



## Hospital Advisory Committee

### Notice of Meeting

### Open Meeting

Tuesday 14<sup>th</sup> July, 2009  
at 1.00pm in the Board Meeting Room,  
DHB Offices, Blair St, Masterton.



### **Hospital Advisory Committee Agenda**

Wairarapa District Health Board  
DHB Offices, Board Meeting Room, Blair St, Masterton.  
Tuesday 14th July 2009, commencing 1.00pm.

#### **Members:**

Ms Pamela Jefferies (Chair), Dr Liz Falkner, Ms Yvette Grace, Mr Bob Francis, Mrs Janine Vollebregt, Mrs Helen Kjestrup, Mrs Vivien Napier.

#### **Public Forum**

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**Resolution to exclude Public**

**PUBLIC EXCLUDED**

Will commence immediately after the Open Meeting.



## **SECTION 1: Welcome and Apologies**

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## SECTION 2: Registration of Interest

Member	Disclosure Date	Nature of Interest	Other Comments
Pamela Jefferies (Board Member)	23 Apr 2008	<ul style="list-style-type: none"> <li>▪ Trustee and Treasurer - We the People Foundation</li> <li>▪ Trustee Toi Wairarapa</li> <li>▪ Chairman of Biomedical Services NZ Ltd (subsidiary 100% owned by the Wairarapa DHB)</li> <li>▪ Member of Care Plus Scheme, provided through the Wairarapa Community Primary Health Organisation</li> <li>▪ Trustee - Greytown District Trust Lands Trust</li> <li>▪ Trustee Aratoi Foundation</li> <li>▪ Wairarapa Organisation for Older Persons (WOOPS) Board Member</li> </ul>	
Liz Falkner (Board Member)	18 Dec 2007	<ul style="list-style-type: none"> <li>▪ Salaried General Practitioner with The Doctors</li> <li>▪ Practice, Chapel Street, Masterton</li> <li>▪ General Medical Practice in which Doctor Falkner works is a member of the Wairarapa Community PHO</li> <li>▪ Board Member of New Pacific Studios</li> <li>▪ Medical Advisor – Post Polio Support Society NZ Inc</li> </ul>	
Yvette Grace (Board Member)	28 Feb 2008	<ul style="list-style-type: none"> <li>▪ Coordinator of King Street Artworks</li> <li>▪ Mother works for FOCUS as the Assessment Facilitator Service Coordinator</li> <li>▪ Chair of Rangitane o Wairarapa</li> <li>▪ Husband works for WDHB as Clinical Family Violence Co-ordinator</li> </ul>	



Member	Disclosure Date	Nature of Interest	Other Comments
<p>Bob Francis (Board Chairman) Appointed Chairman November 2006</p>	<p>14 Feb 2008</p>	<ul style="list-style-type: none"> <li>▪ Chairman, Pukaha Mount Bruce</li> <li>▪ Board Member, New Zealand Fire Commission</li> <li>▪ Council Member, UCOL</li> <li>▪ Chairman, Wairarapa Sports Education Trust</li> <li>▪ As at April 2008 – Chairman of Wairarapa Healthy Homes</li> </ul>	
<p>Janine Vollebregt (Board Member and Board Deputy Chair)</p>	<p>14 Feb 2008</p>	<ul style="list-style-type: none"> <li>▪ Self employed Registered Nurse who is providing occasional relief for the Wairarapa Community PHO Contracted Nursing Outreach Clinics</li> <li>▪ DHB Nurse Educator for the UCOL Undergraduate Maori Students. This 0.4 FTE position will take effect from the 30th April 2008</li> </ul>	
<p>Helen Kjestrup (Board Member)</p>	<p>18 Apr 2008</p>	<ul style="list-style-type: none"> <li>▪ Nurse Manager at Masterton Medical Practice</li> <li>▪ Director, Property Investment Company – Kjestrup Properties</li> <li>▪ Assessor for Royal College of GPs for Cornerstones Programme</li> <li>▪ Member, Long term Conditions Steering Group</li> <li>▪ Member, Mana Wahine Group</li> <li>▪ Member, Wairarapa Nurses Advisory Group</li> </ul>	
<p>Vivien Napier (Board Member)</p>	<p>21 Oct 2008</p>	<ul style="list-style-type: none"> <li>▪ Member, RNZ Plunket Society</li> <li>▪ Deputy Mayor, South Wairarapa District Council</li> <li>▪ Director, Katson Developments (importing of farm machinery)</li> <li>▪ Vice President, Wairarapa Branch of Plunket</li> </ul>	



## SECTION 3: Terms of Reference

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### INTRODUCTION / BACKGROUND:

The Hospital Advisory Committee of the Wairarapa District Health Board, and its functions, are established under the New Zealand Health and Disability Act 2000.

### PURPOSE / SCOPE:

The Hospital Advisory Committee will advise the Wairarapa District Health Board on matters relating to Wairarapa Hospital, Community, Public and Mental Health, and on strategic issues affecting these services.

### FUNCTIONS:

The functions of the Hospital Advisory Committee of the Wairarapa District Health Board are to:

- Monitor the financial and operational performance of Wairarapa Hospital (and related services) of the Wairarapa District Health Board.
- Monitor the financial and operational performance of Wairarapa Community, Public and Mental Health of the Wairarapa District Health Board.
- Assess strategic issues relating to the provision of the hospital services by or through the Wairarapa District Health Board.
- Assess strategic issues relating to the provision of Community, Public and Mental health services by or through the Wairarapa District Health Board.
- Give the Wairarapa District Health Board advice and recommendations on that monitoring and that assessment.

### MANAGEMENT SPONSOR:

Anne McLean - General Manager Hospital Services

### COMPOSITION:

Members

Members of the Wairarapa District Health Board appointed to the Committee, and co-opted members appointed by the Board

#### Membership

- Ms P Jefferies
- Dr L Falkner
- Ms Y Grace
- Mr B Francis
- Mrs J Vollebregt
- Mrs H Kjestrup
- Mrs V Napier

#### In Attendance

- Other Board Members
- Chief Executive
- General Manager Hospital Services
- General Manager Community, Public and Mental Health
- General Manager Human Resources
- Director of Nursing
- Chief Financial Officer

#### Quorum

The quorum of members of the Health Advisory Committee is:

- If the total number of members of the committee is an even number, half that number but;
- If the total number of members of the committee is an odd number, a majority of the members.

### ACCOUNTABILITY:

The Hospital Advisory Committee is accountable to the Wairarapa District Health Board.

### FREQUENCY OF MEETING:



Monthly, held on Tuesday, one week prior to the District Health Board Meetings, at a time to be publicly notified, at the Wairarapa District Health Board Offices, Blair Street, Masterton.

RELATIONSHIPS (External / Internal):

- The Wairarapa District Health Board
- Other Committees of the Wairarapa District Health Board
- Wairarapa Maori Health Committee
- Hospital Services Management and Clinical Staff
- District Health Board Management
- General Public

REPORTING:

- The Committee will report to the Wairarapa District Health Board at each Board meeting.
- Hospital Advisory Committee Meetings will be open to the public.
- Meetings will be minuted for confirmation at the subsequent Committee meeting,
- A report will be submitted to the Board following each Committee meeting.

REVIEW:

These Terms of Reference will be modified as and when required.



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## SECTION 4: Confirmation of Minutes of Previous Meeting

Hospital Advisory Committee Meeting of the  
Wairarapa District Health Board  
Held on Tuesday 16 June 2009 at 1pm,  
Board Meeting Room, Wairarapa District Health Board Office  
Blair Street, Masterton

**Present:**

Dr Liz Falkner, Ms Pamela Jefferies (Chair), Mrs Vivien Napier and Mrs Janine Vollebregt

**In Attendance:**

Mrs Tracey Adamson (Chief Executive), Mrs Diane Chesmar (Minute Taker), Ms Anne McLean (General Manager Hospital Services), Ms Maggie Morgan (General Manager Community, Public & Mental Health), Mrs Helen Pocknall (Director of Nursing) and Mr Eric Sinclair (Chief Financial Officer)

**1. Apologies**

Ms Janeen Cross, Mr Bob Francis, Ms Yvette Grace, Ms Helen Kjestrup and Mr Bruce McGregor

**2. Registration of Interest**

There were no changes to the Interests Register nor any conflicts with any of the business of the meeting notified.

**3. Terms of Reference**

There was no discussion regarding the Terms of Reference.

**4. Confirmation of Minutes of the Meeting held 19 May 2009**

THE MINUTES OF THE MEETING HELD ON 19 MAY 2009 WERE CONFIRMED AS A CORRECT RECORD OF THAT MEETING.

**4.2 Matters Arising**

There were no matters arising.

**5.0 HAC Workplan**

Presentations to update the Model of Care and Good to Great project to be included in the HAC workplan for August.

**6. Routine Reports**

**6.1 Chairperson's Report**

The Chairperson advised that she attended two finance meetings.

**6.2 Provider Arm Executive Summary**

- The Provider Arm has a deficit of (\$154k) for the month which is (\$232k) adverse to plan. This brings the YTD result to a deficit of (\$2,855k) which is (\$2,815k) adverse to the planned result.
- The payroll accruals were checked with the actuals for the end of May to determine the accuracy of accruals. This highlighted that for most months the accruals calculated within the HRIS are accurate however it also highlighted that manual accrual adjustments will need to be made when there are a number of statutory holidays in a month and periods when annual leave uptake is naturally higher e.g. Christmas.
- Costs continue to track above budget in the areas of outsourced costs, clinical supplies and infrastructure.
- Cost control measures already in place have started to make an impact and will be actively managed and monitored. The risk to the year end breakeven position has been identified to the Board.

**6.3 General Manager Hospital Services Report**

Points raised:

- The Provider contract performance is \$2,065k YTD ahead of budget.
- Total caseweights are 351 ahead of plan YTD.
- Elective caseweights are 123 ahead of plan. ESPI figures remain green, with the exception of orthopaedics and ophthalmology. The variance represents a small number of patients.



- The Ministry has verbally indicated that all additional elective funding applied for will be granted due to good performance in electives. Weekend theatre sessions are being planned in the remaining weekends in June to maximise this opportunity.
- MidCentral Health and Hutt Valley Health have accepted the DHB offer for elective surgery. Three MidCentral joint replacements will be undertaken in June.
- In July, additional general surgery work will commence for six months for Hutt Valley Health.
- The BFHI and BFCI accreditation certificates have been received at a formal presentation at the Town Hall.
- Contingency plans are in place to deal with N1H1 (Swine flu). A Community Based Assessment Centre has been set up to become operational when required. There are daily update meetings with key staff.
- Covering ED after hours and the RMO and Senior Medical Staff on call rosters continues to be a challenge. Other DHBs are experiencing similar problems.
- The Radiology contract is nearing finalisation.
- Commencing in July, Hutt Valley DHB will deliver a Paediatric Rheumatology Clinic on site, likely to be twice a year. The Hospital Advisory Committee requested that progress is reported as necessary.
- Hospital bed occupancy has declined since February. Analysis will be undertaken to determine the reason for this.

#### 6.5.4 Nursing Directorate

- The Nursing and Midwifery project commenced during May. The goals for this project are to make recommendations in regard to the DHB's nursing / midwifery profile and recommend a nursing and midwifery structure which will enhance clinical leadership and engagement. The first reference group meeting was held in June with a workshop. The evaluation of the Model of Care in MSW has commenced and will be incorporated into the nursing and midwifery project.
- The Nursing Directorate team is making excellent progress towards certification with policy and procedure review.
- An excellent presentation was given on the functions of TrendCare by the founder and CEO of TrendCare Systems at a recent meeting. A process of prioritisation is currently occurring in order to establish what parts of the system can be utilised more effectively in the short term. This work will occur after certification.
- An analysis of the nursing workforce is being undertaken. Only 15% of the nursing workforce are full time.

#### 6.3 General Manager Hospital Services Report [continued]

Points raised:

- Ringing patients to remind them of their Outpatient appointment has helped decrease the number of DNAs. Text messaging may be considered as an option in the future.
- The Hospital Advisory Committee commented that the theatre utilisation for the month of May at 90.9% was an exceptional performance and the staff responsible are to be congratulated.
- The Hospital Advisory Committee requested a report from the Dietitian on the effectiveness of the Optifast programme and the progress of patients who have benefited from the programme and those who have had bariatric surgery.

#### 6.4 General Manager Community, Public & Mental Health Reports

The General Manager Community, Public & Mental Health spoke to the report

- Community nursing and health service contract performance, including ACC, is \$359,209 YTD ahead of budget. It is expected that the ACC revenue will be adjusted favourably during June. Excellent work is happening to achieve improved financial outcomes.
- Volumes continue to trend upwards in community health.
- Hours for home help delivered by the support workers within the community service continue ahead of contract.
- The Hospital Advisory Committee asked if there was a waiting list of people in aged care waiting to be reassessed.
- The Hospital Advisory Committee asked if Palliative Care costs could be reflected in one cost centre.
- Mental Health referrals are increasing in both adult and CAMHS services. CAMHS referrals for Maori children have seen a major increase from one referral in April to 11 in May.
- Public Health staff are fully engaged in dealing with H1N1.
- A feasibility study will be undertaken of community nursing to determine the best patient delivery. This will be one component of the Community Nursing Review.
- Focus – outsourced bed expenditure is higher than forecast and reflects the support services purchased.

#### 6.5.3 Human Resources

- RDA Mecca and Apex (MRT) negotiations are about to commence.



**6.5.5 Maori Health**

- The Hospital Advisory Committee requested a report detailing what ante natal classes are being provided for Maori mothers and an ethnicity breakdown of people attending antenatal classes.

**Resolved:**

THAT THE HOSPITAL ADVISORY COMMITTEE:

**RECEIVE** THE ROUTINE REPORTS FOR THE PERIOD ENDING 31 MAY 2009

**7. Ad Hoc Reports**

**7.1 Wairarapa District Health Board Quality & Risk Report May 2009**

- Incident Management training will take place on 17 and 18 June.
- Much work is being undertaken to prepare the organisation for certification.
- Emergency Preparedness staff have been involved in H1N1 epidemic.
- Four Health and Disability Commissioner complaints are currently being dealt with.

**Resolved:**

THAT THE HOSPITAL ADVISORY COMMITTEE:

**RECEIVE** THE WDHB QUALITY & RISK REPORT FOR MAY 2009

**8. General Business**

There were no items of general business.

The meeting was declared closed at 3.05 pm.

\_\_\_\_\_ Chairman

\_\_\_\_\_ Date



## 4.2 Matters Arising

This table identifies the matters arising from previous meetings and provides an update on them.

Item #	HAC Meeting Date / Ref	Action Item	Responsibility of	Due for Next Meeting Day	Comments/ Exception
1.	19/05/09	Report back on the funding and referral process for the Ministry's newborn hearing screening programme	Anne McLean and Tracey Adamson	14/07/09	
2.	16/06/09	Ethnicity breakdown of people involved in antenatal classes requested.	Anne McLean	14/07/09	
3.	16/06/09	Request made for Palliative Care costs to be reflected in one cost centre.	Maggie Morgan	14/07/09	This has already been done see page 42 for the Palliative section of the report.
4.	16/06/09	Report back if there is a waiting list of people in aged care waiting to be reassessed.	Anne McLean	14/07/09	
5.	16/06/09	Report requested from Dietitian regarding effectiveness of the Optifast programme and the progress of patients who have benefitted from the programme.	Anne McLean	18/08/09	
6.	17/02/09 16/04/09	Paper on whether the Wairarapa DHB currently meets the respiratory standards recognised by the MOH in 2004 for DHB's with less than a population of 50,000. If it did not, where it fell short. What steps will be taken to meet the standard.	Clinical Board	18/08/09	
7.	16/04/09 19/05/09	Update on the Self Harm ED Project requested, including ethnicity statistics.	Anne McLean	18/08/09	
8.	19/05/09	When HAC report is reviewed, include graph showing the total number of FOCUS assessments.	Maggie Morgan and Tracey Adamson	18/08/09	
9.	19/05/09	When HAC report is reviewed, Include a report on staff sick leave within the report on staffing.	Bruce McGregor and Tracey Adamson	18/08/09	
10	16/06/09	Report back on outcome of analysis undertaken to determine bed occupancy decline since February.	Anne McLean	18/08/09	
11	16/06/09	Progress report requested on twice yearly Paediatric Rheumatology Clinic commencing in July.	Anne McLean	18/08/09	
12	19/05/09	Provide a six monthly report on Ambulatory Sensitive Hospital (ASH) Admissions & report back.	Anne McLean and Tracey Adamson	17/11/09	



## SECTION 5: HAC Workplan

<b>Service Plans:</b>	<b>Responsibility</b>	<b>Meeting:</b>
Hospital	Anne McLean	Aug 2009
Community	Maggie Morgan	Aug 2009
<b>Service Presentations:</b>		
District Nursing	Maggie Morgan	Aug 2009
Allied Health	Fred Wheeler	Nov 2009
Annual Ambulance Report	Maggie Morgan	Mar 2009
Patient Journey	Carol MacDonald	Feb 2009
Emergency Department	Robyn Brady	Mar 2009



## **SECTION 6: Routine Reports**

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### **6.1 Chairperson's Report**

A verbal report will be given.



## 6.2 Provider Arm Executive Summary

	Jun-2009			YTD				FY Bud
	Act	Bud	Var	Act	Bud	Var	Var %	
<b>FTE's</b>								
Allied Health Staff	91.3	100.1	8.8	90.2	100.4	10.3	10.2%	✓ 105.4
Management/Administrative	99.1	105.3	6.2	100.4	106.7	6.3	5.9%	✓ 106.7
Medical Staff	29.5	41.1	11.6	33.1	41.1	8.0	19.4%	✓ 41.1
Nursing Staff	174.3	173.0	(1.2)	182.5	174.3	(8.2)	-4.7%	174.3
Support Staff	11.9	12.3	0.4	11.4	12.4	1.1	8.6%	✓ 12.4
<b>Total FTE</b>	<b>406.1</b>	<b>431.9</b>	<b>25.8</b>	<b>417.6</b>	<b>435.0</b>	<b>17.4</b>	4.0%	<b>440.0</b>

### Key Points:

Report to be tabled at the meeting.



