# Hospitals Advisory Committee Agenda

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|---|---|---|---|
| **Location:** | Board Room<br>Level 1<br>Hockin Building<br>Waikato Hospital<br>Pembroke Street<br>HAMILTON | | |
| **Date:** | 13 June 2018 | **Time:** | 8.30am |

| | |
|---|---|
| **Committee Members:** | Ms S Christie (Chair)<br>Ms C Beavis (Deputy Chair)<br>Mr M Gallagher<br>Mrs MA Gill<br>Mr D Macpherson<br>Dr K McClintock<br>Ms C Rankin<br>Mr R Scott<br>Ms S Webb |
| **In Attendance:** | Dr P Malpass (Consumer Council)<br>Dr Grant Howard, Interim Chief Operating Officer and other Executives as necessary |

| | | |
|---|---|---|
| **Next Meeting Date:** | 8 August 2018 | |
| **Contact Details:** | Phone: 07 834 3622 | Facsimile: 07 839 8680 |

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# Hospitals Advisory Committee Agenda

Item

**1.** Apologies

**2.** **INTERESTS**
- 2.1 Schedule of Interests
- 2.2 Conflicts Related to Items on the Agenda

**3.** **MINUTES AND BOARD MATTERS**
- 3.1 Hospitals Advisory Committee Minutes, 11 April 2018
- 3.2 Bay of Plenty DHB Hospital Advisory Committee Minutes, 2 May 2018
- 3.3 Lakes DHB Hospital Advisory Committee Minutes, 28 May 2018

**4.** **QUALITY AND PATIENT SAFETY**
- 4.1 Quality and Patient Safety Report

**5.** **SERVICES**
- 5.1 Interim Chief Operating Officer Waikato Hospital Services Report
- 5.2 Care Capacity Demand Management (CCDM)
- 5.3 Improving the Lives of Older People in their Last 1000 Days
- 5.4 KEEZZ Update

**6.** **NEXT MEETING: 8 August 2018**

# Hospitals Advisory Committee Agenda

## RESOLUTION TO EXCLUDE THE PUBLIC
## NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

THAT:

(1) The public is excluded from the following part of the proceedings of this meeting, namely:
Item 7: NZNO Contingency Planning

(2) The general subject of each matter to be considered while the public is excluded, and the reason for passing this resolution in relation to each matter, are as follows:

(3) This resolution is made in reliance on Clause 32 of Schedule 3 of the NZ Public Health & Disability Act 2000 in that the public conduct of the whole or the relevant part of the meeting would likely result in the disclosure of information for which good reason for withholding exists under sections 6, 7 or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982.

| GENERAL SUBJECT OF EACH MATTER TO BE CONSIDERED | REASON FOR PASSING THIS RESOLUTION IN RELATION TO EACH MATTER | SECTION OF THE ACT |
|---|---|---|
| Item 7: NZNO Contingency Planning | Negotiations are currently still been undertaken. | Section 9(2)(j) – To enable the Waikato DHB to carry on negotiations without prejudice or disadvantage |

**7. NZNO CONTINGENCY PLANNING**

## RE-ADMITTANCE OF THE PUBLIC

THAT:

(1) The Public Is Re-Admitted.
(2) The Executive is delegated authority after the meeting to determine which items should be made publicly available for the purposes of publicity or implementation.

# Apologies

# Interests

# SCHEDULE OF INTERESTS AS UPDATED BY HOSPITALS ADVISORY COMMITTEE MEMBERS TO JUNE 2018

Sally Christie

| Interest | Nature of Interest *(Pecuniary/Non-Pecuniary)* | Type of Conflict *(Actual/Potential/Perceived/None)* | Mitigating Actions *(Agreed approach to manage Risks)* |
|---|---|---|---|
| **Chair, Hospitals Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Board member, Waikato DHB** | Non-Pecuniary | None | Refer Notes 1 and 2 |
| **Member, Chief Executive Performance Review Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Thames Coromandel District Council** | TBA | TBA | |
| **Partner, employee of Workwise** | Pecuniary | Potential | |

Crystal Beavis

| Interest | Nature of Interest *(Pecuniary/Non-Pecuniary)* | Type of Conflict *(Actual/Potential/Perceived/None)* | Mitigating Actions *(Agreed approach to manage Risks)* |
|---|---|---|---|
| **Deputy Chair, Hospitals Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Board member, Waikato DHB** | Non-Pecuniary | None | Refer Notes 1 and 2 |
| **Member, Community & Public Health Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Sustainability Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Chief Executive Performance Review Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Director, Bridger Beavis & Associates Ltd, management consultancy** | Non-Pecuniary | None | |
| **Director, Strategic Lighting Partners Ltd, management consultancy** | Non-Pecuniary | None | |
| **Life member, Diabetes Youth NZ Inc** | Non-Pecuniary | Perceived | |
| **Trustee, several Family Trusts** | Non-Pecuniary | None | |
| **Employee, Waikato District Council** | Pecuniary | None | |

Sally Webb

| Interest | Nature of Interest *(Pecuniary/Non-Pecuniary)* | Type of Conflict *(Actual/Potential/Perceived/None)* | Mitigating Actions *(Agreed approach to manage Risks)* |
|---|---|---|---|
| **Acting Chair and Board member, Waikato DHB** | Non-Pecuniary | None | Refer Notes 1 and 2 |
| **Chair, Chief Executive Performance Review Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Community & Public Health Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Hospitals Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Audit & Corporate Risk Management Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Sustainability Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Chair, Bay of Plenty DHB** | TBA | TBA | |
| **Member, Capital Investment Committee** | TBA | TBA | |
| **Director, SallyW Ltd** | TBA | TBA | |

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

Martin Gallagher

| Interest | Nature of Interest *(Pecuniary/Non-Pecuniary)* | Type of Conflict *(Actual/Potential/Perceived/None)* | Mitigating Actions *(Agreed approach to manage Risks)* |
|---|---|---|---|
| **Board member, Waikato DHB** | Non-Pecuniary | None | Refer Notes 1 and 2 |
| **Member, Hospitals Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Audit & Corporate Risk Management Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Deputy Mayor, Hamilton City Council** | Pecuniary | Perceived | |
| **Board member Parent to Parent NZ (Inc), also provider of the Altogether Autism service** | Pecuniary | Potential | |
| **Trustee, Waikato Community Broadcasters Charitable Trust** | Non-Pecuniary | Perceived | |
| **Wife employed by Wintec (contracts with Waikato DHB) with some contract work for Selwyn Foundation** | Pecuniary | Potential | |
| **Member, Hospital Advisory Committee, Lakes DHB** | Pecuniary | Potential | |

Mary Anne Gill

| Interest | Nature of Interest *(Pecuniary/Non-Pecuniary)* | Type of Conflict *(Actual/Potential/Perceived/None)* | Mitigating Actions *(Agreed approach to manage Risks)* |
|---|---|---|---|
| **Board member, Waikato DHB** | Non-Pecuniary | None | Refer Notes 1 and 2 |
| **Member, Hospitals Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Sustainability Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Employee, Life Unlimited Charitable Trust** | Pecuniary | Perceived | |
| **Member, Public Health Advisory Committee, Bay of Plenty DHB** | Pecuniary | Potential | |
| **Member, Disability Support Advisory Committee, Bay of Plenty DHB** | Pecuniary | Potential | |
| **Member, Health Strategic Committee, Bay of Plenty DHB** | Pecuniary | Potential | |

Dave Macpherson

| Interest | Nature of Interest *(Pecuniary/Non-Pecuniary)* | Type of Conflict *(Actual/Potential/Perceived/None)* | Mitigating Actions *(Agreed approach to manage Risks)* |
|---|---|---|---|
| **Board member, Waikato DHB** | Non-Pecuniary | None | Refer Notes 1 and 2 |
| **Member, Hospitals Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Audit & Corporate Risk Management Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Maori Strategic Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Councillor, Hamilton City Council** | Pecuniary | Perceived | |
| **Deputy Chair, Waikato Regional Passenger Transport Committee** | Non-Pecuniary | Potential | |
| **Member, Waikato Regional Transport Committee** | Non-pecuniary | Potential | |
| **Member, Future Proof Joint Council Committee** | Non-pecuniary | None | |
| **Partner is an occasional contractor to Waikato DHB in "Creating our Futures"** | TBA | Potential | |

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.

Dr Kahu McClintock

| Interest | Nature of Interest *(Pecuniary/Non-Pecuniary)* | Type of Conflict *(Actual/Potential/Perceived/None)* | Mitigating Actions *(Agreed approach to manage Risks)* |
|---|---|---|---|
| **Member, Hospitals Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Member, Iwi Maori Council, Waikato DHB** | Non-Pecuniary | None | |

Christine Rankin

| Interest | Nature of Interest *(Pecuniary/Non-Pecuniary)* | Type of Conflict *(Actual/Potential/Perceived/None)* | Mitigating Actions *(Agreed approach to manage Risks)* |
|---|---|---|---|
| **Member, Hospitals Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Board member, Bay of Plenty DHB** | Non-Pecuniary | None | |

Ron Scott

| Interest | Nature of Interest *(Pecuniary/Non-Pecuniary)* | Type of Conflict *(Actual/Potential/Perceived/None)* | Mitigating Actions *(Agreed approach to manage Risks)* |
|---|---|---|---|
| **Member, Hospitals Advisory Committee, Waikato DHB** | Non-Pecuniary | None | |
| **Deputy Chair and Board member, Bay of Plenty DHB** | Non-Pecuniary | None | |

Note 1: Interests listed in every agenda.

Note 2: Members required to detail any conflicts applicable to each meeting.


# Minutes
# and
# Matters Arising

# WAIKATO DISTRICT HEALTH BOARD
## Minutes of the Hospitals Advisory Committee Meeting
## Held on Wednesday 11 April 2018
## Commencing at 9:00am

**Present:**
Ms S Christie (Chair)
Ms C Beavis (Deputy Chair)
Mr M Gallagher
Mrs MA Gill
Mr D Macpherson
Ms S Webb
Dr K McClintock
Ms C Rankin

**In Attendance:**
Ms L Aydon, Executive Director, Public and Organisational Affairs
Mr N Hablous, Chief of Staff
Dr G Howard, Interim Chief Operating Officer, Waikato Hospital
Ms M Neville, Director, Quality & Patient Safety
Mr M Spittal, Executive Director, Community & Clinical Support
Dr R Tapsell, Acting Chief Medical Advisor
Mr M ter Beek, Executive Director, Operations and Performance
Ms A Welsh, Human Resources Manager
Ms B Garbutt, Director Older Persons and Rehabilitation
Ms G Pomeroy, Co – Chair Consumer Council
Mr C Wade, Chair of Community and Public Health Advisory Committee

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**IN THE ABSENCE OF DELEGATED AUTHORITY ALL ITEMS WERE FOR RECOMMENDATION TO THE BOARD**

## ITEM 1: APOLOGIES

Apologies received for Ms Rolleston.

## ITEM 2: INTERESTS

**2.1 Schedule of Interests**
Mr Macpherson noted that two interests need to be removed and one added. He will communicate this with the PA to the CE.

**2.2 Conflicts Related to Items on the Agenda**
No conflicts of interest.

# ITEM 3: MINUTES AND MATTERS ARISING

**3.1 Performance Monitoring Committee Meeting: 11 October 2017**

**Resolved**
**THAT**
The Performance Monitoring Committee meeting minutes on 11 October 2017 are confirmed as true and correct.

**3.2 Bay of Plenty DHB – Hospital Advisory Committee: 7 February 2018**
Minutes were noted.

**3.3 Lakes DHB – Hospital Advisory Committee: 26 February 2018**
Minutes were noted.

It was noted that the committee would like the finalised HAC meeting minutes to be sent to Lakes DHB and BOP DHB.

# ITEM 4: QUALITY

**4.1 Quality report**
Ms M Neville presented this agenda item.

Areas highlighted:

- Governance responsibilities in regard to quality and patient safety to be discussed further.
- Reporting to be focused on improvements rather than challenges and issues.
- Key strategic imperatives for the HAC
    - Health equity for high need populations / Oranga
    - Safe, quality health services for all / Haumaru
    - People centred services / Manaaki

**Resolved**
**THAT**
The committee received the report.

# ITEM 5: SERVICES CHALLENGES

**5.1 Mental Health and Addictions**
Mr R Tapsell presented this agenda item.

Areas highlighted:

- Working with the community and clinical support team to identify how to improve the mental health after hour services.
- Pressure on services is a nationwide issue, attracting a skilled workforce has many challenges.

- The Waikeria Prison expansion has not been finalised, however, concerns were raised on the extra pressure it could put on the mental health and addictions services.

It was noted by the committee that they would like to:

- Propose that the Board consider putting through a submission on the mental health review.
- Mental health acute patient area proposal to be taken to the Iwi Maori council.
- Continue to discuss the relationship between Wintec and nursing.

**5.2 Community and Clinical Support**

Mr M Spittal presented this agenda item.

Radiology

A project manager has been appointed to assist with the sustainability of the radiology service. Staffing within radiology is underway with plans to advertise positions internationally.

**5.3 Waikato Hospital Services**

Dr G Howard presented this agenda item.

Areas highlighted:

- Clinical services plan underway with ENT.
- The Francis Group have been engaged to support the patient flow process from ED to the Medical and OPR wards.

**Resolved**
**THAT**
The Committee received the reports.

## ITEM 6: CULTURE

**6.1 Culture report**

Anne Welsh and Marc ter Beek presented this agenda item.

Areas highlighted:

- Board and Executive workshop in July 2018 with the Cognitive institute.
- Health roundtable staff survey will take place in 2018, which 11 other DHBs are participating in.
- Emphasised the importance of all staff including the governance groups living the values.

**Resolved**
**THAT**
The Committee received the report.

## ITEM 13: NEXT MEETING SCHEDULED FOR 13 JUNE 2018

Chairperson: _____

Date: _____

Meeting Closed:

# Minutes

## Bay of Plenty Hospital Advisory Committee

**Venue: Tawa Room, 889 Cameron Road, Tauranga**
**Date and time: Wednesday 2 May 2018 at 10:30am**

**Committee:** Geoff Esterman (Chair), Yvonne Boyes, Peter Nicholl, Ron Scott, Sally Webb, Stewart Ngatai (Runanga Rep), Clyde Wade (Waikato DHB Rep), Lyall Thurston (Lakes DHB Rep).

**Attendees:** Helen Mason (Chief Executive), Pete Chandler (Chief Operating Officer), Debbie Brown (Quality & Patient Safety Manager/Acting General Counsel), Lorraine Wilson (Programme Manager, Quality & Patient Safety), Julie Robinson (Director of Nursing – 11.40 am)

| Item No. | Item | Action |
|---|---|---|
| 1 | **Karakia**<br>The meeting opened with a karakia. | |
| 2 | **Apologies**<br>There were no apologies | |
| 3 | **Presentations**<br>3.1 Quality and Patient Safety – Progress on Clinical Governance Framework Development<br>Lorraine Wilson, Programme Manager, Quality & Patient Safety<br>• Mary Seddon review undertaken in 2016 limited to secondary care. Used methodology from National Clinical Governance Framework.<br>• Have completed a review of the recommendations.<br>• Adopting national framework.<br>• GMMHGD is working with Commission to address Maori and Treaty issues.<br>• Looking at placing an emphasis on patient safety<br>• It has been suggested that credentialling committee report into clinical governance. .<br>• Looking at mortality and morbidity review processes and how to strengthen these within departments.<br>• Draft structure shows 19 reports to Clinical Governance Committee. Consideration being given to what's helpful and what's driving the organisation's quality improvement agenda.<br>• Role of CGC is to support services with eg changes and what changes need to be made at a systemic level.<br>• BOPDHB did really well in review. | |

| Item No. | Item | Action |
|---|---|---|
| | Mary Seddon did make recommendations with regard to:<br>• Mortality and Morbidity<br>• Clinical Audit<br>• Consumer Engagement and Participation – It has been found that some of the recommendations could add value to systems already in place.<br>• Patient stories being a focus. Looking at videoing.<br>• Engaged and Effective Workforce. A lot of investment in this since review undertaken withCreating our Culture and impending Cognitive Institute<br>• Quality Improvement & Patient Safety. Need to look at what Quality &Patient Safety is doing, eg Datix – strengthen and what is role in strengthening Clinical Governance.<br>• 2009 In Good Hands is still a valuable paper.<br>• Intending to visit Canterbury and Waikato DHBs which are further along in the Clinical Governance System as is MidCentral DHB. Then looking at what BOPDHB's draft Clinical Governance framework will look like.<br>Query was raised around Clinical Audit and who would carry out. Acting GC advised that this includes clinicians undertaking their College requirements for example which is not being effectively captured at the moment.<br>Comment was made on the organisation's work on culture and how important that is in permeating to good effect with developing such things as Clinical Governance.<br>It was felt that resources to support clinicians were important. There are also databases that can be used. eg renal, joint registry. Acting GC advised that there is HQSC information that is useful to the process as well.<br>Committee Chair queried the intended reporting line through BOPHAC and whether the alignment is more to AFRM, considering risk and finance. CEO advised that Clinical Governance is whole of system which needs to be considered. It was also considered that Clinical Governance should ultimately track towards whole of sector.<br>The next iteration of the Clinical Governance framework should be drafted within 3 months. Work is towards improvement rather than starting at ground level. The framework should be easily understood and uncomplicated.<br>The Committee reviewed the reporting and makeup of Clinical Governance.<br>Comment was made that the clinical indicators are important in alerting service area to service issues | |

