CAPITAL & COAST DISTRICT HEALTH BOARD

Public Agenda

22 MARCH 2017

Board room, 11th Floor, Grace Neill Block, Wellington Regional Hospital, 1.00pm

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS					1.00pm	
1.1	Karakia					
1.2	Apologies	**RECORD**	A Blair			
1.3	Continuous disclosure - Interest Register - Conflicts of Interest	 **CONFIRM** **ACCEPT**	 A Blair A Blair			 3 6
1.4	Confirmation of draft Minutes 22 February 2017	**APPROVE**	A Blair			8
1.5	Matters arising	**NOTE**	A Blair			
1.6	Action list	**NOTE**	A Blair			14
1.7	CCDHB Work plan 2017	**NOTE**	A Blair			17
2 PRESENTATIONS						
2.1	Māori Partnership Board (verbal)	**NOTE**	J Rikihana			
2.2	Emergency Preparedness (verbal)	**NOTE**	C Lowry			
3 FOR DISCUSSION						
3.1	Chair's report (verbal)	**NOTE**	A Blair			
3.2	Chief Executive's report 3.2.1 Financial summary, February 2017	**NOTE**	D Chin			19 28
3.3	Health and Safety Report February 2017	**NOTE**	T Davis			36
3.4	Mental Health Addictions and Intellectual Disability 3DHB Service update and scorecard	**NOTE**	N Fairley			56
3.5	Quality and safety	**NOTE**	C Lowry			65
3.6	Accountability and planning processes	**NOTE**	R Haggerty			73
4 INFORMATION						
4.1	Kenepuru Accident and Medical	**NOTE**	C Lowry R Haggerty			77
OTHER						
5	General Business	**NOTE**	A Blair			
6	Resolution to Exclude the Public	**APPROVE**	A Blair			79
ADJOURN						
APPENDICES						

3.2	• Letter to Chairs and DHBs, Health Partnership Limited • Māori Health Development Group monthly report	80 81
3.4	• Police Handover form • Section 109 Checklist • Te Haika data • 3DHB MH & Addiction work programme 2017 • Balanced score card – January 2017 • Wairarapa pre admission and post discharge contact – January 2017.	96 98 100 109 111 112
3.5	• Patient Experience Survey March 2017 • Clinical Quality Measures Report	113 114

CAPITAL & COAST DISTRICT HEALTH BOARD

Interest Register

22 MARCH 2017

Name	Interest
Mr Andrew Blair *Chairperson*	• Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector • Chair, Southern Partnership Group (appointed jointly by Ministers of Finance and Health to provide governance for the redevelopment of Dunedin Hospital) • Director, Breastscreen Auckland Limited • Director, St Marks Women's Health (Remuera) Ltd • Director, Safer Sleep Ltd • Director, Safer Sleep LLC Ltd • Advisor to the Board, Forte Health Limited, Christchurch • Former Member of the Hawkes Bay District Health Board (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO Acurity Health Group Limited • Member of the Board of Trustees of the Gillies McIndoe Research Institute • Chair, Hutt Valley District Health Board (from 5 December 2016)
Dame Fran Wilde *Deputy Chairperson*	• Deputy Chair, Capital & Coast District Health Board • Chair, Remuneration Authority • Deputy Chair NZ Transport Agency • Chair Wellington Lifelines Group • Director Museum of NZ Te Papa Tongarewa • Member Whitireia-Weltec Council • Director Business Mentors NZ Ltd • Director Frequency Projects Ltd • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims • Chair Wellington Culinary Events Trust • Chair National Military Heritage Trust
Mr Roger Jarrold *Member*	• Member, Capital & Coast District Health Board • Chair, Capital & Coast DHB FRAC committee • Trustee, Auckland District Health Board Charitable Trust • Employee CFO, Downer New Zealand Ltd • Director, Downer New Zealand Ltd • Director, Works Infrastructure Cortex Resources JV Ltd • Director, Works Infrastructure Harker Underground Construction JV Ltd • Director, Works Finance (NZ) Ltd • Director, DGL Investments Ltd • Director, TSE Wall Arlidge Ltd • Director, Waste Solutions Ltd • Employer (Downer NZ) subcontracts to Spotless • Director, Underground Locators Ltd

Name	Interest
	• Trustee, Works Superannuation Scheme • Member, Finance and Risk Committee, Health Research Council • Past member, Ministry of Health Audit and Risk Committee (resigned 6 December 2013) • Director, Downer Utilities Alliance New Zealand Ltd • Director, Downer Utilities New Zealand Ltd • Assisting ADHB with a Cost of Service programme
Mr Darrin Sykes *Member*	• Member, Capital & Coast District Health Board • Deputy Chair, Capital & Coast District Health Board, FRAC committee • Trustee, Wellington Regional; Sports Education Trust (trading as Sports Wellington) • Member, Sport and Recreation New Zealand (trading as Sport NZ) • Chief Executive, Crown Forestry Rental Trust
Ms Sue Kedgley *Member*	• Member, Capital & Coast District Health Board • Member, CCDHB HAC committee • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Shareholder in Green Cross Health • Step son works in middle management of Fletcher Steel • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council
Dr Roger Blakeley *Member*	• Member of Capital and Coast District Health Board • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • Member, Harkness Fellowships Trust Board • Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington
Ms Kim Ngarimu *Member*	• Member of Capital and Coast District Health Board • Member, Medical Council of New Zealand (MCNZ) • Member, Māori Heritage Council • Board Member, Te Māngai Pāhō (Māori Broadcasting Agency) • Alternate Crown Trustee, Crown Forestry Rental Trust • Director, Taaua Ltd (Public policy and management consulting company) • Trustee, Judith and Taina Ngarimu Whānau Trust (has shareholdings in various health related companies – share acquisition and sale is independently managed)

Ms ‘Ana Coffey *Member*	• Member of Capital & Coast District Health Board • Councillor, Porirua City Council • Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation
Ms Eileen Brown *Member*	• Member of Capital & Coast District Health Board • Board member (until Feb. 2017), Newtown Union Health Service Board • Employee of New Zealand Council of Trade Unions • Senior Policy Analyst at the Council of Trade Unions (CTU) – whose affiliated members include NZNO, PSA, E Tū, ASMS, MERAS and First Union.
Dr Kathryn Adams *Member*	• Member, Capital & Coast District Health Board • Fellow, College of Nurses Aotearoa (NZ) • Reviewer, Editorial Board, Nursing Praxis in New Zealand • School Nurse Vaccinator (casual) Regional Public Health, HVDHB • Workplace Health Assessments and seasonal influenza vaccinator, Artemis Health • Secretary, National Party Ohariu Electorate • Director, Agree Holdings Ltd, family owned small engineering business, Tokoroa
Ms Sue Driver *Member*	• Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Daughter, Policy Advisor, College of Physicians • Former Chair, Robinson Seismic (base isolators, Wgtn Hospital) • Advisor to various NGOs

CAPITAL & COAST DISTRICT HEALTH BOARD

Interest Register

EXECUTIVE LEADERSHIP TEAM

22 MARCH 2017

Debbie Chin *Chief Executive Officer*	• Member, Rotary • Member, HBL FPSC Procurement Steering Group (regional Chief Executive representative) • Member, HBL Shared Services Council (regional Chief Executive representative) • Trustee, Wellington Hospitals Foundation • DHB lead CE for sector performance frameworks
Chris Lowry *General Manager Hospital and Healthcare Services*	• Son works at HVDHB
Rachel Haggerty *General Manager, Strategy Innovation & Performance*	• Director, Haggety & Associates • Chair, Takanini Care Ltd
Donna Hickey *General Manager, People and Capability*	• Sister is a nurse, working for Plunket
Thomas Davis *General Manager, Corporate Services*	• None
Nigel Fairley *General Manager of 3DHB Mental Health, Addictions and Intellectual Disability Services*	• Fellow, NZ College of Clinical Psychologists • President, Australian and NZ Association of Psychiatry, Psychology and Law • Trustee, Porirua Hospital Museum • Director and shareholder, Gerney Limited
Mr John Tait *Chief Medical Officer*	• Member Fertility Associates • Member, National Maternity Monitoring Group • Member, ACC taskforce neonatal encephalopathy • Member, Waikato Women's service taskforce • Board member, Wellington Hospitals Foundation
Catherine Epps *Executive Director of Allied Health, Technical & Scientific*	• Expert Advisor (Leadership) to New Zealand Speech-Language Therapists Association • Deputy Chair, National DHB Directors Allied Health • Brother is employed at Waikato and Waitemata DHBs
Andrea McCance *Executive Director of Nursing & Midwifery*	• Trustee, Mary Potter Hospice

21-Feb-17

Tony Hickmott *Chief Financial Officer*	• Sister-in-law is medical director for Student Health Services at Victoria University • Niece is employed by Deloitte Auckland as a senior marketing advisor • Director, Allied Laundry (CCDHB representative)
Roger Palairet *Chief Legal Counsel*	• Practices law as Palairet Law, specialising in public law • Chair and Trustee of Carers NZ (non-profit organisation promoting the interests of family carers; funders include MoH, MSD and Waitemata DHB) • Sister-in-law is a paediatric nurse at CCDHB
Shayne Hunter *Chief Information Officer Technology, 3 DHB*	• Currently in transition from a role at the Ministry of Health and assisting Rillstone Wells on the RHIP/CRISP review
Dr Pauline Boyles *Director of Disability Strategy and Performance*	• 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
Arawhetu Grey *Director Māori Health Services/Manager Planning & Funding Mental Health and Addiction Services*	• Director, Gray Partners • Co-chair, Health Quality Safety Commission – Maternal Morbidity Working Group
Taima Fagaloa *Director of Pacific Peoples' Health/Manager Planning & Funding, Child & Population*	• Cousin works as a community health worker for Ora Toa Health • Director, TCF Consulting Limited
Jannel Fisher *Communications Manager*	• Mother-in-law and sister-in-law are a Bureau nurse and Healthcare assistant respectively • Another sister-in-law is a nurse at CCDHB
Robyn Fitzgerald *Board Secretary*	• Daughter is a nurse at HVDHB

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Board
Held on Wednesday 22 February 2017 at 1pm
Level 11 Grace Neill Block,
Wellington Regional Hospital

PUBLIC SECTION

PRESENT:
Mr A Blair (Chair)
Dame F Wilde (Deputy Chair)
Dr K Adams
Dr R Blakeley
Ms E Brown
Ms A Coffey
Ms S Kedgley (1.25 pm)
Mr R Jarrold
Ms K Ngarimu
Mr D Sykes (2.43 pm)

IN ATTENDANCE:
Mrs D Chin (Chief Executive)
Ms C Lowry (General Manager Hospital and Healthcare Services)
Ms R Haggerty (Director Strategic Innovation and Performance)
Mr T Davis (General Manager Corporate Services)
Mr N Fairley (General Manager 3DHB Mental Health, Addictions and Intellectual Disability Services)
Ms C Epps (Executive Director, Allied Health, Technical and Scientific)
Mr J Tait (Chief Medical Officer)
Ms A McCance (Executive Director of Nursing and Midwifery)
Ms J Fisher (Communications Manager)
Mrs R Fitzgerald (Board Secretary)

MEMBERS OF PUBLIC: 2 members of the public

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1 PROCEDURAL BUSINESS

ITEM 1.1 PROCEDURAL

Karakia was led by Kim Ngarimu. Chair, Andrew Blair, welcomed Board members, Executive team members and members of the public.

ITEM 1.2 APOLOGIES

Apologies were **RECEIVED** from Ms Sue Driver and Mr Darrin Sykes. Notice of late arrival was **RECEIVED** from Ms Sue Kedgley.

ITEM 1.3 INTERESTS

1.3.1 REGISTER OF INTERESTS

Changes to members' registers of interests were received from:

- Ms E Brown – Senior Analyst with the Council of Trade Unions (CTU) who advised the following unions are affiliated with CTU:

- Association of Salaried Medical Specialists (ASMS)
- E'tu (merged between EPMU and Service and Food Workers Union)
- FIRST Union
- Midwifery Representation and Advisory Service
- NZNO
- PSA
- Unite

It was also noted that the CTU is not a bargaining party to wage negotiations.

- Ms K Ngarimu is no longer on the Education Committee of the Medical Council of New Zealand.
- Mr R Jarrold – employer, Downer, contracts with CCDHB (directly or indirectly).

Action:
1. Update interest register.

1.3.2 CONFLICTS RELATED TO ITEMS ON THE AGENDA

No other conflicts were foreshadowed in respect of items on the current agenda but there would be an additional opportunity at the beginning of each item for members to declare conflicts of interest.

ITEM 1.4 MINUTES OF PREVIOUS MEETING 25 JANUARY 2017

RESOLVED THAT:
The minutes of the CCDHB Board meeting held on 25 January 2017, taken with the public present are confirmed as a true and correct record.

Moved: Roger Blakeley **Seconded**: Roger Jarrold **CARRIED**

ITEM 1.5 MATTERS ARISING UPDATE

Nil.

ITEM 1.6 ACTION LIST

Discussion included:

- Changes to OSH reporting requested by the Board. This continues to be developed including a scorecard and the highlighting of major issues. FRAC to receive a one page report on H&S statistics as part of Risk Review.
- Rationalise OSH actions on action list.
- Obtain OSH reports across the regional and review consistency and whether there is an opportunity for standardisation.

The reporting timeframes on the other open action items were **NOTED**.

ITEM 1.7 CCDHB WORK PLAN 2017

Discussion included:

- Relationship between primary and secondary health
- Provision of regular updates on the Sustainability plan through the CEO's report
- Alignment of action list and work plan.

2 DISCUSSION ITEMS

ITEM 2.1 CHAIR'S REPORT

Discussion included:

- Health targets and how CCDHB compares with other DHBs and expectations for improved performance
- Feedback from board members on MOH DHB induction –discussion on what worked well and opportunities for improvement; clearer objectives; more time for interaction;
- Regular MIF meetings to resume with chair and CEO
- A programme to visit community leaders is in place
- Attended the regional Chairs meeting – members were advised of a Central Region Board members meeting in March. Notification to be sent to board members
- Correspondence received from Grey Power and Kapiti Older Persons Council on after hours clinic at Kenepuru Hospital; Waitangirua lease agreement; invitations to meet with Compass Health Chair

The report was **RECEIVED.**

Action:

1. Email placeholder date to Board members to attend Central Region Board members' meeting in Wairarapa

ITEM 2.2 CHIEF EXECUTIVE'S REPORT

Items in the CEO's report were discussed and further details provided by executive members.

- Clinical Council Group – Terms of reference to be developed and meetings have been established. Structure and membership representation explained.
    - Clinical leaders reporting lines explained. An organisation structure of clinical governance was requested and tabled. The structure chart notes disestablishment of two committees.
    - Relevant reports and papers to be endorsed by the Council. Chair of Council to attend Board meetings to advise the Board.
- Misreporting by media and impact on staff, services and general public perception was discussed. Executive advised against pursuing complaint to Press Council.

The report was **RECEIVED.**

ITEM 2.3 CCDHB HEALTH AND SAFETY REPORT (for the month of January 2017)

Discussion included:

- Employee participation on OSH committee
- Ceiling tiles

The report was taken as **read**.

The Board **NOTED**:

(a) The health and safety report for the month of January 2017
(b) The current health and safety risks
(c) The number of staff and 'Other' reported incidents
(d) The individual Director H&S Reports.

The Board **requested:**
(e) That the key risks be included in the main report
(f) That a report on sub-contractors be provided next month.

Moved: Roger Jarrold **Seconded**: Sue Kedgley **CARRIED**

ITEM 2.4 HOSPITAL REPORT January month end report

Discussion included:

- Pod model of care; structured teams around modules
- General medicine – projects underway between other groups
- Long stay patients and how this is managed
- Clinical leadership training
- Health targets and strategies to meet annual targets without impacting on other areas like operating theatres and ICUs.

The report was taken as **read**.

The Board **NOTED**:
(a) The contents of the report
(b) The balance scorecard.

Moved: Fran Wilde **Seconded**: Roger Blakely **CARRIED**

3 INFORMATION PAPERS

ITEM 3.1 HEALTH CARE HOME AND PRIMARY OPTIONS FOR ACUTE CARE

Discussion included:

- Home health care shared investment
- Roll out programme will continue
- Lessons learned from first roll out

The Board **NOTED**:
(a) The Health Care Home model of care that is progressing across CCDHB that will deliver new models of primary health care as well as the integration of hospital based services
(b) The progress in the Primary Options for Ambulatory Care across CCDHB.

Moved: Ana Coffey **Seconded**: Roger Blakely **CARRIED**

Action:
1. Management to organise a Health Care Home visit
2. Management to communicate to community on progress of community engagement of Kenepuru and other community initiatives.

ITEM 3.2 2017-18 ANNUAL PLAN

The Board **NOTED**:
(a) The 2017-18 Annual Plan requirements as set out by the Ministry of Health
(b) The process and timeline for the development of the first draft of the CCDHB Annual Plan.

The Board **requested**:

(a) Opportunity to workshop the plan and requested Board engagement with the work program in Stage 2 is incorporated into work plan.

Moved: Ana Coffey **Seconded**: Roger Blakely **CARRIED**

ITEM 3.3 MINISTRY OF HEALTH QUARTERLY PERFORMANCE MONITORING REPORT

The quarterly published report of DHB performance against health targets was tabled together with a briefing on those where CCDHB has not achieved the target.

The Board **NOTED**:

(a) Management's summary of Quarter Two Health Target Results.
(b) The Ministry of Health Performance Monitoring Report Quarter One 2016/17.

Moved: Andrew Blair **Seconded**: Roger Blakely **CARRIED**

4 GENERAL BUSINESS

Nil.

5 RESOLUTION TO EXCLUDE THE PUBLIC

ITEM 5.1 RECOMMENDATION

The Board **NOTED** and **RESOLVED** to:

(a) **AGREE** 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:

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the respective public excluded papers	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in respective public excluded papers	
FRAC Report	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(f)(i)(j)(k)
Chair's report		
CEO's report		
Strategy business case for new services		
Annual Planning – Population based funding formula – Sapere		

* Official Information Act 1982.

Moved: Roger Blakeley **Seconded:** Darrin Sykes **CARRIED**

The meeting closed at 3.00pm.

6 DATE OF NEXT MEETING

22 March 2017, 11th Floor Boardroom, Grace Neill Block, Wellington Regional Hospital.

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting

DATED this .....day of.....2017

Andrew Blair
CCDHB BOARD CHAIR

DRAFT

Meeting Type: BOARD PUBLIC

SCHEDULE OF ACTION POINTS – MARCH 2017 PUBLIC MEETING

Date of meeting	Agenda item number	Topic	Action	Designated to	How dealt with	Delivery date
22 Feb 2017	3.1	**Healthcare Home and Primary Options for Acute Care**	Management to organise a Health Care Home visit by Board members.	Dir SIP	Invitation	April 2017
			Management to communicate to community on progress on community engagement of Kenepuru and other community initiatives.		Paper	March 2017
25 Jan 2017	3.1	**Chair's Report**	CEO to ask at the next CEO forum and Chair at the National Chairs' meetings what other DHBs are doing about fluoridation.	CEO/Chair		March 2017
			Management to report back to the Board on emergency preparedness next month.	GM HHS	Presentation	March 2017
	3.3	**Health and Safety Report**	Revamp the Health & Safety Report to the Board with dashboard and less detail, making the detail available in Board books. In main report identify exceptions, trends, comparative data, mitigation strategies and process.	GM CS	New H&S Report	
			Schedule a Board 'walk-around' with a health and safety view.		Schedule	March 2017
			'Near misses' reporting will be actively promoted across the organisation. Board to be updated as details and results come to hand.		Add to report	March 2017
			Report to the Board on bullying comments and feedback from EAP.	GM PC	Add to OSH report	March 2017
28 Oct 2016	2.2		Ratios are to be developed for the key indicators.	GM CS	Inclusion in report	When data becomes available
			The Health & Safety manager is to benchmark against other DHBs and industries.	GM CS		
			Include in the next report information on risks that have been increasing in severity from the risk register and what is being done to manage this.		Inclusion in report	March 2017

		Health and Safety Report	The committee requested management to progress discussions through various avenues on the issue of addressing drugs and alcohol in the workplace and to provide advice to the new Board early in 2017.	GM PC	Report	March 2017
			The committee requested management investigate the accuracy of the directorate statistics graph as the incident patterns correlate to days off to clarify if this is coincidental or an error.	GM CS		
			Management were requested to provide an update on the process of auditing aged residential care health and safety compliance to the new committee in early 2017.	GM SIP		
			Targets for the total recordable injury rate, serious harm and lost time injuries are to be set for the New Year.	GM CS		April 2017
11 Nov 2016			Management to request a one page summary from contractors to identify ratio per work hours; targets to be met; trends and overall performance. Reporting process to flow through FRAC then onto the Board.			March 2017
	4.2	**Chief Executive's Report**	Management to provide an update to the new Board on transition of Home Care Support Services; KPIs and monitoring reports.	Dir SIP	Include in CPHAC reporting	April 2017
			Management to describe the work programme with primary care that includes an acute demand work stream and the health care home programme of work.			May 2017
14 Oct 2016			Management to provide timeline for System Level Measures Plan.			March 2017
			Management to take report to Board workshop to discuss outcomes from engagement with community.			
			Management to confirm Birthing Unit timeline and decisions needed.			

8 Nov 2013			Schedule a presentation to the Board by HWFNZ	Chair	CCDHB Chair to write to HWFNZ Chair and invite to Board meeting to present long term strategic direction.	July 2017
14 Oct 2016	2.1	**Māori Partnership Board Update**	The Intervention Case Studies be presented to new Board.	Ex Dir MH	Include in Advisory update to Board	March 2017
15 May 2015	H77	**Operational Services Report**	Following the presentation to HAC, the committee requested that Dr Anne O'Donnell be invited to present/speak at a Board workshop.	Chair	Update to Board	

Closed since last meeting – 22 February 2017

Date of meeting	Agenda item number	Topic	Action	Designated to	How dealt with	Delivery date
22 Feb 2017	**1.3.1**	**Register of Interest**	**Update interest register**	**Board Secretary**	**Edit**	**March 2017**
	2.1	**Chair's Report**	**Email placeholder invitation to Board members to attend Central Region Boards' Symposium in Wairarapa**	**Board Secretary**	**Send invitations**	

Capital & Coast Health District Health Board Workplan 2017

Regular monthly items: (Public) Chair's Report; CEO's Report; Health & Safety Report; Resolution to Exclude
(Public Excluded): Chair's Report; CEO's Report; FRAC recommendations; FRAC minutes; Litigation and legal risk update; Mental Health update.

	January	February	March	April	May	June	July	August	September	October	November	December
Decision	• 2017 Board Work programme • CPHAC-DSAC membership and meeting timetable	• Loan rollover • Insurance renewals	• Integrated Support services plan • Health System Plan	• Disability Strategy (Revised) • Regional Services Plan	• Final Draft Annual Plan 2017/18 • A Strategic Assessment of CCDHB's Children's Health Services and Facilities • 3DHB Mental Health Working Group Report •	• Sustainability Plans	• Mental Health System Plan	• NZHP • Final budget • Final capex • 2018 Board Schedule		• Draft Annual Report 2016/17 • Allied Laundry AGM		
Discussion		• Annual Planning • Sustainability Plan Options • Quarterly performance report	• Quality and safety • Sustainability Plan Options • Draft Annual Plan Overview • Porirua and Kapiti Community response	• DHB Strategic Planning	• Quarterly performance report	• Quality and safety		• Quarterly performance report	• Quality and safety	• Strategic Topic	• Quarterly performance report	• External Audit • Workforce
Information		• Hospital Services update and scorecard	• Mental Health Services update and scorecard • OSH Report • Legal update • Media update	• Strategic Topic • Hospital Services update and scorecard • OSH Report • Media update	• Strategic Topic • Mental Health Services update and scorecard • OSH Report • Media update	• Strategic Topic • Hospital Services update and scorecard • OSH Report • Legal update • Media update	• DHB strategic plan • Strategic Topic • Mental Health Services update and scorecard • OSH Report • Media update	• PHO review • TAS annual plan • Strategic Topic • Hospital Services update and scorecard • OSH Report • Media update	• Strategic Topic • Mental Health Services update and scorecard • OSH Report • Legal update • Media update	• Strategic Topic • Hospital Services update and scorecard • OSH Report • Media update	• Strategic Topic • Mental Health Services update and scorecard • OSH Report • Media update	• Strategic Topic • Hospital Services update and scorecard • OSH Report • Legal update • Media update
Presentation			• Maori Partnership Board	• SRDAG	• SRPHAG • TBA (Public Health	• TBA(Pharmac) • Wellington	• TBA (HWNZ presentation) • Antimicrobial	• MPB • WHF		• SRDAG		• SRPHAG • WHF

V2:24/1/2017

			• Health and Safety • Emergency Preparedness • Sapere Presentation • (David Moore)`		Organisation - PHO)	Hospital Foundation (WHF)update	resistance, infectious diseases within the hospital and community					

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DISCUSSION**
	Date: 22 March 2017
Author	Debbie Chin, Chief Executive Capital & Coast DHB
Subject	**Chief Executive's report**

RECOMMENDATION

It is **recommended** that the Board:

a. **Note** the contents of this report

b. **Note** the SSC guide for the 2017 elections

c. **Endorse** the Health Partnership special resolution.

APPENDICES

1. Letter to Chairs and DHBs – Health Partnerships Limited
2. Māori Health Development Group monthly report.

1 FINANCIAL UPDATE

1.1 Financial overview

The DHB result is favourable to budget by $3.9m for February 2017 and favourable to budget by $528k year to date.

The DHB has an actual surplus of $2.4m for the month and a year to date actual deficit of ($11.3m).

The year to date variance had been impacted by two industrial action periods, increased throughput volumes in the hospital, the November earthquake and copper pipe costs.

Activity movement compared to last year

As reported in MoH MIF report	Feb-17	Feb-16	Variances Month	Months % change	YTD 16/17	YTD 15/16	Variances YTD	YTD % change
Discharges	4,799	5,147	348	6.8%	41,046	42,574	1,528	3.6%
Caseweights (Excl MH)	5,318	5,258	(60)	-1.1%	45,073	45,280	208	0.5%
Bed Days (calculated from Hours)	11,978	11,283	(695)	-6.2%	99,477	99,098	(379)	-0.4%
Length of Stay (excluding day patients)	4.05	3.72	(0.33)	-8.9%	3.88	3.82	(0.06)	-1.6%
ED Presentations	4,887	5,071	184	3.6%	41,787	41,288	(499)	-1.2%
ED Admissions	1,700	1,656	(44)	-2.7%	14,616	14,175	(441)	-3.1%
Theatre Throughput (Hospital)	1,314	1,455	141	9.7%	10,891	11,310	419	3.7%

PUBLIC

Net Result	February 17 Actual $	February 17 Budget $	Month Variance $	YTD Actual $	YTD Budget $	YTD Variance $
Total CCDHB	2,402,819	(1,531,308)	**3,934,127**	(11,301,114)	(11,829,504)	**528,390**

2 HEALTH TARGETS

2.1 Short Stays in Emergency Department (SSiED)

Target: 95% of patients will be admitted, discharged, or transferred from the Emergency Department within six hours.

2.1.1 Current performance

Summary of Key features for the last month

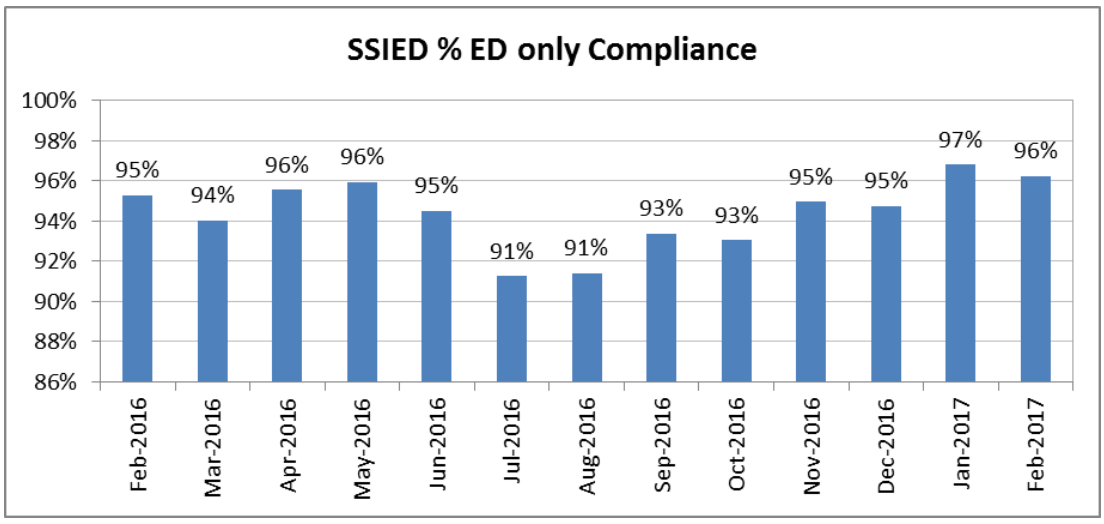
The overall SSIED performance for February was 92.5%. Improvement achieved in January has been sustained in February. Admitted patients compliance was 86% which is the highest it has been for this category in 13 months. Occupancy and admission rates were both higher than previous months but response times in stage one in ED did improve by 25 minutes and time spent in ED improved by 44minutes for admitted patients.

Acute flow improvement projects are well underway with trials of new models of care in progress.

SSIED and flow Results

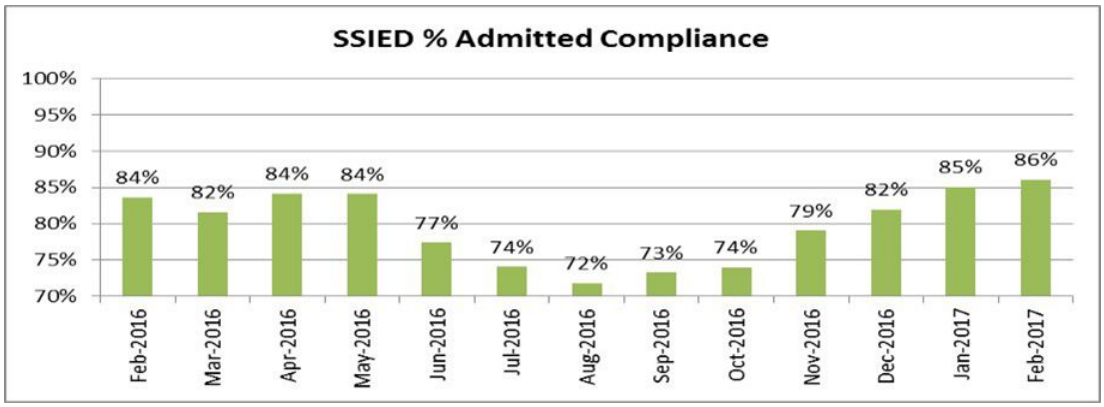
Month Year	Numerator: Patients with LOS less than Six Hours	Denominator: The total patients seen in the ED	Percentage within Target	Variance from 95% Target
Dec-2016	4,511	5,003	90.2%	(4.8)
Jan-2017	4,490	4,854	92.5%	(2.5)
Feb-2017	**4,317**	**4,666**	**92.5%**	**(2.5)**

CCDHB performance for ED treated and discharged patients for February 2017 was 96%.



PUBLIC

CCDHB performance for ED admitted patients for February 2017 was 86% which is an improvement of 2% on the result for February 2016 and the highest compliance for the last 13 months.



2.1.2 Priority work streams – acute flow

Frances Health (FH) has continued to work with both ED and General Medicine over January and February.

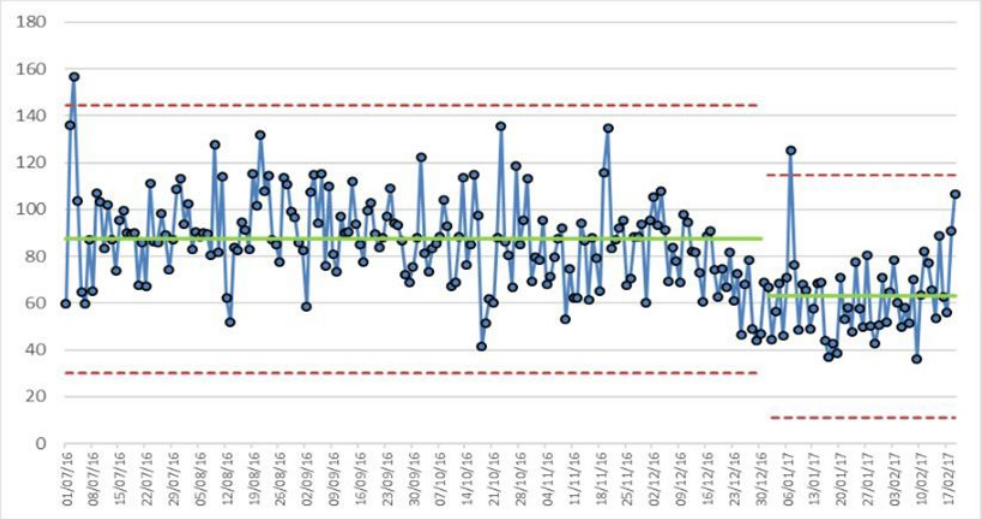
Emergency department:

- Rapid Cycle Tests of Change continue and prioritisation and theming of initiatives is underway
- Team based nursing randomised control trials (RCT) ran this month to inform the approach to zoning in the department. Initial feedback was positive with some issues to work through
- Zoning workshop session is scheduled with a go live date set for 13 March
- Rapid ward rounding continues at 11:00, 14:00, 16:30 and 20:15 in the department and in triage each day with good result.
- SMO & Associate Charge Nurse managers' workshop is planned for 9th March to set expectations and roles.

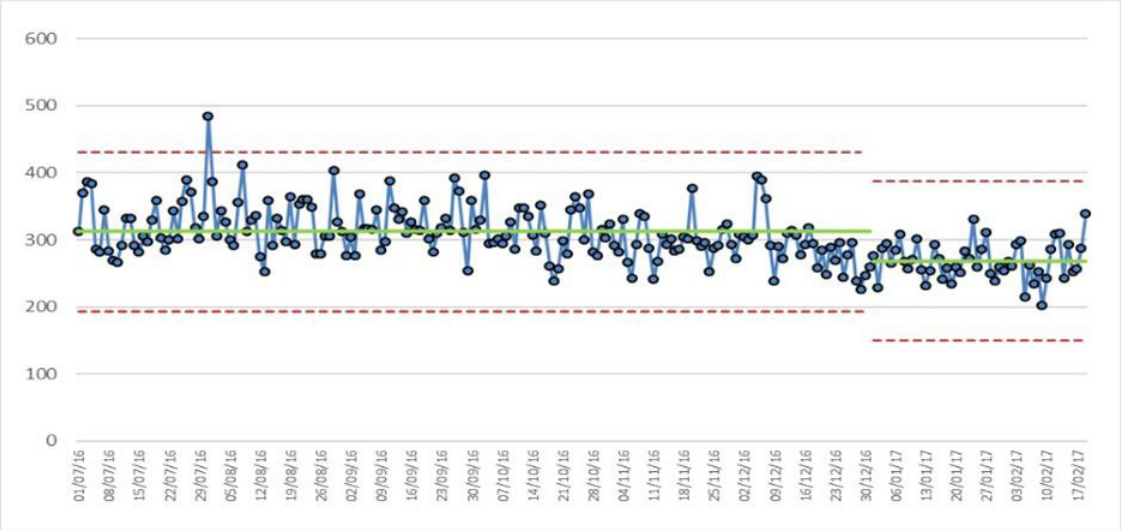
Although there have been few real changes as yet to the models of care there has been a step change in results with the additional focus and trials undertaken so far as demonstrated in the graph below:

PUBLIC

Internal professional standards for ED



Early results show an average time from arrival to ED doctor assessment time was 63 min for all ED Patients admitted and non-admitted. The internal professional standard agreed is 60 minutes. This is an improvement (reduction) of 25 minutes over the last three months.



