Bay of Plenty Hospital Advisory Committee

Venue: Tawa Room, 889 Cameron Road, Tauranga
Date and Time: Wednesday 4 October 2017 at 10:30am

Health Targets

- Shorter Stays in Emergency Departments
- Improved Access to Elective Surgery
- Shorter Waits for Cancer Treatment/Radiotherapy
- Increased Immunisation
- Better Help for Smokers to Quit
- Raising Healthy Kids

Minister's Expectations

- National Health Targets
- Care Closer to Home
- Regional and Clinical Integration
- Living Within our Means
- Working Across Government
- Tackling Obesity
- Shifting Integration Services
- Health IT Programme 2015-2020

Board Priorities

- Maori Health / Achieving Equity
- Health of Older People
- Long Term Conditions
- Child and Youth

The Quality Safety Markers

- Falls
- Healthcare Associated Infections
- Hand Hygiene
- Surgical Site Infection
- Perioperative Harm
- Medication Safety

HSP Objectives

- **Strategic Objective 1:** Empower our populations to live healthy lives
- **Strategic Objective 2:** Develop a smart, fully integrated system to provide care close to where people live, learn, work and play
- **Strategic Ojective 3:** Evolve models of excellence across all of our hospital services

CARE
Compassion All-one-team Responsive Excellence
Manaakitanga

Item No.	Item	Page
1	**Apologies**	
2	**Presentation** 2.1 Health Targets	
3	**Minutes of Meeting** – 05.07.17	3
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5	**Reports requiring Decision** 5.1 Chief Operating Officers Report 5.2 Strategic Health Services Plan – No papers	7
6	**Reports for Noting** 6.1 Work Plan	29
7	**General Business**	
8	**Next Meeting** – Wednesday 7 February 2018.	

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

Minutes

Bay of Plenty Hospital Advisory Committee

Venue: 889 Cameron Road, Tauranga
Date and time: Wednesday 5 July 2017 at 10:30am

Committee: Geoff Esterman (Chair), Peter Nicholl, Matua Parkinson, Ron Scott, Sally Webb, Stewart Ngatai (Runanga Rep)

Attendees: Helen Mason (Chief Executive), Gail Bingham (GM Governance & Quality), Letham White (GM Corporate Services), Julie Robinson (Director of Nursing), Hugh Lees (Medical Director)

Item No.	Item	Action
1	**Apologies** Apologies were received from Clyde Wade and Yvonne Boyes. **Resolved** that the apologies be received. Moved: R Scott Seconded: G Esterman	
2	**Minutes** **Resolved** that the minutes of the meeting held 5 April 2017 be confirmed as a true and correct record. Moved: G Esterman Seconded: R Scott	
3	**Matters Arising** The Chair congratulated the Provider Arm on the positive results obtained from its Acute Demand project.	
4	**Reports requiring decision** 4.1 Chief Operating Officers Report	

Item No.	Item	Action
	The Committee discussed the report as circulated with the agenda. Working safely while planning for retirement: gradual move into retirement is in place for nurses. Older doctors want to stop doing on call; however this is unfair for younger staff who have to take up the slack. A number of employees reduce hours; however need to consider the requirements of the job. **Resolved** that the Committee receive the report. Moved: S Webb Seconded: P Nicholl 4.2 Renewing Work Plan - discussion Discussion on work plan was postponed	
5	**Reports for Noting** 5.1 Work Plan The Committee noted the information. 5.2 Provider Arm Balanced Scorecard The Committee noted the information.	
6	**Presentations** 6.1 Health Services Plan Strategic Objective 3 Walkthrough The Committee thanked Trevor Richardson and Pete Chandler for the informative presentation. Trevor demonstrated the decline in average bed days from the previous 6 years and the increase in triage 2 and 3 presentations to the ED. Success is due to the cumulative effect of everyone's effort. The Committee recommended that this approach be	COO: presentation on

Item No.	Item	Action
	presented to the SHC to see if it can be applied across the sector. Pete discussed the implementation plan for SO3.	Provider Arm approach to improvement to SHC – All I've done is…..
7	**General Business** There was no general business	
8	**Next Meeting** – Wednesday 4 October 2017.	

The open section of the meeting closed at 12:15pm.

The minutes will be confirmed as a true and correct record at the next meeting.

BAY OF PLENTY
DISTRICT HEALTH BOARD
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Bay of Plenty Hospitals Advisory Committee

Matters Arising (open) – October 2017

Meeting Date	Item	Action required	Action Taken
05.07.17	6.1	**Health Services Plan Strategic Objective 3 Walkthrough** COO: presentation on Provider Arm approach to improvement to SHC – All Ive done is….	Completed

PROVIDER ARM BOPHAC REPORT

July - September 2017

Introduction to Connexion Week
During July 2017, the BOP community were invited, via the DHB website and Facebook page, to tell the DHB how they wanted to receive appointments from Tauranga and Whakatane Hospital. The results indicated text (59%), email (29%), letter (8%), phone call (4%), and private message on Facebook (0%).

Combined with the information gathered from the new Preferred Method of Contact field in the patients demographics area in Webpas, the results indicated that there is not one way that patients prefer to be communicated with. However, primarily, text followed by email were the preferred options. At the DHB the predominant communication method currently used is a combination of letter and text.

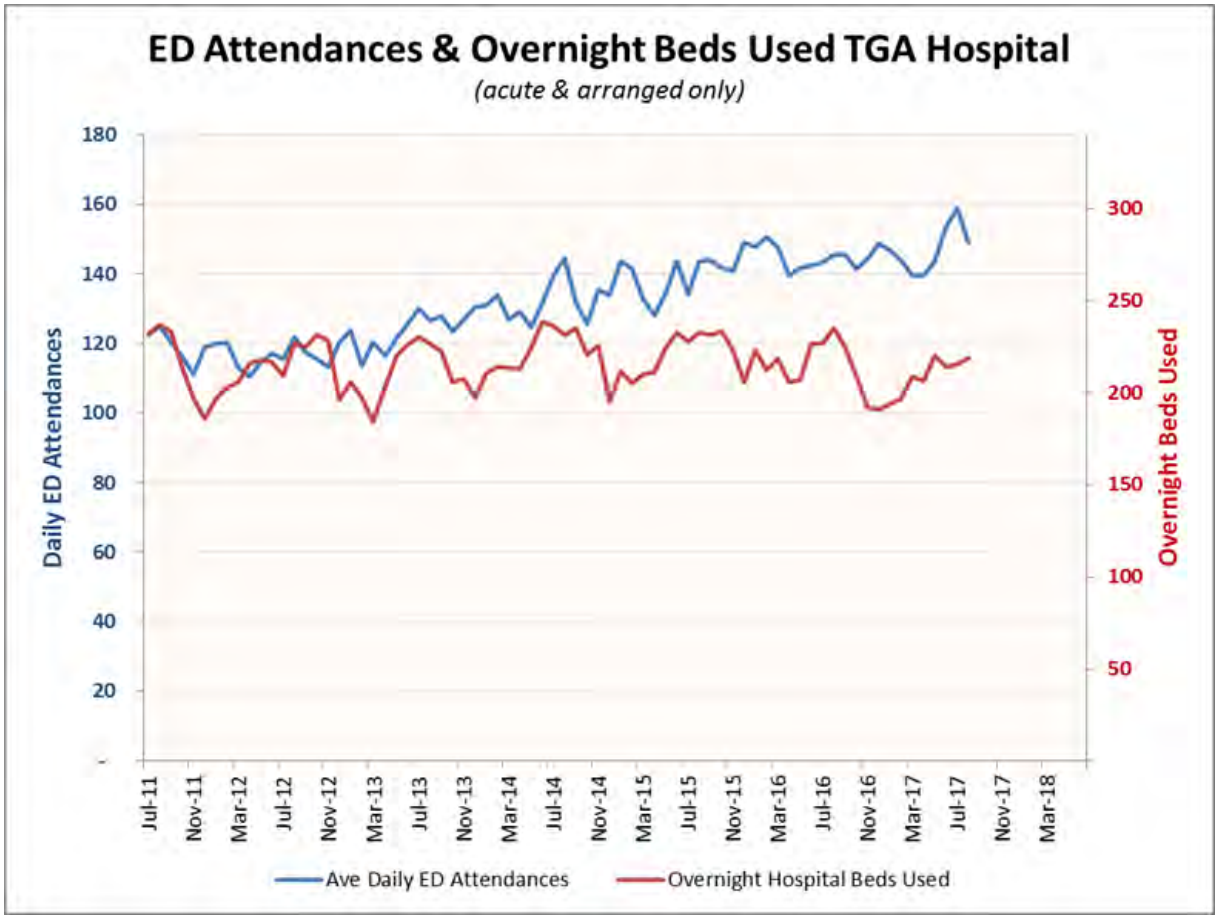
Purpose
This project is intended to accelerate the implementation of a patient communication system driven by the preferred method of contact across all services in the DHB.

