
MEMO

To: Board Members
From: Peter Bramley, Chief Executive
Date: 22 November 2017
Subject: Chief Executive's Report

<p><i>Status</i></p> <p>This report contains:</p> <p><input type="checkbox"/> For decision</p> <p><input checked="" type="checkbox"/> Update</p> <p><input checked="" type="checkbox"/> Regular report</p> <p><input type="checkbox"/> For information</p>

1. INTRODUCTORY COMMENTS

Our values are crucial to our organisation. If we are to deliver great care to our community our values will permeate the way we work. In my role I get to see, as I move around our health system, wonderful examples of care being delivered by dedicated and talented people. I observe that where TEAMWORK and INNOVATION flourish RESPECT and INTEGRITY are present in the way people are working together.

I read recently in a report from the Nuffield Trust titled "NHS Leadership in Hard Times" the following quote - "Ultimately it is leadership behaviour that will have a long-term impact on organisations and systems". Health is a challenging business. We need people who will rise to the challenge of leadership to help us figure out how we can deliver the best care in a resource constrained environment. Our leaders, be they clinicians or managers, need all our encouragement. Leadership behaviours are crucial to the culture of our organisation and good leadership will always be underpinned by values.

We are at a crucial time. We need INNOVATION like never before if we are to find new models of care for future healthcare. TEAMWORK is vital – as the models of care will no doubt require services and professions to team up, and people to work collaboratively to find solutions to tough problems. INTEGRITY means our staff will do the right thing in their day to day activities, and integrity is integral to quality healthcare. RESPECT is perhaps the value that makes the most difference to patient experience, teamwork and staff feeling safe and appreciated.

My desire is that Nelson Marlborough Health is considered a great place to work, and one that our staff are proud to work at. Our VALUES will be a key to realising this desire.

2. PRIMARY & COMMUNITY

- Due to the delay in forming a new government and appointment of the Minister for Health, the Annual Plan 2017-18 is yet to be signed.
- The Annual Plan process for 2018-19 has begun with the focus on refreshing the priorities matrix. During October ELT, the Consumer Council and Public Health have provided input to the matrix.
- The establishment phase of the Models of Care programme continues with a focus on information and communications. A draft proposal outlining how to develop an information tool to support the MOC programme has been produced. The Terms of Reference for the Clinical Advisory Group has been established, and recruitment is underway for a Support & Intelligence Analyst.
- Work with the PHO on developing processes for the MSD referral to General Practice roll-out is underway. It is aimed to roll-out a simple enrolment first, followed by a Hauora Direct assessment in the New Year.
- Obesity health target referral rates were close to target this quarter at 89%, however acknowledgement of referrals was disappointingly at 61%. A check on this found

several that were due to incorrect data entry, or an error in the MoH reporting which is being corrected.

- A multi-disciplinary team have met to agree how to work with a local employer to support their staff towards better health. Smoking cessation support is now in place. The business will also be a pilot site for Hauora Direct, a comprehensive assessment tool.
- The new Home & Community Support Service has been live for 6 weeks. Complaints have increased related to missed visits, inconsistent care and employee grievances. Complaints are followed up by the Needs Assessment Service Coordination (NASC) service. A meeting was held with Nurse Maude, Access and the DHB to discuss operational issues and to establish a governance structure. Work continues on in-bedding the changes to Needs Assessment Service (Support Works). The new structure is working well with some great client stories showing the benefits of a rehabilitation approach in NASC.
- Work has been undertaken to develop a Kaumatua programme for older Maori in conjunction with Te Piki Oranga (TPO).
- A Falls Alliance meeting was held this month to discuss current delivery of in home and community falls reduction programmes.
- In October, there was a total of 63 referrals to the Stop Smoking Service with 23 (including 6 PepiFirst) in Wairau and 40 (including 1 PepiFirst) in Nelson. The conversion rate, measured as referrals turning into active enrolments in the programme, was 52%.
- Quarter 1 stop smoking service results were as follows:
 - Referrals – 186 (up 50% from last quarter)
 - Enrolments – 130 (up 80% on last quarter, but still 84 short of contract)
 - Maori Enrolments – 35%
 - Pepi First Enrolments – 32
 - Setting Quit Date – 97 (up 90% on last quarter)
 - CO validated Quit – 43% (same as last quarter)
 - CO Validated Quit for pregnant women – 41%.

3. INFORMATION TECHNOLOGY

- The pace of the PICS project continues to accelerate as it moves into Go-live planning. This is still on track for 11 April 2018. A workshop was held with a group of administration staff identified as Super Users, as part of the change management process, and included a positive message about change and support by the new executive sponsor Lexie O'Shea (GM Clinical Services).
- The paper medical records project is also progressing well, with scanning of old records already underway and the 'eRecords' document management system set up and integrated with Health Connect South.
- The Microsoft Office upgrade (from 2007 to 2013) was completed successfully across most devices, before the final end of support date.
- The appointment of a dedicated 0.5 FTE Project Manager for Patienttrack and Mobility Strategy has been completed.

4. CLINICAL SERVICES

- There was a reduction in the overall activity for medicine for October, however the acuity and occupancy remains high in ICU requiring high resource allocation. There were 14 days exceeding 85% occupancy on the Nelson site.

- Our referral ICUs, CDHB and CCDHB, have been at capacity so patient transfer ability has also been limited. Agreement was reached at the end of the month to increase nursing resource in the ICCU, and recruitment is underway.
- ICU continues to maintain over 700 hours of ventilation time and, therefore, the staffing required is for a one to one patient care environment. The ICCU review was recently conducted in November.
- ESPI compliance continues to be a challenge, in particular for Orthopaedics where there are a high number of patients requiring surgery in December. The Surgical Services Manager (SSM) is working with the administrative team in booking patients and using all available capacity across the district.
- A 'war room' has been established in the Level 4 corridor to assist with visibility and planning to ensure ESPI compliance is achieved. The Surgical Services Manager and Elective Surgery team are posting information regarding referral acceptance, FSAs seen, a 4 month predictive ESPI picture for both FSA and surgery, and theatre activity to ensure better planning and utilisation of capacity across the district within current resource.
- NMH took over the running of the Motueka Maternity Unit at the end of September 2017. The service is due to be reviewed in April 2018, and is receiving positive reviews.
- The cataract initiative year to date delivery (to end of October) indicates 195 cataracts undertaken against a plan of 174.
- The Orthopaedic initiatives year to date delivery (to the end of September) indicates the elective joint procedures are 95 undertaken against a plan of 112. The year to date delivery (to the end of September) indicates the other orthopaedic procedures are 175 undertaken against a plan of 184.
- The 2018 NetP ACE recruitment programme was completed mid-October with 32 NETP, and five NESP graduate positions chosen. A backup of 10 applicants has also been chosen. The final numbers will be identified and matched mid-November.
- The Professional Development and Recognition Programme has recently undergone audit by Nursing Council, and received accreditation for the next five years. We are seeing great benefit from the partnership at regional level to run a consistent programme across the South Island.
- The "End PJ Paralysis" programme presented by Brian Dolan was well received with Ward 9 being the first area to drive a pilot for the month of November. The pilot is being led by the Nursing Team and the Orthopaedic Registrar, and half way through the team are indicating great success some surprise at the benefits being identified. The Inpatient Unit will run a similar pilot for the month of December.
- 85% of patients referred to Pain Management were seen by the Charge Nurse Specialist (CNS). Further work is required with this service to utilise the skills of the CNS, who will move to Nurse Practitioner level at the beginning of 2018. Opportunities exist to review current Models of Care with anaesthetists.
- The new Wairau and Nelson Midwifery Team Model of Care was released with implementation on 27 November 2017. New features include the introduction of on-call to cover sudden increase in care workload.

5. ALLIED HEALTH

- The external Allied Health review has continued to be the main focus during October, and has been now been presented to NMH sponsors. The lead reviewer will be returning to present the findings to staff, team leaders and key stakeholders in November.
- The Child Development Services team have met and discussed the recommendations from the recent internal review, and identified initial key priorities.
- Staff Engagement: Working Together group will review the recent staff survey results, to generate a work plan going forward.

