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Committee Members
- Barbara Robson (Chair)
- Lindsay Burnell (Deputy Chair)
- Kate Joblin
- Karen Naylor
- Phil Sunderland (ex officio)
- Dennis Emery
- Duncan Scott
- Cynric Temple-Camp
- Vacancy

Board Members
- Diane Anderson
- Adrian Broad
- Barbara Cameron
- Ann Chapman
- Nadarajah Manoharan
- Oriana Paewai

Management Team
- Kathryn Cook, CEO
- Mike Grant, General Manager, Clinical Services & Transformation
- Neil Wanden, General Manager, Finance & Corporate Support
- Jill Matthews, PAO
- Carolyn Donaldson, Committee Secretary
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Next Meeting Date: 7 June 2016
Deadline for Agenda Items: 20 May 2016

MIDCENTRAL DISTRICT HEALTH BOARD

A g e n d a

Hospital Advisory Committee

Part 1

Date: 26 April 2016

Time: 8.45 am

Place: Board Room
Board Office
Heretaunga Street
Palmerston North

MIDCENTRAL DISTRICT HEALTH BOARD

Hospital Advisory Committee Meeting
26 April 2016

Part 1

Order

1. APOLOGIES

2. LATE ITEMS

3. CONFLICT AND/OR REGISTER OF INTERESTS UPDATE

3.1. Amendments to the Register of Interests

3.2. Declaration of conflicts in relation to today's business

4. MINUTES

Pages: 1 - 7
Documentation: minutes of 15 March 2015
Recommendation: that the minutes of the previous meeting held on 15 March 2015 be confirmed as a true and correct record.

4.1. Recommendations to Board

To note that the Board approved all recommendations contained in the minutes.

5. MATTERS ARISING FROM THE MINUTES

To consider any matters arising from the minutes of the meeting held on 15 March 2015 for which specific items do not appear on the agenda or in management reports.

6. 2015/16 WORK PROGRAMME

Pages: 8 - 13
Documentation: Acting Chief Executive Officer's report dated 18 April 2016
Recommendation: that the updated work programme for 2015/16 be noted.

7. STRATEGIC PLANNING

7.1. Annual Leave Plan – Update on Progress

Pages: 14 - 21
Documentation: Report from the Manager, Human Resources & Organisational Development dated 5 April 2016
Recommendation: that this report be received.

7.2. Maternity Review update

Pages: 22 - 48
Documentation: Report from the General Manager, Clinical Services and Transformation dated 14 April 2016
Recommendation: that this report be received

7.3. Renal Plan for MidCentral DHB

Pages: 49 - 51
Documentation: Report from the General Managers, Strategy, Planning and Performance and Clinical Services and Transformation dated 11 April 2016
Recommendation: that the report be received

8. OPERATIONAL REPORTS

8.1. Provider Division Operations Report, February/March 2016

Pages: 52 - 112
Documentation: Report from the General Manager, Clinical Services and Transformation dated 15 April 2016
Recommendation: that this report be received.

9. LATE ITEMS

To discuss any such items as identified under item 2 above.

10. DATE OF NEXT MEETING

7 June 2016

11. EXCLUSION OF PUBLIC

Recommendation: that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	*Reason*	*Reference*
"In Committee" minutes of the previous meeting	For reasons stated in the previous agenda	
Operations Report: : Potential Serious Adverse Events and Complaints	To protect personal privacy	9(2)(a)
Maternity Root Cause Analysis Reports	To protect personal privacy	9(2)(a)
2016/17 Draft Regional Service Plan (version 2)	Subject of negotiation	9(2)(j)
2016/17 Annual Plan update	Under negotiation	9(2)(j)

MidCentral District Health Board

Minutes of the Hospital Advisory Committee meeting held on 15 March 2016 commencing at 8.45 am in the Boardroom, MidCentral District Health Board

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PRESENT

Barbara Robson (Chair)
Lindsay Burnell
Kate Joblin
Karen Naylor
Phil Sunderland
Dennis Emery
Duncan Scott

In attendance
Kathryn Cook, CEO
Mike Grant, General Manager, Clinical Services and Transformation
Carolyn Donaldson, Committee Secretary

Diane Anderson, Board Member,
Nadarajah Manoharan, Board Member
Adrian Broad, Board Member, (part meeting)
Barry Keane, Nurse Director, Mental Health
Greig Russell, Medical Administration Trainee
Jan Dewar, Acting Director of Nursing
Janine Ingram, Project Manager, Mental Health (part meeting)
Lyn Horgan, Operations Director, Hospital Services
Muriel Hancock, Director, Patient Safety & Clinical Effectiveness
Neil Wanden, General Manager, Finance & Corporate Support
Nicholas Glubb, Operations Director, Specialist Community & Regional Services
Scott Crowley, Webmaster
Stephanie Turner, Director of Maori Health & Disability (part meeting)
Vivienne Ayres, Manager, DHB Planning and Accountability
Public (3)
Communications (1)
Media

The Chair advised Mrs Hume and Dr Manoharan wanted to speak to the committee. This would be done prior to the relevant agenda items.

1. APOLOGIES

An apology was received from Cynric Temple-Camp.

2. LATE ITEMS

There were no late items.

3. CONFLICT AND/OR REGISTER OF INTERESTS

3.1 Amendments to the register of interests

There were no amendments.

3.2 Declaration of conflicts in relation to today's business

Karen Naylor declared a conflict in relation to item 7.5, Maternity Review, in terms of her role in the women's health service.

Duncan Scott declared a conflict in relation to the medical imaging update in item 8.1, Operations Report, in terms of the contract held by his company.

Barbara Robson declared a conflict in relation to the Maternity Clinical Information System in item 7.5, Maternity Review, in terms of her membership as a consumer representative on the Maternity Information Systems Programme Steering Group.

4. MINUTES

It was recommended

that the minutes of the meeting held on 2 February 2015 be confirmed as a true and correct record.

4.1 Recommendations to Board

It was noted that the Board approved all recommendations contained in the minutes.

5. MATTERS ARISING FROM THE MINUTES

There were no matters arising from the minutes.

6. WORK PROGRAMME

It was recommended

that the updated work programme for 2015/16 be noted.

7. STRATEGIC PLANNING

7.1 Regional Service Plan Implementation – 2015 Quarter 2 update

A member expressed concern regarding MidCentral Health's (MCH) cardiology service particularly in terms of transport and asked whether there were any benefits gained from the Regional Service Plan (RSP) initiatives. The member was informed that MCH provided separate cardiac road transport for patients being transferred to Wellington. Work within the cardiology service was ongoing. The Regional Cardiac Clinical Director recently visited to discuss what further work could be done here.

It was recommended

that this report be received.

7.2 2016/17 Regional Service Plan – Development of Draft 1

It was recommended

that this report be received.

7.3 Non Financial Monitoring Framework an Performance Measures – Quarter 2, 2015/16

A member referred to the increase in attendances at the Emergency Department, suggesting it would be interesting at some stage to have an understanding of what was driving the increase and how it was being managed. Management responded advising the number of GP consultations had recently declined, but the introduction of free consultations for under 13 year olds had seen an increase in these attendances after hours. This had displaced a group

of the over 45 year old population to ED. It was felt that over time, the situation would flatten out. Another member said cost was also a factor.

It was noted that the sexual health service was doing well in relation to picking up family violence issues.

With regard to the arrears in the Child and Adolescent Oral Health Service, it was advised the longest waiting time was 6 months and there were 336 children in this group.

It was recommended

that this report be received.

7.4 Mental Health Service Reconfiguration update 3

Mrs Hume then spoke to the Committee. The main issues she covered were:

- Reporting on the DBT programme and its development
- Transparency of reporting - requesting that the reporting on the DBT programme to be in the public arena, as opposed to internal to the DHB (last reporting was in the workshop).

The Service Director, Mental Health and Addictions opened discussion on the report, noting some of the key activities:

- The clinical governance model was being further developed and the service is now engaging with teams in regular clinical governance forum.
- Employment of the outstanding consumer advisor roles and their strong representation on the executive and clinical management teams.
- Work continued on key focus areas identified. Pressure on over-utilisation in Ward 21 of existing resources was a key risk factor being monitored. There was a need to build up capacity along the acute continuum and support inpatient services.

In respect to DBT reporting, the programme was being reviewed, as advised at the last work shop where the update report had been presented. The current trend of training staff only to have them leave was not sustainable so a more sustainable model was being developed. At the moment there were about 12 people in the programme and six on the referral list. As noted there has been reduced uptake of referrals due to a limited capacity, as a result of the departure of key psychology staff. The service was recruiting to replace this staff.

With regard to DBT reporting data and narrative, Mr Nolan said this issue would be considered at a meeting later in the afternoon with Mr and Mrs Hume and the Mental Health Executive.

Concern was expressed at the occupancy demand at times on Ward 21. The Service Director advised there were some management strategies in place, but there were key element members should be aware of. As an example of key issues, there was 30 per cent increase in admissions in January. However the average length of stay decreased from the previous month, so occupancy was better managed with a reduced number of times the unit was over its bed state (about 6 times in January). The use of transition beds and the cooperation with community partners, and the added benefit of taking over STAR 1 unit which is now taking clients over 65 who were sometimes inappropriately placed in ward 21 had helped the situation. These developments are part of the service forward planning.

In terms of double shifts, an examination of the data has revealed that full double shifts are not necessarily occurring in the numbers presented in the graph and further work was being done to refine the reporting. When analysing the data more closely, it appears that of the total number of reported shifts, some shifts were only a few hours of additional time and not a full shift. There is an expected reduction in the next month. The service was also developing intensive and acute care pathways for ward 21 which would improve the standards of clinical service and bed management. The service was also working with Oranga Hinengaro as there are a number of Maori people who are referred to the service, highlighting the need to do better around cultural aspects of the service. The CCTV policy

was another issue to be addressed. An updated policy was on the agenda for discussion this afternoon at the service's quality improvement forum, which Mr and Mrs Hume join as part of the service engagement with family input to improve services.

Reporting on involvement with community teams would be part of future reporting to the Committee. The main strategy was to make sure the service was outward looking, building relationships across the sector, and developing contacts. This was also work in progress.

The attendance at the various community and clinical governance meetings was raised, with the suggestion that participation should be included in future reporting as a key indicator. Mr Nolan agreed it was a good point. He said at the moment, all operational management meetings were well attended.

The readmission rate within 28 days and people being seen within seven days following discharge were issues. Work is being done to make the system more robust. The figures were being reviewed and outliers explained. An outlier is a client who may have highly individual circumstances and who therefore may require services which are beyond the normal or average service measures. Therefore their data was sometimes accounted for separately as including their activity in data may skew the overall report. For instance if one person in an inpatient setting accounts for 50% of reported incidents it may look like an overall increase in whole of inpatient incidents by a number of clients, unless we understand that the increase is due to one client and therefore needs to be understood in the context of their type of care. Or if a person or small group do not present to an appointment within the required timeframes (missing appointments due to ill health or medical admission to hospital) so they were not seen within the required timeframes. These individuals were still reported on but it is noted that they show as a variance on the overall report of data. The clarification about 'outliers' helps understand the total data by providing some context for variations.

Mr Emery expressed concern that not enough was being done for Maori people who had mental health issues. He said more work was required with services like Oranga Hinengaro. The Service Director indicated he was working on this issue, and was already in discussion with Oranga Hinengaro. The Director of Maori Health and Disability was also working on this matter and in the coming months would be reporting on it. The service agrees the focus on the needs of Maori as a priority.

The clinical governance meetings with CAFs, AOD and Feilding community teams were noted, and a suggestion was made that some base line information would provide insight into these and the other community mental health services, so committee members better understood them and were able to question and monitor them. The General Manager Clinical Services and Transformation noted the recent workshop presentation set out what would be reported to the Committee by way of base line data across the service and also any emerging issues. A range of things were happening at an organisational level, eg refreshment of the strategic plan, a possible cluster arrangement for services, as well as focusing on Maori, community, the social sector and investment planning.

It was pleasing to note the successful approval of the Ward 21 unit as a training placement for registrars.

The commitment and effort being put into the Erica Hume implementation plan was noted.

Phase two of the review recommendations was considered. The primary mental health model of care was a critical part of the continuum of community services, but it was not working very well at the moment. A key service improvement goal was to update the model in partnership with the PHO, and progress to date was noted. Progress was heading in the right direction with good engagement taking place. Reporting on this work would continue.

A member referred to the non-financial performance quarterly report that had been considered earlier in the meeting, noting that shorter waits for non urgent mental health and addiction services for 0-19 year olds did not achieve the targets. The Service Director said although the missed target margin was low, that is one target missed by 0.5 per cent, he expected this to improve. There had been a number of staff movements, vacancies were

being recruited to, an external review was planned of the CAF service, and demand had gone up by at least 50 per cent. So there was a lot of work going on with this service.

It was recommended

that this report be received.

7.5 Maternity Review update

Barbara Robson declared her conflict in terms of her membership as a consumer representative on the Maternity Information Systems Steering Group. This was noted. It was agreed it did not need any action on the part of the Committee.

Karen Naylor declared a conflict in terms of her role in the women's health service. Karen was excluded from the Board discussion on this subject prior to the report becoming a public document and as Karen worked in the service. However as the document was now public the Committee did not see any reason to preclude her from discussion.

Mr Manoharan was invited to speak to the Committee. Given he was a Board Member, it was suggested he could be part of the discussion. Diane Anderson was also invited to join the discussion but deferred to do so.

Before commencing discussion on the report, the Chair took the opportunity to express regret to the families who had experienced tragic outcomes.

The Chair said it was regrettable to be in this situation, particularly following the Mental Health Service Review. The Maternity Review identified issues that were damming and as the governing committee, the Hospital Advisory Committee must see they were resolved and ensure clinical governance was strengthened across the service and other hospital services. She said the Committee must ensure that reporting was meaningful and provided in a timely way so the Committee could more readily identify any problems and be sure action was taken to address them.

She referred to the Health Quality & Safety Commission booklet just circulated on guidance for board members, particularly regarding clinical governance.

Adrian Broad joined the meeting.

Mr Manoharan then spoke to members. He said situations like this were difficult for staff. However they should be able to bring forward any concerns to management without fear of victimisation, and he felt the organisational culture had to be improved in this respect.

The CEO commented that one of the key areas of focus in the revised strategic plan was the development of culture and the four areas associated with it. There would be a significant cultural change programme.

Committee members also conveyed their regret to the families, and endorsed the various comments expressed regarding the situation.

Karen Naylor also supported commissioning the review, saying the outcome highlighted a number of areas to be addressed. However she urged caution saying care should be taken not to automatically draw links or assumptions to each outcome in a clinical sense. Members had not seen the Root Cause Analysis reports or recommendations from them, and they should not make assumptions that the outcomes were as a result of deficiencies in the service. There would always be negative outcomes in any service, and there was always an opportunity to improve services.

Mr Emery suggested there should be Iwi representation on the steering group. Mr Burnell suggested Information Systems should also be represented.

Members were advised recruitment to the clinical directorship should be underway shortly. It would be advertised both internally and externally.

The Memorandum of Understanding that was developed between the two DHBs would need to be robust and provide a good service for the women of both DHBs. It would come under the auspices of the centralAlliance, who would maintain oversight.

A member suggested patient focused bookings as being more convenient for mothers with young families.

Kate Joblin reported on decisions made at last week's Whanganui board meeting including the Regional Women's Health Service being redesigned with the respective CEOs reporting back on this by July, the importance of a strong Memorandum of Understanding, management aspects of developing a collaborative framework for monitoring and reporting, and keeping a close eye on developments.

The General Manager, Clinical Services and Transformation, clarified that the steering group membership would have an independent view through input from an independent midwife. There was also a general acceptance within the service that an independent external appointment would be made to the clinical director role. The model of care would be sufficiently developed that the clinical director would have to have congruence with that model of care. The acting charge midwife was new to the service and therefore could be perceived as independent.

In relation to the information system, the General Manager Clinical Services and Transformation said the view was that it did not require a separate work programme, but possibly required greater visibility, transparency of issues, and resolution pathways. The National Health Information Technology Board was leading this work. He was happy to add it to the work programme though.

Mr Grant also clarified the Maternity Clinical Information System was implemented by MDHB as the early adopters of a system that was evolving. The adoption of the system was a work in progress from the National Health IT Board perspective, which was probably a little different to how MDHB usually implemented IS systems.

It was recommended that

> that this report be received, and it be noted that six-weekly updates against the maternity services health work programme will be provided to the Hospital Advisory Committee, and
>
> that the current arrangements with Whanganui DHB for the Regional Women's Health Service be replaced by an explicit memorandum of understanding that will detail the clinical integration and collaboration for our women's services going forward, for implementation before 1 July 2016.

8. OPERATIONAL REPORTS

8.1 Provider Division Operating Report - January 2016

The General Manager, Clinical Services and Transformation spoke to this report.

It was noted that the internal audit programme being completed this year would include clinical governance. It would be reported through to the Finance and Risk Advisory Committee.

In response to a query regarding any emerging themes from complaints, the Director, Patient Safety & Clinical Effectiveness advised detailed reporting occurred via the six monthly reports. However at a high level, staff communication could be a common thread.

The increase in readmission rates was noted. Management advised they had not drilled down into these figures, but re-presentations to ED had just been done.

The Operations Director, Hospital Services advised the Elective Services Performance Indicators (ESPIs) were now compliant. Further consideration was required around leave planning and managing workloads, particularly in areas like ENT which had got behind over the Christmas holiday period due to leave arrangements.

It was recommended

that this report be received.

9. LATE ITEMS

There were no late items.

10. DATE OF NEXT MEETING

26 April 2016

11. EXCLUSION OF PUBLIC

It was recommended

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	*Reason*	*Reference*
"In Committee" minutes of the previous meeting	For reasons stated in the previous agenda	
Operations Report: : Potential Serious Adverse Events and Complaints	To protect personal privacy	9(2)(a)
2016/17 Draft Annual Plan	Subject of negotiations	9(2)(j)

TO Hospital Advisory Committee

FROM Acting Chief Executive Officer

DATE 18 April 2016

SUBJECT **2015/16 Work Programme**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

This report updates progress against the Committee's 2015/16 work programme. It is provided for the Committee's information and discussion.

2. SUMMARY

The Committee's work programme is attached. Generally reporting is progressing in accordance with this, with the following notable exceptions:

- 2016/17 Price : Volume Schedule
  The Strategy, Planning & Performance Unit advises this is still being developed as part of the annual plan and budget and will be presented to the Committee next month.

- Business Cases
  As previously advised, business cases will be progressed once we have more certainty regarding our financial pathway. These include IT systems and Emergency Department facility upgrades. The business case for the upgrade of Ward 21 will be provided to the Committee at its next meeting.

Set out below is a summary of the reports provided to the Hospital Advisory Committee. This includes reports provided to the Committee at its last meeting, its current meeting, and those scheduled for its next meeting.

Reporting Category	Last Meeting	Current Meeting	Next Meeting
2016/17 Annual Plan Development	• Regional Service Plan 2016/17 – update • Draft 2016/17 Annual Plan	• 2016/17 Draft Regional Service Plan • 2016/17 Annual Plan update	• 2016/17 price:volume schedule
Monitoring Annual (AP) & Regional (RSP) Plan Implementation	• 2015/16 RSP implementation – update 3 • Mental health service update 3	• Palmerston North site reconfiguration update (as part of General Manager's report) • Renal plan for MDHB	• 2015/16 RSP implementation – update 4 • 2015/16 AP – update 2 re secondary care initiatives • Mental health service update 4

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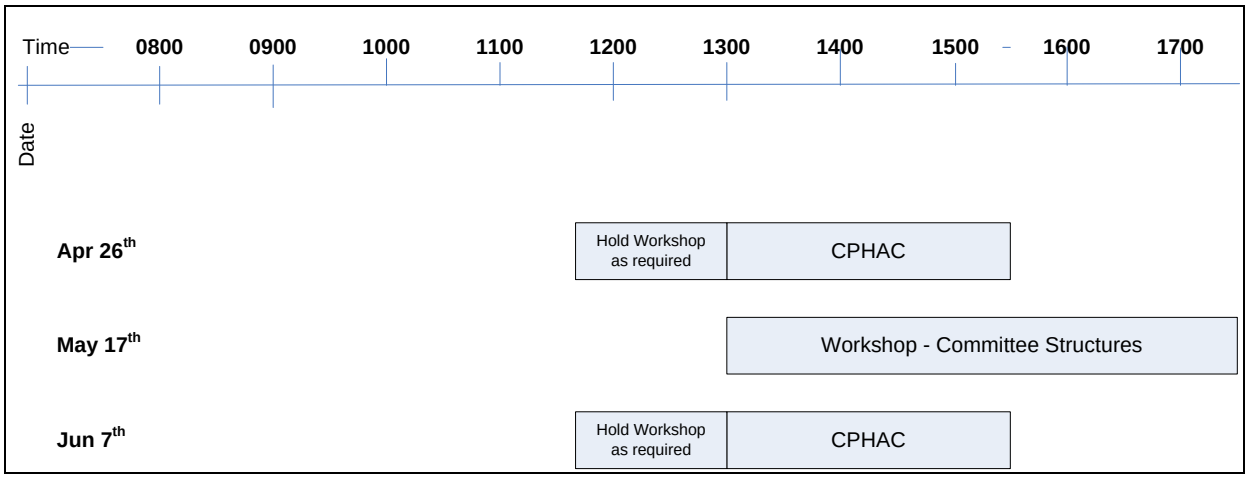
Sub-regional work - centralAlliance	• Women's health review	• Maternity review	• Maternity review & RCAs • Memorandum of understanding with Whanganui DHB re maternity services • 2015/16 AP – update 2 (as above. Includes cA secondary care initiatives)
Quality	• Non-financial performance measures for quarter ended December 2015		• Non-financial performance measures for quarter ended March 2016
Operational Matters	• January/February results	• General Manager's reports – February/March results • Annual leave update	• General Manager's report - April results • Business cases –Ward 21 facilities and others as appropriate • Indicative business case for regional cancer centre building • Outcome of Titanium case • Contracts update
Reporting	• Work programme update	• Work programme update	• Work programme update
Workshops	• Women's health workshop		

Committee commitments through until the June 2016 are set out below:



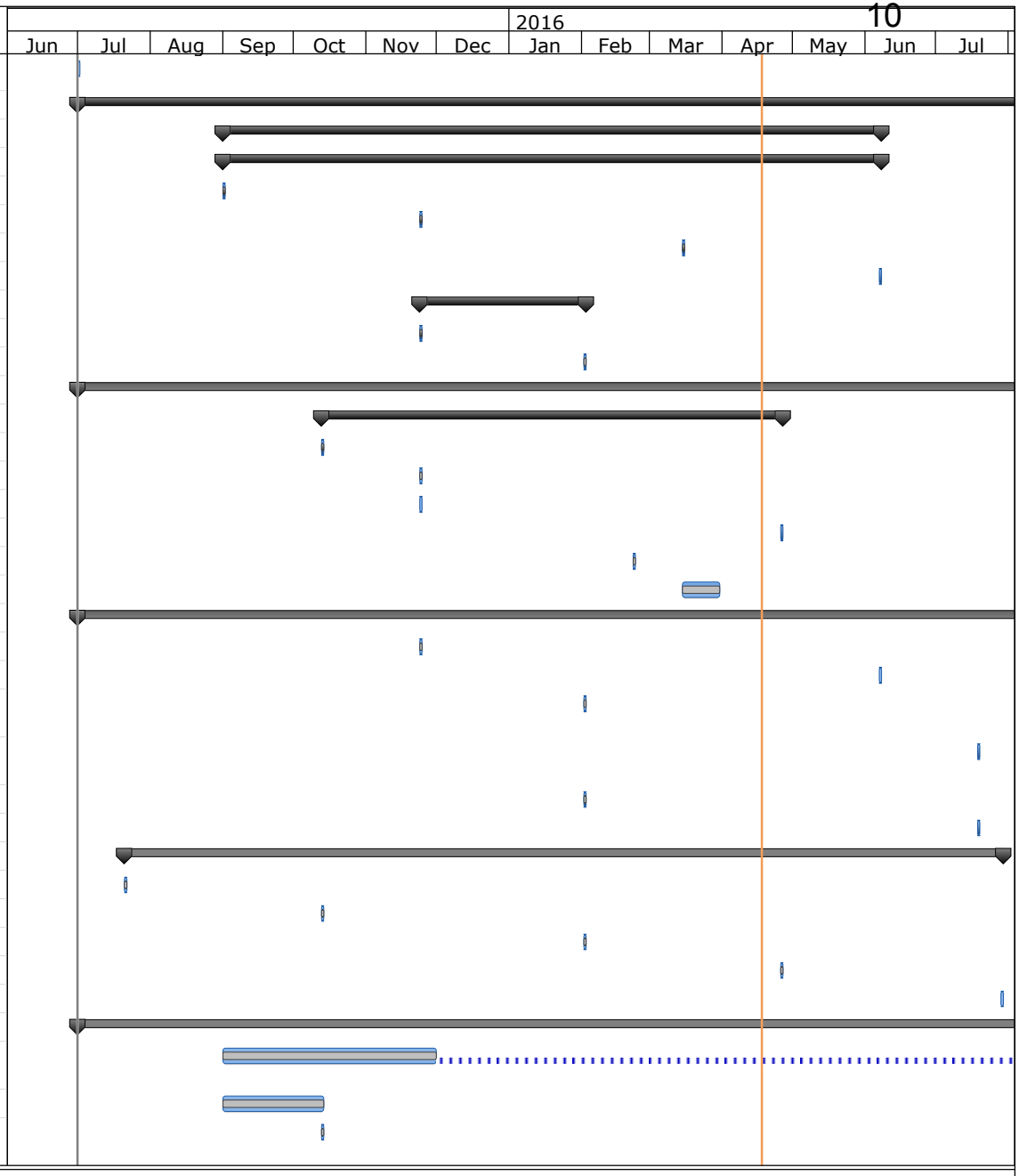
3. RECOMMENDATION

It is recommended:

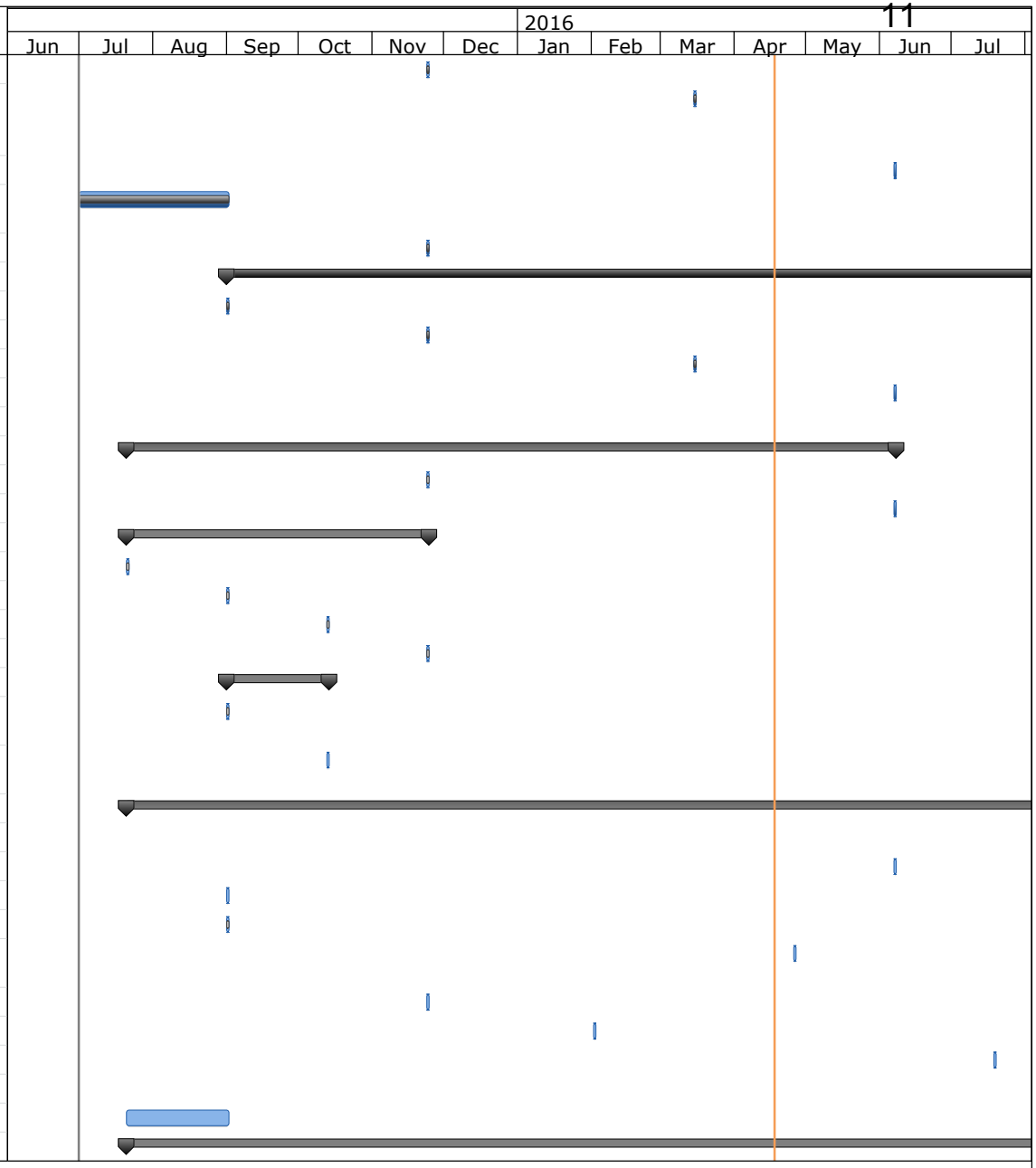
that the updated work programme for 2015/16 be noted.

Mike Grant
Acting Chief Executive Officer

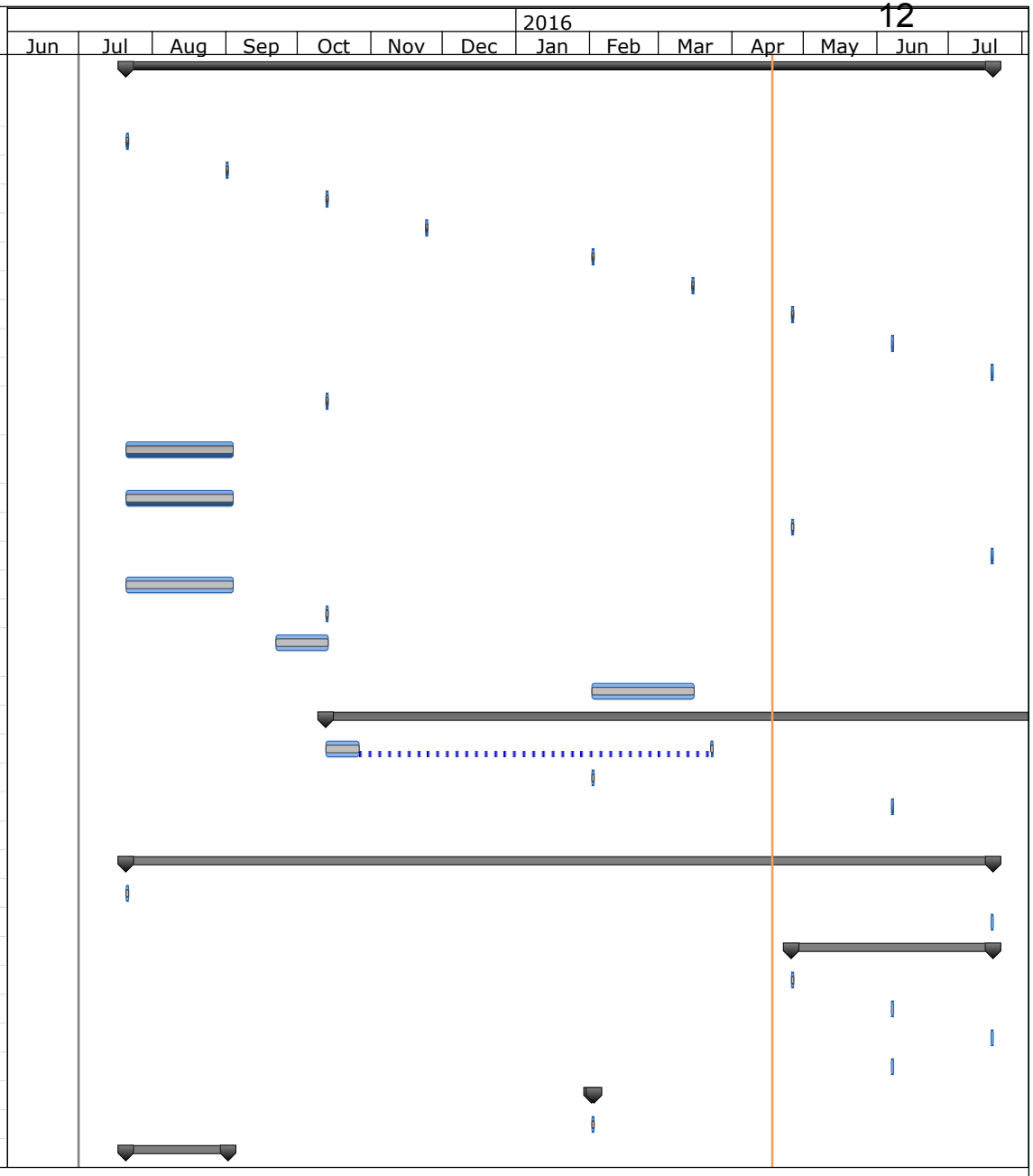
ID	Task Name
1	**HAC WORK PROGRAMME 2015/16**
2	**STRATEGIC ISSUES**
3	**Regional Services Plan**
4	**2015/16 Implementation**
5	Update 1
6	Update 2
7	Update 3
8	Update 4
9	**2016/17 RSP Development**
10	Approach & timeline
11	Draft 1
12	**Annual Plan**
13	**2016/17 AP Development**
14	Assumptions - hospital related
15	Assumptions - hospital related
16	Price volume schedule (draft)
17	Price volume schedule 2016/17
18	Planning workshop
19	Draft AP
20	**2015/16 AP Implementation**
21	Secondary care initiatives, inc centralAlliance: update 1
22	Secondary care initiatives, inc centralAlliance: update 2
23	Quality (inc customer satisfaction & clinical governance indicators): update 1
24	Quality (inc customer satisfaction & clinical governance indicators): update 2
25	Workforce: update 1
26	Workforce: update 2
27	***PNH Site Reconfiguration***
28	Update 1
29	Update 2
30	Update 3
31	Update 4
32	Update 5
33	***Mental Health Service Reconfiguration***
34	Update 1 (inc progress Phase 1 recommendations, consumer engagement)
35	Info re CCTV policies, clinicial governance structure
36	Facilities upgrade report, including clarification of bed nos



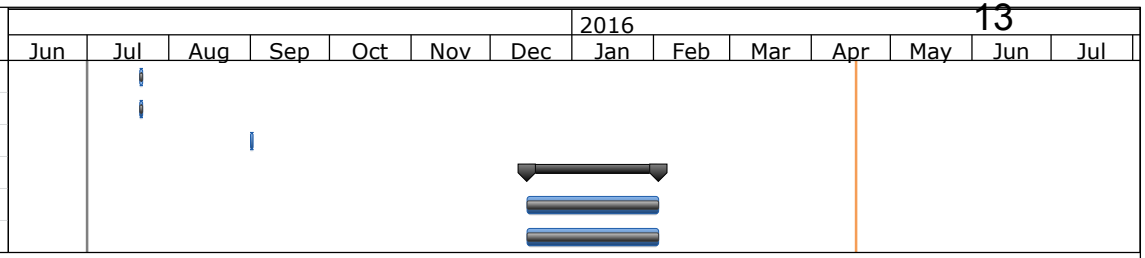
ID	Task Name
37	Update 2 (inc how phase 2 to be implemented)
38	Update 3 (inc key themes from Nov workshop, and, more info re recommendations 4+5 EH longitudinal review)
39	Update 4
40	Use of CCTV (inc storage of tapes following an incident)
41	Workshp re scorecard/benchmarking
42	***Non-financial Performance Indicators***
43	2014/15, Quarter 4
44	2015/16, Quarter 1
45	2015/16, Quarter 2
46	2015/16, Quarter 3
47	2015/16, Quarter 4
48	***Information Only***
49	Primary care initiatives: update 1
50	Primary care initiatives: update 2
51	*centralAlliance Strategic Plan*
52	Update 1
53	Update 2
54	Update 3
55	Update 4
56	**Major Projects 14/15 Annual Plan**
57	Regional Women's Health Service Update 1 (including cancer sub-specialty workstreams)
58	RHWS future reporting arrangements (post evaluation - Hospital Audit) - NOW JUNE 16
59	**Business Cases**
60	Linear accelerators
61	Indicative case for regional cancer centre building
62	Hospital operations centre It system
63	Titanium (oral health) business case
64	Titanium (oral health) business case: outcome of ELT decision
65	Public and sexual health electronic health record
66	eReferrals business case
67	ePrescribing business case
68	eAdministration business case
69	Business case for Ward 21
70	**OPERATIONAL REPORTS**



ID		Task Name
71		**General Manager's Report [inc health targets, ESPIs & Non-ESPIs, and mental health updates (alternate meetings)]**
72	✓	Report 1 (results for May/June)
73	✓	Report 2 (results for July)
74	✓	Report 3 (results for August)
75	✓	Report 4 (results for Sep/Oct)
76	✓	Report 5 (results for Nov/Dec)
77	✓	Report 6 (results for Jan/Feb)
78	✓	Report 7 (results for March)
79		Report 8 (results for April)
80		Report 9 (results for May/June)
81	✓	Sugar Sweetened Beverages: outcome of MCH's challenge to other businesses to go sugar-free
82	✓	Confirmation re incidence of food contamination (as per HB)
83	✓	Annual Leave Plan
84	✓	Annual leave update
85		Annual leave update
86	✓	CCDM progress report
87	✓	Annual maternity & maternity quality & safety report
88	✓	Women's health (inc RCA recommendation & implementation progress)
89	✓	Zika Virus Update
90		**Contract Updates (>$250k)**
91	✓	Update 1
92	✓	Update 2
93		Update 3
94		Update 4
95		**Quality**
96	✓	Annual report from MCH Clinical Board
97		Annual report from MCH Clinical Board
98		**Maternity's Services**
99	✓	Update 1, including RCAs
100		Update 2
101		Update 3
102		MoU with WDHB re maternity services
103	✓	**GOVERNANCE**
104	✓	HAC terms of reference review
105		**CARRIED FORWARD FROM 2014/15**



ID		Task Name
106	✓	2014/15 Quality update 2
107	✓	2014/15 Workforce update 2
108		ED triage room/reception business case
109	✓	**WORKSHOPS**
110	✓	Mental Health - continuation from Nov workshop
111	✓	Women's Health



TO Hospital Advisory Committee

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

FROM Anne Amoore
Manager
Human Resources and Organisational **Development**

DATE 5 April 2016

SUBJECT **Annual Leave Plan – Update on Progress**

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1. PURPOSE

This paper provides an update to the Hospital Advisory Committee (HAC) on progress made towards implementing the initiatives in MDHB's annual leave plan.