Aim
To develop and deliver by 24 November 2017, 90% of DHB services via a responsive communication system between the DHB and the patient, driven by the patient's preferred method of contact

CHIEF OPERATING OFFICER: STRATEGIC OVERVIEW

Hospital Activity

The winter months have been more of a challenge to us in Whakatane this year than at Tauranga. The Eastern Bay has seen a notable step increase in ED and acute demand presentations which needs some detailed analysis to understand what has changed; in Tauranga the demand growth has not lessened but our model of care changes have paid off immensely. The below graph illustrates this well, showing a widening of the gap between ED attendances (our acute demand front door measure) and acute beds used.



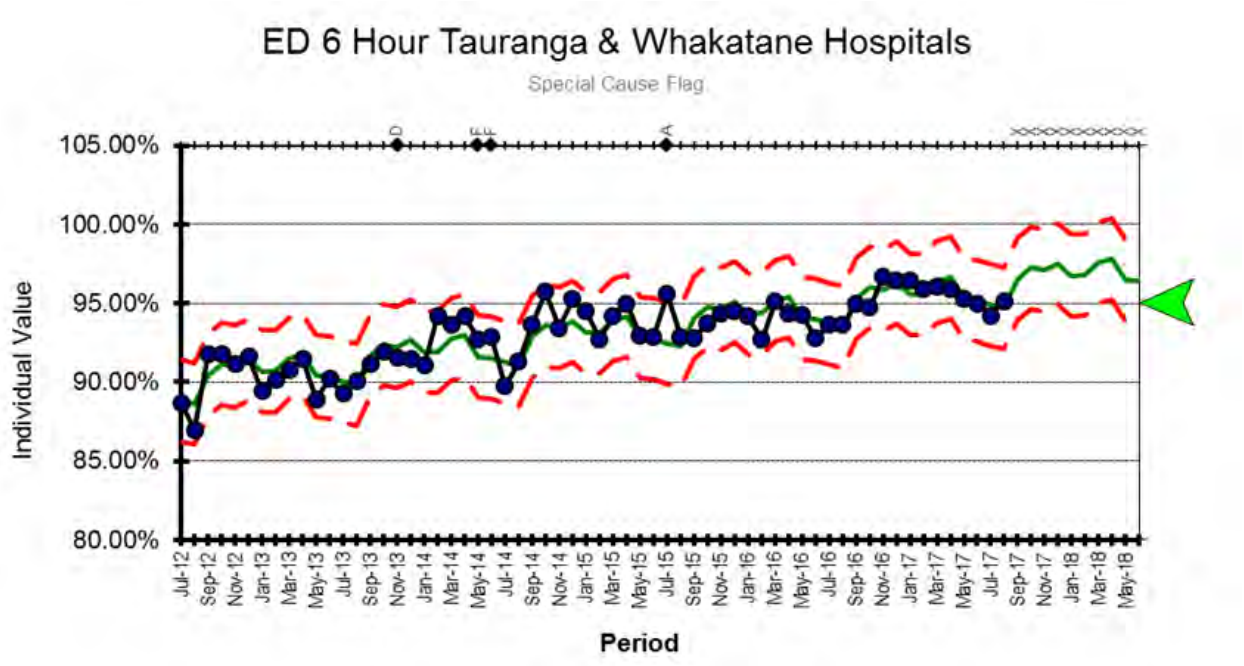
This data perfectly illustrates the benefit of our Ambulatory Emergency Care (AEC) model, which has been at the heart of our development work over the last year. If we had continued with our historic clinical approaches we would have been in very serious difficulty due to the quantum of bed demand from acute presentations. Instead, we have only opened our overflow (Medical Day Stay) once and we have had frequent days of < 90% occupancy – something which has not been seen in Winter for many years.

More recently, AEC implementation has been supplemented with:

- A strong multidisciplinary focus on optimal management of frail, older people
- Clinically led fresh approaches to improving patient flow on our wards (including the implementation of ***Red & Green Days,*** our ***Four Questions*** Tray liners etc
- Developing early senior clinician assessment of patients in ED

- As of the end of September, a high publicity focus on keeping patients dressed to drive ambulatory, rather than admitted care.

Despite inherent winter peaks in activity, we are seeing an increased ability (at Tauranga) to cope with these and to recover quickly from very significant activity phases. The below graph shows compliance against the 6 hour target and the notably reduced variation over the last year, which is extremely encouraging.



There are however some very important messages to share in reflecting on where we are:

1. Acute demand is overall continuing to grow and whilst we have bought some capacity benefits these will only last so long. It is imperative that we use the next year or so to significantly re-define our whole of system approach to acute care. At the Committee meeting it would be helpful to explore the following question:

   Who has the responsibility for monitoring and planning GP out of hours capacity in the Western Bay?

2. We should be increasingly concerned by the speed of population growth and land being opened up for development in all three directions from Tauranga, and increasingly around Whakatane. The next year will require some critical decision making on how we are going to cope with this and if we don't have some tangible capacity increases progressing in WBOP by this time next year we will almost certainly be heading for considerable difficulty in a reactionary rather than proactive environment

3. Whilst performance looks very good, and teams are excited and energized by the results of their efforts, the clinical workload should not be understated. We have more patients coming through our hospitals than ever before and all still receiving care, and faster. This means that on the ground clinical care is extremely intensive and work is highly concentrated. Staff sickness (one of our balancing measures) has increased this year and we need to determine whether this is related to workload or just a particularly nasty round of winter illnesses

4. From current activity trend data it appears that we are going to have to think carefully but quickly about similar models of care changes at Whakatane, how we might resource these (enabling costs and skills) and what the best demand solutions are. This was not expected, certainly at this stage, because all official projections have showed EBOP population as static, or even declining.

Performance

We are introducing a new performance measure for this BOPHAC Committee meeting for use this year as a trial – CCR (COO Comfort Rating). This provides an ***overall assessment*** on our key measures of how we are tracking in consideration of improvement trajectory aspirations, challenges ahead, new issues, ease or difficulty in achieving etc.

The scale is as follows:

1	**We're doing brilliantly and really pleased with this performance area**
2	**We're tracking well/ nicely on track with our delivery or improvement plans**
3	**We're comfortable with where we're at and what we're doing, but there are risks and challenges**
4	**This is a tough challenge for us but are working through a plan**
5	**This is as area we are concerned about and requires more intervention**

The health target presentation at the BOPHAC October Committee meeting will use these ratings.