6. MENTAL HEALTH & ADDICTIONS

- Philippa Gains (author of MOH sponsored 'On Track') and Emma Woods (Te Pou) were invited by the GM Mental Health Addictions & DSS to support facilitation of a professional development day with the psychology team, with the focus on how to support Top of Scope working.
- Key appointments have been made to the Integrated Community Manager Nelson & Tasman, the Charge Nurse Manager Wāhi Oranga, and the Clinical Nurse Coordinator Wāhi Oranga.
- MH&A NGO contracts have been extended for three years for most contracts with adjustments to the service specification aligning to high trust contracting and in line with service integration objectives.
- Scott Gallagher from MSD (Deputy Chief Executive Housing NZ) met with the GM Mental Health Addictions & DSS to discuss opportunities to work collaboratively with health in regards to housing issues. The key theme was to think about the housing continuum, with Health having an interest in wrap around services and support, but with MSD and Housing NZ leading the discussions around transitional and sustainable housing options.
- Mental Health Addictions Service have been attending Youth Interagency meetings with Te Piki Oranga, Youth Aid, CAMHS, SVS Living Safe and Nelson Bays PHO. This is to further develop the vision towards an Integrated Youth service across the specialties.
- Mental Health Addictions Service continues to maintain an acceptable waiting list with urgent clients seen immediately, and non-urgent clients waiting less than two weeks. This is across both AOD services. All clients are contacted within a week of referral and an appointment is given.

6.1 Activity – Specialist

	Last Three Months			Year to Date	Year End 16/17
	Aug-17	Sep-17	Oct-17	Monthly Average	Monthly Average
Inpatient Acute Admissions	31	34	25	28	30
Inpatient Acute LOS (days)	12.78	13.70	16.00	15.0	15.5
Inpatient Seclusion Use (hours)	422.4	343.1	39.4	235.5	80.4
Inpatient Seclusion Client Count	9	14	3	8	3
Community Crisis Contacts ***	126	98	60	99	160
People Seen In Month **	2239	2165	1822	2068	1938
Psychogeriatric IP Admissions	6	7	9	6.5	8.3
Psychogeriatric IP Occupancy (%) - Actual bed days vs Funded bed days.	85.8%	82.7%	97.7%	93.7%	88.0%

* N/A - figures not available at time of report completion, ** Change in data collection / reporting metric (no prior years data).

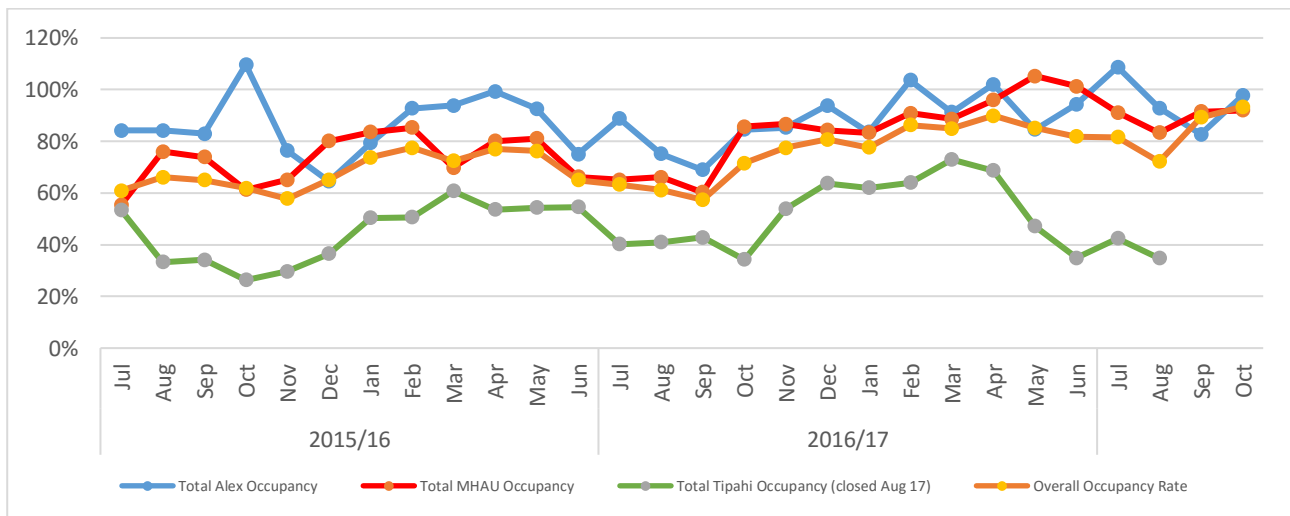
*** Provisional figures only (due to timing), may change once all data has been received and loaded.

6.2 Activity – NGO

Service	Last Three Months			Year to Date	Year End 16/17
	Aug-17	Sep-17	Oct-17	Monthly Average	Monthly Average
Emerge*	20	24	0	23	27
Gateway Housing Trust	188	202	156	173	183
MHSS*	35	35	0	35	35
Te Whare Mahana	44	44	43	44	39
Te Ara Mahi	93	113	57	89	90
Health Action Trust (Kotuku)*	21	18	0	20	19
Care Marlborough - day activity (average clients per day)*	14	14	0	14	15
The White House (average clients per day)*	18	17	0	17	13
SF Nelson (contact hours)*	74	88	0	85	83
SF Blenheim (contact hours)*	132	127	0	128	98
St. Marks	36	46	40	42	42
Te Piki Oranga*	351	357	0	341	290

* N/A - figures not available at time of report completion

6.3 Inpatient Occupancy

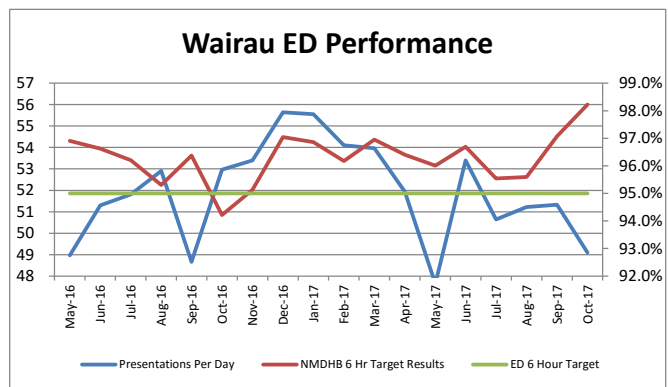
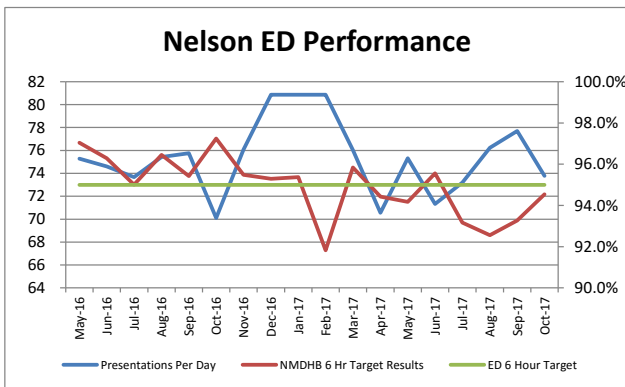
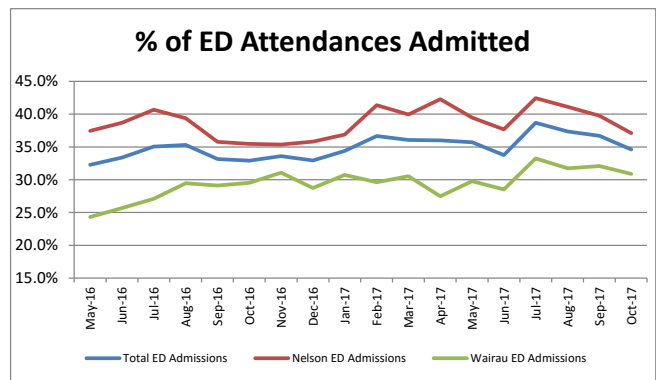
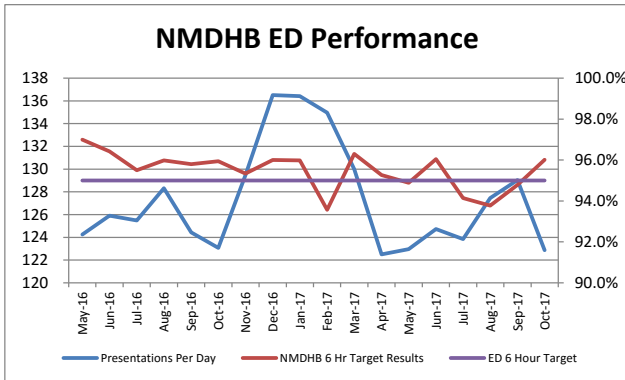