| Item No. | Item | Action |
|---|---|---|
| | The Committee thanked Lorraine for her presentation and requested a report on progress to the Committee in November.<br><br>3.2 <u>Patient Centred Care – an Introduction to ACEs (Adverse Child Experiences)</u><br>Pete Chandler, Chief Operating Officer<br>COO advised the presentation contained information that is considered key to the future. He asked Committee Members how many had heard of ACEs.<br>Realities of difficult lives are difficult to talk about.<br>The presentation showed latest data on teenage suicide rates internationally which reflects New Zealand as highest.<br>There is now information on ACEs from many sources around the world. The question is what to do and how.<br>Research indicates that trauma changes the brain. The COO advised of studies being undertaken on children who have lived through Christchurch earthquakes and the ongoing trauma effects.<br>First 1000 days are priority. Feeds through to acute demand.<br>Latest research is suggesting epigentics (rewiring the brain) does not take as long as initially thought.<br><br>*Next Steps*<br>Comment was made that early childhood teachers could be a valuable opportunity for partnership.<br>The Committee considered that action could be taken with a rapid trial, a test of change to see how it works and go from there.<br>Review of resilience data was considered important. How do some children who may have had 4 ACEs manage to have had successful lives.<br>CEO advised there is a lot of work around resilience. She had mentioned Collective Impact at the last Board Meeting which is coming into the region.<br>Query was raised how much connection there is with the Child Youth Mortality Team. It was considered that information is gathered. However the mechanisms were not there to effectively connectComment was also made that children have a school number which is not the same as their NHI number. Would be good to connect the two.<br>The Committee thanked the COO for the informative information and conveyed a vote of thanks for the bringing the presentation to the Committee. | |

| Item No. | Item | Action |
|---|---|---|
| 4 | **Minutes**<br>BOPHAC Meeting – 7.2.18<br><br>**Resolved** that the minutes of the meeting held on 7 February 2018 be confirmed as a true and correct record.<br><br>Moved: L Thurston<br>Seconded: Y Boyes | |
| 5 | **Matters Arising**<br>As per report circulated with the agenda.<br>Health Services Plan – 5.2 - Complete<br>Draft Work Plan – 6.2 – Quality & Patient Safety to be a focus for May meeting – Complete<br>Draft Work Plan – 6.2 – HRT to be invited to present in November - in progress – HRT Booked – Remove.<br>Draft Work Plan – SHSP – to be circulated to Committee - Complete | |
| 6 | **Reports requiring decision**<br>6.1 Chief Operating Officers Report<br><br>COO highlighted:<br>Contingency work for impending nurses strike has taken a lot of resource. It is slowing down normal business considerably.<br>CMA and COO involved in working with Mental Health Service teams.<br>Director Allied Health, Scientific & Technical is in the last stages of realigning Allied Health services.<br>Most of Exec have found that 2018 has created considerable challenges.<br>The Committee thanked the COO for the paragraphs at beginning of the report indicating his priorities.<br>DON gave update on potential strike. 5 July and 12 July full withdrawal of labour 24 hours which will impact on all elective work. Acute emergency work will be taken care of. Majority of members belong to NZNO – 80%.<br>Criticial areas have high membership. Any nurses who choose to work will be utilised in acute work. Life Preserving Services request will be applied. Last full national Nursing strike was 1984.<br>Query raised around H&S Act and its impacts. DON advised that it will impact with respect particularly to volunteers as does police vetting.<br>Discussion was had regarding CCDM and implications of not keeping up with intent and requirements going forward. | |

| Item No. | Item | Action |
|---|---|---|
| | The Committee commented that it was pleasing to see results on Surgical Site Infection table indicating good results and also that Te Kaha is working well.<br>**Resolved** that the Committee receive the report.<br>Moved: Y Boyes<br>Seconded: C Wade<br><br>6.2 Work Plan | |
| **7** | **General Business**<br>There was no general business | |
| **8** | **Resolution to Exclude the Public**<br>**Resolved** that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation:<br><br>Confidential Minutes of last meeting<br><br>That the following persons be permitted to remain at this meeting, after the public have been excluded, because of their knowledge as to organisational matters or for the purpose of legal records. This knowledge will be of assistance in relation to the matter to be discussed:<br>Helen Mason<br>Pete Chandler<br>Julie Robinson<br>Debbie Brown<br>Lorraine Wilson<br><br>**Resolved** that the Board move into confidential.<br>Moved: G Esterman<br>Seconded: R Scott | |
| **9** | **Next Meeting -** Wednesday 1 August 2018 | |

The open section of the meeting closed at 12.25pm
The minutes will be confirmed as a true and correct record at the next meeting.

**MINUTES OF THE MEETING OF THE HOSPITAL ADVISORY COMMITTEE**
**HELD ON MONDAY 28th MAY 2018 AT 10.00 A.M.**
**BOARDROOM, ROTORUA HOSPITAL, PUKEROA HILL, ROTORUA**

**Meeting:** **[158]**

**Present:** L Thurston (Chair), A Morrison, D Shaw, J Morreau, J Horton, C Rankin, M Gallagher and M Guy

**In Attendance:** D Epp (from 10.35am), R Dunham, N Saville-Wood, A Mountfort, Dr S Kletchko, K Evison, G Lees, P Tangitu, G Fannin, S Wilkie, presenter Pete Chandler, Chief Operating Officer, Bay of Plenty DHB and B E Harris (Board Secretariat)

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|---|---|---|
| **158.10** | | **MEETING CONDUCT** |
| | | The Chair welcomed everyone to the meeting before asking A Morrison to lead the opening karakia. |
| | | **Resolution:** |
| | | THAT that this meeting depart from the Standing Orders and invite Pete Chandler to remain for the duration of the Hospital Advisory Committee meeting including the Public Excluded section. |
| | | **L Thurston : A Morrison** |
| | | CARRIED |
| | | |
| | | Introductions were made from around the table for the benefit of the presenter, Pete Chandler. |
| | | |
| 158.11 | | Apologies: *(Agenda Item 1.1)* : R Isaac and P Marks |
| | | **Resolution:** |
| | | THAT the apologies be accepted. |
| | | **L Thurston : C Rankin** |
| | | CARRIED |
| | | |
| 158.12 | | Schedule of Interests Register *(Agenda Item 1.2)* |
| | | The Interest Register was circulated during the meeting with no additions or deletions made. |
| | | |
| 158.13 | | Conflict of interest relating to agenda items *(Agenda Item 1.3)* |
| | | The Chair asked for any disclosures of interest regarding agenda items to which M Guy advised that she is a member of NZNO (item 7.5 NZNO Industrial Action 5 & 12 July 2018 contingencies briefing). The Chair stated he was happy for her to remain and participate in discussion. |
| | | |
| 158.14 | | General Business *(Agenda Item 1.4)* : |
| | 158.14.1 | M Gallagher<br>➢ Public item – tabling of Waikato DHB Hospital Advisory Committee minutes 11th April 2018<br>➢ Public Excluded item : Healthtap |
| | | |
| **158.20** | | **SIGNIFICANT ISSUES** |
| 158.21 | | Presentation |
| | 158.21.1 | **Presentation on Patient Centred Care and introduction to Adverse Childhood Experience Initiative (ACE) and Research by Pete Chandler, COO, Bay of Plenty DHB**<br><br>The above presentation covered:-<br>➢ Exploring Trauma Informed Care<br>➢ Background at Bay of Plenty<br>➢ History<br>➢ Study Findings (1) and Study conclusion<br>➢ ACE Score vs. COPD<br>➢ Adverse childhood experiences vs. smoking as an adult<br>➢ Childhood experiences underlie chronic depression |

| | | |
|---|---|---|
| | | ➢ ACE Score and rates of antidepressant prescriptions<br>➢ Childhood experiences vs. adult alcoholism<br>➢ ACE Score vs. injection drug use<br>➢ Looking for Love ACE Score vs >50 sexual partners<br>➢ Childhood experiences underlie later being raped<br>➢ ACE Score and the risk of perpetrating domestic violence<br>➢ Childhood experiences underlie suicide attempts<br>➢ Impact of ACEs on brain development<br>➢ ACE Score and indicators of impaired worker performance<br>➢ Learning to shape the future<br>➢ Reflections and next steps<br><br>J Morreau proposed a vote of thanks and appreciation to Pete Chandler for presenting to the Hospital Advisory Committee and looked forward to collectively working together on a solution. |
| **158.30** | | **CHIEF OPERATING OFFICER** |
| 158.31 | | **Hospital & Specialist Secondary Services** *(Agenda Item 3.1)* |
| | 158.31.1 | Chief Operating Officer monthly report *(Agenda Item 3.1.1)* |
| | | N Saville-Wood in taking his report as having been read, briefly referred to:-<br>➢ Financial results for April were an unfavourable variance to budget of ($372k) despite volumes in the month being lower than contract volumes.<br>➢ Project Mauri Ora progressing well with draft strategy assessment provided to MoH.<br>➢ National Bowel Screening Programme going ahead in leaps and bounds. No confirmation that the business case has been approved by Treasury to date. Going live 11th September 2018.<br>➢ Lakes DHB RMO Unit – Positive hospital review completed by RDA.<br>➢ Falls and Fractures Outcomes – the latest report from ACC reflected positive trends. |
| | | **Resolution:** |
| | | THAT the Chief Operating Officer's report be received. |
| | | **C Rankin : A Morrison** |
| | | CARRIED |
| | | |
| | 158.31.2 | Appendix 1 : Balanced Scorecard *(Agenda Item 3.1.2)* |
| | | ➢ Maintained above 95% for the month of April 2018 due to excellent drive from clinical leads.<br>➢ Slipped in smoking cessation relative to performance – need to do more work to reach 95% target. |
| | | **Resolution:** |
| | | THAT the Balanced Scorecard be received. |
| | | **L Thurston : J Morreau** |
| | | CARRIED |
| | | |
| | 158.31.3 | Appendix 2 : Medical Integrated Care update *(Agenda Item 3.1.3)* |
| | | ➢ This update reflected discussions had as a result of the presentations given by Drs Denise Aitken and Michele Bloor on palliative care and integration on aged care.<br>➢ D Shaw acknowledged the informative presentations and the excellent work being carried out. |
| | | **Resolution:** |
| | | THAT the Medical Integrated Care update be received. |
| | | **L Thurston : M Gallagher** |
| | | CARRIED |
| | | |
| | 158.31.4 | Appendix 4 : Lakes DHB RMO unit *(Agenda Item 3.1.4)* |
| | | This item was provided for the information of the committee. |
| | | |
| | 158.31.5 | Appendix 5 : Latest ACC Report – Falls and Fractures Outcomes *(Agenda Item 3.1.5)* |
| | | **Resolution:** |
| | | THAT the ACC report be received. |
| | | **C Rankin : A Morrison** |
| | | CARRIED |
| | | |

| | | |
|---|---|---|
| | 158.31.6 | Chief Operating Officers Newsletter *(Agenda Item 3.1.6)* |
| | | Members noted the newsletter from the COO. |
| | | |
| **158.40** | | **REPORTS** |
| 158.41 | | Performance Monitoring : Finance & Audit 30th April 2018 *(Agenda Item 4.1)* |
| | | A Mountfort spoke to the financials noting:-<br>➢ The Provider had an unfavourable variance for the month of ($373k) : YTD ($1,376k).<br>➢ IDF inflow adjustment $41k.<br>➢ ACC revenue ($17k).<br>➢ ACC elective surgery recoveries, volume/mix ($48k).<br>➢ Overall Personnel costs more than budget by ($293k).<br>➢ Medical Staff variance $101k.<br>➢ Net overall effect of less leave released ($95k) for the month.<br>➢ Nursing staff negative variance ($319k).<br>➢ ($71k) Net FTE variance including agency costs.<br>➢ Allied Health staff ($62k).<br>➢ Management and Administration slightly over at ($12k).<br>➢ Medical Locums MTD ($263k) – main items from Rotorua & Taupo ED/Ward – holidays cover (Anzac) and Locum Anaesthetist.<br>➢ Outsourced services over clinical cost was over slightly.<br>➢ Visiting specialists were high for the month at ($61k).<br>➢ Facilities cost over-run ($89k).<br>➢ Savings in IT costs.<br><br>N Saville-Wood briefed members on the locum vacancies and issues with Taupo Hospital recruitment. A major issue was having to curtail operations due to no orthopaedic staff. This was partially saved from neighbouring DHBs picking up work. It was noted that Lakes DHB was likely to be behind in orthopaedics for the months of May and June. |
| | | **Resolution:** |
| | | THAT the Financial Report for 30th April 2018 be received. |
| | | **D Shaw : J Morreau** |
| | | CARRIED |
| | | |
| 158.42 | | Maori Health report *(Agenda Item 4.2)* |
| | | Points noted from P Tangitu's report were:-<br>➢ Claims proceeding with the Waitangi Tribunal in November 2018.<br>➢ Signing of Memorandum of Understanding between Lakes DHB and Te Roopu Hauora o Te Arawa at the 17th August Board meeting.<br>➢ Ngati Tuwharetoa relationship in progress.<br><br>On request by the Chair, the relationship between Lakes DHB and its iwi partners was explained for the information of Pete Chandler, COO, Bay of Plenty DHB. |
| | | **Resolution:** |
| | | THAT the Maori Health report be received. |
| | | **A Morrison : L Thurston** |
| | | CARRIED |
| | | |
| **158.50** | | **SECRETARIAL** |
| 158.51 | | Public minutes of Hospital Advisory Committee meeting held 26th February 2018 *(Agenda Item 5.1)* |
| | | **Resolution:** |
| | | THAT the public minutes of the previous Hospital Advisory Committee meeting held 26th February 2018 be confirmed as a true and accurate record. |
| | | **J Morreau : C Rankin** |
| | | CARRIED |
| | | |
| 158.52 | | Schedule of Tasks *(Agenda Item 5.2)* |
| | | Delete<br>• presentations – Palliative Care and Geriatric Care<br>• Review of HAC Terms of Reference<br>• GP Liaison Newsletter |

| | | |
|---|---|---|
| | | P Tangitu to provide a date for the Kia Ora Hauora and Midland Workforce Development. |
| | | |
| 158.53 | | Matters Arising *(Agenda Item 5.3)* : Nil |
| | | |
| **158.60** | | **INFORMATION AND CORRESPONDENCE** *(Agenda Item 6.0)* |
| 158.61 | 158.61.1 | Letter of appreciation to L Hughes dated 19.03.18 *(Agenda Item 6.1.1)* |
| | | **Resolution:** |
| | | THAT the letter of appreciation to L Hughes be noted. |
| | | **L Thurston : C Rankin** |
| | | CARRIED |
| | | |
| | 158.61.2 | Review EDMS 54420 Hospital Advisory Committee Terms of Reference *(Agenda Item 6.1.2)* |
| | | N Saville-Wood reported that he had requested a copy of BoP DHB's HAC Terms of Reference for comparison and added an extra paragraph where necessary to elaborate and link to the Act. He explained that this item would be placed before the Board for approval.<br><br>P Tangitu stated that there was another policy *(EDMS 55737 Appointment of Mandated Iwi Representatives to the Statutory Committees of Lakes DHB Policy)* that defined iwi representation and suggested it be referenced in the HAC Terms of Reference. |
| | | **Resolution:** |
| | | THAT the reviewed Terms of Reference for the Hospital Advisory Committee be received and referred to the Board meeting of 22nd June 2018 for approval. |
| | | **L Thurston : C Rankin** |
| | | CARRIED |
| | | |
| | 158.61.3 | Community Representative reports *(Agenda Item 6.1.3)* |
| | | There were no community representative reports to the public section of the meeting. |
| | | |
| | 158.61.4 | Tabled item – Draft Waikato Hospital Advisory Committee Minutes 11th April 2018 |
| | | **Resolution:** |
| | | THAT the above draft minutes from Waikato DHB HAC dated 11th April 2018 be received. |
| | | **M Gallagher : J Morreau** |
| | | CARRIED |
| | | |
| **158.70** | | **PUBLIC EXCLUDED** |
| | | **Resolution:** |
| | | THAT the meeting move into Public Excluded at approximately 11.10am |
| | | **L Thurston : J Horton** |
| | | CARRIED |

…….. 30th July 2018
Lyall Thurston QSO JP Chair

LAKES DISTRICT HEALTH BOARD

**SCHEDULE OF TASKS: Hospital Advisory Committee meeting**
**28th May 2018**

| Agenda Item | Action | Responsibility of | Timeframe |
|---|---|---|---|
| **Presentations:** | | | |
| | | | |
| | | | |
| **Tasks** | | | |
| Kia Ora Hauora and Midland Workforce development | Pathway to employment and the tracking of students as to where they ended up. Interested to know how Lakes used the information, and how proactively did Lakes progress to put people in place? A full report to be provided to the Board covering the points above. | P Tangitu | 30th July 2018 |
| Hospital Advisory Committee Terms of Reference | THAT the reviewed Terms of Reference for the Hospital Advisory Committee be received and referred to the Board meeting of 22nd June 2018 for approval. | B Harris | 22nd June 2018 |

# Quality

# MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
**13 JUNE 2018**

# AGENDA ITEM 4.1

## QUALITY AND PATIENT SAFETY REPORT

| | |
|---|---|
| **Purpose** | 1) To present the health quality safety commission (HQSC) publications supporting the Boards role in clinical governance |

At the last Hospitals Advisory Committee, a presentation on the current position of the DHB with regard to quality was given. Reference was made to the DHB quality governance strategy 2015 – 2018 and a number of publications that outline the role of the Board in quality and governance.

One of these is the 'Clinical Governance – guidance for health and disability providers' published by the HQSC during 2017 as part of a suite of resources. 'Clinical Governance – guidance for health and disability providers' (hard copies will be provided at meeting)
https://www.hqsc.govt.nz/our-programmes/improving-leadership-and-capability/publications-and-resources/publication/2851/

It outlines how clinical governance systems can be implemented to provide accountability for continually improving services and delivering a high standard of care. Clinical Governance means moving towards a culture where safe, high quality patient (person) centred care is ensured by all those involved in the person's journey. Key principles are –

- Consumer / person centred care
- Open and transparent culture
- All staff actively participate and partner in clinical governance
- Continuous quality improvement focus

A previous publication outlined the role of the Board in governance for quality and patient safety – hard copies of this were distributed at the time of publication but the link is here and included as Appendix 1 https://www.hqsc.govt.nz/assets/Quality-Improvement/PR/Governing-for-quality-Apr-2016.pdf

The HQSC have been approached with regard to the workshops that they run for Boards around governing for quality and the knowledge and skills needed by Board and executive members. Tentative date agreed as 26 September 2018

**Recommendation**
**THAT**
After the workshop in September the committee is provided with the staff assessment of how the questions in the publication "Governing for Quality" are answered at Waikato DHB, with a view to determining what improvements may be possible.

