Waitematā
District Health Board

Best Care for Everyone

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING

Wednesday 19 June 2019

1.30pm

A G E N D A

VENUE

Waitematā District Health Board
Boardroom
Level 1, 15 Shea Tce
Takapuna

Waitematā District Health Board
Best Care for Everyone

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING
19 June 2019

Venue: Waitematā DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna **Time: 1.30pm**

Committee Members	WDHB Management
James Le Fevre – Committee Chair	Dale Bramley – Chief Executive Officer
Sandra Coney – Deputy Committee Chair	Robert Paine – Chief Financial Officer and Head of Corporate Services
Judy McGregor – WDHB Board Chair	Andrew Brant – Deputy Chief Executive Officer and Chief Medical Officer
Max Abbott – WDHB Board Member	Jocelyn Peach – Director of Nursing and Midwifery
Edward Benson-Cooper – WDHB Board Member	Cath Cronin – Director of Hospital Services
Kylie Clegg – WDHB Deputy Chair	Joanne Brown – Funding and Development Manager, Hospitals
Warren Flaunty – WDHB Board Member	Tamzin Brott – Director of Allied Health
Matire Harwood – WDHB Board Member	Fiona McCarthy – Director Human Resources
Brian Neeson – WDHB Board Member	Peta Molloy – Acting Board Secretary
Morris Pita – WDHB Board Member	
Allison Roe – WDHB Board Member	

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**
1.30pm	2.1	Confirmation of Minutes of Hospital Advisory Committee Meeting (08/05/19) Actions Arising from previous meetings
	3.	**PROVIDER REPORT**
1.35pm	3.1	Provider Arm Performance Report – March 2019 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
	3.2	Provider Arm Performance Summary Report – April 2019
	4.	**CORPORATE REPORTS**
2.50pm	4.1	Clinical Leaders' Report
3.00pm	4.2	Quality Report
3.10pm	4.3	Human Resources Report
	5.	**INFORMATION ITEMS**
3.30pm	**6.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Waitematā District Health Board

Hospital Advisory Committee Member Attendance Schedule 2019

NAME	FEB	MAR	MAY	JUN	AUG	SEP	OCT	DEC
James Le Fevre (Committee Chair)	✓	✓	✓					
Max Abbott	×	✓	✓					
Edward Benson Cooper	✓	×	✓					
Kylie Clegg	✓	✓	✓					
Sandra Coney	✓	✓	×					
Warren Flaunty	✓	✓	✓					
Matire Harwood	×	×	×					
Judy McGregor	✓	✓	✓					
Brian Neeson	✓	×	✓					
Morris Pita	×	×	×					
Allison Roe	×	✓	×					

✓ ***Attended the meeting***
x Absent
**** 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
Judy McGregor (Board Chair)	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	28/03/19
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean - Faculty of Health and Environmental Sciences, Auckland University of Technology Patron - Raeburn House Advisor - Health Workforce New Zealand Board Member - AUT Millennium Ownership Trust Chair - Social Services Online Trust Board member - Rotary National Science and Technology Forum Trust	19/03/14
Edward Benson-Cooper	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
Kylie Clegg (Deputy Chair)	Trustee - Well Foundation Director - Auckland Transport Director - Sport New Zealand Trustee and Beneficiary - Mickyla Trust Trustee and Beneficiary, M&K Investments Limited (includes a share of less than 1% in Orion Health Group). Orion Health Group has commercial contracts with Waitemata DHB and healthAlliance Director of High Performance Sport New Zealand Limited Board member, Counties Manukau District Health Board Shareholder – Genesis Energy Ltd.	03/04/19
Sandra Coney	Member - Waitakere Ranges Local Board, Auckland Council Patron - Women's Health Action Trust Member - Portage Licensing Trust Member - West Auckland Trusts Services	15/12/16
Warren Flaunty	Member - Henderson–Massey Local Board Auckland Council Trustee (Vice President) - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder - Green Cross Health	12/09/18

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
	Director - Life Pharmacy Northwest Chair - Three Harbours Health Foundation Director - Trusts Community Foundation Ltd Trustee – Hospice West Auckland (past role) Shareholder - Genesis Energy	
Dr Matire Harwood	Senior Lecturer - Auckland University Director - Ngarongoa Limited, which is contractor providing services to National Hauora Coalition GP at Papakura Marae Health Clinic Advisory Committee Member - State Foundation NZ (Māori Health) Member Te Ora, Māori Medical Practitioners Step-daughter is a surgical registrar at Waitemata DHB	10/05/18
James Le Fevre	Emergency Physician - Auckland Adults Emergency Department Trustee - Three Harbours Foundation Member - Medical Protection Society Member - Northern Regional Clinical Practice Committee Shareholder - Pacific Edge Ltd DHB Representative (Auckland and Waitemata DHBs) - Air Ambulance Co-design Procurement Governance Board (past role) James' wife is an employee of the Waitemata DHB, Department of Anaesthesia and Perioperative Medicine and a Medico-Legal Advisor for the Medical Protection Society Board Member - Auckland District Health Board (past role) Shareholder - Genesis Energy	21/11/18
Brian Neeson	Member - Upper Harbour Local Board Member - Human Rights Review Tribunal Member - Auckland District Licensing Committee Managing Director - BK & VS Neeson Limited Managing Director - Apollo Property Investments Limited Property Development Consultant Chair – Wilson Home Committee of Management (past role)	19/12/18
Morris Pita	Owner/operator - Shea Pita and Associates Limited. Shareholder - Turuki Pharmacy Limited Member - Eden Park Trust Board Shareholder and Director of Healthcare Applications Limited. In December 2018 this company won an RFP with Waitemata DHB for provision of the Emergency Q software service to reduce overcrowding in the ED and the company is currently (as at 27 March 2019) in the final stages of negotiation for a potential contract for service at both North Shore and Waitakere EDs. Morris' wife is a: Board member - Northland District Health Board Board member - Auckland District Health Board Director - Healthcare Applications Limited Director - Shea Pita & Associates	27/03/19

REGISTER OF INTERESTS

Board/Committee Member	Involvements with other organisations	Last Updated
Allison Roe	Chairperson - Matakana Coast Trail Trust Member - Rodney Local Board, Auckland Council Member - Wilson Home Committee of Management (past role)	22/08/18

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.

2.2 Minutes of the Hospital Advisory Committee meeting held on 08 May 2019

Recommendation:

That the Draft Minutes of the Hospital Advisory Committee meeting held on 08 May 2019 be received.

Draft Minutes of the meeting of the Waitematā District Health Board

Hospital Advisory Committee

Wednesday 108 May 2019

held at Waitematā District Health Board Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 1.34 p.m.

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT

James Le Fevre (Committee Chair)
Judy McGregor (Board Chair)
Max Abbott
Edward Benson-Cooper
Kylie Clegg (Deputy Board Chair)
Warren Flaunty
Brian Neeson

ALSO PRESENT

Dale Bramley (Chief Executive Officer)
Robert Paine (Chief Financial Officer and Head of Corporate Services)
Cath Cronin (Director of Hospital Services)
Jocelyn Peach (Director of Nursing and Midwifery)
Fiona McCarthy (Director Human Resources)
Tamzin Brott (Director of Allied Health)
Lorraine Bailey (IDF Performance Manager)
Peta Molloy (Acting Board 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 members of the public or media present.

WELCOME

The Committee Chair welcomed those present.

APOLOGIES

Apologies were received and accepted from Sandra Coney, Allison Roe, Matire Harwood and Morris Pita.

DISCLOSURE OF INTERESTS

There were no additions to the Interests 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 08 May 2019 (agenda pages 8 - 18)

Resolution (Moved Kylie Clegg/Seconded Warren Flaunty)

That the Minutes of the Hospital Advisory Committee meeting held on 08 May 2019 be approved.

Carried

Actions Arising (agenda pages 19)

The actions were noted. No issues were raised.

3. PROVIDER ARM PERFORMANCE REPORT

3.1 Provider Arm Performance Report – February 2019 (agenda pages 20 - 79)

Executive Summary/Overview

Cath Cronin (Director Hospital Services) summarised the key highlights reported in this section of the report.

Matters covered in discussion and response to questions included:

- That a paper would be presented to the Committee focussed on ESPI.
- That the Auckland region is represented on the Cancer Health Information Strategy Governance Board. Cath Cronin noted that she is on the Committee along with Richard Sullivan (Director, Cancer and Blood, Auckland DHB) and Ailsa Claire (Chief Executive, Auckland DHB). The DHB shares what it is doing in its area with the group.
- That with regard to ORL (Otorhinolaryngology) patients waiting longer, it was noted that locums could be used to assist with reducing the wait time.

Human Resources

No issues were raised.

Acute and Emergency Medicine Division

Dr Gerard de Jong (Division Head Acute and Emergency Medical Services) and Alex Boersma (General Manager Acute and Emergency Medical Services) were present for this section of the report.

Alex Boersma introduced the report, noting the highlight of the month 'Role Extension for Cardiovascular Unit Nurses – Implant Loop Recorder Implanter'. The scorecard was also noted.

Gerard de Jong noted the update provided on the Implementation of Home Based Wards at Waitakere Hospital. The Committee agreed that a letter of appreciation would be sent to those involved acknowledging their commitment to this programme by so many people.

Gerard also noted that RACP basic training was credited for one year at both the North Shore and Waitakere Hospitals; the significant improvement in training was noted.

Matters covered in discussion and response to questions included:

- The Committee Chair acknowledged the achievement on patients being seen within two hours of triage in ADU.
- Noting that Counties Manukau DHB presents information on the number of presentations seen by Provider staff; Gerard advised that in dialogue with external colleagues, it is intended to look at data collected to determine benchmarking.

Specialty Medicine and Health of Older People Division

Dr Gerard de Jong (Division Head Acute and Emergency Medical Services) and Brian Millen (General Manager) were present for this section of the report.

Brian Millen summarised the reported highlight of the month – 'Māori Workforce Development'. The work in this area was acknowledged and should be rolled out extensively.

The Committee Chair asked that the outpatient DNA rate be disaggregated by ethnicity, this could also be done for each service and will assist in identifying any potential inequities.

Child, Women and Family Services

Meia Schmidt-Uili (Head of Division Medical Child Women and Family), Emma Farmer (Head of Division Midwifery) and Marianne Cameron (Head of Division Midwifery) were present for this section of the paper. An apology was received from Stephanie Doe (General Manager).

Meia Schmidt-Uili noted the reported highlight for the month, the launch of the new mobile dental clinic (page 53 of the agenda).

Emma Farmer summarised the key issue update provided on 'increased maternity and neonatal demand'. She noted that there had been an increase in admissions, but it is not yet clear if this is a trend.

Matters covered in discussion and response to questions included:

- That there is a number of women presenting with diabetes in pregnancy; the first diabetes diagnosis is given when pregnant.

- That with regard to the increase need for neonatal cots, Marianne Cameron noted that babies very near to discharge (around one week) had been outlied to neonate nurses in the Hine Ora Ward. The outlie of neonate babies can only be done if it does not create a capacity issue in another area; each case is considered individually.
- Work continues in the area of oral health and improving arrears. The service is being looked at region by region.

Specialist Mental Health and Addiction Services

Dr Susanna Galea-Singer (Director and Head of Division), Pam Lightbown (General Manager) and Alex Craig (Head of Division Nursing) were present for this item.

Alex Craig summarised the highlight of the month 'clozapine project' (page 61 of the agenda), the project trains providers giving confidence to work with a wider range of people in this area. It was noted that clients are frequently under the care of the Waitematā DHB SMHA for two or three years before being transferred. The transfer of community detox clients is done in liaison with GPs.

Matters covered in discussion and response to questions included:

- That the DHB will consider submitting to the New Zealand cannabis referendum when more information is available.
- Susanna Galea-Singer noted the increase in Whitiki Maurea referrals (page 62 of the agenda). This is being addressed with a budget bid submitted and the Psychiatry Regional Training Services having a registrar available for support. The capacity of the team needs to be reviewed and increased.
- Noting that the scorecard reports that bed occupancy is running at 100%. The Committee Chair requested historical bed occupancy be provided over the past five to ten years to show upward and downward trends.

Surgical and Ambulatory Services

Debbie Eastwood (General Manager), Jonathan Wallace (Head of Department), Charles McFarlan (Clinical Director) and Penny Andrew (Director i3) were present for this item.

Debbie Eastwood introduced the paper, noting in particular the update provided on surgical pathology (page 67 of the agenda).

Jonathan Wallace noted that the report shows a gradual trend upwards for CT scans and MRI scans done within six weeks. He also noted the update provided on Diagnostic Services. In response to a question from the Committee Chair, Jonathan confirmed that these services would be presenting balanced scorecards.

Penny Andrew summarised the more detailed information provided on the three pathways reported (from page 69 of the report): Abscess Pathway, Acute Cholecystitis Pathway and the Appendicitis Pathway.

The Committee received the report.

4. CORPORATE REPORTS

4.1 Clinical Leaders' Report (agenda pages 80 - 87)

Jocelyn Peach (Director of Nursing and Midwifery) and Tamzin Brott (Director of Allied Health) presented this paper. An apology was received from Andrew Brant (Deputy Chief Executive Officer and Chief Medical Officer).

The Chief Executive summarised the Medical Staff report.

Jocelyn Peach summarised the Nursing and Midwifery and Emergency Planning Systems section of the report. In response to a question about the workforce planning and professional development update related to the new graduate intake being low, it was noted that whole sector needs to work on increasing intake and ensuring students complete the programme.

Tamzin Brott summarised the Allied Health, Scientific and Technical Professions section of the report, noting in particular the #O2TheFix toolkit shared nationally.

Kylie Clegg acknowledged the presentation to be given by Heather Gunter (mother of Matthew Gunter) as part of the ACC Treatment Safety programme bringing Matthews story to New Zealand. She referenced a similar campaign '*one ear in and one ear out*' from the mother of a teenage tragically killed running across railway tracks with headphones on. The campaign is to encourage people to not wear headphones in both ears in certain situations.

4.2 Quality Report (agenda pages 88 - 182)

Penny Andrew (Clinical Lead, Quality), Jacky Bush (Quality and Risk Manager) and David Price (Director of Patient Experience) presented this report.

In response to a question during the discussion of item 4.1 regarding the presentation from Heather Gunter (mother of Mathew Gunter) Jacky Bush advised that the presentation is scheduled on Friday 21 June at 8am.

Matters covered in discussion and response to questions on this item included:

- That NZEWS (New Zealand Early Warning System), part of the Patient Deterioration Programme, was launched in April 2019, the scoring system for NZEWS is a national system. Penny Andrew acknowledged the work of the staff involved in the launch. An update will be provided to the Committee on this later in the year.
- That the reported (page 96 of the agenda) standardised mortality rate is the lowest achieved.
- Noting that it is international hand hygiene week.
- Monitoring complaint response times continues and data is being reviewed of a survey undertaken, as reported in the Complainant Survey Report (page 170 of the agenda). Jacky Bush noted that a complainant survey will be undertaken on an annual basis. Reports will be presented to the Committee either six monthly

or annually; the Committee Chair suggested the reports coincide with the HDC reports released.
- The number of measles cases occurring in the Auckland area was noted.
- David Price said that he had completed a workshop on how the DHB welcomes people and providing a good reception environment; consumers were involved with the workshop.
- Interviews for the new DHB Consumer Council are scheduled to take place next week.
- Random calls continue to be made to different numbers across the organisation. The majority of calls made are connected quickly and if a message is left a response is received.

4.3 Human Resources Report (agenda pages 183 - 188)

Fiona McCarthy (Director Human Resources) summarised this item, noting in particular the update provided on Workforce Development.

In response to a question about the progress and targets to grow the Māori Workforce, it was noted that the Rangitahi programme provides information on where people are employed after completing the programme. There is less visibility of this in relation to the Pacific Academies.

5. INFORMATION PAPERS

5.1 Winter Plan May- October 2019 (agenda pages 189 - 212)

The Committee noted the Winter Plan May-October 2019.

6. RESOLUTION TO EXCLUDE THE PUBLIC (agenda pages 213 - 214)

Resolution (Moved Edward Benson-Cooper/Seconded Kylie Clegg)

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 27/03/19	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.	**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.

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
	[NZPH&D Act 2000 Schedule 3, S.32 (a)]	
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)]
4. 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)]
CSSD	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)]	

Carried

The open session of the meeting concluded at 3.46 p.m.

SIGNED AS A CORRECT RECORD OF THE WAITEMATA DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 08 MAY 2019

_____COMMITTEE CHAIR

Actions Arising and Carried Forward from

Meetings of the Hospital Advisory Committee

as at June 2019

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
05/12/18	3.1	Provider Arm Performance Report A semi-regular report to come to HAC highlighting services that are considered vulnerable.	Cath Cronin		Noted for action.
05/12/18	3.1.6	Specialist Mental Health and Addiction Services That indicators in addition to performance against the shorter stays in ED target be developed to ensure that any inequities between patients with acute mental health presentations and acute medical/surgical presentations are captured.	Susanna Galea-Singer		Request has been clarified with Committee Chair.
13/02/19	3.1	Provider Arm Performance Report - Mobile dental clinics – check to be made that clinic locations are well chosen. - Obtain information from ACC on number of lime scooter accidents (for advice to HAC – but also forward as soon as available to Kylie Clegg)	Stephanie Doe Cath Cronin	mid-2019	Review of locations is underway – an extensive process. As per email of 22.03.19 (in house response). Request is also with ACC (response awaited).

3.1 Provider Arm Performance Report – March 2019

Recommendation:

That the report be received.

Prepared by: Robert Paine (Chief Financial Officer and Head of Corporate Services) and Cath Cronin (Director of Hospital Services)

This report summarises the Provider Arm performance for March 2019.

Table of Contents

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How to interpret the scorecards
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  - Strategic Initiatives
  - Financial Performance
  - Human Resources
- Divisional Reports
  - 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

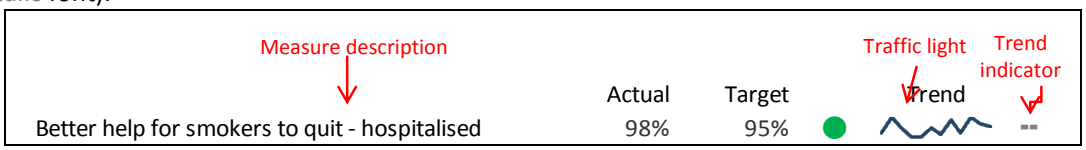
Glossary

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
CADS	-	Community Alcohol, Drug and Addictions Service
CAMHS	-	Child, Adolescent Mental Health Service
CT	-	Computerised Tomography
CWF	-	Child, Women and Family service
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
ICU	-	Intensive Care Unit
KMU	-	Kingsley Mortimer Unit
SMHOPS	-	Specialty Medicine and Health of Older People Services
MECA	-	Multi-Employer Collective Agreement
MRI	-	Magnetic Resonance Imaging
MoH	-	Ministry of Health
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
SMHA	-	Specialist Mental Health and Addiction Services

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.

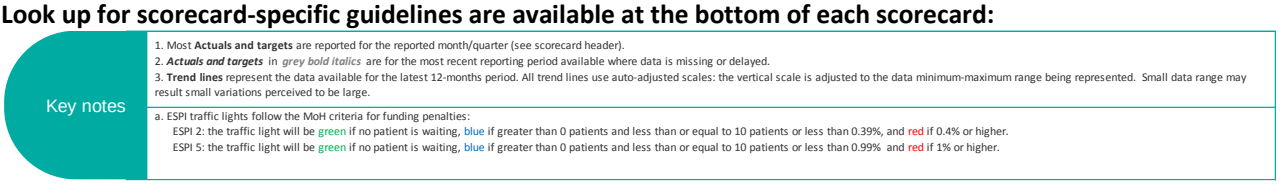
Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance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

Highlight of the month

Safe Staffing Accord

In 2018 year the MoH funded 46 additional FTE for Waitematā DHB to implement the Care Capacity Demand management (CCDM) programme. CCDM is a programme developed by the Safe Staffing Healthy Workplace (SSHW) unit in partnership with the health unions and District Health Boards. CCDM is a set of tools developed to help DHBs better match the workload and demand with capacity to meet patient demand. The objective is that by getting the balance right between patient demand and staff capacity means DHBs can improve the *quality of care* for patients, the *staff working environment* and *use health resources* in the best possible way.

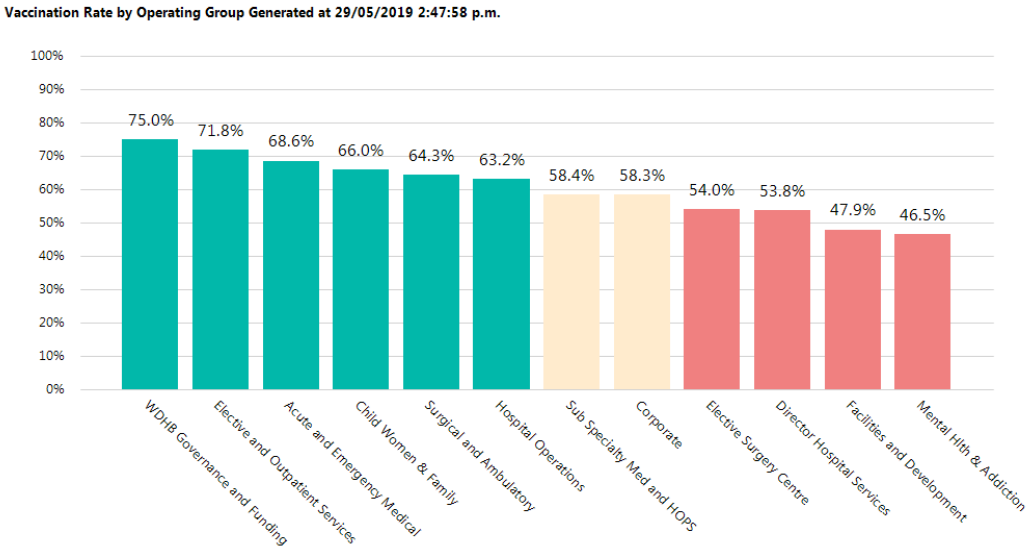
To date 39 FTE have been recruited. 4.9 HCA positions and the Trendcare co-ordinators will be recruited to by 30 June 2019.

All roles have been positively received by the nursing team and we will report the improvements in patient care and experience that is expected from the additional staff. The new FTE has been distributed in the community with district nursing, ICU/HDU and midwifery. The inpatient ward shift coordinator roles have been implemented as supernumerary on a shift working 1300 – 2130. These roles ensure timely patient flow and pro-active movement of patients from ED and ADU to mid-afternoon peak pressures and queues. These nurses briefly meet each afternoon to ensure they understand the wider hospital pressures and then work to facilitate patient flow to optimise best care for all our patients.

Key Issue of the Month

Preparation for Winter Months

Despite the weather holding for a pleasant autumn we are preparing for winter with a pro-active operational plan to ensure we optimise patient flow, access and timeliness of care including maintaining access to planned surgery. The flu vaccination rates have improved compared to last year but we are working with staff to improve this further.



Immunisation is a personal choice - but it is also the most effective way to protect our patients, ourselves, our loved ones and our colleagues against needless suffering.

Media reports this week say an outbreak of influenza in Australia has claimed 126 lives to date and cite fears that a similar scenario might unfold in New Zealand.

The same reports point to two deaths in Auckland and our own records show the number of cases confirmed at our hospitals is steadily rising - though, fortunately, at this stage not at the same rates evident across the Tasman.

We need to achieve immunity in order to best safeguard our community and that means overall vaccination rates in excess of 80%.

Financial Performance Summary

The Provider Arm result for the month ended March 2019 was unfavourable by $1.414m. The result has been impacted YTD by the NZNO and Resident Doctors Association industrial action and winter acute demand pressures that resulted in the displacing of some elective surgery.

Scorecard – All services

Waitemata DHB Monthly Performance Scorecard

ALL Services
March 2019
2018/19

Health Targets

	Actual	Target		Trend	
Shorter Waits in ED	95%	95%	●		▼
Faster cancer treatment (62 days)	83%	90%	●		▼

Best Care

	Actual	Target		Trend	
Patient Experience					
Complaint Average Response Time	16 days	≤14 days	●		▼
Net Promoter Score FFT	76	65	●		▼
Improving Outcomes					
Better help for smokers to quit - hospitalised	98%	95%	●		▼
Quality & Safety					
Older patients assessed for falling risk	98%	90%	●		--
Rate of falls with major harm	0.1	≤2	●		▲
Good hand hygiene practice	90%	80%	●		▲
S. aureus infection rate	0.0	≤0.25	●		▲
Occasions insertion bundle used	100%	95%	●		--
Pressure injuries grade 3&4	0	0	●		▲
HR/Staff Experience					
Sick leave rate	3.3%	≤3.4%	●		--
Turnover rate - external	13%	≤14%	●		--
Vacancies - %	7%	≤8%	●		--

Service Delivery

	Actual	Target		Trend	
Elective Volumes					
Provider Arm - Overall	99%	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	13%	≤10%	●		▲
Outpatient DNA rate (FSA + FUs) - Pacific	13%	≤10%	●		▼

Value for Money

	Actual	Target		Trend	
Financial Result (YTD)					
Revenue	713,117 k	704,142 k	●		▲
Expense	733,723 k	721,563 k	●		▼
Net Surplus/Deficit	-20,606 k	-17,421 k	●		▼
Contracts (YTD)					
Elective WIES Volumes	12,934	14,291	●		▲
Acute WIES Volumes	49,260	49,657	●		▼

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

Strategic Initiatives Variance Report

Deliverable/Action	On Track
Cancer Services	
1. Develop a work plan for Māori and Pacific Cancer Nurse Coordinators to further support improved cancer outcomes (EOA) – July 2018	✓
2. Work with primary care to provide education and support to implement the prostate cancer decision support tool – ongoing.	✓
3. With the Northern Cancer Network (NCN),review current resourcing and provision of survivorship care – as determined by NCN	✓
4. Further develop the local delivery of oncology plan; introduce local delivery of zoledronic acid infusions for breast cancer patients – August 2018	✓
5. Evaluate the live outcome process in the melanoma MDM (Minimal Deviation Melanoma) and plan to pilot in further MDMs – Evaluate by August 2018, pilot planned for October 2018	✓
Access to Elective Services	
6. Implement patient-focused booking for scheduling first specialist assessment (FSA) appointments across all services within Elective Services – May 2019	✓
7. Develop processes, systems and implementation plan for scheduling follow-up appointments using the patient-focused booking process by 2019/20; implement initially within Medical Services – June 2019	✓
8. Implement perioperative nurse-led coordination and management of all procedure/theatre bookings for Elective Services, including improved coordination of patient flow with clinical guidance and oversight. This will include management of high acuity, high complexity patients, in support of better access to earlier intervention for Maori and Pacific Populations (EOA) – March 2019	✓
9. Alignment of all Waitematā DHB services to the Elective Patient Access Policy and Guidelines to ensure our standards, key requirements and processes are adhered by for the delivery of planned care – February 2019	✓

Areas off track for month and remedial plans
All areas on track.

Scorecard Variance Report

Health Targets

Faster Cancer Treatment (62 days)

The Faster Cancer Team has engaged with all specialty teams to regain the Faster Cancer Treatment times. Individual patients are being navigated through the system. Our forecast is that we will meet 90% for the month of June.

Best care

Complaint Average Response time

The average response time for March was 16 days against a target of 14 days for all DHB services. The provider arm is tracking well and CWF are working to meet compliance.

Specialty Medicine and Health of Older People	14 days
Acute and Emergency Medicine	12 days
Surgical and Ambulatory Services	8 days
Child Women and Family	19 days
Diagnostic Services	8 days
Mental Health	15 days

Service Delivery

Elective Volumes

All specialty services have recovery plans in place. We will meet the surgical health target at 30 June 2019. ESPI 1 is compliant, ESPI 2 – all services except ORL are compliant and ESPI 5 report General Surgery are compliant and Gynaecology, Orthopaedic, ORL and Urology are not compliant.

Outpatient DNA rate

Our performance is tracking favourably. This area continues to be a focus for all services in 2019.

Value for Money

Financial result

The Provider remains on track for 30 June forecast deficit.

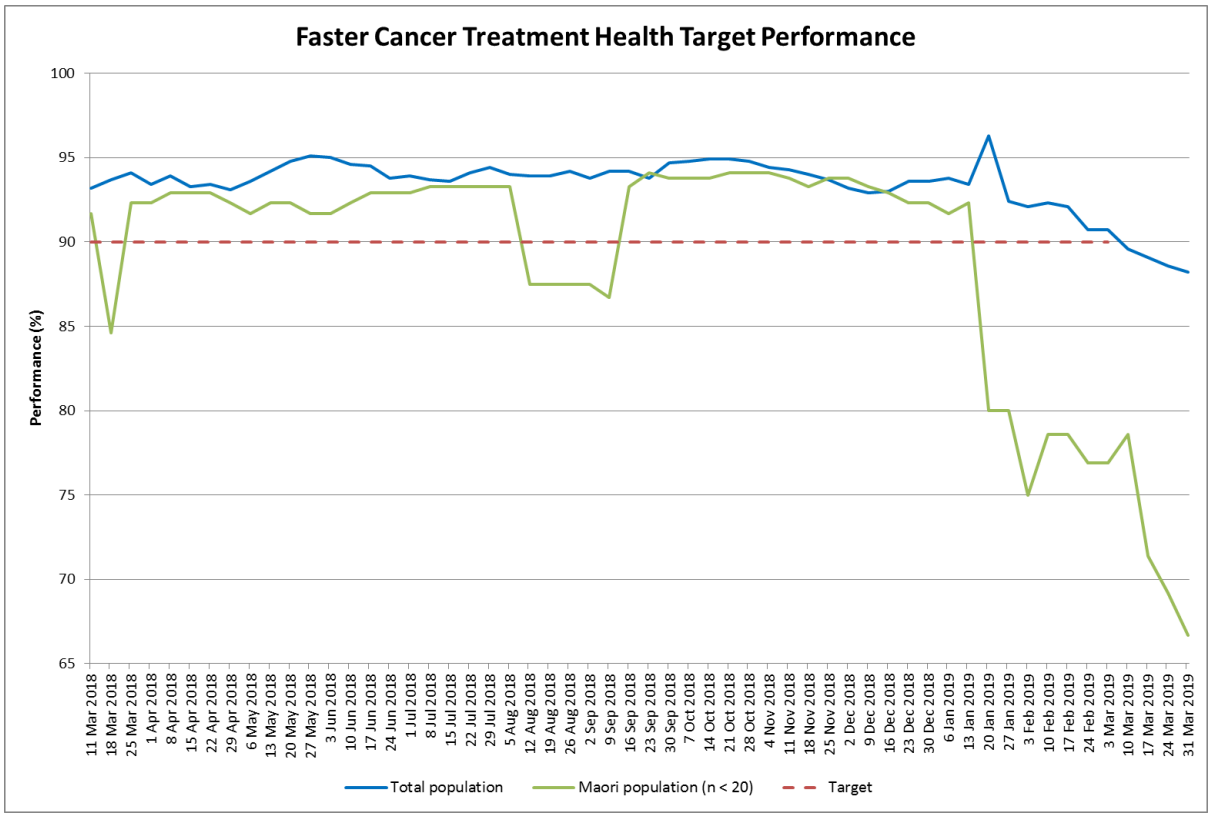
Contracts

Elective WIES

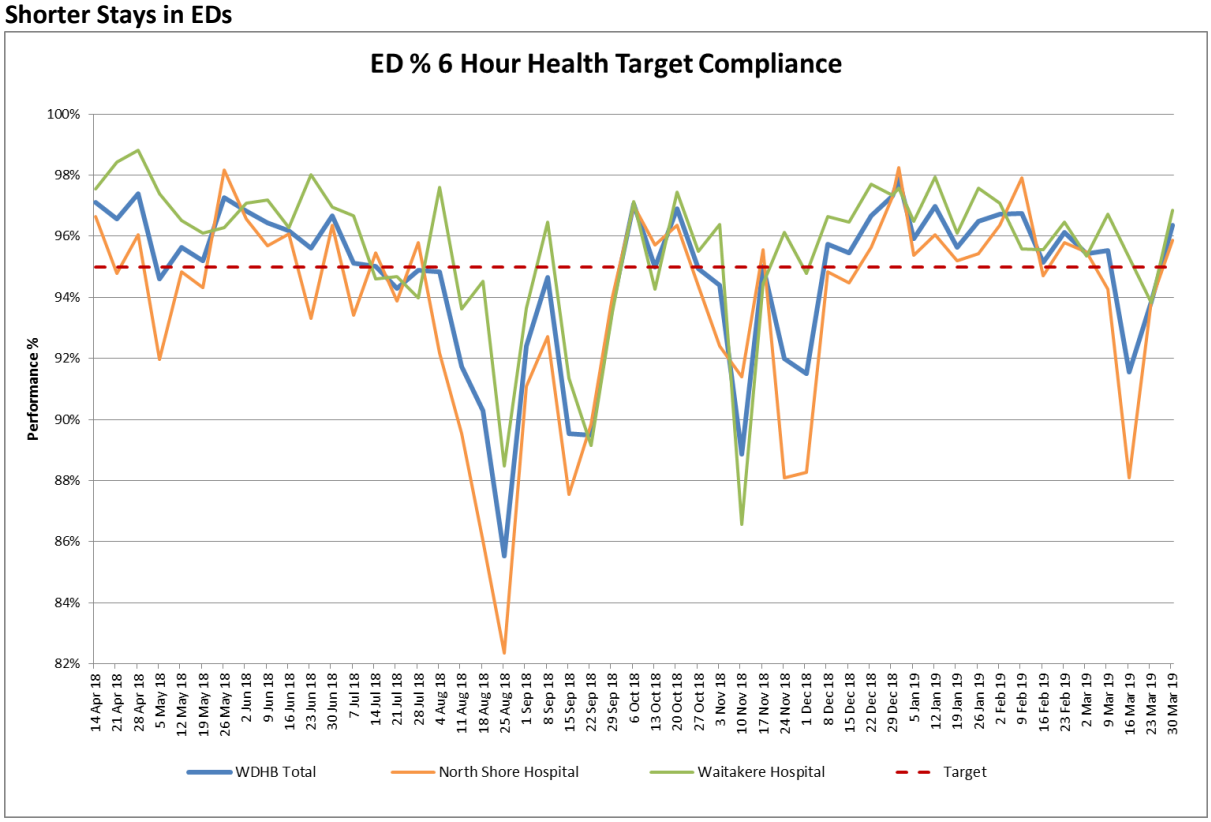
Surgical production is returning to plan to meet discharge volumes. We are also reviewing our coding to ensure optimal revenue is achieved by 30 June.

Health Targets

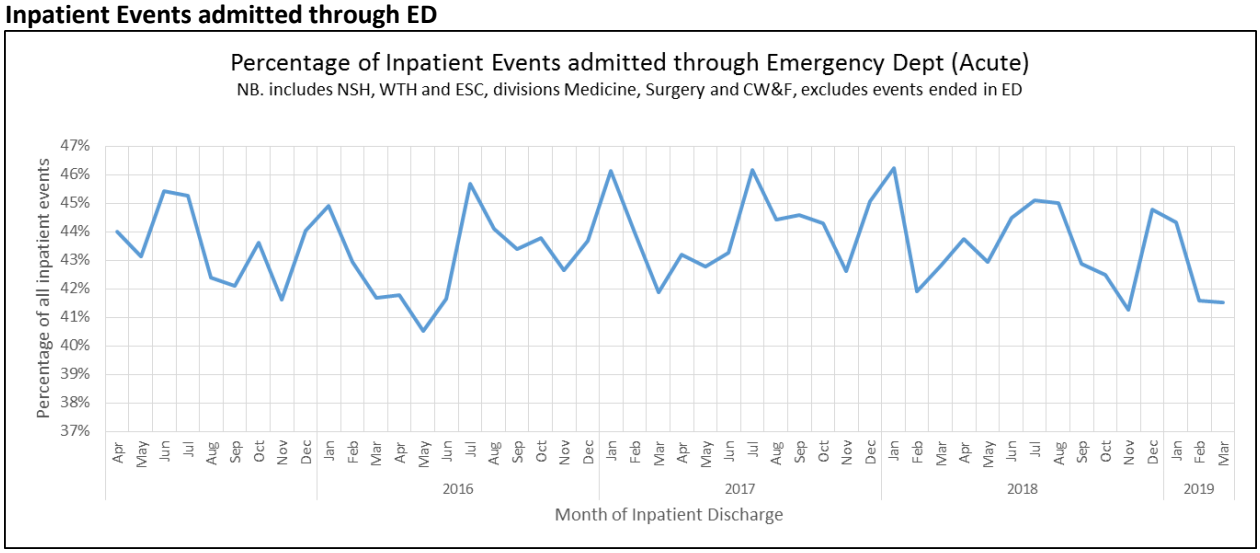
Faster Cancer Treatment



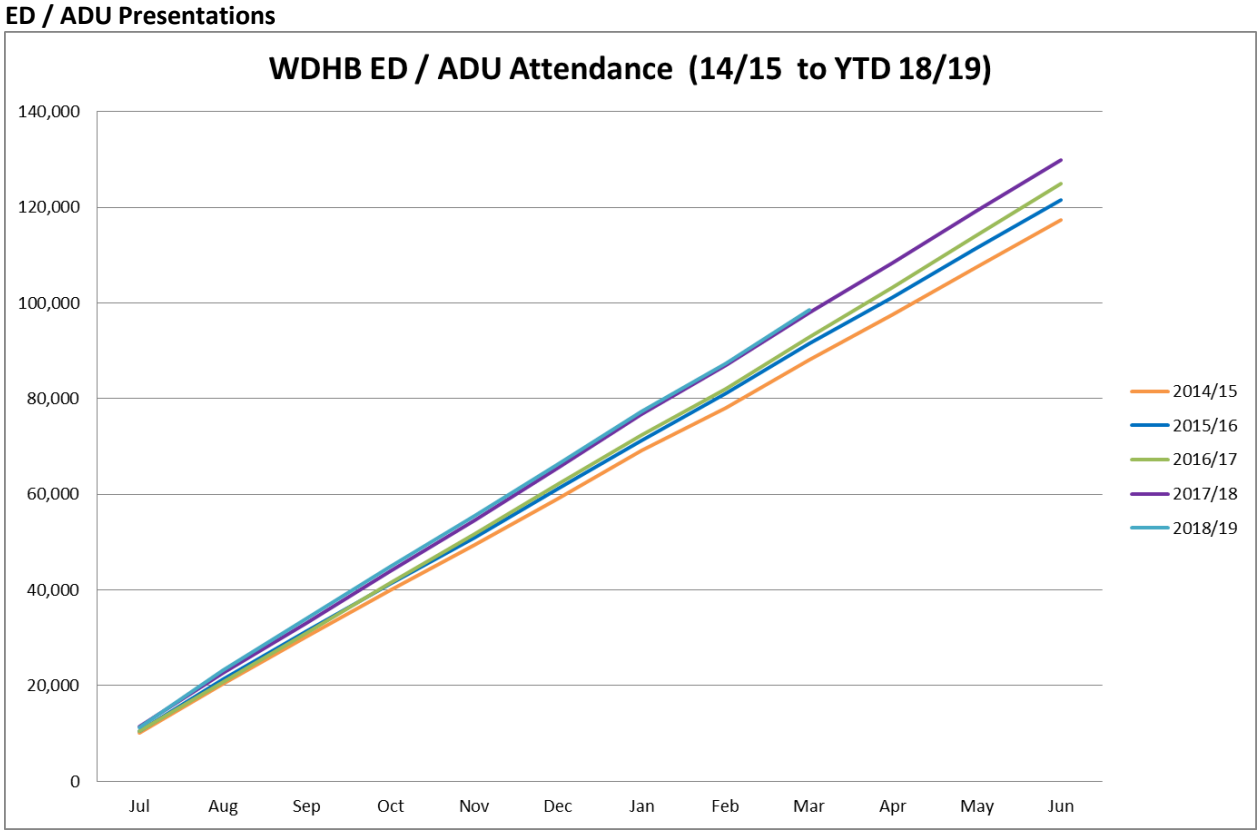
Shorter Stays in EDs



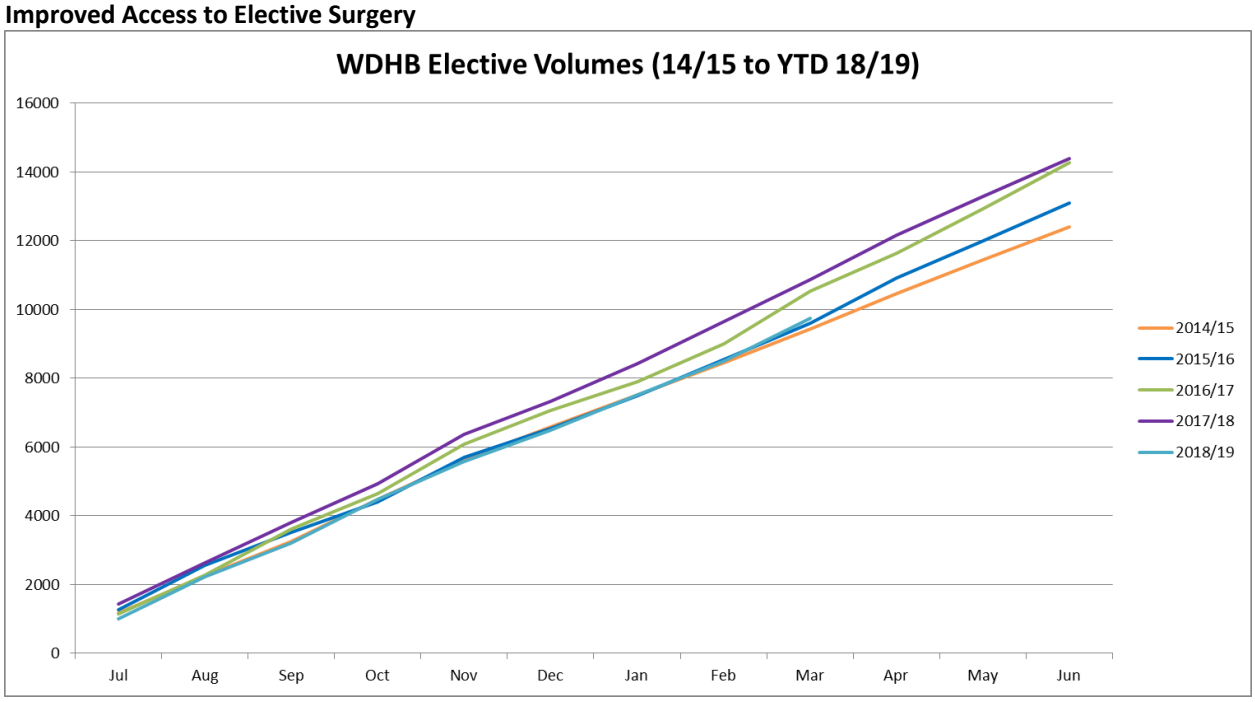
Inpatient Events admitted through ED



ED / ADU Presentations



Improved Access to Elective Surgery



Note: Changes were made to the electives health target for 2015/2016

Percentage Change ED and Elective Volumes

March 2019	Month Volumes	% Change (last year)	YTD Volumes	% Change (last year)
ED/ADU Volumes	11,255	2%	98,591	1%
Elective Volumes	1227	1%	9730	-10.5%

Elective Performance Indicators

Zero patients waiting over 4 months

Summary (Mar 19)	
Speciality	Non Compliance %
ESPI 2 - Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	5.21%
ESPI 5 - Patients given a commitment to treatment but not treated within the required timeframe.	4.24%

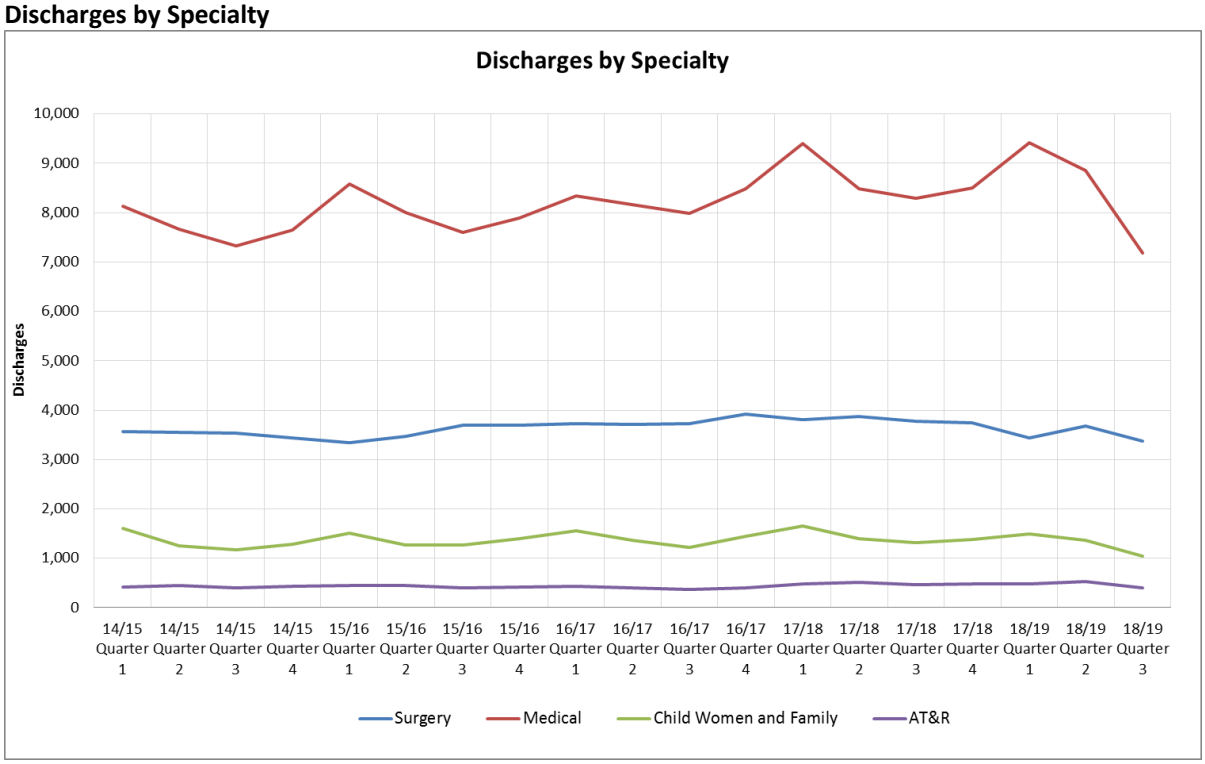
ESPI	WL Specialty	Compliant	Non Compliant	Non Compliant
ESPI 2	Anaesthesiology	107	-	0.00%
	Cardiology	1,293	3	0.23%
	Dermatology	151	-	0.00%
	Diabetes	118	-	0.00%
	Endocrinology	297	-	0.00%
	Gastro-Enterology	838	1	0.12%
	General Medicine	242	-	0.00%
	General Surgery	1,705	12	0.70%
	Gynaecology	875	6	0.68%
	Haematology	119	-	0.00%
	Infectious Diseases	49	-	0.00%
	Neurovascular	97	-	0.00%
	Orthopaedic	1,897	3	0.16%
	Otorhinolaryngology	1,470	603	29.09%
	Paediatric MED	886	-	0.00%
	Renal Medicine	240	-	0.00%
	Respiratory Medicine	659	13	1.93%
	Rheumatology	175	1	0.57%
	Urology	621	9	1.43%
	Total	11,839	651	5.21%
ESPI 5	Cardiology	146	1	0.68%
	General Surgery	1,590	12	0.75%
	Gynaecology	509	38	6.95%
	Orthopaedic	1,039	66	5.97%
	Otorhinolaryngology	415	34	7.57%
	Urology	321	27	7.76%
	Total	4,020	178	4.24%

90% of outpatient referrals acknowledged and processed within 10 days

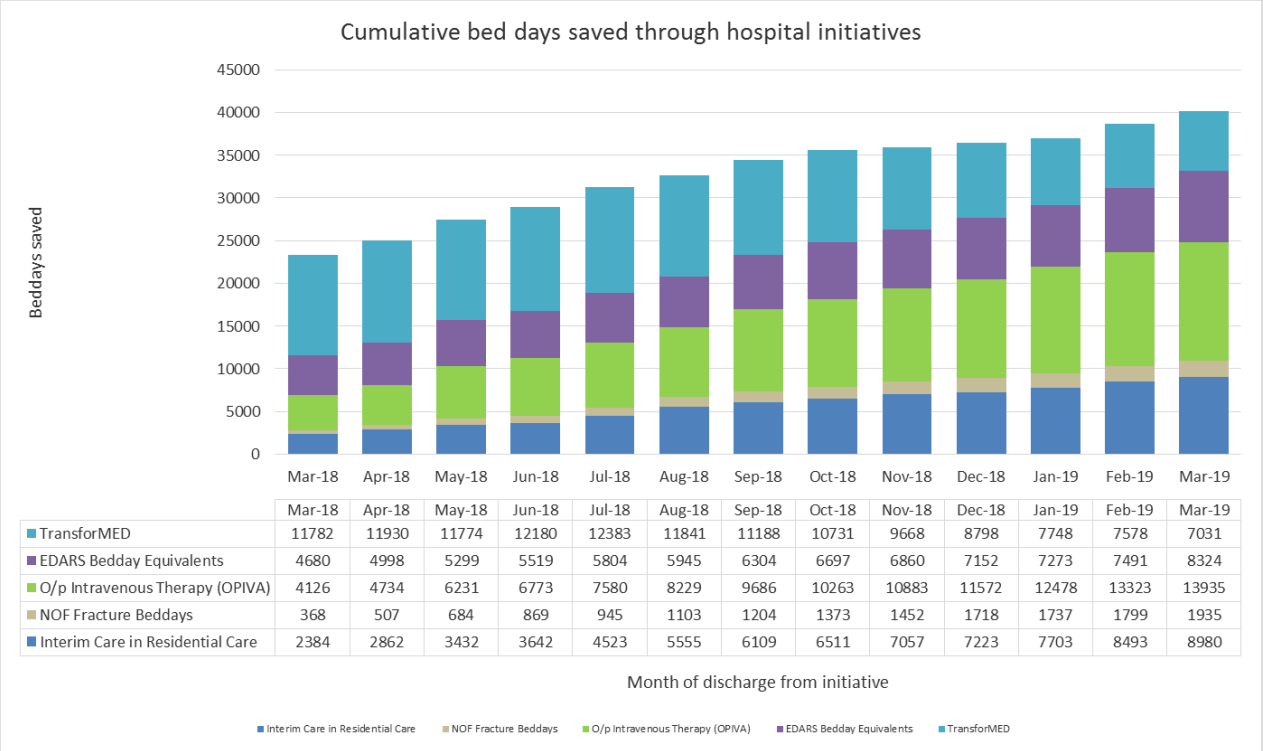
ESPI 1 (Mar 19)	
Specialty	Compliance %
Anaesthesiology	100.00%
Cardiology	98.27%
Dermatology	100.00%
Diabetes	99.03%
Endocrinology	99.12%
Gastro-Enterology	99.23%
General Medicine	98.57%
General Surgery	98.89%
Gynaecology	99.60%
Haematology	99.57%
Infectious Diseases	100.00%
Neurovascular	100.00%
Orthopaedic	99.13%
Otorhinolaryngology	97.94%
Paediatric MED	99.40%
Renal Medicine	100.00%
Respiratory Medicine	98.45%
Rheumatology	98.00%
Urology	99.48%
Total	98.96%

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

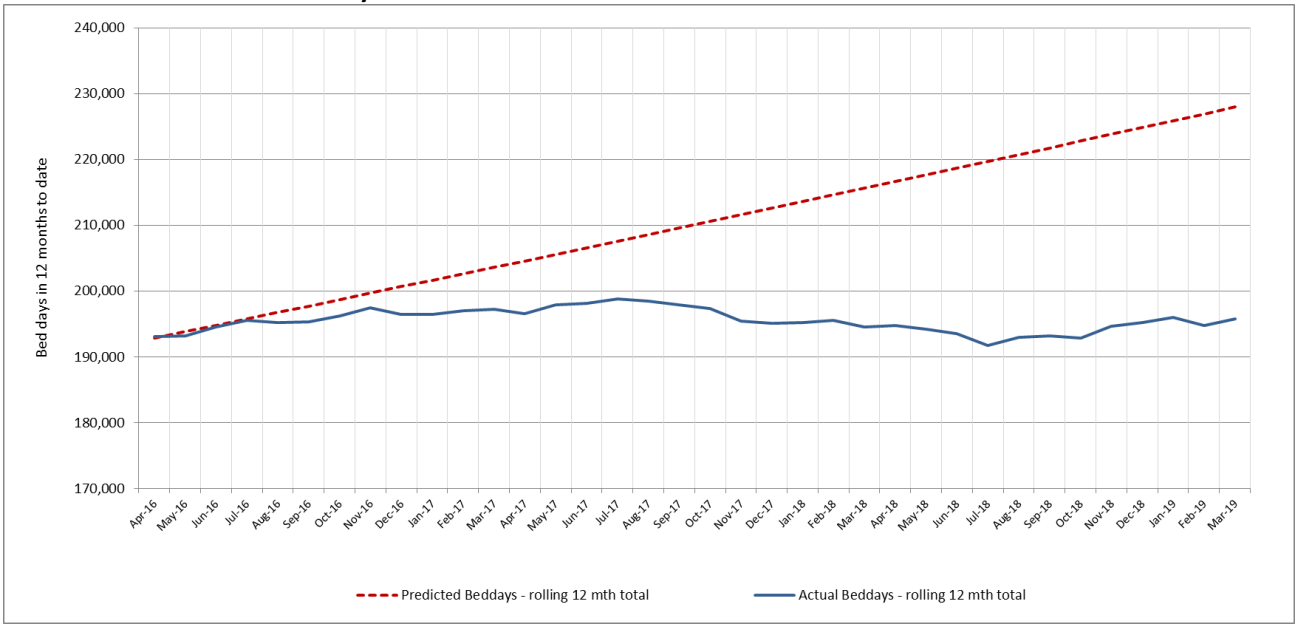


Cumulative Bed Days saved through Hospital Initiatives



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
TransforMED	11782	11930	11774	12180	12383	11841	11188	10731	9668	8798	7748	7578	7031
EDARS Bedday Equivalents	4680	4998	5299	5519	5804	5945	6304	6697	6860	7152	7273	7491	8324
O/p Intravenous Therapy (OPIVA)	4126	4734	6231	6773	7580	8229	9686	10263	10883	11572	12478	13323	13935
NOF Fracture Beddays	368	507	684	869	945	1103	1204	1373	1452	1718	1737	1799	1935
Interim Care in Residential Care	2384	2862	3432	3642	4523	5555	6109	6511	7057	7223	7703	8493	8980

Predicted versus Actual Bed Days



Financial Performance

Waitemata DHB Statement of Financial Performance

Provider - March 2019

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	80,240	75,849	4,391	691,754	682,131	9,624	909,648
Other Income	2,507	2,514	(7)	21,362	22,011	(649)	29,462
Total Revenue	82,747	78,364	4,384	713,117	704,142	8,975	939,110
EXPENDITURE							
Personnel							
Medical	17,084	15,965	(1,119)	145,545	142,934	(2,611)	194,170
Nursing	21,805	19,721	(2,085)	189,872	181,795	(8,077)	243,593
Allied Health	10,597	10,428	(169)	88,414	88,962	548	119,212
Support	1,931	1,695	(237)	16,092	15,483	(610)	20,729
Management / Administration	6,223	5,663	(560)	52,705	51,737	(968)	69,051
Outsourced Personnel	1,670	1,122	(548)	13,433	9,672	(3,761)	12,955
	59,310	54,593	(4,717)	506,062	490,584	(15,478)	659,710
Other Expenditure							
Outsourced Services	4,801	4,641	(160)	42,524	42,705	181	56,555
Clinical Supplies	11,258	10,763	(495)	94,643	93,709	(934)	126,343
Infrastructure and Non-Clinical Supplies	10,242	9,816	(426)	90,495	94,566	4,070	118,202
	26,301	25,221	(1,080)	227,662	230,979	3,318	301,100
Total Expenditure	85,611	79,814	(5,797)	733,723	721,563	(12,160)	960,810
Cost Net of Other Revenue	**(2,864)**	**(1,450)**	**(1,414)**	**(20,606)**	**(17,421)**	**(3,185)**	**(21,700)**

Comment on major financial variances

The overall result for Provider is $1.414m unfavourable for March and $3.185m unfavourable for the YTD.

Revenue ($4.384m favourable for March, $8.975m favourable YTD)

The favourable revenue variance includes MECA timing benefits offset by expenses, and revenue from PHARMAC rebates that are now accounted for as revenue relating to the new Ministry Combined Pharmaceutical Budget (CPB) strategy. Up until December 2018 the rebates had been accounted for and budgeted as an offset in pharmaceutical expenditure. From January onwards the rebate has been accounted for as revenue (unbudgeted).

Expenditure ($5.797m unfavourable for March, $3.185m unfavourable YTD)

Personnel ($15.478m unfavourable YTD)

The unfavourable variance was due to premium costs to cover vacancies and leave across all services, KMU model of care changes, training and high winter demand. Variance by service; Acute and Emergency ($3.841m) SMHOPS ($1.761m), CWF ($940k), SMHA ($2.583m) and S&A ($1.215m). Active management of vacancies and leave continues to be a focus for the Provider.

Other Expenditure ($3.318m unfavourable)

Outsourced Services ($181k favourable)

Outsourced colonoscopy and gastroscopy volumes were reduced due to contracted volumes with suppliers. S&A also contributed to the favourable variance due to the timing of outsourcing volumes of radiology, ultrasound and MRI.

Clinical Supplies ($934k unfavourable)
The unfavourable variance was due to mobility aids rental volume being consistently high, MHSOA respite volume and acuity and district nursing patient's volume demands. A project to reduce mobility aids costs will begin implementation in July 2019. The unfavourable variance was also contributed to by medical gases in Facilities $210k.

Infrastructure and Non-Clinical Supplies ($4.070m unfavourable)
The unfavourable variance was due to unrealised expenditure reduction initiatives.

Waitemata DHB Statement of Financial Performance

Provider - March 2019

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
CONTRIBUTION							
Surgical and Ambulatory	(14,085)	(13,770)	(315)	(125,088)	(124,627)	(461)	(172,728)
Acute and Emergency	(11,585)	(10,547)	(1,038)	(105,240)	(101,258)	(3,983)	(140,665)
Specialty Medicine and HOPS	(7,191)	(6,873)	(317)	(65,414)	(62,467)	(2,947)	(86,925)
Child Women and Family	(7,187)	(6,822)	(365)	(63,521)	(63,357)	(164)	(87,028)
Specialist Mental Health and Addiction	(10,368)	(10,099)	(269)	(96,310)	(95,146)	(1,164)	(131,094)
Elective Surgery Centre	(2,445)	(2,433)	(12)	(20,216)	(20,640)	424	(27,984)
Corporate and Provider Support	49,996	49,095	901	455,183	450,074	5,109	624,724
Net Surplus/Deficit	**(2,864)**	**(1,450)**	**(1,414)**	**(20,606)**	**(17,421)**	**(3,185)**	**(21,700)**

Comment on major variances by Provider Service

The overall result for Provider was $1.414m unfavourable for March and $3.185m unfavourable for the YTD.

Surgical and Ambulatory (S&A) ($461k unfavourable YTD)
While tracking close to budget overall the service continues to benefit financially from additional revenues from orthopaedic ACC cases, and lower volumes due to the impact of industrial action and acute bed encroachment from medical services. Offsetting this, additional costs have been incurred with over-allocations of registrars, an increase in skin lesions, and unplanned repairs and maintenance costs. The service is facing cost pressures in the remaining months to ensure ESPI compliance, plans to deliver to plan on outsourced MRI and ultrasound scans, and unbudgeted outsourced costs to meet Interventional Radiology demands that exceed internal capacity.

Acute and Emergency Medicine ($3.983m unfavourable YTD)
The unfavourable variance was due to premium cover costs for medical staff, additional sessions to shorten the patient waiting list, RMO strike cover cost by senior medical officers, extra beds and resources required to meet high winter demand, high watch costs and ADU observations cost not fully budgeted.

Specialty Medicine and Health of Older People (SMHOPS) ($2.947m unfavourable YTD)
The unfavourable variance was due to $299k of ACC revenue not yet claimed. KMU model of care changes requiring more patient watches and increased demand in District Nursing requiring extra nurses. Mobility Aids rental costs were consistently high due to increased noting this should reduce in July 2019. There was an increased spend in dressings due to increased demand within the hospital and within district nursing.

Child Women and Family (CWF) ($164k unfavourable YTD)
The unfavourable result YTD was the result of patient demand driven cost increases across predominately Maternity and Neonatal services involving use of external staffing resource and overtime to cover vacancies and roster gaps, cleaning outsourced costs, patient food and to a lesser extent increased maintenance costs in the facilities. These cost increases have been partly mitigated by service wide vacancies and an improved revenue position.

Specialist Mental Health and Addiction (SMHA) ($1.164m unfavourable YTD)
The unfavourable result YTD was due to the use of locums to cover medical vacancies and increasingly 'acute' caseloads. This is particularly the case in the Rodney region, both for adult and child and youth specialist psychiatrists. There remains a difficulty recruiting to nursing vacancies, again specifically in more specialist areas such as child and youth as well as intellectual disability. Also, vacancies in both the adult inpatient units and forensics are covered with overtime rates which are paid at a premium.

Elective Surgery Centre (ESC) ($424k favourable YTD)
Three factors have reduced the capacity to deliver to plan and resulted in the favourable financial variance YTD; industrial action, acute bed encroachment at NSH impacting ESC, and the holiday closure. This has resulted in lower costs. Offsetting this, the service has realised higher than budgeted non-volume related clinical supplies, e.g. repairs and maintenance, and minor purchases.

Corporate and Provider Support ($5.109m favourable YTD)
Revenue is favourable ($6.649m) due to additional revenue from MoH ($5.448m) for CCDM and MECA settlements, along with additional cost recoveries and includes additional interest income ($317k) and back-dated SLA in Primary Health Care Nursing for vaccination program at Auckland DHB ($307k). Also contributing were favourable personnel costs due to vacancies along with risk pool provisions ($431k); this was offset with unfavourable variances driven by timing differences in implementing some of the financial sustainability initiatives and unfavourable expenditure in Facilities outsourced maintenance and consultants costs ($1.219m). Overall the costs in Facilities are being contained and result has been close to breakeven over the past three months.

Human Resources

Method of calculation of graphs:

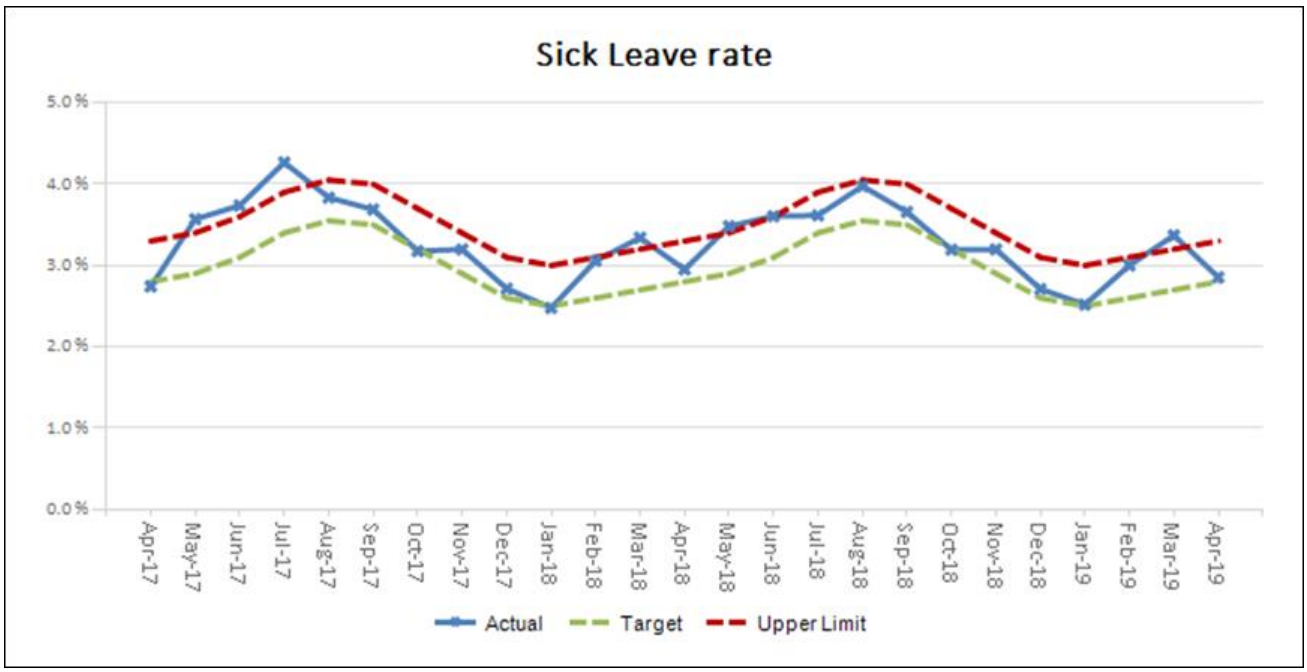
1. Overtime Rate: The sum of overtime hours worked over the period divided by worked hours over the period.
2. Sick Leave Rate (days): The sum of sick leave hours over the period divided by total hours over the period.
3. Annual Leave balance days: Count of staff with 0-76+ days equivalent 8 hour days 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

The upward trend is corrected in April; this is a positive result as we move towards winter.

CWF and ESC reported highest variances for March but both have reflected significant improvements in April. SMHA have reported close to tolerance level over both months which is a positive trend.

Sick leave usage is regularly monitored and addressed all services using reporting facilities available and addressed with guidance and tools available where instances of high intermittent or long term absences are identified.

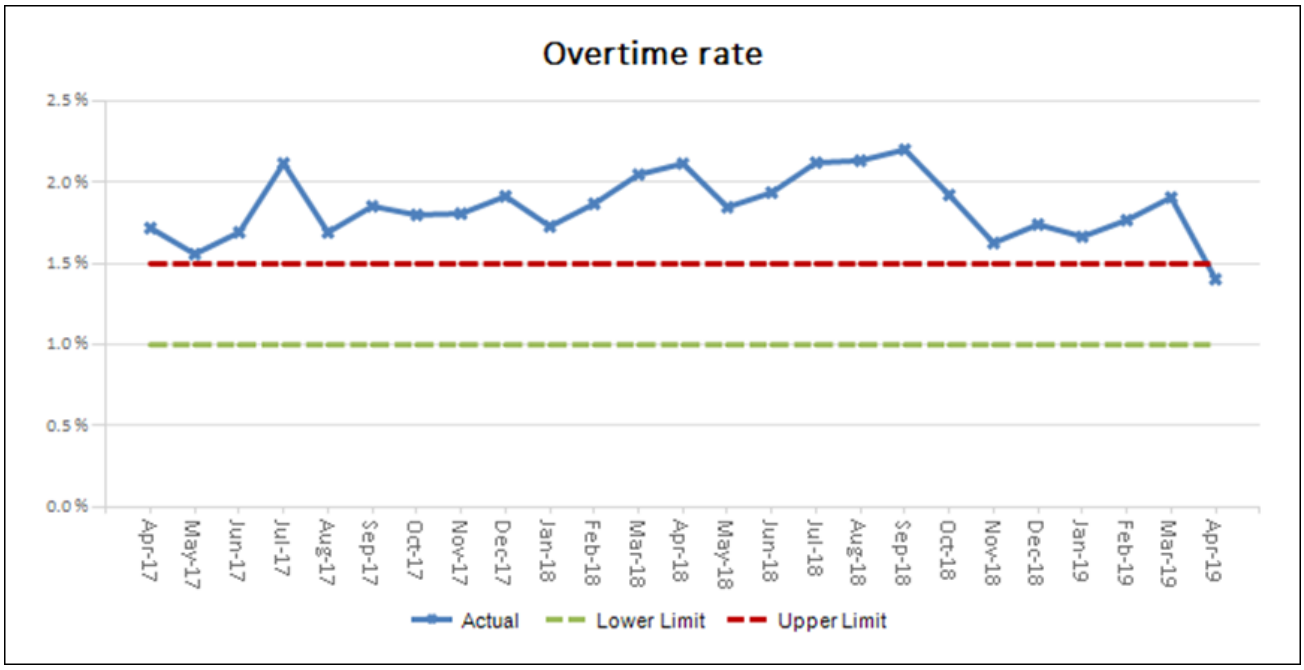


Overtime

March organisational figures reflect a slight increase in overtime rates but there has been a significant improvement reported in April with the rate falling below the upper tolerance level for the first time since May 2017 where the tolerance level was met.

There has been significant focus on a range of activities to support overtime reduction over the past six months including filling vacancies and use of casual employees. The April report indicates a favourable response to initiatives in place.

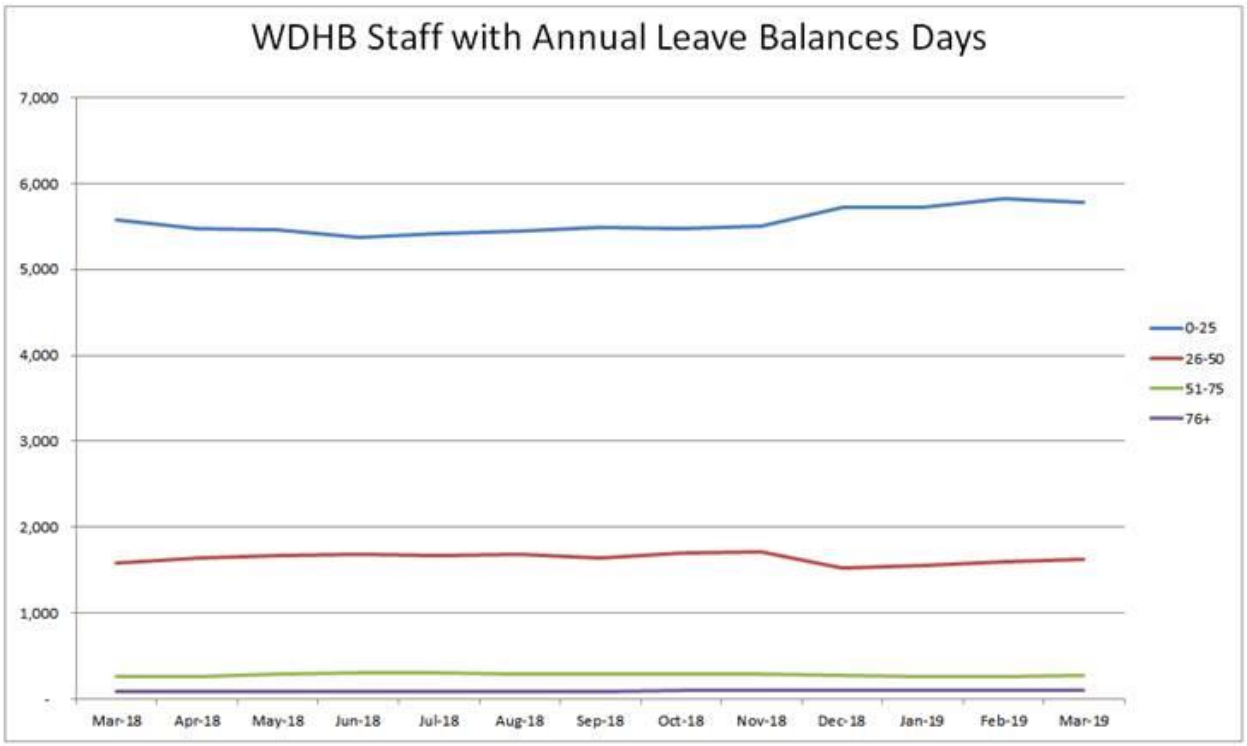
SMHA are reporting the highest positive variance due to new graduates coming onto service rosters and a reduction in high needs observations.



Annual Leave

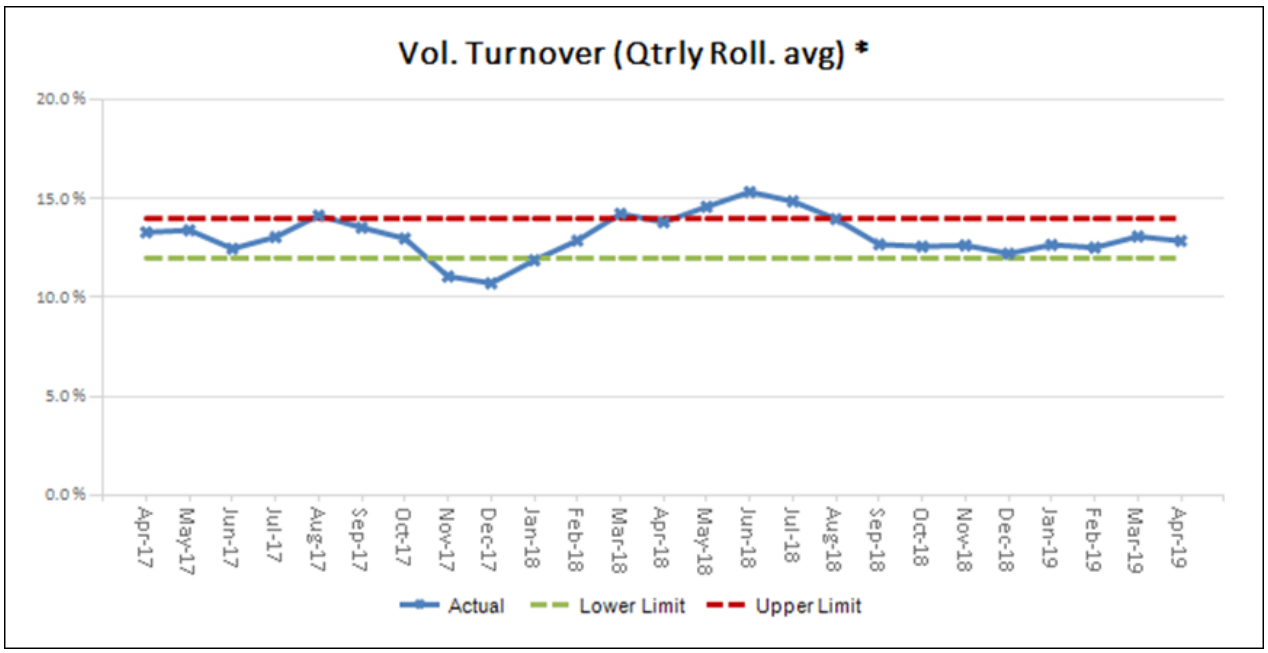
Leave continues to remain relatively consistent with high leave balances improving from March 2018. Work is continuing on actions to reduce leave overall year on year.

Annual Leave March 2019	Leave Bal 0-25 days	Leave Bal 25-50 days	Leave Bal 50-75 days	Leave Bal 75 days +
S&A	846	316	77	27
ESC	86	14	1	-
CWF	941	148	22	13
Hospital Operations	426	149	14	1
Facilities & Development	34	11	3	-
Corporate	334	94	13	5
Acute & Emergency Medicine	937	331	65	35
Director of Hospital Services	214	51	9	-
Elective & Outpatient Services	60	19	2	-
SMHA	1058	279	28	3
Specialty Medicine and HOPS	764	193	36	12
WDHB Governance and Funding	85	16	3	3
Total	**5785**	**1621**	**273**	**99**
Comparison – March 2018	5454	1575	300	80



Staff Turnover

The organisational turnover rate continues to track close to the lower tolerance level with a slight decrease reported in April. Turnover in services and professional groups continues to be monitored and additional review and analysis undertaken where indicated.



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 Acting Associate Director of Nursing Medicine is Melody-Rose Mitchell. The Clinical Directors are Dr Hamish Hart for General Medicine, Dr Willem Landman 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

The Safe Staffing Accord funding which was agreed as part of the NZNO settlement has resulted in the successful recruitment and implementation a shift co-ordinators across the medical wards on an afternoon shift. In total eight nurses have been recruited to this role, five across the NSH medical and AT&R wards and three across the WTH medical and AT&R wards. The aim of this supernumerary position is to assist in the frontline management of hospital flow and inpatient ward activity, particularly after hours to ensure that:

- **Care of patients and service delivery is safe and clinically effective** i.e. the right people are in the right place, doing the right things at the right time, supported by experienced clinical staff and a pathway for the prompt escalation of the deteriorating patient.
- **Patients receive the best care possible** because of experienced oversight of each team and support from clinical colleagues 24/7
- **Patient flow is efficient and effective** due to appropriate progression of clinical care, multidisciplinary team appropriate planned discharge, timely and appropriate bed management.
- **Emergencies are managed effectively** because staff in each unit/department and hospital management as a whole (Waitematā Central) know what is expected and act in a prompt and appropriate manner.

The feedback from the Ward, ADU and ED staff has been positive and the staff have felt supported by the increased senior nursing leadership particularly out of hours.

We have had positive feedback regarding the afternoon co-ordinator positions. *"It's been really good to support patients coming into the ward from ED and ADU"; "the PM co-ordinator is free to support other staff"; "patient assessments are done sooner"*.

Key Issue

Unplanned follow up appointments in General Medicine

Historically there have been high volumes of overdue patient follow-ups in General Medicine as well as in a number of other medical sub-specialities. Over the last twelve months we have significantly reduced the number of overdue routine patient follow ups in General Medicine from over 3,000 to fewer than 1,000 and from over one year to within nine months. The Service has achieved this reduction as a result of the following processes.

a) A clerical review has been implemented to remove patients who had moved out of the Waitematā DHB area and to remove patients who had already had their appointment, or a subsequent admission and those where the original request for an outpatient follow up had not been cancelled in the system.

b) A clinical review of the remaining patients is currently in progress and several senior clinicians are taking part. This review has identified that there are a number of general medicine patients who are also under the care of specific medical sub-specialties, and seeing them within a general medical clinic is a duplication of effort. In addition a number of patients have had the investigations that were requested following their initial appointment. These test results have been reviewed and the GPs of patients who have had normal test results have been written to and advised that the test is normal and follow up is not required.

This review is on-going and the aim is to eliminate overdue follow ups in general medicine by the beginning of 2020, giving the SMOs confidence that patients will be seen within the time frame requested. The Service has reviewed the model of care for follow up appointments, and any patient requiring a further follow up appointment should be discussed with the registrars supervising SMO.

Scorecard – Acute and Emergency Medicine Division

Waitemata DHB Monthly Performance Scorecard

Acute and Emergency Medicine
March 2019
2018/19

Health Targets

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

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	12 days	≤14 days	--
Net Promoter Score FFT	74	65	
Improving Outcomes			
PCI w/in 120 minutes (STEMI patients)	88%	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	0.1	≤2	
Good hand hygiene practice	88%	80%	
Pressure injuries grade 3&4	0	0	--
HR/Staff Experience			
Sick leave rate	3.1%	≤3.4%	--
Turnover rate - external	18%	≤14%	
Vacancies - %	5%	≤8%	

Service Delivery

Waiting Times	Actual	Target	Trend
General Medicine - % seen w/in 120 mins	77%	85%	
Elective coronary angiography w/in 90 days	86%	95%	
b. Angiography for ACS w/in 72 hours	80%	70%	
Chest pain clinic wait time under 6 weeks	30%	80%	
O/P Transthoracic Echo wait time under 12 weeks	27%	95%	--
Patient Flow			
Elective Discharge Volumes (Cardiology)	106%	100%	
Outpatient DNA rate	7%	≤10%	
Patients with EDS on discharge	89%	85%	--

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue	2,947 k	2,692 k	
Expense	108,187 k	103,950 k	
Net Surplus/Deficit	-105,240 k	-101,258 k	
Contracts (YTD)			
Elective WIES Volumes	834	894	
Acute WIES Volumes	27,370	27,099	

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. Data for Medicine overall
b. Quarterly, Mar 19

A question?

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

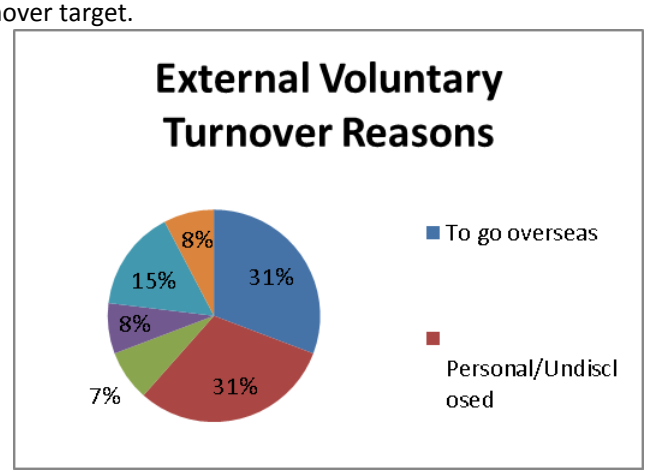
Scorecard Variance Report

Best Care

Turnover rate *– External 18.7% against a target of ≤14%*

There continues to be a decline in external turnover since December (19.4%) with external turnover now sitting at 18.7%. Whilst it is declining slowly and still above the DHB target of 14%, the downward trend is a positive sign that things are continuing to improve. Since October 2018, there continues to be a decline in the internal turnover rate – now sitting just 0.4% above the DHB turnover target.

69% of voluntary leavers in March 2019 were Registered Nurses. Of the nine nurses who left – four left to go overseas, one left the district, two took another job in public health, one took a job in the private health sector and one stated personal reasons. There were two doctors who also left in March – an SMO and Medical Officer both of which stated personal reasons for their departure. The top three reasons for external voluntary turnover were to travel overseas, personal/undisclosed reasons and to take up another role in public health.



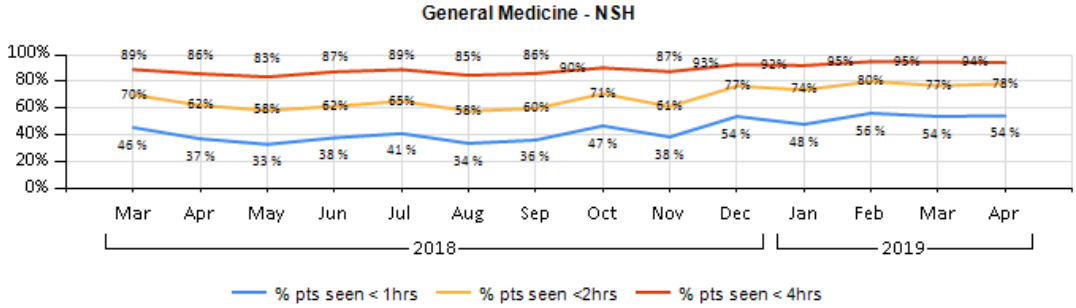
Service Delivery

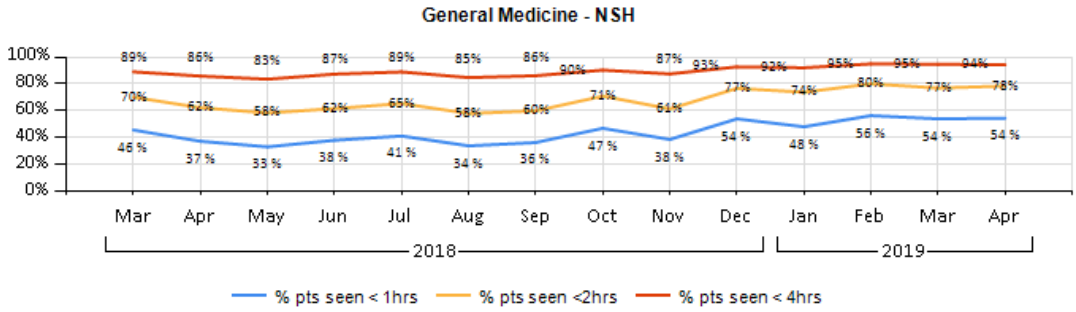
ADU % seen from triage within 120 minutes *– 77% against a target of 85%*

- ***General Medicine – 78% against a target of 85%***

In March 2019 78% of medical patients were seen within two hours of triage. Performance against this target has improved since December 2018 and has fluctuated between 74% and 80% since then. General Medicine continues to monitor time to be seen for all patients. A daily report is analysed for any patient waiting longer than four hours.

