AGENDA
Held on Friday, 12 August 2016
Kenepuru Education Centre
Kenepuru Community Hospital
Commencing at 8.30am

HOSPITAL ADVISORY COMMITTEE
PUBLIS SECTION

QUORUM is a majority of Committee members

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
<th>Presenter</th>
<th>Min</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Procedural Business</td>
<td></td>
<td>5</td>
<td>8:30 – 8:35</td>
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<tr>
<td>1.1</td>
<td>Apologies</td>
<td>To Note</td>
<td>Chair</td>
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<tr>
<td>1.2</td>
<td>Continuous Disclosure</td>
<td>To Consider</td>
<td>Chair</td>
<td>2-5</td>
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<tr>
<td>1.2.1</td>
<td>Interest Register</td>
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<td>1.2.2</td>
<td>Conflicts of Interest</td>
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<td>1.3</td>
<td>Minutes of Previous Meeting</td>
<td>To Discuss</td>
<td>Chair</td>
<td>6-9</td>
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<td>1.4</td>
<td>Matters Arising</td>
<td>To Consider</td>
<td>Chair</td>
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2.1 Operational Services Monthly Report
- Strategic issues and priorities
- Financial performance
- Balanced score card reporting
   To Note | Chris Lowry | 20 | 8:35 – 9:10 | 12-27 |

2.2 MHAID Service 3DHB Report
   To Note | Nigel Fairley | 15 | 9:10 – 9:25 | 28-33 |

2.3 Professional Heads Report
   To Note | Andrea McCance Catherine Epps John Tait | 10 | 9:25 – 9:35 | 34-37 |

2.4 Infection Prevention Control (deferred from June meeting)
   To Note Presentation | Dr. Timothy Blackmore | 15 | 9:35 – 10:00 | Nil |

3.1 General
   To Approve | Chair | 5 | 10:05 – 10:10 | 38 |

CLOSE

DATE OF NEXT MEETING
14 October 2016 | Kapiti District Council Chambers, 175 Rimu Road, Paraparaumu

APPENDICES

2.1.1 Theatre measures dashboard
2.1.2 CCDHB monthly balanced scorecard
2.2.1 MHAID Service 3DHB balanced scorecard
2.2.2 MHAID Wairarapa balanced scorecard
2.2.3 MHAID monthly inpatient report
2.3.1 Background information on pressure injuries
### Interest Register

#### 10 June 2016

<table>
<thead>
<tr>
<th>Name</th>
<th>Interest</th>
</tr>
</thead>
</table>
| **Dr Bryan Betty**<br>Chairperson | - General Practitioner, Porirua Union & Community Health  
- Chair, Porirua Kids Group  
- Deputy Chair, Wellhealth Trust PHO  
- Chair, CCDHB ICC (Alliancing) leadership group  
- Member, CCDHB Diabetes network  
- Board member, Porirua Union & Community Health Services  
- Deputy Medical Director, PHARMAC |
| **Dr Virginia Hope**<br>Member | - Chair, Hutt Valley District Health Board, member CPHAC/DSAC and FRAC and Chair HAC  
- Chair, Capital & Coast District Health Board and member, statutory committees  
- Member, Regional Governance Board  
- Medical Director, Institute of Environmental Science & Research  
- Director & Shareholder, Jacaranda Limited  
- Fellow, Royal Australasian College of Medical Administrators and New Zealand College of Public Health Medicine  
- Fellow and New Zealand Committee Member, Australasian Faculty of Public Health Medicine  
- Member, Territorial Forces Employer Support Council  
- Member, Laboratory Round Table  
- Brother and sister work in health sector in the Wairarapa in disability support and laboratories |
| **Dr Judith Aitken**<br>Member | - Member, Capital & Coast District Health Board  
- Member, Finance Risk & Audit Committee, Capital & Coast District Health Board  
- Member, CCDHB FRAC committee  
- Member, 3DHB FRAC committee  
- Member, HAC committee  
- Councillor, Greater Wellington Regional Council  
- Chair, Audit, Risk & Assurance Committee, Greater Wellington Regional Council  
- Member, Strategy and Policy Committee, Greater Wellington Regional Council  
- Trustee, Carter Observatory Trust  
- Board member, Citizenship Trust  
- Board member, Holocaust Centre of New Zealand |
| **Mr David Choat**<br>Member | - Member, Capital & Coast District Health Board  
- Member, CCDHB Hospital Advisory Committee  
- Member, 3DHB CPHAC/DSAC committee  
- Partner employed as Solicitor, New Zealand Public Service Association  
- Chief Policy Analyst, Ministry of Education |
| **Mr Nick Leggett**<br>Member | - Member, Capital & Coast District Health Board  
- Chair, 3DHB CPHAC/DSAC committee  
- Member, CCDHB FRAC committee  
- Member, 3DHB FRAC committee |
### Dr Leo Buchanan
**Member**
- Member, HAC committee
- Board representative, Sub Regional Pacific Strategic Health Advisory Group
- Mayor, Porirua City Council
- Trustee, Spark Foundation
- Chairperson, Wellington Regional Emergency Management Committee, Greater Wellington Regional Council
- Member, Wellington Regional Transport Committee, Greater Wellington Regional Council
- Member, Wellington Water Committee
- Director, Village at the Park Facilities
- Advisory Trustee of Te Aro Pa Trust engaged in social housing project development at Evans Bay

### Ms Sue Kedgley
**Member**
- Member, Capital & Coast District Health Board
- Member, CCDHB HAC committee
- Member, Greater Wellington Regional Council
- Member, Consumer New Zealand Board

### Dr Margaret Wilsher
**Crown Monitor**
- Crown Monitor, Capital & Coast District Health Board
- Chief Medical Officer, Auckland District Health Board
- Clinical Associate Professor, University of Auckland
- Member, Capital Investment Committee
- Member, Hospital Redevelopment Partnership Group (Canterbury)
- Director, New Zealand Health Innovation Hub
- Independent Physician, Auckland Medical Specialists
- Fellow, Royal Australasian College of Medical Administrators
- Fellow, Royal Australasian College of Physicians
- Member, ASMS
- Member, Southern Partnership Group
- Director, Northern Region Alliance Health Ltd
# Executive Leadership Team

**10 June 2016**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debbie Chin</td>
<td>Chief Executive Officer</td>
<td>• Member, Rotary</td>
</tr>
<tr>
<td>Chris Lowry</td>
<td>Chief Operating Officer</td>
<td>• Son employed by Hutt Valley DHB</td>
</tr>
<tr>
<td>Donna Hickey</td>
<td>Director, Human Resources, 3DHB</td>
<td>• Sister is a nurse, working for Plunket</td>
</tr>
<tr>
<td>Tony Hickmott</td>
<td>Interim Executive Director, 3DHB Corporate Services</td>
<td>• Wife employed by Capital &amp; Coast District Health Board</td>
</tr>
<tr>
<td>Nigel Fairley</td>
<td>General Manager, Mental Health Addictions &amp; Intellectual Disability Service, 3 DHB</td>
<td>• Fellow, NZ College of Clinical Psychologists</td>
</tr>
<tr>
<td>Shayne Hunter</td>
<td>Interim Chief Information Officer, 3 DHB</td>
<td></td>
</tr>
<tr>
<td>Cheryl Goodyer</td>
<td>Capability Manager, Māori Health Development Group</td>
<td>• Director, Otarere Māori Arts and Crafts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Various family members working across the DHB health sector – HV/Auckland/Canterbury DHBs</td>
</tr>
<tr>
<td>Taima Fagaloa</td>
<td>Director, Pacific Health</td>
<td>• Cousin works as a community health worker for Ora Toa Health</td>
</tr>
<tr>
<td>Mr John Tait</td>
<td>Chief Medical Officer</td>
<td>• Member Fertility Associates</td>
</tr>
<tr>
<td>Catherine Epps</td>
<td>Director of Allied Health, Technical &amp; Scientific</td>
<td>• Expert Advisor (leadership) to New Zealand Speech-language Therapists Association</td>
</tr>
<tr>
<td>Andrea McCance</td>
<td></td>
<td>• Trustee, Mary Potter Hospice</td>
</tr>
</tbody>
</table>
| **Director, Nursing & Midwifery** | • Past President/ Advisor to Board, Wellington Riding for the Disabled  
• Managing Director, Dream Achievers Ltd  
• Member on the Ministry of Health National Advisory Group for Review of Behaviour Support Services |
| **Dr Pauline Boyles**  
**Senior Disability Advisor** | • Mother-in-law and sister-in-law are a Bureau nurse and Healthcare assistant respectively  
• Another sister-in-law is a nurse at CCDHB |
| **Jannel Fisher**  
**Communications Manager** |
# Hospital Advisory Committee Public

**Capital & Coast District Health Board**  
Page 1  
June 2016

## Draft Minutes

Held on Friday, 10 June 2016  
Ratonga Rua o Porirua, 20 Upper Main Drive, Kenepuru  
Commencing at 8:30am

### Hospital Advisory Committee  
**Public Section**

| Present: | Dr V Hope (Chair)  
Dr J Aitken  
Dr L Buchanan  
Mr N Leggett  
Ms S Kedgley |
| APOLOGIES: | Dr B Betty  
Dr M Wilsher (Crown Monitor) |
| In Attendance: | Ms D Chin (Chief Executive, Capital & Coast DHB)  
Ms C Lowry (Chief Operating Officer, Capital & Coast DHB)  
Mr N Fairley (General Manager, Mental Health, Addictions & Intellectual Disability 3DHB)  
Mr J Tait (Chief Medical Officer, Capital & Coast DHB)  
Ms C Epps (Executive Director, Allied Health Technical & Scientific)  
Ms A Nicholas (Minute Taker)  
Ms C Virtue, Executive Director, Medicine, Cancer & Community Directorate  
Mr B Storey, Charge Nurse Manager, Emergency Department  
Ms H Ritchie (Board member)  
Mr D Choat (Board member) |

### 1.0 Procedural Business

#### 1.1 Apologies

The Committee(s) **accepted** the apologies as listed above.

#### 1.2 Interests

**1.2.1 Interest Register**  
No amendment was declared by the committee.

**1.2.2 Conflict of Interest**  
No conflicts of interest were declared for any items listed on the agenda.

The Committee **confirmed** that it was not aware of any other matters (including matters reported to, and decisions made, by the Committee at this meeting) which require disclosure.

#### 1.3 Confirmation of Meeting Minutes 8 April 2016

**Resolved** that the minutes of the Committee meeting(s) held on 8 April 2016 taken with the public present were confirmed as a true and correct record.

**Moved** J Aitken  
**Seconded** S Kedgley  
**Carried**
1.4 MATTERS ARISING

REQUESTED:
The committee requested management provide a clear and focused strategy for Child Healthcare within the region and consider:

- Progress to date (from previous discussions as per recommendation agreed by the Board)
- Strategic expectations over the next 10 years specifically for low income families including ethnicity
- The changing demographics
- Cohesive child health services (despite not being funded)
- The progress of child healthcare planning within the context of Vision 2030
- The impact of no funding streams

The Committee:
Noted that the strategy for Child Health Services is being developed as part of the Health System Planning work that is underway

ACTION:
1. Management to provide an update on the Child Health Strategy that is under development to the next Board Workshop – Friday, 8 July 2016 and report back to the Health Advisory Committee post workshop. (H103)

2.1 OPERATIONAL MONTHLY SERVICE REPORT
The report was taken as read and the Committee Chair invited the Chief Operating Officer to provide an update of the report.

The Committee:

a. Noted the matters arising updates
b. Noted the emergency management update
c. Noted the areas of key priority to support an ongoing improvement in patient flow
d. Noted the performance against the elective surgery health target and confirmation of an additional 65 procedures to be completed by the end of June
e. Noted the change process with Mental Health patients within the Emergency Department
f. Noted the current performance and areas of focus reported in the Balance Scorecard

PRESENTATION, SHORTER STAYS IN ED – a Charge Nurse Manager’s perspective
In Attendance: Benjamin Storey, Charge Nurse Manager, Emergency Department
Carey Virtue, Executive Director (Operations), Medicine, Cancer and Community Directorate (joined the meeting at 8:45am)

The presenter outlined highlights of his tenure as Charge Nurse Manager, ED over the past four years.

