Waikato District Health Board

MEMORANDUM

TO: Board and Committee Members

FROM: Donna Straiton

DATE: 26 November 2018

SUBJECT: **Committee Meetings – 12 December 2018**

0830-1200:	Hospitals Advisory Committee Meeting **Venue: Board room, level 1, Hockin building**
1200-1300:	Christmas Lunch **Venue: Committee room, level 1, Hockin building**
1300-1600:	Community and Public Health Advisory Committee Meeting **Venue: Board room, level 1, Hockin building**
1600-1630:	Waikato Health Trust Meeting **Venue: Board room, level 1, Hockin building**

Hospitals Advisory Committee Agenda

Location:	Board Room Level 1 Hockin Building Waikato Hospital Pembroke Street HAMILTON		
Date:	12 December 2018	**Time:**	8.30am

Committee Members:	Ms S Christie (Chair) Ms C Beavis (Deputy Chair) Mr M Gallagher Mrs MA Gill Mr D Macpherson Dr K McClintock Ms C Rankin Dr A Rolleston Ms S Webb
In Attendance:	Mr D Wright, Interim Chief Executive Mrs V Aiken, Interim Executive Director Mental Health and Addictions Service Ms L Aydon, Executive Director Public and Organisations Affairs Mr C Cardwell, Executive Director Facilities and Business Ms L Elliot, Executive Director Maori Health Mr N Hablous, Executive Director Chief Executive Office Mrs S Hayward, Chief Nursing and Midwifery Officer Mr G Howard, Chief Operating Officer Ms T Maloney, Interim Executive Director Strategy and Funding Ms H McConnell, Deputy Chief Operating Officer/Director of Community Services and Clinical Support Ms M Neville, Director Quality and Patient Safety Dr G Hopgood, Chief Medical Officer Mr M ter Beek, Executive Director Operations and Performance Dr D Tomic, Clinical Director Primary and Integrated Care Ms C Tahu, Chief Advisor, Allied and Technical Minute Secretary Board Records Mrs Barb Garbutt, Director - Medicine, Older Persons rehabilitation and Allied Health Mr Alex Gordon, Director, Ambulatory, Cancer and Regional Services, Waikato Hospital Services Ms Riana Manuel, Chief Executive, Te Korowai Hauora o Hauraki Ms Shona Duxfield, Manager, Screening Services

Next Meeting Date:	13 February 2019

Hospitals Advisory Committee Agenda

Contact Details:	Phone: 07 834 3622	Facsimile: 07 839 8680

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Item

1. Apologies

2. **INTERESTS**

2.1 Schedule of Interests
2.2 Conflicts Related to Items on the Agenda

3. **MINUTES AND BOARD MATTERS**

3.1 Hospitals Advisory Committee Minutes, 8 August 2018
3.2 Bay of Plenty DHB Hospital Advisory Committee Minutes, 7 November 2018
3.3 Lakes DHB Hospital Advisory Committee Minutes, 26 November 2018

4. **QUALITY AND PATIENT SAFETY**

4.1 Health and Disability Commissioner Complaint Report Jan-June 2018
4.2 Learning from adverse events 2017/18

5. **RURAL AND COMMUNITY SERVICES**

5.1 Renal Services

5.2 Rural and Community Services Update

5.3 Thames/Te Korowai Hauora o Hauraki - Presentation

5.4 Maori Access Change Project

5.5 Screening

5.6 START

6. **NEXT MEETING: 13 February 2019**

Apologies

Interests

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

Sally Christie

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

Crystal Beavis

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

Sally Webb

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

Note 1: Interests listed in every agenda.

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

Martin Gallagher

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Board member, Waikato DHB	Non-Pecuniary	None	Refer Notes 1 and 2
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Audit & Corporate Risk Management Committee, Waikato DHB	Non-Pecuniary	None	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Deputy Mayor, Hamilton City Council	Pecuniary	Perceived	
Board member Parent to Parent NZ (Inc), also provider of the Altogether Autism service	Pecuniary	Potential	
Trustee, Waikato Community Broadcasters Charitable Trust	Non-Pecuniary	Perceived	
Wife employed by Wintec (contracts with Waikato DHB)	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	
Member, Chief Executive Performance Review Committee, Waikato DHB	Non-Pecuniary	None	
Employee, Life Unlimited Charitable Trust	Pecuniary	Perceived	
Member, Public Health Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Member, Disability Support Advisory Committee, Bay of Plenty DHB	Pecuniary	Potential	
Member, Health Strategic Committee, Bay of Plenty DHB	Pecuniary	Potential	

Dave Macpherson

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

Note 1: Interests listed in every agenda.

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

Dr Kahu McClintock

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

Christine Rankin

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

Ron Scott

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Hospitals Advisory Committee, Waikato DHB	Pecuniary	Potential	
Deputy Chair and Board member, Bay of Plenty DHB		None	
Chair, SILC Charitable Trust		None	
Member, Bay of Plenty Region Council of AA		None	
Director, Stellaris Ltd		None	
Director, Stellaris PPE Ltd		None	

Dr Paul Malpass

Interest	Nature of Interest *(Pecuniary/Non-Pecuniary)*	Type of Conflict *(Actual/Potential/Perceived/None)*	Mitigating Actions *(Agreed approach to manage Risks)*
Member, Hospitals Advisory Committee, Waikato DHB	Non-Pecuniary	None	
Member, Consumer Council, Waikato DHB	Non-Pecuniary	None	
Fellow, Australasian College of Surgeons	Non-Pecuniary	None	
Fellow, New Zealand College of Public Health Medicine	Non-Pecuniary	None	
Trustee, CP and DB Malpass Family Trust	Non-Pecuniary	None	
Eldest Son employed by Bayer Pharmaceuticals	Non-Pecuniary	None	
Eldest Daughter registered nurse employed by Tuwharetoa Health	Non-Pecuniary	None	
Youngest Daughter employed by Access Community Health	Non-Pecuniary	None	

Note 1: Interests listed in every agenda.
Note 2: Members required to detail any conflicts applicable to each meeting.

Fungai Mhlanga

Interest	**Nature of Interest** *(Pecuniary/Non-Pecuniary)*	**Type of Conflict** *(Actual/Potential/Perceived/None)*	**Mitigating Actions** *(Agreed approach to manage Risks)*
Member, Community and Public Health Advisory Committee, Waikato DHB **Employee, Hamilton City Council** **Member, Public Health Association** **Board member, Waikato Family Services Trust (WFST)** **Committee member, Ethnic Communities Development Fund (ECDF) Allocation**	Non-Pecuniary	None	Refer Notes 1 and 2

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

WAIKATO DISTRICT HEALTH BOARD
Minutes of the Hospitals Advisory Committee Meeting
Held on Wednesday 08 August 2018
Commencing at 8.30am

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

In Attendance:
Dr C Wade, Board member
Dr P Malpass, Consumer Council member
Dr R Tapsell, Director, Clinical Services, Mental Health
Ms V Aitken, Interim Executive Director, Mental Health Services
Dr G Howard, Interim Chief Operating Officer, Waikato Hospital
Ms L Aydon, Executive Director, Public and Organisational Affairs
Mr N Hablous, Executive Director, Office of the Chief Executive
Mr M ter Beek, Chief Data Officer
Mr D Nicholson, Operations Director, Surgery and Cardiovascular
Mr R Carpinter, Operations Manager, Waikato ISR (Integrated Safety Response)

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

ITEM 1: APOLOGIES

The Hospitals Advisory Committee (HAC) Chair welcomed Mr Rod Carpinter, Operations Manager, Waikato ISR (Integrated Safety Response) and received Ms S Webb who was attending via teleconference.

- No apologies noted.

ITEM 2: INTERESTS

2.1 Schedule of Interests

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

ITEM 3: MINUTES AND BOARD Matters

3.1 Hospitals Advisory Committee Minutes: 13 June 2018

Resolved
THAT
The Hospitals Advisory Committee meeting minutes on 13 June 2018 confirmed as true and correct.

3.2 Matters Arising

Deputy Chair, Ms C Beavis presented *Our Values* story based on "Respect".

Main points presented:

- Give and earn respect - Whakamana
- When staff feel respected they demonstrate an engaged commitment.

Ms S Webb commended Ms C Beavis on the presentation which was well received by the Committee members.

ITEM 4: SERVICES

4.1 Executive Director (Interim) Mental Health and Addictions Services, State of the Nation Presentation

Ms Vicki Aitken, Executive Director (Interim) Mental Health and Additions, led the presentation 'How do we measure up in Mental Health and Addictions'.

Main points presented:

The presentation was in response to the Mental Health Commissioner's recently published "State of The Nation report on New Zealand's Mental Health and Addictions Services" (May 2018) focusing on Safety, Access, Experience, Equity, Effectiveness and Efficiency.

The Waikato DHB Mental Health and Addictions Services perspective across these domains was presented, noting there are clearly a number of challenges to be addressed locally, but Waikato is generally consistent with national trends.

This with the exclusion of access rates, which are slightly higher than overall population access rates.

Specific discussion points included:

- Equity for Maori and non-Maori, reflecting the demographic and population of the Waikato region.

- Impacts of prison locations and forensic psychiatric services that are again, linked to the region.
- Areas of concern across all services
- What are services doing to address these issues.

The presentation was well received and members of the Committee thanked the presenter for providing an appraisal of the current state of Mental Health and Addictions Service and additional context for the planned programme of change and building.

Resolved
THAT
The Committee received the presentation

4.2 Integrated Safety Response (ISR) Presentation

Rod Carpinter, Operations Manager of the Waikato Integrated Safety Response (ISR) initiative presented to the Committee members on the Waikato ISR Pilot "Making Waikato Whanau Safer Together through High Trust Relationships".

Main points of the presentation included:

Overview and context of the ISR pilot and the issues it is intended to address along with the partnership approach undertaken to respond to the increasing levels of family violence in New Zealand. Specifically collaborative partnerships with iwi, NGOs (non-government organisations) and key government agencies.

Noting that victims are likely to seek help through mental health, emergency department, primary care and other specialty services, the importance of health in the partnership was emphasized.

Through discussion it was also noted that long term success of the pilot would be demonstrated through minimized harm to family and whanau, healthy family and whanau relationships, increased awareness and decreased tolerance towards family harm, and New Zealanders motivated and supported to act on concerns.

The Committee received the presentation and Ms Sally Webb thanked Mr R Carpinter for his presentation.

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Resolved
THAT
The Committee noted the presentation.

4.3 Mental Health and Addictions Services Performance Report (June 2018). Report prepared by Ms V Aitken, Executive Director (Interim), Mental Health and Addictions Service.

Resolved
THAT

The Committee received the report

4.4 Site Visit – Henry Rongomau Bennett Centre (Committee Members only)

Committee members Ms S Christie, Ms C Beavis, Mr R Scott and Mr P Malpass along with executives, Dr R Tapsell, Ms V Aitken, Dr G Howard, Mr D Nicholson, Ms S Pinny (minute secretary) attended a site visit to Henry Rongomau Bennett Centre which included access to wards 34, 35, 36 and the Puwawai: Regional Forensic Psychiatric Service wards.

ITEM 8: NEXT MEETING: 10 October 2018

Minutes

Bay of Plenty Hospital Advisory Committee

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

Committee: Geoff Esterman (Chair), Ron Scott, Sally Webb, Peter Nicholl, Matua Parkinson, Clyde Wade (Waikato DHB Rep) and Lyall Thurston (Lakes DHB Rep)

Attendees: Bronwyn Anstis (Acting Chief Operating Officer), Julie Robinson (Director of Nursing), Hugh Lees (Chief Medical Advisor), Debbie Brown (Senior Advisor, Governance & Quality), Martin Chadwick (Director Allied Health, Scientific and Technical),

Item No.	Item	Action
1	**Karakia** The meeting opened with a karakia.	
2	**Apologies** An apology was received from Yvonne Boyes **Resolved** that the apology from Y Boyes be accepted. Moved: C Wade Seconded: R Scott	
3	**Presentations** Nil	
4	**Minutes** BOPHAC Meeting – 1.8.18 **Resolved** that the minutes of the meeting held on 1 August 2018 be confirmed as a true and correct record. Moved: M Parkinson Seconded: P Nicholl	
5	**Matters Arising** As per report circulated with the agenda. Query was raised on LMCs regarding Christmas Leave and whether contracts require LMCs to provide services. DON advised that the DHB does not have control over LMC contracts. The Committee considered the issue should be raised with MOH. Advice was given that there are several groups working at National level to work through the issue.	

Item No.	Item	Action
	Matter Arising from Board Meeting 15.10.18 *Lakes DHB Reciprocal HAC member*. A request had been made as to whether a BOPDHB BOPHAC member would be better suited to attend. P Nicholl advised that he would like to attend as BOPDHB representative. Board Chair advised Midland Board Development days in December would be discussing reciprocal committee arrangements. **Resolved** that the Committee recommend to the Board that P Nicholl be put forward as BOPDHB's representative to Lakes DHB HAC. Moved: R Scott Seconded: M Parkinson	
6	**Reports requiring decision** 6.1 Acting Chief Operating Officer's Report Acting Chief Operating Officer highlighted the following: *Preschool Oral Health* – very successful. 95%. The Committee congratulated the success of enrolments. Treatment following enrolment was queried. It is indicated that a further 6.0 FTE is required to treat. Acting COO advised there is a business case being prepared. *Allied Health working with Orthopaedic teams*. Proactive and working well. *CCDM core data* – A member queried whether there was a slip into understaffing. DON advised that the report was correct. Resources had not met acuity. The late start to Winter had put pressure on services. *Faster Cancer Treatment* – Ethnicity not reported on this month, however the 62 day target is better for Maori than non Maori. *Elective Services and pathways*. Dir AH advised of patients being brought in for example, on an Orthopaedic pathway which then follows an Orthopaedic process which may not always be appropriate. There are options for intervention. *National Air Ambulance*. Lakes DHB has lost its air ambulance as from 1 November. Lakes DHB representative gave background. Lakes will rely on BOP and Waikato DHB. *MRI* - Discussion was had regarding engagement with clinicians on demand and whether MRIs should be carried out on particularly conditions. It was considered that the matter fits with Clinical Governance. *Whk Acute flow*. A significant piece of work which has saved 1100 bed days over 8 months.	

Item No.	Item	Action
	Resolved that the Committee receive the Acting Chief Operator's report. Moved: S Webb Seconded: C Wade	
7	**Matters for Noting** 7.1 Work Plan	
7	**General Business** There was no general business	
8	**Resolution to Exclude the Public** **Resolved** that Pursuant to S9 of the Official Information Act 1982 and Schedule 3, Clause 33 of the New Zealand Health and Disability Act 2000 the public be excluded from the following portions of the meeting because public release of the contents of the reports is likely to affect the privacy of a natural person or unreasonably prejudice the commercial position of the organisation: Confidential Minutes of last meeting Health Round table Reports CCDM ADON That the following persons be permitted to remain at this meeting, after the public have been excluded, because of their knowledge as to organisational matters or for the purpose of legal records. This knowledge will be of assistance in relation to the matter to be discussed: Martin Chadwick Bronwyn Anstis Debbie Brown Julie Robinson Hugh Lees **Resolved** that the Board move into confidential. Moved: G Esterman Seconded: S Webb	
9	**Next Meeting -** Wednesday 6 March 2019	

The open section of the meeting closed at 11.00 am
The minutes will be confirmed as a true and correct record at the next meeting.

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

Meeting: **[161]**

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

In Attendance: D Epp, S Burns, R Dunham, N Saville-Wood, Dr S Kletchko, A Mountfort, S Wilkie, G Fannin, G Lees, K Evison, presenter Yvonne Rogers and B E Harris (Board Secretariat)

161.10 MEETING CONDUCT

The Chair welcomed everyone to the meeting and asked A Morrison to lead the opening karakia.

161.11 Apologies: *(Agenda Item 1.1)* : J Horton
Resolution:
THAT the apology be accepted.
J Morreau : L Rickard
CARRIED

161.12 Schedule of Interests Register *(Agenda Item 1.2)*
The Interest Register was circulated during the meeting with no entries made.

161.13 Conflict of interest relating to agenda items *(Agenda Item 1.3)* : Nil

161.14 General Business *(Agenda Item 1.4)* : Nil

161.15 Presentation by Yvonne Rogers on Bowel Screening Promotion and Outreach

The presentation by Yvonne covered:-

- Why NZ needs a National Bowel Screening Programme
- National Bowel Screening Programme
- Participant pathway
- Who should not do the bowel screening test
- Health promotion and Outreach for Lakes NBSP
- Engagements
- Community Events/Engagement
- Reducing the risk
- Opportunistic value
- Outreach – Improving Maori Health Outcomes
- Lakes DHB – Projections
- Reporting and Monitoring

From discussion following the presentation, it was noted that:-

- Midland DHBs have a special group to look at "why start at 60 years and not earlier"
- Biggest issue is to encourage population in the scope to take part
- With priority population, if birthday is on an odd number, person can request a kit themselves
- Postage of letters is a major concern due to people being transient
- Resource and delivery is a risk – delivery February 2019

J Morreau stated that Y Rogers is the right person for the Bowel Screening programme and D Shaw liked the work being done around the wider environment of other cancers. The meeting

thanked Y Rogers for her excellent presentation.

161.20 SIGNIFICANT ISSUES

161.30 CHIEF OPERATING OFFICER

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

161.31.1 Chief Operating Officer monthly report : October 2018 *(Agenda Item 3.1.1)*

161.31.2 Balanced Scorecard : October 2018 *(Agenda Item 3.1.2)*

N Saville-Wood highlighted the following points:-

- Acknowledged and thanked Greg Vandergroot for standing in for him whilst he was on holiday
- Rotorua Hospital complex cases – acute complexity appears to have increased by 4.5% over the seven years being reviewed
- Electives have shown a slight reduction probably due to introduction of Paed Surg from 13/14 which have shown lower complexity cases
- Level of ICU bed utilisation has indicated a steady increase over a five year period
- Financial position – despite inpatient volumes being 2.6% higher than contracted, the Provider's financial position is only ($11k) worse than budget as at end October 2018 – 4% worse than budget
- Advisory Board session with Service Managers – Dan Dellaferrera presented a session on Proactive Patient Flows outlining the need for more proactive discharge management
- Introduced flow manager in ED to assist with resolving flow issues
- Lakes DHB has the lowest LOS in the country
- Commissioning of two new DR Mobile x-ray units and new Digital Radiography x-ray room
- Go live of the new RIWS/PACs system with few teething problems – running on new system
- Smoking cessation down by 14% - not at front of mind for months but setting up a referral service

M Gallagher expressed his gratitude of the arranged visit organised for him to the Taupo Hospital recently. He was very impressed with the running of the Taupo Hospital and the work of its Site Manager.

Resolution:

THAT the Chief Operating Officer's report for the month of October be received including the Balanced Scorecard.

M Gallagher/D Shaw

CARRIED

161.40 REPORTS

161.41 Performance Monitoring : Finance & Audit 31st October 2018 *(Agenda Item 4.1)*

A Mountfort briefed members on the following:-

- HSSS ($70k) negative to budget
- Year to Date variance ($11k)
- Revenue variance MTD ($149k)
- Overall Personnel costs variance MTD $202k positive
- Medical staff $202k partially offset by outsourcing (locums)
- Nursing staff positive $33k
- Allied health staff variance $73k
- Medical locums ($162k) over budget – other categories are close to budget
- Pharmaceuticals variance ($157k)

Resolution:

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

L Thurston : D Shaw

CARRIED

161.42 Maori Health report *(Agenda Item 4.2)*

This report was also placed before the Board meeting of 16th November 2018

Resolution:

THAT the Maori Health report be received.
A Morrison : D Shaw
CARRIED

161.50 SECRETARIAL

161.51 Public minutes of Hospital Advisory Committee meeting held 24th September 2018 *(Agenda Item 5.1)*
Resolution:
THAT the public minutes of the previous Hospital Advisory Committee meeting held 24th September 2018 be confirmed as a true and accurate record.
A Morison : J Morreau
CARRIED

161.52 Matters Arising *(Agenda Item 5.2)* : Nil

161.53 Schedule of Tasks *(Agenda Item 5.3)* – All tasks completed

161.54 Copy of Taupo Hospital presentation slides by Angela Guy, Taupo Site Manager : Noted

161.60 INFORMATION AND CORRESPONDENCE *(Agenda Item 6.0)*

161.61 Draft Bay of Plenty DHB Hospital Advisory Committee Minutes 1st August 2018
Resolution:
THAT the draft Bay of Plenty DHB Hospital Advisory Committee Minutes 1st August 2018 be received.
L Thurston : C Rankin
CARRIED

M Gallagher advised:-

- All Board members from Waikato DHB are intimately involved in the CE process of appointment
- Replacement of Henry Rongomai Bennett Cente and what it means?
- Sally Webb appointed as new Chair
- Margaret Wilson appointed Deputy Chair

The Chair reported that Marion Guy was no longer available to attend the HAC meetings and that Peter Nicholl has been put forward as her replacement. The Secretariat will be advised formally in due course.

161.62 Lakes DHB Sustainability Initiatives
The overall aim of the Sustainability Committee is to foster a culture of sustainability and encourage leadership in sustainability throughout the organisation. Focus is on minimising our carbon footprint in terms of energy use and vehicular transport, purchase whenever possible environmentally friendly products from sustainable sources and promoting health through exercise, clean air and fresh food communally grown and distributed.

J Morreau enjoyed reading this report, requesting that the momentum continue.
Resolution:
THAT the report be received.
L Thurston : J Morreau
CARRIED

161.63 Letter 26.9.18 of acknowledgement to Dr Ulrike Buehner
161.64 Letter 25.9.18 to Mr David Trewavas, Mayor of Taupo District Council re fundraising for Echocardiogram Machine
161.65 Letter 26.9.18 of congratulations to Anupam Modi, Chair Lakes FCT Work Group
The Chair stated that the letters of acknowledgement and congratulations were well received by staff.

C Rankin also confirmed that the Taupo Hospital presentation by Site Manager, Angela Guy was to take place on 27th November 2018 at the Taupo District Council and Taupo District Community

Health Forum.
Resolution:
THAT the outward letters be approved.
L Thurston : C Rankin
CARRIED

161.66 The Advisory Board presentation to Service Managers on Proactive Patient Flows (presented 12.10.18) : For information

161.67 Faster Care Treatment Lakes DHB Key Performance Indicators 2018/19 Q1
The meeting noted:-

- The KPI information came from the Ministry of Health
- The Lakes DHB team is pushing and managing to get good results
- An excellent presentation on lung cancer - clinicians believed it to be useful re inequities. Suggestion made that the presentation be given to HAC next year some time
- Midland DHBs carry out equity reporting

Resolution:
THAT the above report be received.
L Thurston : D Shaw
CARRIED

161.68 Community representative reports *(Agenda Item 6.1.3)*
Lydia Rickard
TRHOTA had an excellent evening on 16th November 2018 at the signing ceremony for the MoU and had positive feelings with the Board relationship. D Shaw was impressed with the mana of the occasion and the warm hospitality received.

161.70 PUBLIC EXCLUDED
Resolution:
THAT the meeting move into Public Excluded at approximately 11.10am
L Thurston : D Shaw
CARRIED

…….. 25th February 2019
Lyall Thurston QSO JP Chair

LAKES DISTRICT HEALTH BOARD

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

Agenda Item	Action	Responsibility of	Timeframe
Presentations:			
1. Faster Care Treatment Lakes DHB Key Performance Indicators 2018/19 Q1 *(Minutes 26.11.18 Item 161.67)*	Suggestion made that the presentation on lung cancer be given to HAC next year some time	N Saville-Wood	2019
Tasks			
1.			
2.			
3.			

REPORT TO HOSPITALS ADVISORY GROUP

Health and Disability Commissioner Complaint Report Jan-June 2018

Purpose of the Report

The Health and Disability Commissioner's office (HDC) completes a six-monthly report of all complaints received by the HDC, outlining the trends.

These are some of the key findings for complaints received in the first six months of 2018.

Key Points or Issues

- The Commissioner has emphasized unexpected treatment outcomes, the lack of systematic follow-up of test results, and inadequacies in electronic systems as current national areas of concern
- The rate of complaints per 1000 discharges is 50.4 for Waikato DHB, compared to 94.74 nationally. This is the lowest rate of complaints for Waikato DHB in 5 years
- The 3 top issues are:
    - Delay in treatment
    - Waiting lists/prioritisation issues
    - Failure to communicate openly/honestly/effectively
- Of the 41 complaint outcomes in this 6 month period, there was 1 breach finding for Waikato DHB

Actions required by Executive Group

- Note the findings; more detail attached
- Share with your direct reports as appropriate

Mo Neville
Director – Quality and Patient Safety
06.11.2018

Subject: Health and Disability Commissioner Complaint Report Jan-June 2018

The Health and Disability Commissioner's office (HDC) completes a six-monthly report of all complaints received by the HDC, outlining the trends. The national results will be published on the HDC's website on 29th October, 2018.

The Commissioner has emphasized unexpected treatment outcomes, the lack of systematic follow-up of test results, and inadequacies in electronic systems as current areas of concern.

These are some of the key findings for complaints received in the first six months of 2018.

Number of complaints

(Jan-June 2018)	Nationally (all DHBs)	Waikato DHB
Rate of complaints per 1000 discharges	94.74	50.4
Number of complaints received	452	24

This rate is down from an average of 81.08 over the last 4 report periods. While 50.4 is the 2nd lowest rate across all DHBs, the Commissioner is quick to point out how much this can vary from report to report, given the relatively small numbers. However it is a considerable improvement from 9th in the rankings, and is the lowest rate for Waikato DHB in the last 5 years.

Primary issues

The primary issues raised by complainants were:

Category		Largest sub-category
Care/Treatment	41.7%	*Delay in treatment*
Access/funding	20.8%	*Waiting list/prioritisation issues*
Communication	16.7%	*Failure to communicate openly/honestly/effectively*

This result is echoed in the general complaints received, where at least 75 complaints so far this calendar year refer to perceived delays in treatment[1]

Services complained about

[Note that the number of services complained about does not match the number of complaints, as some complaints refer to more than one service.]

[1] Headings in Datix do not directly match those used by HDC, so complaints coded as "Unacceptable time to wait for appointment", "Length of time to be seen in different departments" and "Delay in admission" are included here.

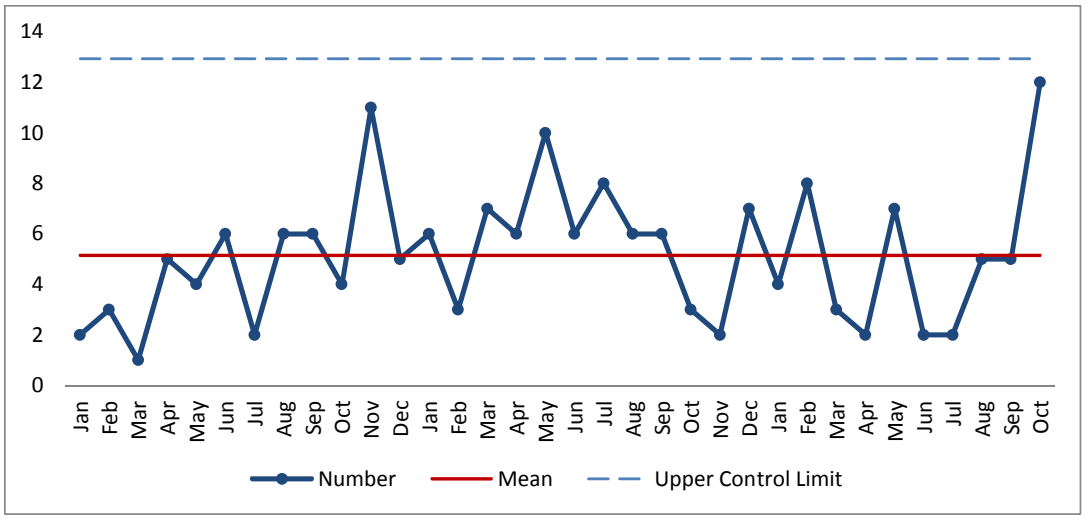
Department/facility subject to complaint	Number of complaints
Thames Hospital	***2***
Emergency department	**2**
Tokoroa Hospital	***1***
Emergency department	**1**
Waikato Hospital	***21***
Diagnostics	**1**
Emergency department	**1**
General medicine	**6**
Cardiology	1
Geriatric medicine	1
Neurology	1
Respiratory	1
Other/unknown	2
Intensive care/critical care	**1**
Maternity	**2**
Surgery	**10**
General	3
Ophthalmology	1
Orthopaedics	4
Plastic and reconstructive	1
Urology	1
Not specified	***1***

Outcomes of complaints

The outcomes for complaints closed in the six month period are:

Outcome for Waikato DHB	Number of complaints
Investigation	***5***
Breach finding	1
No further action with follow-up or educational comment	3
No breach finding	1
Other resolution following assessment	***36***
No further action with follow-up or educational comment	9
Referred to DHB	8
Referred to Advocacy	3
No further action	15
Withdrawn	1
TOTAL	**41**

While the number of Health & Disability Commissioner complaints received was relatively low for the first six months of 2018, this is within the normative range.



(Jan 2016 – October 2018)

Complaints to the Health and Disability Commissioner involving District Health Boards

Report and Analysis for the Period 1 January to 30 June 2018

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Feedback
We welcome your feedback on this report. Please contact Natasha Davidson at hdc@hdc.org.nz

Authors
This report was prepared by Natasha Davidson (Senior Advisor – Research and Education).

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PO Box 1791, Auckland 1140

This report is available on our website at www.hdc.org.nz

Contents

Commissioner's Foreword

I am pleased to present you with HDC's second six monthly DHB complaint report for the 2017/2018 year.

The trends in complaints about DHBs in January to June 2018 have remained broadly consistent with previous periods. Surgery, mental health and general medicine have remained the most commonly complained about service types at DHBs, and misdiagnosis was again the most commonly complained about primary issue. However, complaints regarding an unexpected treatment outcome became more prominent in January to June 2018, with this issue increasing from being the primary issue in around 8% of DHB complaints in previous periods to 12% in January to June 2018. This issue often relates to post-surgical complications, and can sometimes reflect the quality of information provided to the consumer around the risks and possible complications of surgery.

Over the last year, I have noted that inadequate follow-up of test result has been a feature of a number of investigations closed by this Office about DHBs[1]. These cases are often contributed to by the lack of a clear, effective formalised system for the reporting and follow-up of test results. It is important that DHBs communicate their expectations around test result follow-up to staff clearly and that systems have a number of defences built into them to ensure that test results are actioned in a timely manner. Another issue I often see in these cases are inadequacies in electronic systems, including:

- incomplete rollout of electronic systems;
- lack of appropriate safeguards built into such systems;
- lack of clarity in policies and procedures around their use; and
- staff not being trained/competent in the use of electronic systems.

While I support the introduction of digital systems, it is important that these systems are fit-for purpose and the roll out and use of such systems are well planned, well designed, and subject to close scrutiny. Providers need to be trained appropriately on the use of these tools to ensure that they make the best use of the safety features and DHBs need to make their expectations regarding the use of such systems clear.

Anthony Hill
Health and Disability Commissioner

[1] 17HDC00316, 16HDC01980, 15HDC01289, 15HDC01204

National Data for all District Health Boards

1.0 Number of complaints received

1.1 Raw number of complaints received

In the period Jan–Jun 2018, HDC received a total of **450**[2] complaints about care provided by District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

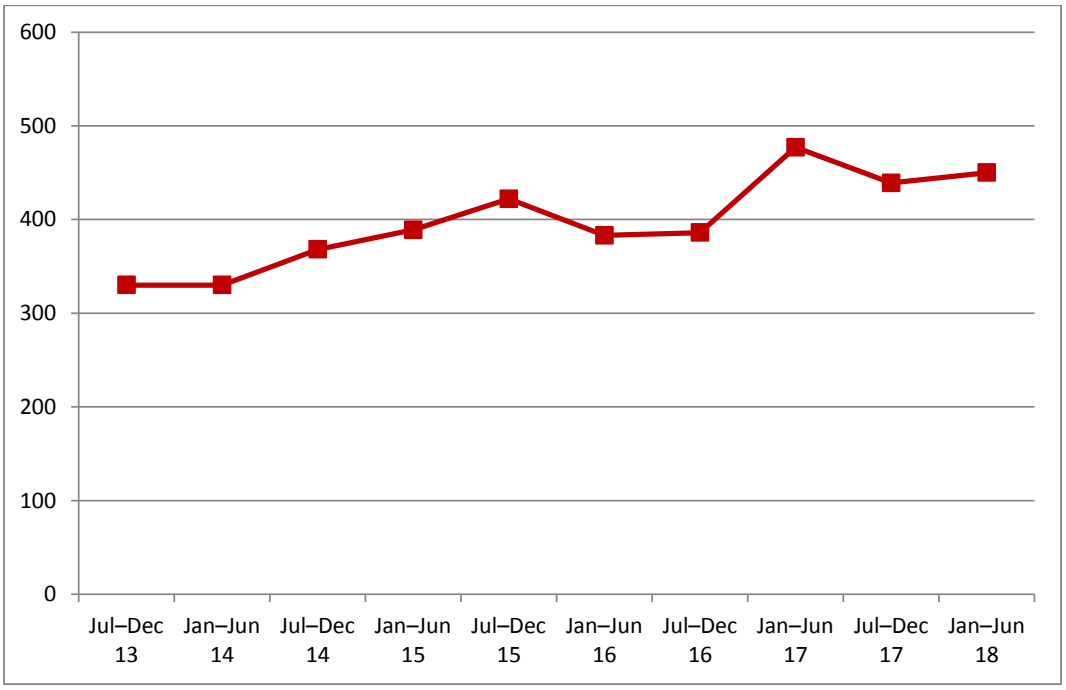
Table 1. Number of complaints received in the last five years

	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17	Average of last 4 6-month periods	Jan–Jun 18
Number of complaints	330	330	368	389	422	383	386	477	439	**421**	**450**

The total number of complaints received in Jan–Jun 2018 (450) shows an increase of 7% over the average number of complaints received in the previous four periods.

