Waitematā
District Health Board

Best Care for Everyone

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING

Wednesday 2 December 2020
2.00pm

AGENDA

VENUE:
Boardroom, Level 1, 15 Shea Tce
Takapuna

Waitematā District Health Board
Best Care for Everyone

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING
2 December 2020

Venue: Boardroom, Level 1, 15 Shea Tce Takapuna **Time: 2.00pm**

Committee Members	WDHB Management
Sandra Coney –Committee Chair Edward Benson-Cooper – Deputy Committee Chair Judy McGregor – WDHB Board Chair John Bottomley – WDHB Board Member Chris Carter - WDHB Board Member Warren Flaunty – WDHB Board Member Allison Roe – WDHB Board Member Renata Watene - WDHB Board Member Board Observers Wesley Pigg Amber-Paige Ngatai	Dale Bramley – Chief Executive Officer Robert Paine – Chief Financial Officer and Head of Corporate Services Mark Shepherd – Director, Provider Healthcare Services Jonathan Christiansen – Chief Medical Officer Jocelyn Peach - Director of Nursing and Emergency Systems Planner Tamzin Brott - Director of Allied Health, Scientific and Technical Professions

APOLOGIES:

AGENDA

DISCLOSURE OF INTERESTS

- Does any member have an interest they have not previously disclosed?
- Does any member have an interest that might give rise to a conflict of interest with a matter on the agenda?

PART I – Items to be considered in public meeting

All recommendations/resolutions are subject to approval of the Board.

	1.	**AGENDA ORDER AND TIMING**
	2.	**CONFIRMATION OF MINUTES**
2.00pm	2.1	Confirmation of Minutes of Hospital Advisory Committee Meeting (21/10/20) Actions Arising from previous meetings
	3.	**PROVIDER REPORTS**
2.05pm	3.1	Provider Arm Performance Report – September
	3.1.1	Executive Summary
	3.1.2	Human Resources
	3.1.3	Acute and Emergency Medicine Division*
	3.1.4	Specialty Medicine and Health of Older People Services *
	3.1.5	Child, Women and Family Services
	3.1.6	Specialist Mental Health and Addiction Services
	3.1.7	Surgical and Ambulatory Services/Elective Surgery Centre
	3.1.8	Diagnostic Services
	3.1.9	Clinical Support Services
	3.2	Provider Arm Summary Report – October
	4.	**CORPORATE REPORTS**
2.35pm	4.1	Clinical Leaders' Report
2.45pm	4.2	Quality Report - September/October
	5.	**GENERAL BUSINESS**
2.55pm	**6.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

**Reports for noting only*

Waitematā District Health Board

Hospital Advisory Committee Member Attendance Schedule 2020

NAME	FEB	MAR	MAY	JUN	JUL	SEP	OCT	DEC
Sandra Coney (Committee Chair)	✓	Meetings Cancelled due to COVID-19		✓	✓	✓	✓	
Edward Benson Cooper (Deputy Committee Chair)	✓			✓	✓	✓	✓	
Judy McGregor	✓			✓	✓	✓	✓	
John Bottomley	✓			✓	✓	✓	✓	
Chris Carter	*x*			✓	✓	✓	✓	
Warren Flaunty	✓			✓	✓	✓	✓	
Allison Roe	✓			✓	*x*	✓	✓	
Renata Watene	✓			✓	✓	✓	✓	

✓ ***Attended the meeting***
x ***Apologies***
******* ***Attended part of the meeting only***
# ***Absent on Board business***
^ ***Leave of absence***

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Sandra Coney (Committee Chair)	Member – Waitakere Ranges Local Board, Auckland Council Patron – Women's Health Action Trust	18/12/19
Edward Benson-Cooper (Deputy Committee Chair)	Chiropractor - Milford, Auckland (with private practice commitments) Edward has three (different) family members who hold the following positions: Family member - FRANZCR. Specialist at Mercy Radiology. Chairman for Intra Limited. Director of Mercy Radiology Group. Director of Mercy Breast Clinic Family member - Radiology registrar in Auckland Radiology Regional Training Scheme Family member - FANZCA FCICM. Intensive Care specialist at the Department of Critical Care Medicine and Anaesthetist at Mercy Hospital	25/03/19
John Bottomley	Consultant Interventional Radiologist - Waitematā District Health Board	17/12/19
Chris Carter	Chairperson – Henderson-Massey Local Board, Auckland Council Trustee – Lazarus Trust	18/12/19
Warren Flaunty	Chair – Trust Community Foundation Trustee (Vice President) – Waitakere Licensing Trust Shareholder – EBOS Group Shareholder – Green Cross Health Director – Life Pharmacy Northwest Chair – Three Harbours Health Foundation Trustee – Hospice West Auckland (past role)	05/02/20
Judy McGregor (Board Chair)	Chair – Health Workforce Advisory Board Associate Dean Post Graduate - Faculty of Culture and Society, AUT Member - AUT's Academic Board New Zealand Law Foundation Fund Recipient Consultant - Asia Pacific Forum of National Human Rights Institutions Media Commentator - NZ Herald Patron - Auckland Women's Centre Life Member - Hauturu Little Barrier Island Supporters' Trust	11/09/19
Allison Roe	Chairperson – Matakana Coast Trail Trust Member – Rodney Local Board, Auckland Council Member – Wilson Home Committee of Management (past role)	22/08/18
Renata Watene	Owner – Occhiali Optometrist Board Member – OCANZ Strategic Indigenous Task Force Council Member - NZAO	17/12/19
Wesley Pigg (Board Observer)	Employee (physiotherapist) – Waitematā DHB	14/10/20
Amber-Paige Ngatai (Board Observer)	Employee (nurse) – Waitematā DHB	14/10/20

Conflicts of Interest Quick Reference Guide

Under the NZ Public Health and Disability Act 2000, a member of a DHB Board who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest to the Board.

A Board member is interested in a transaction of a DHB if the member is:

- a party to, or will derive a financial benefit from, the transaction; or
- has a financial interest in another party to the transaction; or
- is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is (i) the Crown; or (ii) a publicly-owned health and disability organisation; or (iii) a body that is wholly owned by 1 or more publicly-owned health and disability organisations; or
- is the parent, child, spouse or partner of another party to, or person who will or may derive a financial benefit from, the transaction; or
- is otherwise directly or indirectly interested in the transaction.

If the interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence the Board member in carrying out responsibilities, then he or she may not be "interested in the transaction". The Board should generally make this decision, not the individual concerned.

A board member who makes a disclosure as outlined above must not:

- take part in any deliberation or decision of the Board relating to the transaction; or
- be included in the quorum required for any such deliberation or decision; or
- sign any document relating to the entry into a transaction or the initiation of the transaction.

The disclosure must be recorded in the minutes of the next meeting and entered into the interest register.

The member can take part in deliberations (but not any decision) of the Board in relation to the transaction if a majority of other members of the Board permit the member to do so. If this occurs, the minutes of the meeting must record the permission given and the majority's reasons for doing so, along with what the member said during any deliberation of the Board relating to the transaction concerned.

Board members are expected to avoid using their official positions for personal gain, or solicit or accept gifts, rewards or benefits which might be perceived as inducement and which could compromise the Board's integrity.

IMPORTANT

Note that the best course, when there is any doubt, is to raise such matters of interest in the first instance with the Chair who will determine an appropriate course of action.

Ensure the nature of the interest is disclosed, not just the existence of the interest.

Note: This sheet provides summary information only.

2.1 Minutes of the Hospital Advisory Committee meeting held on 21 October 2020

Recommendation:

That the draft Minutes of the Hospital Advisory Committee meeting held on 21 October 2020 be approved.

Draft Minutes of the meeting of the Waitematā District Health Board

Hospital Advisory Committee

Wednesday, 21 October 2020

held at Boardroom Level 1, 15 Shea Tce Takapuna
commencing at 1.31pm.

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT

Sandra Coney (Committee Chair)
Judy McGregor
Edward Benson-Cooper
John Bottomley
Chris Carter – *present until 3.20pm*
Warren Flaunty
Allison Roe
Renata Watene –*present by video conference*

ALSO PRESENT

Robert Paine (Chief Financial Officer and Head of Corporate Services) – *present from 2.06pm*
Jonathan Christiansen (Chief Medical Officer) – *present from 1.50pm*
Jocelyn Peach (Director of Nursing and Midwifery)
Sharon Russell (Associate Director, Allied Health)
Mark Shepherd (Director, Provider Healthcare Services)
Peta Molloy (Board Secretary)
Deanne Manuel (Committee Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item.)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

There were no public and media representatives were present during the meeting.

WELCOME

The Committee Chair welcomed those present

APOLOGIES

Chris Carter noted he needed to retire from the meeting early, at 3pm.

Apologies were received and accepted from Dr Dale Bramley and Dr Tamzin Brott and for late arrival from Dr Jonathan Christiansen and Robert Paine.

DISCLOSURE OF INTERESTS

There were no additions to the Interest Register.

There were no interests declared that might give conflict with a matter on the open agenda.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed in the agenda.

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Hospital Advisory Committee Meeting held on 9 September 2020 (agenda pages 6-14)

Resolution (Moved Sandra Coney/Seconded Edward Benson-Cooper)

That the Draft Minutes of the Hospital Advisory Committee meeting held on 9 September 2020 be approved.

Carried

Actions Arising (agenda pages 15-19)

Verbal updates on matters arising were provided by the services during the discussion of their reports. The update presented to the Board in relation to the equity based principle was noted.

3. PROVIDER ARM PERFORMANCE REPORT

In view of the rotational format for the discussion of the HAC Provider Arm report to allow for a more robust divisional discussion, sections 3.1.6, 3.1.7, 3.1.8 and 3.1.9 of the report were taken as read.

3.1 Provider Arm Performance Report – August 2020 (agenda pages 20-80)

Executive Summary/Overview

Mark Shepherd (Director Provider Healthcare Services) summarised this section of the report.

Matters discussed and response to questions included:

- Work undertaken between the first and second COVID-19 outbreaks allowed the service provider to continue 'business as usual', planned care and allowed uninterrupted management of acute workload during the second outbreak.
- Improvement in the reduction of non-compliance rates for ESPI1 and ESPI5 were noted. The increase in production volume which was 90% YTD prior to

COVID-19 and is now at 104%, despite the pandemic response, was highlighted.

- The Outpatient DNA rate has reduced, however, remains high for Māori and Pacific patients. The service is working to understand the underlying reason of non-attendance.
- Noting the reduction of paediatric presentations, the Committee suggested continued messaging to communities on the importance of hand hygiene and infection prevention. A lower threshold for attendance of sick children in early learning centres and schools has also been observed.
- Noting the work underway with the Ministry of Health in relation to the development of a Cancer Plan, a request was made by the Committee Chair to establish contact with the National Cancer Agency to learn more about their mandate and priorities.
- Extra-ordinary costs are a result of the COVID-19 response and Holiday Pay provision. COVID-19 costs are monitored and work around Holiday Pay is underway.

This section of the report was received.

Human Resources

Fiona McCarthy (Director Human Resources) was present for this item. The report was taken as read.

- Staff are reminded to take annual leave. There is messaging around leave and its impact on wellbeing.
- Mark Shepherd advised the work underway to manage staff leave, focusing on those with high leave balances.
- Annual close-downs are provided by law, however, this is not invoked by the DHB. There is a reduction of service level during the Christmas and New Year holiday period and staff are encouraged to take annual leave during this time.

This section of the report was received.

Acute and Emergency Medicine Division

Gerard de Jong (Division Head) and Alex Boersma (General Manager) were present for this item.

The report was taken as read. Matters covered in the discussion and response to questions included:

- The Rapid Cardiology Screening pilot is underway and analysis of the service model and response will be conducted after the service has seen 100 patients. The Chair acknowledged the work undertaken for this service model, noting that this will improve patient experience. Learning from the review could be applied to other clinical services. An update on the pilot upon completion of the assessment was requested by the Committee.

- Cardiology consultations were conducted via Telehealth during the COVID-19 alert level restrictions. Work is underway to continue provision of this model of care and potentially adopting this in other clinical areas.

The Committee thanked Gerard and Alex and acknowledged their work with the Financial Sustainability Programme.

This section of the report was received.

Specialty Medicine and Health of Older People Division

Gerard De Jong (Division Head) and Brian Millen (General Manager) were present for this item.

Matters covered in discussion and response to questions included:

- Brian Millen provided a summary of the Interim Care Services (ICS) noting that the initiative has contributed to a reduction of patients returning for inpatient rehabilitation resulting to bed-day savings. Work is underway to further improve this model of care. An assessment is made to ensure that facilities are 'fit for purpose' prior to discharging patients. The ICS model of care is an example of gains when services are provided 'closer to the community'. The positive impact of patient outcome and experience was noted. The staff also welcomed the opportunity to work in the 'community' setting.
- Noting the key issue as highlighted in the report, there is regional work underway to respond to growing challenges in the community; this inter-agency regional work is led by the Auckland Council. Harm screening is in place in a number of key areas (e.g. Emergency Department, Child, Women and Family services). The DHB ensures staff are trained to respond and which agencies to refer clients to.
- During the COVID-19 response, acute care and rehabilitation was conducted in one ward which received positive feedback. A review of this integrated model of care is underway.

This section of the report was received.

Child Women and Family Division

Stephanie Doe (General Manager) and Emma Farmer (Director of Midwifery) were present for this item. Stephanie provided a summary of the report and Emma Farmer summarised the findings of the maternity survey provided under matters arising.

Matters covered in discussion and response to questions included:

- COVID-19 has provided an opportunity to develop engagement with younger children through Telehealth. The service is looking into working with a community provider to address challenges in engaging with Māori and Pacific whānau. An update will be provided in a future report.

- The service is developing streams of work to reduce arrears which has been impacted by COVID-19 and the pre-screening requirement. This will be a balance of those with clinical need and those who are most vulnerable.
- There is work by the MOH to achieve consistency in tracking of oral health data.
- The DNA strategy is being revisited and an update will be provided to the Committee.
- There is messaging on dental caries - information leaflets are provided to the parents and children when they visit. The importance of visual reminders for children was also highlighted. It was noted that the key message should be prevention. There is a need to consider equity of outcomes and efforts towards lower decile schools.
- A session with Rob Beaglehole (National Public Health Advocate), to discuss work around diet, obesity and healthy eating, will be scheduled in 2021.
- The maternity survey had mixed feedback. The outstanding concern was the lack of support person during delivery. The visiting rule in the first lockdown followed the national guidelines and this was revisited during the second lockdown restrictions in August. However, limitations of the facility, specifically how the wards are configured and the potential to increase risk of transmission of virus should it present. This is a learning that will be considered in future builds.
- Pre-term birth rate has reduced during the pandemic. There was a reduction on the average number of days in the hospital from 2.5 to 1.5; however, the rate of re-admission has increased due to infection.
- Use of Telehealth provided easier access to lactation consultants. Lessons learned will be considered moving forward.
- The service has been asked by the MOH to provide feedback on their experience and learning as a result of the pandemic.
- Noting the gains and opportunities for learning, the Committee resolved to recommend that the Board writes too the Minister of Health to inquire about undertaking a review of the response to COVID-19 and compiling all learnings by the health sector from the pandemic.

Resolution (Moved Sandra Coney/Seconded Allison Roe)

That the Hospital Advisory Committee recommends to the Board:

That the Board writes to the Minister of Health to inquire about a review being undertaken on the response to COVID-19 and compiling all learnings from the health sector during the pandemic.

Carried

The following sections of the report were taken as read and received:

- Specialist Mental Health and Addiction Services
- Surgical and Ambulatory Services/Elective Surgical Centre
- Diagnostic Services
- Clinical Support Services

An update will be provided at the next meeting on the unfavourable leave variance noted in Specialist Mental Health and Addiction Services report.

Resolution (Moved Sandra Coney/Seconded Edward Benson-Cooper)

That the report be received.

Carried

Chris Carter retired from the meeting at 3.20pm.

4. CORPORATE REPORTS

4.1 Clinical Leaders' Report (agenda pages 81-91)

Jonathan Christiansen (Chief Medical Officer), Jocelyn Peach (Director, Nursing) and Sharon Russell (Associate Director, Allied Health) were present for this item.

Medical Staff

Jonathan Christiansen took the report as read. He noted that the shifting of the schedule of Registered Medical Officer (RMO) training will have long term gains. RMO over-allocations have reduced.

This section of report was received.

Allied Health, Scientific and Technical Professions

Sharon Russell took the report as read. She highlighted that the DHB has recently welcomed Caroline Bartholomew, a Speech and Language Therapist. Caroline brings strong focus on reducing inequities in health.

This section of the report was received.

Nursing and Midwifery and Emergency Planning Systems

Jocelyn Peach took the report as read. She acknowledged the contributions of the nurses and midwife that have recently retired.

This section of the report was received.

Resolution (Moved Sandra Coney/ Second Warren Flaunty)

That the report be received.

Carried

4.2 Quality Report – August (agenda pages 92-139)

Jacky Bush (Quality and Risk Manager) and Penny Andrew (Director, i3 and Clinical Lead), David Price (Director Patient Experience) and Allanah Winiata-Kelly (Māori Patient and Whānau Experience Lead) were present for this section of the report.

Matters covered indiscussion and response to questions included:

Quality Update

- Information around falls and pressure injuries and the work underway to ensure recommendations are implemented. There will be regular reporting to track progress.
- There have been no influenza cases diagnosed in June, July and August 2020.

i3 update

- Work on a regional data platform has commenced.
- Nomination of Dr Lara Hopley (Clinical Adviser, Digital Innovation) for the 2020.
- Peter Taylor, a DHB volunteer, was awarded the Health Care Provider Service Individual Award at this year's Minister of Health Volunteer Awards.

Patient and Whānau Centered Care

- Work to engage with Māori patients and whānau is ongoing. There is a focus on providing support to Waitakere community.
- A review of the recruitment process to recruit more Māori in the DHB's workforce is underway.
- Cultural support is provided to patients and whānau, however, this is dependent on the patient declaring this when admitted. This has been identified as an opportunity to provide a pro-active cultural support in particular for outpatients.
- The service provides support for Māori cancer patients. A database of patients requiring cultural support is also in place.

The report was received.

Resolution (Moved Sandra Coney/ Second Allison Roe)

That the report be received.

Carried

5. GENERAL BUSINESS

No matter of general business was raised.

6. RESOLUTION TO EXCLUDE THE PUBLIC (agenda pages 140-141)

Resolution (Moved Edward Benson-Cooper/Seconded Renata Watene)

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 09/09/20	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2. Quality Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]
3. Human Resources Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
4. Waitematā DHB – cancer and colonoscopy (bowel screening programme)	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.	**Conduct of Public Affairs** The disclosure of information would not be in the public interest because of the greater need to maintain the effective conduct of public affairs through the protection of members, officers and employees from improper pressure or harassment. [Official Information Act 1982 S.9 (2) (g)(ii)]

Carried

The open session of the meeting concluded at 3.41p.m.

SIGNED AS A CORRECT RECORD OF THE WAITEMATĀ DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 21 OCTOBER 2020.

_____CHAIR

Actions Arising and Carried Forward from Meetings of the Hospital Advisory Committee as at 26 November 2020

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back/Comment
29/07/20	3.1	Provider Arm Performance Report Update on vascular services	Mark Shepherd	25/03/21
09/09/20	3.1	Provider Arm Performance Report Review/update DNA strategy paper and to update with COVID-19 learning	Mark Shepherd/ Jonathan Christiansen	Early 2021

3.1 Provider Arm Performance Report – September 2020

Recommendation:

That the report be received.

Prepared by: Robert Paine (Chief Financial Officer and Head of Corporate Services) and Mark Shepherd, (Director Hospital Services)

This report summarises the Provider Arm performance for September 2020.

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  - Strategic Initiatives
  - Financial Performance
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  - Acute and Emergency Medicine Division
  - Specialty Medicine and Health of Older People Division
  - Child, Women and Family Services
  - Specialist Mental Health & Addiction Services
  - Surgical and Ambulatory Services
  - Elective Surgery Centre
  - Diagnostic Services
  - Clinical Support Services

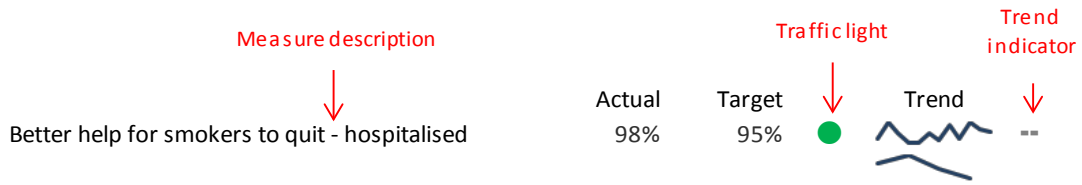
Glossary

ACC	-	Accident Compensation Commission
ADU	-	Assessment and Diagnostic Unit
ALOS	-	Average Length of Stay
ARDS	-	Auckland Regional Dental Service
AT&R	-	Assessment Treatment and Rehab
ASA	-	American Society of Anaesthesiologists
CADS	-	Community Alcohol, Drug and Addictions Service
CAMHS	-	Child, Adolescent Mental Health Service
CT	-	Computerised Tomography
CWF	-	Child, Women and Family service
DCNZ	-	Dental Council of New Zealand
DHB	-	District Health Board
DNA	-	Did Not Attend
ED	-	Emergency Department
ECHO	-	Echocardiogram
ESC	-	Elective Surgery Centre
ESPI	-	Elective Services Performance Indicators
FTE	-	Full Time Equivalent
GP	-	General Practitioner
HCA	-	Health Care Assistant
HT	-	Hypertensive Disorders
ICU	-	Intensive Care Unit
KMU	-	Kingsley Mortimer Unit
LMC	-	Lead Maternity Carer
LOS	-	Length of Stay
SMHOPS	-	Specialty Medicine and Health of Older People Services
MRI	-	Magnetic Resonance Imaging
MoH	-	Ministry of Health
NGO	-	Non Government Organisation
NSH	-	North Shore Hospital
NZNO	-	New Zealand Nurses Organisation
ORL	-	Otorhinolaryngology (ear, nose, and throat)
RMO	-	Registered Medical Officer
S&A	-	Surgical and Ambulatory Services
SCBU	-	Special Care Baby Unit
SGA	-	Small for Gestational Age Baby
SMHA	-	Specialist Mental Health & Addiction Services
SMO	-	Senior Medical Officer
WIES	-	Weighted Inlier Equivalent Separations

How to interpret the scorecards

Traffic lights

For each measure, the traffic light indicates whether the actual performance is on target or not for the reporting period (or previous reporting period if data are not available as indicated by the *grey bold italic* font).



The colour of the traffic lights aligns with the Annual Plan:

Traffic light	Criteria: Relative variance actual vs. target		Interpretation
●	On target or better		Achieved
●	95-99.9% achieved	0.1–5% away from target	Substantially Achieved
●	90-94.9%*achieved	5.1–10% away from target AND improvement from last month	Not achieved, but progress made
●	<94.9% achieved	5.1–10% away from target, AND no improvement, OR >10% away from target	Not Achieved

Trend indicators

A trend line and a trend indicator are reported against each measure. Trend lines represent the actual data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. The small data range may result in small variations appearing to be large.

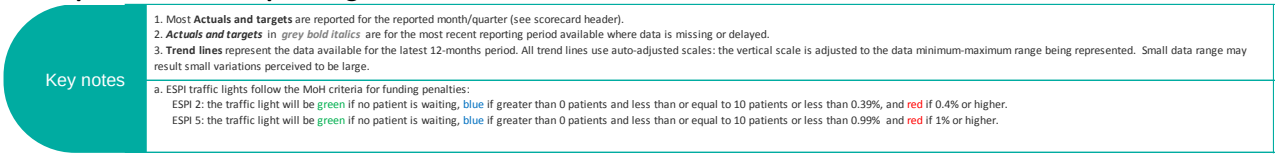
Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance trend, use the trend indicator as described below.

The trend indicator criteria and interpretation rules:

Trend indicator	Rules	Interpretation
▲	**Current > Previous** month (or reporting period) **performance**	Improvement
▼	**Current < Previous** month (or reporting period) **performance**	Decline
--	**Current = Previous** month (or reporting period) **performance**	Stable

By default, the performance criteria is the actual:target ratio. However, in some exceptions (e.g., when target is 0 and when performance can be negative (e.g., net result) the performance reflects the actual.

Look up for scorecard-specific guidelines are available at the bottom of each scorecard:



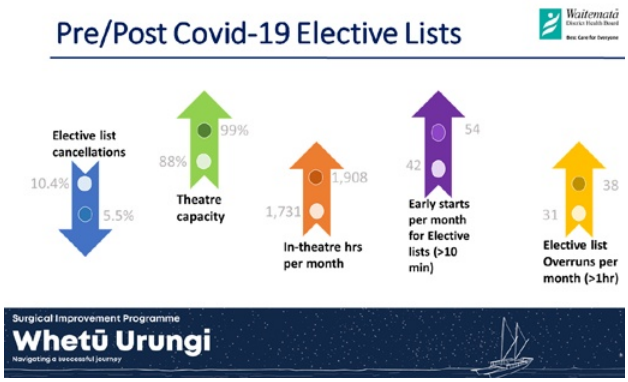
Provider Arm Performance Report

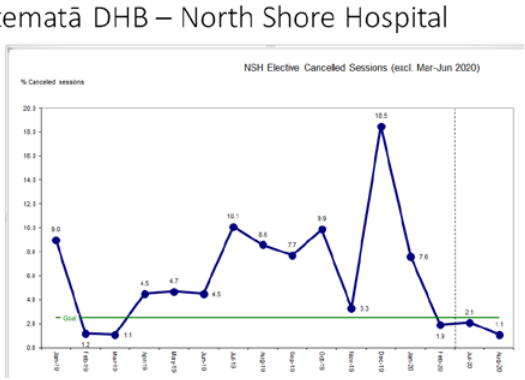
Executive Summary/Overview Summary

September 20 saw COVID-19 in the Auckland community settle back down as we resumed Community Alert level 1. The COVID-19 Readiness Plans put in place between wave 1 (April-June) and wave 2 (August-September), saw dedicated units within NSH manage approximately 10 COVID-19 positive patients without mishap. Additionally, given the significant cancellations of care in wave 1 , Provider Services did not cancel planned care and delivered above targets for most access to treatment targets though this time. Waiting times for clinics, diagnostics, endoscopy, cardiac procedures and surgery all improved.

Highlight of the month

Since the first wave of COVID-19 in the community in April-June 2020, the Surgical and Ambulatory Services division has commenced work to increase the delivery of planned elective surgical care and treatment by optimisation of the service. The preliminary results have been significant with North Shore Hospital improving cancellations for 18% to 1.1% in August. These reductions in cancellations have meant that we have had approximately 240 additional operating theatre sessions made available to provide treatment to our patients. Other additional improvements include 11% increase in capacity, approximately 200 hours per month operating theatre time and improvements in theatre sessions commencing on time. The Whetu Urungi (a journey navigating to a better place) was launched on October and is designed to ensure sustainability of these significant improvements.

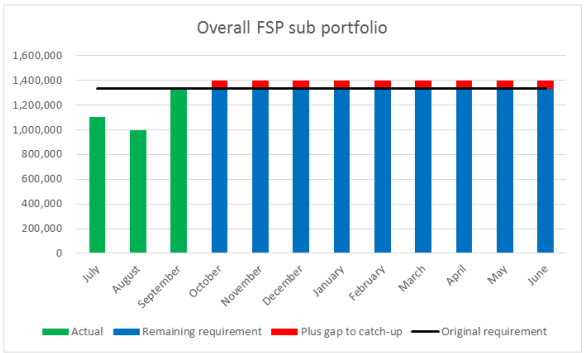




Key Issue of the Month

The revised Financial Sustainability Programme has been in place for three months and delivered $1.18m in expense reduction in September and $3.4m year to date (YTD). There are 49 different expense reduction initiatives running to deliver these returns. $11.8m in expense reduction initiatives have been validated for the programme which requires $16m in savings in the 2020/21 financial year.

The following table clearly shows original monthly requirement, with the red highlighting the additional savings required, given prior month actuals were below requirement.



Scorecard – All services

Waitematā DHB Monthly Performance Scorecard

ALL Services
September 2020
2020/21

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	93%	95%	▼
Faster cancer treatment (62 days)	90%	90%	▲

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	11 days	≤14 days	▼
Net Promoter Score FFT	83	65	▲
Improving Outcomes			
Better help for smokers to quit - hospitalised	100%	95%	▲
Quality & Safety			
Older patients assessed for falling risk	99%	90%	▼
Rate of falls with major harm	0.10	≤2	▼
Good hand hygiene practice	91%	80%	▲
S. aureus infection rate	0.04	≤0.13	▲
Occasions insertion bundle used	100%	95%	▲
Pressure injuries grade 3&4	2	0	▼
HR/Staff Experience			
Sick leave rate	3.3%	≤3.4%	--
Turnover rate - external	10%	≤14%	--
Vacancies - %	4%	≤8%	--

Service Delivery

Elective Volumes	Actual	Target	Trend
Provider Arm - Overall	97%	100%	▼
Waiting Times			
ESPI 2 - % patients waiting > 4 months for FSA		Non-Compliant	
ESPI 5 - % patients not treated w/n 4 months		Non-Compliant	
ESPI 1 - OP Referrals processed w/n 10 days		Compliant	
Patient Flow			
Outpatient DNA rate (FSA + FUs) - Total	6%	≤10%	▲
Outpatient DNA rate (FSA + FUs) - Māori	12%	≤10%	▲
Outpatient DNA rate (FSA + FUs) - Pacific	14%	≤10%	▲

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue excl. extraordinary items	261,296 k	258,853 k	▲
Expenses excl. extraordinary items	271,966 k	268,778 k	▼
Net surplus/(deficit) excl. extraordinary items	-10,670 k	-9,925 k	▼
COVID-19 net benefit/(cost)	-1,719 k		▼
Holiday Pay provision	6,000 k		▲
Net surplus/(deficit) incl. extraordinary items	-18,389 k	-9,925 k	▼
Contracts (YTD)			
Elective WIES Volumes	4,688	5,154	▼
Acute WIES Volumes	17,234	17,266	▲

How to read

Performance indicators:
- Achieved/ On track
- Not Achieved but progress made
- Substantially Achieved but off target
- Not Achieved/ Off track

Trend indicators:
- ▲ Performance ***improved*** compared to previous month
- ▼ Performance ***declined*** compared to previous month
- -- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in ***grey bold italics*** are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-month period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. A small data range may result in small variations appearing to be large.

A question?

Contact:
Victoria Child - **Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz**
Planning, Funding and Health Outcomes, Waitematā DHB

Scorecard Variance Report

Priority Health Outcome Areas

Shorter waits in ED 93% with a target of 95%

A slight decline in access times in the Emergency Department has seen an increase in the numbers of patients waiting more than 6 hours in the emergency department. Clusters of patients arriving within short periods has impacted on our ability to manage workload and process high volumes of patients in clinically appropriate timeframes. The development of a demand and capacity action plan has commenced to improve escalation, communication and reliable organisation-wide action when the Emergency Department has high demand.

Best Care

2 patients were recorded as having grade 3-4 pressure injuries on a target of 0.

Waitematā DHB has developed a strong pressure injury prevention programme, that has been implemented across all wards. Results of the programme are proudly displayed on our ward quality boards. Two grade 3-4 pressure injuries were reported and are currently under investigation to determine what could have been done more proactively to prevent these injuries.

Service Delivery

DNA rates for Maori 12% and Pacifica 14% are higher than the target rate of 10%

Patients who do not attend appointments are recorded as a DNA. There are numerous reasons preventing patients from being able to attend appointments, including social, financial, logistic and cultural reasons. A DHB DNA strategy has been developed and will be implemented to better improve access to care through developing more choice for patients on when and how to access our outpatient services. Of note, total DNA rates for all patients is significantly lower at 6%.

Value for Money

Net financial surplus/deficit is -$750k against a budget of $9.925m

Currently the provider is -$750k unfavourable net to budget YTD. This is due to not all divisions being able to deliver on Financial Sustainability Program targets. Additional strategies and initiatives are being developed to bridge this gap and work to deliver the appropriate financial results.

Elective WEIS Volumes

***Elective Volume** – 92% against a target of 100%*

This is the WIES percentage YTD. (There is a lag in accurate WIES information - the most up to date data indicates that current WIES achievement across all services is now 95.2%.)

Key areas of concern include General Surgery at 85% with ORL at 93%. Orthopaedics at 98% and Urology at 99% are not of concern. The drivers for General Surgery being behind are reduced number of bariatric surgery patients post COVID-19 as higher clinical priority cases have had priority. This has resulted in overall lower than average case weight (WIES) . ORL are behind in their WIES due to reduced elective discharges and reduced number of patients with tracheostomy in 2020 which has a particularly high case weight WIES .There are two additional ORL SMOs starting in January 2021 which will assist production.

Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Improving Quality Actions to improve equity in outcomes and patient experience		
Patient experience With Auckland DHB: • establish a gold standard approach to improve medication communication and patient empowerment for acute and primary care pharmacy staff and the broader multi-disciplinary team • develop a medication communication improvement plan to empower patients, including Māori and Pacific, to ask questions regarding their medications to support safety (EOA) • Improve our results for the national inpatient experience survey for the question 'did a member of staff tell you about medication side effects to watch for when you went home' from 44.8% (CY2018 baseline) to 47.0% (this is the lowest scoring question for both Waitematā and Auckland DHBs)	 Mar 2020 Sep 2019 September 2020	 ✓ × ✓
With our Māori and Pacific health teams (EOA), develop: • a Māori Health action plan and seek endorsement by the Māori Equity committee • Māori patient guidance (Tikanga Māori) – how to provide best care to Māori patients and whānau • evidence-based patient feedback methods for specific populations (including Māori and Pacific) to enable patients to safely comment on their experience	 Sep 2019 Mar 2020 Mar 2020	 ✓ × ×
Workforce Actions to support and improve the skills of our staff members, and improve our organisational health literacy		
Health Literacy • Launch the joint Waitematā-Auckland DHB Health Literacy Policy and e-learning module • Monitor and evaluate uptake of the e-learning module	 Sep 2019 Ongoing	 ✓ ✓

• Hold a joint DHB health literacy symposium as part of health literacy/patient experience month • Develop and deliver face-to-face training for all telephonist and patient centre staff	Oct 2019 Dec 2019	✓ ✓

Areas off track for month and remedial plans
Equity Committee endorsed the key priorities and gaps identified within a paper about Māori Patient and Whānau Experiences at Waitematā DHB. Approval received to recruit a Māori Patient Experience and Whānau Lead position to lead the areas of work identified. Unfortunately there was a delay with finding a suitable candidate for the role and we are very pleased our new Māori Patient and Whānau Experience Lead started in April 2020. The new incumbent is in the midst of establishing her work plan to progress the above priorities. We have a plan in place for medication communication with our pharmacists at Auckland DHB and Waitematā DHB, however this work will recommence in July due to COVID-19 and resourcing challenges. Counties Manukau will also join the working group from July – to establish a regional approach.

DHB activity	**Milestone**	**On Track**
Cancer Services Actions to reduce inequalities between Māori and non-Māori patients with cancer		
Equity of access Commence a pilot programme of early contact by Māori and Pacific Cancer Nurse Specialists for all Māori and Pacific patients triaged as P1 and HSC (EOA)	Jul 2019	✓
Bowel cancer quality improvement • Review and analyse data for patients with unplanned return to surgery within 30 days • Review patient-specific data to confirm reasons why some rectal patients do not receive preoperative radiation	 Sep 2019 Dec 2019	 ✓ ✓
Cancer plan development • Work with the Ministry to develop a Cancer plan • Implement and deliver local actions from the plan	 Ongoing Jun 2020	 ✓ ✓
90% compliance for Māori and Pacific patients on the 62-day FCT pathway (SS11 measure) At least 85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat (SS01 measure)		

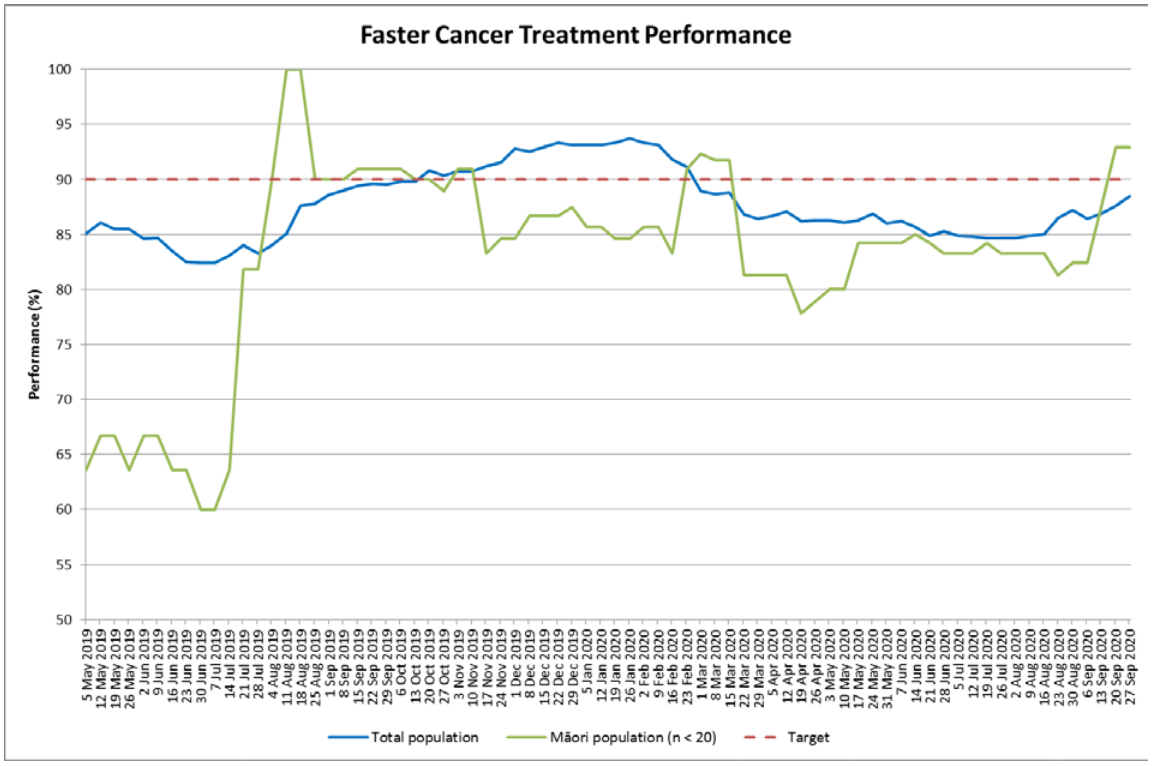
DHB activity	**Milestone**	**On Track**
Planned Care Actions to ensure that our population receives equitable and timely access to services in the most appropriate setting to support improved health outcomes		
Elective Services • Implement and oversee a process of optimising booking of elective patients as identified in the elective surgery production plan to ensure delivery of 100% of the target volumes • Prioritise high risk cancer patients and clinical priority one patients (with other patients being treated in turn) for treatment within 4 months • Ensure equity of access for Māori patients by continuing interaction	 Ongoing Ongoing Ongoing	 ✓ ✓ ✓

with Cancer Clinical Nurse Specialist Māori, Faster Cancer Tracking (EOA) • Ensure equity of access for Pacific patients by continuing patient-focused booking (PFB; EOA) - implement PFB in three additional specialty areas • Work towards enabling patients to self-book appointments online: - email validation and digital post as BAU - clinic profile review completed - vendor workshops completed • Incorporate self-referral on symptoms (SOS) process into business as usual for Orthopaedics, General Surgery and ORL and introduce to other specialities *Deliver 32,119 Planned Care interventions* *SS07 measures: ESPI 1 100% - ESPI 2 0% - ESPI 3 0% - ESPI 5 0% - ESPI 8 100%* *Demonstrate equity of access for Pacific patients with 90% being seen within ESPI 2 timeframe* *90% of referral and outpatient letters sent via digital post*	Ongoing September 2020 Dec 2019 Dec 2019 Jan 2020 From Oct 2019	✓ ✓ ✓Completed ✓ Completed ✓ Completed ✓ Completed
Three-year plan • Outline of engagement, analysis and development activities • Consultation and analysis to understand local needs • Develop plan • Update on progress against plan	Sep 2019 Dec 2019 Mar 2020 Jun 2020	✓ ✓ ✓ ✓

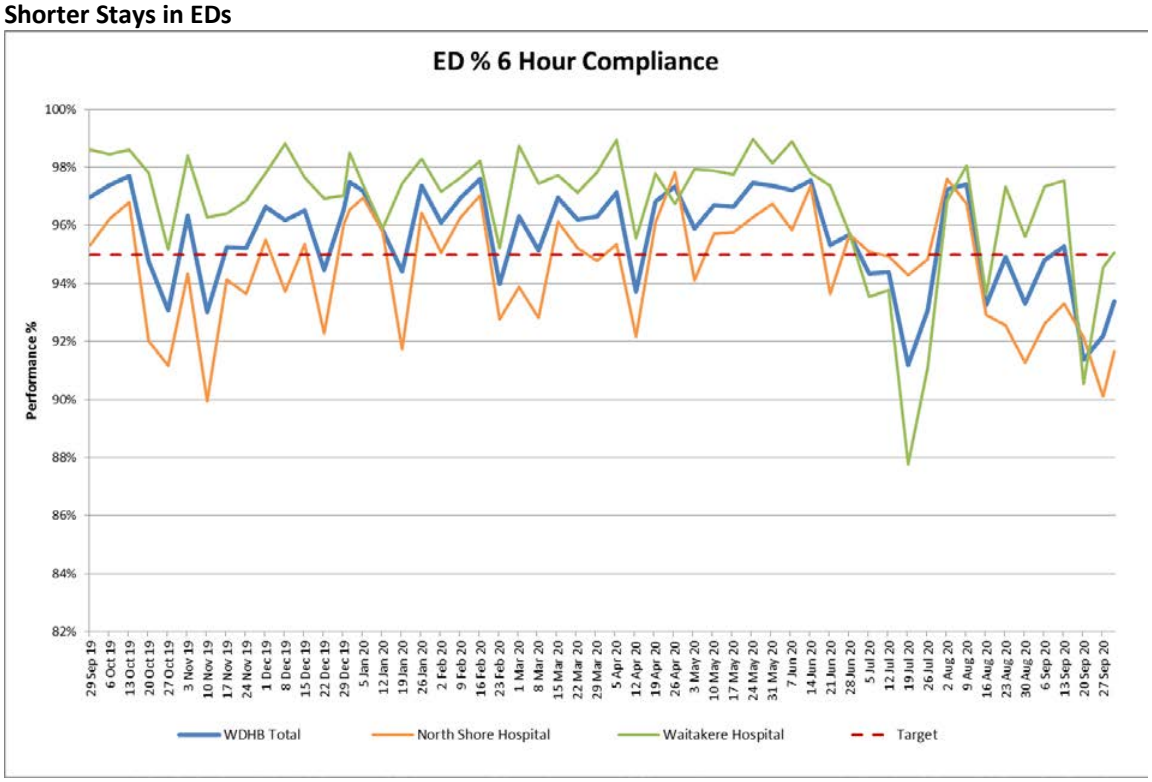
Areas off track for month and remedial plans
By March 2020, ESPI 2 compliance was being met by all but 2 surgical specialties (General Surgery and ORL) and on track to meet our predicted compliance position by September 2020. The impact of COVID-19 has seen all surgical specialties return to a non-compliant status. Gynaecology and Urology were both on track to be compliant by September 2020. Medicine has continued to deliver usual volumes over this period through the introduction of telehealth initiatives with only a very low volume of non-compliant patients. ESPI 5 compliance volumes have suffered the greatest impact due to reduced theatre capacity with ESC being stood down from surgical activity as part of the DHB pandemic planning and P1 / Urgent patients only being treated during Alert Level 4. All surgical specialties have developed action plans and have identified compliance trajectory timeframes. Patient Focused Booking (PFB) remains a priority to support services booking practices. The current focus of ensuring all high acuity patients receive assessment and treatment within clinical compliance adds a level of complexity to services changing booking practices in the current environment. As we return to normal booking practices work will continue to bring services online with PFB. Performance recovery plans have been developed and forwarded to the MoH for review and endorsement.

Priority Health Outcome Areas

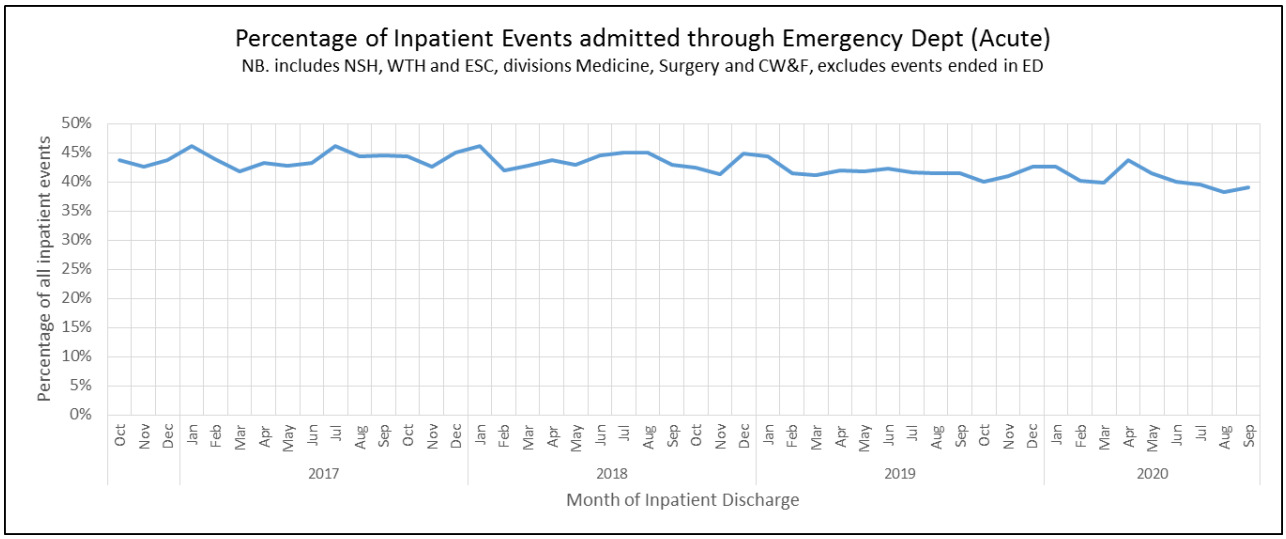
Faster Cancer Treatment

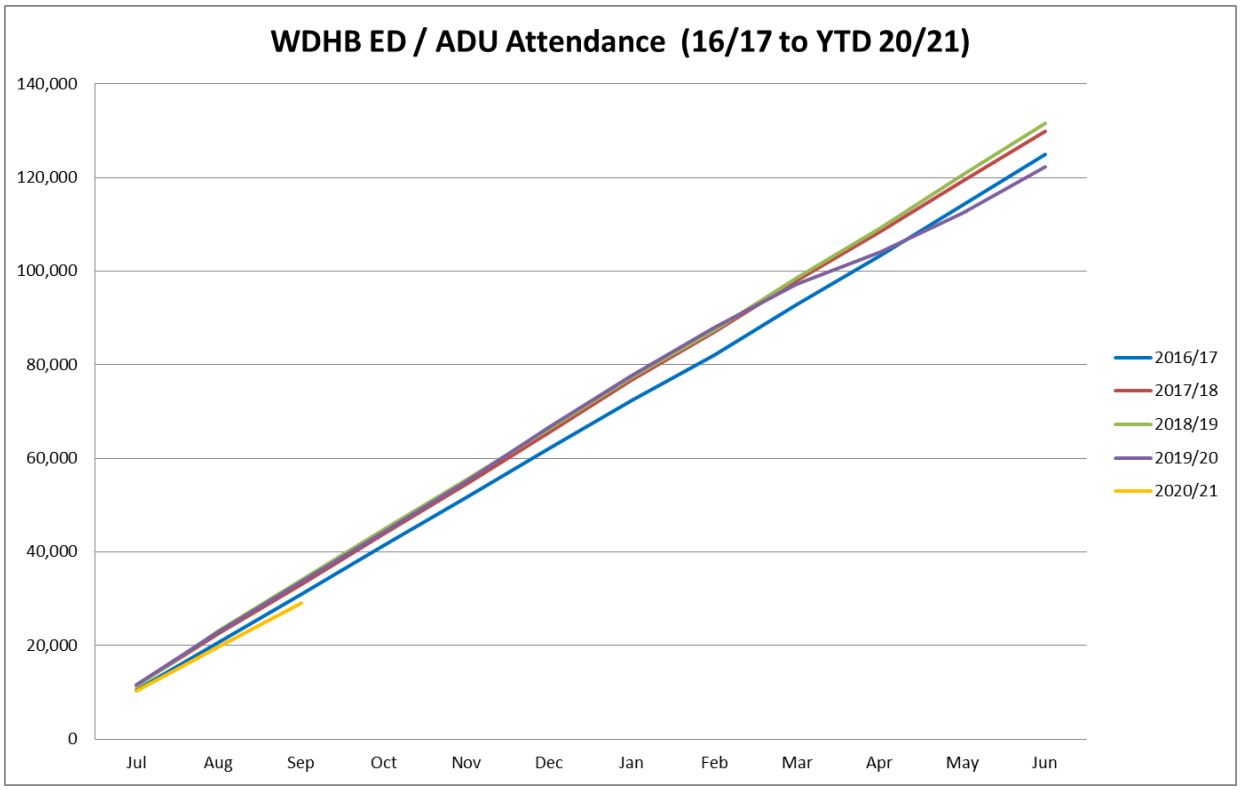


Shorter Stays in EDs

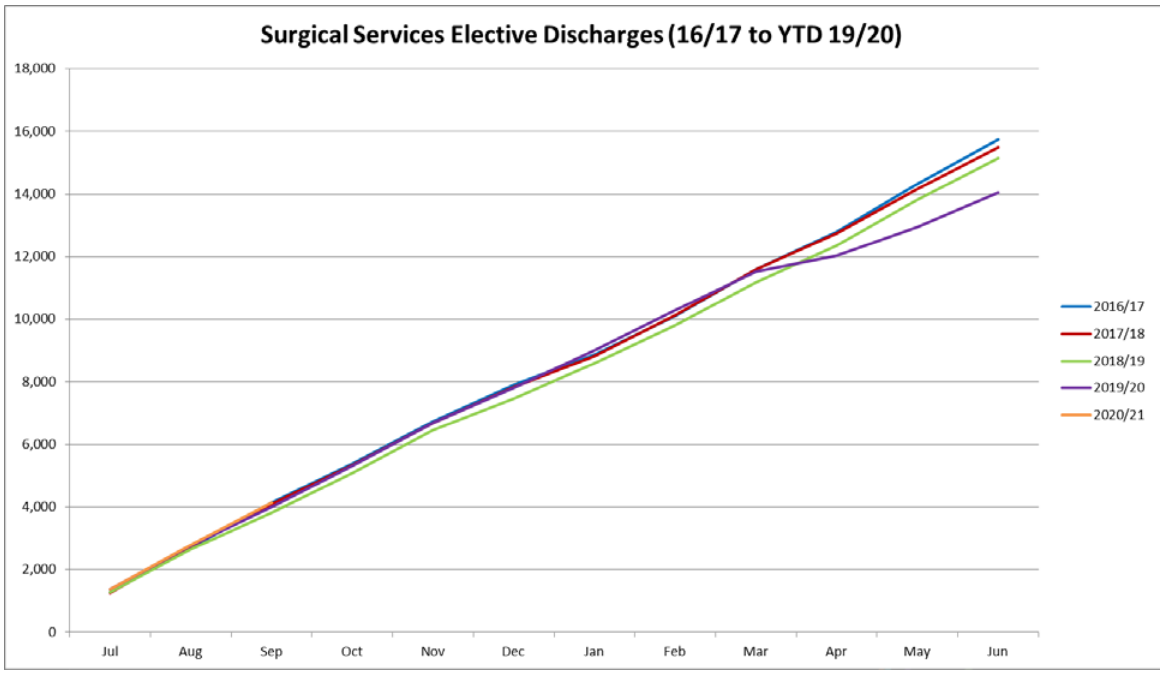


Inpatient Events admitted through ED





Surgical Services Elective Discharges



* Surgical discharge volumes include all elective Orthopaedic, Gynaecology, ORL, Urology and General Surgery discharges (including skin lesions).