The Committee:

a. Noted the ED journey and progress made over the past eight years identifying successes, the importance of culture as well as strategy and the importance of transparency
b. Noted the positive impact this work has had on achieving the Ministry targets
c. Noted the motivational expert advice provided by Ian Sturgess and Professor Mike Ardagh
HOSPITAL ADVISORY COMMITTEE

The Chair on behalf of the committee commended the Charge Nurse Manager on his presentation, the leadership being shown, the culture shift that has been achieved and the efforts of the people in his team.

The committee members acknowledged the wonderful job the ED staff are doing and REQUESTED that the acknowledgment be formally ENDORSED

ACTION:
2. The committee requested management follow up on what training is provided for ED staff to help them deal with patients with disabilities. (H104)

Presentation / Discussion ended at 9:45am

EMERGENCY MANAGEMENT
The Emergency Management update and the letter from the Ministry of Health – Exercise Tangaroa, outlining what DHBs need to be prepared for in the case of an emergency and what needs to be done collectively was taken as read.

The committee:

NOTED Wellington Water and the Prince of Wales reservoir development plans. This is not seen as funding from Health but rather approaching the government under an infrastructure banner.

SHORTER STAYS IN ED HEALTH TARGET
The committee:

NOTED the enormous amount of work going into the acute flow programme, particularly the Chief Medical Officer and Clinical Directors work leading discussions with the specialties regarding the development of Professional Standards.  
NOTED the development and success of the Integrated Operations Centre (IOC).
FINANCIAL PERFORMANCE
The committee:

NOTED that the financial commentary could be improved by the addition of trend analysis reporting and graphs
NOTED that the deficits show that the DHB is over budget in most areas
NOTED that the plan and forecast is on track
NOTED that the Ministry of Health expectation for the last financial year is for the DHB to breakeven. The DHB needed to achieve a 3.5% saving to achieve this. Currently achieved 2.3% with a gap of 1.2% that we have not been able to close

ACCESS TO DIAGNOSTICS - COLONOSCOPIES
The committee members acknowledged the excellent work undertaken to achieve all of the indicators for access to colonoscopies.

2.2 MHAID SERVICE 3DHB REPORT
The report was taken as read.
The Committee:
NOTED the contents of the report.

ACTION:
3. The committee requested management to provide more graphs on Mental Health trends of activity. (H105)

2.3 PROFESSIONAL HEADS REPORT
The paper was taken as read. The Committee Chair invited John Tait (Chief Medical Officer) and Catherine Epps (Executive Director of Allied Health, Technical & Scientific) to provide a brief summary on the report.

The Committee:
NOTED the contents of the reports:
Highlighting:
- The Paediatric Malnutrition screening tool has been rolled out across the children’s wards
- The national tertiary shortage of midwives and the involvement of a lactation consultant to focus on the low breastfeeding rates within Maori

2.4 CCDHB QUALITY REPORT
The report was taken as read.
The Committee:

NOTED that the Health and Safety report would be included on the FRAC and Board meeting agendas.
NOTED the phased approach to the full implementation of CCDHBs Primary Secondary Consumer Council VOICE.

ACTION:
4. The committee requested that the governance level Consumer Council be included in the Board Workshop work plan. (H106)
3.0 OTHER

3.1 GENERAL
No items of general discussion were required.

3.2 RESOLUTION TO EXCLUDE PUBLIC
RESOLVED: The Committee(s) AGREED that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>NZ Public Health &amp; Disability Act</th>
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<tbody>
<tr>
<td>Confirmation of Minutes of the previous “Public Excluded Section” of the Hospital Advisory Committee Meeting</td>
<td>Section 9(2)(i) of the OIA which enables the withholding of information to allow the carrying out, without prejudice or disadvantage, negotiations</td>
</tr>
<tr>
<td>Operational Services Monthly Report</td>
<td>Section 9 (2) (j) which enables the withholding of information to allow the carrying on, without prejudice or disadvantage, commercial activities.</td>
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<tr>
<td>• Capital and Coast DHB - SAC1 and 2 Events</td>
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<tr>
<td>• Capital and Coast DHB - Complaints</td>
<td>Section 9(2) (c) enables the withholding of information to avoid prejudice to measures protecting the health or safety of members of the public.</td>
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MOVED S Kedgley SECONDED J Aitken CARRIED

The public section of the meeting adjourned at 10:25am
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<tr>
<th>Meeting date</th>
<th>Ref</th>
<th>Topic</th>
<th>Action Arising</th>
<th>Responsible</th>
<th>How Dealt with</th>
<th>Delivery date</th>
<th>Date Completed</th>
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<tbody>
<tr>
<td>10 Jun 2016</td>
<td>H103</td>
<td>Operational Monthly Service Report</td>
<td>The committee requested management to provide an update on the Child Health Strategy that is under development to the next Board Workshop – Friday, 8 July 2016 and report back to the Health Advisory Committee post workshop</td>
<td>Secretary</td>
<td>Notify Board Secretary</td>
<td>tbc</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>H104</td>
<td></td>
<td>The committee requested management follow up on what training is provided for ED staff to help the deal with patients with disabilities</td>
<td>COO</td>
<td>Included in report</td>
<td>Aug 2016</td>
<td>Completed</td>
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<tr>
<td></td>
<td>H105</td>
<td>MHAID Service 3DHB Report</td>
<td>The committee requested management to provide more graphs on Mental Health trends of activity</td>
<td>General Manager</td>
<td>Included in report</td>
<td>Aug 2016</td>
<td>Completed</td>
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<td></td>
<td>H106</td>
<td></td>
<td>The committee requested that the governance level Consumer Council be included in the Board Workshop work plan.</td>
<td>Secretary</td>
<td>Notify Board Secretary</td>
<td>tbc</td>
<td>Completed</td>
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**RECOMMENDATION**

It is recommended that the Committee:

a. **Note** the matters arising updates

b. **Note** the current performance and priorities to support an improvement in acute patient flow

c. **Note** the update on the introduction of the Endoscopic Ultrasound and the impact this is having

d. **Note** the performance and areas of focus reported in the Balance Scorecard

e. **Note** the theatre measures dashboard reporting and improvement in theatre throughput in the past year.

f. **Note** the Infection Prevention & Control presentation to follow

**APPENDICES**

2.1.1 Theatre measures board

2.1.2 CCDHB monthly balanced scorecard

**PART ONE – MATTERS ARISING UPDATES**

1.1 **Training provided for emergency department (ED) staff to help deal with patients with disabilities**

The question relating to training provided for ED staff on managing patients with disabilities was raised at the last HAC meeting. Disability responsiveness training is compulsory for staff and ED has required all nursing staff complete this.

Disability responsiveness is included in the orientation for all new nursing staff orientating to ED, along with the expectation they complete disability responsiveness e-learning. The Nurse Educators review the achievement of this as part of the mandatory training required for all new staff nurses at three months post orientation.

When Health Passports were introduced the ED nursing team were provided with information and training. Since then ED have had patients and advocates come and speak to staff on disability issues, and ran a disability awareness week in 2015 with guest speakers and training.

The administration team have disability awareness training as part of their orientation and this forms part of their desk file to ensure they know how to capture and insert icons / disability alerts in the electronic patient record. The DHB is leading nationally in this area together with the awareness training.
All disability data is captured and reported monthly as a number and percentage, see following statistics for April – June 2016:

April 2016: 5,149 presentations to ED of which 214 patients were identified with a disability - 4%
May 2016: 5,248 presentations to ED of which 243 patients were identified with a disability - 5%
June 2016: 5,171 presentations to ED of which 252 patients were identified with a disability - 5%

PART TWO – KEY STRATEGIC ISSUES / PRIORITIES

2.1 Shorter Stays in ED (SSIED) Health Target

2.1.1 Current Performance

CCDHB performance in Quarter 4 of this financial year (2015/16) was 90.5%, which is below the result of 95% achieved for Quarter 4 2014/15.

The SSIED performance for June has dropped compared to the previous month and also for the quarter compared to the same quarter last year. This is despite a similar number of acute presentations, admissions and admission rate from ED. The number of presentations to ED and the profile of those presenting were very similar compared to Quarter 4 in 2015.

This reduction in performance was a result from higher planned and elective admissions to CCDHB, leading to higher bed occupancy overall across the organisation.

2.1.2 Occupancy

In the last quarter the occupancy across the hospital was consistently above 95% which had a significant impact on our acute flow. It is well known that when occupancy is lower we are able to achieve patient flow out of ED.

Weekly SSIED Performance in combination with Adult Bed Occupancy i.e. capacity - in Quarter 4 2016 continues to demonstrate how the two KPIs run in parallel, lower occupancy enabling improved patient flow and therefore SSIED performance as demonstrated in the following graph:

2.1.3 Admissions

Total admissions for acute and planned admissions are higher than the previous year resulting in occupancy level being consistently above 95%.
Acute Admissions
Acute admissions from ED remain higher than the previous year however were lower in June with the ED admission rate remaining between 33% and 35%

Planned Admissions and Impact on Bed Days
The total number of bed days utilised by planned admissions (arranged and elective) increased significantly for the quarter. This impacted bed availability:

- The total elective bed day rose by over 16% from 2,584 to 3,006
- The increase in planned bed days was most significant for June in comparison to any month in the last 15 months
- The increase in Quarter 4 was mostly in cardiothoracic, general surgery, orthopaedics and vascular services
- In addition the number of acute bed days increased by 4% from 16,979 to 17,618 as overall utilisation increased
2.1.4 Inpatient Length of Stay (LOS)
The average LOS for inpatient beds in WRH continue to show continued improvements year on year.

<table>
<thead>
<tr>
<th>Year</th>
<th>MCC</th>
<th>SWC</th>
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</thead>
<tbody>
<tr>
<td>2010</td>
<td>4.48</td>
<td>2.72</td>
</tr>
<tr>
<td>2011</td>
<td>4.54</td>
<td>2.80</td>
</tr>
<tr>
<td>2012</td>
<td>4.43</td>
<td>2.73</td>
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<tr>
<td>2013</td>
<td>4.00</td>
<td>2.75</td>
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<tr>
<td>2014</td>
<td>3.48</td>
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<tr>
<td>2015</td>
<td>3.32</td>
<td>2.63</td>
</tr>
<tr>
<td>2016</td>
<td>3.21</td>
<td>2.56</td>
</tr>
</tbody>
</table>

The average hours saved for admissions between Quarter 4 2015 and Quarter 4 2016 for the Medicine, Cancer and Community Directorate (MCC) was 4.08 hours per patient and for the Surgery, Women and Children’s Directorate (SWC) 1.2 hours per patient.

2.1.5 Organisation wide focus on patient flow
The organisation wide focus on the patient journey continues with the development of a clinical leadership group with Chief Medical Officer (CMO) leadership. The first step has been to socialise with the aim of agreeing a set of internal professional standards for all parts of the patient journey within CCDHB with a key focus on reducing delays and reducing wasted patient time, underpinned by early senior review of all patients along all parts of the pathway.

The Executive Clinical Directors have commenced the second round of meetings with all clinical teams to agree specific acute flow initiatives for each specialty that will support improvements in acute flow. Discussion includes options for improved discharge times, ward rounds, and specialty response to ED.

A clinical lead forum has been established to agree and support initiatives for whole of organisation change/improvement.

While projects in the past have focussed on process improvements, we are now looking for opportunities to address model of care change – continued culture change to do things differently. The overall aim is to create sufficient hospital capacity to safely manage the care of our current and future patients and reduce the time wasted for patients.