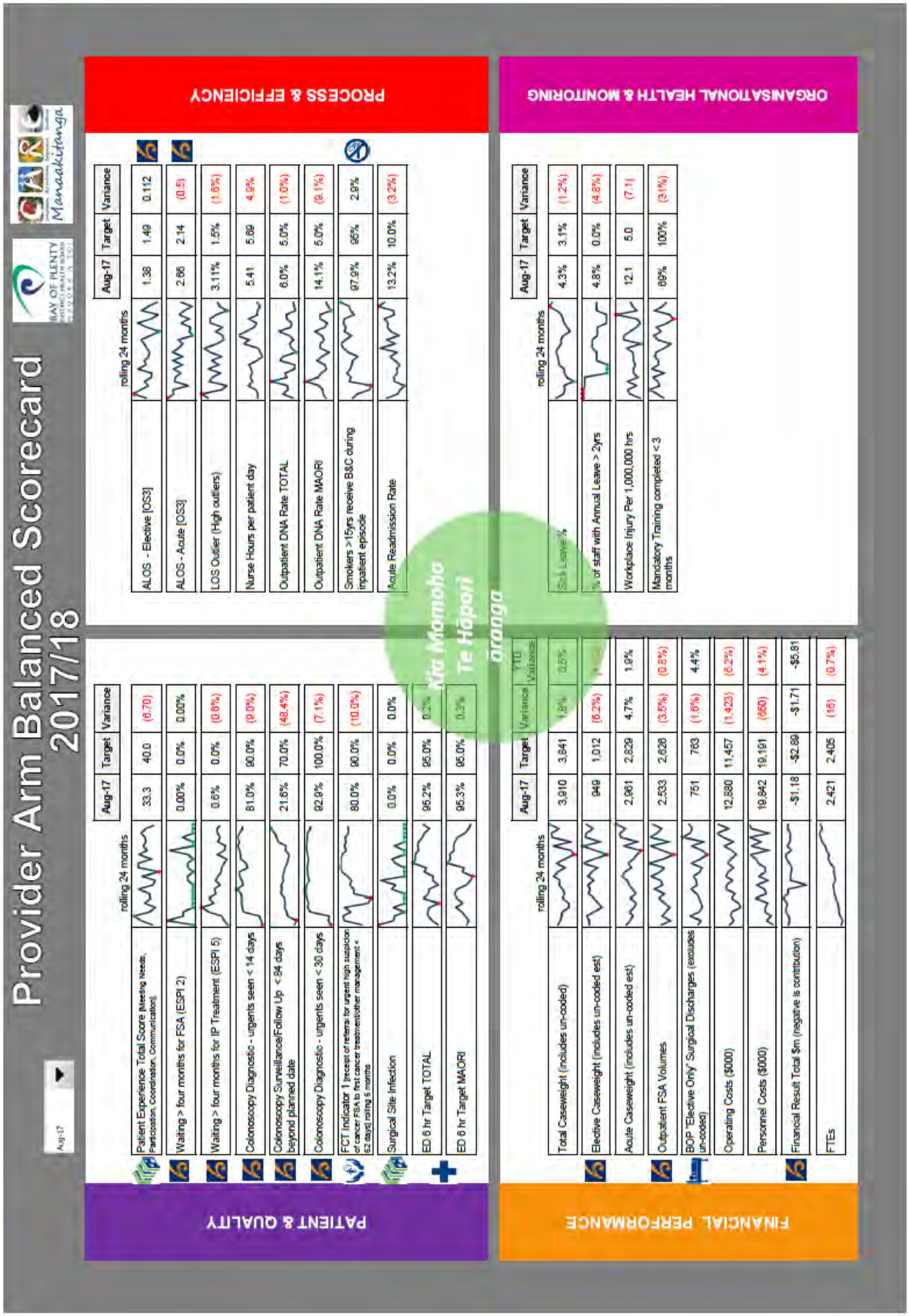
Toi Te Ora Public Health Services

As of September, Toi Te Ora transfers to the management remit of Planning & Funding. This means that Toi Te Ora reports will not generally be included in BOPHAC papers unless there is something particularly pertinent to Provider Arm Hospital and Community services.

Culture shift within Mental Health & Addictions Services

Over the last few months there has been increasing awareness of, and appetite for, the need for a refreshing of workplace and team culture within some parts of the mental health & addictions services. Executive led discussions have taken place with the Cluster Leadership Team, Unions and management teams to share perspectives and seek a joined up approach to what we believe is very important work to strengthen a group of services which is under considerable demand pressure.

Open forums are being held in Whakatane and Tauranga in early October to involve all staff and unions in a new journey of working together to shape the future of the services.


Provider Arm Balanced Scorecard 2017/18
Aug-17
PATIENT & QUALITY
FINANCIAL PERFORMANCE
PROCESS & EFFICIENCY
ORGANISATIONAL HEALTH & MONITORING
rolling 24 months
Aug-17
Target
Variance
Patient Experience Total Score (Meeting Needs, Participation, Coordination, Communication)
Waiting > four months for FSA (ESPI 2)
Waiting > four months for IP Treatment (ESPI 5)
Colonoscopy Diagnostic - urgents seen < 14 days
Colonoscopy Surveillance/Follow Up < 84 days beyond planned date
Colonoscopy Diagnostic - urgents seen < 30 days
FCT Indicator 1 (except of referral for urgent high suspicion of cancer FSA to first cancer treatment/other management < 62 days) rolling 6 months
Surgical Site Infection
ED 6 hr Target TOTAL
ED 6 hr Target MAORI
Total Caseweight (includes un-coded)
Elective Caseweight (includes un-coded est)
Acute Caseweight (includes un-coded est)
Outpatient FSA Volumes
BOP "Elective Only" Surgical Discharges (excludes un-coded)
Operating Costs ($000)
Personnel Costs ($000)
Financial Result Total $m (negative is contribution)
FTEs
ALOS - Elective [OS3]
ALOS - Acute [OS3]
LOS Outlier (High outliers)
Nurse Hours per patient day
Outpatient DNA Rate TOTAL
Outpatient DNA Rate MAORI
Smokers >15yrs receive B&C during inpatient episode
Acute Readmission Rate
Sick Leave %
% of staff with Annual Leave > 2yrs
Workplace Injury Per 1,000,000 hrs
Mandatory Training completed <3 months
Te Mauri Momoho
Te Hāpori
oranga

DIRECTOR OF NURSING AND MIDWIFERY

Care Capacity Demand Management (CCDM)

One of the measures for the CCDM dashboard is the nursing hours per patient day variance between the hours required by patient acuity against the hours provided. As noted for July 2017 the medical and mental health service were not able to match demand. The impact for medical service was particularly at Whakatane. With the higher rate of staff sickness the pool of casual staff was insufficient to meet the need.

HPPD

	This Month	Required	Variance	Variance %	Variance Target + / -	Indicator
Medical	5.27	5.88	-0.61	-10.4%	2.5%	✗
Surgical	5.12	5.12	0.00	0.0%	2.5%	✓
WCF - Paed	5.25	5.36	-0.11	-2.1%	2.5%	✓
WCF - Mat	6.95	7.04	-0.09	-1.3%	2.5%	✓
Mental Hlth	7.15	9.63	-2.48	-25.8%	2.5%	✗
Allied Hlth	U/D					

Values Based Recruitment Workshop
Why recruit for CARE values? Engaged teams deliver better care

85 hiring managers participated in a values based recruitment workshop with Tim Keogh. Such was the interest in this workshop the available places were filled in two days and a bigger venue was required. This work comes under the performance development work stream. The graphic below identifies the phases of recruitment currently under revision to align recruitment processes with our values. This is quite a different approach to hiring staff and all managers will be required to complete the training. When a staff member's values, and the DHB's values are a good 'fit,' staff are more likely to feel more comfortable, more energised, and get greater satisfaction from their work. Also new staff settle quicker, stay longer and demonstrate our CARE values more consistently.

Surgical Site Infection Summary Report

There were no surgical site infections for June. It was also pleasing to note there were no incomplete records at Tauranga which is an area that has been a challenge to meet to date.

BAY OF PLENTY DISTRICT HEALTH BOARD

Patient Safety

SSIS Surgical Site Infection Surveillance Programme

Monthly denominator data summary and variance report – June 2017

Denominator data: *(The number of surgical procedures done this month)*

	Hip Arthroplasty			Knee Arthroplasty		
	Primary	Revision	TOTAL	Primary	Revision	TOTAL
Tauranga	18	2	20	18	0	18
Whakatane	8	0	8	18	0	18
Grace	4	0	4	4	0	4

Variance: *record the number of surgical Site infections (SSI)*

Compliance: *record the number of incomplete health records and compliance with best practice for antibiotic prophylaxis and skin preparation.*

	Number of incomplete health records	% Compliance with antibiotic prophylaxis		% Compliance with skin preparation	Infections (SSI)
		Dose	Timing		
Tauranga	0	100	100	100	0
Whakatane	0	92	100	100	0
Grace	0	100	100	100	0

Reason for variance:

Tauranga:

Whakatane: 2 patients received 3g Cephazolin despite being under 120kg and normal range BMI (same anaesthetist). 1 of those patients also received 4 doses (5 including OT) 2g Cephazolin on ward. Not sure why. Will speak with prescribing doctor.

Grace:

Complete health record

The national database records non-compliance where a dataset is incomplete. This is most often because the ASA score and/or the dose or times of administration of prophylactic antibiotics are missing from the anaesthetic chart.

Antibiotic prophylaxis

National surgical prophylactic antibiotic guidelines are as follows:

For adults (unless contraindicated):
2gm cephazolin 0 – 60 minutes prior to incision.

Our DHB has an additional protocol whereby 3gm cephazolin is given for patients >120kg, also to be given 0 – 60 minutes prior to incision.

Skin preparation

*The National SSIS programme follows the recommendation that skin preparation should include **alcohol** and either chlorhexidine or povidine iodine.*

Surgical site infection

This summary only reports the number of infections that occurred for the month. For further details about each infection contact the Infection Control Team or the Quality & Patient Safety Team.

SERVICE UPDATES

Outreach Kawerau Clinics

Outreach clinics for ENT, Paediatrics and Dental are continuing to be held at Tuwharetoa Ki Kawerau. These clinics are well supported by DHB clinicians working in a partnership that has formed with Tuwharetoa Ki Kawerau staff led by Jayne Beeching the Health Services Manager. For example at a recent clinic the two Tuwharetoa Ki Kawerau staff members worked with and alongside us to ensure efficient flow of patients and ultimately good attendance.