For admitted patients, results show an average time from arrival in ED doctor to departure time is 268 minutes. The internal professional standard agreed is 210 minutes. This is an improvement (reduction) of 44 minutes over the last three months.

General medicine

The Four work streams have commenced this month and have begun to identify improvement ideas including:

- Improving the interface between ED and MAPU
- Facilitating Ambulatory Care in MAPU
- Timely discharge
- Meeting the needs of long stay patients in a more timely fashion
- Tools to improve the efficiency of our teams.

Rapid Cycle Tests of Change have commenced in February for earlier day of discharges time. Identification and planning of Wave 1 improvement initiatives are underway.

Other specialties
Developing the approach to improve responsiveness to ED with a focus on General Surgery, Paediatric Medicine and Orthopaedics.

Mental Health
Mental health and ED have met and completed process mapping of current process and issues.

A meeting is to be held with Francis Health and senior team to look at options for improvement work.

Acute inpatient bed availability

- Work has started this month with general medical wards and Orthopaedic ward discharges earlier in the day
- Developing standard operating principles to support the earlier identification of patients for transfer to Kenepuru orthopaedics
- The Timely Discharge Project in general medical services has started to trial new models to remove barriers to patient discharges earlier in the day (early results show significant increased use of transit lounge before 11
- Project to improve management of care for long stay patients has commenced and a governance group led by the Chief Medical Officer to review very complex patients has also commenced.

2.2 Elective Services

2.2.1 Elective Discharges Health Target

As at the end of February we are 459 discharges unfavourable to the health.

2.2.2 Recovery Plan

A recovery plan has been in place since November and has been reviewed following the February results. The plan includes increasing in house throughput, a targeted increase in out sourcing and includes the current volume trends for arranged and nonsurgical discharges that contribute to the total target.

In-house production
The plan requires us to deliver an additional 60 cases more per month over and above what has been achieved to date. This will achieve a result of 219 cases below the in house target.

Outsourced procedures
We are significantly behind target YTD, driven by a number of factors including not having the appropriate patients on the waiting list to outsource, private surgery capacity, surgeon vacancies impacting on FSA throughput and therefore wait listing patients for surgery. The recovery plan forecasts us achieving 43 discharges over plan by 30 June. Additional actions are in place to support the achievement of this.

Based on current case mix assumptions this outsourcing will occur within the full year outsourced budget provision.

IDF outflow

Based on year to date activity we are forecasting for IDF outflow to be 21 behind target at year end. Most outflows are done at Hutt Valley DHB. This has been discussed with the Chief Operating Officer at the Hutt who has advised there is little capacity to catch up on CCDHB patients.

Arranged and nonsurgical discharges

We are forecasting favourable 199 discharges at year end. There is little to no risk associated with this forecast.

Within the revised plan the risk of under delivery has been estimated at 219 discharges. Additional options are being developed and put in place to offset this and include:

- Additional after hours lists
- Staffing more trauma on Saturdays to allow for more electives to be done during the week
- Pre-assessing patients on Saturdays to support additional out sourced volumes
- A review of coding is currently being completed to ensure all patients are accurately captured in the reporting

We are currently confirming additional cases that may be outsourced against available capacity. A further 100-200 cases may be required. This has been allowed for in the forecast.

These actions will manage the risk of not achieving the electives target and will be balanced against ensuring we achieve all of the funding against the Elective Funding schedule and remain within the threshold for ESPI compliance.

2.2.3 Elective Services Performance Indicator Compliance

Under the electives services policy DHBs are required to have zero patient waiting >four months for a first specialist assessment - ESPI 2 and treatment - ESPI 5. For a DHB to be compliant there is a threshold of 1% that we have to be within at the end of each month.

The table below shows the ESPI compliance rates for CCDHB from August 2016 to February 2017.

	August	September	October	November	December	January	February	March*
ESPI 2	10	21	23	13	11	15	9	17
ESPI 5	9	3	6	12	14	16	15	5

February ESPI 2 and 5 results are not yet confirmed by MOH however our internal reporting confirms that we remain within the threshold for compliance.

We are forecasting 17 non-compliant ESPI 2, and 5 patients non-compliant for ESPI 5 at March month end. This will be within accepted tolerance levels.

We continue to be within the threshold for compliance and are one of the few DHBs who have maintained compliance over the past 4years

2.3 Cardiothoracic Waiting List

The cardiac waitlist is currently at 68 which is within the maximum number of 71 patients. Numbers peaked at 84 in January post the Christmas break and RMO industrial action but have dropped to 68 as we have had good capacity in ICU over the last 2-3 weeks.

3 MEDIA

3.1 Health Information Privacy Code training

Our chief legal counsel and communications manager have held a privacy training session with Fairfax this month. The session was focused on the disclosure of information, primarily what patient information we can release. This was a proactive initiative by the communications to help strengthen the relationship between the DHB and Fairfax.

4 CLINICAL

4.1 Clinical Council

As discussed at the previous Board meeting, a clinical council will be formed to further strengthen the linkage between the Board and those fulfilling clinical leadership roles. Following feedback from General Practice leaders to the Chair and Chief Executive, the Clinical Council will accommodate the continued role and function of the successful primary care alliance. The Clinical Council will refine the Terms of Reference, and a verbal update will be provided at the Board meeting, for information.

4.2 Advance Care Planning – Conversations that Count Day

Conversations that Count (CtC) Day is on Wednesday 5 April and the theme is *'Get them talking'.* CtC day aims to raise awareness about advance care planning to encourage people to think about, talk about, and plan for their future and end-of-life care. The day is supported by the Health Quality & Safety Commission and the National ACP Cooperative.

The primary audience for CtC day is the general public, particularly older New Zealanders and their whānau. The secondary audience is the health sector - primary, secondary care, community and aged residential care. A range of activities are planned in the CCDHB area to help promote CtC day. These include use of social media, release of local ACP stories and a range of community engagement activities, for example, a stand at Pataka, a piece on Pacific radio, a public presentation at Kapiti Community Centre, retirement village presentations and a display at Wellington Central Library.

ACP was also recently discussed at a study evening for primary care and community nurses. A key message to come out of the presentation and discussion was that starting ACP conversations early, while people are well, is a key enabler of facilitating late conversations

when a person is facing a life limiting or terminal condition. Primary care health practitioners are well placed to introduce early ACP.

For more information see: www.advancecareplanning.co.nz. Health navigator also has a useful ACP section: http://www.healthnavigator.org.nz/health-a-z/a/advance-care-planning/

5 STATE SERVICES COMMISSIONER'S GUIDE FOR THE 2017 ELECTIONS

The New Zealand General Election is being held on Saturday 23 September 2017.

State Services Commission (SSC) provides guidance to agencies to assist all staff to understand their role and responsibilities on matters of integrity and conduct during an election year.

Guidance documents are available on SSC's website: https://www.ssc.govt.nz/parliamentary-elections. The guidance material provides general principles and obligations and provides a framework to assist Executive Leadership teams and their staff to reach decisions appropriate to the context.

The main guidance document 'State Servants, Political Parties, and Elections' is comprehensive and covers topics such as advertising, costing party political policies, interaction with social media, Official Information Act requests and briefings for incoming Ministers. Two additional resources are also available:

- Fact Sheet – a summary of the key points from the main guidance document
- Question and Answer Sheet – focusing on political neutrality and what it means in practice for State servants.

6 HEALTH PARTNERSHIPS LIMITED

NZ Health Partnerships Ltd (NZHPL) is seeking to amend their constitution. This amendment seeks to make DHB Deputy Chairs eligible to be Directors (replacing Chief Executives). Chief Executives will still be integrated within the organisation at a Programme Sponsor level. It seeks to ensure a governance focus for the directors of the NZHPL Board.

The CCDHB Board members have been asked to consider and vote on the HPL special resolution:

Health Partnerships Limited
IT IS RESOLVED AS A SPECIAL RESOLUTION THAT:

1. The existing constitution of the Company is altered in the following manner:

The paragraph found at the end of **clause 9.3(b) (i)** of the constitution, which reads:

"The notice of appointment of each director must be signed by each DHB Shareholder jointly appointing that Director. Each Director must be a Chair or Chief Executive of one of the DHB Shareholders appointing the Director. The DHBs will endeavour to ensure that the composition of DHB Directors includes a mix of DHB Chairs and DHB Chief Executives."

Is altered by deleting the term "Chief Executive" and replacing it with the term "Deputy Chair", and deleting the last sentence of that paragraph so that the altered paragraph now reads:

"The notice of appointment of each director must be signed by each DHB Shareholder jointly appointing that Director. Each Director must be a Chair or Deputy Chair of one of the DHB Shareholders appointing the Director."

7 MĀORI HEALTH DEVELOPMENT GROUP

This month's Maori Health Development Group report (see full report – **Appendix 2**) outlines:

1. Capital & Coast District Health Board performance indicators specific to Māori Health; and,
2. Māori Health Development Group activity.

Included in this month's report are Whānau Care Service intervention case studies. These are real and highlight the collaborative and integrated approach required to provide individuals support to achieve the right outcomes for both themselves and their whanau.

For some individuals they face complex challenges to achieve positive results. Listening to their journey and understanding individual needs is paramount to ensure the right resources and assistance is provided.

Capital & Coast DHB

Board Financial Overview

February 2017

Chief Executive Officer
Debbie Chin

Chief Financial Officer
Tony Hickmott

FINANCIAL PERFORMANCE RESULT AND OVERVIEW

Result for period ended Feb 2017

	February 2017			Year to Date			2016/17
Account Type in $000s	**Actual**	**Budget**	**Variance**	**Actual**	**Budget**	**Variance**	**Annual Budget**
1000. Revenue	86,116	85,758	358	689,086	690,411	(1,324)	1,036,819
2000. Personnel	35,761	35,558	(203)	295,299	297,286	1,987	452,215
3000. Outsourced Services	2,575	2,411	(164)	20,939	18,602	(2,336)	28,416
4000. Clinical Supplies	9,494	8,830	(664)	76,842	75,353	(1,489)	113,316
5000. Infrastructure & Non-Clinica	7,878	8,463	585	70,356	69,725	(632)	100,942
6000. Other Providers	28,005	28,214	209	236,951	237,459	508	357,890
Total	**2,403**	**2,283**	**120**	**(11,301)**	**(8,015)**	**(3,286)**	**(15,960)**
Add Revised Additional Budget		(3,814)	3,814		(3,814)	3,814	(12,040)
Total	**2,403**	**(1,531)**	**3,934**	**(11,301)**	**(11,829)**	**528**	**(28,000)**

The DHB result is favourable to budget by $3.9m for February 2017, and favourable to budget by $528k year to date. The DHB has an actual surplus of $2.4m for the month and a year to date actual deficit of ($11.3m).

The year to date variance had been impacted by two industrial action periods, increased throughput volumes in the hospital, the November earthquake and copper pipe costs. The final Budget for 2016/17 has been revised to a deficit projection of ($28m) for the year.

Revenue year to date is impacted by the deferral of the elective revenue due to lower volumes achieved in Hospital Services. This is offset by additional revenue for ACC related work, research funds, and inter-district revenue flow from other DHBs.

Staff costs have been contained and there are a number of staff vacancies. Medical staff vacancies in critical areas are being backfilled with locums to make sure that the patient journey is not compromised.

Clinical supplies costs have been impacted by higher pharmaceutical volumes and the release of new Pharmac drugs as well as price increases and the mix of other treatment related disposables used. A high priority in the ongoing sustainability plan is consistent reviews of clinical supplies and consumables costs and volumes. The key focus in this area is to identify cost pressures as early as possible and seek to mitigate the financial risk through process and system changes or price and product changes.

External Providers Review

Month - February 2017					Capital & Coast DHB - Funder	Year to Date				
			Variance		Ext Provider Payments - $000s				Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	YTD February 2017	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
					External Provider Payments:					
4,974	4,897	5,370	(77)	396	- Pharmaceuticals	45,728	46,206	44,415	478	(1,313)
(58)	28	(7)	86	51	- Laboratory Transition	141	224	826	83	685
4,826	4,747	4,668	(79)	(158)	- Capitation	39,368	38,649	37,954	(719)	(1,414)
1,450	1,328	1,402	(122)	(48)	- ARC-Rest Home Level	11,881	11,525	11,326	(356)	(555)
2,787	3,392	3,381	604	594	- ARC-Hospital Level	27,862	29,433	28,996	1,572	1,134
1,666	1,468	2,160	(198)	494	- Other HoP	14,437	13,794	17,879	(643)	3,442
1,922	1,753	1,105	(169)	(816)	- Mental Health	14,937	14,324	13,968	(613)	(968)
689	689	664	1	(25)	- Palliative Care/Fertility/Comm Rad	5,532	5,534	5,331	2	(201)
1,722	2,086	1,874	364	152	- Other	15,811	16,953	15,899	1,142	88
8,027	7,826	6,198	(201)	(1,829)	- IDF Outflows	61,253	60,816	47,790	(437)	(13,463)
28,005	**28,214**	**26,815**	**209**	**(1,189)**	**Total Expenditure**	**236,951**	**237,459**	**224,384**	**509**	**(12,566)**

The external provider payments variance year to date is $509k favourable to budget. The main drivers for these variances are:

- Pharmaceuticals $478k favourable variance due to timing of claims.
- Capitation costs are ($719k) adverse mainly due to MOH unbudgeted programmes. These are all offset by MoH additional revenue for new contracts.
- ARC rest home, hospital services have a total favourable variance of $1,216k. Services are volume driven and subject to a review process. A trend of lower average volumes has been achieved with better NASC management.
- HoP (Health of Older People) is ($643k) adverse due to higher claims for In Between Travel (some of which has additional funding) as well as respite service volume increases.
- Mental Health expenses are ($613k) unfavourable due to some services under review.
- Other expenses are $1,142k favourable mainly due to the release of a favourable IDF wash-up for 2015-16.
- IDF outflows for the current year are ($437k) adverse mainly due to sleepover settlement paid to Hutt DHB as well as increased share of 3 DHB contracts for Labs and Home Community Support.

Employee FTE Financial Reporting to Ministry of Health (MOH Accrued FTE)

For financial accounting purposes MOH require an accrued FTE measure (as shown in the table below). This measure includes all hours on an accrual basis including leave accruals, overtime and casual hours. As an FTE measure this is highly volatile for a 24/7 facility due to the divisor being set based on the number of working days in the month. The year to date total is an average for the year. The average dollars per FTE year on year is impacted by MECA increases.

Month - February 2017					**Capital & Coast DHB**	Year to Date					Annual				
			Variance		**MOH Accrued FTE**				Variance					Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	**YTD February 2017**	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	Year end forecast	Annual Budget Average FTE	Last year	Forecast vs Annual Budget	Budget vs Last year
					FTE										
873	865	896	(9)	22	Medical	866	846	852	(21)	(15)	863	863	827	0	(36)
2,396	2,348	2,334	(48)	(62)	Nursing	2,218	2,230	2,164	12	(54)	2,257	2,257	2,099	0	(158)
674	676	682	2	8	Allied Health	696	672	722	(24)	26	688	688	763	0	75
144	144	180	0	36	Support	139	142	180	3	41	142	142	176	0	33
766	909	799	143	33	Management & Administration	831	879	843	48	12	884	884	841	0	(43)
4,853	**4,942**	**4,891**	**89**	**37**	**Total FTE**	**4,751**	**4,769**	**4,761**	**18**	**11**	**4,834**	**4,834**	**4,705**	**0**	**(128)**
					Average $ per FTE										
13,501	13,558	12,619	57	(882)	Medical	109,886	114,320	108,999	4,434	(887)	167,853	172,170	171,566	4,316	(603)
6,014	5,991	5,935	(23)	(78)	Nursing	54,161	53,697	52,323	(464)	(1,838)	80,724	80,756	82,309	32	1,553
6,665	6,427	6,263	(238)	(402)	Allied Health	51,007	51,681	50,316	673	(692)	76,885	77,099	70,765	214	(6,334)
4,079	3,864	3,965	(215)	(114)	Support	34,965	33,583	31,982	(1,382)	(2,983)	49,818	50,737	45,762	919	(4,976)
5,849	5,354	5,776	(494)	(73)	Management & Administration	47,627	47,046	45,212	(580)	(2,414)	67,112	69,127	68,004	2,014	(1,122)
7,368	**7,195**	**7,106**	**(173)**	**(262)**	**Cost per FTE all Staff**	**62,157**	**62,336**	**60,127**	**179**	**(2,030)**	**92,251**	**93,556**	**92,209**	**1,305**	**(42)**

CCDHB STATEMENTS OF FINANCIAL POSITION

Month : Feb 17							Carital & Coast DHB
				Variance			Balance Sheet
Actual	Budget	At Feb 2016	At June 2016	Actual vs Budget	Actual vs Jan 2016	Notes	YTD Feb 2017
97	93	88	12,868	4	9	1	Bank
20,638	12,996	26,096	0	7,642	(5,457)	1	Bank NZHP
8,122	7,232	7,237	7,232	890	885	1	Trust funds
37,550	35,310	38,765	44,284	2,240	(1,214)	2	Accounts receivable
8,454	7,345	8,207	7,345	1,109	247		Inventory/Stock
3,964	4,017	5,111	4,017	(53)	(1,147)	2	Prepayments
78,825	**66,993**	**85,503**	**75,746**	**11,832**	**(6,678)**		**Total current assets**
465,051	491,678	474,839	473,318	(26,627)	(9,788)		Fixed assets
9,201	8,360	4,862	8,360	841	4,339		Work in Progress - CRISP
14,731	11,987	20,762	18,395	2,743	(6,031)		Work in progress
488,983	**512,026**	**500,463**	**500,074**	**(23,043)**	**(11,480)**	3	**Total fixed assets**
6,468	6,468	6,468	6,468	0	0		Investments in New Zealand Health Partnership
1,150	1,150	0	1,150	0	1,150		Investment in Allied Laundry
7,618	**7,618**	**6,468**	**7,618**	**0**	**1,150**		**Total investments**
575,425	**586,636**	**592,434**	**583,437**	**(11,211)**	**(17,008)**		**Total Assets**
0	0	0	0	0	0	1	Bank overdraft HBL
58,741	67,461	61,683	64,504	8,720	2,942	4	Accounts payable, Accruals and provisions
81	62,326	37,081	34,326	62,244	37,000	7	Loans - Current portion
930	1,316	1,316	0	386	385	6	Capital Charge payable
77,984	69,314	69,107	69,314	(8,670)	(8,877)	5	Current employee provisions
137,737	**200,417**	**169,187**	**168,144**	**62,680**	**31,450**		**Total current liabilities**
628	277,628	302,954	305,628	277,000	302,326	7	Crown loans
8,223	7,407	7,401	7,407	(816)	(822)		Restricted special funds
229	229	292	229	0	63		Insurance liability
5,765	5,765	6,236	5,765	0	471		Long-term employee provisions
14,845	**291,029**	**316,883**	**319,029**	**276,184**	**302,037**		**Total non-current liabilities**
152,582	**491,446**	**486,070**	**487,173**	**338,864**	**333,488**		**Total Liabilities**
422,843	**95,190**	**106,364**	**96,264**	**327,653**	**316,479**		**Net Assets**
424,373	424,817	425,976	428,302	(444)	(1,603)	7	Crown Equity
0	0	0	(3,484)	0	0		Capital repaid
0	10,000	2,800	0	(10,000)	(2,800)		Deficit support
339,000	0	0	0	339,000	339,000		Capital Injection
23,596	24,271	23,791	24,271	(675)	(195)		Reserves
(364,126)	(363,898)	(346,204)	(352,825)	(228)	(17,922)		Retained earnings
422,843	**95,190**	**106,364**	**96,264**	**327,653**	**316,480**		**Total Equity**

Month : Feb 17						Capital & Coast DHB	Year to Date				
			Variance			Statement of Cashflows				Variance	
Actual	Budget	Last year	Actual vs Budget	Actual vs Last year	Notes	YTD Feb 2017	Actual	Budget	Last year	Actual vs Budget	Actual vs Last year
						Operating Activities					
86,114	**87,056**	**87,082**	**(942)**	**(968)**		**Receipts**	**722,012**	**702,902**	**699,320**	**19,110**	**22,692**
						Payments					
34,210	35,728	33,540	1,519	(670)		Payments to employees	284,154	287,825	283,356	3,671	(798)
49,559	47,666	46,759	(1,893)	(2,800)		Payments to suppliers	399,264	392,423	384,445	(6,841)	(14,819)
0	0	0	0	0		Capital Charge paid	3,269	4,381	4,138	1,112	869
169	(90)	(90)	(259)	(259)		GST (net)	2,054	1,586	350	(468)	(1,704)
83,937	**83,304**	**80,209**	**(633)**	**(3,728)**		**Payments - total**	**688,741**	**686,215**	**672,289**	**(2,526)**	**(16,452)**
2,177	**3,752**	**6,873**	**(1,575)**	**(4,696)**	**8**	**Net cash flow from operating Activities**	**33,271**	**16,687**	**27,031**	**16,584**	**6,240**
						Investing Activities					
81	50	111	(31)	30		Receipts - Interest	**1,022**	**525**	**1,329**	**(496)**	**307**
0	0	0	0	0		Receipts - Other	0	0	0	0	0
81	**50**	**111**	**(31)**	**30**		**Receipts - total**	**1,022**	**525**	**1,329**	**(496)**	**307**
						Payments					
332	0	0	(332)	(332)		Investment in associates	840	0	1,902	(840)	1,062
1,048	2,500	1,519	1,452	471		Purchase of fixed assets	13,127	20,000	18,049	6,873	4,922
1,380	**2,500**	**1,519**	**1,120**	**139**		**Payments - total**	**13,967**	**20,000**	**19,951**	**6,033**	**5,984**
(1,299)	**(2,450)**	**(1,408)**	**1,089**	**169**	**9**	**Net cash flow from investing Activities**	**(12,945)**	**(19,475)**	**(18,622)**	**5,537**	**6,291**
						Financing Activities					
0	10,000	2,800	(10,000)	(2,800)		**Equity - Capital**	0	10,000	5,600	(10,000)	(5,600)
0	0	0	0	0		**Other Equity Movement**	0	0	0	0	0
0	(81)	(81)	(81)	(81)		Other	0	(243)	(243)	(243)	(243)
0	**9,919**	**2,719**	**(9,919)**	**(2,719)**		**Receipts - total**	**0**	**9,757**	**5,357**	**(9,757)**	**(5,357)**
						Payments					
4,792	**0**	**0**	**(4,792)**	**(4,792)**		Interest payments	**11,568**	**6,748**	**7,066**	**(4,820)**	**(4,502)**
4,792	**0**	**0**	**(4,792)**	**(4,792)**		**Payments - total**	**11,568**	**6,748**	**7,066**	**(4,820)**	**(4,502)**
(4,792)	**9,919**	**2,719**	**(14,711)**	**(7,511)**	**10**	**Net cash flow from financing Activities**	**(11,568)**	**3,009**	**(1,709)**	**(14,577)**	**(9,859)**
(3,914)	**11,221**	**8,184**	**(15,197)**	**(12,038)**		**Net inflow/(outflow) of CCDHB funds**	**8,757**	**221**	**6,700**	**7,544**	**2,672**
32,771	9,100	25,236	(23,671)	(7,535)		**Opening cash**	20,100	20,100	26,720	0	6,620
86,195	97,025	89,912	(10,892)	(3,657)		Net inflow funds	723,034	713,185	706,006	8,857	17,643
90,109	85,804	81,728	(4,305)	(8,382)		Net (outflow) funds	714,276	712,964	699,306	(1,313)	(14,971)
(3,914)	**11,221**	**8,184**	**(15,197)**	**(12,038)**		**Net inflow/(outflow) of CCDHB funds**	**8,757**	**221**	**6,700**	**7,544**	**2,672**
28,857	**20,321**	**33,420**	**8,536**	**(4,563)**		**Closing cash**	**28,857**	**20,321**	**33,420**	**8,536**	**(4,563)**

Notes to the Balance Sheet and Cashflows

A) Notes to Balance Sheet:

1. The DHB's cash balance at the end of February is higher than budget mainly due to less than expected capital spend and other timing differences. All surplus funds are invested by New Zealand Health Partnerships in short term investments;
2. Accounts receivable is slightly higher than budget due to timing differences. Some of the main customers include Ministry of Health $5.7m, Hutt Valley DHB $2.7m, Clinical Training agency $0.8m;
3. Total non-current assets are lower than budget. This mainly due to lower than expected capital spend;
4. Accounts payable, accruals and provisions is lower than the budget mainly due to timing differences. Some of main suppliers include Spotless $1.6m, Healthcare Logistics $1.2m, Central Region Technical Advisory Services $0.6m, various Strategy, Innovation and Performance Directorate (SIPD) related accruals $22.7m;
5. Employee entitlements are significantly higher than budget. This is due to the increase in accrual for unpaid days and annual leave liability;
6. Capital charge payable is lower then budget due to the reduction in the capital charge rate from 8% to 7%;
7. Crown loans and equity are significantly different to budget. This is due to the conversion of all Crown loans to equity in February 2017. The Government has changed its policy on the capital financing of the DHB health sector. DHBs will no longer have access to Crown debt financing for funding of capital investment. Instead the Crowns contribution to DHB capital investment will now be solely funded via Crown equity injections. As a result of the new capital financing policy, in February 2017, CCDHB converted total loans of $339 million into equity.

B) Notes to Cash flow statement:

8. The net cash flow from operating activities is lower than budget. This is due to timing differences;
9. The net cash flow from investment activities is less than the budget. This is due to timing differences;
10. The net cash flow from financing activities is significantly lower than the budget. This is mainly due to the non receipt of deficit support of $10m from the Ministry. The Ministry expects to pay the deficit support to CCDHB in April 2017.

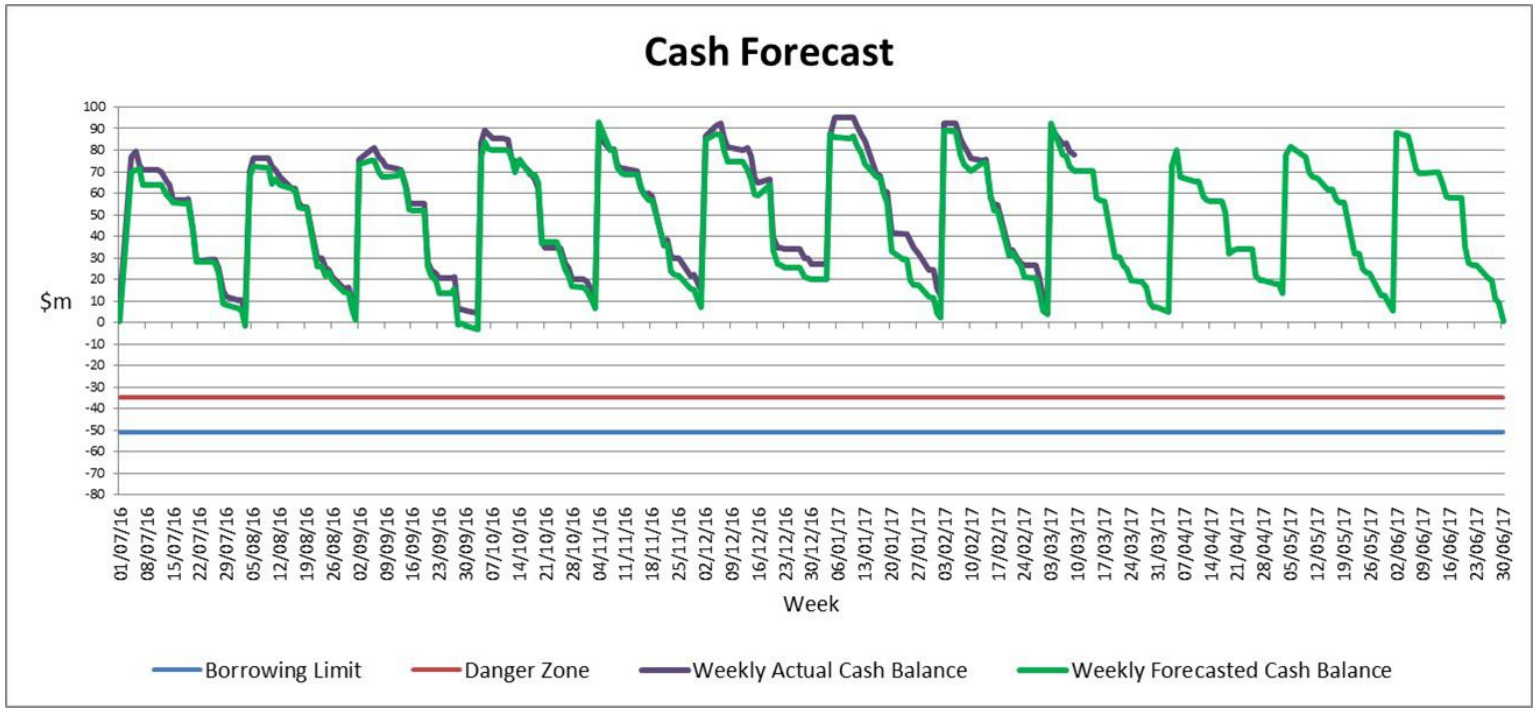
C) Ratios

1. Current Ratio – This ratio determines the DHB's ability to pay back its short term liabilities.
   DHB's current ratio is 0.57 (2015/16: 0.45);

2. Debt to Equity Ratio - This ratio determines how the DHB has financed the asset base.
   DHB's total liability to equity ratio is 26:74 (2015/16: 83:17). For a detailed explanation, refer note 5 on Crown loans and equity under 'Notes to balance sheet'.

Cash Forecast

We have projected our cash position based on the proposed capital budget and a forecast deficit of $28m for 2016/17. However any deterioration in these forecasts may put the facility limit at risk and we continue to monitor this closely. The projected cash position includes deficit support of $10m which is expected to be received in April 2017. The working capital facility limit is approximately $50m.



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Capital & Coast District Health Board	**BOARD DISCUSSION**
	Date: 7 March 2017

Author:	Dave Lewis, Health & Safety Manager
Endorsed By:	Thomas Davies, General Manager Corporate Services
Subject:	**CCDHB Health and Safety Report (for the month of February 2017)**

RECOMMENDATIONS

It is **recommended** that the Board:

a. **Note**: The Health and Safety Report for the month of February 2017

b. **Note**: The current Health and Safety Risks

c. **Note**: The number of Staff and Others H&S reported incidents.

All information accurate at time of report production – 05/03/2017

APPENDICES

1 Health & Safety Risk Register
2 Health & Safety Incident Statistics
3 Wellness and Injury Management.

EXECUTIVE SUMMARY

The report format has been slightly updated for this month and will continue to be developed over the coming months as further data becomes available.

1. RISK REGISTER – Appendix 1.

There are currently 11 active health and safety risks identified on the risk register.

2. INCIDENTS – Appendix 2

H&S incident reporting is encouraged from all workers. Each incident reported is required to be investigated by the relevant manager and appropriate actions are put into place to prevent a re-occurrence. As part of the investigation managers are required to state what actions are required to prevent a recurrence and how they intend to implement them.

Higher reporting indicates a stronger health and safety culture and provides a more realistic picture of the exposure to hazards experienced by our workers. It is the actual work injury claims that accurately reflect the level of harm that is occurring.

2.1 Statistics

- There has been a slight rise in the number of overall incidents reported in February (see 2.5). There was a large decline in the number of reported incidents involving patient handling.

2.2 Lost Time Injuries (LTI)

No LTI were reported for this period.

Quarterly data for all DHBs (below) show that CCDHB is below the national average for LTIs in comparison with the other NZ DHBs.

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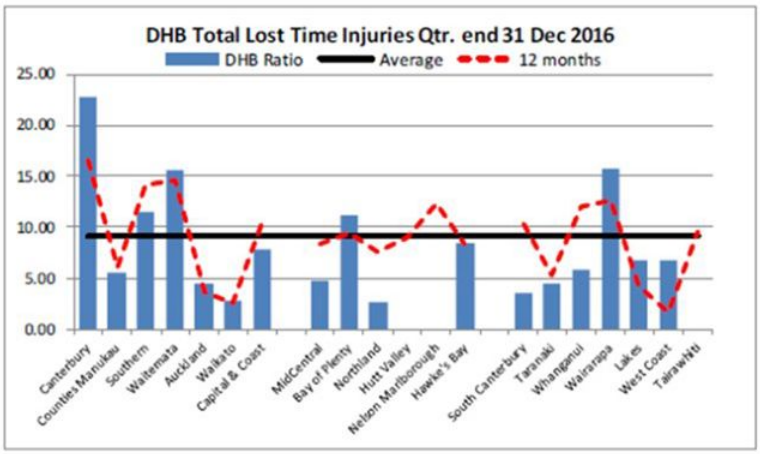
Lost Time Injury Rate

All workplace injuries or illnesses that result in lost work time divided by worked hours (in millions).

Notes –As numbers are pretty low for this KPI a DHB Total graph only is provided.



	Dec-16	Dec-15
All DHBs	9.2	8.8

DHB Size	Dec-16	Dec-15
Large	10.3	8.5
Medium	6.8	10.8
Small	5.6	6.0

Outliers	Dec-16	Dec-15
Highest	22.8	16.0
Lowest	0.0	0.0

Region	Dec-16	Dec-15
Northern	7.5	9.1
Midlands	5.2	4.5
Central	7.4	11.2
Southern	17.6	10.6

Lost Time Injury Frequency Rate is calculated by all DHB's as follows - The number of lost-time injuries (**per million hours worked**) within a given accounting period relative to the total number of hours worked in the same accounting period (number of LTIs x 1,000,000 / number of hours worked for month).

2.3 Notifiable Events – No notifiable events were reported in February 2017
There have been 2 Notifiable Events reported in the past 12 months.

2.4 Serious Injury Reduction - The Government has set a target of reducing serious injuries and fatalities in the workplace by at least 25% by 2020. As can be seen from 2.3 above, CCDHB has a very low incidence of Notifiable Events which are serious injuries and fatalities.

2.5 Performance Summary

Definitions:

- **Incidents** - Total number of incidents that were reported
- **Injury Claims -** Any injury resulting in an ACC45 claim
- **Medical Fee Only Claims** - Any incident which results in an ACC45 claim for treatment but with no lost time
- **Lost Time Injury.** Any incident which results in an ACC45 lost time injury
- **Lost Time Injury Frequency Rate -** The number of lost-time injuries (**per million hours worked**) within a given accounting period relative to the total number of hours worked in the same accounting period (number of LTIs x 1,000,000 / number of hours worked for month).