Percentage Change ED and Elective Volumes

September 2020	Month Volumes	% Change (last year)	YTD Volumes	% Change (last year)
ED/ADU Volumes	9,308	-13%	29,106	-14%
Surgical Services Elective Discharge Volumes	1,343	10%	4,143	4%

Elective Performance Indicators (part of Planned Care Services)

Zero patients waiting over four months

Summary (September 2020)	
Speciality	Non Compliance %
ESPI 2 - Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	2.13%
ESPI 5 - Patients given a commitment to treatment but not treated within the required timeframe.	18.88%

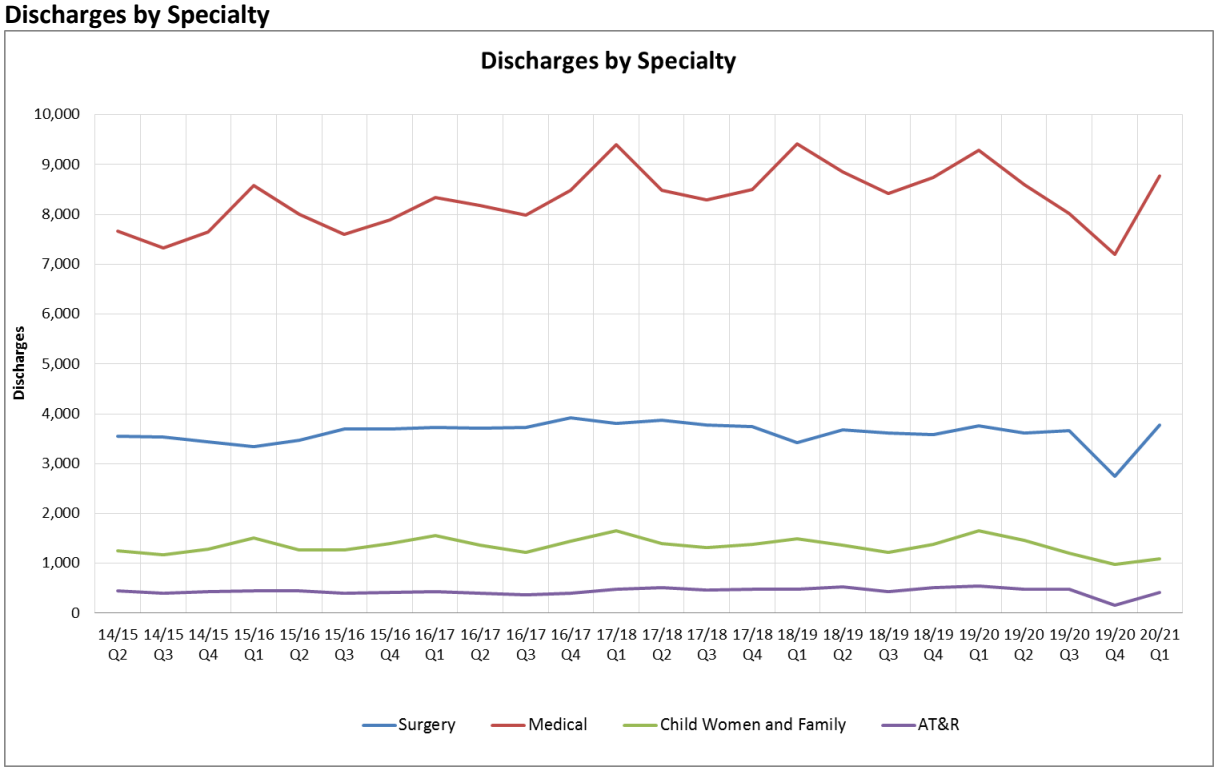
ESPI	WL Specialty	Compliant	Non Compliant	Non Compliant
ESPI 2	Anaesthesiology	87	-	0.00%
	Cardiology	1,148	-	0.00%
	Dermatology	288	-	0.00%
	Diabetes	200	-	0.00%
	Endocrinology	189	-	0.00%
	Gastro-Enterology	862	-	0.00%
	General Medicine	218	-	0.00%
	General Surgery	1,430	159	10.01%
	Gynaecology	1,100	10	0.90%
	Haematology	197	-	0.00%
	Infectious Diseases	60	-	0.00%
	Neurovascular	67		0.00%
	Orthopaedic	2,170	12	0.55%
	Otorhinolaryngology	1,213	56	4.41%
	Paediatric MED	554	-	0.00%
	Renal Medicine	246	-	0.00%
	Respiratory Medicine	479	-	0.00%
	Rheumatology	286	-	0.00%
	Urology	734	14	1.87%
	Total	11,528	251	2.13%
ESPI 5	Cardiology	78	-	0.00%
	General Surgery	1,503	94	5.89%
	Gynaecology	507	133	20.78%
	Orthopaedic	1,206	421	25.88%
	Otorhinolaryngology	306	87	22.14%
	Urology	375	190	33.63%
	Total	3,975	925	18.88%

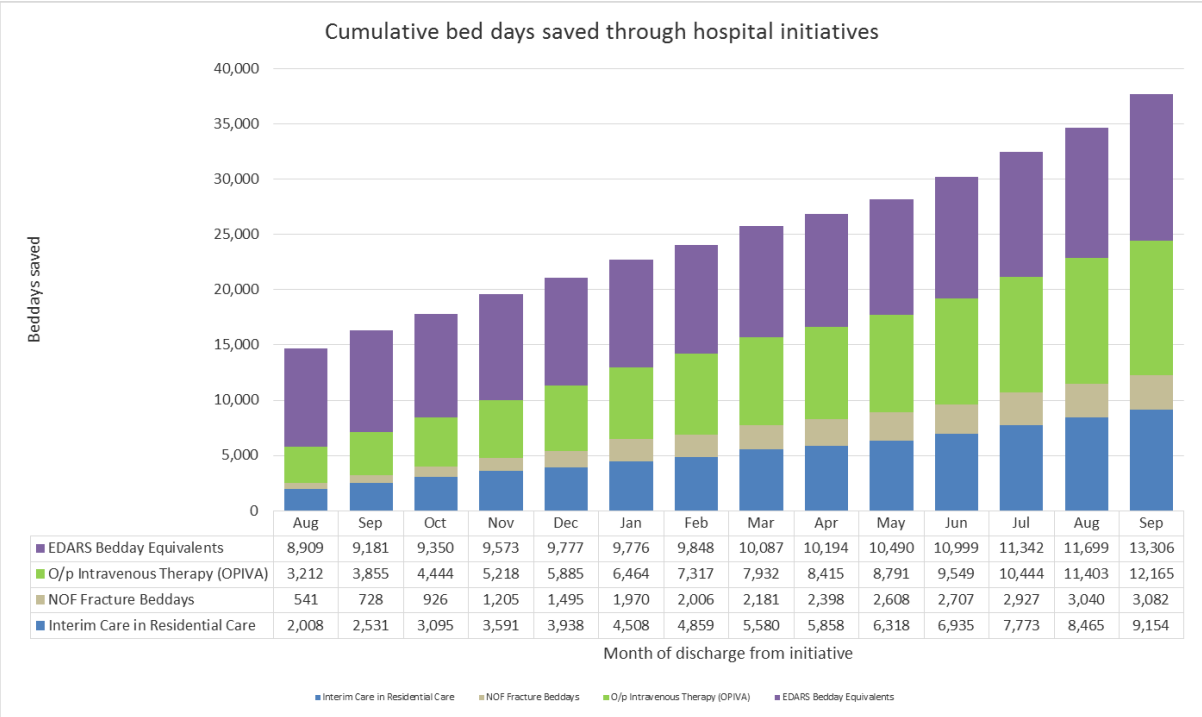
90% of outpatient referrals acknowledged and processed within ten days

ESPI 1 (September 2020)	
Specialty	Compliance %
Anaesthesiology	100.00%
Cardiology	99.84%
Dermatology	100.00%
Diabetes	100.00%
Endocrinology	100.00%
Gastro-Enterology	98.56%
General Medicine	96.92%
General Surgery	98.88%
Gynaecology	98.18%
Haematology	99.55%
Infectious Diseases	94.20%
Neurovascular	100.00%
Orthopaedic	98.47%
Otorhinolaryngology	99.87%
Paediatric MED	95.78%
Renal Medicine	100.00%
Respiratory Medicine	99.74%
Rheumatology	98.48%
Urology	100.00%
Total	98.86%

Legend	
ESPI 1	Green if 100%, Yellow if between 90% and 99.9%, and Red if 90% or less.
ESPI 2	Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.39%, and Red if 0.4% or higher.
ESPI 5	Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.99%, and Red if 1% or higher

Discharges by Specialty





	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
EDARS Bedday Equivalents	8,909	9,181	9,350	9,573	9,777	9,776	9,848	10,087	10,194	10,490	10,999	11,342	11,699	13,306
O/p Intravenous Therapy (OPIVA)	3,212	3,855	4,444	5,218	5,885	6,464	7,317	7,932	8,415	8,791	9,549	10,444	11,403	12,165
NOF Fracture Beddays	541	728	926	1,205	1,495	1,970	2,006	2,181	2,398	2,608	2,707	2,927	3,040	3,082
Interim Care in Residential Care	2,008	2,531	3,095	3,591	3,938	4,508	4,859	5,580	5,858	6,318	6,935	7,773	8,465	9,154

Financial Performance

Waitematā DHB Statement of Financial Performance

Provider - Sep-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	84,523	83,995	527	253,187	252,721	466	1,008,037
Other Income	3,330	2,210	1,120	8,109	6,132	1,978	41,825
Total Revenue (excl. extraordinary items)	87,852	86,205	1,647	261,296	258,853	2,443	1,049,862
EXPENDITURE							
Personnel							
Medical	17,469	18,022	552	52,509	51,619	(890)	221,100
Nursing	23,642	23,364	(277)	72,600	73,417	817	296,150
Allied Health	11,403	10,899	(505)	34,119	33,613	(506)	134,634
Support	2,177	2,152	(26)	6,314	6,802	488	27,550
Management / Administration	6,715	7,442	728	19,917	22,005	2,088	88,151
Outsourced Personnel	2,105	1,345	(761)	6,261	3,798	(2,463)	15,503
	63,512	63,223	(288)	191,719	191,253	(466)	783,088
Other Expenditure							
Outsourced Services	5,187	5,504	317	17,145	16,783	(362)	66,234
Clinical Supplies	12,045	11,325	(720)	34,960	35,465	504	138,622
Infrastructure & Non-Clinical Supplies	9,143	7,952	(1,191)	28,142	25,278	(2,864)	98,719
	26,374	24,781	(1,593)	80,247	77,525	(2,722)	303,575
Total Expenditure (excl. extraordinary items)	89,886	88,004	(1,882)	271,966	268,778	(3,188)	1,086,662
Surplus/(Deficit) excl. extraordinary items	**(2,033)**	**(1,799)**	**(235)**	**(10,670)**	**(9,925)**	**(745)**	**(36,800)**
Extraordinary items							
COVID-19 Net benefit/(cost)	(208)	0	(208)	(1,719)	0	(1,719)	0
Holiday Pay provision	(2,000)	0	(2,000)	(6,000)	0	(6,000)	0
Surplus/(Deficit) incl. extraordinary items	**(4,241)**	**(1,799)**	**(2,442)**	**(18,389)**	**(9,925)**	**(8,463)**	**(36,800)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Waitematā DHB Statement of Financial Performance

Provider by service - Sep-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
CONTRIBUTION (excl. extraordinary items)							
Surgical and Ambulatory	(12,089)	(11,016)	(1,074)	(38,169)	(35,797)	(2,372)	(144,248)
Acute and Emergency	(11,967)	(11,866)	(101)	(38,459)	(38,119)	(339)	(156,907)
Specialty Medicine and HOPS	(7,312)	(7,189)	(123)	(23,546)	(23,555)	9	(93,971)
Child Women and Family	(4,639)	(4,569)	(70)	(15,245)	(15,229)	(16)	(62,620)
Regional Dental	(2,033)	(2,137)	104	(6,797)	(7,408)	611	(27,492)
Specialist Mental Health and Addiction	(10,415)	(10,120)	(295)	(34,711)	(33,354)	(1,356)	(136,581)
Elective Surgery Centre	(2,519)	(2,402)	(117)	(7,476)	(7,285)	(191)	(27,889)
Clinical Support	(2,735)	(2,565)	(169)	(8,872)	(8,489)	(383)	(33,093)
Diagnostics	(7,144)	(8,080)	935	(25,830)	(26,432)	602	(104,906)
Corporate and Provider Support	58,821	58,145	676	188,434	185,742	2,692	750,907
Net Surplus/(Deficit) excl. extraordinary iten	**(2,033)**	**(1,799)**	**(235)**	**(10,670)**	**(9,925)**	**(745)**	**(36,800)**
Extraordinary items							
COVID-19 Net benefit/(cost)	(208)	0	(208)	(1,719)	0	(1,719)	0
Holiday Pay provision	(2,000)	0	(2,000)	(6,000)	0	(6,000)	0
Surplus/(Deficit) incl. extraordinary items	**(4,241)**	**(1,799)**	**(2,442)**	**(18,389)**	**(9,925)**	**(8,463)**	**(36,800)**

Financial Performance Summary

Provider $745k unfavourable year to date (excluding Holiday Pay and COVID-19 impacts) - key financial performance factors:

- Unfavourable personnel costs, primarily in Mental Health Nursing personnel, with higher than usual staff retention rates and sick leave.
- Unfavourable clinical supply costs, primarily in Surgery and Ambulatory due in part to unmet savings and increased activity which is subject to further deep dive analysis of drivers.
- These unfavourable variances are partially offset by staff vacancies and releases of prior year MECA and ACC provisions, $585k.

The Provider Arm operating result for YTD September 2020 was a deficit of $10.670m against a budget deficit of $9.925m and therefore $745k unfavourable, prior to the extraordinary impacts of COVID-19 and Holidays Act accruals.

The overall result however shows an unfavourable position of $18.389m after the extraordinary impacts of COVID -19 net of revenue $1.719m and $6.00m for accruals in relation to the Holidays Act, which will continue to be booked on a monthly basis for the 2020/21 financial year, as directed by the Ministry of Health (MoH).

The full year effect of Holidays Act cost is expected to be $24m which will lead to a forecast deficit of $60.8m against the planned deficit of $36.0m.

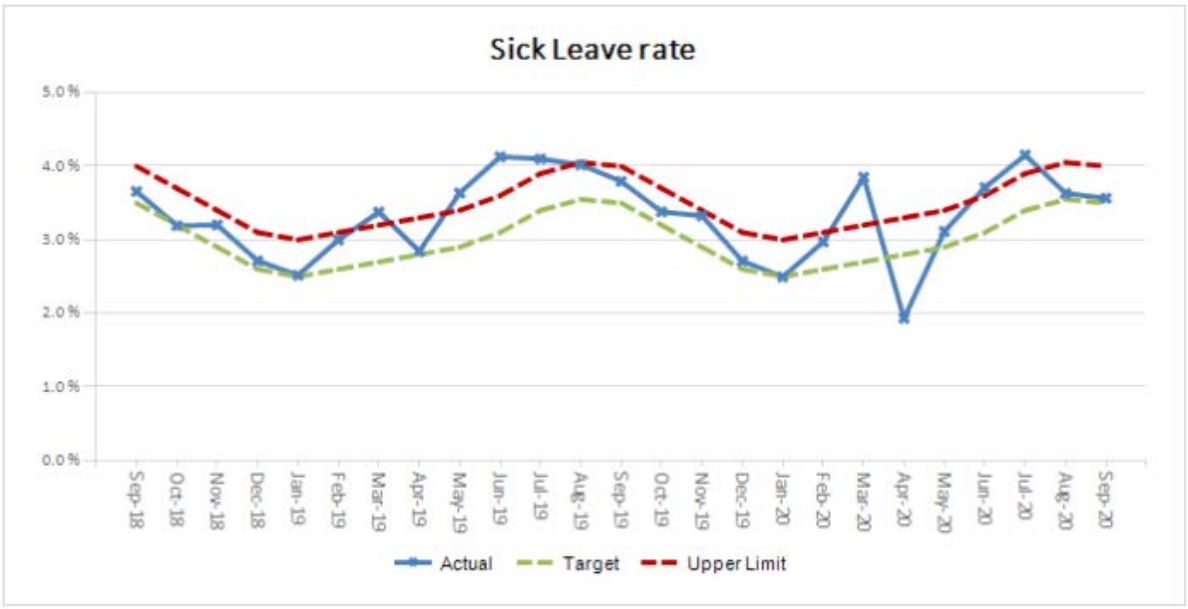
Human Resources

Method of calculation of graphs:

1. Overtime Rate: The sum of overtime hours worked over the period divided by worked hours over the period.
2. Sick Leave Rate (days): The sum of sick leave hours over the period divided by total hours over the period.
3. Annual Leave balance days: Count of staff with 0-76+ days equivalent 8 hour days accumulated leave entitlement.
4. Voluntary Turnover Rate: Count of all staff resignations in the last 12 months. This data excludes RMOs, casuals, and involuntary reasons for leaving such as redundancy, dismissal and medical grounds.

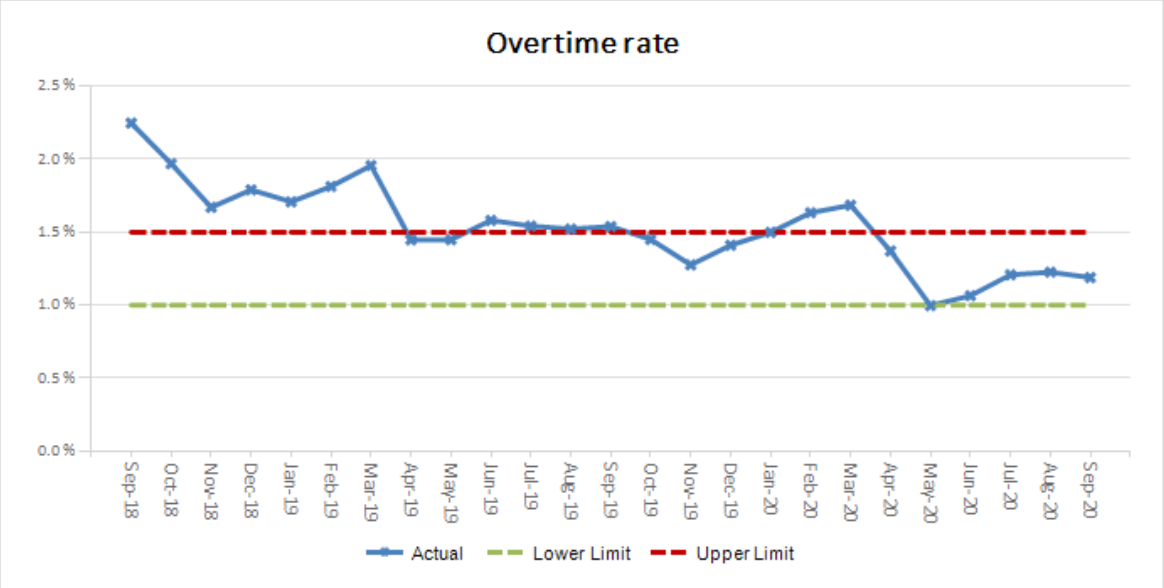
Sick Leave

Sick leave is tracking within our expected target range and decreases again slightly in October.



Overtime

Over time continues at low levels, rising marginally from 1.2% to 1.4% in October as additional work is underway to respond to patient needs delayed due to COVID-19 alert levels.



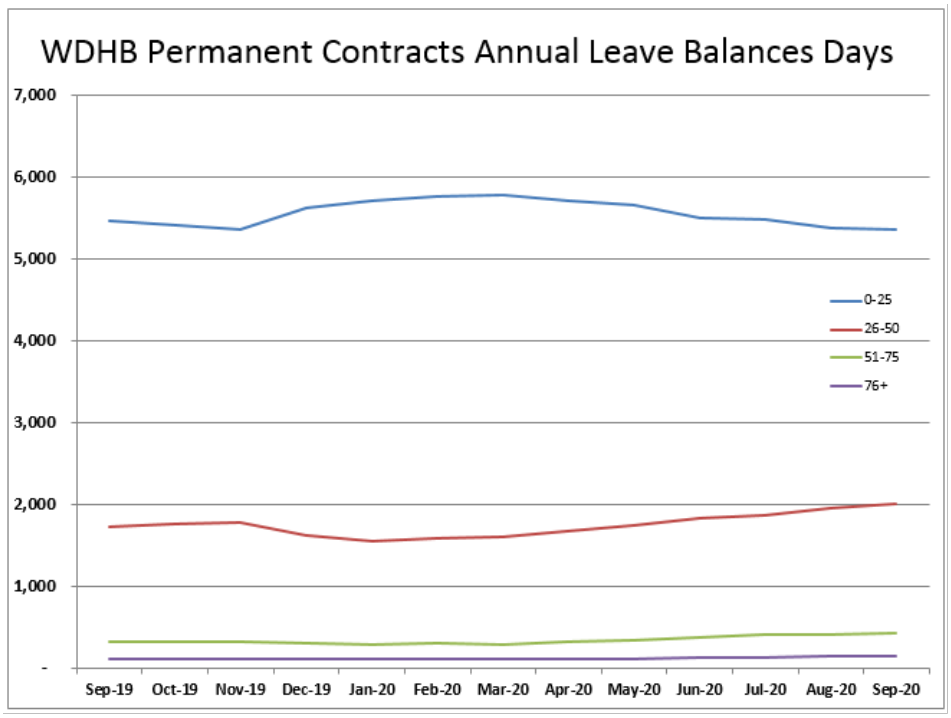
Annual Leave

Annual leave balances have increased on average by three additional days per annum due to impact of National COVID-19 alert levels 2-4 in late March-September 2020.

Our winter and Spring is a popular time for conference and overseas holidays and the leave balances in 2019 compared to 2020 show the impact of not taking leave during this time. People have commenced taking leave again from June, over school holidays and for shorter periods, but not as much as last year.

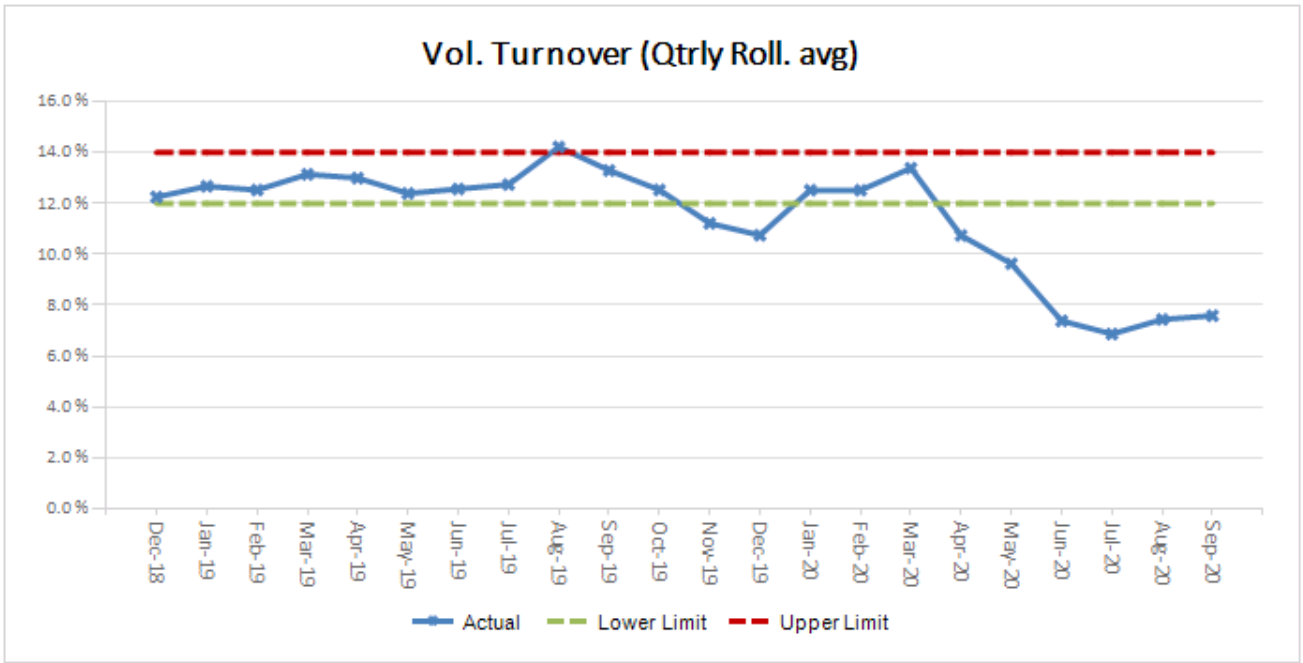
Christmas and New year and public holidays in February are times that we are requesting staff to take leave, in particular those with balances over two years. Staff who have not set a leave plan are being requested to meet with their manager to put a plan in place.

Annual Leave September 2020	Leave Bal 0-25 days	Leave Bal 25-50 days	Leave Bal 50-75 days	Leave Bal 75 days +
Surgical and Ambulatory	687	293	78	41
Elective Surgery Centre	77	22	2	-
Child Women & Family	605	153	26	12
Facilities and Development	45	17	2	3
Corporate	309	125	19	8
Acute and Emergency Medical Divison	906	370	97	48
Clinical Support	221	104	19	1
Diagnostics	298	162	48	16
Director Hospital Services	120	69	18	3
Elective and Outpatient Services	79	23	7	-
Mental Health & Addiction	997	348	48	4
Sub Specialty Med and HOPS	277	75	5	-
Governance and Funding	666	243	53	14
Total	**5,287**	**2,004**	**422**	**150**
Comparison - September 2019	**5,767**	**1,719**	**321**	**114**



Staff Turnover

Staff turnover has remained stable with this pattern reducing to just over 8% in October 2020.



Divisional Reports

Acute and Emergency Medicine Division

Service Overview

This division is responsible for the provision of General, Acute and Emergency Medical services. The division includes the departments of General Medicine, Assessment and Diagnostic Unit (ADU), Emergency Medicine, Cardiology, Medical wards and Hyperbaric Medicine.

The service is managed by Dr Gerard de Jong, Division Head Acute and Emergency Medicine and Alex Boersma, General Manager. The Associate Director of Nursing Medicine is Melody-Rose Mitchell. The Clinical Directors are Dr Hamish Hart for General Medicine, Dr Kate Allan for Emergency Care, Dr Tony Scott for Cardiology, Dr Hasan Bhally and Dr Hugh de Lautour for North Shore Hospital ADU and Dr Chris Sames for Hyperbaric Medicine.

Highlight of the Month

Therapeutic Observation for Patients with Behaviours of Concern in the NSH Emergency Department

Background

Over 50,000 patients present to the Emergency Department (ED) at North Shore Hospital (NSH) annually. It has been routine practice in the ED over a number of years, to utilise security watches, usually external security guards, to 'watch' or observe patients who are demonstrating, or potentially demonstrating behaviours of concern or where there is a patient safety concern. Patients seen as needing a 'security watch' range from those presenting with psychosis, self-harm, alcohol and substance abuse to frail elderly patients presenting with acute delirium and confusion. A guard's role is to observe these vulnerable patients and escalate any concerns to the nurse responsible for the patient's care.

At NSH ED, in liaison with Mental Health and the Security Service we are in the process of implementing model of Therapeutic Observation, utilising the Health Care Assistants (HCA) already working in the ED, with the support of the ED Nurse Educator, a dedicated mental health trained HCA, the ED Associate Clinical Charge Nurses (ACCNs) and Registered Nurses (RN) in a multidisciplinary approach.

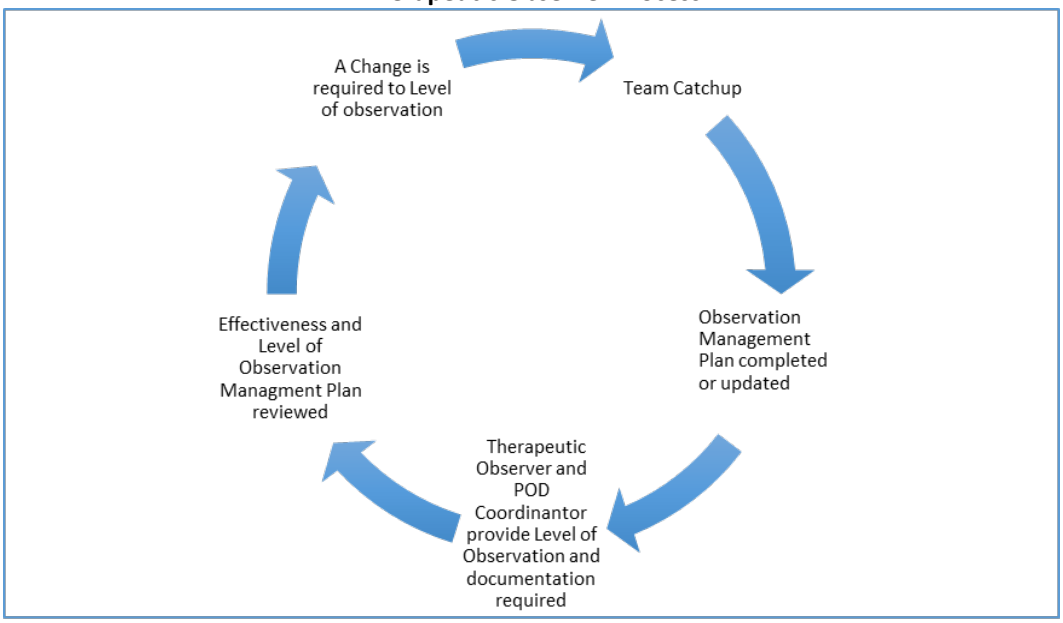
L-R: Maddie Mitchison, Flow Nurse; Di Bratton, ED Educator; Pearl Narcario, RN; Ofa Taufoou, HCA; Simone Marsh, RN; Melissa Rameka, RN

The NSH ED HCAs have all completed on line CALM training and are in the process of completing their Management of Actual and Potential Aggression (MAPA) training and this will be supplemented with a number of new training initiatives including Behaviour Management, Connecting with Patients and Distraction techniques. Mentorship and on-going support will also be provided to the HCAs.

The aim of the new model is to move away from a 1:1 approach to watching individual patients with a security guard – to creating a team approach, with patients assessed by the team on presentation to the ED and an individualised therapeutic observation plan completed, with a number of highly skilled HCAs available in the department to observe and interact with patients, with a regular review process to change the level of observation as required and with support from the multidisciplinary team in ED, including security staff.

An essential element of the new model is the regular team catch-ups (huddles) throughout the day involving the security, mental health and ED staff where patients displaying behaviours of concern are discussed and appropriate management plans are completed or updated. These were introduced early in the trial to improve communication between ED, MH and security team. These huddles consist of the ACCN, ED Nurse Educator, Security staff, Psych Liaison Nurse and the lead ED SMO. The purpose of the huddle is to highlight any patient where there is a behaviour of concern, to develop a clear plan of care and to agree patient disposition. These have been very well received by all and have been a highlight of the trial.

Therapeutic Observer Process



The trial has been in progress since 1 September 2020. As a result of this programme we anticipate:

1. Improved communication between Mental Health, ED and Security staff with the introduction of x3 daily huddles.
2. Improved patient care and assessment.
3. Improved knowledge and skills of the ED based HCAs in the care and support of patients with behaviours of concern.
4. Decrease in the use of external security guards.
5. Decrease in code orange incidents in the ED.

Weekly meetings have been in place to review the pilot, and to understand what needs to be worked on for the following week. Changes are implemented as necessary based on feedback from all teams involved. This work will continue to be evaluated on an on-going basis.

Scorecard – Acute and Emergency Medicine Division

Waitematā DHB Monthly Performance Scorecard

Acute and Emergency Medicine
September 2020
2020/21

Priority Health Outcomes

		Actual	Target	Trend
a.	Shorter Waits in ED	94%	95%	

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	7 days	≤14 days	
Net Promoter Score FFT	77	65	
Improving Outcomes			
PCI w/in 120 minutes (STEMI patients)	78%	80%	
Better help for smokers to quit - hospitalised	99%	95%	
Quality & Safety			
Older patients assessed for falling risk	100%	90%	
Rate of falls with major harm	0.03	≤2	
Good hand hygiene practice	90%	80%	
Pressure injuries grade 3&4	1	0	
HR/Staff Experience			
Sick leave rate	3.4%	≤3.4%	
Turnover rate - external	11%	≤14%	
Vacancies - %	3%	≤8%	

Service Delivery

		Actual	Target	Trend
Waiting Times				
	General Medicine - % seen w/in 120 mins	74%	85%	
	Elective coronary angiography w/in 90 days	100%	95%	
b.	Angiography for ACS w/in 72 hours	*75%*	*70%*	
c.	Chest pain clinic wait time under 6 weeks	*99%*	*80%*	
c.	O/P Transthoracic Echo wait time under 12 weeks	*32%*	*95%*	
Patient Flow				
	Elective Discharge Volumes (Cardiology)	93%	100%	
	Outpatient DNA rate	6%	≤10%	
	Patients with EDS on discharge	91%	85%	

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue excl. COVID-19	937 k	818 k	
Expenses excl. COVID-19	39,395 k	38,937 k	
Net surplus/(deficit) excl. COVID-19	-38,459 k	-38,119 k	
COVID-19 net benefit/(cost)	-291 k	0 k	
Net surplus/(deficit) incl. COVID-19	-38,750 k	-38,119 k	
Contracts (YTD)			
Elective WIES Volumes	278	333	
Acute WIES Volumes	9,612	9,425	

How to read

Performance indicators:
- Achieved/ On track
- Substantially Achieved but off target
- Not Achieved but progress made
- Not Achieved/ Off track

Trend indicators:
- ▲ Performance ***improved*** compared to previous month
- ▼ Performance ***declined*** compared to previous month
- -- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** *in grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-month period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. A small data range may result in small variations appearing to be large.

a. Data for Medicine overall
b. Quarterly, Jun 20
c. Aug 20 data, Sep n/a yet

A question?

Contact:
Victoria Child - Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz
Planning, Funding and Health Outcomes, Waitematā DHB

Scorecard Variance Report

Best Care

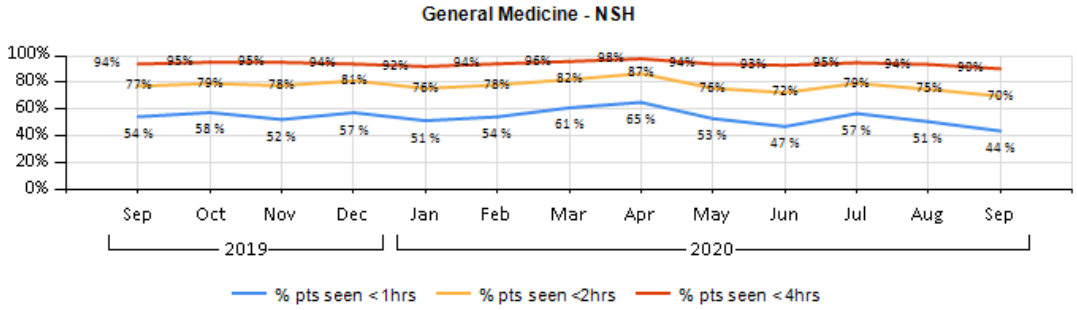
Pressure injuries grade 3&4 – 1 against a target of 0

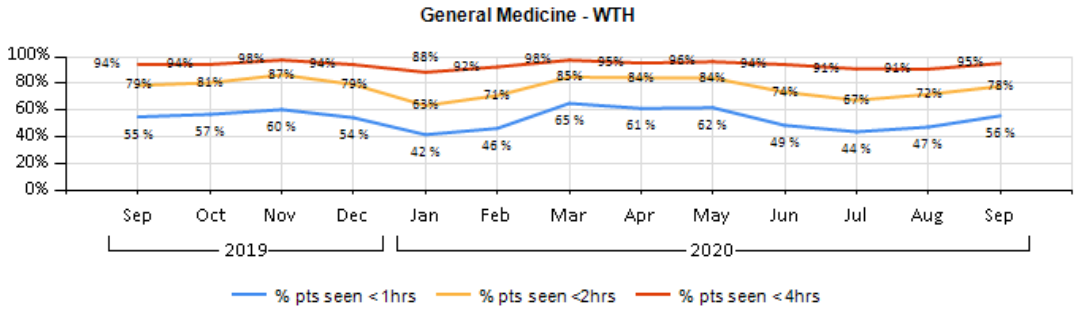
In September, Acute and Emergency Medicine reported one (1) stage 3/4/unstageable Hospital-Acquired Pressure Injury, related to a patient in Ward 10. This is the first pressure injury of this nature in 2020 for the division. Compared to previous years 2018 (22) and 2019 (5), on-going vigilance in assessment and prevention of hospital-acquired pressure injuries is still a focus for the division across North Shore and Waitakere Hospitals. Nursing representation from the division is engaged in Waitematā DHB Falls and Pressure Injury Prevention Steering and Working Group streams.

Service Delivery

General Medicine - % seen within 120 minutes of triage – 74% against a target of 85%

The time to be seen at NSH has remained the same as in the month of August. WTH continues to show a gradual improvement in the number of patients seen in under two hours with the additional registrar in ADU who is not on ward rounds producing a model similar to NSH and the additional of a Floor Manager on Monday and Tuesday morning during winter. There is an SMO present in the ADU NSH on a daily basis between 8:00am and 8:00pm to support the assessment of acute patients. Patients who wait longer than four hours are minimal and are reviewed on a daily basis. There is a noticeable increase in the time to be seen during the change of shifts and the service will continue to monitor this.

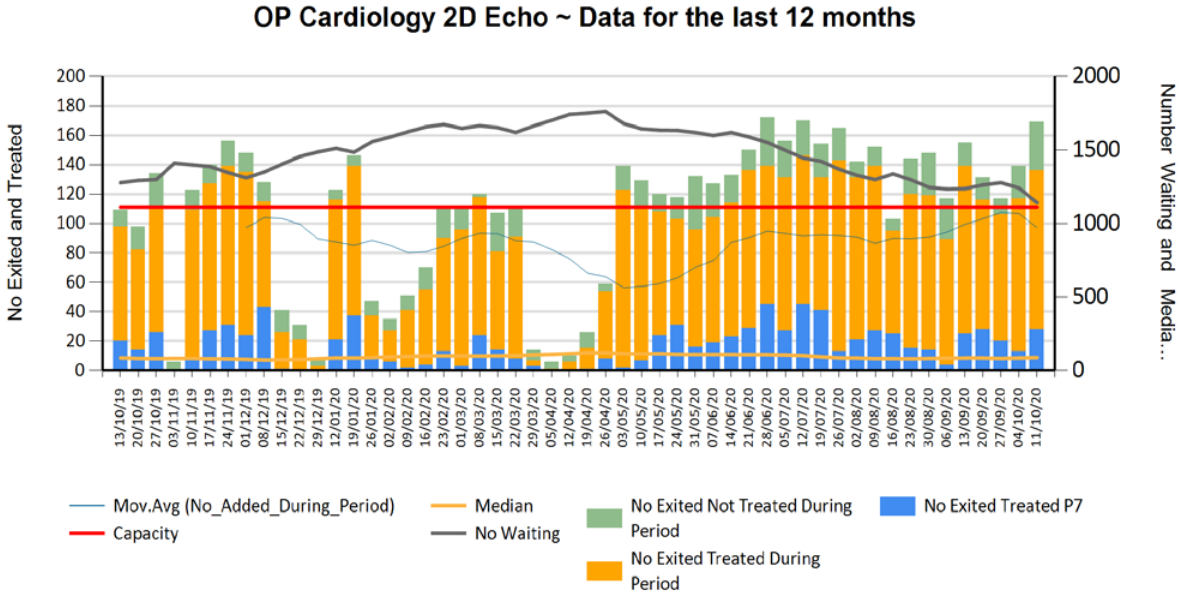




O/P Transthoracic Echo wait time under 12 weeks – 32% against a target of 95%

Various initiatives such as weekend lists have achieved temporary wait time gains. In September 32% of ECHOs were completed in outpatients within the 12-week Northern Region target. While the waiting time for P1 patients has been maintained, the median wait time for all patients is 12 weeks – an improvement in comparison to 2019 when the median was as high as 22 weeks. P2 patients are now down to 8-10 weeks.

The graph below shows the improvements made since the beginning of June, the sustained increase in productivity since production resumed in May and the continued downward trend on the waiting list, which at the beginning of October sits at 1,143.



Elective Discharge Volumes (Cardiology) – 93% against a target of 100%
The refurbishment of the Cath Lab, which commenced on the 21st September 2020 has impacted on elective volumes.

Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track	
Planned Care Actions to ensure that our population receives equitable and timely access to services in the most appropriate setting to support improved health outcomes			
Quality. Support consumers to navigate their health journeys *Acute readmissions* Establish effective outpatient management pathways and clinics for patients with heart failure and monitor the impact of this on their readmission rate	Dec 2020	Congestive Heart Failure (CHF) working group established. Data analysis of patient flows by service (ethnicity and age). Discharge check list developed.	✓
Utilise both General Medicine and Cardiology resources to support and further develop the chronic heart failure management system/clinic	Jun 2021	Focus on initial diagnosis of CHF in Maori patients and those <65. Developing process to support General Medicine admissions to facilitate early discharge and reduce admission rate.	✓
Acute Demand Actions to improve the management of patient flow and data in the Emergency Department			
Acute data capturing • Implement SNOMED coding of ED presenting complaints • Investigate and scope requirements for ED Procedures and Diagnosis codes	Jul 2019 Dec 2019		✘
Improving patient flow for admitted patients Continue to support inpatient home-based wards in Medicine in both hospitals with a focus on further improving patient flow through daily consultant-led ward rounds, daily multidisciplinary board rounds supported by daily review of patients with a length of stay (LOS) >7 days. Further enhance these processes by providing cultural support to facilitate discharge planning for Maori and Pacific patients.	On-going	Current focus on establishing a review process for patients who have had 4+ admissions in 6 months.	✓
Acute clinics Continue to develop same-day acute outpatient clinics in Medicine as an alternative to assessment in the ADU.	On-going	Daily acute clinics at NSH continue. Plan to implement daily acute SMO clinics at WTH.	✓
Establish the baseline for virtual clinics and develop a robust virtual clinic follow-up process in General Medicine.	Dec 2020	Review of General Medicine Outpatient clinics with the aim of establishing Acute Clinics (above) and developing a process for telehealth.	✓
Geriatric Medicine in ED and ADU Work with the Health Care of the Elderly to develop a system to ensure the early assessment and management of frail elderly patients	Dec 2020	Acute Care of the Elderly working group established. Data analysis of acute patient flows.	✓

DHB activity	Milestone	On Track	
presenting to the hospital to facilitate early discharge to community geriatric support or direct admission for rehabilitation.			
Acute Care of the Elderly Provide a more co-ordinated and specialised care pathway for the acute care of frail elderly (evidence suggests that this facilitates earlier discharge and shorter LOS in secondary services) • Trial Concept • Implementation	 Jul 2020 Jun 2021	Acute Care of the Elderly working group established. Data analysis of acute patient flows.	✓
Improving wait times for patients requiring Mental Health and addition services who present to ED • Implementation of a rapid assessment process for mental health patients to ensure timely assessment	Dec 2020	Bundle of care trialled and implemented for the assessment of mental health patients.	✓
• Review of current model of care to minimise patient waiting times; action at least one recommendation.	June 2021	Mental Health reviewing current model of care. Change in ED model of care for the observation of patients with behaviours of concern.	✓

Areas off track for month and remedial plans
Acute data capturing • **Implement SNOMED coding of ED presenting complaints** • **Investigate and scope requirements for ED Procedures and Diagnosis codes** There are three parts to SNOMED coding in ED the coding of presenting complaints, the coding of procedures and the coding of diagnosis. The Waitematā DHB IT service has assessed and scoped the implementation of SNOMED and have concluded that they cannot support this with the current IT tools. They have made a capital request for $400k, however funding for this IT project was not approved. Plan to link the implementation of the ED white board in July 2021.
Acute Care of the Elderly Provide a more co-ordinated and specialised care pathway for the acute care of frail elderly (evidence suggests that this facilitates earlier discharge and shorter LOS in secondary services) • Trial Concept • Acute Care of Elderly working group established – data analysis of acute patient flows.

Financial Results - Acute and Emergency Medicine

Waitematā DHB Statement of Financial Performance

Acute & Emergency Medicine - Sep-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	260	215	46	739	644	96	2,574
Other Income	57	58	(1)	198	175	23	698
Total Revenue (excluding COVID)	317	273	44	937	818	119	3,272
EXPENDITURE							
Personnel							
Medical	4,150	4,312	163	14,242	14,786	544	56,768
Nursing	5,707	5,637	(70)	17,116	17,018	(98)	75,525
Allied Health	243	240	(3)	822	831	9	3,184
Support	0	0	0	0	0	0	0
Management / Administration	534	529	(4)	1,906	1,829	(78)	6,860
Outsourced Personnel	64	137	73	488	422	(66)	1,673
	10,698	10,856	158	34,574	34,885	311	144,010
Other Expenditure							
Outsourced Services	31	38	6	88	115	28	458
Clinical Supplies	1,211	1,171	(40)	3,731	3,694	(37)	14,768
Infrastructure & Non-Clinical Supplies	344	74	(270)	1,003	243	(760)	944
	1,586	1,283	(304)	4,822	4,053	(769)	16,169
Total Expenditure (excluding COVID)	12,284	12,139	(145)	39,395	38,937	(458)	160,180
Surplus/(Deficit) excluding COVID	**(11,967)**	**(11,866)**	**(101)**	**(38,459)**	**(38,119)**	**(339)**	**(156,907)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	(146)	0	(146)	(291)	0	(291)	0
Surplus/(Deficit) including COVID	**(12,113)**	**(11,866)**	**(247)**	**(38,750)**	**(38,119)**	**(631)**	**(156,907)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Comment on major financial variances

The overall result for Acute and Emergency was $247k unfavourable for September and $631k unfavourable for the YTD.

Revenue ($44k favourable for September, $119k favourable YTD)

The favourable variance for the month was due to ACC revenue. The favourable YTD variance was due to higher ACC revenue and University of Auckland teaching.

Expenditure excluding COVID ($145k unfavourable for September, $458k unfavourable YTD)

The unfavourable variance for September was mainly due to high cost in cardiology relates to afterhours sessions for catching up the volume impacted by one of the Cath labs rebuild and saving budget. Savings from better management on patient watch activity, ED medical cover and nursing offsets adverse cost impact of COVID-19 of 291k for September YTD. The unfavourable variance for the YTD was mainly due to unmet saving target.

Personnel ($311k favourable YTD)

Medical ($544k favourable YTD)

The favourable variance was due to reduced ED medical cover cost from additional sessions and savings from skill mix in general medicine for junior doctors. Overspend on cardiology medical cost due to high activity level had offset some savings from other areas.

Nursing ($98k unfavourable YTD)

The unfavourable variance was due to high ED and ADU nursing cover and watch cost across the division. Extra nursing staff deployed at North Shore Hospital ED and ADU since COVID level 3 in September. In addition, as a

longer term COVID-19 impact has imposed on extra cost pressure on the areas of accumulated annual leave and additional safety measures implemented in some areas caring for COVID-19 patients.

Allied Health ($9k favourable YTD)

Support and Management/Administration ($78k unfavourable YTD)
The unfavourable variance was due to high sick leave cover in ED.

Outsourced Personnel ($66k unfavourable YTD)
The unfavourable variance was due to lower external bureau cost adjusted for COVID impact.

Other Expenditure ($769k unfavourable YTD)
Outsourced Services ($28k favourable YTD)

Clinical Supplies ($37k unfavourable YTD)
The unfavourable variance was due to high cardiology catheter and implant costs.

Infrastructure and Non-Clinical Supplies ($760k unfavourable YTD)
The unfavourable variance was due to unmet saving target.

COVID-19 impact
Total COVID-19 impact (291k for YTD):
There was extra cover cost for staff that stood down or was under self-isolation for various reasons due to COVID. Additional RN and HCAs have been deployed at NSH ED, ADU, ward 10 and ward 11 since August incurring extra nursing cost. In addition, COVID-19 restrictions on travels have caused big increase on accumulated annual leave balance. Clinical supplies for face masks, protective clothing and related products also increased during last few months. A breakdown by account group as follows:

EXPENDITURE	
Personnel	
Medical	360
Nursing	107
Allied Health	18
Support	0
Management / Administration	(46)
Outsourced Personnel	(172)
	268
Other Expenditure	
Outsourced Services	24
Clinical Supplies	0
Infrastructure & Non-Clinical Supplies	0
	24
COVID Expenses	291
COVID-19 Net benefit/(cost)	**(291)**

Specialty Medicine and Health of Older People Division

Service Overview

This Division is responsible for the provision of medical sub-specialty and health of older people services. This includes respiratory, renal, endocrinology, stroke, dermatology, haematology, diabetes, rheumatology, infectious diseases, medical oncology, neurology, gastroenterology, smoke-free, fracture liaison services and Older Adults and Home Health, which in turn includes palliative care, geriatric medicine, district nursing, EDARS (early discharge and rehabilitation service), needs assessment and service coordination, the specialist gerontology nursing service Nga Kaitiaki Kaumatua, Mental Health Services for Older Adults, and the AT&R wards. The division also includes the Medicine patient service centre. Allied Health provides clinical support across (inpatient, outpatient and community services) across the Acute and Emergency Medicine Division, Specialty Medicine and Health of Older People Division and Surgical and Ambulatory Service and reports to the General Manager Specialty Medicine and Health of Older People.

The service is managed by Dr Willem Landman, Head of Division, and Brian Millen, General Manager. Melody-Rose Mitchell is the Associate Director of Nursing Acute and Emergency Medicine and Specialty Medicine and Health of Older People. The Clinical Directors are Dr Cheryl Johnson for Geriatric Medicine, Dr Sachin Jauhari for Psychiatry for the Older Adult, Dr Moira Camilleri for Palliative Care, Dr Stephen Burmeister for Gastroenterology, Dr Simon Young for Diabetes/Endocrinology, Dr Naveed Ahmed (Acting) for Renal, Dr Megan Cornere for Respiratory, Dr Eileen Merriman for Haematology, Dr Nicholas Child for Stroke, Dr Matthew Rogers for Infection, Dr Blair Wood for Dermatology and Dr Michael Corkill for Rheumatology.

Highlight of the Month

Implementation of the new Colonoscopy Surveillance Guidelines

The Waitematā DHB Gastroenterology Service began work early this year during the first lockdown to proactively review the revised British Society of Gastroenterology, Association of Coloproctology of Great Britain and Ireland and Public Health England (BSG/ACPGBI/PHE) Post-polypectomy and post-colorectal cancer resection surveillance guidelines. This updated the high risk criteria for future colorectal cancer following high quality colonoscopy with polypectomy and the resultant surveillance interval required.

With input this year from Waitematā DHB gastroenterologists and colorectal surgeons this was adopted with slight modifications as the New Zealand national guidelines from September 2020. The key recommendations are that after high quality colonoscopy, most patients with one or two small adenomas can wait five more years for surveillance colonoscopy (i.e. a total of ten years). Secondly, the threshold for high risk patients now requires ten or more polyps; which greatly reduces the one and two year surveillance cases. Given the potential for reducing the frequency that people needed to be brought back into hospital, these guidelines were reviewed against patients on the Waitematā colonoscopy surveillance waitlist. The adoption of these revised guidelines was subsequently endorsed by the Waitematā DHB Endoscopy User Group (EUG) for action.

The correct surveillance interval still depends on a number of factors such as previous cancer history, number of polyps, size of polyps, histology of polyps, bowel preparation, family history and more. Initially, we needed our Gastro Fellows to manually compile all of this information into an Excel spreadsheet which was slow and labour intensive. The service allocated time for Dr Marius van Rijnsoever, Gastroenterologist, who developed a Qlik application (app) to combine patient, endoscopy and waitlist data as well as pathology reports and Privation data to allow for re-grading against the new guidelines. This included, for the first time, information on prior outsourced and private colonoscopies. The aim was to allow for effective review of colonoscopy interval timeframes retrospectively and also to be able to apply correct surveillance intervals prospectively.

In terms of impact, the conservative estimate is that, of the total 10-year current colonoscopy waiting list of over 10,000 patients will reduce by around 1,000 patients. Two thousand patients will also need less frequent

monitoring. This equates to approximately a 10% reduction in demand for surveillance colonoscopy over the next 1-3 years.

Key Issue

Respiratory Monoclonal Antibodies

Respiratory patients with Severe Refractory Eosinophilic Asthma require lifelong treatment of Respiratory Monoclonal Antibodies (MABs) via sub cutaneous injection to control their asthma symptoms. These respiratory MABs block various allergic pathways that prevent the development of symptoms.

Prior to April of this year, there were only a handful of patients in New Zealand with access to Respiratory MABs (Omalizumab) on compassionate grounds as this medication was not approved by Pharmac. In April both Omalizumab and Mepolizumab were added to the Pharmac register and since then, numbers of patients approved for use on these medications have been slowly but steadily increasing.

Mepolizumab is an extremely important asthma medication for the treatment of the most severe asthma patients. Its use can dramatically improve the lives of the most severe patients, reducing their risk of life-threatening attacks resulting in hospital admission, and reducing their requirement for long term oral steroids. Both of these drugs are administered via a sub-cutaneous injection. Mepolizumab (Mepo) is given as a single injection monthly. Omalizumab requires multiple injections fortnightly.

Scorecard – Specialty Medicine and Health of Older People Services

Waitematā DHB Monthly Performance Scorecard

Specialty Medicine and Health of Older People

September 2020

2020/21

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	8 days	≤14 days	
Net Promoter Score FFT	85	65	
Improving Outcomes			
a. Patients admitted to stroke unit	*71%*	*80%*	
a. Acute Stroke to rehab w/in 7 days	*38%*	*80%*	
b. InterRAI assessments - LTHSS clients	*98%*	*95%*	
Better help for smokers to quit - hospitalised	100%	95%	
Quality & Safety			
Older patients assessed for falling risk	93%	90%	
Rate of falls with major harm	0	≤2	
Good hand hygiene practice	89%	80%	
Pressure injuries grade 3&4	1	0	
HR/Staff Experience			
Sick leave rate	3.1%	≤3.4%	
Turnover rate - external	9%	≤14%	
Vacancies - %	3%	≤8%	

Service Delivery

	Actual	Target	Trend
c. **Waiting Times**			
Urgent diagnostic colonoscopy w/in 14 days	*96%*	*90%*	
Diagnostic colonoscopy w/in 42 days	*41%*	*70%*	
Surveillance colonoscopy w/in 84 days	*44%*	*70%*	--
Patient Flow			
Outpatient DNA rate	6%	≤10%	
Patients with EDS on discharge	90%	85%	

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue excl. COVID-19	2,834 k	2,410 k	
Expenses excl. COVID-19	26,380 k	25,965 k	
Net surplus/(deficit) excl. COVID-19	-23,546 k	-23,555 k	
COVID-19 net benefit/(cost)	-637 k	0 k	
Net surplus/(deficit) incl. COVID-19	-24,183 k	-23,555 k	
Contracts (YTD)			
Elective WIES Volumes	131	127	
Acute WIES Volumes	690	618	

How to read

Performance indicators:
- Achieved/ On track
- Substantially Achieved but off target
- Not Achieved but progress made
- Not Achieved/ Off track

Trend indicators:
- Performance ***improved*** compared to previous month
- Performance ***declined*** compared to previous month
- -- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in *grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-month period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. A small data range may result in small variations appearing to be large.

a. Aug 2020 - coding dependent
b. Quarterly Dec 19 latest data
c. Aug data, Sep n/a yet

A question?

Contact:
Victoria Child - Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz
Planning, Funding and Health Outcomes, Waitematā DHB

Scorecard Variance Report

Best Care

Patients admitted to Stroke unit *– 71% against a target of 80%*

For the month of August, 71% of patients (46 out of 65) admitted with an acute stroke were admitted to our Stroke wards. A clinical review of the nineteen patients that were not admitted to a stroke ward has been completed.

Following clinical review by our Stroke CNS team and Clinical Lead, seven of the nineteen patients identified in our reporting were found to not have been admitted for stroke. These were included in the data as a result of inaccurate discharge summaries, or identification of historical strokes during patient's admission. Excluding these patients would increase our percentage compliance to 79% for the month of August 79% against our target of 80% (46 out of 58). We are working with Clinical Coding to get the coding amended.
Of the remaining twelve patients who did not get admitted to a Stroke ward; five were discharged within 2 days, two were admitted to non-stroke wards for specialised input (cardiology and psychiatry), two were admitted to ward 11 for infection control purposes, one patient required End of Life cares, and one patient had a minor stroke post op and was not referred to our service.

Acute Stroke to rehab with-in seven days *– 38% against a target of 80%*

For the month of August, 37.5% of patients (6 out of 16) with an acute stroke were transferred to rehab within seven days. A clinical review of the ten patients that did not make it to rehab within seven days has been completed.

Following clinical review by our Stroke CNS team and Clinical Lead we identified three patients had evolving strokes during their admission and three patients were medically unwell which resulted in both groups experiencing delayed transfers to rehabilitation; two patients had strokes whilst inpatients which affects the calculation of time to be transferred to rehabilitation; and one patient was originally planned for discharge to Early Discharge and Rehabilitation Service (EDARS) however, this then changed to inpatient rehabilitation resulting in a delay in transfer. For the last patient, there was no one obvious factor that appeared to contribute to their delay and they were transferred on day eight of their admission.

