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
Advisors:
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Media – Daily News, Newstalk ZB, Hawera Star, Midweek, Opunake & Coastal News, Stratford Press,
Health Centres – Stratford, Patea, Opunake, Mokau
Base Hospital Library
Hawera Hospital Library
Tui Ora Limited
Corporate Reception

TARANAKI DISTRICT HEALTH BOARD

AGENDA

HOSPITAL ADVISORY COMMITTEE

ORDINARY MEETING

OPEN

Thursday 7 February 2013
10am am

Corporate Meeting Room 1
Taranaki Base Hospital
David Street
New Plymouth

HOSPITAL ADVISORY COMMITTEE

MEETING AGENDA

Thursday 7 February 2013
10 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. Minutes

5.1 Minutes of meeting held 6 December 2012

Pages 1 - 6

Resolution
That the Hospital Advisory Committee resolve to 6 December 2012.

6. Arising From Minutes

7. Management Reports

7.1 General Manager Hospital Services and attachments,

Pages 7 - 52

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

8. Other Business

9. Next Meeting

7 March 2013 in New Plymouth

TARANAKI DISTRICT HEALTH BOARD

M I N U T E S Open (unconfirmed)

HOSPITAL ADVISORY COMMITTEE

6 December 2012
9.30am
Corporate Meeting Room 1
Base Hospital David Street
New Plymouth

Present:
Ella Borrows (Chair), Mary Bourke, Peter Catt, Kura Denness, Karen Eagles Flora Gilkison, Brian Jeffares, Pauline Lockett

In Attendance:
Tony Foulkes (Chief Executive), George Thomas (General Manager Finance & Corporate Services), Rosemary Clements (General Manager Hospital & Specialist Services), Greg Simmons (Chief Medical Advisor), Sandra Boardman (General Manager Planning & Funding), Katherine Fraser-Chapple (Management Accountant), Ramon Tito (Kaumatua), Sue Carrington (Communications Advisor), Jenny McLennan (PA to Chief Executive)

Greg Stevens – HOD Emergency Department

761.0 Apologies
The Chair noted the apologies received from Alex Ballantyne, Alison Rumball and Colleen Tuuta for non-attendance and from Kura Denness and Flora Gilkison for lateness.

762.0 Conflict of Interest Minutes of Previous Meeting
The Conflict of Interest Register was circulated with no new conflicts declared.

763.0 Presentation – Triage – Emergency Department
The Chair welcomed Dr Greg Stevens, HOD Emergency Department to the meeting.

Dr Stevens gave a presentation on ED Triage with details and points of discussion noted as follows:

<u>Presentation</u>
- French verb *trier*, meaning to separate, sift or select
- Initial military use – Napoleonic war, WWI
- Developed for use as a prioritisation tool in Emergency Departments
    - Australasia
    - UK
    - Canada
    - US
    - Australasian Triage Scale

- *"This patient should wait for medical assessment and treatment no longer than…."*
- Scale from 1-5
- Parameters set for each triage score
- Moderately subjective
- "Triage first" is standard of care
- ATS Category
    - 1 – maximum wait - Immediate (Performance 100%)
    - 2 – maximum wait – 10 minutes (Performance 80%)
    - 3 – maximum wait – 30 minutes (Performance 75%)
    - 4 – maximum wait – 60 minutes (Performance 70%)
    - 5 – maximum wait - 120 minutes – (Performance 120%)
    -

Ms Denness joined the meeting.

Discussion

- Mr Foulkes advised that advertising did occur regarding ED presentation appropriateness over the Christmas period, with the advertisement including reference to patients going to General Practitioners.
- Dr Stevens advised the average waiting time was 68 minutes and that data errors regarding the patient throughput had been resolved. A measure of the time taken to be seen by a health professional may provide more meaningful data, rather than only by a doctor.
- Mrs Eagles advised that there was a misconception that nothing happened until you were seen by a doctor.
- Dr Stevens confirmed that a number of tests including ECGs were undertaken by nursing staff.
- Noted that there were incidences where a triage 1 person may be discharged – eg. seizure cases.

Mr Thomas joined the meeting followed by Dr Gilkison.

- Dr Stevens advised that some patients would be better presenting to a GP, but that the reasons for attending ED included:
    - Cannot afford to see GP
    - Capacity issues
    - Can't or won't see a GP
- Ms Denness sought feedback on the focus of having tools on the floor and the impact of this.
  Dr Stevens advised:
    - X-ray services available in ED for last three years meant no longer need to escort patients to radiology.
    - Laboratory tests go straight to hub.
    - Senior staff specialist trained
    - 24 hour Senior Doctor coverage
- Dr Stevens advised the six hour wait time measure was a defacto measure of quality and that internal measures were in place to ensure no adverse events occurred eg. patients thrombolysed in ED rather than ICU.
  Easy to measure time, hard to measure quality. While the six hour measure was a blunt tool it had highlighted other organisational issues

such as the impact on waiting for beds. Corrective responses to these issues have since been developed.

- Ms Denness also asked for feedback on how the decision to 'embrace' patients presenting to ED rather than to their GP.
  Dr Stevens advised the impact has not been huge, noting the provision of a family room where patients can quickly be seen had assisted, along with the establishment of a Nurse Specialist role for afternoon and early evening shifts.
- The advanced nursing roles were discussed with Dr Gilkison noting the Des Gorman model and the training underway in Waitemata DHB.
- Mr Foulkes advised that the message to the community was that patients should still present to their GP when appropriate, however from a capacity point of view ED was able to accommodate these patients although they may need to wait.
- Dr Stevens advocated that patients with chronic conditions should see their own GP.
- It was noted that there are no GP services available after 8pm.

The Chair thanked Dr Stevens for the presentation. Dr Stevens then left the meeting.

764.0 Minutes of Previous Meeting

Resolution

That the Hospital Advisory Committee resolve to accept the minutes of the meeting held 8 November 2012 as a true and correct record.

Eagles/Lockett
Carried

764.1 Matters Arising

764.2 HDC Report

While the HDC Report and Analysis for the period 1 January – 30 June 2012 reflected an increase in the number of reporting incidents there had also been a revision of reporting requirements associated with falls.

765.0 General Manager Hospital & Specialist Services Report

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

- Overall casemix for the month was 3% ahead year to date.
- Provider financial results for the year, to 30 October was $1.90M worse than the budgeted deficit of $1.76M.
- Total discharges reflected a reasonably busy month.
- ED presentations remain above contract for October, maintaining a 12% over delivery year to date.
- TDHB remains compliant with zero patients waiting over 6 months.

Discussion

- Dr Catt questioned the plan of action regarding the waiting times for radiology services. Mrs Clements confirmed that the number of accepted referrals waiting up to 21 weeks for CT or MRI services was high.
  Dr Gilkison confirmed that in comparison with other DHB's, Fulford were not performing well and tabled the October Diagnostic report.

- It was noted that in general services provided in excess of contracted volumes did not receive associated revenue.
  Mrs Clements advised monitoring of throughput and volumes against contractual requirements occurred on a weekly basis.
- Mrs Fraser-Chapple advised that due to an error the infrastructure results presented were over stated,
- The anticipated reduction in inpatient services over the Christmas / New Year period was noted.
- It was advised that a Community Registrar was to commence in the New Year and that interviews had also recently occurred for a Rural Specialist role.
- Dr Gilkison referred to her ratio results which could provide trend data over a period of time.
- Ms Lockett noted that outsourced clinical services were demand driven and questioned whether a review of clinical testing management would be appropriate.
  Mrs Clements advised that reviewing clinical testing management was routine and that consideration of available tests occurred constantly. New technology was under continual consideration, especially as new testing regimes become available outside of the region.
  Dr Catt referred to consideration by the NHC on new technology and its introduction to the sector.
  Mrs Clements confirmed that clinical judgement was applied to the vigorous management of referrals through the various clinical pathways.
  Mrs Boardman also noted the access of primary cares providers to secondary services and sometimes the long wait times for diagnostic tests.
  Mrs Lockett questioned the availability of an alternative provider for Interventional Radiology, noting the gaps in associated positions.
  Mr Foulkes highlighted that the service was one previously provided by a part-time clinician of the provider and that as this service was not longer provided by Fulford, Taranaki DHB ended up accessing this service directly from outside the region. In recognising the gap Mr Foulkes advised that the question of continued funding was under consideration in conjunction with discussions with Fulford. Ms Lockett noted that there was no action identified to address the issue moving forward and noted that as there were significant associated costs there was a need for strategic considerations by the Board on the receipt of on going feedback.
  Mrs Clements advised an explanation on Outsourcing management was provided as an appendix to the report.
  Miss Bourke noted that the Radiology position was one of a number of positions that had been vacant for over 12 months and that it would be appropriate for information on all long term clinical vacancies to be provided.
  Ms Lockett added that costs incurred whilst roles remained vacant would be of interest. Mr Foulkes advised discussion regarding long-term succession planning was common place within services, at hospital level and with HR.
  Ms Denness questioned the contract management of the radiology provider for it's under performance and whether contract costs had reduced as a result of the DHB sourcing the services elsewhere.

Dr Gilkison referred to the complexity of the situation and questioned whether this should in fact be managed through IDFs.
Mr Foulkes noted the expectation of contract delivery.

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

Catt/Denness
Carried

766.0 Next Meeting
It was noted that the next meeting was scheduled to be held Thursday, 7 February 2013 in New Plymouth

Meeting closed at 10.45am

…… ……
Chairman Date

TO	CEO and Hospital Advisory Committee
FROM	General Manager Hospital & Specialist Services
DATE	28 January 2013
SUBJECT	Exception Report for December 2012 and Quarter Two 2012 /13

TARANAKI DISTRICT HEALTH BOARD

MEMORANDUM

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1 OVERVIEW

This report for December 2012 provides the Hospital Advisory Committee (HAC) with an overview of hospital activity focused predominantly on the year to date.

The overall casemix delivery for the first 6 months of the financial year was 2% ahead of contract. This figure is made up of medical case mix delivery 4% ahead of plan and overall surgical delivery 2% behind (electives 3% ahead and acute delivery -6% year to date).

With December encompassing the Christmas period, the average occupancy in the adult inpatient wards (including Mental Health) decreased significantly to 79%. This was a pleasing result compared to last Christmas when the occupancy, while dropping from the rest of the year, remained high for a holiday period.

The Provider financial result for the year to 31 December is $3.30M worse than the budgeted deficit of $3.27M. Revenue was $66K below budget and expenditure $3.2M higher than budget. Total expenses are 4% above budget to date. Expenditure is being monitored closely in light of the emerging situation and the need to set appropriate budgets for the 2013-2014 financial year.

2 ACTIVITY

DHB Funded Activity

Patient Activity Summary

Metric	Month				YTD		
	Actual	Budget	Var	Var%	Actual	Budget	Var%
Total Patient Discharge Base	1,730	1,618	112	7%	10,354	9,900	5%
Total Patient Discharge Hawera	158	177	-19	-11%	1,155	1,049	10%
Elective Surgical Discharge	319	334	-15	-5%	2,270	2,318	-2%
ED Attendance Base	1,676	1,466	210	14%	9,860	8,799	12%
ED Attendance Hawera	1,354	1,050	304	29%	7,185	6,299	14%
Outpatient Attendances	2,505	2,787	-282	-10%	19,086	16,722	14%
Theatre Visits	482	521	-39	-7%	3,771	3,330	13%
Deliveries Base	107	108	-1	-1%	658	652	1%
Deliveries Hawera	8	10	-2	-20%	42	55	-24%

The total discharges through both Base and Hawera hospitals year to date reflect a reasonably busy first half of the financial year with ED presentations above contract year to date of 12% and 14% respectively.

Electively, OPD delivery year to date was 14% above contract. A portion of this delivery reflects volumes 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

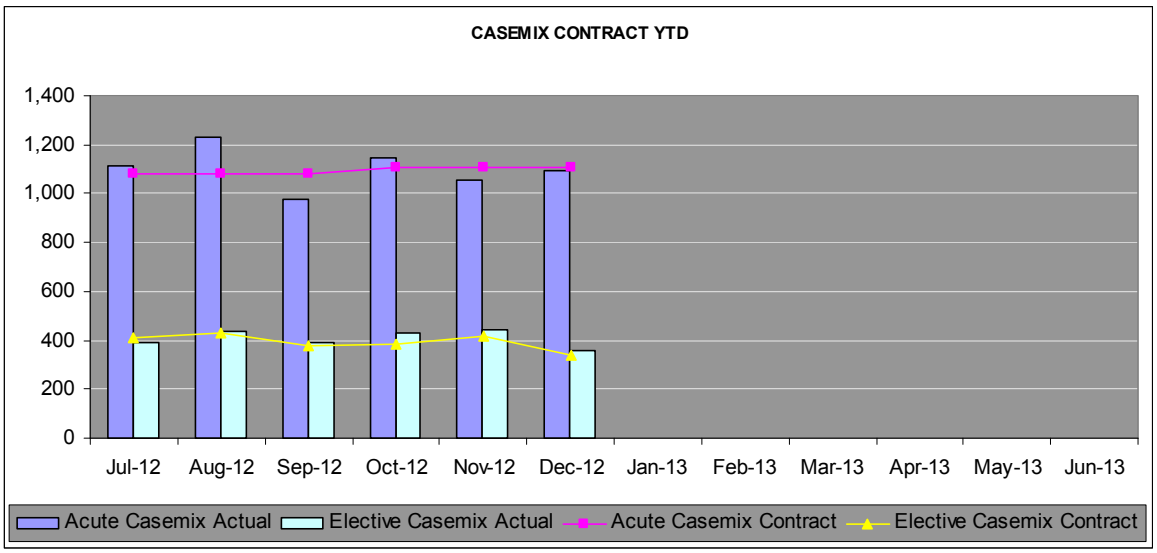
2.1.1 Casemix Delivery for 2011/12

Casemix delivery for December was at plan (1.35 cwd). Year to date casemix is at 2% ahead of plan, down 1% from November.