This report is for information only; no decision is sought.

2. SUMMARY

Slower than anticipated progress is being made to reduce our "accrued Annual Leave – greater than two years accumulation".

For the six month period between 1 July 2015 and 31 December 2015, accrued annual leave above two years had reduced by 6,027 hours, or an average of 1,004 hours reduction per month. Steady progress was being made, and we were tracking slightly below our six monthly target of 6,600 hours.

However, our progress for the three months January – March 2016 was lower than anticipated. This can be attributed, in part, to high numbers of presentations to the Emergency Department, with a flow on to high occupancy across the hospital, relative to our plans for summer.

The Central Region Leave Improvement Plan for the next three years will assist us to bring our leave balances to an acceptable level, as will our improved reporting processes. MDHB's internal audit programme for 2015/16 will also assist and any findings of this review will be built into MDHB's Annual Leave Plan.

Our focus will continue to be on reducing annual leave balances to allow our employees the opportunity for rest and recreation and to enjoy regular breaks from the workplace, acknowledging that this will take longer than anticipated to achieve.

3. RECOMMENDATION

It is recommended

that this report be received.

4. BACKGROUND

An annual leave plan was developed in July 2015 to address and monitor MidCentral District Health Board's (MDHB) high annual leave balances, with a focus on those employees with greater than two years accrued annual leave.

MDHB has been tracking the highest of all DHBs, and above our MDHB target of 9.5 percent "accrued Annual Leave – greater than two years accumulation".

The annual leave plan contains initiatives and measures to reduce excess leave to the target of <9.5 percent. This means the number of annual leave hours for staff with leave greater than two years, needs to be below 25,887, a reduction of 13,352 hours over a twelve month period from 1 July 2015. This equates to a net monthly reduction of 1,100 hours per month.

It should be noted that both the MDHB target of <9.5 percent, and the national DHB rating, measures the number of employees with greater than two years accumulation. It is considered appropriate that MDHB also measures the amount of annual leave hours and the $ value of these hours. Our reporting is therefore based on these two components.

5. PROGRESS

5.1 Progress for nine month period 1 July 2015 – 31 March 2016

For the nine month period between 1 July 2015 and 31 March 2016, accrued annual leave above two years reduced from 40,552 hours (as at 30 June 2015) to 33,638 hours, a total reduction of 6,914 hours, or an average of 768 hours reduction per month. This is below the monthly target of 1,100 hours and our nine month target of 9,900 hours. The 6,914 hours reduction is made up of:

Leave Earned/Accrued	43,824
Leave Taken	-43,192
Leave Buy-out	-4,197
Transfer Finish	-3,349
Total	6,914

Up to 31 December 2015 we were making steady progress and annual leave above two years reduced by 6,027 hours, an average of 1,004 hours reduction per month. It was anticipated that during January – March our balances would further reduce given it was the holiday period. While leave taken in January exceeded leave earned/accrued by 1,835 hours, and we achieved a total reduction of over 2,064 hours for January, this was negated in February/March by leave earned/accrued exceeding leave taken.

As shown in Appendix One, Graph One the financial value of annual leave hours over two years accumulation has reduced over the past three months by $72,846 and for the nine month period by $292,406.

It is disappointing that we did not achieve our target for the past three months. However, the past months have been notable for high numbers of presentations to the Emergency Department with a flow on to high occupancy across the hospital, relative to our plans for summer. This has affected our ability for staff to be able to take short notice leave.

Managers are continuing to work with individual staff members to ensure leave plans are in place. Human Resources has also been working with managers to put in place new annual leave reporting tools which will assist in leave planning, and will predict when employees are likely to exceed their two year accrued leave entitlement. This will ensure that the leave plans in place are updated early so that the two year entitlement is not exceeded.

5.2 MDHB's Internal Audit Programme – Leave Balance Management Review

As part of MDHB's internal audit programme for 2015/16, Central Region's Technical Advisory Service (TAS) is undertaking a Leave Balance Management review covering the following areas:

- Roles and responsibilities for the management of leave are appropriate and have been assigned and accepted.
- Documentation – that appropriate policies and procedures are in place to support the management of leave.
- Reporting – ensuring that appropriate processes exist for management to review and monitor leave balances in a timely manner and for staff to review and monitor their own leave balances.
- Systems and processes – ensuring that appropriate processes exist to capture leave entitlements, leave is appropriately accruing over time and that the processes followed by MDHB for capturing and recording leave apply within approved policies. Identify if there are any gaps in the process that could lead to incorrect leave balance adjustments.
- Controls – Assess the efficacy of controls and processes. Ensure that appropriate controls are in place to ensure safe staffing levels are maintained.
- Risk management – assess and identify.
- Capability and Capacity – confirm how leave balance management plans are working and if there is appropriate guidance and knowledge around identifying the most appropriate methods to manage leave.

The review is commencing in mid April, and it is expected a final report will be issued in mid May. The findings will determine what further actions MDHB needs to take in terms of leave management.

5.3 Leave Management Improvement Actions within the Central Region DHBs

Ensuring employees have the opportunity for rest and recreation, and benefit from regular breaks from work, is a key priority for all the Central Region DHBs. It is recognised that it is a continual challenge to ensure budgeted staffing levels are sufficient

and positions are recruited to, in order to enable staff to take leave regularly. It is also recognised that there will be seasonal trends in reducing balances.

As at 31 December 2015, nine DHBs, including three in the Central Region, are tracking over the national DHB average of 8.2 per cent for employees with excessive leave balances, that is, the numbers of employees with "accrued Annual Leave – greater than two years accumulation".

To address this and to ensure annual leave management continues to be a key area of focus, the Central Region CEs had asked the General Managers Human Resources (GMsHR) to share best practice initiatives on reducing outstanding leave and to develop a regional strategy for the next three years. The GMsHR have therefore brought together a Leave Management Improvement Plan with actions for the next three years. The plan includes initiatives to be implemented immediately and longer term initiatives the DHBs will work on implementing.

It is acknowledged that the DHBs are at different stages in implementing the actions in the plan, for example, some of the DHBs have been working on reducing balances for several years. Irrespective of the stage of implementation each DHB is at, it is important that the focus and momentum is always on leave management to ensure all leave is maintained at an acceptable level.

The Leave Management Improvement Actions do have a focus on accrued annual leave over two years. However, the actions also focus on a reduction in all leave balances, with a goal over the next three years to reduce all accrued leave balances to an acceptable level. To measure progress in this regard, there is to be a strengthening of measurement and reporting, and this is currently being worked on regionally and nationally.

The CEs have endorsed the Leave Management Improvement Actions. Each DHB is now considering the actions and will implement these as appropriate to their DHB.

MDHB has implemented most of the immediate initiatives in the Leave Management Improvement plan. For example, we have our Annual Leave Plan in place which has monthly targets for reducing leave and our toolkit is in place.

Given our latest results, we do need to continue our focus on managing leave, recognising that this is a longer term goal as we are addressing an issue that has arisen over a number of years. Various factors have contributed to this. MDHB has one of the lowest staff turnovers of all the DHBs. Most other DHBs also have low staff turnover. With many long serving staff, leave accumulations within DHBs have built up over time without being actively managed. Coupled with the gradual growth of annual leave balances, leave plans have not routinely been in place. Another contributing factor is that in addition to annual leave entitlements, most employment agreements provide for long service leave, lieu leave and shift entitlements.

The Leave Management Improvement Actions that the DHBs are to work on implementing are as follows:

- Developing a KPI to measure and report monthly as to whether leave plans are in place for each employee.

- Introducing a national KPI of total accrued all leave/total staff (average leave balance per employee) and report quarterly to Executive Teams and Service Managers.
- Focusing on leave being planned and leave requests being submitted in accordance with the leave plan.
- Implementing where available a "closed loop" leave request and leave capture electronic system to ensure all leave is easily applied for and is captured 100 percent.

As reported above, MDHB is strengthening its reporting of annual leave balances. Human Resources is working with managers and others to scope and test a leave risk report which, based on leave patterns, will show if and when an employee is likely to go over two year accumulation. This will assist in annual leave planning so that this does not occur. We are also looking at modifying our Human Resource Information System so that we can capture and report on the completion of individual employee leave plans.

5.4 New National Annual Leave Measure

In terms of national KPI reporting, a new measure has been introduced that shows the average hours of leave owing to each employee. This new measure includes all annual leave, lieu leave and shift leave. The national DHB average at 31 December 2015, is 147.82 hours per employee. MDHB is tracking at 180 hours average hours per employee. Eight other DHBs are also tracking over the national average. Three DHBs have a higher average than MDHB, with the highest average being 201.48 hours.

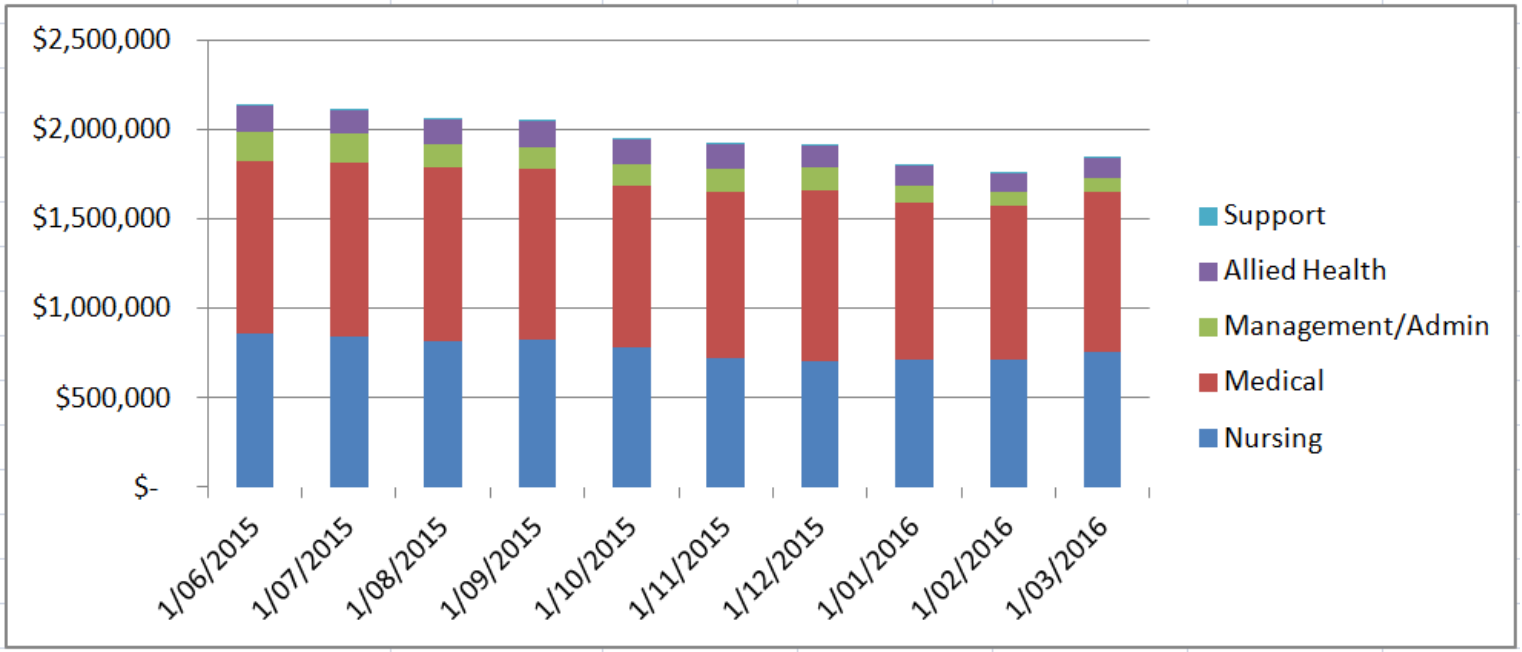
Attached in Appendix One are further details and graphs showing our progress over the past nine months.

Anne Amoore
Manager, Human Resources and Organisational Development

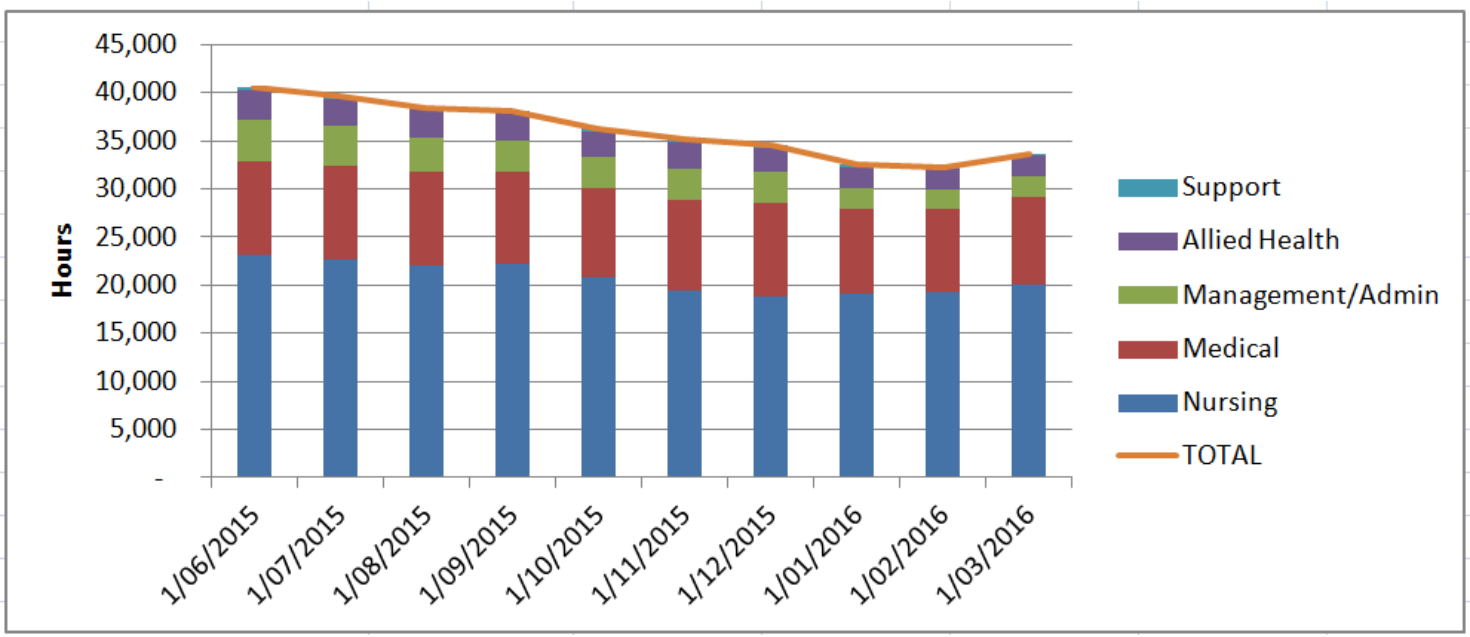
Annual Leave Progress Graphs
1 July 2015 – 31 March 2016

Graph One – Financial value of "leave hours over two years accumulation"

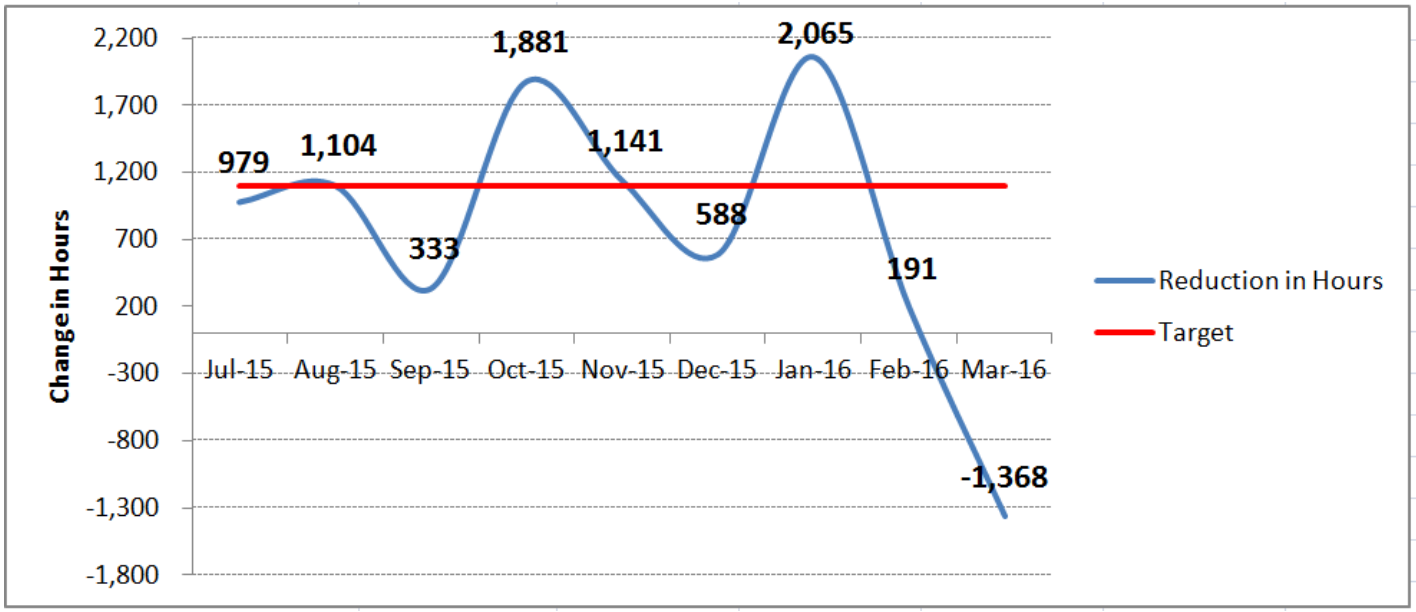
Workforce Group	30/06/2015	31/07/2015	31/08/2015	30/09/2015	31/10/2015	30/11/2015	31/12/2015	31/01/2016	29/02/2016	31/03/2016
Nursing	$ 859,048	$ 843,236	$ 817,146	$ 821,987	$ 780,296	$ 725,389	$ 701,669	$ 712,701	$ 717,247	$ 754,631
Medical	$ 964,721	$ 971,755	$ 967,686	$ 958,168	$ 903,053	$ 927,207	$ 961,165	$ 874,736	$ 855,677	$ 892,407
Management/Admin	$ 160,841	$ 160,385	$ 129,198	$ 122,152	$ 125,232	$ 125,945	$ 126,138	$ 94,381	$ 80,958	$ 82,677
Allied Health	$ 146,836	$ 132,902	$ 140,591	$ 140,212	$ 130,705	$ 134,628	$ 122,079	$ 110,806	$ 103,737	$ 109,573
Support	$ 4,917	$ 5,219	$ 5,767	$ 5,417	$ 6,153	$ 5,720	$ 5,753	$ 4,425	$ 5,454	$ 4,670
TOTAL	$ 2,136,364	$ 2,113,497	$ 2,060,389	$ 2,047,935	$ 1,945,439	$ 1,918,889	$ 1,916,804	$ 1,797,049	$ 1,763,073	$ 1,843,958



Graph Two – Occupational Group Annual Leave Movements

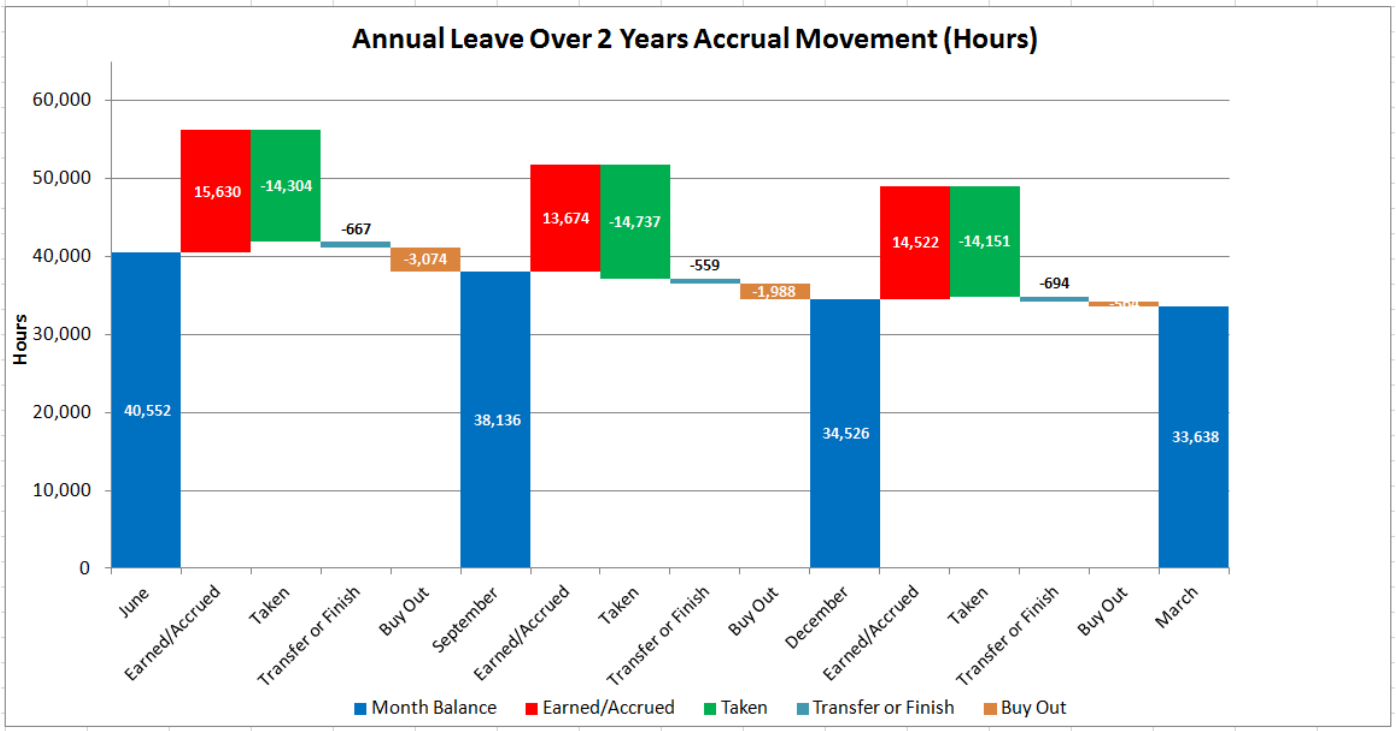


Graph Three – (a) Reduction in Hours



Graph Three – (b) Reduction in Hours Broken Down 1 June 2015 – 31 March 2016

1 July 2015 - 31 March 2016										
	2015						2016			Reduction at 31 March 2016
Period	1-Jul	31-Aug	30-Sep	31-Oct	30-Nov	31-Dec	31-Jan	29-Feb	31-Mar	
Leave Earned/Accrued	4,446	6,418	4,765	4,366	4,946	4,361	6,016	4,028	4,476	
Leave Taken	-4,553	-5,417	-4,334	-5,055	-5,167	-4514	-7,850	-3,621	-2,678	
Leave Buy-out	-796	-1,776	-502	-811	-741	-435	-96	-346	-121	
Transfer/Finish	-76	-328	-263	-381	-179	-	-133	-250	-309	
	-979	-1,103	-334	-1,881	-1,141	-588	-2,064	-191	1,368	6,914



TO Hospital Advisory Committee

FROM General Manager
Clinical Services and Transformation

DATE 14 April 2016

SUBJECT **Maternity Review update**

MidCentral District Health Board
Te Pae Hauora o Ruahine o Tararua

MEMORANDUM

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1. PURPOSE

This report provides an update on the actions underway and progress over the past month with the development of the work programme to address the findings of the independent review of the Maternity Services.

2. SUMMARY

Good progress is being made with the work programme, which is now well established, overseen by the Steering Group. The Working Group is now established to take responsibility for the implementation of the service improvement initiatives. Forums for Maternity Service Staff and Lead Maternity Carers have been well attended and enabled a good exchange over the issues facing the service and the actions underway.

A project manager has been engaged, from 11 April 2016, to support the implementation of the work programme overall. Catherine Marshall is a former MDHB Service Manager. She will provide direct support to the working group and ensure key milestones are met and reported on.

The themes from the six RCA reports have been collated and reviewed to identify any further actions that may be required. The MidCentral Health Serious Adverse Event Governance Group (MCHSAEGG) has confirmed that successful implementation of the relevant service review recommendations will ensure that systemic issues related to the six RCA reports will be addressed.

The Charge Midwife has commenced, from 4 April 2016, as the Clinical Lead for the service improvement activities. Her role is to focus on service improvement in midwifery care, the engagement of LMCs, and the development of a revised model of maternity care, along with supporting the wider multidisciplinary work central to our service improvements.

Incorporating the requirements of the Maternity Quality and Safety programme into our overall service developments has commenced with a scoping of the work involved to achieve better alignment. This work will focus on safety of care, women's experience of care, effectiveness of care along with key projects for service improvement

An Associate Charge Midwife has been identified to complete the Improvement Advisor training, commencing in early May 2016. She will be undertaking a project as part as part of this programme. The project is focussing on reducing stillbirths by raising awareness of the need for women to monitor changes in baby movements during pregnancy, and acting immediately on those changes.

The monthly maternity consumer survey provides direct feedback on women's experience of care in our maternity services. Recent feedback has included that women get varying messages from different staff, particularly around baby care and breastfeeding. There are areas where we can do better and these will be included in our improvement work.

Ten core midwives attended a fetal surveillance course on 14 April 2016, and a final group will attend the next course in November 2016 ensuring that all midwives are trained. The Associate Charge midwives will be participating in a training day on 20 April 2016 to support cohesive and consistent midwifery leadership. That day they will also join with the local College of Midwives for their regular lunchtime meeting.

The review report identified that Women's Health outpatient clinic space was severely compromised. It also highlighted that the model of care for outpatient services created cramped and unsatisfactory conditions for women who were expected to wait long periods of time to be seen. In response to this senior clinical staff, consumer and LMC representatives have undertaken a review of the Women's Health Clinic environment and have identified options for how space could be better organised to support women's care. The next step is for discussion with the clinic staff and to ensure that there is careful consideration around how the model of care can be improved before decisions are made to make changes to the facility.

An external resource has been used to undertake an assessment of the current state of the Maternity Clinical Information System (MCIS). An experienced project manager has met with clinical staff, and the key staff involved internally and externally in supporting the implementation of MCIS. While this will be reported fully for the next update, the preliminary findings largely relate to that need to strengthen understanding of the expectations MDHB has of the system operationally and ensuring that all those that use the system are trained and supported to meet those expectations.

3. RECOMMENDATION

It is recommended:

that the report be received

4. BACKGROUND

In October 2015, an external review was requested by the DHB CEOs following concern that there had been seven reported serious adverse events in the Regional Women's Health Services (RWHS) over the previous nine months; six at Palmerston North Hospital and one at Whanganui Hospital. The events had led to two intrauterine deaths, three neonatal deaths and three neonates with significant morbidity.

The main aim of the review was to establish whether the RWHS was equipped to provide safe and effective maternity care. Together, MDHB and WDHB wanted to ensure that women can access woman and family-centred maternity care at both Palmerston North Hospital and Whanganui Hospital which meets all established standards for service delivery.

The review was carried out by Emma Farmer, Head of Division - Midwifery, Waitemata DHB, Dr Chris Hendry, Midwifery and Maternity Service Development Advisor and Dr Ian Page, Clinical Head, Obstetrics & Gynaecology, Northland DHB.

The review report identified a number of factors that were affecting the effectiveness of service delivery and made eleven (11) major recommendations (along with 20 subsidiary recommendations) to address the issues that had been identified.

As previously reported, a comprehensive work programme (attached as Appendix 1) has been developed to address the recommendations taking a DHB-wide approach. This spans the full continuum of care. Women (and their families) and all providers involved in providing care (from health promotion through ante-natal care, and transfer to well child services) will be included. The timeframe is two years, with the expectation that an ongoing, annual quality assurance/service development work programme would continue as part of "business as usual".

5. COMMUNICATIONS

Ongoing communications is a key focus for the first phase of the work programme. Two forums have been held with maternity service staff and Lead maternity carers (LMCs), with the most recent forum being with the combined groups reflecting the commitment to bringing all the stakeholders together to support better understanding and a shared approach to the improvements underway. The forums have been well attended by both LMCs and service staff. The forums have included both an update on process, along with an opportunity for questions and robust discussion over the challenges the service has been facing and opportunities for improvement.

In addition two written updates have been provided (attached as Appendix 2) to provide update on progress with the establishment of the work programme, steering group, working group and project support, along with information around actions taken in relation to priority areas

The Operations Director is taking time when in the maternity unit with the Charge Midwife to stop and talk with staff. These informal discussions give an opportunity to share perspectives and for the Operations Director to get direct feedback from staff regarding the challenges and frustrations they have experienced.

Next steps from a communications perspective include engagement with wider consumers and Maori, along with the key MidCentral Health Services that interface with Maternity services, Anaesthetics, Diabetes, Child health, maternal Mental Health, Orthopaedics and Emergency Department. This is timetabled for May 2016, by which time the Project Working Group will be fully operational and able to undertake this engagement.

6. PROGRESS UPDATE

Overall good progress is being made in establishing the work programme, with the project structures and support arrangements substantially in place.

6.1. Project Approach

Steering Group
The steering group has now been meeting weekly for over a month, taking responsibility for addressing the recommendations and the work arising from them, and providing support, guidance and direction to the leadership of the service in relation to the necessary actions to be taken. Since 5 April the steering group has a Lead Maternity Carer (midwife) Amanda Douglas join. Arrangements are being made for an Iwi Maori representative to also join the steering group.

Project Sponsor:	Mike Grant – General Manager, Clinical Services and Transformation
Clinical Sponsors:	Michele Coghlan – Director of Nursing Dr Kenneth Clark – Chief Medical Officer
Steering group	Mike Grant, Chair, General Manager, Clinical Services and Transformation Jenny Warren, Consumer Representative Amanda Douglas, Lead maternity Carer (midwife) Michele Coghlan, Director of Nursing Dr Kenneth Clark, Chief Medical Officer Dr Jeff Brown, Clinical Director, Child Health Anne Amoore, Manager, Human Resources Muriel Hancock, Director, Patient Safety & Clinical Effectiveness Iwi Maori Representative – To be confirmed

As previously reported the steering group will provide oversight of and support to the programme of work, however the changes including the service development work will be undertaken by the working group.