Pressure injuries (PI) grade 3&4 *– 1 against a target of 0*

Relates to PI unstageable on Muriwai ward which is under investigation. The ward has introduced an admission checklist to ensure assessments are done upon admission and appropriate interventions implemented.

Service Delivery

Diagnostic colonoscopy within 42 days *– 41% against a target of 70%*

While the target was not met in terms of compliance against the indicators, the total number of people waiting for their colonoscopy (non-urgent and surveillance) was ahead of the recovery trajectory forecast in our improvement action plan, i.e.:

- 1 July: forecast 2815, actual 2611
- 1 August: forecast 2952, actual 2652
- 1 September: forecast 2932, actual 2780

Surveillance colonoscopy with-in 84 days *– 44% against a target of 70%*

As above

Compliance with patient safety checks in Adult Mental Health Ward

Thirteen clinical notes were randomly audited throughout from 1-30 September. The need for safety checks was correctly documented in all cases and all current risk assessments were up to date.

Deliverable/Action	On Track
Patients admitted to Stroke unit target 80%	✘
Acute Stroke to rehab with-in 7 days target of 80%	✘
Diagnostic colonoscopy with-in 42 days target of 70%	✘
Surveillance colonoscopy with-in 84 days	✘
Compliance with patient safety checks in Adult Mental Health Ward	✓

Areas off track for month and remedial plans

Stroke:
Our Clinical Lead continues to work with Clinical Coding to try and address issues with coding errors and our Stroke Nurse Specialists continue to work closely with Duty Nurse Managers on a daily basis to ensure patients who have experience a stroke receive their care on one of our dedicated Stroke wards.

Colonoscopy:
The initiatives outlined in our last report have been successfully actioned, including:

- 2019/20 outsourced contracts were extended through to November 2020
- A proposal was submitted to Audit and Finance on 21 October requesting outsourcing continues through to July 2021
- Internal production continues at the level planned for 2019/20
- Additional internal sessions are on track to deliver an extra 300 colonoscopies
- We have implemented the new national surveillance guidelines that we believe will reduce or defer demand by up to 1000 colonoscopies in 2020/21

Financial Results – Specialty Medicine and Health of Older People

Waitematā DHB Statement of Financial Performance

Specialty Medicine and HOPS - Sep-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	714	739	(25)	2,432	2,217	215	8,838
Other Income	124	65	60	403	194	209	774
Total Revenue (excluding COVID)	839	803	35	2,834	2,410	424	9,612
EXPENDITURE							
Personnel							
Medical	1,834	1,839	5	6,282	6,365	83	24,541
Nursing	2,345	2,507	162	7,136	7,540	404	33,562
Allied Health	1,871	1,745	(126)	6,431	6,106	(325)	22,254
Support	0	0	0	0	0	0	0
Management / Administration	345	338	(7)	1,145	1,184	38	4,299
Outsourced Personnel	23	48	25	144	147	3	582
	6,418	6,477	59	21,138	21,341	203	85,238
Other Expenditure							
Outsourced Services	377	447	69	1,339	1,345	6	5,373
Clinical Supplies	1,084	1,019	(64)	3,129	3,130	1	12,420
Infrastructure & Non-Clinical Supplies	272	49	(223)	774	149	(625)	551
	1,733	1,515	(218)	5,242	4,624	(618)	18,345
Total Expenditure (excluding COVID)	8,151	7,992	(159)	26,380	25,965	(415)	103,583
Surplus/(Deficit) excluding COVID	**(7,312)**	**(7,189)**	**(123)**	**(23,546)**	**(23,555)**	**9**	**(93,971)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	(149)	0	(149)	(637)	0	(637)	0
Surplus/(Deficit) including COVID	**(7,461)**	**(7,189)**	**(273)**	**(24,183)**	**(23,555)**	**(628)**	**(93,971)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Comment on major financial variances

The overall result for Specialty Medicine and Health of Older People Division was $273k unfavourable for September and $628k unfavourable for the YTD once COVID-19 impacts are taken into account.

Revenue ($35k favourable for September, $424k favourable YTD)

The September revenue result is driven by additional research revenue to cover research costs, and YTD the favourable result contains both research revenue as well as additional gastro revenue carried over from FY19/20. This is partly being offset by lower numbers of bed nights qualifying for reimbursement from ACC under the Non-Acute Rehab contract, due to admitting much fewer patients from interim care services back to the hospital for rehab. The YTD revenue result would be negatively impacted by $279k as ACC's July and August revenue is also down from lower demand as we recover slowly from the COVID-19 lockdown impacts, and this is reported in the under extraordinary COVID-19 impacts.

Expenditure ($159k unfavourable for September, $415k unfavourable YTD)

The unfavourable variance for September was due to allied personnel which, due to improved retention and recruitment, have vacancies below the churn savings target level and also due to lower leave taken due COVID-19. The YTD unfavourable result is also due to the allied churn pressure, as well as a partially unmet savings target allocated to the service.

Personnel ($203k favourable YTD)

Medical ($83k favourable YTD)

The YTD favourable medical variance is mainly due to a slight underspend in allowances in July, as well as vacancies. In reality, this result is worsened due to an annual leave taken deficit YTD of $80k which is at least partially attributable to the COVID-19 environment. This figure is included and reported in the COVID-19 extraordinary cost line above.

Nursing ($404k favourable YTD)
The YTD favourable nursing variance is mainly due to savings in Ward 15, with nursing staff redeployed across the hospital whilst there are 24 beds closed in this ward. This result is negatively impacted due to an annual leave taken deficit YTD of $125k which is at least partially attributable to the COVID-19 environment. This figure is included and reported in the COVID-19 extraordinary cost line above.

Allied Health ($325k unfavourable YTD)
The YTD unfavourable variance for allied was mainly due to improved retention and recruitment, with vacancies now below the churn savings target level, worth ($200k). There was also a couple of one off back payments for allied staff to correct a pay error spanning across a few years in August ($80k). This result is negatively impacted due to an annual leave taken deficit YTD of $81k which is at least partially attributable to the COVID-19 environment. This figure is included and reported in the COVID-19 extraordinary cost line above.

Support and Management/Administration ($38k favourable YTD)
Support and Management/Administration is largely on budget, but the slight favourable figure was adjusted to take into account the annual leave taken deficit YTD of $72k which is reported in the COVID-19 extraordinary cost line, and would leave this professional group slightly unfavourable to budget.

Outsourced Personnel ($3k favourable YTD)
Outsourced Personnel is on budget YTD.

Other Expenditure ($618k unfavourable YTD)

Outsourced Services ($6k favourable YTD)
Outsourced services are on budget YTD.

Clinical Supplies ($1k favourable YTD)
Clinical Supplies in on budget YTD.

Infrastructure and Non-Clinical Supplies ($625k unfavourable YTD)
The YTD unfavourable infrastructure and non-clinical supplies is mainly due to the savings target allocated to the service, partially met in other areas above, worth ($475). There are also expenses relating to research which are offset by additional revenue ($146k).

Extraordinary impacts COVID-19 ($637k unfavourable YTD)
As broken down in account groups above, this is a combination of lost ACC revenue, and annual leave taken deficits in all personnel groups.

Child, Woman and Family Services

Service Overview

This Division is responsible for the provision of maternity, obstetrics, gynaecology and paediatric medicine services for our community, for the regional Out of Home Children's Respite Service, the Auckland Regional Dental Service (ARDS), and the national Child Rehabilitation Service. Services are provided within our hospitals, including births, outpatient clinics and gynaecology surgery, and within our community, e.g. community midwifery, mobile/transportable dental clinics and the Wilson Centre.

The service is managed by Dr Meia Schmidt-Uili, Division Head and Stephanie Doe, General Manager. Head of Division Nursing is Marianne Cameron, Director of Midwifery is Emma Farmer and Head of Division Allied Health is Susan Peters. The Clinical Directors are Dr Christopher Peterson for Child Health, Dr Diana Ackerman for Women's Health and Dr Kirsten Miller (acting) for ARDS.

Highlight of the Month

Connected – Development of Snoezelen at the Wilson Centre

The play specialists at the Wilson Centre have successfully undertaken training and established a designated Snoezelen room and programme for children to access. The development of the room, including the purchase of equipment, has been enabled through donations received from families/whānau.

A Snoezelen (or controlled multisensory environment) is a therapy, which is used with children with disabilities. It is designed to reduce anxiety and promote relaxation. The room has been specially designed to deliver stimuli to the various senses; using lighting effects, colour, sounds, music and touch. Each session is carefully tailored to the individual child's need and is aimed at evoking pleasant memories and experiences, distracting the child from stressors and promoting well-being and connections. This in turn, has a positive impact on the holistic care provided to children and whānau.

Feedback to date from children, families/whānau and staff has been very positive and an official opening took place on 30 October. This provided an opportunity to thank the families and other donors for the contributions that enabled this initiative.

Key Issues

Increased Maternity and Neonatal Demand

Both Maternity and the Special Care Baby Units (SCBUs) have been experiencing a period of high demand. Whilst it is usual to have demand peaks and troughs in these services, through August, September and October there has been unprecedented demand for beds.

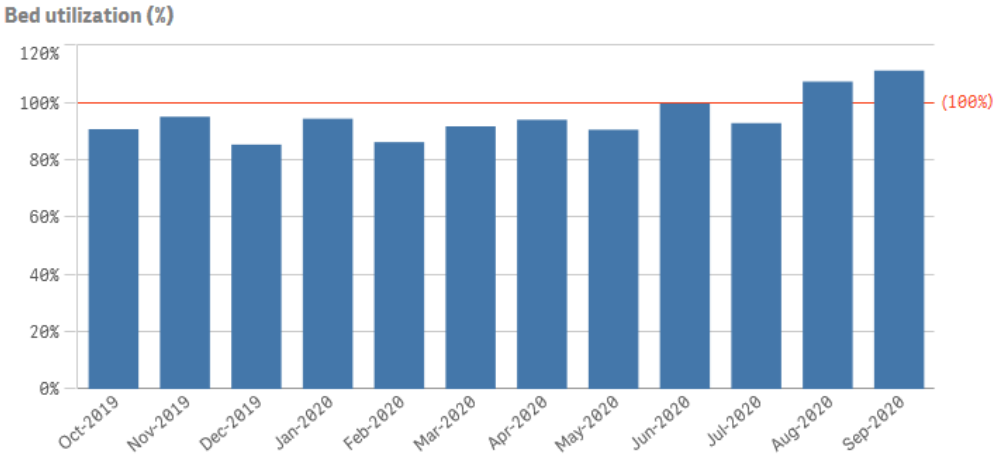


Figure: Bed utilisation in Birthing Suite at North Shore Hospital

For the past three months ,the average capacity in the birthing unit on a day shift at North Shore has been over 100% occupancy. The recommended occupancy rate for a Maternity unit is 75% (as this enables capacity for the unpredictable labour admissions). As a result, at times elective inductions and caesarean sections have had to be delayed. Seasonally, we would generally expect a peak in births during September/October, and anticipate that the surge will subside by November.

Similarly, the SCBUs have also experienced high demand – and across both units the average occupancy has been 100% over the last two months. There is no agreed safe level of occupancy of neonatal units in New Zealand, however, it is a widely held view that the units operate most effectively at an occupancy of 85-90%.

There has been a steady increase of cot occupancy over time – from an average of 15 cots (63% occupancy) to an average of 21 (88% occupancy) year to date in 2020.

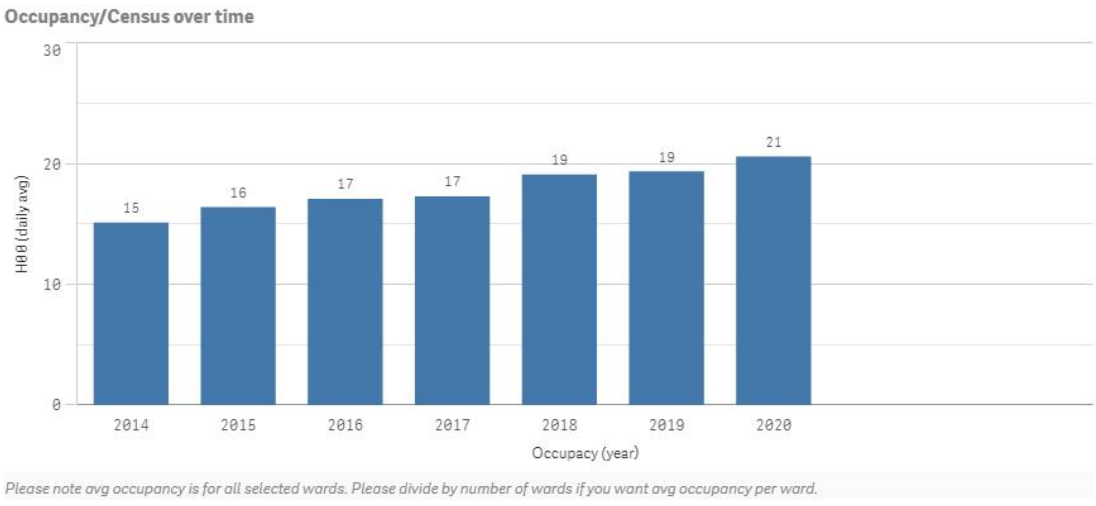


Figure: average neonatal cot occupancy

As demonstrated in the graph below, the average length of stay for October is markedly higher than the previous two months.

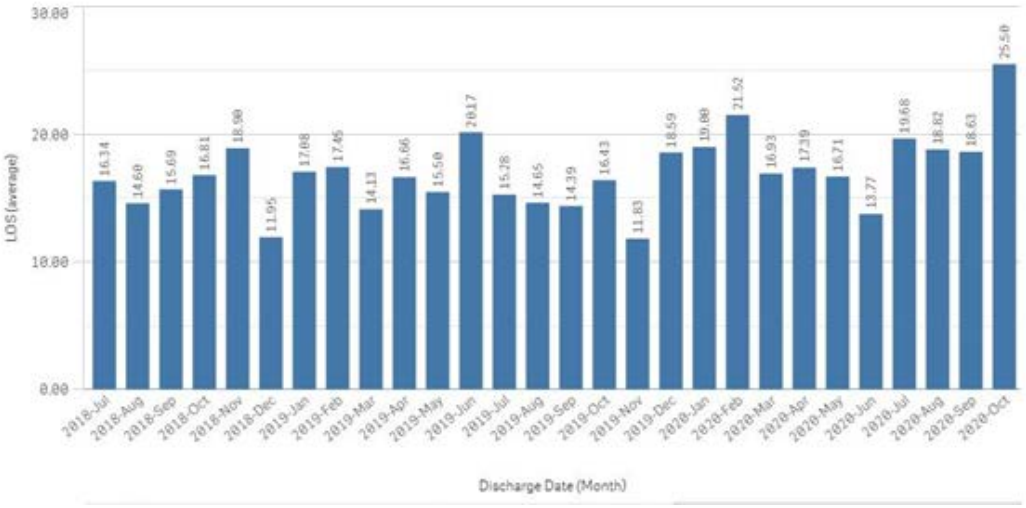


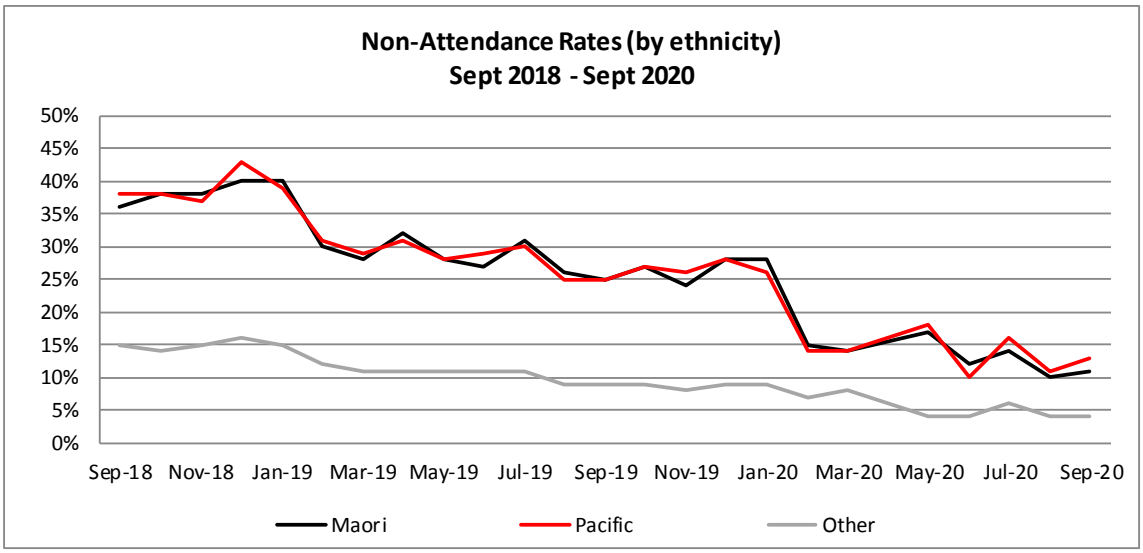
Figure: Neonatal average length of stay

Both services are continuing to manage demand on a shift-by-shift basis and prioritise clinical work. Where appropriate, additional capacity has been provided by other areas within the hospital.

Update: COVID-19 recovery work underway

The Auckland Regional Dental Service (ARDS) has been continuing to focus on supporting children to attend their oral health appointments. This has included engaging with families/whānau to understand the barriers to care, implementing new whānau-focused booking practices and updating all communication to ensure that the language used is appropriate and strengths-based.

As demonstrated in the graph below, the service has seen an on-going improvement in attendance rates across all ethnicities. There has also been a reduction in the gap between Māori/Pacific children and children of other ethnicities. Specifically, in January 2018 non-attendance rates for Māori and Pacific children were 23% higher than rates for children of other ethnicities. In September 2020, rates were 8% higher.



Scorecard – Child, Women and Family Services

Waitematā DHB Monthly Performance Scorecard

Child Women and Family Services

September 2020

2020/21

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	98%	95%	▲

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	9 days	≤14 days	▲
Net Promoter Score FFT	82	65	▲
Improving Outcomes			
Exclusive breastfeeding on discharge	78%	75%	▲
Women smokefree at delivery	93%	95%	▼
Better help for smokers to quit - hospitalised	100%	95%	--
a. Oral health - % infants enrolled by 1 year	90%	95%	--
a. Oral health - exam arrears 0-12 yr	61%	≤10%	▼
Quality and Safety			
Good hand hygiene practice	89%	80%	▼
HR/Staff Experience			
Sick leave rate	3.6%	≤3.4%	--
Turnover rate - external	9%	≤14%	▲
Vacancies - %	6%	≤8%	▼

Service Delivery

	Actual	Target	Trend
Elective Volumes			
CWF Services	97%	100%	▼
Waiting Times			
Gateway referrals waiting over 8 weeks	40	5	▼
Patient Flow			
Outpatient DNA rate	7%	≤10%	▲
Theatre utilisation Gynaecology	83%	85%	▲
Patients with EDS on discharge	89%	85%	▲
a. Oral Health - chair utilisation	6.7	11	▼

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue excl. COVID-19	2,776 k	2,681 k	▲
Expenses excl. COVID-19	18,021 k	17,910 k	▼
Net surplus/(deficit) excl. COVID-19	-15,245 k	-15,229 k	▲
COVID-19 net benefit/(cost)	-153 k	0 k	▼
Net surplus/(deficit) incl. COVID-19	-15,398 k	-15,229 k	▲
Contracts (YTD)			
Gynaecology Elective WIES (excl ESC)	308	331	▼
Gynaecology Acute WIES	351	360	▼
Maternity WIES	1,834	2,109	▲
Paediatrics WIES	264	462	▲
Neonatal WIES	620	612	▼

How to read

Performance indicators:

- Achieved/ On track
- Substantially Achieved but off target
- Not Achieved but progress made
- Not Achieved/ Off track

Trend indicators:

- ▲ Performance ***improved*** compared to previous month
- ▼ Performance ***declined*** compared to previous month
- -- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in *grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-month period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. A small data range may result in small variations appearing to be large.

a. Oral health data - Total WDHB, ADHB and CMDHB, DHB of service. 2019 updated census (2013) population projections from Jan 20 onwards significantly reduce population to be enrolled, resulting in increased enrolment coverage compared with 2019.

A question?

Contact:

Victoria Child - **Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz**

Planning, Funding and Health Outcomes, Waitematā DHB

Scorecard Variance Report

Best Care

Oral health % infants enrolled by 1 year *– 90% against a target of 95%*

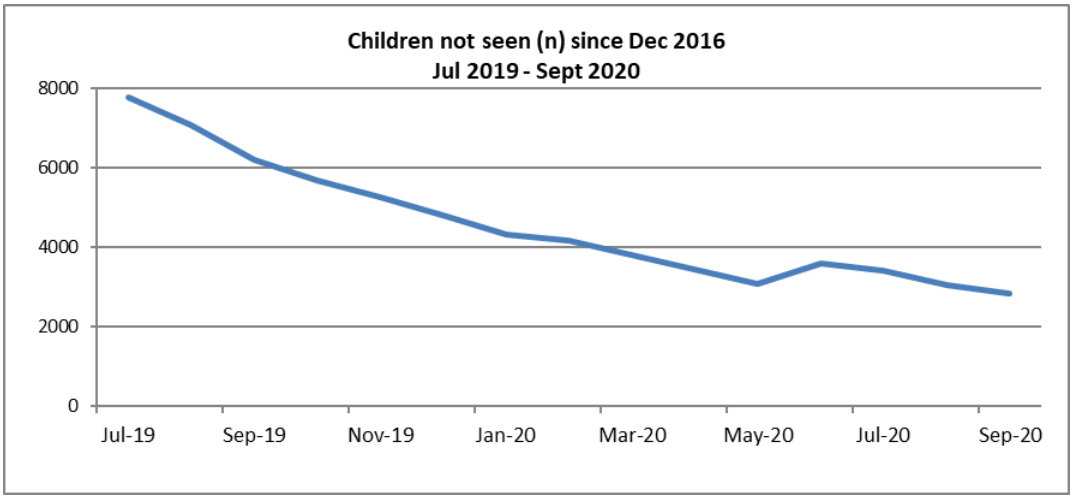
The service has undertaken a data matching exercise to understand why the infant enrolment target is not being met, when babies are enrolled from automated birth lists. To date, infants enrolled with ARDS has been compared with those who are enrolled with the National Immunisation Register. This showed that the data sets are consistent. The service is now working with the Northern Child Health Information Platform (NCHIP) team to ensure that there is also consistency between these two data sets.

Oral health – exam arrears 0-12yrs *– 61% against a target of ≤10%*

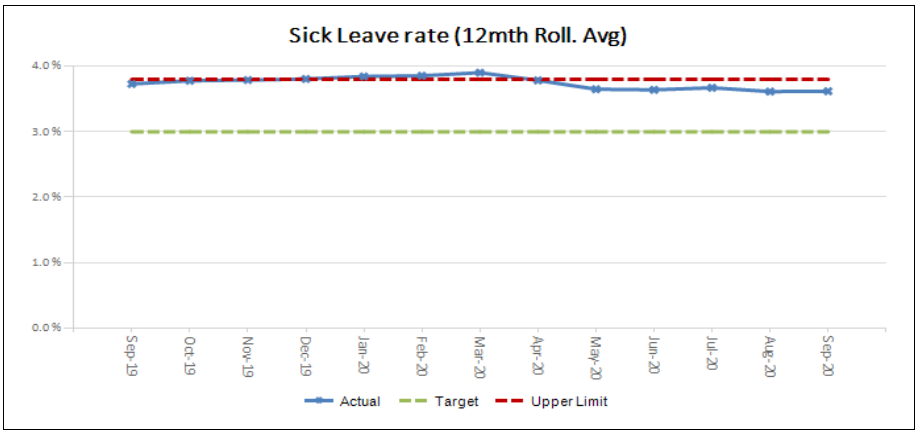
As previously reported, the service continues to experience challenges with rising arrears following the significant service disruption during Alert Level three and four (where Dental Council guidance directed that no routine oral health care services could be provided). In total, the service has lost ten weeks of clinical service provision as a result of the pandemic.

A plan has been developed, which focuses on improving service performance, without further exacerbating oral health inequities. This is currently being implemented and progress is being monitored weekly.

Positive results are being seen, as demonstrated in the graph below, the service has made significant progress with reducing the number of long waiting children (those not seen by the service since December 2016). Further progress has been made over October - at the time this report was being prepared there are 2,441 long waiting children. This is a reduction of 5,321 children since 31 July 2019.



Sick leave rate *– 3.6% against a target of ≤3.4%*
Sick leave remains static at 3.6% and below the upper limit.



Service Delivery
Gateway referrals waiting over 8 weeks *– 40 against a target of 5*
The Gateway service had an increase of referrals over September. On average, the service receives 25 new referrals a month. In September, 48 referrals were received. Extra clinic sessions are currently being held to reduce the number of children waiting.

Oral health – chair utilisation *– 6.7 against a target of 11*
Additional infection prevention and control measures (required by Dental Council) and the completion of pre-screening of all children has impacted on service productivity.

The pre-screening requirement has also meant the service has been unable to operate its usual model of care (seeing children at school without prior contact with a parent/caregiver). This has also impacted on productivity, as the service has not been able to proactively offer children attending school unscheduled appointments.

Strategies to maximise chair utilisation, within the current constraints, have been identified. These include centralising some tasks in order to reduce the administrative workload in clinics.

Value for Money

Gynaecology Elective WIES *– 303 against a target of 331*

There was a reduction in elective Gynaecology WIES delivered during September (80% to contract). However, the service is on track with the surgical health target (103% year to date) and has delivered additional lists to reduce the number of women waiting (post COVID-19).

Maternity WIES *– 1,834 against a target of 2,109*

It is continues to be unclear why Maternity WIES is below target, particularly given the high demand for the service over September. The issue is currently being investigated with support from the Information Systems team.

Paediatric WIES *– 264 against a target of 462*

There continues to be unseasonably low demand for acute paediatric inpatient care. This is thought to be attributed to physical distancing measures and lockdown, which has reduced the spread of respiratory illnesses amongst children over recent months.

Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Work with the National Midwifery Accord (NMA) group to implement additional clinical coach roles to support the transition of undergraduate midwives to employed practice. Develop position descriptions and agree ratio of coaches to midwives with National Midwifery Leaders group and TAS.	Jul 2021	×
Appoint coaches in line with new graduate intake	Apr 2021	✓
Work with the NMA group to implement greater wrap-around support for Māori and Pacific undergraduate students (EOA) Agree package of support with midwifery education providers, DHB midwife leaders and MoH working group Implement support packages	Feb 2021	×

Areas off track for month and remedial plans
The clinical coach position description is still in development with NMA group. The NMA group is yet to agree on the package of support.

Financial Results - Child, Women and Family Services

Waitematā DHB Statement of Financial Performance

Regional Dental - Sep-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	0	7	(7)	0	22	(22)	87
Other Income	46	44	3	130	131	(1)	525
Total Revenue (excluding COVID)	46	51	(5)	130	153	(23)	612
EXPENDITURE							
Personnel							
Medical	64	74	9	209	260	50	996
Nursing	0	0	0	(14)	0	14	0
Allied Health	1,525	1,624	100	5,244	5,763	519	21,099
Support	0	0	0	(1)	0	1	0
Management / Administration	70	86	16	236	301	65	1,109
Outsourced Personnel	0	0	0	0	0	0	0
	1,659	1,784	125	5,674	6,323	649	23,205
Other Expenditure							
Outsourced Services	0	0	0	2	1	(0)	5
Clinical Supplies	242	267	25	653	815	162	3,231
Infrastructure & Non-Clinical Supplies	179	137	(42)	597	421	(176)	1,663
	421	404	(16)	1,252	1,237	(14)	4,899
Total Expenditure (excluding COVID)	2,080	2,188	108	6,926	7,561	634	28,104
Surplus/(Deficit) excluding COVID	**(2,033)**	**(2,137)**	**104**	**(6,797)**	**(7,408)**	**611**	**(27,492)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	74	0	74	59	0	59	0
Surplus/(Deficit) including COVID	**(1,960)**	**(2,137)**	**178**	**(6,738)**	**(7,408)**	**670**	**(27,492)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Waitematā DHB Statement of Financial Performance

Child Woman and Family - Sep-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	893	819	75	2,527	2,456	70	9,355
Other Income	79	75	4	249	225	25	898
Total Revenue (excluding COVID)	973	894	79	2,776	2,681	95	10,253
EXPENDITURE							
Personnel							
Medical	1,449	1,532	83	5,232	5,355	124	20,573
Nursing	2,365	2,437	72	7,239	7,482	243	33,433
Allied Health	579	593	14	2,090	2,147	57	7,713
Support	23	24	0	74	83	9	338
Management / Administration	344	361	17	1,139	1,265	127	4,578
Outsourced Personnel	196	107	(89)	535	329	(206)	1,306
	4,958	5,054	97	16,308	16,662	353	67,941
Other Expenditure							
Outsourced Services	28	45	17	150	137	(14)	542
Clinical Supplies	410	288	(122)	950	888	(62)	3,540
Infrastructure & Non-Clinical Supplies	216	76	(140)	612	224	(389)	850
	654	408	(245)	1,713	1,248	(464)	4,932
Total Expenditure (excluding COVID)	5,612	5,463	(149)	18,021	17,910	(111)	72,873
Surplus/(Deficit) excluding COVID	**(4,639)**	**(4,569)**	**(70)**	**(15,245)**	**(15,229)**	**(16)**	**(62,620)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	38	0	38	(153)	0	(153)	0
Surplus/(Deficit) including COVID	**(4,601)**	**(4,569)**	**(31)**	**(15,398)**	**(15,229)**	**(169)**	**(62,620)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Comment on major financial variances

The overall result for Child, Women and Family and Regional Dental was $147k favourable for September and $501k favourable for the YTD.

Revenue ($75k favourable for September , $72k favourable YTD)

The favourable variance for September and YTD was attributed to backdated Service Level Agreement funding for the Child Development Services Expansion Programme . This 2019/20 programme has been extended into 2020/21.

Expenditure ($41k unfavourable for September, $523k favourable YTD)

The unfavourable variance for September was due to increased neonatal ambulance charges and higher medical locum costs. The YTD favourable position was partly driven by dental supplies due to reduced service delivery, public health nursing staff redeployment to the Auckland Regional Public Health Service and reduced paediatric inpatient ward staff and supplies costs. Cost pressures remain across neonatal services with high admissions and increased acuity levels. Obstetrics and Gynaecology and Paediatric medical staffing and outsourcing costs are trending higher than normal due to high sick leave, low annual leave and external locum costs. Neonatal admission and acuity demand tracks at 103% of contracted CWD. This WIES figure is being influenced by a long length of stay and is likely to be higher than actually reported.

Personnel ($1,002k favourable YTD)

Medical ($174k favourable YTD)

The favourable medical variance is due to vacancies across Obstetrics and Gynaecology and ARDS. This is partly offset by high sick leave, allowances, reduced annual leave and timing of professional membership payments.

Nursing ($257k favourable YTD)

The favourable variance was due to a combination of reduced acute paediatric inpatient demand that has enabled staff to take annual leave or be redeployed to other areas, delays in newly funded nursing activities and several midwifery vacancies across Maternity services. Partially offsetting this are neonatal nursing cost pressures due to increased admissions and higher levels of acuity.

Allied Health ($576k favourable YTD)
The favourable variance was primarily due to ongoing therapist and therapy assistant vacancies across ARDS. An ongoing focus on improving recruitment and retention has enabled to service to increase its staffing levels by 7% and hold this since the last new graduate recruitment in January/February 2020.

Support and Management/Administration ($202k favourable YTD)
The favourable variance was due to vacancies across the division.

Outsourced Personnel ($206k unfavourable YTD)
The unfavourable variance was due to Obstetrics and Gynaecology and Paediatric medical locum and after hours cover as a result of service vacancy, unexpected leave and service demand.

Other Expenditure ($478k unfavourable YTD)
Outsourced Services ($14k unfavourable YTD)
The favourable variance was due to fewer external postnatal transfers to Birthcare Auckland.

Clinical Supplies ($100k favourable YTD)
The favourable clinical supplies variance was attributed to reduced dental clinic output. Dental supplies spending is expected to fluctuate as clinics reopen and chair utilisation increases. Partially offsetting these underspends are cost pressures across Maternity and Neonatal services due to increased service demand and patient acuity.

Infrastructure and Non-Clinical Supplies ($565k unfavourable YTD)
The unfavourable variance was due to a combination of increased ARDS staff mileage claims due to staff relocating to alternate clinics to meet service need, registration and maintenance expenses on mobile dental facilities, outsourced cleaning costs and embedded savings, which are being met by reduced clinical supplies and staff vacancies.

COVID-19 impacts
Leave creep, high sick leave, public health nurse redeployment to the Auckland Regional Public Health Service, reduced supplies spending resulting from closed dental clinics have impacted the Child, Women and Family and Regional Dental financial results to date.

Specialist Mental Health & Addiction Services

Service Overview

This service is responsible for the provision of specialist community and inpatient mental health services to Waitematā residents. This includes child, youth and family mental health services, adult mental health services including two acute adult in-patient units, community alcohol, drug and other addiction services across the Auckland metro region, Whītiki Maurea providing mental health services to Waitematā residents and addiction services across metro-Auckland, Pasifika Peoples mental health services and regional forensic services that deliver services to the five prisons across the northern region as well as eight in-patient villas and a regional medium secure Intellectual Disability unit including an intellectual disability offenders liaison service. Mental Health and Addiction services have around 9000 active tāngata whai i te ora in our care at any point in time. Less than 1% of these would be in an inpatient unit. This means 99% of the tāngata whai i te ora in our care are living in the Community.

The group is led by Derek Wright (Director Mental Health & Addictions Lead), Dr Murray Patton (Clinical Director) and Pam Lightbown (General Manager). The Associate Director of Nursing is Alex Craig and the Clinical Directors are Dr Greg Finucane for Adult, Dr Frances Agnew for Whitiki Maurea and Takanga A Fohe, Dr Krishna Pillai for Forensics, Dr Emma Schwarcz for CADS, and Dr Mirsad Begic for Child, Youth and Family.

Highlight of the Month

Reducing seclusion

Reducing seclusion has been a longstanding aim of the Specialist Mental Health and Addiction Service Inpatient Units. This goal was fast tracked when a five-year programme funded by the 20 District Health Boards and led by the Health Quality and Safety Commission (HQSC) was established. The programme identified five priority areas. Eliminating seclusion was identified as the first priority area to focus on. Currently, Adult Mental Health inpatient services have the lowest seclusion rate in the county.

In November 2018, project groups were set up to undertake change through improvement initiatives which have included in the adult units:

- The implementation of Safe Wards (Safe Wards being an internationally recognised Best Practice Model for Inpatient Units)
- Developing a prescribing bundle to be used on admission
- Enhancing Nicotine Replacement Therapy (NRT) prescribing and use
- Focusing on seclusion panels and feedback with staff
- Training for shift coordinators
- Training and coaching in the area of communication and de-escalation for staff
- Rolling out SPEC (Safe Practice and Effective Communication)
- Using safety huddles to identify and intervene with treatment options early
- Identifying expert staff to work in the most acute areas of the wards

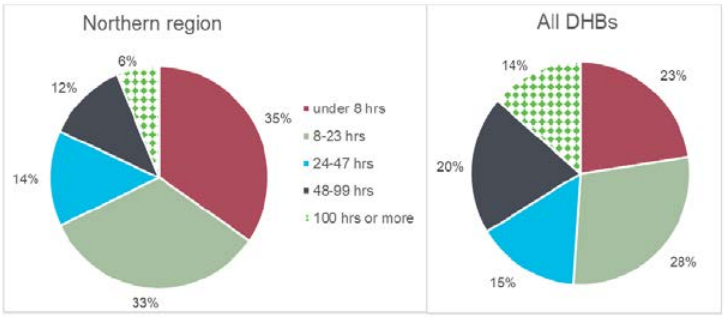
The Adult Services are committed to continuing to reduce the use of seclusion and although the Zero Seclusion project with the Health Quality and Safety Commission (HQSC) will be concluding at the end of the year, the service will continue to work though the change ideas that have been identified.

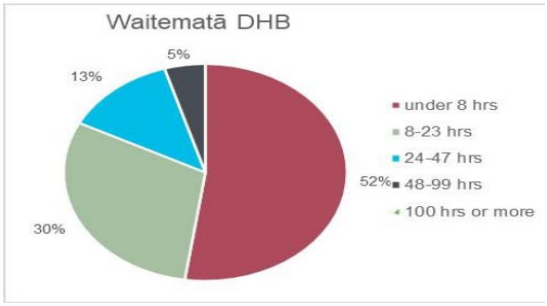
Similar efforts have been underway in units at Mason clinic, although with the range of change ideas being tested, has differed slightly in light of the different nature of the physical environment, the pathways of care into the unit and the nature of the clinical presentations of people in that setting.

Graph below: illustrates that as well as the numbers of people being secluded is low in Waitematā DHB, the time spent in seclusion is also minimal.

Time spent in seclusion

Graph 4: Distribution in number of hours people spent in seclusion during an admission, DHBs of the Northern region and All DHBs, April 2017 – March 2020





There has been good progress in each setting, although there is now concern that to make further progress, additional staffing resource is likely to be a key determinant in the national goal of eliminating seclusion.

Key Issues

Leased Property

With several services tenancy due to expire over the next few months/years there has been active review of the potential leased properties across Waitematā district for some time now. Unfortunately, finding suitable premises in appropriate locations due to a lack of rental properties becoming available is a challenge. The service is working closely with the DHB's leasing department also reviewing the models of care going forward.

Scorecard – Specialist Mental Health & Addiction Services

Waitematā DHB Monthly Performance Scorecard

Specialist Mental Health and Addiction Services
September 2020
2020/21

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	75%	80%	

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	13 days	≤14 days	
Improving Outcomes			
Better help for smokers to quit	98%	95%	
Seclusion use Forensics - Episodes	37	≤14	
Seclusion use Adult - Episodes	3	≤5	
High Care Area/ICU 15 min observations	100%	95%	
a. MH Access Rates 0-19 years (Total)	*3.69%*	*3.82%*	
a. MH Access Rates 0-19 years (Māori)	*5.09%*	*5.24%*	
a. MH Access Rates 20-64 years (Total)	*3.83%*	*3.77%*	
a. MH Access Rates 20-64 years (Māori)	*9.03%*	*9.40%*	
HR/Staff Experience			
Sick leave rate	3.6%	≤3.4%	
Turnover rate - external	8%	≤14%	
Vacancies - %	5%	≤8%	

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue excl. COVID-19	4,429 k	3,828 k	
Expenses excl. COVID-19	39,140 k	37,182 k	
Net surplus/(deficit) excl. COVID-19	-34,711 k	-33,354 k	
COVID-19 net benefit/(cost)	-395 k	0 k	
Net surplus/(deficit) incl. COVID-19	-35,105 k	-33,354 k	

Service Delivery

	Actual	Target	Trend
Waiting Times (latest available)			
a. Adult (20-64) <3 weeks	*82%*	*80%*	
a. CADS (0-19) <3 weeks	*81%*	*80%*	
a. CADS (20-64) <3 weeks	*90%*	*80%*	
CYF <3 weeks	100%	95%	
a. Forensic (20-64) <3 weeks	*79%*	*90%*	
Prison inpatient waiting list	3	0	
b. **Patient Flow**			
Bed Occupancy - Adult Acute	90%	80-90%	
Bed Occupancy - CADS Detox	93%	80-90%	
Bed Occupancy - Forensics Acute&Rehab	99%	80-90%	
Community Care			
Preadmission community care - adult	77%	75%	
Post discharge community care - adult	76%	90%	
Clinical contact directly with consumer - adult	85%	80%	
Clinical contact directly with consumer- CADS	87%	80%	
Clinical contact directly with consumer - CYF	88%	80%	
Clinical contact directly with consumer - Forensic	89%	80%	
Whanau contacts per service user - adults	57%	70%	
Whanau contacts per service user - child	100%	80%	
Whanau contacts per service user - youth	100%	80%	

How to read

Performance indicators:
- Achieved/ On track
- Not Achieved but progress made
- Substantially Achieved but off target
- Not Achieved/ Off track

Trend indicators:
- ▲ Performance ***improved*** compared to previous month
- ▼ Performance ***declined*** compared to previous month
- -- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in *grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-month period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. A small data range may result in small variations appearing to be large.

a. Reported approx 3 months in arrears (Jun 20 data). b. Rolling 3 month indicator.

A question?

Contact:
Victoria Child - **Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz**
Planning, Funding and Health Outcomes, Waitematā DHB

Scorecard Variance Report

Priority Health Outcome Areas

Shorter Waits in ED*- 75% against a target of 80%*

Daily auditing of the ED breaches has identified that for the month of September, the breaches were due to delays in assessments due to intoxication/overdose or emergency sedation. The clinician workload including travel time for on call registrars and consultants, also made up a significant portion. Also, an inability to access respite after hours from NSH/WTH did pose a portion of breaches as people could wait longer to access respite care as it has been more difficult to secure security personnel following COVID-19. The service is looking at alternative options to addressing this.

Best Care

Seclusion use for Forensics – Episodes – 37 against a target of <14

The seclusion episodes were spread across the admitting units with two distinct care recipients in Pohutukawa (Intellectual Disability stream) continuing to present with behavioural acuity. Despite the episodes increasing in this stream for the reporting month, the duration of episodes were shorter. In relation to mental health, there were seven tangata whai i te ora in Kauri and one in Totara who required seclusion.

HR/ Staff Experience – Sick leave – 3.6% against a target of 3.4%

Sick leave is higher than expected due to a precautionary zero tolerance for any respiratory illness due to COVID-19. This has been largely offset by a far lower incidence of Influenza than previous years.

Value for Money

Financial Results (YTD)- Expenses excluding COVID-19

The unfavourable variance for September was due to the continued effects of COVID-19 resulting in significantly higher staff retention, high winter sick leave taken. Retention and recruitment of staff has increased year on year such that 83 additional FTE are now in service when compared to this time last year.

Service Delivery

Waiting Times- Forensic (20-64) <3 weeks – 79% against a target of 90%

This metric was adversely affected by the COVID-19. . During this time, the service's ability to enter the prisons to conduct routine psychiatric in-reach work was constrained by the Department of Corrections. The Forensic Prison Team continued to receive referrals. Those referrals that were triaged as non-urgent were deferred until constraints around entrance to prisons had relaxed.

Waiting Times- Prison inpatient waiting list – 3 against a target of 0

The three individuals were clinically overridden due to more acutely unwell tangata whai i te ora needing admitting from Mt Eden Correctional Facility. Bed occupancy has continued to exceed capacity and continued difficulty with finding safe and sustainable places to discharge those with enduring psychiatric and cognitive disability. The Service cannot directly influence the demand from Courts and Prisons, but maintains good working relationship with both those stakeholders and is always working to find better ways of meeting mental health needs of those in custody, including a new initiative working with Bail Support Services for the Remand population, and participation in a new special circumstances court to streamline processes for mentally ill defendants appearing in the Auckland Courts.

Patient Flow-Bed Occupancy – Forensics Acute & Rehab – 99% against a target of 90%

The Service continues to have supernumerary Intellectual Disability contracted beds, but the Ministry of Health has agreed to purchase five additional beds. This is being worked through with Funding and Planning. The reopening of Kaupapa Māori step-down beds by Kahui Te Kaha occurred in the month and five service users have now being discharged there. It is anticipated that this should relieve some of the inpatient pressures and occupancy rates will fall.

Community Care- Post Discharge Community Care *– 76% against a target of 90%*

Challenges remain in relation to early visits from community following discharge from the in-patient units. As well as discrepancies occurring at times when transfer of care to another out of area service occurs and has not been close to admitting service. We continue to have reports daily that the clinical co-ordinators in each service follow up.

Community Care- Family/Whānau Contacts – Adult 57% against a target of 70%

Whānau engagement continues to be the focus for adult services with emphasis on finding ways to improve how we communicate and involve families. Whilst we are one of the top performers across the county, there is recognition that the feedback we receive from whānau via complaints and adverse events processes indicates

that more work is required. Single session family therapy is recommended for clinicians who are working in the more acute ends of the service to maximise engagement and involvement during crisis periods.

Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Inquiry into mental health and addiction Working in partnership with all stakeholders to build an integrated approach to mental health, addiction and wellbeing in response to He Ara Oranga		
Embedding a wellbeing focus Collaborate with schools to expand access to programmes led by Child Youth and Family Mental Health services on school sites, including those with high Māori and Pacific populations (EOA); expand the programme to two further schools	Jun 2020	✓
Building the continuum/increasing access and choice Increase access to Pacific children and youth by receiving referrals from NGOs, existing services, and Pacific parents who are clients of mental health and addictions services, consistent with the Takanga A Fohe service delivering a family-inclusive service; evaluate outcomes, including youth and family feedback	Dec 2019	✓
Review current primary care liaison programmes with a view to expanding effective programmes	Dec 2019	✓
Crisis Response Improve the consistency of crisis team responses and grow staff capability in standardised assessment tools and evidence-based brief interventions across all population groups	Jun 2020	✓
Workforce Develop a centralised workforce capability database to track staff training initiatives progress, including cultural competency training for working with Māori and Asian patients (EOA)	Dec 2019	✓
Forensics Provide a summary of existing workforce development plans or programmes within Waitematā DHB and work to expand the volume and capability of the forensic specialist staff group	Summary by Sep 2019; expansion by Dec 2019	Awaiting guidance from MoH re Wellbeing budget
Confirm the establishment of any new roles allocated to Waitematā DHB during 2019/20, including risks identified, mitigated, and any impact on other essential services	Jun 2020	Awaiting guidance from MoH re Wellbeing budget
Contribute as appropriate to the MoH Forensic Framework project to identify an agreed Forensic model of care, including provision of Kaupapa Māori services (EOA)	Ongoing	✓
Population mental health Actions to improve population mental health and addiction, particularly in our priority populations		
Implement phase II of Supporting Parents Healthy Children	Dec 2019	✓
With Equally Well sector partners, determine and plan an appropriate response to Māori and Pacific with enduring co-morbid health issues (EOA)	Dec 2019	✓
Continue to reduce Māori compulsory treatment order rates (EOA)	Ongoing	✓

DHB activity	Milestone	On Track
Mental health and addictions improvement activities Actions to support an independent and high quality of life in our population		
Participate in the HQSC project to improve service transitions to primary care by ensuring transition plans/discharge letters contain a follow-up plan (with a copy to the person concerned); this activity is supported across all services, including kaupapa Māori and Pacific mental health and addiction services (EOA)	Nov 2019	✓ In progress – timeframe extended by HQSC
Minimise restrictive care through engagement in HQSC Zero Seclusion project activities, with a focus on the regional forensic services, which has a high prevalence of Māori patients (EOA)	Sep 2019	✓ In progress – timeframe extended by HQSC
Participate in the HQSC project to reduce the occurrence of serious adverse events through ensuring learnings are introduced into clinical practice in a responsive manner, including Māori and Pacific representation in the adverse event investigation and recommendation process (EOA)	Dec 2019	✓ In progress – timeframe extended by HQSC
Participate in the HQSC project to improve physical health	Jun 2020	Deferred by HQSC
Addiction Actions to support an independent and high quality of life in people with addiction issues, particularly priority groups		
Increase access to Māori kaupapa addiction services for Māori who are in community probation services (EOA)	Jun 2020	**X** Due to Covid-19 limiting access to community probation services and low internal capacity we have not been able to progress this piece of work
Improve access for Pacific youth with substance use issues; establish a consult-liaison relationship with 5 schools across Auckland with high proportions of Pacific students (EOA)	Jun 2020	✓
Identify an appropriate outcome measure for Maternal Mental Health specialist services, ensuring cultural acceptability to Māori and Pacific (EOA)	Jun 2020	✓

Financial Results – Specialist Mental Health & Addictions Services

Waitematā DHB Statement of Financial Performance

Specialist Mental Health and Addiction - Sep-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	1,238	1,031	208	3,438	3,092	346	12,368
Other Income	407	255	153	991	736	255	2,905
Total Revenue (excluding COVID)	1,645	1,285	360	4,429	3,828	602	15,273
EXPENDITURE							
Personnel							
Medical	2,096	2,387	291	7,690	8,224	534	31,263
Nursing	5,287	4,959	(328)	15,747	14,983	(764)	66,565
Allied Health	2,832	2,528	(304)	9,565	8,935	(629)	33,739
Support	143	132	(11)	442	458	16	1,781
Management / Administration	546	505	(41)	1,917	1,741	(177)	6,635
Outsourced Personnel	443	167	(277)	1,395	532	(863)	2,058
	11,348	10,677	(671)	36,756	34,874	(1,883)	142,040
Other Expenditure							
Outsourced Services	15	12	(3)	36	38	2	149
Clinical Supplies	62	105	43	247	320	74	1,270
Infrastructure & Non-Clinical Supplies	636	610	(26)	2,101	1,951	(150)	8,394
	713	728	15	2,384	2,308	(75)	9,813
Total Expenditure (excluding COVID)	12,061	11,405	(655)	39,140	37,182	(1,958)	151,853
Surplus/(Deficit) excluding COVID	**(10,415)**	**(10,120)**	**(295)**	**(34,711)**	**(33,354)**	**(1,356)**	**(136,581)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	(180)	0	(180)	(395)	0	(395)	0
Surplus/(Deficit) including COVID	**(10,595)**	**(10,120)**	**(475)**	**(35,105)**	**(33,354)**	**(1,751)**	**(136,581)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Comment on major financial variances

The overall result for Specialist Mental Health and Addictions Services was $475k unfavourable for September and $1,751k unfavourable for the YTD.

Revenue ($360k favourable for September, $602k favourable YTD)

The favourable variance for September was due to a combination of additional revenue for service users within care needs (Intellectual Disability) in the Pohutakawa ward of the Mason Clinic, additional funding provided from MOH for the level of care exceeding the base level funding and revenue for court reporting continued to be higher than budgeted due to higher volumes than expected. A one-off funding injection of $145k was received to set up crisis support in the Emergency Department.

Expenditure ($655k unfavourable for September, $1,958k unfavourable YTD)

The unfavourable variance for September was due to the continued effects of COVID-19 resulting in significantly higher staff retention, high sick leave taken (this was especially high in Medical leading to an increase in additional sessions and locum cover). Retention and recruitment of staff has increased year on year such that 83 additional FTE are now in service when compared to this time last year.

Personnel ($1,883k unfavourable YTD)

Medical ($534k favourable YTD)

The favourable variance was due to vacancies, 11.87 FTE and an average of 11.81 FTE YTD.

Nursing ($764k unfavourable YTD)
The unfavourable variance was due to 65.3 FTE nursing vacancies in August and an average of 67.9 FTE YTD offset by overtime and the use of Healthcare Assistants to support gaps in Registered Nursing positions.

Allied Health ($629k unfavourable YTD)
The unfavourable variance was due to backfill requirements and the increased need to support nursing vacancies where possible.

Support and Management/Administration ($161k unfavourable YTD)
The unfavourable variance was mainly due to retention of staff and additional sick leave taken for July, August, and September.

Outsourced Personnel ($863k unfavourable YTD)
The unfavourable variance was due to an increase in cover for sick and maternity leave mainly in medical, as well as cover for vacancies equivalent to 11 FTE. In addition, overflow work for court reporting accounts for around 30%.

Other Expenditure ($75k unfavourable YTD)
Outsourced Services ($2k favourable YTD)
The favourable variance was due to the reduced use of contract staff to cover non-medical vacancies. This is offset by staff overtime in personnel costs.

Clinical Supplies ($74k favourable YTD)
The favourable variance was due to a reduced number of after care services in the Flexifund, however this is expected to increase over the next few months.

Infrastructure and Non-Clinical Supplies ($150k unfavourable YTD)
The unfavourable variance was mainly driven by additional OPEX charges on rented properties and outsourced meals to reduce the risk of COVID-19 spread in tangatai whai i te ora self-catered facilities. Laundering and cleaning cost increased due to additional deep cleaning to comply withCOVID-19 appropriate activity.

Surgical and Ambulatory Services/Elective Surgical Centre

Service Overview

The Surgical and Ambulatory Services provide elective and acute surgery to our community, encompassing surgical specialties such as general surgery, orthopaedics, otorhinolaryngology and urology, and includes outpatient, audiology, clinics, operating theatres and pre and post-operative wards and ICU. The service is managed by Dr Richard Harman (Acting Chief of Surgery), Karen Hellesoe (Acting General Manager) and Kate Gilmour (Associate Director of Nursing).

The Elective Surgery Centre provides elective surgical services to our community, led by Dr Bill Farrington (Clinical Director) and Janine Wells (ESC Operations Manager).

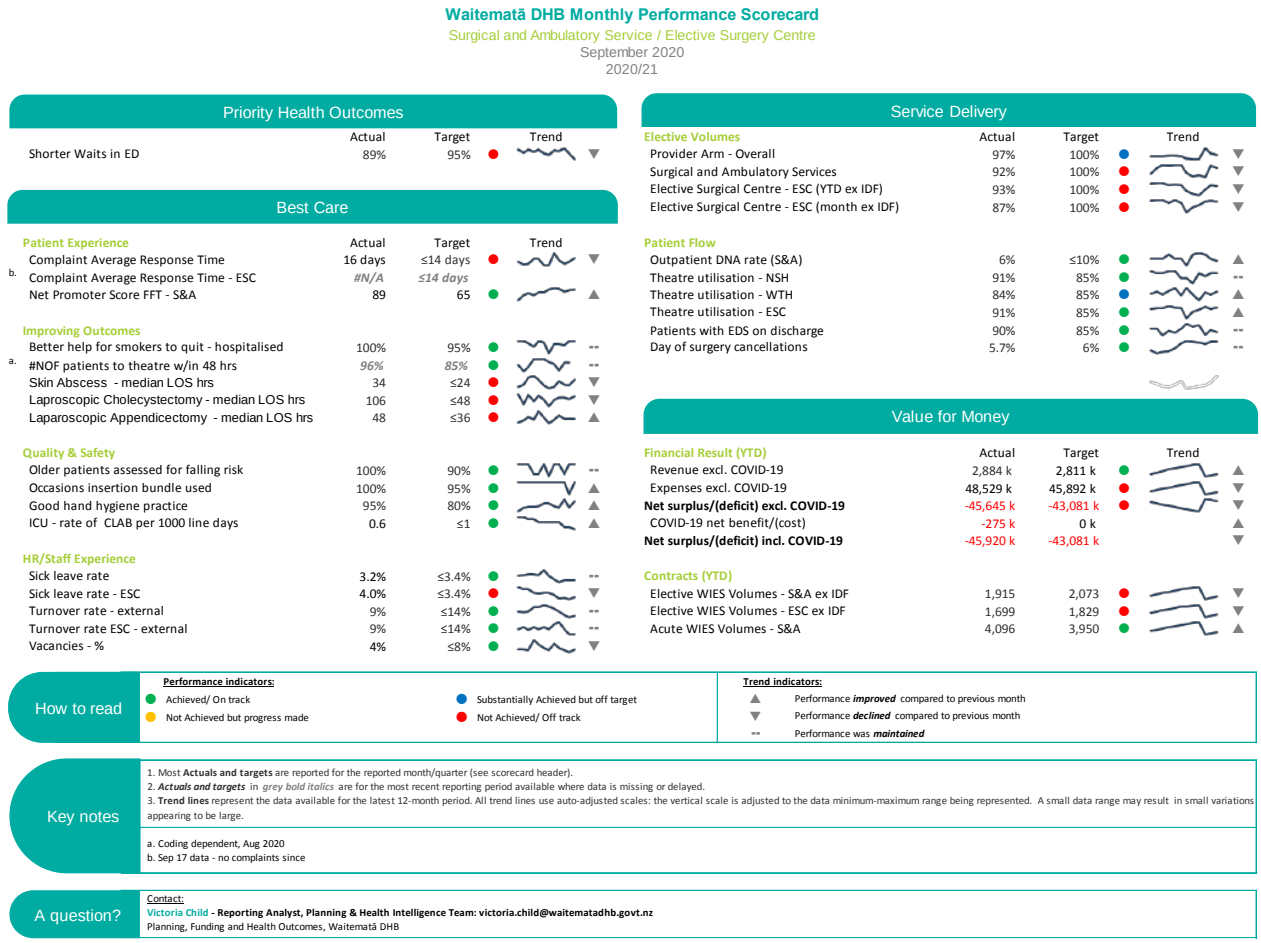
Highlight of the Month

The development of the new Diagnostic Breast Service facility is well underway, due for building completion by Christmas with commissioning planned for the new year.