December 2012 YEAR TO DATE result Case Mix delivery						
	Dschg	Total Cwd's	Contract	Cwd var	Avg Cwd.	% Variance
Medical	5993	3561	3432	129.20	0.59	4%
Surgical Acute	1939	2212	2362	-150.51	1.14	-6%
Surgical Elective	2067	2338	2273	65.03	1.13	3%
Total Surgical	4006	4550	4635	-85.48	1.14	-2%
Maternity	1510	957	857	100.11	0.63	12%

December medical casemix was 5% 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 (3% = 11 cwd) offset by acute surgical delivery (-5% = -21.29 cwd) for December. Year to date total surgical delivery stands at 2% behind contract.



2.1.2 Specialty breakdown

Acute delivery

- Cardiology volumes have slowed again and are now 28% ahead for December and 26% ahead year to date.
- Urology is 39% ahead and all other specialties are behind contract.
- Orthopaedics is at contract for the month which is a good result for this period and an improvement on previous months.

Elective delivery

- Cardiology is 66% ahead of plan for the month and 27% year to date. This is a result of the additional lists we are providing to ensure patients receive their diagnostics in a timely manner.
- General Surgery and Urology are also ahead of plan at months end, which has smoothed the year to date delivery to within the +/- 5%.

Dec-12	YTD Volumes - Actual v Contract				
	Actual	Contract	Var	% Var	Comment
Casemix	**cwd**	**cwd**	**cwd**		
ENT	185.44	206.72	-(21.28)	-10%	
Acute	16.63	26.39	-(9.76)	-37%	Demand driven
Elective	168.81	180.33	-(11.52)	-6%	Small service affected by leave of clinicians
Cardiology	349.41	275.99	73.42	27%	
Acute	239.93	189.75	50.18	26%	Offset by over delivery in elective
Elective	109.48	86.24	23.24	27%	
Emer Med	667.26	724.53	-(57.27)	-8%	
Base	446.81	531.74	-(84.93)	-16%	CWD under contract however presentations are above contract as per previous comment
Hawera	220.45	192.79	27.67	14%	
Paed Med	330.89	272.27	58.63	22%	Reflective of busy month
Base	330.89	272.27	58.63	22%	
Hawera	0.00	0.00	0.00	-	
Urology	188.38	205.12	-(16.74)	-8%	
Acute	63.39	73.87	-(10.48)	-14%	Demand driven
Elective	124.99	131.25	-(6.26)	-5%	Contracted service affected by availability of clinicians
Maternity	584.82	616.93	-(32.11)	-5%	Demand driven
Neonatal	372.12	239.90	132.22	55%	A busy month

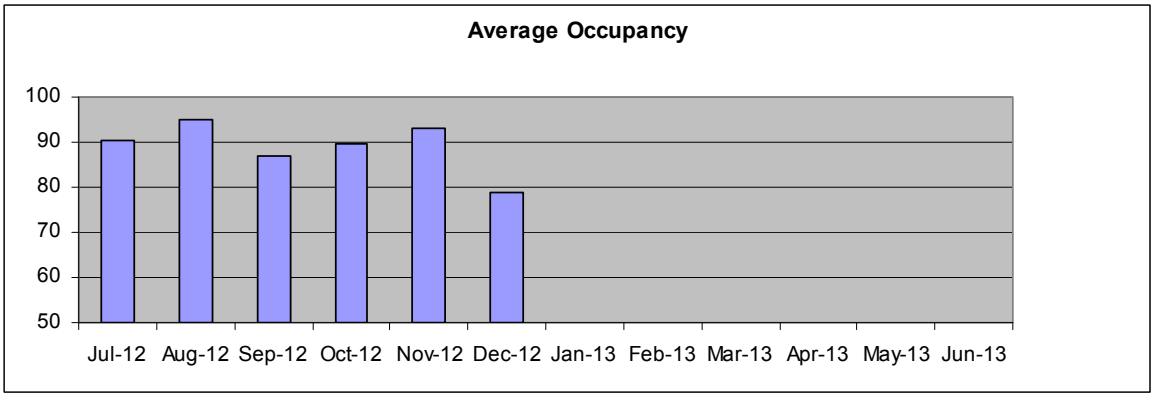
Procedure targets

Joints: Year to date 116 joints have been completed, which is slightly behind our plan (24 joints). Unfortunately, there has again been a number of electives cancelled for acute cases.

Cataracts: 207 cataracts have been completed year to date (25 ahead of plan).

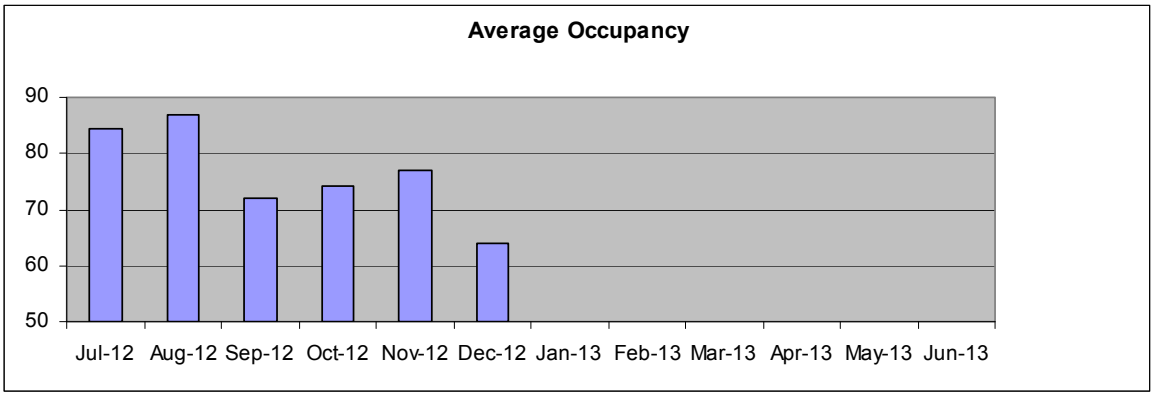
2.2 Inpatient Delivery

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



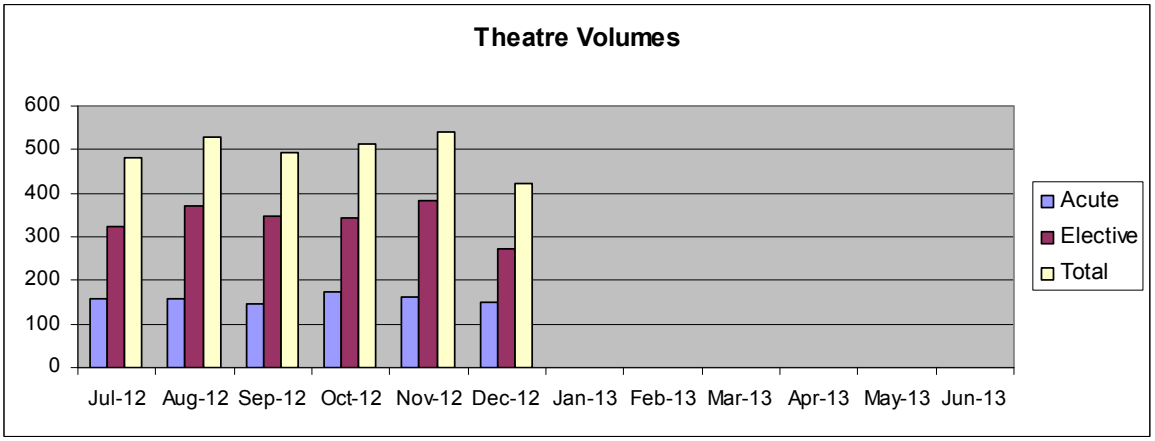
(This table reflects how many patient beds are occupied each day on average. It therefore provides an indicator of the busyness of the 4 main inpatient wards and because they make up the greater number of total hospital beds, usually the general busyness of the whole hospital. It includes a mix of acute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



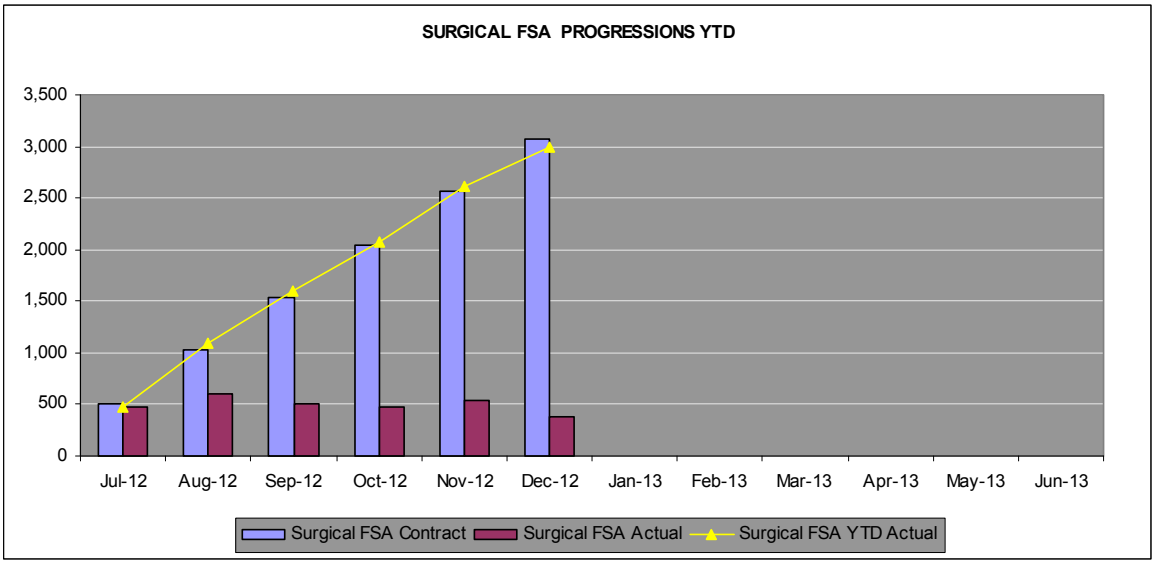
Comment: Of note, the average occupancy in the adult inpatient wards decreased significantly this month reflecting the theatre closure.

2.2.1 Hawera Inpatient Ward

December occupancy for Hawera inpatients was 50%, a decrease from 58% in November. HMU occupancy is at 32%, a decrease from 34% in November.

2.3 Outpatient FSA Delivery for 2012/13

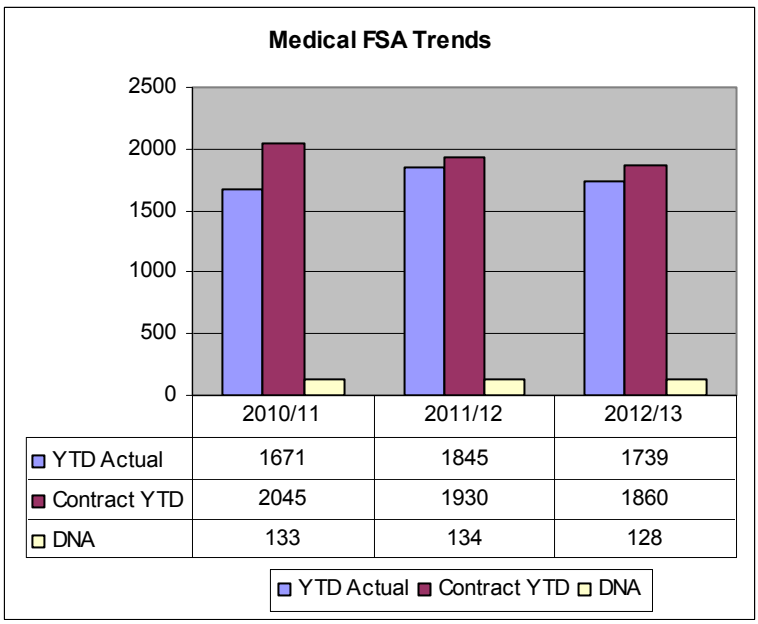
Surgical First Specialist Assessments (FSA)



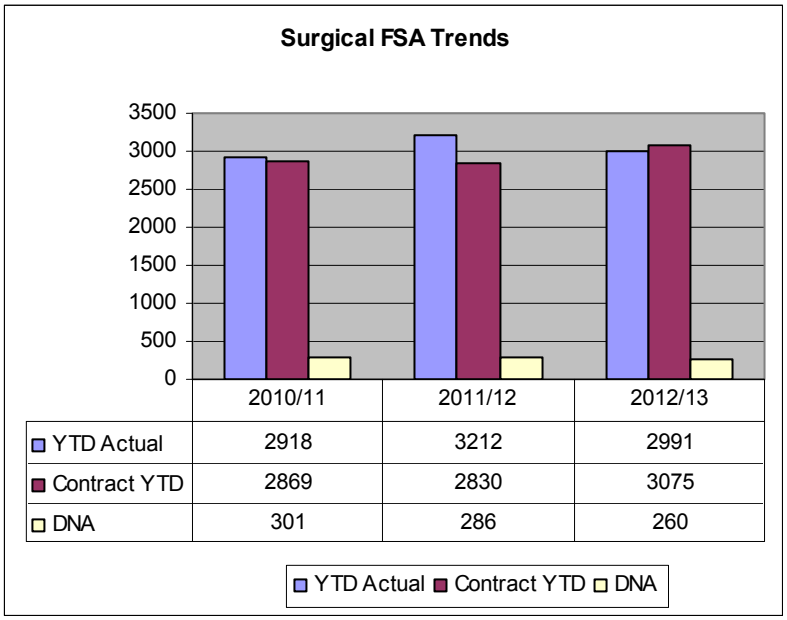
	Act Vols	Ctrct Vols	Var	% Var
Ear Nose and Throat - FSA	312	360	-48	-13%
Gynaecology - FSA	376	425	-49	-12%
Ophthalmology - FSA	649	508	142	28%
Orthopaedics - FSA	488	550	-62	-11%
Urology - FSA	208	250	-42	-17%

- Ophthalmology delivery remains above plan and is being closely monitored.
- Most specialties are slightly behind contract and plans will be put in place to improve in these areas.