Working Group
The core of the working group has been taking responsibility for implementing the improvement work to date. The Service Manager, Acting Clinical Director and Charge Midwife have been meeting weekly with the General Manager to ensure necessary actions are being undertaken. A second Obstetrician and Gynaecologist has been confirmed to join the steering group, along with consumer, Maori and LMC representation. This first formal meeting of the full working group will take place in the week beginning 18 April.

Working Group	Diane Hirst, Chair, Charge Midwife and Project Clinical Lead Jayne Waite, Lead Maternity Carer and Midwife Kelly Wylie, Consumer Representative Dr Steven Grant, Acting Clinical Director Dr Sarah Machin, Obstetrician & Gynaecologist Julie Rob-O'Connell, Iwi Maori/Lead maternity Carer & Midwife Robyn Williamson, Service Manager Barbara Ruby, Quality Coordinator Amanda Rouse, MQSP Coordinator & Midwife

Clinical Lead
The Charge Midwife has been backfilled in her day to day clinical responsibilities to allow her to take the clinical project lead role for the work programme. Her role will be to focus on service improvement in midwifery care and the engagement of LMCs, along with supporting the wider multidisciplinary work central to our service improvements. There are key areas of the work programme that she will take the lead on, including the alignment of the maternity Quality and Safety programme with service improvement plan, the development of the model of care for the service, and the transfer of care audit.

Project Management
A project manager has been engaged to support the implementation of the work programme overall. Catherine Marshall is a former MDHB Service manager. She will provide direct support to the working group and ensure key milestones are met and reported on. In addition an external resource has been engaged to undertake an assessment of the current state of the Maternity Clinical Information system.

6.2. Work Programme Progress

As previously reported the work programme has been developed to address the recommendations. This is attached (refer Appendix 1), and cross references the review team's recommendations. It is a working document and it is being updated on a weekly basis for the steering group meetings to demonstrate progress against each initiative, in line with the established priorities and timeframes.

The work programme is structured to align to the review team's findings and is grouped to align with the MDHB Strategic Imperatives, identified in the new strategic direction, namely:

i. Quality and Excellence by Design
ii. Partner with People and whanau to support health and wellbeing
iii. Connect and transform primary community and specialist care
iv. Achieve equity of outcomes across communities.

Progress against each of these areas is discussed below and details of the actions to date and/or approach going forward is outlined.

i. *Quality and Excellence by Design*

The initial work for the organisation wide review of the current RCA/investigation methodology to strengthen the process, system, leadership and communication is underway. A literature review is being undertaken as well as a review of other DHBs resources is in progress. Key staff have attended a Root Cause Analysis (RCA) workshop in Christchurch. Work continues to progress in considering information from several DHBs and the HQSC.

The themes from the six RCA reports have been collated and reviewed to identify any further actions that may be required. It is noted that this review is primarily a numerical analysis enabling the visibility of the significance of the underlying issues. Taking this into consideration, the MidCentral Health Serious Adverse Event Governance Group (MCHSAEGG) has confirmed that successful implementation of the relevant service review recommendations will ensure that systemic issues related to the six RCA reports will be addressed. In addition the successful, full implementation of every recommendation with the individual RCA action plans and a robust evaluation of the impact of that action will also ensure desired outcomes are achieved, successful and embedded.

An Associate Charge Midwife has been identified to complete the Improvement Advisor training, commencing in early May 2016. She will be undertaking a project as part as part of this programme. The project is focussing on reducing stillbirths by raising awareness of the need for women to monitor changes in baby movements during pregnancy, and acting immediately on those changes.

Key staff have been interviewed in early April as part of the internal Audit on DHB clinical governance.

Incorporating the requirements of the maternity Quality and Safety programme into our overall service developments is underway, commencing with a scoping of the work involved in achieving that better alignment. Initial work has been undertaken to identify the points of alignment, to ensure that the benefits from this key national programme are delivered across the whole maternity environment. This work will focus on

- Safety of Care
- Women's experience of care
- Effectiveness of Care
- Key projects for service improvement

Examples of key projects that will advance the MSQP include, Maternity Clinical Information System Improvements, promoting normal birth, monitoring baby movements in pregnancy, hip checks, and management of miscarriage.

The approach to this work will ensure there is a high level of consumer and stakeholder engagement, engagement with Maori and rural women, and ensuring information for parents.

As reported last month the Director of Midwifery is undertaking a national stocktake of models of midwifery care and will present the outcome of that work by 23 April 2016 for consideration as part of the service development planning.

ii. *Partner with People and whanau to support health and wellbeing*

The MDHB Board at its April meeting approved the HAC recommendation that the current arrangements with Whanganui DHB for the Regional Women's Health Service will be replaced by an explicit memorandum of understanding (MOU) that will detail the clinical integration and collaboration for our women's services going forward before 1 July 2016. Dr Clark, CMO MDHB and Dr Rawlinson, CMO WDHB have met twice to workshop the principles underpinning the future relationship between the Women's Health services of the two DHBs. As there are clear corollaries with how all services interact across the districts initial concepts are to be presented at the centralAlliance subcommittee meeting on 3 May 2016.

The formal engagement leading to consumers and Maori becoming partners in our service improvement journey across all our work streams will commence in May 2016. This will be enabled by the establishment of consumer and Maori on both steering and working groups and the support in place from the project manager to arrange this crucial work.

The steering group has endorsed the approach being used for the current maternity "Partners in Care" (co-design) project around hyperemesis to be expanded for future "co-design" work.

The current monthly maternity consumer survey provides direct feedback on women's experience of care in our maternity services. Recent feedback has included that they get varying messages from different staff, particularly around baby care and breastfeeding. This feedback has been discussed with the steering group. There are clear areas of feedback where we can do better and these will be included in our improvement work, particularly around improving women's experience of postnatal care on the maternity ward.

The midwifery and medical leadership have agreed to participate in a two day team development workshop to support their teamwork and effective functioning. This is planned for 1 and 2 June 2016.

iii. *Connect and transform primary community and specialist care*

The CEO has confirmed the Executive Leadership Team reconfiguration that will inform the development of a proposal for the revised leadership structure for Women's Health.

A local, national and international recruitment process for the Clinical Director position is underway. The job description is being updated to ensure that the position will reflect the recommendations regarding an expectation that Clinical Leaders will work to support the New Zealand Model of Maternity Care. The current Director of Midwifery has resigned, effective 26 April 2016, to take up a position with Health Quality and Safety Commission. Recruitment to the Director of Midwifery position will be undertaken once the Executive

Director Nursing and Midwifery is in place. Michele Coghlan will be Acting Executive Director Nursing and Midwifery from 26 April 2016.

The Charge Midwife will lead the development of the revise maternity model of care that responds to the NZ Model of Maternity care. This work will commence in May 16 with further engagement across the maternity sector, with a focus on bringing together core and LMC midwives with their medical colleagues from the service. This work will include achieving a better mutual understanding of the Section 88 provisions. We are planning to have a series of forums looking at these provisions, the maternity standards and the referral guidelines. We will be inviting wide participation, and envisage contribution from the Ministry of Health, Colleges, and MDHB's legal team, for their perspectives.

Ten core midwives have attended fetal surveillance course on 14 April 2016, and a final group will attend the next course in November 2016 ensuring that all midwives are trained.

The job sizing for Senior Medical Officers has been completed, with two additional senior medical staff positions being established. These positions are being recruited to on a temporary basis with locum appointments, one for a year from 23 May 2016 and another for two years from 26 September 2016, during which time permanent recruitment will be undertaken.

Considerable progress has been made in strengthening midwifery staffing, and developing leadership capacity across maternity services. The Charge Midwife has been backfilled to allow her to focus on service improvement related to the service review implementation. A total of nine midwives have been appointed as Associate Charge Midwives, providing leadership in delivery suite and the maternity ward during the day Monday to Friday and ensuring midwifery leadership is present after hours. A total of twelve midwives have been recruited into the service since November 2015, (including three new graduates). Six of the experienced midwives appointed have been LMCs returning to core midwifery roles. By May 2016, core midwifery staffing will be only 0.2 FTE short.

The Associate Charge midwives will be participating in a training day on 20 April to support cohesive and consistent midwifery leadership. That day they will also join with the local College of Midwives for their regular lunchtime meeting.

The interface between Maternity services and the Diabetes Service, Anaesthetic Department, Emergency Department, Child Health and Maternal Mental Health Service will be the subject of forums with those services in May 2016 to engage and receive feedback on how these interfaces can be improved.

The review report identified that the Women's Health outpatient clinic space was severely compromised by dual gynaecology and obstetric clinics being held that involved both registrars and house officers, supervised by SMOs. It also highlighted that the model of care for outpatient services created cramped and unsatisfactory conditions for women who were expected to wait long periods of time to be seen (up to four hours for women with diabetes in pregnancy). The report noted that staff reported that anecdotally some women did not attend the clinic or left before being seen because of the length of time they waited and the cramped waiting room. In response to this senior clinical staff have undertaken a review of the Women's Health Clinic environment and have identified how space could be better organised to support women's care. This has a focus on looking to dedicate space for women attending clinic for miscarriage. It addition rationalising some office space would allow for an additional clinic space. This would assist in separating gynaecology and obstetric clinics, and to provide more available clinic space generally. There has been an opportunity for a consumer and LMC walk through with their feedback incorporated. The next step is for discussion with the clinic staff as a whole to ensure all the issues and potential opportunities have been canvassed and that there is careful discussion around how the model of care can be improved before decisions are made to make changes to the facility.

An external resource has been used to undertake an assessment of the current state of the Maternity Clinical Information System (MCIS). An experienced project manager has met with clinical staff, and the key staff involved internally and externally in supporting the implementation of MCIS. This work will deliver an assessment report that identifies all the issues for the system, their current status and a pathway for resolution. This will recognise that there are local, regional, national and international dimensions to the issues MDHB has encountered. While this will be reported fully for the next update, the preliminary findings largely relate to that need to strengthen understanding of the expectations MDHB has of the system operationally and ensuring that all those that use the system are trained and supported to meet those expectations. There are technical issues affecting the interface between MCIS and other systems and the speed of the system overall that when resolved will improve the users experience of the system. In relation to the national arrangements there is a need for the national contract to be finalised to clarify global issues of ownership and accountability for the system going forward.

iv. *Achieve equity of outcomes across communities.*

Bringing a fully operational Maternity Quality and Safety Programme into the service improvement approach for our maternity services will provide a much stronger emphasis on the quality of outcomes and delivering services to established standards and guidelines. Much of the work that has been undertaken by the MSQP is ready for wider implementation. An example was a substantial piece of work to map women's journey through maternity services. This provides a benchmark for looking at how our services can be improved.

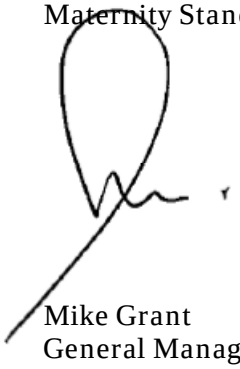
Improvement in outcomes for women is a crucial focus for our improvement programme. Establishment of clinical governance arrangements and a suite of measures to be reported on will give confidence that our service improvements are delivering the benefits that were planned. In addition performance will be monitored via the annual reports for Maternal and Prenatal mortality and morbidity.

7. NEXT STEPS

Structured engagement with stakeholders will occur over May 2016. This includes consumer, Maori, and the range of DHB services that interface with maternity services.

A stocktake will be undertaken of all actions to address the Root Cause Analysis recommendations for the six adverse events.

Service model of care work will be advanced through the incorporation of the MQSP programme and forums with staff and stakeholders over the Sec 88 guidelines, and the NZ Maternity Standards



Mike Grant
General Manager
Clinical Services & Transformation

APPENDIX 1: Women's Health Work Programme
Updated April 2016

The work programme includes all recommendations from the independent review. These recommendations are attached as an appendix to this work programme, and each is referenced against the particular sub-areas.

The work programme also includes key issues noted in the report, and will be expanded to include other issues identified through socialisation of the report which are not already covered.

Stream of Work	Sub-Area	Initiatives	Timeline	Status	Responsibility	Comments	Notes
Quality & Excellence • People • Partners • Information • Stewardship • Innovation	Adverse event/RCA policy and process – organisation wide (Recommendation 9, 28, 29 & 30)	An organisation wide review of the current RCA/investigation methodology will be completed and changes implemented to strengthen process, system, leadership and communication.	Sep 16		Director PSCE	This review will take into account best practice in adverse event review in other DHBs in addition to HQSC advice. The Serious Adverse Event Review Group will provide the clinical leadership to this review.	**30.03.16** Literature review as well as review of other DHBs resources in progress. Attendance at RCA workshop in Christchurch confirmed for early April. **15.04.16** Work continues to progress in considering information from several DHBs and the HQSC.
	Adverse event RCA policy & process – women's health, including awareness and results of index case RCAs (Recommendations 9, 25, 28, 29 & 30)	Collate themes from 6 RCAs and communicate to clinicians and leadership in Maternity Service.	Apr 16	Completed	Director PSCE		**30.03.16** In progress with further work planned on aligning to actions plans and current status. **15.04.16** Completed and endorsed by Serious Adverse event Governance Group.

Stream of Work	Sub-Area	Initiatives	Timeline	Status	Responsibility	Comments	Notes
		Ensure action plans are updated to address any outstanding matters relating to the themes.	May 16		OD		**15.4.16** Themes work to be reviewed by working group and actions updated as required
		All action plans from the 6 RCA and any subsequent adverse events are fully implemented and a follow up of effectiveness of recommendations is undertaken.	June 16		OD		**15.4.16** Stocktake of progress against action plans to be completed by mid May
		Review Terms of Reference, including membership of the Service Improvement Committee.	May 16		Director PSCE	This will ensure that the membership is widely representative of all staff groups including LMCs and that all representatives are supported to attend and participate.	**30.03.16** For working group to progress although a recent review has been completed.
		A small number of senior clinical and management staff to undertake the 4 hour Quality Improvement Training.	Sep 16		Director PSCE	All clinical staff will be provided the opportunity to attend a short session e.g. up to one hour on the PDSA process and principles of quality improvement as opposed to the four hours for senior staff.	**30.03.16** For working group to progress. **15.4.16** Staff to be identified by Working group by end of May
		Staff who are likely to be involved in open disclosure processes or complaint resolution will undertake Open Disclosure training.	July 16		Director PSCE	The Open Disclosure training provides a framework not only for Open Disclosure but also for complaint resolution.	**30.03.16** For working group to progress.

Stream of Work	Sub-Area	Initiatives	Timeline	Status	Responsibility	Comments	Notes
		A minimum of one staff member to undertake Improvement Advisor training with Ko Awatea.	Nov 16		Director PSCE		**30.03.16** Associate Charge Midwife (ACM) confirmed to commence in early May 2016. **15.4.16** ACM has identified "Baby Movements" project to be undertaken as part of this programme
	Internal audit on DHB clinical governance completed (Recommendation 8)	To be undertaken in accordance with Audit work programme.	April 16		TAS	An enabler to support the revised clinical governance arrangements for maternity Services.	**15.4.16** Key MDHB staff have been interviewed by the audit team
	Quality assurance and policies (Recommendations 9, 10, 11 & 25)	Review of policies to be undertaken once clinical governance arrangements, inclusive of LMCs are in place.	Oct 16		CD/DOM	A programme for review will be developed once all the partners in the process are in place. Work has been completed in terms of a stocktake and looking at other DHBs process and system for policies.	

Stream of Work	Sub-Area	Initiatives	Timeline	Status	Responsibility	Comments	Notes
	Maternity Quality & Safety Programme (MQSP) (Recommendations 9, 10, 11 & 25)	MQSP Coordinator on Project Working group.	March 16	Completed	OD	The aim is to have one integrated quality programme for maternity overall – that incorporates all aspects of primary and secondary care and allows for all clinicians to fully participate.	**30.3.16** MSQP Coordinator has agreed to join working group to support alignment.
	Arrangements with Whanganui DHB (Recommendation 1 & 2)	Align MQSP programme with Quality programme for secondary care.	May 16		CD/DOM	To be led by Clinical Lead, Charge Midwife	**15.3.16** Initial scoping work undertaken – map of activities being developed
		Establishment of integrated quality programme.	Dec 16		CD/DOM		
Partnering • People • Partners • Information • Stewardship • Innovation		Recommendation to replace current RWHS arrangements with an explicit memorandum of understanding.	March 16	Completed	GM CS&T		**5.4.16** Approach approved by MDHB Board **15.4.16** Two meetings with WDHB undertaken to date
		Updates to cA sub-committee.	Six-weekly April onward		GM CS&T		
		Recommendation to Boards.	April 16		GM CS&T		
		MoU drafted for CEO approval.	May 16		GM CS&T		
		Strategic Plan advanced.	As per timeline			Separate project	
		Formal review of arrangements with Whanganui DHB.	August 16		CMO		

Stream of Work	Sub-Area	Initiatives	Timeline	Status	Responsibility	Comments	Notes
	Consumer and Maori and Iwi engagement (Recommendation 26 & 27)	Secure consumer input to Steering Group.	March 16	Completed	GM CS&T		22.3.16 Jenny Warren joined Steering group
		Provide findings of review to consumer and Maori participants.	May 16		GM CS&T		**30.3.16** To be commenced once iwi steering group rep confirmed **15.4.16** Included in scope of MQSP work
		Consumer focus group held as part of "socialisation" process.	May 16		GMCS&T	*Further actions to be included following socialisation phase, and as part of service development/model of care. Anticipate consumer/Maori focus group as part of process.*	**30.3.16** For action once project manager commences 11 April 2016
		Review current monthly maternity consumer survey to ensure it meets consumer requirements.	June 16		DPSCE		**30.03.16** For working group to progress with consumer participation. **15.4.16** Feedback from surveys incorporated into service improvement
		Collate both the maternity survey and the national inpatient survey results to share learnings service wide and develop quality initiatives in response to feedback.	June 16		DPSCE		**30.03.16** National inpatient survey data analysed and provided to Maternity services Quality Coordinator. To be progressed by working group.

Stream of Work	Sub-Area	Initiatives	Timeline	Status	Responsibility	Comments	Notes
		Complete implementation of the outcome of the current Partners in Care project (Co design).	July 16		DOM	Once the outcome is fully implemented the skills developed from this will then be utilised for considering a further opportunity for a co design project.	**30.03.16** Current project continues through until May/June at this stage.
		Consumer Council established for Board.	TBC		CEO	Separate but linked project	
Connect & Transform • People • Partners • Information • Stewardship • Innovation	Organisational service structure (Recommendations 3, 8, 15 & 23))	ELT configuration and roles finalised, including DoN/DoM role(s).	March 16	Completed	CEO	Separate but linked project.	**8.4.16** CEO confirmed ELT Structure for implementation
		Service structure/cluster approach determined.	April 16		CEO	Separate but linked project.	
		Consultation on service/cluster structure and roles.	May 16		CEO	Separate but linked project.	
		Service/cluster structure and roles determined.	June 16		CEO	Separate but linked project.	
	Service structure, including LMC linkages (Recommendations 3, 4, 5, 8, 15, 23 & 24)	Job description for CD role developed.	Mar 16		CMO		**30.3.16** Draft developed – for consultation with key stakeholders
		Recruitment of CD.	April 16		CMO		Commenced
		Service structure proposal developed.	April16		GM CS&T		
		Consultation on service structure.	May 16		GM CS&T		
		Decision on service structure.	June 16		GM CS&T		
		Roles and responsibilities detailed and job descriptions developed.	June 16		GM CS&T		

Stream of Work	Sub-Area	Initiatives	Timeline	Status	Responsibility	Comments	Notes
		Recruitment to service structure.	Jun/Jul 16		GM CS&T		
	Service model of care development, including LMC and other providers (Recommendation 3 & 4)	Staff forums held (as part of socialisation phase). *Future steps to be developed.*	May 16 June 16		GM CS&T	To be led by Clinical Lead, Charge Midwife	**15.416** Initial forum 6.4.16 further engagement
	MCIS (Recommendations 7 & 19)	Feedback from staff forums (socialisation phase) re MCIS collated.	April 16		OD		**15.4.16** Project Manager undertaking current state assessment
		Work programme developed.	April 16		OD		
		Awareness and clarification of Registrar and SHO roles provided for each new junior medical staff run.	March, June, Sept, Dec 16		CD		
	Clinical training (inc mandatory training) and support, including teaching hospital status (Recommendations 18, 21 & 22)	Undertake a stocktake of current orientation for all RMOs.	May 16		CD		**15.4.16** The RMO handbook is being reviewed including training requirements
		Identify gaps.	May 16		CD		
		Implement new Orientation Programme and make available to all team members.	May 16		CD		
		Do stocktake of all training requirements.	May 16		CD & DoM		
		Confirm what training should be mandatory and for whom.	June 16		CD & DoM		
		Develop of schedule of training and monitor compliance.	July 16 & ongoing		CD & DoM		

Stream of Work	Sub-Area	Initiatives	Timeline	Status	Responsibility	Comments	Notes
		Implement mandatory training requirement reporting system.	Aug 16		CD & DoM		
	Clinical governance structure for service, inc LMCs (Recommendations 3 & 8)	Systematic review of clinical governance.	Sep 16			Will be undertaken by those in revised leadership positions.	
	Medical staff workforce (size and skill mix) (Recommendations 12 & 17)	Job sizing of SMOs undertaken.	Feb 16	Completed			**30.3.16** Awaiting final decision re FTE **15.4.16** Two additional SMO positions to be established, recruitment underway
	Midwifery workforce (size and skill mix) (Recommendations 13 & 17)	Support for Charge Midwife.	Feb 16	Completed	OD		**4.4.16** Charge Midwife released for Clinical lead role and backfilled for day to day work
		Associate Charge Midwifes appointed for after-hours.	Feb 16	Completed	OD		**15.4.16** All new appointees in place
	Service workforce capacity & capability (Recommendations 6, 7 & 16)	Flex-up and down arrangements and capacity.	May 16		OD	The maternity services will utilise all aspects of the MCH wide approaches to matching workforce to workload.	
		Project management support requirements identified.	Mar 16	Completed	GM CS & T		**30.3.16** Project manager commenced 11 April 16

Stream of Work	Sub-Area	Initiatives	Timeline	Status	Responsibility	Comments	Notes
	Transfer of care audit, inc LMCs (Recommendation 14)	Audit tool Developed. Audit undertaken Audit results incorporated into model of care development.	June16 July 16 August 16		DOM DOM DOM	Charge Midwife to lead this work – timeframe adjusted taking into consideration related work that needs to be undertaken first	
	Maternity work environment, inc LMCs (Recommendation 31)	Confirm Scope of work.	April 16		OD		**30.3.16** Initial options being identified **15.4.16** Options discussed with stakeholders
		Detail Plan.	May 16		OD		
		Undertake Work.	June /July 16		OD		
	Interface with diabetes service, inc LMCs (Recommendation 3)	Forum held (as part of socialisation phase).	May 16		GM CS&T		**30.3.16** For action once project manager commences 11 April 2016
	Interface with orthopaedics service (Recommendation 3)	Forum held (as part of socialisation phase).	May 16		GM CS&T		**30.3.16** For action once project manager commences 11 April 2016
	Interface with maternal mental health service (Recommendation 3)	Review approach to hip checks for congenital abnormality.	May 16		CD		
		Recommendation to Steering Group.	May 16		CD		
		Recommendations implemented.	Jun 16		CD		
		Forum held (as part of socialisation phase).	May 16		GM CS&T		**30.3.16** For action once project manager commences 11 April 2016

Stream of Work	Sub-Area	Initiatives	Timeline	Status	Responsibility	Comments	Notes
	Interface with child health service (Recommendation 3)	Forum held (as part of socialisation phase).	May 16		GM CS&T		**30.3.16** For action once project manager commences 11 April 2016
	Interface with anaesthetic service (Recommendation 3)	Forum held (as part of socialisation phase).	May 16		GM CS&T		**30.3.16** For action once project manager commences 11 April 2016
	Team Development, inc LMCs (Recommendations 5 & 20)		June 16			To be determined once new leadership and governance arrangements are in place.	
Equity of Outcomes • People • Partners • Information • Stewardship • Innovation	National datasets and trends for MDHB (Recommendation 4)	National Maternity Monitoring Group Annual Report reviewed by Steering Group, Clinical Governance Council and Service	TBC			To be determined once new leadership and governance arrangements are in place.	**15.4.16** To be informed by MQSP work
		Monitor performance via Annual perinatal & Maternal Mortality Review Report.	TBC				
		Future steps to be developed.					

Recommendations from Independent Review

No	Recommendation
	Contextual factors
1.	In light of the failure of the RWHS to develop into a fully integrated service, it is recommended that the project be reviewed and a less complex process developed to enable reliable obstetric cover for Whanganui DHB to be maintained.
2.	Whanganui DHB and MidCentral DHB develop a memorandum of understanding or similar arrangement that lays out clearly for staff and the community steps to take in the event of suspension of services due to staff shortages.
3.	Accountability and responsibility for developing and maintaining relationships between clinicians within these maternity services need to be clarified.
4.	MDHB needs to provide clear leadership and an expectation that the Clinical Leaders will work to support the New Zealand Model of Maternity Care.
5.	The role of the LMCs within the service need to be supported within a collegial environment reflective of the philosophy underpinning the New Zealand Maternity Service model of care.
6.	The resources required for these nationally-mandated activities need to be adequately assessed and provided. Obtain broader DHB support for the activities to achieve economies of scale and better integration with other similar activities within the DHBs.
7.	Mitigate risk associated with the MCIS roll out until the system and processes are identified as clinically appropriate.
	Organisational & management factors
8.	The MDHB organisational and governance structure needs to be reviewed to provide more clarity over the responsibilities and accountabilities of the clinical leaders and management.
9.	• Consider greater integration of the quality activities within the MDHB maternity service with the DHB quality team, including training of staff and LMCs in the standardised quality processes, such as the RCA process and related quality assurance activities. This may require additional resources.
10.	• Clarify the lines of accountability and responsibility for quality and outcomes at both service and organisational level.
11.	• Actively include all maternity staff including LMCs in maternity service quality assurance and policy development activities.
	Work environment factors
12.	• Alter the SMO requirements of the service to ensure appropriate Obstetric cover 24/7 and support for registrars in training.
13.	• Alter the midwifery staffing model to include the presence of an Associate Clinical Charge Midwife on every shift. This is an important cornerstone of clinical safety and should be undertaken as a matter of urgency
14.	• Undertake a (DHB Midwife Leaders and NZCOM) Transfer of Care Audit to obtain a more accurate picture of how often and why transfer of care occurs. The results will be benchmarked with other DHBs and shared with LMCs and core midwives to inform discussion on continuity of midwifery care strategies.
15.	• The role of the DOM should be reviewed to ensure that they have responsibility and accountability for safe staffing and sufficient latitude and influence to manage the unit safely
16.	• Explore ways that the service can respond more efficiently and effectively to workload variance, by implementing an on-call system or similar.
	Team factors
17.	Given the increased complexity in maternity care, the midwifery and obstetric staffing needs to be reviewed to ensure that appropriate cover and skill mix is provided 24/7.
18.	The clinical training programmes need to be multidisciplinary and attended by all clinicians.
19.	• The MCIS development process needs to be inclusive of all clinicians and services that interface with the Maternity Service. This includes the quality team.
20.	• Once the leadership and management accountabilities are established, team building activities need to be developed that include LMCs and interface clinicians.
21.	• At the beginning of each SHO quarter all members of each team have the roles of the SHO and the registrar explained.
22.	• Identify and support attendance at mandatory clinical training/learning sessions for all clinicians.
	Individual staff factors

23.	• Clarify the roles and responsibilities of the clinical leaders, then support them to develop a more collegial environment among clinicians, including LMCs.
24.	• Ensure standards are met around communication, interdisciplinary training, and service planning.
	Task & technology factors
25.	• The main means of managing the adverse events seemed to be the generation of more policies and guidelines. Once the clinical leadership responsibilities are clarified, a genuine multidisciplinary process, including LMCs, interface providers and consumers needs to be established to review all of the policies and guidelines for the service.
	Patient factors
26.	The service should consider more active engagement with consumers in service development and feedback.
27.	• The service should consider more actively engaging Maori and consumers in service development and feedback. With a growing level of patient complexity, the service needs to ensure that it meets the growing service need.
	Adverse events
28.	All RCA reports should be completed as soon as possible and the key themes that emerge out of these need to inform future service development activities.
29.	• All RCA reports should be completed as soon as possible and should consider the service context (similar to the London Protocol framework).
30.	• The key themes that emerge out of the full set of RCA reports need to be shared with clinicians and management to inform future service development activities.
	Environment
31.	The working environment within the MDHB Maternity Service needs to improve as a matter of priority. Both the physical surroundings and the way the LMC and facility maternity staff work within it need to be addressed.

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11 March 2016

Open letter to the Women's Health Service and LMCs

Thank you to all maternity service staff and our partners, the lead maternity carers of our district, for the professionalism you have demonstrated over the past week. The maternity review has brought publicity and scrutiny on us and I appreciate just how difficult this can be.

We are public health service providers so it is important we are open and transparent with our communities.

The review findings will be discussed at next week's meeting of our Board's Hospital Advisory Committee, together with a work programme for addressing all recommendations. This may generate more publicity. You can access a copy of the report from our website: http://www.midcentraldhb.govt.nz/HealthServices/WomensHealth/Pages/MS-Review.aspx

In presenting the report, management will be focusing attention and discussion on the way forward – how together we will reshape our service so that it exceeds expectations for women and their families, and for all those who work in and with the service.

Regional Women's Health Service Arrangement

We will be recommending to the Hospital Advisory Committee that we replace the current regional women's health service structure with a local service model, and that our relationship with Whanganui is managed through a Memorandum of Understanding. This will set out how we will work together on clinical integration and collaboration, including when either of our services are unable to provide full cover and require support. It is recommended the new arrangements come into place by 1 July 2016 and I will keep you updated.

New Model of Care

Looking forward, our Director of Midwifery, Dr Leona Dann, is currently researching the way maternity services are structured and delivered in other parts of the country, and the model of care used. Leona's research will be shared with you. This work will help inform us as we reshape our own service and discuss all options to provide a better service to our communities.

Current & Future Leadership Arrangements

Robyn Williamson, Service Manager, and Diane Hirst, Charge Midwife are the contact points for all operational matters. Leona remains available to assist on matters of a midwifery professional nature.

The development of a new leadership structure for our service is a key first step on the work programme we are developing. At an organisational level consultation on the make-up of our Executive Leadership Team closes today. The decisions around professional roles (Executive Director, Medical; Executive Director, Nursing & Midwifery; and Executive Director, Allied Health) will influence what happens at a service level. Once these decisions are known, we will look at what structure is best for our service. Your involvement in this is very important.

The decision to move away from the Regional Women's Health Service model has prompted Dr Digby Ngan Kee to relinquish his clinical director duties so he can concentrate on his gynaecology work. We thank Digby for his dedication in leading the Regional Women's Health Service. Dr Steven Grant has agreed to continue as Acting CD while we recruit a permanent replacement. We will be using a search company specialising in medical recruitment and you can expect to see advertisements over coming weeks.

Current Focus

Work on improving the root cause analysis process used across the organisation will also get underway over the next week or so. This will be led by Muriel Hancock, Director, Patient Safety & Clinical Effectiveness.

For the service, the next steps involve a number of staff and LMC forums to discuss the report findings and the work programme for moving forward. Details of these forums will be advised next week. We will also be meeting with consumer and Iwi groups, clinical stakeholders, and other services we work with closely such as anaesthetics, paediatrics, diabetes and ED to get their input. Collectively, we have a wealth of knowledge and experience, and a range of perspectives and I am looking forward to hearing from you all.

This work will be overseen by a Steering Group and co-ordinated by a Working Group.

Thank You

Thank you for your ongoing support and commitment to women and babies of the region. These are challenging times but it is also a great opportunity for us to reshape our service and future.

Mike Grant
General Manager, Clinical Services & Transformation

1 April 2016

Maternity Service Staff
Lead Maternity Carers

Update on progress with the implementation of recommendations from the Maternity Service Review

Thank you all for your ongoing professionalism and hard work in the last few weeks following the release of the review findings. This update provides information on the work being undertaken to support the implementation of the Maternity Review recommendations.

Follow up forums with service staff and LMCs

A meeting has been arranged **for 4.45pm** on **Wednesday to 6th April,** following the Perinatal meeting, for the first follow up forum with service staff and LMCs. This forum will focus on updating around the establishment work and the urgent matters that have been given attention. Further forums will be undertaken on a regular basis to support the free flow of communication regarding the developments in Women's Health.

Work Programme
Good progress is being made in establishing the Maternity Review work Programme, building on the urgent actions that have been already completed. The steering group is meeting weekly. Clinical staff, consumer and Maori representation is being finalised for the working group, which will commence its work in the next fortnight. Work is underway in line with the work programme timeline and priorities. The key areas of focus over the next few weeks are:

- Establishing the working group and Diane Hirst has been released to undertake a clinical project lead role
- Identifying improvements to the outpatient clinic environment
- Collating themes from the adverse events to ensure all necessary improvements are being undertaken
- Aligning the maternity work programme with the maternity Quality and Safety Programme
- Improving MCIS
- Finalising Senior Medical Staff arrangements
- Strengthening relationships between professional groups, including O&Gs, midwives, LMCs and the key services that interface with Maternity, Child Health, Anaesthetics, Diabetes, Orthopaedics and Maternal Mental Health.

Recent Appointments

Acting Clinical Director
Steven Grant has kindly agreed to continue as Acting Clinical Director whilst recruitment takes place for a permanent replacement. This recruitment process is expected to commence over the next couple of weeks, and will include a national and international search for a suitable candidate.

Locum Senior Medical Officers
Dr Bill Ridley O & G, commences 4 April 2016 until the 3rd of June
Dr Joann Titelis O & G commences 23 May 2016 and will be with us for 12 months.

Associate Charge Midwives
Roz Newman will be the ACM in Delivery Suite during the day, Monday to Friday
Fiona McConnon will be the ACM on the Antenatal/Postnatal ward, Monday to Friday during the daytime.
Nicky Budding, Miriam Cahill, Carolyn Mack, Za Vivian, Annie Kinlock, Andrea Howard, and Susanne Saunders will work the afternoon, night and weekday rosters.