Key Issues – Impact of COVID-19

- ESPI 2 and 5 compliance. All services have made significant gains in reducing patient waitlists for both FSA and surgery however increased P1 demand and prioritizing surgery means that ESPI 2 non-compliant volumes in October, November and December will rise in some services.
- Equipment in the Central Sterile Services Department (CSSD) is reaching end-of life but will be replaced as part of a substantial refurbishment programme.

Scorecard - Surgical and Ambulatory and Elective Surgical Centre



Waitematā DHB Monthly Performance Scorecard
Surgical and Ambulatory Service / Elective Surgery Centre
September 2020
2020/21

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	89%	95%	

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	16 days	≤14 days	
b. Complaint Average Response Time - ESC	*#N/A*	*≤14 days*	
Net Promoter Score FFT - S&A	89	65	
Improving Outcomes			
Better help for smokers to quit - hospitalised	100%	95%	
a. #NOF patients to theatre w/in 48 hrs	*96%*	*85%*	
Skin Abscess - median LOS hrs	34	≤24	
Laproscopic Cholecystectomy - median LOS hrs	106	≤48	
Laparoscopic Appendicectomy - median LOS hrs	48	≤36	
Quality & Safety			
Older patients assessed for falling risk	100%	90%	
Occasions insertion bundle used	100%	95%	
Good hand hygiene practice	95%	80%	
ICU - rate of CLAB per 1000 line days	0.6	≤1	
HR/Staff Experience			
Sick leave rate	3.2%	≤3.4%	
Sick leave rate - ESC	4.0%	≤3.4%	
Turnover rate - external	9%	≤14%	
Turnover rate ESC - external	9%	≤14%	
Vacancies - %	4%	≤8%	

Service Delivery

	Actual	Target	Trend
Elective Volumes			
Provider Arm - Overall	97%	100%	
Surgical and Ambulatory Services	92%	100%	
Elective Surgical Centre - ESC (YTD ex IDF)	93%	100%	
Elective Surgical Centre - ESC (month ex IDF)	87%	100%	
Patient Flow			
Outpatient DNA rate (S&A)	6%	≤10%	
Theatre utilisation - NSH	91%	85%	
Theatre utilisation - WTH	84%	85%	
Theatre utilisation - ESC	91%	85%	
Patients with EDS on discharge	90%	85%	
Day of surgery cancellations	5.7%	6%	

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue excl. COVID-19	2,884 k	2,811 k	
Expenses excl. COVID-19	48,529 k	45,892 k	
Net surplus/(deficit) excl. COVID-19	-45,645 k	-43,081 k	
COVID-19 net benefit/(cost)	-275 k	0 k	
Net surplus/(deficit) incl. COVID-19	-45,920 k	-43,081 k	
Contracts (YTD)			
Elective WIES Volumes - S&A ex IDF	1,915	2,073	
Elective WIES Volumes - ESC ex IDF	1,699	1,829	
Acute WIES Volumes - S&A	4,096	3,950	

How to read

Performance indicators:
- Achieved/ On track
- Substantially Achieved but off target
- Not Achieved but progress made
- Not Achieved/ Off track

Trend indicators:
- Performance ***improved*** compared to previous month
- Performance ***declined*** compared to previous month
- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in *grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-month period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. A small data range may result in small variations appearing to be large.

a. Coding dependent, Aug 2020
b. Sep 17 data - no complaints since

A question?

Contact:
Victoria Child - **Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz**
Planning, Funding and Health Outcomes, Waitematā DHB

Priority Health Outcomes

Shorter Waits in ED *– 89% against a target of 95%*

Core reasons for the drop for surgical patients are related to clinical complexity meaning patients need to stay longer than 6 hours in ED to be stabilised.

Best Care

Complaint Average Response Time – *16 days against a target of ≤14 days*

The division received four complaints that were complex in their nature therefore requiring an extended period (average 31 days) to resolve.

Skin Abscess Median LOS *– 34 hours against a target of ≤24*

There were 51 patients treated surgically for abscess drainage, 34 of whom come under the surgical pathway criteria. Interestingly the non-pathway patient median LOS was 26hrs. Many of the pathway patients had complex abscesses due to e.g. newly diagnosed diabetes, Crohn's, requiring longer stays to manage the new condition or longer term IV antibiotics.

***Laparoscopic Cholecystectomy Median LOS** – 106 hours against a target of ≤48*
Some of this cohort of patients required ERCP (procedure to check the bile and pancreatic ducts and remove stones present in the ducts). Those with gallstone pancreatitis needed a settling down period prior to removal of gallbladder resulting in a longer LOS. There were also factors of Registrar sickness and theatre nursing sickness which meant a second acute theatre was not always available.

***Laparoscopic Appendicectomy Median LOS** – 48 hours against a target of ≤36*
The median length of stay remains the same as August. Only three out eight patients flagged for criteria led discharge met the target LOS. Two had post op fevers requiring IV antibiotics.

***Sick leave rate ESC** – 4% against a target of ≤3.4%*
The sick leave for ESC whilst higher than our target number remains stable (as ESC is a sub group of SAS the smaller number of staff can disproportionately affect the percentage).

Service Delivery

***S&A Elective Volume** – 92% against a target of 100%*
This is the WIES percentage YTD (There is a lag in accurate WIES information -the most up to date data indicates that current WIES achievement across all services is now 95.2%.)

General Surgery is at 85% with ORL at 93%, Orthopaedics at 98% and Urology at 99%. The drivers for General Surgery being behind are reduced bariatric surgery post COVID-19 to allow higher priority cases to be done and an overall lower than average case weight. ORL are behind in their WIES due to reduced elective discharges. This is a result of medical staffing shortfalls and reduced ability to secure locums. There are two additional ORL SMOs starting in January 2021 which will assist production.

***ESC Elective Volume (YTD ex IDF)** – 93% against a target of 100%*
As per S& A Elective volume target comment above. ESC did lose three days (13%) of production in July as it did not re-open as a Point of Care (POC) facility until Monday 6 July 2020.

***ESC Elective Volume (month ex IDF)** – 87% against a target of 100%*
As per S& A Elective volume target comment.

Value for Money

***Expenses excluding COVID-19** – 48,529k against a target of 45,892k*
As per financial result commentary below.

***Net surplus/ (deficit) excluding COVID-19** – -45,920k against a target of - 43,081k*
As per financial result commentary below.

***Elective WIES Volumes – S&A ex IDF** – 1,915 against a target of 2073*
As per S& A Elective volume target comment.

***Elective WIES Volume – ESC ex IDF –** 1,699 against a target of 1,829*
As per S& A Elective volume target comment.

Overall, including acutes, Surgical Services are 102% of target volumes.

Surgical and Ambulatory Services

Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Bowel Screening Actions to meet colonoscopy wait times and equitable access to bowel screening		
Provide equitable access to diagnostic procedures for Māori and Pacific people who have a positive result by: • contacting participants with a positive result for a colonoscopy pre-assessment within 15 days (EOA) • offering an appointment for colonoscopy within 45 days (EOA)	Ongoing	✓
Work with primary care to improve Māori and Pacific participation by trialling a process whereby people for whom a GP has sent a test kit request are telephoned and supported to participate (EOA)	Jun 2020	x
Implement an audit process for data correctness and completeness on the Register and the endoscopy system	Jun 2020	✓
Work with our patient experience team to improve engagement with our Māori and Pacific colonoscopy patients, with the aim of reducing the ethnic gap in DNA rates between ethnicities (EOA)	Jun 2020	✓
Undertake a clinical audit of our colonoscopy surveillance waitlist to identify individuals or cohorts that no longer require a procedure	Dec 2019	✓
95% of Māori and Pacific participants with a positive result: • are contacted for a colonoscopy pre-assessment within 15 days • receive a first offered appointment within 45 days 5% increase in Māori and Pacific participation where request for a test kit has come via primary care <5% error rate SS15 colonoscopy measures		

Areas off track for month and remedial plans
The data was analysed after an initial six months of telephone support work and found to have no impact on participation in this group. This activity was subsequently discontinued as the results did not justify the use of the staffing resources.

Financial Results - Surgical and Ambulatory and Elective Surgical Centre Combined

Waitematā DHB Statement of Financial Performance

S&A and ESC Combined - Sep-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	1,008	820	188	2,662	2,459	203	9,838
Other Income	75	114	(39)	222	351	(129)	1,234
Total Revenue (excluding COVID)	1,083	933	149	2,884	2,811	73	11,072
EXPENDITURE							
Personnel							
Medical	4,822	4,720	(102)	16,155	16,309	154	62,959
Nursing	4,299	4,127	(172)	12,804	12,241	(563)	54,374
Allied Health	539	507	(32)	1,858	1,782	(77)	6,713
Support	188	198	10	651	686	35	2,634
Management / Administration	397	373	(24)	1,338	1,289	(49)	4,828
Outsourced Personnel	695	627	(68)	2,021	1,919	(102)	7,099
	10,940	10,552	(388)	34,828	34,226	(602)	138,607
Other Expenditure							
Outsourced Services	263	166	(97)	751	509	(242)	1,739
Clinical Supplies	4,166	3,571	(596)	11,979	10,952	(1,027)	42,089
Infrastructure & Non-Clinical Supplies	321	62	(259)	972	206	(766)	773
	4,751	3,799	(952)	13,702	11,666	(2,036)	44,602
Total Expenditure (excluding COVID)	15,691	14,351	(1,340)	48,529	45,892	(2,637)	183,209
Surplus/(Deficit) excluding COVID	**(14,608)**	**(13,417)**	**(1,191)**	**(45,645)**	**(43,081)**	**(2,564)**	**(172,137)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	(93)	0	(93)	(275)	0	(275)	0
Surplus/(Deficit) including COVID	**(14,701)**	**(13,417)**	**(1,283)**	**(45,920)**	**(43,081)**	**(2,839)**	**(172,137)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Comment on major financial variances

The overall result for S&A and ESC was $1,283k unfavourable for September and $2,839k unfavourable for the YTD.

Revenue ($149k favourable for September, $73k favourable YTD)
Revenue was favourably impacted by money received from the funder which should have been received at provider management level. This will reverse out in October. The underlying result for September was therefore $10k unfavourable and 177k YTD, which was due to continued shortfalls in Bowel Screening and Surgical Pathology as well as lower orthopaedic ACC revenue due to the impact of the COVID-19 lockdown in Auckland. These shortfalls were partly offset by additional revenue from Auckland DHB for use of theatre space at Waitakere.

Expenditure ($1,340k unfavourable for September, $2,637k unfavourable YTD)
The unfavourable variance for September was driven by additional personnel costs ($388k) particularly in nursing ($172k) across the divisions and in outsourced personnel services ($68k) at S&A and ESC, in addition to higher than expected costs in clinical supplies $596k.

Personnel ($602k unfavourable YTD)
Medical ($154k favourable YTD)

The positive variance was driven by SMO vacancies within Anaesthesia and ORL partly offset by a negative leave impact arising from the latest RMO rotation and locum costs to provide vacancy cover within outsourced personnel.

Nursing ($563k unfavourable YTD)
Nursing was over budget, for which there are a number of contributing factors.

NSH short stay unit operated for the first two months as a surgical ADU without an uplift in budget for the required FTE, resulting in a -$98k variance to budget.

Surgical and gastro theatre overspend continued to be driven by increased volume and productivity, resulting in higher use of casuals, extra hours, overtime and allowances.

NSH theatre is budgeted to run eight-hour operating elective sessions, but extended theatre lists have become increasingly BAU since July in order to maximise utilisation to address surgical waitlists and planned care production targets, contributing to a -$185k variance to budget. There were some one-off costs in the quarter -$100k. The remainder of the overspend was in surgical wards (excluding NSH short stay) mostly driven by the use of watches for high acuity patients (Spinal, Tracheostomy, peri-prosthetic, Enhanced Recovery After Surgery Neck of Femur [ERAS NOF]).

Allied Health ($77k unfavourable YTD)
The unfavourable variance represents the vacancy factor of the personnel budget which was not achieved as a result of the lower than expected turnover of staff.

Outsourced Personnel ($102k unfavourable YTD)
Outsourced personnel was above budget due to the vacancies within Anaesthesia and ORL. This has resulted in reliance on locums to assist in production to meet the planned care target. $47k has been spent on external agency theatre nursing in the first quarter.

Other Expenditure ($2,036k unfavourable YTD)
Outsourced Services ($242k unfavourable YTD)
The unfavourable variance arose due to a cost budget deficit for the outsourcing of skin lesion procedures to GPs ($283k).

Clinical Supplies ($1,027k unfavourable YTD)
The clinical supply budget has not grown in line with demographic growth in recent years and part of the unfavourable variance is as a result of this. Under production in those years has, for various significant reasons, e.g. strikes, COVID-19, theatre nursing staff shortfalls and White Island, camouflaged this issue. However, the current high levels of production in the first quarter of the year has highlighted the shortfall in budget and resulted in an overspend.

The main driver of the unfavourable variance in clinical supplies was in gastroenterology and theatre consumable costs. Costs are above budget across most consumables particularly in the use of treatment disposables ($217k); instruments and equipment ($267k), disposable instruments ($106k) and laparoscopic equipment ($76k) and in implants and prostheses ($357k). The latter reflects the over production in Orthopaedics which has brought down the number of patients on the waitlist significantly from June, particularly in non-joints.

There has been a $50k YTD above budget spend that relates to the move to a Surgical ADU model of care in the short stay unit mainly due to the requirement to provide IV supplies, including fluid. This additional cost will continue as it was not budgeted in the transfer of costs from ADU.

There was and will continue to be an on-going and significant COVID-19 effect on the supply chain of consumables. Theatres and Gastro are increasingly having to rely on or move to other suppliers whose product is more expensive. This is difficult to quantify.

Infrastructure and Non-Clinical Supplies ($766k unfavourable YTD)
The negative variance represented the YTD embedded budgeted savings related to the Financial Sustainability Programme ($844k). This line was partially offset by additional revenue and cost savings in other areas. Projects related to these budgeted savings, particularly in ACC revenue, Outsourced Personnel cost management and Clinical Supplies are now underway and are expected to show benefits over the year.

COVID-19 Impacts ($275k unfavourable)
These costs related to the staffing and leave impact.

Diagnostic Services

Service Overview

This division is responsible for the provision of Pharmacy, Laboratories and Radiology services.

The service is managed by Brad Healey General Manager. The Operation Managers and Clinical Directors are Ariel Hubbert for Pharmacy, Lee-Ann Weiss and Dr Matt Rogers (Clinical Director) for Laboratories and Bronwyn Ness and Dr Philip Clark (Clinical Director) for Radiology.

Highlight of the Month

Pharmacy – Jo Hikaka was awarded Pharmacist of the Year by the Pharmaceutical Society of New Zealand. Jo is the second Waitematā DHB pharmacist to win the award in the last decade.

Key Issues

Laboratory – COVID-19 has put significant pressure on the laboratory workforce. We are considering what the medium to long term implications are.

Radiology – we have noticed a consistent increase in referrals over the last three months compared with same period last year. Work is underway to understand this and to ensure we can complete these scans within the timeframe to meet the MoH six-week waiting time target.

Scorecard – Diagnostic Services

Waitematā DHB Monthly Performance Scorecard

Diagnostic Services
September 2020
2020/21

Best Care

HR/Staff Experience	Actual	Target	Trend
Sick leave rate	2.7%	<3.4%	--
Turnover rate - external	7%	<14%	▲
Vacancies - %	4%	<8%	▼

Service Delivery

Waiting Times				
% of CT scans done within 6 weeks	90%	95%	●	▲
% of MRI scans done within 6 weeks	85%	90%	●	▼
% of US scans done within 6 weeks	95%	75%	●	▲

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue excl. COVID-19	2,651 k	1,117 k	▲
Expenses excl. COVID-19	28,481 k	27,549 k	▼
Net surplus/(deficit) excl. COVID-19	-25,830 k	-26,432 k	▼
COVID-19 net benefit/(cost)	861 k	0 k	▲
Net surplus/(deficit) incl. COVID-19	-24,969 k	-26,432 k	▼

How to read

Performance indicators:
- Achieved/ On track
- Substantially Achieved but off target
- Not Achieved but progress made
- Not Achieved/ Off track

Trend indicators:
- ▲ Performance ***improved*** compared to previous month
- ▼ Performance ***declined*** compared to previous month
- -- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in *grey bold italics* are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-month period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. A small data range may result in small variations appearing to be large.

A question?

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Planning, Funding and Health Outcomes, Waitemata DHB

Scorecard Variance Report

% of CT scans done within six weeks – 90% against a target of 95%
Outsourcing of 1,450 CT scans was completed at the end of September. We are improving significantly towards achieving the target of 95%. The service continued to perform weekend sessions throughout September to reduce the total waiting list, which brings us closer to our target.

% of MRI scans done within six weeks – 85% against a target of 90%

Outsourcing is ongoing for MRI, and the service is continuing with additional sessions most weekends to increase internal capacity. A consistent increase in demand over the last three months has been observed and this has impacted the service's ability to achieve the 90% target.

Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Planned Care Actions to ensure that our population receives equitable and timely access to services in the most appropriate setting to support improved health outcomes		
Radiology - CT		
• Install new CT scanner at North Shore Hospital	Aug 2019	✓
• Streamline acute and elective workflows across CT scanners for improved service efficiency	Nov 2019	✓
• Recruitment and workforce development	On-going	✓
Radiology - MRI		
• Achieve compliance with 90% target	Oct 2019	✓
• Continue outsourcing programme to maintain compliance	On-going	✓

DHB activity	Milestone	On Track
Improving Quality Actions to improve equity in outcomes and patient experience		
Antimicrobial resistance The DHB works closely with the Auckland Regional Public Health Service to ensure advice, information and education is disseminated about antimicrobial resistance and supports efforts to inform the public Complete a hospital-wide antibiotic prescribing survey using the National Antibiotic Prescribing Survey (NAPS) tool to assess prescribing appropriateness for all patients	Sep 2019	✓ Completed

Financial Results

Waitematā DHB Statement of Financial Performance

Diagnostic Services - Sep-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	326	209	117	991	627	364	2,510
Other Income	1,252	163	1,089	1,659	489	1,170	1,958
Total Revenue (excluding COVID)	1,577	372	1,205	2,651	1,117	1,534	4,468
EXPENDITURE							
Personnel							
Medical	1,235	1,155	(80)	4,191	3,955	(236)	15,503
Nursing	265	236	(29)	782	700	(81)	3,138
Allied Health	2,353	2,187	(167)	8,246	7,592	(654)	29,671
Support	0	0	0	0	0	0	0
Management / Administration	196	196	0	642	679	37	2,473
Outsourced Personnel	79	57	(22)	149	185	36	707
	4,128	3,831	(298)	14,010	13,111	(899)	51,491
Other Expenditure							
Outsourced Services	570	568	(2)	2,165	1,722	(443)	6,974
Clinical Supplies	3,860	3,859	(1)	11,697	12,145	448	48,365
Infrastructure & Non-Clinical Supplies	164	194	30	609	571	(39)	2,544
	4,593	4,621	28	14,471	14,438	(33)	57,884
Total Expenditure (excluding COVID)	8,722	8,452	(270)	28,481	27,549	(932)	109,374
Surplus/(Deficit) excluding COVID	**(7,144)**	**(8,080)**	**935**	**(25,830)**	**(26,432)**	**602**	**(104,906)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	1,020	0	1,020	861	0	861	0
Surplus/(Deficit) including COVID	**(6,124)**	**(8,080)**	**1,956**	**(24,969)**	**(26,432)**	**1,464**	**(104,906)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Comment on major financial variances

The overall result for Diagnostic Services was $1,956k favourable for September and $1,464k favourable for the YTD.

Revenue ($1,205k favourable for September, $1,534k favourable YTD)

The favourable variance for the YTD is due to increased billing to other DHBs for Radiology scans and billing to drug trials from the Inpatient Pharmacy and Laboratory.

Expenditure ($270k unfavourable for September, $932k unfavourable YTD)

The unfavourable variance for the YTD was due to Outpatient Pharmacy not being fully funded for the activity per the Community Pharmacy Programme and Radiology Services performing additional volumes to aid back log of procedures.

Personnel ($298k unfavourable YTD)

Personnel costs are over in Radiology as the service is doing additional sessions to catch up on procedures delayed due to COVID-19 restrictions and the anticipated vacancy savings have not materialised due to retention of staff in the post COVID-19 environment.

Other Expenditure ($33k unfavourable YTD)

Outsourced Services ($443k unfavourable YTD)

The unfavourable variance YTD is due to outsourced CT radiology volumes ($727k) which have also been utilised to facilitate catch up of procedures delayed to COVID-19 restrictions. Additional plain film outsourcing ($225k) to reduce the wait list arising from strike action earlier in 2020.

Clinical Supplies ($448k favourable YTD)
The favourable variance for the YTD was due to drug costs in the inpatient pharmacy being $363k favourable YTD primarily due to a lower Pharmac negotiated price on two Pharmaceutical Cancer Treatment (PCT) drugs. Laboratory consumable and blood products are also $215k favourable YTD with less than anticipated inpatient volumes. Radiology clinical supplies were $380k favourable mainly due to one off accrual releases ($230k) in July relating to terminated service contracts and leases and on-going savings on contracts and leases.

Infrastructure and Non-Clinical Supplies ($39k unfavourable YTD)
The unfavourable variance for the YTD was due to phasing of Laboratory and Radiology accreditation costs where budget is in future periods. Laboratory also $21k unfavourable YTD for installation costs relating to new analyser that will be reimbursed in future periods.

COVID-19 ($861k favourable YTD)
COVID-19 related transactions are favourable due to revenue from Ministry of Health for the laboratory carrying out over 30,000 COVID-19 tests. The revenue exceeds the direct costs incurred to perform the tests.

Clinical Support Services

Service Overview

This division is responsible for the provision of Clinical Support Services Division includes Food Services, Security, Traffic and Fleet, Clinical Engineering, Clinical Support Services, Contact Centre Collaboration.

The service is managed by Brad Healey General Manager. The Operation Managers are Barbara Schwalger for Clinical Support Services, Barbara Schwalger (acting) for Clinical Engineering, Chris Webb for Security, Traffic and Fleet, Teresa Stanbrook for Food Services and Matthew O'Connor for Contact Centre.

Highlight of the Month

Diabetes diet was launched for inpatient food services in October**.** This involves diets for non-insulin dependent diabetics, insulin dependent diabetics and gestational diabetics.

Key Issues

Clinical Engineering – to date we have been unable to fill the vacant Operations Manager role.

Food Services – we continue to focus effort on improving the quality of patient food services to Mason Clinic. A site have been identified afor a "pop-up kitchen" at Mason Clinic and the service is working on business case.

Scorecard – Clinical Support Services

Waitematā DHB Monthly Performance Scorecard

Clinical Support
September 2020
2020/21

Best Care

HR/Staff Experience	Actual	Target		Trend
Sick leave rate	3.4%	<3.4%	●	▼
Turnover rate - external	16%	<14%	●	▼
Vacancies - %	2%	<8%	●	▲

Value for Money

Financial Result (YTD)	Actual	Target		Trend
Revenue excl. COVID-19	94 k	48 k	●	▲
Expenses excl. COVID-19	8,967 k	8,537 k	●	▼
Net surplus/(deficit) excl. COVID-19	-8,872 k	-8,489 k	●	▼
COVID-19 net benefit/(cost)	-31 k	0 k		▲
Net surplus/(deficit) incl. COVID-19	-8,903 k	-8,489 k		▼

How to read

Performance indicators:
- ● Achieved/ On track
- ● Substantially Achieved but off target
- ● Not Achieved but progr
- ● Not Achieved/ Off track

Trend indicators:
- ▲ Performance ***improved*** compared to previous month
- ▼ Performance ***declined*** compared to previous month
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Key notes

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2. ***Actuals and targets*** in *grey bold italics* are for the most recent reporting period available where data is missing or delayed.
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Planning, Funding and Health Outcomes, Waitemata DHB

Scorecard Variance Report

Best Care

Turnover Rate – external - 16% against a target of 14%

Turnover rate has reduced this month to 16% for 12 month rolling average. Turnover is primarily in Support personnel of cleaning, orderly, traffic and security staff and vacancies are covered by casual staff. This KPI is lower than the 22% rate as at January 2019 reflecting the concerted effort being done in recruitment and retention of this staff group.

Value for Money

Expenses excluding COVID-19 – $8,967k against a target of $8,537k

The unfavourable variance was primarily due to the Financial Sustainability Programme allocated savings target for Clinical Support and Diagnostic Services which is $664k. A number of initiatives are being progressed that will realise benefits in future periods. Patient Meal costs are favourable $217k with lower than anticipated inpatient volumes.

Financial Results

Waitematā DHB Statement of Financial Performance

Clinical Support Services - Sep-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	0	0	0	0	0	0	0
Other Income	42	16	26	94	48	47	190
Total Revenue (excluding COVID)	42	16	26	94	48	47	190
EXPENDITURE							
Personnel							
Medical	0	0	0	0	0	0	0
Nursing	1	0	(1)	17	0	(17)	0
Allied Health	0	0	0	0	0	0	0
Support	1,448	1,476	29	4,939	5,110	171	20,204
Management / Administration	160	159	(1)	496	556	59	2,093
Outsourced Personnel	31	19	(13)	84	57	(27)	227
	1,639	1,654	15	5,536	5,723	187	22,524
Other Expenditure							
Outsourced Services	2	0	(2)	2	0	(2)	0
Clinical Supplies	133	114	(19)	441	352	(89)	1,396
Infrastructure & Non-Clinical Supplies	1,003	813	(190)	2,988	2,462	(526)	9,363
	1,138	927	(210)	3,430	2,814	(616)	10,759
Total Expenditure (excluding COVID)	2,777	2,581	(196)	8,967	8,537	(430)	33,283
Surplus/(Deficit) excluding COVID	**(2,735)**	**(2,565)**	**(169)**	**(8,872)**	**(8,489)**	**(383)**	**(33,093)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	(0)	0	(0)	(31)	0	(31)	0
Surplus/(Deficit) including COVID	**(2,735)**	**(2,565)**	**(170)**	**(8,903)**	**(8,489)**	**(414)**	**(33,093)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Comment on major financial variances

The overall result for Clinical Support Services was $170k unfavourable for September and $414k unfavourable for the YTD.

Revenue ($26k favourable for September, $47k favourable YTD)

The favourable variance for the YTD was due to new concession levies from staff café sales as well as Security Services charging for the issuance of ID cards.

Expenditure ($196k unfavourable for September, $430k unfavourable YTD)

The unfavourable variance for the YTD was primarily due to The Financial Sustainability Programme allocated savings target for Clinical Support and Diagnostic Services which is $664 unfavourable YTD. A number of initiatives are being progressed that will realise benefits in future periods.

Patient Meal costs are favourable $217k YTD with lower than anticipated inpatient volumes.

Personnel ($187k favourable YTD)
The favourable variance for the YTD does not include $33k of casual security guard costs that are coded in Infrastructure and Non-Clinical Supplies. Vacancy factor savings are being met by turnover in Clinical Support cleaners and orderlies where approximately 19% of shifts are covered by lower cost casual workforce

Other Expenditure ($616k unfavourable YTD)
Clinical Supplies ($89k unfavourable YTD)
The unfavourable variance for the YTD was due to clinical equipment consumables, repair and maintenance including outsourced bed repairs.

Infrastructure and Non-Clinical Supplies ($5261k unfavourable YTD)
The unfavourable variance YTD was due to Financial Sustainability Programme allocated savings target for Clinical Support and Diagnostic Services which is $666k unfavourable YTD.
Outsourced casual security guards where the budget is held as personnel cost are also $33k unfavourable YTD.
Patient Meal costs are $217k favourable YTD with lower than anticipated inpatient volumes.

COVID-19 ($31k unfavourable YTD)
COVID-19 related transactions are in relation to ventilation equipment and consumables.

3.2 Provider Arm Performance Summary Report – October 2020

Recommendation:

That the report be received.

Prepared by: Robert Paine (Chief Financial Officer and Head of Corporate Services) and Debbie Holdsworth (Acting Director of Hospital Services)

This report summarises the Provider Arm performance for October 2020.

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        Priority Health Outcome Areas
        Elective Performance Indicators (part of Planned Care Programme)
        Financial Performance

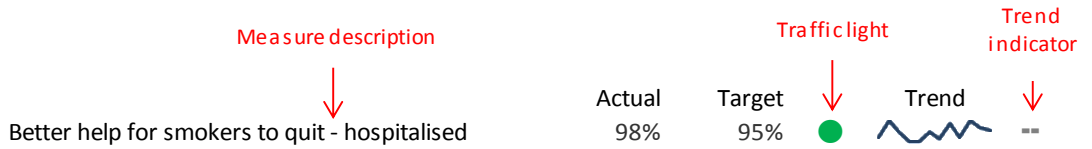
Glossary

ACC	-	Accident Compensation Commission
ADU	-	Assessment and Diagnostic Unit
ALOS	-	Average Length of Stay
ARDS	-	Auckland Regional Dental Service
AT&R	-	Assessment Treatment and Rehab
ASA	-	American Society of Anaesthesiologists
CADS	-	Community Alcohol, Drug and Addictions Service
CAMHS	-	Child, Adolescent Mental Health Service
CT	-	Computerised Tomography
CWF	-	Child, Women and Family service
DCNZ	-	Dental Council of New Zealand
DHB	-	District Health Board
DNA	-	Did Not Attend
ED	-	Emergency Department
ECHO	-	Echocardiogram
ESC	-	Elective Surgery Centre
ESPI	-	Elective Services Performance Indicators
FTE	-	Full Time Equivalent
GP	-	General Practitioner
HCA	-	Health Care Assistant
HT	-	Hypertensive Disorders
ICU	-	Intensive Care Unit
KMU	-	Kingsley Mortimer Unit
LMC	-	Lead Maternity Carer
LOS	-	Length of Stay
SMHOPS	-	Specialty Medicine and Health of Older People Services
MRI	-	Magnetic Resonance Imaging
MoH	-	Ministry of Health
NGO	-	Non Government Organisation
NSH	-	North Shore Hospital
NZNO	-	New Zealand Nurses Organisation
ORL	-	Otorhinolaryngology (ear, nose, and throat)
RMO	-	Registered Medical Officer
S&A	-	Surgical and Ambulatory Services
SCBU	-	Special Care Baby Unit
SGA	-	Small for Gestational Age Baby
SMHA	-	Specialist Mental Health & Addiction Services
SMO	-	Senior Medical Officer
WIES	-	Weighted Inlier Equivalent Separations

How to interpret the scorecards

Traffic lights

For each measure, the traffic light indicates whether the actual performance is on target or not for the reporting period (or previous reporting period if data are not available as indicated by the *grey bold italic* font).



The colour of the traffic lights aligns with the Annual Plan:

Traffic light	Criteria: Relative variance actual vs. target		Interpretation
●	On target or better		Achieved
●	95-99.9% achieved	0.1–5% away from target	Substantially Achieved
●	90-94.9%*achieved	5.1–10% away from target AND improvement from last month	Not achieved, but progress made
●	<94.9% achieved	5.1–10% away from target, AND no improvement, OR >10% away from target	Not Achieved

Trend indicators

A trend line and a trend indicator are reported against each measure. Trend lines represent the actual data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. The small data range may result in small variations appearing to be large.

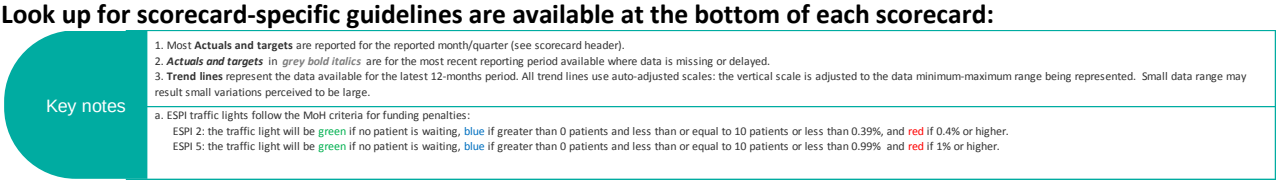
Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance trend, use the trend indicator as described below.

The trend indicator criteria and interpretation rules:

Trend indicator	Rules	Interpretation
▲	**Current > Previous** month (or reporting period) **performance**	Improvement
▼	**Current < Previous** month (or reporting period) **performance**	Decline
--	**Current = Previous** month (or reporting period) **performance**	Stable

By default, the performance criteria is the actual:target ratio. However, in some exceptions (e.g., when target is 0 and when performance can be negative (e.g., net result) the performance reflects the actual.

Look up for scorecard-specific guidelines are available at the bottom of each scorecard:



Scorecard – All services

Waitematā DHB Monthly Performance Scorecard

ALL Services
October 2020
2020/21

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	94%	95%	▲
Faster cancer treatment (62 days)	89%	90%	▼

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	12 days	≤14 days	▼
Net Promoter Score FFT	81	65	▼
Improving Outcomes			
Better help for smokers to quit - hospitalised	100%	95%	--
Quality & Safety			
Older patients assessed for falling risk	99%	90%	--
Rate of falls with major harm	0.13	≤2	▼
Good hand hygiene practice	90%	80%	▼
S. aureus infection rate	0.13	≤0.13	▼
Occasions insertion bundle used	100%	95%	--
Pressure injuries grade 3&4	1	0	▲
HR/Staff Experience			
Sick leave rate	3.3%	≤3.4%	--
Turnover rate - external	10%	≤14%	--
Vacancies - %	4%	≤8%	▼

Service Delivery

Elective Volumes	Actual	Target	Trend
Provider Arm - Overall	100%	100%	▲
Waiting Times			
ESPI 2 - % patients waiting > 4 months for FSA		Non-Compliant	
ESPI 5 - % patients not treated w/n 4 months		Non-Compliant	
ESPI 1 - OP Referrals processed w/n 10 days		Compliant	
Patient Flow			
Outpatient DNA rate (FSA + FUs) - Total	7%	≤10%	▼
Outpatient DNA rate (FSA + FUs) - Māori	16%	≤10%	▼
Outpatient DNA rate (FSA + FUs) - Pacific	16%	≤10%	▼

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue excl. extraordinary items	349,073 k	345,086 k	▲
Expenses excl. extraordinary items	366,202 k	358,687 k	▼
Net surplus/(deficit) excl. extraordinary items	-17,129 k	-13,600 k	▼
COVID-19 net benefit/(cost)	-1,287 k		▲
Holiday Pay provision	8,000 k		▲
Net surplus/(deficit) incl. extraordinary items	-26,416 k	-13,600 k	▼
Contracts (YTD)			
Elective WIES Volumes	6,335	6,765	▲
Acute WIES Volumes	23,164	23,084	▲

How to read

Performance indicators:
- Achieved/ On track
- Not Achieved but progress made
- Substantially Achieved but off target
- Not Achieved/ Off track

Trend indicators:
- ▲ Performance ***improved*** compared to previous month
- ▼ Performance ***declined*** compared to previous month
- -- Performance was ***maintained***

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in ***grey bold italics*** are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 12-month period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. A small data range may result in small variations appearing to be large.

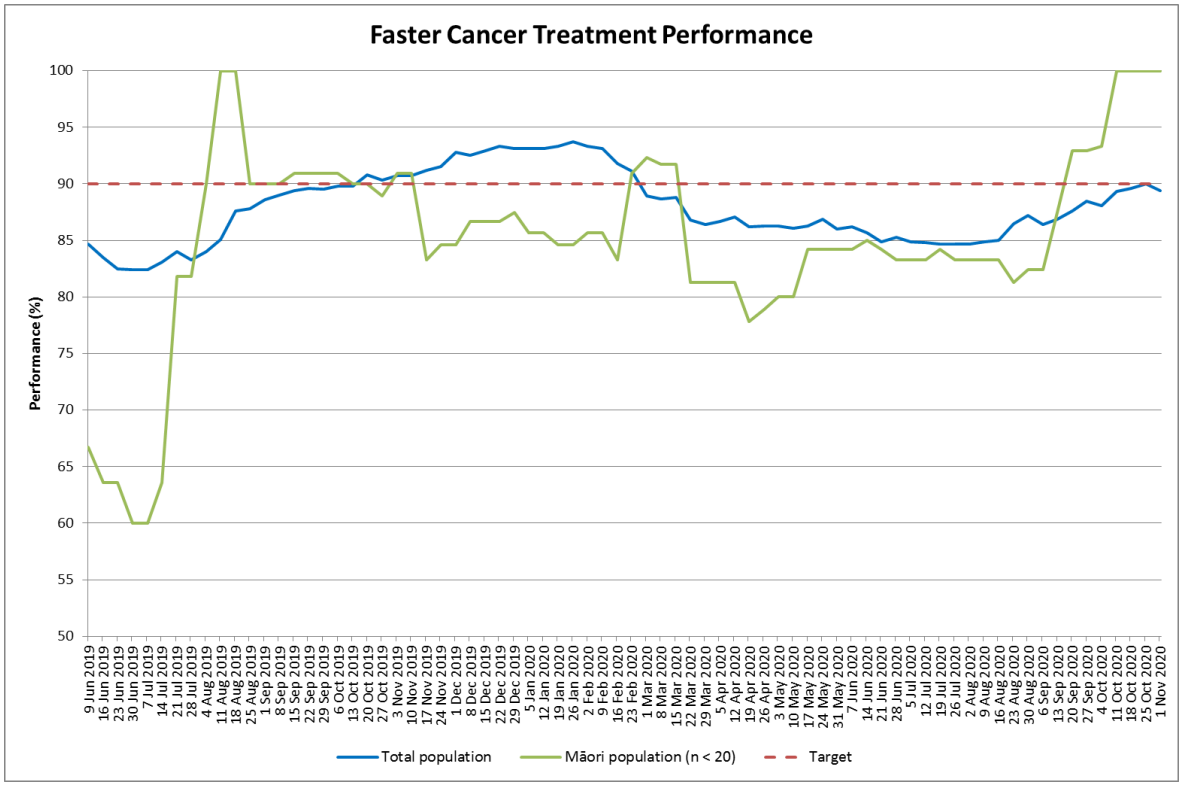
a. September data

A question?

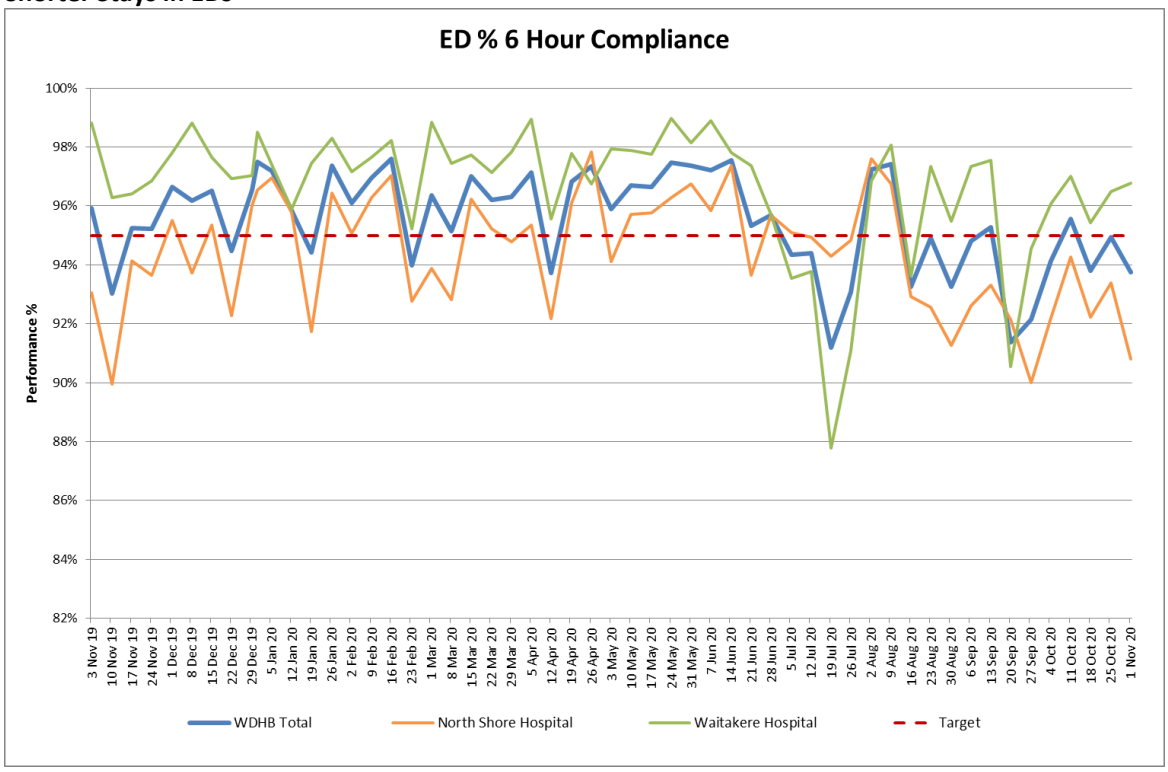
Contact:
Victoria Child - **Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz**
Planning, Funding and Health Outcomes, Waitematā DHB

Priority Health Outcome Areas

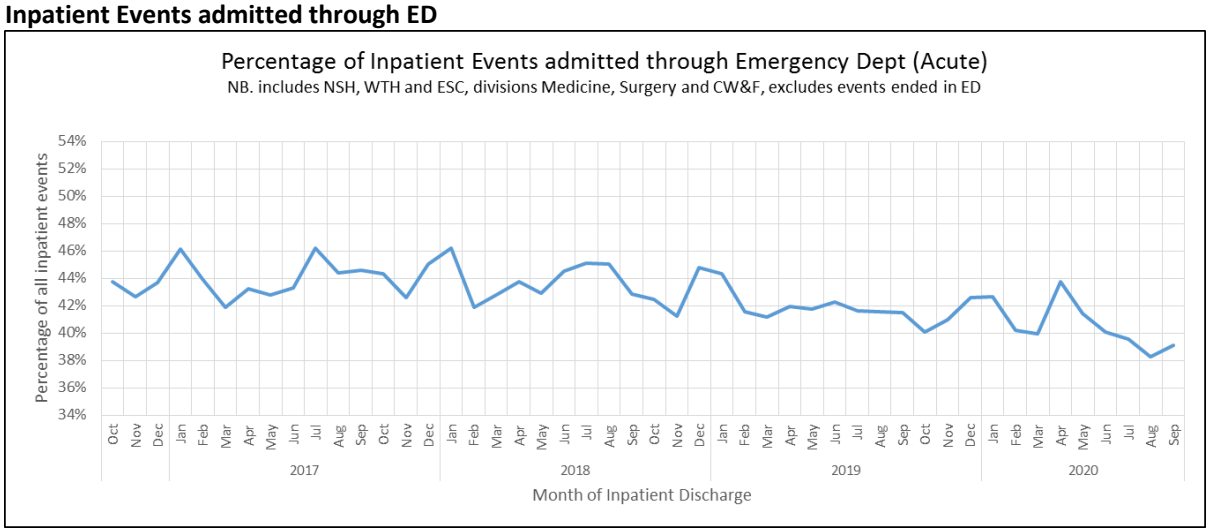
Faster Cancer Treatment



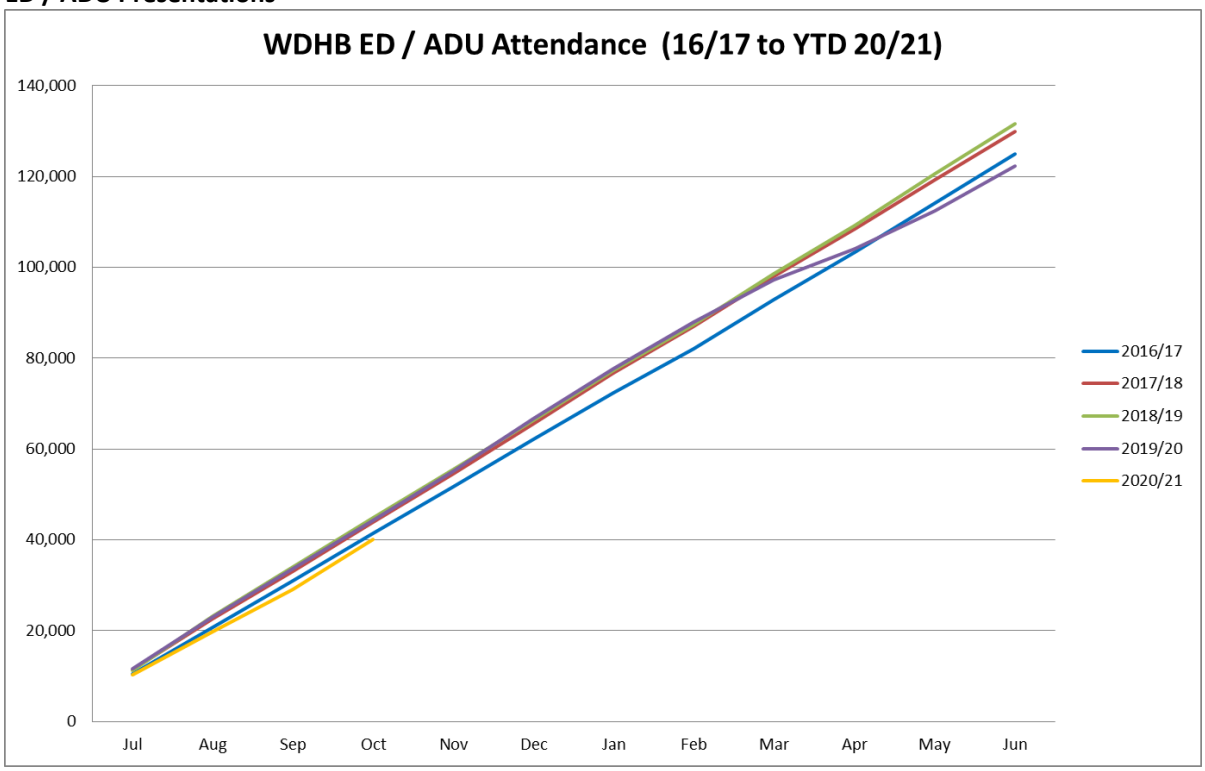
Shorter Stays in EDs



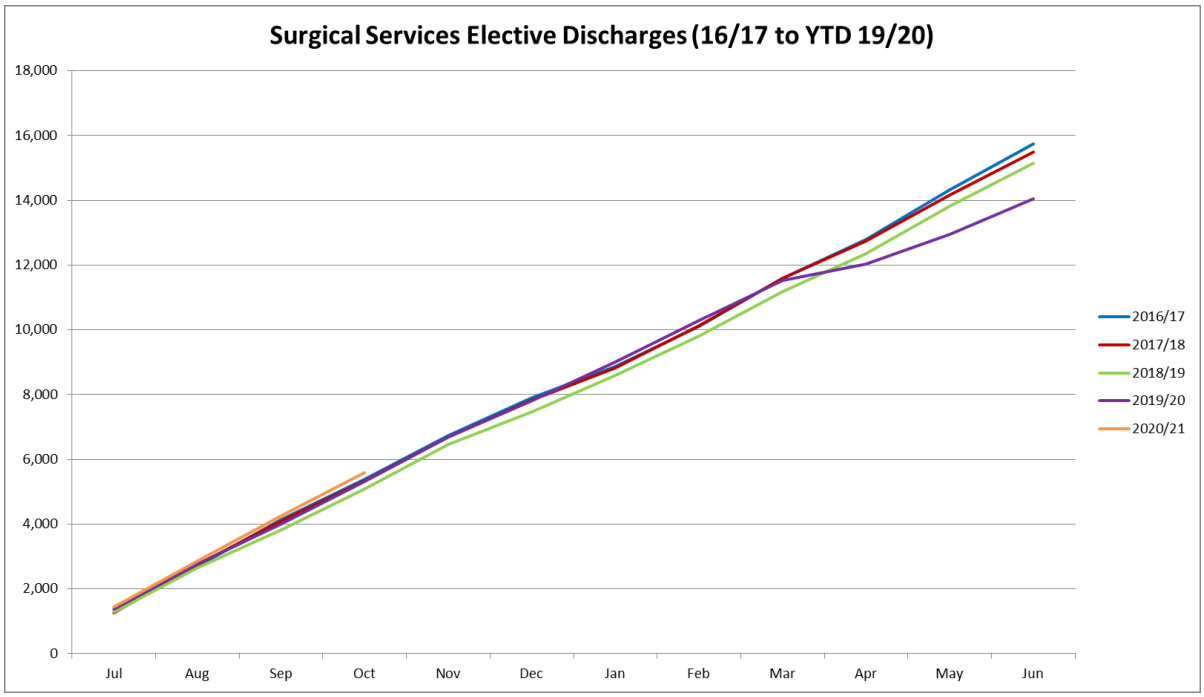
Inpatient Events admitted through ED



ED / ADU Presentations



Surgical Services Elective Discharges



* Surgical discharge volumes include all elective Orthopaedic, Gynaecology, ORL, Urology and General Surgery discharges (including skin lesions).

