERED MIDWIFE	Financial Hardship	69.13	32.76	381.61
HOUSE OFFICER	Financial Hardship	172.78	-	-
Grand Total		**576.60**	**84.60**	**1,021.83**

Emergency Department, Medicine & Integrated Care

May 2018

Glossary

BSP	Bowel Screening Programme
CNC	Cancer Nurse Coordinator
ERCP	Endoscopic Retrograde Cholangiopancreotography
EUS	Examination under Ultrasound
FCT	Faster Cancer Treatment
MMH	Middlemore Hospital
MoH	Ministry of Health
SLA	Service Level Agreement
YADS	Young Adults with Diabetes

Service Overview

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

Report back on actions assigned during previous Hospital Advisory Committee meetings

The Committee asked for a "Bowel Screening Programme regular update via the Medicine report each meeting" to be provided.

National Bowel Screening Programme (NBSP) – regular update for the Hospital Advisory Committee

The Ministry of Health Bowel Screening Programme readiness assessment was carried out on 7th May. We have completed all of the actions that the MoH requested to enable go live. The Ministry will confirm our "go live" date on 18 June. This is the date that the National Centre will start sending letters to participants, 2 weeks following this test kits are sent out. We do not expect to have any positive screening tests to follow-up until toward the end of July.

The service has been recruiting to key positions to ensure staff are employed on time, a nurse co-ordinator, practice team liaison and community co-ordinator have all been offered positions. Information on the programme is available on the HealthPathways site for GPs and a media campaign is about to commence.

Due to the later than planned commencement of the programme at CM Health, later recruitment of some staff, and lower IT costs than budgeted, there have been fewer costs in the 2017/18 year. We have therefore asked the MoH to amend timing (but not the overall funding level) of the Service Delivery funding so that limited funding will be paid this year and increased funding will be available next year. This will ensure adequate funding for 2018/19. Funding levels for out years may still be a risk. We are awaiting further advice from the MoH around the budget announcement funding for the programme the impact, (if any) for CM Health.

Highlights

General Medicine

Re-purposing and recommissioning of Level 5 Galbraith Ward 21 approached completion during the month. Procurement of necessary equipment and beds is well underway to facilitate ward readiness for the beginning of the winter period should a decision be made to open the ward for the winter period. New nursing appointees for Ward 21 began commencement and team-building activity on the pre-existing medical wards.

Change of Ownership of Diaverum (NZ) Limited

The change of ownership of the Toto Ora dialysis unit to B. Braun from Diaverum has gone smoothly. We will be meeting with B. Braun senior leadership in June to discuss details of the contract and how the relationship will work going forward.

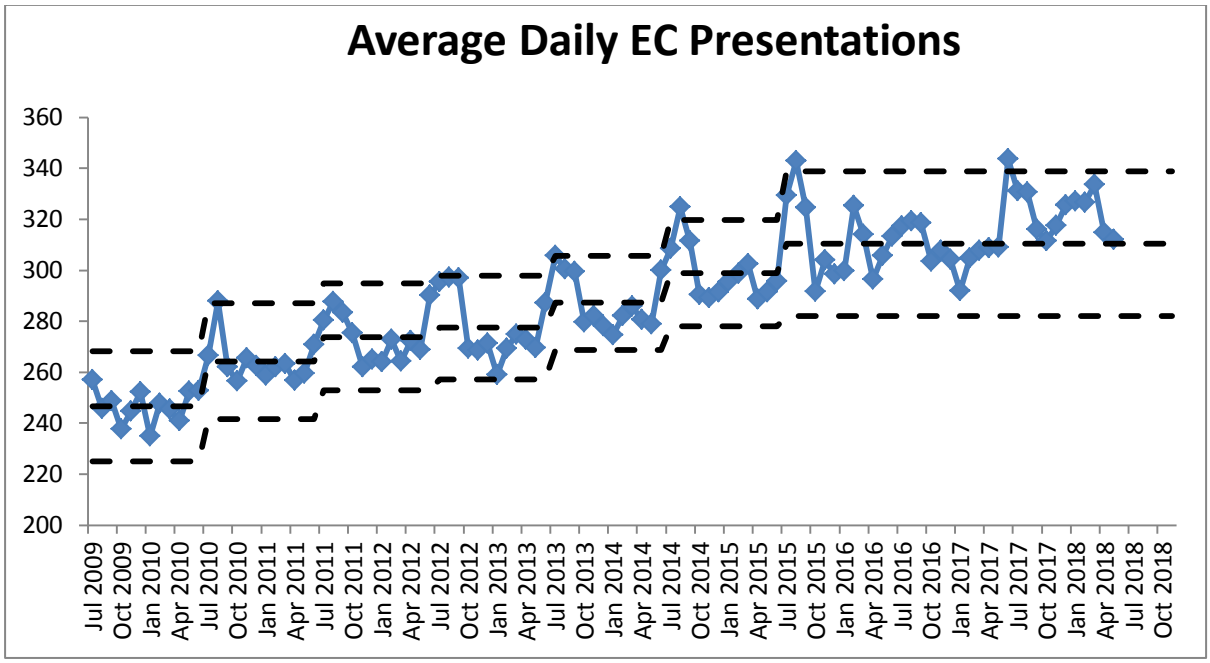
Acute Demand Update

Emergency Department

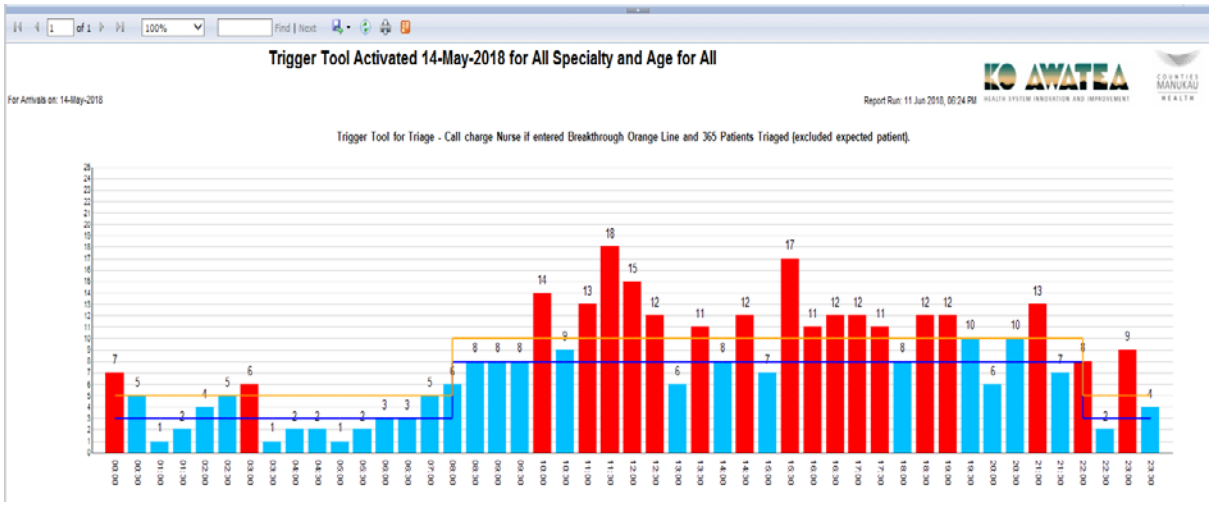
During May presentations totalled 9,678 which is a **0.8 %increase** over last year's volumes for the same month. However year-to-date (YTD) presentations represent a **3.7 % increase** from YTD last year.

July 2017 – May 2018 -total presentation 107,804
July 2016 – May 2017 -total presentation 103,761

Emergency Department continues to have high presentations with an average of 312 patient presentations per 24 hours throughout May compare to 309 presentation per day in May 2017.



As can be seen in the diagram below, surge presentations with this continued volume of people and complex case mix presenting to the department, with the resource make achieving the to be seen times (TBS) a continual challenge.



Emerging Issues

Improving Utilisation of the Infusion Centre

We are currently undertaking a review of current and future facilities requirements for outpatient infusions. This arises from the pressure the Haematology Day Stay Unit is under together with the potential expansion of Local Delivery of Oncology services and the need to free up bed capacity. We are taking a production planning approach working with all services.

Update on previously reported issues

Issue	Date reported	Update
Gastroenterology challenge of maintaining FCT MoH Targets for Colonoscopy and CM Health Targets for Gastroscopy	August 2016	CM Health has not achieved the MoH colonoscopy target in May for P2 colonoscopy. P1 and surveillance were attained. In addition, we are not achieving the P2 gastroscopy internally set targets. This is due to reduction in production due to a statutory holiday, along with unprecedented growth in demand for the six months from December with 28% to 33% month on month creating a backlog of patients on the waitlist. There is also another trend with an increase in acute/urgent work with ERCPs and EUS increasing due to the FCT timelines and more cancers being diagnosed. ERCPs will also contribute to the waitlist issues potentially from early June when the Radiology Dept will be refurbished. ERCPs will have to be performed in the Gastroenterology area and this will reduce the ability to do other endoscopy procedures by approx. 35-40 procedures per week for a 5-6 month period.

		A paper outlining the need for outsourcing and volumes, based on modelling and forecasts, was presented to ELT and approved. The volumes agreed are 560 procedures over June/July to remove the backlog on all endoscopy waitlists, and then a further 500 procedures over the 2018/19 year to maintain the waitlist and targets.

National Health Targets

Cancer Treatment

Faster Cancer Treatment	**Description** 90% 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.	**April (indicative)** Achieved ✓ **100%**

Commentary:

Urology, gynae and breast tumour streams are currently experiencing large referral volumes. This is creating capacity concerns for FSA and follow up slots in clinics. Cancer Tracking and Cancer Nurse Coordinators are working closely to ensure 62-day patients are not impacted by this as far as possible. Clear escalation processes are in place and are being followed.

We are aiming to have sustainability action plans completed by end June and a clear plan in place for maintenance and governance of FCT in a business as usual capacity from July onwards. This includes data and reporting / performance monitoring across each tumour stream.

There is a plan in place to develop a cancer steering group to replace some of the smaller more focused cancer working groups. Membership and Terms of Reference have been agreed and this will replace the current FCT governance group from July.

Contingency plans have been developed to minimise risk of patients breaching the FCT Health Target in the event of NZNO nurses strike.

Improved equity in access to timely cancer treatment

An audit of patients entering the Faster Cancer Treatment 62-day pathway over the 12-month period 1 Feb 2015 - 31 Jan 2016 found Maaori and Pacific patients, along with those living in the highest areas of socioeconomic deprivation were significantly less likely to meet the 62-day target than their counterparts. A more recent audit covering the 12 months between 1 Nov 2016 - 31 Oct 2017 has found ethnicity and level of deprivation is no longer associated with passing the target. This means that Maaori, Pacific, and those patients living in the most deprived areas are just as likely to meet the 62-day Faster Cancer Treatment Health Target as European/Other patients, and those living in the least deprived areas.

The findings from this recent audit have demonstrated that the efforts to achieve equity through developing standardised pathways for patients and improving care coordination these vulnerable patient groups has been working at CM Health.

This outcome is significant. It indicates that the sustained focus on reducing disparities in health for more vulnerable groups referred with a high suspicion of cancer has made a tangible difference. The number of tumour streams less likely to meet the target has reduced from 6 in the original audit period to 2 tumour streams as noted.

Improved care coordination has been achieved by raising the profile and awareness of our population based Cancer Nurse Coordinators for Pacifica and Maaori patients ensuring that patients are referred to them early in the pathway and not when problems occur. In addition reporting has been developed that enable visibility of individual patients who identify as Maori and Pacific within 24 hours of them being graded as high suspicion for cancer. This allows for increased engagement in services, and better support for these high needs populations.

Performance data related to patients that go on to receive treatment is broken down by treatment type and ethnicity and is used to measure against the 62 day FCT Health Target and the 31 day priority indicator.

Colonoscopy

	Description	May
Colonoscopy Targets	• 90% urgent (P1) colonoscopies done within 14 days	95% ↓
	• 70% non-urgent (P2) colonoscopies done within 42 days	65% ↑
	• 70% of Surveillance colonoscopies done with 84 day	74% ↓

Colonoscopy	2017								2018				
Period End	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb	Mar	April	May
P1 – % within 14 days (target 75%)	96%	98%	96%	100%	99%	99%	97%	98%	98%	99%	100%	98%	95%
P1 – % within 30 days (target 100%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
P2 – % within 42 days (target 70%)	58%	63%	59%	63%	70%	71%	77%	91%	65%	64%	68%	65%	65%
P2 – % within 120 days (target 100%)	98%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%
Surveillance – % within 84 days (target 70%)	93%	96%	98%	97%	81%	82%	84%	82%	72%	68%	78%	77%	74%
Surveillance - % within 120 days (target 100%)	99%	99%	100%	100%	100%	100%	100%	99%	94%	99%	100%	100%	97%
CT Colonography - % within 42 days (targt 65%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Gastroscopy

Gastroscopy Targets (CM Health Targets)	• 85% urgent (P1) gastroscopies done within 14 days	95% ↑
	• 70% non-urgent (P2) gastroscopies done within 42 days	42% ↑
	• 70% of Surveillance gastroscopies done with 84 days	81% ↓

Gastroscopy	2017								2018				
Period End	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan-18	Feb	Mar	April	May
P1 – % within 14 days (target 75%)	98%	96%	95%	99%	97%	99%	98%	98%	89%	97%	97%	92%	95%
P1 – % within 30 days (target 100%)	99%	100%	93%	100%	100%	100%	100%	100%	98%	100%	98%	100%	100%
P2 – % within 42 days (target 70%)	29%	33%	32%	32%	32%	40%	44%	48%	38%	38%	42%	41%	42%
P2 – % within 120 days (target 100%)	55%	56%	88%	57%	55%	51%	58%	67%	63%	84%	82%	83%	83%
Surveillance – % within 84 days (target 70%)	54%	81%	90%	92%	83%	83%	85%	75%	68%	63%	66%	84%	81%
Surveillance - % within 120 days (target 100%)	75%	89%	93%	97%	95%	96%	93%	89%	80%	64%	64%	94%	100%

Commentary:

MoH targets for P2 and Surveillance colonoscopy and CM Health targets for P2 gastroscopy not met in May. This is due to ongoing issues with lack of capacity and the continued higher than forecast volume growth. The volume growth, though reduced from previous months, was 25% higher for 2018 than 2017.

Mitigation strategies for this include hiring another SMO, due to start in August, to cover for SMO leave. In addition, approval has been given to ensure we can achieve and maintain performance against our colonoscopy and gstroscopy targets and to outsource 560 procedures immediately and then another 500 throughout the 2018/19 year.

Cardiology Angiography

Description Cardiology - 90% elective angiograms within 90 days	**April** Achieved ✓ **95%**
Commentary: Target achieved.	

EMERGENCY DEPARTMENT, MEDICINE AND INTEGRATED CARE SCORECARD

May-18

		Trend				Year to date			Rating	Commentary (by exception)
		FY17-18	May-18	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Total Caseweight		**2,239**	2,402	-6.8%	**25,017**	24,861	0.6%		
	Elective Caseweight		**53**	72	-26.4%	**562**	710	-20.8%		
	Acute Caseweight (includes Intensive Care Unit)		**2,186**	2,331	-6.2%	**24,455**	24,151	1.3%		
	Outpatient First Specialist Assessment (FSA) Volumes		**1,201**	1,035	16.0%	**12,979**	12,625	2.8%		
	Outpatient Follow Up Volumes		**3,407**	2,783	22.4%	**34,639**	33,105	4.6%		
	Virtual First Specialist Assessments (FSAs)		**133**	161	-17.4%	**1,977**	1,685	17.3%		

		Trend				12 month average			Rating	Commentary (by exception)
		FY17-18	May-18	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years			5.0%	5.0%		5.0%	5.0%		
	% Staff Turnover			10.0%	10.0%		10.0%	10.0%		
	% Sick Leave			2.8%	2.8%		2.8%	2.8%		
	Workplace Injury per 1,000,000 hours			10.5	10.5		10.5	10.5		

		Trend				Year to date			Rating	Commentary (by exception)
		FY17-18	May-18	Target	Var	Actual	Target	Var		
Safety	No. Falls causing major harm		**2**	0	2	**4**	0	2		1 fall with subdural bleed – died 10 days post. And 1 fall with fracture (mandible)

		Trend				Year to date			Rating	Commentary (by exception)
		FY17-18	May-18	Target	Var	Actual	Target	Var		
Timely	% Radiotherapy commences in 4 weeks		**100%**	100%	0%	**100%**	100%	0%		
	% Chemotherapy commences in 4 weeks		**100%**	100%	0%	**100%**	100%	0%		
	% of patients admitted, discharged, transferred from ED within 6 hrs		**92%**	95%	-3%	**92%**	95%	-3%		Patent volume and bed demand mean that the hospital was unable to reach the six hour target achieving 92% for May against the target of 95%.
	P1 (urgent) % diagnostic colonoscopy patients receive the procedure within 14 days		**95%**	85%	10%	**98%**	85%	13%		
	P2 (routine)% diagnostic colonoscopy patients receive the procedure within 42 days		**65%**	70%	-5%	**69%**	70%	-1%		Targets not met due to capacity issues and increased demand. Outsoucing and employment of a new SMO have been implemented to reduce waiting lists and manage volumes.
	% surveillance colonoscopy patients receive their procedure within 84 days of planned date		**74%**	70%	4%	**81%**	70%	11%		
	P1 (urgent) % diagnostic gastroscopy patients receive the procedure within 14 days		**95%**	85%	12%	**97%**	85%	14%		
	P2 (routine)% diagnostic gastroscopy patients receive the procedure within 42 days		**42%**	70%	-38%	**41%**	70%	-30%		Targets not met due to capacity issues and increased demand. Outsoucing and employment of a new SMO have been implemented to reduce waiting lists and manage volume.
	% surveillance gastroscopy patients receive their procedure within 84 days of planned date		**80%**	70%	13%	**78%**	70%	8%		
	% cardiac STEMI - PCI (angiography) within 120 mins - Northern Region Target		**94%**	80%	14%	**81%**	80%	1%		Note that this result is always measured 1 month in arrears
	% Coronary Angiography within 90days (1 month in arrears)		**95%**	95%	0%	**93%**	95%	-2%		
	Medical Assessment – Triage 3-5 patients seen within 60 minutes		**92**	60	32		60	-30		
	Door to Cathlab suspected Acute Coronary Syndrome < 3 days (median time)		**84%**	70%	14%	**75%**	70%	5%		

Timely (continued)	General Medicine - Seen By Time (minutes)									
	1st Time to be seen Triage 1 & 2 patients (median time in minutes)		**45**	30	-15	**40**	30	-10		Winter volumes have impacted increasing the TBS
	1st Time to be seen Triage 3 - 5 patients (median time in minutes)		**97**	60	-37	**95**	60	-35		Winter volumes and RMO/SMO vacancies have impacted seen by times
	2nd Time to be seen Triage 1 & 2 patients (median time in minutes)		**82**	30	-52	**73**	30	-43		Winter volumes and RMO/SMO vacancies have impacted seen by times
	2nd Time to be seen Triage 3-5 patients (median time in minutes)		**101**	60	-41	**92**	60	-32		Winter volumes and RMO/SMO vacancies have impacted seen by times
	FCT - % high suspicion first cancer treatment within 62 days - MOH Health Target		**100%**	90%	10%	**95%**	90%	5%		
	FCT - %confirmed diagnosis first cancer treatment within 31 days		**97%**	85%	12%	**94%**	85%	9%		

		Trend				Year to date			Rating	Commentary (by exception)
		FY17-18	May-18	Target	Var	Actual	Target	Var		
System Integration (Effective)	Average Length of Stay - Acute		**3.6**	3.5	-0.1	**3.5**	3.5	0.0		Slight increase for month, YTD on target.Winter impact on Wards and delays to placement options.
	Acute Readmissions within 28 days - Total		**12%**	10%	2%	**13%**	10%	4%		
	Acute Readmissions within 28 days - 75+		**13%**	10%	-3%	**14%**	10%	-4%		Overall YTD rates have been high and is reflective to the increased demand and work pressures and complexity. The readmission rate this month has improved compared to the last 6 months
	% of patients on home wards in General Medicine		**40%**	75%	-35%	**37%**	75%	-38%		Still low rates of home ward occupancy. High bed occupancy increases outliers. Average occupancy for General Medicine 116% during May.
	% of Outliers on non-medicine wards		**10.0%**	0.0%	-10.0%	**12.0%**	0.0%	-12.0%		Occupancy was 116% this month for General medicine. Consultation for Home Based wards underway.

		Trend				Year			Rating	Commentary (by exception)
		FY17-18	May-18	Target	Var	Actual	Target	Var		
Efficient	% Discharges from transit lounge or home by 1100hrs		**17%**	30%	-13%	**17%**	30%	-12%		Winter demand has begun to impact efficiency further. While strategies such as NFDs and review of long-stay continues, consultation to move to Home based wards is underway.
	% Discharged from Medical Assessment Unit by 1100hrs		**13%**	40%	-27%	**21%**	40%	-19%		Winter demand has reduced the efficiency of the medical teams to discharge before 11am. Consultation to Home Based wards is underway. Review of the APAC service in conjunction with the transition coach role is under consideration & review.
	% of patients < 28 hrs discharged from inpatient wards		**9%**	10%	-1%	**10%**	10%	0%		
	Implement Home First Renal policy - (increase Continuous Ambulatory Peritoneal & HD rate)		**43%**	50%	-7%	**43%**	50%	-7%		Ratio of home therapies:total dialysis has risen slightly on April, with 2 new home haemodialyisis patients and 3 peritoneal dialysis patients but the overal dialysis volumes dropping by 6. There was also 2 transplants done in May.

		Trend	Volumes Screened			% Screened in last 24 Months			Rating	Commentary (by exception)
		FY17-18	May-18	Target	Var	Actual	Target	Var		
Equity	% Women with Breastscreen in last 24 months - total		**2287**	2400	-113	**71%**	70%	1%		A multi media campaign has commenced to encourage Maaori women to be screened with advertising on Maaori TV and selected radio stations.
	% Women with Breastscreen in last 24 months - Maaori		**331**	289	42	**65%**	70%	-5%		
	% Women with Breastscreen in last 24 months - Pacific		**552**	377	175	**83%**	70%	13%		

Counties Manukau District Health Board
Hospital Advisory Committee
Maaori BreastScreen Coverage

Recommendation

It is recommended that the Hospital Advisory Committee:

Receive this paper discussing Maaori participation in the national BreastScreen Aotearoa programme.

Note The strategies currently being undertaken to increase participation.

Prepared and submitted by: Kathy Pritchard, Service Manager Cancer Screening Services on behalf of Brad Healey, General Manager, Emergency Department, Medicine & Integrated Care and Phillip Balmer, Director of Hospital Services

This paper has been through HMT/P&CLT/CGG/ISGG			No
Financial Implications	No	Finance have been consulted	No
HR Implications	No	HR have been consulted	No

Purpose

This paper is to update the Hospital Advisory Committee on progress and the strategies utilised to increase Maaori BreastScreen rates to achieve the national target of 70% coverage.

Executive Summary

Breast Screen Counties Manukau (BSCM) is contracted to provide the free BreastScreen Aotearoa Programme (BSA), in the Counties Manukau Region. The programme includes 2 yearly mammograms for women aged 45-69 years and assessment services.

The aim of the BSA programme is to reduce breast cancer mortality and morbidity by finding cancers early. Research has shown that screening 70% of the population decreases mortality by around 30%. Women who have had breast cancer diagnosed through a screening programme are generally diagnosed at an earlier stage and therefore require less treatment and have better outcomes.

Maaori and Pacific women, women who have never been screened and women who have not been screened for over five years are priorities for the breastscreen programme. Maaori women have higher rates of breast cancer and have the potential to benefit most from the programme.

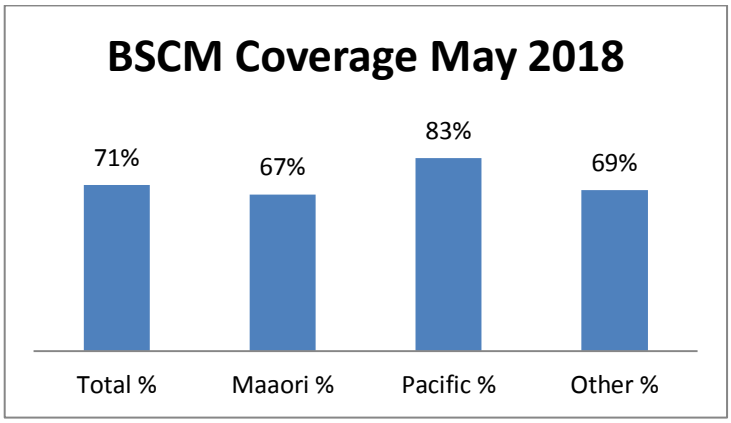
Current coverage (as at 31 May) in BSCM for women aged between 50 and 69 years is 67.1% for Maaori, 82.8% for Pacific, 69.3% for “other” women and 71.2% total. Coverage has increased since June 2017 which was 65.9% for Maaori, 76.8% for Pacific, 67.8% coverage for “other” women and 69% total.

BSCM have a number of strategies to increase Maaori coverage including a media campaign based on feedback from focus groups of Maaori women (TV, radio and outdoor advertising), invitation and recall processes, data matching, community awareness activities, use of the mobile unit and afterhours screening services, and utilising our Screening Support Services. We will continue to share information nationally and talk to our Maaori Health colleagues and providers and will trial new ideas with an aim to continue to increase coverage.

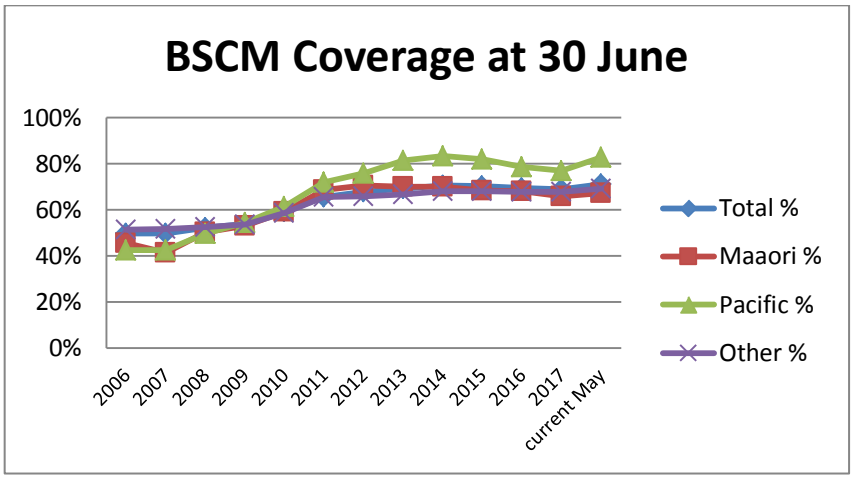
Background

BreastScreen Counties Manukau (BSCM) provides the BreastScreen Aotearoa programme (BSA) in Counties Manukau. While the majority of women screened by the service are CMDHB residents, as this is a national programme, to increase access women can choose where they are screened. For example a women living in ADHB but working in the Manukau SuperClinic can be screened at MSC.

Current BSCM coverage for women aged 50-60 years is graphed below:

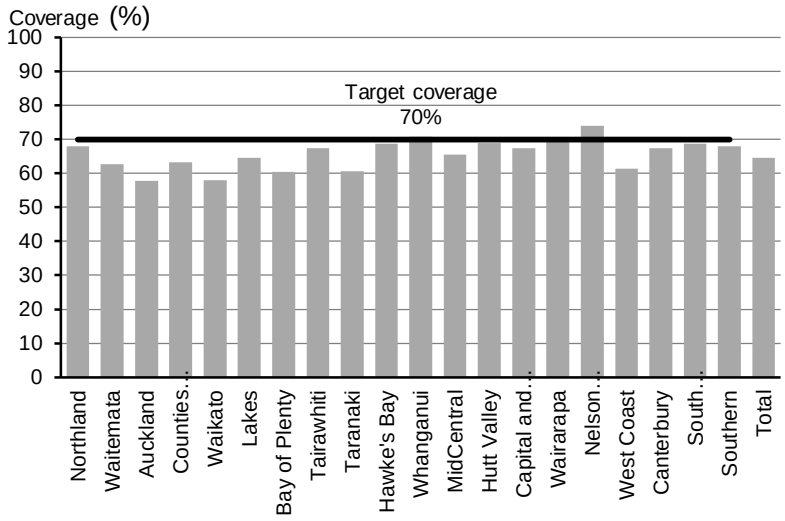


Coverage in the BSCM BSA programme has declined since 2014 when the programme had achieved 70% coverage for all groups including Maaori. This was due mainly to a shortage of Medical Radiation Technologists (MRTs) to carry out the mammograms. The service is currently almost fully staffed with a 0.4 FTE MRT vacancy and as a result we have been screening record volumes some months and screening coverage is increasing. The graph below shows coverage for 50-69 year old women.

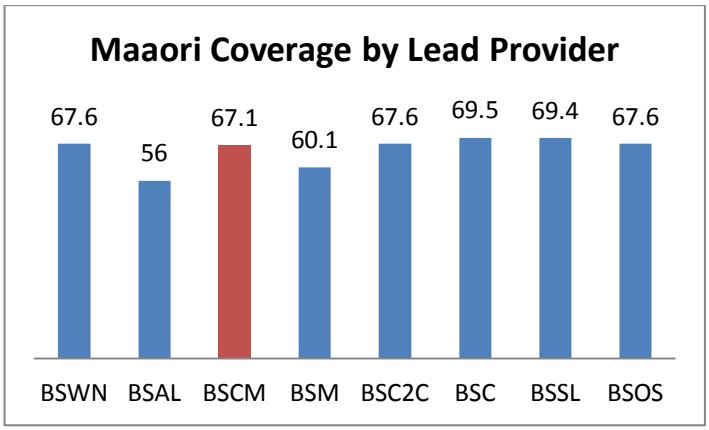


Achieving equitable coverage for Maaori in the BreastScreen Aotearoa programme is a challenge nationally. The most recent reporting by District Health Boards (March 2018) shows that although the 70% overall target had been met by 17 DHBs, only 2 DHBs had reached 70% for Maaori coverage (Nelson-Marlborough and Whanganui). National coverage for Maaori women was 64.6%.

BSA coverage (%) of Māori women aged 50–69 years in the two years ending 31 March 2018 by District Health Board



More recent data, showing coverage by lead provider at at 30 May 2018 is tabled below. There are 8 lead providers who provide services to the 20 DHBs in New Zealand.



BreastScreen Counties Manukau has a number of strategies to increase Maaori coverage.

1. **Focus groups** "Engaging Maaori Women in Converations". During 2016 four focus groups were run with Maaori women to seek advice on developing a media campaign that would encourage wahine to participate in the programme. This was funded through CMH Maaori Health. An external facilitator was contracteded to assist with the process. Women who had not responded to invitations to attend screening were invited to attend. The groups identified:
    a. Key messages that should be considered (including doing it for your whanau and emphasising that the check doesn't take long)
    b. How the messages should be conveyed in advertising, conversations with loved ones was recommended
    c. Adverts should be in English with some Te Reo
    d. Need for some humour

    The groups identified barriers to screening as anxiety / fear of the unknown or getting a cancer diagnosis, having compression applied to the breasts and having someone touch your breasts. Information was also gathered on what advertising media the women watched, listened to or used.

2. **Media campaigns**. A report with the findings of the focus groups was sent to three media companies with experience working on Maaori campaigns requesting proposals for a campaign. Maaori TV was selected as the preferred provider and as part of the process they were required

to present their proposal to the focus groups, who provided feedback.

A televsion advertisement and radio adverts were produced by Maaori TV, and were aired on Maaori TV and selected radio stations for three months in 2017. The TV advert was filmed at Papakura Marae. These adverts have just been run again from April to June this year on Maaori TV, and on radio; Breeze, Flava, Mia and More FM. Trailor advertising using images from the TV adverts are also placed in locations prior to the mobile arrival, outdoor advertising was recommended as a good medium for this population.

3. **Data matching.** Data matching with primary care practices and once a year with the DHB patient information system identifies women who are not enrolled in the screening programme and provides contact details for women who may have moved. For women who are not enrolled, BSCM facilitate GP letters (or from the GM Maaori and GM Pacific for DHB data matching) to women encouraging them to enroll into the programme. This is followed up with a phone call. Women who are enrolled but are overdue who have new contact details are followed up generally by phone.

4. **Screening Support Service (SSS) Contract** for breast and cervical screening. CMH successfully responded to an RFP for these services. Staff in the support to screening team have been recruited to reflect the priority populations for the programmes and are Maaori, Pacific and Asian (for cervical screening) and have been combined under one team leader with the BSCM recruitment and retention staff and are co-located with BSCM. The service provides transport and other support as required and assists with follow up of priority women. This gives a large responsive team that can combine both breast and cervical screening to priority women. This is a unique model, and the Ministry of Health are interested in the success of this model.

5. **Community Awareness.** BSCM and the SSS team attend Poukai and other Marae and community activities to promote the programme. Breast and cervical screening promotional activities are combined (as are some screening activities) and will include bowel screening in the future.

6. **Location of the mobile unit.** The location of the mobile unit at Marae / Whare Oranga and in areas with high Maaori populations ensures that higher numbers of Maaori women are screened.

7. **Screening sites and hours of operation.** Late nights, clinics every Saturday and Sunday clinics once a month at MSC are provided to increase accessibility. Apart from the fixed site and MSC, our Mangere site and the sub-contracted site at Pukekohe screen reasonable numbers of Maaori women.

8. **Invitation and recall processes**. The service phones women who have not responded to invitation letters to arrange appointments. DNR and DNA lists are regualry generated and all attempts are made to contact women including after hours phone calls. Text reminders are sent to remind women of their appointments, in addition all Maaori and Pacific women receive a phone reminder.

Future Initiatives.

We have meet with representatives of our ten contracted Maaori health providers to discuss breast, cervical and bowel cancer screening programmes and are currently considering piloting a contract with providers to support Maaori women who are underscreened or unscreened. Outcomes in current Maori provider contracts include referrals to health services and we have been working with the Maaori Health team to promote referrals to BreastScreen as part of the contract activities.

The Ministry of Health is currently working with PHOs nationally to data match with PHO data and

provide lists of unscreened and underscreened Maaori and Pacific women to lead providers. This may be more effective than current data matching by practice.