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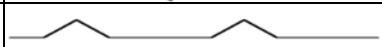
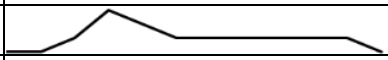
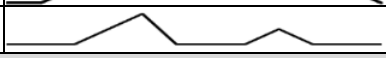
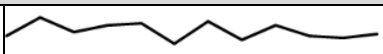
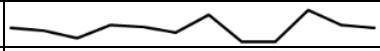
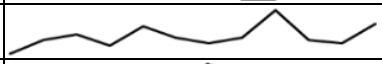
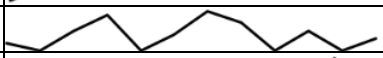
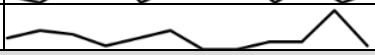
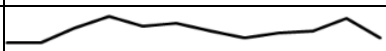
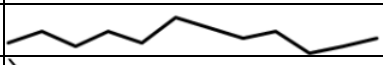
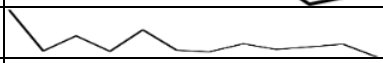
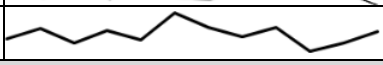
Key: In comparrison to previous month - ▲ - Increased ▼ - Decreased ● - Maintained

Performance Indicator	Current Month	Previous Month	Target	Status	Trend (Past 12 months)
H&S Incidents					
• Total Number of Reported Incidents^	158	154		▼	
• Number of Notifiable Events	0	0	0	●	
• Number of Incidents involving visitors	0	1		▼	
• Number of Incidents involving contractors	0	0		●	
Top Six Staff & Others Incident Lag Indicators					
• Blood or Body Fluid Exposure	13	11		▲	
• Slips, Trips, Falls	7	8		▼	
• Physical Assault of Workers - Excluding MHAIDS	6	4		▲	
• Physical Assault of Workers - MHAIDS	19	21		▼	
• Patient Handling	2	14		▼	
• Object Handling	7	4		▲	
• Hit by or Ran into Object	3	2		▲	
Claims & Injury Statistics					
• Number of Injury Claims	16	24		▼	
• Number of Medical Fees Only Claims	16	12		▼	
• Number of Lost Time Injuries	0	7		▼	
• Number of Lost Days	0	99		▼	
• Lost Time Injury Frequency Rate	0	12		▼	
Leading Indicators ● - Meeting Target ● - Below Target					
• % of Pre-Employment Health Screening completed prior to start+	89%	83%	100%	●	Information not available at time of report production
• % of H&S Fundamentals Managers completed	70%	64%		●	
• % of H&S Incidents investigated within 14 days*	58%	57%		●	

^Figures only available from April 2016 due to introduction of new reporting system
*a two month lag in reporting is required to allow for accurate reporting

3. WELLNESS AND INJURY MANAGEMENT – Appendix 3

3.1 EAP – After a slight rise, the number of employees referring to EAP has started to decline. Information is now provided in Appendix 3 to show the number of referrals by Directorate as well as the reasons stated for referral.

3.2 Workplace Injury Management - WellNZ - A Government syndicated contract commenced on the 1st January 2017. We should start to see a reduction in the monthly management costs form the end of January 2017 onwards.

Lumbar sprain injuries remain the most frequent type of injury reported.

4. EMPLOYEE PARTICIPATION AND ENGAGEMENT

4.1 Health & Safety Representative (HSR) Elections

Information has been sent Directorate General Managers and Executive leads to disseminate to managers. The election process commenced in February 2017 with elections taking place in March 2017.

5. OTHER BUSINESS

5.1 On-Line Hazard Identification & Risk Assessment System and Register

Work is underway with QIPS to develop the Square reporting system to be able to report hazards, perform risk assessments and to populate a risk register to ensure legal compliance.

5.2 Workplace Bullying

EAP Services have been contacted and it has been reaffirmed with them the need to inform any employee who reports an incident of bullying and harassment to them, that that CCDHB has a protected disclosure policy and that they should be encouraged to follow this process outlined in this policy. The monthly usage report from them will now be shared with the General Manager, People & Capability for review.

Any employee who has an appointment with an Occupational Health Nurse or Physician and discloses an incident of bullying or harassment will also be advised to follow the same process. Due to the confidential nature of all appointments with the service, full details cannot be passed on without the employees consent. However, if such a disclosure is made, then in line with the information supplied by EAP services to the DHB, details of the Directorate and Service (where appropriate) will be provided to the General Manager, People & Capability.

The H&S Service will monitor any incidents of bullying or harassment which is reported via SQUARE and make these known to the General Manager, People & Capability.

A full report from the General Manager, People & Capability follows.

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5.3 Bullying, Harassment and Victimisation Prevention

Previous board discussions/decisions

A report on bullying and surveys was requested by the Board at its meeting of 25 January 2017 following discussion of the Employee Assistance Programme (EAP) report.

Two areas of clarification of the report were also requested as part of that. One was the split between the numbers contacting EAP for bullying issues in comparison to workplace issues.

The answer to this is that in the six month period of the report (May – Oct 2016) 21 workers in total contacted them to talk about Bullying issues and for 39 workers in total regarding Conditions (2 for work hours, 17 for workload and 20 for environment).

The other question was how the percentage was defined. The percentage was derived by comparing the reported reasons against the 275 staff who referred to EAP in the time period.

Work undertaken

WorkSafe NZ identifies a number of key areas for employers to focus on in preventing bullying. These include:

- Building good relationships in a respectful work environment
- Building managers who are leaders
- Making the workplace culture clear
- Ensuring good policies, processes and training is in place
- Providing a designated contact person and other support
- Employing staff who understand the workplace culture
- Assessing the workplace culture.

We have been working on all of the above areas.

The HR Plan for the organisation for the last two years has been focused solely on building a positive work environment. This focus was approved by the executive and many of the initiatives have been led by or involved support from professional leaders. The HR Plan supports the Health and Safety at Work Act 2015 and the Employment Relations Act 2000 and the Crown Entities Act 2004 requirements to be a good employer and was informed by previous staff survey data and research on the importance of engagement and a safety culture.

Work undertaken as part of it has included:

- Developing and implementing a new Code of Conduct and Bullying, Harassment, Discrimination and Victimisation Prevention Policy and Guidelines
- A campaign lead by the professional leaders to launch and educate staff and managers on the policy and code and what was acceptable behaviour. The launch included sessions for staff and managers. The unions were very supportive and involved in both the development of the policies and the implementation. They were also able to participate in the training for HR and other staff. The launch also included legal advisors providing sessions for managers.
- Training for staff that included explaining behaviours the DHBs consider to be bullying, harassment, discrimination and victimisation

- Training for managers clarifying responsibilities of the DHBs, managers, and employees in relation to unacceptable behaviour
- Identifying and training staff, chosen by professional leaders, to be another avenue for staff (called contact people) who are feeling they may be being bullied or treated badly to go to. They advise the staff on ways to try to manage it at the lowest level and provide an additional way to get help and advice for staff who do not want to go to their manager or Human Resources
- EAP have been briefed on the processes we have in place so EAP are able to encourage staff to use one of the avenues they have to report a complaint
- Training for the contact staff occurred and this will be adapted for a training programme for managers
- Finalising an eLearning package on the new Code of Conduct for all new staff
- Reporting processes for bullying and harassment have been developed for the reportable events system and events will be incorporated with those reported to HR
- Developing tools for leaders including one for employee engagement and the subsequent interventions to enhance engagement within teams and the organisation
- The Leadership Ethos which sets out the leadership style and culture we wish to promote at CCDHB
- "What managers need to know" training has been developed for new managers. It includes information on our priorities and values, our expectations of managers in building engagement and highlights our zero tolerance for bullying and harassment.
- The Leadership and Management Capability Profile which includes the development of leadership skills in developing positive relationships, motivating and engaging staff, developing staff, etc.

Next steps

We have an extensive programme in train to support both our legislative responsibilities and effective human resource practice. The programme includes:

- A bullying and harassment prevention eLearning module for all staff
- A "management essentials" bullying and harassment training package for managers
- Investigating the NZ Police early intervention programme which is designed to identify staff at risk in terms of health and safety and bullying and harassment
- The national GM HR group is also working on initiatives in this area and the GM People and Capability for CCDHB is one of the two leads for the "Stay Well" work stream which incorporates national work on bullying and harassment prevention. Decisions on national initiatives in this area will be made in late February
- Introduction of reporting of complaints of bullying and harassment via incident reporting, Occupational Health and Safety, HR and contact people process to enable monitoring of complaints for bullying and harassment and poor behaviour
- An engagement survey is scheduled for late March. The results will be analysed and provided to each of the directorates. Each directorate will be required to ensure that action plans that focus on the appropriate areas are in place. The HR plan will also be reviewed to ensure it is cussed in the relevant areas – it will also be broadened to consider workforce development and planning. This will also pick up some national issues, including those related health and safety that have been identified as part of union and bargaining discussions
- A meeting has been scheduled with the Cognitive Institute to consider the programmes and approaches that they have been using in Australia (particularly the work at the Royal Melbourne Hospital)
- A refresh of the DHB values which identifies a set of behaviours to embed the values throughout the organisation
- Promotion of the Leadership and Management Capability framework.

5.4 Drug and Alcohol Policy Update

The New Zealand Council of Trade Unions has provided advice on drug and alcohol issues in the Health Sector. This was developed at the request of the National Bipartite Action Group which comprises unions and executive of DHBs.

It reviewed research and law regarding alcohol and drug issues in the health sector and found:

- Little clear evidence regarding the link between drug use and absenteeism, low productivity, poor performance and accidents at work (with the exception of actual impairment by alcohol use at work
- Health workers do not appear to abuse alcohol and drugs at a greater rate than the general populations
- The deterrent value of drug testing regimes I limited and must be weighed against the cost of introduction in dollar terms and staff trust
- Any policy or process will be judged on "reasonableness"; performance policies which when in operation give reasonable cause to suggest drug or alcohol use at work may be a factor may be a better starting point than a stand-alone drug and alcohol testing policy.

Drawing on good practice and case law CTU suggested a set of six key principles that any wellbeing or impairment policy should be founded upon.

These are:

- A holistic approach to impairment at work
- A rehabilitative focus
- Impairment management
- Procedural fairness
- Respect for privacy; and
- Worker involvement.

A draft impairment policy aligned to these principles is being finalised for ELT approval to consult on it with staff and unions in April.

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APPENDIX 1 – HEALTH & SAFETY RISK REGISTER AS AT 28TH FEBRUARY 2017

Risk Number	Risk Description	Risk Owner	Pre Mitigation Likelihood	Pre Mitigation Consequence	Risk Rating	Risk Category	Mitigation	Post Mitigation Likelihood	Post Mitigation Consequence	Post Mitigation Residual Risk rating	Risk Profile Change in Reporting Period
118	**Asbestos Management** The presence of asbestos containing material (ACM) is known to be present in buildings constructed prior to 2000 and could result in exposure to asbestos fibres during activity where the product is friable or disturbed during maintenance or construction activity	Clinical Support	Unlikely	High	2	H&S	Removal of asbestos containing material (ACM) will only be undertaken as required. Asbestos removal or investigation activities are currently occurring around campuses using certified asbestos management contractors. Register in place Trades staff have been provided specific PPE and training when there is a need to manage asbestos	Likely	High	2	1/2/2017 Continued identification & management of ACM areas. Monitoring, assessment and removal is undertaken by external specialist contractors
QIPS 15/15 (CSS1228)	**Overfilled Linen Bags** Overfilled linen bags and incorrect placement in disposal rooms could lead to injury for support staff during manual handling.	DON&M	Likely	High	2	H&S	Allied Laundry have agreed to sew the current linen bags to make them smaller and to replace older bags with small bags. At current rate, estimated to date to have them all gone and replaced is 01/01/2018	Unlikely	High	3	09/02/2017b At current rate, estimated to date to have them all gone and replaced is 01/01/2018
SWC 0210	**Inadequate Physical Space** Genetic Services has had a significant service expansion this has now resulted in inadequate physical space and has the potential to adversely impact on future service expansion.	Delwyn Hunter	Likely	High	2	H&S	Feasibility for additional adjacent space being explored. QM SWC	Unlikely	High	3	27/01/2017 No change

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Risk Number	Risk Description	Risk Owner	Pre Mitigation Likelihood	Pre Mitigation Consequence	Risk Rating	Risk Category	Mitigation	Post Mitigation Likelihood	Post Mitigation Consequence	Post Mitigation Residual Risk rating	Risk Profile Change in Reporting Period
130	**Staff Risk of Exposure to Blood and Body Fluids** Staff caring for patients are at risk of exposure to blood and body fluids that has the potential to cause them long term harm.	COO	Likely	High	2	H&S	Staff training in required blood, body fluid safety process and action required if exposed. Regular monitoring of BBFE reportable events. Hazard Register 7 South/Ward 2 as a residual hazard risk rating of a 2.	Unlikely	High	3	No change
129	**Slips, Trips & Falls** Staff through work duties at risk of slips, trips and falls which has the potential for harm.	COO	Likely	High	2	H&S	Prompt reporting of contributing factors for repair, staff awareness and education, regular monitoring of reportable events. Hazard Register Kenepuru Theatres a residual hazard risk rating of a 2	Unlikely	High	3	No change
139	**Manual Handling – Patient & Object** (Risks 127 & 128 combined) While moving patients' and equipment staff at risk of a manual handling injury	COO	Likely	High	2	H&S	Manual handling training, regular monitoring of reportable events. Hazard Register Kenepuru Theatres a residual hazard risk rating of a 2	Unlikely	High	3	28/02/2017 - Discussions are still taking place regarding changing the current method of training delivery to meet the requirements of the NZ Moving & Handling Guidelines

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Risk Number	Risk Description	Risk Owner	Pre Mitigation Likelihood	Pre Mitigation Consequence	Risk Rating	Risk Category	Mitigation	Post Mitigation Likelihood	Post Mitigation Consequence	Post Mitigation Residual Risk rating	Risk Profile Change in Reporting Period
155	**Management of Aged Residential Care Contracts** The management of contracts for aged residential care need to be aligned to the requirements of the Health and Safety at Work Act 2015	SIDU	Likely	High	2	H&S	Update contractors' procedure (Control of Contractors) due to be disseminated for consultation. All contractors will be benchmarked against the requirements of the policy. An audit of all contractors will take place following the implementation of the policy.	Likely	Moderate	3	No change
116	**Temperature at Ward Block Kenepuru Hospital** Fluctuating environmental temperatures in clinical areas within the ward block throughout the year. The temperature variance is unpredictable as can change dependant on weather conditions. This impacts on delivery of patient care, staff and general business.	COO	Likely	High	2	H&S	Monitoring the temperature routinely. When entering reportable event informing staff to record the actual temperature at the time. Encourage staff with regular hydration to prevent dehydration when temp exceeds acceptable levels. Portable Dyson fans in place combined with other portable fans. Portable air conditioning units in medication rooms Open windows within the limits of safety dependant on patients group	Likely	Moderate	3	2/2/17 No adverse variance in temperatures noted for January. Risk continues currently. QM, MCC

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Risk Number	Risk Description	Risk Owner	Pre Mitigation Likelihood	Pre Mitigation Consequence	Risk Rating	Risk Category	Mitigation	Post Mitigation Likelihood	Post Mitigation Consequence	Post Mitigation Residual Risk rating	Risk Profile Change in Reporting Period
67 (QIPS19 /15)	**Physical Assaults on Staff** On-going high rate of physical assaults on Emergency Department and MHAID DHB staff by patients.	COO GM MHAID	Likely	High	2	H&S	A gap analysis has been completed looking at current practice and strategies against appropriate standards. The report and recommendations have been reviewed. A time framed action plan has been completed and was discussed at the Health & Safety Steering Committee on the 14/06/2016. Mitigations: 1. Policy - Management of healthcare incidents – All events have a reportable event lodged for visibility. 2. Policy – Security & presence of a security orderly 24/7 3. Meeting between Charge Nurse manager and Police Liaison to discuss individual cases/define process. 4. Violence Intervention Programme training for ED staff 5. Monitoring group is well established in MHAID NB: Purehurehu/Tawhirimatea Hazard Register a residual risk of a 2. ED hazard register residual risk rating to be reduced as MCC risk 68 closed.	Unlikely	High	3	28/02/2017 Draft Management of Workplace Violence & Aggression Procedure to go for consultation next month. Meeting held with MHAIDS & Capability Development on how better to promote personal safety & de-escalation courses.

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Risk Number	Risk Description	Risk Owner	Pre Mitigation Likelihood	Pre Mitigation Consequence	Risk Rating	Risk Category	Mitigation	Post Mitigation Likelihood	Post Mitigation Consequence	Post Mitigation Residual Risk rating	Risk Profile Change in Reporting Period
148	**Increased Risk to Staff and Patients of Physical Assault** Risk of physical and psychological harm to staff and other patients as a result of long stay patient of Tawhirimatea Rehabilitation Unit with persistent assaultive behaviour associated with a chronic treatment resistive mental health condition.	MHAID	Likely	High	2	H&S	Staff control and restraint training. Use of environmental restraint Use of seclusion Personal alarms and duress devices Patient management/treatment plan A moderate to long term plan has been formulated to transition the patient into a purpose build facility.	Likely	Moderate	3	The SPEC training (M) has replaced C & R. Safe Practise Effective Communication (SPEC) – focuses on de-escalation and communication skills. The SPEC training began in November 2016. The training programme should be through the transition process and able to return to 'Business As Usual' around November 2018.

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Risk Number	Risk Description	Risk Owner	Pre Mitigation Likelihood	Pre Mitigation Consequence	Risk Rating	Risk Category	Mitigation	Post Mitigation Likelihood	Post Mitigation Consequence	Post Mitigation Residual Risk rating	Risk Profile Change in Reporting Period
162	**Ceiling Tiles/Seismic Event** Potential risk of failure /movement of unsecured heavy plaster ceiling during a design level seismic event which may lead to serious harm	Clinical & Support Services	Likely	High	2	H&S	Initial assessment needs to be undertaken to identify areas most at risk from a failure. Heavy plaster ceiling tiles weighing between 11 and 15kg each are likely to be the most predominant component creating risk and are present in all buildings over 20 years old. Areas such as corridors and lift foyers represent higher potential risk due to minimal areas to take cover. Solutions based on replacement / restraint need to be considered in conjunction with the campus master plan to determine recommended solutions, cost, ability to implement during normal operation and priority.	Likely	High	2	1/2/2017 Initial assessment needs to be undertaken to identify areas most at risk from a failure

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APPENDIX 2 – MONTHLY H&S INCIDENT STATISTICS

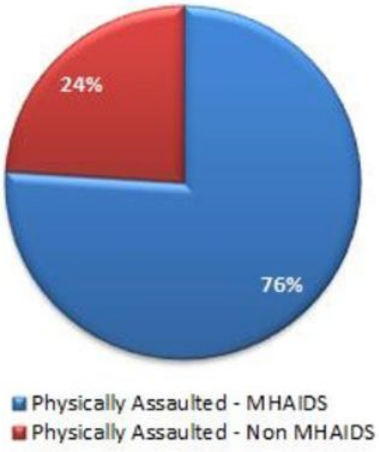
2.1 Reported Lost Time Injuries

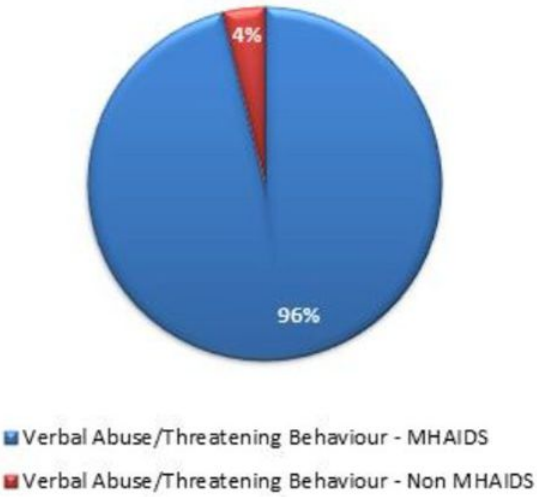
No lost time injuries were reported at time of report production.

2.2 Lost time injuries by Directorate

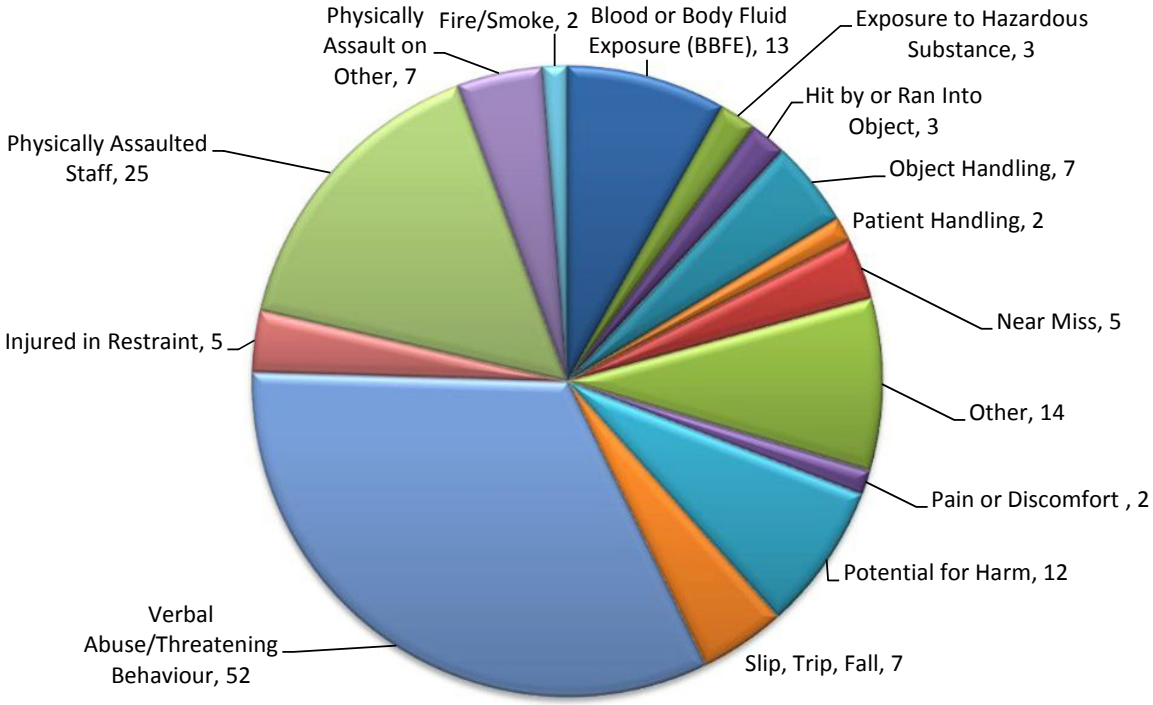
No lost time injuries were reported at time of report production.

2.3 Reported Physical Assaults and Abusive/Threatening Behaviour





2.4 Total Reported Incidents



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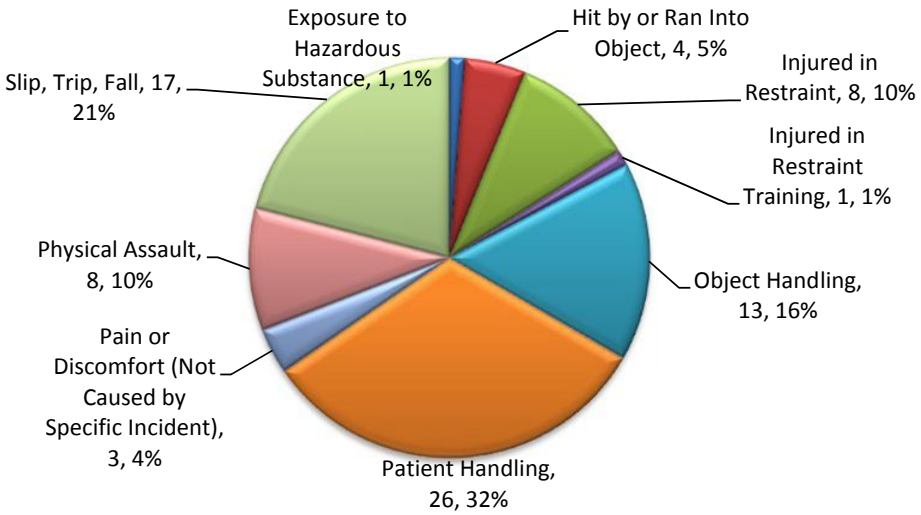
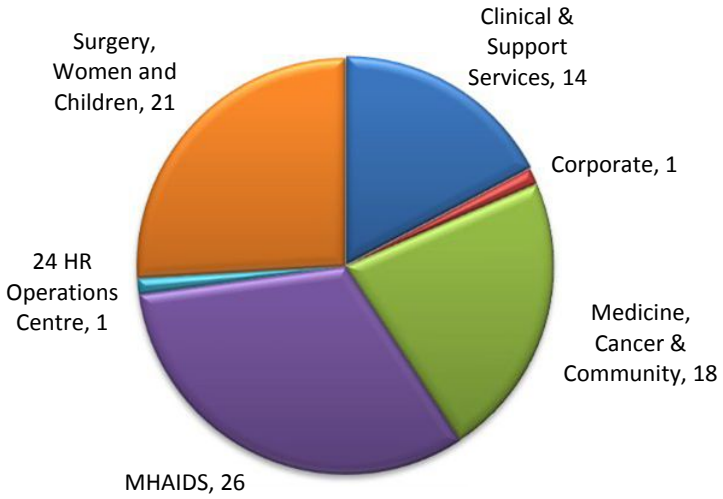
YEARLY STATISTICS (past 12 months)

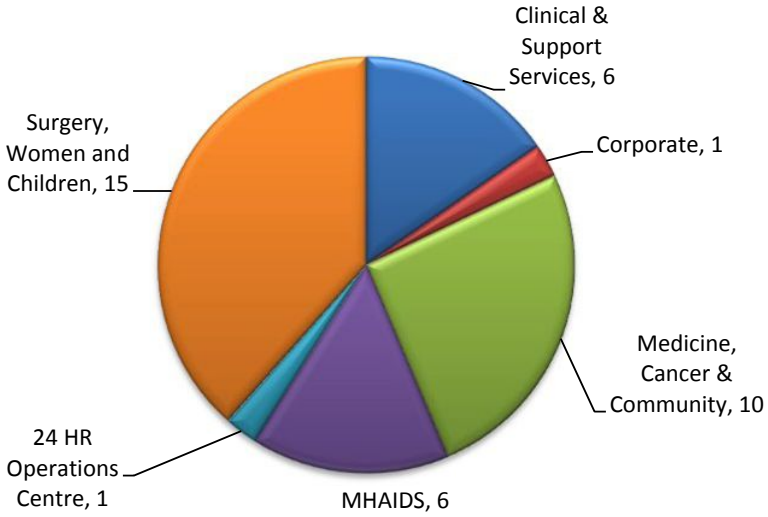
2.5 Reported Lost Time Injuries



2.6 Lost Time Injuries by Directorate



2.7 Moving & Handling Lost Time Injuries by Directorate



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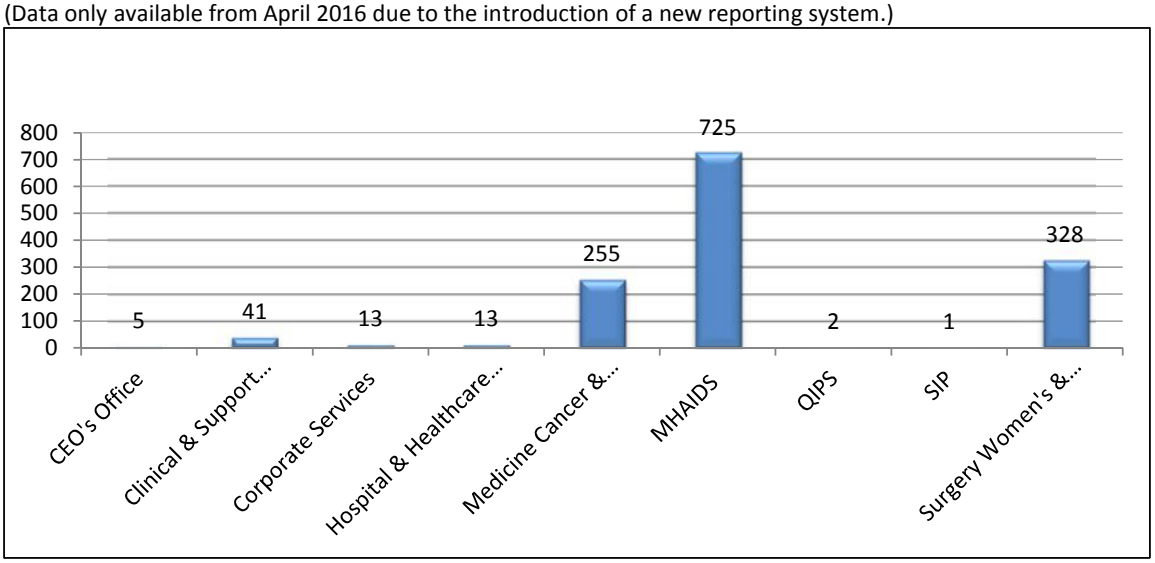
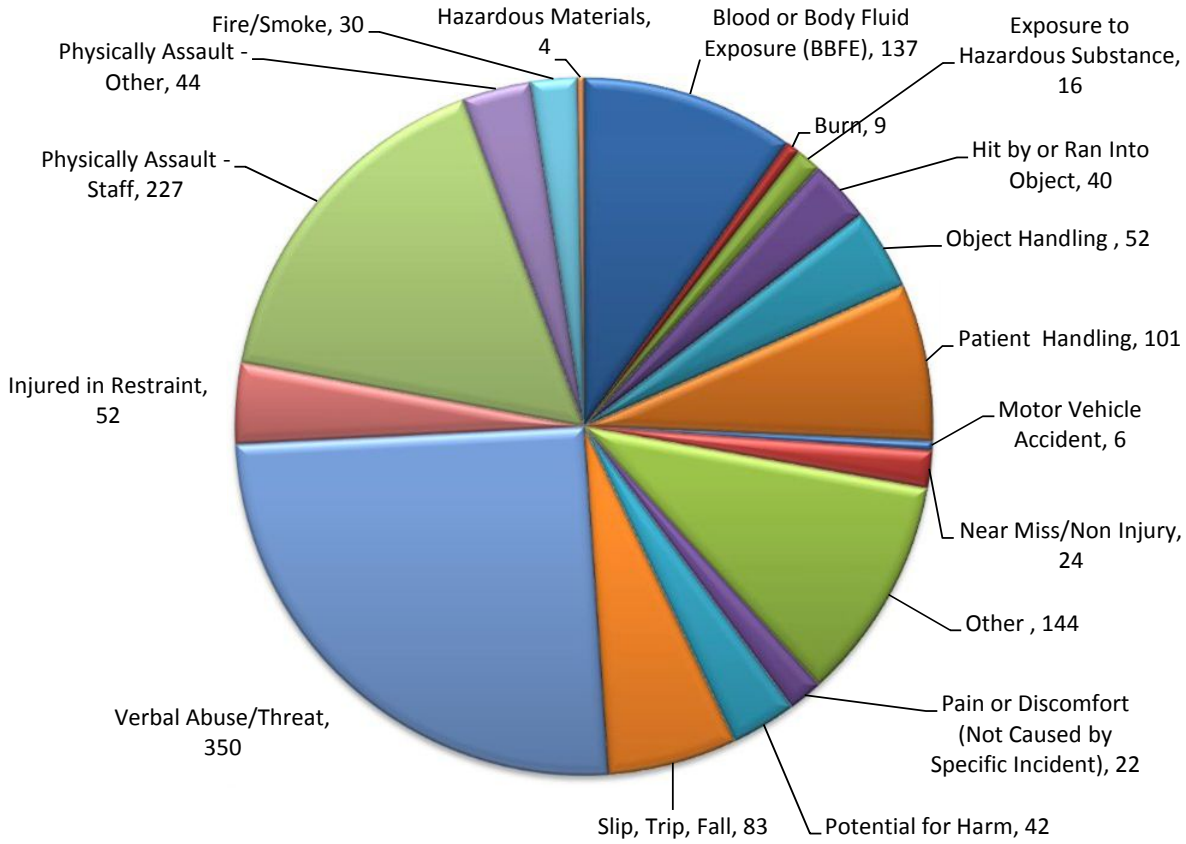
2.8 Total Incidents Reported By Directorate

(Data only available from April 2016 due to the introduction of a new reporting system.)



2.9 Total Reported Incidents



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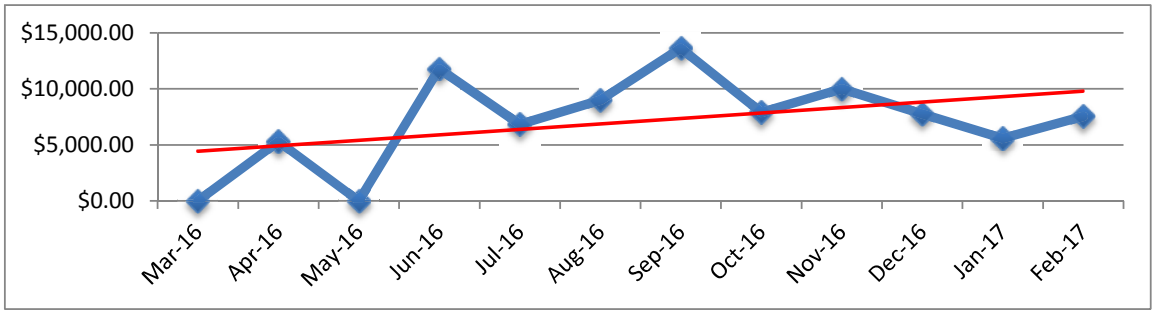
APPENDIX 3 – WELLNESS & INJURY MANAGEMENT

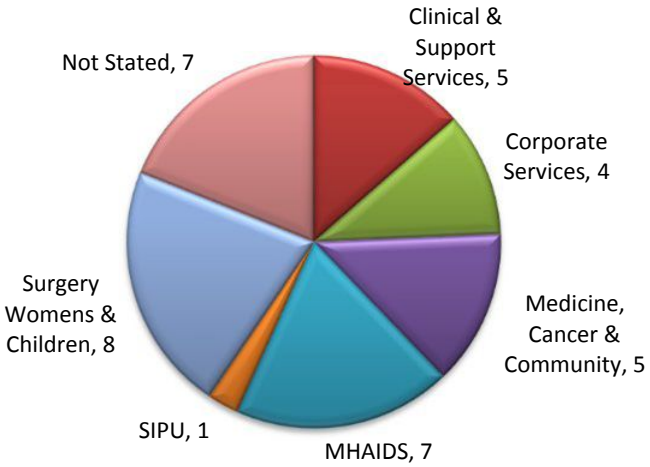
3.1 EAP SERVICES STATISTICS (last 12 months)

3.1.1 Costs – Total = $85,201.34

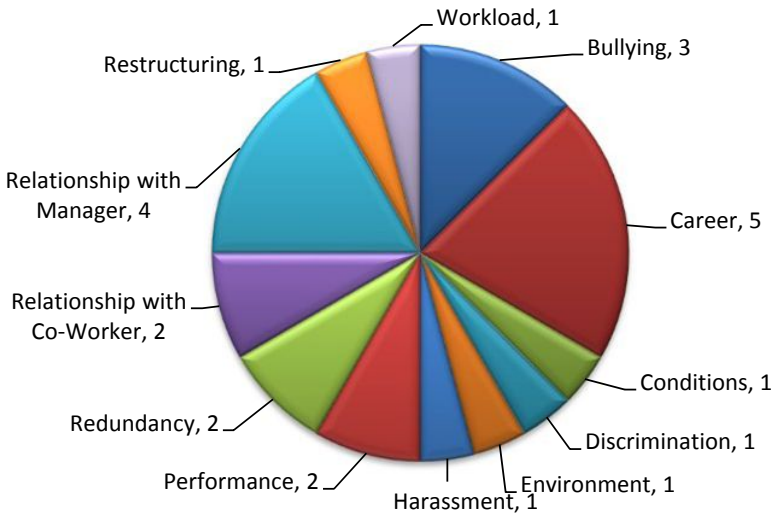


Note: No invoices were received for the months of March-16 & May-16. Any costs incurred were added to the following months invoices.