Project Clinical Lead for Midwifery
With Associate Charge Midwives (ACMs) in both delivery and the ward Monday to Friday during the day Diane Hirst will take up a project lead role to support our clinical service improvements with a focus on midwifery. Diane will continue as Charge Midwife providing oversight and leadership for the ACMs.

Project Manager
The development work being undertaken is a large programme of activities that will need careful planning, coordination and reporting of progress. Catherine Marshall (formerly Service Manager Surgical Services until 2014) has been appointed to project manage the work programme. She will support the Steering Group and Work Group in ensuring that our work programme takes place as planned. Catherine commences on 11 April and will be working 20 hours a week.

Steering Group and Working Group

Steering Group
The steering group is meeting weekly to oversee and direct our maternity improvement work. The members are

Mike Grant, General Manager Clinical Services and Transformation (Chair)
Jenny Warren, Consumer Representative
Dr Ken Clark, Chief Medical Officer
Michele Coghlan, Director of Nursing
Anne Amoore, Manager of Human Resources
Muriel Hancock, Director Patient Safety & Clinical Effectiveness
Dr Jeff Brown, Clinical Director, Child Health

We are in the process of finalising Iwi Maori and LMC representation. The steering group will provide oversight and support to the programme of

work, however the changes including the service development work will be undertaken through the working group.

Working Group
The working group is being established, with consumer and LMC and iwi representation being finalised.

Robyn Williamson, Service Manager, Child & Women's Health
Diane Hirst, Clinical Project Lead & Charge Midwife
Dr Steven Grant, Acting Clinical Director
Dr Sarah Machin, Obstetrician & Gynaecologist
Paula Spargo, Charge Nurse Neonatal Unit
Amanda Rouse, Coordinator, Maternity Quality & Safety Programme
Barbara Ruby, Quality Coordinator

It is intended that the working group meet weekly and work across the practice environment with service clinical staff, LMCs, staff from other services, consumers and families to put in place the changes and developments to improve the service.

Section 88

To support achieving a better mutual understanding of the Section 88 provisions, we are looking to have a series of forums looking at these provisions, the maternity standards and the referral guidelines. We will be inviting wide participation, and envisage contribution from the Ministry of Health, Colleges, and MDHB's legal team, for their perspectives. We will let you know of the dates as soon as they are finalised.

Facility changes

Changes to the SMOs' office are being drawn up to ensure 5-6 working office spaces are available. Plans are expected back for approval in the next week.

For the Women's Health Outpatients area we are looking at two options to improve the flow for patients and their experience of care. It is important that we get a better balance of staff and patient spaces. When the plans are available these will be released for feedback. Included in the options we are looking at a proposal for a miscarrying women's area and moving the staff office. While we are limited with the space we have to work within the clinic, improvements can and will be made to make for a better environment for care to women. This should in turn improve things for staff.

MCIS

Improving MCIS is a key priority. I am meeting with the MCIS steering group early next week where we wish to identify what improvements can be made to improve the system as a matter of priority. Jane Stojanavic, Charge Midwife Horowhenua/Otaki maternity has kindly offered to work alongside clinicians in Palmerston North, where she can share her knowledge and practical understanding of the system.

Thank You

I would like to reiterate my thanks to you all for your ongoing support and the commitment you show to the women and babies of our district. Making progress with improvements to our services is crucial and we need your support for this to be a success.

Mike Grant
General Manager, Clinical Services & Transformation

TO Hospital Advisory Committee
Community & Public Health Advisory Committee

FROM General Manager - Strategy, Planning and Performance
General Manager – Clinical Services & Transformation

DATE 11 April 2016

SUBJECT **Renal Plan for MidCentral DHB**

MidCentral District Health Board
Te Poe Hauora o Ruahine o Tararua

MEMORANDUM

1. PURPOSE

The purpose of this report is to update the committees on the Renal Plan. No decision is required.

2. EXECUTIVE SUMMARY

A project to develop a plan for MidCentral DHBs renal service has commenced. Capacity has recently been reached for facility based haemodialysis provided at the renal unit and the self-care facility on Ruahine Street. Spare capacity is needed in order to treat new patients, acute presentations or transfers from home dialysis. Patient sessions are being juggled in order to maintain an appropriate level of service. This needs a solution, however it is important that this solution reflects current and future service requirements.

3. BACKGROUND

Most people with kidney disease are managed by general practice teams. Specialist services for those with severe deterioration in kidney function, including dialysis are provided by MidCentral Health for the MidCentral and Whanganui populations. Capital & Coast DHB is the principle tertiary provider and performs kidney transplant operations.

The demand for renal services has been steadily growing over the past two decades. More people are receiving dialysis or transplant for end stage kidney disease. The prevalence of dialysis in New Zealand has increased significantly from 436 people per million in 2004 to 606 per million in 2013. MidCentral Health has experienced a similar increase in demand for its dialysis services. There are currently 147 people receiving dialysis, 41% at home and 59% at MidCentral Health facilities.

Previous MidCentral DHB planning exercises have developed strategies to cope with this – a self-management facility for haemodialysis was opened opposite the hospital in 2007 and there have been a number of initiatives in primary care to improve the detection and management of chronic kidney disease. 'Kidney Health in Horowhenua' improved general practice systems and processes for kidney disease and clinical collaborative pathways for chronic kidney disease and renal impairment have been introduced.

Strategy, Planning &Performance
MidCentral DHB
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Palmerston North 4440
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The most recent review in 2013 found that current facilities for haemodialysis would be adequate until the year 2022. However, since this time (particularly in the last year) there has been a significant rise in the number of people requiring haemodialysis and capacity has been reached much earlier than expected – this shows how difficult it is to accurately estimate the demand for dialysis services.

Renal service costs have been escalating, MidCentral DHB's investment has increased from $6 million to over $8 million in the last five years.

Project goal and approach
The goal of the project is to provide a plan to guide future decision making for renal service delivery, workforce and facilities and make improvements to service sustainability.

New options for services will be considered including where and how they are delivered and the resources required, in particular, the facilities required for MidCentral DHB. The project will look at the whole of the patient journey recognising that dialysis in the hospital is part of a journey that begins in primary care. The future model of care will consider what needs to occur in general practice to better manage chronic kidney disease, home dialysis and what is needed to support this and the best location for haemodialysis including consideration of non-hospital locations.

A transition plan will outline the actions required to resolve the immediate service and capacity issues.

Input will be obtained from a range of people including clinicians and managers from primary and specialist services. Patients will be informed of the project via letter and will also have opportunity to provide input.

The process will include interviews, analysis of service information and looking at the situation elsewhere, including other DHBs.

Project resources and governance
Project management has been outsourced – Sharon Bevins is undertaking this work.

General managers Mike Grant and Craig Johnston are project co-sponsors and have formed a steering group. Members are:

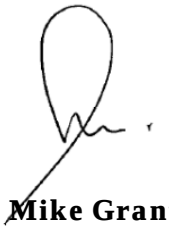
- Valerie Barnes and Tony Davis – Consumers
- Dr Bruce Stewart – Medical Director Primary Care
- Dr Norman Panlilio – HOD Renal Services
- Gillian Treloar – Nurse Manager Renal
- Amanda Driffill – Service Manager Medical Services
- Dr Mark Beale – Clinical Director Medical Services
- Lyn Horgan – Operations Director
- Jan Dewar – Nurse Director

Progress
Information gathering is well underway with stakeholder discussions and benchmarking work nearing completion. The focus over the next month will be analysis of service information, short term capacity planning and initial work on future options. The report is expected to be submitted to CPHAC's July 2016 meeting.

4. RECOMMENDATION

It is recommended:

that the report be received



Craig Johnston
General Manager
Strategy, Planning and Performance

Mike Grant
General Manager
Clinical Services & Transformation

TO Hospital Advisory Committee

FROM Mike Grant
General Manager
Clinical Services and Transformation

DATE 15 April 2016

MEMORANDUM

SUBJECT **MCH Operations Report – February/March 2016**

1 PURPOSE

This report is for the Committee's information and discussion. It provides information about MCH's (MCH) financial and operating performance for February 2016. The report also provides updates on the progress MCH has made towards meeting the Ministry of Health's health targets and other initiatives currently under way.

2 SUMMARY

Business initiatives remain a priority in addressing revenue shortfalls and managing expenditure. The initiatives relate to targeted improvements at a service level and include work on managing increased demand while retaining similar workforce resource, improving demand management in medical imaging, as well as the ongoing work on improvements in patient flow, average length of stay and seasonal planning.

Overall the March contribution is $840k unfavourable to budget, which is an improvement on the previous month. Revenue is favourable to budget by $383k. Expenditure for March is $1.2 unfavourable, impacted by the associated costs of a continued high level of unfunded acute activity and demand which in turn drives clinical costs. Pharmaceuticals are over budget this month as are prosthesis and ambulance costs.

The Shorter Stays in the Emergency Department target was not achieved in March (94 per cent). This was due to high levels of presentations through the Emergency Department(ED). Trend analysis indicates that the volume of presentations to the ED and subsequent admissions will continue to remain high going into winter. Teams across the DHB are working together to instigate strategies that will assist in the planning and management of patient flow across the district and to support patients to manage their health during the winter months. The initiatives which were introduced for previous winter plans continue and where appropriate work continues to build and develop upon them.

The 2016 Influenza Vaccination campaign commenced on 5 April and will be managed as a high profile high saturation campaign for six weeks until 18 May.

The Faster Cancer Treatment 62 day target was not achieved in March however the results are improving. Twenty three patients were managed through the pathway, the highest result since the target was reported. The Faster Cancer Treatment in Secondary Care project continues to make good progress, increasing participation and leveraging improvements for all cancer patients. Nationally MidCentral DHB continues to perform well over time.

MCH has achieved yellow status in ESPI 2 and 5. A concentrated effort has been made throughout January and February in order for MCH to achieve compliance.

Further to discussion at a previous Hospital Advisory Committee meeting, the Chief Pharmacist, Lorraine Welman, will provide a presentation during the operations report section, in relation to medication events.

3 RECOMMENDATION

It is recommended

that this report be received

4 OPERATING RESULTS – FEBRUARY/MARCH 2016

The following information provides a summary of the financial results for MidCentral Health for the prior month, month and year to date based on MidCentral DHB's District Annual Plan (DAP) 2015/16.

Table 1 MidCentral Health - Financial Performance

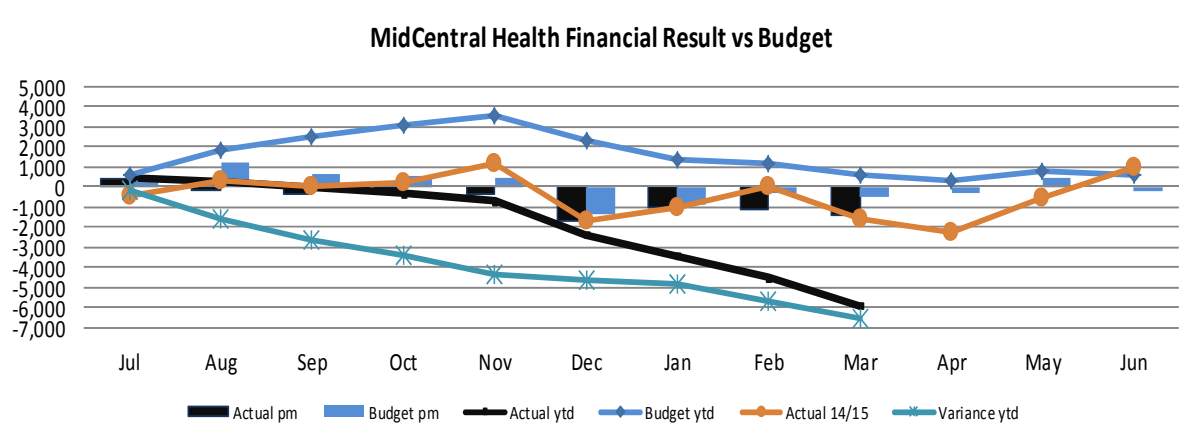
$000	Prior Month			March			Year to date	
	Actual	Variance	%	Actual	Variance	%	Actual	Variance
Revenue	**25,030**	**385**	1.6%	**27,360**	**383**	1.4%	**237,722**	**2,781**
Expenditure								
Personnel	15,068	(389)		16,467	(107)		137,807	(1,417)
Outsourced Personnel	345	(283)		433	(369)		3,573	(2,999)
Sub-Total Personnel	15,413	(672)	(4.6%)	16,899	(476)	(2.9%)	141,380	(4,416)
Other Outsourced Services	1,695	(383)	(29.2%)	1,769	(297)	(20.2%)	15,455	(2,749)
Clinical Supplies	4,027	(303)	(8.1%)	4,764	(583)	(13.9%)	39,566	(3,197)
Infrastructure & Non-Clinical	4,516	150	3.2%	4,838	133	2.7%	43,127	1,095
Total Expenditure	**25,650**	**(1,208)**	(4.9%)	**28,270**	**(1,223)**	(4.5%)	**239,529**	**(9,267)**
Operating Surplus/(Deficit)	**(620)**	**(824)**		**(911)**	**(840)**		**(1,807)**	**(6,486)**
Corporate Services	450	(0)		450	(0)		4,053	(0)
Surplus/(Deficit)	**(1,071)**	**(824)**		**(1,361)**	**(840)**		**(5,860)**	**(6,486)**

Commentary on the result is provided further below.

4.1 Forecast

The forecast is currently being re-evaluated.

Graph 1 Financial Result Graph



The bar graph represents the month's result against budget and the line graph represents the year to date result against budget.

Table 2 MidCentral District Health Board - Financial Performance

$000	Prior Month			March		Year to date	
	Actual	Budget	Variance	Actual	Variance	Actual	Variance
MidCentral	(1,071)	(247)	(824)	(1,361)	(840)	(5,860)	(6,486)
Enable	(11)	(4)	(8)	(22)	(11)	243	139
Funding Division	1,486	1,467	18	(283)	426	1,575	519
Governance	(39)	(31)	(8)	194	(65)	(203)	168
Total DHB	364	1,185	(821)	(1,473)	(490)	(4,246)	(5,659)

The Provider Division result above includes the Health Care Development Team and Support Links.

4.2 Commentary - February

4.2.1 Financials

The monthly result was $1,074k unfavourable to budget.

4.2.2 Revenue /Funding

Overall revenue was $305k favourable. Total case weights were 101 above target, acute cwds were 128 above target with surgical elective cwds 15 below target; total first attendances were 333 above target and follow up attendances were 652 above target.

4.2.3 Cost Structure

Overall expenditure was $1,378k unfavourable. Personnel costs were $559k unfavourable and outsourced personnel $283k unfavourable. Outsourced services were $383k unfavourable relating mostly to services with other DHBs.

Clinical supplies were $303k unfavourable; treatment supplies was $216k unfavourable, blood products $90k unfavourable; pharmaceutical costs were $206k unfavourable; the majority of this ($150k) has revenue offset. Infrastructure costs were $150k favourable.

4.3 Commentary - March

4.3.1 Financials

The monthly result was $840k unfavourable to budget.

4.3.2 Revenue /Funding

Overall revenue was $383k favourable. Total case weights were on target, acute cwds were 21 above target with surgical elective cwds 27 below target; total first attendances were 510 above target and follow up attendances were 853 above target.

4.3.3 Cost Structure

Overall expenditure was $1,223k unfavourable. Personnel costs were $107k unfavourable and outsourced personnel $369k unfavourable. Outsourced services were $297k unfavourable, relating mostly to services with other DHB's.

Clinical supplies were $583k unfavourable; hips and knees $73k unfavourable; pharmaceutical costs were $312k unfavourable; the majority of this ($180k) has revenue offset, with infections $126k unfavourable; other client costs relating to road and air ambulance was $120k unfavourable. Infrastructure costs were $133k favourable.

Business initiatives remain a priority in addressing revenue shortfalls and managing expenditure. The initiatives relate to targeted improvements at a service level and include work on managing increased demand while retaining similar workforce resource, improving

demand management in medical imaging, as well as the ongoing work on improvements in patient flow, average length of stay and seasonal planning.

Table 3 Actual to Budget Trend

$000				<Actual	Budget >		
	Dec	Jan	Feb	Mar	Apr	May	Jun
Revenue	**26,104**	**24,723**	**25,030**	**27,360**	**25,376**	**27,317**	**26,364**
Expenditure							
Personnel	15,717	14,939	15,068	16,467	15,053	15,462	15,662
Outsourced Personnel	455	348	345	433	64	64	64
Total Personnel	**16,173**	**15,287**	**15,413**	**16,899**	**15,117**	**15,527**	**15,726**
Outsourced Clinical Services	1,657	1,668	1,695	1,769	1,384	1,526	1,442
Clinical Supplies	4,765	3,718	4,027	4,764	3,927	4,287	4,058
Intrastructure & Non-Clinic	4,729	4,644	4,516	4,838	4,813	5,044	4,895
Expenditure	**27,324**	**25,317**	**25,650**	**28,270**	**25,241**	**26,384**	**26,120**
Recharging	450	450	450	450	450	450	450
Net Result	**(1,671)**	**(1,044)**	**(1,071)**	**(1,361)**	**(315)**	**483**	**(206)**

The schedule shows the actual and the next budgeted months of the financial year

4.4 CAPITAL EXPENDITURE

Table 4 Capital Expenditure Programme 2015/16

Capital Expenditure Programme 2015/16
MCH Year Ended 30 June 2016-March 2016 Month End

	Budget 2015/16 $'000's	Approved $'000's
MCH Provider		
Commercial Support		
Generators	605	605
Substation (Phase 2)	400	
Laundry Substation	250	250
Seismic Work	450	450
Fire Cell Penetration	485	
Items under $250k	2,225	871
	4,415	
MCH		
Linac Sinking Fund	360	
Bed Replacement Programme	427	312
Planning Equipment -Radiotheraphy	350	
Anaesthetic Machines	530	530
Medical Imaging equipment	1,250	280
Items Under $250k	4,275	883
	7,192	
Investment		
Master Health Services Plan- Hospital Reconfiguration	2,000	2,000
	2,000	
Total MCH Provider (MCH & Comm Support)	**13,607**	**6,181**
TOTAL CAPEX 2015/16		
Earlier Years	**14,369**	
Current Year	**13,607**	
Total	**27,976**	
Total Cfwd 30 June 2015 (Approved or in action at 30 June 2015)		
Earlier Years	14,369	
Total	**14,369**	
CAPITAL SPENT YTD		
Carried Forward Approved CAPEX Prior Years	4,942	
CAPEX Programme 2015/16	2,637	
Total	**7,579**	

5 PERFORMANCE MEASURES

Table 5 Summary KPIs February/March 2016 and Year to Date

Report		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		YTD
Personnel costs (including locums)		X	X	X	X	X	X	X	X	X		X
Elective Initiative plan	CWD	X	√	X	X	√	√	X	X	√		X
	Discharges	X	X	X	X	√	√	√	√	√		√
Medical bed occupancy		√	X	√	X	X	X	X	√	√		√
Faster Cancer Treatment		√	X	√	X	√	√	X	X	X		X
ED wait times		X	X	X	X	√	X	√	X	X		X
ESPI 2: Patients waiting longer than four months for their FSA		√	√	√	√	√	X	X	√			√
ESPI 5: Patients given a commitment to treatment but not treated within four months		X	X	√	√	√	X	X	√			√
Smoking Cessation (secondary services)		X	√	√	√	√	√	√	√	√		√

Detailed information regarding performance against these measures is given in Appendices 5 and 6 (except for Shorter Stays in ED, which is reported below).

Graph 2 Faster Cancer Treatment – March 2016

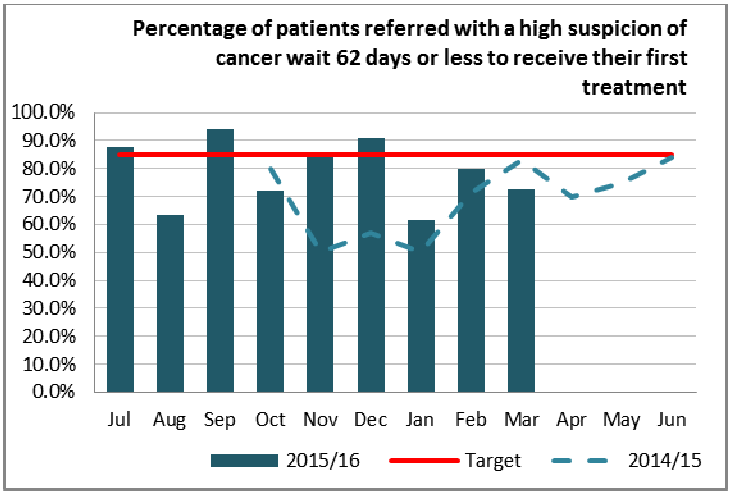


Table 6 MidCentral Domicile Patients

	Mar	Feb		YTD
Number of patients treated within 62 days	16	12		108
Number of patients identified with high suspicion of cancer	22	15		137
Percentage treated within time frame	*72.7*	*80*		*78.8*

An improving result for the FCT target, although the percentage did decrease in March it should be noted that 23 patients were managed through the pathway, the highest result since the target was reported.

5.1 Shorter Stays in Emergency Department (ED) Target

Target: Ninety five per cent of patients will be admitted, discharged, or transferred from ED within six hours.

The Shorter Stays in the Emergency Department target was not achieved in February (92.4 per cent). This was due to exceptionally high levels of presentations through the Emergency Department(ED).

Prior to the 2015/2016 financial year, this level of ED presentations in a single month has only been seen twice before and that was in August 2010 and 2012. Traditionally February sees the lowest number of presentation through ED. In addition, there were 500 more acute admissions in February 2016 compared to February 2015.

The shorter stays in the Emergency Department target result for the quarter was at 94.1% at the end of February.

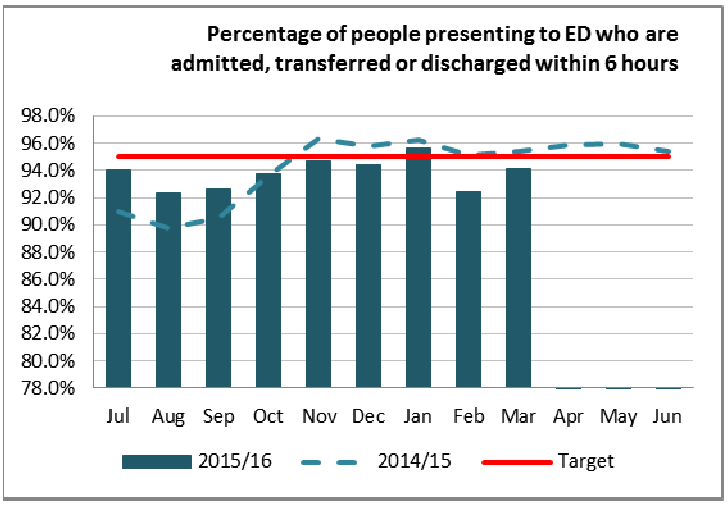
In March the number of ED presentations remained high, only exceed once before prior to this financial year and that was in August 2010. The admissions were almost in line with March 2015, seeing 22 more admissions in 2016.

The shorter stays in the Emergency Department target result for the quarter was 94 per cent.

Table 7 Percentage of Patients Discharged or Transferred within Six Hours

	Mar	Feb		YTD
Presentations admitted discharged transferred within six hours	3484	3344		31,028
Presentations	3701	3619		33,086
Percentage treated within timeframe	*94.1*	*92.4*		*93.8*

Graph 1 Emergency Department (ED) Patients Discharged or Transferred within Six Hours – March 2016



The daily presentation average was 124 for February, with variations between 106 and 149. The daily presentation average was 119 for March, with variations between 96 and 146. The annual daily average was 111 for 2014/15, in 2015/16 the daily average has increased to 120. The percentage of patients admitted in February (29 per cent) was lower than for February 2015 (30.8 per cent). However, there was an increase of 90 patients requiring admission. The average daily admission rate was 36 patients with variations between 20 and 50.

The percentage of patients admitted in March (29.4 per cent) was also lower than for March 2015 (30.5 per cent) but with a 22 patient admission increase. The daily admission rate was 35 with variations between 27 and 49. The annual daily admission average was 34 for 2014/15.

For the first nine months of the 2015/16 year the ED presentation increases equate to a 9.2 per cent increase compared to 2014/15. For acute admissions there is a 10.3 per cent increase compared to the first nine months of 2014/15.

Trend analysis of the data is indicating that the volume of presentations and admissions will continue to remain high going into winter.

February and March continued with high acute surgical admission. The acute demand on the Orthopaedic specialty in particular has resulted in a number of elective cases being deferred for acute patients. February saw 896 elective and acute procedures through theatre,

this being the highest throughput ever. There have been a number of elective specialty lists delayed or patients deferred due to acute specialty patients. We are aware this may have the potential to impact the four month threshold and to assist with managing this issue, patients on the Theatre list that are close to or on the four month threshold are being identified.

Teams across the DHB are working together to instigate strategies that will assist in the planning and management of patient flow across the district and to support patients to manage their health during the winter months. The initiatives which were introduced for previous winter plans continue and where appropriate work continues to build and develop upon them, such as:

- The *Winter Warrant of Fitness* letters will be going out to patients who in past years have been admitted with chronic obstructive pulmonary disease and chronic heart failure. This year the letters will be a joint collaboration between the patient's GP and their secondary care consultant.
- The *influenza immunisation programme* has commenced with a target of seventy per cent of staff immunised, having achieved sixty per cent in 2015.
- The *bed resource requirements* for winter have been reviewed. A number of the beds will be flexibly used during April and May within both the surgical and medical lines. In addition, the nursing staff bureau will build up staffing to enable beds to be resourced as required dependent upon the clinical requirement of patients. Areas identified for this purpose are based in medical, surgical and rehabilitation ward areas.

6 HUMAN RESOURCES UPDATE

6.1 Collective Employment Agreements

Negotiations are under way as follows.

Table 8 Collective Employment Agreements

Agreement	Status	Expiry Date
LNI Administration/Clerical MECA	Negotiations have concluded and a settlement reached within the DHBs bargaining strategy and financial parameters. The PSA is taking the DHBs' offer out for ratification and it is expected the results will be know at the end of April, or early May.	31 December 2015
Resident Medical Officers	Negotiations are continuing. Progress is being made with discussions being had on a process for identifying rostering related issues at each DHB.	29 February 2016

Preparations for the following negotiations are underway:

- Sonographers
- Clinical Psychologists
- Senior Medical Officers

7 QUALITY, SAFETY AND OTHER UPDATES

7.1 Quality and Safety Markers update – October/December 2015

Results for the period October to December 2015 have just been received. The full report is attached for reference (Appendix 8) and shows trending for each DHB nationally over time. We have achieved above target in both falls process measures with 93 per cent for falls risk assessments completed and 99 per cent for individualised care plans against a target of 90 per cent for both measures.

Hand hygiene results are not improving with a result of 75 per cent against a target of 80 per cent. With the recent development of monthly reports for all areas audited and the circulation of these to each areas leadership group, far greater attention has been paid to results and strategies required. The Hand Hygiene Taskforce continues to support local level leadership with regard to ownership and accountability for this programme. Promotional materials such as posters and alerts will be renewed throughout our facilities to refresh the messages provided. In addition two hand wash stations are being placed in the staff café and if feedback from these is positive we will trial hand wash stations at our main entrance to Palmerston North Hospital.

All three process markers for surgical site infection achieved 99 per cent which equates to two measures being above target and the third 1 per cent below target.

The implementation of electronic medication reconciliation has not commenced as this is reliant on the upgrade to Clinical Portal Core and ePharmacy implementation.

7.2 Influenza Vaccination Campaign

The 2016 Influenza Vaccination campaign commenced on 5 April and will be managed as a high profile high saturation campaign for six weeks ie until 18 May. Whilst the vaccine will continue to be available after this time the campaign will not be as intense. This strategy has been successful in other DHBs and given that this is a resource intensive high energy programme it is not sustainable over a long period of time. A prize draw will be held for all those being vaccinated in the first six weeks with good prizes on offer including a cake mixer, coffee maker, slow cooker and blender. A personalised letter has been sent to all staff and contractors from the Chief Executive Officer with a focus on keeping well in winter and promoting the free influenza vaccination. Clinic schedules are available to all staff on the intranet and on posters throughout staff areas. Daily reminder emails are being sent out.

7.3 Improvement Advisor Training

Three staff, two from the Quality and Clinical Risk Team and an Associate Charge Midwife from Maternity services, have registered and been confirmed to undertake the nine month Improvement Advisor Training with Ko Awatea at Counties Manukau. This training equips staff with a high level of expertise in relation to improvement science and a range of improvement methodologies. All three staff will use a project from within MidCentral Health as their programme for the duration of the training. Within Maternity Services the project will be based on an aspect of the work programme from the Maternity Services Review and a staff member undertaking this training is also a part of that work programme. Up to five more staff will complete this training commencing in March 2017.

7.4 Partners in Care Programme (Co design)

All four groups are making good progress with ongoing support from Dr Lynne Maher at Ko Awatea via monthly online webexes. The formal programme ends in late May however not all groups will be at implementation stage. Monthly newsletters continue to the wider organisation with a presentation to Senior Management Team planned in May/June 2016. A more comprehensive update will be provided to Hospital Advisory Committee in the July Quality and Safety report.

7.5 Palmerston North Site Reconfiguration update

Work on the Master Health Service Plan is about to re-commence. We intend to commission Sapere to refresh the indicative business case. As this work is not yet underway, it is too early to provide a progress report as scheduled.

7.6 Medication Events At MidCentral Health

Further to discussion at a previous meeting this update is provided for members' information in conjunction with a presentation from the Chief Pharmacist.

A conservative estimate of the number of medicine doses delivered at MidCentral Health is close to 2 million annually. This figure excludes medicines delivered in out-patient clinics, theatre and the emergency department. The medication management journey involves approximately 50 process steps, which involve prescribing, dispensing/supply, administration and monitoring. At each point there is unfortunately opportunity for error. Rates of observed medication error vary in international literature and range from 8.6–28.3% of administered doses (if wrong-time of administration is included) to 8-10% (if wrong-time of administration is excluded). [1]

Addressing medication errors is complex and there is no one mitigation solution. The Health Quality Safety Commission (HQSC) and national eMedicines program were established to assist health professionals to reduce untoward events in health care.

From a national level a systems approach has been adopted to reduce medicine related events and is necessarily multifaceted. A systems approach seeks to identify situations or factors that are likely to give rise to human error and alter underlying systems to reduce the occurrence of errors.

At MidCentral several system approach tools have been introduced, examples include –

- The National Medication Chart
- Medicines Reconciliation to high risk patient groups
- Redesign of subcutaneous insulin chart
- Alteration of graphs for medicine fridge monitoring
- Increase in individual patient supply of high risk medicines
- Antibiotic stewardship
- Establishing a "culture of safety", which includes an environment where individuals are encouraged to report errors or near misses.

The reporting of errors has increased and over time as the co-operation between primary and secondary care has increased and the culture of reporting has been encouraged, reporting has increased to include more regular reporting from nurses and also more notably prescribers. Reports of events involving primary care have also been recorded to assist with learning in GP practice and community pharmacy. The Riskman tool has made reporting more transparent and trackable and has encouraged staff to report errors and more importantly near misses.

Work in the complex area of medicine management is on-going and will continue to be a strong focus for staff across disciplines at MidCentral Health.

7.7 Fluoridation of Water Supplies

On 12 April 2016 Health Minister Jonathan Coleman and Associate Health Minister Peter Dunne announced proposed legislative changes to allow District Health Boards (DHBs), rather than local authorities, to decide on which community water supplies are fluoridated in their areas. Changing the decision-making process for water fluoridation will require an amendment to Part 2A (Drinking-Water) of the Health Act 1956 and consequential amendments to the New Zealand Public Health and Disability Act 2000. It is anticipated that a Bill will be developed for initial consideration by Parliament by the end of 2016. Once drafted, the Bill will pass through the normal Parliamentary processes. Other interested parties (including communities and individuals) will be able to comment on the Bill as it is considered by the Health Select Committee. If passed before the end of the Parliamentary term in 2017 it is likely that legislation would come into force from mid-2018.

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[1] Keers R, Williams S, Cooke J, Ashcroft D. Prevalence and nature of medication administration errors in health care settings: a systematic review of direct observational evidence. Ann Pharmacotherapy 2013; 47:237-56.

Subject to legislative change, District health boards (DHBs), rather than local authorities, will decide which community water supplies are fluoridated in their areas. Under the proposed change, each DHB will:

- assess the oral health of its communities and the water supplies serving its population
- consider the scientific evidence about the benefits and risks of fluoridation of community water supplies to the relevant levels
- decide whether specific water supplies in its community should be fluoridated and
- if appropriate, direct water suppliers to fluoridate community water supplies.

Local authorities will continue to be responsible for supplying drinking water. A local authority would be required to fluoridate a water supply if it is directed to do so by the DHB. It would also not be able to stop fluoridation unless the DHB directed it to. Local authorities would continue to be responsible for the costs of fluoridating community water supplies. The cost of making decisions on fluoridation would be met by DHBs.

7.8 Child and Adolescent Oral Health

Titanium

The Business case for implementation of Titanium has been prepared and is currently being considered by senior management prior to presentation to Executive Leadership team

Arrears

Arrears for February 2016(children and adolescents not seen within agreed timeframes) are 3816. As a number of children were assessed in December, the February focus was treatment rather than assessment and there was not a lot of rotation through school sites. Staffing resource has been impacted by vacancies, unplanned absences and staff on return to work programmes which further impacts on arrears. Arrear information for March is not available at time of reporting.

Recruitment has been undertaken this month with staff due to commence March 2016.

Progression with implementation of Titanium will assist in greater efficiencies within the service and management of a number of issues including management of arrears.

7.9 Regional Cancer Treatment Service

Faster Cancer Treatment in Secondary Care project

This project continues to make good progress.

Consultation with the urologists, regarding a potential process to connect the new oncology social workers with urology patients has commenced. Currently about 40-50% of urology patients have cancer and, aside from having access to pamphlets, there is little psychosocial support offered to them.

Agreement has been obtained as to the type of stable patient who could potentially be transferred from hospital based services to the general practice environment for ongoing monitoring and follow up. Better management of how and where patients are monitored will provide the opportunity for increased capacity in Urology to manage new referrals.

A Head and Neck Cancer patient pathway has been drafted. Currently the project team is seeking initial feedback on portions of this and then, once in an electronic form, will be released for wider consultation. Thereafter a project team will determine where barriers are and a list of quality improvement initiatives will be developed. These will be prioritised for action.