**MO NEVILLE**
**DIRECTOR QUALITY AND PATIENT SAFETY**

Appendix 1

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

open FOR BETTER CARE
Hāpai ake te taiora

A QUALITY & SAFETY GUIDE FOR DISTRICT HEALTH BOARDS

# GOVERNING FOR QUALITY

Published in February 2016 by the Health Quality & Safety Commission, PO Box 25496, Wellington 6146, New Zealand

ISBN 978-0-908345-14-4 (Print)
ISBN 978-0-908345-15-1 (Online)

The document is available online on the Health Quality & Safety Commission's website: www.hqsc.govt.nz

# About this guide

This guide will help district health boards (DHBs) put quality and safety at the centre of governance and drive improvement in their organisations. While the guide has been written with DHBs in mind, the principles and guidance are relevant and can be applied to all health care providers.

It includes:

- an outline of the role of boards as agents for quality and safety improvement
- the seven essential steps boards can take to improve the quality and safety of health care services:
  1. Lead and set clear goals
  2. Gather information and seek out patient stories
  3. Establish system-wide measures and monitor them
  4. Put a high quality and safety culture in place
  5. Ensure the right mix of people and encourage discussion
  6. Commit to ongoing learning at all levels
  7. Define roles and establish clear accountability at all levels
- a checklist to guide boards and assess progress.

# CONTENTS

# Foreword

If we are serious about improving the quality of health and disability services and reducing avoidable or preventable harm to patients, boards must engage in this imperative – it is the board that sets the priorities for a DHB and culture begins at the top.

An increasing body of evidence points to board leadership as a critical element for better, safer health care. Bader and O'Malley have made the point that boards 'can choose to be either active leaders or passive overseers in this process'.[1]

Leadership in this context requires a commitment to act, but it also requires an understanding of the issues. There is quite a lot to understanding the fundamentals of quality and safety in health care, much as there is to understanding the fundamentals of board responsibilities in respect of governance and finances. Many board members are already knowledgeble in all these areas, but for many more, education and training will be required – and for all who take on the responsibility of directorship, ongoing education is important.

The Health Quality & Safety Commission is responsible for driving improvement in the quality and safety of New Zealand's health and disability services. Our objectives have been captured in the New Zealand Triple Aim:

- Improving quality, safety and experience of care.
- Improving health and equity for all populations.
- Gaining best value from public health care resources.

Achieving these objectives requires, first, that we do the right things and, second, that we do these things right first time.

Ensuring the quality of health care is inextricably linked to ensuring the financial health of DHBs. It is vital to ensure we do the right things. The health outcomes of a population are determined by many other factors as well as health care services. Continuing to increase the funding invested directly in health care can only be achieved at the cost of other essential social requirements, such as housing, employment and education. Health care is not just about increasing production, in the sense of more procedures and consultations. If patients in New Zealand are to receive effective care that meets their needs, we cannot waste money on treatments not supported by reasonable evidence. Nor can we waste money on the costs of avoidable or preventable patient harm.

Variation in accessed health care is recognised as a problem internationally. The discrepancies in outcomes between different population groups in New Zealand is evidence that we have not yet met the needs of all New Zealanders – although progress is being made.

Governing for quality has a critical role to play in furthering these goals and getting the best possible results out of available resources – for all our populations.

There is a great deal of impressive improvement work already underway across New Zealand DHBs, and many examples of good governance. However, if we want to have truly world class services, the pursuit of excellence must continue. I hope *Governing for quality* will be a catalyst for further discussion and action in this regard. I encourage board members to use this resource to help drive quality improvement even further – and to provide feedback on its value, and on ways to improve future editions of this publication.

**Professor Alan Merry** ONZM FRSNZ
Chair, Health Quality & Safety Commission

1 Bader B, O'Malley S. 2006. Great Boards. *7 things your board can do to improve quality and patient safety*. Bader and Associates Governance Consultants. 6(1). URL: www.greatboards.org (accessed November 2015).

# Introduction – the role of governance in improving quality and safety

Improving quality and safety is fundamental to the DHB's governance role.

It is the board, with the senior leadership team, which sets the organisation's strategic quality direction and goals for improvement. It is the board and senior leaders that model desired attitudes and values that drive quality improvement. Their approach to governance will reflect the compassionate, patient-centred, high-quality care they expect of others.

That's why boards are so instrumental in setting and championing a culture within their organisations that puts the quality and safety of consumer care at the heart of everything they do.

The board, along with senior leaders, needs to put effective governance structures in place so teams can adapt to constantly changing health care environments.

The board environment should be safe, where honest and unfiltered discussion on patient safety and quality issues is encouraged.

Board members are responsible for putting in place systems that involve patients and families/whānau in quality-of-care discussions – listening to the consumer voice. This is also essential for ensuring equitable outcomes for all.

It is the role of the board and senior leaders to set clear expectations of staff and communicate compellingly about quality and safety. The aim is to create the right environment for organisational learning.

The board needs to drive a culture where education and training are valued and readily available to all staff. Such a culture will help to create an environment where all staff have the knowledge, skills and behaviours appropriate to their role. And board members themselves need to ensure they understand quality and safety issues to fulfill their responsibilities. This guide has been developed to improve understanding and encourage discussion about these issues. If you would like a two-hour workshop on quality and safety issues at your DHB, please contact the Health Quality & Safety Commission.

# Boards *do* affect quality

A growing body of international research into health organisations shows boards can make an enormous contribution to improving quality and patient safety. Effective governance and oversight by well-informed and skilled board members lies at the heart of improving quality and patient safety in health organisations.

In particular, evidence highlights the importance of strong and committed leadership. It is the board's role to make better quality of care their organisation's top priority, and to set clear and measurable goals for improvement.

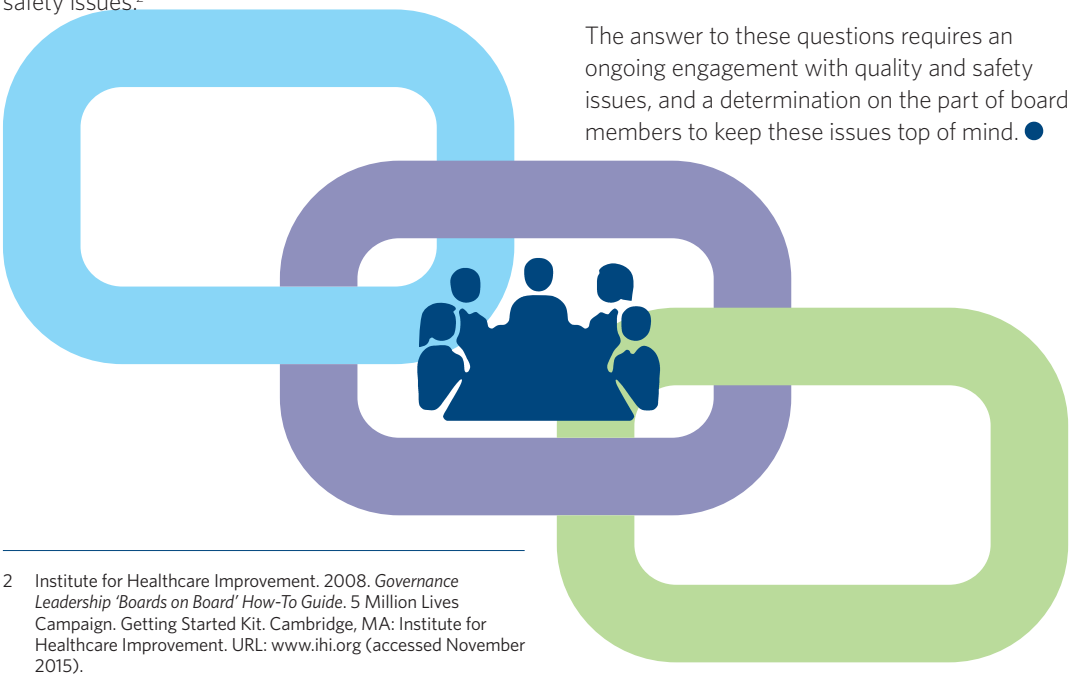
An effective board supports and expects a culture that continually strives to improve the quality and safety of care provided, and values experience, diversity and respect.

International studies recommend that boards need to allocate adequate meeting time to quality and safety issues.[2]

All board members should be able to answer these questions about quality and safety:

- How safe is your organisation?
- Is your organisation treating patients and families/whānau with respect and compassion?
- Is your organisation responsive to the cultural needs of all your patients, families/whānau and communities?
- Is patient safety improving year by year?
- Does your organisation collect robust data to measure quality and patient safety?
- Does your organisation achieve equitable outcomes for all patients, families/whānau and communities?
- Does your board report publicly against its quality and safety aims?
- How does your organisation compare with other similar organisations?

The answer to these questions requires an ongoing engagement with quality and safety issues, and a determination on the part of board members to keep these issues top of mind. ●



2 Institute for Healthcare Improvement. 2008. *Governance Leadership 'Boards on Board' How-To Guide*. 5 Million Lives Campaign. Getting Started Kit. Cambridge, MA: Institute for Healthcare Improvement. URL: www.ihi.org (accessed November 2015).

# What the research tells us

Around the world, research is being conducted into the impact of board decision-making on patient safety. Evidence shows better outcomes are achieved in organisations where the focus on quality issues is paramount.

Recent research[3] involving nearly 4000 New Zealand health professionals established there is already an encouraging foundation on which to build a more robust quality and safety culture.

Key findings included:

- 77 percent agreed or strongly agreed health professionals in their DHB involved patients, families and whānau in efforts to improve family care
- 71 percent agreed or strongly agreed in their clinical area it was easy to speak up if they perceived a problem with patient care
- 71 percent agreed or strongly agreed there were people and processes in place to identify, analyse and act upon all adverse events to prevent future occurrences
- 74 percent agreed or strongly agreed their organisation had zero tolerance for patient harm anywhere in the organisation.

Overall the results of the survey provide a positive view of the existing quality and safety culture within DHBs. However, people saw room for improvement in the systems, structures and work processes across departments, work groups and with outside providers. A third of those surveyed agreed or strongly agreed 'there was little coordination of quality improvement efforts across departments and work groups'.[4]

The need for greater inspiration and leadership in these areas was also identified. Less than half of those surveyed agreed the organisation inspired them to do the best job they could every day. And nearly 60 percent of those surveyed thought there was further room for improvement in the quality of patient care.[5]

There is a challenge here for DHBs to advance quality and safety through their leadership, planning and system-level coordination.

Another three-year study[6] of New Zealand organisations highlighted that collective learning and continuous improvement are the central elements of an adaptive, resilient, high-performing organisation. The study describes organisational learning as 'a powerful and sophisticated competency' to help organisations 'adapt, survive and thrive in turbulent environments'. In this study, the specific characteristics of an adaptive organisation are identified as:

- an openness to learning, feedback and ongoing improvement
- an environment that encourages problem-solving, rather than handing out blame
- a safe culture where it is okay to admit mistakes and jointly learn from them
- an ability to pause and reflect as individuals and as a group
- an ability to listen to others and consider alternative options
- a willingness to explore untested new ideas.

3 Martin G, Mason D, Lovelock K, et al. 2015. *Health professionals' perceptions of quality survey. A report for the Health Quality & Safety Commission*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/General-PR-files-images/Perceptions-of-quality-survey-Oct-2015.pdf (accessed November 2015).

4 *Ibid.*

5 *Ibid.*

6 Nilakant V, Walker B. 2015. *Building Adaptive Resilience, high-performing today, agile tomorrow, thriving in the future. Key findings from the Building Resilient Infrastructure Organisations Project*. Christchurch: University of Canterbury.

Other international research also demonstrates a strong correlation between high-performing health care organisations and boards that are actively engaged with quality assurance measures and issues. One US study showed 91 percent of high-performing health care organisations had boards that regularly reviewed quality data and information.[7]

Research also shows, however, that quality and patient safety is an area boards often neglect.

A study of over 5000 health care organisations in the USA described the state of health care governance as 'highly variable'.[8] Another survey of 1000 board chairs in US hospitals found 'fewer than half of the boards rated quality of care as one of their two top priorities, and only a minority reported receiving training in quality'.[9]

A national survey of health trust boards in the UK reached a similar conclusion. It found boards of governors were generally 'well-meaning but largely ineffective in helping to promote and deliver safer healthcare within their organisations'.[10] This was mainly due to a lack of awareness and understanding of the vital role of board members in assuring quality.

An Australian study[11] confirmed boards *are* key agents for change and reform in any health system. It identified the need for boards to elevate their vision beyond day-to-day processes, and give the organisation its direction, 'the purposes and values that define its actions'. The key message in this study was that board members were responsible for 'big-picture', strategic thinking that directly impacts on quality and patient safety.

7 Jha A, Epstein A. 2010. Hospital Governance and the quality of care. *Health Affairs* 29(1). URL: http://content.healthaffairs.org/content/29/1/182.full.html (accessed November 2015).

8 Institute for Healthcare Improvement 2008, *op. cit.*

9 Jha et al 2010, *op. cit.*

10 Mannion R, Freeman T, Millar R, et al. 2015. Effective board governance of safe care: A theoretically underpinned, cross-sectioned examination on the breadth and depth of relationships through local case studies and national surveys. *Health Services and Delivery Research* no 4.4. URL: http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0020/144821/FLS-10-1007-02.pdf.

11 Duckett S, Beaumont M, Bell G, et al. 2015. *Leading Change In Primary Care: Boards Of Primary Health Networks Can Help Improve The Australian Health Care System*. URL: http://ahha.asn.au/sites/default/files/docs/policy-issue/leading_change_in_primary_care.pdf (accessed November 2015).

# The need to challenge outmoded views of governance

One of the main barriers to improving quality and safety is a narrow, outmoded view of governance. Too often boards are seen as only being responsible for an organisation's financial health and reputation.

As a consequence, little attention is given to establishing an organisational culture that will drive ongoing improvements in quality and patient safety.

Research in the USA has shown quality issues often receive significantly less attention at board level than financial issues. Ninety-three percent of US hospital boards put financial performance on the agenda at every board level compared with only 63 percent putting quality performance issues on the agenda at every board meeting.[12] Another telling statistic was that at low-performing hospitals, nearly half the boards did not regularly review quality measures.

Another barrier that can arise at board level is the perceived tension between financial considerations and quality improvement, as if a trade-off is required between the two. Enhancing quality does not necessarily cost more – in fact improved processes and workflows may use fewer resources and can reduce costs over the long term.

A study[13] of the link between quality improvement and health care financial performance, involving 1784 community hospitals in the USA, found quality programmes were a consistent predictor of positive financial performance. 'The longer a hospital's involved with QI (quality improvement), the higher the cash flow and the lower the cost per case.'[14]

'... [M]any of the arguments against quality improvement have been based on the premise that such programmes are expensive and divert scarce resources... This has proved not to be the case.' [15]

DHBs that effectively implement quality improvement programmes can expect to improve their financial performance. An integral part of quality improvement is therefore getting the chief financial officers of health organisations to view their role as chief quality enabler, rather than simply budget-keeper.

Board members will also be aware of the high costs of neglecting quality and safety. Examples include under-investment in regional/national electronic systems and adverse event review/investigation processes. An organisation's reputation is easily damaged by a serious failure in patient safety.

Just how damaging it can be, and the enormous costs involved, is vividly outlined in the Francis Report,[16] which many in the health sector will be familiar with. This report highlighted a whole-system failure at the Mid-Staffordshire NHS Foundation Trust. Its central message was that improving quality and safety requires the safety of the patient to be at the centre of service delivery, the first concern of professionals and the shared responsibility of all. ●

12 Jha et al 2010, *op. cit.*

13 Alexander JA, Weiner BJ, Griffith J. 2006. Quality Improvement and hospital financial performance. *Journal of Organizational Behavior* 27 (7): 1003–29.

14 *Ibid.*

15 *Ibid.*

16 www.nhsemployers.org/your-workforce/need-to-know/the-francis-inquiry

# Modern view of governance

The modern view of governance is that boards have a significant responsibility to make better quality of care their organisation's first concern. This responsibility cannot just be delegated to medical staff and executive leadership – it is the boards' responsibility to ensure these delegations are acted on effectively. Ensuring patient care is safe and harm-free is at the very core of a board's legal and fiduciary responsibility.

In practice, taking responsibility for improving patient quality care means boards will:

- spend an adequate amount of board time on quality issues
- hold the chief executive accountable for quality and safety goals, and see the chief executive as the person who has the greatest impact on quality
- base the chief executive's remuneration on quality and safety performance
- participate in the development of explicit quality criteria to guide clinical staff
- review patient and family/whānau satisfaction scores annually
- set the agenda for quality
- involve clinical staff in discussions around quality, with clinical staff taking the lead.[17]

A core role of the board is to improve how quality systems function. To achieve this, boards need to actively pursue change, innovation and reform. A board is not there to maintain the status quo. It has to think and act creatively.

A board must articulate its vision of change and strike the right balance between stability and innovation. The active pursuit of change is an evolutionary process that involves board members seeing themselves as enablers. They must have a clear vision and use all means at their disposal to achieve safer care.

Research highlights[18] a number of things all boards can do to improve quality and reduce avoidable or preventable harm. These are outlined in the next section.

17 Institute for Healthcare Improvement 2008, *op. cit.*

18 *Ibid.*

# What boards can do – the seven essentials

## 1. Lead and set clear goals

It is vital an organisation is unified around a clear mission, vision and strategy to improve quality and patient safety. This involves the board setting a clear direction and monitoring performance. The board's commitment to improving quality must be unwavering and visible to all who work in the organisation.

This vision must be communicated repeatedly to all stakeholders. Boards and chief executives will drive the right leadership culture and nurture people with the skills to lead the changes they desire.

Board members will demonstrate an energy and appetite for improvement. Studies have shown lack of will and commitment on the part of the board is a common cause of quality improvements stalling. A highly engaged board 'will be the source of will for the entire organisation'.[19]

Boards can set specific goals to reduce harm each year and make a public commitment to measurable quality improvement.