## 6.3 GM Hospital Services Report

### 6.3.1 Summary

The Provider contract performance is \$2,169k YTD ahead of budget [Refer Appendix D]. Total case weights are 317 ahead of plan YTD. Elective case weights are 103 ahead of plan. ESPI figures remain green, previous orange status has been remedied due to data issues. Weekend theatre session went according to plan. Midcentral Health (MCH) and Hutt Valley Health (HV) have accepted the DHB offer for elective surgery, 3 Joint replacements (MCH) were undertaken in June. In July additional General Surgical work will commence (HV). Work is underway for certification visit 1<sup>s</sup>-3<sup>rd</sup> July.

	Act	Jun-2009 Bud	Var	Act	YTD Bud	Var	Var %	+/- 5%	FY Bud
<b>Contract Volumes</b>									
ED Attendances (not incl ED Admissions)	1,159	924	235	14,304	11,182	3,122	27.9%	✓	11,182
Acute CWD	282	283	(1)	3,763	3,549	214	6.0%	✓	3,549
Elective CWD	115	138	(23)	1,730	1,627	103	6.3%	✓	1,627
<b>Total CWD</b>	<b>397</b>	<b>421</b>	<b>(24)</b>	<b>5,494</b>	<b>5,177</b>	<b>317</b>	<b>6.1%</b>	✓	<b>5,177</b>
OP FSA's	588	550	39	6,592	6,727	(135)	-2.0%		6,727
OP Follow's	889	707	182	10,180	8,978	1,202	13.4%	✓	8,978
<b>Total OP</b>	<b>1,477</b>	<b>1,257</b>	<b>221</b>	<b>16,772</b>	<b>15,705</b>	<b>1,067</b>	<b>6.8%</b>	✓	<b>15,705</b>
<b>KPI's</b>									
Readmissions	10.9%	10.0%	-0.9%	11.2%	10.0%	-1.2%	-11.6%	✘	10.0%
OP DNA's	8.8%	7.5%	-1.3%	7.9%	7.5%	-0.4%	-5.1%	✘	7.5%
Theatre Utilisation	81.2%	85.0%	-3.8%	84.8%	85.0%	-0.2%	-0.3%		85.0%
Daycase Electives	83.3%	75.0%	8.3%	72.8%	75.0%	-2.2%	-2.9%		75.0%
<b>FTE's</b>									
Allied Health Staff	30.4	30.3	(0.2)	29.2	30.0	0.9	2.8%		30.0
Management/Administration Staff	47.5	48.2	0.7	49.9	49.1	(0.8)	-1.7%		49.1
Medical Staff	26.6	37.6	11.0	30.0	37.6	7.5	20.1%	✓	37.6
Nursing Staff	127.1	129.9	2.8	135.3	131.2	(4.2)	-3.2%		131.2
Support Staff	3.5	3.9	0.4	3.6	3.9	0.3	7.7%	✓	3.9
<b>Total FTE</b>	<b>235.0</b>	<b>249.8</b>	<b>14.7</b>	<b>248.0</b>	<b>251.7</b>	<b>3.7</b>	<b>1.5%</b>		<b>251.7</b>

\* Refer to the Glossary for definitions of these measures.



### 6.3.2 Key Risks and Opportunities

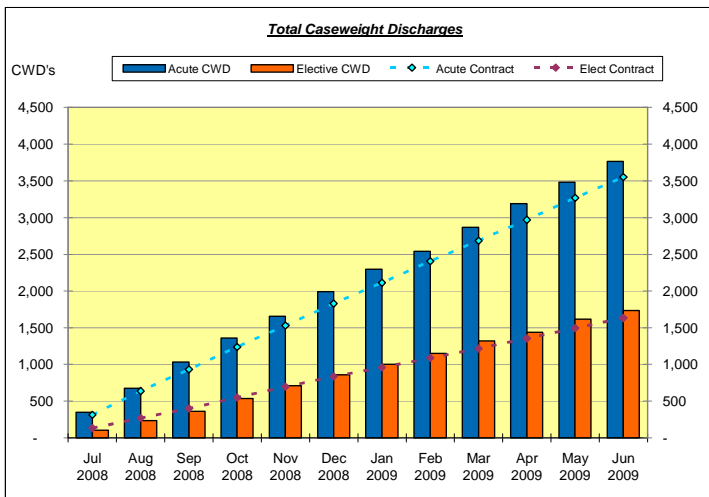
1. Locum costs nationally are increasing due to limited medical staff availability.
2. Supervision arrangement for new Senior Doctors is increasing complexity of recruitment.

### 6.3.3 Mitigation Strategies

1. Locum employed for essential services only.
2. Discussion at national meetings to manage locum costs.
3. Liaise with other DHB on SMO supervision arrangements.

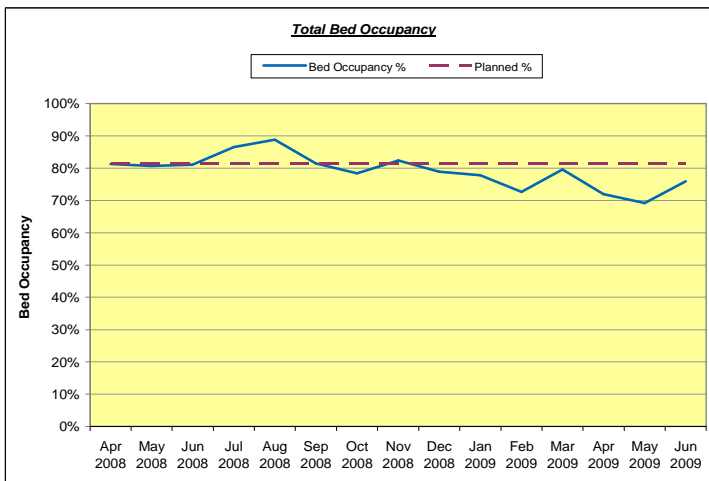
### 6.3.4 Service Initiatives

1. Review of radiology contract.
2. Good to Great programme



*This is a cumulative trend graph of the acute and elective caseweighted discharges at the Wairarapa hospital. The contracted targets have been set in the Provider Service Level Agreement.*

Electives on target.

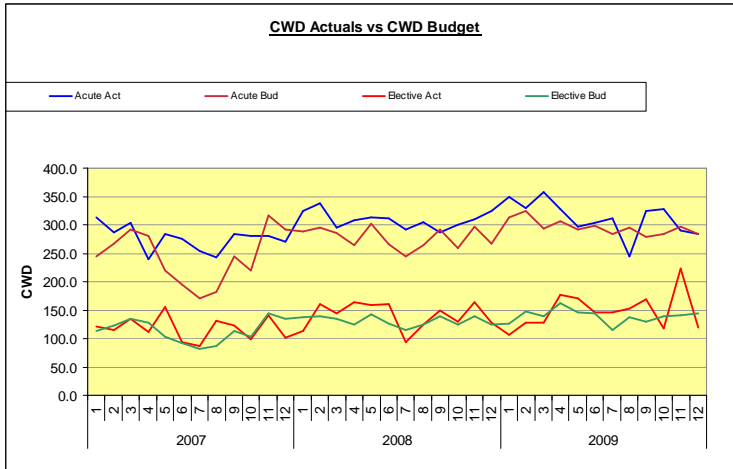


*Occupancy Rate (Occupied bed days divided by Resourced bed days).*

*The wards included are MSW (38 beds), Paediatrics (7), AT&R (13), HDU (6) and Maternity (6). This is a total of 70 beds resourced.*

*AAU beds are excluded because occupancy is calculated in hours rather than days. Also excluded are Borders, Newborns, and MH patients.*

Consistent patient flow has reduced occupancy.



This is a graph showing the **actual** acute and elective case weighted discharges vs. the **budgeted** case weighted discharges.

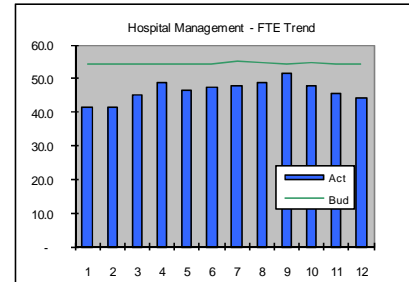
Elective activity ahead of target this will be offset against additional funding. Actuals for the month reflect planned reduced activity.



### 6.3.5 Hospital Services Management

#### FTE Analysis

Hospital Management	FTE Actual	FTE Budget	Variance
Allied Health Staff	-	-	-
Management/Administration Staff	12.7	11.7	(1.0)
Medical Staff	26.6	37.6	11.0
Nursing Staff	4.9	5.1	0.2
Support Staff	-	-	-
<b>Total FTE's</b>	<b>44.2</b>	<b>54.4</b>	<b>10.2</b>



#### Summary

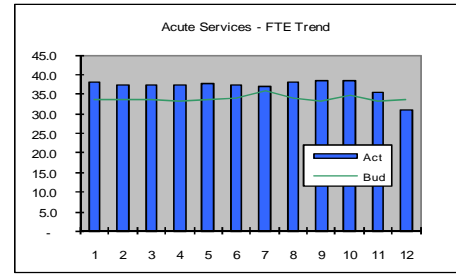
- Medical staff FTE favourable this is offset by locum costs. Locum costs causing significant pressure on costs, recruitment of permanent staff ongoing.
- Nursing FTE is reflective of Selina Sutherland activity.
- Clinical Supply costs are higher than planned across the hospital. Analysis of the ordering and usage will be undertaken in order to reduce costs.



### 6.3.6 Acute Services

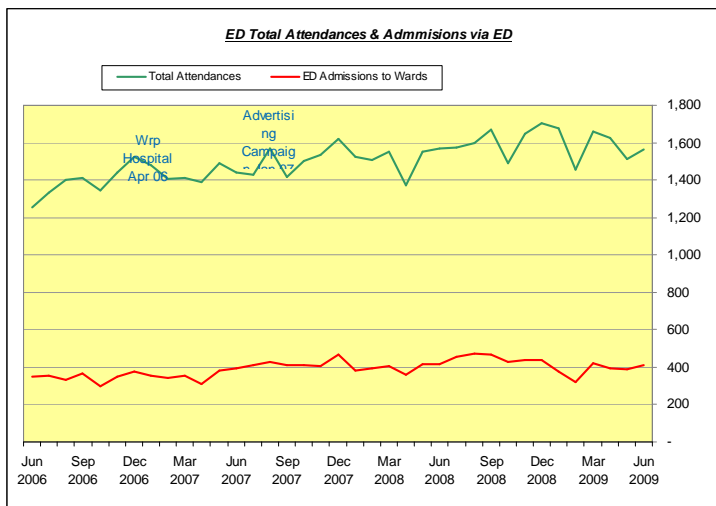
#### FTE Analysis

Acute Services	FTE Actual	FTE Budget	Variance
Allied Health Staff	-	-	-
Management/Administration Staff	2.5	2.6	0.1
Medical Staff	-	-	-
Nursing Staff	28.3	31.0	2.6
Support Staff	-	-	-
<b>Total FTE's</b>	<b>30.8</b>	<b>33.5</b>	<b>2.7</b>



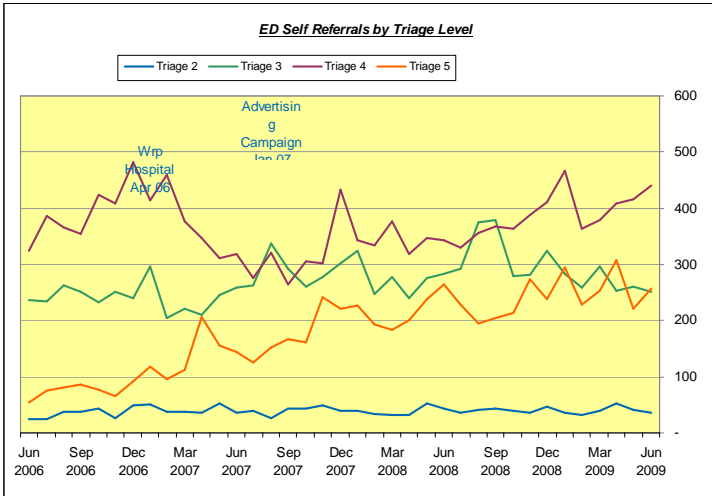
#### Summary:

- 6 acute air retrievals for June. 39 Interhospital transfers by road requiring cardiac, neuro, orthopaedic, burns/plastic and maternity services.
- Reviewing clinical and clerical practices for the triage 4 & 5 patients who are fracture clinic reviews in ED. Revenue and contract implications being worked through.
- On line Smokefree training provided with 50 health professionals successfully completing programme. Screening in outpatient settings is between 94-97%. The numbers of patients who are not smokefree at the time of preassessment range from 10 – 17%. Acute presentation screening and intervention rates are lower. This is an area of focus for inpatient settings. Despite this there has been an increase in the number of patients offered NRT
- FTEs under for the period. Reflected in lower activity in AAU and HDU combined with admitting direct to wards and not staffing AAU.



ED Attendance is the total number of ED presentations. Admissions via ED show the number of patients admitted under the 3 hour rule from ED into the wards. The target for ED Attendances is set in the SLA volumes. Admissions via ED are targeted to be decrease to illustrate better management of the ED cases.

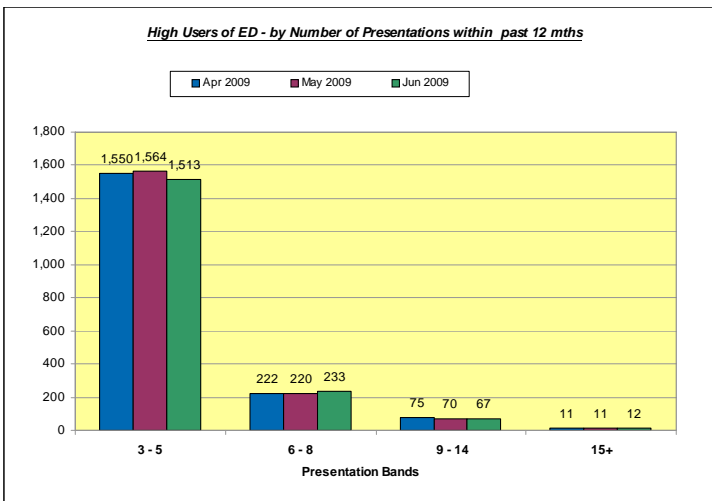
Attendances and admissions remain steady.



The Referral Source looks at where patients attending ED are coming from. Self Referrals make up the largest percentage and it is these referrals, with a low triage level of 4 to 5, which the DHB is aiming to reduce through communication channels.

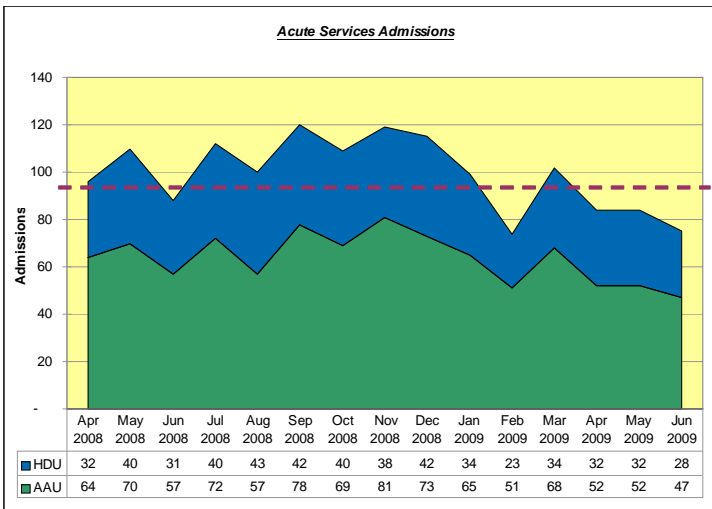
Triage 2 remains steady.  
Triage 3 steady decline – maybe associated with inter-reliability between triage nurses  
Triage 4 & 5 continue to trend upward from 2006.

Fracture clinic reviews are part of triage 4 & 5, and some triage 3 maybe being coded as triage 4. No change to total attendances.



This graph shows how many people presented to ED 3-5 times, 6-8 times, 9-14 times or over 15 times within the past 12 months. The target is to reduce the high users, and to provide more effective forms of treatment.

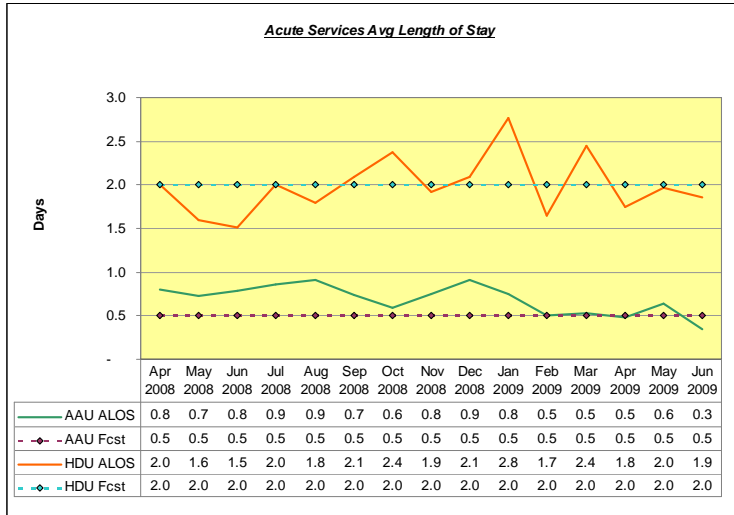
Long Term Conditions Collaborative has commenced.



Acute Services Admissions is the number of admissions to the High Dependency Unit (HDU) & Acute Assessment Unit (AAU). Based on historical data and staffing levels the combined forecasted number of admissions is 80.

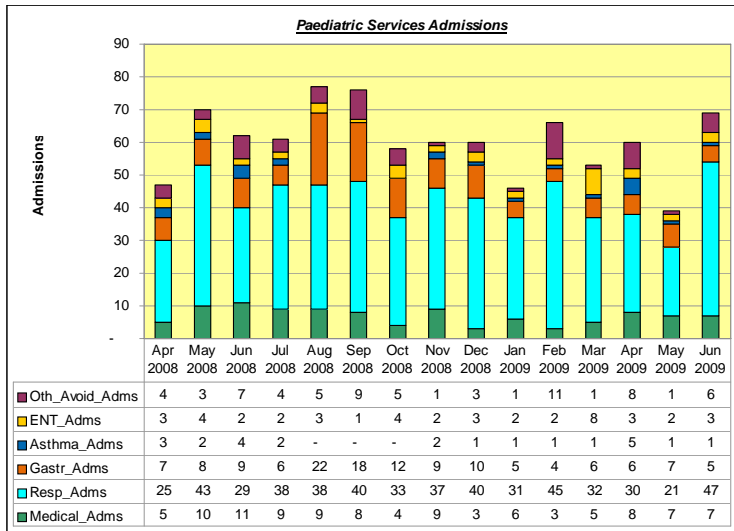
Total number of admissions is 75.