Percentage Change ED and Elective Volumes

October 2020	Month Volumes	% Change (last year)	YTD Volumes	% Change (last year)
ED/ADU Volumes	10,956	2%	40,063	-10%
Surgical Services Elective Discharge Volumes	1327	1%	5584	5%

Elective Performance Indicators

Zero patients waiting over four months

Summary (October 2020)	
Speciality	Non Compliance %
ESPI 2 - Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	3.55%
ESPI 5 - Patients given a commitment to treatment but not treated within the required timeframe.	19.69%

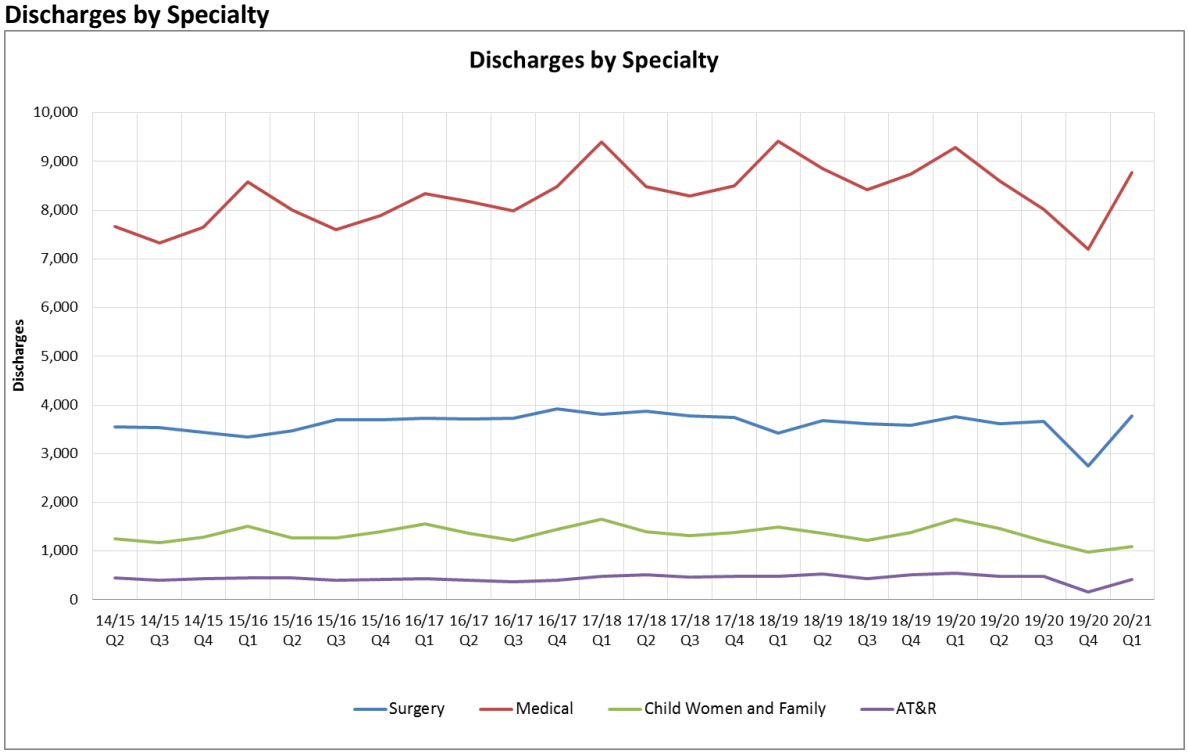
ESPI	WL Specialty	Compliant	Non Compliant	Non Compliant
ESPI 2	Anaesthesiology	120	-	0.00%
	Cardiology	1,242	-	0.00%
	Dermatology	281	-	0.00%
	Diabetes	219	-	0.00%
	Endocrinology	191	-	0.00%
	Gastro-Enterology	989	-	0.00%
	General Medicine	247	-	0.00%
	General Surgery	1,377	170	10.99%
	Gynaecology	1,104	36	3.16%
	Haematology	90	-	0.00%
	Infectious Diseases	61	-	0.00%
	Neurovascular	95		0.00%
	Orthopaedic	2,296	17	0.73%
	Otorhinolaryngology	1,232	167	11.94%
	Paediatric MED	648	-	0.00%
	Renal Medicine	277	-	0.00%
	Respiratory Medicine	499	-	0.00%
	Rheumatology	217	-	0.00%
	Urology	729	49	6.30%
	Total	11,914	439	3.55%
ESPI 5	Cardiology	101	-	0.00%
	General Surgery	1,589	110	6.47%
	Gynaecology	502	140	21.81%
	Orthopaedic	1,134	470	29.30%
	Otorhinolaryngology	303	71	18.98%
	Urology	359	187	34.25%
	Total	3,988	978	19.69%

90% of outpatient referrals acknowledged and processed within 10 days

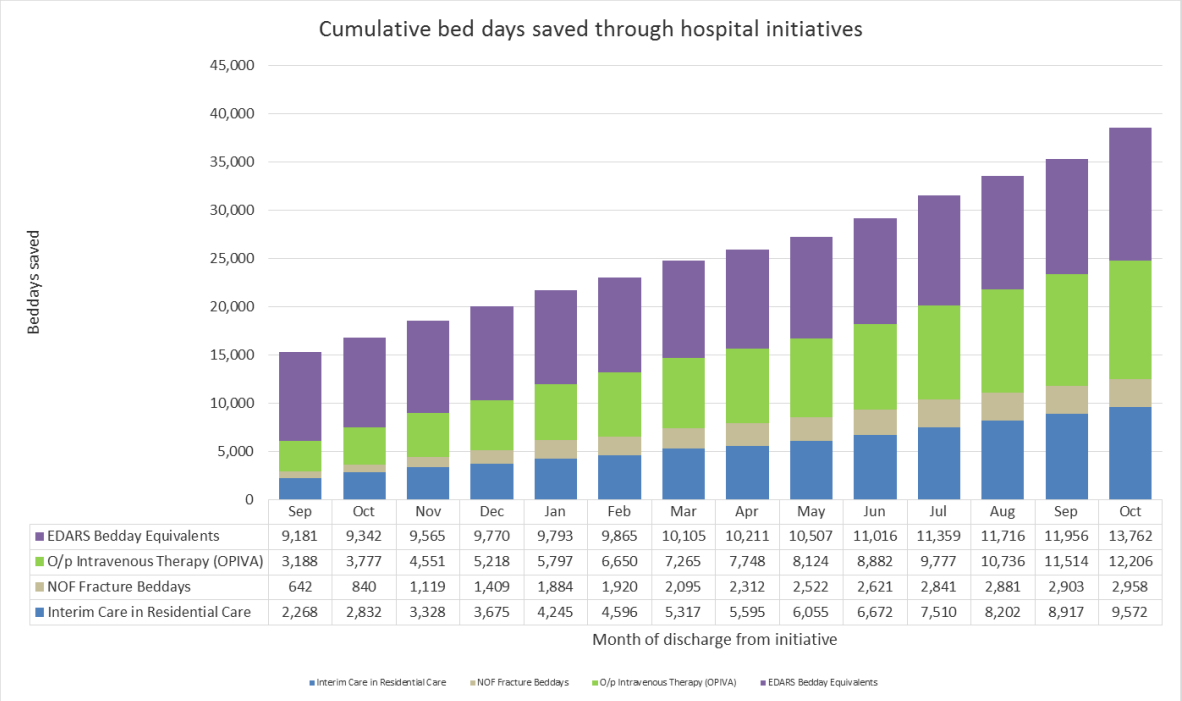
ESPI 1 (October 2020)	
Specialty	Compliance %
Anaesthesiology	100.00%
Cardiology	99.49%
Dermatology	100.00%
Diabetes	99.30%
Endocrinology	100.00%
Gastro-Enterology	99.54%
General Medicine	98.95%
General Surgery	97.93%
Gynaecology	94.39%
Haematology	98.73%
Infectious Diseases	100.00%
Neurovascular	98.65%
Orthopaedic	96.80%
Otorhinolaryngology	100.00%
Paediatric MED	99.05%
Renal Medicine	100.00%
Respiratory Medicine	99.72%
Rheumatology	99.35%
Urology	99.73%
Total	98.55%

Legend	
ESPI 1	Green if 100%, Yellow if between 90% and 99.9%, and Red if 90% or less.
ESPI 2	Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.39%, and Red if 0.4% or higher.
ESPI 5	Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.99%, and Red if 1% or higher

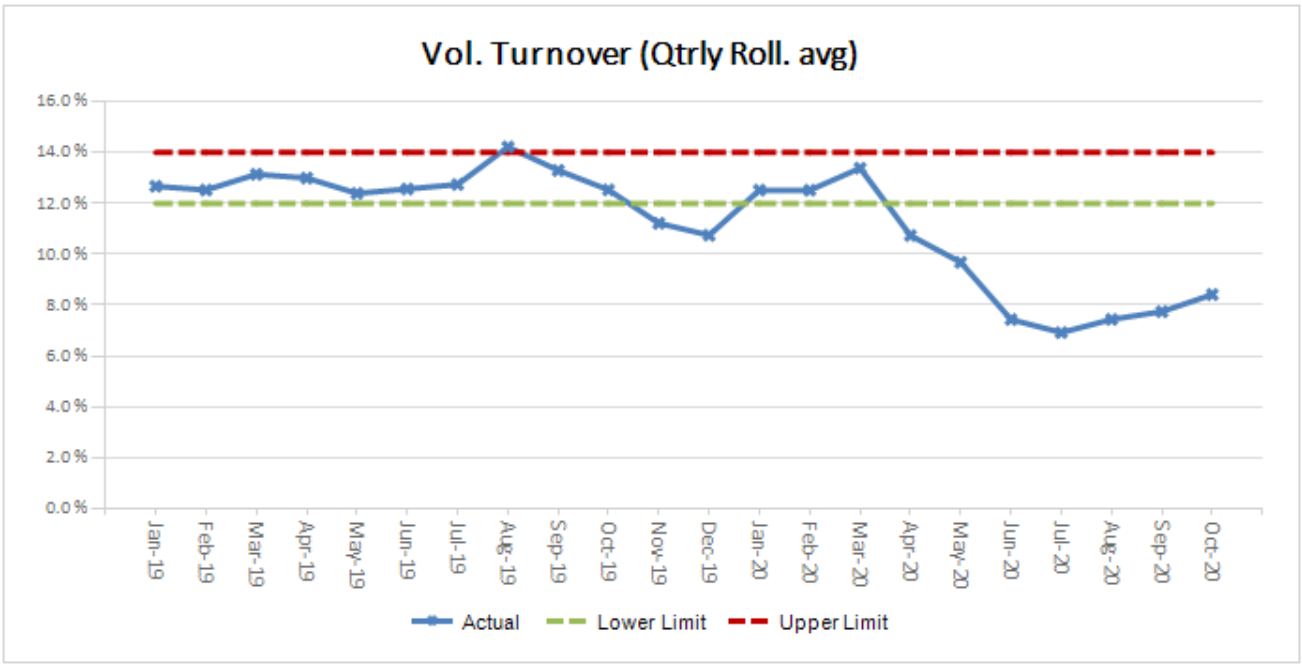
Discharges by Specialty

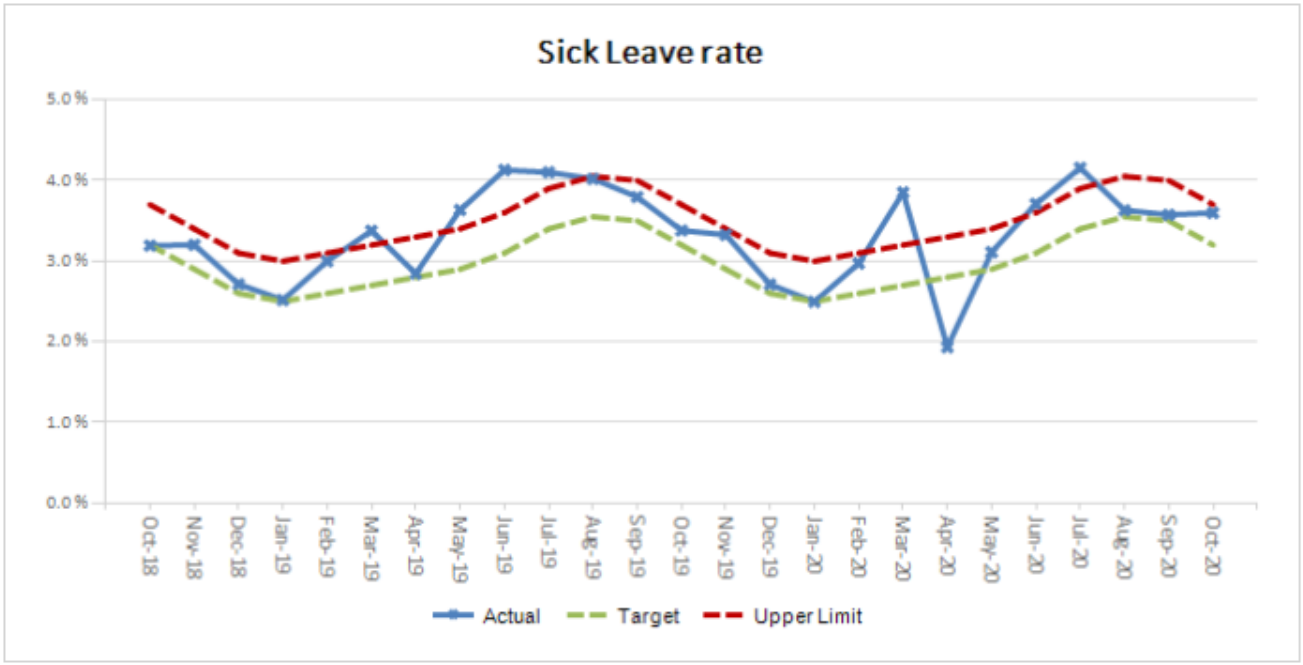


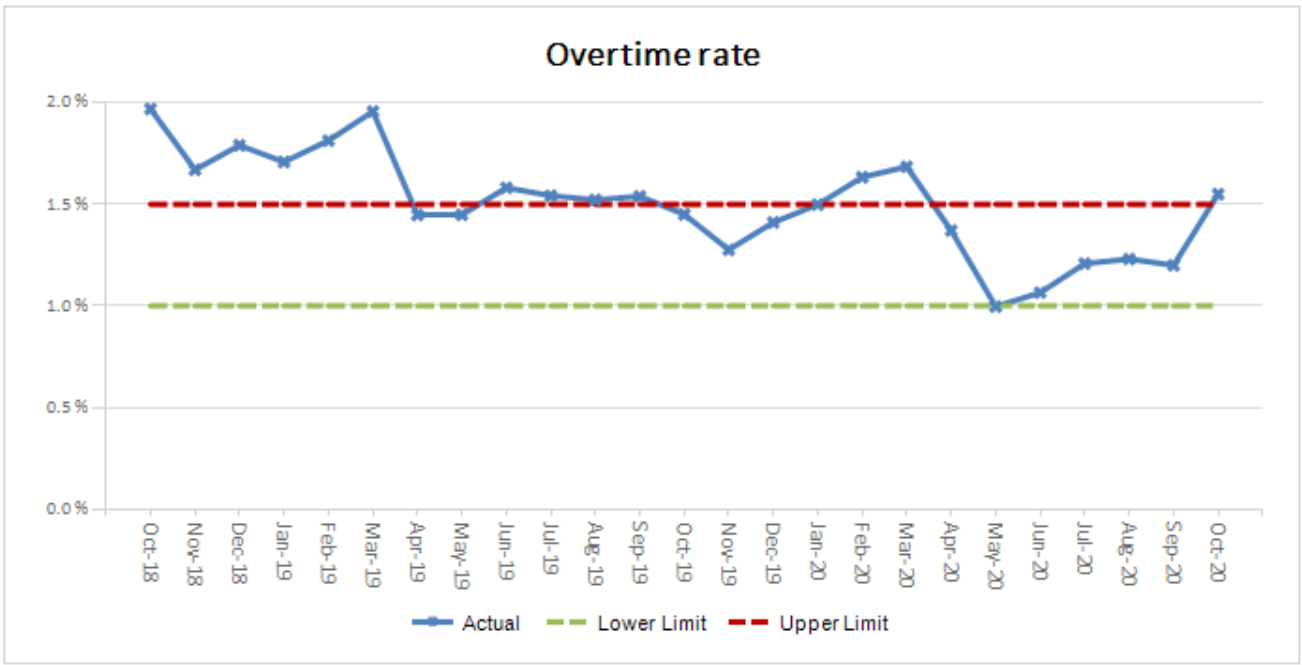
Cumulative Bed Days saved through Hospital Initiatives



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
EDARS Bedday Equivalents	9,181	9,342	9,565	9,770	9,793	9,865	10,105	10,211	10,507	11,016	11,359	11,716	11,956	13,762
O/p Intravenous Therapy (OPIVA)	3,188	3,777	4,551	5,218	5,797	6,650	7,265	7,748	8,124	8,882	9,777	10,736	11,514	12,206
NOF Fracture Beddays	642	840	1,119	1,409	1,884	1,920	2,095	2,312	2,522	2,621	2,841	2,881	2,903	2,958
Interim Care in Residential Care	2,268	2,832	3,328	3,675	4,245	4,596	5,317	5,595	6,055	6,672	7,510	8,202	8,917	9,572




Sick Leave rate
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Actual
Target
Upper Limit


Overtime rate
2.0%
1.5%
1.0%
0.5%
0.0%
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Actual
Lower Limit
Upper Limit

Financial Performance

Waitematā DHB Statement of Financial Performance

Provider - Oct-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	85,100	83,998	1,102	338,287	336,719	1,568	1,008,037
Other Income	2,677	2,236	441	10,786	8,367	2,419	41,825
Total Revenue (excl. extraordinary items)	87,777	86,234	1,543	349,073	345,086	3,987	1,049,862
EXPENDITURE							
Personnel							
Medical	18,011	18,391	380	70,520	70,010	(511)	221,100
Nursing	23,933	23,843	(90)	96,533	97,260	727	296,150
Allied Health	11,451	11,045	(406)	45,569	44,657	(912)	134,634
Support	2,299	2,191	(108)	8,613	8,993	380	27,550
Management / Administration	7,010	7,470	460	26,927	29,474	2,547	88,151
Outsourced Personnel	2,274	1,359	(914)	8,535	5,157	(3,377)	15,503
	64,978	64,299	(679)	256,698	255,552	(1,146)	783,088
Other Expenditure							
Outsourced Services	5,343	5,615	272	22,488	22,398	(90)	66,234
Clinical Supplies	12,627	11,802	(825)	47,587	47,267	(320)	138,622
Infrastructure & Non-Clinical Supplies	11,287	8,192	(3,095)	39,429	33,469	(5,959)	98,719
	29,257	25,610	(3,648)	109,504	103,135	(6,370)	303,575
Total Expenditure (excl. extraordinary items)	94,236	89,909	(4,327)	366,202	358,687	(7,515)	1,086,662
Surplus/(Deficit) excl. extraordinary items	**(6,459)**	**(3,675)**	**(2,784)**	**(17,129)**	**(13,600)**	**(3,528)**	**(36,800)**
Extraordinary items							
COVID-19 Net benefit/(cost)	432	0	432	(1,287)	0	(1,287)	0
Holiday Pay provision	(2,000)	0	(2,000)	(8,000)	0	(8,000)	0
Surplus/(Deficit) incl. extraordinary items	**(8,027)**	**(3,675)**	**(4,352)**	**(26,416)**	**(13,600)**	**(12,815)**	**(36,800)**

* Government and Crown Agency : Includes MoH direct revenue, ACC and CTA revenue. Excludes PBFF revenue.

Waitematā DHB Statement of Financial Performance

Provider by service - Oct-20

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
CONTRIBUTION (excl. extraordinary items)							
Surgical and Ambulatory	(13,773)	(13,321)	(452)	(51,942)	(49,118)	(2,824)	(145,917)
Acute and Emergency	(15,018)	(14,895)	(123)	(53,477)	(53,014)	(463)	(157,065)
Specialty Medicine and HOPS	(8,336)	(8,550)	214	(31,882)	(32,105)	223	(94,334)
Child Women and Family	(5,859)	(5,993)	134	(21,104)	(21,222)	118	(62,811)
Regional Dental	(2,197)	(2,219)	23	(8,993)	(9,627)	634	(27,498)
Specialist Mental Health and Addiction	(13,296)	(12,694)	(602)	(48,006)	(46,048)	(1,958)	(136,524)
Elective Surgery Centre	(2,818)	(2,723)	(95)	(10,294)	(10,008)	(286)	(28,228)
Clinical Support	(3,067)	(2,555)	(512)	(11,940)	(11,045)	(895)	(32,987)
Diagnostics	(8,496)	(9,024)	528	(34,326)	(35,456)	1,131	(106,096)
Corporate and Provider Support	66,402	68,301	(1,899)	254,835	254,043	792	754,661
Net Surplus/(Deficit) excl. extraordinary iten	**(6,459)**	**(3,675)**	**(2,784)**	**(17,129)**	**(13,600)**	**(3,528)**	**(36,800)**
Extraordinary items							
COVID-19 Net benefit/(cost)	432	0	432	(1,287)	0	(1,287)	0
Holiday Pay provision	(2,000)	0	(2,000)	(8,000)	0	(8,000)	0
Surplus/(Deficit) incl. extraordinary items	**(8,027)**	**(3,675)**	**(4,352)**	**(26,416)**	**(13,600)**	**(12,815)**	**(36,800)**

Provider $3.528m unfavourable year to date (excluding Holiday Pay and COVID-19 impacts) - key financial performance factors:

- Unfavourable personnel costs, primarily in Specialist Mental Health & Addiction - Nursing personnel, with higher than usual staff retention rates and sick leave.
- Unfavourable clinical supply costs, primarily in Surgery and Ambulatory due in part to unmet savings and increased levels of activity.
- These unfavourable variances are partially offset by staff vacancies and releases of prior year MECA and ACC provisions in Corporate & Provider Support of $585k.

Extraordinary cost year to date are Holidays Act impact for 2020/21, $8.000m and COVID-19 impacts after offsetting additional revenue, $1.287m

Surgical Services and ESC (YTD $3.110m unfavourable to budget)

- $1.128m of the variance relates unachieved savings plan, due to the focus on increasing elective outputs to regain compliance, as well as acute volumes at 6.5% over contract (370 WIES above - $2.05m) which has made it very challenging to introduce savings initiatives.
- Combined acute and elective cost-weight (WIES) discharges YTD are 11.71k compared to 10.93k as at October 2019. This represents an additional $4.325m delivery in volumes. Year on year the non-personnel budget, including Clinical supplies, Infrastructure and Outsourced costs have increased by $390k YTD versus the $4.325m of additional delivery, which has resulted in a $1.51m unfavourable variance in non-personnel costs.
- Elective discharges YTD for the five key surgical services have followed the following cumulative YTD pattern over recent years:

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
July	1,310	1,283	1,264	1,289	1,375	1,444
August	2,571	2,697	2,743	2,650	2,780	2,874
September	3,828	4,145	4,089	3,821	3,999	4,265
October	4,906	5,374	5,341	5,094	5,315	5,691

The results to October 2020 reflect a 7.0% increase when compared to last year.

- Weekend acute theatres in July and extended elective lists since August have increased Nursing costs in NSH theatre and PACU. NSH PACU has also required additional staff due to increased volumes of ECT and Interventional Radiology, the latter arising from the recently agreed SLA with ADHB. Overall Nursing costs are $297k over budget for NSH theatres service.
- Skin Lesions continue to be outsourced above the budgeted value ($360k) to meet the PVS production plan.

Acute and Emergency Medicine Services (YTD $0.463m unfavourable to budget)

The unfavourable variance is driven by:

- Emergency Departments (ED) had a busy month in October, with patient presentations 15% and 2% higher in NSH and WTH respectively, compared to the same month last year. Good management and increased availability of SMOs has resulted in lower medical cover costs in the month, as well as for the YTD. Some of this saving is offset by the cover cost for two senior doctors who have been on long term sick leave.
- Inpatient wards were tracking close to plan both in terms of bed days and WIES. The service had contained costs successfully, with active control of staffing around flexed bed management. Nursing costs were higher for patient watches however the service has realised some cost reductions in the month when a new policy in this area was implemented. Medical costs are anticipated to increase over the remaining months of this year with recruitment now underway for the home-based wards initiative.

- Cardiology services has another busy month with a high number of cases for both pacemakers and ICDs in the month. Extra resources were deployed in the month in order to reduce the volume of outpatient follow up appointments. This high-level productivity resulted in higher clinical consumable costs and higher medical cost for the month. There is ongoing financial risk here, due to higher cost levels that will be needed to reduce the waiting list to a compliant level given that the list has grown due to Covid-19. As part of the volume catch up plan, the commencement of cath-lab rebuild extended working hours from 22nd September has increased the cost pressure for the service.

Specialty Medicine and Health of Older Persons Services (YTD $223k favourable to budget)
The service has achieved savings of approximately $730k YTD against the FSP programme, much of which has contributed to the favourable budget variance. However, off-setting this was an unfavourable variance driven by pressure from a record low average vacancy rate of 17 FTEs, as at October ($356k).

Child, Women and Family (YTD $118k favourable to budget)
The service continues to make good progress with its 2020/21 financial sustainability savings programme with benefits being realised across Paediatric Inpatient staffing and supply costs, Maternity service overtime has reduced with improved staffing levels and there has been less reliance on external postnatal transfers to Birthcare Auckland and reduced expenditure associated with activity either ceasing, or being relocated back to ADHB (Starship clinics exit from the Wilson Centre) .

Regional Dental Service (YTD $634k favourable to budget)
The favourable variance is driven by:
Regional Dental Service (YTD $634k favourable to budget)
The favourable variance is driven by:

- Staffing levels have remained steady over the past eight months. COVID-19 related clinic closures and pre-screening of children prior to appointment along with new NZ Dental Council measures around infection prevention and control have impacted productivity across the service. A reduction in children being seen is evident in reduced spending in clinical supplies and infrastructure costs. The service continues to develop its workforce recruitment and retention strategies as part of an overarching ARDS Improvement Plan.
- The 2020/21 financial sustainability savings programme for ARDS has financial benefits being realised through reduced clinical supply costs. Work continues on service contract reviews and managing staff transport costs. It is expected that the financial sustainability savings requirements will be met this year through reduced clinical supplies and the more complex contract work will be more prominent in the next financial year.

Specialist Mental Health and Addiction Services (YTD $1.958m unfavourable to budget)
The unfavourable variance was driven by:

- Revenue is $744k favourable to budget, this is driven by an uplift in ID unit revenue in Pohutakawa ($221k), research grants ($63k), court reporting ($221k) and the new Registrar Training Program ($67k).
- Staff costs are $2.167m unfavourable, mostly due to staff retention being higher than normal, in particular in Nursing which is $1.454m unfavourable and Allied Health which is $1.050m unfavourable. Year on year the service has carried a high number of vacancies and looked to Allied staff to support vacancies in Nursing staff, however recently Nursing vacancies have reduced to 64 FTE compared to 99 FTE this time last year and Allied Heath vacancies have reduced from 53 to 22.
- Overtime has significantly increased due to acuity and is still high due to sick leave (50% above run rate). Overtime is 8.4% against target 6.7% and up from 6.9% last month.
- Outsourced services are $1.111m unfavourable and mainly driven by an overspend on locums ($880k), equivalent to 8.4 FTE to cover sick leave, maternity leave and vacancies.
- Infrastructure & Non-Clinical Supplies are $176k unfavourable mainly driven by rent and IT support charges from prior year.

- Clinical Supplies are $102k favourable, most notably with a reduced number of after care services (Flexifund), this however is expected to increase over the next few months.

Diagnostics Services (YTD $1.131m favourable to budget)
The favourable variance is driven by:

- Revenue of $2.2m from Ministry of Health for COVID-19 testing in Laboratory and $340k for Radiology COVID-19 catch up. There has also been additional $455k unbudgeted revenue from Auckland DHB through identification of additional scanning which could be charged back.
- Outpatient Pharmacy is $1.061m unfavourable YTD driven by higher volumes of claims under Community Pharmacy Programme than prior years.
- Despite additional revenue of almost $800k, Radiology is $552k unfavourable due to the cost of catch up through additional sessions resulting in additional personnel costs, overtime and outsourcing.
- MITs are currently over-recruited leading to a higher than planned personnel cost. Normally it is prudent to over recruit at the time of graduation (January) to absorb turnover as MITs leave the DHB in the course of the year.
- The new Northern Region Interventional Radiology service involves increasingly complex procedures, involving higher cost consumables being carried out at NSH. Year to date the impact is $80k unfavourable.
- The service has had to outsource X-Rays ($200k) due to the backlog that arose from the strikes at the start of 2020 and which could not be cleared in the interim due to COVID-19.
- CT COVID-19 catch up has required a reliance on outsourcing to support inpatient capacity to process the necessary volumes. YTD spend, all unbudgeted, is $727k which has improved the MoH KPI from 52% at 1 July to 90% at end of September; MoH KPI is 95%.

Corporate and Provider Arm Support Services (YTD $792m favourable to budget)
The favourable variance is driven primarily by:

- Savings from staff vacancies $855k
- Underspends on provisional initiatives and finalisation of MECA and ACC provisions.

4.1 Clinical Leaders' Report

Recommendation:

That the report be received.

Prepared by: Dr Jonathan Christiansen (Chief Medical Officer),
Dr Jocelyn Peach (Director of Nursing and Emergency Systems Planner) and
Sharon Russell (Associate Director of Allied Health, Scientific and Technical Professions)

Quality and Risk

The incident reporting system RiskMonitor Pro was successfully upgraded to the latest version RL6, on 15th October 2020. This was a significant upgrade as RiskMonitor Pro had not been upgraded since it was introduced 14 years ago. RL6 provides improved functionality and connectivity, using the same information it allows staff to report both patient and staff injuries sustained as a result of the same incident, as well as enabling the reporter of an incident to track the progress of the management of the incident.

Te Rā Haumaru Tūroro o Aotearoa | Aotearoa Patient Safety Day was celebrated on 17th November 2020. The day was coordinated by the Health Quality & Safety Commission, with support from ACC and PHARMAC, and was promoted throughout the health sector. This year's theme was Getting through together | Whāia e tātou te pae tawhiti. Waitematā DHD used the day to remind staff the importance of taking care of their own wellbeing as well as our community's. The day also provided an excellent opportunity to formally launch the Wellbeing Navigator tool. This tool has been designed by our staff, for our staff; it asks users to complete a series of questions based on a World Health Organisation wellbeing questionnaire, and then provides a customised list of resources based on the result. The tool can be found at http://www.ourwellbeing.waitematadhb.govt.nz/ .

Informed Consent

The implementation of the revised Agreement to Treat/Consent form is well underway and the full transition should be complete by early December. The new form is the first at Waitematā DHB to have extensive input from the Consumer Council and is written in plain language to aid patient and whānau understanding.

Medical Education report

Key issues:

1. RMO rotation date change - update
2. RMO recruitment
3. Countersignatures for health student entries in clinical notes
4. Prevocational education supervisors (PES) required
5. Community based attachments (CBA) – no change since 29.07.20 HAC report
6. Observerships
7. End of Life choice Act – impact on RMOs

Change to RMO annual training and employment rotation – update
The national annual employment and training cycle for RMOs has been shifted from late November to late January. There are significant short and long term gains for NZ healthcare from this change. There

has been significant discussion with Resident Doctors' Association (RDA) and Specialty Trainees of New Zealand (SToNZ) with resolution of issues.

Waitematā DHB has 22 PGY1s starting in November. Multiple RMO placement changes have occurred to allow these early starters to work in service (rather than supernumerary) roles however, there will still be more than 10 supernumerary PGY1s. Forty PGY1s will start in January 2021, which is the new standard start date. There are some RMO staffing gaps during the transition period but no significant issues are anticipated.

RMO recruitment
Recruitment for the 2021 training year has been markedly more competitive than in previous years. Waitematā DHB has recruited fewer IMGs than usual due to more local applicants and barriers to immigration (visas, flights, isolation). The long term impact of COVID-19 on recruitment and RMO staffing is not yet clear.

Countersignatures for health student entries in medical notes
eNotes has been successfully rolled out across most Waitematā DHB departments. The rollout has highlighted previously unknown inconsistencies in the approach to health care student entries in the clinical notes. Waitematā DHB is working with its education provider partners to ensure a uniform approach to this issue across all disciplines.

Prevocational Educational Supervisors (PES)
Supervision of PGY1+PGY2 RMOs is strictly monitored by the Medical Council New Zealand (MCNZ). Waitematā DHB currently has a shortfall of PESs (who can only supervise up to 10 interns). Additional FTE are a requirement for MCNZ accreditation and an updated business case will be submitted to ELT in early 2021.

Community Based attachments (CBA)
The DHB Chairs and CEOs have received a further letter from the MCNZ on 21 September, highlighting the requirements for all PGY1 and 2 interns to complete a CBA. The letter strongly urges all DHBs to continue to work towards fully achieving the CBA target as soon as possible.

At present, Waitematā DHB offers more CBA opportunities than the other two metro Auckland DHBs, however, to achieve the requirements of the MCNZ, additional positions are needed. There are significant challenges in ensuring CBAs are suitable learning opportunities, are appropriately supervised and are sustainable.

The Director of Clinical Training has a strategic plan to comprehensively review past and current CBAs prior to planning future CBAs. This will lead a program of work to identify further positions that could be considered for CBAs. Additional funding will be needed for those positions, estimated at ~85k pa per position (NRA data).

Observerships
Waitematā DHB has suspended all clinical observerships at present due to COVID-19, lengthening of the University of Auckland medical student year and RMO rotation date changes. Observerships are usually undertaken by doctors who have graduated from the NZREX programme. At present there are no employment opportunities in metro-Auckland for NZREX graduates.

End of Life Choice Act
The End of Life Choice Act has widespread implications for RMOs across Waitematā DHB. This will be closely monitored and training and support will need to be rapidly planned and delivered as End of Life Choice are incorporated into standard care.

Senior Medical Officers

The Executive Leadership Team, representatives from Association of Salaried Medical Specialists (ASMS) and a large and diverse group of SMOs met on 3 November to discuss key issues related to the provision of patient care and maintenance of clinical skills. Topics included Telehealth, systems and personal learnings from the experience of the COVID-19 pandemic, the Clinical Ethics Advisory Group and the RMO transition (as highlighted in the report above). SMOs also discussed the challenges of maintaining currency of learning with the inability to attend major conferences and hands-on workshops. Ideas and some innovative solutions for local opportunities were presented. Two such forums are scheduled for 2021.

Allied Health, Scientific and Technical Professions

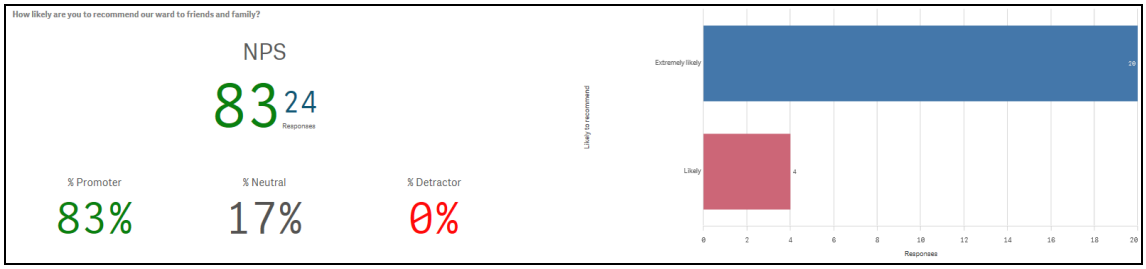
Prepared by Sharon Russell, Associate Director Allied Health, Scientific and Technical Professions
and Tamzin Brott, Director of Allied Health, Scientific and Technical Professions

(Forty-two (43) professions, accounting for 24% of the Waitematā DHB workforce.)

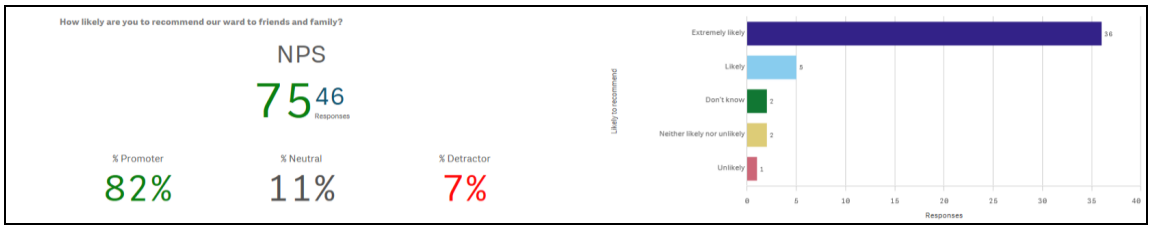
Everyone Matters, With Compassion, Connected and Better, Best, Brilliant

Friends and Family Test – Allied Health September and October 2020

September 2020



October 2020



A selection of comments received in September and October 2020 for the Allied Health group:

- *"Everyone is so kind and caring and I wouldn't have gotten to where I am now without them."*
- *"Because the exercises and the activities suited to my needs."*
- *"This service is extremely important for stroke patients. Admire the whole team. Very responsible. Answering all questions and doing additional research to answer enquiries. All Team act in very friendly manner. Patient feels respected and appreciated. "*
- *"Because I found the exercises and advice help me doing things for myself, also including the speech practice. Everything just worked and I enjoyed it because it helped me spiritually, physically and emotionally."*
- *"Very warm service. Feel comfortable talking with."*
- *"My Mum was bed bound when she left hospital. She had done good progress with Louise that she can now walk with help."*
- *"Dentist Pam is outstanding!"*
- *"I would not be walking around if it was not for them."*
- *"Excellent advice, and attention to patient's/client's needs. Very grateful."*
- *"Caroline was very diligent in contacting me and providing helpful advice for my problems. She was most helpful with my particular difficulties and offered very useful and easily followed advice as well as caring about the outcomes for me from following that advice for my better enjoyment of daily life!"*

Recruitment and retention of Māori and Pasifika workforce

Four allied health professions (Oral Health, Dietetics, Occupational Therapy and Physiotherapy) are in focus, with work plans in place locally, regionally and nationally in order to recruit and retain Māori and Pasifika clinicians reflecting the communities we serve. These workplans include maintaining links with tertiary institutions, promoting Waitematā DHB scholarship programmes across all professions within Allied Health, and encouraging the promotion of Allied Health professions within secondary education.

Current Māori and Pasifika staff across those priority professions and staff required to reflect the working population as of August 2020 are:

MALT PRIORITY ALLIED September 2020	Māori in current workforce	% of Māori in current workforce	Number of Māori to reflect working population	Additional Māori required	Recruited last 12 months	Terminated last 12 months	Last 12 months Movement
Oral Health Therapist	14	8.0%	16	2	1	-3	-2
Dietitian	3	5.7%	5	2	1	0	1
Occupational Therapist	9	5.4%	15	6	5	-2	3
Physiotherapist	10	9.1%	10	0	4	-2	2
Total AH Priority Professions	**36**	**7.1%**	**46**	**10**	**11**	**-7**	**4**

PALT PRIORITY ALLIED September 2020	Pacific in current workforce	% of Pacific in current workforce	Number of Pacific to reflect working population	Additional Pacific required	Recruited last 12 months	Terminated last 12 months	Last 12 months Movement
Oral Health Therapist	15	8.5%	13	0	0	0	0
Dietitian	0	0.0%	4	4	0	0	0
Occupational Therapist	3	1.8%	12	9	0	0	0
Physiotherapist	3	2.7%	8	5	0	-1	-1
Total AH Priority Professions	**21**	**4.1%**	**37**	**18**	**0**	**-1**	**-1**

Reasons for leaving Waitematā DHB, across all allied health scientific and technical professions for Māori and Pasifika, continues to be to leave the district, leaving for personal reasons and leaving to go to another job in public health. On-going work is being undertaken to better understand those that choose not to disclose why they are leaving via choosing personal reasons, including offering exit interviews with the Director of Allied Health Scientific and Technical Professions.

Everyone Matters

<u>World Allied Health, Scientific and Technical Professions (AHP) day</u>

On 14 October 2020, we celebrated World Allied Health Scientific and Technical Professions day. The day provides an opportunity to celebrate the people working across the 43 professions/occupations that make up the Allied Health, Scientific and Technical workforce across Waitematā DHB and New Zealand. AHP day originated in the United Kingdom in 2018 and was created by a Dietitian and Speech and Language therapist to show recognition and appreciation for the AHP workforce.

Some facts relating to the group here at Waitematā DHB:

- 2,087 staff (including casuals)
- 1,639 FTE
- We make up 24% of Waitematā DHB's employed workforce
- 43 professional disciplines/occupations
- Working across eight divisions/corporate areas
- Reporting to approximately 142 different managers
- 58% work in the community, 33% in the inpatient setting, 4% in outpatients, and 5% in corporate/support
- 54% require registration with a professional body, 20% are required by Waitematā District Health Board to hold a professional affiliation, and 24% are unregulated

Pictured below: North Shore Acute Rehabilitation and Outpatient Allied Health Therapy staff including Occupational Therapy, Physiotherapy, Social Workers, Speech and Language Therapists, Therapy Assistants.

Better, Best, Brilliant

<u>World Occupational Therapy (OT) Day - 27 October 2020</u>

Each year the Occupational Therapy group celebrates their profession by recognising clinicians that go above and beyond for their community across adult physical health, specialist mental health and addictions, and child, women and family services. This year's recipients are Marieke Dijk (adult physical health), Romelli Rodriguez-Jolly (specialist mental health and addictions) and Vicky Taylor (child, women and family).

Adult Physical Health.
Marieke Dijk (pictured below) works as a dedicated and experienced community occupational therapist at Waitakere.

(Marieke Dijk – community occupational therapist)

Marieke has supported her team over a very challenging year. She has embraced telehealth to ensure patients were safe during lockdown. Marieke has a broad depth of skill and values which is continually demonstrated in her practice as an occupational therapist. Marieke is always willing to help other occupational therapists with complex situations, sharing her knowledge and skills when there are challenges. Marieke advocates for patients and will investigate all areas to find solutions. Marieke empowers her patients to be independent and take the lead in their care. She is dedicated to exploring cultural aspects for the broader occupational therapy practice, this is evident in her ongoing research investigating the bias in healthcare.

Specialist Mental Health and Addiction services
Romelli Rodriguez-Jolly (pictured fourth from the left with her Mason Clinic work colleagues) works within the Kaupapa Māori service in forensic mental health. Romelli demonstrates leadership skills and has recently being appointed to represent the Occupational Therapy profession on the executive board of OraTaiao New Zealand Climate and Health Council (https://www.orataiao.org.nz).

In an article in the October 2020 occupational therapy magazine (*OT Insight October 2020*. 41(6), 4-5.), Romelli said:

"*We (occupational therapists) are solution focused and have valuable enablement skills in supporting people to achieve change that is personally meaningful and important even when the barriers seem insurmountable.*

Occupations are part of the cause and solution.

In these times of climate uncertainty, people are having to adapt and acknowledge that occupations do not happen in isolation but in complex interrelation with our environment.

We are well positioned to contribute to advocacy and policy development that will influence these everyday practical implications of climate change action in occupation".

(Romelli Rodriguez-Jolly (pictured fourth from the left) with her Mason Clinic work colleagues)

Child, Women and Family (CWF) Health
Vicky Taylor (pictured with her CWF colleagues below) works within the CWF works as a community OT within the community North CWF team.

Over the last two years, Vicky has completed a considerable amount of work to support parents of children with Autistic Spectrum Disorder with one of their biggest challenges: feeding.

Vicky has completed a sequential oral sensory (SOS) training programme to help parents adapt their mealtime routine, modify the dining environment, and coach them on how to extend their child's limited range of foods eaten.

The SOS approach to feeding is designed to review the child and factors that lead to feeding difficulties. It integrates posture, sensory, motor and behavioural learning to evaluate and manage a child's feeding and growth concerns.

Vicky is very skilled and passionate about children's occupations and supporting whānau to achieve their child's goals.

Vicky empowers carers through an occupational performance coaching perspective to continue to be the expert in their child's care

(Vicky Taylor (fourth from the left) pictured with her CWF colleagues)

Connected

Welcoming Speech- Language Therapy (SLT) Students
To create a welcoming environment for our students, the SLT clinical centre leader has created a unique welcome package for the students who are due to undertake their placements at Waitematā DHB.

The welcome package includes pepeha's from the Professional Clinical Leader Becca Hammond as well as the dedicated team and staff members who will superivise the students. Please follow this link to view the short video: https://www.youtube.comSLTwelcome

Speech-language Therapy (SLT) awareness week
This year the SLT team raised the awareness of the profession by undertaking quizzes on each ward to raise awareness of the role that SLT play within the acute hospital. The winners of the quiz were wards 4 (North Shore) and Wainamu (Waitakere) . Both wards recieved a morning tea made and provided by the SLT team.

With Compassion

World Physiotherapy Day

The focus of World Physiotherapy day this year is rehabilitation for patients who have been affected by COVID-19 and the role that physiotherapists play in the treatment and management of not only the patients but also their whānau.

The global campaign focused on how exercise and movement can aid recovery, using modalities, such as telehealth, as an effective conventional healthcare method to support access to improve physical function. Traditionally the teams at Waitematā DHB have stands in the foyers at North Shore and Waitakere Hospitals to promote the profession whilst informing staff and the public how physiotherapy can support ongoing health. Due to COVID-19, this year the teams decided to focus their efforts on giving back to the communities by supporting our vunerable population. In conjunction with the Well Foundation, the teams completed a "bake off" sale. Staff were invited to trade non perishable foods for baked goods. The non perishable goods were then packaged up to aid the food parcels currently given to vunerable patients within our communities.

(North Shore Physiotherapists: Steen Baskjaer (Senior ED/ADU), Student: Te Waka Smit, Physiotherapist Kane Nickles)

(Waitakere Physiotherapists: Tarani Paul and Jess Ross)

Nursing and Emergency Planning Systems

Prepared by Jocelyn Peach, Director of Nursing and Emergency Systems Planner

Nurses, Midwives and Health Care Assistants account for 43.9% of the total Waitematā DHB workforce.

Quality, Safety and Practice Development

November is the month for the quality and safety review. The reviews this month include care standards, IV line, pressure and falls management.

Patient and Whānau Care Standards reviews occur from 16 November to 28 November 2020, undertaken by the senior nurse and midwife leaders.

Point prevalence audit occurred Monday 9 November 2020 for IV line practices. We have trialled the new MEG on-line audit tool which generates immediate reports for the wards audited. The IV Line audit shows areas for improvement which will be implemented immediately.

Renal services have recently implemented the ANTT (Aseptic Non Touch Technique) infection control programme with impressive results and good consumer engagement in refreshing written resources.

Workforce Planning and Workforce Development

Workforce Planning & Development

- Planning: supply and demand
- Professional Development & Recognition Programme [PDRP]
- Learning Framework /Education
- New Graduate Programme [NEtP, NESP]
- Return to Practice / CAP
- Unqualified Staff Devt [HCA]
- Undergraduate student placements
- Post Graduate Education
- Extended / Advanced Practice

Workforce analysis and forecasting is underway to understand replacement needs for the next three years. This involves work with the five Schools of Nursing, regionally and nationally, to consider supply and demand modelling. Some schools have increased their student numbers which challenges the DHB in providing the clinical experience wanted.

Waitematā DHB has been offered 74 applicants for the February 2021 new graduate intake [51 NETP general and primary care and 23 NESP mental health nursing]. This is comparable to past years.

Planning for the learning framework for 2021 is nearing completion. There is catch-up underway since much of the essential skills learning opportunities were missed in 2020 due to COVID-19 shut down.

Recruitment continues for Māori and Pacific applicants. Career development discussions are occurring.

MAORI PRIORITY Professions Sept 20	Māori in current workforce	% of Māori in current workforce	Number of Māori to reflect working population	Additional Māori required	12 months Mvmt	% 12 Mths	WDHB September 2020
Junior Medical	21	5.30%	36	15	11	110.00%	393
Nursing	149	5.30%	261	112	8	5.70%	2,836
Midwifery	18	12.40%	13	0	5	38.50%	145
Nursing Support Worker	64	12.40%	48	0	2	3.20%	517
Dental Therapist	14	8.00%	16	2	-2	-12.50%	176
Dietician	3	5.70%	5	2	1	50.00%	53
Occupational Therapist	9	5.40%	15	6	3	50.00%	168
Physiotherapist	10	9.10%	10	0	2	25.00%	110
Priority	**288**	**8.10%**	**325**	**37**	**30**	**11.60%**	**4,398**

PACIFIC PRIORITY Professions September 20	Pacific in current workforce	% of Pacific in current workforce	Number of Pacific to reflect working population	Additional Pacific required	12 months Mvmt	% 12 Mths	WDHB September 2020
Junior Medical	12	3.10%	29	17	1	9.10%	393
Nursing	109	3.80%	207	98	9	9.00%	2,836
Midwifery	6	4.10%	11	5	0	0.00%	145
Nursing Support Worker	105	20.30%	38	0	15	16.70%	517
Dental Therapist	15	8.50%	13	0	0	0.00%	176
Dietician	0	0.00%	4	4	0	0.00%	53
Occupational Therapist	3	1.80%	12	9	0	0.00%	168
Physiotherapist	3	2.70%	8	5	-1	-25.00%	110
Priority	**253**	**5.80%**	**321**	**68**	**24**	**10.50%**	**4,398**

Professional Relationships and Resilience

Professional Relationships & Resilience

- Staff Experience and Resilience
- Code of Practice for Managing Fatigue and Shift Work in Hospital based Nursing
- Professional networks
- Schools of Nursing
- Primary Care, Aged Residential Care, NGO
- Technology and Innovation: evitals e-notes, infusion
- Innovation projects
- Clinical Awards

An end of year event is planned to acknowledge the nurses recognised through the year as making a significant contribution and modeling the Waitematā DHB values.

Nursing now Aotearoa 2020 INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE

Monthly 2020 Nursing Now nominations

Name	Role/Service	Division
John Ramos	Nurse Educator Cardiology	Acute and Emergency Medicine
Ruth Noel Kirsty Pascoe	Child Health	Child Women & Family
Fiona Smorag	Maternal Mental Health Service	Specialist Mental Health & Addiction
Sofia Krykova	Nurse Practitioner Intern Endoscopy	Specialty Medicine
Kerlvin Ocado Hayley McKinney	Nurse Educator Ward 8	Surgical & Ambulatory
Satoko (Toko) Kaneko	Ostomy Clinical Nurse Specialist	Community Nursing team
Georgina MacPherson	Pacific Nurse Colposcopy Nurse Practice	Womens Health

Waitematā DHB is fortunate to have nurses and midwives who are committed to quality patient care and service effectiveness.

It is a pleasure to work alongside the nurses and midwives working across community settings and inpatient wards and units.

2020 International Nurses Day Awards

Focus/Values	Name/role	Service
Leadership	**Sarah Peters** Nurse Manager	Shore care
Everyone matters	**Laura Williams [RN]** Registered Nurse	Specialist Mental Health & Addiction Services
Compassion	**Desna Wickramasinghage** Health Care Assistant	ADU N
Connected	**Geraldine Kirkwood** Charge Nurse Manager **Sonny Shi** Specialty Nurse	Outpatients WTH Trendcare Coordinator
Better Best Brilliant	**Neethu Job** Registered Nurse **Gale Sorenson** Registered Nurse	Waiatarau, Specialist Mental Health & Addiction Services Titirangi Ward Waitakere
Te Kauae Raro Maori Nursing & Midwifery Award	**Chloe Maiava** Registered Nurse	Moko Services Mental Health Cultural Services
Shellie Burnett Award	Connie Wong Registered Nurse	Short Stay Ward NSH Surgical Division

We are proud of their professionalism, commitment to patient and whānau-centered care and engagement with the values of the organisation where everyone matters, where every day there is evidence of compassion and relief of suffering, connectedness and commitment to providing brilliant service.

Through this year with COVID-19, nurses and midwives have been willing to adapt to different ways to do things, to focus on meeting the needs of patients and to reassure the families who could not be there. We have seen leadership at the ward, team and service level and an empathetic team leadership acknowledging staff stress and pressure.

Emergency Systems Planning

Work continues with planning for fire and emergency systems for Tōtara Haumaru. This is part of the DHB-wide review of fire response and evacuation according to Fire and Emergency New Zealand [NENZ] and national standards. The model is being used with other units e.g. Waitakere Special Care Baby Unit (SCBU) and other key departments.

4.2 Quality Report – September/October 2020

Recommendation:

That the report be received.