## 2. Gather information and seek out patient stories

Boards will review progress toward safer care as part of considering every agenda item at every board meeting. It is also important they put a 'human face' on harm data by hearing stories of patients and families/whānau who have experienced harm. Such story-telling is a powerful way of provoking fresh conversations and helps to guarantee a patient-centred approach at board discussions.

Boards will also receive detailed information from various sources to help establish patterns of harm. One idea is to report back to the board on a significant patient injury in the health care organisation. This will involve sharing the stories of the patient, family/whānau and staff involved. The aim is to illuminate the nature and source of hazards in a complex health care system.

Other potential sources of valuable information include:

- surveys of patient and family/whānau experience
- surveys of staff attitudes and perceptions towards organisational safety culture.

## 3. Establish system-wide measures and monitor them

Boards need to identify organisation-wide measures of patient safety, update the measures continually and make them transparent to the entire organisation and stakeholders.

A board must make sure it is getting the right information on quality of care and the reports it receives contain data that can help board members track quality improvement at the system level. These measures will also include benchmarks against comparable organisations as a way to monitor progress. An example is the rate of medical harm per 100 admissions or per 1000 patient days.

Boards should be educated to understand data in a range of formats. It is also recommended boards present their organisation's key safety data in an easily understood 'dashboard' format. Simple, visual displays are an important aspect of providing a high-level overview of performance against selected quality and safety indicators. Dashboards should be designed to include those areas that impact on quality and safety in an organisation.

19 *Ibid.*

Boards will also consider establishing a quality and safety sub-committee, chaired by a board member, which analyse quality and safety issues in greater depth than is possible at a board meeting. This is common practice when dealing with financial issues.

## 4. Put a high quality and safety culture in place

Boards will commit to establishing and maintaining an environment that is respectful, fair and just for all who experience pain and loss as a result of avoidable or preventable harm – patients, families/whānau and frontline staff.

Boards need to drive a culture of high quality and safety characterised by:

- respect
- transparent and open communication
- a commitment to full disclosure
- apology and support where needed
- resolution for patients and families/whānau where harm has occurred.

Boards will demonstrate the courage and commitment to confront these issues, and model expected attitudes and behaviours to the rest of the organisation. They will encourage staff members to proactively manage risk and maximise clinical safety.

In seeking a culture change, experience shows organisations should concentrate on identifying existing pockets of good practice that other groups can emulate. If people are doing good work, it's important for organisations to understand how they got there, and how staff leaders and clinicians worked together to achieve the results.

It is best to focus on delivering positive messages about change rather than negative ones. Every organisation will have examples of great culture and exceptional performance. The challenge is to replicate them. Usually it is not a matter of people not wanting to change, but not knowing how.

It is also important to celebrate learning and achievement, when quality milestones are achieved.

## 5. Ensure the right mix of people and encourage discussion

To tackle quality and safety issues, boards need a diverse range of skills and experience. Traditionally, for their appointed members, boards have tended to include people with a narrow band of skills, ie, people with technical, professional or financial expertise.

A more modern view is that there needs to be a broad mix of board members including those who can think 'outside the square', challenge the status quo and come up with imaginative solutions. Research shows[20] including 'mavericks' who think and behave differently from others will help efforts to achieve change.

Boards members need to be capable of ranging across multiple areas and appointments to the board should reflect this. The overall aim is to create an environment which encourages robust analysis and debate.

20 Massie S. 2015. *Talent management. Developing leadership not just leaders.* London: The King's Fund. URL: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/talent-management-leadership-in-action-jun-2015.pdf?utm_source=The+King%27s+Fund+newsletters&utm_medium=email&utm_campaign=5770588_HMP+2015-06-05&dm_i=21A8,3FOM4,FLXAAH,CALXO,1 (accessed November 2015).

An observational study[21] of four health boards in England revealed great variation in board members' level of engagement with patient safety. It described wide variation in how board debate was steered and influenced by chief executives and board chairs. The most effective discussions happened when there was reasoned and respectful questioning of management, and discussion was framed within the narrative of improving patient and family/whānau experience. This allowed improvements to be explored dispassionately in relation to culture change, rather than being seen as a personal challenge.

## 6. Commit to ongoing learning at all levels

A board needs to develop its own capabilities to engage effectively with quality and patient safety issues and work out the best strategies to drive continuous improvement. Boards need the skills and knowledge to lead effectively in this area.

On a practical level, board members will have the competence to:

- review quality and safety plans and reports
- evaluate their effectiveness
- consider recommendations for improvement.

Board competencies go to the heart of an organisation's health and safety culture. A recent study[22] found the competencies of board members 'appear to be linked to staff feeling safe to raise concerns about patient safety issues and also their confidence that their organisation would address their concerns'.

Keeping staff engaged and motivated is also crucial to an organisation's ability to provide high-quality care. Through senior management, the board will set an expectation for levels of education and training for all staff. It is easy to over-estimate the ability of frontline staff to improve without the right assistance. Some health care organisations develop their own programmes to build the specific skills staff require to deliver improvements.

A broader view of staff competencies is also required. In the safety and harm context, communication, consultation and relationship-development skills are as important as technical knowledge.

Leadership development is also vital to create an innovative culture. People with talent need to be nurtured so there is confident and empowered leadership at every level.

Boards will place a premium on accessing fresh ideas about improving clinical best practice. They must actively seek out new ideas that are superior to the status quo. The aim is for quality improvement to become part of business as usual.

## 7. Define roles and establish clear accountability at all levels

The roles of boards and senior leaders in the area of safety and quality are complementary.

A board sets the strategic leadership and direction. It drives an organisation's safety and quality culture. Senior leaders implement the strategic direction, manage operations, report on safety and quality, and implement a high quality and safety culture throughout the organisation.

21 Freeman T, Millar R, Mannion R, et al. 2015. Enacting corporate governance of healthcare safety and quality: a dramaturgy of hospital boards in England. *Sociology of Health and Illness* 38(2): 233–51.

22 Mannion et al 2015, *op. cit.*

As the diagram below illustrates, this relationship is two-way and dynamic.


More specifically, boards will set clear quality improvement targets for the executive team, and link improved performance in quality and safety to remuneration. Organisational managers will ensure quality and safety figure prominently in performance reviews and are part of day-to-day discussions.

It is the board's responsibility to ensure action is taken to address and remedy poor performance.

# Assess your progress – a high quality and safety checklist for boards

Here are some questions to help your board assess the robustness of its quality and safety processes and identify areas for improvement. Working through this checklist will help your board identify gaps and initiate discussion.

Please note a separate tool, *Improving quality and safety in the New Zealand health system: A framework for building capability*, is being developed and will be made available to all DHBs.

## Supporting a culture of care and compassion

**1**. *Supporting a culture of care and compassion will be the single most important factor in driving high quality and safety across health services.*

- What is the process for staff to raise concerns about high quality and safety? How do you ensure they can do this in a safe environment?
- What processes or systems are in place to enable referrers (eg, GPs) or other providers to provide input?
- How do you collect, monitor and analyse patient and family/whānau experience data? How do you use this data when making strategic and/or operational decisions?
- How do you ensure everyone in your organisation takes responsibility for high quality and safety in their role?
- How is high quality and safety reflected in the strategic vision of your organisation?
- How do you recognise the importance of care quality in your staff appraisal systems? What are your procedures for managing poor quality care?
- How do you ensure your staff are aware of and adhere to high quality standards and strategies in the health system?

## Promoting board responsibility for high quality and safety

**2**. *Quality and safety in a DHB is ultimately the responsibility of the board, and will be central to the strategic vision of the organisation. In addition to this, every staff member will be aware of their responsibility in ensuring high quality and safety, whatever their role.*

- What quality and safety information is provided to the board? What else does your board do to assure itself all patients and families/whānau are receiving quality care within your responsible population?
- What priority does the board give to high quality and safety? How is this reflected in the board's work and in the education and training provided to board members?
- How do you address high quality and safety issues with your contracted providers? Whose responsibility is it in your organisation?
- What information do you collect or receive to monitor quality and safety within your contracted providers?

## Communicating with and listening to patients and families/whānau

**3**. *Communicating with patients involves listening to them, and providing them and their families/whānau with the right information to be active participants in their own care. Communication will be respectful, understandable and caring. Patients should be able to answer several key questions to determine the quality of care they are receiving.*

**4**. *Listening to patients and families/whānau helps alert organisations to issues and sensitive events as well as enabling them to make improvements in the care of their patients.*

- What communication standards do you have to govern staff communication with patients and families/whānau?
- How do you encourage patients and families/whānau to give feedback (including complaints)? What proportion of your discharged patients and their families/whānau has provided feedback to you in the last year?
- How do you ensure patients and families/whānau are aware of the Code of Rights and of the role of the Health and Disability Commissioner if they do not feel they receive the appropriate standard of care?
- What is the role of the patient in their care while they are admitted? What information is given to the patients and their families/whānau to enable them to be active participants in their own care, during their time in hospital and post-discharge? How is this information given?
- How do you enable patients and families/whānau to participate in quality improvement in your organisation, and how do you share the results with them?
- How do you close the 'quality loop' and ensure lessons learnt are applied?

## Effective information and monitoring systems

**5**. *Each organisation needs to collect data and build a comprehensive picture about quality and safety in the organisation, to enable issues and sensitive events to be identified before they escalate.*

**6**. *Data such as the standardised mortality ratio and clinical quality indicators, if analysed effectively, contribute to a robust data set to drive quality and safety.*

**7**. *The public reporting of key quality and safety data also ensures patients and families/whānau are informed about the quality of care in their DHB.*

- How do you collect, monitor and analyse patient experience data? How do you use this data when making strategic and/or operational decisions?
- How do you collect, monitor and analyse staff experience data? How do you use this data when making strategic and/or operational decisions?
- What is your early warning data set, to enable you to identify and monitor risks and pick up issues before they escalate?
- How do you collect, monitor and analyse data on adverse events?
- How do you collect, monitor and analyse data on mortality?
- Where is the information shared and discussed, and resulting actions agreed? How is progress against agreed actions measured and monitored?
- How do you ensure appropriate action is taken and is working?

## Maintenance of high professional standards and confidence

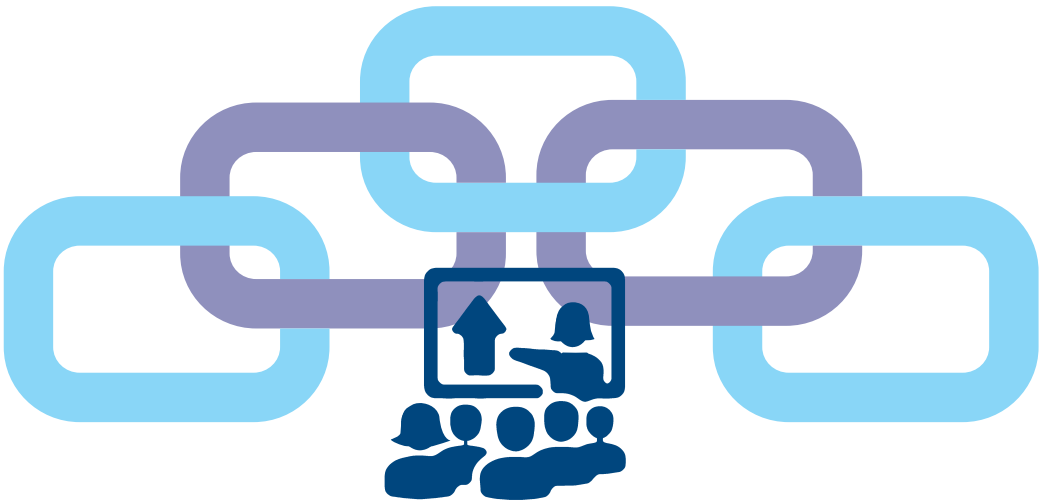
**8**. *High quality and safety in the health system is also maintained through law and regulation. This includes auditing services, credentialing of clinicians and a range of standards staff working in the health sector are required to meet.*

- How do you ensure recommendations from the Health and Disability Commissioner are put into practice? Whose responsibility is it to ensure this happens?
- How do you ensure your credentialing processes are robust? How often are senior clinical staff credentialed?
- How do you ensure issues raised in HealthCert and other audits are addressed? Whose responsibility is it to ensure this happens?

## Strengthening clinical governance and clinical leadership

**9**. *Clinicians are not only responsible for the provision of high quality patient care; their leadership is also important at all levels of the system. Clinical participation in the management and governance of DHB services is essential in creating the culture needed for high quality and safety.*

- What clinical governance processes and structures do you have?
- How are clinicians represented at the board and executive leadership level?
- How does your board identify potential clinical leaders and what development processes do you have in place for them?
- What clinical audit processes do you have?
- How do you address deficiencies in practice and service, and how do you ensure your organisation learns from any issues that arise?
- How do you ensure the 'quality loop' is closed and lessons learnt are applied?



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# Services

# MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
## 13 JUNE 2018

# AGENDA ITEM 5.1

## INTERIM CHIEF OPERATING OFFICER, WAIKATO HOSPITAL SERVICES REPORT

| | |
|---|---|
| **Purpose** | For information |

### Introduction

***Preamble***

This first report to the Committee will provide a mid-to-long term overview of where we have come from, in terms of services delivered, to frame an ongoing discussion on what our current challenges are and what we ought to be considering in the future.

The form and content of the report assumes:

- Formal reporting on performance will continue to be channelled through the full Board reporting.
- The HAC will be provided, on a rotational basis, with a view of each part of the health services sectors (Waikato Hospital, Mental Health, Community and Clinical Support).

This first report focuses on Waikato Hospital.

***Format***

For the purposes of consistency this report will follow an operational planning format. i.e.

The reason for following this format is that the various parts of the operational reality ought to be aligned and congruent. The following sections approximate the headings of the above planning process as a mapping tool.

***General Comments on Reporting***

As one of the twenty or so largest corporate entities in New Zealand, with a range of accountabilities, we generate reports for many audiences with a tremendous order of complexity.

For example we report against different parts of the Health Board (provider arm versus hospital etc), different geographic concepts (DHB of service vs DHB of domicile) and varying constructs for classifying activity, so that as arranged admissions are counted in elective volumes but not under the elective initiatives separately funded by the Ministry of Health.

This dynamic complexity led to the development of "trusted" reports in 2008 for the purposes of understanding changes in activity. These reports and the associated taxonomy are provided in part as appendices to this report.

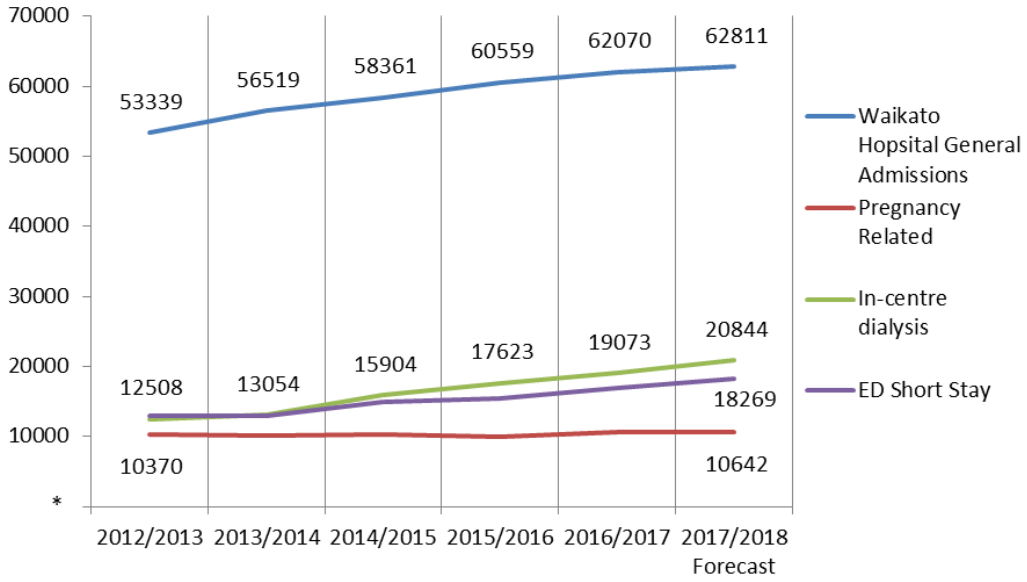
**Performance/Activity**

Performance generally comprises both quantitative and qualitative components, where the quality indicators can be either process focussed (ESPI etc) or measures of undesired outcomes (falls, hospital acquired infections etc).

For the purpose of providing an overview of service provision, this report concerns itself largely with quantitative measures.

***Changes over five years***

Appendix 1 provides a performance profile for the period 2012 to 2018. It shows that general admission to Waikato Hospital has grown by about 20%.



Other notable trends include:

- A growth in in-centre dialysis of greater than 60% across the 5 years
- A growth in ED short stay episodes of approximately 50%
- Very little change in pregnancy related admissions, which feels counterintuitive.

***Changes over ten years***

The front page of the same performance profile run ten years ago is provided as appendix 2 for reference.

- Over a ten year period, the number of general admissions has risen by closer to 50% (43 000 approximately in 2007/8 to about 63 000 forecast for this year).
- The number of patients treated as daycase episodes of care grew from almost 15 000 to 25 000 patients.
- The number of short stay episodes in the Emergency Department really hadn't increased much 2007 – 2013, with almost all the increase in volumes occurring in the last 5 years.
- Notably the number of people admitted and discharged from a rehabilitation episode has increased threefold and other ancillary programs have grown rapidly (eg: START[1]).

**Capacity Measures and Changes**

Our ability to understand capacity centres both on staffing number and capability, and buildings and processes.

Although unsatisfactory, the shorthand measures used traditionally focus on beds, bed days, and various theatre perspectives. Understanding other areas in terms of capacity to do things has lagged behind these and other measures that are prioritised in funding and performance frameworks.

Significant attention is now turning to extended measurement frameworks in terms of outpatient capacity and flow, for example. At present capacity in these areas are inferred from measures of waitlist performance (ESPI).

***Beds and bed days***

As has been discussed with the Board in the last months the physical bed capacity has not increased in a material fashion over a number of years.