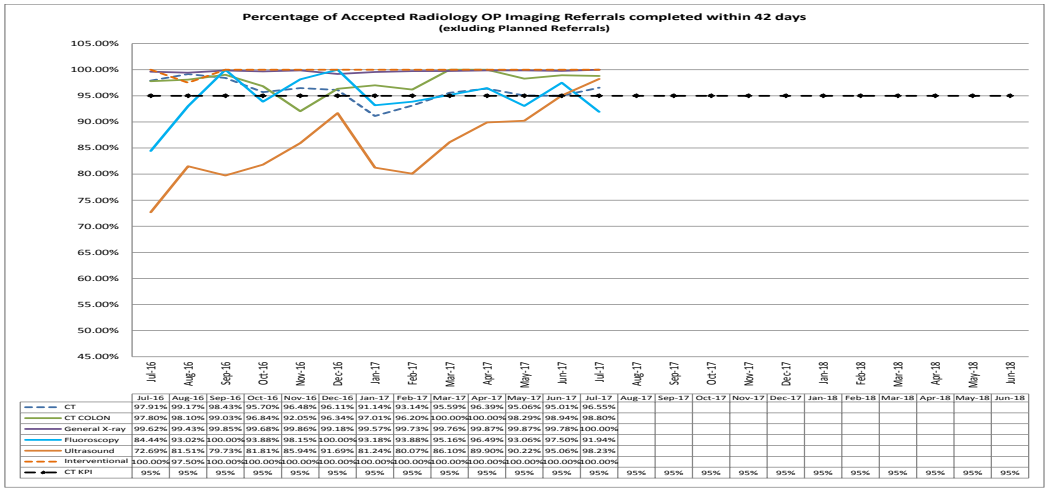
General feedback from clinicians after this clinic was of incredible satisfaction as all these children had very real ENT conditions requiring intervention whether it be prescriptive therapy, Otomicroscopy and aural toileting, surgery or a further follow up.

"Being able to make a positive difference to health outcomes exemplifies the purpose of our employment enabling positive outcomes for these children. Interestingly our working relationship with this community and Tuwharetoa has shown to us the trust upheld in our team by these parents as they are coming to clinic and all showing for theatre on scheduled dates."

Radiology Improvements

Waiting times for Ultrasound

Over the last 3 months there has been a significant improvement in Ultrasound with 98.23% of patients receiving their scan within 42 days. This improvement has been enabled by the successful recruitment of sonographers, including the appointment of a training position. Sonographers are a scarce resource within New Zealand and we are extremely lucky to have been able to recruit and make an immediate improvement in our waiting times.



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
CT	97.91%	99.17%	98.43%	95.70%	96.48%	96.11%	91.14%	93.14%	95.59%	96.39%	95.06%	95.01%	96.55%											
CT COLON	97.80%	98.10%	99.03%	96.84%	92.05%	96.34%	97.01%	96.20%	100.00%	100.00%	98.29%	98.94%	98.80%											
General X-ray	99.62%	99.43%	99.85%	99.68%	99.86%	99.18%	99.57%	99.73%	99.76%	99.87%	99.87%	99.78%	100.00%											
Fluoroscopy	84.44%	93.02%	100.00%	93.88%	98.15%	100.00%	93.18%	93.88%	95.16%	96.49%	93.06%	97.50%	91.94%											
Ultrasound	72.69%	81.51%	79.73%	81.81%	85.94%	91.69%	81.24%	80.07%	86.10%	89.90%	90.22%	95.06%	98.23%											
Interventional	100.00%	97.50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%											
CT KPI	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Reduction of DNA for radiology appointments

DNA Percentage for Radiology Services by Site for All Ethnicity 2018				
Month	Tauranga	Whakatane	Opotiki	Total
Jul-17	2.25%	3.08%	6.17%	2.55%

DNA Percentage for Radiology Services by Site for Maori Ethnicity 2018				
Month	Tauranga	Whakatane	Opotiki	Total
Jul-17	6.74%	7.12%	12.82%	7.23%

The following actions have supported an improvement to DNA results :

1. The service introduced Text Messaging reminders and confirmations in late 2014 and in July 2015 implemented the GP Electronic Referral System.

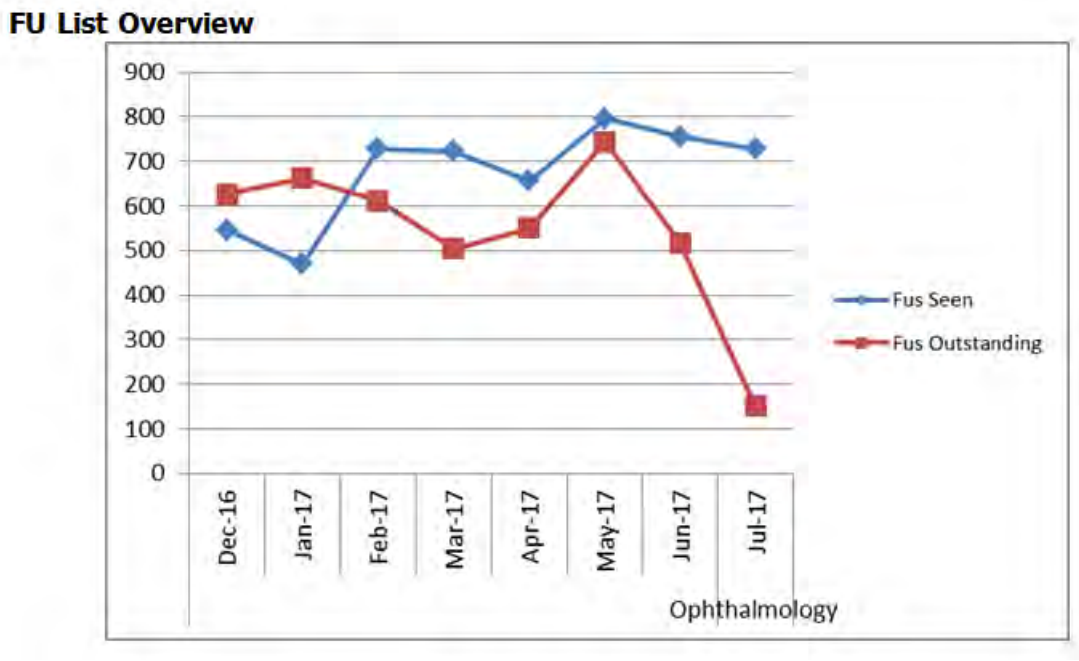
2. Extended hours in Tauranga CT Scanning started in May 2014
3. Implementation of Tauranga MRT Rotating Roster 2015-2016 and move to 40 hour week.
4. Waiting Times significantly reduced from 2015.
5. A change in referral process as requested by Opotiki GP's was introduced in 2015 which increased DNA rate. The process has been reviewed and GP's contact the department for an appointment while the patient is in their clinic.
6. Ability to offer an appointment within 4 to 6 weeks (if offered sooner it is more likely they attend)
7. Consistent overview of appointment diary, data audits and contact by admin staff to ensure every appointment (other than general x-ray) has been confirmed by the patient; otherwise the appointment time is re-allocated to another patient.

Eye Health Service Improvement Project

BOPDHB, in partnership with Park Street Eye Hospital, has commenced a Ministry of Health supported Eye Health Service Improvement project with the goal of improving eye health services for our community.

The specific actions are as follows:

- ***Improve management and timeliness of follow-up care for eye health services.*** This will include managing backlog, developing consistent standards across the specialty, and investigating alternative options to deliver services. To date this work has achieved excellent progress as shown in the following table



- ***Create an alternative to specialist delivery of Avastin injections*** to reduce cost and capacity constraints. A registered nurse has commenced specific training to enable this role to provide this service.

- ***To improve the care model for high-risk patients with Macular Degeneration (MD)*** by ensuring a shorter wait time from referral to treatment, thus reducing the risk of further loss of sight and potentially reduction in number of treatments required. Changes to the care model will include patient representatives providing input to ensure that the new model best meets their needs and that services delivered are appropriate for Maori.