Lower levels of surgery and less demand on HDU beds.



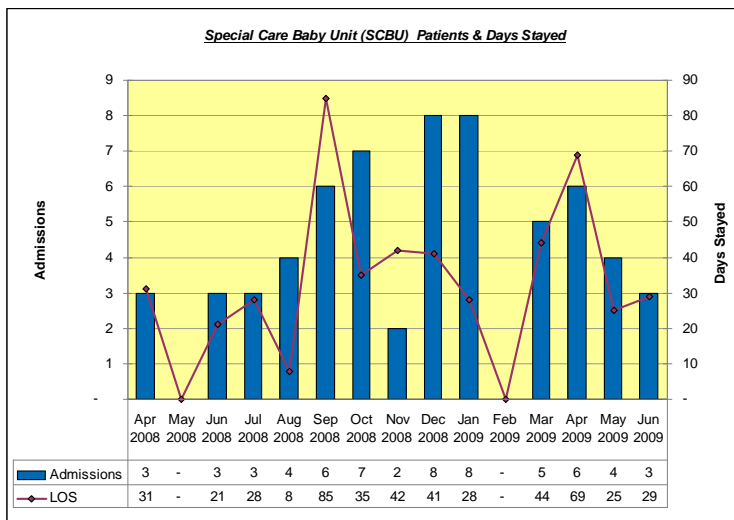
The Average Length of Stay (ALOS) in HDU & AAU is an indicator of the effectiveness of the service in the units and the type of patients they are admitting. The forecasted ALOS is based on expected patient numbers and acuity.

- LOS Decline indicates appropriate use of HDU and AAU



This graph shows the admissions to the Paediatric ward. Avoidable admission categories are provided, medical admissions indicate that admissions categorised as unavoidable. Lower Avoidable Admissions is one of the Key Provider targets for 2007/08.

Higher respiratory illness rate when compared to June last year.



The number of babies who were admitted to SCBU in the month is shown by the bars, and the days stayed is shown by the line based on the right hand axis, depicting utilisation of the unit.

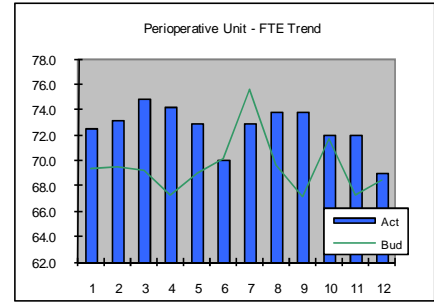
The number of babies in SCBU is demand driven. Impact on staffing is significant as ward is double-staffed to care for SCBU patients.



**6.3.7 Perioperative Services (OPD, Theatre, Day Procedures)**

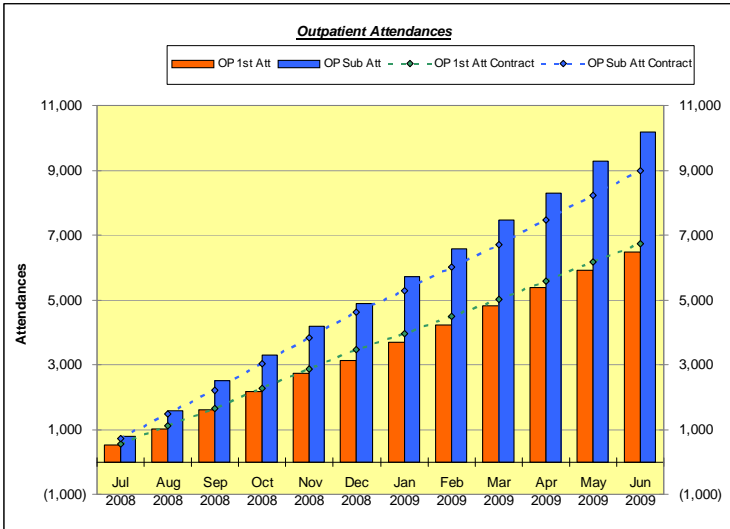
FTE Analysis

Perioperative Unit	FTE Actual	FTE Budget	Variance
Allied Health Staff	0.9	0.9	0.0
Management/Administration Staff	7.0	8.1	1.1
Medical Staff	-	-	-
Nursing Staff	57.5	55.6	(1.9)
Support Staff	3.5	3.9	0.4
<b>Total FTE's</b>	<b>68.9</b>	<b>68.5</b>	<b>(0.4)</b>



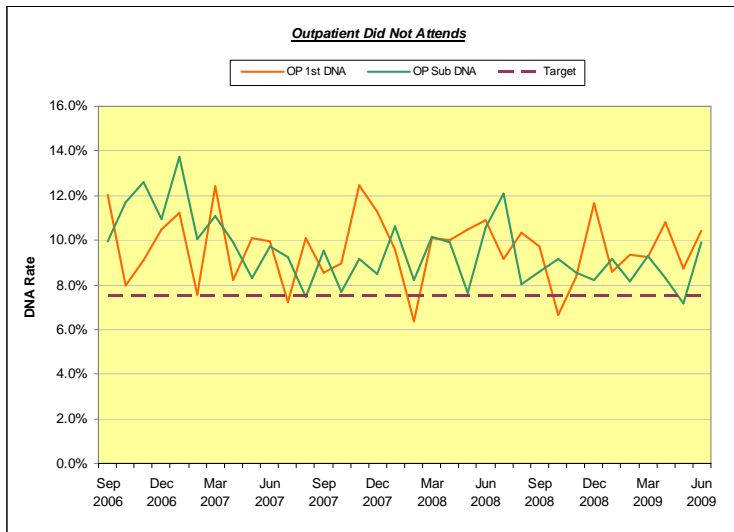
Summary

- Nursing personnel remains slightly high due to acutes, weekend call outs and weekend minor plastic list surgery undertaken on the weekend of 20<sup>th</sup> June 2009.
- Model of Care Trial – the Project Group is undertaking the evaluation, report due in July.
- HCA commenced 29 June for the remainder of the Model of Care trial
- Nursing students have continued placement this month
- Preparation for certification was undertaken
- Additional ENT OPD undertaken on weekend of 27th June 2009 as additional elective funding had been offered to the DHB.



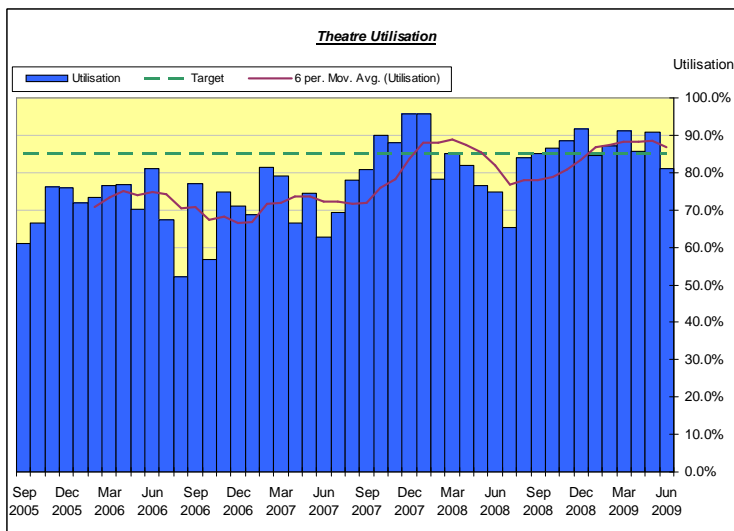
An accumulating total of OP 1<sup>st</sup> and subsequent attendances and a comparison to the SLA contracted volumes. This includes all specialties that the Provider is contracted for, and excludes OP attendances done by other DHB's for our population.

Work in progress on capacity planning being undertaken to match volumes and case-weights to better manage FSA to FUP volumes.



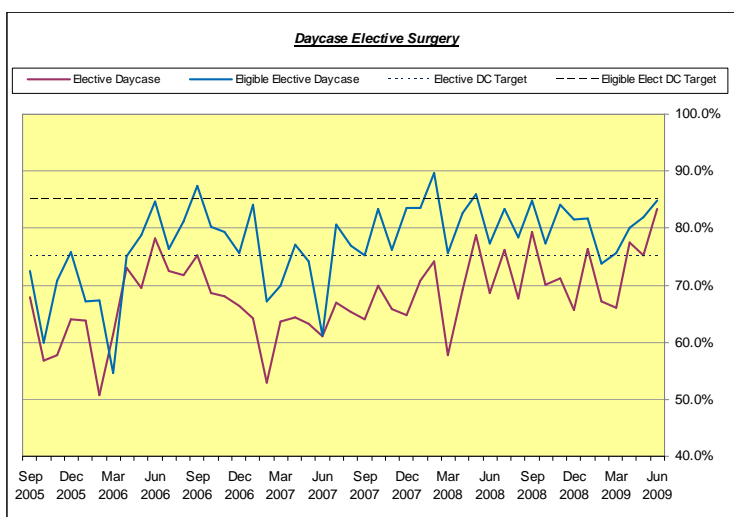
The Outpatient DNA rate is calculated by taking the number patients who did not attend a booked clinic and dividing this by the total OP clinic's booked. Decreasing OP DNA's below a target rate of 7.5% is a key Provider priority for 2007/08.

Impact of DNA project not apparent this month, discussion is underway with project team for possible explanation.



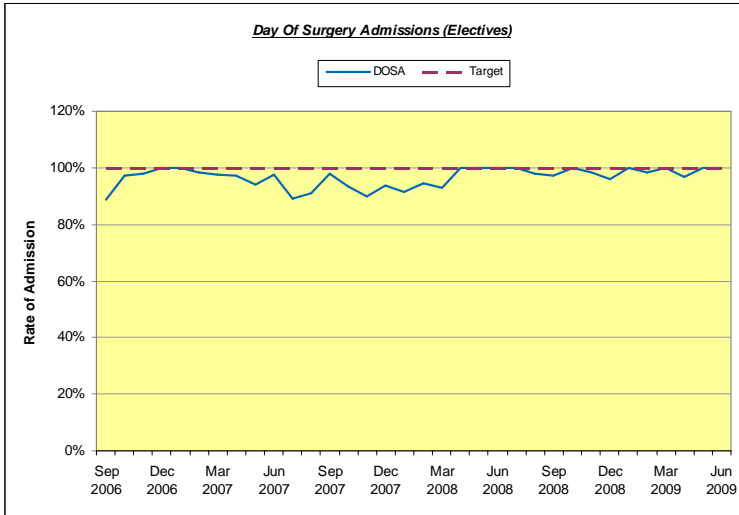
Theatre Utilisation is based on theatre's 1 & 2 as they are both fully resourced. The rate is based on the total procedure minutes (including 10 mins per session for turnaround), divided by the total resourced mins between 8:30am – 5:00pm weekdays. The utilisation rate of 85% is a national benchmark, and was set in the Hospital Development Business Case.(HDBC)

Theatre utilisation to date is at 76.9%. This statistic is excellent given the reduction in theatre activity during June with lists reducing to 1 GA list per session due to limited anaesthetists.



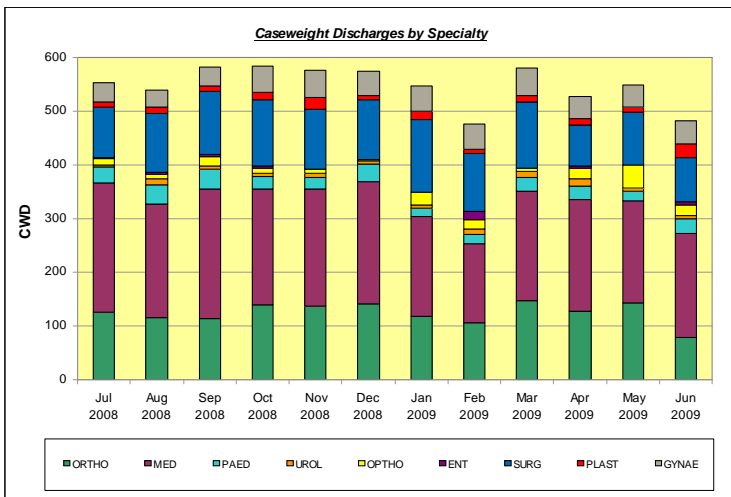
The Daycase Elective Surgery rate is the % of elective patients who did not stay overnight when admitted for their elective procedure. Eligible Elective Daycase focuses on those procedures that should be done only on a daycase basis, therefore the target is higher. These targets are national benchmarks and were set in the HDBC.

Increased due the nature of the case-mix of surgery undertaken during June, majority of cases day case elective.



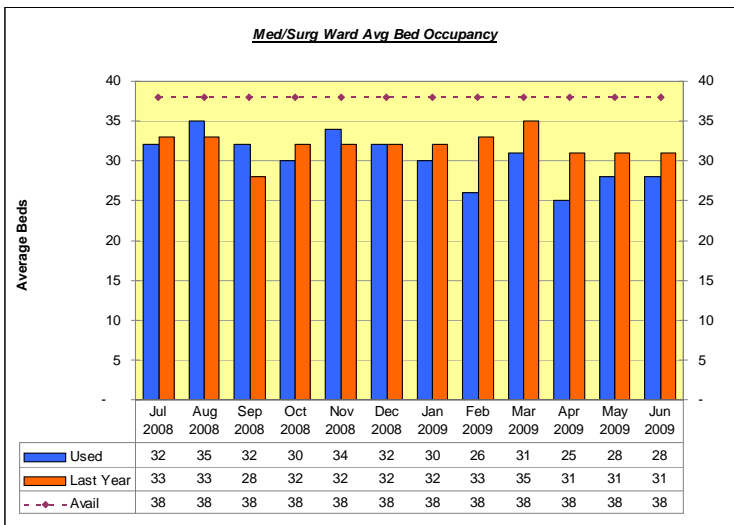
Day of Surgery Admissions (DOSA) are patients who are admitted on the day that they actually had their surgery performed. This is shown as a proportion of total non-daycase elective patients. The DOSA rate of 100% was set in the HDBC.

On target.



This graph shows the total caseweight discharges for the month broken down by the health specialty. The average Provider contract total for the month is 440 CWD.

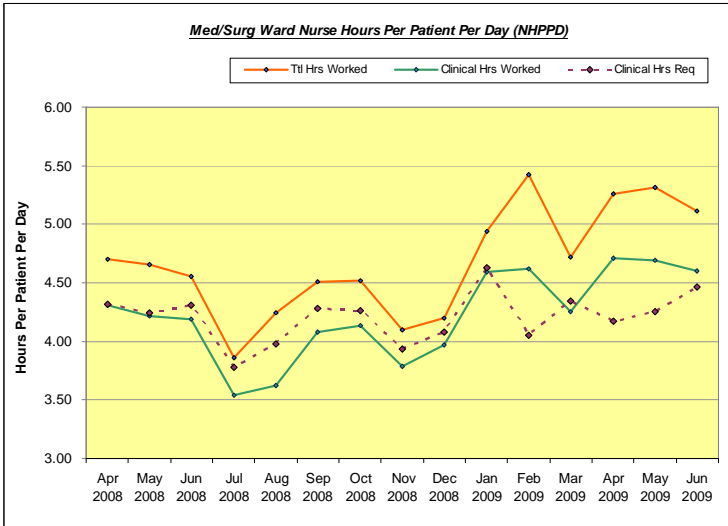
Lower caseweights related to planned reduced elective surgery in June



This graph shows the average occupancy per month in the Med/Surg ward, taken at 12pm each day. There is no target for this, only a capacity of 38, and a comparison of the average occupancy for the same month last year.

The effect of aiming for discharge time of 1100 hours is having an effect on this occupancy statistic measured at 1200 hours

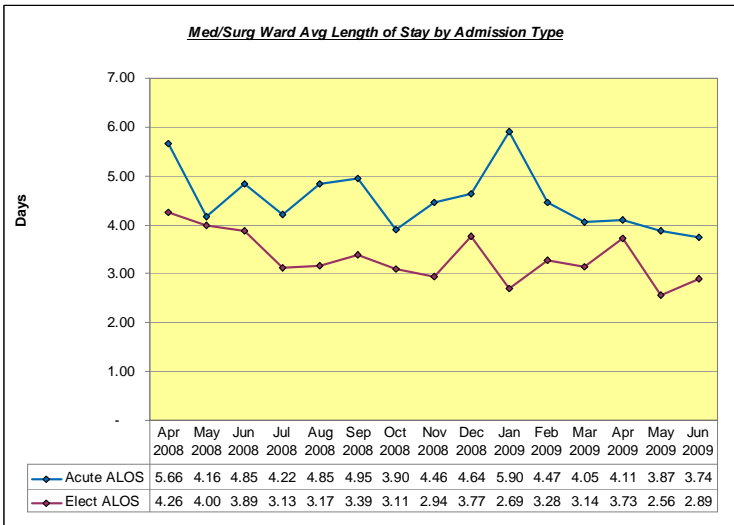
Utilisation on usual resourced beds is 89.93 %  
Average number patients on  
Am duty 31  
Pm duty 29  
Night duty 28



Total Nurse Hours per Patient Day (NHPPD) is a measure from the nursing workload acuity system Trendcare. It is calculated by taking the total number nurse hours worked in a shift clinical and non clinical and dividing this by the number of patients in that ward.

Actual required and clinical hours worked are within bench mark.

Total hours include Casual RN orientation, RN competency training non core staff



The average length of stay (ALOS) of inpatients to the MedSurg ward, broken down by acute and elective admissions.

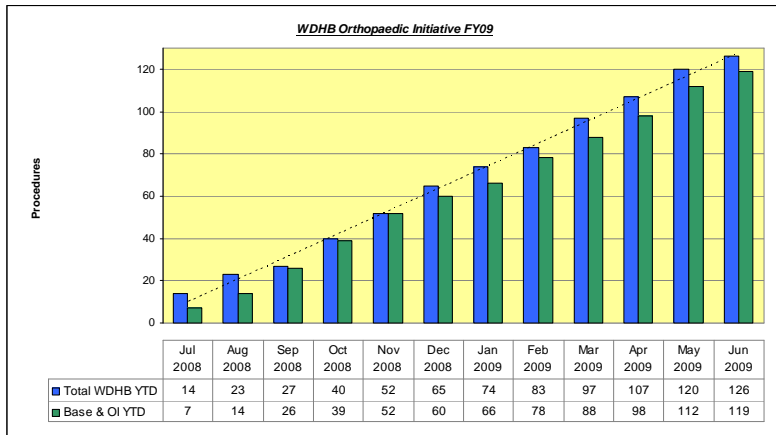
Lower elective and acute ALOS most likely related to Admission discharge RN role introduced as part of the Model of care which commenced late January 09.