The current bed plan, based on forecast demand, exceeds physical bed spaces and will continue to do so until the commissioning of level 8 of the Menzies block in late July 2018. The deficit in terms of forecast demand to beds available is about a ward, every day.

The staffing issues for this measure of capacity are discussed below.
In terms of bed days used for patients the growth over the last five years has been about 20 000 bed days, or approximately 54 beds staffed 365 days a year.

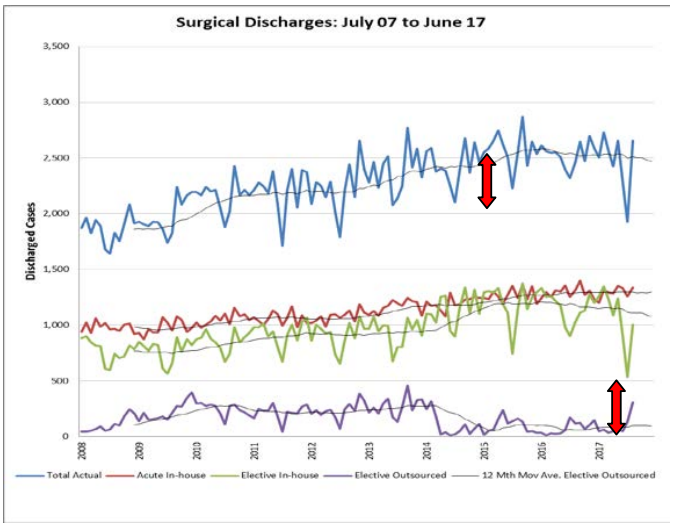
Interestingly there was almost no growth in bed days used between 2008 and 2013.

***Theatres and Theatre Capacity***

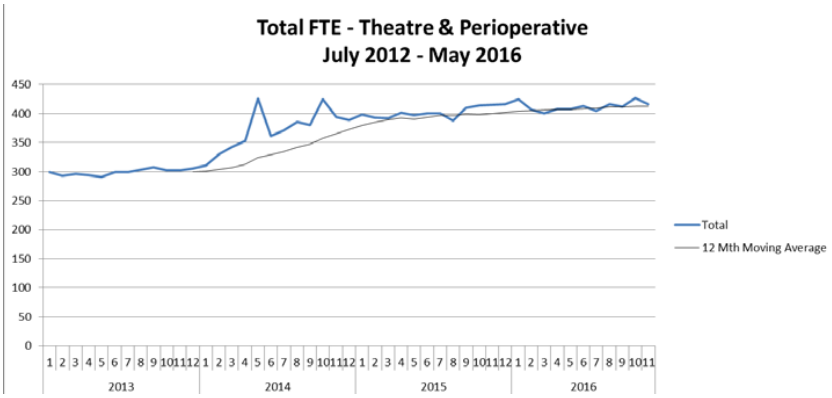
Theatre throughput and productivity are reported to the Board monthly in some shape or form. In terms of understanding the capacity to do work the change in the last 5 years has been the commissioning of the new Meade Clinical Center (MCC) theatre complex. There was a step change in volume of surgery performed in-house

[1] START represents a care episode delivered in the community for older patients.

and a drop off in outsourced surgery following that, that lasted for a couple of years or so, and then subsequently grew to the former level and past that at the end of the 2016/17 financial year.

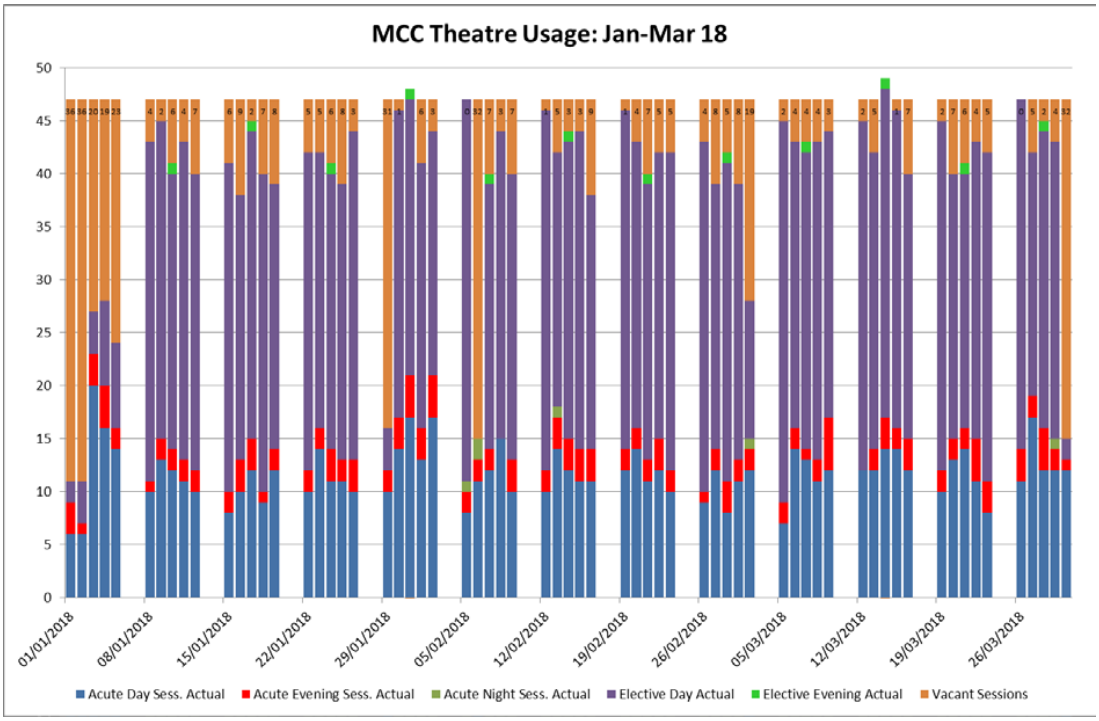



The timing of the changes in capacity (the commissioning of the MCC complex) can be inferred from the changes in FTE in the relevant area. i.e.




The resurgence of outsourced elective work in 2017 is a reflection, assuming no change in productivity, of a decision to limit the number of theatres that were included in the master schedule (staffing), and at some point will be affected by the number of physical theatres left to commission or staff.

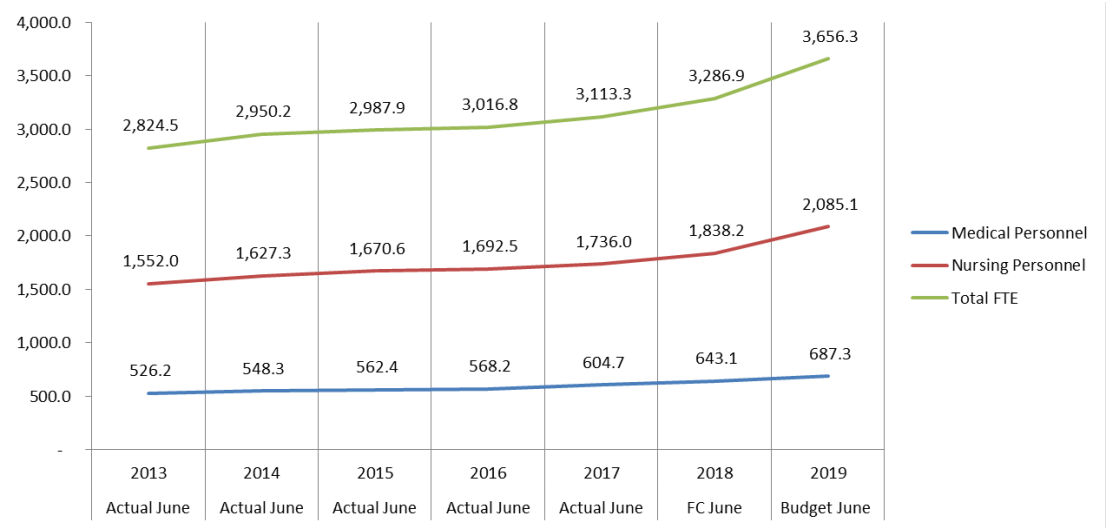
The following graph provides a view (January to March 2018) of the theatre master schedule use across the different work groups, and how much capacity is left unused, for whatever reason, at this point in time.




In addition to the Waikato Hospital schedule we participate in about 20 facility lists a month, and outsource a significant number of elective operations beyond that number. This would suggest that without major increases in productivity, and/or increased use of theatres outside of "normal working hours" we have already largely exceeded the capacity provided for in the Service Campus Redevelopment project from 2008 to 2015.

**Staffing**

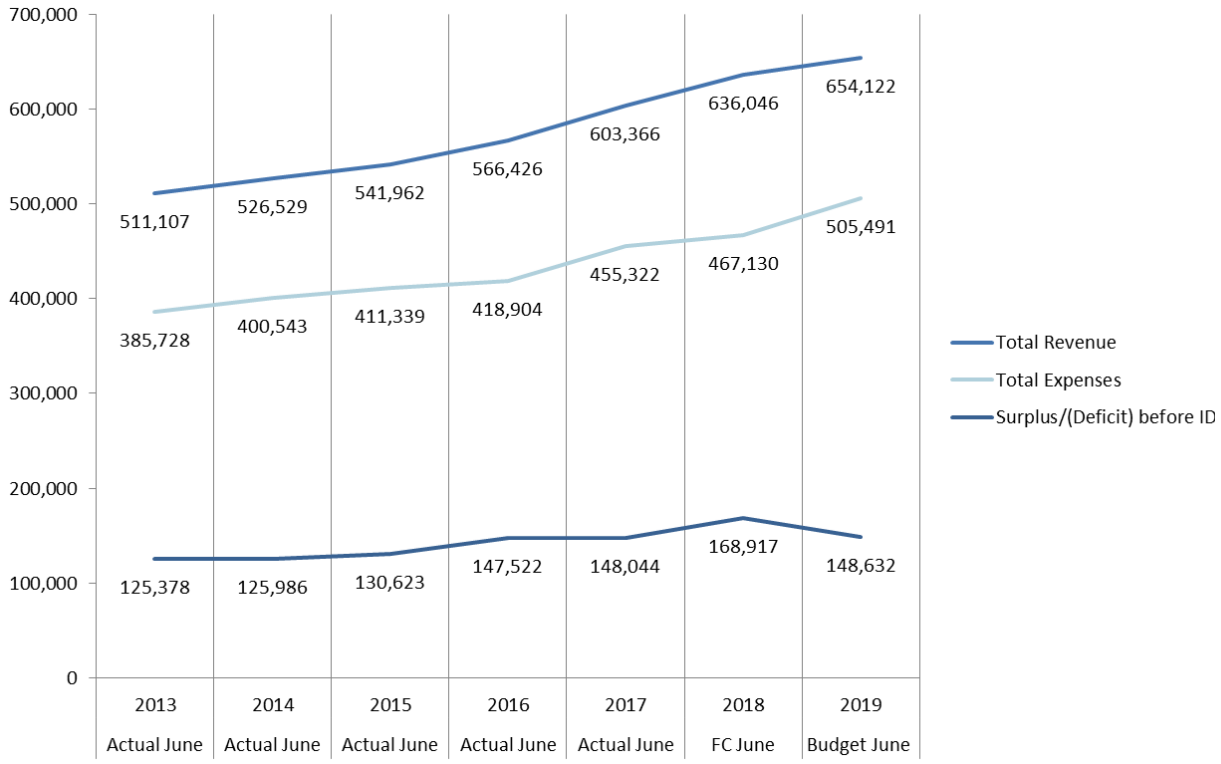
In keeping with the timeframe under consideration in this report to the HAC, the number of staff employed in the Waikato Hospital Service Group has changed as follows:



The growth in number of staff employed across the period is about 30%, while the growth in expenditure has grown, and is forecast to grow by about 40%, indicating a growth in number and average cost of employment.

This depiction does not deal with the issue of whether the current number is appropriate or not. Elsewhere on this HAC agenda the issue with regard nursing will be explored through the lens of workload and acuity measures.

**Expenditure, Revenue and Contribution**




Expenditure, revenue and contribution (assuming actual casemix funding transfer for example) are provided for the period under discussion in this report.

The growth across all expenditure and revenue is consistent with about a 30% increase, or about 5% per annum. The difference between revenue earned and expenditure is not purely applicable to overhead costs, as there are clinical support services not included in the analysis provided (laboratory, radiology etc).

**Overview**

A difficult issues confronting Boards and Executives alike is the development of a common view of the organisation, its performance, and the issues facing it in the future.

One of the reasons for this is that there is a plethora of reporting formats, generators and end-users such that it is easy to lose sight of where we are and how we are doing.

A second consideration is the complexity of organisations of the size of the Waikato District Health Board and its various subcomponents.

The information in this report provides a longitudinal view using a standard reporting format over a 15 year course, to frame our current trajectory and to provide substance for future discussions with the Board (HAC) building on a common understanding of how much we are doing and where, how fast we are growing or not, and what it costs and earns, using a framework that allows most of the required information to be consumed in on conversation.

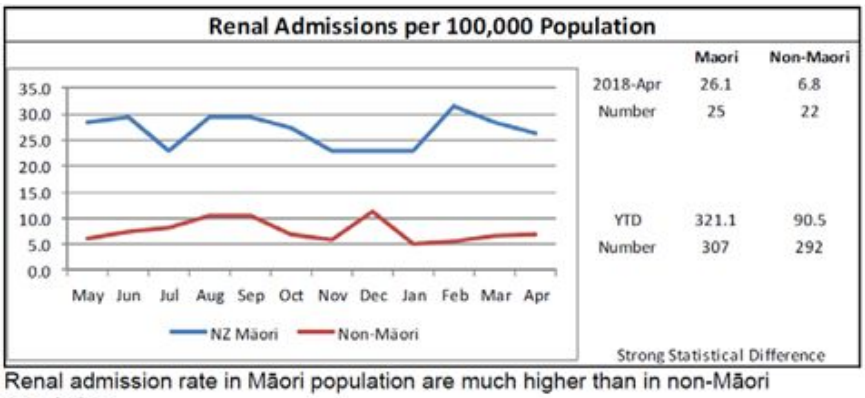
**Closing**

The two most pressing issues for us at this point in time is the development of a long run health strategy plan, and the need we all feel, to do something different, because if we don't, the service will become unsustainable.

In considering these issues we must also confront the issue of health inequity as it relates to health promotion, disease prevention, the detection of disease, and the treatment of ill health once it has occurred.

In order to be able to do this, we need to understand clearly where we are headed if we don't change anything, and where we ought to focus in order to make something different happen. What is more, this understanding needs to be based on fact as much as possible, and not necessarily what we feel.

For example: we know that we are growing our dialysis population (at least our in-centre portion) very quickly, and we also know from reports starting to look at reporting by ethnicity that renal disease is a significant issue for Maori.




Renal admission rate in Māori population are much higher than in non-Māori population.

.

It seems a given that when the health service plan is formed it is explicit about our strategy to deal with this, and other similar, issues.

Beyond these considerations, the take-home message from the last 5 years is that we are in an accelerated phase of growth that was not evident in prior 5 year segments, and that we are seeing increases in expenditure greater than the increase in workload. In some areas this means that we will have reached our maximum capacity very soon, if we have not already, going by the two major traditional considerations, being beds and theatres.

The implicit strategy being pursued by the Waikato Hospital in June 2018, is very much growth at the margin, by way of adding an extra ward, and looking to both staff remaining theatre sessions, to grow the theatre schedule outside of normal week days and hours, and to continue to try and grow capacity and productivity from within the current model of healthcare provision.

The other items on the agenda of this HAC meeting will address matters germane to the issues raised in this report:

1. What is our actual theatre capacity and how are we maximising it's use (Surgical Reinvention Project)?
2. What are our needs with regard appropriate, safe and sustainable staffing on wards and related areas?
3. How do we deal with tailoring care to demand and need over the next years, with particular reference to the elderly, and those who are at high risk of both unmet need and over-treatment as dual considerations of the same problem.

**Recommendation**
**THAT**

1) The Committee receives the report.