There is now a daily handover at 1545 in NSH ADU run by the ADU afternoon Floor Manager and attended by all ADU RMOs about to leave for the afternoon and those that are on an admission long day. There is a review of the white board and a discussion of patients seen during the day, identifying any delays to discharge or changes in plans for patients. Patients waiting to be seen are allocated to the RMOs on admission to ensure that they are seen in a timely manner. There is also a review of the daily register to ensure that the evening and afternoon staff are aware of the patients that are due to come in. During April all except three week day evening shifts were covered by an SMO. There has been an improvement in the number of patients seen since December 2018 and it is expected this will be sustained and further improved upon.





- ***Surgery*** – In March 2019 55% of surgical patients were seen within two hours of triage. Performance against this target remains relatively static and fluctuates from 54% to 67%.

- ***Orthopaedics*** – In March 2019 78% of patients seen within two hours of triage. This is a significant improvement in performance. Performance against the target has previously fluctuated between 36% to 75%.

Elective coronary angiography within 90 days – *86% against a target of 95%*
The failure to meet the target this month has been identified as the result of a clerical error in the management of the waiting list and this error has subsequently been addressed. It is anticipated this we be back on track in April 2019.

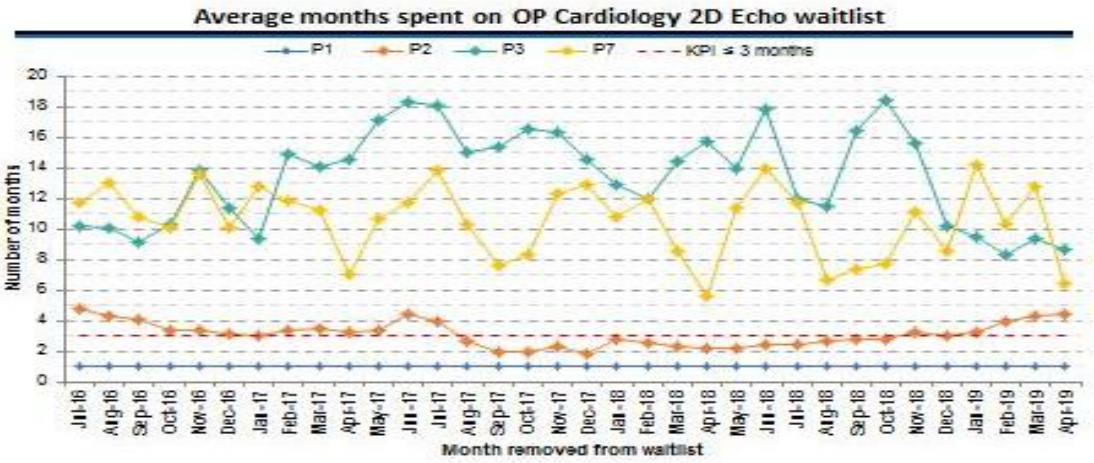
Chest pain clinic wait times under six weeks – *30% against a target of 80%*
Performance against the chest pain clinic wait times will not begin to improve until April 2019, and is forecast to be at 56% for April. The Service has reviewed all of the referrals to the chest pain service and developed clear

processes to ensure that only appropriate patients are seen within this clinic. In addition resources have been realigned to meet this demand.

The current median wait time for appointment is 24 days which is an improvement on February; all patients are being reviewed as they are added to the chest pain clinic list. The Service is also working with the clinical graders to ensure patients referred are graded appropriately. An in-depth analysis of the Waitematā DHB chest pain referrals shows that the Cardiology Service accepts a significantly higher number of low risk chest pain patients than other cardiology services in the region and nationally.

The Service is looking to develop and trial a nurse led screening process for these patients to ensure that the referrals are appropriately managed.

O/P Transthoracic ECHO wait times under 12 weeks *– 27% against a target of 95%*
There are currently 1,850 patients without a date on the outpatient Transthoracic ECHO waiting list at Waitematā DHB. Priority one patients are scheduled within two weeks of referral. Priority two patients are being managed within three to four months as shown in the graph below.



Patient focussed booking was implemented in December 2018 and has resulted in a downward trend in wait times for priority three patients to an average of nine months. The patient focussed booking process has reduced the number of DNAs (did not attend) resulting in better utilisation of ECHO appointments. The patient focussed booking process will be evaluated at the end of six months and we are planning implement patient focused booking for priority two patients as well.

The Service working with the clinicians to understand the role of fast/focused scan and to develop further strategies to manage the ECHO demand. We are looking to develop protocols for different types of ECHO patients in order to reduce the scanning time for these patients. The waiting list has remained stable at around 1,800 which is a significant reduction from 3,000 in early 2017. We are working on strategies to reduce demand and further improve productivity and we are pleased to announce that we have recently employed two senior sonographers.

We are working closely with the Auckland Regional Cardiology Network to understand and assess current demand patterns and to enable more timely access to services and reporting.

Strategic Initiatives Variance Report

Deliverable/Action	On Track
Shorter stays in ED	
1. Implement a review of all 'stranded' patients, i.e. those with a length of stay >10 days in general medicine – June 2019.	✓
2. Develop and plan to improve access to acute outpatient clinics from the ADU: next day for general medicine and access to subspecialty outpatient clinics in a timely manner for acute patients – June 2019.	✓
3. Ensure diversity in our work force to represent our patient population (EOA) – June 2019	✓

Areas off track for month and remedial plans
All areas on track.

Financial Results - Acute and Emergency Medicine

Waitemata DHB Statement of Financial Performance

Acute and Emergency Medicine - March 2019

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	240	251	(12)	2,373	2,263	110	3,017
Other Income	63	44	19	574	429	145	561
Total Revenue	302	295	7	2,947	2,692	255	3,578
EXPENDITURE							
Personnel							
Medical	4,136	3,804	(331)	36,966	35,729	(1,237)	50,102
Nursing	5,427	4,808	(619)	50,024	47,822	(2,202)	66,641
Allied Health	196	221	25	1,805	1,908	103	2,652
Support							
Management / Administration	453	451	(2)	4,351	4,266	(85)	5,872
Outsourced Personnel	97	76	(20)	1,141	721	(421)	949
	10,308	9,361	(947)	94,287	90,446	(3,841)	126,216
Other Expenditure							
Outsourced Services	46	38	(8)	292	343	51	458
Clinical Supplies	1,201	1,188	(13)	10,378	10,492	114	14,012
Infrastructure & Non-Clinical Supplies	333	255	(77)	3,230	2,668	(562)	3,557
	1,580	1,482	(98)	13,901	13,504	(397)	18,027
Total Expenditure	11,887	10,842	(1,045)	108,187	103,950	(4,238)	144,243
Cost Net of Other Revenue	**(11,585)**	**(10,547)**	**(1,038)**	**(105,240)**	**(101,258)**	**(3,983)**	**(140,665)**

* 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 $1,038k unfavourable for March and $3,983k unfavourable for the YTD.

Revenue ($7k favourable for March, $255k favourable YTD)

The favourable variance for March and YTD was due to revenue received from non-residents and from the University of Auckland teaching.

Expenditure ($1,045k unfavourable for March, $4,238k unfavourable YTD)

The unfavourable variance for March and YTD was due to premium cover cost for medical staff (additional duties and locum costs), as well as the resources required to meet high winter demand and high medical bed utilisation. The Service continues to have high vacancies and turnover within the cover model and with a larger than usual new graduates intake there has been an increase in orientation costs. In addition there were costs related to the RMO strike as well as cardiology and general medicine SMO back-pay relating to job sizing and the implementation of home based wards. There were high security watch cost for NSH ED.

Personnel ($3,841k unfavourable YTD)

Medical ($1,237k unfavourable YTD)

The unfavourable variance was due to high levels of sick leave in ED for the winter period, the cost of additional sessions by ED SMOs to cover vacant shifts and cardiology SMOs to cover an ongoing vacancy, SMO back pay and RMO strike cover cost by SMOs.

Nursing ($2,202k unfavourable YTD)
The unfavourable variance was due to increased staffing requirements as a result of winter demand, high over time in ED due to the lack of experienced ED nurses for cover, high orientation costs, the use of external agency to cover unfilled positions and not fully budgeted cost commitment for watches and ADU observation beds.

Allied Health ($103k favourable YTD)
The favourable variance was due to vacancies.

Support and Management/Administration ($85k unfavourable YTD)
The unfavourable variance was due to high penal cost for ED administration staff.

Outsourced Personnel ($421k unfavourable YTD)
The unfavourable variance was due to outsourced nursing expenditure for watches demand and locums for ED.

Other Expenditure ($397k unfavourable YTD)
Clinical Supplies ($114k favourable YTD)
The favourable variance was due to a one off benefit from reversal of prior year clinical equipment services which will not be invoiced.

Infrastructure and Non-Clinical Supplies ($562k unfavourable YTD)
The unfavourable variance was due to high security watch cost and unrealised savings which was allocated in the budget to encourage savings within the whole division.

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 (inpatient, outpatient and community) 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 John Scott, Head of Division, and Brian Millen, General Manager. Melody-Rose Mitchell is the Acting 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 Janak de Zoysa for Renal, Dr Megan Cornere for Respiratory, Dr Ross Henderson for Haematology, Dr Blair Wood for Dermatology and Dr Michael Corkill for Rheumatology.

Highlight of the Month

Innovation in practice- Telehealth Outpatient Physiotherapy

Our outpatient physiotherapy team receives referrals for patients who require support related to continence, bladder and bowel conditions. Patients' needs can often be met by providing education and a set of exercises. Normally this is provided through a one on one appointment.

Patients were typically waiting several weeks from referral and sometimes months to be scheduled into clinician clinics. Once seen, a high percentage of issues were able to be addressed by education. The opportunity to deliver care in a different way came from the Acting Team Leader who was keen to undertake the challenge as one of her 'Career and Salary Progression' (CASP) objectives. As a team they began working through a variety of opportunities for improving timeliness in meeting patient's needs by exploring options for delivering outpatient education sessions to patients through telehealth.

Over the last couple of months a protocol has been developed and trialled with a small group of patients offering people the opportunity to log in to an online education group session from the comfort of their home. Those who would still like to be followed up are offered the opportunity to attend a one on one appointment. Initial feedback is that the sessions are useful with patients enjoying the flexibility and appreciating being able to have the education in a timely manner. To date very few patients have requested follow up appointments.

Like all innovative projects the team have faced some challenges with implementation, and in particular, from the technology used for the video conferencing. For example, when patients join a group, all people in the group need to be able to see and hear other in order to mimic what happens when everyone is in the same room. What they hadn't realised was that the name people were entering at log on was visible to others when they first connected. Protocols are being developed to address this and in the interim people have been given depersonalised user names which the therapist can match to actual names.

The plan from here is to continue to develop telehealth and to look at other groups of patients with similar educational components in their treatment programme including: pre and post-operative groups such as joint replacement, dietitian services such as eating for health, and potentially bariatric support.

One of the potential added benefits with this method of service delivery is that patients can connect from their homes or workplace which we hope will help reduce non-attendance rates.

Overall, it is becoming clear that while telehealth is a not an option desired by all our clients and it is not suitable for all clinical scenarios, it is for some people an effective and convenient way of delivering care.

Key Issues

Lower than anticipated volumes for fracture liaison services

Osteoporosis is a chronic disease of bone. While the actual disease is asymptomatic, it is the leading contributor to "fragility fractures" - fractures that result from a low impact fall in older patients with compromised bone strength. Around half of people with a first fragility fracture will have a further fracture later in their lives. These people are a high risk group and are a high priority for treatment. Starting these people on treatment reduces their risk of future fractures by up to 50%.

The Waitematā DHB Fracture Liaison Service (FLS) was established in late 2012 to systematically identify and manage hospital inpatients and outpatients with fragility fractures.

FLS at Waitematā DHB is a case-finding service. Patients are identified from inpatient fracture lists, ED, orthopaedic hand over sheet, trauma and x-ray lists, fracture clinics and more recently from a monthly report provided by ACC. Patients are assessed either as inpatients, outpatients, or by phone (where appropriate). Patients eligible for the service are those patients over 50 years of age who present with a fracture of the hip, arm, leg, vertebra or pelvis; resulting from a minimal trauma event such as a simple trip or fall from standing height.

In 2016 Waitematā and Auckland DHBs entered into a partnership agreement with ACC aimed at reducing falls. The partnership has funded both community falls prevention programmes (for higher risk older people); and additional provision of FLS. A service level agreement followed in mid-2017 that provided funding for FLS to assess 4,500 patients at risk of a fragility fracture over a three year term.

However, identifying 1,500 eligible patients annually has proved challenging with just 808 identified so far in the current financial year (nine months). In the previous financial year 1059 patients were identified and referred. There are a number of factors that have led to these lower than anticipated numbers.

- Fractures that are treated in the community (i.e. the patient was not admitted) were previously missed - but are now being picked up through the monthly ACC reports.
- Hip fractures for patients > 75years (approximately 400 per annum) are cared for by our AT&R Orthogeriatrician and do not come under the FLS. While eligible from a population health or risk reduction perspective, assessment and treatment is not reliant on FLS input.
- FLS is a case finding service with very few referrals received. Case finding is time consuming and reliant on having experienced/knowledgeable Clinical Nurse Specialists in position.
- FLS is still in its infancy nationally and internationally which means there is no existing expertise in the nursing workforce. Staff therefore need to time to upskill and develop.
- In hindsight, knowing what we now know about patient and fracture numbers, we believe that 1500 patients per year not currently on an appropriate treatment pathway likely overestimates the eligible population at Waitematā, and that the true number requiring service is probably around 1200.

A service audit completed last year suggests that we are now identifying almost all relevant cases that present to our hospitals. That said, we continue to proactively seek new ways to identify patients who could benefit from bone protection treatment. Awareness of the service is increasing in primary care as the service provides education to GPs around osteoporosis and its treatment and also through information sent to GPs to promote the service. The receipt of letters recommending treatment for primary care patients identified off the ACC lists is also

highlighting the presence of the FLS. We intend to capitalize on this and we are in the process of developing a direct e-referral pathway from primary care with our information technology department.

The service has successfully established of Zoledronic Acid intravenous infusions which are now available at both NSH and WTH. (One of the known side-effects of oral bone therapy treatments is stomach upsets which means that many patients refuse to continue treatment long-term. The intravenous treatments only needs to be given once every 12-18 months so this is a significant step forward for on-going patient treatment and bone protection.)

FLS addresses many of the historic shortcomings in traditional management of fragility fractures and has proven to improve diagnosis, improve long-term treatment and to decrease morbidity in patients at risk of fragility fractures. As Waitematā's population continues to grow and age, managing and preventing life-altering fractures will become an increasingly important issue. Current funding for this service is due to expire in December 2019. We plan to renegotiate later in the year.

Scorecard – Specialty Medicine and Health of Older People Services

Waitemata DHB Monthly Performance Scorecard

Specialty Medicine and Health of Older People
March 2019
2018/19

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	14 days	≤14 days	
Net Promoter Score FFT	77	65	
Improving Outcomes			
Patients admitted to stroke unit	78%	80%	
Acute Stroke to rehab w/in 7 days	78%	80%	
a. InterRAI assessments - LTHSS clients	*99%*	*95%*	
Better help for smokers to quit - hospitalised	93%	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	0	0	
HR/Staff Experience			
Sick leave rate	3.1%	≤3.4%	
Turnover rate - external	15%	≤14%	
Vacancies - %	6%	≤8%	

Service Delivery

Waiting Times	Actual	Target	Trend
Urgent diagnostic colonoscopy w/in 14 days	96%	90%	
Diagnostic colonoscopy w/in 42 days	49%	70%	
Surveillance colonoscopy w/in 84 days	41%	70%	
Patient Flow			
Outpatient DNA rate	6%	≤10%	
Patients with EDS on discharge	89%	85%	

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue	6,092 k	6,864 k	
Expense	71,506 k	69,331 k	
Net Surplus/Deficit	-65,414 k	-62,467 k	
Contracts (YTD)			
Elective WIES Volumes	387	341	
Acute WIES Volumes	1,787	1,617	

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. Quarterly Dec 18 latest data

A question?

Contact:
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Planning, Funding and Health Outcomes, Waitemata DHB

Scorecard Variance Report

Turnover rate – external *– 15% against a target of 14%*

Internal turnover remains stable with little activity driven by movement to other areas with Waitematā DHB in March 2019. March showed a continuing down turn on February's results (15.9%) it is however still well above the first and second quarter figures for 2018. The raw rates of turnover for March (on a per capita basis) is holding steady on a par with January and February 2019's figures but they are still considerably lower than the average annualised figures, which are not sensitive enough to show the downwards trend in turnover that is apparent in the raw turnover figures. Allied Health continues to track at 21.5% turnover giving them the highest rolling continuous average turnover in the area. Mitigations include using annual leave progressively and reviewing levels of professional attainment to encourage development activity and engagement.

Service Delivery

Diagnostic colonoscopy within 42 days *– 48.64% against a target of 70%*

March showed a 10% improvement over last month and represents our highest percentage since December 2018. All strategies noted previously remain in place ensuring optimum utilisation of available lists and low nonattendance.

Surveillance colonoscopy within 84 days *– 41.67% against a target of 70%*

March showed a marginal improvement over February. All strategies noted previously remain in place ensuring optimum utilisation of available lists and low nonattendance.

Value for Money

Revenue *– $6,092k against a target of $6,864k*

Revenue is tracking lower than budgeted due to a decline in hepatitis bulk funded revenue and also low volumes of AT&R ACC revenue. Efforts are being made to increase the ACC revenue in line with budget.

Compliance with patient safety checks in Adult Mental Health Ward

Fourteen clinical notes were randomly audited throughout from 1-28 March. The need for safety checks was correctly documented in all cases and all current risk assessments were up to date.

Strategic Initiatives Variance Report

Deliverable/Action	On Track
Stranded Patients	
1. Implement a review of all 'stranded' patients, i.e. those with a length of stay >20 (i.e. 'stranded') in AT&R – June 2019.	✓
Fracture Liaison	
2. Identify and address barriers to older people being referred to and using the Fracture Liaison Service (FLS) – June 2019.	✓

Areas off track for month and remedial plans
All areas on track.

Financial Results – Specialty Medicine and Health of Older People

Waitemata DHB Statement of Financial Performance

Specialty Medicine and HOPS - March 2019

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	654	674	(20)	5,656	6,017	(361)	8,022
Other Income	46	94	(48)	436	846	(410)	1,128
Total Revenue	700	768	(68)	6,092	6,864	(771)	9,150
EXPENDITURE							
Personnel							
Medical	1,863	1,682	(181)	16,022	15,558	(463)	21,817
Nursing	2,323	2,195	(128)	21,901	20,823	(1,078)	29,232
Allied Health	1,665	1,817	152	15,060	15,107	47	21,085
Support							
Management / Administration	421	410	(10)	3,944	3,987	43	5,509
Outsourced Personnel	126	49	(78)	747	437	(310)	582
	6,398	6,153	(245)	57,673	55,912	(1,761)	78,225
Other Expenditure							
Outsourced Services	366	349	(17)	3,052	3,315	264	4,363
Clinical Supplies	974	975	1	8,936	8,600	(336)	11,490
Infrastructure & Non-Clinical Supplies	152	164	12	1,845	1,503	(342)	1,996
	1,492	1,489	(4)	13,833	13,419	(415)	17,849
Total Expenditure	7,890	7,642	(249)	71,506	69,331	(2,176)	96,075
Cost Net of Other Revenue	**(7,191)**	**(6,873)**	**(317)**	**(65,414)**	**(62,467)**	**(2,947)**	**(86,925)**

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

Comment on major financial variances

The overall result for SMHOPS was $317k unfavourable for March and $2,347k unfavourable for the YTD.

Revenue ($68k unfavourable for March, $771k unfavourable YTD)

The unfavourable variance to March was due to Hepatitis bulk funded revenue $303k not being received and low volume of AT&R ACC revenue $299k.

Expenditure ($249k unfavourable for March, $2,176k unfavourable YTD)

Personnel ($1,761 unfavourable YTD)

Medical ($463k unfavourable YTD)

The unfavourable variance was due to unbudgeted sabbatical leave and premium rate paid to cover costs approximately $266k and SMO training new endoscopic nurse. Also unbudgeted strike costs of $188k.

Nursing ($1,078k unfavourable YTD)

The unfavourable variance was due to the following:

- KMU model of care changes requiring more patient watches which are not fully budgeted $350k.
- Constant patient observation demand was covered by overtime which was paid at an additional cost of $60k.
- District nursing volume demand increased resulting in overtime at an additional cost of $160k.
- Nurse Endoscopic cost approximately $59k.

Outsourced Personnel ($310k unfavourable YTD)

The unfavourable variance was due to outsourced nursing to cover the KMU watches and other unplanned nursing leave. Outsourced locum to cover medical vacancies and leave.

Other Expenditure ($415k unfavourable YTD)

Outsourced Services ($264k favourable YTD)

Outsourced colonoscopy and gastroscopy volumes were reduced due to contracted volumes with suppliers.

Clinical Supplies ($336k unfavourable YTD)

The unfavourable variance was due to Mobility Aids rental volume being consistently high, Mental Health Service for Older Adults (MHSOA) respite volume and acuity and District Nursing patients volume demands.

Infrastructure and Non-Clinical Supplies ($342k unfavourable YTD)

The division is aiming to improve this result by reducing staff turnover and improving efficiency.

Child, Women 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, Head of Division Midwifery is Emma Farmer and Head of Division Allied Health is Susan Peters. The Clinical Directors are Dr Sathananthan Kanagaratnam for ARDS, Dr Christopher Peterson for Child Health, Dr Diana Ackerman for Gynaecology and Dr Helen Allen (Acting) for Obstetrics.

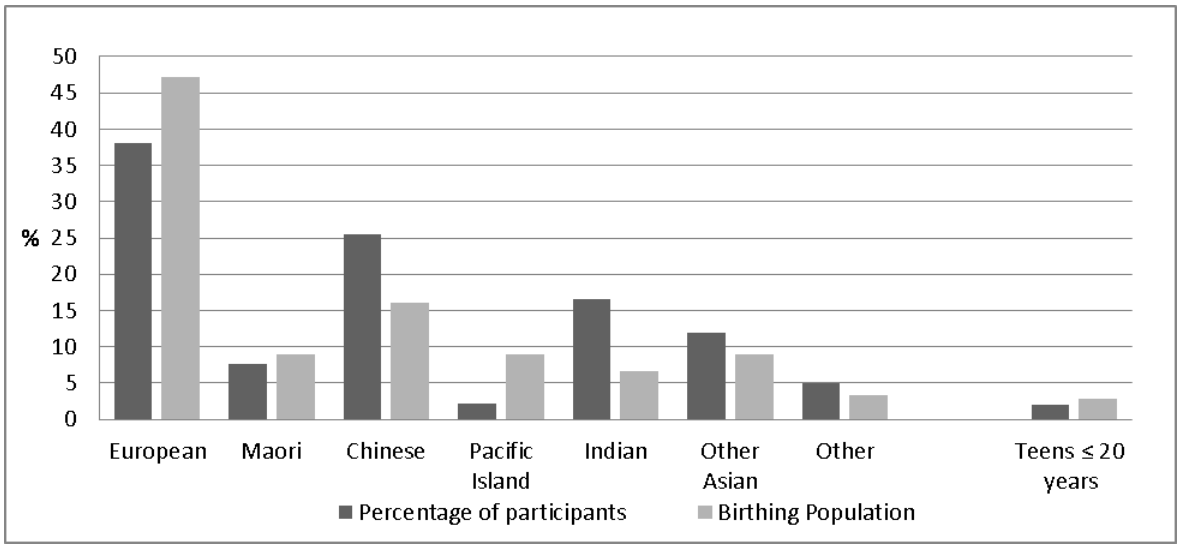
Highlight of the Month

Better, best, brilliant – Completion of the Pregnancy and Parenting Improvement Plan

In 2016 Maternity Services developed a quality improvement plan for the delivery of pregnancy and parenting education. The plan had a number of short and medium term goals. In March 2019 the final stated goal was achieved in that all educators are now Waitematā DHB employees. The programme has undergone a significant change to ensure high quality information and advice is provided to parents. The service is already working on new innovations such as an early pregnancy drop in session and greater availability of on-line parenting resources. In addition access to education is regularly monitored for Māori, Pacific and teen parents and the uptake levels in all these groups is improving.

Please note, the birthing population is different to the general population as the demographic mix is changing with younger migrants. As demonstrated in the graph below, there continues to be gaps in access. It is intended that the revised programme will support reducing these gaps.

Table showing percentage of education participation alongside percentage of birthing population



Key Issues

Oral Health and Dental Therapy vacancies remain high due to the lack of success with recruiting new staff. This is an issue across New Zealand with many centres reporting difficulties filling vacancies. Retention of staff is an important continuing focus for ARDS. The dual scope of practice for Oral Health Therapists is requiring further exploration in regard to how ARDS can support the Oral Health Therapists to maintain their hygiene skills. Planning has commenced and an alternative recruitment process is being explored for the 2020 new graduates, with the aim of Auckland University of Technology and Otago University students choosing ARDS as their preferred employer and securing the recruits earlier.

Scorecard – Child, Women and Family Services

Waitemata DHB Monthly Performance Scorecard

Child Women and Family Services and Elective Surgical Centre
March 2019
2018/19

Health Targets

	Actual	Target		Trend	
Shorter Waits in ED	94%	95%	●		▼

Best Care

	Actual	Target		Trend	
Patient Experience					
Complaint Average Response Time	19 days	≤14 days	●		▼
Net Promoter Score FFT	80	65	●		▲
Improving Outcomes					
Exclusive breastfeeding on discharge	81%	75%	●		▲
Women smokefree at delivery	94%	95%	●		▼
Better help for smokers to quit - hospitalised	98%	95%	●		▼
a. Oral health - % infants enrolled by 1 year	72%	95%	●		▲
a. Oral health - exam arrears 0-12 yr	32%	≤10%	●		▼
Quality and Safety					
Good hand hygiene practice	90%	80%	●		▼
HR/Staff Experience					
Sick leave rate	3.6%	≤3.4%	●		--
Turnover rate - external	11%	≤14%	●		--
Vacancies - %	7%	≤8%	●		▼

Service Delivery

	Actual	Target		Trend	
Elective Volumes					
Provider Arm - Overall	99%	100%	●		▲
CWF Services	80%	100%	●		--
Waiting Times					
Gateway referrals waiting over 8 weeks	26	5	●		▲
Patient Flow					
Outpatient DNA rate	7%	≤10%	●		▲
Theatre utilisation Gynaecology	79%	85%	●		▼
Patients with EDS on discharge	91%	85%	●		▲
Oral Health - chair utilisation	11	11	●		▲

Value for Money

	Actual	Target		Trend	
Financial Result (YTD)					
Revenue	5,031 k	4,928 k	●		▼
Expense	68,552 k	68,285 k	●		▼
Net Surplus/Deficit	-63,521 k	-63,357 k	●		▼
Contracts (YTD)					
Gynaecology Elective WIES (excl ESC)	676	897	●		▲
Gynaecology Acute WIES	1,029	1,099	●		▲
Maternity WIES	5,677	5,897	●		▲
Paediatrics WIES	1,443	1,427	●		▼
Neonatal WIES	1,695	1,704	●		▼

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 not domicile

A question?

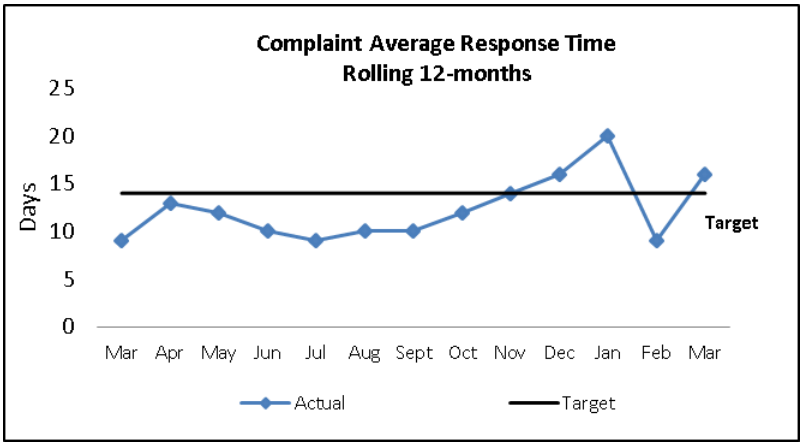
Contact:
Victora Child - **Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz**
Planning, Funding and Health Outcomes, Waitemata DHB

Scorecard Variance Report

Best Care

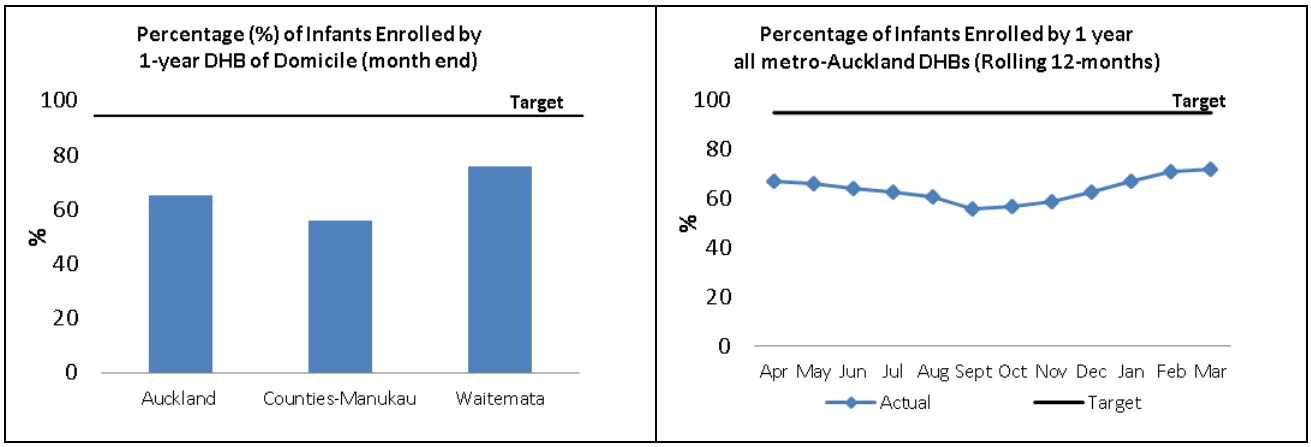
Complaint average response time *– 19 days against a target of ≤14 days*

The complaint average response time is back above target this month. This has occurred because we have had a number of complex complaints that required in depth investigation. Complainants were kept informed during this process.

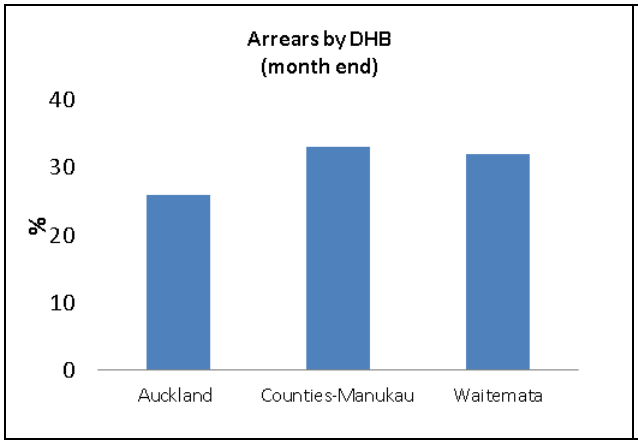


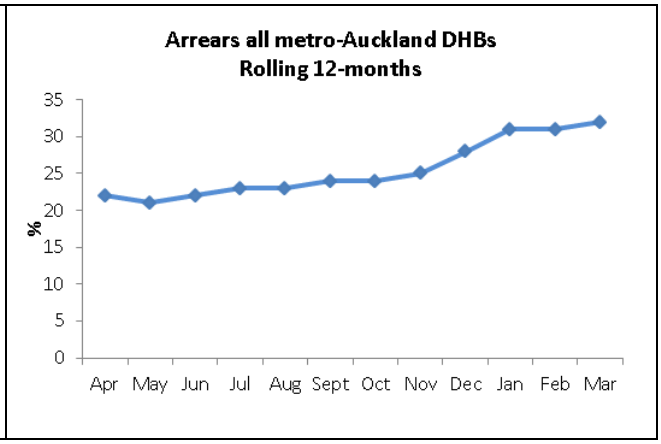
Oral health - % infants enrolled by one year *– 72% against a target of 95%*

There continues to be steady progress towards achieving the target.

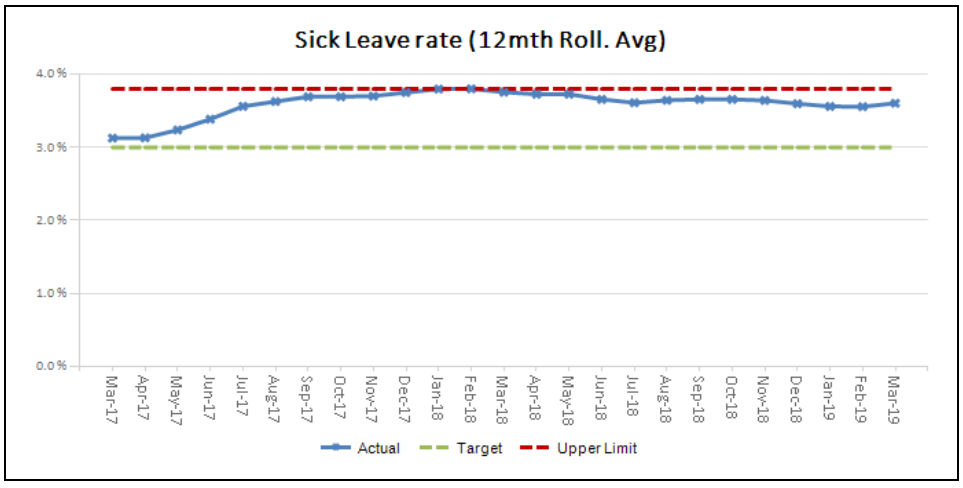


Oral health - exam arrears 0-12 years *– 32% against a target of ≤10%*
Arrears remain high at 32%. The factors that are impacting on current performance include on-going dental therapy vacancies (approximately 17 FTE) and changes in the way in which the service is managing children who have not been brought to appointments. That is, previously children who had not been brought to three appointments had their episode of care administratively completed. This practice has been stopped, as the service has introduced new processes to support engagement in the service. Between January and March 2018 there were 4,033 children were administratively completed. Over the same period this year 1,078 children have been administratively completed.



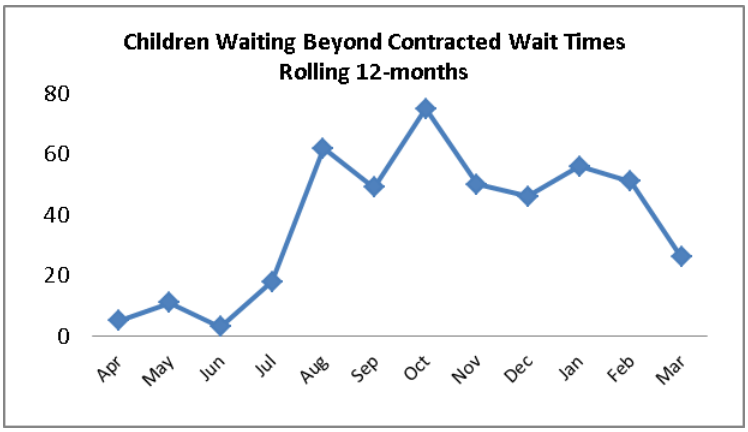


Sick leave rate *– 3.6% against a target of ≤3.4%*
The sick leave rate continues to be slightly above target in ARDS (3.9%) and Women's Health (3.7%).



Service Delivery
Elective Volumes *– 80% against a target of 100%*
Gynaecology has not achieved the target to date. As per our Provider Production Plan and agreed WIES annual target, Gynaecology electives are running at 90% YTD.

Gateway referrals waiting over 8 weeks – *26 against a target of 5*
There has been further improvement in the number of children waiting over eight weeks for a Gateway assessment.



Theatre Utilisation – *79% against a target of 85%*
This number excludes day of surgery cancellations which happens not infrequently in gynaecology (eight patients in March 2019) due to; patient unwell, failed to follow pre-operation instructions, DNA, etc. and this continues to affect the theatre utilisation figure above. When comparing the utilisation based on first patient ready to last patient out as a proportion of the scheduled theatre session time, the utilisation rate is currently 85%. The Service continue to monitor and strive to improve this figure.

Value for Money
Gynaecology Elective WIES *– 676 against a target of 897*
Gynaecology remains below elective target.

Gynaecology Acute WIES *– 1,029 against a target of 1,099*
Gynaecology acute WIES performance to date has been impacted by reduced acute demand over September (88% to target), October (88% to target) and January (82%). There has been improved performance over February (112% to target) and March (106% to target).

Strategic Initiatives Variance Report

Deliverable/Action	On Track
Support to Quit Smoking	
1. Employ a Midwife Smokefree Coordinator to improve the quality of ABC and smoking cessation support for pregnant women and their whanau – June 2019	✓
Child Wellbeing	
2. Fully implement the fluoride varnish programme for pre-schoolers – June 2019	✓
3. Trial a tool to identify unmet health needs in new entrants – June 2019	✓

Areas off track for month and remedial plans
All areas on track.

Financial Results - Child, Women and Family Services

Waitemata DHB Statement of Financial Performance

Child, Women and Family - March 2019

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	576	662	(86)	4,170	4,312	(142)	6,298
Other Income	187	155	32	860	616	245	893
Total Revenue	763	817	(54)	5,031	4,928	103	7,190
EXPENDITURE							
Personnel							
Medical	1,767	1,524	(243)	13,865	13,968	103	19,310
Nursing	2,496	2,302	(194)	22,724	21,784	(940)	30,164
Allied Health	2,193	2,365	172	18,321	19,614	1,293	27,328
Support	20	27	7	195	221	26	307
Management / Administration	349	388	38	3,293	3,484	191	4,776
Outsourced Personnel	114	109	(5)	1,322	980	(342)	1,306
	6,940	6,715	(226)	59,721	60,051	331	83,192
Other Expenditure							
Outsourced Services	46	47	1	396	421	24	561
Clinical Supplies	541	546	6	4,683	4,680	(3)	6,290
Infrastructure & Non-Clinical Supplies	423	331	(92)	3,753	3,134	(619)	4,176
	1,009	924	(85)	8,831	8,234	(597)	11,026
Total Expenditure	7,949	7,639	(311)	68,552	68,285	(267)	94,218
Cost Net of Other Revenue	**(7,187)**	**(6,822)**	**(365)**	**(63,521)**	**(63,357)**	**(164)**	**(87,028)**

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

Comment on major financial variances

The overall result for CWF was $365k unfavourable for March and $164k unfavourable for the YTD.

Revenue ($54k unfavourable for March, $103k favourable YTD)

The unfavourable variance for March was due to a recent MoH funding model change for Child Respite services. A shortfall in referrals along with a reduced bed day price is driving this result. The YTD favourable position was driven by back dated ACC claiming and new service level agreements being partially offset by reduced Colposcopy activity and MoH changes to the Respite funding model.

Expenditure ($311k unfavourable for March, $267k unfavourable YTD)

The unfavourable variance for March was due to a combination of junior doctor strike related cover costs, backdated allowance claims, midwifery staffing pressures and patient demand across the neonatal units. The YTD unfavourable position was driven by the above mentioned cost pressures along with patient supplies, cleaning, motor vehicle and facility repairs and maintenance. A partial mitigation of these costs has been through service wide vacancies.

Personnel ($331k favourable YTD)

Medical ($103k favourable YTD)

The favourable variance was due to multiple registrar vacancies with a reduction in the allocation of junior doctors to Obstetrics and Gynaecology. SMO vacancies also exist within Women's Health. The service continues to actively recruit to vacant positions. Elective Gynaecology activity has been impacted by staffing gaps with volume delivery at 76% of contracted volume to date.

Nursing ($940k unfavourable YTD)
The unfavourable variance was due primarily to increased demand in Maternity Services. Workforce shortages has made managing maternity rosters challenging. The current mixed midwife/nurse model and recent success in attracting new graduates has provided partial cost mitigation. Paediatric and Neonatal inpatient wards are also experiencing increased patient demand which is placing additional pressure on nursing budgets.

Allied Health ($1,293k favourable YTD)
The favourable variance was due to ongoing therapist, therapy assistant and health promotion vacancies across ARDS. Recent successes in attracting new graduates has been positive. Retention strategies are being implemented to retain core staffing.

Support and Management/Administration ($217k favourable YTD)
The favourable variance was due to service vacancies.

Outsourced Personnel ($342k unfavourable YTD)
The unfavourable variance was due to medical locum and external nursing cover for service vacancies.

Other Expenditure ($597k unfavourable YTD)

Infrastructure and Non-Clinical Supplies ($619k unfavourable YTD)
The unfavourable variance was due to a rise in motor vehicle repairs costs, maintenance of dental facilities, patient food and groceries, back dated cleaning and unbudgeted costs associated with new service level agreements that have a funding offset.

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, Maori and Pacifica 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.

The group is led by Dr Susanna Galea-Singer (Director and Head of Division) and Pam Lightbown (General Manager). The Head of Division Nursing is Alex Craig and the Clinical Directors are Dr Mike Ang for Adult, Dr Andrew Howie for Whitiki Maurea, Dr Jeremy Skipworth for Forensics, Dr Emma Schwartz for CADS, Dr Francis Agnew for Takanga A Fohe and Dr Mirsad Begic for Child, Youth and Family.

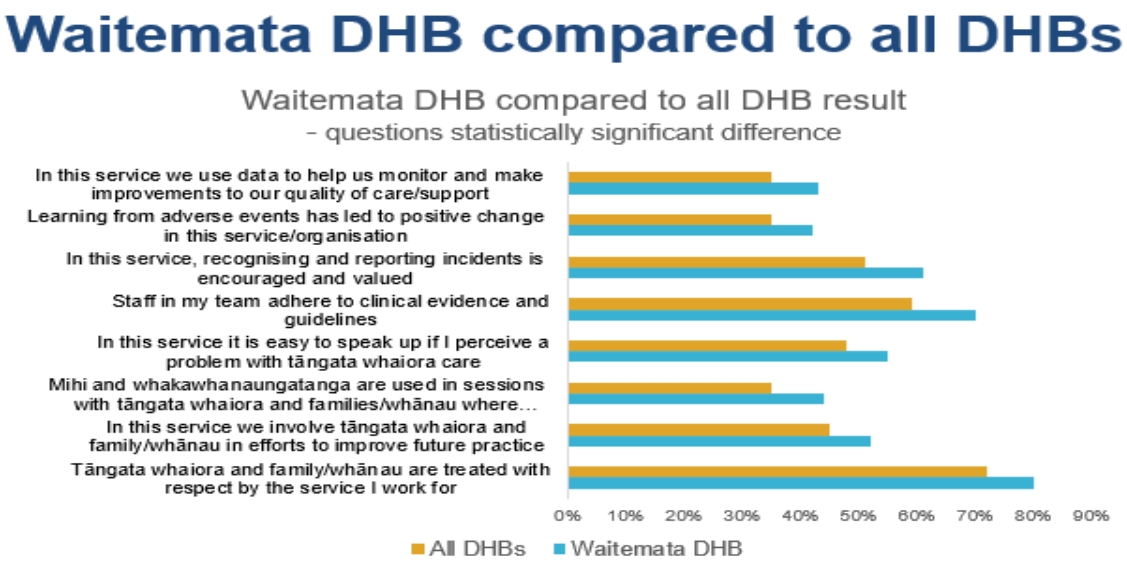
Highlight of the Month

Ngā Poutama Oranga Hinengaro – An HQSC Quality in Context Survey:

In August 2018 the Health Quality and Safety Commission (HSQC) conducted a national online survey of Mental Health and Addiction staff, as part of the five year mental health and addiction improvement programme. The purpose was to better understand the quality and safety culture of services as this is known to impact the experience of service users and whānau and the outcomes of care. The survey information was provided back to organisations to enable improvement initiative and organisational change. Further surveys are expected to monitor improvements over time.

Nationally 2,500 mental health and addiction workforce members were involved, with 224 Waitematā DHB Specialist Mental health and Addictions staff completing the survey. Waitematā DHB did not have any results that were statistically significantly below the national average. However, Waitematā DHB had results that were statistically significantly higher as identified in the table below.

Figure 1: Ngā Poutama 2018 - Questions rated statistically significantly more positively than the national DHB average



Some statistically differences were identified between Waitematā DHB community and inpatient ratings and between general mental health, addictions and forensic services. In particular forensic inpatient staff rated access to kaumātua, cultural advisors and cultural supervision more highly, adult and forensic inpatient staff rated the

use of te reo Māori more highly, and community staff rated access to supervision, coaching or mentoring more highly. Balancing these areas is being addressed as part of the SMHA Workforce Development Strategy.

Zero Seclusion

Zero Seclusion is a national quality improvement project supported by the Health Quality Safety Commission (HQSC), as one of five national projects being undertaken in a five year period. Both Adult Mental Health Services and Forensic Services have workgroups, which using co-design and Model for Improvement quality improvement methodologies. At the national Zero Seclusion project forum in Christchurch on May 8 2018, staff from Forensic and Adult Mental Health Services presented two story boards about the Waitematā plan and progress to date on seclusion elimination initiatives. The team was awarded best *Co-design and Consumer Participation* project.

Pictured L to R: Lesley Turner – Clinical Improvement Coordinator; Michelle Dawson – Adult Nurse Lead; Elly Weber – Clinical Nurse Specialist, Waiatarau; Mark Ashby – Operations Manager, Forensic Services; Hinerau Ruakere - Cultural Advisor, He Puna Waiora

The Adult Mental Health Services workgroups are currently testing three change ideas:
1. Enhancing the "welcome" people receive when being admitted (He Puna Waiora)
2. Involving whānau in the admission process (Waiatarau)
3. A lead RN position in ICU (Waiatarau)

Three further planned change ideas include:
1. Reducing glove use during non-contact admission activities (He Puna Waiora)
2. Developing an intervention protocol for high levels of agitation where synthetic or methamphetamine use is suspected (Waiatarau and He Puna Waiora)
3. Increasing sensory modulation use in high care (Waiatarau)

Forensic Services are also currently working on three change ideas:
1. Increasing the activities available after business hours
2. Increasing access to phones for service users
3. Increasing community access

Three further planned change ideas include:
1. In-services on de-escalation skills
2. Providing cold water throughout day
3. Longer trial periods out of seclusion

Four in-services have been provided to Forensic Services on the progress of the project and a further three are planned for across the services. An HSQC national learning workshop is being held in Christchurch on 8 May 2019 and five staff will attend. On track with regard to scope and progress.

Key Issues

It was with deep sadness that Waitematā DHB advised there were deaths of two patients by suicide in He Puna Waiora in less than a week. Subsequently, on 17 May, Waitematā DHB announced an independent review of the He Puna Waiora adult inpatient unit. The DHB has reached out to both families directly affected by these tragic events and offered its aroha and support.

Understandably, the families are seeking answers about how these deaths could occur in an inpatient unit. The DHB moved quickly to commission the review to ensure they receive timely answers and to ensure the unit is functioning to the highest of clinical standards. Interim Terms of Reference have been shared this with the families of both patients for their input and feedback.

The families have also been invited to be involved in the selection of consumer representation to the review panel. The review will examine how He Puna Waiora has been functioning clinically, the unit's governance and any factors relating to the facility itself.

Scorecard – Specialist Mental Health & Addiction Services

Waitemata DHB Monthly Performance Scorecard

Specialist Mental Health and Addiction Services
March 2019
2018/19

Health Targets

	Actual	Target	Trend
Shorter Waits in ED	79%	80%	▲

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	14 days	≤14 days	▼
Improving Outcomes			
Better help for smokers to quit	98%	95%	▲
Seclusion use Forensics - Episodes	19	≤14	▲
Seclusion use Adult - Episodes	6	≤5	▼
Adult Inpatient Unit AWOL (clients)	2	≤1	▼
Forensic Unit AWOL (clients)	0	≤1	--
c. CTO - Māori (Rate per 100,000)	*293*	*≤274*	
Therapeutic Observations - High Care/ICU	97%	95%	▼
a. MH Access Rates 0-19 years (Total)	*3.82%*	*3.49%*	▼
a. MH Access Rates 0-19 years (Māori)	*5.22%*	*4.70%*	▲
a. MH Access Rates 20-64 years (Total)	*3.62%*	*3.43%*	▲
a. MH Access Rates 20-64 years (Māori)	*8.73%*	*7.80%*	▲
HR/Staff Experience			
Sick leave rate	3.7%	≤3.4%	--
Turnover rate - external	12%	≤14%	--
Vacancies - %	8%	≤8%	--

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue	6,238 k	4,330 k	▲
Expense	102,548 k	99,475 k	▼
Net Surplus/Deficit	-96,310 k	-95,146 k	▼

Service Delivery

Waiting Times (latest available)	Actual	Target	Trend
a. Adult (20-64) <3 weeks	*83%*	*80%*	▼
a. CADS (0-19) <3 weeks	*91%*	*80%*	--
a. CADS (20-64) <3 weeks	*96%*	*80%*	--
CYF <3 weeks	100%	95%	--
a. Forensic (20-64) <3 weeks	*86%*	*90%*	▼
Prison inpatient waiting list	1	0	--
b. Patient Flow			
Bed Occupancy - Adult Acute	100%	80-90%	--
Bed Occupancy - CADS Detox	90%	80-90%	--
Bed Occupancy - Forensics Acute&Rehab	100%	80-90%	▼
Bed Occupancy - ID	85%	80-90%	--
Community Care			
Preadmission community care - adult	81%	75%	▼
Post discharge community care - adult	86%	90%	▲
Clinical contact directly with consumer - adult	87%	80%	▼
Clinical contact directly with consumer- CADS	91%	80%	--
Clinical contact directly with consumer - CYF	88%	80%	▼
Clinical contact directly with consumer - Forensic	79%	80%	▼
Whanau contacts per service user - adults	37%	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 (Jan data).
b. New rolling 3 month indicator and target
c. Quarterly data Sep 18

A question?

Contact:
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Planning, Funding and Health Outcomes, Waitemata DHB

Scorecard Variance Report

Best Care

Seclusion use Forensics – Episodes *– 19 against a target of ≤14*

The 19 events were attributable to eight service users in three units. The service continues monitoring with a 24 hour seclusion review in addition to the standard clinical reviews. Work also continues on the zero seclusion project.

Seclusion use Adult – Episodes *– 6 against a target of ≤5*

During this month, Adult Services experienced a higher use of seclusion across both units. This was coupled with increased bed occupancy.

Adult Inpatient Unit AWOL (clients) *– 2 against a target of ≤1*

In March there were two AWOLs from Waiatarau. Both service users were returned to the unit.

Community Treatment Orders (CTO) Māori – *293 against a target of ≤274*

The target in the scorecard represents a year-end target. A project group is currently working with the Māori health gain team to evaluate and reduce the application of CTOs with Māori.

Sick leave rate *– 3.7% against a target of ≤3.4%*

SMHA continue to work at reducing this including on-going including having discussions and developing management plans with staff with low sick leave balances and general reminder to all staff on importance of maintaining adequate sick leave balances and supports that are available (e.g. Employee Assistance Programme and Occupational Health).

Service Delivery

Prison Inpatient Waiting List *– 1 against a target of 0*

In March 2019 there was one individual on the Prison Inpatient Waiting List who waited more than six weeks. The individual's prolonged wait for admission reflects the on-going imbalance between acute forensic psychiatry inpatient beds and the acute mental health needs of the prisoners in the Northern region. They were identified as in need of compulsory inpatient assessment and treatment under the Mental Health Act but the admission was repeatedly deferred for other prisoners whose acute health care needs were judged as greater at the time.

Bed Occupancy - Adult Acute *– 100% against a target of 80-90%*

Since March 2019, the Adult in-patient units have experienced 85% occupancy twice, lasting only a few days at a time. This is the first time the target has been reached in over three years. However, it is not being sustained for longer periods. The benefits have been significant over the two brief periods with improvements in the quality of care for people both in the in-patient units and in the community. Staff have reported that their ability to spend time with people and their whanau and provide a better quality of service has been significant during these brief periods of 85% occupancy. The in-patient units continue bed management meetings several times daily, as well as liaising with non-government organisation partners for beds available in the community as acute alternatives or least restrictive option along with continuous review of efficiency within the service.

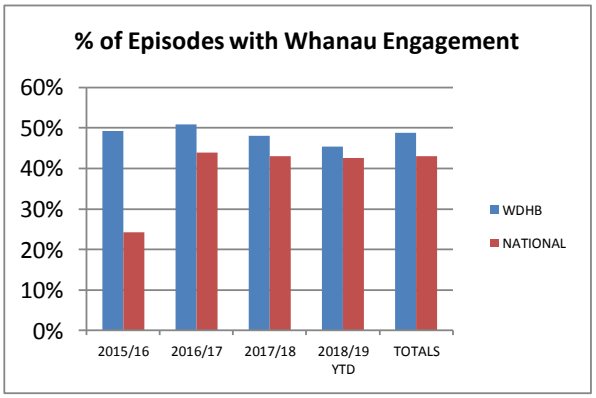
Bed Occupancy – Forensics Acute and Rehabilitation *– 100% against a target of 80-90%*

The Mason Clinic has experienced high demand across the service in the last reporting period: medium secure Intellectual Disability and Mental Health units have regularly been over numbers, and minimum secure units are at capacity. The Service is working hard to get back to a more manageable inpatient volumes, but a lack of community discharge options for example Step Down beds and high prison acuity are presenting barriers to this.

Whanau contacts per service user – adult *– 37% against a target of 70%*

Contact with Whanau is the National key performance indicator (KPI) focus for 2019. The National group have indicated that there is likely to be adjustments to how this KPI is measured. Currently it is only face to face contacts with the client present. However, family are often contacted via phone due to difficulty attending

appointments because they work. These occasions are not captured in the KPI. The Nation KPI data provides the following examples in relation to where Waitematā DHB is against national average;



Strategic Initiatives Variance Report

Deliverable/Action	On Track
Participate in the Health Quality and Safety Commission Project (HQSC)	
1. Participate in the HQSC project commencing June 2018 with the aim to improve service transitions to primary care through ensuring 95% of transition plans/discharge letters contain a follow-up plan (with a copy sent to the person concerned); this activity is supported across all services, including kaupapa Māori and Pacific mental health addiction services (EOA) – June 2019.	✓
2. Participate in the HQSC project commencing March 2019 that aims 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) – June 2019.	✓
3. Minimise restrictive care through engagement in HQSC Zero Seclusion project activities, with the aspirational goal of eliminating seclusion in inpatient units and a focus on the regional forensic services, which has a high prevalence of Māori patients (EOA) – June 2019.	✓
Supporting Parents Healthy Children	
4. Implement adequate systems to identify parents across all services - June 2019.	

Areas off track for month and remedial plans
All areas on track.

Financial Results – Specialist Mental Health & Addictions Services

Waitemata DHB Statement of Financial Performance

Specialist Mental Health and Addiction - March 2019

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	661	291	371	3,975	2,616	1,359	3,488
Other Income	262	209	54	2,263	1,714	549	2,287
Total Revenue	924	499	424	6,238	4,330	1,909	5,775
EXPENDITURE							
Personnel							
Medical	2,321	2,257	(64)	20,489	20,918	429	29,002
Nursing	4,928	4,462	(466)	45,267	43,151	(2,116)	59,652
Allied Health	2,430	2,495	65	22,303	22,827	524	31,302
Support	122	141	19	1,134	1,190	56	1,626
Management / Administration	461	468	7	4,335	4,323	(12)	5,900
Outsourced Personnel	295	98	(197)	2,367	903	(1,464)	1,191
	10,557	9,921	(636)	95,895	93,312	(2,583)	128,673
Other Expenditure							
Outsourced Services	20	7	(13)	141	56	(85)	77
Clinical Supplies	88	136	48	807	1,225	418	1,635
Infrastructure & Non-Clinical Supplies	627	534	(93)	5,705	4,882	(823)	6,484
	735	677	(58)	6,653	6,164	(490)	8,196
Total Expenditure	11,292	10,598	(693)	102,548	99,475	(3,072)	136,869
Cost Net of Other Revenue	**(10,368)**	**(10,099)**	**(269)**	**(96,310)**	**(95,146)**	**(1,164)**	**(131,094)**

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

Comment on major financial variances

The overall result for SMHA was $269k unfavourable for March and $1,164k unfavourable for the YTD.

Revenue ($424k favourable for March, $1,909k favourable YTD)

The favourable variance for March was due to recognising three months (January-March) of revenue for a new contract for a high acuity intellectually disabled patient in the process of being signed by the Funder and the MoH, as well as revenue recognised in March for two other patients with contracts already in place. The YTD variance was due to these intellectual disability variation contracts worth $1,197k, as well as court billing revenue volumes being higher than forecasted worth $268k. The Incredible Years contract in Child and Youth is worth $135k YTD, and the University of Auckland revenue received for our doctors providing teaching services is worth $107k YTD.

Expenditure ($693k unfavourable for March, $3,072k unfavourable YTD)

The unfavourable variances for March was partly due to strike costs, but also there were variances in March and YTD due to the use of locums to cover medical vacancies, and nursing overtime to cover nursing vacancies and patient acuity which are paid at a premium.

Personnel ($2,583k unfavourable YTD)

Medical ($429k favourable YTD)

The favourable variance was due to vacancies, 10.1 FTE in March and an average of 9.1 FTE YTD.

Nursing ($2,116k unfavourable YTD)

The unfavourable variance was due to 72.5 FTE nursing vacancies in March and an average of 91.9 FTE YTD, valued at $970k. This was offset by overtime ($1,361k) and casual spend ($306k), as well as pricing including allowances ($706k).

Allied Health ($524k favourable YTD)
The favourable variance was due to 47.4 FTE Allied vacancies in March, and 51.4 FTE YTD, valued at $184k, as well as pricing including allowances of $185k.

Outsourced Personnel ($1,464k unfavourable YTD)
The unfavourable variance was due to the use of locums to cover medical vacancies for 4.2 FTE in March, and 1 FTE to help cover the acute caseload in Rodney, paid at a 30% premium ($1,239k). The variance was also due to an increase in court reports being outsourced due to volume increases ($240k).

Other Expenditure ($490k unfavourable YTD)
Outsourced Services ($85k unfavourable YTD)
The unfavourable variance was due to clinical and research services provided by Auckland University of Technology.

Clinical Supplies ($418k favourable YTD)
This favourable variance was due to underspend in the mental health flexifunds worth $296k including forensics worth $186k.

Infrastructure and Non-Clinical Supplies ($823k unfavourable YTD)
The unfavourable variance was due to unallocated savings ($457k), maintenance ($102k) and the Health and Quality Safety Commission regional programme ($117k).

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. ICU and radiology services are with this service. The service is managed by Dr Michael Rodgers (Chief of Surgery), Debbie Eastwood (General Manager) and Kate Gilmour (Associate Director of Nursing).

The Elective Surgery Centre provides elective surgical services to our community, managed by Dr Bill Farrington (Clinical Director). Currently the ESC Operations Manager role is vacant.

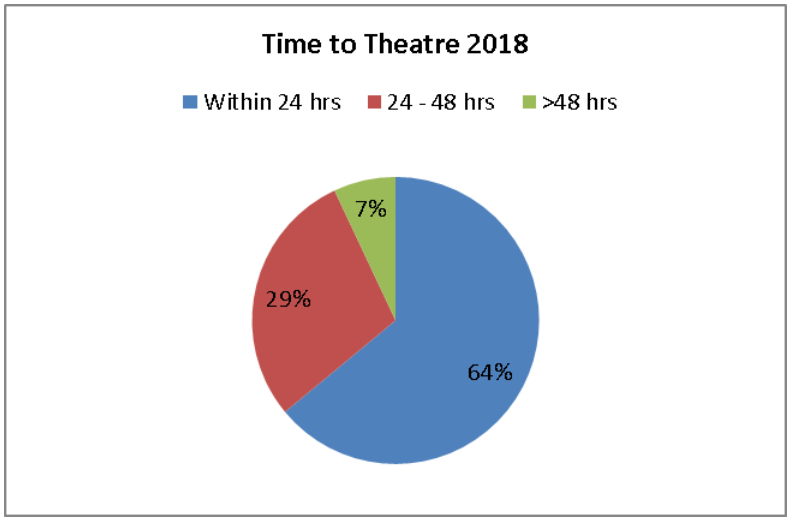
Highlight of the Month

Orthogeriatrician Update

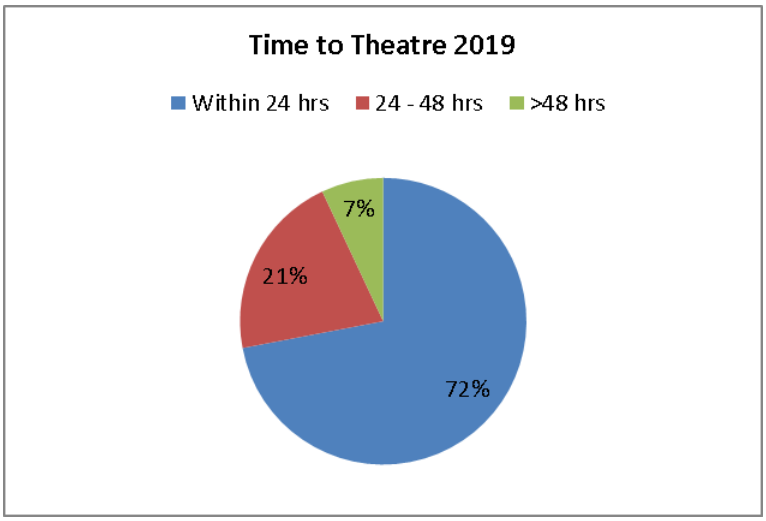
In January 2018, an orthogeriatrician model of care was implemented at NSH. The model of care involved the appointment of an orthogeriatrician, Dr Min Yee Seow. Dr Seow has provided specialist orthogeriatrician services in the orthopaedic wards in a shared care model with the orthopaedic surgery team for hip fracture patients. Dr Seow's clinical focus primarily is in the pre-operative optimisation of the patient in preparation for surgery and then she takes a lead in the post-operative medical care and coordinates the discharge planning process. Implicit in this role are many of the aspects of basic care including nutrition, hydration, pressure care, bowel and bladder management and monitoring of cognition. One of the key metrics for this cohort of patients that impacts on their outcome is time to surgery, the following is an update on progress since implementing this model of care. The service has a comprehensive Fractured Neck of Femur Performance Dashboard with a number of other key measures like acute readmissions, mortality, LOS.

Time to surgery for neck of femur fracture

In the 2018 calendar year, 387 neck of femur fracture patients presented to Waitematā DHB of which 64% received their surgery within 24 hours. As per Australia and New Zealand hip fracture registry, delayed time to surgery is considered to be > 48 hours. The time to surgery at less than 48 hours for 2018 was 93% for this cohort of patients.



For the first quarter of 2019 (January – April), there were 100 neck of femur fracture patients that presented to Waitematā DHB of which for patients were non-operative and 72% received surgery within 24 hours. Time to surgery for less than 48 hours was maintained at 93% the same level as for last calendar year. Pleasingly, our performance for surgery within 24 hours has improved from 64% in 2018 to 72% YTD 2019.



This model of care has demonstrated many of the benefits identified in the original business case and we need to work on developing the model of care further in to ensure it is sustainable from a resource perspective.

Key Issues

Support and developing theatre culture

The Chief of Surgery and the Associate Director of Nursing (S&A) are working closely with North Shore Theatre leadership team on a number of work streams to improve the culture and wellbeing of the staff. One important component of this work is to bring together the wider theatre team (anaesthetics, surgeon, clinical support) and provide dedicated time for multidisciplinary staff education/teaching. The theatre leadership team after consultation with the services, agreed that setting aside a Friday morning every 5th week where elective lists will not run, will enable all staff to engage in educational opportunities. This time will also be used for our theatre simulation training which can be run over a half day and has to date been led by one of our senior anaesthetists. The opportunity for staff to come together will provide both time for structured education, but also encourage more interaction between professional groups and support building a multidisciplinary team culture.

The first education session was run on 12 April and below is a snap shot of the outline of the session.

- Multidisciplinary staff session
- Nursing and HCA staff session
- Time allocated to roll out new policies and/or practice (count policy, nurse assist)
- Specialty-based training

As noted above we will also incorporate simulation training. The education session will be evaluated after we have held six sessions. However, there will also be an informal review after each session to look at opportunities to improve the sessions and learning experience for staff and to gauge the impact on staff morale.

Scorecard - Surgical and Ambulatory and Elective Surgical Centre

Waitematā DHB Monthly Performance Scorecard

Surgical and Ambulatory Service / Elective Surgery Centre
March 2019
2018/19

Health Targets

	Actual	Target		Trend	
Shorter Waits in ED	94%	95%	●		▼

Best Care

	Actual	Target		Trend	
Patient Experience					
Complaint Average Response Time	8 days	≤14 days	●		--
b. Complaint Average Response Time - ESC	*7 days*	*≤14 days*	●		
Net Promoter Score FFT - S&A	75	65	●		▼
Improving Outcomes					
Better help for smokers to quit - hospitalised	99%	95%	●		--
a. #NOF patients to theatre w/in 48 hrs	100%	85%	●		▲
Skin Abscess - median LOS hrs	33	≤24	●		▼
Laproscopic Cholecystectomy - median LOS hrs	118	≤48	●		▼
Laparoscopic Appendicectomy - median LOS hrs	47	≤36	●		▲
Quality & Safety					
Older patients assessed for falling risk	92%	90%	●		▲
Occasions insertion bundle used	100%	95%	●		--
Good hand hygiene practice	90%	80%	●		▲
ICU - rate of CLAB per 1000 line days	0.68	≤1	●		--
HR/Staff Experience					
Sick leave rate	3%	≤3.4%	●		--
Sick leave rate - ESC	4.8%	≤3.4%	●		--
Turnover rate - external	10%	≤14%	●		--
Turnover rate ESC - external	9%	≤14%	●		--
Vacancies - %	7%	≤8%	●		--

Service Delivery

	Actual	Target		Trend	
Elective Volumes					
Provider Arm - Overall	99%	100%	●		▲
Surgical and Ambulatory Services	86%	100%	●		▲
Elective Surgical Centre - ESC (YTD)	94%	100%	●		▲
Elective Surgical Centre - ESC (month)	101%	100%	●		▲
Waiting Times					
% of CT scans done within 6 weeks	71%	95%	●		▲
% of MRI scans done within 6 weeks	70%	90%	●		--
% of US scans done within 6 weeks	93%	75%	●		▲
Patient Flow					
Outpatient DNA rate (S&A)	7%	≤10%	●		--
Theatre utilisation - NSH	88%	85%	●		▲
Theatre utilisation - WTH	85%	85%	●		▲
Theatre utilisation - ESC	89%	85%	●		▲
Patients with EDS on discharge	89%	85%	●		▼

Value for Money

	Actual	Target		Trend	
Financial Result (YTD)					
Revenue	6,967 k	6,156 k	●		▼
Expense	152,271 k	151,423 k	●		▼
Net Surplus/Deficit	-145,304 k	-145,267 k	●		▼
Contracts (YTD)					
Elective WIES Volumes - S&A	5,208	6,475	●		▲
Elective WIES Volumes - ESC	4,624	4,932	●		▲
Acute WIES Volumes - S&A	10,995	11,511	●		▼

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. Mar 19, coding dependent
b. Sep 17 data - no complaints since

A question?

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

Scorecard Variance Report

Best Care – these are stretch clinical targets

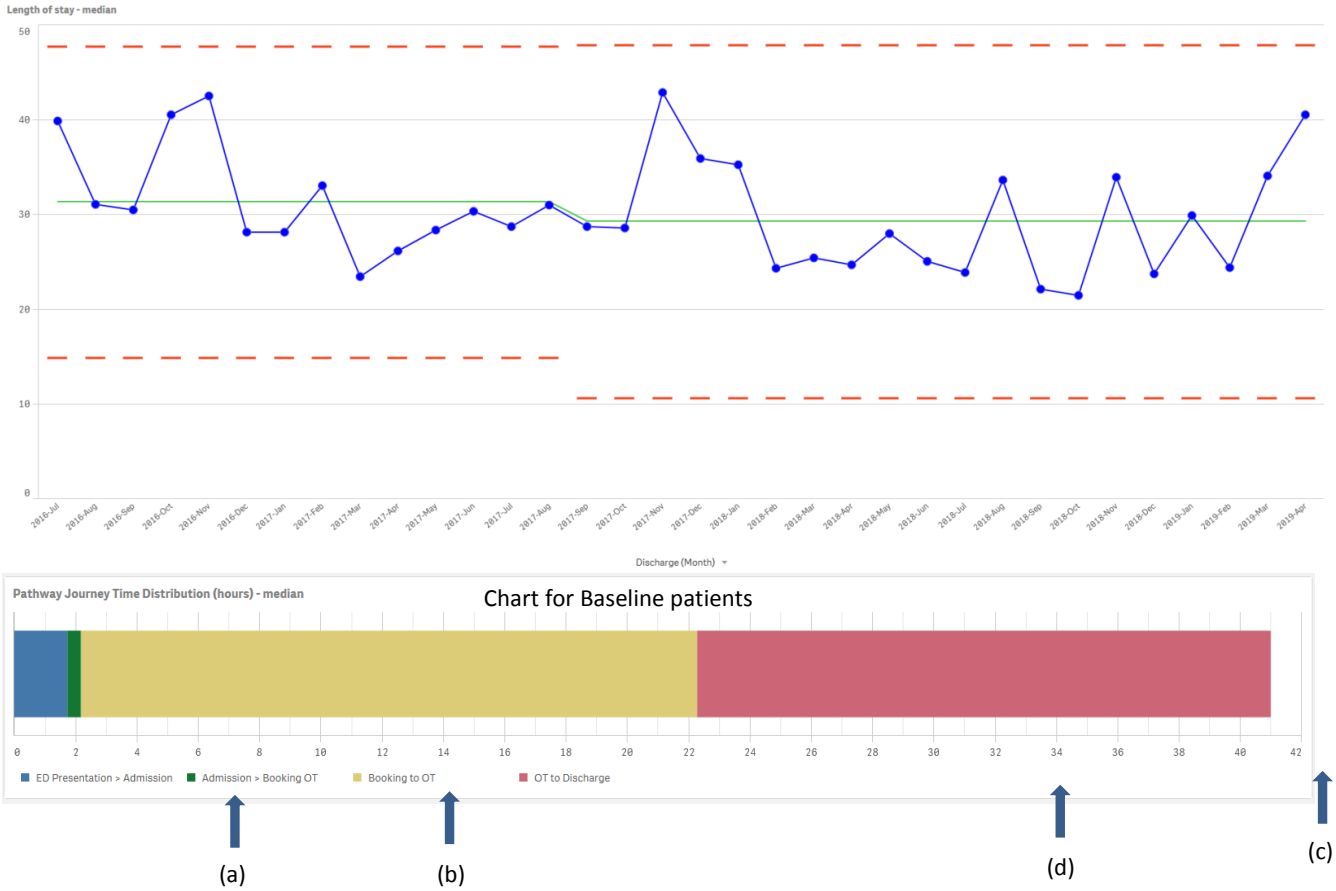
Skin Abscess Median LOS *- 33 hours against a target of ≤24 hours*

Laparoscopic Cholecystectomy Median LOS *- 118 hours against a target of ≤48 hours*

Laparoscopic Appendicectomy Median LOS *- 47 hours against a target of ≤36 hours*

a) Abscess Pathway: abscess drainage for acute American Society of Anaesthesiologists (ASA) 1 and 2 (low risk) patients

Aim: LOS ≤ 24 hours



(i) Baseline patients (between 2 April 2019 to 3 May 2019): patients with an acute abscess treated via traditional pathway, Median LOS = 40.1 hours

(ii) Abscess Pathway (Minor Procedures List in the Procedure Room): a total of 16 abscess patients have had surgery via Minor Procedures List between 2 April 2019 to 3 May 2019 (these include the seven inpatients, five acute arranged patients and four fast track patients). Median LOS = 24 hours

a. Five patients treated via the abscess pathway (Minor Procedures List) were treated as *acute arranged (seen in ED, discharged home and returned for daycase surgery)*. Median LOS = 7 hours

b. Four patients treated via the abscess pathway (Minor Procedures List) were treated as *fast track* patients (surgery on day of admission). Median LOS = 14 hours

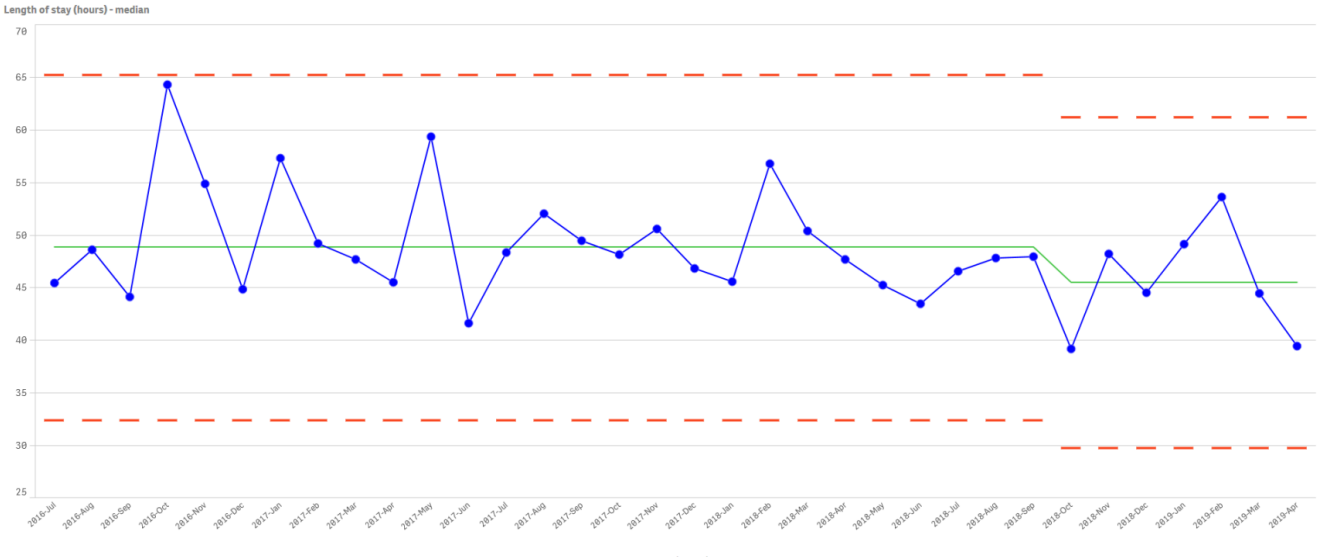
c. Seven patients treated via the abscess pathway (Minor Procedures List) were treated as *procedure room inpatients (admitted as inpatients, surgery done in procedure room)*. Median LOS = 43 hours

d. Overall, all acute ASA 1 & 2 patients for abscess drainage had a Median LOS of 34 hours when filtered for April 2019.

Comments:

- The general surgery team is currently unable to reliably access the Procedure Room due to limited availability (lists available two days per week only and unable to staff room), which can lead to reluctance to book patients on the Procedure Room List. Comments from surgical registrars include:
  - *"List always starts late when it is available"*
  - *"If we send patients home as acute arranged there is no guarantee the list is available"*
- Minor procedures lists were cancelled during Easter and ANZAC day period.
- Work is in progress to look at staffing lists with agency nurses while undertaking modelling of theatre flow and use to identify how the Procedure Room could be run five days per week.
- Further work is being undertaken with surgical clinicians to book suitable patients as acute arranged than to admit as overnight inpatients

b) Appendicitis Pathway for acute ASA 1 and 2 (low risk) patients. Aim: LOS ≤ 36 hours

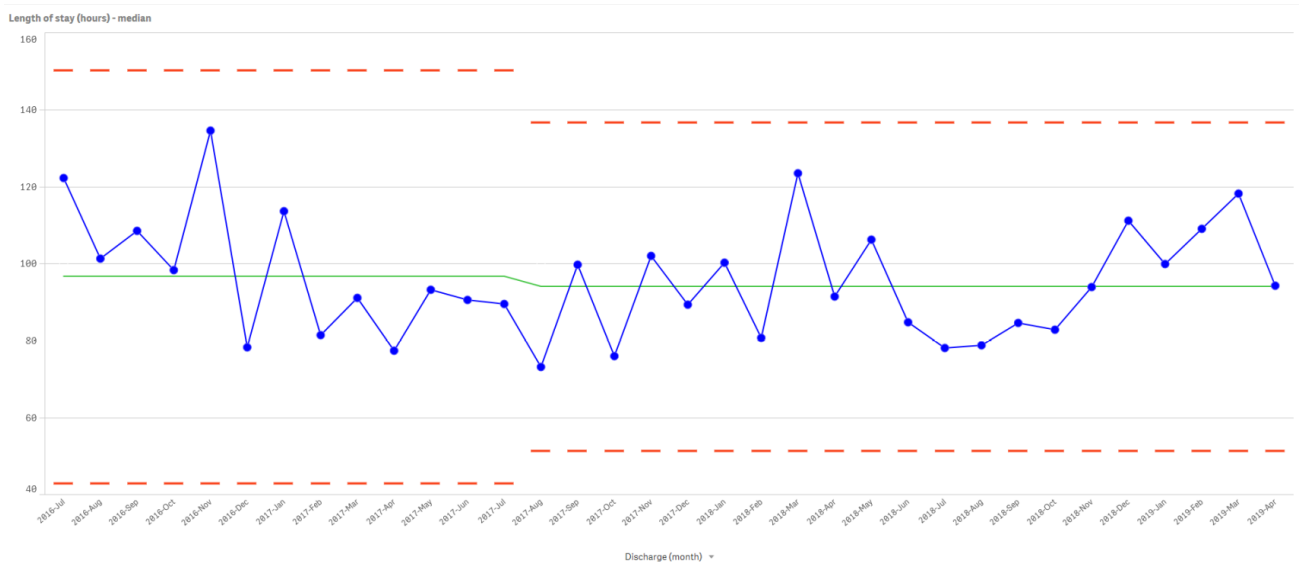


Median LOS for ASA 1 and 2 patients along appendicitis pathway during April 2019 is **35.4** hours

Comments:

- Improvement work currently is centred in sustaining criteria led discharges.
- Electronic work certificate is in development with minor changes currently in progress.
- Planning in progress to initiate criteria led discharge training competency testing for nurses using the Awhina online learning platform.
- Planned discussions with nurse educators on how to embed training for criteria led discharge at nursing induction for all surgical nurses.

c) Cholecystitis (inflamed gallbladder) Pathway for acute ASA 1 and 2 (low risk) patients
Aim: LOS ≤ 48 hours



Median LOS for ASA 1 and 2 patients on the cholecystitis pathway during April 2019 is **83.2** hours

Comments:

- Cholecystitis bedside 'point of care' ultrasound scan project has gone live with bedside scanning occurring in ED. ED consultants and surgeons (consultants and registrars) have undergone training and are performing the scanning. We are currently evaluating data to understand specificity, sensitivity and diagnostic accuracy (compared to scanning being undertaken by a sonographer and reporting by a radiologist). If comparable specificity, sensitivity and diagnostic accuracy is achieved, the project will progress to phase two with patients with a positive diagnosis of gallstones proceeding to theatre (not going to radiology for a scan).
- The service is exploring acute arranged laparoscopic cholecystectomy lists by redistribution of theatre lists.

Sick leave rate - ESC - *4.8% against a target of ≤3.4%*
Human Resources and the Charge Nurse Manager of Cullen Ward have held sick leave review meetings with four staff who have high sick leave.

Service Delivery
S&A *- 86% against a target of 100%*
ESC YTD *- 94% against a target of 100%*

Percentage against target	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 18	Feb 18	Mar 18
S&A Volumes (YTD)	80%	76%	76%	80%	83%	86%	86%	85%	86%
ESC Volumes (Month)	85%	92%	83%	98%	97%	76%	98%	96%	100%
ESC Volumes (YTD)	85%	90%	88%	91%	93%	91%	92%	92%	94%

As noted in the table above we are seeing a steady improvement in the YTD performance for ESC with 100% being achieved in March. The overall YTD S&A volumes are steady. However, the winter impact continues to be a challenge to mitigate along with the reduction in elective orthopaedic lists to manage acute demand, SMO vacancy/unplanned leave and the impact of continuing industrial action.

% of CT scans done within six weeks *- 71% against a target of 95%*
CT continued to improve from the 66% of the previous month. Demand however remains high and it is difficult to reduce the waitlist sufficiently to achieve compliance. The third scanner at NSH is on target to be delivered by 28 June.

% of MRI scans done within six weeks *- 70% against a target of 90%*
MRI stabilised somewhat this month. Outsourcing increased and staffing also improved slightly. This together with increased outsourcing should see a continued improvement over the next months.

Value for Money
Elective WIES Volumes – S&A *- 5208 against a target of 6475*
Elective WIES Volumes – ESC *- 4624 against a target of 4932*

Specialty	Actual (March)	Contract (March)	Variance (March)	Actual (YTD)	Contract (YTD)	Variance (YTD)
Orthopaedic	501	495	6	4769	5134	(365)
ORL	82	104	(22)	912	1110	(198)
Urology	102	106	(4)	939	1126	(187)
General Surgery	362	445	(83)	4332	4718	(386)
TOTAL	**1047**	**1150**	**(103)**	**10952**	**12088**	**(1136)**

There are a number of contributing factors that have impacted on the elective program and the shortfall in actual WIES performance against target:
- NZNO strike
- Continuing RDA strikes,
- Acute winter workload,
- Surgeon resignations,
- Surgeon availability/locums,
- Surgeon illness/special leave/sabbatical,
- Acute volumes impacting on electives,
- Mix of elective cases due to the factors above.

However, the Service is continuing to work in line with the production plan and is trying to mitigate the impact of these factors going forward.

Strategic Initiatives Variance Report

Deliverable/Action	On Track
Access to Elective Services	
1. Implement perioperative nurse-led coordination and management of all procedure/theatre bookings for Elective Services, including improved coordination of patient flow with clinical guidance and oversight. This will include management of high acuity, high complexity patients, in support of better access to earlier intervention for Maori and Pacific populations (EOA) – June 2019	✖

Areas off track for month and remedial plans
1. We have recruited three Perioperative nurse coordinator (PNC) leads for Orthopaedics, Urology and ORL and the PNC lead for Gynaecology will be commencing in late February. As part of the team recruitment has commenced for PNCs who will work closely with the PNC leads and the booking clerks to achieve the objectives noted for this strategic initiative. It is anticipate the majority of the roles for both PNC leads and PNCs to be in place and largely orientated to the role by the end of April/May. Whilst supporting the management of high acuity and high complexity patients is underway and a core component of the role, more work needs to be done to provide of better access to earlier intervention for Maori and Pacific populations.