The three key areas of focus continue on:

- Avoiding unnecessary admissions to ED
- Front loaded responsive decision making in ED
- Reducing delays in the inpatient stay
A priority within the acute flow programme has been the development of an Integrated Operations Centre (IOC). During this quarter an Executive Director – Clinical Innovation, Performance and Training position, reporting to the Chief Operating Officer (COO) and Chief Medical Officer (CMO), has been developed and advertised to help assist with this programme, drive improvement, safety, culture and strengthen clinical engagement with a focus on:

- Supporting the development of new service models which improve patient flow across the organisation
- Engaging with the CMO and clinical colleagues to define the strategy for medical staff engagement, capability development and to implement improvements across the Capital & Coast District Health Board (CCDHB)
- Fostering a culture of improvement, responsibility and commitment

2.1.6 Project Progress

- The Executive Clinical Directors have commenced the second round of meetings with all Medicine, Cancer and Community (MCC) and Surgery, Women and Children’s (SWC) clinical teams to discuss acute flow initiatives and gain support for principles. Discussion includes options for improved discharge times, ward rounds, response to ED etc
- The project team have met with the ED Clinical Leader and Charge Nurse Manager and are developing a programme plan focusing on three areas of improvement for ED:
  - Fast Track Pathways
  - Early Assessment and Decision making in ED
  - Triage and discharge
- Development of a process around long stay vulnerable patients that have specific accommodation needs. And a plan to restart 10 day LOS patients review
- Development of change in model of care including diversional therapy on Kenepuru inpatient wards with complex patients to reduce watches
- Increase use of Ward 7 at Kenepuru – flexibly admitting patients with smaller fractures - orthogeriatric service and Health of Older People (HOP) service oversight
- Clinical Leader geriatrics meeting with Clinical Leader orthopaedics to discuss improved orthogeriatric cover

2.1.7 Mental Health in ED Project

The work streams include appropriate streaming of inpatients through ED, CATT team presence in ED / Shorter Stay Unit (SSU), admission of patients under the Mental Health (MH) Psychiatrist (rather than the ED Senior Medical Officer (SMO)) and the development of an acute assessment model of care.

- A change process has been on-going within MH to have crisis MH nurses present in ED and SSU 24/7. It is aimed to have this change implemented in the second quarter of 2016/17
- The model of care (MOC) for use of the Short Stay beds for MH patients has been clarified with the MH, ED and Shorter Stays Unit (SSU) teams. This has been documented and agreed between the services to ensure those patients requiring inpatient stay or short stay assessment are appropriately streamed to either SSU or the inpatient ward. This change has ensured the appropriate placement of MH patients presenting to ED
- Those patients who have been deemed to need in-patient psychiatric care continue to remain in ED under the care of the MH specialty until a bed is available on the MH unit. Occupancy rates in our in-patient MH unit this past quarter has allowed timely admission from ED when needed
- Work to ensure that the Psychiatrist is the attending doctor when in SSU has been completed and this is being reviewed by the MH service to ensure patients have a consultant responsible for the patients referred to their service
- There has been further work this quarter to progress a CAPEX case to develop the SSU facility to support this change in MOC with construction to begin in late first quarter 2016/17
2.2  Theatre productivity and throughput

Improving theatre productivity and throughput has been a priority for the DHB this year. A dashboard report has been developed as part of the theatre project – attached Appendix 2.1.1

The report shows improvement in performance against a number of key measures when compared to the previous year:
- Total Number of Operations – 6% (637) more operations completed
- Utilised lists – 6% (311) more elective lists
- List utilisation – 0.5% increase in utilisation of actual lists

The service continues to focus on reducing avoidable cancellations, and improving start and finish times and patient turnaround time to maximise the utilisation of each list

2.3  Use of Endoscopic Ultrasound (EUS) compared to percutaneous transhepatic cholangiography (PTC) at CCDHB

The Endoscopic Ultrasound (EUS) service has been running for nine months since the approval and purchase of the EUS. The most significant impact the service has seen to date has been in treating patients with pancreatic cancers. Historically this cohort of patients had a painful radiological procedure (percutaneous transhepatic cholangiography (PTC)) and a lengthy stay. The EUS has reduced the length of stay (LOS) by two thirds.

A recent review of the success of the EUS for biliary duct interventions has shown the impact on hospital LOS and on complication rates compared for these two procedures. Consecutive cases performed by the gastroenterology clinical leader are shown below:

**PERCUTANEOUS TRANSHEPATIC CHOLANGIOGRAPHY-BD**
- 7 cases
- Mean age 68
- 13.3 days mean post-procedural stay
- 4 (58%) complications
- Sepsis, pneumonia, biloma, pancreatitis

**ENDOSCOPIC ULTRASOUND CHOLANGIOGRAM – BD**
- 12 cases
- Mean age 73
- 4.5 days mean post-procedural stay
- 2 (17%) complications
- Sepsis, stent migration/sepsis

- Average LOS following EUC-BD is **8.8 days shorter** with fewer complications
- EUS-BD results in approximate savings of **$17,000 per patient**

A presentation on this service will be made to the Hospital Advisory Committee at the December meeting and will provide more details on the post implementation evaluation.
PART THREE – FINANCIAL PERFORMANCE

3.1 Capital and Coast DHB Hospital Operating Costs

The financial performance for Hospital and Health Services (HHS) for the year 2015/2016 is ($17.6m) unfavourable to budget. This variance reflects the higher than budgeted hospital activity year to date and the impact this has had on costs.

The table below summarises the funded activity that partially offsets the costs. It also identifies the value of the unfunded local activity:

<table>
<thead>
<tr>
<th>YTD Variance - Provider</th>
<th>($17,630)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offset by</td>
<td></td>
</tr>
<tr>
<td>New funding Streams Held Centrally</td>
<td>$1,193k</td>
</tr>
<tr>
<td>IDF over delivery</td>
<td>$2,535k</td>
</tr>
<tr>
<td></td>
<td>Inclusive of $2m WIES change</td>
</tr>
<tr>
<td>Net variance</td>
<td>($13,902k)</td>
</tr>
<tr>
<td>Additional Volumes (contributing to costs)</td>
<td></td>
</tr>
<tr>
<td>Unfunded Local Activity</td>
<td>$7,993k</td>
</tr>
</tbody>
</table>

The provider has delivered $2.5m more IDF activity than budgeted. This is recognised centrally within the DHB.

The DHB has also received an additional $1,193k of additional funding for services such as clinical genetics and cancer services. This is also held centrally with the costs relating to this funding within the provider expenditure.

The change in WEIS calculation from Version 14 to Version 15 for 2015/2016 has resulted in the DHB having $2m less IDF revenue for the same level of activity.

There is also $8m of unfunded local activity of which $4.5m is local acute and Health of Older People (HOP) bed days and $3.5m relates to non-inpatient activity.

The specialities that have higher activity for local acute CWD’s are Orthopaedics, Neonatal, Haematology and Neurosurgery. The non-inpatient local acute activity is primarily in Oncology, Orthopaedics, Haematology, Renal and Ophthalmology.

The key variances to budget were:

- **Revenue** ($4,633k) favourable due to increased ACC volumes, donations and Ministry of Health (MOH) contracts

- **Personnel** ($4,597k) unfavourable YTD
  - Medical costs are adverse ($4,986k) YTD.
  - Senior Medical Officer (SMO) costs are adverse to budget by ($2.64m). Of this $1,114k relates to allowances which include job sizing adjustments, backfilling of theatre sessions retirement gratuities; $630k relates to less vacancies than budgeted; and less annual leave taken than budgeted.
Registered Medical Officers (RMO) costs are adverse to budget by ($2.3m) YTD. $616k relates to the laboratory. Costs were not budgeted from the time of transition but the costs are recovered centrally. $929k relates to overtime and call back with the remaining variance relating to adverse annual leave movement. Focus continues on leave management and ensuring leave management plans are in place for staff with high annual leave balances. An audit of leave taken against leave reported is being completed to ensure all leave is captured. Work is under way with Hutt Valley DHB to review the process for the management and transfer of leave as RMOs rotate across the DHBs.

- Nursing costs are ($2.6m) adverse YTD. ($1,217k) relates to annual leave targets not met and the impact of the revaluation of annual leave for the NZNO MECA; ($1,062k) relates to penalties from statutory holidays from the Monday-ised Waitangi day and NZNO full cost impact of 2.5%. Overtime is also adverse to budget by ($776k). This is predominantly in NICU as a result of vacancies and higher activity than budgeted and Womens Health – offset by vacancies. CCDHB has had a higher volume of NICU admissions compared to historical patterns. There has not been a change in practice in the service. Approval for casual staff and Healthcare Assistants for patient watches has been elevated to the Manager of the Integrated Operations Centre (IOC). Overtime has been reviewed and processes implemented to ensure this can be reduced where possible. The focus continues on annual leave management and ensuring staff plans are in place. Roster reviews and practice against the Watch Policy are in progress.

- Allied Health is $1,256k favourable to budget YTD and reflects the level of vacancies that have been unable to be filled - $679k relates to Anaesthetic Technicians and $960k to other Allied Health staff in the Medicine, Cancer and Community Directorate (MCC).

- Management administration is $1,345k favourable to budget YTD reflected vacancies and positions not filled.

- Outsourced Personnel costs are unfavourable ($2,511k) YTD
  Medical Outsourced – $1,034k relates to Senior Medical Officers. The variance is made up of $114k Accident and Medical, $270k SWC surgery and $650 MCC to fill vacancies and sabbatical leave in Respiratory, Cardiology, Immunology, General Surgery and Dermatology offsetting vacancies in personnel.
  - Allied Outsourced – $797k YTD relates to Anaesthetic Technicians offset by vacancies above.

- Outsourced clinical services are ($1,835k) adverse YTD due to the need to outsource for MRI. MRI outsourcing to reduce the waiting list is ($653k) adverse and YTD costs for outsourced elective surgery of ($712k). The costs relating to outsourced surgery is $2m less than the previous year. This includes the additional cardiac surgery that we needed to outsource to manage the waiting list and additional electives volumes that were completed at the end of the year and funded by the MOH.

- Treatment related costs are ($10,640k) unfavourable YTD.
  The unbudgeted activity – both funded and unfunded are contributing to the higher spend on clinical supplies. The savings programme has reduced the supplies cost per CWD by 0.25% compared to the previous year. This demonstrates that savings are being made to offset the known price increases and remaining costs are being controlled.
  This negative variance has been driven by high demand for Intragram (blood products) - $678k adverse YTD, catheters, implants knee prostheses and pharmaceuticals.
  The request for proposal (RFP) process for Total Parenteral Nutrition is complete with the vendor chosen. This is expected to result in a $320k per annum savings to the DHB.

Priority areas to reduce cost of clinical supplies
The clinical supplies work programme has been reviewed and three key priorities identified based on current spend:
1. Pharmaceutical Demand Management
The Choosing Wisely Committee has been reviewing cost pressure in pharmaceuticals. Expressions of interest have been sort for the chair of the Pharmaceutical Demand Management Working Group and most membership is now confirmed. The group will be widely representative of services in which pharmaceutical spend is high cost. The medical staff involved will review indications, international literature and local utilisation before proposing suitable clinical solutions for CCDHB.

2. Intragram (blood products)
The Immunoglobulin Advisory Group (IAG) has commenced and a review of existing patients is underway. From 16 May 2016 all outpatient applications for immunoglobulin will be reviewed by the IAG against Australasian standards before approval is granted to administer therapy. A three monthly review will follow to ensure the expected outcomes of therapy are being achieved.

The graph below shows the trends of blood product usage. In April the Intragram usage was much lower than the past few months. The trend in the past two months has shown a decrease and seems to be reflecting the work of the IAG and evidence based assessment of patient needs.

![](Blood Trend 2014-2016.png)

3.2 Central Equipment Pool
Alternative products are currently under review to reduce internal costs of equipment replacement whilst providing equal or better clinical outcomes for patients. This particularly relates to mattresses and pressure relieving devices which form a significant amount of our current spend. Charge Nurse Managers (CNMs) are renewing all rental equipment on a weekly basis and recording has improved which accounts for some of the cost reduction.

- **Non-treatment related expenses** ($3,074k) unfavourable YTD
  - Spotless supplies and cleaning and laundry services were higher due to increased throughput in the hospital.
  - Facility repair costs have been impacted by higher outsourced maintenance and compliance needs.

Costs to budget have an unfavourable variance of ($979k) YTD. This is offset by vacancies. To manage this overspend on maintenance, a prioritisation of work requests has been introduced by Technical Services. The prioritisation is based on legal compliance and health and safety.
The following table summarises the HHS financial result.