The number of complaints received in Jan–Jun 2018 and previous six-month periods are also displayed below in Figure 1.

Figure 1. Number of complaints received



[2] Provisional as of date of extraction (14 August 2018).

1.2 Rate of complaints received

When numbers of complaints to HDC are expressed as a rate per 100,000 discharges, comparisons can be made between DHBs, and within DHBs over time, enabling any trends to be observed.

Rate of complaints calculations are made using discharge data provided by the Ministry of Health. This data is provisional as at the date of extraction (14 September 2018) and is likely incomplete; it will be updated in the next six-monthly report. It should be noted that this discharge data excludes short-stay emergency department discharges and patients attending outpatient clinics.

Table 2. Rate of complaints received per 100,000 discharges during Jan–Jun 2018

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
450	477,118	**94.32**

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jan–Jun 2018 and previous six-month periods.

Table 3. Rate of complaints received in last five years

	Jul–Dec 13	Jan–Jun 14	Jul–Dec 14	Jan–Jun 15	Jul–Dec 15	Jan–Jun 16	Jul–Dec 16	Jan–Jun 17	Jul–Dec 17[3]	Average of last 4 6-month periods	Jan–Jun 18
Rate per 100,000 discharges	71.15	72.99	76.65	84.60	87.57	81.44	78.79	99.08	88.23	**86.89**	**94.32**

The rate of complaints received during Jan–Jun 2018 (94.32) shows a 9% increase over the average rate of complaints received for the previous four periods.

Table 4 shows the number and rate of complaints received by HDC for each DHB.[4]

[3] The rate for Jul–Dec 2017 has been recalculated based on the most recent discharge data.

[4] Please note that some complaints will involve more than one DHB, and therefore the total number of complaints received for each DHB will be larger than the number of complaints received about care provided by DHBs.

Table 4. Number and rate of complaints received for each DHB in Jan-Jun 2018

DHB	Number of complaints received	Number of discharges	Rate of complaints to HDC per 100,000 discharges
Auckland	67	60164	111.36
Bay of Plenty	23	25664	89.62
Canterbury	51	56445	90.35
Capital and Coast	45	29386	153.13
Counties Manukau	43	50666	84.87
Hawke's Bay	17	17390	97.76
Hutt Valley	16	15888	100.70
Lakes	13	11491	113.13
MidCentral	13	15013	86.59
Nelson Marlborough	13	9561	135.97
Northland	15	20635	72.69
South Canterbury	2	5935	33.70
Southern	36	26806	134.3
Tairāwhiti	6	5009	119.78
Taranaki	7	13177	53.12
Waikato	24	47618	50.40
Wairarapa	14	4366	320.66
Waitemata	48	51999	92.31
West Coast	7	3401	205.82
Whanganui	7	6504	107.63

Notes on DHB's number and rate of complaints

It should be noted that a DHB's number and rate of complaints can vary considerably from one six-month period to the next. Therefore, care should be taken before drawing conclusions on the basis of one six-month period. For smaller DHBs, a very small absolute increase or decrease in the number of complaints received can dramatically affect the rate of complaints. Accordingly, much of the value in this data lies in how it changes over time, as such analysis allows trends to emerge that may point to areas that require further attention.

It is also important to note that numbers of complaints received by HDC is not always a good proxy for quality of care provided, and may instead, for example, be an indicator of the effectiveness of a DHB's complaints system or features of the services provided by a particular DHB. Additionally, complaints received within a single six-month period will sometimes relate to care provided within quite a different time period. From time to time, some DHBs may also be the subject of a number of complaints from a single complainant within one reporting period. This is important context that is taken into account by DHBs when considering their own complaint patterns.

2.0 Service types complained about

2.1 Service type category

Complaints to HDC are shown by service type in Table 5. Please note that some complaints involve more than one DHB and/or more than one hospital; therefore, although there were 450 complaints about DHBs, 472 services were complained about.

Surgical services (31.4%) received the greatest number of complaints in Jan–Jun 2018, with orthopaedics (8.1%) and general surgery (7.4%) being the surgical specialties most commonly complained about. Other commonly complained about services included mental health (21.2%), general medicine (16.3%), emergency departments (10.6%) and maternity services (6.8%). This is broadly similar to what has been seen in previous periods.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Aged care	**2**	**0.4%**
Alcohol and drug	**3**	**0.6%**
Anaesthetics/pain medicine	**4**	**0.8%**
Dental	**3**	**0.6%**
Diagnostics	**16**	**3.4%**
Disability services	**8**	**1.7%**
District nursing	**3**	**0.6%**
Emergency department	**50**	**10.6%**
General medicine	**77**	**16.3%**
Cardiology	8	1.7%
Dermatology	1	0.2%
Endocrinology	4	0.8%
Gastroenterology	7	1.5%
Geriatric medicine	9	1.9%
Haematology	1	0.2%
Infectious diseases	2	0.4%
Neurology	9	1.9%
Oncology	7	1.5%
Palliative care	1	0.2%
Renal/nephrology	2	0.4%
Respiratory	6	1.3%
Rheumatology	1	0.2%
Other/unspecified	19	4.0%
Hearing services	**2**	**0.4%**
Intensive care/critical care	**4**	**0.8%**
Maternity	**32**	**6.8%**
Mental health	**100**	**21.2%**
Paediatrics (not surgical)	**12**	**2.5%**
Rehabilitation services	**5**	**1.1%**
Surgery	**148**	**31.4%**
Cardiothoracic	1	0.2%
General	35	7.4%
Gynaecology	20	4.2%
Neurosurgery	7	1.5%
Ophthalmology	12	2.5%
Oral/Maxillofacial	1	0.2%
Orthopaedics	38	8.1%
Otolaryngology	14	3.0%
Plastic and Reconstructive	5	1.1%
Urology	11	2.3%
Vascular	3	0.6%
Unknown	1	0.2%
Other/unknown health service	**3**	**0.6%**
TOTAL	**472**	

3.0 Issues complained about

3.1 Primary complaint issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received in Jan–Jun 2018 are listed in Table 6. It should be noted that the issues included are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, those issues provide a valuable insight into the consumer's experience of the services provided and the issues they care most about.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	***80***	***17.8%***
Lack of access to services	29	6.4%
Lack of access to subsidies/funding	3	0.7%
Waiting list/prioritisation issue	48	10.7%
Boundary violation	***1***	***0.2%***
Care/Treatment	***214***	***47.6%***
Delay in treatment	11	2.4%
Delayed/inadequate/inappropriate referral	3	0.7%
Inadequate coordination of care/treatment	7	1.6%
Inadequate/inappropriate clinical treatment	20	4.4%
Inadequate/inappropriate examination/assessment	10	2.2%
Inadequate/inappropriate follow-up	5	1.1%
Inadequate/inappropriate monitoring	5	1.1%
Inadequate/inappropriate non-clinical care	8	1.8%
Inadequate/inappropriate testing	1	0.2%
Inappropriate/delayed discharge/transfer	11	2.4%
Inappropriate withdrawal of treatment	3	0.7%
Missed/incorrect/delayed diagnosis	59	13.1%
Refusal to assist/attend	1	0.2%
Refusal to treat	9	2.0%
Rough/painful care or treatment	3	0.7%
Unexpected treatment outcome	54	12.0%
Unnecessary treatment/over-servicing	4	0.9%
Communication	***38***	***8.4%***
Disrespectful manner/attitude	12	2.7%
Failure to accommodate language/cultural needs	2	0.4%
Failure to communicate openly/honestly/effectively with consumer	7	1.6%
Failure to communicate openly/honestly/effectively with family	12	2.7%
Insensitive/inappropriate comments	5	1.1%
Complaints process	***13***	***2.9%***
Inadequate response to complaint	13	2.9%
Consent/Information	***42***	***9.3%***
Consent not obtained/adequate	10	2.2%
Inadequate information provided regarding adverse event	1	0,2%
Inadequate information provided regarding condition	4	0.9%
Inadequate information provided regarding fees/costs	2	0.4%
Inadequate information provided regarding results	2	0.4%

Primary issue in complaints	Number of complaints	Percentage
Inadequate information provided regarding treatment	4	0.9%
Issues regarding consent when consumer not competent	2	0.4%
Issues with involuntary admission/treatment	17	3.8%
Documentation	***7***	***1.5%***
Delay/failure to disclose documentation	1	0.2%
Inadequate/inaccurate documentation	6	1.3%
Facility issues	***18***	***4.0%***
General safety issue for consumer in facility	11	2.4%
Waiting times	2	0.4%
Other	5	1.1%
Medication	***19***	***4.2%***
Administration error	2	0.4%
Prescribing error	2	0.4%
Inappropriate administration	4	0.9%
Inappropriate prescribing	8	1.8%
Refusal to prescribe/dispense/supply	3	0.7%
Reports/Certificates	***3***	***0.7%***
Inaccurate report/certificate	3	0.7%
Other professional conduct issues	***11***	***2.4%***
Disrespectful behaviour	7	1.6%
Inappropriate collection/use/disclosure of information	4	0.9%
Disability-related issues	***3***	***0.7%***
Other issues	***1***	***0.2%***
TOTAL	**450**	

The most common primary issue categories were:

- Care/treatment (47.6%)
- Access/funding (17.8%)
- Consent/information (9.3%)
- Communication (8.4%)

The most common specific primary issues complained about in complaints about DHBs were:

- Missed/incorrect/delayed diagnosis (13.1%)
- Unexpected treatment outcome (12.0%)
- Waiting list/prioritisation issue (10.7%)
- Lack of access to services (6.4%)

Table 7 shows a comparison over time for the top five primary issues complained about. The top five primary issues have remained broadly consistent over time, with the exception of "unexpected treatment outcome" which increased from being the primary issue in around 8% of complaints in previous periods to 12% in Jan-Jun 2018, and "inadequate/inappropriate treatment" which decreased from being the primary issue in around 7-8% of complaints in previous periods to 4% in Jan-Jun 2018.

Table 7. Top five primary issues in complaints received over the last four six-month periods

Top five primary issues in all complaints (%)							
Jul–Dec 16 n=386		**Jan–Jun 17 n=477**		**Jul–Dec 17 n=439**		**Jan–Jun 18 n=450**	
Misdiagnosis	15%	Misdiagnosis	15%	Misdiagnosis	12%	Misdiagnosis	13%
Unexpected treatment outcome	8%	Waiting list/ Prioritisation	10%	Waiting list/ prioritisation	10%	Unexpected treatment outcome	12%
Inadequate treatment	8%	Unexpected treatment outcome	9%	Unexpected treatment outcome	8%	Waiting list/ prioritisation	11%
Lack of access to services	8%	Inadequate treatment	6%	Inadequate treatment	7%	Lack of access to services	6%
Waiting list/ Prioritisation	7%	Lack of access to services	6%	Lack of access to services	6%	Inadequate treatment	4%

3.2 All complaint issues

As well as the primary complaint issue, up to six additional other complaint issues are identified for each complaint received by HDC. Table 8 includes these additional complaint issues, as well as the primary complaint issues, to show all issues identified in complaints received.

Table 8. All issues identified in complaints

All issues in complaints	**Number of complaints**	**Percentage**
Access/Funding	***111***	***24.7%***
Lack of access to services	49	10.9%
Lack of access to subsidies/funding	8	1.8%
Waiting list/prioritisation issue	61	13.6%
Other	1	0.2%
Boundary violation	***2***	***0.4%***
Care/Treatment	***357***	***79.3%***
Delay in treatment	86	19.1%
Delayed/inadequate/inappropriate referral	7	1.6%
Inadequate coordination of care/treatment	71	15.8%
Inadequate/inappropriate clinical treatment	171	38.0%
Inadequate/inappropriate examination/assessment	119	26.4%
Inadequate/inappropriate follow-up	48	10.7%
Inadequate/inappropriate monitoring	31	6.9%
Inadequate/inappropriate non-clinical care	43	9.6%
Inadequate/inappropriate testing	48	10.7%
Inappropriate admission/failure to admit	11	2.4%
Inappropriate/delayed discharge/transfer	46	10.2%
Inappropriate withdrawal of treatment	3	0.7%
Missed/incorrect/delayed diagnosis	94	20.9%
Personal privacy not respected	2	0.4%
Refusal to assist/attend	13	2.9%
Refusal to treat	13	2.9%
Rough/painful care or treatment	20	4.4%
Unexpected treatment outcome	78	17.3%
Unnecessary treatment/over-servicing	10	2.2%
Communication	***292***	***64.9%***
Disrespectful manner/attitude	71	15.8%
Failure to accommodate language/cultural needs	4	0.9%
Failure to communicate openly/honestly/effectively with consumer	167	37.1%
Failure to communicate openly/honestly/effectively with family	103	22.9%
Insensitive/inappropriate comments	15	3.3%
Complaints process	***68***	***15.1%***
Inadequate response to complaint	68	15.1%
Consent/Information	***102***	***22.7%***
Consent not obtained/adequate	26	5.8%
Failure to assess capacity to consent	7	1.6%
Inadequate information provided regarding adverse event	7	1.6%
Inadequate information provided regarding condition	12	2.7%
Inadequate information provided regarding fees/costs	2	0.4%
Inadequate information provided regarding options	6	1.3%

All issues in complaints	**Number of complaints**	**Percentage**
Inadequate information provided regarding provider	3	0.7%
Inadequate information provided regarding results	10	2.2%
Inadequate information provided regarding treatment	26	5.8%
Incorrect/misleading information provided	12	2.7%
Issues regarding consent when consumer not competent	4	0.9%
Issues with involuntary admission/treatment	23	5.1%
Documentation	***32***	***7.1%***
Delay/failure to disclose documentation	7	1.6%
Inadequate/inaccurate documentation	24	5.3%
Intentionally misleading/altered documentation	1	0.2%
Facility issues	***71***	***15.8%***
Accreditation standards/statutory obligations not met	2	0.4%
Cleanliness/hygiene issue	6	1.3%
Failure to follow policies/procedures	2	0.4%
General safety issue for consumer in facility	12	2.7%
Inadequate/inappropriate policies/procedures	25	5.6%
Issue with quality of aids/equipment	12	2.7%
Issue with sharing facility with other consumers	6	1.3%
Staffing/rostering/other HR issue	7	1.6%
Waiting times	9	2.0%
Medication	***44***	***9.8%***
Administration error	4	0.9%
Prescribing error	4	0.9%
Inadequate storage/security	1	0.2%
Inappropriate administration	8	1.8%
Inappropriate prescribing	22	4.9%
Refusal to prescribe/dispense/supply	6	1.3%
Reports/Certificates	***10***	***2.2%***
Inaccurate report/certificate	7	1.6%
Refusal to complete report/certificate	3	0.7%
Teamwork/supervision	***12***	***2.7%***
Inadequate supervision/oversight	12	2.7%
Other professional conduct issues	***23***	***5.1%***
Disrespectful behaviour	10	2.2%
Inappropriate collection/use/disclosure of information	9	2.0%
Other	4	0.9%
Disability-related issues	***9***	
Other issues	***7***	

On analysis of all issues identified in complaints about DHBs, the most common complaint issue categories were:

- Care/treatment (present for 79.3% of all complaints)
- Communication (present for 64.9% of all complaints)
- Access/funding (present for 24.7% of all complaints)
- Consent/information (present for 22.7% of all complaints).

The most common specific issues were:

- Inadequate/inappropriate clinical treatment (38.0%)
- Failure to communicate effectively with consumer (37.1%)
- Inadequate/inappropriate examination/ assessment (26.4%)
- Failure to communicate effectively with family (22.9%)
- Missed/incorrect/delayed diagnosis (20.9%)
- Delay in treatment (19.1%)
- Unexpected treatment outcome (17.3%)
- Disrespectful manner/attitude (15.8%)
- Inadequate coordination of care/treatment (15.8%)
- Inadequate response to the consumer's complaint by the DHB (15.1%)

These issues are broadly similar to what was seen last period.

Also similar to the last six-month period, many complaints involved issues with a consumer's care/treatment, including: inadequate/ inappropriate testing", "inadequate/inappropriate follow-up", "inappropriate/delayed discharge/transfer" and "inadequate/inappropriate non-clinical care". These issues were each present in around 10% of complaints.

3.3 Service type and primary issues

Table 9 shows the top three primary issues in complaints concerning the most commonly complained about service types. This is broadly similar to what was seen in the last six-month period. However, compared to last period, access/prioritisation issues became more prominent for mental health services and less prominent for general medicine services.

Table 9. Three most common primary issues in complaints by service type

Surgery n=148		**Mental Health n=100**		**General medicine n=77**		**Emergency department n=50**		**Maternity n=32**	
Unexpected treatment outcome	24%	Issues with involuntary admission/ Treatment	18%	Missed/ incorrect/ delayed diagnosis	18%	Missed/ incorrect/ delayed diagnosis	44%	Unexpected treatment outcome	22%
Waiting list/ prioritisation issue	20%	Lack of access to services	11%	Unexpected treatment outcome	10%	Refusal to treat	18%	Delay in treatment	9%
Missed/ incorrect/ delayed diagnosis	8%	Waiting list/ prioritisation issue	8%	Inadequate/ inappropriate treatment	8%	Waiting list/ prioritisation issue	6%	Inadequate/ inappropriate treatment	9%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **476**[5] complaints involving DHBs in the period Jan–Jun 2018. Table 10 shows the number of complaints closed in previous six-month periods.

Table 10. Number of complaints about DHBs closed in last five years

	Jul–Dec 13	**Jan–Jun 14**	**Jul–Dec 14**	**Jan–Jun 15**	**Jul–Dec 15**	**Jan–Jun 16**	**Jul–Dec 16**	**Jan–Jun 17**	**Jul–Dec 17**	**Average of last 4 6-month periods**	**Jan–Jun 18**
Number of complaints closed	280	411	344	410	365	482	316	465	383	**412**	**476**

4.2 Outcomes of complaints closed

Complaints that are within HDC's jurisdiction are classified into two groups according to the manner of resolution — whether investigation or other resolution. Within each classification, there is a variety of possible outcomes. Notification of investigation generally indicates more serious issues.

In the Jan–Jun 2018 period, 6 DHBs had no investigations closed, 6 DHBs had one investigation closed, 1 DHB had two investigations closed, 1 DHB had three investigations closed, 2 DHBs had 4 investigations closed, 2 DHBs had 5 investigations closed, 1 DHB had 6 investigations closed and 1 DHB had 8 investigations closed by HDC.

The manner of resolution and outcomes of all complaints about DHBs closed in Jan–Jun 2018 is shown in Table 11.

[5] Note that complaints may be received in one six-month period and closed in another six-month period — therefore, the number of complaints received will not correlate with the number of complaints closed.

Table 11. Outcome for DHBs of complaints closed by complaint type[6]

Outcome for DHBs	Number of complaints closed
Investigation	***38***
Breach finding – referred to Director of Proceedings	3
Breach finding	18
No breach finding with recommendations or educational comment	13
No breach finding	4
Other resolution following assessment	***432***
No further action[7] with recommendations or educational comment	117
Referred to Ministry of Health	2
Referred to District Inspector	16
Referred to other agency	5
Referred to DHB[8]	98
Referred to Advocacy	44
No further action	143
Withdrawn	7
Outside jurisdiction	***6***
TOTAL	**476**

[6] Note that outcomes are displayed in descending order. If there is more than one outcome for a DHB upon resolution of a complaint then only the outcome that is listed highest in the table is included.

[7] The Commissioner has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or that the matters that are the subject of the complaint have been, or are being, or will be appropriately addressed by other means. This may happen, for example, where a DHB has carefully reviewed the case itself and no further value would be added by HDC investigating, or where another agency is reviewing, or has carefully reviewed the matter (for example, the Coroner, the Director-General of Health, or a District Inspector). Assessment of a complaint prior to a decision to take no further action will usually involve obtaining and reviewing a response from the provider and, in many cases, expert clinical advice.

[8] In line with their responsibilities under the Code, DHBs have developed systems to address complaints in a timely and appropriate way. It is often appropriate for HDC to refer a complaint to the DHB to resolve, with a requirement that the DHB report back to HDC on the outcome of its handling of the complaint.

4.3 Recommendations made to DHBs following a complaint

Regardless of whether or not a complaint has been investigated, the Commissioner may make recommendations to a DHB. HDC then follows up with the DHB to ensure that these recommendations have been acted upon. Table 12 shows the recommendations made to DHBs in complaints closed in Jan–Jun 2018. Please note that more than one recommendation may be made in relation to a single complaint.

Table 12. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	20
Audit	23
Meeting with consumer	5
Presentation/discussion of complaint with others	14
Provision of evidence of change to HDC	65
Provision of information to consumer	2
Reflection	5
Review/implementation of policies/procedures	44
Training/professional development	35
Total	**213**

The most common recommendation made to DHBs was that they provide evidence to HDC of the changes they had made in response to the issues raised by the complaint (65 recommendations). Often, when HDC asks for this evidence, it is also recommended that the provider conducts a review of the effectiveness of the changes made. Conducting a review of their policies/procedures or implementing new policies/procedures (44 recommendations) and staff training (35 recommendations) were also often recommended. Staff training was most commonly recommended in relation to clinical issues. Where new policies/procedures have been introduced by providers following a complaint, HDC will often recommend an audit to ensure that staff are complying with these new policies/procedures.

5.0 Learning from complaints — HDC case reports

Delay in follow-up ophthalmology review (16HDC01010)

Background

A 20-year-old man presented to a DHB's Ophthalmology Service (the Service). The man had been referred urgently by a community optometrist and had a family history of glaucoma. He was prescribed eye drops and a follow-up review went ahead. Two months later, at a further scheduled appointment, the man was diagnosed with ocular hypertension. The consultant requested that the man be reviewed again in six months' time.

The man's follow-up appointment was delayed by six months. By this time, he had suffered vision loss in his right eye (which many clinicians subsequently attributed to the delay) and he required an urgent referral for management and surgery. In short, the man did not receive follow-up ophthalmology specialist care relating to his glaucoma management in line with the clinical time frames requested.

Findings

The Commissioner was mindful, as detailed in a thorough external review of the Service commissioned by the DHB, of a combination of factors that have driven rapidly increasing demand for ophthalmology services in New Zealand, including outpatient clinic time, over the last ten years. A key factor has been the introduction of very effective new therapies and treatment, which have resulted in consumers needing to see specialists for regular ongoing follow-up and/or treatment, fueling increased demand for ophthalmology services.

The Commissioner commented that provider accountability is not removed by the existence of such systemic pressures. A key improvement that all DHBs and the Ministry of Health must make, now and in the future, is to assess, plan, adapt, and respond effectively to the foreseeable effects that new technologies will have on systems and demand.

At the time of the man's care, the Service lacked capacity, in that the clinics did not have enough appointments for the number of patients clinicians had to see. In the context of resource constraint, prioritisation schemes become vital in ensuring those patients at greatest risk are seen first. However, the Service lacked an appropriate prioritisation system.

The pressure on the Service was contributed to by an insufficient response by senior management at the DHB to growing demands for ophthalmology services over many years. Management at the DHB failed to communicate effectively with its clinical staff and act on valid concerns raised by senior clinicians, and to ensure that a system was in place that effectively managed and prioritised patients waiting for follow-up specialist ophthalmology care. Additionally, to some degree, a culture of tolerance emerged and delays became normalised. As a result, the DHB tolerated a situation that put patients at risk.

The DHB failed to arrange a timely follow-up appointment because it did not have a prioritisation system that focused on patients' clinical need. Instead it relied on administration staff who lacked training and clear guidance to prioritise appropriately. Despite concerns being raised with the DHB, it did not recognise the clinical risk created by the lack of capacity at the Service, and did not take action to rectify the situation after an earlier serious event review in relation to a similar matter had raised associated concerns. In addition, there were missed opportunities for the DHB to rectify the delay in the follow-up appointment. The DHB did not provide the man services with reasonable care and skill and, accordingly, was found in breach of Right 4(1) of the Code.

Recommendations

The Commissioner made a number of detailed recommendations to the DHB, including that it provide HDC with a detailed update report on the steps taken to carry out the recommendations of an external review of the Service and those arising out of the DHB's own reviews with specific reference to:

- An independent evaluation of the systems in place to identify and prioritise overdue ophthalmology patients. This should include the use of clinically driven patient acuity scores so that patients with higher acuities are prioritised and patients identified as specifically high risk do not have appointments delayed, and patients who self-identify with severe pain or sudden loss of vision are booked for urgent review.
- A quantitative and qualitative audit of the management of Ophthalmology Service referrals and follow-ups, to be certain that tracking systems are in place so that all referrals are responded to in a timely manner
- The proactive steps taken to build departmental capacity, responsiveness, and adaptability, including regular accurate measurement and reporting of demand and capacity, using objective agreed criteria that account for actual and projected increases in demand, as well as details regarding:
    - Training and implementation of nursing staff and ancillary and non-specialist staff to remove inefficiency associated with lower priority tasks.
    - The effectiveness of the department's relocation to enhanced physical space.
    - Recruitment of ophthalmologists, optometrists, orthoptists, and ophthalmology staff.
- Details of the redefined roles and responsibilities of those involved in the management of the Ophthalmology Service.
- Routine telephone access to clinical staff so that DHB Ophthalmology Service patients can contact the Eye Department readily, speak to an appropriately trained person when clinical concerns are raised, receive an appropriate response, and have this recorded in their clinical notes.
- Shared learning:
    - Use of regular forums involving ophthalmology departmental staff and management staff, to include discussion and planning to assist development of treatment protocols in the context of an ageing population.
    - Confirmation that the external review report was discussed with all other DHBs via their Chief Medical Officers, to ensure that any patient risk arising from similar circumstances is identified and controlled.
- The Ophthalmology Service and its facilities undergoing regular credentialling, as occurs in most DHBs.
- A further update on how the Ophthalmology Backlog Programme project has been established across the DHB, involving its weekly stakeholder updates to track and monitor progress toward zero patients waiting beyond clinically appropriate timeframes.

The Commissioner also made recommendations to the Ministry of Health, including that it:

- Establish systems to identify worthwhile major new healthcare technologies, such as the advent of Avastin therapy, in the future, so that adequate planning and funding responses can occur in a timely way, and report to HDC on progress towards the development of those systems

- Update HDC on the progress it has made towards addressing the other national improvement recommendations made by the external review, including a national discussion on ophthalmology priorities (such as that initiated with RANZCO), and national reporting of overdue eye appointment statistics.

Management of incidental finding of rectal lymph nodes (17HDC00316)

Background

A 72-year-old man presented to the Emergency Department (ED) of a public hospital after falling approximately three metres. He sustained injuries to his left hip and left side of his chest. A senior ED consultant ordered an urgent CT scan of the chest, abdomen, and pelvis.

When reporting on urgent CT scans, a preliminary acute report was issued to help determine the immediate care of the patient (a "sticky note"). The sticky note mechanism is an immediate, rough tool to assist clinicians to proceed with treatment of the patient and to answer the immediate clinical questions. The case is then fully reported – usually within 24 hours. The ED acted on the reporting radiologist's sticky note, which did not mention an incidental finding of rectal lymph nodes. The man was treated with pain relief and transferred to the surgical ward for ongoing care.

The following day, full reporting of the CT scan was entered into the information technology (IT) system at the hospital. This final report noted numerous enlarged meso-rectal lymph nodes and suggested endoscopic examination to rule out a rectal tumour. Several days later, the man was discharged from hospital. However, the final CT scan report was not sighted until eight months after discharge, when further investigation was initiated. The man was diagnosed with Stage IIIa squamous cell carcinoma of the anus, and underwent chemo-radiotherapy treatment and surgery.

At the time of these events, the IT system did not allow for electronic sign-off of test results. There was no alert system to notify a doctor that a result had arrived, nor was there a doctor-specific list of results to review. This meant that doctors could not look up all the results of tests or procedures they had ordered that day apart from proactively on an individual patient basis. The hospital acknowledged that this was a significant weakness in its system and, until this could be improved, there was no protection from recurrence.

A further complicating factor in this case was that there appeared to be a lack of clarity around who was responsible for following up and acting on the results of the CT scan once it was reported on. The ED consultant considered that clinical responsibility for the final CT report was handed over when the man was transferred to the surgical ward. However, the surgeon advised that as he was not the practitioner who ordered the CT scan, he did not receive a paper copy of the report and therefore, did not and would not have viewed the final CT scan report. There were no internal policies or procedures at the DHB relating to this issue.

Findings

The DHB had a weak IT system that did not allow for electronic sign-off, and it did not have a clear, effective, and formalised system in place for the reporting and following up of test results. This systems failure resulted in a number of opportunities being missed by clinicians to review and action the man's final CT scan report, and a delayed diagnosis of squamous cell carcinoma of the anus.

In respect of this case the Commissioner commented that the basic system principle with respect to the follow-up of test results is clear — the person who orders the test must follow up, or know by whom and how in the system it will be. The Commissioner was concerned about the inconsistencies in clinicians' understanding of how this principle applied at their hospital, stating that it was not acceptable that systems and clinicians lacked clarity on this.

The Commissioner found that the DHB did not provide services to the man with reasonable care and skill, and breached Right 4(1) of the Code.

The Commissioner was thoughtful about the use of the "sticky note" function in this case. He emphasised that this function is only a preliminary reporting tool that answers the immediate clinical question. It should not be relied on in place of the final report.

Recommendations

The Commissioner made a number of recommendations to the DHB, including that it:

- Update HDC on the progress and effectiveness of its IT system upgrade, including the development of policies and procedures with respect to electronic sign-off of test results and radiology reports. This update should include evidence that the new system reliably captures all relevant data.

- Advise whether "sticky notes" are still being used under the new IT system, and what measures have been taken to ensure that they are used as a preliminary reporting tool only, and that the final reports are also reviewed.

- Audit, over a period of three months, the management of test results ordered at ED where patients have been transferred to another ward.

- Take steps to ensure that discharge summaries accurately reflect available final diagnostic reports, and report back to HDC on the steps that have been taken.

- Develop policies and procedures on the management of test results and radiology reports.

Delay in neurology review (16HDC00761)

Background

A 62-year-old man presented to an emergency department with sudden onset of left-sided weakness and twitching, and reported a week-long history of dizziness upon standing. A CT scan identified the possibility of a dural arteriovenous fistula, and the report recommended a neurological opinion.

The man was admitted to the general medicine ward with a working diagnosis of an ischaemic stroke the same day. The admitting medical registrar completed a handwritten neurology referral but it was erroneously sent using the process for outpatient referrals. There was nothing on the form to indicate that it was intended to be an inpatient referral. As a result, the referral was not triaged until three days later.

The man was noted to have left arm tremors, which progressed to intermittent twitching of the left leg. The consultant general physician maintained the working diagnosis of ischaemic stroke when he reviewed the man in the morning of the following day. Nursing notes throughout that day refer to twitching and "on and off restlessness" in the man's left leg. On the third day of admission, another medical registrar queried in the notes whether the man's ongoing left-sided weakness was caused by seizures. This possibility was raised again during the physiotherapy and occupational therapy review in the afternoon, but the matter was not escalated to the consultant general physician.

On the fourth day of admission, the medical registrar from the previous day noted that the man had yet to be been seen by a neurologist, and made active enquiries about the referral. As a result of these enquiries, the man was reviewed by the visiting neurologist, who diagnosed focal status epilepticus. The man was commenced on intravenous anti-seizure medication, and his involuntary

movements improved. He was later transferred to another hospital, where he received further treatment.