Discussion

Reaching breast screening targets for Maaori women is a priority and we continue to work hard to encourage Maaori women to participate in the programme. We remain concerned that high numbers of women ask to be excluded from the programme or DNA appointments. We continue to share information nationally and will continue to work with our DHB Maaori Health colleagues and providers to trial and evaluate initiatives to increase participation.

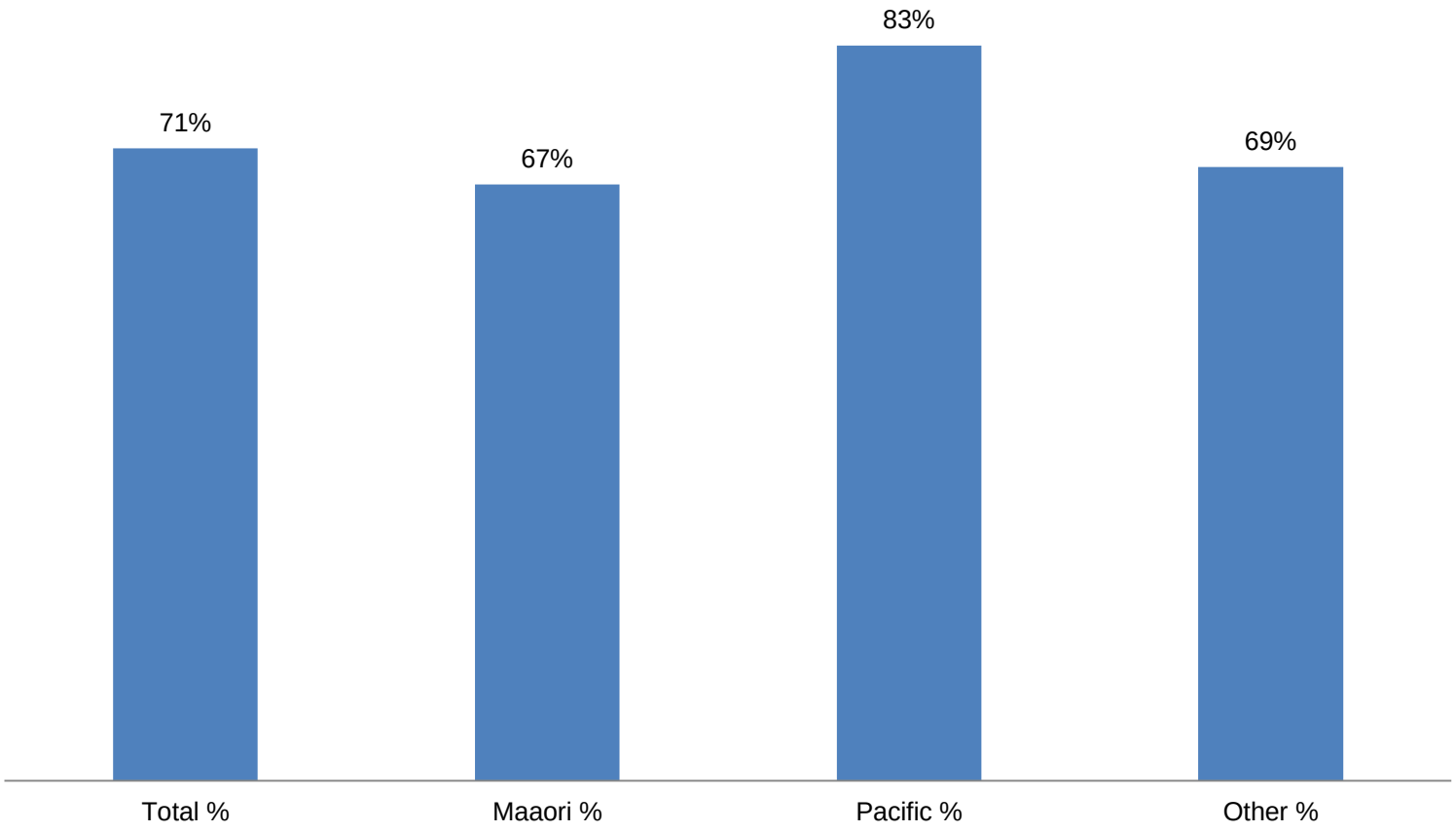
BreastScreen Counties Manukau

Presentation to Hospital Advisory Committee

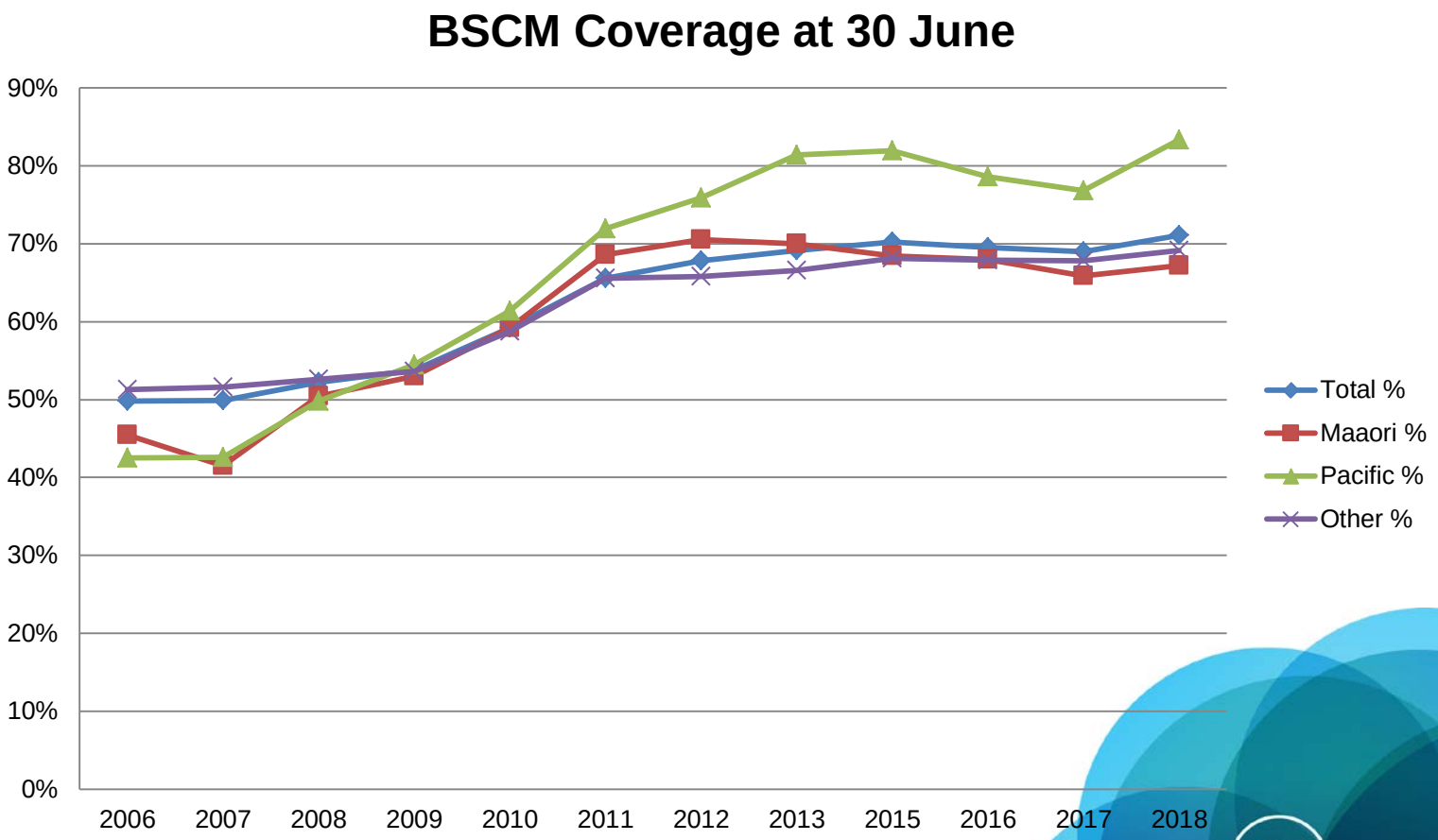
BreastScreen Aotearoa

New Zealand Government

BSCM Coverage 50-69 years



Coverage trends 50-69 years



Coverage by DHB – June 18

DHB	Māori	Pacific	Other	Total
Northland	68.4%	60.6%	70.4%	69.9%
Waitemata	63.8%	67.5%	65.1%	65.2%
Auckland	58.7%	69.4%	62.9%	63.4%
Counties Manukau	65.2%	81.8%	69.5%	71.0%
Waikato	58.1%	58.8%	70.7%	68.6%
Lakes	64.4%	62.1%	71.6%	69.7%
Bay of Plenty	61.4%	70.7%	73.4%	71.4%
Tairawhiti	66.6%	60.0%	72.4%	69.9%
Taranaki	61.4%	66.0%	76.6%	74.8%
Hawke's Bay	70.0%	66.4%	76.6%	74.8%
Whanganui	72.8%	69.6%	80.1%	78.6%
MidCentral	65.0%	66.1%	77.1%	75.5%
Hutt Valley	68.6%	66.3%	73.9%	72.9%
Capital and Coast	68.1%	68.9%	72.7%	72.2%
Wairarapa	70.3%	70.8%	76.8%	76.2%
Nelson Marlborough	74.1%	70.7%	78.9%	78.7%
West Coast	66.6%	36.0%	75.0%	74.5%
Canterbury	68.7%	68.3%	75.5%	75.0%
South Canterbury	67.5%	60.0%	76.6%	76.2%
Southern	67.4%	60.9%	74.8%	74.3%
Total				71.5%

Volumes 2017/18 year

Volumes	YTD (Financial Year)		
	Actual	YTD target	Variation
Total 45-69 years	29382	28800	+582
Māori 45-69	3359	3468	-109
Pacific 45-69	5804	4524	+1280

Contract Targets 2017/18

	Actual	Target	Variation
Maaori 50-69	2384	2384	0
Pacific 50-69	4192	3133	1059

Activities to increase coverage

- Focus group and media campaign

- Invitation and recall processes
- Data matching - GP and IPM
- Increasing accessibility – hours and location
- Support to Screening Services – unique model
- Community promotional activities

Outdoor Advertising

Future initiatives

- Pilot with Maaori providers
- PHO data matching – MoH lead
- GP dashboards
- Ongoing media – local papers, DHB Facebook
- Priority screening day with cervical screening

QUESTIONS

Surgery, Anaesthesia & Perioperative Services

May 2018

Glossary

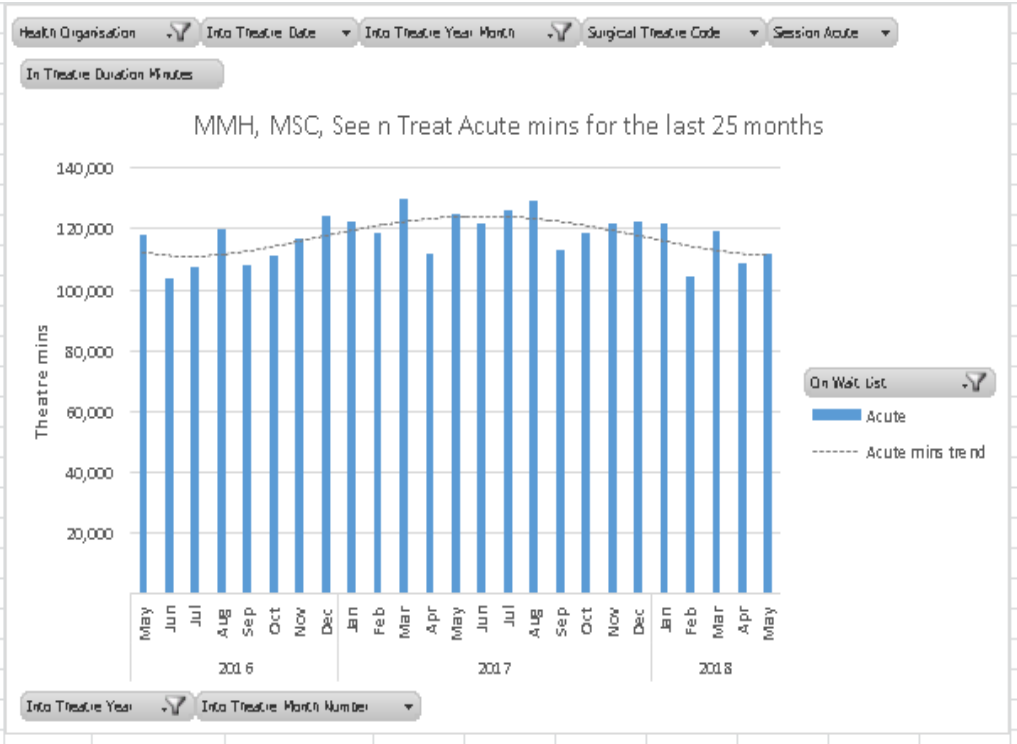
AT	Anaesthetic Technician
CLAB	Central Line Associated Bacteraemia
CCC	Critical Care Complex
DNA	Did Not Attend
DOSA	Day of Surgery Admissions
ESPI	Elective Services Patient Flow Indicator
FCT	Faster Cancer Treatment
FSA	First Specialist Assessment
HoD	Head of Department
ICU	Intensive Care Unit
LOS	Length of Stay
MMH	Middlemore Hospital
MoH	Ministry of Health
MSC	Manukau SuperClinic
ORL	Otorhinolaryngology
PAR	Patient at Risk
PCIMS	Perioperative Clinical Information Management System
RMO	Registered Medical Officer
SAPS	Surgery, Anaesthesia and Perioperative Services
SMO	Senior Medical Officer
VTE	Venous Thrombosis
WIES	Weighted Inlier Equivalent Separations
YTD	Year to Date

Service Overview

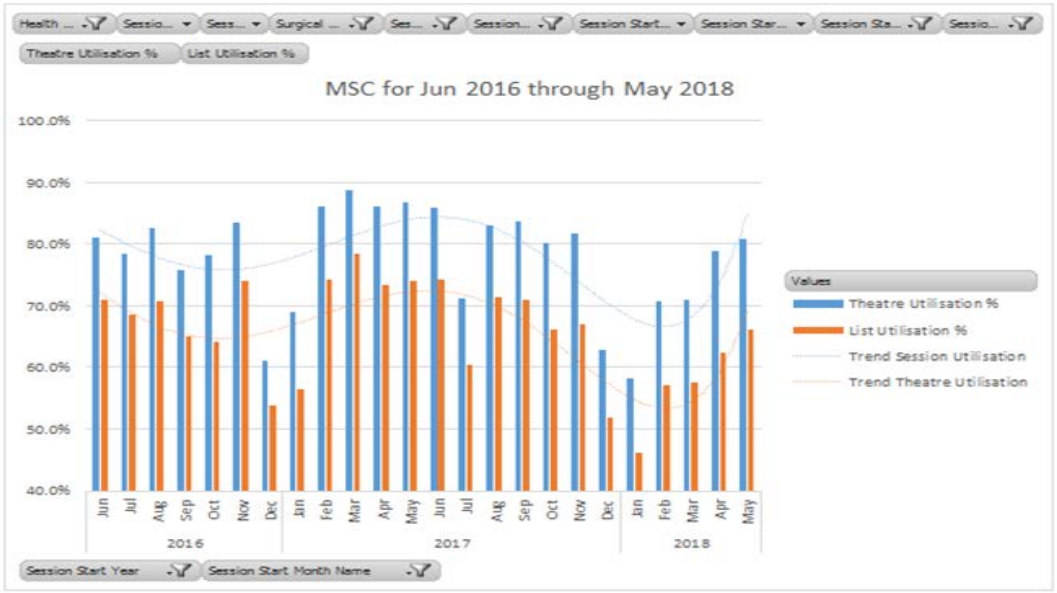
Surgery, Anaesthesia, and Perioperative Services is managed by Mary Burr (General Manager), with Dr Mark Moores (Clinical Director, Surgery, Anaesthesia and Perioperative Care), Dr Tony Williams (Clinical Director, Critical Care Complex), Jacqui Wynne-Jones (Clinical Nurse Director, Surgery, Anaesthesia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

Highlights

- Discharge Target for April 2018 is confirmed at 100.2% and 100% for May 2018
- Acute WIES over contract by 1.48% YTD.
- Electives WIES were at 26.2% above flexed contract for the month but 4.96 % below contract YTD. The month's elective outputs were the highest for any one month during the financial year with a record 586 half day elective lists being utilised for operating patients.
- Theatre Performance - Acute outputs returned to higher volumes in May 2018 .



- Theatre utilisation at MSC has increased to 80.9% for May 2018.

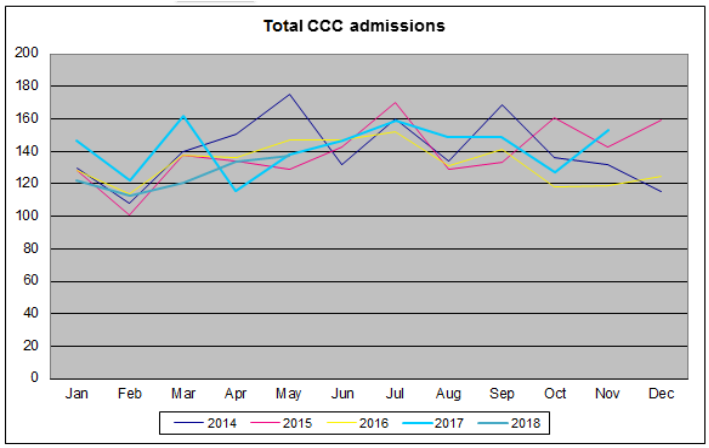


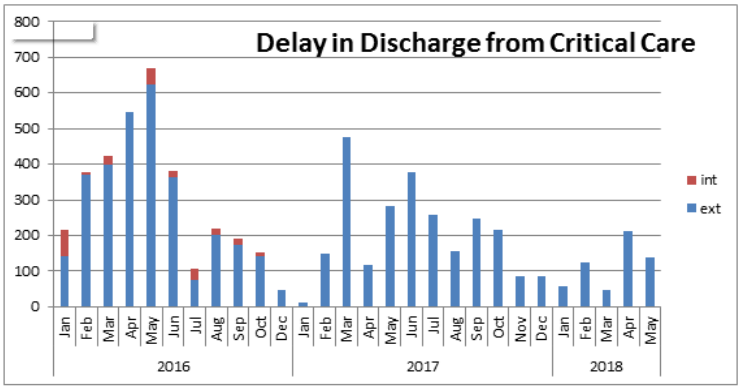
- The month's elective outputs were the highest for any one month during the financial year with a record 586 half day elective lists being utilised for operating patients.
- We have treated 85 patients for hip or knee operations (YTD 794 patients) against target of 76 and 198 cataracts patients for the month (YTD 1685).

Theatre Outputs at a Glance- May 2018

	May 2017 (mins)	May 2018 (mins)	Total Variance May 17 to May 18 (mins)	Increase/Decrease %
Month on Month				
Acutes – MMH	120,190	110,760	(9,430)	⇩8%
Acutes – MSC	4,955	1,348	(3,607)	⇩27%
Overall Acutes May 17 cf May 18	125,185	112,108	(13,077)	⇩10%
Month on Month				
Electives – MMH	40,294	42,256	1,962	⇧5%
Electives – MSC	73,058	70,608	(2,450)	⇩3%
Overall Electives May 17 cf May 18	124,786	123,638	(1,148)	⇩1%
Month on Month 2018				
Overall Electives April 18 cf May 2018	53,455	70,608	17,153	⇧24%
Year on Year Comparison	**Jul to May 2017**	**July to May 2018**	**Total Variance**	**Increase / Decrease %**
Overall Acutes Jul to May 18	1,295,579	1,298,255	2,646	⇧1%
Overall Electives Jul to May 18	1,182,137	1,125,940	(56,197)	⇩5%

Challenges - Update on items previously reported

Challenges	Date reported	Update
Critical Care beds under increasing demand- monitoring.	27 July 2016	May admissions for the Critical Care Complex have slightly increased but remain manageable. Winter Plan has been written to prepare for the upcoming seasonal increase. 

		Delays in discharge from the unit have reduced again for May 2018. 
Demand on Ophthalmology Services	27 July 2016	Mega clinics are providing a boost to the department. To date we have run three All Day 'Mega Clinics' staffed from our own resources, RANZCO recruited SMOs, locum registrars, locum fellows, external registered nurse injectors and technicians with 414 overdue patients seen within these clinics so far.
Anaesthetists' shortage	15 October 2017	• Recruitment- We have recruited five new anaesthetists with varying start dates and provided four with letters of intention to start in 2020 or2021. This should improve our theatre production for 18/19 and address acute demand pressures within the department. • Fixed term cover- We are exploring fixed term cover for the recruited positions with late starts out to 2021 and have a number of candidates interested to pick up this work. • Service Sizing- Service Sizing is nearing completion. • Progress workforce plan: Anaesthetic Department and HR are working together on a Workforce Plan. • Governance Group- We propose to establish a Governance group to support the Anaesthetic Department to address their key issues and concerns.
High Acute Demand	31 December 2017	Our acute demand has been consistently high with less fluctuation for recovery periods throughout 2017 and this continues in 2018. We have had a small period of reprieve in the past two months but acute complexity continues to be high with high acute spinal and orthoplastic trauma volumes.
Elective performance is under threat	15 October 2017	Due to high acute volumes and anaesthetists shortages over this year, there is continued pressure on both ESPI 2 (FSAs) and ESPI 5 (Treatment) in a number of services. We have received REDs in May 2018. The Health Targets are also under threat. We have achieved 100% of our elective discharge target however, despite our strong recovery plan, we have struggled to recover our elective WIES target which has financial implications for the organisation. We are working hard in June 2018 to ensure we deliver as close to

		the funded volumes as possible. • MoH procedure targets for hips, knees and cataracts are well in excess of targets. • Increased outsourcing overall until 30 June 2018. • Increase throughput of small cases to boost discharges. • Working with Anaesthesia to pick up extra lists by offering increased additional duty rates up to 30th June 2018 (yet to be picked up by Anaesthetics. • Continuing to fill theatre lists and ensuring we manage the start and finish times well. • Increasing output levels in the See and Treat unit and other out of theatre facilities that generate WIES or discharge numbers- example is Radio Frequency Ablation (RFA) in procedure rooms. • A theatre optimisation group has been established to review theatre processes including acute management, elective processes, and data management to ensure maximum use of resource. • Utilising alternative workforce e.g. Nurse Practitioners and Medical Officer (non specialist) to contribute to outputs and release medical staff for other activities. • A Lessons Learned Report is being prepared for the ELT with planned versus actual volumes to explain why we have seen the elective shortfall.

Months Critical Output Targets May 2018

Activity	Comments
Months Critical Output Targets May 2018	Total surgical patients (excluding Gynae) treated and discharged for the month was 3321 compared with a contract of 3383 and 3350 for the corresponding month of the previous year. Year to date actuals were 32304 patients in comparison with contract of 33450 and 32366 for the previous year. This shows a reduction of 62 patients year on year for the eleven month period. Outsourced elective patients totalled 183 for the month compared with target of 66 set for the month and 949 for the 11 months to end May 18. Internal elective productivity (excluding outsourcing) is 5.6% or 730 patients lower for the 11 months of this year compared with the corresponding eleven month period of the previous financial year. 19 patients received bariatric surgery (YTD 119) compared with target of 14 (YTD 144). Bariatric outputs are below target. It is now clear that we may be only able to meet the base volume of 144 by financial year end.
WIES	Acute WIES is 5.01% lower than contract for the month but over contract by 1.48% YTD. Electives WIES 26.20 % above flexed contract for the month but 4.96 % below contract YTD. **The month's elective outputs were the highest for any one month during the financial year with a record 586 half day elective lists being utilised for operating patients.** Overall outputs 266 WIES above contract for the month but 391 WIES behind contract YTD. Acutes are 113 WIES under contract for the month (YTD 327 WIES over contract) and electives 379 WIES above contract for May (718 WIES behind YTD).
Discharges	Acute discharges are 270 cases lower than contract for the month or 13.7%. The comparative figures YTD are 346 cases under contract at 1.79%. Elective discharges (inpatients /day patients) were 208 patients higher than contract but 800 patients below contract YTD. Overall 62 patient discharges lower than contract and 1146 YTD. In comparison with that of last financial year acute discharges are 432 patients over and elective patients are 494 patients under. Overall therefore 62 patients lower compared with the corresponding period of the last financial year. There were 31 patients breaching ESPI2 (120 day FSA threshold). However elective patient cancellations at CM Health facilities (mainly due to a backlog as a result of high acute demand resulted 82 patients (excluding Gynae and Kidz first) breaching ESPI5 (120 days treatment threshold) for the month. This has resulted in a red ESPI for the month.
Gynaecology	Important to note that the SAPS does not include Gynae and therefore any comments above exclude Gynae. The outputs for Gynae for both WIES and discharges are well below contract.

SURGERY, ANAESTHESIA & PERIOPERATIVE SERVICES SCORECARD

May 2018

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Total Caseweight (Provider view)		3,964	3,698	7.2%	36,152	36,543	-1.1%		Overall caseweight slightly behind YTD.
	Elective Caseweight		1,825	1,446	26.2%	13,762	14,479	-5.0%		Elective WIES are at 95%. High acute demand and anaesthetic shortage are responsible.
	Acute Caseweight		2,139	2,252	-5.0%	22,390	22,064	1.5%		
	Acute discharges		1,699	1,969	-13.7%	18,951	19,297	-1.8%		As noted above, Elective activity has been impacted by acutes and anaesthteic shortages. We are completing a lessons learned report.
	Elective Surgical Discharges		1,622	1,414	14.7%	13,353	14,153	-5.7%		
	Outpatient FSA Volumes		2,578	2,529	1.9%	24,192	27,329	-11.5%		
	Outpatient Follow Up Volumes		6,106	6,319	-3.4%	62,260	68,283	-8.8%		
	Budgeted FTEs		1,361	1,328	-2.5%	1,344	1,328	-1.1%		
	Operating Costs ($000)		18,946	18,893	-0.3%	196,424	196,503	0.0%		
	Virtual FSAs/Follow ups -(GP consult and nonpatient appointments)		71	132	-46.2%	1,331	1,426	-6.7%		RAC team have delays in logging virtual FSA. Working with the team to remedy.
	Personnel Costs ($000)		$13,735	$13,652	-0.6%	$141,202	$143,508	1.6%		
	Financial Result Total ($m)		$16,890	$16,666	-1.3%	$169,340	$170,792	0.9%		
	Reduce clinical outsourcing ($000)		$612	$381	-60.6%	$5,330	$3,956	-34.7%		Increased outsourcing to recover lost prodcutivity referred to above.

		Trend				12 month average			Rating	Commentary (by exception)
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years		15.3%	5.0%	-10.3%	15.4%	5.0%	-10.4%		We continue to work with staff with high leave balances.
	% Staff Turnover		8.2%	10.0%	1.8%	9.1%	10.0%	0.9%		
	% Sick Leave		2.7%	2.8%	0.1%	2.5%	2.8%	0.3%		
	Workplace Injury per 1,000,000 hours		6.0	10.5	4.5	11.99	10.5	-1.5		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)	Hand Hygiene compliance rate (based on Gold Audit) - Ward 11		80%	80%	0.0%	77%	80%	-2.6%		Pleasing result for May indicates continuing improvement.
	Pressure Injuries / 100 patients		0.00	0.00	0.00	0.00	0.00	0.00		
	Falls causing major harm / 1000 bed days		0.00	0.00	0.00	0.77	0.00	0.77		Maintaining good outcomes in relation to falls.
	Severe Pressure Injury (ungradeable) per 1000 bed days		0.00	0.00	0.00	0.00	0.00	0.00		
	Surgical Site Surveillance for Major joints-									
	Antibiotics given 0-60mins before "knife to skin"		92%	95%	-3%	91%	95%	-4%		We continue to work with the theatre team to improve recording of this data.
	2 grams or more Cefazolin given		99%	100%	-1%	99%	100%	-1%		
	Appropriate skin preparation		97%	100%	-3%	98%	100%	-2%		

Safety (cont.)	CLAB rate/ 1000 line days		0.0	0.0	0.0	9.0	0.0	-9.0		
	Rate of S. aureus bacteraemia per 1000 bed days		0.0	0.0	0.0	0.3	0.0	-0.3		VTE committee reviews each case and provide education to teams.
	VTE - Ortho (Acute and Elective)		7.0	2.0	-5.0	55.0	0.0	-55.0		
Timely		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
	Pre-operative Length of Stay Days (from admit to surgery)		NA	1.0	#VALUE!	1.26	1.0	-0.3		Month data not available . YTD result is good. We have reduction as a target for 18-19.
	ESPI 2 No. patients waiting >120 days for FSA - Elective (Surgical Services incl Gynae)		31	0	-31.0	31	0	-31.0		Yellow ESPIs for May 2018.
	ESPI 5 No. patients waiting >120 days Treatment - Elective (Surgical Services incl Gynae)		82	0	-82.0	82	0	-82.0		Recovery plan for ESPIs is underway.
System Integration (Effective)		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
	Average Length of Stay - Acute Inpatient incl Burns		3.84	3.8	0.0	3.82	3.8	0.0		Excellent results in this area. We expect to improve further in 18-19.
	Average Length of Stay - Acute Inpatient excl: Burns		3.78	3.8	0.0	3.78	3.8	0.0		
	Average Length of Stay - Acute Inpatient excl: Burns and Spinal Ortho		3.74	3.8	0.1	3.75	3.8	0.1		
	Average Length of Stay - Electives		1.04	1.5	0.5	1.10	1.5	0.4		
Efficient		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
	Theatre list utilisation - % used MMH/MSC		86.5%	85%	2%	81.8%	85%	-3%		Theatre utilisation is improving each month.
	Theatre session utilisation - % used MMH/MSC		96%	95%	1%	93%	95%	-2%		
	Elective Theatre turnaround times- Mins (MSC only)		11.95	15	3	11.66	15	3		
	Elective cancellations - Day of surgery as % of all Elective (all reasons)- SAPS only		6.7%	5%	-2%	8.6%	5%	-4%		Much improved % for May continuing a trend downward.
	Day of Surgery Admissions (DOSA)		NA	90%	-	90%	90%	0%		
	Day Case Rate (Elective/ Arranged) -Subspecialties in SAPS only Adults/kids		NA	65%	-	66%	65%	1%		
	MMH % patients discharged to discharge lounge or home by 1100hrs		25%	30%	-5%	25%	30%	-5%		Maintaining 25% which is creditable. We continue to monitor for further improvement.
	MMH % patients discharged to discharge lounge or home by 1100hrs -GEN SURG		24%	30%	-6%	26%	30%	-4%		
	MMH % patients discharged to discharge lounge or home by 1100hrs- ORTHO		25%	30%	-5%	21%	30%	-9%		
	MMH % patients discharged to discharge lounge or home by 1100hrs- PLASTICS		25%	30%	-6%	23%	30%	-7%		
	Ratio FSA/FU clinic ratio		42%	31%	11%	38%	31%	7%		
	Outpatient DNA rates - overall- Surgical Services only		8.6%	10%	1.5%	8.5%	10%	1.5%		
	Outpatient DNA rates - Maori (FSA) - Surgical Services only		14.3%	10%	-4.3%	15.3%	10%	-5.3%		YTD has improved. Needs further organisational focus.
	Outpatient DNA rates - Pacific (FSA)- Surgical Services only		17.0%	10%	-7.0%	13.9%	10%	-3.9%		
Equity		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
	% of hospitalised smokers receiving smokefree advice & support -Total (Surgical)		95%	95%	0%	94%	95%	-1%		Maintaining % between 94-95%.
P&WCC		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
	Patient Experience Survey - month (n=91) and YTD (n=91)		96%	90%	6%	90%	90%	0%		Excellent result.

Counties Manukau District Health Board
Hospital Advisory Committee
Response to Question Asked

Recommendation

It is recommended that the Hospital Advisory Committee:

Note a response to the question asked about how many cataract patients are outsourced to ADHB.

Prepared and submitted by: Mary Burr, General Manager, Surgery, Anaesthesia and Perioperative Services on behalf of Phillip Balmer, Director of Hospital Services

Purpose

This paper provides a response to the question- How many cataracts are outsourced to Auckland District Health Board (ADHB)?

Response

CM Health does not outsource cataract patients/surgeries to ADHB.

Any CM Health patient who has had a cataract operation at ADHB will have clinical reasons for that occurring such as oncology, posterior retina or an acute episode of care or they will have been referred for another surgical procedure that is not offered at CM Health such as vitrectomy.

If a patient already has a cataract then it is dealt with at the same time to save the patient from undergoing two separate procedures.

Mary Burr
General Manager
Surgery, Anaesthesia and Perioperative Services

Central Clinical Services

Monthly Report – May 2018

Glossary

CAR	Corrective Action Recommendation
CM Health	Counties Manukau Health
CT	Computed Tomography
ED	Emergency Department
eMR	Electronic Medicine Reconciliation
ePA	Electronic prescribing and administration
FTE	Full Time Equivalent
IANZ	International Accreditation New Zealand
LWOP	Leave without pay
iPM	i.Patient Manager
MoH	Ministry of Health
MOW	Meals on Wheels
MRI	Magnetic Resonance Imaging
MRT	Medical Radiation Technologist
NHI	National Health Index
NPF	National Patient Flow
PBM	Patient Blood Management
RMO	Registered Medical Officer
SMO	Senior Medical Officer
TAT	Turn Around Time
YTD	Year to date

Service Overview

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

Highlights

Laboratory Services

The Laboratory conducted a long service recognition ceremony for 56 staff who have served 10 years or longer at CM Health. This was a really heart-warming occasion with staff enjoying a morning tea and a large celebratory cake. There were 35 staff over 10yrs, eleven over 20yrs, seven over 30yrs and three over 40yrs.

The Histopathology business case was approved by the Board on the 16th of May. Subsequent to the approval IANZ have been notified that the business case for relocation of the laboratory has been approved, they have provisionally removed the CAR that was in place but will continue to monitor that progress towards the relocation is satisfactory. The MoH have also been notified that IANZ have lifted the CAR which has allowed for the bowel screening program to progress as planned. An initial project kick off meeting has been held.