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Variance</th>
<th>Capital &amp; Coast DHB</th>
<th>Year to Date</th>
<th>Variance</th>
<th>Annual</th>
<th>Variance</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Budget</td>
<td>Last year</td>
<td>Actual vs</td>
<td>Actual vs</td>
<td></td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>YTD Jun-16</td>
<td></td>
<td></td>
<td>Budget</td>
<td>Last year</td>
<td></td>
<td>budget</td>
<td></td>
</tr>
<tr>
<td>2,800</td>
<td>2,383</td>
<td>3,214</td>
<td>425</td>
<td>(574)</td>
<td></td>
<td>2,742</td>
<td>(6,695)</td>
</tr>
<tr>
<td>1,761</td>
<td>1,776</td>
<td>630</td>
<td>(14)</td>
<td>(1,133)</td>
<td></td>
<td>1,852</td>
<td>2,085</td>
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<td>41,869</td>
<td>41,893</td>
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<td>0</td>
<td>1,949</td>
<td></td>
<td>493,446</td>
<td>493,446</td>
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<tr>
<td>46,432</td>
<td>46,031</td>
<td>45,865</td>
<td>2,546</td>
<td></td>
<td></td>
<td>540,772</td>
<td>536,139</td>
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<td>2,383</td>
<td>3,214</td>
<td>425</td>
<td>(574)</td>
<td></td>
<td>2,742</td>
<td>(6,695)</td>
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<tr>
<td>1,761</td>
<td>1,776</td>
<td>630</td>
<td>(14)</td>
<td>(1,133)</td>
<td></td>
<td>1,852</td>
<td>2,085</td>
</tr>
<tr>
<td>41,869</td>
<td>41,893</td>
<td>39,921</td>
<td>0</td>
<td>1,949</td>
<td></td>
<td>493,446</td>
<td>493,446</td>
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<tr>
<td>46,432</td>
<td>46,031</td>
<td>45,865</td>
<td>2,546</td>
<td></td>
<td></td>
<td>540,772</td>
<td>536,139</td>
</tr>
</tbody>
</table>

*Note – This report is for the HHS directorates and excludes corporate Directorates and Mental Health.*

**Note:** This report is for the HHS directorates and excludes corporate Directorates and Mental Health.
3.2 Overview of activity April 2016 compared to April 2015

- Emergency Department volumes for FY2015/2016 have increased by 2.95% YTD over the previous fiscal year. Highest increase occurred in February (482 more) over that expected with the additional day in the month. Average daily presentations for June 2016 were 169.5 compared with 170.9 for June 2015.
- All inpatient discharges for June (including mental health) are 4.1% higher compared to the same month in June 2015 and 2.9% higher for the full year compared to FY2014/2015. WIES funded discharges are 2.1% higher for June 2016 compared with June 2015 and 1.9% higher for the full year compared to FY2014/2015.
  - Medicine, Cancer and Community Directorate (MCC) is 2.1% higher for June and 1.9% higher for the full year compared to FY2014/2015.
  - Surgery, Women and Children’s Directorate (SWC) is 8% higher for June and 3% higher for the full year compared to FY2014/2015.
- Theatre elective throughput has increased by 6% compared to FY2014/2015 with Kenepuru having increased by 17% over the last 12 months compared to FY2014/2015.

A summary of total provider activity is shown in the table below.

For the 15/16 year 68,205 case weights (CWD) were delivered compared to 66,452 CWD in 2014/15. The discharges increased 1,226 from 14/15 to 63,984.
PART FOUR - BALANCED SCORECARD REPORTING

Good progress continues to be made against a number of the measures reported within the Balanced Scorecard for the CCDHB. A summary of the areas that are of concern or are a high priority is outlined below. (Appendix 2.1.2)

**Shorter stays in ED**
CCDHB performance in Quarter 4 of this financial year (2015/16) was 90.5%, which is below the result of 95% achieved for Quarter 4 2014/15.

The SSIED performance for June has dropped compared to the previous month and also for the quarter compared to the same quarter last year. This is despite a similar number of acute presentations, admissions and admission rate from ED. The number of presentations to ED and the profile of those presenting were very similar compared to Quarter 4 in 2015.

This reduction in performance resulted from higher planned and elective admissions to CCDHB, leading to higher bed occupancy overall across the organisation.

**Improved Access to Elective Surgery**
As of end of June we are 385 discharges favourable to the health target as detailed below.

**Local Elective Discharges: Year to date results at June month-end**
The Local Elective YTD variance from planned discharge target for CCDHB is 156 adverse for the period ending 30 June, including additional Orthopaedic volume.

**Arranged and Non-Surgical Discharges: Year to date results at June month-end**
CCDHB finished 550 discharges ahead of target as of month end for arranged and non-surgical; this is an increase on last month’s result of 507.

**Electives Wait List**
The DHB continues to be within the threshold for First Specialist Assessments (FSAs) and surgical treatment at the end of June 2016.

**Better Help for Smokers to Quit**
For Quarter 4 – 92% and for the year 93%

**Non-attendance Rates** – these tables need to be updated to show the month by month actual DNA %
- The DNA rate remains between 6 – 7% for Outpatients overall.
Maori and Pacific Island June rates for Outpatients were 14% and 15% respectively.

Work continues with primary care to follow up the patients who have the high DNA rates. Follow ups are also an area where DNA rates are higher. There is a particular focus on this.

### 4.2 Elective Services Performance Indicators

<table>
<thead>
<tr>
<th></th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ESPI 2</strong></td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>ESPI 5</strong></td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>10</td>
<td>7</td>
<td>11</td>
<td>9</td>
</tr>
</tbody>
</table>

**Note:**
- ESPI 2 – First Specialist Assessment
- ESPI 5 – Surgical treatment

June ESPI2 and ESPI5 results are not yet confirmed by the Ministry of Health (MOH) however our internal reporting confirms we remain within the threshold.
4.2.1 Cardiothoracic Waiting list
The cardiac waitlist has continued to reduce and is now between 42 – 47 patients waiting in total. The focus continues on ensuring all patients are treated within clinically appropriate timeframes. The MoH maximum waiting time is 120 days but the cardiac network recommend a maximum wait for Band4 patients of 90 days. The service has is aiming for a maximum wait of 90 days in line with the cardiac network advice.

4.3 Access to Diagnostics – Colonoscopies

Shorter Wait Times
Urgent Colonoscopy
Internal Diagnostic reports for June indicated that 100% of people accepted for an urgent diagnostic colonoscopy received their procedure within two weeks (14 days) against a Target of 75%. Target Met.

Non-Urgent Colonoscopy
Internal Diagnostic reports for June indicated that 86% of people accepted for a non-urgent colonoscopy received their procedure within six weeks (42 days) against a Target of 65%. Target Met.

Surveillance Colonoscopy
Internal diagnostic reports for June indicated that 71% of people waiting for surveillance waited no longer than twelve weeks (84 days) beyond the planned date against a target of 65%. Target Met.

In reporting to the additional MoH targets:

<table>
<thead>
<tr>
<th></th>
<th>Urgent within 30days</th>
<th>Non-Urgent within 120days</th>
<th>Surveillance within 120days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent within 30days</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Urgent within 120days</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surveillance within 120days</td>
<td>92.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The service is reviewing why surveillance has continued to drop and aim to improve this in the coming months.
Working towards a Sub Regional Endoscopic Retrograde Cholangiopancreatogram (ERCP) Services
Radiology has agreed to an extra list every second Tuesday. Terms of ‘engagement’ are required for access between services if competing demand arises. CCDHB is still working with HVDHB as to the most appropriate Registered Nurse model as this will require some change process for HVDHB nurses.

National Bowel Screening Programme (NBSP)
The MoH have signalled their intention to roll-out the National Bowel Screening Programme (NBSP), although this is a welcomed initiative we need to work through the detailed implications of introducing this service. A regional Bowel Screening meeting is being held 2 August 2016 to clarify some off the issues, roles and responsibilities of the DHBs involved.

4.4 Access to Diagnostics – Radiology
(The radiology targets are based on referrals from the community and outpatients and does not reflect the total demand on the service which will include the inpatient component)

CT – MOH target has increased the target from 90% to 95% in 2015/2016
MRI – MoH target has increased the target from 80% to 85% in 2015/2016

Performance against the target for the year is detailed below:

<table>
<thead>
<tr>
<th></th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>95%</td>
<td>82%</td>
<td>84%</td>
<td>84%</td>
<td>87%</td>
<td>85%</td>
<td>85%</td>
<td>84%</td>
<td>78%</td>
<td>85%</td>
<td>92%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>MRI</td>
<td>85%</td>
<td>37%</td>
<td>36%</td>
<td>47%</td>
<td>45%</td>
<td>41%</td>
<td>49%</td>
<td>43%</td>
<td>41%</td>
<td>61%</td>
<td>68%</td>
<td>58%</td>
<td>63%</td>
</tr>
</tbody>
</table>

Achievements:
- The new MRI scanner was successfully delivered and installed with the first scanning appointment booked for the first week of July.

Challenges:
- Although CT, MRI and Ultrasound bookings have increased, they still do not meet the MoH targets.

4.5 Faster Cancer Treatment (FCT)
The target is that patients receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and the triaging clinician believes the patient needs to be seen within two weeks.

The 62-day wait is measured from receipt of the referral to the date of the patient’s first cancer treatment (or other management). The target is that by July 2016, 85 per cent of patients meeting the criteria should commence treatment within 62 days, increasing to 90 per cent by June 2017.

Approximately 25 per cent of newly-diagnosed cancer patients will be covered by the 62-day target. A large proportion of newly-diagnosed cancer patients will continue to access treatment through pathways not covered by the target.
**HOSPITAL ADVISORY COMMITTEE**

<table>
<thead>
<tr>
<th>Year</th>
<th>Quarter</th>
<th>Month</th>
<th>&lt;62 days</th>
<th>&gt;62 days</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/2016</td>
<td>Q1</td>
<td>Jul</td>
<td>20</td>
<td>7</td>
<td>27</td>
<td>74%</td>
</tr>
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<td></td>
<td></td>
<td>Aug</td>
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<td>5</td>
<td>31</td>
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<td></td>
<td></td>
<td>Sep</td>
<td>20</td>
<td>2</td>
<td>22</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td>Q2</td>
<td>Oct</td>
<td>19</td>
<td>8</td>
<td>27</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nov</td>
<td>28</td>
<td>6</td>
<td>34</td>
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<td></td>
<td></td>
<td>Dec</td>
<td>37</td>
<td>4</td>
<td>41</td>
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<tr>
<td></td>
<td>Q3</td>
<td>Jan</td>
<td>18</td>
<td>5</td>
<td>23</td>
<td>78%</td>
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<td>5</td>
<td>30</td>
<td>83%</td>
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<tr>
<td></td>
<td></td>
<td>Mar</td>
<td>22</td>
<td>4</td>
<td>26</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td>Q4</td>
<td>Apr</td>
<td>25</td>
<td>7</td>
<td>32</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May</td>
<td>24</td>
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<td></td>
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<td>Jun</td>
<td>9</td>
<td>2</td>
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<td>82%</td>
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<tr>
<td></td>
<td>Total</td>
<td>273</td>
<td>58</td>
<td>331</td>
<td>82%</td>
<td></td>
</tr>
</tbody>
</table>

- Quarter3 MOH reporting CCDHB second nationally at 81.8%, change from last report is 1.0% (national average 75%), second to Taranaki base hospital.
- CCDHBs ‘indication of number of records submitted each month’ (62day target) (calculated as 25% of expected cancer registrations) is 27 records per month and is averaging 30 per month.

The FCT work plan continues as previous months focusing on multidisciplinary and multi service breach reviews, on-going work with radiology and pathology regarding pathways and improvements in diagnostics reporting turnaround.

**31 Day Indicator**: patients with a confirmed diagnosis of cancer to receive their first cancer treatment within 31 days. In June 28 patients were included at time of reporting:

- 26 patients (93%) were within the indicator timeframe for the month of June.
- CCDHBs ‘expected monthly cancer registrations’ for the 31day indicator is 107 records per month, with CCDHB achieving on average 67 per month.
  We achieved 86.9% for Quarter4 - a 1.8% improvement from the last quarter.

