Distribution:
Committee Members:
E Borrows, Chairman
K Eagles, Deputy Chairman
A Ballantyne,
M Bourke
P Catt
K Denness,
F Gilkison,
B Jeffares
P Lockett
A Rumball
P Moeahu (Co-opted member)
C Tuuta

Management:
CEO
GM Finance & Corporate Services
GM Hospital Services
GM Planning & Funding & Population Health
Chief Advisor Maori Health
Chief Medical Advisor
Nursing Director
GM HR & Organisational Development
Quality Risk Manager
Management Accountant
PA to Board
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Tui Ora Limited
Corporate Reception

TARANAKI DISTRICT HEALTH BOARD

AGENDA

HOSPITAL ADVISORY COMMITTEE

ORDINARY MEETING

OPEN

Thursday 6 December 2012
9.30 am

Corporate Meeting Room 1
Taranaki Base Hospital
David Street
New Plymouth

HOSPITAL ADVISORY COMMITTEE

MEETING AGENDA

Thursday 8 November 2012
9.30 am
Corporate Meeting Room 1, Base Hospital
David Street
New Plymouth

1. Declaration to Open Meeting

2. Apologies

3. Conflicts of Interest

4. Public Comment

5. Presentation – Dr Greg Stevens, ED Medical Officer

5. Minutes

5.1 Minutes of meeting held 8 November 2012

Pages 1 - 7

Resolution
That the Hospital Advisory Committee resolve to accept the minutes of the meeting held 8 November 2012.

6. Arising From Minutes

7. Management Reports

7.1 General Manager Hospital Services and attachments,

Pages 8 -47

Resolution
That the Hospital Advisory Committee note and receive the report and attachments.

8. Other Business

9. Next Meeting

7 February 2013 in New Plymouth

TARANAKI DISTRICT HEALTH BOARD

M I N U T E S Open (unconfirmed)

HOSPITAL ADVISORY COMMITTEE

8 November 2012
10am
Corporate Meeting Room 1
Base Hospital David Street
New Plymouth

Present:
Karen Eagles (Acting Chair), Alex Ballantyne, Mary Bourke, Peter Catt, Kura Denness, Flora Gilkison, Brian Jeffares, Pauline Lockett. Alison Rumball, Colleen Tuuta,

In Attendance:
Tony Foulkes (Chief Executive), George Thomas (General Manager Finance & Corporate Services), Rosemary Clements (General Manager Hospital & Specialist Services), Anne Kemp (Quality & Risk Manager), Charles Hunt (Medical Recruitment Manager), Katherine Fraser-Chapple (Management Accountant), Ramon Tito (Kaumatua), Sue Carrington (Communications Advisor), Jenny McLennan (PA to Chief Executive)

757.0 Apologies
The Chair noted the apology received from Ella Borrows for non-attendance and from Pauline Lockett for lateness.

758.0 Minutes of Previous Meeting
Resolution
That the Hospital Advisory Committee resolve to accept the minutes of the meeting held 4 October 2012 as a true and correct record.

Gilkison/Catt
Carried

758.1 Matters Arising
758.2 Waiting List Management
Mrs Rumball referred to waiting list management and questioned whether patients were cognisant with the system and if the letters used adequately portrayed how the system functioned.

758.3 Submissions
Dr Gilkison requested a copy of the TDHB submission on the Health Practitioners Act and noted the ongoing work by HQSC in the area of quality indicators.

758.4 ED Presentation – Dr Stevens
Mrs Clements confirmed the ED presentation was scheduled for the December meeting.

759.0 General Manager Hospital & Specialist Services Report

759.1 Quality & Risk

The Quality & Risk Manager took her report as read highlighting the following:

- Certification Surveillance visit underway 6-8 November 2012.
- Work continues on the presentation of patient feedback data.
- Noted increase in HDC patient complaints.
- Pleasing downward trend of Clostridium Difficile infection noted, with TDHB Infection Control Nurse invited to present at a national forum on TDHB control policy and associated procedures.
- The HDC Report and Analysis for the period 1 January – 30 June 2012 had been received was presented for discussion.

Discussion followed with the following points noted:

- Utilisation of the Australian definition of Clostridium Defficile in infection control management had improved local control and management.
- Patient complaints regarding facility maintenance should decrease with new build.
- Pleasing to note more compliments received than complaints.
- Facility preparedness at Hawera hospital had been reviewed and it was noted that the Facility Overseer, while based in New Plymouth had sound Hawera Hospital knowledge and briefing of other staff had occurred.
- Complainants may choose to go directly to HDC who then collaborate with DHBs in complaint resolution.
- Any significant complaints regarding individual practitioners are referred to the respective professional council.
- HDC do receive and consider complaints which may have been managed initially by DHBs and then liaise with DHBs advising whether local resolution management was appropriate.
- The Chair thanked Mrs Kemp for her full report.

Mrs Kemp left the meeting.

759.2 General Manager Hospital & Specialist Services Report cont'd

The General Manager Hospital & Specialist Services took her report as read highlighting the following:

- Report covers hospital activity for the first quarter of the 2013/14 financial year.
- Overall casemix now 2% ahead of plan YTD.
- Average occupancy in the adult inpatient wards reduced this month to 87%.
- First quarter financial results find the provider arm $1.17M worse than the budgeted deficit of $1.01M.
- Revenue was $87K below budget and expenditure was $1.09M higher than budget.
- ACC revenue contracts behind, with trend set to continue.
- Average month of activity in both EDs.
- ED Shorter Stay target results improved by 2%.

- Smokefree results have dropped, with the initiatives in place to improve results now having a positive impact.
- 'Outline of Hospital Services Project' report presented provides an update of individual projects currently underway, with the following noted:
    - Recent discussions have occurred regarding efficiency options within Orthopaedic Service.
    - Elective surgery management over Christmas/New Year period plans three weeks with no elective delivery.
    - High cost pharmaceuticals are being highlighted and clinical consideration being given to appropriate utilisation.

Discussions with the following points noted:

- Good information provided on projects underway.
- Ongoing trends of reduction in ACC contract revenue was noted with concern.
- Mrs Clements advised that the new facility would provide opportunities for theatre management flexibility and that the ongoing viability of some ACC contracts was under review.
- The high number of radiology accepted referrals waiting for 21 weeks was noted with concern. It was agreed that more information regarding this was necessary to enable further consideration, and that national comparative information would be beneficial.
- It was noted that the TPOT project provided the tools necessary to ensure effective utilisation of theatre facilities and their management.
- Mrs Rumball noted the reference to Hawera community 'being happy' with the progress being made in the provision of oral health services, advising that this contradicted comments made in an email received from one Hawera resident – Mrs Rumball tabled the email which had been received by a number of other members.
  Miss Bourke advised that the challenge was whether the individual was speaking on behalf of the wider community.
- In response to questions on the reported involvement of surgeons in the TPOT project, Mrs Clements advised that opportunities to ensure the availability of SMOs when required to participate in the development of the project had been addressed, with positive engagement resulting.
- Following the cancellation of a number of elective sessions (26) to accommodate acutes, the Orthopaedic team have developed a plan to minimise this occurring again.
- It was noted anecdotally that when GP's gained direct referral access to Ultrasound the maximum waiting time target was to be six weeks however the actual time was up to 20 weeks. Mrs Clements advised that Ultrasound data would be included in future reports.

759.3 Financial Commentary

Mrs Fraser-Chapple highlighted the following:

- FTE reduction of 12.6 while 1.5% above budget.
- Supplies expenditure reducing.

Discussion with following points noted:

- Dr Gilkison referred to noted trends in ratio costs that she had prepared over the last three months.
- In response to discussion on the use of locums and vacancies and the associated budgeting, Mrs Clements advised it was necessary to review both locum use and medical staff lines together when considering financial results.
- The opportunity for the utilisation of Base Hospital staff at Hawera was raised. Mrs Clements advised:
    - Geriatric and Medical services were provided from Base in Hawera.
    - Required supervision for junior staff and registrars is not always available in Hawera.
    - Rural Training model will assist in recruitment in South Taranaki.
    - Majority of locums are engaged through an agency.
- In response to questions on successive planning for likely staff shortages due to retirements etc, Mr Foulkes advised that this was constantly happening with strategic planning discussions between Managers and clinicians. Mrs Clements provided some practical examples.
- It was noted that when TDHB employees (clinicians) were engaged to undertake additional sessions they were paid at their normal rate rather than at locum rate.

Ms Lockett joined the meeting.

759.4 Human Resources and Organisational Development

Mr Hunt took the report as read noting the following points of interest:

- Increase in Maori participation, recognising the good results of the Incubator programme.
- Voluntary Bonding Scheme was beneficial in Rural Health Medicines and Midwifery areas.

Discussion with following points noted:

- It was noted that the 'Reason for Leaving' data was collected through a tick box response form with staff not required to give a reason for leaving.
- Mr Foulkes advised that the Ministry had applied the criteria regarding 'hard-to-staff community areas and that while Taranaki was not initially included it now designated for the voluntary bonding scheme. The initiative provided opportunities for staff to gain access to funding for personal support for training and was a means of targeting a limited resource.
- The awarding of 28 scholarships for the 2012 study year was noted, with 35% of the students identifying themselves as being of Maori ethnicity.

Resolution

Resolved that the Hospital Advisory Committee receive and discuss the report and attachments of the General Manager Hospital & Specialist Services.

Bourke/Catt
Carried

760.0 Next Meeting

It was noted that the next meeting was scheduled to be held Thursday, 6 December 2012 in New Plymouth

Meeting closed at 11am

…… ……

Chairman Date

TDHB Hospital Advisory Committee Task List as at 8 November 2012						
Action No	**Date Raised**	**Action Description**	**Status**	**Assigned**	**Due Date**	**Updates**
12	8 November 12	**Radiology waiting time** - comparative information		GM H&SS	Dec 2012	
~~11~~	~~8 November 12~~	~~**Ultra Sound Data**~~		~~GM H&SS~~	~~Dec 2012~~	~~Provided in Dec report~~
10	8 November 12	**Health Practitioners Act –** Copy of submission made		PA to CE	Nov 2012	
~~9~~	~~4 October 12~~	~~**ED Presentation** - To be scheduled~~		~~GM H&SS~~	~~Nov/Dec~~	~~Scheduled for Dec meeting~~
8	6 October 11	**New Facilities –** Consideration of acknowledging former Chairman		Chair	2013	

TO	CEO and Hospital Advisory Committee
FROM	General Manager Hospital & Specialist Services
DATE	26 November 2012
SUBJECT	Exception Report for October 2012

TARANAKI DISTRICT HEALTH BOARD

MEMORANDUM

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1 OVERVIEW

This report provides an overview for the Hospital Advisory Committee (HAC) of hospital activity for October 2012.

Overall casemix delivery for the month was 6% ahead of plan (year to date 3% ahead), up 1% from September.

Medical case mix for the month was 8% ahead against plan, with year to date delivery 4% ahead.

Overall surgical delivery is 1% behind plan year to date with electives over delivered 10% against plan for the month and acute surgical delivery 6% behind contact for October. However, it remains our intention to ensure exact delivery of plan by year end.

The average occupancy in the adult inpatient wards increased slightly this month to 89%. However, Ward 1 remained high at 101%.

Mental Health occupancy was 82.6% for the month (compared to 76.5% in September).

The Provider financial result for the year to 31 October is $1.90M worse than the budgeted deficit of $1.76M. This was made up of revenue $67K above budget and expenditure $1.97M higher than budget. Total expenses are 3% above budget to date and 5% higher than the same period last year.

2 ACTIVITY

DHB Funded Activity

Patient Activity Summary

Metric	Month				YTD		
	Actual	Budget	Var	Var%	Actual	Budget	Var%
Total Patient Discharge Base	1,846	1,660	186	11%	6,898	6,588	5%
Total Patient Discharge Hawera	198	177	21	12%	822	694	18%
Elective Surgical Discharge	414	377	37	10%	1,549	1,572	-1%
ED Attendance Base	1,616	1,466	150	10%	6,562	5,866	12%
ED Attendance Hawera	1,192	1,050	142	14%	4,718	4,199	12%
Outpatient Attendances	3,216	2,787	429	15%	13,071	11,148	17%
Theatre Visits	650	525	125	24%	2,591	2,222	17%
Deliveries Base	94	109	-15	-14%	401	435	-8%
Deliveries Hawera	7	9	-2	-22%	32	36	-11%

The total discharges through both Base and Hawera hospitals reflect a reasonably busy month. ED presentations remain above contract for October, maintaining a 12% over delivery year to date.

