Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**AGENDA** Held on Friday 28 May 2018 Lecture Room, CSSB Building, Wairarapa DHB, Masterton Commencing at 8.30am
HOSPITAL ADVISORY COMMITTEE	**PUBLIC SESSION**

Public HAC Meeting to open at 8.30am

1.	**PROCEDURAL BUSINESS**			**15**	**8.30am**	
1.1	Welcome		R Karaitiana			
1.2	Apologies	ACCEPT				
1.3	Continuous Disclosure Interest Register/Conflict of Interest	ACCEPT / CONFIRM				
1.4	Minutes/Actions of previous meeting	ADOPT				
1.5	Matters Arising					
2.	**REPORTS**			**60**	**8.45am**	
2.1	Quality Report	NOTE	C Parker			
2.1.1	Health & Safety Report	NOTE	C Parker			
2.1.2	Infection Prevention & Control Service Report	NOTE	C Parker			
2.2	Provider Arm Report	NOTE	K McCann			
2.2.1	Communications – 3DHB Falls Programme	NOTE				
2.2.2	3DHB Falls Fracture Model	NOTE				
2.3	Executive Leader Nursing	NOTE	M Halford			
3.	**DECISION PAPERS**					
4.	**DISCUSSION PAPERS**					
5.	**INFORMATION PAPERS**					
5.1	April Dashboard					
6.	**PRESENTATION**					
7.	**LATE PAPERS**					
8.	**RESOLUTION TO EXCLUDE THE PUBLIC**					

Proceed to Public Excluded Session

HOSPITAL ADVISORY COMMITTEE

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Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**MINUTES** Held on Friday 23 March 2018 Room A, Training Centre Wairarapa District Health Board 8.30am
HOSPITAL ADVISORY COMMITTEE	**PUBLIC SECTION**

PRESENT

COMMITTEE

Ron Karaitiana	Chair
Liz Falkner	Member
Nick Crozier	Member
Fiona Samuel	Member

ATTENDANCE

Adri Isbister	CE
Debbie Beech	HAC Secretary
Chris Parker	Executive Leader Quality, Risk & Innovation
Kieran McCann	Executive Leader Integration, Allied & Community
Selena McKay	Executive Leader People & Capability
Vicki Hookham	Associate Leader Nursing

APOLOGIES

Michele Halford	Executive Leader Nursing
Tom Gibson	Executive Director Medical Services
Alan Shirley	Board Member

1.0 PROCEDURAL BUSINESS

1.1 OPENING

Ron Karaitiana opened the meeting of the Wairarapa Hospital Advisory Committee (HAC) at 8.30am with a Karakia.

1.2 APOLOGIES

As noted above.

1.3 CONTINUOUS DISCLOSURE

1.3.1 INTEREST REGISTER

1.4 CONFIRMATION OF MINUTES

The Public minutes of the HAC meeting held on 29 January 2018 were approved as a true and accurate record of the meeting.

HOSPITAL ADVISORY COMMITTEE

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Moved: Ron Karaitiana Seconded: Fiona Samuel

CARRIED

MATTERS ARISING FROM THE MINUTES

Liz asked Adri whether we will be following up with Wairarapa MP's re: the $100k shortage for midwives. Adri advised that there has been lots of change within the Ministry and preference is to keep following the same process. This shortfall has also been discussed with MIF.

Kieran advised that nationally there has been a wider discussion around midwives. Nick asked what is actually happening in Maternity and would like a better picture both nationally and locally as the decisions HAC have to make are based on what the situation is.

Chris noted that there has been drops in Caesar rates – Nick asked why the Caesar rate is what it is and what is the health of our Maternity unit around funding and how to manage numbers effectively? How can HAC help make the delivery of our service better.

Action: Kieran – to put together a report regarding maternity services.

ACTIONS:

Patient Experience Presentation – May HAC.

Norman Gray presentation for May meeting – Tom to follow up with Norman.

Urgent Care Centre: advised no easy fix and one of the issues is that the after-hours service usually refers patients to ED. How do we manage urgent care?

The Committee **RECOMMENDED** Urgent Care Centre go back to WrDHB Board for discussion.

2.0 REPORTS

2.1 QUALITY REPORT

Report to be taken as read with questions by exception:

Complaints / Compliments process – HAC requested more in depth information.

Patient Experience survey – advised data was unable to be extracted and reporting issues due to WebPas

- Nick raised that the participation percentage is low. Chris raised that we our rates were not bad comparatively with other DHBs however, the current goal is4 0% return and long term 60%.
- Fiona raised concerns around the drops all round and the issues in Quarter 4. Asked what reasons management was putting this decline down to. Chris advised this was due a number of issues and part of this may be around communications staff have with patients due to busyness. Need to look at how to get staff engaging with patients.
    - Fiona advised that as a committee we need to keep considering these numbers as the busyness hasn't stopped and is having significant impact on the patient experience. Adri advised that any applications for extra nurses have not been declined and noted that the busyness has been relentless. However there is no easy answer, it's about culture, listening.

HOSPITAL ADVISORY COMMITTEE

PUBLIC

- It's also clear that the volume and workloads have been unusual and this is an issue. Agreed that this needs to be looked at further if it is a continuing trend. The health sector as a whole needs to be looked at as nationally staff are under pressure.
- Kieran advised that we also need to understand where this is coming from – what areas, where is it more prevalent, is it due to waiting in ED, waiting for surgery etc. We need to take a snapshot and see what the patient loads, workloads etc were like at that particular time.
- Liz asked if there were other areas of concern that could be looked into at the same time.
- Ron raised that we have national benchmarking but have not formalised local trends and this would give us the opportunity to understand cohorts coming in. Noted this was dependant on when this data would be collected ie; the time of the year.
- Chris raised that complaint numbers reflect what was happening and Adri noted that we also received staff compliments too at the same time.
- Fiona raised that communications are part of nursing competencies and need to look at this as a system not individuals. Notes this is part of the job but do nurses have time to do this part of the job and is this indicative of a pressured staff, health system etc.
- Nick advised the importance of knowing what's driving these figures, not just seeing the data but to understand why is it happening, what's the feeling, etc.
- Vicki raised that we continue to drop in ALOS but we are not keeping up with the "churn" and missing the work that needs to be done in the middle. Practices haven't changed to keep up with the changes in healthcare.

Fiona raised the Wairarapa Times Age article regarding resus skills lacking and advised the importance of HAC being briefed as the report had not been to HAC as yet. Also noted that this article was hard on staff who were seeing this report. Adri advised that she was unware of the article prior to seeing it in the paper.

- Kieran advised that training for SMOs is monitored.

ACTION: Chris to write a paper re: What benchmarks are there and what quality improvement capabilities do we need to develop in this organisation as a result.

The Committee **RECOMMENDED:** HAC receive a paper for SAC 1s prior to this information going public.

2.1.1 Health & Safety Report

HOSPITAL ADVISORY COMMITTEE

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- 0.4 Emergency Preparedness Coordinator has been appointed.
- Kieran gave assurance that there are lots of detailed pieces of work going on for Manual Handling and equipment, training etc. have been actively progressed.
- Chris advised going forward the risk register will be separated around training and to be more specific around where the risks are.

2.1.2 Infection Prevention & Control Service Report

2.1.3 Appendix A: Document summary reports for HQSC Projects

- Rachael was asked to look at the information required for HQSC projects / reporting. This report notes there is a large component of manual work that has to be done to meet the reporting demands. HQSC is listening to feedback from the hospitals regarding the huge amount of compliance data that needs to be collected for these reports.
- Discussed audits and the reality of staff on the floor to be able to do these audits. How do we ensure this audit work is done alongside of delivery of patient care?

The Committee **RECEIVED** and **NOTED** the reports.

2.2 PROVIDER ARM REPORT

- Kieran apologised for the lack of information and advised this was currently not available due to the change to WebPas. HAC noted the lack of detail in the current report but acknowledged the gaps were due to WebPas.
- Raised the requirement for the Clinical Board to provide a report and a level of assurance to HAC around effectiveness and quality of clinical care.

The following points of note in this report were raised:

- Financials: ACC may be around WebPas
- Staffing costs: Clinical, non-clinical and supplies are broken down in report
- Activity data: Kieran flagged concerns around ESPI performance but notes that we do not have enough information to be able to give definitive reasons but acute workloads are a big driver. There have been discussions with the Ministry around ESPI compliance and we are working on a plan with MoH. HAC will receive a detailed copy of this plan.
  - ESPIs 2 and 5 are RED.
- MRI waiting times: anticipated start to return to wait times for March. Now at 47% however we do have big challenges around radiology provision, as there will be a dramatic shortage of Radiologists until June. Currently meeting with radiology staff and physicians around wait times.
  - Fiona asked if there is anyone else who could do this work for us. Kieran advised there is no one in the region but that we are also checking regionally.
- Ultrasound: is an at risk workforce. Kieran is monitoring and actively working with specialists to manage and look at alternative treatments.
  - Fiona asked if Dr's are asking patients to go private if they have insurance and if not, should this be done? Kieran advised we are working with clinicians around service constraints and asking clinicians to advise patient to consider alternatives if appropriate.
  - Working with clinicians and considerations for the level of people who self-fund or have insurance to go privately should be part future planning.

- Adri advised this could also assist with Ophthalmology patients. However, Kieran advised that he is not aware of third party data available for these services unlike orthopaedics submit to the National Joint Registry.
- Ron raised the vulnerable community and that there are subsidies available for these people but concerns around how to fund their care in different places.

- Liz asked about the cost of air ambulance to Wellington. Kieran advised it is between $3 – 5K each and that these costs are currently being looked at in detail. We are getting tighter around these payments and pushing back on some of these costs where we can.

Action: Kieran to provide HAC with an expanded report and to have a separate Nursing and Medical report for the next committee meeting.

Action: Management to provide ongoing advice regarding possible impact from lack of patients using private services regarding pressure on Hospital services

The Committee **RECEIVED** and **NOTED** the report.

3.0 DECISION PAPERS

4.0 DISCUSSION PAPERS

5.0 INFORMATION PAPERS

6.0 PRESENTATION

7.0 RESOLUTION TO EXCLUDE THE PUBLIC

RECOMMENDATION

IT IS RECOMMENDED that the Board **AGREES** that Public be excluded from the following parts of the of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 ("the Act") where the Board is considering subject matter in the following table.

The grounds for the resolution is the Board, relying on Clause 32(a) of Schedule 3 of the Act believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists under the Official Information Act 1982 (OIA), in particular:

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the 16 June 2015 Board Agendas	
Quality Report, Medical Services Report, Financial Narrative report, 3DHB MHAID reporting, RPH report and sensitive information	Papers contain information and advice that can identify individuals, or is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	Section 9(2)(i)(j)

HOSPITAL ADVISORY COMMITTEE

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MEETING CLOSED AT: 9.33AM

Date of next meeting: Monday 28 May 2018

DATED this day of 2018

RONALD KARAITIANA
Chair, Hospital Advisory Committee
Wairarapa District Health Board

HOSPITAL ADVISORY COMMITTEE

PUBLIC
HAC ACTIONS

MARCH 2018 – ALLOCATED TASKS
PUBLIC MEETING HAC

ACTION ITEMS

Carried over / Transferred

Current

Future

Completed

		Action	Responsible	Meeting date	How Dealt with	Delivery date	Date Completed
23.3.18	Maternity Services	Kieran to put together a report re: maternity Services	Kieran	28.5.18			
23.3.18	Provider Arm Report	Expanded EL Operations report and to feedback with comments from Nursing and Medical.		28.5.18			
23.3.18		Management to provide ongoing advice regarding possible impact from lack of patients using private services regarding pressure on Hospital services	ELT	28.5.18			
29.1.18	Patient Experience Presentation	Quarterly presentation to HAC.	Kieran / Clare	29.1.18			Ongoing – quarterly
29.1.18	Norman Gray Presentation	Request that Norman Gray present to HAC – re: his fact finding visits to communities similar to WrDHB	Tom	~~23.3.18~~ 28.5.18			
29.1.18	Acknowledging staff achievements	HAC to acknowledge staff in the minutes and request acknowledgement noted in newsletters	Ron / Deb	Ongoing			
~~29.1.18~~	~~Urgent Care Centre~~	~~HAC to discuss with the Board HACs function and how HAC can assist with moving on with Urgent Care.~~	Ron	**CLOSED**	For Board to discuss		

HOSPITAL ADVISORY COMMITTEE

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HAC ACTIONS

PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**HAC INFORMATION PAPER** **Date: 7 May 2018**

Author	Chris Stewart, Executive Leader Quality, Risk and Innovation
Endorsed By	Adri Isbister, Chief Executive, Wairarapa District Health Board
Subject	**Wairarapa DHB Quality Report for Hospital Advisory Committee (HAC)**

RECOMMENDATION:

It is recommended that the Wairarapa DHB Hospital Advisory Committee:

a. **NOTES** the report for March and April 2018.

APPENDICES:

A. Health, Safety and Preparedness Report
B. Infection, Prevention and Control Report

1. INTRODUCTION

As a DHB we are working towards meeting our quality goals by working together at all levels of the DHB to achieve patient centred care, openness and transparency, learning from error or harm and ensuring that the contributions of staff for quality improvement and innovation are truly valued. All of our goals are in line with the triple aim outcomes, national and regional priorities as identified by the Health and Disability Services Standards, Health Quality and Safety Commission, Regional Services Plan and the Wairarapa DHB Annual Plan.

2. CONSUMER VALUE (PATIENT EXPERIENCE)

Focussing on consumer value encourages our DHB to involve our communities in improving current performance and planning for the future, and to achieve improved health outcomes and equity for our population. We receive consumer information through our complaints and compliments feedback and the National Patient Experience Survey.

WrDHB Annual Plan 2017/18 includes the Planning Priority “Improving Quality” which requires planned actions on how to improve patient experience as measured by HQSC’s national patient experience survey. WrDHB will be focussing on ‘communication’.

a) Compliments and complaints

Compliments and complaints trends /numbers are reported on the WrDHB Dashboard. A more detailed breakdown for March and April is below:

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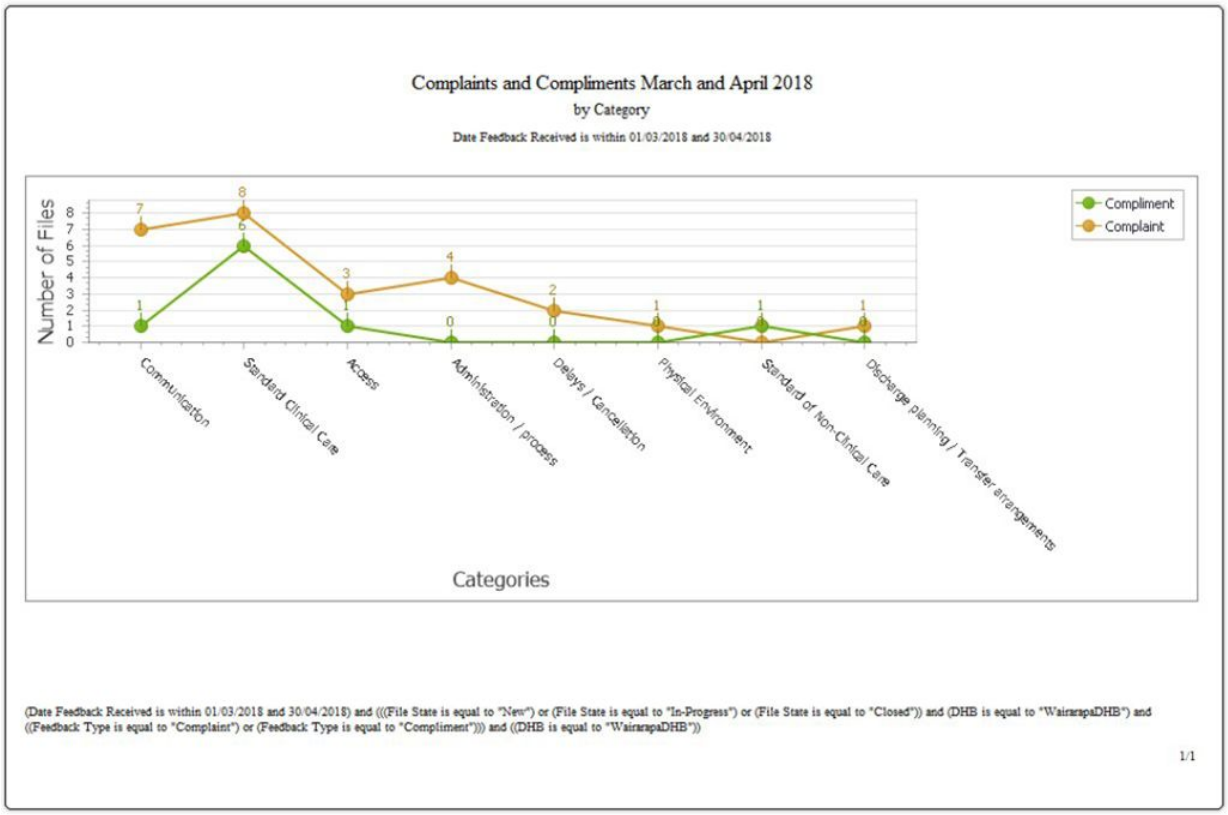
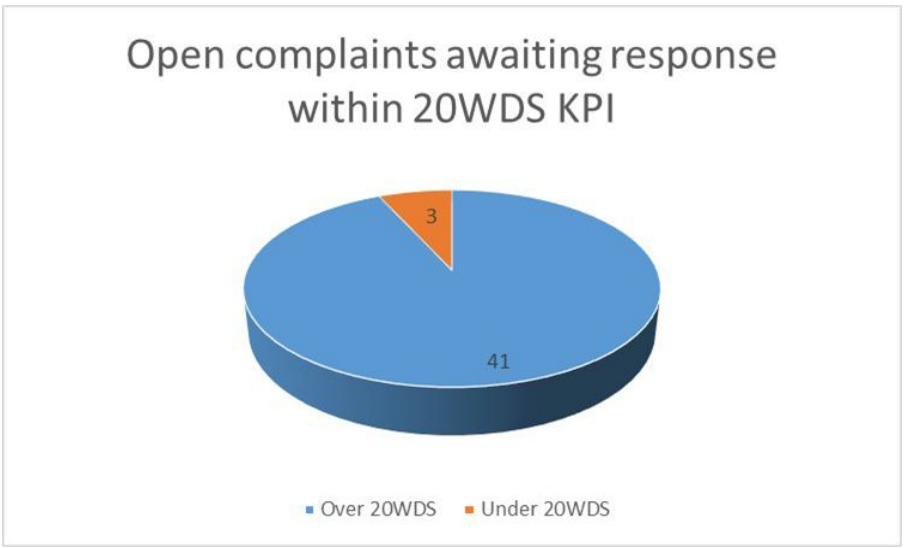
Feedback March and April 2018



- We are again seeing a spike in compliments for the standard of Clinical Care over this period as with the January/February 2018 report period. However Standard of Clinical Care and Communication remain the highest reported complaints for this period and year to date.

Response times for complaints in relation to 20 working day requirement as per HDC guidelines.



It is recognised that the complaints response process needs to be more robust in order to meet the 20 working day timeframe. A reporting system is underway to remind managers of their outstanding complaints.