**4.6 Acute Coronary Syndrome (ACS) – ANZACS-QI**

ANZACS-QI is a web-based system to support clinical quality improvement in secondary care. Key indicators are:

- 70% of high-risk patients will receive an angiogram within three days of admission. (‘Day of Admission’ being ‘Day 0’)

The CCDHB result for June was 93.1% and as a region 85.8%, (103/120). Wairarapa and Whanganui DHBs did not achieve the 70% target; 50% and 64.7% respectively.

A regional ACS meeting facilitated by the Central Cardiac Network is scheduled for July to discuss plans to manage when demand exceeds capacity.

- The second measure relates to data quality, integrity – the target is that over 95% of patients presenting with acute coronary syndrome (ACS) who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days.

For May 100% of CCDHB patients presenting with ACS who undergo coronary angiography have completion of ANZACS-QI ACS and Cath/PCI registry data collection within 30 days; 96.6% for the region.
1.0 Perinatal Mental Health
Women with a personal or family history of mental illness are more vulnerable to a new onset, exacerbation or re-occurrence of mental health problems during the perinatal period. MHAID Service 3DHB, coordinated by the perinatal mental health project coordinator, in conjunction with community and primary care providers, has developed pathways for guidance to manage these clients in primary care. The four new pathways, launched in July 2016, are:

- Assessment and Management (Perinatal Mental Health)
- Medications for Depression and Anxiety in Pregnancy and Breastfeeding
- Specialist Maternal Mental Health Services
- Mother and Babies Community Support

The Specialist Maternal Mental Health Service is the first mental health team to go live on Health Pathways. This new service will provide easier access to information and care for women in the perinatal period and is a significant development for GPs, midwives and clients.

The loading of Clozapine information onto Health Pathways is now underway.

2.0 GP Consultation
A pathway for GPs to directly access specialist mental health and addictions advice (access a consultant psychiatrist) has been developed, after consultation, and started on 1 August 2016. This development was launched with the support of the chair of ICC, including a jointly signed letter to PHOs and GPs. facilitating timely access to specialist mental health advice will assist GPs to build on their existing strengths and optimise the mental health care they provide to their patients
3.0 Integrating a Community Acute and Crisis Service Approach

The aim is for the three DHBs to develop integrated acute and crisis services that are more explicitly focused on meeting the needs of clients and their family/whanau and where the service provision is in the community rather than in a hospital. The Hutt Valley DHB and MHAID Service 3DHB have been working closely with service consumers and providers to improve the quality of mental health acute and crisis services delivered on behalf of the HVDHB population.

To achieve this, there will be some changes which will enhance the current services and close a significant gap, by putting in place different acute options to hospital. Changes are:

- **Acute Crisis Respite Service** will consist of three acute crisis beds in Upper Hutt, with an average length of stay between 1-3 days.
- **Acute Transition Service** will be situated in Upper Hutt with an average length of stay between three and six months.
- **Enhanced Community Support Service** will provide intensive support to people in the community between 7.00am to 10.00pm in Lower Hutt and 8.00am to 8.00pm in Upper Hutt. The service is seven days a week.
- **Planned Respite** beds will be situated in Lower Hutt for people recovering from mental health issues who from time to time need a break from their routine to help to get back to everyday living.

A non-government organisation (NGO) presently provides mental health peer support to adults in the CCDHB acute inpatient unit. From 1 September 2016 this service will be extended to the HVDHB acute inpatient unit, Te Whare Ahuru.

4.0 Infant, Child, Adolescent, Family Service (ICAFS)

The MOU with Te Awakairangi Health Network (TeAHN) to address waiting for treatment clients of the Hutt ICAFS Youth Team is finalised and signed by both parties. Arrangements are complete for:

- Activity data collection
- Acute pathway in case of deterioration during treatment
- Consultant input from ICAFS to the TeAHN Wellbeing Team
- Letters and follow-up telephone calls to all identified clients/families
- Transfer of referral and any existing assessment documentation for identified clients to TeAHN.

TeAHN Wellbeing Service has commenced making contact with clients/families to make appointments and aims to pick up five cases per week until the 25 cases target is met.

5.0 Crisis Resolution Service

Implementation of this service work streams are continuing with the view to launch the service on 1 November 2016. As indicated in the last report, the Rostering, Infrastructure, Information and Technology, Documentation, Policies and Procedures and Models/Case Management working groups are making progress. Further workshops are planned for greater staff engagement over the next month in partnership with the unions.

6.0 Restraint Minimisation Programme

A new restraint minimisation training programme is due to be introduced into the Service in the next few months. There will be national standards for a Restraint Training Programme which will be based on Evidence Based Practice. The programme will lead to restraint minimisation, and fewer injuries to both clients and staff. The Nursing Director and Learning & Development Manager are looking at ways to reduce costs to enable the programme to proceed.
HOSPITAL ADVISORY COMMITTEE

7.0 Planning

Recently, senior leadership staff met for a strategic planning day, facilitated by Anne Patillo. By way of summary:

- Achievements, strengths and challenges of the past 15 months since the advent of MHAID Service 3DHB
- Critical goals the Service needs to achieve in the next 3-5 years, and the steps towards this
- Continuing to work together to develop a 'one entity' approach to MHAID service provision – with a continuum of integrated care across all sectors – focused on early response, close to home/locality-based and access to specialty services
- Developing an operational plan based on the high-level strategic framework already developed by SIDU – via a leadership group with representation from across the sector (e.g. clinical services, primary care, NGOs)

Another initiative has been the three hour forum for staff at the training centre, led by Training & Development. Staff from the three DHBs including team leaders, family advisers and other staff in lead roles met for the quarterly forum. The theme of this session was responding to critical incidents. It was an interactive session, with speakers and time for questions and comments. This is a Service initiative to encourage staff to think and reflect and plan for 2016/17 as well as feel part of the decision making.

A summary document of the MHAID Service 3DHB has been produced and circulated to the MOH and three Chief Executive’s. The document provides a good summary of the services, structures and governance in place. This is a living document which will be updated regularly.

8.0 Activities

<table>
<thead>
<tr>
<th></th>
<th>TWOM</th>
<th>Rangatahi</th>
<th>RaUta</th>
<th>Purehu</th>
<th>Rangipapa</th>
<th>Hikitia</th>
<th>Haumie</th>
<th>Tane M</th>
<th>Tawhiri</th>
<th>TWA</th>
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<td>11</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>61</td>
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<td>86.4%</td>
<td>92.5%</td>
<td>89.1%</td>
<td>100.8%</td>
<td>100%</td>
<td>87.4%</td>
<td>96.5%</td>
<td>96.9%</td>
<td>-</td>
</tr>
<tr>
<td>ALOS</td>
<td>10</td>
<td>42</td>
<td>58</td>
<td>76</td>
<td>14</td>
<td>-</td>
<td>-</td>
<td>597</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

There have been nine referrals into Rangatahi for July which is very low however; there has been a higher than usual number of young people being referred to the day programme. There have also been some home placements which have broken down and have resulted in accommodation problems on discharge from Rangatahi and readmission within a couple of weeks.

We are exploring ways we can increase respite services for children and youth in the Hutt Valley to ensure high need clients are receiving adequate therapeutic respite.

For monthly Inpatient Reports see Appendix 2.2.3

Nga Taiohi, the new national Youth Forensic Secure Facility which opened in April, has experienced a lower number of referrals than originally planned. Staff who have not been rostered on due to the low numbers have been able to relieve vacancies elsewhere in the hospital.

9.0 Facilities

The Board have asked for a review to be carried out of the environment at Tawhirimatea. The purpose of the review is to identify any opportunities to improve facilities to provide greater safety for clients and staff. Terms of Reference for the review have been completed.
A psychiatrist from Melbourne, a Professor of Forensic Mental Health from AUT, and a Maori consumer will be undertaking the review. They will be at the unit for three days in August. It is expected that the review team will report back to the Board in September.

The de-escalation area in Tawhirimatea was renovated in July, including painting the interior of the unit and laying new carpet. The area has also been re-named Te Whare Awatea, which means a safe peaceful space.

Along with the new Crisis Resolution Service and the work with the Police and Emergency Department, there is approval for the design and construction of a space in Wellington Hospital’s Short Stay Unit (SSU) as a more appropriate venue for mental health assessments.

The acute admission unit in the Hutt, Te Whare Ahuru, received an unannounced visit by the Crimes of Torture Act team (COTA).

10 Finances
June 2016 Financial Year end, Mental Health, Addictions and Intellectual Disability Service 3DHB delivered a surplus of $15.398m, before overheads, as opposed to a budgeted surplus of $15.525m, unfavourable to budget $126k. In addition $714k of one off revenue is yet to be transferred to the Service making the YTD surplus variance from unfavourable $126k to favourable $588k. The surplus was achieved after delivering the YTD savings target of $5.88m and with addition of $288k for the year end adjustment actuarial for sick leave costs.

External revenue was favourable to budget $4.29m YTD largely due to the commencement of the new youth forensic inpatient service funding, Te Haika funding from Wairarapa, specialist assessments and forensic court revenue. There are costs associated with these revenue increases which is reflected in the personnel and outsourced expenses.

The personnel cost was adverse to budget $3.715k, including the savings target of $4.810k, year end adjustment of $288k and additional revenue associated cost. High occupancy occurred in acute inpatient, rehabilitation, forensic and intellectual disability units, plus lower annual leave taken and overtime contributing to personnel cost variance.

Active management of sick leave and overtime is assisting to deliver in excess of budget.
The service forecasted and achieved budget for 2015/16 including a stretch savings target of $5.8m with the financial focus continuing to be in the following areas.

- Reducing annual leave balance in the >200 category
- Continued attention to overtime in inpatient units
- Continuous monitoring of sick leave

11 HVDHB mental health data extracted to CCDHB Datamart

Investment over the past couple of years has significantly improved mental health and addiction service information that is now readily available in the CCDHB datamart. There is an excellent suite of inpatient and community teams operational and performance reports available on SharePoint.

Currently, MHAIDS 3DHB operations managers and clinical leaders access team reports from three different systems; team leaders within the different DHBs are operating with different operational reports and team process. There is significant duplication of effort and demand on the limited MHAIDs 3DHB analyst resource to manually line up information and monthly reporting.

It is vital to build on the MHAIDS 3DHB investment by using an extract (copy) of the Hutt Valley DHB mental health information, which will be stored in and reported from the CCDHB datamart. This will aid for transparent, consistent and joined up reporting across the mental health and addiction services. Access will be available from one system – CCDHB SharePoint.

Work is underway for Hutt Valley DHB Mental Health clinical and administrative data to be copied to CCDHB datamart to allow the data to be more easily accessed by MHAID 3DHB managers and staff to support service delivery, monitoring and quality improvement. This plan is now in pre-implementation phase, with target for rollout due to be set within the next three months.

12 HDC Complaints

<table>
<thead>
<tr>
<th>DHB</th>
<th>Sector</th>
<th>HDC Number</th>
<th>Outstanding HDC Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCDHB</td>
<td>Intensive Recovery</td>
<td>HDC7923/BR</td>
<td>Complaint made to HDC in relation to the death of a female patient by unknown cause on Te Where e Makaenga - response sent 25/06/15 3/11/15 informed by HDC that he has commenced a formal investigation into CCDHB’s care of the client</td>
</tr>
<tr>
<td>CCDHB</td>
<td>Intensive Recovery</td>
<td>HDC8517/467/15</td>
<td>Complaint made to HDC in relation to the standard of care provided to a client of TACOM who died by a suspected suicide on the unit - complaint made in relation to the practice of an employee, not informing the family re. alleged previous suicide attempts, poor or non-documentation of such events and alleged misinform</td>
</tr>
</tbody>
</table>
13 Balanced Score Card
The performance indicators for the month are attached in the Balanced Score Card (BSC) Appendix 2.2.1 and 2.2.2. Users of BSC have access to trend line simply by clicking on the graph icon next to each of the indicators.