Electively, OPD experienced another busy month at 15% variance from contract for the month (17% year to date). This activity reflects the workload required to ensure the three week elective closure does not impact on ESPI compliance for FSA waiting times.

2.1 Casemix and Non Casemix Activity

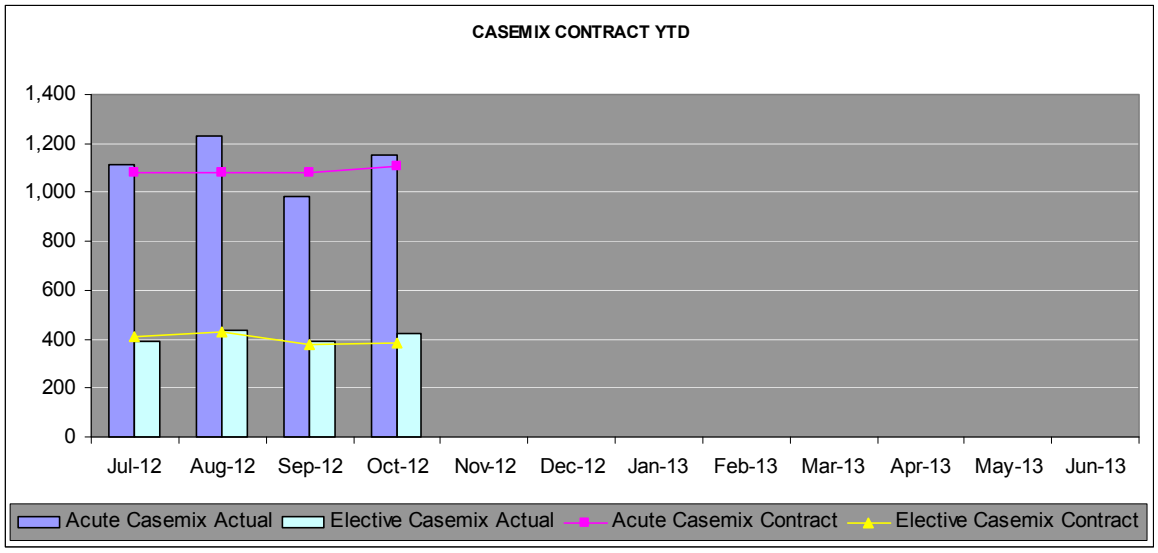
2.1.1 Casemix Delivery for 2011/12

Casemix delivery for October was 6% ahead of plan (82.47 cwd). Year to date casemix is at 3% ahead of plan (169 cwd), up 1% from September.

October 2012 YEAR TO DATE result Case Mix delivery						
	Dschg	Total Cwd's	Contract	Cwd var	Avg Cwd.	% Variance
Medical	4039	2371	2283	88.73	0.59	4%
Surgical Acute	1257	1496	1549	-53.56	1.19	-3%
Surgical Elective	1414	1568	1541	26.42	1.11	2%
Total Surgical	2671	3064	3091	-27.14	1.15	-1%
Maternity	1010	680	571	108.30	0.67	19%

October medical casemix was 8% ahead for the month. Year to date medical casemix is now 4% ahead of plan.

Once again over delivery occurred within the elective delivery for surgery (10% = 36.15 cwd) offset by acute surgical delivery (-6% = -24.95 cwd) for October. Year to date total surgical delivery stands at 1% behind contract.



2.1.2 Specialty breakdown

Acute delivery

- Cardiology volumes have slowed slightly from 90% over plan for September, to 76% over plan in October, this results in Cardiology sitting at 30% ahead of plan year to date.
- Orthopaedics is at 0% for the month and 6% ahead of plan year to date, an improvement on previous months.

Elective delivery

- Cardiology is 38% ahead of plan for the month and 20% year to date.
- ENT, General surgery, Ophthalmology and Urology are also ahead of plan at months end which has smoothed the year to date delivery to within the +/- 5%.

Oct-12	YTD Volumes - Actual v Contract				
	Actual	Contract	Var	% Var	Comment
Casemix	**cwd**	**cwd**	**cwd**		
Dental	80.96	88.49	-(7.53)	-9%	
Acute	21.57	26.03	-(4.46)	-17%	This is demand driven
Elective	59.39	62.46	-(3.07)	-5%	Acceptable result although will require monitoring
ENT	129.15	139.62	-(10.47)	-7%	
Acute	11.35	17.31	-(5.95)	-34%	Demand driven
Elective	117.80	122.32	-(4.52)	-4%	Small service affected by leave of clinicians
Cardiology	232.14	182.99	49.15	27%	
Acute	161.94	124.49	37.45	30%	Offset by over delivery in elective
Elective	70.19	58.50	11.70	20%	
Emer Med	443.75	475.14	-(31.39)	-7%	
Base	287.83	348.71	-(60.89)	-17%	CWD under contract however presentations are above contract as per previous comment
Hawera	155.92	126.43	29.50	23%	
Paed Med	239.55	178.55	60.99	34%	Reflective of busy month
Base	239.55	178.55	60.99	34%	
Urology	122.47	137.47	-(15.00)	-11%	
Acute	33.45	48.44	-(14.99)	-31%	Demand driven
Elective	89.02	89.03	-(0.01)	0%	Contracted service affected by availability of clinicians
Maternity	346.23	411.29	-(65.06)	-16%	Demand driven
Neonatal	333.29	159.93	173.36	108%	A busy month

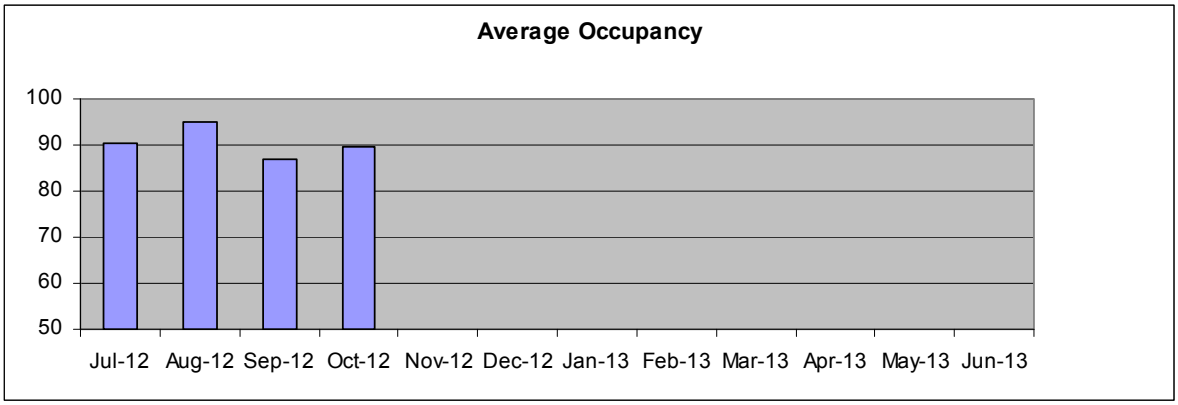
Procedure targets

Joints: Year to date 79 joints have been completed, which is slightly behind our plan (25 joints). Unfortunately, there has again been a number of electives cancelled for acute cases. A contingency plan has been put in place for Feb/March 2013.

Cataracts: 157 cataracts have been completed year to date (17 ahead of plan).

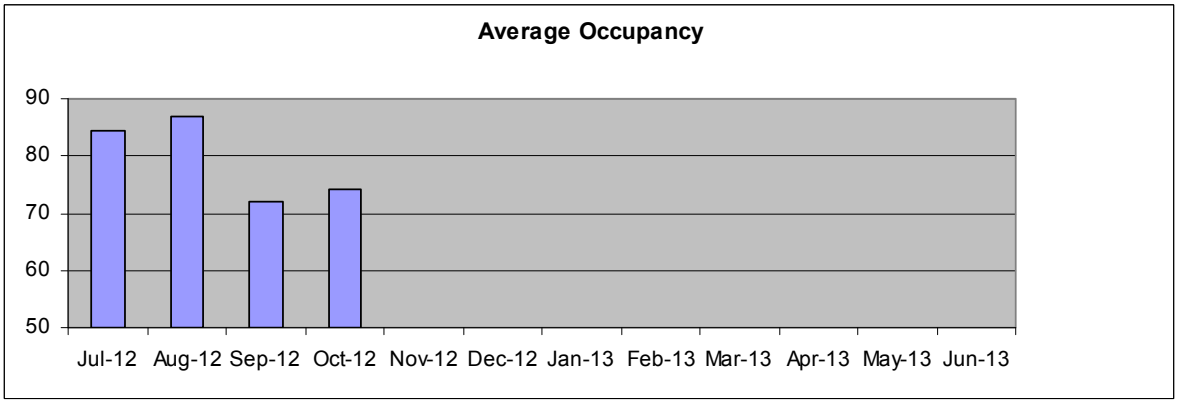
2.2 Inpatient Delivery

Graph One (A): AVERAGE OCCUPANCY FOR ADULT INPATIENT WARDS (includes WARDS 1, 3, 4 & 5 - a total of 126 beds)



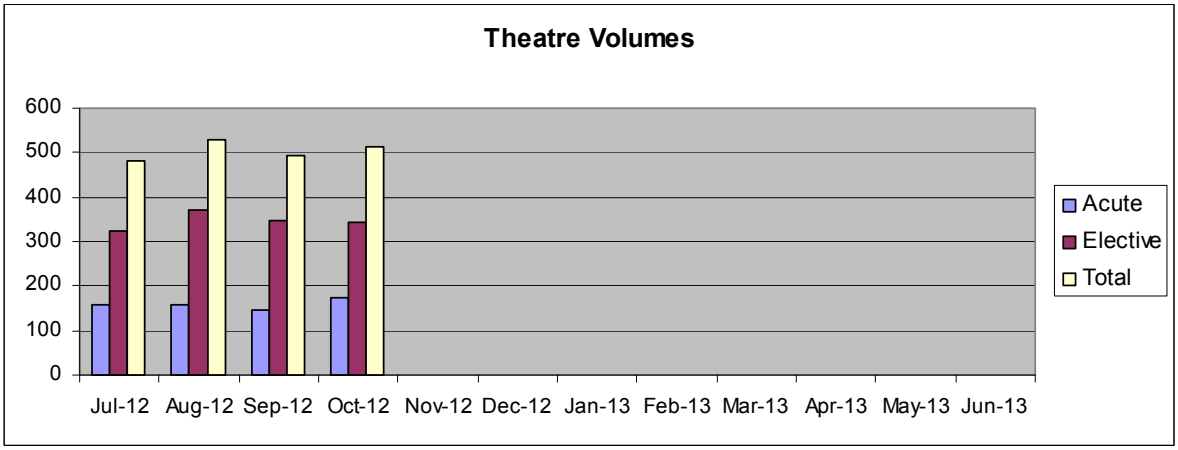
(This table reflects how many patient beds are occupied each day on average. It therefore provides an indicator of the busyness of the 4 main inpatient wards and because they make up the greater number of total hospital beds, usually the general busyness of the whole hospital. It includes a mix of acute ie. unplanned patients and elective ie. planned patients.)

Graph One (B): AVERAGE OCCUPANCY FOR SPECIALIST UNITS (includes ICU, NNU, WD 2 & MATERNITY – a total of 53 beds)



(This table reflects how many beds are occupied each day on average for the specialist units. Typically specialist units do not run with a high occupancy and their busyness is more often dictated by the acuity of their current patients – see Graph 4 B)

Graph Two: THEATRE VOLUMES



Comment: Of note, the average occupancy in the adult inpatient wards increased slightly this month to 89%. Ward 1 remained high at 101%.