**GRANT HOWARD**
**INTERIM CHIEF OPERATING OFFICER, WAIKATO HOSPITAL SERVICES**

# Appendix 1: Performance Profile 2012- 2018

| Report 1: Waikato Health, All Patients Discharged, Volumes, by Year | | | | | | | |
|---|---|---|---|---|---|---|---|
| CARE TYPE: All Admitted Patients | | | | | | | |
| Period: 2012/2013 to 2017/2018 (forecast) | | | | | | | |
| Seq 12016_1 | | | | | | | |
| | | | | | | | Actuals to FP |
| **Waikato DHB - General Patients** | | | | | | | 11 |
| CareType | Hospital | 2012/2013 | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 Forecast |
| General | 5311 - Waikato | 53339 | 56519 | 58361 | 60559 | 62070 | 62811 |
| | 5011 - Thames | 5257 | 5803 | 6191 | 6125 | 6120 | 4953 |
| | 4811 - Taumarunui | 950 | 826 | 771 | 647 | 581 | 552 |
| | 5323 - Tokoroa | 1253 | 994 | 1036 | 1061 | 1249 | 1202 |
| | 5313 - Te Kuiti | 1110 | 1082 | 1154 | 1156 | 1117 | 1079 |
| | 5330 - Rhoda Read | 24 | 38 | 21 | 39 | 30 | 39 |
| | 5331 - Matariki | 27 | 18 | 26 | 33 | 31 | 28 |
| | 5311 - Waikato Ward Outsourced | 48 | 68 | 627 | 378 | 203 | 1320 |
| | Outsourced Hospitals | 3661 | 1535 | 1440 | 1203 | 2276 | 2167 |
| General Total | | 65669 | 66883 | 69627 | 71201 | 73677 | 74151 |
| NB: * Not recorded or not extracted | | | | | | | |
| **Pregnancy Related Patients** | | | | | | | |
| Pregnancy Related | 5311 - Waikato | 10370 | 10076 | 10229 | 10038 | 10682 | 10642 |
| | 5011 - Thames | 828 | 699 | 673 | 671 | 678 | 670 |
| | 4811 - Taumarunui | 166 | 125 | 151 | 121 | 139 | 136 |
| | 5323 - Tokoroa | 752 | 721 | 715 | 648 | 630 | 542 |
| | 5313 - Te Kuiti | 123 | 128 | 116 | 97 | 62 | 29 |
| | 5330 - Rhoda Read | 349 | 316 | 144 | * | * | * |
| | 5331 - Matariki | 324 | 299 | 135 | * | * | * |
| | 3260 - Outsourced Auck | 41 | 29 | 47 | 61 | 31 | 43 |
| Pregnancy Related Total | | 12953 | 12393 | 12210 | 11636 | 12222 | 12062 |
| | | | | | | | |
| **Renal CAPD and Incentre Patients** | | | | | | | |
| Renal CAPD | 5311 - Waikato | 423 | 577 | 451 | 557 | 671 | 896 |
| Incentre Dialysis | 5311 - Waikato | 12508 | 13054 | 15904 | 17623 | 19073 | 20844 |
| Renal Total | | 12931 | 13631 | 16355 | 18180 | 19744 | 21740 |
| NB: Renal capd and incentre patients are defined as outpatients from 1/07/2007 | | | | | | | |
| **Boarder Patients** | | | | | | | |
| Boarder | 5311 - Waikato | 5 | 8 | 8 | 5 | 1 | 4 |
| | 5011 - Thames | * | * | * | * | * | * |
| | 4811 - Taumarunui | * | * | * | * | * | * |
| | 5323 - Tokoroa | * | * | * | * | * | 1 |
| | 5313 - Te Kuiti | * | * | * | * | * | * |
| | 5331 - Matariki | * | * | * | * | * | * |
| Boarder Total | | 5 | 8 | 8 | 5 | 1 | 5 |
| NB: Since iPM implementation Boarder Patients are not counted!? | | | | | | | |
| **ED Shortstay (Puc M00004/5 , *-ED)** | | | | | | | |
| EDSS | 5311 - Waikato | 12980 | 12954 | 14885 | 15494 | 16936 | 18269 |
| | 5011 - Thames | 2276 | 2381 | 2581 | 3388 | 3403 | 4133 |
| | 4811 - Taumarunui | 656 | 500 | 463 | 488 | 591 | 442 |
| | 5323 - Tokoroa | 620 | 653 | 713 | 838 | 936 | 993 |
| | 5313 - Te Kuiti | 12 | 25 | 121 | 111 | 145 | 209 |
| EDSS Total | | 16544 | 16513 | 18763 | 20319 | 22011 | 24047 |
| shortstay changed to outpatient status (therefore no LOS recorded) 2006/07 | | | | | | | |
| **Rehabilitation Patients** | | | | | | | |
| Rehab | 5311 - Waikato | 1167 | 1217 | 1290 | 1321 | 1287 | 1436 |
| | 5011 - Thames | 202 | 174 | 166 | 142 | 185 | 148 |
| | 4811 - Taumarunui | 5 | 10 | 9 | 9 | * | 4 |
| | 5323 - Tokoroa | 3 | 14 | 18 | 13 | 17 | 2 |
| | 5313 - Te Kuiti | 19 | 14 | 8 | 5 | 8 | 2 |
| | 5336 - Home Hospital | * | * | * | * | * | * |
| | 5330 - Rhoda Read | * | * | * | * | * | * |
| | 5331 - Matariki | * | * | * | * | * | * |
| Rehab Total | | 1396 | 1429 | 1491 | 1490 | 1497 | 1593 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **START Programme** | | | | | | | |
| Home Based Support | 5311 - Waikato | 505 | 582 | 603 | 690 | 597 | 698 |
| | 5011 - Thames | 111 | 157 | 176 | 164 | 164 | 192 |
| | 4811 - Taumarunui | 2 | 11 | 28 | 37 | 71 | 63 |
| | 5323 - Tokoroa | 100 | 91 | 98 | 88 | 88 | 87 |
| | 5313 - Te Kuiti | 3 | 29 | 34 | 20 | * | * |
| Rehab Total | | 721 | 870 | 939 | 999 | 920 | 1041 |
| **Rural Inpatients & Transitional Care** | | | | | | | |
| Rural Inpatients | 5313 - Te Kuiti | 59 | 35 | 28 | 13 | 15 | 10 |
| Transitional Care | 5323 - Tokoroa | 23 | 59 | 53 | 37 | 32 | 8 |
| | 4811 - Taumarunui | 32 | 30 | 35 | 23 | 1 | * |
| | 5330 - Rhoda Read | 170 | 167 | 140 | 189 | 166 | 164 |
| | 5331 - Matariki | 117 | 110 | 117 | 129 | 130 | 151 |
| Rehab Total | | 401 | 401 | 373 | 391 | 344 | 332 |
| **Longterm Patients** | | | | | | | |
| Longterm | 5313 - Te Kuiti | 1 | 2 | 3 | 2 | 1 | * |
| | 5330 - Rhoda Read | 16 | 9 | 23 | 14 | 10 | 14 |
| | 5331 - Matariki | 27 | 32 | 17 | 14 | 33 | 13 |
| Longterm Total | | 44 | 43 | 43 | 30 | 44 | 27 |
| **Mental Health Patients** | | | | | | | |
| Psych | 5335 - Henry Bennett | 1439 | 1486 | 1619 | 1437 | 1603 | 1572 |
| Psych Total | | 1439 | 1486 | 1619 | 1437 | 1603 | 1572 |
| **Respite** | | | | | | | |
| Respite | 5011 - Thames | * | * | * | * | * | * |
| | 5323 - Tokoroa | * | * | * | * | * | * |
| | 5313 - Te Kuiti | 1 | * | 1 | * | * | * |
| | 5330 - Rhoda Read | 17 | 22 | 15 | 5 | 12 | 26 |
| | 5331 - Matariki | 2 | 5 | 11 | 3 | 5 | 3 |
| Respite Total | | 20 | 27 | 27 | 8 | 17 | 29 |
| **Palliative Care** | | | | | | | |
| Palliative | 5311 - Waikato | 102 | 15 | 13 | 16 | 12 | 8 |
| | 5011 - Thames | * | * | * | * | * | * |
| | 5313 - Te Kuiti | * | * | * | * | * | * |
| Palliative Total | | 102 | 15 | 13 | 16 | 12 | 8 |
| **Totals - Only admitted Patients (2008 excludes EDSS, Boarder and Renal)** | | | | | | | |
| 5311 - Waikato | | 65483 | 68409 | 70496 | 72624 | 74648 | 75595 |
| 5011 - Thames | | 6398 | 6833 | 7206 | 7102 | 7147 | 5963 |
| 4811 - Taumarunui | | 1155 | 1002 | 994 | 837 | 792 | 756 |
| 5323 - Tokoroa | | 2131 | 1879 | 1920 | 1847 | 2016 | 1841 |
| 5313 - Te Kuiti | | 1316 | 1290 | 1344 | 1293 | 1203 | 1120 |
| 5335 - Henry Bennett | | 1439 | 1486 | 1619 | 1437 | 1603 | 1572 |
| 5330 - Rhoda Read | | 576 | 552 | 343 | 247 | 218 | 243 |
| 5331 - Matariki | | 497 | 464 | 306 | 179 | 199 | 195 |
| 5311 - Waikato Ward Outsourced | | 48 | 68 | 627 | 378 | 203 | 1320 |
| Outsourced Hospitals | 3260 - Outsourced Auck | 3702 | 1564 | 1487 | 1264 | 2307 | 2209 |
| **Waikato Health Total** | | **82745** | **83547** | **86342** | **87208** | **90336** | **90815** |

# Appendix 2: Performance Profile 2003- 2010

| Report 1: Waikato Health, All Patients Discharged, Volumes, by Year | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| CARE TYPE: All Admitted Patients | | | | | | | | |
| Period: 2003/2004 to 2009/2010 | | | | | | | | |
| Seq 12016_1 | | | | | | | | |
| **Waikato DHB - General Patients** | | | | | | | | |
| CareType | Hospital | 2003/2004 | 2004/2005 | 2005/2006 | 2006/2007 | 2007/2008 | 2008/2009 | 2009/2010 |
| General | 5311 - Waikato | 42,258 | 43,418 | 42,129 | 41,935 | 43,134 | 44,236 | 47,806 |
| | 5011 - Thames | 4,696 | 4,873 | 5,010 | 5,040 | 4,292 | 4,279 | 4,465 |
| | 4811 - Taumarunui | 1,118 | 1,249 | 1,002 | 1,192 | 953 | 1,180 | 1,364 |
| | 5323 - Tokoroa | 1,036 | 1,002 | 1,116 | 1,203 | 1,142 | 1,014 | 1,067 |
| | 5313 - Te Kuiti | 821 | 866 | 909 | 747 | 867 | 895 | 1,053 |
| | 5336 - Home Hospital | - | - | - | 3 | - | - | 3 |
| | 5330 - Rhoda Read | - | - | - | 100 | 245 | 172 | 138 |
| | 5331 - Matariki | - | - | - | 38 | 106 | 78 | 105 |
| | Outsourced Hospitals | - | - | - | 489 | 1,503 | 3,005 | 3,324 |
| General Total | | 49,929 | 51,408 | 50,166 | 50,747 | 52,242 | 54,859 | 59,325 |
| **Pregnancy Related Patients** | | | | | | | | |
| Pregnancy Related | 5311 - Waikato | 9,305 | 9,246 | 9,497 | 10,293 | 9,987 | 10,326 | 10,382 |
| | 5011 - Thames | 877 | 918 | 922 | 969 | 930 | 954 | 867 |
| | 4811 - Taumarunui | 919 | 893 | 210 | 237 | 206 | 197 | 196 |
| | 5323 - Tokoroa | 186 | 219 | 849 | 936 | 1,004 | 921 | 865 |
| | 5313 - Te Kuiti | 228 | 149 | 188 | 164 | 221 | 215 | 205 |
| | 5330 - Rhoda Read | - | - | - | 452 | 490 | 433 | 415 |
| | 5331 - Matariki | - | - | - | 543 | 580 | 505 | 437 |
| | Outsourced Hospitals | - | - | - | 11 | 94 | 52 | 53 |
| Pregnancy Related Total | | 11,515 | 11,425 | 11,666 | 13,605 | 13,512 | 13,603 | 13,420 |
| **Renal CAPD and Incentre Patients** | | | | | | | | |
| Renal CAPD | 5311 - Waikato | - | - | - | 413 | 407 | 417 | 488 |
| Incentre Dialysis | 5311 - Waikato | - | - | - | 10,603 | 10,393 | 11,129 | 13,575 |
| Renal Total | | - | - | - | 11,016 | 10,800 | 11,546 | 14,063 |
| **Boarder Patients** | | | | | | | | |
| Boarder | 5311 - Waikato | 197 | 248 | 185 | 171 | 5 | 5 | 9 |
| | 5011 - Thames | 1 | - | - | - | - | 1 | 1 |
| | 4811 - Taumarunui | - | - | 1 | 7 | - | 1 | 1 |
| | 5323 - Tokoroa | 5 | 3 | 5 | 1 | 1 | - | 1 |
| | 5313 - Te Kuiti | 4 | 1 | 2 | 1 | 1 | 2 | - |
| | 5331 - Matariki | - | - | - | - | 1 | - | - |
| Boarder Total | | 207 | 252 | 193 | 180 | 8 | 9 | 12 |
| **ED Shortstay** | | | | | | | | |
| EDSS | 5311 - Waikato | 6,389 | 6,065 | 7,518 | 8,937 | 12,147 | 12,438 | 11,585 |
| | 5011 - Thames | - | - | - | 293 | 1,166 | 1,625 | 1,799 |
| | 4811 - Taumarunui | - | - | - | 59 | 273 | 150 | 34 |
| | 5323 - Tokoroa | - | - | - | 86 | 447 | 660 | 704 |
| | 5313 - Te Kuiti | - | - | - | 4 | 4 | 99 | 17 |
| EDSS Total | | 6,389 | 6,065 | 7,518 | 9,379 | 14,037 | 14,972 | 14,139 |
| **Rehabilitation Patients** | | | | | | | | |
| Rehab | 5311 - Waikato | 309 | 376 | 386 | 596 | 493 | 568 | 819 |
| | 5011 - Thames | 163 | 131 | 163 | 175 | 180 | 148 | 157 |
| | 4811 - Taumarunui | 46 | 33 | 34 | 24 | 23 | 29 | 21 |
| | 5323 - Tokoroa | 58 | 52 | 28 | 49 | 63 | 61 | 70 |
| | 5313 - Te Kuiti | 130 | 144 | 22 | 46 | 33 | 58 | 86 |
| | 5336 - Home Hospital | - | 304 | 471 | 332 | 364 | 346 | 327 |
| | 5330 - Rhoda Read | - | - | - | 26 | 45 | 17 | 14 |
| | 5331 - Matariki | - | - | - | 13 | 19 | 9 | 1 |
| Rehab Total | | 706 | 1,040 | 1,104 | 1,261 | 1,220 | 1,236 | 1,495 |

| CareType | Hospital | 2003/2004 | 2004/2005 | 2005/2006 | 2006/2007 | 2007/2008 | 2008/2009 | 2009/2010 |
|---|---|---|---|---|---|---|---|---|
| **Mental Health Patients** | | | | | | | | |
| Psych | 5335 - Henry Bennett | 1,555 | 1,644 | 1,682 | 1,719 | 1,676 | 1,595 | 1,648 |
| Psych Total | | 1,555 | 1,644 | 1,682 | 1,719 | 1,676 | 1,595 | 1,648 |
| **Longterm Patients** | | | | | | | | |
| Longterm | 5311 - Waikato | 1 | 3 | - | - | - | - | - |
| | 5313 - Te Kuiti | 2 | 2 | 1 | 3 | 1 | 1 | - |
| | 5330 - Rhoda Read | - | - | - | 16 | 13 | 19 | 8 |
| | 5331 - Matariki | - | - | - | 25 | 23 | 38 | 34 |
| Longterm Total | | 3 | 5 | 1 | 44 | 37 | 58 | 42 |
| **Respite** | | | | | | | | |
| Respite | 5011 - Thames | 4 | 1 | - | - | - | - | - |
| | 5323 - Tokoroa | - | - | 1 | - | - | - | - |
| | 5313 - Te Kuiti | 8 | 12 | 1 | - | 1 | 3 | 1 |
| | 5330 - Rhoda Read | - | - | - | 18 | 32 | 18 | 8 |
| | 5331 - Matariki | - | - | - | 16 | 21 | 25 | 10 |
| Respite Total | | 12 | 13 | 2 | 34 | 54 | 46 | 19 |
| **Palliative Care** | | | | | | | | |
| Palliative | 5311 - Waikato | 309 | 347 | 312 | 321 | 368 | 282 | 376 |
| | 5011 - Thames | 6 | 8 | 5 | 5 | - | - | - |
| | 5313 - Te Kuiti | 12 | 3 | 1 | 3 | 12 | 16 | 20 |
| Palliative Total | | 327 | 358 | 318 | 329 | 380 | 298 | 396 |
| **Totals - Only admitted Patients ( excludes EDSS and Renal)** | | | | | | | | |
| 5311 - Waikato | | 52,379 | 53,638 | 52,509 | 53,316 | 53,987 | 55,417 | 59,392 |
| 5011 - Thames | | 5,747 | 5,931 | 6,100 | 6,189 | 5,402 | 5,382 | 5,490 |
| 4811 - Taumarunui | | 2,083 | 2,175 | 1,247 | 1,460 | 1,182 | 1,407 | 1,582 |
| 5323 - Tokoroa | | 1,285 | 1,276 | 1,999 | 2,189 | 2,210 | 1,996 | 2,003 |
| 5313 - Te Kuiti | | 1,205 | 1,177 | 1,124 | 964 | 1,136 | 1,190 | 1,365 |
| 5336 - Home Hospital | | - | 304 | 471 | 335 | 364 | 346 | 330 |
| 5335 - Henry Bennett | | 1,555 | 1,644 | 1,682 | 1,719 | 1,676 | 1,595 | 1,648 |
| 5330 - Rhoda Read | | - | - | - | 612 | 825 | 659 | 583 |
| 5331 - Matariki | | - | - | - | 635 | 750 | 655 | 587 |
| Outsourced Hospitals | | - | - | - | 500 | 1,597 | 3,057 | 3,377 |
| **Waikato Health Total** | | 64,254 | 66,145 | 65,132 | 67,919 | 69,129 | 71,704 | 76,357 |
| **Waikato Health Total ( includes EDSS and Renal** | | 70,643 | 72,210 | 72,650 | 88,314 | 93,966 | 98,222 | 104,559 |

# MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
**13 JUNE 2018**

# AGENDA ITEM 5.2

## CARE CAPACITY DEMAND MANAGEMENT (CCDM)

| | |
|---|---|
| **Purpose** | 1) To provide an update on the utilisation of the acuity tool Assignment Workload Manager that measures the workload of nurses and midwives. The expected outcome when using a tool such as this, is that it will inform the appropriate hours per patient day required for safe care to be delivered. |

**Background**

Each DHB is required to achieve the standards set out within the Care Capacity Demand Management (CCDM) programme. This joint NZNO/DHB programme consists of three components: core data set measures, variance response management (responding to daily patient activity) and staffing methodology. Assignment Workload Manager (AWM) meets the latter component.

Assignment Workload Manager (AWM) is now in place in the majority of wards across the DHB. Expected completion of the rollout is June 2019.

Each specialty informs the way acuity is assigned, and then validated through a process that can be likened to a “Time and Motion” study over a period of weeks capturing a determined number of patients. From that data, analysis determines the acuity levels for that specialty are correct and then the average hours per patient day (HPPD), which are the hours of care a patient requires over a 24 hour period, are established. This measure is then converted to full time equivalents (FTEs) and a ward based requirement is established.

**Situation**

With the majority of wards now utilising AWM we are in a position to view the presently allocated HPPD converted to FTE and compare with the AWM results.

Across the majority of the wards the presently allocated HPPD fall short of what the AWM tool is indicating is required to deliver and maintain quality care. For some wards where the gap is urgent, the Charge Nurse Manager already accesses casual, internal agency, and part time staff working more than contracted hours to reduce the gap in order to provide the level of care with a skill mix that the patient population of that ward requires.