Financial Results - Surgical and Ambulatory and Elective Surgical Centre Combined

Waitemata DHB Statement of Financial Performance

S&A/ESC - March 2019

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	738	625	113	6,397	5,568	829	7,443
Other Income	37	81	(45)	570	588	(18)	831
Total Revenue	774	706	68	6,967	6,156	811	8,274
EXPENDITURE							
Personnel							
Medical	5,439	5,418	(20)	49,285	48,632	(653)	68,050
Nursing	3,863	3,702	(161)	34,728	34,970	241	48,812
Allied Health	1,381	1,258	(123)	11,669	11,398	(271)	15,793
Support	177	214	38	1,777	1,966	189	2,701
Management / Administration	498	525	26	4,741	4,712	(29)	6,508
Outsourced Personnel	704	584	(120)	5,598	5,278	(320)	6,954
	12,062	11,702	(360)	107,798	106,955	(843)	148,819
Other Expenditure							
Outsourced Services	663	671	9	5,333	5,665	332	7,588
Clinical Supplies	4,166	4,184	19	35,582	35,563	(19)	48,282
Infrastructure & Non-Clinical Supplies	413	351	(62)	3,558	3,239	(319)	4,298
	5,242	5,207	(35)	44,473	44,468	(5)	60,167
Total Expenditure	17,304	16,909	(394)	152,271	151,423	(848)	208,986
Cost Net of Other Revenue	**(16,529)**	**(16,203)**	**(326)**	**(145,304)**	**(145,267)**	**(37)**	**(200,712)**

* 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 $326k unfavourable for March and $37k unfavourable for the YTD.

S&A continues to track close to budget YTD. Overall the service has benefited financially from additional revenue from orthopaedic ACC cases and SLA income from other DHBs. On the cost side, lower volumes due to the impact of industrial action and acute bed encroachment from medical services earlier in the year as well as lower than planned production has had a positive impact on personnel costs and clinical supply costs. Offsetting these benefits there were additional costs incurred with over-allocations of registrars, locums to cover vacancies, skin lesion outsourcing and unplanned repairs and maintenance costs. There are also unbudgeted outsourced costs to meet Interventional Radiology demands that exceed internal capacity.

ESC was favourable YTD. This was driven by lower than budgeted package of care costs as a result of favourable volume, price and case mix impacts as well as the additional week of closure over the Christmas period.

Refer to below commentary for a detailed overview for S&A and ESC performance against budget.

Surgical and Ambulatory – S&A

Waitemata DHB Statement of Financial Performance

S&A - March 2019

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	738	625	113	6,397	5,568	829	7,443
Other Income	37	81	(45)	570	588	(18)	831
Total Revenue	774	706	68	6,967	6,156	811	8,274
EXPENDITURE							
Personnel							
Medical	5,436	5,416	(20)	49,263	48,615	(649)	68,026
Nursing	3,372	3,232	(141)	30,432	30,592	159	42,724
Allied Health	1,381	1,258	(123)	11,669	11,395	(274)	15,789
Support	171	206	35	1,711	1,898	186	2,606
Management / Administration	485	510	25	4,618	4,579	(39)	6,326
Outsourced Personnel	(157)	(277)	(119)	(1,588)	(2,187)	(600)	(2,967)
	10,688	10,345	(343)	96,106	94,891	(1,215)	132,502
Other Expenditure							
Outsourced Services	645	652	7	5,131	5,491	360	7,356
Clinical Supplies	3,208	3,212	4	27,925	27,910	(15)	37,847
Infrastructure & Non-Clinical Supplies	318	268	(50)	2,893	2,491	(402)	3,297
	4,171	4,131	(39)	35,949	35,892	(57)	48,500
Total Expenditure	14,859	14,476	(383)	132,055	130,783	(1,272)	181,002
Cost Net of Other Revenue	**(14,085)**	**(13,770)**	**(315)**	**(125,088)**	**(124,627)**	**(461)**	**(172,728)**

* 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 was $315k unfavourable for March and $461k unfavourable for the YTD.

Revenue ($68k favourable for March, $811k favourable YTD)

The favourable variance for March was due to the unbudgeted revenue streams from services provided to other DHBs. The YTD favourable variance was made up of $262k upside in ACC revenue with another significant benefit of $298k for the provision of theatres and staff to Auckland DHB Ophthalmology and Auckland DHB Dental at WTH. The balance was due to the additional service level agreement revenue from other DHBs.

Expenditure ($383k unfavourable for March, $1,272k unfavourable YTD)

The result for March was above budget in the key personnel categories but other expenditure was in line with budget. The YTD unfavourable variance was due to RMO costs and the use of outsourced personnel offset by the timing of Radiology outsourcing and vacancies in Nursing.

Personnel ($1,215k unfavourable YTD)

Medical ($649k unfavourable YTD)

The unfavourable variance was due to higher than budget RMO mix in the current run as well as the RMO over-allocations in General Surgery, and in ICU for the first six months. There were higher than budgeted SMO costs in Orthopaedics and General Surgery which were partly offset by vacancies in ORL, Anaesthesia and Radiology. The NZRDA strikes in January and February were of limited financial impact in S&A.

Nursing ($159k favourable YTD)

The favourable variance was due in part to the NZNO strike in July. Ongoing vacancies for senior nurses and registered nurses have created a positive variance which was partially offset by increased costs in enrolled nurses

$178k and internal bureau nurses, $715k. Ongoing difficulty in recruiting to HCA vacancies across the surgical wards has contributed $522k to the positive variance.

Allied Health ($274k unfavourable YTD)
The unfavourable variance continued due to budgeted leave and vacancy impacts not occurring.

Support and Management/Administration ($147k favourable YTD)
The favourable variance was due to vacancies in Sterile Supply for which recruitment is an ongoing issue.

Outsourced Personnel ($600k unfavourable YTD)
The unfavourable variance was due to the lower than budgeted SMO package of care recharges from S&A to ESC arising from lower elective volumes as well as additional locum costs to cover off vacancies in Surgical Services and Anaesthesia. External bureau nurse expenditure in theatres and wards to cover vacancies, unplanned leave and sick leave also contributed to the unfavourable variance.

Other Expenditure ($57k unfavourable YTD)
Outsourced Services ($360k favourable YTD)
The favourable variance continued to come from Radiology due to the timing of outsourcing volumes of CT scans ($267k), ultrasound ($150k) and MRI ($289k). This was partly offset by unbudgeted Interventional Radiology outsourced costs of $250k. The demand for outsourced skin lesion surgeries continued to be higher than expected and the cost partially offset the favourable Radiology variance.

Infrastructure and Non-Clinical Supplies ($402 unfavourable YTD)
The YTD variance was due to unrealised expenditure reduction initiatives.

Elective Surgical Centre - ESC

Waitemata DHB Statement of Financial Performance

ESC - March 2019

($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							
Total Revenue	0	0	0	0	0	0	(0)
EXPENDITURE							
Personnel							
Medical	2	2	(0)	22	18	(4)	25
Nursing	490	470	(20)	4,296	4,378	82	6,089
Allied Health	0	0	0	0	3	3	4
Support	6	9	3	66	68	3	95
Management / Administration	14	15	1	123	133	10	182
Outsourced Personnel	862	861	(1)	7,186	7,465	279	9,922
	1,374	1,357	(16)	11,692	12,064	372	16,317
Other Expenditure							
Outsourced Services	18	19	2	202	174	(28)	232
Clinical Supplies	958	973	15	7,657	7,654	(3)	10,435
Infrastructure & Non-Clinical Supplies	95	84	(12)	665	748	83	1,000
	1,071	1,076	5	8,524	8,576	52	11,667
Total Expenditure	2,445	2,433	(12)	20,216	20,640	424	27,984
Cost Net of Other Revenue	**(2,445)**	**(2,433)**	**(12)**	**(20,216)**	**(20,640)**	**424**	**(27,984)**

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

Comment on major financial variances

The overall result for ESC was $12k unfavourable for March but $424k favourable for the YTD.

Three factors have reduced the capacity to deliver to plan: industrial action, acute bed encroachment at NSH impacting ESC, and the holiday closure. This resulted in lower personnel costs.

Personnel ($372k favourable YTD)

Nursing ($82k favourable YTD)

In addition to the reasons mentioned above, vacancies in the Cullen Ward during the year contributed to the favourable variance.

Outsourced Personnel ($279k favourable YTD)

The favourable variance was due to the lower than budgeted SMO package of care recharges from S&A to ESC arising from lower elective volumes.

Other Expenditure ($52k favourable YTD)

Outsourced Services ($28k unfavourable YTD)

The unfavourable variance was due to higher than budgeted costs for Auckland Breast Centre Services.

Infrastructure and Non-Clinical Supplies ($83k favourable YTD)

The favourable variance was due to savings in laundry offset by higher patient meal costs.

Diagnostic Services

Service Overview

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

The service is managed by Dr Jonathan Wallace General Manager and Head of Division. The Operation Managers and Clinical Directors are Marilyn Crawley for Pharmacy, Lee-Ann Weiss and Dr Matt Rogers (Clinical Director) for Laboratories and Wilhelmina Mentz and Dr Hament Pandya (Clinical Director) for Radiology.

Highlight of the Month

X-ray Room 3 refurbishment and NSH third CT scanner

X-ray Room 3 is back in use after a refurbishment as part of the new NSH CT scanner project. The team coordinated this well with referring services to ensure continuity of service during the construction period. The 3rd NSH CT scanner project remains on track for 28 June. Two new SMO radiologists have been interviewed appointments are due to commence in the coming months.

Key Issues

PHARMAC consultation on hospital medical devices

Representatives from PHARMAC recently held two sessions at Waitematā DHB to seek feedback on their consultation document, "Managing fairer access to hospital medical devices", which closes on 28 June. Pharmacy and Laboratories were represented at the meeting.

The main concern raised was one of scope, and how this could impact on the timeliness of access to more complex equipment, such as that used by these two services. For example, the Laboratory service's ability to access equipment required for testing of a new pathogen. The proposed centralised structure may also impact on regional initiatives, such as the Laboratory service is currently participating in with regional DHBs.

A risk highlighted by Pharmacy was the potentially increased frequency of out-of-stock events if a single supplier is utilised.

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 Dr Jonathan Wallace General Manager and Head of Division. The Operation Managers are Barbara Schwalger for Clinical Support Services, Bill MacDougall 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

New Dinex food heating system

The Dinex food heating system is being introduced to improve food temperature stability and meal quality and is now fully operational. Teresa Stanbrook, the new Operations Manager for Food Services, is coordinating staff training in consultation with ward Charge Nurses and company representatives. This new system will improve patient experience and was introduced in response to patient feedback. Teresa is working on a number of other quality initiatives that will improve patient experience while ensuring the nutritional value of food is maintained.

Key Issue

Equipment installation, commissioning and decommissioning

Following the serious injury of a contractor at another DHB while decommissioning clinical equipment, Waitematā DHB is undertaking a review of our risks in this area and exploring potential solutions. Clinical Engineering will play a role in this solution in collaboration with Facilities and Development and healthAlliance.

WorkSafe conducted an audit of systems in place at Waitematā DHB to ensure the on-going safety and compliance of such equipment. This included a review of electrical safety and maintenance checks by local and third party providers. The Operations Manager and General Manager attended this review, and Waitematā DHB received a pass on the audit.

3.2 Provider Arm Performance Summary Report – April 2019

Recommendation:

That the report be received.

Prepared by: Robert Paine (Chief Financial Officer and Head of Corporate Services) and Cath Cronin (Director of Hospital Services)

This report summarises the Provider Arm performance for April 2019.

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Glossary
How to interpret the scorecards
Provider Arm Performance Report – April 2019
    Executive Summary / Overview
        Scorecard – All services
        Health Targets
        Elective Performance Indicators
        Strategic Initiatives
        Financial Performance

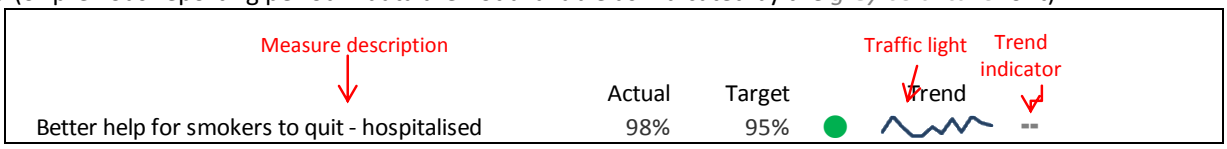
Glossary

CWF	-	Child, Women and Family service
DHB	-	District Health Board
ED	-	Emergency Department
ESC	-	Elective Surgery Centre
ESPI	-	Elective Services Performance Indicators
HOPS	-	Health of Older People Services
MECA	-	Multi-Employer Collective Agreement
MoH	-	Ministry of Health
RMO	-	Registered Medical Officer
S&A	-	Surgical and Ambulatory Services
SLA	-	Service Level Agreement
SMHA	-	Specialist Mental Health & Addiction Services
WIES	-	Weighted Inlier Equivalent Separations
YTD	-	Year To Date

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.

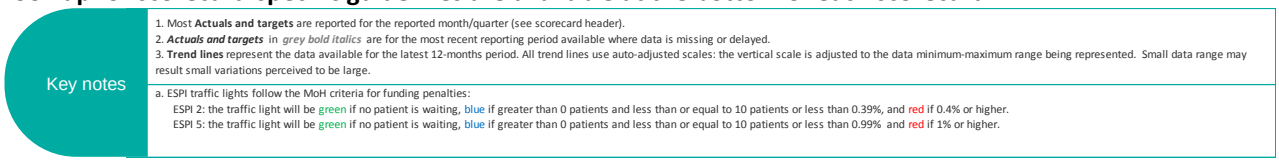
Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance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

Waitemata DHB Monthly Performance Scorecard

ALL Services
April 2019
2018/19

Health Targets

	Actual	Target		Trend	
Shorter Waits in ED	95%	95%	●		--
Faster cancer treatment (62 days)	81%	90%	●		▼

Best Care

Patient Experience	Actual	Target		Trend	
Complaint Average Response Time	13 days	≤14 days	●		▲
Net Promoter Score FFT	75	65	●		▼
Improving Outcomes					
Better help for smokers to quit - hospitalised	99%	95%	●		▲
Quality & Safety					
Older patients assessed for falling risk	97%	90%	●		▼
Rate of falls with major harm	0.1	≤2	●		▼
Good hand hygiene practice	89%	80%	●		▼
S. aureus infection rat	0.1	≤0.25	●		▼
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	13%	≤14%	●		--
Vacancies - %	6%	≤8%	●		▲

Service Delivery

Elective Volumes	Actual	Target		Trend	
Provider Arm - Overall	99%	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	14%	≤10%	●		▼
Outpatient DNA rate (FSA + FUs) - Pacific	13%	≤10%	●		--

Value for Money

Financial Result (YTD)	Actual	Target		Trend	
Revenue	794,136 k	782,406 k	●		▲
Expense	823,368 k	803,313 k	●		▼
Net Surplus/Deficit	-29,231 k	-20,907 k	●		▼
Contracts (YTD)					
Elective WIES Volumes	14,288	15,786	●		▲
Acute WIES Volumes	54,683	55,094	●		▲

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

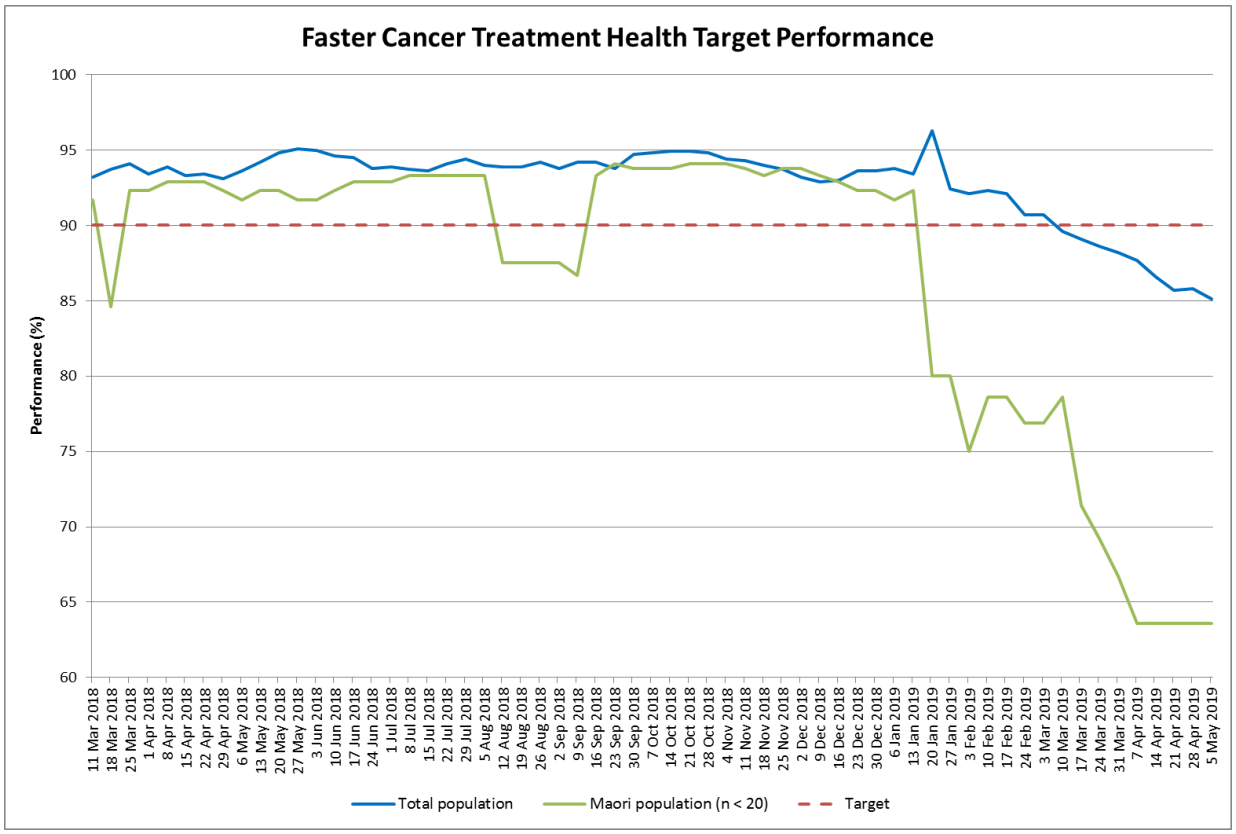
1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in ***grey bold italics*** are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest 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?

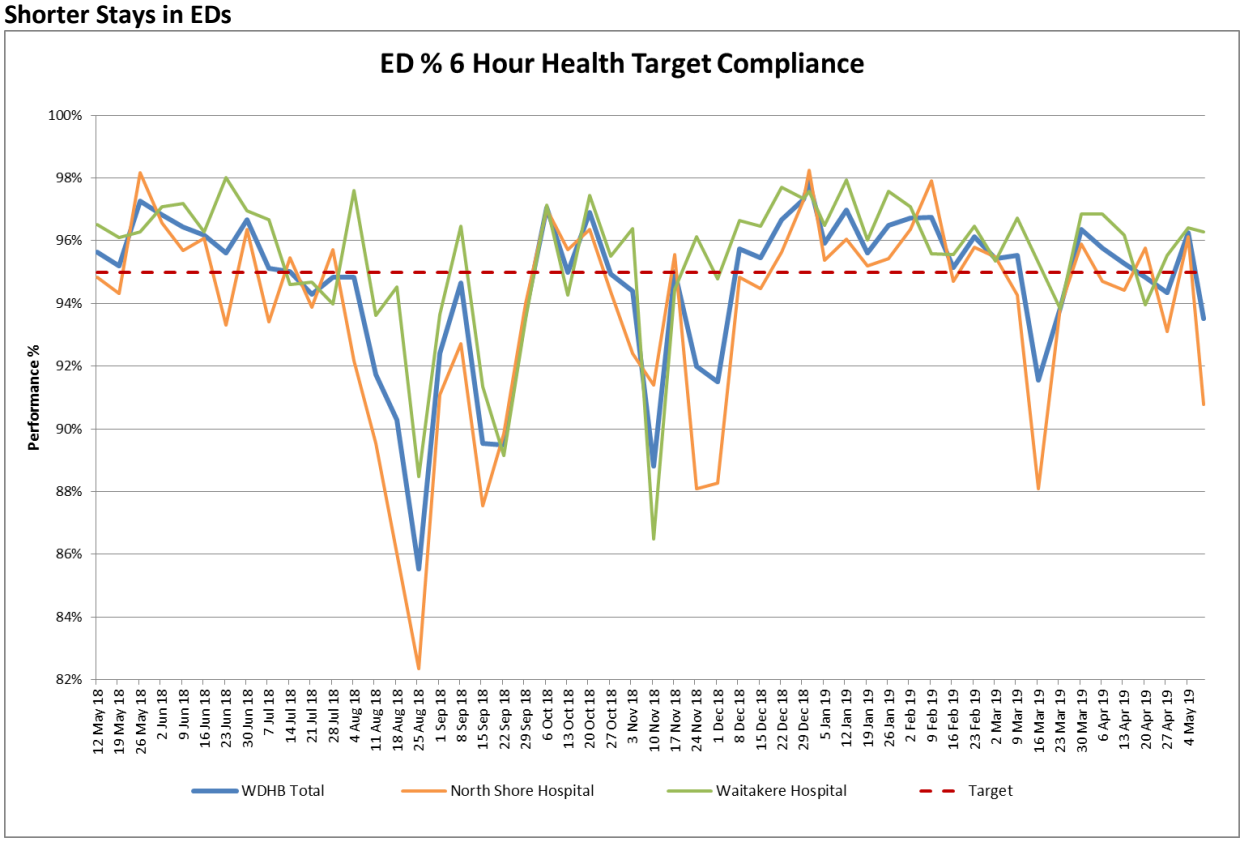
Contact:
Victora Child- **Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz**
Planning, Funding and Health Outcomes, Waitemata DHB

Health Targets

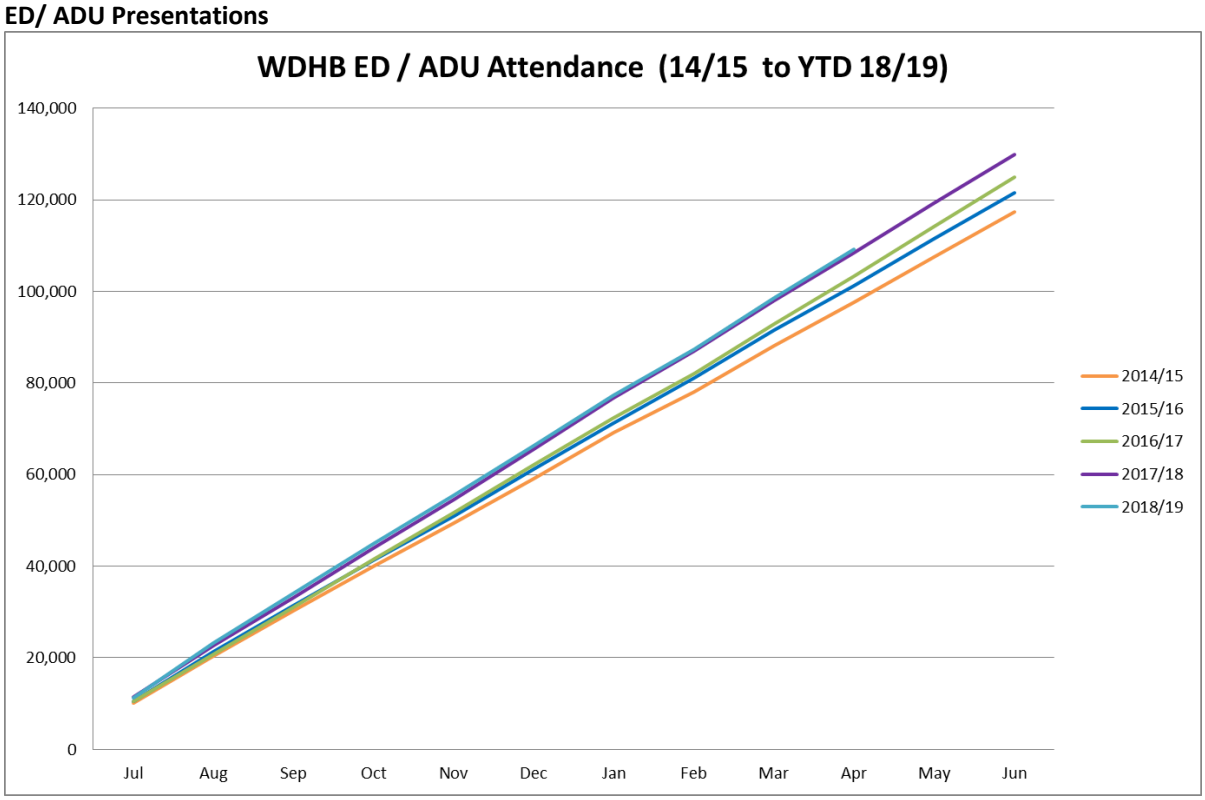
Faster Cancer Treatment



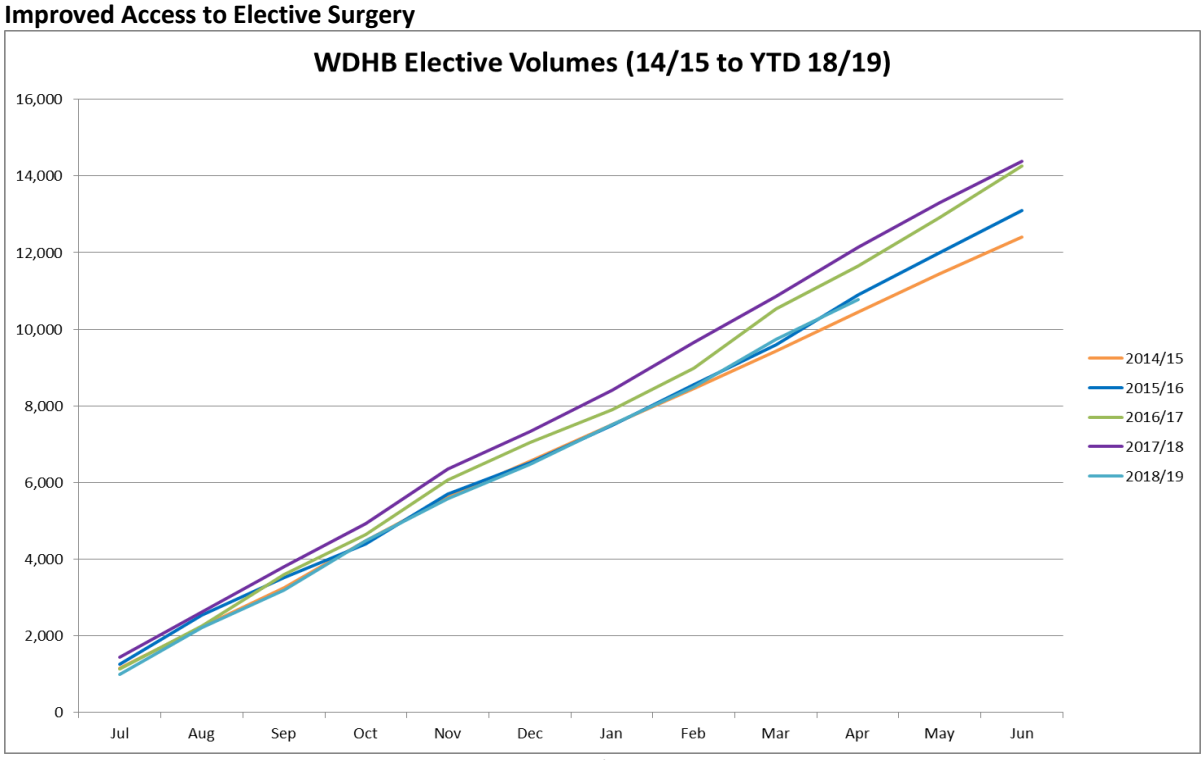
Shorter Stays in EDs



ED/ ADU Presentations



Improved Access to Elective Surgery



Note: Changes were made to the electives health target for 2015/2016

Percentage Change ED and Elective Volumes

April 2019	Month Volumes	% Change (last year)	YTD Volumes	% Change (last year)
ED/ADU Volumes	10,535	1%	109,131	1%
Elective Volumes	1053	-14%	10,783	-11.3%

Elective Performance Indicators

Zero patients waiting over 4 months

Summary (April 19)	
Speciality	Non Compliance %
ESPI2 - Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	5.35%
ESPI5 - Patients given a commitment to treatment but not treated within the required timeframe.	4.45%

ESPI	WL Specialty	Compliant	Non Compliant	Non Compliant
ESPI 2	Anaesthesiology	82	-	0.00%
	Cardiology	1,208	5	0.41%
	Dermatology	165	-	0.00%
	Diabetes	111	-	0.00%
	Endocrinology	316	-	0.00%
	Gastro-Enterology	849	-	0.00%
	General Medicine	213	1	0.47%
	General Surgery	1,669	7	0.42%
	Gynaecology	886	7	0.78%
	Haematology	108	-	0.00%
	Infectious Diseases	57	-	0.00%
	Neurovascular	86	-	0.00%
	Orthopaedic	1,890	10	0.53%
	Otorhinolaryngology	1,529	575	27.33%
	Paediatric MED	887	5	0.56%
	Renal Medicine	245	-	0.00%
	Respiratory Medicine	681	-	0.00%
	Rheumatology	206	1	0.48%
	Urology	616	56	8.33%
	Total	**11,804**	**667**	**5.35%**
ESPI 5	Cardiology	149	2	1.32%
	General Surgery	1,628	3	0.18%
	Gynaecology	561	51	8.33%
	Orthopaedic	1,025	85	7.66%
	Otorhinolaryngology	388	37	8.71%
	Urology	333	12	3.48%
	Total	**4,084**	**190**	**4.45%**

90% of outpatient referrals acknowledged and processed within 10 days

ESPI 1 (Apr 19)	
Specialty	Compliance %
Anaesthesiology	100.00%
Cardiology	97.76%
Dermatology	98.66%
Diabetes	99.02%
Endocrinology	98.10%
Gastro-Enterology	97.55%
General Medicine	95.95%
General Surgery	97.54%
Gynaecology	98.32%
Haematology	99.46%
Infectious Diseases	100.00%
Neurovascular	100.00%
Orthopaedic	98.40%
Otorhinolaryngology	98.44%
Paediatric MED	99.53%
Renal Medicine	100.00%
Respiratory Medicine	99.67%
Rheumatology	97.73%
Urology	100.00%
Total	98.46%

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

Financial Performance

Waitemata DHB Statement of Financial Performance

Provider - April 2019

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	78,526	75,821	2,705	770,281	757,952	12,329	909,648
Other Income	2,493	2,443	51	23,856	24,454	(598)	29,462
Total Revenue	81,020	78,264	2,756	794,136	782,406	11,731	939,110
EXPENDITURE							
Personnel							
Medical	17,968	17,692	(276)	163,513	160,626	(2,886)	194,170
Nursing	24,655	21,111	(3,544)	214,527	202,906	(11,621)	243,593
Allied Health	10,599	9,448	(1,151)	99,013	98,411	(603)	119,212
Support	1,961	1,703	(257)	18,053	17,186	(867)	20,729
Management / Administration	6,460	5,597	(864)	59,165	57,334	(1,832)	69,051
Outsourced Personnel	2,040	1,054	(986)	15,473	10,726	(4,747)	12,955
	63,683	56,606	(7,077)	569,745	547,189	(22,555)	659,710
Other Expenditure							
Outsourced Services	5,404	4,594	(809)	47,927	47,299	(628)	56,555
Clinical Supplies	10,603	10,731	128	105,246	104,440	(806)	126,343
Infrastructure & Non-Clinical Supplies	9,955	9,819	(135)	100,450	104,385	3,935	118,202
	25,961	25,145	(817)	253,623	256,124	2,501	301,100
Total Expenditure	89,644	81,750	(7,894)	823,368	803,313	(20,054)	960,810
Cost Net of Other Revenue	**(8,625)**	**(3,486)**	**(5,138)**	**(29,231)**	**(20,907)**	**(8,324)**	**(21,700)**

Waitemata DHB Statement of Financial Performance

Provider - April 2019

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
CONTRIBUTION							
Surgical and Ambulatory	(17,993)	(18,007)	13	(143,081)	(142,633)	(448)	(172,547)
Acute and Emergency	(14,248)	(14,123)	(125)	(119,488)	(115,380)	(4,108)	(140,923)
Specialty Medicine and HOPS	(9,008)	(8,870)	(138)	(74,422)	(71,337)	(3,086)	(86,917)
Child Women and Family	(8,682)	(8,583)	(98)	(72,203)	(71,941)	(262)	(87,047)
Specialist Mental Health and Addiction	(13,237)	(12,792)	(445)	(109,547)	(107,937)	(1,609)	(131,093)
Elective Surgery Centre	(2,449)	(2,263)	(186)	(22,665)	(22,903)	238	(27,982)
Corporate and Provider Support	56,993	61,151	(4,158)	512,176	511,224	951	624,808
Net Surplus/Deficit	**(8,625)**	**(3,486)**	**(5,138)**	**(29,231)**	**(20,907)**	**(8,324)**	**(21,700)**

Comment on major variances by Provider Service

The overall result for Provider was $5.138m unfavourable for April and $8.324m unfavourable for the YTD.

Surgical and Ambulatory Services (S&A) ($488k unfavourable YTD)

While tracking close to budget overall the service continues to benefit financially from additional revenues from orthopaedic ACC cases, and lower volumes due to the impact of industrial action and acute bed encroachment from medical services. Offsetting this, additional costs have been incurred with over-allocations of registrars, outsourced skin lesions, and unplanned repairs and maintenance costs. The service is facing cost pressures in the remaining months to ensure Elective Services Performance Indicators (ESPI) compliance, plans to deliver to plan on outsourced MRI and ultrasound scans, and unbudgeted outsourced costs to meet Interventional Radiology demands that exceed internal capacity.

Acute and Emergency Medicine ($4.108m unfavourable YTD)
The unfavourable variance was due to premium cover costs for medical staff, additional sessions to shorten the patient waiting list, RMO strike cover cost by senior medical officers, extra beds and resources required to meet high winter demand and high watch costs.

Specialty Medicine and HOPS ($3.086m unfavourable YTD)
The unfavourable variance was due to increased patient watches in the KMU, increased demands in District Nursing, and increased demand for mobility aids.

Child, Women and Family (CWF) ($263k unfavourable YTD)
The unfavourable result YTD was the result of on-going patient demand driven cost increases across predominately Maternity (antenatal assessments and caesarean section activity) and Neonatal services involving use of external staffing resource and overtime to cover vacancies and roster gaps, cleaning outsourced costs, patient food and to a lesser extent increased maintenance costs in the mobile dental units and fixed dental facilities. These cost increases have been partly mitigated by service wide vacancies and an improved revenue position.

Specialist Mental Health and Addiction (SMHA) ($1,610k unfavourable YTD)
The unfavourable result YTD was due to the use of locums to cover medical vacancies and increasingly 'acute' caseloads. This is particularly the case in the Rodney region, both for adult and child and youth specialist psychiatrists. There remains a difficulty recruiting to nursing vacancies, again specifically in more specialist areas such as child and youth as well as intellectual disability. Also, vacancies in both the adult inpatient units and forensics are covered with overtime rates which are paid at a premium.

Elective Surgery Centre (ESC) ($238k favourable YTD)
Three factors have reduced the capacity to deliver to plan and resulted in the favourable financial variance YTD; industrial action, acute bed encroachment at NSH impacting ESC, and the holiday closure. This has resulted in lower costs. Offsetting this, the service has realised higher than budgeted non-volume related clinical supplies, e.g. repairs and maintenance, and minor purchases.

Corporate and Provider Arm Support ($951m favourable YTD)
Revenue is favourable $8.864m due to additional revenue from MoH for Care Capacity and Demand Management (CCDM), Capital Charge and MECA settlements, along with additional cost recoveries and includes additional interest income $384k and back-dated SLA in Primary Health Care Nursing for vaccination program at Auckland DHB $307k. Also contributing were favourable personnel costs due to vacancies along with risk pool provisions $431k; this was offset with unfavourable variances driven by timing differences in implementation some financial sustainability initiatives and unfavourable expenditure in Facilities outsourced maintenance and consultants costs $1.324m. Overall the cost overspends in Facilities have improved and result has been closer to breakeven over the past four months.

4.1 Clinical Leaders' Report

Recommendation:

That the report be received.

Prepared by: Dr Andrew Brant (Chief Medical Officer and Deputy Chief Executive Officer),
Tamzin Brott (Director of Allied Health, Scientific and Technical Professions)
Dr Jocelyn Peach (Director of Nursing and Midwifery; Emergency Systems Planner) and

Medical Staff

Senior Medical Officers (SMO)

In April 2019, two doctors joined Waitematā DHB as Senior Medical Officers:

- Dr Nicola Dykes, Child Women & Family Service
- Dr Claudia Weidekamm, Radiology Service North

Registrar orientation project

The 12 month fixed term Registrar Orientation Coordinator role for General Medicine will end in July.

Outcomes of the Orientation candidate role includes:

- CeDS Orientation site has been set up – well received, requires further refinement
- Orientation manual has been reviewed – well received, requires further work
- Successful contribution to RACP Accreditation (with 5-year Accreditation period granted)
- New Orientation format developed due for delivery and evaluation in June 2019
    - RMO feedback integrated
    - Operations Manager session introduced
    - Content spread across the week in shorter sessions at more convenient times
    - Modular format to enable self-directed learning
    - Navigating ward demands is a priority to enable attendance

Community Based Attachments (CBAs)

The DHB currently has five CBAs with a target of 15 by November 2020. It is intended that three more will be added in the 2019/2020 financial year. Two in Specialist Mental Health and Addiction Services (one from a converted FTE and one new FTE) and one new FTE in the Health Outcomes Team (Public Health). There will need to be an increase in Health Outcomes positions in 2020/21 to achieve at least one CBA position during their prevocational training.

Medical Education Fellows

There are currently three Medical Education Fellows (sharing two FTE) working in the Clinical Education and Training Unit (CETU). One FTE is dedicated to prevocational training at Waitematā DHB. This role is currently job shared by Dr George Shand and Dr Kate Richardson. Dr Shand is responsible for the PGY1 programme and Dr Richardson for the PGY2 programme. The other role is 50% co-funded with the University of Auckland, School of Medicine. Dr Ellen Miller is the current incumbent and looks after training and pastoral care for 3rd – 6th year medical students. In addition to their teaching work, all three fellows are involved in project work and have professional development opportunities.

The fellows report to and work closely with the Manager of CETU who supports, mentors and enables their work. A key outcome of this relationship is a growing reputation for quality in undergraduate medical education and prevocational education at Waitematā DHB, and that the DHB is increasingly well regarded amongst early career doctors as an employer of choice.

RMOs in Clinical Governance
The programme run by Naomi Heap and Jonathan Wallace is in its fourth cycle. Three interns are working on projects that enable their learning about quality improvement and that contribute to existing improvement work in the DHB such as the Acute Kidney Injury programme.

The next step for this programme is to ensure that the Interns have the opportunity to attend governance forums in order to increase their exposure to systems level discussion and decision making.

Quality Team

As reported to the Committee at its last meeting, Heather Gunter, mother of 15-year-old Matthew Gunter who died following a routine appendectomy in 2012, will be coming to Waitematā DHB on 21st June 2019 to share her story. The talk is open to the whole organisation and will commence at 08:00am in the Whenua Pupuke Auditorium. This coincides with the five-weekly theatre shut down ensuring as many staff as possible from the surgical specialties are available. ACC has partnered with Heather Gunter as part of their Treatment Safety programme and both will be available to answer questions at the end of the session. Heather will also be talking to the Charge Nurse Manager group at their regularly Friday meeting. Heather's presentation will be at the end of a Learning from Adverse Events week, during which we will be able to share a number of examples of where learning from adverse events has led to improvements in the quality of the services offered by Waitematā DHB.

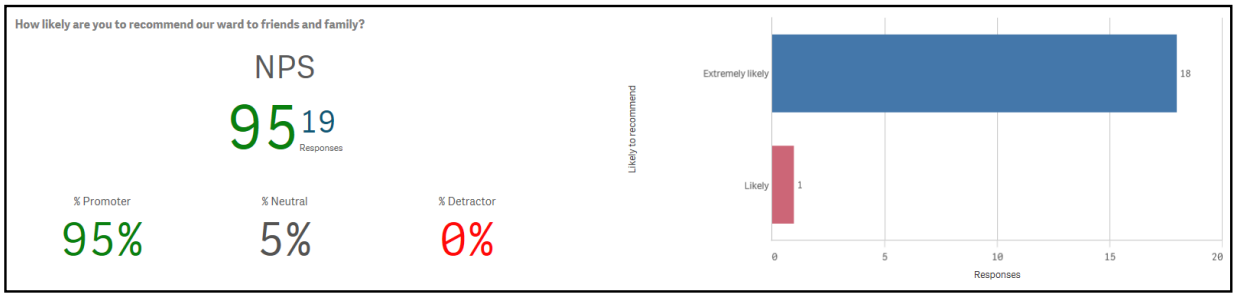
The Quality and Risk team continue to focus on the development and delivery of training. As previously reported a number of Charge Nurse Manager adverse event investigation training sessions have taken place and in July the team will be running two Lead Investigator training sessions. Both these sessions are aimed at supporting those who are responsible for undertaking adverse event investigations and ensure that they have the knowledge, confidence and tools to fulfil these roles. The Complaints and Adverse Events Manager in partnership with the Director of Patient Experience has commenced the development of a serious of Complaint Management sessions, which are planned to be delivered later this year.

Allied Health, Scientific and Technical Professions

(Forty-two (42) professions, accounting for 24% of the Waitematā DHB workforce.)

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

Friends and Family Test – Allied Health – February 2018



Comments received in April 2019 include:

- Very professional, very high standard of performance
- I found them all (people) extremely good in helping me
- Lovely and well explained. Great outcome.
- Expert help. Could not ask for more
- Kind and caring
- Helpful with my recovery.
- Everything ok and very good. Everything was explained very nice and clear

Recruitment and retention of Māori and Pacifica workforce

Four allied health professions (Oral Health, Dietetics, Occupational Therapy and Physiotherapy) are in focus over the 2018/19 period, with a work plan in place locally, regionally and nationally in order to recruit and retain Māori and Pacifica clinicians to reflect the communities we serve.

We continue to connect undergraduate students who identify as Māori and Pacifica to the Waitematā DHB scholarship programme and the cultural and peer support that we offer them throughout their undergraduate programme and beyond as new graduates. Current numbers of Māori and Pacifica staff across those priority professions, and staff required to reflect the working population as at April 2019 are:

MALT PRIORITY AH PROFESSIONS Apr 2019	Maori in current workforce*	% of Maori in current workforce	Number of Maori to reflect working population	Additional Maori required	Recruited last 12 months	Terminated last 12 months
Oral Health Therapist	16	9.58%	15	0	2	-6
Dietitian	2	4.08%	5	3	0	-3
Occupational Therapist	3	1.92%	14	11	1	-5
Physiotherapist	7	6.36%	10	3	4	-1
Total AH Priority Professions	28	5.81%	44	16	7	-15

PALT PRIORITY AH PROFESSIONS Apr 2019	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
Oral Health Therapist	14	8.38%	12	0	2	-1
Dietitian	0	0.00%	4	4	0	0
Occupational Therapist	3	1.92%	11	8	1	0
Physiotherapist	4	3.64%	8	4	0	-3
Total AH Priority Professions	21	4.36%	35	14	3	-4

Reasons for leaving Waitematā DHB, across all allied health scientific and technical professions for Māori and Pacifica, 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 more fully 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.

Announcement – Professional and Clinical Leader Dietetics
I am pleased to announce the appointment of Tracy Coote to the role of Professional and Clinical Leader Dietetics, Waitematā DHB. Tracy formally started in the role on 20 May 2019.

Tracy comes to the Professional and Clinical Leader role from her current role as a Senior Dietitian at Waitakere Hospital, bringing 15 years' clinical dietetic and leadership experience from across New Zealand and the United Kingdom. Tracy has a strong portfolio of clinical experience across multiple specialities including inherited metabolic disorders, paediatric diabetes, acute adult inpatients, paediatrics and most recently community and inpatients at Waitakere Hospital.

Along with professional supervision experience, Tracy also brings considerable leadership skills to the role having been the Auckland Branch President for Dietitians New Zealand for the past five years, and chair of the organising committee for the 2018, 75th jubilee conference.

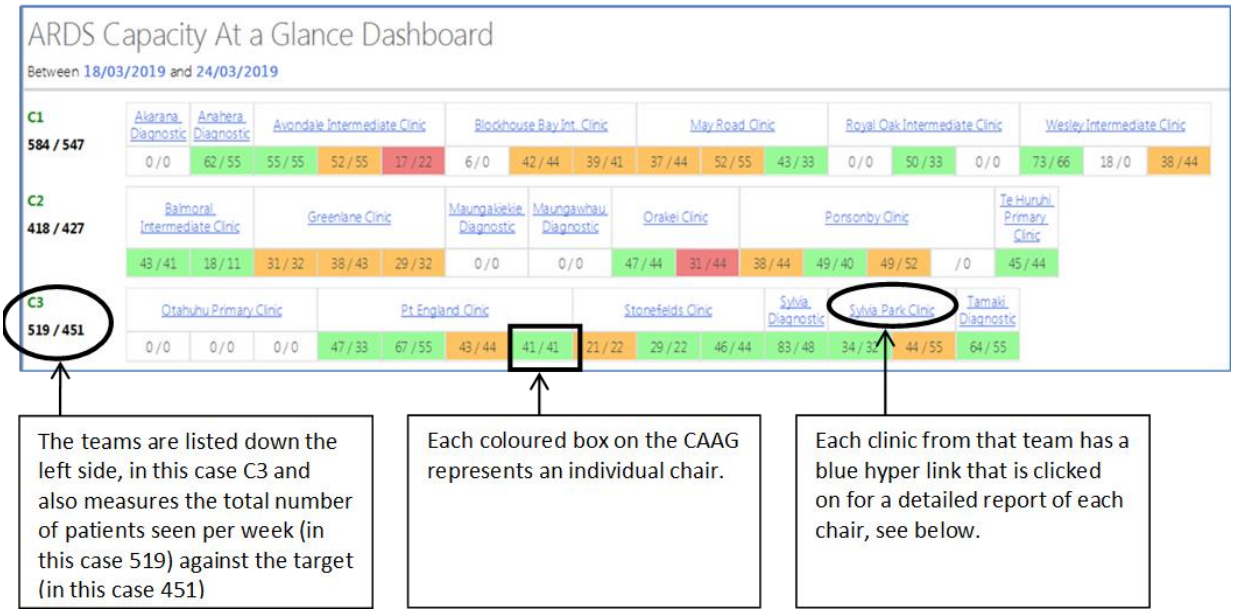
Auckland Regional Dental Service (ARDS) – Development of a Capacity at a Glance (CAAG) Screen

The challenge:
The Auckland Regional Dental Service ARDS is a far reaching complex service made up of around 83 clinics across the three Auckland Metro District Health Boards. Services are provided via a mixture of fixed clinics, transportable dental units (TDUs) and diagnostic vans, each with a number of dental chairs. The service has approximately 190 chairs in total. Obtaining an overall capacity view for the chairs has been an on-going challenge for the service. Team Leaders were previously required to manually count patients from an appointment book in Titanium (ARDS electronic clinical record system) to measure capacity against Ministry of Health targets.

The solution:
We have developed a Capacity at a Glance Dashboard (CAAG) which provides a quick view of all clinics and individual chairs across the Auckland Regional Dental Service. Each chair has a specific target attached to it based on Ministry of Health recommendations. The target will change based on other factors, such as whether the chair is operated by a new graduate therapist, a dentist, or a student under the supervision of a registered therapist. The target is also influenced by the clinical purpose for that chair on any given day. For example, a 'screening' chair for pre-schoolers will have a higher target than a 'standard' chair as appointment times for pre-schoolers are shorter.

Team Leaders currently select the chair 'status' and 'type' in a background screen, which then automatically calculates the target for that chair. 'Traffic light' colours indicate the percentage of the target reached and leaders and staff are able to quickly identify these. The CAAG is a valuable planning tool and gives leaders and clinicians vital information to further investigate the 'story' of each chair and modify booking and scheduling practices to suit any given situation.

High level ARDS CAAG View:



The teams are listed down the left side, in this case C3 and also measures the total number of patients seen per week (in this case 519) against the target (in this case 451)

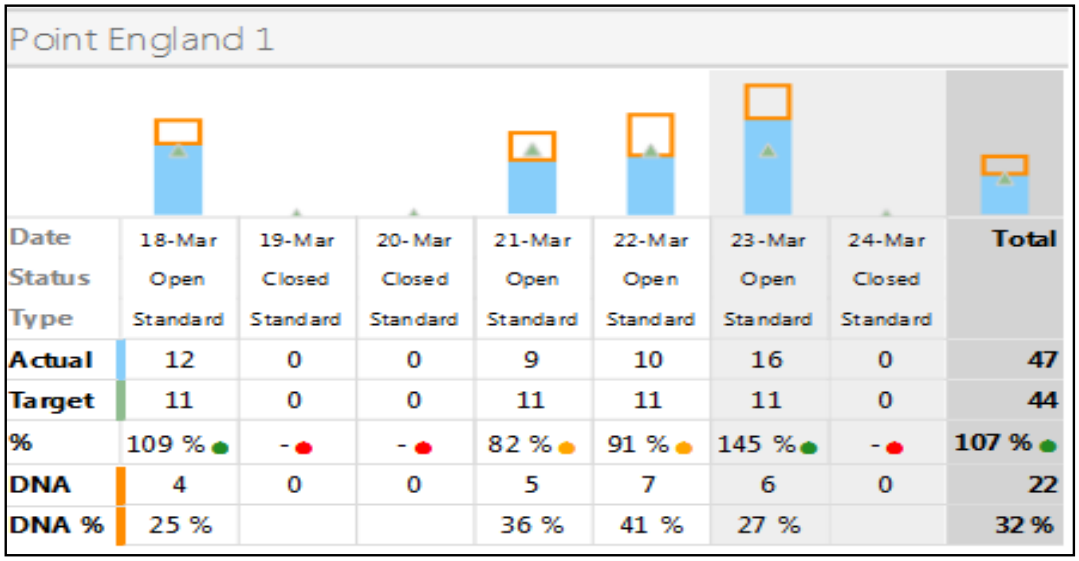
Each coloured box on the CAAG represents an individual chair.

Each clinic from that team has a blue hyper link that is clicked on for a detailed report of each chair, see below.

CAAG Legend:

- Meets Ministry of Health's target at 100%
- 80-99% of Ministry of Health's target
- Below 80% of Ministry of Health's target

Individual chair view



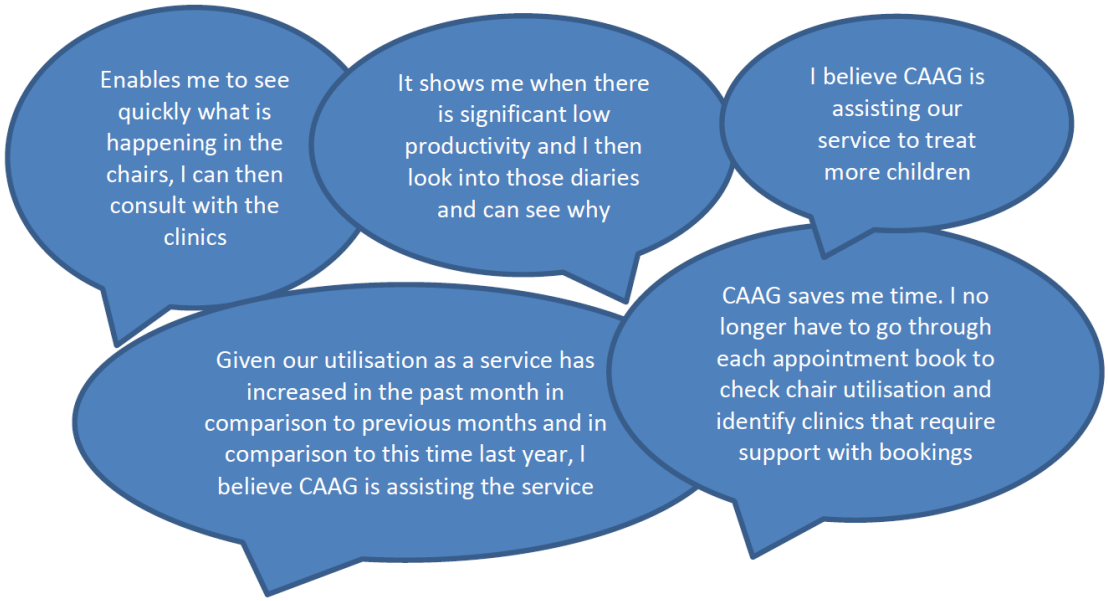
Point England 1

Date	18-Mar	19-Mar	20-Mar	21-Mar	22-Mar	23-Mar	24-Mar	Total
Status	Open	Closed	Closed	Open	Open	Open	Closed	
Type	Standard	Standard	Standard	Standard	Standard	Standard	Standard	
Actual	12	0	0	9	10	16	0	**47**
Target	11	0	0	11	11	11	0	**44**
%	109 %	-	-	82 %	91 %	145 %	-	**107 %**
DNA	4	0	0	5	7	6	0	**22**
DNA %	25 %			36 %	41 %	27 %		**32 %**

The blue column shows the patients that have been seen (in this case 47)
The orange box shows the number of Did Not Attends (DNAs) (in this case 22). The percentage of DNAs from the total appointments on the day is also shown (in this case 32%)

Actual - patients seen on the selected day
Target – Ministry of Health target depending on the chair type
% - percentage of patients that met the target

Roll-out:
The CAAG was introduced to staff and rolled out through a training program in February 2019. Staff were involved in its trial and further development and overall it has been a great success! The CAAG tool has assisted the service in planning, understanding where issues lie, and ultimately and most importantly has provided an opportunity for the service to treat more children!



Next steps:
ARDS are looking to further develop the CAAG based on chair profiling analysis. Once all staff are confident and consistently using the tool some of the other reports currently completed by Team Leaders can be removed, allowing more time to focus on leadership and service improvement.

World Oral Health Day at Waitematā DHB
March 20 2019 was World Oral Health Day. Speech Language Therapists, Oral Health Therapists, Dietitians and Registered Nurses joined together at both North Shore and Waitakere Hospitals to spread the word on the importance of oral hygiene. This was an opportunity to raise awareness of the need for good oral care and the health risks associated with poor oral health.

A lot of people don't know that speech language therapists (SLTs) can provide education and advice on oral hygiene practice. Many populations SLTs work with (people with dysphagia, head and neck cancer, people who receive non-oral nutrition) are at increased risk of insufficient oral care management, as well as aspiration (breathing foreign objects into your airway/lungs such as food, drink or saliva) and aspiration pneumonia. World Oral Health Day was an opportunity to raise awareness of the role of SLTs in oral cares and the risks associated with poor oral health.

One of the highlights was the multidisciplinary conversations that arose whilst spreading awareness to the public. It was so valuable to get the perspective of nurses, and those who deliver oral care on a regular basis.

Keiko Oda, a specialist nurse with a passion for oral health, is set to publish her research into why oral care matters for dependent adults in hospital. Keiko explains in her research that oral care is a key intervention that can help prevent vicious circles of deconditioning, aspiration pneumonia, sarcopenia (degenerative loss of skeletal muscle mass), and lower respiratory function. However, oral care is one of the most missed nursing interventions in hospital. The goal of her research is to identify the barriers and facilitators for oral care practice. Some of her preliminary findings show key barriers and gaps to oral care provision. These include:

1. Lack of oral care protocols and policies.
2. Insufficient oral care training.
3. The limited time and awareness available for the implementation of oral cares.

These findings suggest that a key step forward is establishing oral care protocols in hospitals. This will lead to enhanced awareness, more effective training and education, and better health outcomes for hospitalised older adults.

With this in mind, we are now in the process of organising an in-service for the SLTs at Waitematā DHB, in collaboration with our Oral Health Therapists. From this we hope to increase our knowledge of oral care delivery. This will enable to us to more confidently provide training and advice to those in need.

(Kate Hedworth, Gabrielle Simpson, Lara Shasha, Suzanne Morris, Tanya Watt, Waitematā DHB Inpatient and Community SLT services)

Better, Best, Brilliant

Laboratory celebrates staff achievements
Waitematā DHB Laboratory team celebrated three achievements for laboratory staff in May 2019.

Ernie Tanurhardja, received the highest total mark for the Qualified Medical Laboratory Technicians exam, completed in November 2018. This year saw a change in the exam structure where candidates were required to complete both a generic and discipline specific, in this case Phlebotomy, component in the exam. This is the second year in a row that a Waitematā DHB Phlebotomist has received top marks in this exam.

Lee Gaseltine and Nicolette Loo attended and presented at the National Immunohaematology Continuing Education weekend, held in Taupo on 17-19 May 2019 to 69 attendees from across New Zealand.

- Lee was awarded the top speaker award for her presentation titled ‘Anaphylaxis through the Looking Glass’, which has a prize of an all-expenses paid trip to the National Immunohaematology Continuing Education weekend in Australia in October 2019. This is the second year in a row that a scientist from Waitematā DHB has received this award

- Nicolette received the runner up award for her presentation titled 'Managing Transfusion Interference of Anti-CD38 (Daratumumab) for the Treatment of Multiple Myeloma'. Nicolette will attend the conference in Australia on Lee's behalf, as Lee is unable to attend.

We are extremely proud of their achievements.

Nursing and Midwifery

Nurses, Midwives and Health Care Assistants account for 43% of the total DHB workforce.

Support for frontline staff and acknowledgement of their contribution

In May we celebrated two professional dates - Midwives day (5th May) and Nurses day (12th May). The two professions were acknowledged for their contribution to the health of our community and health outcomes. The DHB is fortunate to have the quality of professionals we do to achieve the service we provide to our community.

A professional forum was held on 17th May that focused on strengthening our professional cultural context, building team health and well-being; self-care and support of teams, mindfulness and managing wellness. The day was well received and a positive experience for about 100 attendees.

Janice Riegen facilitated the sessions through the day.

Ronitha Reddy was appreciated for her wonderful cupcakes and cake to acknowledge anti bullying - 'Pink Day'

We also celebrated nurses nominated by their peers. The following people received awards in each category.

Te Kauae Raro Maori	**Stella Querida Williams**	Whītiki Maurea Maori Community Mental Health and Addiction Services
Best Care for Everyone	**Alison Patterson**	Adult Mental Health
Relief of Suffering	**Adrienne Reed**	Ward 15 Assessment Treatment and Rehabilitation
Promoting Wellness	**Karen Pollock**	Colorectal
Everyone Matters	**Linda Agnew**	Emergency Department North
Compassion	**Grace Barlow**	Rangitira Ward Waitakere
Compassion	**Emma Neely**	Emergency Department North
Connected	**Sasha McKinley**	Primary Health Care team, Planning and Funding
Connected	**Louise Guy**	Rangitira Ward Waitakere
Better Best Brilliant	**Sonya English**	Critical Care Outreach
Leadership	**Carole Schneebeli**	Regional Forensic Psychiatry Services
Leadership	**Sue Osborne**	Urology Service

Pictured is **Stella Williams** who won the Te Kauae Raro Maori Nurses Award. She is able to wear the korowai for the next 12 months.

Also in the picture is Whaea Louise Elia, Clinical Nurse Director Dianna MacGregor and Carol Seymour – Nurse Leader for Whikiti Maurea.

Focus on practice safety priorities, quality standards and service effectiveness

Pressure Injury Prevention Management [PIPM]
Waitemata DHB has signed up to participate in the ACC national improvement programme for pressure injury prevention and management. This is a two year commitment. The work is progressing in the provider services and a pilot will commence with selected community agencies. The Director of Nursing will attend the 20 June national meeting to report on the DHB programme activities and progress.

The **Patient and Whanau Centred Care standards** review will commence on 17 June to 30 June.

After a review, it has been agreed that after eight cycles of review the reviews can now change to annual, with time between reviews to complete quality improvements and not focus on the review only.

Ward/Unit teams are preparing to meet the care standards requirements. The Nursing & Midwifery Leadership Group will undertake the ward assessments with the patient experience team.

	Orgn		
	Dec-18	Jun-18	Dec-17
Communication	86.6%	88.7%	91.2%
Clinical Monitoring and Management	78.8%	78.7%	75.4%
Care Environment	92.6%	95.5%	93.3%
Comfort and Pain Management	92.0%	92.4%	92.0%
Respect, Privacy and Dignity	93.3%	92.4%	94.1%
Nutrition and Hydration	90.8%	91.6%	87.9%
Safety and Prevention	93.9%	93.0%	92.7%
Personal Care	84.6%	85.1%	85.4%
Self Care	88.0%	89.4%	87.6%
Overall Score	89.0%	89.7%	88.8%

Workforce planning, professional development and recognition for the future service needs
Recruitment: Waitemata DHB was pleased to welcome a group of new graduate midwives (nine) and small group of registered nurses (three) in May. We are working towards recruitment of nurses who have completed the Return to Practice programme from April to end of May in our clinical settings.

Recruitment is underway for the September intake of new graduate nurses. There were limited applicants nationally and we are working hard to recruit the 79 new graduate nurses we have positions for. The national ACCORD work seeks to ensure that all new graduate nurses get offered employment. This is being largely achieved nationally as there are few in the talent pool and each DHB is looking to recruit those who apply.

Undergraduate experience: Considerable work continues to support undergraduate students to ensure that they consider Waitemata DHB their employer of choice. Excellent support is offered by our staff to welcome and teach these students.

Health Care Assistant development: Waitemata DHB continues to support development of these unqualified workers, offering comprehensive orientation, especially for people new to health. Twenty-five of these staff also receive support to undertake the National Certificate (NZQA Level 3) each year.

On May 29th, a group of nurse leaders were pleased to welcome **Moana Hapeta** as the Maori Nurse Educator to work alongside Dianna MacGregor, Clinical Nurse Director Maori Health Nursing.

Moana was welcomed in a powhiri by some of the increasing number of Maori nurses working for the Waitematā DHB in frontline and advanced practice roles, some NGO Maori nurses and a Maori student nurse. Moana was originally a graduate of the AUT nursing programme, then a new graduate nurse in our Waitematā DHB programme.

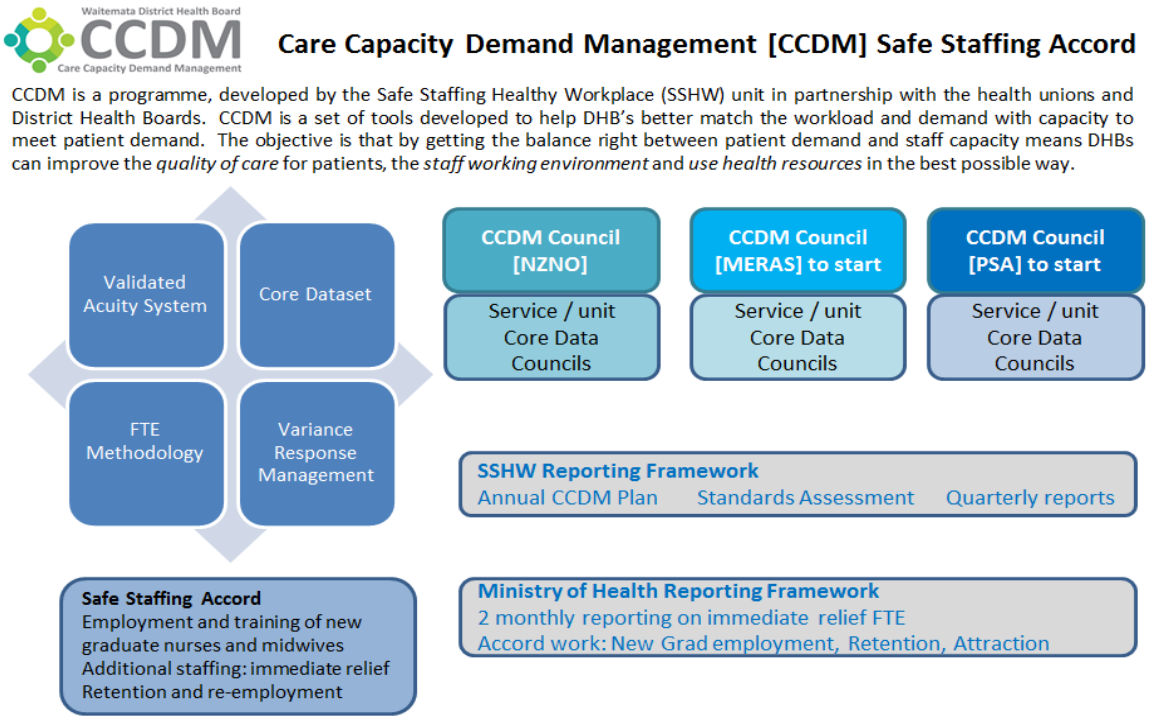
We are pleased she has returned from Otago University to support the work planned to support Maori nurses across the district.

Initiatives to support safe staffing and healthy workplaces

Work continues to implement the requirements of the CCDM programme.

Updates per the diagram below:

- *Trendcare database* - is being upgraded to 3.6 in late June which will add functionality across all groups using the application
- *Core dataset* - good progress is being made to present key measures using Qlik sense. The Institute for Innovation and Improvement (i3) is assisting with this work
- *FTE methodology* - the first report [Wards 5 and 10] is being finalised. The next group of wards is being completed (Wards 2, 3, 6, 14, 15). The next group of wards is identified to start in August.
- *Variance Response Management* - update of the main screen is underway. the escalation cards are finalised and will be promoted in late June.



The Waitematā DHB is achieving all milestones, submitting various reports to demonstrate achievement according to the plan agreed with the Safe Staffing Healthy Workplace executive and the Ministry of Health.

The programme is extending to include two other union and staff groups, namely MERAS with midwives and PSA for mental health and public health nurses and allied health. How the programme works with these groups is being scoped and timelines set.

As referenced in other reports the FTE added as part of the ACCORD funding has been well received and is increasingly showing benefit in terms of patient flow and clinical team support. In particular, the shift coordinator roles are developing the facilitation of patient and team experience.

There are high staff and union expectations for what this work will achieve. The resource commitment of this work is high. The Waitematā DHB progress with CCDM will be audited in the December certification audit. It also is required to be reported to the Ministry in Planning and Funding reporting.

Emergency Systems Planning

Work continues to ensure that the Waitematā DHB programme and plans are refreshed, that the key components are in place, key staff engaged and aware and exercise/testing scheduled. This is particularly important as we progress with the building programme to ensure that business continuity and response processes are robust as major infrastructure work is initiated. The webpage has been updated. More work is planned.

4.3 Quality Report – April 2019 (June 2019 HAC)

Recommendation:

That the report be received.

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

Contents

1. Health Quality and Safety Markers
2. HQSC QSM Dashboard
3. DHB Quality Indicator Trends –October 2018
4. Key Quality Indicators
5. Improvement Active Projects Report
6. Safe Care
7. Patient and Whānau Centred Care

Acronyms

Acronym	Definition	Acronym	Definition
ADU	Assessment and Diagnostic Unit	KPI	Key Performance Indicator
AMS	Antimicrobial Stewardship	LOS	Length of Stay
CAUTI	Catheter Associated Urinary Tract Infection	MACE	Major Adverse Cardiac Events
CDI (C.diff)	*Clostridium difficile (C.difficile) infection*	MALT	Maori Alliance Leadership Team
CGB	Clinical Governance Board	MRSA	Methicillin Resistant Staphlococcus aureus
CLAB	Central Line Associated Bacteraemia	MRO	Micro Resistant Organism
CCOT	Critical Care Outreach Team	MSU	Mid-Stream urine
CeDSS	Clinical e-Decision Support	N/A	Not Applicable
CPP	Chronic Pelvic Pain	NPS	Net Promoter Score
ESC	Elective Surgery Centre	PACE	Pathway for Acute Care of the Elderly
ePA	Electronic Prescribing and Administration	PDP	Patient Deterioration Programme
eMR	E-Medicine Reconciliation	PERSy	Patient Experience Reporting System
ED	Emergency Department	PICC	Peripherally Inserted Central Catheter
EDARS	Early Discharge and Rehabilitation Services	PROM	Patient Reported Outcome Measure
ELT	Executive Leadership Team	PWCCS	Patient Whānau Centre Care Standards
ETT	Exercise Tolerance Test	QI	Quality Improvement
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		
IT	Information Technology		
IVL	Intravenous luer		

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 (*data collection commenced July 2018*)
6. deteriorating patient (*data collection commenced July 2018*)
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 aged 65 years and over (55 and over for Māori and Pacific people) where electronic medicine reconciliation was undertaken within 72hrs [of admission] *(target has not been set by HQSC)*
- Percentage of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic medicine reconciliation was undertaken within 24hrs [of admission] *(target has not been set by HQSC)*
- Percentage of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic medicine reconciliation was included within as part of the discharge summary *(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 2019 is:

Period covered	Publication date (indicative)
Q1 2019 (Jan -Mar 19)	28/06/2019
Q2 2019 (Apr-Jun 19)	30/09/2019
Q3 2019 (Jul-Sep 19)	13/12/2019

2. Health Quality and Safety Commission QSM Dashboard

Quality Safety Markers (QSM)			Target	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Last Quarter Change
Falls		% older patients assessed for falls risk.	90%	98%	95%	99%	97%	96%	95%	98%	96%	98%	⇧
		% older patients assessed as significant risk of falling with an individualised care plan.	90%	96%	96%	100%	95%	95%	98%	97%	96%	94%	⇩
Health Care Associated Infections	Hand Hygiene (HH)	% of compliant HH moments.	80%	86%	86%	87%	88%	89%	90%	89%	89%	89%	⇔
	CLAB	% occasions insertion bundle used in ICU.	90%	99%	100%	99%	100%	99%	99%	98%	100%	99%	⇧
		% occasions maintenance bundle used in ICU (*not currently an HQSC Target*).	90%	95%	98%	91%	96%	95%	91%	96%	97%	92%	⇩
	Surgical Site Infections	Surgical Site Infections rate per 100 procedures [target has not been set by HQSC. ***National Q3 2018 rate 0.9 infections per 100 ops).***	HQSC has not defined a target	2.2	1.2	0.3	0.7	0.9	0.7	0.0	0.0*	3.1*	⇧
				Cumulative rate 1.0 (From Jul 13)							*Preliminary		
		100% primary hip and knee replacements antibiotic given 0 - 60 minutes before 'knife to skin' [first incision].	100%	92%	90%	96%	96%	98%	95%	97%	*HQSC SSI data lags by two quarters*		⇧
		95% primary hip and knee replacements right antibiotic in the right dose - Cefazolin 2g or more.	90%	96%	97%	97%	97%	96%	97%	99%			⇧
		100% of primary hip and knee replacements will have alcohol based skin preparation.	100%	100%	99%	100%	98%	94%	100%	98%			⇩
		100% of primary and knee replacements will have surgical antimicrobial prophylaxis discontinued with 24 hours post-operatively.	100%	94%	94%	96%	100%	100%	100%	100%			⇔
	eMedRec	% of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic	TBD	*Orion working nationally on version of SQL script for testing/validation*									-

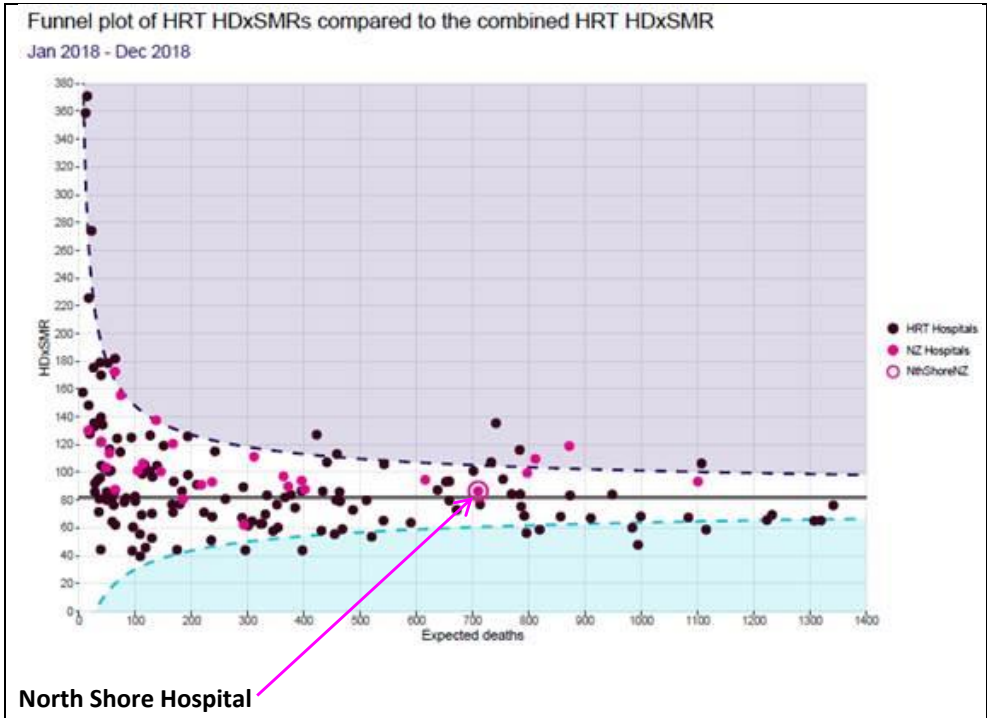
Quality Safety Markers (QSM)			Target	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Last Quarter Change
Medication Safety		reconciliation was undertaken - within 72hrs [of admission]											
		% of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic reconciliation was undertaken within 24hrs [of admission]	TBD	*Orion working nationally on version of SQL script for testing/validation*									-
		% of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic reconciliation was included within as part of the discharge summary	TBD	*Orion working nationally on version of SQL script for testing/validation*									-
	Opioids	% of patients with a documented sedation score	TBD	*Until Privacy Impact Assessment is completed by HQSC for Waitematā DHBs data we will provide aggregated data only*							85%	TBA	-
		% of patients with documented bowel function monitored	TBD								10%	TBA	-
		% of patient with uncontrolled pain	TBD								30%	TBA	-
		% of patients with documented opioid related adverse events	TBD								Not Available		-
Patient Deterioration		% of eligible wards using the NZ Early Warning System (EWS)	TBD	*NZ-EWS will commence 6 May 2019 –reporting will be available next quarter*									-
		% of audited patients with an EWS score calculated correctly for the most recent set of vital sign	TBD	*NZ-EWS will commence 6 May 2019 –reporting will be available next quarter*									-
		% of audited patients that triggered an escalation of care and received appropriate response to that escalation as per DHB agreed escalation pathway	TBD	*NZ-EWS will commence 6 May 2019 –reporting will be available next quarter*									-
		Number of in-hospital cardiopulmonary arrests in adult inpatient wards, units or	TBD	*Reporting Commenced Q1 2018*				***6***	***11***	**17**	**12**	**3**	⇩

Quality Safety Markers (QSM)		Target	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Last Quarter Change
	departments											
	Number of rapid response escalations	TBD	*NZ-EWS will commence 6 May 2019 –reporting will be available next quarter*									-
Pressure Injuries	% of patients audited for pressure injury risk who received a score	90%	*Reporting commenced Q3 2018*						88%	86%	85%	⇩
	% of patients with the correct pressure injury care plan implemented	90%	*Reporting commenced Q3 2018*						71%	96%	68%	⇩
	% of patients audited with a hospital acquired pressure injury	TBD	*Reporting commenced Q3 2018*						1.6%	2.4%	0.6%	⇩

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		Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Last Quarter Change
Peri-Operative Care	Surgical Safety	Uptake: % of audits where all components were reviewed.	100%	Sign In	90%	100%	100%	98%	98%	98%	100%	100%	⇔
				Time Out	93%	100%	100%	100%	97%	100%	98%	98%	⇔
				Sign Out	98%		100%	92%	100%	98%	98%	100%	⇧
		Engagement: % of audits with engagement scores of five or higher.	95%	Sign In	85%	75%	94%	84%	93%	85%	96%	88%	⇩
				Time Out	92%	89%	84%	89%	90%	92%	94%	94%	⇔
				Sign Out			83%	94%	95%	95%	100%	92%	⇩
		Observations: number of observational audits carried out for each part of the surgical checklist (Minimum of 50 observations per quarter).	≥ 50	Sign In	52	52	51	57	56	56	52	51	⇩
				Time Out	56	53	56	54	64	61	51	53	⇧
				Sign Out	49	49	52	52	55	56	52	50	⇩
Data not published by the HQSC if audits were <50													
Less than 75%													
More than 75%													
Target Achieved													

3. DHB Quality Indicator Trends – November/December 2018



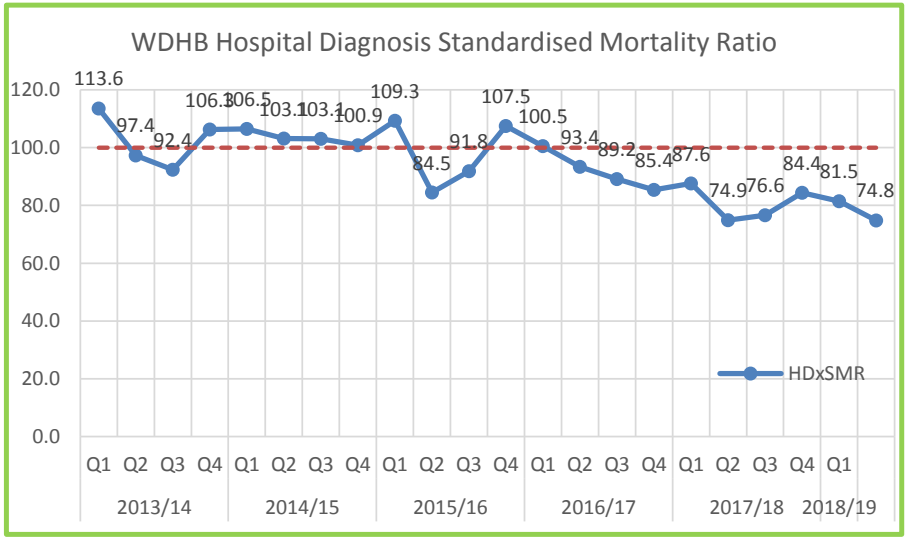
HDxSMR	**87**
(12 months: Jan – Dec 2018)	
Episodes	**68,752**
Deaths	**614**
Expected Deaths	**709.7**
Combined HRT HDxSMR for Jan – Dec 2018	**82**
NZ HDxSMR for Jan – Dec 2018	**100**
Network HDxSMR	**79**

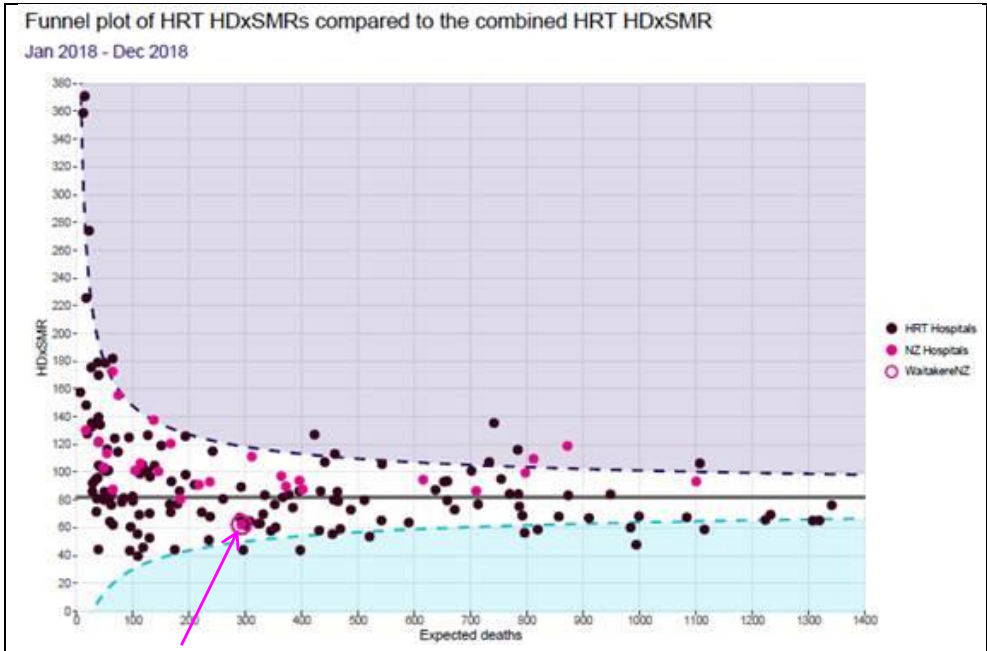
Hospital Diagnosis Standardised Mortality Ratio (HDxSMR)

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)

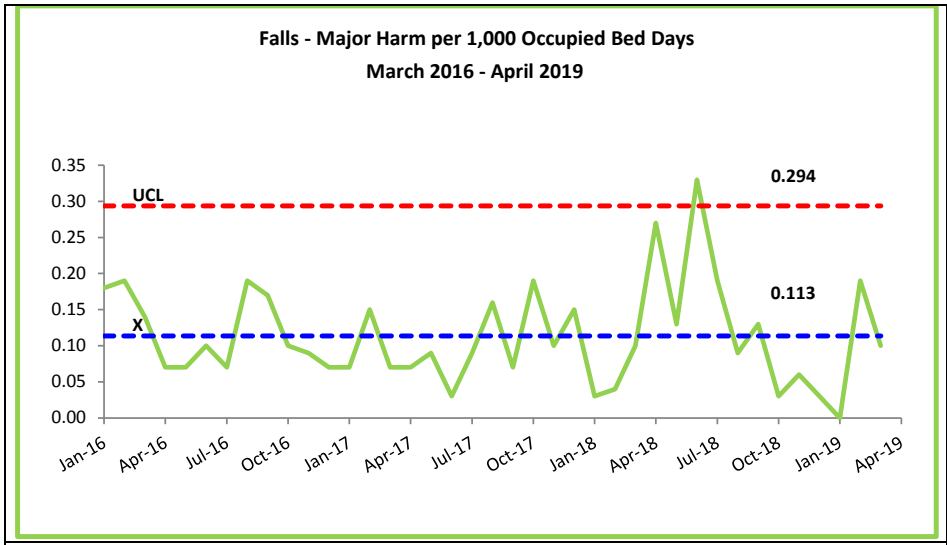
Waitematā DHB's HDxSMR (combined NSH + WTH) Q2 FY2018/2019 = **74.8**

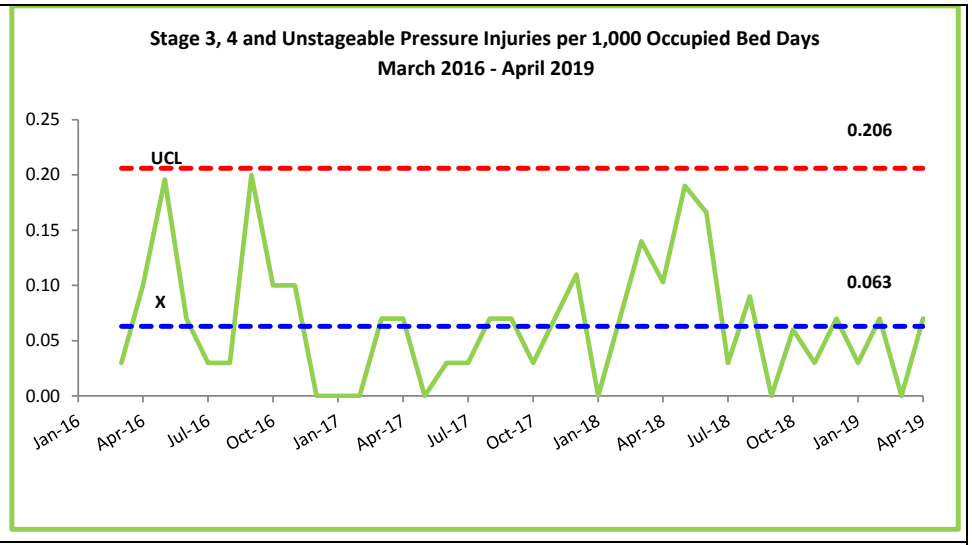




Waitakere Hospital

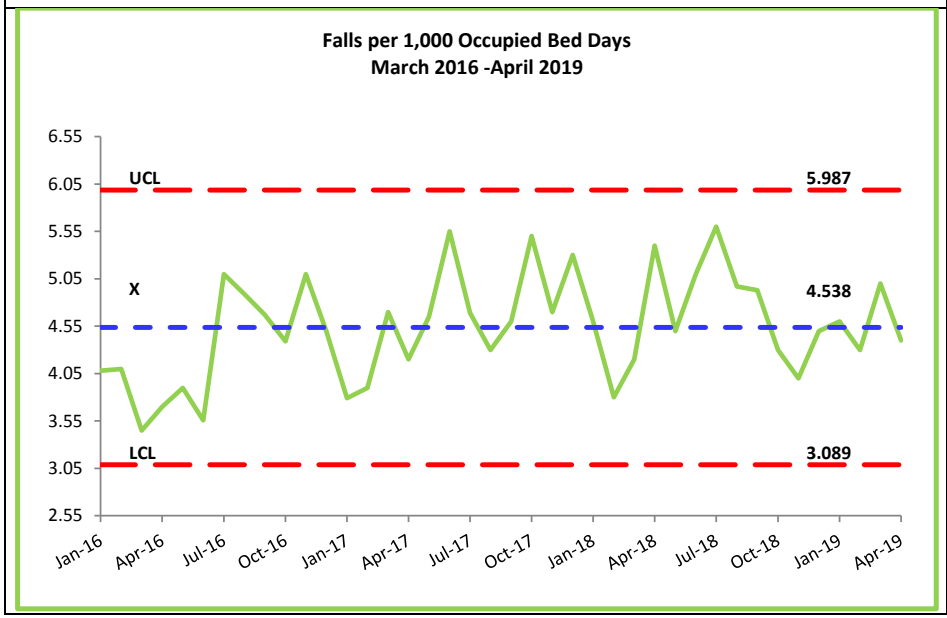
HDxSMR	**62**
(12 months: Jan – Dec 2018)	
Episodes	**33,581**
Deaths	**182**
Expected Deaths	**292.6**
Combined HRT HDxSMR for Jan – Dec 2018	**82**
NZ HDxSMR for Jan – Dec 2018	**100**
Network HDxSMR	**79**

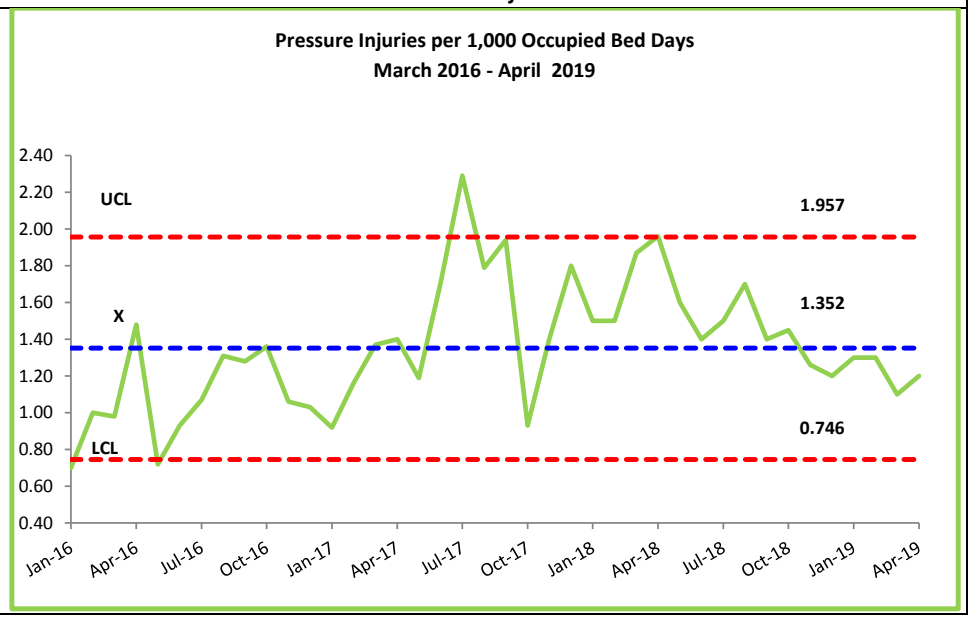


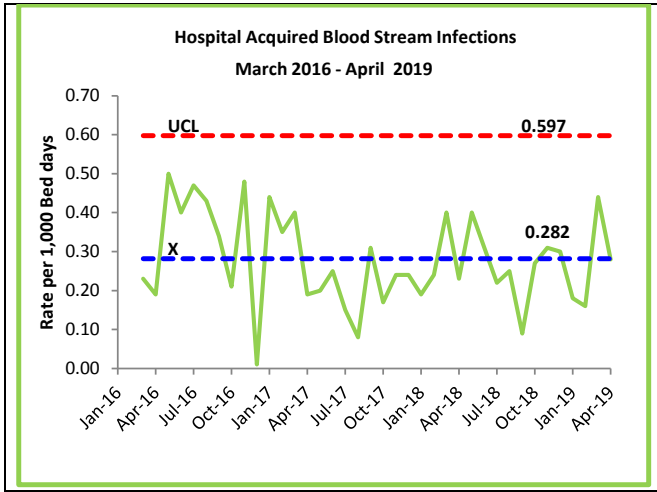


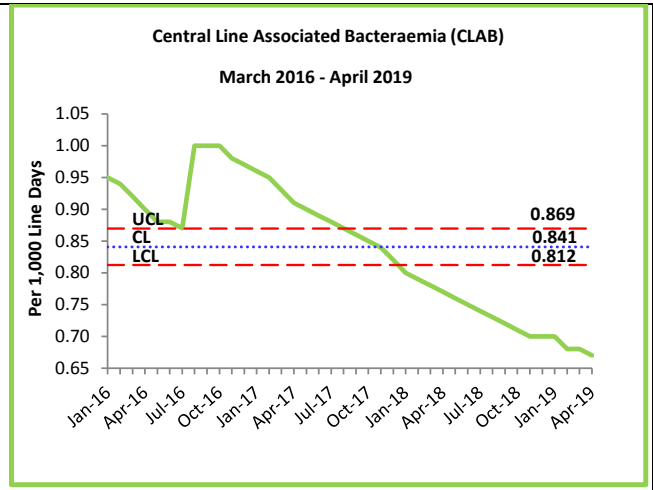
Falls

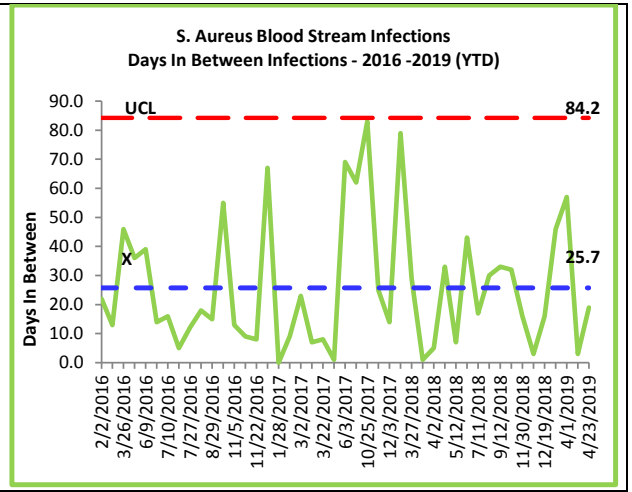
Pressure Injuries











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 a procedure (if no alternate source identified) is categorised as a HABSI. There is **no** recognised national benchmarking 'acceptable' rate or target for HABSI.*

Comment
HABSI rate 2017 **0.25/**1,000 bed days
HABSI rate 2018 **0.25/**1,000 bed days

HABSI rate:
April 2019 = **0.27**
Q1 2019 Rate: **0.30**

Source	April (=6)
IV Luer	2
Other	2
Unknown	2

Central Line Associated Bacteraemia (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.

