DISTRIBUTION:

Committee Members (1 copy each)
- Ms S Christie (Chair)
- Ms C Beavis (Deputy Chair)
- Mr M Gallagher
- Mrs MA Gill
- Mr D Macpherson
- Ms S Webb
- Dr K McClintock
- Dr A Rolleston
- Ms C Rankin

Board Members (1 copy each)
- Ms T Hodges
- Ms S Mariu
- Mrs P Mahood
- Dr C Wade

Executive Management Team
- Mr D Wright, Interim Chief Executive
- Mrs V Aitken, Interim Executive Director, Mental Health & Addictions Service
- Ms L Aydon, Executive Director, Public and Organisational Affairs
- Mr C Cardwell, Executive Director, Facilities and Business
- Ms M Chrystall, Executive Director,Corporate Services
- Ms L Elliott, Executive Director, Maori Health
- Mr N Hablous, Chief of Staff
- Mr D Hackett, Executive Director, Virtual Care and Innovation
- Mrs S Hayward, Chief Nursing & Midwifery Officer
- Dr G Howard, Interim Chief Operating Officer, Waikato Hospital
- Prof R Lawrenson, Clinical Director, Strategy and Funding
- Ms T Maloney, Interim Executive Director, Strategy and Funding
- 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
- Dr D Tomic, Clinical Director, Primary and Integrated Care
- Mr I Wolstencroft, Executive Director, Strategic Projects
- Ms S Mason, Ministry of Health
- Minute Secretary
- Board Records

Contact Details:

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Facsimile 07-834 3674
www.waikatodhb.health.nz

Next Meeting Date: 13 June 2018

Waikato District Health Board

WAIKATO DISTRICT HEALTH BOARD

A g e n d a

Hospitals Advisory Committee

Date: **11 April 2018**

Time: **9:00am**

Place: **Board Room**
Level 1
Hockin Building
Waikato Hospital
Pembroke Street
HAMILTON

Meeting of the Hospitals Advisory Committee

to be held on Wednesday 11 April 2018, at 9:00am
Board Room, First Floor, Hockin Building

AGENDA

Item		
1.	**APOLOGIES**	
2.	**INTERESTS** 2.1 Schedule of Interests 2.2 Conflicts Related to Items on the Agenda	
3.	**MINUTES AND MATTERS ARISING** 3.1 Minutes of Performance Monitoring Committee 11 October 2017 3.2 Minutes of Bay of Plenty Hospital Advisory Committee 7 February 2018 3.3 Minutes of Lakes DHB Hospital Advisory Committee 26 February 2018	
4.	**QUALITY** 4.1 Quality Report	
5.	**SERVICE CHALLENGES** 5.1 Mental Health and Addictions 5.2 Community and Clinical Support 5.3 Waikato Hospital Services	
6.	**CULTURE** 6.1 Culture Report	
7.	**NEXT MEETING** - 13 June 2018	

Apologies

Interests

SCHEDULE OF INTERESTS AS UPDATED BY HOSPITALS ADVISORY COMMITTEE MEMBERS TO APRIL 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	Non-Pecuniary	None	
DHB Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
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, Remuneration 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
Deputy Chair, Remuneration Committee, Waikato DHB	Non-Pecuniary	None	
Member, Community & Public Health Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Health Strategy 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	
Member, 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	
Son is an employee of Hongkong and Shanghai Banking Corp Ltd (NZ)	Non-Pecuniary		
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, Western Community Centre, Inc	Non-pecuniary	Potential	
Partner is Chair of Ngaruawahia Community House, Inc	Non-pecuniary	Potential	

Note 1: Interests listed in every agenda.

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

Member, Waikato Regional Transport Committee	Non-pecuniary	Potential
Member, Waikato Water Study Governance Group	Non-pecuniary	None
Member, Future Proof Joint Council Committee	Non-pecuniary	None

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	Non-Pecuniary	None	
DHB Member, Iwi Maori Council, Waikato DHB	Non-Pecuniary	None	

Anna Rolleston

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	Non-Pecuniary	None	
DHB Board member, Bay of Plenty 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	Non-Pecuniary	None	
DHB 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.

Conflicts related to items on the agenda

Minutes
and
Matters Arising

WAIKATO DISTRICT HEALTH BOARD

Minutes of the Performance Monitoring Committee Meeting Held on Wednesday 11 October 2017 Commencing at 8:30am

Present:

Ms S Christie (Chair)
Ms C Beavis (Deputy Chair)
Mr M Gallagher
Mrs MA Gill
Dr K McClintock
Mr D Macpherson
Ms A Rolleston
Mr B Simcock
Ms S Webb

In Attendance:

Mr B Paradine (Executive Director Waikato Hospital Services)
Mr M Spittal (Executive Director Community & Clinical Services)
Mr D Wright (Executive Director Mental Health & Addictions Service
Ms B Garbutt (Director Older Persons Rehabilitation and Allied)
Ms C Coles (Service Manager, Oncology, Emergency and Ambulatory Services)
Ms C Nolan (Director, Surgery, CCTVS, Care & Theatre)
Ms M Sutherland (Director Women's and Children)
Ms M Neville (Director Quality and Patient Safety)
Mr G King (Director, Information Services)
Ms J Wilson (Executive Director Strategy and Funding)
Mr A McCurdie (Chief Financial Officer)
Ms S Hayward (Chief Nurse and Midwifery Officer)
Mr L Wilson (Manager, Allied Health)
Mr N Hablous (Chief of Staff)
Mr C Wade (Chair Health Strategy Committee)
Mr G Peploe (Director People and Performance)
Ms K Hugill (Planning Manager, Strategy and Funding)

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

ITEM 1: APOLOGIES

Ms A Morrison has tendered her resignation from the Committee which has been formally accepted.

Ms C Rankin will be put forward for nomination to the Performance Monitoring Committee at the December Board meeting.

ITEM 2: INTERESTS

2.1 Schedule of Interests
No changes.

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: 9 August 2017

Resolved
THAT
The Performance Monitoring Committee meeting minutes on 9 August 2017 are confirmed as true and correct.

3.2 Bay of Plenty DHB – Hospital Advisory Committee: 5 July 2017
Minutes were noted.

3.3 Lakes DHB – Hospital Advisory Committee: 28 August 2017
Minutes were noted.

ITEM 4: SYSTEM LEVEL MEASURES

4.1 Developmental System Level Measures
Ms J Wilson and Ms Kathryn Hugill presented this agenda item.

<u>Babies living in smoke free households</u>
A smoke free household is classified as no person living in the house identifying as a smoker. The committee thoroughly discussed the issue of smoking, and emphasized the importance of smoke free households and communities. There will be more discussion when the smoking cessation report from Midland Health Network is presented at the December PMC meeting.

Self-Harm
The committee discussed the Service Level Measures (SLM) that the Ministry of Health has put forward. The Committee noted they would like more information on what other districts and DHB are focusing on, so findings and trends can be shared.

The Committee would like the reporting on smoking and self-harm to continue.

Resolved
THAT
The Committee approves the two developmental System Level Measure Plans for submission to the Ministry of Health.

ITEM 5: OPERATIONS AND PERFORMANCE

5.1 Operations and Performance Report

Mr M ter Beek presented this agenda item.

Service Development work
Implementation of the SAFER project is showing promising results and is well received by staff.

National patient flow
Struggling to recruit for a Business analyst for the National Patient Flow, this will impact the project. The Rapid Improvement Event (RIE) will be held on 25-27 October.

The Committee would like to see the "Towards a learning organisation" Strategy paper.

Resolved
THAT
The Committee received the report.

ITEM 6: SERVICES

6.1 Community and Clinical Support

Mr M Spittal presented this agenda item.

There was discussion on the areas of health which are contributing to unplanned presentations in the Emergency Department (ED).

Areas highlighted:

- ED presentations are declining in Taumarunui, and so is the population. There is more focus on planned care.
- Tokoroa and Thames are struggling with ED presentations as there is a shortage of General Practitioners.

Waikato DHB is interested in working with rural communities to address and solve these issues. Waikato DHB is currently in talks with communities and practitioners in these areas.

Smoke-free approaches
Fencing off common smoking areas has begun and there are plans to have new signs around the campus that encourage people not to smoke. Nicotine Replacement Therapy (NRT) will be readily available for patients and visitors at all times.

It was noted by the Committee that they would like:

- Further information on the health and improvement team and workflow.
- A review on the continence services.
- Early Childcare Education feedback to be provided at next meeting.

6.2 Mental Health and Addictions

Mr D Wright presented this agenda item.

Areas highlighted:

- Concerns around patient transfers from Auckland putting pressure on more rural areas. Derek is meeting with colleagues at the Auckland District Health Board to discuss transfer options.
- Waiting times over 7-8 weeks are been looked at closely including care after the initial patient assessment is taking place, including regular communication with families.
- The Addictions Comprehensive Health Enhancement Support System (ACHESS) app will be piloted in November, the feedback so far has been extremely positive.
- Relooking at how the service operates in regards to the Infant/Child/Adolescent area. In discussions with NGO's/various partners. Report to be presented on the outcomes.
- Housing – working with the Link Group around the current housing issues in the area.

It was noted that the Henry Bennett Centre proposal will be presented to the Board in October.

6.3 Waikato Hospital Overview Reports

Mr B Paradine introduced Ms C Nolan (Director Surgical and Critical Care), Ms C Coles (Service Manager, Oncology, Emergency and Ambulatory Services), Ms M Sutherland (Director of Women's and Children's Health) and Ms B Garbutt (Director Older Persons & Rehabilitation Service and Allied Health).

Medicine, Oncology, Emergency and Ambulatory Services

Ms C Coles presented this agenda item.

Surgical and Critical Care
Ms C Nolan presented this agenda item.

- The Committee noted they would like to see the paper on ICU patient transfers.

Women's and Children
Ms M Sutherland presented this agenda item.

Areas highlighted:

- The Committee would like to commend the Women's Health Service on the outstanding review from the Royal Australian and New Zealand College of Obstetricians and Gynecologists.
- In December 2017 the Waikato DHB will reach full staffing levels (12 new registrars 8 of whom are senior).
- Currently in discussions with MoH regarding having a case-load model for Maori LMCs.
- The committee noted that they would be interested in receiving a report on waiting times for patients in clinics. This could also lead to a customer survey.

Older Persons Rehabilitation and Allied Health
Ms B Garbutt presented this agenda item.

Child Development Services
Ms B Garbutt presented this agenda item.

- The Committee noted they would like to see the final report on the review of Child Development Services. A tour of the facility will be arranged at a later date.

Resolved
THAT
The Committee received the reports.

ITEM 7: QUALITY

7.1 Quality Report

Ms M Neville presented this agenda item.

Areas highlighted:

- There have been no reported falls or fractures since March, this shows that the steps to eliminate these cases are working effectively.
- The Health and Disability Commission reviews do not mean that the Waikato DHB cannot do internal reviews. Once final reviews are received the Waikato DHB is still in a position to do an internal review if needed.

The Committee noted they would like to see the complaints on a trend graph for future reports.

Resolved
THAT
The Committee received the report.

7.1 Draft Quality Account 2016/2017
Ms M Neville presented this agenda item.

Draft report presented to the Committee. The finalised version will be presented to the Committee, with the report also to be presented to the Board for sign-off before publication.

The Committee noted that this information should be available to the public/staff in a more pro-active manner as it sends a very positive message about what the DHB does.

Resolved
THAT
The Committee received the report.

ITEM 8: FINANCE REPORT

8.1 Finance Report
Mr A McCurdie presented this agenda item.

Areas highlighted:

- Discussions with the Ministry have taken place and a $10m deficit budget has been tabled and will be presented to the new government.
- Work is in process around the Clinical Supplies negative variance and pay equity.

Resolved
THAT
The Committee received the report.

ITEM 9: PEOPLE

9.1 People and Performance Report
Mr G Peploe presented this agenda item.

Areas highlighted:

- The Staff Safety Culture Working Group's terms of reference (TOR) have been modified to focus on staff safety, wellbeing and engagement. Committee noted that there needs to be Maori representation on the executive sponsors and/or membership group.

- A staff survey will be undertaken by 10 different health boards in April/May next year.
- Electronic onboarding will go live in November, which will significantly speed up the recruitment process and onboarding experience for new starters.

Resolved
THAT
The Committee received the report.

ITEM 10: INFRASTRUCTURE

10.1 Facilities and Business Report due 13 December

ITEM 11: INFORMATION SERVICES

11.1 Information Services Plan Report

Mr G King presented on this agenda item

Areas highlighted:

- Windows 10 - Waikato DHB will be updating within two years. Discussions are currently underway with vendors.
- Disaster Recovery Plan – this will be presented to the Board at the November Board meeting.

Resolved
THAT
The Committee received the report.

ITEM 12: PERFORMANCE OF FUNDED ORGANISATIONS

12.1 No papers

ITEM 13: NEXT MEETING SCHEDULED FOR 13 DECEMBER 2017

Minutes

Bay of Plenty Hospital Advisory Committee

Venue: Tawa Room, 889 Cameron Road, Tauranga
Date and time: Wednesday 7 February 2018 at 10:30am

Committee: Geoff Esterman (Chair), Peter Nicholl, Ron Scott, Clyde Wade (Waikato DHB Rep), Lyall Thurston (Lakes DHB rep), Yvonne Boyes.

Attendees: Helen Mason (Chief Executive), Julie Robinson (Director of Nursing), Hugh Lees (Chief Medical Advisor), Pete Chandler (Chief Operating Officer)

Item No.	Item	Action
1	**Karakia** The meeting opened with a joint karakia.	
2	**Apologies** An apology was received from Sally Webb **Resolved** that the apology from Sally Webb be received Moved: P Nicholl Seconded: C Wade	
3	**Presentations** **Resolved** that the Committee move into confidential Moved: C Wade Seconded: R Scott Trevor Richardson, Service Improvement Manager Health Round Table Reports	
4	**Minutes** BOPHAC Meeting – 4.10 17 **Resolved** that the minutes of the meeting held on 4 October 2017 be confirmed as a true and correct record. Moved: C Wade Seconded: P Nicholl	

Item No.	Item	Action
	Lakes DHB HAC Committee Meeting – 28.08.17 The Lakes DHB Committee Member drew to the Committee's attention, notification within the minutes of the retirement of Dr Paul Malpass who had worked with and was well known to both BOP and Lakes DHBs. The Committee received the minutes Moved: L Thurston Seconded: C Wade	
5	**Matters Arising** As per report circulated with the agenda. 5.2 Health Services Plan The COO advised that a good workshop had been held with Provider and P&F. A driver diagram is being produced. The Service Improvement Unit will submit to next Committee meeting. - Completed A query was raised around the SHSP and initiatives not able to proceed at the moment due to pressures on funds. The COO advised that hospital service delivery changes are not being held back as most of the current work is expected to be cost saving and is focussed on managing current demand pressures. Primary / secondary workstreams may be affected if they need priming funds but no impact at this stage.	COO
6	**Reports requiring decision** 6.1 Chief Operating Officers Report The COO mentioned the the new Whakatane acute flow workstream being undertaken this year, also noting that concurrently maintaining progress/ improvements that have been made at Tauranga is very important. A query was raised around weekend work which can now be as busy as weekdays but with less infrastructure.The COO advised that this is an issue internationally.	