6.4 Disability Support Services

Disability Support Services (DSS)		Current October 2017				YTD October 17	
<i>Contracted Services</i>		ID	PD	LTCH	Total	YTD Total	
Service provided	Current Moh Contract	As per Contracts at month end	168	17		185	
	Beds – Moh Individual contracts	As per Contracts at month end	10	2		12	
	Beds – S&P- Chronic Health Conditions	As per Contracts at month end	1		13	14	
	Beds – Individual contracts with ACC	As per Contracts at month end	1	1		2	
	Beds – Others - CY&F & Mental Health		2	1		3	
		Residential contracts - Actual at month end	182	21	13	216	
	<i>Number of people supported</i>						
	Total number of people supported	Residential service users - Actual at month end	182	21	13	216	
		Respite service users - Actual at month end	1	2		3	
		Personal cares service users - Actual at month end	0	1		1	
		Total number of people supported	183	24	13	220	
	Total Available Beds - Service wide	Count of ALL bedrooms	231				
Total available bed days		7,161				28,351	
Total Occupied Bed days	Actual for full month - includes respite	6,721				26,382	
Total Occupied Beds	Based on actual bed days for full month (includes respite volumes)	93.9%				93.1%	
		Last month	Current month	Variance			
Total number of people supported		218	220	2	Increase		
Referrals	Total referrals	11	10				
	New Referrals in the month	4	4				
Of above total referrals	Transitioning to service	2	-				
	On Waiting List	9	10				
Vacant Beds at End of month		13	11				
	Less people transitioning to service	- 2	-				
Vacant Beds		11	11				

7. PERFORMANCE INFORMATION

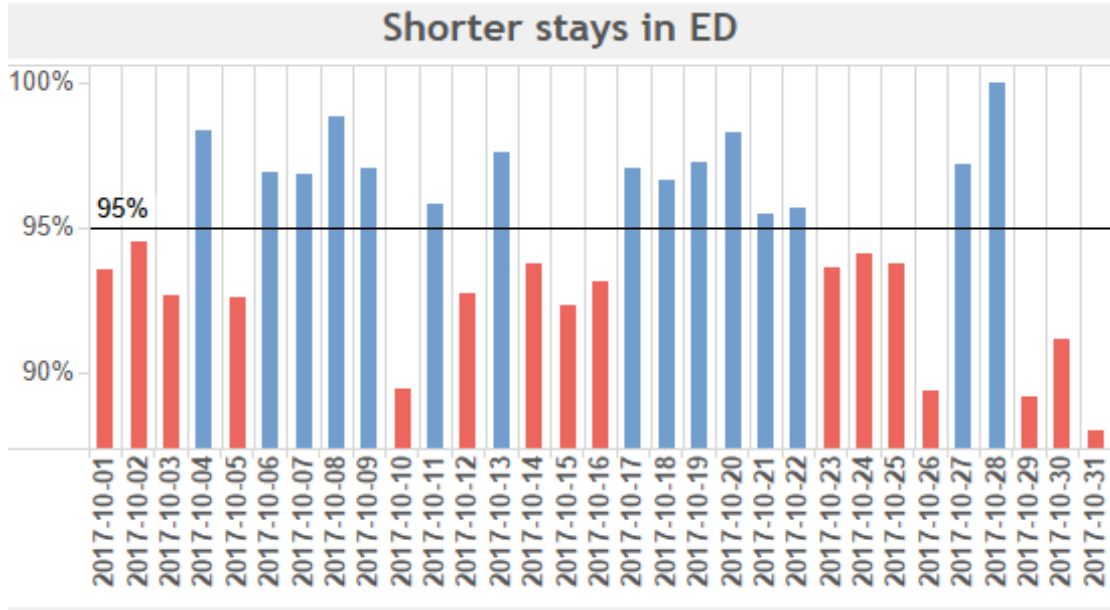
7.1 Shorter Stays in Emergency Department



Length of stay target for past 3 months

	August 2017		September 2017		October 2017	
	Total	<6hrs	Total	<6hrs	Total	<6hrs
Nelson	2,322	2,142 92.25%	2,407	2,242 93.14%	2,287	2,162 94.53%
Wairau	1,547	1,474 95.25%	1,585	1,474 97.16%	1,522	1,474 96.29%

