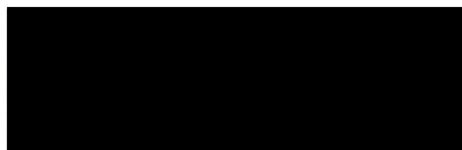
Waitematā
District Health Board
Best Care for Everyone

Hospital Services
North Shore Hospital Campus
Shakespeare Road, Takapuna
Private Bag 93-503, Takapuna
Auckland 0740
Telephone: 09 489 0527

8 October 2021



Dear

Re: OIA request – ICU beds and CPAC thresholds

Thank you for your Official Information Act request received 14 September 2021 seeking information from Waitematā District Health Board (DHB) about ICU beds/staffing and CPAC thresholds.

Before responding to your specific questions, it may be useful to provide some context about our services.

Waitematā is the largest and one of the most rapidly growing DHBs in the country, serving a population of around 650,000 across the North Shore, Waitakere and Rodney areas. We are the largest employer in the district, employing around 8,500 people across more than 80 locations.

In addition to providing care to our own resident population, we are the Northern Region provider of forensic mental health services and child rehabilitation services, plus the metro Auckland provider of child community dental services and community alcohol and drug services.

On 14 September, we contacted you to clarify the following:

1. Waitematā DHB does not operate a paediatric ICU and we would provide information in relation to our adult ICU only
2. that your request for CPAC thresholds for each speciality is in relation to surgical services.

That same day, you confirmed that information about adult ICUs would be appreciated and that you were seeking data on First Specialist Appointments (FSAs) in addition to surgical services.

On 6 October, we contacted you again to further clarify the information we would be providing. You advised that you were happy to receive information on general surgery, gynaecology, otorhinolaryngology (ORL), urology as provided in this response and, if further information is needed, you will submit another OIA request.

In response to your request, we are able to provide the following information:

1. **How many intensive care unit (ICU) beds are available at Waitematā DHB that meet the staffing requirements outlined in the College of Intensive Care Medicine (CICM) minimum standards for Level I, II, III? See: https://www.cicm.org.au/CICM_Media/CICMSite/Files/Professional/IC-1-Minimum-Standards-for-Intensive-Care-Units.pdf**

The Level II ICU/HDU complex at North Shore Hospital has 14 physical bed spaces for ICU and HDU patients, with seven allocated to ICU patients.

Our current staffing of eight registered nurses (RNs) on a shift, with a senior nurse coordinating, allows six ICU-level patients with a further four HDU-level patients. Using the minimum standards for intensive care units, we can potentially increase numbers if patients are at HDU-level care and, therefore, receive 1:2 nursing ratio. Using the CICM standards, we are able to use our nursing team flexibly to open as many beds as possible.

There are no designated ICU beds at Waitakere Hospital.

2. What is the DHB's current Clinical Priority Assessment Criteria (CPAC) threshold for each specialty?

3. What were the CPAC thresholds over the previous five years and how many patients were declined treatment (FSA or surgery) due to capacity of the service to deliver?

General Surgery

We do not use the CPAC thresholds for first specialist appointments (FSA) or surgery in general. We use referral acceptance thresholds to manage capacity rather than restricting surgery once the referral has been accepted. For example: general surgery increased its threshold in June 2021, as we do not have the clinic or theatre capacity to see patients below this threshold.

Gynaecology

CPAC threshold is 65. We do a clinical override when clinically indicated for:

1. clinical priority (P1, P2, P3) and
2. to offer surgery if clinically indicated (despite not reaching CPAC threshold).