14 Index
TWOM – Acute unit Wellington Hospital
TWA – Acute unit Hutt Hospital
Rangatahi – Regional Acute Adolescent unit, Kenepuru Hospital
Ra Uta – Psychogeriatric unit, Kenepuru Hospital
Hikitia – National Intellectual Disability Secure Youth unit
Haumietiketike – National Intellectual Disability Secure Adult unit
Manawanui and Whakaruru – Intellectual Disability Step Down Cottages
Purehurehu and Rangipapa – Regional Forensic Secure units
Pukeko and Saunders House – Forensic Service Step Down Cottages
Tane Mahuta, Tawhirimatea and 7 Cottages – Regional Inpatient Rehabilitation and Extended Care
1.0 Shorter safer health journeys

1.1 Pressure Injury Prevention & Management (PIPM) Programme
The next focus for the national patient safety indicators programme is pressure injuries. The good work that has been undertaken at CCDHB with our PIPM programme means that we are privileged to have been invited on to the national expert advisory group to oversee the roll out of this programme. The Pressure Injury (PI) Data and Measurement Expert Group is currently considering what DHBs will be asked to report on monthly as ACC, The Health Quality and Safety Commission (HQSC) and MOH work together to address the harm caused by pressure injuries. Care process auditing increases the practice focus on PIPM and supports areas where issues are identified. CCDHB was also invited to present at recently held national forums to showcase our PIPM programme. (Refer Appendix 2.3.1 on Pressure Injuries).

1.2 Care Capacity Demand Management (CCDM), Trendcare, Releasing Time to Care (RTC)
National experience shows that CCDM with TrendCare will optimise personnel resource allocation. Essential to success is the standardised use of Releasing Time to Care (RTC) foundation modules and a team approach to providing care. Nursing in small teams is being re-energised at CCDHB by a group of Charge Nurse Managers to re-introduce team nursing in the pods. This involves revamping the role of the pod leader, ensuring regular communication between team and completing a bedside handover.

1.3 CCDHB falls prevention programme
CCDHB staff are continuing to work with our community and cross sector partners on a number of projects within the community falls prevention programme. Most recently, ACC, in conjunction with the MoH, HQSC and local DHB partners have initiated a national framework for the provision and growth of sustainable Community Strength and Balance programmes as part of a suite of services that contribute to the on-going independence of older people.

1.4 Audit: Adherence to inpatient hypoglycaemia Management Protocol
Following the routine audit of adherence to inpatient hypoglycaemia management protocol, we identified a range of system improvements. These have included; addressing workforce knowledge deficits, improved referral processes and access for patients with diabetes, plus a whole of organisation training programme that will include an e-learning module.
1.5 Shared Care Planning
A clinically led group from across the health system has commenced work on operationalising the newly created electronic shared care planning tool. Shared Care Plans are envisaged to be an enabler of the integration of health services across the health system. The aim is for community based DHB staff and those health practitioners from other organisations to be able to discuss and document their plans together to enable safer, and more integrated patient care for those people living in the community with the most complex healthcare needs.

1.6 Registered Nurse Prescribing
Registered nurse (RN) prescribing regulations come into force on 20 September 2016. This allows suitably qualified RNs who meet Nursing Council prescribing standards to prescribe from a limited list of commonly used medicines in addition to nurse practitioners and diabetes nurse specialists who are currently able to prescribe. This will make a big difference to patients and will reduce double handling and improve access to medicines, particularly for people living in rural or remote regions.

Nurse Practitioners have been prescribing for the past 14 years and for the past five years approved diabetes clinical nurse specialists had been prescribing under the same designated prescriber provision of the Medicines Act 1981 that was now being extended to approved registered nurses.

2.0 Growing our people

2.1 Celebrating Success
Mikaela Shannon (Nurse Manager, Health of Older Persons) presented at the: Gerontology conference (Sydney), NZNO AGM Conference, NZNO Gerontology Conference on delirium and the Care with Dignity Programme at CCDHB. As previously reported, the Care in Dignity programme initiated at CCHDB, is generating interest nationally and overseas. Mikaela has also published an article on Care with Dignity in Gerontological Nursing. Alison Rowe, Karen Bennington has achieved Nurse Practitioner registration with NCNZ.

2.1.1 Making Human Immunodeficiency Virus (HIV) testing routine
Article published this month in Kia Tiaki by James Rice-Davies HIV/ID Clinical Nurse Specialist, CCDHB. Key points:

- New Zealand has a good record of successfully treating people diagnosed with HIV and has a low rate of infection compared to other countries. Reaching the undiagnosed, remains a challenge.
- Until there is a cure or a vaccine for the human immunodeficiency virus (HIV), all health professionals have a role in reducing the numbers of people infected with it.
- A way to do this is by being more proactive in offering and routinely carrying out HIV testing. HIV testing needs to be normalised to reduce the spread of infection. The HIV test is cheap and easy to carry out, and allows rapid access to treatment.
- This starts with health professionals not being frightened to ask about HIV testing and making it easier for everyone to get a test.

2.2 Vulnerable Workforces
Anaesthetic Technicians at CCDHB have taken part in the making of a video for use in the UK at immigration events to recruit Anaesthetic Technicians. The making of the video was carried out by Immigration NZ and will be used to promote the advantages of migration to New Zealand and working in the public health system. The final video can be viewed at the following link: http://www.kiwihealthjobs.com/anaesthetic-tech-campaign.
2.3 Engaging our Workforce
A Central Region workshop hosted by CCDHB for Innovating on the Nursing Care Team Model (Advisory Board) focused on optimising all team members to top of scope and addressing the issues of increasing health cost as unsustainable and the need for international solutions based on more effective team work. There were 89 attendees - CCDHB (46), Hutt (29) and Wairarapa (10).

The Director of Nursing and Midwifery Office continue to support Primary Care/Community nursing practice by participating in the Professional Development and Recognition Programme and assessor workshops, Nursing Entry to Practice programme, Preceptor Education and Health Workforce NZ post graduate study funding and working to provide access to e-learning, library databases and IV certification processes.

2.4 Workforce of the Future- Building the pipeline
The Director of Nursing (Primary Health and Integrated Care) was invited by Massey and Otago Universities to the inter-professional education programme with dietetic, medicine, physiotherapy and radiation therapy students (Otago) as well as the newly invited Nursing students from Massey University.

Dedicated education units (DEU) will be launched in July. The DEUs create an environment to support students to learn nursing practice in clinical environments where socialisation is imperative in this teaching and learning process. Students are part of the ward teams learning from clinical staff and academic staff. This aligns with CCDHB’s Nursing and Midwifery priorities ‘Knowing, Growing and Engaging our Workforce’.

Allied Health, Scientific and Technical staff teamed up with the HR Recruitment Team, nursing and midwifery colleagues, and Kia Ora Hauora to attend the 2-day Wellington Careers Expo at the TSB arena. Students travelled from across the Wellington region to this event, and again the focus was on promoting the large range of Allied Health, Scientific and Technical professions and the opportunities available in health.

The careers expo is one of a programme of activities completed during 2016 to encourage greater numbers of Maori and Pacific students to enter health and the DHB workforce. A summary of this collaborative work will be presented at the Tū Kaha Central Region Maori Health Conference in September. An abstract for the presentation, entitled “Improving health equity by promoting allied health, scientific and technical professions to the workforce of the future” has recently been accepted by the organising committee.
3.0 Living within our means

3.1 Choosing Wisely
As reported previously, the multi-disciplinary programme to ensure the ceasing of obsolete practice and duplicate processes continues to build momentum across the DHB. A new sub-committee has been developed within the Choosing Wisely programme that has a specific focus on Pharmaceutical use, including a process for the introduction of any new pharmaceuticals into the DHB.

3.2 Observation and Engagement (Watch) work
Watches are those individuals (usually a health care assistant (HCA)) who are asked to sit with an inpatient for a period of time as the patient (for a range of reasons) is assessed as needing constant observation. Work is well established to ensure that the policy is well implemented across the organisation; ensuring that watches are present when identified as needed, and ceased in a responsive manner when not, ensuring resources are managed effectively.

3.3 Roster Working Group
The purpose of the nursing and midwifery resource management project is to address resource usage and management issues and to ensure rosters are MECA and financially compliant. An audit of all rosters during June shows an improvement in rostering practice since the last audit. Working with ACTOR (the roster provider) to progress changes via an expert users group for the following:

- Enable the cost analytics of the roster to ensure cost effective rosters
- Develop and initiate roster targets and reports for study and annual leave
- Review rostering standards and audit tool
- Develop education for effective roster management.

3.4 Integrated Models to Improve Health Equity
Integration of health care provision continues to be developed through implementation of the Health Care Home. Initial practices are preparing to join with community and allied health services (District Nursing, Community ORA teams) to integrate, collaborate and proactively manage complex patient needs. In addition, supporting current health system integration partnerships such as the Diabetes Practice Nurse Partnership to refine model delivery and optimise outcomes.
HOSPITAL ADVISORY COMMITTEE

Date: 12 August 2016

Author: Bryan Betty

Subject: Resolution to Exclude the Public

RECOMMENDATION

It is recommended that the Public be excluded from the following parts of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 (“the Act”) where the Board is considering subject matter in the following table.

The grounds for the resolution is the Committee, relying on Clause 32(a) of Schedule 3 of the Act believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists under the Official Information Act 1982 (OIA), in particular:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>NZ Public Health &amp; Disability Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmation of Minutes of the previous “Public Excluded Section” of the Hospital Advisory Committee Meeting</td>
<td>Section 9(2)(i) of the OIA which enables the withholding of information to allow the carrying out, without prejudice or disadvantage, negotiations. Section 9(2)(j) which enables the withholding of information to allow the carrying on, without prejudice or disadvantage, commercial activities.</td>
</tr>
<tr>
<td>Monthly Performance Report</td>
<td>Section 9(2)(c) enables the withholding of information to avoid prejudice to measures protecting the health or safety of members of the public.</td>
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</table>
Theatre Measures Board

Total Number of Operations
Completing 6% (637) more elective operations compared to the same 12 month period last year (highest increases were: 25% for General Vascular and 20% for Ophthalmology and Orthopaedics) however, over the 12 month period volumes at Wellington Regional Hospital (WRH) have increased 1% (91 operations) and Kenepuru increase by 17% (495 ops more).

Used Lists
Using 6% (311) more elective lists compared to the same 12 month period last year
No change from last month
WRH: 3% increase (135 lists)
Kenepuru: 16% increase (176 lists)

List Utilisation
Using 77% of available elective minutes
0.5% increase compared to the same 12 month period last year
Kenepuru utilised 68% of available elective minutes and WRH utilised 79% of available elective minutes.

Day of Surgery (DOS) Cancellations
Cancelled 958 elective patients on DOS this financial year: 13% increase compared to the same period last year.
May and June had a 7% decrease in cancellations compared to the same 2015 period. A 50% decline in ‘Patient Unavailability’ offset at WRH by a 50% increase in ‘Theatre/Staff/Equipment Unavailability’ 50% increase in ‘Hospital/Service Unavailability’ compared to the same period last year – specifically 81% increase in ‘No Bed/Staff (Ward)’ and ‘No ICU Bed Available’ combined.

Late Starts
48% of elective lists started late overall in lists starting more than five minutes late.
41% started late at Kenepuru - 51% started late at WRH
26% of elective lists started late overall in lists starting more than 15 minutes late: 21% started late at Kenepuru/28% started late at WRH
27 minutes on average are lost when lists start more than five minutes late
Over April/May 2016 on average 70% of late starts had a Delay Reason entered
NB. Paediatric session start time (OT14) has moved 15 minutes forward to 08:30

Early Finishes:
34% of lists are finishing more than 30mins early; 1% increase compared to the same 12 month period last year
Kenepuru: 49% of lists are finishing early (5% increase compared to last FY), OT91, 92 and 93 are equally contributing to this increase.
WRH: 29% of lists are finishing early (1% decrease compared to last financial year (FY))

Late Finishes:
22% of lists are finishing late. (74% are All Day sessions – General Surgery 20%, Urology and Orthopaedics both 13%). 2% decrease compared to last year.
Kenepuru: 8.5% of lists finishing late. WRH: 28% of lists finishing late.
APPENDIX 2.1.1

Lists are finishing on average **84 minutes late** – **4% increase** compared to last year.