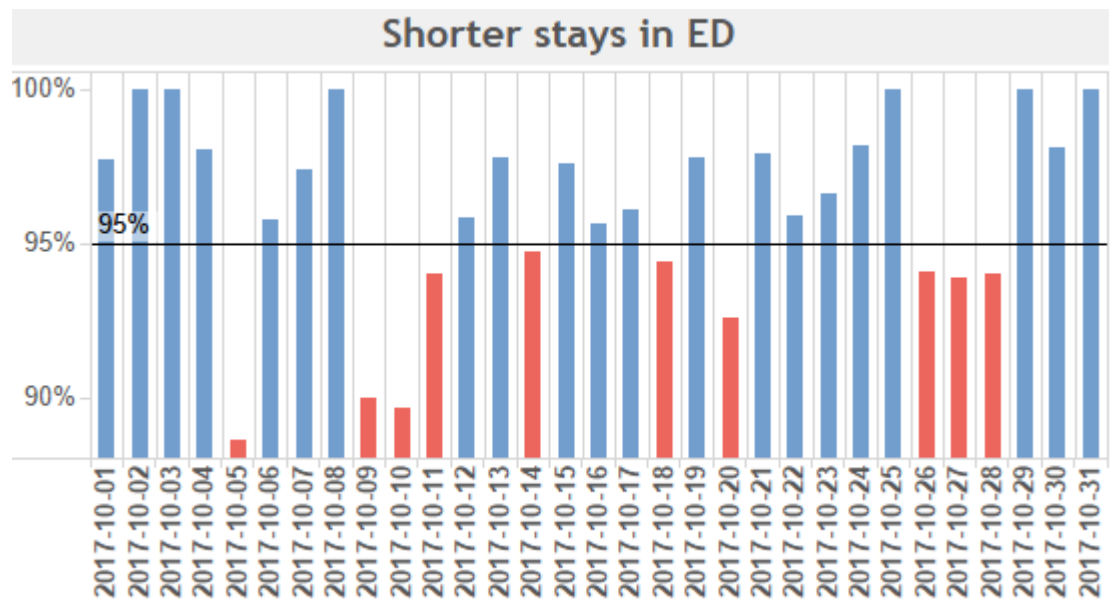
Emergency Department Nelson



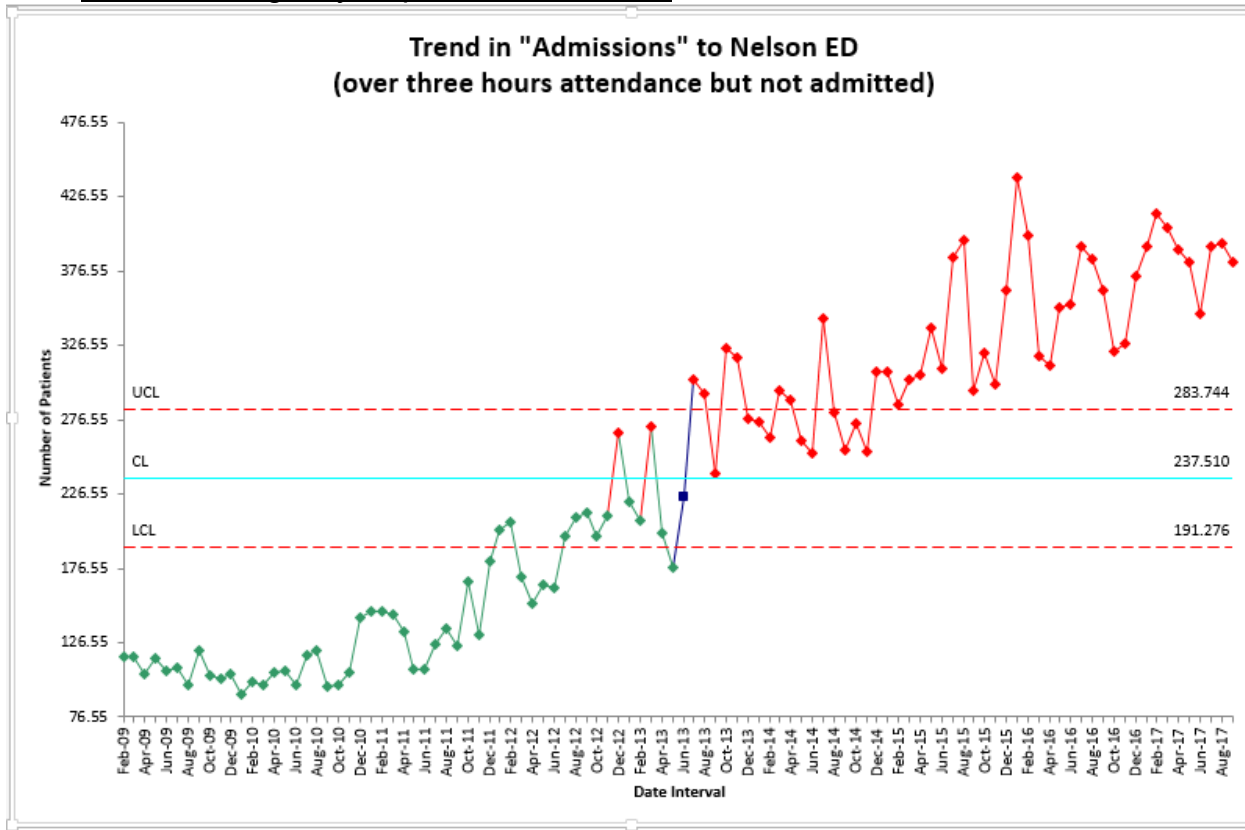
BREACH ANALYSIS – Nelson

The key areas of breach in Nelson were waiting for a ward team (32%) and waiting for an inpatient bed (23%). Discussion continues on the model of care for the additional short stay beds proposed for the Nelson site.

Emergency Department Wairau



Nelson Emergency Department Workload



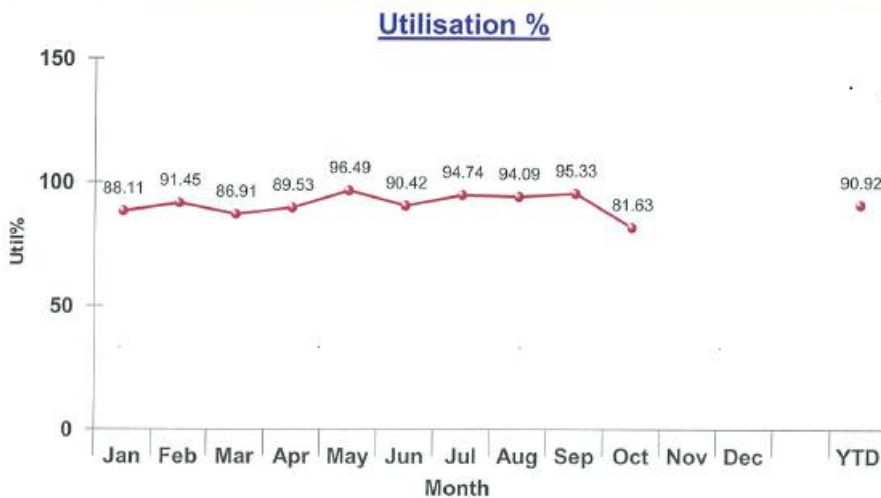
While spending longer than 3 hours in ED is in itself not a significant issue, except for those who are waiting, this graph does show the increasing pressure on ED from slowing patient flow. The summer of 2017/18 is likely to be a major challenge.

7.2 Hospital Occupancy / Acute Demand

Business Unit Efficiency Graph

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Business Unit: a) Nelson Adult (109 beds) (* All Shifts *)
Period: Calendar year 2017