In regard to skin lesions, a group are looking to trial a secure electronic system to supersede the current process for transmitting skin lesion images between general practice and hospital (triaging) clinicians. A pilot with several GPs is being planned.

The Breast Cancer Collaborative Clinical Pathway (Map of Medicine) project has commenced. This work aims to embed the planned pathway for patients with breast

symptoms to be referred through the Amesbury St Breast Imaging clinic for work up prior to referral to surgical services.

Ongoing liaison is occurring with a local Maori cancer advisory group. The Central PHO project focused on developing a localised, user friendly equity tool continues.

The FCT Governance Group has now formed and an initial meeting held in March determined the membership and meeting structure. The group will meet monthly and oversee all FCT activity for MDHB.

E-Chemotherapy

Within the MOSAIQ Oncology Information System is the functionality to allow for electronic prescribing of chemotherapy. It was decided in 2015 to implement the use of this part of the system for the RCTS and after considerable preparation and anticipation; electronic prescribing of chemotherapy went live on 21 March.

Currently Breast and Lymphoma Care Plans (combinations of chemotherapy and supportive drugs that make up each prescription) are being prescribed, dispensed and administered with the new programme. A phased plan to introduce other tumour types is now underway to allow staff time to assimilate this change of practice into everyday operations and to adapt any processes that require updating due to the change from paper-based to electronic.

The roll out has gone well, with medical and nursing staff keen to continue the introduction of further tumour streams. Having the new system means all of the team have the opportunity to track the progress of a patients care plan from prescription, to manufacture and dispensing, through to administration. The software within MOSAIQ undertakes the complex calculations required for the safe prescribing and administration of these drugs and therefore reduces the possibility of errors that previously were a recognised risk with manual calculations.

Breast and Lymphoma are the first of 11 tumour streams that need to be approved and loaded onto MOSAIQ. Electronic prescriptions have been introduced in outpatients initially and 20 patients were transferred to the system in the first two weeks as they came through their regular chemotherapy clinics. Once all the tumour streams are approved, and all processes surrounding the care and treatment of patients are streamlined, the electronic prescribing will be extended to the regional chemotherapy treatment units in Hawkes Bay and Taranaki and to the inpatient setting on Ward 23.

7.10 Mental Health and Addictions Service

Leadership

The Mental Health and Addiction Services Leadership Team (MHASLT) continue to lead implementation of the Mental Health external review with cultural change being a key area of focus in 2016.

Signs of a positive change in culture are emerging with more active SMO cooperation and contribution to growth in effective leadership in each team through partnerships with the clinical managers. Our quality team is leading service improvement with completed service wide policy updates, and clinical programme development such as ECT treatment and inpatient intensive care and calming and restraint updates. The MHASLT regularly meets all teams as part of our clinical governance development programme.

Consumer & Family Whanau Advisory Team

We now have Family and Whãnau Advisor and Consumer Advisor input at all systems and service level. The consumer and family advisor team leads the Mental Health & Ministry of Health survey - from 15/3/2016- 13/4/2016 including the OST (Opioid Substitution Team) survey.Over 500 surveys have been offered across child, adolescent, adult, acute inpatient, older adult, community, specialist services inclusive of our MASH Trust and Dalcam Health partners. Consumer engagement is entrenched in quality improvement, with input to Policy updates, initial assessment process and documentation, and Serious Adverse Events forum. Consumer advisors participate in strategic and management Leadership forums.

Ward 21 Redesign

The options paper for the redesign of Ward 21 is on the agenda for the Executive Leadership Team meeting and therefore will be provided to HAC for the June meeting.

DBT report

The DBT programme continues to be provided but requires additional resource to be sustainable. Activity is outlined in the table below. Planning for increased capacity focuses on enabling four people who are on the Palmerston North waiting list to join the programme and we expect that this will be achieved in April. The waiting list varies for each individual, but is currently about 4-6 weeks. While on a waiting list for this programme, all four have a psychiatrist and key worker input, and so are receiving treatment. There are ongoing programmes of treatment but groups are planned ahead, and a table outlining completed events is below. Planning for the next round of groups is underway.

Date	Content
11th February	Mindfulness 1
18th February	Mindfulness 2
25th February	Emotion Regulation 1
3rd March	Emotion Regulation 2
10th March	Emotion Regulation 3
17th March	Emotion Regulation 4
24th March	Emotion Regulation 5
31st March	Emotion Regulation 6
7th April	Emotion Regulation 7

Vacancy reports are based on an estimate of required capacity and currently sit at about 0.6 FTE for Palmerston North. The current available resource in Horowhenua is adequate and sustainable for this area, (at about 0.6 available FTE between two clinical staff) and in Palmerston North the current 1.3 FTE allocated to DBT provision (including coordination and between three staff) is to increase by 0.2 FTE. Although DBT is not discipline dependent (provided by occupational therapists, nursing staff as well as psychologists) we are planning to recruit to a minimum of 0.6 FTE psychology input to the Palmerston North DBT programme. We also plan to approach staff who are trained (six staff of various disciplines) to re-engage with provision of DBT. The 0.6 FTE vacancy has emerged in February of this year and is the focus of current recruitment. There are educational events planned for March April, June and September.

A meeting with the RPDS Regional Personality Disorders Service is occurring on 19 April to plan for an updated and potentially more efficient model of delivery.

Location	Programme	skills group	Assessment	Waiting list
PN	skills group	7	0	4
Horowhenua	5	5	3	0

Quality and Risk

Mental Health and Addictions Service (MHAS) Quality Reporting Dashboard

Over the past year, MHAS have been working with Data Quality to create a MHAS Quality dashboard. The new dashboard now includes a report in graph form on community services activity. Another addition to the report is an indicator of key result areas. These are identified in commentary under each graph. If there is a variance to expected activity and reporting, a variance commentary is added with each graph. For instance, explaining changes in double shifts, or indicating issues with community activity. A key community activity is number of referrals. The key result area is to monitor and manage any increase above 20% of referrals. In this report, note the doubling of contacts with our crisis teams over the past 18 months. Please see attached MHAS Quality Reporting dashboard attached as Appendix 9.

Ombudsmen reports

The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OP-CAT) was adopted in New Zealand as a United Nations Initiative which required oversight of places of detention.

In 2007 the Ombudsmen were designated as one of the National Preventive Mechanisms (NPHs) under the Crimes of Torture Act (COTA), (1989) with responsibility for examining and monitoring the general conditions and treatment of clients in New Zealand secure hospitals. The Ombudsmen Office carries out this responsibility by conducting unannounced visits to places of detention, including psychiatric wards.

There was an unannounced visit December 2015 to MidCentral Health from the Ombudsmen Office of three auditors who conducted an audit of Star One (Psychogeriatric Unit) and Ward 21 (Psychiatric unit). Two audit reports were received on 29 March of this year. A summary of recommendations and immediate actions in response is noted here.

Star One

There are critical observations in the report about using 'duty of care' as authority to detain, but this is not a formal basis for restricting patient's freedom and there is a recommendation to urgently address this issue. This is noted as a 'repeat' recommendation.

The report also makes recommendations about the need to redesign the Intensive Care area, and the over use of mechanical restraint. Other recommendations highlight the need for an improved activity (occupational therapy) programme. There are positive comments on nutrition, clinical areas and the courtyard, as well as nursing care.

Ward 21

The report also makes strongly critical recommendations about the need to redesign- specifically that 'the whole unit is in need of an urgent upgrade/redesign'. There is positive comment about bedrooms, activity, nutrition, and staff interaction but critical recommendations about improvement of seclusion and restraint records. The Report positively notes that use of mechanical restraint was ceased following a directive memorandum (October 2015) from the Service Director.

Ombudsmen reports: Summary

All recommendations from both reports are being addressed through improvement action plans for both units. All immediately required actions are completed. In Star One for instance, full legal basis for detention for treatment has been properly established. All other recommendations are actioned. A detailed report will follow in the full HAC report next meeting.

Erica Hume action plan

The Erica Hume action plan continues to be implemented and a full update on progress will accompany the next report.

Incidents for February 2016

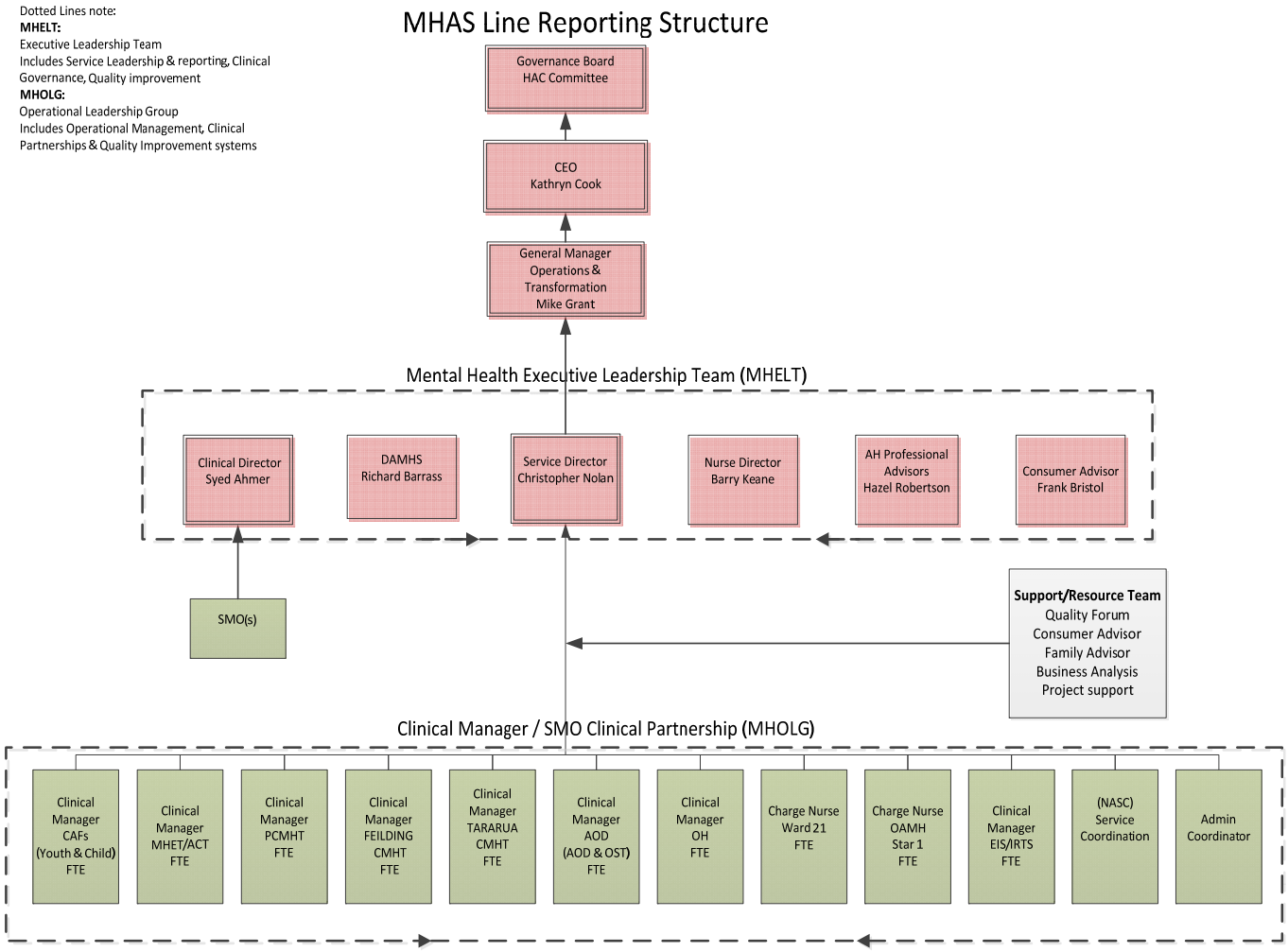
The number of total incidents was down from 108 in January to 45 in February 2016. We continue to improve the quality and accuracy of data provided by patient safety and clinical effectiveness.

Community Activity

As shown in the attached graphs in Appendix 9, please find the activity and active episodes for each individual community service. Palmerston North and Tararua teams have maintained referral volume, but there has been a significant increase in referrals for the Child Adolescent Family service (CAFS) over the past year, and an increase in referrals in Horowhenua. Our crisis services have had a doubling of contacts over about 18 months. The report will have added items in the full HAC which are not yet currently available. These include a report on the NGO capacity in the Acute Care Continuum (Transition beds) and reported community based clinical incidents. (there are few currently reported)

Mental Health and Addictions Service Organisational Structure

Please find Mental Health and Addiction Service Organisational Chart as requested by the HAC committee.



Staffing Resource Ward 21

Staffing overtime/double shifts has reduced significantly as shown in the attached graph (Appendix A).As reported to HAC in our prior reports, this positive trend is the culmination of a concentrated focus on roster reorganisation, nursing numbers and transfer of care.

7.11 Nursing

Releasing Time to Care

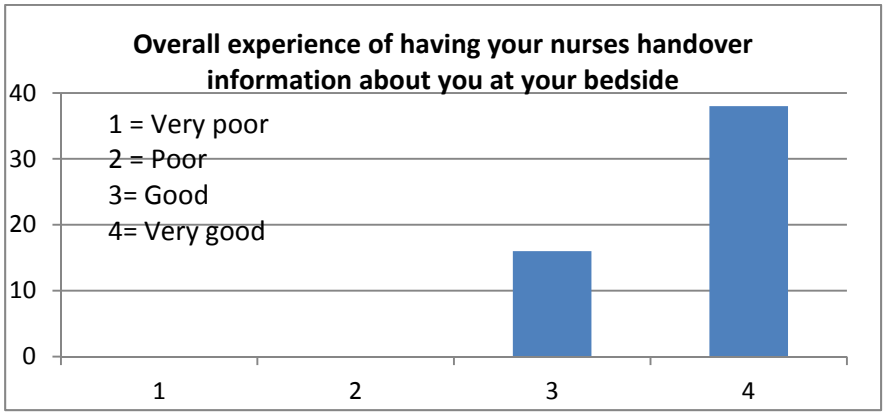
Over the past few months Ward 24 and Ward 26 have completed the bedside handover module of Releasing Time to Care (RTC). This includes reinvigorating the process to fit with acute demand, putting clear guidelines in place and auditing the process using a PDSA (Plan, Do, Study, Act) cycle to improve and streamline handover between shifts. Alongside regular auditing, surveys of staff, patients and the senior nursing team in each ward have been carried out with excellent feedback as the following comments and table demonstrate.

Comments from patients: Oh yes, so I knew nothing was going on that I didn't know about - this is mainly in PN Hospital, felt secure, very helpful to understand where you are at and where you are going, great improvement on last experience.

Comments from staff: It has increased my confidence with handovers, I like there being a clear, linear system to go through, introduction right at the start and involves patient a bit more, gets their point of view, wouldn't want to go back to the old handover format EVER, so inefficient.

Comments from Charge Nurses: Nurse now take responsibility for ensuring they have up to date information & latest plan, staff expect to get out on time, nobody expects to do overtime, safety improved significantly, all patients checked, all infusions checked, all drug charts checked, all observation charts checked, any issue would be identified early, feel confident leaving ward at end of day knowing all patients have been seen,

Table 9 Overall result from patient survey



7.12 April Falls

A full program of falls prevention awareness is planned for April following the theme "eyes on falls". This year's campaign is targeted to patients/clients, their families and the community in general, in order to raise awareness that problems with vision can increase the risk of falling. 'Eyes on Falls' brochures and posters that include questions to help people identify if they may have a vision problem as well as some general tips and simple ways to reduce the risk falling due to poor vision, have developed by the Falls Action Group and distributed widely through the district, along with educational resources for clinicians to support and promote the use of this information.

An April Falls Month flyer (attached) has been sent to all Health services and community groups across the district, encouraging the use of these vision questions and resources to raise the topic of falls prevention at every client interaction during April, and listing four Falls Prevention Education forums available to attend during April. Let's Talk About Health, following the same theme (copy attached) will be featured in local newspapers and distributed via our network. Central region's six DHBs have elected to use the campaign approach and material developed by the MDHB Falls Group, partnered by ACC funding the Eyes on Falls Brochure and Posters distributed to all six DHBs.

7.13 Older People Living Well with Frailty

The Health of Older People (HOP) Team, working from Kauri HealthCare and providing services to the over 75 year old living with frailty, pilot has now been operational for over three months. Kauri General Practitioners have greater access to a specialist Geriatrician who provides advice and support for their most complex older patients, and the HOP Team comprising of nursing and allied health staff are able to offer support to appropriate Kauri patients in their own homes. There have been 51 referrals over this time, with an increasing trend in the latter part of the quarter. A slower start than anticipated was experienced due to Christmas and New Year and the team not being fully recruited. The feedback for this initiative continues to be positive.

7.14 MRI

The current contract with Broadway Radiology for the provision of MRI will enter its final two year extension in May 2016 and negotiations have already commenced in anticipation of the expiry. MRI's have now become a standard diagnostic and demand and associated costs remain high. A small working group has been established comprising MidCentral Health staff to explore options for this service delivery, including alternate providers and the option to purchase.

Mike Grant
General Manager
Clinical Services and Transformation

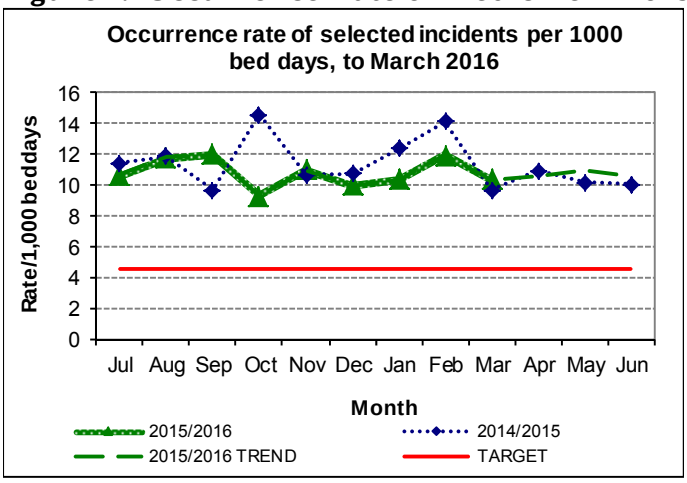
Appendix 1: Customer/Patient Performance Scorecard Summary
Appendix 2: Financial Performance Scorecard Summary
Appendix 3: Internal Process and Operations Performance Scorecard Summary
Appendix 4: Organisation Health and Learning Performance Scorecard Summary
Appendix 5: Elective Services Performance Indicators (ESPIs)
Appendix 6: Key Performance Indicators
Appendix 7: Personnel and Outsourced Personnel
Appendix 8: Quality and Safety Markers update: October/December 2015
Appendix 9: Mental Health Quality and Risk Report – February 2016

Appendix 1

MCH Scorecard
Customer/Patient Performance Summary – March 2016

Customer Patient	Month	YTD	Target	Achieved
Complaints responded to within 15 working days (%)	100.00%	98.89%	> 95.00%	Y
Inpatients developing one or more pressure ulcers during their admission (%)	0.55%	0.57%	< 0.50%	N
Occurrence Rate of Falls per thousand bed days	4.8	5.03	< 5.00	Y
Occurrence Rate of Medicine Errors per thousand bed days	5.2	5.49	< 3.50	N
Patients waiting greater than 4 months for FSA (%)	4.37%	N/A	< 0.00%	N
Percentage of patients discharged without incident	94.84%	95.07%	> 97.50%	N
Percentage of patients who were acute readmissions within 28 day of previous discharge (related DRG)	7.71%	8.87%	< 7.50%	N
Percentage of patients with urinary tract infections	2.44%	3.22%	< 2.40%	N
Percentage of unplanned returns to theatre within the same admission	0.72%	0.43%	< 0.50%	N
Triage 2 Wait Times	75.45%	71.71%	> 80.00%	N
Triage 3 Wait Times	55.15%	50.41%	> 75.00%	N

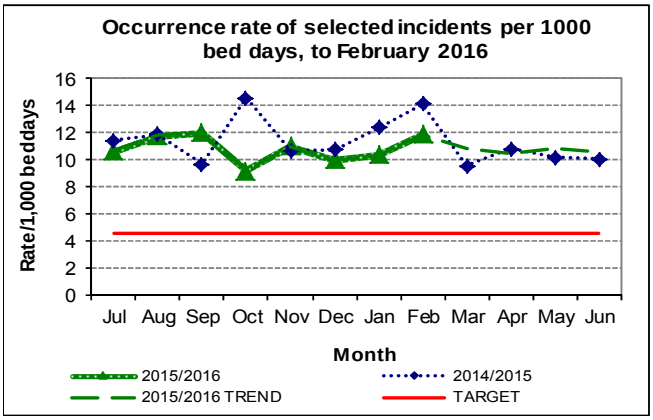
Figure 1: Occurrence Rate of Medicine Errors



MCH Scorecard
Customer/Patient Performance Summary - February 2016

Customer Patient	Month	YTD	Target	Achieved
Complaints responded to within 15 working days (%)	100.00%	98.70%	> 95.00%	Y
Inpatients developing one or more pressure ulcers during their admission (%)	0.65%	0.58%	< 0.50%	N
Occurrence Rate of Falls per thousand bed days	5.21	5.06	< 5.00	N
Occurrence Rate of Medicine Errors per thousand bed days	6.23	5.52	< 3.50	N
Patients waiting greater than 4 months for FSA (%)	5.98%	N/A	< 0.00%	N
Percentage of patients discharged without incident	95.40%	95.16%	> 97.50%	N
Percentage of patients who were acute readmissions within 28 day of previous discharge (related DRG)	7.07%	8.96%	< 7.50%	Y
Percentage of patients with urinary tract infections	1.72%	3.31%	< 2.40%	Y
Percentage of unplanned returns to theatre within the same admission	0.39%	0.41%	< 0.50%	Y
Triage 2 Wait Times	71.02%	71.19%	> 80.00%	N
Triage 3 Wait Times	53.37%	49.82%	> 75.00%	N

Figure 1: Occurrence Rate of Medicine Errors



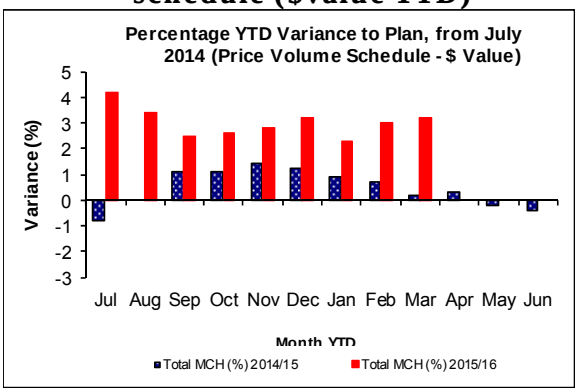
The occurrence rate of selected incidents (medication errors) while trending lower than in 2014/15 remains higher than target. The year-long medication safety campaign continues along with regular review of all medication incidents and regular auditing of medication charts.

Appendix 2

MCH Scorecard
Financial Performance Summary – March 2016

Financial	Month	YTD	YTD Target	Projected Year End	Achieved
Budget variance ($000) - Expenses	($1,222,791)	($9,266,897)	$0	$0	N
Budget variance ($000) - FTEs	-7.36	-6.99	0	0	Y
Budget variance ($000) - Operating Surplus / (loss)	($840,037)	($6,485,569)	$0	$0	N
Budget variance ($000) - Revenue	$382,753	$2,781,328	$0	$0	Y
Clinical Supply Costs / HSRevenue	12.92%	12.69%	11.62%	11.64%	N
Costs per bed day	$602	$577	$564	$565	N
Health Service Revenue / FTE	$13,608	$117,722	$116,531	$155,743	N
Personnel Costs as a Proportion of Total Expenditure	58.84%	58.04%	58.45%	58.50%	N
Personnel Costs / FTE	N/A	$69,614	$69,141	N/A	N

Figure 1 Performance against Provider Arm volume schedule ($value YTD)



MCH Scorecard
Financial Performance Summary – February 2016

Financial	Month	YTD	YTD Target	Projected Year End	Achieved
Budget variance ($000) - Expenses	($1,378,358)	($8,214,106)	$0	$0	N
Budget variance ($000) - FTEs	-6.55	-6.9	0	0	Y
Budget variance ($000) - Operating Surplus / (loss)	($1,073,598)	($5,895,532)	$0	$0	N
Budget variance ($000) - Revenue	$304,760	$2,318,574	$0	$0	Y
Clinical Supply Costs / HSRevenue	12.55%	12.67%	11.61%	11.64%	N
Costs per bed day	$608	$574	$562	$565	N
Health Service Revenue / FTE	$12,465	$104,111	$103,130	$155,725	N
Personnel Costs as a Proportion of Total Expenditure	59.32%	57.97%	58.28%	58.50%	N
Personnel Costs / FTE	N/A	$61,376	$60,841	N/A	N

Figure 1 Performance against Provider Arm volume schedule ($value YTD)

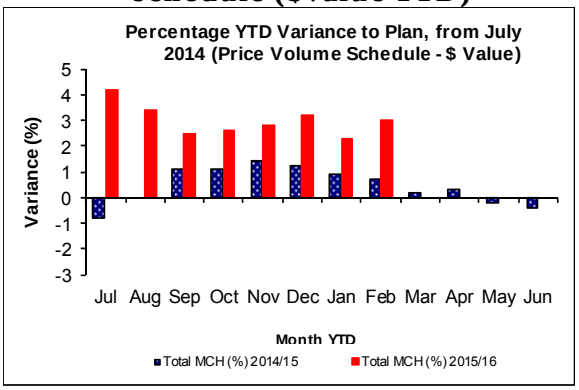
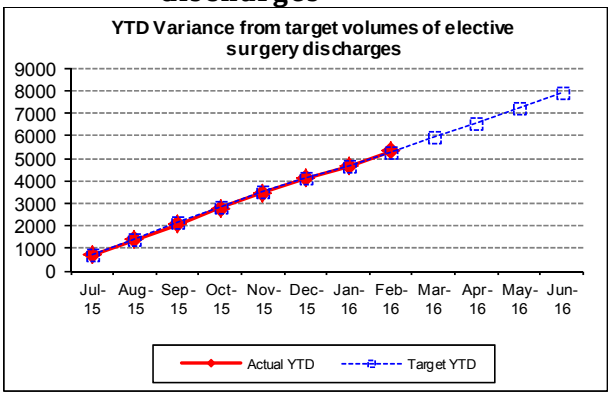


Figure 2 YTD Variance from target volumes of elective surgery discharges



MCH Scorecard
Internal Process and Operations Performance Summary - March 2016

Internal Process and Operations	Month	YTD	Target	Achieved
Acute Inpatient Length of Stay (days)	3.82	3.82	< 4.00	Y
Bed day usage (%)	92.98%	90.89%	> 85.00%	Y
Beddays per caseweight	3.47	3.59	< 3.50	Y
Day case surgery as a proportion of total elective and arranged surgery (%)	52.90%	54.14%	> 60.00%	N
ED patients admitted, transferred or discharged within 6 hours (%)	94.14%	93.76%	> 95.00%	N
Elective and Arranged Inpatient Length of Stay (days)	3.73	3.66	< 3.40	N
Percentage of Elective & Arranged patients admitted on the same day as surgery	85.21%	87.15%	> 90.00%	N
Percentage of patients given a commitment to treatment but not treated within four months	1.43%	N/A	< 0.00%	N
Percentage of patients referred with a high suspicion of cancer waiting 62 days or less to receive their first treatment	72.73%	79.07%	> 85.00%	N
Percentage of patients who did not attend booked outpatient clinic appointment	6.57%	6.55%	< 6.00%	N
Percentage of PAVS target elective surgery discharge volumes delivered	97.47%	100.84%	> 100.00%	N
Performance to contract ratio	1.02	1.01	> 1.00	Y
Proportion of hospitalised smokers provided with help to quit (%)	97.55%	96.89%	> 95.00%	Y

Figure 1: Average Length of Stay (ALOS) overall (includes day case and is for acute and elective ALOS)

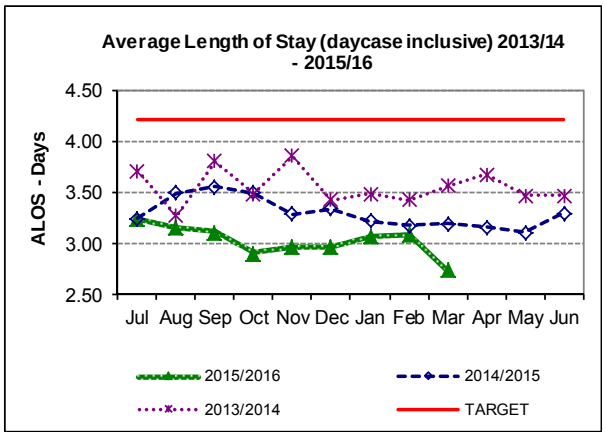
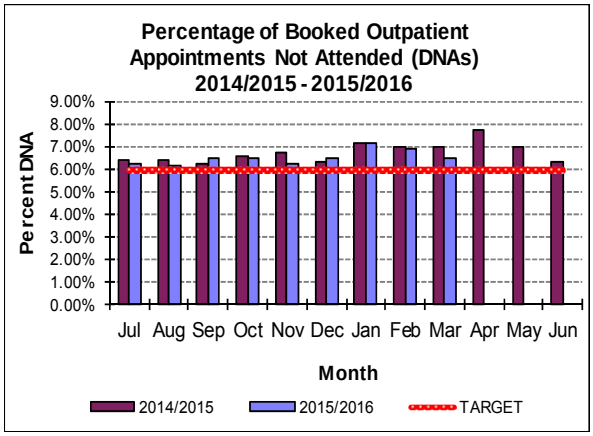


Figure 2: Outpatient Clinic (clinician only) Attendances – DNAs



MCH Scorecard
Internal Process and Operations Performance Summary - February 2016

Internal Process and Operations	Month	YTD	Target	Achieved
Acute Inpatient Length of Stay (days)	3.83	3.82	< 4.00	Y
Bed day usage (%)	88.24%	90.03%	> 85.00%	Y
Beddays per caseweight	3.58	3.6	< 3.50	N
Day case surgery as a proportion of total elective and arranged surgery (%)	63.06%	54.42%	> 60.00%	Y
ED patients admitted, transferred or discharged within 6 hours (%)	92.40%	93.71%	> 95.00%	N
Elective and Arranged Inpatient Length of Stay (days)	4.14	3.65	< 3.40	N
Percentage of Elective & Arranged patients admitted on the same day as surgery	86.57%	87.60%	> 90.00%	N
Percentage of patients given a commitment to treatment but not treated within four months	1.62%	N/A	< 0.00%	N
Percentage of patients referred with a high suspicion of cancer waiting 62 days or less to receive their first treatment	80.00%	80.37%	> 85.00%	N
Percentage of patients who did not attend booked outpatient clinic appointment	6.64%	6.58%	< 6.00%	N
Percentage of PAVS target elective surgery discharge volumes delivered	111.06%	101.32%	> 100.00%	Y
Performance to contract ratio	1.02	1.01	> 1.00	Y
Proportion of hospitalised smokers provided with help to quit (%)	97.78%	96.74%	> 95.00%	Y

Figure 1: Average Length of Stay (ALOS) overall (includes day case and is for acute and elective ALOS)

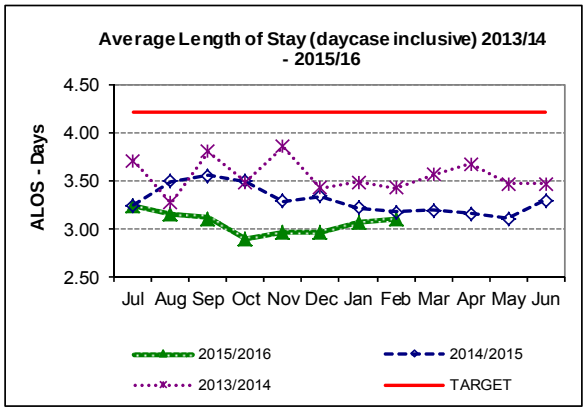
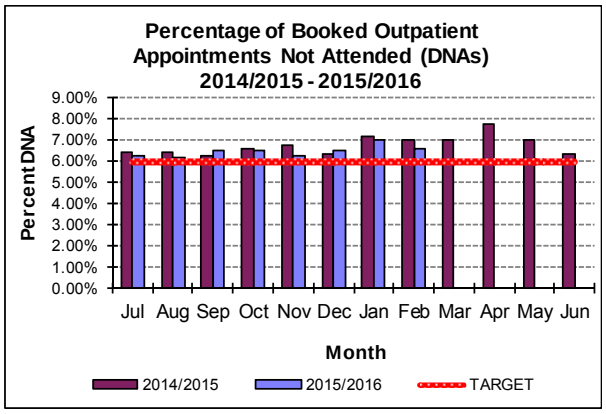


Figure 2: Outpatient Clinic (clinician only) Attendances – DNAs

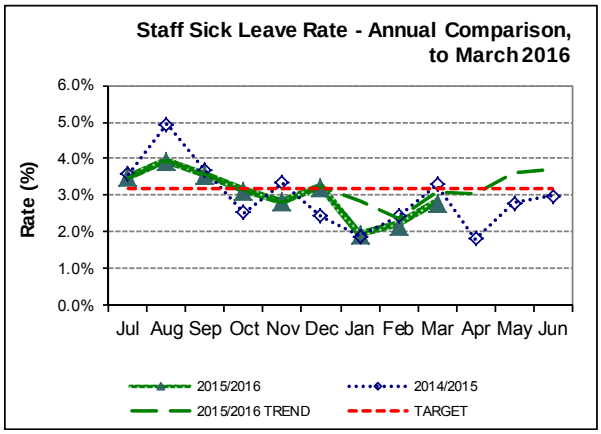


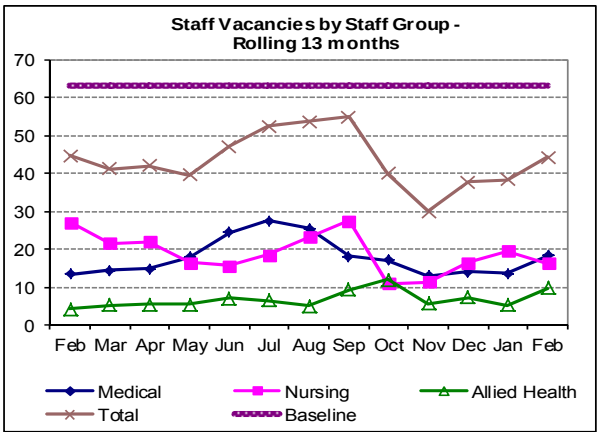
Refer other sections of this report for information regarding health targets including help for current hospitalised smokers to quit, radiation oncology wait times and elective surgery volumes.