Comment
Rate of CLAB/1,000 line days: **April 2019** rate was 0.**67**/1,000 line days the target for this is **<1** per 1,000 line days.

ICU/HDU **120** "CLAB Free" days as at 30 April 2019
(restarted as of 01/01/2019).*

The National target is >90% compliance for insertion and maintenance bundles use.

Month	Insertion Bundle	Maintenance Bundle
April 2019	100%	94 %

Staph Aureus Blood Stream Infections

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.

This is a 'days between' control chart and, therefore, the clustering of data points below the mean (X̄) represents events occurring close in time or an increased relative frequency of events.

Comment
The length of time between infections is increasing which may reflect improved compliance with hand hygiene practices.

Waitematā DHB's SAB rate (quarterly rate of 0.02-0.06 per 1,000 bed days) is consistently well below the national average (0.11-0.13 per 1,000 bed days) with an approximate average of one SAB per month.

SAB Rates:
April 2019 = **0.14** (x three SAB)
2018 = **0.05**
2017 = **0.07**

4. Key Quality Indicators

4.1 Hospital Acquired Blood Stream Infections (HABSI)

Target	Measure	Prev. Report Period	Current Report Period	Commentary
0	Total # of infections	10 (Mar)	6 (Apr)	*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.* • Mean rates of HABSI/1,000 occupied bed days over the last five years are:
0.00	# of infections per 1,000 occupied bed days	0.44 (Mar)	0.27 (Apr)	

	Rate	N=
2014	0.32	79
2015	0.33	79
2016	0.35	89
2017	0.25	67
2018	0.26	70

HABSI Analysis April 2019

Source	Total	Area	Organism	Comments
IV Luer	2	ICU	Staph aureus	• Presence of left ante-cubital fossa (ACF – Elbow) IV Luer (IVL) missed by clinical staff • Source of sepsis located two days after positive blood culture • Inconsistent documentation in both eVitals and clinical notes • No visual inspection for phlebitis (VIP) scoring documented as per DHB policy
		Ward 2	Staph aureus	• IVL inserted in R) ante-cubital fossa (ACF – Elbow) • Patient developed cellulitis • No documentation on eVitals • No VIP scoring
Other	2	Ward 12 (KMU)	E coli	• A patient admitted for treatment of a mood disorder with associated drowsiness developed a hospital acquired pneumonia following an aspiration event
		Muriwai	E coli	• A patient with decreased mobility secondary to fall developed a urinary sepsis; this was not related to an indwelling urinary catheter
Unknown	2	Ward 7	Streptococcus dysgalactiae (Group c/G)	• A patient with renal cancer with associated secondary metastases of the spine required a CT guided biopsy of a spinal mass • The patient developed a bloodstream infection possibly introduced during the procedure but unable to be confirmed
		Special Care Baby Unit (SCBU)	E coli	• A newborn infant in SCBU developed a bloodstream infection; the source has not been able to be identified

4.2 Hand Hygiene (HH) Compliance

<table>
<tr><th>Target</th><th>Measure</th><th>Prev. Report Period</th><th>Current Report Period</th><th>Commentary</th></tr>
<tr><td>>80%</td><td>% rate of compliance with five Hand Hygiene Moments</td><td>90% (Mar)</td><td>89% (Apr)</td><td rowspan="2">
<table>
<tr><th colspan="4">Hand Hygiene Results by Division April 2019</th></tr>
<tr><th>Division</th><th>Correct Moments</th><th>Total Moments</th><th>Compliance</th></tr>
<tr><td>Acute & Emergency Medicine</td><td>1290</td><td>1505</td><td>87%</td></tr>
<tr><td>Child Women & Family</td><td>570</td><td>637</td><td>90%</td></tr>
<tr><td>Specialty Mental Health + Addictions</td><td>238</td><td>245</td><td>97%</td></tr>
<tr><td>Specialist Medicine + Health of Older People</td><td>632</td><td>700</td><td>90%</td></tr>
<tr><td>Surgical & Ambulatory</td><td>1,527</td><td>1,696</td><td>90%</td></tr>
<tr><td>Total</td><td>4,257</td><td>4,783</td><td>89%</td></tr>
</table>
• The ***Hand Hygiene Report for April 2019*** is attached at ***Appendix 1***</td></tr>
<tr><td>0</td><td>Total # of Hospital Acquired SAB infections</td><td>0 (Mar)</td><td>3 (Apr)</td><td rowspan="2">• Waitematā DHBs Staphylococcus aureus Bacteraemia (SAB) rate (quarterly rate of 0.02-0.06 per 1,000 bed days) is consistently well below the national average (0.11-0.13 per 1,000 bed days), with approximately one SAB per month.
• The ***Infection, Prevention and Control Committee's Executive Reports for April 2019*** are attached at ***Appendix 2***</td></tr>
<tr><td>0</td><td># of Hospital Acquired SAB infections per 1,000 bed days</td><td>0.00 (Mar)</td><td>0.14 (Apr)</td></tr>
</table>

4.3 Surgical Site Infections

Target	Measure	Previous Report Period	Current Report Period	Commentary
TBA	-	0.0% (SSI Rate Q3 Jul – Sep 2018)	0.0% (SSI Rate Q4 Oct – Dec 2018)	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.

Target	Measure	Previous Report Period	Current Report Period	Commentary
				• **Quarter 3 2018** SSI Rate has been downgraded by HQSC to 0.0/100 procedures – **no** SSIs identified (HQSC Data) • **Quarter 4 2018** SSI rate is 0.0/100 procedures – **no** SSIs identified • **Preliminary Q1 2019** data indicates that we have had four SSIs two deep and two superficial infections. The cause of each of these SSIs is yet to be determined. Both deep SSIs occurred in February with one case isolating Staph aureus; one case was a left total hip revision (Elective Surgery Centre) and the other a right total knee revision (NSH Theatre). • Of note there, is a much lower rate of procedures reported in the **Q1 2019 (127)** compared to the usual 200-300 procedures; the result of this increases the rate/100 procedures significantly (**3.1**); the DHB's cumulative rate is currently 1.0/100 procedures. We are awaiting official confirmation of the Q1 2019 data from the HQSC. • The National average SSI rate was **0.9**/100 procedures (Q3 2018). *Reporting of the national SSI rate is delayed by two quarters*

SSIs per 100 operations (Q1 2015 –Q1 2019)

Quarter	Q1 2015	Q2	Q3	Q4	Q1 2016	Q2	Q3	Q4	Q1 2017	Q2	Q3	Q4	Q1 2018	Q2	Q3	Q4	Q1
Procedures	285	205	292	250	299	340	311	267	274	331	288	303	217	304	240	229	127
#SSIs	2	2	1	2	1	1	6	4	6	4	1	2	2	2	0	0	4
Waitematā 's Rate	0.7	1.0	0.7	0.8	0.3	0.3	1.9	1.5	2.2	1.2	0.3	0.7	0.9	0.7	0.0	0.0	3.1 *
National Rate	1.0	1.2	1.1	0.8	1.2	0.7	1.2	1.0	1.1	0.8	0.6	1.3	0.7	0.9	0.9	TBC	TBC

*Preliminary Result

Number of SSI per quarter by classification (Q1 2015 – Q1 2019)

Quarter	Q1 2015	Q2	Q3	Q4	Q1 2016	Q2	Q3	Q4	Q1 2017	Q2	Q3	Q4	Q1 2018	Q2	Q3	Q4	Q1
Superficial hip	0	0	0	0	0	0	2	0	3	0	0	0	1	0	0	0	1
Deep hip	0	1	1	1	1	0	2	3	2	3	1	0	0	0	0	0	1
Superficial knee	1	1	0	0	0	1	2	0	0	1	0	1	1	2	1	0	1
Deep knee	1	0	1	1	0	0	0	1	1	0	0	1	0	0	0	0	1
Total SSIs	**2**	**2**	**1**	**2**	**1**	**1**	**6**	**4**	**6**	**4**	**1**	**2**	**2**	**2**	**1**	**0**	**4**

4.4 Central Line Associated Bacteraemias (CLAB)

Target	Measure	Previous Report Period	Current Report Period	Commentary
<1	# of CLAB infections per 1,000 line days (ICU)	0.68 (Mar)	0.67 (Apr)	The ICU is currently **120 days** CLAB Free as at **30 April 2019 – *count restarted 01/01/2019*** • *Central lines are inserted in the operating theatre and maintenance of the lines on the wards is followed up by theatre, ICU and the Infection Prevention and Control team staff supporting ward staff.* • *The total number of central lines (centrally and peripherally) inserted in **April = 46*** • *CLAB rates at Waitematā DHB remain low and most wards have very long CLAB free periods due to both good compliance and infrequency of patients with central lines.*
>98%	% bundle compliance at insertion (ICU)	100% (Mar)	100% (Apr)	
>98%	% bundle compliance maintenance (ICU)	92% (Mar)	94% (Apr)	

4.5 Falls with Harm

Target	Measure	Prev. Report Period	Current Report Period	Commentary
	Total number (#) of falls	154 (Mar)	130 (Apr)	*Verbal update from Dr Jocelyn Peach Director of Nursing/Midwifery*
<5.0	Number of falls per 1,000 Occupied Bed Days (OBD)	5.0 (Mar)	4.4 (Apr)	
	Total number of multi-fallers	18 (Mar)	16 (Apr)	
>90%	% patients 75 years and over (55 years and over Māori and Pacific) assessed for the risk of falling	96% (Mar)	97% (Apr)	
>90%	% patients 75 years and over (55 years and over Māori and Pacific) assessed for the risk of falling within eight hours of admission	77% Mar)	83% (Apr)	
>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	91% (Mar)	99% (Apr)	
	Total number of falls where an injury has occurred (including Major Harm)	44 (Mar)	39 (Apr)	
	Number of falls where an injury has occurred (including Major Harm) per 1,000 Occupied bed day	1.4 (Mar)	1.3 (Apr)	

Target	Measure	Prev. Report Period	Current Report Period	Commentary
	Total number of falls with major harm (SAC 1 and 2)	3 (Mar)	4 (Apr)	
	Number of falls with major harm per 1,000 Occupied bed day	0.10 (Mar)	0.14 (Apr)	
<1	Total number of fractured neck of femurs (NOF) as a result of a fall while in hospital (included in the major falls with harm rate)	0 (Mar)	1 (Apr)	

4.6 Peri-Operative Harm – surgical safety checklist

Target	Measure	Previous Report Period	Current Report Period	Commentary
100%	Uptake: % of audits where all three components of the Surgical Safety Checklist were reviewed.	99%	100%	*Please see the Quality QSM Dashboard for trends.*
95%	Engagement: % of audits with engagement scores of five or higher.	97%	92%	
≥ 50	Observations: number of observational audits carried out for each part of the surgical checklist (Minimum of 50 observations per quarter).	Sign in 52	Sign in 51	
		Time Out 51	Time Out 53	
		Sign Out 52 (Jul – Sep 2018)	Sign Out 50 (Oct –Dec 2018)	

4.7 Pressure Injuries

Target	Measure	Prev. Report Period	Current Report Period	Commentary
100%	% patients risk assessed within specified time frame (eight hours)	74% (Mar)	77% (Apr)	*Verbal update from Dr Jocelyn Peach Director of Nursing/Midwifery*
100%	% patients audited who received a score	86% (Mar)	85% (Apr)	
100%	% patients with the correct care plans implemented	% (Mar)	69% (Apr)	

Target	Measure	Prev. Report Period	Current Report Period	Commentary
	Number of patients with reported confirmed pressure injuries (Incident Reporting System – Risk MonitorPRO)	35 (Mar)	37 (Apr)	
	Number of confirmed pressure injuries per 1,000 Bed Days	1.1 (Mar)	1.2 (Apr)	
0	Number of reported confirmed Stage 3, 4 or unstageable pressure injuries (Incident Reporting System – Risk MonitorPRO)	0 (Mar)	2 (Apr)	
	Number of confirmed Stage 3, 4 or unstageable pressure injuries per 1,000 Bed days	0.0 (Mar)	0.07 (Apr)	

4.8 Specimen Errors

Target	Measure	Previous Report Period	Current Report Period	Commentary
	Total number of specimen errors/month	661 (Mar)	664 (Apr)	
<1%	% of specimen errors (defect rate)	2.5%	2.5%	
	% of specimen errors related to wrong blood in tube	0.01 (Mar)	0.01 (Apr)	
	% of specimen errors related to: mismatched specimens/labels; unlabelled specimens; specimens with incorrect/insufficient patient details	0.5% (Mar)	0.6 (Apr)	
	% of specimen errors related to incorrect/incomplete group and hold specimens/documentation (for blood/blood product transfusions)	0.2% (Mar)	0.1% (Apr)	
	% of blood specimen recollections required due to specimen integrity issues (e.g. leaked, haemolysed/clotted, not enough blood)	0.6% (Mar)	0.7% (Apr)	

4.9 E-Medicine Reconciliation (eMR), ePrescribing and Administration (ePA)

Target	Measure	Previous Report Period	Current Report Period	Commentary
100%	% patients with eMR completed within 24 hours on admission and discharge	87%	-	**Electronic Medicines Reconciliation (eMR/eMedRec)** eMedRec is live in 919 acute beds across North Shore and Waitakere Hospitals. Our completion rates for inpatients sit between 85-95% of all ward patients having an eMedRec form completed by a pharmacist during their admission (in areas where eMedRec available). The rollout of eMedRec has now been completed to all planned areas. Maternity, and the Emergency departments been enabled for limited use in selected, complex paediatric patients. WDHB has been working with HQSC and other eMedRec stakeholder DHBs to agree on nationally appropriate quality and safety markers (QSMs) around the Med Rec process. Updated QSMs had been proposed and reports were under development but the HQSC value of reporting QSMs for eMedRec given the low uptake of the software among other DHBs with only six DHBs currently using it. Feedback was provided by stakeholders and the HQSC Medication Safety Expert Advisory Group's (MSEAG) recommended that QSMs for Med Rec should be kept. The new QSM development remains on hold. **Electronic Prescribing and Administration (ePA)** **Medchart Performance:** healthAlliance (hA) has agreed to move the remaining Medchart servers to the new Virtual Farm as there was some performance improvement when some servers were moved across. We are waiting for this to be scheduled by hA. **iPad Freezing:** Freezing of iPads is still occurring; we have put many hours into manually upgrading the entire fleet to iOS12 which provides performance improvements for older devices. A new wireless network called TWA has been stood up which is more like Northair than SWA2. We are waiting for some iPads to be connected to this new network so we can test whether this resolves the freezing issue.

4.10 Complaint Responsiveness

Target	Measure	Previous Report Period	Current Report Period	Commentary
<15 days	Average time to respond to complaints in the reporting month	16 (Mar)	13 (Apr)	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.

	Average Days to Respond
2015	18
2016	19
2017	15
2018	14

Average Days to Close by Division for April 2019

Division	Average Days to Respond
Acute and Emergency Medicine	4
Child Women and Family	8
Specialist Mental Health and Addiction	32
Specialty Medicine and Health of Older People	19
Surgical and Ambulatory	18

4.11 Hospital Mortality

Key Quality Indicators	Target	Measure	Previous Report Period	Current Report Period	Commentary
Mortality (death rate)	<100	Hospital Standardised Mortality Ratio (HDxSMR)	81.5 (Q1 FY 18/19)	74.8 (Q2 FY 18/19)	See latest data under **Section 3, DHB Quality Indicators Dashboard**

5. Improvement Team Active Projects Report

Innovation and Improvement Project Team: Active Projects Report

April 2019				000'000		Overall Status		
Project Name	**Project Summary**	**Sponsor(s)**	**PM Resource**	**Budget**	**Forecast Variance**	**This Period**	**Last Period**	**Phase**
Organisation wide / Multiple Divisions								
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	Andrew Brant Jos Peach Penny Andrew	Jeanette Bell	N/A	N/A			
	1. PDP: Recognition and Response Systems	Penny Andrew	Sue French	N/A	N/A			Executing
	2. PDP: Kōrero mai: Patient, family and whānau escalation	David Price	Jeanette Bell	N/A	N/A			Closing
	3. PDP: Shared Goals of Care	TBA	Jeanette Bell	N/A	N/A			Scoping
Survive Sepsis Improvement Collaborative	A quality improvement project that aims to reduce inpatient sepsis mortality to <15% by September 2017	Dr Penny Andrew Dr David Grayson Dr Matt Rogers Shirley Ross Kate Gilmour	Kelly Bohot Kelly Fraher Renee Kong	N/A	N/A			Closing
Leapfrog (refer to Leapfrog project update)	Data Discovery Project: Implement and ensure use of QlikSense Business Intelligence tool across Waitematā DHB	Penny Andrew	Renee Kong	$1.2m	0%			Executing
	Outpatients	Dale Bramley & Robyn Whittaker	Kelly Bohot	N/A	N/A			Executing
PROMs Programme	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	Jay O'Brien	Mustafa Shaabany	N/A	N/A			Planning
SmartPage	Extend the use of SmartPage messaging system for calls to House Officers during business hours (Mon-Fri 08:00 – 16:00) by deploying DHB-managed smartphones with the SmartPage app installed to all House Officers who currently have a pager. Then extend to all RMOs (House Officers + Registrars).	Penny Andrew Stuart Bloomfield	Dina Emmanuel	$50k (Opex) phase 2	0%			Executing
IC-Net Optimisation	Optimise the use of ICNet, a software solution for infection surveillance and management in the Waitematā DHB environment	Matthew Rogers, Stuart Bloomfield	Barbara Corning-Davis	N/A	N/A			Executing

Improve "unapproved" clinical letters backlog	Reduce unapproved clinical letters backlog to meet the KPI of 5 days for P1 documents and 10 days for P2 documents from the time letters being transcribed and ready for approval by the author	Lara Hopley	Dina Emmanuel	N/A	N/A			Executing
Radiology Service Care Transformation	Develop Care Transformation Programme to ensure high quality, high value service addressing: demand and outsourcing; patient flow; service utilisation; evidence-based care and elimination of unnecessary procedures (Choosing Wisely); patient experience and staff experience	Cath Cronin Robert Paine	Renee Kong Kelly Fraher	N/A	N/A			Planning
Acute Pain Service Review	Review Acute Pain Service, with possible re-design. Current referral demand and workload not fitting within current model		Lydia Gow	N/A	N/A			Scoping
Surgical								
General Surgery Clinical Pathways (appendicitis, laparoscopic cholecystectomy, abscesses)	Improve general surgery patient experience: reduce length of stay, variation and cost of care	Richard Harman Kate Macfarlane	Lisa Sue	N/A	N/A			Executing
Conversion of Short-Stay to Surgical ADU	Convert the Short Stay Ward into a Surgical ADU (surgical specialties + gynae) to facilitate the introduction of acute clinical pathways for surgery, smooth RMO workflow, and potentially free up space in the current ADU for medical patients + pathways	Michael Rodgers Debbie Eastwood	Kelly Fraher	N/A	N/A			Scoping
Surgical Implant Tracking	Develop a system to track surgical implants. The aim is to capture product information at point of entry into Waitematā DHB and assign a unique Waitematā DHB identifier in bar code format that can be captured and linked to a patient at point of care (in theatre) and beyond	Michael Rodgers	Mustafa Shaabany	N/A	N/A			Scoping
Medical								
TransforMED	Improve the experience of acute medical inpatients by eliminating unnecessary waiting, reducing deconditioning, improving flow, and providing team-based care through four workstreams: • Inpatient Wards: eliminate unnecessary patient waits + implement SAFER bundles of care • ADU: improve flow, earlier access to senior doctor + diagnostics • PACE: early identification and care of frail elderly • Medical Model: home-based wards and collaborative, MDT ward service	Cath Cronin Alex Boersma Gerard de Jong John Scott	Kelly Bohot Kelly Fraher Renee Kong	N/A	N/A			Executing

Chest pain pathway Review	Complete a review of the chest pain pathway including: • Review of local and international literature • Audit of ETTs and patient outcomes	Jonathan Christiansen Laura Chapman, Kate Allan	Kelly Bohot	N/A	N/A			Closing
Choosing Wisely-Optimise Abdominal X-ray (AXR) requests in Emergency Department	Abdominal X-ray has long been regarded as overused, with low diagnostic yield in the Emergency Department. The aim is to refine the e-ordering process by adopting Choosing Wisely approach to refine the list of indications "Indication list" for patients requiring abdominal X-ray with the view of reducing the unnecessary X-ray orders that does not add value and in some occasions can cause harm to the patient.	Willem Landman Amanda Holgate	Dina Emmanuel	N/A	N/A			Executing
OptimisED+ Providing best care by continuous improvement	Review, identify opportunities and implement further improvements in the Emergency department, to consistently deliver best emergency care by optimising ED staffing, capacity-demand matching, and leadership structures and roles.	Cath Cronin Willem Landman	Dina Emmanuel	N/A	N/A			Executing
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	Lisa Sue Kelly Bohot	N/A	N/A			Planning
Endoscopy Service Care Transformation	Develop Care Transformation Programme to ensure high quality, high value service addressing: demand and outsourcing; patient flow; service utilisation; evidence-based care and elimination of unnecessary procedures (Choosing Wisely); patient experience; and staff experience	Cath Cronin Robert Paine	Delwyn Armstrong Penny Andrew	N/A	N/A			Execution
Cardiology Outpatient Triaging and Grading	Review and improve the process for triaging cardiology outpatient referrals to the Cardiology Service to ensure more timely access to the service, appropriate prioritisation, and identification of patients who require specialist assessment	Tony Scott Alex Boersma Linda Flay	Kelly Bohot	N/A	N/A			Planning
Child Woman and Family								
Urogynaecology Service	Develop a local service for women requiring management of urogynaecological conditions; Stress Urinary Incontinence (SUI) and Pelvic Organ Prolapse (POP) and management of complications associated with previously implanted surgical mesh as a treatment type. Development of a business case will include care for women in	Cath Cronin	Sue French	N/A	N/A			Initiating

	Waitematā and the Northern Regions with SUI or POP, and those affected by complications secondary to treatment of these conditions where mesh was used							
Mental Health and Addiction Services								
Mental Health and Addiction (MHA) Quality Improvement Programme	Support the development and delivery of the national MHA quality improvement programme, **Whakapai i ngā mahi hauora hinengaro waranga hoki**, at Waitematā DHB. The programme aims to improve the quality and safety of mental health and addiction services and the experience of care for consumers	Susanna Galea	Kevin Cleary	N/A	N/A			Execution
Community								
Safety in Practice Programme	Waitematā DHB's Safety in Practice (SiP) 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. The i3 provides quality improvement and project management support to the programme.	Tim Wood Stuart Jenkins	Sue French	N/A	N/A			Execution
Ear Nurse Service Process Improvement	Improve Ear nursing service (ENS) by identifying the required nursing FTE to maintain a sustainable workforce. Define and implement more efficient streamlined processes and clear parameters to enhance patient outcomes.	Marianne Cameron Michele Kooiman	Dina Emmanuel	N/A	N/A			Execution
District Nursing Service Review	Review and work to improve DN service across West, North and Rodney	Jos Peach Brian Millen	Lydia Gow Kelly Bohot	N/A	N/A			Initiating

Other Work In Progress	Overview	Involvement	Sponsor(s)	PM Resource	Comment
Innovation Partnership	Develop, test and refine mobile app review process	Research and develop a process including a review questionnaire to screen apps based on business/clinical relevance, quality, functionality and security	Stuart Bloomfield Robyn Whittaker	Kelly Bohot	Ongoing

Quality Improvement Training	Overview	Involvement	Sponsor(s)	PM Resource	Comment
Tier 2 project-based 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	Ongoing
Mental Health and Addiction (MHA) Quality Improvement Programme	As above	As above	Susanna Galea	Kevin Cleary	Ongoing

Safety in Practice	As above	As above	Tim Wood Stuart Jenkins (ADHB/WDHB) Lisa Eskildsen Diana Phone	Sue French	Ongoing
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	Ongoing
Management Foundations	Teach QI skills to 22 participants and mentor each to deliver a QI project	Content development and delivery Ongoing mentorship	Sue Christie	Barbara Corning-Davis	Ongoing

Support Requests						
Current Support Requests						
Project Name	**Sponsor / Requestor**	**Description**	**Request received**	**Scoping Completed Approved date**	**Assigned to**	**Comment**
Organisation-wide/Multiple Divisions						
eProgress Notes roll-out	Stuart Bloomfield David Ryan	Project management support for the roll out of eProgress notes across the acute wards at NSH and WTH during June and July 2019.	May 2019		Lydia Gow	
eOrders: support with training and change management in ED/ADU	Robyn Whittaker Michael Sheehan	Project management support for the implementation of eOrders Phase 2 – training and change management in ED/ADU	February 2019			
Review of clinical monitoring across the DHB		Most of the monitoring equipment is outdated. The purpose of the review is to scope options for a new system addressing existing shortcomings; develop a replacement strategy; write a business case to replace the equipment	February 2019			
Further development of the skin service model of care	Cath Cronin Debbie Eastwood Michael Rodgers Richard Martin (Clinical Lead)	Support for the Operations Manager and Clinical Lead to: • Set up a clinical governance structure for the skin service • Bring all the stakeholders together to discuss service development • -Review contracts for GPs within	September 2018			

		the scheme including the process for appointment • Review GP pay rates (this is a regional piece of work) • Review the service specification so a procurement process can be completed • Review resources across the service and bring them together into one service (GP, General Surgery + ORL) • Streamline the referrals flows and allocation process – current duplication • Further develop Qlik scorecard for the Skin Service				
Pressure Areas	Cath Cronin, Jos Peach, Kate Gilmore, Lucy Adams	Assistance with review of current state, literature review and education campaign	May 2018			Proposal for Quality Executive Committee to lead. i3 to scope QI programme when i3 PM capacity available
Staff security	Cath Cronin	Prepare an overview of where we are at with security from an operational and Health and Safety view following the work of a Security Review Programme developed by a service project manager in 2016/17. The work is spread over the operational team, Occupational Health team, and Health and Safety team. Develop a proposal for one service to lead and own this work, with responsibility for keeping a full oversight and accountability for the programme.	September 2018			Awaiting i3 project manager capacity
Mission Home Ground	Sarah Masson, Planning Funding & Outcomes	Request for business analyst/process mapping for development of a 10 bed medical detox floor at Waitematā DHB and 15 bed social detox floor for ADHB, to be				Awaiting confirmation that support required. More information provided end March 2019. Follow up

		operational by October 2020. Proposed start date mid-November				discussion about scope required.
Child Women and Family Service						
Maternity Nurse Call Evaluation	Robyn Whittaker	We need an evaluation of the system Shane Fullam has put into the maternity ward NSH as a nurse call system. We need to make a decision about whether we would expand to WTH or not	April 2019		Carolyn Czepanski	
Surgical						
Gynaecology Theatre informed consent process for sensitive examinations	Cath Cronin Diana Ackerman	Project management support to improve the process of informed consent for patients undergoing sensitive examinations in the gynaecology theatre	May 2019	20 May 201	Lisa Sue	Scoping has commenced, further work to be completed to understand current process and issues.
Meeting the community's need for equitable elective surgery	Mike Rodgers	How can the surgical triage tools and thresholds for elective surgery tell us whether we are being equitable between and within specialties?	May 2018			
NSH Operating Theatres: Improving the function of and culture	Mike Rodgers Debbie Eastwood	Work with the theatre teams (by profession, by area etc.) collaboratively on how we can improve the way theatres function linked to how staff work together	28 August 2018			

Closed since last report				
Project/Work/Request	**Sponsor/Requestor**	**Overview**	**Outcome**	**Close out / summary report location**
QI Support for Renal Medicine Service Improvement	Andrew Salmon	QI specialist to support/review programme of quality work in the renal service. We require some strategic oversight/focus, as well as guidance on resources we might draw on for key individual projects.	April 2019	

Patient Deterioration Programme (PDP) Progress Summary

Sponsors: Andrew Brant, Jos Peach, Penny Andrew
Project Manager: Jeanette Bell
Phase: Scoping - Planning - Closing

Opportunity / Problem Statement:
Our processes and systems to support safe, consistent, effective 24-hour care for the clinically deteriorating patient are not always adequate, presenting an on-going risk to patient safety. Local and national scoping has identified a number of improvement opportunities and initiatives to further develop and strengthen our management of the deteriorating patient.
Waitematā DHB has identified a local programme of work to consider as well as participation in the Health Safety and Quality Commission (HQSC) national and regional patient deterioration programme (July 2016 to June 2021).

Objective / Aim:
To introduce a patient deterioration programme to promote a structured and systematic approach towards improving the management of deteriorating patients at Waitematā DHB.

Status Update:

- Monthly Executive Sponsor meetings and regular updates to CGB scheduled

Recognition and Response Systems (see separate progress summary reports)

- 24-hour Critical Care Outreach service at North Shore from 26 April 2019.
- Introduction of national vital signs chart and early warning system took place on Monday 6th May (delayed by one week due to Doctor's strike). Some technical issues with SmartPage unresolved
- National Maternity Early Warning System (MEWS) HQSC workshop for Cohort two 15 May 2019 Waitematā DHB group attending

Kōrero mai: Patient, family and Whānau Escalation (see separate progress summary report)

- 18 calls since November
- Maternity North Shore has introduced service this month
- Post implementation staff and patient/ whānau awareness survey completed, analysis underway
- Transition to business as usual under the Patient Experience Team near completion

Shared Goals of Care

- Waitematā DHB working with HQSC as 1 of 2 test DHB's for new national Shared Goals of Care principles, tools and resource – waiting more information but will start within next 2 months
- DHB decision not to join national Advanced Care Planning programme confirmed

Measurement

- Quarterly HQSC quality safety markers reporting
- Development of patient deterioration programme dashboard in Qlik Sense in progress
- New Interim QlikSense app called NZEWS Live launched to allow hourly monitoring of EWS activity and modifications
- Deteriorating patient database -refinement of database in progress
- Quarterly Early Warning Score (EWS) audit will move from quarterly to weekly auditing in May

Project Risks:

- Large scale of programme and change
- Need to keep large number of stakeholders informed
- Clinician availability, staff engagement
- Potential for local and national priorities and timelines to differ
- Impact of other service and staffing changes on project timelines and plans

Project Issues:

- Delays to work stream 1 delaying timelines for all other work streams

Next Steps:

- Continue monitoring and supporting and supporting New Zealand Early Warning System (NZEWS) changes
- Continue to develop Patient Deterioration Dashboard
- Complete transition of Kōrero Mai to Patient Experience team
- Meeting with HQSC to discuss Shared Goals of Care
- Support Maternity with planning MEWS

Timeline

	Milestone	Status	Completion
Recognition and Response Systems - Implementation of National Vital Signs Chart & Early Warning Score (adult)	Executing	Adult EWS implemented 6 May 2019	TBC
Recognition and Response Systems - Implementation of National Vital Signs Chart & Early Warning Score (maternity)	Not yet started	May 2019 start	TBC
Kōrero mai: Patient, family and Whānau Escalation Co-design	Closing	Awaiting evaluation to close	March 2019 (Was December 2018)
Shared Goals of Care	Scoping	In progress	September 2020

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	Delayed	N/A

PDP Work Stream 1: Recognition and Response Systems

Clinical Leads: Jonathan Casement
Project Manager: Sue French
Phase: Executing

Opportunity / Problem Statement:

Ensuring deteriorating patients receive appropriate and timely care is essential to meeting the aim of safe, effective, quality patient care. Early recognition and response to clinical deterioration can minimise and reverse the severity of deterioration and the level of intervention required to stabilise a patient's condition and can reduce patient harm, morbidity and mortality, hospital length of stay and associated health costs. Evidence demonstrates that patients exhibit many signs and symptoms of deterioration for a reasonable period of time before cardiac arrest or unplanned admission to intensive care occurs. Evaluation of our current systems indicates that there is inconsistent processes and pathways and an absence of processes and mechanisms to support safe, consistent, effective 24-hour care for the deteriorating patient

Objective / Aim:

Develop and deploy a robust strategy for the implementation of a Waitematā Recognition and Response program that will reduce the harm associated with unrecognised deterioration and its subsequent delayed treatment for all adult in-patient (excluding maternity) care areas.

Status Update:

- Organisation wide transition to NZEWS in all electronic systems completed at 2300 hours; May 6 (Launch delayed due to Junior Doctors Strike)
- Pre-launch education programme completed May 6th
- Increased House Officer and Registrar cover at both sites for 24 hours from implementation; increased Nursing staff availability at both sites, for first 8 hours. Operations Manager's covered associated cost
- Patient At Risk (PAR) Huddle meeting at both sites for Outreach, Medical and Surgical Staff and Duty Nurse manager teams during launch week
- Widespread technical issues occurred. eVitals transitioned correctly, upgrade to data representation in secondary systems did not occur as per user testing outcomes
- Health Information Group and eVitals team are working with vendors to deploy solutions
- Twice daily briefing meetings at both sites for senior managers, executive on-call , Clinical Nurse Directors, outreach service and eVitals occurring to address issues arising from changes and issues associated to technical problems

Project Risks:

- Engagement from existing clinical teams
- Human resource resistance to organisation wide change process
- Resource requirements (clinical staff) for potential changes to escalation and response systems and delivery of education

Project Issues:

- Technical issues with Smartpage, In-patient, Clinical Whiteboard, Trendcare and Capacity-At-A-Glance Board occurred secondary to eVitals changes

Next Steps:

- Morning briefing meetings to continue this week
- Commence auditing of new system
- Commence process of moving education into Business as Usual planning
- Commence work on New Zealand Maternal Early Warning Score (NZMEWS) implementation

Timeline

Milestone	Status	Estimated Completion Date
Initiating	Complete	September 2017
Planning	Complete	July 2018
Executing	Complete	6th May 2019
Closure	Pending	TBC

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	Delayed	N/A

PDP Work Stream 2: Kōrero mai: Patient, Family and Whānau Escalation Progress Summary

Sponsor: David Price
Project Manager: Jeanette Bell
Phase: Closing

Opportunity / Problem Statement:
Staff inaction in the face of patient or family/whānau reports of patient deterioration is considered an adverse event. Sadly, case studies in New Zealand identify that lack of follow up by staff following such reports have led to poor patient outcomes and/or death. The Health and Disability Commissioner has identified that communication between patients, families and medical teams is a key point of concern in approximately 42 per cent of complaints. It is thought that an escalation process for patients, family and whānau will help reduce adverse events occurring in response to reports of patient deterioration. There is no such system currently in place at Waitematā DHB. The Health Quality and Safety Commission (HQSC) sponsored Waitematā DHB as one of four national sites to co-design a patient, family and whānau escalation system (Kōrero Mai).

Objective / Aim:
To co-design a patient, family and whānau escalation system for deteriorating patients with consumers, family, whānau and staff at Waitematā DHB

Status Update:
- Kōrero mai telephone service went live across both hospital sites 19 November 2018 in inpatient settings and phone line staffed by Waitematā Central
- Patient experience team now manage service. I3 project management support until transition complete.
- Eighteen calls since November 2018. No calls for acute physical deterioration
- North Shore Hospital Maternity Service joined service last week, Waitakere Maternity Service and SCBUs will introduce service shortly.
- Kōrero Mai service guidelines and Committee ToR published.
- Committee meetings initiated.
- Additional language resources being finalised.
- Service measures agreed
- Post implementation staff and consumer awareness surveys completed, analysis underway

Project Risks:
Nil at present

Project Issues:
Closure timeline delayed to allow full transition to business as usual and to allow for post implementation evaluation

Next Steps:
- Complete transition of service to business as usual under the Patient Experience Team
- Fully Implement in maternity and SCBUs
- Analysis of patient and staff surveys
- Post survey awareness campaign
- Project close out report

Timeline

Milestone	Status	Estimated Completion Date
Initiating	Complete	29 August 2017
Planning	Complete	31 October 2017
Executing	Complete	14 June 2018 (Co-design process) 19 November 2018 (DHB roll out)
Closure (of HQSC co-design project) and transfer to business as usual	In progress	June 2019 (was Dec 18)

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
	June 2019 (was Dec 18)	N/A

PDP Work Stream 3: Shared Goals of Care Progress Summary

Sponsors: Andrew Brant, Jos Peach, Penny Andrew
Project Manager: Jeanette Bell
Phase: Scoping

Opportunity / Problem Statement:

Unwanted or unwarranted treatments at the end of life can contribute to suffering for patients, families and whānau, moral distress for clinicians, and unnecessary expenditure for the health system.

Planning and managing end of life decision making and care can be challenging for clinicians and is often not adequately addressed, placing acutely deteriorating patients at risk of unwanted or unwarranted treatment, particularly at the end of life.

Objective / Aim:

To develop a consistent organisational approach to determining, communicating and documenting shared goals of care for adult inpatients to ensure all adult inpatients have patient centred clinically appropriate care plans in the event of acute deterioration and at the end of life.

Status Update:

- Scoping document presented to PDP Executive Sponsor Group August 2018
- Advance Care Planning (ACP) discussion document submitted to ELT in September 2018
- DHB decision not to join national Advanced Care Planning programme confirmed
- Waitemata DHB to work with HQSC as one of two national test sites for the nationally developed Shared Goals of Care principles, tools and resources. Mid Central DHB is the other site. Telephone meeting this week

Project Risks:

- Work stream will require across service engagement
- Need to keep large number of stakeholders informed
- Clinician availability, staff engagement
- Potential for local and national priorities and timelines to differ
- Potential for scope creep as work overlaps into community and to multiple specialties

Project Issues:

- HQSC using national Advance Care Planning Programme (ACP) to meet some Shared Goals of Care objectives. Waitematā DHB is not taking part in full national ACP programme so will not have access to this resource and will have to find an alternative approach to meet objectives
- Changes in work stream 1 timelines and work stream 2 resources impacting on timelines for this work stream
-

Next Steps:

- Await HQSC proposal on being a test site
- Meet with programme leads to establish work stream leads, plan working group and work stream content once additional scoping complete

Timeline

Milestone	Status	Completion
Initiating	Scoping	TBC with new work
Planning	Not started	(delayed)
Execution	Not started	(delayed)
Close	Not started	September 2020 (HQSC time line)

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
	TBA	N/A

Survive Sepsis Improvement Collaborative - Progress Summary

Sponsor:	**Dr Penny Andrew, Dr David Grayson, Shirley Ross, Kate Gilmore and Dr Matt Rogers**
Project Manager:	**Kelly Bohot**
Phase:	**Closing**

Problem Statement: Sepsis poses significant morbidity and mortality risks to our patients, and with every hour delay to treatment there is an 8% increase in mortality. Waitematā DHB does not reliably recognise and treat patients with sepsis in a timely manner.

Aim: To reduce the rate of inpatient sepsis mortality to less than 15% by August 31, 2017.

Status Update:

Work stream 1: Best Practice Guidelines

- Maternity guidelines agreed and signed off by Antimicrobial Stewardship Committee and Pharmacy Committee. Awaiting publication.

Work stream 2: Improvement Activities

Work stream 3: Clinical education program

Work stream 4: Measurement and Evaluation

Our coding system will be updated on 1st July 2019. Impact on sepsis coding is not quantified at present. Since implementing our measurement set there are a number of different approaches being taken within New Zealand and overseas regarding the coding definition of sepsis. We have started some conversations with Waikato DHB and Imperial College London with a view to better understanding their approaches.

Project Issues:

Further validation of data required. There are issues with specificity and sensitivity of the data which uses multiple sources (eVitals, laboratory, clinical notes and coded data). Further work is needed to develop a reliable sepsis data dashboard. An expert group (Dr Matt Rogers, Dr Hasan Bhally; Dr Nick Gow, and Kirsten Bondesio is working with the i3 team to further develop the dashboard.

Next Steps:

Work stream 1: Best Practice Guidelines

Adult guideline

- Nil

Maternity guidelines

- Complete publication process

Paediatric guidelines

- Nil

Work stream 4: Measurement and Evaluation

- Project Implementation Review document in progress
- Explore impact of changes to clinical coding due 1st July 2019 (moving from ICD10 edition 8 to ICD10 edition 10)
- Video call with Imperial College London planned for 7 June 2019.
- Explore options to validate sepsis screening tool
- Meeting with Waikato DHB sepsis project team on 17 June to discuss measurement alignment

Project Timeline

Activities	Status	Timeline
Publish adult guidelines	Complete	January 2018
Complete maternity guidelines	Complete	January 2018
Identify resource for paediatric workstream	Complete	January 2018
Develop test and analyse Qlik data	In progress	TBA
Complete Project Implementation Review	In progress	TBA

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	Extend	N/A

Patient Reported Outcome Measures (PROMs) Progress Summary

Sponsor: Jay O'Brien
Project Manager: Mustafa Shaabany
Phase: Planning

Opportunity / Problem Statement:

Data collection for patient reported and clinician assessed outcome measures and patient experience of service is currently fragmented, requires extensive resources and lacks transparency for clinical providers and service funder and planners. The lack of an efficient data capture system limits the capacity to make improvements in real time for patients and whānau.

Objective / Aim:

Develop a reliable, systematic PROMs data collection and reporting system.

Triangulate patient reported outcomes (PROMs), patient experience, clinical outcomes data and health economics analysis to provide a meaningful and reliable dataset for clinicians about an individual patient's potential to achieve improved quality of life throughout their condition and treatment.

Provide reliable PROMs data for population health analysis and improvement.
To create a synthesis between PROMs, PERSy and the HOPE project (health outcome prediction engine in stroke) for greater efficiency and improvement opportunities for service providers and end user application.

Status Update:

- Currently creating a view of PROMs in Clinical Portal 8 (electronic health record) - Delayed
- PROMS website is live now
- Online playbook (checklist) has been developed – being tested by governance group and select clinicians
- PROMS results report is drafted and being reviewed by select clinicians
- Integration between PERSy and Waitematā DHB data warehouse complete and data coming in to the warehouse within 5 minutes of surveys being submitted by patients
- 20 iPads purchased to give to clinical teams for collecting PROMs in Clinic
- Electronic version of EQ-D5 has been submitted to EuroQol for approval
- Diabetes patient interviews undertaken to test acceptability and utility of PROMs from a consumer perspective

Project Risks:

- Cost/acquisition of electronic devices and licence fees for individual services to carry out surveying with patients – there is no budget in the services or HIG/i3

Project Issues:

- Currently working through ethical and privacy requirements for each service, and the organisation as a whole.
- Position statement being developed on how the organisation will manage incidental findings in PROMs, particularly reports of depression and/or anxiety. As PROMs will be held in health records, reports of difficulties with mental health may have implications for patients in terms of accessing insurance, and impact clinicians in terms of their duty of care.

Next Steps:

- Develop a communications plan to assist onboarding of services
- Develop position statement for incidental findings
- Patient interviews to be held to test acceptability and utility of PROMs from a consumer perspective in Septoplasty, Renal, Urogynaecology and Orthopaedics

Timeline

Milestone	Status	Estimated Completion Date
Initiating	Completed	June 2018
Planning	Current	April 2019
Executing	Pending	May 2019
Closure	Pending	September 2019

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	Delayed	N/A

Smartpage-Clinical- Progress Summary

Sponsor: Penny Andrew/Stuart Bloomfield
Project Manager: Dina Emmanuel
Phase: Executing

Opportunity / Problem Statement:
The primary communication method, during the day, between the ward doctors and others is alphanumeric pagers. Pagers have limited ability to share information effectively and efficiently. Smartpage is a smart mobile and web-based clinical messaging and mobile task management system that has been used after hours (4pm-8am) by ward nurses, Duty nurse managers, Smartpage Coordinators, and house surgeons (RMOs) since 2013. The system is overwhelmingly endorsed by the RMOs and other users, and the RMOs and other users have consistently requested Smartpage be made available to them over all shifts (24/7). An extended trial in 2013-14 reported significant time savings and improved communication, with up to 15-20 minutes of time saved every hour. Recent quality improvement programmes, in particular TransforMED and the Deteriorating Patient Programme, have highlighted the need for better communication and RMO task management across all shifts, both of which can be improved significantly by the use of Smartpage.

Objective / Aim:
To extend the use of Smartpage messaging system for calls to HOs during business hours (Mon-Fri 08:00 – 16:00) by deploying approximately DHB-managed smartphones with the SmartPage app installed to all House Officers who currently have a pager. Following that, extend to all RMOs (House Officers + Registrars).

Status Update:
The project is structured in phases to roll out Smartpage phones to HO first then registrars
Phase 1 August 18- SmartPage for 100 HO replacing the pagers (HO Quarter 4 final run)
Phase 2 Nov 18- SmartPage for 100 HO replacing the pagers (HO new run)
Phase 3 June 19- SmartPage to 165 HO (100 HO already have SmartPage+65 without pagers)
Phase 4 June 19- SmartPage for registrars
Phase 5 Nov 19- SmartPage for all HO at the changeover
Phase 6 Jun 20- SmartPage for all registrars at the changeover

- Phase1 and 2 of the project is now complete and gone live. Getting ready for Phase 3
- Appointed process owner from Waitematā Central. i3 will continue with PM support for the next phases
- Work in progress to create one RC code for project operational cost
- confirmed the availability of phase 3 and 4 funding required for additional 150 phones to be given to registrars and possibility of 60 phones to pharmacy at an approximate cost of $150K (hardware)
- Established the time required to set up one smartphone by one person (~1hr). 10 phones can be set up simultaneously by the same person within the hour
- Confirmed the availability of volunteers to assist with Smartphone set up for the next HO's rotation change over which will include all HO's

Project Risks:
Setting up all phones at House officers and Registrars' rotation change over in a timely manner

Project Issues:
Nil

Next Steps:
- Work with the finance team to create one operational RC code (instead of 22 RC codes) that can be used by all services/ departments
- Liaise with the Director of Patient Experience and confirm volunteers availability in setting up Smartpage phones for the next rotation changeover
- Complete "Smart phone set up "guide document to assist volunteers setting up the phones
- Map the detailed process for Smartpage phones rollout
- Work closely with the RMO office, HIG and process owner to organise the next roll out and handing out the phones to registrars

Timeline

Milestone	Status	Estimated Completion Date
Initiating	Complete	April 2018
Planning	Complete	May 2018
Executing	On going	June 2019
Closure	Not started	September 2020

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	TBA	N/A	$0
Opex $	TBA	$50k	TBA

Scope	Timeline	Budget
On track	On track	N/A

ICNet Optimisation Progress Summary

Sponsors: Matthew Rodgers, Stuart Bloomfield
Project Manager: Handed over by Arti Chandra to Graham Upton – Infection Prevention & Control, supported by Barbara Corning-Davis (i3)
Phase: Closing

Opportunity / Problem Statement:
ICNet (infection control surveillance + management system) went live at Waitematā DHB on 28 March 2018 after two failed starts in April 2017 and November 2017. This is a shared system with ADHB. The system was implemented 'out of the box' and needs to be configured in order to deliver the benefits highlighted in the business case. Implementation into the IP&C service is led by IPC Clinical Nurse Specialist, Graham Upton.

Objective / Aim:
To develop the ICNet functionality for the Infection Prevention and Control (IP&C) team to realise the benefits of:

1) improving patient safety by facilitating earlier identification of patients with health-care associated infection (HCAI)
2) improving data quality, providing real time quality information and timely access to clinical knowledge
3) reducing administrative overhead so the IP&C team can focus on infection prevention best practice

Status Update:

- Details of expenditures will be added to the Post Implementation Review as an appendix.
- Mapped system support process to define ICNet support roles and reviewed with Matt Rogers and Leapfrog group.

Project Risks:
Project Issues:

- Need to identify individual who will provide SuperUser role.
- Canterbury DHB has been identified as an ICNet Support Hub for New Zealand. Clarification of this resource's scope, cost, and governance is needed.
- Testing of ADHB LabPlus results (Sendaways) feed has been put on hold until Labs IT resource can be obtained for Waitematā DHB. Auckland laboratory referred tests not showing up in ICNET.
- MedChart interface on hold, pending resources.
- SSI interface is put on hold, pending resources.

Next Steps: (Time boxed for 1 months – 1 May – 31 May 2019)

- Identify ICNet Super User
- Present Post Implementation Review of ICNET to the Clinical Governance Board; publish report

Timeline

Milestone	Status	Estimated Completion Date
Initiating	Complete	June 2017
Planning	Complete	June 2017
Executing (Project handed over to Service January 2018)	Extended	May, 2019
Closure	Extended	June 2019

Budget	Spend to Date	Forecast to Complete	Variance
Nil	N/A	N/A	$0

Scope	Timeline	Budget
	Extended until May 2019	N/A

Chest pain pathway - Progress Summary

Sponsor: Jonathan Christiansen & Alex Boersma

Clinical Leads: Laura Chapman & Kate Allan

Project Manager: Kelly Bohot

Phase: Execution

Problem Statement:

The purpose of the project is to understand whether our care of patients presenting with chest pain can be improved. The pathway was implemented 3-4 years ago. Since this time there have been new publications about improving care processes for patients with chest pain/acute coronary syndrome. The review of the pathway includes:

- Review of national and international literature
- Review of local data

The following were investigated:

1. Which of our current three risk scores identifies patients
   a. who are safe to discharge?
   b. who will have a coronary event <30 or < 180 days from presentation?
2. Is an exercise tolerance test (ETT) useful for low risk patients?
3. Does an ETT have negative or positive predictive value or neither?
4. Is high risk ethnicity a predictor of clinical course?
5. Do demographics alone identify safe for discharge/high risk patients?

Gestalt and Troponin identified as most effective indicators for risk stratification in the Chest Pain Pathway (most effective predictors of a chest pain event in patients with low risk chest pain).

Status Update:

- Qlik dashboard under development.

Project Risks:

Nil

Project Issues:

- Need to agree data markers to define patients are on the chest pain pathway for Qlik dashboard. *Dataset proposed 18.02.2019.*
- Patients on the chest pain pathway do not always have an electronically documented risk score available.
- Development of chest pain pathway dashboard is on hold as resource required has been allocated to ED capacity and demand dashboard.

Next Steps:

- Develop Qlik app to assist ED to monitor chest pain pathway and cardiac outcome data once resource is available again.

Milestone	Status	Estimated Completion Date
Complete audit and data analysis	Complete	April 2018
Validate model with additional dataset	Complete	April 2018
Develop new interim Chest Pain Pathway document	Complete	May 2018
Implement interim Chest Pain Pathway document	Complete	June 2018
Develop Chest Pain Pathway (New assay)	To be confirmed	December 2018
Develop Qlik dashboard	In progress	May 2019

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	N/A

Choosing Wisely-Optimise Abdominal X-ray (AXR) requests in Emergency Department- Progress Summary

Sponsor: Willem Landman/Amanda Holgate
Project Manager: Dina Emmanuel
Phase: Executing

Opportunity / Problem Statement:
There are delays in completing radiology procedures for ED patients. Over-requesting abdominal x-ray with low diagnostic yield causing delays in completing procedures and exposing patients to unnecessary radiation. Patients undergoing AXR are then exposed to further radiation with a CT scan.

Objective / Aim:
Adopt Choosing Wisely approach to refine the "Indication list" for patients requiring abdominal X-ray with the view of reducing the unnecessary X-ray orders that does not add value and in some occasions can cause harm to the patient.

Status Update:

Completed the following tasks:

- Scoping document
- ED-Radiology patient current process map
- Collected data for initial capability study
- Audit of the collected data and results discussed with the team
- Established the percentage of AXR requests (50-60%) that didn't add value or improve patient experience
- Completed survey (44 responders) to better understand the reasons for ordering an AXR. Feedback has been graphed and shared with project team and communication poster created for wider communication. 45% of participant indicated that rarely the AXR outcome alters the management of the patient
- Project team communicated survey feedback with the wider teams involved in the survey
- Project team agreed to look at the number of AXR ordered by ED following the work and communication started in Jan 2019.

Project Risks:
Not all clinicians follow the pathway and continue ordering AXR unnecessarily
Project Issues:
Nil

Next Steps:

- Collect data (number of AXR ordered by ED teams and locations) from Jan 2019-March 19 and measure the impact of process changes by comparing results to the initial capability data

Timeline

Milestone	Status	Estimated Completion Date
Scoping	Complete	April 2018
Initiating	Completed	August 2018
Planning	Completed	August 2018
Executing	In progress	April 2019
Closure	Not started	July 2019

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0

Scope	Timeline	Budget
On track		N/A

OptimisED+ (plus) - Progress Summary

Sponsor: Cath Cronin
Willem Landman

Project Manager: Dina Emmanuel

Phase: Planning

Opportunity / Problem Statement:

Since 2012 Emergency Department-ED has experienced an increased demand and growth in presentation numbers and complexity. This has limited our ability to consistently deliver optimal emergency care which compromises patients and staff safety and wellbeing.

Objective / Aim:

Through OptimisED + we will be able to consistently deliver best emergency care by optimising our staffing, capacity-demand matching and leadership structure and roles.

Outcome Measures

Stream One: Staffing

- Define adequate staffing numbers and skills to meet 85th centile demand
- Improve staff safety
- Better understand the reasons for nurses leaving ED
- Review salary and rates over the last 5 years
- Identify improvement opportunities for ED recruitment process

Stream Two: Capacity and Demand

- Short Stay in ED SSED >95%
- No inappropriate spaces
- Adequate staffing numbers and skill mix to meet 85th centile demand

Stream Three: Leadership structure and roles

- Review the current leadership structure throughout our ED

Stream Four: Mental Health

- Analyse physical areas for mental health patients in ED
- Identify ED nurse time spent caring for mental health patients

WIP

- Trial new process to more efficiently and effectively manage patients presented to ED by "Pit Crew" team (first PDSA cycle scheduled for Wednesday 15 May) swiftly assessing, ordering the required tests and initiating referral/disposition process as required
- Measure the number of times nurses insert IV cannulation or take bloods and the number of attempts

Completed

- future nursing recruitment process map and identified required changes to improve the process
- time and motion study for nurses

Project Risks:

- Unable to execute and implement recommendations resulting in deterioration of the current situation with declining patient and staff safety and wellbeing

Project Issues:

- Financial constraints
- Environmental constraints (physical areas/space)
- Impact of other services on ED

Next Steps:

- Analyse results for time and motion study for nurses
- Review demand and occupancy data via ED explorer
- "Pit Crew" PDSA cycle (scheduled for Wednesday 15 of May)
- Measure the number of times nurses insert IV cannulation/bloods per shift to determine if phlebotomist position will add value

Timeline

Milestone	Status	Estimated Completion Date
Scoping	Completed	Feb 2019
Initiating	Completed	March 19
Planning	Completed	March 19
Executing	Started	October 19
Closure	Not started	November 2019

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	N/A

Community Child and Family Ear Nursing Service Improvement- Progress Summary

Sponsor: Marianne Cameron
Michele Kooiman
Project Manager: Dina Emmanuel
Phase: Executing

Opportunity / Problem Statement:
The Ear nurse service has no clearly defined designated full time employee (FTE). The processes for service delivery are inconsistent and out-dated.
The ear nursing service is a non-acute, community-based service delivering ear health assessment and treatment for children aged 3 months to 18 years. The community ear nurse works with all children, prioritising those from identified at risk groups and those for whom barriers create an inequality or gap in access to health services.

Objective / Aim:

Improve ear nursing service (ENS) by identifying the required nursing FTE to maintain a sustainable workforce (capacity and demand). Define and implement more efficient processes and clear parameters to enhance patient outcomes.

Status Update:

Completed tasks:

- Created project charter
- Established team working group
- Agreed on tasks that need to be completed as part of the project scope
- Completed "as is" service delivery process map for both Waitakere and North Shore regions
- Identified improvement opportunities
- Completed future map
- Established community services "Child and family" explorer. Information viewed via Qlik dashboard
- Streamlined referral data entry process. Created guide document with screen shots to assist the administrators' when creating new referrals in iPM
- Administrators' can select one of the pre-defined sources when completing referrals in iPM

Work in progress:

- Confirm base line and initial capability via Qlik dashboard
- Understand and streamline the current process for creating "presenting referral" and "related referral" in both sites (North and West)
- Map the current outpatient booking process (North and West sites) with the aim of Improving the current manual process by moving to electronic iPM booking system
- Analyse the current Ear Nursing capacity and demand

Project Risks:
Nil
Project Issues:
Nil

Next Steps:

- Map current outpatient booking process in both sites (North and west)
- View e bookings in test environment
- Collect data following the agreement on referral sources definitions

Timeline

Milestone	Status	Estimated Completion Date
Initiating	Complete	October 2018
Planning	Complete	December 2018
Executing	In progress	TBA
Closure	Not started	TBA

	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	N/A

General Surgery Clinical Pathways - Progress Summary

Sponsor: Richard Harman, Kate Macfarlane

Project Manager: Lisa Sue (PM support for Angie Hakiwai)

Phase: Executing

Opportunity / Problem Statement:

The Department of General Surgery has identified an opportunity to quantify ways to improve patient outcomes and experience, and reduce health care costs within General Surgery. The focus of this work is the development and implementation of evidence-based protocols for three presentations – abscess, appendicitis and cholecystitis, which account for approximately two thirds of general surgery acute cases booked for theatre.

Objective / Aim:

To identify and implement solutions to meet target length of stay and improve patient experience and outcomes for patients who undergo simple abscess drainage, appendicectomy, and cholecystectomy procedures, by December 2020

Status Update:

- Diagnosis of simple cholecystitis with bedside ultrasound scans
  - Went live for gallbladder bedside scanning on 10 April 2019 across NSH and WTK ED and NSH ADU.
  - Working group decided to have a practise phase before commencing audit. This is to identify issues and allow clinicians time to adjust to new technical processes.
  - Data collection and evaluation in progress.
- Criteria Led Discharge
  - Changes are being made to electronic work certificate.
  - Scoping how to implement criteria led discharge nurse competence test online and how to record training completion online.
- Acute Arranged Abscesses – Minor Procedures List
  - Clinical Nurse Director, NSH Theatres working on solution for nursing shortage for list. Provisional plan is to commit 2 regular agency nurses with 1 enrolled nurse to list.
  - Plan to re-campaign booking patients as acute arranged with registrars. Lists between 16 Oct 2018 to 07 May 2018 showed 68% of abscess patients booked as inpatients compared to 24% acute arranged and 13% fast tracked.
- Redistribution of theatres currently planned with anticipation to re-trial an acute arranged laparoscopic cholecystectomy list.

Project Issues:

- Wi-Fi signal strength low in NSH ED which impacts ease to upload images to PACS (radiology picture archive system).
- Technical process issues for bedside scanning, for example forgetting to send or cancel referrals or archive images to PACS. Temporary solutions in place but will require a review in current process.
- Unwarranted variation in the way diagnostic worksheet is filled out. Reviewing to change worksheet with yes/no questions.
- Shortages of nurses or anaesthetists impact on the ability to run a Minor Procedures List. Issue anticipated to be resolved by end of May.

Next Steps:

Cholecystitis bedside ultrasound scan project:

- Discuss resolutions for technical process issues with working group
- Review the first 20 true negative and true positive bedside scan cases and evaluate specificity, sensitivity, diagnostic accuracy to inform next steps

On-going monitoring for all other projects.

Timeline

Milestone	Status	Estimated Completion Date
Initiate	Complete	September 2017
Plan	Complete	December 2018
Execute	In progress	March 2020
Close	On track	December 2020

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	N/A

Safety in Practice - Progress Summary

Sponsor: Stuart Jenkins
Project Manager: Sue French (Improvement Advisor role)
Phase: Ongoing

Opportunity / Problem Statement:

Safety in Practice (SiP) is designed to enhance quality improvement capability of general practice (GP) teams within the Auckland region, by focusing on patient safety. In order to achieve this goal, a range of tools and resources (adapted from the Scottish Patient Safety Programme in Primary Care), alongside support from improvement and clinical experts are provided to general practice teams to foster a patient safety culture.

In 2017 a pilot programme for twenty community pharmacies and four acute care clinics to participate in SiP commenced; clinical modules specific to this practice domain were developed and tested.

Objective / Aim:

To develop more reliable practice systems and to promote a safety and improvement culture within general practices and community pharmacies

Status Update:

- Expressions of Interest for 2019-20 Safety in Practice Programme year closed. Selection process for 120 teams in progress
- Combined Waitemata & Auckland District Health Board Learning Session 4 event occurring June 2019
- Improvement Methodology teaching strategy for 2019-20/21 confirmed
- Development of 2019-2020/21 Clinical module supporting documents in progress

Project Risks:

Nil noted

Project Issues:

- Insufficient resource/mismatch of skills and expertise required to support programme (administration; quality improvement; programme development)
- Reduction in Improvement Advisor capacity for 2019-2020 programme year

Next Steps:

- Confirm 2019-2020/21 Improvement Methodology teaching strategy
- Outcome from withdrawal of Auckland District Health Board dedicated Improvement Advisor hours from the commencement of 2019-2020 Programme year is not yet known. Discussions with Tim Wood regarding impact and mitigation of this decision in progress

Timeline

Milestone	Status	Estimated Completion Date
Initiate (SiP year 2018-19)	Complete	July 2018
Plan	Complete	August 2018
Execute	In progress	March 2019
Close (Year 5 GP, Year 2 Pharmacy)	On track	July 2019

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	N/A

Rapid Cardiac Screening Clinic Model of Care business case - Progress Summary

Sponsor: Penny Andrew & Robyn Whittaker
Project Manager: Lisa Sue / Kelly Bohot
Phase: Planning

Opportunity / Problem Statement:
The initial outpatient evaluation of patients with cardiac symptoms is complicated and an outmoded process that has resulted in long wait times and rapidly rising costs as population demand increases. This situation is unsustainable and requires innovative approaches to improving patients' experience and efficient use of limited health system resources.

Objective / Aim:
Develop a model of care for a new rapid cardiac screening (RCS) clinic model of care
An initial business analysis for a new RCS model of care has been completed. A business case is being developed to introduce a new model of care and 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

The model utilises multiple new mobile and rapid screening technologies to accurately risk-stratify patients with undifferentiated cardiac symptoms. These technologies are point-of-care cardiac biomarkers, a 5-minute point-of-care echocardiogram and an AI-based electrocardiogram evaluation – all of these approaches have been locally validated and have a sound evidence base. The RCS clinic has been piloted and found to have a much higher throughput than the traditional cardiology clinic model – this will potentially enable a significant impact on waiting lists.
The innovative use of new medical technologies presents an opportunity for a highly valuable collaboration between Waitematā DHB, MedTech CoRE and industry partners. The establishment of formal clinical research collaboration for the RCS has been proposed, with a defined programme of research into cardiac screening, outcomes and integration of new technologies into pathways and decision-making processes.

Status Update:

- Shadowed private cardiology clinic and mapped out flow and clinic infrastructure set up.
- In preparation for next echo meeting, analysed inpatient transthoracic echo referral data. On average per month, 83 referrals are cardiology and 276 referrals are non-cardiology. The highest referral group is general medicine.
- Updated data on outpatient transthoracic echo wait lists.

Project Risks:
N/A
Project Issues:
N/A

Next Steps:

A working group that includes GM, operations manager, cardiologist and i3 team members is continuing to meet to explore options for a new model(s) of care, and identify an appropriate patient group for a screening clinic

Timeline

Milestone	Status	Estimated Completion Date
Data analysed	Completed	15 March 2019
Defined aim and objectives	WIP	13 May 2019 (SRO Extended)

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
	Extended	N/A

Mental Health and Addiction (MHA) Quality Improvement Programme

Sponsor: Dr Susanna Galea-Stringer

Project Manager:

Phase:

Opportunity / Problem Statement:
Health Quality and Safety Commission (HQSC) National QI Programme Phase 1: Reduction in Seclusion

Objective / Aim:
The project aims to improve patient experience on inpatient units by reducing the use of seclusion and or restraint. The overall aim is to achieve zero seclusion in adult acute and forensic services

He Puna Waiora
Reduce the average number of minutes service users spend in seclusion in He Puna Waiora Acute Unit by 50% (from 466 minutes to 233 minutes) by September 2019

Waiatarau
Reduce the percentage of all restraints experienced by service users admitted to Waiatarau Acute Unit that are prone restraint by 50% (from 23% to 11%) by September 2019

Forensics
Reduce the average number of minutes service users spend in seclusion at Mason Clinic by 50% (from 858 minutes to 429 minutes) by September 2019

Status Update:

- Story Board completed
- Baseline data completed

Project Risks:
Waitematā DHB has very low levels of clinical staff trained in QI Methodology (<0.25%)

Project Issues:
Nil

Next Steps:

Pocket QI methodology training commenced week beginning 21 November 2018.

Two Pocket QI workshops have taken place, one at Waitakere and one at North Shore with mental health professionals.

Next two workshops planned for February 2019

Timeline

Milestone	Status	Estimated Completion Date
Storyboard	completed	
Aims	completed	
Training Adult inpatient	Start first cycle	21 November 2018
Training Forensics	Start	Mid December 2018

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	N/A

Tier 2 Quality Improvement Workshops
Quality Improvement Programme

Sponsor: Penny Andrew

Project Manager: Barbara Corning-Davis

Phase:

Opportunity / Problem Statement:
An understanding of quality improvement and experience in the applying quality improvement tools is essential for systematic, continuous quality improvement and innovation across the organisation

Objectives / Aims:
- Develop Tier 1 Quality Improvement e-learning modules that provide basic, foundation-level QI knowledge that is available through Awhina Learning. (Completed)
- Develop an experience-based quality improvement training programme available to all staff across the DHB (Tier 2 of the Transforming Care Programme).
- Develop a teaching faculty and an alumni network to sustain a culture of continuous quality improvement.

Status Update:
- Round 5 of Quality Improvement Workshop completed on 9 May with nine projects.
- Additionally, ½ day workshops are held for team training upon request. Other workshops held/planned for this year:
  - Management Foundations (1 day) date: 6 April 2019
  - Waimarino Clinic (1/2 day) date: 16 May 2019
  - Te Whanau o Waipareira (1/2 day) date: June 2019
  - Hospice and Residential Care Providers (15 interested) date: July 2019
  - NSH – Starting 5 September
- A collaboration between the Auckland region DHBs and the HQSC has developed and will publish 13 QI tools to be made available nationally by July, 2019.

Project Risks:
Due to competing clinical duties, low levels of clinical staff uptake of opportunity to learn and apply QI Methodology (Waitematā DHB has very low levels of clinical staff trained in QI Methodology: (<0.25%)

Project Issues:
Nil

Next Steps:
Community QI Workshops
Education sessions to support innovation – Case study piloted with AUT students on 10 May.

Timeline

Milestone	Status	Estimated Completion Date
Training at NSH and WTH	completed	Ongoing
Training in community	In progress	2019

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	N/A

Urogynaecology Service Development

Sponsor: Cath Cronin
Project Manager: Sue French
Phase: Initiating

Opportunity / Problem Statement:
The treatment of Stress Urinary Incontinence (SUI) and Pelvic Organ Prolapse (POP) with surgical mesh has occurred at Waitematā DHB since 1995 for SUI, and 2000 for POP
The implantation of a mesh mid-ureteral sling (MUS) has become the 'gold standard' procedure for SUI surgery. Most mesh devices were launched without clinical trials, meaning complication rates were never established prospectively. For the majority of women surgical treatment with mesh for SUI and POP has led to good long-term results with no complications.
However, some women experience complication, and for some women complications have devastating and lifelong consequences.
Increasing national and international concern for the failure rate and complications of mesh in these procedures has led to several large-scale reviews and investigations world-wide. The Ministry of Health has asked all District Health Boards (DHB) to stop using surgical mesh in urogynaecological surgery unless they can guarantee that credentialing standards and robust informed consent process are being met.

Objective / Aim:
To review Waitematā DHB's urogynaecology services and develop a proposed model of care for the provision of secondary and tertiary urogynaecology services with scope for national delivery of tertiary care for this patient group. The model of care will surgeon credentialing, informed consent and surgical implant tracking processes that meet national and international standards.

Status Update:
- Board Paper presented April 2019
- Working group agreement to confirm Model of Care and credentialing process for Waitematā DHB that could be scaled to include regional partners
- Request from Dr Andrew Simpson, Ministry of Health Chief Medical Advisor, to collaborate with Waitematā DHB on credentialing process
- Surgeon credentialing document development continues for Waitemata
- Consumer focus group for next phase of informed consent documents occurring June 2019
- Work commenced on 'first patient contact' process with Patient Service Centre staff
- Agreement with Primary Care Director to work with General Practice (GP) Liaison to enhance patient information at referral phase
- Work commenced on Non-Contact First Specialist Assessment process with Health Information Group
- Demand forecasting work commenced with i³ Data Analyst

Project Risks:
- Large scale of programme and change
- Potential for local, regional and national priorities and timelines to differ
- Resistance to organisation wide change process

Project Issues:
- Nil at present

Next Steps:
- Meet with Ministry to outline future collaboration
- Commence work on Advanced Practice Nursing Role
- Formal discussion with regional partners on credentialing process required, Cath Cronin to lead
- Confirm capacity of i³ GP Fellow to work on Referral information process
- Complete Investment Logic Map with Portfolio Support Office
- Submit paper to Portfolio Investment Committee
- Steering group to commence recruitment career plan

Timeline

Milestone	Status	Estimated Completion Date
Scoping	Complete	November 2018
Initiating	In progress	April 2019
Planning	Pending	TBC
Executing	Pending	TBC

Budget	Spend to Date	Forecast to Complete	Variance
Capex $nil to date	N/A	N/A	$0
Opex $nil to date	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	On track

District Nursing Service Review

Sponsor: Brian Miller/Jocelyn Peach
Project Manager: Lydia Gow/Kelly Bohot
Phase: Initiating

Opportunity / Problem Statement:
With an ageing population and a strategic move towards delivering care closer to home, the District Nursing Service is seeing increasing referrals. The Service reports they are struggling to manage their workload, often resulting in overtime and casual labour use. The Service is currently not meeting the Ministry of Health entry criteria for a community nursing service with patients deemed high risk needing to be seen within 8-24 hours of referral. The criteria was met for 47.5% of high risk patients referred to the service in 2018. This is likely to also be influenced by a lack of understanding and accurate utilisation of this risk measure by the service. Anecdotally, nurses are often not able to attend professional supervision and other non-clinical meetings due to workload, and staff experience is poor. The Service feels better care could be given to staff and patients with safe workloads.

Objective / Aim:
To deliver timely patient care, aligned to the Service's Entry and Transfer of Care criteria for 90% of patients, within allocated District Nursing FTE, by October 2019.

Status Update:
- Five extra District Nursing FTE (CCDM funding) have commenced orientation with teams.
- Currently testing 'live' laptops and point of care access to patient notes in community, including online assessment forms (reducing paper documentation).
- Review of 43 district nursing paper forms with view of making Service more paper-light. Gap analysis of electronic forms already available.
- Planning the implementation of Airwatch to DN mobile phones, enabling clinical photography with phones.
- Staff Survey completed to collect data on staff experience: 49 responses (63%).
- Horizon scanning and literature review being undertaken with the topic: workload management and safe staffing in DN Services.
- Currently only paper referrals to the District Nursing Service are monitored out-of-hours (i.e. evenings and weekends). Developing process for e-referrals to be monitored out-of-hours.
- Pilot underway: new referrals are phoned by an allocated nurse who assesses risk and care need with patient and/or carer. First visit allocated based on Ministry of Health risk assessment response criteria, and on upcoming Service demand.
- Testing new electronic report for allocation (visit date, expected duration, care need etc.) which would enable a forward projection of demand. Working with Health Information Group to understand potential for reporting.

Project Risks:
- Nil at present

Project Issues:
- Nil at present

Next Steps:
- Decision point after live laptops and point of care access to Clinical Portal testing.
- Documentation for new patients is currently paper-based until office hours when administrative staff registers referral onto iPM/Soprano: to scope options for improvement.
- Continue to refine risk and new referrals pilot with PDSA cycles.
- Developing education sessions for district nurses around risk and the patient journey, including real-life examples.
- Working with Finance to implement a cover model.
- Working with Health Information Group to develop a Qlik app for the District Nursing Service.

Timeline

Milestone	Status	Estimated Completion Date
Scoping	Complete	
Initiating	In progress	May 2019
Planning	Pending	TBC
Executing	Pending	Sept 19

Budget	Spend to Date	Forecast to Complete	Variance
Capex $nil to date	N/A	N/A	$0
Opex $nil to date	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	On track

Cardiology triage and grading

Sponsor: Alex Boersma
Clinical Lead: Tony Scott
Project Manager: Kelly Bohot
Phase: Planning

Opportunity / Problem Statement:
Demand for Cardiology outpatient appointments at Waitemata DHB exceeds current appointment capacity. Referral data indicates demand for first specialist Cardiology appointments for this financial year (FY2018/19) is 31% higher than the last. Our current first specialist appointment demand is greater than other Auckland DHBs and the rest of the New Zealand. The largest growth has been for patients prioritised as priority 2 and priority 3. Priority 1 patients have remained stable which suggests the burden of disease in the community is unchanged. There are national referral guidelines for cardiology in use in other DHBs which are not currently systematically implemented in our cardiology service. There are opportunities to standardise our triage and grading process and expand our modes of delivery (eg nurse led clinics, virtual clinics) to better manage demand and ensure the right patients receive the right advice and care in the right place at the right time.

Objective / Aim:
tbc

Status Update:

- Baseline data complete
- Initial meeting with Cardiology triage and grading group complete. Identified some improvement opportunities to test including clinical nurse specialist nurse to review referrals and remove duplicates, follow ups and requests for communication (30% referrals in recent 1 day audit), implement national referral guidelines, develop and test chest pain screening questions, test virtual clinics.
- Clinical Nurse Specialist now in post
- Clinical Nurse Specialist meeting with Cardiologists to observe and better understand triage and grading process.

Project Risks:

- Nil at present

Project Issues:

- Nil at present

Next Steps:

- Plan PDSA to test concept of clinical nurse specialist reviewing referrals with aim to remove and manage duplicates, follow ups and requests for communication.
- Clinical Nurse Specialist to meet with cardiologist and record findings in spreadsheet template
- Plan PDSA to test concept of clinical nurse specialist reviewing referrals with aim to remove and manage duplicates, follow ups and requests for communication.
- Align project to work to better manage demand for ECHOs.
- Meet with Cardiology triage and grading group to discuss Clinical Nurse Specialist's findings and next steps Monday 10 June at 8am.