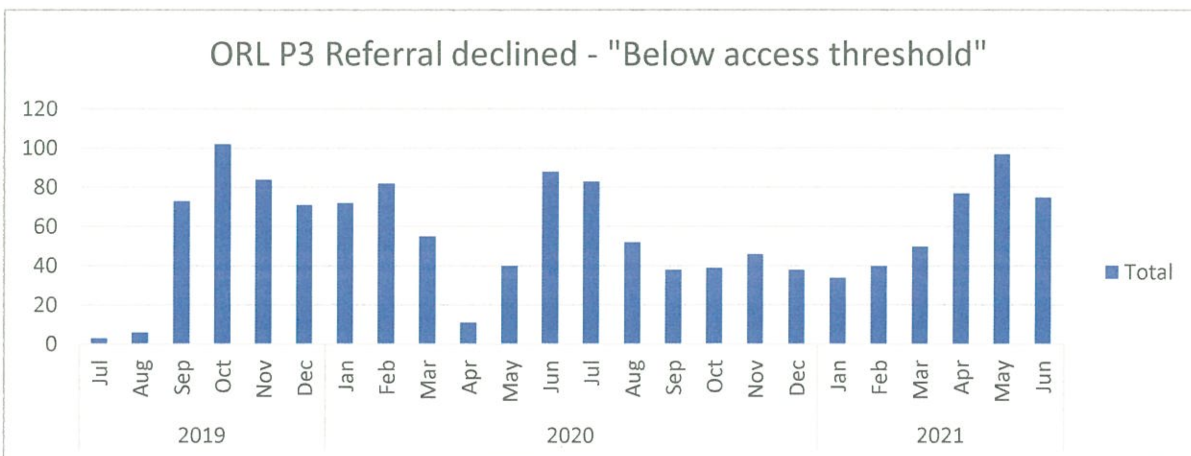
As a general rule, we do not decline surgery if clinically indicated. No change in the threshold for the past five years.

Otorhinolaryngology (ORL)

The CPAC score threshold for the ORL service is 50. Clinicians utilise the online National Prioritisation tool in clinic, usually at FSA, to ascertain their clinical priority on the Inpatient Waitlist for surgery (refer to **Appendix 1** for relevant scores). CPAC is not utilised as a threshold for presentation to FSA.

Patients requiring surgery will generally be progressed according to their CPAC score assessed in clinic, as opposed to being declined due to failure to meet the appropriate CPAC scores.

The graph below shows the number of patient referrals that have been declined by the ORL service. Note that we were still accepting Priority 3 (P3) patients prior to 2019. However, access thresholds were reviewed in 2019 to ensure that P3 patients, who do not need to be seen for FSA according to Ministry of Health guidelines, remain under the care of their GP until a change in their condition prompts the need for specialist review. This is to ensure that patients with a higher acuity are seen and treated in a timely manner. Please note that the total number of ORL referrals accepted in this time was 10,872.



Orthopaedics
We implement the National Elective Medical Services Prioritisation Tool (refer to **Appendix 2**) as an adjunct to the following criteria to support prioritisation decision-making:

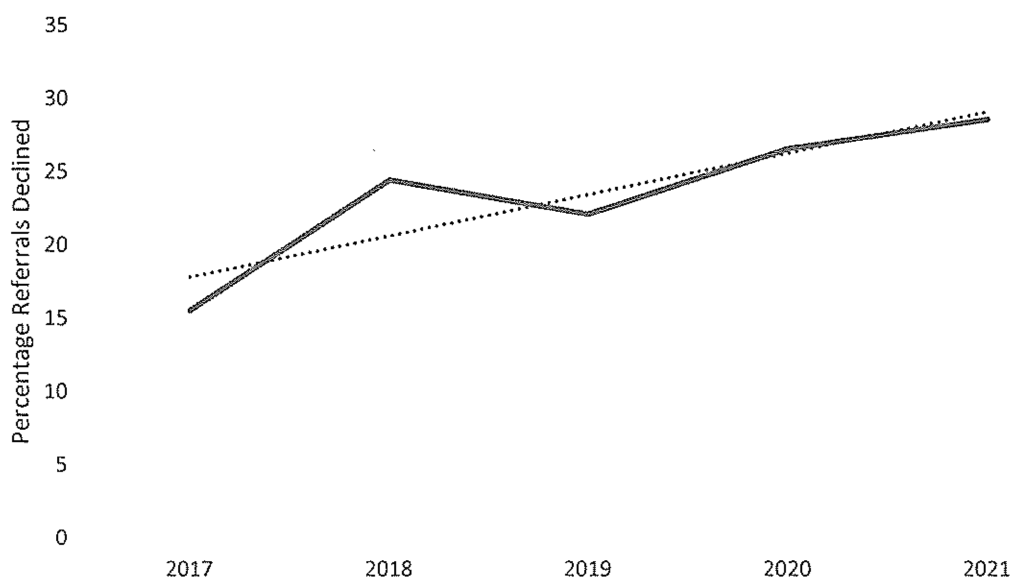
P1 – Patients presenting with cancer

P2 – Patients utilizing opioids for pain management, mobility/function significantly impaired (wheelchair bound, house-bound, unable to continue standard vocation, limited ability access to community services).