### 6.3.8 Elective Services

#### Key Points

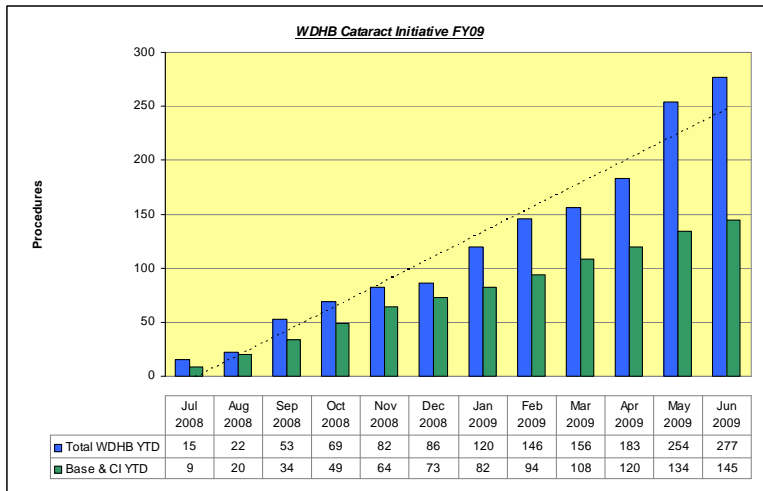
- Refer Section 10; Appendix A. ESPI summary for May 09 is preliminary at time of writing however is not expected to change when finalised. Of note is the green result at overall hospital level and the reversal of the previous Orange results in ESPI 5 and 7 in Orthopaedics, corrected data was submitted.
- At the end of May Elective targets for the full year have been met.



*The Orthopaedic Initiative is additional funding for achieving targeted orthopaedic joint procedures.*

*The blue bar is the actual number YTD including IDF's. The green bar is the base amount plus the additional MOH target. The dotted line is the trend of actual production. Achievement of the base & additional target makes additional funding available.*

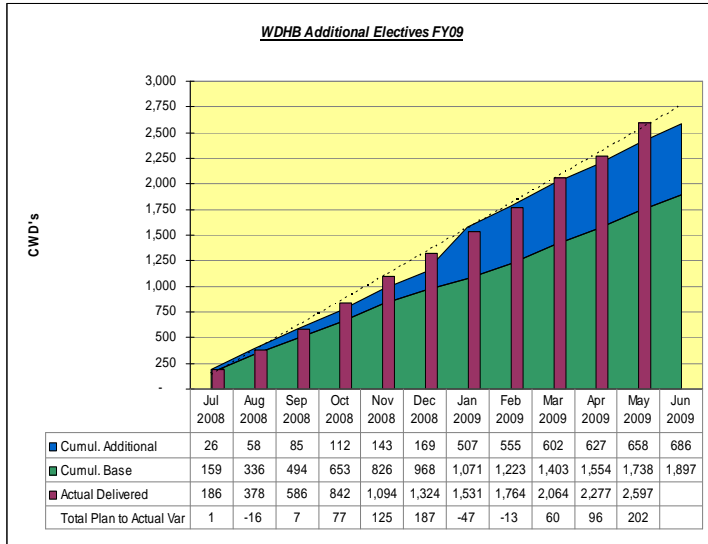
OI completed for 08/09. Further procedures counted in EI



*The Cataract Initiative is additional funding for achieving targeted cataract procedures.*

*The blue bar is the actual number YTD including IDF's. The green bar is the base amount plus the additional MOH target. The dotted line is the trend of actual production. Achievement of the base & additional target makes additional funding available.*

CI completed for 08/09. Further procedures counted in EI



There is Additional Elective funding available to the DHB for achieving a targeted number of elective caseweights discharges (CWD). The blue bar is the actual number of elective CWD YTD including IDF's. The green bar is the base amount plus the additional MOH target. The dotted line is the trend of actual production. Achievement of the base & additional target makes additional funding available.

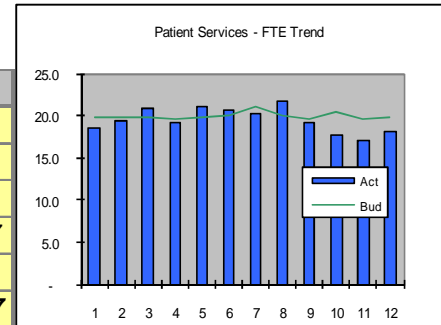
Elective performance ahead of target.



### 6.3.9 Patient Services (Maternity, Nursing Relief Team)

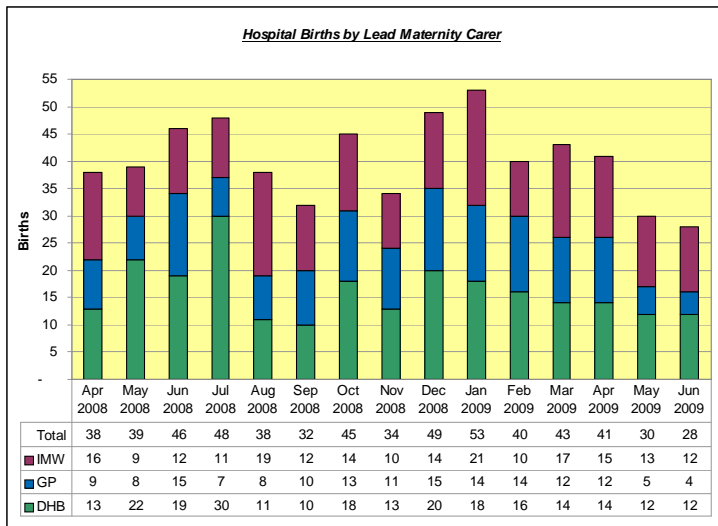
#### FTE Analysis

Patient Services	FTE Actual	FTE Budget	Variance
Allied Health Staff	-	-	-
Management/Administration Staff	-	-	-
Medical Staff	-	-	-
Nursing Staff	18.0	19.8	1.7
Support Staff	-	-	-
<b>Total FTE's</b>	<b>18.0</b>	<b>19.8</b>	<b>1.7</b>



#### Summary

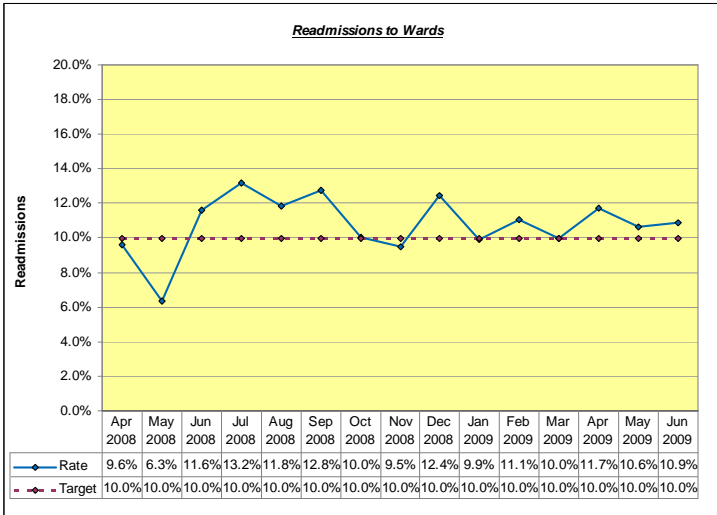
- Interview and recruitment process underway for 1.0 FTE midwifery vacancy.
- Antenatal HIV testing is Go Live mid July. Attendance by WDHB AHIV coordinator at the national hui for AHIV in Auckland was very useful to discuss aspects of rapid testing, unbooked women, boundary between microbiologist and infectious diseases consultant.
- Antenatal Newborn Screening \$56K available 1 July. Capital investment for audiology equipment is included in new money. All babies tested within first month of birth. Majority will be tested prior to discharge. Arrangements for repeat testing or catch-up screening will be made at clinic or during community postnatal visit. Referrals will be made through for more comprehensive testing to Audiology Services. The volumes are anticipated to be 10 per annum with 2 babies going on to tertiary centre as profoundly deaf. Links with Hutt Valley to undertake training and aim for this to be Go Live February 2010. Both screening programmes have similar framework and WDHB is combining roles into 1 position.
- Deliveries for the month - 40. Average is 42 deliveries per month. No transfers out to tertiary centre
- FTE are under budget. Vacancy of 1.1 FTE in Relief team.



*Births by Lead Maternity Carer (LMC) shows who admitted the baby to the ward, and therefore has been taken as a proxy to the primary lead in the birth. This has then been grouped into either an Independent Mid-Wife (IMW), a General Practitioner (GP), or a DHB provided mid-wife or obstetrician. The total of the stacked bars shows the accumulated births in the month. The FY2008 budgeted number in the SLA is 42. Lag time between discharge and coding*

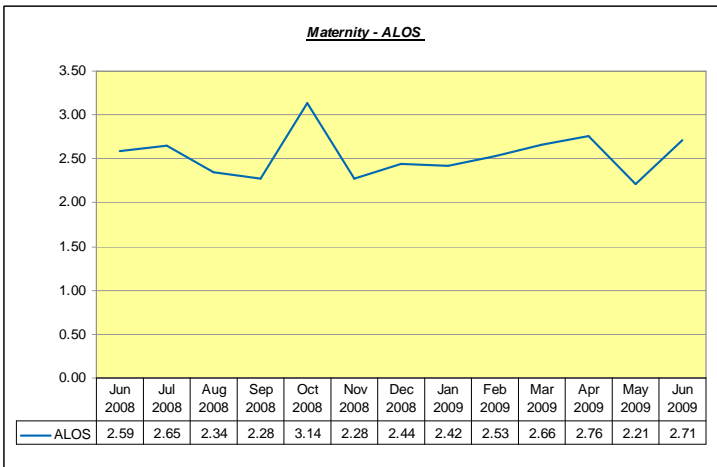
There were 40 admitted deliveries in June

- 16 Caesareans – 8 elective & 8 emergency
- 24 Vaginal deliveries
- 1 set twins



*This graph shows the proportion of inpatients admitted that had previously been admitted in the past 30 days, and were readmitted acutely to the same specialty. The target is to keep these readmissions to 10% through effective discharge plans and community care.*

Readmissions are consistently above the benchmark. A detailed review of readmissions is being undertaken, with a focus on splitting planned and unplanned readmissions.



*This graph shows the average length of stay (ALOS) in the Maternity Ward over the past 12 months.*

ALOS 2.51 days  
Normal delivery ALOS 1.43 days  
Caesarean Delivery ALOS 4.24 days  
Other complications (forceps) ALOS 2.32 days

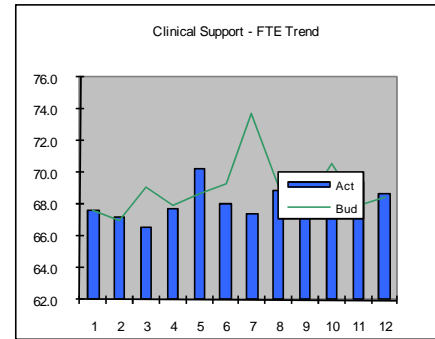
A new measure has been introduced to monitor MOH priority for extended LOS in Maternity.



### 6.3.10 Clinical Support, Therapies & Allied Health

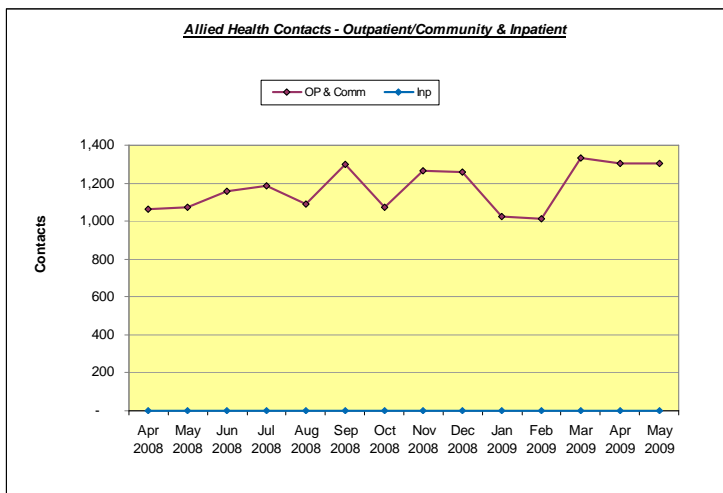
FTE Analysis

Clinical Support	FTE Actual	FTE Budget	Variance
Allied Health Staff	29.5	29.3	(0.2)
Management/Administration Staff	23.4	24.0	0.6
Outsourced Personnel	-	-	-
Nursing Staff	15.8	15.2	(0.6)
Support Staff	-	-	-
<b>Total FTE's</b>	<b>68.7</b>	<b>68.5</b>	<b>(0.2)</b>



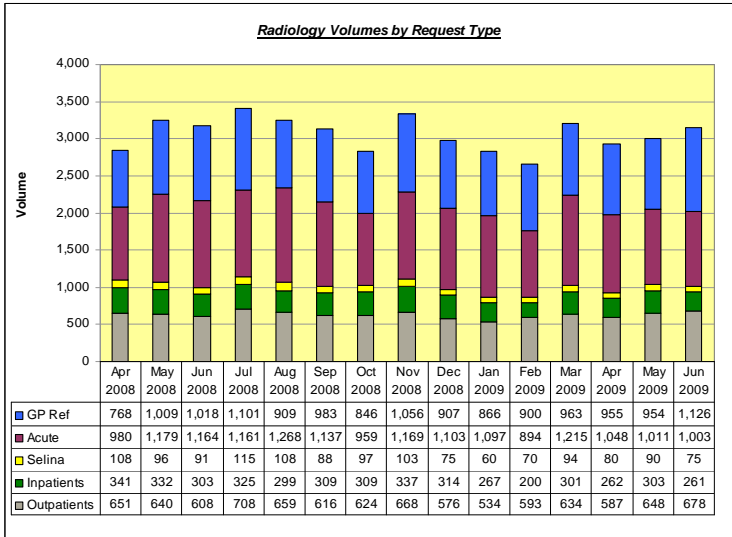
Summary

- Family Violence Training for trainers’ staff has commenced on a fortnightly basis and the programme was audited in May. Formal feedback is very encouraging with scores of 82% for Partner abuse training and 83% for child abuse training achieved.
- A vacancy still exists for a Sonographer. Ongoing attempts to recruit to this position continue. There is a national shortage.
- Improved terms have been agreed and PRL will commence the new pricing structure from April the service specification and contract are still to be finalised.
- Dietetics has underperformed to contract this year by approximately 350 contacts. This is mainly attributable to the resignation in March of the second dietician who hasn't been replaced.
- Social work is also underperforming to contract by approximately 280 contacts this is linked to the increase in demand for more complex care associated particularly with Termination of pregnancy and palliative care.
- An outbreak of viral D&V has impacted on both the activity for the month as admission and discharge was restricted and also the clinical costs associated with infection control measures.
- Some specials were required for confused patients transferred from MSW
- Earlier identification of stroke patients for transfer to Rehab from ED and MSW is occurring.



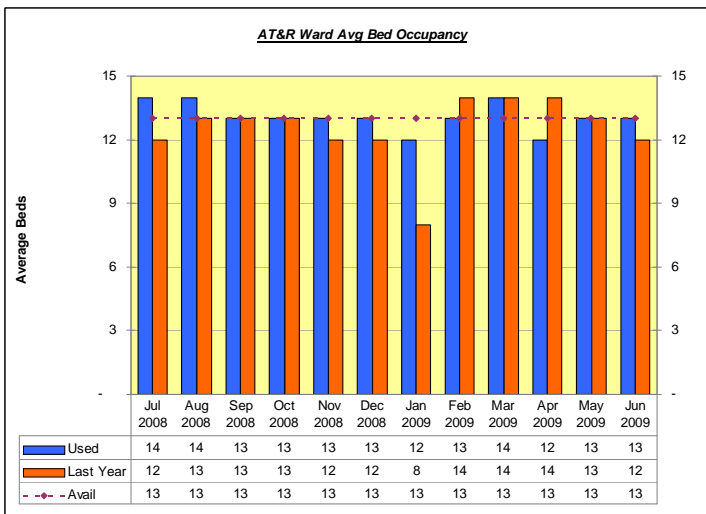
All Allied Health contacts in the month shown as either community or inpatient contacts. The community contacts are funded via separate contracts with the Funder, whereas the inpatient contacts are an input into the overall case weight.

Increase in outpatient allied health contacts.



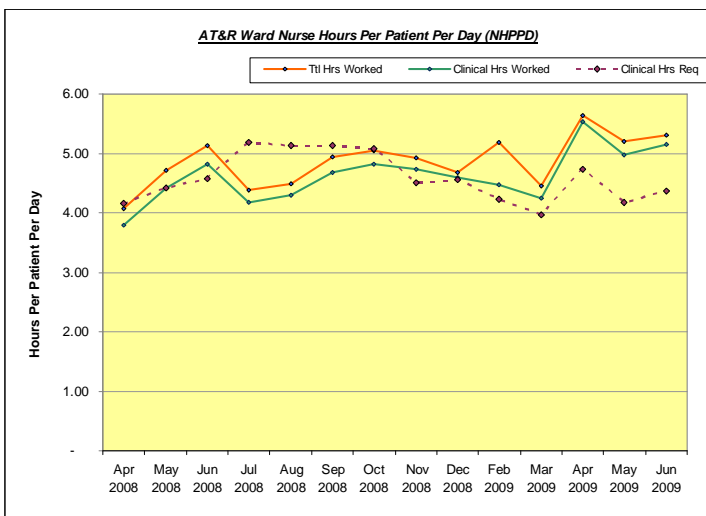
This graph shows the total number of radiology tests done, and then breaks this down by the referral type for those tests. GP referred are those requested by GP's, Acute are requests by the acute wards in the hospital, Selina are Selina Sutherland requests, Inpatients are from all inpatient wards and Outpatients are requests from the outpatient clinics.

Discussion underway with GP liaison officer to better manage demand.