Findings

There were deficiencies in the care provided, which constituted a pattern of poor care on a service level, for which the DHB was ultimately responsible:

- The admitting medical registrar did not make an acute referral to the neurology service following the abnormal CT scan result.
- The admitting medical registrar's non-urgent referral was erroneously sent to the outpatient clinic.
- The consultant general physician did not discuss the CT report with the neurology service on his ward round the day after admission, when the man had been experiencing ongoing involuntary twitching.
- Junior staff did not escalate concerns about the man's ongoing involuntary movements, and the consultant general physician did not enquire.

The Commissioner was most concerned by the lapses in communication within the general medicine team and the lack of safeguards in place to identify errors in the neurology referral process. These factors hindered the coordination of the man's care within the team and across specialities, and contributed to the delay in him receiving the neurological review he required. For the above reasons, the Commissioner considered that the DHB failed to provide services with reasonable care and skill to the man, in breach of Right 4(1) of the Code.

Recommendations

The Commissioner recommended that the DHB:

- Conduct an audit of neurology referrals within the last three months to ensure that the correct process has been followed.

- Use this case as an anonymised case study for education on the importance of team communication, and report back to HDC on this within three months of the date of this report.

- Update HDC on the implementation of its "TransforMED" project (a project which aims to ensure that time is set aside for subspecialists who participate in General Medicine to undertake a ward round daily on inpatients on their designated ward).

Delayed diagnosis of kidney problems in premature baby (15HDC00464)

Background

At 31 weeks' gestation, a woman had an ultrasound performed by a sonographer at a private radiology service. The reporting radiologist was working from a location remote from where the scan was performed. During the scan, the sonographer noticed that the fetal kidneys appeared dilated, and that the fetal bladder was full and not seen to empty. She recorded on the sonographer's worksheet: "Kidneys appear dilated ? rescan once born." She sent the images and worksheet to the radiologist, but did not discuss this case with him.

The radiologist wrote in the ultrasound report: "[B]ilateral fetal renal dilation (5mm). Fetal bladder appears somewhat overfilled. Bladder was not seen to empty during the study … [P]ostnatal assessment is suggested." The actual findings of the scan were fluctuating renal pelvis measurements of 4.1mm to 9.5mm on the right and 5.1mm to 14mm on the left.

The baby was born at 32 weeks' gestation, and was admitted to the Neonatal Unit at a DHB. It was verbally reported to paediatric staff that an antenatal ultrasound had shown bilateral fetal renal dilation of 5mm, but a copy of the radiology report was not transferred from the mother's clinical records to the baby's records. A copy of the report was obtained from the private radiology service by the hospital, but not disseminated to paediatric staff, and paediatric staff did not request a copy.

Subsequently the baby developed oedema and had episodes of high blood pressure. Nursing staff were told that medical staff had no concerns and that they needed to give consistent feedback to the woman about this. A renal ultrasound was performed, and a diagnosis of posterior urethral valves (a condition where obstructing membranes in the posterior male urethra prevent normal urine flow from the bladder) was made. The baby was catheterised and transferred to another hospital, where he underwent posterior urethral valve ablation (surgery to remove the valve through the urethra).

At the time of these events, the DHB was testing a new electronic health record. This meant that staff were electronically recording in bullet or abbreviated form the clinical decisions made, but not necessarily the thinking behind those diagnoses or the alternative diagnoses considered. There was also a lack of clinical workstations, and it was difficult to enter data cot-side.

Findings

The Commissioner considered that the DHB responded appropriately to the reported antenatal ultrasound findings of bilateral fetal renal dilation of 5mm, and the care provided to the baby on the first four days of his life was appropriate. However, the DHB paediatric medical staff did not investigate the baby's worsening oedema and high blood pressure from day five of his life. The Commissioner was particularly concerned about these delays in investigation, given that the baby's parents repeatedly raised their concerns and requested earlier investigations. The Commissioner considered that this represented a lack of responsiveness and clinical judgement on the part of paediatric medical staff. Accordingly, the Commissioner found that the DHB did not provide care to the baby with reasonable care and skill in breach of Right 4(1) of the Code.

By not transferring a copy of the antenatal ultrasound report from the woman's clinical records to the baby's clinical records when he was born; not disseminating to relevant paediatric staff the copy of the report obtained from the private radiology service; and paediatric staff not requesting a copy of the report, the Commissioner considered that the DHB failed to ensure continuity of care and, therefore, breached Right 4(5) of the Code.

The Commissioner noted that there was a pattern of suboptimal documentation by multiple staff involved in the baby's care, and the environment in which the DHB staff were operating (with a new electronic system being tested, but insufficient equipment provided to use it properly) contributed considerably to the documentation failures in this case. Therefore, the Commissioner considered that

the DHB failed to provide services to the baby that complied with relevant standards, and thereby breached Right 4(2) of the Code.

The Commissioner was concerned that nursing staff were instructed to reassure the baby's parents that the baby was fine, and were told that the baby did not require multiple medical reviews in relation to his oedema. This was particularly concerning in light of the fact that the DHB's Root Cause Analysis (RCA) found that some nursing staff felt that they were not listened to. The Commissioner noted that it is important that medical staff work in partnership with nursing staff and take their views into consideration, and that the DHB should encourage a culture where it is acceptable to voice concerns and ask questions from any point in the hierarchy.

Recommendations

The Commissioner made a number of recommendations to the DHB, including that it:

- Report back to HDC on the implementation of the recommendations arising from the RCA, including a review of current best practice for fetal/renal antenatal ultrasound scanning for renal abnormalities.
- Provide refresher training to all paediatric staff on the procedure for obtaining copies of external ultrasound reports, and remind all maternity staff of the importance of transferring relevant information from the mother's clinical records into the baby's clinical records.
- Undertake a qualitative audit to check for appropriate use of the electronic health record in the Neonatal Unit, obtain feedback from staff regarding any user issues and implement a mechanism for ensuring ongoing staff communication of issues.
- Provide a detailed update to HDC on progress toward additional clinical workstations being situated cot-side.

MEMORANDUM TO THE HOSPITAL ADVISORY COMMITTEE
DECEMBER 2018

AGENDA ITEM 4.2

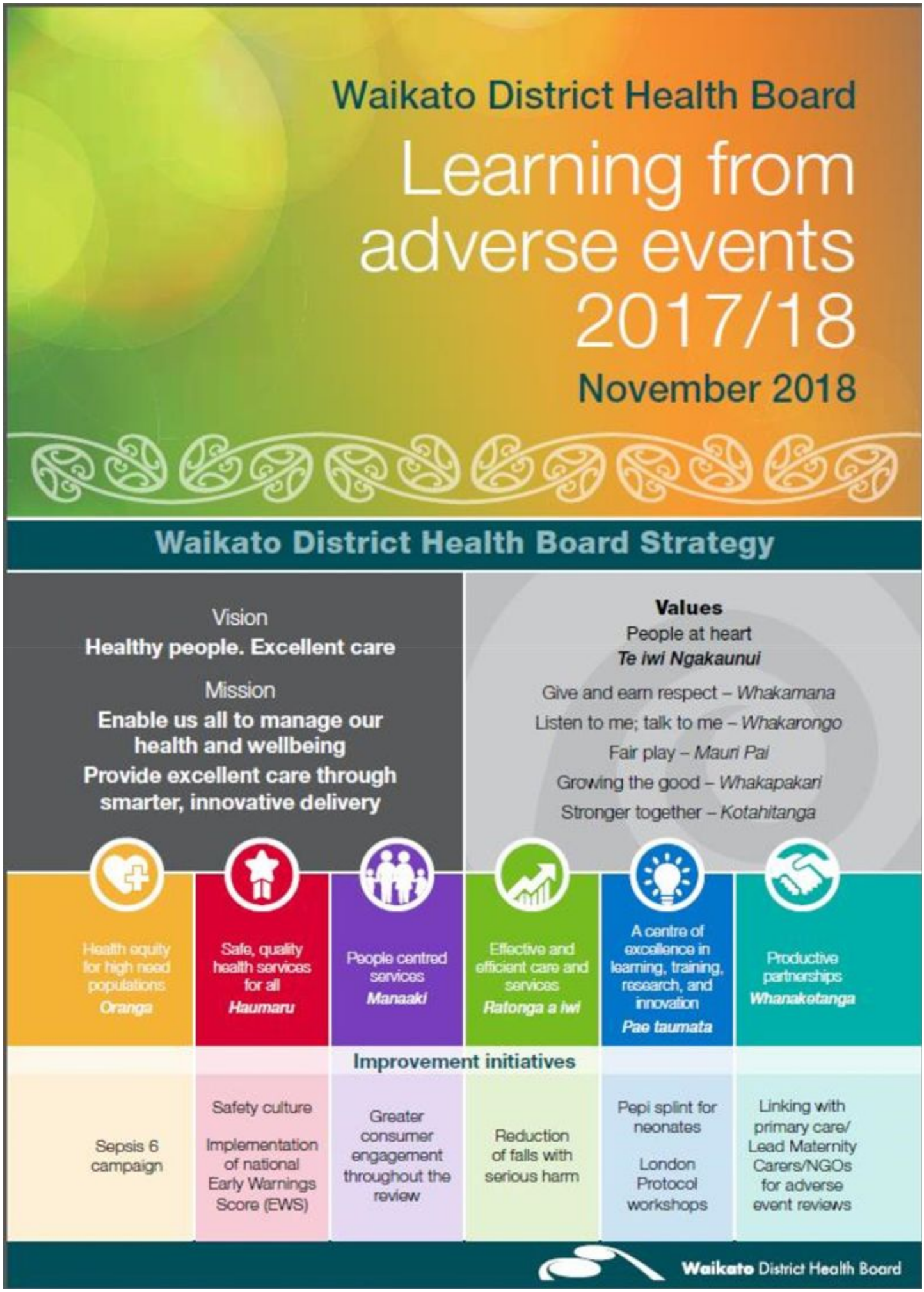
Learning from adverse events 2017/18

Purpose	1) For information prior to publication on the DHB website

- The national adverse event report from HQSC will be released on Friday 7 December 2018
- This is the first time that Mental Health events have been noted in this report in line with the national direction and links to the quality improvement programme being led out by the Health Quality Safety Commission.
- 63 adverse events were reported and reviewed in line with the DHB serious event review process. Fourteen of these events (22%) involved Maori patients.
- The increase in events from 2016/17 is due to including mental health events and also our inclusion of a number of health care acquired infections.
- This year has seen a steady increase in the involvement of patients and their families / whanau in the process - further work is needed in this area
- Shared learning summaries are developed as part of the review process and made available to staff on the intranet
- Commentary in the report focuses on insights, lessons learned and emerging issues.

Recommendation
THAT
The report be received

Mo Neville
Director Quality and Patient Safety
December 2018


Waikato District Health Board
Learning from adverse events 2017/18
November 2018
Waikato District Health Board Strategy
Vision
Healthy people. Excellent care
Mission
Enable us all to manage our health and wellbeing
Provide excellent care through smarter, innovative delivery
Values
People at heart
Te iwi Ngakaunui
Give and earn respect – Whakamana
Listen to me; talk to me – Whakarongo
Fair play – Mauri Pai
Growing the good – Whakapakari
Stronger together – Kotahitanga
Health equity for high need populations
Oranga
Safe, quality health services for all
Haumaru
People centred services
Manaaki
Effective and efficient care and services
Ratonga a iwi
A centre of excellence in learning, training, research, and innovation
Pae taumata
Productive partnerships
Whanaketanga
Improvement initiatives
Sepsis 6 campaign
Safety culture
Implementation of national Early Warnings Score (EWS)
Greater consumer engagement throughout the review
Reduction of falls with serious harm
Pepi splint for neonates
London Protocol workshops
Linking with primary care/ Lead Maternity Carers/NGOs for adverse event reviews
Waikato District Health Board

Waikato DHB Learning from adverse events 2017-18

This report summarises the adverse events that occurred at Waikato DHB from 1 July 2017 - 30 June 2018. Adverse events are reported to the Health Quality & Safety Commission's (HQSC) in accordance with their national Adverse events reporting policy.

Executive Summary

The purpose of adverse event reporting is to improve patient safety and to understand the experience of the affected patient and whānau. The process of national reporting demonstrates to the public an openness and culture of learning from these events.

Each event involves a person and their whānau, family and friends; the DHB acknowledges the people affected by the adverse events outlined in this report. They are often life changing for patients, families and staff and we need to continue to work hard to prevent them. These reviews help us achieve safer health care and reduce the risk of future events of the same kind.

The reporting of adverse events is one part of a broader safety framework to make healthcare as safe as possible; other measures and methods demonstrate changes over time - at Waikato these include Quality Safety Markers, mortality screening, mortality and morbidity meetings across the DHB, Health Roundtable data, trigger tools, internal and external audit, etc. All contribute to the overall picture; the process of improvement is gradual but incremental gains are made each year in the pursuit of patient safety.

The adverse events presented in this 2017-18 *Learning from adverse events* report are based on the requirements of the HQSC's Adverse event policy 2017 (and the matrix from the HQSC's previous National Reportable Events policy due to the delay with uploading of the new matrix to the Midland electronic reporting system). In 2017-18 sixty-three adverse events were reported:

- Clinical management events, a grouped category with 17 cases, largely related to delayed diagnosis or treatment
- Healthcare acquired infections were the largest single category with 17 cases - the introduction of the Surgical Site Infection Improvement Programme (HQSC), focused on reporting such infections in orthopaedic and cardiac procedures but the programme, and reporting, has now been extended at Waikato DHB to all serious infections.
- Serious harm from falls - 10 cases. Half of these caused a fracture of the neck of femur (hip). There has been an overall reduction in the reported incidence of falls with harm
- There were 3 medication-related, 1 patient accident, and 1 medical device / equipment related events
- Behaviour (Mental Health & Addiction Services) – this is the first year this data has been included in our report. Previously this data was released annually by the Director General of Mental Health but from 2017-18 will be included in the Health Quality & Safety Commission in their annual *Learning from adverse events report* hence the inclusion of this data in Waikato DHB's report.

Introduction

At Waikato DHB the adverse events reporting, review and learning process is in place to facilitate learning and quality improvement and to enable analysis of contributory factors / trends over a cluster of events or time. We have a responsibility to learn from them to improve the safety and experience for patients and their whānau.

We have a responsibility to communicate openly with patients and their families about this. The DHB has reviewed the adverse event process and finalised our procedure to make sure we let patients and their families know early that we are reviewing the care, asking what they might want us to specifically look at, keeping them informed during the review process and also letting them know what changes we have made to reduce the chance of a similar incident happening again.

We have put arrangements in place to share learning and improvements from adverse event reviews across services, the wider organisation and nationally as appropriate. A brief learning summary that outlines what happened, what went well, what if anything could be improved and what has been learned is produced following a reportable adverse event review. These summaries are shared with the executive group, directorate teams and also placed on the staff intranet.

The purpose of this report is to provide focused commentary, raise themes from adverse events for Waikato DHB to consider in the coming year and to update on quality improvement activities underway.

Brief outline of the review process for reportable adverse events

An adverse event which requires reporting to HQSC, i.e. a reportable event, is an event with negative or unfavourable reactions or results that are unintended, unexpected or unplanned. In practice this is most often understood as an event which results in significant harm to a consumer or even death.

All reportable adverse event reviews at Waikato DHB are undertaken by a team of clinicians (e.g. doctors, nurses, midwives) and a member of the Quality & Patient Safety team who has been trained in adverse event review methods such as root cause analysis and London protocol methodology. No-one in the review team has been involved in the event; all reviews are impartial.

If at any stage in the event review process it is deemed that disciplinary processes are required, the People and Performance (Human Resources) department is informed so that their process can begin - this is a separate process and not part of the event review.

With the exception of pressure injury reviews, deep wound infections and falls resulting in a fracture which are presented at their respective committees, each event report is reviewed by the Serious Adverse Event Panel, chaired by the Chief Medical Officer (CMO), to ensure the review has appropriately established the facts, addressed all issues and that the recommendations are robust. All recommendations are assigned to a responsible owner and completion is tracked by the senior management team of the area, on a monthly basis. The DHB board also receives quarterly reports on the incidence and findings from these events.

The DHB (and health) is a complex system and adverse events will occur. Each of these events is regarded as an opportunity to learn and to improve in order to increase the safety of our care system for everyone. We are on a journey to become an open and transparent organisation, aiming to provide high quality care that is safe, effective and person-centered. The adverse event process will need to continue to evolve and improve as national and international best practice emerges.

Learning from Adverse Events reported by Waikato DHB 2017-18

The adverse events presented in this report are based on the requirements set out in the Health Quality & Safety Commission's (HQSC) *National Reportable Events* policy 2012. The policy contains a matrix to assist providers when assessing the Severity Assessment Code (SAC) for each event (from 1-4): only those events assessed as SAC 1 (severe) or SAC 2 (major) are reported to HQSC. Although this policy was updated in 2017, the amended SAC matrix was not uploaded into the Midland electronic reporting system until June 2018: most staff continued to be guided by the previous matrix which considered likelihood as well as consequence when assessing severity. Any changes from the removal of the likelihood of an event occurring as a contributor to the SAC rating will therefore not be seen until the next financial year.

In 2017-18 sixty-three (63) adverse events were reported; in the same period 104,046 patients were discharged *from* Waikato DHB *(excludes patients discharged/transferred to other parts of the DHB and self-discharges),* a rate of approximately 0.06% per inpatient admissions. This compares with 102,806 discharges in the previous financial year and 43 adverse events (rate of 0.04% per inpatient admissions)). 14 (22%) of the patients affected were of Māori ethnicity and 40 (64%) identified as NZ European.

The increase in reportable adverse events this year relates to data in two of the categories: reported events from these two categories make up 31 of the 63 adverse events. Previously mental health adverse events data (often 'behaviour' category) was released by the Director General of Mental Health rather than being incorporated in the adverse event reports but from 2017-18 it will be included in HQSC's annual report hence that data also now features in Waikato DHB's report. For the other (Healthcare associated infections), the reporting criteria has been extended to a wider group of infections with a corresponding increase in number of events reported.

Adverse event reporting is not a reliable way of demonstrating change nor is the use of the number or rate of reported events reliable way of judging a hospital's safety as there is considerable variation in the rates of reporting rates, not just in the rate of events. Incident reporting is actively encouraged at Waikato DHB to enable learning and improvement.

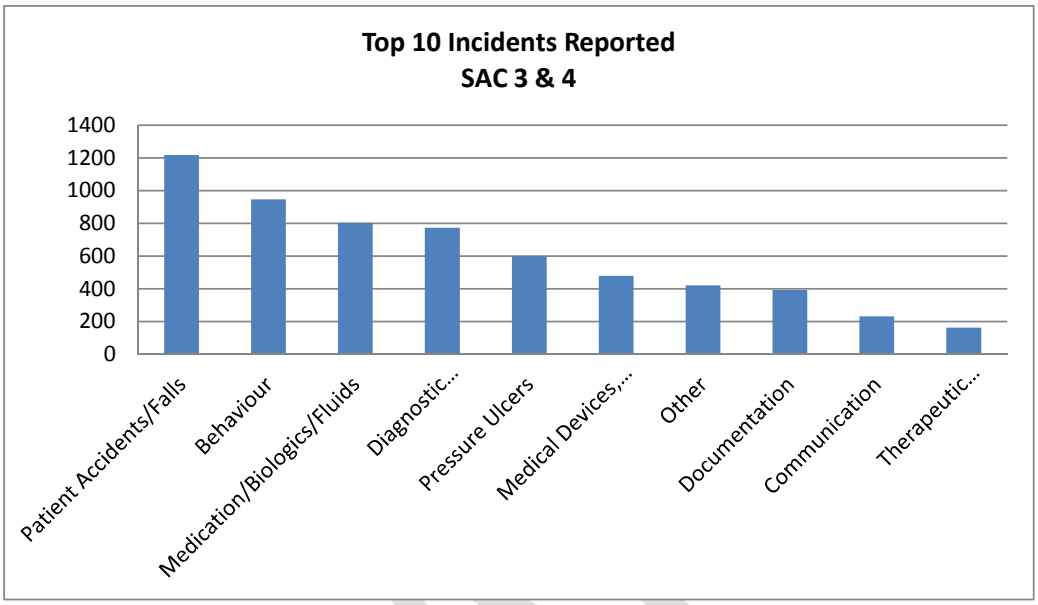
Commentary focuses on insights, lessons learned and emerging issues (rather than total numbers or year-on-year comparisons). This is consistent with the emphasis on learning, recommendations and actions taken that occur as a result of the reviews.

Table 1: Waikato DHB reported adverse events by World Health Organisation category, 2017-18

Adverse event category	Event code	Reported adverse events 2017-18
Clinical process/ procedure	02	17 (27%)
Healthcare associated infections	04	17 (27%)
Medication/IV fluids	05	3 (5%)
Behaviour	10	14 (22%)
Patient falls	12	10 (16%)
Patient accidents	11	1 (1.5%)
Medical device / equipment	09	1(1.5%)

Of note, over the same period a further 6788 incidents were reported and assessed as moderate (SAC 3 - 1570) or minor / minimal (SAC 4 - 5208). Refer Chart 1 below for the top ten classifications for these incidents.

Chart 1



The peak occurrence time for these incidents was between 10:00 - 12:00 hours i.e. immediately prior to and during the first hour of morning visiting hours.

N.B. Ongoing efforts are underway to reduce the number of incidents classified as 'other' and thus improve analysis of incident date. Over the last six months the use of 'other' as a classification has seen it move from the second highest category to the seventh.

Overview

This part of the report is designed to provide an anonymised overview of events reported in the last financial year, these include the findings from the review of events and the changes that have been made with the aim of preventing the event happening to another patient.

This section has been split into five sections,

- Clinical management (17)
- Healthcare associated infections (17)
- Patient falls resulting in harm (10)
- Other clinical events (5)
- Behaviour (Mental Health & Addiction Services) (14)

1. Clinical management events

Clinical management event	No. of events	Description
Retained item	2	Item left in wound beyond expected time A missing component of another instrument became dislodged and was left in wound.
Wrong side/site	2	Technically challenging procedure attempted but abandoned, then recognised it had been attempted on wrong side Referral not clear and site not obvious due to previous surgery
Pressure injury	1	Pressure injury from insufficient position change and delayed access to pressure relieving devices
Deterioration	3	Patient deterioration not recognised or managed in expected timeframe
Complication	1	Complication of treatment / procedure
Transfer	1	Harm related to transfer of care between providers
Assessment and diagnosis	2	Initial assessment did not find key issue
Delayed diagnosis or treatment	2	Delays in referral process
Resources/organisation/management	1	Insufficient staff/appointments to meet demand
Other	2	Reviews not completed at the time of this report

Reviews of clinical management events identified the following themes:

Patient factors:

- Patients also had other medical conditions
- Physiological factors typically indicating significant blood loss not present
- The baby's presentation meant the labour was less effective

Staff factors:

- Surgeon was reluctant to move the patient post procedure for an X-ray due to the very long surgery
- Process / procedure issues with replacement of missing items in theatre trays, communication of missing clamp, findings from X-rays not escalated due to assumptions that object seen was external to the chest.
- Anaesthetist working alone without usual support
- Inconsistent compliance with policy / procedure / skills deficit
- Confusion between staff regarding responsibilities

Communication factors:

- Documentation not clear e.g. clarity, comprehensiveness, rationale for decisions, treatment plans, responsibilities / handover of care
- Unable to contact service regarding results
- Escalation process not activated within expected timeframe
- Ineffective communication between departments / staff
- Inadequate communication with family

Work / environment factors:

- Resources: no assistant available so procedure started late, high acuity (number of nursing hours required to care for patients that shift) and workload, demand exceeded capacity / resources
- Equipment related: no magnifier stand to assist with site identification, delayed access to pressure relieving devices equipment as none on ward, clocks not aligned (different rooms, electronic monitoring equipment, etc) making accurate time keeping difficult, current equipment does not facilitate easy monitoring of maternal and fetal pulse simultaneously
- Inappropriate transfer of patient

What did we do?

- We informed patients / whānau of the outcome of the reviews.
- Event socialised at various forums, staff education given
- Policy / procedural: processes reviewed / updated, need for compliance with policy, national early warning signs chart implemented
- Equipment related: purchase of new equipment expedited, improved access to equipment in the ward, alignment of clocks investigated for greater clarity with time keeping
- Audit related: sepsis audit programme rolled out to other services, documentation audits
- Further review undertaken regarding theatre access
- Communication related: reviewing and standardising key clinical information to improve transfer of information and handover, review of communication system with other services,
- Reviewing scheduling

2. Healthcare associated infections

Healthcare acquired infections made up 27% of the total reportable adverse events this year (compared to 14% last year).

The initial focus of the HQSC Surgical Site Infection Improvement (SSI) Programme was on reporting infections in orthopaedic and cardiac procedures: Waikato DHB has extended this to include all serious infection such as HA *Staphylococcus aureus* bacteraemia.

Improvements have been focused on addressing / decreasing infection rates and achieving the Quality Safety Markers

Quality Safety Markers (QSM)

Quality Safety Marker	*Target*
QSM 1: Timing of antibiotic prophylaxis for primary procedures is 100% "on time" i.e. before knife to skin	*100%*
QSM 2: Choice of prophylaxis is 2g of Cefazolin in >95% of procedures	*95%*
QSM 3: Skin antisepsis is use of an alcohol based preparation for 100% of procedures	*100*

Refer to the following charts for the Orthopaedic & Cardiac Infection Rates and achievement against QSMs

Chart 2 Waikato DHB Orthopaedic Surgery Infection Rates by %

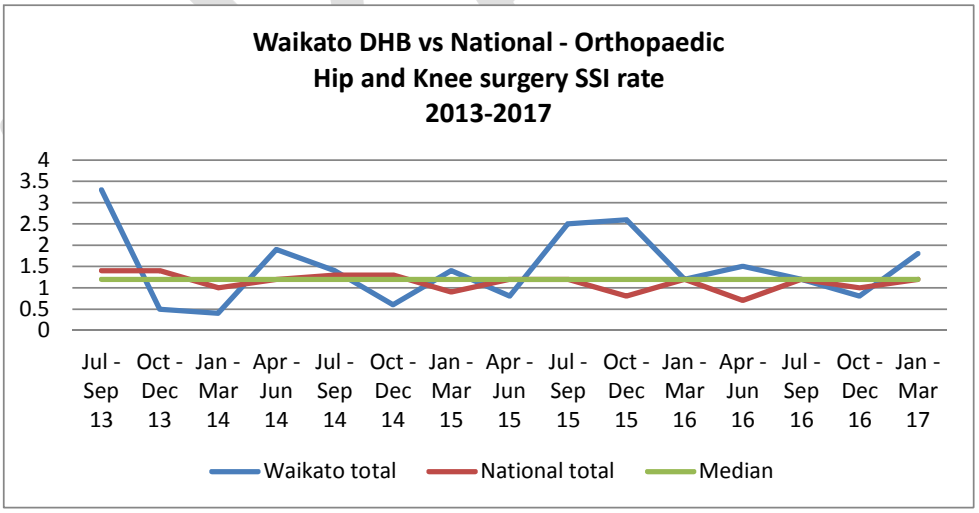


Chart 3 Orthopaedic Surgery Quality Safety Markers 2016 – 2017

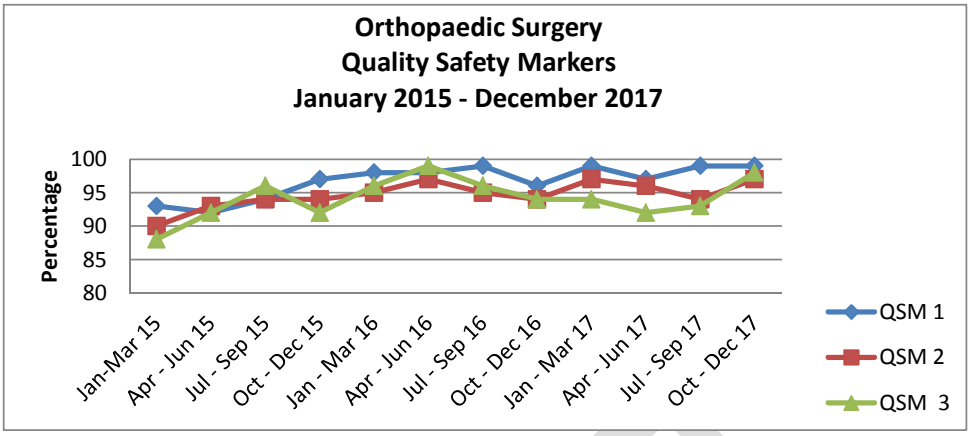


Chart 4 Cardiac Surgery Infection Rate comparison to National Infection Rates

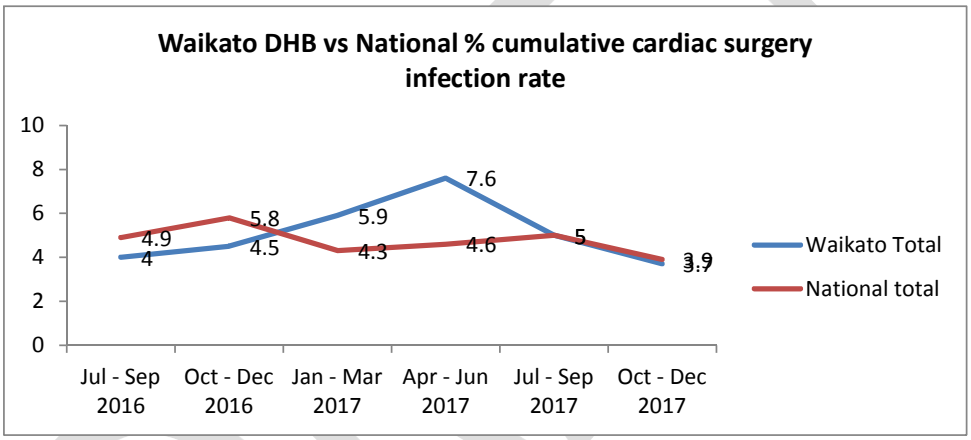
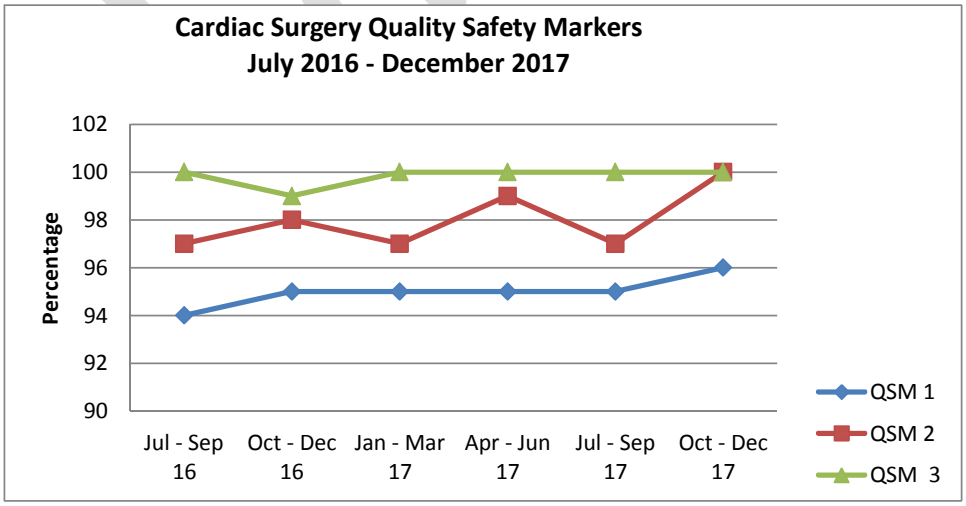


Chart 5 Cardiac Surgery Quality Safety Markers July 2016 – December 2017



Hospital Acquired *Staphylococcus aur*eus Bacteraemia (SAB)

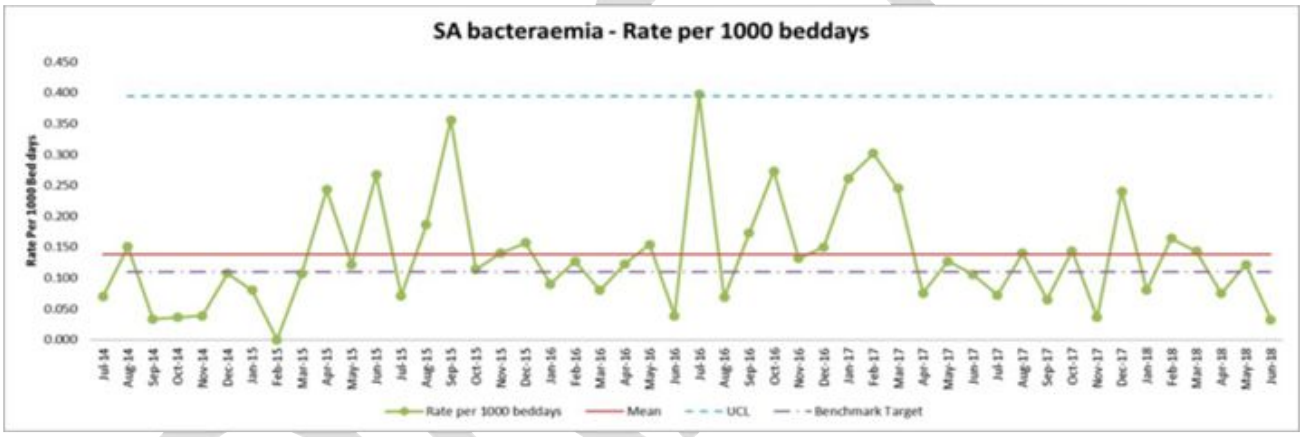
In 2015 Waikato DHB identified there was a 100% increase in rate of hospital acquired SAB and 50% of these were caused by infected peripheral intravenous lines.