The Patient Blood Management (PBM) project continues to track well. The new PBM nurse has started and is undergoing orientation. The project has resulted in a significant reduction in unnecessary usage of red blood cells and iron deficient patients have more appropriately received

iron transfusions as a first line treatment. The project has delivered $244,000 in net savings in the first 5 months it has been running.

Pharmacy

MedChart was rolled out successfully to four elderly care wards (92 inpatient beds) by end of May 2018. The uptake of MedChart in these wards has been excellent and there have been no significant clinical issues or risks identified. There are some product deficiencies and bugs identified, the majority of which have either some work around or do not pose clinical risk. There are also some integration bugs which would be fixed using a patch upgrade to ePharmacy.

The project is now considering rollout to two other wards. Baseline data has been collected and post implementation study will enable the project to demonstrate the value add to the patients, clinical staff and the wider system. The post implementation data will be collected once the system has had time to be properly embedded.

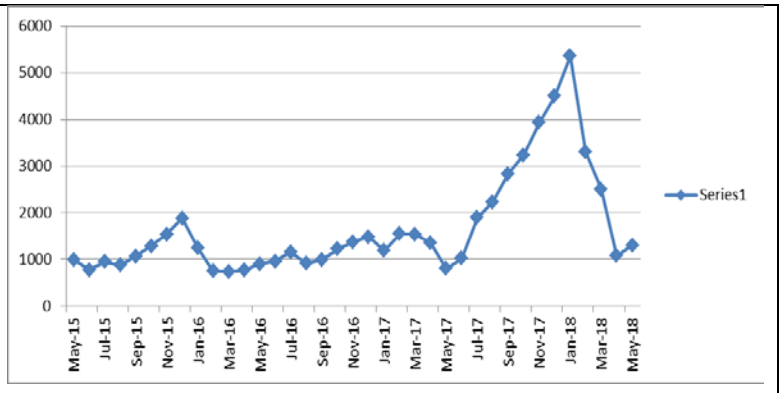
The Pharmaceutical User Group projects achieved the project target for medication related savings in 2017/18.

Emerging Issues

Nil

Update on previously reported issues

Issue	Date reported	Update
Reduced Radiologist FTE	Sept 2016	The Radiologist FTE continues to be in a state of flux- the current ability of the Radiology service to meet the demands placed upon it is challenging. Recruitment for new permanent staff has been successful over the past 6-12 months, as of the end of May 2018, whilst we are technically 'over recruited' by 1.23FTE, we have 6 people on parental leave (4.6FTE) and by June we will have 8 staff off (5.6FTE) on parental leave leaving a significant shortage across the service. We continue to advertise for short-term and long-term staff. Some outsourcing continues both for imaging and for reading of images. The Radiologist shortage accompanied by the MRT workforce issues provides a challenging environment in terms of meeting MoH targets.
General x-ray service (update to the above)	Sept 2016	**Waiting List of Patients for General X-ray** We continue to work through the general x-ray waiting list and have added in evening and weekend sessions. This has had a marked effect on the numbers. The demand for general x-ray is increasing to such a degree that without additional sessions we will find it very difficult to reduce the waiting lists. With the installation of a new Digital radiology room in MMH (installation Sept/October 2018) we will be able to make further inroads into reducing the number of patients waiting to be screened.

		
Histopathology Lab	March 2017	The CMH Board have approved the Histopathology Business Case to move the lab to the vacant area in the Ground Floor of the Galbraith Building. IANZ have been notified and have provisionally lifted the CAR. The Laboratory will continue to report progress to IANZ on a monthly basis and lack of progress according to the stated timeline will result in reinstatement of the CAR.
MRT FTE	Apr 2017	May vacancy rate has increased to 6.8FTE, and without additional recruitment we will creep back up to 8.00FTE vacancies by October. We have re-advertised overseas with good results for MRT staff; however MRI staff recruitment remains problematic. MRT staffing is a regional and national issue with other DHB's experiencing similar issues.

Food Service – Patient Satisfaction Report

Food Service is contracted to Compass and has oversight of patient and MOW aspects of food service at all CM Health facilities. The contract is almost three years into the 15 year national DHB/Compass food service contract with six DHBs participating.

Patient Survey and KPI reporting

The patient satisfaction survey response is a KPI in the Food Service Agreement, with a survey aiming for 150 responses per month carried out. In May 90 surveys were distributed with 65 patients responding along with 25 staff surveys being distributed and 24 completed. CM Health patient survey responses are from the post discharge Cemplicity survey with a variable monthly response rate

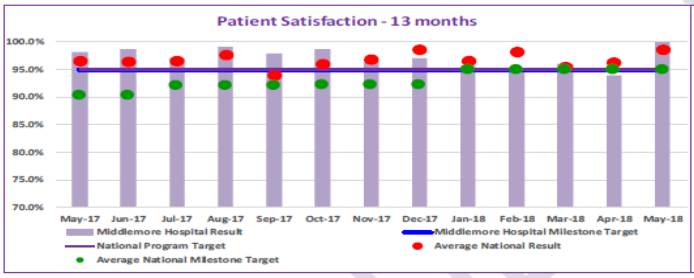
Compass KPI Reporting and Patient Satisfaction Results

Medirest Key Performance Indicators — **Monthly Sites**

Middlemore Hospital — May-18 — CMDHB

	Yes / No	Notes:
Tier 1		
Food Control Plan	Yes	
Safe Food and Beverages	Yes	

	Invitations	Responses	Satisfactory or Better	Result	Target	Response Rate	Result May-17
Tier 2							
Patient Satisfaction	90	65	65	100.0%	95.0%	72.2%	98.2%
Tier 3							
Customer Satisfaction	25	24	22	91.7%	90.0%	96.0%	100.0%
Meal Tray Accuracy	410	410	375	91.5%	95.0%	100.0%	95.4%
Tier 4							
Meal Substitutions				1	10		



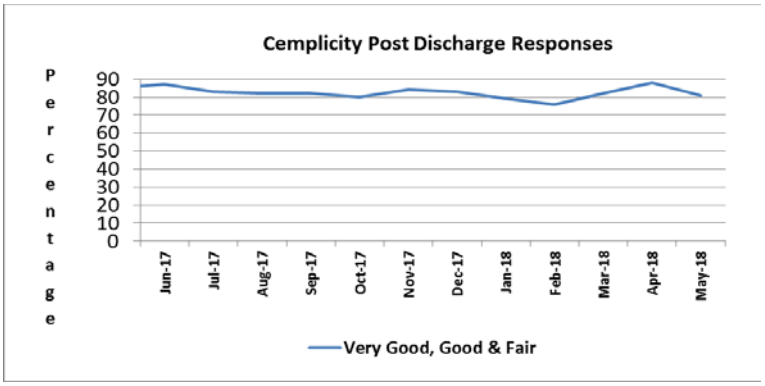
Notes / Issues / Actions

The responses for were great and they seemed happy to provide us with good and constructive feedback. We had some suggestions for some more Chinese food options which I have passed this on to our dietetics team. It was good to see at least two comments about how or vegans enjoyed their meals and felt the FSA could assist them with providing something they were happy with. Again awesome service is noted.

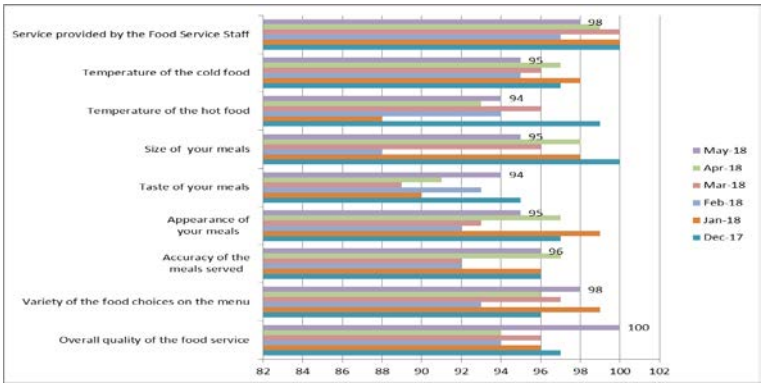
Compass patient satisfaction rate is 100% this month compared with 95.9% last month.

Complicity patient satisfaction rating this month is 88% compared with 82% in March

Complicity Survey Response

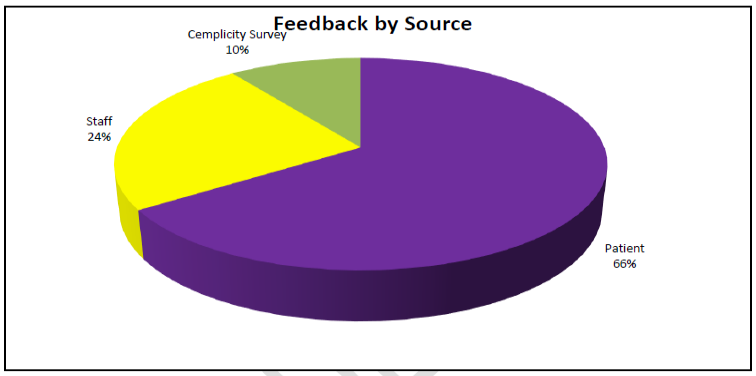


The Compass survey asks questions re the different elements of food service, these are reported in the chart below. The lower scoring element this month again was taste of food. There were 23 constructive verbatim comments from the survey responses.

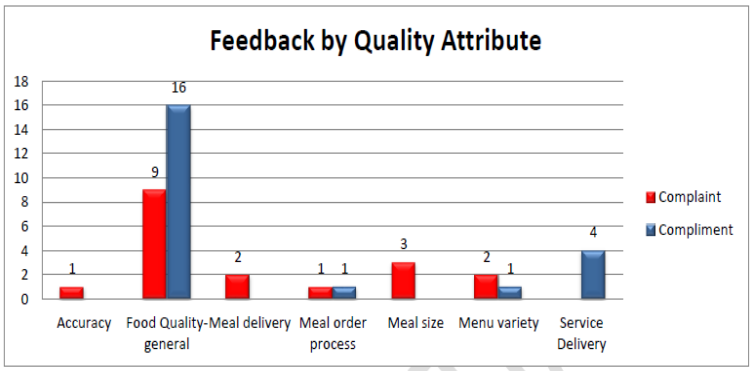


Middlemore Hospital Patient Feedback

Patient feedback from all sources including Risk Monitor, clinical staff, survey comments, issues reported directly to the kitchen. All items are categorised and placed in a feedback database. This is used as a basis for the quality improvement programme for the kitchen to target areas



The comments have been categorised to develop action plans where possible to address the issues.



May feedback has seen an increase in satisfaction with the taste of meals and temperature of hot food and overall increased levels of satisfaction.

Continuous Improvement

Compass Continuous Improvement plan has been developed from the feedback received over the last three months.

Continuous Improvement MMH

Description	Responsible	Complete
Temperature monitoring of meals at wards	BPOD's all calibrated during the month	May
FSA's ingredient and pronunciation training beginning June	Karen and supervisors	June
Quality controls of vegetables ensuring they are not to soggy	Karen and supervisor	End of May

Satellite Summary

Major focus for all the satellites was the Telarc audit at each site this month.

A food service meeting was held at Pukekohe to discuss and agree the new menu with unit staff prior to implementation.

CENTRAL CLINICAL SERVICES SCORECARD — May 2018

		Trend				12 month average			Rating	Commentary (by exception)
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years		**10.5%**	5.0%	-5.5%	**9.6%**	5.0%	-4.6%		Services continue to work with staff with high leave balances.
	% Staff Turnover		**2.8%**	10%	7%	**3.0%**	10%	7%		
		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Safety	% electronic medication reconciliation completed for high risk patients within 48hrs		**79%**	80%	-1%	**78%**	80%	-2%		Very close to target now despite some staffing shortages.
		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Timely	% MRI scans completed within 6 weeks from acceptance of referral		**34%**	85%	-51%	**44%**	85%	-41%		Demand >for acute MRI. Recruiting ongoing, casual staff used. Outsourcing temporarily increased.
	% CT scans completed within 6 weeks from acceptance of referral		**90%**	95%	-5%	**90%**	95%	-5%		Demand increasing, evening sessions implemented. Improving from last month with the additional sessions. Slight decrease in productivity last month with the installation of the new CT scanner at Building 58.
	Radiology - Inpatient radiology times < 24hours		**88%**	95%	-7%	**89%**	95%	-6%		Capacity increasing with new MRT staff on board. New DR room to be installed +- Sept/Oct will increase throughput.
	Radiology ED radiology times < 2 hours		**90%**	95%	-5%	**92%**	95%	-3%		Orderly timings remain an issue - work in hand. New electronic orders has resulted in more accurate reporting of turnaround times which is showing longer times for provision of CT. Process improvement work ongoing.
	Laboratory -Test turnaround time (TAT) within 60mins									
	Potassium		**98%**	90%	8%	**98%**	90%	8%		
	Haemoglobin		**95%**	98%	-3%	**98%**	98%	0%		
	PT/INR		**96%**	98%	-2%	**97%**	98%	-1%		Slight drop with specimens travelling back from MSC with new lab operating approach. Expected to return to normal.
	Troponin 1 for ED		**96%**	90%	6%	**95%**	90%	5%		
	Histology - All - 5 working days		**76%**	90%	-14%	**86%**	90%	-4%		Changing the number format for order numbering and impact of this is unknown until a full month of data. Recent resignation of one staff member may have a future impact as advertising has been unsuccessful
	Breast - 3 working days		**94%**	80%	14%	**96%**	80%	16%		
	Non gynae FNAs - 3 working days		**94%**	90%	4%	**91%**	90%	1%		
	Blood Bank - antibody screen within 4 hours		**95%**	90%	5%	**95%**	90%	5%		
	Microbiology									
	CSF cell count <30mins		**97%**	90%	7%	**94%**	90%	4%		
	ESBL screens <2days		**95%**	95%	0%	**94%**	95%	-1%		on track this month
	CDT (C. diff Toxin) <25hrs		**97%**	90%	7%	**93%**	90%	3%		
	UCHM (Urine Chemistry) <60mins		**93%**	90%	3%	**94%**	90%	4%		
	% radiology results reported within 24 hours		**50%**	75%	-25%	**50%**	75%	-25%		Radiology continues to work on reducing the number of unreported films. Currently have 7 FTE down on parental leave, recruiting for locums.
		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
System Integration (Effective)	% transcribed clinical summaries (meddocs) authorised <7 days of creation		**65%**	95%	-30%	**66%**	95%	-29%		Ongoing communication with services and clinical leads to improve. The high workload for transcriptionists and delayed turnaround for dictation is potentially having a further impact.

Women's Health and Kidz First

May 2018

Glossary

ALOS	Average Length of Stay
CLAB	Central Line Associated Bacteraemia
CS	Caesarean Section
DNA	Did Not Attend
ED	Emergency Department
ESPI	Elective Services Patient Flow Indicators
HCA	Health Care Assistant
KF	Kidz First
LMC	Lead Maternity Carer
MoH	Ministry of Health
MQSP	Maternity Quality and Safety Programme
NHPPD	Nursing Hours Per Patient Day
SUDI	Sudden Unexplained Death of Infant
VIP	Violence Intervention Programme
YTD	Year to Date
WH	Women's Health

Service Overview

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

Highlights

Following the very mild and lower volume 16/17 winter, we anticipated the 17/18 winter period to return to more usual winter volumes and therefore set the WIES contracted volumes on 15/16 actuals. The 17/18 WIES based on 15/16 actuals and remains down by 397 YTD due to another mild 2017 winter. YTD May there are in fact 36 more discharges then the previous year but WIES remains lower as 15/16 actuals were used. Paediatric ED attendances in May were up by 3%, YTD May 2018 also remain up on May 2017 by 1102 (almost 5%). In contrast, Paediatric discharges are only up by 1%.

Based on core volumes only, the Neonatal Unit has 4 fewer discharges YTD; WIES however are up by 163 WIES. Discharges under WH for Secondary Neonates (i.e. Neonates transferred from Neonatal Unit to maternity) is up by 138 discharges (56 WIES) YTD. Occupancy and acuity in May in the Neonatal Unit remain high. The combined Kidz First and WH neonatal discharges and WIES are up by 134 discharges and 216 WIES YTD excluding non-core activities. However, when all activities (both core and non-core) are included, NNU volumes are 198 discharges and 256 WIES up May 2018 YTD.

N.B. Core-only volumes are used on the scorecard (excluding non-core volumes i.e. ACC, non-resident chargeable, private), the actual volumes delivered when adding back the 'ineligible patients' are mentioned in the comment sections on the scorecard.

With the Unit reaching capacity frequently we have seen an increase in babies moving to the postnatal floor and being discharged from there. In addition, since March 2018 we have commenced using Kidz First Medical C-Pod for lower acuity level 2 Neonates. On average 4 babies and their mothers are accommodated. Resource nurses on Kidz First Medical have developed a Resource Board on C Pod to provide education to the staff on caring for these neonates and provide support to the nurses when required.

There were 544 births at MMH and 73 at the community units, a total of 617 births for May 2018, which is up by 26 compared to last year May. Births for May for the primary birthing units are 15 up on May 2017, YTD they continue to be down by 49. MMH births YTD are up by 194. YTD overall births are up 2% which is the first time in 5 years that the birth rate has increased by more than 1%. Occupancy for postnatal stay at the Primary Birthing Units (in particular Botany and Papakura) remains high reflecting the utilisation of the Units for women transferring from MMH after birth to the Units.

The increasing acuity and complexity in maternity (YTD Caesarean Section rate up by 2% and Induction of Labour rate up by 1%) combined with the additional neonatal workload is resulting in more midwifery workforce being required than budgeted. Fortunately, the availability of bureau staff has been good over the past 3 months as well as the commencement of the new graduate midwives (20) and the very end of April but we still needed to allocate significant overtime hours as well to support the new graduate midwives during their orientation. Staff sickness in Women's Health continues to be higher than previous year reflecting the pressure on the workforce due to vacancies and increasing acuity particularly in the Birthing and Assessment area.

Nursing and Midwifery Awards

Kidz First and Women's Health staff were recognised in the Nursing and Midwifery awards held on 10 May 2018. These awards included the Esme Green Nursing Professional Development Scholarship, Most Valuable Preceptor Award, Excellence in Clinical Practice Award, Leadership Award and Patient Care Award. The Women's Health Service Award went to the Maternity Ward Living our Values Project and the Kidz First Service Award went to the Neonatal Unit recognising the extraordinary efforts from staff in both these areas.

Newborn Hearing National Screening Programme

Counties Manukau Health hosted the first North Island newborn hearing screening education day which was previously organised as a regional meeting. Eighty screeners representing 10 District Health Boards (DHBs) joined together for a day of sharing, learning and robust debate about the Newborn Hearing National Screening Programme. Presenters from the Ministry of Health, local DHBs and Hearing House (regional service provider for cochlear implant programme) all presented separately before the experts formed a panel for a question and answer session.

Update on previously reported issues

Issue	Date first reported	Update
Neonatal Unit capacity	April 2016	• Occupancy for May 2018 was 91% (we increased our resourced cots to 36 and also transferred more babies to Kidz First as per aforementioned). Regional multidisciplinary meeting (including Neonatologist, Obstetricians and Planning

		and Funding) continue with the last meeting on May 2018 preparing a Regional Neonatal Service Visioning statement and Key principles for the regional CEO/CMO/Planning and Funding forum. Once signed off this will then form the base for more detailed regional capacity planning. This work will be combined with the anticipated national work on definitions of levels of care in neonatal units and the MoH's new work on national neonatal cot capacity as most of the country's units are now reporting significant capacity issues. • Locally, we are also working with the nursing leadership, HR and the NZNO on rostering, recruitment and Unit morale issues identified. • The ongoing neonatal unit demand will be entered on the organisational Risk Register as well.
Caesarean Section (CS)rate	January 2017	CS rate for May 2018 was 26 %, YTD the rate is 28% (2% up on last year). The CS rate and processes are reviewed routinely with the clinical team. As shown in the table below acute C-section minutes are up by 12.9% this is offset by a reduction in the elective C-section rates.

Caesarean Section Interventions

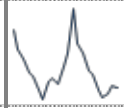
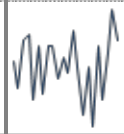
	Financial Year	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Trend
Caesarean Section - emergency	Theatre Interventions	1,237	1,182	1,177	1,168	1,342	1,501	
	Theatre Minutes	96,376	97,245	97,322	97,553	117,355	132,495	
Caesarean Section - elective	Theatre Interventions	504	492	502	499	565	261	
	Theatre Minutes	46,958	49,139	51,818	51,874	59,638	27,293	
Total	Theatre Interventions	1,741	1,674	1,679	1,667	1,907	1,762	
	Theatre Minutes	143,334	146,384	149,140	149,427	176,993	159,788	

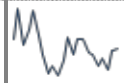
	Annual growth rate		12/13-13/14	13/14-14/15	14/15-15/16	15/16-16/17	16/17-17/18
Caesarean Section - emergency	Theatre Interventions		-4.4%	-0.4%	-0.8%	14.9%	11.8%
	Theatre Minutes		0.9%	0.1%	0.2%	20.3%	12.9%
Caesarean Section - elective	Theatre Interventions		-2.4%	2.0%	-0.6%	13.2%	-53.8%
	Theatre Minutes		4.6%	5.5%	0.1%	15.0%	-54.2%
Total	Theatre Interventions		-3.8%	0.3%	-0.7%	14.4%	-7.6%
	Theatre Minutes		2.1%	1.9%	0.2%	18.4%	-9.7%

Midwifery workforce	January 2017	• In anticipation for the 18/19 budget we have reviewed the midwifery ratios required for our current workload and complexity which amounts to 12 FTE additional midwives as well as 4 HCAs across MMH and the 3 Units. A budget bid for these resources was submitted and ELT has approved an additional 10.14 FTE to address the immediate pressure in Birthing and Assessment. • In addition, a midwifery workforce planning meeting with the Chief Nurse/Midwifery, DoHS, CMO and the Women's Health clinical and operational management team has been set up in May to develop a longer term strategic maternity workforce plan taking into account the now endorsed MERAS Midwifery Staffing Standards, national workforce predictions and DHB growth projections. This will be combined with an overall maternity bed capacity review as well.
MCIS	April 2017	Update May 2018: • The Ministry of Health (MoH) has a set up new P300 (i.e. 300 outstanding issues) project to work with early adopter DHBs and Clevermed on all these outstanding MCIS issues. First workshops are now scheduled for 6 and 7 June 2018. Four CM Health representatives will be attending (including CD,

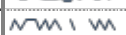
		Service manager, Specialist Midwife and Systems Administrator from Clinical Information Services). • Clevermed also declined the MCIS-Portal 8 link which has now been done internally by hA and the MCIS Clinical Information Services support team.
Eligibility Coding impacting on core volumes	March 2018	Since iPIM upgrade at the end of Sept 2017, significant issues have inadvertently been occurring with the exclusion of the 'ineligible patients'. Although we understand the need for the organisation to report these volumes differently, from an actual workload point of view Kidz First and Women's Health have delivered the services and used workforce and bed capacity for these patients. Not including them is significantly understating the overall discharges and WIES particularly in maternity. For KF and WH divisions, volumes relate to 2471 cases / entries May 2018 YTD are excluded from reporting for Inpatient activities in addition to 3673 cases / entries for outpatient activities May 2018 YTD. Potential IDF exposures are a maximum of $41,777 for outpatient and $414,123 for inpatient as of May 2018 YTD. We are working to identify a way of addressing this problem.

KIDZ FIRST SCORECARD — May 2018

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Acute Caseweight - Paediatric Medicine Inpatients		**204**	247	-17%	**2608**	2990	-13%		Lower average WIES, and volumes not at 15/16 level YTD 16 - non-resident chargeable & overseas-eligible check pending. **Overall WIES is 2617**
	Acute Caseweight - Emergency Medicine - ED		**79**	74	7%	**746**	798	-7%		Lower average WIES, and volumes not at 15/16 level
	Acute Caseweight - Inpatient Paediatric Intensive Care Unit		**2**	3	-33%	**18**	28	-36%		small numbers & variances
	Acute Caseweight -Secondary Neonatal Unit		**210**	161	30%	**1900**	1737	9%		non-resident chargeable & overseas-eligible check pending. **Overall WIES is 1942**
	Acute Caseweight - Paed Surg - accounted under Adult Surgery		**108**	164	-34%	**1516**	1605	-6%		non-resident chargeable & overseas-eligible check pending. **Overall WIES is 1573**
	Elective Caseweight - Paed Surg - accounted under Adult Surgery		**72**	94	-23%	**813**	942	-14%		non-resident chargeable & overseas-eligible check pending. **Overall WIES is 881**
	Total Discharges - Paediatric Medicine Inpatients		**407**	470	-13%	**4692**	4656	1%		non-resident chargeable & overseas-eligible check pending. **Overall discharges are 4705**
	Total Discharges - Emergency Medicine - ED		**273**	273	0%	**2700**	2765	-2%		small variances
	Total Discharges - Inpatient Paediatric Intensive Care Unit		**2**	1	100%	**20**	23	-13%		Small numbers
	Total Discharges - Secondary Neonatal Unit		**33**	33	0%	**337**	341	-1%		Small decrease in discharges YTD, but 10% increase from WH (postnatal floor) non-resident chargeable & overseas-eligible check pending. **Overall discharges are 346**
	Total Discharges- Acute Paed Surg - accounted under Adult Surgery		**130**	193	-33%	**1809**	1825	-1%		non-resident chargeable & overseas-eligible check pending. **Overall discharges are 1833**
	Total Discharges- Elective Paed Surg - accounted under Adult Surgery		**135**	165	-18%	**1311**	1351	-3%		non-resident chargeable & overseas-eligible check pending. **Overall discharge is 1418**
	ED attendances		**2056**	2003	3%	**23015**	21913	5%		Demand in ED remains high
	Paed Medicine - 1st Attendance		**172**	222	-23%	**1845**	2139	-14%		off set by increase in VFSA non-resident chargeable & overseas-eligible check pending. **Overall FSA is 2158.**
	Paed Medicine - Subsequent Attendance		**410**	352	16%	**3635**	3394	7%		non-resident chargeable & overseas-eligible check pending. **Overall follow up is 3667**

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Non-Contact FSA - Any Medical specialty -- Paed Medicine		**53**	50	6%	**512**	482	6%		continue to focus on Virtual FSA non-resident chargeable & overseas-eligible check pending. **Overall count is 586**
	Non contact Follow Up - Any health specialty - Medical		**17**	0		**143**	0			Introducing new measure non-resident chargeable & overseas-eligible check pending. **Overall count is 147**
	Budgeted FTEs		**310**	288	-8%	**301**	289	-4%		impacts from RMO /SHO change over and stat days over Easter and anzac day
	Operating Costs ($000)		**$282**	$353	20%	**$3,832**	$3,862	1%		High acuity and complexity in NNU
	Personnel Costs ($000)		**$2,639**	$2,595	-2%	**$27,435**	$27,399	0%		Vacancies in neonatal unit
	Financial Result Total ($000)		**-$2,635**	-$2,760	5%	**-$27,988**	-$29,195	4%		Additional revenues
	Reduce Clinical Outsourcing ($000)		**$5**	$7	29%	**$67**	$72	7%		Offset against revenues

		Trend				12 month average			Rating	Commentary (by exception)
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years		**14.8%**	5.0%	-9.8%	**15.7%**	5.0%	-10.7%		Decreasing Trend
	% Staff Turnover		**9.9%**	10.0%	0.1%	**9.1%**	10.0%	0.9%		
	% Sick leave		**3.1%**	2.8%	-0.3%	**3.2%**	2.8%	-0.4%		Sick leave high across all areas
	Workplace injuries recorded per 1,000,000 hours		**0.0**	10.5	10.5	**14.5**	10.5	-4.0		No issues identified from H&S quarterly report

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)	Neonatal Rate of medication errors/1000 bed days per month		**1.0%**	4%	2.6%	**4%**	3.2%	-1.2%		small numbers
	Neonatal Care CLAB rate per 1000 line days per month		**0.0**	0.0	0.0	N/A	N/A	N/A		
	CLAB insertion bundle compliance - NNU		**100%**	100%	0%	**95%**	100%	-5%		
	CLAB prevention maintenance bundle compliance- NNU		**88%**	90%	-3%	**91%**	90%	1%		
	Emergency trolley checks (compliance with checking)		**86%**	100%	-14%	**N/A**	N/A	N/A		No data for NNU
	Hand hygiene (compliance with checking)		**90%**	80%	10%	**N/A**	N/A	N/A		
	Safe sleep - audits compliance		**86%**	100%	-14%	**N/A**	N/A	N/A		
	Health and Safety Environmental Audit (Bi-monthly)		**100%**	100%	0%	**N/A**	N/A	N/A		
	Violence Intervention Programme (VIP) Screening		**64%**	80%	-16%	**66%**	N/A	N/A		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Timely	ED 6 hour target - National Health target (Kidz First ED) - Initial speciality		**96%**	95%	1%	**96%**	95%	1%		
	ESPI 2 - No. waiting >4 months for FSA - Elective		**0.0**	0.0	0.0	**0.0**	0.0	0.0		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	LY Act	Var	Actual	YTD*	Var		
System Integration (Effective)	Admission Rate Babies in the first year of life (Total)		**23%**	21%	-2%	**21%**	21%	0%		
	Admission Rate Babies in the first year of life (Maaori)		**28%**	25%	-3%	**25%**	25%	0%		
	Admission Rate Babies in the first year of life (Pacific)		**32%**	29%	-3%	**28%**	28%	0%		
	ALOS (raw)- Kidz First - Surgical - Surgical Floor		**2.19**	2.25	0.1	**1.91**	2.10	0.2		
	ALOS (raw)- Kidz First Medicine - Kidz First Wards		**2.52**	2.78	0.3	**2.64**	2.70	0.1		
	ALOS (raw)- Kidz First Medicine - ED Short Stay (hrs)		**4.77**	4.17	-0.6	**4.48**	4.26	-0.2		small variance
	ALOS (raw) - Kidz First - Neonatal		**31.5**	18.7	-12.8	**22.7**	21.1	-1.6		reflecting acuity

		Trend				Year			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Efficient	Outpatient DNA - FSA		**9%**	7%	-2%	**10%**	10%	0%		
	Outpatient DNA - Follow up		**9%**	11%	2%	**10%**	12%	2%		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
P&WCC	Patient experience survey v good/excellent- month (n=7) YTD (n=65)		**86%**	76%	10%	**77%**	76%	1%		

NOTES

LY Act - Last year actuals

^FY17-18 - fiscal year 2017 and fiscal year 2018

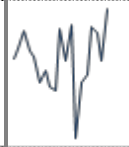
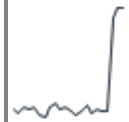
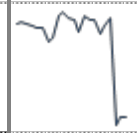
Target delivered.

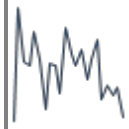
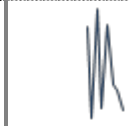
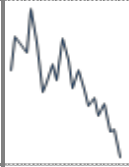
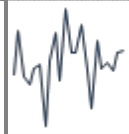
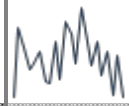
Target NOT delivered, remedial plan in place to reach target by end of fiscal year, and plan is monitored. GM to enter commentary.

Target NOT delivered without plan.