3.1.2 Monthly Referrals to EAP by Directorate



3.1.3 Reasons for Referrals (as stated by worker)



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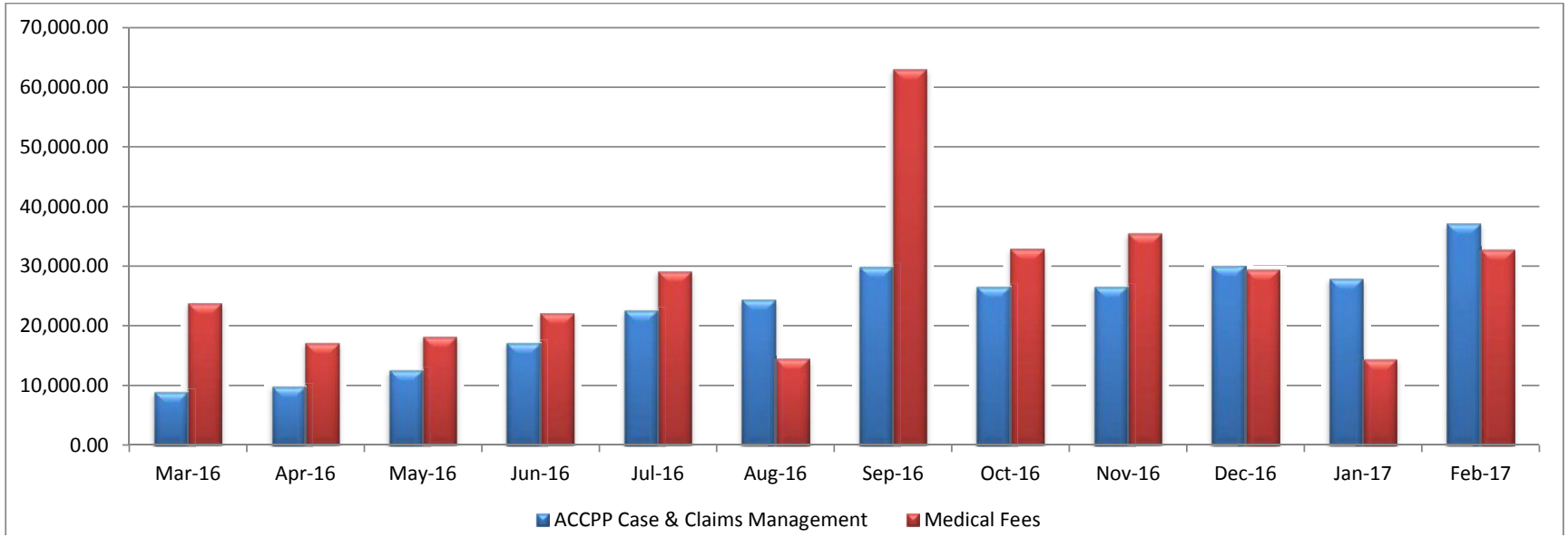
3.2 Injury Management Costs

3.2.1 Monthly costs (last 12 months)

	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Total
Case & Claims Management	8,898.00	9,814.00	12,471.00	17,095.00	22,541.00	24,386.90	29,942.55	26,483.35	26,478.75	30,065.60	27,908.20	37,079.71	**$248,086.35**
Medical Fees	23,718.14	17,124.34	18,138.57	22,050.86	29,087.77	14,381.36	62,962.20	32,905.90	35,524.90	29,368.29	14,309.65	32,719.80	**$330,409.64**
Total	32,616.14	26,938.34	30,609.57	39,145.86	51,628.77	38,768.26	92,904.75	59,389.25	62,003.65	59,433.89	42,217.85	69,799.51	**$578,495.99**

Notes:

- **Mar-16** - Inclided a late invoice for medical fees for Nov-15 of $11895.66
- **Sept-16** - has shown a spike in costs mainly due to $30,514.65 being paid out in surgery fees
- **Feb-17 –** has shown a spike inmedical fees due to $7,759.29 in surgery fees, $2,720 in dental fees and $10,185.32 in specialist consultation fees



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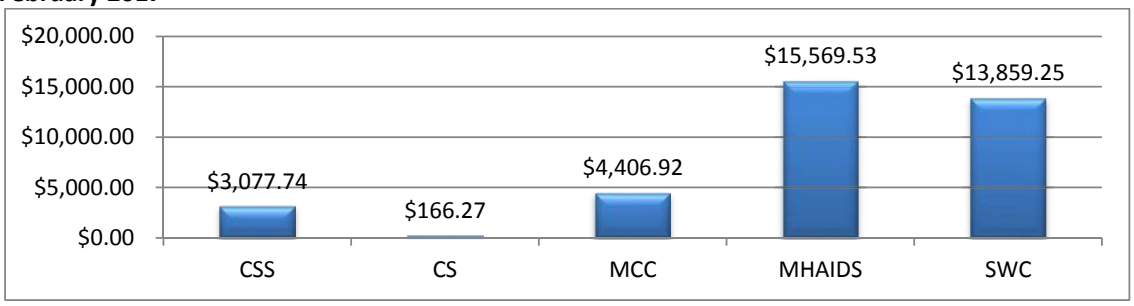
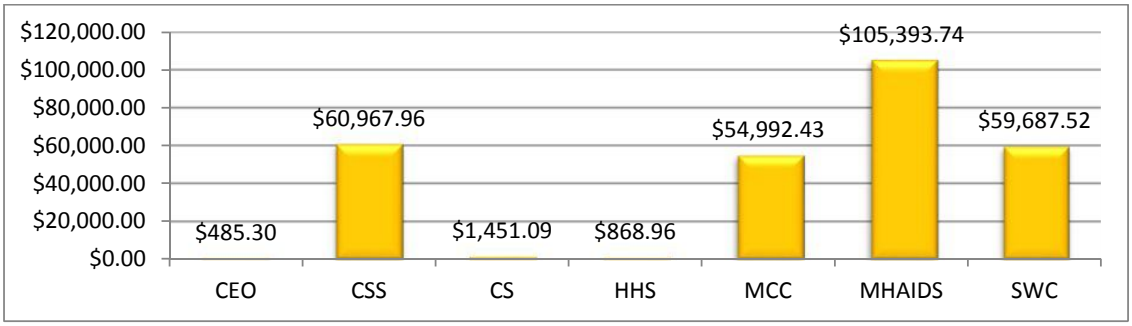
3.2.2 Medical Fees Breakdown by Directorate

February 2017



Past 12 Months



Key:

CEO = CEO's Office

CSS = Clinical & Support Services

CS = Corporate Services

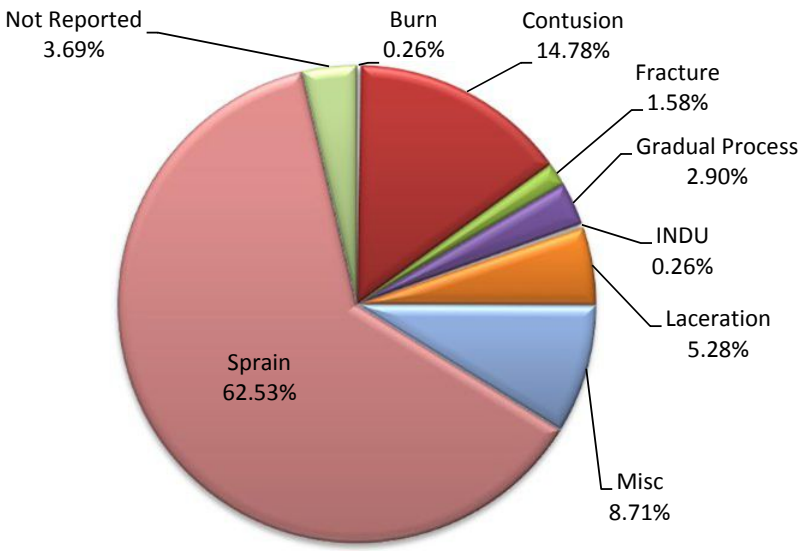
HSS = Hospital & Healthcare Services

MCC = Medicine, Cancer & Community

MHAIDS = Mental Health, Addictions & Intelectual Disabilities

SWC = Surgery , Women & Children

3.2.3 Injury Claims by Type (past 12 months)



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3.2.4 Claims Summary by Accident Date

Month	No. of Claims	Medical Fees Only Claims	No. of Lost Time Injuries	Days Lost*
Mar-16	19	10	9	360.9
Apr-16	21	16	5	47.0
May-16	30	21	9	162.5
Jun-16	23	17	6	44.0
Jul-16	31	18	13	210.5
Aug-16	25	15	10	52.3
Sep-16	19	12	7	39.8
Oct-16	23	14	9	102.5
Nov-16	18	15	3	59.0
Dec-16	25	20	5	79.0
Jan-17	24	12	7	98.5
Feb-17	16	16	0	0

*The number of days lost are attributed to the month in which the lost time injury occurred i.e the 360.9 days lost in March 16 is the cumulative days lost relating to the 9 LTIs since then, not the days lost in the month.

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TE-UPOKO-ME-TE-WHATU-O-TE-IKA MENTAL HEALTH, ADDICTIONS & INTELLECTUAL DISABILITY SERVICE 3DHB	**BOARD DISCUSSION** **Date: 3 March 2017**

Author	Nigel Fairley, General Manager, MHAID Service 3DHB
Endorsed by	Adri Isbister, Chief Executive Wairarapa District Health Board Debbie Chin, Chief Executive Capital & Coast District Health Board Ashley Bloomfield, Chief Executive Hutt Valley District Health Board
Subject	**Update Mental Health, Addictions & Intellectual Disability Service 3DHB**

RECOMMENDATION

It is **recommended** that the Board:

a. **Notes** the contents of this report.

APPENDICES

1. Police Handover Form
2. Section 109 Checklist
3. Te Haika Data
4. 3DHB Mental Health & Addiction Work Programme 2017
5. Balanced Score Card – January 2017
6. Wairarapa Pre Admission and Post Discharge Contact – January 2017.

1. PURPOSE

With new Boards of Wairarapa DHB, Hutt Valley DHB and Capital & Coast DHB this is an opportunity to reflect on and summarise the developments for MHAID Service 3DHB over the last 12 months.

2. BACKGROUND

MHAID Service 3DHB was launched on 15 February 2015. The launch started at Ratonga Rua o Porirua, followed by a function at Hutt Valley DHB and finishing with a pōwhiri in the Wairarapa. The MHAID Service 3DHB has local, sub-regional, central region and national services with bases (and staff) from Auckland to Dunedin. There is approximately 1450 staff employed by the 3DHBs. A summary of progress for the first 12 months was circulated in 2016. This is an update on that summary.

3 CRISIS RESOLUTION SERVICE (CRS)

A single Crisis Resolution Team has been established, combining the Hutt Valley and Capital & Coast DHB teams (this excludes the Wairarapa DHB where we continue to operate an integrated crisis service). This includes a single roster working 24 hours/7 days per week with three bases located at Hutt and Wellington Hospitals, and a sub base at Kenepuru Hospital. A single Team Leader is responsible for the management of the team to support the vision of a single team providing crisis resolution service across the communities. A Clinical Nurse Specialist leads the practice of nursing and support the clinical development of the wider team. Staff are co-located with the Emergency Departments at Hutt and Wellington Hospitals. The change in the crisis services reflects a new approach for delivering these services, a need for the service

to be multidisciplinary, to be responsive to other changes such as the work with the police, and to be very mobile in the community no matter where the crisis might be.

On November 1 the modernisation of the Crisis Resolution Service was launched in a limited way. There have been structural changes to the SSU area in Wellington Hospital to provide a specific area for assessment and management of mental health presentation – in Hutt Hospital there wasn't a need for any changes to the emergency Department.

4 POLICE, AMBULANCE, EMERGENCY DEPARTMENTS

There has been a significant amount of work between the Police, Ambulance, Emergency Departments and MHAID Service over the last year. An interagency Working Group and a Steering Group are in place. There have been a number of significant developments/agreements:

- A Wellington Health Interagency Initiative Steering Group (IASG): the ISAG oversees the working group, providing strategic leadership, manage escalated issues/risks and approve the final processes developed
- A Wellington Health Interagency Working Group (IAWG): The IAWG will be responsible for developing processes, provide regular reporting to the IASG, and escalating any issues/risks to the ISAG as required
- A handover form for Police to Emergency Departments, signed by both parties (see **Appendix 1**)
- A checklist for Police to assess section 109 Mental Health Act (the is the power for Police to pick up from a public place anyone they believe is behaving in a mentally disordered manner – as opposed to disordered manner) (see **Appendix 2**)
- Service Agreement between Wellington Free Ambulance (WFA) and Te Haika (the MHAID Service phone contact centre). This agreement relates to the paramedic management of acute mental health patients. It ensures that the person is transported to the most appropriate facility and places Ambulance as first responder
- The Frequent Mental Health Presenters is a cross agency demand reduction initiative. The initiative focuses on the small number of people with mental health issues who frequently contact emergency services in circumstances which generally do not require an emergency response. Frequent presenters use a disproportionate amount of resources and do not always receive an appropriate or consistent response from emergency services. MHAID Service 3DHB is part of this initiative and has identified 10 frequent presenters. Emergency services in conjunction with MHAID Service have compiled Intervention information to enable a consistent and most appropriate response to these clients' needs.

5 TE WHARE AHURU

Te Whare Ahuru is the adult acute mental health unit, at Hutt Valley Hospital. There are a number of working groups around the development of this service:

- **Model of Care**: discussions and workshops around the role of the service in relation to the other acute unit (Te Whare o Matairangi), the acute alternatives to hospital and specific need

- **Renovations**: a draft architectural plan has been presented to management and alterations to the unit will ensure maximum use of space and fit into any refurbishment in the future. A project group, coordinated by the Director of Operations, is established to coordinate the next phase – which will include consultation with staff, service users and other parties

- **Skill Mix**: skill mix for the unit has clarified a multidisciplinary approach to achieve the best outcome for clients. This has started with the recruitment of three mental health support

workers (in place of two nurses). Further multidisciplinary team members will be employed, to transition from a nursing only model

- **Programme Development**: As well as contracting in other resource (such as psychology), Buddies, a peer run organisation, has started running programmes on the unit.

6 ALTERNATIVE TO HOSPITAL, HUTT VALLEY

One of the aims for the 3 DHBs is 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. To achieve this, there have been changes that have enhanced the services and are closing significant gaps, by putting in place different acute options to hospital in the Hutt Valley. These go along with the establishment of an acute day programme in the Lower Hutt community (run by an NGO, Pathways). Changes are:

Acute Crisis Respite Service: Consists of three acute crisis beds in Upper Hutt, with an average length of stay between 1-3 days

Acute Transition Service: Situated in Upper Hutt with an average length of stay between 3 and 6 months

Enhanced Community Support Service: Provides 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: 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.

Such alternatives to hospital are in place in CCDHB and Wairarapa.

7 ADULT COMMUNITY TEAMS IN HUTT

There were previously 4 adult community teams in the Hutt Valley. A proposal to reduce this to two teams indicated that clients would receive a more consistent service, with equity of access to specific therapies and alignment of leadership structure across the MHAID Service 3DHB community teams. The two teams – Hutt North team is based in Upper Hutt and Hutt South team is based in Lower Hutt, each with a geographical focus. The next phase is to improve integration with primary care.

8 TE HAIKA

Te Haika is the telephone call centre which triages crisis and acute calls 24 hours per day / 7 hours per week. Clients phone in on a specific phone number – 0800745477. The call centre is staffed by registered health professionals who manage referrals to MHAID Services for Wairarapa, Hutt Valley and Capital & Coast. Prior to July 2015, this service only covered CCDHB. In July 2015, the service was expanded to Wairarapa and Hutt during normal work hours, and from July 1, 2016 the service has covered the region 24/7.

See **Appendix 3** for data.

9 SOUTH ADULT COMMUNITY TEAM

The earthquake in November caused considerable damage to the leased South Community Team premises in Kilbirnie. The team was re located to the Administration Building on the Wellington Hospital site, where the space is shared with other teams. An alternative base has been found with detailed seismic assessment currently being undertaken. The aim is to create a single adult community mental

health base for Wellington consisting of the Central Community Mental Team (currently in Tory Street), South Community MH Team and Alcohol & Drug Service.

10 GP DIRECT ACCESS

Liaison with general practitioners in the region has been established facilitating timely access to specialist mental health advice. A pathway for GPs to directly access this specialist mental health and addictions advice has been developed, after consultation, and started on 1 August 2016.

11 ICAFS (INFANT, CHILD AND ADOLESCENT FAMILY SERVICE) – HUTT VALLEY

The ICAFS community service is located in the Hutt Hospital. There has been significant work to improve wait times to the service. In May 2016 MHAID Service contracted Te Awakairangi to provide mental health treatment services for up to 20 young people currently waiting for assessment and treatment at ICAFS. The contract has been renewed for another 6 months.

An independent review of the service will be undertaken. The review will include the times first presentations to the service have to wait and what this may reflect. The Terms of Reference for the review are in draft. The objectives of the project are to ascertain the workflow and practice, as well as provide recommendations on opportunities to improve clinical outcomes.

12 CAMHS (CHILD & ADOLESCENT MENTAL HEALTH SERVICE) WAIRARAPA

The CAMHS team is presently being relocated to a purpose renovated space, co-located with WINZ and Specialist Education Services.

13 FORENSIC SERVICES

MHAID Service 3DHB provides the adult and youth forensic services for the central region, and the national youth forensic secure inpatient service.

- **Update on Adult Service Model of Care**: This project has been set up to review and improve the service pathways. There is consultation with service users, staff, family/whānau and others to identify what features of care are working well and what improvements can be made. There are a number of common themes emerging with parallels between what clients say and what staff have also fed back. The strongest themes are about positive relationships and feeling safe; a desire for more information and structure about pathways especially for Special Patients; the admission process and how the transition of patients between units is managed. The next phase of work is co-design workshops with patients and staff exploring solutions to address these themes
- **Purehurehu**: This forensic unit was opened in 1992. The design is now outdated and needs to be modernised. A statement in the media that the unit was unsafe is inaccurate. Funding for the renovations required has been approved, plans are being finalised to be tendered in March/April. Construction start date is July 2017
- **Ngā Taiohi**: This is the national inpatient youth forensic secure unit, at Kenepuru Hospital. The blessing of the new facility was on April 1, 2016 with the official opening by Hon Hekia Parata (in the absence of the Minister of Health). Liaison by the General Manager and Director of Operations, MHAID Service 3DHB, with Child Youth and Family Service residential managers, and the five Regional Community Youth Forensic Services took place prior to the opening. There is a Memorandum of Understanding between the Service and CYFS. Mauri Tu (admission team) is made up of a representative from each of the five youth regional forensic services. The Service provides accommodation on the Kenepuru Hospital campus. The Service provides a number of ways for the family to communicate with their family member on the unit.

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14 INTELLECTUAL DISABILITY SERVICE

The Forensic Intellectual Disability Services are national. The adult and youth inpatient units are at Ratonga Rua and Kenepuru Hospitals respectively and the community bases in South Auckland, Cambridge, Wellington, Christchurch and Dunedin.

- **Strategic Plan/Model of Care**: In 2016 the ID services implemented a new 5 year strategic plan, and over the last year have developed a new service model and model of care. The Service is currently building the documents and process's to fit under these. This model has been designed by our own clinical team, but is informed by the Good Lives Model of offender rehabilitation which was developed within New Zealand. The implementation of the model of care into the ID service will ensure that client rehabilitation is organised, efficient, consistent and cohesive. Clients are supported to develop the skills they need to lead a good life that is free from future offending.

- **Individual Service Units**: This is a service and development proposal to build individualised units to address the challenges identified by the Ministry of Health in relation to a small number of high risk high profile individuals whose current mental health and disability support related needs are so complex they are unable to be met by current service models. The Ministry of Health have established a governance structure to oversee the project.

15 SPEC (SAFE PRACTICE, EFFECTIVE COMMUNICATION)

This is a new restraint programme being introduced nationally. Since the introduction of the programme, MHAID Service has organised and hosted the central region trainer workshop. 10 MHAID Service 3DHB staff has been trained/retrained as trainers. As well, a new 1-day programme (Personal Safety) is being introduced mid-2017 for MHAID Service community-based staff.

16 LEARNING & DEVELOPMENT CENTRE (L&D)

Major foci over the past 12-18 months have been on aligning systems, processes, and programmes for the MHAID Service 3DHB context. These have included the orientation programme; core requirements, competency sets, and learning plans set up for staff in all 3DHBs; events calendar and programme delivery (30 different face-to-face courses on the calendar as well as other MHAID Service specific eLearning courses).

Core training days have been implemented in the Wairarapa, as well as regular core training and other programmes in Hutt Valley, Wellington and Porirua. A number of new courses have been developed/implemented including:

- Women in Secure Care Environments (Te Pou programme, run by our trainers)
- Ventrogluteal technique for nursing staff
- Employment relations investigation package
- Regular Under Grand Round (for student nurses) offered at 3 sites (Hutt Valley, Wellington, Porirua)
- Regular expert nurses forum
- Health Care Assistant training day
- Food Handling and Hygiene eLearning programme
- MHAID Service 3DHB Community Activity Collection Framework eLearning/ assessment
- Regular in-service programmes at Te Whare Ahuru and Te Whare o Matairangi
- Smokefree eLearning
- Central and Midlands perinatal mental health eLearning package for support workers.

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17 ALLIED HEALTH NEW ENTRANTS (AH NESP)

This was a new initiative implemented in 2016. MHAID Service 3DHB established a new training programme for allied health (2 social worker, 2 occupational therapist). The programme consists of two clinical placements, post-graduate study at AUT, supervision and preceptorship. The first 3 graduates have all secured permanent positions (1 in Hutt Valley and 2 in CCDHB).

18 NURSING NEW ENTRANTS (NESP)

The first group of nursing NESPs for 2017 started with the Service on 16 January 2017. The NESP programme includes three clinical placements in the nine months of training, a number of academic assignments and on the job assessments.

This group of 16 NESPs are placed across the 3 DHBs.

19 CENTRAL RECRUITMENT

MHAID Service 3DHB has centralized its recruitment process. All recruitment is done through the Service. This coordinated approach to recruitment eliminates teams competing with each other for applicants.

20 CONSUMER REVIEW

There are 9 consumer roles across Hutt Valley DHB and CCDHB. In Wairarapa DHB there is no specific consumer role, but on-going discussion about how consumer input into the service can be achieved.

The consumer review for MHAID Service 3DHB, is to be completed. A consultation paper was released in January 2017. A decision is expected by the end of April. The consultation paper proposed a Director of Consumer Participation and a hybrid model (combination of contracted consumer organisations and employed roles).

21 MENTAL HEALTH AND ADDICTIONS WORK 3DHB PROGRAMME – 2017

For the coming year (and beyond), an eight point work programme has been developed for MHAID Service. This incorporates key recommendations from a number of recent reviews. The Work Programme is attached (see **Appendix 4**).

22 BOARDS WORKING GROUP

The Working Group has been meeting. There are two members from each Board. A Terms of Reference is agreed. A tour of various services is organised. Warrick Frater, who chairs the Advisory Group, and Wai Tamehana a consumer consultant on the Advisory Group, will be in attendance at the next meeting.

23 SECLUSION RATES

The following summarises seclusion information submitted into the Programme for the Integration of Mental Health Data (PRIMHD). The data was extracted by the Ministry of Health in January 2017 and analysed by Te Pou. The data is to the year ending September 2016. It excludes forensic services.

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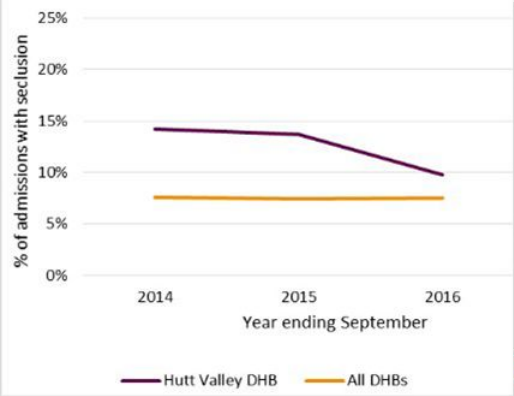
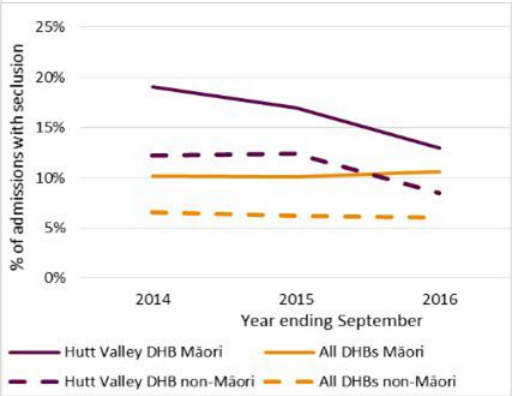
Te Whare Ahuru:

Graph 1. Percentage of people admitted to inpatient units that are secluded, Hutt Valley DHB and All DHBs, October 2013 – September 2016

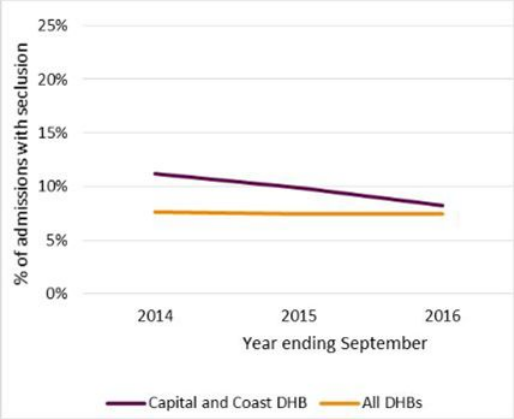


Graph 2. Percentage of people admitted to inpatient units that are Secluded, by Māori and non-Māori, Hutt Valley DHB and All DHBs, October 2013 – September 2016.

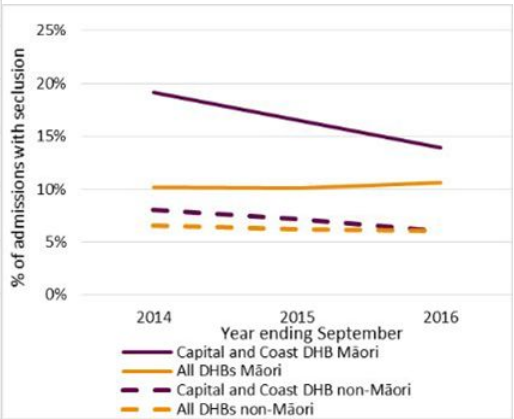


Te Whare o Matairangi:

Graph 1. Percentage of people admitted to inpatient units that are secluded, Capital & Coast DHB and All DHBs, October 2013 – September 2016.



Graph 2. Percentage of people admitted to inpatient units that are Secluded, by Māori and non-Māori, Capital & Coast DHB and All DHBs, October 2013 – September 2016.



24 ACTIVITIES

FEBRUARY

	TWOM	Rangatahi	Ra Uta	Purehurehu	Rangipapa	Hikitia	Haumie	Tane M	Tawhiri	Nga T	TWA
Admissions	40	11	5	2	1	0	0	1	1	0	48
Discharges	41	11	5	2	1	0	0	0	1	2	44
Occupancy	97%	64%	88%	88%	98%	80%	75%	98	102%	0	72%
ALOS	18	28	48	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11

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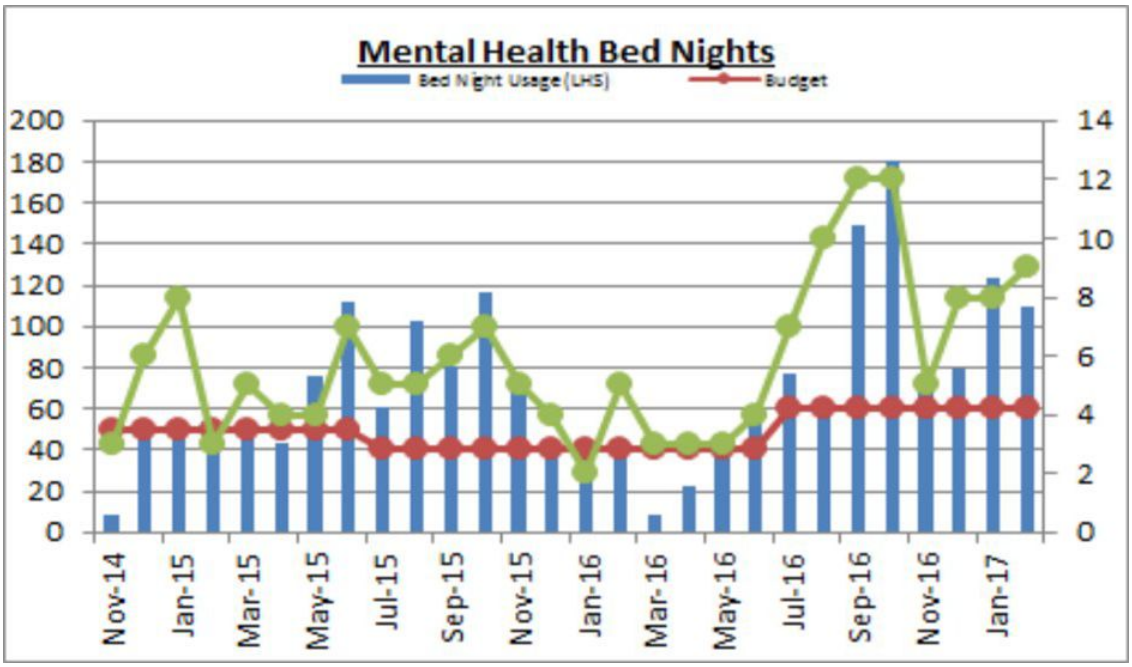
25 MHAIDS 3DHB FINANCIAL OVERVIEW YTD FEBRUARY 2017

YTD ended 28 Feb 2017	CCDHB			HVDHB			WDHB			3D		
(000')	YTD Actuals	YTD Budgets	YTD Variance	YTD Actuals	YTD Budgets	YTD Variance	YTD Actuals	YTD Budgets	YTD Variance	YTD Actuals	YTD Budgets	YTD Variance
1000. Revenue	75,322	75,413	(91)	15,735	15,712	23	3,385	3,400	(15)	94,442	94,525	(83)
2000. Personnel	55,269	55,532	263	10,049	11,211	1,162	2,373	2,315	(58)	67,691	69,058	1,367
3000. Outsourced Services	2,894	2,429	(465)	2,155	701	(1,454)	962	617	(345)	6,011	3,747	(2,264)
4000. Clinical Supplies	649	774	125	97	106	9	20	27	7	766	907	141
5000. Infrastructure & Non-Clinical	2,520	2,351	(168)	574	605	31	83	92	9	3,177	3,048	(128)
8000. Recharging	14,666	14,666	0	2,846	2,919	73	40	40	0	17,552	17,625	73
Grand Total	**(675)**	**(340)**	**(335)**	**14**	**170**	**(156)**	**(93)**	**309**	**(402)**	**189,639**	**188,910**	**(893)**



In Hutt Valley DHB, prior year payments of the deferred clothing allowance of $122k for mental health staff has been paid and included in the current years financials.

Wairarapa budget continues to be impacted on by the increased number of inpatient admissions. A small variation in this creates a significant effect.

External revenue for CCDHB was unfavourable to budget largely due to under-funding of CCDHB rehabilitation beds which was to cease in December 2015. This adverse variance is offset by favourable variances in specialist assessments and forensic courts' revenue. Costs associated with these revenue increases are reflected in the personnel and outsourced expenses.

Personnel costs have a favourable variance to budget year to date of ($264k), including the stretch and savings targets of $3.2m and additional revenue associated cost as per above.

YTD Outsourced Staff costs are adverse to budget by ($453k) due to backfilling of medical and allied staff vacancies.

The service is continuing to actively manage overtime which is trending downwards towards 2.5% of total personnel hours over the last 12 months. Both overtime and sick leave are trending downwards in costs. Sick leave is currently averaging at 3%, well within the range between 3%– 4% amongst the participating DHBs at the national KPI forum.

Overall operational performance is $3.9mil favourable, after the savings target of $4.2mil for YTD and we are $335k adverse to budget. With constant occupancy and vacancy management challenges MHAID Service 3DHB has still successfully achieved 92% YTD.

Over the remainder of the financial year, the operational team is focusing on high annual leave balances and a targeted approach towards higher than two year entitlements across MHAID Service 3DHB. The approach is to target high leave balances with careful leave planning over the next few months.

Different performance appraisal methods across the 3DHBs are proving a challenge for the achievement of appraisals being undertaken. Notwithstanding, managers needing improvement on their appraisal numbers are being supported by the HR team to devise a plan of action.

26 BALANCED SCORE CARD (BSC)

MHAID Service continues to invest in the Balanced Score Card as a single portal for its performance indicators. There are a number of audits underway and data fixes are applied. Some measurements are still in draft until we can be confident about the data. As an interim measure Wairarapa DHB data is being collated manually and reported as an appendix to the BSC. Comments and mitigation plans on annual leave balance, sick leave, performance appraisal are noted under financials above. A monthly audit of data undertaken for the Post Discharge contacts for all Wairarapa and Capital & Coast teams shows an achievement of 100% and for Hutt Valley 66%. Efficiencies with capturing of data in a timely manner are being explored.
(see **Appendices 5 and 6)**

27 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.

PUBLIC

Capital & Coast District Health Board ŌPOKO KI TE URU HAUORA	**BOARD DISCUSSION** **Date: 10 March 2017**

Author	Caroline Tilah, Executive Director Quality Improvement & Patient Safety Directorate CCDHB Shawn Sturland, Executive Director Quality Improvement & Patient Safety Directorate CCDHB
Endorsed By	Chris Lowry, General Manager Hospital & Healthcare Services
Subject	**Quarterly Quality Report**

RECOMMENDATION

It is **recommended** that the Board:

a) **Note** the report for the period December 2016 to February 2017.

APPENDICES

1 Patient Experience Survey

2 Clinical Quality Measures.

1.0 EXECUTIVE SUMMARY

The Health Round table Executive Summary report was received in February. The Relative Stay Index (RSI) is a calculation that is used to determine how quickly hospitals discharge their patients compared with their peers. For CCDHB, the RSI showed for the period between July 2015 – September 2016 there was a decrease from 96% to 93%, meaning that CCDHB has decreased the actual bed days for patients by three precent.

The Ministry of Health Certification corrective action progress report has been completed and submitted to the MoH. Good progress is being made across the three moderate actions identified at the time of the certification audit.

The Quality Improvement strategy is focused on developing an improvement culture within the DHB. One of the priorites within this is to develop capability amongst our staff. The first 12 week CCDHB Improvement Movement in house improvement training programme started 01/03/2017. 15 places were filled from the Hospitasl and healthcare Services and mental health Addictions and ID Services. As part of the programme participants are required to complete a quality improvement project that is relevant to the area they work in and aligned to the organisations priorities.

2.0 SHORTER SAFER HEALTH JOURNEYS

A shorter safer health journey is one of the DHBs strategic priorities. Our purpose is to provide high quality health care and educate people on how to stay healthy. We want people to get the health care they need, in a way that suits them. To do this we need to be innovative and work with our community. Quality is a fundamental part of the patient experience, and enabled through our Quality Framework (Consumer Value, Effectiveness, Risk, Workforce) which provides the infrastructure for quality reporting and clinical governance direction throughout the organisation.

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2.1 Consumer Value (Patient Experience)

Focussing on consumer value encourages our DHB to involve our communities in improving equity for our populations. We receive consumer information through our complaints and compliments feedback, the National and CCDHB patient satisfaction surveys and through consumer engagement. This information is analysed and reflected in continuous improvement activities.