Item No.	Item	Action
	The situation is being monitored in our organisation and modest change/ investment opportunities are being sought that will leverage the most gains in flow improvement. The system is not funded to allow a full 7 day service. The DON mentioned that within the Daily Ops meetings that take place, reviewing event submissions provides patterns of opportunities where small but valuable improvements can be made. A query was raised on demand projections and whether there is for example 5 years forward planning with consideration to changing demographics. Census data is going to be a very important cross check with the data and projections in our SHSP. CEO advised that there had been recent discussion at Midland CEOs with regard to this and mentioned the HRT report indicating suggested bed numbers that could be saved when applied to improved length of stay. COO commented that the current HRT report would be influenced by some of the recent changes made but wouldn't show the latest improvements yet. COO mentioned the recent successful visit by the Queensland Health Team. They were impressed with our culture change work as well as clinical change work. BOPDHB teams were enthusiastically involved in showcasing their work. COO advised that latest indicators were showing that we would meet 5 of our health targets this quarter for the first time ever CEO commented that with current discussion around health targets, it is important to continue implementing and embedding practice. COO tabled an enlarged Provider Arm Balanced Scorecard 2017/18 sheet for ease of review, commenting that DNAs continue to be a concern. The sheet will be brought to each BOPHAC Committee. A comment was made within the table on staff results. COO commented that this year had been a tough one for staff sickness. This is being monitored.	

Item No.	Item	Action
	Mention was made of the acute readmission rate which was still moving upwards and it was agreed that this should be a focus area during 2018. Comment was also made on the Smoking Cessation programme for young pregnant Maori women and whether a stronger stance needs to be taken. CEO advised that it required behavioural change and counselling which is being undertaken. There is research being undertaken nationally on what the drivers are for non-cessation. **Resolved** that the Committee receive the report. Moved R Scott Seconded: C Wade 6.2 <u>Draft Work Plan</u> The BOPHAC Terms of Reference (TOR) updated in 2017 were tabled for consideration against the Draft Work Plan. The Committee Chair asked Committee Members for comment. The Chair advised that some of the monitoring indicated for the Committee within the TOR was carried out well. There may be room for improvement in some other aspects, eg Balanced Scorecard, HSP Strategic Objectives. He queried of the Committee how to incorporate some of these into the Work Plan and whether the Work Plan could be modified. Comment was made that with regard to papers to the Committee, as discussed at Board level, such things as the COO report submitted to BOPHAC should outline in a cover sheet, matters of most importance for attention of the Committee. It was suggested that Quality and Patient Safety and Organisational Health could be a focus and incorporated for May. The August meeting can remain open at this stage. For November it was suggested that HRT be invited to link with the Committee for presentation of the results.	COO COO

Item No.	Item	Action
	Draft plan to be updated. Comment was made with regard to Clinical Risk. It was thought that the COO, DON and CMA could provide information in the Closed section of the next meeting. CEO advised that if the Committee found it helpful, links to the SHSP could be sent so that the Committee could review helpful information, also mentioning that the SHSP contains a 5 – 10 year horizon and any changes to the direction of that would need to be considered.	COO COO / DON / CMA Board Secretariat
1	**General Business** There was no general business	
9	**Next Meeting** – Wednesday 2 May 2018.	

The open section of the meeting closed at 12.30 pm

The minutes will be confirmed as a true and correct record at the next meeting.

LAKES DISTRICT HEALTH BOARD

MINUTES OF THE MEETING OF THE HOSPITAL ADVISORY COMMITTEE HELD ON MONDAY 26th FEBRUARY 2018 AT 10.00 A.M. BOARDROOM, ROTORUA HOSPITAL, PUKEROA HILL, ROTORUA

Meeting: **[157]**

Present: L Thurston (Chair), A Morrison, D Shaw, J Morreau, J Horton, C Rankin, M Gallagher, P Marks and R Isaacs

In Attendance: D Epp, W Webber, S Burns, R Dunham, N Saville-Wood, A Mountfort, Dr S Kletchko, H Schoeman, S Wilkie, Presenters D Aitken and M Bloor and B E Harris (Board Secretariat)

157.10 MEETING CONDUCT

The Chair welcomed everyone to the meeting before asking P Marks to lead the opening karakia.

157.11 Apologies: *(Agenda Item 1.1)* : M Guy and G Fannin
Resolution:
THAT the apologies be accepted.
L Thurston : A Morrison
CARRIED

157.12 Schedule of Interests Register *(Agenda Item 1.2)*
The Interest Register was circulated during the meeting with no additions or deletions made.

157.13 Conflict of interest relating to agenda items *(Agenda Item 1.3)*
The Chair asked for any disclosures of interest regarding agenda items to which none were submitted.

157.14 General Business *(Agenda Item 1.4)* :
157.14.1 Orthopaedics update – Public Excluded item

157.20 SIGNIFICANT ISSUES

157.21 Presentations

Presentations on

157.21.1 **Palliative Care by Dr Denise Aitken**

This presentation covered the following headings:-

- What is Palliative Care?
- Concepts of Specialist Palliative Care and Generalist Palliative Care
- Integrated Specialist Care Service in Lakes, Lake Taupo Hospice, Rotorua Community Hospice
- What next?

Following the presentation it was noted that:-

- Delivery and structure of care with a focus on equity of care was important
- Help for carers was important
- Look critically at Planning and Funding current fund spend
- Three priority areas would be:-
  - Model of funding – Ministry issue
  - Inadequate community nursing to deliver first level care to people at top of their scope
  - Under service specialist med service
- Government policy is Palliative Care is funded 50% - some directly from MoH and some by DHBs. Lakes expressed concern of inequity promotion.

Resolution:

THAT the Palliative Care presentation be presented to the Board.
L Thurston : C Rankin
CARRIED

Resolution:
THAT the Board look at funding around Palliative Care with a view to increasing specialist resources
D Shaw : C Rankin
CARRIED

157.21.2 **Geriatric Care by Dr Michelle Bloor**

The presentation by Dr Michelle Bloor involved:-

- Parkinson's MDT Clinic
- Memory Clinic
- Dementia Midlands criteria
- Community MDT meetings
- Community visits

Following Dr Michelle Bloor's presentation, brief discussion was had around:-

- Concern regarding isolated communities and difficulty in providing community-based care (Turangi and Mangakino areas)
- Murupara home-based care serviced by providers from Whakatane
- Another concern is age residential and home-based care workforce – language barriers etc.

On a positive note, R Dunham stated Lakes is delivering a lot more than previously in the community with good connections with primary care NGOs and residential care.

L Thurston thanked Dr D Aitken and Dr Michelle Bloor for their excellent presentations and noted the brilliant work being carried out in the Memory Clinics.

Resolution:
THAT the Geriatric Care presentation be presented to the Board also.
L Thurston : C Rankin
CARRIED

The committee adjourned for a 10 minute tea break at 10.50am and reconvened at 11am

157.30 CHIEF OPERATING OFFICER

157.31 **Hospital & Specialist Secondary Services** *(Agenda Item 3.1)*

157.31.1 Chief Operating Officer monthly report : 31 January 2018 *(Agenda Item 3.1.1)*

It was reported that:-

- The financial performance for the Provider has been very good in both December 2017 and January 2018.
- January 2018 had another favourable variance of $357k which resulted in a positive variance to budget in the YTD of $347k. This was despite the overall inpatient volumes YTD tracking 4% above contract levels and the impact of a number of material prior year adjustments impacting the 2017/18 year.
- Experiencing difficulties in our orthopaedic services with limited success in finding locums to fill the immediate gap.
- Project Mauri Ora – Next steps established to undertake an Investment Logic Mapping exercise with workshops to be held 22 February and 7 March.
- National Bowel Screening Programme – Planning for National Bowel Screening Establishment Workshop - underway and set for 7 March. Hawkes Bay going live in October.
- St John Take Home and Settle Trial – from Lakes DHB's view this is a good initiative. Still waiting for the actual review of the trial.

Resolution:
THAT the Chief Operating Officer's report be received.
L Thurston : J Horton

CARRIED

157.31.2 Balanced Scorecard *(Agenda Item 3.1.2)* : Information noted

157.31.3 Operating Officers Newsletter *(Agenda Item 3.1.3)*

N Saville-Wood acknowledged the good news stories pulled together by S Wilkie. The newsletter would be available every two months.

157.40 REPORTS

157.41 Performance Monitoring : Finance & Audit 31st January 2018 *(Agenda Item 4.1)*

A Mountfort advised:-

- A positive month with $358k and positive YTD of $347k
- Graphs showing debts less than budgeted
- ACC revenue across services received higher IDF inflows for month with a positive impact on the bottom line.
- Personnel costs overall less than budget by $76k
- Management and Administration – Net FTE and rate variances due to vacancies $103k
- Nursing staff variance – realised January results nursing back pays worse than budget
- Medical locums for the month ($269k)
- Clinical supply costs – implants and prosthesis are major
- IT systems and telecommunications MTD $162k for the month due to delays in projects and uptakes on capital items etc.
- Orthopaedics and paediatricians negative

Resolution:

THAT the Financial Report for 31st January 2018 be received.

J Horton : C Rankin

CARRIED

157.42 Maori Health report *(Agenda Item 4.2)*

R Dunham gave P Tangitu's apology commenting that the current MoH had requested GM Maori Health participate in workshops relating to mental health and physical health. He was happy to take questions in her absence.

A Morrison's focus was on the pathway to employment and the tracking of students as to where they ended up. She was interested to know how Lakes used the information, and how proactively did Lakes progress to put people in place.

The CE advised that P Tangitu will produce a full report to the Board covering the points made by A Morrison.

Resolution:

THAT the Maori Health report be received.

A Morrison : C Rankin

CARRIED

157.50 SECRETARIAL

157.51 Public minutes of Hospital Advisory Committee meeting held 30th October 2017 *(Agenda Item 5.1)*

Resolution:

THAT the public minutes of the previous Hospital Advisory Committee meeting held 30th October 2017 be confirmed as a true and accurate record.

A Morrison : C Rankin

CARRIED

157.52 Schedule of Tasks *(Agenda Item 5.2)*

157.53 Presentation slides on Shorter Stays in ED & Update on Faster Cancer Treatment *(Agenda Item 5.3)* : Noted

157.54 Matters Arising *(Agenda Item 5.4)* : Nil

157.60 INFORMATION AND CORRESPONDENCE *(Agenda Item 6.0)*

157.61 157.61.1 Review of Terms of Reference for Lakes DHB Hospital Advisory Committee*(Agenda Item 6.1.1)*

The Chair and N Saville-Wood to discuss the terms of reference and feedback to members.

157.61.2 Lakes DHB Liaison Newsletter : November 2017 *(Agenda Item 6.1.2)*

Resolution:

THAT a letter of congratulations to be written by the Chair acknowledging the informative newsletter produced by Dr Lisa Hughes.

J Morreau : J Horton

CARRIED

157.61.3 Community Representative reports *(Agenda Item 6.1.3)*

This was held over until the conclusion of the Public Excluded items.

157.70 PUBLIC EXCLUDED

Resolution:

THAT the meeting move into Public Excluded at approximately 11.30am

L Thurston : D Shaw

CARRIED

The item 157.61.3 below was brought back into the public domain at the conclusion of the Public Excluded items.

157.61.3 Community Representative reports *(Agenda Item 6.1.3)*

R Isaac

- NGOs were visited last week by Te Ariki Tumu Te Heuheu to explain the Whanau Ora structure
- There is a shift in the health and well-being of the Tuwharetoa men with assistance for eyes, ears and oral health being offered to 50-59 year old men
- Tuwharetoa Sports Day held in Turangi, promoting health and well being
- Just commenced a programme for men and women with diabetes – meeting at pools for three months and the Trust is looking at giving a year's pass to assist

P Marks closed the meeting with a karakia at 11.55am.

…….. 28th May 2018

Chair

LAKES DISTRICT HEALTH BOARD

SCHEDULE OF TASKS: Hospital Advisory Committee meeting
26th February 2018

Agenda Item	Action	Responsibility of	Timeframe
Presentations:			
Palliative Care and Geriatric Care	That the two presentations be an agenda item for a future Board meeting.	Dr D Aitken Dr Michelle Bloor	18th May 2018 18th May 2018
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	20 April 2018
Review of Hospital Advisory Committee Terms of Reference	Item to be discussed and outcome to be fed back to the HAC members.	L Thurston/N Saville-Wood	As soon as possible
GP Liaison newsletter	That a letter of congratulations to Dr Lisa Hughes be written by the Board Chair acknowledging the informative newsletter.	Board Chair	As soon as possible

Quality

MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
11 APRIL 2018

AGENDA ITEM 4.1

QUALITY AND PATIENT SAFETY

Purpose	1) To present an overview of the current quality picture and proposed approach to gain additional assurance.

There is a need for robust assurance / governance processes in the DHB, in order to identify services 'at risk' at an early stage by monitoring performance of key quality and patient safety indicators.

There should be no surprises for the Executive Group or the Board but we have experienced lost accreditation and HDC breaches over the past 12-18 months that, if the governance processes from floor to Board had been more open, transparent and robust, we may have been better prepared for.

This presentation will give a snap shot of the 'quality picture' today and outline the processes that need to be put in place if we are to know (not quite in real time), manage and improve …in other words *'Listen, Learn, Improve'*

Recommendation
THAT
The report be received

MO NEVILLE
DIRECTOR QUALITY AND PATIENT SAFETY

Quality at Waikato DHB now

…and next steps

Safe, quality health services for all

6 Dimensions of quality

- Safety - *avoiding harm to patients from care that is intended to help them*
- Effectiveness - *providing services based on scientific knowledge and which produces clear benefit*
- Patient centeredness – *providing care that is respectful or responsive to individual needs and values*
- Timeliness – *reduced waits and sometimes harmful delays*
- Efficiency – *avoiding waste*
- Equity – *providing care that does not vary in quality because of a person's characteristics*

Safe, quality health services for all

The New Zealand Triple Aim

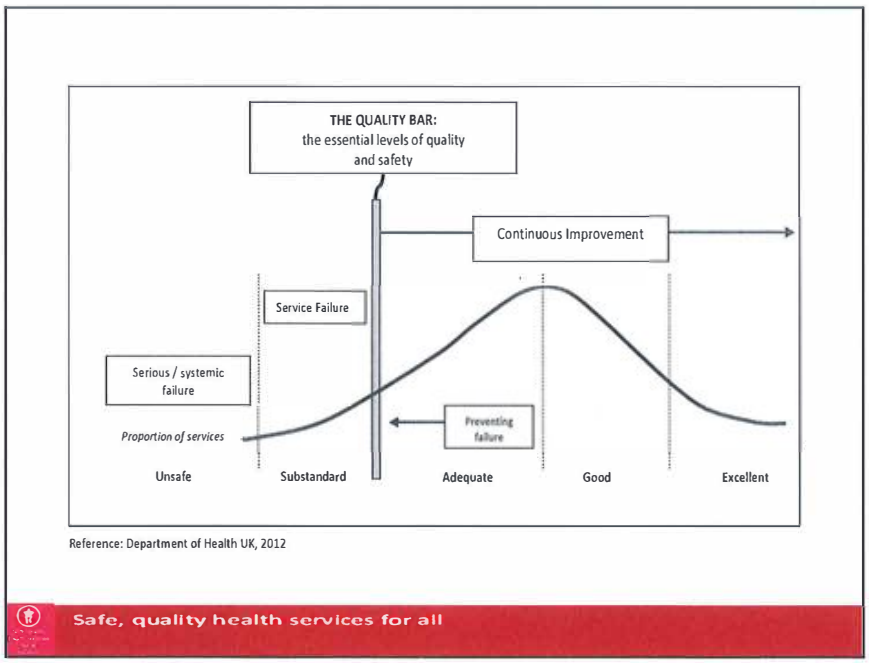
- Improved quality, safety and experience of care
- Improved health and equity of all populations
- Best value for public health systems resources

Safe, quality health services for all

Ask ourselves...