Prepared by: Stacey Hurrell (Corporate Compliance Manager), David Price (Director of Patient Experience) and Dr Penny Andrew (Clinical Lead, Quality)

Contents

1. Health Quality and Safety Markers
2. HQSC Quarterly QSM Dashboard
3. DHB Key Quality Indicators and Trends
4. Safe Care
5. Improvement - Active Projects Report
6. Patient and Whānau Centred Care

Acronyms

Acronym	Definition	Acronym	Definition
ADU	Assessment and Diagnostic Unit	IT	Information Technology
ACP	Advance Care Planning	IVL	Intravenous luer
AKI	Acute Kidney Injury	KPI	Key Performance Indicator
AMS	Antimicrobial Stewardship	LOS	Length of Stay
ANTT	Aseptic non-Touch Technique	LCC	Lakeview Cardiology Centre
BSI	Blood Stream Infections	MACE	Major Adverse Cardiac Events
CADS	Community Alcohol and Drug Service	MALT	Māori Alliance Leadership Team
CAUTI	Catheter Associated Urinary Tract Infection	M&M	Mortality and Morbidity
CCOT	Critical Care Outreach Team	MRSA	Methicillin Resistant Staphlococcus aureus
CDI (C.diff)	*Clostridium difficile (C.difficile) infection*	MRO	Micro Resistant Organism
CeDSS	Clinical e-Decision Support	MSU	Mid-Stream urine
		NMDS	National Minimum Data Set
CGB	Clinical Governance Board	N/A	Not Applicable
CLAB	Central Line Associated Bacteraemia	NRFit	Neuroaxial and Regional connectors
CPP	Chronic Pelvic Pain	NZEWS	New Zealand Early Warning Score
CWFS	Child Woman and Family Service	NPS	Net Promoter Score
CXR	Chest X-Ray	PACE	Pathway for Acute Care of the Elderly
ESC	Elective Surgery Centre	PDP	Patient Deterioration Programme
ePA	Electronic Prescribing and Administration	PERSy	Patient Experience Reporting System
eMR	E-Medicine Reconciliation	PICC	Peripherally Inserted Central Catheter
ED	Emergency Department	PROM	Patient Reported Outcome Measure
EDARS	Early Discharge and Rehabilitation Services	PWCCS	Patient Whānau Centre Care Standards
ELT	Executive Leadership Team	QI	Quality Improvement
ETT	Exercise Tolerance Test	QoL	Quality of Life
FFT	Friends and Family Test	QSM	Quality and Safety Markers
FHC	Front of House Coordinator	SAB	S.aureus bacteraemia
FY	Financial Year	SAC	Severity Assessment Code
HABSI	Hospital Acquired Blood Stream Infection	S&A	Surgical and Ambulatory
HCAI	Health-care associated infection	SAQ	Safety Attitude Questionnaire
HDU	High Dependency Unit	SCBU	Special Care Baby Unit
HH	Hand Hygiene	SMART	Specific, Measurable, Achievable, Reliable and Time bound
HOPE	Health Outcomes Prediction Engineering	SMT	Senior Management Team
HQSC	Health Quality and Safety Commission	TBA	To Be Advised
HRT	Health Round Table	TRAMS	Tracheostomy Review and Management Service
ICU	Intensive Care Unit	UTI	Urinary Tract Infection
IORT	Intraoperative Radiotherapy	WTK	Waitakere Hospital
IP&C	Infection, Prevention and Control	XPs	Extended Properties
ISBAR	Identify, Situation, Background, Assessment, Recommendation	YTD	Year to date

1. Health Quality and Safety Markers

The Quality and Safety Markers (QSMs) are used by the Health Quality and Safety Commission to evaluate the success of its national patient safety campaign, *Open for better care*, and determine whether the desired changes in practice and reductions in harm and cost have occurred. The markers focus on the four areas of harm covered by the campaign:

1. Falls
2. Healthcare associated infections (hand hygiene, central line associated bacteraemia and surgical site infection)
3. Perioperative harm
4. Medication safety
5. Pressure injuries
6. Deteriorating patient
7. Patient experience

For each area of harm there are a set of process and outcome markers. The process markers show whether the desired changes in practice have occurred at a local level (e.g. giving older patients a falls risk assessment and developing a care plan for them). The outcome markers focus on harm and cost that can be avoided. Process markers at the DHB level show the actual level of performance, compared with a threshold for expected performance:

- 90% of older patients are given a falls risk assessment
- 90% of older patients at risk of falling have an appropriate individualised care plan
- 90% compliance with procedures for inserting central line catheters in ICU (insertion and maintenance bundle compliance)
- 80% compliance with good hand hygiene practice
- Surgical Site Infections rate per 100 procedures [target has not been set by HQSC)
- 100% primary hip and knee replacements antibiotic given 0-60 minutes before 'knife to skin' [first incision]
- 95% primary hip and knee replacements right antibiotic in the right dose - Cefazolin 2g or more
- 100% of audits where all components of the surgical safety checklist were reviewed
- 100% of audits with surgical safety checklist engagement scores of five or higher
- >50 observational audits are carried out for each part of the surgical checklist
- Number of DVT/PE cases per quarter *(target has not been set by HQSC)*
- Percentage of patients where eMedRec was finished at any time during the patients' admissions *(target has not been set by HQSC)*
- Percentage of patients aged 65 years and over (55 and over for Māori and Pacific people) where eMedRec was finished at any time during the patients' admissions *(target has not been set by HQSC)*
- Percentage of patients where eMedRec was finished within (≤) 24 hours of admissions *(target has not been set by HQSC)*
- Percentage of patients aged 65 years and over (55 and over for Māori and Pacific people) where eMedRec was finished within (≤) 24 hours of admissions *(target has not been set by HQSC)*
- Percentage of patients with a documented sedation score *(target has not been set by HQSC)*
- Percentage of patients with documented bowel function monitored *(target has not been set by HQSC)*

- Percentage of patient with uncontrolled pain*(target has not been set by HQSC)*
- Percentage of patients with documented opioid related adverse events*(target has not been set by HQSC)*
- Percentage of patients with a hospital acquired pressure injury *(target has not been set by HQSC)*
- Percentage of patients audited for pressure injury risk who received a score *(target has not been set by HQSC)*
- Percentage of patients with the correct pressure injury care plan implemented *(target has not been set by HQSC)*
- Percentage of wards using the NZ early warning score *(target has not been set by HQSC)*
- Percentage of audited patients with an early warning score calculated correctly for the most recent set of vital signs *(target has not been set by HQSC)*
- Percentage of audited patients that triggered an escalation of care and received the appropriate response to that escalation as per the DHB's agreed escalation pathway *(target has not been set by HQSC)*
- Number of in-hospital cardiopulmonary arrests in adult inpatient wards, units or departments *(target has not been set by HQSC)*
- Number of rapid response escalations *(target has not been set by HQSC)*
- Score of 8.5 per domain - improvement in national patient experience survey response results over time
- Maintain and improve national patient experience survey response rate over time

The future timetable for Health Quality and Safety Commission Quality Safety Marker (QSM) reporting in 2020 is:

Period covered	Publication date (indicative)
Q3 2020 (Jul–Sep 20)	18 December 2020

2. Health Quality and Safety Commission Quarterly QSM Dashboard

Quality Safety Markers (QSM)			Target	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Last Quarter Change
Falls		% older patients assessed for falls risk	90%	98%	96%	98%	97%	98%	99%	99%	100%	98%	⇩
		% older patients assessed as significant risk of falling with an individualised care plan	90%	97%	96%	94%	99%	99%	98%	96%	97%	97%	⇔
Health Care Associated Infections	Hand Hygiene (HH)	% of compliant HH moments	80%	89%	89%	90%	89%	90%	93%	91%	92%	90%	⇩
	CLAB	% occasions insertion bundle used in ICU	90%	100%	99%	100%	100%	100%	100%	100%	100%	99%	⇩
		% occasions maintenance bundle used in ICU (*not currently an HQSC Target*)	90%	97%	92%	96%	97%	99%	99%	98%	91%	97%	⇧
	Surgical Site Infections	Surgical Site Infections rate per 100 procedures [target has not been set by HQSC. *National Q1 2020 rate = 1.1 infection per 100 procedures*	HQSC has not defined a target	0.0	0.5	1.5	0.3	0.7	0.4	0.4	2.2	0.9	⇩
											Preliminary Results		
		100% primary hip and knee replacements antibiotic given 0 - 60 minutes before 'knife to skin' [first incision]	100%	95%	97%	97%	97%	98%	100%	99%	*HQSC SSI data lags by one – two quarters*		⇩
		95% > primary hip and knee replacements right antibiotic in the right dose - Cefazolin 2g or more	90%	97%	99%	98%	97%	98%	100%	99%			⇩
		100% of primary hip and knee replacements will have alcohol based skin preparation	100%	100%	98%	100%	95%	95%	100%	99%			⇩
		100% of primary and knee replacements will have surgical antimicrobial prophylaxis discontinued with 24 hours post-operatively	100%	100%	100%	100%	99%	99%	99%	98%			⇩
	eMedRec	eMedRec on admission implemented anywhere in the hospital	TBD	*New Quality Safety Mark*								Yes	-
		% of patients with access to eMedRec Services	TBD	*New Quality Safety Mark*								86%	-
		% of patients where eMedRec was finished at any time during the patients' admissions	TBD	*New Quality Safety Mark*								75%	-

Quality Safety Markers (QSM)			Target	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Last Quarter Change
Medication Safety		% of patients aged 65 years and over (55 and over for Māori and Pacific people) where eMedRec was finished at any time during the patients' admissions	TBD	*New Quality Safety Mark*								91%	-
		% of patients where eMedRec was finished within (≤) 24 hours of admissions	TBD	*New Quality Safety Mark*								54%	-
		% of patients aged 65 years and over (55 and over for Māori and Pacific people) where eMedRec was finished within (≤) 24 hours of admissions	TBD	*New Quality Safety Mark*								68%	-
	Opioids	% of patients with a documented sedation score	TBD			72%	76%	85%	86%	86%	85%	83%	⇩
		% of patients with documented bowel function monitored	TBD			4.0%	3.0%	3.5%	3.0%	4.3%	5.0%	4.5%	⇩
		% of patient with uncontrolled pain	TBD			18%	8%	0.5%	0.0%	0.8%	0.1%	0.3%	⇩
		% of patients with documented opioid related adverse events *HQSC Provide*	TBD				0.49%	0.35	0.58%	0.59%	0.48%	TBC	⇩
Patient Deterioration	% of eligible wards using the NZ Early Warning System (EWS)		TBD				100%	100%	100%	100%	100%	100%	⇔
	% of audited patients with an EWS score calculated correctly for the most recent set of vital sign		TBD				100%	100%	100%	100%	100%	100%	⇔
	% of audited patients that triggered an escalation of care and received appropriate response to that escalation as per DHB agreed escalation pathway		TBD				70%	72%	78%	69%	70%	86%	⇧
	Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, units or departments per 1000 admissions (NMDS) *HQSC Provide*		TBD	0.9%	1.3%	1.0%	0.2%	0.6%	0.5%	0.2%	0.7%	TBC	⇧
	Rate of rapid response escalations per 1000 admissions (NMDS) *HQSC Provide*		TBD	*HQSC Data provided from Q3 2019*				19%	19.7%	13.2%	19%	TBC	⇧

Pressure Injuries	% of patients audited for pressure injury risk who received a score (NMDS)	90%	88%	86%	85%	86%	87%	89%	88%	88%	90%	⇧
	% of patients with the correct pressure injury care plan implemented	90%	71%	62%	68%	68%	68%	65%	70%	69%	65%	⇩
	% of patients audited with a hospital acquired pressure injury	TBD	1.6%	2.4%	0.6%	1.2%	1.0%	0.6%	1.3%	0.6%	1.4%	⇧

	% of patients audited with non-hospital acquired pressure injury	TBD		2.1%	1.6%	2.2%	1.4%	2.9%	3.3%	1.9%	⇩

Meets or exceeds the target	Within 5% of the target	More than 5% away from target	Positive increase ⇧	No change ⇔	Positive Decrease ⇩	Negative Increase ⇧	Negative Decrease ⇩

Quality Safety Markers			*Target*		*Q2 2018*	*Q3 2018*	*Q4 2018*	*Q1 2019*	*Q2 2019*	*Q3 2019*	*Q4 2019*	*Q1 2020*	*Q2 2020*	*Last Quarter Change*
Peri-Operative Care	Surgical Safety	Uptake: % of audits where all components were reviewed	100%	Sign In	98%	100%	100%	98%	100%		98%			
				Time Out	100%	98%	98%	100%	100%		100%			
				Sign Out	98%	98%	100%	98%	98%		100%			
		Engagement: % of audits with engagement scores of five or higher	95%	Sign In	85%	96%	88%	89%			97%			
				Time Out	92%	94%	94%	100%	98%		100%			
				Sign Out	95%	100%	92%	98%			98%			
		Observations: number of observational audits carried out for each part of the surgical checklist (minimum of 50 observations per quarter)	≥ 50	Sign In	56	52	51	57	48	49	65	40	TBC	
				Time Out	61	51	53	53	52	45	64	40	TBC	
				Sign Out	56	52	50	51	45	36	55	33	TBC	

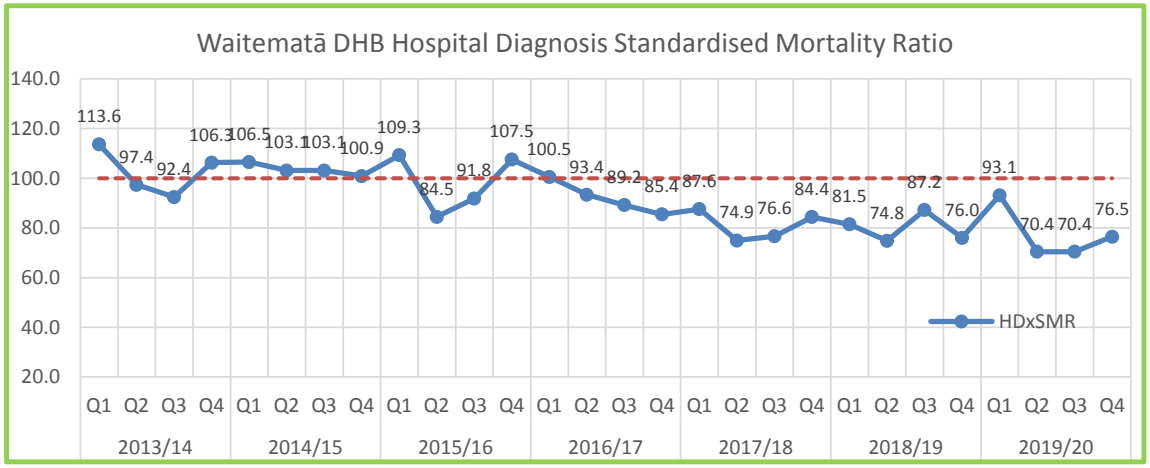
Data not published by the HQSC if observations were <50
Less than 75%
More than 75%
Target Achieved

3. DHB Key Quality Indicators and Trends

Quarterly HDxSMRs

Hospital Diagnosis Standardised Mortality Ratio (HDxSMR)
The HDxSMR is expressed as a ratio and seeks to compare actual deaths occurring in hospital (or in hospital and following hospital admission), with a predicted number of deaths based on the types of patients admitted to the hospital. The HDxSMR is a new HRT mortality methodology introduced in November 2016 (see Key Quality Indicator 'Mortality' below for further description of the new HRT mortality methodology).

Hospital Diagnosis Standardised Mortality Ratio (HDxSMR)
Waitematā DHB's HDxSMR (combined NSH + WTH) **Q4 FY2019/2020 = 76.5**



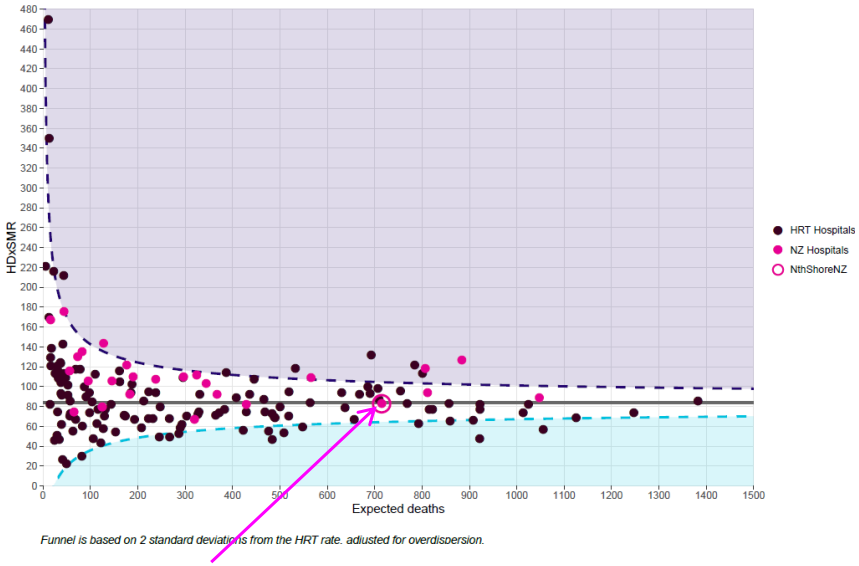
12 month Data - HDxSMR Jul 2019 – Jun 2020:

NB: Delays incurred by Health Round Table impacting on the receipt of the latest HDxSMR; will be updated as soon as available

NthShoreNZ | Jul 2019 - Jun 2020 | HDxSMR Mortality Report |

Funnel plot of HRT HDxSMRs compared to the combined HRT HDxSMR

Jul 2019 – Jun 2020



Funnel is based on 2 standard deviations from the HRT rate. adjusted for overdispersion.

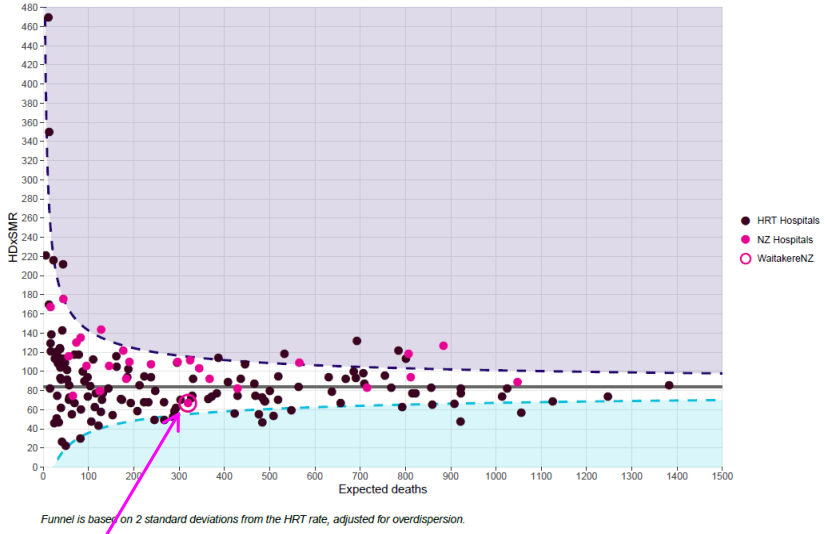
North Shore Hospital 83

HDxSMR	
(12 months: Jul 2019 – Jun 2020)	
Episodes	**66,906**
Deaths	**592**
Expected Deaths	**715.1**
Combined HRT HDxSMR for Apr20 – Mar20	**84**
NZ HDxSMR for Apr20 – Mar20	**102**
Network HDxSMR	**78**

WaitakereNZ | Jul 2019 - Jun 2020 | HDxSMR Mortality Report |

Funnel plot of HRT HDxSMRs compared to the combined HRT HDxSMR

Jul 2019 – Jun 2020



Funnel is based on 2 standard deviations from the HRT rate, adjusted for overdispersion.

Waitakere Hospital 67

HDxSMR	
(12 months: Jul 2019 – Jun 2020)	
Episodes	**32,285**
Deaths	**214**
Expected Deaths	**319.4**
Combined HRT HDxSMR for Apr20 – Mar20	**84**
NZ HDxSMR for Apr20 – Mar20	**102**
Network HDxSMR	**78**

3.1 Hospital Acquired Blood Stream Infections (HABSI)

HABSI is defined as a bloodstream infection attributable to hospital where acute or rehabilitation care is provided, if the infection was not incubating on admission. Typically bacteraemia diagnosed after 48 hours of admission, on readmission, related to a device, or within 30 days of procedure (if no alternate source identified) is categorised as a HABSI. There is no recognised national benchmark 'acceptable' rate or target for HABSI.

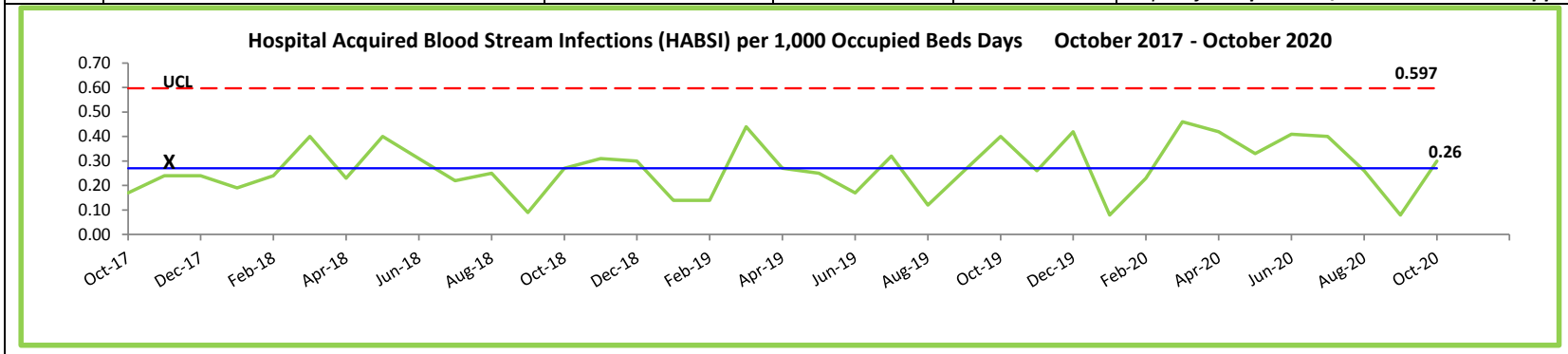
Target	Measure	Prev. Report Period	Current Report Period	
		Aug	Sept	Oct
0	Total # of infections	6	2	7
0.00	# of infections per 1,000 occupied bed days	0.26	0.08	0.30

Commentary/Trends

Mean rates of HABSI/1,000 occupied bed days

	Rate	N=
2016	0.35	89
2017	0.25	67
2018	0.26	70
2019	0.26	71
2020 (YTD)	0.30	62

The Infection, Prevention and Control Committee's Executive Report for ***September/October 2020 is in Appendices 1/2***



HABSI Analysis Sept 2020

Source	Total	Area	Organism	Comments
CAUTI	1	ICU/HDU	Klebsiella Pneumoniae/E coli	An unstable patient was acutely admitted to the Intensive Care Unit for management of a gastrointestinal bleed; four days after insertion of a urinary catheter they developed a hospital acquired blood stream infection related to the catheter. The urinary catheter was required to accurately measure the patient's output in the context of their bleeding.
Other	1	Ward 8	E coli	A patient developed a hospital acquired blood stream infection following an intra-abdominal procedure.

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
		Aug	Sept	Oct	

HABSI Analysis Oct 2020

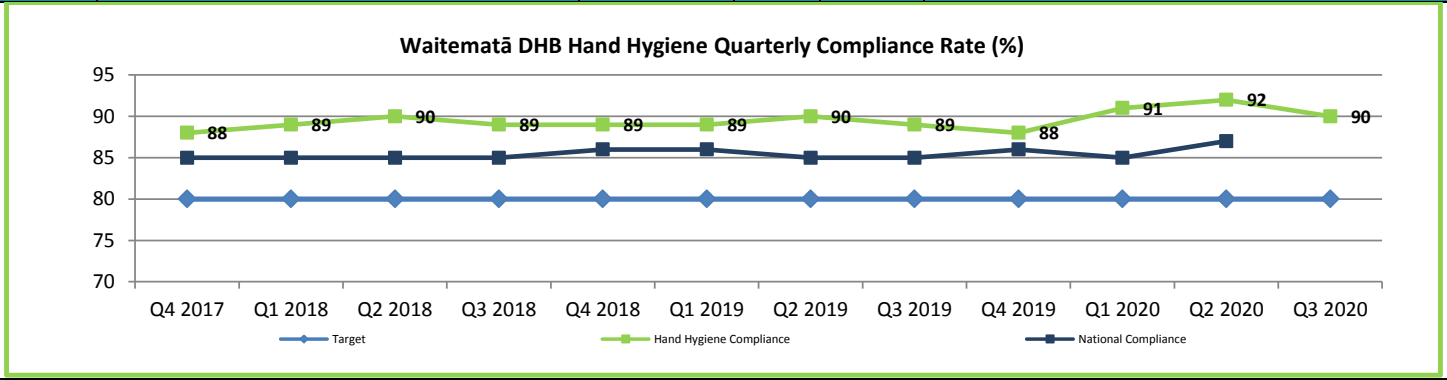
Source	Total	Area	Organism	Comments
IVL	1	Ward 10	Staph aureus	A patient developed a hospital acquired blood stream infection following the insertion of an intravenous luer in the ante-cubital fossa (crook of the elbow). Investigation determined that there was poor compliance with IVL management.
Other	5	Ward 4	Klebsiella pneumoniae	A patient developed a hospital acquired blood stream infection secondary to
		Ward 8	Pseudomonas aeruginosa	A patient developed a hospital acquired blood stream infection secondary to extensive intra-abdominal surgery.
		Ward 5	Klebsiella variicola	A patient developed a hospital acquired blood stream infection secondary to intra-abdominal sepsis.
		Outpatients	E coli (ESBL positive)	A patient developed a hospital acquired blood stream infection secondary to urosepsis which developed following and emergency caesarean section for delay second stage labour.
		Theatre	E coli (ESBL positive)	A patient developed a hospital acquired blood stream infection secondary to an intra-abdominal procedure following and emergency caesarean section for foetal distress.
Unknown	1	Anawhata	Enterococcus faecalis	A patient with bladder cancer developed a hospital acquired blood stream infection the source of which was unable to be identified.

3.2 Hand Hygiene (HH) Compliance

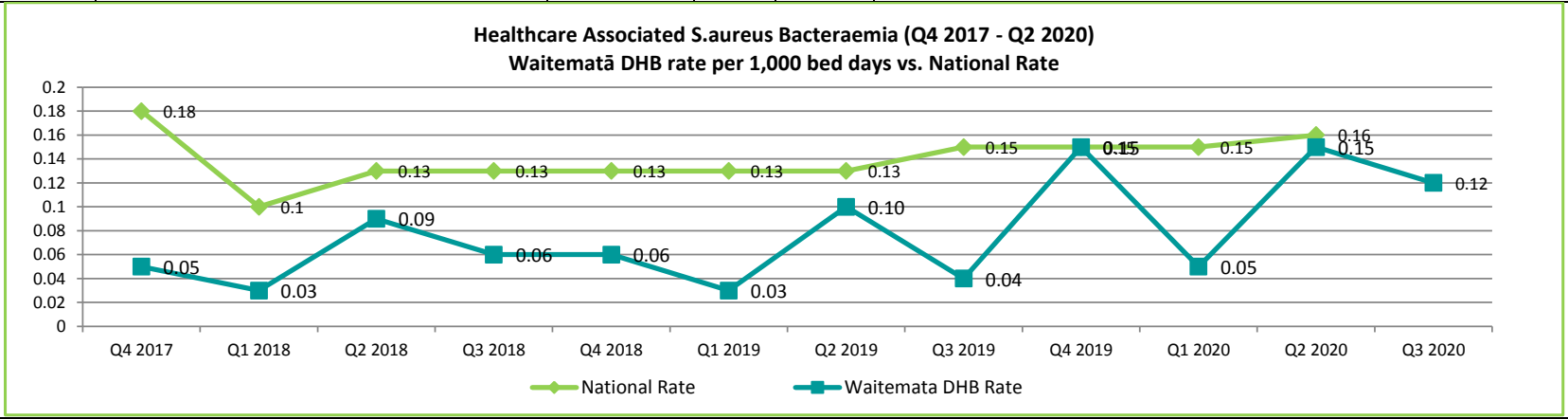
Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
		Aug	Sept	Oct	
>80%	% rate of compliance with five Hand Hygiene Moments	90%	91%	90%	*Waitematā DHB continues to achieve a Hand Hygiene compliance rate above the National Target of >80% and the National average compliance rate of 85%*

Hand Hygiene Results by Division – Q3 2020	
Division	**Compliance**
Acute & Emergency Medicine	90%
Child Women & Family	91%
Specialty Mental Health + Addictions	96%
Specialist Medicine + Health of Older People	92%
Surgical & Ambulatory	88%
Total	**90%**

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
		Aug	Sept	Oct	



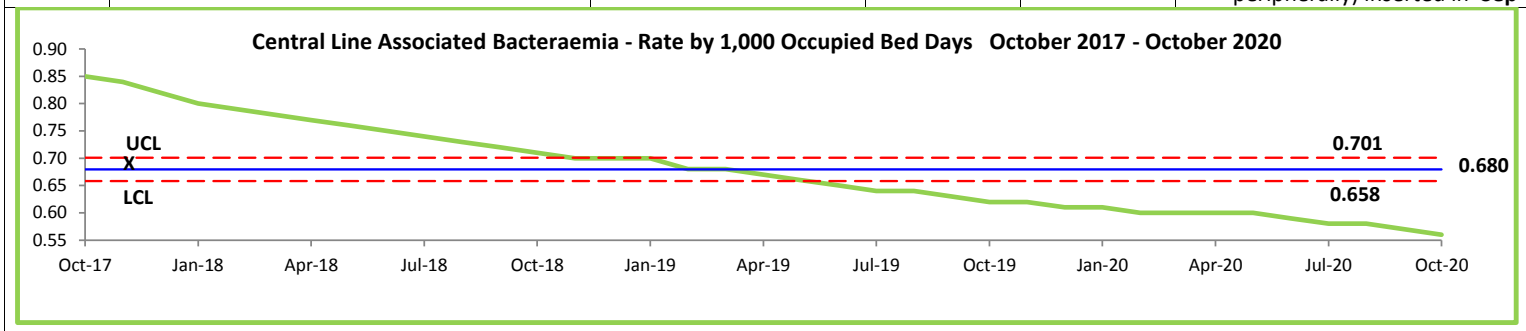
0	*Total # of Hospital Associated SAB infections*	2	1	3	**Staph Aureus Blood Stream Infections/Healthcare Associated Bacteraemia (HCA-BSI)**
0	*# of Hospital Associated SAB infections/1,000 bed days*	0.09	0.04	0.13	*The rate of S.aureus bacteraemia (SAB) infections attributed to healthcare is the national outcome measure for hand hygiene compliance. The SAB rate is based on HHNZ's definition to maintain consistency in DHB reporting.* *The Waitematā DHB Hand Hygiene Reports for* ***Sept/Oct 2020 is in Appendices 3/4***



3.3 Central Line Associated Bacteraemias (CLAB)

Patients with a central venous line are at risk of a blood stream infection (CLAB). Patients with a CLAB experience more complications, increased length of stay, and increased mortality; and each case costs approximate $20,000 - $54,000. CLAB infections are largely preventable using a standardised procedure for insertion and maintaining lines (insertion and maintenance bundles of care). NSH's ICUs compliance with standard procedure and rates of CLAB are Health Quality and Safety Markers.

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
		Aug	Sep	Oct	
<1	# of CLAB infections per 1,000 line days **(ICU)**	0.58	0.57	0.56	**Central Line Associated Bacteraemia (CLAB)**
>98%	% bundle compliance at insertion **(ICU)**	97%	100%	100%	
>98%	% bundle compliance maintenance **(ICU)**	100%	99%	98%	The ICU is currently **1157 days** CLAB Free as at **31 October 2020** • The total number of central lines (centrally and peripherally) inserted in **Sep = 29; Oct = 27**



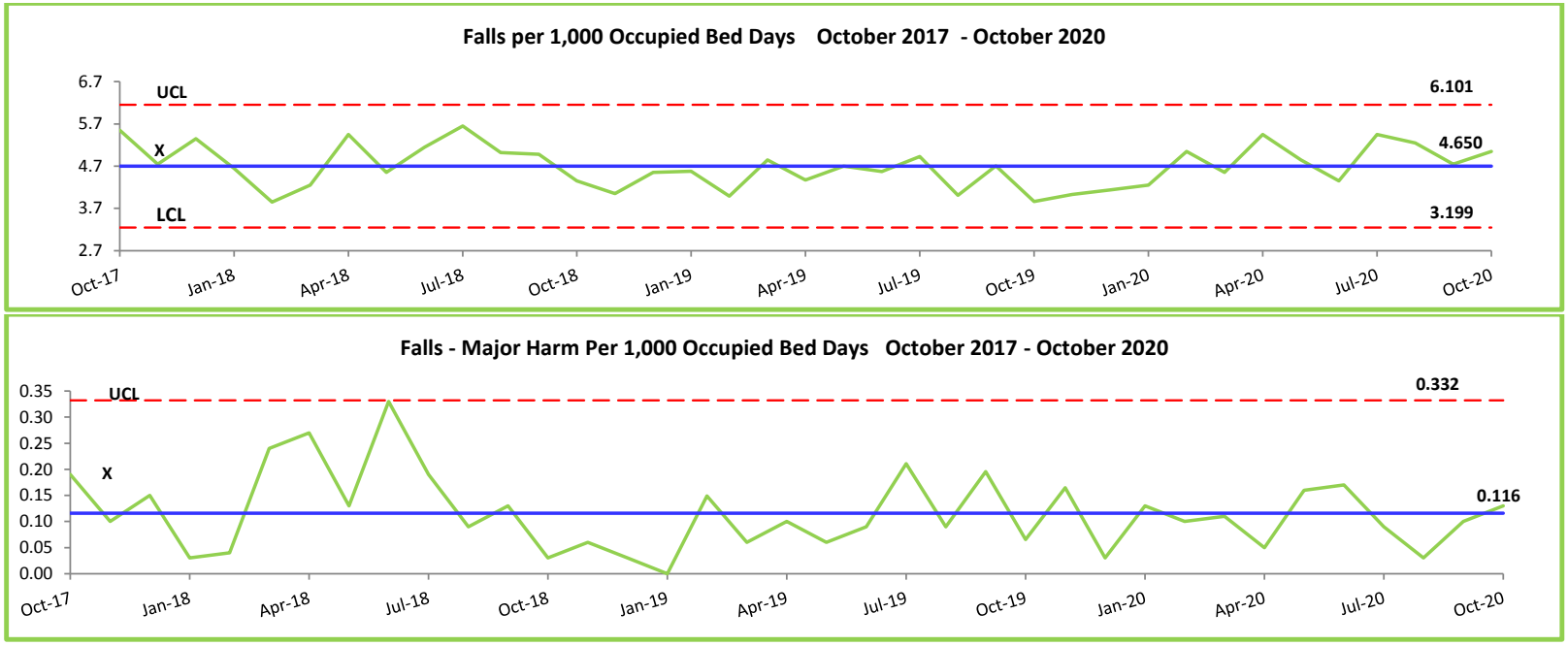
3.4 Surgical Site Infections

Surgical Site Infections (SSIs) – in scope procedures for SSI are primary and revision hip and knee arthroplasty at either North Shore Hospital or the Elective Surgery Centre (ESC) in accordance with the National Surgical Infection Improvement Programme. The surveillance criteria are 90 days post-operatively for deep and 30 days for superficial infection.

Target	Measure	Previous Report Period	Current Report Period	Commentary/Trends
TBA	-	0.4% (SSI Rate) Q1 Jan – Mar 2020 *232 procedures* *One superficial SSI (NSH)*	2.2% (SSI Rate) *(Preliminary)* Q2 Apr – Jun 2020 *NB only 45 procedures performed* *One superficial SSI (NSH)*	**Q3 2020 Preliminary Results** • *0.9% (SSI Rate)* • *321 procedures* • *Two superficial and one deep (ESC/NSH)*

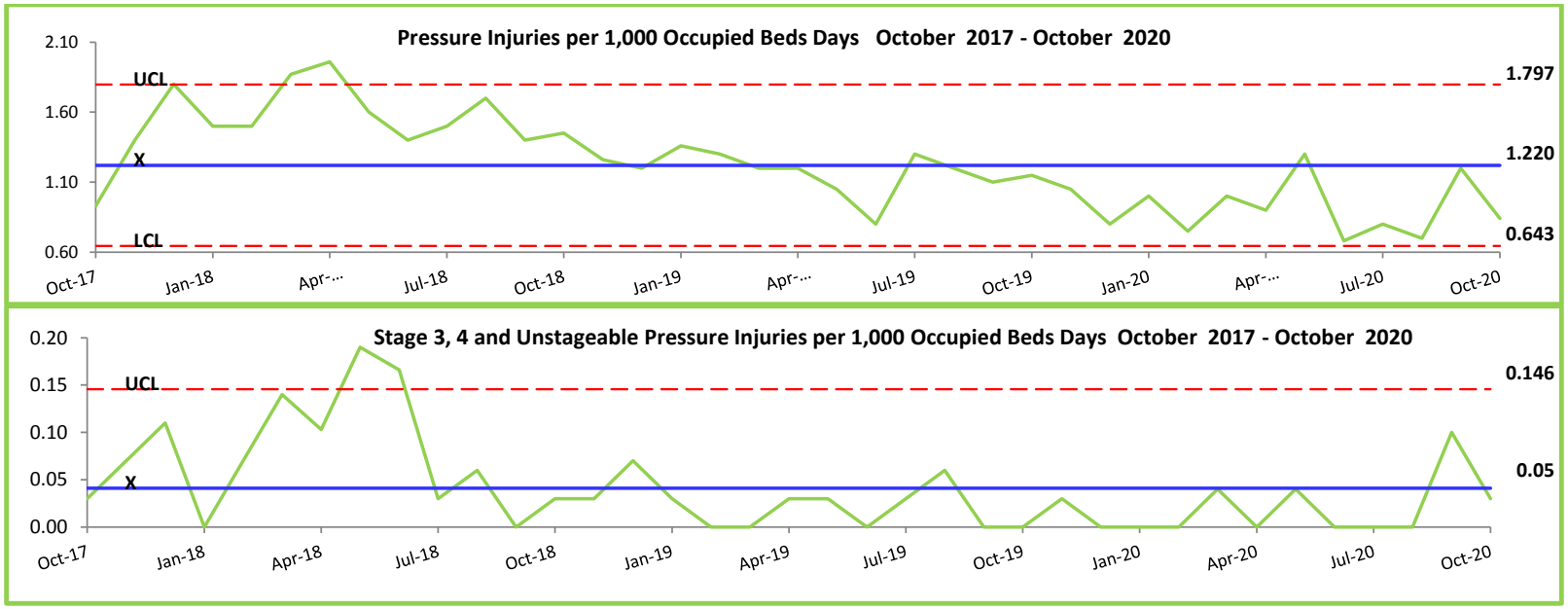
3.5 Falls with Harm

Target	Measure	Prev. Report Period	Current Report Period	
		Aug	Sept	Oct
	Total number (#) of falls	155	140	155
<5.0	Rate of falls per 1,000 Occupied Bed Days (OBD)	5.2	4.5	5.0
	Total number of multi-fallers	17	11	20
>90%	% patients 75 years and over (55 years and over Māori and Pacific) assessed for the risk of falling	100%	99%	99%
>90%	% patients 75 years and over (55 years and over Māori and Pacific) assessed for the risk of falling 8 hours of admission	82%	81%	82%
>90%	% patients 75 years and over (55 years and over Māori and Pacific) assessed as being at sufficient risk of falling have an individualised care plan in place	95%	94%	98%
	Total number of falls where an injury has occurred (including Major Harm)	42	41	40
	Rate of falls where an injury has occurred (including Major Harm) per 1,000 Occupied bed day	1.4	1.4	1.3
	Total number of falls with major harm (SAC 1 and 2)	1	3	3
	Rate of falls with major harm per 1,000 Occupied bed day	0.03	0.10	0.10
0	Total number of reported fractured neck of femurs (NOF) as a result of a fall while in hospital (included in the major falls with harm rate)	0	0	1
0	Total number of coded fractured neck of femurs (NOF) as a result of a fall while in hospital	TBC	TBC	TBC



3.6 Pressure Injuries

Target	Measure	Prev. Report Period	Current Report Period	
		Aug	Sept	Oct
100%	% patients risk assessed within specified time frame (eight hours)	75%	77%	73%
100%	% patients audited who received a score	88%	92%	87%
100%	% patients with the correct care plans implemented	65%	68%	56%
	Number of patients with reported confirmed pressure injuries *(Incident Reporting System – Risk MonitorPRO)*	21	36	27
	Rate of confirmed pressure injuries per 1,000 Bed Days	0.7	1.2	0.9
0	Number of reported confirmed Stage 3, 4 or unstageable pressure injuries *(Incident Reporting System – Risk MonitorPRO)*	0	3	2
	Rate of confirmed Stage 3, 4 or unstageable pressure injuries per 1,000 Bed days	0.00	0.10	0.06



3.7 Complaint Responsiveness

<table>
<tr><th>Target</th><th>Measure</th><th>Previous Report Period</th><th colspan="2">Current Report Period</th><th>Commentary</th></tr>
<tr><td><15 days</td><td>Average time to respond to complaints in the reporting month</td><td>9 (Aug)</td><td>11 (Sep)</td><td>12 (Oct)</td><td>
The average days to respond have gradually decreased over the last four years and services across the DHB are working diligently to ensure they meet the target of <15 calendar days to respond
<table>
<tr><th></th><th>Average Days to Respond</th></tr>
<tr><td>2015</td><td>18</td></tr>
<tr><td>2016</td><td>19</td></tr>
<tr><td>2017</td><td>15</td></tr>
<tr><td>2018</td><td>14</td></tr>
<tr><td>2019</td><td>12</td></tr>
<tr><td>2020 YTD</td><td>13</td></tr>
</table>
<table>
<tr><th colspan="3">Average Days to Respond – Provider Arm</th></tr>
<tr><th>Division</th><th>Sept 2020</th><th>Oct 2020</th></tr>
<tr><td>Acute & Emergency Medicine</td><td>6</td><td>6</td></tr>
<tr><td>Child, Women & Family</td><td>11</td><td>10</td></tr>
<tr><td>Specialist Mental Health & Addictions</td><td>11</td><td>13</td></tr>
<tr><td>Specialty Medicine and Health of Older People</td><td>10</td><td>12</td></tr>
<tr><td>Surgical & Ambulatory</td><td>12</td><td>17</td></tr>
</table>
</td></tr>
</table>

3.8 Report – Complaints Received by the Nationwide Health and Disability Advocacy Service

For individual DHBs, the number of complaints received by the Nationwide Health and Disability Advocacy Service ranged from between **six** to **141 complaints**, and the rate of complaints ranged from 67 to 312 per 100,000 discharges. The Advocacy Service received 72 complaints about services provided by Waitematā DHB, equating to a complaint rate of 70 per 100,000 discharges. When DHBs are ranked according to their rate of complaints, Waitematā DHB is **DHB 2** (with DHB 1 being the lowest rate of complaints and DHB 20 being the highest rate of complaints).

The Advocacy Service has not provided the number and rate of complaints per individual DHB in the report; this was due to difficulty in interpreting the reason behind the number of complaints received per each individual DHB. For example a DHB's number of complaints may be indicative of a pro-active culture at the DHB towards complaints management.

*Please find the detailed report in **Appendix 5***

4. Safe Care

4.1 Infection Prevention and Control (IP&C)

*IP&C Surveillance Overview and Audit Results for **September/October 2020***

Month	Total ESBL (Def)	Total HABSI	Total C.diff (HO-HCA)	Total Waitematā DHB Hand Moments	% National HH Moments Passed (Ave)	%I&PC Facilities Standards Met Overall (Ave)	% Commodes Clean
January 2019	17	3	3	5079	89%	97%	100%
February 2019	18	3	3	4824	89%	98%	83%
March 2019	16	10	4	4939	90%	98%	98%
April 2019	15	6	4	4783	89%	97%	86%
May 2019	12	6	5	4722	90%	97%	91%
June 2019	4	4	2	4516	90%	97%	95%
July 2019	16	7	8	4859	88%	100%	97%
August 2019	7	3	5	4583	91%	96%	100%
September 2019	9	6	2	4989	89%	97%	100%
October 2019	9	8	4	5039	87%	99%	99%
November 2019	7	6	4	4486	87%	98%	99%
December 2019	8	9	5	4560	89%	98%	95%
Overall 2019	138	71	49	57,379	89%	99%	99%
January 2020	5	2	2	4897	89%	97%	100%
February 2020	6	5	2	4392	91%	98%	100%
March 2020	3	9	4	4624	93%	97%	97%
April 2020	3	6	6	3818	93%	95%	100%
May 2020	4	6	4	4730	92%	99%	100%
June 2020	4	6	5	4656	90%	97%	100%
July 2020	11	10	4	4750	91%	97%	96%
August 2020	8	6	4	5457	90%	98%	100%
September 2020	12	2	4	5267	91%	98%	97%
October 2020	9	7	2	5246	90%	97%	100%

RAG Rating Legend

% National HH Moments Passed	% I&PC Facilities Standards Met	% of Clean Commodes
≥ 80%	≥ 99%	≥ 99%
≥ 70%	≥ 90%	≥ 90%
< 70%	< 90%	< 90%

4.2 Surveillance

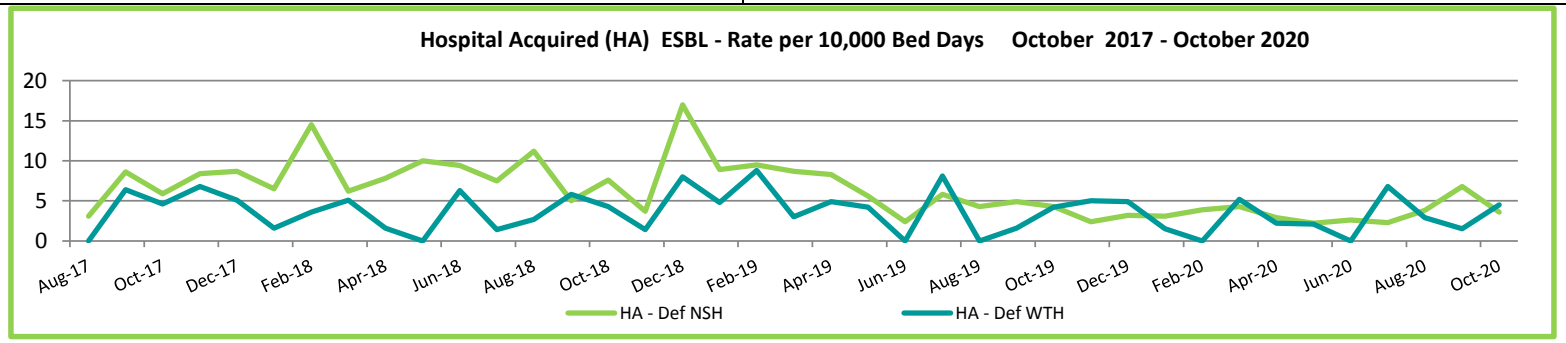
4.2.1 Extended Spectrum Beta Lactamase (ESBL)

HA-ESBL is now defined as Isolation of ESBL producing Enterobacteriaceae (e.g. E.Coli or Klebsiella sp.) from a clinical or screening specimen >72 hours post admission (not 48 hours as per the old definition), in a patient with previously negative or unknown ESBL status. This new definition now aligns with ICNET and CDC Surveillance Definition

September/October 2020

HA –ESBL 2020	NSH		WTH	
	Counts	Rates	Counts	Rates
September	11	6.8	1	1.5
October	6	3.6	3	4.5

- Increase in ESBL rate for Waitakere Hospital which was spread across three wards
- No evidence of cross-transmission
- ESBL was identified from transfer screening



4.2.2 Clostridioides difficile (CDI)

Waitematā DHB Surveillance Definitions for CDI
Healthcare facility Onset (HO-HCA) *- CDI symptom onset is more than 48 hours after admission (third calendar day).*
Community Onset healthcare facility associated (CO-HCA) *-Discharged from a healthcare facility within previous four weeks.*
Community Onset Community Associated (CO) *-No admission in the last 12 months.*
Indeterminte *-Discharged from a healthcare facility within the previous 4-12 weeks.*
Recurrent *-Episode of CDI that occurs eight weeks or less after the onset of a previous episode provided the symptoms from the prior episode have resolved.*

Clostridium difficile (C.difficile) infection (CDI) Summary

Clostridium difficile infection (CDI) typically results from the use of antibiotics that affect the normal gut flora, promoting the growth of gut flora. Prevention, therefore, is dependent on appropriate antibiotic use.

September/October 2020

Q3 (July –Sept) 2020
30 CDI cases detected, comprising

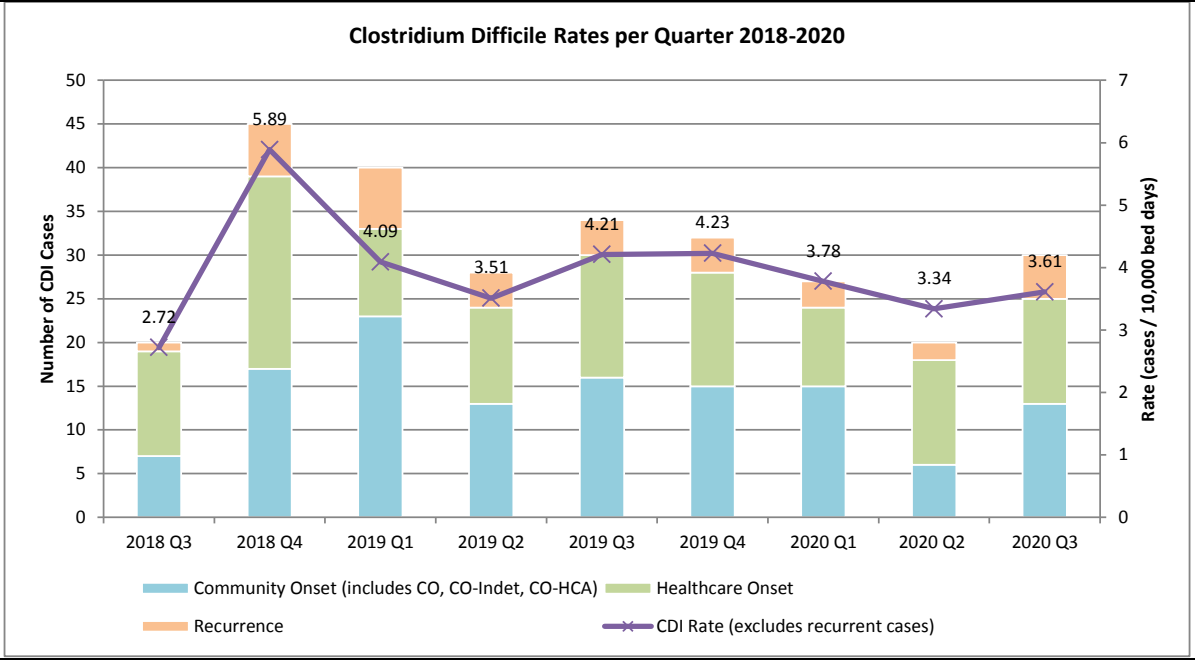
- 13 CO
- 12 HO-HCA
- 5 recurrent

The proportion of HO-HCA infections is 44%

The overall rate of CDI for Q3 is 3.61 per 10,000 bed days

4.2.2 Clostridioides difficile (CDI)

September/October 2020



4.2.6 Seasonal Influenza

Waitematā DHB has a yearly seasonal Influenza surveillance program which usually commences in March every year. In addition, hospital acquired (HA-Inf) is a unique designation used in our surveillance since 2017. It identifies inpatients admitted initially for other medical reasons but developed Influenza during their hospital stay, likely through acquisition from either other patients, staff, visitors or environment. Therefore, confirmation of Influenza after 72 hrs of admission is defined as HA-Inf.

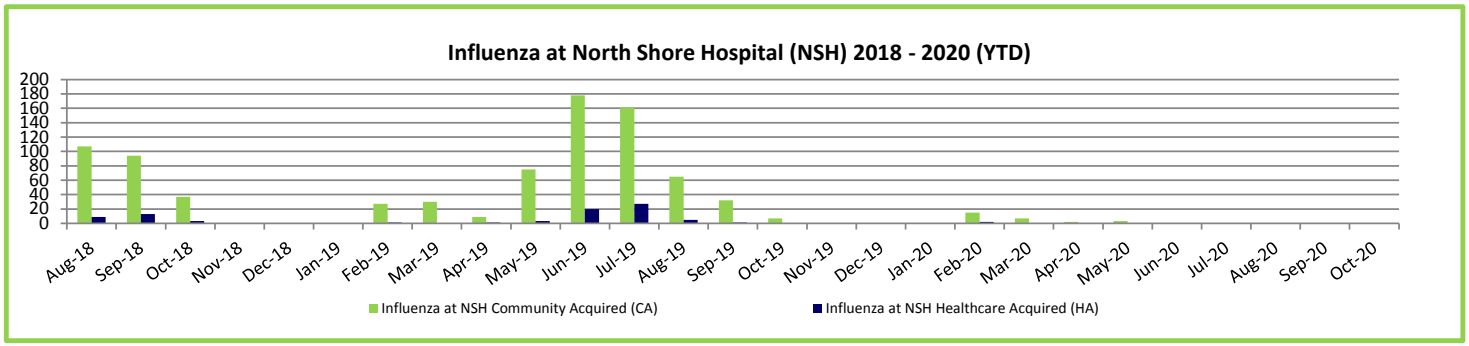
Data includes only confirmed patient cases where influenza like illness (ILI) symptoms developed 48 hours after admission. Source of acquisition variable (healthcare worker, patient, visitors)

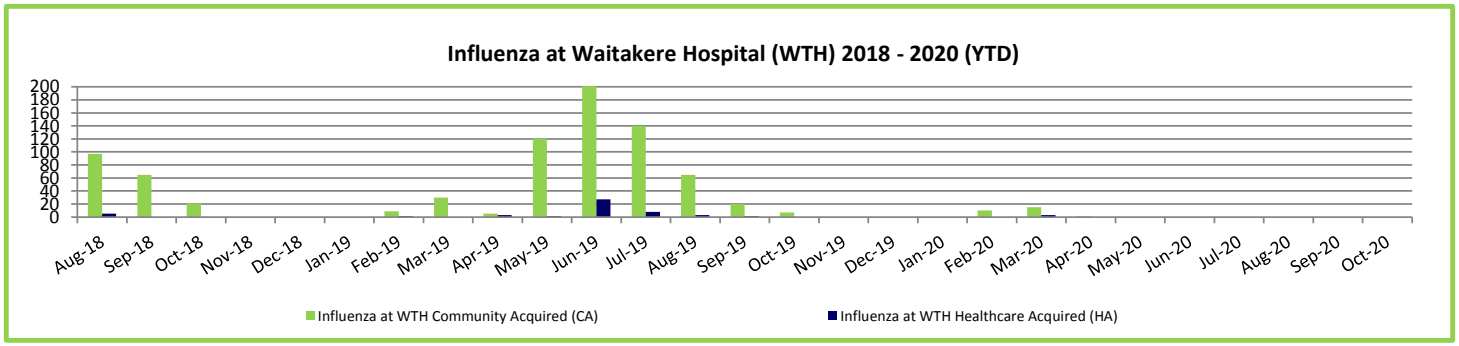
- Influenza Season is now over for 2020
- Nil further influenza identified for September/October 2020

NSH	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
CA-INF	15	7	2	3	0	0	0	0	0
HA-INF	2	0	0	0	0	0	0	0	0

WTH	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
CA-INF	10	15	1	0	0	0	0	0	0
HA-INF	0	3	0	0	0	0	0	0	0

4.2.6 Seasonal Influenza





4.2.7 Communicable Diseases, Clusters and Outbreaks

- Nothing to report for September/October 2020

5. Innovation and Improvement Team Active Projects Report

Overview of Work Programmes

November 2020

CURRENT i3 WORK IN PROGRESS

Leapfrog Programme

- *See Leapfrog Programme Report – Phase 3 projects (separate report)*
- Information Systems Strategic Group (meets fortnightly)

Data/Analytics

- Qlik Sense
  - newly published – Palliative Care, Laboratory Explorer, Cancer Dashboard upgrade
  - currently in development: Congestive Heart Failure; COVID-19 Staff Availability app; Surgical Pathology, Costing, PPE Mask Fit Testing
  - Regional COVID-19 health information platform
- Regional Data Design Authority – representation
- AI lab concept development
- Collaboration with HQSC on impact of COVID on health service delivery
- MH Snapshot – design + implementation
- Care Pathways system development – currently outpatients eOutcomes (with SNOMED coding); surgical waitlist; ED best care bundles
- Clinical calculator register/approval process – review of existing calculators

Digital Transformation

- i3 website: **http://i3.waitematadhb.govt.nz/** (upgrade in progress)
- Waitematā DHB website rebuild
- Intranet website migration to Office 365
- Sharepoint development (Intranet update + off-site access; preparation for potential Controlled Docs and CeDSS transition)
- PERSy analytics + PROMs: Bulk/individual emailing surveys to patients – supporting Outpatients + Telehealth; new Patient Experience (FFT) Surveys go-live 1 Nov
- Risk Pro / RL6 upgrade – go live 15 October 2020
- Web Apps (MHS: THEO)

Health Leadership + QI

- Tier 1: QI e-learning via Awhina Learning for all staff
- Tier 2: Annual QI Workshop series; Safety in Practice Programme (Primary Care and Community Pharmacies); MH QI programme 2020
- Fellows Programme – currently 4 fellows (range of FTE among fellows)
- RACMA programme – currently x1 RACMA fellow sponsored by CMO
- Public Health Registrars – new registrar commencing 2021
- Summer students – advertising studentships for Dec 2020/Jan 2021
- Health Excellence Awards – Planning for May/June 2021

Care Redesign Innovation and Improvement Team Projects

- *See Innovation and Improvement Project Team report (below)*

Innovation + Research

Leapfrog Programme – *see separate report*

Regional + National IS Development – Clinical Director of Innovation

- Business Design Council MoH + national Digital Investment Board
- HSDC: refresh of Northern Region's ISSP; review of data governance/RDDA
- Managed Isolation/Quarantine Facilities COVID health IS Design

Digital Academy

- 2nd academy held 2-6 Nov 2020; 16 participants

Academic Partnership Programmes

- Interns: Bioscience Enterprise AI commercial model
- AUT Good Health Design partnership – Design Space & communications
- Summer studentships (10/52) commencing Nov 2020

Innovative Design

- Design Space (Portacom) mock-up of negative pressure room for Tōtara Haumau

AI Lab

- Development of foundation structures: principles, commercial models, governance, ethics, guidelines

Precision Driven Healthcare (research projects)

- Smart Search/ NLP of free text documents for clinical use (ICU)
- GP referrals triage (cardiology + gynae)
- Risk calculators (readmission risk prediction)
- Inpatient and Outpatient Survey about to start – patient perspective on use of info

Horizon Scanning/ Innovation Library

- Hospital in the Home models
- Patient Focused Booking

Research

- Gynae – endometriosis in Māori + Pacifica; oestrogen pessary
- Tranexamic sutures – pharmacokinetic study
- mPR – mobile pulmonary rehab development

Person Centered Design

- Patient reported outcome measures (PROMS) - see Project Report
- PREMs
- Values Programme – appreciative inquiry
- Patient Engagement System – see Leapfrog Programme
- AUT Good Health Design – Design space mock-ups; Masters students projects (Stroke ward; rehab gym; AR

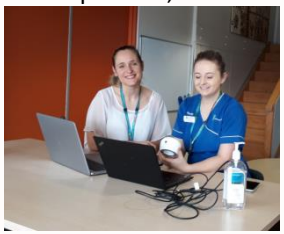
Achievements/Events

Clinical Digital Academy commences week of 2 November

The 2020 Waitematā DHB Clinical Digital Academy was held the week of 2 November this year. Sixteen multidisciplinary clinicians spent the week with our clinical IT leaders and faculty from the National Institute for Health Innovation, University of Auckland. Topics covered include design and evaluation of digital health solutions, leading clinical IT change, analytics and Qlik, building forms, AI and ethics, our health information systems context and vision.

Silhouette Clinical Photography Pilot

Clinical champions from several teams have been trialling the Silhouette medical imaging and data-capture devices and analysis software, for the last two months. The champions have tested iPhones and iPads with Lite+ 2D sensors, and the Star2 3D camera (pictured). Clinical photography is an essential clinical tool for diagnosis, treatment and monitoring of a patient's condition. It can enhance patient outcomes and experience by providing visual documentation throughout wound healing progression and treatment, and facilitate accurate communication across members of the care team. The next phase is to complete the evaluation and understand the impact of the tools tested on clinical practice, outcomes and experience.



AUT Design Students Best Design Awards winners

Good Health Design at AUT offer a paper for 3rd year design students called Integrated Studio in collaboration with i3. A group of students have worked with the Auckland Regional Dental Service (ARDS) over the last two years. This year, the ARDS education game *Kete Menemene (Smile Kit)* received a gold pin in Student Public Good, and the patient app *Your Health Pal* received bronze in Student Digital.