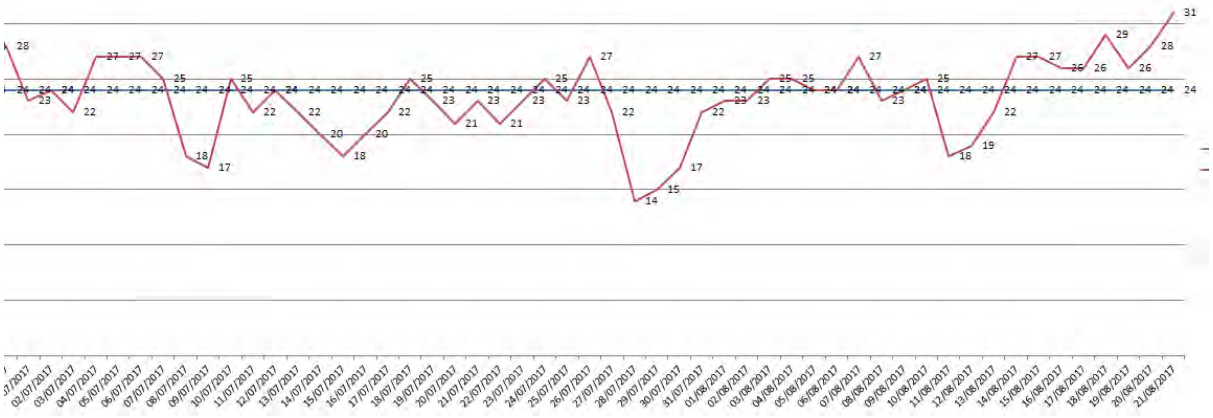
MENTAL HEALTH & ADDICTIONS SERVICES

Dialectical Behavioural Therapy (DBT) development
The service has made a commitment to developing a DBT Service in the Bay of Plenty. DBT is an intensive therapy that works with people with a diagnosis of borderline personality disorder; this will enable the service to respond more effectively to clients with severe emotional dysregulation.

In order to meet the needs across the age range, staff from both the Maternal Infant & Child Mental Health Service (MICAMHS) and the Adult Mental Health & Addictions Service (AMH&AS) have sent ten clinicians on the intensive DBT training. The ten therapists have formed a working group and a series of meetings with relevant stakeholders are planned in order to develop pathways, ensure co-working, and sharing or resources across the services.

Joint initiative with Oranga Tamariki
The management of both Maternal Infant & Child Mental Health Service (MICAMHS) and Oranga Tamariki met to discuss possibilities of working together more closely. Both services focus on vulnerable children and young people but often there is misunderstanding between the two teams and frustration about the perceived lack of action. As a result it was decided that we will launch a series of “interventions” to enhance co-working and improve relationships between the services. A meeting was organised and the Oranga Tamariki team joined the MICAMHS team for a formal welcome and morning tea. Over the next few months staff will spend some time in each other’s service and a fortnightly case management meeting’s where joint cases are discussed in person will be trialled.

Inpatient Activity in Te Whare Maiangiangi
Te Whare Maiangiangi had a period of time since February with exceptionally high bed occupancy and safe staffing challenges, the situation improved during July and continued through August to a level where staffing is considered in the safer “green zone” of Hospital with a Glance for all of August. However in the last days the occupancy started to increase again, but staffing remained in the green zone. Below is a graph indicating in red the daily bed occupancy of patients with exclusion of those on leave.



Changes to inpatient bed configuration
A change to the IPC bed configuration in Te Whare Maiangiangi has been agreed with funding and planning, the change will increase the numbers of IPC beds from 4 to 6 and decrease the number of acute beds from 20 to 18. The overall number of beds remains at 24.

In order to support the increase in IPC beds an increase in staffing has been approved the additional staff will be utilised to provide an increase in 1 to 1 support for clients in the acute ward

who would have previously required IPC level care, with the aim to reduce over occupancy in the IPC environment and providing better treatment options for clients with higher care needs.
Recruitment for the additional staffing has commenced.
Discussion have occurred with staff on the planned changes and rationale for this, further meetings with staff and union representatives are planned for August and September.

It is expected that the new approach will be operational by October.

Seclusion reduction
Te Whare Maiangiangi (Mental Health In-Patient Unit) has formed a group to address the issues around the use of seclusion with a focus on seclusion reduction. This work stream included consumer participation and involvement from Regional Maori Health Services working together in this complex and challenging area of improvement.

The Terms of Reference have been agreed with a focus on actions such as the initial decision to transform and use one of the three seclusion rooms into a de-escalation space.

The Director of Area Mental Health Services has accordingly decommissioned one seclusion room for that purpose. A Team Leader and Occupational Therapist visited the Forensic Unit at the Henry Rongomau Bennett Centre in Hamilton to view the sensory environment and gain an understanding of the sensory profiles that are in use. The team will present their learnings from this at the Te Whare Maiangiangi leadership and staff meetings.

MEDICINE

BOPDHB clinical teams are increasingly being asked to present on our developments and initiatives at national and international conferences. On the following pages are three examples of poster presentations which outline some of our specialty based developments which we think the Committee will find of particular interest.

Heartbreaker you've got the best of me – why don't you keep going to the pharmacy?

Lauren Assink, Kok Lam Chow, Jennifer Goodson
Bay of Plenty District Health Board

Introduction

Literature shows adherence to secondary prevention medication after an acute coronary syndrome (ACS) is suboptimal (1,2) however local comparative data is lacking. We believe we are good at prescription initiation but there is limited information after hospital discharge. This review investigates whether the prescription initiation in the inpatient setting translates to medication adherence after a confirmed ACS event at BOPDHB.

Inpatient care is routinely audited to ensure appropriate baseline monitoring and prescription initiation using the All New Zealand Acute Coronary Syndrome Quality Improvement (ANZACS-QI) register (3). Once discharged, the decision to adhere to the prescribed medication becomes the responsibility of the patient. It is well known that adherence to secondary prevention medication may prevent further cardiovascular events (4-7).

Method

Data collected from ANZACS-QI registry was used to generate a report of the number of patients admitted to Tauranga Hospital with ACS for the 6 month period (01/09/15-29/2/2016). Exclusion criteria included patients that experienced type 2 myocardial infarction (8) or patients who died within the study period and patients with incomplete dispensing data. Incomplete data was defined as patients located outside of the DHB domicile or where community pharmacy data was not linked for the complete duration of the patients review.

Utilisation of Tauranga Hospital's Clinical Health Information Portal (CHIP) and Eclair system allowed retrieval of a patient's dispensing record using the National Health Index (9). Community pharmacy dispensing records were analysed for prescriptions of aspirin, P2Y12-receptor inhibitors, beta-blockers, ACE/ARB inhibitors and statins allowing the number of tablet days for each medication to be calculated. Medication adherence was measured using a medication possession ratio (MPR) (10) as an estimate of each patient's adherence. If the MPR was over the 80% adherence threshold for the allocated period adherence was presumed (1)(11).

Results

208 records were screened resulting in 160 patients eligible for analysis. 72% of patients were assumed as being compliant with aspirin therapy at the end of the 1 year period. These figures were 52% for ACE inhibitors, 68% for beta-blockers and 75% for statin therapy. $P2Y_{12}$-receptor inhibitor therapy was adhered to by 63% of patients. In patients prescribed Ticagrelor, 75% completed a 1 year course (MPR<0.8) compared with 63% of those prescribed Clopidogrel. All medication classes experienced a reduction in adherence when compared to prescription rates at discharge.

Demographics

Total number of patients	160
Male	72% (n=115)
Female	28% (n=45)
Age, male (mean), years	69
Age, female (mean), years	74

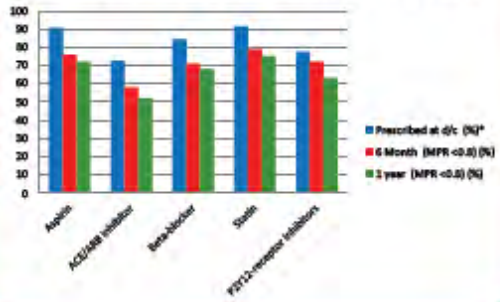
Summary of Points

- Patient adherence after discharge is much lower than prescribing rates initiated in hospital following a confirmed ACS diagnosis.
- Patient adherence reduces longitudinally.
- Further research is required to identify barriers to adherence.

Medication	Prescribed at d/c (%)*	6 Month (MPR <0.8) (%)	1 year (MPR <0.8) (%)
Aspirin	90.5	76	72
ACE/ARB inhibitor	72.5	58	52
Beta-blocker	84.2	71	68
Statin	91.4	79	75
$P2Y_{12}$-receptor inhibitors	77.5	72	63

*Based on ANZACS-QI registry data for review period.

Patient Adherence at 6 months & 1 Year



Conclusion

Data from BOPDHB is similar to other studies that have estimated adherence of secondary prevention medication. (1,2) There is potential to optimise patient care if we can identify and address some of the barriers to non-adherence.