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 moving into the second quarter, with the results for November also green.

Some specialties are now able to book patients within a 5 month wait time, however the Christmas break has put significant pressure on other specialties.

In ESPI2, there have been some low numbers of patients waiting over 6 months resulting in TDHB being in the Yellow zone for compliance. Most of these cases have been due to visiting consultant clinics being cancelled, however there are plans in place and clinics in January and February should reduce pressure in these.

2.5 ACC

- **Non Acute Rehabilitation Contract**: This contract continues behind budget and an internal audit has taken place to determine the cause. ACC has been requested to include Enhanced Intermediate Care patients under this contract and we are awaiting a decision.

- **Clinical Services Contract**: This contract continues to be monitored closely with the patients primarily being seen in the consultants private rooms.

- **Elective Surgery**: We continue to be under budget at -$400k (19%) – however this is an improvement on previous months. The redesigned theatre schedule ensures capacity for ACC lists at Base and we are working with consultants to ensure these will be well utilised.

- **Nursing Services**: The new contract is in place, the additional complexity and administration of this contract 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 HED for December 2012 was 49.4 compared to 43.2 for November.

Hawera ED

	December 2012	% Admitted	Average 2012/13 YTD	Average 2011/12
Triage 1	3	0%	2.5	2
Triage 2	65	45%	87	87
Triage 3	376	23%	394	345
Triage 4	801	4%	689	630
Triage 5	286	1%	229	219
Total Visits	**1531**	10%	1402	1283

Base ED

	December 2012	% Admitted	Average 2012/13 YTD	Average 2011/12
Triage 1	12	100%	11	7
Triage 2	186	61%	197	186
Triage 3	951	43%	997	981
Triage 4	1387	15%	1237	1138
Triage 5	223	3%	206	176
Total Visits	**2759**	27.08%	2648	2488

Above average numbers across both low and high acuity triages and overall when compared to 2011/12 levels. 3.5% increase in visits year to date compared to same period last year.

2.7 Mental Health

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

- Adult = 96.8%
- Elderly = 58.8%
- Intensive Psychiatric Care = 41.1 %
- There were 6 clients through IPC in December compared to 19 for the month of November.

Average number of specials:

- Two shifts for all of December compared with 10 from November. This is a significant improvement.

Brixton House (**Te Whare Whakauhuru)** (4 bed residential facility): was 98.4% occupancy in December.

3 TARGET UPDATES

The Provider Arm continues 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%	December 2012	Q2 2012/13	Average 2011/12
TBH ED	90.68%	89.82%	85%
Hawera ED	100%	99.90%	99.81%
Total TDHB	94.06%	93.35%	90.01%

This result shows ongoing improvement in this target compared to previous year, despite ongoing increase in presentations for this quarter. Average admission rate 27% for December.

The below initiatives related to the Acute Pathway which is expected to improve the 6 hour target result continue:

Emergency Department

- Implementation of an electronic screen to display patient list in arrival order, colour coded to highlight 6 hour target is expected to be in place in the next quarter.
- The EDO is proving successful with an average of 7 admissions into this area per day an increase of 2 patients per day from previous average
- The minor injuries' unit is continuing to increase throughput and is now averaging 5 patients per day. Feedback from senior medical staff and patients is very positive.

Ward 5 (Medicine)

- Rapid Rounding is continuing to be very successful. There are improvements in overall patient management and knowledge by the MDT.
- Enhanced discharge planning in medical ward is progressing against the KPI's that have been set. (20%+ discharges by 11am, Expected Date Discharge for all admissions on post intake ward round)
- Early completion of discharge documentation to meet discharge time of 11am has improved.
- Nurse led discharges – this is being piloted on Ward 5.

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.
- Implementation of proformas from point of entry into ED, through to admission

Acute Pathway Project

- Key pieces of work identified include bed block procedure and escalation pathway, transfer of patient procedure and communication plan.
- Refining the process for movement of patients between ED and wards, continues to be evaluated and adapted
- Escalation process in development for patients at 5 hour length of stay and likely breach of 6 hour target
- Development of enhanced hospital operations status meeting

3.2 Smokefree Health Target

Target 95%	December 2012	Q2 2012/13	Average 2011/12
	93.14	92.68%	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 December.

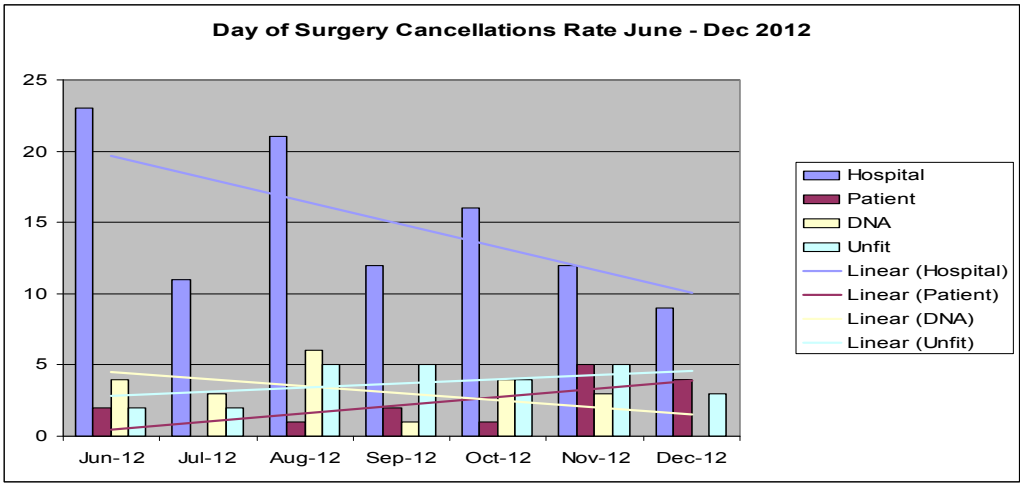
3.3 Radiology Health Target

Monthly Return for Taranaki Health (Computed Tomography, Magnetic Resonance Imaging Statistics and Ultrasound)	CT	MRI	US
Month = December 2012			
Overall Patient events (Community and Outpatient referrals)			
Total number accepted referrals waiting for scan at month end	**260**	**304**	**610**
Total number of referrals accepted for scanning during month	**218**	**85**	**388**
Total number scanned and reported during month	**210**	**87**	**368**
Total number of DNAs during month	**3**	**3**	**23**
Total number of referrals not accepted during month	**14**	**0**	**15**
Waiting times for Community and Outpatient referrals except planned procedures			
Total number accepted referrals waiting for scan at month end	**166**	**224**	**465**
Number of accepted referrals waiting for scan within 6 weeks (42 days)	**110**	**56**	**342**
Number of accepted referrals waiting within 21 weeks (147 days)	**166**	**190**	**463**
Monthly activity and demand for Community and Outpatient except planned procedures			
Total number of referrals for scan accepted during the month	**181**	**63**	**358**
Total number of accepted referrals scanned and reported in month	**177**	**74**	**342**
Total number of accepted referrals scanned and reported in month within 6 weeks	**105**	**21**	**118**
Total number of accepted referrals scanned and reported in month within 21 weeks	**170**	**49**	**333**

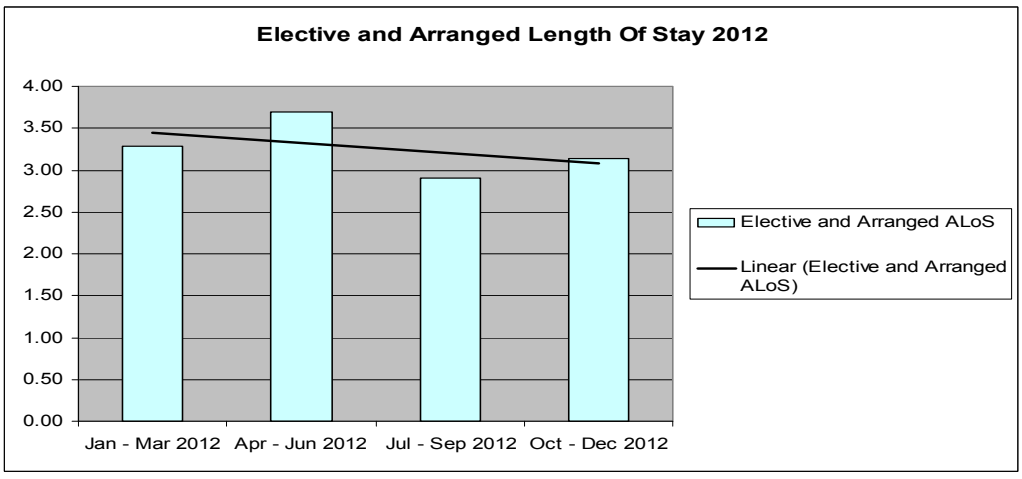
3.4 Projects *(Year to date update)*

The three surgical projects (Preadmission Review, TPOT and ERAS) continue to provide an opportunity to review aspects of the surgical pathway from start to finish. Early indications and trends of improved performance are starting to be realised. Specific examples of this include:

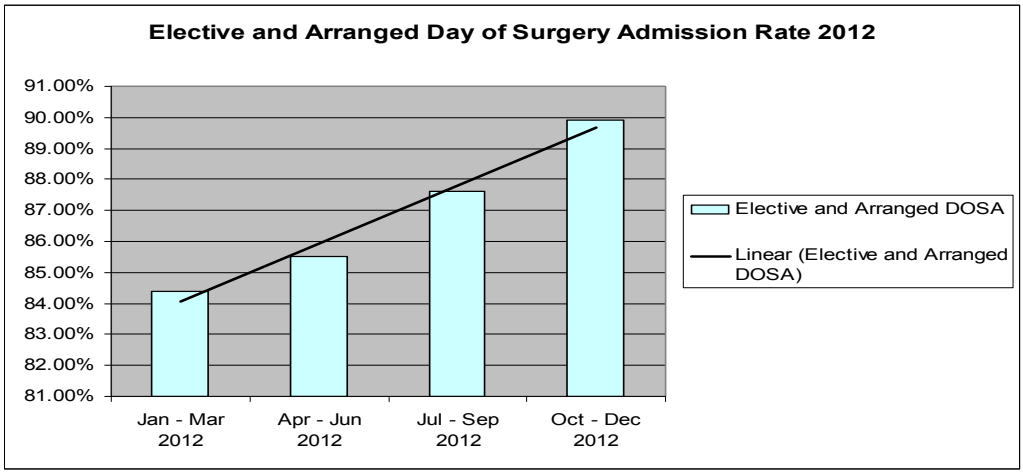
1. In the period June to December 2012 the day of surgery cancellation rate fell by over 2.5% to 5.23% moving close to the 5% tolerance for cancellations on the day of surgery. The below graph shows an impressive decreasing trend for number of day of surgery cancellations that were caused by the Hospital directly. In recent months, the number of this type of cancellation have halved from previous months. There also appears to be a decreasing trend in patient DNAs:



2. Elective Length of stay showed a decreasing trend for 2012:



3. Increasing rates of Day Of Surgery Admission (DOSA); the second half of 2012 began to show significant improvement in TDHB's DOSA rate, increasing to 87.61% and ending the year at 89.93%, only 0.07% short of the 90% target.



The Releasing Time To Care work continues to explore new ways of delivering more direct patient contact time, and CCDM is about to embark upon multi-disciplinary team workshops to understand how to enhance the hospital's capability around ensuring flexible and responsive operational processes.

The Acute Pathway Review Group has made its initial recommendations for three rapid change ideas focussed on delivering greater compliance with the 6-hour Emergency Department Access target and to improve patient flow.

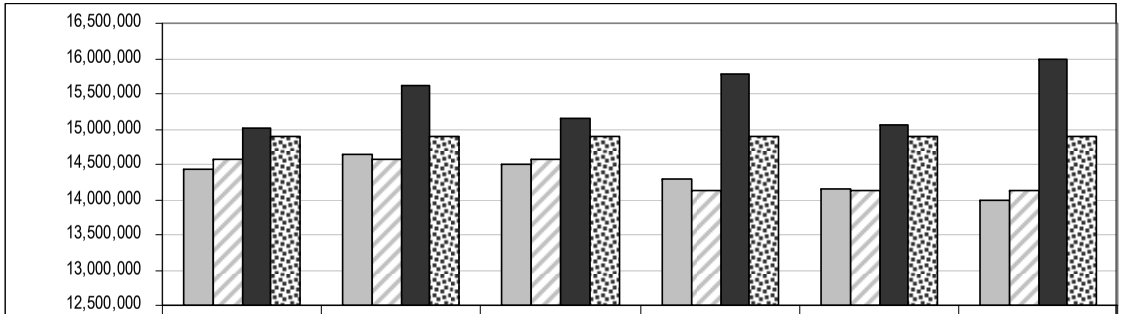
The implementation of the recommendations from the Endoscopy Review are well-underway. The recommendations should ensure that referrals for endoscopy are more effectively prioritised with capacity better matched to demand.