Timeline

Milestone	Status	Estimated Completion Date
Scoping	Complete	March 2019
Initiating	In progress	May 2019
Planning	Pending	TBC
Executing	Pending	TBC
Closing	Pending	TBC

Budget	Spend to Date	Forecast to Complete	Variance
Capex $nil to date	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	On track

Surgical Implant Tracking

Sponsor: Michael Rodgers
Project Manager: Mustafa Shaabany
Phase: Scoping

Opportunity / Problem Statement:
We do not have a reliable, efficient system to track surgical implants; this means we cannot:

- track exactly which devices are implanted in which patients
- quickly trace and alert individual patients in the event of a product recall

Currently:

- Data collection for surgical implants is fragmented; in some locations data is stored in an isolated IT system, in others it is documented manually in the physical (paper) patient record
- A lack of standardised data results in data gaps, poor visibility, and difficulties connecting patient information and technical details about implants (e.g. implant model no, manufacturer or lot number)
- Surgical implant spend is not accurately tracked, which adversely impacts our reporting to the MoH
- We lack a local register to collect information about surgeries involving mesh. As a result of world-wide concerns about surgical mesh, the MoH (in Sept 18), directed DHBs to hold and maintain such a register

Objective / Aim:

(i) Develop a surgical implant tracking system that will:
  - Enable fast, efficient and complete identification of patients with implants in the event of a product recall
  - Allow tracking of implant outcomes (e.g. cost, complications, clinical outcomes) by patient demographics, procedure type and surgeon

(ii) Measure and minimise the cost of waste and unwarranted variation

Status Update:

- Option analysis commenced
- Consultation with clinical lead and senior responsible officer regarding potential options – pending
- Hernia repair with Mesh added to project scope
- Staged approach requires further consideration with working group
- Baseline surgical mesh data collection completed for July 2018 – Jan 2019

Project Risks:

- Capturing implant cost details might slow down the progress of the project

Project Issues:
Nil

Next Steps:

- Complete the option analysis
- Agree on potential options with senior responsible officer
- Agree on high level timelines with the governance group

Timeline

Milestone	Status	Estimated Completion Date
Scoping	Complete	March 2019
Initiating	Pending	TBC
Planning	Pending	TBC
Executing	Pending	TBC

Budget	Spend to Date	Forecast to Complete	Variance
Capex $nil to date	N/A	N/A	$0
Opex $nil to date	N/A	N/A	$0

Scope	Timeline	Budget
On track	On track	On track

Radiology Service Care Transformation

Sponsors: Cath Cronin, Robert Paine, Penny Andrew
Project Manager: Renee Kong, Laura Broome
Phase: Planning

Objective / Aim:
Optimise radiology services by:

- Optimising patient flow and service utilisation
- Optimising demand by embedding evidence-based care and eliminating unnecessary procedures (Choosing Wisely)
- Developing robust data to inform current + future service planning including outsourcing, capacity and workforce design
- Improving patients' experience
- Improving staff experience

Project Risks: Nil

Project Issues: Nil

Status Update:

- Radiology Service overview presentation given to Executive Leadership Team on 14 April 2019 by Penny Andrew and Jonathan Wallace, General Manager - Radiology
- Focus areas are – Capacity, Workflow and Utilisation, Demand, Workforce, Data, Innovation, and Governance
- Project measures identified and available in Qlik including method for tracking utilisation, outpatient waitlist and inpatient bed days waiting
- First cut of Qlik dashboard pending service review and sign off. Aiming to publish app by end of May. Next phase of development to include refinement of inter-DHB requests and scans. Weekly meetings held with Information Analyst, Data Warehouse Manager, Radiology Subject Matter Expert to progress this work
- Improvement efforts focused on two priority areas Winter Acute Flow and CT Bay utilisation, from longer list of opportunities identified for improvement:
  - Winter Acute Flow
    - Radiology appointments on Ward Whiteboard – pending data warehouse team changes
    - Increase lead times for morning CT slots – PDSA planning underway
    - Reinvigorate Radiology Ready – revisiting existing material and exploring practical methods of ensuring patients are radiology ready
    - Scans for discharge – confirmed these scans are already prioritised. Working with team to identify these requests
  - CT Bay Blockages
    - Data collection underway by volunteer medical student
- Project reallocation has meant Laura Broome will take over from Kelly Fraher as one of thei3 project manager's supporting this programme

Next Steps:

- Publish Radiology Dashboard
- Progress ideas for Winter Acute Flow
- Complete data collection of CT Bays
- Develop KPI report and dashboard for reporting

Timeline

Milestone	Status	Completion
Initiating	Complete	14 April 2019
Planning	Underway	31 May 2019
Execution	Underway	30 June 2020
Close	TBC	

Budget	Spend to Date	Forecast to Complete	Variance
Capex $	N/A	N/A	$0
Opex $	N/A	N/A	$0

Scope	Timeline	Budget
		N/A

6. Safe Care

6.1 Infection Prevention and Control (IP&C)

*IP&C Surveillance Overview and Audit Results for **2018/2019***

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 2018	8	4	2	4,935	88%	100%	97%
February	18	5	3	5,441	89%	98%	95%
March	12	8	4	5,272	89%	98%	98%
April	13	4	3	5,423	90%	98%	99%
May	15	9	5	5,664	90%	100%	98%
June	19	7	4	5,174	91%	97%	100%
July	13	5	6	5,521	89%	99%	100%
August	19	6	1	5,526	88%	99%	98%
September	12	2	5	4,694	89%	98%	95%
October	15	6	5	4939	89%	99%	97%
November	7	6	4	4718	88%	97%	97%
December	30	6	11	4753	91%	99%	100%
2018 Total	**181**	**68**	**53**	**62,060**	**89%**	**98%**	**98%**
January 2019	**15**	**2**	**TBA**	**5079**	**89%**	**97%**	**100%**
February 2019	**18**	**4**	**3**	**4824**	**89%**	**98%**	**83%**
March 2019	**16**	**10**	**TBA**	**4939**	**90%**	**98%**	**98%**
April 2019	**15**	**6**	**TBA**	**4783**	**89%**	**97%**	**86%**

RAG Rating Legend

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

6.2 Surveillance

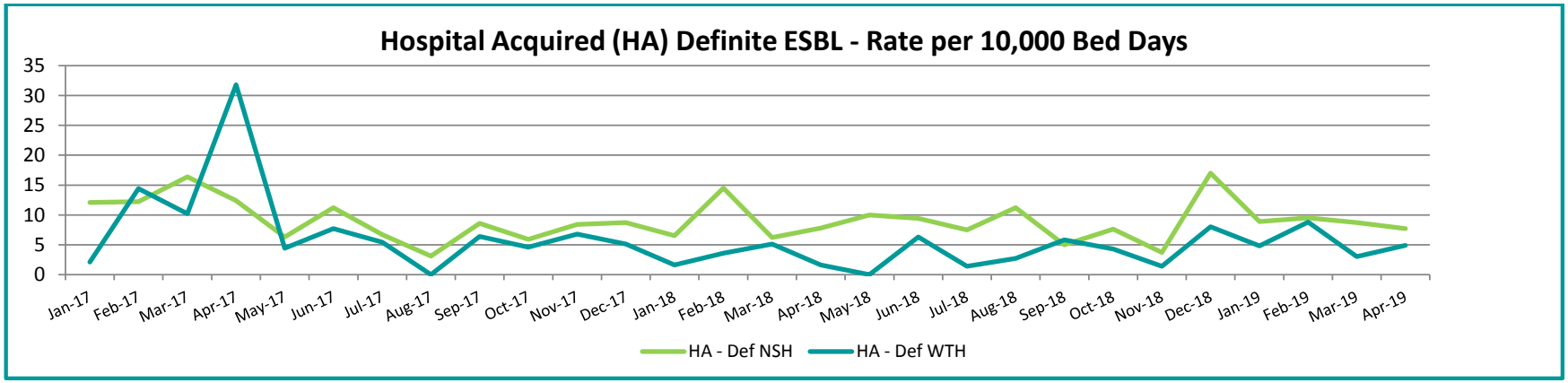
6.2.1 Extended Spectrum Beta Lactamase (ESBL)

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

ESBL Overview for April 2019

- Waitemata DHB's HA-ESBL rate for North Shore Hospital (NSH) remains relatively unchanged
- Approximately 30% of all HA-ESBL is related to E coli
- In April 2019 HA-ESBL was spread across nine wards
- The "TAKE CHARGE Bundle" education programme implemented in 2017 continues with consistent, sustained implementation DHB wide prevention required to further reduce ESBL rates

April 2019	NSH		WTH	
	Counts	Rates	Counts	Rates
HA –ESBL	**12**	**7.7**	**3**	**4.9**

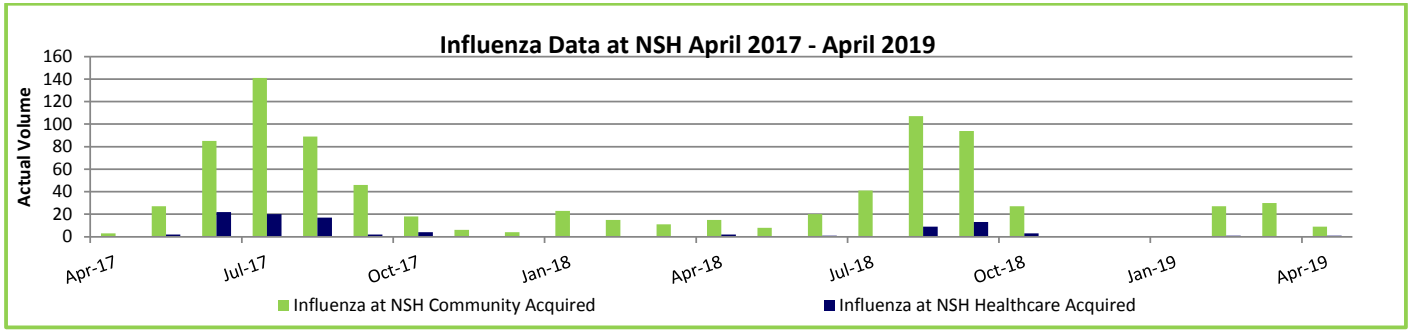


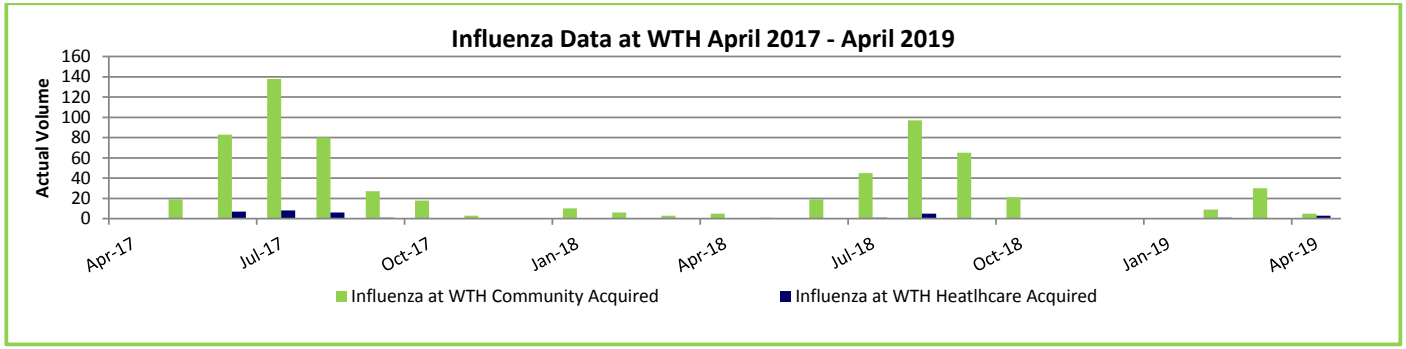
6.2.2 Influenza Surveillance

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)

Update for April and up to 27 May 2019

- Since March 2019 there has been an increase in influenza like illness (ILI) presentations
- In May 2019 the majority of these cases were seen at Waitakere Hospital (WTH)
- In May 21 patients per day were tested and of these 26% were positive for either Influenza A or B
- Hospital Acquired (HA) influenza is still occurring despite dedicated influenza wards; in response to this there has been an increase in influenza education and awareness for staff
- Waitemata DHB's staff influenza prevention campaign, using the quadrivalent influenza vaccine, has commenced with an approximate 60% uptake to date





6.2.3 Communicable Diseases, Clusters and Outbreaks – Update for April 2019

Disease	Total cases	Ward	No of pt. contacts	No of staff contacts	Comments
Measles	39	ED WTH = 37 ED NSH = 2	537	334	• West Auckland has had the highest number of measles cases in the Auckland region • A total of **104** measles cases were sent for testing between March – May 2019; with **39** of these isolates returning as positive for measles • **Three** staff with confirmed measles, which accounted for majority of staff and patient contact tracing • Majority of contact tracing for patients occurred prior to be triaged; these were from ED waiting room contacts • **Three** person to person measles cross-transmissions have been attributed to the ED waiting room. These **three** patients were identified as contacts of the index cases • **33%** of the positive cases were under the age of 14 months who would not have received 1st does of MMR • **67%** of the confirmed cases over the age either had no measles immunity or equivocal Immunoglobulin G (IgG) antibody • **16** of the confirmed measles cases required hospitalisation from **2-10** days due to secondary infections
Norovirus	3	Ward 10	8	7	• **Ward 10** had **eight** patients and **seven** staff reported symptoms of diarrhoea and or vomiting. • Index case was admitted with diarrhoea but not isolated in enteric precautions on admission • **Two** rooms (L and M) were closed from the 15-18 April 2019. With heightened infection control measures and increased environmental cleaning the norovirus did not spread to rest of the ward

6.3 ACC Treatment Injury Claims

Attached at **Appendix 3** is a copy of ACC's 2019 Report, **Supporting Treatment Safety: Treatment Information**. The report provides an overview of treatment injury claims (claims for injuries caused by medical treatment) made in FY2017/18.

Notable features from the report include:

- ACC received a total of 16,479 treatment injury claims in FY 2017/18. The number of all treatment injury claims declined slightly in 2017/18 after seven years of steady growth
- ACC accepted 9,772 of the total 16,479 claims (~60%); of the accepted claims, 5,713 (~60%) resulted from treatment provided at a public hospital
- The actual and predicted future costs for all treatment injuries in FY2017/18 financial year is $486 million
- The rate of claims increases with age: ~4 per 1,000 population at 65-69yrs cf ~7.5 per 1,000 population at 85+yrs
- The rate of claims Waitematā DHB in FY2017/18 was 41 (previous rate was 31). ACC emphasises in its report that comparing rates of claims between DHBs is not useful
- The 'more serious' (costly) claims are for: treatment omission ($30.3m); neonatal encephalopathy ($16m in FY2017/18); surgical mesh (two-thirds of which relates to urogynaecology or urology mesh) ($4m); and equipment failure ($2.3m)
- Areas of focus for prevention of treatment injury identified by ACC are: Infections; Pressure Injuries; Medication Errors; Medication Adverse Reactions.
- For Waitematā DHB, the rate of accepted claims for infections, medication errors and medication adverse reactions has increased from FY 2016/17, most significantly for Pressure Injuries and line infections. In FY 2016/17 the rate of accepted claims for pressure injury was 0.95 and in FY2017/18 was 4.22. And for line infections was 0.55 in FY2016/17, and 1.03 in FY2017/18

7. Patient and Whānau Centered Care

7.1 Complaints to HDC Involving DHBs – HDC Annual Report 2017-18

The Office of the Health and Disability Commissioner (HDC) has published its annual report analysing complaints made to the HDC for the FY2017-18: *Complaints to the Health and Disability Commissioner involving District Health Boards. Report and Analysis for period 1 July 2017 to 30 June 2018*. The full report is attached as **Appendix 4**.

The report's executive summary provides an excellent overview. The HDC received 889 complaints involving DHBs, a small increase (3%) on the number received in the previous year. These 889 complaints equate to a rate of 91 complaints per 100,000 discharges – a very small increase on the rate of complaints received in the previous year. This increase is similar to the increase seen at Waitematā DHB.

Nationally, the service types complained about have remained broadly consistent over the past five years: surgical, mental health, general medicine and emergency department services. The issues also have remained consistent, however the proportion of complaints regarding a disrespectful manner/attitude and an inadequate response to the consumer's complaint by the DHB have decreased.

Services with high diagnostic workloads, such as general medicine and emergency departments, commonly received more complaints primarily regarding missed, incorrect or delayed diagnoses. Primary issues in complaints about mental health services are distinct, with issues relating to involuntary admission/treatment and safety issues for consumers in inpatient units being common.

The HDC has included a number of case studies in the report, highlighting issues and recommendations in cases. Two cases relate to Waitematā DHB (delay in neurology review, and inadequate referrals system).

7.2 Patient Experience Feedback – January update

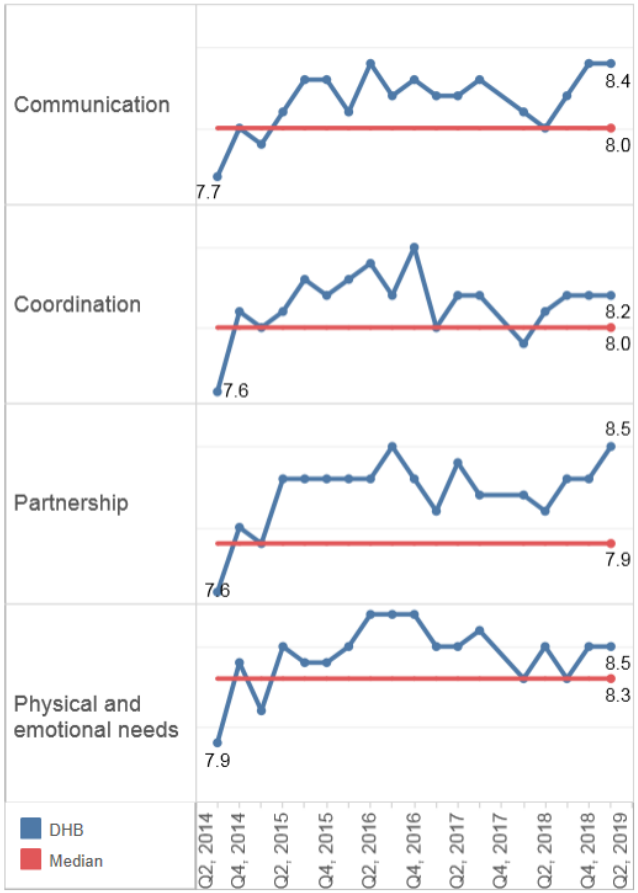
7.2.1 National Inpatient Survey

HQSC final weighted results			
Communication	**Partnership**	**Co-ordination**	**Needs**
8.3 National Average	**8.5 National Average**	**8.3 National Average**	**8.6 National Average**
8.4 WDHB	**8.5 WDHB**	**8.2 WDHB**	**8.5 WDHB**

Table 1: National Survey Quarter One (January – March 2019)

Table 1 above represents the first quarter of 2019 for the adult inpatient patient experience survey. The date range for this survey was patients discharged between 4 February and 17 February 2019. Following a similar trend from the previous quarter, all surveys were sent electronically due to the increased collection of patient emails. The response rate for quarter four was 32%, which is an increase from last quarter (27%). National response rate for this quarter was 24%. For this quarter (like previous quarters) there was little variation between district health boards. Waitematā DHB scores for communication and partnership were our highest scores since the national survey was introduced.

There was a notable increase in the communication and partnership domain this quarter as seen in the run chart below (Graph 1). All other domains are above our median score.



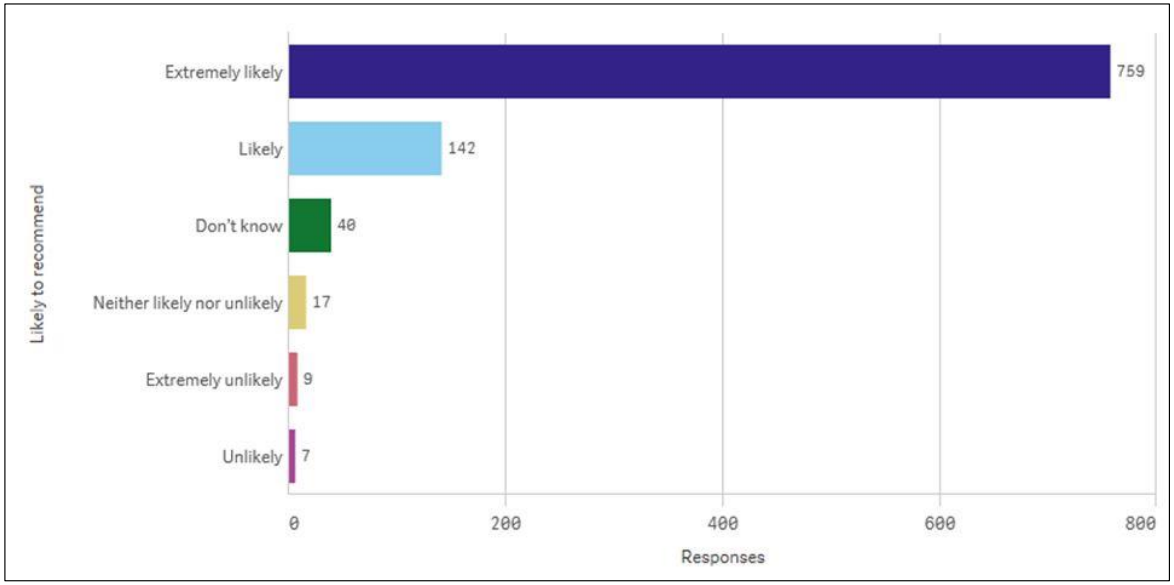
Graph 1: Waitematā DHB run chart

7.2.2 Friends and Family Test

In April 2019 we achieved a Net Promoter Score (NPS) of 75 and received feedback from 974 people. The NPS is down slightly by 1 point from the previous month and the number of responses is down 11% from 1100 responses last month. The NPS continues to perform well and scores above the DHB target of 65.

Friends and Family Test Overall Results

Figure 1: Waitematā DHB overall NPS



Graph 1: Waitematā DHB overall FFT results

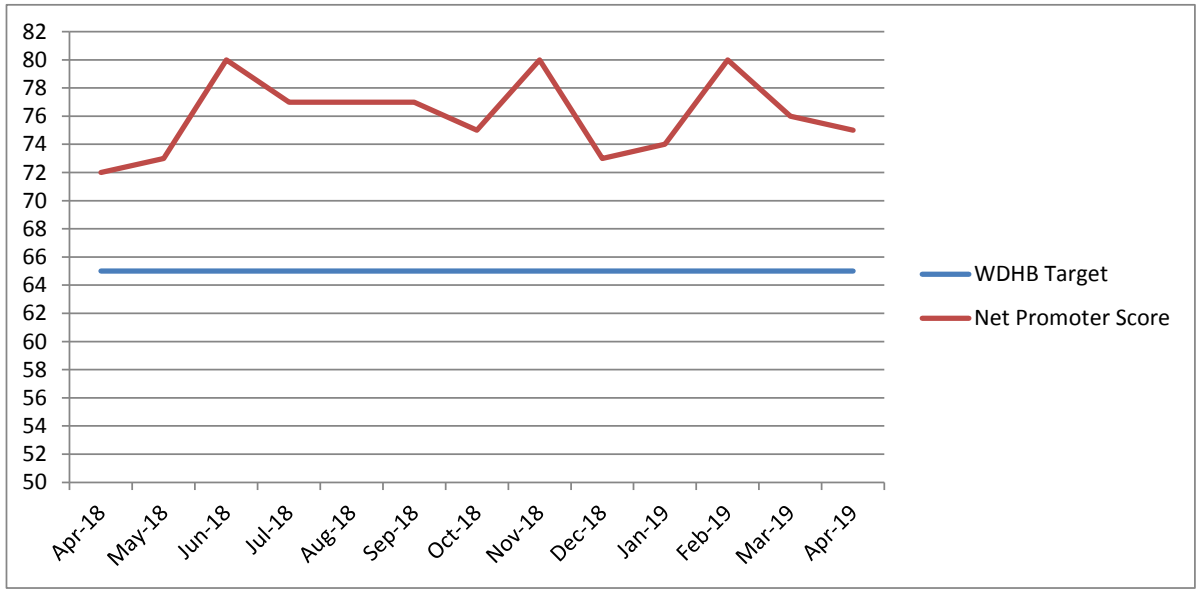
FFT Overview by Month & Year -

Month & Year	Surveys	How likely are you to recommend our ward?	Did we see you promptly?	Did we listen and explain?	Did we show care and respect?	Did we meet your expectations?	Welcoming and friendly?
Totals	**966**	**75**	**75**	**80**	**88**	**78**	**89**
Apr-2019	966	75	75	80	88	78	89

Table 2: Waitematā DHB FFT results (each question)

The net promoter scores in April have met target for all Friends and Family Test questions. This month, 'did we see you promptly' improved by 2 points and achieved a score of 75 compared to 73 in March. 'Did we meet your expectations' has dropped slightly from 81 last month to 78 this month. 'Welcoming and friendly' and 'care and respect' are on a par with last month, both achieving scores of 89 and 88 respectively.

Net Promoter Score over time



Graph 2: Waitematā DHB Net Promoter Score over time

Total Responses and NPS to Friends and Family Test by ethnicity

March 2019	Māori	Overall Asian	Overall Pacific	Other
Responses	77	80	45	199
NPS	73	70	64	70

Table 3: NPS by ethnicity

This month, all ethnicities with the exception of Pacific have met the Waitemata DHB NPS target and score 65 and above. Overall, the scores have fallen since last month for our Net Promotor Score.

March 2019	Māori	Overall Asian	Overall Pacific	Other
Did we see you promptly?	79	72	66	74
Did we listen and explain?	81	83	77	80
Did we show care and respect?	88	86	86	87
Did we meet you expectations?	82	77	73	77
Were we welcoming and friendly?	87	83	89	86

Table 4: NPS for all questions by ethnicity

'Did we see you promptly' continues to be our lowest rating measure for all ethnicities, particularly Pacific where the rating was 66. Pacific also scored low for meeting expectations. The areas that we consistently do well is 'welcoming and friendly' and 'showing care and respect'.

Friends and Family Test Comments

- "*I had a difficult pregnancy and had multiple stays and the staff were beyond caring and professional. I couldn't have got through without them.*" ***Maternity, NSH***
- "*I feel the staff go well beyond their call of duty. You couldn't wish for better treatment.*" ***Anawhata Ward, WTH***
- *"Everything was okay and very good. Everything was explained very nicely and clearly."* ***Allied Health Community Adults West***
- *"Everyone was so nice, friendly and helpful. It was my first visit so they eased my nerves, thank you."* ***Radiology, NSH***
- *"Staff are authentically interested in people. All the service/support in the little things is outstanding. A culture of some serious value adding here. Feels like a family. Legends!"* ***Rangatira Ward, WTH***
- *"I found that everyone is helpful and caring. Everyone responds well if I am in pain. We always have lovely cheerful faces, which is important of being health practitioners"* ***Ward 9, NSH***
- *"So generous, kind and loving. They go out of their way to do things."* ***Ward 14, NSH***

Friends and Family Test by ward

		April-2019	
Division	**Ward**	**Responses**	**NPS**
AH	Allied Health Community Adults North	3	100
AH	Allied Health Community Adults Rodney	1	100
AH	Allied Health Community Adults West	2	100
AH	Allied Health Community Child Health North	2	100
AH	Allied Health Early Discharge and Rehabilitation Service (EDARS)	8	100
AH	Allied Health Outpatients Physiotherapy WTH	2	100
ESC	Elective Surgery Centre	21	100
A&EM	North Shore Hospital Assessment Diagnostic Unit (ADU)	27	52
A&EM	North Shore Hospital Assessment Diagnostic Unit Clinic	2	0
SMHOP	North Shore Hospital Dialysis Unit	1	-100
A&EM	North Shore Hospital Emergency Department (ED)	50	82
S&AS	North Shore Hospital Hine Ora Ward	13	100
S&AS	North Shore Hospital Intensive Care Unit/High Dependency Unity (ICU/HDU)	6	83
A&EM	North Shore Hospital Lakeview Cardiology	87	84
CWF	North Shore Hospital Maternity Unit	90	64
S&AS	North Shore Hospital Outpatients	19	28
S&AS	North Shore Hospital Radiology	6	83
CWF	North Shore Hospital Special Care Baby Unit (SCBU)	13	77
S&AS	North Shore Hospital Short Stay Ward	56	49
S&AS	North Shore Hospital Surgical Day Stay	2	0
A&EM	North Shore Hospital Ward 2	37	89
A&EM	North Shore Hospital Ward 3	47	98
S&AS	North Shore Hospital Ward 4	52	75
A&EM	North Shore Hospital Ward 5	11	27
A&EM	North Shore Hospital Ward 6	27	70
S&AS	North Shore Hospital Ward 7	20	90
S&AS	North Shore Hospital Ward 8	33	97
S&AS	North Shore Hospital Ward 9	20	85
A&EM	North Shore Hospital Ward 10	39	72

A&EM	North Shore Hospital Ward 11	17	82
SMHOP	North Shore Hospital Ward 14	16	88
SMHOP	North Shore Hospital Ward 15	11	91
CWF	Wilson Centre	11	100
A&EM	Waitakere Hospital Assessment Diagnostic Unit (ADU)	26	60
A&EM	Waitakere Hospital Anawhata Ward	15	93
SMHOP	Waitakere Hospital Dialysis Unit	8	75
A&EM	Waitakere Hospital Emergency Department (ED)	22	24
A&EM	Waitakere Hospital Huia Ward	11	91
CWF	Waitakere Hospital Maternity Unit	2	100
SMHOP	Waitakere Hospital Muriwai Ward	24	71
S&AS	Waitakere Hospital Outpatients Reception 2	2	100
CWF	Waitakere Hospital Rangatira Ward	18	78
CWF	Waitakere Hospital Special Care Baby Unit (SCBU)	10	30
S&AS	Waitakere Hospital Surgical Unit	8	100
A&EM	Waitakere Hospital Titirangi Ward	30	90
A&EM	Waitakere Hospital Wainamu Ward	21	71

Table 5: FFT results by ward

Key for above table:
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)*

This month, only 59% of services and wards met their response targets, down 7% on last month. Of these wards/services, 81% scored at or above the Waitemata DHB target. Three wards exceeded expectations and achieved an NPS score of 100 (see table 6 below). The main reasons for these positive comments include great staff (understanding, friendly, kind and professional), a high level of care, good communication and a clean and comfortable environment.

This month, the lowest NPS is for Special Care Baby Unit, Waitakere Hospital and Short Stay Ward, North Shore Hospital (NPS 30 and 49 respectively). The reason for a low NPS score in SCBU is because of 50% of respondents provided a neutral rating 'likely to recommend'. In Short Stay Ward, the main reasons for the negative feedback include long wait times for scans and surgery, and poor treatment from staff – rude and uncaring.

A summary of the FFT results can be seen below.

Ward/Service – Exceptional NPS	Target Responses	Achieved	NPS Score
Haematology Day Stay, North Shore Hospital	20	21	100
Ward 15, North Shore Hospital	10	13	100
EDARS, Allied Health	10	12	100
Hine Ora Ward, North Shore Hospital	10	11	100
Ward/Service – Low NPS	**Target Responses**	**Achieved**	**NPS Score**
Outpatients, North Shore Hospital	10	10	30
Ward 11	10	10	49

Table 6: FFT Results Summary

Kōrero Mai/Talk to Me Programme

Korero Mai is a patient and whānau led escalation service that was launched in mid-November 2018. Patients are empowered to use a three step process to escalate their concerns. The third step instructs patients/whānau to call an 0800 number which is triaged by a Senior Nurse 24 hours/7 days a week who can request a medical review for a reported deterioration or intervene to support patient concerns. At the end of April we have had 16 phone calls, please see details of five April phone calls below. Out of the 16 calls, four were not Kōrero Mai calls and were forwarded to the phone line via switchboard - these calls were resolved and are highlighted in amber.

DATE	Department	Caller	Event detail	Follow up actions (as stated in RiskPro)
Apr-19	Urology Outpatients - Waitakere	Daughter	Patient has an extensive clinical history and was seen in the Urology OPD clinic. His family live in Australia and his daughter in law called this evening asking for a clinician to please contact the family as soon as possible. Patient had phoned his family after his appointment and tried to explain that the Dr in clinic today said he has a tumour. Family requested clarification via the Kōrero Mai phone line.	Not Kōrero Mai call - Handover to Urology to manage after consent provided by patient to liaise with family. **Outcome:** Urology doctor called family - information provided.
Apr-19	ADU - Waitakere	Patient	Was inpatient in ADU last night? Reported air conditioning in room was very noisy and room was very cold. Nurses reported “it’s always like this". Patient told nurses he would complain on their behalf and has been trying to get hold of someone all day.	Not Kōrero Mai call - re-categorised on RiskPRO and forwarded to feedback to manage **Outcome:** Inservice with Switchboard due to pattern of calls being transferred to Kōrero mai number - via Switch inappropriately.
Apr-19	Emergency – North Shore	Patient	Concerns due to delay in pain relief and inability for nurses to provide appropriate medication to support.	Escalated to CNM and triage nurse. **Outcome:** Frequent presenter with similar admissions. Referred to ED for consideration of management plan.

Apr-19	Ward 5 – North Shore	Daughter	Daughter not happy that her father's 1:1 watch has been discontinued by the Behaviour of Concern RN. He now has a watch which he shares with the patient opposite to him.	DNM spoke with daughter explained rationale for change and that regular reviews will be made. Regular checks throughout night, patient settled. **Outcome:** Escalated to CNM, who met with daughter on ward. Daughter described situation last time when her father's behaviour escalated and he was injured - does not want this to happen again.
Apr-19	Emergency – North Shore	Patient	Told to come to NSH due to reported post-surgical complications - no referral letter therefore orthopaedics declined to see her and would have to go through Emergency.	DNM escalated the situation, orthopaedics accepted a referral. Patient added to orthopaedic expect list and transferred to ADU. **Outcome:** Patient thankful for DNM intervention and support. Appreciate follow up call to learn about her experience. Haematoma drained, follow up appointment in 4 weeks.

Table 7: Kōrero Mai Call Summary

7.3 Patient Experience Activity Highlights

Volunteer Recruitment Statistics

Volunteer numbers have decreased by two from previous month. The numbers may start to increase the following month as we are about to start recruitment for ward volunteers.

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)
55	100	0	155

Table 8: Volunteers Recruitment

Volunteer Activity Highlights

- ***Recruitment***

With the assistance of the communications team, we have developed a video about the satisfaction and benefits of volunteering with Waitematā DHB. We are going to use this video on socio-media and on our website to advertise for recruitment. The Waitematā DHB volunteer webpage has been updated and is now easier for volunteers to apply online.

- ***Ward volunteer receiving compliment***

Ward volunteer role has been created to enhance patient experience and support staff on the ward. The role has been established since September 2017 with the first group of volunteer working in Titirangi. Since then, we have volunteers working now in 8 wards across both hospitals providing social care to our patients, their Whānau and visitors. Now, we are starting to have positive feedback from the patient about this service

Patient Experience Team Highlights

- ***Consumer Council Short Listing completed***

The inaugural Consumer Council Expression of Interest recruitment process commenced in late February and applications closed on the 18th of March. 62 applications were received from a variety of consumers representing many different aspects of our community. Nominations have been received from each Health Link Board and two Māori representatives have been appointed by our MOU partners Te Whanau o Waipareira and Te Runanga o Ngati Whatua. Short listing has been completed and interviews have been scheduled mid-May. We hope to have the final council membership confirmed by the end of May.

- ***Health Literacy at Waitematā DHB***

The joint Waitematā and Auckland DHB Health Literacy policy was endorsed by the Waitematā DHB Executive Leadership team in April. This coincides with the Health Literacy Intranet page going live for full staff access and the 'Your stay at hospital' guide publication. 56.2% of adult New Zealanders have poor health literacy skills, scoring below the minimum required to meet the demands of everyday life and work. Therefore, it is essential that healthcare professionals check in with patients and their whānau to ensure they have understood what has been communicated both verbally and in writing. Awareness campaigns about the policy and the guide will take place soon as we build up to the 2nd Health Literacy Symposium that is to take place at Waitematā DHB in October.

➢ ***Patient Experience Training in ARDS***

Director of Patient Experience continues to facilitate training across the Auckland Regional Dental Service with over 250 staff attending one of seven four hour sessions. The training focuses on mapping the patient experience journey for patients through the service and a focus on communication/health literacy for all administrators, dental assistants and dental therapists.

Asian Health Services Team Highlights

➢ ***Health seminar for the Japanese community***

Asian Health Services (AHS) worked with the Japanese Society to provide a health seminar for Japanese speaking commuity members. New Zealand Health & disability system information and Asian Health Services information were delivered on the day.

Community feedback on the workshop

- The vast majority of respondents were pleased with the topic of this seminar. Eight stated they were “very satisfied” and one responded “satisfied”. This shows that health system information is suitable for the needs of this group.
- All respondents gave their best ranking of “very satisfied” to the presenters’ in-depth knowledge of the topic. It indicates the demonstration was pleasantly received by the audience.
- All participants believed the key message was clearly conveyed by the presenter, with 7 replies of “very satisfied”, and 1 response of “satisfied”.
- The survey results show that interaction with the participants was good, and seven of eight respondents were very satisfied. Presenters actively engaged with the audience throughout the seminar by encouraging them to participate in the conversation, providing feedback, and offering prizes during a spot quiz at the end.

Other comments

- Pleasantly surprised to learn Waitematā DHB had Japanese speaking workers to provide patient and mental health support to the Japanese community in the Waitematā area. They thought such services were very promising and hoped to see more Japanese services available in the future.
- Even though half of the participants have lived in NZ for a long time, they still learned something new about the NZ health system today, such as how to request language support (hospital interpreter and language line telephone interpreter) and subsidised prescriptions.

➢ ***#WannaTalk - A youth suicide prevention workshop at Kristin school***

Asian Mental Health Service (AMHS) offered several youth mental health workshops in previous years and we are now focusing on suicide prevention for youths aged between 14 to 18 years old.

New Zealand has the highest youth (15-18 yrs) suicide rate according to global data. Their mental health and wellbeing are priorities of the Mental Health and Addction (MH & A) services.

Parents and caregiver are encouraged to attend this workshop to learn useful information to help their teenage children build positive coping strategies when they are stressed or at risk of self-harm.

Date & Time Tuesday 21 May 2019 7 to 9pm
Venue Kristin School ***(Albany)***

Speakers Patrick Au & Dr Hyeeun Kim
Programme Presentations, Group discussions
Group feedback

➢ ***Asian Health Services (AHS) staff – Full time Equivalent (FTE)***

No. of current staff	22 FTE
No. of management	1
No. of iCare Call Centre & Asian Patient Support Service (APSS)	4.7
No. of APSS Bureau (contractors)	10
No. of Asian Mental Health Service (AMHS)	5.5
No. of AMHS Bureaus (contractors)	20
No. of WATIS interpreting service	9.5
No. of interpreters (contractors)	164
Vacancy	1.3 (0.5 APSS & 0.75 WATIS)
Total	216 (22FTE + 194 contractors)

- ***Asian Patient Support Service & iCare call Centre (April 2019)***

No. of total enquiries	1,333
No. of iCare call centre enquiry - NZ Health info, GP, Breast Screen etc.	906
No. of new inpatient referrals - complex issue & cultural support	101
No. of support episodes by cultural support coordinators	427
No. of clinical meetings & face to face liaison	252
No. of phone support	66
No. of clinical coordination	109
No. of health or cultural workshop or promotion or survey	1
No of cultural talks for health professionals	1
No. of document – cultural review /input	2 (1Chinese &1Korean)

- ***Asian Mental Health Service (April 2019)***

No. of active mental health clients (target KPI: 75)	85
No. of new referral - mental health client	10
No of client support hours	180
No. of support meeting hours	102
No. of liaison psychiatry referral	1
No. of active forensic MH clients	1
No. of acute MH inpatient ward or crisis team referral	3
No. of Asian Clinical Psychological Service referral	6
No. of exit	13
No. of Asian Wellbeing Group Sessions /meetings	4

- ***WATIS Interpreting Service (April 2019)***

No. of interpreters (cover 90+ languages & dialects)	164
No of interpreting episodes	4,136
No. of face to face interpreting	2,381
No. of appointment confirmation	1,320
No. of telephone assignment	318
No. of telephone interpreting	117
No. of document translated or proof reading	0
% DNA of WATIS users	1.16%
Booking unfulfilled	1.90%

Pastoral Care Update

The Chaplains are busy planning for the opening week of the new Waitakere Chapel to be held from the 4th to the 7th of June. A dedication service led by the Catholic and Anglican Bishops will be held on the 4th of June, with other events planned throughout the week, including a dawn service, a Pasifika celebration, Asian Health services, community open day and a multifaith celebration.

Meetings have taken place with Chaplain Team and the ICHC to progress plans for an on-call spiritual service. A paper will be developed for endorsement by the end of June.

7.4 Patient Experience Activity Overview

On track	*Generally on track – minor issues/delays*	*Off track/not started*

Project Name	Project Summary	Patient Experience Lead	Update	Domain	Status
Organisation wide / Multiple Divisions					
Kōrero Mai – Whānau/Patient led escalation	Kōrero Mai (Talk to Me) aims to co-design a patient/family/whānau-led escalation system for patients whose condition is deteriorating (getting worse).	David Price Jeanette Bell Ravina Patel Lara Cavit	- Patient Experience Director is Project Sponsor. - All working/steering groups formed - Ongoing communication plan and audit of Kōrero Mai promotional reach and evaluation of calls that are made to the Kōrero Mai phone lines. - Nine calls and one text message received to date. - KMU roll out completed in February. - Roll out to maternity and SCBU in April. - Staff and Patient Surveys on all wards to assess awareness of the programme. Over half of the wards have been surveyed. - Translated collateral development completed.	Patient & Community Participation	
Consumer Council	As part of the annual planning DHB priorities guidelines for 2016/17 an expected focus for improving quality at WDHB is to 'commit to either establish or maintain a consumer council (or similar) to advise the DHB'. Waitemata DHB is a unique position with key stakeholders (Waitakere Healthlink and Healthlink North), contracted to support consumer engagement activity.	David Price	- Key principles agreed following two meetings with Healthlink Boards, awaiting sign off before progressing to Board presentation. - ToR and Board paper draft completed and endorsed by ELT. - Presentation to the Board in July – endorsement received with revisions to Board recommendations to be presented in September. - Further presentation to Board in September - Presentation to Board at December for approval – endorsement received to establish Consumer Council. - Recruitment for Consumer Council continues, short listing of 62 applications completed, interviews to be completed in May.	Governance	
Mystery Shopping Programme	To further understand the experiences of patients and consumers accessing our services via phone a mystery shopping programme will be piloted.	Ravina Patel	- PE team has developed a programme for 2019 to ensure that the mystery shopper phone calls are undertaken monthly. SMT has endorsed the programme. - Each month 10-12 services are contacted.	Measurement & Evaluation Patient & Community	

			- 10 calls completed in April. More calls are scheduled for May. - Quarterly report complete and presented to CEO. - PE team will progress training of Contact Centre and Patient Service Centre staff with best practice guidelines that are co-designed with staff.	Participation	
Website/Intranet Update	To enhance both the public and staff understanding of the patient experience team's role, function and activity, the current information available via the Waitemata DHB website and staff intranet requires updating.	David Price Ravina Patel Lara Cavit	- Content is live for the patient experience intranet site. Small refinements continue.	Communication & Information	
Patient Stories	Capturing patient stories on video for internal and external audiences. The purpose is for staff to learn from experiences and assist with providing the best level of support and care to our patients.	Ravina Patel	- Patient story – Autism. Challenges people with autism face and augmented communication. Seeking a patient to support the video. Disability Advisor to provide patient details. - Patient story - PACU. Educational video taking patients through PACU and what to expect. Filming will take place in April/May. - Patient Story – Maternity. Educational video to support new parents with caring for their new born baby. Date TBC - Patient Story – Māori Health planned to take place mid-2019. - Patient Story – Asian Health. Filming to take place in July.		
Patient Information Booklet	Patients and staff have consistently requested the availability of information related to their inpatient stay. The provision of a patient information booklet was endorsed by local community groups as a solution to this challenge.	Lara Cavit	- Patient Information Booklet has been completed and printed. It is available on the intranet in electronic form. - Copies to be distributed to ward throughout May.	Communications & Information	
Patient Feedback - Survey Design	Advisory role supporting services to develop patient surveys which capture feedback to understand if we are providing our patients with a quality service.	David Price Ravina Patel	- Anaesthetic service - Parenteral nutrition - Rheumatic Fever Clinic - Patient Focused Booking - Gynaecology - Anaesthesia survey - Gynae pelvic pain survey - Endometrial cancer survey - Local delivery of oncology treatment (LDO) survey - Intramuscular Injections - Pacific week evaluations	Measurement & Evaluation	

			- Onepoto School Pacific Week event evaluation - Ortho survey - Renal survey In process of developing survey tool development policy to enable staff to design surveys and use the most appropriate tool.		
Health Literacy	Collaboration with Auckland DHB to enhance health literacy awareness across the organisation in supporting patients to make informed choices about their healthcare and improve communication both written and verbal.	David Price Leanne Kirton	- Health Literacy Policy endorsed by Executive Leadership Team in April for endorsement. - Health Literacy intranet site updated and to went live in March. - Launch of awareness campaign across organisation to promote policy, new resource intranet page and e-learning modules adapted from a Hawkes Bay DHB resource. - Health Symposium to be organised for 31st of October 2019 – Key note speakers confirmed.		
Patient and Whānau Centered Care Standards (PWCCS) Review	The Patient Experience team is leading a review of the Patient and Whānau Centred Care Standards to engage the multi-disciplinary team in the process and ensure the results of the survey provide effective insight into ward performance in the fundamentals of patient and whānau centred care.	David Price Meg Smith	- Interviews with all CNMs, Clinical Nurse Directors and Heads of Division have been completed. - Four focus groups have been completed with focus on solution generation. - Meetings with cultural teams have taken place. - Allied Health planning meeting occurred in February – pilot requested on AT&R wards. - Further investigation into medical engagement in process. - Recommendations for change finalised and presented to the PWCCS Steering group. - Socialisation of recommendations to be completed with development of recommendations and improvements to continue throughout 2019.		
Joint Māori Health and Patient Experience Action Plan	Patient Experience reporting lacks cultural understanding and the ability to tell the story of our Māori patients and their whānau. The Māori Health and Patient Experience team have come together to align our focus and understand the Māori patient experience.	David Price Riki Nia Nia	- Joint team meeting on Waitakere Marae conducted in late November 2018. - Draft paper collated and circulated to both teams for endorsement – paper endorsed. - Presented to and endorsed by Maori Equity Committee – action plan now to be created to meet objectives of the Maori Health & Patient Experience Team collaboration.		

Volunteers					
Ward and outpatients Volunteer Programme	Waitemata DHB aims to have volunteers working on all wards throughout the organisation to support specific tasks and enhance the patient experience. Providing social connections and meeting basic patient needs in a busy ward environment is important to our patients.	Genevieve Kabuya Lara Cavit	- Hine Ora, ICU, Waitakere ADU, Short Stay Ward, Anawhata, Titirangi wards have been set up and functioning independently with pool of volunteers. - Consultation between Patient Experience team and ward 14 staff still in the process to set up agreed measures to fully utilise volunteer pool. - The St John volunteers have settled in well in their role in ward 15. - Follow up and recruitment continue for Rangatira, Outpatient service, Muriwai ward and maternity at Waitakere. - Consistent on-boarding processes and support systems have been developed. - Positive feedback about this service start to come through Friend and Family Tests (FFT) - To commence recruitment for Ward 5 and Ward 10 volunteers in June 2019.	Patient and community participation	
Better Impact	An online volunteer management system that provides access to volunteer information within one database.	Team	- Spread sheet containing volunteer information has been sent to Better Impact to input into the Better Impact System - Five training sessions were completed in August. - Better Impact linked with Waitemata DHB website to streamline the volunteer application process. - Better Impact automation of rosters has commenced. - Ongoing data maintenance progressing with June 2019 go-live date for volunteers to actively use Better Impact	Patient and community participation	
On-boarding and training for volunteers	Developing systems and processes to ensure that the on boarding and training programme for staff aligns with current processes for Waitematā DHB staff/contractors. This will be linked to a central database managed through Occupational Health and Safety. This new process will ensure that volunteers have completed their mandatory training before receiving or renewing their Waitematā ID cards. The aim is to have all	Lara Cavit Genevieve Kabuya	- Review of current processes has been completed and a recruitment and on boarding process has been developed. - Learning and Development have included volunteers in Welcome to Waitematā for orientation with staff. - An online training module has been developed with Occupational Health and Safety Services which will include mandatory training for volunteers.		

	current volunteer on boarded into this new training system by the end of 2019.		- This online training is currently being rolled out with current volunteers.		
Volunteer Website	Volunteer page on the public facing Waitematā DHB website to be updated to support a targeted recruitment approach for volunteers.	Lara Cavit Genevieve Kabuya	- Website has been revamped and now live. - New video about volunteer's testimony and satisfaction to volunteer with Waitematā DHB has been created and will be uploaded on the website.		
Child Woman and Family					
Auckland Regional Dental Service (ARDS) Patient Experience paediatric measurement	Currently the experience of paediatrics who access ARDS is not measured. There is some research in to various methods of paediatric patient experience and ARDS would like to explore these to determine which overarching method can be adopted by their services. From paediatric feedback, service improvement priorities can be identified.	Lara Cavit	- ARDS to continue the FFT trial with the view to look at how they plan to disseminate their findings. - Trial group will meet again in February 2019 to discuss a plan for rollout. This will depend on the new questions offered for the FFT. - Patient Experience training with all ARDs staff took place in January 2019 across four days. - In-depth training of all ARDs staff progressing over April/May and June – four hour sessions focussed on communication and health literacy.	Measurement & Evaluation	

Monthly Report for Hand Hygiene April 2019

Highlights:

- The overall Waitemata DHB hand hygiene compliance for the month of April 2019 is 89%.
- The ***Hand Hygiene New Zealand National Hand Hygiene Report November 2018 to March 2019*** has been released. Waitemata DHB had the largest number of auditing moments collected and the second highest compliance rate in New Zealand. This demonstrates the massive commitment that Waitemata DHB makes to hand hygiene and patient safety.

Table 2: National compliance rates by DHB, 1 November 2018 to 31 March 2019

DHB	Correct moments	Total moments	Compliance rate	Lower 95% confidence interval	Upper 95% confidence interval
Auckland DHB	11,889	13,845	85.9%	85.3%	86.4%
Bay of Plenty DHB	1,799	2,363	76.1%	74.4%	77.8%
Canterbury DHB	4,631	5,654	81.9%	80.9%	82.9%
Capital & Coast DHB	2,703	3,251	83.1%	81.8%	84.4%
Counties Manukau Health	15,353	17,566	87.4%	86.9%	87.9%
Hauora Tairāwhiti*	289	401	72.1%	67.5%	76.2%
Hawke's Bay DHB*	1,418	1,612	88.0%	86.3%	89.5%
Hutt Valley DHB	1,520	1,830	83.1%	81.3%	84.7%
Lakes DHB	893	1,095	81.6%	79.1%	83.7%
MidCentral DHB	1,568	1,991	78.8%	76.9%	80.5%
Nelson Marlborough DHB*	1,438	1,641	87.6%	85.9%	89.1%
Northland DHB	2,841	3,244	87.6%	86.4%	88.7%
South Canterbury DHB	712	845	84.3%	81.7%	86.6%
Southern DHB	2,057	2,543	80.9%	79.3%	82.4%
Taranaki DHB	581	835	69.6%	66.4%	72.6%
Waikato DHB	3,263	4,123	79.1%	77.9%	80.4%
Wairarapa DHB	242	265	91.3%	87.3%	94.1%
Waitemata DHB	21,837	24,490	89.2%	88.8%	89.6%
West Coast DHB	674	798	84.5%	81.8%	86.8%
Whanganui DHB	883	1,039	85.0%	82.7%	87.0%

- Special mention to the following clinical units that achieved compliance of above 95%:
    - Haematology Day Stay NSH HR = 100%
    - Maternity NSH = 100%
    - ESC PACU = 100%
    - Emergency Department WTK HR = 100%
    - Ward 4 = 100%
    - Kahikatea Unit Mason Clinic = 100%
    - Kauri Unit Mason Clinic = 100%
    - Pohutukawa Unit Mason Clinic = 100%
    - Rata Unit Mason Clinic = 100%
    - Tane Whakapiripiri Unit Mason Clinic = 100%
    - Te Aka Unit Mason Clinic = 100%
    - Totara Unit Mason Clinic = 100%
    - Waiatarau Acute Mental Health Unit = 100%
    - Hine Ora Ward = 96%
    - ADU NSH = 96%
    - Ward 11 = 96%

- Radiology WTK = 96%
- Rangitira Unit = 96%

- Congratulations to the professional group with the highest compliance rate:
  - Phlebotomy Invasive Technician = 93%

Areas of concern:

- Clinical units performing below the 80% benchmark are:
  - Emergency Department NSH HR = 77%
  - Ward 10 = 77%
  - Ward 3 = 75%
  - He Puna Waiora = 75%
  - CVU NSH = 69%
  - Theatre NSH = 69%
  - Wainamu = 62%

Accessing department reports:

- Monthly reporting is available via two reports:
  - A short 6 page DHB level report (this report).
  - Individual department reports are be available from the shared drive:
    - NSH site on G drive:
      G:\Nurses\AUDITS PROGRAM\1 Audit Schedule & Specific Results 2019\Hand Hygiene\2019
    - WTK site on M drive:
      M:\Nurses\AUDITS PROGRAM\1 Audit Schedule & Specific Results 2019\Hand Hygiene\2019
  - It is recommended that the department reports are printed and publically displayed in each department's quality board.

Hand Hygiene Program Update

New Waitemata DHB Hand Hygiene Policy authorized

Please see ***controlled documents > policies & procedures > infection control*** to view the Waitemata DHB Hand Hygiene Policy authorized in November 2018. This new policy has an expanded section on the Below the Elbows (BBE) policy and Waitemata DHB's expectations of HCWs.

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), Ward 11, 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 2019

Friday 21st June 2019 08:00 – 16:00 hours	Kawakawa Room, level 1, Whenua Pupuke, NSH
Friday 20th September 2019 08:00 – 16:00 hours	Kawakawa Room, level 1, Whenua Pupuke, NSH

Recommendations for improving compliance:

If your compliance is below 80%:

- Work with your hand hygiene auditors to identify any compliance issues
- Notify the Waitemata DHB hand hygiene coordinator (Graham Upton – Mobile: 021828047) of any issues that may need further assistance. These issues will be discussed at the monthly Waitemata DHB hand hygiene committee meeting.
- A plan for improvement will be created between the hand hygiene committee, line managers and auditors.

Your area does not have any auditor:

- Please nominate a staff member and book them into the next hand hygiene training day. Please contact Graham Upton – Mobile: 021828047 for the booking / or via email.

You did not meet the required moments for your department:

- Please provide your auditors with dedicated time to collect the required moments.

Graph 1: Waitemata DHB hand hygiene compliance in the last 12 months

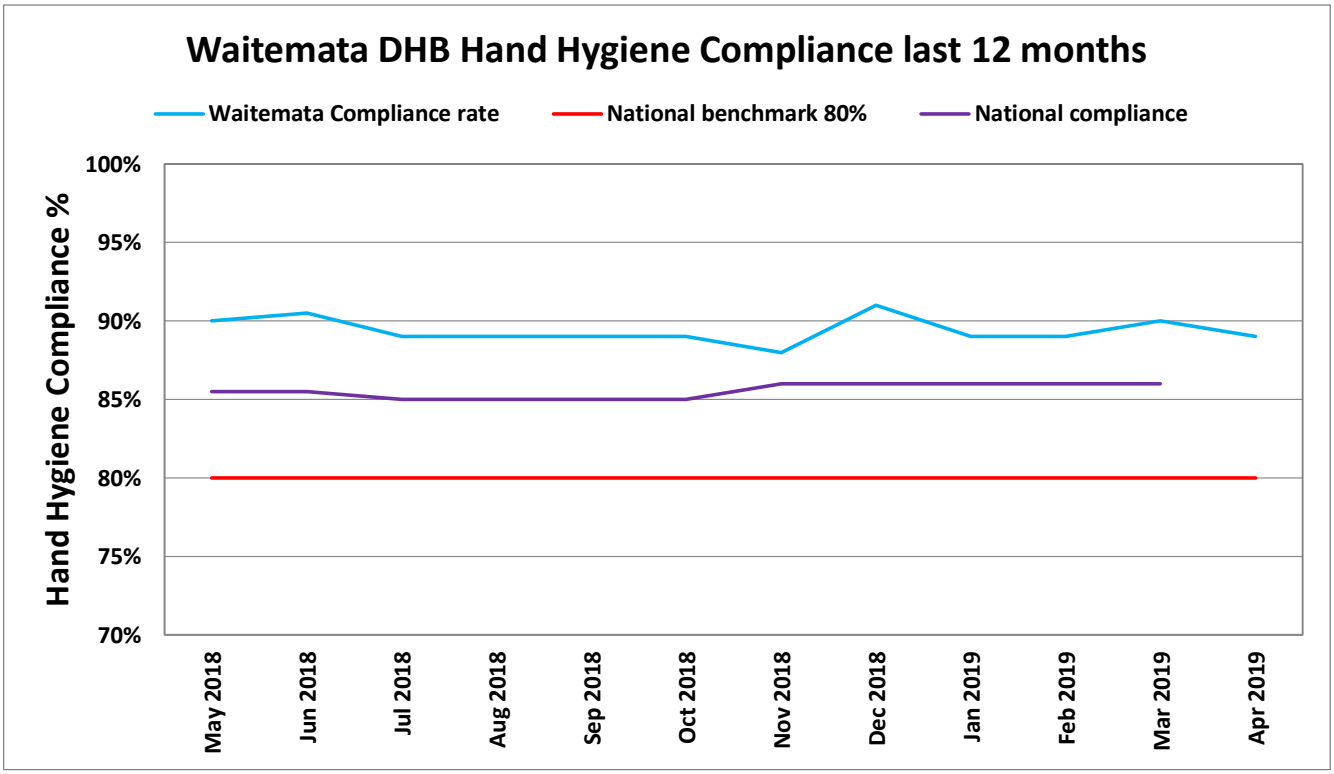


Table 1: Overall Waitemata DHB hand hygiene compliance by facility

Name	Correct Moments	Total Moments	Compliance Rate
Mental Health	213	220	97%
Waitakere Hospital	1277	1403	91%
Elective Surgery Centre	243	269	90%
Wilson Centre	44	50	88%
North Shore Hospital	2712	3086	88%
Waitemata DHB	4232	4758	89%

Table 2: Overall Waitemata DHB hand hygiene compliance by professional group

Name	Correct Moments	Total Moments	Compliance Rate
Phlebotomy Invasive Technician	160	172	93%
Nurse/Midwife	2438	2649	92%
Student Allied Health	21	23	91%
Health Care Assistant	491	562	87%
Student Doctor	12	14	86%
Student Nurse/Midwife	204	239	85%
Medical Practitioner	541	648	84%
Allied Health Care Worker	205	252	81%
Orderly & Cleaners & Others	114	141	81%
Meal staff	36	45	80%
Administrative and Clerical Staff	10	13	77%

Table 4: Overall Waitemata DHB hand hygiene compliance by moment

Name	Correct Moments	Total Moments	Compliance Rate
1 - Before Touching A Patient	1244	1446	86%
2 - Before Procedure	487	546	89%
3 - After a Procedure or Body Fluid Exposure Risk	578	615	94%
4 - After Touching a Patient	1383	1496	92%
5 - After Touching A Patient's Surroundings	540	655	82%

Table 5: North Shore Hospital hand hygiene compliance by department

Name	Correct Moments	Total Moments	Compliance Rate
Haematology Day Stay NSH HR	50	50	100%
Maternity NSH	104	104	100%
Ward 4	114	114	100%
Hine Ora Ward	68	71	96%
ADU NSH	66	69	96%
Ward 11	147	154	96%
Ward 7	95	100	95%
Ward 14	101	109	93%
Ward 12 KMU	100	109	92%
Endoscopy NSH	91	100	91%
Haemodialysis NSH HR	91	100	91%
Ward 6	102	113	90%
Outpatients Department NSH	73	81	90%
Short Stay NSH	90	100	90%
Ward 5	106	119	89%
PACU 1 & 2 NSH	86	97	89%
Haemodialysis Apollo HR	53	60	88%
ICU HR	89	101	88%
Ward 15	141	163	87%
Ward 8	128	148	87%
SCBU NSH	95	110	86%
Ward 9	88	105	84%
CCU NSH	93	114	82%
Ward 2	88	108	82%
Radiology NSH	88	109	81%
Emergency Department NSH HR	78	101	77%
Ward 10	77	100	77%
Ward 3	91	121	75%
CVU NSH	36	52	69%
Theatre NSH	18	26	69%

Table 6: Waitakere hospital hand hygiene compliance by department

Name	Correct Moments	Total Moments	Compliance Rate
Emergency Department WTK HR	6	6	100%
Radiology WTK	24	25	96%
Rangitira Unit	97	101	96%
Titirangi	115	122	94%
Haemodialysis WTK HR	47	50	94%
Theatre WTK	94	100	94%
Endoscopy WTK	93	100	93%
Anawhata	103	112	92%
Huia	91	100	91%
Outpatients Department WTK	45	50	90%
SCBU WTK	88	102	86%
Maternity WTK	142	170	84%
Muriwai Ward	49	59	83%
ADU WTK	83	101	82%
Wainamu	8	13	62%

Table 7: Elective Surgery Centre hand hygiene compliance by department

Name	Correct Moments	Total Moments	Compliance Rate
ESC PACU	64	64	100%
Cullen Ward	95	101	94%
Theatre ESC	84	104	81%

Table 8: Mental Health hand hygiene compliance by department

Name	Correct Moments	Total Moments	Compliance Rate
Kahikatea Unit Mason Clinic	36	36	100%
Kauri Unit Mason Clinic	27	27	100%
Pohutukawa Unit Mason Clinic	25	25	100%
Rata Unit Mason Clinic	26	26	100%
Tane Whakapiripiri Unit Mason Clinic	25	25	100%
Te Aka Unit Mason Clinic	25	25	100%
Totara Unit Mason Clinic	26	26	100%
Waiatarau Acute Mental Health Unit	2	2	100%
He Puna Waiora	21	28	75%

Waitemata District Health Board

Best Care for Everyone

Waitemata DHB Infection Prevention and Control
April 2019

1. Hospital acquired bacteremia (HABSI)

HABSI is defined as a positive blood culture more than 48 hours after admission, or after procedure or previous admission in last 48 hours. There were two avoidable IVL bacteraemia for April; investigations identified that there was inconsistent documentation in eVitals, with no Visual Inspection for Phlebitis (VIP) scoring undertaken to identify early detection and intervention.

2019	Jan	Feb	March	April
Total No. HABSI	3	3	10	6
Rates/1000 Bed Days	0.14	0.14	0.44	0.27

Table: HABSI classification for April 2019

Source	Total	Ward	Organism	Comments
IVL	2	ICU	Staph aureus	• Presence of left ante-cubital fossa (ACF – Elbow) IV Luer (IVL) missed by clinical staff • Source of sepsis located two days after positive blood culture • Inconsistent documentation in both eVitals and clinical notes • No VIP scoring documented as per DHB policy
		Ward 2	Staph aureus	• IVL inserted in R) ante-cubital fossa (ACF – Elbow) • Patient developed cellulitis • No documentation on eVitals • No VIP scoring
Other	2	Ward12 (KMU)	E coli	• Unwell patient admitted for treatment of a mood disorder with associated drowsiness developed a hospital acquired pneumonia following an aspiration event
		Muriwai	E coli	• A patient with decreased mobility secondary to fall developed an E urinary sepsis; this was not related to an indwelling urinary catheter.
Unknown	2	Ward 7	Streptococcus dysgalactiae (Group C/G	• A patient with renal cancer and associated secondary metastases of the spine required a CT guided biopsy of a spinal mass • The patient developed a bloodstream infection possibly introduced during the procedure but unable to be confirmed
		Special Care Baby Unit (SCBU)	E coli	• A newborn infant in SCBU developed a bloodstream infection; the source has not been able to be identified

HABSI source Jan- April 2019

HABSI SOURCE	Jan-April 2019 n= 22
Vascular device	**Total 6** 2 CLAB & 4 IVL
CAUTI	-
Post proc/ surgical	1
Other (mostly non-IDC related UTI)	11
Unknown	4

2. Extended spectrum Beta lactamase producing bacteria (ESBL)

HA-ESBL is defined as Isolation of ESBL producing Enterobacteriaceae (e.g. E.coli or Klebsiella sp.) from a clinical or screening specimen > 72 hrs post admission in a pt. with previously negative or unknown ESBL status.

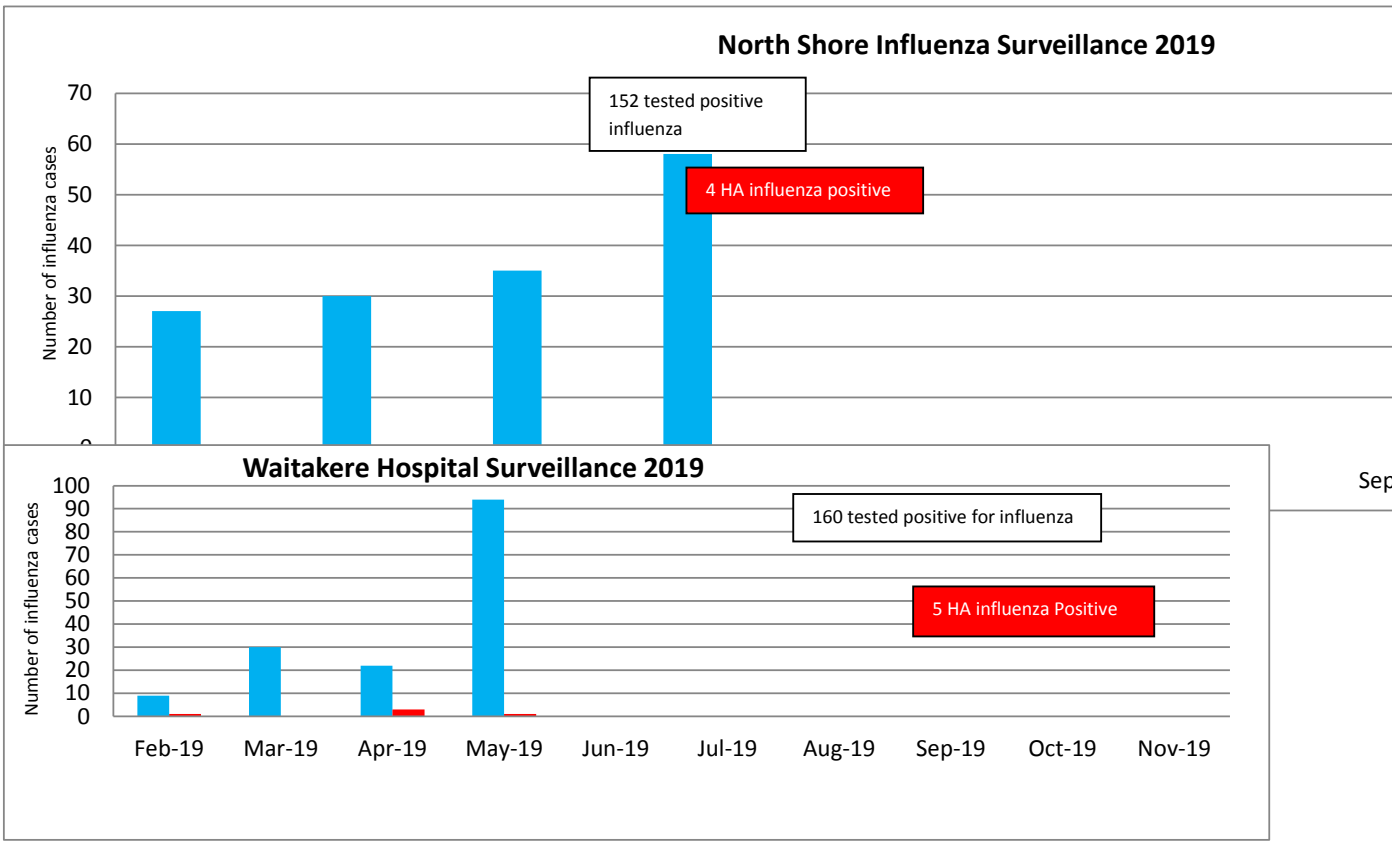
- Our HA-ESBL rate at NSH is consistent and reasonably high as shown in Table below
- About 30% of HA-ESBL is E.coli
- In April 2019 HA RESBL was spread across nine wards
- An educational program 'TAKE CHARGE bundle' has been in place since 2017.
- While some aspects of the bundle like hand hygiene (monthly) and contact precautions (periodically) are audited and successful, consistent and sustained implementation of a DHB wide prevention strategy can be improved further

.

	Aug –Dec 2018	2019	Jan	Feb	March	April
HA-ESBL rate/10,000 bed days (number)	8.8 (70)	NSH	8.9 (14)	9.5 (13)	8.7 (14)	8.3 (12)
	4.4 (15)	WTH	4.8 (3)	8.8 (5)	3.0 (2)	4.9 (3)

3. Influenza Feb till 27th May 2019

- Since March we have seen an increase in ILI presentations
- Majority of the cases for May are from Waitakere
- For month of May, we tested approximately 21 patients per day, of these 26% are positive for either Influenza A or B
- We are still seeing HA influenza despite dedicated influenza wards and heightened influenza education and awareness
- WDHB 'flu' prevention campaign using a quadrivalent influenza vaccine for staff has commenced and information about compliance with vaccination uptake to date approx. 60%



Communicable Diseases, Clusters and Outbreaks- MEASLES EPIDEMIC

Disease	Total Confirmed cases	Ward /Hospital	No of pt. contacts	No of staff contacts	Comments
Measles	39	WTH ED = 37 NSH ED = 2	537	334	• West Auckland has had the highest number of measles cases in the Auckland region • A total of **104** measles cases were sent for testing between March – May 2019; with **39** of these isolates returning as positive for measles • **Three** staff with confirmed measles, which accounted for majority of staff and patient contact tracing • Majority of contact tracing for patients occurred prior to be triaged; these were from ED waiting room contacts • **Three** person to person measles cross-transmissions have been attributed to the ED waiting room. These **three** patients were identified as contacts of the index cases • **33%** of the positive cases were under the age of 14 months who would not have received 1st does of MMR • **67%** of the confirmed cases over the age either had no measles immunity or equivocal Immunoglobulin G (IgG) antibody • **16** of the confirmed measles cases required hospitalisation from **2-10** days due to secondary infections
Norovirus cluster confirmed	3	10 NSH	8	7	• **Ward 10** had **eight** patients and **seven** staff reported symptoms of diarrhoea and or vomiting. • Index case was admitted with diarrhoea but not isolated in enteric precautions on admission • **Two** rooms (L and M) were closed from the 15-18 April 2019. With heightened infection control measures and increased environmental cleaning the norovirus did not spread to rest of the ward.

ACC
PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara
Supporting Treatment Safety
Treatment Injury Information
2019

ISBN: 978-1-98-852621-8 Supporting Treatment Safety (printed version)
ISBN: 978-1-98-852623-2 Supporting Treatment Safety (electronic version)

ACC number: ACC7971

Title: Supporting Treatment Safety: Treatment Injury Information.

Author: Accident Compensation Corporation.

Suggested Citation: Accident Compensation Corporation, 2019.
Supporting Treatment Safety: Treatment Injury Information. ACC, Wellington, New Zealand.

An online version of this report can be found at ***www.acc.co.nz/treatmentsafety***

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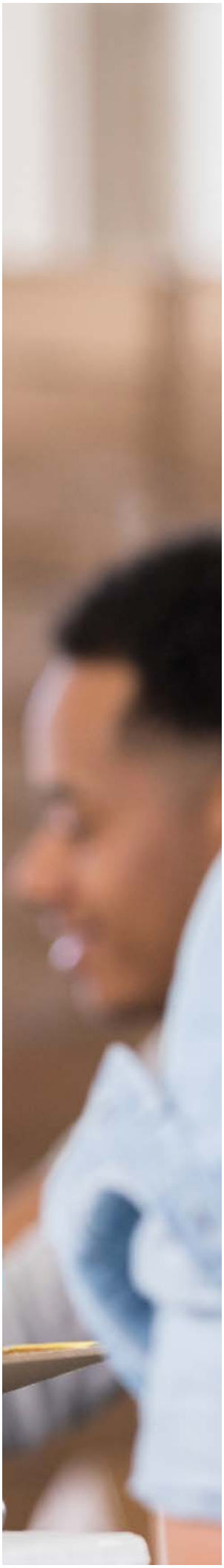

Foreword and Executive Summary

Foreword

The Royal New Zealand College of General Practitioners and its members work closely with ACC to provide essential wraparound support for New Zealanders and visitors who suffer an injury, including people injured during medical treatment.

The standard of health care provided in New Zealand is high, and is delivered by medical professionals like GPs, who work tirelessly to provide safe care for their patients.

As a New Zealander, a GP and the President of the College, I am extremely proud of the work our members and their general practice teams deliver. The doctors who complete our vocational training are specialists in the scope of general practice and are well equipped to deliver world-class care to patients.

This publication details situations where medical treatments did not go according to plan. I am not shying away from the information contained here. Despite best intentions, diagnosis and treatment of health conditions does not turn out as we expect one hundred percent of the time. The key thing is to learn from these situations and make positive changes to improve future outcomes.

This publication helps us identify risk areas and therefore areas where we can make improvements. It is helpful to notice changes in the number of ACC claims in particular areas. As a GP who does minor surgery in my practice, I was particularly interested in the post-surgery infection rates. These have increased during the last five years, and this should be a reminder to take appropriate precautions when offering minor surgery to patients.

'The standard of health care provided in New Zealand is high, and is delivered by medical professionals, like GPs, who work tirelessly to provide safe care for their patients'.

While the number of claims accepted for treatment omissions or adverse reactions to medications have been fairly stable over the last five years, these are areas of concern as the resulting injuries can have a significant effect on patients' lives.

We can learn a lot from the data contained on the following pages, and I encourage all GPs and primary healthcare workers to invest time in digging into the detail. This type of reflection, and a commitment to ongoing continuous improvement, will help the medical profession provide even safer care and achieve even better patient outcomes in future.

We look forward to continuing to work with ACC and other health sector organisations to continue improving our world-leading health and disability services.

Dr Samantha Murton
President
The Royal New Zealand College of General Practitioners

Executive Summary

Overview of the Treatment Safety landscape

In 2017/18[1], ACC received 16,479 and accepted 9,772 claims for injuries caused by medical treatment. Each of these claims represents a person who was harmed during treatment.

In most cases, the injury will resolve quickly, but in a small number of cases, the treatment injury can have a lifelong impact on that person and their family/whānau. ACC is there to support people when things go wrong during treatment.

Many of these injuries are preventable. That is why ACC encourages improvements in treatment safety – just as we do in workplaces, during sport, on the roads, at home, and in all the other ways that people may be injured.

Investing to drive change

Each claim provides ACC with information about injuries caused by a registered health professional. ACC has shared treatment injury data for the last two years and this year information about general practice settings is also included.

ACC encourages open and informed discussions about treatment injuries by publishing this information. The objective is to enable health professionals to better understand and learn from treatment injuries, and ultimately reduce the number and impact of injuries in the future.

To support this, ACC has committed to investing at least $45 million in treatment injury prevention programmes until 2021. ACC sees this as a collaborative approach and is working with the Ministry of Health (MoH), the Health Quality and Safety Commission (HQSC), District Health Boards (DHBs), clinicians, patients and other organisations on initiatives to improve treatment safety.

Summary of the data

The number of claims is not a direct indicator of a safety record. Simple comparisons between DHBs or treatment settings are not valid. The population for each treatment setting is made up of different case mixes, demographics and/or socio-economic conditions. These can influence the risk of treatment injuries.

The number of all treatment injury claims declined slightly in 2017/18 after seven years of steady growth.

In 2017/18, ACC accepted:

- 5,713 claims from treatment in a public hospital
- 1,236 claims from treatment in private hospitals that are members of the New Zealand Private Surgical Hospital Association (NZPSHA)
- 1,384 claims from treatment in general practice
- 1,439 claims for treatment in other health settings such as aged care facilities.

Each accepted treatment injury claim represents a person inadvertently harmed.

The actual and predicted future costs for all treatment injuries in the 2017/18 financial year was $486 million. This is a sum that ACC calculates to set aside sufficient funds for future liability. ACC's predicted liability for future costs of all treatment injuries (that have been accepted to date) is $5.42bn.

Information about ACC's treatment safety initiatives is available at ***www.acc.co.nz/treatmentsafety.***

1 *Throughout this publication 2017/18 refers to the financial year period 1 July 2017 to 30 June 2018.*

Supporting safer health care in New Zealand

Supporting safer health care in New Zealand

ACC continuously collects treatment injury data and this publication is a summary of this information. This is the largest data set of harm to people caused by treatment from registered health professionals. The publication summarises the numbers, costs, and liability to ACC, and ultimately, New Zealand.

Each accepted treatment injury claim represents a person harmed from treatment.

In the 2017/18 financial year, ACC accepted 9,772 treatment injury claims. During the same period, 16,687 claims were active – claims that occurred in that year or previous years and received a payment for treatment or support during that time. As of 30 June 2018, the estimated future cost to care for people who have suffered a treatment injury is $5.42bn.

We want to share this information to:

- support improvements in treatment safety
- provide a case for investing in treatment safety to reduce patient harm
- increase transparency of the health information we hold
- be consistent with the New Zealand Health Strategy.

This is our third publication on treatment injury claims. It focuses on claims from public hospitals, New Zealand Private Surgical Hospital Association (NZPSHA) hospitals and general practice settings.

The data presented in this report has been extracted in February 2019, but references treatment injury claims until 30 June 2018.

If you want more information about this report, contact us at: ***treatmentsafety@acc.co.nz***

Better information supports improved treatment safety

ACC is an important part of the health sector and patient safety is of great importance to us. Our injury prevention responsibility requires us to work to reduce the incidence and severity of treatment injuries. Reducing the severity of treatment injuries also allows us to carry out our care and recovery roles better.

Enabling safer health care means fewer patients injured during treatment and the severity of the injuries decreasing. Reducing the impact of treatment injuries will improve health outcomes for New Zealanders.

To achieve this, all those involved in treatment need a greater understanding of the extent and types of treatment injuries. We need open discussion about treatments that are causing injuries so we can understand the reasons these injuries occur. We can then collaborate with the health sector to determine the best places to invest in improving treatments to keep more people safe.

Improved treatment safety will mean less impact on our communities and better use of resources for the health sector and ACC.

Improving patient safety is a priority action of the 2016 New Zealand Health Strategy. To achieve this goal, clinicians, managers, institutions, consumers, ACC, health agencies, and organisations need to work together.

To support improving patient safety, this publication:

- aims to inform and guide collective efforts to reduce patient harm
- recognises that treatment injury information is one measure of patient safety that can add to other measures across the health sector
- provides evidence that informs approaches to reduce patient harm
- confirms ACC wants to work with clinicians, managers, institutions, consumers of health care, and health agencies to improve patient and treatment safety.

We work with partners to improve treatment safety

We consider the best way to tackle treatment injuries is to work collaboratively to improve treatment safety using evidence-informed approaches to reduce patient harm.

We are working in partnership with stakeholders, clinicians and patients across primary, secondary, and tertiary providers in the health sector, including District Health Boards (DHBs), the New Zealand Private Surgical Hospital Association (NZPSHA), Ministry of Health (MoH), the Health Quality and Safety Commission (HQSC), health practitioner registration authorities, and professional associations.

Improving treatment safety will generate substantial benefits through improved health outcomes, reduced suffering, shorter periods of hospitalisation, reduced readmissions, and avoid the ongoing costs of injuries. This, in turn, will help to manage the impact of treatment injury claims on ACC.

Information about ACC's treatment safety initiatives is available at ***www.acc.co.nz/treatmentsafety***

Publication of information about treatment injuries is part of a process to systematically use ACC information to help improve treatment safety.

We support people with treatment injuries

ACC supports people by providing cover for treatment injuries. We provide this support according to the provisions of the Accident Compensation Act 2001 (AC Act). Exclusions in the AC Act mean that not all discomfort, symptoms, or harm experienced by a person having treatment is accepted as an injury caused by that treatment.

ACC accepts a treatment injury claim when a person is injured by treatment from a registered health professional. The definition of 'treatment injury' means that treatment injury claims are a subset of all patient harm.

All treatment injury claims are clinically assessed before cover is determined. If an injured person's claim is accepted, they can access the care and support they need. ACC contributes to the cost of treatment and ongoing care to address the injury and its effects.

The range of treatment injuries is very wide. Most injuries are easily remedied and only require medical treatment. Most have no lasting impact. Where the injured person is incapacitated, we compensate that person for lost income and any permanent loss of function. We also provide rehabilitation to help the person return to activity and work, and to participate in society, including home help and modifications to their house and vehicle.

To improve patient safety, we need to understand patient harm

Since its inception over 40 years ago, ACC has provided various types of cover for people harmed while being treated. Improving patient safety is an important priority for health systems around the world. An important way to improve safety is to find out more about the types and level of patient harm.

The full extent of patient harm is not known in New Zealand or any other country. Yet, between 40% and 60% of patient harm is preventable in some way, depending on the patient's health condition and types of treatment used, according to scientific literature.

No single data set provides a complete picture of patient safety and harm. Available indicators include:

- treatment injury claims (an important, yet incomplete, indicator)
- hospital standardised mortality ratios from MoH
- complications captured by the National Minimum Data Set (NMDS) or by private surgical hospitals
- adverse event reporting to HQSC
- complaints to the Health and Disability Commissioner (HDC)
- deaths in health care investigated by Coronial Services.

ACC Risk of Harm reporting

The purpose of Risk of Harm reporting is to provide information to support the prevention of harm to patients by the health sector.

ACC is required to consider the information provided with all treatment injury claims (whether accepted or declined) and assess if there is a risk of harm to the public[1].

The principal reason for adverse event reporting to exist in any health system is to support learning from clinically meaningful events and near misses so that the same or similar incidents can be prevented in the future.

ACC is currently working with key health agencies, eg MoH and HQSC, regulatory and professional health bodies, medical indemnity insurers, and clinicians to update the Risk of Harm reporting process. The intention is to provide information and insight to support the health sector and improve patient safety.

Risk of Harm reports and treatment injury claims decided by financial year

	Decision financial year				
	2013/14	2014/15	2015/16	2016/17	2017/18
Number of claims decided	10,397	12,623	13,868	16,014	16,479
Number of Risk of Harm reports	283	358	589	498	461
Percentage of claims decided	3%	3%	4%	3%	3%

1. *Section 284 of the Accident Compensation Act 2001 requires ACC to report 'risk of harm to the public' based on information collected in the course of processing claims for treatment injury, including those that are in the nature of claims for treatment injury but are caused by a person who is not a registered health professional.*

This publication updates information about treatment injury

This publication provides updates about treatment injury and includes information about general practice settings for the first time.

The number of accepted treatment injury claims is useful to help quantify the amount of injuries occurring. In 2017/18, 14.2% of accepted treatment claims for injuries occurred in general practice settings, and 71% occurred in public and NZPSHA member hospitals. The types of injuries differ in each setting. One reason is that many patients are admitted to hospital in a clinically compromised state, and treatment often includes the use of invasive devices and procedures that carry an inherent risk of patient harm. Private and public hospitals are not comparable due to the wide differences in the types and severity of illnesses being treated, and the ages of the patients.

Statistics alone do not show the causes or lead directly to improvements. Rather, they emphasise the need to develop and use more effective prevention strategies. We have used the collected information in a systematic way for the past three years, to inform patient safety initiatives and improve outcomes.

We will continue to update the range and level of information with each edition of this annual publication.