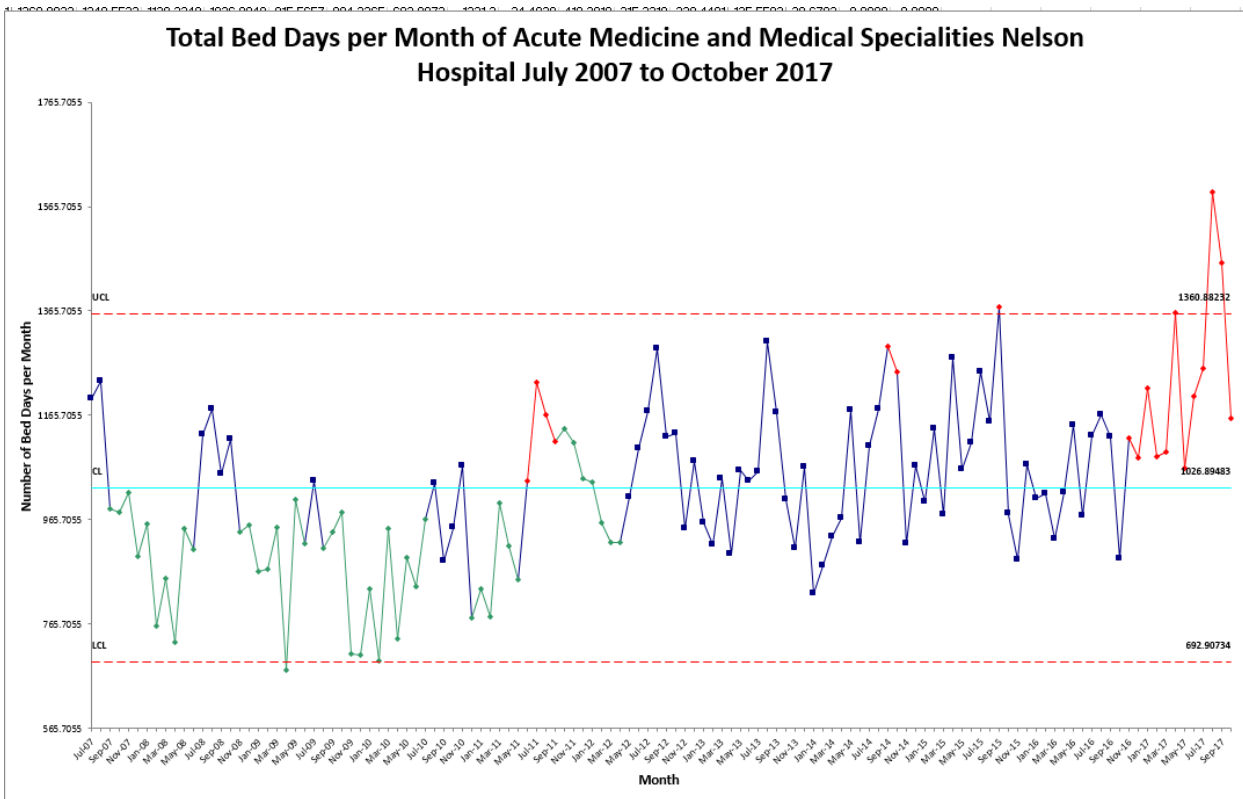
Business Unit Efficiency Graph

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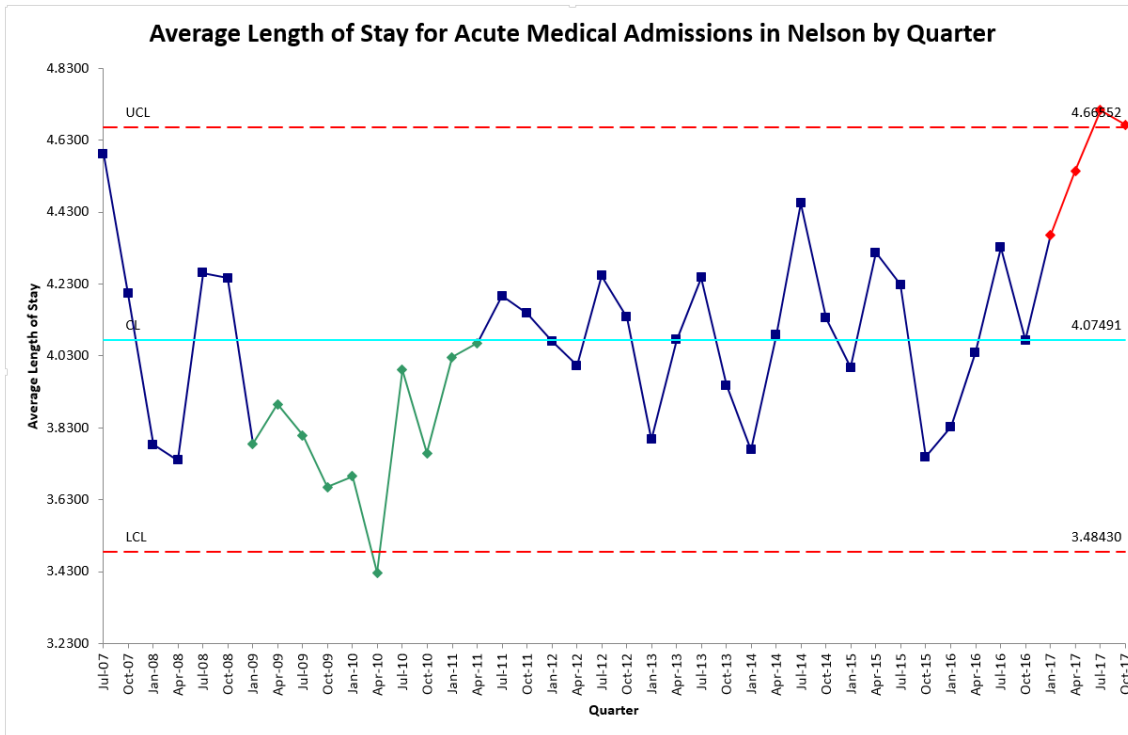
Business Unit: **b)Wairau Adult (57 beds) (* All Shifts *)**
Period: **Calendar year 2017**



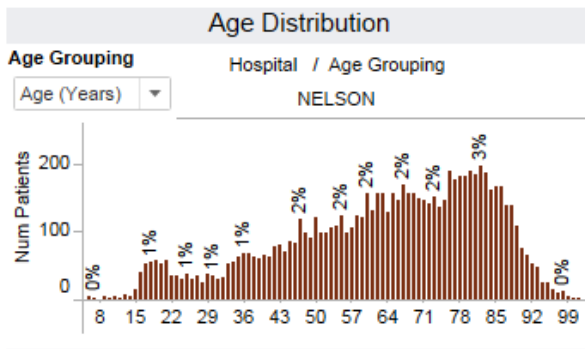
Nelson Hospital Bed Pressure



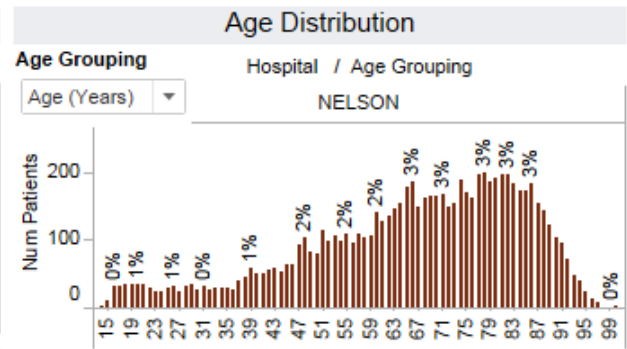
The high acute medical workload persisted into September, dropping back in October. The trend to higher acute medical workload is apparent with the last 12 points being above the long term mean. The high workload is associated with high numbers of outlier patients with an accompanying clinical risk.



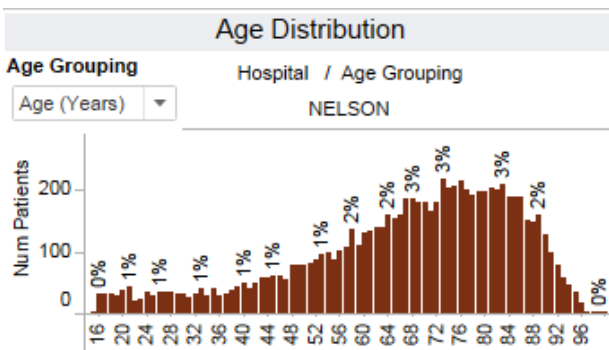
Changing Age Distribution of Acute Medical Admissions