4 FINANCIAL COMMENT

Financial Comment for the Month Ending 31 December 2012

The Provider financial result for the year to 31 December is $3.30M worse than the budgeted deficit of $3.27M. This was made up of revenue $66K below budget and expenditure $3.2M higher than budget. Total expenses are 4% above budget to date and 5% higher than the same period last year. Expenditure is being monitored closely in light of the emerging situation and the need to set appropriate budgets for the 2013-2014 financial year.

	December 2012 Actual	December 2012 Budget	Variance	Year to Date Actual	Year to Date Budget	Variance	Percentage Variance	December 2011 YTD	Movement	Percentage Movement	Comment
Revenue	**(13,995,590)**	**(14,139,047)**	**143,462**	**(86,031,375)**	**(86,097,273)**	**65,896**	**0%**	**(85,621,582)**	**(409,793)**	**0%**	Revenue is reduced in the Provider due to the ongoing reduction in ACC revenue
Personnel Costs	9,107,457	8,438,209	669,244	52,245,711	50,674,889	1,570,829	3%	49,607,572	2,638,139	5%	Staff costs are high for the month, however the true impact of leave and statutory holidays will not be visible until January.
Outsourced Services	1,958,120	1,629,274	328,843	10,933,056	9,775,656	1,157,403	12%	10,852,695	80,361	1%	
Clinical Supplies	1,958,453	1,968,453	(9,984)	12,198,721	11,814,060	384,663	3%	12,203,088	(4,367)	0%	
Infrastructure & Non Clinical Supplies	2,967,207	2,860,083	107,135	17,235,148	17,114,421	120,718	1%	15,629,990	1,605,158	10%	High costs in facilities and affiliation fees
Internal Allocations	(173)	(1,680)	1,508	(2,398)	(10,099)	7,682	-76%	(2,608)	210	-8%	
Total Expenses	**15,991,064**	**14,894,339**	**1,096,746**	**92,610,238**	**89,368,927**	**3,241,295**	**4%**	**88,290,737**	**4,319,501**	**5%**	
Result	**1,995,475**	**755,292**	**1,240,208**	**6,578,863**	**3,271,654**	**3,307,191**		**2,669,155**	**3,909,708**		

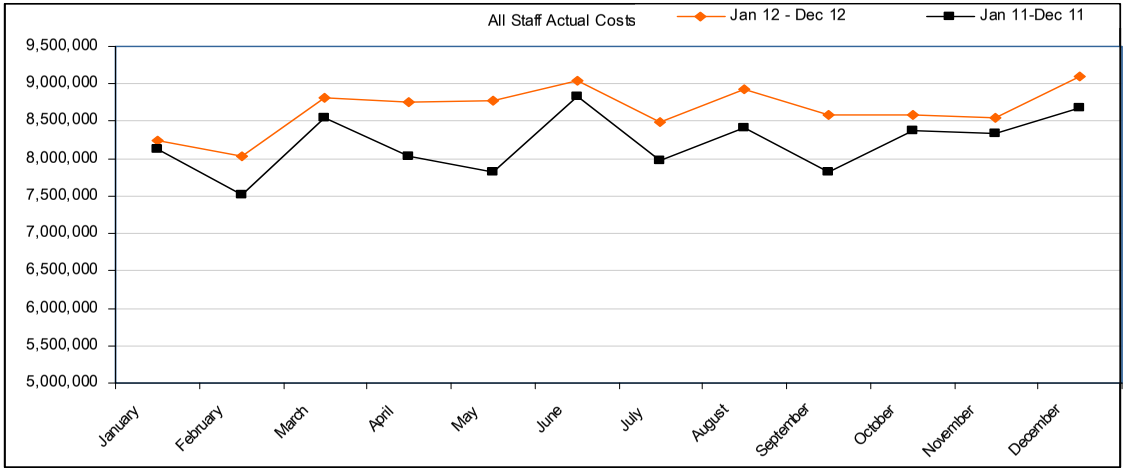


	July	August	September	October	November	December
Revenue	14,439,244	14,642,089	14,511,617	14,293,977	14,148,857	13,995,590
Revenue Budget	14,560,045	14,560,042	14,560,042	14,139,047	14,139,047	14,139,047
Total Expenses	15,015,848	15,626,644	15,143,338	15,769,217	15,062,426	15,991,064
Expenses Budget	14,890,979	14,899,797	14,903,306	14,889,953	14,890,744	14,894,339

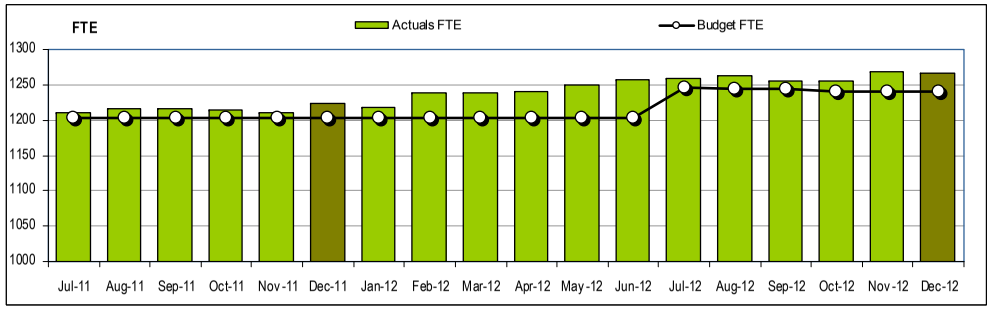
Year to date personnel costs are higher than budget by $1.57M. The total year to date variance is 3% above budget. The majority of the overspend relates to clinical areas and includes Medical staff ($336K YTD), nursing ($1.0M YTD) and allied health ($544K). A number of factors that influence staff costs at this time of year including payments for public holidays and increased levels of leave, and the annual change over of junior medical staff. The impact of holidays and leave will continue into January 2013 and the true financial cost of reduced staffing levels will not be felt until then.

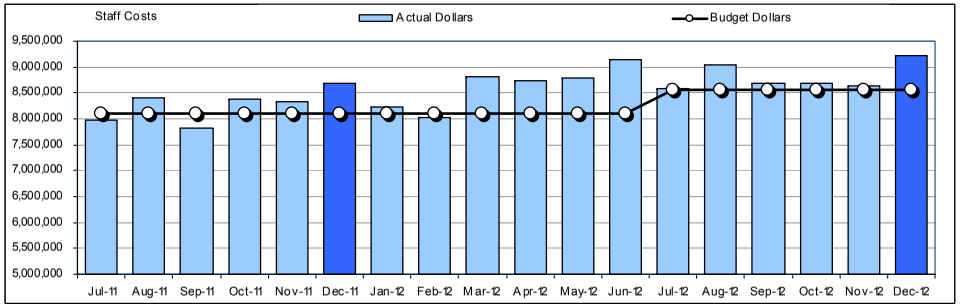
Comparative analysis of previous years shows that staff costs are following similar monthly cost trends with a slight peak in December offset by reduced costs in January the following year (highlighted in the following charts).

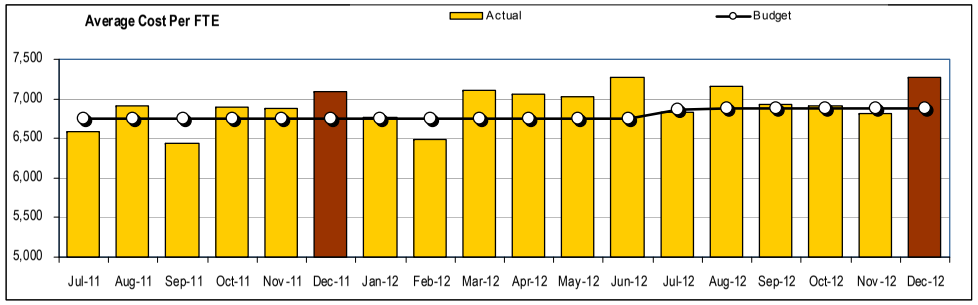
$000	December Actual	December Budget	Variance	December Actual FTE	December Budget FTE	FTE Variance	YTD Actual	YTD Budget	YTD Variance	Percentage Variance	Annual Budget	Comments
Medical Staff	2,333	2,273	60	138.6	142.3	(3.7)	13,973	13,637	336	2%	27,273	Reducing from previous highs,
Nursing Staff	3,864	3,428	437	561.8	543.5	18.3	21,639	20,616	1,023	5%	40,826	Nursing costs are higher than budget, impact of public holidays, leave and reduced staffing will be apparent over both December and January figures.
Allied Health Staff	1,339	1,205	134	235.8	222.0	13.8	7,762	7,217	544	8%	14,449	A number of project staff in this category - 3.6 FTE
Support Staff	356	303	53	86.9	81.2	5.7	2,069	1,818	251	14%	3,636	
Management and Administration Staff	1,215	1,229	(15)	226.4	234.5	(8.1)	6,804	7,387	(583)	-8%	14,763	
	9,107	**8,438**	**669**	**1,249.5**	**1,223.5**	**26.0**	**52,246**	**50,675**	**1,571**	**3%**	**100,948**	
Medical Staff	2,333	2,273	60	138.6	142.3	(3.7)	13,973	13,637	336	2%	27,273	
Locum Medical Staff	183	100	83	0.0	0.0	0.0	1,269	602	667	111%	1,203	High costs in Hawera, offset by staff vacancies
Total Cost of Medical Staffing	**2,516**	**2,373**	**143**	**138.6**	**142.3**	**(3.7)**	**15,241**	**14,238**	**1,003**	**7%**	**28,477**	

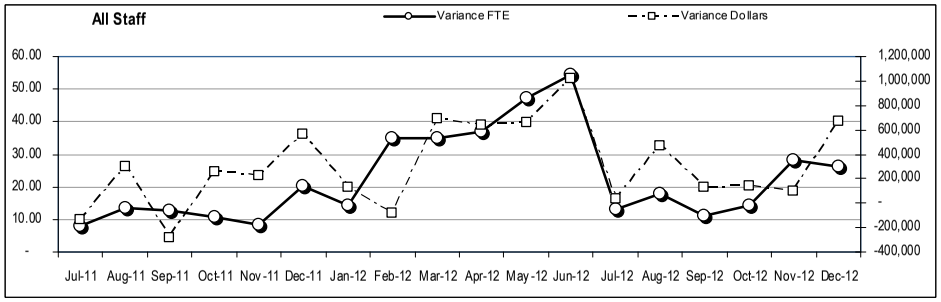


Provider Arm FTE are 26.0 above budget. The majority of this is in nursing staff (18.3 above budget), while medical staff vacancies total 3.7 FTE under budget for the month. Vacancies in employed medical staff continue at Hawera Hospital along with associated use of high cost locum staff to fill rosters, however recent successful recruitment will reduce this cost in coming months. The total cost of medical labour including locums is $15.2M YTD, $1.0M higher than budgeted. Management and Administration FTE continue to be under budget for both FTE and costs.