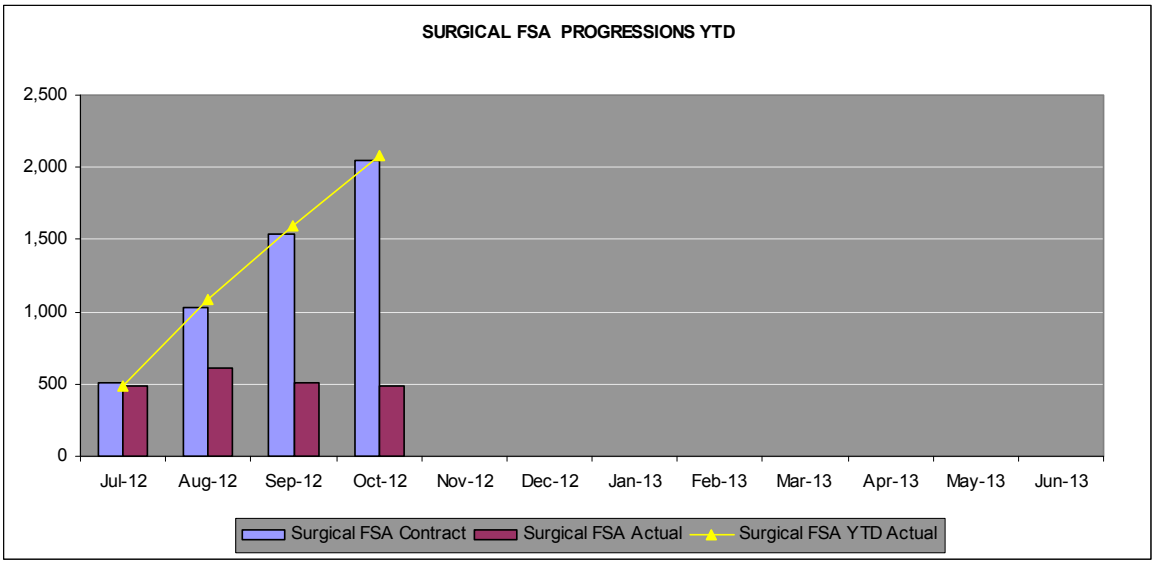
The specialist units also had a slightly busier month with Ward 2 at 81%.

2.2.1 Hawera Inpatient Ward

October occupancy for Hawera inpatients was 59%, an increase from 50% in September. HMU occupancy is 40%, an increase from 35% last month.

2.3 Outpatient FSA Delivery for 2012/13

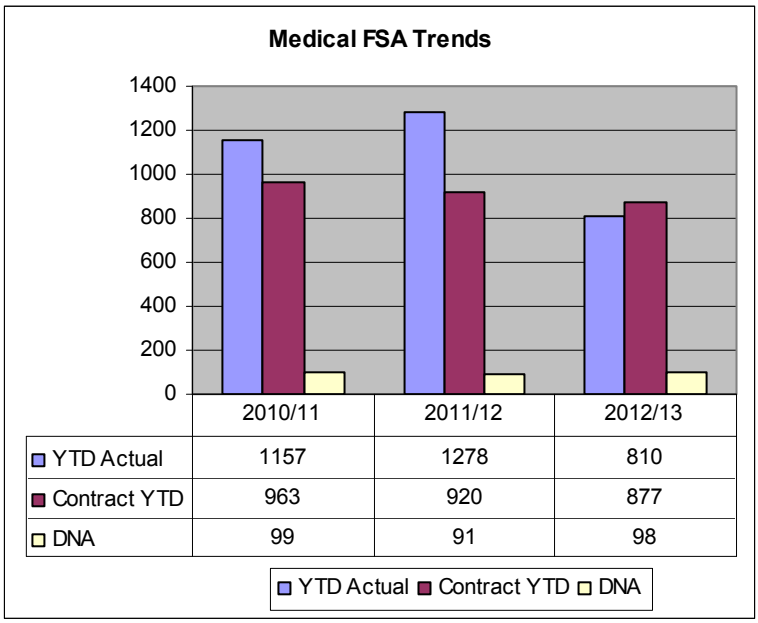
Surgical First Specialist Assessments (FSA)



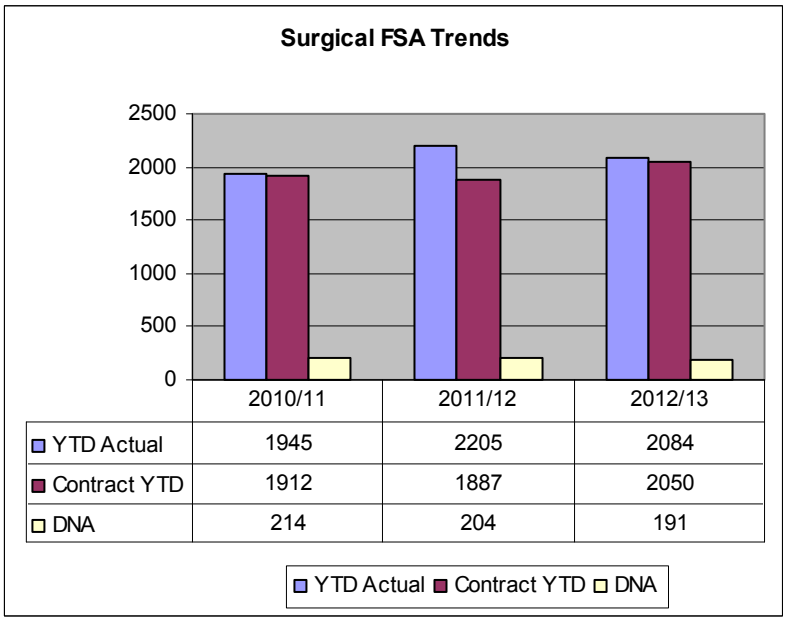
	Act Vols	Ctrct Vols	Var	% Var
Ophthalmology - FSA	434	338	96	28%
Orthopaedics - FSA	340	367	-27	-7%
Urology - FSA	150	167	-17	-10%

- Ophthalmology delivery remains above plan, however in line with elective closure, there will not be any clinics in January for this service.
- Urology and ENT are slightly under delivered against plan, however we are now closer to contract overall and remain 2% ahead of delivery year to date.

2.3.1 FSA Trends



This month's delivery remains close to contract.



This month's delivery remains close to contract.

2.4 Waiting List Management

TDHB continue to be compliant with the tighter Ministry of Health requirements to have zero patients waiting over 6 months in ESPI 5. This has now been maintained for the first quarter, with the preliminary results for October also green.

Some specialties are now able to book patients within a 5 month wait time, however the lead up to the Christmas break is putting significant pressure on other specialties. The resignation and departure of one of the Gynaecologists has added to this, however recruitment has occurred and it is hopeful that this pressure will be relieved swiftly.

The plan to phase out Active Review in Orthopaedics for joint replacements is ongoing, with careful planning to ensure these patients receive surgery within prescribed time frames. The consultants are now the only ones able to score patients against recognised CPAC tools. This method of assessment is being carefully monitored to ensure consistency.

ESPI 2 is likely to be yellow for October as one patient is unable to be seen in the target timeframe due to the cancellation of clinics by visiting consultants.

2.5 ACC

- **Non Acute Rehabilitation Contract**: Once again this contract is behind budget year to date despite the large increase in the bed day rate. Internal investigations are occurring to determine whether new initiatives are impacting on this contract. This contract will be a focus for some time.

- **Clinical Services Contract**: Outpatient billing has decreased for this contract and an audit will be carried out to ensure we are capturing all activity.

- **Elective Surgery**: We continue to be under budget – now at 25%. The valid concern continues that this trend will result in a reduced budget for the 2013/14 year. Our DHB team is focussed on improving this result working closely with the private rooms and the consultants to achieve this. TDHB are currently able to offer more ACC lists and the two more full time surgeons have started to use these.

- **Nursing Services**: The new contract is in place, the additional complexity and administration this contract demands is being carefully monitored.

- **Other contracts**: Hand Therapy and Physiotherapy contracts are running well with the Hand therapy contract results showing it to be the best performing ACC contract - $18,000 (38%) ahead year to date.

2.6 Emergency Departments

The average number of patients per day in Hawera ED for October 2012 was 45.8, compared to 45.6 for September.

Hawera ED

	October 2012	% Admitted	Average 2012/13 YTD	Average 2011/12
Triage 1	3	33%	3	2
Triage 2	79	45%	94	87
Triage 3	358	28%	401	345
Triage 4	729	6%	673	630
Triage 5	251	2%	226	219
Total Visits	1420	13%	1398	1283

Base ED

	October 2012	% Admitted	Average 2012/13 YTD	Average 2011/12
Triage 1	9	100%	10	7
Triage 2	214	58%	202	186
Triage 3	1028	40%	1014	981
Triage 4	1162	18%	1202	1138
Triage 5	230	5%	209	176
Total Visits	2643	29%	2637	2488

Above average numbers across all triages and overall when compared to 2011/12 levels. 6% increase in visits year to date compared to last year.

2.7 Mental Health

TPW: Combined occupancy for October was 82.6%. This figure was made up of the following patient groups:

- Adult = 96.8%
- Elderly = 49.2%
- Intensive Psychiatric Care = 62.9 %
- There were 14 clients through IPC in October compared to 15 for the month of September.

Average number of specials:

- Number of shifts from HWS = 0.4 FTE, compared to 2.84 FTE for the month of September. (This will not include any specials/constants we have been able to achieve without supplementary staff).

Brixton House (**Te Whare Whakauhuru)** (4 bed residential facility): was 81.5% occupancy in October.

3 TARGET UPDATES

The Provider Arm are continuing to liaise with the Ministry of Health and Target Champions to assist our progress towards achieving each of the targets below.

3.1 ED Shorter Stays

Target 95%	October 2012	Q1 2012/13	Average 2011/12
TBH ED	88.77	88.14	85%
Hawera ED	99.78	99.78	99.81%
Total TDHB	92.60	92.18	90.01%

This result shows ongoing improvement in this target compared to previous year, despite above average presentations for this quarter. 29% admission rate for October, which is slightly higher than average also.

Emergency Department

- Planning occurring for electronic screen to display patient list in arrival order, colour coded to highlight 6 hour target.
- Averaging 5 admissions per day to the EDO.
- Minor Injuries' Unit continuing to increase throughput, initial feedback from senior medical staff and patients is very positive.
- Audit of 6 hour breaches continue on a weekly basis. In November a real time audit of patients through the ED will be completed for 1 week to further identify delays in patients with length of stay longer than 6 hours.

The below initiatives to improve the 6 hour target result continue:

Ward 5

- Rapid Rounding is continuing to be very successful. There are improvements in overall patient management and knowledge by the MDT. Earlier identification of EDD and appropriate planning taking place.
- Discharges are continuing to be earlier overall, for October 24% of patients were discharged before 11am.
- Early completion of discharge documentation to meet discharge time of 11am has improved.

Department of Medicine

- Review of rostering for SMO and RMO within Department of Medicine to improve ability to meet needs of acute admission, reduce length of stay, and deliver elective delivery.
- A registrar based in the ED from 1400-2200 has proved to be successful in meeting work load peak during these hours. How this will be rostered long term is being developed with the RMO team.

Acute Pathway Project

- Key pieces of work identified include bed block procedure and escalation pathway, transfer of patient procedure and communication plan.

A procedure for transfer of patients has been developed and is to be implemented in November.

3.2 Smokefree Health Target

Target 95%	October 2012	Q1 2012/13	Average 2011/12
	91.2%	86.74%	91.38%

Smokefree target has shown improvement this month, based on improved recording. The smokefree co-ordinator continues to work with areas of high turnover of patients where this target is most challenging to attain. A focus is being placed on maintaining and improving the achievements seen in October.

3.3 Radiology Health Target

The tables below outline the monthly movements for CT, MIR and Ultrasound. The total number of accepted referrals in all modalities out strips delivery. This trend is being examined and discussed with Fulford.