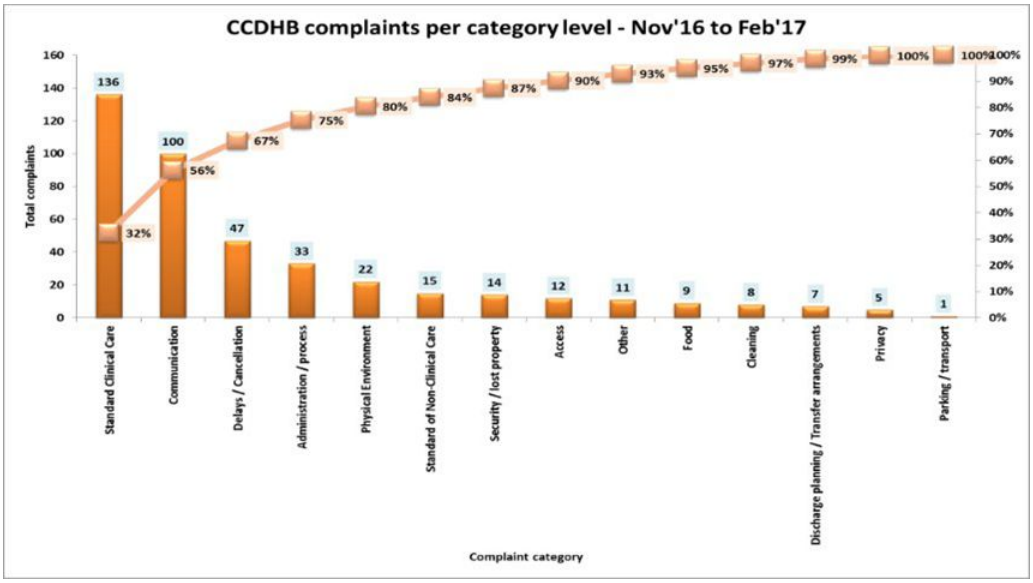
2.1.1 Compliments & complaints

The number of compliments and complaints for CCDHB from April 2106 – February 2017 are detailed below:

CCDHB	16-Apr	16-May	16-Jun	16-Jul	16-Aug	16-Sep	16-Oct	16-Nov	16 Dec	16 Jan	17 Feb	Total
Number of Complaints by Month	66	68	70	65	66	66	57	77	50	64	75	827
Number of Compliments by Month	59	104	88	77	105	109	79	93	64	80	89	1074

CCDHB - Complaint themes	Mar to May 15	Jun to Sept 15	Oct to Dec 15	Jan to Mar 16	Apr to June'16	Jul to Aug'16	Sep to Oct'16	Nov'16 to Feb'16
Standard of Clinical Care	47%	37%	35%	39%	35%	27%	39%	32%
Communication	19%	24%	25%	28%	21%	30%	20%	24%

The two highest complaint themes continue to be in the area of standard of clinical care and communication.
Compliments continue to outnumber complaints.
For November to February all the complaint themes are demonstrated in the following Pareto Chart.



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2.1.2 Capital and Coast DHB's Health & Disability Commission (HDC) complaint report for Jul-Dec 2016

The HDC provides a report every six months outlining the number and type of complaints that are received by CCDHB. The latest report for the period 1 July to 31 December 2016 was received in February. In this period CCDHB received 32 complaints, (29 for the last reported period) which equates to 100.03 complaints per 100,000 discharges.

The most common service type complained about at CCDHB in this period was medical services – 31.3% for general medical and 15.5% for Emergency Department. There was a decrease in the mental health service complaints, from 27.6% to 18.7%.

HDC identifies one primary issue for each complaint. Similar to national trends, the most common primary issue category for CCDHB was care/treatment (56.3%). The report is currently being reviewed to identify opportunities where we can improve with a view to promoting an increase in low level resolution of all complaints.

2.1.3 CCDHB monthly patient experience survey

CCDHB completes a monthly Patient Experience Survey for 10 months of the year. The February report is attached - **Appendix 1.**

Food is an area where we receive negative feedback. A number of improvements have been identified as a result of this and include:

- Spotless have focused on improving the food service at ward level by up skilling food service staff and encouraging excellence in customer service.
- There has been an investment in insulated plates and bowls to improve food temperatures at ward level.
- There has also been improved the communication between ward staff and the kitchen staff to ensure any allergies are identified and managed accordingly.
- The presentation of the meals is also constantly monitored and any patient feedback to improve the service we provide is acted on.

The February report also concentrated on coordination between Hospital and Home. This is the area that we have the most opportunity to improve secondary to food services. The main improvement activity underway is the focus on informing patients about their medication on discharge.

2.1.4 CCDHB Consumer engagement

The Executive Director Strategy, Innovation & Performance is presenting a report regarding the development of a consumer council to the Board in April. Key staff within the Quality Improvement and Patient Safety service and Disability Support services have met to inform this report based on the on-going development of consumer engagement at CCDHB.

2.1.5 Quality accounts 2015/2016

The Health Quality & Safety Commission (HQSC) requires all DHB's to produce a Quality Account each year. The 2015/16 Quality Accounts have been completed. This was the fourth annual publication and focused on providing our community with examples of improvements made to services based on what they have told us matters to them through their feedback. These were distributed to all GP Practices in January of this year.

2.2 Effectiveness

Effectiveness focuses on monitoring and evaluation of patient care and performance in relation to our peers to ensure focussed quality improvement.

2.2.1 Benchmarking

At CCDHB we recognise the importance of benchmarking our activity to assist with the identification of opportunities for improvement. Health Round Table (HRT) and the Australian Council for Healthcare Standards (ACHS) are two key areas we work with. With all data it is important to recognise this as a tool to focus improvement activity.

The Health Round Table Executive Summary report was received in February 2-17. The Relative Stay Index (RSI) is a calculation that is used to determine how quickly hospitals discharge their patients compared with their peers. The RSI is calculated by dividing the actual bed days by the expected bed days. For CCDHB, the RSI showed a decrease from 96% to 93%, for the period between July 2015 – September 2016. This means that CCDHB has decreased the actual bed days for patients by three percent; the top hospital has a RSI of 84%.

2.2.2 Improvement

CCDHB is focussed on innovation and the method of achieving sustainable change through improvement. The DHB uses the Institute for Healthcare Improvement (IHI) - Model of Improvement and Lean as our improvement methodologies. Staff receive training on the methodologies through the Service Improvement Section of the Front Line Leadership Programme and more recently the "CCDHB Improvement Movement Training" that is aimed at building capability and capacity within our work force. A summary of the organisation wide improvement projects currently underway include:

Project Name	Aim	Related Strategic Objective/s	Status
Electronic Results Sign Off	To understand the issues leading to high numbers of electronic results remaining unsigned and identify areas of improvement.	Shorter, Safer, healthcare journeys	• Serial Laboratory test protocol approved. Next step is implementation of SMT for handover to GP and communications to follow. • Autosign rules protocol in final draft to go to next HHS meeting for sign off. • Implementation of new ordering doctor windowlet ('ordering doctor') to occur anticipated for April.
Sweet As	To reduce preventable hypoglycaemic events on 5 South Ward by 25% by 01/12/2016.		Sub-regional Insulin prescription Chart finalised.
Management Operating System - Phase 2	To implement the management operating system in ICU by July 2017.	Shorter, Safer, healthcare journeys Growing our People Better Value for Money	The ICU team held meeting with senior staff to discuss the ICU strategy. The team is currently working on identifying strategic objectives for ICU which align with CCDHB strategic objectives.
Improving Dental & Oral	This project aims to standardise the Dental	Growing our People	A working group has defined the problem, set an aim statement,

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Health Reception Processes	& Oral Health services reception processes across the Wellington and Kenepuru sites to reduce unutilised appointments.	Better Value for Money	established measures and brainstormed change ideas. Change ideas are currently being trialled (PDSA cycles).
Tu Pounamu	To increase the cumulative composition of Māori staff from 5.3% to 7% by December 2017. To increase the cumulative composition of Pacific staff from 6% to 8% by December 2017.	Growing our People	The initial focus is on improving the current staff ethnicity data in order to give better quality information on which to base further improvements. Improvements have been identified and approved by the steering group. Working with Payroll and HR to progress changes.
Alerts	To implement a policy for electronic patient alerts and have a clear process across CCDHB by June 2017.	Shorter, Safer, Healthcare journeys	Currently drafting new alerts policy, looking at trialling different processes for different types of alerts.

In the data capture/problem defining phase to focus improvement activity

Improving acute patient flow	The DHB is working with Francis Health to improve acute patient flow. The Improvement Advisors are supporting this work and are currently working on process mapping the Mental Health patient process in ED and doing a stocktake of ward rounding processes at Wellington regional Hospital.
Outpatients paper vs electronic medical records	Work to be presented at HHS in March 2017.
Management Operating System Phase 1	Establishing data collection and display capability, & scoping up dashboard requirements. Currently working up RFI for a data visualisation tool.
Health Care Home – Capacity development Community District Nurse (DN) and Older Persons Rehabilitation (ORA) teams	This is a workstream of the Health Care Home Programme with Primary Care. The project is aimed at releasing capacity in the Community DN and ORA teams in order to support new model of working with the GP practices. Current improvement activity is being reviewed and further opportunities are being identified to bring to the steering group.
7 South	Working with 7 South Performance Improvement team. Currently getting some baseline information to inform potential improvement workstreams.
Consumer Engagement	Consumer engagement guideline, and Consumer engagement payment and reimbursement of expenses approved by HHS. To go to ELT for approval. Further development of Consumer Council is being scoped.

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2.2.3 HQSC opens campaign - Quality safety markers

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's health care through the national patient safety campaign *Open for better care*. The quality and safety markers (QSMs) help evaluate the success of the campaign nationally and determine whether the desired changes in practice and reductions in harm and cost have occurred. CCDHB July to September 2016 QS Markers were published 19/12/2016.

For Safer Surgery the HQSC introduced a new quality and safety marker for Q3, which measures levels of teamwork and communication. Direct observational audit is used to assess the use of the three surgical checklist parts: sign in, time out and sign out. A minimum of 50 observational audits per quarter per part (sign in, time out and sign out) are required before the observation is included in uptake and engagement assessments. Eight out of 20 DHBs achieved 50 audits for all three parts in quarter 3.

The use of the safe surgery checklist is considered well embedded at CCDHB and the roll out of the paperless checklist occurred at CCDHB in December 2015 as part of a national change in the use of the checklist. The intent of the QSM and the auditing has changed significantly and the time taken by specifically trained auditors to complete the data collection of the QSM is a significant factor. The auditing of team engagement is completed by the four operating theatre staff who has received training by HQSC in this activity. The first quarter the new QSM has been challenging as a result of the impact of this change and is reflected in the results below. It is anticipated that the target will be met for the next reporting period.

Marker Definition	NZ Goal	NZ Avg	Q1 Jan – Mar 15	Q2 Apr – Jun 15	Q3 Jul – Sept 15	Q4 Oct – Dec 15	Q1 Jan to March 2016	Q2 April to June 16	Q3 July to Sept 16
FALLS: Percentage of patients aged 75 and over (Maori and Pacific Islanders 55 and over) that are given a falls risk assessment.	90%	93%	87%	92%	94%	94%	**94%**	**94%**	**91%**
FALLS: Percentage of patients assessed as being at risk have an individualised care plan which addresses their falls risk.	90%	90%	91%	95%	99%	99%	**99%**	**99 %**	**96%**
SAFE SURGERY Percentage of operations where all three parts of the surgical safety checklist (SSC).	100 %	97%	98%	99%	New Safe Surgery QS Marker as of **01/07/2016**: All 3 part of the SSC are used in 100% of surgical procedures				88% **Not Achieved**
	95 %	NA	NA	NA	With levels of team engagement with the SSC at 5 or above 95% of the time.				66% **Not achieved**
HAND HYGIENE: Percentage of opportunities for hand hygiene	80%	80%	72%	79%	81%	**80%**	**78%**		**82%**
SURGICAL SITE INFECTIONS: Percentage of hip and knee arthroplasty primary procedures were given an antibiotic in the right time.	99%	95%	98%	100 %	100 %	**100 %**	**100%**		**100%**
SURGICAL SITE INFECTIONS:	99%	98%	98%	98%	100	**99%**	**99%**		**99%**

Percentage of hip and knee arthroplasty primary procedures were given an antibiotic in the right dose					%			
SURGICAL SITE INFECTIONS: Percentage of hip and knee arthroplasty primary procedures were given appropriate skin prep	99%	100 %	100 %	100 %	100 %	**100 %**	**100%**	**99%**

2.2.4 Certification

A progress report on the 3 moderate actions was sent to the MOH on the 27/02/2016 Good progress is being made.

2.2.5 Clinical & quality safety measures

CCDHB monitors 13 agreed clinical and quality measures which are reported monthly. The report includes control charts for the 13 clinical and quality measures with data reported from reportable events and other relevant data sources. As at 28 February there was normal variation for all 13 indicators - Refer **Appendix 2.**

2.2.6 Risk (Safety)

CCDHB is committed to providing a safe environment for all patients/clients who use our services and recognise that despite the best intentions of the staff, incidents and errors will occur. The risk management and patient safety systems enable early identification, review and system changes to improve safety.

2.2.7 Risk framework

The CCDHB revised Risk Policy is in its final draft and will be presented to the April Finance Risk & Audit Committee meeting for approval. Discussion will need to be had with the Wairarapa and Hutt Valley VDHBs to agree the risk matrix as 3DHB endorsement is required for the risk and hazard module on SQUARE – the risk reporting system.

3.0 GROWING OUR PEOPLE

We want to be a highly regarded organisation and a preferred place to work. A place where our staff feel valued, have development opportunities, are involved in improving the way we do things, and have a safe workplace. Workforce is focused on how we are facilitating collaboration and thereby ensuring CCDHB is getting the best value for public health system resources.

3.1 Workforce (Includes Sub-Regional/Regional Collaboration)

Workforce is focused on how we are facilitating regional and sub-regional collaboration and thereby ensuring CCDHB is getting the best value for public health system resources.

3.1.1 Improvement movement

Improvement Training

The QIPS improvement team started the CCDHB Improvement Movement in November 2016. The purpose of the improvement movement is to build a culture of continuous improvement and improvement capability at CCDHB. Progress to date:

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Training Type	Numbers trained to date	Target (by Dec. 2017)	% of target
Stream 1: Join the Movement! 1 hour taster sessions	174	500	35%
Stream 2: 12 week improvement training	15	45	33%

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DISCUSSION**
	Date: 14 March 2017

Author	Faye Ryan, Strategy, Innovation & Performance
Endorsed by	Rachel Haggerty, Director - Strategy, Innovation & Performance
Subject	**Planning and Accountability Documents**

RECOMMENDATIONS

It is **recommended** that the Board:

a) **Note** the accountabilities of CCDHB to the Minister of Health and the Ministry of Health described below.

b) **Comment** on the approach to planning and accountability that is described below and being used to guide the performance of CCDHB**.**

c) **Note** the Board has currently involved in approving the Annual Plan, Sustainability Plan, Regional Service Plans, Long Term Investment Plan, System Level Measures Plan, Health System Plan 2030, and Disability Strategy.

d) **Note** that the development of these plans will be represented in the Board work plan by April 2017 meeting and that all Plans developed in the framework will be approved by the Board.

1 PURPOSE

The Board requested an understanding of the mechanisms available to them to be effective as Board members in discharging their responsibilities. This paper outlines the planning and accountability processes relevant to the Capital & Coast DHB. It provides a brief overview of the position of the DHB within the context of the NZ health system and the key nationwide documents that govern DHBs including the non-financial accountability mechanisms. We then provide an overview of the framework being adopted in CCDHB and some the planning process and opportunities for engagement and direction from the Board.

2 BACKGROUND

CCDHB is one of 20 DHBs with accountabilities under the New Zealand Public Health and Disability Act 2000 created DHBs. Under this act the objectives of CCDHB are:

- Improving, promoting and protecting the health of people and communities
- Promoting the integration of health services, especially primary and secondary care services
- Seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs
- Promoting effective care or support of those in need of personal health services or disability support.

CCDHB is both a funder and provider of health and disability services for its population. There are some services that are centrally contracted by MoH within our communities. This includes community midwifery, Tamariki Ora/Well Child, Public Health services, nationally specialty services such as forensic mental health and liver transplant and the largest being disability support services for those under 65 years. ACC also contract services directly for their clients from CCDHB and other community providers.

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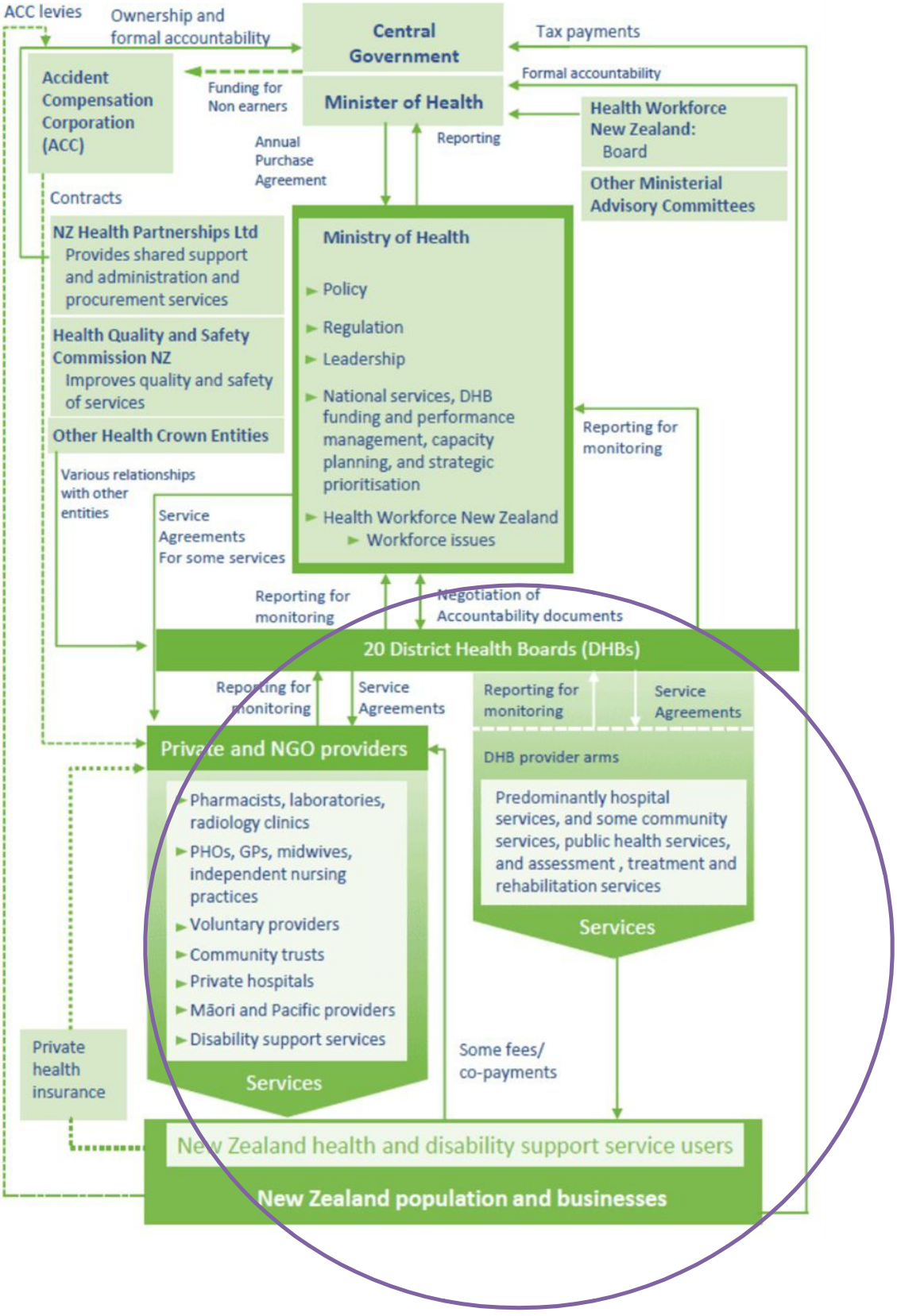
The structure of the New Zealand health and disability sector



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3 ACCOUNTABILITY TO THE MINISTRY OF HEALTH

CCDHB is accountable to the Ministry of Health through mandatory documents which outline service requirements, performance monitoring and financial reporting. These documents outlined below establish the operating environment being established by the Minister.

- **Crown Funding Agreement** the agreement between the Minister of Health and the DHB which is issued with a letter of expectation, which is attached as an appendix to this paper. The Letter of Expectation is direct advice from the Minister to the Chair of the Board.
- **Annual Plans** which are agreed between the Minister and the DHB, via the Ministry of Health, on an annual basis.
- **Operational Policy Framework** is a set of business rules, policy and guideline principles that outline the operating functions of district health boards.
- **Service Coverage Schedule** outlines the agreed level of service coverage that the Ministry and DHBs are held accountable to.
- **Performance and monitoring** based on a large set of performance measures DHBs are required to report on and baseline data to use for target setting.

In addition to these accountability documents a series of strategic documents provide the context, supported by more detailed service specifications and frameworks. There are **166** strategic documents which include:

- NZ Health Strategy
- Faiva Ora 2016–2021 National Pasifika Disability Plan
- Healthy Ageing Strategy
- Taking Action on Fetal Alcohol Spectrum Disorder: 2016–2019: An action plan
- Mental Health and Addiction Workforce Action Plan 2017–2021

This does not include regional plans and strategies for the full range of services. In addition there are in addition to intersectoral or whole of population strategies which are strongly engaged with health including Tamariki Oranga/Vulnerable Children and social investment strategies.

4 CCDHB PLANNING AND ACCOUNTABILITY MECHANISMS

With the formation of SIP (Strategy, Innovation &Performance) CCDHB is developing a comprehensive approach to planning that is represented in the diagram below. The approach is to ensure a layered planning system that enables CCDHB to be responsive to its environment through a clear and agreed framework. This approach is specifically designed to provide whole of system commissioning as the key mechanism to inform integrated sector and service plans. The Board including CPHAC DSAC, will be engaged in the development of the three levels of strategy. These documents are where the key parameters that will focus activity will be defined. They include performance measurement and form the accountability mechanisms.

The **Strategic Frameworks** set the context and direction for decision making. CCDHB has a draft Health System Plan and Disability Strategy which are moving through Board processes after significant engagement with the previous Board, CPHAC DSAC and the sub regional Disability Advisory Group. All of these strategic frameworks require significant engagement with our partners, communities and our Boards.

The **Whole of System Investment Plans** are a key output following the Health System Plan 2030. These Plans have not been developed but will identify the approach that should be taken to investment based on evidence, system analysis and engagement across consumers, communities and providers. These investment plans will be critical enablers in creating sustainability.

The **Integrated Sector Plans** describe in more detail the expectations of service delivery including the system level measures and locality plans. The Locality Plans will be developed with our communities.

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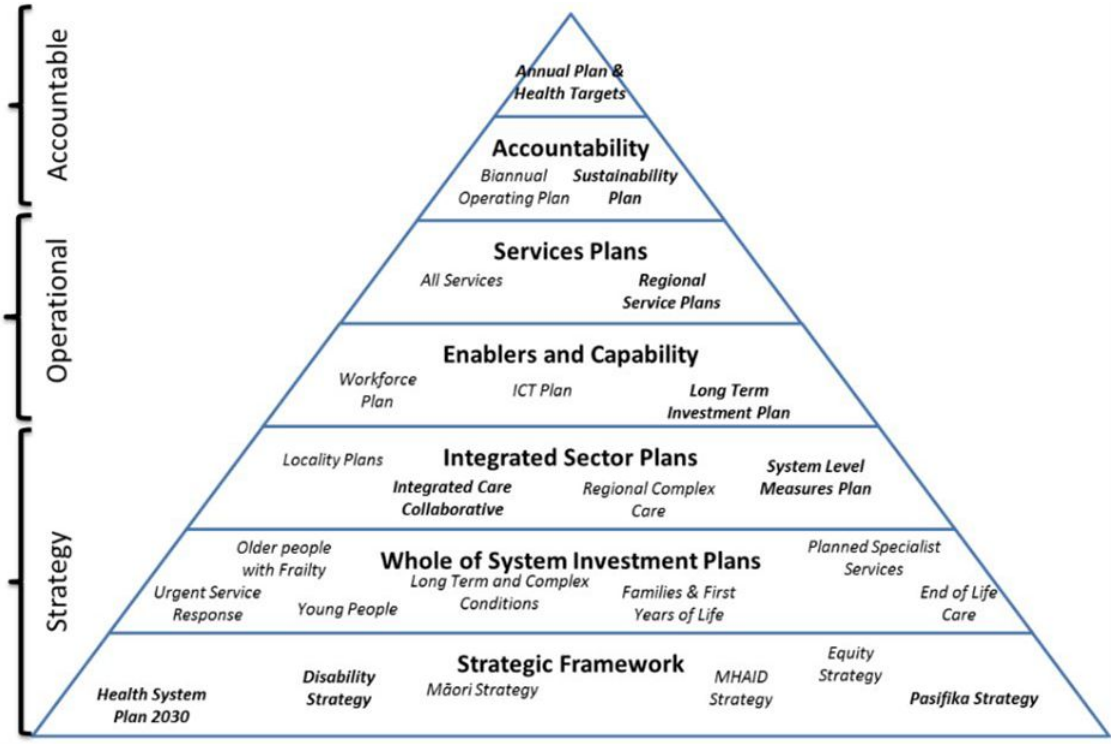
The **Enabler and Capability Plans** focus on the investment required to deliver on the plans, as will the service plans.

The key accountabilities of CCDHB will be held in a Biannual Operating Plan and a Sustainability Plan. These two documents will identify the actions to be taken by CCDHB to deliver on its accountabilities.
The CCDHB Biannual Operating Plan is the detailed two year operating plan. This will be the most comprehensive plan. It will be developed over the next 12 months with engagement across the organisation and CCDHB providers. It will capture the implementation of the Health System Plan, the second phase of the Sustainability Plan as well as the implementation of a comprehensive range of strategies and systems that support the achievement of the strategies and goals of Government, Ministry of Health and CCDHB Board including sustainability and greater equity. **The Sustainability Plan** is the core project approach to drive a focus on sustainability. The draft Plan is phase-one of a three year plan. This Plan may be incorporated in the Biannual Operating Plan in future years.

Finally, the **CCDHB Annual Plan** is the key accountability document between CCDHB and the Ministry of Health (MoH). (In draft) This Plan is an annualised accountability document between CCDHB and MoH. Its scope and focus is determined by MoH. This is the first year this structure has been used by MoH.

Planning and Accountability Framework CCDHB



The Board is asked to comment on the approach to planning and accountability that is being used to guide the performance of CCDHB. This includes noting that the Annual Plan, Sustainability Plan, Regional Service Plans, Long Term Investment Plan, Integrated Care Collaborative, System Level Measures, Health System Plan 2030, Disability Strategy and Pasifika Strategy are final or in draft for Board consideration over the next two months.

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD INFORMATION**
	Date: 15 March 2017

Author	Chris Lowry, General Manager Hospital & Healthcare Services
Endorsed By	Rachel Haggerty, Director, Strategy, Innovation and Performance
Subject	**Kenepuru Accident and Medical**

RECOMMENDATIONS

It is **recommended** that the Board:

a) **Endorse** the processes underway to deliver a service solution that meets the needs of the population in line with the CCDHB Health System Plan

b) **Endorse** the development work underway to support interim solutions to support the Kenepuru Accident and Medical service while the wider system level solutions are developed.

1 INTRODUCTION

In August 2016 the Board considered the challenges facing the Accident & Medical (A&M) Service at Kenepuru. The Kenepuru A&M service is greatly valued by the local communities of Porirua and Kapiti. CCDHB is cognisant of the community interest in the provision of a safe and appropriate service for the local populations.

The key challenge for the service has been to deliver a clinically safe and efficient service, while trying to manage roster gaps on the night shift. The service is also facing escalating staffing costs while the overnight volumes remain low at approximately 10-12 patients a night.

The following is an outline of the proposed development process to resolve these challenges for the service in line with the community interest. The aim is to deliver a service that will meet the needs of the population in line with the CCDHB Health System Plan.

2 HEALTH SYSTEM BASED SOLUTION

The WHO defines urgent as “including the health system components, or care delivery platforms, used to treat sudden, often unexpected, urgent or emergent episodes of injury and illness that can often lead to death or disability without rapid intervention.” Urgent care can start in the home where people are making decisions as to how ill their child may be; or may be a significant event that happens in the workplace or in a public setting. As per the CCDHB Health System Plan, solutions will incorporate the community health networks, technology solutions, responsive Health Care Homes, empowered patients, access to diagnostics and partnering with support services. Both the interim and long term solutions for Kenepuru A&M service will be developed in line with this direction to deliver a service that is clinically safe and efficient for the population. The Porirua locality has been

identified as a focus area for development in the draft 2017/18 CCDHB Annual Plan which will include the need to identify appropriate urgent care services and support for its population.

The delivery of this whole of system approach for Kenepuru A&M services will require the development and maturing of relationships across the health sector and with the community to enable collaboration on the health service provision. This will lead to a long term partnership being established with the local community to drive a shared vision for the health care system, including the most appropriate solution for urgent after hours care requirements for the Porirua and Kapiti communities.

3 INTERIM SOLUTIONS

While maintaining a focus on the longer term solutions, interim solutions to support the delivery of a clinically safe service have been discussed with a collaborative primary and secondary group. CCDHB remains committed to the on-going provision of over-night support through Kenepuru A&M. The elements of longer term solutions are incorporated into these solutions, as they will be supportive of the future direction. Further work is being done to understand similar models being run in other DHBs and their possible application in CCDHB.

The potential solutions will be developed in collaboration with clinical staff, services and unions. Components of the proposed solution may include:

- Increased resourcing for the afternoon and evening shifts to reduce the numbers of patients waiting to be treated by the beginning of the overnight shift; this will make recruitment to night-shifts easier and reduce demand on night-time services.
- A staffing model that provides an appropriate and sustainable solution that supports the overnight service. This will take into consideration the role of medical staff, nurses and telehealth enablers.
- Dedicated support from the ambulance service to respond and transport those people that require ED care
- Increasing over-night fees to match those of other providers in the district, incentivise patients to seek non-night assessments where feasible, and help off-set additional resource requirement.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DECISION**
	Date: 22 March 2017
Author	Andrew Blair, Capital & Coast District Health Board Chair
Subject	**Resolution to Exclude the Public**

RECOMMENDATION

It is recommended that the Board

a. AGREE 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:

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the respective public excluded papers	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in respective public excluded papers	
Chair's report CEO's report FRAC report	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(i)(j)
Population Base Funding and CCDHB's future funding environment (Sapere) Annual Plan Sustainability plan	Subject to Ministerial approval	9(2)(f)(v)
Litigation and legal risk update	Maintain legal professional privilege	9(2)(h)

* Official Information Act 1982.

All District Health Boards

6 March 2017

All Chairs
National District Health Boards (DHBs)

Dear Chairs

Proposed Amendment to the Constitution of New Zealand Health Partnerships

In recognition of the smaller pool of DHB Chairs since the most recent changes in Board composition, we would like to propose an amendment to the constitution of NZ Health Partnerships. The amendment would make DHB Deputy Chairs eligible to be Directors replacing DHB Chief Executives. This change would expand the pool of DHB Board Members who are eligible for these roles, particularly as there are now only 13 DHB Chairs. NZ Health Partnerships has been successful in integrating DHB Chief Executives at the Programme Sponsor level within the organisation and it is felt that this is the most effective way for them to be involved in the governance model.

The specifics of the amendment are attached. Unanimous DHB approval of this resolution is required. We will print out a copy of the written resolution for signing at the 20 March 2017 shareholders' meeting and we will include space on the agenda for any discussion of the proposed amendment. The resolution will not need to be formally moved or seconded and a shareholders' vote won't be necessary.

Each DHB will need to consider their own internal process for approving this resolution however we would like to be in a position to action this change shortly after 20 March 2017 to allow full DHB representation at NZ Health Partnerships Board meeting on 30 March 2017.

Yours sincerely

Jenny Black
Chairman
National DHB Chairs

All District Health Boards
PO Box 23075
Wellington 6140
04 801 2340
04 801 6230

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**Date: 10 March 2017**
Author	Cheryl Goodyer, Manager Capability Angela Wilson, Quality Project Facilitator Jim Wiki, Manager Accountability
Endorsed by	Arawhetu Gray, Director Māori
Subject	**CEO Report: February 2017**

1. PURPOSE

The purpose of this paper is to provide the Chief Executive Officer a summarised report of:

1. Capital & Coast District Health Board performance indicators specific to Māori Health; and,
2. Māori Health Development Group activity.

2. DISCUSSION

2.1 Equity performance

The following table provides a dashboard of Capital & Coast District Health Board's performance against national and local indicators specific to Māori Health. Additionally, it provides a comparison to CCDHB's Total Population performance and Hutt Valley and Wairarapa DHBs performance for Māori.

Narrative and data has been drawn from the draft 3DHB Equity report. Key indicators include:

2.3.1 Breastfeeding

In June 2016, breastfeeding targets increased in June 2016 to 75 percent of infants exclusively or fully breastfed at six weeks (discharge from Lead Maternity Carer (LMC)), 60 percent of infants are exclusively or fully breastfed at three months of age, and 65 percent of infants are receiving breast milk at six months (exclusively, fully or partially breastfed).
The introduction of Maternal Green prescriptions for targeted women from 1 January 2017 will also contribute to improved equity.

2.3.2 Oral Health

It is important to note that Oral Health data is based on a calendar year. 2016 calendar year data is due to be published early April 2017.

The percentage of Capital & Coast DHB children enrolled in the Bee Healthy Regional Dental Service was substantially greater in 2015 than in previous years for all ethnic groups. Despite the improvement on previous years, the percentage of Māori children enrolled is still of concern.

Although the dental examination arrears rates have substantially decreased from previously very high levels, there has been a slight increase in 2015. This increase was anticipated with the large number of enrolments and no change in staffing.

2.3.3 Immunisation

The immunisation rate for Māori and Pacific infants at eight months was 96% in June 2016. General practice teams, supported by immunisation outreach services, continue to target Māori and Pacific infants to ensure eight months immunisation rates are equitable across all ethnicities.

2.3.4 Breast Screening

To improve equity in our breast screening coverage, screening services are using PHO Data Matching Reports to identify women who are not enrolled or under screened to target these women. Screening services also implemented 'combined breast and cervical priority' women days for Māori, Pacific, and women living in the most deprived areas, and monthly Saturday clinics at Kenepuru Hospital for women who cannot attend during working hours.

A new fixed breast screening site was opened on Lambton Quay in central Wellington. This site aims to improve access for women to breast screening services who are working in the CBD and can attend during working hours. To make breast screening mobile clinics more accessible for priority women, the mobile clinic now visits Kapiti annually as part of the clinic rotation. Independent service providers, such as Mana Wahine and the Central Pacific Collective have been engaged to locate and assist priority women to engage with screening services.

2.3.5 Cervical Screening

Key to improving equity in cervical screening is the PHO Cervical Screening Data Matching Reports that were first published in February 2016. These reports are sent from PHO's to practices with information on the screening status of all women enrolled in their PHO and can assist practices in recalling women. The PHO Cervical Screening Data Matching Reports ensure timely, accurate information is available each month allowing easier follow-up of women needing to be recalled for screening. As a result this should significantly impact on equity increasing coverage for NCSP priority women. Priority women include Māori, Pacific (and Asian for NCSP), as well as unscreened and under-screened women.

2.3.6 Tobacco - Primary Care

Capital & Coast DHB invests in a Smoking Cessation coordinator located in Compass Health that provides support across all PHOs. Capital & Coast DHB have also recently invested in a Hapū Ora service located in Ora Toa PHO. The primary focus for the Hapū Ora Service is to work with young Māori women and encourage them to stop smoking through smoking cessation interventions. The programme is available to all young women aged 15 – 25 years who smoke and are pregnant or have young tamariki up to five years of age and reside in the Capital & Coast DHB area. There is an expectation of this service to be delivered alongside other health and social services within Ora Toa PHO and with health and social agencies in the wider CCDHB community including the Tākiri Mai te Ata Regional Stop Smoking Service and Quitline.

2.3.7 Tobacco - Hospital Services

Review and analysis indicates that ED and 'short stay/high turnover' areas are preventing achievement of the 95% target for Capital & Coast DHB hospital services. A project to address this issue has shown that ED staff have all been trained in ABC and in general they

are carrying out the processes up to the point of documentation. We are currently revising our systems to better enable clinicians to easily document evidence. We continue to have challenges with reducing coding error rates.
Capital & Coast DHB has refreshed its Smoking Cessation Policy and revised its referral forms to reflect the new Regional Stop Smoking Service and is working with providers across the DHB to improve referral rates.