- Is appropriate quality information being analysed and challenged – are we measuring the right things?
- Is the Board / executive assured of the robustness of the quality information
- Is quality information used effectively – do we avoid distraction by random variation in organisation performance measures
- Are risks to quality of care being effectively managed

Safe, quality health services for all



What are we currently measuring and what is it telling us?

- Patient care safe in the past – nearly all our reporting is in the past e.g. incidents, mortality, health round table
- Little if any reporting of the other dimensions of quality reported - equity, timeliness, effective, efficient
- Safe today?
- Safe in the future?
- Improving?

Safe, quality health services for all

Executive Summary for Waikato (based on the trends)

Newly Red

Indicator	Page
2043 Non-Indigenous Acute care type Relative Stay Index (excluding mental health)	11
2100 Proportion of formal complaints closed within 35 days	19
2120 Proportion of discharges before noon	21
4060 Rate of hospital acquired complications	32
4101 Rate of healthcare associated SAB per 10,000 bed days (Collected Online)	42
4200 Rate of blood transfusions in planned major gastrointestinal surgeries	45
4210 Rate of blood transfusions in planned hip and knee replacements	46
6030 Annual nursing staff turnover	58

Leaving Green For Yellow

Indicator	Page
2070 Same day elective surgery rate	15
6050 Nursing staff workers compensation claims (per 100,000 hours)	60
6060 Other staff workers compensation claims (per 100,000 hours)	61

Newly Green

Indicator	Page
3040 Percentage of inpatients presenting to ED within 14 days of discharge	27
4070 Percentage of patients with pressure injuries stage 3 or 4	38

Consistent Green (last 4 periods)

Indicator	Page

Leaving Red For Yellow

Indicator	Page
3080 Percentage of ED waiting times within 6 hours	25
3080.1 Percentage of ED waiting times within 6 hours (admitted patients only)	26
3060 Percentage of non-admitted ED patients returning to ED within 24 hours	26
4100 Rate of healthcare associated SAB per 10,000 bed days (Coded)	41

Stubborn Red (last 4 periods)

Indicator	Page
2060 DOSA rate	14
3010 Percentage of ED patients seen within clinically recommended time	22
3025 Percentage of ED waiting times within 4 hours	23
3026.1 Percentage of ED waiting times within 4 hours (admitted patients only)	24
4061 Rate of major hospital-acquired complications	33
4091 28 day emergency readmission rate (excluding short stay)	35
4130 Proportion of patients with a hip fracture receiving surgery within 2 days after admission with hip fracture	44

Online Indicators Submission Status

Provided: 14 indicator(s)

Not Provided: 9 indicator(s)

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Waikato is in the best performance quartile for 3 indicators

Standard	Indicator	Latest 12 months	HRT median	Performance*	3 year trend	Latest quarter	Details on page
1- Governance for safety and quality	1.1 - Hospital Diagnosis Standardised Mortality Ratio (HDeSMR)	109	97			97	3
	1.2 - Percentage of ED waiting times within 4 hours	61%	71%			66%	4
	1.3 - Acute care type RSI (excluding mental health)	102%	94%			103%	5
2- Partnering with consumers	2.1 - Proportion of formal complaints closed within 35 days*	72%	90%				6
	2.2 - Proportion of formal complaints acknowledged in 5 days*	100%	100%				7
3- Preventing and controlling HAIs	3.1 - Healthcare associated SAB per 10,000 bed days	0.8	0.7			0.5	8
	3.2 - Rate of hand hygiene compliance*	82%	83%			92%	9
	3.3 - Risk adjusted rate of urinary tract infections	0.5%	0.4%			0.5%	10
4- Medication safety	4.1 - Skin adverse effects per 10,000 bed days	1.3	2.2			1.0	11
	4.2 - Coagulation defects due to drugs per 10,000 bed days	4.4	2.7			3.9	12
6- Clinical handover	6.1 - 28 day emergency readmission rate	7.9%	7.3%			8.4%	13
	6.2 - 28 day emergency readmission rate (excluding short stay)	9.2%	6.9%			10.6%	14
	6.3 - Mental health 28 day readmission rate	10.8%	11.0%			11.0%	15
7- Blood Management	7.1 - Transfusions in planned major gastrointestinal surgeries	10.2%	6.6%			11.1%	16
	7.2 - Transfusions in planned hip and knee replacements	3.7%	3.6%			6.8%	17
8- Preventing and managing pressure injuries	8.1 - Risk adjusted rate of pressure injuries	2.0%	1.4%			2.7%	18
	8.2 - Risk adjusted rate of stage 3 and 4 pressure injuries	0.03%	0.02%			0.00%	19
	8.3 - Rate of unspecified pressure injuries	25.9%	16.9%			33.1%	20
9- Recognising and responding to clinical deterioration	9.1 - Risk adjusted rate of cardiac and respiratory arrests	0.15%	0.06%			0.15%	21
10- Preventing falls and harm from falls	10.1 - Risk adjusted rate of in-hospital falls	0.24%	0.25%			0.27%	22
	10.2 - Falls with fracture or intracranial injury per 10,000 bed days	0.7	1.0			0.7	23

* Performance bands are quartiles of the z-score. * Indicators marked have results for the last 6 months as they are collected at a different frequency.

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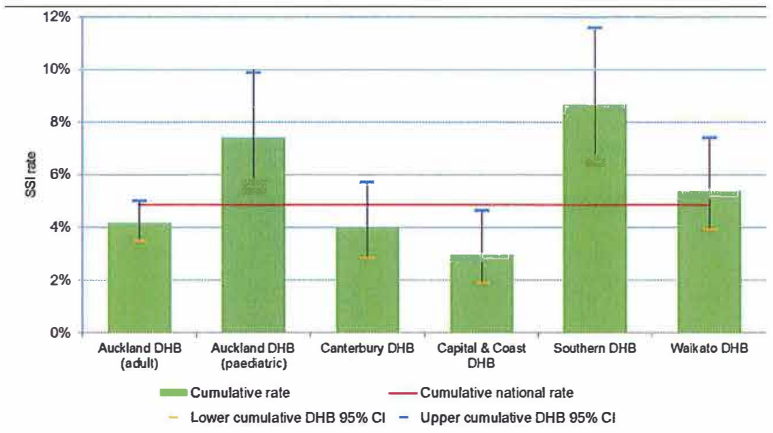
Cardiac Surgical Site infection (SSI)

Cumulative rate Oct 14 – Sept 17



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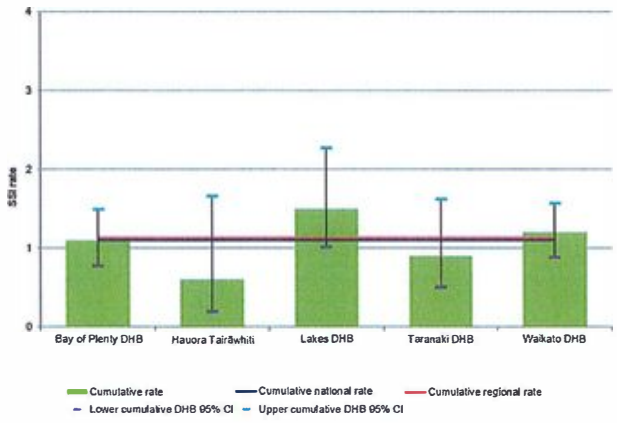
Orthopaedic Surgical Site Infection (SSI)

Cumulative rate Oct 14 – Sept 17



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Quality Safety Markers QSM

hand hygiene

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

Safe, quality health services for all

Indicator	Tolerance per Month	Quarter 1	Quarter 2	currently
HDSMR (mortality)	<100	Amber (101)	Amber (102)	Red (103)
Attributable Grade 3 & 4 Pressure Ulcers	Zero	Green (0)	Red (1)	Green (0)
Patients with a fractured hip as a result of a fall	<2	Green (0)	Amber (1)	Green (0)
Staph Aureus Bacteraemia (SAB) per 1000 bed days	< 0.1	Amber (0.15%)	Amber (0.15%)	Red (0.2%)
Complaints (responded to within 20 working days)	70%	Amber (60%)	Amber (60%)	Red (64%)
National Patient Survey response	> 30%	Green (38%)	Green (35%)	n/a
Policy / guideline compliance	> 95%	Red (76%)	Red (74%)	Red (73%)
Always report event (previously known as never events)	Zero	Red (2 in Q)	Red (1)	Red (1)
Hand hygiene	> 85%	Amber (82.3%)	Green (85.8%)	Amber (84.2%)

Safe, quality health services for all

Policy compliance

stubborn red

Waikato DHB Wide

Document Type	Currency	Number	
Policies	76%	102/135	▲
Guidelines	90%	28/31	■
Procedures	88%	53/60	▼
Protocols	98%	44/45	■
Total	84%	227/271	▲

Drug Documents

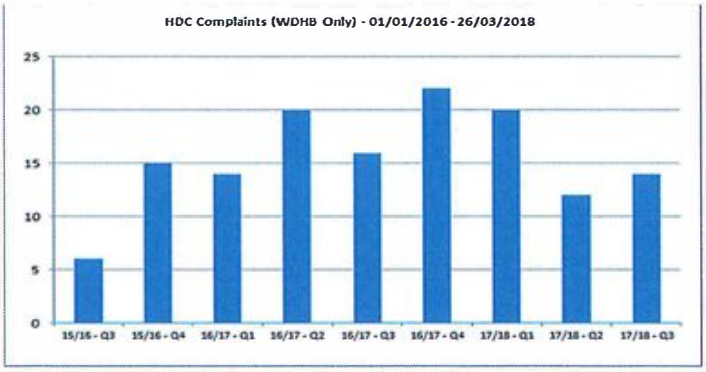
Document Type	Currency	Number	
Drug Guidelines	55%	40/73	■
Standing Orders	42%	29/69	▼
Total	49%	69/142	▼

Clinical Management

Business Area	Currency	Number	
Community and Clinical Support	86%	403/466	▲
Medicine and Oncology	63%	271/430	■
Mental Health and Addictions	82%	37/45	▲
Older Persons and Allied Health	95%	88/93	▼
Surgery, Critical Care	61%	205/334	▼
Women's and Children's Health	69%	168/242	■
Other*	100%	18/18	■
Total	73%	1190/1628	■

Safe, quality health services for all

Number of HDC complaints to Waikato District Health Board over time



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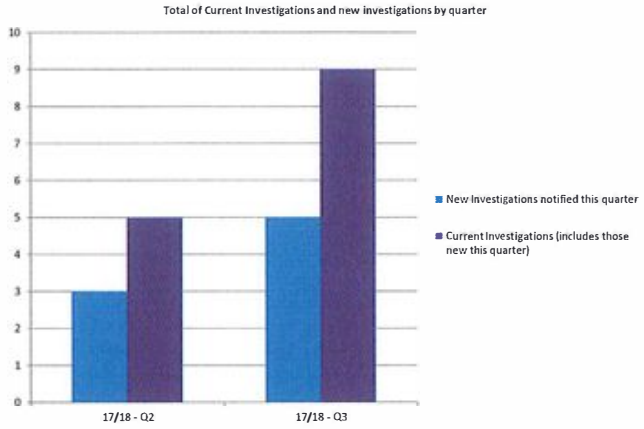
HDC Investigation



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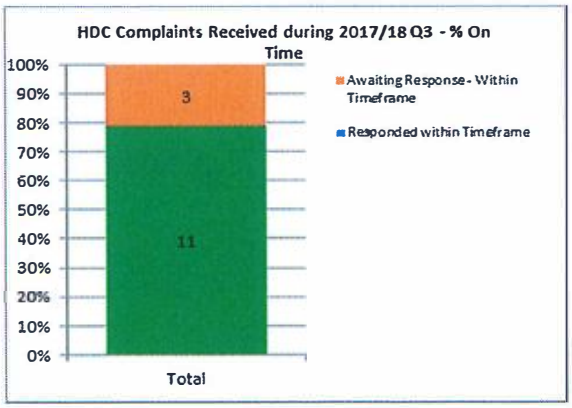
Performance within timeframes



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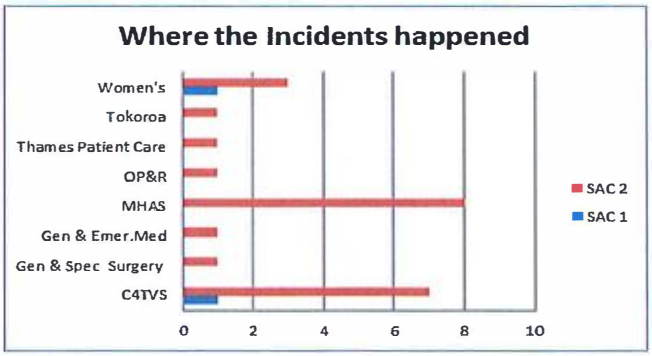
Serious events

WAIKATO DHB

QUARTER 3 2017-18
TOTAL DISCHARGES Not available
TOTAL SAC 1 2
TOTAL SAC 2 23
RE CLASSIFIED TO SAC 3 1
SERVICE REVIEWS LED BY QPS 3

Safe, quality health services for all

Serious adverse events



Safe, quality health services for all

Challenges

- Transparency of Board discussions on safety and quality
- Lack of robust governance processes from floor to board –
  - Lack of transparency of information or action being taken
  - What happens when the data flags there is an issue?
  - What performance management processes exist?
  - Are we responding and improving?
- Too much data, fragmented approach, no balanced score card / limited real time data
- Fragile system - daily firefighting versus time for improvement

Safe, quality health services for all

The future ….