*NB. The results are currently inclusive of ‘In Service’ days – to be taken out for future reporting.*

**Turnaround Time:**

Average turnaround time is **24mins**; 26mins at WRH (decreased 0.5% across latter six months), 19mins at Kenepuru (increased 1% across latter six months)
APPENDIX 2.1.1

PUBLIC Hospital Advisory Committee 12 August 2016 - APPENDICES

HOSPITAL ADVISORY COMMITTEE

Used Lists

Turnaround Time

Early Finishes

Late Finishes

DOS Cancellations

Reason for DOS Cancellation

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<tr>
<th>Specialty</th>
<th>Number cancelled last year</th>
<th>Cancelled as % of total ops</th>
<th>Number cancelled this year</th>
<th>Cancelled as % of total ops</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Surgery</td>
<td>103</td>
<td>27%</td>
<td>100</td>
<td>27%</td>
</tr>
<tr>
<td>Dental Surgery</td>
<td>78</td>
<td>11%</td>
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<td>General Paediatric</td>
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<td>General Surgery</td>
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<td>6%</td>
<td>100</td>
<td>6%</td>
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<td>General Vascular</td>
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<td>Gynaecology</td>
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<tr>
<td>Neurosurgery</td>
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<tr>
<td>Ophthalmology</td>
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<td>Orthopaedic</td>
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<td>Otolaryngology</td>
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<td>46</td>
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<td>Paediatrics Painful Procedures</td>
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<td>Urology</td>
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Total 862 9% 967 9%
### PATIENT EXPERIENCE

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<th>Actual</th>
<th>Target</th>
<th>YTD</th>
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<tr>
<td>Shorter Stays in Emergency Departments</td>
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<td>88%</td>
<td>95%</td>
<td>91%</td>
<td></td>
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<tr>
<td>Improved Access to Elective Surgery</td>
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<td>100%</td>
<td>108%</td>
<td>100%</td>
<td>105%</td>
<td></td>
<td></td>
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<tr>
<td>Better Help for Smokers to Quit</td>
<td>↓</td>
<td>95%</td>
<td>93%</td>
<td>95%</td>
<td>92%</td>
<td></td>
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</tr>
<tr>
<td>Number of Patient Deaths</td>
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<td>42</td>
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<tr>
<td>Severity 1 &amp; 2 (Confirmed)</td>
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<td>36 (6)</td>
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<td>395 (38)</td>
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<tr>
<td>All Reported Events</td>
<td>↔</td>
<td>U/D</td>
<td>731</td>
<td>0.0</td>
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<tr>
<td>Hospital Acquired Pressure Areas</td>
<td>↔</td>
<td>0</td>
<td>7</td>
<td>U/D</td>
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<tr>
<td>Patient Falls Causing Harm (per 1000 bed days)</td>
<td>↔</td>
<td>0</td>
<td>65 (0.6)</td>
<td>0.0</td>
<td>941 (0.5)</td>
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<tr>
<td>Medication Errors (per 1000 bed days)</td>
<td>↔</td>
<td>0</td>
<td>79 (1.5)</td>
<td>0.0</td>
<td>836 (0.5)</td>
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<tr>
<td>Complaints (per 1000 bed days)</td>
<td>↔</td>
<td>0</td>
<td>58 (3.0)</td>
<td>0.0</td>
<td>805 (2.9)</td>
<td></td>
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<tr>
<td>Compliments (per 1000 bed days)</td>
<td>↔</td>
<td>0</td>
<td>88 (4.5)</td>
<td>0.0</td>
<td>892 (3.8)</td>
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### WAITLISTS

<table>
<thead>
<tr>
<th>Waitlist Patients (ESP15 &amp; ESP12)</th>
<th>Target</th>
<th>Month</th>
<th>Booked</th>
<th>Unbooked</th>
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<tbody>
<tr>
<td>Waiting &gt;120 days for Treatment (ESP15)</td>
<td>↔</td>
<td>0</td>
<td>10</td>
<td>0</td>
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<tr>
<td>Waiting &gt;120 days for Outpatient FSA (ESP12)</td>
<td>↔</td>
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### HEALTHY WORKPLACE

<table>
<thead>
<tr>
<th></th>
<th>Jun-16</th>
<th>YTD</th>
<th>Trend</th>
<th>Target</th>
<th>Month</th>
<th>Target</th>
<th>YTD</th>
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<tbody>
<tr>
<td>Staff Turnover % (Headcount)</td>
<td>↑</td>
<td>15.6%</td>
<td>24.6%</td>
<td>15.6%</td>
<td>20.6%</td>
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<tr>
<td>Sickness Absence - % Paid Hours Worked</td>
<td>↑</td>
<td>2.3%</td>
<td>3.1%</td>
<td>2.3%</td>
<td>2.9%</td>
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<tr>
<td>Number of Staff having &gt;200 Hrs A/L</td>
<td>↑</td>
<td>0</td>
<td>1,573</td>
<td>0</td>
<td>1,546</td>
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<tr>
<td>Physical Assaults</td>
<td>↓</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>330</td>
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<tr>
<td>Blood and Body Fluid Exposure</td>
<td>↔</td>
<td>0</td>
<td>17</td>
<td>0</td>
<td>192</td>
<td></td>
<td></td>
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<tr>
<td>Slips, trips and falls</td>
<td>↔</td>
<td>0</td>
<td>7</td>
<td>0</td>
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<tr>
<td>Staff Appraisals (Non Medical Staff)</td>
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### PROCESS & EFFICIENCY

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<tr>
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<th>YTD</th>
<th>Trend</th>
<th>Target</th>
<th>Month</th>
<th>Target</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Length of Stay</td>
<td>↔</td>
<td>3.66</td>
<td>4.00</td>
<td>3.66</td>
<td>3.86</td>
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<tr>
<td>Elective Inpatient Length of Stay (Surgical)</td>
<td>↔</td>
<td>4.00</td>
<td>3.66</td>
<td>4.00</td>
<td>3.52</td>
<td></td>
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</tr>
<tr>
<td>Elective/Arranged Day Surgery Rate</td>
<td>↔</td>
<td>58%</td>
<td>51%</td>
<td>58%</td>
<td>53%</td>
<td></td>
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<tr>
<td>Ward Bed Utilisation - Daily (Incl Weekends)</td>
<td>↑</td>
<td>90%</td>
<td>96%</td>
<td>90%</td>
<td>91%</td>
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<tr>
<td>Ward Bed Utilisation - Weekdays Only</td>
<td>↑</td>
<td>90%</td>
<td>97%</td>
<td>90%</td>
<td>92%</td>
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<tr>
<td>Resourced Theatre Sessions Utilised</td>
<td>↔</td>
<td>85%</td>
<td>95%</td>
<td>85%</td>
<td>96%</td>
<td></td>
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<tr>
<td>Theatre Session utilisation (Time in Theatre)</td>
<td>↔</td>
<td>85%</td>
<td>82%</td>
<td>85%</td>
<td>83%</td>
<td></td>
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<tr>
<td>Acute Patients impacting on Elective Sessions</td>
<td>↔</td>
<td>5.0%</td>
<td>15</td>
<td>147</td>
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<tr>
<td>Cancelled on Day of Surgery - Patient</td>
<td>↔</td>
<td>15</td>
<td>239</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cancelled on Day of surgery - Hospital</td>
<td>↔</td>
<td>74</td>
<td>732</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cancelled on Day of Surgery - Percentage</td>
<td>↔</td>
<td>7.8%</td>
<td>5.0%</td>
<td>8.3%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Outpatient DNA (FSA &amp; Followup) - DNA Rate</td>
<td>↔</td>
<td>6.0%</td>
<td>6.0%</td>
<td>6.3%</td>
<td>6.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient DNA (FSA &amp; Followup) - Maori</td>
<td>↔</td>
<td>6.0%</td>
<td>14.8%</td>
<td>6.0%</td>
<td>15.0%</td>
<td></td>
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</tr>
<tr>
<td>Outpatient DNA (FSA &amp; Followup) - Pacific</td>
<td>↔</td>
<td>6.0%</td>
<td>15.9%</td>
<td>6.0%</td>
<td>16.3%</td>
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### VALUE FOR MONEY

<table>
<thead>
<tr>
<th></th>
<th>Jun-16</th>
<th>YTD</th>
<th>Trend</th>
<th>Target</th>
<th>Month</th>
<th>Target</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Caseweight</td>
<td>↔</td>
<td>5,817</td>
<td>5,850</td>
<td>68,175</td>
<td>68,205</td>
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<tr>
<td>Local Acute Caseweight</td>
<td>↔</td>
<td>2,730</td>
<td>2,618</td>
<td>32,424</td>
<td>32,881</td>
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<tr>
<td>Local Elective Caseweight</td>
<td>↑</td>
<td>1,111</td>
<td>1,159</td>
<td>12,252</td>
<td>11,448</td>
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<tr>
<td>IDF Acute Caseweight</td>
<td>↑</td>
<td>1,252</td>
<td>1,277</td>
<td>15,229</td>
<td>15,082</td>
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<tr>
<td>IDF Elective Caseweight</td>
<td>↑</td>
<td>725</td>
<td>801</td>
<td>8,721</td>
<td>8,795</td>
<td></td>
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<tr>
<td>Outpatient FSA Volumes</td>
<td>↔</td>
<td>3,974</td>
<td>3,699</td>
<td>45,177</td>
<td>45,394</td>
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</tr>
<tr>
<td>Outpatient FU Volumes</td>
<td>↑</td>
<td>9,551</td>
<td>9,488</td>
<td>109,817</td>
<td>119,052</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital FTEs</td>
<td>↑</td>
<td>4,232</td>
<td>4,251</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Operating Costs ($'000)</td>
<td>↔</td>
<td>53,928</td>
<td>54,409</td>
<td>657,152</td>
<td>683,545</td>
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<td></td>
</tr>
<tr>
<td>Hospital Personnel inc outsourced ($'000)</td>
<td>↔</td>
<td>34,266</td>
<td>35,868</td>
<td>420,501</td>
<td>428,311</td>
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### MOH Targets

<table>
<thead>
<tr>
<th>MOH Targets</th>
<th>Key Issue</th>
<th>Alert</th>
<th>Good News</th>
</tr>
</thead>
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PUBLIC Hospital Advisory Committee 12 August 2016 - APPENDICES
**APPENDIX 2.2.1**

**Mental Health, Addictions & Intellectual Disability Service 3DHB**

**Balanced Score Card - June 2016**

**(FY 2015/2016)**

### Patient Experience

<table>
<thead>
<tr>
<th>Target</th>
<th>WDHB</th>
<th>HVDHB</th>
<th>CCDHB</th>
<th>Forensic &amp; Rehab</th>
<th>ID Services</th>
<th>Jun-16</th>
<th>Total YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 Day acute readmissions rate - adult acute units (%)</td>
<td>10%</td>
<td>NA</td>
<td>15%</td>
<td>NA</td>
<td>25%</td>
<td>NA</td>
<td>21%</td>
</tr>
<tr>
<td>Long-term consumers with a current wellness plan (%)</td>
<td>95%</td>
<td>NA</td>
<td>93%</td>
<td>45%</td>
<td>41%</td>
<td>44%</td>
<td>NA</td>
</tr>
<tr>
<td>Better help for inpatients smokers to quit (%)</td>
<td>95%</td>
<td>NA</td>
<td>100%</td>
<td>90%</td>
<td>50%</td>
<td>NA</td>
<td>91%</td>
</tr>
<tr>
<td>HoNOS compliant inpatient discharges - matched pairs (%)</td>
<td>80-100%</td>
<td>89%</td>
<td>61%</td>
<td>64%</td>
<td>11%</td>
<td>0%</td>
<td>75%</td>
</tr>
<tr>
<td>HoNOS compliance - Community (%)</td>
<td>80-100%</td>
<td>80%</td>
<td>61%</td>
<td>64%</td>
<td>15%</td>
<td>50%</td>
<td>61%</td>
</tr>
<tr>
<td>Consumer death by suspected suicide (n)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>28</td>
</tr>
<tr>
<td>SAC 1 &amp; 2 (n)</td>
<td>NA</td>
<td>2</td>
<td>27</td>
<td>135</td>
<td>121</td>
<td>96</td>
<td>381</td>
</tr>
<tr>
<td>All reportable events (n)</td>
<td>NA</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Medication errors (n)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Complaints (n)</td>
<td>NA</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Complaints resolved within 30 days (%)</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
<td>30%</td>
<td>NA</td>
<td>NA</td>
<td>50%</td>
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<tr>
<td>Health &amp; Disability Commission Complaints (n)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Complaints count</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<tr>
<td>Personal restraints count (n)</td>
<td>NA</td>
<td>0</td>
<td>3</td>
<td>16</td>
<td>3</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>All consumers under Section 11 to Section 15 (n)</td>
<td>1</td>
<td>26</td>
<td>95</td>
<td>6</td>
<td>NR</td>
<td>128</td>
<td>1435</td>
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<tr>
<td>All consumers under Compulsory Treatment Order (n)</td>
<td>NA</td>
<td>35</td>
<td>111</td>
<td>386</td>
<td>109</td>
<td>11</td>
<td>612</td>
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<tr>
<td>Maori under Community Treatment Order (n)</td>
<td>15</td>
<td>35</td>
<td>84</td>
<td>41</td>
<td>6</td>
<td>181</td>
<td>656</td>
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<tr>
<td>Seclusion hours per 100,000 pop</td>
<td>46.21</td>
<td>37.21</td>
<td>8.15</td>
<td>15.63</td>
<td></td>
<td></td>
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<tr>
<td>Seclusion hours per 100,000 pop - Maori</td>
<td>NA</td>
<td>54.17</td>
<td>135.29</td>
<td>21.35</td>
<td>0.00</td>
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<tr>
<td>Seclusion hours per 100,000 pop - Pacific</td>
<td>NA</td>
<td>56.36</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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### Healthy Workforce