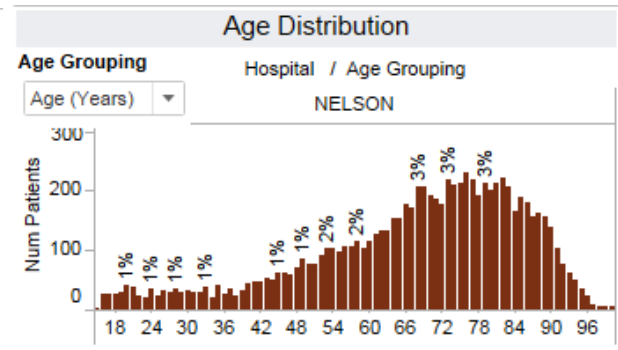
July 2007-2010



July 2010-2013



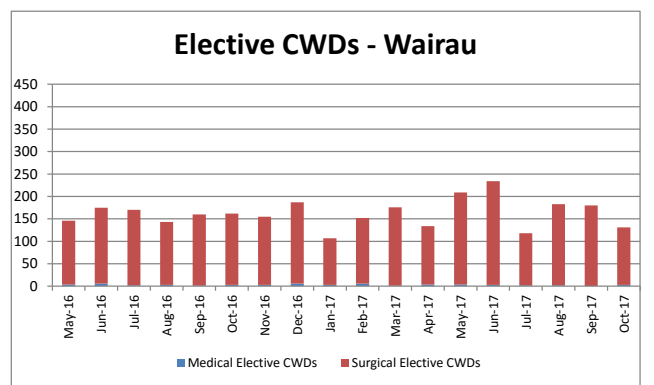
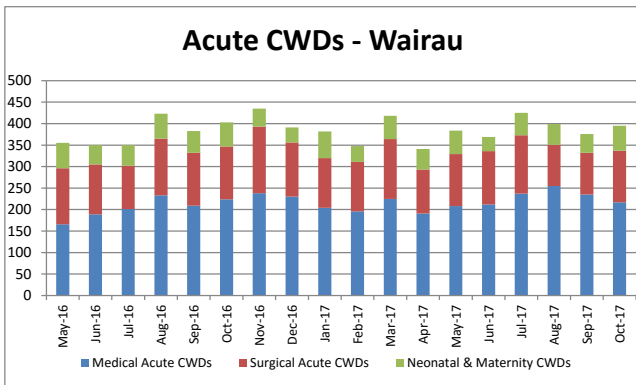
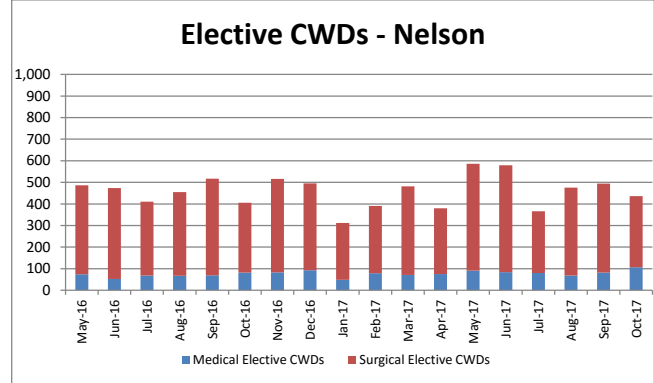
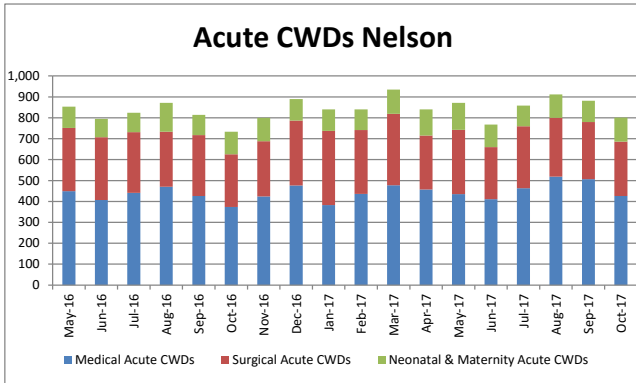
July 2013-2016



July 2014-2017

These graphs all have a mode value of 83 - 86. However over a ten year period an increasing proportion of acute medical cases are in the over 85 age group as evidenced by the increasing volume under the curve after age 85. In 2016-7 the average length of stay for acute medical admissions over age 85 reached 6 days. For

those under 85 it was 4.6 days so the shift in age group has a large impact of bed space requirements.



7.3 Elective / Acute Arranged Services

At the end of October, NMH is above plan by 105 discharges for MOH requirements for elective surgery, with the number of elective surgical procedures at 105.5% of the Health Target for 2017/18 (1,997 discharges delivered against a plan of 1,892).

Nelson Marlborough District Health Board 2017/18 Electives Health Target Report

2017/18 Health Target Delivery

	Year to Date HT Plan	Year to Date HT Delivery	Variance from plan	2017/18 Health Target
Elective surgical PUC	1,544	1,636	92	7,533
Elective non-surgical PUC	41	47	6	
Arranged surgical PUC	286	292	6	
Arranged non-surgical PUC	21	22	1	
YTD Health Target	1,892	1,997	105	105.5%

Health Target includes elective and arranged inpatient surgical discharges, regardless of whether they are discharged from a surgical or non-surgical specialty (excluding maternity). Surgical discharges are defined as discharges from a surgical purchase unit (PUC) including Intraocular Injections and Skin Lesions reported to NMDS, or discharges with a surgical DRG.

	Q1 Result	Q2 Result	Q3 Result	Q4 Result
Final Published Health Target Result	105.6%			

MoH Elective Services Online

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

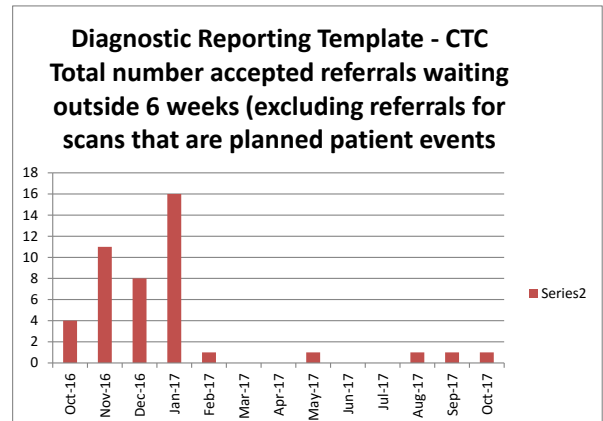
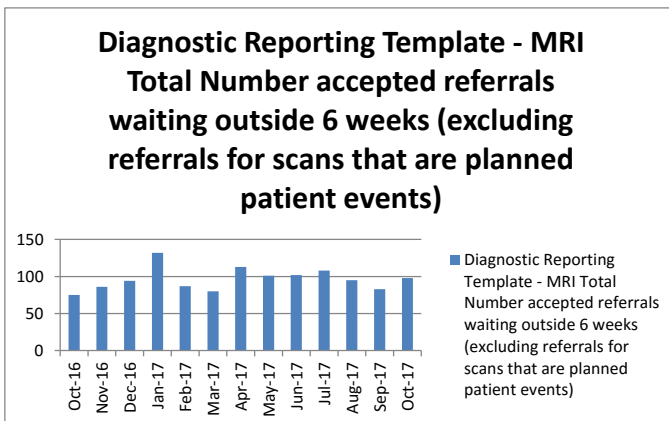
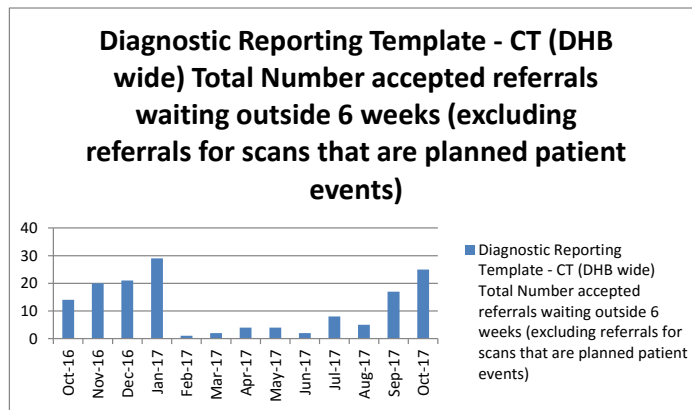
DHB Name: Nelson Marlborough

	2016			2016			2016			2017			2017			2017			2017			2017			2017			2017			2017					
	Oct			Nov			Dec			Jan			Feb			Mar			Apr			May			Jun			Jul			Aug			Sep		
	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 patient referrals within required timeframes.	17 of 21	81.0%	4	20 of 21	95.2%	1	14 of 21	66.7%	7	20 of 21	95.2%	1	12 of 21	57.1%	9	21 of 21	100.0%	0	17 of 21	81.0%	4	18 of 21	85.7%	3	21 of 21	100.0%	0	20 of 21	95.2%	1	17 of 21	81.0%	4	0 of 0	X	0
2. Patients waiting longer than the required timeframe for their first specialist assessment (PSA).	12	0.0%	-12	38	-1.1%	-39	12	0.4%	-12	73	2.6%	-73	29	0.8%	-29	12	0.4%	-12	44	1.3%	-44	12	0.4%	-12	12	0.4%	-12	26	0.7%	-26	11	0.2%	-11	25	0.8%	-25
3. Patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (ATT).	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
4. Patients given a commitment to treatment but not treated within the required timeframe.	21	2.1%	-21	12	0.2%	-12	52	3.9%	-52	47	3.3%	-47	14	1.2%	-14	18	1.6%	-18	28	2.4%	-28	32	2.8%	-32	12	0.8%	-12	41	2.8%	-41	21	2.1%	-21	18	1.6%	-18
5. Patients in active review who have not received a clinical assessment within the last six months.	0	X	0	0	X	0	0	X	0	0	X	0	0	X	0	0	X	0	0	X	0	0	X	0	0	X	0	0	X	0	0	X	0	0	X	0
6. The proportion of patients who were prioritised using approved nationally recognised processes or tools.	528	100.0%	0	527	100.0%	0	534	100.0%	0	494	98.8%	1	582	100.0%	0	728	100.0%	0	582	100.0%	0	711	100.0%	0	595	100.0%	0	514	100.0%	0	625	100.0%	0	640	100.0%	0