Monthly Return for Taranaki Health (Computed Tomography and Magnetic Resonance Imaging Statistics)		CT	MRI
Month = October 2012			
1	**Overall Patient events (Community and Outpatient referrals)**		
a)	Total number accepted referrals waiting for scan at month end	**251**	**270**
b)	Total number of referrals accepted for scanning during month	**230**	**111**
c)	Total number scanned and reported during month	**188**	**100**
d)	Total number of DNAs during month	**5**	**1**
e)	Total number of referrals not accepted during month	**11**	**6**
2	**Waiting times for Community and Outpatient referrals except planned procedures**		
a)	Total number accepted referrals waiting for scan at month end	**168**	**189**
b)	Number of accepted referrals waiting for scan within 6 weeks (42 days)	**108**	**66**
c)	Number of accepted referrals waiting within 21 weeks (147 days)	**165**	**189**
3	**Monthly activity and demand for Community and Outpatient except planned procedures**		
a)	Total number of referrals for scan accepted during the month	**204**	**96**
b)	Total number of accepted referrals scanned and reported in month	**156**	**88**
c)	Total number of accepted referrals scanned and reported in month within 6 weeks	**75**	**23**
d)	Total number of accepted referrals scanned and reported in month within 21 weeks	**142**	**53**

Monthly Return for Taranaki Health (Ultrasound Statistics)		US
Month = October 2012		
1	**Overall Patient events (Community and Outpatient referrals)**	
a)	Total number accepted referrals waiting for scan at month end	**553**
b)	Total number of referrals accepted for scanning during month	**458**
c)	Total number scanned and reported during month	**442**
d)	Total number of DNAs during month	**25**
e)	Total number of referrals not accepted during month	**25**
2	**Waiting times for Community and Outpatient referrals except planned procedures**	
a)	Total number accepted referrals waiting for scan at month end	**436**
b)	Number of accepted referrals waiting for scan after 6 weeks (42 days)	**296**
c)	Number of accepted referrals waiting within 21 weeks (147 days)	**427**
3	**Monthly activity and demand for Community and Outpatient except planned procedures**	
a)	Total number of referrals for scan accepted during the month	**425**
b)	Total number of accepted referrals scanned and reported in month	**400**
c)	Total number of accepted referrals scanned and reported in month within 6 weeks	**146**
d)	Total number of accepted referrals scanned and reported in month within 21 weeks	**370**

3.4 Projects *(see Appendix 1 and 2)*

This month we have included five program reports. TPOT, Pre Admission Process Redesign and Enhanced Recovery for colorectal, Releasing Time to Care and Care Capacity Demand Management. The whole five projects are well underway and on plan. (*Appendix 1*)

Also attached is an updated table outlining the Projects currently underway to ensure efficient and productive patient services, as well as contributing to the overall budget maintenance for the year. (*Appendix 2*)

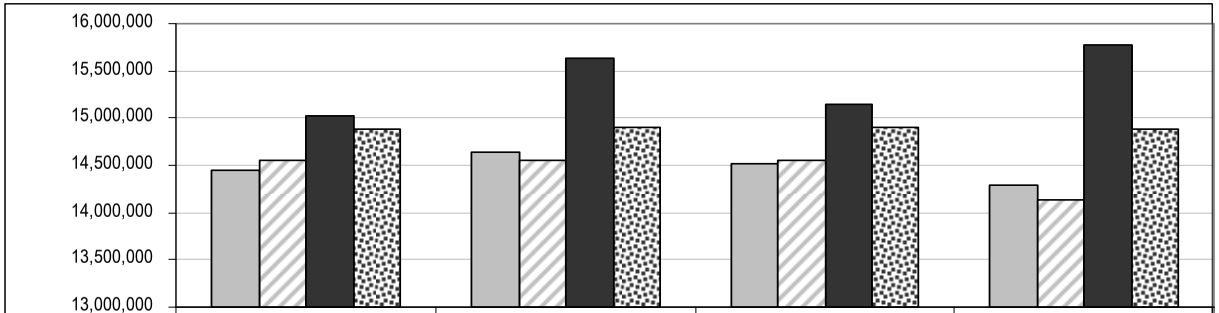
Colorectal bowel cancer has gained Ministry focus with the waiting times for colonoscopy being a large factor within this. With the move to a new Endoscopy Suite courtesy of Project Maunga, and an awareness of the ongoing timeframe expectations within all services, the DHB commissioned a review of our endoscopy services and the associated waiting time. This has now been completed with the associated recommendations. A steering group has been put in place to oversee the implementation phase. (Further information is contained in *Appendix 2*).

4 FINANCIAL COMMENT

Financial Comment for the Month Ending 31 October 2012

The Provider financial result for the year to 31 October is $1.90M worse than the budgeted deficit of $1.76M. This was made up of revenue $67K above budget and expenditure $1.97M higher than budget. Total expenses are 3% above budget to date and 5% higher than the same period last year. Analysis of expenditure continues as we move into budgeting for the 2013-2014 financial year.

	October Actual	October Budget	Variance	Year to Date Actual	Year to Date Budget	Variance	Percentage Variance to Budget	October 2011 YTD	Movement	Percentage Movement	Comment
Revenue	(14,293,977)	(14,139,047)	(154,927)	(57,886,931)	(57,819,175)	(67,757)	0%	(57,795,396)	(91,535)	0%	
Personnel Costs	8,581,621	8,438,209	143,414	34,595,629	33,798,489	797,147	2%	32,597,024	1,998,605	6%	October clinical staff costs have reduced from previous months. Clinical staff higher than budget YTD, offset by savings in administration
Outsourced Services	2,040,852	1,629,274	411,576	7,305,843	6,517,100	788,742	12%	7,475,414	(169,571)	-2%	High costs in locums and outsourced Radiology
Clinical Supplies	2,034,834	1,968,737	66,111	8,103,877	7,877,002	226,875	3%	8,217,078	(113,201)	-1%	
Infrastructure & Non Clinical Supplies	3,111,911	2,853,733	258,187	11,549,704	11,391,348	158,334	1%	15,692,492	(282,772)	-2%	High costs in facilities and corporate. Smaller overspend in patient meals and linen
Total Expenses	15,769,217	14,889,953	879,288	61,555,053	59,583,939	1,971,098	3%	63,982,008	1,433,061	2%	
Grand Total	**1,475,241**	**750,906**	**724,361**	**3,668,122**	**1,764,764**	**1,903,341**	**108%**	**6,186,612**	**1,341,526**		



	July	August	September	October
Revenue	14,439,244	14,642,089	14,511,617	14,293,977
Revenue Budget	14,560,045	14,560,042	14,560,042	14,139,047
Total Expenses	15,015,848	15,626,644	15,143,338	15,769,217
Expenses Budget	14,890,979	14,899,797	14,903,306	14,889,953

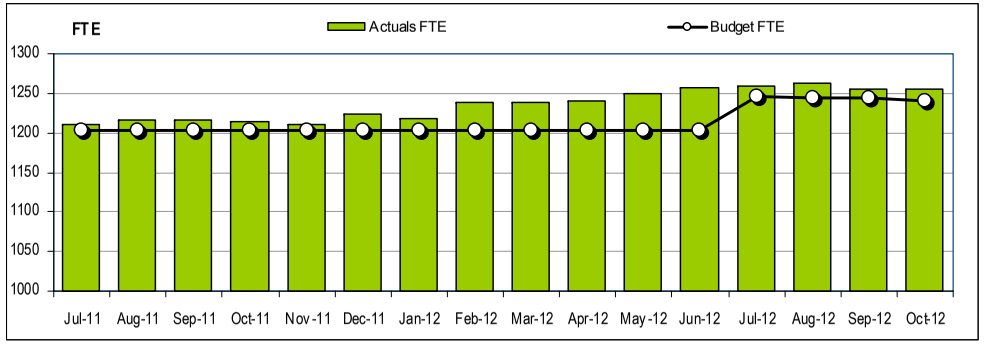
October personnel costs are have reduced from earlier months, however remain higher than budget year to date. The majority of the overspend relates to clinical areas and includes Medical staff ($312K YTD), nursing ($470K YTD) and allied health ($318K). The total year to date variance is $797K or 2% above budget. FTE are reducing from the winter highs and further savings are anticipated over the Christmas/New Year break, where services are reduced to a minimum.

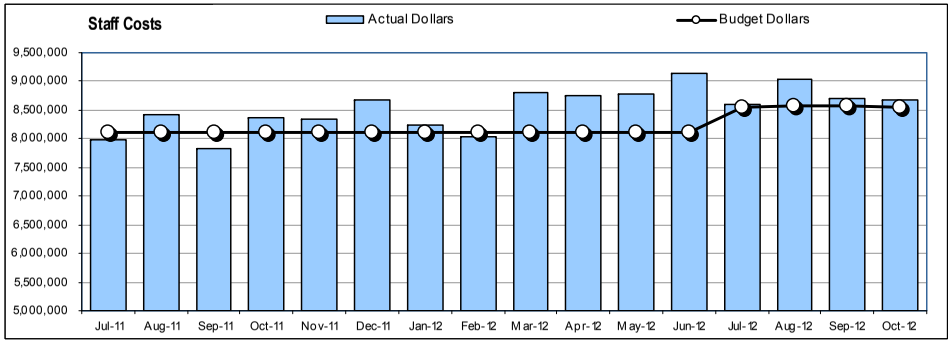
$000	October Actual	October Budget	Variance	October Actual FTE	October Budget FTE	FTE Variance	YTD Actual	YTD Budget	YTD Variance	% Variance	Annual Budget	Comments
Medical Staff	2,240	2,273	(33)	135.8	142.3	(6.5)	9,403	9,091	312	3%	27,273	Reducing from previous highs
Nursing Staff	3,613	3,428	185	559.4	542.7	16.7	14,231	13,761	470	3%	40,826	Nursing costs are slightly over, impact of public holiday. High FTE in acute clinical areas
Allied Health Staff	1,259	1,205	54	227.8	222.1	5.7	5,124	4,807	318	7%	14,449	A number of project staff in this category - 3.6 FTE
Support Staff	347	303	44	88.9	81.2	7.7	1,355	1,212	143	12%	3,636	
Management and Administration Staff	1,123	1,229	(106)	224.4	234.4	(10.0)	4,482	4,928	(446)	-9%	14,763	
	8,582	**8,438**	**143**	**1,236.3**	**1,222.7**	**13.6**	**34,596**	**33,798**	**797**	**2%**	**100,948**	Overall close to budget
Medical Staff	2,240	2,273	(33)	135.8	142.3	(6.5)	9,403	9,091	312	3%	27,273	
Locum Medical Staff	217	100	117	0.0	0.0		819	401	418	104%	1,203	High costs in Hawera, offset by staff vacancies
Total Cost of Medical Staffing	**2,457**	**2,373**	**84**	**135.8**	**142.3**	**(6.5)**	**10,222**	**9,492**	**729**	**8%**	**28,477**	

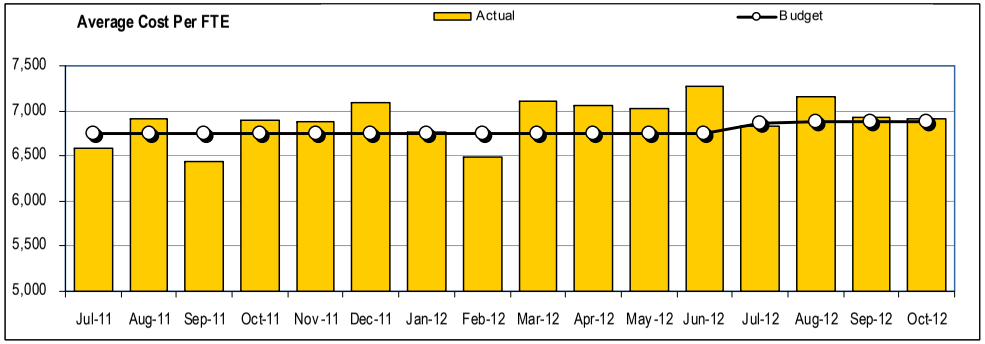
Provider Arm FTE are 13.6 above budget. The majority of this is in nursing staff (16.7 above budget), while medical staff vacancies total 6.53 FTE under budget for the month. Vacancies in employed medical staff continue at Hawera Hospital (3.5 FTE) along with associated use of high cost locum staff to fill rosters. The total cost of medical labour including locums is $10.2M YTD, $729K higher than budgeted. The overspend in locum costs continues to relate to Hawera Hospital. There has been some recruitment in this area and locum costs are expected to reduce accordingly. Management and Administration FTE continue to be under budget for both FTE and costs.

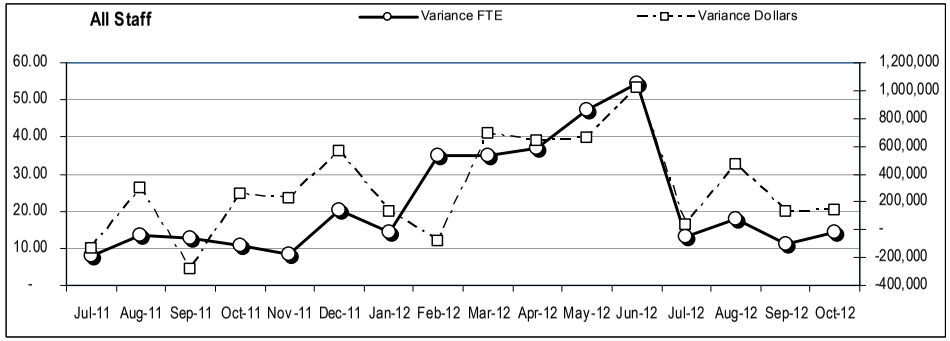
Nursing staff is above budget for acute wards and emergency services including maternity, ED and wards. Nursing staff in these areas are 17.5 above budget, with 15.5 FTE being Enrolled Nurses and Health Care Assistants. Of particular note is the reduction in nursing staff costs in Te Puna Waiora, where staff costs have been significantly above budget for some time. October costs for this ward are $5K and 1.8 FTE above budget, compared to previous monthly overspend of approximately $30K.