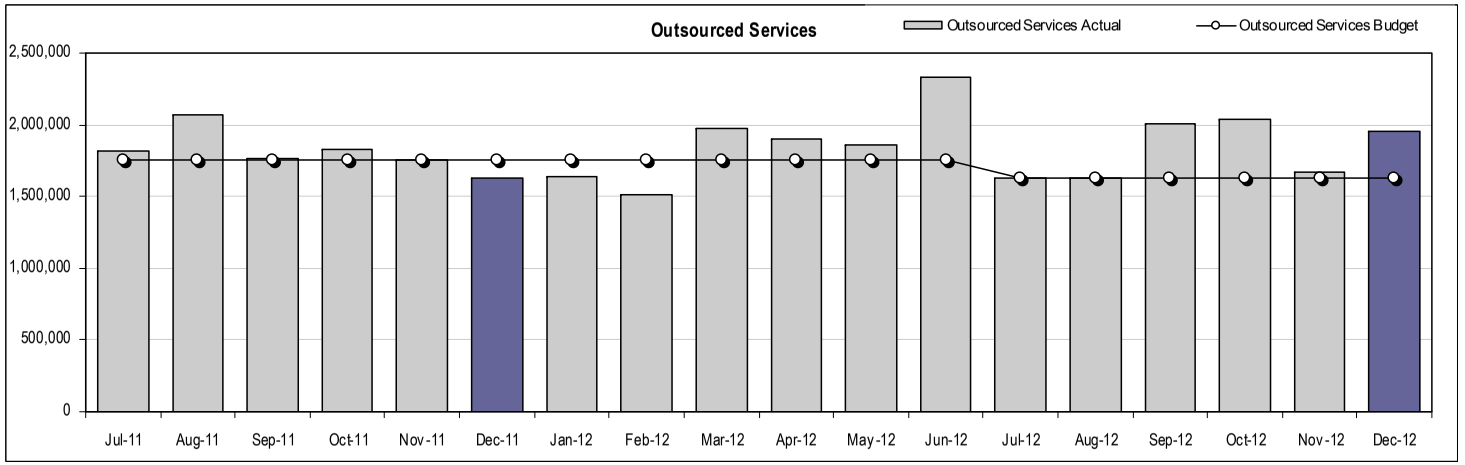






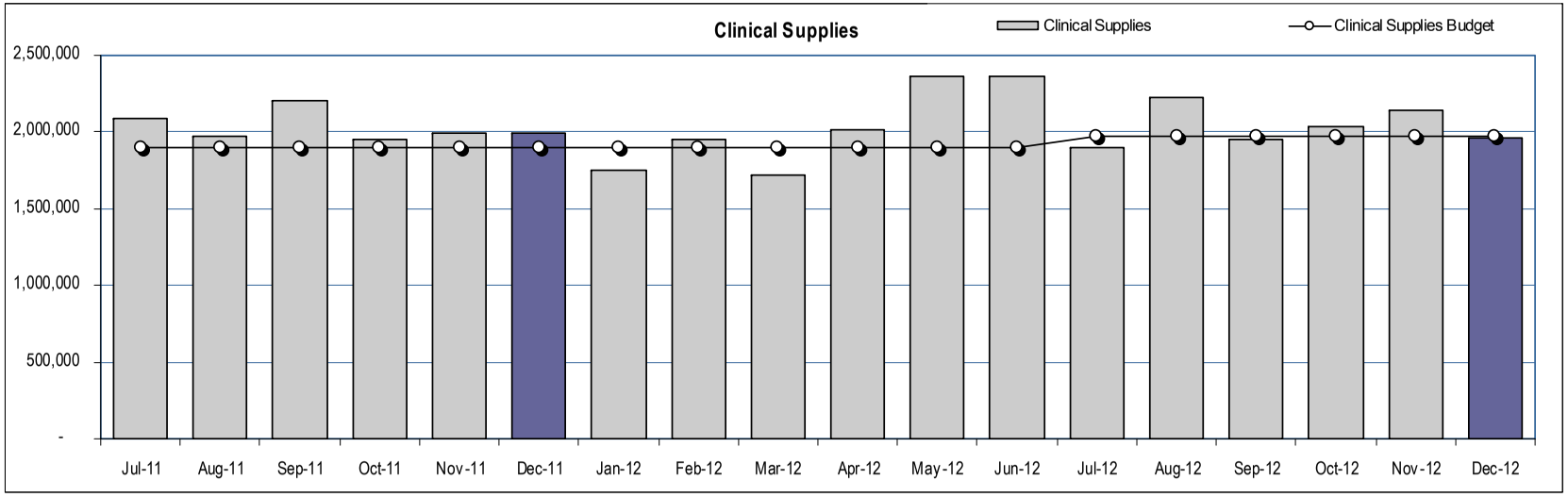
Outsourced Services costs are high, relating to locum costs at Hawera Hospital as previously discussed, and outsourced radiology costs being higher than expected. Outsourced clinical services are under budget, relating to reduced costs from ACC surgery.

	December Actual	December Budget	Variance	YTD Actual	YTD Budget	Variance	Percentage Variance	Sum of Annual Budget	Percent Expended (target 50%)	
Outsourced Medical Staff	183,248	100,269	82,979	1,268,604	601,612	666,992	111%	1,203,225	105%	High costs relate to Hawera Medical staff
Other Outsourced Staff	77,047	32,694	44,352	271,048	196,166	74,882	38%	392,332	69%	Allied Health staff offset by vacancy
Referred Services	861,471	610,860	250,611	4,261,669	3,665,163	596,506	16%	7,330,326	58%	Radiology and laboratory costs
Outsourced Clinical Services	836,356	885,451	(49,099)	5,131,735	5,312,715	(180,977)	-3%	10,625,425	48%	Reduced due to less ACC work
	1,958,120	**1,629,274**	**328,843**	**10,933,056**	**9,775,656**	**1,157,403**	12%	**19,551,308**	56%	



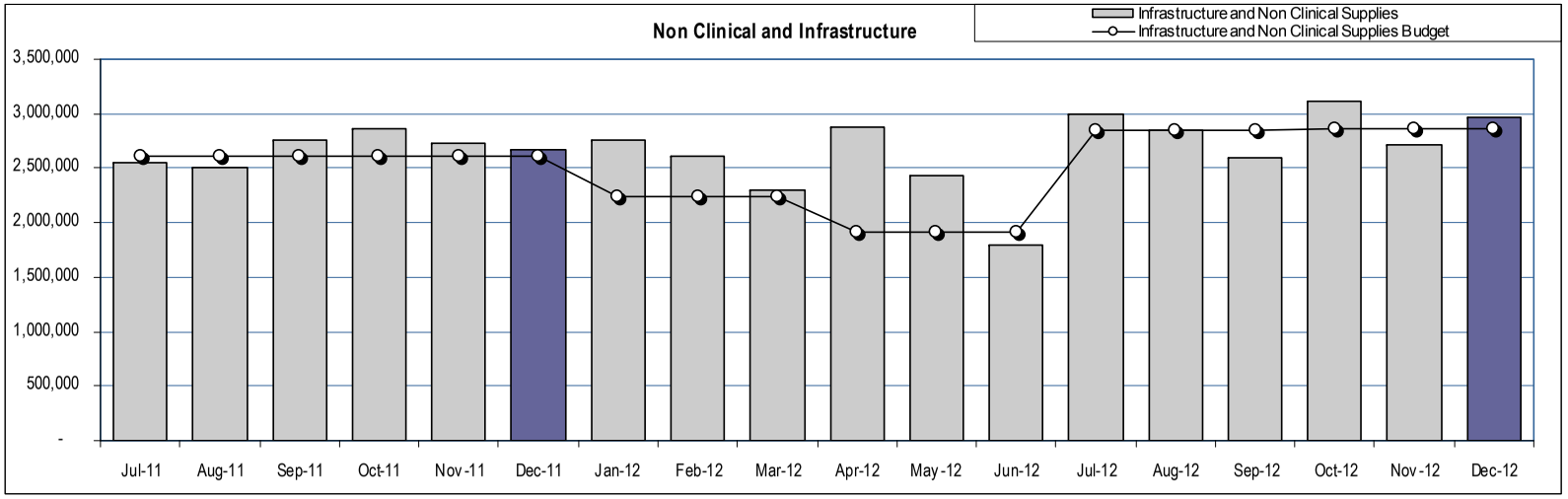
Clinical supply costs are under budget for December by $10K and over budget for the year to date by $384K. Overspend in Pharmaceuticals relates to demand for cancer treatments, where over delivery is funded through internal revenue from the DHB Funder. There are increased costs in implants relating to knee replacement and spinal surgery, and a number of projects are looking at avenues to reduce this expenditure.

	December Actual	December Budget	Variance	YTD Actual	YTD Budget	Variance	Percentage Variance	Sum of Annual Budget	Percent Expended (target 50%)	Comments
Patient Consumables	818,882	738,301	80,593	4,507,928	4,429,739	78,192	2%	8,859,475	51%	High costs for dressings
Diagnostic Supplies	109,937	116,229	(6,293)	690,792	697,379	(6,586)	-1%	1,394,754	50%	
Clinical Equipment	200,316	226,775	(26,459)	1,239,629	1,364,095	(124,465)	-9%	2,680,510	46%	
Patient Appliances	80,319	90,460	(10,141)	510,698	542,757	(32,058)	-6%	1,085,512	47%	
Implants and Prostheses	148,699	167,532	(18,833)	1,394,593	1,005,184	389,408	39%	2,010,370	69%	High costs in Orthopaedics, relating to volume
Pharmaceuticals	255,965	331,676	(75,708)	2,055,061	1,990,032	65,026	3%	3,980,070	52%	Costs for Cancer Treatments offset by Revenue
Patient Transport and Accommodation	336,080	288,501	47,580	1,737,230	1,731,000	6,230	0%	3,462,000	50%	Year to date expense close to budget
Other Clinical Supplies	8,256	8,979	(723)	62,790	53,874	8,916	17%	107,748	58%	
Clinical Supplies Total	**1,958,453**	**1,968,453**	**(9,984)**	**12,198,721**	**11,814,060**	**384,663**	**3%**	**23,580,439**	**52%**	



Infrastructure and Non-Clinical costs are $107K (4%) above budget for the month and $120K (1%) above budget for the year to date. Year to date hotel service continue to be over budget, however December costs are lower than budget related to reduced occupancy. 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). High professional fees and expenses relates to TDHB's share of costs for regional services.

	December Actual	December Budget	Variance	YTD Actual	YTD Budget	Variance	Percentage Variance	Sum of Annual Budget	Percent Expended (target 50%)	Comments
Hotel	258,954	272,787	(13,831)	1,685,320	1,636,694	48,626	3%	3,273,383	51%	
Facilities	835,607	752,438	83,168	4,952,423	4,513,599	438,822	10%	9,029,696	55%	Higher than budgeted depredciation costs, insurance expenses transferred between categories
Staff Transport & Accommodation	84,212	74,821	9,388	524,782	453,860	70,919	16%	904,103	58%	High costs relating to TDHB vehicles
IT & Telecommunications	693,696	795,671	(101,974)	4,526,165	4,717,752	(191,588)	-4%	9,589,026	47%	
Interest & Financing Charges	684,796	659,633	25,163	3,992,028	3,957,800	34,228	1%	7,915,600	50%	
Professional Fees & Expenses	268,827	154,939	113,892	947,686	929,625	18,061	2%	1,859,250	51%	Reduced insurance expenses, high affiliation costs related to shared services
Other Operating Expenses	141,115	149,711	(8,588)	605,847	904,591	(298,747)	-33%	1,802,193	34%	
Democracy	0	83	(83)	897	500	397	79%	1,000	90%	
Cost Savings	0	0	0	0	0	0	0%	(2,000,000)	0%	
Total	**2,967,207**	**2,860,083**	**107,135**	**17,235,148**	**17,114,421**	**120,718**	**1%**	**32,374,251**	**53%**	



5 GENERAL

- Our longstanding Community Medical Officer retired at the end of December after 29 years of service.
- Another longstanding employee, in charge of telecommunications, retired in December after 18 years of service.
- Planning for the new model for Sexual Health services is well underway. This coincides with a change of premises for the Sexual Health Team.
- The Cancer Nurse Coordinator role has been successfully recruited to. This role commences in February and will support patients from diagnosis to commencement of treatment.
- Successful recruitment of a Dermatology consultant, who will commence work in March 2013 will reduce the outsourcing costs of this service.
- A new O&G MOSS accepted employment with TDHB and will commence work with the O&G Consultants in March 2013.
- CCDM National Forum was held over two days in Tauranga and had Allied Health personnel looking at what will be required to create a National data set for these professions. This will enable comparisons to be made and consistent best practise provided.
- In November 2012, the CT scanner was replaced with minimal impact noted as contingency plans worked well. MRI replacement proposed for January 2013.
- The Hawera Hospital Oral Health Community clinic rebuild is due for completion in mid February 2013.
- A new pre admission model was introduced in Surgical Outpatients following widespread consultation with clinicians and administrative staff. The feedback from patients has been very positive.
- Our Vascular Surgeon, has developed a plan with the Waikato Vascular service to commence training in Interventional Radiology. This training will commence in early February 2013.
- Finalised a new contract for the provision of Urology services that will provide a more comprehensive service with on site clinicians.

RECOMMENDATION

That the Hospital Services Reports for the month of December 2012 and the second quarter of the current fiscal year be noted and received.

Rosemary Clements
General Manager
Hospital & Specialist Services

Appendices:

1. Outline of Hospital Services Projects
2. Whakapai Dashboard
3. Quarterly Report – HR and Organisational Development
4. Q&R Report – Oct – Dec 2012

Outline of Hospital Services Projects (updated 18 Jan 2013)

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. New ideas for trial using PDSA methodology: Daily Operations Meetings 5-hour escalation policy Potential use of 3-2-1 milestones in ED	
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 *Appendix 1*
CCDM	Decreasing the number of resourced beds by using forecasting to define bed requirements to meet variable acute demand. Matching staffing levels/mix to demand though higher staffing flexibility and leveraging potential of all providers of care.			See GM H&SS Exception Report for December 2012 - Point 3.4 Projects (year to date update)	
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 GM H&SS Exception Report for December 2012 - Point 3.4 Projects (year to date update)	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 GM H&SS Exception Report for December 2012 - Point 3.4 Projects (year to date update)	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 GM H&SS Exception Report for December 2012 - Point 3.4 Projects (year to date update)	
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 GM H&SS Exception Report for December 2012 - Point 3.4 Projects (year to date update)	See status report