Safe, quality health services for all

What	Meaning	How
A consistent and coherent approach to quality improvement - Agree definitions and methods for quality improvement	Quality improvement is different from project management – staff need to see the differentiation Use one quality improvement methodology (IHI Science of improvement) and change management tool Use in all approaches and courses that we support / fund Systemic approach – avoid conflicting approaches and prevent the 'latest conference fad', align to the international evidence and national approach from HQSC	Agreed by Exec team If new / better tools appear, bring to exec to agree – avoids rework / conflict / duplication of effort whilst remaining adaptable to 'new evidence'
Increase staff capability and capacity	• In quality improvement methodology • In the nature of systems • How to use data to understand variation	Invest time and resource Implement the ' capability framework' including trainee doctor program and CD (and team) development program
Reduce variation	Overuse – potential for harm outweighs the benefits (investigations, drugs, interventions) Underuse – effective care not delivered when it is needed (can lead to people needing more complex care as condition worsens – Maori?) Misuse	'Choosing wisely' Use Atlas of variation Heath round table data and innovations Local data Getting it right first time – right place, right time, right patient, right cost Support teams to 'close the gap'
No service improvement, care model change without the consumer at the start	Co-design with consumers- get them to help define the problem and the solutions. Involved from the outset	Consumer council Consumer engagement tools inc co-design
Work and monitor as a system	Measure across the continuum Measure all dimensions of quality Patient experience for whole of their episode of care	Need a combined approach with strategy and funding
Measurement - Use data to drive and sustain improvement	• Are we measuring the right things? • Measurement is important to show that any change to a process / service is an improvement • Put sustaining measures in after every quality improvement / project to ensure changes remain fit for purpose / changes stick	Report using SPC charts (not RAG rating) Report with clear links to lives saved or savings identified (potential and actual) Report against the IoM definition of quality Outcome measure such as falls with serious harm is the sustaining measure for the falls prevention program – if this rises, we know we have to look
Avoid short termism	Transformational change is complex and takes time	Small steps (PDSA) rather than big projects

High performing organisations

- Positive organisation culture
- Senior management support (including Board)
- Effective performance management
- Proficient workforce – build and maintain
- Effective leaders across the organisation
- Expertise driven practice
- Interdisciplinary teamwork

Safe, quality health services for all

Service Challenges

MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
11 APRIL 2018

AGENDA ITEM 5.1

MENTAL HEALTH & ADDICTIONS SERVICES

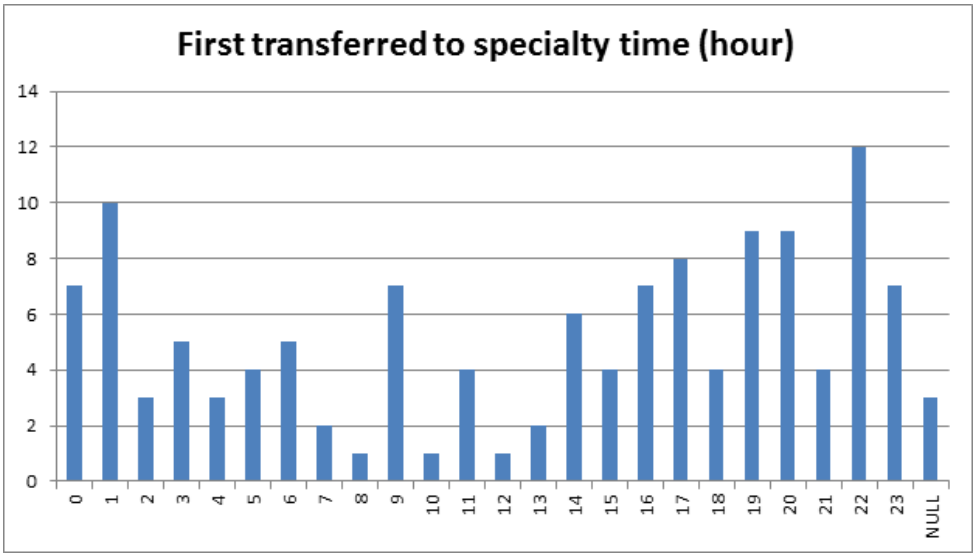
Purpose	1) For information

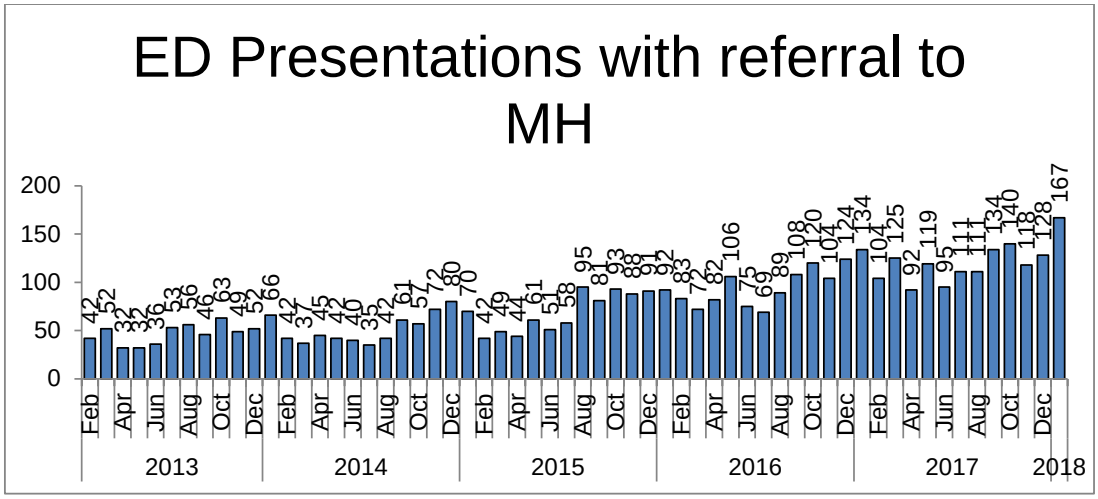
Service overview

Occupancy and length of stay in adult inpatient services continue to put pressure on the services. The sustained pressure in the inpatient setting is a mirror image of what is occuring in our community teams – and the wider community. Demand has continued to grow across services. The number of open referrals in our general adult community teams has increased by approximately 1000 since late 2014.

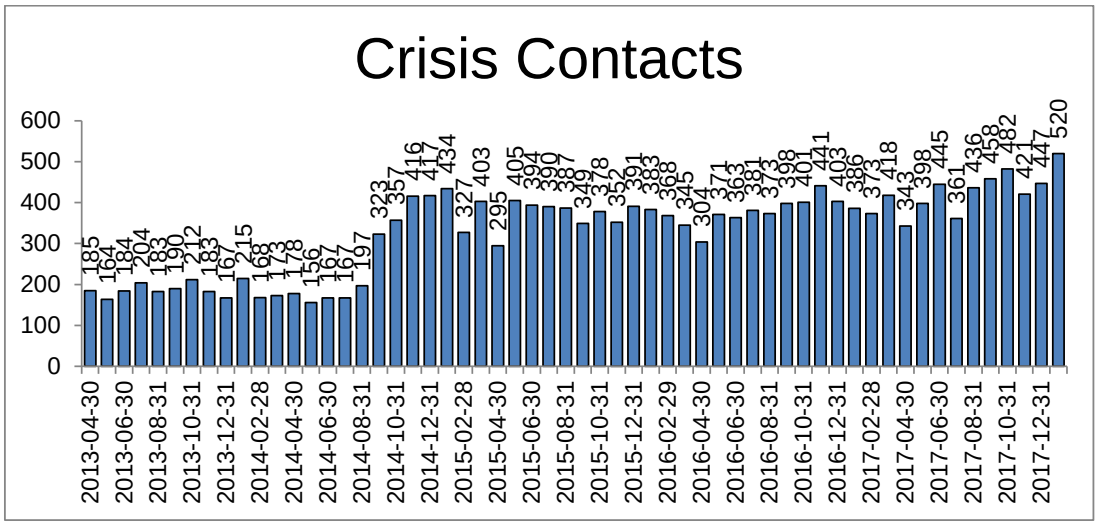
Over time existing adult community resource has been drawn from in order to effectively provide resourcing for crisis and home treatment services. This has a knock on effect of creating strain across all areas of community mental health. The impact of this on teams is clear; there are less staff to provide the necessary treatment interventions. The total resourcing for the Crisis service provides 3-4 staff in the morning and afternoons with an on-call system over night. This resource is deployed across the district, which means that at times response times and demand can result in unnecessary delays for much needed assessment. This is particularly the case if staff are deployed to a crisis in Hauraki and another occurs in South Waikato at the same time, which is not uncommon.

In addition it appears from ED data that the times of referrals to MHAS increase after 5pm through to 2am, when the least amount of staff are available to respond (as noted below).





Referrals to the crisis team come from a variety of sources: existing clients, new individuals, family members/ neighbours, police, emergency department etc. the following graph shows over the last 4 years, the increase in referrals for a crisis response with no additional resources to respond to that need. This peaked in December at 520 referrals in a month (See below):



Meanwhile, adult community services are struggling to meet demand across our community settings. Demand for services continues to grow, with presentations largely of high and complex acuity. There appears to be a direct correlation between this demand on community mental health teams and the requirement for inpatient care, often for longer periods where individuals take a considerable amount of time to get well.

With the increased prison muster, the number of acute patients requiring hospital admission and treatment has increased. This has meant that a number of individuals who are mentally unwell are awaiting transfer. This wait list is sent to the Ministry of Health weekly. Individuals, who are unwell in prison, have a detailed wrap around plan and a nurse is on site at each prison where individuals reside. An on-call system is provided at the weekends to support the prison. Communications have been sent to Lakes, Bay of Plenty, Waikato and Taranaki DHB's alerting them to the pressures on the Regional Forensic Psychiatric Service and the need to expedite transfers back to DHB of origin for service users whose requirement for inpatient medium secure level care is over.

Whilst all areas of our service are under significant stress, some areas are now having staff whom are visibly distressed by the workload and the limited ability to respond to referrals. This is particularly true in the Infant, Child and Adolescent Mental Health Team. Child and Youth crisis presentations are often complex and can take considerable time to resolve. This impacts on the capacity to continue to undertake routine clinical work, which is disrupted when this occurs.

Inpatient registered nurse roles are nearly fully recruited with recent exiting new graduate nurses (RN1's) all finding employment within our service if that was their choice. For the first time in 5 years new graduate nurses have been placed in community teams (rather than inpatient only) and those wanting to continue in their roles in community secured employment with our service. Inpatient senior medical roles are nearly fully recruited with the last locum being replaced by a permanent employee in April.

Initiatives and highlights

Collaborative partnerships

The leadership team have initiated a whole of system approach to managing flow and movement through inpatient, community residential NGO beds, social housing and out to independent living. Leaders from NGO services met with the mental health team to identify the barriers for service users moving through a clear pathway, the changes required to ensure a whole of system view and approach and ultimately an agreement to manage the resource collectively.

Registered Nurses are now deployed into our two main Prisons (Waikeria and Springhill), instead of only attending to run clinics. They are embedded in the At Risk units, where additional mental health supports are required and have a strong liaison component of their role with both health and corrections staff.

Due to a new service level agreement for regional forensic resources, the community forensic team will be implementing an approach to better support and re-integrate individuals released from prison into the Waikato region who have mental health needs. This means that during a potentially vulnerable transition time the individual will have better wrap around supports in an effort to reduce the risk of re-offending in relation to deteriorating mental health. In addition this SLA provides funding for a Cultural FTE (Kaitakawaenga) to support prisoners under the forensic prison team and increased FTE for the wider forensic prison team. Both these initiatives will mean forensic service users receive improved care.

The recently approved Nurse Practitioner (Louise Quinn) is scoping up her role to be based in the Emergency Department and to be part of a wider pilot to increase mental health nursing roles within the ED. This will also extend outside regular business hours and is aimed at improving our responsiveness to the increasing numbers of individuals who attend ED in distress.

Initial discussions are underway with ED and Medical directorate about sharing the responsibility to progress the development of services to address acute mental health presentations. This might include a case to develop a full acute mental health response team into the Emergency Department with short stay beds.

The National Addiction Leadership Day occurred in early April at Parliament. This was an opportunity for the sector to hear from the Minister of Health, Helen Clarke in her role as member of the Global Commission on Drug Policy and others in the addiction sector. One of the aims of the day was to formulate some clear messages and response to the Mental Health and Addictions Inquiry. The messages were clear and very similar to those we are aspiring to in our work with Creating our Futures. The impact of addiction on communities and countries is of course a topic of global concern. When overlaid with Mental Health concerns the impact is very significant. This is obvious for those delivering Mental Health

and Addiction Services, but also for families, community providers, police and the judiciary. The overwhelming sentiment at the forum was to invest and empower communities to respond earlier, work together to work holistically with people. Helen Clarke called for a focus on the wider social determinants, a move away from criminalisation of those with addiction problems, a strong focus on harm reduction and interventions that are community based that transcend our current models and take a more coordinated, balanced and preventative approach.

Thames Hospital and the Thames mental health and addictions services have worked together to ensure an integrated approach for detox. Alcohol and other Drug clinicians and Thames Hospital staff managed a planned admission for a medically assisted detox from alcohol. This was a positive process and a good outcome for the service user who was able to be supported by her team close to home.

Using a redistribution of existing resources the Mental Health Service Older People will be moving from the triage of urgent assessments being undertaken by the Team Leader to a specific triage role. This will increase both efficient use of the wider team's time and ensure we are able to respond in a timely manner to referrers. The new model will provide a more targeted response, which may prevent or defer inpatient admissions. Through the service pressure process it has been identified that being able to deliver an acute response team to the district (crisis and home treatment response) would significantly reduce the demand for inpatient care and provide a 'closer to home' approach for the growing older adult population.

Community Engagement – Let's Talk

Let's talk wellbeing is the approach the service has been engaged with now for at least 18 months. Let's Talk Wellbeing began as a post vention response to suicide in the Coromandel. The success of managers and staff going to communities, opening our doors, offering information and support is twofold. We have been able to engage with over 8000 people through this process, ensuring that those with mental health or addictions concerns get information for themselves or a loved one. In addition, we have also had opportunity to engage with communities and listen to what people are saying they need. We ensure that our service is visible, and that we are demystifying mental distress and hopefully making help more accessible.

In the past few months we have attended events in Ngaruawahia, Te Kuiti, Tokoroa, Taumarunui and within Waikato Hospital for staff. These events often occur in the weekends. We always have managers and staff in attendance and days are run in collaboration with Clare Simcock, Suicide Prevention / Post Vention Coordinator.

Our Police colleagues are now going to take our Lets Talk Wellbeing branded cards with details on getting help. These will be taken to incidents where people may be experiencing mental health difficulties and where there are arrests or operations associated with the misuse of drugs.

Integrated Safety Response (ISR) pilot

In the Waikato the Mental health and Addictions Service has a significant presence, in this large cross-agency work programme. The ISR aims to deliver more effective safety responses to families to minimise and prevent family harm using a multiagency approach. All family harm episodes across the Waikato are referred via a police response to a daily meeting. This requires daily participation in collaborative meetings, identifying risks and issues, planning a coordinated response, and engaging in weekly intensive case management of high risk cases. All are assessed on a 5-point scale, ranging from tier 1 'crisis-urgent intervention' to tier 5 'zero to low risk – no further action required".

Referral volumes are high for the Waikato (averaging over 200 per week), and the ISR respond to urban and rural notifications. Partner agencies involved include: NZ Police, Oranga Tamariki, Corrections, Education, ACC, MSD, plus non government agencies such as Te Whakaruruhau Womens Refuge, and HAIP. This pilot is resource intensive, and requires considerable administrative and clinical contribution. The response is a seven day a week commitment. However, it is recognised as an important component of effective integration in the collaboration, and recognises the correlation between family violence and mental health and addiction issues.

The multi agency Operations Group is chaired by the Interim ED for Mental Health and Addictions and both the ED and CE are on the combined Joint ISR and Childrens Team governance group.

While the MH and A response to ISR at times is challenging due to resourcing and demands on services – there is a core team of committed members of the workforce, inspired by achieving outcomes for those requiring input, and in facilitating improved systems and process to better support this pilot, response and interventions needed into 2018.

Addiction Services

The Substance Abuse Compulsory Assessment and Treatment Act **(**SACAT) implementation date is February 21 2018. The preceding few months have involved significant service planning in order to be able to best respond to local and anticipated demand. This compulsory legislation has resulted in the need to recruit and appoint 8 authorised officers across Community Alcohol and Drug Services (CADS). An approved specialist has been appointed, and information and application forms for SACAT are profiled on the DHB website. Planning has occurred regarding the anticipated increased administrative workload as result of paperwork and prescribed legislative process for any and all applications made. The CADs leadership team has been actively involved in local and national planning. Communication and key messages have been identified as an ongoing piece of work, to support the sector and to help address potential perceptions of public about SACAT. SACAT is a capacity based act, and it is very likely that while there may be a number of applications, very few are likely to be upheld as a result of the capacity component. It is likely however that a number of people with serious alcohol and drug issues and concerned family members will be seeking assessment under the new legislation. While they may not meet the criteria under the Act, they are very likely to require assessment and treatment interventions.