This graph shows the average occupancy per month in the AT&R ward, taken at 12pm each day. There is no target for this, only a capacity of 13, and a comparison of the average occupancy for the same month last year. However the used number can be above capacity because of the AT&R flat beds.

Activity has remained steady due to demand. Daily meetings are held to plan upcoming transfers from MSW following discharges from AT&R.



Nurse Hours per Patient Day (NHPD) is a measure from the nursing system Trendcare. It is calculated by taking the total number of nurse hours in a shift and dividing this by the number of patients in that ward. The required hours are calculated by the system based on the acuity of the patients in the ward. Total NHPD includes any team leader and educational/training hours.

Nursing hours worked exceeding hours required since January.

Director of Nursing is undertaking a workforce review. Capacity planning and a review of the Model of Care will also ensure there are improved systems to match workforce to activity.



## 6.4 GM Community, Public, and Mental Health Report

### 6.4.1 Summary

Community nursing and health service contract performance (including ACC) is \$379,935 YTD ahead of budget [Refer Appendix D]. It is expected that the ACC revenue will be adjusted favourably during July. Volumes continue to trend upwards in community health particularly in the DOM 101 contract for professional services. Hours for home help delivered by the support workers within the community service continue ahead of contract. FTE has come back close to budget and is only 0.1 FTE over for the month.

All services are working on a cost recovery plan and reductions have occurred in locum costs for mental health and a robust plan is in place to reduce clinical supplies costs in community nursing. There are three projects within the 'Good to Great' programme that directly involve staff from community services: the FOCUS review, Community Nursing review and the Transport review.

	Jun-2009			YTD					FY
	Act	Bud	Var	Act	Bud	Var	Var %	Bud	
<b>Contract Volumes</b>									
FOCUS Needs Assessments	8	10	(2)	121	120	1	0.8%	120	
District Nurse Contacts	2,953	2,283	670	34,332	29,217	5,115	17.5%	29,217	
Healthy Homes Nurse Assmnts	3	9	(6)	104	100	4	4.0%	100	
Student Assessments	21	13	8	249	200	49	24.5%	200	
Mental Health New Referrals	52	50	2	490	600	(110)	-18.3%	600	
<b>FTE's</b>									
Allied Health Staff	60.8	69.9	9.0	61.0	70.4	9.4	13.3%	75.4	
Management/Administration Staff	20.6	22.4	1.7	21.5	22.6	1.2	5.1%	22.6	
Medical Staff	2.9	3.5	0.6	3.1	3.5	0.4	11.8%	3.5	
Nursing Staff	46.0	42.1	(3.9)	46.2	42.1	(4.1)	-9.7%	42.1	
Support Staff	-	-	-	-	-	-	0.0%	0.0	
<b>Total FTE</b>	<b>130.4</b>	<b>137.8</b>	<b>7.4</b>	<b>131.8</b>	<b>138.7</b>	<b>6.9</b>	<b>5.0%</b>	<b>143.7</b>	

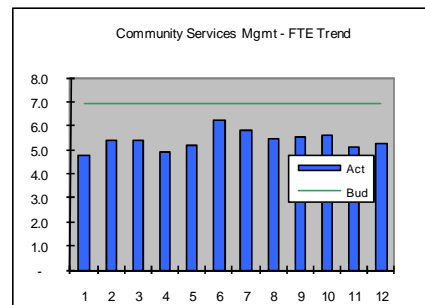
\* Refer to the Glossary for definitions of these measures.



## 6.4.5 Community & Public Health Management

### FTE Analysis:

Community Services Management	FTE Actual	FTE Budget	Variance
Allied Health Staff	-	-	-
Management/Administration Staff	5.2	7.0	1.7
Medical Staff	-	-	-
Nursing Staff	-	-	-
Support Staff	-	-	-
<b>Total FTE's</b>	<b>5.2</b>	<b>7.0</b>	<b>1.7</b>



### Summary

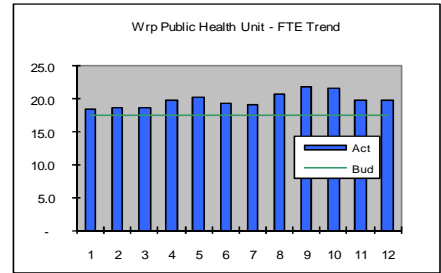
- Infrastructure and non-clinical costs for the Choice Health campus have been coded against this responsibility centre and should more correctly be coded against Public Health, this will not occur until the new budget year 09/10
- Ambulance Service Manager position was not replaced which explains the actual FTE against budget



**6.4.6 Wairarapa Public Health Unit**

FTE Analysis:

Public Health Unit	FTE Actual	FTE Budget	Variance
Allied Health Staff	8.5	10.0	1.6
Management/Administration Staff	3.0	2.5	(0.5)
Medical Staff	-	-	-
Nursing Staff	8.5	5.0	(3.5)
Support Staff	-	-	-
<b>Total FTE's</b>	<b>19.9</b>	<b>17.5</b>	<b>(2.4)</b>



Summary

- Public Health contracts for 09/10 have been confirmed by email only, with no hard copy contracts yet received.
- Regional Public Health have indicated a decrease in FTE for HEHA contracts. RPH intend to negotiate the subcontract at the end of July 2009. Resources required to manage the pandemic have lead to delays in all negotiations, including those with the Ministry.
- The Health Impact Assessment Unit at the Ministry have indicated that there will be future funding for 09/10. This financial year the PHU was contracted for \$48500 to complete Assessments on Makoura College Wellbeing Policy and a Paper for South Wairarapa District Council regarding Fluoridation as part of a submission toward the SWDC LTCCP.

Key Activities

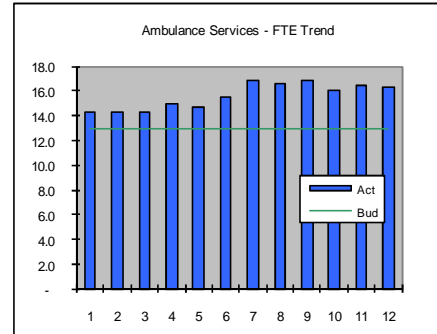
- Wairarapa was congratulated nationally for excellent work in the HPV campaign, again being the only DHB to achieve 100% return of consent forms



**6.4.7 Ambulance Services**

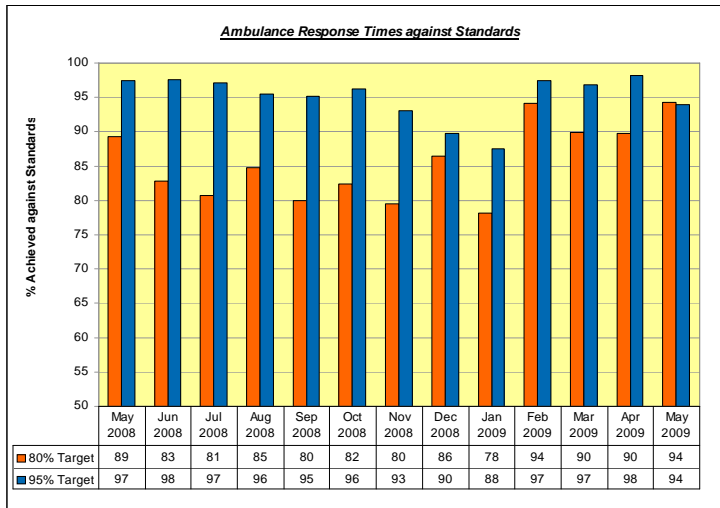
FTE Analysis:

Ambulance Services	FTE Actual	FTE Budget	Variance
Allied Health Staff	16.2	12.9	(3.3)
Management/Administration Staff	-	0.1	0.1
Medical Staff	-	-	-
Nursing Staff	-	-	-
Support Staff	-	-	-
<b>Total FTE's</b>	<b>16.2</b>	<b>13.0</b>	<b>(3.3)</b>



Summary

- Note that FTE reflects overtime hours and a miscalculation at budget time in regard to the number of hours required for a Patient Transfer Officer.
- The Ministry have confirmed extra funding for 09/10 for 2 extra FTE at \$75000 each. These FTE's and revenue has not been included in the budget at the time of writing this report.
- The service has managed to retrieve \$7700 of declined ACC claims from a total of \$17500. There may be a further \$1000 to come.
- Monthly stats not available prior to report deadline



*This graph shows the response time performance for the Wairarapa ambulance service against national standards.*

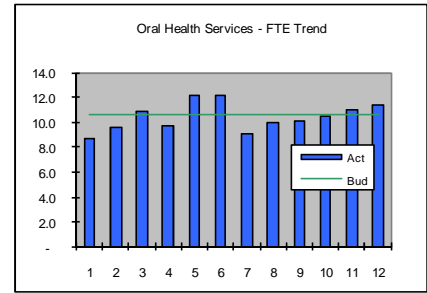
The service has exceeded the target in both categories.



### 6.4.8 Oral Health Services

FTE Analysis:

Oral Health Service	FTE Actual	FTE Budget	Variance
Allied Health Staff	10.1	9.4	(0.7)
Management/Administration Staff	1.2	1.2	(0.0)
Medical Staff	-	-	-
Nursing Staff	-	-	-
Support Staff	-	-	-
<b>Total FTE's</b>	<b>11.3</b>	<b>10.6</b>	<b>(0.7)</b>



Summary

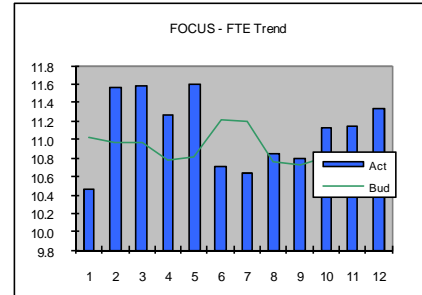
- Note that FTE numbers reflect those working within the Oral Health Implementation project, which was not budgeted.
- The quarterly report for the Ministry has been completed and shows that 1324 extra children were seen in the service for the quarter against targeted examination figures. This is a reflection of the additional preschoolers enrolled in the service through B4 school referrals, as well as increased productivity due to a full complement of staff.
- A separate paper has been prepared and will be presented to the July board meeting in regard to the costs of electrical works required to make schools 3 phase power/mobile ready.
- The Maori student from Auckland has signed an agreement with the DHB to be bonded to us for a 2 year period on completion of her degree.



**6.4.9 FOCUS**

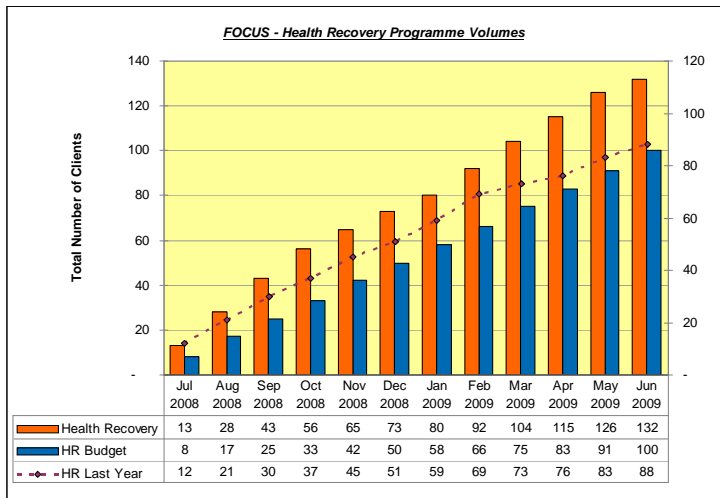
FTE Analysis:

FOCUS	FTE Actual	FTE Budget	Variance
Allied Health Staff	6.3	6.5	0.2
Management/Administration Staff	4.6	4.2	(0.4)
Medical Staff	-	-	-
Nursing Staff	0.4	-	(0.4)
Support Staff	-	-	-
<b>Total FTE's</b>	<b>11.3</b>	<b>10.7</b>	<b>(0.6)</b>

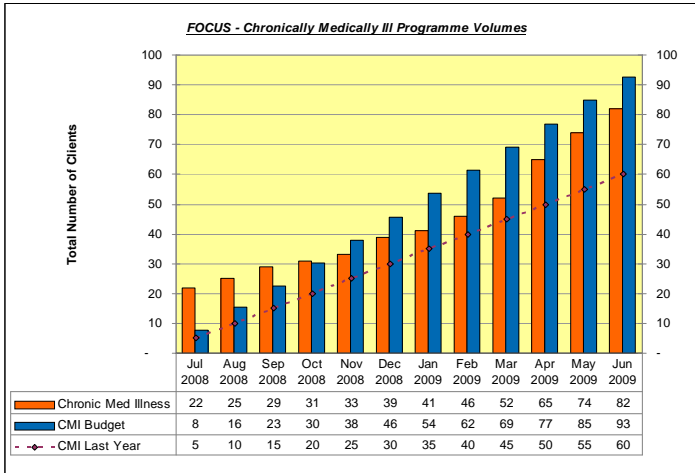


Summary

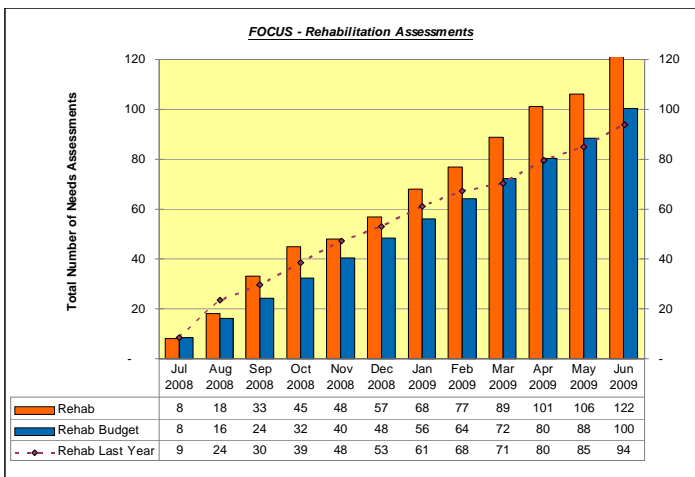
- FTE is above budgeted due to positions appointed post budget setting.
- Outsourced, expenditure continues to be higher than forecast, this reflects the support services purchased
- FOCUS has a waiting list of 4 weeks. The waiting time has been reduced by 1 week over the past month.
- Workload Targets have been set for NASC staff in the Seniors Team
- FOCUS will undergo an audit by the Ministry of Health for the Child and Adult NASC on 15 and 16 July
- IT are currently assisting FOCUS to develop reports to separate referral numbers to FOCUS and other services that come under the Single Point of Entry



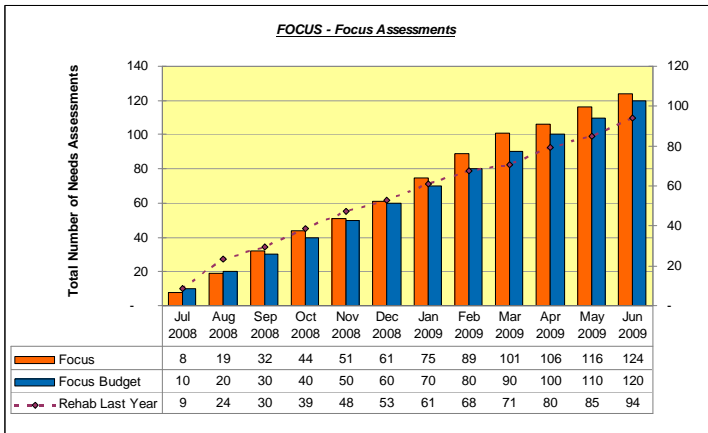
Health Recovery has over delivered in services for the third year in a row. To curb this usage other ways of supporting this demand would need to be found. Most referrals are post a hospital admission and assist in patient through put and lower bed number days. In 2010 the management of health recovery access could be tightened to keep to budget but any flow on effect to hospital and community services should be considered



CMI funding covers clients that 1) Would fall between traditional disability funding gaps or 2) are palliative. This funding buys flexible services according to individual need. If a person is over 65 years and longer term palliative, they switch to disability funding after a period of time. There are plans in 2010 to separate out the numbers of people using this funding that are palliative



This graph shows the volume of assessments completed for Rehab patients by Dr Mathews and Dr Duncan. In the past these volumes were combined with all other assessments completed in rehab by FOCUS staff.



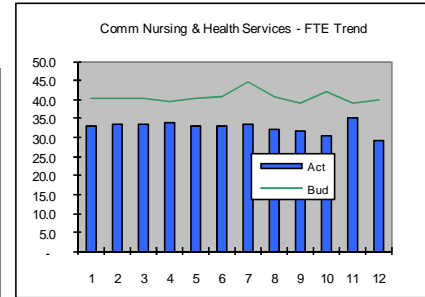
FOCUS completes assessments in the rehab ward if a person is unable to go home with short term support. Determining if an assessment is needed, depends on if a person can go home safely with short term supports or if interventions needed are beyond what short term can provide.