Kete Menemene (Smile Kit) is an interactive card game designed to help tamariki and their whānau take ownership of their wellbeing. The students sought to increase awareness and education on the importance of oral health, in order to inspire attendance and engagement within our communities. With its cheeky approach and fun character illustrations, the game provides an approachable way for tamariki to learn about ARDS and the importance of oral health. The Best Design Awards judges had this to say about the project:
"A delightful use of design for an age appropriate audience."
"Interactive take bringing fun and ingenuity to a serious problem."
"An aesthetically pleasing design and clear way to address the issue of tooth decay among hard to reach audiences – much needed!"

Your Health Pal is a digital companion to help guide patients through their healthcare journey, which can often be overwhelming and stressful for patients. The app can help patients gain a sense of security and reassurance by bringing together the small but important tasks necessary to support their healthcare journey.

Read about these Integrated Studio projects on the Good Health Design website here

Additionally, two i3 summer students who worked with ARDS over the 2019-20 summer, were finalists in Student Public Good.
Welcome to the Children's Community Dental Service is a kit of collectable figures, activity booklets, 'Mission control' and an education animation about the dental service, to reframe dental check-ups for our tamariki as a fun experience. Dental services are critical for children to maintain healthy teeth and develop healthy dental habits, thus preventing debilitating dental caries in adulthood. The kit is centered around animal mascots as the proposed 'face' of the service that accompany children on their journey through the dental service.

Read more about their project here (Smile Agents resources) and here (Patient Journey animation).

Innovation and Improvement Project Team: Active Projects Report Summary

Project Name	Project Summary	Requester	PM Resource	Budget	Forecast Variance	This Period	Last Period	Phase
Organisation wide / Multiple Divisions								
Outpatients *See Leapfrog Programme Report*	Expedite implementation of telephone appointments at scale across outpatients and community	Dale Bramley Jonathan Christiansen	Kelly Bohot					Executing
	Expedite implementation of video conference appointments at scale across outpatients and community	Jonathan Christiansen	Kelly Bohot Charlie Aiken					Executing
	Telehealth community pod We have purchased the pod in Ops. New pods eta ~ 23 Nov. Contacts made through Māori Gains team and organising to meet up with Helensville Community. Also meeting up with Fono.	Penny Andrew	Tim Alvis Charlie Aiken					Executing
	Paperlite-paperless outpatient appointments (incl ePrescribing; eOutcomes; eNotes;eLabs; eSurgical Waitlist (incl eAnaesthetic assessment, CPAC score); eForms + eACC	Jonathan Christiansen Lara Hopley	Kelly Bohot Tim Alvis Dean Croft					Executing
	Remote patient monitoring	Penny Andrew/Robyn Whittaker	Barbara Corning-Davis					Executing
Patient Deterioration Programme (PDP)	An organisation and national programme to improve the management of the clinically deteriorating patient. The Programme has 3 main streams: (1) Recognition and response systems; (2) Kōrero mai: Patient, family and whānau escalation (3) Shared goals of care	Jos Peach Penny Andrew	Jeanette Bell	N/A	N/A			
	1. PDP: Recognition and Response Systems - National Early Warning System (completed) Maternity National Maternal Early Warning System (MEWS) (Executing) , NZEWS for Mental Health (Initiating)	Penny Andrew	Jeanette Bell	N/A	N/A			Executing
	2. PDP: Kōrero mai: Patient, family and whānau escalation	David Price	Jeanette Bell	N/A	N/A			Closed
	3. PDP: Shared Goals of Care	Penny Andrew Carl Peters	Jeanette Bell	N/A	N/A			Pilot closed Planning next phase
Anaesthesia Outpatients Service	Support service redesign –pre-assessment process model of care; scoping current processes in ESC, NSH + WTH	Dave Burton	Lisa Sue	N/A	N/A			On hold
Smartpage *See Leapfrog Programme*	BAU budget approved. Smartpage 777 module questionable due to connectivity issues.	Stuart Bloomfield	Joel Rewa-Morgan	$80k (opex)	0%			Executing

Report	Regional RFP underway for 777 replacement.			phase 2				
Allied Health Telehealth Toolkit	Scoping tools required to sustain telehealth in AH outpatients and community AH teams	Jude Sprott	Danni Yu	N/A	N/A			Executing
Patient Engagement System *See Leapfrog Programme Report*	Joel Rewa-Morgan assigned as Project Manager. PIC decision: funding on hold, however, re-scoping work underway.	Penny Andrew	Joel Rewa-Morgan	$88K	0			Planning
PROMS Programme *See Leapfrog Programme Report*	Establish a system for developing, collecting and utilising patient reported outcome measures (PROMs) to inform patient experience and outcome improvements in clinical practice and health care delivery planning	Penny Andrew	TBC	N/A	N/A			Phase 1 Closed Planning Phase 2
Clinical Photography Silhouettelite Test See Leapfrog Programme Report	Test Silhouettelite app to understand benefits for wound assessment and monitoring	Jos Peach Kate Gilmour	Kelly Bohot Marlé Dippennar	N/A	N/A			In progress
Pathology Tracking	Request in response to recent incident: specimen inadequately labelled, delivered to incorrect collection point at WTH, picked up by SUB60courier and delivered to Labplus who incorrectly managed package.	Rachel Petrich	Mustafa Shaabany					Scoping
Paperlite Hospital	Stocktake of e-sytems and status of paper remaining in the clinical environment	Penny Andrew	Lisa Sue Danni Yu Mustafa Shaabany					In progress
Surgical and Ambulatory Services								
Surgical Programme	Support the Surgical Division to develop an improvement programme that attracts and retains highly skilled clinicians and delivers a positive patient experience and optimal outcomes within clinically appropriate timeframes.	Mark Shepherd Richard Harman	Jonathan Wallace Laura Broome Kelly Bohot	N/A	N/A			Initiating
	1. Acute Workstream		Laura Broome					
	2. Staffing model workstream		Laura Broome					
	3. Education and Orientation workstream		Marlé Dippenaar					
	4. Booking and scheduling process mapping							
Osteoarthritis Chronic Care Programme	Support AH leader to scope a programme of work to introduce low intervention medical pathway for osteoarthritis patients; develop a project plan to create working model	Mark Shepherd Richard Harman Matt Walker Jude Sprott	Danni Yu	N/A	N/A			Scoping

Enhancing patient safety with NRFit Neuraxial Connectors	Develop plan to pilot ISO 80369-6 NRFit connectors to replace the traditional Luer devices for all neuraxial procedures; scope scale of roll-out; develop business case for procurement; implement replacement	Andrew Love	Dina Emmanuel	N/A	N/A			Planning
Informed Consent Patient Surveys	Design and undertake a survey of patients regarding the informed consent process for elective Caesarean Section patients	Jonathan Christiansen	Marlé Dippennar					
Acute and Emergency Medicine, Specialist Medicine and Health of Older People Services								
Renal Service Quality Improvement Programme	Support service with QI Programme • Reduce CLAB infection rate • Establish ANTT audit and CLABSI Qlik dashboard • Enhance and streamline current practices	Naveed Ahmad	Dina Emmanuel	N/A	N/A			Executing
Chest Pain Pathway	Complete a review of the chest pain pathway including: - Review of local and international literature - Audit of ETTs and patient outcomes	Jonathan Christiansen Kate Allan	Kelly Bohot	N/A	N/A			On hold – closing approx. Sept 2020
Rapid Cardiac Screening Clinic Model of Care	Develop a model of care for a new rapid cardiac screening (RCS) clinic model of care. Develop a business case to introduce a new model of care that will include • Improved, timely access to initial outpatient cardiology evaluation • Improved screening process to allow risk stratification that enables early intervention for higher acuity patients Identification and elimination of unwarranted tests and investigations	Patrick Gladding Alex Boersma	Kelly Bohot	N/A	N/A			Executing
TransforMED phase 2	Support medicine and older adults to develop and implement integrated, patient centred models of care across inpatient, outpatient and community settings	Brian Millen Alex Boersma	Kelly Bohot	N/A	N/A			Initiating
	1. Congestive Heart Failure							
	2. Integrated Stroke							
	3. Interim Care							
	4. Hospital in the Home							
	5. Acute Care of the Elderly							
Child Woman and Family Services								
Urogynaecology Service	Develop a local service for women: management of urogynaecological conditions stress urinary incontinence (SUI) + pelvic organ prolapse (POP); and management of complications associated with previously implanted surgical mesh Support development of a business case for women in Waitematā DHB and the Northern Regions with SUI or POP, and those affected by mesh complications	Jonathan Christiansen Eva Fong	Sue French	N/A	N/A			On hold PM seconded to NHRCC

Project Management Mentoring for CWF	Project Management Support for x3 projects funded by the MoH	Shirley Campbell Stephanie Doe	Laura Broome					
Mental Health and Addiction Services								
NZEWS Implementation	Request to support the implementation of NZEWS in MHS inpatient units (He Puna; Waiatarau; Forensics (See Patient Deterioration Programme)	Derek Wright Murray Paton	Jeanette Bell					Planning
Electronic therapeutic observation tool (THEO)	Design and implement a tool to enable staff to record electronically therapeutic observations (eg 15min client checks)	Derek Wright Murray Paton	David Ryan Sharon Puddle					Executing
Community Services								
PM secondment to NHRCC to support quarantine/isolation facility management processes	NHRCC – extension of secondment till June 2021		Sue French					In progress

Quality Improvement Training	Overview	Involvement	Sponsor(s)	PM Resource	Comment
Tier 2 project-based Quality Improvement (QI) Training Programme	Teach QI skills to hospital and community staff and mentor each to deliver a QI project	Content development and delivery Ongoing mentorship	Penny Andrew	Barbara Corning-Davis Lisa Sue Laura Broome Dina Emmanuel Jeanette Bell	Ongoing
Safety in Practice Programme	The programme aims to promote a safety and improvement culture within community teams including general practice (GP), pharmacy and urgent care teams, within the Auckland region. The programme is adapted from the Scottish Patient Safety Programme in Primary Care	I³ Innovation and Improvement PM	Tim Wood Stuart Jenkins	Sue French	On hold awaiting availability of PM to support QI training
RMO Clinical Governance Training	QI training involving project-based learning in the workplace with QI coaching	Content development and delivery	Andrew Brant Penny Andrew Naomi Heap Ian Wallace	Jonathan Wallace	RMO Clinical Governance Training
Management Foundations	Teach QI skills to participants and mentor each to deliver a QI project	Content development and delivery Ongoing mentorship	Sue Christie	Barbara Corning-Davis	Management Foundations

Support Requests						
Current Support Requests						
Project Name	**Sponsor / Requestor**	**Description**	**Request received**	**Scoping Completed Approved date**	**Assigned to**	**Comment**
Organisation-wide/Multiple Divisions						
Choosing Wisely	Penny Andrew	PM support to document programme: (i) what we are doing with decision support in eOrders labs + radiology; and eReferrals (primary care clinical pathways) + virtual clinics (ii) maintain a list of the current ANZ Choosing Wisely recommendations (ii) Qlik dashboards and clinical pathways this to identify + implement further opportunities	01/2019			On hold
Day Case Procedures	David Wilson Merit Hanna	Follow up from adverse event investigation 4/08/2020. Request to process map day case procedures and develop e-documentation that aligns to outpatient processes. Explore adapting registrar credentialing app developed by Gynaecology (for procedure sign off)	4/08/2020			
Pigtail Chest Drains	Penny Andrew	Follow up from 2 x adverse event investigation 4/08/2020 related to pigtail chest drains. Ensure recommendations are implemented and explore opportunities for improvement.	4/08/2020			
Fax Free	Vanessa McGill	PM support for fax free programme with a view to removing faxes from the organisation by Dec 2021. Work is due to commence in January 2021. hA has seed funding in place	12/11/2020			
Surgical and Ambulatory Services						
Transition Pain Service	Michael Kluger	Request to support the development of a transition pain service (TPS) model of care	05/08/20			

Equity tracking in Bariatric Surgery	Jonathan Christiansen	Support HIG with implementation of equity tracking process in Bariatric Surgery in iPM	12/11/2020			
Economic evaluation of paramedic model of care trial	Amber Smith	Evaluation of cost-effectiveness of the paramedic model of care trialled at WTH	18/11/2020			
Acute and Emergency Medicine, Specialist Medicine and Health of Older People Services						
Child Women and Family Services						
Mental Health and Addiction Services						
Community Services						

Closed since last report				
Project/Work/Request	**Sponsor/Requestor/ Project Manager**	**Overview**	**PM /Outcome**	**Close out / summary report location**
Informed Consent Operating Theatres	Jonathan Christiansen Diana Ackerman Lisa Sue	PM support to improve the process of informed consent for patients undergoing surgery, particularly for patients undergoing sensitive examinations in gynaecology + maternity.	Closed	

6. Patient and Whānau Centered Care

6.1 Patient Experience Feedback – October 2020 update

6.1.1 National Inpatient Survey

In January 2020 , the Commission announced they had contracted Ipsos New Zealand, an independent research In January 2020 The Commission announced they had contracted Ipsos New Zealand, an independent research company, for the provision of the inpatient survey and primary care survey data collection and reporting system services. A subsequent review of the former Inpatient Patient Experience Survey was also conducted and a refresh of the survey was launched in August 2020.

The first revised survey commenced on 18th August 2020 for patients discharged between 27th July and 9th August. In an effort to increase participation rates the cap of 400 participants was removed for Waitematā DHB. Waitematā DHB invited 1,079 patients via email to participate. 387 patients responded (36% response rate). Weighted results have not been made available at the time of this report; however examples of how the results will be presented are below:

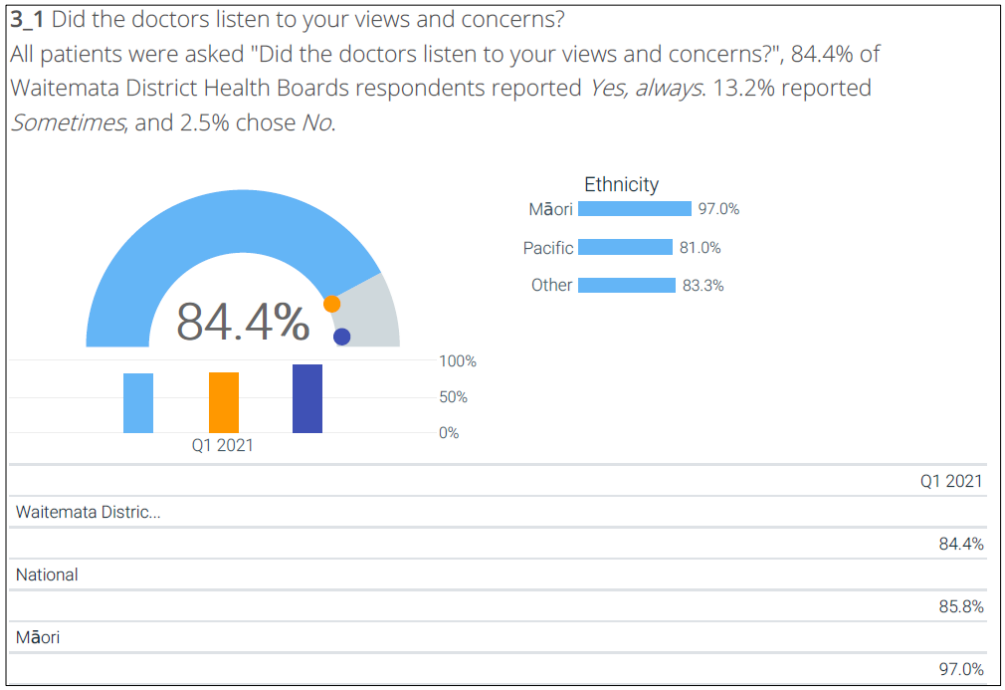


Figure 1: Did the doctors listen to your views and concerns? – National Patient Experience Result

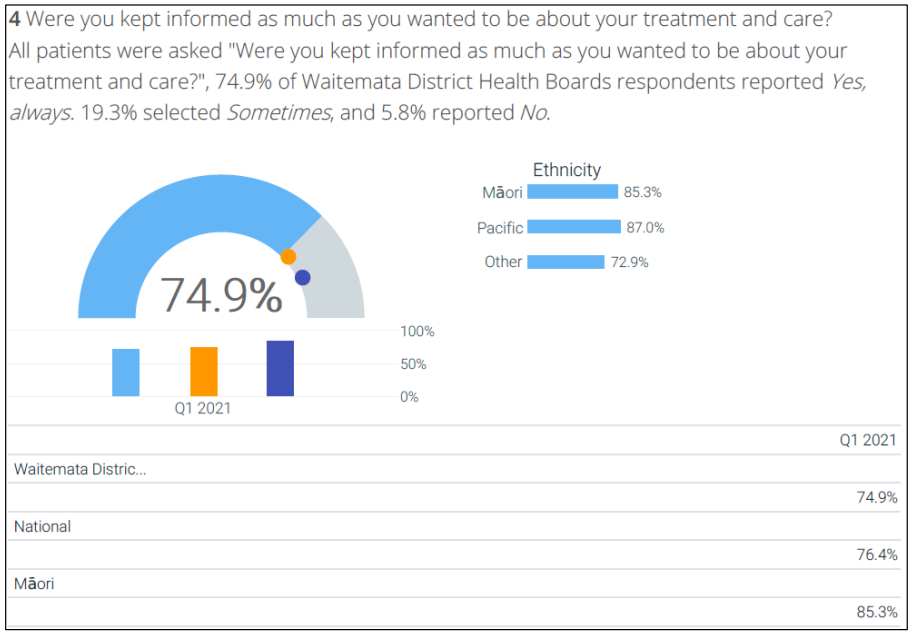


Figure 2: Were you kept informed as much as you wanted to be about your treatment and care?– National Patient Experience Result

6.1.2 Friends and Family Test

In October, the Net Promoter Score (NPS) decreased slightly from 83 in September to 81. We received feedback from 854 people which is up from 616 responses in September but remains below our pre-COVID-19 response rate of over 900. The NPS performs consistently above the DHB target of 65.

Friends and Family Test Overall Results

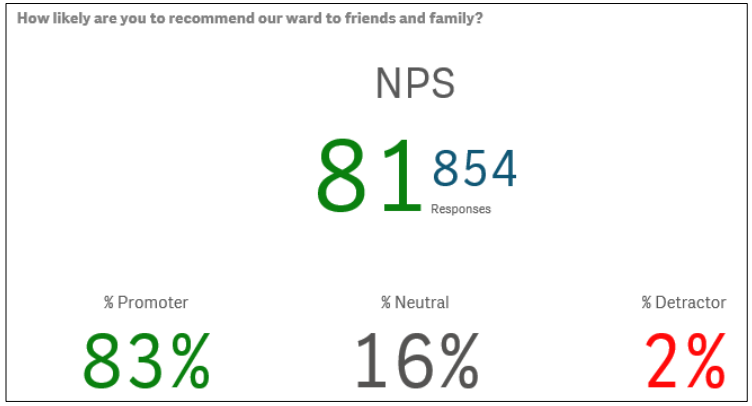
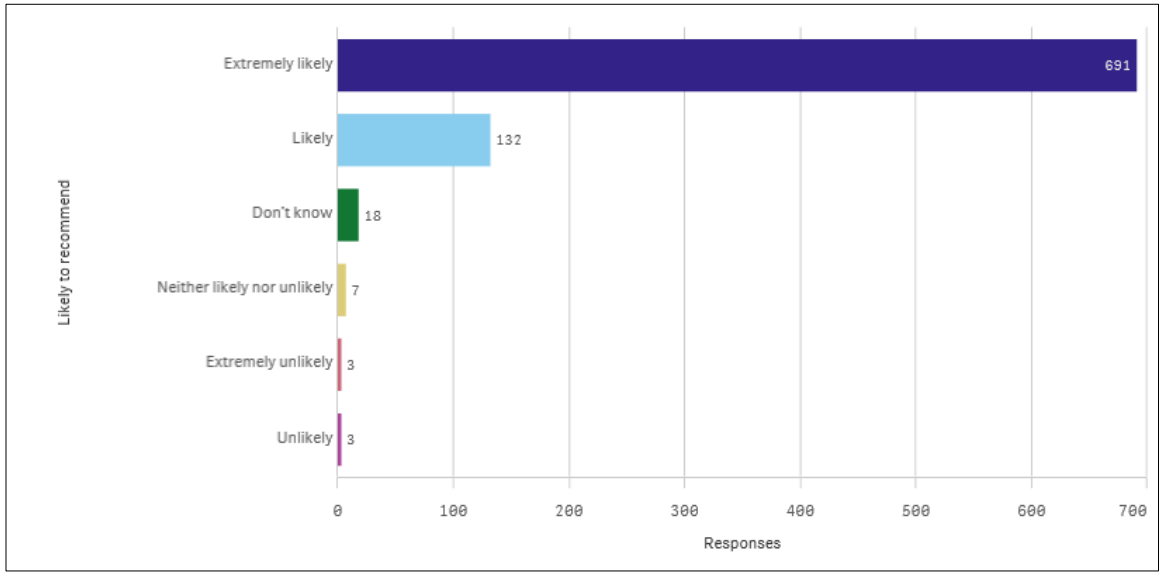
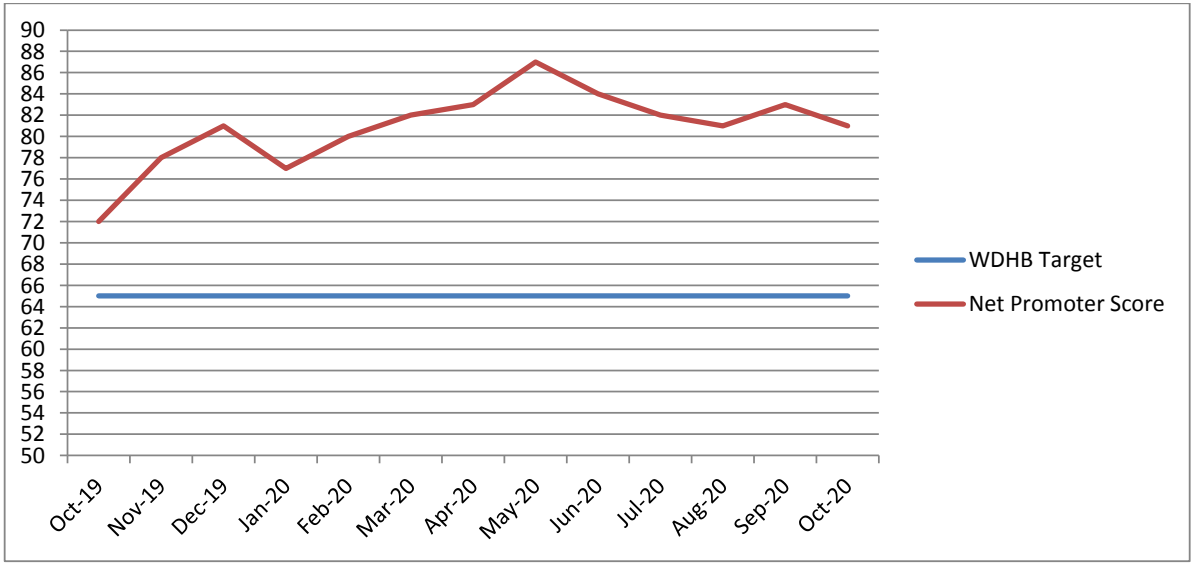


Figure 3: Waitematā DHB overall NPS



Graph 1: Waitematā DHB overall FFT results



Graph 2: Waitematā DHB Net Promoter Score over time

Total Responses and NPS to Friends and Family Test by ethnicity

October 2020	NZ European	Māori	Overall Asian	Overall Pacific	Other/ European
Responses	513	64	60	41	163
NPS	83	85	59	77	75

Table 1: NPS by ethnicity

In October, all ethnicities met the Waitematā DHB NPS target and score 65 and above except Asian which achieved an NPS score of 59. Māori achieved the highest NPS score of 85 this month.

October 2020	NZ European	Māori	Overall Asian	Overall Pacific	Other/ European
Did we see you promptly?	77	87	75	79	81
Did we listen and explain?	86	87	78	81	82
Did we show care and respect?	91	93	75	90	85
Did we meet you expectations?	86	90	71	88	82
Were we welcoming and friendly?	92	93	81	93	89

Table 2: NPS for all questions by ethnicity

All measures score above the DHB target with Māori scoring us highly for 'welcoming and friendly' and 'care and respect', both achieving a score of 93. Pacific also rated highly for 'welcoming and friendly' with a score of 93. Whilst we scored above our target for Asian, 'did we meet your expectations' scored lower than all other measures.

Friends and Family Test Comments

- "*All staff members made us feel comfortable and took good care of us.*" ***Short Stay Ward, NSH***
- "*All staff were lovely plus friendly and caring. Very relaxed environment. Very efficient.*" ***Titirangi Ward, WTH***
- *"Informative, respectful, positive, appointments on time, knowledgeable, spoke through options.* ***New Lynn Paediatric Outpatient Clinic***
- *"The ward was clean, staff friendly and helpful. Food was good and the late night snack was a life saver. Thank you for looking after me and my baby."* ***Maternity Unit, WTH***
- *"My mum is in good hands. She has been getting stronger every day. I am so grateful. Ward 10 has made a wonderful impression on me."* ***Ward 10, NSH***
- *"Because I have found everyone so good and when I have been in hospital they are lovely."* ***Allied Health Community Adults North***
- *"My partner was very stressed at having the procedure but was put at ease with the wonderful staff."* ***Gastroenterology, NSH***

Friends and Family Test by ward

		October 2020	
Division	**Ward**	**Responses**	**NPS**
AH	Allied Health Community Adults North	18	78
AH	Allied Health Community Adults Rodney	7	100
AH	Allied Health Community Adults West	11	70
AH	Allied Health EDARS	7	86
ESC	North Shore Hospital Elective Surgery Centre Cullen Ward	21	100
A&EM	NSH Assessment and Diagnostic Unit (ADU)	7	33
A&EM	North Shore Hospital Emergency Department	51	69
SMHOP	North Shore Hospital Gastroenterology	24	96
SMHOP	North Shore Hospital Haematology Day Stay	20	100
S&AS	North Shore Hospital Hine Ora Ward	10	100
S&AS	North Shore Hospital Intensive Care Unit/High Dependency Unity (ICU/HDU)	3	100
A&EM	North Shore Hospital Lakeview Cardiology (LCC)	63	90
CWF	North Shore Hospital Maternity Unit	80	64
CWF	North Shore Hospital Special Care Baby Unit (SCBU)	13	75
S&AS	North Shore Hospital Short Stay Ward	5	100
A&EM	North Shore Hospital Ward 2	10	90
A&EM	North Shore Hospital Ward 3	10	80
S&AS	North Shore Hospital Ward 4	30	83
A&EM	North Shore Hospital Ward 6	58	75
S&AS	North Shore Hospital Ward 7	31	84
S&AS	North Shore Hospital Ward 8	24	100
S&AS	North Shore Hospital Ward 9	18	89
A&EM	North Shore Hospital Ward 10	12	92
A&EM	North Shore Hospital Ward 11	34	91
SMHOP	North Shore Hospital Ward 14	12	92
SMHOP	North Shore Hospital Ward 15	14	64
CWF	Wilson Centre	8	75
A&EM	Waitakere Hospital Assessment and Diagnostic Unit (ADU)	4	67
A&EM	Waitakere Hospital Anawhata Ward	8	63
A&EM	Waitakere Hospital Huia Ward	20	90
CWF	Waitakere Hospital Maternity Unit	10	80

SMHOP	Waitakere Hospital Muriwai Ward	9	88
CWF	Waitakere Hospital Rangatira Ward	31	97
CWF	Waitakere Hospital Special Care Baby Unit (SCBU)	11	82
S&AS	Waitakere Hospital Surgical Unit	28	96
A&EM	Waitakere Hospital Titirangi Ward	11	55
A&EM	Waitakere Hospital Wainamu Ward	22	73

Table 3: FFT results by ward

Key for above table 3:
Service/Ward Responses: *Green – achieved response target, Red – did not achieve response target*
NPS: *Green – met NPS target (65+), Amber – nearly met target (50-64), Red – did not meet target (<50)*

In October, only 54% of wards and services who met their response targets. Of these wards/services, 90% scored at or above the Waitematā DHB target. Four wards achieved an NPS score of 100, these are Ward 8, Elective Surgery Centre, Haematology Day Stay and Hine Ora Ward, all at North Shore Hospital (see table below). The main reasons for these positive scores include great staff (friendly, helpful, attentive, organised and kind), wonderful care and a nice clean environment.

This month, the lowest NPS scores are for Maternity Unit and Ward 15 at North Shore Hospital. The low NPS scores are mostly attributed to neutral scores, however some reasons for the negative scores include unhelpful/rude staff, not enough staff and long discharge process.

A summary of the FFT results can be seen below.

Ward/Service – Exceptional NPS	**Target Responses**	**Achieved**	**NPS Score**
Ward 8, North Shore Hospital	20	24	100
Elective Surgery Centre, North Shore Hospital	20	21	100
Haematology Day Stay, North Shore Hospital	20	20	100
Hine Ora Ward, North Shore Hospital	10	10	100
Ward/Service – Low NPS	**Target Responses**	**Achieved**	**NPS Score**
Maternity Unit, North Shore Hospital	20	80	64
Ward 15, North Shore Hospital	10	14	64

Table 4: FFT Results Summary

Patient and Whānau Centred Care Standards Programme (PWCCSP)
A PWCCSP November 2020 check in tool for Mental Health and Addictions were endorsed at the August PWCCSP steering group. Patient interviewing by a small team of specially recruited and trained hospital volunteers to obtain patient experience data for the PWCCSP at North Shore and Waitakere Hospitals briefly recommenced then stopped due to Level 3 restrictions and will commence again in November.

Other focus areas for the PWSCCP are:

- Expanding the program content. Work groups have been set up to develop a whānau standard and a staff wellbeing standard. There is also work starting on developing a Leadership standard.

- On-going work continues to support both the Community Mental Health Service and Auckland Regional Dental Service who are both anticipated to be able to run pilots later this year.

Māori Patient and Whānau Experience Lead
Whiringa-ā-nuku (October) 2020 Monthly Report

Key Activities:

- Support with two kura Māori to have access to ARDS dental caravans/teams to check their tauira (students). This activity is also to support an on-going access and delivery of service to the community of whānau Māori in the future. Participation in this area of the DHB has given insight to the perspectives and experiences of whānau in the community around DHB services.
- Majority of these school rolls had children who weren't engaged by ARDS and had not been seen in years (in some cases had not been seen at all).
- Positive observation was the benefit that having a Māori team in the vans had with engaging both the whānau and the school. Having a Māori staff team who understood how to move with the tikanga of the schools was vital in the rapport building with the tauira.
- Challenges identified with adequate access to orthodontic care for West Auckland whānau. The list of orthodontists that ARDS provides whānau does not currently present options for West Auckland providers. From a school unit of 40 Māori students, there were eight 8 students identified as needing orthodontic care of which the additional concern is the financial barrier for these whānau to be able to access this care. .
- Attendance to the Launch of the Auckland DHB Champions of Māori Patient and Whānau Experience group. The counter-part for this role at Auckland DHB – Vanessa Duthie, has led the implementation of a champions support group focussed on the improvement of Māori patient and whānau experience. The group is intended to meet monthly to share tools, approaches and perspectives to support staff and leadership teams in understanding and practicing ways to improve Māori experience. It is with hope that a similar approach can be undertaken if deemed appropriate in areas at Waitematā DHB.
- Work with the ED department to support development and growth around their equity culture has been positive. The leadership team (particular – Dr Sarah Olsen, Dr Kate Allen and Kamini Ghosh) have been very proactive in sessions to explore tools they can use to support their teams. A patient, who had previous negative experience in June, reported a noticeable positive difference in the tone of care she received from the ED team at Waitakere when they re-presented in October. Planned for November are the two strategic planning days with the ED teams at both sites where there will be a practical focus on the experience of whānau and implementation of the Tikanga Best Practice policy.
- The use of Māori specific teams in areas (such as ARDS) has proven to be beneficial to support positive relationship building between DHB and community Māori (especially with tamariki/rangatahi).

Goals for November:

- Support a paper for the delivery of ARDS services to Māori Community (with Māori Health Gains Team).
- Begin the implementation of changes to the physical environment of the Waitakere Hospital site in departments to support positive engagement improvement and improvement of Māori patient experience.
- Begin the development of a set of presentations to support the understanding of Māori Patient and Whānau Experience – inclusive of the 1st set of practical components of the Tikanga Best Practice policy.
    1. Kia Ora (using it as the official welcome of the DHB and the start to engagements with all patients and whānau)
    2. Use of Blue pillowcases vs White Pillowcases in patient areas
    3. Mindfulness of surfaces and their uses (E.g. kai and bodily fluids (or relative) should not share the same surface and the leaning/ sitting on surfaces/tabletops)
    4. How to have a conversation of learning how to pronounce a name correctly and why it is so important.

6.2 Patient Experience Activity Highlights

Consumer Council Update & Highlights

The Consumer Council met on October 14th. They discussed the following agenda items at their most recent meeting:

- **Informed Consent: Gynaecology Patient Information Package**
- **Auckland Regional Dental Service (ARDS) : Effective Communication and Community Engagement to Promote Equity in Accessing Children's Dental Services**
- **Disability: General Discussion**
- **Patient Experience Report**

The Consumer Council Chair hosted representatives from St John, Pete Loveridge (Deputy Chief Executive - Customers and Supporters) and Natalie Davis (Head of Brand and Customer Experience) who observed the meeting of the Consumer Council to learn more about the meeting process as they look into establishing a similar consumer group.

Patient Experience Highlights

The new Friends and Family Test (FFT) was successfully rolled out on 1st November to over 100 wards and services across the organisation. The Adult questions have been updated with new questions, put together in consultation with staff and consumers and tested across a broad range of patients and whānau members from a variety of hospital wards and services. The Child and Youth version ensures tamariki have a voice and their opinions are listened to and acted on.

Volunteer Recruitment Statistics

Volunteer number has decreased by six compared to last month. We will be experiencing some fluctuations with the number in the next months because of the challenges the current pandemic has brought.

Green Coats Volunteers (Front of House) (A)	Other allocated Volunteers (B)	Volunteers on boarded awaiting allocation (C)	Total volunteers available (D) (A) + (B) + (C) =(D)
52	121	1	174

Table 5: Volunteers Recruitment

We are still receiving and processing applications online who are hearing about the programme via other volunteers. The patient experience team is planning at exploring new approach to recruitment starting next year. The new approach will take into account the organisation's needs and the sustainability of the programme. The West Lake Boy and Girls Schools have had limited opportunity to volunteer this year due to the 2nd wave of COVID-19. We will have a volunteer programme in place with a West Auckland School in 2021 to support Waitakere.

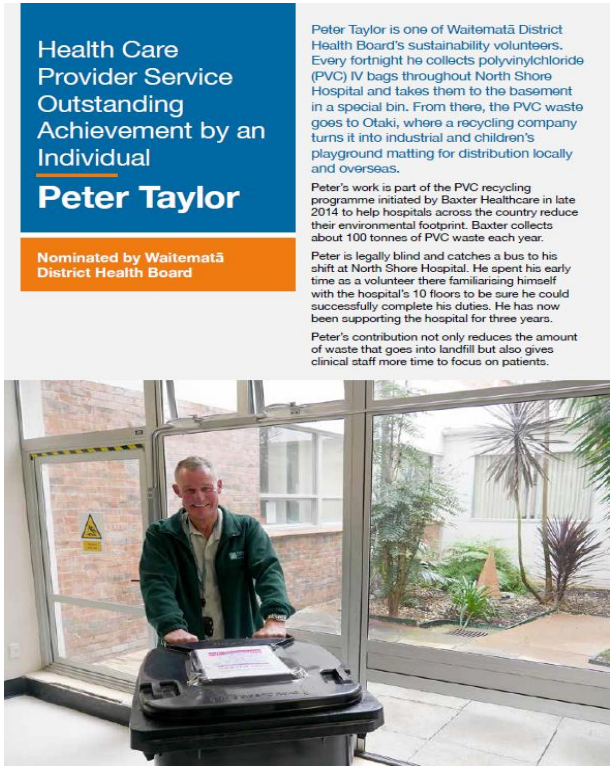
Volunteer Activity Highlights

- ***Better Impact Roll Out***

Better impact volunteer user training is progressing steadily at North Shore Hospital and most volunteers have positively welcomed the new signing in process. We are aiming at getting all North Shore volunteers trained by December 2020. The Better Impact software will enable the patient experience team to measure the impact of volunteer services throughout the organisation.

- ***Volunteer recognised in Ministry of Health volunteer awards***

On Monday 12 October 2020, Waitematā DHB celebrated and acknowledged Peter Taylor (pictured below). Peter is one of our sustainability volunteers who won the Ministry of Health volunteers awards in the category of **Health Care Provider Service Individual Awards**. Peter was recognized for his amazing work and contribution to the organisation.



Pastoral Care Update

As a part of enabling Results Based Accountability (RBA) and ensuring accountability to the Ministry of Health, a new chaplain's reporting system called "My Week in Review" was implemented. The system collects information on the time and activities of chaplains that are directly associated with the spiritual care of patients, whānau and staff. The information gathered will allow us to explore how we can improve our patient centred care. With such a significant change to the way of reporting we were keen to ensure that we set ourselves an achievable goal and the system is being well used by chaplains. At present, our Volunteer Chaplaincy Assistants (VCAs) are not a part of this system and we hope to incorporate them in a simplified form of reporting as we develop the system.

Types of Spiritual Care

The care that chaplains offer is split into four sub-categories of spiritual care identified in the World Health Organisation's International Disease Classification Codes version 10 (WHO-ICD10): Assessment, Counselling, Support and Ritual:

- **Spiritual Assessment**: Initial and subsequent assessment of needs and resources of patient or support network. Can be formal or informal and often leads to other interventions.
- **Spiritual Counselling, Guidance or Education**: spiritual care that includes a facilitative in-depth discussion in matters of beliefs, traditions, values and practices.
- **Spiritual Support**: the ministry of presence, emotional support and relationship building, enabling conversations to nurture spiritual wellbeing and healing.
- **Spiritual Ritual**: all ritual activities, worship, rites and sacraments, both formal and informal, private and public.

These categories overlap and sometimes take place simultaneously so chaplains make a judgement as to what proportion of time is spent on each of the four activities with each client or client group. As the focus is on how chaplains are using their time, the figures reported are the number of care activities and it should be noted that an activity may be with a single patient, whānau member or member of staff or with groups of them. It is recorded this way so that we know the average length of an activity. Currently, this does not tell us how many patients, whānau and staff have been cared for as a part of groups.
In this report, the Chaplains 'My Week in Review' report for 2020 quarter 3 is summarised. These statistics are from 29 June 2020 to 26 September 2020 (13weeks); with 63 reports from six chaplains.

➢ **Pastoral Care Activity for the Voluntary Chaplains Assistants (VCAs) across Waitematā DHB**

Activities : 1. Support patients and their whānau or support networks through providing spiritual and pastoral support			
Key Performance Measures			
How many (Quantity of effort = #)		**How well (Quality of effort = %)**	
# Patients provided spiritual care	2018		
# (patient) Spiritual rituals provided	1378		
# Patient pastoral care hours (h:m)	497:30	% of time spent with patients	28.1%
# whānau groups provided spiritual care	249		
# (whānau groups) Spiritual rituals provided	82		
# Whānau Group pastoral care hours (h:m)	75:15	% of time spent with whānau or support networks	3.7%
# Staff provided spiritual care	411		
# (Staff) Spiritual rituals provided	171		
# of staff pastoral care hours (h:m)	139:35	% of time spent with staff	8.3%
# of reflective accounts by chaplains/week	10.8	% of contact time (total)	40.0%
Complimentary narrative reporting		**Complimentary narrative reporting**	
# of patient spiritual assessments	1562	% patient time - assessment	17.4%
# of patient spiritual guidance	1042	% patient time - guidance	24.3%
# of patient spiritual support	1300	% patient time - support	35.9%
# (patient) Spiritual rituals provided	1378	% patient time - ritual	22.4%
# of whānau group spiritual assessments	179	% whānau time - assessment	19.5%
# of whānau group spiritual guidance	119	% whānau time - guidance	28.5%

# of whānau group spiritual support	166	% whānau time - support	42.0%
# (whānau groups) Spiritual rituals provided	82	% whānau time - ritual	10.0%
# of staff spiritual assessments	156	% staff time - assessment	10.1%
# of staff spiritual guidance	153	% staff time - guidance	32.3%
# of staff spiritual support	187	% staff time - support	31.2%
# (Staff) Spiritual rituals provided	171	% staff time - ritual	26.4%
# of anointing of the sick	40	# of private prayers	1135
# of Blessings	76	# of public prayers / services	183
# of Baptism/Dedications/Naming	1	# of other rituals	54
# of bedside communions	221		
Activities : 2. Manage service access through internal and external referrals			
Key Performance Measures			
How many (Quantity of effort = #)		**How well (Quality of effort = %)**	
# referrals from internal staff/departments	164		
# referrals to internal staff/departments	47		
# referrals from external organisations	92		
# referrals to external organisations	35		
# of MDT attended	42		
Complimentary narrative reporting		**Complimentary narrative reporting**	
Referrals from whānau	31	Referrals to whānau	2
Referrals from patient	11	Referrals to church/faith group	27
Referrals from church/faith group	49	Referrals to social worker	6
Referrals from other	1	Referrals to other	0

- **Pastoral Care Activity Volunteer Chaplains Assistants (VCAs) across Waitematā DHB**

No. of visits to patients	290
No. of visits to family	49
No. of visits to staff	34
Hours volunteered	11.5 (Waitakere) 71.9 (North Shore)

Not all the VCAs resumed their duties in October due to personal COVID-19 precautions. However, in the last week of October, the trainees VCAs have completed their training so they started their ward visits with a buddy VCA. Therefore the numbers reported are not a true indication as the same patient was visited by two VCAs. The buddy system will continue until the trainee VCAs are confident to visit the wards independently.

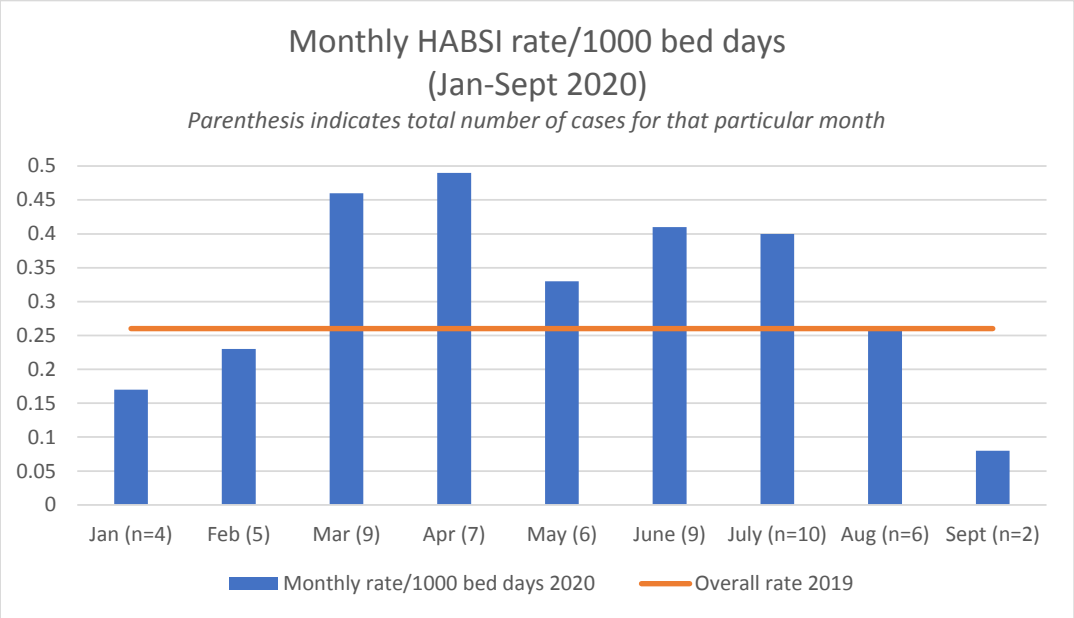
Appendix 1

Waitemata DHB Infection Prevention and Control Report September 2020

Please note that this report was prepared at the time of resurgence of COVID-19 in Auckland. It includes highlights of the IPC surveillance for September 2020. Please refer to the mid-year report 2020 for more details of surveillance activities, definitions and trends.

1. Hospital Acquired Bloodstream Infections (HABSI)

Graph: HABSI rate and numbers at WDHB for 2020.



Monthly HABSI rate (per 1000 bed days) at WDHB Jan –September 2020

2020	Jan	Feb	Mar	April	May	June	July	August	Sept
Total No. HABSI	4	5	9	7	6	9	10	6	2
Rates/1000 Bed Days	0.17	0.23	0.46	0.49	0.33	0.41	0.40	0.26	0.08

Table: HABSI cases in September 2020

Source	Total	Ward	Organism	
Other	1	8	E coli	
CAUTI	1	ICU/HDU	Klebsiella Pneumonia /E coli	4 days after IDC was inserted for monitoring in view of recurrent GI bleed.

2. Extended spectrum Beta lactamase producing bacteria (ESBL)

- NSH had and increse in HA ESBL in September to 11 compared to 4 to 6 in last 8 months .
- HA ESBL was spread across 5 wards , with surgial survices accounting for 64% of HA ESBL Ward 8 =3, Ward 9=3 , ICU=1)
- HA ESBL identifed from either late /discharge /transfer screening
- 1 ESBL KP isolated from clinical isolate
- Contact sreening did not identify any evidence of ESBL cross transmission

		2020	Jan	Feb	Mar	Apr	May	Jun	July	August	September
HA-ESBL rate/10,000 bed days (number)	2019 Rate 5.1 (138	**NSH**	3.1 (5)	3.9 (6)	4.3 (6)	2.9 (3)	2.2 (3)	2.6 (4)	2.3 (4)	3.8 (6)	6.8 (11)
		WTH	1.5 (1)	0	5.2 (3)	2.2 (1)	2.1 (1)	0	6.8 (5)	2 (2.9)	1 (1.5)

3. Seasonal Influenza

Despite a winter season where influenza viruses always circulate in the community and healthcare systems, no influenza cases were diagnosed in June or July at either NSH or WTH. Influenza PCR testing is part of the respiratory viral panel implemented for COVID surveillance in all patients presenting to ED/ADU with suspected respiratory tract infections. This strategy continued despite 'elimination' of COVID from New Zealand during the time period. Influenza surveillance period ceases after October. No identified cases in last 4 months

Table: Monthly cases of Influenza (community acquired- CA vs hospital acquired- HA) at NSH/WTK compared to overall numbers in 2019.

	2019	2020 Feb	2020 March	2020 April	2020 May	2020 Jun	2020 July	2020 August	2020 September
NSH CA- INF	**603**	15	7	2	3	No cases			
HA- INF	**58**	2	0	0	0				
WTH CA-INF	**606**	10	15	1	0				
HA-INF	**44**	0	3	0	0				

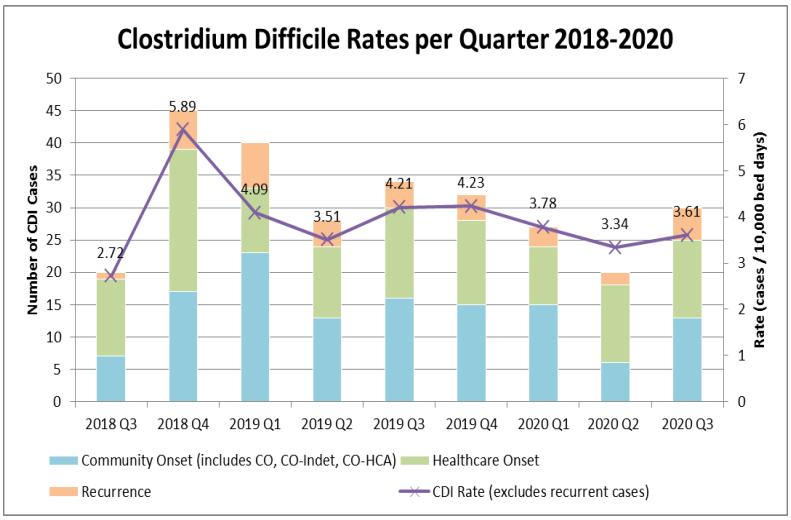
4. Clostridium Difficile – CDI (Clostridioides difficile)

Clostridium difficile numbers and classifications 2020, quarter 3

Quarter 3
Overall rate of CDI for Q3 is 3.6 per 10,000 bed days
30 CDI cases detected comprising

- 13 CO
- 12 HO-HCA
- 5 recurrent

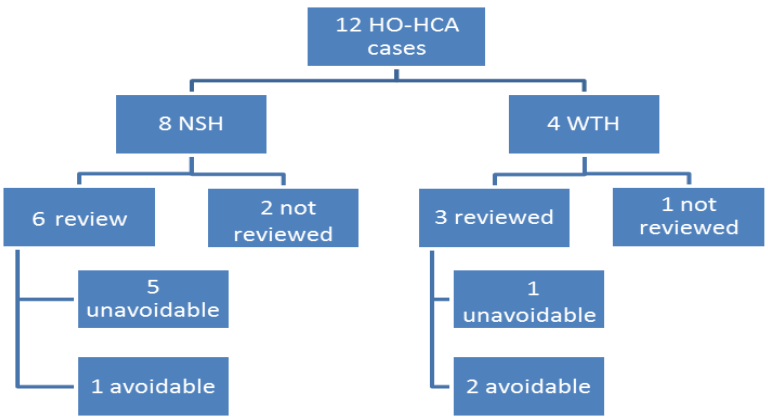
The proportion of HO-HCA infections is 44%.



HO-HCA Q3 2020:

WDHB has an active review process of all HO-HCA and recurrent CDIs. The process aims to identify avenues for improvement of antimicrobial prescribing practices in order to reduce the incidence of CDI. These reviews are undertaken by the ID physician / microbiologist and AMS pharmacist at the time of CDI diagnosis. A letter outlining the causes and corrective actions is sent to the responsible clinician if the case is considered avoidable.

75% of all HO-HCA cases reviewed Q3.
Cases were not reviewed during level 3 due to COVID related work load.



5. Surgical Site Infections (SSI) for knee and hip arthroplasties

Table: SSI number and rates from 2016 to Quarter 1 2020 at Waitematā DHB

In scope procedures for SSI surveillance are primary and revision hip/knee arthroplasty performed at either NSH or elective surgical centre (ESC) in accordance with National Surgical Infection Improvement (SSII) program. The surveillance criteria 90 days post-operatively for deep and 30 days for superficial infection

2020

Q1 - **One superficial SSI** (rate **0.4**/100 procedure)- NSH

Q2 - **One superficial SSI** (rate **2.2** /100 procedures)- NSH. Note only 45 procedures performed.

Q3 - 2 superficial and 1 deep (rate 0.9/100 procedures) ESC and NSH

***Staph* decolonisation bundle commenced in Nov 2017**

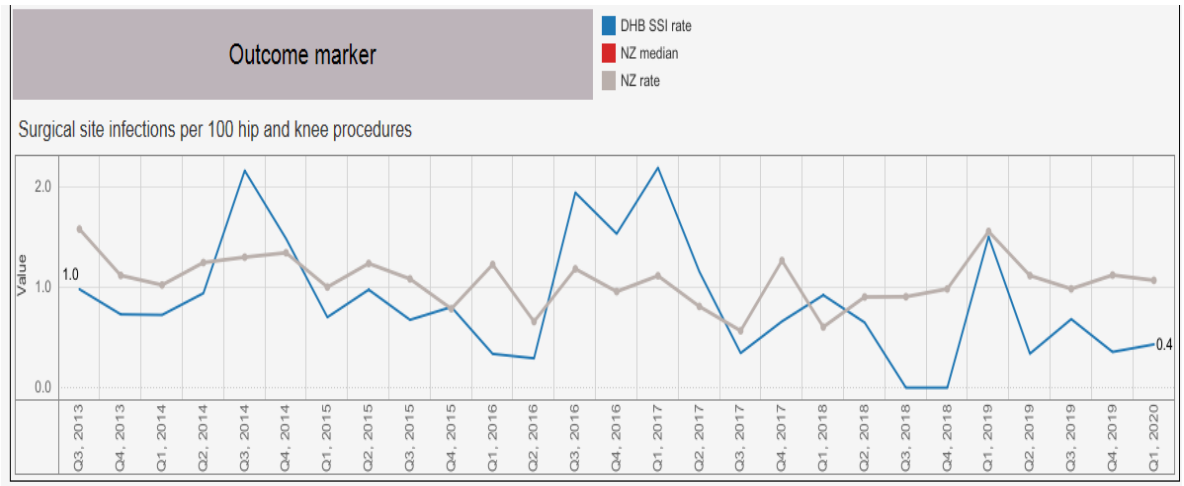
- Staph aureus and Staph epidermidis isolated in deep SSI for Q3. SSI investigation found 100% adherence to SAB bundle
- Pseudomonas isolated in superficial SSI in Q1

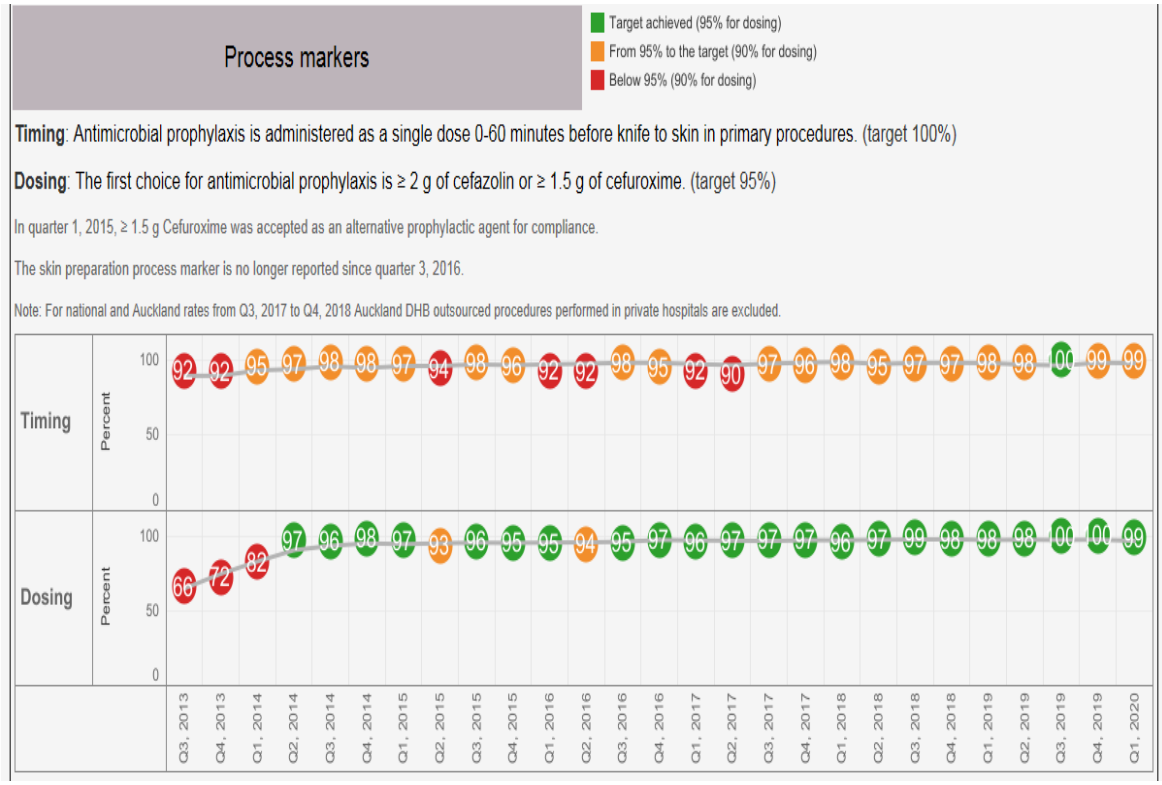
Table: SSI number and rates 2016 to Q3 2020 at Waitemata DHB

Year	2016		2017		2018		2019				2020		
Quarter			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3 *
Total procedures	1217	1191	217	304	240	229	261	297	289	287	**232**	**45**	**321**
SSI's (n)	12	13	2	2	1	0	4	1	2	1	**1**	**1**	**3**
Rate %	1		1		0.5		1.5	0.3	0.7	0.3	**0.4**	**2.2**	**0.9**

*Data for Q3 provisional, surveillance period ends 31st December 2020

HQSC Quality Safety Markers Data until March 2020





6. Communicable Diseases, Clusters and Outbreaks July –Sept

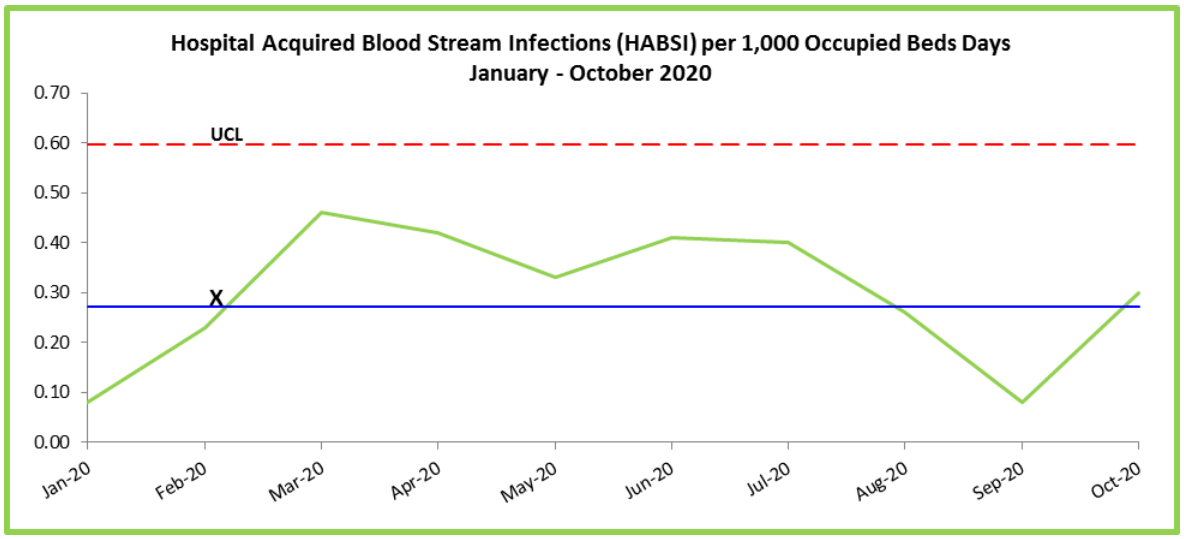
Disease	Confirmed cases	Ward	Staff contacts	Patient contacts	Comments
TB	5	ED NSH ED WTH Ward 10 Ward 2 Huia	nil	Nil	Patients were isolated appropriately in airborne precautions on admission

Appendix 2

Waitemata DHB Infection Prevention and Control Brief report October 2020

Please note that this report was prepared at the time of resurgence of COVID-19 in Auckland. It includes highlights of the IPC surveillance for August 2020. Please refer to the mid-year report 2020 for more details of surveillance activities, definitions and trends.