Occupancy has eased from previous months, with general wards between 82% and 100% occupancy. Mental Health inpatient occupancy was 87%, Neonatal unit 76% and ICU 64%. Patient acuity and the need for one on one care of patients adds a further layer of demand on nursing and associated services.









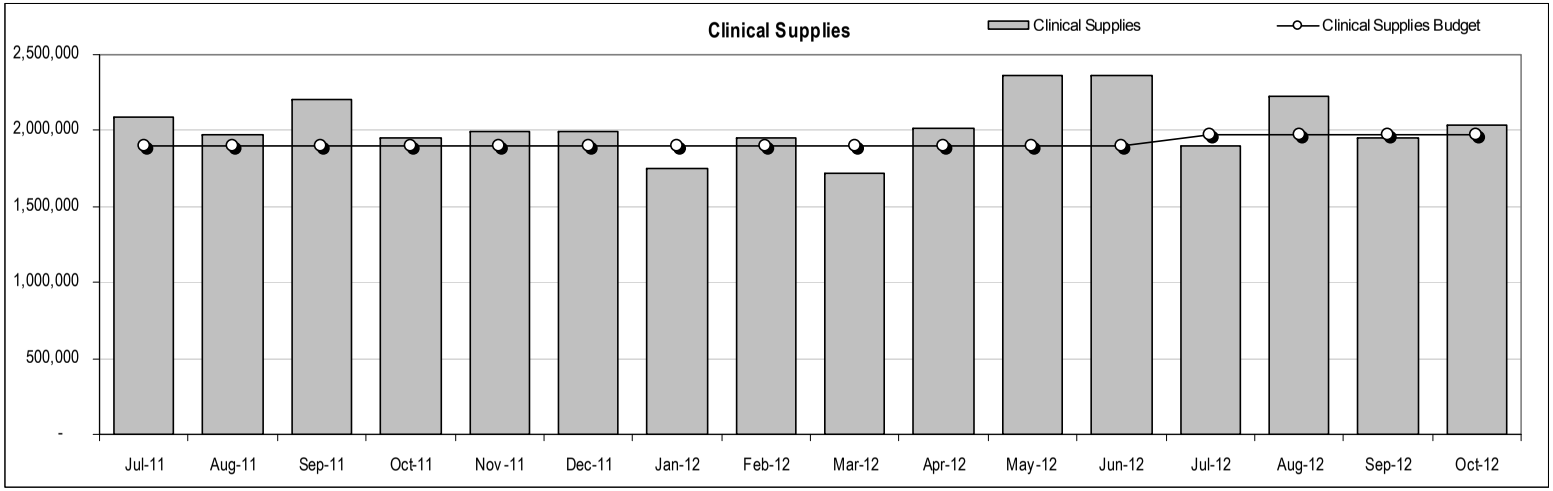
** Graphs represent all TDHB staff including 17.4 FTE from Governance division*

Outsourced Services costs are high, relating to locum costs at Hawera hospital as previously discussed, and outsourced radiology costs being higher than expected. Outsourced clinical services are under budget, relating to reduced costs from ACC surgery.

	October Actual	October Budget	Variance	YTD Actual	YTD Budget	Variance	Percentage Variance	Sum of Annual Budget	Percentage Expended (Target 33%)	Comments
Outsourced Medical Staff	217,450	100,269	117,181	818,761	401,074	417,687	104%	1,203,225	68%	High locum costs in Hawera
Other Outsourced Staff	55,586	32,694	22,891	166,713	130,777	35,935	27%	392,332	42%	Offset by staff vacancy
Referred Services	712,731	610,860	101,871	2,882,375	2,443,442	438,934	18%	7,330,326	39%	Higher than budgeted Radiology costs
Outsourced Clinical Services	1,055,084	885,451	169,633	3,437,994	3,541,807	(103,814)	-3%	10,625,425	32%	
Outsourced Services Total	**2,040,852**	**1,629,274**	**411,576**	**7,305,843**	**6,517,100**	**788,742**	**12%**	**19,551,308**	**37%**	

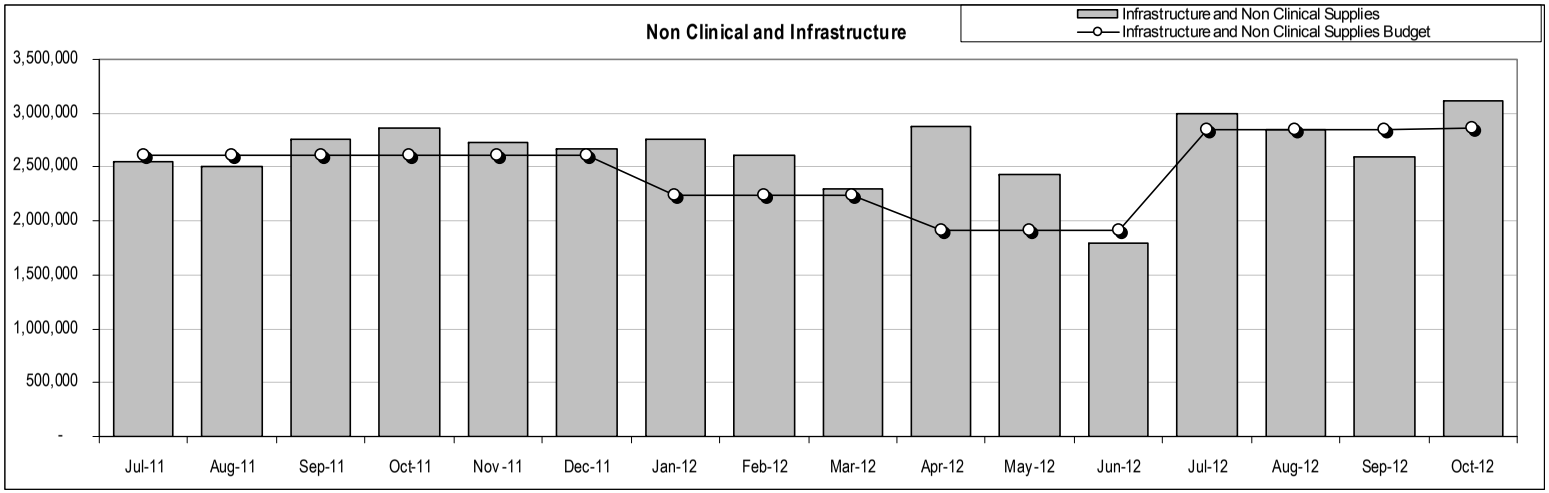
Clinical supply costs are over budget for the month of October by $66K and for the year to date by $227K. Overspend in Pharmaceuticals relates to demand for cancer treatments, where over delivery is funded through internal revenue from the DHB Funder. There are increased costs in implants relating to knee replacement and spinal surgery, and a number of projects are looking at avenues to reduce this expenditure.

	October Actual	October Budget	Variance	YTD Actual	YTD Budget	Variance	Percentage Variance	Sum of Annual Budget	Expended (Target 33%)	Comments
Patient Consumables	795,451	738,301	57,158	2,970,143	2,953,158	16,982	1%	8,859,475	34%	
Diagnostic Supplies	110,580	116,229	(5,647)	442,287	464,919	(22,630)	-5%	1,394,754	32%	
Clinical Equipment	235,567	227,059	8,507	800,460	910,359	(109,901)	-12%	2,680,510	30%	
Patient Appliances	104,548	90,460	14,088	356,507	361,837	(5,332)	-1%	1,085,512	33%	
Implants and Prostheses	258,667	167,532	91,136	977,735	670,123	307,611	46%	2,010,370	49%	High costs in Orthopaedics, relating to volume
Pharmaceuticals	291,927	331,676	(39,747)	1,412,443	1,326,689	85,757	6%	3,980,070	35%	Costs for Cancer Treatments offset by Revenue
Patient Transport and Accommodation	227,344	288,501	(61,156)	1,097,549	1,154,001	(56,451)	-5%	3,462,000	32%	
Other Clinical Supplies	10,750	8,979	1,772	46,753	35,916	10,839	30%	107,748	43%	
Clinical Supplies Total	**2,034,834**	**1,968,737**	**66,111**	**8,103,877**	**7,877,002**	**226,875**	**3%**	**23,580,439**	**34%**	



Infrastructure and Non-Clinical costs are $257K (9%) above budget for the month and $152K (1%) above budget for the year to date. High costs continue in Hotel services however this will return to lower levels over the summer months. Facilities costs continue to be high, relating to utilities, building depreciation higher than expected due to building improvements, and movement of insurance expenses between categories (offset in Professional Fees). IT and Telecommunication expenses are higher than budget due to the one off payment of annual software charges. This has been offset by additional revenue in the month.

	October Actual	October Budget	Variance	YTD Actual	YTD Budget	Variance	Percentage Variance	Sum of Annual Budget	Expended (Target 33%)	Comments
Hotel	293,451	272,787	20,658	1,145,951	1,091,129	54,824	5%	3,273,383	35%	
Facilities	831,171	752,299	78,872	3,334,463	3,008,787	325,673	11%	9,029,696	37%	Higher than budgeted depreciation costs, insurance expenses transferred between categories
Staff Transport & Accommodation	84,345	75,149	9,194	361,315	304,280	57,032	19%	904,103	40%	High costs relating to TDHB vehicles
IT & Telecommunications	1,055,621	789,631	265,990	3,167,589	3,131,037	36,549	1%	9,589,026	33%	One off costs in October relating to software expenses
Interest & Financing Charges	568,927	659,633	(90,706)	2,649,850	2,638,533	11,317	0%	7,915,600	33%	
Professional Fees & Expenses	140,422	154,939	(14,513)	457,112	619,752	(162,639)	-26%	1,859,250	25%	Reduced facility insurance expenses as above
Other Operating Expenses	138,803	150,892	(12,080)	433,867	604,227	(170,360)	-28%	1,802,193	24%	
Democracy	0	83	(83)	897	333	563	169%	1,000	90%	
Cost Savings	0	0	0	0	0	0		(2,000,000)	0%	
Total	**3,112,741**	**2,855,413**	**257,332**	**11,551,044**	**11,398,078**	**152,959**	**1%**	**32,374,251**	**36%**	



5 GENERAL

- E-prescribing ability has now been rolled out into the whole of Ward 1.
- A positive meeting with Coastal Trust in Opunake regarding the new Healthcare Centre plans was recently held.
- Certification audit occurred in early November with positive preliminary results on the day of summation. Awaiting written feedback report.
- Please find memo attached outlining the outsourced costs in detail against budget. (*Appendix 3*)

RECOMMENDATION

That the Hospital Services Reports for the month of October 2012 be noted and received.

Rosemary Clements
General Manager
Hospital & Specialist Services

Appendices:

1. Status Reports for:
    a. Enhanced Recovery (ERAS) for colorectal patients
    b. Preadmission Process Redesign
    c. TPOT
    d. Releasing Time to Care
    e. Care Capacity Demand Management
2. Outline of Hospital Services Projects
3. Memo re Outsourced services
4. Whakapai Dashboard

Status Report

TARANAKI DISTRICT HEALTH BOARD

Project Name	Enhanced Recovery (ERAS) for colorectal patients	**Project Phase**	Implementation
Project Sponsor	Rosemary Clements	**Project Status**	Behind (no threat to completion)
Project Manager	Elizabeth Disney	**Period ending**	23 November 2012

Description

To revise methods and procedures to align with evidence-based practice in the pre-, intra- and post-operative patient pathways/workflows. Production of procedural documentation, and production of revised patient information.