2.3.8 ASH

CCDHB has a number of activities underway that are targeted at improving the ASH rates for both 0-4 years and 45-65 years. For Māori children the main conditions are dental, respiratory and asthma. For Māori adults the main conditions are angina and chest pains, cellulitis and COPD. Initiatives for 2016 / 17 include:

Children

- Increase newborn enrolment rates with PHOs, general practice and Well Child Tamariki Ora
- Improve enrolment with and access to oral health services for Māori tamariki
- Promote 'hand hygiene' and 'skin care' health messaging across health events and within Kohanga Reo, early childhood centres and primary schools
- Improve the care of children from Porirua presenting to the hospital with respiratory conditions through improved referral process between the hospital and primary care services
- Implement a Skin and Respiratory project with a focus on reducing acute readmissions to hospital

Adults

- Reduce smoking prevalence and smoking related-harm with a particular focus on pregnant Māori women
- Monitoring of the System Level Outcome Measures (previously IPIF) framework, with a focus on Diabetes and CVDRA performance for Māori
- Implementation of Health Care Homes (HCH) Tranche 1 to drive better proactive, planned and acute care in the community.

By progressing Annual Plan activities targeted at reducing the equity gap for Maori and Pacific we hope to maintain and improve the downward trend for Maori ASH rates.

2.3.9 Did not attends (DNAs)

To improve DNA rates at Capital & Coast DHB, a DNA oversight group has been set up led by the Chief Operating Officer with the Director of Māori Health and Director of Pacific Health, and PHOs as primary care partners, including the Pacific Navigation Service. The DNA programme has supported a suite of activities to improve clinic attendance. Initiatives include:

- Clinic Appointment Support in Children's Clinics
- Cardiology Clinic Appointment Support
- Māori Did Not Attend (Clinic) monitoring reporting
- Health Literacy Review

Domain	Indicator	Target (National/ Local)	Capital & Coast DHB Māori	Capital & Coast DHB Other (or Total)	Hutt Valley DHB Māori	Wairarapa DHB Māori
Healthy children	Full or exclusive breastfeeding at 6 weeks Data Jan-Jun 2016	75% (National)	53% ▼	73% ▼	50% –	57% ▼
	Full or exclusive breastfeeding at 3 months Data Jan-Jun 2016	60% (National)	43% ▼	68% –	39% ▲	60% ▲
	Any breastfeeding at 6 months Data Jan-Jun 2016	65% (National)	55% –	79% ▲	44% ▼	56% ▲
	Infants fully immunised at 8 months Data at Dec 2016	95% (National)	96% ▲	95% ▲	98% ▼	98% ▼
	Pre-school enrolment in dental services Data for 2015	85% (National)	68% ▲	103% ▲	83% ▲	73% ▼
	Dental examination arrears rate Data for 2015	15% (National)	12% ▲	13% ▼	11% ▼	N/A
	Percentage caries free at 5 years Data for 2015	69% (Local)	51% ▲	77% –	49% ▲	44% –
	Mean number of decayed, missing, filled teeth at Year 8 Data for 2015	0.67 (Local)	0.76 ▼	0.47 ▼	0.87 ▼	0.97 ▼
Screening and early intervention	Breast screening 2 year coverage, 50-69 yrs Data at Dec 2016	70% (National)	67% ▲	74% ▲	67% ▲	70% ▼
	Cervical screening 3 year coverage, 25-69 yrs Data at Dec 2016	80% (National)	63% –	85% ▼	68% ▼	71% ▲

Domain	Indicator	Target (National/ Local)	Capital & Coast DHB Māori		Capital & Coast DHB Other (or Total)		Hutt Valley DHB Māori		Wairarapa DHB Māori	
	Brief advice to quit smoking offered in primary care Data at Dec 2016	90% (National)	85%	–	86%	–	89%	▲	84%	▲
	Brief advice to quit smoking offered to inpatients Data at Dec 2016	95% (National)	87%	▼	89%	▼	93%	–	93%	▲
	Cardiovascular risk assessment completion Data at Jun 2016	90% (National)	87%	–	94%	▲	84%	▼	84%	–
Access and quality care	Ambulatory sensitive hospitalisation ratio 0-4 yrs Data to Sep 2016	100% (National)	96%	▼	79%	▲	146%	▲	125%	▼
	Ambulatory sensitive hospitalisation ratio 45-64 yrs Data to Sep 2016	100% (National benchmark)	148%	▲	74%	▲	172%	▼	137%	▼
	Outpatient 'did not attend' rate Data at Jun 2016	6% (Local)	11%	▼	5%	▲	14%	▼	19%	▲

2.2 Whānau Care Services (WCS)

2.3.1 Activity Summary

Trend legend	▲	Change since last month/ period indicating improved performance	■	No change	▼	Change since last month/ period indicating reduced performance

Domain	Indicator	Jan	Feb	Trend
WCS referrals	Number of referrals	145	166	▲
	Referrals from inpatient setting	24	20	▼
	Referrals from outpatient setting	31	251	▲
	Referrals from community & primary setting	87	90	▲
	Referrals from next of kin or self referrals	17	25	▲
	Proportion of referrals tikanga	34%	33%	■
WCS Contacts	*Contacts are reported a month behind due to entry lag*	**Dec**	**Jan**	
	Number of contacts	1272	448	▼
	Afterhours activity (hours)	7	12	▲
	Proportion of contacts in inpatient setting	42%	68%	▲
	Proportion of contacts in outpatient setting	42%	8%	▼
	Proportion of contacts in community & primary setting	16%	24%	▲
	WCS Clinic Attendance Support DNA proportion	11%	7%	▲

2.3.2 Referrals & Contacts

- January's referrals are down reflecting the seasonal dip. They are gradually increasing in February.
- Contacts for December are down from November, however January's contacts are low reflecting the staff absence due to annual leave impact and lag with data entry (expected wash up within 2 months). Contacts numbers are reported a month behind due to process flow and are manually entered by Patient Administration Unit.
- Although the numbers are small, the on-going need for after-hours support remains

2.3.3 WCS Clinic Appointment Attendance Support (DNA Calling)

Clinic attendance support calling and DNA follow up calling has yielded improved attendance, and at rates lower than the all CCDHB Māori DNA rate.

- 7% DNA as a percent of effort (contacts and attempts to contact) in February (down from 11% in January and Q2's average of 25%. This is lower than the CCDHB Māori rate of 13%
- DNA follow up continues to firms, with direct referrals now being received.
- Reasons for DNA within the Cardiac CSN clinics:
- System error
- Patient unavailable
- Patient does not wish to attend any appointments x1
- Changed clinical condition

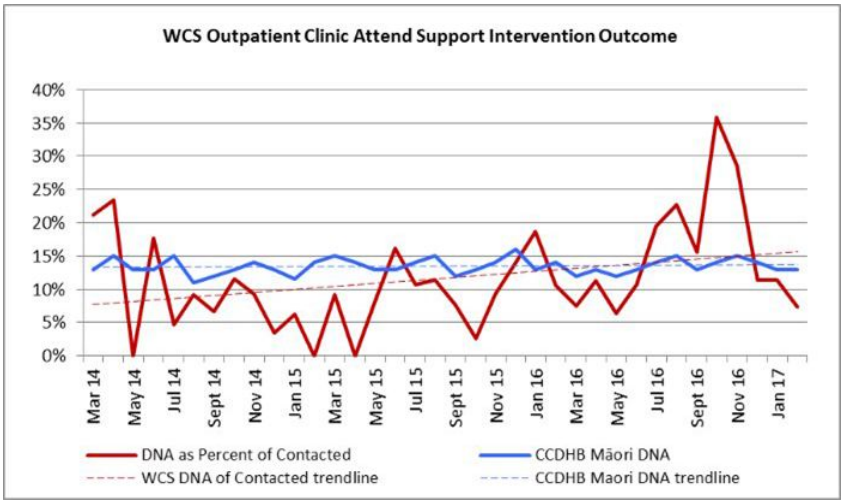


Figure 3: WCS Outpatient Clinic Attend Support Intervention Outcome April 2015 to current
Data Source: WCS data

2.3.4 Whānau Care Services Intervention Case Studies

The following case studies are real; names have been withheld for privacy reasons; a collaborative and integrated interventional approach has been taken in most cases, and the impact of this approach on the patient's health and well-being leads to a positive outcome.

Case Study 1

Whānau Care Services Intervention Case Study – Social Work & Kaiāwhina

Strategic objective linkages	*Shorter, safer patient journey. Value for money.*
MHDG goal:	Zero patient harm; Patient and whanau centred care;; supporting integrated solutions for Maori and whanau with chronic illness; WCS structure supporting models of care

Patient

Patient Pēpe is a 3 month old referred to Whānau Care Service for clinic appointment attendance support, following a 'DNA' (did not attend) of a clinic appointment in December. Pēpe's medical history included a Neonatal Intensive Care admission and testing positive for methamphetamine. Although Pēpe had been discharged home to the care of her parents, she was now being cared for by her paternal whānau following being 'uplifted' by Child Youth and Family (CYF). Prior to her birth, the potential for care and protection risks had been identified. Pēpe's mother had previous engagement with a Whānau Care Service Social Worker. She was on the Vulnerable Pregnant Woman list and had previously had children removed from her care by CYF. There had been past domestic violence episodes between Pēpe's parents, for which her father had been incarcerated. The Kaiāwhina referred Pēpe to the Whānau Care Service Social Worker. This resulted in inter agency liaison and an invite to attend a family group meeting, where it was identified that the care givers had not been receiving any notifications of appointments and agreement that Pēpe was in need of care and protection.

Key Issues

- Clinic non attendances (DNA)
- Care givers unaware of clinic appointments
- Vulnerability and concerned about wellbeing and welfare
  - on-going risk from potential future domestic violence and mother's continued drug abuse
- Whānau Complexity
- Multiple agency involvement

Interventions

- System navigation
  - Negotiated appointment reschedule
  - Linked into Whānau Care Service attendance support reminder system
- Patient advocacy
  - Care givers notified of an upcoming appointment – resulted in an attendance
- Interagency networks
  - Previous successful engagement resulted in timely and successful WCS contribution to Pēpe's health and social outcomes.
- Inter-sectorial liaison
  - Child, Youth and Family, social support services,
- Patient Journey enhancements
  - right assessment by right profession at right time
  - service coordination
- Patient and whānau centred care
  - Collaboratively worked with whānau, clinicians and social services to achieve an outcome acceptable to all, enabling clinic attendance

Commentary

This case study highlights the complexity behind why children 'DNA' clinic appointments. Robust collaborative multi-disciplinary team work between the Kaiāwhina & Social Worker and timely and appropriate interagency liaisons based upon previous engagements has contributed to effectiveness of wrap around services as well as facilitating better outcomes.

Case Study 2

Whānau Care Services Intervention Case Study – Social Work & Kaiāwhina

Strategic objective linkages	*Shorter, safer patient journey. Value for money.*
MHDG goal:	Patient and whanau centred care; Zero patient harm; Supporting integrated solutions; WCS structure supporting models of care

Patient

Patient Wahine-Hapū, a 38 year old woman referred to Whānau Care Service by Delivery Suite with a threatened delivery at 22 weeks pregnant. Wahine-Hapū is a sole parent with 2 adult and 2 primary school aged children, no longer in a relationship and needs to vacate her rental home in five days and has no accommodation sorted. She has a few close friends but

no whānau in Wellington. Wahine-Hapū had informally organised for this baby to be whāngai (customary fostering) by her brother.

Key Issues

- Medical complexities
  - threatened delivery 22 weeks
  - to remain in hospital until delivery
  - baby delivered at 24 weeks and admitted to Neonatal Intensive Care Unit
- Multiple social complexities
  - sole parent with few social supports
  - whānau 'up north'
  - feels isolated without her children/ whānau
- Impending homelessness
  - needs to move out of current rental during hospital stay
  - no forward accommodation sorted
  - working though putting house contents into storage
  - wanting to stay in local area as social supports and schooling consistency
- Cultural complexity
  - informal whāngai arrangement in place
  - whāngai parents wanting formal adoption

Interventions

- Engagement
  - gained confidence and permission to act as conduit between whānau and agencies
- Advocacy
  - birth parent rights and legal responsibilities
  - formal adoption process advise
- Patient and whānau centred care
  - facilitated decisions on care solutions and visiting options for younger children whilst Wahine-Hapū in hospital
- Patient journey enhancements
  - contact with children during hospitalisation
  - linked Wahine-Hapū to Kaiāwhina for support during admission
  - support for adoptive parents and Wahine-Hapū during baby's neonatal intensive care unit admission
- System navigation
  - Te Pehi Parata Whare accommodation for whāngai until alternatives sourced
  - facilitated National Travel Assistance for Wahine-Hapū
  - facilitated Ronald McDonald House accommodation for adoptive parents
- Inter-agency patient advocacy
  - liaised with Ministry of Social Development re housing issues
  - liaised WINZ re financial assistance
  - Accommodation secured

Impact
This case study highlights the precariousness of the hospital journey for some pregnant women. Whānau Care Service's integrated patient and whānau centred approaches, tailoring solutions to individuals makes a difference. Wahine-Hapū said that this support 'helped allay some of the stress and worry' that being in hospital had created for her. Strong advocacy and system navigation enabled a 'win win' outcome - whānau connectivity and well-being.

2.3.5 Bereavement Quilt background to Clinical Governance Group

An update on Palliative Care's Bereavement Quilt initiative linking with in MHDG's Te Wai Bereavement symbol was presented to the Medical Reference Group to establish interest in extending implementation.

Bereavement Quilt Background
Death of a patient is a significant event for whānau. Death of a patient on the ward is also a significant event. It has been identified that the clinical nature of the mortuary trolley can cause additional stress for families at this time. The Bereavement Quilt is a whanau focused quality initiative that aims to improve the patient journey. The Quilt is draped over the mortuary trolley.

Together with volunteers - Waiarapa Quilters and Busy Bee Quilt Shop in Rongotai, the Māori Health Development Group supported Ward 6 East to have it's own Bereavement Quilt. 5 North and 5 South each have their own Bereavement Quilt.

Māori Health Development Group supports wards to achieve bereavement best practice. In a busy acute ward it can be difficult to be mindful when someone has died. As staff we want to acknowledge this and raise awareness and increase our sensitivities for whānau during this time. Bereavement best practice supports the patient journey and is another quality, patient - whānau care focused initiative that seeks to improve the patient experience. The Bereavement Quilt is a tool to achieve this.

Te Wai Bereavement symbol

The Bereavement Quilt is labelled with Te Wai – CCDHBs bereavement symbol. Bereavement symbols are used internationally and are associated with best practice following the death of person in hospitals. Te Wai was created by a CCDHB employee Jim Wiki. This was in response to Internal Medicine's request for our own symbol.

Te Wai is a silent communicator and is a tool to improve the patient/ whānau experience. The symbol makes staff be aware a person has died, and encourages staff to be more aware and mindful of their actions during this significant event for family and staff.

'Te Wai' represents the significance of water as the source of life and spirituality. In this context 'te wai' signifies the ebbs and flows of ones life mimicking the natural flow of water and the ocean, linking people and the environment together as one. In the end we become part of the ever-flowing waters of life.

The large Koru represents the spirit of the person and new growth, new life in spirit and body. It also represents the embodiment of family as they gather to support each other.

The design 'Raperape' represents a pebble dropped in calm water and the ripples it creates. For this purpose it represents serenity.

Image 1: 6 East Bereavement Quilt.

2.3.6 Te Tohu Whakawaiora – 2016 cohort graduates

Te Tohu Whakawaiora, Certificate in Healthcare Capability (TTW/CHC) is a level 3 NZQA accredited course providing standardized cultural competency training regionally, whilst having local application. Te Tohu Whakawaiora is a Central Regional Māori Managers initiative.

March 9th was graduation day for the 21 successful 2016 cohort. 2016 was the second year CCDHB delivered this course. At the graduation both students and their managers noted how the course had challenged them to rethink how they deliver services to be responsive to Māori. The 2016 cohort included primary health care staff as well as staff from mental health, child health and allied health.

Image 2: Te Tohu Whakawaiora 2016 graduates

2.3 Kia Ora Hauora

Kia Ora Hauora "Maori Health as a Career Programme" is a national programme that was established in 2008 to increase the overall number of Maori working in the health and disability sector.

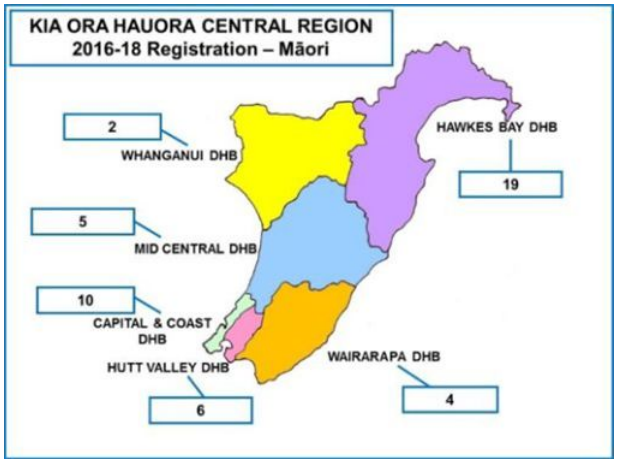
The aim of Kia Ora Hauora is to increase the recruitment of Māori into a range of health careers. The programme coordinates existing recruitment and promotion initiatives and builds on those initiatives specifically targeting young Māori to undertake a pathway towards a career in health.

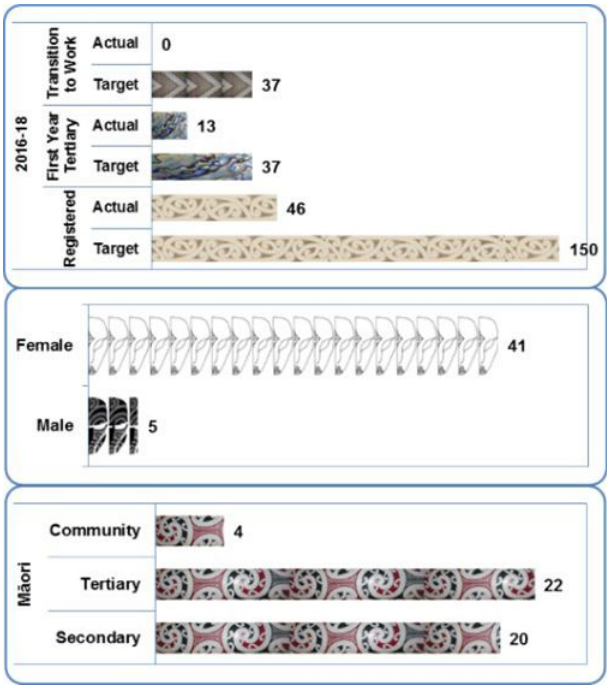
2.3.1 Enrolment

Quarter Two data shows enrolment to the CRCC KOH programme has decreased slightly in the Central Region. Ongoing cleansing of the database to ensure accurate accounting of KOH registrants continues. As at January 2017, the national database shows that:

2016 - 18 Registration

- 99% of Central Region enrolments are Māori
- For the new contract term, the Central Region hub has made a good start to achieving contract targets. The data shows:
  - maintaining the registration target (pro rata)
  - exceeding the 1st Year Tertiary target (pro rata)
- The data continues previous contract trends with a significant number of enrolments being female
- Initially there have been a large number of new Secondary School registrations, however there has been an increase in Tertiary registrations

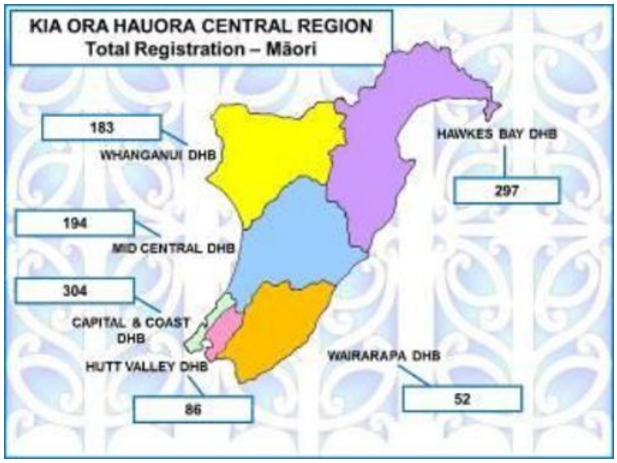


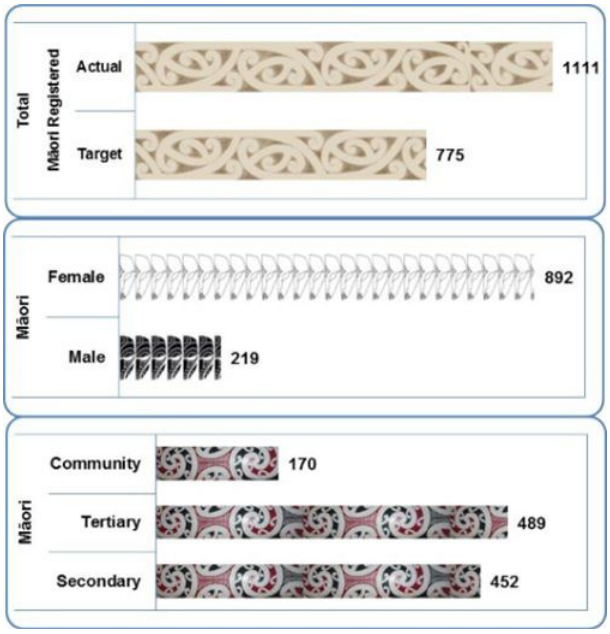


Total Registration

Of the Total programme registration:

- 99% of Central Region enrolments are Māori
- Enrolments show the programme has exceeded to total to date target by 43%. There has been a 1% decrease from the previous report. This is due to the addition of the new targets
- A significant number of enrolments are female
- There is a balance of registrations from Secondary Schools and Tertiary Institutes. However, Tertiary registrations are now greater, possibly indicating our first registrants are transitioning to Tertiary Study. It is also an indication of a focused concentration on working with Tertiary students.





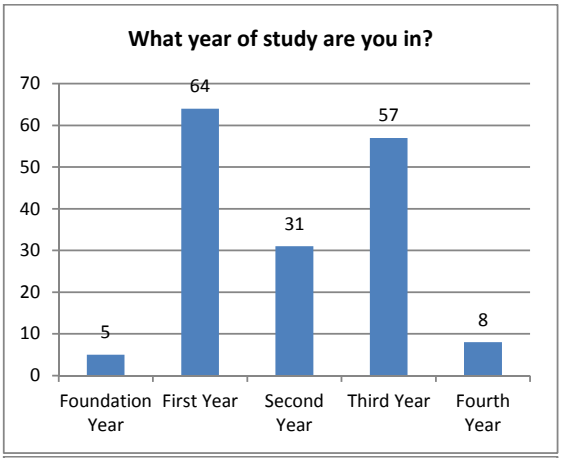
2.3.2 Kia Ora Hauora DHB Survey

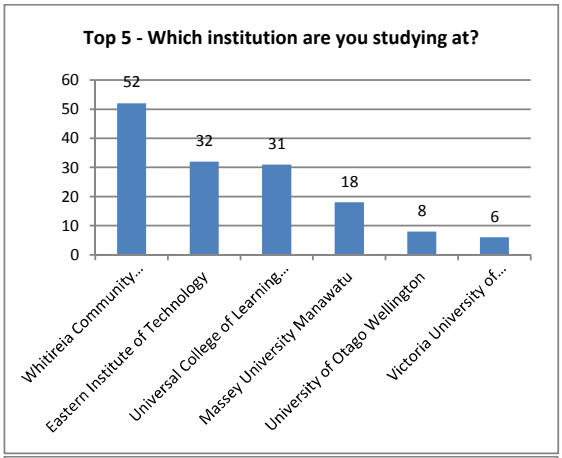
In order to gain a view of our registrants a national survey has been developed to capture tertiary study information and career aspirations. The information for the graphs below is drawn from the national Kia Ora Hauora DHB survey data.

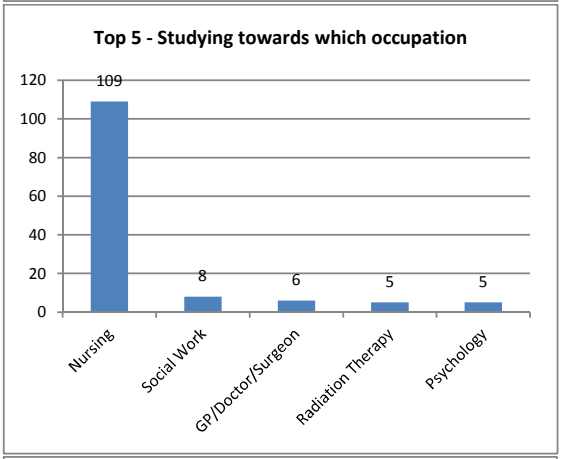
It is important to note that in order to provide a Central Region perspective; the national survey data has been sorted based on the tertiary institute the registrants are attending. As such, any respondent studying at a tertiary institute that is within the Central Region environ has been designated as Central Region. This equated to 188 respondents.

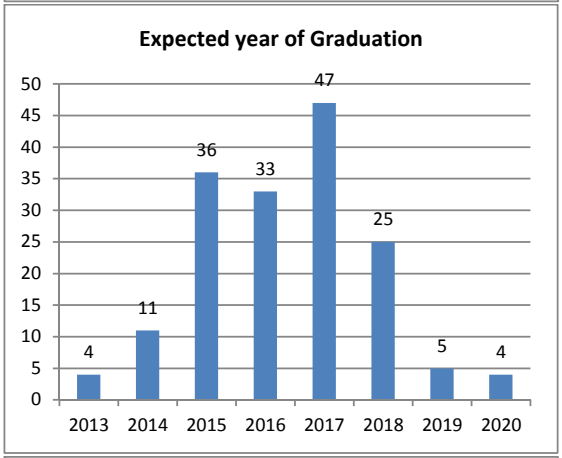
The graphs show:

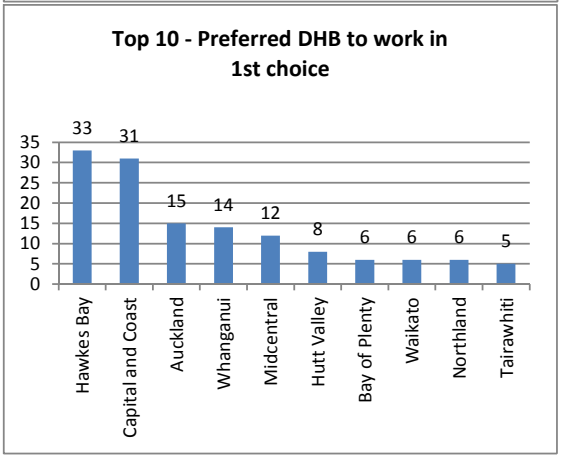
- A significant majority of respondents are well ensconced in tertiary study
- Many are studying undergraduate degrees in 'non-university' institutions
- A significant number are studying Nursing
- The Expected Year of Graduation indicates that we need to consider how we support our registrants in their transition to work in 2017
- In general, it seems the respondents would prefer to work in the DHB where they come from. However, their second choice indicates a more diverse view.

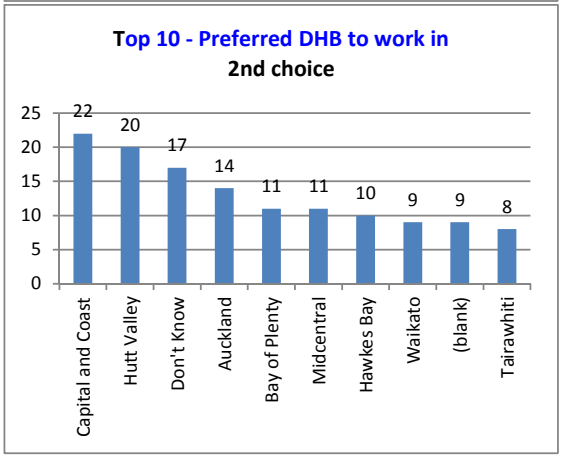

What year of study are you in?
70
60
50
40
30
20
10
0
5
64
31
57
8
Foundation Year
First Year
Second Year
Third Year
Fourth Year


Top 5 - Which institution are you studying at?
60
50
40
30
20
10
0
52
32
31
18
8
6
Whitireia Community...
Eastern Institute of Technology
Universal College of Learning...
Massey University Manawatu
University of Otago Wellington
Victoria University of...


Top 5 - Studying towards which occupation
120
100
80
60
40
20
0
109
8
6
5
5
Nursing
Social Work
GP/Doctor/Surgeon
Radiation Therapy
Psychology


Expected year of Graduation
50
45
40
35
30
25
20
15
10
5
0
4
11
36
33
47
25
5
4
2013
2014
2015
2016
2017
2018
2019
2020


Top 10 - Preferred DHB to work in 1st choice
35
30
25
20
15
10
5
0
33
31
15
14
12
8
6
6
6
5
Hawkes Bay
Capital and Coast
Auckland
Whanganui
Midcentral
Hutt Valley
Bay of Plenty
Waikato
Northland
Tairawhiti


Top 10 - Preferred DHB to work in 2nd choice
25
20
15
10
5
0
22
20
17
14
11
11
10
9
9
8
Capital and Coast
Hutt Valley
Don't Know
Auckland
Bay of Plenty
Midcentral
Hawkes Bay
Waikato
(blank)
Tairawhiti

NZ Police Protocol:
Hand over person to Capital & Coast & Hutt Valley Hospital Emergency Departments (ED)

Person escorted by Police	Blue Boxes	Police Complete	Purple Boxes	ED Complete

Date		Time		
Family Name			DOB	
Given Name(s)				
Address				

Inter-Agency Mental Health Response Units / Staff						
DHB					**Police**	
Hospital	Wellington	Y/N	Lower Hutt	Y/N	Station	
ED Charge / Triage Nurse Name					Officer Name & QID	

Why was person brought to ED?						
Under arrest?	Y/N	INC/OFF Code		INC/OFF Description		
Detained?	Y/N	If detained, what legislation has been used for detention?	s.41 Mental Health (CAT) Act 1992[I]		Y/N	
			s.109 Mental Health (CAT) Act 1992[II]		Y/N	
			s.110C Mental Health (CAT) Act 1992[III]		Y/N	
Other legislation used for detention?	Please specify:					
Physically restrained?	Y/N	If yes state how		Have Police searched patient?	Y/N	
Reason(s) Police give for bringing person to the hospital (brief summary)						

Police handover to ED staff completed	Y/N	Police officer name, QID & signature		ED staff member name & signature	
Job resulted with Police Comms?	Y/N	Police file copy	Please take a photograph of this document for attaching to Police file.		
DHB Comment				NHI Number	
DHB Admin	Please make copy then place original form on patient file. Copy of form to ED for inclusion in clinical notes.				

[i] s.41 MHA: Police assistance to DAO
[ii] s.109 MHA: Police powers in relation to person appearing to be mentally disordered in public place
[iii] s.110C MHA: Police assistance to medical practitioner

New Zealand POLICE
Nga Pirihimana O Aotearoa

MENTAL HEALTH (COMPULSORY ASSESSMENT AND TREATMENT) ACT 1992
SECTION 109 CHECKLIST

All of the below information is to be entered into I/Net against the relevant Comms event.

1. **Was the person found in a public place?**

   If no, Police do not have any power under section 109 to detain the person.
   If no, and if appropriate, officer to ask person to accompany him / her to a place for voluntary assessment or treatment, or to a place of safety.

2. **Is the person exhibiting an abnormal (disordered) state of mind? How?**

   * See below for examples of disordered/abnormal mind as a guide.

3. **Do you consider that the person is a serious danger to themselves or others? If so, why?**

   OR,

   Do you believe that the person's capacity for self-care is seriously diminished? If so, why?

4. **Is it in the interests of this person or the public that they be detained? If so, why?**

ALL FOUR OF THE ABOVE CRITERIA MUST BE MET TO DETAIN UNDER SECTION 109

Subsequent actions:
- Please note in the event log your advice to the Officer.
- Please note in the event log if the officer or DCC called Te Haika for advice (0800 745 477) – if the DCC spoke to Te Haika please note person spoken to and any important comments.