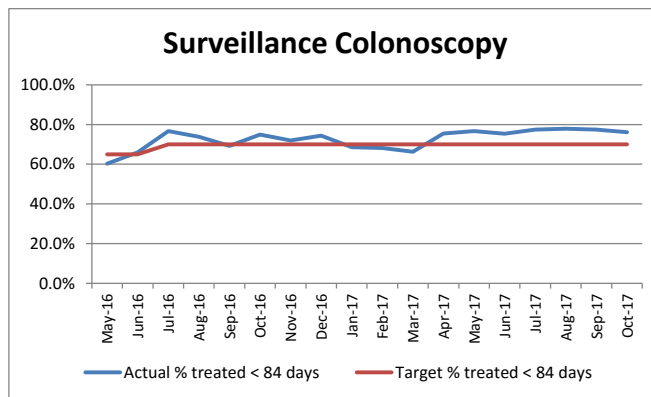
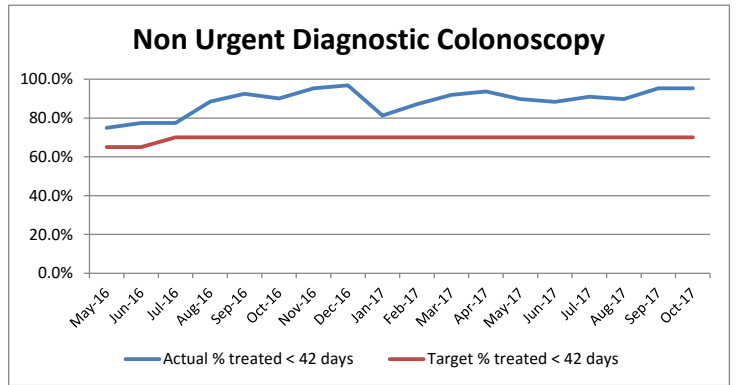
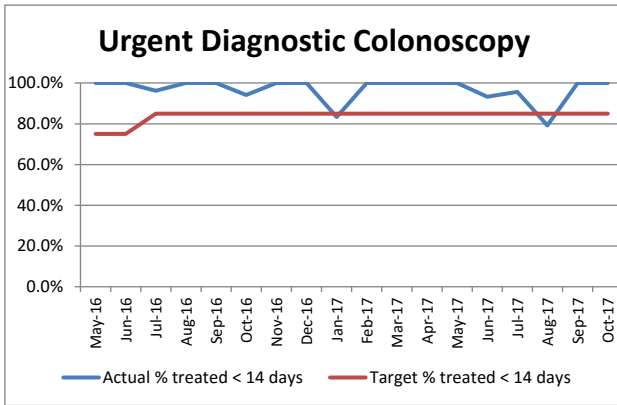
Data Warehouse Refresh Date: 04/Nov/2017
Report Run Date: 06/Nov/2017

Notes:
 1. Before July 2016 the required timeframe for ESPI 1 is 10 working days, and from July 2016 the required timeframe for ESPI 1 is 15 calendar days.
 2. Before July 2016 the required timeframe for ESPI 2 and ESPI 3 is 6 months, between July 2016 and December 2016 the required timeframe for ESPI 2 and ESPI 3 is 5 months and from January 2017 the required timeframe for ESPI 2 and ESPI 3 is 4 months.
 3. ESPI results do not include non-elective patients, or elective patients awaiting planned, staged or surveillance procedures. Medical specialties are currently included in ESPI 1, ESPI 2 and ESPI 3 but excluded from other ESPIs.
 4. Before July 2016 ESPI 1 will be Green if 100%, Yellow if between 90% and 99.9%, and Red if 90% or less. OHS Level Non-compliant Red status for ESPI 1 is temporarily removed for the 2016/17 and 2017/18 years so from July 2016 ESPI 1 will be Green if 100%, and Yellow if 90% or less.
 5. ESPI 2 will be Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.20%, and Red if 0.4% or higher.
 6. ESPI 3 will be Green if 0 patients, Yellow if greater than 0 patients and less than 4.99%, and Red if 5% or higher.
 7. ESPI 4 will be Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.20%, and Red if 0.4% or higher.
 8. ESPI 5 will be Green if 0 patients, Yellow if greater than 0 patients and less than 14.99%, and Red if 15% or higher.
 9. ESPI 6 will be Green if 100%, Yellow if between 90% and 99.9%, and Red if 90% or less.
 10. From 01 July 2018 the ESPI 6 calculation changed from the tools that were used to prioritise patients who acted during the month to the tools used to prioritise patients during the month.
 Please contact the Ministry of Health's Elective team if you have any queries about ESPIs elective@mbh.org.nz.

7.4 Enhanced Access to Diagnostics



7.5 Improving Diagnostic Waiting Times – Colonoscopy



7.6 Faster Cancer Treatment – Oncology

FCT Monthly Report - October 2017														Reporting Month: Sep 2017 - Quarter 1 - 2017-2018	
62 Day Indicator Records														As at 31/10/2017	
TARGET SUMMARY		Completed Records													
		Oct-17 (in progress)		Sep-17		Aug-17		Quarter 1		Quarter 4		Year to Date		Previous Year (2016-2017)	
Numbers as Reported by MOH (Capacity Constraint delay only)		Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days	Within 62 Days	Exceeded 62 Days
		91%	9%	95%	5%	90%	10%	95%	5%	97%	3%	95%	5%	93%	7%
Number of Records		10	1	19	1	27	3	75	4	88	3	75	4	308	22
Total Number of Records		11		20		30		79		91		79		330	
		(Started 01/07/17)										(Started 01/07/17 - Mandatory from 01/01/17)			
Numbers Including all Delay Codes		71%	29%	86%	14%	79%	21%	84%	16%	87%	13%	84%	16%	86%	14%
Number of Records		10	4	19	3	27	7	75	14	88	13	75	14	308	49
Total Number of Records		14		22		34		89		101		89		357	
90% of patients had their 1st treatment within: # days		84		70		69		69		59		69		62	
		(85% target)										(85% target)			
62 Day Delay Code Break Down		Oct-17 (in progress)		Sep-17		Aug-17		Quarter 1		Quarter 4		Year to Date		Previous Year (2016-2017)	
01 - Patient Reason (chosen to delay)		1		0		0		1		1		1		6	
02 - Clinical Cons. (co-morbidities)		2		2		4		9		9		9		21	
03 - Capacity Constraints		1		1		3		4		3		4		22	
		(Started 01/07/17)										(Started 01/07/17 - Mandatory from 01/01/17)			
TUMOUR STREAM		Within 62 Days	Within 62 Days	Exceeded 62 Days	Exceeded 62 Days	Total Records		ETHNICITY							
12 Months to Date		Within 62 Days	Within 62 Days	Exceeded 62 Days	Exceeded 62 Days	Total Records		12 Months to Date		Within 62 Days	Within 62 Days	Exceeded 62 Days	Exceeded 62 Days	Total Records	
Brain/CNS		0%	0	0%	0	0		African		100%	1	0%	0	1	
Breast		96%	70	4%	3	73		Asian - not further defined		100%	1	0%	0	1	
Gynaecological		91%	20	9%	2	22		Don't know		0%	0	0%	0	0	
Haematological		90%	19	10%	2	21		European - not further defined		85%	11	15%	2	13	
Head & Neck		79%	23	21%	6	29		Indian		0%	0	100%	1	1	
Lower Gastrointestinal		83%	39	17%	8	47		Not stated		100%	2	0%	0	2	
Lung		57%	26	43%	20	46		NZ European		87%	278	13%	40	318	
Other		67%	2	33%	1	3		NZ Maori		50%	5	50%	5	10	
Sarcoma		0%	0	100%	1	1		Other Asian		100%	1	0%	0	1	
Skin		97%	83	3%	3	86		Other ethnicity		0%	0	0%	0	0	
Upper Gastrointestinal		83%	10	17%	2	12		Other European		81%	17	19%	4	21	
Urological		86%	25	14%	4	29		Response unidentifiable		100%	1	0%	0	1	
Blank		100%	2	0%	0	2		Samoan		100%	1	0%	0	1	
Grand Total		86%	319	14%	52	371		Grand Total		86%	319	14%	52	371	

8. MĀORI HEALTH

8.1 Hauora Direct

Hauora Direct is being piloted in several sites including Franklyn Village. This will be a combined initiative with Te Waka Hauora, Public Health, Victory Community Centre, Tahuna Community Centre and Nelson Bays PHO.