References:

Contact: Lauren.assink@bopdhb.govt.nz

Renal – Telemedicine

the role of Rural Renal Nursing (RRN).

Terry Jennings[1]; Eddie Tan[2]
[1]Renal Service, Bay of Plenty DHB, [2]Renal Service, Waikato DHB.

Aim

To explore how telehealth revolutionised the role of Rural Renal Nurses (RRNs).

Top: Hub-and-spoke model of care
Left: BOPDHB (Bay of Plenty District Health Board) catchment area

Introduction

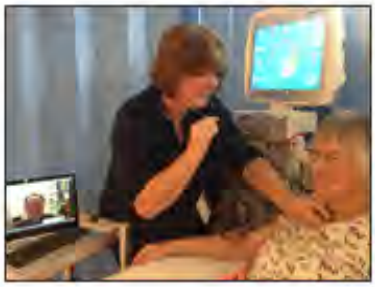
The Bay of Plenty District Health Board (BOPDHB) caters to the health needs of a growing population of approximately 260,000 people[1]. The Bay of Plenty (BOP) renal service falls within the catchment area of the Midland Regional Renal Service. Operating on a "hub-and-spoke" model of care, Waikato (hub) provides renal support to isolated outreach areas including two satellite dialysis units (SDU) located in the Eastern and Western BOP (Tauranga and Whakatane). Our local satellite dialysis units' geographic isolation from the main renal unit increases the vulnerability of their Rural Renal Nurses (RRNs). A lack of onsite medical cover, limited communication and long travel times (3-5 hours) results in missed service development and educational opportunities with the regional hub. The smaller pool of RRNs in satellite units (2 per shift) further exacerbates the problem. The ineffective use of time/resources, disruption leads to stress and fatigue amongst RRNs and they are often left feeling vulnerable, isolated, neglected and disengaged with the regional hub. This changed with the introduction of telehealth.

Below: Virtual Clinic Setup

Methods

Telehealth, introduced in 2014, commenced with video clinics; the hub physician video linked with patients and nurses at the SDU. RRNs performed patient observations, medicines reconciliations, document-filling, fluid assessments and examinations.. Gradually, virtual consultations expanded to include blood result reviews, dialysis rounds, impromptu clinical assessments, patient-family-doctor meetings, dietetics, pre-dialysis counselling and transplant work-ups. Virtual links facilitated meetings and education sessions with the hub and other SDUs. Implementation of these telehealth projects relied heavily on highly skilled senior RRNs with broad expertise in technology, physical assessment skills, disease management, pharmacology and biochemistry. Patient feedback on the video clinics was obtained[2-9].

Top: Virtual Clinics linking Hub and Satellite units
Below: RRN conducting physical examination during video consultation



Results

Telehealth provided nurses with a unique platform for professional development; up-skilling in both clinical and computer knowledge. Increased clinician interaction and attendance at education sessions provided invaluable training and research opportunities. Flexible clinician access through video consults reduced the vulnerability of isolation. Increased opportunities to attend virtual service development meetings meant better engagement with the central hub. Minimal work disruption and reduced travel need resulted in a more efficacious use of nursing time with significant cost and time savings and carbon footprint reduction. Patient feedback obtained was excellent[2-3,6-9].

The Dream Team; Top: virtual clinic (left), virtual ward round (right)
Bottom: virtual blood review (left), virtual team meeting (right)

Conclusions

Telehealth expanded the role of our RRNs, reduced their vulnerability to isolation and bridging the gap towards providing equal opportunities for educational, service and professional development; empowering RRNs to operate semi-autonomously, paving the path for extended practice roles, many of them clinician-based[2-3].

Top: Virtual Clinics leading to time/cost savings and lower carbon footprint with reduced travel

Discussion

Geographic isolation from the regional hub, has led to the rapid expansion of telehealth technology in clinical practice. The success of early ventures (virtual clinic) proved that telehealth is a valuable cost-effective commodity that works well. Video technology is now used to improve and expand our renal service and provide RRNs with increased opportunities to attend multiple development activities that were previously unavailable due to distance and isolation. Use of telehealth has empowered RRNs to operate semi-autonomously and undertake new initiatives that have only been made possible through use of telehealth technology. Future development plans include the introduction of advanced practice roles for RRNs, such as a nurse-practitioner, clinical nurse specialist, nurse prescriber and nurse proceduralist[2-9].

Contact

Terry Jennings
Clinical Nurse Manager
Renal service, BOPDHB.
Email:

BAY OF PLENTY DISTRICT HEALTH BOARD

References

1. [illegible]
2. [illegible]
3. [illegible]

Renal – DNA's

A Single-Centre 12-Month Retrospective Audit of Satellite Haemodialysis Patient Attendance and Unused Slots.

Terry Jennings[1]; Eddie Tan[1,2];
[1]Renal Service, Bay Of Plenty DHB, [2]Waikato Hospital, Hamilton, NZ.

Aim

To analyse the impact of wasted/unused Satellite Haemodialysis Unit (SHU) slots.

Top: Hub and Spoke model of care.
Bottom: Bay of Plenty DHB (BOPDHB) Catchment area.

Introduction

All renal patients located within the Regional Waikato area commence their dialysis journey at the Waikato Regional Renal Centre. Once established on dialysis therapy, patients are then relocated back to their local satellite dialysis unit, space permitting for ongoing treatment.
The Tauranga SHU is run by Renal Registered Nurses (RRNs) with tertiary based nephrologist supervision operating on a hub-and spoke model of care[1].
Vacant Dialysis Sots (VDS) result from hospitalisation, patient non-attendance or delayed /non- allocated (after death, transplantation or relocation). Resources are wasted and other patients are deprived of these slots. With limited SHU capacity, determining the extent of wasted/ unused slots is important. Cost disparities are huge due to under utilized dialysis slots, with capital costs increasing dramatically when fewer patients are treated [2]. Additionally, the clinical risk to patients who skip dialysis treatment at least one session per month is huge, and associated with a 25-30% higher risk of death [2,3].

Chart 1. Available/ Utilised/ Wasted Dialysis slots

Methods

Data was retrospectively collected using electronic and hardcopy records. Haemodialysis patient attendances for 2016 were analysed, looking at VDS and efforts to fill them (by swapping patients and/or dialysing holiday patients). Slot wastage was expressed as extent of patient slot deprivation, nursing/ patient ratios and dialysis reimbursement loss.

Above: The Tauranga Dialysis Unit
Below: The beautiful and glamorous Nurses of the Dialysis Unit

Results

4178 (95.04%) out of 4396 Total Dialysis Slots (TDS) were utilized, with NZD$401.93/slot reimbursement (NZD$354.14/holiday slot) [4] and requiring 6.4 Full-Time Equivalent (FTE) RRNs (average salaries NZD$66219.46/annum)[5]. There were 229 VDS (5.20% TDS), due to: hospitalisation (93, 41%), non-attendance (49, 21%) and non-allocation (87, 38%). Only 11 slots (4.80% VDS) were filled last-minute (7 swaps and 4 holiday slots); all from predictable hospitalisation and non-allocations. No non-attendance slots were filled. 218 slots (4.96% TDS) were unused/wasted; 1.38 FTE patients could have been accommodated (each FTE requiring 157 slots/year). This amounts to wastage of RRN FTE: 0.31 (using nursing/patient ratios) or 1.32 (using salaries/dialysis reimbursement ratios). Equivalent lost dialysis reimbursement: NZD$87620.74/annum (normal slots) or NZD$120802.52/annum (holiday slots).

Below: Calculations.

Above: Breakdown of VDS (81) M,W,F (24fte)
Below: Breakdown of VDS (181) T,T,S (2 slots)

Conclusions

There is sizeable dialysis slots wastage expressed as patient-slot deprivation, nursing FTEs and reimbursement loss. Predictable vacancies were rarely filled. Avoidable non- allocation comprises a large proportion (38%) of slot-wastage.