Table Performance results for 03/12/2012 to 30/12/2012

Type	Key Performance Indicator	Unit Measure	Target	50 03/12/2012	51 10/12/2012	52 17/12/2012	53 24/12/2012
Budget Dollar	Salary & wage budget variance	Percentage	<0%	0.1%	0.9%	(0.8%)	0.9%
	Variance Dollar	Dollar	<0	($061)	$16,331	($14,193)	$16,889
	Allied Health $ performance	Dollar	<0	($5,685)	($4,574)	($1,427)	$878
	Medical $ performance	Dollar	<0	$70,764	$61,669	$16,241	$24,112
	Nursing $ performance	Dollar	<0	($46,273)	($23,377)	($22,659)	($549)
	Support $ performance	Dollar	<0	($18,867)	($17,386)	($6,347)	($7,553)
Workforce FTE	Budget EFT variance	FTE	<9	(28.2)	(13.7)	(25.1)	(12.0)
	Allied Health FTE performance	FTE	<1	(2.3)	(1.7)	2.4	2.5
	Medical FTE performance	FTE	<1	15.7	17.8	(3.2)	(3.2)
	Nursing FTE performance	FTE	<1	(24.4)	(13.1)	(11.8)	0.4
	Support FTE performance	FTE	<1	(17.2)	(16.7)	(12.5)	(11.8)
Supplementary	Bank (casual) use	FTE	<50	54.1	44.0	43.5	39.2
	Part-time extra	FTE	<50	55.4	48.3	43.7	41.6
	Overtime use	FTE	<10	8.6	6.2	4.6	4.3
	Pool use	FTE	<12	8.6	8.3	8.3	8.9
	Agency use	FTE	<1	1.0	0.4	0.0	0.0
Shortfall	True shortfall	FTE	<50	63.1	57.2	38.7	45.8
	Overall staff vacancy	Percentage	<5%	5.3%	4.8%	3.3%	3.8%
	Allied Health vacancy	Percentage	<5%	3.7%	3.7%	4.2%	4.2%
	Medical vacancy	Percentage	<5%	11.0%	12.5%	(2.3%)	(1.3%)
	Nursing vacancy	Percentage	<5%	4.6%	3.2%	3.5%	4.5%
	Support vacancy	Percentage	<5%	4.9%	4.3%	4.5%	4.8%

Definitions

Budget Dollar *Includes all salary and wages, except contracted staff. Expressed as a percentage variance*

Workforce FTE *Includes permanent and supplementary staff, but excludes contracted staff. Expressed as FTE.*

Supplementary *Includes part-time staff working extra hours, overtime, casual, pool and agency staff. Expressed as FTE.*

Shortfall *Represents the variance between Budget Base FTE and Actual Base FTE. Expressed as a percentage variance.*

Agency Use *Contracted staff working over their contracted hours.*

** *Brackets represent an over budgeted value*

Analysis

- Compliance has improved overall.
- Increase annual leave utilisation as per plan.
- Shortfall has reduced.
- Salary and wage variance for hours worked is positive.
- Reduced use of supplementary staff and operating theatres.

TO General Manager Hospital & Specialist Services

FROM Gavin Woolley,
General Manager
Human Resources and
Organisational Development

TARANAKI DISTRICT HEALTH BOARD

MEMORANDUM

DATE 24 January 2013

SUBJECT **Human Resources and Organisational Development Report for October to December 2012**

(Quarter 2 2012/13)

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1 INTRODUCTION

The purpose of this report is to provide a summary of the activity that occurred from a Human Resources and Organisational Development perspective (Organisational Development, Learning and Development, Employment Relations, and Recruitment) which had a direct impact on the Hospital Services Provider during the quarter ending 31 December 2012.

2 ACTIVITY

2.1 Organisational Development

2.1.1 Learning and Development

The DHB will be sending five new and frontline leaders on the Midland Region Leadership in Practice Programme, commencing on 31st January. These individuals come from a range of disciplines across the DHB.

A regional approach for eLearning has been determined and work has commenced at TDHB on rolling out the existing Midland Learning site established by BOPDHB. Course implementation will consist of adaptation of existing courses on the site as well as the development of new courses. The region will be working together on common priorities for course development. A TDHB eLearning implementation group has been established to oversee the rollout of eLearning and ensure it meets stakeholder needs.

The clinical and compliance education programme for the 2013 year has been developed in consultation with the Nursing Directorate and Quality and Risk. In addition, a schedule of proposed learning and development offerings focusing on management development and communication skills has been drafted and is under consultation with managers.
Implementation has commenced on a behaviours awareness programme focusing on education around TDHB expected values. The programme will involve education sessions for managers and employees and the establishment of a support network of contact people to provide another level of first line support for any concerns about behaviours.

Learning and Development will now be coordinating the Wellness Programme for TDHB, initially established by the Health Improvement Manager for Healthy Taranaki.

2.2 New Hires

There were 97 new hires (64.54 FTE) in October to December 2012:

- 27 casual positions (nil FTE)
- 53 full time positions (53.0 FTE)
- 17 part time positions (11.54 FTE)

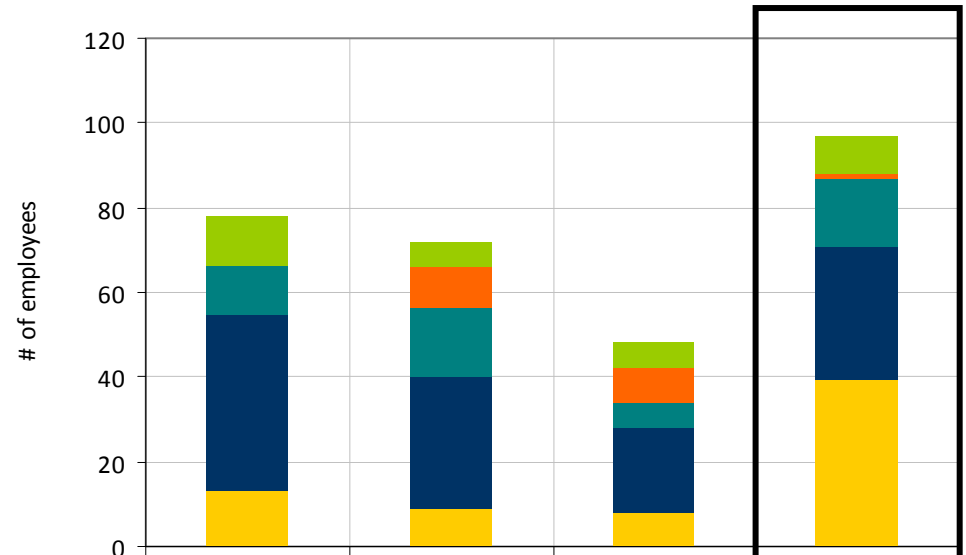
The increase in new hires is due to:

- Annual intake of registrars, house officers and house surgeons (37 new hires)
- Annual intake of scholarship students (8 new hires)
- Higher than usual intake of casual staff across all five position types:
  - Medical..... 2
  - Nursing (includes 11 x RNs)..... 18
  - Allied 1
  - Non health support 1
  - Management/administration 5

These positions included 21 (18.5 FTE) temporary contracts, primarily to support staff shortfall and key projects/secondments, broken down as follows:

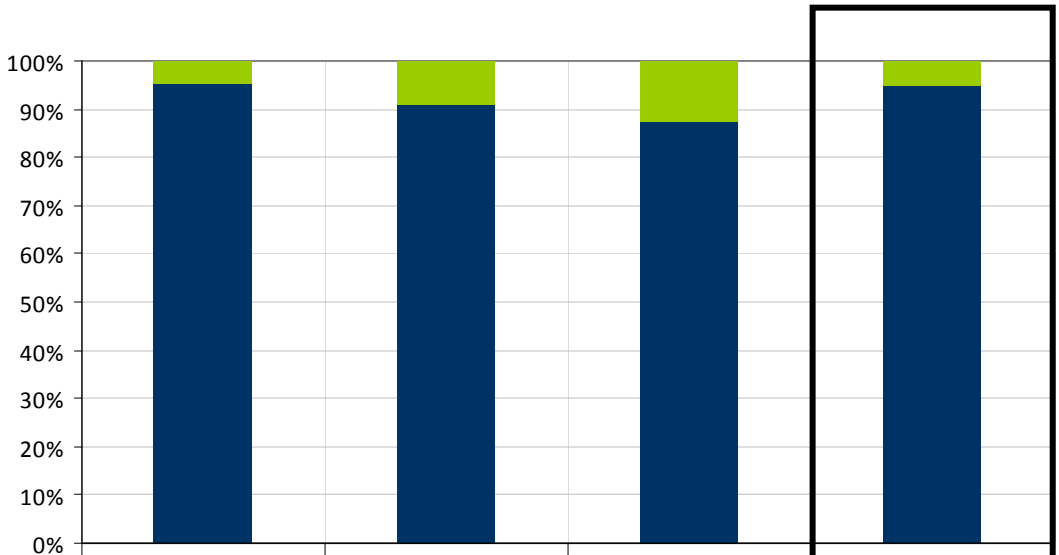
- 2 medical employees (2.0 FTE)
- 6 nursing employees (4.3 FTE)
- 11 allied employees (10.7 FTE)
- 2 management/administration employees (1.5 FTE)

Graph 1: Breakdown of new hires by position type



	Q3 2011-12	Q4 2011-12	Q1 2012-13	Q2 2012-13
Mgmt/Admin	12	6	6	9
Non Health Support	0	10	8	1
Allied	11	16	6	16
Nursing	42	31	20	32
Medical	13	9	8	39

Graph 2: % of new hires identified as New Zealand Maori



	Q3 2011/12	Q4 2011/12	Q1 2012-13	Q2 2012-13
NZ Maori	4.65%	9.09%	12.50%	5.15%
Non Maori	95.35%	90.91%	87.50%	94.85%

Table 1: Breakdown of new hires identified as New Zealand Maori

Position Type	No. of employees	FTE
Medical 1 x Anaesthetic Registrar 1 x House Surgeon	2	2.0
Nursing/Midwifery • 1 x Midwife	1	Casual
Allied • Scholarship student	1	1.0
Support • Orderly	1	Casual
Management/Administration • Business Analyst	1	1.0

2.3 Position Changes

116 employees had a position/role/FTE change (increased/reduced work hours) in October to December 2012.

2.4 Terminated Employees

19 employees (14.7 FTE) left TDHB between October to December 2012 (excluding casuals and staff employed on temporary contracts). Reasons given for leaving as follows:

Table 2: Reasons for leaving

Personal/family/whanau reason	26%
Career development opp/advmnt	16%
Partner transferred	11%
Retirement	11%
Work relationships	11%
Personal/ Family/ Whanau Reason	11%
Change in profession/role	5%
Health	5%
Other	5%

There are no employees who identify themselves as New Zealand Maori on this list.

2.5 Recruitment

A summary of recruitment activity below:

2.5.1 Senior Medical Officer Positions

Table 3: Appointments made

Position	Headcount	Start date
Medical Officer, Emergency Medicine	1	December 2012
Medical Officer, Rural Hospital Medicine - Hawera	1	December 2012

Pending commencements in January 2013:

- Medical Officer, Paediatrics – 1.0 FTE for 12 months
- Medical Officer, Sexual Health – 0.4 FTE Permanent
- Medical Officer, Rural Hospital Medicine – Hawera – 0.7 FTE for 10 months
- Consultant Physician, Internal Medicine – 1.0 FTE Locum for 3 months
- Consultants x 2, Emergency Medicine – 1.0 FTE both temporary for minimum of 2 years

Offers have been accepted for the following positions to commence during 2013:

- Consultant General Surgeon
- Medical Officer, O&G
- Consultant Dermatologist
- Consultant Psychiatrist – Addictions Specialist
- Consultants Emergency Medicine (4)

Recruitment campaigns are being conducted for the following:

- Medical Officers under the Rural Hospital Medicine (RHM) scope of practice for Hawera Hospital - an offer has been made though not yet accepted
- Consultant Community Paediatrician
- Consultant Physician – interest on Respiratory Medicine – an offer has been made though not yet accepted

2.5.2 Resident Medical Officers

New House Officers and Registrars commenced in November and December commencement respectively with a full compliment of First Year House Officers.

2.5.3 Nursing and Midwifery

Currently vacancies are for a total of 1.3 FTE only which is lower than the previous four quarters. One graduate midwife was recently appointed that contributes to managing the future midwifery workforce.

Taranaki DHB has been designated a “hard-to-staff-community” for midwifery with the Voluntary Bonding Scheme.

2.5.4 Voluntary Bonding Scheme

Information for the 2013 Voluntary Bonding Scheme has not yet been posted on the Ministry’s website. Relevant managers will be advised to notify and encourage eligible employees, i.e. 2012 graduates, for medicine, nursing and midwifery.

Notable successes between 2010 - 2012 Taranaki enrolments on the Voluntary Bonding Scheme for hard to fill specialities are:

- A second year Senior House officer being accepted on to the Rural Hospital Medicine vocational training scheme. A specific programme will be initiated that will enable this person to take up a post in the Hawera Hospital;

- A first year Registrar completing their first year of training on the General Practice Educational programme (GPEP 1) training scheme in Taranaki;
- A first year Midwifery graduate completing their first year of training.

2.5.5 Scholarships

Applications for scholarships are currently being accepted for the 2013 year with the closing date being 31 January 2013.

Assessment of applications and decisions are completed from February to April after which time applicants are advised of the outcome.

Of the 28 scholarship recipients in 2012, 11 graduated and 5 were offered one-off awards which means they will be required to apply for the 2013 study year.

2.6 Human Resources Management and Employment Relations

Management/Admin FTE Cap
Every month, TDHB provide MoH updated accrued FTE figures for the Management/Admin FTE cap. A revised (reduced) cap was set with effect from 1 April 2012. The DHB operates within the revised cap.

2.6.1 Bargaining Activity

Human Resources continue to work with health sector unions and DHB Shared Services on various Collective Employment Agreements.

National

- DHB Shared Services have started work on the Senior Medical and Dental Officers' Collective Agreement which expires on 28 February 2013. Bargaining has been initiated by the union.
- The next main collective after this is the Resident Medical Officers' collective which expires in August 2013.