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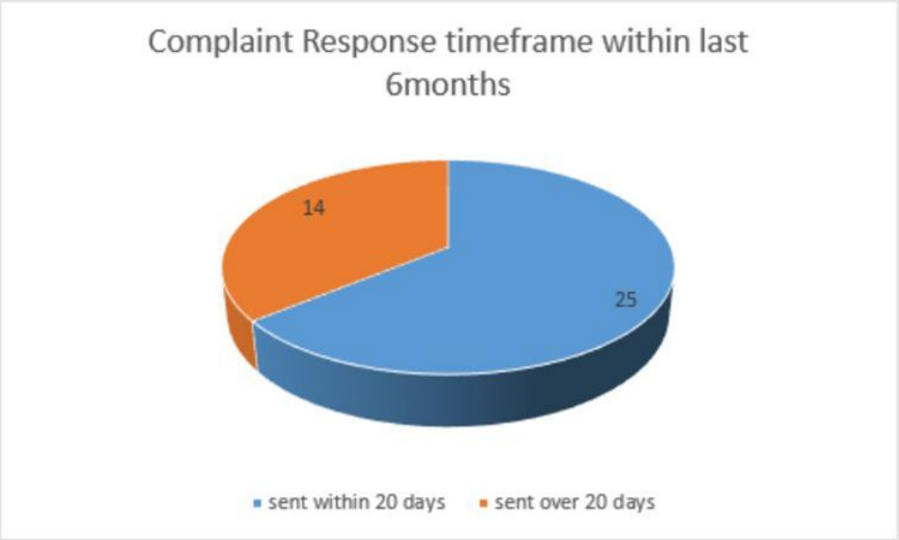

b) National quarterly patient experience survey

WrDHB is required to and has consistently met the requirements by participating and submitting quarterly national adult patient experience survey (adult inpatient's over 15 years of ages, excluding mental health patients) data as part of the MOH non-financial monitoring framework and performance measures report since August 2014.

Cemplicity (www.cemplicity.com) currently holds the contract with HQSC to administer the DHB National Adult In-Patient Experience survey. The benefits of using an external specialist provider is the advanced technology available to collect and report results, access to international 'best-practice' survey questions that are proven to be relevant and national benchmarking.

The process currently involves the Cemplicity system securely accessing data from our Patient Administration System and then cascading invitations via email, SMS and then paper for a period of two weeks prior to the quarterly reporting period.

Cemplicity has upgraded its Dashboard to provide more user friendly reports and align its reporting period quarters and data parameters to allow direct comparison with data from HQSC.

Quarter 3 (HQSC) Jan – Mar 2018 update:

Data was unable to be extracted for the survey round due to the introduction of webPAS. The possibility of a workaround by sending all surveys via paper was considered but unfortunately this process failed to provide the data required. HQSC and MOH were notified at the time and received a report, there are no result showing for Wairarapa DHB in the quarterly report due to this reason.

The next round of surveys is planned for 16th April - 13th May 2018 and all indications to date are that it should be rectified by then.

3. EFFECTIVENESS

Effectiveness focuses on monitoring and evaluation of patient care and performance in relation to our peers to ensure focused quality improvement.

Medication Errors, Patient Falls, Hospital Acquired Pressure Areas data is also reported within the Wairarapa DHB Balanced Scorecard. The accuracy of the data being provided is currently being reviewed. In order for data driven decisions to be made, accurate data needs to be presented. SQUARE, our electronic reporting system which was implemented in April 2016 is where our data is pulled from and this is reliant on timely and accurate ratings being done.

The quality team is currently working on how to maximise the use of the data the system provides and also streamline administration requirements to encourage ease of use for end users. We are in the process of talking with staff as to what does and does not work and will then work on developing a new education package to get maximum gain from the reporting system and data it provides.

HQSC – QUALITY SAFETY MARKERS

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's health care through the national patient safety campaign *Open for better care.* The quality and safety markers (QSM) help evaluate the success of the campaign nationally and determine whether the desired changes in practices and reductions in harm and cost have occurred.

HQSC has a dashboard that presents DHB data from the QSM and Patient Experience reports in one easy to use dashboard. This dashboard is publicly accessible from their website:

HQSC QSM Dashboard

Quality and safety markers national compliance data report includes comparisons with DHB's nationally in regards to QSM for falls, safe surgery, hand hygiene and surgical site infection improvement (SSII)-orthopaedic surgery.

Wairarapa DHB does not perform cardiac surgery and is currently not involved with eMedRec so medication QSM and cardiac surgical site infection QSM will not be commented on but are inclusive of the national compliance update report. Additional new QSM to be implemented this year are pressure injuries, deteriorating patient and opioids and will be reported and commented on in due course.

Summary Report - WrDHB Results

Timely reporting for HQSC continues as required.

Hand Hygiene

- WrDHB overall compliance was 92.5% which put the hospital **first in NZ** for compliance with the 5 Moments of Hand Hygiene.
- Wairarapa rose from 82.1% compliance the previous quarter to 92.5%
- National average for compliance is 84.7%.
- 5 of the 6 DHBs in the Central region achieved the threshold level of 80% compliance with the 5 moments of hand hygiene.
- As a comparison to a similar sized DHB, Wairarapa has been grouped with West Coast DHB. West Coast DHBs overall compliance was 79% for the same period.
- Compliance over time is shown below, with the last quarter provided being Q3 2017. (Please note: Hand hygiene national compliance data is reported 3 times a year; therefore, no data point is shown specifically for quarter 4 in any year)

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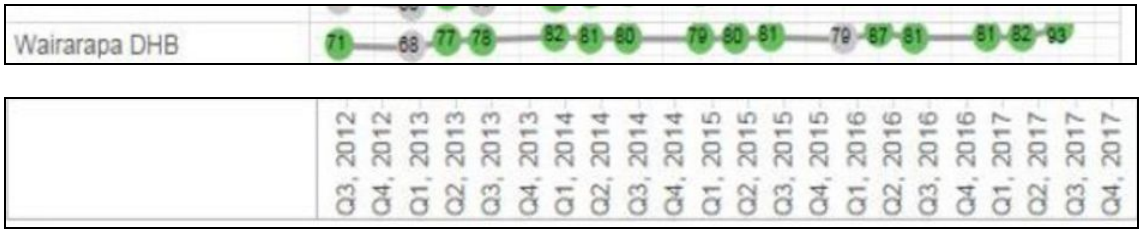

Surgical Site Infection Improvement Programme (SSIIP) Orthopaedic.
Relates to hip and knee arthroplasties.

NB. HQSC uses a 90 day outcome measure for surgical site infection, so the data runs one quarter behind other measures. HQSC reconciled and reviewed historic programme data and changes have been reflected in the October to December 2017 report.

Consistently Wairarapa DHB achieves both QSM for the SSIIP. QSM 1: Antibiotic administered in the right time and QSM 2: Right antibiotic in the right dose. Best practice is embedded in the organisation for reducing SSIs.

Wairarapa achieved **100**% for QSM 1 and **97%** for QSM 2 for the last reporting period.

- Since Q2 2014 Wairarapa has achieved levels of 94-100% for both QSM.
- **100%** was achieved 12 out of 16 quarters for QSM 1.
- Three of the six central region DHBs achieved the threshold of 100% for QSM 1.
- West Coast achieved 100% for QSM 1 and 93% for QSM 2.

The question does remain as to the value of the approximately 10 hours a month that is spent manually collecting this data and if the Infection Prevention Control Clinical Nurse Specialist could utlilise the time more effectively reviewing other meaningful data at a local level that could lead to other quality improvement activity.

Falls

- The WrDHB QSMs for falls for Oct– Dec 2017 were met; QSM 1 (% of patients aged 75 and over (Maori and Pacific Islanders 55 and over) who received a falls risk assessment. We achieved **99.2%,** this is above the national target of 90%.

- Four of the six central region DHBs achieved the threshold level of 90 % for QSM 1.

- West Coast attained 97% for QSM 1 and 91% for QSM 2.

- For QSM 2 (% of patients being at risk have an individualised care plan which addresses their falls risk, WrDHB reached a result of 82%. This slightly increased from the July- September 2017 reporting period of 80%.

- The results for QSM 2 are to be discussed at the next Falls Committee meeting with a proposed plan of action to be generated as to how locally we can improve this figure.

- The new admission to discharge planning booklet educations sessions will be an opportunity to remind staff of the requirement for this.

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- Of interest for the year 01 January 2018 – 30 April 2018 Wairarapa DHB has had 38 falls reported, comparable to the 36 within the same time frame in 2017. The majority were unwitnessed falls.

- Please see the table below of national in-hospital falls resulting in a fractured neck of femur. The central region DHBs of which includes Wairarapa, Hawkes Bay, Capital and Coast, Whanganui, Hutt Valley and Mid Central is in parentheses( ).

Measurements	Year ending Dec 2012	Year ending Dec 2017
Falls resulting in a fractured neck of femur	105 (17)	65 (13)
Falls resulting in a fractured neck of femur per 100,000 admissions aged 15 and over	13.3 (11.1)	7.3 (7.6)
Cost of fractured neck of femur ($m)	4.9 (0.8)	3.1 (0.6)

- Reported in the HQSC website Wairarapa last had an in hospital fall causing a fractured neck of femur in June 2017!

Safe surgery

- This is the sixth report for the safe surgery QSM, which measures levels of teamwork and communication around the paperless surgical safety checklist.

- There was no available data reported for Wairarapa for the Oct-Dec 2017 due to us reviewing the value of continuing to use the electronic collection tool that has previously been paid for by HQSC that we now need to fund ourselves. We have continued to collect manually in the interim for assurance purposes, however have decided to go back to an electronic version for the time being – this comes at a cost of $3000 per annum

4. INFECTION CONTROL

The March and April report is attached - please refer to Appendix B.

5. HEALTH AND SAFETY AND PREPAREDNESS

The Health and Safety and Preparedness report is attached - please refer to Appendix A.

6. RISK

The Wairarapa DHB SharePoint Risk Register is being used in the interim for risk reporting until CCDHB, HVDHB and WairDHB can access the risk register component of the upgraded reportable event system SQUARE for risk reporting.

Risk review is a standing item on the ELT agenda at the second meeting of every month where new risks are assessed and RAC rating agreed on, sign off on closed risks occurs and active risks are reviewed as per organisation policy.

A summary of the current risk register is provided in the Public Excluded Quality, Risk and Innovation Report.

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Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**HAC INFORMATION PAPER**
	Date: 1 May 2018

Author	Dianne Mazey, Health, Safety and Preparedness Coordinator
Endorsed By	Chris Stewart, Executive Leader Quality, Risk & Innovation
Subject	**Health and Safety and Preparedness Report**

RECOMMENDATION

It is recommended that HAC note the information in this paper.

PURPOSE

To update the Health Advisory Committee on significant:

- Health, safety and emergency preparedness risks within WrDHB
- Leading and lagging strategies to address health and safety hazards/risks
- Initiatives and improvements
- Significant trends in event reporting.

BACKGROUND

The role of Occupational Health & Safety is to support a progressive and continuous improvement philosophy within the WrDHB by providing health and safety advisory services and facilitating change aimed at improving the work environment to reduce risk.

1 INITIATIVES AND IMPROVEMENTS

- **Mass Casualty training video developed:** This training video has been developed for Acute Services Staff following on from the drafting of the new Acute Services Mass Casualty plan and is pre-requisite viewing prior to participation in the upcoming Mass Casualty exercise Pahi.
- **Emergency Management audit of critical supply storage.** This audit has led to the securing of supplies to shelves in Acute Services and the review of storage of sterile packs in Periop leading to the investigation of feasible options for securing these during seismic events.
- **UCOL Students** incorporated into upcoming Mass Casualty training exercise "Pahi" (bus). A collaborative initiative aimed at providing additional learning opportunities for this group whilst utilizing them as participants within the exercise.
- **An independent hazardous substances site audit** has been scheduled for the hospital campus.

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2 POSITIVE PERFORMANCE INDICATORS

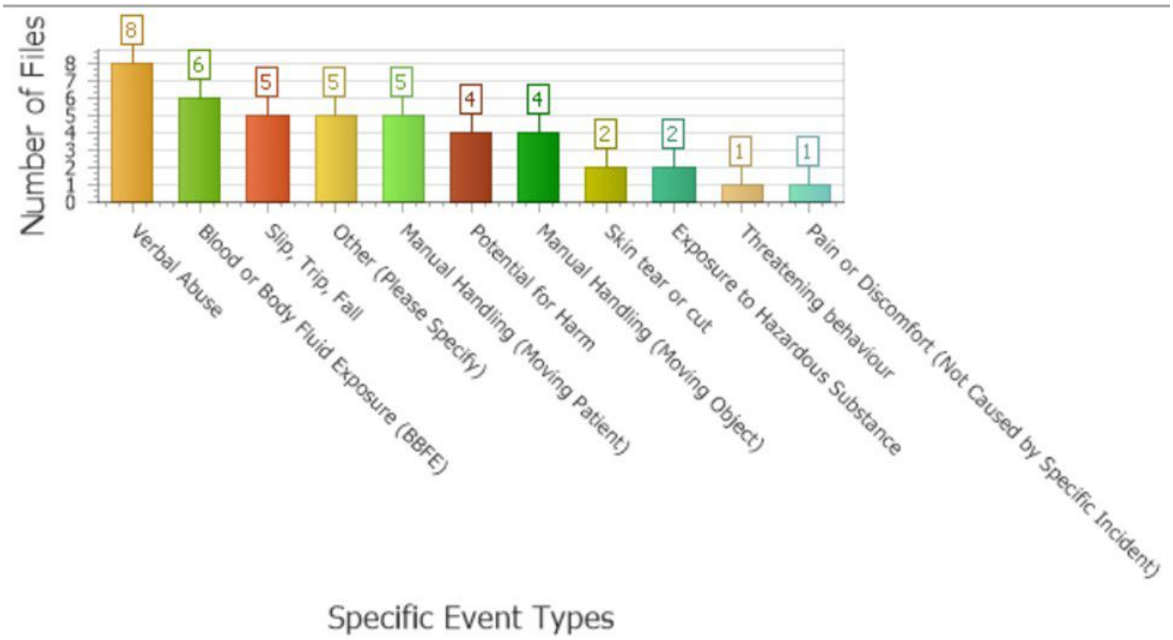
- **New Health and Safety Representatives** have been inducted in both Health Records and Maternity.
- **Work Well Assessor Training** attended at HVDHB by WrDHB Health Safety & Preparedness Manager and a Regional Public Health Advisor, to review for possibility of implementation at WrDHB.
- **Specialised Training** delivered on Health and Safety and Emergency Preparedness.
- **Police Liaison Committee** meeting held.
- **WrDHB Health and Safety Advisory Committee** meeting convened April 2018 and included education topics:
    - violence and aggression towards healthcare workers
    - the WrDHB staff engagement survey, purpose and promotion
    - the new national 24/7 cell phone mental health support initiative “Need to Talk” which aims to provide free mental health and addiction support to those who text or phone in.

3 NOTIFIABLE EVENTS SINCE LAST REPORT

- Nil.

4 STATISTICS - REPORTABLE EVENT DATA YTD

Staff & Others Heatlh and Safety Events by Specific Event Type - Year to Date 2018



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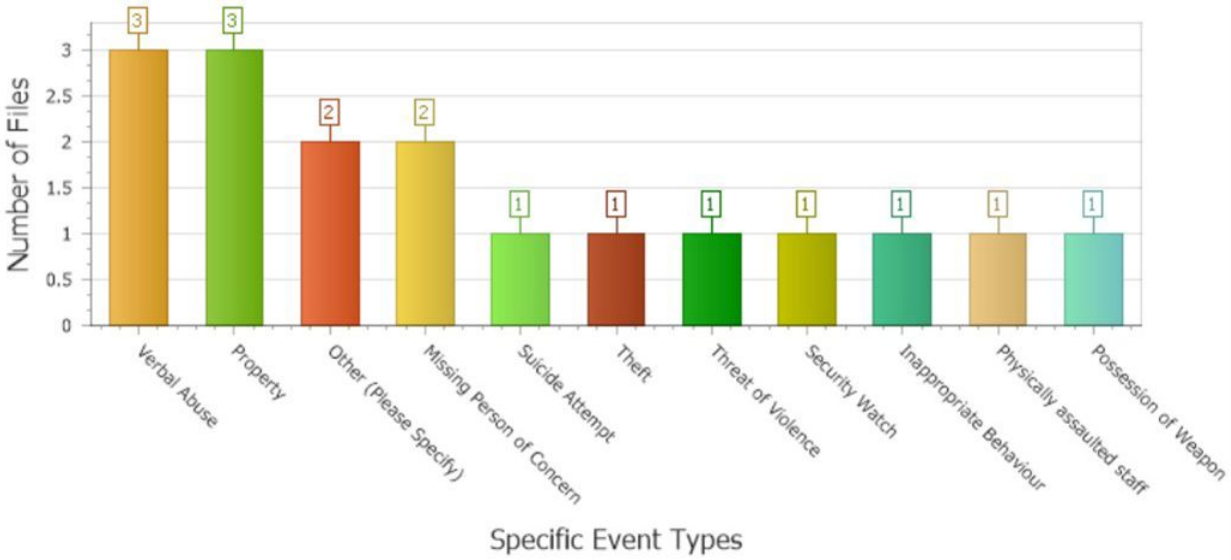
Safety/Security Events by Specific Event Type – Year to Date 2018



5 HAZARDS OF SIGNIFICANCE (NEW, EMERGING OR REQUIRING ESCALATION)

Manual Handling

The limited manual handling programme within the DHB remains a hazard.

- Review of manual handling training options, e.g. on-line modules is underway
- A state of the art bariatric bed has been sourced and is currently being trialled within the hospital
- Capex proposal for additional electric beds has been submitted

Night Security

Following discussion with the DHB Security Lead Kate Sheridan, a group has been formed to review Security events and will run parallel to the Police Liaison group chaired by the Health, Safety and Preparedness Manager. As a first piece of business of this newly formed group it has been requested a review of night security be undertaken and all available data in relation to night security is currently being collated and reviewed for formal presentation back to Kate Sheridan.

Verbal Abuse

Information has been provided to the Communications team on the "Your Choice of Treatment" campaign which will be displayed on the new hospital electronic information screens. This campaign provides a clear statement that "We are here to help you at Wairarapa DHB so let us get on with our jobs free from abuse, violence and aggression and if you don't, we'll call the police. It's your choice of care."

6 GENERAL

An ongoing review of emergency management equipment has led to the additional review of the DHB's emergency air-shelter and implementation of a structured layout plan for rapid set up and identification of equipment to facilitate this set up.

Infection Prevention and Control Service HAC Report May 2018 Covering: March/April 2018	Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa
Nurses: Lizzie Daniell Medical Staff: Matthew Kelly	

Standard 1 Managed environment:

- Matt Kelly to speak at Theatre meeting on cleaning on 18/5/18, IPC Committee will meet that day.
- IPC initiative for vaccinating AT&R inpatients with seasonal influenza vaccine progressing. Education session with District Immunisation Facilitator Tina Brady had to be postponed to 21/5/18 due to ill health. Checklist has been developed:

  Fluvax checklist for AT&R inpatients.doc
- ARC Facility Lansdowne Court have had a gastroenteritis outbreak, causative organism confirmed to be Norovirus. Declared over on Tuesday 24/4/18. Admissions from Lansdowne Court isolated until 48 hours without symptoms.
- CNS IPC to research if the Standard AS4381:2015 on Surgical Masks applies in NZ.
- Planning promotion of World Hand Hygiene Day 5/5/18, liaising with Comms.

Standard 2 Adequate IPC resources:

Standard 3 Policies and Procedures:

- Some feedback received for annual review 2015 – 2018 IPC Programme, has been reviewed and to be added to the Programme (Programme available on Sharepoint IPC site).
- CNS IPC working on implementing Quality Guideline on management of Patient Fridges.
- Ongoing work on Pandemic Planning: Brent Hollow (Emergency Preparedness) met with Matt Kelly and Lizzie Daniell on 26/4/18.

Standard 4 Education:

- HQSC Workshop on May 17th "Putting prevention first, leadership and action on preventing healthcare associated infections", to be held at Te Papa 9am – 4pm. Registration on https://ppf2018.lilregie.com or katie.monteith@hqsc.govt.nz

HQSC Workshop 17 May 2018.pdf

- IPCNC National Conference to be held in Lower Hutt 31st October – 2nd November 2018. Registrations are open to members and non-members of the IPCNC (NZNO) and will be opening in June. The theme is "Learning from the Past, Looking to the Future".