Implementation of ERAS aims to:

- Promote effective use of the preadmission process to plan for recovery and discharge
- Revise surgical technique to reduce the physical stress of surgery
- Structure the approach to peri-operative and immediate post-operative management
- Standardise clinical processes

Key Milestones	**Delivery Dates**	**% Delivered**		**Current Status Update**
	Finish	**Last**	**Now**	
Initial Scoping work completed	End May 2012	100	100	Complete
Regional Meeting/Training	End May 2012	100	100	Tauranga training 21 May
Initial baseline data collected and analysed (including patient survey)	End July 2012	100	100	228 responses analysed – results in August Cleancut Newsletter
Initial meeting with surgeons, anaesthetists and nursing teams to agree principles and approach	July 2012	80	100	Principles agreed
Stage One and Project Plan produced	8 Aug 2012	100	100	Completed and submitted under Stage One Contract Report
Draft of surgical, anaesthetic and nursing protocols complete	Early Sept 2012	25	100	Draft protocol produced requires combination with nursing and surgical approach
Draft of supporting documentation complete (patient information, pathway documentation etc)	Early Sept 2012	40	90	Minor changes required for supporting documentation
Documentation circulated to key stakeholders via ERAS Implementation Leads	End Sept 2012	0	90	Awaiting final sign off
ERAS education and training sessions for all staff involved	Early October 2012	0	80	Training delivered to all non-medical staff. Awaiting change over of junior doctors

Status Report

TARANAKI DISTRICT HEALTH BOARD

First ERAS patients identified and agreed – ERAS principles implemented as per protocols	October 2012	0	0	Formally delayed until Dec however some patients already receiving aspects of ERAS pathway
Audit of ERAS compliance monthly	October 2012	0	0	Planned for Registrars to complete audit as Project
Feedback ERAS compliance results to ERAS Implementation leads monthly	November 2012	0	0	
Stage 2 Report produced – initial implementation reporting	8 Dec 2012	0	0	
Review Protocols and staff training	January 2013	0	0	
Stage 3 Report produced – ERAS as BAU	22 May 2013	0	0	

Key Achievements	• Final Draft protocol produced sent for approval • Some nursing aspects of ERAS already being implemented – seeing dramatic reductions in LOS in certain cases
Issues and Risks	Requires final approval – taking time with senior clinical staff
Critical Delays	None anticipated
Next Period Plans	• Agree a suitable approach for education of junior doctors
Action Items for Sponsor	None

Status Report

TARANAKI DISTRICT HEALTH BOARD

Benefits Summary

Enhanced Recovery After Surgery					
	Benefit	**Benefit Type**	**Measure**		**Category**
Safe	Revise Surgical technique to reduce the physical stress of Surgery	Reduced exposure to hospital infection	Hospital Acquired Infections		Financial - Non Cash releasing
		Fewer Complications and reduced Re-Admissions	Readmission rate OS8		Financial - Cash releasing
Effective	Structure the approach to peri-operative and immediate post operative management	Potential to treat more patients with same resource	Surgical throughput/Bed days OS5		Financial - Non Cash releasing
		Improved Multidisciplinary experience	Staff Satisfaction Survey		Qualitative
		Improved focus on the use of technology identified and implemented			
Timely	Standardise Clinical Processes	National Standards of care and wait times met	ALOS OS3		
Efficient	Standardise Clinical Processes	Increased capacity	Bed fill		Financial - Non Cash releasing
		Reduced length of Stay = reduced bed- days	ALOS - OS3		Financial - Non Cash releasing
		Improved primary/secondary interface and communication	Stakeholder survey		Qualitative
		Increased DOSA rate	DOSA Rate OS7		
Patient Centred	Promote effective use of the pre-admission process to plan for recovery and discharge	Early Detection of Complications	ALOS OS3		Financial - Non Cash releasing
		Additional Interventions may be given earlier	ALOS OS3		Non Financial
		Planned Earlier Rehabilitation - earlier return to normal activities	ALOS OS3		Non Financial
		Improved patient experience	Patient Satisfaction Survey		Qualitative
		improved reputation	Patient Satisfaction Survey		Qualitative
Equitable	Standardise Clinical Processes	Standardised care across midlands region			Non Financial

Status Report

TARANAKI DISTRICT HEALTH BOARD

Project Name	Preadmission Process Redesign	**Project Phase**	Implementation (awaiting Gateway Three sign off)
Project Sponsor	Rosemary Clements	**Project Status**	On Plan
Project Manager	Elizabeth Disney	**Period ending**	23 November 2012

Description

To review current practice, research options for change which are evidence based, and facilitate the implementation of a new pathway to:

- Improve patient safety through a systematic approach to peri-operative assessment that identifies, quantifies and appropriately manages peri-operative risk
- Enable post-operative care to be planned for the patient prior to admission
- Increase patient commitment to the patient pathway, by providing the opportunity for explanation and discussion

Key Milestones	**Delivery Dates**	**% Delivered**		**Current Status Update**
	Finish	**Last**	**Now**	
Initial Scoping work completed	End May 2012	100	100	Complete
Project initiation meeting held	End May 2012	100	100	Presentation on 23 May
Overall project methodology confirmed and incorporated into Project Plan	End May 2012	100	100	Complete
Baseline data analysis completed	Early June 2012	85	100	Final write up completed
Completion of discovery phase	Mid June 2012	100	100	Complete
Gateway One: Steering Group sign off Project Plan and findings of discovery phase	Mid June 2012	100	100	Agreed Steering Group 12 July
Initial pathway redesign and associated recommendations produced in Business and Implementation Plan	Mid July 2012	80	100	Full implementation plan developed
Gateway Two: Steering Group sign off Business Case recommendations and Implementation Plan	Mid July 2012	0	100	Agreed Steering Group 16 August
Initial recommendations implemented	Mid Aug 2012	0	100	Date for full implementation set as 19 November
Recommendations fully implemented	End Sept 2012	N/A	100	Date for full implementation set as 19 November – six weeks behind
Gateway Three: Steering Group review implementation and sign off	Early Oct 2012	N/A	0	Will need to be signed off at Steering Group Meeting planned on 6 December 2012
Initial evaluation of changes made	Mid Jan 2013	N/A	0	Likely that this will need to move to mid-February to allow for enough time for implementation
Gateway Four: Steering Group agree evaluation recommendations for further change and agree plan for next 3 months	End Jan 2013	N/A	0	Likely that this will need to move to mid-February to allow for enough time for implementation
Further changes implemented	April 2013	N/A	0	

Status Report

Project Close Report including full evaluation	End April 2013	N/A	0	

Prioritised issues update:

- Inadequate ANA appointments – criteria better defined therefore potential for fewer ANA appointments required. Anaesthetic Department rostering will change to this from January 2013
- ICU/HDU not notified of patients requiring bed soon enough – there are additional checks built in to the process to address this and administrative support to follow up on notifications
- Inadequate information for bed management – no current plan
- Inappropriate time set aside for larger surgery – Scheduling meetings are addressing these issues, need greater surgeon input for better results
- Planning for discharge/support not in place prior to admission – Allied Health screen to be used at Nurse Triage and also early flag of complex social situations for Case Manager
- Doctors not checking lab results – system for ensuring appropriate tests completed and results reviewed – Preadmission Nurses will have time in their schedule for checking results, where specific issues are consistently arising plans are being developed to address e.g. UTI with joint patients – being screened earlier
- Surgeon listing everyone without consideration of anaesthetic risk – opportunity for patients to be seen in High Risk Clinic
- No afternoon ANA clinics – PM clinics will be routinely available from January 2013
- Issues with multiple visits for South Taranaki patients – transport and travel arrangements – telephone and 'one-stop' visits for PAC and ANA
- Inadequate use of telephone assessments – telephone assessments introduced for preadmission

Key Achievements	• Launch of new processes has so far been very successful with excellent support from all nursing and admin staff and majority support from Surgeons and Anaesthetists • Training of Preadmission Administrator in new role • All new documentation (clinical and patient)
Issues and Risks	None
Critical Delays	None anticipated - second phase of implementation to being in January 2013
Next Period Plans	• Close management of new processes • Ensuring second phase implementation ready for January 2013
Action Items for Sponsor	None

Status Report

TARANAKI DISTRICT HEALTH BOARD

Benefits Summary

Pre-Admission System Re-Design					
	Benefit	**Benefit Type**	**Measure**		**Category**
Safe	Improve patient safety through a systematic approach to peri-operative assessment that identifies, quantifies and appropriately manages peri-operative risk	Fewer Complications and reduced Re-Admissions	Readmission rate OS8	Qtrly	Financial - Non Cash releasing
		Identifying higher risk patients sooner for more appropriate assessment			Financial - Cash releasing
Effective	Enhances the delivery of surgery to the patient by improving their journey and eliminating waste (re-booking, DNA's, cancellations)	Potential to treat more patients with same resource	Surgical Throughput - OS5/Day Surgery OS6/DOSA 0S7	Qtrly	Financial - Non Cash releasing
		Improved Multidisciplinary experience	Staff Satisfaction Survey		Qualitative
		System and pathway clarity for increased staff role definitions	Staff Satisfaction Survey		Qualitative
		Greater clarity on levels of patient preparation for ease of managing surgical wait list	Reduced cancellations (Hospital and patient)	Qtrly	Financial - Non Cash releasing
Timely	Improves outcomes and experience for surgical patients through timely and appropriate processes	National Standards of care and wait times met	o Patient satisfaction o Staff satisfaction. o Incident reporting	year	Qualitative
		Reduction in administrative burden	Reduced re-work	year	Financial - Non Cash releasing
Efficient	Enable post-operative care to be planned for the patient prior to admission	Reduce the Average Length of Stay of patients	ALOS OS3	Qtrly	Financial - Non Cash releasing
		increase Day of Surgery Admissions (DOSA) and Day Surgery interventions	DOSA OS7 and Day Surgery OS6	Qtrly	Financial - Non Cash releasing
		Fewer patient visits and unnecessary appointments – particularly suitable for patients living in South and rural Taranaki	Patient/Clinic Volumes	year	Financial - Non Cash releasing
Patient Centred	Increase patient commitment to the patient pathway, by providing the opportunity for explanation and discussion	Clearer and less confusing care pathways and experience for patients	o Patient satisfaction o Staff satisfaction. o Incident reporting	year	Qualitative
		Fewer patient visits and unnecessary appointments – particularly suitable for patients living in South and rural Taranaki	Clinic DNA rates	year	Financial - Non Cash releasing
Equitable	Standardise Clinical Processes	Standardised care across midlands region			Non Financial

Status Report

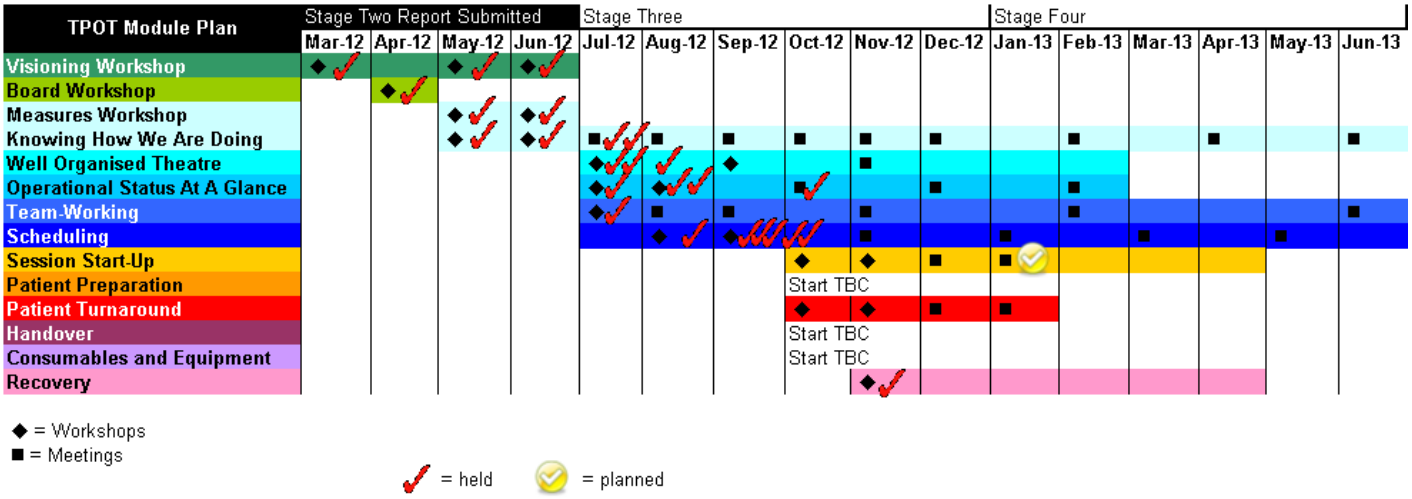
TARANAKI DISTRICT HEALTH BOARD

Project Name	TPOT	**Project Phase**	Implementation
Project Sponsor	Rosemary Clements	**Project Status**	On Plan
Project Manager	Judyth Marsh/Elizabeth Disney	**Period ending**	23 November 2012