### 6.4.10 Community Nursing & Health Services

FTE Analysis:

Community Nursing & Health Services	FTE Actual	FTE Budget	Variance
Allied Health Staff	8.2	14.2	6.0
Management/Administration Staff	2.5	2.3	(0.2)
Medical Staff	-	-	-
Nursing Staff	18.6	18.5	(0.1)
Support Staff	-	-	-
<b>Total FTE's</b>	<b>29.2</b>	<b>35.0</b>	<b>5.7</b>



Summary

Personnel costs contributing factors:

- o One additional FTE has been used to backfill the two staff members sharing the acting Clinical Nurse Manager role.
- o The service has incurred the cost of having a super-numerary new graduate

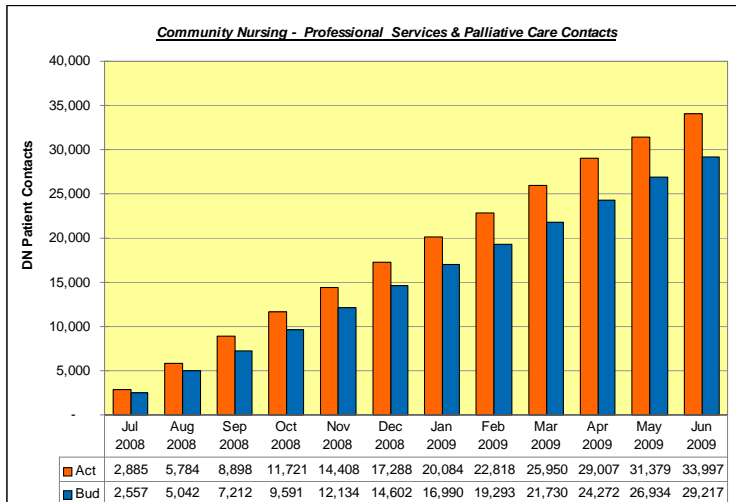
Clinical supplies:

- o Direct delivery of continence products has ceased
- o Actual patient volumes:
- o Stomal 94 clients.
- o Continence – 573 clients - 457 (80%) of which are prescribed continence products by the CNS

Patient Consumables:

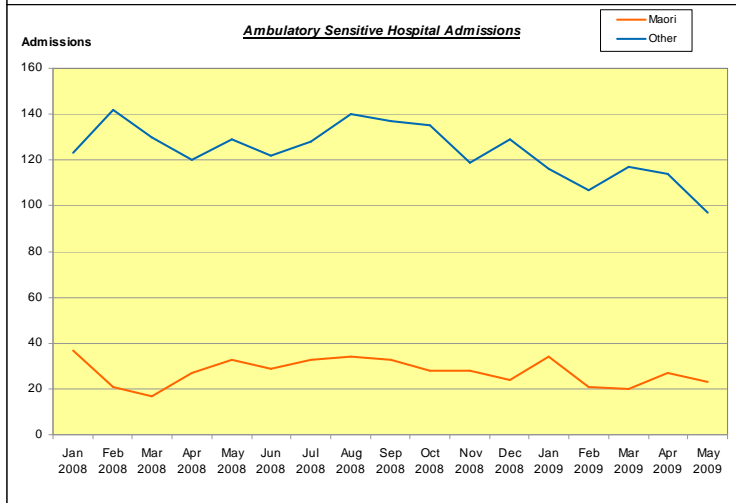
- o To ensure appropriateness of treatment/products, additional wound care education for nurses within the service is underway.
- o The 'higher cost' wound care products have been removed from the shelves and are only obtainable via CNS or Team Leaders upon detailed assessment of wound and development of an appropriate care-plan.

Technology – The Clinical Nurse Manager is participating in the IT project. This involves scoping systems that have modules suitable for Community Nursing Services



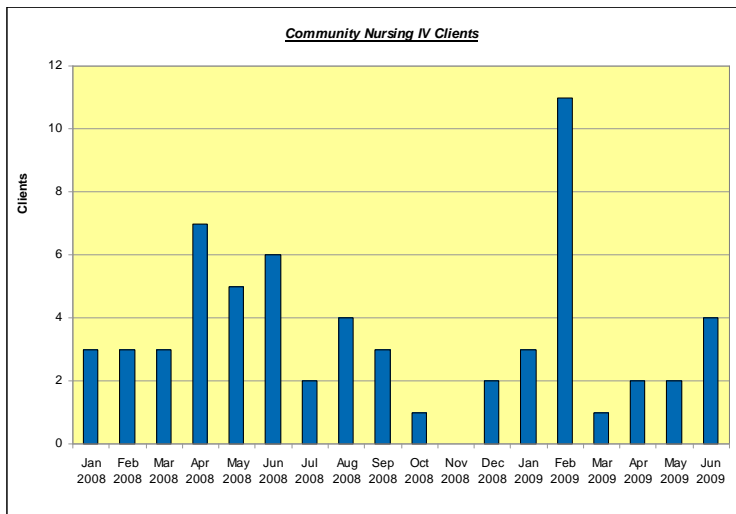
Community Nurse contacts include both DHB and ACC funded visits to patients. Client services such as continence, stomal and oxygen are not included.

Increasing numbers of contacts reflects higher activity through the hospital



Ambulatory Sensitive Hospital (ASH) Admissions are those which effective delivery of services in a community setting may have prevented. Their reduction is an indicator in the MOH's Health Targets for 2007/08. One of the main influences on ASH admissions is ethnicity, therefore this is included here. ASH admissions include a number of diagnoses such as asthma, immunisation preventable, cancer, and stroke.

Community, public and primary health services are undertaking initiatives to prevent ambulatory sensitive admissions. The group has started to identify and commence planning for the frequent attendees within above group. The project team have written their first report for the long term conditions project



**Community Nurse IV clients**

4 Clients received IV therapy in the community.

Note: A consistent approach by the In-reach team should capture those patients attending ED for IV therapy that meet the criteria for IV in the community. The patient care can then be transferred to the Community Nursing Service.

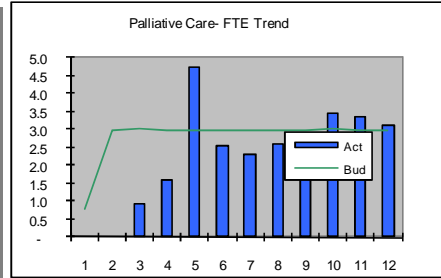
The use of this service is under review as part of the above initiative around ASH.



**6.4.11 Palliative Care**

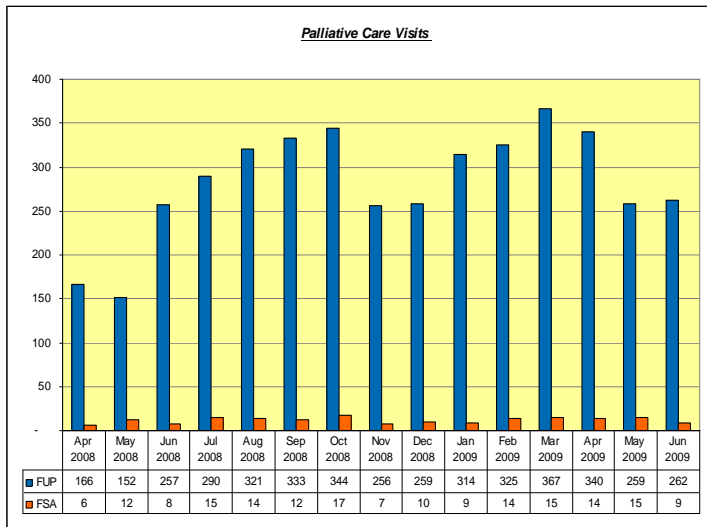
FTE Analysis:

Palliative Care	FTE Actual	FTE Budget	Variance
Allied Health Staff	0.7	0.6	(0.1)
Management/Administration Staff	-	0.2	0.2
Medical Staff	-	-	-
Nursing Staff	2.4	2.2	(0.2)
Support Staff	-	-	-
<b>Total FTE's</b>	<b>3.1</b>	<b>3.0</b>	<b>(0.1)</b>



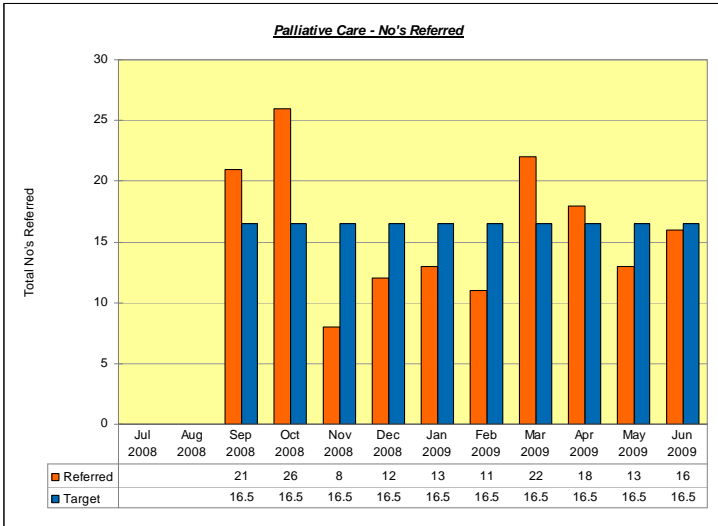
Summary

- The actual FTE adverse to budget reflects extra hours worked by staff to get the service up and running and for staff covering extra shifts while new staff orienting.
- The specialist nurse statistics for the month of June are 28 assessments and 594 follow up contacts (phone and face to face). There are weekly clinics with the specialist doctor from Te Omanga.
- There were 10 education sessions carried out by the clinical nurse educator this month:
  - ❖ Clinical Assessment Tool training for residential Care providers
  - ❖ Sessions for Med/Surg and Rehab wards
  - ❖ Session for Cancer Society
  - ❖ Breakfast Lecture attended by GPs, community nurses and aged care.



*This graph shows, in blue, the Palliative Care "Follow UP" activity each month and, in orange, the "First Specialist Assessments" each month.*

This is work carried out by the generalist community nursing service – not assessments by the specialist nurses



*This graph compares actual referred numbers to the Palliative Care Service each month against expected referrals.*

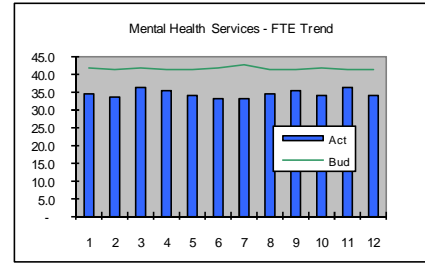
16 New Referrals in June. 50 clients as at 30<sup>th</sup> June 2009.



### 6.4.12 Mental Health

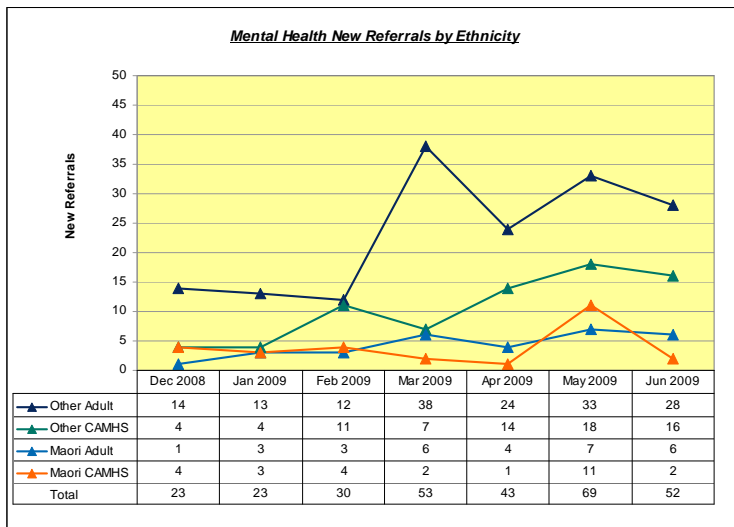
#### FTE Analysis

Mental Health	FTE Actual	FTE Budget	Variance
Allied Health Staff	10.9	16.2	5.3
Management/Administration Staff	4.1	5.0	0.9
Medical Staff	2.9	3.5	0.6
Nursing Staff	16.1	16.4	0.3
Support Staff	-	-	-
<b>Total FTE's</b>	<b>34.0</b>	<b>41.1</b>	<b>7.1</b>



#### Summary

- Continued adverse trend in Personnel due to high locum psychiatrist costs and associated on call allowances. The renegotiated locum contract which began on 1 April continues to show cost reduction. Locum psychiatrist will reduce to 1 day only from 1 July which will be insufficient to cover the service with on call/after hrs/weekend and crisis duties.
- On call allowances in the Adult team are tightly controlled and every effort is being made to reduce expenditure on this budget line. The budget for actual number of after/hrs hours worked is favourable.
- Outsourced expenditure for inpatient beds will have exceeded budget in June due to 2 invoices having been received from HuttValley DHB for clients with a domicile address in Wairarapa, who were admitted to Hutt DHB Inpatient Unit by the Hutt team without advising Wairarapa. We are obliged to pay this and a letter has been sent to the Manager Mental Health Service Hutt Valley making them aware of the lack of communication.
- Maori Mental Health Professionals: Adult MHS 1.7 fte. CAMHS 2.0 fte. Recruitment delayed until new financial year.
- Additional 1.0 fte Maori CSW position implemented in Crisis Respite. 0.3 fte Maori Mental Health Professional position filled in the Adult service.
- CAMHS: 0.1 fte vacancy in Allied Health covers Incredible Years programme staff and is used when the programme is active.
- Psychiatrist 1.0 fte - overseas psychiatrist has accepted the position with starting date on 1 October 2009, depending on Medical Council vocational registration being awarded. In the meantime 0.4 fte of this vacancy is being filled by locum psychiatrist

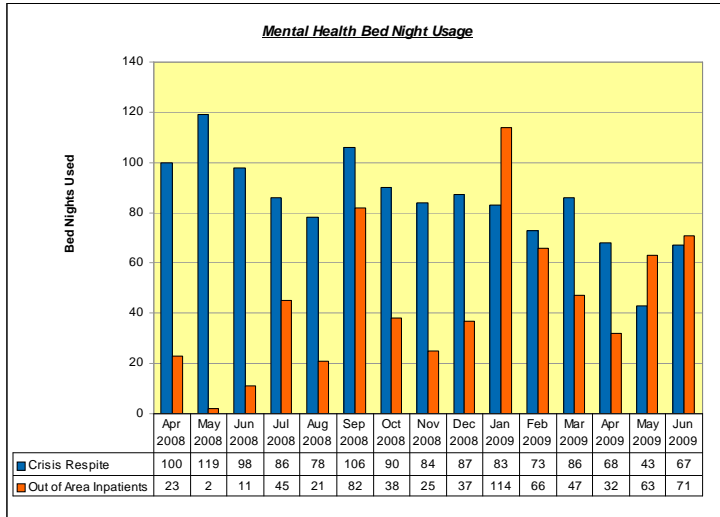


*This graph shows the new referrals to the Mental Health services in the month. Those referrals from Maori patients are shown separately as this is an area of particular focus for the service.*

CAMHS: Drop off in referral of children of Maori ethnicity may be explained by the very high numbers referred in the previous month. Ongoing collaboration with Maori NGO's and Maori workers in government agencies continues, and will be increased...

There were 3 Maori children referred to the Paeds/CAMHS trial not counted in these figures.

The Adult MHS received a total of 34 referrals during June. Maori comprised 6 of these which is approximately 17% of all referrals. Total referrals YTD are 45 Maori and 271 other. Maori represent approximately 16% of all referrals to the Adult MHS over the past year.



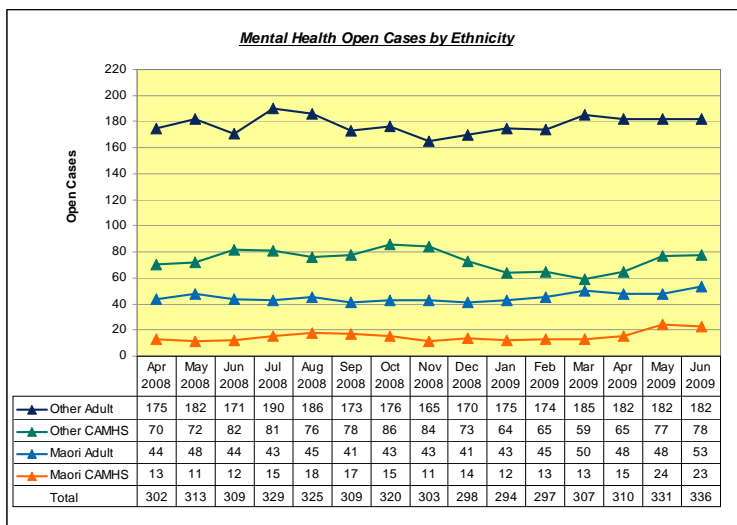
The bed night usage shows how bed nights were used in the Mental Health Service own Crisis Respite beds, and in the Inpatient beds the service contracts from other DHBs

ADULT: Over the past 12 months there has been a gradual trend downwards in CRRC bed utilisation. Inpatient bed utilisation represents peaks and troughs corresponding to a limited number of individuals having acute inpatient admissions.

The WDHB continues to utilise its four contracted regional rehab' beds in CCDHB. One of these clients will be discharged shortly. There is a referral pending for this bed when it becomes vacant

CAMHS had one client at the Rangatahi Unit this month with a total of 19 bed nights.

CAMHS: CRRC youth bed not used in June for the third consecutive month. Evaluation of bed usage will take place at the end of August. It is becoming more and more apparent that intensive support by Youth CSW's is reducing the need for this bed.



Open cases in both the Adult MH and Children & Adolescent MH (CAMHS) are shown in this graph. Again a particular focus is given to the number of Maori cases open in the services

CAMHS: Open cases for June remains similar to previous month. The proposed mobile service will hopefully increase the current very low % of Pacific Island children accessing the service.

Adult: MHS caseload reflects a level of throughput of clients and individual clinician case loads remaining stable.



## 6.5 Support Services

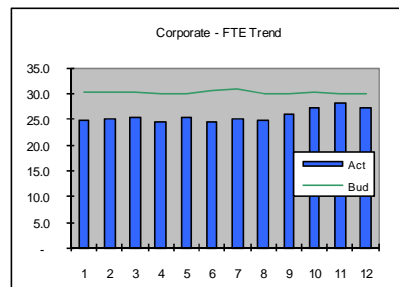
	Act	Jun-2009 Bud	Var	Act	YTD Bud	Var	Var %	+/-	FY Bud
<b>FTE's</b>									
Allied Health Staff	-	-	-	-	-	-	0.0%		-
Management/Administration Sta	31.0	34.7	3.7	29.0	34.9	6.0	-17.1%	*	34.9
Medical Staff	-	-	-	-	-	-	0.0%		-
Nursing Staff	1.2	1.1	(0.1)	1.0	1.1	0.1	-8.2%	*	1.1
Support Staff	8.4	8.4	0.0	7.8	8.6	0.8	-8.9%	*	8.6
<b>Total FTE</b>	<b>40.6</b>	<b>44.3</b>	<b>3.7</b>	<b>37.8</b>	<b>44.6</b>	<b>6.8</b>	15.3%	✓	<b>44.6</b>



### 6.5.1 Corporate

FTE Analysis:

Corporate Services	FTE Actual	FTE Budget	Variance
Allied Health Staff	-	-	-
Management/Administration Staff	18.8	21.4	2.6
Medical Staff	-	-	-
Nursing Staff	-	-	-
Support Staff	8.4	8.4	0.0
<b>Total FTE's</b>	<b>27.3</b>	<b>29.9</b>	<b>2.6</b>



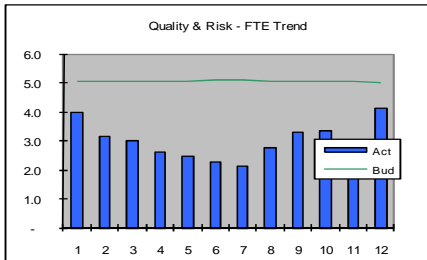
Summary



**6.5.2 Quality & Risk**

FTE Analysis:

Quality & Risk	FTE Actual	FTE Budget	Variance
Allied Health Staff	-	-	-
Management/Administration Staff	3.0	3.9	0.9
Medical Staff	-	-	-
Nursing Staff	1.2	1.1	(0.1)
Support Staff	-	-	-
<b>Total FTE's</b>	<b>4.1</b>	<b>5.0</b>	<b>0.9</b>



Summary

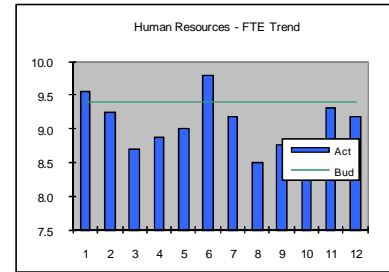
Please refer to Section 7 Ad Hoc Reports, for the Quality & Risk Report.