IPCNC Conference 2018.pdf

Standard 5 Surveillance:

2018	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	2017	2016	2015	2014
mMRSA	0	0	0										0	6	9	6	1
ESBL E.Coli	1	0	2										3	10	21	8	6
ESBL Klebsiella	0	0	0										0	1	1	0	
C difficile	1	0	0										1	6	4	9	13
CLAB	0	0	0										0	0	0		
HASABSIs	0	1	0										1	1	1	4	1
Hip/knee SSI	0	0	0										0	0	0	0	1
Hand Hygiene			90%			%				%							

Comments on Surveillance:

- At date of writing this report (3/5/18) April surveillance statistics not yet available.
- Hand Hygiene audits are done 3 x per year by March 31st, June 30th and October 31st as per HQSC programme.
  Result of Wairarapa Hospital Hand Hygiene auditing compliance for the 5 Moments of HH for 31/3/18 was 90%, putting us first in the country for the second audit period in a row. This was particularly pleasing as it included the 3 new areas to be audited: HDU, Paeds/SCBU & Maternity.
  National Hand Hygiene report for 1/11/17 – 31/3/18:

National hand hygiene compliance

Standard 6 Antimicrobial Stewardship:

- Conrad McCaffrey has just completed Point Prevalence Survey on Adult Antibiotic Use in April 2018, results to be sent to Dr Matt Kelly for review.

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Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**HAC INFORMATION PAPER** **Date: 11 May 2018**

Author	Kieran McCann – Executive Leader Operations
Endorsed By	Adri Isbister, Chief Executive, Wairarapa District Health Board
Subject	**Provider Arm Report for Hospital Advisory Committee (HAC)**

RECOMMENDATION It is recommended that the Hospital Advisory Committee:

NOTES the content of this report

This report outlines the consolidated position for the overall DHB provider services for the reporting period of April 2018.

Wairarapa DHB Provider
Financial Statement for the month of April 2018

Month				$000s	Year to Date				Annual
Actual	Budget	Variance	Last Year		Actual	Budget	Variance	Last Year	Budget
				Revenue					
				Government and Crown Agency					
1	1	0	(0)	MoH - Devolved Funding (Funds arm)	13	13	0	8	16
7	7	0	(0)	MoH - Personal Health	92	75	18	1	90
4	8	(4)	6	MoH - Public Health	41	78	(37)	64	94
69	70	(1)	68	MoH - Disability Support Services	690	701	(11)	694	841
40	42	(1)	13	Clinicial Training Revenue	443	418	25	435	502
63	34	29	36	Revenue From Other DHBs	509	337	172	463	404
210	183	27	128	ACC Revenue	1,639	1,833	(195)	1,902	2,200
(0)	(0)	0	(0)	Other Government Revenue	3	(0)	3	2	(0)
395	346	49	250	Total Government and Crown Agency	3,431	3,456	(25)	3,569	4,147
				Non Government Revenue					
4	5	(1)	2	Patient Revenue	38	46	(8)	42	55
338	336	2	544	Other Income	4,002	3,357	645	3,566	4,029
4,879	4,906	(27)	4,748	DHB Internal Revenue	49,128	49,065	63	48,163	58,878
5,221	5,247	(26)	5,293	Total Non Government Revenue	53,168	52,468	700	51,770	62,962
5,616	5,592	23	5,543	Total Revenue	56,599	55,924	675	55,339	67,109
				Expenditure					
				Employee Expenses					
915	953	38	915	Medical Employees	9,507	9,612	105	8,751	11,608
1,747	1,556	(191)	1,702	Nursing Employees	16,848	15,931	(917)	15,983	19,192
438	439	1	415	Allied Health Employees	4,430	4,494	64	4,266	5,414
82	69	(13)	79	Support Employees	723	699	(23)	695	844
387	410	22	342	Management and Admin Employees	4,009	4,218	209	3,630	5,080
3,569	3,426	(143)	3,453	Total Employee Expenses	35,517	34,955	(562)	33,326	42,137
				Outsourced Personnel Expenses					
294	187	(107)	210	Medical Personnel	2,450	1,870	(580)	2,286	2,244
8	14	7	34	Nursing Personnel	78	142	64	157	170
12	9	(3)	16	Allied Health Personnel	125	87	(37)	117	105
0	0	0	0	Support Personnel	0	0	0	(1)	0
47	32	(14)	37	Management and Admin Personnel	350	321	(28)	503	386
360	242	(118)	297	Total Outsourced Personnel Expenses	3,002	2,421	(581)	3,062	2,905
256	288	33	426	Outsourced Other Expenses	2,764	2,881	117	4,006	3,457
955	857	(98)	875	Clinical Supplies	9,748	8,572	(1,177)	8,154	10,286
773	834	62	713	Non Clinical Expenses	7,642	8,654	1,012	7,463	10,338
3	2	(1)	49	Financing Expenses	943	997	54	1,039	1,924
(1)	(1)	0	(2)	Internal Allocations	(10)	(10)	0	(16)	(12)
5,914	5,649	(266)	5,811	Total Expenditure	59,606	58,469	(1,138)	57,034	71,036
(299)	(56)	(242)	(267)	Net Surplus / (Deficit)	(3,008)	(2,545)	(463)	(1,695)	(3,927)

There may be rounding differences in this report

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The Provider Arm for the year to 30 April 2018 is a net deficit of ($3.0m), which is unfavourable to budget by ($463k).

The key factors contributing to this result are as follows:

Revenue
Total Revenue for the Provider is $56.6m, favourable to budget by $675k.

- Revenues from other DHB's are favourable by $172k, arising from Radiology services $140k and Laboratory tests $22k charged to other DHBs.
- ACC revenue is favourable for the month by $27k, reducing the YTD shortfall to ($195k). Employee related ACC claim reimbursements are $155k favourable YTD, which is offset by labour costs. Patient related recoveries are under budget by ($350k) due to substantially less AT&R revenue ($349k) and small losses across the departments with the exception of additional revenue in Imaging of $62k YTD.
- In Other Income, donations and bequests of $444k YTD, $299k is offset by the cost of a specific pharmaceutical product and a donation from ACC of a "sim man" manikin valued at $120k.
- Focus funding of ($258k) has been transferred to support home and community services within the Funder Arm, along with the associated expenditure. The Pharmac rebates is up on budget by $61k, offsetting some of the additional pharmaceutical costs. Additional revenue received for Bowel Screening returns a positive of $80k.

Expenditure

Total Expenditure for the Provider is $59.6m YTD, an overspend to budget of ($1.1k). In the April month the expenditure was ($266k) unfavourable to budget.

Staffing costs

- Total personnel expenses (employed and outsourced) were ($261k) unfavourable in April, with YTD ($1,144k) unfavourable;

Sub Group Acct Tots	Month Actuals	Month Budget	Month Variance	YTD Actuals	YTD Budgets	YTD Variance
Employee Expenses	**3,568,879**	**3,425,791**	**(143,088)**	**35,516,784**	**34,954,514**	**(562,270)**
Medical Employees	915,095	952,650	37,555	9,506,666	9,612,044	105,378
Nursing Employees	1,746,658	1,555,699	(190,959)	16,848,080	15,931,176	(916,904)
Allied Health Employees	437,870	438,988	1,118	4,429,795	4,493,534	63,739
Support Employees	81,965	68,794	(13,171)	722,890	699,496	(23,394)
Management and Admin Employees	387,293	409,660	22,367	4,009,353	4,218,264	208,911
Outsourced Personnel Expenses	**360,028**	**242,070**	**(117,958)**	**3,002,057**	**2,420,700**	**(581,357)**
Medical Personnel	294,005	186,992	(107,013)	2,449,782	1,869,920	(579,862)
Nursing Personnel	7,512	14,201	6,689	77,727	142,010	64,283
Allied Health Personnel	11,894	8,748	(3,146)	124,880	87,480	(37,400)
Support Personnel	0	0	0	0	0	0
Management and Admin Personnel	46,618	32,129	(14,489)	349,668	321,290	(28,378)
Total Employed & Outsourced	**3,928,908**	**3,667,861**	**(261,047)**	**38,518,841**	**37,375,214**	**(1,143,627)**

Medical personnel expenses, employed and outsourced, were ($69k) unfavourable to budget this month, with YTD at ($474k) unfavourable. Previous reported impacts of the Orthopaedic job sizing is temporarily offset by an additional 1.0 FTE RMO that was phased from November that has yet to be placed. A 0.5 FTE vacancy in Ophthalmology has not been recruited to but remains to offset associated outsourced costs. Higher than budget locums costs were used to cover vacancies in RMO, and provide leave cover in Anaesthetics and General Surgery as well as high on call demand in Mental Health.

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Sub Group Acct Tots	Month Actuals	Month Budget	Month Variance	YTD Actuals	YTD Budgets	YTD Variance
Employee Expenses	**915,095**	**952,650**	**37,555**	**9,506,666**	**9,612,044**	**105,378**
Medical Employees	915,095	952,650	37,555	9,506,666	9,612,044	105,378
Outsourced Personnel Expenses	**294,005**	**186,992**	**(107,013)**	**2,449,782**	**1,869,920**	**(579,862)**
Medical Personnel	294,005	186,992	(107,013)	2,449,782	1,869,920	(579,862)
Total Employed & Outsourced	**1,209,099**	**1,139,642**	**(69,457)**	**11,956,448**	**11,481,964**	**(474,484)**

Nursing Personnel expenses, employed and outsourced, were ($184k) unfavourable this month, YTD stands at ($853k) unfavourable. Additional HCA's (Health Care Assistants) required in MSW and AT&R for patient watches. Excess sick and ACC leave required cover. ACC revenue received as offset is $176k YTD. Additional revenue of $92k was received to cover additional bowel screening nursing staff can be offset, as can outsourced HCA's which are favourable $64k YTD.

Sub Group Acct Tots	Month Actuals	Month Budget	Month Variance	YTD Actuals	YTD Budgets	YTD Variance
Employee Expenses	**1,746,658**	**1,555,699**	**(190,959)**	**16,848,080**	**15,931,176**	**(916,904)**
Nursing Employees	1,746,658	1,555,699	(190,959)	16,848,080	15,931,176	(916,904)
Outsourced Personnel Expenses	**7,512**	**14,201**	**6,689**	**77,727**	**142,010**	**64,283**
Nursing Personnel	7,512	14,201	6,689	77,727	142,010	64,283
Total Employed & Outsourced	**1,754,170**	**1,569,900**	**(184,270)**	**16,925,806**	**16,073,186**	**(852,620)**

Allied Health personnel expenses, employed and outsourced, were unfavourable by ($2k) to budget this month, YTD $26k favourable. Earlier vacancies are being actively recruited to and the services are overall forecast to come in on budget.

Sub Group Acct Tots	Month Actuals	Month Budget	Month Variance	YTD Actuals	YTD Budgets	YTD Variance
Employee Expenses	**437,870**	**438,988**	**1,118**	**4,429,795**	**4,493,534**	**63,739**
Allied Health Employees	437,870	438,988	1,118	4,429,795	4,493,534	63,739
Outsourced Personnel Expenses	**11,894**	**8,748**	**(3,146)**	**124,880**	**87,480**	**(37,400)**
Allied Health Personnel	11,894	8,748	(3,146)	124,880	87,480	(37,400)
Total Employed & Outsourced	**449,764**	**447,736**	**(2,028)**	**4,554,675**	**4,581,014**	**26,339**

Management & Admin workforce, employed and outsourced, $8k favourable for April, YTD is $181k favourable, also due to vacancies and time to recruit to the positions and some roles being covered by other areas.

Sub Group Acct Tots	Month Actuals	Month Budget	Month Variance	YTD Actuals	YTD Budgets	YTD Variance
Employee Expenses	**387,293**	**409,660**	**22,367**	**4,009,353**	**4,218,264**	**208,911**
Management and Admin Employees	387,293	409,660	22,367	4,009,353	4,218,264	208,911
Outsourced Personnel Expenses	**46,618**	**32,129**	**(14,489)**	**349,668**	**321,290**	**(28,378)**
Management and Admin Personnel	46,618	32,129	(14,489)	349,668	321,290	(28,378)
Total Employed & Outsourced	**433,911**	**441,789**	**7,879**	**4,359,021**	**4,539,554**	**180,533**

Other Outsourced Expenses were favourable by $33k in April, bringing the YTD position to $117k favourable;

- Underspends in Focus outsourced service of $302k YTD, due to lower service demand than planned, is offset by the deduction in funding of internal revenue. Radiology is $78k under budget due to lower than budgeted demand for PRL services and slow MRI turnaround at HVDHB. Outsourced

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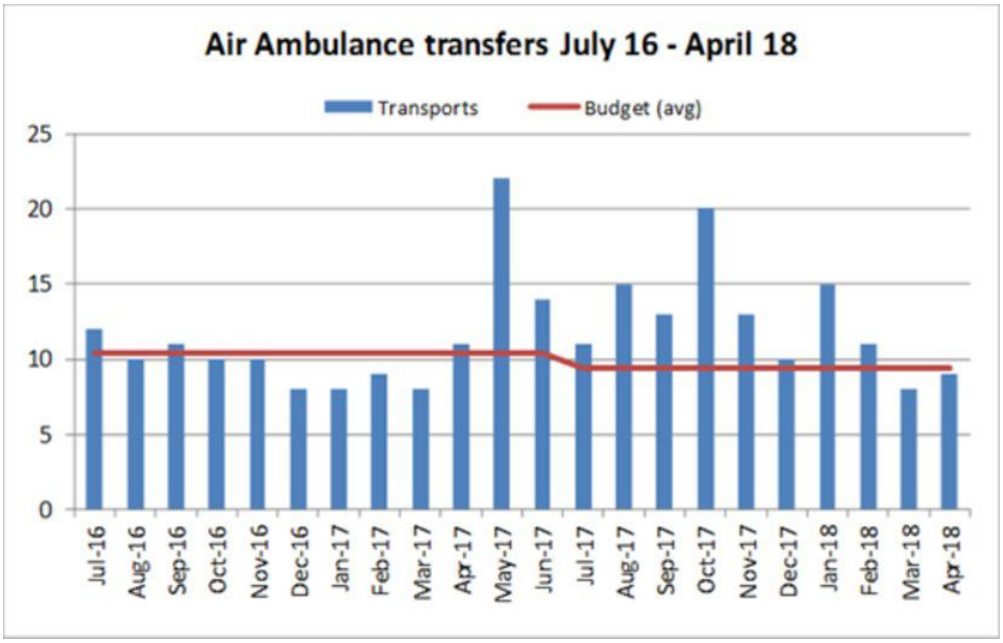
Ophthalmology is overspent by ($169k) in mitigation of non-compliance of elective wait time.

- Non-compliance for both ESPI2 (patients waiting longer than 4 months for a first specialist appointment) and ESPI5 (patients waiting longer than 4 months for surgery) has seen the need to pay some outsourced clinical services more than budget. The penalty for 4 months non-compliance for ESPI's is a 2 month deduction of 5% of total electives funding. Total Electives funding for this year is $2,840,167, therefore the potential penalty is $284k, being a financial risk for the DHB. Results post January 18 are not available due to reporting issues, it is anticipated that the DHB has been non-compliant for both ESPI2 & ESPI5 through to April-18.

Supplies and Treatment Costs

- Clinical supply costs were ($98k) unfavourable for April, YTD ($1,177k) unfavourable to budget;
    - Treatment disposables were overspent on Bloods ($235k) YTD, with Intragram contributing ($190k) of this variance.
    - Implants and prostheses were overspent by ($13k) this month and ($325k) YTD, due to increased acute Orthopaedic activity since November in addition to a higher mix of shoulder surgery with the associated higher average implants cost.
    - Pharmaceuticals are ($43k) unfavourable this month and ($527k) YTD, due to monoclonal antibody drugs, mainly Infliximab which is ($181k) and Aglucosidase Alfa and TPN costs ($321k). This can be in part offset by a donation of $299k for the dispensing of Aglucosidase Alfa and $61k estimated additional PHARMAC rebate recorded in the revenue account codes.
    - Air ambulance were (5k) unfavourable for April returning an overall ($75k) unfavourable YTD, due to more expensive individual transports than planned. Whilst provisional reporting of flight transfer activity reflects budgeted volumes, fixed wing transfers to Auckland and an alternative rotor wing provider for one specific case resulted in higher than average costs.



Non Clinical Supplies

- Non clinical supply costs were $62k favourable to budget for April, YTD is $1,012k favourable;

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- Hotel and Laundry costs are $128k favourable YTD, due to reductions in food and groceries costs and meal volumes $128k, offset by higher than budgeted demand driven laundry costs ($13k) over budget.

- Transport and Travel YTD $62k favourable. Business related travel is underspent by $55k and vehicle maintenance is underspent YTD by $18k.

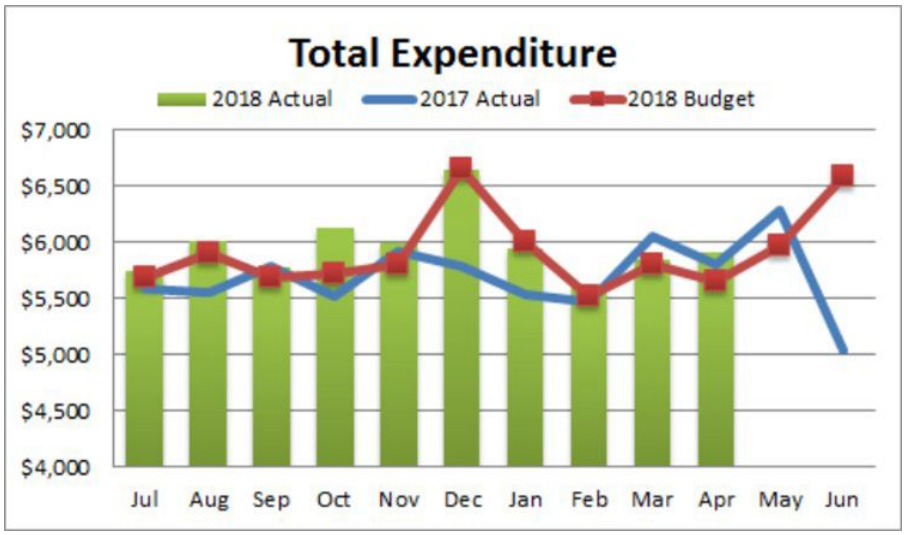
- ITC expenses are $194k favourable due to favourable outcomes for IT rentals $57k, software license fees $59k resulting in part from deferred database developments in Focus, repairs & maintenance costs $32k and telecoms $31k, due to timing/deferral of projects in the business and efficiencies in telecoms.

- Depreciation phasing due to the timing of capitalisation has resulted in a $35k favourable result for the month and $365k YTD.

- Financing Expenses are $55k favourable to budget due to the December Capital Charge calculation coming in under budget.

Graphs of Key Expenditure Items

The following graphs show the Provider Arm total expenditure, total personnel costs (employee & outsourced) and total clinical supplies expense by month for the current financial year against budget and 2017 financial year. Note dollars are in thousands.