Description

Implementation of TPOT to transform operating theatre performance across four main aims:

- Patient's experience and outcomes
- Safety and reliability of care
- Team performance and staff wellbeing
- Value and efficiency



Key Achievements	• Weekly Scheduling Meetings moved to fortnightly – good attendance and continued work on providing timely information to surgeons • WOT Team work on Large Store Room and Linen Room • KHWD Team measures being regularly discussed by Programme Team to inform further work • OSAG Team – new Staff Allocation Board now put up and in use the theatre following a successful trial • Recovery Module started with an initial focus on pre-operative checks (carried out by Recovery staff) • Visit to Tauranga Hospital to share best practice – new ideas for starting process modules
Issues and Risks	Availability of theatre staff – clinical workload impacting at times Ensuring participation and positive engagement of all clinical staff
Critical Delays	None

Status Report

TARANAKI DISTRICT HEALTH BOARD

Next Period Plans	• Launch Session Start-Up Module using data collected by KHWD Team – likely to be in the new year • Continue to hold Scheduling Meetings and discuss outcomes with Surgeons • Support team looking at Recovery
Action Items for Sponsor	Discussion with senior clinical leadership and staff around the intended benefits and their required approach and input – positive engagement and availability of SMOs challenging at times

Status Report

TARANAKI DISTRICT HEALTH BOARD

Benefits Summary

The Productive Operating Theatre					
	Benefit	**Benefit Type**	**Measure**		**Category**
Safe	Revise Surgical technique to reduce the physical stress of Surgery	Reduced exposure to hospital infection	Hospital Acquired Infections		Financial - Non Cash releasing
		Fewer Complications and reduced Re-Admissions	Readmission rate OS8		Financial - Cash releasing
Effective	Improvement in the team working and cohesion of the theatre team with the objective of delivering the "perfect list/session"	Potential to treat more patients with same resource	Surgical throughpu OS5, ALOS OS3		Financial - Non Cash releasing
		Improved Multidisciplinary experience	Staff Satisfaction Survey		Qualitative
		Improved focus on the use of technology identified and implemented			
Timely	Standardise Clinical Processes	National Standards of care and wait times met	o Patient satisfaction o Staff satisfaction. o Incident reporting		
Efficient	Efficient processes in the preparation, booking and scheduling of patients	reduce the Average Length of Stay of patients	ALOS OS3		Financial - Non Cash releasing
		increase Day of Surgery Admissions (DOSA) and Day Surgery interventions	DOSA OS5 and Day Surgery OS6		Financial - Non Cash releasing
		reduce the "waste" of theatre resources through improved list utilisation	o Waiting list cancellations by Hospital before admission o Operating Theatre cancellations by Hospital after admission o Theatre Staff overtime arising from list overruns o Theatre consumable utilisation o Session start and finish times o Theatre turnaround times		Financial - Non Cash releasing
Patient Centred					
Equitable	Standardise Clinical Processes	Standardised care across midlands region			Non Financial

Summary Status Report

Project Name	**Releasing Time to Care Programme**	**Project Phase**	Executing
Project Sponsor	Director of Nursing	**Project Status**	On Plan
Project Manager	Kareen McLeod	**Month**	November 2012

Description

Releasing Time to Care – the productive ward is part of the productive series developed by the English National Health Service (NHS). The aim of the programme is to free up time in our nurses' day so they can increase the amount of time they have for direct patient care and thus improve the safety, reliability and efficiency of the care delivered to the patient.

Key Achievements	***Number of staff involved/trained this month*** **= 36** ***Total number of staff involved/trained to date*** **= 199** ***Total number of wards and beds implementing programme*** **= 5 wards and 129 beds.**
Issues and Risks	• Ward 4 has managed to hold 2 RTC days to look at the meals module and work on this is now going well • ICU – are now completing daily audits as the Nurse Manager is ensuring the morning coordinator is allocating someone to complete the audit. • Ward 3 had their CCDM study day and it was evident that some staff are once again disengaged and lacking ownership of RTC and issues in the ward.
Critical Delays	• Reduced ability to release staff – activity levels plus CCDM impacting this month. • Signs of change fatigue affecting the engagement by ward 3 staff this month
Next Period Plans	• Ward 4 continue the meals module • Team organising a KHWD day to re engage staff back into the programme and create some ownership and responsibility • Ward 2 continue with the WOW module • Ward 5 have had their 2 KHWD days and have WOW days booked in December • ICU work on consolidating work they have already achieved
Action Items for Sponsor	Note pressure on staff and difficulty in recruiting pool staff is impacting on ability to deliver aspects of the programmes and release staff, this still remains an issue

Summary Status Report

Project Name	**Care Capacity Demand Management Programme**	**Project Phase**	Executing
Project Sponsor	General Manager Hospital and Specialist Services	**Project Status**	On Plan
Project Manager	Brenda Hall	**Month**	November 2012

Description

Care Capacity Demand Management is a programme that supports DHB's to achieve their core mandate to safely and consistently match the demand it places on its services (care required by patients) with the resources required to meet this (staff, knowledge, equipment, facility).
That is balancing DEMAND v CAPACITY.

Key Achievements	Mix and Match Phase commenced, ward 3 staff trained for data collection, commenced 20 November for two weeks 24/7 capture of every 15 minutes of work activity.
Issues and Risks	Nil
Critical Delays	Nil
Next Period Plans	▪ CCDM Governance Council Meeting scheduled for 22 November ▪ Planning for Churchill Exercise for Variance Response Management ▪ Confirm Programme Plan for 2013, mindful of move to new building.
Action Items for Sponsor	Nil

Outline of Hospital Services Projects (updated 26 Nov 2012)

Project	Objective	Actions	Measure	Key Achievements	Benefits
Acute Pathway	Improved access to the most appropriate urgent care and meeting the Health Target.	Analyse and monitor the types of ED presentations and the likely impact on LOS, based on this analysis remedial actions in terms of the way we manage these going foward will be actioned. We will align resource levels with patterns of demand by forecasting staffing levels, managing sick and annual leave through the HWS tools. Resource allocation will be reviewed across the ED disclipines to maximise utlisation and improve the process of streaming in the ED. Restructure of ward rounds, early completion of discharge paper work, clear identification of expected discharge date on post acute ward rounds, nurse facilitated discharge and introduction of rapid rounds will all support this KPI.	95% of patients presenting to the ED will be admitted, discharged or transfered from an ED within six hours. Achieve a set KPI of 50% disharges by 1100hours in Medical Wards by June 2013.	24% patients discharged by 11am Early completion of discharge documentation to meet discharge time of 11am has improved. Rapid Rounding is continuing to be very successful.	
Cancer FCT	Improved access to cancer services and meeting the Health Target	Impoved access to colonoscopies, as part of the detection and management of bowel cancer. More services will be delivered closer to home (as evidenced by local radiotherapy option) Full Oncology and Haematology FTE staffing will be maintained. Achieve faster cancer treatments, noting that Tumour Work Streams will be managed through the Central Cancer Network. Continue improving the functionality and coverage of regional cancer treatment multidisciplinary meetings (MDMs) within available resources. Working with CCN to implement a Multi-Disclipinary Meeting (MDM) conferencing solution. Undertake baseline stock take of systems capability to capture regional data for national minimum cancer data and business processes and FCT indicators. Working with CCN to support the development of the Nursing in Cancer Strategy. MDM Project	100% of people ready for radiotherapy	Endoscopy review complete. Implementation plan in progress.	
Elective Services	Improved access to Elective Services and meeting the Health Target.	Elective funding has been allocated to support appriopriate levels of elective surgey, specialist assessment, diagnostics and alternative models of care. Services will be delivered locally where appriopriate and no patient will wait longer than five months. Equity of access to regional services will be agreed within the Midland region. Patients will be prioritised for treatment using national tools and treatment will be in accordance with assigned priority. Levels of elective access will match the funding allocated to ensure finanical compliance.	4,156 elective surgical discharges will be delivered for Taranaki domicile patients ESPIs will be met, no patient will wait more than five months for FSA / treatment More CPAC tools will be used this year to improve consistency in prioritisations Reduce cancellations due to no bed available - from July 2012 Reduce overall day of surgery cancellations Reduction in average LOS for specialties involved in ERAS Reduced hospital cancellation Improve patient satisfaction	ESPI compliance maintained for first quarter of financial year.	
MOU for Laboratory Services	To ensure the population of Taranaki receive efficient and effective service delivery from their Pathology Service providers.	LabCare and Taranaki Medlab to identify areas where they can work together to gain efficiencies, work collaboratively to ensure they maintain the high level of service they currently provide while working to address any funding constraints.	Stronger inter-laboratory collaboration with increased efficiency and the current high quality service maintained.	Exploration of some shared equipment / space underway.	
Long Term Chronic Conditions					
➢Enhanced Intermediate Care	Establishment of an Enhanced Intermediate Care Service at a residential care facility that enables ongoing community rehabilitation where patients would otherwise have had to stay in hospital.	Enhanced Intermediate Care Service implemented July 2012	A reduction in the admission rate to long term residential care, sustaining people on support packages at the same needs level for longer at home, Improving functioning and independence.	To date 3 people supported to remain in home who would otheriwse have entered a residential care facility permanently.	Cost per bed day- Intermediate care $268.32 versus hospital inpatient $461.56.
➢Stroke	Administration of thrombyltic therapy for ischaemic stroke patients	Implementation of thrombylysis service that is supported by evidence based guidelines/best practice by July 2013	Thrombylotic therapy administered within 3 hours of entry to hospital service	Reduction in patient dependency following therapy administration	
Radiology Services Waitlist times	That information for CT, MRI and Ultrasound waittimes is provided to the Ministry and the Midlands Regional Radiology Network	To work with Fulford Radology to ensure this data is provided to relevant parties.	The provision of this data will allow us to measure local performance against other Midland DHBs and also nationally.		
Whakapai	To monitor and plan appropriate staffing levels for the organisation To ensure skill mix of staffing appropriate to each area	Undertake project to ensure appropriate staffing over Christmas/New Year period	A reduction in financial costs previously budgeted A reduction in leave liability for the organisation	TPW within budget this month. Budgeted skillmix achieved in Mental Health.	$750K projected over financial year
CCDM	Decreasing the number of resourced beds by using forecasting to define bed requirements to meet variable acute demand.			See status report	

	Matching staffing levels/mix to demand though higher staffing flexibility and leveraging potential of all providers of care.				
ERAS	To revise methods and procedures to align with evidence-based practice in the pre-, intra- and post-operative patient pathways/workflows. Production of procedural documentation, and production of revised patient information.	See status report key milestones	a) Reducing Average Length of Stay (Ownership Dimension Three as defined in the National Collections) consistent with patient safety across all surgical specialties to which ERAS is applied b) Increasing rates of relevant elective patient satisfaction c) Increasing percentage of patients within relevant elective surgical d) Decreasing rates of post-operative clinical complications prior to e) Increasing rates of day of surgery admissions DOSA (Ownership f) Compliance with ERAS principles as per Audit Checklist	See status report	See status report
PreAdmission Project	To redevelop the current pre-admission process to reduce re-work and increase patient readiness for surgery		Elective and arranged day surgery Elective and arranged day of surgery admissions (DOSA rate) Elective and arranged inpatient length of stay (days) Waiting list cancellations by Hospital before admission Operating Theatre cancellations by Hospital after admission Pre-admission and Anaesthetic clinic DNA rates Patient satisfaction Staff satisfaction	See status report	See status report
RTTC	Releasing time to care (Productive ward)	Currently being undertaken in Wards 2,3, 4, 5 and ICU	Patient satisfaction surveys, Staff satisfaction surveys, Direct Care Time monthly results, daily pt safety audits	See status report	
TPOT	Implementation of TPOT to transform operating theatre performance across four main aims: 1) Patient's experience and outcomes 2) Safety and reliability of care 3) Team performance and staff wellbeing 4) Value and efficiency	Implement TPOT Modules - see Status Report for update on progress	Percentage of on-time surgical operation starts Operating Theatre Utilisation Patient turn-around times Elective and arranged day surgery Elective and arranged day of surgery admissions (DOSA rate) Elective and arranged inpatient length of stay (days) Waiting list cancellations by Hospital before admission Operating Theatre cancellations by Hospital after admission Staff satisfaction	See status report	See status report

Appendix 3

TARANAKI DISTRICT HEALTH BOARD

TO: Rosemary Clements
General Manager Hospital and Specialist Services

MEMORANDUM

FROM: Katherine Fraser-Chapple
Management Accountant

DATE: 30 November 2012

SUBJECT: Outsourced Services Expenditure

1. INTRODUCTION

Over recent months there has been a number of enquiries from board members around the costs of services outsourced by the Provider Arm. This memo is intended to give an understanding of the process and associated costs.