A two pronged approach to address this issue was implemented;

1. Implementation of monthly intravenous (IV) peripheral line audits
2. Monthly reviews of hospital acquired SAB's at ward level to determine any breaches in practice, improvements and learnings.

Hospital acquired SAB is monitored monthly by the Infection Prevention and Control (IPC) team and is reported to the Infection Prevention and Control Committee. The Health Quality & Safety Commission and Hand Hygiene NZ also monitor SAB rates as a quality measure for the Hand Hygiene Programme.

Chart 6 Hospital Acquired *Staphylococcus aureus* Bacteraemia – Rate per 1000 bed days



Reviews of the healthcare associated infections identified the following themes:

Patient factors:

- Noted risk factors were:
  - Diabetes
  - High ASA score prior to surgery (anaesthetic risk assessment)
  - Increased Body Mass Index (obesity)
  - Other medical conditions

- Regular daily doses of a steroid (increases vulnerability to infection)

Staff factors:

- Inconsistent knowledge of and compliance with policy / procedure

Work / environment factors:

- One patient had only one pre-operative wash instead of two
- One patient received only one dose of cephazolin

What did we do?

- Continued monitoring of compliance with the anti-staphylococcal bundle for skin and nasal decolonisation.
- Anaesthetists reminded of the national SSII guideline and the requirement of an additional dose of vancomycin for patients with methicillin resistant staph aureus (MRSA)
- Ensure all patients undergoing knee and hip surgery receive two preoperative washes and use chlorhexidine wash cloths.
- Implementation of the anti-staphylococcal bundle for skin and nasal decolonisation for joint replacements by June 2018
- Monthly cleaning audits
- Ongoing discussion with theatre, ward personnel and SSI collaborative team related to identification of areas for improvement in practice and assistance with establishing practice changes
- Continued to monitor hand hygiene compliance rates against 80% national target – we achieved 85%

3. Other clinical events

Other clinical event	No. of events	Description
Patient accident	1	Patient drove wheelchair into solid object and suffered an injury
Medication event	3	Another patient's medication given Incorrect dose of medication given Inadvertent overdose of medication
Equipment-related	1	Surgery abandoned due to equipment failure following administration of anaesthetic

Reviews of the above events have identified the following themes:

Patient factors:

- Co-morbidities (other medical conditions present) and cognition led to reduced reaction time

Staff factors:

- Staff not familiar with the medication as not commonly used in this ward
- Prescribing different from what staff were accustomed to
- All patient folders had been collected and taken to the medication room
- Medication checking process not followed
- Staff not familiar with equipment or its error messages
- Patient had previously been safely mobilising in her electric wheelchair – this was a miscalculation

Communication factors:

- No instructions 'in use' instructions with equipment
- Description of equipment fault, connections and outlet were unclear / ambiguous

Work / environment factors:

- Workload pressures and fatigue
- No med-dispense machine on the ward
- Staff member distracted when preparing the medications
- Only one machine available on site i.e. no replacement handy
- Equipment delivery did not follow required process

What did we do?

- Patient and whānau advised of the outcome of the review
- Staff member has shared the experience with the team
- Staff reminded of medication room etiquette e.g. taking only one chart to the room at a time, not being disturbed when preparing medications,
- Staff attended medication safety workshop
- Medication administration audit undertaken
- Review Partnership nursing model
- Staff training for use of equipment, written instructions developed to guide staff
- Patient given manual wheelchair only rather than electric one following the accident

4. Patient falls resulting in harm

Background

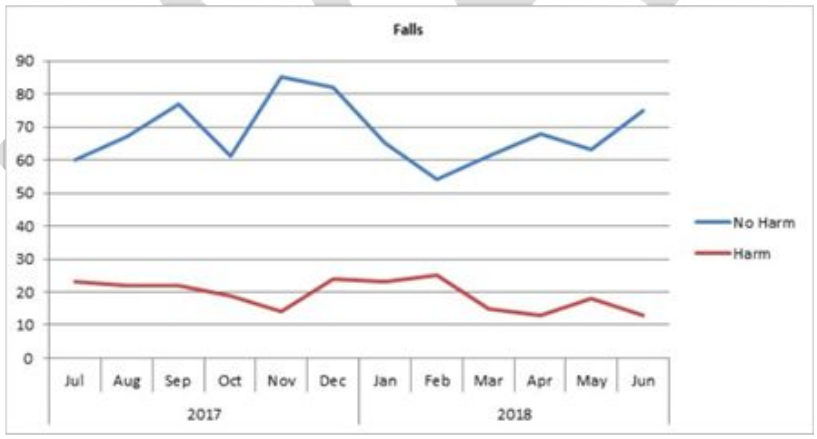
Falls can occur at any age but are more common, with more serious consequences, in our older patients. A fall after the age of 55 is more likely to cause injury and around 1 in 3 people aged 65 or over will fall in any one year. Patients admitted to hospital are particularly vulnerable due to their illness or the medications they are taking. The harm a patient may sustain following a fall whilst under the care of Waikato DHB may range from minor cuts or bruises through to falls with serious harm. Falls with serious harm such as a fracture result in additional treatment and longer inpatient stays.

Waikato DHB has an active Falls Committee which has representation from nursing, allied health, medical and pharmacy. Nursing staff attend and present their improvement work and progress to the committee on a regular basis. This provides an excellent avenue for supporting quality improvement work, sharing ideas and celebrating successes.

We have a wide range of equipment to use where patients are at risk of falling, as well as making sure care plans are personalised and appropriate to individual needs. One of the Quality & Safety markers for Waikato DHB is that "90% of older patients are given a falls risk assessment and an individualised care plan where indicated" – we have achieved 98% against this measure.

Over the past year there have been 231 patient falls with harm which is 22% of all our reported falls (the same percentage as last year). Chart 7 shows the number of falls with harm and without harm per month for the last financial year.

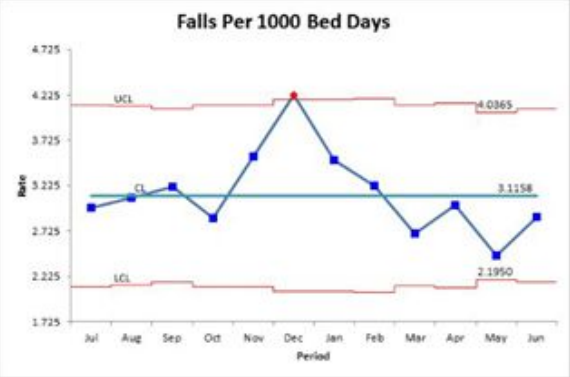
Chart 7

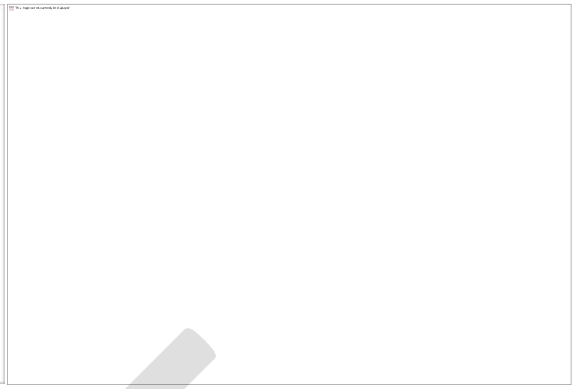


Patient falls made up 10 (16%) of the total reportable adverse events this year (compared to 30% 2016-17) and half of these patients suffered a fractured neck of femur.

The below two graphs show the number of falls and the number of falls with harm per bed day for the last **two** years respectively (injury can range from minor e.g. minor skin tear or bruise to major injury e.g. fracture).

Chart 8 **Chart 9**





Reviews of reportable falls with serious harm (usually fracture) have identified the following themes:

Patient factors:

- Cognition e.g. dementia, delirium, confusion, impulsivity
- Previous falls
- On multiple medications
- Hearing and/or visual impairment
- Toileting issues e.g. urgency, incontinence
- Altered manner of walking
- Desire to be independent and be discharged
- Had several medical conditions

Staff factors:

- Staffing mix and workload
- High acuity (number of nursing hours per patient per shift)
- Poor compliance with policy

Communication factors:

- Delay in confirming fracture
- Lack of information on care plan about previous falls or prevention strategies
- Handover not completed at the bedside

Work / environment factors:

- Safety alarm not in use
- Inappropriate use of bedrails
- Bed location

What did we do?

- We informed all patients / whānau of the outcome of the reviews.
- Policy / procedural: releasing time to care handover, fall prevention modules, handover sheets to include falls assessment and strategies, teamwork at night, handover done at the bedside, intentional rounding, ward meetings that focus on falls risks.
- Education: the Stand up to Falls How to use bedrails safely poster displayed and discussed to improve staff knowledge of appropriate use of bedrails, involve patient / family with

education around falls risk status, prevention strategies and rationale, completion of module focussing on falls and vulnerable patients, focus board in place on the ward,

- Organisational: assisting family to stay with patients in a single room, rooms closer to staff to increase visibility / monitoring.
- Each fall which results in serious harm is reviewed with the Charge Nurse Manager from the ward presenting the findings from the review to the Falls Committee and reports of progress with actions to reduce the likelihood of recurrence. This practice has provided a forum for raising awareness, education and sharing of learnings and strategies amongst the Charge Nurse Managers and other nursing staff.

Patient story

Harry (not his real name), aged in his nineties, was admitted with a history of falls, impaired balance and dementia; he had been managing at home with assistance from family.

When assessed Harry was alert and pleasantly confused - a presumptive diagnosis of urinary tract infection was made and an indwelling urinary catheter was inserted. Following admission he was orientated to the ward and placed in a room that facilitated close monitoring. Overnight it was noted that Harry was confused; he was regularly re orientated and reassured. The next day Harry's catheter was removed and an extra staff member was allocated to provide increased supervision and keep Harry safe.

The increased supervision remained in place for the next 3 days – during this period Harry's behaviour went from being very agitated and verbally aggressive, to settled but confused. It was unclear at this stage whether Harry's cognitive decline was secondary to his urinary tract infection or a progression of his dementia. The plan was for Harry to be transferred to a rest home once a bed became available.

That night the ward had high acuity with high needs patients; additional staff were rostered for the shift. Harry slept intermittently, was restless, engaging in conversation and wandering at times but easily redirected. At 06:00 Harry was assisted to the toilet. At 07:15 (time of handover from one shift to the next) a loud bang was heard and Harry was found on the floor; he was able to stand up with the assistance of two staff members. Harry told staff he was going to the toilet.

An x-ray indicated a fractured neck of femur (hip): Harry underwent surgery and was later discharged to a rest home.

Since this fall, the ward has completed a module on focussing on falls and vulnerable patients, they have a focus board in place on the ward, their focusses have been on family staying with patients in a single room if they are able to, high vigilance rooms, intentional rounding and handover is now done at the bedside. There are also ward meetings that focus on falls risks.

5. Behaviour

This is the first year mental health adverse events (other than falls with fracture) have been included in the Waikato DHB Learning from adverse events report.

Reviews of mental health adverse events (excluding falls with fracture) have identified the following themes:

Patient factors:

- Polysubstance dependence e.g. alcohol, illicit drug use, etc.
- Recurrent depression / anxiety disorders
- Other concurrent mental health conditions
- Previous behaviour e.g. risk to self (suicidal thoughts, self-harm) and to others (threatening e.g. physical / verbal), poor coping strategies, addiction (gambling / alcoholism)
- Past abuse (physical and /or sexual)
- Non-compliance e.g. medications, did not keep appointments

Staff factors:

- Inadequate engagement with family / inclusion of family in rehabilitation
- Use of GP rather than DHB staff to monitor and prescribe, despite significant risk issues
- Focus on addictions rather than mental health issues
- Inadequate integration of care e.g. different services / multidisciplinary team members
- Staff resource issues / large, complex caseloads

Communication factors:

- Family support / education / involvement

Environment factors:

- Social stressors e.g. accommodation / relationship / financial issues, family bereavement
- Changing location of residence e.g. different geographical areas
- Level of family support
- Legislative e.g. prescribing requirements, Mental Health Act,
- Unemployed – long-term / recent
- No regular GP

Recommendations:

1. Clear co-existing disorders pathway to facilitate shared care between teams
2. Improve family focused care to be included in current review of acute care pathways
3. Whānau support, engagement, education
4. Support, clinical supervision and oversight of community mental health staff
5. Education and support for primary care and community care partners on medication management and risks

What are we doing?

- Waikato DHB Mental Health and Addictions Services has embarked on a significant programme of change – Creating our Futures. The programme of change focuses not just on the building of a new inpatient facility, but on a future proofed model of care that informs the way services are delivered across the full continuum of mental health care services. Engagement and consultation to inform the development of the model has occurred across the Waikato region and communities with over 700 individuals and groups participating. The model of care development includes communities, other social sector agencies, primary and secondary health care services and is following a co-design methodology with service users and whanau at the heart of its formation.
- Waikato DHB Mental Health and Addictions services has identified the need for specific focus and improvement in the area of family/whanau engagement and support in service delivery. We are currently working to develop a dedicated Family/Whanau advisor role that will support this focus on a permanent basis.
- The Mental Health and Addictions Service has worked with the two largest providers of primary health care services in the Waikato region to support the appointment of dedicated psychiatrist roles within these organisations. This will provide access to dedicated support and education for local GPs and improve the interface between primary and secondary services involved in the provision of mental health care and treatment.
- A dedicated workforce development role has been developed and appointed to, to support and enhance learning and development opportunities for mental health and addictions staff across the service, including areas of supervision, risk management, whanau engagement and person centric care.
- A one-year trial of a smartphone app to support people recovering from alcohol or drug addictions at Waikato DHB is proving successful and is likely to be extended. The Recovery in Hand app connects service users to their clinical team, recovery community, peers and other resources 24/7. There is a good evidence base for digital and e-support for people with addictions; for people going through alcohol and drug recovery, one of the significant issues is not feeling connected and part of wider support.

  The programme has gone well and the DHB is looking to extend it beyond the initial year-long pilot. Feedback indicates Recovery in Hand is improving patient care and outcomes and the service is looking to build its outcome measurement tool into the app as well as integrating it with the clinical records system.

- The Waikato DHB has recently completed the Waikato Suicide Prevention and Postvention (SPP) Plan 2018-21 which covers the next three financial years' major actions. The plan's actions and initiatives have been developed following consultation with range of stakeholders through focus groups, individual discussions, information provided by key informants, written submissions and an online survey.

  The major premise of the plan is that suicide prevention is much wider than health. The plan's actions have been developed to address some of the psychosocial factors which have been shown to be contributors to extreme emotional distress associated with suicides in our region. A number of activities are already underway and more planned.

MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
DECEMBER 2018

AGENDA ITEM 5.1

Purpose	For information and discussion

Both nationally and regionally Renal service are facing exponential demand for their services. This is a disease that affects our local community, especially in Maori communities, with >60% of patients being Maori.

The cost for Renal dialysis is expensive for the DHB and onerous for the patients, who require 3 days of treatment each week, including travel to the Regional in-centre based at Waikato Hospital. There has been recent demand from local communities South of Hamilton for the development of a separate facility to treat patients more locally.

There will be a presentation from the Renal Service on the role they provide across the Region, the challenges they are facing and options for the future, including changes required at other DHBs in the Region.

Attached as Appendix 1 is the recently completed Renal Clinical Service Plan, and Appendix 2 provides details of the geo-mapping exercise that has been undertaken in conjunction with Population Health on where the patients live that have been accessing the in-centre in 2013 and in 2018 for comparison purposes.

Recommendation

1) **THAT:**
The Committee notes the content of the Clinical Service Plan.

2) **THAT:**
The Committee receives the presentation from the service .

3) **THAT:**
The Committee comments and provides input and guidance on the ambitions and support required for changes to the Regional service moving forward, including how to negotiate with neighbouring DHBs

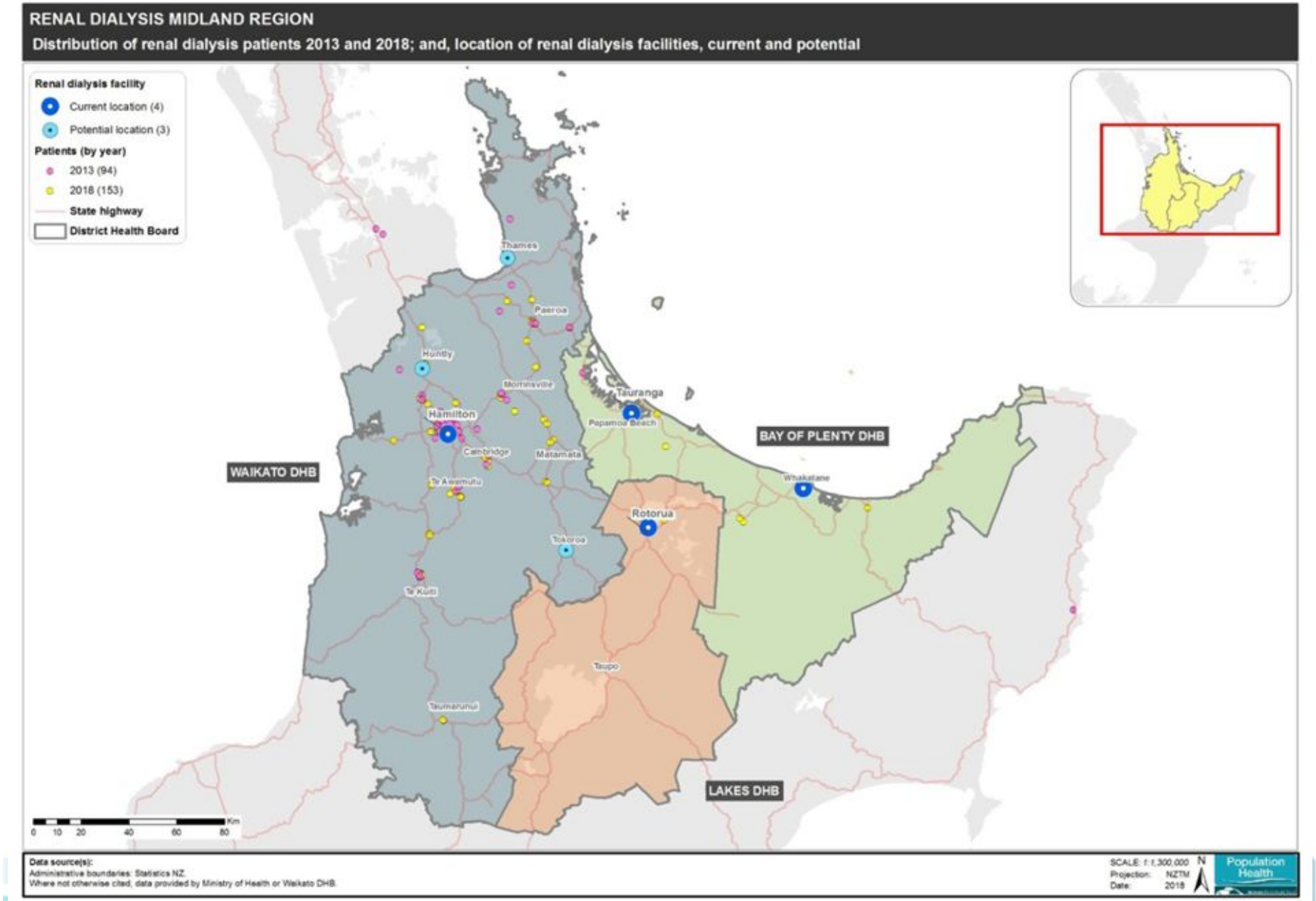
Alex Gordon
Director, Ambulatory, Cancer and Regional Services, Waikato Hospital Services

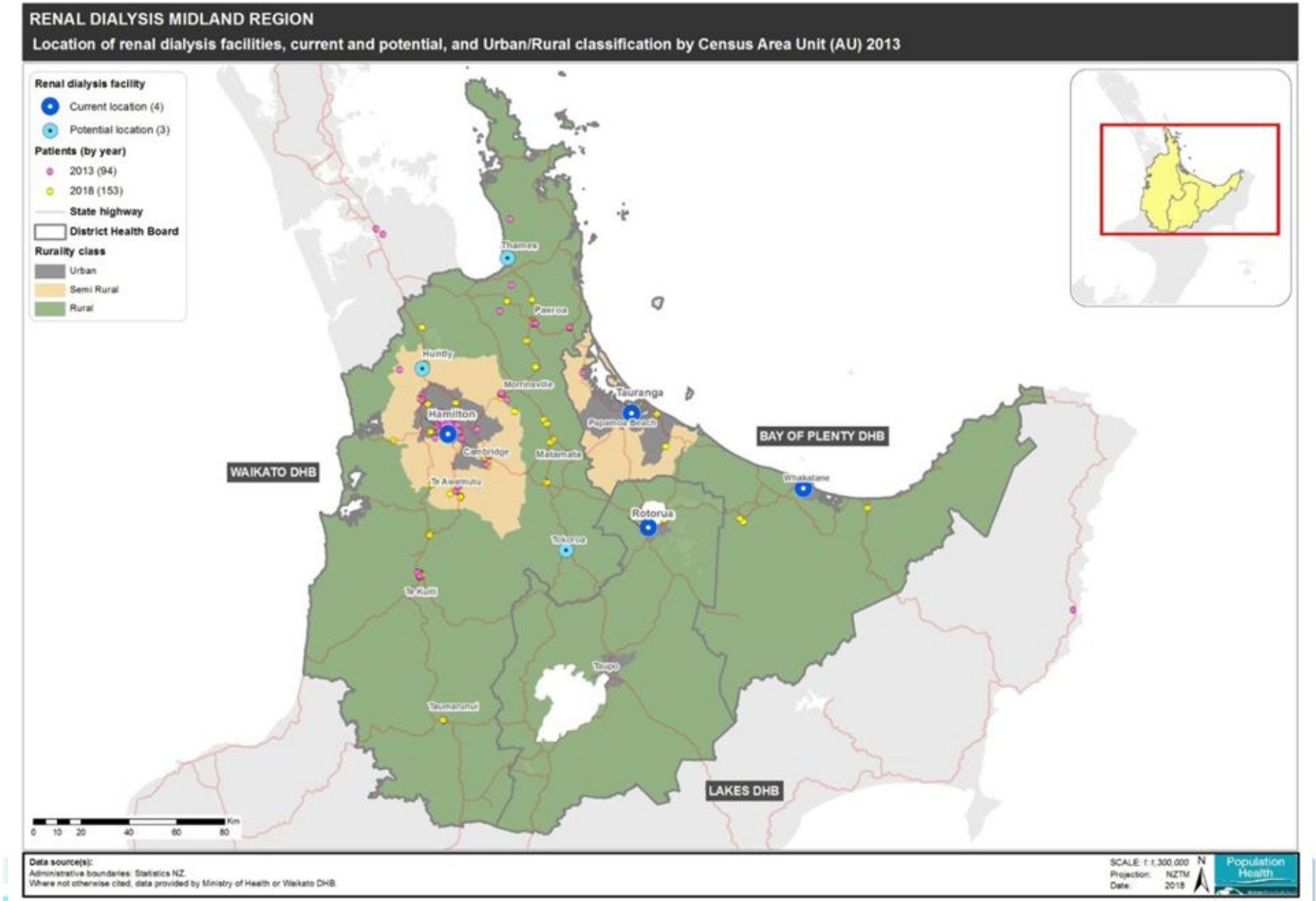
Renal dialysis facilities : Geo-mapping of where our patients are coming from

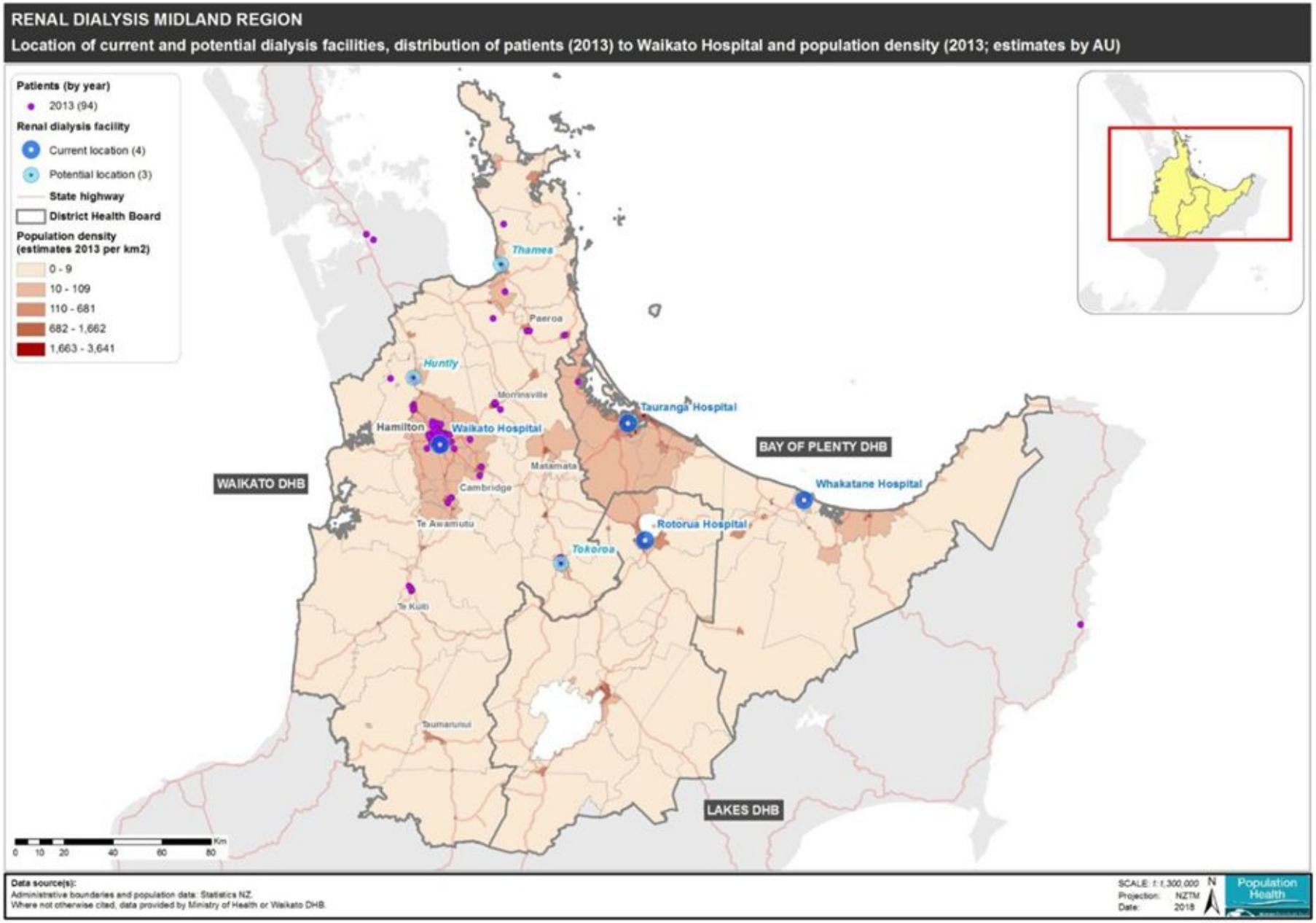
Waikato DHB – Bay of Plenty DHB – Lakes DHB

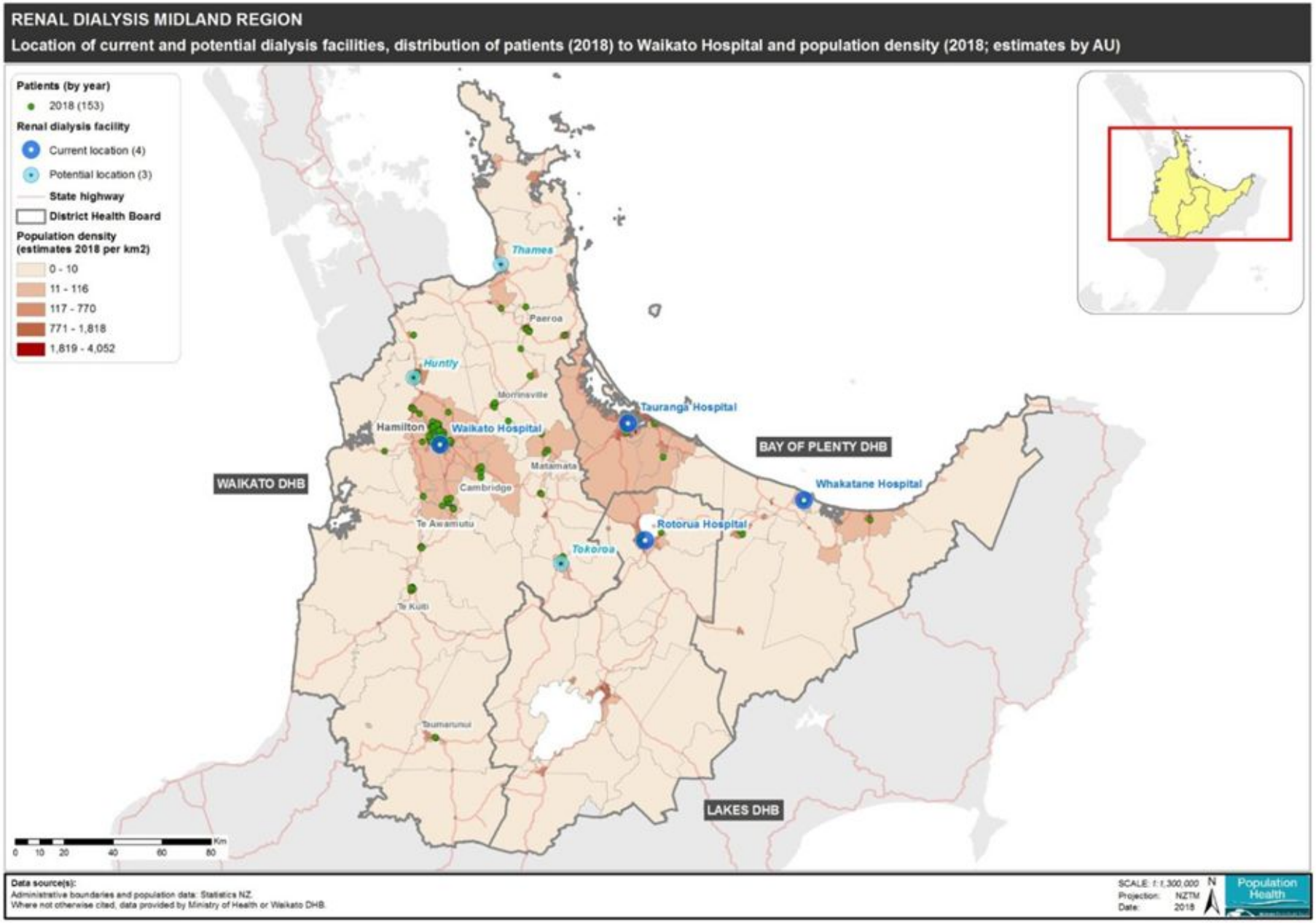
Waikato DHB data - Dialysis patients 2013 & 2018