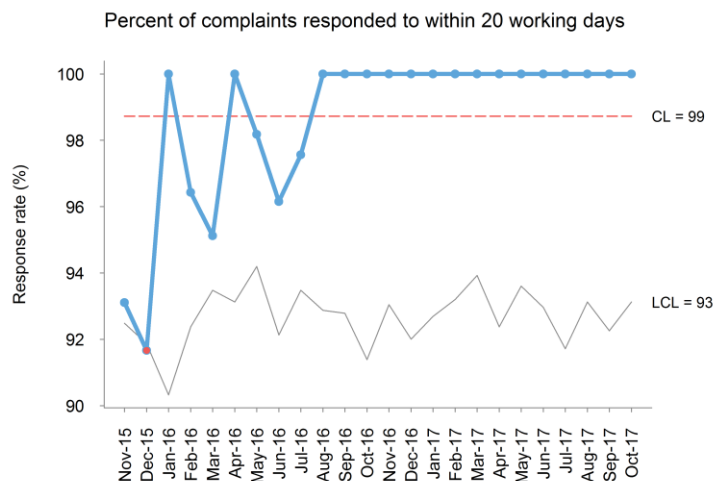
Hauora Direct is also being piloted with an intersectorial health whanau programme which will be run with Ministry of Social Development to make sure that high needs whanau across our district are linked to GPs and a range of primary care services. It has been agreed to pilot Hauora Direct in GP practices, specifically to target whanau who are beneficiaries and are new to the area with children in their care. The GM Maori Health & Vulnerable Populations will be presenting to the PHO's Clinical Governance Groups on the project.

9. CLINICAL GOVERNANCE

9.1 Service User Compliments and Complaints

9.1.1 Complaints

There were 36 complaints received for October compared to 27 the previous month. The graph below shows the number of complaints responded to within 20 working days over the past two years.



9.1.2 Compliments

Approximately 65 compliments were received in October across the services, including some referring to the more challenging areas such as Mental Health and hospital food services.

9.2 Global Trigger Tool (GTT)

The quarterly report continues to provide reassurance regarding the general safety of the hospital and information on the most frequent causes of adverse events. Internationally the rate of harms per 1,000 bed days sits at around 91/1,000 bed days. Our rate over the past 4 years of data has been around 84/1,000 bed days and is not showing any indication of change. The most common reasons for harm relate to surgical site infections, surgery related adverse events, and medication related adverse events with 42% of our in-patient harms leading to an increased length of stay for the patient. This reinforces the importance of work on medication safety, surgical safety and reducing the rates of hospital acquired infections.

9.3 HQSC Quality & Safety Measures

Preliminary data on HQSC quality and safety measures (QSMs) for Quarter 2 of 2017 indicates that our falls assessments and care plans have improved, with the care plan section reaching the 90% target for the first time in 2 years. Hand hygiene remains at 80% (the target) but we did not achieve the 95% target for correct dose of hip and knee arthroplasty antibiotic for the first quarter since 2014. This will be addressed by the Infection Control team.

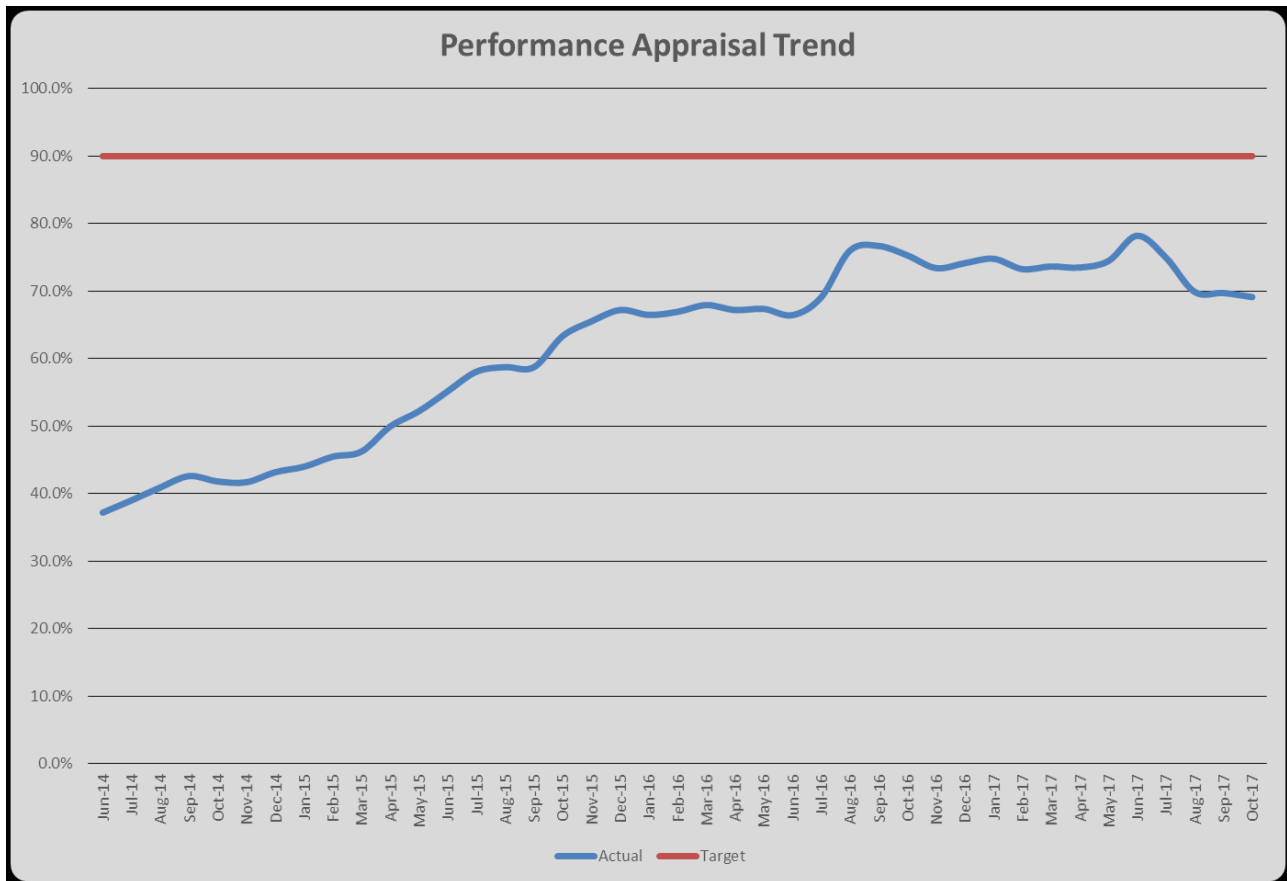
9.4 Hospital Certification Audit

The audit has been completed and we await the first draft of the report.

10. HUMAN RESOURCES

10.1 Performance Appraisals

To date we are at 69% of staff with a current appraisal. More focus needs to be given to this important area by our managers.



Peter Bramley
CHIEF EXECUTIVE

RECOMMENDATION:

THAT THE CHIEF EXECUTIVE’S REPORT BE RECEIVED