<table>
<thead>
<tr>
<th>Target</th>
<th>WDHB</th>
<th>HVDHB</th>
<th>CCDHB</th>
<th>Forensic &amp; Rehab</th>
<th>ID Services</th>
<th>Jun-16</th>
<th>Total YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff turnover/heads-count - YTD average annualised (%^2)</td>
<td>8-10%</td>
<td>12%</td>
<td>17%</td>
<td>12%</td>
<td>8%</td>
<td>8%</td>
<td>NA</td>
</tr>
<tr>
<td>Sick leave (%^2)</td>
<td>2-4%</td>
<td>2.2%</td>
<td>4.5%</td>
<td>2.8%</td>
<td>3.9%</td>
<td>4.8%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Staff with annual leave &gt; 200 hours (n)^1</td>
<td>NA</td>
<td>4</td>
<td>51</td>
<td>156</td>
<td>75</td>
<td>60</td>
<td>346</td>
</tr>
<tr>
<td>Physical assaults on staff (n)</td>
<td>NA</td>
<td>0</td>
<td>1</td>
<td>18</td>
<td>3</td>
<td>2</td>
<td>24</td>
</tr>
<tr>
<td>Performance appraisals completed (%)</td>
<td>100%</td>
<td>19%</td>
<td>18%</td>
<td>26%</td>
<td>44%</td>
<td>53%</td>
<td>31%</td>
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### Financial

<table>
<thead>
<tr>
<th>Target</th>
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<th>HVDHB</th>
<th>CCDHB</th>
<th>Forensic &amp; Rehab</th>
<th>ID Services</th>
<th>Jun-16</th>
<th>Total YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating (actual) costs ($’000)</td>
<td>262</td>
<td>1,890</td>
<td>4,665</td>
<td>2,413</td>
<td>1,196</td>
<td>10,486</td>
<td>12,151</td>
</tr>
<tr>
<td>Personnel including outsourced ($’000)</td>
<td>305</td>
<td>1,381</td>
<td>4,246</td>
<td>2,288</td>
<td>1,102</td>
<td>9,523</td>
<td>10,186</td>
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<tr>
<td>Overtime hours (%^3)</td>
<td>1.9%</td>
<td>3.6%</td>
<td>2.0%</td>
<td>2.8%</td>
<td>4.9%</td>
<td>2.8%</td>
<td>2.9%</td>
</tr>
<tr>
<td>FTEs - actual</td>
<td>36</td>
<td>169</td>
<td>567</td>
<td>336</td>
<td>166</td>
<td>1,273</td>
<td>11,325</td>
</tr>
<tr>
<td>FTEs - vacancies</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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### Productivity

<table>
<thead>
<tr>
<th>Target</th>
<th>WDHB</th>
<th>HVDHB</th>
<th>CCDHB</th>
<th>Forensic &amp; Rehab</th>
<th>ID Services</th>
<th>Jun-16</th>
<th>Total YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access rate (%^3)</td>
<td>3%</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>NA</td>
<td>4%</td>
<td>NA</td>
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<tr>
<td>Acute Adult Inpatients ALOS (days)</td>
<td>14-21</td>
<td>13</td>
<td>10</td>
<td>11</td>
<td>17</td>
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<tr>
<td>ALOS Adolescent Unit (days)</td>
<td>32</td>
<td></td>
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<td></td>
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<tr>
<td>ALOS Psychiatric Unit (days)</td>
<td>39</td>
<td>NA</td>
<td>46</td>
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<tr>
<td>ALOS Eating Disorders Inpatient Unit (days)</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>ALOS Regional Rehabilitation Units (days)</td>
<td>NA</td>
<td>NA</td>
<td>410</td>
<td>NA</td>
<td>588</td>
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<tr>
<td>ALOS Adult Forensic Inpatient Units (days)</td>
<td>379</td>
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<td></td>
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<tr>
<td>ALOS Adult Intellectual Disability Unit (days)</td>
<td>252</td>
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<tr>
<td>ALOS Youth Intellectual Disability Unit (days)</td>
<td>NA</td>
<td>355</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Inpatient Units Occupancy (%)</td>
<td>85%</td>
<td>81%</td>
<td>83%</td>
<td>86%</td>
<td>74%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Adolescent Unit Occupancy (%)</td>
<td>99%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Unit Occupancy (%)</td>
<td>92%</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorders Unit Occupancy (%)</td>
<td>47%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional Rehabilitation Units Occupancy (%)</td>
<td>47%</td>
<td>99%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Forensic Inpatient Occupancy (%)</td>
<td>NA</td>
<td>92%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Intellectual Disability Unit Occupancy (%)</td>
<td>95%</td>
<td>99%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth Intellectual Disability Unit Occupancy (%)</td>
<td>72%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-admission community care (%)</td>
<td>75-100%</td>
<td>NA</td>
<td>31%</td>
<td>61%</td>
<td>50%</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Post-discharge community care (%)</td>
<td>80-100%</td>
<td>61%</td>
<td>68%</td>
<td>NA</td>
<td>65%</td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>Consumer related time - child and youth (%)</td>
<td>10-40%</td>
<td>NR</td>
<td>NR</td>
<td>16%</td>
<td>9%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Consumer related time - adults (%)</td>
<td>35-40%</td>
<td>NR</td>
<td>NR</td>
<td>11%</td>
<td>9%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Community treatment days per quarter (%)</td>
<td>10-20</td>
<td>NR</td>
<td>NR</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Wait-time &lt; 3 weeks - child and youth (%)</td>
<td>80%</td>
<td>85%</td>
<td>41%</td>
<td>56%</td>
<td>98%</td>
<td>NA</td>
<td>58%</td>
</tr>
<tr>
<td>Wait-time &lt; 3 weeks - child and adult (%)</td>
<td>95%</td>
<td>96%</td>
<td>76%</td>
<td>89%</td>
<td>99%</td>
<td>87%</td>
<td>NA</td>
</tr>
<tr>
<td>Wait-time &lt; 3 weeks - adult (%)</td>
<td>80%</td>
<td>84%</td>
<td>79%</td>
<td>67%</td>
<td>94%</td>
<td>70%</td>
<td>75%</td>
</tr>
<tr>
<td>Wait-time &lt; 8 weeks - adult (%)</td>
<td>95%</td>
<td>98%</td>
<td>95%</td>
<td>88%</td>
<td>97%</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>Community DNA rate (%)</td>
<td>8%</td>
<td>11%</td>
<td>8%</td>
<td>2%</td>
<td>3%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Community DNA rate - Maori (%)</td>
<td>NA</td>
<td>0%</td>
<td>18%</td>
<td>12%</td>
<td>2%</td>
<td>0%</td>
<td>12%</td>
</tr>
<tr>
<td>Community DNA rate - Pacific (%)</td>
<td>13%</td>
<td>12%</td>
<td>9%</td>
<td>2%</td>
<td>NA</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Case load consumer participation in last 90 days (%)</td>
<td>95%</td>
<td>98%</td>
<td>86%</td>
<td>88%</td>
<td>94%</td>
<td>98%</td>
<td>88%</td>
</tr>
</tbody>
</table>

### Key

- **One month lag**
- **Different measures so not comparable**
- **Rolling year, 1 month lag (Rolling Report)**
- **Not reported, under development**
- **Not applicable**
- **Not comparable with 3DHB measure**
- **Increased compared to previous month**
- **Decreased compared to previous month**
June 2016 Pre Admission and Post Discharge Contact - Wairarapa site*

**Pre-admission contact**

**Numerator:** Number of acute adult IP admissions occurring during the reference period for which service user participation contact is recorded in the seven days preceding the admission but not on the day of admission.

**Denominator:** Admissions to Te Whare Ahuru and Te Whare o Matairangi when the client is a current client on the Wairarapa DHB community mental health service case load with a referral open for at least 7 days prior to the admission.

**Exclusions:** Planned admissions as a result of non-acute treatment requirements are excluded, for example overnight admission for electroconvulsive therapy.

**Post - discharge contact**

**Numerator:** Number of in-scope, overnight, acute adult IP discharges occurring during the reference period for which service user participation contact is recorded within seven days of discharge but not on the day of discharge.

**Denominator:** Discharges from Te Whare Ahuru or Te Whare o Matairangi where there is an open Wairarapa community mental health team referral.

**Exclusions:** Planned admissions as a result of non-acute treatment requirements are excluded, for example overnight admission for electroconvulsive therapy.

* As the National Mental Health and Addiction Service KPI Program specifications for pre admission and post discharge do not apply to district health boards without an inpatient unit, these indicators are not reported for Wairarapa DHB in the MHAIDS 3DHB Balanced Score Card (BSC). As defined above, local indicators have been developed and are reported with a one month lag which allows time for the post discharge contact to occur and be recorded. This is consistent with the Hutt Valley and Capital and Coast DHB indicators reported in the BSC.
APPENDIX 2.2.3

MATAIRANGI UNIT JUL-2016

**Admissions**

- **67**
- 12 MONTH TREND

**Discharges**

- **63**
- 12 MONTH TREND

**Occupancy %**

- **697**
- **78 %**
- 12 MONTH TREND

**Avg Length of Stay**

- **10 Days**
- 12 MONTH TREND

**28 Day Readmission**

- **16 %**
- 12 MONTH TREND

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* Merged Admissions / Discharges: Where a person is administratively discharged from the mental unit and admitted medically for less than 7 days then readmitted to the mental health unit, the administrative discharge to period to non-mental health inpatient services is merged to create a continuous mental health inpatient episode of care.
Background information on pressure injuries

Pressure injuries (also known as pressure ulcers) are a major cause of preventable harm for patients using health care services (including hospital, aged residential care and home care).

Pressure injuries impact the New Zealand health system by increasing patients’ length of stay, ACC treatment injury claims and care costs.

With the right knowledge and care, most pressure injuries can be avoided. All health professionals, family/whānau members and patients have important roles to play in prevention.

Some key findings from the KPMG report commissioned last year revealed:

- An estimated 55,000 people receive a pressure injury every year in New Zealand with a prevalence estimated at 4–8 percent
- Pressure injuries are more commonly associated with age, immobility, incontinence and malnutrition
- Most pressure injuries can be prevented through improved care practices, consistent measurement and implementing clinical guidelines
- Reducing pressure injuries will reduce direct health service costs and improve quality of life for people at risk of pressure injuries
- Every grade III pressure injury (estimate of 2500 cases per year) costs around $123,000
- The annual direct cost of pressure injuries is estimated at around $68 million
- It is difficult to put a cost on quality of life and suffering from pressure injuries but the report estimates total annual cost of pressure injuries to society is $694 million (including quality adjusted life years [QALY] calculation)