Population Health


RENAL DIALYSIS MIDLAND REGION
Distribution of renal dialysis patients 2013 and 2018; and, location of renal dialysis facilities, current and potential
Renal dialysis facility
Current location (4)
Potential location (3)
Patients (by year)
2013 (94)
2018 (153)
State highway
District Health Board
Thames
Paeroa
Huntly
Morrinsville
Hamilton
Cambridge
Matamata
Te Awamutu
Te Kuiti
Tauranga
Papamoa Beach
Whakatane
Rotorua
Tokoroa
Taupo
Taumarunui
WAIKATO DHB
BAY OF PLENTY DHB
LAKES DHB
0 10 20 40 60 80 Km
Data source(s):
Administrative boundaries: Statistics NZ.
Where not otherwise cited, data provided by Ministry of Health or Waikato DHB.
SCALE: 1:1,300,000
Projection: NZTM
Date: 2018
N
Population Health

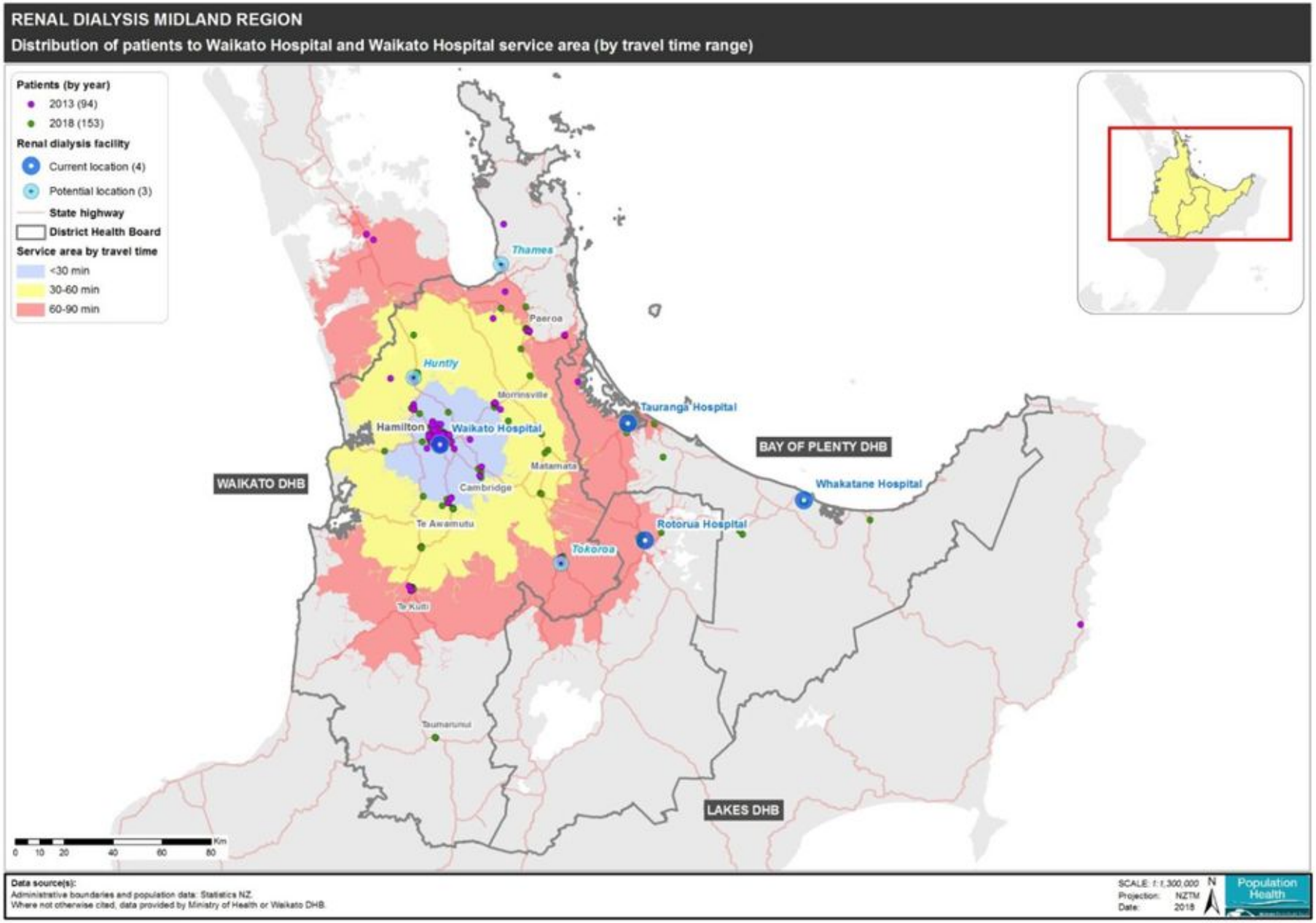

RENAL DIALYSIS MIDLAND REGION
Location of renal dialysis facilities, current and potential, and Urban/Rural classification by Census Area Unit (AU) 2013
Renal dialysis facility
Current location (4)
Potential location (3)
Patients (by year)
2013 (94)
2018 (153)
State highway
District Health Board
Rurality class
Urban
Semi Rural
Rural
Thames
Paeroa
Huntly
Morrinsville
Hamilton
Cambridge
Matamata
Te Awamutu
Tauranga
Papamoa Beach
Whakatane
Rotorua
Tokoroa
Te Kuiti
Taupo
Turnaruhui
WAIKATO DHB
BAY OF PLENTY DHB
LAKES DHB
0 10 20 40 60 80 Km
Data source(s):
Administrative boundaries: Statistics NZ.
Where not otherwise cited, data provided by Ministry of Health or Waikato DHB.
SCALE: 1:1,300,000
Projection: NZTM
Date: 2018
N
Population Health


RENAL DIALYSIS MIDLAND REGION
Location of current and potential dialysis facilities, distribution of patients (2013) to Waikato Hospital and population density (2013; estimates by AU)
Patients (by year)
2013 (94)
Renal dialysis facility
Current location (4)
Potential location (3)
State highway
District Health Board
Population density (estimates 2013 per km2)
0 - 9
10 - 109
110 - 681
682 - 1,662
1,663 - 3,641
Thamea
Paeroa
Huntly
Morrinsville
Hamilton
Waikato Hospital
Tauranga Hospital
BAY OF PLENTY DHB
Matamata
WAIKATO DHB
Cambridge
Whakatane Hospital
Te Awamutu
Rotorua Hospital
Tokoroa
Te Kuiti
Taumarunui
LAKES DHB
0 10 20 40 60 80 Km
Data source(s):
Administrative boundaries and population data: Statistics NZ.
Where not otherwise cited, data provided by Ministry of Health or Waikato DHB.
SCALE: 1:1,300,000
Projection: NZTM
Date: 2018
N
Population Health

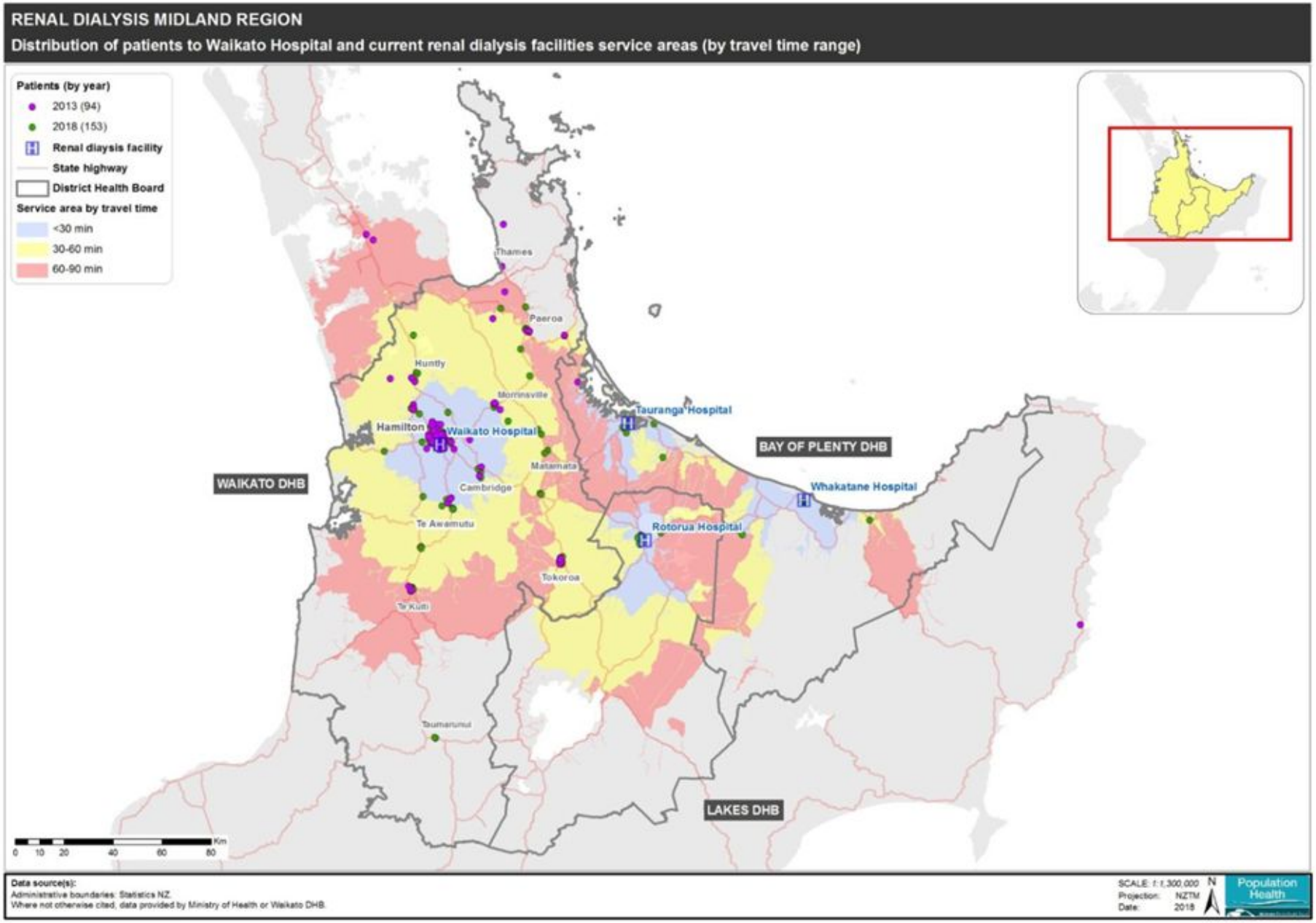

RENAL DIALYSIS MIDLAND REGION
Location of current and potential dialysis facilities, distribution of patients (2018) to Waikato Hospital and population density (2018; estimates by AU)
Patients (by year)
2018 (153)
Renal dialysis facility
Current location (4)
Potential location (3)
State highway
District Health Board
Population density (estimates 2018 per km2)
0 - 10
11 - 116
117 - 770
771 - 1,818
1,819 - 4,052
Thames
Paeroa
Huntly
Morrinsville
Tauranga Hospital
Hamilton
Waikato Hospital
Matamata
BAY OF PLENTY DHB
WAIKATO DHB
Cambridge
Whakatane Hospital
Te Awamutu
Rotorua Hospital
Tokoroa
Te Kuiti
Taumarunui
LAKES DHB
0 10 20 40 60 80 Km
Data source(s):
Administrative boundaries and population data: Statistics NZ.
Where not otherwise cited, data provided by Ministry of Health or Waikato DHB.
SCALE: 1:1,300,000
Projection: NZTM
Date: 2018
N
Population Health

Renal dialysis facilities - Service Areas *by travel time*

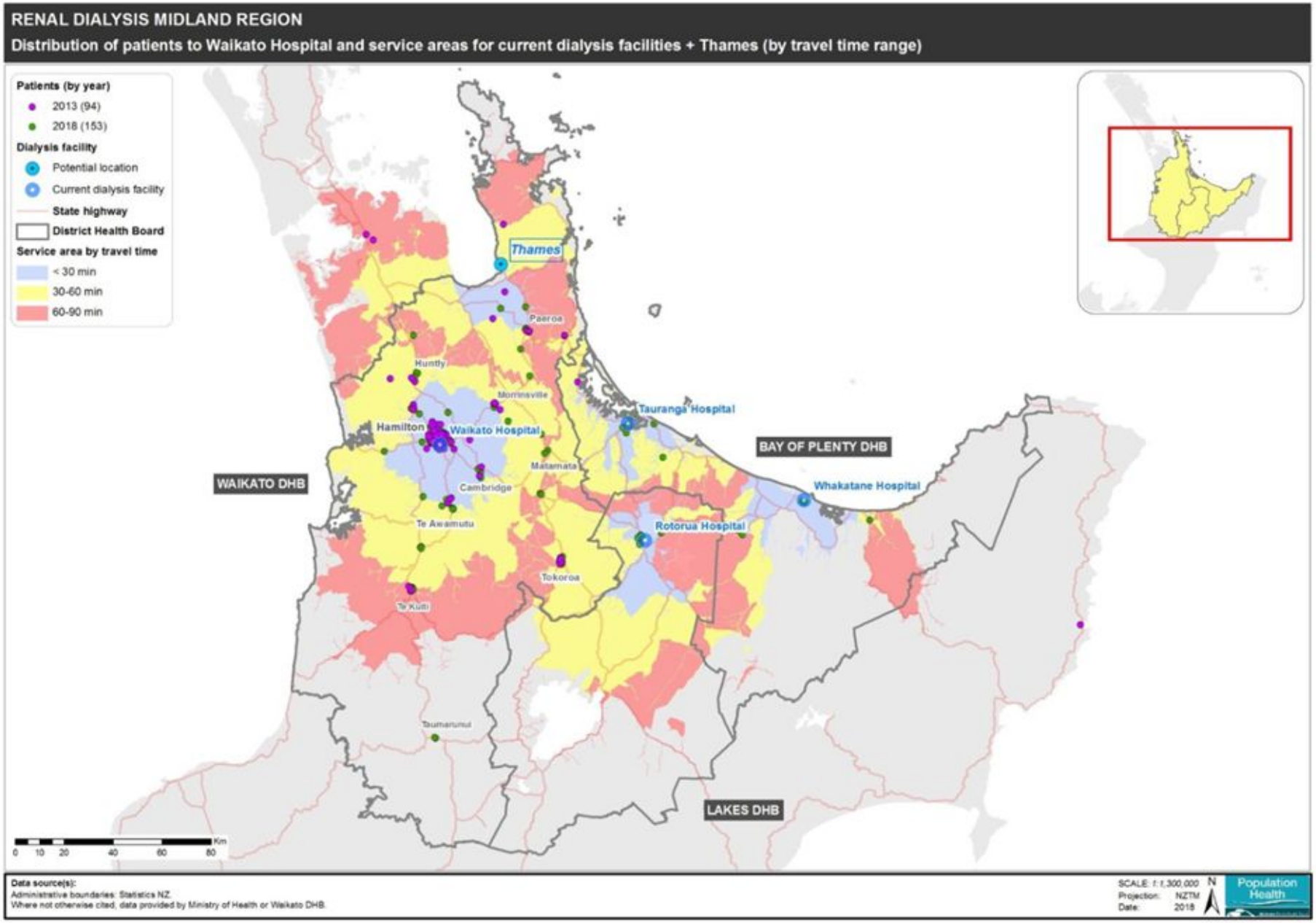
Waikato Hospital coverage (service areas based on travel time)



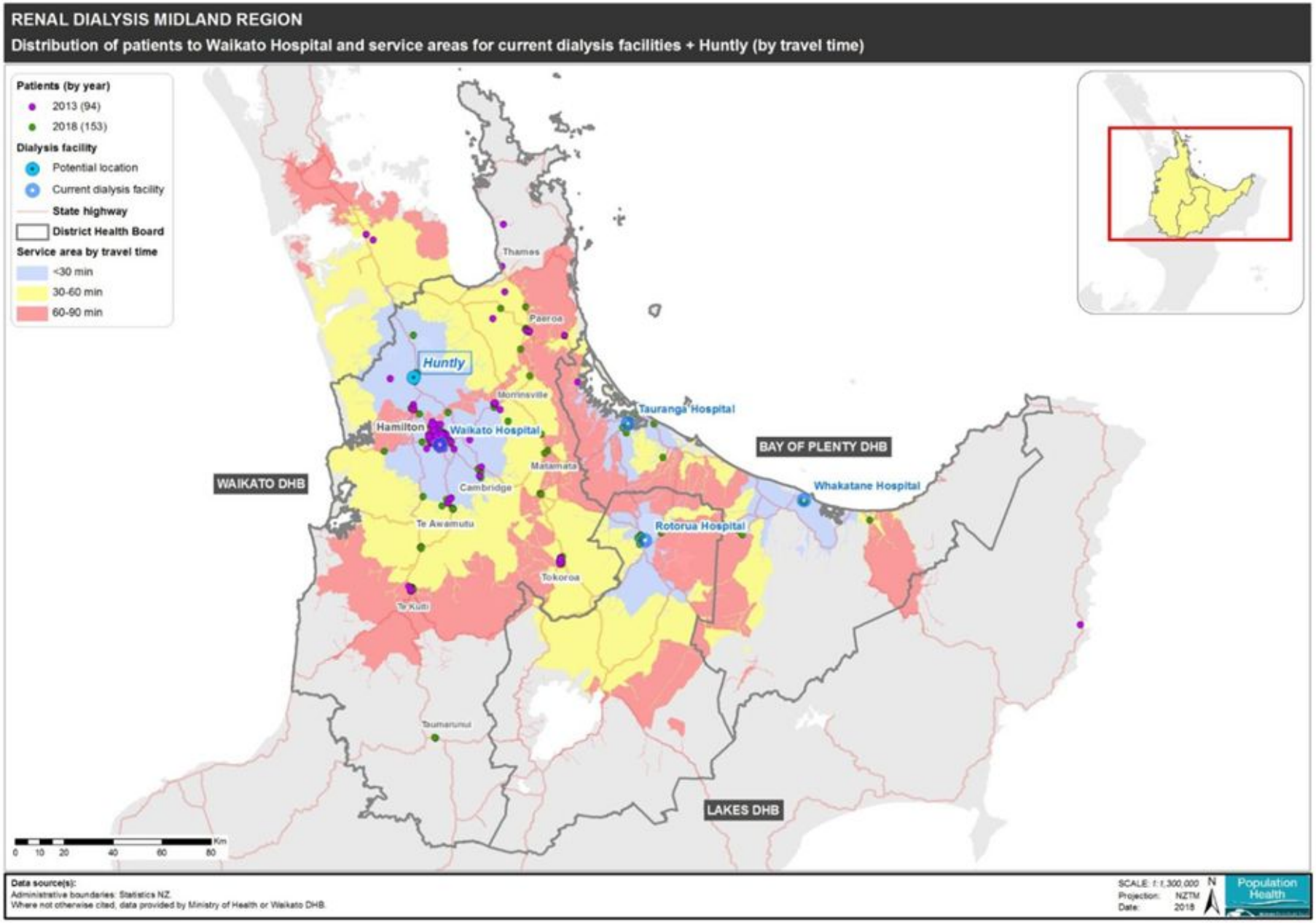
Scenario 0 - Current facilities coverage (facilities service areas based on travel time)



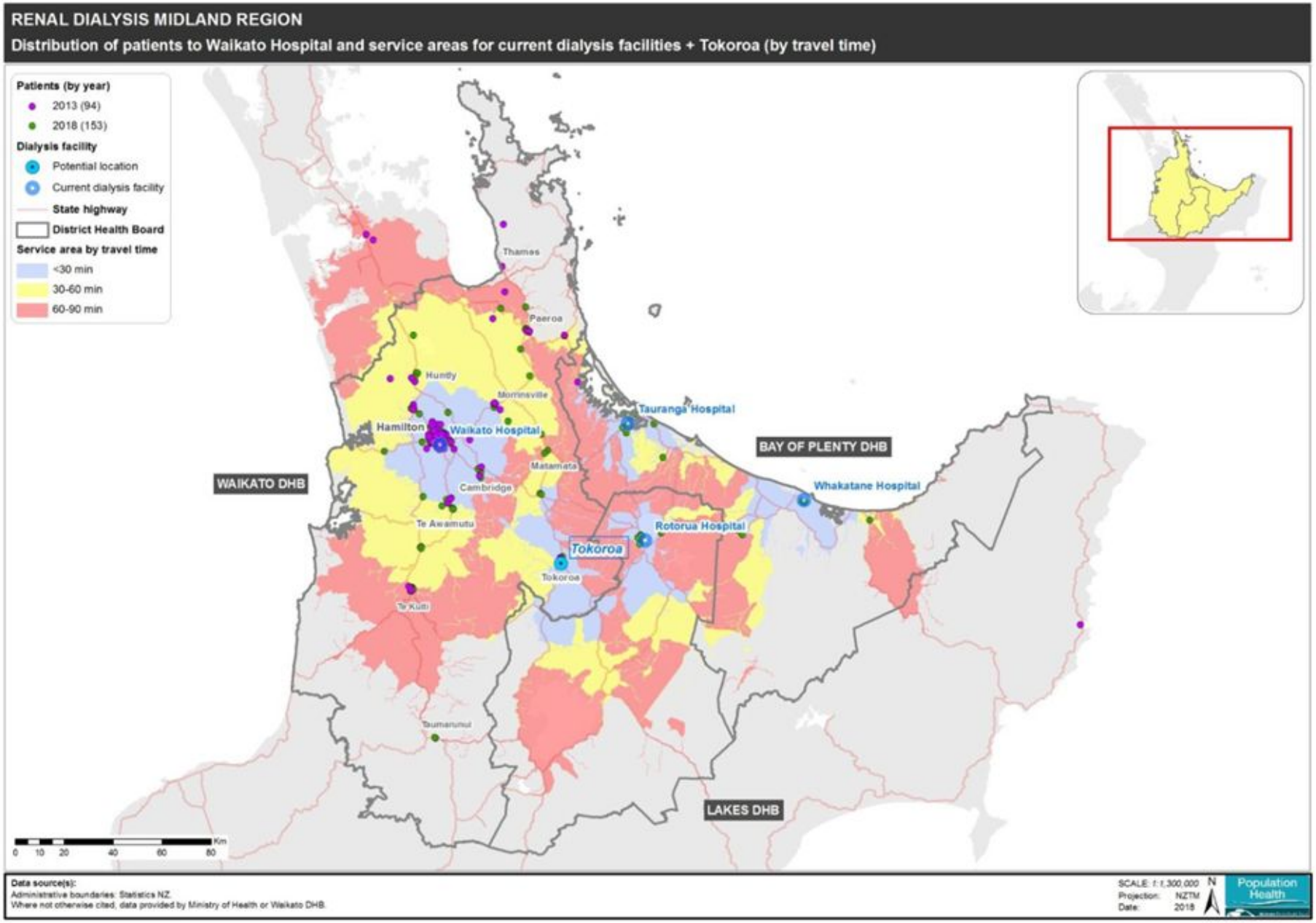
Scenario 1 - **Current facilities + THAMES** (service areas by travel time)



Scenario 2 - **Current facilities + HUNTLY** (service areas by travel time)



Scenario 3 - Current facilities + TOKOROA (service areas by travel time)



Scenario assessment

Current and potential facilities – THAMES, HUNTLY & TOKOROA

Distribution of patients 2013 & 2018 – Waikato DHB data

Count of patients by travel time to Waikato Hospital (treatment facility) **and dialysis type**

	2013	2018	Total
Waikato Hospital	**92**	**145**	**237**
< 30min	**71**	**93**	**164**
long term	64	86	150
short term	7	7	14
30 - 60min	**10**	**29**	**39**
long term	6	28	34
short term	4	1	5
60 - 90min	**11**	**23**	**34**
long term	8	16	24
short term	3	7	10
90+ min	**2**	**8**	**10**
	2	**8**	**10**
long term	1	3	4
short term	1	5	6
Total	**94**	**153**	**247**

Count of patients by travel time to a closest facility and dialysis type

	2013	2018	Total
< 30min	**72**	**110**	**182**
long term	65	94	159
short term	7	16	23
30 - 60min	**16**	**39**	**55**
long term	12	35	47
short term	4	4	8
60 - 90min	**4**	**2**	**6**
long term	1	2	3
short term	3		3
90+ min	**2**	**2**	**4**
long term	1	2	3
short term	1		1
Total	**94**	**153**	**247**

Looking at 2018 patients, **31 patients** (13%) **currently treated at Waikato Hospital live more than 1h drive away.**

If we can move patients to existing facilities closest to home, a total of **4 patients** (2%) **will travel more than 1h drive to the treatment facility**.

Note – *All patients are currently treated at Waikato Hospital. Travel time is estimated from patients' residency to a dialysis facility*

Scenario assessment – *Current facilities (Scenario 0)*

Distribution of patients by travel time to closest facility

247 patients (combined number 2013 and 2018) **are treated at Waikato Hospital** .

With the distribution of current dialysis facilities:

- **206 patients** (86%) live **closer to Waikato hospital** than to any other facility
- **37 patients** (15%) live **closer to other facilities** and within **less than 1h travel time** - 12 patients are closer to Tauranga hospital, 20 patients closer to Rotorua hospital and 5 patients closer to Whakatane hospital
- **10 patients** (4%) live **more than 1h travel time to any facility**. 6 patients have Waikato hospital as closest facility and 4 patients live more than 1.5h travel time to any dialysis facility

	2013	2018	Total
Waikato Hospital	**84**	**122**	**206**
< 30min	71	93	164
30 - 60min	9	27	36
60 - 90min	4	2	6
Tauranga Hospital	**2**	**10**	**12**
< 30min	1	6	7
30 - 60min	1	4	5
Rotorua Hospital	**6**	**14**	**20**
< 30min		7	7
30 - 60min	6	7	13
Whakatane Hospital		**5**	**5**
< 30min		4	4
30 - 60min		1	1
90+ min	**2**	**2**	**4**
Total	**94**	**153**	**247**

Note *– All patients are currently treated at Waikato Hospital. Travel time is estimated from patients' residency to closest facility*

Scenario assessment - *Scenario 1, 2 & 3*

Distribution of patients by travel time to closest facility

S1 – current facilities + THAMES

21 patients will have **Thames as closest facility**, **81%** of them (17 patients) **currently closer to Waikato Hospital** than to any other facility

	2013	2018	Total
Waikato Hospital	**77**	**112**	**189**
< 30min	71	93	164
30 - 60min	6	19	25
Thames	**9**	**12**	**21**
< 30min	5	7	12
30 - 60min	1	5	6
60 - 90min	3		3
Tauranga Hospital	**1**	**8**	**9**
< 30min	1	6	7
30 - 60min		2	2
Rotorua Hospital	**6**	**14**	**20**
< 30min		7	7
30 - 60min	6	7	13
Whakatane Hospital		**5**	**5**
< 30min		4	4
30 - 60min		1	1
90+ min	**1**	**2**	**3**
Total	**94**	**153**	**247**

S2 – current facilities + HUNTLY

32 patients will have **Huntly as closest facility**, **all** of them **currently closer to Waikato Hospital**

	2013	2018	Total
Waikato Hospital	**71**	**103**	**174**
< 30min	67	88	155
30 - 60min	4	15	19
Huntly	**13**	**19**	**32**
< 30min	6	11	17
30 - 60min	7	8	15
Tauranga Hospital	**2**	**10**	**12**
< 30min	1	6	7
30 - 60min	1	4	5
Rotorua Hospital	**6**	**14**	**20**
< 30min		7	7
30 - 60min	6	7	13
Whakatane Hospital		**5**	**5**
< 30min		4	4
30 - 60min		1	1
90+ min	**2**	**2**	**4**
Total	**94**	**153**	**247**

S3 – current facilities + TOKOROA

16 patients will have **Tokoroa as closest facility**, **most** of these patients are **currently closer to Rotorua hospital** and **only 2** patients are **closer to Waikato Hospital**

	2013	2018	Total
Waikato Hospital	**84**	**120**	**204**
< 30min	71	93	164
30 - 60min	9	25	34
60 - 90min	4	2	6
Tokoroa	**6**	**10**	**16**
< 30min	6	8	14
30 - 60min		2	2
Tauranga Hospital	**2**	**9**	**11**
< 30min	1	6	7
30 - 60min	1	3	4
Rotorua Hospital		**7**	**7**
< 30min		7	7
Whakatane Hospital		**5**	**5**
< 30min		4	4
30 - 60min		1	1
90+ min	**2**	**2**	**4**
Total	**94**	**153**	**247**

Note – *All patients are currently treated at Waikato Hospital. Travel time is estimated from patients' residency to closest facility*

Scenario assessment

Patients living more than 30 min drive from a dialysis facility

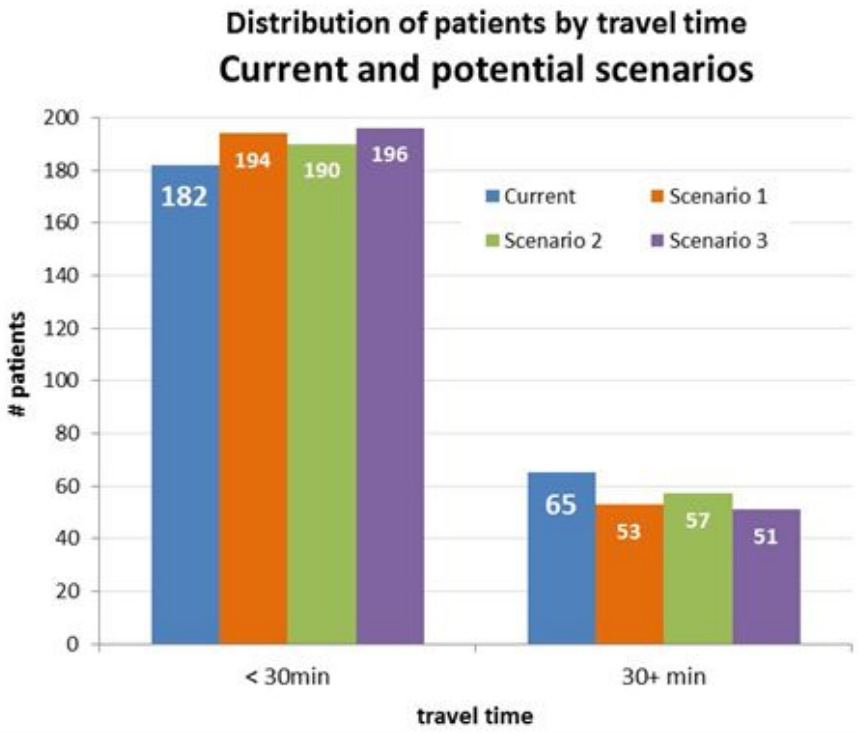
Scenario 0 - Current facilities

247 patients (combined number 2013 and 2018) **were treated at Waikato Hospital.**

44 patients (18%) **drove more than 1h to Waikato Hospital.**

However, **only 10 patients** (4%) **live more than 1h drive to a renal dialysis facility.**

65 patients (22%) live more than 30 min drive away to the closest dialysis facility



Scenario 1 – current facilities + **THAMES**

proportion (%) of **patients living more than 30 min drive** from a dialysis facility **drops to 21%** (53 patients)

Scenario 2 – current facilities + **HUNTLY**

proportion (%) of **patients living more than 30 min drive** from a dialysis facility **drops to 23%** (57 patients)

Scenario 3 – current facilities + **TOKOROA**

proportion (%) of **patients living more than 30 min drive** from a dialysis facility **drops to 21%** (51 patients)

Note – *All patients are currently treated at Waikato Hospital. Travel time is estimated from patients' residency to closest facility*

Scenario assessment

Conclusions

The **biggest gain** for reducing patients transport time would be for **patients to travel to the nearest current facility**. This will have a greater impact than opening a new facility.

The biggest impact would be Tokoroa patients going to Rotorua, which have physical capacity for 24 more patients.

A benefit for developing a new facility would be minimal. Huntly would benefit more patients but Thames would potentially reduce more patients' travel time.

Recommendations

1. The Board agree that we should engage formally with Lakes DHB to discuss opening further capacity in Rotorua Hospital
2. The Board endorse a discussion at Midland Region level to utilize current dialysis facilities to maximum capacity prior to considering new facility options
3. A northern solution is preferable to a southern solution, at this time, based on patients volume. This is dependent upon recommendation 1 being achieved

Waikato District Health Board

WAIKATO HOSPITAL

RENAL MEDICINE CLINICAL SERVICE PLAN (Phase 1)

December 2018

Contents

Executive summary

- *Service core work is supporting patients with progressive chronic kidney failure including patients who require renal replacement therapy (RRT)*
- *The number of patients requiring RRT is growing at an annual rate of 4%*
- *Within the RRT case mix most growth has occurred with facility (hospital) haemodialysis. Over the last 5 years the number of patients on long term hospital haemodialysis has increased at an annual rate of 8%*
- *The Waikato Hospital dialysis unit is at capacity (150 patients)*
- *We require a service plan that incorporates:*
    - *Service devolution*
    - *Capacity to accommodate short and long term facility dialysis dependent patients*
    - *A relationship with other local and regional providers that facilitates disease prevention, identification at an early stage, and salutary interventions to influence the natural history of chronic health conditions including renal failure*

Background

The service

Introduction

The renal medicine service is a regional service, with its base at Waikato Hospital. It predominantly manages patients with progressive chronic kidney disease (CKD) or end stage kidney failure (ESKF).