Overview of all treatment injury claims for 2017/18

Setting	Number of accepted claims	Number of Active Claims	Total Active Claim cost $m
DHB	5,713	10,153	113
NZPSHA	1,236	2,563	25
General practice settings	1,384	1,800	11
Other	1,439	2,171	10
Total	**9,772**	**16,687**	**159**

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Treatment Injury national summary

A treatment injury is a personal injury caused by seeking or receiving treatment from a registered health professional. Claims that meet the following requirements are considered:

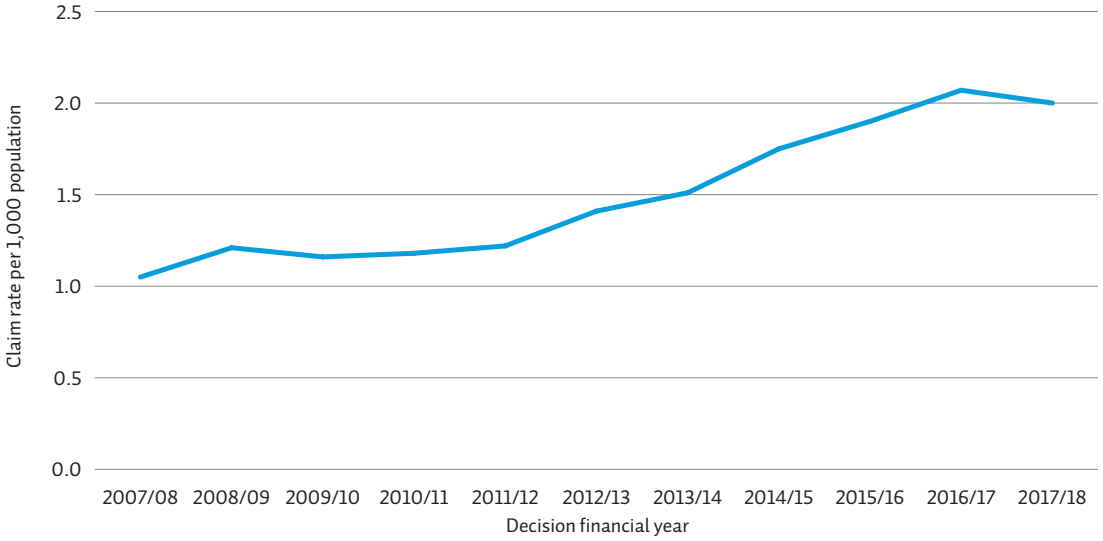
- an injury has occurred (physical harm or damage to the patient)
- treatment has caused the injury
- the injury is not a necessary part or an ordinary consequence of treatment, after considering the clinical knowledge at the time of treatment, and the underlying health condition of the injured person.

Treatment injuries occur in many settings, such as in hospitals, general practice, and rest homes.

National summary of the number and rate of treatment injury claims

The number and rate of all treatment injury claims declined slightly in 2017/18 after seven consecutive years of steady growth. In 2017/18, ACC accepted 9,772 treatment injury claims (about two claims per 1,000 people). This growth is nearly double the 2007/08 rate of 1.1 claims per 1,000 people.

All accepted treatment injury claims from all settings



Note: *This data is standardised by the national population because it includes all treatment injury claims from all settings.*

Treatment injuries occur in a wide range of settings

The health sector is complex and involves a wide range of professions that provide care and treatment in various settings. Hospitals are the most common setting for treatment injuries as many patients are admitted in a clinically compromised state, and care often includes the use of invasive procedures and devices that carry inherent risk.

A treatment injury can occur wherever a registered health professional provides treatment. This can be in a hospital, a general practice setting, private clinic, rest home, or a patient's home.

All treatment injury claims, 2017/18

Setting	Number of claims accepted	Number of claims decided	Percentage accepted
Public hospitals	5,713	8,737	65.4%
NZPSHA hospitals	1,236	1,718	71.9%
General practice settings	1,384	2,003	69.1%
Other	1,439	4,021	35.8%
Total	**9,772**	**16,479**	**59.3%**

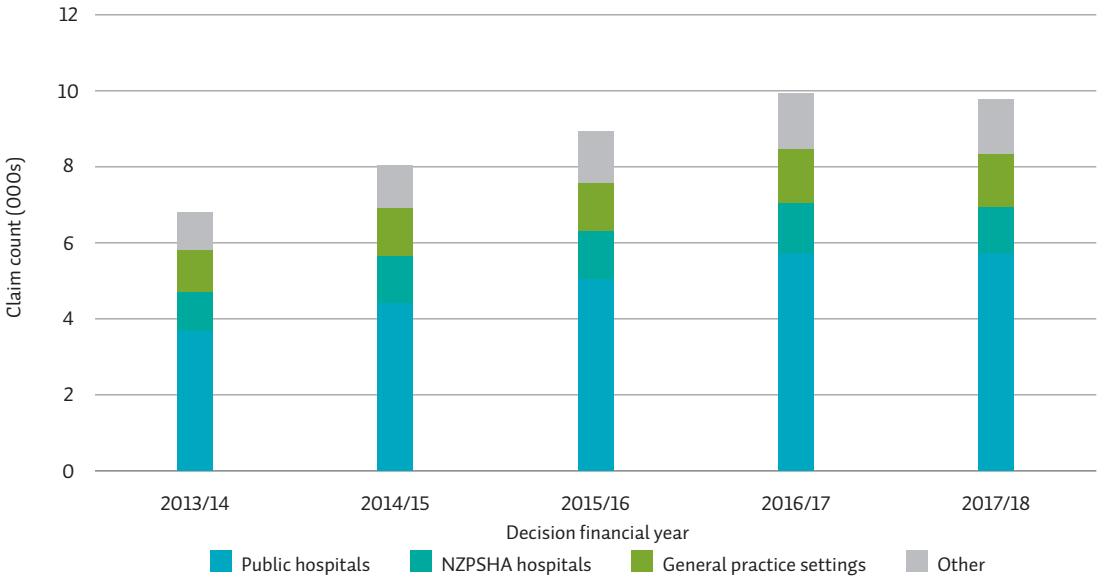
Hospital settings account for 71% of accepted treatment injury claims

Public and NZPSHA hospitals account for 71% of accepted treatment injury claims. Many hospitals have established treatment safety activities to help reduce these injuries. Hospitals are important partners of ACC for initiatives to improve treatment safety.

In 2017/18, 58.5% of treatment injury claims were the result of treatment in public hospitals, 12.6% in NZPSHA hospitals, 14.2% in general practice settings, and 14.7% in other locations (including aged residential care).

Many of these injuries were preventable, so hospital settings are an important focus for improving treatment safety.

All accepted treatment injury claims by treatment setting and decision financial year



Note: *General practice settings include general practitioners (GPs) as well as practice nurses and other health professionals working within a general practice setting. The 'other' category includes community settings such as rooms-based procedures and aged residential care.*

The volume and complexity of treatment across the health system has been increasing. In 2017/18, there were 1.15 million discharges following treatment at a DHB facility, around 8.8% more than in 2013/14. New Zealand's population grew from 4.5 million to 4.9 million (by about 8.3%) over the same period.

Areas of focus for injury prevention in hospitals

ACC has selected areas of focus in collaboration with the various health sectors that have the following characteristics:

- injuries that significantly impact the injured person and their families/whānau
- injuries that evidence indicates will respond to prevention strategies
- injuries that may indicate safer care.

The table below shows the volumes and costs for areas of focus for the ACC Treatment Safety Team, based on all accepted treatment injury claims in the 2017/18 financial year where the treatment provider is a DHB or a NZPSHA hospital.

Over time, we will increase the number of categories that we monitor and use this information to support more prevention approaches.

Accepted treatment injury claims and costs in the 2017/18 financial year for hospitals, highlighting the areas of focus for prevention

Injuries	Accepted claims	Claim costs (does not include lifetime costs)	Context of claims
Infections			Includes infection following procedures (eg skin lesion removal, and hip and knee surgery).
Infections following surgery	1,696	$17,677,839	
Line infections	112	$515,126	Peripheral line infections are higher by volume, while central line infections are more costly due to the level of support required.
Other infections	89	$1,421,960	
Total	1,897	$19,614,926	
Pressure injury	434	$869,370	The major causes are lack of identifying risk factors (65%), immobilisation (17%) and splints or other casts (8%).
Medication adverse effect	319	$7,405,746	A reaction to medications such as antibiotics and pain relievers. Reactions to injections make up 16% of this injury type.
Medication error	18	$860,372	Error in prescribing, formulating, dispensing and administering medication.
Pulmonary embolism (PE)	31	$481,551	The absence of PE and DVT are considered to be markers of safer surgery.
Deep vein thrombosis (DVT)	61	$339,517	

| **Note:** *Detailed information on neonatal encephalopathy is included on page 28.*

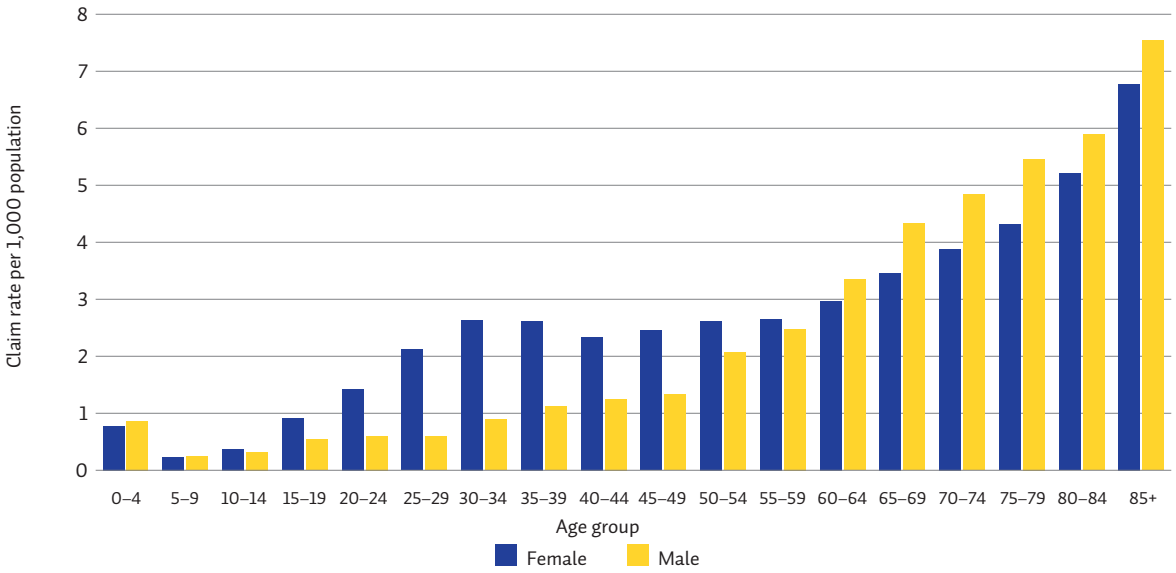
Many factors influence the risk of being injured during treatment

The treatment delivered in different settings varies due to differences in illnesses, the availability of services and types of treatment. These are all factors that can influence the safety and outcome of any treatment.

Rates of treatment injury claims vary with age and gender

Patterns by age and gender reflect different uses of treatment services.

Rate per 1,000 population for all accepted treatment injury claims in 2017/18, by age and gender



Note: *This data is standardised by the national population because it includes all treatment injury claims from all sources.*

The population served by each health care setting is different

Different treatment settings provide varying types of treatments, surgery, and services. Many of these carry inherent risks of injury to the patient. For example, some facilities provide complex medical and surgical interventions such as cancer management, neurosurgery, cardiac surgery, treatment for severe burns and advanced services in neonatology.

Similarly, each DHB will have a distinctive case-mix that reflects the age and health status of people within their district. These characteristics can also increase the risks of treatment injury. For example, some hospitals have relatively high proportions of older people in their admitted population, while other hospitals have relatively high levels of socio-economic disadvantage. In addition, some hospitals have relatively high rates of diabetes and obesity in their resident population, while others cover large geographical areas with a mostly rural population.

This highlights the difficulty of making comparisons between settings.

Measuring the impact and severity of treatment injuries

Measuring the impact of an injury on a person is challenging. ACC and others use the overall cost of a treatment injury claim as an indicator of the severity of the injury because more costly claims have a more severe impact on the person injured. While not always directly related, overall cost is one measure of severity and impact.

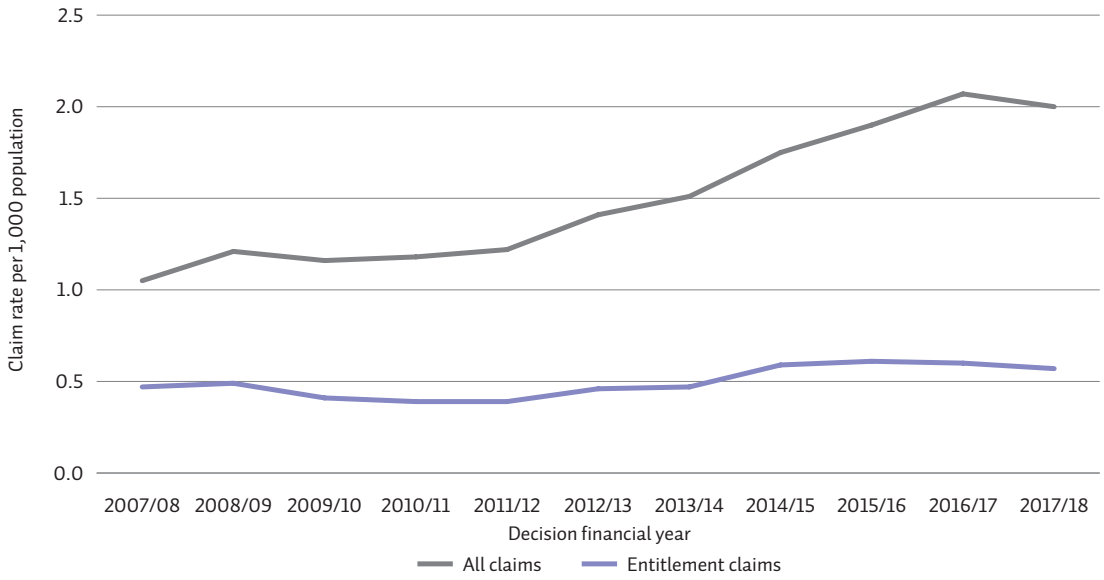
An entitlement claim is a "claim that has received additional support such as weekly compensation or social or vocational rehabilitation for a covered injury as well as any funded medical treatment required". (Accident Compensation Corporation *Annual Report 2018*).

An entitlement claim is for people who have received additional support, not just treatment for their injury.

Another measure is comparing the number of people who only need medical treatment for their treatment injury with the number of people who receive additional support as well as treatment.

The growth in accepted treatment injury entitlement claims between 2007/08 and 2017/18 is smaller than the growth rate of accepted treatment injury claims per 1,000 population.

All accepted treatment injury and entitlement claims, in all settings



Note: *This data is standardised by the national population because it includes all treatment injury claims from all settings.*

Factors that may contribute to growth of treatment injury claims include:

- increased volumes of treatment across the health system
- greater risk factors in the patient population
- efforts to encourage greater reporting of treatment injury.

An entitlement claim may become a serious injury claim

A small number of entitlement claims each year are further classified as serious injury claims.

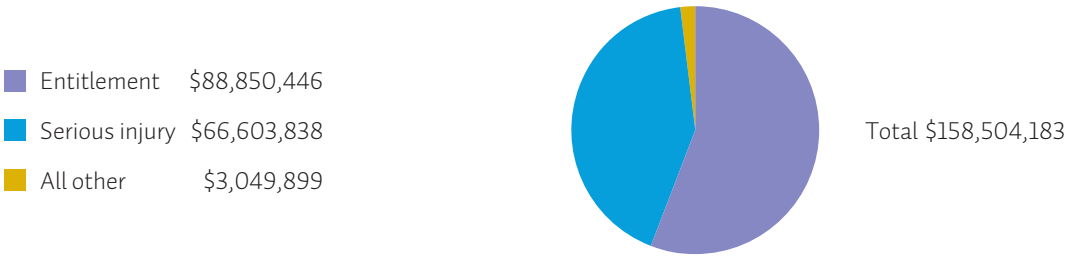
A serious injury claim enables ACC to ensure:

- people are supported through rehabilitation
- appropriate funding is allocated to support rehabilitation.

Serious injury claims are rare. In the last five years on average, 65 entitlement claims a year were classified as serious injuries. ACC needs to focus on reducing the incidence and severity of these treatment injuries which have the greatest impact on the injured person and their family/whānau.

Active entitlement claims (including serious injury claims) accounted for 98% of all costs paid by ACC for treatment injury in 2017/18. Of all the costs paid for treatment injury in 2017/18, 42% were for serious injury claims (a subset of entitlement claims).

Costs paid in 2017/18 for all active treatment injury claims



A serious injury claim is an internal classification that ACC uses for clients who will have a lifelong relationship with ACC. Clients are only allocated to the serious injury category if they satisfy specific clinical criteria, because this provides access to long-term support. These criteria include spinal cord injury, moderate and severe brain injury, multiple limb amputations, severe burns and blindness in both eyes.

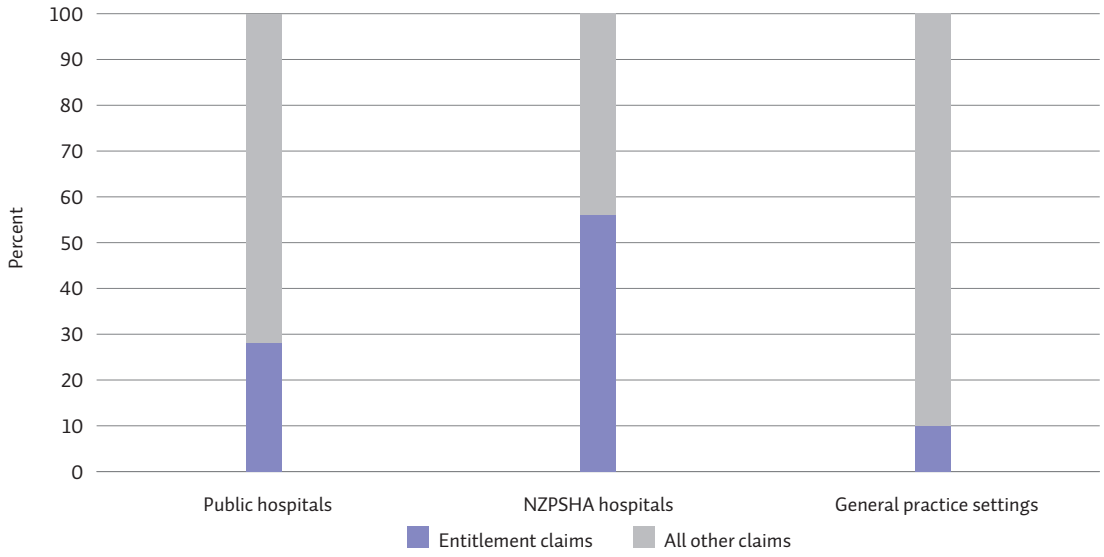
Note: *This cost information includes all treatment injury claims from all sources:*

- *public hospitals (DHB facilities)*
- *NZPSHA hospitals*
- *general practice settings*
- *other locations (including residential care).*

Entitlement claim rates vary between settings

- 29% of accepted treatment injury claims from public hospitals are entitlement claims. These claims involve rehabilitation and compensation support beyond initial medical treatment. Public hospitals provide various types of surgery, medical treatments, and supportive services. These can be either planned (elective) or emergency.
- 56% of accepted treatment injury claims from NZPSHA hospitals are entitlement claims. NZPSHA members provide around 50% of all elective surgeries performed in New Zealand.
- 10% of accepted treatment injury claims from general practice settings are entitlement claims. General practice settings are often the first point of contact for people in need of health care.

Proportion of accepted entitlement claims for public hospitals, NZPSHA hospitals and general practice settings, 2017/18



Treatment injury costs are considered in multiple ways

These include:

- future estimated costs for the lifetime of the claim
- costs paid for active treatment injury claims each year
- actual costs incurred in the years after the claim is accepted (eg if the injury happened before 2017/18, but payments are still being made during 2017/18).

Estimated outstanding claims liability of treatment injury

The estimated outstanding claims liability (OCL) for treatment injury was $5.42bn as at 30 June 2018.

This is an estimate of the current value of the lifetime impact, including all future treatment and care and support to those patients who have already been injured.

One way of understanding the outstanding claims liability is if ACC went out of existence, this is the amount that would still have to be paid out in the future.

Treatment injury claims continue to increase, but are showing some signs of slowing. In addition, some people have recovered faster than expected from injuries. The combination of these two factors has resulted in the OCL decreasing from $5.7bn in 2016/17 to $5.42bn in 2017/18.

Incurred costs – past and estimated future payments of accepted treatment injury claims

The actual and predicted costs reflect the cost of treatment, expected ongoing care, support and rehabilitation for people harmed while receiving medical treatment. These costs that will cover the lifetime of the claim are called incurred costs, and have increased by 33% since 2008.

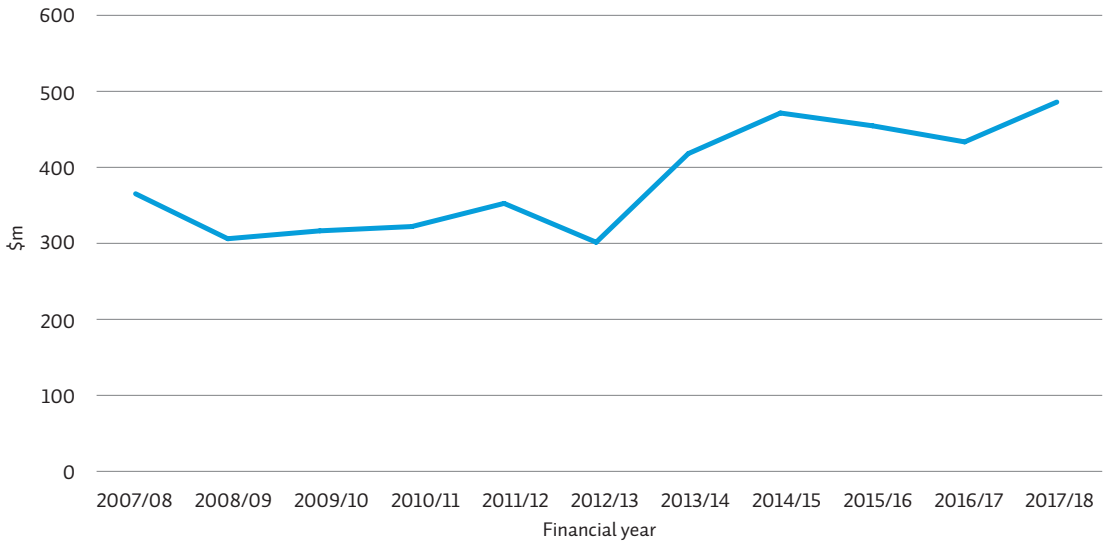
Predicted costs also include estimates of claims that will be accepted in future years for treatment injuries that occurred during this year and previous years. For this reason, it is not possible to analyse incurred costs by treatment facility and injury type.

Incurred costs for all treatment injury claims in 2017/18

The estimated lifetime costs for all treatment injury claims that occurred in 2017/18 is $486m.
These costs include:

- costs paid to date for new claims accepted for injuries that occurred in 2017/18
- an estimate of the costs that will be incurred in future years for those claims (expressed as a present value – that is, the amount needed in 2017/18 to meet those future costs)
- an estimate of the costs for future claims for injuries that occurred in the current year (that is, the present value of claims made in 2019 or later years, for injuries that occurred in 2017/18)
- costs paid for declined treatment injury claims: ACC may pay some costs before a claim is decided (for example, to get assessments or expert reports).

Incurred costs for all treatment injury claims in all settings, by financial year

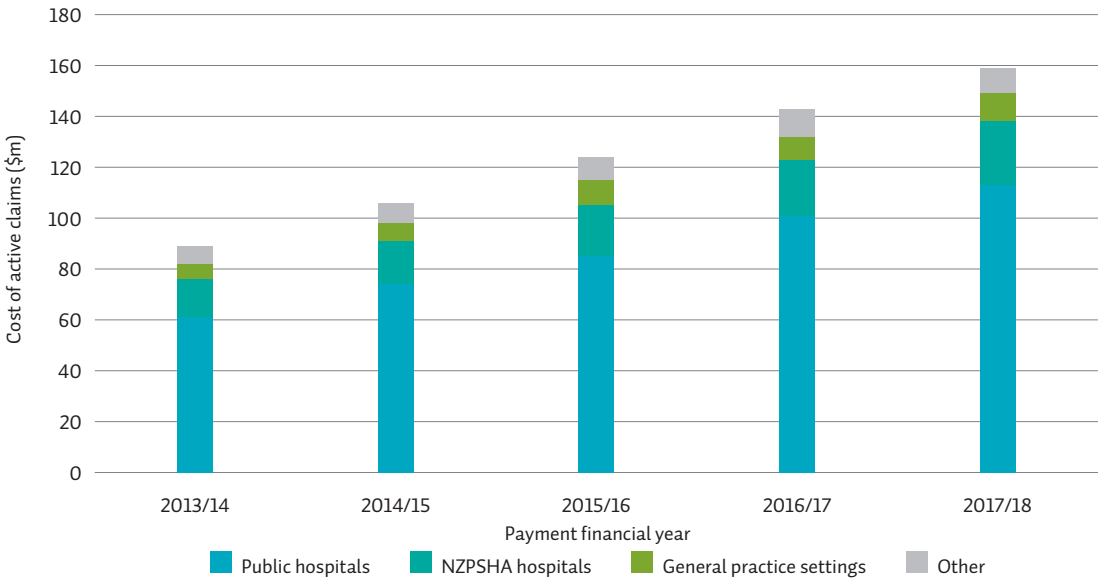


Note: *Incurred cost includes actual and predicted costs of all injuries that occurred in 2017/18.*

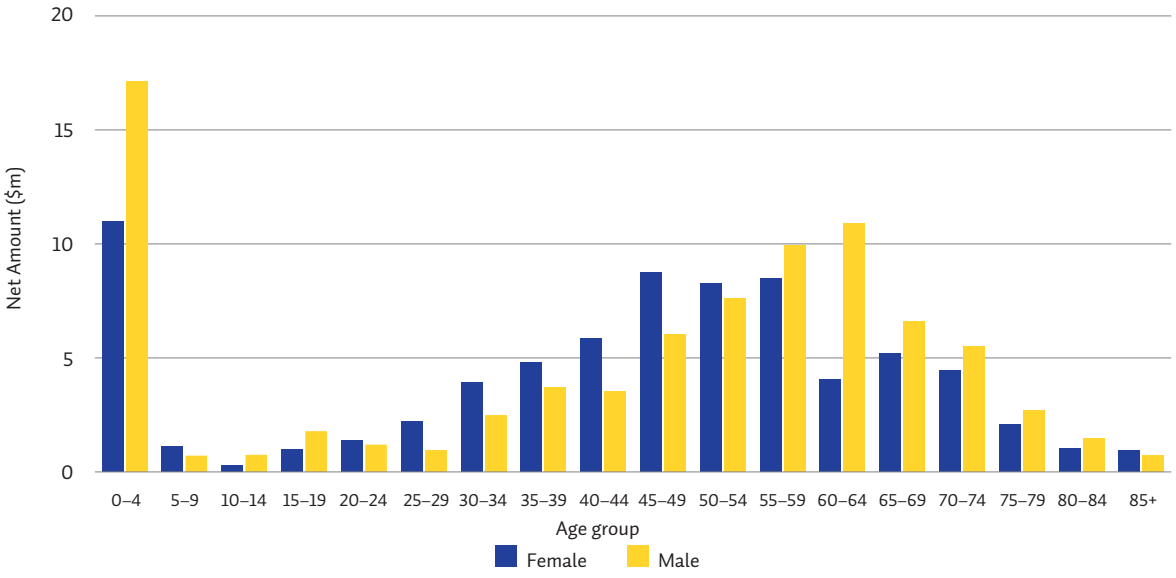
Costs paid for active treatment injury claims

Costs paid for active treatment injury claims were $158.5m in 2017/18. These do not include the expected lifetime costs of claims, but this measure can help to show the relative impact of differing treatment injury settings.

Costs paid for active claims, by treatment setting and payment year



Costs paid in 2017/18 for active treatment injury claims, by age and gender



Accepted treatment injury claims

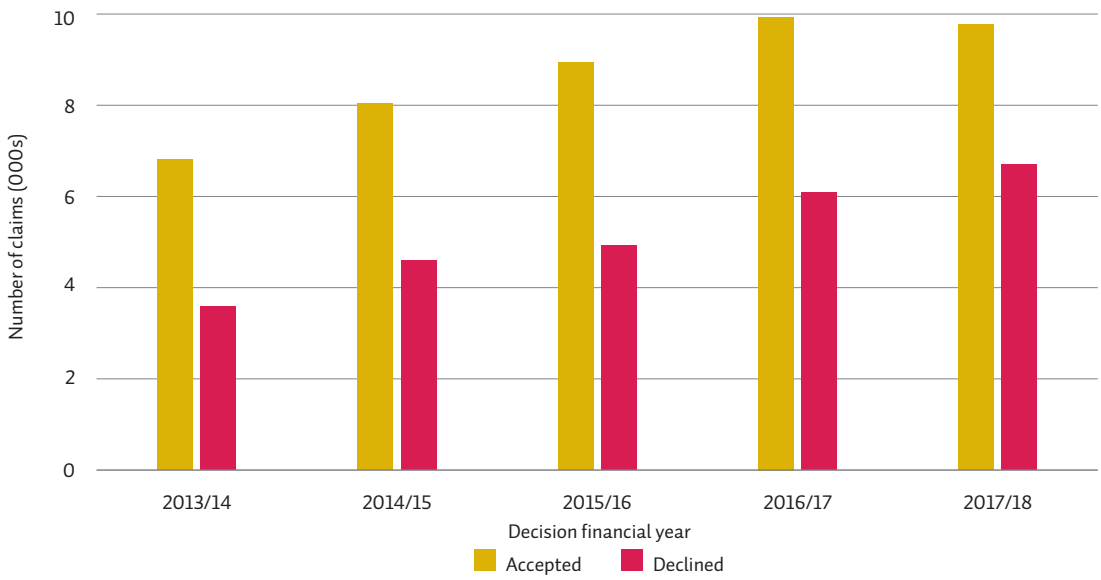
Two-thirds of treatment injury claims are accepted each year

The proportion of treatment injury claims accepted has remained relatively stable over the last five years, at around 63%. During the same period, the number of claims decided has increased (from 10,397 in 2013/14 to 16,479 in 2017/18).

All treatment injury claims should be submitted by a registered health professional. The proportion of accepted and declined claims varies between health care settings.

The relatively high rate of declined claims in all settings presents an opportunity for ACC to work more closely with health professionals. This includes developing stronger guidance and assistance to better identify cases of treatment injury, and ensuring all necessary information is presented to support ACC's decision on the claim. In light of this, ACC and hospital representatives have developed a Lodgement Guide to assist clinicians, patients and support staff to better understand the criteria for treatment injury. The guide is available at ***www.acc.co.nz/lodgementguide***

Proportion of accepted and declined treatment injury claims by decision financial year



Treatment injury claims are declined for three broad reasons:

- 56% of declined claims **do not have an injury** caused by treatment (for 28% there is no injury; for 25% there is no causal link between the treatment and the injury; and 3% are the result of an underlying health condition)
- 14% of declined claims **do not meet the tests** to be a treatment injury (13% are an 'ordinary consequence' of the treatment; 1% a necessary part of the treatment; and <1% did not involve a registered health provider in the treatment)
- 24% of declined **claims are withdrawn (15%) or have insufficient information** to make a decision within the legislative timeframe of nine months (9%).

All accepted claims for selected injury types

The following section includes selected injury types that are more serious and require more assistance. The number of cases is low but the impact to the person and their family/whānau is high. The information in this section relates to injuries occurring nationally across all health care settings.

Neonatal Encephalopathy

Neonatal encephalopathy (NE) is a syndrome of disturbed neurological function in a newborn. While the number of NE cases is low overall, the impact to the person and their family/whānau is extremely high and lasts throughout the person's lifetime.

The features of NE include difficulty with breathing, reduced muscular tone and reflexes, reduced consciousness and often seizures. When NE is due to a period of reduced oxygen supply during birth, the term Hypoxic Ischemic Encephalopathy (HIE) is used. Other reasons why a baby may have signs and symptoms of NE include metabolic abnormalities, medication, infection or bleeding within and around the brain.

Most cases of NE are not caused by treatment. For ACC to accept a claim for NE or similar, it must be concluded that the brain injury was caused by treatment by a registered health professional. Nearly all claims for NE accepted by ACC involve an omission – that is, the treating health professionals could and should have undertaken different treatments.

ACC has undertaken additional analysis in 2018 to identify all claims for a brain injury to a baby caused by treatments provided before birth, during the birth or immediately after birth. This includes babies who received inadequate treatment of low blood sugar, or inadequate treatment of newborn jaundice, or bleeding around the brain due to manual extraction at the time of birth.

By using these updated methods of sourcing data held by ACC, an additional 52 claims for NE have been identified since 2005. Of these 52 NE-related claims, 36 were accepted and 16 declined.

The predicted lifetime cost for a NE serious injury claim was estimated at between $36 million and $56 million as of 31 December 2017.

ACC accepted an average of 16.6 claims each year for NE over the period from 2013/14 to 2017/18 in all settings.

Neonatal encephalopathy (NE) claims

	Financial Year				
	2013/14	2014/15	2015/16	2016/17	2017/18
Accepted claims	14	17	12	17	23
Active claims	88	86	100	121	126
Cost of Active claims*	$9,001,253	$9,524,974	$11,856,921	$15,038,067	$16,634,503
Cost per Active claim	$102,287	$110,756	$118,569	$124,282	$132,020

* The figures do not include investment required for future costs.

Claims for injuries caused by surgical mesh

Surgical mesh is a medical device that has been used for many years. The most common use is for abdominal surgical wounds such as hernia repairs. More recently, mesh has also been used for plastic surgery work, stress urinary incontinence and pelvic organ prolapse.

In the period between 2013/14 and 2017/18, ACC accepted 503 claims for injuries caused by surgical mesh. Two-thirds of those claims were for mesh implanted in the pelvis for gynaecological or urological reasons. The majority of other claims were for injuries due to mesh used in repair of abdominal wall defects.

Claims accepted for mesh-related injuries include infections with or without erosion, and damage to other organs. Infections from mesh implants make up 20% of injuries, while mesh erosion or migration into nearby tissues together make up 55% of all injuries that ACC accepted.

Almost 100% of mesh claims are entitlement claims.

Surgical mesh claims

	Financial Year				
	2013/14	2014/15	2015/16	2016/17	2017/18
Accepted claims	73	82	92	121	135
Active claims	144	185	212	266	318
Cost of Active claims*	$2,257,080	$2,800,800	$2,926,734	$3,415,147	$4,065,379
Cost per Active claim	$15,674	$15,139	$13,805	$12,839	$12,784

* The figures do not include investment required for future costs.

Claims for injuries caused by equipment failures

ACC receives claims for injury when equipment, devices, or tools used as part of the treatment process have failed. Two examples of failure are equipment breakage and mechanical failure.

Most of the claims ACC receives about equipment failing are from people being injured while having orthopaedic treatment. Nearly half of the claims ACC accepts are because a person's prosthesis has failed. Not all claims are accepted. For example, we may accept a claim if an implant or prosthesis fails, but not if it failed due to wear and tear.

Equipment failure claims

	Financial year				
	2013/14	2014/15	2015/16	2016/17	2017/18
Accepted claims	115	107	104	91	46
Active claims	209	235	258	231	196
Cost of Active claims*	$2,415,189	$2,547,544	$2,530,907	$3,519,500	$2,269,718
Cost per Active claim	$11,556	$10,841	$9,810	$15,236	$11,580

* The figures do not include investment required for future costs.

Claims for injuries caused by treatment omission

For a small proportion of accepted claims, the treatment event that caused injury involves a failure to provide treatment or a failure to provide treatment in a timely manner. Collectively, these are termed treatment omissions, as the failure relates to whether at the time of investigation, diagnosis or treatment the practitioner should reasonably have reached a different decision or adopted a different treatment pathway.

Omission encompasses failure to diagnose, to follow-up, to provide treatment, to refer, to monitor, and to provide the right treatment. To determine if the injury has been caused by an omission requires consideration of the patient's presentation and the clinical knowledge at the time, and the usual care in similar circumstances.

In deciding these claims, we seek expert reports from registered health practitioners in the same field of practice. If an omission is identified, we must be satisfied that this omission has caused a personal injury.

Treatment omission claims

	Financial year				
	2013/14	2014/15	2015/16	2016/17	2017/18
Accepted claims	105	131	166	166	152
Active claims	388	450	519	582	605
Cost of Active claims*	$15,396,922	$18,035,948	$22,428,841	$26,187,283	$30,306,028
Cost per Active claim	$39,683	$40,080	$43,215	$44,995	$50,093

* The figures do not include investment required for future costs.

Treatment injuries in three health care settings

This report outlines treatment injuries that occurred in public hospitals, NZPSHA hospitals and general practice settings.

The following sections provide information at the national level about the number and costs of treatment injury types that occur in three health care settings.

Public hospitals provide various types of surgery, medical treatments, and supportive services. These can be either planned (elective) or emergency.

NZPSHA hospitals provide around 50% of all elective surgeries performed in New Zealand. They do not usually provide emergency care.

General practice settings are often the first point of contact for patients with a wide range of health care needs.

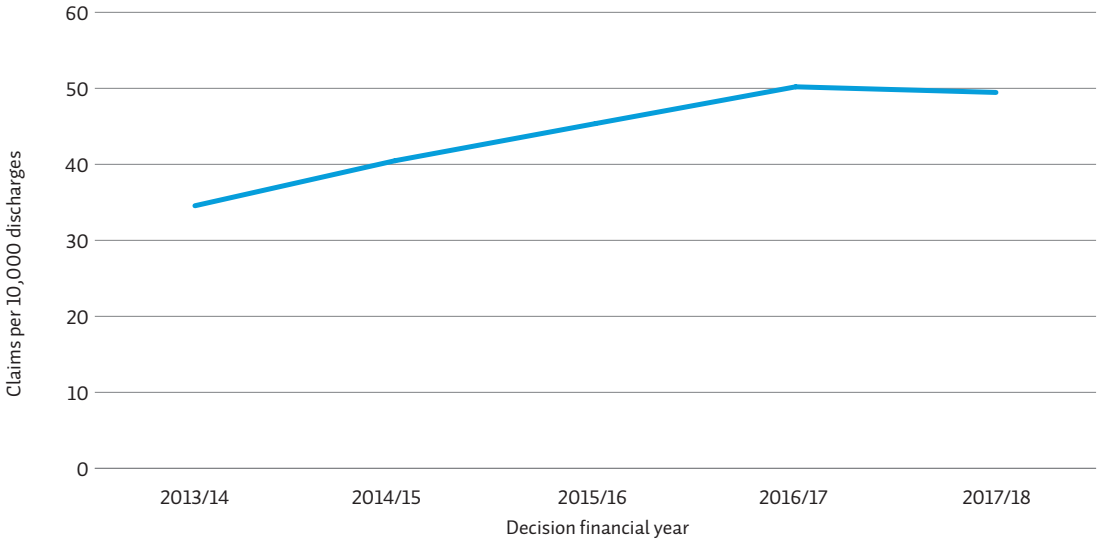
To improve accuracy, we have refined the way we aggregate some injury types. For this reason, we have revised previously published information now that new information is available.

Treatment injuries in public hospitals

The number of claims has increased since 2013/14, but opportunities still exist to improve treatment safety within all hospitals. ACC is working with the health sector to improve safety. National initiatives are focusing on common issues in particular areas, leading to action at regional and local levels. Publishing treatment injury information will help to increase the profile of patient safety and support actions to improve patient safety and limit harm.

In 2017/18, according to the MoH's data, 1.15m people were discharged after treatment at a public hospital. During the same period, 5,713 treatment injury claims from public hospital treatment were accepted by ACC. Overall, 0.5% of discharges from public hospitals resulted in an accepted treatment injury claim (that is 50 accepted treatment injury claims per 10,000 discharges). This proportion has increased from 0.35% in 2013/14 (35 accepted treatment injury claims per 10,000 discharges).

Accepted claims per 10,000 discharges



Note: *This data is standardised by the number of DHB discharges. It includes treatment injury claims resulting from treatment in public hospitals. The name of the DHB facility is provided to ACC by the registered health professional lodging the claim.*

DHB claims by decision financial year

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Accept	Number	3,666	4,399	5,046	5,717	5,713
	%	69	67	69	68	65
Decline	Number	1,627	2,162	2,227	2,748	3,024
	%	31	33	31	32	35
Total decided claims	Number	5,293	6,561	7,273	8,465	8,737
Entitlement claims	Number	1,120	1,500	1,635	1,707	1,626

Comparing DHBs is not meaningful

Public hospitals are spread throughout the country. Each DHB is different – with a distinctive case-mix due to the demographics and health status of its population. As a result, they provide different types of surgery, treatments and services. In addition, each DHB may provide differing levels of primary, secondary and tertiary levels of service. For these reasons, directly comparing between DHBs is not meaningful.

We have used DHB discharge numbers as a denominator to standardise as a proxy for numbers of treatments.

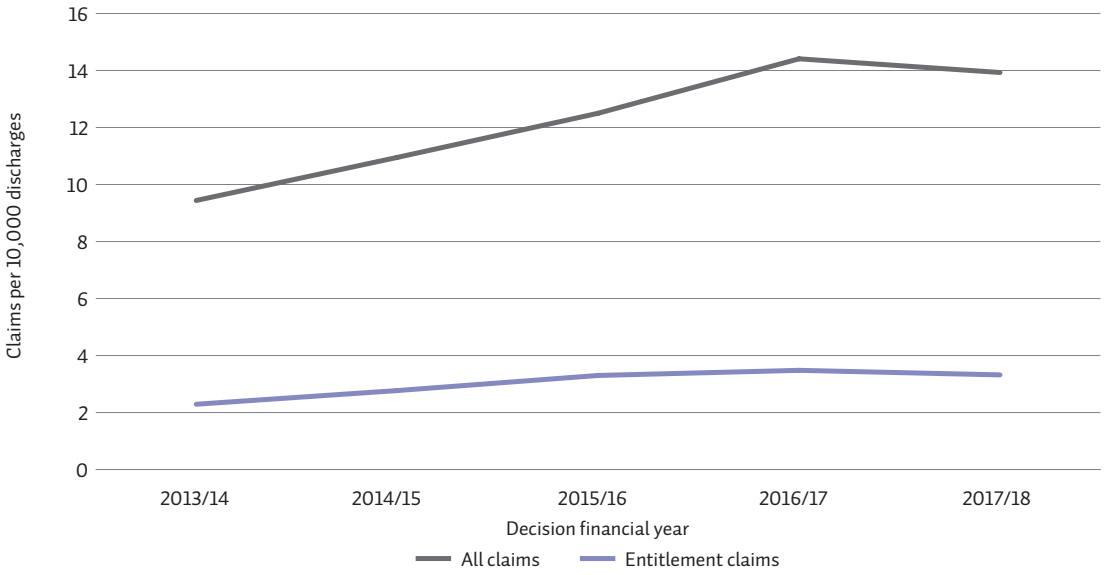
Summary claims information for all public hospitals, 2017/18

DHB region	Number of accepted claims	Number of discharges	Accepted claims per 10,000 discharges
Auckland	563	142,310	40
Bay of Plenty	206	61,480	34
Canterbury	518	124,232	42
Capital & Coast	645	71,488	90
Counties Manukau	456	119,100	38
Hawke's Bay	130	42,212	31
Hutt Valley	263	38,863	68
Lakes	98	29,313	33
MidCentral	192	39,008	49
Nelson Marlborough	237	31,254	76
Northland	262	48,139	54
South Canterbury	123	14,459	85
Southern	311	69,295	45
Tairāwhiti	73	11,114	66
Taranaki	230	34,311	67
Waikato	620	114,913	54
Wairarapa	85	11,541	74
Waitematā	521	125,613	41
West Coast	38	7,920	48
Whanganui	142	18,402	77

The following charts provide information on the number and costs of selected treatment injuries occurring in public hospitals.

DHB infections of all types

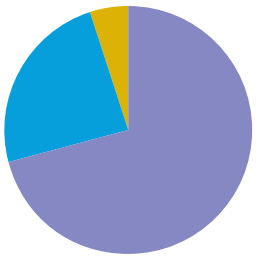
Accepted claims per 10,000 discharges



Accepted claims in 2017/18 for infections of all types	Active claims in 2017/18 for infections of all types
1,609	2,579

Costs paid in 2017/18 for active claims

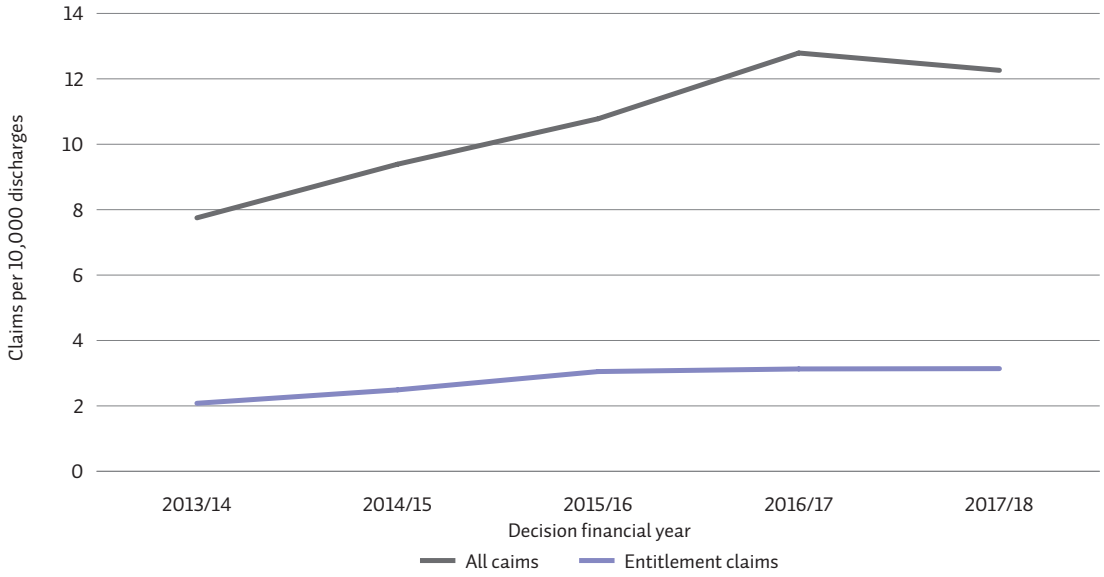
Entitlement	$11,182,744
Serious injury	$3,768,548
All other	$779,736



Total $15,731,027

DHB infections following surgery

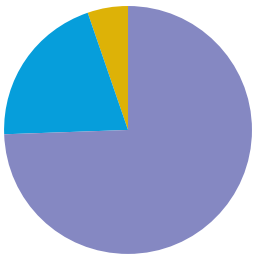
Accepted claims per 10,000 discharges



Accepted claims in 2017/18 for infections following surgery	Active claims in 2017/18 for infections following surgery
1,416	2,302

Costs paid in 2017/18 for active claims

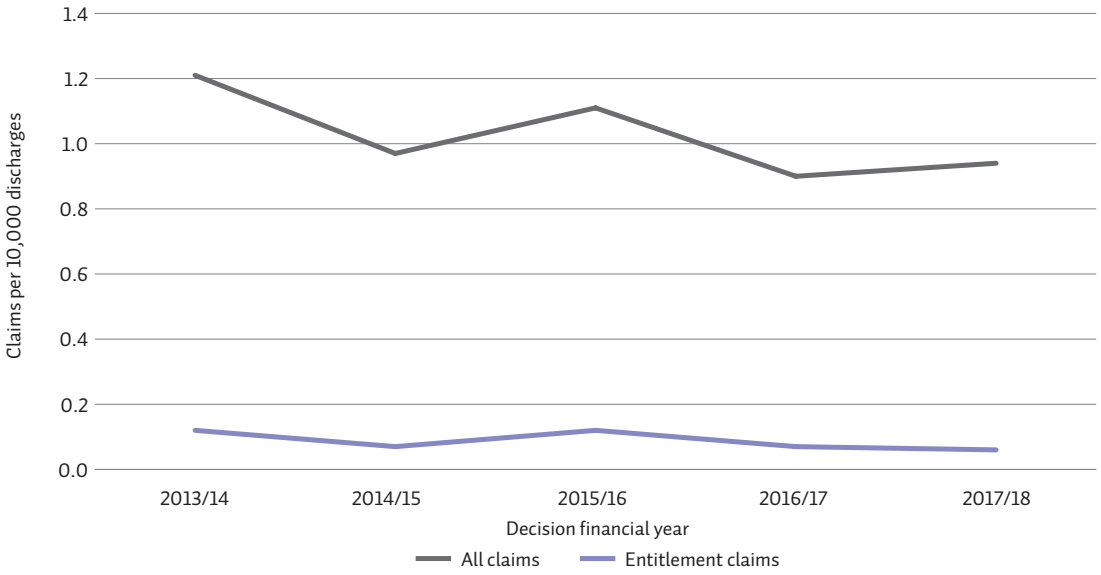
Entitlement	$10,337,387
Serious injury	$2,787,316
All other	$727,799



Total $13,852,502

DHB line infections (peripheral and central)

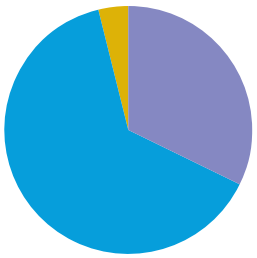
Accepted claims per 10,000 discharges



Accepted claims in 2017/18 for line infections (peripheral and central)	Active claims in 2017/18 for line infections (peripheral and central)
109	125

Costs paid in 2017/18 for active claims

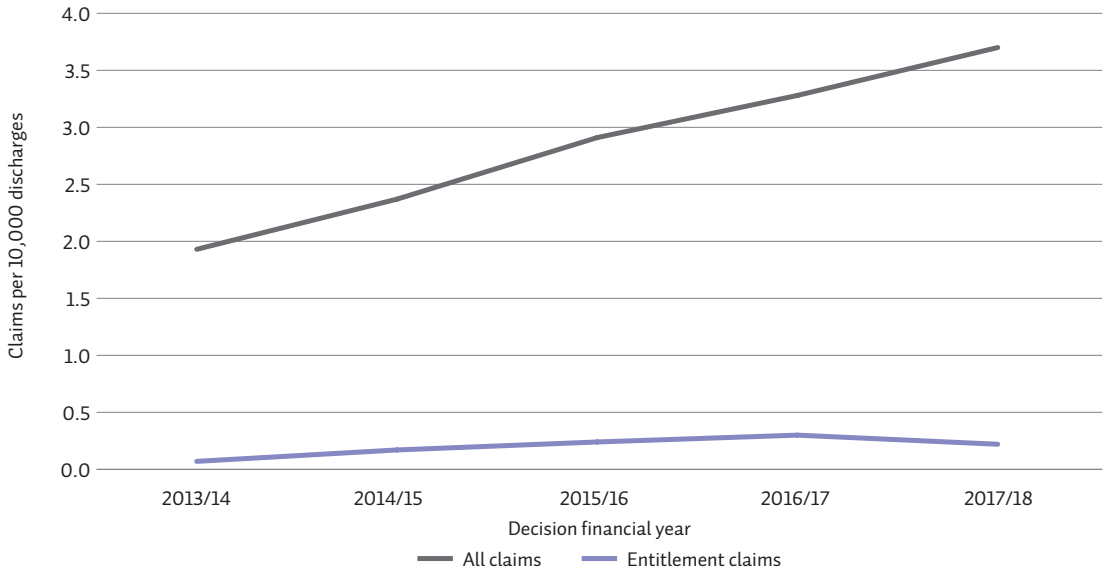
Entitlement	$166,870
Serious injury	$328,614
All other	$18,581



Total $514,065

DHB pressure injuries

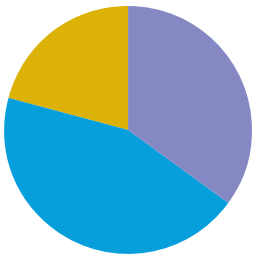
Accepted claims per 10,000 discharges



Accepted claims in 2017/18 for pressure injuries	Active claims in 2017/18 for pressure injuries
427	505

Costs paid in 2017/18 for active claims

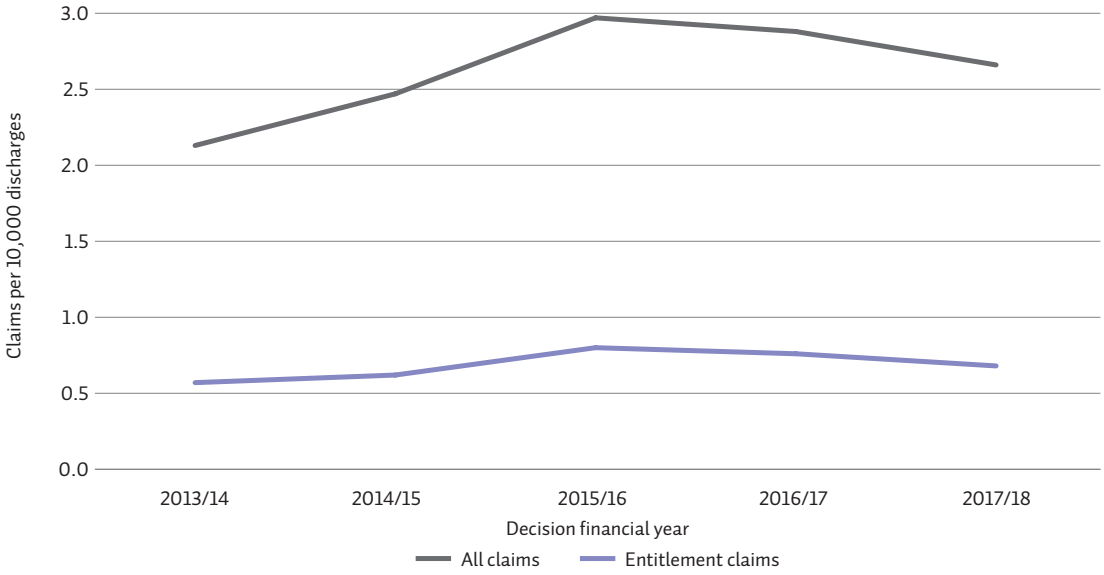
Entitlement	$300,415
Serious injury	$377,378
All other	$178,044



Total $855,836

DHB medication adverse reactions

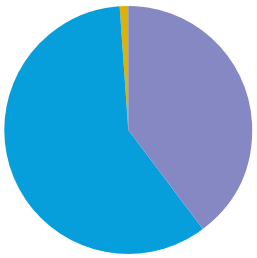
Accepted claims per 10,000 discharges



Accepted claims in 2017/18 for medication adverse reactions	Active claims in 2017/18 for medication adverse reactions
307	587

Costs paid in 2017/18 for active claims

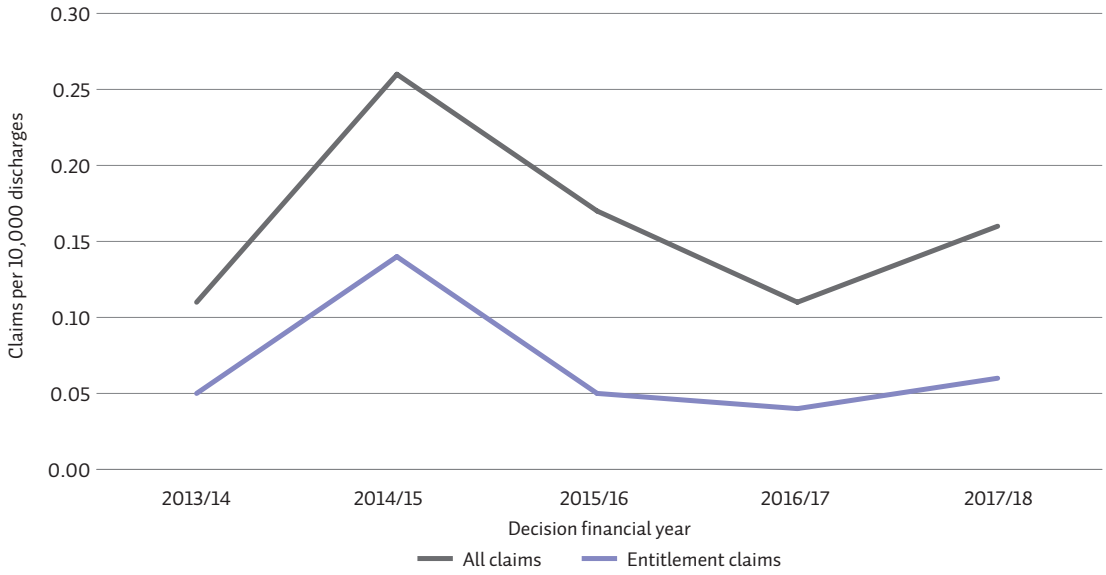
Entitlement	$2,895,574
Serious injury	$4,284,044
All other	$61,765



Total $7,241,382

DHB medication errors (prescribing and dispensing)

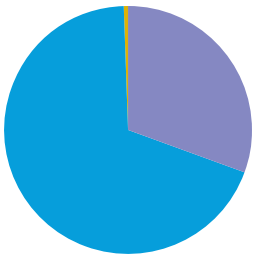
Accepted claims per 10,000 discharges



Accepted claims in 2017/18 for medication errors (prescribing and dispensing)	Active claims in 2017/18 for medication errors (prescribing and dispensing)
18	36

Costs paid in 2017/18 for active claims

Entitlement	$248,906
Serious injury	$556,887
All other	$2,688

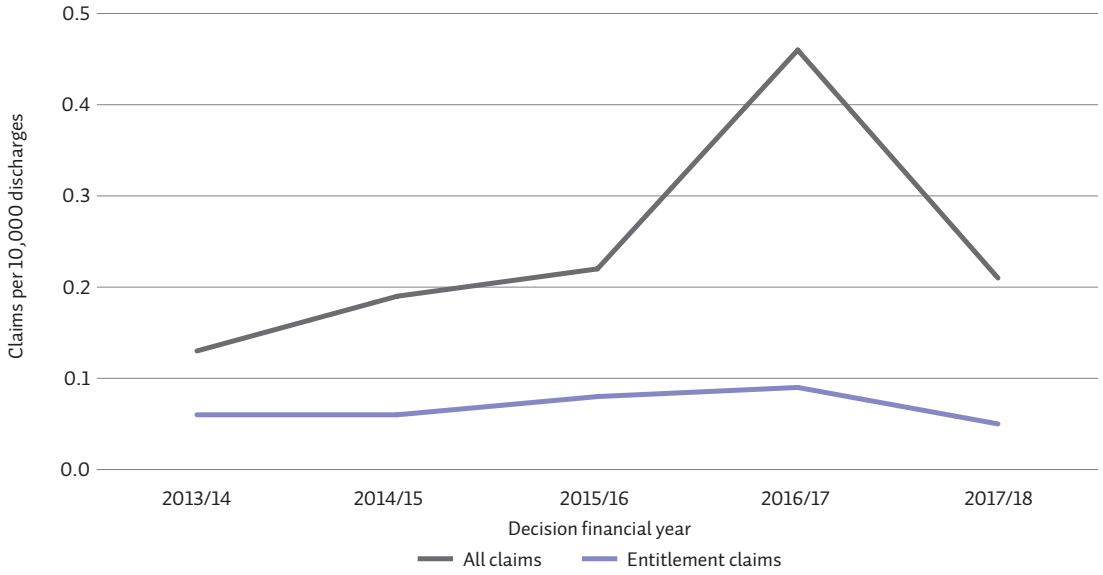


Total $808,480

DHB pulmonary embolism (PE)

The absence of PE and DVT are indicators of surgical safety. Due to the numbers of accepted treatment injury claims being small for these injury types, they are only reported at the national level.

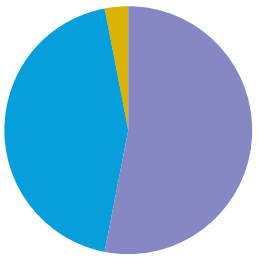
Accepted claims per 10,000 discharges



Accepted claims in 2017/18 for pulmonary embolism	Active claims in 2017/18 for pulmonary embolism
24	63

Costs paid in 2017/18 for active claims

Entitlement	$204,849
Serious injury	$168,111
All other	$11,460

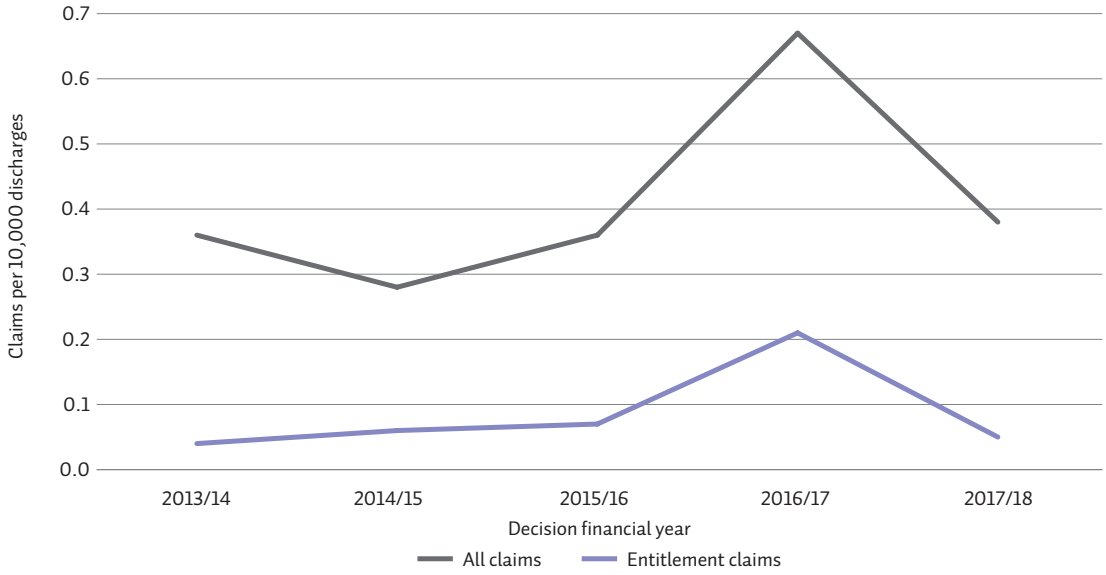


Total $384,420

DHB deep vein thrombosis (DVT)

The absence of PE and DVT are indicators of surgical safety. Due to the numbers of accepted treatment injury claims being small for these injury types, they are only reported at the national level.

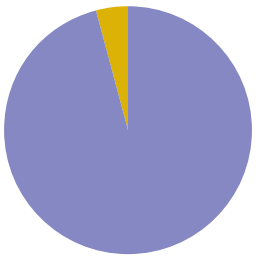
Accepted claims per 10,000 discharges



Accepted claims in 2017/18 for deep vein thrombosis	Active claims in 2017/18 for deep vein thrombosis
44	84

Costs paid in 2017/18 for active claims

Entitlement	$296,426
Serious injury	$0
All other	$12,728



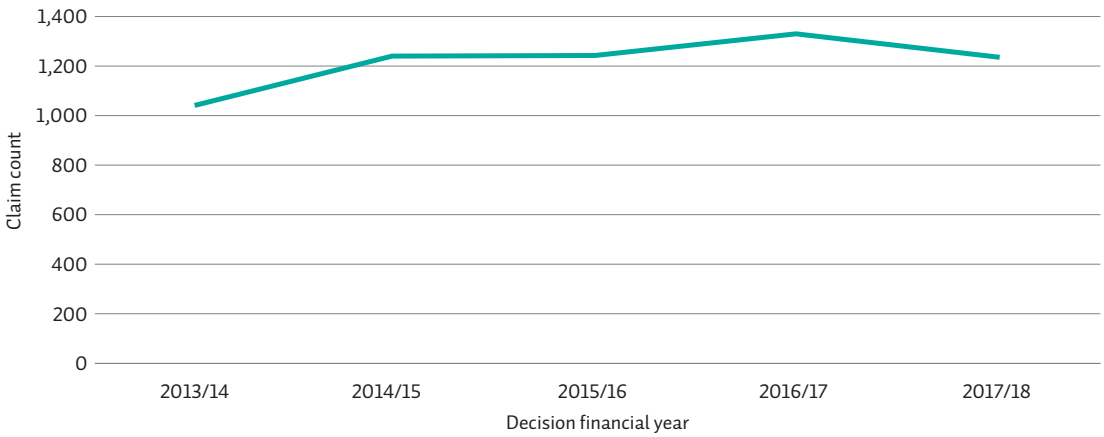
Total $309,154

Treatment injuries in NZPSHA hospitals

In 2017/18, about 180,000 people were discharged after treatment at NZPSHA hospitals, and 1,236 treatment injury claims due to treatment by NZPSHA hospitals were accepted. Overall, 0.69% of discharges from an NZPSHA hospital resulted in an accepted treatment injury claim (that is 69 accepted treatment injury claims per 10,000 discharges).

The five-year claim rate per 10,000 discharges is not able to be presented due to a change from procedure numbers to discharge numbers provided by NZPSHA. Numbers of accepted claims are shown.

Accepted claims for NZPSHA hospitals



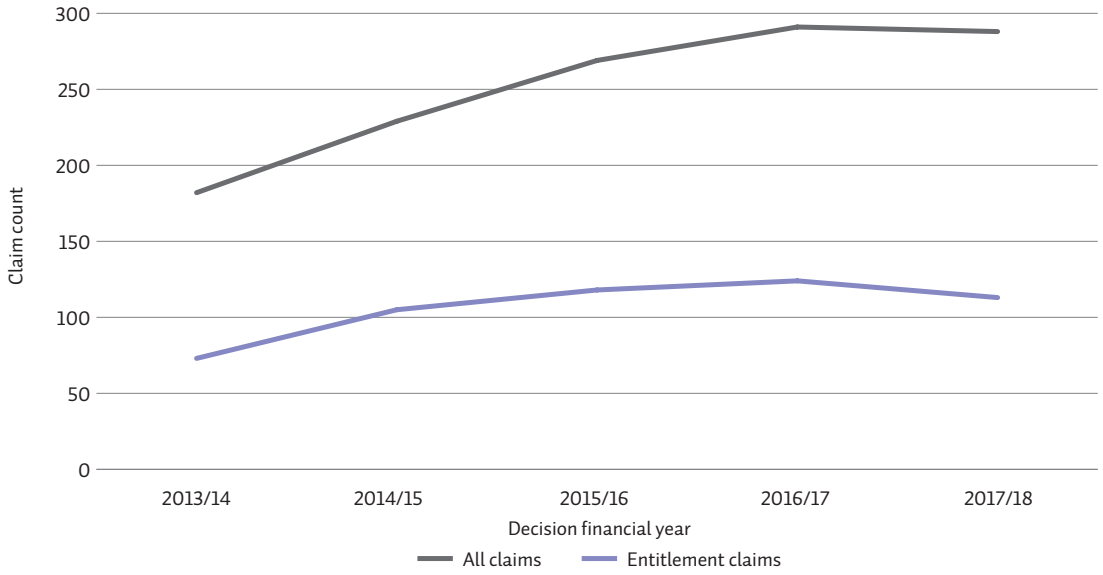
Note: *This data is the claim count of treatment injury claims resulting from treatment in NZPSHA hospitals. The name of the facility is provided to ACC by the registered health professional lodging the claim.*

NZPSHA claims by decision financial year

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Accept	Number	1,043	1,239	1,243	1,333	1,236
	%	77	76	76	75	72
Decline	Number	310	382	388	441	482
	%	23	24	24	25	28
Total Decided Claims	Number	1,353	1,621	1,631	1,774	1,718
Entitlement Claims	Number	632	774	764	749	689

NZPSHA infections of all types

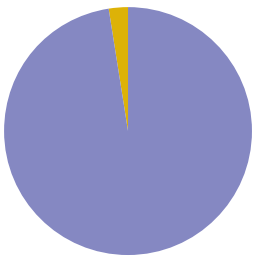
Accepted claims



Accepted claims in 2017/18 for infections of all types	Active claims in 2017/18 for infections of all types
288	520

Costs paid in 2017/18 for all active claims

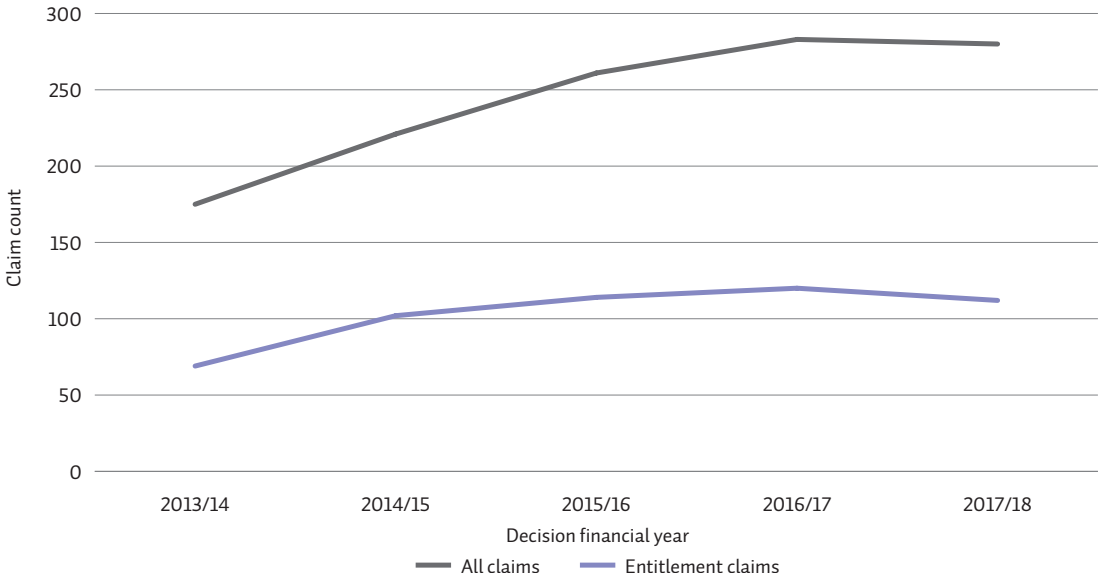
Entitlement	$3,791,466
Serious injury	$0
All other	$92,432



Total $3,883,898

NZPSHA infections following surgery

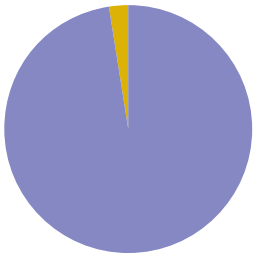
Accepted claims



Accepted claims in 2017/18 for infections following surgery	Active claims in 2017/18 for infections following surgery
280	506

Costs paid in 2017/18 for all active claims

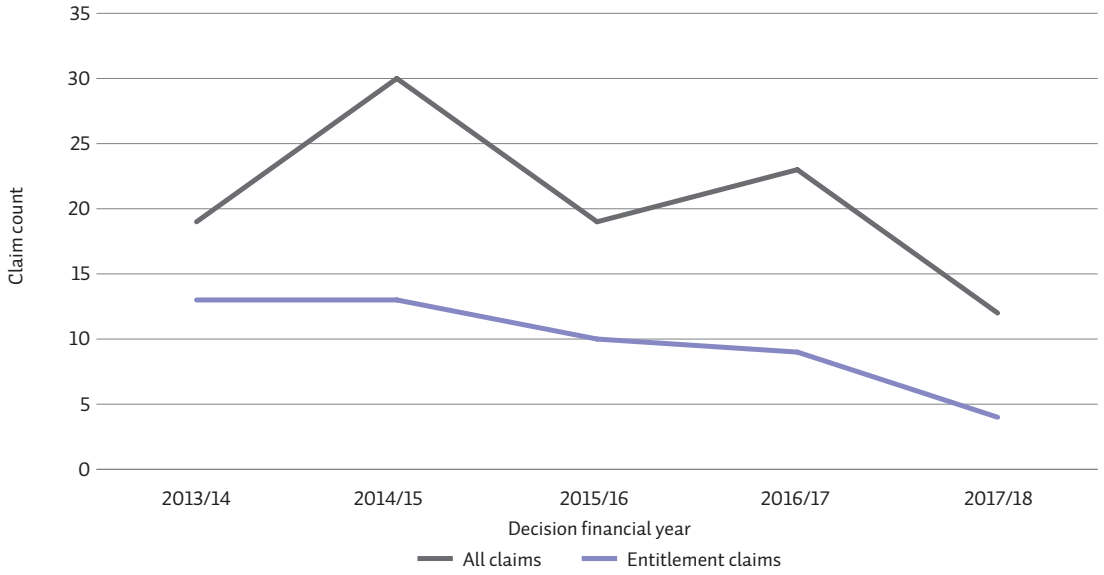
Entitlement	$3,736,577
Serious injury	$0
All other	$88,760



Total $3,825,337

NZPSHA medication adverse reactions

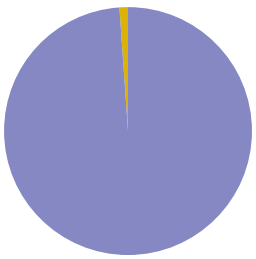
Accepted claims



Accepted claims in 2017/18 for medication adverse reactions	Active claims in 2017/18 for medication adverse reactions
12	26

Costs paid in 2017/18 for all active claims

Entitlement	$162,567
Serious injury	$0
All other	$1,797

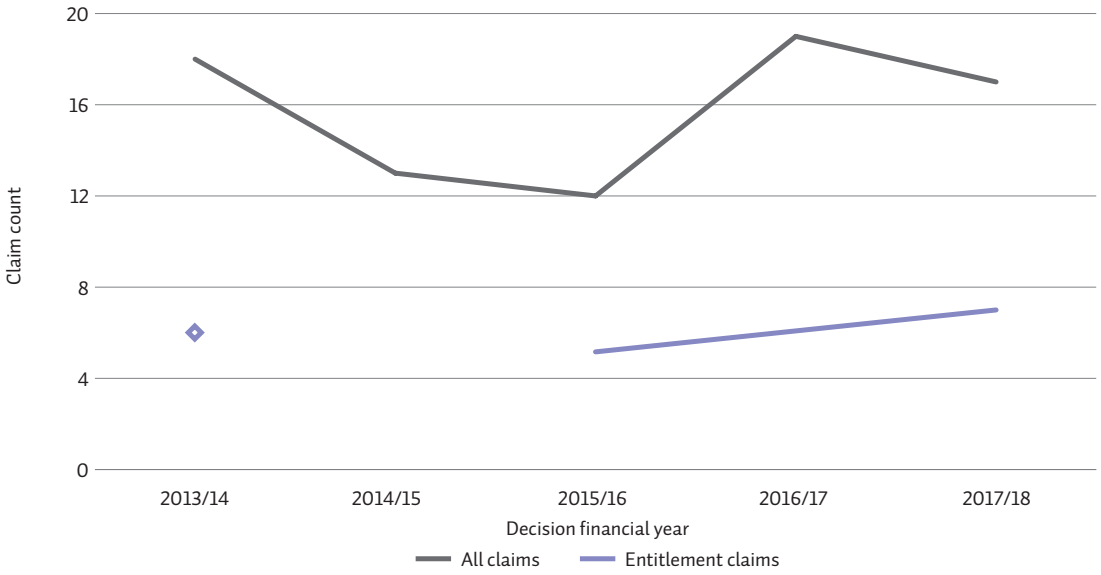


Total $164,364

NZPSHA deep vein thrombosis (DVT)

The absence of PE and DVT are indicators of surgical safety. Due to the numbers of accepted treatment injury claims being small for these injury types, they are only reported at the national level.

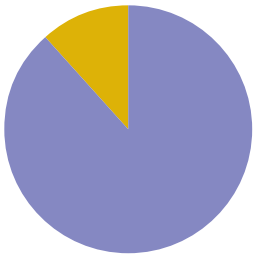
Accepted claims



Accepted claims in 2017/18 for deep vein thrombosis	Active claims in 2017/18 for deep vein thrombosis
17	23

Costs paid in 2017/18 for all active claims

Entitlement	$26,853
Serious injury	$0
All other	$3,510

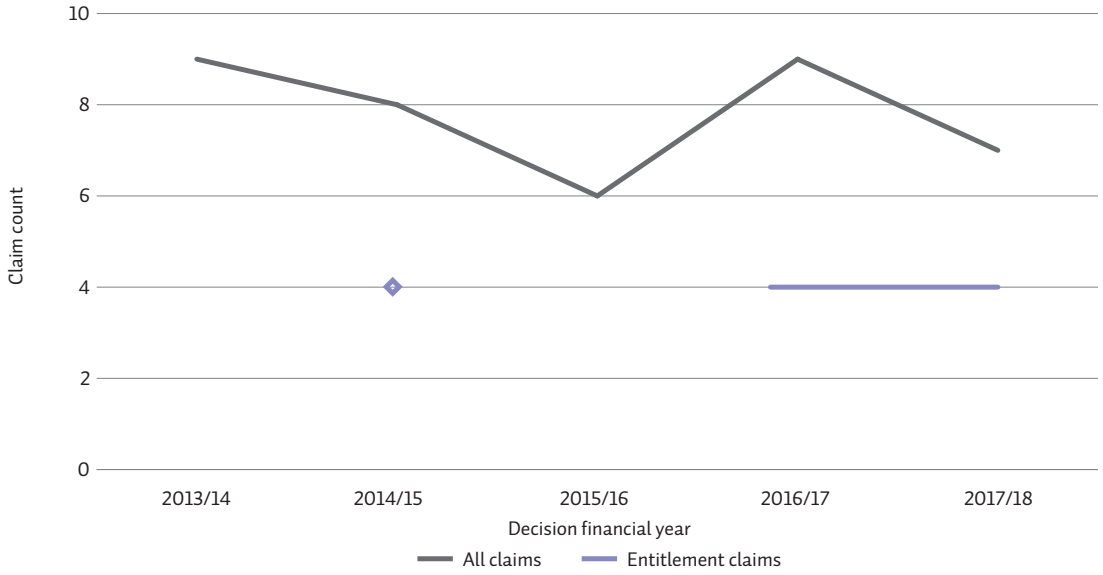


Total $30,363

NZPSHA pulmonary embolism (PE)

The absence of PE and DVT are indicators of surgical safety. Due to the numbers of accepted treatment injury claims being small for these injury types, they are only reported at the national level.

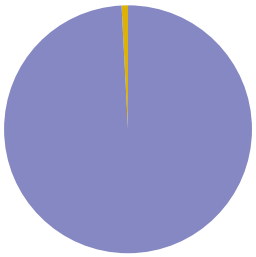
Accepted claims



Accepted claims in 2017/18 for pulmonary embolism	Active claims in 2017/18 for pulmonary embolism
7	15

Costs paid in 2017/18 for all active claims

Entitlement	$96,445
Serious injury	$0
All other	$685



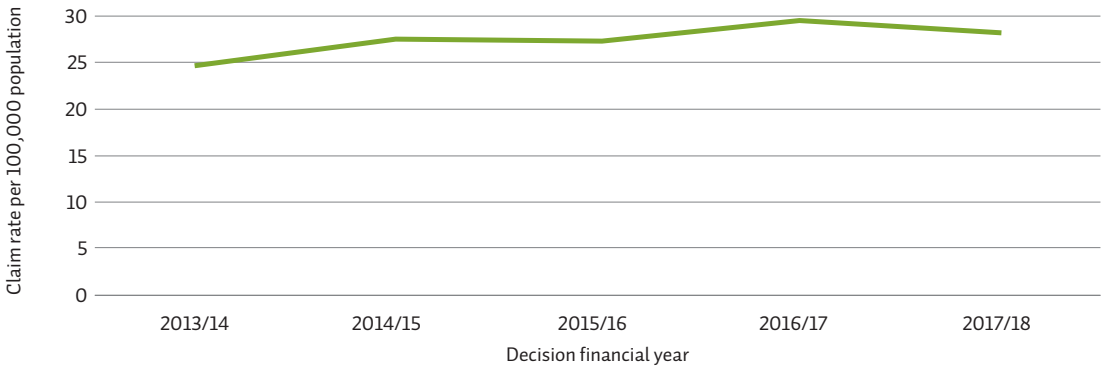
Total $97,131

Treatment injuries in general practice settings

General practice plays a central role in the delivery of health care to the New Zealand community. A wide range of services are provided in general practice settings including diagnosis and treatment, health education, counselling, disease prevention and screening. The information in this publication covers health care provided in the community. This is usually from a general practitioner (GP), but also includes practice nurses and other health professionals working within a general practice setting.

In 2017/18, 1,384 treatment injury claims were accepted for people injured by treatment in a general practice setting. This equates to 28.3 accepted treatment injury claims per 100,000 population. Overall, 0.03% of the New Zealand population received treatment injuries while being treated in general practice settings. This proportion has increased slightly since 2013/14.

Accepted treatment injury claims per 100,000 population for general practice settings, by decision financial year



Note: *This data includes treatment injury claims resulting from treatment in general practice settings and is standardised by the national population.*

General practice settings treatment injury claims by decision financial year

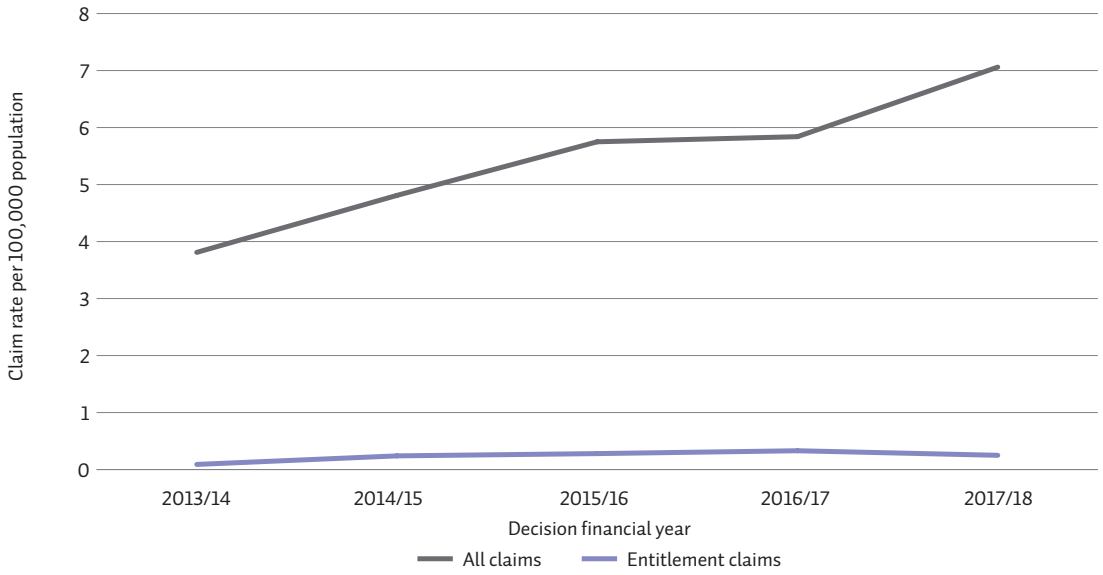
		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Accept	Number	1,105	1,264	1,284	1,419	1,384
	%	68	68	69	70	69
Decline	Number	518	593	577	616	619
	%	32	32	31	30	31
Total Decided Claims	Number	1,623	1,857	1,861	2,035	2,003
Entitlement Claims	Number	99	130	147	138	132

The rate of accepted claims and the costs are shown for three injury types. Medication adverse reactions and infections following a minor procedure account for the majority of treatment injuries occurring in general practice settings. By contrast, treatment omissions causing injury are fewer in number, but can have a greater impact on people and their families/whānau. This is reflected in higher costs for these injuries.

Infection in general practice settings following a minor procedure

This injury type includes infections following minor procedures carried out in general practice settings, such as removal of skin lesions, cryotherapy, and biopsies.