Staff morale

Despite considerable and enduring workload pressures, workforce morale and commitment to their roles is actively demonstrated. Services work effectively and where possible, apply creative thinking to support one another, and deliver services.

Enthusiasm for shaping change and improving outcomes for service users is paramount, and a number of the workforce are very committed to striving for change, while also endeavoring to meet business as usual demands. A recent staff survey indicated that whilst they were stretched, they were committed to providing the best care to service users and their families.

Regular opportunities are being scheduled in for staff to meet the leadership team. These are informal opportunities for the ED and various leadership team members to be available and get feedback on areas working well in the service and ideas for improvement.

The Executive Director and Clinical Services Director have presented an update of Creating our Futures which has been filmed and will be accessible to all staff. This is an informal presentation discussing some of the priority areas and opportunities for staff involvement. Communicating in this way will occur in regular intervals throughout the year.

Quality Improvement Collaboratives

The launch of the National Collaborative - Zero Seclusion: towards eliminating seclusion by 2020 is occuring on 7 March 2018. This is the planned mental health and addiction quality improvement national collaborative with the aspirational goal of eliminating seclusion by 2020. The collaborative is a partnership between the Health Quality and Safety Commission (the Commission), Te Pou o te Whakaaro Nui (Te Pou), the National Mental Health and Addiction Key Performance Indicator (KPI) project and DHBs.

The national collaborative will adopt a quality improvement approach to eliminating the need for seclusion and increasing safety.

We have a team of clinicians, consumers and whānau/families forming a project team and attending regionally-based learning opportunities and co-design workshops. With Māori more likely to experience seclusion than non-Māori, there will be a strong focus on ensuring culturally safe approaches with Māori mental health consumers and their whānau.

Creating Our Futures

The Waikato DHB Mental Health and Addictions Strategic Plan 2016 – 2021 and Creating Our Futures Programme 2016 – 2019 have been developed to progress the wellness and health system opportunities. The focus of the Creating Our Futures programme is on the development and implementation of a new system of care that will inform what it is the service delivers; the acute environment/s and capital infrastructure needed; and the resources required supporting that delivery. The programme of work sets the agenda for responding to the need for change. The system-wide transformation is characterised by prevention and earlier intervention, better outcomes, a focus on wellbeing, higher quality, better value, and greater performance than could ever be achieved under the current system. The objectives described within the Creating Our Futures programme are based on the investment objectives:

a. Transforming service delivery in order to improve safety, effectiveness and efficiency.
b. Creating safe and therapeutic environments that support holistic quality care at all times.
c. Building sustainable capacity and capability of services to meet future demand, values and need.

The Board had the opportunity to review the draft Indicative Business case at their meeting of 28 March 2018.

At the same time the considerable resource requirements for delivering fully on such a significant programme were presented to the Board for consideration.

Recommendation
THAT
The report be received.

VICKI AITKEN
EXECUTIVE DIRECTOR (INTERIM) MENTAL HEALTH & ADDICTIONS SERVICES

MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
11 APRIL 2018

AGENDA ITEM 5.2

COMMUNITY AND CLINICAL SUPPORT

Purpose	1) For assessment by the Committee

Content of Report

Each of the eight services that make up the Community & Clinical Support group are making good progress against the broad range of service priorities for the 2017/18 year. This report summarises the progress made to date.

A comprehensive programme of work to improve the sustainability of the District Radiology Service is underway. A dedicated project manager has been appointed to oversee that transformation.

The birthing unit at Te Kuiti was closed on March 29 as planned. The upgrade of the birthing units at both Tokoroa and Taumarunui is well into the design stage. The upgrades should be evidenced by the first quarter of the 2018/19 year.

Additional nurses are being recruited to support the Tokoroa Emergency Department and urgent retrievals from that site. Progress on establishing a stand-alone clinical retrieval service has been slow. Collaborative work between the Auckland and Waikato Helicopter services to develop clinical retrieval teams and protocols has been suspended while the Ministry of Health undertakes a national tender for air retrieval services in order to avoid any potential for probity concerns. The DHB will continue its attempts to address this issue at a local level in the interim.

A ten-year strategic plan for the District Laboratory service has been developed. Developed in conjunction with staff and vendors the plan clearly identifies the need to develop a future workforce that spans across the multiple areas of subspecialty in laboratory science. The blending of molecular biology and genetic science will be particularly important, as will the separation of a 24-hour automated laboratory from more specialised diagnostic testing.

The Division is generally on track to deliver on its planned activity and priorities.

Recommendation
THAT
The report be received

MARK SPITTAL
EXECUTIVE DIRECTOR – COMMUNITY & CLINICAL SUPPORT

Summary of Progress against the 2017/18 Service Level Priorities: Quarter Three

(Refer to Appendix One to gauge the link between the indexed service priorities and the DHB strategic plan.)

Clinical Support

District Pharmacy Service

P1 Implement the Medication Safety Programme (MSP) across the provider arm
Significant progress is evidenced. Audits of high cost medicines, e.g. idarucizumab, have commenced. Pharmaceutical utilisation analysis reporting and monitoring – which includes all CNMs/CMMs receiving monthly reports of their ward area pharmaceutical usage – has been implemented. A patient prioritisation reporting tool has been developed to better inform the deployment of pharmacists to the highest risk inpatients. The new Formulary (NZF) medicines information platform has been rolled out and the DHB's medication Management policy has been reviewed.

P2 Actively participate in the regional E-pharmacy project
The Clinical Director and District Pharmacy manager participate in the Midland eMedicines management governance group, which includes oversight of ePharmacy. Other staff are actively involved in the operational working groups that involve staff from each DHB in the region.

P3 Focus on workforce development; developing sustainable leadership capacity, enhancing how the pharmacy functions as an overall team, and implementing advanced clinical (prescribing pharmacist) roles
A team-based approach for input into wards by clinical pharmacists has been developed, allowing a patient prioritisation tool to be utilised and resulting in improved integration between the pharmacist staff, pharmacy teams and hospital clinical services. A specialised renal outpatient pharmacist position has been created with scope to become a pharmacist prescriber. A Pharmacist prescriber now exists within the cardiology service and training options for future pharmacist prescribers have now developed. An additional clinical team leader position, resulting in two clinical team leaders, who work collaboratively but also hold specific portfolios has been developed within existing resources. The number of merited pharmacy technicians to support operation of dispensary/ supply team has been enhanced.

District Laboratory Service

L1 Implement the haematology analysers in the rural labs
Successfully completed.

L2 Implement the biochemistry mass spectrometer
The tenders for Liquid Chromatography Mass Spectrophotometer (Toxicology) has been delivered and is awaiting installation. Validation and implementation will take most of the year. The infectious serology analyser RFP is complete and at the stage of vendor negotiation.

L3 Implement the histology digital x-ray scanner
This project is being re-evaluated and may not proceed. No resulting risk.

L4 Undertake a pilot of bed-side labelling

L5 Implement an e-ordering link between Pathlab and Waikato

A global programme of work to establish electronic ordering of laboratory and radiology requests has been commenced. The relevant business cases have been approved but technical delays due to the complexity of the challenge are meaning that the project will not be delivered until mid-2019 at the earliest. This is approximately twelve months later than originally envisaged. Some of the technical work is reliant on associated IT project being completed by Pathlab who have also experienced delays due to the complexity of the interfaces being developed.

L6 Enhance Point Of Care Testing (POCT) and rural transportation for samples

Rural inpatients have typically waited up to three days longer than Hamilton patients to get confirmed test results when the samples had to be sent to Hamilton. New transport arrangements have been put in place for the rural laboratories meaning that patients diagnostics will be turned around much more quickly, especially for patients who present late on a Friday.

L7 Plan and design the business model underpinning the Waiora facility development that is planned for 2018/19

An agreement has been reached that the laboratory will eventually occupy two floors of the Waiora building. Enabling works and decanting options are planned for 2018/19 year to enable sufficient space to be created and it is expected that the laboratory will developed in 2019/20. The DHB's capital plan reflects these developments.

L8 Develop the ten-year laboratory services plan including an SMO and scientist workforce plan

The ten-year plan has been completed subject to final round of staff input. The plan signals the need for a fundamental change in the way staff are trained and work. Traditional laboratory science disciplines are becoming increasingly blurred and new disciplines, such as a combination of molecular biology and genetic science, need to rapidly emerge. Moving forward a 24-hour automated laboratory floor that delivers rapid turnaround across a broad range of common diagnostic tests is envisaged. A separate laboratory floor for the more specialised laboratory disciplines also needs to be catered for. Two additional pathologists, one in microbiology and one in haematology are currently being recruited in line with the initial priorities in the workforce plan.

L9 Significantly expand the range and impact of Choosing Wisely campaigns

Little progress has been made. Strategic service planning has rightly taken precedence.

L10 Secure the consortium bid for the Coronial Mortuary & post mortem services tender

The coronial agreement for the Mortuary facility has been extended until September 2018 while the Ministry of Justice finalise new contracts. The DHB has agreed to thereafter move to a consortium service delivery model with Communio as the lead provider.

<u>District Radiology Service</u>

R1 Implement two Computerised Tomography machine (CT) upgrades at Waikato

Completed. Ongoing technical refinement to enhance image quality is underway.

R2 Implement a CT upgrade at Thames and redirect patients to Thames

Completed. The CT colonography service has now largely been shifted to Thames.

R3 Ensure sufficient radiologists are recruited and develop a robust radiology workforce plan

R4 Create leadership team capacity (time to lead)

A comprehensive demand, capacity, productivity and workforce modelling has been completed for Radiology. A significant gap between the budgeted fte and the number required to deliver the required outputs has been identified. This is currently being masked to a significant degree by the extensive use of overtime, call-backs and outsourced services. These short-run solutions are both inadequate and are unsustainable. The net investment required to right size the service is currently being prioritised against other demands as part of the 2018/19 annual planning cycle. A significant gap between the salary packages paid to Radiologists in the Waikato relative to most other North Island DHBs has also been identified in a benchmarking process.

It is crucial that the DHB addresses the workforce capacity issues because this service is an input into virtually every clinical service.

A revised departmental structure which addresses the current lack of capacity to lead has also been developed and will be the subject of consultation with staff and unions over the next month or so.

A robust action plan to transform the service which includes more than 60 different actions, including a specific recruitment effort, is currently being implemented.

R5 Define and implement a robust quality framework across the entire service

The new Quality Coordinator commenced in January and excellent progress is being made on implementing the quality framework within the District Radiology service.

R6 Achieve national MRI & CT targets (both performance metrics increase)

Performance against the national target that 90/95% of MRI/ CTs will be reported within six weeks of referral has declined in line with all other tertiary DHBs. Waikato's specific issues are radiologist workforce gaps (the constraint is in reporting images, not in scheduling patients for imaging) coupled with an increase in demand for CTs. Waikato is still performing well despite these pressures. As at the end of February Waikato was below the national average but second best amongst the tertiary DHBs for timely access to CT (79% in 6 weeks). Waikato's outsourced MRI service was the best performing of any tertiary DHB and well above the national average (71.7% compared to 54% for the country).

R7 Undertake comprehensive capacity and service planning for interventional radiology

Multiple clinical specialties make shared use of the same staff and facilities in the interventional suites. The use of interventional technologies is rapidly changing and the combined pressures are significant. The old Harris Suite which was moved into the new department is now beyond end of life and is periodically failing. A business case to replace the angiography suite and to establish a schedule of angiography sessions that reflects patient demand will be presented to the executive and Board within the next 4-6 weeks.

R8 Implement Choosing Wisely, initially focussing on MRI and CT

Little further progress has been made. There was a 37% increase in the number of CTs performed over Easter this year compared to last, primarily because of the significant number of serious trauma cases that presented.

R9 Implement a robust clinical photo archival and storage system
A project is underway to ensure that all clinical images taken on cell-phones and mobile devices will be automatically archived into the clinical record in a secure manner. The project is on track to go-live later this year.

R10 Significantly reduce DNA rates for Māori
DNA for specific groups of people attending Radiology can be as high as 40%. All DHBs in the Midland region have collaborated on an upgrade to the radiology information system that will enable txt reminders to be sent to patients and enable patients to confirm appointments by return txt. The upgrade is due to go live later this month. Once implemented the clerical team will be able to concentrate on added value activities such as telephoning patients in advance rather than rebooking non-attendees.

R11 Actively participate in whole of provider arm production planning
A draft delivery plan for the 2018/19 year has been developed.

Blood service

B1 Focus on Intravenous Immunoglobulin (IVIG) usage and clinical reviews

B2 Assess work plan, team capacity, and structure required from 2018/19 onwards
The Patient Blood Management Service continues to be highly successful. Agreement has been reached to transfer the PBM programme to the Theatre and Perioperative Service in July now that the project has become business as usual.

Community

Screening

S1 Investigate and secure sustainable capacity for business as usual and probable changes in screening service configuration (age range, etc).

S2 Prepare for funding and contracting reform in Breast Screening
Information on future capacity constraints has been provided to the Ministry of Health should the age of eligibility for women to access the screening programme be extended in 2019. The service has insufficient capacity on its current fleet of mobile mammography units to improve coverage without adding a new mobile trailer unit.

S3 Improve Māori enrolment and coverage in screening (breast and cervical)
The service is now meeting its monthly and annual targets for numbers of women receiving a screening mammogram. There has been considerable effort applied to achieving this turnaround in service performance since last August.

BSM	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
BSM Volumes Target	3875	4182	3899	3954	3790	1260	2469	3429
BSM Cumulative Target	3875	8057	11956	15023	18813	20073	22542	25970
Appointments given/avail	3605	3992	4055	3568	0	0	0	0
BSM Screens	3441	3778	3850	3671	4009	1482	3251	3491
BSM Cumulative Screens	3441	7219	11069	14740	18749	20231	23482	26973
Month performance	Below target	Below target	Below target	Below target	Met target	Met target	Met target	Met target
YTD performance	Below target	Below target	Below target	Below target	Below target	Met target	Met target	Met target
YTD variance	-434	-838	-887	-283	-64	158	940	1,003

Further work continues on identified hot spots such as Opotiki, Kawerau and Whakatane. Resourcing has been increased at the Whakatane fixed site to improve

capacity. BreastScreen Midland, Bay Radiology and the Eastern Bay PHO have met and have agreed a pilot project to increase access to screening services for priority wahine in Opotiki and Kawerau. Close monitoring and data analysis is happening to ensure service issues in Eastern BoP are addressed.

S4 Reinvigorate smoke-free approaches across the provider arm
A comprehensive smoke-free improvement plan continues to be implemented across the provider arm. The project is on track to be 'launched' on 31 May, which coincides with World Smoke Free Day.

S5 Improve immunisation enrolment and coverage
Strategy & Funding are now taking the lead role in reviewing and revitalising the DHB's immunisation plan. The plan has recently been redrafted in conjunction with the PHOs. Whether the provider arm will have a greater role in supporting the immunisation of children beyond simply operating the national immunisation register is a matter that the funder has yet to determine.

S6 Confirm and prepare for a future role in bowel screening
The dates for the rollout of the programme in the Waikato has yet to be confirmed.