Appendix 4

MCH Scorecard
Organisation Health and Learning Performance Summary - March 2016

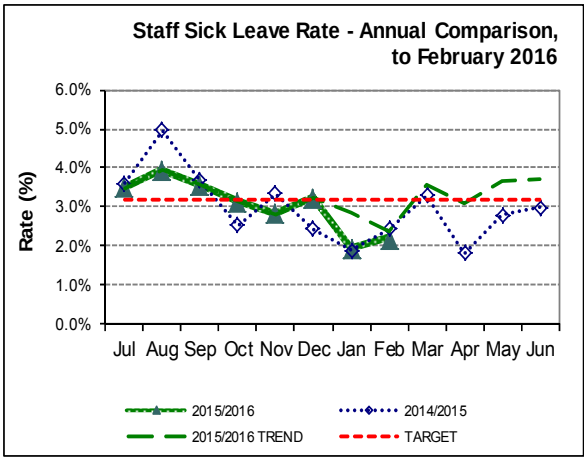
Organisational Health and Learning	Month	YTD	Target	Achieved
Sick leave rate (%)	2.79%	2.98%	< 3.20%	Y
Staff stability rate (%)	99.74%	99.75%	> 99.00%	Y
Staff turnover rate (voluntary) average per month (%)	0.83%	0.70%	< 1.00%	Y
Staff with leave entitlement in excess of two years (%)	16.79%	16.37%	< 9.50%	N

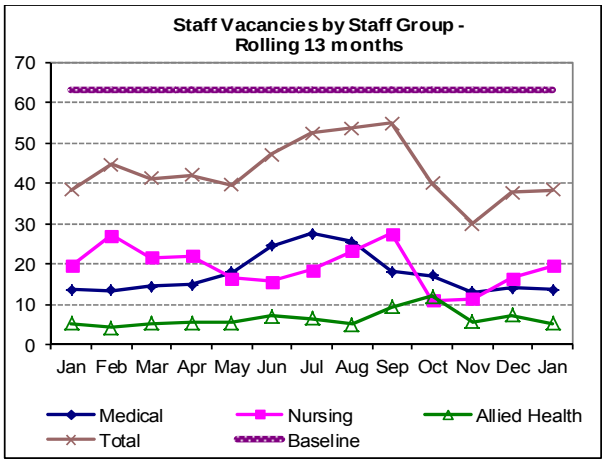




MCH Scorecard
Organisation Health and Learning Performance Summary - February 2016

Organisational Health and Learning	Month	YTD	Target	Achieved
Sick leave rate (%)	2.18%	3.00%	< 3.20%	Y
Staff stability rate (%)	99.84%	99.75%	> 99.00%	Y
Staff turnover rate (voluntary) average per month (%)	0.68%	0.68%	< 1.00%	Y
Staff with leave entitlement in excess of two years (%)	15.95%	15.95%	< 9.50%	N





MCH Elective Services Patient Flow Indicators (ESPIs)

The criteria of zero patients waiting greater than four months is in place for both ESPI 2 and ESPI 5.

The measurement criteria for this year remain as follows;

ESPI 2	Green	- zero patients waiting greater than four months
	Yellow	- 0.39 per cent or less waiting greater than four months
	Red	- 0.40 per cent or more waiting greater than four months
ESPI 5	Green	- zero patients waiting greater than four months
	Yellow	- 0.99 per cent or less waiting greater than four months
	Red	- 1 per cent or more waiting greater than four months

The denominator for this measurement remains the same, being the total number of new patients on the waiting list for each individual speciality and at a DHB level the total waiting list. This significantly reduces the buffer between compliance and non compliance.

The following ESPI information relates to February only. March data is not available from the Ministry of Health for ESPI 2 and 5.

ESPI 2 Patients Waiting Greater than Four Months for First Specialist Assessment (FSA)

As at the end of February 2016, MCH had a total of 4,524 patients on the FSA waiting list. This means the compliance threshold is 18 patients before MCH becomes non-compliant (red status).

At the end of February 2016, MCH had yellow status in ESPI 2 with 17 patients waiting greater than four months.

Individual service ESPI 2 data can be found in Appendix 5.

ESPI 5 Patients Waiting Greater than Four Months with Certainty of Treatment

As at the end of February 2016, MCH has a total of 1,484 patients on the treatment waiting list for surgery. This means the compliance threshold is 15 patients before MCH becomes non-compliant (red status). As at the end of February 2016, MCH recorded a yellow status in ESPI 5 with 14(0.9%) patients waiting greater than four months.

Individual service ESPI 5 data can be found in Appendix 5.

Note: Patients waiting greater than four months with an appointment/treatment date remain greater than four months until seen and or treated.

Plans are in place with the clinical teams to address the number of patients waiting greater than four months in order for MCH to achieve compliance.

A concentrated effort has been made to address the ESPI waiting times. These strategies include:

- The opportunity to ensure that the impact of booked leave is taken into account when planning clinics in advance.
- Short term establishment of additional outpatient clinics within existing working hours.
- Re-organisation of existing clinic schedules to facilitate the booking of additional FSA patients.
- Patients waiting greater than four months for FSA have priority bookings.

- All wait lists are being monitored daily.
- All Clinical Directors and Medical Heads have met and have agreed to prioritise those waiting greater than four months for treatment.
- All theatre lists will continue to be monitored to ensure all available capacity is utilised.

Table 1 ESPI 2 – Patients Waiting Greater than Four Months for a First Specialist Assessment (FSA)

Service	Total New Patients February 2016	New Patients waiting greater than 4 months February 2016	New Patients waiting greater than 3 months February 2016
Cardiology	113	0	3
Dermatology	189	0	39
Diabetes/Endocrinology	47	8	25
Endoscopy	166	0	8
Gastroenterology	169	0	6
General Medicine	116	4	18
Haematology	62	0	1
Infectious Diseases	12	0	0
Neurology	127	0	0
Medical Oncology	119	0	0
Paediatric Medicine	349	0	84
Renal Medicine	32	0	5
Respiratory	162	2	15
Rheumatology	77	0	9
ENT	658	3	134
General Surgery	727	0	39
Gynaecology	259	0	49
Ophthalmology	132	0	7
Oral Maxillo Facial	5	0	0
Dental	123	0	0
Orthopaedics	514	0	23
Urology	366	0	56
TOTAL	**4,524**	**17**	**521**

Table 2 ESPI 5 – Patients Waiting Greater than Four Months with Certainty of Treatment

Service	Total Patients with certainty waiting February 2016	Patients with certainty waiting greater than 4 months February 2016	Patients with certainty waiting greater than 3 months February 2016
Cardiology	33	0	0
Dental	141	0	41
ENT	160	8	37
General Surgery	377	1	68
Gynaecology	109	0	22
Ophthalmology	300	0	64
Orthopaedic	238	3	65
OMF	3	0	0
Urology	122	2	28
Total	**1,484**	**14**	**325**

Table 3 Non-ESPI Waiting Lists for Services as at March 2016

- Please note the non ESPI waiting time has been reduced to four months in line with the ESPI 2 wait times.
- New patients waiting greater than four months are a sub-set of Total New Patients.
- The figures in brackets are the numbers of patients waiting greater than four months in December 2015.

Service	Total New Patients March 2016	New Patients waiting greater than 4 months March 2016	New Patients booked
Surgical Services			
Audiology	113	104(115)	100
Continence	55	7(4)	37
Continence Dannevirke	7	1(1)	6
Continence Horowhenua	10	0(2)	8
Dietician Clinic	77	7(5)	70
Podiatry Dannevirke	16	4(4)	12
Eye Diabetic Photo Screening	0	0 (0)	0
Eye Orthoptist	67	2(1)	58
Dietician Clinic Horowhenua	10	0 (0)	10
Orthopaedic Muscular Skeletal Clinic	119	42(63)	35
Urodynamics	4	3 (3)	3
Podiatry	68	10(11)	47

Service	Total New Patients March 2016	New Patients waiting greater than 4 months March 2016	New Patients booked
Medical Services			
Respiratory Dannevirke	3	2(1)	2
Respiratory Nurse Assessment	4	0 (0)	4
Respiratory Laboratory Clinic	188	5(17)	95
Sleep Apnoea Service	2	2(2)	0
Sleep Apnoea Screening	100	38(33)	0
ECG (Electrocardiograph)	102	6(5)	97
EEG (Electro Encephalograph)	62	0 (3)	33
ERCP (Endoscopic Retrograde Cholangio Pancreatography)	0	0 (0)	0
Neurology Tests	135	2 (2)	54
Radiology Transoesophageal Echocardiography (TOE)	0	0 (0)	0
Holter Monitor	112	4 (9)	37
Exercise Test	38	0 (0)	20
Echo	94	0 (0)	0
Pace Maker	0	0 (0)	0
Diabetes Nurse Clinic	6	1 (1)	4
Women's Health			
Colposcopy	158	31 (29)	55
Fertility	17	1(1)	8
Gynaecology Urodynamics	21	9(18)	10
Colposcopy Horowhenua	0	0 (0)	0
ElderHealth			
ElderHealth Clinic Horowhenua	29	0(1)	19
Elderly Psychogeriatric Horowhenua	12	0(0)	1
Radiology Services *			
Ultrasound	2027	1 (1)	547
Computed Tomography (CT)	541	0 (0)	80
Gastrointestinal	80	4 (4)	7
Mammogram	217	15(23)	161
Angioplasty (non cardiac)	3	0(0)	2

Cardiac Rest/Stress test	90	5(13)	18
Bone Scans	84	0 (2)	23

These services are now being reported against the same criteria as the ESPI 2 with the goal to have no patients waiting greater than four months.

Overall the number of patients waiting greater than four months for a non-ministry reported assessment or diagnostic has reduced by 34 over the last month. As at the end of March 825 of the 1,629 new patients waiting had a date to be seen.

Medical Imaging Update

The total number of patients waiting for an ultrasound continues to increase. Demand continues to exceed capacity. One weekend session each month will be held commencing April which will provide some assistance in reducing the number waiting. A 0.8 FTE Sonographer vacancy remains.

All referrals to ultrasound and CT are triaged and prioritised by a radiologist according to the clinical information provided by the referring clinician. All referrals accepted are deemed to be clinically appropriate; those that are not are declined or queried with the referring clinician. Very few referrals received do not meet the criteria for imaging.

The number of patients waiting for a CT dropped in March, with the highest ever throughput achieved despite the statutory holidays. Saturday sessions are planned over the next couple of months which will assist in reducing this further. A number of machine faults have also impacted with operational time being reduced.

In March the Clinical Director, Operations Director and Team Leader for Medical Imaging visited Canterbury DHB Radiology Department to gain an over view of strategic processes that have enabled service improvements. Key outcomes from this visit have been to review the way in which Radiologists are rostered and work is allocated and extensive work around production and forecast planning. CDHB are providing some assistance with this work.

A key focus for Medical Imaging over the next 12 months is demand management. With the support of the PHO and other imaging providers in the MCH region, the National Community Referred Access criteria will be released shortly, providing GPs with supporting documentation and explanation on examinations to request for clinical conditions. This document is further supported by an initiative called 'Choosing Wisely' which the College of Radiologists has partnered with. Waikato DHB has implemented imaging guidelines in line with the Choosing Wisely. They have shared this document which will be the basis of initial discussions here at MCH.

Diagnostic Service Waiting Times

Cardiology

A project group has been established to re-develop the business case for a Percutaneous Coronary Intervention (PCI) capable cardiac catheterization laboratory on site at MidCentral Health. Terms of Reference are being finalized to describe the project, with the project group reviewing existing patient pathways and establishing new patient pathways to develop the business case and demonstrate the advantages of a dedicated facility.

The business case will focus on a PCI capable facility (the facility will also enable pacemaker implantation in a dedicated area) and will demonstrate the expected savings to MidCentral Health in providing PCI locally. The project group consists of two MCH cardiologists, two clinical nurse specialists, the Nurse Practitioner, Head Physiologist and Echocardiographer representation as well as the Service Managers from Medical Sub-Specialty Services and Inpatient Wards. Further external support is provided by Dr Nick Fisher, Cardiologist, Nelson-Marlborough DHB who is also the acting Clinical Director for Central Region Cardiology Network who supports the establishment of this facility at MidCentral Health.

Sleep Service Waiting times.

The pilot for the Community Sleep Assessment Service is almost completed with approximately 550 patients receiving community based assessment and overnight oximetry studies by primary care providers.

Following the overnight study, the results are returned to the MidCentral Health Sleep Service to determine ongoing care and management. These will include specialist FSA, specialist nursing input, further diagnostic studies and commencement of long term overnight breathing support.

The service is presently completing a formal report on the results of the pilot – this will include an assessment of the referral and treatment pathway as well as patient volumes referred on for further follow up and diagnostic assessment. These numbers will determine current service capability and capacity, and identify short, medium and long term planning for future service delivery. This will include the ongoing development of an integrated service with a community based focus on initial patient assessment, as well as long term planning for patient diagnostics and management outside of secondary care.

This report will be complete by the end of April.

First Specialist Assessment (FSA) – Declines

Definition of "decline" for the purpose of this table is decline due to reasons of service capacity and ability to see the patient within four months.

Table 4 First Specialist Assessment (FSA) – Referral Declines

Services	Referral Decline December 2015	Referral Decline January 2016	Referral Decline February 2016	Referral Decline March 2016
Medical				
Cardiology	21	25	27	49
Dermatology	10	6	11	7
Diabetes/Endocrinology	0	2	1	0
Endoscopy	0	0	0	0
Gastroenterology	5	0	1	0
General Medicine	10	10	9	7
Haematology	0	0	0	0
Infectious Diseases	0	0	0	0
Neurology	13	9	7	8
Oncology	0	0	0	0
Paediatric Medicine	0	0	4	1
Renal Medicine	13	3	10	11
Respiratory	2	2	2	3
Rheumatology	9	4	6	1
ENT	7	5	19	15
General Surgery	3	2	24	28
Gynaecology	43	26	55	50
Ophthalmology	22	7	27	20

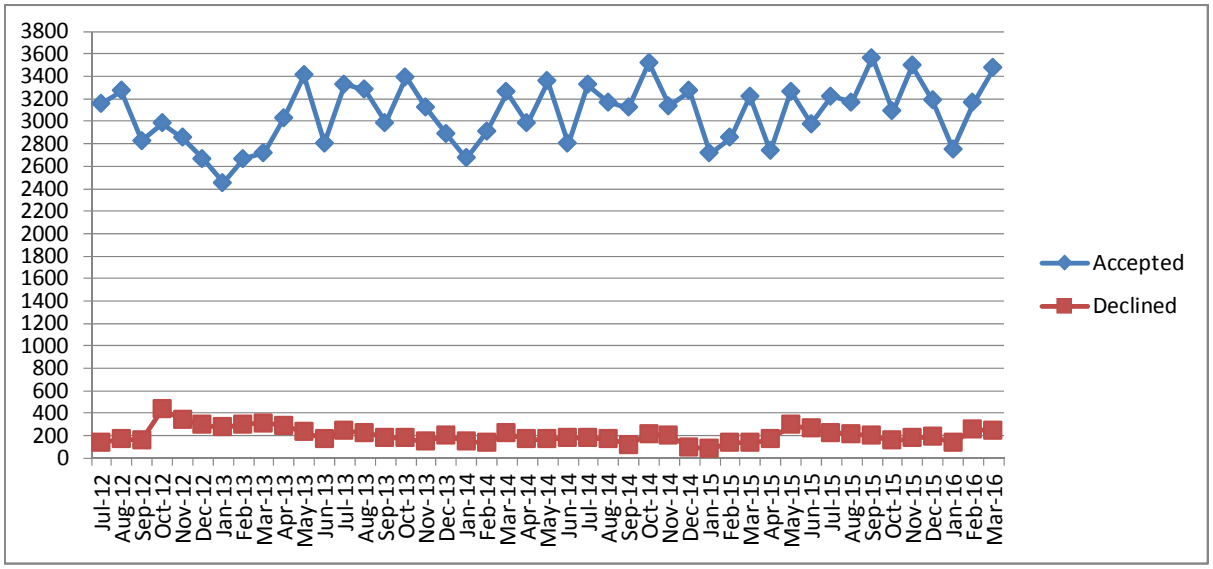
Oral Maxillo Facial	0	0	0	0
Dental	0	0	0	0
Orthopaedics	36	32	56	43
Urology	0	0	0	0
TOTAL	**194**	**133**	**259**	**243**

Over the last four months 13,674 referrals have been received into the organisation. A total of 829 were declined and returned to their GP for ongoing management as they did not meet the access threshold at the time. The decline rate for referrals over the last 4 months was 6%. All patients accepted are required to be seen within 4 months.

The data for March is a snapshot as at 1 April 2016 and is subject to change for both referrals received and referrals declined. The remaining three months have been updated to give a more accurate reflection of referrals and declines for each month.

Graph 3 FSA Referrals – All Sub Specialities Accepted vs. Declines

July 2012 – February 2016



The graph above shows the number of referrals accepted and the number of referrals declined over the last three years.

MCH Key Performance Indicators – February 2016
(NB: Includes outsourced clinical personnel)

Table 1. Personnel Costs

	March	February		YTD
Actual	$16,899,409	$15,582,857		$141,380,046
Budget	$16,423,453	$14,740,852		$136,964,282
Variance	($475,956)	($842,005)		($4,415,764)
Percentage variance	*-2.9*	*-5.7*		*-3.2*

Total personnel costs (inclusive of outsourced clinical personnel) were over budget in March by $475,956 (-2.9 per cent). Personnel costs were $161k favourable, Outsourced personnel costs were $284k unfavourable; the majority of this lies within Mental Health as recruitment for permanent medical staff continues. This is also the major reason for the year to date variance.

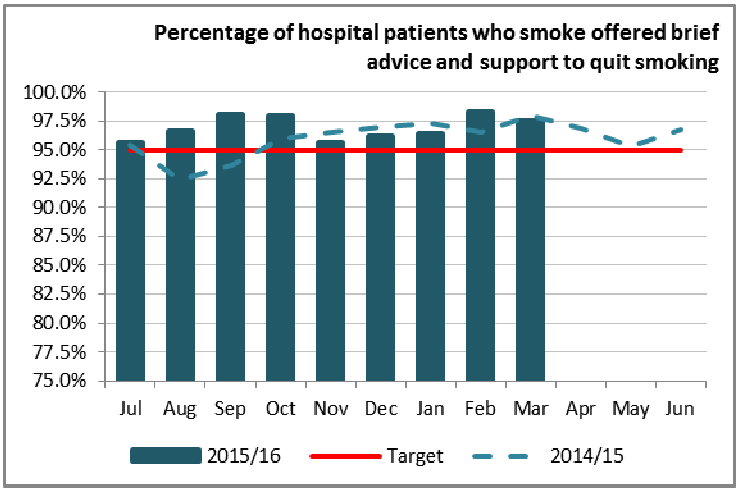
Table2. Medical Bed Occupancy

	Mar	Feb		YTD
Beds used by Medical inpatients	81	77		80
Medical Beds available	96	96		96
Percentage Bedday usage	*84*	*80*		*83*

The above available beds have reduced from the usual 101, to 97 in November and 95 in December, being reflective of the summer planning in Wards 25 and 26.

Smoking Cessation Target
Ministry of Health Target: *95 per cent of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and help to quit.*

Graph 1 Proportion of Hospitalised Smokers Provided with Advice to Help to Quit (Secondary Services)



The result for February 2016 was 98 per cent and for March 97 per cent, compared to 96 per cent for January. The result for quarter 3 is 97 per cent.

Electives Health Target and Electives Initiative

MCH reports against the Ministry of Health Elective Health Target and the Elective Initiative. The Elective Health Target reports on discharge targets only (excludes CWD).

The Health Target to be achieved in the 2015/16 year is 7,550 which is an increase of 996 discharges from the 2014/15 target. The significant increase is a result of the Ministry of Health's review of the Elective Health Target effective 1 July 2015 that now includes "arranged" admissions. The increase has been made up of a target of 672 for arranged admissions and 151 surgical DRGs from non-surgical purchase units.

The definition for inclusion in the Health target is:

> Elective and arranged discharges from a surgical purchase unit, elective and arranged discharges with a surgical diagnosis-related group (DRG) from a non-surgical purchase unit (excluding maternity) and skin lesions or intraocular injections where these are reported to the National Minimum Dataset.

This target excludes cardiology and dental services and estimates for IDFs.

The Electives Initiative reports on CWDs and discharge targets for the month and year-to-date, showing the overall performance of MCH. This is the basis on which MCH receives elective funding.

The Health Target for February/March and year to date along with the Elective Initiative delivery reports for February/March 2016 are presented below.

Health Target Delivery (excludes dental and cardiology).

Table 3. Elective Health Target – February and March 2016

	February 2016	**March 2016**	**Year-to-date**	**Annual Target**
Numerator (actual)	622	657	5744	7,550
Denominator (plan)	592	683	5,652	
Percentage	105.0%	96.1%	101.6%	

MCH was behind in discharges against the Elective Health Target for the March 2016 by 26 and remains ahead year to date by 92 discharges.

Table 4. Elective Initiative Discharges

CWD	**Feb**	**Mar**	**YTD**		Discharges	**Feb**	**Mar**	**YTD**
Actual	677.3	838.2	6,670.4		Actual	660	727	5,986
Plan	705.0	816.2	6,752.7		Plan	611	705	5,837
Variance	-27.8	+22.0	-82.3		Variance	+49	+22	+149
%	96.1%	102.6%	98.7%			108.0%	103.1%	102.5%

MCH finished March ahead of the planned Elective Initiative target by 22.0 CWDs for the month and behind year to date by 82.3 CWDs. Against the elective initiative discharges target, MCH was ahead by 22 discharges for the month and ahead year to date by 149 discharges.

MidCentral Health is ahead of the IDF inflow year to date by 101.3 CWDs. These do not form part of the Elective Initiative as they are patients that have had their procedures performed at Palmerston North but they reside in another DHB region. These volumes contribute to the Elective Initiative for their respective DHB. Approximately 94.6 CWDs have been performed on patients residing in the Wanganui DHB region.

IDF outflow volumes are behind by approximately 251.98 CWD's year to date against the Elective Initiative plan. The most significant under delivery is in Cardiothoracic which is currently behind by 212.49 CWDs, with the remaining being in plastics.

Personnel and Outsourced Personnel

Table1. Personnel and Outsourced Personnel

MidCentral Health - Personnel Costs

$000

	Prior month			March	Month		Year to date		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Variance	%
Mental Health	1,925	1,726	(198)	2,092	1,905	(188)	17,802	(1,713)	-9.6%
Surgical Specialties	2,659	2,429	(230)	2,785	2,706	(80)	23,527	(718)	-3.1%
Internal Medicine	2,162	1,891	(271)	2,227	2,152	(75)	18,403	(718)	-3.9%
RCTS	1,404	1,256	(148)	1,525	1,402	(123)	12,242	(591)	-4.8%
Women's Health	819	702	(117)	892	805	(87)	7,083	(570)	-8.1%
Medical Imaging	565	549	(15)	700	621	(78)	5,677	(478)	-8.4%
Emergency	1,050	1,100	50	1,233	1,210	(23)	10,543	(276)	-2.6%
Child Health	758	719	(39)	787	799	12	6,816	(189)	-2.8%
Dental Health	236	243	7	241	238	(3)	2,127	(103)	-4.8%
Rehab & Therapy	728	701	(27)	797	814	17	6,743	(93)	-1.4%
Commercial Support	212	211	(0)	233	236	3	2,064	(92)	-4.4%
PS&CE	271	263	(8)	292	286	(6)	2,467	(60)	-2.4%
Hospital Services	35	23	(12)	35	25	(10)	244	(32)	-13.0%
Community & Rural	21	22	1	31	24	(6)	229	(23)	-9.9%
Human Resources	59	148	89	166	189	23	1,526	(8)	-0.5%
Rural Health	23	17	(6)	18	18	0	159	(3)	-1.8%
Public Health	396	370	(26)	438	408	(30)	3,434	41	1.2%
Clinical Support	264	260	(4)	297	299	2	2,434	42	1.7%
ICU / Anaesthetics	1,019	991	(27)	1,078	1,077	(1)	9,112	53	0.6%
Elderly Health	636	679	43	694	745	51	6,004	244	4.1%
H&A Services	172	440	268	339	463	125	2,745	870	31.7%
Total	15,413	14,741	(672)	16,899	16,423	(476)	141,380	(4,416)	-3.1%

Patient Transport & Accommodation

$000

	Prior Month		Month		Year to date		Annual
	Actual	Variance	Actual	Variance	Actual	Variance	Budget
Ambulance	49	(24)	89	(63)	476	(243)	312
Air Ambulance	76	15	157	(57)	984	(109)	1,169
Patient Transport	36	62	99	13	784	172	1,278
Total	161	53	345	(107)	2,244	(179)	2,758

Patient Transport and Accommodation reflects lower demand with a resulting reduction in income. The major variances in ambulance and air ambulance occurred in women's, children's and neonatal unit areas, medical and surgical wards, and ICU.

Flight Information for March 2016

Type of Flight	June	July	August	September	October	November	December	January	February	March	April	May	June	TOTAL
Doctor Required	5	6	7	8	11	8	14	8	8	8				83
Flight Nurse	18	17	11	15	20	11	19	31	12	22				176
TOTAL	23	23	18	23	31	19	33	39	20	30				259

In March there were 2 'nurse only' transfers, which were part of the RCTS tertiary service and will be charged back to Taranaki and Hawkes Bay DHBs.

In addition, twenty were transfers to and from Wellington. Four were transfers to and from Auckland. Two were transfers to Christchurch. Two were transfers to and from Waikato

Quality and safety markers update, October–December 2015

Falls

Nationally, 92 percent of older patients* were given a falls risk assessment in quarter 4, 2015. This is 15 percentage points higher than the baseline level of 77 percent in quarter 1, 2013. It was the fifth consecutive quarter where the 90 percent target was achieved nationally. At the DHB level, 13 out of 20 DHBs achieved the target. Results from Hutt Valley DHB, Bay of Plenty DHB, Northland DHB and Southern DHB are significantly lower than the national average (see Figure 1).

Figure 1: Process marker, percentage of older patients assessed for the risk of falling

- Upper group: percentage >=90%
- Middle group: percentage is between 75-89%
- Lower group: percentage <75%

*Patients aged 75+ (55+ for Māori and Pacific peoples)

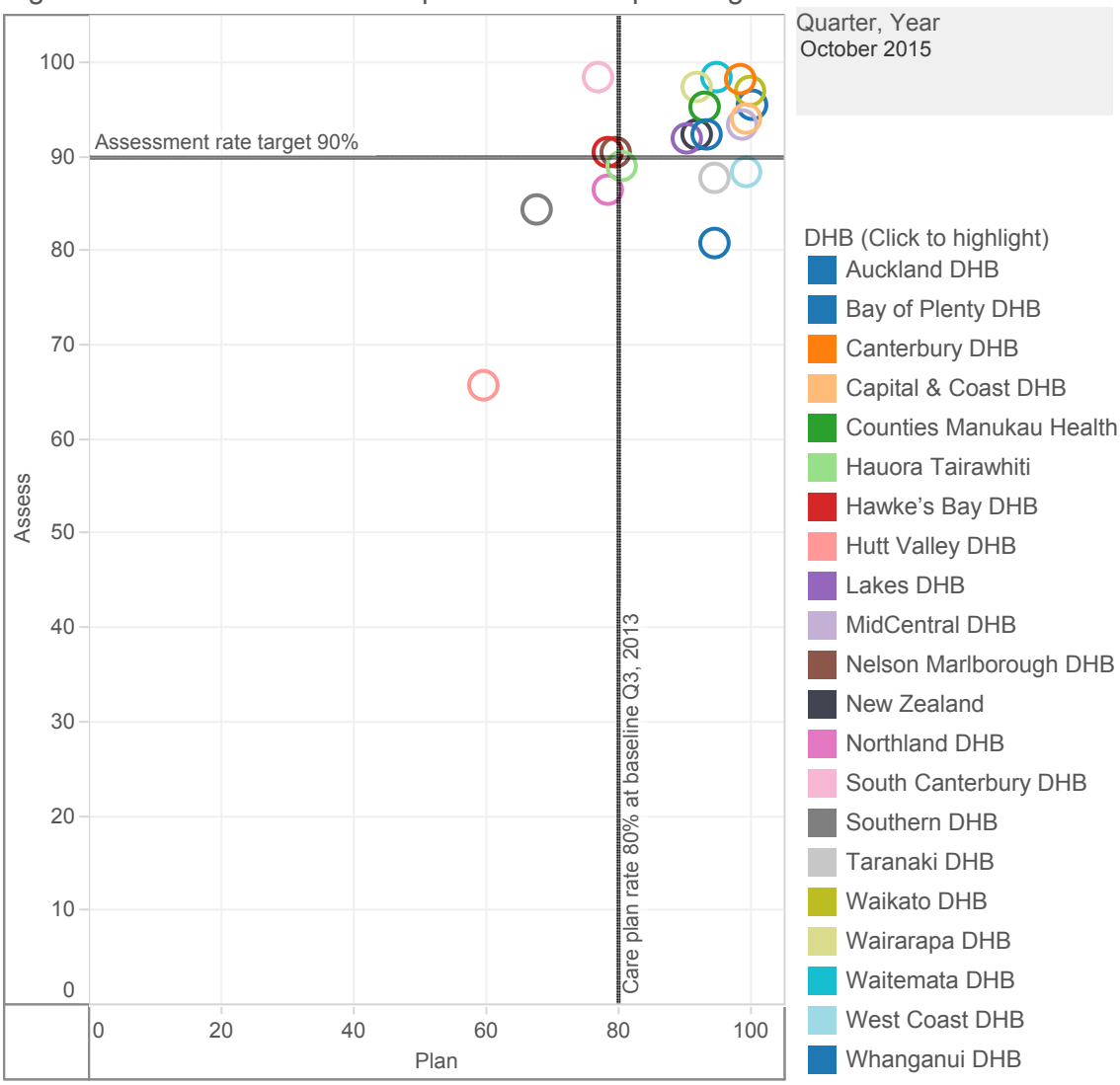
About 92 percent of patients at risk of falling received an individualised care plan. This measure has remained broadly consistent at 90 percent or above since quarter 2, 2014. Figure 2 shows the number of DHBs performing at a higher level continues to increase.

Figure 2: Process marker, percentage of older patients assessed as at risk of falling who received an individualised care plan that address these risks

- Upper group: percentage >=90%
- Middle group: percentage is between 75-89%
- Lower group: percentage <75%

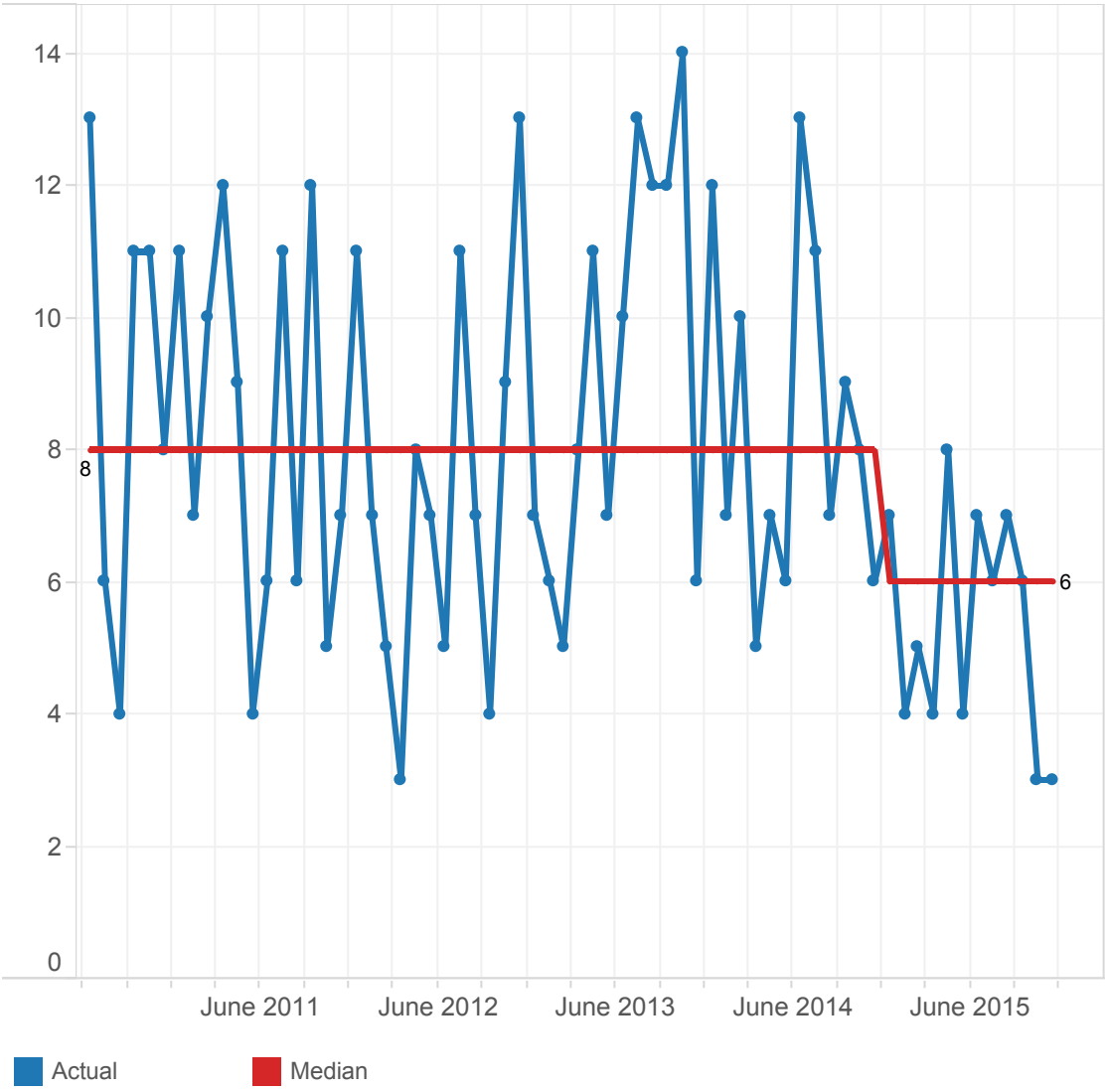
When assessments and care plans are plotted against each other, a trend of movement over time is shown from the bottom left corner to the top right corner. Compared with only five DHBs sitting at the top right corner in quarter 1, 2013, in the current quarter, 10 DHBs are in this 'ideal' box (see Figure 3).