WOMEN'S HEALTH SCORECARD

May 2018

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Acute Caseweight - Gynaecology Inpatients- acute		**152**	127	20%	**1626**	1368	19%		High acuity, volume increasing - non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Overall WIES is 1634**
	Acute Caseweight - Secondary Neonatal Womens health		**91**	133	-32%	**1451**	1433	1%		Reflecting those babies progressing from neonatal unit non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Overall WIES is 1484**
	Acute RVU - Inpatient maternity care primary maternity facility (one month in arrear)		**685**	708	-3%	**6950**	7176	-3%		non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Overall RVU should be 7404**
	Acute Caseweight - Women's Health secondary		**419**	640	-35%	**5713**	6397	-11%		non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Overall WIES is 6573**
	Elective Caseweight - Gynaecology Inpatients - elective		**103**	148	-30%	**1173**	1424	-18%		Theatre and Anaesthetics impacts non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Overall WIES is 1174**
	Hysteroscopy		**32**	23	39%	**207**	220	-6%		catch up plan in place
	Total Discharges - Gynaecology Inpatients- acute		**274**	269	2%	**2904**	2757	5%		Significant increase non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Overall discharges are 2915**
	Total Discharges - Secondary Neonatal Womens health		**164**	174	-6%	**1872**	1733	8%		non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Overall discharges are 1926**
	Total Discharges - Inpatient maternity care primary maternity facility (one month in arrear)		**671**	601	12%	**6697**	6449	4%		non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Overall discharges are 7039**
	Total Discharges - Women's Health secondary		**938**	1210	-22%	**12040**	13147	-8%		non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Overall discharges are 13466**
	Total Discharges - Gynaecology Inpatients - elective		**111**	129	-14%	**1173**	1335	-12%		Theatre and Anaesthetics impacts

		Trend				Year to date			Rating	
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Gynaecology - 1st Attendance		**227**	276	-18%	**2476**	2660	-7%		Offset by virtual FSA non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Total outpatients is 2531**
	Non-Contact FSA Gynae Virtual		**116**	45	158%	**721**	482	50%		non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Total outpatients is 751**
	Non-Contact FSA Maternity		**127**	34	274%	**1201**	330	264%		New from March 2017, reflecting ability to VFSA in MCIS. non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Total outpatients is 1315**
	First Obstetric Consults S/B Doctors		**293**	297	-1%	**2876**	2864	0%		non-resident chargeable & overseas-eligible check pending. Takes 3 mths for eligibility status to be confirmed. **Total outpatients is 3080**
	DHB non-specialist antenatal consults		**917**	1488	-38%	**10597**	16085	-34%		Volumes similar to last year's actual. non-resident chargeable & overseas eligible checking pending. Takes 3 mths for eligibility status to be confirmed. In addition, Not including antenatal visits while inpatient at CMDHB facilities. **Total volume is 13055**(19% down not 34%)
	Gynaecology - Subsequent Attendance		**315**	285	11%	**3003**	2752	9%		non-resident chargeable & overseas eligible checking pending. Takes 3 mths for eligibility status to be confirmed. In addition, Not including antenatal visits while inpatient at CMDHB facilities. **Total volume is 3017**
	Subsequent Obstetric Consults F/U S/B Doctors		**246**	276	-11%	**2558**	2660	-4%		non-resident chargeable & overseas eligible check pending. 3 mths for eligibility to be confirmed. **Total volume is 2750**
	DHB non-specialist postnatal consults		**1160**	1306	-11%	**12,353**	14114	-12%		Not including postnatal visits while inpatient at CMDHB facilities
	Budgeted FTEs		**385**	356	-8%	**369**	356	-4%		Processing of Stat days in lieu completed for Easterstat days.
	Operating Costs ($000)		**$506**	$468	-8%	**$5,480**	$5,142	-7%		High bureau usage, due to midwifery vacancies & sick leave and high clinical supply usage - due to high C-section and inductions
	Personnel Costs ($000)		**$3,055**	$3,171	4%	**$33,078**	$32,987	0%		Midwifery vacancies
	Financial Result Total ($000)		**-$3,499**	-$3,572	2%	**-$37,751**	-$37,382	-1%		High sick leave and high use of bureau staff due Midwifery vacancies
	Reduce Clinical Outsourcing ($000)		**$13**	$6	-117%	**$138**	$60	-130%		High bureau usage, due to midwifery vacancies and sick leave, MDES expenses offset against maternity review board funding

		Trend				12 month average			Rating	Commentary (by exception)
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years - (one month in arrear)		**20.5%**	5.0%	-15.5%	**20.4%**	5.0%	-15.4%		Remaining midwifery vacancies
	% Staff Turnover - (one month in arrear)		**10.1%**	10.0%	-0.1%	**10.9%**	10.0%	-0.9%		Decreasing Trend
	% Sick leave - (one month in arrears)		**3.3%**	2.8%	-0.5%	**3.2%**	2.8%	-0.4%		sick leave remains high - Several Long Term
	Workplace injuries recorded per 1,000,000 hours - (one		**0.00**	10.5	10.5	**3.5**	10.5	7.0		No concerns raised
		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)	Emergency trolley checks (days checked) per month		**76%**	100%	-24%	**N/A**	N/A	N/A		No data for Maternity South, Pukekohe Birthing Unit
	Hand hygiene (compliance with checks) per month		**82%**	80%	2%	**N/A**	N/A	N/A		No data Maternity North and South, B&A, Pukekohe and Botany Downs
	Safe Sleep audits compliance		**99%**	100%	-1%	**N/A**	N/A	N/A		
	Health and Safety Environmental Audit (bi-monthly)		**100%**	100%		**N/A**	N/A	N/A		
	Violence Intervention Programme (VIP) Screening		**57%**	80%		**69%**	N/A	N/A		
		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Timely	ED 6 hour target - National Health target (Gynae)		**87%**	95%	-9%	**83%**	95%	-12%		small numbers
	ESPI 2 - No. waiting >4 months for FSA - Elective		**0.0**	0.0	0.0	**0.0**	0.0	0.0		
	ESPI 5 - No. waiting > 4 months for treatment - Elective		**5.0**	0.0	5.0	**198.0**	0.0	198.0		
		Trend				Year			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
System Integration (Effective)	% transcribed clinic letters authorised <7 days created		**77%**	95%	-19%	**83%**	95%	-12%		
	ALOS Women's Health - babies (WNB and Neonates)		**2.50**	3.20	0.70	**3.10**	3.30	0.20		Increasing trend reflecting Neonatal demand
	Average Length of Stay Gynaecology - Middlemore		**1.78**	1.83	0.05	**1.71**	1.57	-0.14		reflecting Acuity and complexity
	Average Length of Stay Gynaecology - MSC Inpatients		**0.95**	0.81	-0.14	**0.87**	0.70	-0.17		Small variances across ALOS measures
	Average Length of Stay Obstetric (DHB Mat) (1 month in arrear)		**2.33**	2.16	0.17	**2.37**	2.34	0.03		Small variances across ALOS measures
	Average Length of Stay Obstetric (Ind. Mat) (1 month in arrear)		**2.22**	2.21	0.01	**2.27**	2.26	0.01		Small variances across ALOS measures
	Average Length of Stay Vaginal Deliveries overall		**2.21**	2.03	0.18	**2.16**	2.07	0.09		
	Maaori - 1st time mothers		**3.25**	2.10	1.15	**2.66**	2.54	0.12		
	Pacific - 1st time mothers		**3.49**	3.03	0.46	**3.22**	2.75	0.47		

		Trend				Year			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Efficient	FSA / Follow up ratio - Gynae		1:1.39	1:1		1:1.21	1:1			small variances
	DNA - Midwifery Antenatal clinics - First		**10%**	11%	1%	**14%**	14%	0%		Monitoring DNA Rate
	DNA - Midwifery Antenatal clinic - Follow up		**14%**	12%	-2%	**13%**	13%	0%		
	DNA - Doctor Antenatal clinics- FSA		**8%**	13%	5%	**11%**	13%	2%		
	DNA - Doctor Antenatal clinics - Follow up		**12%**	11%	-1%	**12%**	11%	-1%		
		Trend				Year			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	YTD*	Var		
	Outpatient DNA - Maaori (Gynae)		**17%**	13%	-4%	**13%**	10%	-3%		
	Outpatient DNA - Pacific (Gynae)		**14%**	15%	1%	**12%**	10%	-2%		
	Outpatient DNA - Maaori (Obst)		**23%**	21%	-2%	**22%**	10%	-12%		
	Outpatient DNA - Pacific (Obst)		**13%**	14%	1%	**15%**	10%	-5%		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
P&WCC	Patient experience survey v good/excellent- month (n=72), YTD (n=804)		**82%**	76%	6%	**79%**	76%	3%		Increased numbers due to Tablets being offered to women in antenatal ward

Target delivered.

Target NOT delivered, remedial plan in place to reach target by end of fiscal year, and plan is monitored. GM to enter commentary.

Target NOT delivered without plan.

Adult Rehabilitation and Health of Older People

May 2018

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
CGG	Clinical Governance Group
FLS	Fracture Liaison Service
HBSS	Home Based Support Services
IBC	Indicative Business Case
LOS	Length of Stay
MMH	Middlemore Hospital
SMMH	Safe Moving and Manual Handling
SMO	Senior Medical Officer
YTD	Year to Date

Service Overview

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

Highlight

Patient Moving and Handling

Implementation following the TROPHI assessed areas to commence focussed on 3 priority areas (safety culture, staff education and training, and equipment assessment), and identifying standardising processes organisationally where appropriate.

Specialised Rehabilitation Investment Project update

CM Health has yet to receive formal written notification from the Capital Investment Committee (CIC) regarding our Indicative Business Case submission in April 2018. Further to CMDHB Board and Northern Regional Governance Group approvals, a project group has been formed to progress to development of the Detailed Business Case (DBC).

Spinal Cord Injury Registry release first report

The first SCI Registry report was produced and released in May, 2018. It provides useful information that can be used to guide real improvements in care and outcomes for individuals with a spinal cord injury. The report can be found through this link: https://nzspinaltrust.org.nz/current-nzscir-statistics-and-information/

E-prescribing and e-vitals

E-prescribing has now been successfully implemented and is live across wards 4, 5, 23, 24 and 31. Additionally, E-vitals is now implemented across all ARHOP wards and the ASRU.

Challenges

ASRU Demand

High demand and occupancy of the 20 beds in ASRU with an additional 6 patients in acute spinal services and a request from private pay non-resident in US Samoa (more common in summer months) over May highlights the need for more inpatient and community capacity planning for these very medically and surgically complex patients' specialised rehabilitation needs. This is being included in the specialised rehabilitation centre service delivery planning over the next 3 years to inform the future capital investment.

Activity

ARHOP continues to exceed budgeted bed days YTD. We continue to see budgeted bed days exceed for ACE and Acute Stroke. Compared to April, there has been an increase in bed days for AT&R, Spinal and the Integrated Stroke Ward but a decrease in bed days for Stroke Rehab and ACE.

Update on Previously Reported Issues

Issue	Date reported	Update
Safe Moving and Manual Handling	06/06/2018	updates from Subgroups as follows - 1) Safety Culture * draft policy & procedure for patient handing & mobility being worked on * reviewing staff incidents process 2)Staff Education & Training * identified list of trainers, MOU pending * training/simulation room options being looked at * draft proposal with WDHB in pipeline for train our trainers, competency framework and course materials 3) Equipment assessment. * stocktake of equipment in initial wards this month * sourcing equipment gap analysis from TROPHI assessment data Work continues on the implementation project plan in relation to engagement of subgroups with the TROPHI assessed areas to commence improvement methodology focussed on the above 3 areas and identifying standardising processes organisationally where appropriate.

ADULT REHABILITATION AND HEALTH OF OLDER PEOPLE SCORECARD

May 2018

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Spinal Inpatient ACC Revenue ('000s)		$647	$572	13.1%	$7,044	$6,684	5.4%		
	Non-acute Rehabilitation ACC Revenue ('000s)		$372	$388	-4.0%	$4,239	$3,379	25.4%		Eight months, March '18 awaiting ACC approval
	Budgeted FTEs		525	481	-9.2%	511	481	-6.1%		Nursing personnel with additional beds opened in Ward 31 due to demand requirements
	Operating Costs ($000)		$4,307	$4,137	-4.1%	$45,790	$45,189	-1.3%		
	Personnel Costs ($000)		$3,464	$3,287	-5.4%	$35,646	$35,836	0.5%		
	Financial Result Total ($000)		$3,681	$3,587	-2.6%	$38,825	$38,911	0.2%		
	Reduce clinical outsourcing ($000)		$222	$302	26.4%	$2,962	$3,319	10.8%		
		Trend				12 month average			Rating	Commentary (by exception)
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years (1)		5.3%	5.0%	-0.3%	4.7%	5.0%	0.3%		
	% Staff Turnover (2)		10.6%	10.0%	-0.6%	12.4%	10.0%	-2.4%		down from previous month
	% Sick Leave (3)		3.0%	2.8%	-0.2%	3.0%	2.8%	-0.2%		
	Workplace Injury per 1,000,000 hours (4)		0.0	10.5	10.5	7.6	10.5	2.9		
		Trend				12 month average			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety	Falls - % of falls assessments done in first 6 hours (5)		77%	100%	-23%	93%	100%	-7%		Some consistency issues identified with migration to Care Compass
	Falls - % of Interventions completed		95%	100%	-5%	92%	100%	-8%		
	Pressure Injuries - % of assessments done in first 6 hours		89%	100%	-11%	95%	100%	-5%		CND to Follow Up with Wards <95%
	Pressure Injuries - % of interventions completed		96%	100%	-4%	91%	100%	-9%		
	% Over ride rate of Pyxis on AT&R wards (excludes Ward 31)		14%	15%	1%	17%	15%	-2%		
		Trend	Reporting in arrears			12 month average			Rating	Commentary (by exception)
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var		
Timely	% Acute Stroke Patients Transferred to Inpatient Rehab within 7 days		64%	80%	-16%	58%	80%	-22%		
	% Patients Referred to Community Stroke Rehab seen within 7 days		33%	60%	-27%	41%	80%	-39%		
		Trend	Reporting in arrears			12 month average			Rating	Commentary (by exception)
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var		
System Integration (Effective)	% Acute Stroke Patients Admitted to Organised Stroke Unit		86%	80%	6%	87%	80%	7%		
	% Eligible Patients Thromboylsed		15%	10%	5%	15%	8%	7%		
	Acute 7 Day Readmission Rate (excludes Stroke and ACE) - Current Month		4.6%	2.9%	-1.7%	3.9%	2.9%	-1.0%		
	Acute 28 Day Readmission Rate (excludes Stroke and ACE)		14.1%	11.0%	-3.1%	11.4%	11.0%	-0.4%		
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
	Number of Patients Seen by ED Geriatrics Service		57	50	7	57	50	7		
	% Patients Seen by ED Geriatrics discharge to Community (inc Respite and POAC)		63%	50%	13%	53%	50%	3%		
		Trend				Year			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Efficient	MMH % patients discharged to discharge lounge or home by 1100hrs		21%	32%	-11%	25%	32%	-7%		
		Trend	Reporting in arrears			12 month average			Rating	Commentary (by exception)
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var		
Equity	% Acute Stroke Patients Admitted to Organised Stroke Unit - Maori/Pacific		73%	80%	-7%	84%	80%	4%		
	% Acute Stroke Patients Transferred to IP Rehab within 7 days - Maori/Pacific		100%	80%	20%	58%	80%	-22%		
		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
P&WCC	Patient experience rated good or above - month (n=8) and YTD (n=174)		89%	90%	-1%	95%	90%	5%		

Mental Health & Addictions

May 2018

Glossary

AMHIU	Acute Mental Health Inpatient Unit
AWOLs	Absent Without Leave
CM Health	Counties Manukau Health
DASA	Dynamic Appraisal of Situational Aggression
FTE	Full Time Equivalent
HQSC	Health Quality & Safety Commission
MH&A	Mental Health & Addictions
MH	Mental Health
PSA	Public Service Association
QIP	Quality Improvement programme

Service Overview

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

Highlights

Governmental Inquiry into Mental Health & Addiction Services

The Minister of Health has identified mental health and addictions as one of four priorities for Health. In January the Government announced an inquiry into mental health and addiction. The aim of the inquiry is to:

- Identify unmet need
- Identify those groups of people for whom there is the greatest opportunity for prevention, early intervention, or a more effective response
- Recommend changes to create an integrated approach to responding effectively to need

We have welcomed the opportunity to engage with the inquiry team to reflect on the needs of the Counties Manukau population, our current service provision and our future focus on an integrated model of care. We have provided a written submission (included as Appendix One) which is intended to complement the breadth of information presented to the inquiry team during its visit to our DHB on 11th April. Our submission is deliberately brief with a view to focussing on what we consider to be the key priorities and accompanying actions to effect change and build a robust system capable of responding effectively to population need.

The two constants underpinning our identified priorities are (i) a truly joined-up, or integrated, system response to population need, and (ii) a holistic, whaanau-focussed, life-course approach to individuals and their families. There are enormous opportunities to make a significant difference in outcomes but we need to be bold and open to change, moving beyond traditional boundaries.

The priorities identified in this submission have been informed by the work to develop an integrated model of care for the Counties Manukau population. The priorities reflect the themes that have emerged from our co-design engagement and discussions within our organisation.

Community Mental Health Services Reconfiguration to support the Integrated Model of Care

As reported last month one of the four key areas within the Mental Health & Addiction (MH&A) Integration Agenda is the reconfiguration of our Community Mental Health teams. We are realigning our community MH specialist services and FTE with the CM Health localities - based on population needs and addressing equity.

We are progressing well through the important process of appointing to key leadership roles, and at the same time progressing all the other aspects of preparing Community Mental Health Services for its new journey.

N**ew Acute Mental Health Unit Progress Update**

Stage One

The clinical service has been given early access to the new building and staff training has begun. Early training has focussed on orientation to the new facility including understanding bedroom design and anti-ligature features. The focus is now moving to the clinical operations area. It is anticipated that the security system and the duress alarm system will be completed in mid-June. The flexible mode electronic system is also expected to be completed mid-June. An overview of these systems will be presented to staff while the service waits for the formal 'user acceptance training' from the providers of each system. This is likely to occur at the end of June or early July.

Scenario based training is being planned for the duress alarm system, flexible mode electronic system, fire evacuation, medical emergency and acute admission processes as soon as the systems become available. Because the dates are not known it has been challenging for the service to plan to release staff for training purposes while also running the service.

Most of the construction work is now focussed on the reception area, officers and support areas including the whare. This work is, we are told, nearing completion. The target for completion is end of June.

Stage Two

Ground work has commenced and the hoardings around the existing Tiaho Mai will be altered in June in preparation for the next stage of construction.

Safety for all: 'coercion-free' practice at Counties Manukau Mental Health Services.

Goal of Zero Seclusion 2020

Background

The use of coercion is a balance between depriving a person's autonomy and dignity and preventing endangerment of the body or health of self or others. Restrictive measures, such as personal restraint are implemented to managing highly challenging situations and should be used as a last resort in psychiatric inpatient care.

Behaviours of concern such as aggression in an inpatient setting require a response that is safe, fit for purpose, uses the appropriate response to level of aggression evident and should be used for the least amount of time as possible. Seclusion is the most extreme form of 'restrictive practice' utilised in acute inpatient mental health services.

The Mental Health (Compulsory Assessment and Treatment) Act 1992, is the legislation that outlines the Use of Force (S122B) and S 71 describes the use of seclusion. New Zealand Standards

(NZS8134.2:2008) defines restraint and clearly articulates that it must not be used as a routine measure and is a serious intervention of last resort.

The Counties Manukau Health Mental Health Response

The Health Quality and Safety Commission are embarking on a national campaign and quality improvement process to support a national stretch goal of Zero Seclusion by 2020.
https://www.hqsc.govt.nz/assets/Mental-Health-Addiction/Resources/Zero_seclusion_infographic_Mar_2018.pdf

CMH has a team progressing this initiative. Current Practice includes CMH mental health acute services utilise a safety first approach in adult acute inpatient mental health services by:

- an admission process that includes a focus on engagement and risk assessment and use of the Dynamic Appraisal of Situational Aggression (DASA) scale
- admission plans for people who have had a previous aggressive behaviours
- we utilise the regional behavioural management prescribing guidelines which help to support assertive clinical management
- there are weekly reviews of all incidents that involve aggression, restraint, seclusion and AWOLs.
- there are monthly liaison meetings with the Police and with the District Inspectors.
- Use of evidence based practices such as 6 Core Strategies© to support reducing all restrictive interventions
- utilising agreed staffing levels with the PSA
- rostering practices that include skill mix and gender appropriateness wherever possible

Next steps

- Establish a working group including: charge nurse managers, frontline nursing staff, clinical quality coordinator, cultural support, consumer and family whaanau advisors is now established to progress this campaign
- Commence PSA discussion
- The working group are participating in co-design master class workshops sponsored by the HQSC
- Utilisation of co-design stakeholder engagement methodology [i.e. including staff, service users, whanau and other stakeholders] to map the experience of seclusion and by working together to design solutions that will enable us to create an environment that is ***safe for all***; creates a place that enhances mana; is culturally safe and provides a holistic approach to support recovery and wellbeing.
- Training and engagement of all with the new Model of Care for the new Acute Mental Health Inpatient Unit (AMHIU).

Police Mental Health App

Development of a Police Mental Health App – this app explains the powers of the police to detain under the Mental Health Act and the role of the Duly Authorised Officer. It was re-written with assistance from Jeremy Stockton (Acting Clinical Charge Nurse) and Laurie Culpan (Police Liaison) to reflect the environment in which we work. The app has been rolled out to front line police staff and the feedback has been good.

E-Vitals Implementation in Ward 35 East Koropiko

E-Vitals have been successfully implemented on the ward and staff are being supported to gain in confidence in using this tool. This replaces the paper physical health recording sheet in favour of a

new system – Early Warning Signs. The ward has been provided with 10 new IPad and 2 mobile computers which have greatly assisted staff mobility and ease of access of the information and ensures service user information is confidential.

Suicide Prevention

Mental Health Promotion

During May there has been a consistent focus on mental health promotion using our mental health first aid program. We are continuing to be approached by community groups as well as promoting this program through our established networks.

Workforce Development

May has been focussed on continuing with our schools workforce development in collaboration with the Ministry of Education by upskilling school education staff, as well as a more focussed approach by delivering workshops to our school based health practitioners across the region.
Rural workforce development delivered to primary care in Franklin over two days and was supported with good attendance particularly in Waiuku.

HQSC MH&A Quality Improvement Programme Leadership Group - Consumer Representative

At the completion of a robust national recruitment process; Cassandra Laskey, Professional Leader Peer Support, Consumer and Family Whaanau Centred Care has been appointed to the role of Consumer representative on the MH&A Quality Improvement programme (QIP) Leadership Group. As described by the HQSC, the consumer representative will:

- Provide advice from a mental health and/or addiction consumer perspective, and be able to represent your own views from lived experience and represent the relevant views of your consumer community.
- Provide advice and review materials from the Commission's MHA programme, working collaboratively with other leadership group members, and other agencies when required.
- Promote the work of the Commission and the Mental Health and Addiction Quality Improvement Programme with local, regional and national consumer groups and health providers.
- Support and promote consumer leadership capability development in the health and disability sector.
- Provide strategic guidance and support to enhance collaboration between consumer groups, health providers and government agencies.

Cassandra is looking forward to working with the MH&A QIP Leadership Group and bringing a consumer perspective from CMH to this national programme.

MENTAL HEALTH SCORECARD

May 2018

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Overtime costs ($000)		$157	$149	-5.8%	$2,038	$1,638	-24.4%		High acute demand, off-set by community vacancies
	Budgeted FTEs		669	724	7.6%	674	709	4.9%		
	Operating Costs ($000)		$6,119	$5,989	-2.2%	$65,081	$66,090	1.5%		
	Personnel Costs ($000)		$5,466	$5,650	3.3%	$58,401	$62,355	6.3%		YTD arises from vacancies in the community and release of over-provision of long service leave provisions in March '18
	Financial Result Total ($000)		$6,059	$5,928	-2.2%	$65,370	$65,414	0.1%		

		Trend				12 month average			Rating	Commentary (by exception)
		FY1617-1718	Apr-18	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years		9.8%	5.0%	-4.8%	9.1%	5.0%	-4.1%		Managers are working with staff on individual plans to reduce annual leave 2 years
	% Staff Turnover		11.0%	10.0%	-1.0%	11.0%	10.0%	-1.0%		
	% Sick Leave		3.2%	2.8%	-0.4%	3.6%	2.8%	-0.8%		Sick leave reviews undertaken with staff with high sick leave
	Workplace Injury Per 1,000,000 hours		0.0	10.5	10.5	13.4	10.5	-2.9		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)	Number of Seclusion events/ 100,000		2.8	5.0	2.2	N/A	N/A	N/A		)
	Seclusion hours/ 100,000		54	50	-4	N/A	N/A	N/A		)All seclusion events are reviewed at the weekly risk review meeting
	Number of Clients Secluded/ 100,000		1.8	3.0	1.2	N/A	N/A	N/A		)

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Timely	Shorter wait times for non urgent mental health and addiction Services (%< 3 week wait) - 12 months rolling									
	0-19 years		70%	80%	-10.3%	N/A	N/A	N/A		Unique Clients seen has exceeded MOH Target by 1531
	20-64 years		83%	80%	3.3%	N/A	N/A	N/A		
	65+ years		86%	80%	5.6%	N/A	N/A	N/A		
	Shorter wait times for non urgent mental health and addiction Services (%< 8 week wait)- 12 months rolling									
	0-19 years		91%	95%	-4.1%	N/A	N/A	N/A		Unique Clients seen has exceeded MOH Target by 1531
	20-64 years		94%	95%	-0.7%	N/A	N/A	N/A		Unique Clients seen has exceeded MOH Target by 2831
	65+ years		96%	95%	1.0%	N/A	N/A	N/A		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
System Integration (Effective)	Access rate - Number of CM domiciled unique clients seen by all MH services ((PRIMHD reporting services include AOD and NGO services) 12 months as a % of population) - Total									
	0-19 years		4.1%	3.2%	1.0%	N/A	N/A	N/A		
	20-64 years		3.9%	3.2%	0.7%	N/A	N/A	N/A		
	65+ years		2.3%	2.6%	-0.3%	N/A	N/A	N/A		Meeting the wait time targets - no build-up of a waitlist
	Readmissions to Tiaho Mai within 28 days - Total (1 month in arrears)		13.1%	12.0%	-1.1%	7.8%	12.0%	4.2%		

		Trend				Year			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Efficient	Inpatient Occupancy - Tiaho Mai Acute Mental Health Unit		94%	85%	-9.1%	94%	85%	-9.2%		Signifies overcrowding
	Number of Tiaho Mai Inpatient LOS >35 days		8	10	2.0	10	10	-0.4		Some patients not responding to treatment & a number waiting for beds at Tamaki Oranga

		Trend				Year			Rating	Commentary (by exception)
		FY1617-1718	May-18	Target	Var	Actual	Target	Var		
Equity	Access rate - Number of CM domiciled unique clients seen by MH services (PRIMHD) 12 months as a % of population - Maori									
	0-19 years		6.2%	4.5%	1.8%	N/A	N/A	N/A		
	20-64 years		9.2%	7.7%	1.5%	N/A	N/A	N/A		
	65+ years		2.9%	2.6%	0.3%	N/A	N/A	N/A		

Appendix 1

Government inquiry into mental health and addiction

Written submission – 05 June 2018

To: **Professor Ron Paterson, Inquiry Chair, Government Inquiry into Mental Health and Addiction**

From: **Tess Ahern, General Manager, Mental Health and Addictions**
Dr Peter Watson, Clinical Director, Mental Health and Addictions
Anne Brebner, Clinical Nurse Director, Mental Health and Addictions

Date: **5th June 2018**

Re: **CM Health written submission to the Government inquiry into mental health and addiction**

Dear Ron,

We have welcomed the opportunity to engage with the inquiry team to reflect on the needs of the Counties Manukau population, our current service provision and our future focus on an integrated model of care. This written submission is intended to complement the breadth of information presented to the inquiry team during its visit to our DHB on 11th April. Our submission is deliberately brief with a view to focussing on what we consider to be the key priorities and accompanying actions to effect change and build a robust system capable of responding effectively to population need.

The two constants underpinning our identified priorities are (i) a truly joined-up, or integrated, system response to population need, and (ii) a holistic, whaanau-focussed, life-course approach to individuals and their families. There are enormous opportunities to make a significant difference in outcomes but we need to be bold and open to change, moving beyond traditional boundaries.

The priorities identified in this submission have been informed by the work to develop an integrated model of care for the Counties Manukau population. The priorities reflect the themes that have emerged from our co-design engagement and discussions within our organisation.

Yours sincerely,

Tess Ahern Peter Watson Anne Brebner

Priority considerations

1 HOLISTIC RESPONSE TO WELLBEING

1.1 Mental health and addictions models of care

New and improved models of care should be focussed on enhancing health outcomes and people's experience of care. Inclusion of cultural models and a 'customer care' focus will drive a shift away from a 'one size fits all' approach. New models need to enable a truly joined-up, or integrated, response across primary care, specialist services, the NGO sector and inter-sectorial partners. These new models must explicitly acknowledge Maaori as tangata whenua, the Treaty of Waitangi commitments, and the need to address Maaori mental health and addictions outcome disparities.

1.2 Joined-up mental health and addictions service provision

Recognising the prevalence of co-existing mental health and addiction needs, AOD and mental health clinical and non-clinical capability should be accessible from within the same service provision. This approach should acknowledge the factors that have led to a separation of services, ensuring that both specialty areas have the necessary on-going leadership and strategic development.

1.3 Enhanced primary care capability and capacity to address mental health and addictions

A clear expectation that primary healthcare provision includes mental health and addiction capability. Enhancing the capacity of primary care to provide this will require designated resourcing. Primary care should be providing (i) shared-care approaches to wellbeing for people with serious mental health and/or addiction issues who are also receiving care from specialist services and (ii) a range of approaches focussing on self-management, wellbeing and early intervention. An example of the latter is the CM Health Wellness Support model, which is a deliberate move away from a criteria, diagnosis, severity driven model of care, to a patient-centred model with primary care providing meaningful interventions, with support from a wider team.

1.4 Address population level determinants of wellbeing

Actions are required to address the wider socio-economic and environmental determinants of mental health and addiction problems, including poverty, homeless and inadequate housing, job stress, discrimination and unconscious bias, widespread access to cheap alcohol and a culture of hazardous alcohol use. Alcohol is frequently used to 'self-medicate' underlying psychological distress. Actions to address these determinants will require strong commitment and a long-term view.

2 FLEXIBLE FUNDING AND CONTRACTING ARRANGEMENTS

2.1 New commissioning and contracting arrangements

There is a need for a nationally consistent approach that establishes a new funding/pricing framework for the sector that focuses on (i) delivery of improved health outcomes, (ii) the necessary flexibility to meet local population need, and (iii) supports and enables the strategic direction of the sector.

2.2 Joined up funding for those with complex needs

Funding arrangements need to enable a 'system' (inter-sectorial) response to better meet an individual's needs, with joined-up funding streams. These joint funding streams would need a robust but flexible decision making process (potentially co-ordinated by a 'lead' sector/agency) that keeps the needs of the person at the centre. A system response to funding will recognise that it is increasingly common for some people to present with multiple needs, e.g. mental illness and intellectual disability, addiction and chronic physical conditions etc.

2.3 Addressing unintended funding consequences

Current arrangements for Community Treatment Orders, whereby individuals have their medication paid for whilst under the Act, have created a disincentive to remove people from under the Act if they are unable to fund their own prescription costs. Unintended consequences such as this need to be addressed and, if need be, funding allocated in a different way that supports enabling people's independence.

2.4 An equity approach to funding

Underlying need should be considered and accounted for in the distribution of mental health and addiction resources. For example, psychological distress, as measured in the New Zealand Health Survey, may offer a better proxy of 'need' than estimates based solely on service utilisation.

3 A FULLY RESOURCED AND CAPABLE WORKFORCE

3.1 Enhancing recruitment and retention

Initiatives that address the real and significant recruitment and retention challenges, ensuring better remuneration and conditions across the mental health and addictions sector, including a recognition of the high cost of housing in the Auckland region and the need for an Auckland-weighting or similar.

3.2 Workforce capability to reduce inequities

Greater efforts at supporting Maaori and Pacific into mental health and addictions tertiary training. In addition, a significantly greater emphasis on the entire sector workforce's cultural capability, recognising that an inability to understand and respond appropriately to the cultural beliefs and needs of individual's and their family/whaanau creates significant barriers to enabling wellbeing.

3.3 Workplace-based training

More opportunities for students in clinical training to gain mental health and addictions workplace-based experience. This will support recruitment into the mental health and addictions workforce and also increase capability across the broader health sector.

4 GREATER INVOLVEMENT AND EMPOWERMENT OF FAMILY/WHAANAU

4.1 Removing barriers for family/whaanau

As part of a holistic, life-course approach, there needs to be a greater recognition of the role and importance of family, including better enabling families to advocate on behalf of/represent adult children. To support this, consideration should be given to

a mandatory requirement that family/whaanau are given the opportunity to be involved in the support of people receiving mental health and addictions services (unless there are circumstances that make this counter-therapeutic, for example where there is family harm).

5 A TECHNOLOGY SMART SECTOR

5.1 Technology enabled workforce

Mental health and addictions staff need quality technology that is convenient and easy to use. A greater use of user-friendly technology will enable the workforce to be mobile. This will include providing consultation advice – both with service users and with other inter-sectorial partners within integrated models of care.

5.2 A comprehensive electronic healthcare record

Priority (and funding) to be given to the development of an integrated healthcare record – this will require a sector-wide commitment that puts aside individual organisational interests and costs already incurred in the development of disparate systems. People should be empowered in their self-management by having access to their healthcare records.

6 LIFE COURSE FOCUS

6.1 Investing in the early years

Increased resourcing for multi-agency, multi-sector evidence-based interventions that support the healthy development of New Zealand's children are required. This should have a focused approach on those populations experiencing the greatest adversity and disadvantage. Reducing accumulated life stressors will enable increased mental and emotional bandwidth for parents to support positive child development and future mental wellbeing.

In addition, increased (community, primary and specialist) service capability and capacity is required to intervene and respond to children and young presenting earlier in the course of mental health and addiction disorders, with dedicated resources to respond to the differing needs of each age group.

6.2 Supporting the aging population

The significant growth in the aging population requires further investment in approaches to address specific issues of the elderly (such as dementia) but also the high prevalence of co-morbid disorders that impact on wellbeing.

7 MENTAL HEALTH AND ADDICTION SECTOR QUALITY AND SAFETY

7.1 Re-establishment of the Mental Health Commission

The sector requires leadership that has ability to advocate on its behalf and whose voice carries the necessary weight. This leadership must be enabled to set the direction and approach for accelerating change, with a clear focus on policy and strategy. To do this, a mental health commission should be re-established with the mandate to set the direction for at least the next ten years. In addition to advocating for the sector, this re-established entity must have a strong service user, family/whaanau, and community voice.

7.2 Continued development of improvement initiatives

There should be a continued commitment to quality improvement programmes such as the work of the HQSC. To develop and maintain an ability to be fit for the future, the sector needs to be continually seeking to improve the quality of its response and its willingness to learn.

8 SUICIDE PREVENTION

8.1 Enhanced community responsiveness to distress

More efforts are required to enable communities to recognise people experiencing mental health distress. Communities require knowledge and skills that support responsiveness and capability to assist people who are experiencing suicidal thoughts and behaviours.

8.2 Enhanced Maaori suicide prevention efforts

Recognising the disparities for Maaori in the suicide statistics, greater efforts are required to address suicide prevention efforts in Maaori communities.

8.3 Strong action on alcohol

Evidence shows that when countries take strong action on alcohol, suicides are reduced. Evidence-based strategies include: increasing the price of alcohol; reducing the availability of alcohol; increasing the minimum legal purchase age; reducing alcohol advertising, promotion and sponsorship; appropriate labelling of alcoholic products, and ensuring equitable access to services for early intervention and addiction support.

9 MENTAL HEALTH PROMOTION

9.1 A comprehensive and coordinated approach to wellbeing promotion

The importance and value of the sector's ability to provide a 'medical' response, including providing diagnosis and treatment for disorders, must be maintained and not undermined through shortfalls in funding and resourcing. However, we need to broaden our approaches to enhance wellbeing. This wider approach to improving mental health and addiction outcomes in our communities requires looking beyond the individual to the needs of family/whaanau/communities and the wider determinants of wellbeing. To achieve this requires significant new investments in a comprehensive programme of sustainable mental health promotion activities. This should be considered as a greater priority for the Health Promotion Agency, and should complement local community activity and the work of mental health and addiction NGOs. Strong national leadership to coordinate mental health and AOD health promotion activities would be beneficial to ensure a co-ordinated, comprehensive approach that minimises duplication. [A nationally led, co-ordinated response to current efforts may negate the need for significant new investment.]

10 POPULATION-BASED DATA ON MENTAL HEALTH

10.1 Updated population-based survey of mental health

It is twelve years since the last comprehensive population-based survey examining the prevalence of mental illness in New Zealand was published (Te Rau Hinengaro;

2006. Note: data was collected in 2004). Through the New Zealand Health Survey with its 'clip on' methodology, there is an opportunity to run a mental health-focused module. This should enable sufficient explanatory power to examine lower prevalence conditions, and prevalence for Maaori, Pacific and Asian communities in a relatively cost-effective way.