Accepted claims per 100,000 population



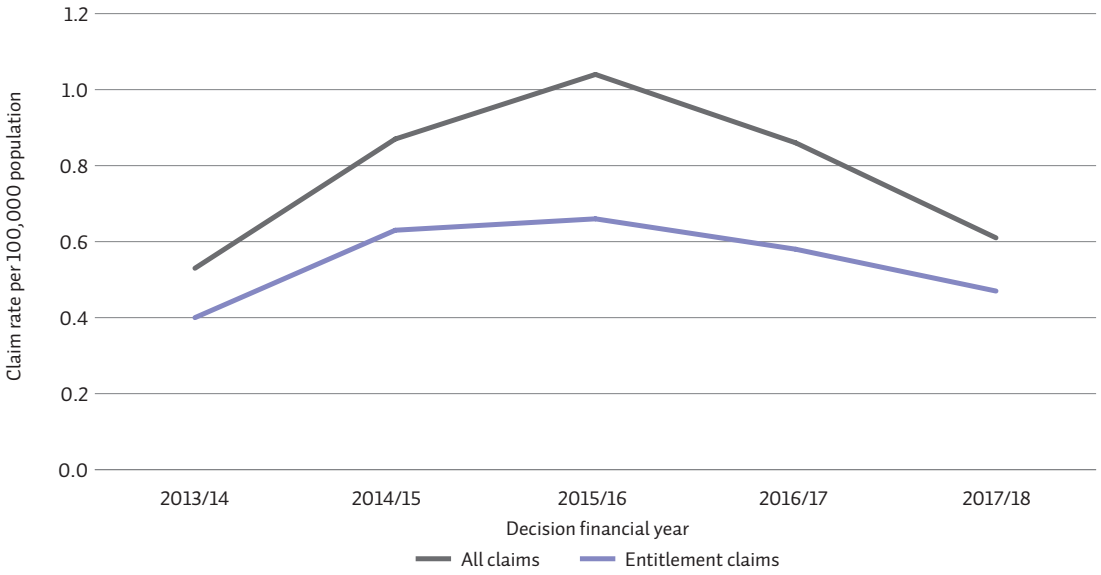
Infection claims by financial year

	Financial year				
	2013/14	2014/15	2015/16	2016/17	2017/18
Accepted claims	172	221	270	280	345
Active claims	192	243	311	322	403
Cost of Active claims	$63,330	$140,496	$168,600	$332,225	$197,524
Cost per Active claim	$330	$578	$542	$1,032	$490

Treatment omissions in general practice settings

These omissions refer to failure to provide treatment or failure to provide treatment in a timely manner. The failure may be at the time of investigation, diagnosis or treatment, including medication errors.

Accepted claims per 100,000 population



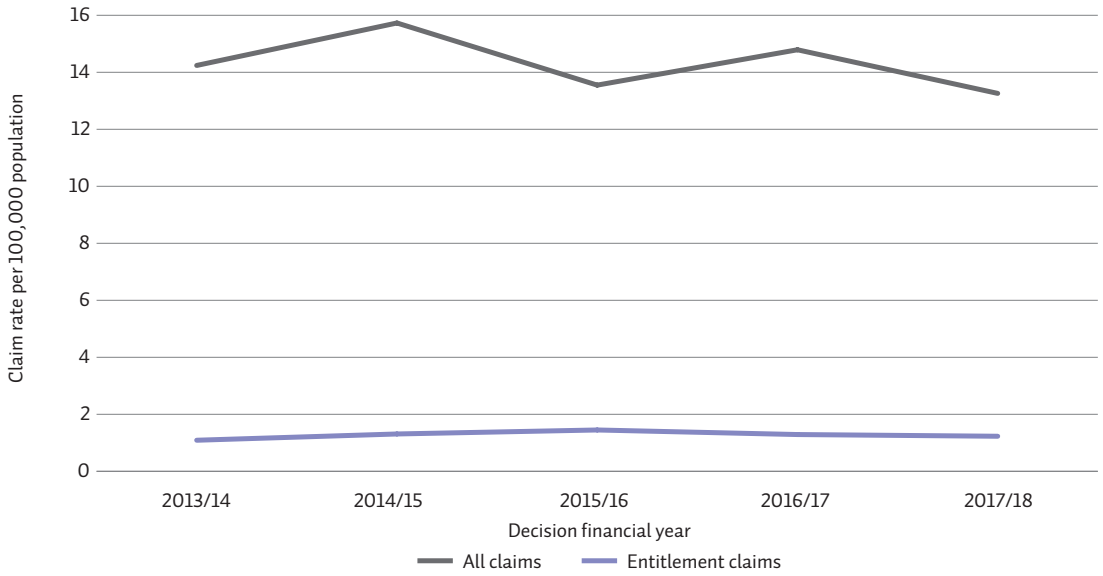
Treatment omission claims by financial year

	Financial year				
	2013/14	2014/15	2015/16	2016/17	2017/18
Accepted claims	24	40	49	41	30
Active claims	93	120	130	129	129
Cost of Active claims	$3,558,719	$3,558,719	$5,365,719	$3,788,245	$5,074,883
Cost per Active claim	$34,343	$29,650	$41,275	$29,366	$39,340

Medication adverse reaction in a general practice setting

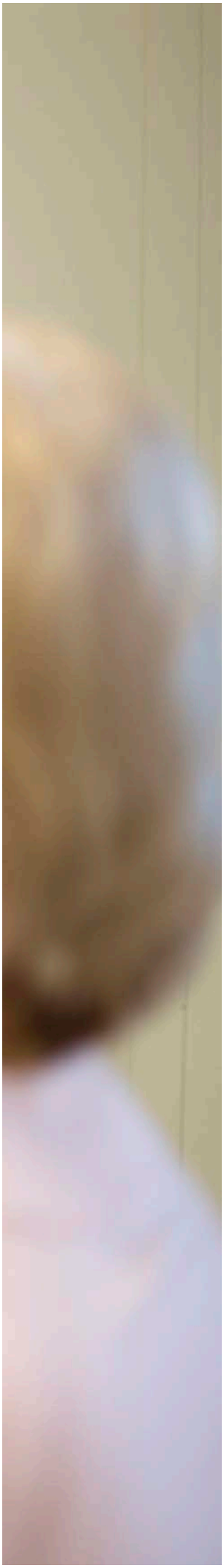
These are adverse reactions to medications such as antibiotics and pain relievers.

Accepted claims per 100,000 population



Medication adverse reaction claims by financial year

	Financial year				
	2013/14	2014/15	2015/16	2016/17	2017/18
Accepted claims	642	723	636	709	648
Active claims	782	821	781	854	806
Cost of Active claims	$2,461,575	$3,069,578	$3,638,014	$4,252,949	$4,754,085
Cost per Active claim	$3,148	$3,739	$4,658	$4,980	$5,898



Treatment Injury dashboards

This section contains Treatment Injury dashboards for public hospitals, NZPSHA and general practice settings. The injury types for each setting were selected because of the significant impact on the person, or because the injuries are amenable to prevention strategies or are indicators of safer care.

Further injury types may be added in the future.

These dashboards provide a comparison across time for each setting. The main purpose of tracking the number of treatment injuries over time is to encourage improvement within each setting. Each accepted claim represents a person who was inadvertently harmed while being treated. The numbers and rates are indicators of how that person was injured while being treated.

The information in this section is useful because it:

- aims to inform and guide collective efforts to reduce patient harm
- recognises that treatment injury information is one measure of patient safety that can add to other measures across the health sector
- provides evidence to inform approaches to reduce patient harm
- enables ACC to co-design prevention initiatives with clinicians, managers, institutions, consumers of health care and health agencies to improve patient and treatment safety.

What each dashboard contains

The information outlined in each dashboard only includes treatment injury claims resulting from treatment in that setting (eg hospital or general practice setting).

The registered health professional who lodged the claim identified the setting where the treatment that caused the injury was delivered.

As a matter of practice, ACC has a policy not to disclose data below a certain value to maintain privacy. Therefore when the number of claims is less than four we will indicate that (<4) and the corresponding rate will be withheld (–).

Information is outlined for three types of health care settings

- District Health Boards – each DHB has an individual dashboard
- New Zealand Private Surgical Hospitals Association members – a single dashboard for the NZPSHA combined national totals
- General Practice settings – a single dashboard for combined national totals.

Direct comparisons between hospitals are not meaningful due to different case-mix and context.

The types of treatment injuries seen in hospital settings differ from those in general practice settings.

Information included in the dashboards for DHBs, NZPSHA members and General Practice settings

Information included	How information is shown	Comments
Rate of accepted claims per 10,000 discharges from the DHB over the last five years	A chart that also includes the rate for all DHBs	Data is standardised by the number of DHB discharges because it includes only treatment injury claims resulting from treatment in DHB facilities (public hospitals). Discharge numbers provided by the MoH from the NMDS.
Number of accepted claims from NZPSHA members	A chart that shows number of treatment injuries over time	The five year claim rate per 10,000 discharges can only be presented for one year due to the lack of historical data.
Rate of accepted claims per 100,000 population over the last five years	A chart that shows rate of treatment injuries over time	Data is standardised by the national population.
Total costs paid for all active accepted treatment injury claims that arose (from treatment in the relevant setting during 2017/18)	A chart to identify costs paid for serious injury, entitlement and all other claims	Entitlement claims have ongoing costs above the initial medical treatment. Serious injury claims are a subset of entitlement claims.

Information included	How information is shown	Comments
Proportion of treatment injury claims that were accepted and declined (from treatment in the relevant facility during 2017/18)	A chart showing the proportion of accepted and declined claims	We have developed a Lodgement Guide to assist clinicians to understand treatment injury and clarify the acceptance criteria for claims. (www.acc.co.nz/lodgementguide)
Number of accepted treatment injury claims and rates per 10,000 discharges for six types of injuries	Shown as six injury types for hospitals: • infections of all types • infections following surgery • line infections • pressure injuries • medication adverse reactions • medication errors	These six types: • have significant impact on the person and their families/whānau • are injuries identified internationally as amenable to prevention strategies • are injuries that may be indicators of safer care. Over time, we will increase the number of categories monitored. We will use this information to support more prevention approaches.
Number of accepted treatment injury claims and rates per 100,000 population for three types of injuries	Shown as three injury types for general practice settings: • infections following minor procedures • treatment omissions • medication adverse reactions	These three types: • have significant impact on the person and their families/whānau • are injuries identified internationally as amenable to prevention strategies • are injuries that may be indicators of safer care. Over time we will increase the number of categories monitored. We will use this information to support more prevention approaches.

Each DHB and the NZPSHA also provided background information to include in the dashboard. This provides context about the numbers and costs of accepted treatment injury claims within each type of setting, including:

- population served, and an outline of key features of the population
- facilities or hospitals within each DHB
- locations and names of all the NZPSHA member facilities.

Auckland DHB

People	Accepted claims 2017/18	Active claims 2017/18
536,800	563	1,180

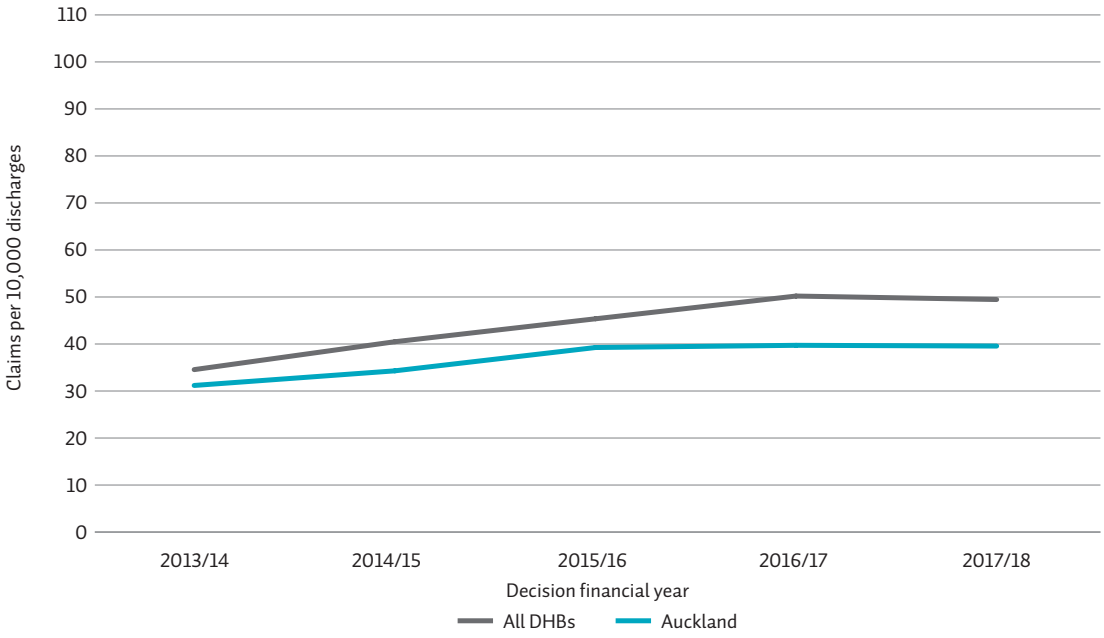
Demographics

- Auckland's population tends to be younger than the national average.
- Auckland has fewer Māori and more Pacific people than the national average.
- Auckland's deprivation levels are lower than the national average.

Major facilities

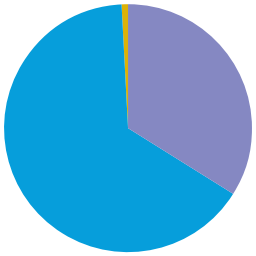
- **Auckland City Hospital** is New Zealand's largest public hospital and the largest clinical research facility.
- **Greenlane Clinical Centre.**
- **Starship Children's Hospital** is a dedicated paediatric health care service and major teaching centre. It provides family-centred care to children and young people throughout New Zealand and the South Pacific.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement $7,496,216
Serious injury $14,371,481
All other $165,186

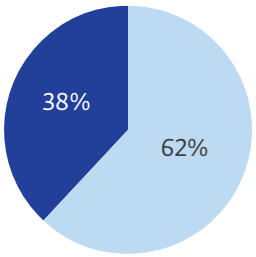


Total $22,032,884

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	5.82	7.78	8.02	6.88	8.99
	Number	78	105	112	98	128
Infections following surgery	Rate	4.33	5.78	6.66	5.76	7.52
	Number	58	78	93	82	107
Line infections	Rate	0.9	0.96	0.86	0.63	0.77
	Number	12	13	12	9	11
Pressure injuries	Rate	0.82	1.93	1.15	2.39	2.60
	Number	11	26	16	34	37
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	2.91	2.67	3.65	3.02	3.02
	Number	39	36	51	43	43

Bay of Plenty DHB

People	Accepted claims 2017/18	Active claims 2017/18
237,000	206	448

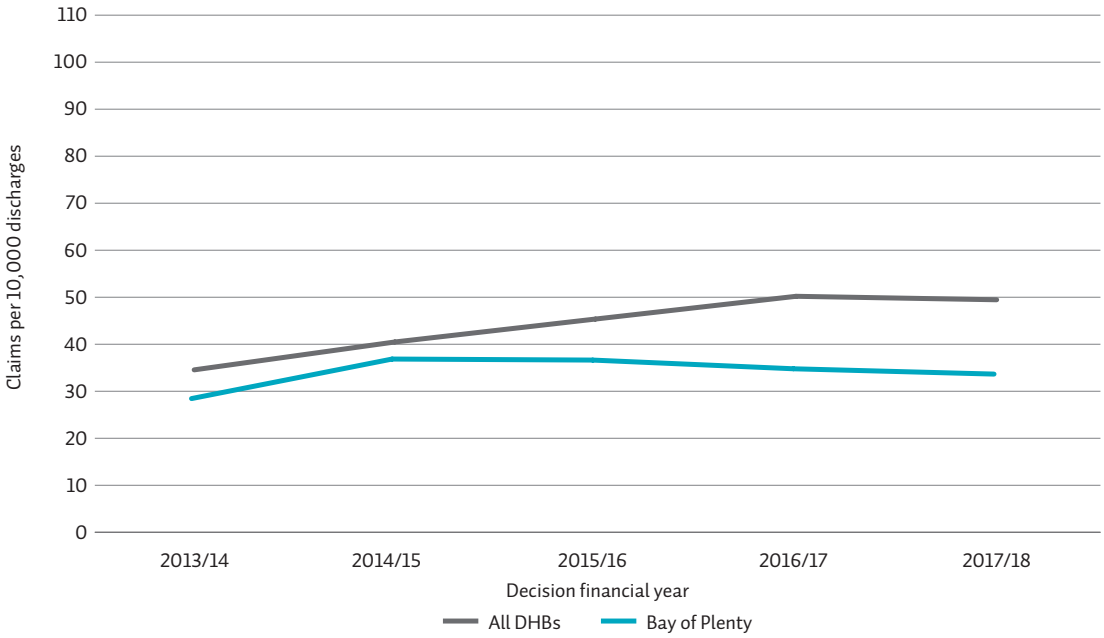
Demographics

- Bay of Plenty's population tends to have more people aged 50 years and above than the national average.
- Bay of Plenty has more Māori but fewer Pacific people compared with the national average.
- Bay of Plenty's deprivation levels are higher than the national average.

Major facilities

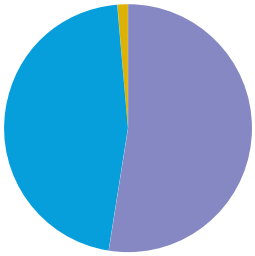
- **Tauranga Hospital** is a secondary hospital that has experienced significant expansion to keep pace with its rapidly growing population.
- **Whakatāne Hospital** is a secondary hospital that serves a rural and coastal population. It is also home to the Project Hope Cancer Centre, which represents a community/DHB collaboration.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$2,964,001
Serious injury	$2,607,093
All other	$64,731

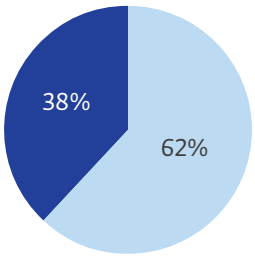


Total $5,635,824

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	5.89	7.20	5.41	6.33	5.20
	Number	31	40	31	38	32
Infections following surgery	Rate	5.13	5.40	4.19	5.00	3.90
	Number	27	30	24	30	24
Line infections	Rate	–	1.26	0.70	–	–
	Number	<4	7	4	<4	<4
Pressure injuries	Rate	2.85	1.98	3.84	2.50	1.95
	Number	15	11	22	15	12
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	2.09	3.06	2.79	2.50	1.79
	Number	11	17	16	15	11

Canterbury DHB

People	Accepted claims 2017/18	Active claims 2017/18
563,200	518	998

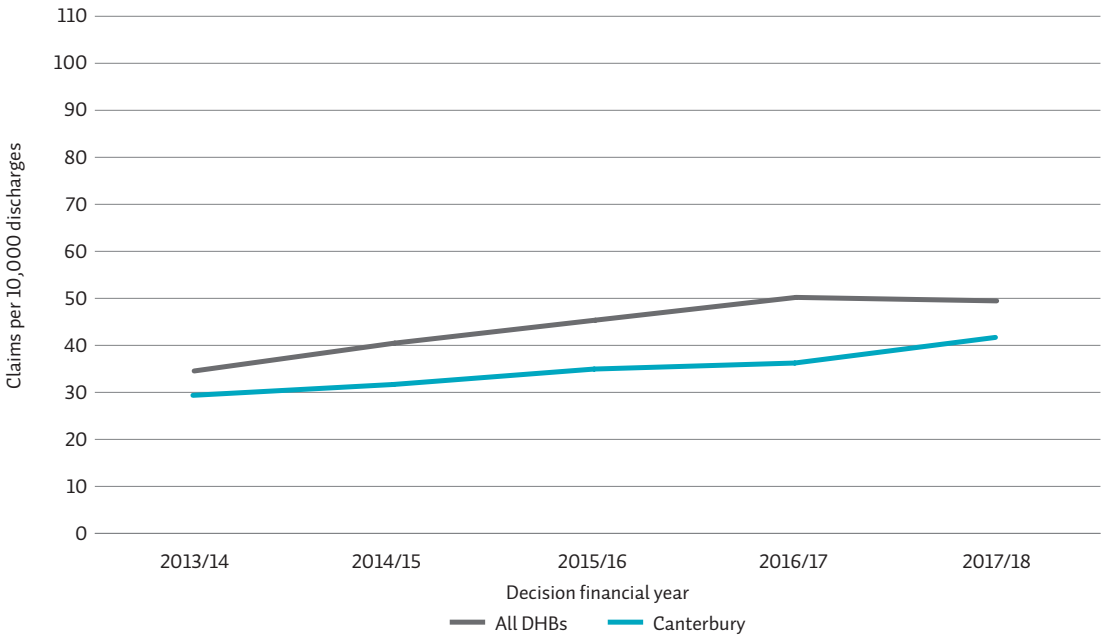
Demographics

- Canterbury DHB funds and provides health services to people in Canterbury and the Chatham Islands.
- Canterbury's population tends to be of similar age structure to the national average, with slightly more people aged 40 and over.
- Canterbury has a fewer Māori and Pacific people, compared with the national average.
- Canterbury has New Zealand's largest elderly population.
- Canterbury's deprivation levels are lower than the national average.

Major facilities

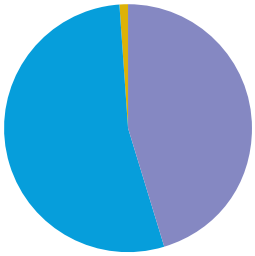
- Akaroa Hospital.
- Ashburton Hospital.
- Burwood Hospital provides orthopaedic services, spinal injury treatment and rehabilitation, and brain injury treatment.
- Christchurch Hospital.
- Christchurch Women's Hospital.
- Hillmorton Hospital.
- Kaikōura Hospital.
- Princess Margaret Hospital.
- Rangiora Health Hub.
- Chatham Islands Health Centre.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$5,660,123
Serious injury	$6,654,962
All other	$124,275

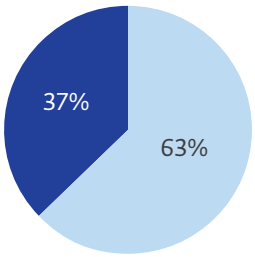


Total $12,439,361

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	5.81	4.61	4.64	8.67	7.97
	Number	67	54	55	106	99
Infections following surgery	Rate	5.20	3.84	3.54	7.85	7.08
	Number	60	45	42	96	88
Line infections	Rate	0.43	–	0.59	0.57	0.56
	Number	5	<4	7	7	7
Pressure injuries	Rate	2.25	2.48	4.21	4.09	4.19
	Number	26	29	50	50	52
Medication errors	Rate	–	–	–	–	0.32
	Number	<4	<4	<4	<4	4
Medication adverse reactions	Rate	1.91	2.65	3.20	3.11	2.90
	Number	22	31	38	38	36

Capital & Coast DHB

People	Accepted claims 2017/18	Active claims 2017/18
317,500	645	1,028

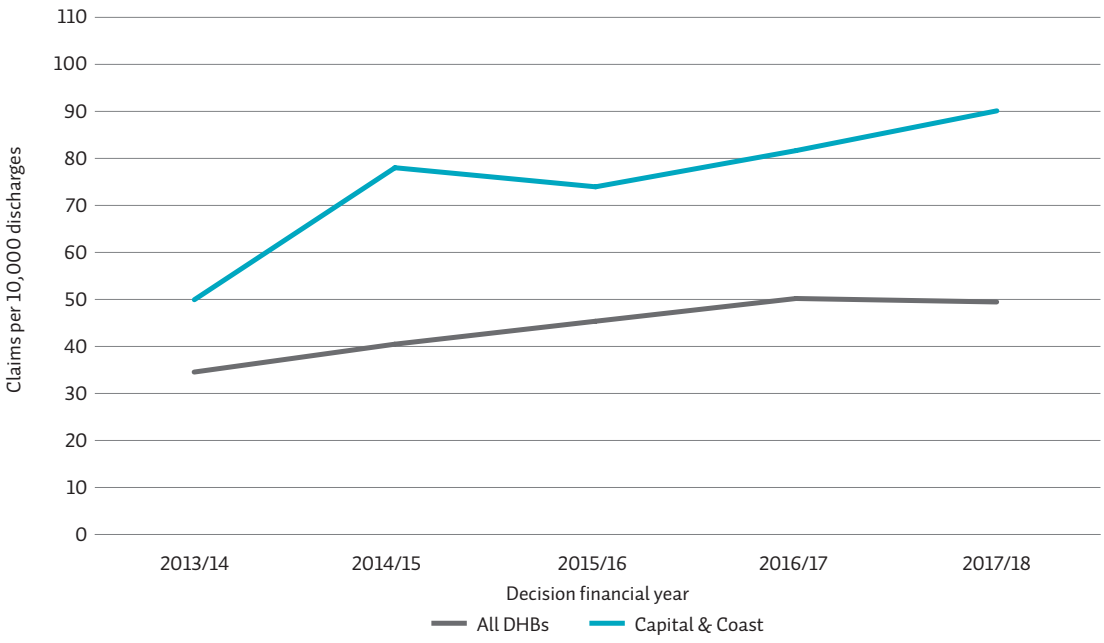
Demographics

- Capital & Coast's population tends to be younger than the national average.
- Capital & Coast has fewer Māori and slightly more Pacific people than the national average.
- Capital & Coast's deprivation levels are lower than the national average.

Major facilities

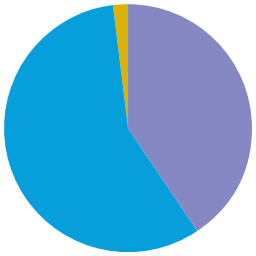
- **Kāpiti Health Centre** in Paraparaumu.
- **Kenepuru Community Hospital** in Porirua is a secondary hospital, which also includes an adult and adolescent psychiatric facility.
- **Rātonga-Rua-O-Porirua** mental health campus in Porirua.
- **Wellington Regional Hospital** is one of five major tertiary hospitals in New Zealand (for Otago University's Wellington School of Medicine and post-graduate training for clinical professionals). It is also the region's main emergency and only trauma service (with helipad).

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$4,403,141
Serious injury	$6,201,118
All other	$188,677

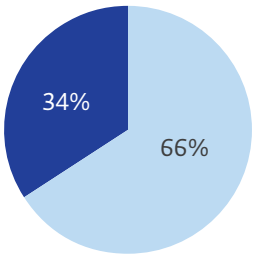


Total $10,792,936

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	12.22	17.64	19.45	23.93	25.32
	Number	85	124	140	168	181
Infections following surgery	Rate	10.21	15.23	17.23	20.80	21.96
	Number	71	107	124	146	157
Line infections	Rate	1.44	1.71	1.53	1.57	1.68
	Number	10	12	11	11	12
Pressure injuries	Rate	3.45	3.84	5.00	5.41	6.29
	Number	24	27	36	38	45
Medication errors	Rate	–	0.85	–	–	–
	Number	<4	6	<4	<4	<4
Medication adverse reactions	Rate	2.59	4.70	5.97	5.13	5.04
	Number	18	33	43	36	36

Counties Manukau DHB

People	Accepted claims 2017/18	Active claims 2017/18
558,200	456	927

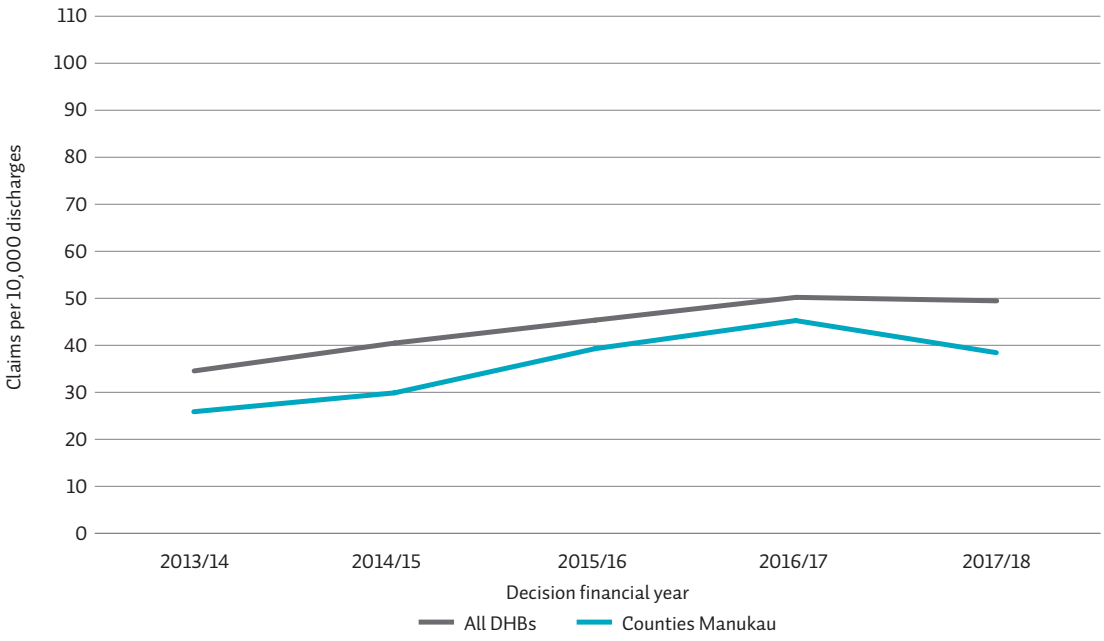
Demographics

- The population is ethnically diverse. Approximately 16% of the population identifies as Māori, 21% Pacific, 24% Asian, and 38% NZ European and other ethnicities.
- At the time of the 2013 Census, 36% of the population lived in areas classified as being the most socio-economically deprived in New Zealand (that is, Deprivation Index 9 and 10), including 45% of children aged 14 years and under.
- This population has high rates of diabetes and obesity.

Major facilities

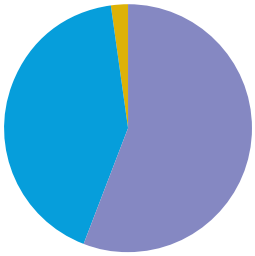
- Franklin Memorial Hospital .
- Middlemore Hospital is one of the largest tertiary teaching hospitals in New Zealand.
- Pukekohe Hospital.
- The DHB services include the national burns unit and supra-regional spinal injury services. It also provides surgery for complex orthopaedic and plastic/reconstructive surgical cases referred from other DHBs.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

- Entitlement $5,492,509
- Serious injury $4,130,563
- All other $196,997

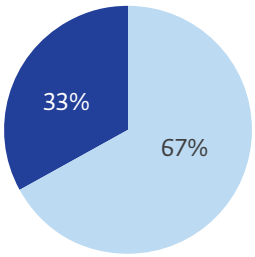


Total $9,820,069

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	8.16	9.23	13.47	11.49	10.50
	Number	99	113	159	136	125
Infections following surgery	Rate	6.84	7.27	11.69	10.31	9.57
	Number	83	89	138	122	114
Line infections	Rate	0.99	1.55	1.52	0.76	0.76
	Number	12	19	18	9	9
Pressure injuries	Rate	1.15	2.61	2.97	3.46	3.86
	Number	14	32	35	41	46
Medication errors	Rate	–	–	–	0.34	–
	Number	<4	<4	<4	4	<4
Medication adverse reactions	Rate	1.73	1.14	1.86	1.94	1.76
	Number	21	14	22	23	21

Hawke's Bay DHB

People	Accepted claims 2017/18	Active claims 2017/18
165,800	130	217

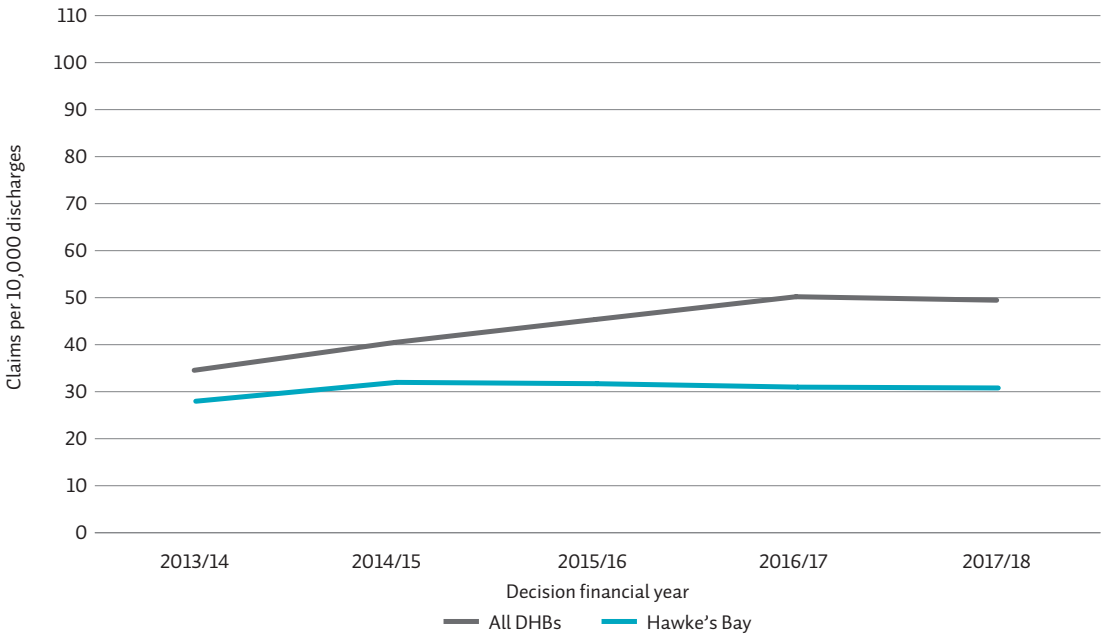
Demographics

- Most of the population lives in Napier or Hastings, two cities located about 20 kilometres apart. Together, they make up more than 80% of the total population in the Hawke's Bay DHB area.
- Hawke's Bay's population tends to be older than the national average.
- Hawke's Bay has more Māori but fewer Pacific people than the national average.
- Hawke's Bay's deprivation levels are higher than the national average (28% versus 20%).

Major facilities

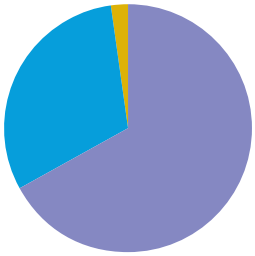
- Central Hawke's Bay Health Centre.
- Hawke's Bay Fallen Soldiers' Memorial Hospital.
- Napier Health.
- Wairoa Health.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$1,316,335
Serious injury	$604,055
All other	$38,871

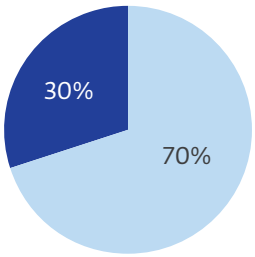


Total $1,959,261

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	8.88	6.87	6.49	8.71	8.53
	Number	33	26	26	36	36
Infections following surgery	Rate	7.26	5.29	4.99	7.74	7.11
	Number	27	20	20	32	30
Line infections	Rate	–	–	1	–	–
	Number	<4	<4	4	<4	<4
Pressure injuries	Rate	1.08	1.59	2.50	1.94	2.13
	Number	4	6	10	8	9
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	–	3.70	2.00	1.69	1.18
	Number	<4	14	8	7	5

Hutt Valley DHB

People	Accepted claims 2017/18	Active claims 2017/18
149,500	263	410

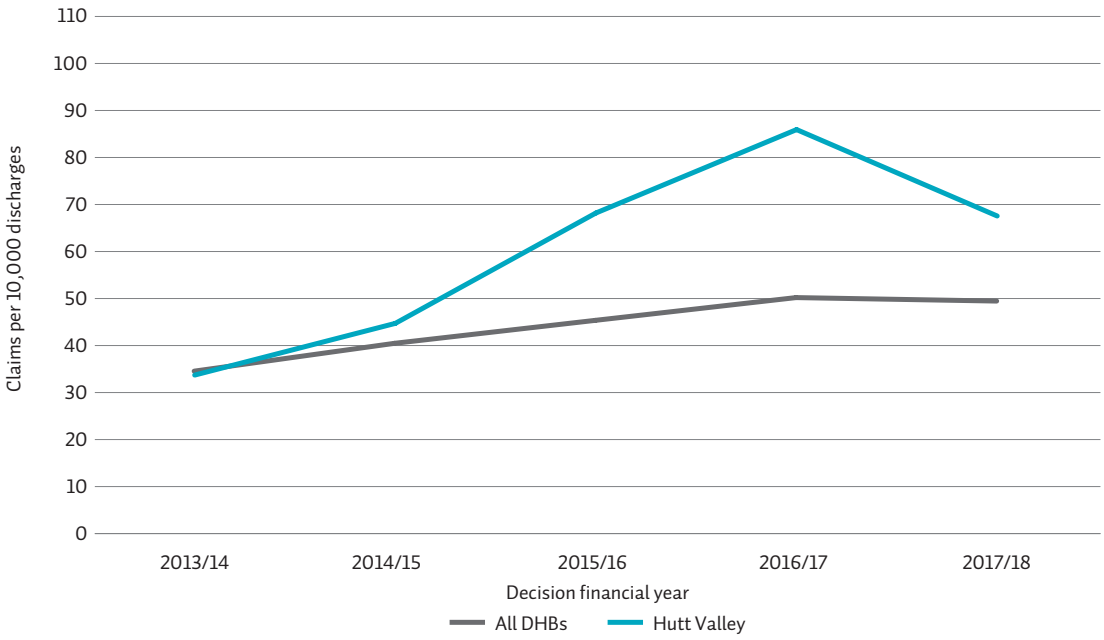
Demographics

- Hutt Valley's population tends to have an age structure similar to the national average.
- Hutt Valley has slightly more Māori and Pacific people than the national average.
- Hutt Valley's deprivation levels are equal to the national average, with slightly more people living in the least deprived section of the Hutt Valley.

Major facilities

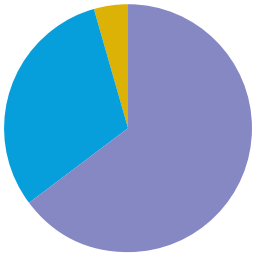
- **Hutt Hospital** is one of New Zealand's four regional burns and plastic surgery providers. It also provides breast screening services for the greater Wellington region.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$1,215,343
Serious injury	$577,778
All other	$78,767

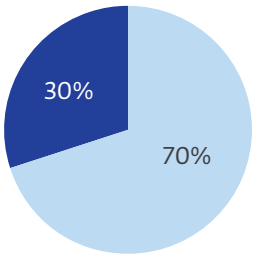


Total $1,871,889

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	11.67	9.83	17.01	25.84	22.90
	Number	40	34	62	97	89
Infections following surgery	Rate	7.58	9.26	11.80	20.25	20.84
	Number	26	32	43	76	81
Line infections	Rate	3.21	–	4.11	3.73	1.54
	Number	11	<4	15	14	6
Pressure injuries	Rate	2.62	6.94	5.49	8.26	4.89
	Number	9	24	20	31	19
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	1.17	3.18	3.84	3.46	2.06
	Number	4	11	14	13	8

Lakes DHB

People	Accepted claims 2017/18	Active claims 2017/18
109,700	98	183

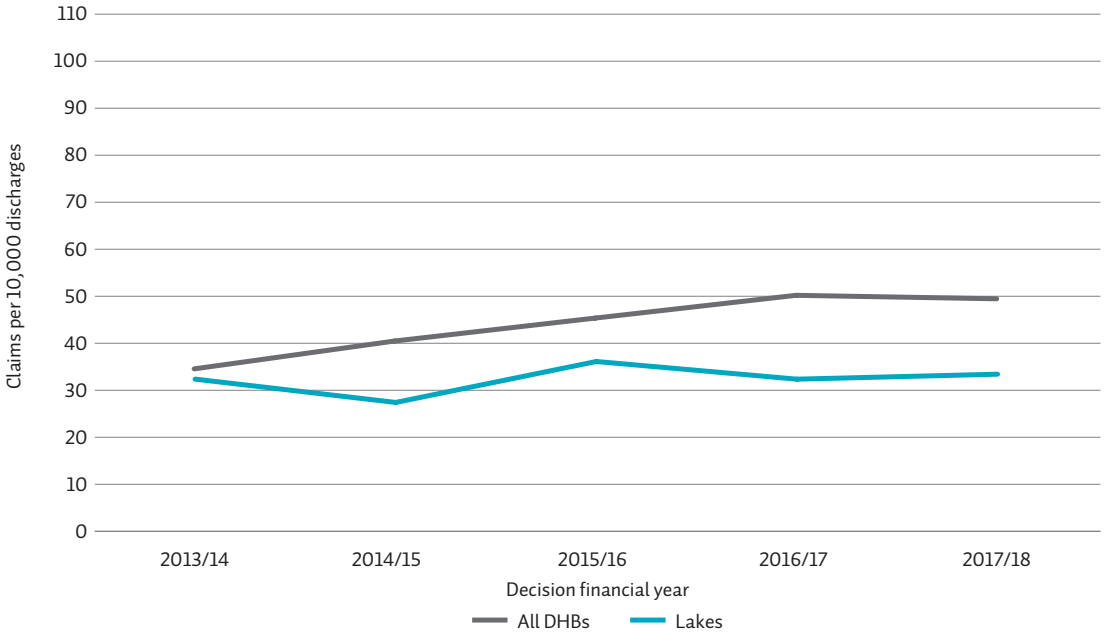
Demographics

- Lakes population tends to be younger than the national average.
- Lakes has more Māori but fewer Pacific people than the national average.
- Lakes deprivation levels are higher than the national average.

Major facilities

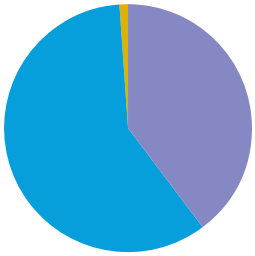
- Rotorua Hospital.
- Taupō Hospital.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$969,069
Serious injury	$1,442,660
All other	$26,780

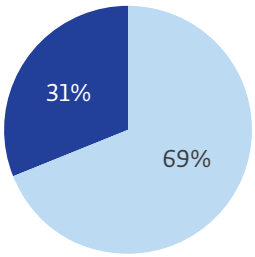


Total $2,438,508

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	8.76	5.12	9.82	8.61	8.87
	Number	23	14	28	25	26
Infections following surgery	Rate	7.24	4.75	9.12	6.89	8.19
	Number	19	13	26	20	24
Line infections	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Pressure injuries	Rate	2.29	2.19	2.10	1.38	1.36
	Number	6	6	6	4	4
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	1.52	–	2.10	1.38	–
	Number	4	<4	6	4	<4

MidCentral DHB

People	Accepted claims 2017/18	Active claims 2017/18
179,300	192	289

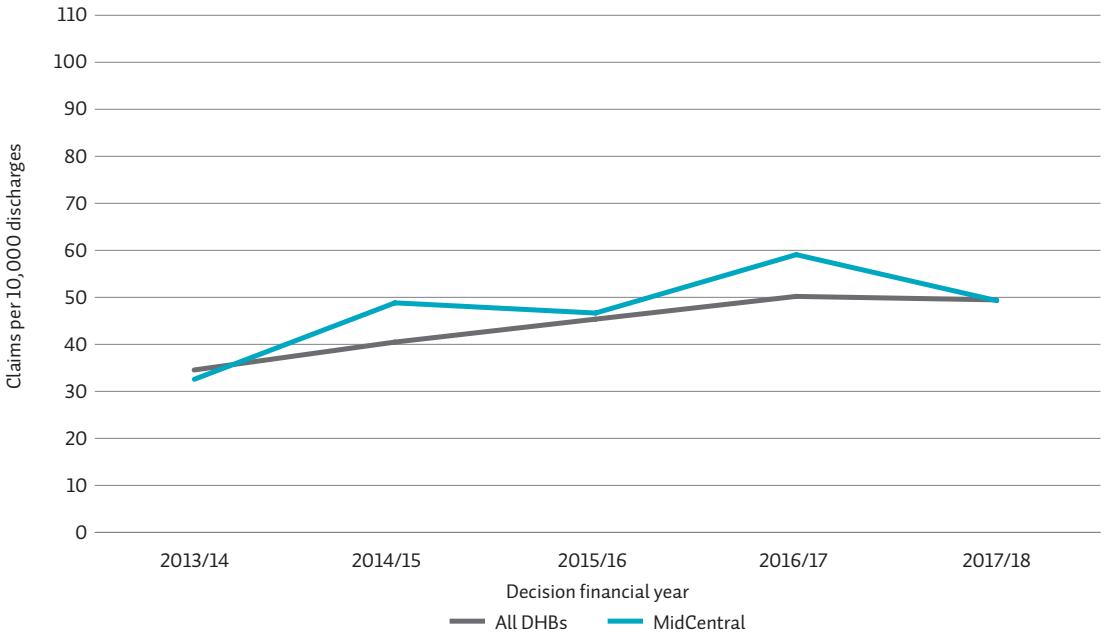
Demographics

- MidCentral's population age profile is broadly similar to the national average but with a slightly higher proportion of older adults.
- MidCentral has more Māori but fewer Pacific and Asian people than the national average.
- MidCentral's population has more people living in more deprived neighbourhoods than the national average.

Major facilities

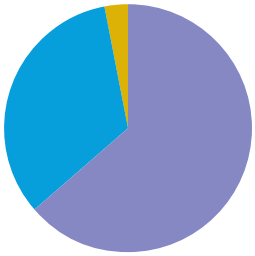
- Palmerston North Hospital.
- The DHB is part of the centralAlliance which is a collaborative agreement between Whanganui and MidCentral DHBs that capitalises on their combined strength to achieve health gains and improve clinical viability for their combined populations.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$1,581,977
Serious injury	$825,394
All other	$75,828

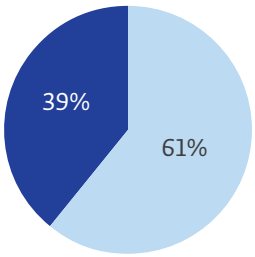


Total $2,483,199

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	9.51	15.99	19.33	24.93	15.38
	Number	36	61	78	98	60
Infections following surgery	Rate	7.93	15.47	15.61	22.89	13.33
	Number	30	59	63	90	52
Line infections	Rate	1.32	–	1.49	1.53	1.03
	Number	5	<4	6	6	4
Pressure injuries	Rate	3.17	3.41	3.72	4.83	4.61
	Number	12	13	15	19	18
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	3.17	3.15	3.72	2.29	2.05
	Number	12	12	15	9	8

Nelson Marlborough DHB

People	Accepted claims 2017/18	Active claims 2017/18
150,600	237	492

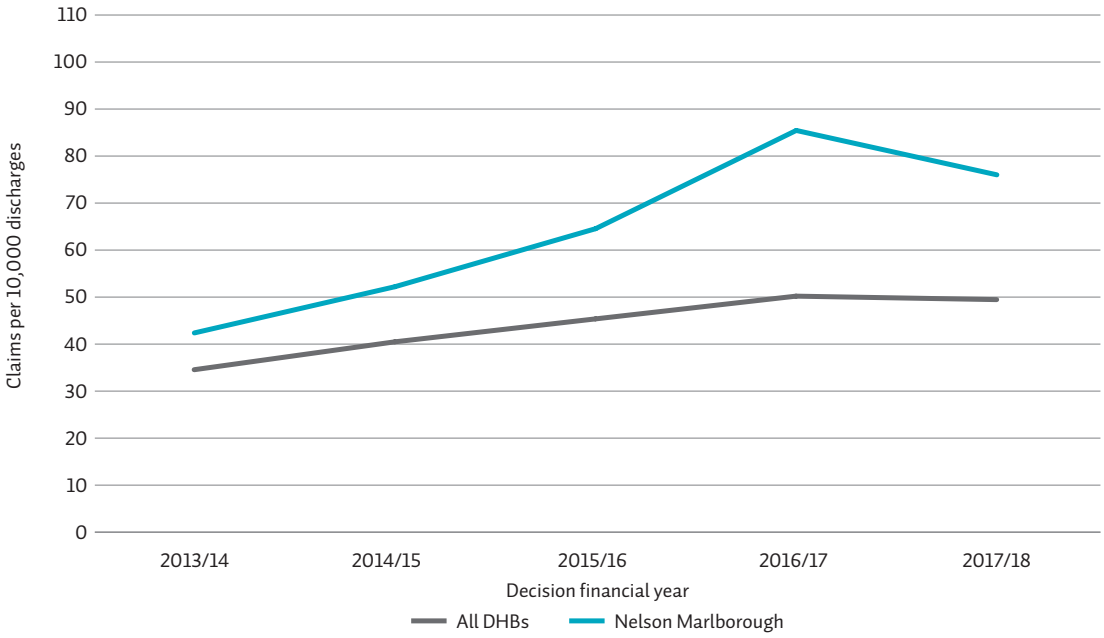
Demographics

- Nelson Marlborough's population tends to be older than the national average.
- Nelson Marlborough has significantly fewer Māori and Pacific people than the national average.
- Nelson Marlborough's deprivation levels are lower than the national average.

Major facilities

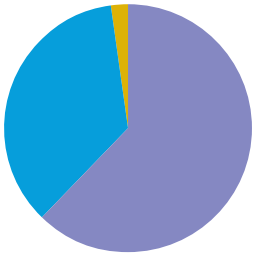
- **Alexandra Hospital** offers mental health services for older people and those with dementia.
- **Murchison Community Hospital** is a rural facility.
- Nelson Hospital.
- Wairau Hospital.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$2,234,792
Serious injury	$1,281,889
All other	$71,158

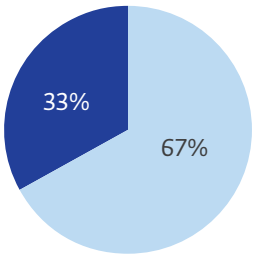


Total $3,587,840

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	10.19	18.56	25.03	31.90	25.60
	Number	30	56	77	101	80
Infections following surgery	Rate	8.16	16.24	24.38	29.05	24.64
	Number	24	49	75	92	77
Line infections	Rate	1.70	1.99	–	1.26	–
	Number	5	6	<4	4	<4
Pressure injuries	Rate	2.38	–	1.63	4.42	2.88
	Number	7	<4	5	14	9
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	2.72	3.31	3.25	4.11	2.24
	Number	8	10	10	13	7

Northland DHB

People	Accepted claims 2017/18	Active claims 2017/18
179,100	262	415

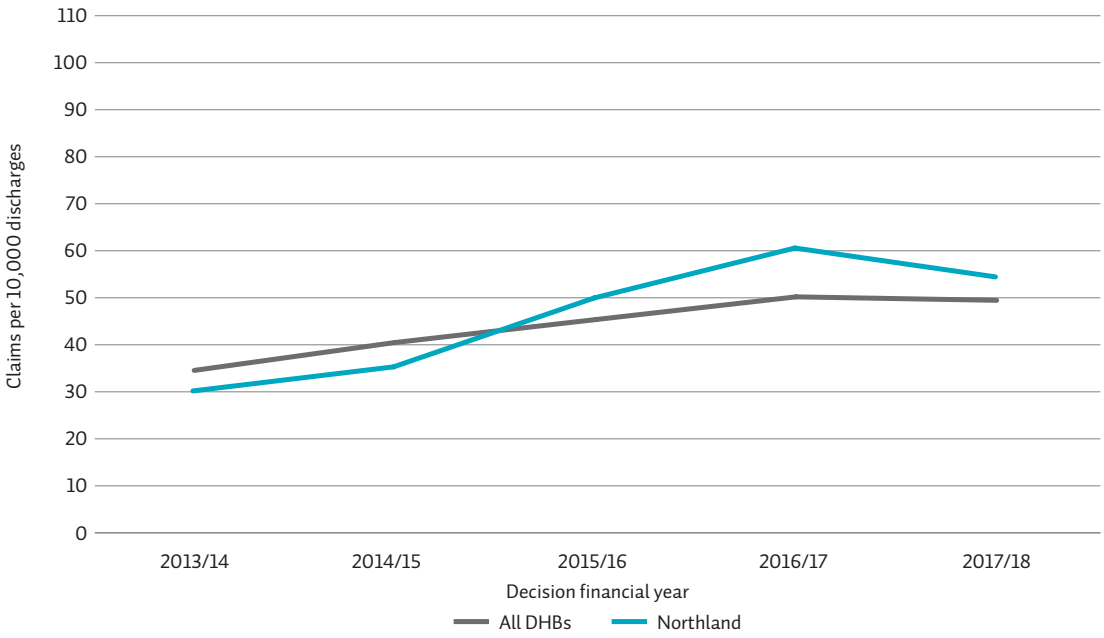
Demographics

- Northland's population tends to be significantly older than the national average.
- Northland has more Māori and fewer Pacific people than the national average.
- Northland's deprivation levels are much higher than the national average.

Major facilities

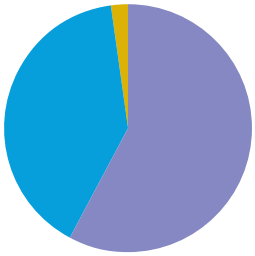
- Bay of Islands Hospital.
- Dargaville Hospital.
- Kaitaia Hospital.
- Whangārei Hospital.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$2,281,814
Serious injury	$1,575,239
All other	$82,799

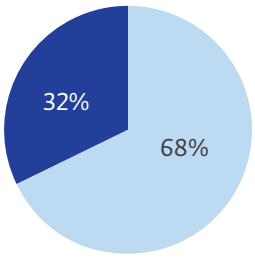


Total $3,939,852

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	8.69	10.63	16.28	20.26	20.57
	Number	36	47	74	95	99
Infections following surgery	Rate	5.79	8.37	14.30	17.49	18.07
	Number	24	37	65	82	87
Line infections	Rate	2.17	1.13	1.54	2.13	1.45
	Number	9	5	7	10	7
Pressure injuries	Rate	1.45	1.58	3.08	4.05	4.78
	Number	6	7	14	19	23
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	1.93	3.39	3.30	3.84	1.66
	Number	8	15	15	18	8

South Canterbury DHB

People	Accepted claims 2017/18	Active claims 2017/18
59,900	123	146

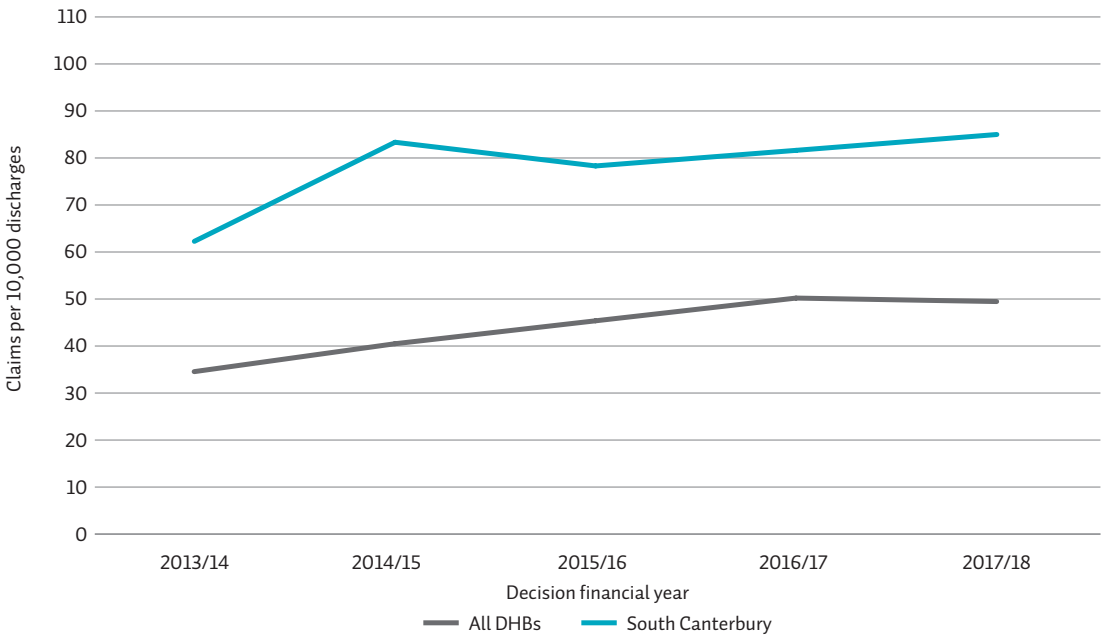
Demographics

- South Canterbury DHB is based in Timaru.
- South Canterbury has the highest percentage of people aged 65 and over, compared with the national average.
- South Canterbury has fewer Māori and Pacific people than the national average.
- South Canterbury's deprivation levels are lower than the national average.

Major facilities

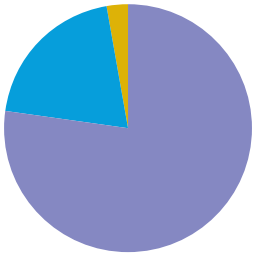
- Timaru Hospital.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$854,228
Serious injury	$219,505
All other	$30,019

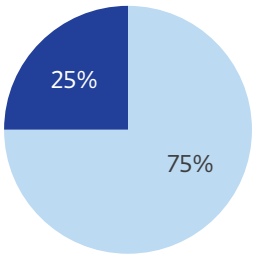


Total $1,103,752

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	15.21	26.30	18.53	22.66	25.59
	Number	20	35	26	33	37
Infections following surgery	Rate	13.69	24.80	13.54	21.97	20.06
	Number	18	33	19	32	29
Line infections	Rate	–	–	3.56	–	4.84
	Number	<4	<4	5	<4	7
Pressure injuries	Rate	12.16	11.27	7.84	8.24	12.45
	Number	16	15	11	12	18
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	–	–	3.56	–	4.15
	Number	<4	<4	5	<4	6

Southern DHB

People	Accepted claims 2017/18	Active claims 2017/18
330,100	311	594

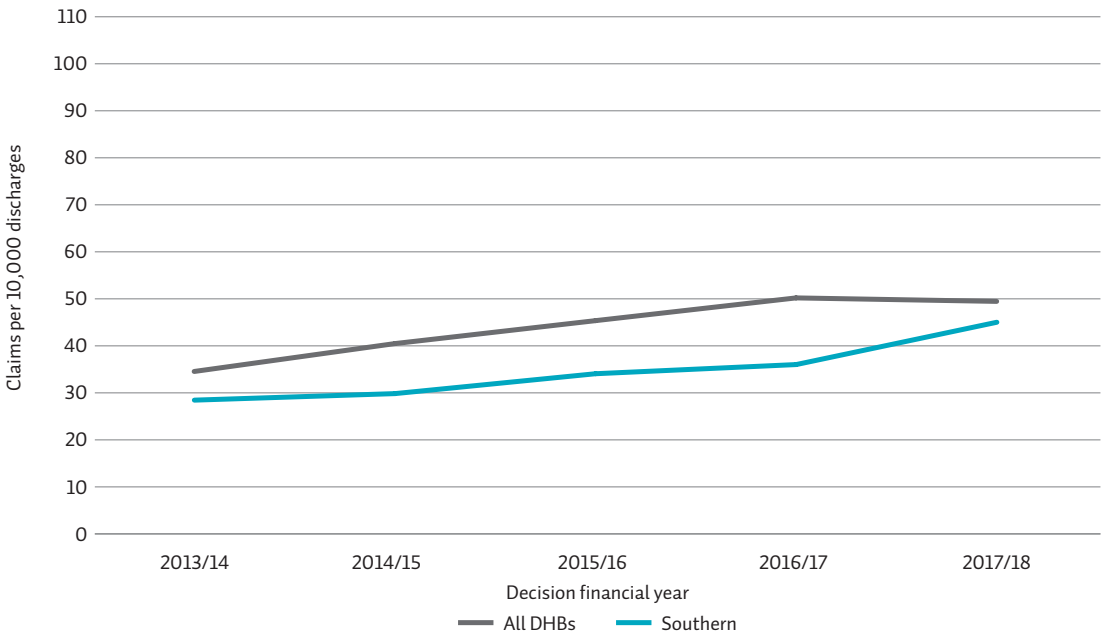
Demographics

- Southern's population tends to be slightly older than the national average.
- Southern has fewer Māori and Pacific people than the national average.
- Southern's deprivation levels are lower than the national average.
- Southern covers the largest geographic area of all DHBs and has a large rural constituency.

Major facilities

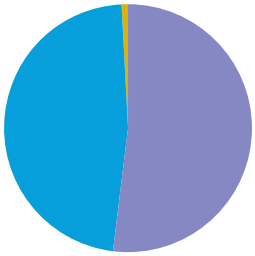
- **Dunedin Hospital** is being redeveloped (a long-term project).
- **Lakes District Hospital.**
- **Southland Hospital.**
- **Wakari Hospital.**
- The region also has **five rural trust hospitals**.
- Southern DHB was formed in 2010 as a result of the merger of Southland and Otago DHBs.
- Southern DHB has a close working relationship with Otago University's School of Medicine.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$4,443,624
Serious injury	$4,040,919
All other	$66,386

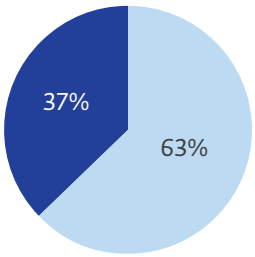


Total $8,550,930

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	4.09	5.61	5.21	6.20	6.21
	Number	27	37	35	42	43
Infections following surgery	Rate	2.88	4.70	4.32	4.87	5.34
	Number	19	31	29	33	37
Line infections	Rate	0.76	0.61	–	0.59	0.58
	Number	5	4	<4	4	4
Pressure injuries	Rate	0.76	0.76	2.23	1.18	3.46
	Number	5	5	15	8	24
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	1.36	2.27	2.38	1.77	3.03
	Number	9	15	16	12	21

Tairāwhiti DHB

People	Accepted claims 2017/18	Active claims 2017/18
49,100	73	118

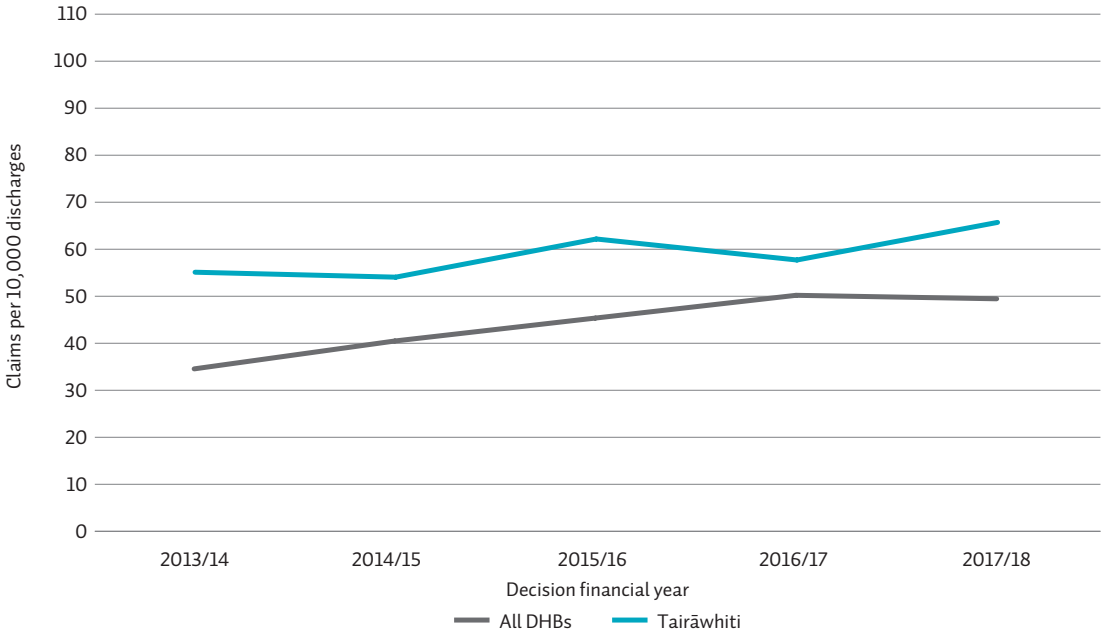
Demographics

- Tairāwhiti's population tends to be much younger than the national average.
- Tairāwhiti has more Māori but fewer Pacific people than the national average.
- Tairāwhiti's deprivation levels are much higher than the national average.

Major facilities

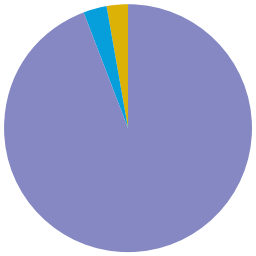
- Gisborne Hospital.
- Te Puia Hospital.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$1,067,281
Serious injury	$35,313
All other	$30,006

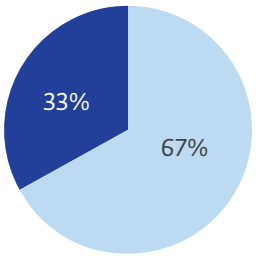


Total $1,132,600

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	23.19	14.22	26.12	22.18	20.69
	Number	24	15	29	25	23
Infections following surgery	Rate	21.26	13.27	24.32	22.18	18.90
	Number	22	14	27	25	21
Line infections	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Pressure injuries	Rate	–	5.69	–	–	–
	Number	<4	6	<4	<4	<4
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	–	–	–	–	5.40
	Number	<4	<4	<4	<4	6

Taranaki DHB

People	Accepted claims 2017/18	Active claims 2017/18
119,800	230	358

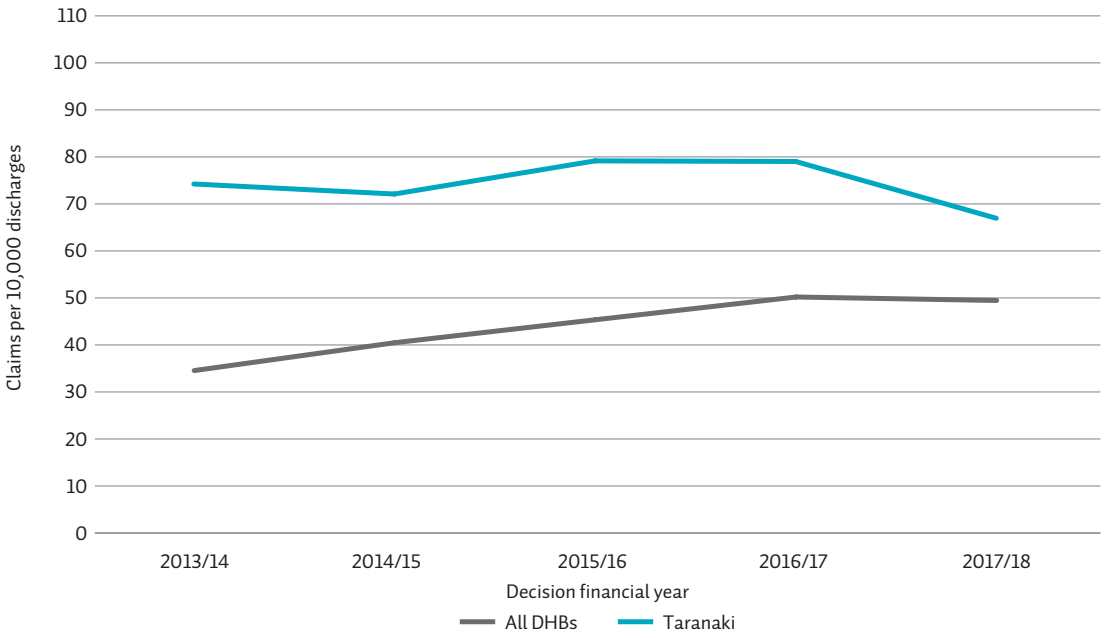
Demographics

- Taranaki's population tends to be older than the national average.
- Taranaki has a slightly more Māori than the national average, and significantly fewer Pacific people than the national average.
- Taranaki's deprivation levels are slightly higher than the national average.

Major facilities

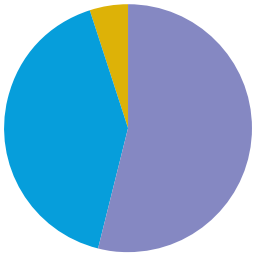
- Hawera Hospital.
- Taranaki Base Hospital.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement $1,398,983
Serious injury $1,061,006
All other $124,324

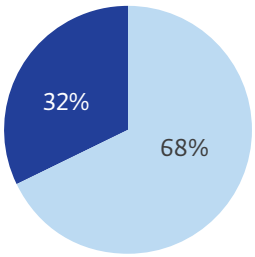


Total $2,584,313

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	38.98	32.35	37.33	30.90	28.85
	Number	107	95	114	100	99
Infections following surgery	Rate	33.52	29.29	34.38	28.43	23.61
	Number	92	86	105	92	81
Line infections	Rate	4.37	2.04	2.62	–	2.91
	Number	12	6	8	<4	10
Pressure injuries	Rate	4.01	2.72	3.27	4.02	3.50
	Number	11	8	10	13	12
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	2.19	3.06	4.91	8.03	6.41
	Number	6	9	15	26	22

Waikato DHB

People	Accepted claims 2017/18	Active claims 2017/18
416,400	620	1,229

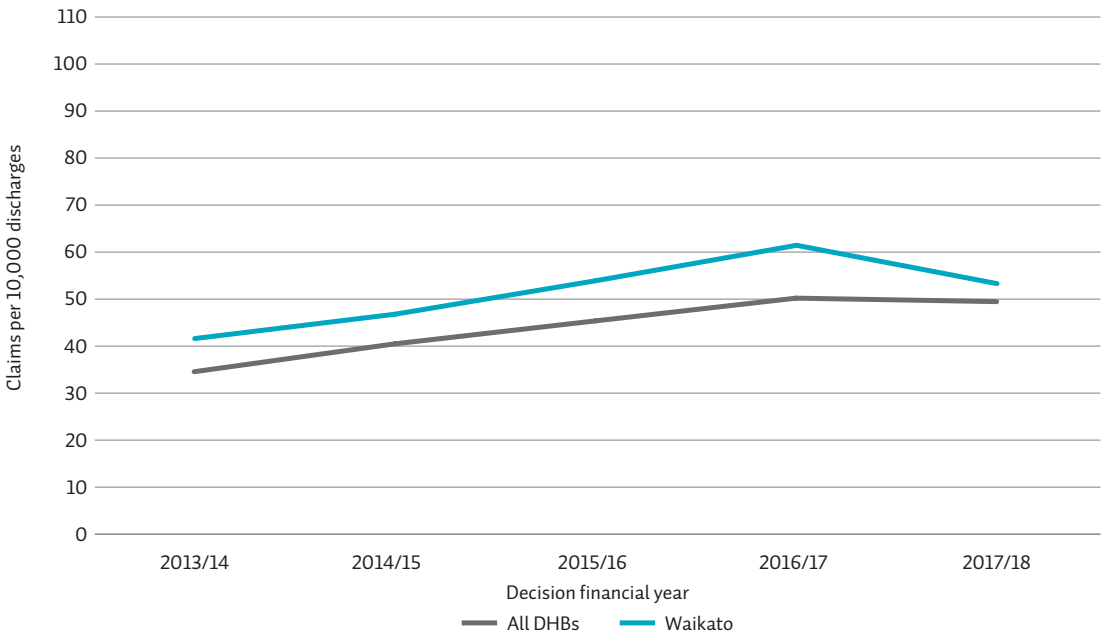
Demographics

- Waikato's population age profile tends to be similar to the national average.
- Waikato has more Māori and fewer Pacific people than the national average.
- Waikato's deprivation levels are slightly higher than the national average.

Major facilities

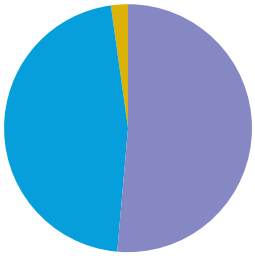
- Thames Hospital.
- Waikato Hospital.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement $6,500,785
Serious injury $5,823,174
All other $276,923

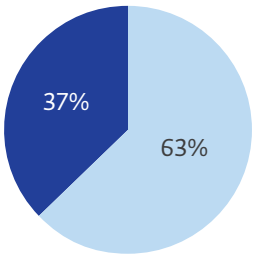


Total $12,600,882

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	11.71	13.74	16.03	18.98	18.27
	Number	117	144	172	213	210
Infections following surgery	Rate	9.61	12.50	13.89	17.64	17.14
	Number	96	131	149	198	197
Line infections	Rate	1.40	0.76	0.93	0.62	0.61
	Number	14	8	10	7	7
Pressure injuries	Rate	2.70	2.29	2.61	2.41	1.65
	Number	27	24	28	27	19
Medication errors	Rate	–	0.38	0.47	–	–
	Number	<4	4	5	<4	<4
Medication adverse reactions	Rate	2.90	1.81	2.24	2.94	2.87
	Number	29	19	24	33	33

Wairarapa DHB

People	Accepted claims 2017/18	Active claims 2017/18
45,400	85	131

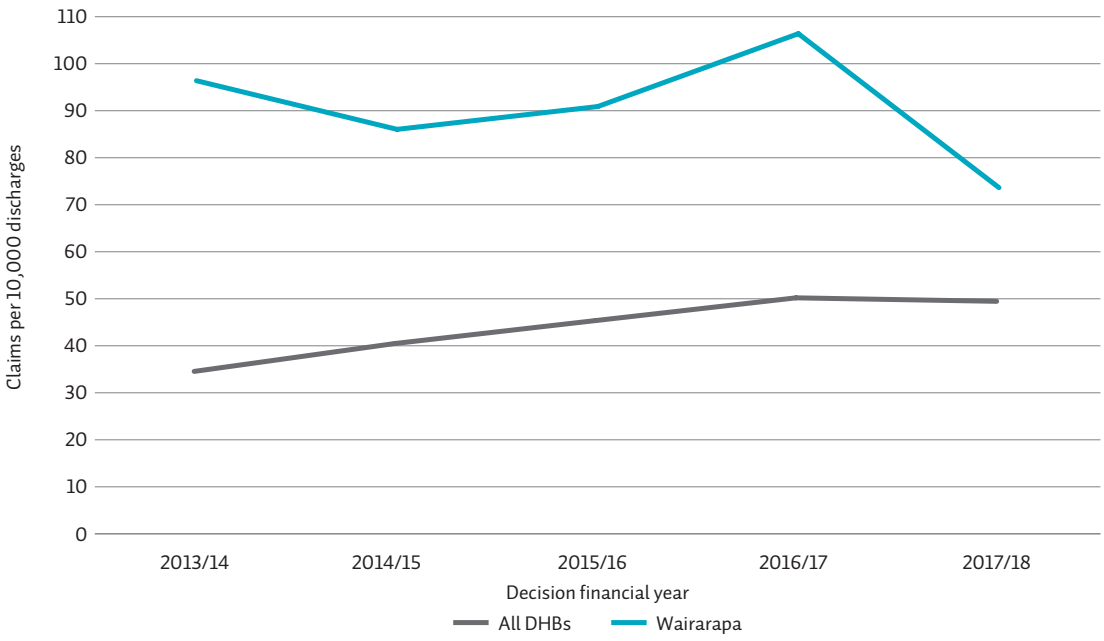
Demographics

- Wairarapa's population is older than the national average.
- Wairarapa has a similar number of Māori and much fewer Pacific people than the national average.
- Wairarapa's deprivation levels are slightly higher than the national average.

Major facilities

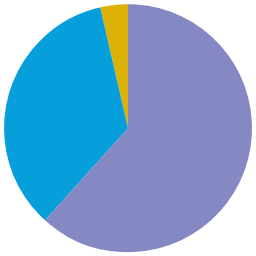
- Wairarapa Hospital.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$366,051
Serious injury	$205,398
All other	$20,234

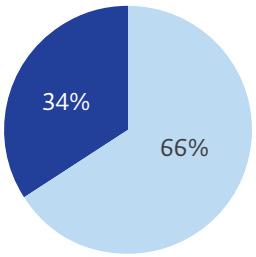


Total $591,683

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	46.61	29.75	20.08	24.18	16.46
	Number	44	28	19	25	19
Infections following surgery	Rate	41.31	26.56	19.03	18.38	12.13
	Number	39	25	18	19	14
Line infections	Rate	–	–	–	4.84	–
	Number	<4	<4	<4	5	<4
Pressure injuries	Rate	5.30	–	–	10.64	4.33
	Number	5	<4	<4	11	5
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	4.24	4.25	8.46	6.77	3.47
	Number	4	4	8	7	4

Waitematā DHB

People	Accepted claims 2017/18	Active claims 2017/18
620,300	521	677

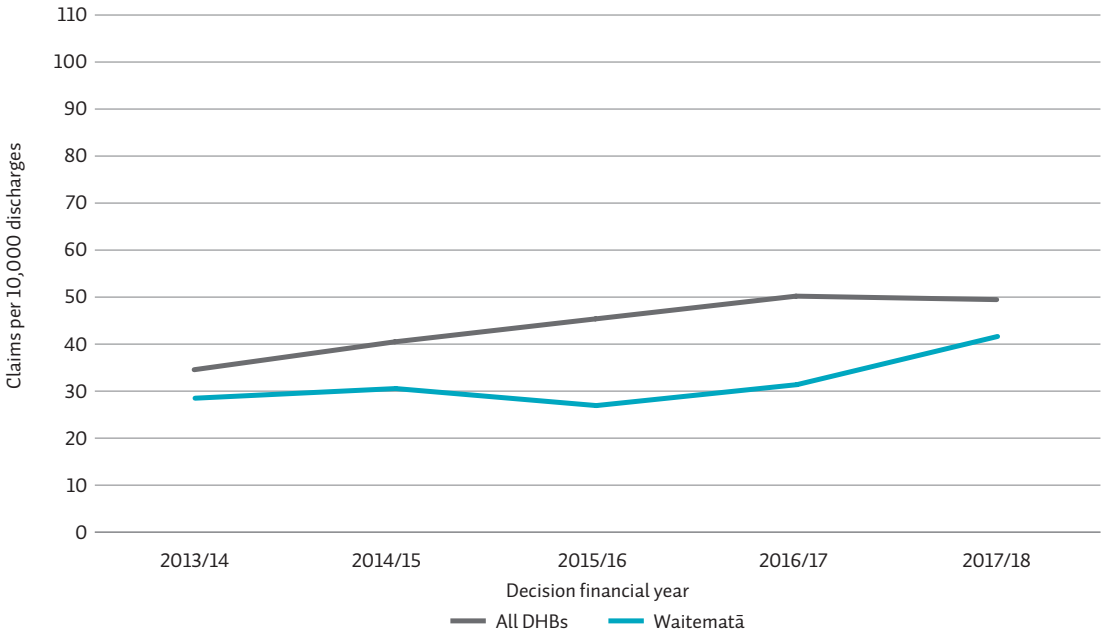
Demographics

- Waitematā DHB is the largest DHB by population.
- Waitematā has fewer Māori and a similar number of Pacific people when compared with the national average.
- Waitematā's deprivation levels are lower than the national average.

Major facilities

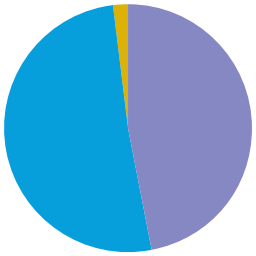
- North Shore Hospital.
- Waitakere Hospital.
- DHB services include the Regional Forensic Psychiatric Services (the Mason Clinic) and a child rehabilitation service (the Wilson Centre).

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement $2,984,490
Serious injury $3,238,601
All other $113,217

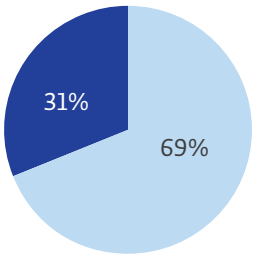


Total $6,336,308

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	8.42	11.13	7.52	8.54	11.94
	Number	95	130	91	108	150
Infections following surgery	Rate	7.00	9.76	6.78	7.43	10.11
	Number	79	114	82	94	127
Line infections	Rate	0.97	1.20	0.58	0.55	1.03
	Number	11	14	7	7	13
Pressure injuries	Rate	0.53	0.77	1.07	0.95	4.22
	Number	6	9	13	12	53
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	1.68	1.46	1.32	1.82	1.99
	Number	19	17	16	23	25

West Coast DHB

People	Accepted claims 2017/18	Active claims 2017/18
32,600	38	73

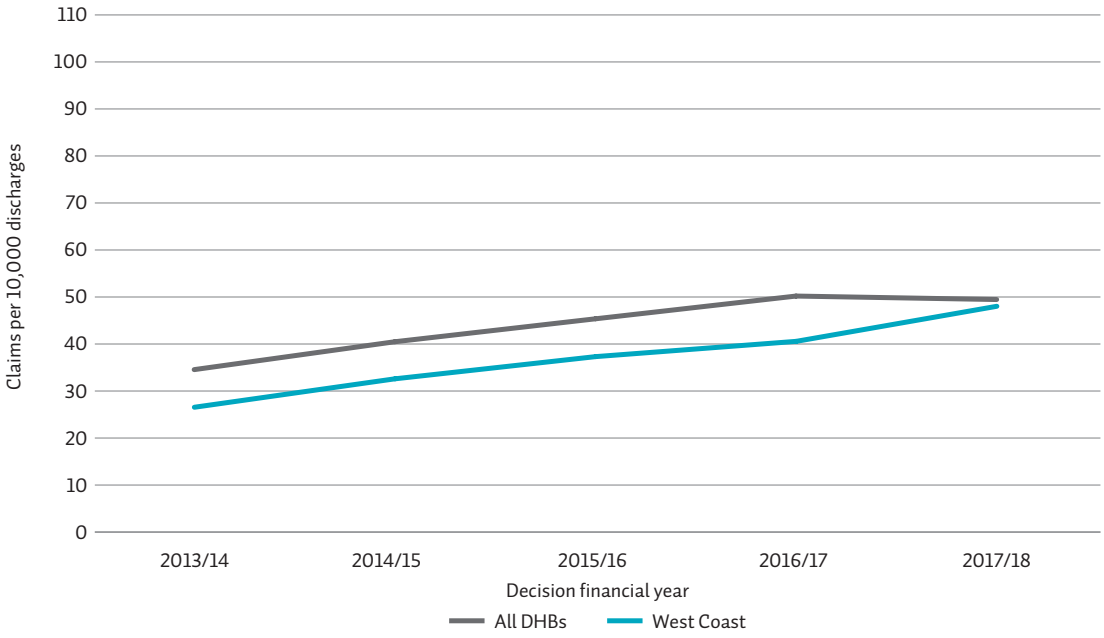
Demographics

- West Coast's population tends to be older than the national average.
- West Coast has fewer Māori and Pacific people than the national average.
- West Coast's deprivation levels are higher than the national average.
- West Coast DHB is the least populated DHB in the country due to the small number of people living in a large, dispersed region.