Local

- TDHB Management Meetings - TDHB Management, HR and unions continue to have a number of forums in which they meet to discuss operational matters. These include the Bipartite Action Group (BAG), TDHB/NZNO Joint Action Committee (JAC), Local Resident Doctor Engagement Group (LREG) for RMOs, Association of Salaried Medical Specialists (ASMS) Joint Consultative Committee (JCC) for SMOs, and the PSA Delegates' Meeting.

2.6.2 Health Benefits Limited (HBL)

HBL is a crown-owned company. It is working with TDHB staff to develop ideas for reducing costs and achieving greater operational efficiencies. It operates in a commercial manner to identify, for all DHBs, the best way of reducing the cost of shared services, as well as facilitating and leading initiatives to make the savings.

Finance Procurement and Supply Chain (FPSC) Programme

- HBL has been revalidating its data, and developing change management plans for consultation with DHBs, regarding the design and implementation of the business processes, organisation structures and working relationships.
- HBL has commenced recruitment to build a team to deliver the programme.

Information Services

- The draft Indicative Case for Change (ICC) document is under development.

FMSS - Food and Laundry

- Non-Binding Indicative Offer (NBIO) process.
- Will have limited impact on TDHB with laundry and food services already outsourced; and with orderlies service providing meal delivery.

Human Resources and Workforce Management

- HBL have tested the market for national HRIS systems. It is anticipated that following assessment, an indicative case for change will be developed for this programme of work.

2.7 Human Resources Information

The following is a summary of the workforce statistics.

2.7.1 Ethnicity Statistics

Maori participation in the TDHB workforce has reduced slightly to 6.73% in quarter 2 (6.89% in quarter 1).

Table 4: Bi-cultural Overview by Occupation

Bi-cultural overview by occupation group (headcount) is as follows:

	Maori	Non Maori	Not Stated	Total	% Maori	% Unknown
Medical	3	138	13	154	1.95%	8.44%
Nursing	48	712	79	839	5.72%	9.42%
Allied	26	261	19	306	8.50%	6.21%
Non Health Support	12	75	19	106	11.32%	17.92%
Administration	23	220	12	255	9.02%	4.71%
Management	2	31	1	34	5.88%	2.94%
Total	**114**	**1437**	**143**	**1694**	**6.73%**	**8.44%**

** figures include casuals, exclude HIQ*

Scholarship Students

Taranaki DHB supports scholarship students via work placement of 3-6 weeks each and financial scholarships. The scholarships are aimed at driving workforce supply with a specific focus on youth, including Maori. TDHB has 28 scholarship students in 2012.

Table 5: Bi-cultural Overview of Scholarship Students

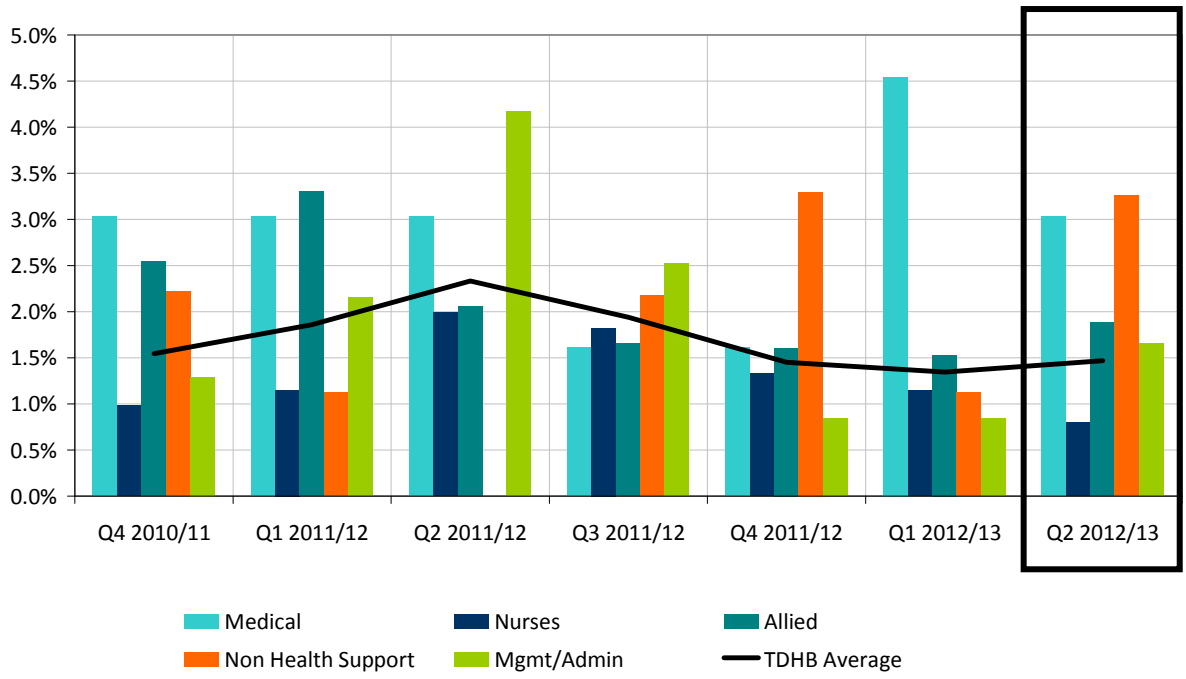
	Maori	Non Maori	Not Stated	Total	% Maori	% Non Maori
Scholarship Students	10	18		**28**	35.71%	64.29%

2.7.2 Turnover (excluding casuals)

The average rolling turnover for the last 12 months is 6.14%.

TDHB's turnover rate continues to decline compared to the previous 12 months. Taranaki DHB has the lowest turnover rate for all the DHBs. The national average is 2.2%, and the Midland DHB region average is 2.5%. TDHB's average quarterly turnover rate is 1.47% which is less than the same quarter in 2011/12 at 2.33%.

Graph 3: Turnover



2.7.3 Sick Leave

Sick leave for this quarter is 2.5% (3.4% in the previous quarter).

Taranaki DHB's sick leave rate is on average lower than the average sick leave rate for all DHBs.

2.7.4 Annual Leave

Annual leave for this quarter is 7.8% (8.0% in the previous quarter).

10.6% of TDHB employees have an annual leave balance that is at least double that of their entitlement. Two programmes have been implemented to help support the management of this, namely a regular audit and planning process for SMO leave, the extended Christmas shutdown at the end of 2012. In addition, Human Resources continues to work with managers in an effort to reduce these leave balances and ensure appropriate time off work is taken by employees.

2.7.5 Planned/Unplanned Leave

Planned/unplanned leave for this quarter is as follows:

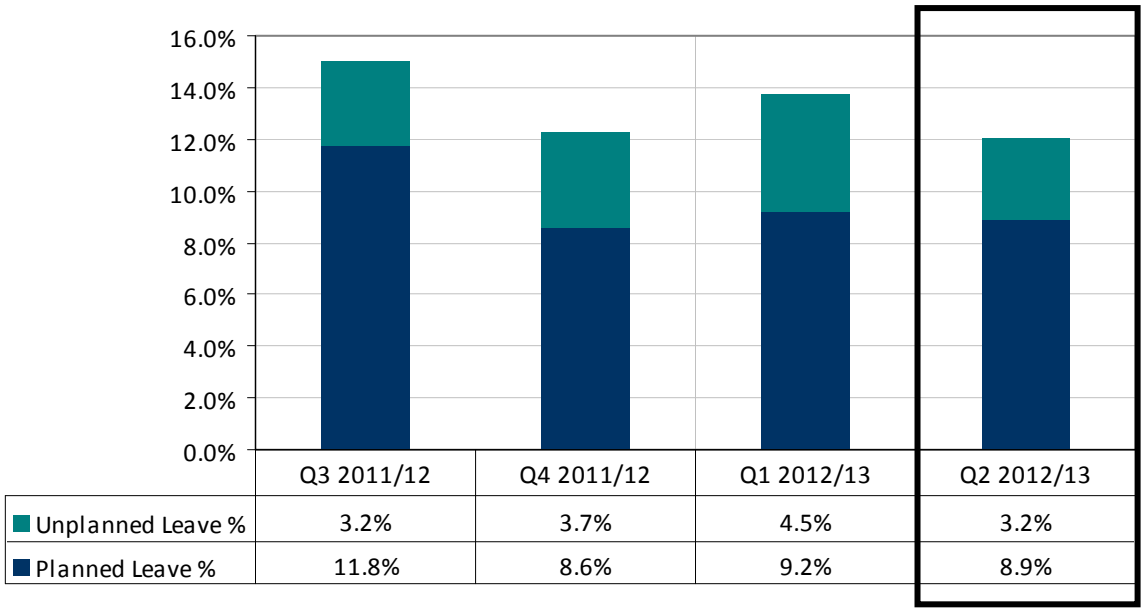
- Planned Leave.....8.9%

  (Annual/Public Holiday/Study, Course and Conference leave)

- Unplanned Leave 3.2%

  (Sick/Other leave, e.g. bereavement leave)

Graph 4: Planned and Unplanned Leave



	Q3 2011/12	Q4 2011/12	Q1 2012/13	Q2 2012/13
Unplanned Leave %	3.2%	3.7%	4.5%	3.2%
Planned Leave %	11.8%	8.6%	9.2%	8.9%

RECOMMENDATION

It is recommended that the Human Resources Report for October to December 2012 is noted.

Gavin Woolley
General Manager
Human Resources and Organisational Development

Appendix 1

Agreement	HR Code	Expiry Date	Headcount Non-Union	Headcount Union	Non-Union FTEs	Union FTEs	Approx salary value of CEA	Update
Senior Medical and Dental Officers' MECA (ASMS union)	SM01, SMO2, SM03, SM11, SMBF, SMCC SMIA	28 Feb 13	6	71	3.65	60.2	$13.8m	Operational - currently in negotiations to re-new
NZNO Nurses & Midwifery MECA	NS01, NS11, NSCC, NSIA, NURS	28 Feb 15	80	706	21.6	468.0	$47.7m	Operational
PSA Allied, Public Health & Technical (APT) MECA	CATH, PAIA, PATH, PSAB, PS11, PTHB	30 Apr 14	34	186	18.2	154.0	$12.8m	Operational
PSA Administration/ Clerical MECA	CACT, CAT, PACT, PAEX, PCIA, PCTB	31 Dec 13	34	162	19.1	131.0	$8.3m	Operational
PSA Nursing MECA	PUBH	30 Apr 14		17		11.2	$1.2m	Operational
Service and Food Workers' Union MECA	SS01, SS02, SSCC, SSIA	30 Sept 13	2	20	0.0	13.1	$759K	Operational
Resident Doctors' Association MECA (RDA union)	RM01, RM02, RM03, RM11, RMIA	31 Aug 2013	13	42	8.5	41.6	$4.9m	Operational
Midwifery Employee Representation & Advisory Services (MERAS union)	MER1	28 Feb 2015		13		7.3	$822K	Operational

Agreement	HR Code	Expiry Date	Headcount Non-Union	Headcount Union	Non-Union FTEs	Union FTEs	Approx salary value of CEA	Update
Medical Laboratory Workers' MECA (for LabCare) (NZMLW union)	LABC, LB01, LB11, LBBF, LBIA	7 Aug 14	5	39	3.6	30.1	$2.5m	Operational
TDHB/CHICCU SECA (Cleaners and Orderlies)	CHIA, CHIC	31 Mar 2014	2	42	0	30.7	$1.5m	Operational
Apex Psychologists MECA	AP01	30 Apr 2014		1		0.7	$85K	Operational

TO General Manager Hospital & Specialist Services

FROM Anne Kemp
Quality & Risk Manager

MEMORANDUM

DATE 28 January 2013

SUBJECT Quality & Risk Report for October, November & December 2012

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1 QUALITY

1.1 Certification and Accreditation

Our certification surveillance audit took place in early November. The draft report has been received and checked for accuracy and comments fed back to the DAA auditing agency. We have received the final report that was sent into HealtCert in December. Several corrective actions from our audit in 2011 have been closed off, but we continue to work on some that remain challenging.

1.2 Public Records Act Audit

In early December, auditors on behalf of Archives NZ, audited the DHB against the four mandatory standards (Create and Maintain, Electronic Recordkeeping Metadata, Storage, and Disposal). Our report has been received and indicates that while we have some very good processes in key areas, we do not have a consistent co-ordinated approach across the DHB. This audit helps us identify and prioritise actions to be taken to improve our compliance and decrease risk.

1.3 Health Quality & Safety Commission

The Health Quality and Safety Commission http://www.hqsc.govt.nz/ was established in November 2010 as a Crown Entity under the New Zealand Public Health and Disability Act 2000 to lead and co-ordinate work across the health and disability sector for the purposes of:

- Monitoring and improving the quality and safety of health and disability support services
- Helping providers across the whole sector to improve the quality and safety of services.

The Health Quality and Safety Commission has identified the following specific priorities for the next few years:

- Reducing harm from:
  - Patient falls
  - Hospital acquired infections
  - Surgery
  - Medications
- Focusing on the four elements that underpin all our work:
  - Measuring and evaluating quality and safety of health care.
  - Facilitating consumer partnerships.
  - Building sector capability and clinical leadership.
  - Creating a culture of quality and safety improvement.

Locally, hospital acquired infection prevention projects including increasing hand hygiene compliance and more recently a national project to decrease central line associated bacteraemia infections, are in place and progressing well. As well, Taranaki DHB is taking a lead role in developing and implementing an integrated inpatient e-medicines solution.