***Examples of abnormal (disordered) state of mind**	
Moving • Lethargic, sluggish movements • Pacing, restless • Self harming **Perceiving** • seeing and hearing things that other people are not (hallucinating) • not hearing or reacting to what is going on **Thinking** • believing in having special powers or being on a mission (delusion) • believing that others want to do them harm or are out to get them (paranoia) • overwhelming preoccupations with death, guilt, failure, etc • confused and disoriented	**Speaking** • very rapid, driven speech • extremely slow speech • talking excitedly or loudly • argumentative • speech jumping from topic to topic with no obvious connection • answers seemingly having little relation to questions asked • talking about harming self or others **Feeling** • emotional reactions that don't seem to fit the situation (e.g. laughing seemingly at nothing) • lack of emotional response • crying / sobbing • agitated or extremely anxious • being high or feeling absolutely great

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New Zealand POLICE
Nga Pirihimana O Aotearoa

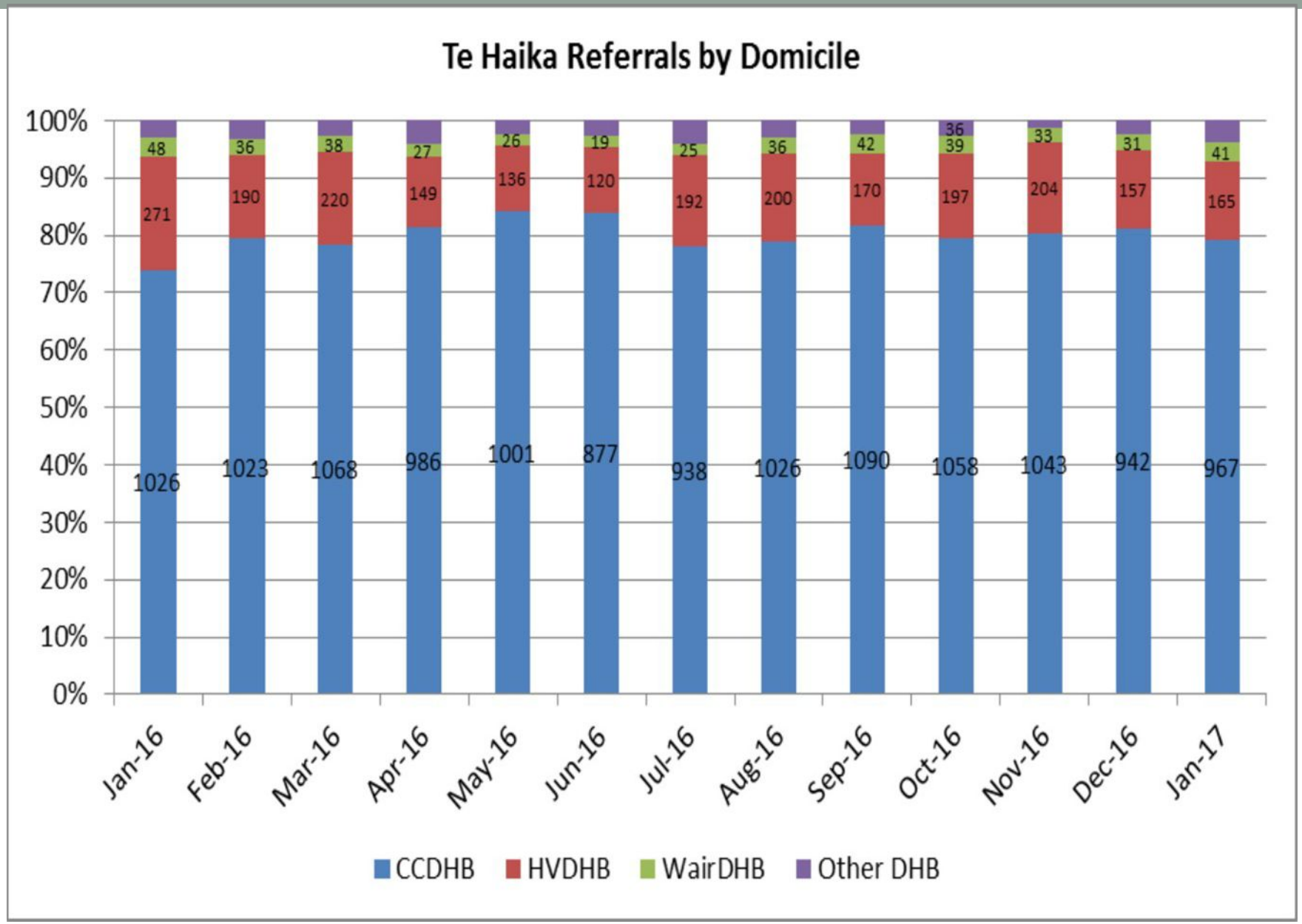
DEFINITION MENTAL DISORDER
Mental Disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it— (a) poses a serious danger to the health or safety of that person or of others; or (b) seriously diminishes the capacity of that person to take care of himself or herself;— Section 2, Mental Health (Compulsory Assessment and Treatment Act 1992)

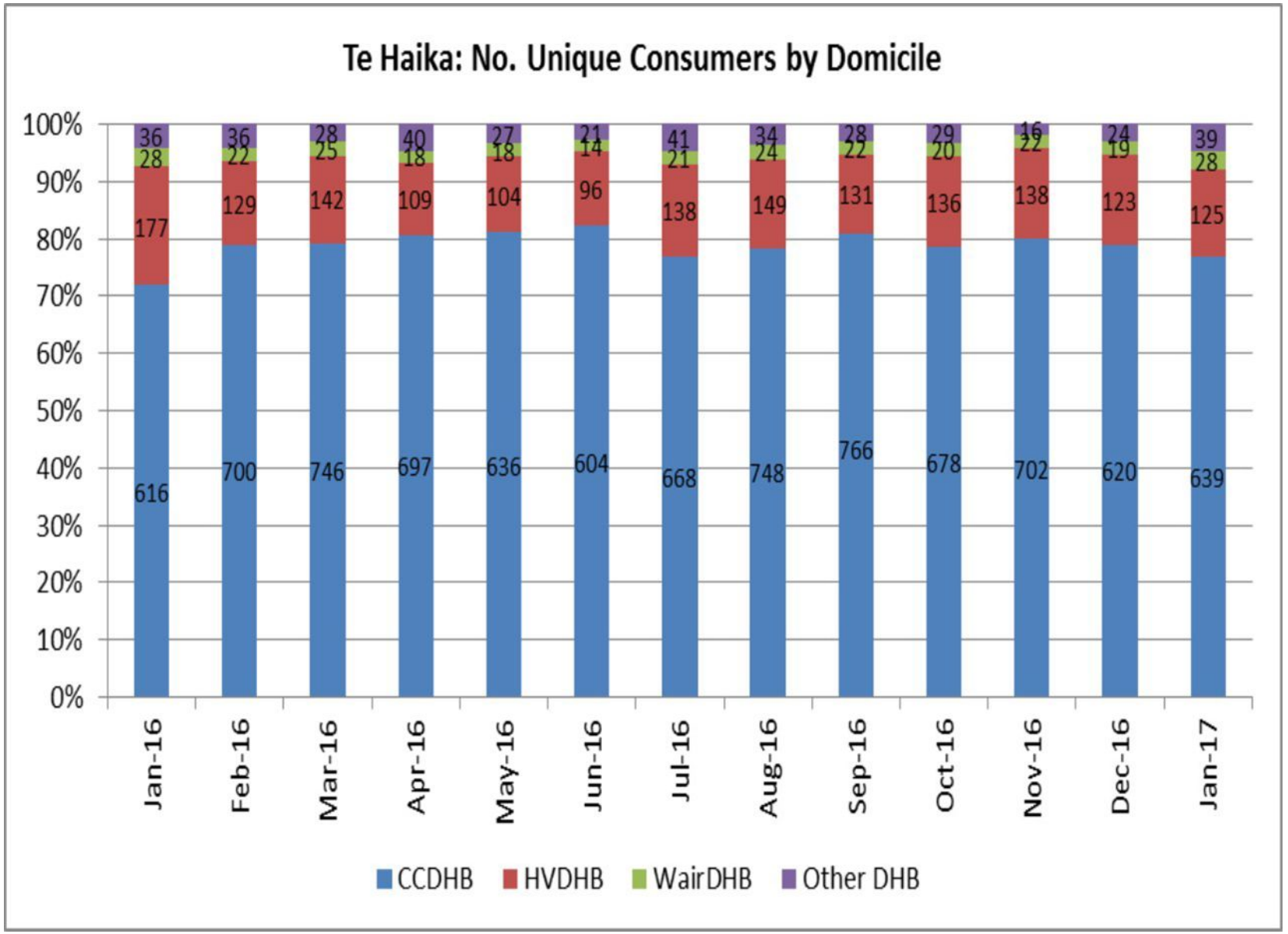
SECTION 109: POLICE POWERS IN RELATION TO PERSON APPEARING TO BE MENTALLY DISORDERED IN PUBLIC PLACE
(1) If any person is found wandering at large in any public place and acting in a manner that gives rise to a reasonable belief that he or she may be mentally disordered, any constable may, if he or she thinks that it would be desirable in the interests of the person or of the public to do so,— (a) take that person to a Police station, hospital, or surgery, or to some other appropriate place; and (b) arrange for a medical practitioner to examine the person at that place as soon as practicable. (2) If the medical practitioner, having examined the person, does not consider that there are reasonable grounds for believing that the person may be mentally disordered, the person shall be released forthwith. (3) Subsection (3A) applies if the medical practitioner, having examined the person, considers that— (a) there are reasonable grounds for believing that the person may be suffering from a mental disorder; and (b) it is desirable for the person to have an assessment examination urgently in the person's own interests or the interests of any other person. (3A) The medical practitioner must, as soon as possible,— (a) issue a certificate under section 8B(4)(b); and (b) make an application under section 8A. (4) Subject to subsection (5), in any case to which subsection (3) applies any constable may— (a) continue to detain the proposed patient at that place until the assessment examination has been conducted; or (b) take the proposed patient to some other place nominated by the medical practitioner for the purpose of an assessment examination, and detain the proposed patient at that other place until the assessment examination has been conducted. (5) Detention under this section may last for no longer than the following times: (a) for the purposes of subsections (1) to (3A), 6 hours or the time it takes to carry out the actions described in those subsections, whichever is shorter: (b) for the purposes of subsection (4), 6 hours or the time it takes to conduct the assessment examination, whichever is shorter.

DRAFT

Te Haika

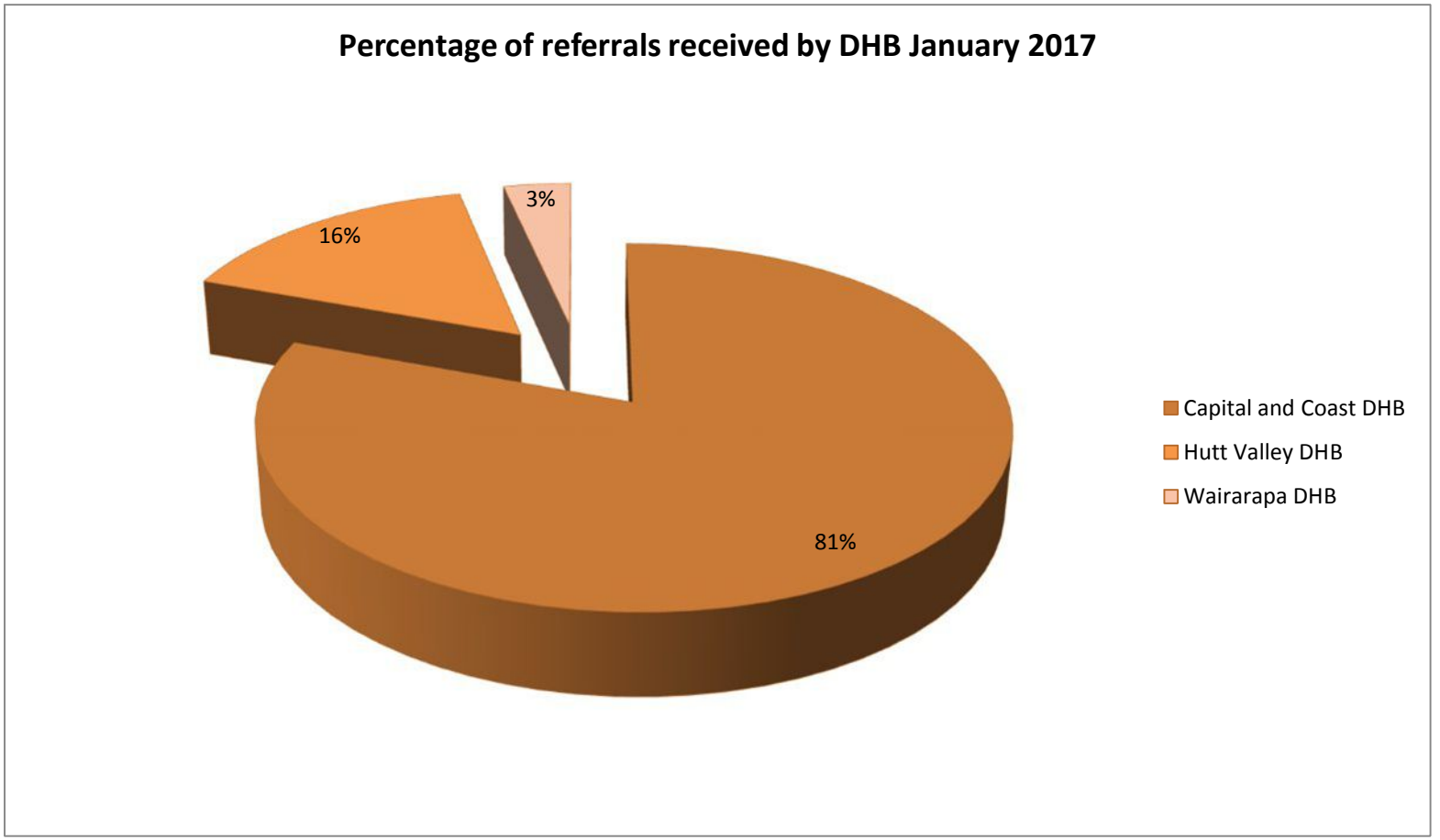
- Telephone call centre
- Operates 24/7, 365 days
- Triaging crisis and acute calls
- Registered Health Professionals
- Managing referrals to MHAID services for Wairarapa, Hutt Valley and Capital and Coast DHBs


Te Haika Referrals by Domicile
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
1026
1023
1068
986
1001
877
938
1026
1090
1058
1043
942
967
271
190
220
149
136
120
192
200
170
197
204
157
165
48
36
38
27
26
19
25
36
42
39
33
31
41
36
CCDHB
HVDHB
WairDHB
Other DHB

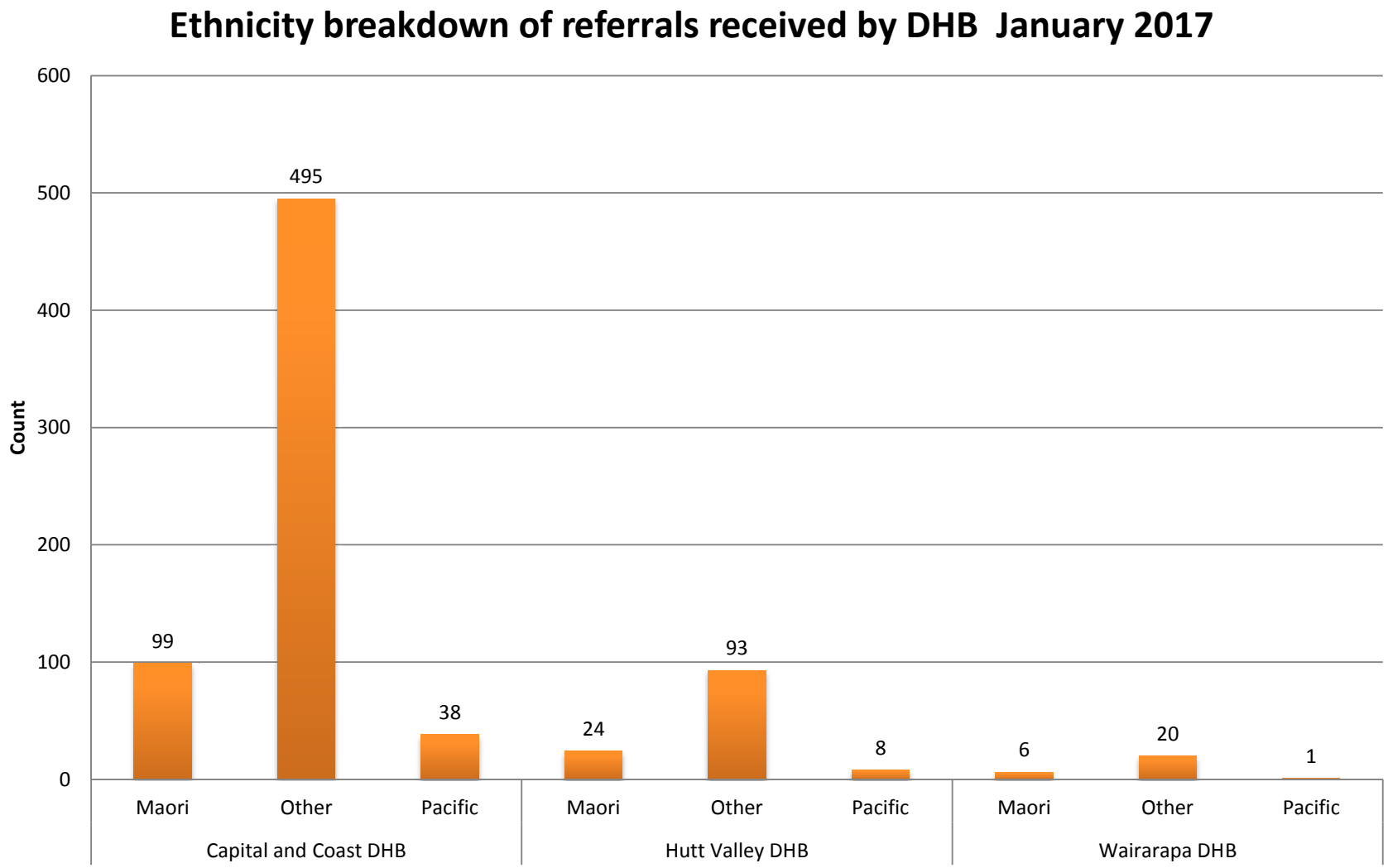

Te Haika: No. Unique Consumers by Domicile
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
616
177
28
36
700
129
22
36
746
142
25
28
697
109
18
40
636
104
18
27
604
96
14
21
668
138
21
41
748
149
24
34
766
131
22
28
678
136
20
29
702
138
22
16
620
123
19
24
639
125
28
39
CCDHB
HVDHB
WairDHB
Other DHB

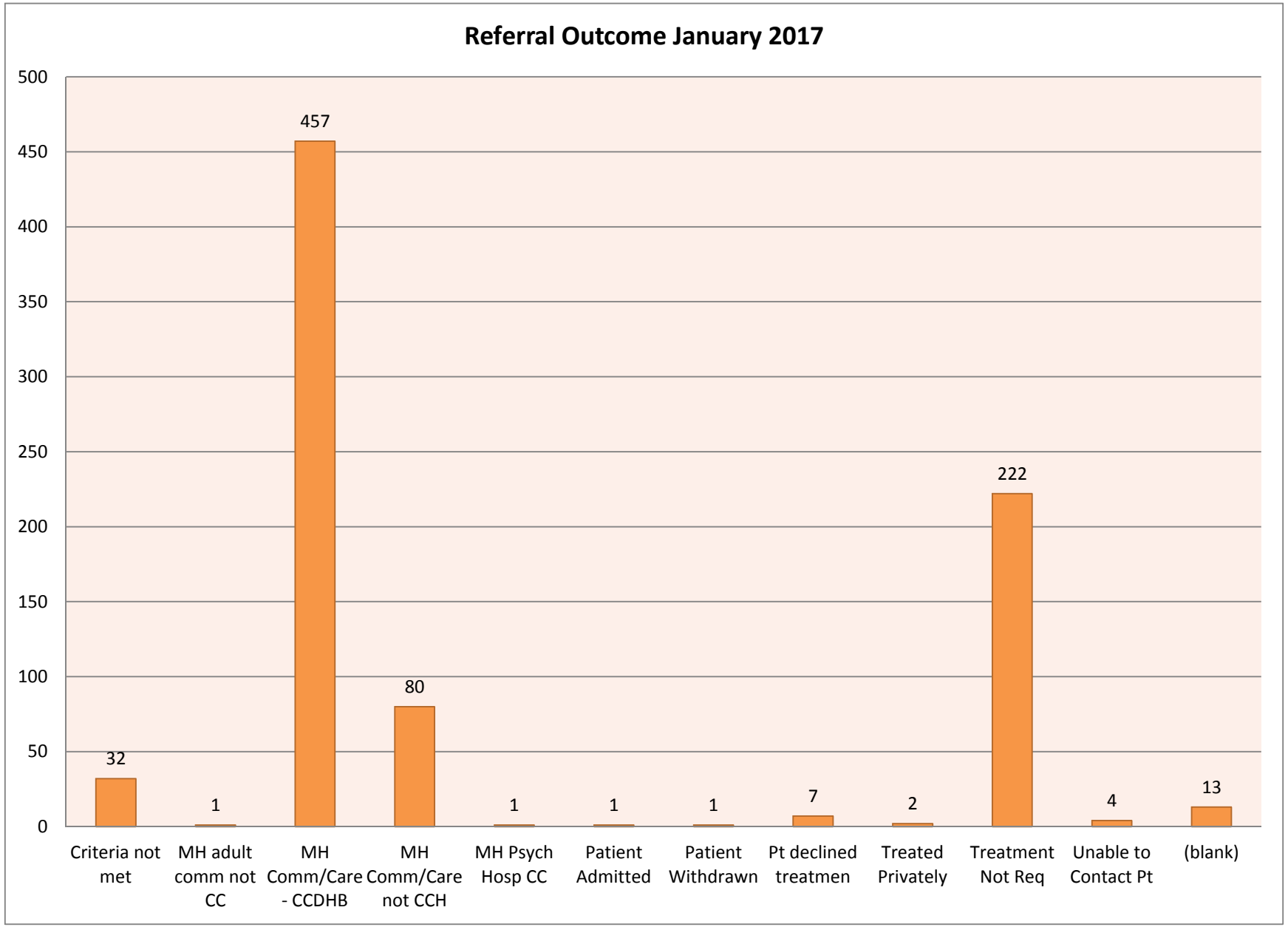
3DHB Data for Te Haika January 2017

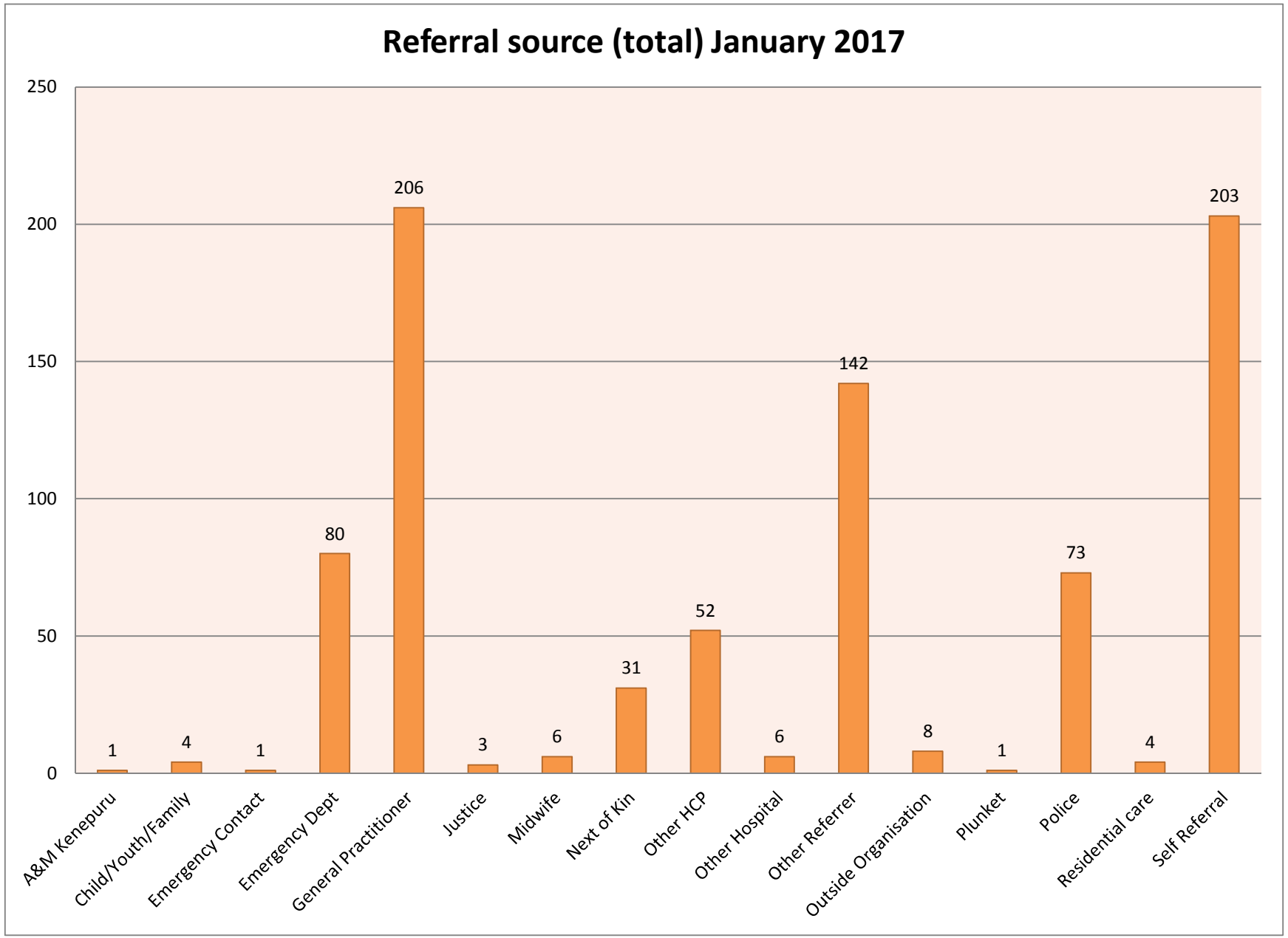
Unique consumers: N= 822



Ethnicity


Ethnicity breakdown of referrals received by DHB January 2017
Count
600
500
400
300
200
100
0
99
495
38
24
93
8
6
20
1
Maori
Other
Pacific
Maori
Other
Pacific
Maori
Other
Pacific
Capital and Coast DHB
Hutt Valley DHB
Wairarapa DHB


Referral Outcome January 2017
500
450
400
350
300
250
200
150
100
50
0
32
1
457
80
1
1
1
7
2
222
4
13
Criteria not met
MH adult comm not CC
MH Comm/Care - CCDHB
MH Comm/Care not CCH
MH Psych Hosp CC
Patient Admitted
Patient Withdrawn
Pt declined treatmen
Treated Privately
Treatment Not Req
Unable to Contact Pt
(blank)


Referral source (total) January 2017
250
200
150
100
50
0
1
4
1
80
206
3
6
31
52
6
142
8
1
73
4
203
A&M Kenepuru
Child/Youth/Family
Emergency Contact
Emergency Dept
General Practitioner
Justice
Midwife
Next of Kin
Other HCP
Other Hospital
Other Referrer
Outside Organisation
Plunket
Police
Residential care
Self Referral

Referral outcome January 2017

Row Labels	Count of NHI
Criteria not met	32
MH adult comm not CC	1
MH Comm/Care - CCDHB	457
MH Comm/Care not CCH	80
MH Psych Hosp CC	1
Patient Admitted	1
Patient Withdrawn	1
Pt declined treatment	7
Treated Privately	2
Treatment Not Req	222
Unable to Contact Pt	4
(blank)	13
Grand Total	821

Priority Response Codes

Count of NHI				
Priority response	Capital and Coast DHB	Hutt Valley DHB	Wairarapa DHB	Grand Total
MH1 Emergency	1	2		3
MH2 Urgent	8	1		9
MH3 Acute	93	28	5	126
MH4 Non-urgent	375	60	9	444
MH5 Co-ordinator Res	118	28	10	156
MH6 Other agency ref	16	3	2	21
MH7 Inconclusive Contact	6	3	1	10
(blank)	15			15
Grand Total	**632**	**125**	**27**	**784**

3DHB Mental Health and Addiction Work Programme – 2017

Version 1 – 7.2.17

Work area	Description/outcome	Lead DHB	Lead/s	Linkages
Investment Strategy	Development of an investment strategy that will identify current and proposed services, programmes, and projects for mental health and addiction 3DHB funding. The strategy will include both 3DHB and specific and/or individual DHB investments. The strategy must also include the Government's emphasis on: Occupation/Employment Housing/homelessness Will need to be reflected in any investment strategy as Te Whare Aramuku is already a success but current investment is limited.	3DHB	SIP	➢ Social Investment strategy (Gov't)
Systems of Care and Support	The emphasis of this project will be on delivering systems focused on improving outcomes for the 3DHB populations, in a viable and sustainable way. These cover elements of the entire health, disability and social sectors e.g. current policy directions, models of care, service delivery models and key partnerships.	3DHB	SIP MHAIDS	➢ Social Investment ➢ Investment strategy ➢ Quality improvement programme
Services of focus	Some service areas which require immediate focus for 2017 have been identified as: NGO - 3DHB Youth respite – HVDHB Primary Mental Health -3DHB Primary Health ICAFS – HVDHB AOD review – Wairarapa DHB Advocacy RFP - CCDHB Acute Alternatives to hospitalisation(Te Whare Ahuru – HVDHB "Silent Clients" link to SACAT- HV/CCDHB BAU continues with carry-over of key projects e.g. SACAT etc.	SIP	SIP/ MHAIDS	➢ Quality improvement programme review ➢ Investment strategy
One Client Record	The focus here is not necessarily on the availability of an "electronic" record but a single client record which follows that client across all health and disability services.	3DHB	ICT/ MHAIDS	➢ Quality improvement programme review
Client Pathways	Development of a client pathway has started. It will reflect the process of care that those using services should expect to receive, as well as being a tool to manage the quality of health care where a standardised care process should be in place.	3DHB	MHAIDS	➢ Quality improvement programme review
Social Investment	The Government's Social Investment Approach is aimed at improving the lives of New Zealanders by applying rigorous and evidenced based investment practices. While the emphasis is on "social services" this approach goes across all government	3DHB	SIP	➢ Investment Strategy ➢ Treasury ➢ Better Public Service

	funded services. Much of the focus is expected to be on early investment to achieve better long-term results for people and helping them to become more independent.			
Infrastructure	This work area relates to the ability to forge towards a single 3DHB set of processes for all Mental Health and Addiction funded services.	3DHB	MHAIDS / SIP	
Quality Systems	The quality of the systems we operate must be underpinned by the quality of our management tools, managers, leadership, culture, and performance management.	3DHB		➢ Quality improvement programme review

Decision Support Unit

Execution DateTime: 24/02/2017 12:30:11

Mental Health, Addictions & Intellectual Disability Service 3DHB

Balanced Score Card - January 2017

(FY 2016/2017)

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa | Hutt Valley DHB | Capital & Coast District Health Board Poho ki te uru hauora

Patient Experience

	Target	Local/Sub-Regional Services: WDHB	HVDHB	CCDHB	Te Korowai-Whāriki: Forensic & Rehab	ID Services	MHAID 3DHB: Jan-17	Total YTD
28 Day acute readmissions rate - adult acute units (%)[1]	10%	NA	10%	15%	NA		12%	14%
Long-term consumers with a current wellness plan(%)[2]	95%	NR	64%	37%	38%	0%	NA	NA
Better help for inpatient smokers to quit (%)	95%	NA	100%	96%	100%	NA	97%	93%
HoNOS compliant inpatient discharges - matched pairs (%)	80-100%		83%	53%	29%	NA	64%	62%
HONOS compliance - Community (%)	80-100%	75%	47%	61%	18%	41%	55%	56%
Consumer death by suspected suicide (n)		0	1	0	0	0	1	16
SAC 1 & 2 (n)		0	1	1	0	0	2	21
All reportable events (n)	NA	1	39	93	153	86	372	2552
Medication errors (n)		0	0	8	4	2	14	126
Complaints (n)		0	4	5	6	1	16	108
Complaints resolved within 30 days (%)[1]	100%	NA	100%	100%	100%	NA	100%	55%
Health & Disability Commission Complaints (n)		0	2	0	0	0	2	6
Compliments count (n)		0	0	0	0	0	0	10
Personal restraints count (n)		0	9	12	8	1	30	222
All consumers under Section 11 to Section 15 (n)		5	43	89	15	NR	152	954
All consumers under Compulsory Treatment Order (n)	NA	40	97	395	88	8	628	1387
Maori under Community Treatment Order (n)		19	25	101	42	4	191	422
Seclusion hours per 100,000 pop			344.52	13.95	22.64	16.78		
Seclusion hours per 100,000 pop - Maori		NA	328.00	120.59	0.00	0.00	NA	NA
Seclusion hours per 100,000 pop - Pacific			1890.91	0.00	117.02	0.00		

Healthy Workforce

	Target	WDHB	HVDHB	CCDHB	Forensic & Rehab	ID Services	Jan-17	Total YTD
Staff turnover(Headcount)-YTD average annualised(%)[1]	8-10%	9%	20%	11%	8%	8%	NA	11%
Sick leave (%)[1]	2-4%	2.0%	4.1%	2.4%	3.7%	3.4%	3.1%	4.0%
Staff with annual leave > 200 hours (n)[1]	NA	2	51	163	81	60	357	NA
Physical assaults on staff (n)		0	2	0	10	0	12	133
Performance appraisals completed (%)[1]	100%	29%	9%	25%	42%	26%	27%	29%

Financial

	Target	WDHB	HVDHB	CCDHB	Forensic & Rehab	ID Services	Jan-17	Total YTD
Operating (actual) costs ($'000)			1,819	6,494	2,304	945	11,563	82,745
Personnel including outsourced ($'000)			1,442	4,392	2,207	908	8,949	63,128
Overtime hours (%)	NA		2.5%	3.0%	3.3%	1.4%	2.8%	2.8%
FTEs - actual			153	538	341	152	1,185	6,133
FTEs - vacancies[1]		NR	NR	NR	NR	NR	NR	NA

Productivity

	Target	Local/Sub-Regional Services: WDHB	HVDHB	CCDHB	Te Korowai-Whāriki: Forensic & Rehab	ID Services	MHAID 3DHB: Jan-17	Total YTD
Access rate (%)[3]	3%	5%	4%	3%	NA		4%	NA
Acute Adult Inpatients ALOS (days)	14-21		0	14			1	5
ALOS Adolescent Unit (days)				15				20
ALOS Psychogeriatric Unit (days)				33	NA			47
ALOS Eating Disorders Inpatient Unit (days)								16
ALOS Regional Rehabilitation Units (days)	NA		NA		823		NA	438
ALOS Adult Forensic Inpatient Units (days)					121			161
ALOS Adult Intellectual Disability Unit (days)						NA		564
ALOS Youth Intellectual Disability Unit (days)						NA		557
Adult Inpatient Units Occupancy (%)	85%		95%	92%			93%	88%
Adolescent Unit Occupancy (%)				61%				71%
Psychogeriatric Unit Occupancy (%)				87%	NA			84%
Eating Disorders Unit Occupancy (%)			52%					72%
Regional Rehabilitation Units Occupancy (%)	NA		NA		95%		NA	93%
Adult Forensic Inpatient Units Occupancy (%)					100%			98%
Adult Intellectual Disability Unit Occupancy (%)					NA	65%		77%
Youth Intellectual Disability Unit Occupancy (%)						69%		73%
Pre-admission community care (%)[1]	75-100%	NA	76%	65%			70%	55%
Post-discharge community care (%)[1]	90-100%		56%	56%	NA		56%	62%
Consumer related time - child and youth (%)[1]	30-40%	NR	NR	19%	11%		18%	22%
Consumer related time - adults (%)[1]	35-40%	NR	NR	17%	3%	14%	15%	18%
Community treatment days per quarter (days)[1]	10-20	NR	NR	3	2	3	2	3
Wait-time < 3 weeks - child and youth (%)[3]	80%	80%	34%	49%	98%	NA	52%	
Wait-time < 8 weeks - child and youth (%)[3]	95%	95%	65%	83%	100%		80%	NA
Wait-time < 3 weeks - adult (%)[3]	80%	83%	78%	50%	97%	48%	68%	
Wait-time < 8 weeks - adult (%)[3]	95%	97%	96%	83%	99%	89%	91%	
Community DNA rate (%)[1]*		8%	11%	6%	3%	4%	7%	8%
Community DNA rate - Maori (%)[1]*	NA	13%	16%	9%	5%	10%	11%	10%
Community DNA rate - Pacific (%)[1]*		44%	13%	5%	4%	0%	7%	10%
Case load consumer participation in last 90 days (%)	95%	95%	83%	86%	69%	82%	85%	87%

Key

- Mental Health & Addiction Services Benchmarking Programme KPI
- National health target
- Health Quality and Safety Commission KPI
- MoH performance measure or Maori Health Measure
- Key Issue
- Alert
- Good News

[1] One month lag

[2] Different measures so not comparable

[3] Rolling year, 3 month lag (MoH Report)

NR Not reported, under development

NA Not applicable

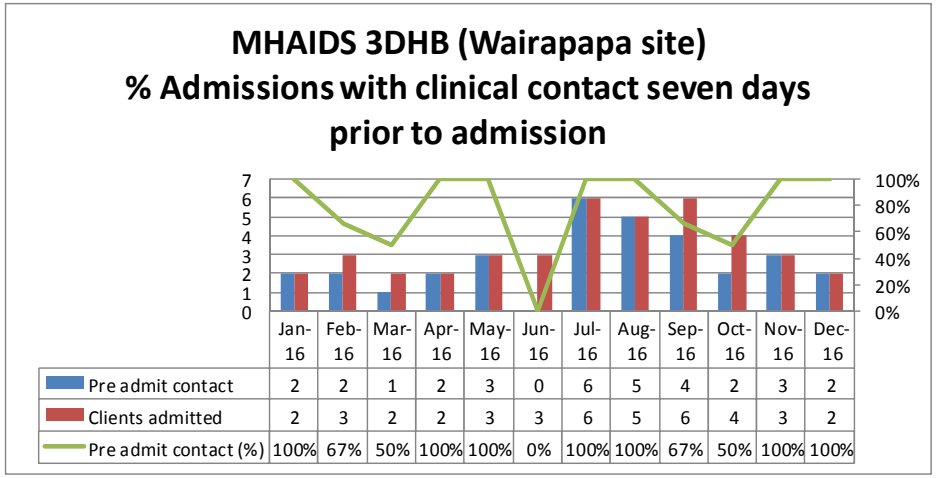
* Not comparable with 3DHB measure

▲ Increased compare to previous month

▼ Decreased compare to previous month

Te-Upoko-me-te-Whatu-o-Te-Ika
Mental Health, Addictions & Intellectual Disability Service 3DHB

January 2017 Pre Admission and Post Discharge Contact - Wairarapa site*



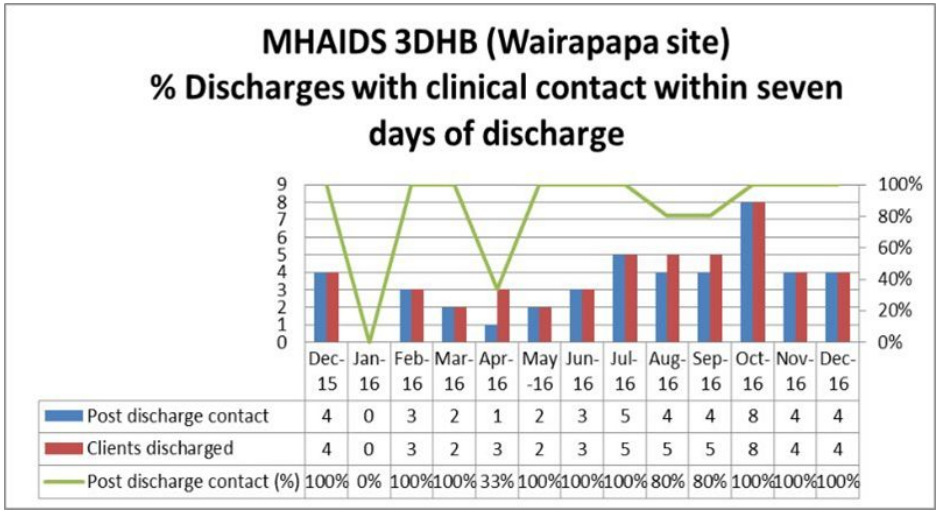
	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Pre admit contact	2	2	1	2	3	0	6	5	4	2	3	2
Clients admitted	2	3	2	2	3	3	6	5	6	4	3	2
Pre admit contact (%)	100%	67%	50%	100%	100%	0%	100%	100%	67%	50%	100%	100%

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.