Public Health

Ph1 Build sustainable water quality assurance
Good progress has been made on addressing the corrective actions required by IANZ that the DHB can rectify. The DHB has formally notified the MoH that it cannot fulfil all aspects of this part of its Public Health contract due to the lack of qualified staff. Other DHBs do not have the capacity to assist and the DHB is unable to get its trainees qualified to work under the delegation of the Director General because the service isn't accredited. The DHB cannot resolve this catch-22. The Ministry is currently preparing a future options paper and expects to be able to discuss this with the DHB later this month. The DHB has a contractual, but not statutory, responsibility in relation to assuring the drinking water safety plans prepared by public suppliers. The contract creates significant liability for the DHB and the revenue will not cover the cost of a fully staffed service.

Ph2 Build health improvement capacity

Ph3 Strengthen health improvement activity across the whanau, workplace and education settings

Ph4 Strengthen the community development activity within Māori and Pacific Island communities of interest

Ph5 Assist the DHB to achieve a step change in Māori in-equality reduction
The health improvement team are now almost fully recruited. The team is actively engaging with Sports Waikato, some local marae, pacific health providers and a small number of local businesses to implement a range of health improvement initiatives in the education, whanau and workplace settings within which it now operates. Analytical work to help inform the Māori Health strategy has commenced.

Ph6 Develop and leverage networks to enhance effectiveness and influence within the DHB and across local and central government agencies
A role specifically designed to promote health in all policies and further enhance how public health and local authorities/ agencies work together has been recruited to. Several submissions related to both Class Four gambling and councils' long-term plans have been made to various councils throughout the district.

Ph7 Implement Healthscape (IT System) to better manage and report service activity
Not yet commenced.

Community & Southern Rural Health Services

C1 Shift all Hamilton community services to Gallagher drive

C2 Implement significant virtualisation / changes to service delivery in lieu of visiting

C3 Develop clinic-based services in lieu of home visiting
The service relocation is complete. The focus is now shifting onto implementing new ways of working.

C4 Implement the single point of entry (ED) model in Taumarunui
Plans to implement the single point of entry model are well advanced. The SPOE is due to go-live in June. The model will disrupt traditional patient flows and challenge both provider and funder to develop new methods for procuring unplanned emergent services in the town.

C5 Implement the rural retrieval service
Progress has been further delayed due to the release of the national air retrieval service tender by the Ministry.

C6 Enhance the leadership structure for rural services
This activity was not yet planned to commence.

C7 Exit the provision of TOPs at Tokoroa
Completed. Plans are now being drafted to repurpose the theatre complex as a primary birthing facility.

C8 Plan the future sustainability of the community oral health general anaesthetic service
This work has been deprioritised.

C9 Improve community oral health enrolment and coverage
The Community Oral Health service is on track to meet the required target of just over 69,000 enrolled children for the year.

C10 Extend the nitrous oxide service delivery model (reduce general anaesthetic cases)
On track. The NO_2 service is now operational as an alternative to general anaesthetic.

C11 Implement the Southern Rural Maternity model of care
On track. The Te Kuiti birthing unit closed on March 29th. A new facility cover contract to provide better LMC support is now in place for Taumarunui. The focus is now switching to improving the viability of the midwifery services at Tokoroa. The work to implement the rural maternity centres is continuing and building designs are being developed for the upgrade of the birthing units at Tokoroa and Taumarunui.

C12 Review the current continence service, succession planning and sustainability

The continence service is being reviewed because of increasing referrals and limited capacity to meet demand. The overall approach to continence services across the DHB is disjointed. A problem statement and action plan has been developed to guide the review. Strategy & Funding has been involved in early planning discussions due to the demand side issues.

C14 Transfer the wound service and refine the overall service delivery model

The service transfer has been completed.

Thames & Coromandel Rural Health Services

T1 Enhance the leadership structure for rural services

T2 Re-assess and formalise required medical capacity

Activity against neither priority was planned to commence yet.

T3 Implement the single point of entry (ED) model in Thames

T4 Implement an on-site GP practice

Expressions of Interest to establish a primary care facility within Thames hospital are now being formally sought.

T6 Confirm the future surgical service direction and quality/capacity

T7 Implement the productive operating theatres programme (TPOT)

The productive operating theatres programme (TPOT) is now well underway at Thames. A range of service improvements are being made.

T8 Improve the overall efficiency of community delivered services

T9 Implement significant virtualisation/changes to service delivery in community

T10 Develop clinic-based services in lieu of home visiting

Thames is now the stand out for the proportion of domiciliary services delivered on a clinic basis. That is releasing more staff time for delivering clinical care.

T11 Design and implement improvements to the chemotherapy, respiratory and cardiology service options available at Thames

A nurse coordinator for the chemotherapy service has been appointed and the number of clinic days has been increased to three per week. Additional nursing staff have now been deployed into this area.

T12 Implement the recommendations from the Nursing Innovation initiative with the PDU (workforce pipeline)

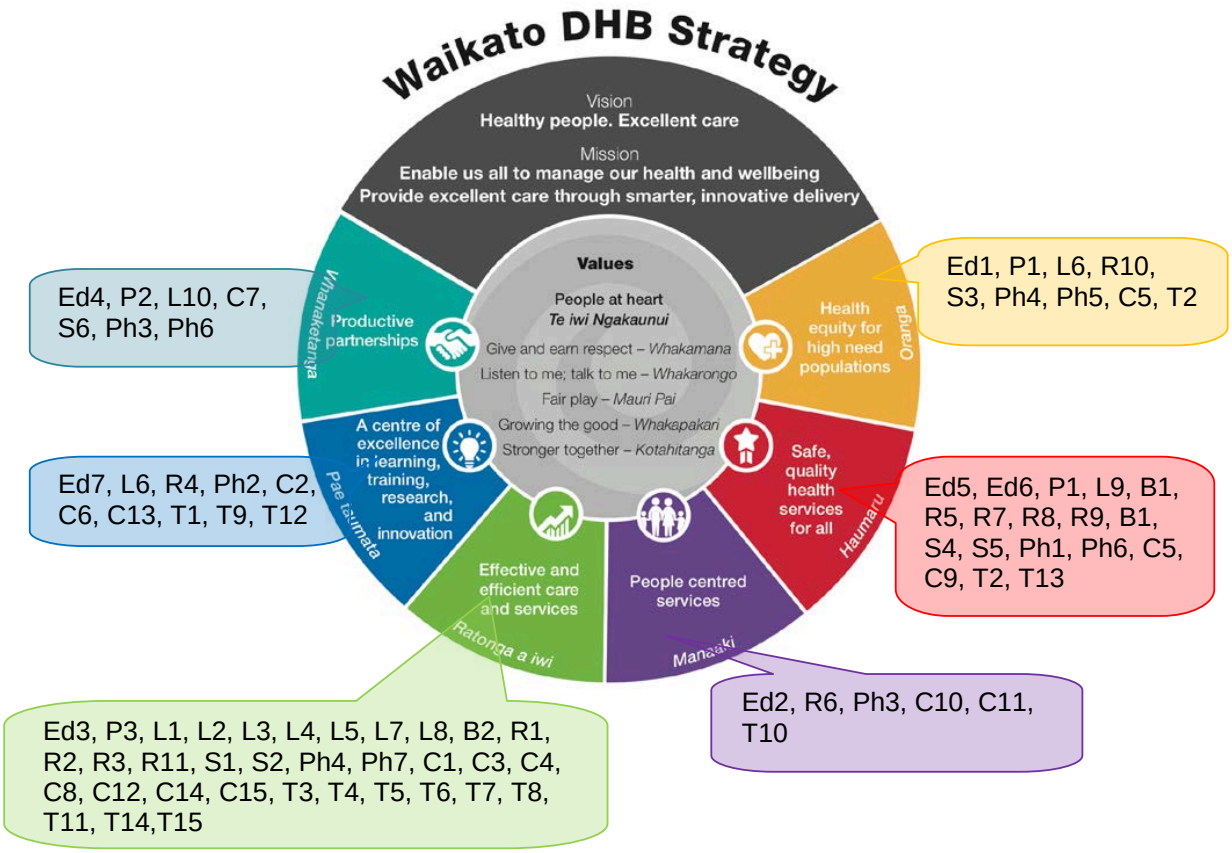
Thames was awarded the Wintec student placement award in March. This award is testimony to the considerable focus that has gone into making Thames an exemplary clinical placement for nursing students.

T15 Pilot the IMPACT inpatient flow tool at Thames prior to rollout at Waikato hospital

Preparatory work for the planned rollout in mid-2018 is underway, led by the Operations & Performance Support team.

Appendix One:

Alignment of the service priorities to the DHB Strategy



Ed4, P2, L10, C7, S6, Ph3, Ph6

Ed1, P1, L6, R10, S3, Ph4, Ph5, C5, T2

Ed7, L6, R4, Ph2, C2, C6, C13, T1, T9, T12

Ed5, Ed6, P1, L9, B1, R5, R7, R8, R9, B1, S4, S5, Ph1, Ph6, C5, C9, T2, T13

Ed2, R6, Ph3, C10, C11, T10

Ed3, P3, L1, L2, L3, L4, L5, L7, L8, B2, R1, R2, R3, R11, S1, S2, Ph4, Ph7, C1, C3, C4, C8, C12, C14, C15, T3, T4, T5, T6, T7, T8, T11, T14,T15

Appendix Two: KPIs

Commentary on the current KPI report (Year to 28 February 2018):

Note	Indicator	Commentary
1	CTs reported within 6 weeks of referral	The decline in performance reflects staffing issues. Waikato was below the national average but second best amongst the tertiary DHBs for timely access to CT (79% in 6 weeks).
2	MRIs reported within 6 weeks of referral	Waikato's outsourced MRI service was the best performing of any tertiary DHB and well above the national average (71.7% compared to 54% for the country).
3	Laboratory– Histology specimens reported within 7 days of receipt	Recent pathologist leave has affected turn-around times. One histologist role is currently vacant but recruitment continues. Performance benchmarking with other DHB services is underway.
4	Outpatient DNA rate	No concerns of note other than in Radiology where a specific IT upgrade to enable txt reminders and confirmations is due to go live in late April.
5	Output delivery against plan – FSA/ Nurse consults etc	Several specialty services have not delivered the contracted level of patient events in the visiting clinics in the four rural hospitals so far this year. Active engagement to remedy that situation is underway.
6	Output delivery against plan – inpatient cwd	YTD almost all planned patient events have occurred but only 91.4% of CWD have been earned. The funder is delighted. This is an artefact of the new WEIS method for calculating CWD that was introduced nationally on 1 July. Essentially the change means less revenue will be earned for treating the same number and type of patients as previously. These artefacts of changes in the calculation method bring periodic joy to the funder.
7	Assigned EDD – Safer	This is a new measure. The SAFER project launched in mid-August and improvements in the use of EDD are already evident.
8	Inpatient Length of Stay - As Arranged	The number of arranged admissions at Thames is so inconsequential that this KPI has no meaning.
9	Better help for smokers to quit	Improving trend. High variability due to small number variance.
10	Falls with harm	No concerns about the trend that are of note.
11	Pressure injuries	No concerns about the trend that are of note.
12	Sick leave	No concerns of note.
13	Overtime $'s	Current levels reflect staff shortages in Radiology in particular. The solution is to employ the number of staff required to staff the productive schedule. This common-sense approach is being advocated for as part of the planning for the 2018/19 year.
14	Annual leave taken	Exemplary performance relative to most industries.

MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
11 APRIL 2018

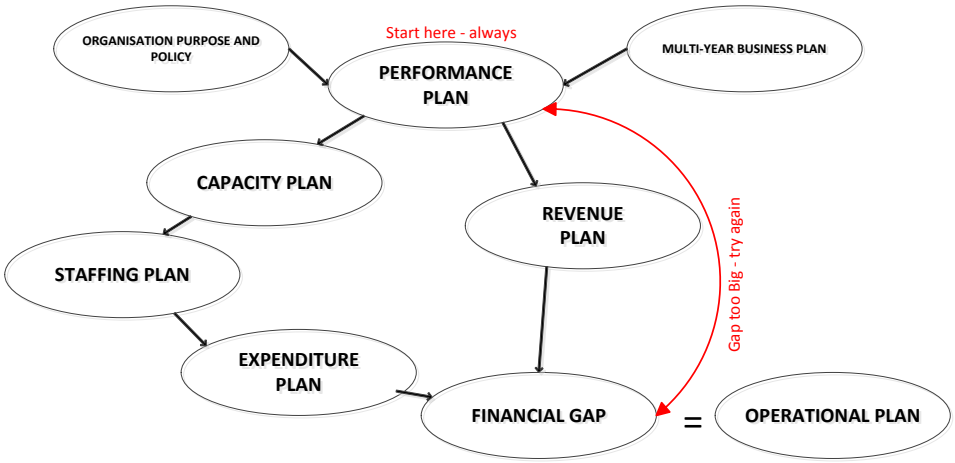
AGENDA ITEM 5.3

INTERIM CHIEF OPERATING OFFICER, WAIKATO HOSPITAL SERVICES REPORT

Purpose	1) For information

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

The Operational Plan Development Process



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.

Performance

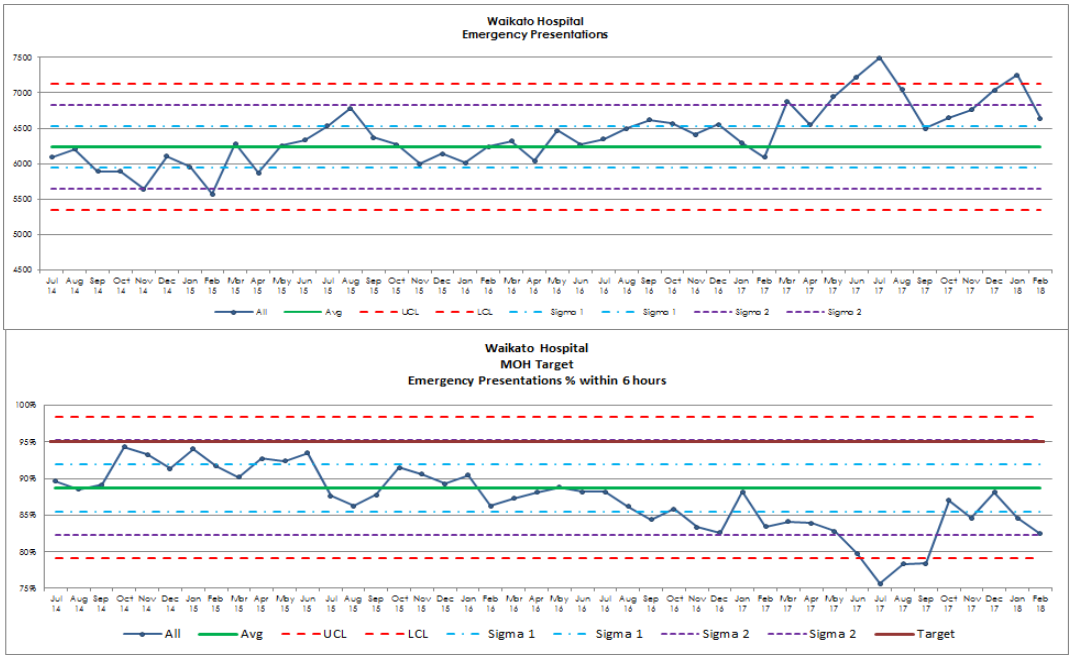
For the purposes of examining performance, Waikato Hospital Services comprise three groups, acute (rescue) services, elective services where the aim is to help people deal with long term health problems, and services that are hospital based to a greater or lesser extent, but where the service delivery is in the community or on a regional scale.