Figure 3: Falls assessment compared with care planning



There were 64 falls resulting in fractured neck of femur in the 12 months ending December 2015 (see Figure 4). The run chart continues to show a significant decrease since December 2014. The median of monthly falls reduced from eight to six. This is the third quarter this quality marker has shown a significant improvement.

Figure 4: Outcome marker, in-hospital falls with fractured neck of femur by month



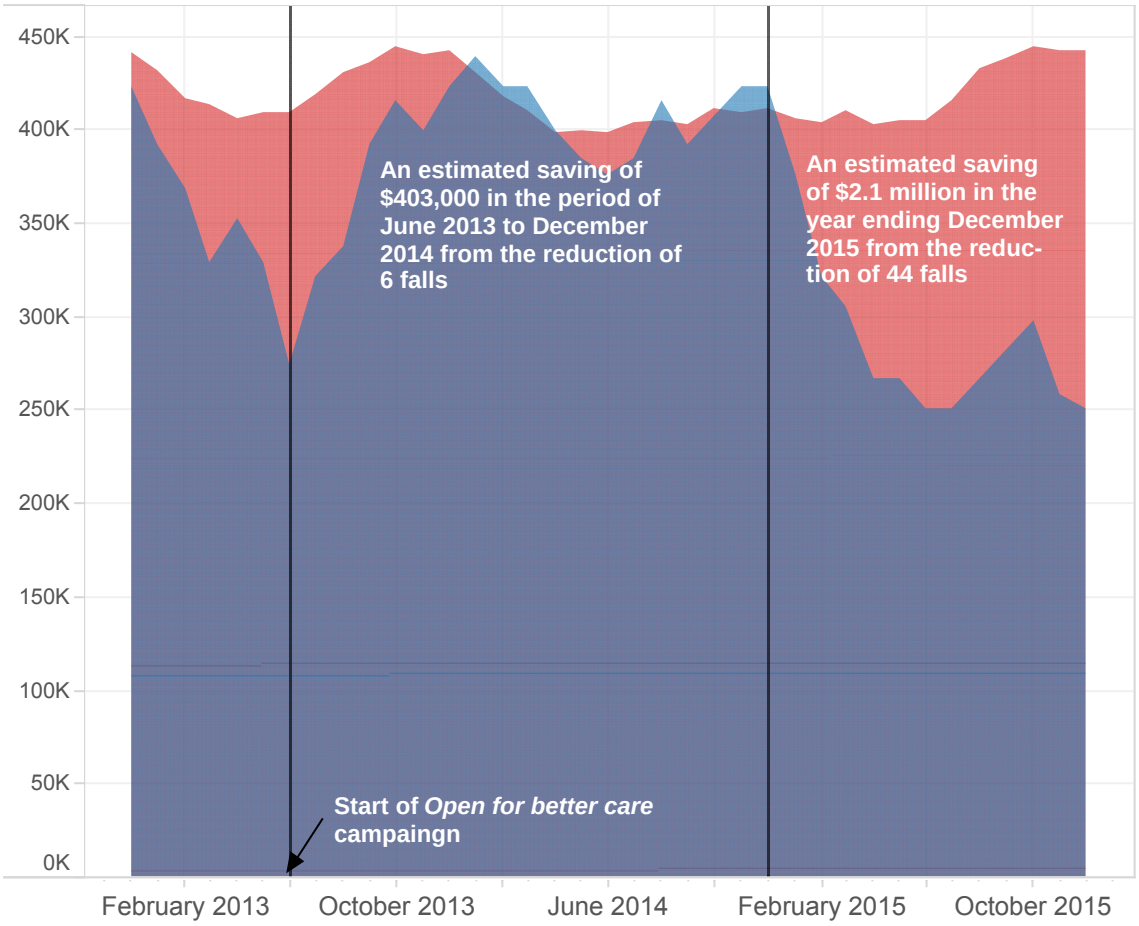
This number of falls is significantly lower than the 108 falls we would have expected in this year, given the falls rate observed in the period from July 2010–June 2012. This reduction is estimated to have saved $2.1 million in the year ending December 2015 based on a comprehensive estimate of $47,000[2] for a fall with a fractured neck of femur.

However, this estimate may be too conservative, as it assumes all patients who fall and break their hip in hospital return home. We know that at least some of these patients are likely to be admitted to aged residential care on discharge from hospital. This is a far more expensive proposition – estimated at $135,000 a time[3]. If we conservatively estimate that 20 percent of the patients who avoided falls were admitted to a residential care facility, the reduction in falls represents $2.8 million in total avoidable costs.

[2] de Raad J-P. 2012. *Towards a value proposition: scoping the cost of falls.* Wellington: NZIER.

[3] Ibid

Figure 5: Cost/saving associated with in-hospital falls with fractured neck of femur (6-month moving average)



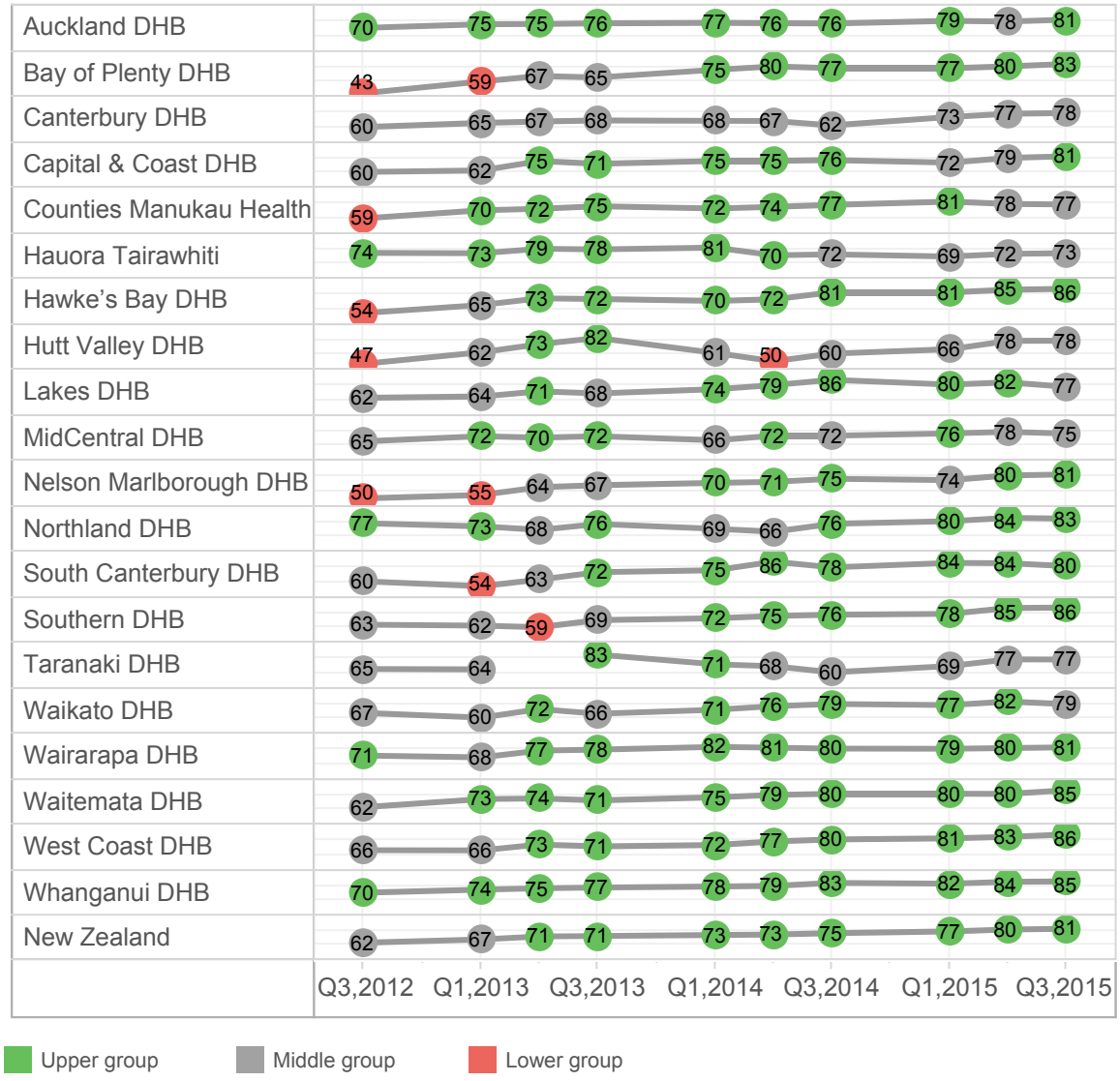
The saving is based on an estimated cost of $47,000 for a fall with a fractured neck of femur.

Expected cost Observed cost

Hand hygiene

National compliance with the five moments for hand hygiene continues to improve. Nationally, DHBs achieved an average of 81 percent compliance in quarter 3, 2015. Twelve DHBs met the 80 percent target and the remaining eight DHBs were within 5 percent of the target. All DHBs once again submitted 100 percent or more of the required hand hygiene data in this period.

Figure 6: Process marker, percentage of opportunities for hand hygiene taken

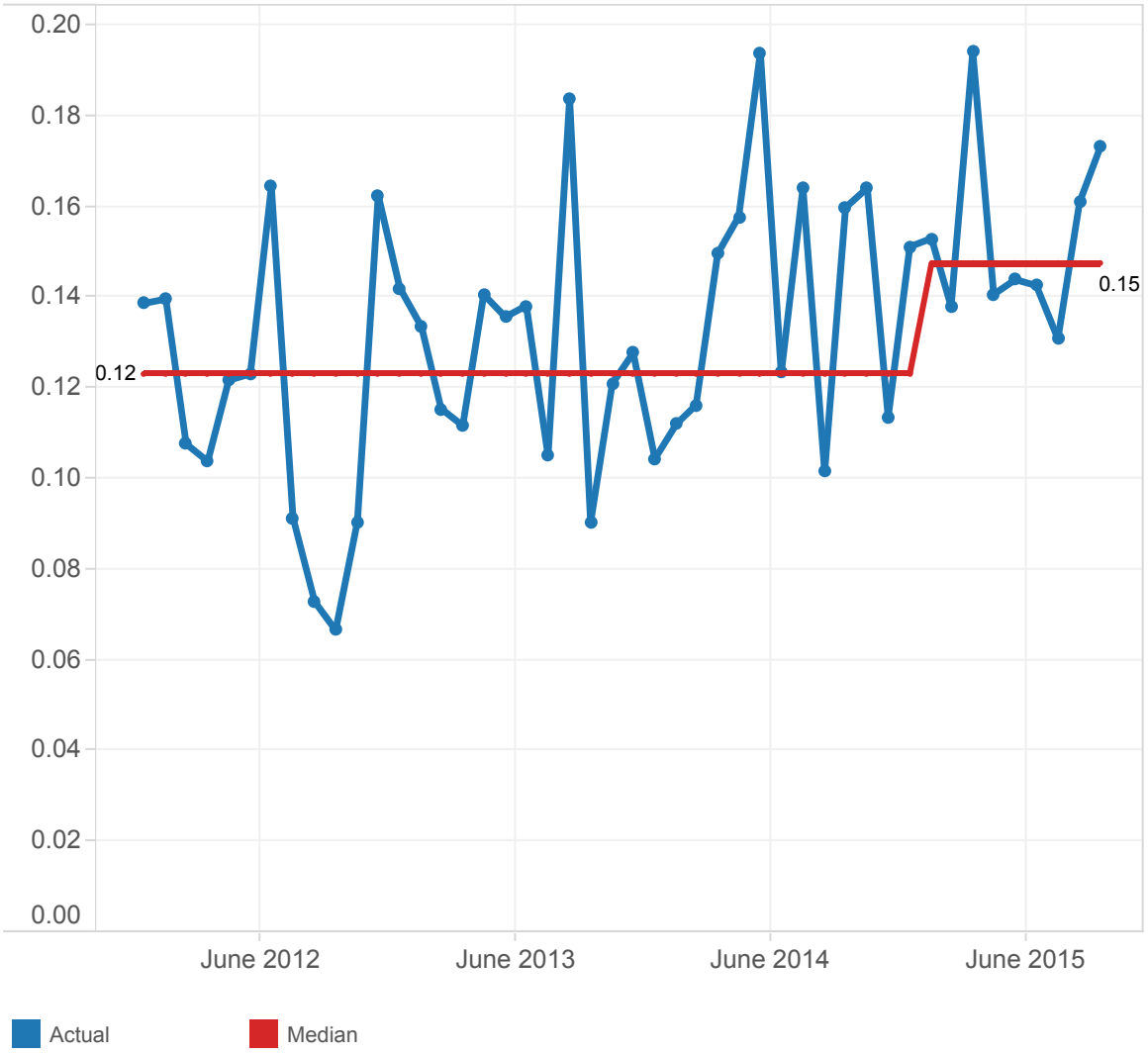


- Upper group: percentage >=70% before Q3, 2014, and then 75% in Q3 and Q4, 2014, and then 80% since Q1, 2015
- Middle group: percentage is 60% to target
- Lower group: percentage <60%
- Hand Hygiene national compliance data is reported on 3-times per annum, therefore no data point is shown specifically for Q4 in any year.

The run chart below shows a minor upward shift since January 2015 for the outcome measure for the hand hygiene programme. The median value of monthly healthcare associated *Staphylococcus aureus* bacteraemia per 1000 bed-days increased from 0.12 to the end of 2014 to 0.15 in the period January to October 2015. Further analysis is needed to explore the possible reason/s for the shift. The November 2015

to March 2016 data will be available in June quarter's report and will show if the shift is continues.

Figure 7: Outcome marker, *Staphylococcus aureus* bacteraemia per 1000 bed-days by month



Safe surgery (previously perioperative harm)

A new QSM aimed at measuring levels of teamwork and communication will be rolled out during the 2015–16 financial year. The first public reporting will be in November 2016 on data for quarter 3, 2016.

Surgical site infection

As the Commission uses 90-day outcome measures for surgical site infection, these data run one quarter behind other measures. Information in this section relates to quarter 3, 2015.

Process measure 1: Antibiotic administered in the right time

For primary procedures, an antibiotic should be administered in the hour before the first incision ('knife to skin'). As this should be happening in all primary cases, the threshold is set at 100 percent. In quarter 3, 2015, 97 percent of hip and knee arthroplasty procedures were given an antibiotic within 60 minutes before 'knife to skin', which is the highest proportion recorded nationally to date. There has been a slow increase for the measure since the start of the programme. Six DHBs achieved the national goal.

Figure 8: Process marker, percentage of operations where antibiotic given 0-60 minutes before 'knife to skin'

- Upper group: percentage =100%
- Middle group: percentage is between 80-99%
- Lower group: percentage <80%

Process measure 2: Right antibiotic in the right dose – cefazolin 2g or more or cefuroxime 1.5g or more

In quarter 1, 2015, 1.5g or more of cefuroxime was accepted as an alternative agent to cefazolin 2g or more for routine antibiotic prophylaxis for hip and knee replacements. It improved the results of this process measure for MidCentral DHB significantly from 10 percent before the change to 96 percent immediately after the change. Nationally, this measurement also increased from 88 percent to 96 percent in quarter 3, 2015. Sixteen DHBs reached the threshold level of 95 percent compared with only three in the baseline quarter. Only Taranaki DHB's results for this measure remain significantly lower than the target rate.

Figure 9: Process marker, percentage of operations where 2g or more cefazolin or 1.5g or more cefuroxime given

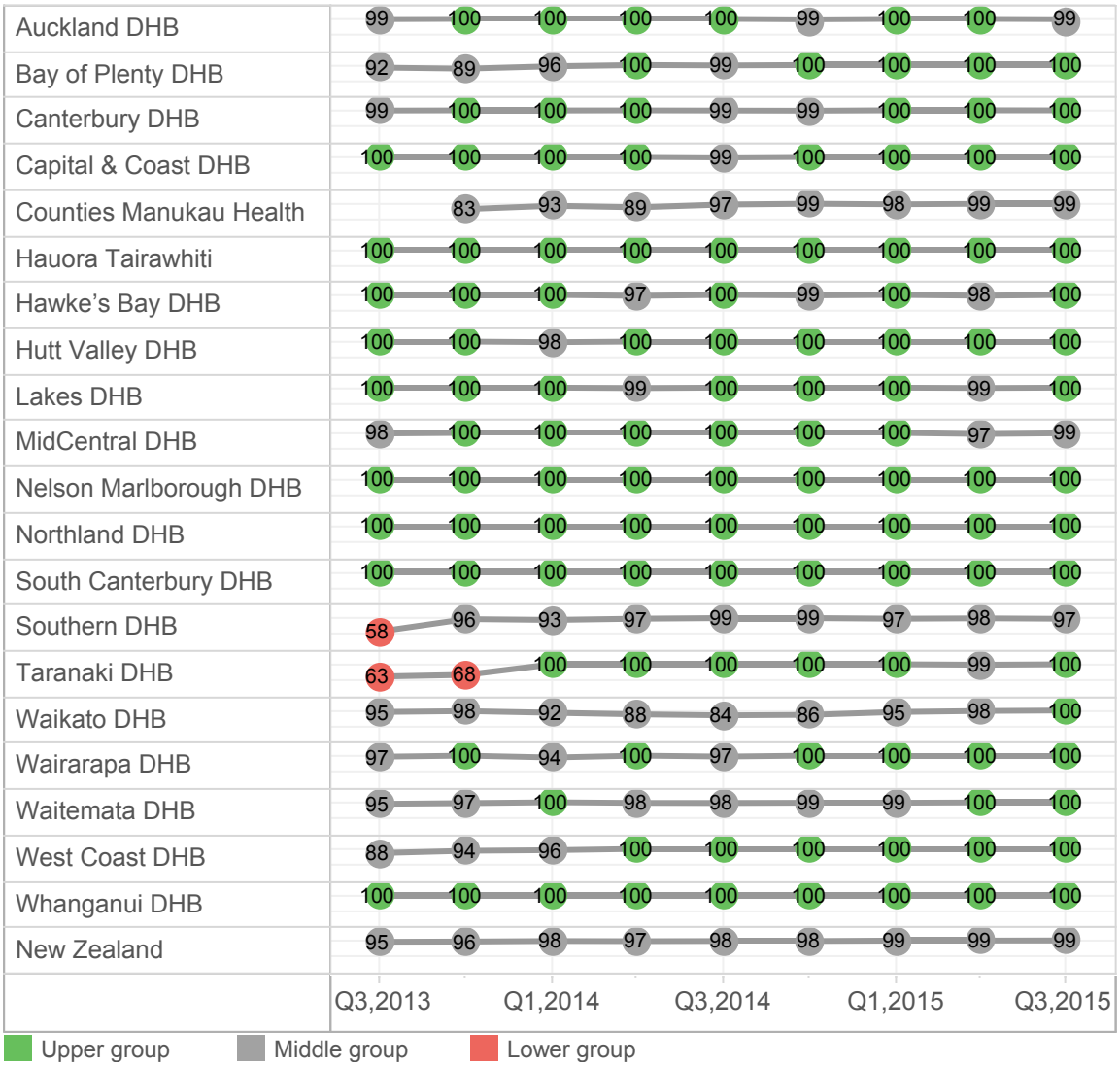
- Upper group: percentage >=95%
- Middle group: percentage is between 80-94%
- Lower group: percentage <80%

Process measure 3: Appropriate skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine

Skin preparation using either chlorhexidine or povidone iodine in alcohol is recommended for all orthopaedic procedures, so the threshold is set at 100 percent. Appropriate skin antisepsis is clearly normal practice across DHBs as the national

compliance rate of 99 percent attests. This is a four percentage point increase from the baseline.

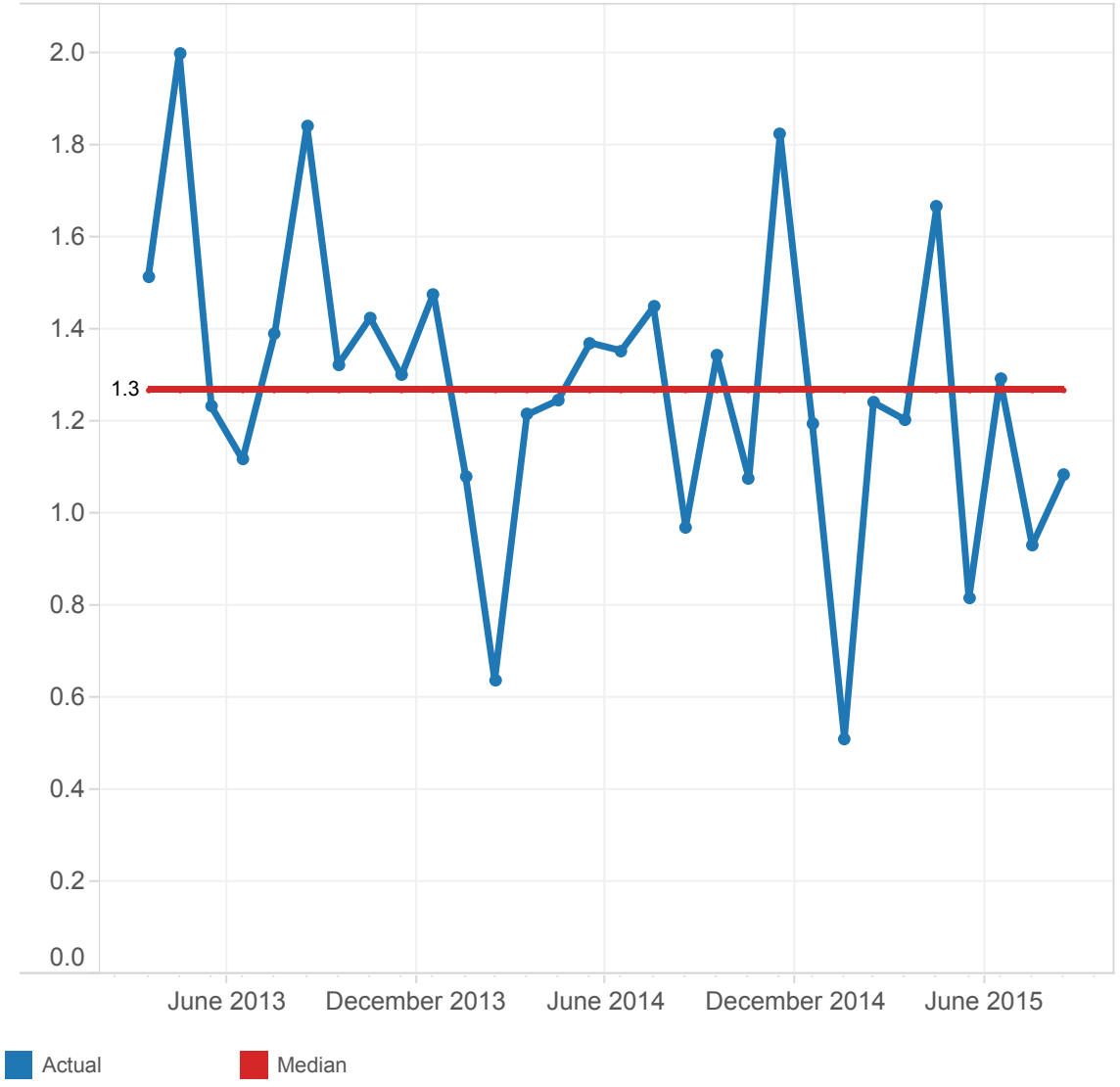
Figure 10: Process marker, percentage of operations given appropriate skin preparation



- Upper group: percentage =100%
- Middle group: percentage is between 80-99%
- Lower group: percentage <80%

Compared with the baseline surgical site infection rate of 1.5 percent in quarter 3, 2013, when 1747 hip and knee arthroplasty procedures were performed, the current quarter showed some improvement. In quarter 3, 2015, DHBs performed 2713 operations, a 55 percent increase on the number of procedures performed in quarter 3, 2013. Thirty surgical site infections were reported, an infection rate of 1.1 percent, which is a point four percent reduction compared with the baseline. However, the improvement in rate has not been stable enough to indicate a shift on the run chart below. It is still too early to confirm a statistically significant, sustained change.

Figure 11: Outcome marker, surgical site infections per 100 hip and knee operations



Medication safety (preliminary results)

We introduced a quality and safety marker for medication safety in September 2014. It focuses on medicine reconciliation – a process by which health care professionals ensure all medicines a patient is taking and their adverse reactions history (including allergy) are accurately documented and the information is used across health care. An accurate medicines list can be reviewed to ensure medicines are appropriate and safe. Medicines which should be continued, stopped or temporarily stopped can be documented on the list. Doing this reduces the risk of medicines being:

- omitted
- prescribed at the wrong dose
- prescribed to a patient who is allergic
- prescribed which has the potential to interact with other prescribed medicines

The introduction of electronic medicine reconciliation (eMR) will enable medicine reconciliation to be done more routinely and including at discharge. There is a national programme to roll-out eMR throughout the country; five DHBs have implemented the system currently.

Figure 12: Structure marker, implementation of eMR

DHB	Status
Counties Manukau Health	Implemented
Northland	Implemented
Taranaki	Implemented
Waitemata	Implemented
Canterbury	Implemented
Auckland	Q2, 2016
Bay of Plenty	Not implemented
Capital & Coast	Not implemented
Hawke's Bay	Not implemented
Hutt Valley	Not implemented
Lakes	Not implemented
MidCentral	Not implemented
Nelson Marlborough	Not implemented
South Canterbury	Not implemented
Southern	Not implemented
Hauora Tairawhiti	Not implemented
Waikato	Not implemented
Wairarapa	Not implemented
West Coast	Not implemented
Whanganui	Not implemented

Figure 13: Structure markers

Structure marker	Northland DHB	Counties Manukau Health	Taranaki DHB	Waitemata DHB
Structure 1: eMR implemented anywhere in the DHB (yes/no)	Yes	Yes	Yes	Yes
Structure 2: Number and percentage of relevant wards with eMR implemented	7	29	6	24
	70%	97%	50%	63%

Within these five DHBs, Northland DHB and Taranaki DHB are able to produce the results of these process measures. Canterbury DHB has implemented the system recently, so no data was collected for the October-December quarter. The other two DHBs are in the process of system upgrades and were unable to report this quarter.

Figure 14: Process markers

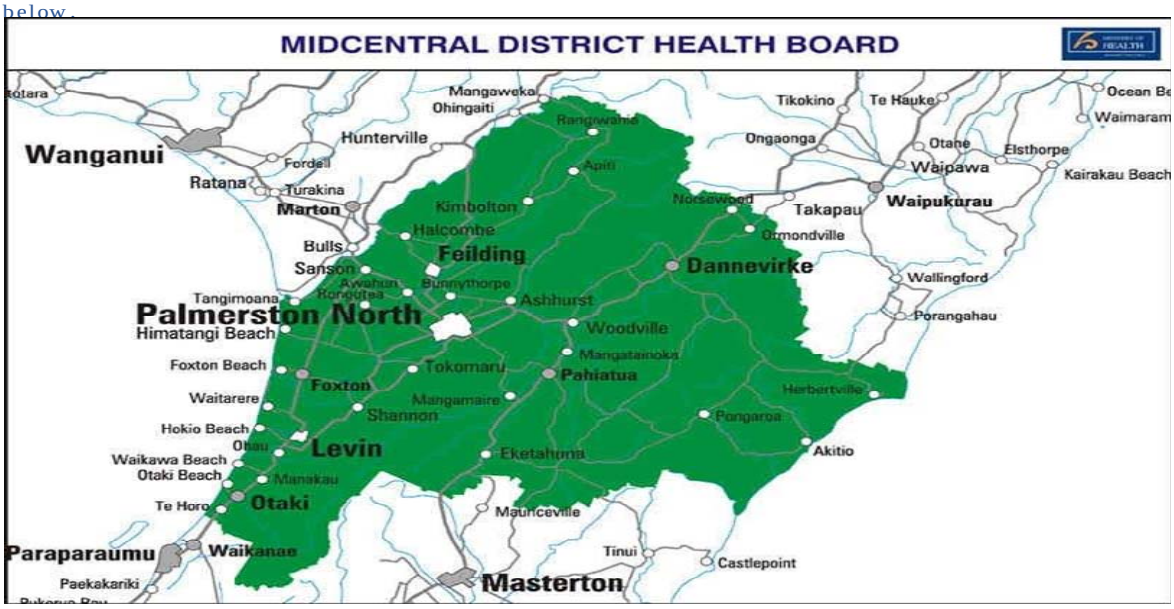
Measurement	Northland DHB (%)	Taranaki DHB (%)	Counties Manukau Health (%)	Waitemata DHB (%)
Process marker 1: Percentage of relevant patients aged **65 and over** (55 and over for Māori and Pacific patients) where *electronic* medicine reconciliation was undertaken within 72 hours of admission	54	42	No data supplied, in the process of upgrading system	No data supplied, in the process of upgrading system
Process marker 2: Percentage of relevant patients aged **65 and over** (55 and over for Māori and Pacific patients) where *electronic* medicine reconciliation was undertaken within 24 hours of admission	47	9		
Process marker 3: Percentage of patients aged **65 and over** (55 and over for Māori and Pacific patients) discharged where medicine reconciliation was included as part of the discharge summary	67	39		

Mental Health and Addiction Secondary Specialist Services Quality and Risk Dashboard

Feb-16

Mid Central District Health Board Area Population Map

The MCDHB responsibility is for the populations in a defined geographic catchment. The defined area is based on territorial authority and ward boundaries, and includes Manawatu, Tararua, Horowhenua, Kapiti districts (Otaki Ward) and Palmerston North City. The map of the district is below.



Four Iwi have manawhenua status within the district: Muaupoko; Ngati Raukawa; Ngati Kahungunu and Rangitaane (manawhenua status means that the Iwi is recognised as having tribal authority within a region)

Muaupoko and Ngati Raukawa Iwi are located on the western side of the mountain ranges, and Ngati Kahungunu Iwi is located on the eastern side. Rangitaane Iwi covers both sides of the ranges for the Manawatu district (including Palmerston North) across to Pahiatua and Dannevirke areas.

The groups of people who experience health status disadvantage in Mid Central are Maori, Pacific peoples, and people experiencing socio economic disadvantage. Horowhenua residents are highly representative of people who experience health status disadvantage.

Break down of DHB District by Population and area

	P.N City	Manawatu	Tararua	Horowhenua	Otaki
All Ethnicitys	**75540**	**28254**	**17634**	**29868**	**5466**
Male	36345	14052	8772	14301	2493
Female	39192	14202	8859	15564	2970
Median Age	32.4yrs	38yrs	37.9yrs	42.3yrs	N/A
<15yrs old	20.3%	23.0%	23.9%	21.2%	20.6%
>65yrs old	11.6%	12.9%	13.9%	20.0%	22.9%
Maori	**11316**	**3867**	**3489**	**6075**	**1858**
Male	5577	1956	1674	2910	N/A
Female	5739	1911	1815	3165	N/A
Median Age	21.1yrs	19.5yrs	22yrs	22.1yrs	N/A
<15yrs old	35.8%	38.7%	37.7%	37.8%	N/A
>65yrs old	2.7%	3.3%	4.3%	5.0%	N/A

**Data Source 2006 Census*

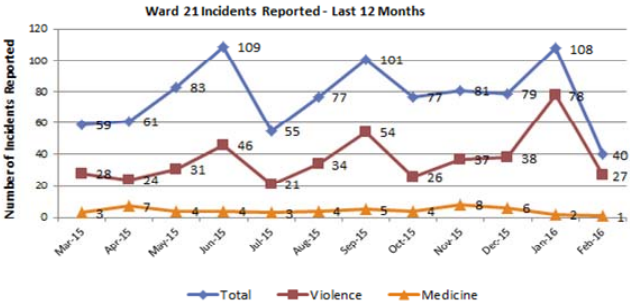
Risk and Incident Summary

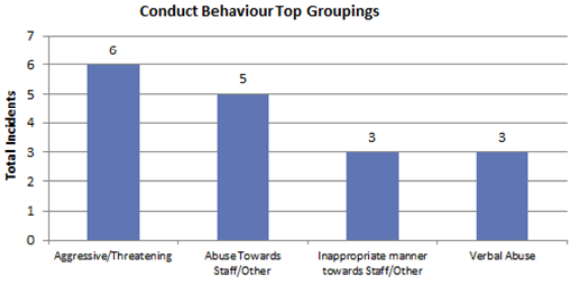
MH&A SAC 2,3,4 Incidents -February

SAERs Month	Totals	SAC 2	SAC 3
Total SAERG reviews	8	1	
Total reviews final draft	7		
Coronial reviews	5		
Total completed reviews	0		
Total yet to be SAC rated	0		
Totals open	8		

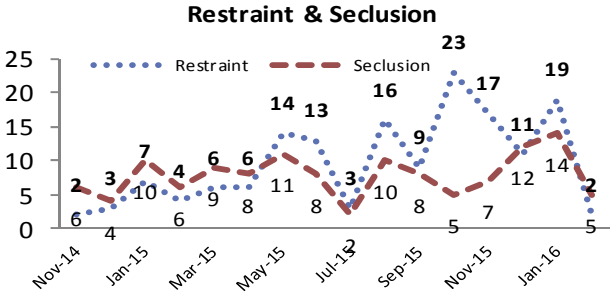
Compliments/Complaints	Current	Last	Change
Complaints	3	5	
HDC Complaints (open)	2	2	
Complaints completed	0	1	
Outstanding Complaints (open)	1	4	
Compliments	0	0	

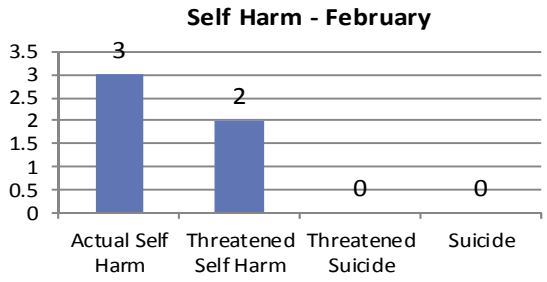
Quality & Risk - Total SAERG reviews for MHAS is sitting at 8, with 7 of these in final draft. An audit has occurred for the previous 12 months of all reviews to determine all actions were completed, 12 plans were fully audited for completion, and it is pleasing to report that 100% of the reviews audited have now been closed. During this period two other external reviews were identified that had not been through the review process, or monitored and we are now auditing these and reporting on completion.