### 6.5.3 Human Resources

FTE Analysis:

Human Resources	FTE Actual	FTE Budget	Variance
Allied Health Staff	-	-	-
Management/Administration Staff	9.2	9.4	0.2
Medical Staff	-	-	-
Nursing Staff	-	-	-
Support Staff	-	-	-
<b>Total FTE's</b>	<b>9.2</b>	<b>9.4</b>	<b>0.2</b>



Summary

Training

On 19 June a workshop entitled Constructive Engagement was held and attended by union organisers, union delegates and DHB managers. It was facilitated by Philippa Branthwaite from the Partnership Resource Centre of the Department of Labour.

Constructive Engagement is a tripartite initiative under the auspices of the Health Sector Relationship Agreement to promote good working relationships between those employed in the health sector. It involves DHB's, the Ministry of Health and Council of Trade Unions affiliated health sector unions.

The aim of the workshop was to explore the issues associated with achieving a productive and constructive union/employee/employer relationship.

The following points were identified by the meeting as being important and to be built on:

- Build a positive working relationship
- Find out what constructive engagement is all about
- Find out what forums are available for addressing issues
- Clear a way forward and identify how we work together
- Build a commitment to this way of working together
- Develop forums where we can:
  - Understand each other's issues better
  - Work on issues for the good of all employees
  - Simplify processes and get action
  - Build a shared commitment to the service we all provide
  - Problem solve our collective issues together, looking for collective solutions

A second meeting is planned for early August.



<b>Employment Group</b>	<b>Progress</b> as at 29 June 2009
Obstetrician & Gynaecologists	<ul style="list-style-type: none"> <li>New appointment commences 10 Aug 09.</li> </ul>
Orthopaedics	<ul style="list-style-type: none"> <li>A clinician departs In July. A preferred candidate has been identified and an offer of employment is currently being progressed</li> </ul>
Anaesthetist	<ul style="list-style-type: none"> <li>New appointment commences 3 August 09. The first week will be supervision at a tertiary hospital and will start at the Wairarapa DHB on 10 August 09.</li> </ul>
Emergency	<ul style="list-style-type: none"> <li>Continue the search for MOSS and Consultants in ED.</li> </ul>
Paediatrician	<ul style="list-style-type: none"> <li>Clinician appointed has withdrawn. Currently interviewing another candidate</li> </ul>
Medical Officer	<ul style="list-style-type: none"> <li>Continue to seek candidates to cover anticipated RMO vacancies for future rotations. RMO's are in high demand nationwide.</li> </ul>
General Surgery	<ul style="list-style-type: none"> <li>A clinician has been appointed to one of two vacancies; commencing Oct/Nov</li> </ul>
Community & Public Health	<ul style="list-style-type: none"> <li>HPV Support Worker – Role Advertised</li> </ul>
Mental Health	<ul style="list-style-type: none"> <li>Nil</li> </ul>
Maori Health Directorate	<ul style="list-style-type: none"> <li>Nil</li> </ul>
Hospital Services	<ul style="list-style-type: none"> <li>RN vacancies – 4.6 FTE across hospital services (excluding below).</li> <li>Midwifery –1 FTE to start early July. Another 2 FTE vacant but 1.0 FTE covered by fixed term until August 2009.</li> <li>Clinical Typist – Fixed term agreement offered and accepted, start date of July.</li> <li>Physiotherapist – 1.0 FTE permanent being advertised</li> <li>Sonographer – advertising continues, locums filling for short period</li> <li>HCA MSW – started</li> </ul>
Other Vacancies	<ul style="list-style-type: none"> <li>Team Leader Facilities – On hold</li> <li>Quality Co-ordinator – permanent 1.0 FTE role, interviewed and offered to internal applicant</li> <li>Admin Assistant Quality – Fixed Term appointed</li> <li>IT Business Analyst – Advertised, completed interviews; final selection pending</li> </ul>



## 6.5.4 Nursing Directorate

### June 2009

Good progress has been made on the nursing and midwifery project with an in-depth analysis of nursing costs being completed. The work undertaken explains why we have one of the highest nursing costs per FTE. There are various contributing factors such as a relatively high average base salary for senior nurses, high levels of overtime and penal in all nursing groups and high allowances for some areas. The first reference group meeting occurred early in the month and a workshop was held with senior nurses. Data collection is more or less complete on the Model of care. This will now be analysed and a report completed.

Policy and procedure review, alongside auditing of practices continued throughout the month prior to certification. The Clinical Nurse Managers worked hard to ensure their environments meet the standards and are supporting staff improve practices. There have been outbreaks of patients with infectious conditions in both MSW and Rehab. These have been managed extremely well by nursing staff with support and back up from the infection control team.

Management of Novel A H1N1 within the public health team, primary care and the hospital has been well undertaken to date. The Wairarapa still has low numbers of confirmed cases, however, monitoring continues on a daily basis and the key components of the CIMS structure are in place.

Senior nursing staff and Unit Managers as well as the Director of Nursing are actively involved in the day to day monitoring. Recording and monitoring of staff sickness is occurring. SLT are meeting weekly for updates. Supplies of personal protective equipment are being used for the other infectious conditions in the hospital, however, there is currently no concern regarding availability of ongoing supplies.

Work base assessor training was held for nurse managers from across the DHB. This was very successful and the feedback from the 2 days will be very beneficial in assisting the nurse managers to manage competence issues amongst their staff and appropriately review their performance against the Nursing Council of New Zealand competencies. An audit of the DHB PDRP occurs late July.

The first study day on health assessment took place early in the month for nursing staff. Medical clinicians presented on the day as well as expert nurses. The need for this type of training was identified through assessment of skills in performance review and the need for regular updating of new techniques, tools and methods. Further work is being done on material for the website and preparation has begun for a road show in September re post graduate education including the application process. Some one on one career counselling has taken place.

The Nursing Council of New Zealand is calling for submissions on the RN Scope of Practice. This piece of work has come about as a result of discussions regarding extended practice in some specialties, for example endoscopy and first surgical assistant roles.

The DON attended the Nursing and Midwifery Strategy Group meeting and central region DONs' and CMOs' meeting. The DONs and CMOs are developing a draft clinical governance framework for the RCSP.



### 6.5.5 Maori Health

## WAIRARAPA DISTRICT HEALTH BOARD – HOSPITAL ADVISORY COMMITTEE MĀORI HEALTH REPORT July 2009

### Core Business

Business as usual this month with a number of clients and whānau wanting support both as admitted service users and OPD clients. Collaborative approaches to supporting these people have proven fruitful again emphasising the need to work collectively to reduce disparities. There is a strong emphasis on engaging with the primary health sector to ensure continuity of health support upon discharge of patients.

Referrals to NGOs, Whānau Care Services CCDHB and smoke free continue to be supported by the Māori Health Unit. Māori Health continues to present at all VIP training days and co-present the Partner Abuse component of this training.

**Attendance** at the Central Regional Māori Managers meeting during June was beneficial, TAS presented on the progress of the RSCP, namely mental health, cardiology, cancer and renal networks. This allowed an opportunity for a collective Māori voice to feedback to TAS.

### Reducing Māori DNA Joint Venture

On one hand there has been a need to take a step back and properly formalise this project, while on the other hand contacting OPD clients continues on a daily bases. There was a problem within the IT data collection that was forwarded to the MHU. Unknown to either IT or the MHU the information being received was only a selection of OPD appointments from each clinic. This has since been rectified which has increased the workload significantly, however is being managed accordingly.

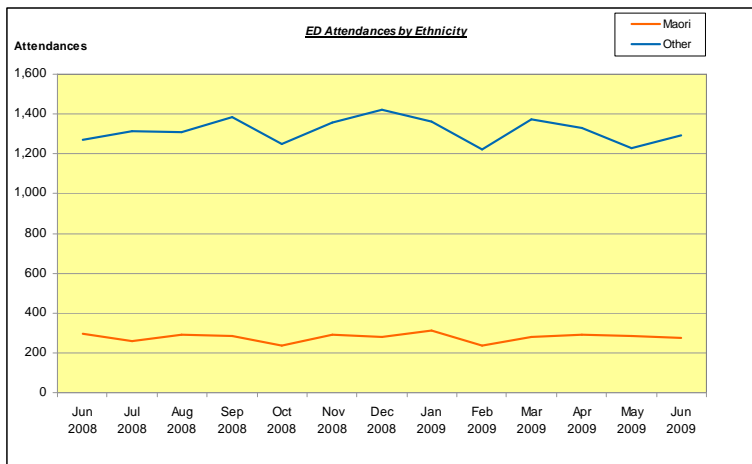
Communication between OPD and the MHU is improving and will continue to become more streamlined. With the support of IT and Maureen Breukers Projects Manager we have been able put in place more proficient ways to capture data which can be collated into a report at the end of this project work.

### Te Arawhata Tōtika

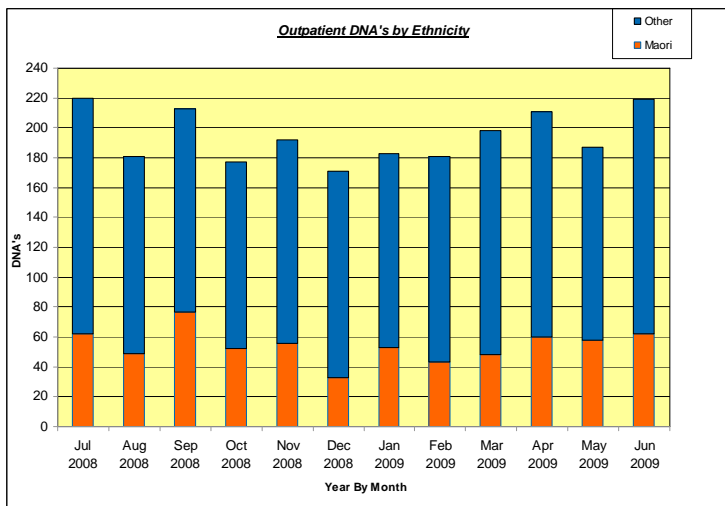
A tool is being developed for implementation of the framework. Awaiting confirmation from maternity to progress collaborative roll out of Te Arawhata Tōtika within that service. A final draft of the Te Arawhata Tōtika guideline of values is near completion just awaiting final sign off of cover for publication.



June 2009 Maori Admissions to Wairarapa Hospital		
	Number	Maori % of total
ED Attendances	274	17.5%
<b>Admissions</b>		
Acute (ED, AAU, HDU)	27	14.8%
ATR	2	8.3%
Daycase	21	12.1%
MATY (SCBU, MAT, MNB)	8	13.1%
MSW	27	11.3%
PAEDS	27	41.5%
<b>OPD First Attendances</b>		
OPD First Attendances DNA's	19	33.3%
OPD Follow Ups	137	13.6%
OPD Follow Ups DNA's	23	26.4%
Births	5	17.2%



This graph shows the trend of all Emergency Department attendances over 15 months broken down by ethnicity.



This graph shows the number of Outpatient Did Not Attends split out between Maori and Non-Maori. Total DNA rates are in the vicinity of 10%.

- % of DNA still appears to be tracking high
- Working on collating data that will offer a comparable view of Māori & non-Māori DNAs using actual numbers, clinics, ages etc
- All OPD appointments now being sent to MHU for 2 week period ahead, however work to be done on clinic changes, cancelations etc



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## SECTION 7: Ad Hoc Reports

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Wairarapa District Health Board

Quality and Risk

June 2009

### 1. Quality and Risk General Overview

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- Incident Management training was cancelled on the 16<sup>th</sup> 17<sup>th</sup> and 18<sup>th</sup> of June due to adverse weather conditions, this has now been rescheduled for the 4<sup>th</sup> 5<sup>th</sup> & 6<sup>th</sup> August all staff involved has been notified of this.
- Preparation for Certification continued. Focus on the development and review process of Policies/Protocols/Procedures.
- Continuing the process of developing service quality plans in each area to reflect the service level developments. The focus of now incorporating the audit and risk component of the quality and risk framework into the operational level has begun, this means that each ward will have a 'living' action plan which is fed from the reviews of complaints and reportable events generated in that area, ensuring that any recommendations are implemented and monitored to achieve a culture of continuous quality improvement..
- Reviewing the DHB wide Risk Register and the related SLT level risks. Review and development of the reporting framework to facilitate escalation and de-escalation of risk will continue once the review of the senior leadership structure is finalised.
- Continuing to update and populate the quality intranet site and raise the role and profile of Q&R identity.
- Appointed to the Quality Coordinator position, Gillian Malton has now joined the team in this capacity.
- Monitoring the increased trend of falls within MSW with Ward Manager. Breakdown and analysis of timing and location of falls has been provided to staff. Possible reasons for the falls discussed and staff are trialling different strategies to mitigate the risk. Early signs are positive showing a reduction in the falls.

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### 2. Health & Safety:

- Begun updating the Health & Safety manuals with staff on the AT&R and MSW.
- Met with IT regarding setting up of Infection Control & Health and Safety section on the Intranet - have begun transferring information and guidelines

#### **Occupational Health**

- Collated the Annual needlestick and blood and body fluids exposure stats -9 reported events 2 down on last year. – report still to be circulated plus recommendations.
- Pre-employment screening x 8
- Staff Flu vaccines x 3
- Workplace assessment X 2

#### **Infection Control**

- Work on Non-seasonal H1N1 Novel A Flu Pandemic eg Naso-pharyngeal swabbing instructions, signage, masks to reception areas, removal of magazines and toys, determining whether correct protocols have been observed for PPE, cleaning etc
- Advice to age care facility regarding probable Noro virus outbreak in that facility and liaising with AT & R regarding Noro virus outbreak – MOH notified.
- Spent a day at the weekend working with the Ward staff and the coordinator regarding closing the ward Isolating patients etc



- Met with Dr Chan Microbiologist (MedLab) Discussed the DHB levels of Blood Stream Infections (BSI), NoroVirus results and incidence, Hand hygiene project (local and National), multi drug resistant organism (MDRO's), Clostridium Difficile and Non Seasonal influenza.
- Worked with Emergency Coordinator setting up CBAC
- Meeting with theatre staff re: infection control procedures and also the trial a new Surgical Scrub in Theatre
- Completed Surgical Site Infection Rates to 2007 – Results to the Surgeons

#### **Complaints:**

**June 09:** 4 inpatient and 2 outpatient complaints for this period were received. They related to processes and treatment provided.

#### **Compliments:**

**June 09:** Six compliments were received for this period all for MSW.

#### **Reportable Events:**

**June 09:** For this period a total of 48 events were received, of these 34 related to patients and 5 related to staff, the rest were facility/equipment related.

#### **Top 5 Reportable Event Categories**

Falls - 14

Security – 9

Medication Errors – 6

Pressure Sores/Patient Injury (ACC) - 5

Quality Deficits – 4

#### **Professional Indemnity Cases Reported to AON**

##### **June 09:**

WDHB lodged one case with AON for the month of June as a precautionary measure.

#### **Current HDC cases open**

**June 09:** For this period a total of 4 cases are currently open with HDC.

**Mortality:** There were six deaths in hospital for the May period.

*Please note that stillbirths do not have National Health Indicators allocated so are not recorded in their own right. The stillbirth is recorded as an outcome against the mother's National Health Indicator. Therefore they are not reported in the monthly hospital mortality figures.*



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## **SECTION 8: General Business**

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## SECTION 9: Glossary of Terms

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ED Attendances - The number of patients presenting to the Emergency Department. This includes those who are then admitted to a ward.

Acute CWD - Casewighted discharges who were admitted for acute reasons.

Elective CWD- Casewighted discharges who were admitted through the waiting list system.

OP FSA's - Outpatient clinic's that were first specialist attendances.

OP Follow's - Outpatient clinic's that are subsequent attendances to the FSA.

Readmissions - Patients who have been admitted to a ward and had previously been admitted in the past 30 days. The new admission must be acutely and to the same specialty. The rate shows the number of readmissions as a proportion of all admissions.

OP DNA's - Outpatient clinic did not attends are when a patient doesn't attend a clinic that was booked for them.

Theatre Utilisation - The amount of theatre time utilised during normal working hours 8.30 - 5.00 Mon - Fri.

Daycase Electives - The proportion of all elective procedures in which the patient does not have an overnight stay, referred to as daycase.

FOCUS Needs Assessments - Assessments done by the FOCUS team on the needs of patients discharged from hospital or referred to them.

District Nurse Contacts - All contacts for services provided in the patients residence by the District nurses. Includes palliative care services.

Healthy Homes Assessments - Assessments done of clients homes to make the home more conducive to a healthy life style e.g. insulation, ventilation.

Student Assessments - Assessments of students to increase their health benefits.

AT&R - Assessment, Treatment and Rehabilitation ward.

MSW - Medical Surgical Ward

HDU - High Dependency Unit

AAU - Acute Assessment Unit

SCUBU - Special Care Birth Unit

CAMHS - Children & Adolescent Mental Health Services

CRRC - Crisis Respite Recovery Centre

FTE - Full Time Equivalent eg someone working 4 days a week is an 08.8 of an FTE.

SMO - Senior Medical Officer

RMO - Registered Medical Officer

CNS - Clinical Nurse Specialist



LMC - Lead Maternity Carer

IMW - Independent Midwife

PHN - Public Health Nurses

RN - Registered Nurse

DAO - Duty Authorisation Officer

ALOS - Average Length of Stay is the number of days stayed, divided by the number of discharges for a given inpatient sample.

ASH - Ambulatory Sensitive Hospitalisation are admissions which effective delivery of services in a community setting may have prevented that admission.