P3 – Mobility/function significantly decreased with walking distance less than 100m – daily pain despite the use of standard analgesia. Pain impacting sleep pattern.

Similar to general surgery, orthopaedics uses referral acceptance thresholds to manage capacity rather than restricting surgery once the referral has been accepted. In support of this, the referral acceptance threshold for arthroplasty has been temporarily increased for a six-month period in 2021.

Below is the annual data of patients declined for FSA as a percentage of the total referral volume. As with ORL, above, access thresholds have been reviewed to ensure that P3 patients, who do not need to be seen for FSA according to Ministry of Health guidelines, remain under the care of their GP until a change in their condition prompts the need for specialist review. As noted, this is to ensure that patients with a higher acuity are seen and treated in a timely manner.



Urology
CPAC threshold of 67 has not changed or increased in the last five years. To date, 592 patients have been declined treatment.

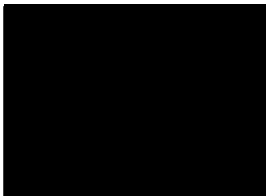
I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare.

This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely



Executive Director Hospital Services
Waitematā District Health Board

Appendix 1: National Prioritisation Tool (ORL)

CPAC Scores:

ORL – Tool Identifier in IPM - 9031		
Excludes "Special Case Selected" from Prioritisation Tool		
CPAC Score	*Priority*	*Time on waitlist*
90 – 100	P1	Within 4 weeks
69 – 89	P2	Within 8 weeks
45 – 68	P3	Within 4 months

ORL Skins – Tool Identifier in IPM - 9051		
Excludes "Special Case Selected" from Prioritisation Tool		
CPAC Score	*Priority*	*Time on waitlist*
90 – 100	P1	Within 4 weeks
69 – 89	P2	Within 8 weeks
45 – 68	P3	Within 4 months

"Special Case Selected" from Prioritisation Tool

A 'Direct to Waitlist' irrespective of the CPAC score happens when the results page from the Online Prioritisation Tool specifies 'Special case selected'.

'Special case selected' scores range from 75-100 and should be placed directly on the surgical wait-list. These are equivalent to a P1.

Appendix 2: National Elective Medical Services Prioritisation Tool (Orthopaedics)

Criteria	Weighting
1. Patient-derived impact on life*	
(Determined by a patient self-reported questionnaire)	
· No significant impact	0
· Minor impact	4.9
· Compromised	9.1
· Major impact	14.6
· Avoids or prevents important activities	17.5
2. Frequency	
(Number of episodes per year that the condition has an impact)	
· Nil	0
· Less than monthly	7.1
· Monthly	8.3
· Weekly	9.4
· Daily	10
· Constant	12
3. Episode duration	
(Time per episode that the condition has an impact)	
· nil (has no impact on important activities)	0
· minutes	7.1
· hours	8.6
· days	9.8
· constant	11.2
4. Overall duration on impact on life	
· no significant impact	0
· < 1 year	0.8
· ≥ 1 year	1.4
5. Risk of deterioration (natural history of disease and condition)	
5a. Significance of deterioration	
· low	0
· medium	2.2
· high	12.1
5b. Likelihood of deterioration	
· low (stable condition unlikely to progress)	0
· medium (gradual and predictable course)	1.9
· high (catastrophic, substantial or unpredictable course)	11.1
6. Benefit	
6a. Degree or quantum (expected or most likely for the proposed treatment)	
· small improvement in symptoms, low impact on risk of deterioration	0
· moderate improvement in symptoms, moderate impact on risk of deterioration	9.1
· large improvement in symptoms, large impact on risk of deterioration	17.3
6b. Likelihood of achieving maximum benefit for this patient	
(Considering frailty, comorbidity, procedural complexity, diagnosis and risk of complications)	
· low (unlikely to achieve maximum benefit <25%)	0
· medium (possibility to achieve maximum benefit 25-75%)	16
· high (likely to achieve maximum benefit > 75%)	17.4