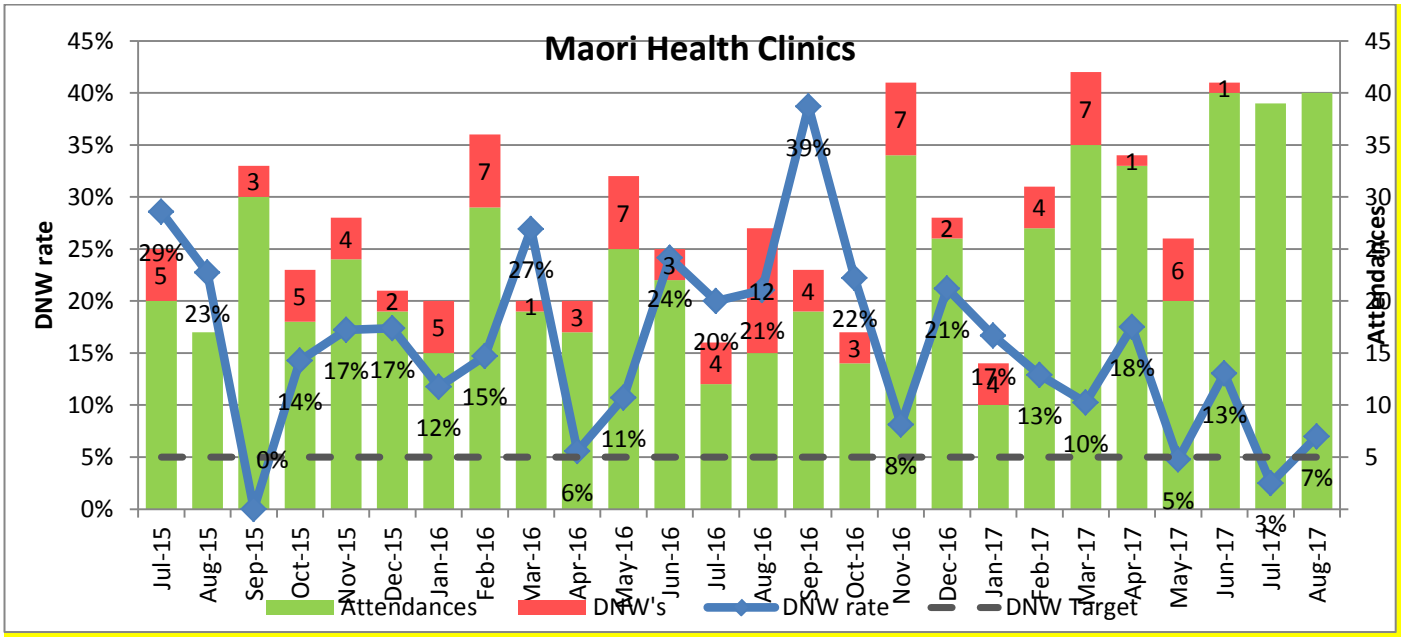
Discussion

The SHU has limited control over the allocation of VDS to patients as responsibility for patient allocation of VDS lies with the Hub- Regional renal service. VDS occurred unpredictably, often as a result of short notice cancelations. As a result only 11 VDS were able to be used. VDS do allow for flexibility in the SHU. However, their unpredictable nature makes filling these VDS at short notice almost impossible. Therefore efficient utilisation of these slots with speedy slot allocations could reduce slot wastage. Additionally, the clinical FTE of the Clinical Nurse Manager has not been included, therefore, calculated costs may be underestimated. Vacant slots on the M,W,F shifts are filled with existing patients from the less popular T,T,S shifts, resulting in high patient turnover for this shift.

REGIONAL MAORI HEALTH SERVICES

Outpatient Clinics (OPC)

Since June 2017, the Regional Maori Health team has been working in partnership with clinical specialty schedulers, admin and Kaupapa community services to expand cultural clinics in Regional Maori Health facilities. These have been extremely successful with high patient satisfaction and a significantly improved attendance rate as demonstrated in the chart below.



WOMENT, CHILD & FAMILY SERVICES

Paediatrics

Whakatane paediatrics was busy over the July period with an increase in respiratory admissions especially in the under 1 year age range. The children are presenting much sicker with more invasive respiratory support (Airvo 2) being required. This impacts on staffing as these children require significant nursing care.

The creating our culture work is regularly discussed in the ward with staff interested in the developments that will be made with inappropriate behaviours. Whilst it is pleasing that staff are keen for others behaviours to improve, the challenge is to enable them to understand their own part in the culture change and how they can make improvements.

Maternity

A number of challenges and changes are arising within the DHB's Maternity service which warrant outlining to the Committee.

Midwifery staffing in both Whakatane and Tauranga units continues to be challenging, with a small team in Whakatane to maintain the full roster as recruitment to positions continues.

The DHB-wide Midwifery Leader, has tendered her resignation effective in October 2017. She has held the position since the establishment of the cluster leadership model in 2006.

The Clinical Midwifery Manager at Tauranga has also resigned effective September 2017 and will take up the midwife position for the Woman's Assessment Unit which manages the antenatal care for woman.

Recruitment for both positions is underway.

Cervical Screening

The latest screening rates below to 30 June show another increase in Maori rates and a reduction in the disparity gap, while Asian screening rates continue to decline. Common reasons are that Asian women often return to country of origin for smears, so are not recorded locally, that it is culturally inappropriate to be screened prior to marriage and there is often no suitable translator (usually children) if language is a barrier. We are looking for ways to address this.

	BOP DHB rate	Rank	National rate
Maori	69.1%	8th	65.3%
Pacific	73.8%	9th	75.5%
Asian	57.6%	17th	63.2%
All Other	85.4%	1st	79.8%
	79.7%	3rd	75.0%

Countdown Kids Launch

The 2017 Countdown Kids appeal has been officially launched with events at Tauranga and Whakatane Hospitals.

The fundraising is already underway and this is the tenth year that BOPDHB has been a recipient with approximately $800,000 worth of equipment donated during that time. This year's appeal will run until 29th October 2017.

Examples of equipment purchased in recent years with Countdown funds are the Panda Resuscitaire (used for resuscitating babies soon after birth - cost $25,000); the Bilisoft (used for treating jaundiced babies – cost $15,000); and the i-Stat Handheld Blood Analyzer (used for testing babies' blood glucose levels for example - cost $11,000).

Community Health 4 Kids

The new childhood immunisation liaison role has been recruited to the National Immunisation Register (NIR) team. The primary purpose of this role is to track children aged from birth to 5 years of age to ensure no child is missed for immunisation events. They will be part of a wider multidisciplinary team under the BOP Childhood Immunisation Collective and will work with nurses and advocates. A core component of their role will be to receive Outreach Immunisation Service (OIS) referrals from GP Practices, screen these, find additional contact information on the child,

contact the families to advocate for them to have the child immunised at their GP Practice plus establish any barriers they may be facing and looking to assist in removing the barriers. Children will be referred to OIS two weeks out from missing a core immunisation. The 8 month immunisation target priority is a core focus.

The community of Murupara has experienced 7 deaths in under 2 weeks, so the community is grieving but out of this NGO's, govt. agencies and staff from the DHB are meeting to map out strategies moving forward. It has impacted our staff personally in Murupara and we have had "to park" pursuing families for overdue childhood immunisations as it would be insensitive to do this. We are recommencing this service shortly but it has been interrupted for the past 2 and ½ weeks.

Community Dental Services has 13 school sites now connected to the schools ultra-fast fibre internet highway "Network 4 Learning". This is solving our connectivity issues in rural areas as well as areas with high congestion on the 3G/4G network.

DHB Community Dental Services

Community Dental is currently scoping how to roll out a fluoride varnish treatment programme to target pre-schoolers and primary age children who are at a higher risk of dental decay. This is a programme that can be carried out by non-clinical staff under the supervision of dental therapists. It only applies to the child's deciduous teeth (baby teeth). We are looking to second a dental therapist one day per week to set up this project and train staff. It will result in our caries free age 5 and Year 8 students increasing in the longer term. Issues around parental consent will need working through.

District Nursing

Integrated Nursing work streams are taking the next steps to implementation

1) Centralized Referrals Centre
2) Routine Care
3) Joint assessment

Update on routine care shifting of services project

The project is moving to test shifting of some routine services into primary care has progressed to the point where on Monday, 7th August, a registration of interest document will be released to General Practice. Essentially this is to gauge interest in taking on some of the routine care wound work over a four month test period, from Oct to the end of January. A copy of the document will be available to review but the key things to note are:

1. Patients enrolled with general practice who participates in the test and have a wound care need that can be managed in primary care will be referred to that practice.
2. Patients can decline and stay with district nursing if they choose.
3. Patients must be able to get to a General Practice appointment (ie: not be housebound)
4. Referring back to District Nursing will be discouraged, the idea being that Primary must explore all avenues in terms of treating patients out in Primary Care.
5. District Nursing workload over the test period will not be affected as there is already enough demand for services.

Mike Agnew, Philippa Jones and Pamela Barke will be available to answer any questions anyone might have about the test. Applications close at the end of August.

General Practice owners asked to take part in Routine Care 'test of change'.

General Practice owners are being asked to take part in the first 'test of change' of the Integrated Community Nursing (ICN) Project - the Routine Care test of change.