1. Hospital Acquired Bloodstream Infections (HABSI)



Monthly HABSI rate (per 1000 bed days) at WDHB Jan –October 2020

2020	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct
Total No. HABSI	4	5	9	7	6	9	10	6	2	7
Rates/1000 Bed Days	0.17	0.23	0.46	0.49	0.33	0.41	0.40	0.26	0.08	0.30

Table: HABSI cases in October 2020

Source	Total	Ward	Organism	
IVL	1	Ward 10	Staph aureus	IVL inserted in ACF. Poor compliance with IVL management
Other	5	Wards 4, 8 5, OPD, Theatre,	X2 ESBL EC, KP, Kleb varicola, PAER,	Secondary source of infection either intra-abdominal , biliary , or urosepsis
Unknown	1	Anawhata	E faecalis	No source identified ,CA bladder

Comment:

X1 IVL related BSI. Total number of IVL related BSI Jan –October = 7.

.

Point Prevalence audit under taken in November for both NSH and Waitakere identified:

1. Time and date not documented
2. IVL placement in ACF

3. IVL left in when not required

Overall compliance rate NSH 69 & WTH 70%. Work is being done by Direct of Nursing to address this issue

2. Extended spectrum Beta lactamase producing bacteria (ESBL)

Comments:

- Increase in ESBL rate for Waitakere, spread across three wards. No evidence of cross transmission
- ESBL identified from transfer screening.
- Fluctuating HA ESBL rates could be attributed to inconsistency with ESBL screening of high risk patients during peak of COVID -19

HA-ESBL rate/10,000 bed days (number)	2019 Rate 5.1 (138	**2020**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**
		NSH	3.1 (5)	3.9 (6)	4.3 (6)	2.9 (3)	2.2 (3)	2.6 (4)	2.3 (4)	3.8 (6)	6.8 (11)	3.6 (6)
		WTH	1.5 (1)	0	5.2 (3)	2.2 (1)	2.1 (1)	0	6.8 (5)	2.9 (2	1.5 (1)	4.5 (3)

Appendix 3

Monthly Hand Hygiene Report: September 2020

Highlights:

- One of the cornerstones of preventing the spread of COVID 19 is **hand washing**
- Well done NSH theatres for getting above 80% for the first time this year
- Waitakere hospital has achieved every area recording more than 80% compliance for the 2nd month in a row!
- The overall Waitemata DHB hand hygiene compliance for the month of Sept 2020 is 90% and increase of 0.4% from Aug.

Waitemata DHB hand hygiene compliance in the last 12 months.

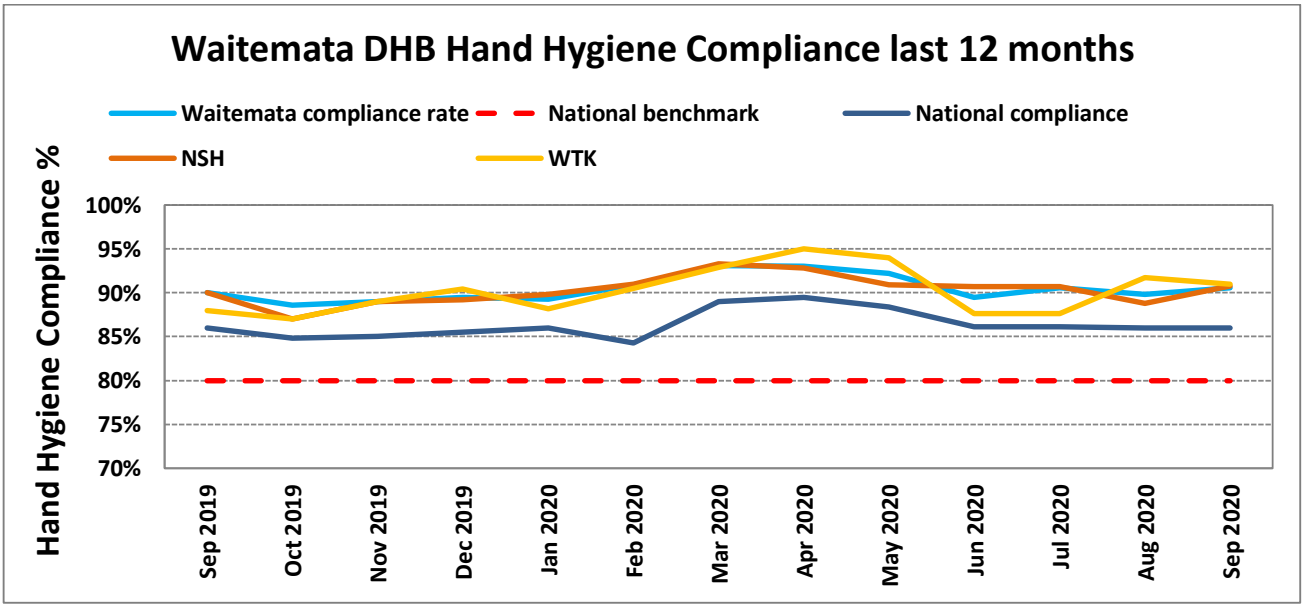


Table 1:Overall Waitemata DHB hand hygiene compliance by facility.

Name	Correct Moments	Total Moments	Compliance Rate
Waitemata DHB	4692	5176	90.6%
Elective Surgery Centre	245	283	86.6%
North Shore Hospital	2846	3133	90.8%
Waitakere Hospital	1601	1760	91.0%
Specialist Mental Health and Addictions	239	243	98.4%
Wilson Centre	68	71	95.8%

All Gold Auditors and Charge Nurses now have logins to be able their own data - It is recommended that the department reports are printed and publically displayed in each department's quality board.

Monthly Hand Hygiene Report: September 2020

Table 2: Overall Waitemata DHB hand hygiene compliance by HCW type

	Name	Correct moments	Total moments	Compliance rate
1	Nurse/Midwife	2,439	2,633	92.6%
2	Medical Practitioner	597	692	86.3%
3	Allied Health Care Worker	158	188	84.0%
4	Phlebotomy Invasive Technician	232	242	95.9%
5	Health Care Assistant	563	626	89.9%
6	Cleaner & Meal staff	191	209	91.4%
7	Administrative and Clerical Staff	27	29	93.1%
8	Student Doctor	68	70	97.1%
9	Other - Orderly & Not Categorised Elsewhere	205	254	80.7%
10	Student Allied Health	15	17	88.2%
11	Student Nurse/Midwife	197	216	91.2%

Table 3:Overall Waitemata DHB hand hygiene compliance by moment.

1 - Before Touching A Patient	1,288	1,460	88.2%
2 - Before Procedure	515	568	90.7%
3 - After a Procedure or Body Fluid Exposure Risk	673	693	97.1%
4 - After Touching a Patient	1,380	1,460	94.5%
5 - After Touching A Patient's Surroundings	836	995	84.0%

Areas which did not meet the national standard of 80%:

Ward/Area	Compliance Rate **Sept 20**	Compliance for previous 3 months	Comments
PACU 1&2 NSH	77.2%	June 90% July 83.8% Aug 71.3%	
Anawhata WTK	78.6%	June 85.7% July 82.5% Aug 85.5%	

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Monthly Hand Hygiene Report: September 2020

National Requirements for the Hand Hygiene Program :

As part of the hand hygiene (HH) program managed by the health quality safety commission (HQSC), we are required to validate our HH audit data. The auditing process and schedule for Northshore and Waitakere hospital are available.

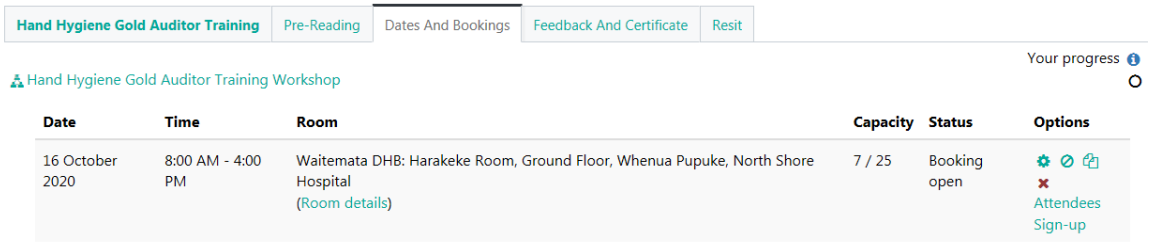
In addition the HQSC requires that all Gold Auditors complete annual online validation training – emails have been sent regarding the process for this.

Number of moments required by clinical units

- Inpatient medical, surgical, radiology, endoscopy, maternity, paediatric units **= 100 moments per month**
- Outpatient units (including outpatient Haemodialysis and Haematology units), Wilson Centre, Hine Ora, CVU, interventional radiology NSH (AIR) **= 50 moments per month**
- Inpatient mental health / detox units, hyperbaric unit **= 25 moments per month.**

Hand hygiene auditor training for 2020

Please register via Ko Awatea for this course



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Appendix 4

Waitemata District Health Board
Best Care for Everyone

Monthly Hand Hygiene Report: October 2020

Highlights:

- One of the cornerstones of preventing the spread of COVID 19 is **hand washing**
- Well done to ADU NSH who have recorded above 80% for the last 3 months
- Well done to Rangitira ward WTK for maintaining above 90% for all of 2020 so far!

The overall Waitemata DHB hand hygiene compliance for the month of Oct 2020
is 90.3% - very similar to Sept 2020
KEEP UP THE GOOD WORK

Waitemata DHB hand hygiene compliance in the last 12 months.

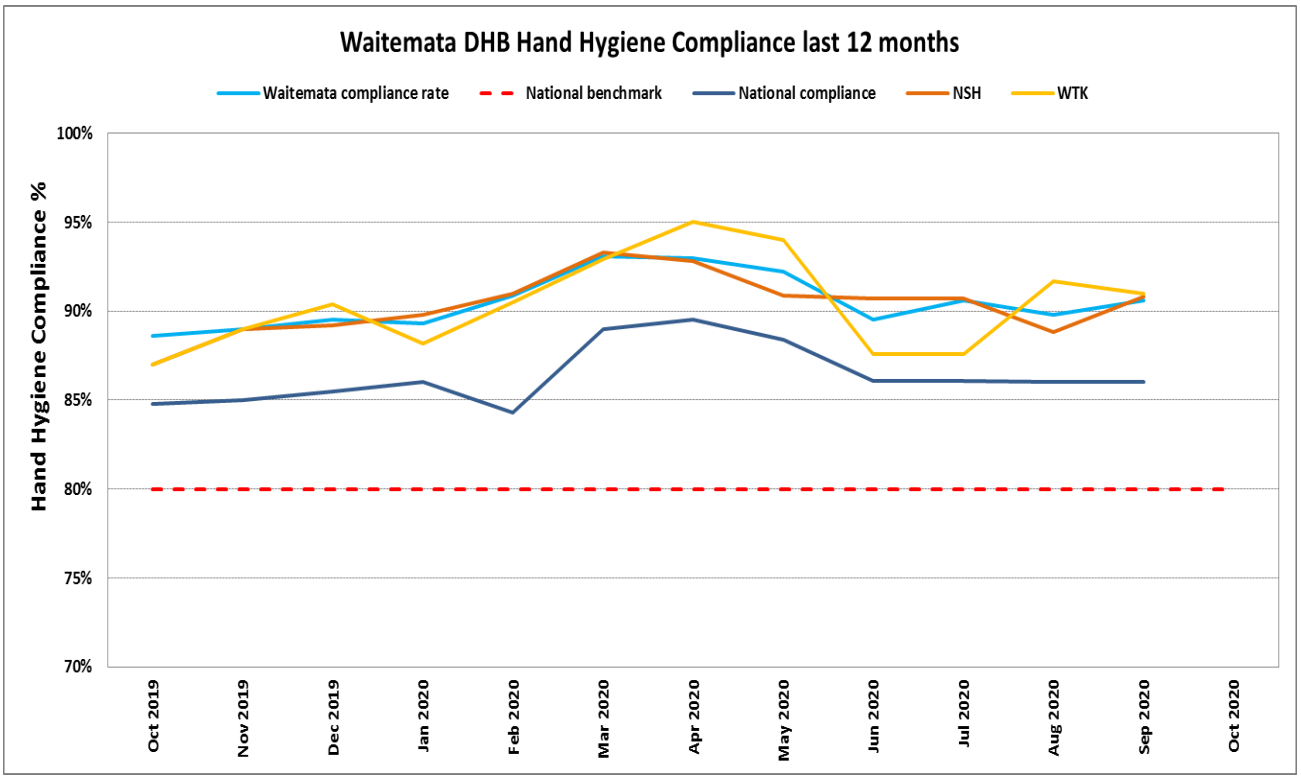

Table 1:Overall Waitemata DHB hand hygiene compliance by facility.

Name	Correct Moments	Total Moments	Compliance Rate
Waitemata DHB	4578	5067	90.3%
Elective Surgery Centre	250	281	89%
North Shore Hospital	2773	3077	90.1%
Waitakere Hospital	1555	1709	91%
Specialist Mental Health and Addictions	182	185	98.4%
Wilson Centre	52	53	98.1%

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Monthly Hand Hygiene Report: October 2020

Table 2: Overall Waitemata DHB hand hygiene compliance by HCW type

	Name	Correct moments	Total moments	Compliance rate
1	Nurse/Midwife	2471	2682	92.1%
2	Medical Practitioner	556	662	84.0%
3	Allied Health Care Worker	217	244	88.9%
4	Phlebotomy Invasive Technician	171	179	95.5%
5	Health Care Assistant	497	551	90.2%
6	Cleaner & Meal staff	173	182	95.1%
7	Administrative and Clerical Staff	28	33	84.8%
8	Student Doctor	25	28	89.3%
9	Other - Orderly & Not Categorised Elsewhere	221	270	81.9%
10	Student Allied Health	26	28	92.9%
11	Student Nurse/Midwife	193	208	92.8%

Table 3:Overall Waitemata DHB hand hygiene compliance by moment.

1 - Before Touching A Patient	1305	1508	86.5%
2 - Before Procedure	514	553	92.9%
3 - After a Procedure or Body Fluid Exposure Risk	595	635	94.1%
4 - After Touching a Patient	1409	1495	94.2%
5 - After Touching A Patient's Surroundings	755	879	85.9%

Areas which did not meet the national standard of 80%:

Ward/Area	Compliance Rate **OCT 20**	Compliance for previous 3 months	Comments
PACU 1&2 NSH	75%	July 83.8% Aug 71.3% Sept 77.2%	
Theatre	79.7%	July 66% Aug 71.3% Sept 82.9%	
ED WTK	79.7%	July 83.5% Aug 86.7% Sept 81.8%	
Theatre ESC	73.3%	July 76.3% Aug 77.1% Sept 80%	

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Monthly Hand Hygiene Report: October 2020

National Requirements for the Hand Hygiene Program :

As part of the hand hygiene (HH) program managed by the health quality safety commission (HQSC), we are required to validate our HH audit data. The auditing process and schedule for Northshore and Waitakere hospital is available.

In addition the HQSC requires that all Gold Auditors complete annual online validation training – emails have been sent regarding the process for this.

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- Inpatient mental health / detox units, hyperbaric unit **= 25 moments per month.**

Hand hygiene auditor training for 2020

All training for 2020 has now been completed. Dates for 2021 will be released shortly

All Gold Auditors and Charge Nurses now have logins to be able their own data - It is recommended that the department reports are printed and publically displayed in each department's quality board.

Appendix 5

Nationwide Health & Disability Advocacy Service
Ngā Kaitautoko

Complaints to the Nationwide Health and Disability Advocacy Service involving District Health Boards

Report and Analysis for the period 1 July 2019 to 30 June 2020

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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DIRECTOR OF ADVOCACY'S FOREWORD

I am pleased to present the Nationwide Health and Disability Advocacy Service's analysis of complaints received in the 2019/20 year about District Health Boards (DHBs). I note this year the significant impact of COVID-19 on health providers and consumers. However, while both the Advocacy Service's and many DHB complaints management processes were impeded by the COVID-19 restrictions, advocates appreciated the strong commitment demonstrated by DHB complaints management teams to continue to respond as quickly and effectively as possible.

This report relates only to complaints made to the Advocacy Service. The Health and Disability Commissioner's DHB Complaints Report for January to June 2020 will be published shortly.

Under the Health and Disability Commissioner Act 1994, advocates are tasked with assisting consumers to resolve their complaints by agreement between the parties. Consumers are always at the centre of the Advocacy Service's complaints resolution process, with advocates guiding and supporting complainants to clarify their concerns and the outcomes they seek. This clarity enables the provider to write or speak effectively and directly to the complainant. Both sides being able to hear each other's perspective is an essential part of the advocacy process. Often the advocacy process can support people to rebuild relationships, which is particularly important when the relationship will be ongoing.

The advocacy process is timely and effective. Over 80% of complaints are closed within three months, and nearly 100% are closed within six months. Eighty-five percent of all complaints to the Advocacy Service were either resolved successfully or withdrawn by the complainant. In the first instance, advocates always talk through the various options for dealing with any concerns, and in some cases just having the opportunity to talk through the options and the events or to draft a complaint letter with an advocate enables someone to achieve a degree of personal reconciliation, and they no longer need to make a formal complaint.

Most importantly, satisfaction surveys show that the advocacy process was a positive one for both consumers and providers, with 93% of consumers and 93% of providers surveyed saying they were satisfied or very satisfied with the advocacy process. The high resolution and satisfaction rates achieved by the Advocacy Service reflects its consumer-focused approach and the commitment of providers to achieving early and effective resolution.

I hope the information contained in this report assists DHBs in understanding their complaint patterns and how these compare nationally.

Jessica Mills
Director of Advocacy
Office of the Health and Disability Commissioner

EXECUTIVE SUMMARY

In the 2019/20 year, the Nationwide Health and Disability Advocacy Service (the Advocacy Service) received 1,097 complaints about services provided by DHBs.[1] This was a 9% decrease on the average number of 1,200 complaints received in the previous four years. This decrease may be attributable to COVID-19 restrictions and an associated decrease in health service activity.

The 1,097 complaints received in 2019/20 equated to a rate of 116 complaints per 100,000 discharges. This is consistent with the rate of complaints received in the previous two years.

Complaints were received about a wide variety of DHB service types. Broadly similar to what was seen last year, the most commonly complained about service types in 2019/20 were surgical (31.4%), medicine (17.6%), and mental health (18%) services.

The majority of complaints about DHBs were about care/treatment (55%) and communication (30%) issues. The most common specific primary issues were a failure to communicate effectively with the consumer (18%) and inadequate coordination of care/treatment (13%). This is similar to what has been seen in previous years.

Of the 1,124 complaints closed by the Advocacy Service in 2019/20, only 128 complaints were closed unresolved, with just 29 of those being referred on to HDC.

The Advocacy Service information leaflet, available from www.advocacy.org.nz

[1] Advocacy closed 1,124 complaints about DHB services in the year.

BACKGROUND

1. The Nationwide Health and Disability Advocacy Service

The Health and Disability Commissioner Act 1994 (the HDC Act) provides for the independent Advocacy Service and sets out the legislative functions of advocates. Since 2008, the Director of Advocacy at HDC has contracted with a charitable trust, the National Advocacy Trust, to provide the Advocacy Service.

The service has recently refreshed its website and branding. Leaflets and posters can be obtained from the Advocacy Service Website — www.advocacy.org.nz.

Nationwide Health & Disability Advocacy Service
Ngā Kaitautoko

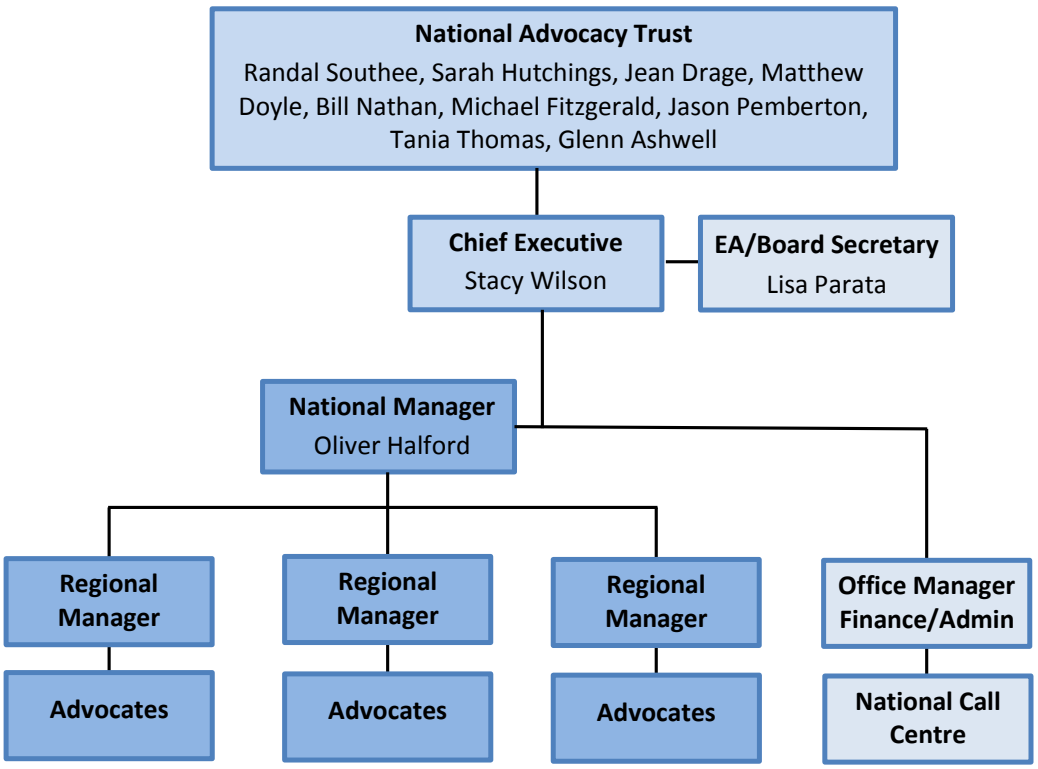

Figure 1. The Nationwide Health and Disability Advocacy Service Organisation

1.1 Services

The Advocacy Service has community-based offices throughout New Zealand. Each year the Advocacy Service expects to receive and close approximately 2,800 complaints, deliver over 1,500 education sessions to consumer and provider groups on the Code of Health and Disability Services Consumers' Rights (the Code), make more than 4,000 network contacts, and respond to an estimated 15,000 enquiries. Advocates work within their local community to support and guide consumers to achieve prompt and successful resolution of their concerns through an alternative dispute resolution process that is flexible and time-effective.

Figure 2. The Nationwide Health & Disability Advocacy Service offices

1.2 The advocacy process

Any consumer in New Zealand can make a complaint to the Advocacy Service about a health or disability service that has been provided to them. When considering complaints, the Advocacy Service has the same jurisdiction as HDC — there must have been the provision of a health or disability service to a consumer by a provider, and a possible infringement of the consumer's rights under the Code.

Advocates use defined complaints resolution processes and aim to achieve positive outcomes for consumers, and develop professional and respectful working relationships with providers and consumers of all backgrounds. Consumers are always at the centre of the Advocacy Service's complaints resolution process, with advocates guiding and supporting complainants to clarify those concerns and the outcomes they are seeking to assist the

consumer to approach complaint resolution with a realistic direction and clarity. This clarity and process enables the provider to write or speak effectively and directly to the complainant. Both sides being able to hear each other's stories is an essential part of the advocacy process.

1.3 Resolution

In the 2019/20 year, 85% of complaints to the Advocacy Service were either resolved successfully between the parties or withdrawn by the complainant. In the first instance, advocates always talk through the various options for dealing with any concerns. In some cases, just having the opportunity to talk through the options and the events or to draft a complaint letter with an advocate enables someone to achieve a degree of personal reconciliation, and they no longer need to make a formal complaint.

Resolution is usually through written communication. In some instances, a face-to-face meeting between the parties is the best way to resolve a complaint. Frequently consumers want to ensure that what happened to them will not happen to someone else, and seek an acknowledgement of the harm or distress suffered. It can be invaluable for providers to be able to respond face to face. Often the advocacy process can support people to rebuild relationships, which is particularly important when the relationship will be ongoing, as with many DHB services.

Ninety-three percent of providers and 93% of consumers surveyed in the 2019/20 year said that they were either satisfied or very satisfied with the advocacy process.

> "I am very grateful for the role the Advocates play in clarifying the patient's concerns and what actions they'd like to take going forward. It can be difficult to ensure a complaint is resolved when the desired outcomes are unclear, so I deeply appreciate the work the advocates in our area do to support consumers." — a provider

The high rate of resolution, and high levels of consumer and provider satisfaction, reflect the strong consumer-centred approach of the Advocacy Service and significant provider commitment to the process.

> "I really appreciated the advocate's efforts on our behalf at what was a very difficult time. She was attentive to my concerns and very supportive and we were able to resolve the issues before my husband passed away." — a complainant

2. This Report

This report describes the complaints the Advocacy Service received and/or closed about DHBs during the 2019/20 financial year.

The complaints are described both in terms of overall numbers and characteristics. In terms of complaints received, the issues included in the analysis are as articulated by the complainant to the Advocacy Service. Although the issues raised in complaints may not always be able to be substantiated by the advocacy process, those issues can provide valuable insight into the consumer's experience of the services provided and the issues consumers care about most.

The report provides a comparison with the data and trends reported in this format about advocacy complaints over the past five years, and with that reported by HDC. We expect that over time, as we continue to analyse the data to the degree of specificity demonstrated in this report, additional time series analysis will become possible, which we anticipate will be significantly useful.

In addition, it may be useful for DHBs to triangulate trends in the complaints received by the Advocacy Service with the trends in complaints received by HDC,[2] and with the complaints received directly by the DHB.

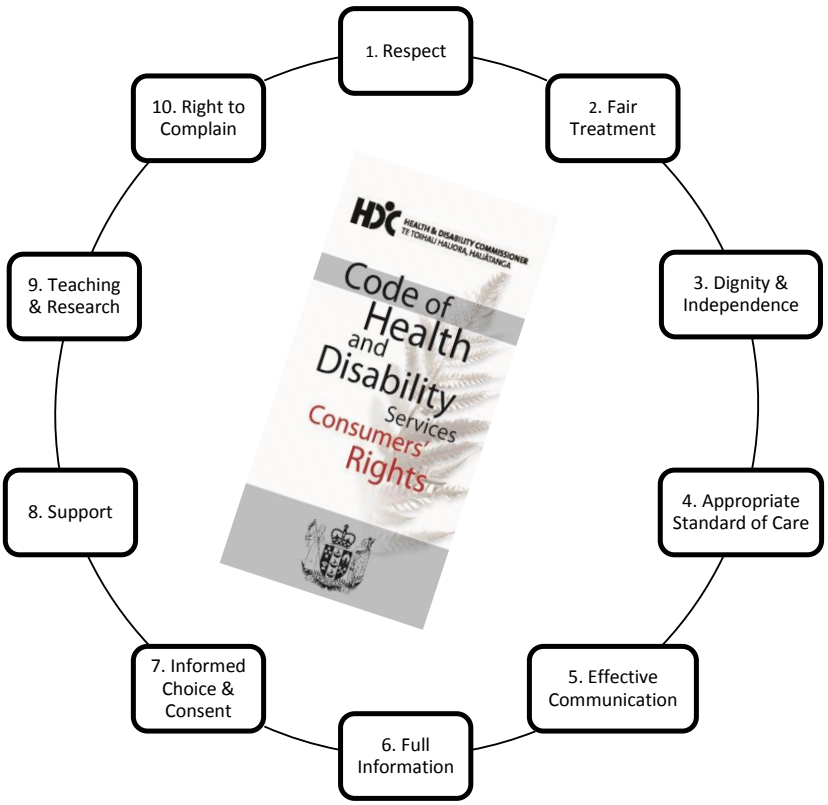

Figure 3. The Code of Health and Disability Services Consumers' Rights

[2] In the 2019/20 year, the Advocacy Service referred to HDC 73 complaints about DHB services, and received 118 complaints about DHB services by way of referral from HDC. This means that 191 complaints in the HDC DHB report and this report are duplicated.

COMPLAINTS RECEIVED BY THE ADVOCACY SERVICE

3. How many complaints were received?

3.1 Complaints received by the Advocacy Service by provider type

Figure 4 below details the commonly complained about group providers in complaints received by the Advocacy Service in 2019/20. The Advocacy Service received 1,097 complaints about DHB services in 2019/20, making DHBs the most commonly complained about group provider. This makes sense given the amount and type of care provided by DHBs in New Zealand.

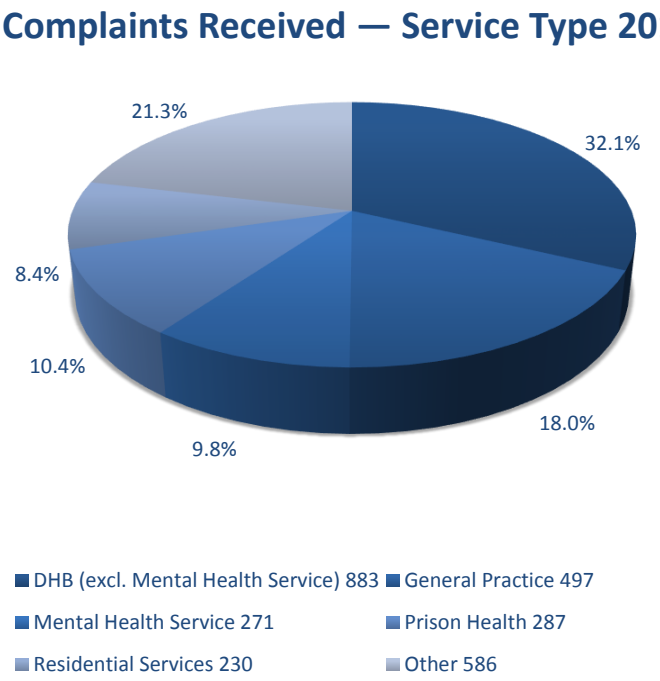

Figure 4. The most common group providers complained about to the Advocacy Service in 2019/20

3.2 Number of complaints received about DHBs over last five years

Figure 5 below details the number of complaints received about DHBs as compared to the total number of complaints received by the Advocacy Service over the last five years. Complaints about DHBs tend to make up around 42% of all complaints received by the Advocacy Service each year.

The 1,097 complaints received about DHBs in 2019/20 was a 9% decrease on the average number of 1,200 complaints received over the previous four years. This decrease may be attributable to COVID-19 restrictions and an associated decrease in health service activity.

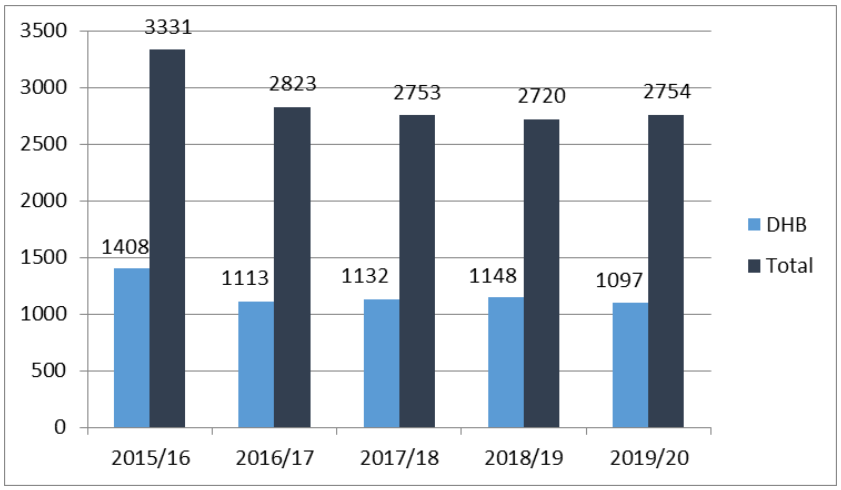

Figure 5. Complaints received by the Advocacy Service over last five years

The number of complaints received about individual DHBs in 2019/20 ranged from six complaints to 141 complaints. Large variability in complaint numbers is not unexpected given the similar variability in the size of populations served and the number of services delivered by different DHBs.

3.3 Rate of complaints received

Expressing complaints to the Advocacy Service as a rate per 100,000 discharges will, over time, enable any trends to be observed better. Rate of complaints calculations are made using discharge data provided by the Ministry of Health. This data is provisional as of the date of extraction (9 October 2020) and is likely incomplete. It should also be noted that discharge data provides a limited picture of DHB activity. Discharge data excludes short-stay emergency department discharges and patients attending outpatient clinics. Furthermore, this data does not take into account the particular characteristics of the population each DHB serves.

In July 2019 to June 2020, according to Ministry of Health data there were 940,233 discharges nationally. This equates to an overall rate of 116 complaints to the Advocacy Service per 100,000 discharges during 2018/19. This is consistent with the rate of complaints received in the previous two years (115 and 116 complaints per 100,000 discharges).

For individual DHBs, the rate of complaints received by the Advocacy Service ranged from 67 complaints per 100,000 discharges to 312 per 100,000 discharges.

In relation to Advocacy Service complaints, an individual DHB's number and rate of complaints can be affected by a number of factors, for example, a high number of complaints may reflect a proactive approach at the DHB to complaints management. Therefore, it is recommended that each DHB assess its individual complaint rate against the number of complaints received directly by the DHB and the number and rate of complaints received by HDC for that DHB, in order to ascertain any trends that may be worthy of further attention.

4. Which DHB services were complained about?

4.1 DHB service types complained about

Figure 6 below details the service types complained about in 2019/20. Service types responsible for less than 1% of complaints have been grouped together and classified as "other".

The most commonly complained about service type in 2019/20 was surgical services (31.36%). The most commonly complained about surgical specialties were orthopaedics (8.3%) and general surgery (10.4%).

Other commonly complained about service types were medicine (18%), mental health (18%), and emergency department services (12.7%). This is broadly consistent with the commonly complained about service types in HDC's DHB complaint reports, and with what was seen for complaints to the Advocacy Service in previous years.

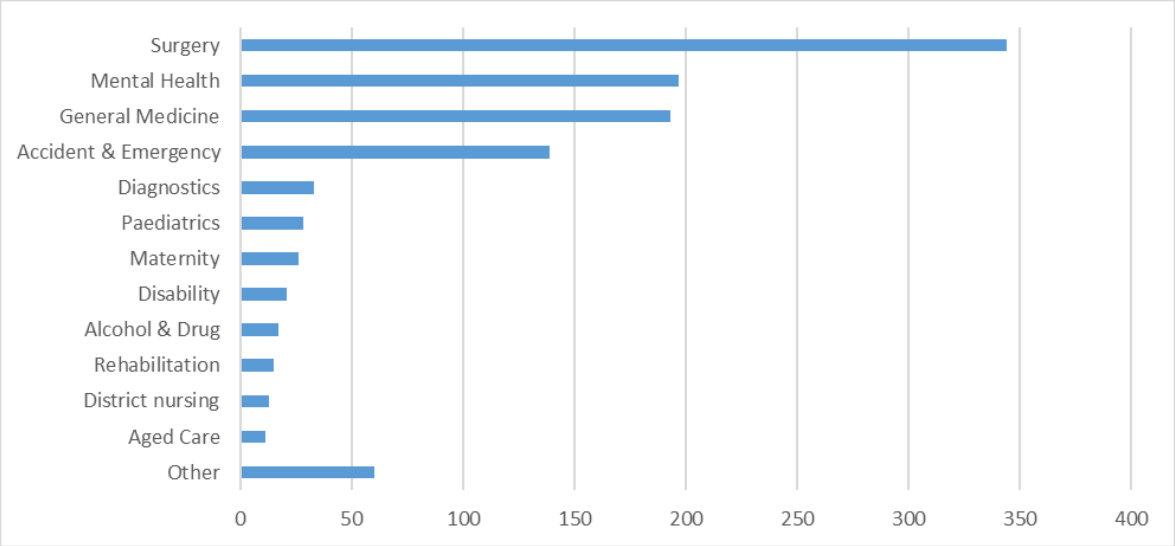

Figure 6. DHB service types complained about

A more nuanced picture of service types complained about, including individual surgical and medicine service categories, is provided below in Table 1.

Table 1. DHB service types complained about

Service type	Number of complaints (%)	
Aged Care	**11**	**(1)**
Alcohol and Drug	**17**	**(1.5)**
Anaesthetics/Pain Management	**9**	**(<1)**
Assessment for third party	**1**	**(<1)**
Counselling	**1**	**(<1)**
COVID-19 issues	**5**	**(<1)**
Dental	**9**	**(<0.8)**
Diagnostics	**33**	**(3)**
Disability Services	**21**	**(1.9)**
District Nursing	**13**	**(1.1)**
Emergency Department	**139**	**(12.7)**
General Practice	**2**	(<1)
Hearing Services	**1**	(<1)
Medicine	**193**	**(17.6)**
Cardiology	23	(2)
Dermatology	1	(<1)
Endocrinology	2	(<1)
Gastroenterology	28	(2.6)
Geriatric Medicine	8	(<1)
Haematology	2	(<1)
Infectious Diseases	1	(<1)
Neurology	18	(1.6)
Oncology	26	(2.4)
Palliative Care	2	(<1)
Renal/Nephrology	10	(<1)
Respiratory	13	(1.2)
Rheumatology	6	(<1)
Other	10	(<1)
Intensive Care/Critical Care	**3**	**(<1)**
Maternity	**26**	**(2.4)**
Mental Health	**197**	**(18)**
Nutrition/Dietetics	**1**	**(<1)**
Occupational Therapy	**4**	**(<1)**
Paediatrics	**28**	**(2.6)**
Pharmacy	**2**	**(<1)**
Physiotherapy	**2**	**(<1)**
Rehabilitation Services	**15**	**(1.4)**
Research	**1**	**(<1)**
Sexual Health	**2**	**(<1)**
Surgery	**344**	**(31.36)**

Cardiothoracic	6	(<1)
General	114	(10.4)
Gynaecology	41	(3.7)
Neurosurgery	7	(<1)
Ophthalmology	12	(1.1)
Oral/Maxillofacial	5	(<1)
Orthopaedics	91	(8.3)
Otolaryngology	7	(<1)
Paediatric	15	(1.4)
Plastic and Reconstructive	9	(<1)
Urology	18	(1.6)
Vascular	6	(<1)
Unknown/Other	10	(<1)
Vision/Eye Services	**6**	**(<1)**
Other	**11**	**(<1)**
TOTAL	**1,097**	

5. What did people complain about?

5.1 Primary issues identified in complaints

For each complaint received by the Advocacy Service, one primary complaint issue is identified. The primary issue is defined as the issue considered to be of most importance to the complainant. Table 2, below, shows the primary complaint issues complained about in complaints received by the Advocacy Service about DHBs in 2019/20.

Primary complaint issues were grouped into several over-arching categories. Among these categories, issues relating to care/treatment (55%) and communication (30%) were the most prevalent. This is similar to what was seen in 2018/19. The Advocacy Service receives a higher proportion of complaints primarily about communication, and a lower proportion of complaints about care/treatment issues, than is seen for complaints to HDC. The most commonly complained about primary issue categories are shown in Figure 7 below.

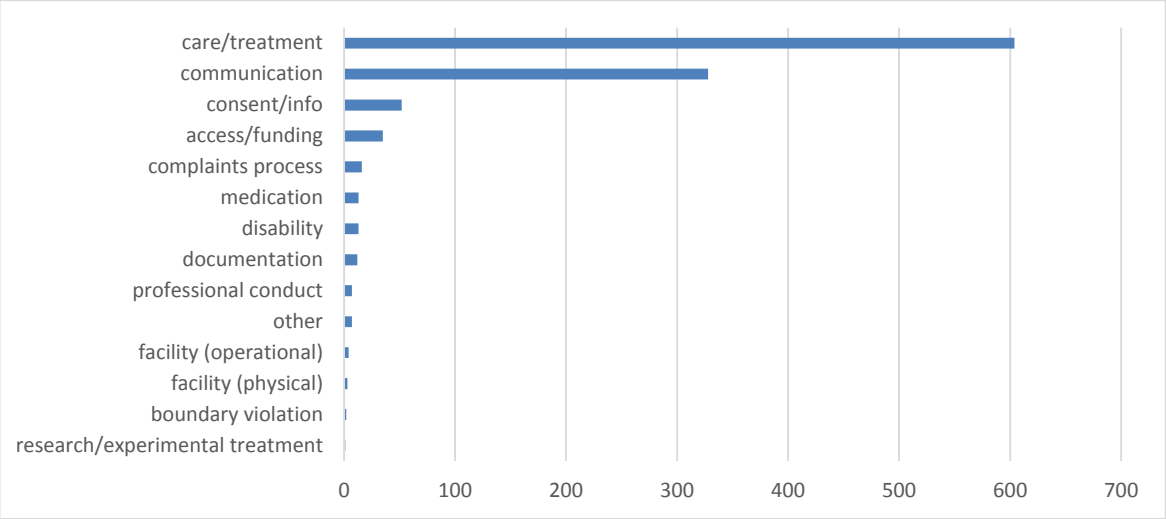

Figure 7: Most commonly complained about primary issues by category

When the specific primary complaint issues under each over-arching category are considered, failure to communicate openly/honestly/effectively with the consumer (18%), inadequate coordination of care/treatment (13%), inadequate/inappropriate treatment/ procedure (8%), delay in treatment (7%), and inadequate/inappropriate examination/ assessment (5%) emerge as the most common primary complaint issues (Table 2 below).

Table 2. Primary issues complained about

Primary issue	Number of complaints (%)
Access/funding	**35 (3.2)**
Lack of access to services	18 (1.6)
Waiting list/prioritisation issue	14 (1.3)
Other access/funding issue	2 (<1)
Lack of access to subsidies/funding	1 (<1)
Boundary violation	**2 (<1)**
Inappropriate communication (non-sexual)	1 (<1)
Inappropriate physical contact (non-sexual)	1 (<1)
Care/treatment	**604 (55)**
Delay in treatment	74 (6.7)
Delayed/inadequate/inappropriate referral	26 (2.3)
Inadequate coordination of care or treatment	139 (13)

Inadequate/inappropriate care (non-clinical)	17 (1.6)
Inadequate/inappropriate examination/assessment	52 (4.7)
Inadequate/inappropriate follow-up	28 (2.6)
Inadequate/inappropriate monitoring	14 (1.3)
Inadequate/inappropriate testing	10 (<1)
Inadequate/inappropriate treatment/procedure (clinical)	85 (7.8)
Inappropriate admission or failure to admit	6 (<1)
Inappropriate withdrawal of treatment	6 (<1)
Inappropriate/delayed discharge/transfer	13 (1.1)
Missed/incorrect/delayed diagnosis	54 (4.9)
Personal privacy not respected	3 (<1)
Refusal to assist/attend	3 (<1)
Refusal to treat	10 (<1)
Rough/painful care or treatment	9 (<1)
Unexpected treatment outcome	26 (2.4)
Unnecessary treatment/over servicing	1 (<1)
Other care/treatment issue	28 (2.6)
Communication	**328 (30)**
Disrespectful manner/attitude	57 (5.2)
Failure to accommodate cultural/language needs	4 (<1)
Failure to communicate openly/honestly/effectively with consumer	193 (17.6)
Failure to communicate openly/honestly/effectively with family	47 (4.3)
Insensitive/inappropriate comments (not sexual)	9 (<1)
Other communication issue	18 (1.6)
Complaints process	**16 (1.5)**
Inadequate information re complaints process	1 (<1)
Inadequate response to complaint	11 (1)
Other complaints process issues	4 (<1)
Consent/information	**52 (4.7)**
Consent not obtained/adequate	16 (1.5)
Failure to assess capacity to consent	1 (<1)

Inadequate information provided re adverse event	2 (<1)
Inadequate information provided re condition	5 (<1)
Inadequate information provided re options	9 (<1)
Inadequate information provided re provider	1 (<1)
Inadequate information provided re results	1 (<1)
Inadequate information provided re treatment	7 (<1)
Incorrect/misleading information provided	5 (<1)
Issues regarding consent when consumer not competent	1 (<1)
Issues with involuntary admission/treatment	2 (<1)
Other consent/information issue	2 (<1)
Disability-specific issues	**13 (1.2)**
Inadequate/inappropriate equipment provided	2 (<1)
Inadequate/inappropriate support provided	8 (<1)
Special needs not accommodated	3 (<1)
Documentation	**12 (<1)**
Delay/failure to transfer documentation	2 (<1)
Inadequate/inaccurate documentation	7 (<1)
Inappropriate maintenance/disposal of documentation	1 (<1)
Other documentation issue	2 (<1)
Facility (Operational)	**7 (<1)**
Cleanliness/hygiene issue	1 (<1)
Staffing/rostering/other HR issues	1 (<1)
General safety issue for consumer in facility	1 (<1)
Issue with sharing facility with other consumers	1 (<1)
Inadequate/inappropriate policies/procedures	2 (<1)
Waiting times	1 (<1)
Medication	**13 (1.2)**
Dispensing error	3 (<1)
Prescribing error	3 (<1)
Refusal to prescribe/dispense/supply	2 (<1)
Inappropriate/unlawful dispensing	1 (<1)

Inappropriate/unlawful prescribing	1 (<1)
Other medication issue	3 (<1)
Professional conduct	**7 (<1)**
Disrespectful behaviour	3 (<1)
Inappropriate collection/use/disclosure of information	2 (<1)
Other professional conduct issue	2 (<1)
Research/experimental treatment	**1 (<1)**
Inaccurate/misleading reporting of research/experimental treatment	1 (<1)
Other	**7 (<1)**
Discrimination	7 (<1)
TOTAL	**1,097**

5.2 Primary complaint issues by service type

Table 3 below displays the most common primary complaint issues complained about for commonly complained about service types.

Communication and coordination of care issues feature for almost all services. Emergency department services saw a higher proportion of complaints around inadequate examinations/assessments than was seen for other service types, which is to be expected considering the nature of the work. These issues are broadly similar to what was seen in the previous year.

Table 3. Three most common primary issues in complaints by service type

Surgery n = 344		Mental Health n = 197		Medicine n = 193		Emergency Department n = 139	
Failure to communicate openly/honestly/ effectively with consumer	19%	Failure to communicate openly/honestly/ effectively with consumer	24%	Failure to communicate openly/honestly/ effectively with consumer	17%	Inadequate/ inappropriate examination/ assessment	14%
Inadequate coordination of care or treatment	11%	Inadequate coordination of care or treatment	14%	Inadequate coordination of care or treatment	17%	Disrespectful manner/attitude	8%
Inadequate/ inappropriate treatment or procedure (clinical)	9%	Disrespectful manner/attitude	8%	Delay in treatment	3%	Inadequate coordination of care or treatment	13%

COMPLAINTS CLOSED

6. How many complaints were closed?

The Advocacy Service closed 1,124 complaints about DHBs during 2019/20. It should be noted that complaints may be received in one financial year and closed in the following year. This means that the number of complaints received will not correlate with the number of complaints closed.

7. What were the outcomes of the complaints closed?

7.1 Available resolution options

The Advocacy Service options for closing complaints were:

- Resolved — which could be with active advocacy support or by self-advocacy with mentoring by an advocate;
- Loss of contact or withdrawal — as a result of the Advocacy Service losing contact with the consumer or the consumer electing to withdraw the complaint, sometimes following discussion of concerns with the advocate and finding personal resolution; or
- Unresolved at advocacy with or without referral to HDC.

Complaints may be referred to HDC, either directly at the consumer's request with advocacy assistance only to draft the referral information, or if the advocate advises the consumer that the complaint is serious and requires HDC review (Direct Referrals). Following an advocacy process, the complaint may be referred to HDC at the consumer's request or if the provider does not engage effectively in the advocacy process.

Of the 1,124 complaints closed by the Advocacy Service in 2019/20, only 147 complaints were closed unresolved, with just 32 of those unresolved complaints being referred on to HDC. In addition, there were 41 Direct Referrals to HDC.

When a complaint that has not been resolved by the Advocacy Service is referred to HDC, actions taken by the DHB to resolve the complaint with advocacy support are taken into account by HDC when assessing the complaint. Where a complaint has been referred to the Advocacy Service by HDC, the advocate is required to report back to HDC formally on the resolution process and outcome.

7.2 Manner of resolution and outcomes in complaints closed

The manner of resolution and outcomes for all DHB complaints closed in 2019/20 is shown in Table 4 below. Complaints assessed as being outside the jurisdiction of the Advocacy Service are not shown.

Table 4. Outcome of complaints about DHBs closed by the Advocacy Service in 2019/20

Outcome for DHB	Number of complaints
Direct referral to HDC	41
Not resolved — no further action	115
Not resolved — referred to HDC	32
Resolved	655
Withdrawn	281
TOTAL	**1,124**

7.3 Timeliness of complaint closure

As shown in Figure 8 below, the Advocacy Service closed 71% of complaints about DHBs within 12 weeks, and 96% of complaints about DHBs within 24 weeks.

In comparison, when all complaints closed by the Advocacy Service in 2019/20 are considered, the Advocacy Service closed 79% of all complaints within 12 weeks, and 97% of all complaints within 24 weeks. This is a reduction in timeliness from previous years, as complaint processes were affected by COVID-19.

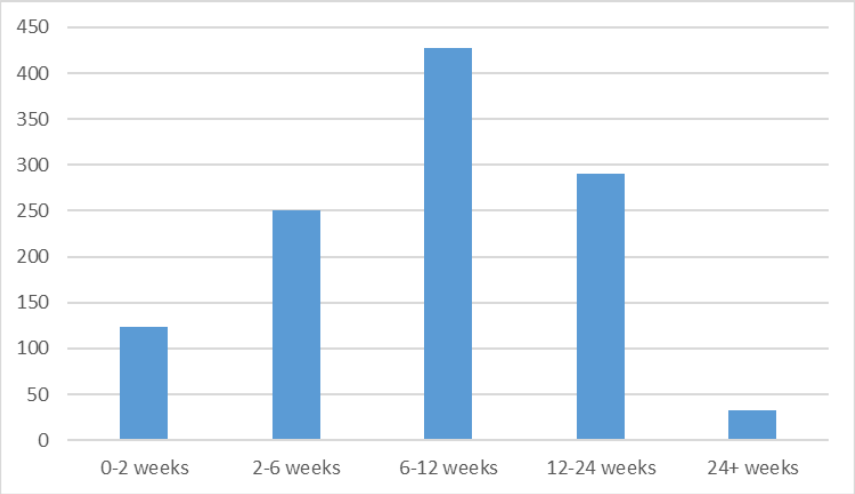

Figure 8. Number of weeks taken to close complaints about DHBs

Example of new poster, available in A2, A3 & A4 sizes from www.advocacy.org.nz

6. Resolution to Exclude the Public

Recommendation:

That, in accordance with the provisions of Schedule 3, Sections 32 and 33, of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 21/10/20	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2. Quality Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]
3. Human Resources Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]
4. Primary Birthing Unit	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under	**Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations.

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
	section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982.	[Official Information Act 1982 S.9 (2) (j)]