Within the wards already allocated the HPPD as determined by AWM, the level of overtime, sick leave, vacancy and staff turnover has reduced considerably.

It should be noted that not all increased HPPD requirements will or need to be filled by experienced Registered Nurses, but rather a skill mix of Health Care Assistants, Enrolled Nurses and novice to expert Registered Nurses would be utilised.

Should the DHB support the results of AWM a further 50 FTE would be required. At present costs that would equate to $4.0 million.

**AWM Example**

Attached (Appendix 1) is an example of AWM for three areas, and as can be seen ward 16 requires attention, ward 2 has been allocated extra staff according to AWM results and therefore the areas in the red are less and more manageable, and ward 4 may need to investigate roster allocation across the 24 hour period.

**Recommendation**
**THAT**
The report is received.

**SUE HAYWARD**
**CHIEF NURSING AND MIDWIFERY OFFICER**

Appendix 1

# Ward Staffing Effectiveness Report - NURSE & HCA

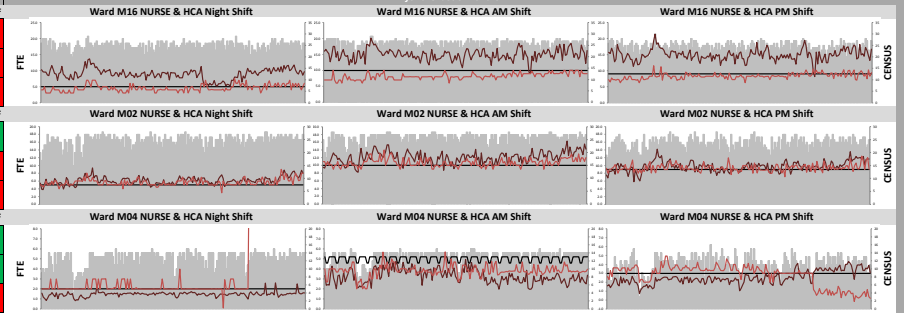
Required Staff *less* Actual Staff: Less than 0 | Between 0 and 1 | Greater than 1 | No FTE required

Census | Budgeted FTE | Required FTE | Actual FTE

| | Week Beginning 04-May | | | | | | | Week Beginning 11-May | | | | | | | Week Beginning 18-May | | | | | | | Week Beginning 25-May | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | T | W | T | F | S | S | M | T | W | T | F | S | S | M | T | W | T | F | S | S | M | T | W | T | F | S | S |
| **Ward M16 NURSE & HCA** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Required Staff *less* Actual Staff |
| NIGHT | 4.6 | 6.8 | 3.8 | 3.9 | 4.1 | 4.9 | 5.9 | 3.9 | 4.9 | 4.7 | 4.7 | 6.2 | 3.5 | 5.5 | 5.4 | 5.5 | 5.7 | 3.0 | 6.3 | 5.0 | 6.7 | 4.1 | 4.3 | 2.9 | 5.1 | 5.8 | 3.6 | 3.7 |
| AM | 7.6 | 6.2 | 5.1 | 4.8 | 4.5 | 6.2 | 8.6 | 6.5 | 9.2 | 7.2 | 4.1 | 8.2 | 4.8 | 5.9 | 9.3 | 8.0 | 8.5 | 6.1 | 5.1 | 5.3 | 5.0 | 3.5 | 6.2 | 7.9 | 7.4 | 6.5 | 3.2 | 7.2 |
| PM | 5.3 | 7.3 | 7.0 | 5.3 | 6.4 | 6.0 | 8.5 | 6.8 | 7.4 | 8.0 | 8.9 | 7.4 | 5.2 | 6.9 | 7.7 | 7.7 | 10.3 | 6.6 | 4.8 | 8.8 | 4.9 | 6.1 | 6.3 | 8.3 | 8.7 | 4.4 | 4.9 | 7.3 |
| **Ward M02 NURSE & HCA** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Required Staff *less* Actual Staff |
| NIGHT | -0.6 | 2.0 | 0.7 | 0.5 | 1.6 | 0.3 | 0.9 | 0.7 | -1.6 | 0.2 | 0.4 | 1.1 | -1.5 | -0.4 | 2.4 | -0.2 | 0.8 | 0.7 | 1.1 | 0.8 | 3.4 | 1.6 | -0.4 | 0.1 | 0.7 | 1.3 | 0.8 | 0.0 |
| AM | -0.3 | 3.7 | 2.7 | 3.3 | 1.4 | 0.9 | 1.1 | 1.7 | 0.9 | 1.1 | 0.9 | 2.5 | 0.9 | 2.3 | 4.6 | 0.5 | 2.7 | 0.0 | 1.3 | 2.4 | 1.6 | 3.8 | 1.2 | 3.7 | 1.9 | 0.8 | 4.5 | 2.2 |
| PM | -0.5 | 2.2 | 0.7 | 0.3 | 0.1 | 0.8 | 0.1 | 0.8 | 0.7 | 0.6 | 1.1 | 1.4 | 1.7 | 2.2 | 1.8 | 0.9 | 3.0 | 1.7 | 1.7 | 2.7 | 2.9 | 2.1 | -0.8 | 1.2 | 1.2 | 0.3 | -0.3 | 2.7 |
| **Ward M04 NURSE & HCA** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Required Staff *less* Actual Staff |
| NIGHT | -20.4 | -21.8 | -20.0 | -23.3 | -21.4 | -23.2 | -23.4 | -22.2 | -24.8 | -17.3 | -18.6 | -19.8 | -18.5 | -15.2 | -15.2 | -24.8 | -23.2 | -23.2 | -19.8 | -21.5 | -19.7 | -25.0 | -18.7 | -23.1 | -21.5 | -19.7 | -17.9 | -23.2 |
| AM | -1.0 | -0.7 | -1.2 | -1.2 | -0.7 | -1.0 | -0.2 | -0.4 | -0.6 | -1.0 | -1.1 | -1.7 | -1.7 | -2.3 | -1.4 | -0.7 | -0.7 | -0.3 | -0.9 | -0.9 | -0.7 | -0.1 | -1.0 | -0.5 | -0.9 | -1.0 | -1.2 | -0.6 |
| PM | 2.8 | 2.4 | 2.6 | 2.8 | 2.5 | 2.1 | 2.7 | 3.0 | 2.4 | 2.4 | 3.5 | 3.2 | 3.3 | 3.2 | 3.2 | 2.4 | 2.5 | 2.8 | 3.6 | 3.7 | 3.6 | 3.6 | 2.6 | 2.4 | 3.2 | 2.3 | 3.5 | 2.9 |

Budgeted versus Required versus Actual FTE

*...for the last 6 Months...*



# MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
**13 JUNE 2018**

# AGENDA ITEM 5.3

## IMPROVING THE LIVES OF OLDER PEOPLE IN THEIR LAST 1000 DAYS

| | |
|---|---|
| **Purpose** | 1) To provide information to the Committee Members |

Attached is a report on the "Improving the lives of older people in their last 1000 days". On the day of the Committee Meeting a presentation will be provided to the Committee to provide further information on the project.

**Recommendation**
**THAT**
The report and presentation be received.

**BARBARA GARBUTT**
**DIRECTOR OLDER PERSONS REHABILITATION AND ALLIED HEALTH**

# Optimising pathways for frail older people

Document brief outlining an approach to improve the quality of life for frail older people by increasing their days in their own home in their last year of life. The approach will reduce:

- ED attendances;
- Admissions to hospital; and
- Complex medical and surgical interventions.

The document is intended to gauge interest only and will require a full business case should the need arise. The intervention aims to integrate Advance Care Planning (ACP) into primary care alongside implementation of an ED administered last year of life prediction tool. The tool aims to support ED clinicians in their difficult conversations with frail older people in relation to their treatment options. The tool should be seen as part of a system wide approach to improve the lives of older people in their last 1000 days of life.

# 1 Predicting the last 1000 days of life

## Key points

- There are 9000 older people in the Waikato region who have had an interRAI assessment undertaken on them
- The assessments were matched with mortality data
- 50% of older people with **non-complex** needs who have a long-term disability requiring help with housework or showering are **dead** within **18 months** of the assessment and 75% are dead within 1000 days
- 50% of older people with complex needs who have a long-term disability are **dead** within **10 months** of the assessment and 91% are dead within 1000 days
- 50% of older people in Aged Residential Care are dead within 8 months of the assessment and 99.9% are dead within 1000 days
- The interRAI assessment by DSL is the best predictor of last 1000 days

Disability Support Link (DSL) manage all assessments for older people (65+)[1]. People with non-complex needs living at home undergo a brief assessment (Contact Assessment), those with complex needs living at home undergo a comprehensive geriatric assessment (Home Care assessment) and those living in Aged Residential Care undergo a modified comprehensive geriatric assessment (Long-Term Care assessment). Figure 1 highlights the relationship.

[1] *or* Māori/Pacific (55+) *or* people (55+) with a condition that is determined to be an age-related condition (Like Age and Interest).

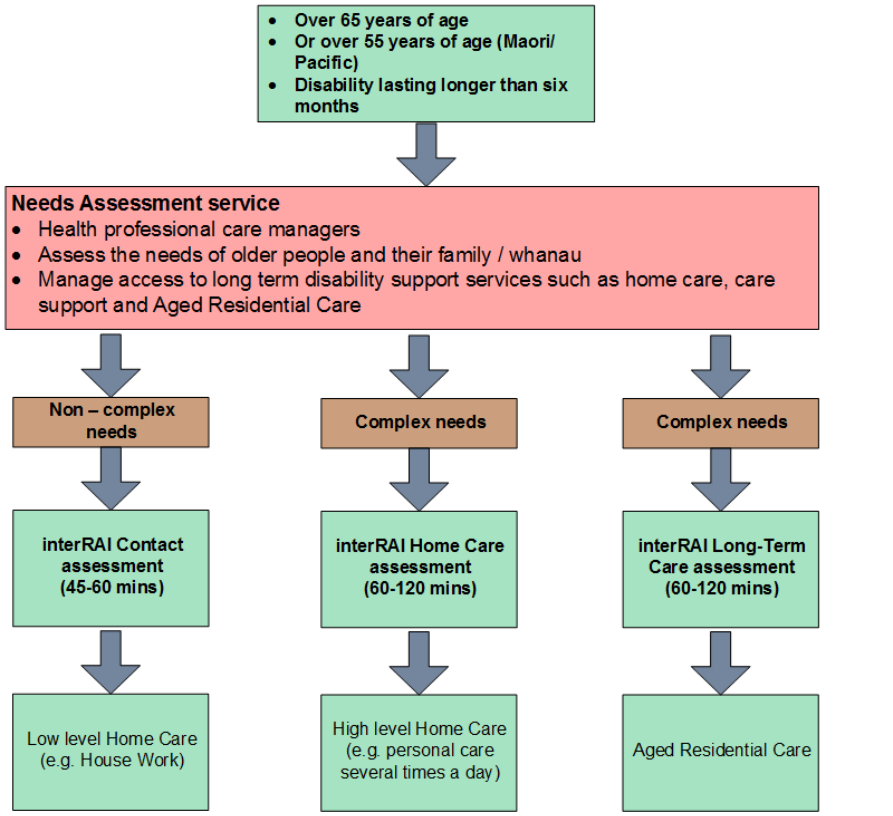



**Figure 1: Assessments of older people in Waikato DHB**

Assessments and mortality were matched over a five-year period and the results are shown in Table 1.

**Table 1: Mortality and assessments in Waikato**

| Assessment | Percentage mortality at 1000 days | Median survival |
|---|---|---|
| **interRAI CA** | 75.0% | 566 days<br>50% dead, **18 months** after 1st assessment |
| **interRAI HC** | 91.0% | 300 days<br>50% dead, **10 months** after 1st assessment |
| **interRAI LTC** | 99.9% | 240 days<br>50% dead, **8 months** after 1st assessment |

## 2 Advance Care Planning to minimise ED presentation and hospital admission

### Key points

- Advance Care Planning (ACP) is an international approach to give patients a voice around how they want to be treated in their last period of life
- GPs are ideally located to deliver ACP and upload the plan to a clinical work-station viewed by ED
- The DSL assessment provides a systematic way of identifying older people who may benefit from an ACP
- DSL can initiate a conversation with the older person and refer to their GP
- GP ACP visits can be funded at a cost of around $150,000 per annum and within two years all older people known to DSL will have an ACP.
- The process can reduce ED attendances and hospital admissions.

Advance Care Planning (ACP) is an international movement, primarily directed at older people towards the end of their lives. There is a standardised training programme, currently being delivered to GPs across the Midlands region. GPs are in an ideal position to develop an ACP for older people as they are invariably the most well acquainted with the older person and their family/whānau. ACP can identify a general direction of response according to illnesses or injuries that the older person may experience. ACP can be uploaded to the clinical work station and viewed by ED. However more importantly, it may prevent ED attendances entirely and the patient may opt to be treated by their GP. Only 4 percent of clients with an interRAI assessment have an ACP recorded.

Given that we now know that the majority of older people following their first assessment with DSL have 1000 days or less to live, the first assessment is the obvious point at which to initiate ACP with the GP. To maximise uptake, visits could be funded (@$100.00 for 30 minutes) and the referral made following the DSL assessment. Initial conversations around the process can take place at the assessment.

There are 200 new assessments per month by DSL (around 130 living at home) and 9000 clients in total. Of these, 3000 live in Aged Residential Care, and the facility is already contracted to develop Advanced Directives for all clients. With this in mind and considering the mortality rates within this group, if the approach is implemented, within two years all older people would have an active ACP, at the cost of around $150,000 per annum (for 30-minute consultation @ $100.00). Analysis of the data reveals that in the last 250 days of life older people on average make over 3 separate visits to ED and spend almost 4 days in hospital.

# 3 Supporting difficult conversations in ED

## Key points

- Despite a successful implementation of ACP, older people in their last year of life will inevitably attend ED and their risk of admission is high
- Difficult and complex decisions are made daily around how to treat older people in those few days within the stressful and acute ED environment.
- ED have been requesting a Frailty index to support decision making. The best tools available are the Frailty Index with predictive qualities of 0.77 and Edmonton Frail Index of 0.76
- The Frailty Index has between 50 and 70 items to be tested and the Edmonton 17 items. Although both have fair predictive qualities, they would be difficult to implement within an ED environment
- Using the same dataset to inform the last 1000 days analysis, we have identified a new approach, whereby age filters the response and two questions have a 0.8 predictive quality at 1 year, a more useful time-period than the 2 years currently being assessed with the Edmonton and Frailty Index.
- The tool should be used to guide conversation rather than direct interventions
- ED and acute care geriatricians can support decision making in these instances and direct care accordingly
- An immediate community care response will be required to redirect older people and START with appropriate Home Care can provide appropriate support.

The Last 1000 days dataset was analysed in several ways to identify the best method of predicting mortality. The most recent interRAI assessment was used and mortality was analysed at 6 months, 12 months and 24 months. Table 2 presents the overview.

**Table 2: Descriptive mortality data (n=15,946)**

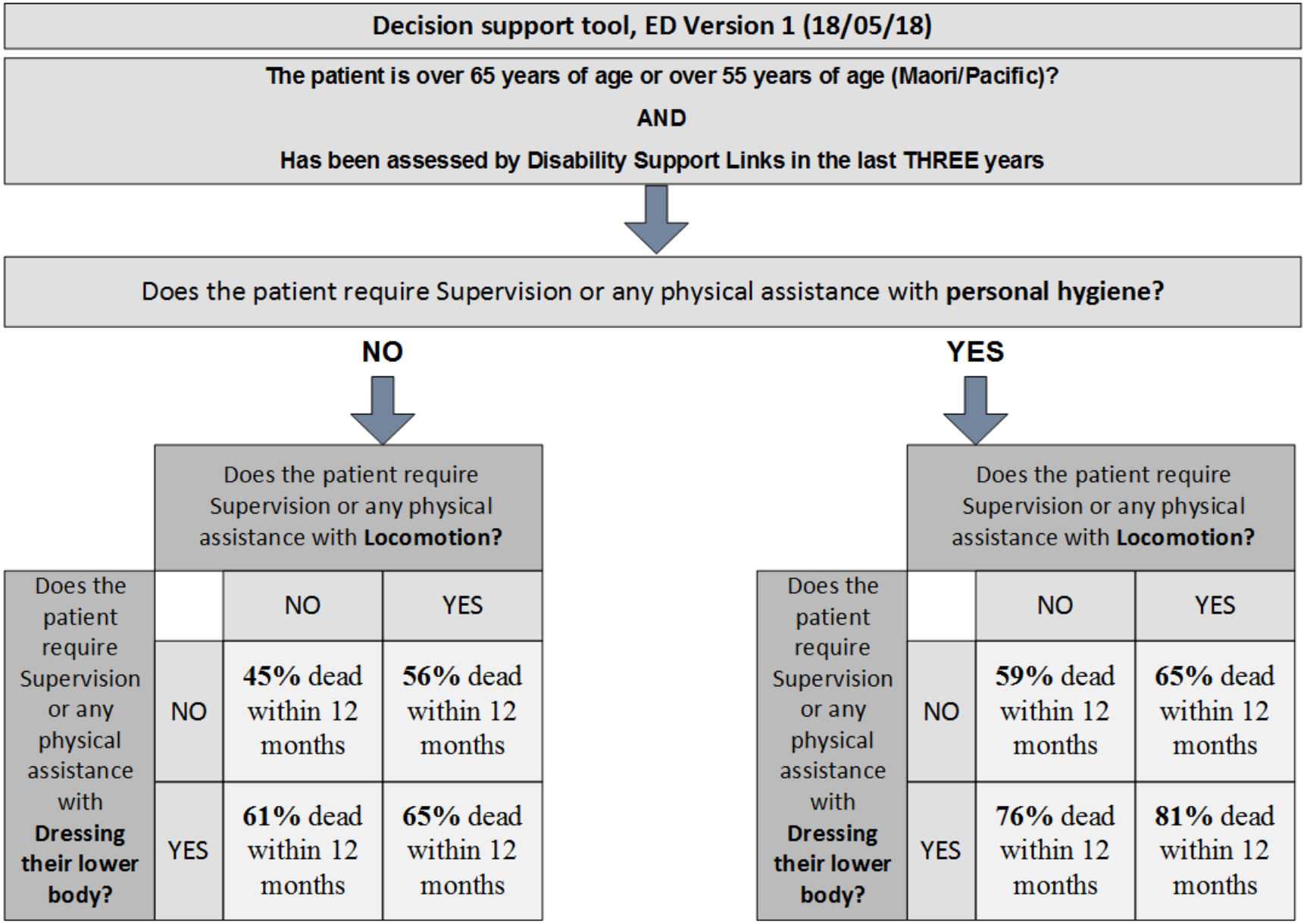
| Days from most recent interRAI assessment to death | Days |
|---|---|
| **6 months** | 5,924 (37% dead) |
| **12 months** | 9,381 (59% dead) |
| **24 months** | 12,220 (77% dead) |

The need to ensure that any tool can be readily and easily applied within an acute ED environment was paramount and therefore two major factors strongly influenced the design of the tool: Ease and speed of completeness by ED staff and type of information required from the older person and/or their family member. Several steps were applied:

1. Identification of variables that were both statistically correlated with mortality AND had the highest relationship with mortality as tested with the Cox's Proportional hazard risk
2. Series of regressions and multiple discriminatory analysis to identify the variables with the best predictor of mortality. Three were selected as the best fit both statistically and clinically:
    a. Does the patient require Supervision or any physical assistance with **personal hygiene?**
    b. Supervision or any physical assistance with **locomotion** (walking)?
    c. Supervision or any physical assistance with **dressing their lower body?**
3. Analysis is ongoing and a more accurate predictor using appropriate algorithms will be ready shortly, but in the meantime, the diagram over-page illustrates the tool that can be implemented within ED.