Options for patients who have kidney failure include:

- Peritoneal dialysis, which the patient manages themselves with funded supplies
- Haemodialysis:
    - Home, which is managed by the patient with a funded machine and relevant supplies
    - "Incentre", where the patient comes to a facility and either self manages (assisted care) or is dependent on dialysis staff to provide their dialysis
- Kidney transplantation.
- Supportive care i.e. no renal replacement therapy

Most patients who undertake their own dialysis complete a training programme and then receive ongoing support as home based dialysis practitioners.

Satellite haemodialysis facilities operate in the regional DHBs, with support from Waikato. Most haemodialysis dependent patients requiring inpatient (IP) care are transferred to Waikato. Other dialysis dependent or kidney transplant patients may be transferred on a case by case basis.

Staffing

Staff employed within the service include:

Staff Type	***FTE***
SMO	8.75
Registrars - training	2
Registrars – non training	3
Registrars - relieving	0.2

Staff Type	*FTE*
House officer	2
Nurse managers	2
Ward nursing	16.4
Ward HCA	4.9
Incentre nursing	39.0
Home support nursing - haemo	7.3
Home support nursing - PD	6.7
Transplant nursing	3.8
CKD nursing	3.4
HCA - Incentre	3.1
Dieticians	3.0
Pharmacists	1.0
Clinical psychologist	0.5
Podiatrist	0.5
Biomedical technicians	3.5
Admin / Typing	4.7
Kaitiaki	0.5

Bed days

The service has 12 beds (increasing to 16 in November 2018) in ward M3 Renal. In 2017/18, the service used 14-15 beds on average per day.

Ward bed days used by the renal medicine service over the last five years are shown below. Variable management of acute patients has contributed to "bed days" being an imprecise metric of inpatient case load. An IP consultation service provides support to other teams caring for patients with acute or chronic kidney conditions. The average length of stay has remained steady at around 4 days, with arranged admissions at 1.7 days and acute admissions at just over 5 days.

Bed days	Financial Year					
Admission Type	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Acute	2635	3419	4036	4259	3792	4228
As Arranged	1034	1168	630	638	708	904
Elective	69	100	133	106	71	80
Total	**3738**	**4687**	**4799**	**5003**	**4571**	**5212**

Historical delivery

Discharges and case weights over the six years to June 2018 are shown below.

Discharges	Financial Year					
Admission Type	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Acute	460	583	742	801	707	819
As Arranged	427	487	422	380	390	523
Elective	20	30	24	30	18	19
Total	**907**	**1100**	**1188**	**1211**	**1115**	**1361**

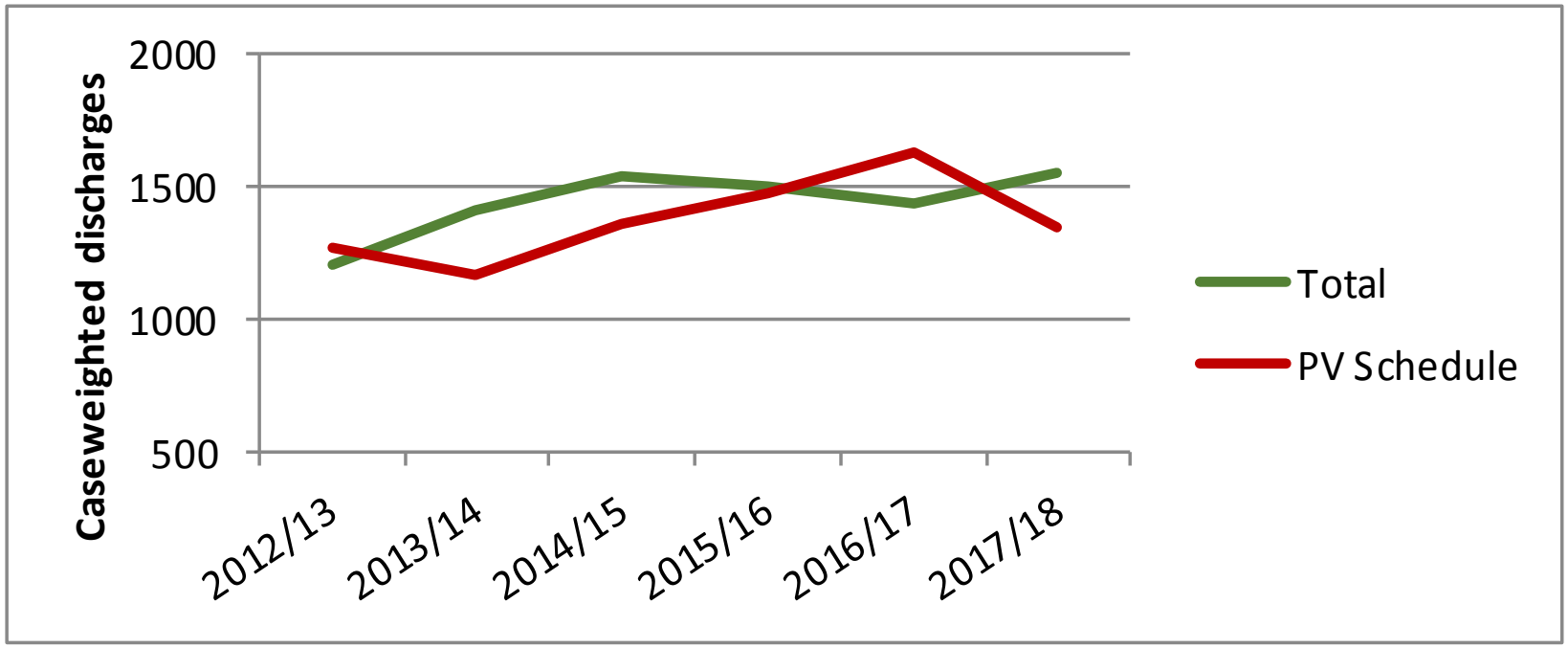
Both acute and arranged admissions have increased over the period, with a significant increase in 17/18. The average case weight has decreased slightly from 1.30 to 1.15, reflecting a drop across all admission types.

Caseweights	Financial Year					
Admission Type	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Acute	716	899	1153	1130	1072	1121
As Arranged	454	453	327	319	321	406
Elective	36	59	62	57	42	39
Total	**1206**	**1411**	**1543**	**1505**	**1435**	**1566**

Further data available if required.

As per the graph below, there have not been large variances between the inpatient case weights 'purchased' and those delivered over the period.

Delivery against PVS (price volume schedule)



Incidence and Prevalence Rates RRT New Zealand

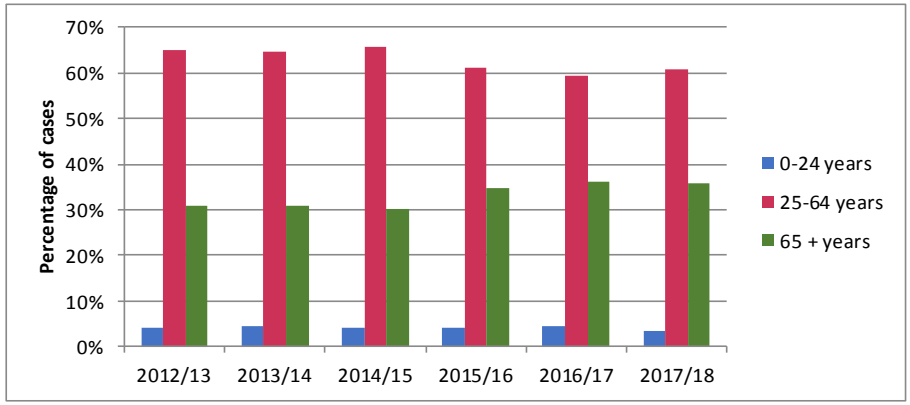
		Incident patients		Prevalent dialysis		Prevalent transplant		Prevalent renal replacement therapy	
District Health Board	**Population**	**No.**	**pmp**	**No.**	**pmp**	**No.**	**pmp**	**No.**	**pmp**
Northland	173,380	33	190	162	934	83	479	245	1413
Waitemata	598,390	40	67	278	465	187	313	465	777
Auckland	515,380	66	128	332	644	265	514	597	1158
Counties Manukau	540,420	102	189	622	1151	181	335	803	1486
Waikato	789,335	118	149	523	663	197	250	720	912
Hawke's Bay	162,630	37	228	130	800	84	517	214	1316
MidCentral	239,035	20	84	133	556	81	339	214	895
Taranaki	117,460	14	119	62	528	42	358	104	885
Capital & Coast	648,210	54	83	255	393	282	435	537	828
Canterbury	637,305	56	88	160	251	269	422	429	673
Southern	321,610	19	59	93	289	111	345	204	634

Patient demographics

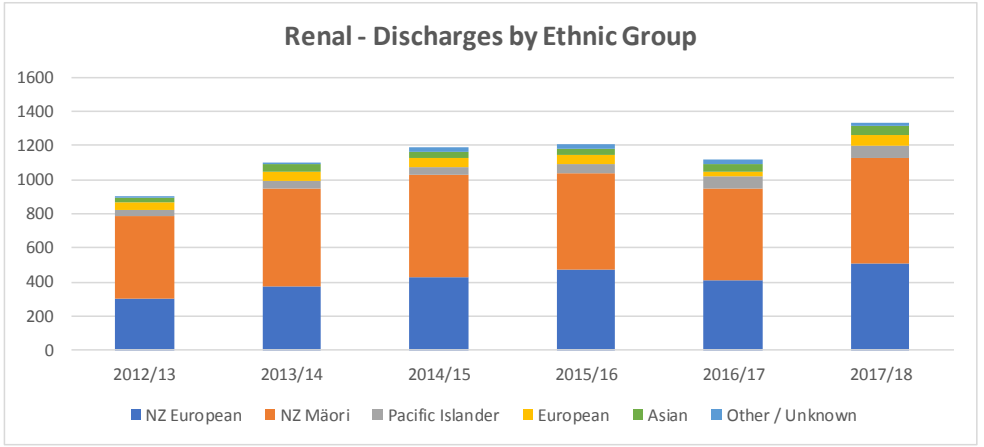
The following information is based on an analysis of the patient group that has utilised renal medicine inpatient services over the last five years.

Age

Less than 5% of the patients treated in the service are younger than 25. While the largest group remains the 25-64 years group, the 65+ year's group is increasing as a percentage of the total.



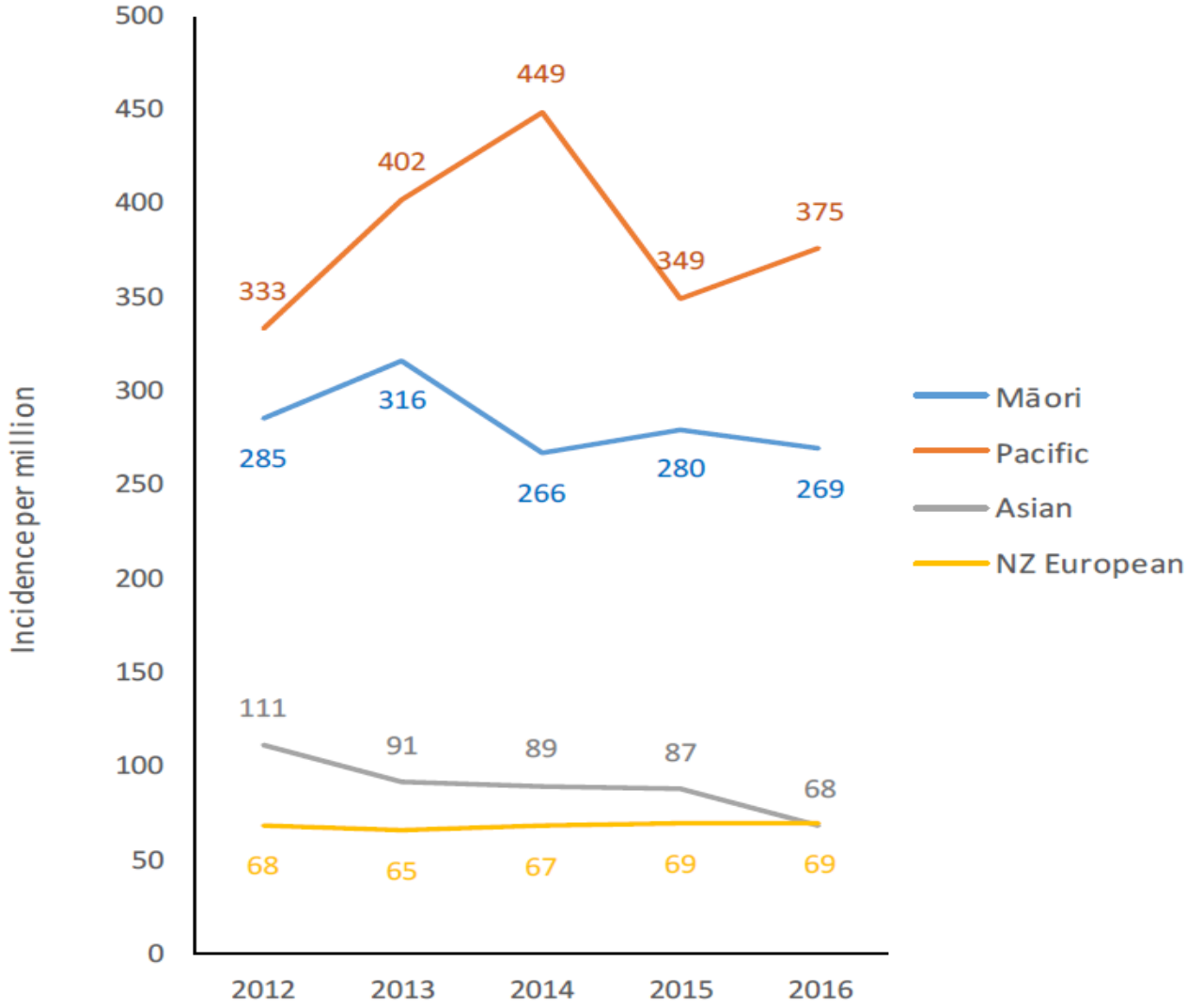
Over the period shown, approx. 50% of renal medicine discharges have been Māori (against a population percentage of approx. 17 % over the age of 24). The prevalence in Māori of diabetes and other long term health conditions lead to their over-representation in all areas of renal medicine (for example, see national incidence figure, below)



As the 'ambulance at the bottom of the cliff' the hospital renal service has no ability or resource to influence the factors that lead to patients developing renal disease. However, the service does aim to offer a culturally appropriate service to the large percentage of Māori in its patient cohort.

The service acknowledges it has a role in developing strategies to prevent chronic renal failure and screen high risk populations for chronic kidney disease. We feel we can help shape programmes which ideally should have national support and co-ordination and be led by PHOs through clinical pathways. However, we are not currently resourced to participate in health promotion/disease prevention. programmes.

Incidence of Renal Replacement Therapies by Race



Clinical governance

A clinical leadership group, headed by the Clinical Director, supports service requirements. This leadership group is broadly representative of the staff within the renal service, and includes CNMs and renal SMOs. The service holds a range of regular meetings, including a bi-monthly quality meeting and mortality and morbidity review. Actions are developed from these reviews, e.g. communication (SMO to SMO), timelines of transfer, responsible IP team for acute issues, care concerns.

An audit programme with rostered physician/registrar presenting quarterly has recently been re-established. Physicians have been assigned portfolios / areas of focus. E.g. PD, home HD, transplantation

A meeting is held with the coding team for all discharges every fortnight.

A regional service workshop has been held with priority projects articulated.

An outpatient questionnaire was distributed (75% return rate) and a presentation given based on the results. Key issues identified were around care continuity, clinic times, the role of SmartHealth, DNA policy, patient ownership, the appointment notification process and nurse led clinics.

Quality improvement outcomes include parathyroidectomies, biopsies including protocol tx biopsies, vascular access patency, effectiveness of alteplase with poorly functioning tunnelled haemodialysis catheters, PD in the larger patient, Tenckhoff catheter outcomes, and the approach to limb threatening ischaemia in dialysis dependent patients.

The service contributes to the PD and ANZDATA registries.

Key issues / risks

The service has identified the following as areas of concern or risk:

- Insufficient staffing to manage increasing patient numbers
- Current facility inadequate for numbers of patients having in-centre dialysis (capacity challenges)
- Encouraging patients to start and continue home-based haemodialysis
- Increasing volumes of patients being managed/overseen across the region
- Timeliness of providing catheter access for peritoneal dialysis patients

- Vascular access service for haemodialysis patients
- The lack of an IT system to monitor patients and collect and collate regional data

What we do to keep people healthy

The hospital based service is not directly engaged in any prevention or screening programmes. However, it is fully cognisant that these programmes need to be developed in order to impact the volumes of patients being managed within the service. Any effect on patient volumes and disease outcomes from such programmes will be in the distant future.

What we do to help people with health issues live good lives

Inpatient services

As a predominantly chronic illness service, the majority of ongoing care of patients occurs in an outpatient (or day case setting). The key aspect of elective inpatient treatment is the creation of access – either vascular (for haemodialysis) or catheter (for PD) – for dialysis. There have been issues of timeliness for both types, due to constraints in theatre and interventional suites. There has also been a lack of clarity as to when the patients require the service – particularly for catheter access. The renal physicians are now inserting an increasing volume of catheters themselves, and there may be the opportunity to "bury' the catheter at an early stage, so it is available when required.

We have developed a forum, with patient and clinician members, to discuss the Waikato Hospital haemodialysis service. This forum has a focus on service improvement and partnership building.

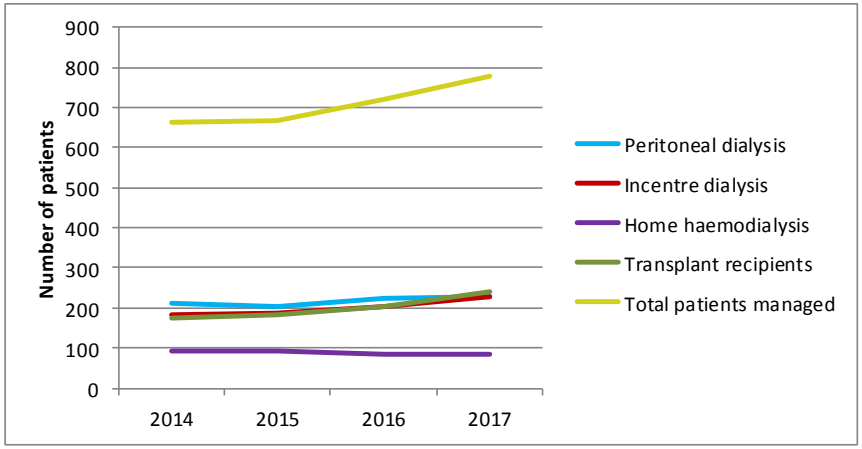
Renal dialysis / kidney transplantation

Renal dialysis – either peritoneal or haemodialysis - is the key treatment option for patients with end stage renal failure. While the number of patients receiving kidney transplants is increasing, dialysis remains the mainstay. All transplant patients are managed by Waikato staff – doctors, nurses and other multi-disciplinary team members.

Waikato Hospital is the regional training centre for patients to have home based dialysis. Once trained, Waikato Hospital nurses manage those on home haemodialysis across the region, while the DHB of domicile nurses manage the PD patients. There are four satellite haemodialysis facilities across the region, which are staffed by local nurses. From a doctor perspective, as well as the local patients (of all descriptions), the Waikato staff provide support across the region for all patients and provide support to clinicians in other DHBs on a 24/7 basis.

The Waikato Hospital incentre facility has 30 chairs (which can accommodate 120 patients), and there are 10 chairs in the Acute Renal Dialysis Unit (ARDU) in Ward M3. This unit was established to provide treatment for acute inpatients and unstable outpatients. However, reflecting capacity challenges, it is being used for regular dialysis patients and this has led to delays in acute patients accessing dialysis.

The volumes of patients being managed – either directly or across the region – is shown in the graph below. (This data has been supplied by the service. Please see appendix)).



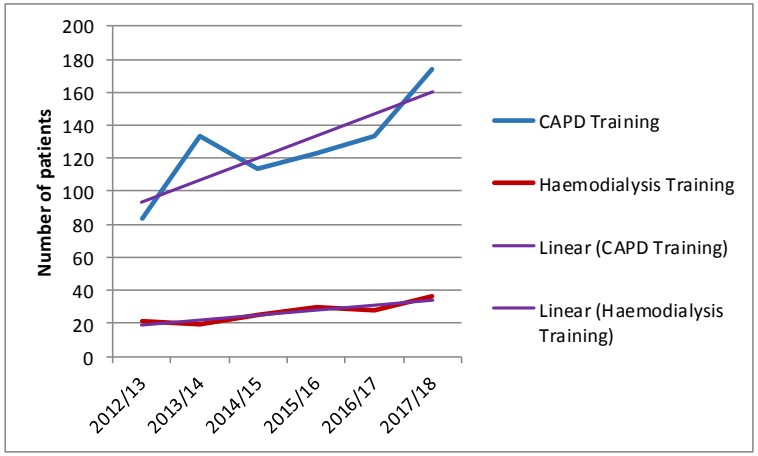
The total number of patients is growing, with the volumes of PD, incentre dialysis and post -transplant patients increasing year on year.

The number of patients being trained on haemodialysis is static and a higher percentage of patients on haemodialysis are remaining on incentre dialysis – the percentage increasing from 66% to 73% over the four years (with the commensurate decrease in those on home haemodialysis).

As previously noted, this volume of incentre patients has stretched the facility with little scope in current configuration to accommodate patient growth.

Please note the graph shows regional incentre patients-it may be helpful to split this into Waikato and satellite as separate curves.

Numbers of patients trained on either form of dialysis are shown here.



The expectation of the department is that, wherever possible, patients will have home based dialysis. For a number of reasons, not always related to their medical situation, it has been difficult to successfully establish and maintain patients on home based haemodialysis. This has led to severe strain on both the incentre facility and the ward based dialysis stations.

The service consistently attempts to ensure that only those who would benefit from dialysis choose to receive it, but there are few agreed circumstances under which dialysis can be denied. Given the medical drivers of kidney disease, patient and whanau expectations, and whether or not the service is successful in increasing the number of patients on home based dialysis, the total volume of patients will continue to increase.

Outpatients

Triage is completed at point of referral. The service has developed health pathways for GPs, including a regional CKD pathway. It has also provided evening education sessions for primary care.

The service does not accept referrals for CKD until they are CKD Stage 4. Due to this filtered approach, the volume of FSAs has remained fairly steady, with an increasing trend in follow-ups. Triaging across the region results in around 35% of FSA referrals being managed as ncFSAs.

	Financial Year					
Outpatient attendances	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
1st Attendances	440	478	529	546	530	538
Subsequent Attendances	2936	3323	3509	3515	3476	4014

The service also delivers outreach clinics at other DHBs – Lakes, BoP, Tairawhiti – and the number of clinics delivered has increased over the last five years. Telephone and virtual clinics are already in use and have the potential to better utilise the medical resources and enhance the patient experience.

Outreach Clinic	2013		2014		2015		2016		2017	
Gisborne Hospital	SMO	15	SMO	12	SMO	9	SMO	10	SMO	9
	RMO	11	RMO	9	RMO	7	RMO	6	RMO	7
	Total	**26**	**Total**	**21**	**Total**	**16**	**Total**	**16**	**Total**	**16**
Tauranga Hospital	SMO	39	SMO	53	SMO	64	SMO	64	SMO	56
	RMO	26	RMO	29	RMO	32	RMO	32	RMO	42
	Total	**65**	**Total**	**82**	**Total**	**96**	**Total**	**96**	**Total**	**98**
Tauranga Telephone Clinic	SMO	0	SMO	0	SMO	0	SMO	2	SMO	4
	Total	**0**	**Total**	**0**	**Total**	**0**	**Total**	**2**	**Total**	**4**
Whakatane Hospital	SMO	16	SMO	21	SMO	24	SMO	24	SMO	24
	RMO	10	RMO	11	RMO	11	RMO	11	RMO	14
	Total	**26**	**Total**	**32**	**Total**	**35**	**Total**	**35**	**Total**	**38**
Whakatane Virtual Clinic (Half day)	SMO	12	SMO	12	SMO	12	SMO	12	SMO	12
	Total	**0**	**Total**	**0**	**Total**	**12**	**Total**	**12**	**Total**	**12**
Rotorua Hospital	SMO	28	SMO	31	SMO	32	SMO	30	SMO	30
	RMO	15	RMO	16	RMO	15	RMO	15	RMO	20
	Total	**43**	**Total**	**47**	**Total**	**47**	**Total**	**45**	**Total**	**50**
Thames Hospital	SMO	4	SMO	4	SMO	4	SMO	1	SMO	2
	RMO	4	RMO	8	RMO	8	RMO	11	RMO	10
	Total	**8**	**Total**	**12**	**Total**	**12**	**Total**	**12**	**Total**	**12**
Clinics per Year	SMO	106	SMO	129	SMO	151	SMO	143	SMO	135
	RMO	62	RMO	65	RMO	57	RMO	75	RMO	95
	Total	**168**	**Total**	**194**	**Total**	**218**	**Total**	**218**	**Total**	**230**

Opportunities

The service has identified the following opportunities in the outpatient environment:

- The development of a focused transplant assessment including a multi-disciplinary team – physician, transplant nurse, psychologist – and support from other specialties as required, with the aim of having all protocol requirements completed within four months
- The development of an Assisted Care facility, where patients develop more treatment independence and may transition to home based haemodialysis
- Greater clarity around the service philosophy of home based therapy and hospital dialysis only being provided to patients who are considered unsuitable for home based therapy
- The provision of a Māori health worker, to enhance the culturally safe practice environment, improve health literacy and encourage patient autonomy
- The development of a young persons' service
- Increased use of telemedicine including the use of technology (smart devices etc) to better connect with and manage home based patients
- Nurse (and allied health) prescribing.
- Telehealth

Regional aspects

As noted throughout the document, the Waikato Hospital staff play a large role in the management of patients across the region. As this work increases, the regional DHBs will need to be encouraged to acknowledge and pay for the work delivered. At present, only outpatient clinics result in a transfer of funds (at an agreed rate unrelated to the funding streams) and the revenue for all patient training sits with Waikato. Both doctors and nurses are providing varying levels of support to different groups of patients in the outlying DHBs and it is a priority of the service to be adequately reimbursed for this.

- It is likely that BoP may develop its own renal service within 5 years and the Waikato service supports this.
- There is also the possibility that the part time renal physician at Tairawhiti will retire and this work may flow to Waikato. Some support is also provided to Taranaki.

- There is the opportunity for Lakes DHB to increase the service it provides and for Tokoroa patients to be treated by Lakes DHB. This would assist the Waikato in-centre with capacity pressures and result in reduced travel time for Tokoroa patients.

What we do to 'rescue' people

Inpatient services

The service's top 10 acute diagnostic groups over the last six years are shown below. While there have been some changes across the groupings over the period, they continue to comprise around 60% of the acute workload

	Financial Year					
Top 10 DRG groups	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Other Kidney and Urinary Tract Disorders	169	203	155	106	118	168
Kidney Failure	86	105	95	99	116	139
Red Blood Cell Disorders	1	7	107	88	95	60
Operative Insertion of Peritoneal Catheter for Dialysis	63	84	70	88	86	121
Heart Failure and Shock	34	58	72	77	71	100
Other Circulatory Disorders	76	57	57	60	42	56
Miscellaneous Metabolic Disorders	25	35	36	41	41	84
Other Procedures for Kidney and Urinary Tract Disorders	17	26	36	33	39	38
Other Factors Influencing Health Status	63	30	27	35	25	40
Oesophagitis and Gastroenteritis	14	25	15	23	22	24

Interdistrict flows

	Financial Year					
Acute inflows	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Lakes	116	108	157	111	126	123
Bay of Plenty	180	212	225	238	232	269
Tairawhiti	55	47	37	37	41	44
Other	14	15	22	13	20	10
Total	**365**	**382**	**441**	**399**	**419**	**446**

As previously noted, a large component of the workload is regional. In terms of acute flows, BoP has shown the greatest increase, while Taranaki is the largest contributor to "Other".

These flows comprise around 35% of the acute work.

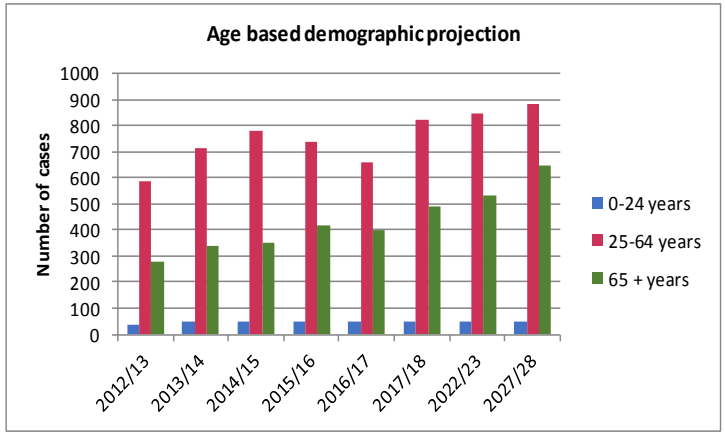
Projected workload

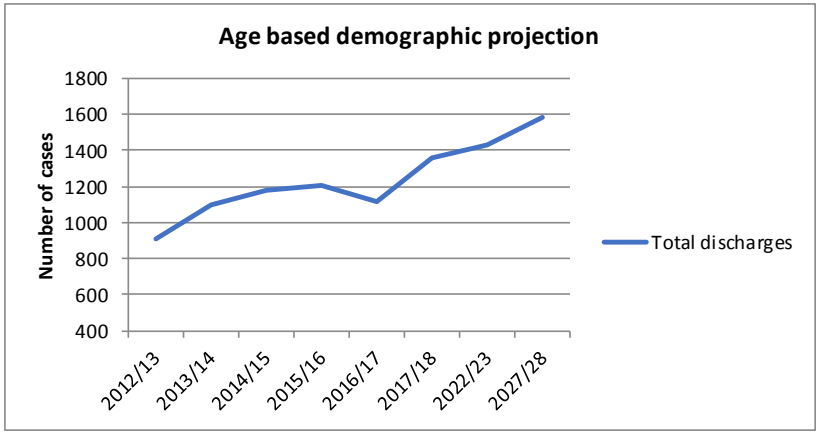
The following projections include both acute and elective workload – at an inpatient level.

Inpatients

Demographic projections

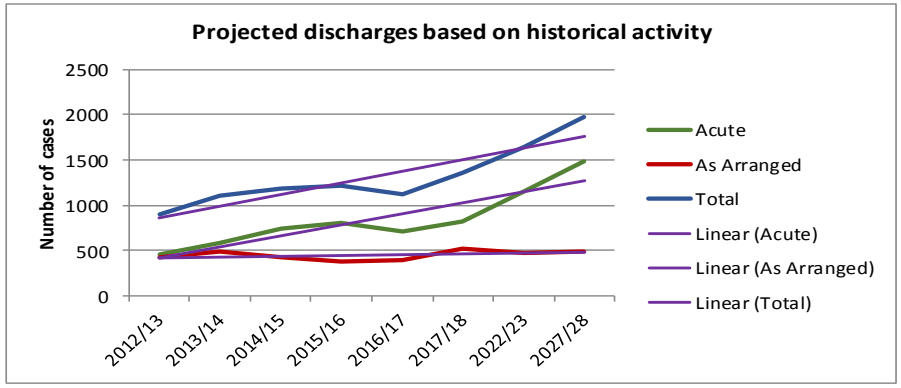
Projections of inpatient discharges (5 and 10 years out) based on demographic changes (and 5 year historic delivery) are shown below. This projects a 5% increase at 5 years and a 17% increase at 10 years (from 2017/18). Using Waikato DHB demographics across a regional cohort may slightly overstate the volumes, as the other regions (as a group) are not increasing at the same rate. However, the movement in age and ethnic mix is not dissimilar.





These projections vary significantly from projections based on historical delivery, which indicate a 21% at 5 years and 46% at 10 years, driven by the increasing trend in acute demand. This represents a variance of nearly 400 ten years out.