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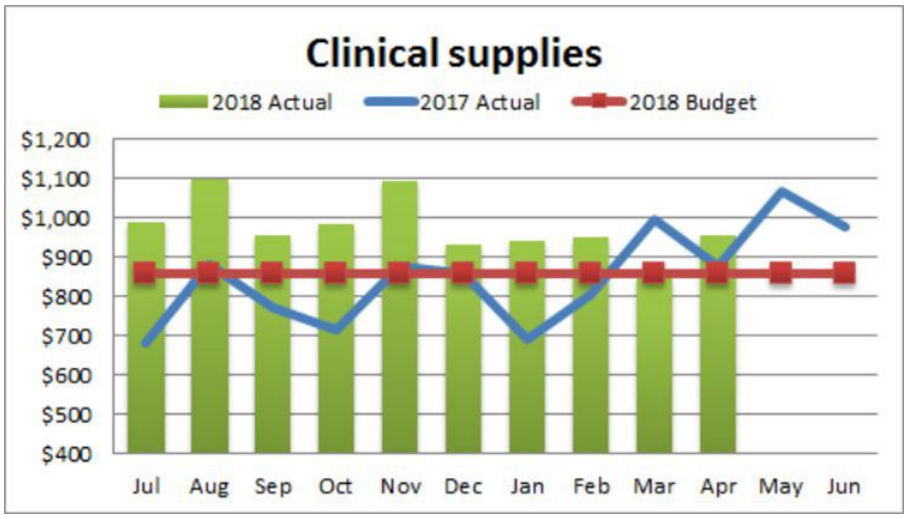

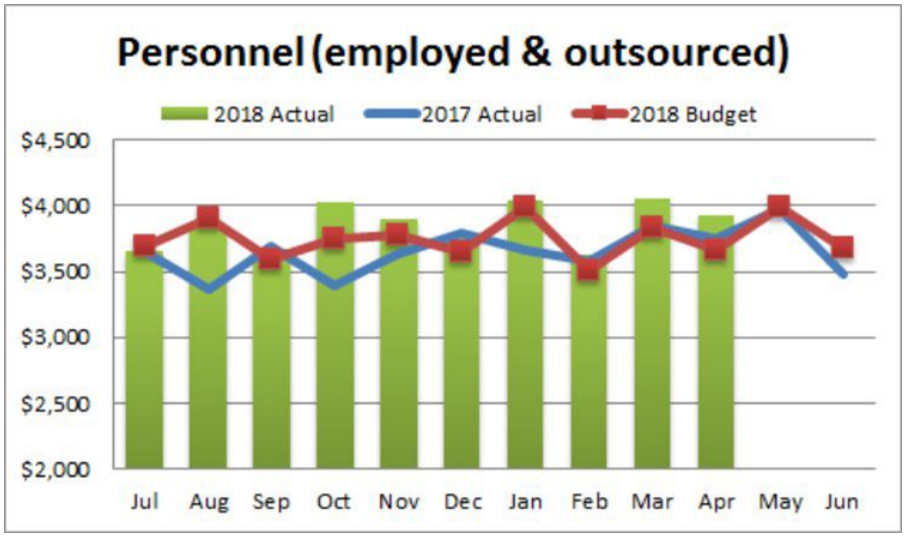

Allied Health, Scientific and Technical Update

ACC Falls contract update

See attached 3DHB falls update communication and the 3DHB model of care.

Since signing the contract in Dec 2017 we have made steady progress on implementing the components of the 3DHB ACC falls contract at a 3DHB and local level. Current activity:

- Recruitment to the 3DHB Programme Manager role (0.5FTE) and the local WrDHB Programme Coordinator role (0.2FTE) is currently underway. This is being led by Compass Health, and interviews will be in the week of 14th May.
- Recruitment to the WrDHB Physiotherapist (0.5FTE) for the in home strength and balance programme is underway, with interviews scheduled for 21st May. The aim is to have the physiotherapist in place by mid – late June, so as we can start delivering volumes from June onwards. The physiotherapist will be based in the DHB physiotherapy team but will work primarily with older adults in their homes, and will liaise closely with primary care to establish this service, including establishing a referral pathway and working alongside the local programme coordinator to promote this service and the overall falls model to primary care.
- Fracture liaison service – Compass have a data analyst working on establishing the framework for the data driven FLS service to primary care. Chris Robinson is the WrDHB contact who is working with

Compass and the other DHBs to ensure the right data streams are linking into this work. The local WrDHB programme coordinator will work with primary care to ensure the info from the FLS service is actioned appropriately by primary care in terms of falls risk management (as per Health Pathways) for older adults identified as a high falls risk following low impact fractures.

- Implementation of ANZHFR Hip Fracture Registry data collection by WrDHB is progressing. This is linked to the #NOF project work Prieur du Plessis is leading. We are aiming to be routinely collecting and entering WrDHB into the hip fracture registry database by June.
- Sport Wellington (lead agency for community strength and balance exercise classes) are continuing to work with local providers to endorse exercises classes in the Wairarapa. To date three providers have been endorsed – class / provider details will continue to be added to www.livestrongerlonger.org.nz as this progresses.

Next steps:

1. Complete recruitment to local roles.
2. Focus on developing referral pathways and programme content and promotion of this to primary care and other potential referral sources (ie. Focus, WFA, home support providers, DHB allied health services).
3. Develop local governance and ensure links with the 3DHB network are sustained, particularly in regards to in home strength and balance volume reporting and FLS development and rollout.

AH leave cover

The business case for AH leave cover was approved by ELT in March. Recruitment to this new 2.63FTE (across 5 disciplines and AH assistants) is underway. All leave cover FTE will be in place by 01/07/18. Progress to date is:

Discipline	Leave cover FTE	Progress
Dietetics	0.21	Discussion underway with current part time dietitian re picking up additional FTE.
Occupational Therapy	0.63	Recruitment anticipated by end of May.
Physiotherapy	0.76	Currently advertised, closing date 16/05/18.
Social Work	0.65	Recruitment complete – Carla Didsbury in post from 30/04/18.
Speech-language Therapy	0.21	Recruitment complete – Ellen Hawke in post from 16/04/18.
AH Assistants	0.18	Discussion underway with Physio and OT Team Leaders re how to best utilise this within the current part time assistants.

We are also looking at how this FTE can be used to best meet winter demand, and early planning is underway re allied health working more proactively in the AAU / front door area.

Calderdale update

- Refer to attached Central Region Calderdale Framework overview.

Wairarapa specific achievements are:

1. A second trainee facilitator (Max Goodall) commenced training in March 2018.
2. Nicky Rivers submitted her final trainee facilitator report in April – waiting to hear the outcome.
3. We have developed a WRDHB Calderdale work plan for the next 12 months to progress work past the service analysis stage. The two projects identified to date are around delegation to assistants of

communication exercises for clients with aphasia, and skill sharing to support implementation of an allied health initial screening assessment in acute services.

AH and WebPas

- Refer to challenges section below.
- We are also working with the WebPas team to accurately use WebPas info for allied health waiting list info – this requires tidying up of data migrated over from Galen as for some disciplines (mainly OT and physio) a large number of very old referrals were transferred over.

CDS update

- Recruitment to WrDHB roles is underway – see details below.
- We will not be in a position to end our SLA with Hutt by 30/06/18 as planned, as transfer of referral management from Hutt to WrDHB WebPas will not be completed by this time. Local admin support is linked to transfer of referral management to the Wairarapa, so these two components will continue to be sourced from Hutt. We will work with IT to get a clear timeframe for completion of this work, and a clear indication of when the SLA with Hutt can cease.
- Discussions are underway re relocation of the CDS office and clinic space from Bannister St to Lincoln Rd, to co-locate with CAMHS, Oranga Tamariki and MoE.

3DHB AHST links

- 3DHB AHST clinical assurance framework – this is now out of draft and in its final version. This will be a very important baseline document for AHST going forward, and implementation of various components of this will shape the majority of quality assurance / professional development work within the AHST teams over the coming year.
- 3DHB allied health documentation policy and audit tool – work continues on finalising this policy, which will replace current documentation guidelines for WrDHB allied health staff. Doc audit is a mandatory component of clinical assurance and implementation of this is anticipated over the coming three months.
- 3DHB AHST strategic plan and actions 2018/19 – work continues on developing and finalising this plan. There will be a WrDHB specific section where we identify local AHST activity that will advance AHST activity locally, in alignment with the sub regional plan.

Quality assurance

- Refer to clinical assurance framework above.
- Conversations have started re introducing a career framework for CSSD – this aligns with work currently happening at Hutt. Conversations are in the early stages and we are currently talking with HR and the PSA prior to discussions with CSSD staff and a formal plan for proceeding.

New opportunities

- Allied health are working with the inpatient rehab team to work out processes for best use of the funding available to support goal focused home rehab programmes – this will support earlier discharge of appropriate rehab clients with a goal directed, time limited home rehab programme.
- Exploring the option of a pilot trial of music therapy in the inpatient rehab unit.

Ongoing activity

- Pharmacy continue to work through E-pharm implementation. This is progressing well, with work underway on entering the 2000+ current stock lines into the E-pharm database. It is anticipated the majority of this data entry will be completed by the next teleconference training session in mid June.

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Challenges

- WebPAS challenges have been significant within allied health, with the extra efforts required to successfully learn and use WebPas being particularly onerous for admin staff and clinicians with OP clinics. The main outstanding issue is lack of AH reporting against PVS (OP and community) and inability to access or use referral management data to support future service delivery work. The process for ACC physiotherapy treatment invoicing is also unclear, and this presents a potential delay in revenue.
  We have been very fortunate to have a dedicated AH WebPas resource with Max Goodall working closely alongside staff to support training and provide a link between the WebPas team and clinicians for problem solving.
- As part of the chemotherapy service pharmacy are now required to handle cytotoxic medications from Mid Central, for clients receiving day chemo via the Mid Central team. This was not identified as part of the chemo service planning, and the requirements and training needed to upskill the pharmacy team in safe cytotoxic handling were not planned in advance. Gail Edwards is working with her Pharmacy Manager colleague in Mid Central to develop local guidelines and staff training is underway.
- Paediatric videofluroscopy (VFSS) remains very challenging, with no ability to access this on site. We have successfully liaised with CCDHB and two children are booked for this procedure in CCDHB in May. This requires the WrDHB SLT to accompany the children to Wellington and work alongside the CCDHB SLT and radiologist during the procedure. The logistics and staffing challenges of this mean children are waiting extended periods (6+ months) for non-urgent VFSS.

Successes

- Recruitment has been successful in a number of teams over the past two months:
  - Oral Health had 3 new dental therapists starting over Feb / March.
  - Social Work welcomed Luana Hohua (1.0FTE paeds and maternity SW) in April, and Carla Didsbury moved from a casual to permanent 0.7 role in May.
  - SLT welcomed Ellen Hawke (0.8FTE) in April.
  - Physiotherapy have recruited to their 1.0FTE vacancy, with an anticipated start date of Aug.
- WrDHB VIP team have been selected to trial a new Delphi tool for completion of MoH VIP audit requirements.

Imaging

The last month has continued to be challenging for the Radiology team with the persistent shortages of Hutt DHB Radiology cover resulting in a significant loss of interventional sessions and ongoing delays. Communications relating to the impact of reduced hot seat urgent reporting of community radiology requests has been provided to primary care providers with only one case where the relevant GP reported difficulty accessing on line provisional reports. Though initial directions form Hutt suggested that there would be no onsite availability until June we have managed to have several days where locum capacity has allowed a restricted number of interventional sessions to proceed.
We have been assured that the recruitment process is well underway with the first of several new Radiologist appointments due to commence in the next six to eight weeks which will progressively restore on site Radiologist to previous contracted levels over the next few months.

There have also been significant delays due to the loss of an Ultrasonographer, this has been compounded by an unusual spike in demand for ultrasound services particularly from Maternity Services. Ongoing discussions regarding more robust prioritisation of requests has been held with midwifery staff to ensure only necessary scans are requested. Additional constraints remain due to lack of appropriate Private capacity and the ongoing ability for the DHB to provide an ancillary private service on a user pays basis for appropriate scanning requests.
It is noted however that we have been successful in recruiting an overseas sonographer form Canada and the process of bringing the candidate over has commenced though there will be ongoing delays

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until the position is in place. This is a significant achievement given the national shortage of sonographers and the pressures on a nationally recognised priority workforce.

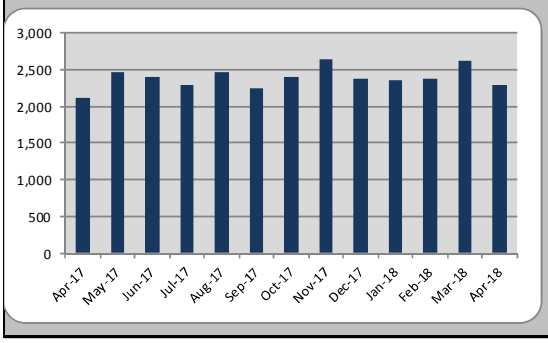
Activity continues to track to broadly to plan and whilst waiting times have continued to be met for CT the ongoing challenges for MRI waits persist due to staffing issues in Hutt DHB.

Key Performance Indicators

April 2018

Referrals

Number of total test done in month

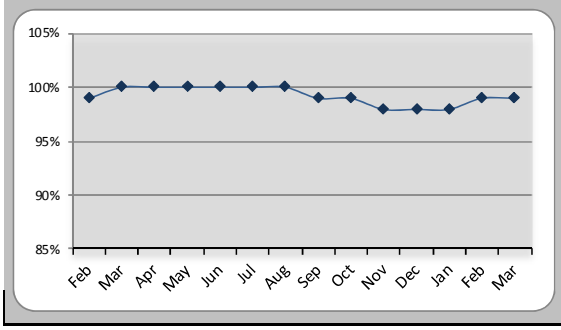


2285

MOST RECENT 6 MONTHS	
Month	**Referrals**
Nov-17	2636
Dec-17	2366
Jan-18	2346
Feb-18	2364
Mar-18	2609
Apr-18	2285

CT Wait Times

Target: 95% of patients seen in 42 days

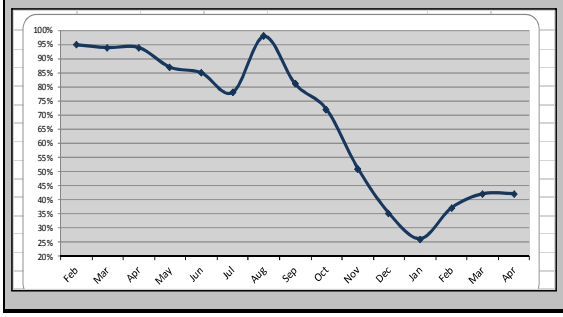


99%

MOST RECENT 6 MONTHS	
Month	**% seen in 42 days**
Nov-17	98%
Dec-17	98%
Jan-18	98%
Feb-18	99%
Mar-18	99%
Apr-18	99%

MRI Wait Times

Target: 85% of patients seen in 42 days



42%

MOST RECENT 6 MONTHS	
Month	**% seen in 42 days**
Nov-17	51%
Dec-17	35%
Jan-18	26%
Feb-18	37%
Mar-18	42%
Apr-18	42%

Operational Updates

WebPAS transition as previously reported has resulted in loss of much of our internal activity and key performance reporting being unavailable. This has caused significant issues in not only reporting and performance monitoring but has also impacted on operational planning. It is anticipated that testing and

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building of new reports and rerunning of existing regular monitoring will commence over the last weeks of May. This has meant that again the key performance reports to inform HAC and Board level dashboards have been absent now for over one full quarter. It is anticipated that a basic level of internal performance reports will be available to inform the next HAC report and Board Dashboard.

The restoration of mandatory reporting for MoH national datasets has now been largely completed and test reports and compliance have been submitted. The challenges associated specifically with regards to planned activity and especially electives is further detailed below.

Elective Services

With the loss of reporting functionality, oversight and management of electives has been mostly absent for the purposes of reporting to Ministry or internally for the management of production since January. Through the diligence and hard work of our staff however we have continued to clinically monitor and plan activity using hard copy information and spreadsheets. Notwithstanding these reporting issues our electives wait times have not been met since then end of last year and consequently large backlogs have been building up. We have significant backlog of patients in Orthopaedics mostly requiring joint surgery who have already waited longer than the target time of 4 months for surgery. There are also significant backlogs in Ophthalmology FSA waiting times. A level of preliminary dispensation from financial penalties for non-achievement of targets from the MoH has been obtained but the ongoing absence of effective reporting data has severely hampered the effective planning for addressing the backlog and maximising any capacity opportunities. In relation to orthopaedics we have in the first instance received an offer from Wanganui DHB to undertake some elective joint replacements to help address some of the backlog. We are currently contacting patients on the waitlist for the purposes of identifying any patients who would consider receiving their surgery at Whanganui. It is also unfortunate that we have in the last week received the resignation of one of our Orthopaedic Surgeons who has accepted an offer for a position at another DHB. This will further create more pressure on capacity for this service. We have approached the Ministry of Health regarding some analytical support and guidance regarding some longer term capacity planning for our overall Orthopaedic coverage in lieu of a growing and aging population.

A full review of elective process in currently underway stemming from the persistent challenges in meeting waiting times that has been evident for the last six months or more. A of service by service review of elective processes has already started to highlight some key areas of process inconsistency and planning gaps that will be contributing alongside acute demand to failing to achieve targets. This work will align well to the imminent national NPF programme which is currently underway. We have been most fortunate to have had good support engagement from our senior medical staff particularly across the surgical disciplines and anaesthetics to assist us in planning and seeking optimal throughput and productivity to contribute to addressing our growing demand. One of our surgeons has further agreed to chair our Surgical Management Group and on restoration of reporting information we will be in a position to provide useful information for decision and planning. As a first step we will also seek GP input into this group to ensure that our improvements start at the very beginning of our patients' journey when patients are identified as possible surgical candidates and referred for assessment. Removing unnecessary barriers and optimising our patients prior to referral will likely greatly assist in shortening waiting times and improving care for our community

Endoscopy Services

There are also some emerging challenges arising from the significant increase in routine and semi urgent colonoscopy referrals. These are likely to be attributed to the recent screening programme and the heightened public awareness of bowel cancer. Whilst a level of increased coincidental demand is always anticipated with screening programmes the volumes in relation to colonoscopy have been much greater than anticipated. These volumes are shown below and will be discussed in further detail at the Board Workshop when the NBSP will present on the roll out in the Wairarapa.

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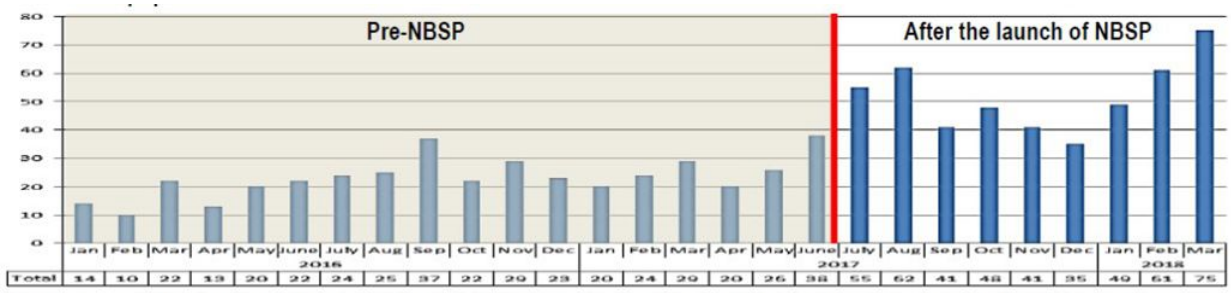

Figure 4 Colonoscopy referrals before (shaded) and after the launch of NBSP (unshaded) in the Wairarapa region. The red line marks the launch of NBSP in July 2017.

In light of this burgeoning demand and the pressure on meeting waiting timeframes we have commenced exploring the potential for weekend and additional endoscopy lists and also exploring potential capacity at other DHBs. Whilst it is expected that over the coming year or so the level of referrals will drop back it is highly likely that the aging and growing population will leave a residual lasting increase in demand that will require a more sustainable capacity plan

Winter Planning

We have been active through the acute communications forum whereby we have a broader sectoral group who look across the wider health system for acute admission avoidance and health wellness over winter for our community.

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In addition to this we have undertaken three major action points to provide some advance Hospital planning and capacity to manage winter demand surges,

- **Staff Flu Vaccination**

  This year has seen an increased focus on promoting flu vaccination for staff as a critical step in reducing the impact of flu on patients and staff and reducing staff sickness due to influenza. An increased availability of mobile vaccinations and repeated messaging has already seen improvement over previous year's uptakes. There are on-going focused initiatives to continue to increase the uptake.

Employee Group April 2018	**%**
Allied Scientific & Technical	81%
Medical Staff	52%
HCAs	36%
Midwives	52%
Nurses	62%
Other	50%
Overall staff flu vaccination coverage	**60.1%**

- **Extended DPU hours**

  We have also worked with our staff in DPU to extend the hours of operation over the winter months. This will enable some patients for whom full recovery form interventions and procedures extended past the closing point for the unit. These patients where then admitted into inpatient beds adding to capacity pressure for scare beds at peak acute times.