The tool requires further validation but has been included here to allow discussion around how such an approach can aid difficult decisions within ED. There is an international trend to base Acute Care Geriatricians in ED to support such decision making and optimise the most appropriate journey for older people

A transition in the way in which acute community services are currently configured is required, particularly in how START can activate from ED and the provision of Home Care services.


Decision support tool, ED Version 1 (18/05/18)
The patient is over 65 years of age or over 55 years of age (Maori/Pacific)?
AND
Has been assessed by Disability Support Links in the last THREE years
Does the patient require Supervision or any physical assistance with personal hygiene?
NO
YES
Does the patient require Supervision or any physical assistance with Locomotion?
Does the patient require Supervision or any physical assistance with Dressing their lower body?
NO
YES
45% dead within 12 months
56% dead within 12 months
61% dead within 12 months
65% dead within 12 months
Does the patient require Supervision or any physical assistance with Locomotion?
Does the patient require Supervision or any physical assistance with Dressing their lower body?
NO
YES
59% dead within 12 months
65% dead within 12 months
76% dead within 12 months
81% dead within 12 months

# MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
**13 JUNE 2018**

# AGENDA ITEM 5.4

## KEEZZ PROJECT UPDATE

| | |
|---|---|
| **Purpose** | 1) To provide an update to Committee members |

**Preface**

This paper is for informational purposes and is supplemental to the visit to the Surgical Operations Centre scheduled for 11th June 2018. During that visit attendees will see the centre in real time operation. Systems that guide respective stream managers will be fully observable not only in terms of the work processes and patient flows that they are controlling but also the logic and structures upon which the systems are fabricated.
A fully functioning Operations Centre is a central platform that supports the effective and efficient patient flow through the hospital. From a patient perspective it underpins a commitment by the organisation to provide suitable treatment in a predictable and reliable manner.

**Background to the project**

At the request of WDHB in May 2017, Keezz completed an operational audit of the hospitals' end to end surgical services including operating theatres. Key finding included:

- Surgical operations processes reminiscent of a bowl of spaghetti
- Organisational silos abounded including a palpable rift between clinical and management sectors that was readily observable
- Throughput seemingly constrained by rosters
- Planning and scheduling appeared to be a reactive exercise both in terms of acute and elective work
- Recognition that some services appeared better than others
- Surgical services were concentrated within 'business hours" Monday to Friday
- Surgical performance appeared to be in decline supported by an expanding reliance on outsourcing
- Conformance to ESPI performance measures were less than impressive
- Conformance to acute service performance measures were less than impressive

Following the operational audit, WDHB engaged Keezz to undertake a program to improve the Surgical Divisions' performance. Key elements included:

- A joint twenty calendar week program driven by Surgical Division control and participation
- Intention to transform the way surgical services are provided
- Appropriate segmentation of patient workflows by constructing distinct productive flows

- Physical and operational resources reorganised to meet presenting and future patient workflows
- Rehabilitate the centralised planning and scheduling function, including an operating system to manage patient flows to length of stay expectation and ensure that the work is completed to schedule.
- Daily and weekly reporting systems driven by exception to be implemented leading to an increase in operational control.
- Support and coaching for planners, schedulers and supervisors with a strong emphasis on active supervision.
- Enhance patient flow and other operational systems and processes generally
- Determine the appropriate operating model based on annual work required. Strong focus being given to logical work streams matched and balanced to presenting work requirements
- Implement a comprehensive system to control the operations at the point where value is created. That is complete tasks and activities to schedule on time every time

**Program of work**

Keezz commenced the Surgical Services reinvention program in September 2017. The following provides a summary of the program.

- A practical hands on program with guiding principles being financial improvement being an outcome as opposed to an input.
- Tactical framework developed to ensure that strategy, structure and process were in a state of fit. Accordingly, surgical work was segmented into four logical patient centred streams; namely,
    - Acute stream
    - Elective inpatient stream
    - Elective day only stream
    - CCTV stream
- Surgical work was consolidated into like work groupings within respective streams. “As is” processes were widely, and at a granular level defined, reviewed and critiqued.
- “To be” processes were developed with gaps between the “as is” and “to be” quantified thereby highlighting base remedial actions required. Emphasis being given to:
    - How is work input into streams (feed)
    - Process of patient treatment or flow (speed)
    - How work is “pulled” from the process (output)

  Systems were subsequently designed and developed to track work traversing defined processes
- In November 2017 Grant Howard was appointed as interim Chief Operating Officer and engaged seamlessly with the project team to elevate and energise the collective work that was somewhat stiffled under its previous positioning within the organisation
- The surgical structure was modified to match the surgical stream processes previously defined. The matrix organisation that pushed patients laterally through a framework of service providers ultimately providing a patient centred structural approach was implemented.

- Tactically a decision was made to establish a new Surgical Operations Centre (SOC) rather than revamp the anachronistic IOC. Within the SOC:
    - Systems to control patient flow were designed, developed and implemented
    - People were coached in the use and application of the systems to upskill their operational capability and performance
    - Individuals were “road-tested” to determine suitability for newly created positions
    - Focus was given to extending acute service hours both after hours and the weekends
- The SOC adopted a range of different approaches to patient flows:
    - Resources are allocated to work (rather than the reverse)
    - Automatic patient cancellation button has been immobilised
    - Structured theatre lists have been developed; for acute and elective streams
    - Optionality over what work would be completed was substantially reduced
    - Schedule adherence assisted patient journeys being managed by exception
    - Progression to a reliance on systems of work rather than individuals through best endeavours
- Elective streams (both inpatient and day stays)
    - All work is now planned
        - Elective patients are planned on 16-week production horizon (formerly 2 weeks)
        - Day procedures are identified at the point of decision to treat
        - List logic is defined by Clinical Nurse Specialists (CNS)
        - Focus on ESPI compliance at point of decision to treat
        - Lists are loaded to reasonable work levels
        - Acute “contamination” of elective lists is identified and addressed
        - List issues are identified well in advance of scheduling
        - Transition from booking clerk controlling list to CNS (as patient advocate) is well underway
- Acute stream:
    - Right sizing capacity to match patient inputs
    - Running lists on a FIFO basis
    - Orthopaedic lists extended from 0815 to 2200 daily to minimise disruptions to flow
    - Focus toward bulking up weekend capacity and treating people closer to admission
    - Implementing Surgical Assessment Unit to improve acute flow from ED to discharge
- Bed management
    - Integrating into streams and operational flows
    - Beds are no longer constraining patient flows
    - Estimated Discharge Dates built into process control
    - Focus toward organising the future rather than managing or explaining the past

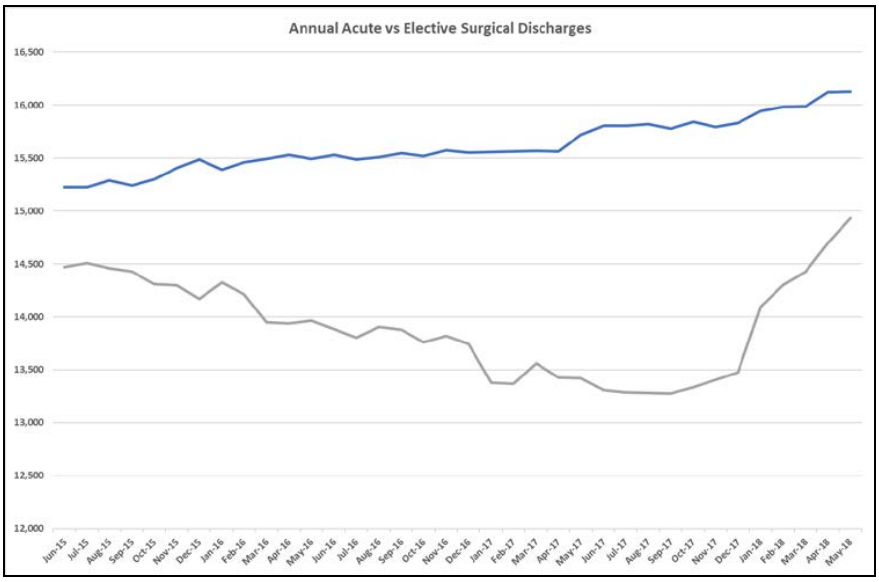
**Outcomes from December 2017 onwards**

- Patient movements within the Hospital are now planned
- Plans are now turned into firm schedules
- Work is being controlled at the point of execution
- Schedule decisions have been centralised within SOC rather than being “optional” with a myriad of operators
- Potential in-patients are now passed through a day case filter and scheduled accordingly
- Orthopaedic senior registrar list has been strengthened and quarantined from interference
- Where the schedule permits, patients are regularly pulled to theatre from ED
- The usage of beds through additional surgery rates and improved patient flows have limited their effect as a constraint point
- Teams have banded together within defined patient service streams for common purpose
- Theatre manager appointed providing a single point of leadership
- Evidence of a continuing optimistic outlook

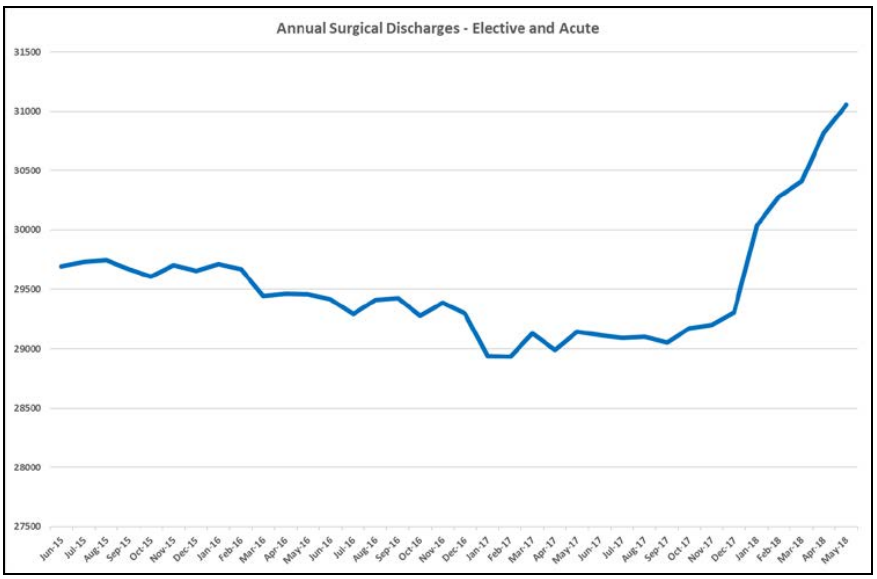
**Performance to date**

The following graphs record performance within the Surgical Division and do not include outsourced work. The graphs are constructed based on annual rolling numbers. Accordingly, each point is comparable as seasonal variations have been normalised.

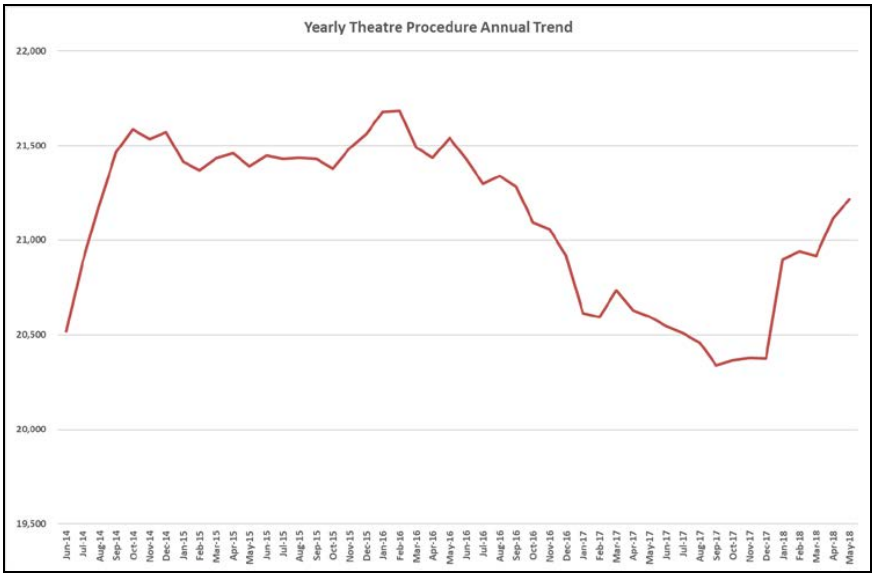
Annual surgical discharges (acute and elective) in WDHB 2015 to date



Annual surgical discharges (total) in WDHB 2015 to date




Annual MCC theatre procedures WDHB 2015 to date



**ESPI Performance Measures to April 2018**

## MoH Elective Services Online

### Summary of Patient Flow Indicator (ESPI) results for each DHB

### DHB Name: Waikato

| | 2017 | | | 2017 | | | 2017 | | | 2017 | | | 2017 | | | 2017 | | | 2017 | | | 2017 | | | 2018 | | | 2018 | | | 2018 | | | 2018 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | May | | | Jun | | | Jul | | | Aug | | | Sep | | | Oct | | | Nov | | | Dec | | | Jan | | | Feb | | | Mar | | | Apr | | |
| | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. | Level | Status % | Imp. Req. |
| 1. DHB services that appropriately acknowledge and process patient referrals within required timeframe. | 8 of 26 | *30.8%* | 18 | 8 of 26 | *30.8%* | 18 | 14 of 26 | *53.8%* | 12 | 16 of 26 | *61.5%* | 10 | 17 of 27 | *63.0%* | 10 | 15 of 27 | *55.6%* | 12 | 20 of 27 | *74.1%* | 7 | 11 of 27 | *40.7%* | 16 | 18 of 27 | *66.7%* | 9 | 24 of 27 | *88.9%* | 3 | 13 of 27 | *48.1%* | 14 | 20 of 27 | *74.1%* | 7 |
| 2. Patients waiting longer than the required timeframe for their first specialist assessment (FSA). | 32 | *0.4%* | -32 | 38 | **0.4%** | -38 | 109 | **1.1%** | -109 | 33 | *0.4%* | -33 | 134 | **1.5%** | -134 | 35 | *0.4%* | -35 | 46 | **0.5%** | -46 | 178 | **1.7%** | -178 | 342 | **3.3%** | -342 | 23 | *0.2%* | -23 | 29 | *0.3%* | -29 | 17 | *0.2%* | -17 |
| 3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT). | 29 | *0.2%* | -29 | 41 | *0.2%* | -41 | 49 | *0.3%* | -49 | 71 | *0.4%* | -71 | 35 | *0.2%* | -35 | 47 | *0.3%* | -47 | 68 | *0.4%* | -68 | 75 | *0.4%* | -75 | 69 | *0.4%* | -69 | 53 | *0.3%* | -53 | 48 | *0.2%* | -48 | 47 | *0.2%* | -47 |
| 5.Patients given a commitment to treatment but not treated within the required timeframe. | 81 | **1.9%** | -81 | 39 | *0.9%* | -39 | 56 | **1.3%** | -56 | 36 | *0.8%* | -36 | 42 | *0.9%* | -42 | 58 | **1.2%** | -58 | 42 | *0.9%* | -42 | 71 | **1.6%** | -71 | 81 | **1.9%** | -81 | 35 | *0.9%* | -35 | 14 | *0.3%* | -14 | 20 | *0.4%* | -20 |
| 6. Patients in active review who have not received a clinical assessment within the last six months. | 4 | *10.8%* | -4 | 2 | *4.3%* | -2 | 2 | *3.8%* | -2 | 3 | *4.0%* | -3 | 9 | *20.9%* | -9 | 8 | *14.5%* | -8 | 0 | **0.0%** | 0 | 0 | **0.0%** | 0 | 0 | **0.0%** | 0 | 0 | **0.0%** | 0 | 0 | **0.0%** | 0 | 0 | **0.0%** | 0 |
| 8. The proportion of patients who were prioritised using approved nationally recognised processes or tools. | 1448 | *90.2%* | 158 | 1293 | **86.7%** | 198 | 1399 | *92.4%* | 115 | 1770 | *95.7%* | 80 | 1587 | *95.5%* | 75 | 1386 | *96.3%* | 54 | 1484 | *94.8%* | 81 | 1030 | *93.2%* | 75 | 1150 | *95.2%* | 58 | 1427 | *93.6%* | 97 | 1716 | *93.8%* | 114 | 1231 | *93.0%* | 93 |

**Recommendation**
**THAT**
The report be received.

**DR GRANT HOWARD**
**INTERIM CHIEF OPERATING OFFICER**


# Date of next meeting
# 8 August 2018