Middlemore Central

May 2018

Glossary

CapPlan	Capacity Planning tool
CCDM	Care Capacity Demand Management
LPS	Life Preserving Services
MMC	Middlemore Central
SSHW	Safe Staffing Healthy Workplace

Service Overview
Middlemore central is managed by Dot McKeen (General Manager) with Dr David Hughes (Clinical Director). The Division is responsible for Daily Operations Unit, Bureau service, Transit Nurses, Discharge Lounge, Emergency Response and Non-Clinical Support Services (Cleaners, Orderlies, Security, Translators, and patient transport).

Highlights/ Key Events

Capacity and demand for the Division of Medicine exceeds the forecast however is offset by lower than forecast surgical services.

Contingency Planning for Industrial Action by NZNO

Contingency planning for potential industrial action is well underway working with Service Managers and Clinical Nurse Directors should the industrial action by the NZNO go ahead.

Service specific plans have been submitted to the National Coordinator as have plans for Life Preserving Services.

With a 98% membership rate for NZNO, we are taking the stance that all members will strike and basing our plans on that assumption when asking for LPS.

Winter Planning

Work has been undertaken over the last three months to prepare and agree on a Metro Winter Plan for the three Auckland region District Health Boards – Auckland, Waitemata and Counties Manukau Health.

The plans will cover daily regional reporting, Influenza preparation and agreed indicators of when escalation to Director of Hospital level may be required taking a regional operational stance.

Care Capacity Demand Management

The CCDM Council have completed two pieces of work for CEO sign off. The Standards of Assessment and the High Level Plan both have been submitted to ELT and approved.
A CCDM Coordinator has been appointed and starts on the 18th June 2018. The CCDM Council is now working on the annual plan and with unions to initiate work streams to progress the programme.

Bureau

While the organisation will endeavour to redeploy staff or use our own internal bureau staff first, where there has not been staff available, external bureau has had to be utilised. Bureau use appears all staff within CM Health, both permanent and casual bureau.

In May 15 Registered Nurses and 24 Health Care Assistants were employed for Bureau. An Induction day for these employees has taken place.

Duty Managers

Currently recruiting for 5 vacancies and 1 secondment out of the group of 12 Duty Managers which will impact on our ability to provide the Clinical Coordinator role on nights until replacements are recruited. Recruitment is currently being finalised however the service will be challenged for the next three months.

Discharge Lounge

Winter opening/closing hours for the Discharge Lounge is currently being finalised with the decision to open the Lounge on Saturdays only, the weekend discharges being so low. One RN has resigned and one remains on maternity leave. The staff member covering maternity leave has moved into the permanent role vacancy. The roster is currently being supported using Bureau staff.

Transit Care

Vacancies are being recruited with one FTE being used to provide support at night. In addition, one transit nurse has indicated she will be retiring. It is intended the support role at night will become part of the THAHT – The Hospital After Hours Team – being available for example, to escort and monitor patients after hours for invasive Radiology procedures, endoscopies and moving patients from Emergency Department. These have all required ward escorts previously if the Clinical Coordinator is busy.

Casual Clerical Staff

Recruitment for casual clerical staff is also underway in preparation for the winter volumes and sick leave cover.

Emergency Response

777/888 Emergency Number Change – The change took place on the 28th May 2018. No issues regarding the change have been identified. The organisational flip charts have been updated and will be distributed to services over the next week. The 888 number will remain operational for at least a year to allow for the change to occur smoothly.

Pandemic Stock presentations 5/4/18 - Suppliers had the opportunity to present a supply and storage system to the Northern Region. There is still no solution to this issue as the stock quantities are too great and suppliers do not want to commit. CMH & ADHB have funding ready to go, WDHB do not have the same preparations.

Chief Nurse and Director of Patient and Whaanau Experience

Prepared and submitted by Karyn Sangster, Deputy Chief Nurse on behalf of Jenny Parr, Chief Nurse and Director of Patient and Whaanau Experience, with updates provided by the Directorate including Nursing, Midwifery, Allied Health, Primary and Integrated Care, People and Professional Development and Clinical Training and Education Centre.

Highlights

The hospital continues to experience high demand for services. There are a number of contingencies in place to cope with the winter surge. Ward 21 opens for patients on 5 July for four months to provide 30 additional beds. Hospital in the Home has also started to receive patients. Both of these along with the System Level Measures programme to reduce hospital bed utilisation are planned to assist with winter workloads.

Our flu vaccination rates for staff remains below target with 69% of our workforce immunised this is the same level of vaccination achieved for 2017. Flu vaccination remains available for staffs who have not taken the opportunity.

We are preparing for industrial action from our nursing staff and working to ensure that we can maintain a safe level of reduced services.

The People and Professional Development Unit have submitted five applications for Health Workforce New Zealand additional funding for inter-professional education innovations. At this time expressions of interest have been requested. Fuller business cases will be requested if selected for the next stage.

Workforce

Nursing

Counties Manukau Health (CM Health) has committed to the goal 'Increase the size of our Māori and Pacific workforce to reflect the communities we serve by 2025'. To support the achievement of this goal, annualised workforce targets have been included in the 2017/18 Maaori and Pacific Health Plans and are monitored and reported on quarterly to the Maaori Health Advisory Committee, Manawhenua and the Board.

The Clinical Nurse Director (CND) Maaori and Maaori Nurse Educator have been working with the Nursing team to identify and address barriers to the recruitment of Maaori and Pacific Nursing Graduates through the New Entry to Practice (NETP) process – as less than 16% of Maaori, and 18% of Pacific Nursing Graduates are successful in gaining entry onto the NETP process – and by default employment - with CM Health. Recommendations from the CND Maaori and Nurse Educators have included:

1 stronger communication from Nursing Executive on workforce diversity at all levels of nursing
2 ensuring that all Maaori and Pacific Candidates are automatically short-listed to be interviewed
3 that a Maaori and or Pacific representative is on all recruitment panels
4 a requirement for hiring managers to document their rationale for not interviewing or hiring and Maaori or Pacific nursing graduate
5 analysis of recruitment patterns by hiring managers
6 improved HR and Recruitment training for Hiring Managers.

The CND Maaori, Maaori Nurse Educator and Deputy Chief Nurse have also been working with Manukau Institute of Technology (MIT) to build the supply of Maaori Nursing graduates. In April, MIT established an agreement with Te Whare Wananga o Awanuiarangi to offer the Bachelor of Health Science (Maaori Nursing) programme through its South Auckland Campus.

A project manager has been appointed to support the integration of the curriculum and the development of appropriate resources. MIT intend to launch the new qualification in February 2020. The addition of this qualification will provide a minimum of 75 more Maaori Nursing students (across the three years of the Bachelor's programme). Further opportunities to collaborate with MIT are being explored. A 2018/19 draft Maaori Nursing Workforce Development Plan has been developed and is undergoing consultation with the Nursing Executive team.

CM Health has recently changed its recruitment and interview processes to ensure that all Maaori and Pacifika applicants are short listed to interview. Panel interviews will include Maaori and/or Pacifika representatives on each panel. All applicants will be welcomed with a Whakatau at the start of the process.

We are working with MIT to improve the retention of Maaori students in the first year and supporting Health Workforce applications to increase the number of Maaori and Pacific enrolled nurses. A Maaori Nurse Educator works with MIT students to provide support in clinical placements.

A Care Capacity Demand Management (CCDM) programme initial agreement on working groups and council has been agreed. A Coordinator has been appointed to assist with on-going development of the programme.

NETP recruitment is currently underway with 24 positions for the hospital and nine for Mental Health identified.

Patient numbers attending the emergency department remain high along with hospital occupancy.

Community Nursing
Community Health Assistants are continuing training to support our short term services and re-enablement programmes within community health teams utilising our own workforce and ensuring multidisciplinary team care remains a focus.

Recruitment is underway to fill a fixed term position for a Nurse Specialist Youth Health – one of the current team has taken a secondment to work with the Advanced Care Planning team for the next 12 months.

Midwifery
In anticipation for the 18/19 budget the midwifery ratios required for our current workload and complexity have been reviewed. This amounts to 12 FTE additional midwives as well as four health care assistants across Middlemore Hospital and the three primary birthing units. An additional 10.14 FTE has been approved to address the immediate pressure in Birthing and Assessment.

Midwifery workforce planning meetings have commenced to develop a longer term strategic maternity workforce plan, taking into account the now endorsed MERAS Midwifery Staffing Standards, national workforce predictions and DHB growth projections. This workforce planning will be combined with an overall review of maternity bed capacity.

Due the majority of midwives belonging to MERAS and a smaller workforce of registered nurses and health care assistants in Maternity, life preserving support respondents have not been required or requested for Maternity Services. Staff who have current Midwifery annual practising certificates who work in non-clinical positions such as education, MCIS and quality have volunteered to be rostered onto Birthing and Assessment and Maternity to cover the shifts of registered nurses and health care assistants who may choose to strike.

Allied Health

Physiotherapy has successfully recruited to all rotational vacancies, which is an extremely positive result at this time of year in such a competitive employment market for physiotherapists. There are several on-going vacancies in the community for senior physiotherapists however there is a recruitment plan in place for these.

There are still several vacancies in Speech Language Therapy, Social Work, Pharmacy and Occupational Therapy, but there are plans in place to continue to recruit to these vacancies.

In Dietetics recruitment to the various vacancies across all teams continues, predominately with internal fixed term candidates applying successfully to permanent positions. Recruitment to a long standing 1.0 FTE in Eastern locality has been finalised and candidate will start this month.

The Anaesthetic Technician workforce is at full FTE, and has been for almost a year. With up to 25% of their workforce being Maaori and Pacifika, this is an excellent achievement. The Audiology workforce is also at full FTE, against the national trend for a shortage in Audiologists.

There is a recognised national shortage of cardiac physiologists and sonographers which has hit CM Health particularly hard due to the small team size, meaning vacancies are not able to be absorbed easily. Current vacancies of 3.8 FTE in a team of 20 have left shortfalls in the ability to at cover all clinical duties resulting in clinic cancellations and increasing wait times in all cardiac investigative services. National and international recruitment continues, but differences in training overseas limits our ability to recruit suitable candidates.

People and Professional Development

Five submissions to Health Workforce New Zealand (HWNZ) Development Fund were made from the People and Professional Development team. The focus was on recruitment and retention of nursing and allied health staff from student through to return to practice along with increasing our number of Maaori and Pacifika professionals. The proposals were:

- Developing interprofessional dedicated education unit that incorporated physiotherapists and occupational therapy (OT) students along with nursing students. This would also test the potential to create a joint appointment with a tertiary education provider that encompassed both the clinical and academic support.
- Mentoring programme for final year OT, Dietetic, Speech and Language Therapy, and Social Work students who are Maaori or Pacifika. This work will build on the current programme which is for physiotherapy students.
- Allied Health, Scientific and Technical (AHST) graduate programme which is principally similar to the current NETP that nurses undergo. There is evidence that whilst we attract AHST new graduates there is a high attrition rate within the first 12 months.
- Support for Nurse Doctorate candidates particularly those of Maaori and Pacifika heritage including financial support. This builds on the BN Hons work that is currently occurring.
- Return to practice programme for New Zealand trained nurses. Evidence from WDHB is that an effective return to practice course can accelerate recruitment in to senior roles.

Twenty-four new graduates have been ranked by the close of the initial ACE process. This means that they have been interviewed and we have identified them as our preferred candidates for the NEtP programme that will commence in September. We are anticipating that this number will increase before the start of the programme. A further nine graduates were selected for New Entry to Specialist Practice (NESP) which is the mental health equivalent.

Appointment of Patient Experience and Engagement Advisor (Maternity Cover)
An appointment has been made to the above position for 12 months Maternity cover. The appointee has prior Experience at CM Health having worked as a Learning and Development Manager and more recently as the Ko Awatea Centre Manager. The appointee will lead some of the initiatives in the *Counties Experience* 2018 – 2021 Work Plan.

Patient Safety
Two new members joined the patient safety team at the end of June to replace the Clinical Quality Coordinator and Clinical Analyst Quality vacancies.

Clinical Training and Education Centre (CTEC)
May/June showed an increased demand for educational facilitation in CTEC with May having a 90% utilisation rate of the facility, including new educational initiatives. All Patient Safety Training courses were fully booked with some attrition due to sick leave or workload demand. Planning is already underway for semester 2 for Manukau Institute of Technology (MIT) Bachelor of Nursing (BN) students.

Two external courses were facilitated in CTEC in May; providing revenue for CM Health and opportunities for CM Health staff to also attend or facilitate.

Patient[1] Experience

Nursing
The first Patient Safety Leadership Walk around commenced in the localities this month – it was based at Pukekohe hospital where the feedback was overwhelmingly positive with the CM Health values being demonstrated, patients feeling safe and their cultural needs met. The experience was valuable for all involved and we are keen to continue with the other locality based CM Health facilities.

Additional Leadership rounds occurred for the 'What matters to me" celebration on 6 June. This special round included members of our Consumer Panel. Meal mats were supplied with each meal.

Community Nursing
Hospital in the Home pathway has commenced this week – patient feedback is positive with a patient stating "she is where she wants to be (to continue her recovery) – at home". The nursing staff are also enjoying the ability to provide more acute assessment and supportive care for this group. We are working with Ko Awatea to ensure we are capturing patient and carer/whaanau experience for those involved in the supported discharge via hospital in the home.

Community nursing staff are attending medical ward rounds to support and educate hospital teams around the breadth of community services – both clinical and support based services available and working in partnership to facilitate patient discharge with the most appropriate support around them

[1] Please note: the term "patient" will be used in this paper to refer to a person receiving health care. Acknowledgement is made that other similar terms can be used including health consumer, health care consumer, and client and service user.

Midwifery

CM Health are currently conducting stakeholder workshops to determine the refreshed model of care for SUDI prevention. A Northern Region SUDI prevention hui was held on 28 June on the North Shore involving the four Northern district health boards and Hapai Te Haurora.

CM Health are currently undertaking a safe sleep promotion as part of the Maatariki celebrations. This includes the following activities:

- Onesies are being given out to all babies born on one day over Maatariki in the maternity wards and birthing units. These onesies are presented in a little kete bag with the new look PEPE message flyer.
- All of the Kidz First and Women's Health's wards and units have developed displays around safe sleep, breast feeding and being smoke free.

- A staff safe sleep quiz was run on Daily Dose until Friday 29th June encouraging staff to test their knowledge on the P.E.P.E acronym.
- A facebook promotion was held gifting a wahakura to a woman and their whaanau.
- A quiz was run for women and their whaanau. The prize included a merino blanket, cot sheets set, baby snug, and onesies.
- Safe sleep T-shirts have also been made available for Kidz First and Women's Health staff to wear.

Allied Health

The adult SLT teams are continuing to work hard to minimise the impact on patients of on-going radiology closures at Middlemore Hospital. The team have been extremely accommodating in carrying out procedures at the 7am slot. The paediatric teams are utilising the radiology services at Starship hospital during this period.

In May, Occupational therapists from the community mental health service ran a flax weaving group for tangata whaiora. As flax weaving requires a large space to work in, they found a free venue at the local community centre, Friendship house, in Manukau. At least 8 tangata whaiora regularly attended the group and at times numbers swelled to 20 as extra whaiora and people visiting Friendship house for other reasons, sat down and joined in. The participants learnt to craft putiputi (flowers), kono (flax bowls) and other items and as they wove, they reminisced about their mothers and grandmothers and in doing so, connected with each other and with their whakapapa. Whaiora spoke about the process of preparing flax and weaving and its soothing effect on their anxiety. While the evaluation report for this group is still nearing completion, it is clear that utilising community spaces for groups supports the ongoing integration of mental health services. It provides opportunities to remove stigmatisation about mental illness; increase the confidence of service users to participate more fully in their local community and showcases cultural activities that

enhance mental wellbeing to a much wider audience. The creativity and energy created by this group was so well received that the CEO and manager of Friendship House have asked the team back to run more groups in the future.

CTEC
CTEC are working alongside the charge nurses and educators for multiple services to improve workflow, familiarisation with new environments, and look at processes and management in an emergency:

- Tiaho Mai – new build
- Ward 21 – General medical ward
- Hospital in the home – Community outpatient initiative.

Patient and Visitor Parking Issues Middlemore Hospital Site
Difficulties with accessing hospital car parking can impact on patient engagement and attendance at appointments, as well as preventing them from receiving much needed support from family and whaanau. The Patient and Whaanau Centred Care Board (PWCCB) requested a Discussion Paper in response to concerns that were being expressed in a variety of forums. The findings identified three core themes that are a source of concern and frustration for our population.

1 Cost of the car park (expense perceived as unfair, lack of transparency about subsidies available etc)
2 Availability of a carpark (takes too long to find one, no disability park available etc)
3 Pay Machine issues (location, performance etc)

A work plan is under development to address the issues.

Patient Experience Surveys (National and Inpatient)
Efforts to increase email registrations and publicise the survey to patients continue (Appendix 1). The initial 2018/19 Annual Planning Guidance (Quality Improvement Section) has asked DHB's to improve their performance on their lowest scoring domain on the HQSC National Inpatient Experience Survey. CM Health's lowest performing domain is Coordination. The Priorities from the 2018–2021 *Counties Experience* Work Plan and the results from the *Fundamental of Care* audit will further inform the project work targeting improvement specifically in Coordination.

Interestingly, CM Health's performance in the National Patient Experience Survey tends to be lower than the Inpatient survey results. Further analysis is underway to understand the reasons for the difference in performance.

Volunteer Service Update
We continue our efforts to increase the number of volunteers at both the Middlemore Hospital and Manukau Super Clinic (MSC) sites. In keeping with CM Health's commitment to diversity we are placing ethnically diverse volunteers at MSC in particular which has tended to have an over representation of elderly Pakeha so as to better reflect the population.

The Volunteer Service continues to provide an opportunity for CM Health employees who are on light duties after experiencing illness or injury to remain engaged with work by providing reception and administration related work. Support for the 5 July potential nurses strike was also offered with volunteers not normally rostered that day asked to come in to provide additional support to staff and patients.

Discontinuation of MSC Patient Shuttle
As agreed, this service was discontinued as of 18 May 2018. Thus far there have been no formal complaints by patients or other stakeholders. The MSC Call Centre staff provide information on alternative travel options when queries are made.

We have been able to offer the shuttle drivers alternative options which has meant we have been able to retain their voluntary services.

Quality and Improvement

Nursing
Preparation for the second Fundamentals of Care audit are underway. The audits will occur between 23 July and 3 August 2018. Over the past 5 weeks at Frontline Focus Friday, Clinical areas have reported on their quality improvement plans to improve measures from the previous audit.

Med chart has been rolled out to all Adult Rehabilitation Health of Older People (ARHOP) wards at Middlemore. This provides electronic prescribing and administration and reconciliation of medicines.

Community Nursing
CTEC have been providing simulation based training to support the expanded roles of district nurses who are involved in the first phase of the Hospital in the home pathway. This will continue to expand as the service grows.

Clinical governance and review has commenced to ensure we are safely managing patients on the supported discharge pathway of hospital in the home, community central is also involved in this process being the key point of coordination between primary and secondary care.

Midwifery
(a) Birthing and Assessment Unit Project

The Birthing and Assessment improvement project continues with strong commitment and effort from those involved. The project has now broken into three work streams. The first work stream is focused on the booking process for induction of labour and is currently undertaking PDSA cycles. The second work stream is determining the creation of an associate clinical charge midwife role for the Assessment Unit that will include the triaging of women. The second phase of the triage process will then include the development of triage algorithms. The third work stream is reviewing equipment. Covering all three of these work streams will be the umbrella of communication.

(b) Obstetric and Gynaecology Acute Model of Care Project

In conjunction with the improvement work occurring in Birthing and Assessment the SMO group has, with the support of Ko Awatea Improvement advisors, commenced work on reviewing their model of care for acute service cover. The first stakeholder meeting was held on 13 June.

(c) Maternity North and South Living Our Values Project

Work on the care pathways continues with the postnatal pathway near completion. The antenatal care pathway is developing with consideration to the on-going updating of controlled documents, and is well underway. The communication work stream progresses with focus being on imbedding the antenatal feedback survey with staff.

As part of the environment work stream the office spaces on the Maternity floor have been rearranged to create an appropriate space for confidential meetings with women and outside agencies. This space will also be used as a lounge in the evenings for women on the ward.

Allied Health

A number of Allied Health staff represented CM Health at the bi-annual Allied Health, Scientific and Technical conference held in Wellington from the 9-11 May. Their presentations were well received and the conference was a worthwhile event for all those that attended.

CM Health staff attended the National Cardiac Society Scientific session, with two cardiac investigation staff presenting novel research implementing new technology and novel proposals to change delivery of care.

Allied Health was well represented in CM Health's research week, with several notable award winners:

- Akshat Shah - Best Research Presentation from the Allied Health and Women's Health Session, for his work on "Training SLT's (Speech and Language Therapy) in cleft speech disorder";
- Julie Collis - Best Allied Health, Scientific and Technical Research Presentation, for her research into "Outcomes following MCPJ (Metacarpophalangeal (knuckle) joint reconstruction) arthroplasty treated postoperatively in a dynamic splint";
- Deirdre Neilsen – commended as an emerging researcher for her work on the "Evaluation of a nutrition training programme for Community Health Workers";
- Melodie Barr –commended for Mental Health Session for "Cognitive dysfunction in service users of adult secondary mental health teams at CM Health"; and
- Marie Young - Mental Health Session award and People's Choice Research Presentation for "We do some great work! Faster cancer treatment at CM Health is reducing inequities in our community. Where to now?"

Grace Manning was the May Occupational Therapy values winner. Grace embodies the CM Health value of whakawhanaugatanga – a great example of this was received from a family member who had a very positive experience under Grace's care alongside a large body of allied and nursing staff who also enjoy Grace's positive proactive manner.See above research week and conference presentations.

The development of an organisational nutrition and hydration policy continues, led by the ADAH Nutrition and Dietetics. A national malnutrition standard has been developed by the dietetic leaders across New Zealand, and will be implemented at CM Health as part of the nutrition related bundles of care identified through the malnutrition screening tool included in the e-Vitals pressure injury risk assessment.

As part of the above policy, a "protected mealtimes" campaign has been initiated. Protected mealtime's is an international initiative that has been developed to allow patients to eat their meals without unnecessary interruption, which subsequently allows healthcare professionals to focus on providing assistance to those patients who require it to obtain an optimal oral intake. As part of this, a standard work document will likely be developed in order for the concept to be implemented hospital wide in due course.

The ADAHs (Nutrition and Dietetics and Physiotherapy) are involved in developing the model of care for the new winter medical ward on ward 21 with emphasis on introducing and establishing the "protected mealtimes' and the "get up, get dressed and get moving" initiatives – to negate the effects of deconditioning for patients while in hospital, and to optimise nutrition, hydration, mobility and function. The aim will be to use ward 21 as an exemplar for these initiatives and then look to roll out across the rest of the medical wards and potentially wider.

A research proposal between CM Health Diabetes Service and AUT University has been approved and funding obtained. The concept will aim to utilise the CM Health diabetes population in order to trial the concept of a "low carbohydrate and healthy fat" diet and the effectiveness of this in type 2

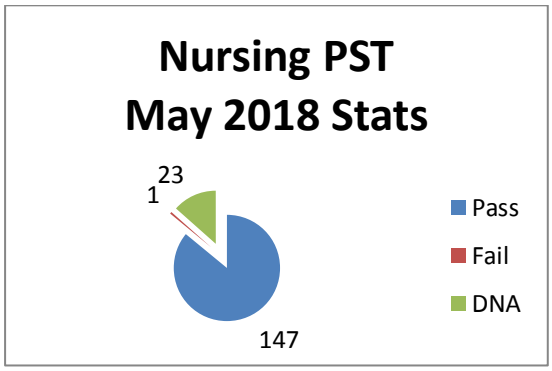
diabetes, versus "usual dietetic care". The methods of this are yet to be determined and on-going discussions are required to ensure that this has rigorous methodology.

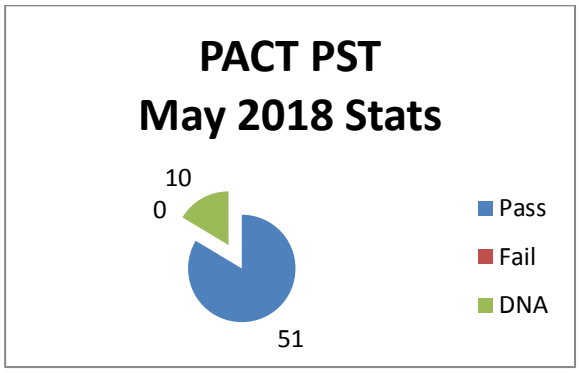
There have been discussions between the clinical director of emergency care (EC) and physiotherapy about how physiotherapy may be able to help meet demand at increased times of need over the winter period. Physiotherapy has initiated conducting a second "screening" of EC patients in the afternoon in addition to the morning. It is hoped that in combination with increased communication with the EC co-ordinators throughout the day this will lead to earlier identification of patients requiring allied health input, and perhaps earlier discharge of these patients from EC.

Simon Kerr, ADAH Physiotherapy, and Jason Guthrie, an experienced physiotherapist and iPMs super user have provided input from an Allied Health perspective into the proposed business case for the adoption of Trendcare by CM Health.

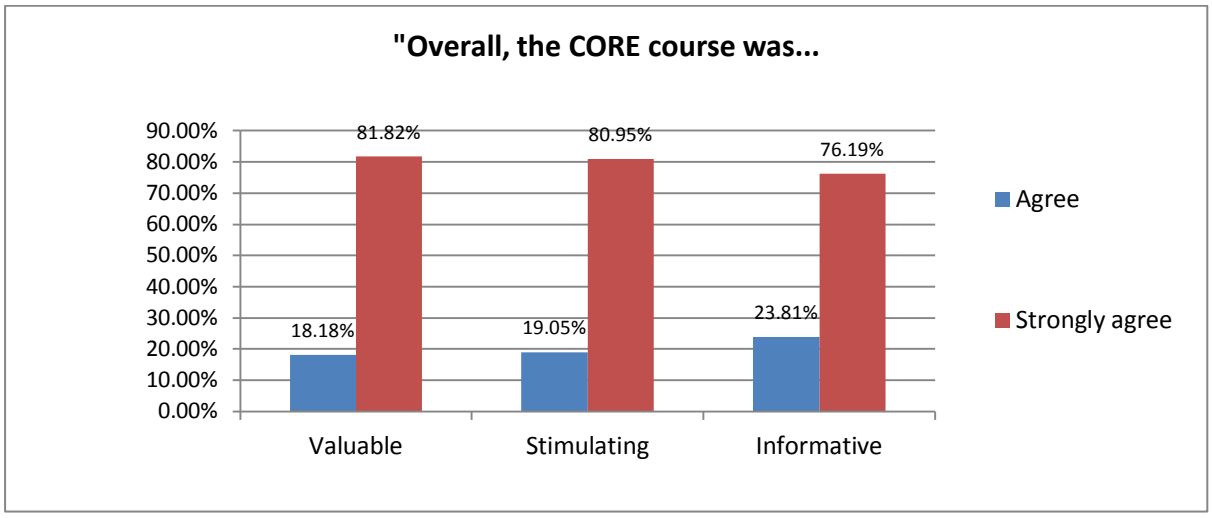
CTEC

The Did Not Attend (DNA) rate for mandatory training continues to improve with managers contacting CTEC and informing them when staff will not attend so that others can be placed on the course. Demand for PST is still high but adequate resources are available to cater to 2018 staffing levels at this point.

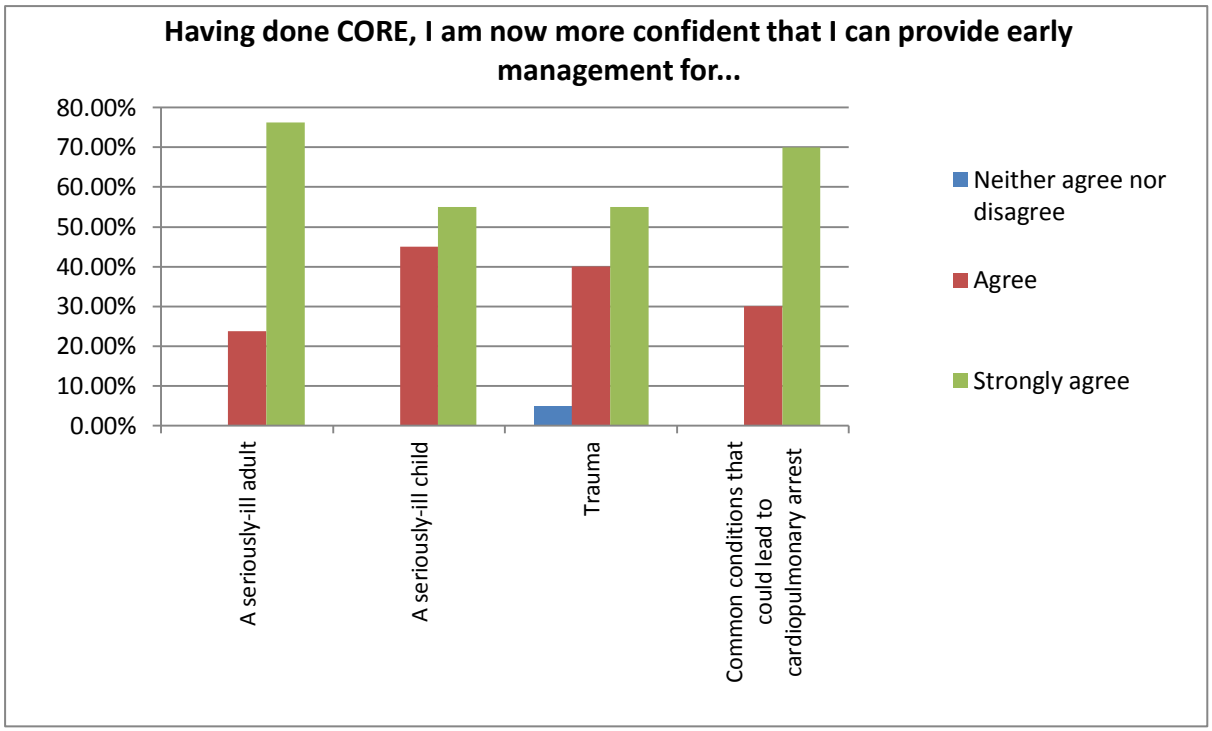




Course satisfaction for CORE courses was high showing value and that they are informative and stimulating.



Collated course feedback for May indicates staff are more confident in approaching management of unwell adult and paediatric patients after attending the CORE courses.



Certification
The final report has been received and pleasingly the change we requested to the wording of bed rail corrective action has been made. It now reflects that the discussion with the patient is documented in the notes (previously stated that the patient must document in the notes).

The first report to the Ministry is due 10 August which is only applicable to the Mental Health and Addiction Services corrective action (documentation of informed consent) with the remainder of the corrective actions for reporting due on 10 November.

Leadership

Nursing
The ANIVA pacific nurse leadership programme continues to support our pacific postgraduate nurses with peer support and mentoring programme.

Preparation for industrial action by New Zealand Nurses Organisation (NZNO) is underway for the 12 July. This is requiring significant resource for planning with daily meetings to ensure that we are able to keep patients and nurses safe during this period of industrial action. CNDs, Deputy Chief Nurse and Chief Nurse and Director of Patient and Whanaau Experience have updated their clinical skills in preparation to assist during any industrial action.

Community Nursing
The Primary care nurse educator and a senior nurse based in a local Secondary school are headed to Wellington to present their involvement and reflection of the Registered Nurse Prescribing – Community Health pilot that was run at CM Health last year. This is a great opportunity to showcase the innovative work done at CMH whilst awaiting the evaluation and review by Nursing Council.

Allied Health
Six allied health staff has been accepted on to the Emerging Leaders programme, including 4 physiotherapists, an occupational therapist and a pharmacist. The programme will commence in September 2018.

Cassandra Laskey, Peer Support Professional Leader has been appointed as consumer representative to the Health and Quality Safety Commission national leadership group for quality improvement in mental health.

Our anaesthetic technician clinical coaches facilitated a training and development meeting in Christchurch for the New Zealand Anaesthetic Technicians Society (NZATs), and assisted with 3rd year training at Auckland Hospital for AUT University. There is on-going support for existing Registered Anaesthetic Technicians towards further academic papers and Degree completion.

People and Professional Development
The Medical and Emergency Care Professional Development team and the People Development team have been facilitating the team development of the staff that will be based on Ward 21 in Galbraith. Creating a cohesive, correct culture and team dynamic will be fundamental to the success of the ward and positive outcomes for patients.

CTEC
CTEC and sponsors Zoll, hosted Elizabeth Hunt - MD, MPH, PhD Associate Professor, Johns Hopkins Medicine Simulation Centre, USA. Dr Hunt presented on; 'exploring innovative methods to improve the quality of care delivered and ultimately clinical outcomes for children who suffer a cardiopulmonary arrest'.

Dr Hunt has been fortunate to have the opportunity to present, practice and teach about paediatric resuscitation issues throughout the world. Dr Hunt's Rapid Cycle Deliberate Practice (RCDP) interactive lecture and workshop discusses and practices a novel instructional method for simulation-based learning that incorporates multiple repetitions of short simulations with interspersed feedback.

Dr Hunt discusses the ideal context for using RCDP, how to design scenarios for RCDP and explores how feedback delivered during RCDP is different than traditional terminal debriefing.

CTEC are designing case-based simulation to accommodate forms of rapid cycle deliberate practice at CMH to aid in skills practice and competency progression in some of our course based simulation.