Acute Services

- Relevant performance indicators:
  - Emergency Department 6 hour target
  - Acute theatre access percent (80% in 24 hours, 100% in 48 hours)
  - Acute Coronary Syndrome pathway (diagnostic coronary angiography within 72 hrs of presentation to a medical facility in the Midland Region)

Emergency Department

Performance at Waikato Hospital against the 6 hour target was 82.4% during February, below the target of 95%. Attendance for February 2018 was 9% higher than the same time period February 2017 last year. The percentage of patients meeting the 6 hour target was lower than February 2017 (82.4% vs 83.4%)



Actions currently being taken in Waikato Hospital:

- The Francis Group have been engaged to support the patient flow process from ED to the Medical and OPR wards.
- General Medicine has moved to a ward based model of care on 26 February, with the stated aim of further enhancing patient flow on the Medical wards. Early indications are that this is having a beneficial impact on patient flow, and more timely discharges.
- The permanent opening of the OPR5 ward has enabled an improved frail elderly pathway of care and provided additional bed capacity.
- Electronic "SBARR" handover sheets to Medicine and Respiratory go live on 01st March
- Recruiting into 2 MOSS position into ED to broaden the skill mix and improve senior cover out of hours.
- GP enrolments continue to be actively promoted in the ED, through designated resource, in an attempt to reduce repeat presentations.

It should be noted that these measures, with the possible exception of the last, will not stop people attending the emergency department but relate more to organisational capability to deal with the increasing number of presentations.

Major tactical solutions are required to address the number of people presenting, and to deal with the number (and more) currently presenting. There is a paucity of these evident across New Zealand and internationally.

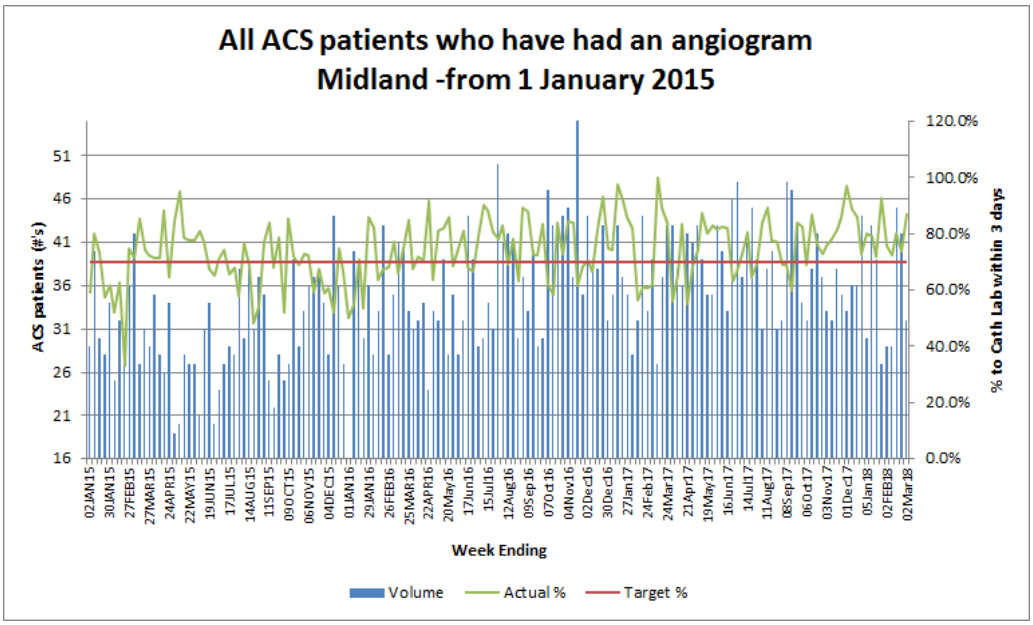
As a predictor of probable future tracking the NHS has introduced all the things we are planning to do, in fact we are planning to do them because they have worked, however there is a significant risk we are "kicking the can down the road". At present it appears the NHS as a whole is tracking at the lowest compliance rate for ED targets since 2015.

Access to Acute and Emergency Surgery

Metrics relevant to this section will be covered under the surgical reinvention project below.

ACS Target

Performance against the ACS target for all Midland patients was above the target of 70% for February with 77% of patients receiving an angiogram within the timeframe across the whole month of February.



Elective Services

- Relevant performance indicators:
  - "Quantitative" – volume of patients treated
  - "Qualitative" – ESPI framework

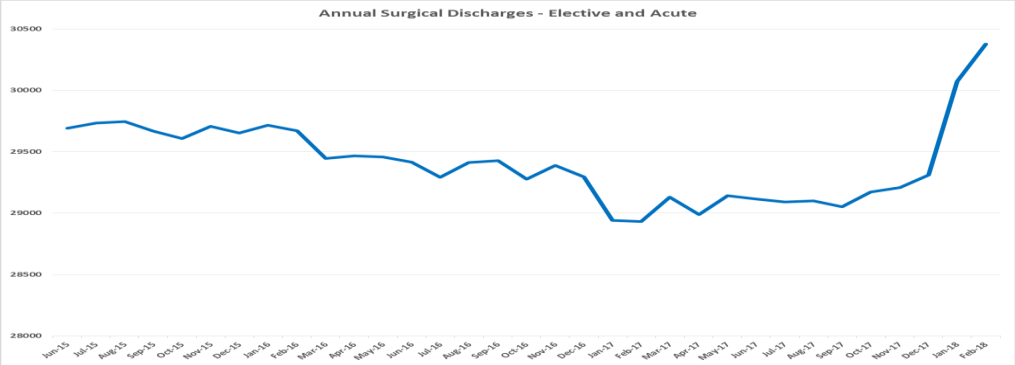
Quantitative

We remain above the volume of elective surgery agreed with the Ministry of Health, by about 4%. This is less than the trend of the last several years.

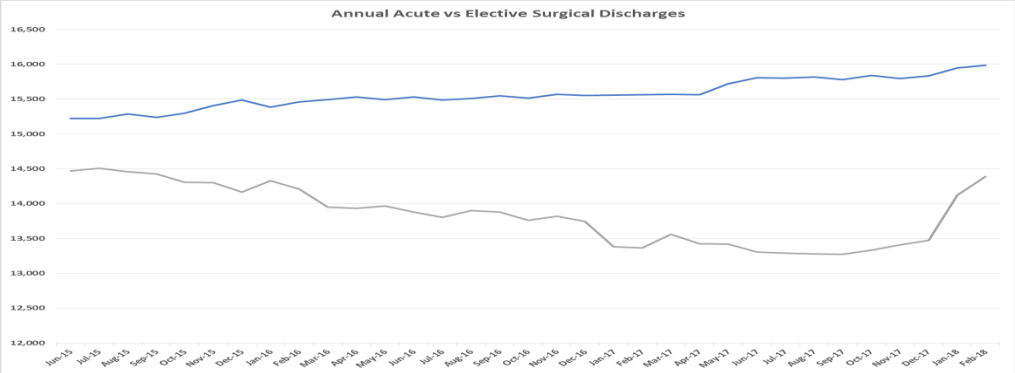
Health Waikato
Elective Health Target Performance - YTD 28 Feb 2018

PUC	Description	Actual Discharges	Health Target Discharges	%
S00001	General Surgery - Inpatient Services (DRGs)	1,446	1,541	94%
MS02016	Skin Lesion	1,331	935	142%
S05001	General Surgery Anaesthesia - Inpatient Services (DRGs)	103	93	111%
S15001	Cardiothoracic Surgery - Inpatient Services (DRGs)	123	126	98%
S25001	Otorhinolaryngology (ENT) - Inpatient Services (DRGs)	1,125	1,177	96%
S30001	Gynaecology - Inpatient Services (DRGs)	762	774	98%
S35001	Neurosurgery - Inpatient Services (DRGs)	138	120	115%
S40001	Ophthalmology - Inpatient Services (DRGs)	1,192	1,103	108%
S40007	Intraocular injections	767	981	78%
S45001	Orthopaedics - Inpatient Services (DRGs)	1,153	1,091	106%
S55001	Paediatric Surgery - Inpatient Services (DRGs)	329	346	95%
S60001	Plastic & Burns - Inpatient Services (DRGs)	1,319	1,194	110%
S70001	Urology - Inpatient Services (DRGs)	481	476	101%
S75001	Vascular Surgery - Inpatient Services (DRGs)	438	400	110%
Surgical Discharges from a Surgical PUC - Elective (Previous HT)		**10,707**	**10,357**	103.4%
	Surgical Discharges from a Surgical PUC - Arranged	826	762	108%
	Surgical Discharges from a Non-Surgical PUC - Elective	245	198	124%
	Surgical Discharges from a Non-Surgical PUC - Arranged	194	138	141%
Elective Health Target Total		**11,972**	**11,455**	104.5%

Nonetheless the total volume of surgical admission and discharges has increased significantly in tandem with the surgical reinvention project.



This composite measure is reflected in acute and elective components as follows:



There is currently a recovery in elective volumes of surgery delivered “in-house” back to the same level as 3-5 years ago while continuing to meet the rising acute demand. Assisted by the Keezz team, the focus of the surgical reinvention program is at present:

- Continuing to embed the management roles related to the adopted operating model (day surgery, elective surgery, acute surgery, cardiovascular surgery).
- Building the tools to manage these processes (16 week elective planning tool)
- Simplifying and standardising referral and outpatient aspects of elective surgical (and medical) processes.
- Adding important aspects of new models of care:
    - Surgical admission unit
    - Increased after hours acute operating capacity
    - Integrated geriatric-orthopaedic care pathways

Qualitative Measures

At the time of writing this report Waikato appeared to be non-compliant in ESPI 2 (4 months) and ESPI 5 (4 months) at the end of January 2018. This risk was escalated to the board in February in the context of the National Burns Unit relying on Waikato to treat major burns patients, and the requirement to provide outreach to other regional providers for basic acute services.

ESPI 2 and ESPI 5 are generally considered the most significant indicators for patient flow in elective services and draw penalties for non-compliance greater than 4 months.

We have confirmed with the Ministry that it is likely we will be compliant for both ESPI 2 and 5 in February 2018, this could not be confirmed beyond doubt at the time of reporting to the Board.

It is interesting to note the national ESPI dashboard as at January 2018 for comparison of Waikato against other centres.

MoH Elective Services Online

National comparison of DHBs for January 2018

	1. DHB services that appropriately acknowledge and process patient referrals within required timeframe.			2. Patients waiting longer than the required timeframe for their first specialist assessment (FSA).			3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).			5.Patients given a commitment to treatment but not treated within the required timeframe.			6. Patients in active review who have not received a clinical assessment within the last six months.			8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.		
	Level	Status %	Imp Req.	Level	Status %	Imp Req.	Level	Status %	Imp Req.	Level	Status %	Imp Req.	Level	Status %	Imp Req.	Level	Status %	Imp Req.
Auckland	31 of 33	93.9%	2	40	0.3%	-40	0	0.0%	0	412	6.9%	-412	0	0.0%	0	2051	96.4%	76
Bay of Plenty	23 of 23	100.0%	0	10	0.2%	-10	0	0.0%	0	25	0.9%	-25	0	0.0%	0	403	100.0%	0
Canterbury	28 of 28	100.0%	0	20	0.2%	-20	60	0.4%	-60	143	3.7%	-143	8	4.2%	-8	1693	99.9%	2
Capital and Coast	21 of 23	91.3%	2	5	0.1%	-5	9	0.1%	-9	15	0.6%	-15	0	0.0%	0	941	99.9%	1
Counties Manukau	20 of 20	100.0%	0	92	0.9%	-92	63	0.4%	-63	90	2.7%	-90	6	2.2%	-6	1183	99.9%	1
Hawkes Bay	6 of 17	35.3%	11	216	6.7%	-216	0	0.0%	0	84	8.0%	-84	0	0.0%	0	418	100.0%	0
Hutt Valley	16 of 16	100.0%	0	112	3.8%	-112	0	0.0%	0	89	6.5%	-89	0	0.0%	0	452	100.0%	0
Lakes	10 of 16	62.5%	6	40	1.3%	-40	1	0.0%	-1	19	2.0%	-19	0	0.0%	0	374	99.7%	1
MidCentral	23 of 23	100.0%	0	7	0.4%	-7	0	0.0%	0	529	30.7%	-529	142	45.5%	-142	0	X	0
Nelson Marlborough	14 of 21	66.7%	7	62	1.8%	-62	0	0.0%	0	152	8.0%	-152	0	0.0%	0	475	100.0%	0
Northland	13 of 15	86.7%	2	620	12.7%	-620	0	0.0%	0	478	22.9%	-478	0	0.0%	0	458	100.0%	0
South Canterbury	14 of 14	100.0%	0	9	0.6%	-9	0	0.0%	0	31	4.7%	-31	0	0.0%	0	276	100.0%	0
Southern	28 of 28	100.0%	0	223	3.5%	-223	16	0.1%	-16	405	13.8%	-405	5	21.7%	-5	1021	99.8%	2
Tairawhiti	17 of 17	100.0%	0	204	11.1%	-204	0	0.0%	0	36	8.3%	-36	0	0.0%	0	140	100.0%	0
Taranaki	20 of 21	95.2%	1	20	0.7%	-20	0	0.0%	0	22	1.9%	-22	3	23.1%	-3	441	100.0%	0
Waikato	18 of 27	66.7%	9	342	3.3%	-342	69	0.4%	-69	98	2.2%	-98	0	0.0%	0	1168	95.3%	58
Wairarapa	14 of 14	100.0%	0	68	7.0%	-68	0	0.0%	0	53	15.1%	-53	0	0.0%	0	75	100.0%	0
Waitemata	20 of 20	100.0%	0	70	0.7%	-70	0	0.0%	0	9	0.3%	-9	0	0.0%	0	1411	100.0%	0
West Coast	18 of 18	100.0%	0	109	11.1%	-109	0	0.0%	0	2	0.9%	-2	0	0.0%	0	127	100.0%	0
Whanganui	10 of 10	100.0%	0	7	0.7%	-7	0	0.0%	0	24	3.0%	-24	0	0.0%	0	271	100.0%	0
Total:				2,276			218			2,716			164			13378		

Regional and Community Based Services[1]

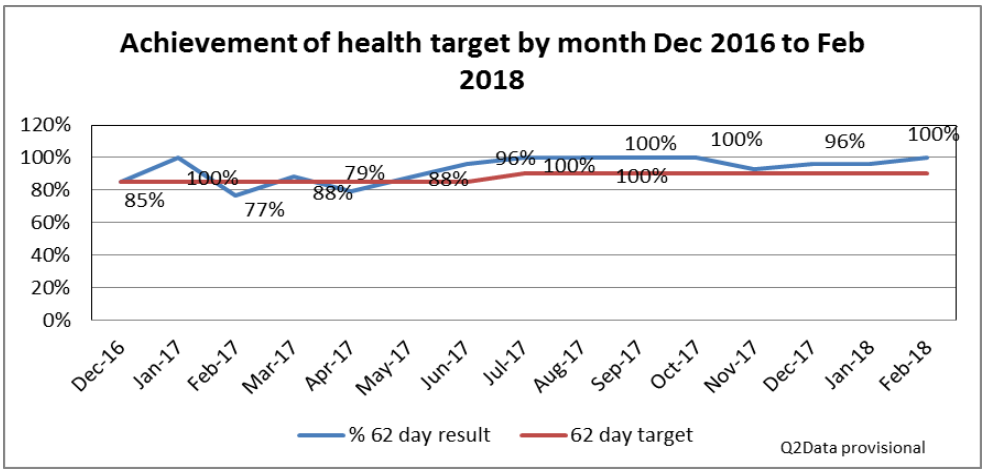
- Relevant performance indicators:
    - Faster cancer treatments

[1] Note this section currently only refers to cancer services. The intention is to broaden this set to include diabetes, renal services and other related service groups.