- **AAU/ APU inpatient admission avoidance model.**
  Planning is currently underway for a proposal to introduce a rapid turn around model for the flexible AAU bed capacity over periods of increased demand. The model would see patients who require short term increased levels of treatment and support or those with some complex social issues or who may currently be admitted via ED under safe bed policy, or "social admission" and "acopia" admitted into the current AAU. The anticipated turnaround for these types of presentations should ideally be <24-36 hrs. The patients would be under the care of the General Physicians and are likely to be a predominantly frail elderly cohort.

  Facilitation will be provided by a trained NASC nurse allocated for up to 4 hrs a day specifically to the unit in addition to increased rapid access to Allied Health support into the AAU (OT, Physio and Social Worker) alongside Health Recovery Beds. We intend that this would see many patients turned around within a shorter period of time. Reviewing seasonal inpatient loads in MSW often shows that patients when admitted into the general ward will have a protracted length of stay as the response to addressing some of these short term supports is overshadowed by the general churn and complexity of ward admissions.

  Pressure on inpatient beds over the winter period and reduced staffing availability due to winter illness is evidenced by reviewing NHPPD over the past year.

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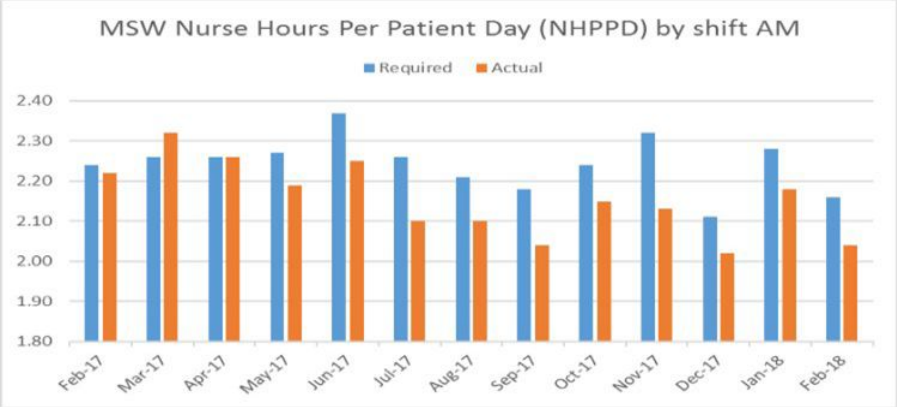
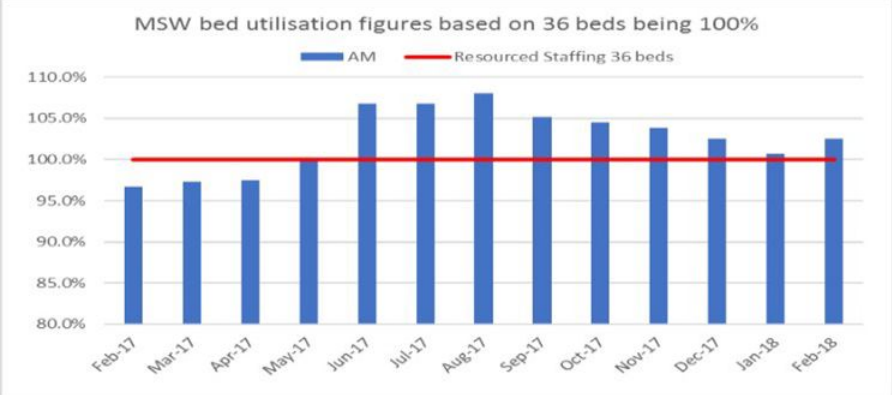
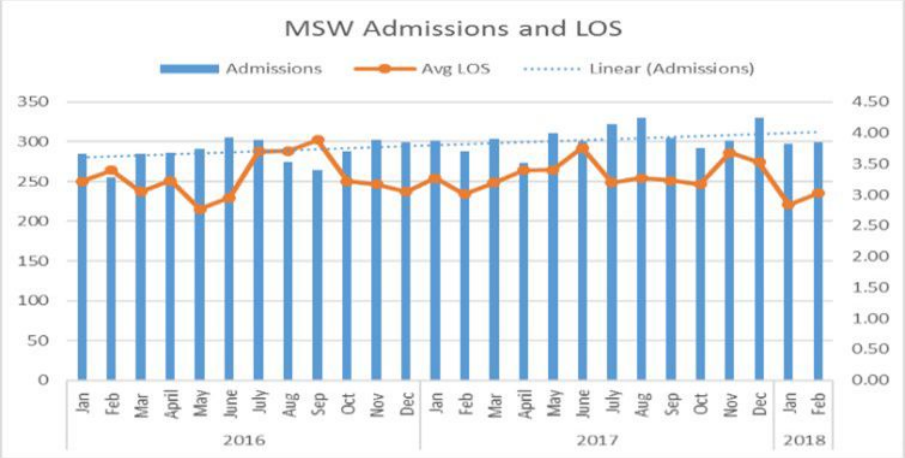


The level of utilisation of beds is also seen to be more pronounced over the winter period which adds additional presuure on the ward team.



Consequently this can be seen to have a flow on impact in average length of stay which will in turen merely compound the acute demand pressures.



Many of these acute presentation occur towards late afternoon and evening, Susequently reduced capacity for admission as cited above results in backlogs within ED and build up for delays and longer waiting times.

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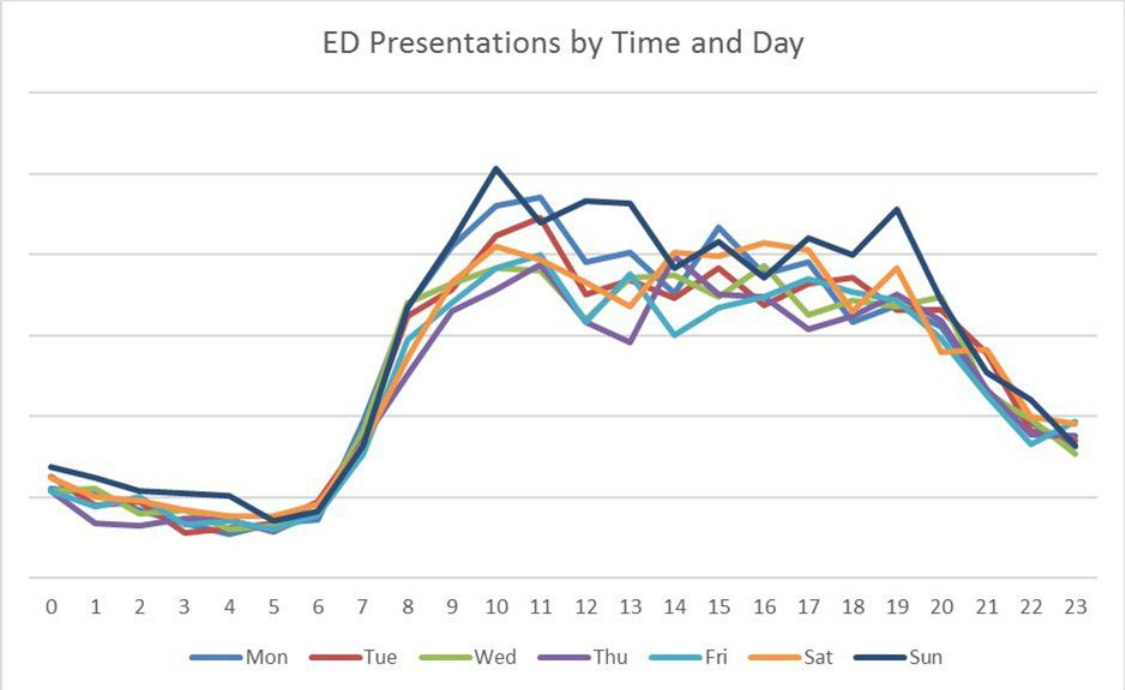
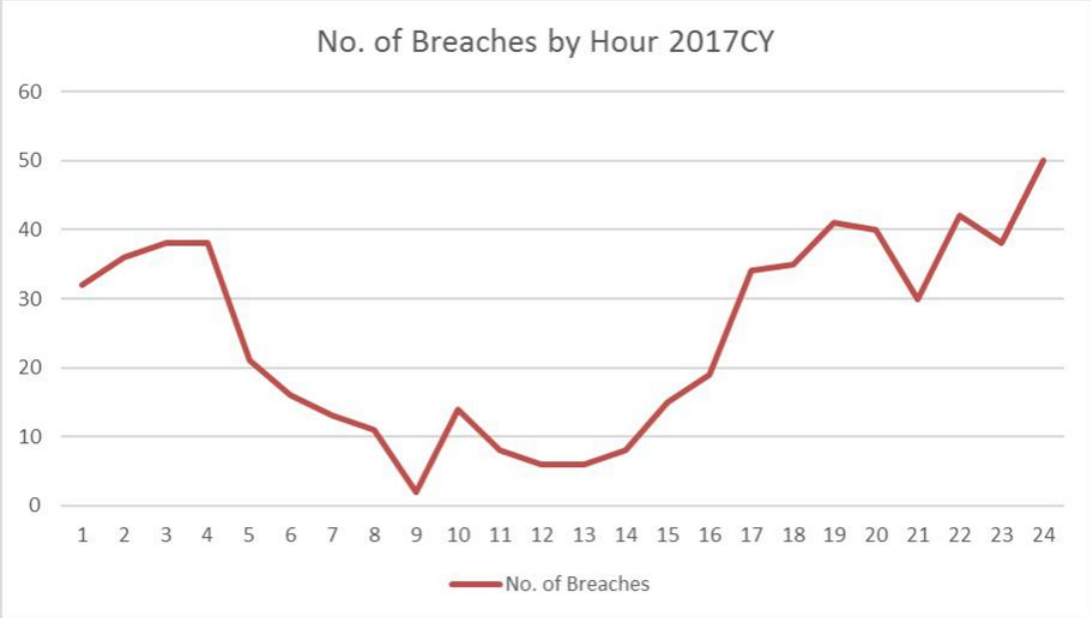




It is hoped that a trial of this model will provide a rapid response to managing patients who require short term elevated care and intervention and facilitate a rapid transfer to home or appropriate care facility for short term response. This will assist in protecting inpatient beds for more complex or higher acuity patients and provide a faster flow through the emergency department.

3DHB Falls Prevention & Management Programme

2016 3DHB Project Steering Group members including:
Astuti Balram, Ken Greer, Chris King, Jan Marment, Felicity Hall, Jenni Masters, Tim Gregg, Paul Quigley, Helen Costello, Martin Hefford, Kim Harriss, Stephanie Fridd, Bridget Allan, Hans Snoek, Sue Walker, Helen Bryant, Joanne Williams, Andrew Harris, Claire Jennings, Chris Kerr, Steve Whittaker, Justine Thorpe, Kieran McCann, Joanne Edwards, Sam MacLean, Michelle van der Raaij, Paul Fake, Glen Mitchell, Anne Barclay, Mardi Postill, Jo Vilipaama, Laura Muller, Jeff Lowe, Lyn Allen, Teiringa Davies, Matiu Rei, , Chris Masters, Adrian Tucker.

Living Stronger for Longer

http://www.livestronger.org.nz/

Exciting news – ACC and 3DHBs partner to improve falls management for older people

In 2016 the 3DHB Falls Prevention and Management Model was developed and approved by the local Alliance Leadership Teams across the subregion. Throughout 2017 the 3DHBs have been working with ACC to seek approval for the model and request funding to support the implementation of the model across the subregion.

Please find attached an updated document that outlines the final 3DHB Falls Model. This was initially developed by the 3DHB Falls Steering Group and has been modified to incorporate feedback from the ACC Clinical Advisory Network to include a strong focus on the evidence based in-home strength & balance component of the model.

ACC have recently finalised the contract to support the 3DHBs to implement this model. We are excited to receive over $2,000,000 over a 3 year period to improve the prevention and management of falls and fractures in older people across the subregion.

To implement the model a number of new services will be progressed including:

- 3DHB Falls Programme Management and Primary Care Based Fracture Liaison Service
  To be delivered by one PHO provider on behalf of the subregion with support from local PHOs.

- Proactive identification and screening for falls risk in Primary Care
  To be delivered by local DHB primary care services with funding to support general practices to identify, screen and manage falls risk in older adults.

- In-home strength & balance
  To be developed and delivered by local DHB services.

3DHB Falls Prevention & Management Programme

- Community based strength & balance
  This is being progressed through a separate process with ACC and the lead agency Sports Wellington. Sports Wellington is currently working to understand what services currently exist across the subregion and will be identifying local gaps and accrediting community based providers.

The Service Specification has been finalised to begin implementing the model. A 3DHB steering group has been established to provide oversight to the overall implementation and monitoring of the programme and will report through to the local Alliance Leadership Teams. In addition, local groups may also be established to support the implementation of the services identified above.

This is an amazing opportunity and we are looking forward to working with you on making improvements to falls and fracture outcomes for our populations.

If you would like more information or would like to be involved – please get in touch.

Kind regards,
Stephanie Fridd, Nicky Rivers, Ken Greer, Jan Marment & Astuti Balram

Reducing the incidence and impact of falls and fractures in older people within 3DHBs

Our model of care is based on proactive and reactive management of falls and fracture risk by the primary care team, and older people actively managing their own risks:

A planned, ***proactive*** and specific focus within 'ongoing care of the whole person' addresses identified risk factors for falls through individualised interventions.

Risk for a first fragility fracture is identified opportunistically within ongoing care. Risk of further fracture is identified ***reactively*** by notification of a low impact fracture, which triggers investigation and treatment with bone-strengthening medicines where appropriate. In other words, a data driven 'fracture liaison service' is provided by the primary care team.

Improved information flows support referral and notification to primary care to ensure an appropriate and timely ***reactive*** response by the team to managing both falls and fracture risk in the enrolled population.

A partnership process means the older person knows their risks and has decided ***the actions they will*** take with their primary care team's support.

Capital and Coast DHB
Hutt Valley DHB
Wairarapa DHB
All PHOs in the 3DHB sub-region
Wellington Free Ambulance
Access Homehealth
Accident Compensation Corporation

4th September 2017

About this document

This document presents a model of care designed to reduce the incidence and impact of fractures in older people in the subregion of the CCDHB, HVDHB and WDHB. The model arises out of a long-standing commitment between the three DHBs to work together - on HealthPathways, on an integrated approach and action plan, and from June 2016, with ACC as the funding partner, to design and implement a model to improve care and deliver specified outcomes.

A proposal was submitted in Dec 2016 for ACC and subsequent to feedback from the ACC Clinical Advisory Network the model has been revised. The following is a summary of the 3DHB model to be implemented to support falls and fractures in older people in the Greater Wellington Region.

The following model details the community based services to reduce the incidence and impact of falls and fractures in the subregion. In addition to these services, the hospital falls projects and Hip Fracture Registries in the DHBs will be key in supporting the population outcome improvements.

Contents

A. INTRODUCTION

Falls and factures in older people in the 3DHB sub-region: our priorities

Fall-related injuries in older people

Overall, about one in three community-dwelling people aged 65 and over will fall at least once each year, and about one in two aged 80 and over will fall. For older people, a high incidence of falls combines with high susceptibility to injury because of age-related physiological changes (such as slower protective reactions) and high prevalence of clinical conditions implicated in increasing risk of falling (such as postural hypotension) or risk of injury (such as osteoporosis)[1].

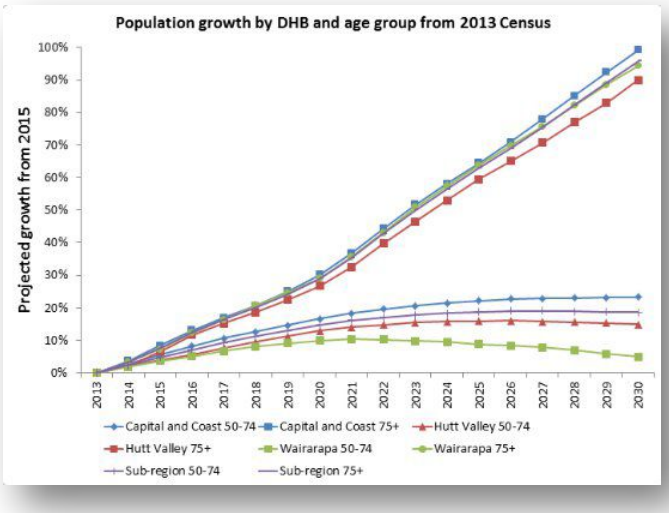
The costs and impacts for older people and their families/whanau of falls and fall-related injuries have been discussed extensively in the local context[2] and are accepted as significant.

The announcement of ACC's investment of $30.5 million to support new and existing initiatives aimed at preventing falls and resulting injuries in older people outlined demographic and cost drivers at population and system levels:

- The number of people aged 65 years and older is expected to double to around 1.2 million by 2035, when they will make up almost one quarter of the population.
- Falls are the most common and costly cause of injury for those aged 65 and over.
- Last year, the cost of fall-related claims in this age group was around $163 million, and this is projected to reach between $296 million and $418 million annually by 2025[3].

3DHB projected population increase

In line with international and national trends, the 3DHB sub-region has an ageing population, with implications for local system capability and service quality for fall-related injuries. The chart below shows the population group of 75 and over virtually doubling by 2030, suggesting that cost and the demand for care and treatment capacity will also double.



In the longer term, the 2030 scenario requires a population health approach. However, within a more immediate timeframe, a 10% increase in the population 75 and over by 2019[4] signals an increased demand for care for fall-related injuries over the next three years.

1 Rubenstein LZ. 2006. Falls in older people: epidemiology, risk factors and strategies for prevention. *Age and Ageing* 35-S2:ii37-ii41.
2 Health Quality & Safety Commission. 2014. Topic 1 Falls in older people: the impacts, Topic 6: Why hip fracture prevention and care matters
3 ACC invests $30m to reduce falls and fractures for older New Zealanders. Press release Nikki Kaye, Maggie Barry,12 July, 2016
4 An increase of 3130 people (from 30,140 in 2016 to 33,270 in 2019).

Those at risk of fall-related fragility fractures are also a priority

It has been reported that one in two women (between the age of menopause and when they die), and one in three men (in that age group) will have a fragility fracture[5]. Therefore the 3DHB model of care emphasises a reactive response to fragility fractures in the population aged 50 and over.

As the population in the 3DHB region aged 50+ years is expected to increase by 32% between 2013 and 2030, the volumes of injury and admissions for fragility fractures are certainly likely to increase.

Fall-related admissions in the 3DHB sub-region

The tables below are drawn from an analysis of 3DHB hospital admissions for fall-related injuries with casemix funded events, including emergency department (ED) short stay (i.e. 3 or more hours)..

In the sub-region for people aged 50 years, in 2015/16 there were approximately 3100 falls related hospital admissions, 926 admissions in the sub-region for low impact fractures and 205 admissions in the sub-region for low impact neck of femur fractures

Table 1: All admissions for fall-related injuries

2015/16 (50+ years)		
DHB of domicile	Number of admissions	Number of unique NHI
CCDHB	1794	1751
HVDHB	932	919
Wairarapa DHB	367	362
3DHB	**3093**	**3032**

Table 2: Admissions for low impact fragility fractures

	2015/16 (50+ years)	
DHB of domicile	Number of admissions	Number of unique NHI
CCDHB	542	523
HVDHB	263	262
Wairarapa DHB	121	118
3DHB	**926**	**903**

Table 3: Admissions for low impact neck of femur fractures

	2015/16 (50+ years)	
DHB of domicile	Number of admissions	Number of unique NHI
CCDHB	120	120
HVDHB	66	65
Wairarapa DHB	19	19
3DHB	**205**	**204**

Low impact neck of femur fractures make up 22% of all low impact fracture admissions, and at a figure of $47,000.00 per event[6], cost $9,635,000.00 in the sub-region.

[5] Professor Ian Reid in a radio interview 'The fracture tsunami' 23 October 2016.

[6] This figure has been used in HQSC and ACC documents. It derives from Hektoen et al's 2009 costing of acute hospital admission and three weeks rehabilitation, converted from NOK to NZD, as given in De Raad JP. 2012 *Towards a value proposition…scoping the cost of falls*. New Zealand Institute of Economic Research: Wellington.