	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Post discharge contact	4	0	3	2	1	2	3	5	4	4	8	4	4
Clients discharged	4	0	3	2	3	2	3	5	5	5	8	4	4
Post discharge contact (%)	100%	0%	100%	100%	33%	100%	100%	100%	80%	80%	100%	100%	100%

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.

Report **33** March 2017

PATIENT EXPERIENCE

Summary Report: Capital and Coast District Health Board

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

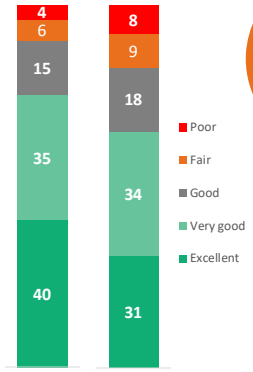
In focus: Coordination between hospital and home

Coordination prior to admission and after discharge

Three-quarters of patients rate our coordination between home and hospital **prior to admission** as very good (35%) or excellent (40%).

Patient ratings are not as high **after discharge**; one in six patients (17%) tell us the coordination between home, hospital and other services is either poor or fair.

There has been no change on either of these measures between 2016 and 2017



Before discharge n=2275
After discharge n=2290

"I wasn't told how to take the pain relief. I got three different ones and no one told me when to take which." [Rated poor 0-4]

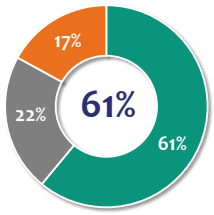
"Not being explained what process would be after I left hospital being told I had to inject myself for 7 days and not been shown the correct ways in doing it just given a booklet and sent on my way home. I had to follow up with gp nurse to show me how. Things should be clearly explained and be transparent." [Rated moderate 5-7]

Coordination matters

One in 10 CCDHB patients (10%) say that **coordination between home and hospital** is one of the three things that makes the most difference to their care and treatment.

How do we rate?

Patients who say coordination between home, hospital and other services is important to them don't tend to rate our performance particularly highly when compared with other measures, with only six out of ten rating our coordination as "very good."

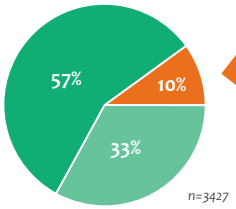


I was given a summary letter of my hospital stay. It states my condition upon arrival, tests performed and pertinent results and medications given ... This has allowed me to reflect on the hospital experience and my illness in a positive light as I can tell how thoroughly I was treated [Rated very good 8-10].

Preparation for leaving hospital

Most patients tell us they felt well prepared for leaving hospital. A small but significant minority, however, tell us they were not sufficiently prepared to leave hospital.

There has been no change on this measure between 2016 and 2017

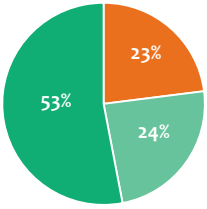


n=3427

One in ten patients tell us they were not given information about what they should or should not do, any danger signals to watch for and who to contact if they were worried about their condition or treatment after leaving hospital.

Medication side effects

About half of all patients say they were not fully informed or told about medication side effects to watch out for when they went home.



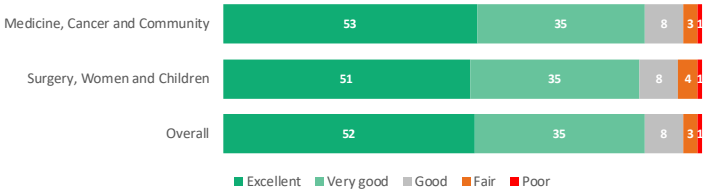
n=1913

How are we doing?

Overall ratings by Health Service Group

More than 10,700 patients have responded to our patient experience survey over the past four years.

Between February 2016 and January 2017, 87% of patients rated our care as either "very good" or "excellent".



Overall n=3446; Medicine, Cancer and Community n=1174; Surgery, Women and CHildren n=2271

The CCDHB In-Patient Experience Survey is online. An email containing a survey link is sent to patients between one and two weeks after they have been discharged from hospital. They are asked about their most recent experience in hospital.

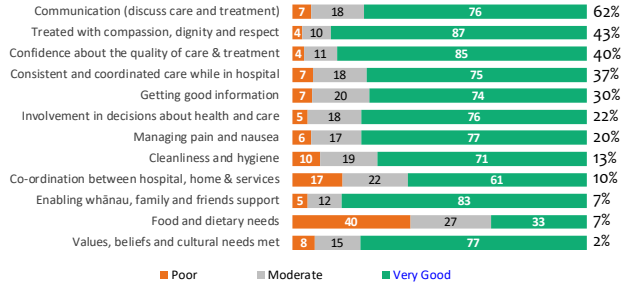
This report is prepared independently of CCDHB by Point and Associates Limited.

For more information on the patient experience survey, contact Catherine Gibson, feedback@ccdhb.org.nz or (04) 806 0724

How patients rate what matters

Respondents to the CCDHB Patient Experience Survey are asked to nominate three things they feel make the most difference to their care and treatment. They are then asked to rate CCDHB's performance on the three things that are most important to them, on an 11-point scale where 0 is `poor' and 10 is `excellent'..

The graph below ranks the dimensions of care in order of what matters most to patients and shows how they think we are doing on each of those dimensions. The percentages of patients who say that each dimension makes a difference to their care and treatment are listed next to each.



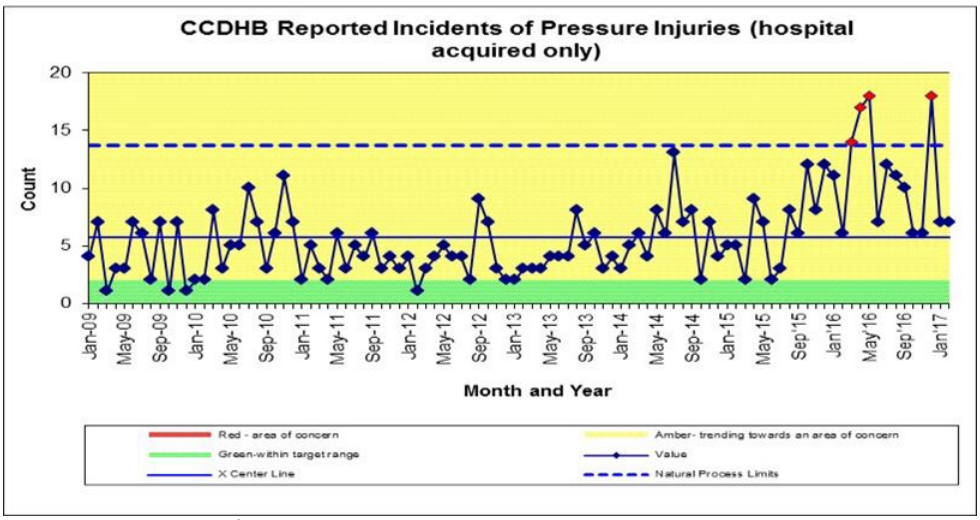
Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Monthly update of Clinical & Quality Measures

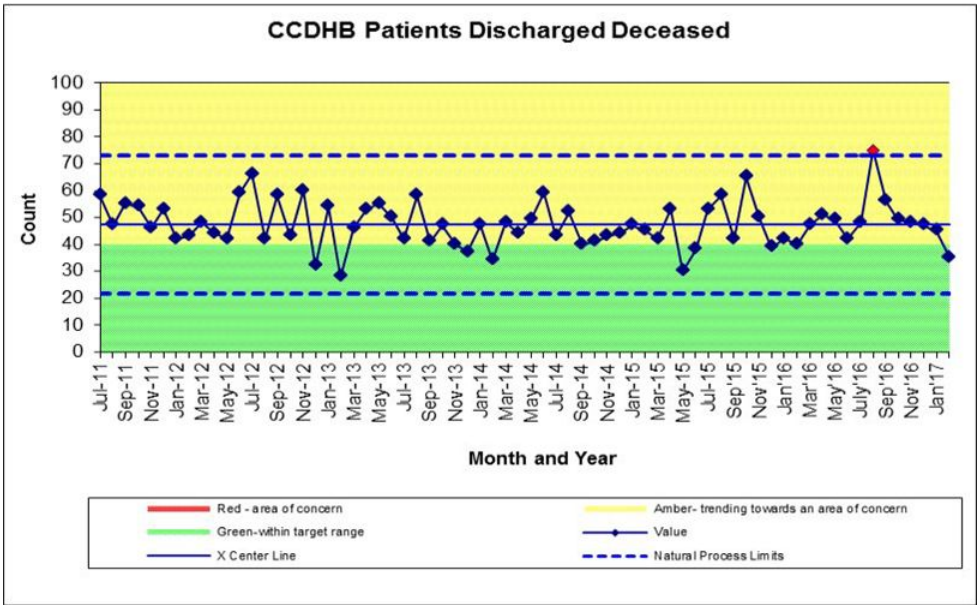
3 March 2017

SUMMARY

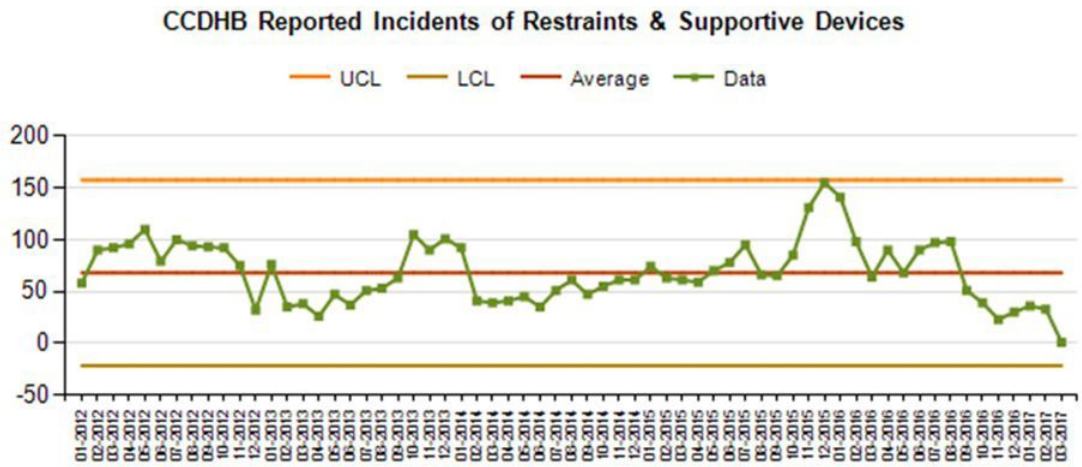
Out of the 13 clinical and quality measures there are no measures showing special cause variation.



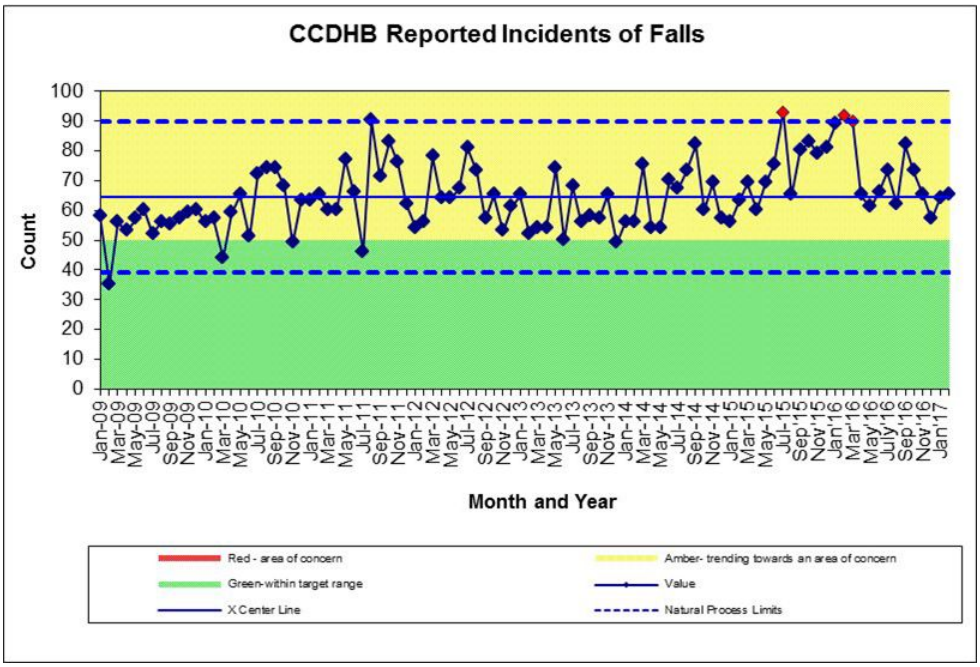
Definition: A count of the number of all Pressure Sores / Ulcers that were acquired onsite reported in the Reportable Events system.
Data source: DSU dashboard, Reportable Events, Reportable Events Monthly Report



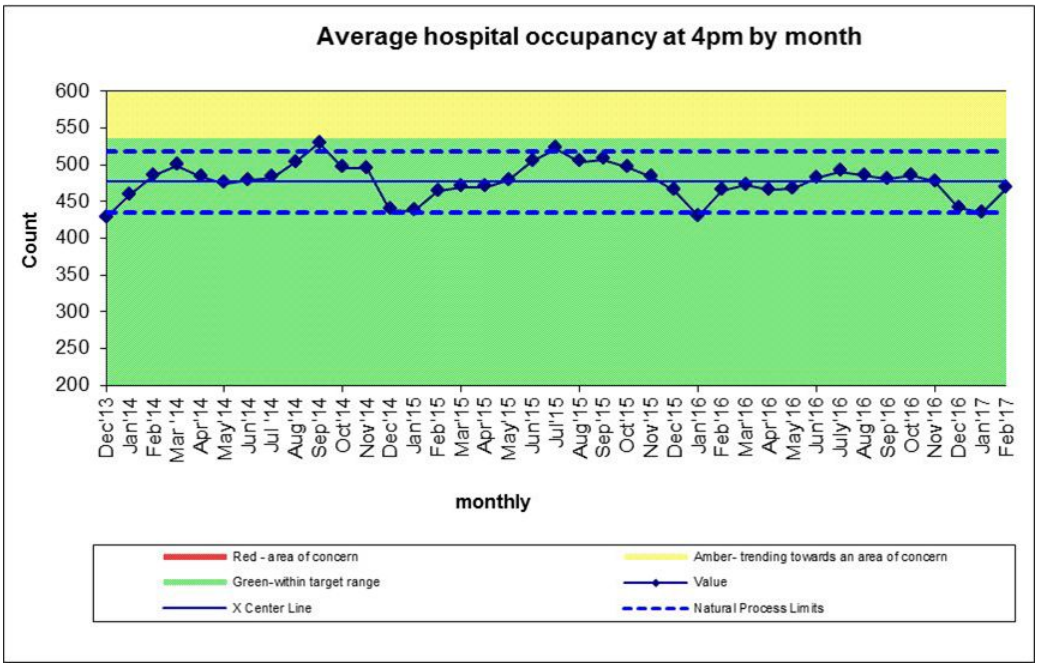
Definition: A count of the number of deaths within the hospitals per month recorded in the DSU database.
Data source: DSU dashboard, Corporate Reports, CPR Clinical Measures



Definition: A count of the number of uses of Restraints or Supportive Devices reported in the Reportable Events system.
Data source: DSU dashboard, Reportable Events, Reportable Events Monthly Report

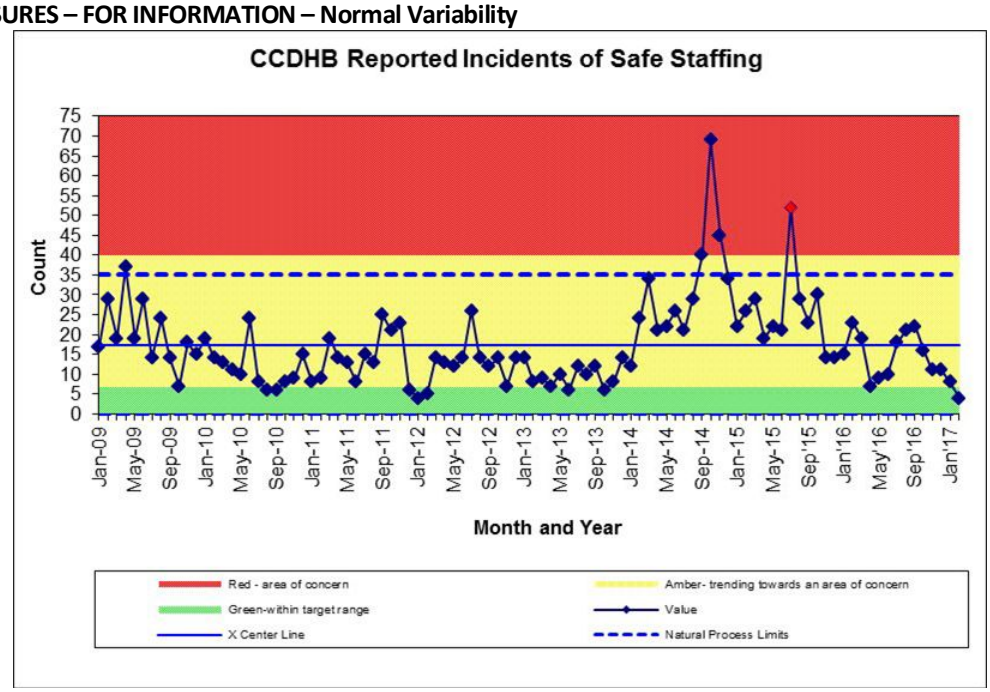


Definition: A count of the number of all falls reported in the Reportable Events system.
Data source: DSU dashboard, Reportable Events, Reportable Events Monthly Report

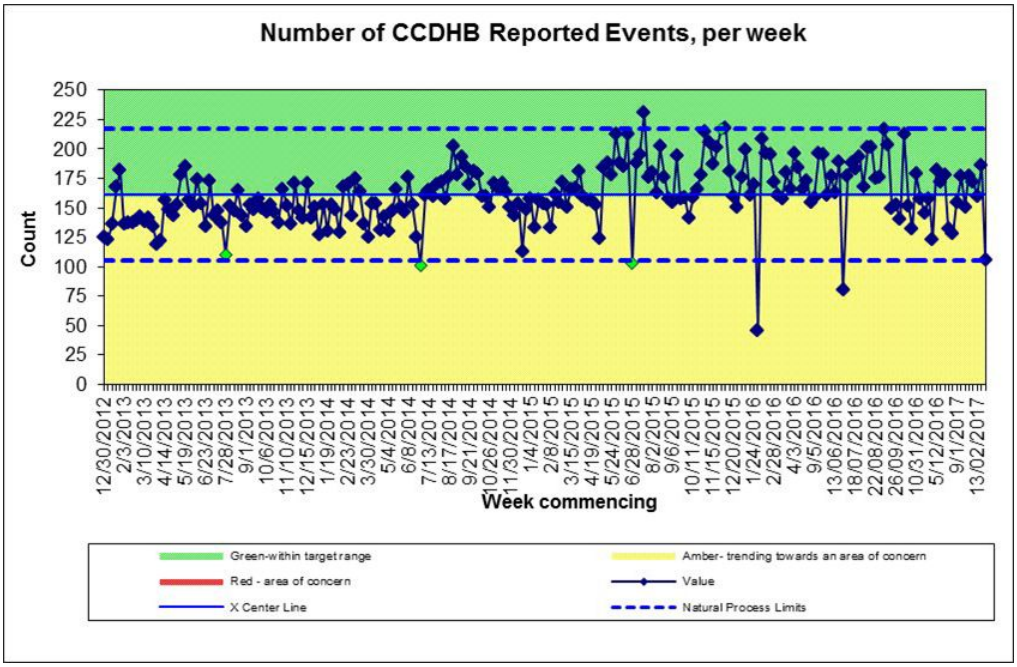


Definition: An average monthly number of occupied beds at 4pm each day including Wellington 1, 2 & Kenepuru locations.
WLG1 = SSU, SAPU, MAPU, 4NG, 5NW, 5SW, 6NW, 6SW, 7NW, 7SW, SSR, ICU, WLG2 = DLV, 4NM, NCU, WRD1, WRD2, IRW, MHW, MHT Kene = WRD5, DTX, WRD6, WRD7, KSU, RaUTA, KMU, PMU. Data source: DSU dashboard, Corporate Reports, CPR Clinical Measures

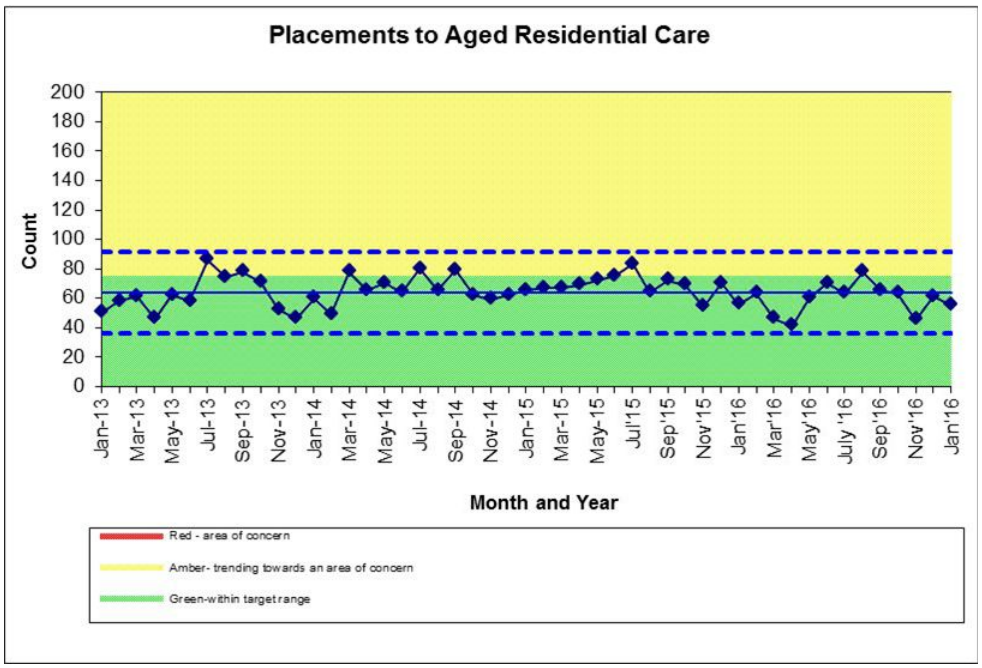
CLINICAL MEASURES – FOR INFORMATION – Normal Variability



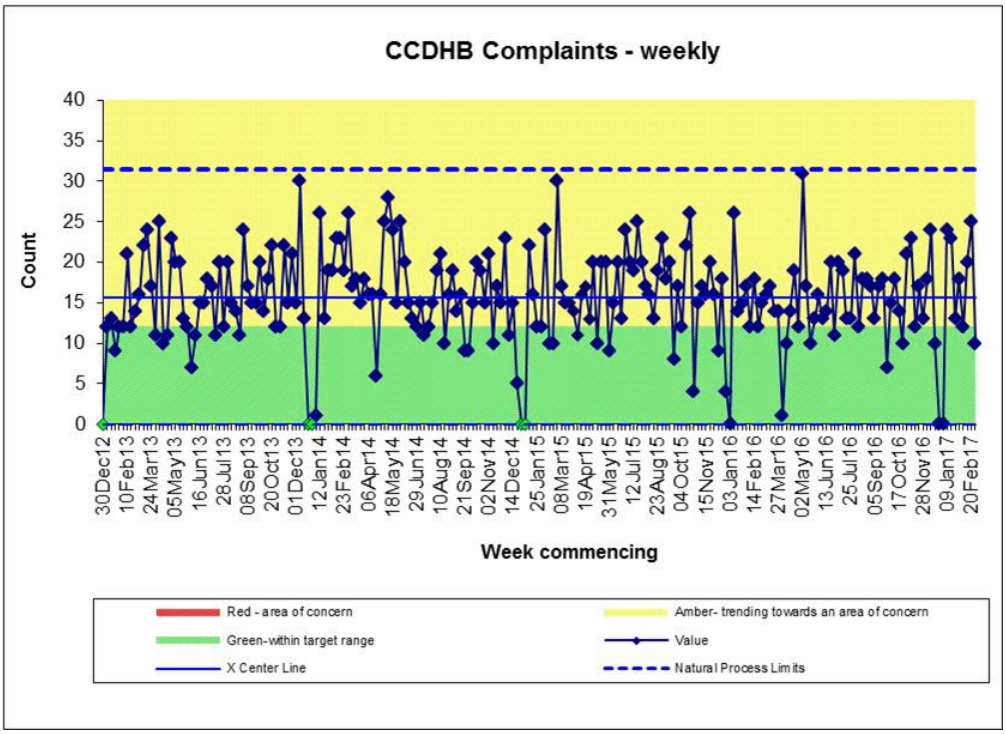
Definition: A count of the number of uses of Safe Staffing incidents (harm to staff) reported in the Reportable Events system.
Data source: DSU dashboard, Reportable Events, Reportable Events Monthly Report



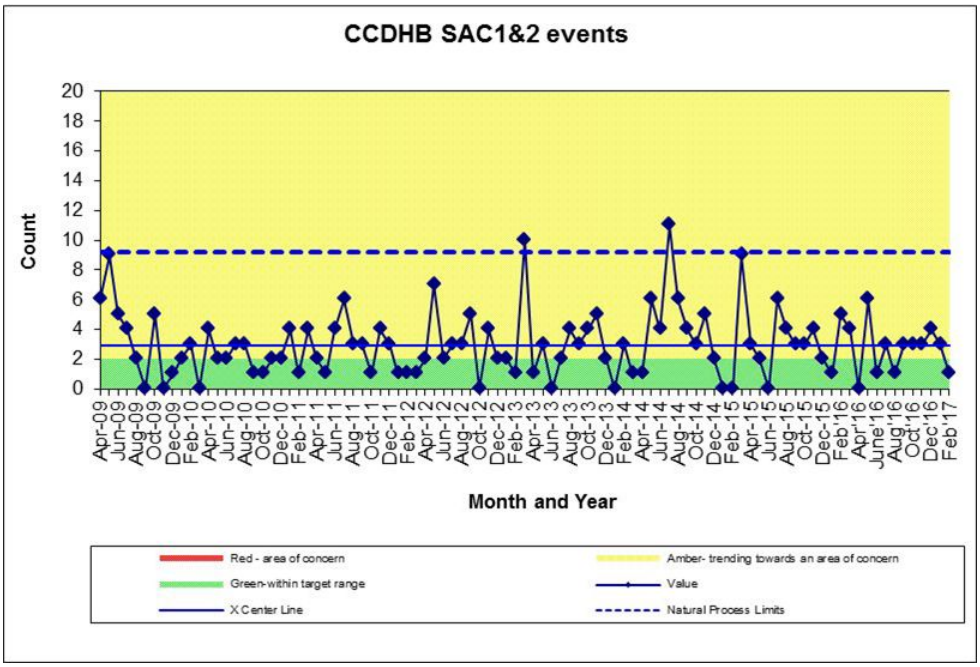
Definition: A count of the number of all reported events captured
Data source: DSU dashboard, Corporate Reports, CPR Clinical Measures



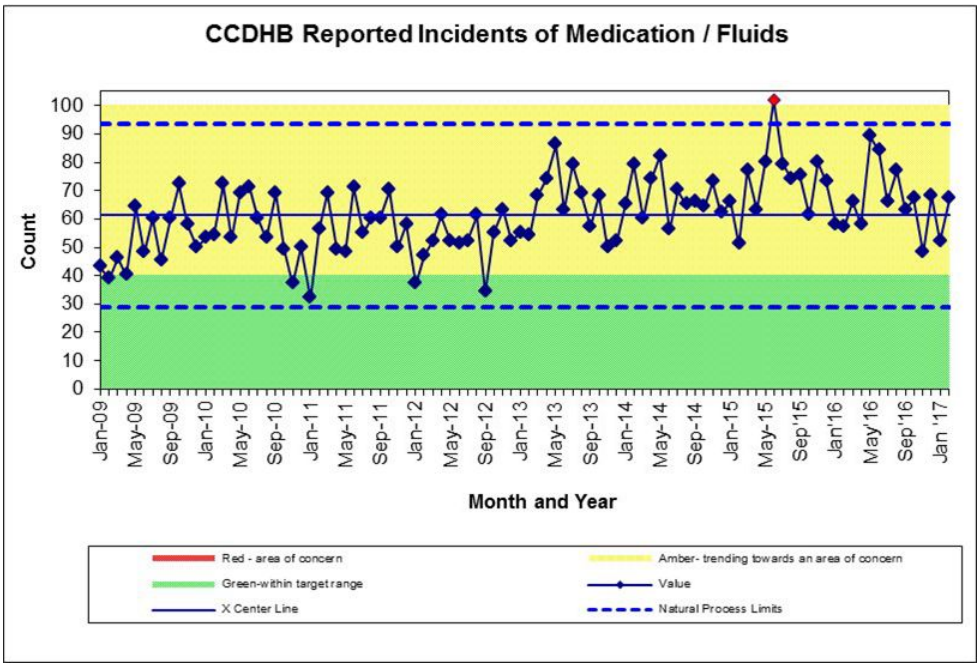
Definition: As CCDHB data was significantly different compared to the sub region the data set was reviewed and found that the data reflected changes in level of care (person already in Aged Residential Care (ARC) moves from Rest Home level care to hospital level or dementia care) as well as new entrants to ARC. This data set has now been refined to reflect only new entrants to ARC and the control chart updated from Jan 2013 accordingly to reflect this".
Data source: SIDU. Please note that this data will always be reported 2 months in arrears i.e. reporting on August figures in October.



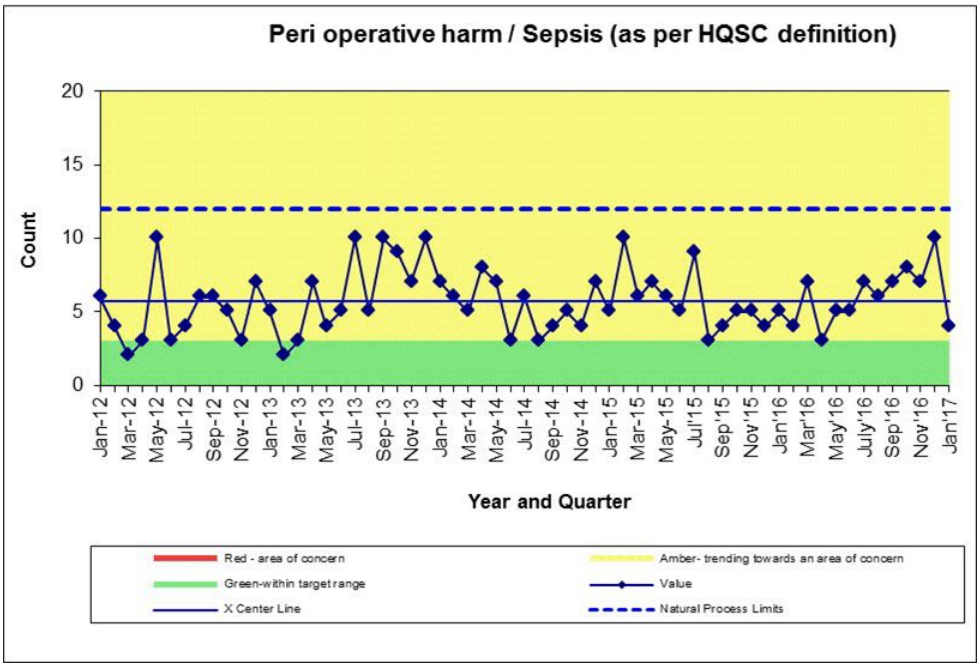
Definition: A count of the number of complaints received and recorded per week by the Quality & Risk team.
Data source: DSU dashboard, Corporate Reports, CPR Clinical Measures



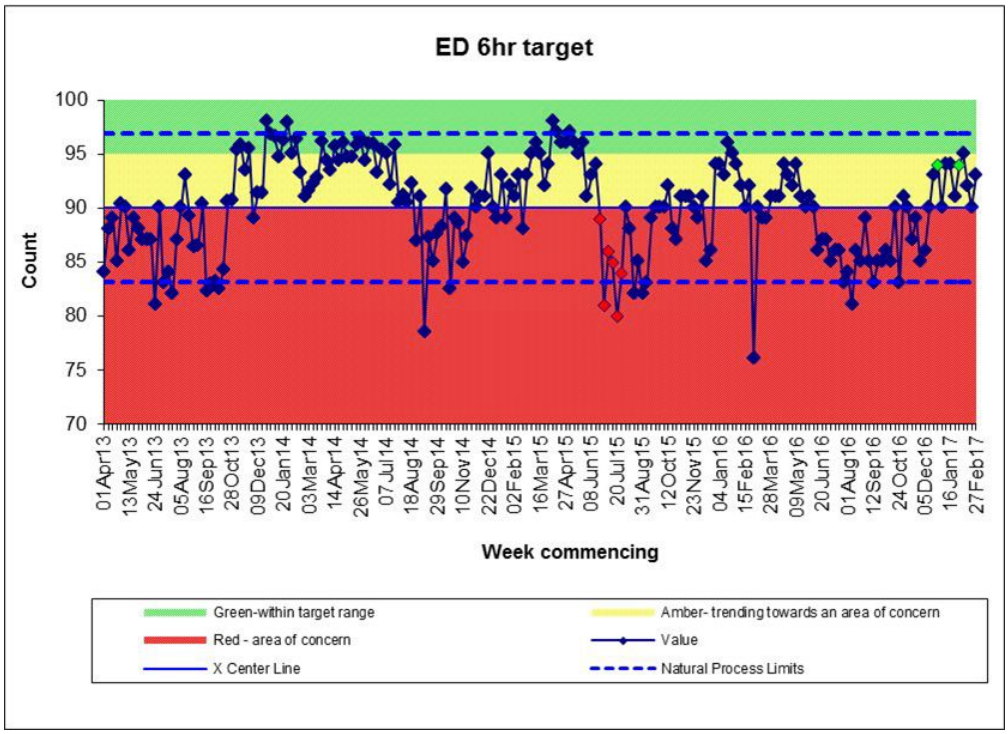
Definition: A count of the number of SAC 1&2 events that have been reviewed and reported by the CCDHB Patient Safety Office per month.
Data source: CCDHB Patient Safety Officer monthly report.



Definition: A count of the number of all Medication and Fluid reported in the Reportable Events system.
Data source: DSU dashboard, Reportable Events, Reportable Events Monthly Report



Definition: A count of the number of peri operative harm events according to the definition used by HQSC. Data is now available monthly within CCDHB.
Data source: DSU dashboard that replicates HQSC definition.
Please note that this data will always be reported 2 months in arrears i.e. reporting on August figures in October.



Definition: The target is 95% of patients are admitted, discharged or transferred from ED within 6 hours.
Data source: DSU dashboard, ED Measures