Historical activity based projections



Acutes were on an upward path until 15/16, but dropped in 16/17 – any ideas what caused drop (17/18 back up at 15/16 levels)

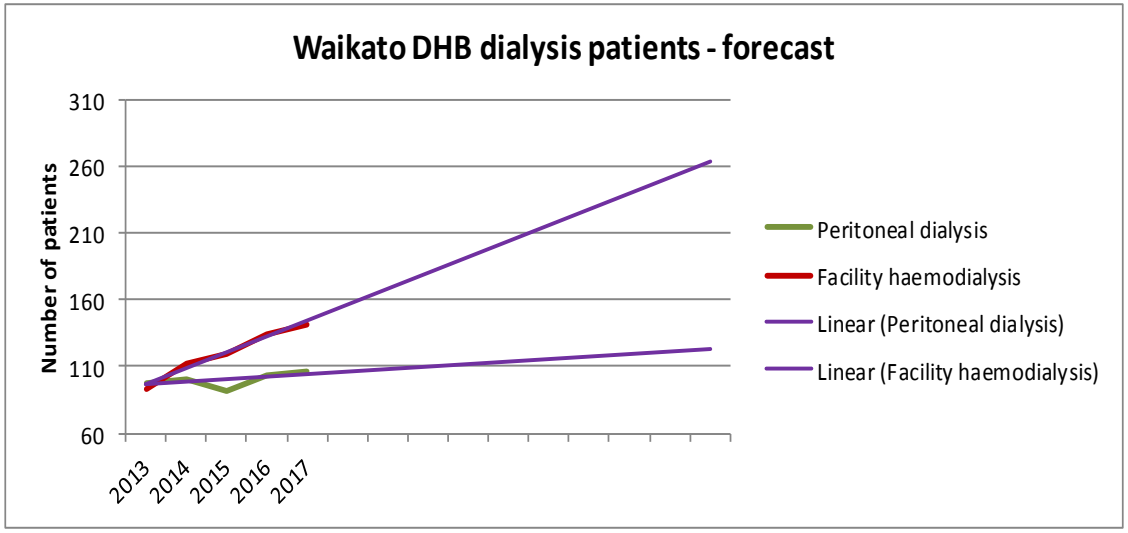
Renal dialysis

Demographic projections

Unavailable, but probable future RRT case cohort pattern will reflect a population with an increasing median and mean age and greater disease complexities including chronic disease burden (co-morbidities).

Historical activity based projections

Based on service data, over the four years shown, the number of patients on incentre (facility) dialysis has increased 53% and PD 8% (2% on PUC counting). If this trend were to continue, there would be over 260 patients requiring incentre dialysis very soon.



Other local and regional support

Projections can be done for the other DHBs. Dialysis case mix will depend on facility haemodialysis capacity.

What we do to train, develop and retain our staff

The service is accredited for training and this is not currently at risk.

Annual performance reviews are for SMOs. Other staff are covered by the DHB's standard annual process.

What we do to contribute to research and innovation

The service participates in the Australasian Kidney Trial Network collaborative research – including SOLID, CKD-FIX.

There is an active drug trial research programme – complement inhibitors, PEXIVAS, ASCEND, new treatments for diabetic nephropathy.

The department's Trust Fund is directed towards staff professional development, service facilities and clinical research projects.

Publications include a BMJ Lesson of the week paper. Abstract submissions and oral and poster presentations have been made to local, Australasian and international meetings.

Declaration and signature

As clinical director of the specialty, I agree that this plan accurately describes the services – both current and future state – according to our knowledge at this point in time.

Signed  **Date** 13/11/18

Comments from DHB senior clinicians

COO response and recommendations

The Renal Service comprises a committed group of staff preparing people for, and then supporting them through, life on dialysis and beyond (transplantation).

Although the service is regional in nature, it is largely centrally delivered (Waikato Hospital and surrounds). There is no regional service plan and no regional governance model that is in anyway binding on other providers. Currently there are satellite dialysis units in Gisborne, Tauranga, Rotorua and Whakatane.

The Service is largely introspective and focussed heavily on helping people with kidney failure. There is no capability to identify and attenuate kidney disease in the wider population. This is not surprising given that the number of patients on dialysis has grown considerably and the number of in-centre dialysis sessions has doubled at least in the last 5-8 years.

For the same reason (incessant, service pressure), the degree to which synergistic service could be provided for people with diabetes and renal failure, for example, has not evolved.

The Renal Service is the prototypical clinical endeavour where Maori are over-represented, the resource required to continue to meet current demand, and that over the next decade, is formidable, and investment in early disease identification and attenuation is glaringly absent.

If the issues evident in providing renal services across the region (early identification and attenuation of disease progression, and management of those with renal failure), can be solved, including the underlying ethical, economic and equity conundrums, the key to a sustainable health system will have been found.

Issues that must be resolved in the next 12 months:

1. Notwithstanding the regional service coordination issues, short term service expansion is required to meet the demand for the next 1-3 years using the existing service model. This is underway on level 3 of the Menzies building and will come on line mid 2019 (an extra 10 beds/chairs).
2. The Service must engage with the Executive and Board to resolve a strategic conundrum unfolding now. Broadly speaking the options are:
    a. Investing in treatment capability

b. Limiting demand and/or disinvesting in dialysis relatively speaking (growth in service less than growth in current projected demand).

c. Investing in identification of kidney disease early and investing in disease attenuation

d. One or more of these in concert.

3. The issue of regional planning and service delivery must be resolved in a way that is binding on the participants, including but not limited to:

a. a regional governance model

b. a mandate to plan and deliver services

c. a binding agreement between parties

Issues that should be resolved in the next 12 months:

4. The delivery of care on-site within the Bay of Plenty should be vigorously pursued with a view to the creation of a standalone unit within 5 years.

5. The development and institution of a suitable information management system for people with renal failure should be planned, and submitted for prioritisation and subsequent implementation.

Issues to be explored in the next 12 months:

6. Further role substitution within the service, increasing involvement of non-medical staff in service delivery.

7. Explore incentives for people to enrol in home-based therapies rather than in-centre dependence.

8. Engage with the primary care sector and community providers to develop effective programmes to identify people at risk of kidney disease, or those with early kidney disease, and to start to address this risk.

9. Train renal physicians to increase their procedural capability and thereby attract staff and decrease dependence on other constrained clinical departments.

Appendix 1 – Patient Stock & flow

Waikato DHB	2013	2014	2015	2016	2017
Total number of patients on dialysis	191	213	210	238	248
Split into:					
PD	98	101	91	104	106
Facility	93	112	119	134	142
Total Number Facility HD sessions	12508	13054	15904	17623	19073
For region:					
Number of patients on Home Haemo	87	94	92	86	84
Transplant recipients being managed	181	173	183	205	239
Total number of patients	459	480	485	529	571
Number of patients trained for PD	63	62	75	98	95
Number of patients retrained PD	25	24	41	32	26
Number of patients trained for Home Haemodialysis	21	27	19	21	18

Lakes DHB		2013	2014	2015	2016	2017
Total number of patients on dialysis		30	56	54	58	67
Split into:						
PD		30	33	34	39	43
Satellite HD			23	20	19	24

Western BoP		2013	2014	2015	2016	2017
Total number of patients on dialysis		0	51	56	53	60
Split into:						
PD			25	33	31	32
Satellite HD			26	23	22	28

Eastern BoP		2013	2014	2015	2016	2017
Total number of patients on dialysis		0	37	33	40	44
Split into:						
PD			27	22	25	26
Satellite HD			10	11	15	18

Tairawhiti DHB		2013	2014	2015	2016	2017
Total number of patients on dialysis		12	38	38	39	38
Split into:						
PD			24	22	25	22
Satellite HD		12	14	16	14	16
Total number of patients on dialysis		12	38	38	39	38
Split into:						
PD			24	22	25	22
Satellite HD		12	14	16	14	16

Midland Regional Renal Service
November 2018

Structure of today's presentation

- What is the Regional Renal Service?
- Where are our patients coming from and who do we serve?
- What is happening with our activity and treatment types?
- What can the DHB do about this?
- Options for the future

What is the Regional Renal Service?

Current Structure

- 2nd largest in the country, providing a service to all Midland DHBs, except Taranaki.
- "Hub and spoke" model, with:
  - Centralised training for home based therapies
  - Centralised support for non-Waikato DHB based services, through
    - Satellite hospital dialysis units at Tauranga, Whakatane, Rotorua, Gisborne

Current practice

- Providing care to patients with chronic kidney disease, including those with end stage renal failure
  - Home based dialysis
    - Peritoneal dialysis
    - Haemodialysis
  - In-centre haemodialysis (Waikato 30 stations + a 10 chaired Assisted Care facility planned; satellite HD network)
  - Transplantation
    - Live donor
    - Deceased donor
  - Supportive care (no dialysis)

Service structure

- Complex service with relationships with numerous teams internally and externally to the DHB

- Team approach, with:
  - Patient/ whanau partnership
  - Shared decision making
    - Doctors, nurses, allied health staff
    - Podiatrist, pharmacist, psychologist
    - Dedicated Maori health worker, since 2018

- Mostly an Out Patient service, via the Regional in-centre

- M3 Renal In Patient ward (recently increased from 12 to 16 beds)
  - 40% of In Patients are IDFs, reflecting the lack of specialist Renal expertise elsewhere

Service Modelling aspirations

- 60% dialysis patients home based
- 40% facility dialysis dependent
- 45/ 55% split (PD/ HD)
- Late presentation <15%
- 3-5% patient growth each year
  - 8% hospital HD growth
- Transplantation is done in Auckland, with the aim to increase transplantation rates by 6-10 more transplants each year, including a couple of pre-emptive transplants
    - Especially important is the need to deliver more Maori transplantation:
      - ***Recipients &***
      - ***Donors***

Where are our patients coming from and who do we serve?

Midlands population circa 800,000 – 23% Maori

Of those who receive dialysis:

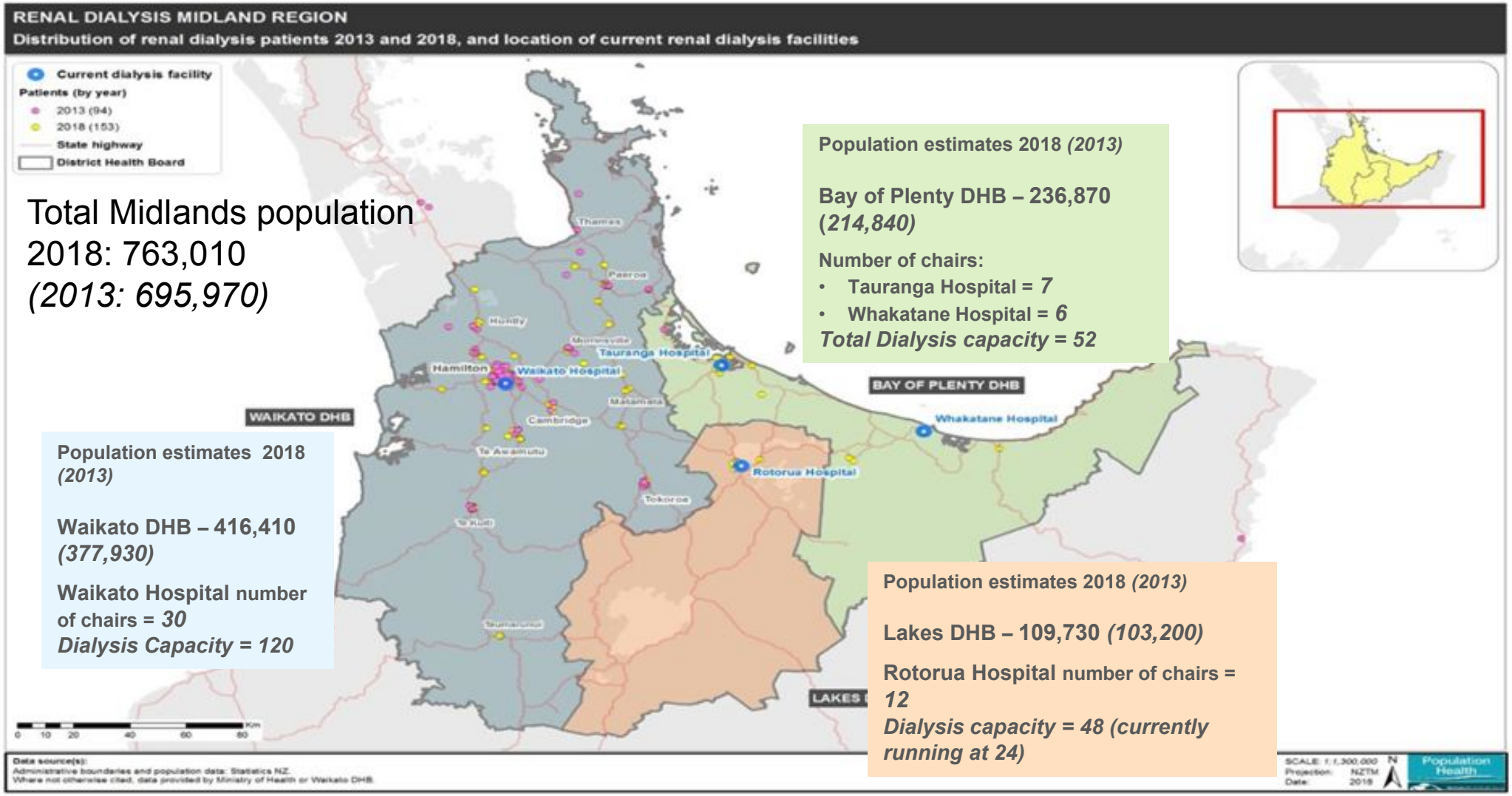
- Midlands renal population: 60.5% Maori, 3.6% Pacific
- NZ average renal population: 25.1% Maori, 26.3% Pacific

Volumes:

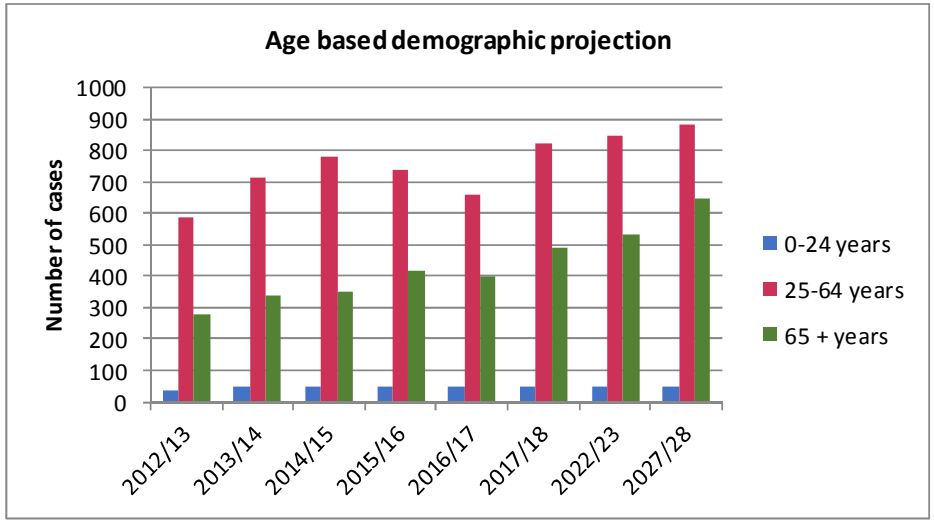
The service looks after approximately 750 patients

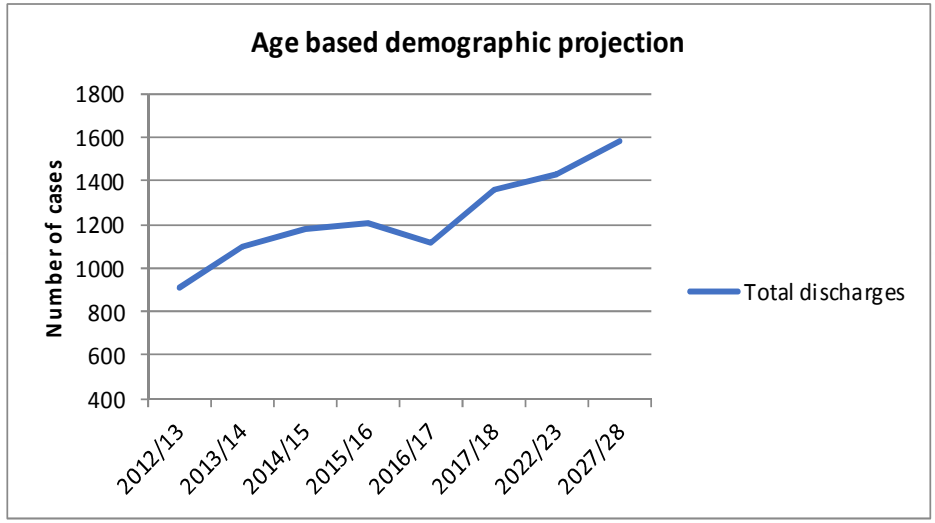
- It accepts ~ 120 new patients per annum;~ 20-25 patients within the services are transplanted each year, and ~ 80 patients on dialysis die each year

- The service supports a high health needs population
  - Medically, Culturally, Emotionally & Socially
  - Deals with all acute services requirements


RENAL DIALYSIS MIDLAND REGION
Distribution of renal dialysis patients 2013 and 2018, and location of current renal dialysis facilities
Current dialysis facility
Patients (by year)
2013 (94)
2018 (153)
State highway
District Health Board
Total Midlands population 2018: 763,010
(2013: 695,970)
Population estimates 2018 (2013)
Bay of Plenty DHB – 236,870 (214,840)
Number of chairs:
• Tauranga Hospital = 7
• Whakatane Hospital = 6
Total Dialysis capacity = 52
BAY OF PLENTY DHB
WAIKATO DHB
Hamilton
Waikato Hospital
Tauranga Hospital
Whakatane Hospital
Rotorua Hospital
Thames
Paeroa
Huntly
Morrinsville
Matamata
Cambridge
Te Awamutu
Tokoroa
Taumarunui
LAKES
Population estimates 2018 (2013)
Waikato DHB – 416,410 (377,930)
Waikato Hospital number of chairs = 30
Dialysis Capacity = 120
Population estimates 2018 (2013)
Lakes DHB – 109,730 (103,200)
Rotorua Hospital number of chairs = 12
Dialysis capacity = 48 (currently running at 24)
Data source(s):
Administrative boundaries and population data: Statistics NZ.
Where not otherwise cited, data provided by Ministry of Health or Waikato DHB.
Population Health
Waikato District Health Board

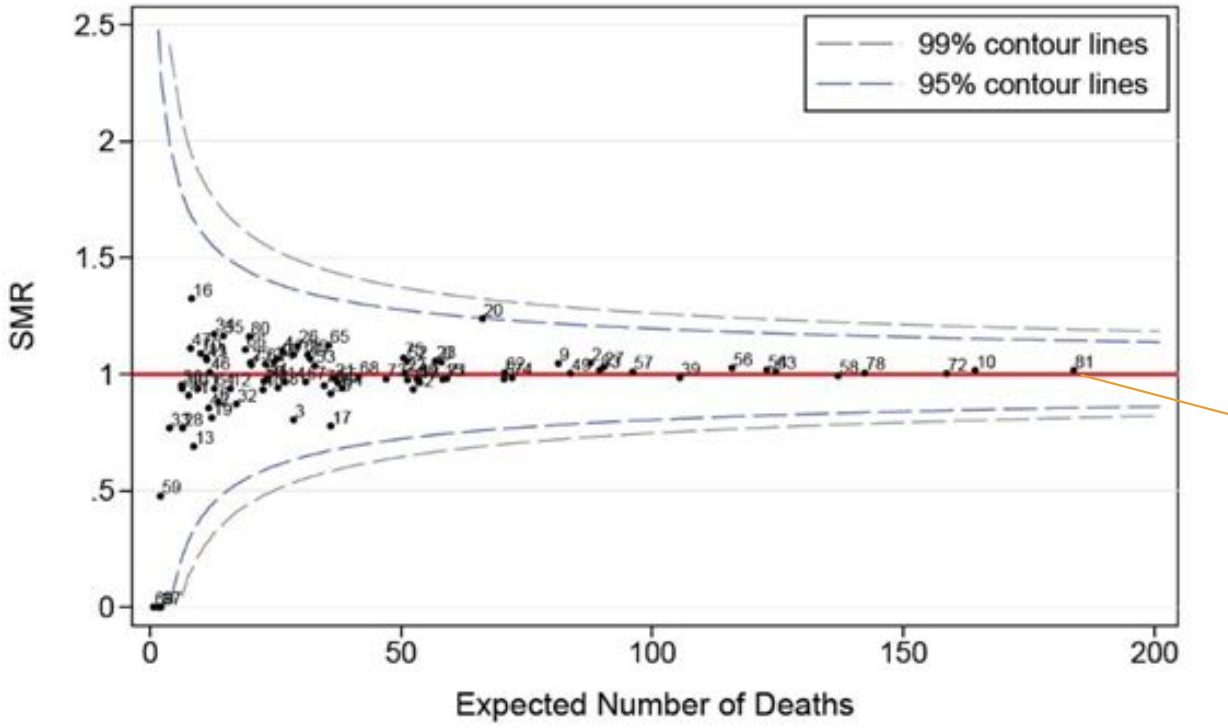
Demographic breakdown of Renal patients & total discharge predictions





Main drivers of patients with kidney failure = diabetes & old age (high blood pressure, vascular disease).

Standardised Mortality Rate



This indicates that the service provides equivalent outcomes, for our high co-morbid patients

Waikato DHB

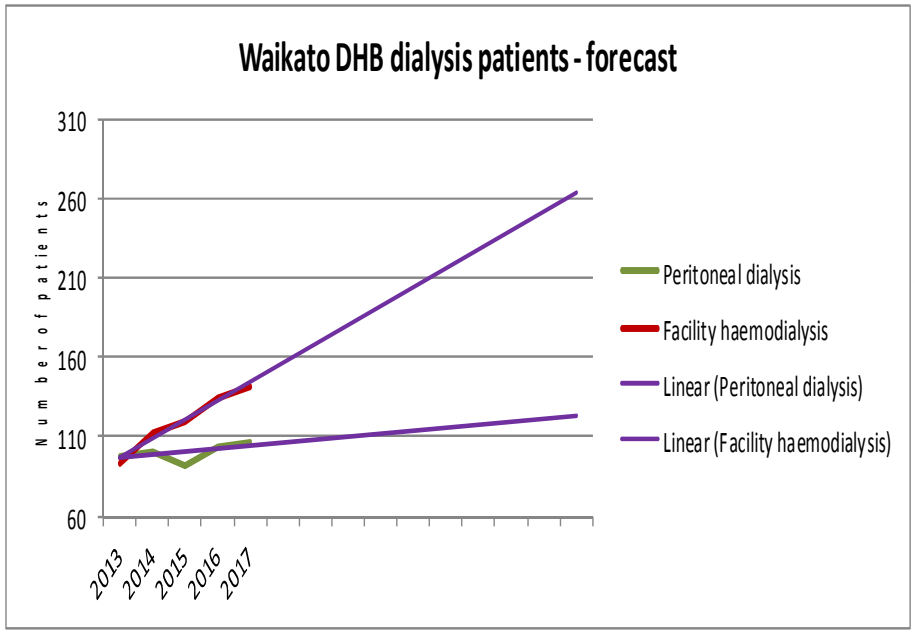
What is happening with our activity & our treatment types?

Dialysis Summary

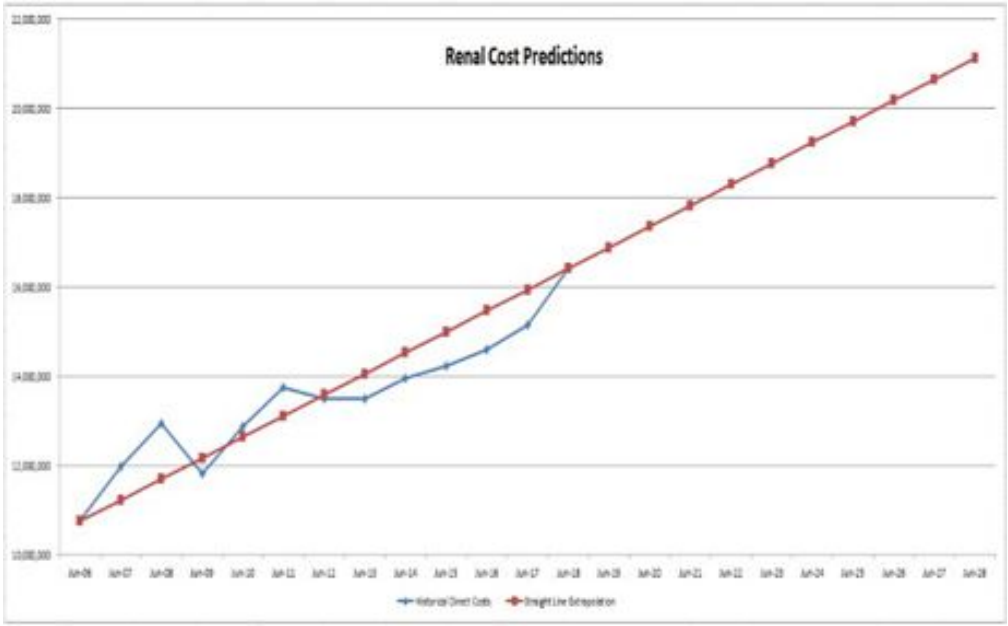
- Total dialysis patient growth 4-5% per year
  - Home dialysis population numerically stable
    - Less home HD
    - Some growth in peritoneal dialysis
  - More incident and prevalent patients receiving hospital HD
  - Some attrition with home based therapies

- ***Waikato Hospital dialysis growth 8% per year. This effectively means the dialysis population doubles every ten years..***

Activity projections



Cost Predictions



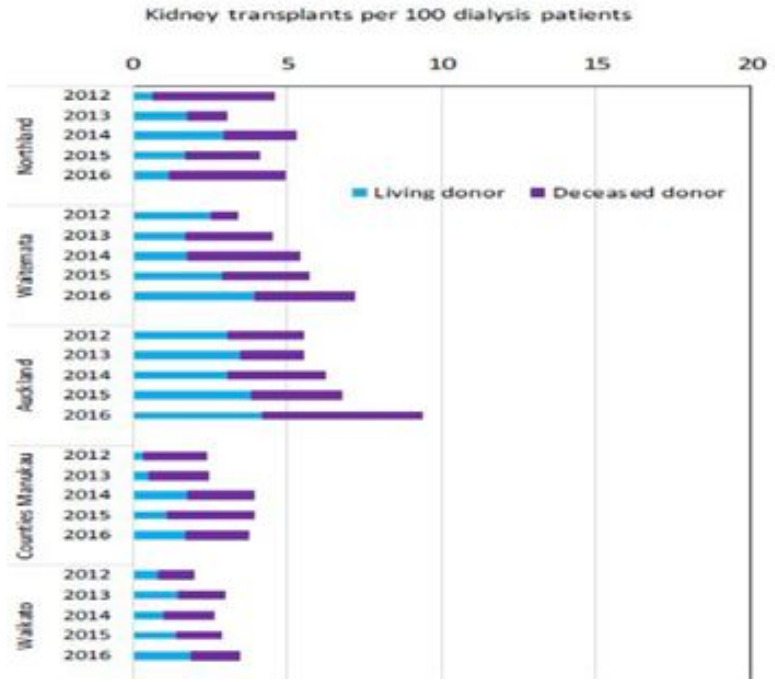
Depending on treatment type the $s can differ substantially

- Renal transplantation and home based dialysis are the most cost effective treatments.
- Estimated costs:

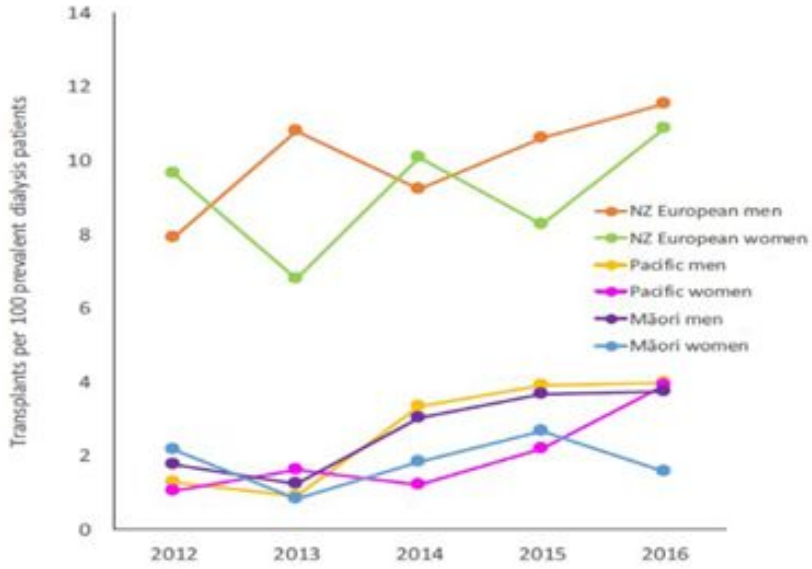
Intervention	Annual cost	3 year cost
In-centre dialysis	$53,000	$159,000
Home haemodialysis	$14,000	$42,000
Peritoneal dialysis	$29,000	$87,000
Renal Transplant	Included in 3 yr costs	$84,000 – much less in future yrs

Transplantation likelihood & ethnicity

Transplantation likelihood



Transplanted patient ethnicity



What can the DHB do about this?

1). Primary Prevention and Disease Modification

- Genes
- Environment
  - Targeted screening (PHOs)
  - Protocol influenced

Risks:

- Uncertain if it will have a major impact
- Lag period before results evident

- Not aware of any DHB elsewhere having achieved this at scale
- The Regional Renal Service has been set up as a treatment service only, ie the 'ambulance at the bottom of the cliff', so is not equipped to do this
- Would need a radical re-think and re-design of the existing arrangements, across organisational boundaries

2). Reduce numbers coming into Facility HDs

- Reduce number of patients requiring long term hospital HD, via:
  - *Treatment rationing*
  - Supportive care programme (regional)
  - Home based therapies
  - Transplants
  - (Population interventions)
  - Acute on chronic peritoneal dialysis programme

- National and local guidelines – and legal precedent – make ***treatment rationing*** extremely problematic to do in practice

3). Doing more of the same – spinning the wheels faster

- Supporting more dialysis dependent patients
  - Home based therapies
  - Facility (hospital) HD. Currently 150 patients at Waikato (30 stations); by 2023 this is expected to be 220 patients (55 dialysis stations)

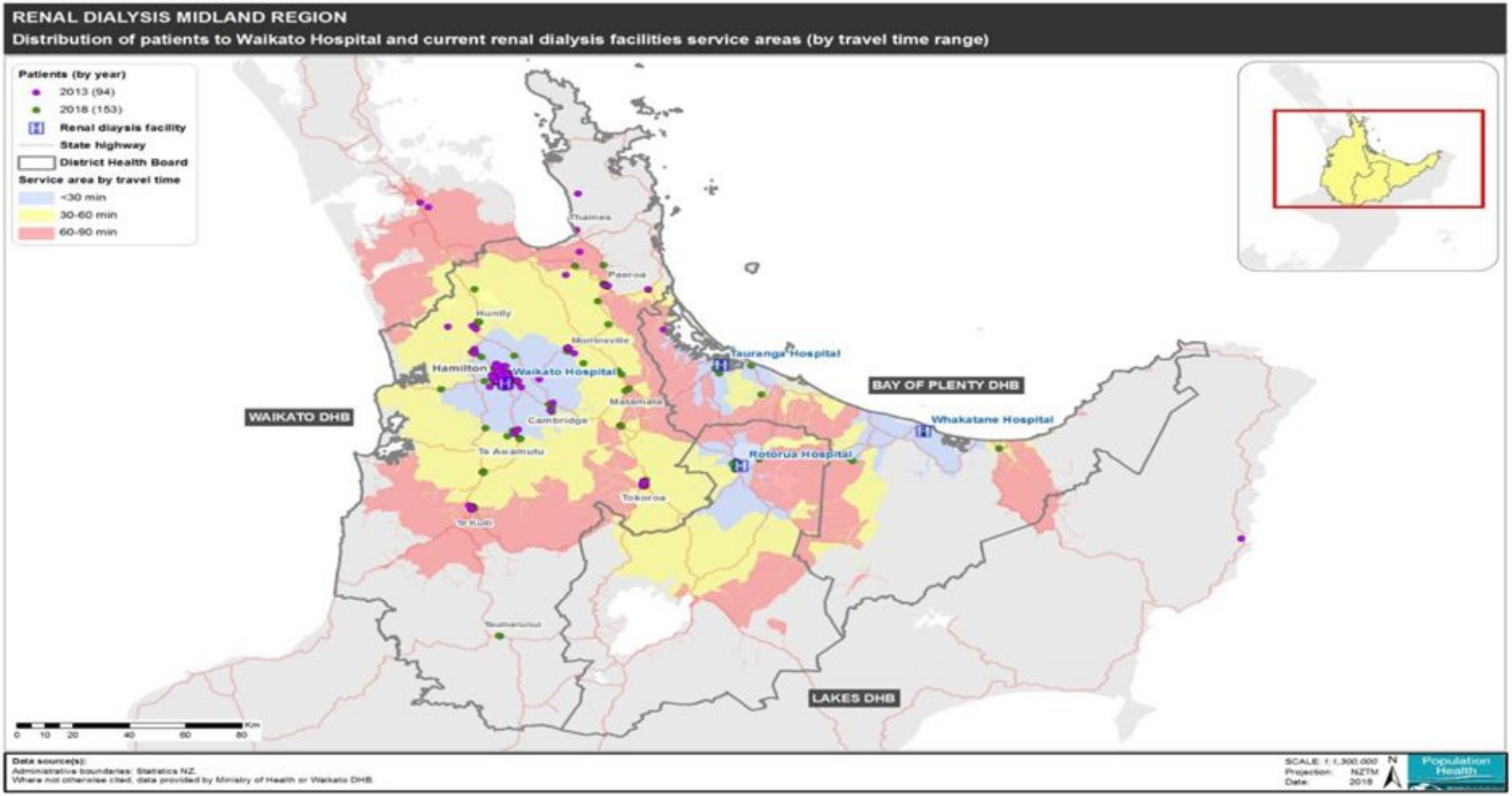
- Providing more outreach services
  - E.g. Tauranga outreach days
    - 2013 65 days
    - 2018 98 days

- Receive more acutely sick patients, requiring in-patient treatment (current 16 beds will need to increase)

4). Increase capacity - should we create another centre & if so, where?