Fall-related ACC claims 3DHB sub-region

In the subregion in 2105/16, there were >20,000 ACC claims for any injury due to falls and >2600 ACC claims for fracture/dislocation due to falls.

In October 2017, ACC are releasing an online dashboard that includes the following measures:

- Falls 65+ Total costs/Medical fees/Entitlements
- New ACC entitlements claims – fracture, non-fracture
- Falls Hospital admissions – Average length of stay
- Acute readmissions for fractured neck of femur
- ACC length of claim
- Entitlement services / Home care support

The above dashboard outcome measures directly link into the 5 indicators referenced in the outcomes and best practice framework in Figure 1 pg.16 (Falls and fractures outcomes fame-work, Live Stronger for Longer, April Report, 2017). The proposed 3 DHB outcome model (see Appendix 3) is based from the ACC outcome measure dashboard. .

The table below illustrates the number of ACC claims (within the 3DHB regions) from injuries resulting from a fall. Injuries include minor or more serious falls resulting in fracture. This indicator is useful as a broad measure of the overall falls that result in ACC claims in the +65 population. The data is taken from the date of reported injury; not when the claim was made nor if the claim was accepted.

Table 1. Approximate national number of ACC claims reported at the date of injury. Quarter ending December 2016 (Falls and fractures outcomes framework, Live Longer for Stronger, April Report pg. 18).

Fewer Fall Injuries Domain (65+ pop)	**Reported ACC Claims Quarter ending Dec 16**
CCDHB	2000
HVDHB	1000
WAIDHB	480
TOTAL:	3480

Our Readiness: the local focus on falls and fractures

National initiatives, local projects

From 2013 onwards national initiatives emphasising safety and quality of care around falls and hip fracture in older people combined expectations of improvement with enabling resources and projects (see Appendix 2 for a summary). In particular, the development of ACC's falls and fracture framework meshed with 3DHB improvements already underway, such as development of a tool to identify a frail and prefrail cohorts in general practice and WFA's Wairarapa trial of referral pathways.

Key developments in the 3DHB sub-region

The timeline below shows the commitments made to a 3DHB approach, formalised in a project charter and realised in the formation of a Project Steering Group to develop a model of care (see Appendix 3 for membership).

Readiness for the project builds on awareness of gaps and areas for improvement, and the project has been well-received in extensive consultation with over 150 stakeholders (see Appendix for a consultation diary). Input and feedback from these meetings shaped and refined the model.

2014	3DHB commitment to developing shared HealthPathways based on Canterbury DHB's pathways.
2014	Discussions between ACC and DHBs regarding ACC's Older People's Falls Strategy and integration with DHB service delivery for older people.
2015	3DHB Health of Older Persons Service Level Alliance identified falls prevention for older people as a priority focus for 2015-16.
May 2015	A cross-sector regional forum workshopped 10 priorities in an integrated approach to falls in older people as background to developing an action plan. Forum convened by Christine King (Associate Director Allied Health, Scientific & Technical, CCDHB) and Jo Vilipaama (Community Injury Prevention Consultant, ACC).
July 2015	Launch of Greater Wellington Region Falls Action Plan 2015-16; discussion included the 3DHB Falls Data set, clinical pathways, referral pathways, fracture liaison services, and exercise programmes in the community. Representatives from ACC, Sport Wellington, PHOs, DHBs, Wellington Free Ambulance (WFA), private fitness programme providers and other organisations have continued monthly meetings as the GWR Falls Network.
June 2016	3DHB Project Steering Group formed to design and implement a model of care to improve care and deliver the outcomes intended by ACC as the funding partner. Dr Ken Greer is the Clinical Champion and Chair. The 3DHB project is supported by a small project team comprising Astuti Balram (ICC Programme Manager, SIDU), Dr Ken Greer, Christine King and Shelley Jones (Project Manager).
Aug 2016	3DHB Alliance Leadership Teams sign off 3DHB project charter.
Sep 2016	Model of care summarised and presented to Project Steering Group.
Oct 2016	Stakeholder engagement with groups across the three DHBs (also includes a meeting of the GWR network held at Hutt Hospital) for input and feedback on the model and its implementation.
Oct-Nov 2016	3DHB Alliance Leadership Teams endorse the 3DHB model of care and general approach.
Nov-Dec 2016	Alliance Leadership Teams sign off 3DHB proposal for funding allocation
Dec 2016	

B. THE MODEL OF CARE

Overview

Overall goal, aims and scope

Our overall goal is that older people in the Greater Wellington Region retain their independence and are able to remain at home. Threats to mobility and self-care, such as falls and fractures, impact on an older person's independence.

Therefore, our aim is to reduce the incidence and impact of falls and fractures in an integrated approach coordinated by the primary care team.

Implementation of the model of care is expected to result in reduced rates of
- first and further fragility fractures (including hip fractures)
- serious harm injuries related to falls
- minor harm injuries related to falls.

There are four 3DHB HealthPathways are the foundation of the model:
- *Fall Risk – Assessment and Reduction*
- *Medication Management and Polypharmacy in Older People*
- *Fragility Fractures*
- *Osteoporosis*

We are prioritising the following age groups according to risk - while recognising that the age groups and risk overlap:
- those aged >75yo or with an identified risk of falling are supported with proactive screening as well as strength and balance where applicable
- those aged >50yo who have had a fragility fracture supported by fracture liaison service

Note a number of the outcome measures will be based on data on those 65y+ as determined by ACC and the overlapping age risk bands.

Older people not falling into these two prioritised groups will generally be offered advice, self-management resources and where relevant multifactorial assessment and management for individualised interventions.

Principles

Six principles guided development of the model:

1 The model is centred on the older person, supported by their primary care team.

2 Management of falls and fracture risks is located within the primary care team because of the continuous and comprehensive nature of the care relationship, especially important when medical management of multiple problems and the older person's preferences make trade-offs necessary. Clinical judgement is needed to individualise the plan of care in each person's situation.

3 The model addresses goals of reducing falls and reducing fractures in older people. Preventing falls prevents fall-related injuries, therefore management of osteoporosis and fracture risk should include multifactorial fall risk assessment and management.

4 The model links a number of key components as shown in the notated diagram. It links a number of components which cover gaps and/or improve care processes (identification of those at risk; referral and notification; risk assessment and management; home safety assessment and modifications; medication management; exercise programmes promoting balance and strength; and a systematic approach to preventing fragility fractures) to deliver individualised interventions for the older person.

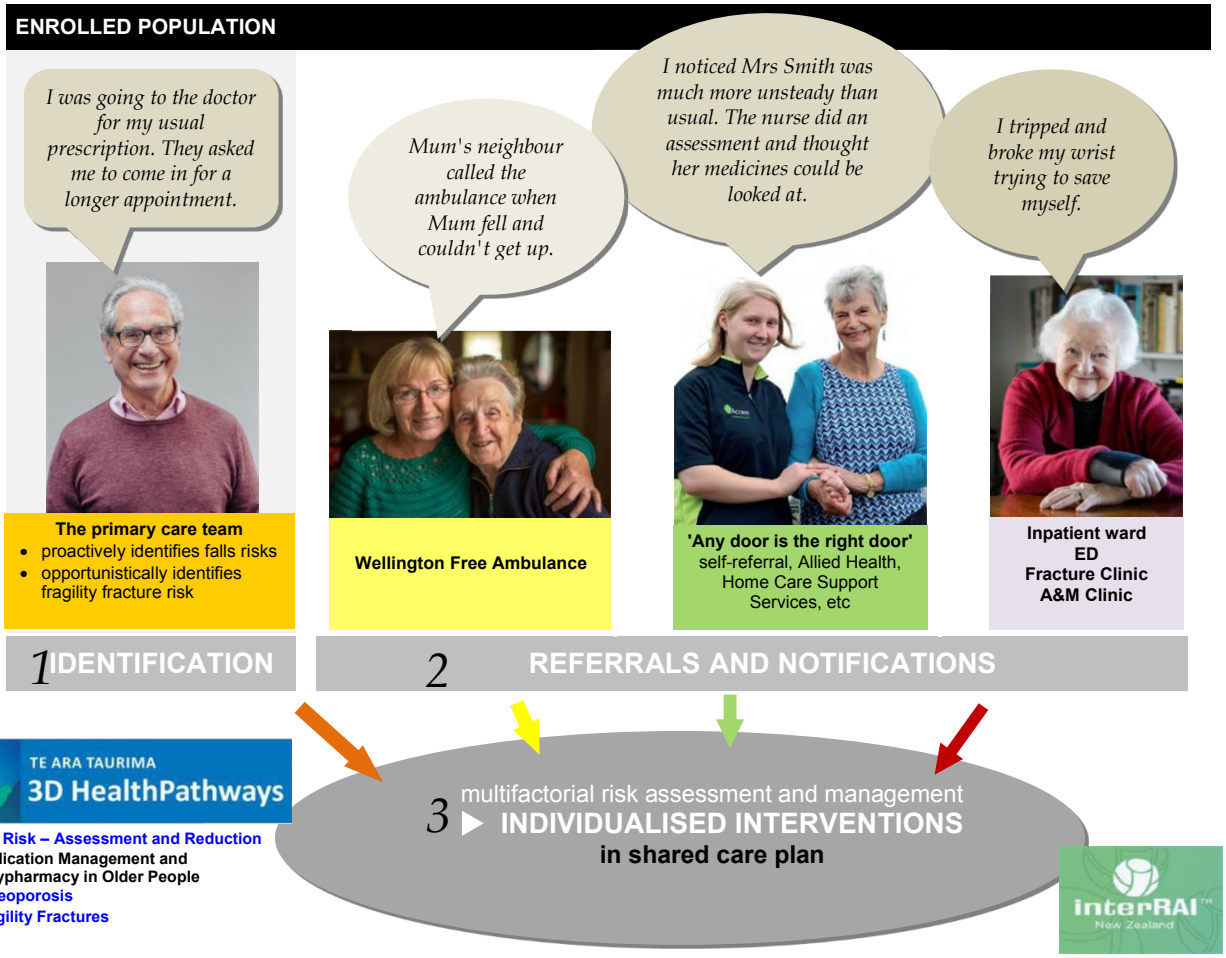
5 Implementation of the model depends on timely information flows (notifications, referrals, discharge letters) from multiple sources to the primary care team, and these information flows also provide data for measurement of processes and outcomes.

6 Implementation of the Model depends on timely information flows (notifications, referrals, discharge letters) from multiple sources to the primary care team, and these information flows also provide data for measurement of processes and outcomes.

Reducing the incidence and impact of falls and fractures in older people

The 3DHB model of care is based on proactive and reactive management of falls and fracture risk by the primary care team, and older people actively managing their own risks:

- A planned, ***proactive*** and specific focus within 'ongoing care of the whole person' addresses identified risk factors for falls through individualised interventions.
- Risk for a first fragility fracture is identified opportunistically within ongoing care. Risk of further fracture is identified ***reactively*** by notification of a low impact fracture, which triggers investigation and treatment with bone-strengthening medicines where appropriate. In other words, a data driven 'fracture liaison service' is provided by the primary care team.
- Improved information flows support referral and notification to primary care to ensure an appropriate and timely ***reactive*** response by the team to managing both falls and fracture risk in the enrolled population.
- A partnership process means the older person knows their risks and has decided ***the actions they will take*** with their primary care team's support.



- **Fall Risk – Assessment and Reduction**
- **Medication Management and Polypharmacy in Older People**
- **Osteoporosis**
- **Fragility Fractures**

HOME SAFETY	EXERCISE FOR BALANCE AND STRENGTH	REVIEW AND OPTIMISE MEDICINE USE
Provide ACC 5218 home safety checklist Refer for environmental safety assessment/ modifications	Recommend self-directed activities Provide balance and strength exercise leaflet Refer to community-based programme Refer for in-home programme	Review medicines for current appropriateness, with a focus on reducing dose or possibly stopping

Image Dame Kate courtesy Health Quality and Safety Commission; Access worker and client courtesy Access Homehealth. Other images from iStock. Image of older Maori woman to come XXX

C. MODEL COMPONENTS

Six Model components

Each component is described in terms of the challenge it meets, such as a gap in practice, or an opportunity to improve practice. Service delivery is described in a narrative of "what it looks like".

- **Proactive identification of risk**
- **Reactive responses to referrals and notification – Fracture Liaison**
- **Multifactorial risk assessment and management for individualised interventions**
- **Safety in the home environment**
- **Exercise programmes to enhance balance and strength**
- **Review and optimise medicine use**

Proactive identification of those at risk

The challenge is to identify those most at risk of falling

Primary care will work to proactively identify those who are at risk of falling across the population, through asking >75yo about falls opportunistically.

The number of people >75yo across the subregion in 2016/17 is as follows:

CCDHB	14,610
HVDHB	9,240
WDHB	3,995

Service elements: inputs, activities and outputs

Asking about falls within the established and ongoing primary care relationship minimises the possibility of unintentionally fostering a fear of falling[7], as the conversation is about the older person's goals.

- The 3 Ask questions will be used in the next practice visit with the older person identified for management of frailty, and opportunistically during episodic care for all older patients, especially where an underlying condition puts them at risk. The self-assessment in the Stay Independent consumer brochure also covers the 3 Ask questions.
- Patients having their 20 minute wait after flu vaccination could have the brochure and complete the self-assessment before leaving the practice, with a quick review of their answers as they check out[8].
- 'Testing positive' on the 3 Ask questions indicates assessment of strength and balance is warranted. Diminished lower limb strength and difficulties with balance may have been demonstrated as the patient is called from the waiting room.

Fracture risk is assessed opportunistically during episodic care for these patients, or subsequent to notification from others involved in the patients care eg. Wellington Free Ambulance, Home-based-support-services and Community Service teams.

Reactive responses to referrals and notifications

The challenge is to ensure timely notifications and referrals which enable risk assessment and appropriate interventions – primary care Fracture Liaison Service

A primary care based Fracture Liaison (FLS) service will systematically identify all people >50yo with fragility fractures. The guiding principle is*: 'Any door is the right door'* for the FLS and will look to capture patients who present with a fragility fracture to services across the including ED, admissions, fracture clinic, General Practice, After Hours.

Table 1. Admissions by DHB of domicile for events due to any fall injury code (50+ years)

	2013/14		2014/15		2015/16	
DHB of domicile	**Number of admissions**	**Number of unique NHI**	**Number of admissions**	**Number of unique NHI**	**Number of Admissions**	**Number of unique NHI**
CCDHB	**1875**	**1818**	**1872**	**1796**	**1794**	**1751**
HVDHB	**824**	**810**	**842**	**825**	**932**	**919**
Wairarapa DHB	**398**	**384**	**378**	**359**	**376**	**362**
3DHB	**3079**	**3012**	**3092**	**2980**	**3093**	**3032**

[7] Jones S. 2015. Fear of falling: friend or foe? Insite Magazine. March 2015

[8] Pairing falls risk assessment with flu vaccination is an idea from Canterbury.

Table 2. Admissions for fragility fractures due to low impact falls (50+ years)

	2013/14		2014/15		2015/16	
DHB of domicile	**Number of admissions**	**Number of unique NHI**	**Number of admissions**	**Number of unique NHI**	**Number of admissions**	**Number of unique NHI**
CCDHB	**529**	**509**	**534**	**499**	**542**	**523**
HVDHB	**278**	**270**	**252**	**245**	**263**	**626**
Wairarapa DHB	**147**	**138**	**127**	**114**	**121**	**118**
3DHB	**954**	**917**	**913**	**858**	**926**	**903**

The FLS will also ensure that the General Practice that the person is enrolled with is notified and supported to complete a bone health assessment; falls risk assessment, provided with supporting health information, a care plan with the person and subsequent management of risk. These are outlined in the subsequent elements.

The FLS should meet the national FLS standards[9].

Service elements: inputs, activities and outputs

A notification (of a fall-related presentation or injury treatment) or request for risk assessment and management may come from any source.

In our model, referrals and notifications come from Inpatient, ED, Fracture Clinic, A&M related to fracture presentation:

- Discharge letters directly to the general practice will provide information for follow up action - a standardised phrase such as 'low impact fracture' will be introduced to facilitate recognition of this notification and scheduling of a visit focusing on falls and fracture risk.
- Monthly aggregated reports based on coding which are provided to PHOs or practices will be a back up if the information in a letter has been missed.

[9] Clinical Standards for Fracture Liaison Services in New Zealand 2016. Osteoporosis New Zealand. Access via: https://osteoporosis.org.nz/resources/health-professionals/clinical-standards-for-fls/

Multifactorial risk assessment

The challenge is to individualise interventions

Individually targeted multifactorial interventions significantly reduce the rate of falls (by 10-35%) in those with specific risk factors. Multifactorial interventions will include strength and balance programmes (in-home or community-based) as appropriate for the older person in a clinical assessment decision.

Service elements: inputs, activities and outputs

The multifactorial risk assessment and management will be done in partnership and shared decision-making between older people (and their families/whanau) and health practitioners as a given. The process will result in a shared care plan that may include the following:

- a plan of action based on the older person's priorities, capabilities and preferences
- self care information and strategies
- medication review
- referral to strength and balance programmes

Individualised interventions are reviewed within usual care as the person's condition and risk factors change.

Safety in the home environment

The challenge is to reduce risks and increase safety in the home environment

A fall is often the result of an interaction between an older person's specific risk factors and the physical environment - at an earlier age, eyesight might have been sharper, protective reactions and recovery of balance quicker. Older people often attribute a fall to an 'accident' involving an environmental hazard.

There is strong evidence from randomised controlled trials in the older age group that home safety assessment and modification programmes (including behaviour modification) are effective in reducing falls, particularly for those at higher risk (i.e. reporting a previous fall) and when the programme is delivered by the appropriate health professional[14].

Service elements: inputs, activities and outputs

Older people and their families can be self-directed in straightforward matters of home safety such as reducing clutter and providing clear pathways. The ACC 5218 home safety checklist will be provided by the primary care team and at WFA callouts as appropriate. The booklets ACC 2383 Standing up to falls and ACC 7202 Keep going for gold, may also be provided.

Home-based services will continue to conduct a health and safety assessment at each client's home (for staff and client safety). An attitude of 'falls prevention is everyone's business' on the part of all interacting with the older person in their home - attending to obvious hazards and with respect to the older person's choices and decision-making.

Guidance will continue to be given to older people as to which low cost equipment and modifications are expected to be funded by them, and where cost is a barrier, assistance may be given from a budget allocated to hardship.

Referrals for home modifications under Ministry of Health funding will continue as usual, with monitoring of wait times in Year 1 towards improvements in timeliness.

Referrals for allied health environmental safety assessment and modifications for older people with more complex falls risks will continue as usual, with monitoring of wait times in Year 1 towards improvements in timeliness.

In practice, allied health assessment for home safety and modifications may be carried out within a home visit that encompasses assessment and planning for an in-home exercise programme.

Exercise programmes to enhance balance and strength

The challenge to provide those at risk of falling with an appropriate exercise programme to improve strength and balance

This component enables a range of exercise interventions to be matched to older people's needs and circumstances, through either community based or in-home strength and balance.

Exercise programmes specifically designed to prevent falls in older adults can reduce

- injuries caused by falls by 37 percent
- the risk of sustaining a fall-related fracture by 66 percent
- the rate of falls requiring medical care by 43 percent[10].

ACC's aspirational goal of 100,000 places in community-based exercise programmes specifically designed to prevent falls in older adults is supported by the appointment of Lead Agencies to coordinate, facilitate and accredit exercise programmes. Sports Wellington has been identified as the Lead Agency for the subregion.

In-home exercise programmes are targeted to older people with reduced mobility or who are otherwise housebound, according to the eligibility criteria guiding clinical-decision making in the *Fall Risk* pathway. In-home exercise programme service delivery should meetsthe criteria defined by ACC's TAG.and detailed in Appendix 6: Description of in-home strength and balance programme service.