Total incidents for February - 40. Of this number of incidents, 27 were captured in the 'violence' reporting category. Of this number a break down of the top four highest concern categories, there were 6 episodes of threat or Aggression, 5 of abuse, 3 verbal abuse, and 3 which were inappropriate behaviour. Four of the incidence of aggression were in our HNU (high needs unit) part of the inpatient unit with 2 in the open ward.

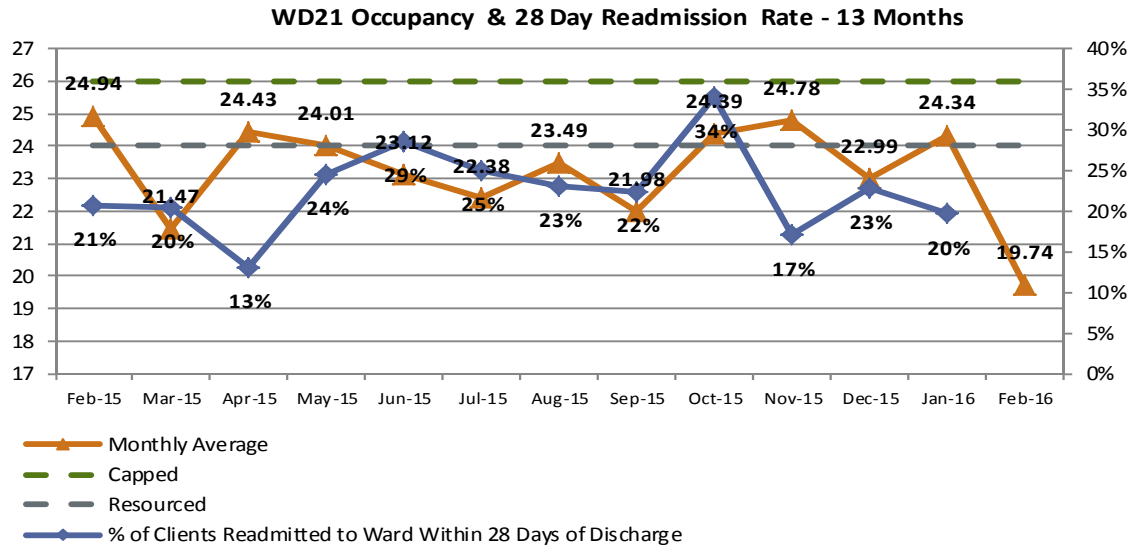


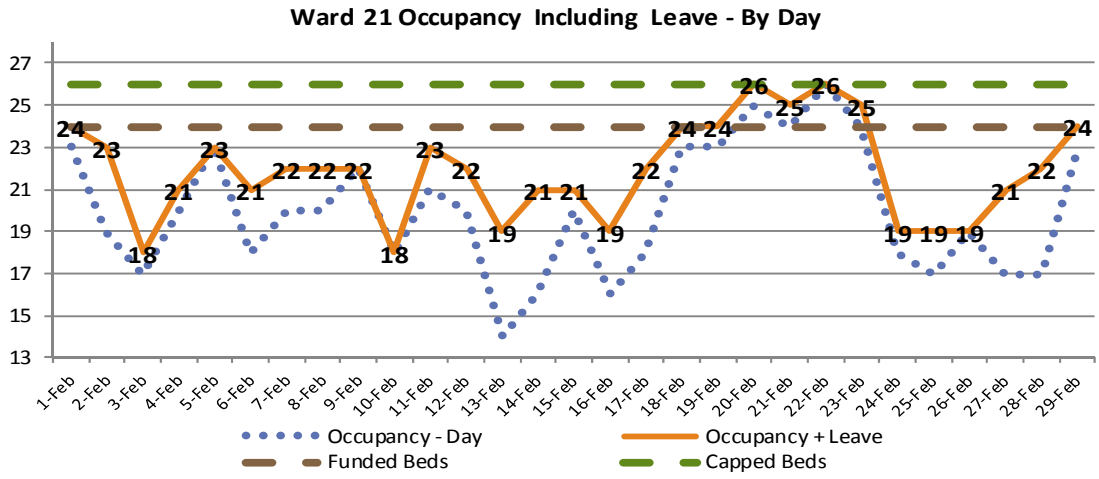


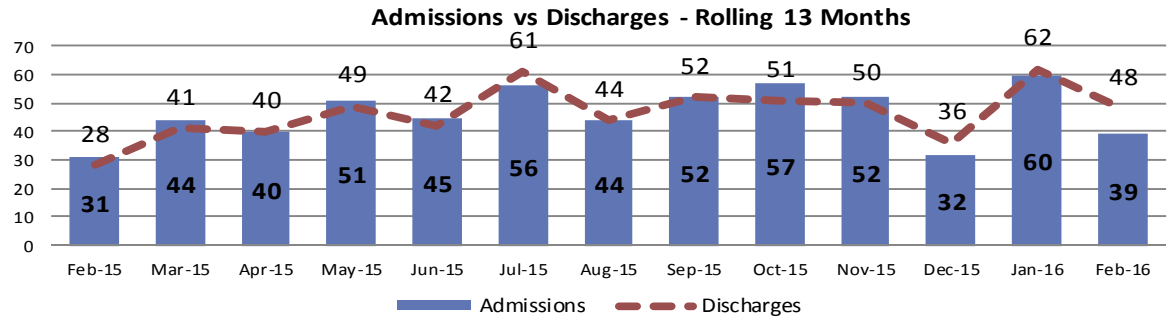
Actual Self Harm/ threatened Self Harm/Suicide/Threatened suicide

Actual Self harm -behavior by 3 individuals. Threatened Self Harm - behavior by 2 individuals

Ward 21

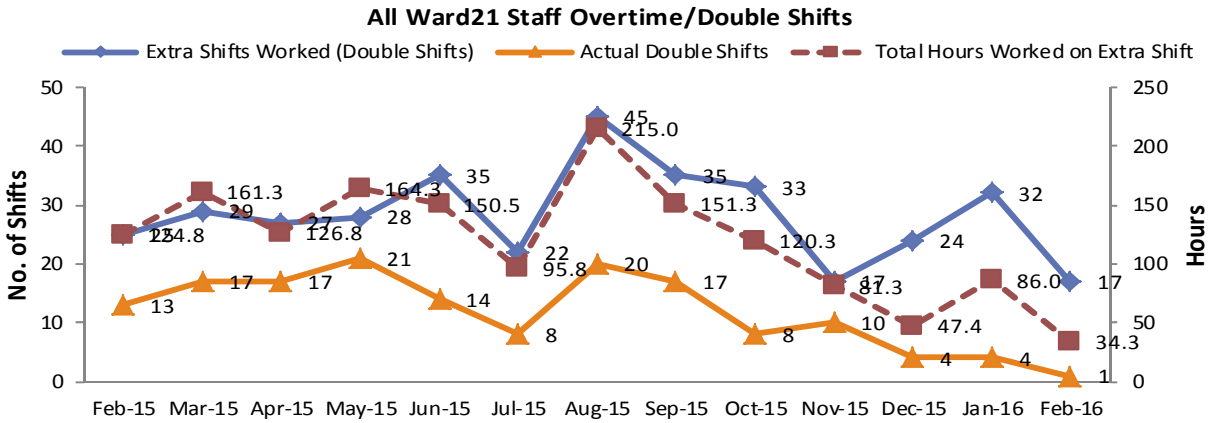






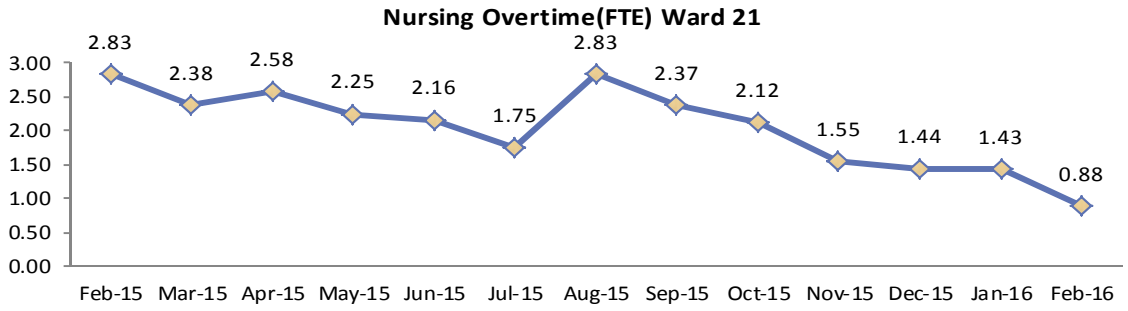
Ward 21 February showed a significant improvement in management of admissions and discharges which resulted in improved management of the bed capacity. This improvement is due to the combined effort of the whole service, and the ward team and our NGO partners. Whilst there is room to improve, it is pleasing to see positive results.

Ward 21 Staffing



Extra Shifts are any shift pre or following on time from a normal shift (Not necessarily full shifts).
The graphed line of extra shifts is the number of shifts, not total hours
Total Hours worked on Extra Shift
Shifts >= 15 hours are shifts where the total hours (first shift + second shift) are greater than 15 hours

The above graph includes all Ward21 staff



With an almost fully resourced MHAS workforce, and improved rostering, we are now able to report a much reduced level of overtime. Total February overtime (additional hours) is 34.3 hours. There is only one true full 'double' shift for the entire month. Much of the small amount of additional hours to extend a shift was directly attributable to staff managing admissions to the ward late in the shift

Mental Health Scorecard - February

Mental Health KPI (National Benchmarking)	Monthly	Target
KPI 2: 28 day acute inpatient readmission rate (for January)*	19.67%	0-10 %
KPI 8: Average length of acute inpatient stay	16.4 Days	14-21 days
KPI 18: Pre-admission community care (Seen in 7 days before ward admission)	54%	75-100 %
KPI 19: Post-discharge community care (Seen in 7 days after ward discharge)	59%	90-100 %
KPI 33: Percentage of contact time with client participation	84.70%	80-90%
KPI 34: Community service-user-related time	21.20%	35-40%
% current clients with deferred diagnosis (DSM-IV **7999**) or no diagnosis (DSM-IV **V7109**)‡	**22.10%**	
% HoNOS/CA/65+ Compliant Admissions and Discharges - Community Teams	62%	80%
% HoNOS/CA/65+ Compliant Admissions and Discharges - Inpatient Team	74%	80%

* 28-day readmission rate is for the *previous* month to allow the full 28 days to pass.

‡ This is the **total** percentage of current clients that have deferred or no diagnosis, not only the ones exceeding 90 days.

Community Mental Health Teams

Teams:

- Mental Health Emergency Team
- Palmerston North Community Mental Health Team
- Maori Mental Health Team (Orang Hinegaro)
- Horowhenua Community Mental Health Team
- Feilding Community Mental Health Team
- Tararua Community Mental Health Team
- Alcohol and Drug Service
- Child Adolescent and Family Community Mental Health Team

Overview:

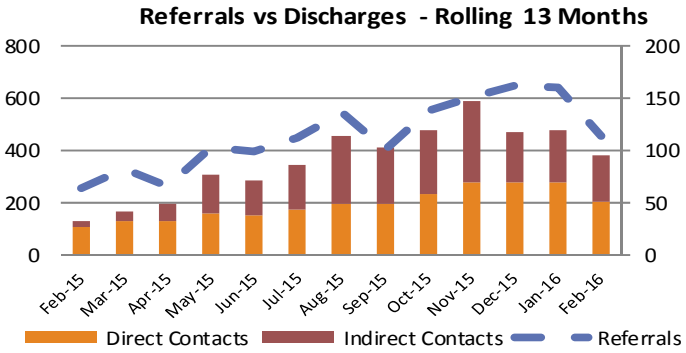
Each Community Team listed below has its own section including; Active Episodes of Care (As at the last day of the reporting month), Referral vs Discharges and Average Length of stay (ALOS), and a break down of current client age ranges. Also included is population data for each area. The Mental Health Emergency Team page shows Direct contacts, Indirect contacts and Referrals. Warning signs are indicated as planned in the recent HAC workshop. The community teams current 'warning signs' are defined as referral volume variance over 20% . In the inpatient unit the warning sign is defined as sustained overutilisation , over 105% occupancy > two days.

Mental Health Emergency Team

Population:	
P.N City	75,540
Horowhenua	29,868
Tararua	16,854
Active Episodes of Care:	
Total	76
FTE:	
Including Clinical Managers	
Clinical	N/A
Total	N/A

Client Age Range:

Age Bracket	*Clients*	*Percentage*
<19yrs	24	31.6%
15-24 yrs	14	18.4%
25-64 yrs	33	43.4%
65+ yrs	5	6.6%



**Referrals scaled on Secondary Axis (Right)*

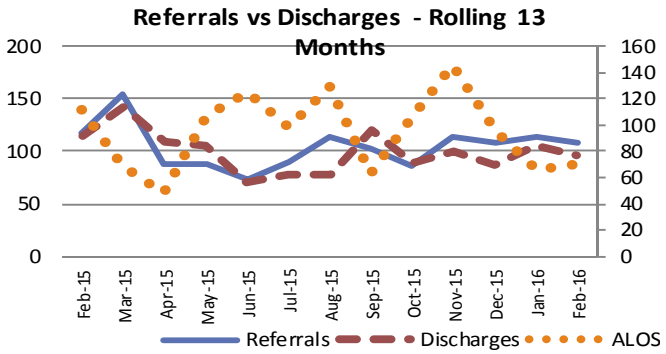
Referrals to the Mental Health Emergency Team (MHET) has increased from less than 50 referrals per month to almost 100 referrals per month, this has had a significant impact on work loads.
Warning sign:
This is a > 20% increase and the work to address this issue has a dedicated development project. Since June 2015, the service increased scope and has provided 24 hour cover over 7 days per week.

Palmerston North Community Mental Health Team

Population:	
P.N City	75,540

Active Episodes of Care:	
Total	548
FTE:	
Including Clinical Managers	
Clinical	29.80
Total	34.60

Client Age Range:		
Age Bracket	*Clients*	*Percentage*
<19yrs	18	3.3%
19-24 yrs	98	17.9%
25-64 yrs	401	73.2%
65+ yrs	31	5.7%



**ALOS (days) scaled on Secondary Axis (Right)*

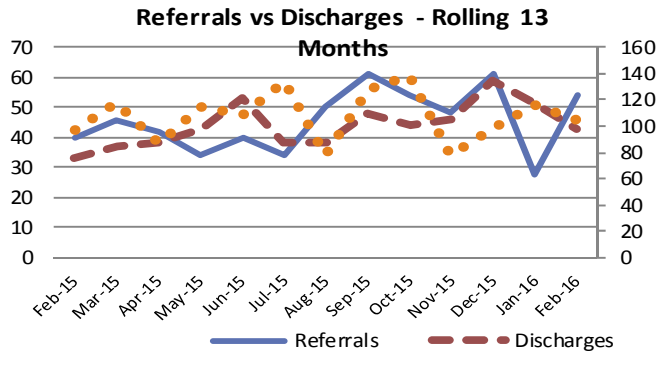
Note the changes to ALOS which reflect the input from new clinical manager input to ensure that reviews are occurring.

Maori Mental Health Team (Orang Hinegaro)

Population:	
P.N City	75,540

Active Episodes of Care:	
Total	237
FTE:	
Including Clinical Managers	
Clinical	N/A
Total	N/A

Client Age Range:		
Age Bracket	*Clients*	*Percentage*
<19yrs	84	35.4%
19-24 yrs	30	12.7%
25-64 yrs	122	51.5%
65+ yrs	1	0.4%



**ALOS (days) scaled on Secondary Axis (Right)*

Note

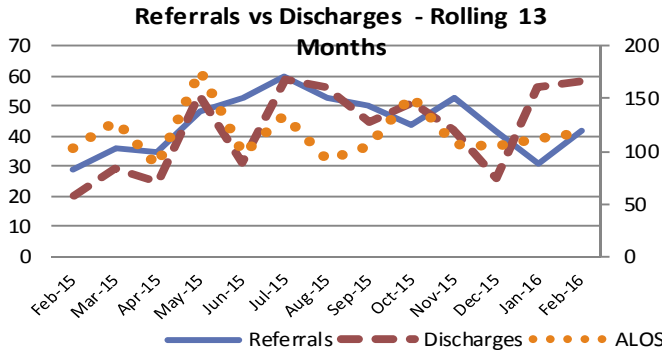
Horowhenua Community Mental Health Team

Population:	
Horowhenua	29,868
Otaki	5,466

Active Episodes of Care:	
Total	267
FTE:	
Including Clinical Managers	
Clinical	13.40
Total	15.40

Client Age Range:

Age Bracket	*Clients*	*Percentage*
<19yrs	1	0.4%
19-24 yrs	29	10.9%
25-64 yrs	225	84.3%
65+ yrs	12	4.5%



**ALOS (days) scaled on Secondary Axis (Right)*

Referrals for the Horowhenua region have been steadily increasing over the passed 12 months. This does place increased workloads for the staff in the region.

An increase of +/- 20% is our Key Result Area, which is our 'warning sign' indicator of a need to focus on

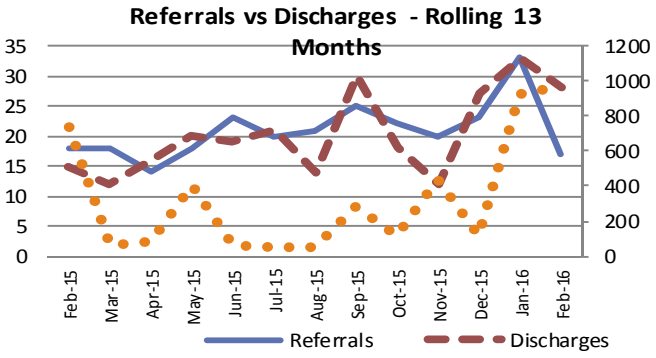
Feilding Community Mental Health Team

Population:	
Feilding	28,524

Active Episodes of Care:	
Total	123
FTE:	
Including Clinical Managers	
Clinical	4.80
Total	5.74

Client Age Range:

Age Bracket	*Clients*	*Percentage*
<19yrs	2	1.6%
19-24 yrs	16	13.0%
25-64 yrs	89	72.4%
65+ yrs	16	13.0%



**ALOS (days) scaled on Secondary Axis (Right)*

Note fluctuating referrals and discharges which reflect a more dedicated focus on quality improvement and case management with reviews and discharges of clients with a long ALOS.

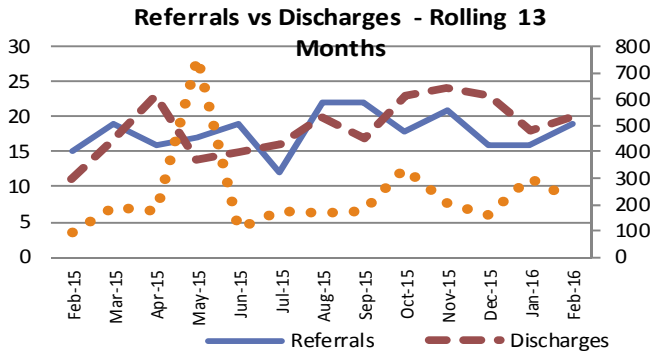
Tararua Community Mental Health Team

Population:	
Tararua (all)	16,854
Dannevirke	5,043
Pahiatua*	4,254
Rural Areas	7,557
Active Episodes of Care:	
Total	147
FTE:	
Including Clinical Managers	
Clinical	5.60
Total	6.40

Note

Client Age Range:		
Age Bracket	*Clients*	*Percentage*
19-24 yrs	22	15.0%
25-64 yrs	116	78.9%
65+ yrs	9	6.1%

**Includes Woodville & Eketahuna*



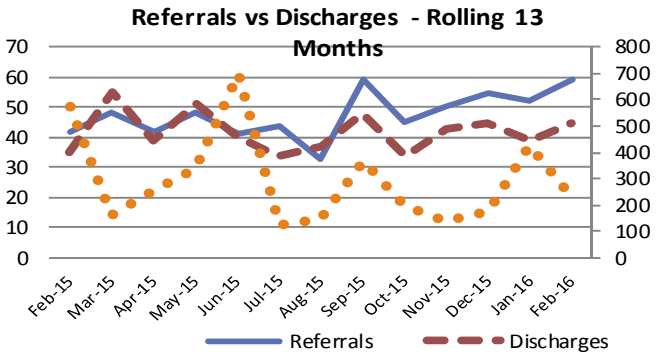
**ALOS (days) scaled on Secondary Axis (Right)*

Alcohol and Other Drug Service

Population:	
P.N City	75,540
Horowhenua	29,868
Tararua	16,854
Active Episodes of Care:	
Total	686
FTE:	
Including Clinical Managers	
Clinical	N/A
Total	N/A

Note.

Client Age Range:		
Age Bracket	*Clients*	*Percentage*
<19yrs	2	0.3%
19-24 yrs	38	5.5%
25-64 yrs	638	93.0%
65+ yrs	8	1.2%



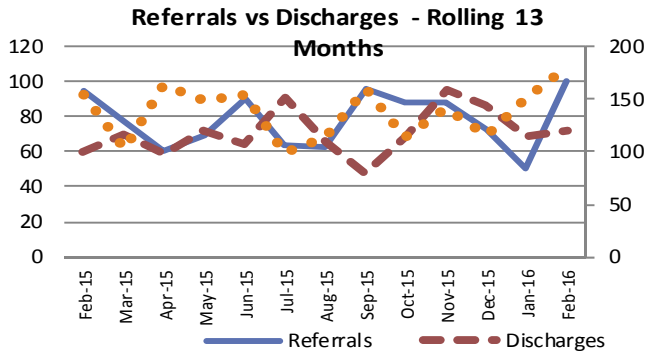
**ALOS (days) scaled on Secondary Axis (Right)*

Child Adolescent and Family Community Mental Health Team

Active Episodes of Care:	
Total	510

FTE:	
Including Clinical Managers	
Clinical	28.25
Total	31.49

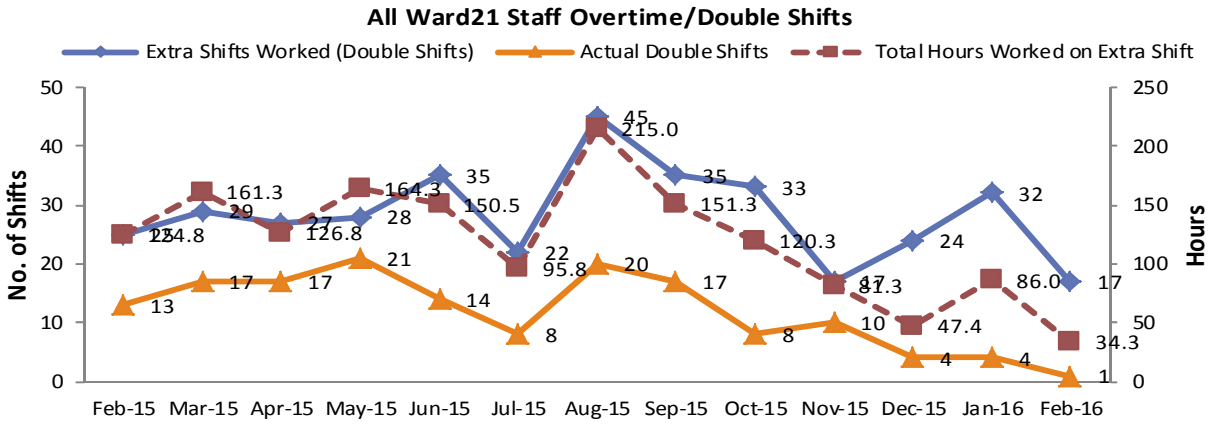
Client Age Range:		
Age Bracket	*Clients*	*Percentage*
<19yrs	500	98.0%
19-24yrs	10	2.0%



**ALOS (days) scaled on Secondary Axis (Right)*

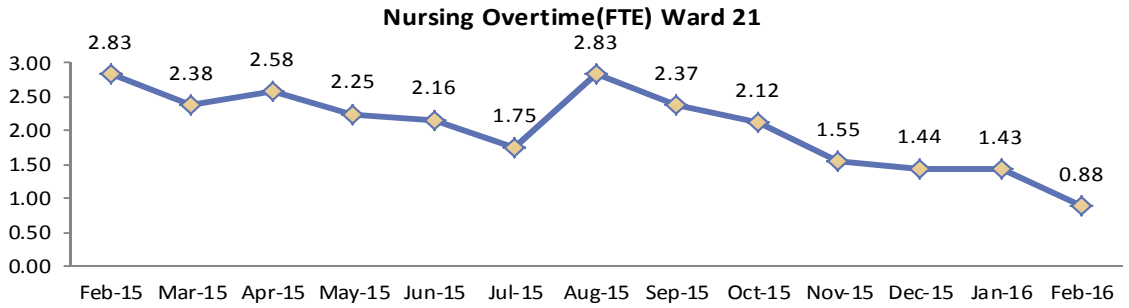
Note increases in referrals as an overall trend, with some 'dips' which may relate to other activity. (school terms)

Ward 21 Staffing



Extra Shifts are any shift pre or following on time from a normal shift. The graphed line of extra shifts is the number of shifts, not total hours
Total Hours worked on Extra Shift
Shifts >= 15 hours are shifts where the total hours (first shift + second shift) are greater than 15 hours

The above graph includes all Ward21 staff



With an almost fully resourced MHAS workforce, and improved rostering, we are now able to report a much reduced level of overtime.
Overtime (additional hours) is 34.3 hours in total for February. This includes only one true full 'double' shift. for the entire month. Much of the overtime was directly attributible to admssions to

Mental Health Scorecard - February

Mental Health KPI (National Benchmarking)	Monthly	Target
KPI 2: 28 day acute inpatient readmission rate (for January)*	19.67%	0-10 %
KPI 8: Average length of acute inpatient stay	16.4 Days	14-21 days
KPI 18: Pre-admission community care (Seen in 7 days before ward admission)	54%	75-100 %
KPI 19: Post-discharge community care (Seen in 7 days after ward discharge)	59%	90-100 %
KPI 33: Percentage of contact time with client participation	84.70%	80-90%
KPI 34: Community service-user-related time	21.20%	35-40%
% current clients with deferred diagnosis (DSM-IV **7999**) or no diagnosis (DSM-IV **V7109**)‡	**22.10%**	
% HoNOS/CA/65+ Compliant Admissions and Discharges - Community Teams	62%	80%
% HoNOS/CA/65+ Compliant Admissions and Discharges - Inpatient Team	74%	80%

* 28-day readmission rate is for the *previous* month to allow the full 28 days to pass.

‡ This is the **total** percentage of current clients that have deferred or no diagnosis, not only the ones exceeding 90 days.

Community Mental Health Teams

Teams:

- Mental Health Emergency Team
- Palmerston North Community Mental Health Team
- Maori Mental Health Team (Orang Hinegaro)
- Horowhenua Communtity Mental Health Team
- Feilding Community Mental Health Team
- Tararua Community Mental Health Team
- Alcohol and Drug Service
- Child Adolescent and Family Community Mental Health Team

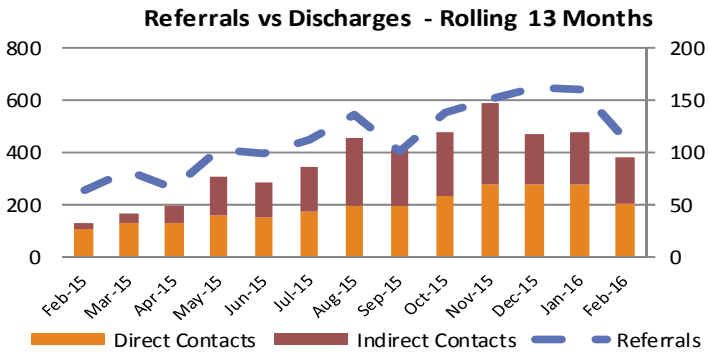
Overview: Each Community Team listed below has its own section including; Active Episodes of Care (As at the last day of the reporting month), Referral vs Discharges and Average Length of stay (ALOS), and a break down of current client age ranges. Also included is population data for each area. Mental Health Emergency Team page shows Direct contacts, Indirect contacts and Referrals. Direct contacts are any activity where the client is physically present at the time of the encounter.

Mental Health Emergency Team

Population:	
P.N City	75,540
Horowhenua	29,868
Tararua	16,854
Active Episodes of Care:	
Total	76
FTE:	
Including Clinical Managers	
Clinical	N/A
Total	N/A

Client Age Range:

Age Bracket	*Clients*	*Percentage*
<19yrs	24	31.6%
15-24 yrs	14	18.4%
25-64 yrs	33	43.4%
65+ yrs	5	6.6%



**Referrals scaled on Secondary Axis (Right)*

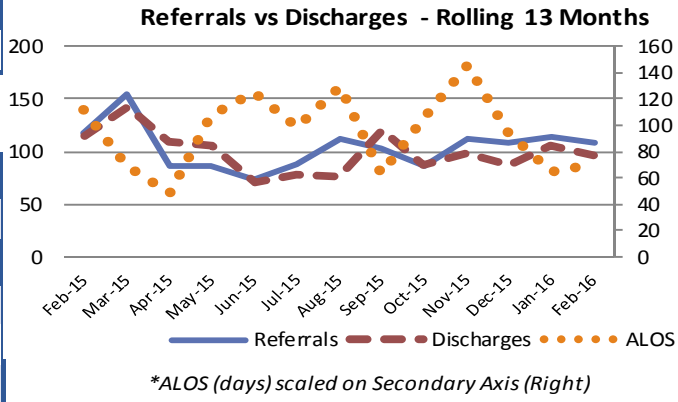
Referrals to the Mental Health Emergency Team (MHET) has increased from less than 50 referrals per month to almost 100 referrals per month, this has had a significant impact on work loads. This is a > 20% increase and has a dedicated project and workstream associated with the development of this service. Since June 2015, the service increased to provide 24 hour cover over 7 days per week.

Palmerston North Community Mental Health Team

Population:	
P.N City	75,540

Active Episodes of Care:	
Total	548
FTE:	
Including Clinical Managers	
Clinical	29.80
Total	34.60

Client Age Range:		
Age Bracket	*Clients*	*Percentage*
<19yrs	18	3.3%
19-24 yrs	98	17.9%
25-64 yrs	401	73.2%
65+ yrs	31	5.7%



ALOS (days) scaled on Secondary Axis (Right)

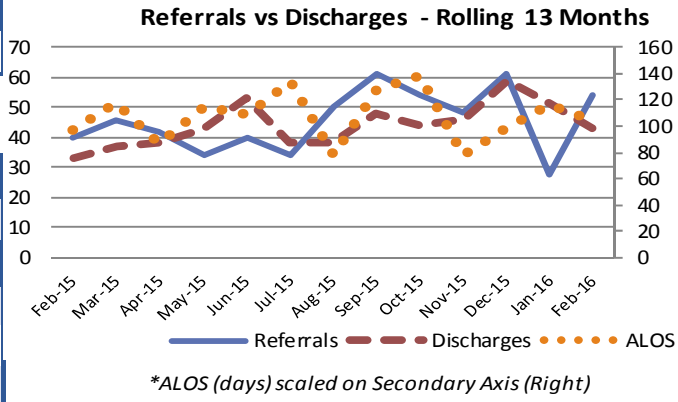
Note the changes to ALOS which reflect the input from new clincial manager input to ensure that reviews are occurring.

Maori Mental Health Team (Orang Hinegaro)

Population:	
P.N City	75,540

Active Episodes of Care:	
Total	237
FTE:	
Including Clinical Managers	
Clinical	N/A
Total	N/A

Client Age Range:		
Age Bracket	*Clients*	*Percentage*
<19yrs	84	35.4%
19-24 yrs	30	12.7%
25-64 yrs	122	51.5%
65+ yrs	1	0.4%



ALOS (days) scaled on Secondary Axis (Right)

Note

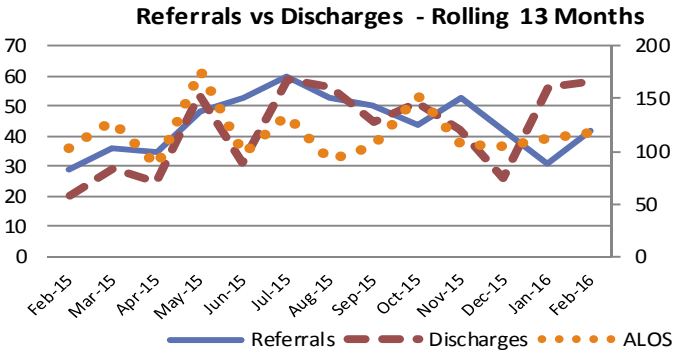
Horowhenua Community Mental Health Team

Population:	
Horowhenua	29,868
Otaki	5,466

Active Episodes of Care:	
Total	267
FTE:	
Including Clinical Managers	
Clinical	13.40
Total	15.40

Client Age Range:

Age Bracket	*Clients*	*Percentage*
<19yrs	1	0.4%
19-24 yrs	29	10.9%
25-64 yrs	225	84.3%
65+ yrs	12	4.5%



**ALOS (days) scaled on Secondary Axis (Right)*

Referrals for the Horowhenua region have been steafily increasing over the passed 12 months. This does place increased workloads for the staff in the region.

An increase of +/- 20% is our Key Result Area, which is our 'warning sign' indicator of a need to focus on

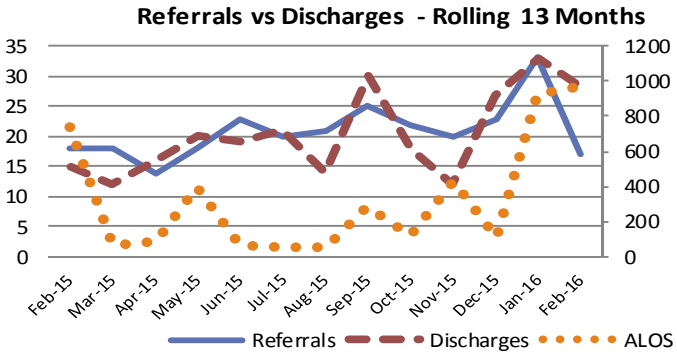
Feilding Community Mental Health Team

Population:	
Feilding	28,524

Active Episodes of Care:	
Total	123
FTE:	
Including Clinical Managers	
Clinical	4.80
Total	5.74

Client Age Range:

Age Bracket	*Clients*	*Percentage*
<19yrs	2	1.6%
19-24 yrs	16	13.0%
25-64 yrs	89	72.4%
65+ yrs	16	13.0%



**ALOS (days) scaled on Secondary Axis (Right)*

Note fluctuating referrals and discharges which reflect a more dedicated focus on quality improvement and case management with reviews and discharges of clients with a long ALOS.