2. OUTSOURCED SERVICES

While often discussed as a group, services outsourced by the DHB encompass a number of different areas and services:

a. Outsourced Personnel
This includes locum medical staff, as discussed in a previous paper to the Hospital Advisory Committee, and other short term staff who are usually engaged on a short term basis to fill essential vacant positions. Staff who are currently engaged by the DHB include: a wheelchair technician, Home Help staff, Pathology management services, medical typists and the joint manager of the Stratford Health Centre.

b. Referred Services
Referred services are those that are referred to by medical staff, such as Pharmacy, Laboratory and Radiology. The Provider Arm outsources radiology to our joint venture partner Fulford Radiology for the majority of work, and some other smaller providers for high tech imaging, such as PET scans, that cannot be done locally.

Laboratory tests are outsourced when they are “send away tests”, meaning they are done at a larger laboratory either in New Zealand or internationally where additional testing technologies are needed.

c. Outsourced Clinical Services

This encompasses the largest range of the outsourced services. These are services that are not performed by the Provider Arm for a number of reasons:

Description	
Facilities	Used where we do not have the capacity available in our own facilities, for example use of theatre and inpatient stay at Southern Cross Hospital for the majority of ENT and ACC surgery.
Medical Services	We have a number of medical specialties where we contract volumes from private practice medical specialists on an annual fixed contract basis, for example ENT, Ophthalmology and Urology services. In the case of Anaesthetists, we are using a mixed model where some staff are employed and others contracted privately. There are also a number of smaller specialties where volumes are small and therefore it makes sense to engage specialists for only the volumes required such as Plastic Surgery, Haematology, etc. A significant proportion of this is contracted through other DHB's.
ACC	Medical staff for ACC Elective Surgery is outsourced to private practice, and facilities are contracted from Southern Cross Hospital for the majority of cases. This is at an agreed price for the procedure performed.
Respite Care	Rest Homes and individuals provide respite care for a number of mental health and personal health patients.
Other Clinical Services	Both Audiology and Podiatry services are outsourced to local providers, performing contracted volumes on a fee for service basis. A large number of other medical providers that deliver services for the DHB, such as General Practitioners, dentists, etc, either on a one off or fee for service basis.

3. FINANCIAL IMPACTS AND BUDGETS

Current Costs

The overall outsourced services budget is approximately 11.5% of the total DHB budgeted annual expenditure. For 2012-2013 the Provider Arm budget for Outsourced Services is $18.9M. The year to date position is $864K (13.7%) above the budget of $6.30M. When looking at the individual lines that make up the overall budget we can see that the majority of expense relates to referred services and MOSS locum staff.

Outsourced referred services are demand driven, based on the need for consultation/examinations and testing. Radiology and Laboratory expenses include the cost of examinations referred by community providers such as GP's and private specialists.

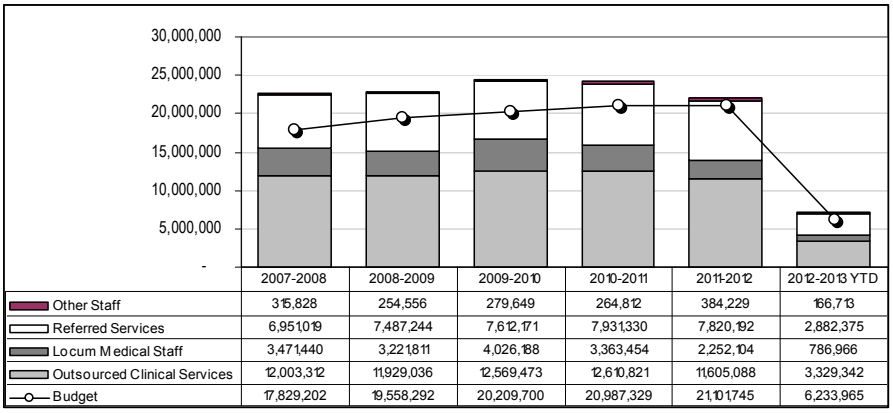
Locum costs are higher than budget, and this relates to locum medical staff engaged at Hawera Hospital to fill vacancies and gaps in the roster. This high cost is partially offset by savings in FTE .

Group	YTD Actual	YTD Budget	Var.	% Var	Annual Budget	Comment
Outsourced Medical Staff	786,966	351,074	435,892	124%	1,053,225	High costs in Hawera Hospital off set by staff vacancies
Other Outsourced Staff	166,713	130,777	35,935	27%	392,332	High costs for home aids, temporary wheelchair technician
Referred Services	2,882,375	2,443,442	438,934	18%	7,330,326	Demand Driven
Outsourced Clinical Services	3,329,342	3,308,672	20,669	1%	9,926,016	Lower than expected ACC work
Outsourced Funder Services	0	66,667	(66,667)	-100%	200,000	Services from HealthShare, midland shared services agency
	$7,165,396	**$6,300,632**	**$864,763**	**14%**	**$18,901,899**	

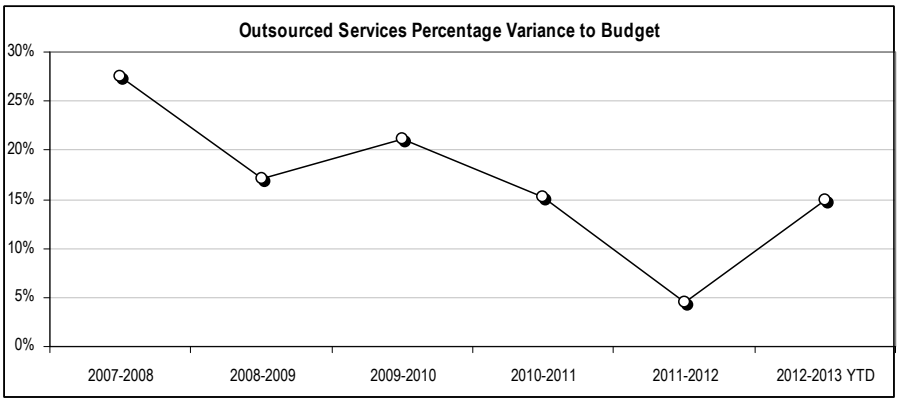
Historical Costs

Costs for Outsourced services have historically been higher than budget, however relative variance to budget has been reducing year on year. This relates to a number of issues around usage:

1. Locum costs are balanced with employed medical staff, so when there are vacancies in employed positions these are filled by locums and the cost is offset by savings in personnel costs. Unfortunately where positions are filled by locum staff long term, the cost differential means that there is an overspend against budget. As reported to HAC in November considerable work over a number of years has been done to reduce this expenditure, including national agreement on locum fees for junior medical staff.
2. Other outsourced staff are also used to fill vacancies, with the exception of home help staff where this service is outsourced to a number of community providers.
3. Referred Services are demand driven and relate entirely to patient need for examinations. Historically we have increasing demand in these areas.
4. Outsourced clinical services is also demand driven based on patient need. There have been a number of years where ACC has been significantly over budget, however there is direct revenue for these services.



	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013 YTD
Other Staff	315,828	254,556	279,649	264,812	384,229	166,713
Referred Services	6,951,019	7,487,244	7,612,171	7,931,330	7,820,192	2,882,375
Locum Medical Staff	3,471,440	3,221,811	4,026,188	3,363,454	2,252,104	786,966
Outsourced Clinical Services	12,003,312	11,929,036	12,569,473	12,610,821	11,605,088	3,329,342
Budget	17,829,202	19,558,292	20,209,700	20,987,329	21,101,745	6,233,965



Budgeting

Budgets for services are based on historical trends and known service changes. For services such as radiology, projections are made on current service delivery and allow for increasing complexity and price.

Where we are contracting for fixed volumes services, such as ENT and Urology, the budget is set at the contracted rate for service.

Potential Risks

Current emerging financial risks around outsourced services include:

1. **Locum costs:** As discussed earlier, and in previous papers to the Hospital Advisory Committee, locum medical staff budgets are balanced with employed staff positions and an allowance made for price differential and possible vacancies. Where vacancies are not filled long term, the budget for the difference in cost between employed and locum staff may not be enough. There is a significant risk that this will happen with Hawera medical staff in this financial year, where a number of longer term vacancies exist.
2. **Radiology costs:** The volume of radiology exams increases annually, and best efforts are made for budgets and projections to keep pace with this. Unfortunately increased patient demand, for example in early 2012 where elective surgery volumes were increased short term, can quickly erode our planning.

   As an outsourced service there can be issues with provision of service outside the control of TDHB which impact on costs. In the last twelve months Interventional Radiology has not been able to be provided by FRSL and TDHB has had to source an alternate provider for this service outside Taranaki. The cost of this has been significantly higher than if the service had continued to be provided locally. There does not seem to be any immediate solution to this problem, however we continue to work with FRSL to progress this.

4. SUMMARY

Outsourced services covers a diverse group of costs and contracts for the District Health Board, covering delivery of services on both a short term and long term basis. Historically costs have been high in this area for a number of reasons, including increased patient demand and staff vacancies. Significant efforts have been made in recent years to slow cost growth in this area and reduce budget variance. There are a number of ongoing risks to budget in these areas - these are being monitored and managed.

Katherine Fraser-Chapple
Management Accountant

Overall performance (dashboard)

Appendix 4

Table Performance results for 01/10/2012 to 28/10/2012

Type	Key Performance Indicator	Unit Measure	Target	41 01/10/2012	42 08/10/2012	43 15/10/2012	44 22/10/2012
Process	Advance fill rate	Percentage	>30%	27.7%	27.7%	32.1%	25.6%
	Compliance	Percentage	>70%	64.4%	74.1%	75.5%	71.7%
	Double bookings and error rate	Shift	0	(0.0)	(0.0)	(0.0)	(0.0)
Budget Dollar	Salary & wage budget variance	Percentage	<0%	-0.7%	-1.5%	-0.1%	-8.6%
	Increased patient acuity variance	Percentage	<0%	47.3%	124.0%	32.0%	136.1%
	Additional beds open variance	Percentage	<0%	-10.6%	-11.1%	-38.8%	-18.0%
	Special budget variance	Percentage	<0%	-23.9%	38.4%	61.6%	97.1%
Staff type	Budget EFT variance	EFT	<9	(10.4)	(7.5)	(13.7)	(21.5)
	Bank (casual) use	EFT	<50	(57.4)	(58.7)	(55.8)	(54.8)
	Part-time extra	EFT	<50	(51.4)	(49.1)	(49.9)	(51.7)
	Overtime use	EFT	<10	(8.7)	(7.6)	(7.3)	(8.4)
	Pool use	EFT	<12	(9.0)	(9.0)	(9.7)	(9.7)
	Agency use	EFT	<1	(0.2)	(0.4)	(0.1)	(0.5)
Shortfall	True shortfall	EFT	<50	(80.1)	(81.0)	(72.7)	(67.3)
	Overall staff vacancy	Percentage	<5%	6.7%	6.8%	6.1%	5.7%
	Allied Health vacancy	Percentage	<5%	4.6%	5.4%	5.5%	4.7%
	Medical vacancy	Percentage	<5%	8.9%	8.5%	8.8%	7.1%
	Nursing vacancy	Percentage	<5%	5.9%	6.0%	5.3%	4.9%
	Support vacancy	Percentage	<5%	8.5%	8.5%	7.0%	7.0%

Analysis

- Patient acuity reasonably high with corresponding budget variance in specialling and FTE in last week.
- Some increased vacancy for support and medical staff.
- Pleasing to note personnel and overtime use improvement.

Actions

- Ongoing approach to specialling (CNS review).
- Ongoing monitoring of bed management.
- See body of HAC report for project updates.