Service elements: inputs, activities and outputs

For those found to have deficits in the brief assessments of strength and balance undertaken as part of the visit, the following exercise options will be discussed with regard to the older person's physical and cognitive ability:

- self-management with the two page handout Exercise at home (link in *Fall Risk* pathway)
- self-enrolment in a non-accredited programme such as Tai Chi (where discounts such as Leisurecard may remove some cost barriers)
- referral to an accredited community-based strength and balance programme
- referral for in-home strength and balance programme meeting the TAG criteria.

We expect that within the group identified as frail and prefrail, a very large proportion of prefrail will be able to access community-based programmes and only a small proportion will benefit from referral for in-home exercise programmes (the frailest frail being most appropriately supported by individualised programmes directed to safety and designed by an AH professional and delivered by home support workers).

Reviewing and optimising medicine use

The challenge is for appropriate prescribing for older people, with an emphasis on deprescribing

Older patients are often prescribed multiple medications to take on a daily basis. Amongst these may be medications that increase the risk of falling and the risk of injury occurring. As these patients become frail, dose reduction and even cessation of these medications is necessary and effective in reducing the incidence and impact of falls.

Certain groups, likely to have vitamin D insufficiency or deficiency, will benefit from prescribed vitamin D supplementation.

Those with osteoporosis are at risk of fragility fracture if they fall, and may benefit from being prescribed bone-strengthening medicines.

This component enables 1) review of an older person's medicines in relation to falls risk, guided by the *Medication Management and Polypharmacy in Older People* pathway, with an emphasis on deprescribing; and 2) in relation to osteoporosis risk, prescribing of bone strengthening medicines, guided by the *Fragility Fracture* pathway and *Osteoporosis* pathway.

Service elements: inputs, activities and outputs

Medication management by the GP as ongoing reviews that is part of usual care.

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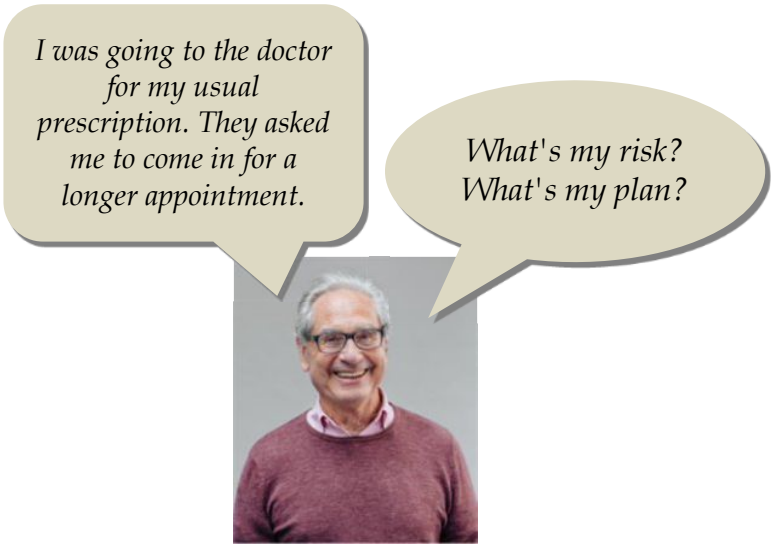
[10] Extracted from HQSC Topic 9 Improving balance and strength to prevent falls. References:
El-Khoury F, Cassou B, Charles M-A et al. 2013. The effect of fall prevention exercise programmes on fall induced injuries in community dwelling older adults: systematic review and meta-analysis of randomised controlled trials. *BMJ* 347: f6234.
Gillespie LD, Robertson MC, Gillespie WJ et al. 2012. Interventions for preventing falls in older people living in the community. C*ochrane Database of Systematic Reviews* (9):CD007146.

D.PATIENT EXPERIENCE

Mini case study to show the model of care in action



What the visit covers

This gentleman planned his usual appointment with his doctor for his medicines, but since he has been identified as frail or prefrail, we'll ask him to schedule a longer visit.

- He gets the Stay Independent consumer brochure by mail to complete and bring with him (or supplied in the waiting room).
- The brief strength and balance tests show his balance is not good.
- We use 3 Ask questions as a conversational lead in - he ***has*** had a fall (lost his balance) and it had concerned him.
- We enquire about family history - mother had several fractures and 'died of a broken hip' - run FRAX calculator.
- BP sitting and standing readings are similar - no postural hypotension.
- We notice that he is taking a PPI (prescribed 10 years ago for heartburn) and we suggest a trial to stop that.
- We ask how long since he had his vision tested and prescription updated - he'll get on to it.
- We talk through exercise options - he is willing to try an accredited community programme - there are several locally.
- He is supplied with ACC 5218 home safety checklist, and Exercise at home handout.

Patient activation

The intended outcome for patient experience is that older people are aware of their risks, and supported by their primary care team, take the actions agreed in the set of individualised interventions. Their experience is that they have a personal plan that helps them keep their independence.

Patient resources

E. OUTCOME & GOVERNANCE

Intended outcomes

Framework and detail

The outcomes framework (Figure 1. Falls and fractures outcomes framework, April Report 2017) describes the measures in relation to the 3DHB model on page 8.

Anticipated benefits and provisos

Anticipated benefits relate to the outcomes identified for implementation of the 3DHB model

- fewer admissions for low impact hip fractures
- fewer admissions for all low impact fractures
- fewer admissions for all fall-related injuries.
- Fewer ACC claims

We might expect a 35% reduction in the falls rate amongst those who participate in an exercise programme designed to prevent falls in older adults, such as the Otago Exercise Programme[11].

Governance

Governance arrangements are yet to be finalised

3DHB approach for Community Based Falls Management

There a number of services and partnering organisations that span the 3DHBs: WFA, some PHOs, home and community support services, ACC and so a subregional approach to oversight of Community Based Falls Management is recommended. Key partners will include:

- Primary Care & Hospital Clinical Co-Leads for falls
- ACC
- Lead Agency for community strength and balance programmes
- WFA
- Access Homehealth
- PHOs
- Allied Health Lead for falls in older people
- 3DHB Health of Older People (HOP) Managers
- Alliance Managers for the three DHBs
- HOP Clinicians.

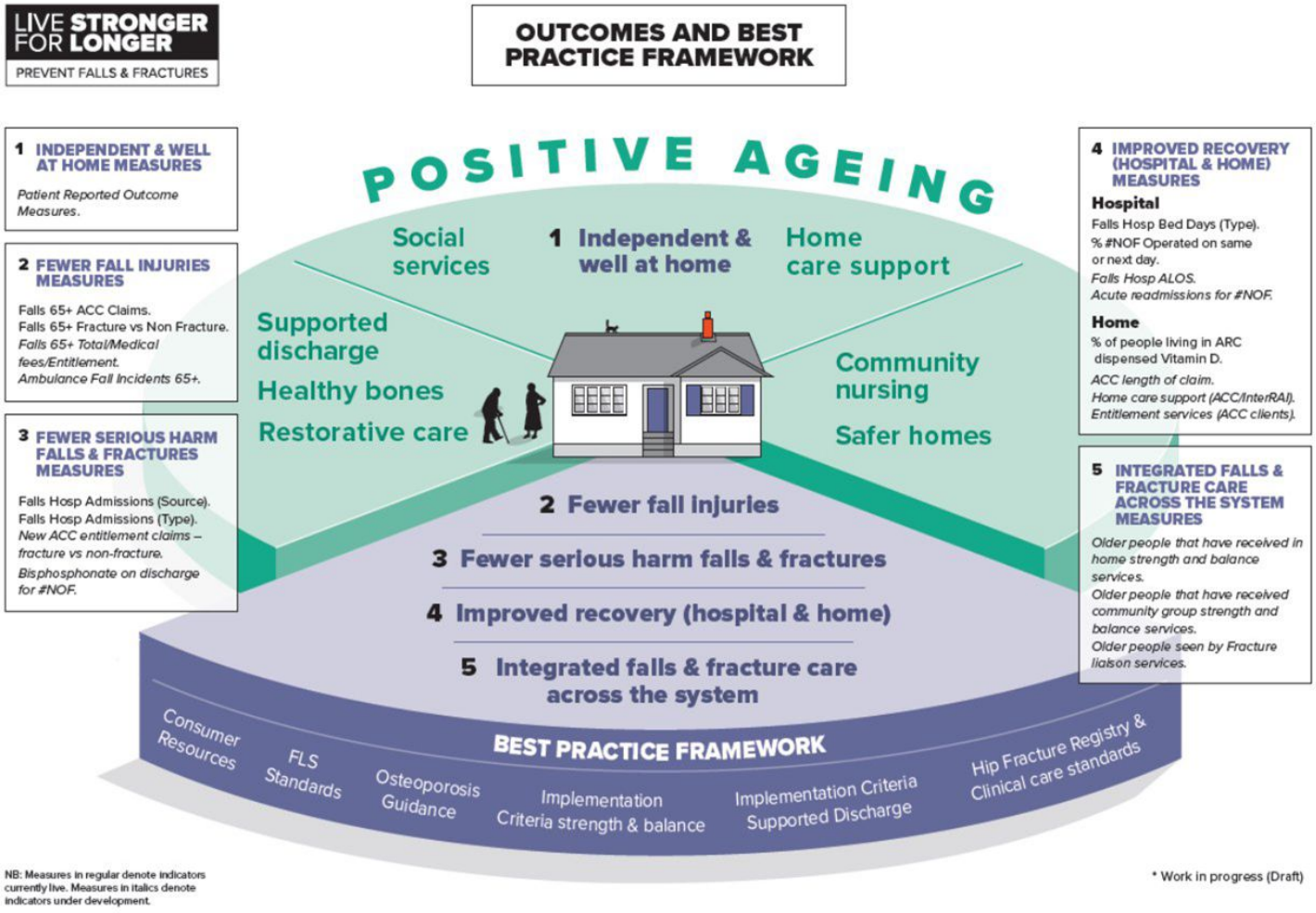
A governance group will also ensure connection and integration with developments in secondary service (e.g. implementation of ANZ Hip Fracture Registry[12] and ANZ hip fracture guidelines and standards) and hospital based falls projects.

[11] See summary of Otago Exercise Programme on page 8 of Stevens JA, Burns E. 2015. *A CDC Compendium of Effective Fall Interventions: What Works for Community-Dwelling Older Adults* 3rd Edn. Division of Unintentional Injury Prevention National Center for Injury Prevention and Control Centers for Disease Control and Prevention: Atlanta, Georgia. Download from here.

[12] Key contacts for ANZFR: Chris Pegg, National Coordinator NZHFR; Nik Florance, Research Nurse, and Mr Chris Hoffman, Orthopaedic Consultant, CCDHB: Dr Joanne Rodwell, SMO OPRS, HVDHB.

Outcomes and best practice model framework.

Figure 1. Falls and Fractures Model. Retrieved from Falls and Fractures Outcomes Framework, April 2017;Quarterly Report.


LIVE STRONGER FOR LONGER
PREVENT FALLS & FRACTURES
OUTCOMES AND BEST PRACTICE FRAMEWORK
1 INDEPENDENT & WELL AT HOME MEASURES
Patient Reported Outcome Measures.
2 FEWER FALL INJURIES MEASURES
Falls 65+ ACC Claims.
Falls 65+ Fracture vs Non Fracture.
Falls 65+ Total/Medical fees/Entitlement.
Ambulance Fall Incidents 65+.
3 FEWER SERIOUS HARM FALLS & FRACTURES MEASURES
Falls Hosp Admissions (Source).
Falls Hosp Admissions (Type).
New ACC entitlement claims – fracture vs non-fracture.
Bisphosphonate on discharge for #NOF.
POSITIVE AGEING
Social services
1 Independent & well at home
Home care support
Supported discharge
Healthy bones
Restorative care
Community nursing
Safer homes
2 Fewer fall injuries
3 Fewer serious harm falls & fractures
4 Improved recovery (hospital & home)
5 Integrated falls & fracture care across the system
BEST PRACTICE FRAMEWORK
Consumer Resources
FLS Standards
Osteoporosis Guidance
Implementation Criteria strength & balance
Implementation Criteria Supported Discharge
Hip Fracture Registry & Clinical care standards
4 IMPROVED RECOVERY (HOSPITAL & HOME) MEASURES
Hospital
Falls Hosp Bed Days (Type).
% #NOF Operated on same or next day.
Falls Hosp ALOS.
Acute readmissions for #NOF.
Home
% of people living in ARC dispensed Vitamin D.
ACC length of claim.
Home care support (ACC/InterRAI).
Entitlement services (ACC clients).
5 INTEGRATED FALLS & FRACTURE CARE ACROSS THE SYSTEM MEASURES
Older people that have received in home strength and balance services.
Older people that have received community group strength and balance services.
Older people seen by Fracture liaison services.
NB: Measures in regular denote indicators currently live. Measures in italics denote indicators under development.
* Work in progress (Draft)

	Risk	Type	Mitigations	Consequence	Likelihood
	Identification of risk Implementation of the model may result in the identification of a larger number of older people at risk for falls and	Clinical	Staged implementation as proposed, prioritising those who have fractured or fallen. Ongoing monitoring of the completion of individualised interventions agreed in shared care plan for those		Possible

	fractures than can be managed versus an ethical obligation to address risk once identified.		that are identified as at risk of falling, as per the Outcomes Framework. If the gap between those identified as at risk and those with individualised interventions is significant, the governance group may need to review the model and its processes.		
	Individualised interventions	Clinical			Possible
	Possibility that a set of individualised interventions is done once and never revisited.		Manage through expectations that ongoing good medical care will encompass management of risk factors; consider specifying triggers or schedule for review. Consider audit of currency of plans.		
	Community-based exercise programmes Providers may not take up the opportunity to develop and offer accredited programmes, and/or may find that the accredited programmes they offer are not viable.	Strategic	Confer with Lead Agencies as to their audit of current programme provision to identify any gap between actual and expected service provision; work in partnership to support development of such programmes and ensure volume of referrals. Keep an open dialogue with ACC as to how any problems in service supply and viability are best addressed.		Possible
	Provision of DEXA scanning Implementation of the model may create an increase in demand for DEXA scanning that cannot be met.	Operational	Manage by modelling predicted referrals, monitoring DEXA referral numbers, capturing trends in dashboard/quarterly reporting and reviewing annually - working closely with local radiology providers.		Possible
	Over-treatment of osteoporosis	Clinical			Possible
	Risk of over-diagnosis, over-investigation and over-treatment of osteoporosis[13].		Manage risk by promoting adherence to guidance in pathways; consider audit of low impact fracture referrals; monitor process measures (i.e. investigations and treatment) and benchmark with other DHBs and international best practice.		
	Sustainability of the model	Strategic			Likely
	ACC funding is available for three years, and services provided within the model may lapse at the end of that time. Additionally, the model's timeframe is for three years, yet a population health approach is needed to deal with population increase by 2030 (see chart page 1).		Monitor progress and review annually for implications for capacity and capability and apply learning in action plans. Maintain an ongoing relationship with ACC that encompasses forward-looking dialogue to understand future resourcing opportunities.		
	New ways of working	Operational			Likely
	The new model requires all stakeholders to hold a picture of the older person in relation to falls and fracture risk, be familiar with the pathways for management and take responsibility for joined up care.		Manage through communications and education as part of implementation planning.		

[13] A recent debate in the literature was triggered by an article in BMJ's 'Too much medicine' series - Järvinen TL, Michaëlsson K, Jokihaara J. 2015. Overdiagnosis of bone fragility in the quest to prevent hip fracture. *BMJ*. 2015(350) pdf. See articles and letters citing.

F. BUDGET

Budget description, assumptions and allocation of funding to components

The model has recently been approved and ACC is looking to establish a contract with CCDHB, HVDHB and WDHB. The following is an outline of the funding received from ACC and the expected budget to deliver the model. Note HVDHB and WDHB have agreed to resource most of the 3DHB functions with some contribution from CCDHB as the funding received on a population basis is higher.

ACC Funding to support the 3DHB Falls Programme								
	Falls and Fracture Pathways			Strength & Balance In home			Total p.a.	Total 3yr
DHB	One off FLS	PBFF adjusted HOP FLS	Subtotal	One off S&B	PBFF adjusted HOP S&B	Subtotal S&B In Home		
Cap Coast	$ 150,000	$103,247	$253,247	$ 20,000	$ 37,857	$ 57,857	$ 311,105	**$ 933,314**
Hutt	$ 150,000	$ 59,261	$209,261	$ 20,000	$ 21,729	$ 41,729	$ 250,990	**$ 752,971**
Wairarapa	$ 150,000	$ 26,323	$176,323	$ 20,000	$ 9,652	$ 29,652	$ 205,974	**$ 617,923**

Budget for Services to Implement Model	2017/18	2018/19	2019/20
3DHB			
3DHB Project Management	$75,000	$55,000	$55,000
3DHB fracture liaison service	$50,000	$50,000	$50,000
CCDHB			
Identification and screening for falls risk in general practice -	$97,400	$97,400	$97,400
In-home strength and balance	$203,000	$213,000	$213,000
HVDHB			
Local Project Support	$20,000	$20,000	$10,000
Identification and screening for falls risk in general practice -	$62,000	$62,000	$62,000
In-home strength and balance	$100,000	$105,000	$115,000
Dexa Scan Access	$5,000	$5,000	$5,000
WDHB			
Local Project Support	$30,000	$30,000	$30,000
Identification and screening for falls risk in general practice -	$26,700	$26,700	$26,700
Falls management in general practice	$10,000	$20,000	$20,000
In-home strength and balance	$64,300	$69,250	$69,250
Home safety modifications	$10,000	$10,000	$10,000
Dexa Scan Access	$5,000	$5,000	$5,000

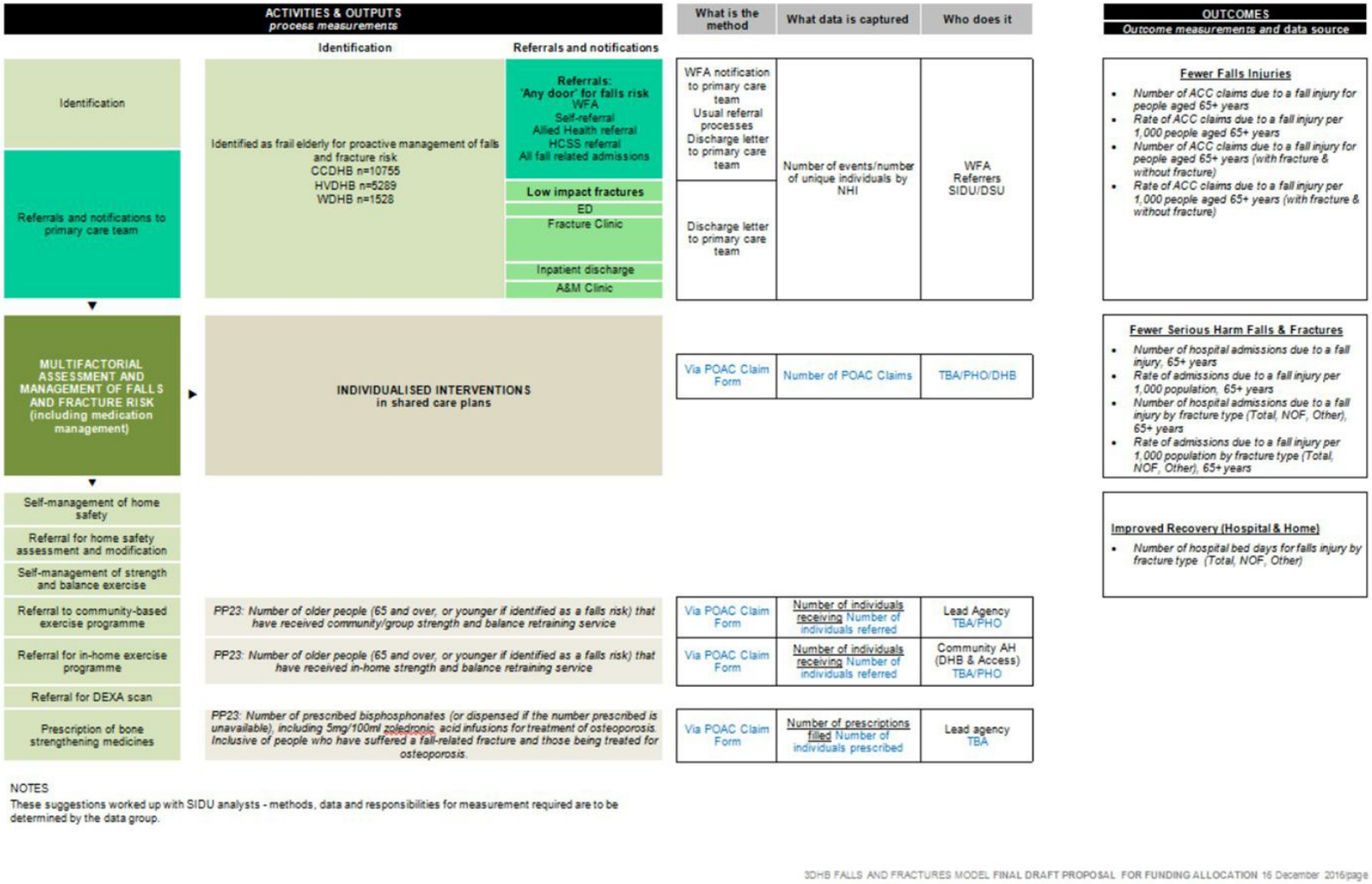
G. APPENDICES

Appendix 1. 3DHB Project Steering Group

The Steering Group has had five meetings in 2016 to guide the model development.