ENT - Ear, Nose & Throat

OPD - Outpatient Department

STOP - Termination of Pregnancy

INR - Elevated bleeding time by blood test

SLA - Service Level Agreement between the hospital and the Funder

HDBC - Hospital development Business Case

MOH - Ministry Of Health

NZNO - New Zealand Nurses Organisation

NGO - Non Government Organisation

SMT - Senior Management Team

MECA - Multi Employee Contract Agreement

IDF's - Inter District Flows, work done by DHB's for patients that are domiciled in another DHB's district.

NHPPD - Nurse Hours Per Patient Day, total number of nurse hours in a shift divided by the number of patients in that ward.

SLT- Senior Leadership Team



## SECTION 10: Appendices

### Appendix A: Elective Services ESPI Compliance Report.

#### Summary of Patient Flow Indicator (ESPI) results for each DHB

DHB Name: Wairarapa

	2006			2006			2006			2006			2008			2008			2008			2008			2009			2009			Target						
	Jun			Jul			Aug			Sep			Oct			Nov			Dec			Jan			Feb			Mar				Apr			May		
	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.	Level	Status %	Imp. Req.		Level	Status %	Imp. Req.			
1. DHB services that appropriately acknowledge and process all patient referrals within ten working days.	14 of 14	100%	0	14 of 14	100%	0	14 of 14	100%	0	14 of 14	100%	0	14 of 14	100%	0	14 of 14	100%	0	14 of 14	100%	0	14 of 14	100%	0	14 of 14	100%	0	14 of 14	100%	0	14 of 14	100%	0	> 90%			
2. Patients waiting longer than six months for their first specialist assessment (F&A).	40	0.7%	0	36	0.7%	0	50	0.9%	0	30	0.5%	0	55	1.0%	0	109	2.0%	0	46	0.8%	0	60	1.1%	0	54	0.9%	0	44	0.8%	0	67	1.1%	0	65	1.1%	0	< 2%
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT).	4	0.0%	0	4	0.0%	0	3	0.0%	0	3	0.0%	0	4	0.0%	0	7	0.0%	0	5	0.0%	0	5	0.0%	0	4	0.0%	0	4	0.0%	0	4	0.0%	0	4	0.0%	0	< 5%
4. Clarity of treatment status.	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	0	0.0%	0	< 5%
5. Patients given a commitment to treatment but not treated within six months.	4	0.0%	0	10	0.7%	0	8	0.0%	0	18	1.2%	0	16	1.0%	0	13	0.8%	0	27	1.7%	0	11	0.7%	0	11	0.7%	0	19	1.1%	0	18	1.0%	0	17	1.0%	0	< 5%
6. Patients in active review who have not received a clinical assessment within the last six months.	3	0.0%	0	1	0.0%	0	1	0.0%	0	2	0.0%	0	1	0.0%	0	4	0.0%	0	8	0.0%	0	3	0.0%	0	4	0.0%	0	6	0.0%	0	5	0.0%	0	4	0.0%	0	< 15%
7. Patients who have not been managed according to their assigned status and who should have received treatment.	5	0.0%	0	10	0.7%	0	9	0.0%	0	14	0.9%	0	14	0.9%	0	12	0.8%	0	22	1.4%	0	11	0.7%	0	11	0.7%	0	17	1.0%	0	16	0.9%	0	13	0.7%	0	< 5%
8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.	103	100%	0%	117	100%	0%	122	100%	0%	153	100%	0%	170	100%	0%	179	100%	0%	130	100%	0%	166	100%	0%	158	100%	0%	157	99%	0%	128	100%	0%	199	100%	0%	> 90%



Comparison of surgical services for May 2009

DHB Name: Wairarapa

Service Name	1. DHB services that appropriately acknowledge and process all patient referrals within ten working days.			2. Patients waiting longer than six months for their first specialist assessment (FSA).			3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (ATT).			4. Clarity of treatment status.			6. Patients given a commitment to treatment but not treated within six months.			8. Patients in active review who have not received a clinical assessment within the last six months.			7. Patients who have not been managed according to their assigned status and who should have received treatment.			8. The proportion of patients treated who were prioritised using nationally recognised processes or tools.		
	Level	Status	Imp. Req.	Level	Status	Imp. Req.	Level	Status	Imp. Req.	Level	Status	Imp. Req.	Level	Status	Imp. Req.	Level	Status	Imp. Req.	Level	Status	Imp. Req.	Level	Status	Imp. Req.
Dental	1 of 1	100.0 %	0	X	0.0 %	X	0	0.0 %	0	0	0.0 %	0	0	0.0 %	0	X	0.0 %	0	0	0.0 %	0	X	X	X
Ear, Nose & Throat	1 of 1	100.0 %	0	3	0.0 %	0	0	0.0 %	0	0	0.0 %	0	0	0.0 %	0	X	0.0 %	0	0	0.0 %	0	X	X	X
General Surgery	1 of 1	100.0 %	0	6	0.0 %	0	0	0.0 %	0	0	0.0 %	0	0	0.0 %	0	0	0.0 %	0	0	0.0 %	0	37	100.0 %	0 %
Gynaecology	1 of 1	100.0 %	0	4	0.0 %	0	0	0.0 %	0	0	0.0 %	0	0	0.0 %	0	1	0.0 %	0	0	0.0 %	0	30	100.0 %	0 %
Ophthalmology	1 of 1	100.0 %	0	5	0.0 %	0	0	0.0 %	0	0	0.0 %	0	0	0.0 %	0	0	0.0 %	0	0	0.0 %	0	76	100.0 %	0 %
Orthopaedics	1 of 1	100.0 %	0	1	0.0 %	0	4	0.0 %	0	0	0.0 %	0	11	3.0 %	0	3	0.0 %	0	11	3.0 %	0	27	100.0 %	0 %
Paediatric Surgery	X	X	0	X	0.0 %	X	0	0.0 %	0	0	0.0 %	0	0	0.0 %	0	X	0.0 %	0	0	0.0 %	0	X	X	X
Plastics	X	X	0	X	0.0 %	X	0	0.0 %	0	0	0.0 %	0	5	0.0 %	0	X	0.0 %	0	1	0.0 %	0	21	100.0 %	0 %
Urology	1 of 1	100.0 %	0	3	0.0 %	0	0	0.0 %	0	0	0.0 %	0	1	0.0 %	0	X	0.0 %	0	1	0.0 %	0	8	100.0 %	0 %
<b>Total</b>				<b>22</b>			<b>4</b>			<b>0</b>			<b>17</b>			<b>4</b>			<b>13</b>			<b>198</b>		

This report displays ESPI results for individual surgical services. The ESPI results do not include non-elective patients or elective patients awaiting planned and staged procedures. ESPIs 3, 7 and 8 assess surgical specialities where patients are prioritised using nationally recognised tools - including General Surgery from 01 January 08 and Vascular and Urology from 01 July 08. So, Medical specialities are currently excluded from the ESPI results. Please contact the Ministry of Health's Electives Team if you have any queries on the ESPI definitions (details on elective website). NZHS's Analytical Services Team can assist with providing variations of this information e.g data for a particular DHB or period (details on the NZHS website - <http://www.nzhs.govt.nz/>).



Appendix B: WDHB Additional Electives Report

200809 Electives Initiative CWD Monitoring Report -Wairarapa.rep

**2008/09 Electives Initiative  
Year to Date Summary**

Figures expressed by DHB of Domicile  
Publicly funded events only  
Surgical and cardiology purchase units only  
Elective admissions only

**093 Wairarapa DHB**

	Year to Date CWD Delivery	Total 2008/09 CWD Delivery
Base Planned CWD Volume	1,737.96	1,897.00
Additional Planned CWD Volume	657.60	686.60
<b>Total Planned CWD Volume</b>	<b>2,395.56</b>	<b>2,583.60</b>
Actual CWD Delivery	2,597.45	
Base Plan to Actual Variance	859.49	
Total Plan to Actual Variance	201.89	
Has the DHB Delivered its Base Volumes?	Yes	
Payment will be made for...	All Eligible Services as Listed Below	

Services Receiving Additional Funding	YTD Base Planned CWD Volume	YTD Additional Planned CWD Volume	YTD Total Planned CWD Volume	Actual CWD Delivery	Base Plan to Actual Variance	Maximum CWDs Available for Payment	Amount (\$) Paid to Date	CWDs Paid to Date	CWDs Available for Payment	Outpatient Inclusive CWD Price	Amount (\$) Available for Payment
M10.01 Cardiology	45.81	31.00	76.81	83.95	38.14	31.00	\$123,544.92	31.00	0.00	\$3,985.32	\$0.00
S25.01 ENT	85.20	9.00	94.20	114.83	29.63	9.00	\$45,316.67	9.91	-0.91	\$4,572.14	-\$4,160.65
S00.01 General Surgery	365.55	107.00	472.55	473.58	108.03	107.00	\$399,281.52	98.46	8.54	\$4,055.41	\$34,633.20
S30.01 Gynaecology	170.41	37.00	207.41	234.07	63.66	37.00	\$147,456.84	37.00	0.00	\$3,985.32	\$0.00
D01.01 Inpatient Dental	6.41	23.60	30.01	39.04	32.63	23.60	\$94,054.05	23.60	-0.00	\$3,985.32	\$0.00
S40.01 Ophthalmology	99.86	35.00	134.86	195.21	95.35	35.00	\$145,722.04	35.00	-0.00	\$4,163.37	\$0.00
S45.01 Orthopaedics	603.75	162.00	765.75	761.36	157.61	157.61	\$511,946.61	121.88	35.72	\$4,200.34	\$150,036.14
S55.01 Paed Surgical	15.57	10.00	25.57	25.01	9.44	9.44	\$31,922.41	8.01	1.43	\$3,985.32	\$5,699.01
S60.01 Plastics	66.88	162.00	228.88	221.97	155.09	155.09	\$560,294.66	131.40	23.69	\$4,264.01	\$101,014.40
S70.01 Urology	82.45	20.00	102.45	125.07	42.62	20.00	\$89,308.39	20.00	0.00	\$4,466.32	\$0.00
S75.01 Vascular	33.90	61.00	94.90	117.04	83.14	61.00	\$243,104.52	61.00	0.00	\$3,985.32	\$0.00
				<b>2,391.12</b>		<b>645.73</b>	<b>\$2,391,952.63</b>	<b>577.26</b>	<b>68.48</b>		<b>\$287,222.10</b>



Appendix C: Collective Employment Negotiations

The following table provides information about the current status of the national collective employment agreements that affect the WDHB:

Parties to bargaining	Current situation
<b>Senior medical officers</b>	Expires 30 April 2010.
<b>Resident Medical Officers (RMO's)</b>	Expires 31 December 2009.
<b>Allied, Public and Technical workers</b>	Expires Oct 2010. Implementation of new provisions nearing completion
<b>NZNO Nursing and Midwifery</b>	Expires 31 March 2010. Work on bargaining strategy for next negotiations has begun with DHBNZ.
<b>PSA Clerical</b>	Expires Dec 2011. Implementation of new financial provisions completed, new leave provisions nearing completion.
<b>Ambulance - NDU</b>	Expires 30 June 2011
<b>Service and Food Workers</b>	Expires 30 June 2009. Consultation with DHB's completed.
<b>Apex - MRT</b>	Expires September 2009, Preparation for bargaining commenced. DHBNZ consulting with DHB's re bargaining strategy and costings. Initiation from APEX expected early June 2009.

Collective Name	Status
SMO (N)	Expires April 2010
Nurse/Midwives (N)	Expires 31 March 2010
Midwifery Employee (N)	Expires March 2010
PSA Allied/technical (N)	Expires October 2010
PSA Nursing (N)	Expires 31 October 2010
Jnr Doc (N)	Expires 31 December 2009
Med Rad Techs (N)	Expires 30 September 2009
Maint Services (L) (NZAEP& M)	Expires September 2010
Clerical PSA (L)	Expires December 2011
Ambulance Officers CEA (CAWUNZ)	Expires 30 June 2010.
Home Links (SFWU) (L)	Expires June 2009
Ambulance (N) Nat Distribution Union	Expires June 2011



Appendix D: Provider Arm Contract Performance Report

**Provider Arm Contract Performance Report**  
For the period ended 30th June 2009



Fisq 2009

PUC2	PUC	Contract Price	YTD Actual Vol	YTD Contract Vol	YTD Vol. Var	YTD Vol. %	YTD Actual Revenue	YTD Contract Revenue	YTD Revenue Var	YTD Revenue Var %	LY YTD Actual Vol	LY YTD Actual Revenue	FY Contract Vol	FY Contract Revenue
<b>DHB Funded</b>														
			15,071.00	11,851.00	3,220.00	27.2%	\$4,839,446	\$3,908,646	\$930,800	23.8%	13,768.23	\$3,466,214	11,851.00	\$3,908,646
			3,763.47	3,549.40	214.07	6.0%	\$14,998,617	\$14,145,493	\$853,124	6.0%	3,673.93	\$13,741,902	3,549.40	\$14,145,493
			1,733.92	1,631.30	102.62	6.3%	\$6,910,225	\$6,501,246	\$408,979	6.3%	1,684.70	\$6,266,863	1,631.30	\$6,501,246
			6,596.00	6,727.00	-131.00	-1.9%	\$1,798,125	\$1,788,486	\$9,639	0.5%	5,804.00	\$1,488,558	6,727.00	\$1,788,486
			10,180.00	8,978.00	1,202.00	13.4%	\$2,173,753	\$1,933,046	\$240,707	12.5%	9,143.00	\$1,764,287	8,978.00	\$1,933,046
			1,136.00	972.00	164.00	16.9%	\$1,068,391	\$936,476	\$131,915	14.1%	1,001.00	\$933,263	972.00	\$936,476
			1,906.00	2,212.00	-306.00	-13.8%	\$469,327	\$545,060	-\$75,733	-13.9%	2,173.00	\$473,445	2,212.00	\$545,060
			11,892.00	10,910.00	982.00	9.0%	\$1,070,640	\$1,029,854	\$40,786	4.0%	10,627.00	\$917,717	10,910.00	\$1,029,854
			3,575.00	4,198.00	-623.00	-14.8%	\$1,778,522	\$1,919,757	-\$141,235	-7.4%	3,518.00	\$1,511,490	4,198.00	\$1,919,757
			346.00	320.10	25.90	8.1%	\$1,273,229	\$1,228,594	\$44,635	3.6%	155.00	\$762,531	320.10	\$1,228,594
			77,114.50	77,110.50	4.00	0.0%	\$1,216,651	\$1,215,799	\$852	0.1%	77,117.50	\$901,889	77,160.00	\$1,215,799
			28,094.83	33,201.00	-5,106.17	-15.4%	\$946,764	\$884,028	\$62,736	7.1%	53,037.65	\$871,646	33,201.00	\$884,028
			8,267.50	11,459.50	-3,192.00	-27.9%	\$1,853,110	\$1,866,108	-\$12,997	-0.7%	11.50	\$1,325,542	11,476.00	\$1,866,108
			41,491.00	38,093.00	3,398.00	8.9%	\$2,801,020	\$2,515,892	\$285,128	11.3%	36,202.00	\$2,675,246	38,093.00	\$2,515,892
			1,499.04	1,516.00	-16.96	-1.1%	\$2,014,889	\$2,035,610	-\$20,720	-1.0%	1,646.00	\$3,044,658	1,527.00	\$2,035,610
			574.23	773.30	-199.07	-25.7%	\$3,862,514	\$4,537,614	-\$675,100	-14.9%	569.18	\$3,912,701	1,194.60	\$4,537,614
			5.00	5.00	0.00	0.0%	-\$1,199,321	-\$1,199,321	\$0	0.0%	1.00	-\$1,578,119	5.00	-\$1,199,321
			213,245.49	213,507.10	-261.61	-0.1%	\$47,875,903	\$45,792,388	\$2,083,515	4.5%	220,132.68	\$42,479,833	214,005.40	\$45,792,388
<b>MOH Direct Funded</b>														
			215.00	198.00	17.00	8.6%	\$59,303	\$57,688	\$1,615	2.8%	232.00	\$62,895	198.00	\$57,688
			687.00	1,187.40	-500.40	-42.1%	\$202,023	\$320,065	-\$118,042	-36.9%	475.00	\$155,109	1,187.40	\$320,065
			2.00	2.00	0.00	0.0%	\$145,650	\$145,650	\$0	0.0%	0.00	\$0	2.00	\$145,650
			3.00	3.00	0.00	0.0%	\$619,000	\$619,000	\$0	0.0%	2.00	\$500,652	3.00	\$619,000
			907.00	1,390.40	-483.40	-34.8%	\$1,025,976	\$1,142,403	-\$116,428	-10.2%	709.00	\$718,657	1,390.40	\$1,142,403
<b>ACC Funded</b>														
			1.00	51.00	-50.00	-98.0%	\$460,000	\$473,994	-\$13,994	-3.0%	254.00	\$458,753	51.00	\$473,994
			51.93	39.40	12.53	31.8%	\$206,944	\$157,022	\$49,922	31.8%	4.80	\$17,943	39.40	\$157,022
			484.00	738.00	-254.00	-34.4%	\$97,952	\$149,356	-\$51,405	-34.4%	1,174.00	\$111,359	738.00	\$149,356
			1.00	1.00	0.00	0.0%	\$10,331	\$10,331	\$0	0.0%	1.00	\$9,997	1.00	\$10,331
			1,295.00	530.00	765.00	144.3%	\$72,774	\$30,769	\$42,005	136.5%	1,425.00	\$71,385	530.00	\$30,769
			1,265.00	1,170.00	95.00	8.1%	\$753,295	\$696,723	\$56,572	8.1%	1,532.00	\$660,292	1,170.00	\$696,723
			4,021.00	3,533.00	488.00	13.8%	\$199,149	\$174,980	\$24,169	13.8%	1,788.00	\$82,965	3,533.00	\$174,980
			3,971.00	2,501.00	1,470.00	58.8%	\$309,780	\$214,965	\$94,815	44.1%	3,140.00	\$207,327	2,501.00	\$214,965
			2.00	2.00	0.00	0.0%	\$10,000	\$10,000	\$0	0.0%	2.00	\$9,996	2.00	\$10,000
			11,091.93	8,565.40	2,526.53	29.5%	\$2,120,224	\$1,918,140	\$202,084	10.5%	9,320.80	\$1,630,017	8,565.40	\$1,918,140
			225,244.41	223,462.90	1,781.52	0.8%	\$51,022,103	\$48,852,931	\$2,169,171	4.4%	230,162.47	\$44,828,507	223,961.20	\$48,852,931