Waikato has continued to deliver sustained achievement against the 90% FCT health target. We are pleased to be able to report that we are currently ranked second nationally for this metric for 2017/18.

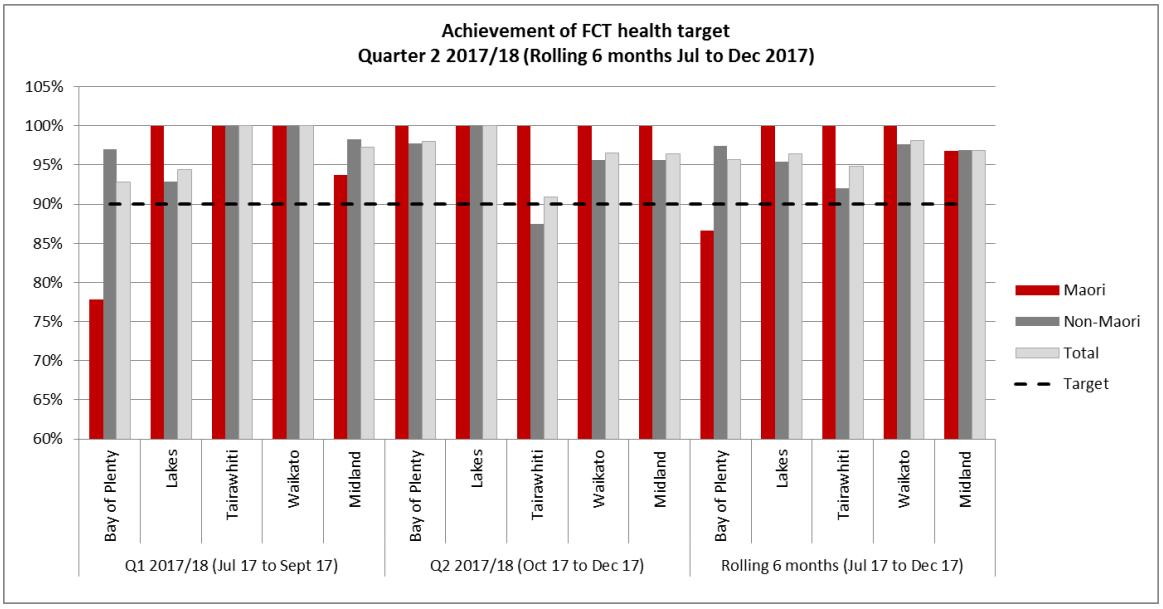
2017/18 Quarter 2 is the second quarter for achievement against the new health target of 90%, which includes the newly excluded breach reasons of patient choice and clinical considerations. Our final result of 96.6% shows that Waikato continues to strongly deliver on this key national target.

The chart below shows the historical monthly percentage performance against the target.



Addressing Inequity

Achievement against 62 day health target



All four Midland Cancer Network DHBs achieved the FCT health target for the quarter 2 reporting period of July to December 2017. The combined Midland

achievement of the health target is 96.8% (up from 94.8% for the previously reported quarter).
Performance of DHBs show improvement in reducing the equity gap. In fact, performance for October to December 2017 period shows that Māori are achieving better than non-Māori for the 62 day health target for the Midland Cancer Network DHBs. This data should be celebrated but also interpreted cautiously as it records progress following diagnosis, and may not reflect barriers to access.

Staffing and Capacity

Measures to usefully comment on capacity and staffing related issues are being developed.
At present, as at the end of February, two observations are warranted.

- The hospital group has accrued a major liability with regard annual leave earned but not taken across both medical and nursing staff groups.
- Nursing workloads remain high across the in-patient areas (wards, theatres etc.) of the hospital group.

Clinical Service Planning

Clinical Service planning has started, using the ENT service as a trial group. The purpose of this activity is to establish what each clinical group wants to do and ought to do, whether this is in line with the DHB direction, whether each clinical unit is fit for purpose, and where the DHB needs to intervene or support units that are at risk.
In turn the planning activity will inform medium and long run investment strategies.

Expenditure

- The hospital group is $1,656,154 unfavourable.
- The major unfavourable variances are in both nursing and medical groups with regard the valuation of annual leave earned but not taken ($2.3 and $2.5 million respectively).

Revenue

- The hospital group is favourable year to date in revenue earned from Waikato DHB ($7,001.012) and non-Waikato DHB sources ($1,421.954).
- For the purposes of District Health Board consideration the former number is a transfer from funder to provider arm.

Contribution

- When contribution is considered against budgeted non-DHB sourced revenue relative to actual expenditure, the hospital group is unfavourable by $234 000.
- When the full funding envelope under a funder – provider split is considered, the hospital group has made a contribution to the DHB of $111,295,221 which is favourable to budget by $6.5 million dollars.

Recommendation
THAT
The report be received.

GRANT HOWARD
INTERIM CHIEF OPERATING OFFICER, WAIKATO HOSPITAL SERVICES

Culture

MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
11 APRIL 2018

AGENDA ITEM 6.1

CULTURE

Purpose	1) For information

Organisation culture can be defined as being the way we do things and the way things work within an organisation.

Culture is a powerful driver of behaviour. Four accepted attributes of culture are;

1. Shared – a group phenomenon
2. Persuasive – permeating multiple levels
3. Enduring – directs thoughts and actions over the longer term
4. Implicit – people recognise and respond to it
   Harvard Business Review, 2018.

Organisational cultures are not fixed but have a relative fluidity. Aspects of an organisation culture can both have negative and positive consequences, an organisation culture that focusses on compliance and adherence to policy can also put up perceived barriers to innovation and change.

It should be acknowledged that a large and complex organisation such as the Waikato District Health Board is not likely to have a homogeneous defined culture. Particularly as there is still significant work to do in the transition of Waikato DHB to a values based organisation, which consistently delivers on the essential levers to sustain employee engagement.

The difficulty in moving the culture of Waikato DHB in a positive direction should not be under-estimated. Equally, a positive culture will be a significant enabler of and catalyst for achieving our strategic priorities.

In seeking to improve the organisation culture, literature would support an approach that:

- Ensures that the values of the organisation are embedded and personified from all levels of an organisation including the Board.
- Acknowledges the existing culture and seeks to build on it.
- Focuses on behaviour - ideally a few critical behaviours.
- Utilises individuals that may be in either informal or formal leadership positions.
- Links values and behaviours into business objectives and decision making.
- Facilitate and encourage programmes that are initiated and developed from the ‘shop floor.’

Measures of our current culture at Waikato DHB have included various surveys:

- Staff Culture Survey in 2015. Results of survey questions are in appendix 1.
- Values survey in 2016.
- Regular nurse surveys on wards as part of Releasing Time to Care.

Current initiatives to develop our organisation culture:

As part of the values survey, value descriptors from staff were themed to create new values, and these became part of the 2016 strategy.

The Staff Safety Culture Working Group was established in late 2013 and their work plan includes the following initiatives:

- Values sessions run since December 2016; allowing staff and managers to align personal values to the DHB values, and to share ideas for living the values every day. The ideas are themed identifying for example that recognition is something every staff member can do.
- Resources for staff safety, to mitigate or in situations of disorderly behaviour or physical assault
- A Workplace Support Person initiative; to address the concern of bullying, mostly found to be rude, discourteous uncivil behaviour.
- Workwell pilot and bronze accreditation achieved in Community and Clinical Support (CCS). Workwell is an evidenced based approach that with local leadership supports the well-being of staff.

Successes to date include traction being gained with the values being used in everyday language and The Accredited Employer Programme Audit report in September 2017, documenting the health and safety strengths and improvement initiatives including the achievement of WorkWell bronze accreditation.

Further success requires the need for ongoing resource and focus, and an efficient and consistent delivery of the values initiatives across our geographically spread and diverse 7,100 workforce.

The goal is <u>one organisational culture for all</u>, shown to exist when staff are engaged with values, they experience well-being, and are safe. An organisational culture for all in our DHB further requires:

- Visibility of the values to staff, for example modelling of the values by the Board, CE, executive group and the rest of the workforce.
- Ownership of values and culture initiatives at the individual and team level; for example again the values being enacted through everyday behavioural recognition, or conversely if a value is not modelled enabling staff to recognize and call out this behaviour.
- Constant and varied sharing and communication of positive stories, and lessons learned from areas for improvement.

Being scoped to occur in 2018 are:

- A Health Roundtable staff survey, which will provide further feedback and DHB benchmarked data regarding our culture.
- Engagement with the Cognitive Institute for a Board and Executive workshop in July 2018.
- Ongoing annual ward nursing surveys.
- Team culture checks undertaken by the People & Performance team on request.
- Pulse surveys for new starters.

Recommendation
THAT
That the Hospitals Advisory Committee endorse the Culture work occurring at Waikato DHB.

GREGORY PEPLOE, DIRECTOR PEOPLE AND PERFORMANCE
MARC TER BEEK, EXECUTIVE DIRECTOR OPERATIONS AND PERFORMANCE

Annex 1

2015 Safety Culture Working Group Survey: Questions 1 – 5

Value = number assigned to response option, Frequency = number of times response chosen, Mode= most frequently chosen response, Median = middle value i.e. 50% of chosen responses fall above this value and 50% of chosen responses fall below this value.

Question 1

How often do you get helpful information or advice?

Value Label	Value	Frequency	Percent
Not Applicable	0	4	0.2
Never	1	90	4.44
Not often	2	329	16.23
Sometimes	3	522	25.75
Often	4	558	27.53
Very often	5	517	25.51
Missing	.	7	0.35
Total		2027	100

Total valid		2020
Total missing		7
Mode		4
Percentiles	50 (Median)	4

How often do you get sympathetic understanding and concern?

Value Label	Value	Frequency	Percent
Not Applicable	0	10	0.49
Never	1	146	7.2
Not often	2	317	15.64
Sometimes	3	534	26.34
Often	4	502	24.77
Very often	5	507	25.01
Missing	.	11	0.54
Total		2027	100

Total valid		2016
Total missing		11
Mode		3
Percentiles	50 (Median)	4

How often do you get clear and helpful feedback?

Value Label	Value	Frequency	Percent
Not Applicable	0	4	0.2
Never	1	148	7.3
Not often	2	411	20.28
Sometimes	3	528	26.05
Often	4	497	24.52
Very often	5	425	20.97
Missing	.	14	0.69
Total		2027	100

Total valid		2013
Total missing		14
Mode		3
Percentiles	50 (Median)	3

How often do you get practical assistance?

Value Label	Value	Frequency	Percent
Not Applicable	0	20	0.99
Never	1	205	10.11
Not often	2	453	22.35
Sometimes	3	521	25.7
Often	4	426	21.02
Very often	5	383	18.89
Missing	.	19	0.94
Total		2027	100

Total valid		2008
Total missing		19
Mode		3
Percentiles	50 (Median)	3

Question 2

I have not felt bullied by other team members in the last 12 months.

Responses grouped into original categories			
Value Label	Frequency	Percent	Cumulative Percent
Strongly disagree	319	16.26	16.26
Somewhat disagree	385	19.62	35.88
Neither agree or disagree	157	8	43.88
Somewhat agree	338	17.23	61.11
Strongly agree	763	38.89	100
Total	1962	100	

Responses grouped into three categories			
Value Label	Frequency	Percent	Cumulative Percent
Disagree	704	35.88	35.88
Neutral	157	8	43.88
Agree	1101	56.12	100
Total	1962	100	

Question 3

Staff performance issues are identified in a timely fashion				
Value Label	Value	Frequency	Percent	Cum Percent
Strongly disagree	1	293	16.65	16.96
Somewhat disagree	2	478	27.16	44.62
Neither agree or disagree	3	392	22.27	67.3
Somewhat agree	4	453	25.74	93.52
Strongly agree	5	112	6.36	100
Total		1760	100	

Total valid		1728
Total missing		32
Mode		2
Percentiles	50 (Median)	3

Staff performance issues are resolved in a timely fashion				
Value Label	Value	Frequency	Percent	Cum Percent
Strongly disagree	1	387	21.99	22.78
Somewhat disagree	2	509	28.92	52.74
Neither agree or disagree	3	402	22.84	76.4
Somewhat agree	4	319	18.13	95.17
Strongly agree	5	82	4.66	100
Total		1760	100	

Total valid		1699
Total missing		61
Mode		2
Percentiles	50 (Median)	2

Question 4

I feel appreciated for the contribution I make				
Value Label	Value	Frequency	Percent	Cumulative Percent
Disagree	1	823	40.6	40.95
Neutral	2	295	14.55	55.62
Agree	3	892	44.01	100
Not Specified		17	0.84	
Total		2027	100	

Total valid		2010
Total missing		17
Mode		3
Percentiles	50 (Median)	2

I feel appreciated by my manager				
Value Label	Value	Frequency	Percent	Cumulative Percent
Disagree	1	655	32.31	33.1
Neutral	2	307	15.15	48.61
Agree	3	1017	50.17	100
Not Specified		48	2.37	
Total		2027	100	

Total valid		1979
Total missing		48
Mode		3
Percentiles	50 (Median)	3

I feel appreciated by my patients/clients/customers				
Value Label	Value	Frequency	Percent	Cumulative Percent
Disagree	1	131	6.46	6.66
Neutral	2	258	12.73	19.79
Agree	3	1577	77.8	100
Not Specified		61	3.01	
Total		2027	100	

Total valid		1966
Total missing		61
Mode		3
Percentiles	50 (Median)	3

I feel appreciated by my peers				
Value Label	Value	Frequency	Percent	Cumulative Percent
Disagree	1	235	11.59	11.92
Neutral	2	284	14.01	26.32
Agree	3	1453	71.68	100
Not Specified		55	2.71	
Total		2027	100	

Total valid		1972
Total missing		55
Mode		3
Percentiles	50 (Median)	3

Question 5

I believe I can have a positive influence on the culture of my workplace				
Value Label	Value	Frequency	Percent	Cum. Percent
Strongly Disagree	1	89	5.6	5.64
Somewhat Disagree	2	120	7.55	13.24
Neither Agree or Disagree	3	153	9.63	22.93
Somewhat Agree	4	666	41.91	65.1
Strongly Agree	5	551	34.68	100
Missing		10	0.63	
Total		1589	100	

Total valid		1579
Total missing		10
Mode		4
Percentile	50 (Median)	4

I am willing to have a positive influence on the culture of my workplace				
Value Label	Value	Frequency	Percent	Cum. Percent
Strongly Disagree	1	35	2.2	2.23
Somewhat Disagree	2	15	0.94	3.18
Neither Agree or	3	60	3.78	7
Somewhat Agree	4	491	30.9	38.23
Strongly Agree	5	971	61.11	100
Missing		17	1.07	
Total		1589	100	

Total valid		157
Total missing		17
Mode		5
Percentile	50 (Median)	5

Date of next meeting
13 June 2018