Appendix 2 has further details on this, through a detailed analysis of where patients are coming from, with data collected from 2013 & 2018.

Scenario 0 - Current facilities coverage (facilities service areas based on travel time)



Conclusions of the geo-mapping exercise:

The **biggest gain** for reducing patients transport time would be for **patients to travel to the nearest current facility**. This will have a greater impact than opening a new facility.

The biggest impact would be Tokoroa patients going to Rotorua, which has physical capacity for 24 more patients.

A benefit for developing a new facility would be costly and the impact would not be radically different. Huntly would benefit more patients, but Thames would potentially reduce more patients' travel time.

Current arrangements for facilities & staffing

Waikato DHB	BoP DHB	Lakes DHB
Purpose built, 30 chaired centre opened in 2012, but already at capacity	Small, 6-7 chaired, facilities at Tauranga and Whakatane Hospitals	12 chaired facility that is under-utilised, operating at only 50% capacity
Further 10 chairs planned for mid-2019 on Ward M3, which will provide capacity until 2012-22 at current growth and demand rates	Tauranga facility is ***completely sub-optimal, not fit for purpose and requires urgent attention*** (personal comms BoP management & clinicians)	
Regional Renal Centre ***building at risk*** if the single storey Mental Health build is approved		
Centre of excellence for the Region	Nursing staff for in-centre facilities & PD patients	Nursing staff for in-centre facilities & PD patients
Employs all the SMOs & the Regional Allied Health staff		
Trains all patients for home therapies		

Options for the future

Options for improvement facilities & staffing

Waikato DHB	BoP DHB	Lakes DHB
Resolution of the in-centre's future	New, improved in-centre facility with greater capacity	Use the "spare" capacity in the in-centre to treat all local patients, as well as the Tokoroa domiciled patients
	Develop their own stand-alone Renal service, with the support of the Waikato team	
Will require substantial capital investment	Will require substantial capital investment	Will require additional nursing resource
	Will require investment in staff + on-going support from Waikato for a number of years	

Unclear on the potential gains available to the Region from adopting a primary prevention strategy. This would need alignment across Strategy and Funding, Population Health and Primary Care expertise and leadership

Ambitions

- Improve Maori health outcomes
- Increase transplantation rates
- Maintain home-based dialysis as first treatment of choice (opportunity to trial co-funding arrangements to increase patient enthusiasm and take up)
- Increase Regional coverage to ensure 90% of patients have access to in-centre dialysis facilities within 60 minutes travel

Support required by the service

Regional plan developed, that is binding for all parties, should cover, for example:

- Increase the provision at Lakes, including movement of Tokoroa patients to Lakes (suspect this will require high level sponsorship to push through)
- Development of a stand alone Renal service at BoP and support for a new build solution at Tauranga hospital
- Renal in-centre strategic solution – there is no further capacity in the existing building **and** if the Mental Health build solution is agreed as a single story building, the in-centre will no longer exist..
- Education & lifestyle management programmes in the community

MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
DECEMBER 2018

AGENDA ITEM 5.2

Purpose	For information and discussion

This month's Hospital Advisory Committee has a focus on the rural and community setting of our DHB.

Presentations will cover:

- START programme update
- Māori Access Change Project - Thames Outpatient Clinics (A rural response)
- Screening services in the community
- A rural hospital and primary care project

In my role as the Director of Community Service and Clinical Support I will take the opportunity to communicate my observations after six months in my role, focusing on the rural and community setting.

My observations are drawn from my attendance at rural meetings, working remotely across all sites and my integration within the Waikato hospital operational setting e.g. IOC, ESPI forums, TIGG etc.

The table attached presents a snapshot of my recent observations and what actions have or will commence in the next six months.

Note: this list is not exhaustive and excludes project or programmes of work that were already underway e.g. Southern Rural Maternity project, Single Point of Entry projects.

Recommendation	1) **THAT:** The Committee notes the information and provides feedback.

Hayley McConnell
Deputy Chief Operating Officer/Director of Community Services and Clinical Support

Past six months	Next six months – outcome focused
1. The rural and community 'can do' ethos	How to best maintain and grow relies on personal leadership, monitoring service delivery, visibility and strong links with Waikato hospital.
2. Facility 'bricks and mortar' is reflective of the level of investment over time; a lot of room but not necessarily fit for service	Capital planning is in place; service delivery models to be agreed; work with 'Care in the Community' and 'Creating the Future' work programmes; resuscitate the Rural Healthcare Project (2016)
3. Outsourced personnel costs – high cost of medical locums	Investigating alternative workforce models (commenced in Thames) but based on future needs (social determinants etc.); to commence a Clinical Services planning process.
4. Some inattention to performance targets e.g. PUC's, attendance/OPD volumes and financial	Full participation in DHB production planning e.g. theatre utilisation, monthly finance forums, OPD cancellations, weekly ESPI forum etc.
5. Use of co-design of is evident	Continue to use this model for all change opportunities; increase staff training in this domain.
6. Patient Transport System (PTS) – a critical need for our rural services but not currently being provided in a consistent manner.	PTS contract nearing completion with preferred provider; a working group to implement is in place; increased governance and leadership is in place; to grow the relationship management ethos with provide.
7. Transport of the seriously and/or critically ill - the recent NASO negotiations has not addressed inter-hospital transport and care for the seriously or critically ill patients.	Identified a lead executive on DHB governance group; working group is in place; cognisance of the significant financial and safety implications (resourcing, compliance, reporting and cost of transport)
8. Consumer Council activity is strong in the rural and community health setting.	Continue and increase utilisation of the consumer council support on offer.
9. Telehealth is well placed to deliver more opportunities for patients/consumers and staff.	Increase the governance 'grunt' to create greater clinical buy-in for acute and scheduled utilisation.
10. Mental Health opportunities at a community and hospital level.	To work closely with Creating the Futures programme of work; respite and detox services.
11. Workforce challenges due to geography and services creates staffing challenges	Service delivery modelling must have workforce planning as key to future provision (in partnership with community health care providers).
12. Opportunities are there for growth of care closer to home (facility and community based).	- Palliative care - Mental Health (respite, detox etc.). - Diagnostics - ED Short Stay - Rehabilitation (AT&R) - Transition care - START

MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
DECEMBER 2018

AGENDA ITEM 5.3

Purpose	For information and discussion

The Hauraki district is a geographically dispersed rural area covering the greater Thames/Coromandal area. Health care is provided by a variety of service providers the largest being the Waikato DHB. Thames is a town is on State Highway 25 and a main thoroughfare for the Coromandel Peninsula a popular summer destination. The hospital services a population of around 46,000 with a summer population of over 60,000. Thames hospital is approximately one and a half hours by road to Hamilton and Waikato hospital Emergency department presentations for the 2017-18 of 19,489

The Hauraki population is aging, approximately 20% identify as Māori and a Māori population growing a faster rate than non-Māori. Data suggests that this area has higher than average deprivation in access, education, income and crime.

In 2017, Te Korowai Hauora o Hauraki ("Te Korowai") its Board and staff presented a business proposal to Waikato DHB proposing a future focused model of care implementing strategies for sustainable long-term primary/rural/secondary health care services with a key focus on recruitment and retention of staff.

This proposal presented a high-level plan for Te Korowai to co-locate to Thames Hospital, one of the country's oldest operating hospitals built on land gifted by Ngāti Maru. The proposal identified opportunities for better client access to services and the potential for integrated health care from a central Te Korowai hub based at Thames Hospital.

Recruitment and retention of health practitioners to this area has had a challenging history. There have been a number of combined strategies between Thames Hospital, community services and Te Korowai over the past two years to help improve training opportunities, placement of registrars, NETP nursing positions and shared services (GP's utilised in ED etc.)

Following the receipt of the above proposal a Waikato DHB Board approved RFP was released in late 2017 and a single submission from Te Korowai was received. The submission recommended that the Waikato DHB accepted the proposal and authorised the development of an Initiation phase and Business Case development. The Waikato DHB approved the submission and agreed with the Initiation phase.

An inaugural workshop occurred in late May 2018 and a governance group was established comprising representation from Te Korowai Hauora o Hauraki Waikato DHB representatives and Ngāti Maru as the land owners. Te Korowai supports a range of services throughout the Hauraki district including primary care clinics, home-based support services, mental health services, Whānau ora services, health

promotion and public health services spread over multiple clinic sites in Thames, Coromandel, Whitianga, Paeroa and Te Aroha.

The goal is to create a more sustainable Health and Wellbeing service for the Hauraki region that joins all of the parts together. Success will ultimately ensure the Hauraki have the best access to a service that is fit for purpose and sustainable. This collaboration seeks to create a service delivery model between Thames hospital (Waikato DHB) services and all primary and support care services that:

- Improves access and navigation for the people of Hauraki seeking health advice, support, assessment and treatment
- Maximises the existing skills and expertise of health practitioners working locally
- Enables a triage and redirect system that improves access to the service best suited to meet the needs of people seeking health care
- Has Whanau Ora navigation as a core service philosophy

There will be a presentation from Riana Manuel (CE Te Korowai) and Hayley McConnell providing an overview of where we have got to and where we are going in relation to a co-location planning and working together i.e. rural health services and primary care, the challenges we are anticipating and options for the future.

Recommendation	1) **THAT:** The Committee notes the content of the progress following RFP. 2) **THAT:** The Committee receives the presentation. 3) **THAT:** The Committee comments and provides input and guidance on the ambitions and support required for changes moving forward.

Hayley McConnell
Director, Community Services and Clinical Support (on behalf of the Governance Group)

MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
DECEMBER 2018

AGENDA ITEM 5.4

Purpose	For information and discussion

Waikato DHB strategy sets the priority to eliminate health inequities for people in rural communities. The Waikato DHB serves a range of communities 60 percent of which are rural. Many of these communities have poor access to health services and care and poorer health outcomes. It is becoming increasingly important that our rural areas are supported to sustain themselves as communities. This includes ensuring appropriate access to services to arrest depopulation and improving health outcomes for Māori living in rural communities (70% of Māori within the Waikato.

Outpatient DNA rates – equity focused reporting
The June 2018 equity focused report highlighted that Outpatient DNA for Māori is significantly higher than for non-Māori and has been consistently so for a long time.

Within this same report the proposed approach to support the elimination of inequities observed in key measures proposed actions the following actions:

1) Establish accountability at service level.
2) Establish an improvement project, led by the logical business owner.
3) Te Puna Oranga (TPO) to provide expertise, evidence and best practice advice to the relevant business owner for each improvement project.

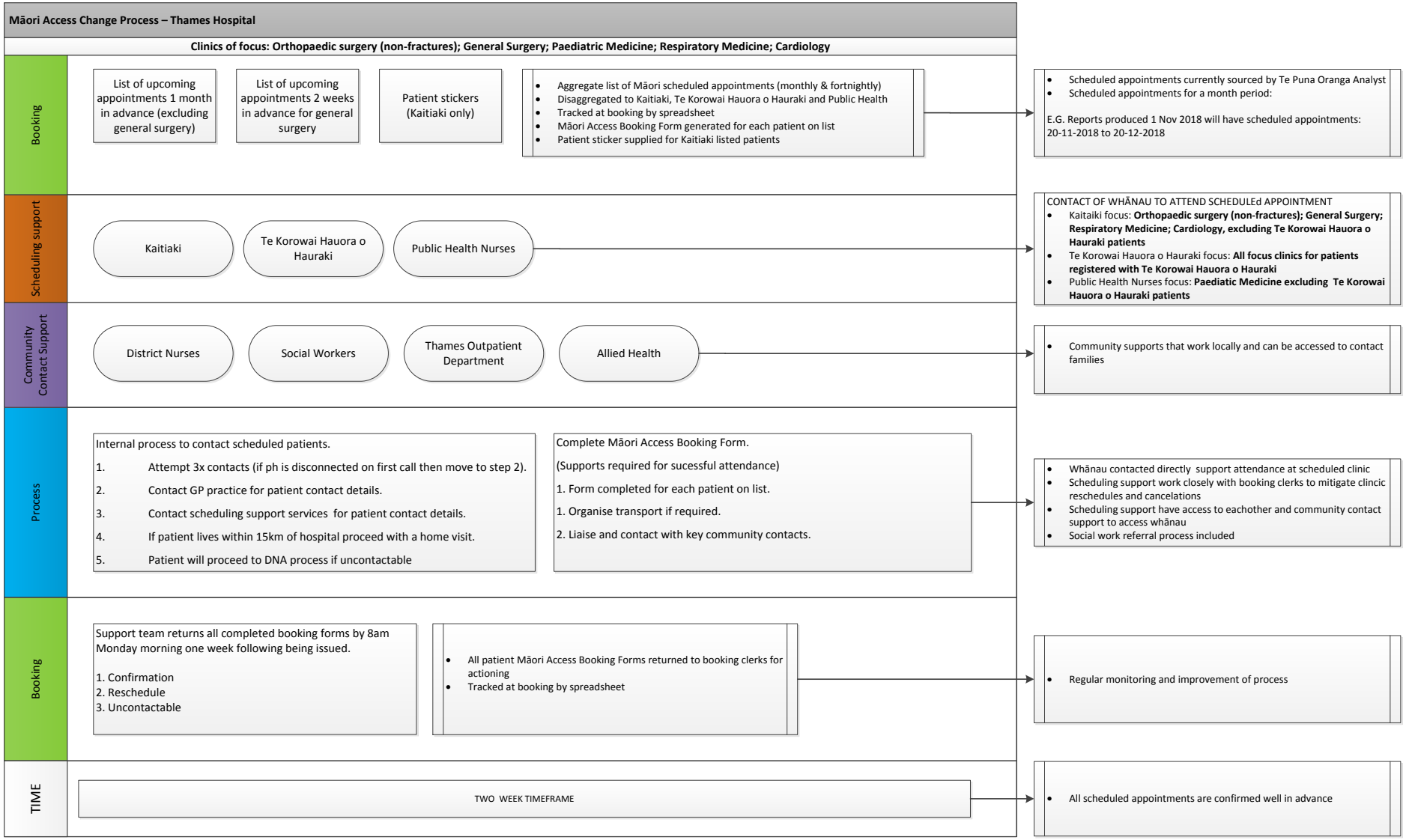
Māori Access Change Project - Thames Outpatient Clinics (A rural response)
In June 2018 the Nurse Coordinator Thames Outpatient Department and Te Puna Oranga met to coordinate an improvement approach specific to the region. With full support from the Service Manager – Thames/Coromandel Health Service, this led to a community collaborative approach to address the Thames Outpatient DNA inequities and the project was thusly named the Māori Access Change Project. The project was rolled out 1 November 2018 and has been met with enthusiastic commitment from all involved.

Please find attached for your information the process map of the change intervention and the baseline data for the Thames Hospital Māori DNA rates which will be used to monitor and evaluate the change approach being undertaken.

Recommendation	1) **THAT:** The Committee notes the Māori Access Change Project

Hayley McConnell
Deputy Chief Operating Officer/Director of Community Services and Clinical Support

Thames Hospital Māori Access Change Project
Process Map Version 1.0



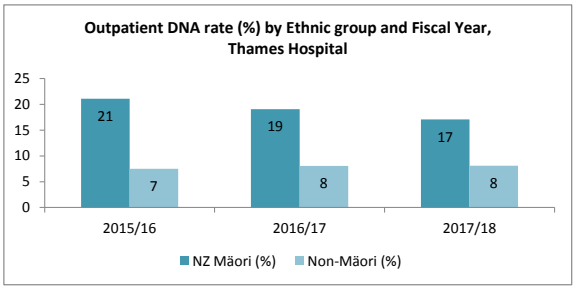
Outpatient DNA - Māori - Thames Hospital
Request: Jade Sewell/ Dale Marriot, OTP

Source: costProBI
Qualifications
Select all actualised outpatient appointments
Filter to Thames hospital
Flag Māori based on prioritised ethnicity recorded in ipm
Time period: Fiscal Year 2015/16 to 2017/18 (July 2015 to June 2018)
Run: 24 July 2018

Hospital	Thames

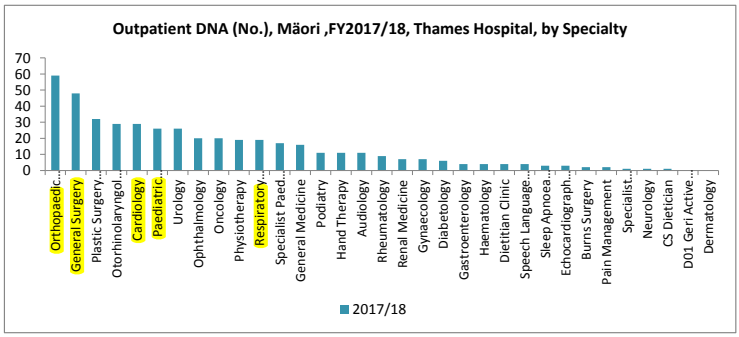
No of cases	FiscalYear		
EthnicityGroup	2015/16	2016/17	2017/18
NZ Māori	**2402**	**2251**	**2642**
DNA	507	429	451
Attended	1895	1822	2191
Non-Māori	**18015**	**17839**	**18558**
DNA	1350	1439	1503
Attended	16665	16400	17055
Total	**20417**	**20090**	**21200**

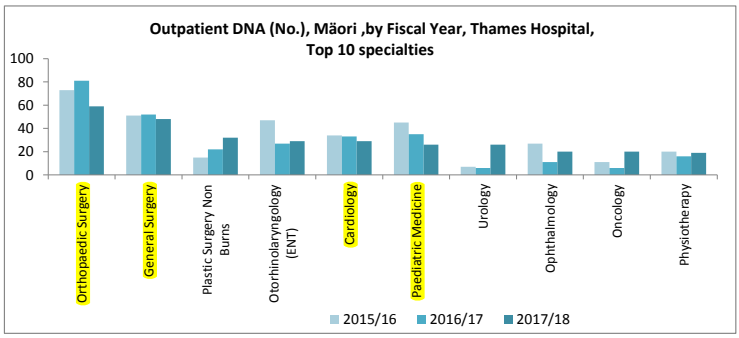
DNA Rate	2015/16	2016/17	2017/18
NZ Māori (%)	21	19	17
Non-Māori (%)	7	8	8



Hospital	Thames
Ethnicity	NZ Māori
IsDNAFlag	1

No of cases	FiscalYear		
Specialty	2015/16	2016/17	2017/18
Orthopaedic Surgery	73	81	59
General Surgery	51	52	48
Plastic Surgery Non Burns	15	22	32
Otorhinolaryngology (ENT)	47	27	29
Cardiology	34	33	29
Paediatric Medicine	45	35	26
Urology	7	6	26
Ophthalmology	27	11	20
Oncology	11	6	20
Physiotherapy	20	16	19
Respiratory Medicine	19	3	19
Specialist Paed Oth Surg	12	28	17
General Medicine	28	21	16
Podiatry	13	9	11
Hand Therapy	9	6	11
Audiology	14	15	11
Rheumatology	16	11	9
Renal Medicine	2	4	7
Gynaecology	17	13	7
Diabetology	3	5	6
Gastroenterology			4
Haematology	5	1	4
Dietitian Clinic	11	8	4
Speech Language Therapy Departmer	2	2	4
Sleep Apnoea Respiratory	8	5	3
Echocardiography Department	8	1	3
Burns Surgery	2	3	2
Pain Management		2	2
Specialist Paediatric Diabetology	4		1
Neurology	1	3	1
CS Dietician			1
D01 Geri Active Rehab	2		
Dermatology	1		
Total	**507**	**429**	**451**





MEMORANDUM TO THE HOSPITAL ADVISORY COMMITTEE DECEMBER 2018

AGENDA ITEM 5.5

Purpose	1) For Information and discussion

The current screening coverage and initiatives to address rural and Māori inequities is the focus of this presentation.

The Screening Services business unit is responsible for delivering the following screening services to the population of Waikato.

- Breast screening and assessment (BreastScreen Midland also services the Lakes and Bay of Plenty DHB districts)
- Cervical screening co-ordination
- National Immunisation Register
- Hospital Opportunistic Immunisation Service
- Hauora iHub

Midland Breast Screening
For breast screening in the sub-region, BreastScreen Midland (BSM) we have a target to achieve a screening coverage of 70% of the eligible population. As at November 2018, BSM is currently achieving a total coverage of 69.4% which is made up of 60.3% Maori, 60.9% Pacific and 71.5% other. This is an improvement on last year where BSMs total coverage was 68.9%; made up of 59.8% Maori, 60% Pacific and 71.1% other.

Waikato DHB Breast Screening
For Waikato DHB, in November 2018 the total screening coverage was 68.5%, which is made up of 57.9% Maori, 59.9% Pacific and 70.7% other. This is has seen an improvement for Maori coverage but a slight decline for Pacific coverage. In November 2017, the total screening coverage was 68.7%, made up of 58.7% Maori, 58.6% Pacific and 70.9% other.

Cervical Screening
For cervical screening in Waikato DHB we have a target of achieving a total coverage of 80% of the eligible population. As at September 2018, Waikato DHB is achieving a total coverage of 76.2% which is made up of 69.3% Maori, 73.3% Pacific, 66.2% Asian and 80.1% other. There is no change in overall cervical screening coverage from 2017 data where the Waikato DHB total coverage was also 76.2%. However there has been a slight decline in Maori, Pacific and other coverage and an improvement in Asian coverage (69.8% Maori, 75.4% Pacific, 63.8% Asian & 80.2% Other).

This presentation will provide you with a background of where we have come from over the past 10 years and what actions and initiatives are in place, or are being explored, to improve the screening coverage of Maori and provide better access to screening services for our rural populations.

Recommendation
THAT

1) The Committee **notes** the content of the presentation.
2) The Committee **provides comment** and feedback to Screening Services.

Hayley McConnell
Deputy Chief Operating Officer/Director of Community Services and Clinical Support

MEMORANDUM TO THE HOSPITALS ADVISORY COMMITTEE
DECEMBER 2018

AGENDA ITEM 5.6

START – SUPPORTED TRANSFER AND ACCELERATED TRANSFER TEAM

Purpose	For information

START - Progress in 2018 and future direction

The START service has evolved over the last eight years and has become the benchmark supported discharge model that other District Health Boards look to emulate. This was acknowledged at November's Health Round Table meeting when the service won an award for outstanding innovation for the second time in two years.

The service supports and delivers rehabilitation in the home for up to 147 clients every day, who would normally be in a hospital bed. The service operates 7 days per week, supporting clients throughout the Waikato. It has gone from being an "additional' service to an "essential" one:

- Supporting demand by actively "pulling" clients from all areas of the hospital
- Reducing demand through targeted admission avoidance as well as reducing readmissions over 90 days, 6 months and one year post discharge.
- Delivering care on the client's terms, establishing goals that focus on "what is important to you?

This report updates on the significant growth in the service this year:

- Near doubling the number of clients in its care
- Widening the cohort and number of ACC funded clients
- Support a small cohort of Ministry of Health funded under 65 client post-stroke

Recommendation	1) **THAT:** The Board notes the content of the report. 2) **THAT:** The Board: Provides comment on the attached report.

Barb Garbutt

Director - Medicine, Older Persons rehabilitation and Allied Health

START

START – Supported Transfer and Accelerated Rehabilitation Team

Over the last few years, the START service has gone from an "extra" option to an "essential". The service has grown in size significantly this year (it now supports up to 147 patients every day in the community who would normally be in a hospital bed) and has become the benchmark supported discharge model that other District Health Boards are attempting to emulate. The service has continually reviewed its practice and continues to evolve. This was acknowledged at November's Health Round Table meeting in Melbourne, with the service receiving an award for "outstanding innovation" - the second time in two years the service has achieved this level of recognition by Health Round Table

What is START and what does it deliver?

START is a community based, intensive rehabilitation program for people aged 65 and over. The Older Person & Rehabilitation Services (OP&RS) of Waikato DHB commenced the START service in Hamilton in October 2010, expanded to include Tokoroa in January 2011 and Thames in February 2011. Evidence from two randomised controlled trials has supported further growth and investment from ACC and Ministry of Health.

The service aims to:

Reduce demand, supporting the management of hospital capacity:

- Facilitating early supportive discharge from the hospital
    - Minimising the risk of readmission
    - Preventing unplanned emergency department presentations and hospital admissions
- Reducing long term dependency:
    - Minimising long term home care utilisation
    - Reducing the risk of long term residential care
- Improving quality of care - Delivering quality care in the home through a coordinated interdisciplinary approach with a team comprising of:
    - Health Care Rehabilitation Assistants
    - Physiotherapists
    - Occupational Therapists
    - Registered Nurses
    - Community Geriatrician
    - Administration support

START is a seven day a week service. Referrals are accepted seven days per week and clients receive care every day of the week. The service starts work at 7.00am and finishes 9.00pm. Registered Nurses are available (on duty/on call) 0700-2100 hours. The programme is developed with the patient and the input of all health disciplines involved. Goals are based on "what is important to you?" with the client setting themselves real functional goals with the support of their care team.

Clients in the care of the service receive up to six weeks of intensive rehabilitation at home. A client can receive up to four visits per day. Following receipt of a referral the START team member will be in the patient's home within two hours, including the equipment collected to support them at home. Every task/visit is a rehabilitation opportunity. For example a client could receive:

- Early morning visit that supports them to shower, dress, make their breakfast, take their medication.
- Lunch time visit that includes exercises, ensuring meal preparation has occurred
- Late afternoon visit that ensure medication has been taken and client is mobilising safely
- Late evening visit that ensure the above has occurred and client is managing well

START

Outcomes so far

As has been referenced, START has demonstrated it's effectiveness through two randomised controlled trials carried out by Auckland University. It has also undertaken several reviews and has robust reporting in place to ensure key performance indicators are being achieved:

- START decreases length of stay prior to discharge home (Parsons et al (2017) Age and Ageing). START has a registered nurse based at the hospital who actively looks to "pull" clients from the inpatient setting. This RN works with the Older Person's Assessment Liaison service to look for clients in the Emergency Department we can take home direct from ED, preventing an admission. Visits to the medical wards, older persons and rehab, orthopaedic wards to seek clients whose care could be delivered at home.
- START more than halves readmission rates - validated by the two randomised controlled trials.
- In the six months following START, there continues to be a reduction in the time an older person spends in hospital by 40%. Clients continue to spend less time in hospital for a year post-discharge from START.
- Mean costs in the care of START are less than usual care.
- START delivers improved outcomes for clients – functional goals are set at home and the client supported to achieve these.

2018 – Key changes implemented

This year has seen further development of the service:

There has been significant growth.

- The service has grown from 86 clients in its care to as many as 147 at a time
- This coverage is Waikato wide. On any day of the week the service may have the following:
  - 62 clients in Hamilton
  - 40 clients in the surrounding area (Cambridge, Morrinsville, Te Awamutu)
  - 25 clients across the Thames/Coromandel region
  - 10 clients in Tokoroa and the surrounding areas
  - 10 clients in TeKuiti, Taumarunui and surrounding areas

The cohort of clients has widened further:

- Further investment from ACC has widened the number and range of ACC funded clients the service can support
- We now have a cohort of Ministry of Health funded clients under the age of 65 that have had a stroke, that are now receiving their rehabilitation at home
- Targeted referrals from Disability Support Link and Primary Care that look to prevent admissions

The further growth in service has meant for more comprehensive coverage of rural Waikato. This has reduced the need to use agency staff in some of our more remote communities and has strengthened the interdisciplinary approach.

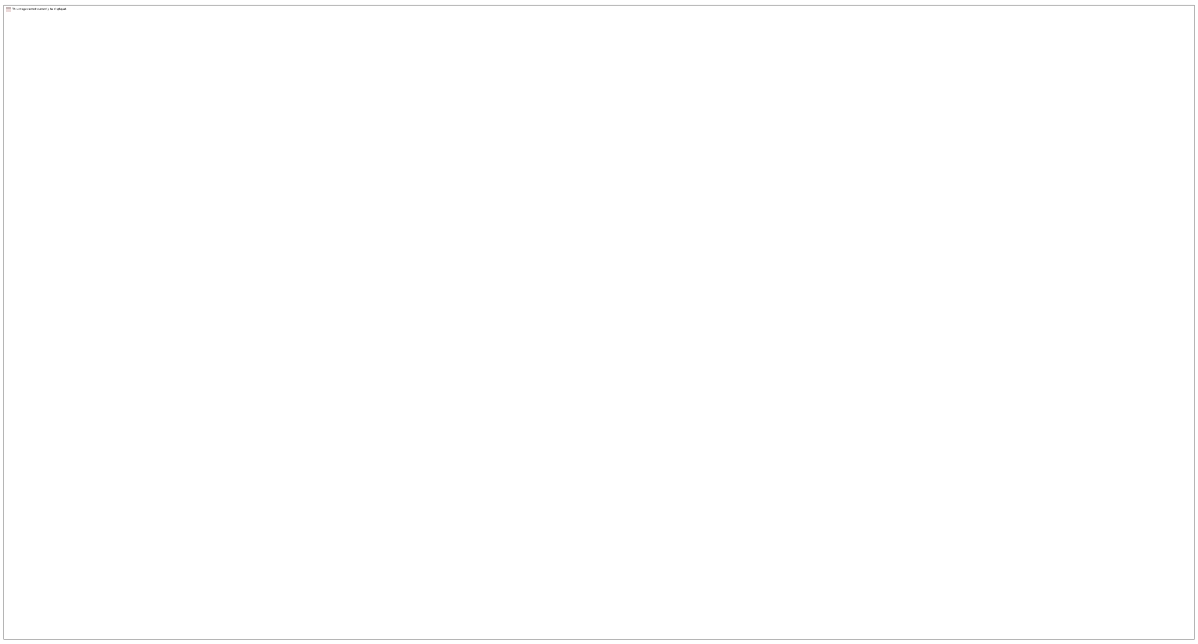
What next?

In its 8 year history the service has continually reviewed and evolved its practice. We do not see that changing going forward. In 2019 we will be looking to develop some of the following initiatives:

- Enhanced START – taking inpatient rehabilitation out of the hospital and delivering rehabilitation in local communities and into local facilities – a step closer to home. Instead of an older person being in a rehab ward in Hamilton, sometimes 1-2 hours from home, taking that person to a nearby local facility and using START to deliver that rehab in the facility.
- Increasing the number of under 65 clients - adding a vocational component

START

- Further primary care access and admission avoidance - using the interRAI assessment tool as a predictor of emergency department and hospital admissions. Making targeted referrals to START to prevent those emergent care presentations
- Reinventing respite care - creating a “warrant of fitness” approach that gives respite care a purpose. Supporting the client and their partner
- Developing a focus on targeting recruitment of Maori staff, embedding the Kaupapa Maori approach within the existing START service.
- Using START as an integral component of a Care Management approach that supports older clients in a whole of life journey approach.



Waikato District Health Board

Date of next meeting
13 February 2019