Patient Safety

Plan of Care
An 18% improvement in the 21 documentation criteria, from 56% pre Plan of Care implementation to 74% after Plan of Care implementation, was highlighted in the initial post-implementation audits. However, room for improvement in Plan of Care documentation was identified in areas such as documenting a change in condition, rationale behind interventions and estimated discharge date. \

RESULTS SUMMARY OF ALL WARDS PRE & POST PLAN OF CARE IMPLEMENTATION

Criteria	1 Patient condition documented	2 Change in condition recorded	3 The change in condition Nurse/patient observed or stated (CA)	4a Falls assessment risk identified in POC	4b CAM assessment risk identified in POC (CA)	4c Pressure injury risk assessment identified in POC	4d MRO status identified in POC	4e Change in EWS (PUP) score 2 and above documented in POC	4f Lines identified e.g. PICC, CVL, IV	5a Input/output measures e.g. FBC	5b Drainage monitoring	5c Other monitoring e.g. VAC, bowel, neuro, weight, telemetry, GCS, BSL, food, watch
Baseline audit pre PoC implementation (average across wards)	81%	69%	49%	63%	42%	59%	44%	67%	54%	44%	55%	79%
Post PoC implementation audit (average across wards)	99%	60%	53%	70%	53%	73%	65%	72%	64%	87%	60%	100%
Difference pre to post audits (improvement)	18%	-9%	4%	7%	11%	14%	21%	5%	10%	43%	5%	21%

Criteria	6 Nurse initiated referrals with rationale	7 Patient goal/wishes recorded (CA)	8 Goal discharge date (CA)	9 Individual patient cares recorded e.g. hygiene cares, PAC, mobilising etc (CA)	10 Planned interventions/ treatment documented e.g. surgery (CA)	11 Nurse recorded interventions/ actions taken with a change in pt condition	12 Rationale behind nurse interventions (CA)	13 Nurse evaluating /reassessment of care in pt with a change in condition (CA)	14 Patient's response to mutally agreed intervention e.g. bed rails	15 Evidence of education provided by nurse and evaluation has met the patient's needs (CA)
Baseline audit pre PoC implementation (average across wards)	47%	15%	14%	75%	74%	68%	40%	35%	43%	15%
Post PoC implementation audit (average across wards)	71%	72%	40%	94%	94%	78%	53%	77%	71%	31%
Difference pre to post audits (improvement)	25%	57%	26%	19%	20%	10%	12%	42%	28%	15%

Criteria	16 Patient identification in PoC e.g. patient labels	17a Date recorded	17b Time recorded	18 Signature/ initials	19 Concise and legible	20 Abbreviations are written in full once	21 Permanent blue/black pen	Overall compliance (average across audit areas)
Baseline audit pre PoC implementation (average across wards)	89%	87%	35%	77%	83%	22%	93%	56%
Post PoC implementation audit (average across wards)	96%	99%	89%	92%	83%	65%	99%	75%
Difference pre to post audits (improvement)	8%	12%	54%	15%	1%	44%	6%	19%

(CA) Certification corrective action

Areas doing well

Areas for improvement

Key:

80 - 100%

50 - 79%

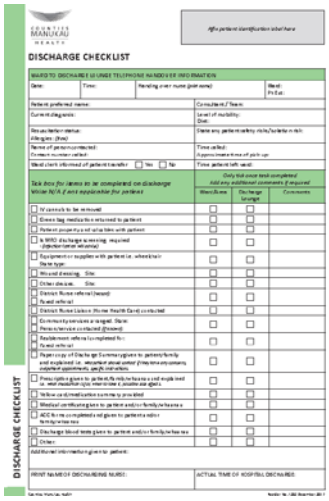
0 - 49%

Plan of Care implementation started in July 2017 and rolled out to the final of the 17 medical/surgical wards in March 2018.

Included in summary results (n = 16): 1, 2, 6, 7, 8, 10, 11, 32N, 33E, 33N, 34E, 34N, 35N, MSC1, MSC2, NBC

Excluded from summary results (n = 1): Ward 9 as did not have a pre-implementation audit done.

As discharge planning was identified as an on-going corrective action during the surveillance Certification audit on 7-9 February 2018, further work is required to embed use of the discharge planning form and checklist. An evaluation of the uptake of the Plan of Care documents on the 17 medical and surgical wards will be carried out in the coming months.



Patient Safety Week 2018

The focus for the public for this year's national Patient Safety Week (5–10 November 2018) will be 'hand hygiene', and for the sector that 'good hand hygiene helps stop the spread of antibiotic resistant infections'. The week following Patient Safety Week is World Antibiotic Awareness Week, and for that week we will continue the focus on minimising antimicrobial resistance, so continued hand hygiene promotion will be very relevant.

The theme of hand hygiene/antimicrobial resistance has been chosen by the Health Quality & Safety Commission (the Commission) because:

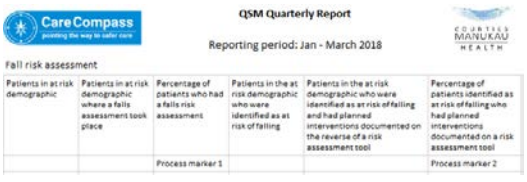
- effective hand hygiene is the simplest, most effective way to prevent the spread of healthcare associated infections
- good hand hygiene in the home is important to prevent spread of infection within families and whaanau, and
- reducing infections not only lessens the need for antibiotics but also reduces the opportunity for microorganisms to develop resistance and share resistance genes.

The Commission has established an 'ideas group' to help with Patient Safety Week planning which is currently meeting monthly. The group includes representation from consumers and different agencies and sectors. Further information about the hand hygiene focus and resources will be available soon.

Care Compass - Point of Care Measure for Safety

As of July 2018, the wards/clinical areas will have visibility of their data from their Care Compass clinical deterioration, documentation, falls, infection prevention surveillance, medication chart, peripheral intravenous line maintenance and pressure injuries monthly audits.

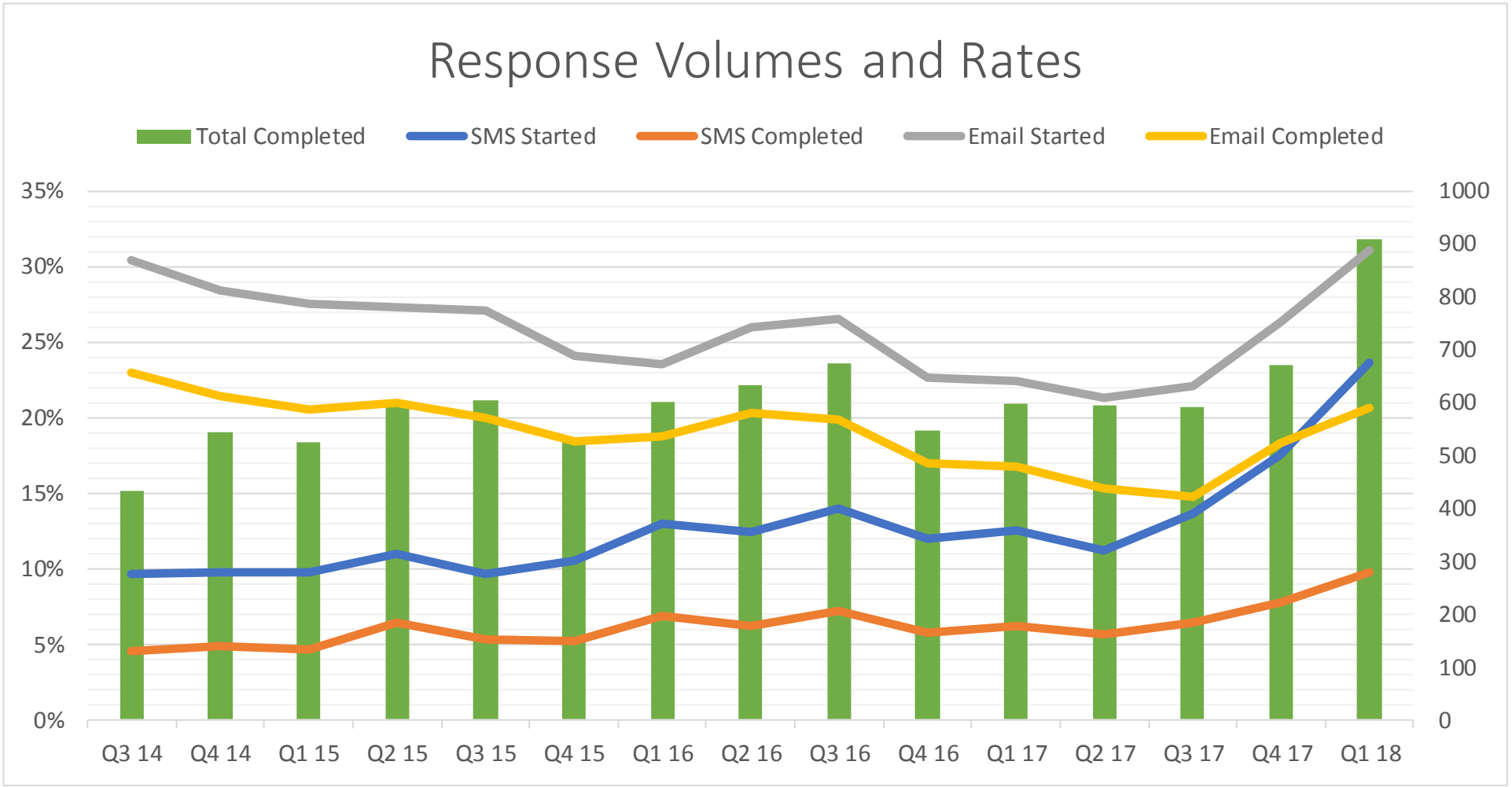
These reports are in dashboard report form for each audit and will be automatically sent to the Charge Nurse Manager, Charge Midwife Manager or Team Leader on the 2nd of each month for their review, to discuss with staff and display on their quality board as required.



One of the aims in providing the ward/clinical areas with an effective way to track their performance is to improve clinical engagement in data quality and outcomes and assist the ward in identifying any areas for improvement.

An organisation key measures report has been developed as well as a mechanism to report on the existing falls quality and safety marker data that is submitted quarterly to the Health Quality & Safety Commission. This report also includes the new pressure injury, opioid and deteriorating patient quality and safety markers that the organisation will be required to report on later in the year.

Appendix 1 – National Inpatient Survey Response Volumes and Rates



What's next for Care Compass

Care Compass is CM Health's point of care measure for safety with the overall goal to:

- Minimise avoidable healthcare related harm.
- Standardise and simplify measurement for safety at the point of care.
- Enhance internal and external reporting of safety data.
- Support effective tracking of organisational performance in a granular way for clinical departments to inform quality improvement initiatives.
- Improve clinical engagement in data quality and outcomes analysis.
- Support delivery of DHB obligations in relation to clinical governance and national quality and safety marker reporting for falls, pressure injuries, deteriorating patient and opioids.

The clinical areas have been collecting data for five core audits (i.e. falls, pressure injuries, documentation, clinical deterioration and medication chart) on five random patients per audit since November 2017. The three-monthly infection prevention surveillance audit commenced in April 2018 and a monthly peripheral IV line audit started in May 2018. The pain/opioid audit will be introduced later in the year in line with the national reporting requirements for the opioid quality and safety marker.

Examples of type of reports that will be available:

1. Ward level per audit, sent monthly to Charge Nurse Manager, Charge Midwife Manager, Team Leader

2. Service and division report selection function on ward level reports

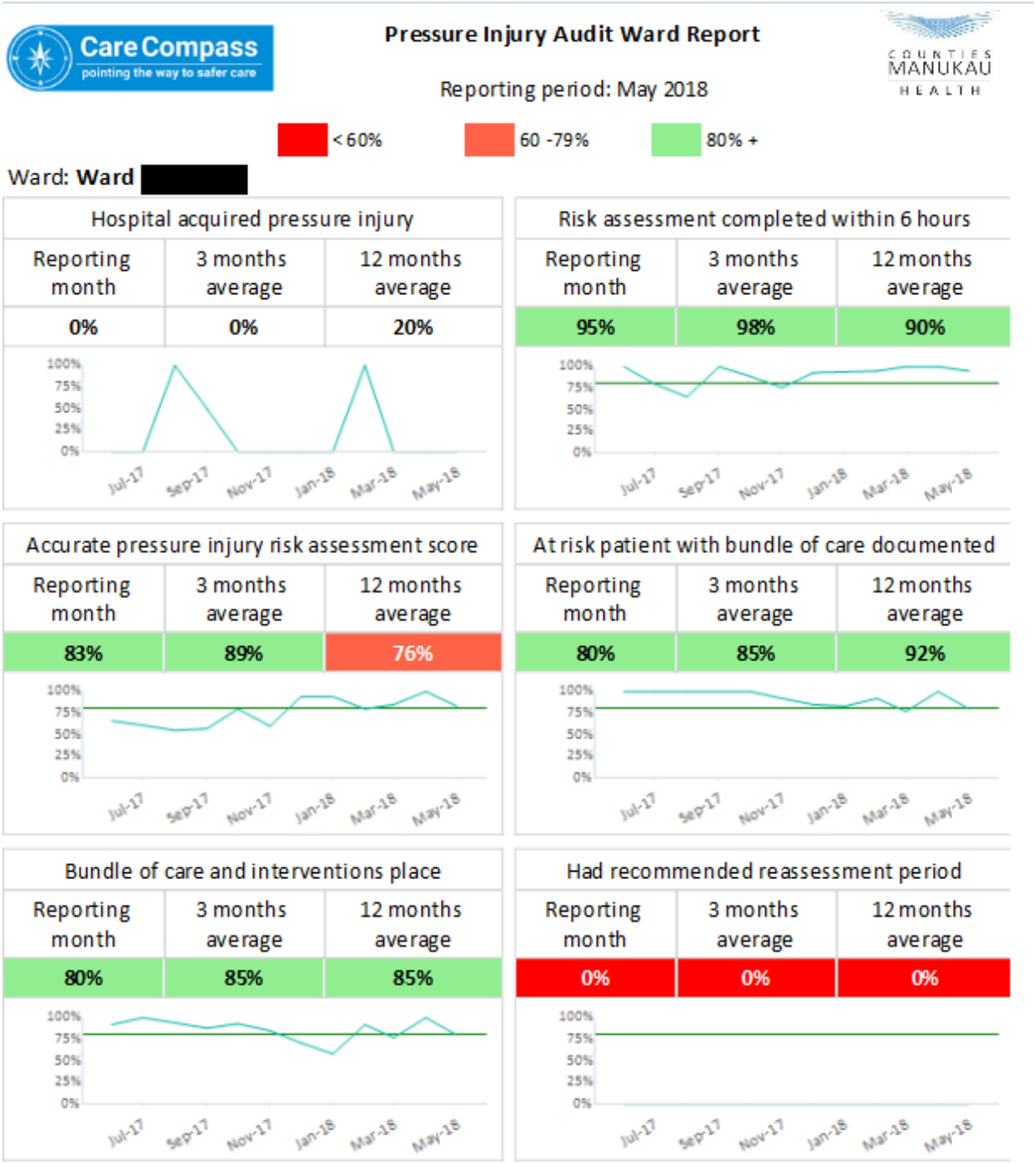
3. Organisation key measures

4. Pressure injury prevalence

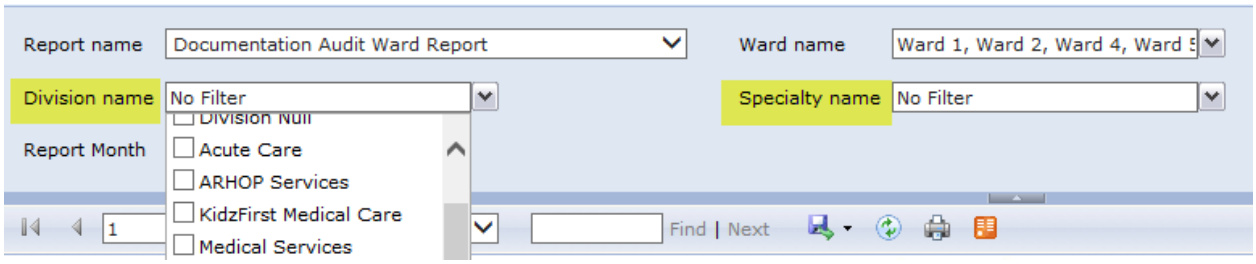
5. ARHOP scorecard for falls, pressure injuries and CAM

6. Quarterly national quality and safety marker data for falls, pressure injuries, deteriorating patient and opioids

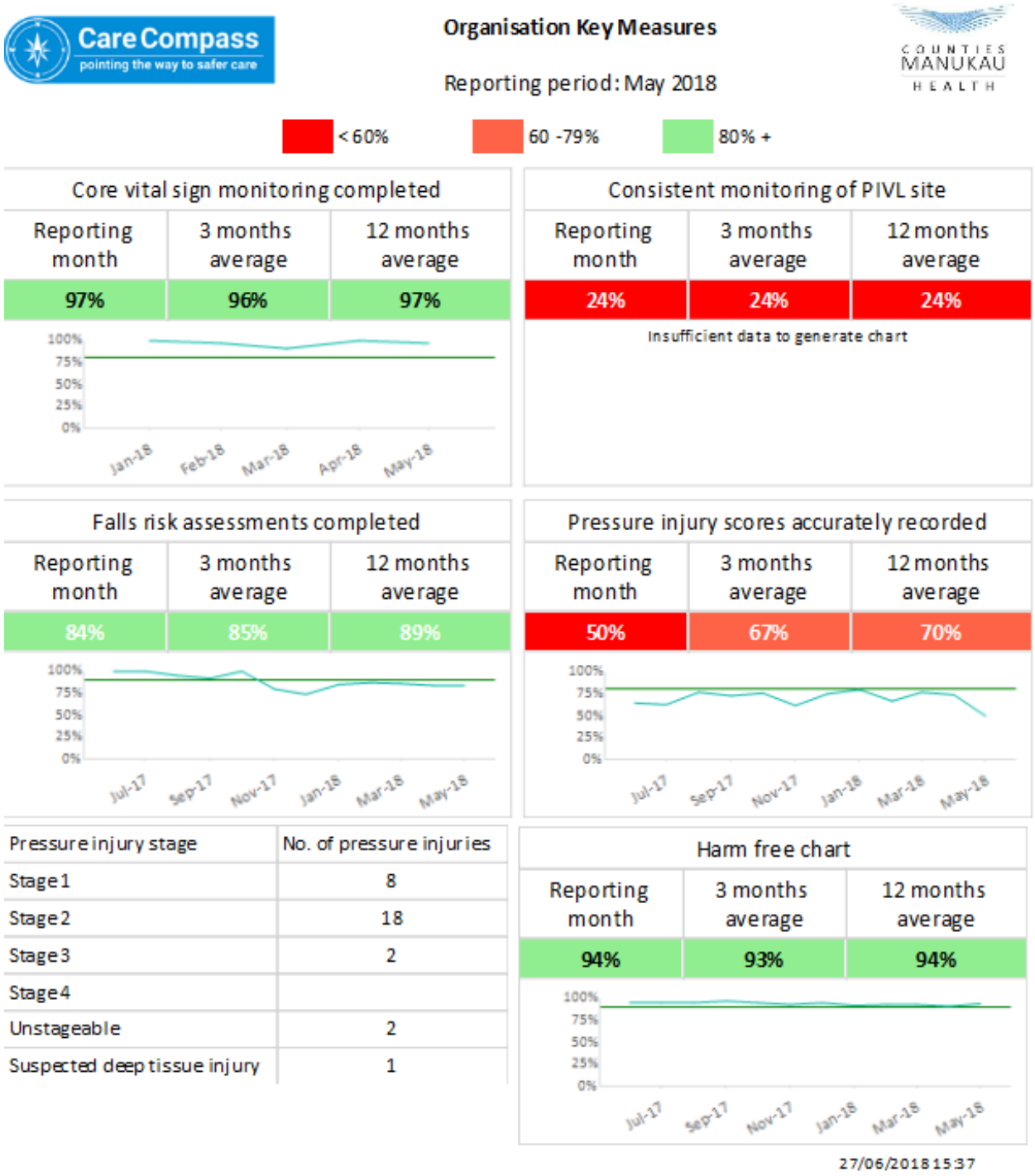
1. Ward level dashboard per Care Compass audit, sent monthly to Charge Nurse Manager, Charge Midwife Manager, Team Leader



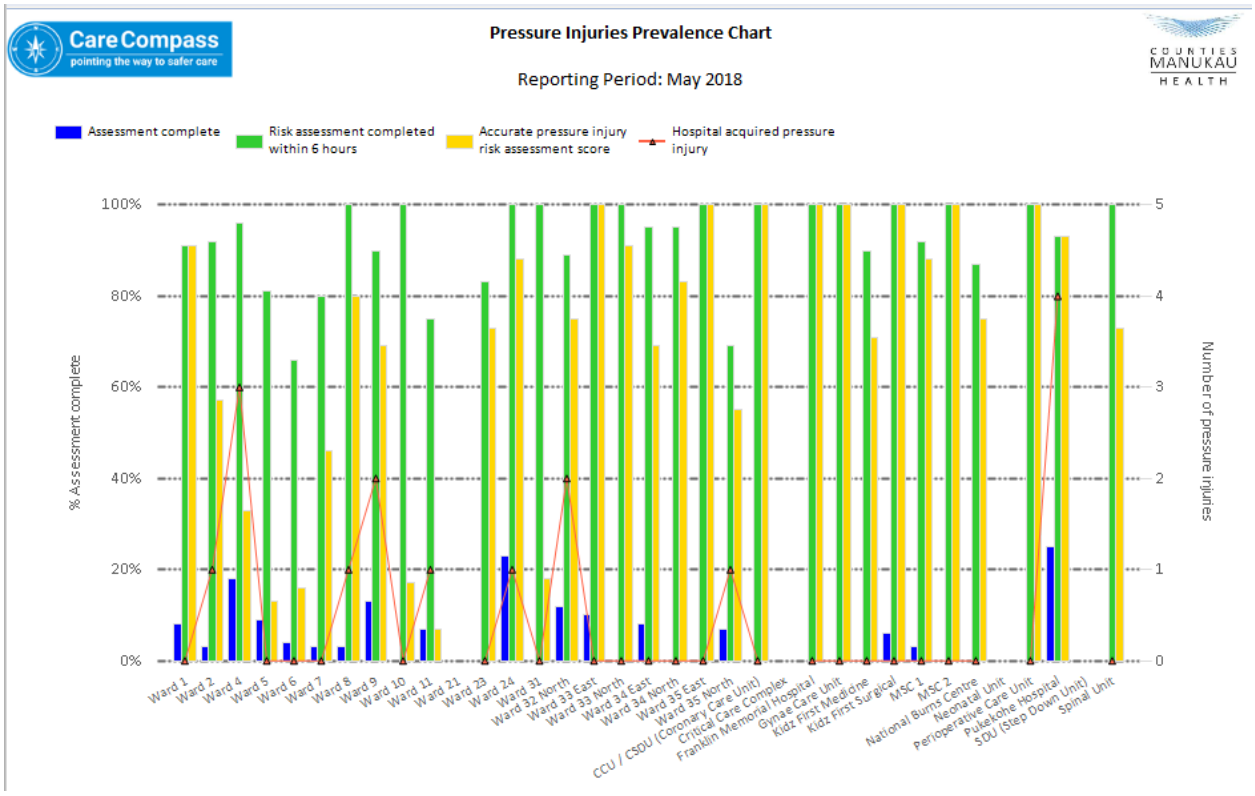
2. Division and specialty report selection function on ward level reports

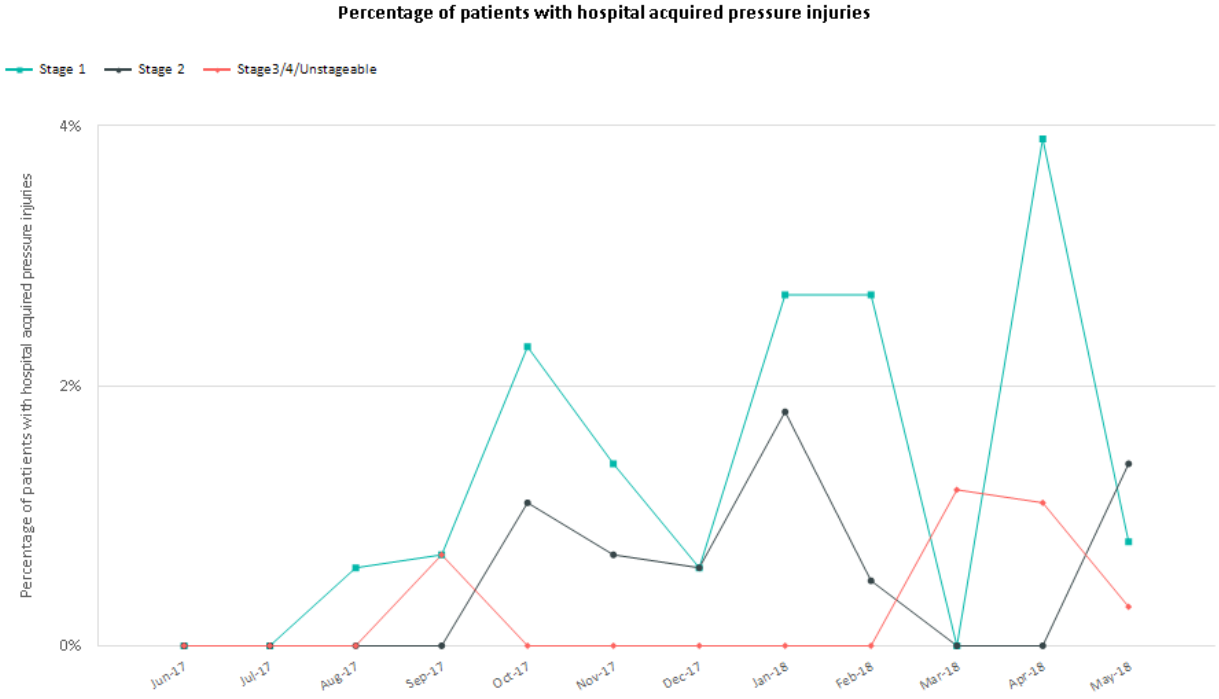


3. Organisation key measures



4. Pressure injury prevalence





5. ARHOP scorecard for falls, pressure injuries and CAM

Care Compass
pointing the way to safer care

ARHOP Scorecard Monthly Report

Reporting period: May 2018

Counties Manukau Health

Falls

	Was the falls risk assessment completed within the 6 hour timeframe of admission to this ward?			Are planned interventions recorded on the reverse of the falls risk assessment tool?		
	Number of patients audited	Number of patients risk assessed in 6 hours	Percentage risk assessed in 6 hours	Number of patients who had a falls risk assessment	Number of patients risk assessed with interventions documented	Percentage of patients risk assessed with interventions recorded on assessment tool
Ward 4	5	5	100%	5	5	100%
Ward 5	5	4	80%	5	5	100%
Ward 23	5	5	100%	5	4	80%
Ward 24	5	5	100%	5	5	100%
Ward 31	5	5	100%	5	5	100%
Spinal Unit	5	5	100%	3	2	66%
Total	30	29	97%	28	26	93%

Pressure injuries

	Was the pressure injury risk assessment completed within the 6 hour timeframe of admission ot this ward?			Are all planned interventions in place?		
	Number of patients having a pressure injury audit	Number of patients having a pressure injury risk assessment within 6 hours	Percentage of patients having a pressure injury risk assessment within 6 hours	Number of patients assessed as being at risk of a pressure injury	Number of patients identified as having all interventions in place	Percentage of patients at risk of a pressure injury with all interventions in place
Ward 4	26	24	92%	25	24	96%
Ward 5	22	18	81%	22	22	100%
Ward 23	19	15	78%	18	18	100%
Ward 24	17	15	88%	15	15	100%
Ward 31	11	11	100%	6	3	50%
Spinal Unit	19	19	100%	19	19	100%
Total	114	102	89%	105	101	96%

Confusion assessment method (CAM)

	Was the CAM completed for patients 65 years and over?			Are all planned interventions in place?		
	Number of patients audited over 65 years	Number of patients over 65 years had a CAM assessment	Percentage CAM audited	Number of patients who scored 1-4 in the last 5 days	Patients scored 1-4 with interventions documented	Percentage of patients scored 1-4 with interventions recorded on assessment tool
Ward 4	5	4	80%	2	1	50%
Ward 5	5	5	100%	3	2	66%
Ward 23	2	0	0%	0	0	0%
Ward 24	4	4	100%	0	0	0%
Ward 31	2	2	100%	1	1	100%
Spinal Unit	0		0%	0	0	0%
Total	18	15	83%	6	4	67%

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6. Quarterly national quality and safety marker data for falls, pressure injuries, deteriorating patient and opioids

QSM Quarterly Report

Reporting period: Jan - March 2018

Fall risk assessment

Patients in at risk demographic	Patients in at risk demographic where a falls assessment took place	Percentage of patients who had a falls risk assessment	Patients in the at risk demographic who were identified as at risk of falling	Patients in the at risk demographic who were identified as at risk of falling and had planned interventions documented on the reverse of a risk assessment tool	Percentage of patients identified as at risk of falling who had planned interventions documented on a risk assessment tool
		Process marker 1			Process marker 2
189	182	96%	160	147	91%

Pressure injuries

Patients audited	Patients who had a pressure injury risk assessment	Patients who had a documented pressure injuries risk assessment	Patients assessed as being at risk of pressure injury	At risk patients who had an individualised care plan	At risk patients who had a documented pressure injuries risk assessment	Patient with a hospital acquired pressure injury	Patients audited who had a hospital acquired pressure injury	Patients with a non-hospital acquired pressure injury	Patients audited who had a non-hospital acquired pressure injury
		Process marker 1		Process marker 2			Outcome marker 1		Outcome marker 2
446	416	93%	329	296	66%	11	2%	6	1%

Clinical deterioration

Ward	Total number of patients audited	Vital sign monitoring completed with most recent vital signs	EWS calculated correctly for most recent vital signs	Escalation triggered and escalated according to the pathway	Escalated according to the pathway and received the appropriate response
		Process marker 1	Process marker 2	Process marker 3	Process marker 4
All	792	97%	97%	75%	67%

Safe use of opioids

Patients audited	Percentage of patients with documented sedation scores at least once every four hours	Percentage of patients with documented bowel function monitored once per shift	Percentage of patients with uncontrolled pain
	Process marker 1	Process marker 2	Balance marker 1

Plan of Care implementation interim results

Jacqueline Ryan
Patient Safety Manager

Acknowledgement to: Vanessa Wheeler, Clinical Quality Coordinator, Patient Safety and Plan of Care Working Group

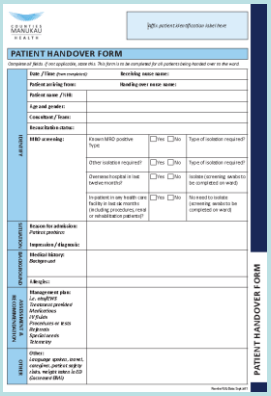
Why did the care plan need to change?

Background

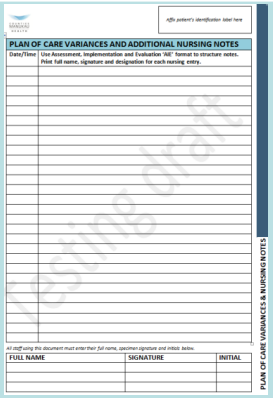
- Corrective actions required to meet Certification standards (i.e. Transition, Exit, Discharge, Or Transfer 1.3.10.2; Assessment 1.3.4.2; Planning 1.3.5.2; Evaluation 1.3.8.2)
- Need to show evidence of planning and evaluating patient care, individualised goals/needs/desired outcomes documented as a basis for care planning and delivery, and coordinated discharge planning
- Inconsistencies in current care plan format amongst medical and surgical areas
- No standardised way of documenting
- Multiple places to find information

Plan of Care documents

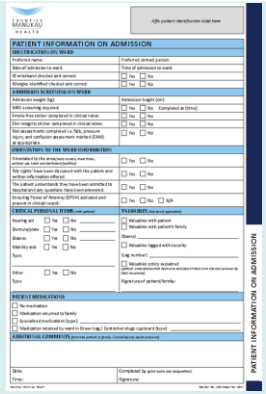
Patient handover form


PATIENT HANDOVER FORM

Documenting variance and other notes


PLAN OF CARE VARIANCES AND ADDITIONAL NURSING NOTES

Patient information on admission


PATIENT INFORMATION ON ADMISSION

New format for writing in clinical notes

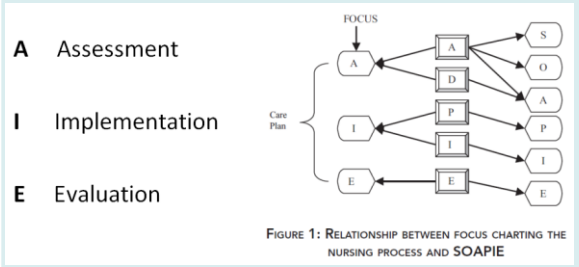
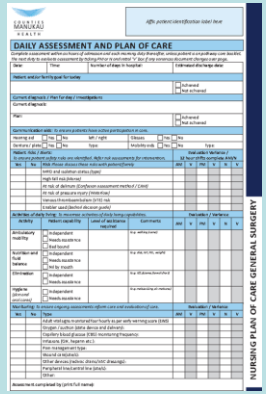
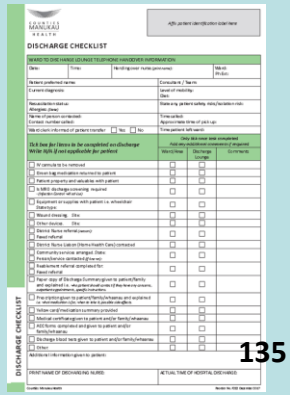


FIGURE 1: RELATIONSHIP BETWEEN FOCUS CHARTING THE NURSING PROCESS AND SOAPIE

Daily assessment and plan of care


NURSING PLAN OF CARE GENERAL SURGERY

Discharge planning and checklist


DISCHARGE CHECKLIST

Where are we now?

- Scope of project, 17 medical and surgical wards
- Plan of Care roll-out started in July 2017 with pilot wards 10 and 33 East
- Roll-out finished with Ward 2 on 22 March 2018
- Education sessions held with staff on new documents
- Pre and post-implementation audits done and results sent to Charge Nurse and Nurse Educator to share with staff

Plan of Care Audit Tool

Ward: _____ Date audited: _____ NHI: _____

24 hour timeframe audited: _____ Audited by: _____
(i.e. 0700 – 0700 hours)

How to audit plan of care documentation (daily care plan):

Step 1	• Pick a recent (within 2-3 days) 24 hour timeframe to audit i.e. 0700 – 0700. • Read the 24 hour period selected of clinical notes including risk assessments, observation chart, FBC, drain charts etc. relevant to that timeframe. NB This should include three shifts (morning, afternoon and night), or two twelve hour shifts within the 24 hour period for auditing selected.
Step 2	• Refer to the plan of care document against the clinical notes while completing this audit.
Step 3	• Tick the category which best suits the evidence found in the plan of care documentation audit. Examples have been provided for further explanation. Note: If there is no change in the patient's condition choose not applicable. The clinical notes category refers to all notes or forms within the notes (excluding plan of care/nursing care plan). *Minimum evidence should be in at least 2 out of 3 shifts over the 24 hour period unless stated otherwise.