The ICN Project is looking at how our community nursing service should look, and operate, to face the demands of the future in the best way for our patients. It is exploring how all the different

services which currently support people and provide care in the community can work together in the most efficient and appropriate way. Learn more about the ICN Project at: http://bopdhb.govt.nz/your-dhb/community-nursing-integration-project/

As the project progresses there will be a number of 'tests of change' examining these new ways of working. The first, the Routine Care test of change, will look at how General Practice nurses might be able to take on some routine wound care cases which are currently managed by District Nursing.

The test will run for four months, from 1 October 2017 to 31 January 2018. All going well, more routine care work will then be offered to primary care. This will enable District Nursing to take on more of the complex and acute cases currently being managed by our hospitals.

Some points to note about this test of change include:

- District Nursing will still be working to capacity as it currently takes on more work than its permanent staff numbers can handle.
- Ward staff will refer into District Nursing as usual, no change.
- Only certain wounds will be referred to General Practice.
- Patients will only be referred if their practice has registered as a test practice.
- Treatment of eligible patients by General Practice will be funded.

Meetings will be held with Mike Agnew and Pamela Barke and the Ward Nurse Managers in the next week or so to discuss messaging as over the test period patients may be seen by either Practice Nurses or District Nurses.

PHOs will also be inviting practices to participate in the test. A link to the registration of interest document will be included on the Bay Navigator website.

Short Term Services
Clinical Nurse Manager District Nursing has moved the coordinator to Tauranga Hospital and she is sitting in with the Social Work team, this is good for communication. The workload has increased considerably especially as there is a huge move on the patient flow work streams except that no one has actually thought about the impact on the community as a result and this and inform us of the potential on service and this continues to put pressure onto the service and we have to use casual staff as back up to manage the workload (finding staff that can cover STS is also a big problem). Pamela and Brent (P&F) are to meet with Pete C and Sandra F to discuss as well as needing to find permanent desk space for the service in the hospital

HOSPITAL SUPPORT SERVICES

Volunteering meaningful and rewarding

"I wanted to do something meaningful with my time and helping others has given me that and more," says mother-of-two, and volunteer, Lynne Riddle.

Lynne has been volunteering at Tauranga Hospital's Ward 2B for three-and-a-half years and loves what she does.
"With my daughters getting older I had more time on my hands and thought it was something I'd like to do."
She describes her role as 'hands off, hearts on'; as volunteers do not move patients or do jobs paid staff would normally perform.
"It's about doing those little things the nurses simply don't have time to do," said Lynne. "Like making cups of tea for the patients and visitors, general tidying, chatting to people, making them

more comfortable, welcoming them and taking their minds off things. Every day is different and it's very sociable."
Bethlehem resident Tony Waters, originally from the Kapiti Coast, said volunteers like Lynne performed a very important role.
"I have been in hospital elsewhere and have never experienced this level of volunteers, it's wonderful," said Tony. "Hospital can be quite a daunting place and to have a friendly face dropping by is very important. Sometimes people don't have visitors, so seeing that regular friendly face and being able to offload to them, it's an extremely valuable contribution."

If you would like to volunteer at Tauranga Hospital you must be over 18 and be able to commit to a minimum of six months reliable service.

Caring: Tauranga Hospital volunteer Lynne Riddle (right) chats with patient Tony Waters (left).

From: Averil Boon
Sent: Monday, 11 September 2017 7:37 a.m.
To: Lesley Grant
Cc: Sherida Cooper; Pete Chandler; Helen Mason
Subject: A few comments from the Patient Experience Survey for Inpatients

A few comments from the Patient Experience Survey for Inpatients, I thought you may wish to share with your wonderful team of Volunteers:

09/09/2017	This was the first time I have been to Tauranga hospital & was impressed with the volunteers , from the ones at the door with any info u wanted. Location of Depts , services etc to the staff in the transition lounge. Very professional . I was looked after & treated with the utmost respect.
08/09/2017	Very fortunate to be in the care of the [Name removed] Team. Very good pre surgery discussions with Anaesthetic Reg [Name removed] and [Name removed]'s Gynae Reg [Name removed]. Really felt listened to by both. [Name removed] did a wonderful job of my post surgical pain relief. Thank you [Name removed]! The pre surgery check was thorough and the little things such as surgical knickers, dressing gown, non slip socks and pre warmed op bed all helped calm, reassure and retain some modesty! " Persian" anaesthetic technician(thank you - a lovely man and sorry name escapes me). Ward care from all three nurse in3C ([Names removed]) was great. Thank you! was very fortunate to be able to be discharged following day(was expecting a 3-4 night stay)- hugely helpful that able to manage pain needs in timely way when nurses busy with other post op patients with greater needs than myself. Good pain relief...able to get up and about :). I think your Transit Lounge is absolutely excellent.The staff and volunteers running this a wonderful resource for ensuring patients are comfortable and provided education/ information if needed. Very grateful to [Name removed] for calling in at the end of his theatre list to check in and feedback to my partner and myself how all went. Thank you [Name removed]- very skilled and an absolute gentleman.
08/07/2017	Your nurses are wonderful, BUT, totally under-resourced, also the ladies? in the blue jackets. Iknow there are a lot of volunteers out there who would gladly volunteer to help, ex-nurses as well, but you say they are not needed, I certainly challenge that!! I spoke of this 18 months ago, nothing changes.
13/06/2017	Cultural, spiritual, emotional options were discussed and offered and volunteer support introduced their availability to which I respect and acknowledge.
30/05/2017	wonderful care from the cleaners , caterers , nurses and volunteers, meal quality ok just cold porridge probably was a poor choice on my part
19/04/2017	the ladies that delivered the meals were really nice and always had a cheery word when they came in the ward. I found the meals very nice and appetising looking The volunteer staff were also very willing to have a chat and fetch anything that was required. It is a great idea to have them on the ward and it must be very helpful to the very busy nurses

Thank you all, you do a great job,
Averil

Averil Boon
Programme Manager
Quality and Patient Safety

Tauranga Hospital, Bay of Plenty District Health Board, Private Bag 12024,Tauranga 3143
Phone 07 5798968

PROVIDER ARM ANNUAL RECORD: HOW WE'VE MADE A DIFFERENCE (2017/18)

FOCUS AREA	WHAT WE'VE ACHIEVED
People-Powered	
Capability and Capacity for Change	Over 200 staff involved in training on Quality Improvement methodology
Closer to Home	
Kawarau ENT Clinic	New clinic resulting in attendance by some frequent non-attenders
Homecare Medical	After hours GP practice triage nurse service for in Western Bay Regular data tracking to show progress
Value and high performance	
Patient Information Centre	Amalgamated with Regional Call Centre so there is a better service for patients
6 hour target	Achieving 95% of ED attendances out or admitted within 6 hours
Hospital overnight beds used	Significant reduction in overnight inpatient beds used at Tauranga Hospital
Transient Ischaemic Attack (TIA)	Reduced median time (days) referral to clinic consult from 10 days to 1 day from first audit in Oct-Nov 2016 to May-June 2017. TIA clinic attendances up from 18 to 52. Prevented 14 hospital admissions in May-June 2017.
One team	
Quality Improvement	Good engagement and high level of passion for Quality Improvement. This spreads through clinical groups as they become more involved in change.
Smart system	
Provation Implemented	Endoscopy software reducing reporting from 1 week to 1 day
Tauranga Community Allied Health Team going electronic	Completing electronic initial assessments and uploading them to CHIP within 1 working day 80% of the time

BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI

Bay of Plenty Hospitals Advisory Committee Work Plan 2017

Month	Activity	Documentation Source
January	• No Meeting	
February	• No Meeting	
March	• No Meeting	
April	• Focus Topic: Performance Improvements in Patient Flow and Experience • COO Highlights Report • COO Performance Report • General Manager Property Services Report	• COO • COO • COO • GMPS
May	• No Meeting	
June	• No Meeting	
July	• Focus Topic: Productivity Improvements • COO Highlights Report • COO Performance Report • Productivity	• COO • COO • COO • COO
August	• No Meeting	
September	• No Meeting	
October	• Focus Topic: Health Targets • COO Highlights Report • COO Performance Report • Health Target	• COO • COO • COO • COO
November	• No Meeting	
December	• No Meeting	
January 18	• No Meeting	
February 18	• Focus Topic: Integrated Health Strategy (IHS) • COO Highlights Report • COO Performance Report • Integrated Health Strategy (HIS)	• COO • COO • COO • COO • COO
March 18	• No Meeting	
April 18	• No Meeting	
May 18	• Focus Topic: Patient Centred Care • COO Highlights Report • COO Performance Report	• COO • COO • COO