DHBs/PHOs		
Capital and Coast	**Astuti Balram**	Programme Manager, ICC, SIDU
	Ken Greer	GP Liaison SIDU – Primary Care/Clinical Champion
	Chris King	Associate Director Allied Health, CCDHB
	Felicity Hall	Geriatrician, CCDHB
	Jenni Masters	Operations Manager, CCDHB
	Tim Gregg	Orthopaedic Consultant, CCDHB
	Paul Quigley	Specialist Emergency Physician, CCDHB
	Helen Costello	Associate Director of Nursing, CCDHB
	Steve Whittaker	Allied Health Manager, ORA Services, CCDHB
	Martin Hefford	CEO, Compass Health
	Chris Kerr	GM, Compass Health
	Kim Harriss	Team Leader Outreach Nursing, Compass Health
Hutt Valley	**Stephanie Fridd**	Service Development Manager, Hutt INC, SIDU
	Bridget Allan	CEO, Te Awakairangi Health Network
	Hans Snoek	GP/Clinical Director, Te AHN
	Sue Walker	Clinical Services Manager, Te AHN
	Helen Bryant	Professional Leader, Physiotherapy, HVDHB
	Joanne Williams	SMO, OPRS, HVDHB (parental leave covered by Teresa M Thompson)
	Andrew Harris	Director Allied Health, Medicine & Community Directorate, HVDHB
	Claire Jennings	Nursing Director, HVDHB
Wairarapa	**Justine Thorpe**	Programme Director, Tihei Wairarapa
	Kieran McCann	Programme Director, Tihei Wairarapa
	Joanne Edwards	Portfolio and Service Integration Manager (Wairarapa), SIDU
SIDU SUPPORT/RESOURCE		
	Shelley Jones	Project Manager, 3DHB Falls and Fracture Model
	Joanne Edwards	Senior Manager Service Integration, Health of Older People
	Jan Marment	Portfolio and Service Integration Manager
	Ondine Claridge	Portfolio and Service Integration Manager (Hutt)
	Sue Ellis	Portfolio and Service Integration Manager
	Sam MacLean	Service Analyst, SIDU
	Michelle van der Raaij	Senior Service Analyst, SIDU
PARTNER TEAMS		
WFA	Paul Fake	Clinical Quality Improvement, WFA
	Glen Mitchell	Clinical Safety Manager, Clinical Services, WFA
Access	Anne Barclay	Clinical Lead, Access Homehealth
ACC	Mardi Postill	Design and Delivery Specialist (Nominee of Lisa Gestro, National Programme Lead ACC)
	Jo Vilipaama	CIPC, Capital and Coast/Hutt Valley
	Laura Muller	CIPC, Wairarapa

Appendix 2. 3DHB Falls and Fractures Outcome Model



PUBLIC

Wairarapa DHB Wairarapa District Health Board Te Poari Hauora a-rohe o Wairarapa	**HAC INFORMATION PAPER** **Date: 11 May 2018**

Author	Michele Halford – Executive Leader Nursing
Endorsed By	Adri Isbister – Chief Executive
Subject	**Executive Leader Nursing Report for Hospital Advisory Committee (HAC)**

RECOMMENDATION IT IS RECOMMENDED THAT THE HOSPITAL ADVISORY COMMITTEE:

NOTES the content of this report

NURSE STAFFING FINANCIALS

Nursing employee expenses are ($168k) unfavourable month to date (MTD) and ($744k) year to date (YTD). FTE is over by 10.9 FTE on budgeted levels.

Account	Month Actuals	Month Budget	Month Variance	YTD Actuals	YTD Budgets	YTD Variance
Expenditure	**1,390,111**	**1,222,425**	**(167,686)**	**13,252,626**	**12,508,725**	**(743,901)**
Employee Expenses	1,390,111	1,222,425	(167,686)	13,252,626	12,508,725	(743,901)
Nursing Employees	1,390,111	1,222,425	(167,686)	13,252,626	12,508,725	(743,901)
Nursing Employees	1,390,111	1,222,425	(167,686)	13,252,626	12,508,725	(743,901)
2204. Nurse Practitioners	20,096	14,253	(5,843)	169,261	143,513	(25,748)
2205. Senior Nurses	304,815	287,227	(17,588)	2,835,657	2,944,591	108,934
2210. Registered Nurses	893,162	784,933	(108,229)	8,603,115	8,024,764	(578,351)
2215. Enrolled Nurses	49,423	48,832	(591)	475,862	501,449	25,587
2225. Registered Midwives	0	0	0	2,051	0	(2,051)
2235. Health Service Assistants	108,658	68,865	(39,793)	1,028,208	706,027	(322,181)
2260. Other Nursing Employee Expenses	13,957	18,315	4,358	138,472	188,381	49,909
Grand Total	**1,390,111**	**1,222,425**	**(167,686)**	**13,252,626**	**12,508,725**	**(743,901)**

FiscalYear	2018
FTEFiscalPeriod	10

	Month			Year			
	Values						
	Actual	Budget	Variance	Actual	Budget	Variance	FY Budget
Nursing Staff	**187.0**	**173.5**	**-13.5**	**184.4**	**173.5**	**-10.9**	**173.5**
Enrolled Nurses	9.7	10.0	0.3	9.3	10.0	0.7	10.0
Health Service Assistants	22.2	15.4	-6.7	22.6	15.4	-7.2	15.4
Nurse Practioners	1.5	1.4	-0.1	1.5	1.4	-0.1	1.4
Registered Nurses	122.8	116.6	-6.1	122.1	116.6	-5.5	116.6
Senior Nurses	30.9	30.0	-0.9	28.9	30.0	1.1	30.0
Grand Total	**187.0**	**173.5**	**-13.5**	**184.4**	**173.5**	**-10.9**	**173.5**

PUBLIC

Nurse Practitioners are unfavourable ($6k) MTD and ($26k) YTD due to penals and extra hours at times for increased demand in Acute Services.

Senior nurses are unfavourable ($18k) MTD and favourable $109k YTD due to timing of leave and leave cover on senior roles.

Registered Nurses (RN's) are unfavourable by ($108k) for the month and ($578k) YTD. RN FTE is 5.5 FTE over budget. This can be offset against favourable enrolled nurse costs of $26k YTD due to resignations being replaced by RN's. Additional staffing in the Acute Assessment Unit (AAU) at peak times which is not budgeted to be resourced. Sick leave cover, in particular ACC cover, has impacted unfavourably however there is some revenue offsets noted below.

Health Care Assistants (HCA's) are unfavourable ($40k) for the month and ($322k) for the year. This is due to patient watches in MSW and AT&R, which are unbudgeted, and sick leave and ACC cover.

Other nursing expenses are $4k favourable MTD and $53k YTD. This is due to training being favourable $16k and timing of payments for Health Workforce. A two day workshop was facilitated by Trendcare in April and was widely attended.

$304k of the unfavourable YTD nursing personnel variance can be offset by ACC staff related revenue which is $148k favourable YTD. Bowel screening revenue of $92k YTD has also been received to offset new nursing roles and outsourced nursing is favourable $64k YTD due to DHB casual HCA's being used in place of agency HCA's.

CELEBRATING PDRP

This year PDRP (Professional Development and Recognition Programme) awards for Proficient and Expert levels were held 9 May, the date chosen for its proximity to International Nurses Day (12 May). The PDRP enables nurses' practice to be recognised and rewarded. These programmes support innovation, reflect contemporary practice and are competency based. Nurses undertaking progression on the PDRP beyond Competent Practitioner demonstrate leadership and commitment to their careers, their profession and above all to excellence in care for their patients/clients/community.

In 2004, the Nursing Council began approving PDRPs as recertification programmes under section 41 of the Health Practitioners Competence Assurance Act 2003. The intention was to allow nurses who were already demonstrating continuing competence through PDRPs to be exempt from the recertification audit.

The programme is about more than simply competence to practice however. It seeks to support individual nurses to develop their practice and recognise the additional contributions made by these nurses to the workplace.

Previously this event has been celebrated in conjunction with NETP graduations, however the increases in the numbers of both groups meant it was timely to separate out these celebrations. PDRP in the Wairarapa has been growing in strength in recent times and this year successful candidates were representative of primary care and provider arm nurses. The exemplars shared with the audience demonstrated a breadth and depth of every-day nursing practice that was a privilege to listen to.

INTERNATIONAL NURSES DAY

International Nurses Day is an annual event held on 12 May. The theme this year is *Nurses a Voice to Lead,* which is why we have moved the PDRP award ceremony to this time of the year. In addition to this we held a Quiz night at the Copthorne and invited all nurses working within the wider DHB to attend. It was a great

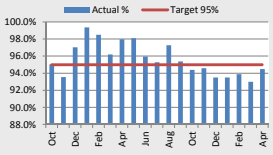
PUBLIC

success with approximately 120 nurses attending in teams representing primary health, aged care and our local UCOL as well as DHB employed nursing staff.

Wairarapa DHB: Dashboard Report - April 2018

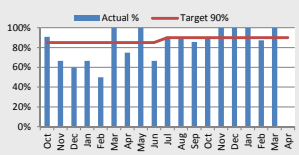
HEALTH TARGETS

Shorter stays in Emergency Departments — 95%

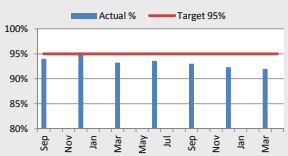


Improved access to Elective Surgery — 99%

Faster Cancer Treatment — 0%



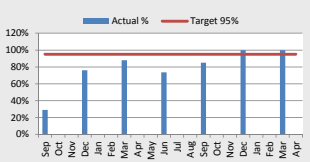
Increased Immunisation — 92%



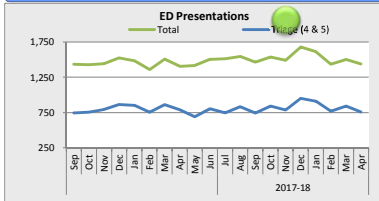
Better help for Smokers to Quit

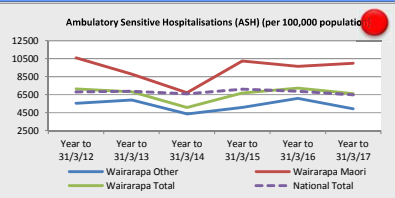
Hospital	100%	✓✓
Primary	90%	✓✓
Maternity	100%	✓✓

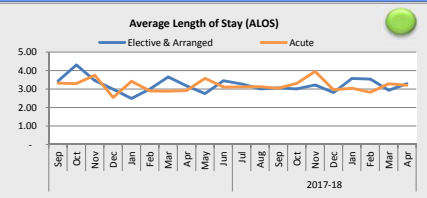
Raising Healthy Kids — 100%

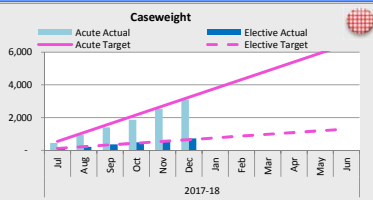


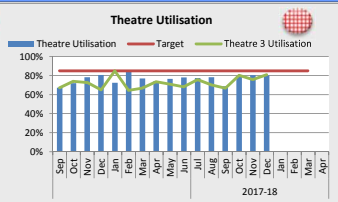
KEY INDICATORS



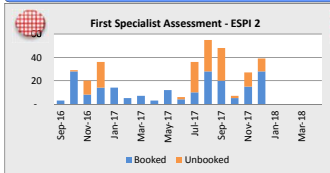


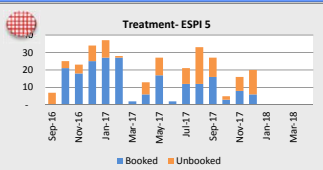






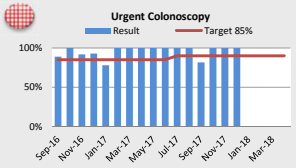
NUMBER LONG WAIT PATIENTS (>4 Months)

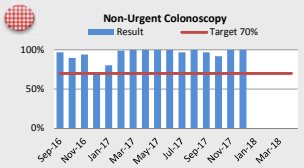




DIAGNOSTIC WAIT TIMES

Diagnostics	Target	Actual	
MRI Wait List seen in 42 days	90.0%	42.0%	✘
Ultrasound Waitlist seen in 42 days	85.0%	56.0%	✘
CT Waitlist seen in 42 days	95.0%	99.0%	✓✓
Urgent Colonoscopy - Wait or Procedure within 14 Days	90.0%	N/A	
Non-Urgent Colonoscopy - Wait or Procedure within 42 Days	70.0%	N/A	
Surveillance Colonoscopy - Wait or Procedure within 84 Days	70.0%	N/A	

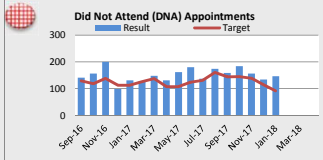


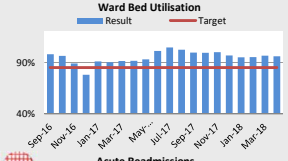


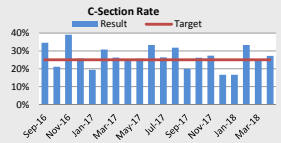
PROCESS & EFFICIENCY

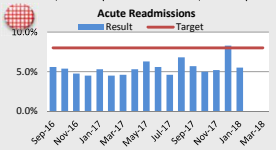
	Target	Actual Mnth	Actual YTD	YTD vs Target
Elective/Arranged Day Surgery rate	62%	N/A	N/A	
Ward Bed Utilisation - MSW	85%	96.1%	98.6%	✓✓
Caesarean Rate (Elective & Acute)	25%	27.3%	25.1%	✘
Acute Readmission Rate	8%	N/A	N/A	
Theatre Sessions Starting on Time	90%	N/A	N/A	
Theatre Session Utilisation (Time in Theatre)	85%	N/A	N/A	
Cancellation on Day of Surgery	5%	N/A	N/A	
Did Not Attend (DNA) Rate	6.2%	N/A	N/A	
Did Not Attend (DNA) Rate - Maori	6.2%	N/A	N/A	
Did Not Attend (DNA) Appointments	845	N/A	N/A	

✓ = Meets Target ✓✓ = Exceeds Target ✘ = Does Not Meet Target

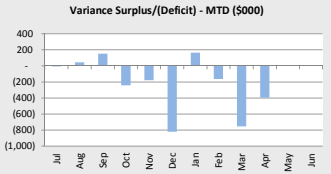


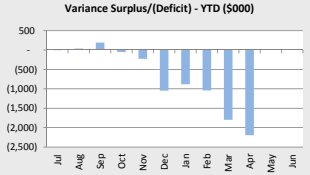






FINANCIAL RESULT



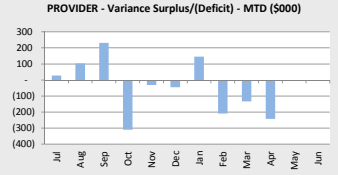


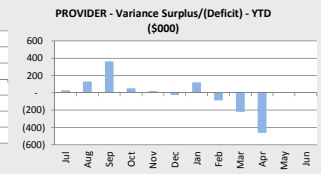
MTD ($000)				Actual vs Budget
Actual	Budget	Variance		
(383)	13	(396)		✘

YTD ($000)				Actual vs Budget
Actual	Budget	Variance		
(4,094)	(1,899)	(2,195)		✘

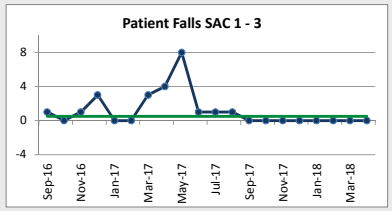
PROVIDER MTD ($000)				Actual vs Budget
Actual	Budget	Variance		
(299)	(56)	(243)		✘

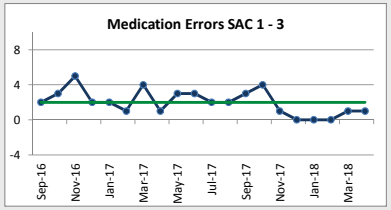
PROVIDER YTD ($000)				Actual vs Budget
Actual	Budget	Variance		
(3,008)	(2,545)	(463)		✘

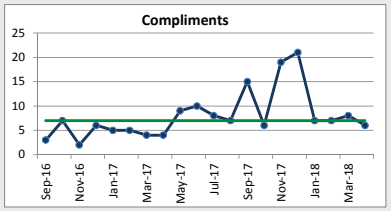


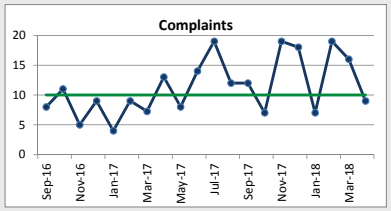


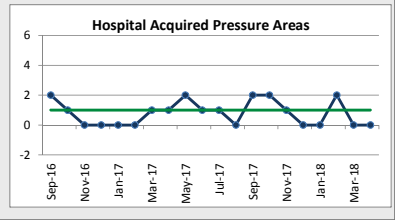
QUALITY MEASURES







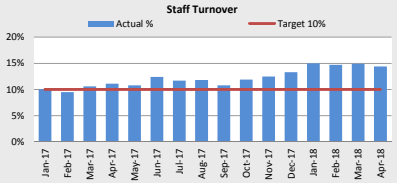


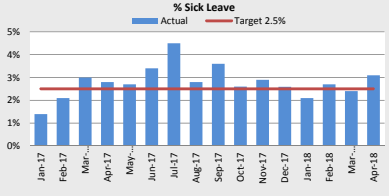


STAFF

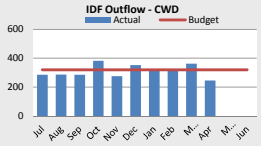
YTD FTE	Actual	Budget	Var
Medical	45	48	3
Nursing	242	231	(11)
Allied	71	72	1
Support	16	16	-
Mgmt/Admin	106	102	(4)
Total	479	468	(11)

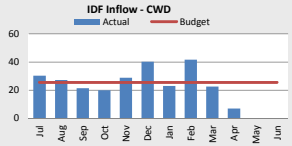
Appraisals Last 12m: 24%





INTER DISTRICT FLOWS





NOTES - APRIL 2018

Not all performance information is available this month. This is due to the switch to WebPas, and difficulties in getting the new system to communicate fully with our Data Warehouse. Work is ongoing to fix this. To enable identification of the performance measures that are affected by this problem, a button with a red grid pattern, as shown in the top left of this box, is affixed to each affected chart. Tables with missing data are shaded red. Note also that IDF data appears with a lag, so the low April volumes are possibly due to incomplete data.