The Health Quality & Safety Commission have developed quality and safety markers. These are sets of process and outcome measures that are designed to track and incentivise progress in the four critical areas of safety and quality: patient falls, hospital acquired infections, surgery and medication. The Commission's approach is to measure specific clinical interventions which are known to improve outcomes so an estimate of the effect of changing practice in terms of avoided harm and cost can be determined. Baseline data in relation to patient falls, hospital acquired infections and surgery is currently being collected. While majority of the data can be derived from routine or pre-existing data collections, some require specific data collection which we are working through.

In order to assist DHBs to use measurement and evaluation as a fundamental part of improving safety and quality, the Quality and Safety Commission recommends that each health and disability service provider document and publish a yearly Quality Accounts document. This is to be published annually alongside the financial accounts and provides the public with a transparent indication of health and quality outcomes being delivered, with the initial document reflecting performance in the 2012/13 year. Responsibility for the Taranaki DHB Quality Accounts document sits with the Clinical Board.

1.3 Patient Satisfaction

Since 2000, all DHBs have been required to send out Patient Satisfaction Survey forms twice a month. While this is not a requirement now, the Taranaki DHB continues to undertake the process. These forms are addressed to a sample of both inpatients discharged and outpatients seen since the previous selection. Individual patient satisfaction responses are converted to percentages for the purpose of analysis.

We continue to determine how best to analyse and present the patient satisfaction survey data obtained that enables increases and decreases in satisfaction to be monitored and followed up as applicable.

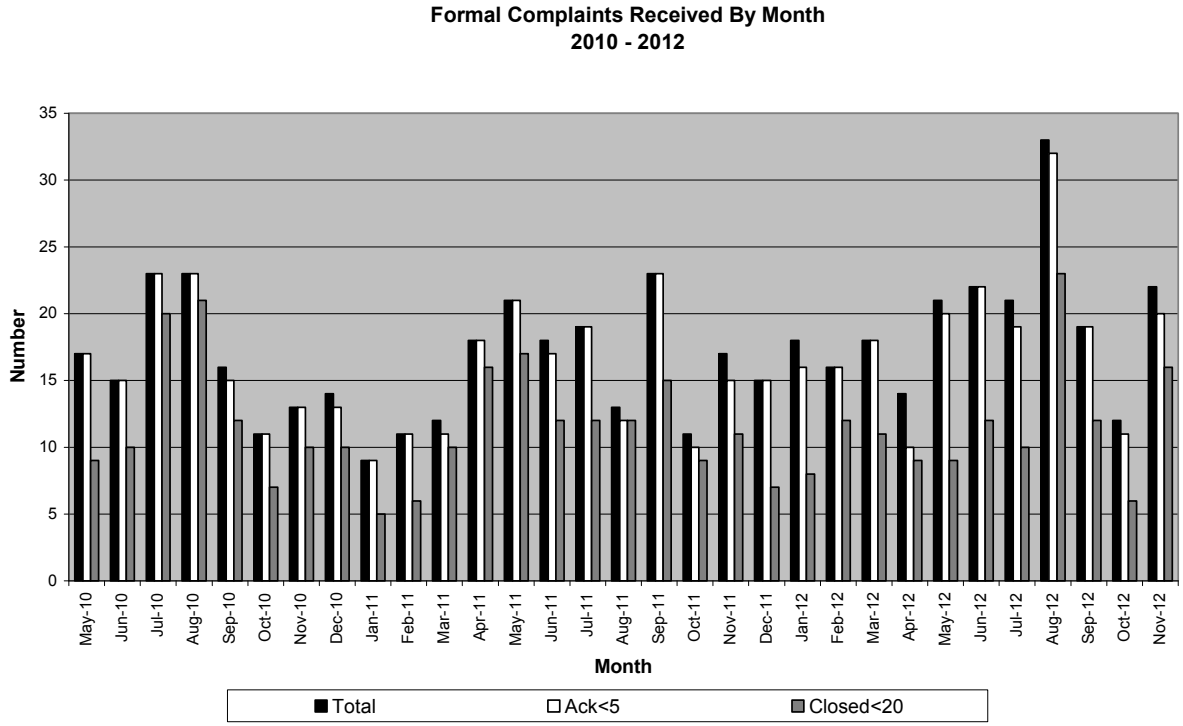
On the last page of the Patient Satisfaction Survey, there is an opportunity for patients to document what they were impressed with, what they were disappointed about and a section for documenting any general comments or suggestions for improvement they might have. A total of 570 comments were received within the December quarter with 408 (72%) representing compliments and 162 (28%) representing complaints. Appendix A outlines the categories and percentage of feedback received from a compliments and complaints perspective respectively.

1.4 Patient Complaints

53 complaints were received during the months of September, October and November 2012 compared to 76 complaints received in the previous three month period. One of the 53 complaints related to a contracted health provider and was responded to via Planning and Funding and one was not patient related.

Utilising the patient satisfaction survey numbers for inpatients and outpatients, the DHB received 28 complaints (0.3%) from the 10,277 outpatients that utilised an outpatient service during this three month period. 23 complaints (1%) related to inpatients and there were 2,224 admitted to hospital during the three month period.

50 out of the 53 complaints were acknowledged within 5 working days and 64% were considered closed within the 20 working day timeframe.



The most common issues captured during these months were as follows:

o Access to service	10
o Attitude of clinical staff	10
o Medical treatment	9
o Delays getting services	6
o Miscellaneous	4

1.4 Health & Disability Commissioner and Privacy Commissioner

Four of the nine events from previous reporting periods are still in progress. The other five events have been closed with applicable actions taken as directed by the Commissioner.

For the September, October and November 2012 period, the Commissioner notified us of three new events. One of these has been closed by the Commission with the remaining two events still in progress.

2 EMERGENCY PREPAREDNESS

2.1 Health Emergency Management Group

The Group continues to progress its work plan with specific focus areas including:

- Reviewing and updating a number of health emergency plans including the Taranaki DHB Health Emergency Plan (HEP), the Base Hospital Emergency Response Plan (HERP) and the Mass Casualty Plan.
- Facility preparedness around backup generator capacity at Hawera Hospital.
- Emergency Operations Centre resourcing and training of the Incident Management Team.
- Engagement of the primary care sector in relation to enhancing emergency response for the Taranaki region.
- The Emergo Train (table-top) exercise focusing on mass casualty management within Base Hospital is scheduled for the 28th February.

3. HEALTH AND SAFETY

3.1 Workplace Injuries or Illnesses

Description	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12
No. of staff injured from the previous month(s)	0	0	1	1	1	0	3	1	2	3	3	3
No. of staff injured this month	0	1	0	0	0	3	0	1	1	0	0	0
TOTAL	**0**	**1**	**1**	**1**	**1**	**3**	**3**	**2**	**3**	**3**	**3**	**3**
Serious Harm	0	0	0	0	0	0	0	0	0	0	0	0

Description	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12
Outcome by end of month												
• Off Work	0	1	0	0	0	2	1	2	1	1	1	1
• Return to Work*	0	0	1	1	1	1	2	0	2	2	2	2

* Return to work incorporates selected hours/selected duties or full hours/selected duties or complete return to work

- Our rate of significant work related injuries ie those requiring time off work and a rehabilitation plan, remains low.

4.0 INFECTION CONTROL

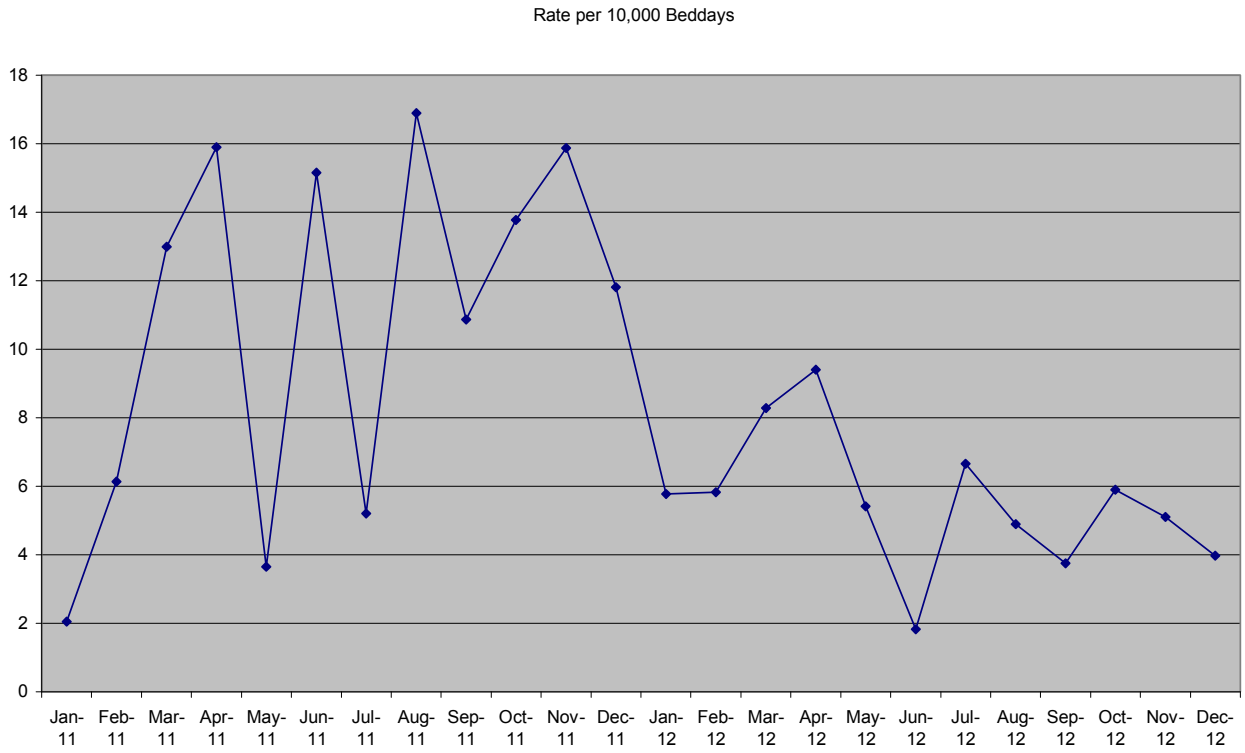
Description	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12
Hospital Acquired Blood Stream Infections	3	3	1	3	3	1	4	3	2	3	0	2
Surgical Site Infections within 30 days post discharge	1	0	2	0	2	5	0	1	3	1	NA	NA

NA - data not available

- There were five Hospital Acquired Blood Stream Infections during October, November and December 2012. Of these five, one patient was suffering from neutropenia (very low numbers of white blood cells). All cases were followed up and monitored by the Infection Control team.
- For the period August to October 2012, five surgical site infections (one emergency caesarian section, one mastectomy, two knee replacements and one other joint replacement) were identified through patient survey. All infections were confirmed by laboratory evidence or hospital staff review.

4.1 Clostridium Difficile Infection

A downward trend of Clostridium Difficile infection occurrence continues as demonstrated below. Monitoring continues.



RECOMMENDATION

That the Quality and Risk Report for October, November and December 2012 be noted and received.

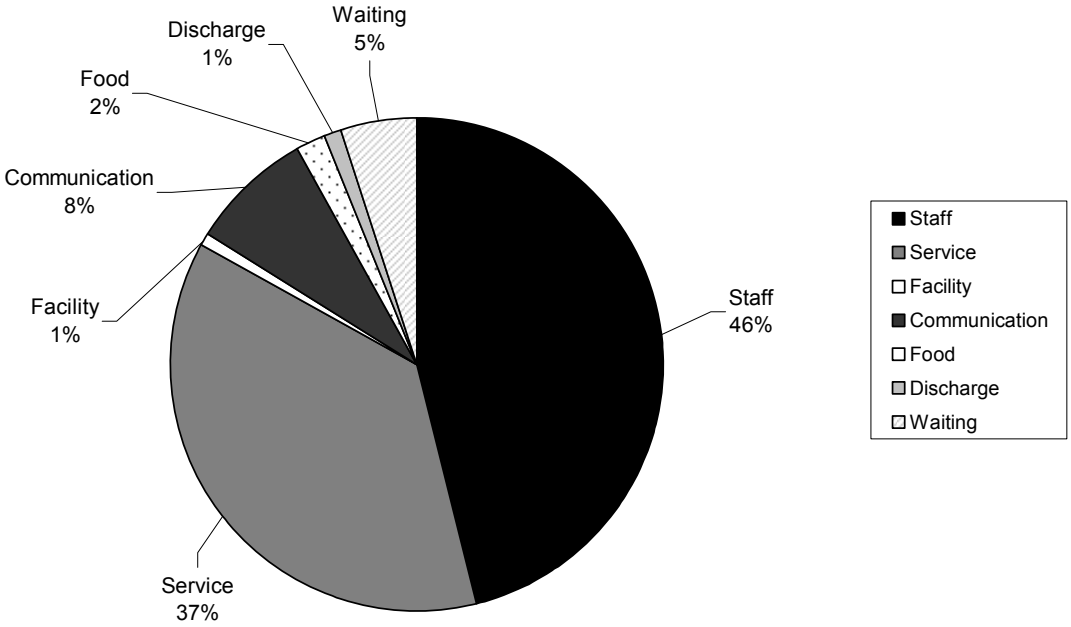
Anne Kemp
Quality & Risk Manager

Appendices

A - Patient Satisfaction Compliments & Complaints Received for the December 2012 Quarter

Appendix A

Patient Satisfaction Compliments 2012-13 December Quarter



Patient Satisfaction Complaints 20112-13 December Quarter