	Criteria Assessment/Planning			Also tick clinical notes if information found there.	
1.	There is an entry about the patient's condition within the plan of care (emphasis is on patient). **Tick Yes/No or in clinical notes** E.g. PUP score, comfortable, pain score etc. E.g. Mrs M was comfortable overnight and refused any analgesia offered.	Yes ☐	No ☐	Comment	Clinical notes ☐
2.	Is a change in the patient's condition recorded in the plan of care. Check against clinical notes. **Yes/No if in the plan of care.** **Also tick clinical notes if information found there.** **If no change in patient condition tick N/A.** E.g. Mr B had a normal HR of 80 bpm at 0800 however at 1000 had tachycardia of 120 bpm with symptoms of sharp lower abdominal with a pain score of 8/10. The house officer has been contacted to review.	Yes ☐	No ☐	N/A ☐	Clinical notes ☐
3.	If there is a change in condition, is what the nurse observed or what the patient actually said within the plan of care. **If no change in patient condition tick N/A** E.g. Mr Z was found clutching at his chest stating "I can't breathe". E.g. Mrs B had a low systolic blood pressure however was asymptomatic stating "I'm feeling fine and not dizzy".	Yes ☐	No ☐	N/A ☐	Clinical notes ☐

RESULTS SUMMARY OF ALL WARDS PRE & POST PLAN OF CARE IMPLEMENTATION

Criteria	1 Patient condition documented	2 Change in condition recorded	3 The change in condition Nurse/patient observed or stated (CA)	4a Falls assessment risk identified in POC	4b CAM assessment risk identified in POC (CA)	4c Pressure injury risk assessment identified in POC	4d MRO status identified in POC	4e Change in EWS (PUP) score 2 and above documented in POC	4f Lines identified e.g. PICC, CVL, IV	5a Input/output measures e.g. FBC	5b Drainage monitoring	5c Other monitoring e.g. VAC, bowel, neuro, weight, telemetry, GCS, BSL, food, watch
Baseline audit pre PoC implementation (average across wards)	81%	69%	49%	63%	42%	59%	44%	67%	54%	44%	55%	79%
Post PoC implementation audit (average across wards)	99%	60%	53%	70%	53%	73%	65%	72%	64%	87%	60%	100%
Difference pre to post audits (improvement)	18%	-9%	4%	7%	11%	14%	21%	5%	10%	43%	5%	21%

Criteria	6 Nurse initiated referrals with rationale	7 Patient goal/wishes recorded (CA)	8 Goal discharge date (CA)	9 Individual patient cares recorded e.g. hygiene cares, PAC, mobilising etc (CA)	10 Planned interventions/ treatment documented e.g. surgery (CA)	11 Nurse recorded interventions/ actions taken with a change in pt condition	12 Rationale behind nurse interventions (CA)	13 Nurse evaluating /reassessment of care in pt with a change in condition (CA)	14 Patient's response to mutally agreed intervention e.g. bed rails	15 Evidence of education provided by nurse and evaluation has met the patient's needs (CA)
Baseline audit pre PoC implementation (average across wards)	47%	15%	14%	75%	74%	68%	40%	35%	43%	15%
Post PoC implementation audit (average across wards)	71%	72%	40%	94%	94%	78%	53%	77%	71%	31%
Difference pre to post audits (improvement)	25%	57%	26%	19%	20%	10%	12%	42%	28%	15%

Criteria	16 Patient identification in PoC e.g. patient labels	17a Date recorded	17b Time recorded	18 Signature/ initials	19 Concise and legible	20 Abbreviations are written in full once	21 Permanent blue/black pen	Overall compliance (average across audit areas)
Baseline audit pre PoC implementation (average across wards)	89%	87%	35%	77%	83%	22%	93%	56%
Post PoC implementation audit (average across wards)	96%	99%	89%	92%	83%	65%	99%	75%
Difference pre to post audits (improvement)	8%	12%	54%	15%	1%	44%	6%	19%

(CA) Certification corrective action

Areas doing well

Areas for improvement

Key:

80 - 100%

50 - 79%

0 - 49%

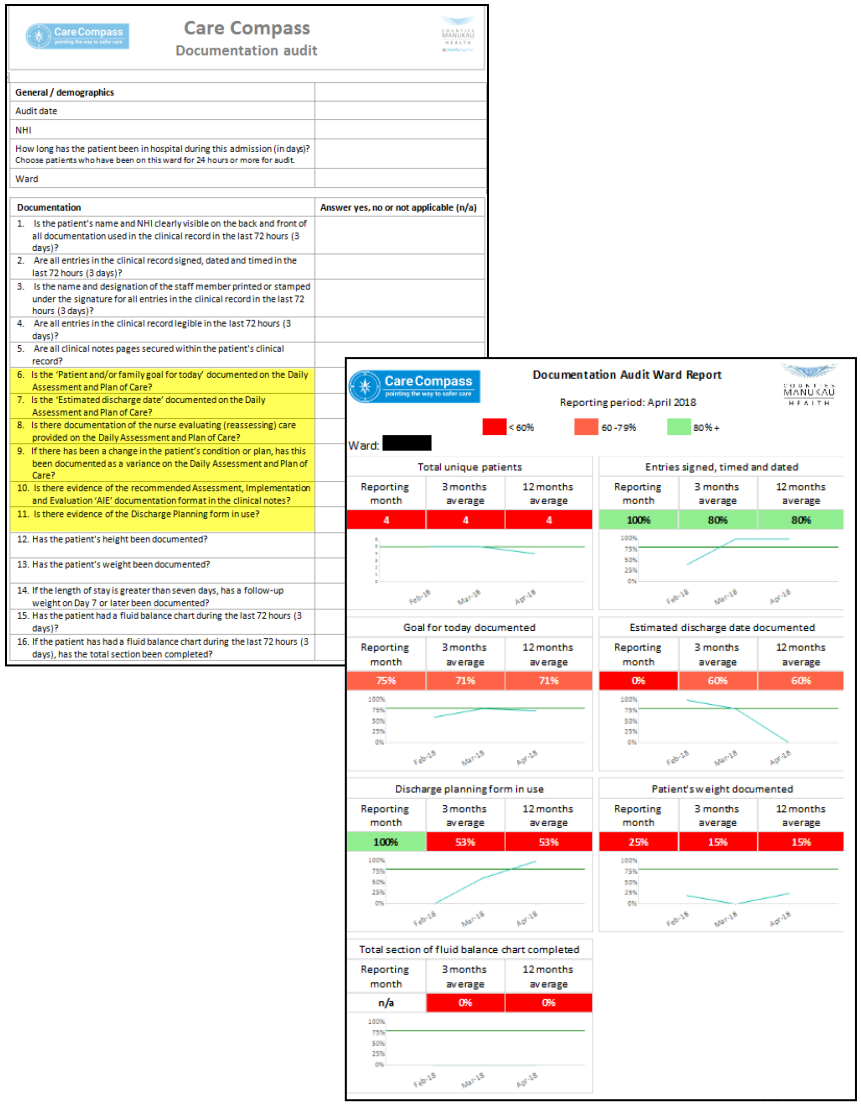
Plan of Care implementation started in July 2017 and rolled out to the final of the 17 medical/surgical wards in March 2018.

Included in summary results (n = 16): 1, 2, 6, 7, 8, 10, 11, 32N, 33E, 33N, 34E, 34N, 35N, MSC1, MSC2, NBC

Excluded from summary results (n = 1): Ward 9 as did not have a pre-implementation audit done.

What's next?

- Look at areas for improvement, individual wards and overall
  - Change in condition recorded
  - CAM assessment risk identified
  - Estimated discharge date
  - Rationale behind nursing interventions
  - Evidence of education provided
- Repeat Plan of Care ward audits/evaluation
- Care Compass monthly documentation audit monitoring Plan of Care patient goal, estimated discharge date, evaluation of change in condition, discharge planning



Care Compass
Documentation audit

General / demographics	
Audit date	
NHI	
How long has the patient been in hospital during this admission (in days)? Choose patients who have been on this ward for 24 hours or more for audit.	
Ward	

Documentation	Answer yes, no or not applicable (n/a)
1. Is the patient's name and NHI clearly visible on the back and front of all documentation used in the clinical record in the last 72 hours (3 days)?	
2. Are all entries in the clinical record signed, dated and timed in the last 72 hours (3 days)?	
3. Is the name and designation of the staff member printed or stamped under the signature for all entries in the clinical record in the last 72 hours (3 days)?	
4. Are all entries in the clinical record legible in the last 72 hours (3 days)?	
5. Are all clinical notes pages secured within the patient's clinical record?	
6. Is the 'Patient and/or family goal for today' documented on the Daily Assessment and Plan of Care?	
7. Is the 'Estimated discharge date' documented on the Daily Assessment and Plan of Care?	
8. Is there documentation of the nurse evaluating (reassessing) care provided on the Daily Assessment and Plan of Care?	
9. If there has been a change in the patient's condition or plan, has this been documented as a variance on the Daily Assessment and Plan of Care?	
10. Is there evidence of the recommended Assessment, Implementation and Evaluation 'AIE' documentation format in the clinical notes?	
11. Is there evidence of the Discharge Planning form in use?	
12. Has the patient's height been documented?	
13. Has the patient's weight been documented?	
14. If the length of stay is greater than seven days, has a follow-up weight on Day 7 or later been documented?	
15. Has the patient had a fluid balance chart during the last 72 hours (3 days)?	
16. If the patient has had a fluid balance chart during the last 72 hours (3 days), has the total section been completed?	

Care Compass
Documentation Audit Ward Report
Reporting period: April 2018
< 60% 60 -79% 80% +
Ward:

Total unique patients		
Reporting month	3 months average	12 months average
4	4	4

Entries signed, timed and dated		
Reporting month	3 months average	12 months average
100%	80%	80%

Goal for today documented		
Reporting month	3 months average	12 months average
75%	71%	71%

Estimated discharge date documented		
Reporting month	3 months average	12 months average
0%	60%	60%

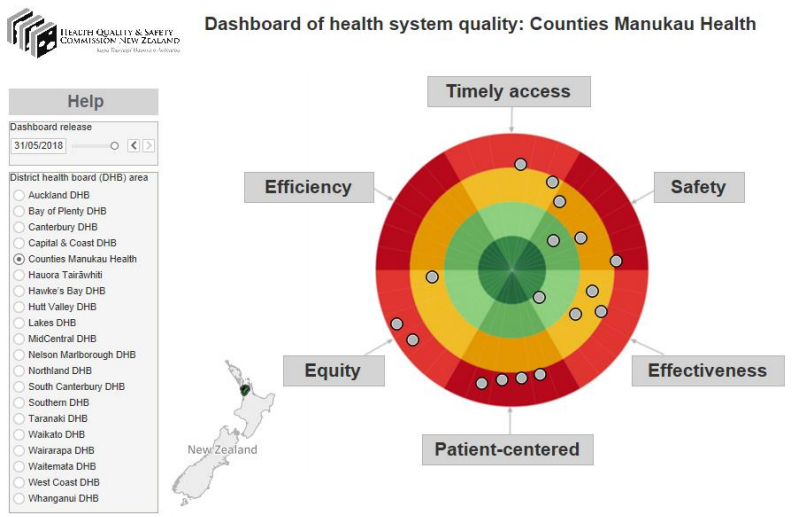
Discharge planning form in use		
Reporting month	3 months average	12 months average
100%	53%	53%

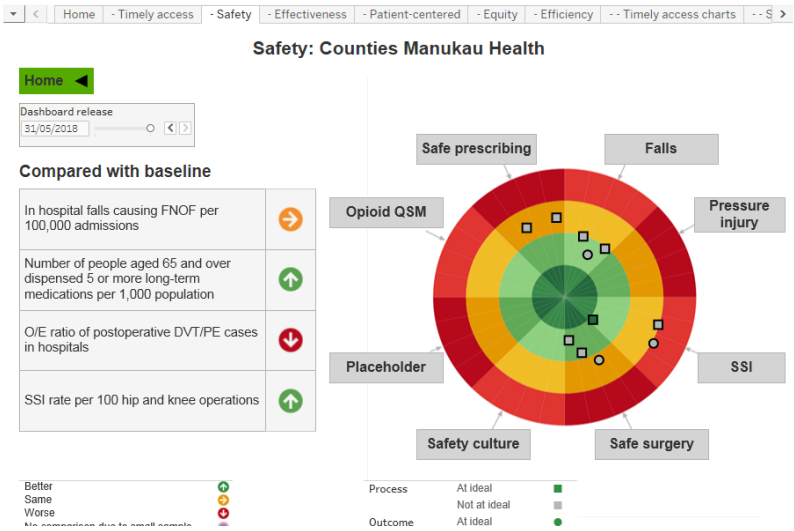
Patient's weight documented		
Reporting month	3 months average	12 months average
25%	15%	15%

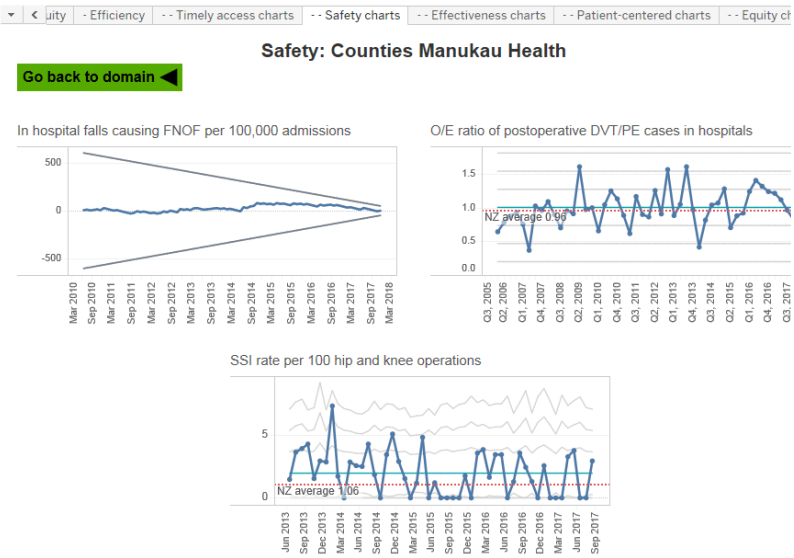
Total section of fluid balance chart completed		
Reporting month	3 months average	12 months average
n/a	0%	0%

On 31 May 2018, the Health Quality & Safety Commission launched a new, publicly-available dashboard of health system quality that shows at a glance how individual district health boards are performing in a variety of areas.

The 'dartboard' format has been introduced to bring a range of measures together in one place allowing many different measures to be put on the same scale. The dartboard also allows click-through to measures for the local system presented in time series and statistical process control format.







Counties Manukau District Health Board
Hospital Advisory Committee
Patient Experience and Safety Report

Recommendations

It is recommended that the Hospital Advisory Committee:

Note that this report was submitted to the Executive Leadership Team meeting on 26 June 2018.

Receive the Patient Experience and Safety Report June 2018.

Prepared by: Jacqueline Ryan, Patient Safety Manager and Dr David Hughes, Clinical Director Patient Safety & Quality Assurance. Submitted by Vanessa Thornton, Acting Chief Medical Officer (Hospital Services) and Jenny Parr, Director of Patient Care, Chief Nurse and Allied Health Professions Officer.

Purpose

To provide a regular update to Counties Manukau Health (CM Health) on the progress of the planned actions as linked to the Annual Plan Improving Quality section work plan.

Report content

1. Monthly Safety, experience, compliance and measurement dashboard
2. Monthly Safety, experience, compliance and measurement variance report

Appendices

1. Care Compass reports update
2. Plan of care summary of pre and post-implementation audits
3. Health Quality & Safety Commission dashboard update

Safety, experience, compliance and measurement dashboard

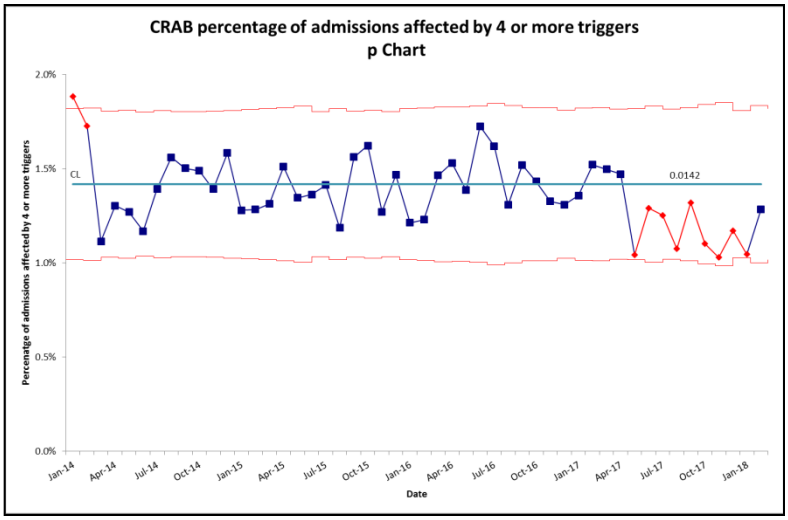
Monthly divisional summary of serious incidents – May 2018

Division	Description
Surgery	1. Patient presented four times over a month with increasing pain and tingling in arms. Diagnosed with dislocations C7/T1 and required urgent surgery. 2. Fall and possible loss of consciousness resulting in small acute intracranial bleed.
Medicine	1. Fall with patient hitting their head on the wall resulting in acute subdural haemorrhage. 2. Patient prescribed 20mg of oral Frusemide but was given 250mg of oral Frusemide. 3. Fall from self-propelling wheelchair when outside unescorted resulting in fractured mandible.
ARHOP	1. Iodine induced anaphylaxis resulting in myocardial infarction. 2. Fall resulting in right neck of femur and superior pubic rami fractures.
Women's Health	1. Fall following birth and post epidural analgesia resulting in a fractured right tibia. 2. Sub-optimal assessment and management of pregnancy with preeclampsia resulting in intrauterine death.

Target	Latest month
0 non-falls serious adverse events	4

This table shows the incidents by Division reviewed by the Serious and Sentinel Events (SSE) Executive Committee and reported to the Health Quality & Safety Commission as potentially meeting Severity Assessment Code (SAC) 1 or 2 criteria.

Copeland Risk Adjusted Barometer (CRAB)



Target	Latest month
<1.4%	1.3%

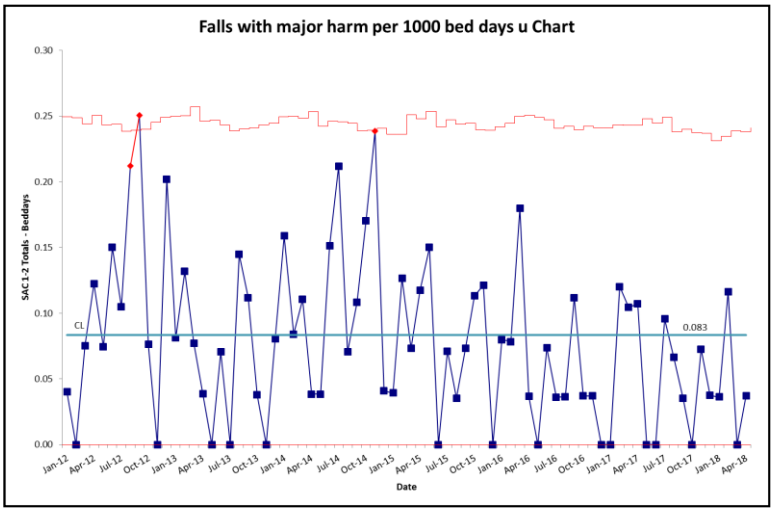
CRAB provides a risk adjusted view of complications, patient harm and mortality of inpatient admissions. An algorithm is applied to coded discharge data equivalent to the Trigger Tool. The review of admissions with four or more triggers will provide important lessons to improve patient safety. This chart shows common cause in the percentage of admissions affected by four or more triggers.

141

Safety, experience, compliance and measurement dashboard

1. National quality and safety markers (QSM)

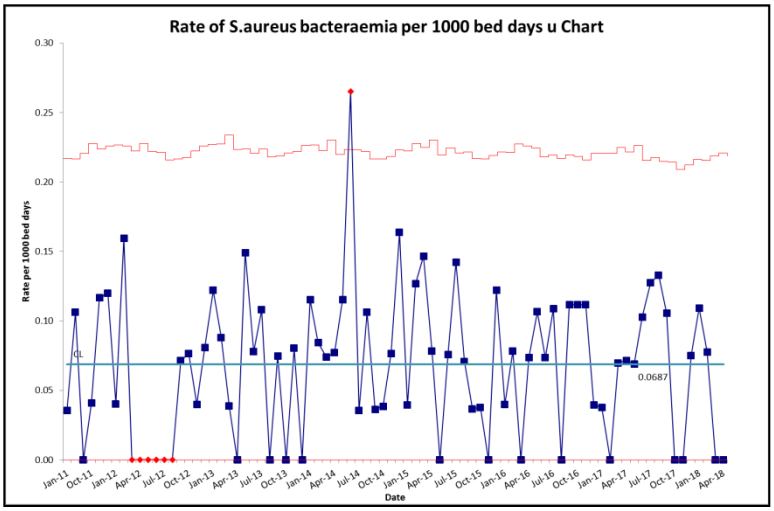
1.1 Falls



Target	Latest month
< 0.09 falls with major harm per month per 1000 bed days	0.03
QSM: 90% of older patients assessed for risk of falling	**Latest quarter** 92%
QSM: 90% of older patients assessed as at risk received an individualised care plan	**Latest quarter** 93%

This chart shows the number of falls with major harm per 1000 bed days. Since January 2014, on average, there has been an 18 per cent reduction in falls with major harm.

1.2 Hand Hygiene

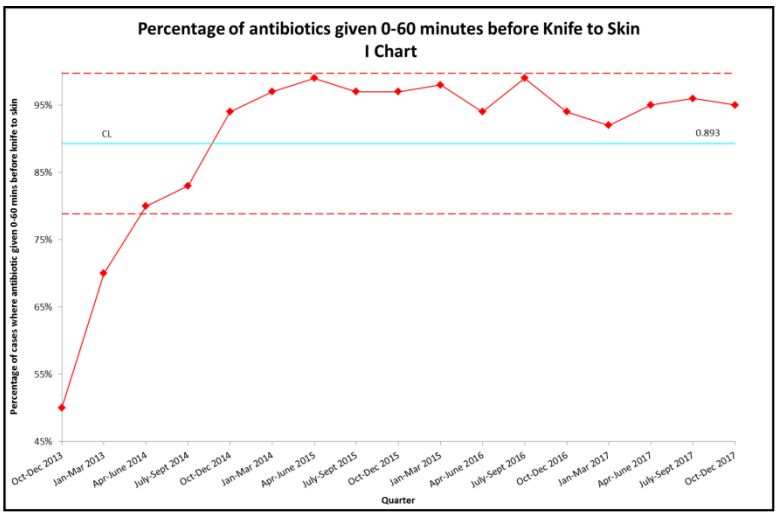


Target	Latest month
<0.06 SAB per 1000 bed days	0
QSM: 80% compliance with good hand hygiene practice	85%

This chart shows the rate of Staphylococcus aureus bacteraemia (SAB) per 1000 bed days. This is a measure of hospital acquired infection.

Since July 2017 the hand hygiene audit programme expanded to 26 clinical areas.

1.3 Surgical Site Infection



QSM Target	Latest quarter
100% of time antibiotics given 0-60 mins before knife to skin	95%
95% of patients receiving 2g or more of Cephazolin	100%

This chart shows antibiotics given within 0-60 minutes of knife to skin. Improvement in documentation of antibiotic administration will occur when the perioperative clinical information management system is embedded in usual practice.

142

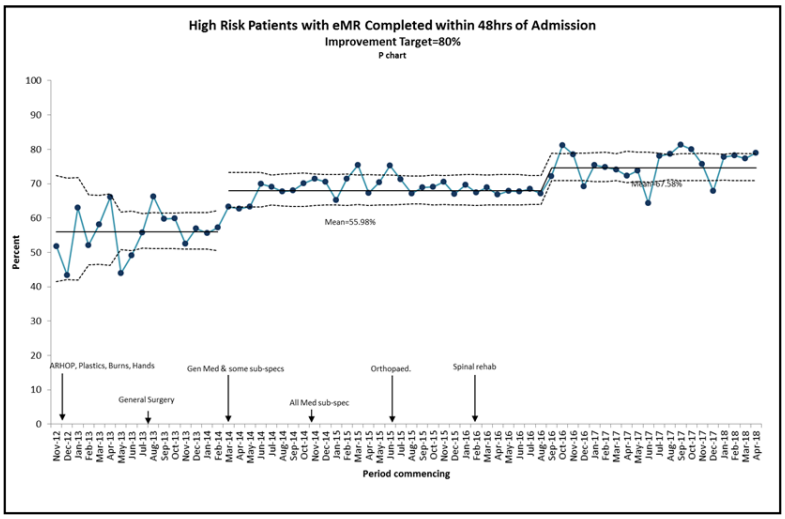
Safety, experience, compliance and measurement dashboard

1.4 Safe Surgery

QSM target	Latest quarter	
50 observation audits per quarter (150 audits in total per quarter)	Sign in	424
	Time out	450
	Sign out	441
100% of observed operations where checklist completed	Sign in	96%
	Time out	100%
	Sign out	93%
95% of observed stages with scores of 5, 6 or 7	Sign in	98%
	Time out	99%
	Sign out	96%

The new Safe Surgery QSM takes the form of an observational audit of the safer surgical checklist in a similar manner to 'Gold Audit' of hand hygiene.

1.5 Medication Safety



Target	Latest month
80%	79%

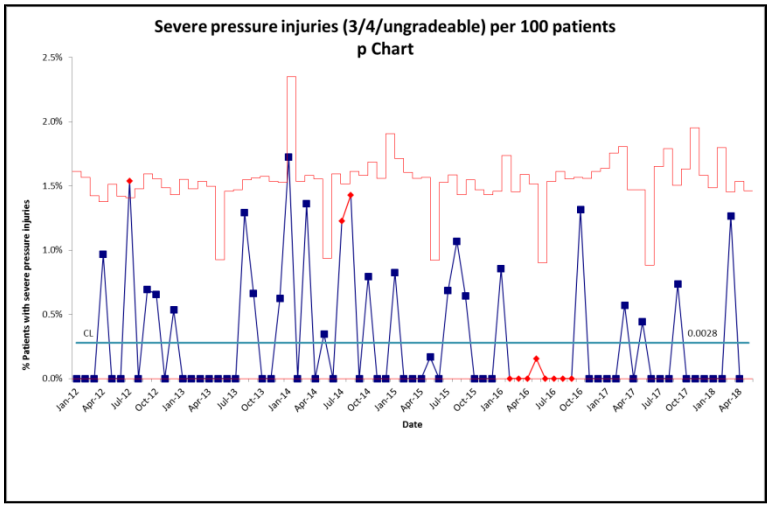
This chart shows the high risk patients with electronic medication reconciliation (eMR) completed within 48 hours of admission. Improvements in October and November 2016 reflected peaks in performance in eMR across both medicine and surgery. This target is yet to be reported nationally as CM Health is only one of five DHBs where eMR has been implemented.

Safety, experience, compliance and measurement dashboard

2. Enhance Quality and Experience of Care

2.2 Quality Monitoring and Improvement Group

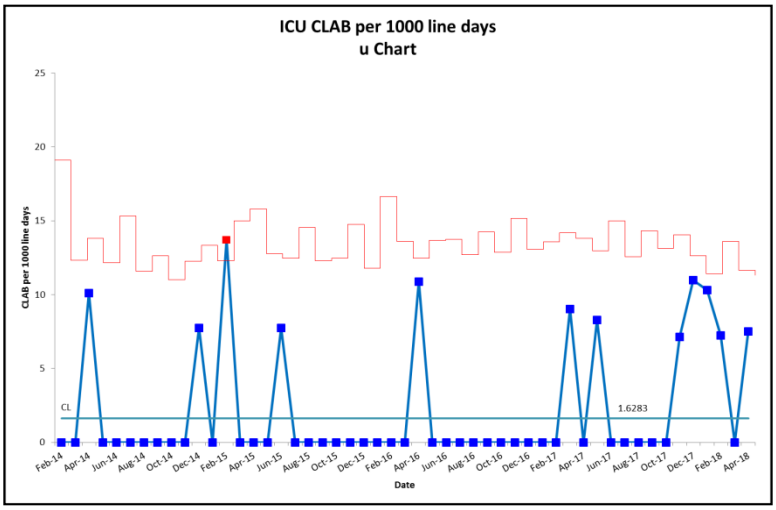
Pressure injuries



Target	Latest month
0 Stage 3, 4 or unstageable pressure injuries	0

This chart shows the severe pressure injuries (Stage 3, 4 or unstageable) per 100 patients on monthly audit. There has been a sustained reduction in the overall number of pressure injuries since June 2012 but common cause variation in Stage 3, 4 and unstageable pressure injuries since that time.

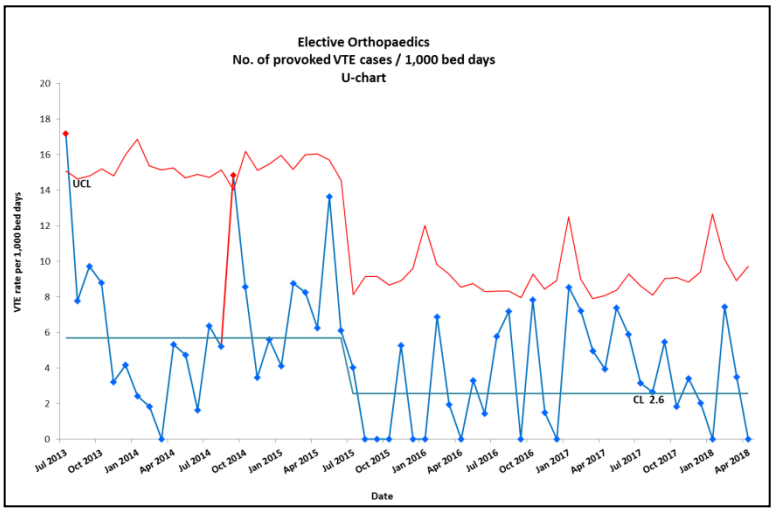
Central line associated bacteraemia



Target	Latest month
<1 CLAB per 1000 line days	1

This chart shows the Intensive Care Unit (ICU) central line associated bacteraemia (CLAB) rate per 1000 line days. The actual line days in ICU average 100 per month.

Venous thromboembolism (VTE)



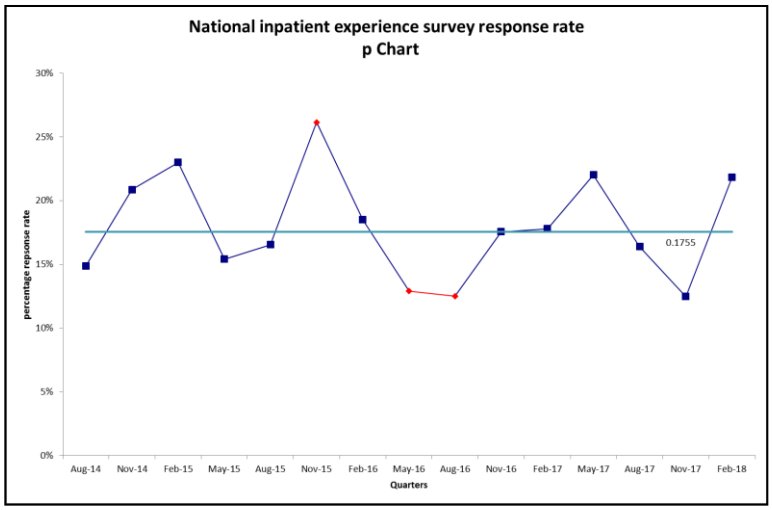
Target	Latest month
<1.7 per 1000 bed days	0

This chart shows the number of elective orthopaedic provoked VTE (venous thromboembolism/blood clot in vein) cases per 1000 bed days. This month's result is common cause variation.

Safety, experience, compliance and measurement dashboard

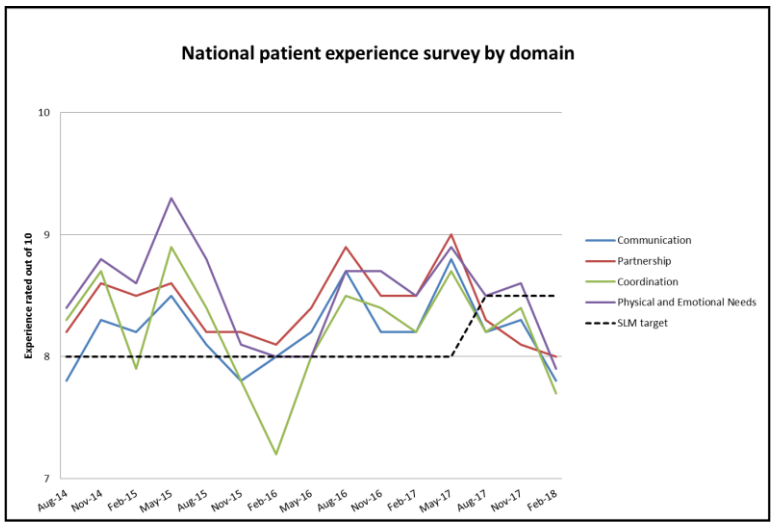
3. Improve consumer engagement

National inpatient experience survey



Target	Latest month
Maintenance of average response rate of 18%	22%

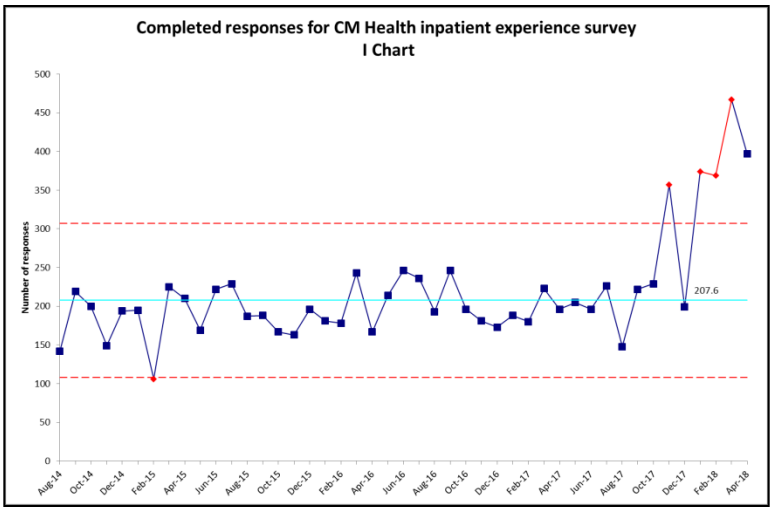
This chart shows the response rate to the National Patient Experience Survey. The current System Level Measure (SLM) target for the financial year 2016/17 is shown above. Efforts are underway to support the wards to collect email addresses and to raise the profile of the survey.



Target	Latest month
8.5 out of 10 average across four domains	7.9

This chart shows the score out of 10 for the four domains of the National Patient Experience Survey. The current System Level Measure (SLM) target the for financial year 2016/17 is shown above. The SLM target increased to an aggregate score of 8.5 across the four domains in July 2017.

3.2 Internal inpatient experience survey

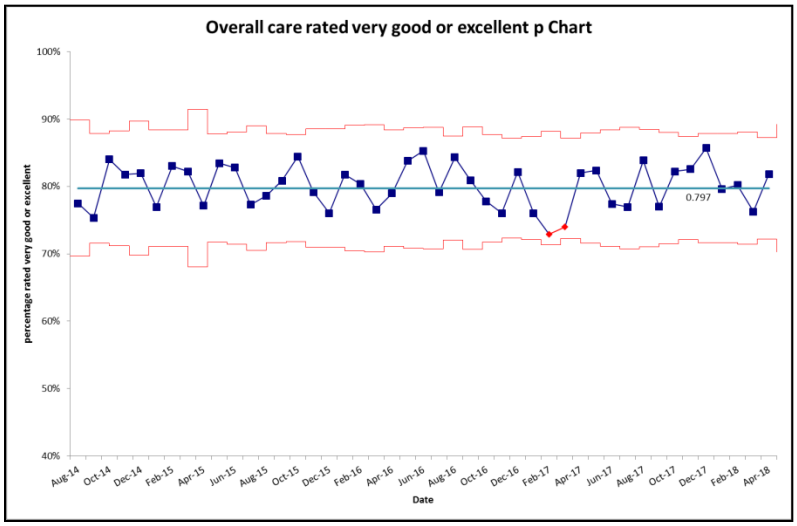


Target	Latest month
> 200 completed surveys per month	397

Since November 2017 there are now three ways for patients to complete the CM Health internal inpatient experience survey: email, text or tablet. This chart shows the number of patients who completed the survey.

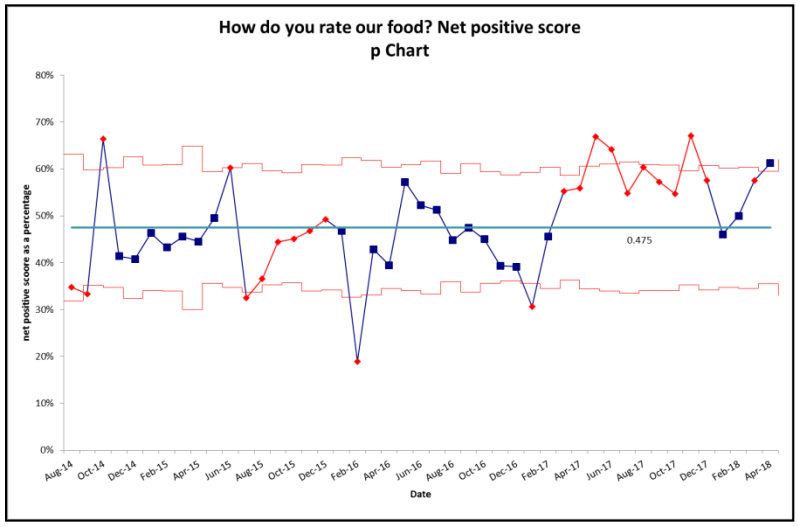
145

Safety, experience, compliance and measurement dashboard



Target	Latest month
80%	82%

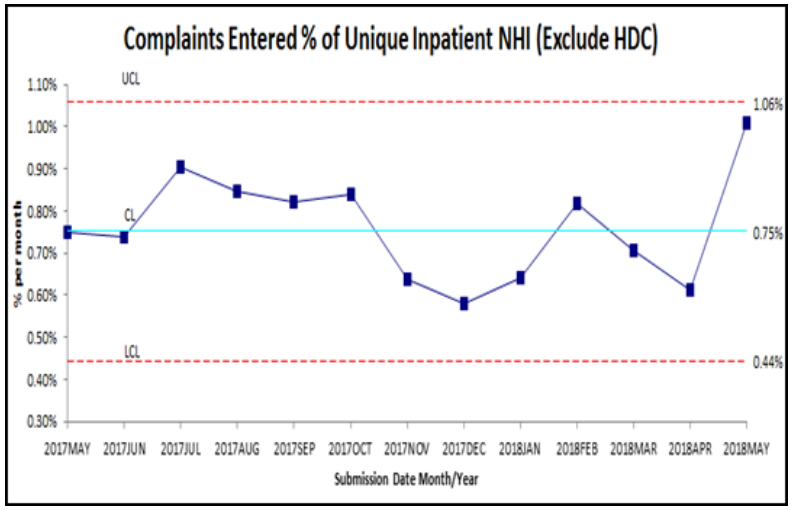
This chart shows the percentage of patients in our internal inpatient experience survey who rated their care as very good or excellent. The average is 80%. The target of 80% was established by ELT in April 2017.



Target	Latest month
Net positive score 66% or above	61%

This chart shows the percentage net positive scores (positive responses minus negative responses) and is a sensitive way of reporting people's strong views on the hospital food. Between 170-190 people answer the question on food each month. A net positive score of 66 per cent means that for every one person who reports our food as poor, there are five people who report it as good or very good.

Complaints



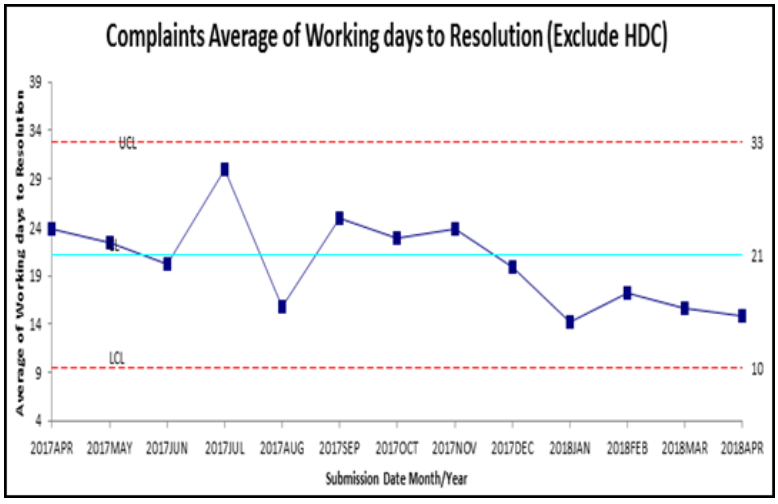
Target	This month
To be developed	

This chart shows the number of complaints in the feedback system as a percentage of the number of patients treated in hospital per month. The average rate is 0.78%. There is common cause variation in the number of complaints per month.

146

Safety, experience, compliance and measurement dashboard

Complaints

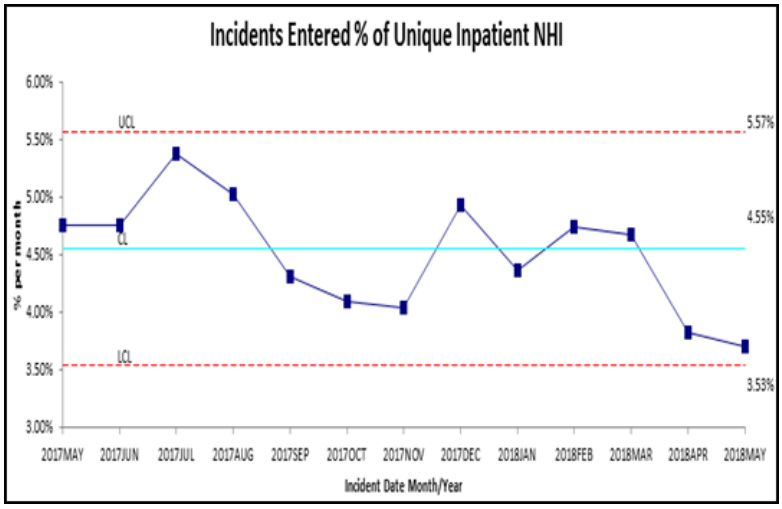


Target	Latest month
To be developed	

This chart shows the time taken to resolve complaints in the feedback system. It is a measure of timeliness of complaint processes. The average time to resolution is 20 days.

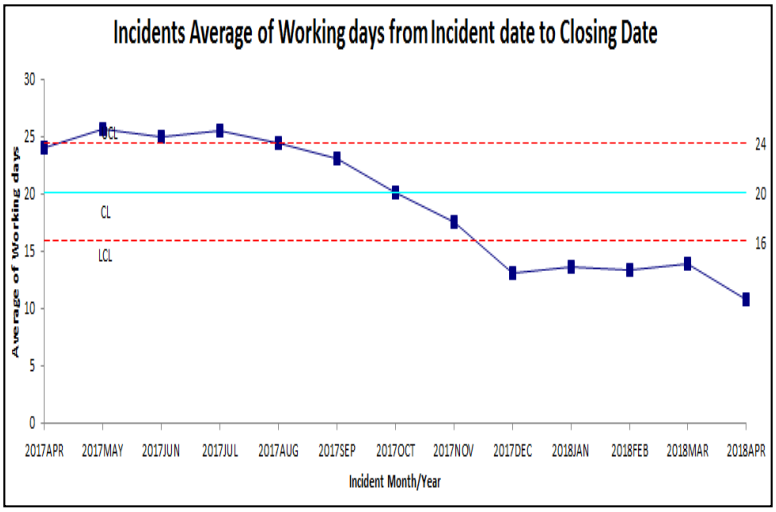
In the preceding 12 months, on average, 71 complaints per month are entered in the feedback system. This is incomplete data due to the lack of an end-to-end system to capture the totality of complaints.

Incidents



Target	Latest month
To be developed	

This chart shows the number of incidents in the incident management system per month. In the preceding 12 months, 500 incidents per month are entered in the incident management system. There is common cause variation in the number of incidents per month.



Target	Latest month
To be developed	

This chart shows the time taken to close off incident reports in the incident management system. It is a measure of timeliness of incident processes. The average time to close an incident is 17 days.

Safety, experience, compliance, measurement dashboard variance report – June 2018

Improving Quality work plan measure	Variance	Issue description	Action	By whom	By when
Serious incidents: 0 non-falls serious adverse events	+4	Four non-fall incidents reported in the last month as described on the dashboard.	Investigations are underway and they will be reported through the draft Counties Manukau Health Serious Adverse Event Report 2017-18.	Quality & Risk Managers	July 2018
Surgical Site Infection QSM: 100% of primary hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision	-5%	Documentation in two different places. No new data.	Improvement in documentation of antibiotic administration has occurred following the implementation of the perioperative clinical information management system (PCIMS). However, the knife to skin time is not a mandatory field in PCIMS and auditors continue to obtain this data from another source that has potential time inaccuracies.	Phillip Balmer/ Engin Ahmed	August 2018
Safe Surgery QSM: 100% of observed operations where checklist completed	Sign in -4% Sign out -7%	Sign in missed on 16 operations out of 458. Sign out checklist missed on 30 operations out of 479. No new data.	Quality & Risk Manager and theatre team continue to consider ways in which sign out is completed consistently.	Mark Moores/ Mary Burr	August 2018
Medication Safety QSM: 80% of high risk patients with electronic medication reconciliation (eMR) completed within 48 hours of admission	-1%	Other than ARHOP, the rate of eMR completion within 48 hours is not achieved mostly due to weekend admissions and availability of pharmacists.	This target is yet to be reported nationally as CM Health is only one of six DHBs where eMR has been implemented. Consider weekend work capacity for clinical pharmacists.	Sanjoy Nand/ Chip Gresham	To be determined
Central line associated bacteraemia: <1 CLAB per 1000 line days in ICU	+1	The actual line days in ICU average 100 per month across this period with one CLAB in April 2018.	Patient was admitted following an acute cervical spinal cord injury. A central line was inserted into the femoral artery at Auckland City Hospital (ACH) following the national insertion bundle. The patient was transferred to Middlemore ICU 24 hours post insertion. Adherence to the maintenance bundle interventions were 100% for both ACH and Middlemore. Patient developed MRSA pneumonia and become febrile. A positive blood culture showed E. coli and the central line was replaced. The patient continued treatment for pneumonia, and had a temporary pacemaker inserted related to a period of bradycardic pulseless electrical activity arrests, and has now been transferred to the Spinal Unit. On review, initial site placement may have contributed to the CLAB.	Catherine Hocking	July 2018
National inpatient experience survey: Average of 4 domains >8.5	-0.6	All four domains were rated below 8.5. No new data.	Continued efforts to improve communication, partnership and coordination of care.	Jenny Parr/ Phillip Balmer	August 2018
CM Health inpatient experience survey: Net positive score 66% or above for hospital food.	-5%	Target raised from net positive score 50% or above to net positive score 66% or above.	Improved response in the last month following the average performance of the previous two months.	Jenny Parr/ Phillip Balmer	Not applicable

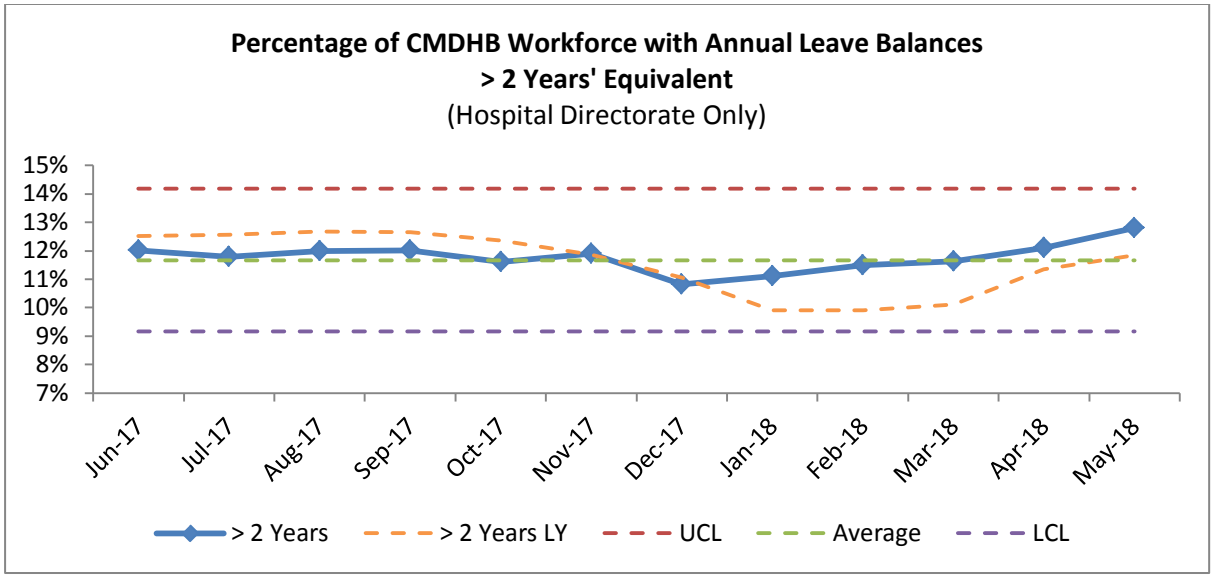
Human Resources

May 2018

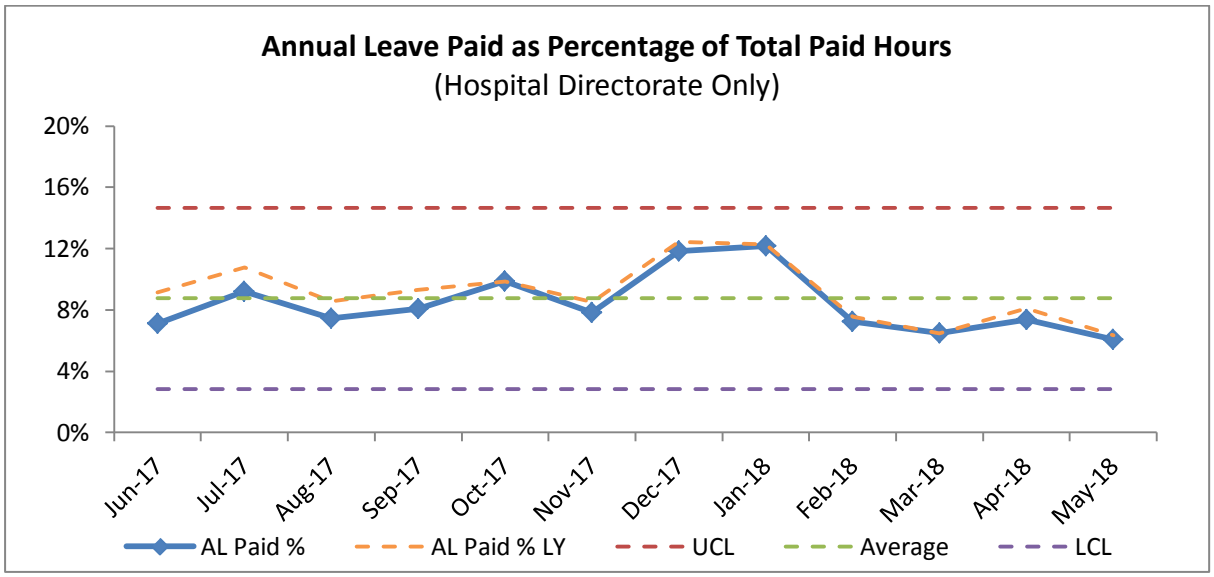
Regular Reporting Items

HR metrics are provided to outline performance for Annual Leave Balances, Sick Leave and Turnover rates. Below are the 12 month trend graphs to May 2018 (*except for the Sick leave April 2018*).

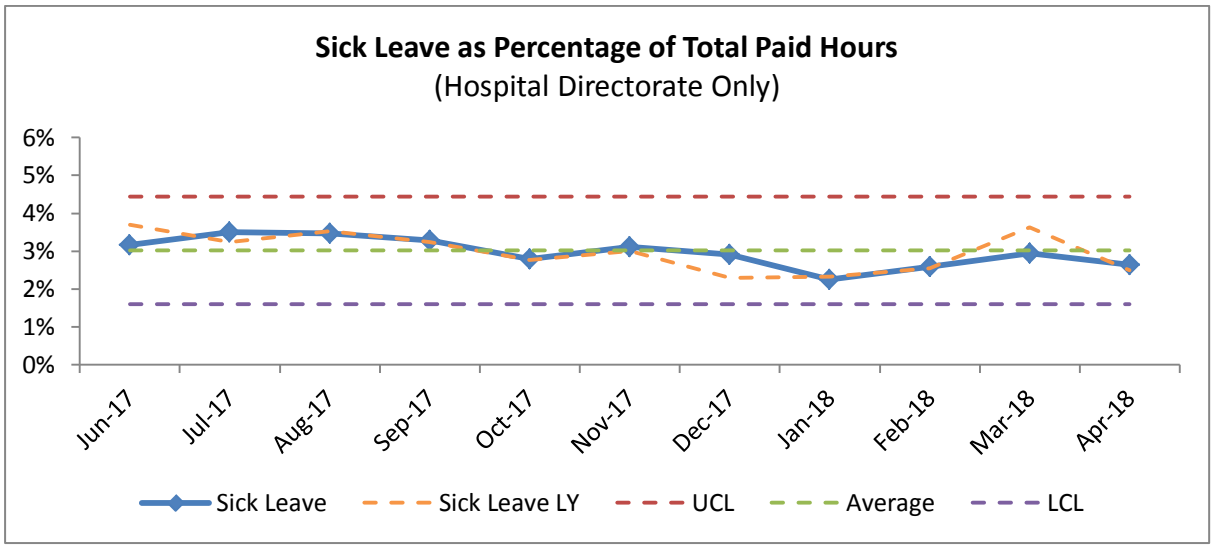
Graph 1: Annual Leave Balance >2 Years Equivalent



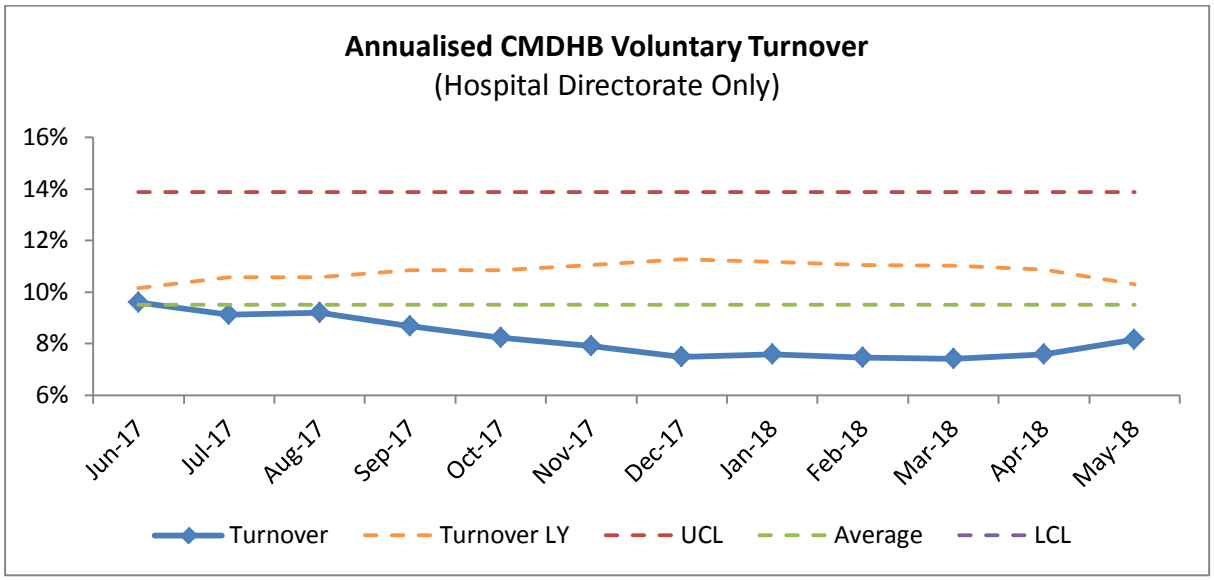
Graph 2: Total Annual Leave Paid Hours



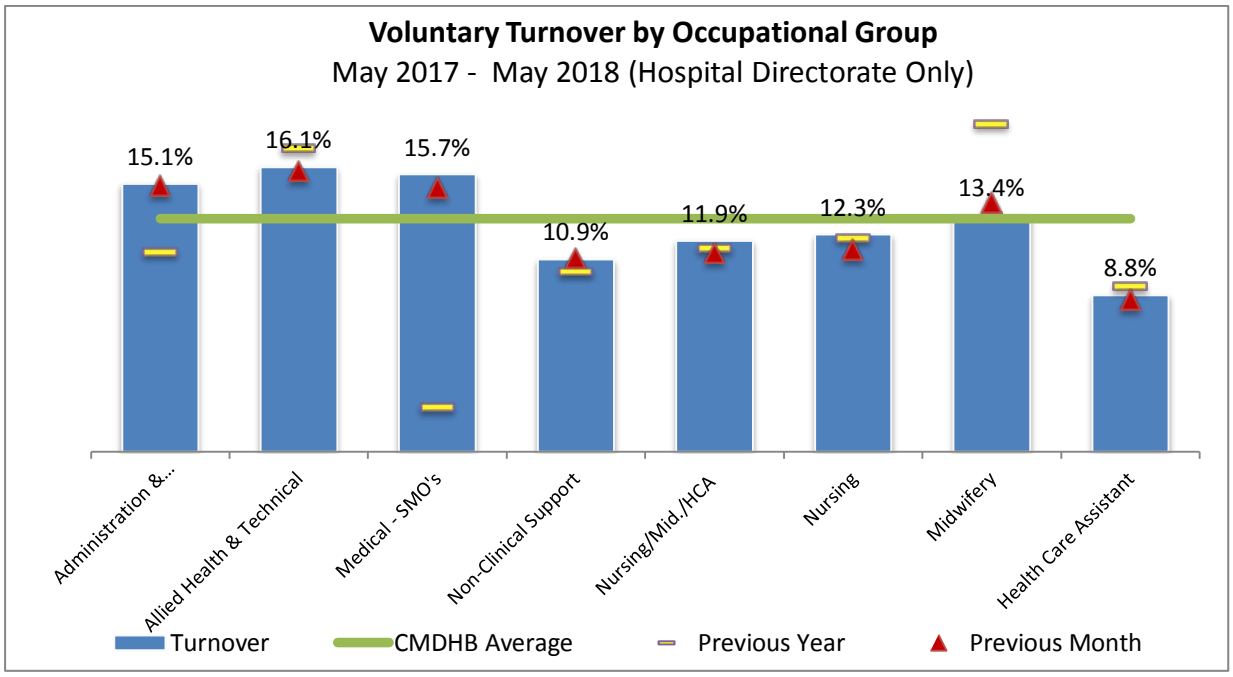
Graph 3: Total Sick Leave Paid Hours



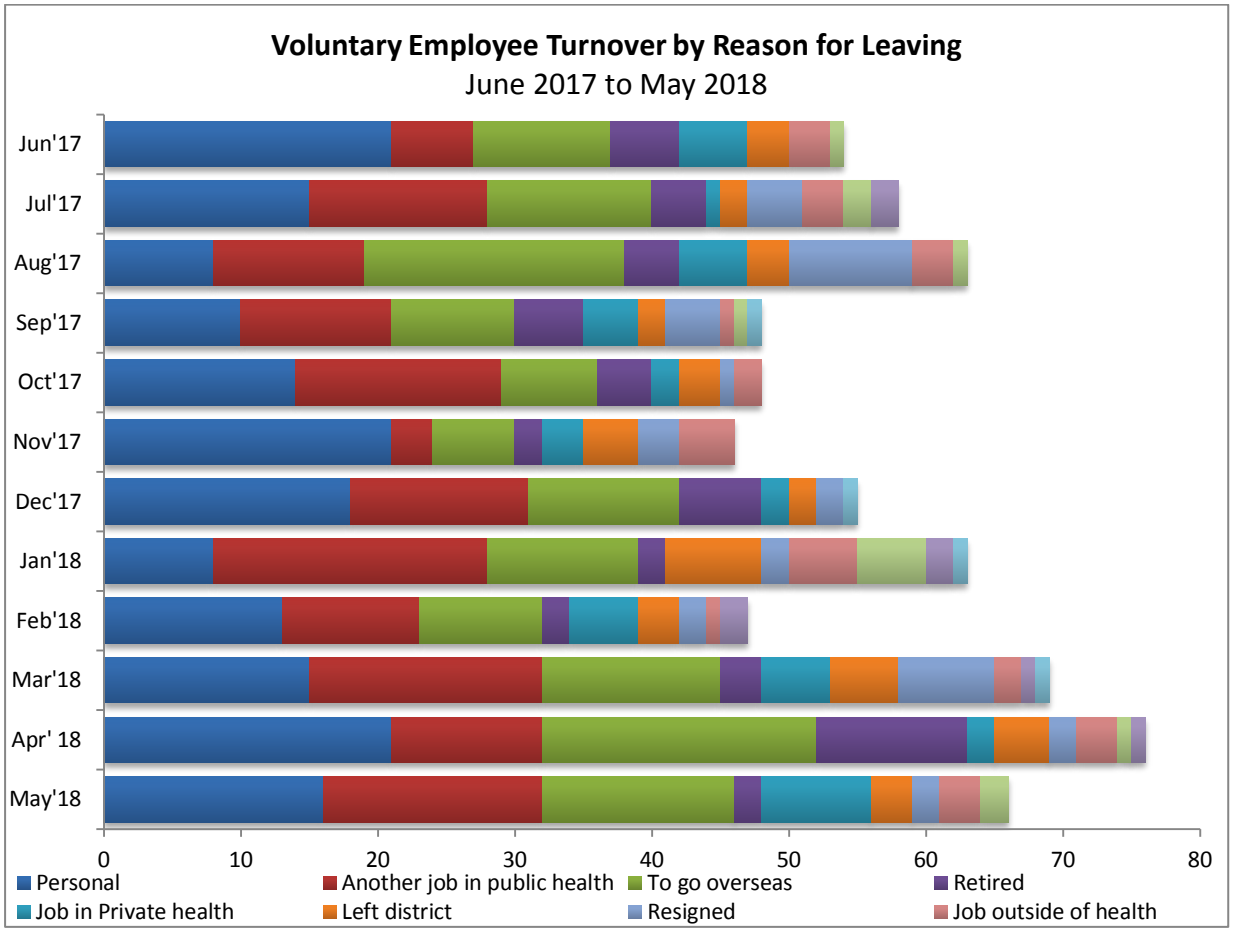
Graph 4: Voluntary Turnover



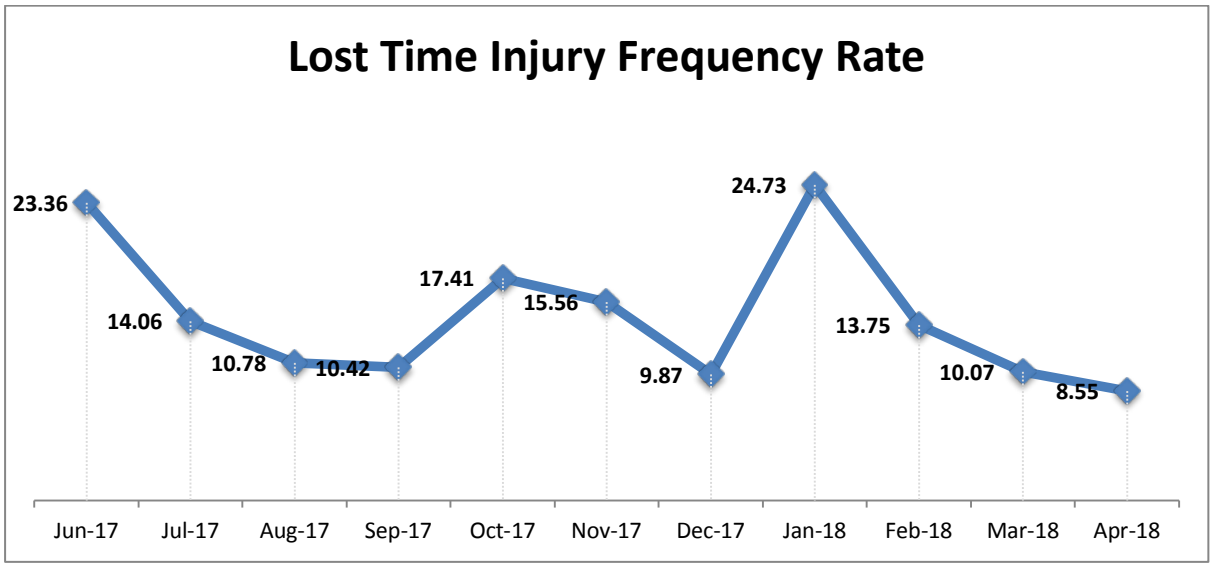
Graph 5: Voluntary Turnover by Workforce Group



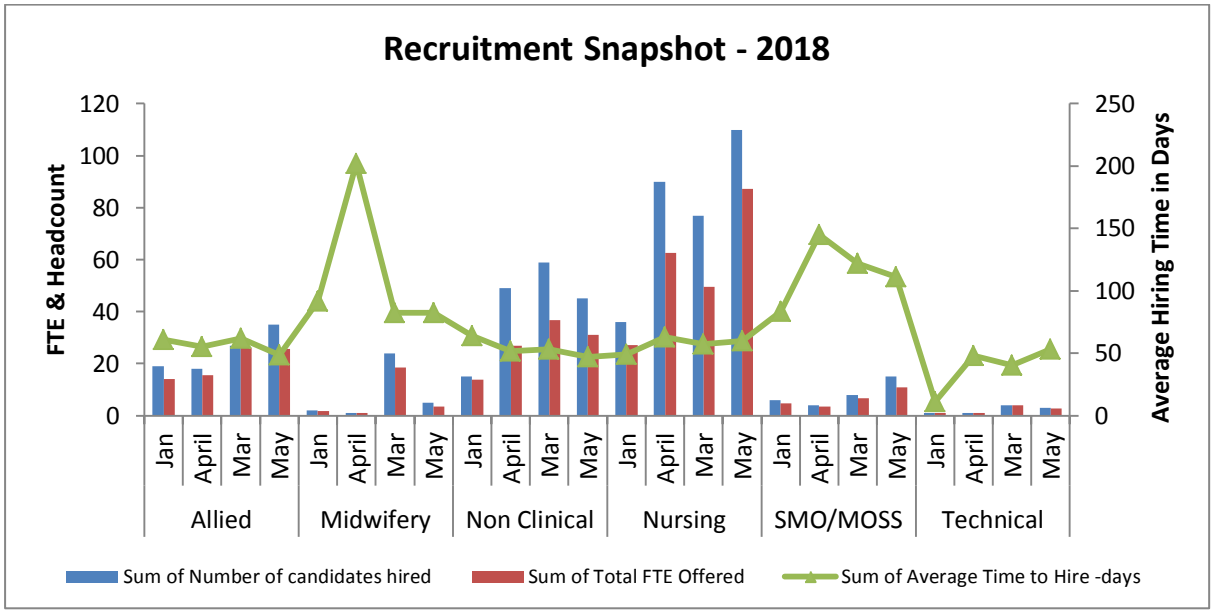
Graph 6: Voluntary Turnover Reason Categorisation



Graph 7: Lost Time Injury Frequency Rate



Graph 8: Recruitment - Hired FTE, Headcount and Average Time to Hire in Days



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:

General Subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
2.1 Public Excluded Minutes of 6 June 2018	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982). [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** For the reasons given in the previous meeting**.**
3.1 Patient Experience and Safety Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982). [NZPH&D Act 2000 Schedule 3, S32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S9(2)(a)]