Major facilities

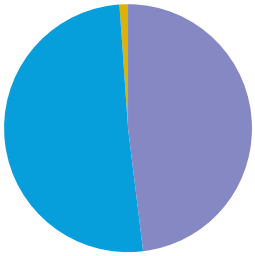
- Grey Base Hospital.
- The Government is funding a new hospital and integrated family health centre in Greymouth to service the West Coast community. The new Grey Base Hospital and Integrated Family Health Centre is due to open later in 2019.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$651,670
Serious injury	$692,204
All other	$11,761

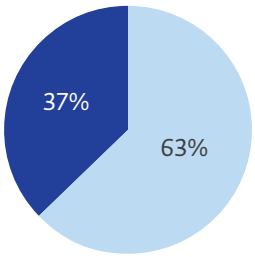


Total $1,355,635

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	–	–	6.66	8.38	7.58
	Number	<4	<4	5	6	6
Infections following surgery	Rate	–	–	–	8.38	6.31
	Number	<4	<4	<4	6	5
Line infections	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Pressure injuries	Rate	–	–	5.32	5.59	15.15
	Number	<4	<4	4	4	12
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4

Whanganui DHB

People	Accepted claims 2017/18	Active claims 2017/18
64,900	142	240

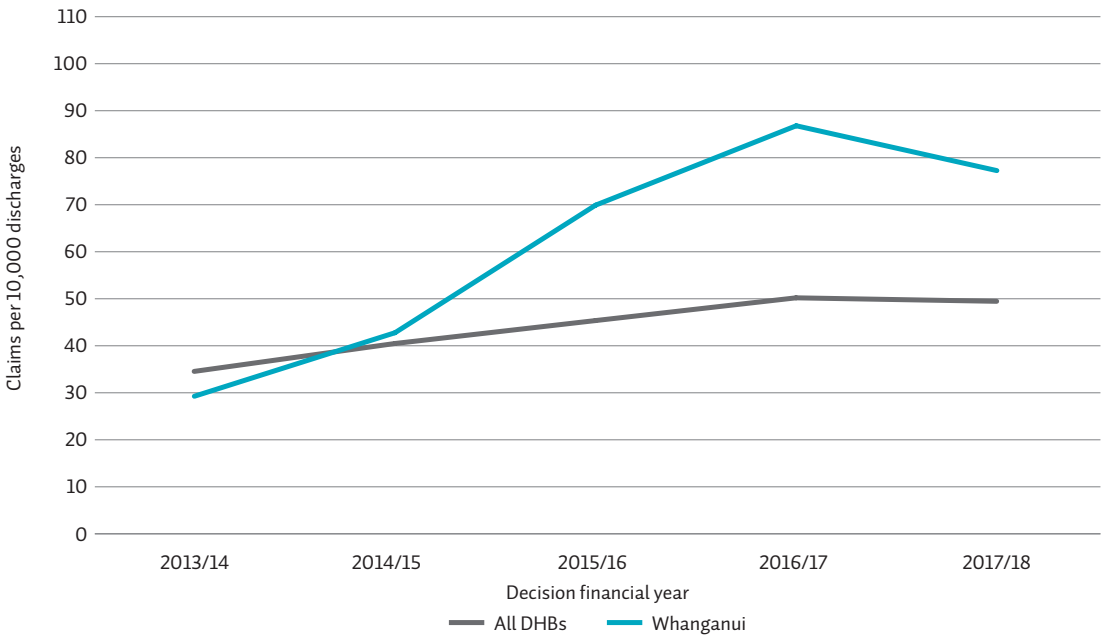
Demographics

- Whanganui's population tends to be significantly older than the national average.
- Whanganui has more Māori but fewer Pacific people than the national average.
- Whanganui's deprivation levels are much higher than the national average.

Major facilities

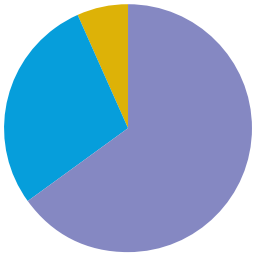
- Whanganui Hospital.
- The DHB is part of the centralAlliance which is a collaborative agreement between Whanganui and MidCentral DHBs that capitalises on their combined strength to achieve health gains and improve clinical viability for their combined populations.

Rate per 10,000 discharges for accepted claims



Costs paid in 2017/18 for all active claims

Entitlement	$922,161
Serious injury	$398,816
All other	$92,994

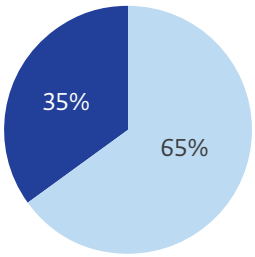


Total $1,413,970

Accepted and declined claims for 2017/18

Claims declined Claims accepted

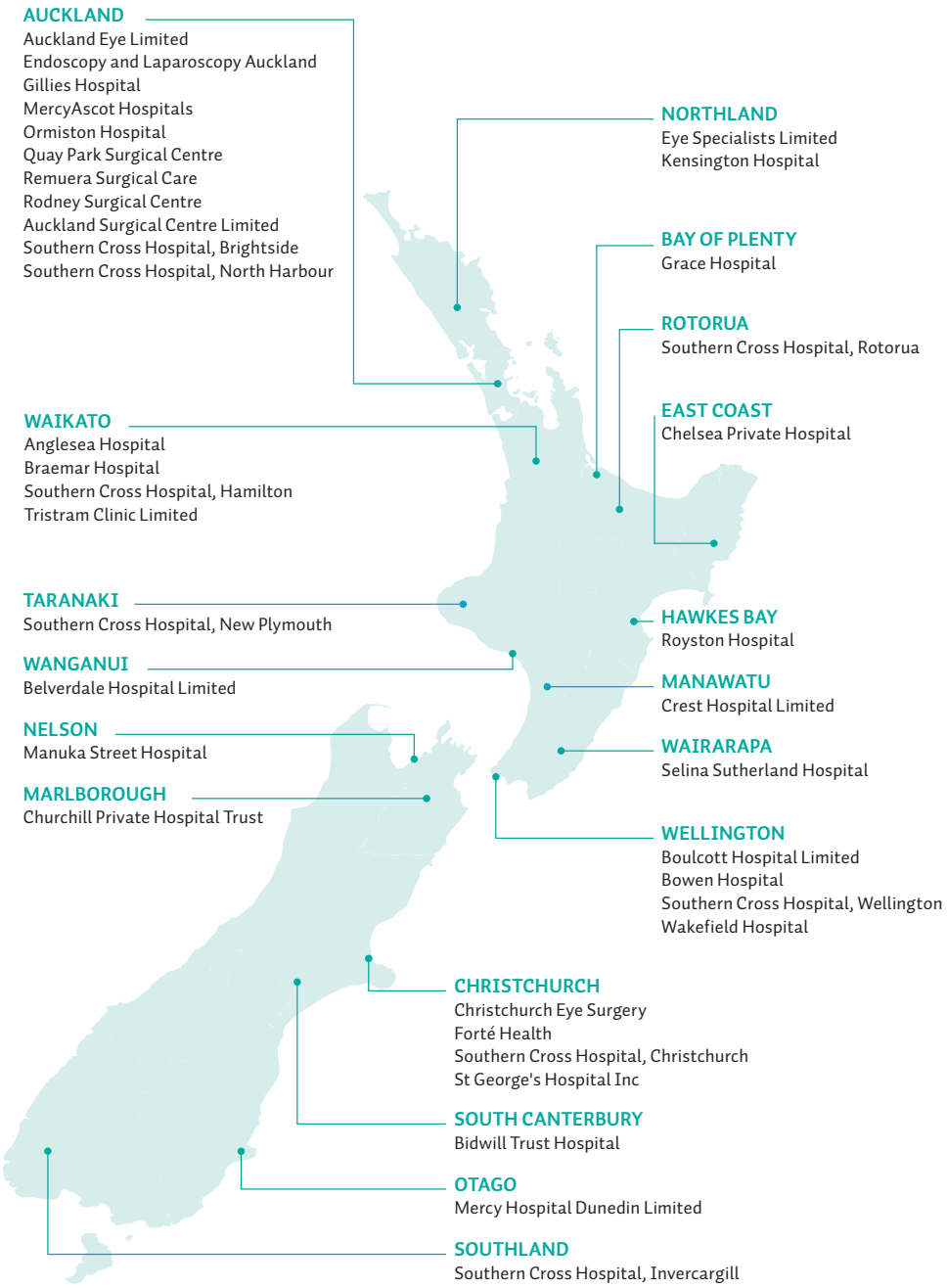
Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		Decision financial year				
		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	6.34	17.79	33.75	51.57	36.41
	Number	10	30	58	91	67
Infections following surgery	Rate	5.07	15.41	31.42	50.44	34.78
	Number	8	26	54	89	64
Line infections	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Pressure injuries	Rate	–	2.96	6.40	5.67	4.35
	Number	<4	5	11	10	8
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Medication adverse reactions	Rate	3.80	2.37	–	–	2.17
	Number	6	4	<4	<4	4

NZPSHA members

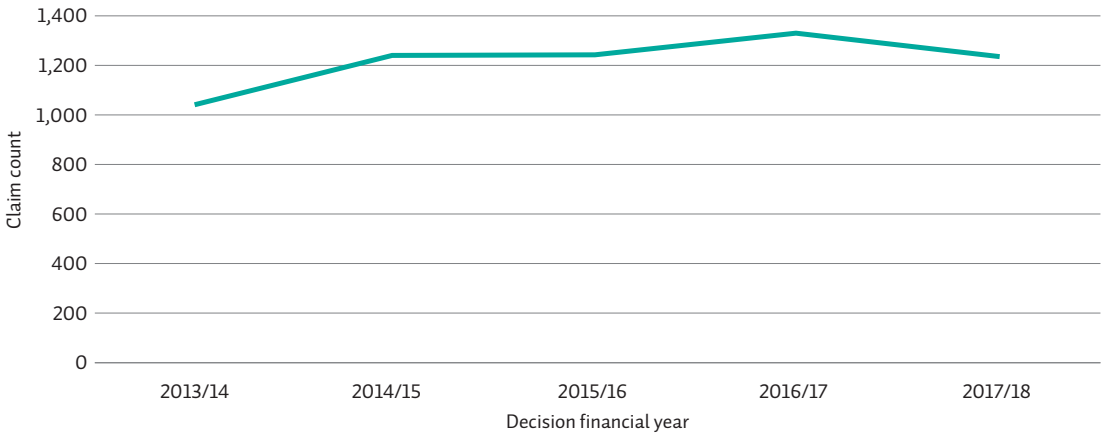


NZPSHA members

Discharges	Accepted claims 2017/18	Active claims 2017/18
179,925	1,236	2,563

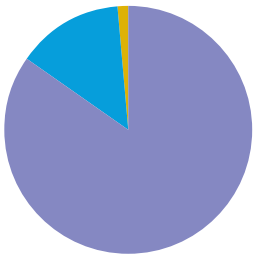
Surgical beds	Surgical facilities
1,710	38

Accepted claims



Costs paid in 2017/18 for active claims

- Entitlement $21,028,982
- Serious injury $3,491,309
- All other $293,598

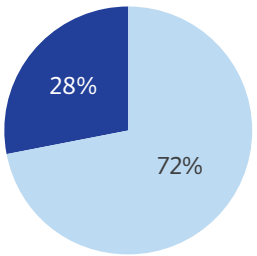


Total $24,813,888

Accepted and declined treatment injury claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 10,000 discharges

		2013/14	2014/15	2015/16	2016/17	2017/18
Infections of all types	Rate	–	–	–	–	16.01
	Number	182	229	269	291	288
Infections following surgery	Rate	–	–	–	–	15.56
	Number	175	221	261	283	280
Line infections	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Pressure injuries	Rate	–	–	–	–	0.39
	Number	<4	<4	4	9	7
Medication errors	Rate	–	–	–	–	–
	Number	<4	<4	<4	<4	<4
Pulmonary embolism	Rate	–	–	–	–	0.39
	Number	9	8	6	9	7
Medication adverse reactions	Rate	–	–	–	–	0.67
	Number	19	30	19	23	12
Deep vein thrombosis	Rate	–	–	–	–	0.94
	Number	18	13	12	19	17

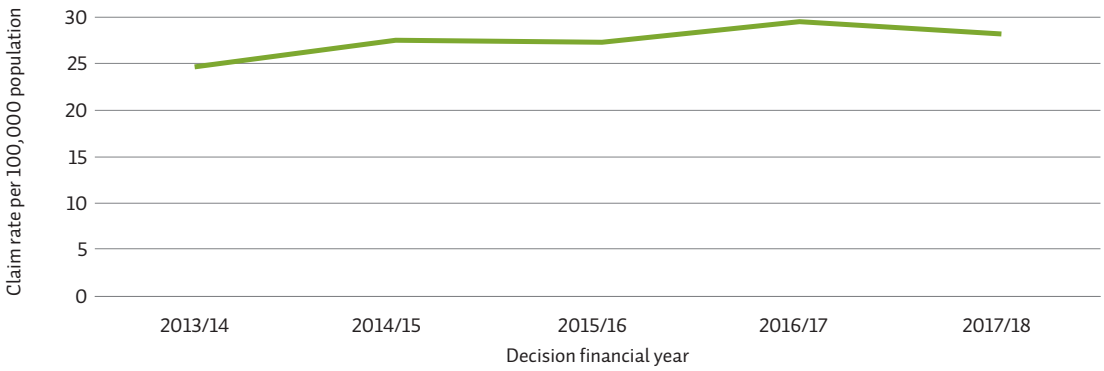
General practice settings

People	Accepted claims 2017/18	Active claims 2017/18
4,885,300	1,384	1,800

General practice plays a central role in the delivery of health care to the New Zealand community. A wide range of services is provided in general practice settings including diagnosis and treatment, health education, counselling, disease prevention and screening. The information in this publication relates to treatment in general practice settings, which includes GPs, practice nurses and other health professionals working in the practice.

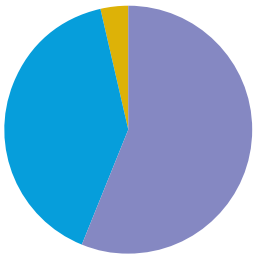
Of the nearly 16,000 registered doctors practising in New Zealand, more than 4,300 doctors work in a general practice setting – see Medical Council workforce survey data at ***www.mcnz.org.nz/news-and-publications/workforce-statistics/***

Rate per 100,000 population for all accepted claims



Costs paid in 2017/18 for active claims

Entitlement	$5,913,696
Serious injury	$4,246,306
All other	$359,273

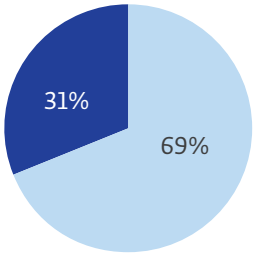


Total $10,519,274

Accepted and declined claims for 2017/18

Claims declined Claims accepted

Each declined claim may result in mismatched expectations. This underpins the need to understand how and why treatment injury claims are accepted or declined.



Numbers of accepted claims and rates per 100,000 population

		2013/14	2014/15	2015/16	2016/17	2017/18
Infection following minor surgery	Number	172	221	270	280	345
	Rate	3.81	4.81	5.75	5.84	7.06
Treatment omission	Number	24	40	49	41	30
	Rate	0.53	0.87	1.04	0.86	0.61
Medication adverse reactions	Number	642	723	636	709	648
	Rate	14.24	15.73	13.55	14.79	13.26

Appendices

Data sources

ACC's treatment injury claims information is based on data collected via the ACC45 and ACC2152 forms. An ACC45 Injury Claim Form is completed by all clients in order to lodge a claim with ACC, often with the assistance of a treatment provider. For a treatment injury claim, a treatment provider also completes an ACC2152 form, to provide clinical information to support the claim.

The published information is based on data from treatment injury related claims. The majority of information in this publication is from treatment injury claims. A small number of treatment injury claims are the result of consequential injuries that result from treatment for an injury that is already covered by another ACC claim. These consequential injuries have been included in the data used for this analysis as they are treatment injuries that are relevant to patient safety.

The treatment injury claims data used in this publication reflects the information held as at February 2019 – for claims lodged and decided between 1 July 2005 to 30 June 2018. All ACC claims data (including treatment injury claims data) is subject to revisions over time. The claim numbers may change as a result of the review or appeal of an ACC decision.

Statistics New Zealand

Population data was sourced from Statistics New Zealand to calculate injury rate for the national summaries as well as for general practice settings.

Ministry of Health

Hospital discharge data was sourced from the MoH NMDS to calculate treatment injury claims rates for DHBs per 10,000 patients discharged.

New Zealand Private Surgical Hospitals Association

Discharge data was provided by the New Zealand Private Surgical Hospitals Association to calculate treatment injury claim rate per 10,000 discharges.

Data assurance

ACC analysts have reviewed the treatment injury data against the original claims information to ensure the data captured accurately reflects the information submitted.

A panel of ACC experts from operational, clinical and analytical backgrounds provided decision-support to develop the inclusion and exclusion definitions used to assemble the data by injury type. The NZPSHA information was presented in draft to the Association for their review. The GP settings information was presented to the New Zealand College of GPs and Best Practice Advocacy Centre New Zealand (BPAC) for feedback on how the GP information has been presented.

ACC history and legislation

ACC has provided comprehensive, no-fault cover for people injured in accidents since 1974.

The right to take legal action for personal injury covered by ACC is removed other than for exemplary damages.

Levies from workers, employers, vehicle registrations, motor fuel, and taxpayers are collected to support the recovery of people with injuries. These monies are then managed to fund the current and future needs of people with long-term injuries.

ACC assistance is available to all New Zealand residents and temporary visitors. New Zealanders who are ordinarily residents may also be covered if they are injured while overseas, with assistance available on their return to New Zealand.

New Zealand residents who suffer an injury from medical treatment overseas may be covered, although restrictions apply.

Once a claim is accepted by ACC, an injured person may have access to a range of entitlements from treatment and rehabilitation aids, to weekly compensation and lump sum compensation – depending on the injury and the person's circumstances.

ACC's primary function is injury prevention (refer to Section 3, AC Act 2001). This is to be achieved with interventions and approaches that reduce the incidence and severity of personal injury (see Section 263, AC Act). Invoking the injury prevention provisions of the AC Act to support patient safety is a new approach for ACC.

Change to treatment injury

Law changes since the Scheme's introduction have also seen the criteria for cover evolve. The Accident Compensation Act 1974 added 'medical, surgical, dental, or first-aid misadventure' as a category of personal injury by accident.

Between 1992 and 2005, cover was available for medical misadventure. The Accident Rehabilitation and Compensation Insurance Act 1992 included specific categories of medical misadventure, namely 'medical error' and 'medical mishap' – injuries that were both a rare and severe outcome from properly given treatment. If there was an issue of medical error, the claim was considered by a Medical Misadventure Advisory Committee.

Changes in 2005 reduced the need to find fault as the cause of an injury, but finding that a health professional could and should have taken an alternative treatment pathway is still one of several 'causes' of a treatment injury.

Treatment Injury (Section 32, AC Act) is a personal injury that is caused by treatment from a registered health professional, and that is not a necessary part or ordinary consequence of that treatment, taking into account the underlying health condition of the patient and clinical knowledge at that time.

Treatment Injury claims

If an individual suffers a treatment injury, they need to see a health professional as soon as possible after the injury appears to avoid delays in getting a decision and assistance.

Medical treatment can be complex, and sometimes the desired outcome is not always achieved. Not all outcomes of treatment are covered by ACC. Actual entitlement will depend on the individual's circumstances, the nature of the injury and the impact of the injury.

If a claim is accepted, ACC may be able to help with the cost of treatment and other assistance, such as rehabilitation or weekly compensation. Only a registered doctor or a nurse practitioner can certify work incapacity.

More information on the claims process is available from the ACC website:
www.acc.co.nz/assets/provider/acc2152- treatment-injury-claim.doc

What is the 'accident' for treatment injury claims?

A treatment injury is a personal injury caused by treatment from a registered health professional – but some exclusions apply. The 'accident' event is treatment by, or at the direction of, a registered health professional. The definition of treatment is broad and includes diagnosis, treatment decisions, as well as omission or failure to provide treatment. In some cases, the cause of the injury will be defined as inappropriate treatment in the circumstances. Examples of treatment injuries range from a deep tissue infection at the site of an injection to operating on the wrong limb.

Exclusions from treatment injury

The AC Act (2001) defines what cannot be accepted as a Treatment Injury. An underlying disease and other pre-existing diseases are not covered – although a significant worsening of disease caused by treatment might be covered.

Also excluded are:

- a necessary part of the treatment (for example, a skin puncture or surgical incision or the removal of a body part when those are a necessary part of the treatment required)
- the ordinary consequences of treatment (for example, hair loss following chemotherapy or radiotherapy burns are unlikely to be covered)
- injury caused solely by decisions about allocating health resources (such as waiting list delays for joint replacement surgery)
- injury caused because a patient unreasonably delayed or refused to give consent for treatment
- treatment that does not achieve the desired result.

Where a failure or omission has caused the injury, the exclusions of necessary part or ordinary consequence do not apply.

Glossary

Important terminology used in this publication

Accepted ACC treatment injury claim	A personal injury that has been clinically investigated and that meets the criteria under Section 32 of the Accident Compensation Act 2001 (AC Act).
Accepted claims	A claim for ACC cover that has been accepted. Most of the information provided in this publication is based on accepted claims. The number of claims accepted is subject to small changes over time, because claims lodged in a specific year but not accepted until a later year are included in the updated dataset. Numbers can also change following a review or an appeal of an ACC decision.
Accident Compensation Act 2001	The major piece of legislation under which ACC is governed.
Active claim	A claim that is open and has received a payment in that financial year. The claim could be a new claim accepted during that year or an existing claim.
Age groups	This relates to the age of the injured person as at the date of injury.
Calendar year	The period from 1 January to 31 December.
Consequential claims	A consequential treatment injury is an injury that occurs during treatment for an already covered personal injury. Treatment related claims information might include consequential claims funded outside the treatment injury account. For instance, a claim for an injury sustained when receiving treatment for an initial injury from a motor vehicle accident will be funded through the motor vehicle account.
Cost per active claim	Average cost per active claim.
Costs paid	Costs paid for active treatment injury claims in a given year are likely to be an underestimate. This is because some treatment, in particular, accident and emergency treatment in the first 24 hours after admission, is funded through the Public Health Acute Services (PHAS) agreement between ACC and the Ministry of Health (MoH). These costs are not included in the calculation of costs for an accepted ACC claim. Claim costs fall under three broad categories: 1. Compensation: weekly compensation for lost earnings, lump sums, and death benefits. 2. Treatment: initial hospital treatment and ongoing primary and secondary treatment. 3. Rehabilitation support: physical rehabilitation and various forms of personal support.
Date of injury	The date the person first sought or received treatment for the personal injury caused by treatment.

Decision financial year	Treatment injury claims that had a cover decision made during 1 July to 30 June.
Discharge	The number of patients discharged from a hospital. Numbers for public hospital discharges are from the Ministry of Health (MoH) National Minimum Dataset (NMDS). New Zealand Private Surgical Hospital Association (NZPSHA) provides the numbers of private surgical discharges.
Entitlement	ACC's contribution to the costs of rehabilitation and treatment, and its provision of financial support to the injured person once ACC has accepted that person's claim. The contribution provided depends on the injury and circumstances of the injured person. An entitlement claim includes: • rehabilitation and treatment (including pharmaceuticals, x-rays, elective surgery), home-based care, and consumables • support with transport, housing modifications, and equipment • services aimed at restoring health and independence • compensation for lost earnings as a result of the injury • death benefits such as funeral grants and payments to dependents • an independence allowance for injuries that occurred before 1 April 2002 • lump sum compensation for injuries that occurred on or after 1 April 2002.
Fatal claim	A claim for ACC to provide financial support to the family of the deceased when someone dies from a treatment injury. If a claim is accepted, two examples of financial support are contributions to the funeral costs and financial assistance to dependents.
Financial year	The period from 1 July to 30 June.
Health practitioner registration authorities	Authorities established under the Health Practitioners Competency Assurance Act 2003 for each health profession to: • set standards • prescribe scopes of practice • promote education and training.
Infection	This includes a range of injuries such as abscesses, cellulitis, endocarditis, osteomyelitis, septicaemia, wound infections, arterial or venous line infections, and post-surgical infections.
Injury caused by accident	Cover is provided for 'personal injury' that is caused by: • an accident • a work-related gradual process, disease or infection • treatment that was provided by a registered health professional (treatment injury).

Long-term costs (Outstanding Claims Liability)	Some injuries result in the injured person requiring long-term or lifetime support from ACC. ACC needs to estimate the total of those costs and put money aside for those people. The amount needed is determined by analysis of the types and numbers of injuries – as well as the expected support needed.
Mental injury	Cover is also available for mental injuries that result from a physical injury, including treatment injuries. A mental injury is a clinically significant behavioural, cognitive or psychological dysfunction. It does not include emotional effects such as hurt feelings, stress or loss of enjoyment.
Neonatal Encephalopathy (NE)	A syndrome of disturbed neurological function in a newborn. Features of NE include difficulty with breathing, reduced muscular tone and reflexes, reduced consciousness and often seizures. When NE is due to a period of reduced oxygen supply during birth, the term Hypoxic Ischemic Encephalopathy (HIE) is used. Other reasons why a baby may have signs and symptoms of NE include metabolic abnormalities, medication, infection or bleeding within and around the brain.
New Zealand Private Surgical Hospitals Association (NZPSHA)	Representative association for private surgical hospitals within New Zealand.
Numbers of claims lodged	Numbers of claims lodged are influenced by factors such as the health status of the population and rates of contact with treatment services, the facilities available (for example, tertiary versus secondary level hospitals) and the familiarity of health providers with the process of making a treatment injury claim. Once a claim is lodged it will be assessed, then accepted or declined. The figures reported will differ from previously released data due to changes in underlying data as new information becomes available and claims are updated.
Treatment omission	Failure to diagnose, to follow-up, to provide treatment, to refer, to monitor, and to provide the right treatment.
Patient harm	Anything that impairs or adversely affects the safety of patients in clinical care, drug therapy, research investigations, or public health.
Patient safety	Prevention of errors and adverse effects to patients associated with health care.
Payment financial year	Financial year in which a payment was made.
Personal injury	Defined in the Accident Compensation Act as: • death • physical injury • damage to dentures or prostheses that replace a part of the human body. With limited exceptions, Work Related Gradual Process, Disease, or Infection, wear and tear or injuries due to the ageing process are not covered by ACC.

Pressure injury	A localised injury to the skin and/or underlying tissue (usually over a bony prominence) as a result of pressure, or pressure in combination with shear and/or friction. Many factors interact to make a person likely to have such an injury. Pressure injuries are graded by level of severity.
Risk of harm	When a treatment injury claim highlights a risk of harm to the public, ACC must report this to the relevant authority responsible for the treatment.
Serious injury	A classification within ACC for people who will have a lifelong relationship with ACC due to the nature of their injury. Examples include damage to the spinal cord or brain.
Treatment Injury	An injury that a person suffers while being treated by a registered health professional or by someone else directed by that health professional. The injury must have been caused by the treatment but not be a necessary part, or ordinary consequence, of the treatment after considering all the circumstances of the treatment.
Treatment injury claims and other data sources	ACC information is based on claims made to ACC. The reasons for lodging a claim with ACC are different from the reasons for making a complaint to the Health and Disability Commissioner or reporting of a serious or sentinel event to the Health Quality and Safety Commission. The data in this publication is complementary and there are some overlaps, however, the rates or numbers or types of injuries in this publication cannot be directly compared with reports from other sources.
Treatment safety	The prevention of injuries caused by treatment.

PREVENTION. CARE. RECOVERY.

Te Kaporeihana Āwhina Hunga Whara

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ACC7971 April 2019 Print ISBN 978-1-98-852621-8 Online ISBN 978-1-98-852623-2
Printed in New Zealand on paper sourced from well-managed sustainable forests

EMBARGOED UNTIL 3 JUNE 2019

Complaints to the Health and Disability Commissioner involving District Health Boards

Report and Analysis for period 1 July 2017 to 30 June 2018

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Feedback
We welcome your feedback on this report. Please contact Natasha Davidson at hdc@hdc.org.nz

Authors
This report was prepared by Natasha Davidson (Principal Advisor – Research and Education).

Citation: The Health and Disability Commissioner. 2019. *Complaints to the Health and Disability Commissioner involving District Health Boards: Analysis and Report 2017/18.*

Published in June 2019
by the Health and Disability Commissioner
PO Box 1791, Auckland 1140

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COMMISSIONER'S FOREWORD

I am pleased to present HDC's analysis of complaints received involving District Health Boards for the 2017/18 year. The aim of this report is to provide the general public and providers with an understanding of the types of complaints HDC receives about services run by DHBs and the positive changes that have been made to services as a result of these complaints.

DHB complaint trends have remained broadly consistent over the last five years. The most commonly complained about service types have continued to be surgery, mental health, general medicine and emergency department services. The most common issues complained about in relation to DHB services tend to be communication issues (in regards to communication with both consumers and their family), inadequate treatment, inadequate examinations/assessments, diagnostic issues and treatment delays.

I note that complaints regarding access issues, including waiting list management/prioritisation issues, make up around a quarter of all complaints received by my Office about DHBs. In 2017/18, I found two DHBs in breach of the Code for inadequate waiting-list management and the lack of an appropriate prioritisation system. One of these cases is detailed in this report and involved a young man with a family history of glaucoma, who experienced a six month delay in receiving a follow-up appointment at a DHB ophthalmology service. By the time the man was seen again, he had suffered vision loss in his right eye. The service lacked capacity, in that the clinic did not have enough appointments for the number of patients clinicians needed to see, and the DHB did not have a prioritisation system in place that focused on patients' clinical need. The case is an important reminder that at all times, and particularly when a system is under pressure, patient prioritisation must be a key focus so that the patients with the highest clinical priority are seen first. Additionally, these cases highlight the importance of providers taking proactive steps to assess, plan, adapt, and respond effectively to the foreseeable effects that new technologies and changing demographics will have on systems and demand.

As you will see as you read through this report, inadequate follow-up of test results and inadequate referral management has been a feature of a number of investigations closed by this Office in the past year. It is important that DHBs communicate clearly to staff their expectations around referral management and test result follow-up, and that their systems have a number of defences built into them to ensure that test results and referrals are actioned in a timely manner.

There is a person and whānau at the centre of every one of these complaints and it is important that we all take every opportunity to learn from these cases and reduce harm in future. I trust that this report will continue to promote ongoing quality improvement and learning for individuals, the organisations they work for, and the wider health system they work within.

Anthony Hill
Health and Disability Commissioner

EXECUTIVE SUMMARY

In the 2017/18 year, HDC received 889 complaints involving DHBs. This was a small increase of 3% on the number received in the previous year. These 889 complaints equate to a rate of 91 complaints per 100,000 discharges – a very small increase on the rate of complaints received in the previous year.

The complaints related to a wide variety of DHB service types, with the most commonly complained about service types being surgical, mental health, general medicine and emergency department services. The service types complained about have remained broadly consistent over the past five years.

Also consistent with complaint trends seen in previous years, doctors were the individual providers complained about most commonly, with 83% of the individual providers identified in DHB complaints being doctors.

Missed, incorrect or delayed diagnosis was the most common primary issue of concern, and was raised by the complainant as the primary issue in 13% of complaints. When all issues raised in complaints were considered, the most common complaint issues involved care/treatment and communication issues, followed by access issues and issues regarding the consent process and the information provided to consumers.

Issues complained about have remained broadly consistent over time. However, the proportion of complaints regarding a disrespectful manner/attitude and an inadequate response to the consumer's complaint by the DHB have decreased over the last five years.

The issues raised in complaints varied by the service type involved. Services with high diagnostic workloads, such as general medicine and emergency departments, commonly received more complaints primarily regarding missed, incorrect or delayed diagnoses. Primary issues in complaints about mental health services are quite distinct, with issues relating to involuntary admission/treatment and safety issues for consumers in inpatient units being common.

When all issues raised in complaints about each service type were analysed, general medicine and mental health services received a greater proportion of complaints involving communication with family than other service types, while emergency department services received a greater proportion of complaints involving inadequate examination/assessments, misdiagnosis and inadequate testing than did other service types. Surgical services received a greater proportion of complaints about a waiting list/prioritisation issue and maternity services received a greater proportion of complaints regarding a delay in treatment than other service types.

In the 2017/18 year, HDC closed 859 complaints about DHB services. This included the conclusion of 51 investigations. Around 21% of complaints were referred back to the DHB for resolution. In around 27% of cases, HDC made recommendations and/or educational comments designed to facilitate improvement in DHB services. The most common recommendation was that DHBs provide evidence to HDC of the changes they had made in response to the issues raised by the complaint, followed by a review of their policies/procedures or implementation of new policies/procedures. Staff training/education was also often recommended.

BACKGROUND

1. The Health and Disability Commissioner

HDC is an independent crown entity established under the Health and Disability Commissioner Act 1994 to promote and protect the rights of health and disability services consumers. The rights of consumers are set out in the Code of Health and Disability Services Consumers' Rights (the Code). The Code places corresponding obligations on all providers of health and disability services, including individual providers and organisational providers such as district health boards.

HDC promotes and protects the rights of consumers of health and disability services by:

- resolving complaints;
- improving quality and safety within the sector; and
- appropriately holding providers to account.

As such, HDC fulfils the critical role of independent watchdog for consumer rights within the sector.

Rights under the Code

1. The right to be treated with respect.
2. The right to freedom from discrimination, coercion, harassment and exploitation.
3. The right to dignity and independence.
4. The right to services of an appropriate standard.
5. The right to effective communication.
6. The right to be fully informed.
7. The right to make an informed choice and give informed consent.
8. The right to support.
9. Rights in respect of teaching or research.
10. The right to complain.

Anyone may make a complaint to HDC about a health or disability service that has been provided to a consumer. It is not uncommon for HDC to receive complaints from third parties, such as family members, friends, or other providers involved in the consumer's care. The Commissioner may also commence an investigation at his own initiative, even without having received a complaint, if he considers it appropriate to do so.

2. District Health Boards

There are 20 district health boards (DHBs) with responsibility for funding or providing a specified range of health and disability services on behalf of the government. Public hospitals, and other public health services, including various clinics and community-based services, are owned and funded by DHBs. Individual providers (for example, doctors and nurses) working in a DHB's facility are usually employed by that DHB.

3. This Report

This report describes the complaints HDC received and/or closed in relation to DHBs during the 2017/18 financial year.

Complaints about DHBs are of particular interest as DHBs are the largest organisational providers of health and disability services in New Zealand. Approximately 40% of complaints received by HDC each year relate, at least in part, to DHB services.

The complaints are described both in terms of overall numbers and characteristics, as well as by reference to case studies. In terms of complaints received, the issues included in the analysis are as articulated by the complainant to HDC. While not all issues raised in complaints are subsequently factually and/or clinically substantiated, those issues can still provide a valuable insight into the consumer's experience of the services provided and the issues they care most about.

Case studies are included to highlight the positive changes that have been made to services as a result of complaints about DHBs. Readers are encouraged to consider their own service provision when reading this report and to ask "could that happen at my place" and, if so, what changes can be made to prevent it?

COMPLAINTS RECEIVED

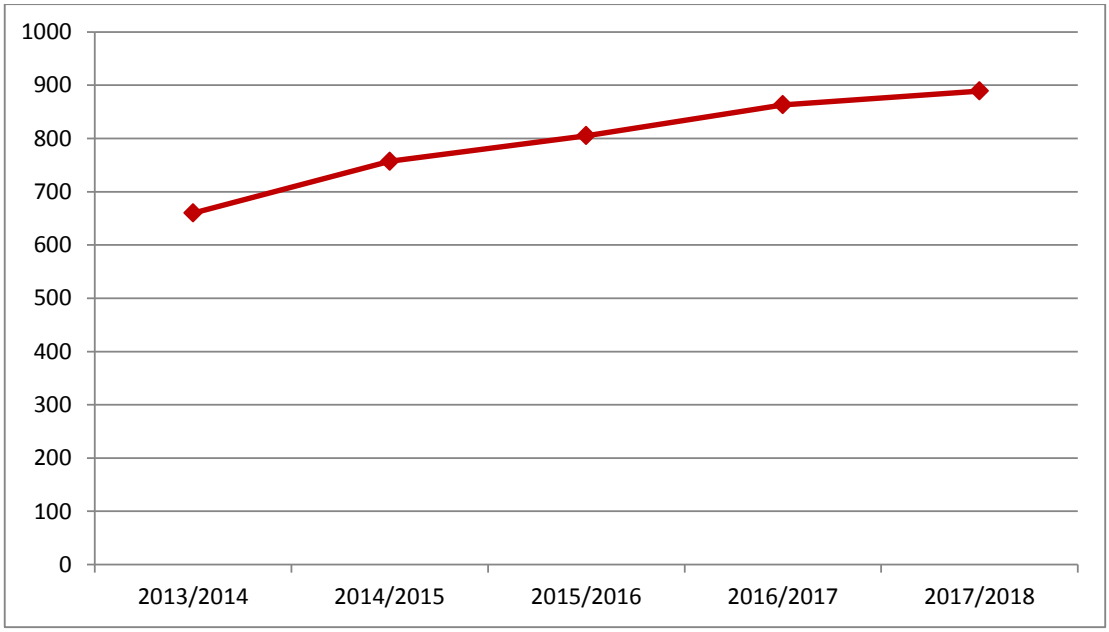
1. How many complaints were received?

1.1 Number of complaints received

In 2017/18, HDC received a total of **889**[1] complaints about care provided by all DHBs. This equates to 36% of the total 2,498 complaints received by HDC that year.

The 889 complaints received in the 2017/18 year represents an increase of 3% over the 863 complaints received in 2016/17. As can be seen from Figure 1 below, DHB complaint numbers have been steadily increasing over the last five years. This reflects an overall trend of growth in complaint numbers to HDC.

Figure 1. Number of complaints received about DHBs



In 2017/18 the number of complaints received about individual DHBs ranged from 7 complaints to 134 complaints. Large variability in complaint numbers is not unexpected given the similar variability in the size of populations served and number and type of services delivered by different DHBs.

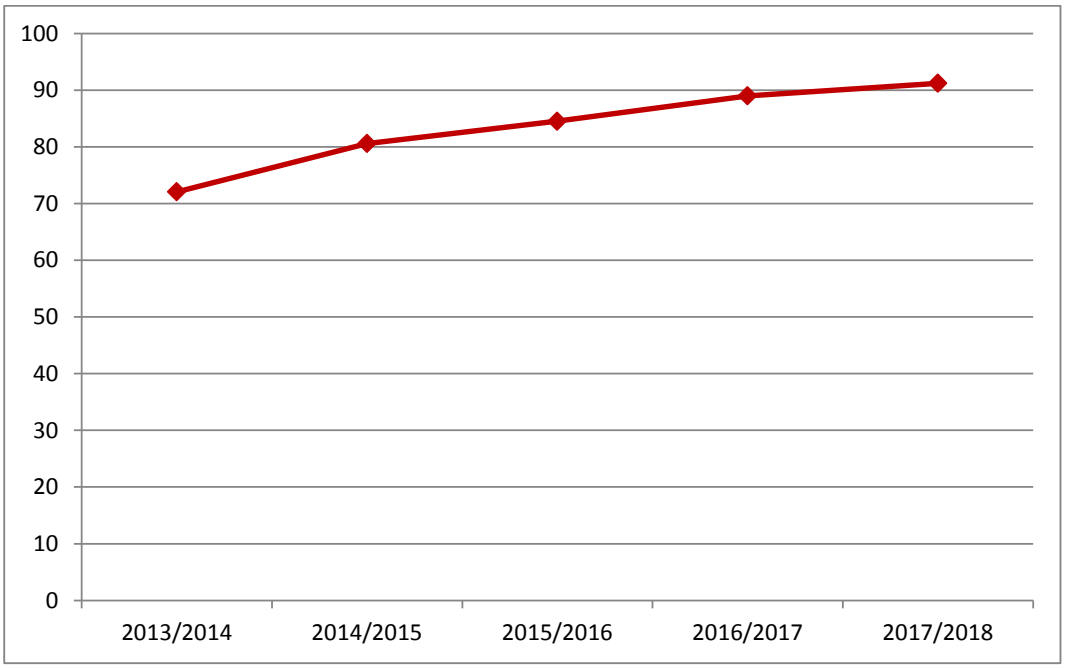
[1] Provisional as of date of extraction, 14 August 2018.

1.2 Rate of complaints received

Expressing complaints received by HDC about DHBs as a rate per 100,000 discharges allows more meaningful comparisons to be drawn between DHBs, and over time, enables any trends to be better observed.

In the 2017/18 year, according to Ministry of Health data,[2] there were 974,675 discharges nationally. This equates to an overall rate of 91 complaints per 100,000 discharges across DHB services. This is a very small increase on the overall rate of 89 complaints per 100,000 discharges received during 2016/17.

Figure 2. Rate of complaints received about DHBs per 100,000 discharges



For individual DHBs, the rate of complaints received ranged from 45 complaints per 100,000 discharges to 231 complaints per 100,000 discharges.

However, while discharge data is useful for standardising DHB activity over time, it is less accurate when comparing DHBs against one another. This is because some services are excluded from the discharge data collected,[3] disproportionately affecting some DHBs more than others. In addition, discharge data does not take into account the particular services provided by a DHB or the nature of the population and geographical area served.

[2] Provisional as at the date of extraction, 14 September 2018.
[3] For example, the discharge data excludes short stay emergency department discharges, and patients attending outpatient units and clinics.

Why are complaint numbers increasing?

The increasing number of complaints being received by HDC about DHBs reflects an overall trend of sustained growth in complaint numbers to HDC. Over the last five years, the number of complaints to HDC has increased by 40%.

This increase must be interpreted with caution. HDC has no evidence to suggest that the increase in complaints relates to a decrease in the quality of services by providers generally, or by DHBs in particular.

The growth in complaint numbers is more likely to be due to the increasing profile of HDC, the improved accessibility of complaints processes due to advancing technology, and an increasing public knowledge of consumer rights. It may also reflect an increased willingness amongst consumers to complain about services received and increasing health care service activity.

HDC's increasing complaint load is not unique, but is consistent with a trend being observed in complaints agencies both around New Zealand and internationally. For example, in 2017/18 complaints to the New South Wales Health Care Complaint Commission and the Office of the Health Complaints Commissioner in Victoria increased by 12% and 13% respectively.

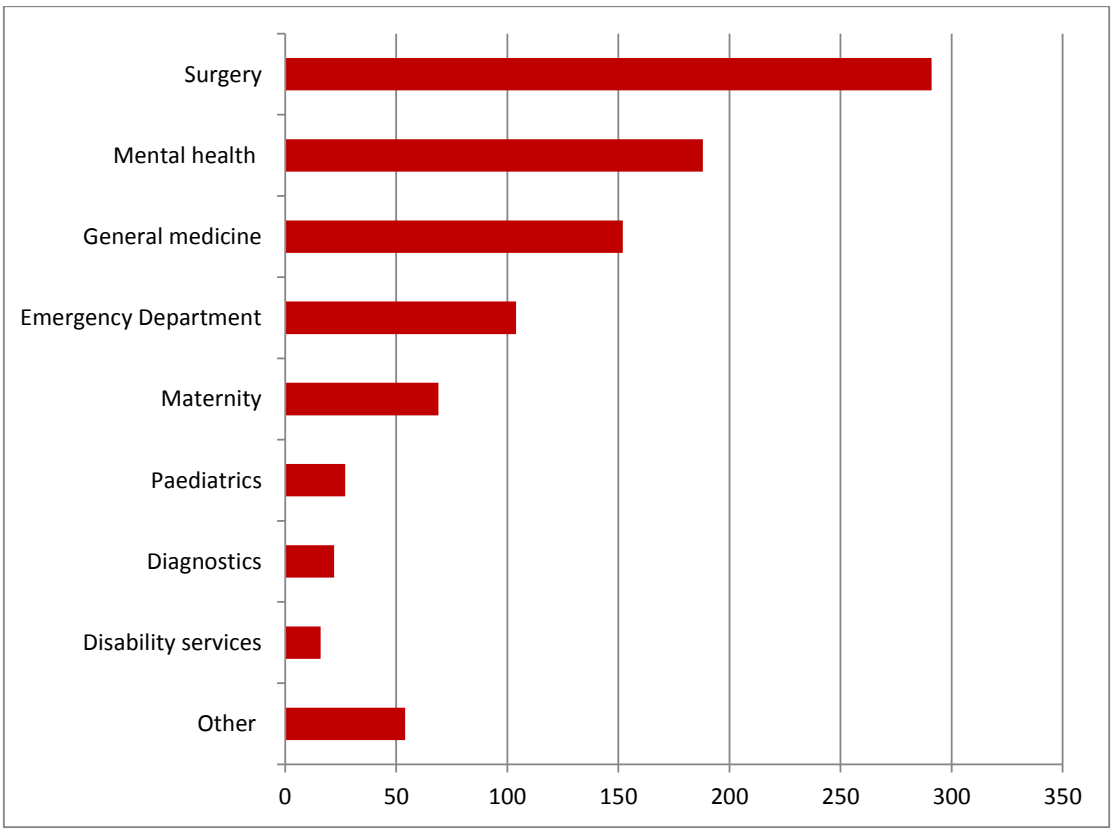
2. Which DHB services were complained about?

2.1 DHB service types complained about

DHBs operate a number of different services within hospitals, in clinics and in the community. It should be noted that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 889 complaints about DHBs, 923 services have been complained about.

Complaints received by HDC in the 2017/18 year were spread across many different service types, as shown in Figure 3 below, with the greatest proportion of complaints being about surgical services (32%), followed by mental health (20%), general medicine (16%), emergency department (11%) and maternity services (7%).

Figure 3. DHB service types complained about



A more nuanced picture of service types complained about, including individual surgical and general medicine service categories, is provided in Table 1.

The most common surgical specialties complained about in 2017/18 were orthopaedics (7%), general surgery (7%) and urology (5%). This is broadly consistent with the surgical specialties complained about in previous years, with the exception of urology services which increased from 2% of services complained about in 2016/17 to 5% in 2017/18.

Table 1. DHB service types complained about

Service type	Number of services (%)
Aged care	**4 (0.4)**
Alcohol and drug	**7 (0.8)**
Anaesthetics/pain medicine	**5 (0.5)**
Dental	**4 (0.4)**
Diagnostics	**22 (2)**
Disability services	**16 (2)**
District nursing	**5 (0.5)**
Emergency department	**104 (11)**
General medicine	**152 (16)**
Cardiology	23 (2)
Dermatology	1 (0.1)
Endocrinology	8 (0.9)
Gastroenterology	14 (2)
Geriatric medicine	19 (2)
Haematology	3 (0.3)
Infectious diseases	3 (0.3)
Neurology	18 (2)
Oncology	13 (1)
Palliative care	2 (0.2)
Renal/nephrology	3 (0.3)
Respiratory	9 (1)
Rheumatology	3 (0.3)
Other/unspecified	33 (4)
Hearing services	**3 (0.3)**
Intensive care/critical care	**6 (0.7)**
Maternity	**69 (7)**
Mental health	**188 (20)**
Paediatrics (not surgical)	**27 (3)**
Rehabilitation services	**6 (0.7)**
Surgery	**291 (32)**
Cardiothoracic	6 (0.7)
General	62 (7)
Gynaecology	35 (4)
Neurosurgery	12 (1)
Ophthalmology	27 (3)
Oral/Maxillofacial	1 (0.1)
Orthopaedics	69 (7)
Otolaryngology	19 (2)
Plastic and Reconstructive	10 (1)
Urology	42 (5)
Vascular	6 (0.7)
Unknown	2 (0.2)
Other health service	**14 (2)**
TOTAL	**923**

Table 2 below, shows a yearly comparison of the proportion of complaints received for the most commonly complained about service types. As can be seen from this table, the most common service types complained about over the last five years have remained broadly consistent, with general medicine showing a small decrease in 2017/18 as compared to the previous year.

Table 2. Yearly comparison of the proportion of complaints received about the most commonly complained about service types

Service type	2013/14	2014/15	2015/16	2016/17	2017/18
Surgery	**26%**	**27%**	**31%**	**28%**	**32%**
Mental health	**19%**	**19%**	**21%**	**21%**	**20%**
General medicine	**19%**	**17%**	**16%**	**20%**	**16%**
Emergency department	**13%**	**13%**	**12%**	**13%**	**11%**
Maternity	**6%**	**7%**	**6%**	**6%**	**7%**

Case study: Emergency department (15HDC01723)

Management of shoulder dislocation

A man dislocated his shoulder in an accident and attended an emergency department. The man was triaged by a Registered Nurse who allocated him a triage category 3 (treatment within 30 minutes). His pain score and vital signs were not documented at triage. An X-ray was taken and pain relief was administered by nursing staff around one and a half hours after his arrival. A clinical nurse specialist attempted to reduce (relocate) the shoulder after the X-ray was reviewed, however this was discontinued due to pain.

The clinical nurse specialist attempted reduction on two further occasions after requesting intravenous opiate pain relief from the consultant. 25mcg IV fentanyl was administered before both of these reductions, but both were stopped at an early stage due to pain. The clinical nurse specialist then requested sedation from the consultant. After this was administered, the shoulder was reduced. A post reduction X-ray was taken to ensure the reduction had been successful. The man was discharged from the emergency department with a copy of his X-rays and notes and advised to follow up with his GP.

The day after discharge, the X-rays were reported on formally. The pre-reduction X-ray report stated that there was a 1 x 0.2mm bone fragment posterior to the humeral head on the lateral view, and the post-reduction X-ray report queried subtle deformities, and stated "if indicated this area can be better evaluated by CT." The consultant viewed and signed off the X-ray reports, noting no action was needed. These reports were not sent to the man and, as his GP's details were not recorded, the GP was not sent copies either.

<u>Findings</u>

The Commissioner was critical that the man's pain score and vital signs were not documented at triage, commenting that this impacted on his patient journey in ED. In particular, he considered it is more likely than not that his pain score was higher than 7/10 on arrival, given that subsequently it was found to be 9/10 on more than one occasion, and, accordingly, he should have been allocated a triage code 2. The Commissioner was also critical that there was no form of ongoing assessment between triage and formal review.

The Commissioner was also concerned that the man's pain was not managed adequately in ED, and that the IV opioid protocol was not used to provide him with adequate analgesia earlier in his

admission, given the extended amount of time he had to wait for formal review.

HDC's clinical advisor commented that there should have been a more detailed systematic assessment of the man's head, chest and abdomen documented and was critical that none of the DHB's staff undertook a secondary survey of him. The Commissioner was also concerned that the man's GP details were not recorded on the DHB's system meaning his pre- and post-reduction X-ray reports were not able to be copied to his GP.

The Commissioner found that these deficiencies indicated a pattern of poor care by staff, and systems issues, for which the DHB is responsible. For these reasons, it was held that the DHB did not provide the man with services with reasonable care and skill, in breach of Right 4(1) of the Code.

The Commissioner was critical that the consultant did not inform the man of the abnormality seen on the X-ray, especially in light of the fact that the reports were not copied to his GP. This was information that a reasonable consumer in the man's circumstances would expect to receive, and by failing to provide this information the consultant breached Right 6(1)(f) of the Code.

The Commissioner made a number of recommendations to the DHB, including that it:

- Provide HDC with an update on the improvements to triage assessment (including ensuring documentation of vital signs and accurate assessment and categorisation of patients).

- Provide HDC with evidence that the letter to patients advising them of additional X-ray results (where a condition or injury is identified on the X-ray report that was not seen at the time of their presentation to ED) is being used where appropriate.

- Consider providing triage nursing staff with appropriate training and authority to order X-rays.

- Provide training to ED nursing and medical staff on the use of the IV opioid protocol and the circumstances in which this should be implemented, and by whom.

- Remind ED reception staff of the importance of obtaining a patient's GP details.

These recommendations have been met.

2.2 Professions of individual providers complained about

When people complain about services provided to them, they often complain about particular individuals involved in the provision of those services. The professions of the individual providers identified in complaints about DHB services are shown in Table 3 below.

Table 3. Professions of individual providers complained about in DHB complaints

Occupation	Number of individuals (%)
Doctors	***171 (83)***
Emergency medicine specialist	3 (1)
General surgeon	17 (8)
Internal medicine specialist	21 (10)
Medical officer	11 (5)
Neurosurgeon	4 (2)
Obstetrician/gynaecologist	25 (12)
Ophthalmologist	7 (3)
Orthopaedic surgeon	13 (6)
Otolaryngologist	6 (3)
Psychiatrist	23 (11)
Registrar	20 (10)
Urologist	9 (4)
Other	12 (6)
Other health providers	***35 (17)***
Midwife	10 (5)
Nurse	13 (6)
Occupational therapist	3 (1)
Social worker	4 (2)
Other	5 (2)
TOTAL	**206**

The vast majority of the individual providers identified in DHB complaints received in the 2017/18 year were doctors. It is likely that doctors are more often seen by complainants as being responsible for the services provided and the outcomes of those services and are, therefore, more frequently viewed as individually responsible for any perceived shortcomings.

The most commonly identified individual provider occupations were obstetrician/gynaecologists (12%) and psychiatrists (11%).

It should be noted that there are a number of factors that may account for the number of complaints about each specialty, such as the amount of patient contact that each specialty has, the clinical activities each specialty performs, the characteristics of the population that each specialty serves and the degree to which an individual can be seen as responsible for the care provided.

Case study: Nurse (15HDC01330)

Inadequate care provided to baby in hospital

A seven-day-old baby was admitted to hospital with 11% weight loss since birth, jaundice, and reduced feeding. She was treated with phototherapy on the children's ward.

The baby's temperature spiked the following day. The consultant paediatrician ordered investigations to try to determine the cause, and decided to commence intravenous (IV) fluids and antibiotics. A junior paediatric registrar prescribed the antibiotics and IV fluids. The registrar prescribed IV fluids at a rate of 180ml/kg/day, which was higher than the amount recommended by the DHB's policy and other national guidelines.

A registered nurse cared for the baby on the following evening shift. During the shift, the nurse administered the baby's antibiotics then recommenced the IV fluids. At about 8.30pm the IV monitor began to flash, saying that there was a "downward occlusion" (indicating a possible blockage or kink in the IV line). The nurse and a senior nurse investigated the line and the IV site but did not find any obvious issues. The nurse did not clearly document the issues she had with the IV line during the shift, nor did she hand these over to the following shift.

Another registered nurse took over the baby's care at 11.15pm for the night shift but did not review the baby for nearly two hours. At around 2.30am, the baby was due for her next antibiotics. The nurse said that there were no signs that the antibiotics had accidentally entered the surrounding tissue rather than the vein (no signs of phlebitis or tissue infiltration). During the administration of the antibiotic, the baby's mother noted a blister forming on the baby's arm, and the arm swelled immediately. The nurse stopped the antibiotic infusion and called for assistance. The baby was reviewed by a senior house officer and treated for an extravasation injury, meaning that the IV antibiotics had been accidentally administered into the tissue around the IV site.

The paediatric fluid balance charts from throughout the baby's hospital admission were not filled in regularly by staff in accordance with the DHB's "Fluid balance chart recording standards (Paediatric)" policy.

<u>Findings</u>

The Deputy Commissioner considered that while the paediatric registrar's prescription of 180ml/kg/day was an individual clinical error, her orientation to the IV fluid guidelines used at the public hospital was inadequate. It was noted that it is not uncommon for junior staff to become confused with regard to fluid requirements for a neonate given the variation in both national and international guidelines, and the Deputy Commissioner was critical of the inadequate orientation and the lack of clear consensus on the guidelines to be followed at the DHB.

The Deputy Commissioner was also concerned that multiple staff reviewed the baby, but did not recognise that her IV fluid prescription was too high; and multiple staff did not fill in the baby's fluid balance chart in accordance with policy requirements. Accordingly, she found that the DHB failed to provide services to the baby with reasonable care and skill in breach of Right 4(1) of the Code.

The Deputy Commissioner considered that by failing to comply with the DHB's policy regarding hourly IV site monitoring and documentation; not documenting an accurate description of the issues she encountered or the actions she took in response to the IV pump alarm; and not handing over the issues she had with the IV pump to the following shift, the evening nurse breached Right 4(1) of the Code.

The Deputy Commissioner also found the night shift nurse in breach of Right 4(1) of the Code for failing to review the baby's IV site for two hours at the start of her shift, and for failing to fill in the

baby's fluid balance chart in accordance with policy requirements.

The Deputy Commissioner made a number of recommendations to the DHB, including that it:

- Establish a clear consensus of which guidelines are to be followed when prescribing IV fluid to neonates.
- Provide HDC with the results of its six most recent monthly audits of IV access.
- Use this case as an anonymised case study during induction of nursing and medical staff to paediatric wards.
- Provide HDC with confirmation that actions taken to meet the recommendations of the DHB's internal investigation of this event are continuing.

The Deputy Commissioner recommended that the nurses undertake audits of their compliance with fluid balance recording standards.

These recommendations have been met.

3. What did people complain about?

3.1 Issues identified in complaints

Many complaints to HDC contain multiple issues of concern to the complainant. For the purposes of analysis, we identified the primary issue being complained about plus up to six additional complaint issues for each complaint received. It is important to note that this section details analyses of the issues raised by complainants in their complaints, rather than analyses of HDC's assessment of the issues raised. Inevitably, some of the complaint issues raised will have been found, on subsequent assessment, not to have been substantiated.

Primary complaint issues

As shown in Table 5, we grouped the complaint issues into several categories. Among these categories, issues relating to care/treatment (47%), access/funding (17%) and consent/information (11%) were the most prevalent. When separate complaint issues under each category are considered, the most common primary issues were:

- Missed/incorrect/delayed diagnosis (13%)
- Waiting list/prioritisation issue (10%)
- Unexpected treatment outcome (10%)
- Lack of access to services (6%)
- Inadequate/inappropriate treatment (6%)

This is broadly similar to what was seen last year.

Case study: Waiting list/prioritisation issue (16HDC1010)

Delay in follow-up of ophthalmology review

A 20-year old man, who had a family history of glaucoma, presented to the Ophthalmology Service of a DHB (the Service), having been referred urgently by a community optometrist. He was prescribed eye drops and a follow-up review went ahead the next week.

Two months later, the man was diagnosed with ocular hypertension. The consultant ophthalmologist requested that the man be reviewed again in six months' time. That follow-up appointment was delayed by six months despite the man telephoning the Service and correspondence being sent by his GP. By this time, the man had suffered vision loss in his right eye and required an urgent referral for management and surgery.

Findings

The Commissioner was mindful of a combination of factors that have driven rapidly increasing demand for ophthalmology services in New Zealand, including outpatient clinic time, over the last ten years. Key factors include changing demographics in the patient population and the introduction of very effective new therapies and treatment resulting in consumers needing to see specialists for regular ongoing follow-up and/or treatment. However, the Commissioner noted that provider accountability is not removed by the existence of such systemic pressures. A key improvement that all DHBs and the Ministry of Health must make, now and in the future, is to assess, plan, adapt, and respond effectively to the foreseeable effects that new technologies and changing demographics will have on systems and demand.

At the time of the man's care, the Service lacked capacity, in that the clinics did not have enough appointments for the number of patients clinicians had to see. The Commissioner was critical that the DHB failed to arrange a timely follow-up appointment because it did not have a prioritisation system that focused on patients' clinical need, and instead relied on administrative staff who lacked

training and clear guidance to prioritise appropriately. Despite concerns being raised with the DHB, it did not recognise the clinical risk created by the lack of capacity at the Service, and did not take action to rectify the situation after an earlier serious event review in relation to a similar matter had raised associated concerns. In addition, there were missed opportunities for the DHB to rectify the delay in the follow-up appointment. Accordingly, the Commissioner considered that the DHB did not provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1).

The Commissioner referred the DHB to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

Following on from the DHB's external review, and the ongoing work of DHBs and the Ministry of Health to address these issues, the Commissioner made a series of detailed recommendations requesting follow-up information and evidence of the effectiveness of corrective actions and strategies adopted from both the DHB and the Ministry of Health. These recommendations have been met.

All complaint issues

On analysis of all issues identified in complaints about DHBs, the most common complaint categories were care/treatment (79%), communication (61%), access/funding (25%) and consent/information (24%).

The most common specific complaint issues were:

- Failure to communicate effectively with consumer (37%)
- Inadequate/inappropriate treatment (36%)
- Inadequate/inappropriate examination/assessment (24%)
- Missed/incorrect/delayed diagnosis (20%)
- Failure to communicate effectively with family (20%)
- Delay in treatment (20%)
- Disrespectful manner/attitude (16%)
- Inadequate response by DHB to complaint (16%)
- Unexpected treatment outcome (16%)
- Inadequate coordination of care/treatment (16%)

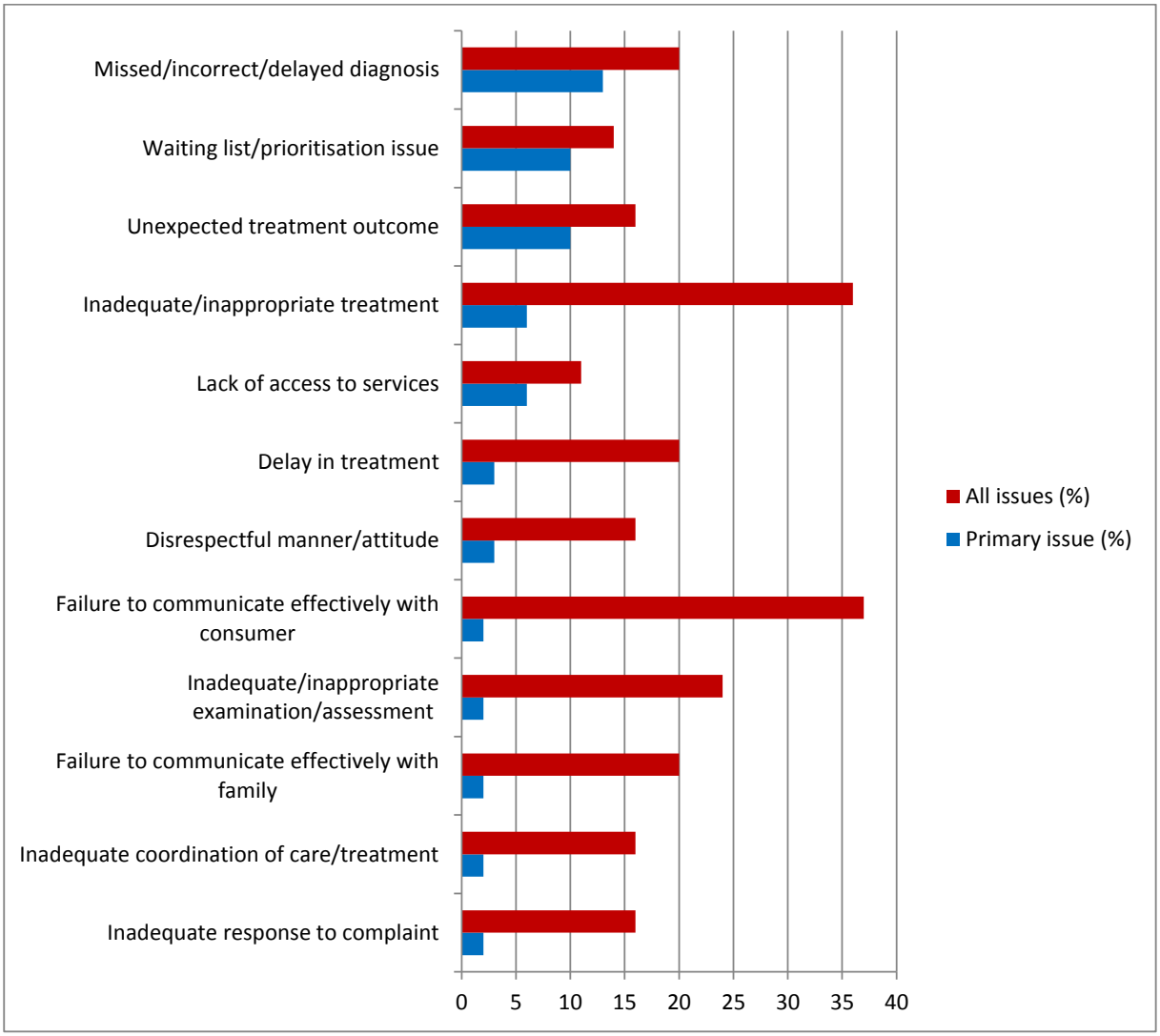
Table 5. Issues complained about in DHB complaints

Complaint issue	Number of complaints primarily about this issue (%)	Number of complaints involving this issue (%)
Access/Funding	***153 (17)***	***223 (25)***
Lack of access to services	55 (6)	97 (11)
Lack of access to subsidies/funding	5 (0.6)	16 (2)
Waiting list/prioritisation issue	93 (10)	122 (14)
Other	0	2 (0.2)
Boundary violation	***2 (0.2)***	***4 (0.4)***
Care/Treatment	***422 (47)***	***699 (79)***
Delay in treatment	25 (3)	175 (20)
Delayed/inadequate/inappropriate referral	5 (0.6)	29 (3)
Inadequate coordination of care or treatment	16 (2)	143 (16)
Inadequate/inappropriate clinical treatment	49 (6)	318 (36)
Inadequate/inappropriate examination/assessment	20 (2)	217 (24)
Inadequate/inappropriate follow-up	9 (1)	92 (10)
Inadequate/inappropriate monitoring	14 (2)	67 (8)
Inadequate/inappropriate non-clinical care	19 (2)	70 (8)
Inadequate/inappropriate testing	2 (0.2)	82 (9)
Inappropriate admission/failure to admit	0	22 (2)
Inappropriate/delayed discharge/transfer	25 (3)	89 (10)
Inappropriate withdrawal of treatment	10 (1)	11 (1)
Missed/incorrect/delayed diagnosis	113 (13)	181 (20)
Personal privacy not respected	1 (0.1)	7 (0.8)
Refusal to assist/attend	1 (0.1)	24 (3)
Refusal to treat	14 (2)	23 (3)
Rough/painful care or treatment	6 (0.7)	40 (4)
Unexpected treatment outcome	89 (10)	144 (16)
Unnecessary treatment/over-servicing	4 (0.4)	15 (2)
Communication	***73 (8)***	***545 (61)***
Disrespectful manner/attitude	28 (3)	146 (16)
Failure to accommodate cultural/language needs	2 (0.2)	6 (0.7)
Failure to communicate openly/honestly/effectively with consumer	15 (2)	332 (37)
Failure to communicate openly/honestly/effectively with family	20 (2)	178 (20)
Insensitive/inappropriate comments (not sexual)	8 (0.9)	28 (3)
Complaints process	***15 (2)***	***146 (16)***
Inadequate response to complaint	15 (2)	145 (16)
Other	0	1 (0.1)
Consent/Information	***97 (11)***	***216 (24)***
Consent not obtained/adequate	19 (2)	53 (6)
Failure to assess capacity to consent	0	7 (0.8)
Inadequate information provided regarding adverse event	1 (0.1)	12 (1)
Inadequate information provided regarding condition	8 (0.9)	28 (3)
Inadequate information provided regarding fees/costs	5 (0.6)	7 (0.8)
Inadequate information provided regarding options	7 (0.8)	24 (3)
Inadequate information provided regarding provider	1 (0.1)	6 (0.7)
Inadequate information regarding results	4 (0.4)	16 (2)
Inadequate information provided regarding treatment	13 (1)	62 (7)
Incorrect/misleading information provided	1 (0.1)	23 (3)

Complaint issue	Number of complaints primarily about this issue (%)	Number of complaints involving this issue (%)
Issues regarding consent when consumer not competent	2 (0.2)	5 (0.6)
Issues with involuntary admission/treatment	36 (4)	43 (5)
Other	0	2 (0.2)
Documentation	***10 (1)***	***67 (8)***
Delay/failure to disclose documentation	1 (0.1)	9 (1)
Delay/failure to transfer documentation	0	2 (0.2)
Inadequate/inaccurate documentation	8 (0.9)	53 (6)
Intentionally misleading/altered documentation	1 (0.1)	4 (0.4)
Facility issues	***44 (5)***	***146 (16)***
Accreditation standards/statutory obligations not met	1 (0.1)	2 (0.2)
Cleanliness/hygiene issue	2 (0.2)	13 (1)
Failure to follow policies/procedures	0	7 (0.8)
General safety issue for consumer in facility	25 (3)	37 (4)
Inadequate/inappropriate policies/procedures	4 (0.4)	45 (5)
Issue with sharing facility with other consumers	1 (0.1)	14 (2)
Issue with quality of aids/equipment	1 (0.1)	19 (2)
Staffing/rostering/other HR issue	4 (0.4)	16 (2)
Waiting times	5 (0.6)	16 (2)
Other issue with physical environment	1 (0.1)	2 (0.2)
Medication	***38 (4)***	***89 (10)***
Administration error	3 (0.3)	9 (1)
Dispensing error	1 (0.1)	1 (0.1)
Prescribing error	2 (0.2)	4 (0.4)
Inappropriate administration	5 (0.6)	14 (2)
Inappropriate prescribing	19 (2)	45 (5)
Refusal to prescribe/dispense/supply	8 (0.9)	17 (2)
Other	0	2 (0.2)
Reports/Certificates	***6 (0.7)***	***16 (2)***
Inaccurate report/certificate	6 (0.7)	11 (1)
Refusal to complete report/certificate	0	5 (0.6)
Training/supervision	***0***	***20 (2)***
Inadequate supervision/oversight	0	20 (2)
Other professional conduct issues	***21 (2)***	***49 (6)***
Disrespectful behaviour	8 (0.9)	21 (2)
Inappropriate collection/use/disclosure of information	11 (1)	21 (2)
Threatening/bullying/harassing behaviour	0	5 (0.6)
Other	2 (0.1)	7 (0.8)
Disability-specific issues	***7 (0.8)***	***16 (2)***
Other issues	***1 (0.1)***	***20***
TOTAL	***889***	

Figure 4 details the twelve most common complaint issues raised in complaints about DHBs received in the 2017/18 year. The blue bars show the percentage of cases in which the particular complaint issue was identified as the primary issue, while the red bars show the percentage of cases in which the particular complaint issue was raised at all. As can be seen from the large difference in the size of the blue and red bars, communication-related complaint issues (disrespectful manner/attitude, and failure to communicate effectively with family or consumer), inadequate/inappropriate examination/assessment, delay in treatment, inadequate coordination of care/treatment, and inadequate response to complaint are present in a significant number of complaints, but are not often the primary issue raised.

Figure 4. Most common primary and all issues in complaints received



Case study: Delay in treatment (16HDC00761)

Delay in neurology review

A 62-year-old man presented to an emergency department with sudden onset of left-sided weakness and twitching, and reported a week-long history of dizziness upon standing. A CT scan report recommended a neurological opinion.

The man was admitted to the general medicine ward the same day with a working diagnosis of an ischaemic stroke. The admitting medical registrar completed a handwritten neurology referral but it was erroneously sent using the process for outpatient referrals. There was nothing on the form to indicate that it was intended to be an inpatient referral. As a result, the referral was not triaged until three days later.

The man was noted to have left arm tremors, which progressed to intermittent twitching of the left leg. The consultant general physician maintained the working diagnosis of ischaemic stroke when he reviewed the man in the morning of the following day. Nursing notes throughout that day refer to twitching and "on and off restlessness" in the man's left leg. On the third day of admission, another medical registrar queried in the notes whether the man's ongoing left-sided weakness was caused by seizures. This possibility was raised again during the physiotherapy and occupational therapy review in the afternoon, but the matter was not escalated to the consultant general physician.

On the fourth day of admission, the medical registrar from the previous day noted that the man had yet to be been seen by a neurologist, and made active enquiries about the referral. As a result of these enquiries, the man was reviewed by the visiting neurologist, who diagnosed focal status epilepticus. The man was commenced on intravenous anti-seizure medication, and his involuntary movements improved. He was later transferred to another hospital, where he received further treatment.

Findings

The Commissioner considered that there were deficiencies in the care provided, which constituted a pattern of poor care on a service level, for which the DHB was ultimately responsible:

- The admitting medical registrar did not make an acute referral to the neurology service following the abnormal CT scan result.
- The admitting medical registrar's non-urgent referral was erroneously sent to the outpatient clinic.
- The consultant general physician did not discuss the CT report with the neurology service on his ward round the day after admission, when the man had been experiencing ongoing involuntary twitching.
- Junior staff did not escalate concerns about the man's ongoing involuntary movements, and the consultant general physician did not enquire.

The Commissioner was most concerned by the lapses in communication within the general medicine team and the lack of safeguards in place to identify errors in the neurology referral process. These factors hindered the coordination of the man's care within the team and across specialities, and contributed to the delay in him receiving the neurological review he required. For the above reasons, the Commissioner considered that the DHB failed to provide services with reasonable care and skill to the man, in breach of Right 4(1) of the Code.

The Commissioner recommended that the DHB:

- Conduct an audit of neurology referrals within the last three months to ensure that the correct process had been followed.

- Use this case as an anonymised case study for education on the importance of team communication.
- Update HDC on the implementation of its "TransforMED" project (a project which aims to ensure that time is set aside for subspecialists who participate in General Medicine to undertake a ward round daily on inpatients on their designated ward).

These recommendations have been met.

Table 6 compares the most common issues raised in 2017/18 with previous years. Common complaint issues have remained broadly consistent over the last five years. However, the proportion of complaints regarding 'disrespectful manner/attitude' and an inadequate response to the consumer's complaint by the DHB have decreased over the last five years.

Table 6. Yearly comparison of the most common issues complained about in DHB complaints in 2017/18

Complaint issue	2013/14	2014/15	2015/16	2016/17	2017/18
Failure to communicate effectively with consumer	**21%**	**34%**	**38%**	**36%**	**37%**
Inadequate/inappropriate treatment	**37%**	**40%**	**43%**	**33%**	**36%**
Inadequate/inappropriate examination/assessment	**14%**	**27%**	**29%**	**23%**	**24%**
Missed/incorrect/delayed diagnosis	**27%**	**24%**	**23%**	**22%**	**20%**
Failure to communicate effectively with family	**21%**	**22%**	**24%**	**22%**	**20%**
Delay in treatment	**15%**	**14%**	**18%**	**21%**	**20%**
Disrespectful manner/attitude	**20%**	**24%**	**25%**	**20%**	**16%**
Inadequate response to complaint	**20%**	**24%**	**22%**	**17%**	**16%**
Unexpected treatment outcome	**15%**	**17%**	**19%**	**14%**	**16%**
Inadequate coordination of care/treatment	**14%**	**19%**	**24%**	**21%**	**16%**

Case study: Coordination of care/treatment (16HDC00460)

Opioid treatment while on Methadone

A woman with a complex medical history including chronic pain and substance dependence attended a methadone programme and also enrolled at a medical practice where she was prescribed dihydrocodeine (DHC) for her chronic pain. She failed to inform the GP that she was on the methadone programme for 16 months.

The GP contacted the methadone treatment service to discuss the woman's ongoing treatment, however although the service confirmed the woman was on the programme, no further advice about her treatment was provided. The GP continued to prescribe DHC regularly.

The methadone treatment service referred the woman to the pain clinic. However, the methadone treatment service stated that because the woman was an ACC client, the referral would have been sent to ACC for approval. It appears that this was not granted by ACC or followed up by the methadone treatment service.

The practice was contacted by Medicines Control who advised that a Restriction Notice in the woman's name had been issued and asked if the practice wished to be included as a prescriber on the Notice in conjunction with the methadone service.

There was confusion over extending the Restriction Notice. The practice thought it was authorised to prescribe DHC and that a plan to reduce the prescription would be forthcoming from the service. The practice continued to prescribe DHC to the woman until the service instructed the practice that all prescribing of DHC was to cease and any reduction would be managed by the service.

Findings

The Mental Health Commissioner was concerned that the standard of communication by the methadone treatment service with the medical practice was frequently ambiguous and inconsistent. He was critical of the methadone treatment service's failure to provide the medical practice with regular updates or to adequately discuss a treatment plan for the woman with the GP. Furthermore, he was critical that once the methadone treatment service became aware of the dual prescribing, there was not a timely, clear instruction from a senior member of the methadone treatment service team to the medical practice for an immediate cessation of prescribing. The Mental Health Commissioner also considered that the methadone treatment service's failure to follow up on the woman's referral to the pain clinic meant that she was unable to access the care she should have received.

As outlined above, the Mental Health Commissioner found there were a number of inadequacies in the coordination of the woman's care which were attributable to the DHB. Accordingly, he found the DHB in breach of Right 4(5) of the Code.

The Mental Health Commissioner also made adverse comment about the failure of the GP to determine beyond doubt if the medical practice could continue to prescribe the DHC and to clarify the reduction plan. Adverse comment was also made about a second GP at the medical practice prescribing 3 months supply of DHC for the woman when a smaller amount could have been prescribed due to the uncertainty of the prescribing responsibility.

The Mental Health Commissioner noted that the DHB had undertaken an external review of the methadone programme, and that the recommendations proposed as a result of this review have largely been implemented and continue to be reviewed, with the aim of providing a service that focuses on patient well-being, recovery, and harm minimisation. In light of these changes he

recommended that the DHB:

- Conduct a random audit of clients covering the past 12 months to ensure that a copy of the opioid substitution treatment assessment had been sent to the client's GP, along with an update following the three-month and six-month review, and report back on the results of the audit, including any actions taken or planned to address any issues identified by the audit.
- Consider, in consultation with the Director of Mental Health and the Ministry of Health Medicines Control, the introduction of an alert to GPs on the clinical records system, and report back on its consideration.

These recommendations have been met.

3.2 Complaint issues by service type

Issues raised in complaints vary, at least to some degree, according to the DHB service type concerned. As shown in Table 7 below, diagnostic issues were most prevalent in complaints about services with high diagnostic workloads, with 40% of emergency department complaints and 14% of general medicine complaints being primarily about a missed/incorrect/delayed diagnosis. Unexpected treatment outcome was prominent for surgical services, as this issue most often relates to post-surgical complications.

These issues are broadly similar to what was seen last year. However, waiting list/prioritisation issues became more prominent for surgical and general medicine services and lack of access to services became more prominent for mental health services.

Primary issues in complaints about mental health services were quite distinct, with issues relating to involuntary admission/treatment and safety issues for consumers in inpatient units being common for this service. 'General safety issue for consumer in facility' became more prominent for mental health services in 2017/18 than has been seen in previous years.

Table 7. Most common primary issues in complaints by service type

Surgery total=291		Mental health total=188		General medicine total=152		Emergency department total=104		Maternity total=69	
Unexpected treatment outcome	22%	Issues with involuntary admission/ treatment	19%	Missed/ incorrect/ delayed diagnosis	14%	Missed/ incorrect/ delayed diagnosis	40%	Inadequate/ inappropriate treatment	17%
Waiting list/ prioritisation issue	20%	General safety issue for consumer in facility	9%	Waiting list/ prioritisation issue	9%	Refusal to treat	13%	Unexpected treatment outcome	16%
Missed/ incorrect/ delayed diagnosis	9%	Lack of access to services	8%	Unexpected treatment outcome	7%	Waiting list/ prioritisation issue	8%	Inadequate/ inappropriate monitoring	10%

Case study: Emergency Department and a missed/incorrect/delayed diagnosis (17HDC00316)

Management of incidental finding of rectal lymph nodes

A 72-year-old man presented to the Emergency Department (ED) of a public hospital after falling approximately three metres. He sustained injuries to his left hip and left side of his chest. A senior ED consultant ordered an urgent CT scan of the chest, abdomen, and pelvis.

When reporting on urgent CT scans, a preliminary acute report was issued to help determine the immediate care of the patient (a "sticky note"). The sticky note mechanism is an immediate, rough tool to assist clinicians to proceed with treatment of the patient and to answer the immediate clinical questions. The case is then fully reported – usually within 24 hours. The ED acted on the reporting radiologist's sticky note, which did not mention an incidental finding of rectal lymph nodes. The man was treated with pain relief and transferred to the surgical ward for ongoing care.

The following day, full reporting of the CT scan was entered into the information technology (IT) system at the hospital. This final report noted numerous enlarged meso-rectal lymph nodes and suggested endoscopic examination to rule out a rectal tumour. Several days later, the man was discharged from hospital. However, the final CT scan report was not sighted until eight months after discharge, when further investigation was initiated. The man was diagnosed with Stage IIIa squamous cell carcinoma of the anus, and underwent chemo-radiotherapy treatment and surgery.

At the time of these events, the IT system did not allow for electronic sign-off of test results. There was no alert system to notify a doctor that a result had arrived, nor was there a doctor-specific list of results to review. This meant that doctors could not look up all the results of tests or procedures they had ordered that day apart from proactively on an individual patient basis. The hospital acknowledged that this was a significant weakness in its system and, until this could be improved, there was no protection from recurrence.

A further complicating factor in this case was that there appeared to be a lack of clarity around who was responsible for following up and acting on the results of the CT scan once it was reported on. The ED consultant considered that clinical responsibility for the final CT report was handed over when the man was transferred to the surgical ward. However, the surgeon advised that as he was not the practitioner who ordered the CT scan, he did not receive a paper copy of the report and therefore, did not and would not have viewed the final CT scan report. There were no internal policies or procedures at the DHB relating to this issue.

<u>Findings</u>

The DHB had a weak IT system that did not allow for electronic sign-off, and it did not have a clear, effective, and formalised system in place for the reporting and following up of test results. This systems failure resulted in a number of opportunities being missed by clinicians to review and action the man's final CT scan report, and a delayed diagnosis of squamous cell carcinoma.

In respect of this case the Commissioner commented that the basic system principle with respect to the follow-up of test results is clear — the person who orders the test must follow up, or know by whom and how in the system it will be. The Commissioner was concerned about the inconsistencies in clinicians' understanding of how this principle applied at their hospital, stating that it was not acceptable that systems and clinicians lacked clarity on this.

The Commissioner found that the DHB did not provide services to the man with reasonable care and skill, and breached Right 4(1) of the Code.

The Commissioner was thoughtful about the use of the "sticky note" function in this case. He emphasised that this function is only a preliminary reporting tool that answers the immediate clinical question. It should not be relied on in place of the final report.

The Commissioner made a number of recommendations to the DHB, including that it:

- Update HDC on the progress and effectiveness of its IT system upgrade, including the development of policies and procedures with respect to electronic sign-off of test results and radiology reports. This update should include evidence that the new system reliably captures all relevant data.

- Advise whether "sticky notes" are still being used under the new IT system, and what measures have been taken to ensure that they are used as a preliminary reporting tool only, and that the final reports are also reviewed.

- Audit, over a period of three months, the management of test results ordered at ED where patients have been transferred to another ward.

- Take steps to ensure that discharge summaries accurately reflect available final diagnostic reports, and report back to HDC on the steps that have been taken.

- Develop policies and procedures on the management of test results and radiology reports.

As mentioned above, many complaints to HDC contain multiple issues of concern to the complainant. Table 8 below shows an analysis of the common complaint issues raised about each service type when all issues complained about are considered (rather than just the primary issue as in Table 7).

When all issues raised in complaints about each service type are analysed, it can be seen that communication issues feature prominently for all service types. However, again complaint issues do vary according to the service type complained about. General medicine and mental health services received a greater proportion of complaints involving communication with family than other service types, while emergency department services received a greater proportion of complaints involving inadequate examination/assessments, misdiagnosis and inadequate testing than did other service types. Surgical services received a greater proportion of complaints about a waiting list/prioritisation issue and maternity services received a greater proportion of complaints regarding a delay in treatment than other service types.

These issues are largely similar to what was seen last year for each service type, although complaints involving a waiting list/prioritisation issue became more prominent for surgical services in 2017/18.

Table 8. Most common issues in complaints by service type

Surgery total=291		Mental health total=188		General medicine total=152		Emergency department totaL=104		Maternity total=69	
Failure to communicate effectively with consumer	46%	Failure to communicate effectively with consumer	29%	Inadequate/ inappropriate treatment	38%	Inadequate/ inappropriate examination/ assessment	52%	Failure to communicate effectively with consumer	55%
Inadequate/ inappropriate treatment	44%	Failure to communicate effectively with family	27%	Failure to communicate effectively with family	35%	Missed/ incorrect/ delayed diagnosis	44%	Inadequate/ inappropriate treatment	54%
Unexpected treatment outcome	30%	Inadequate/ inappropriate treatment	25%	Failure to communicate effectively with consumer	33%	Failure to communicate effectively with consumer	36%	Delay in treatment	32%
Waiting list/ prioritisation issue	21%	Issues with involuntary admission/ treatment	23%	Missed/ incorrect/ delayed diagnosis	26%	Inadequate/ inappropriate treatment	27%	Unexpected treatment outcome	29%
Inadequate/ inappropriate examination/ assessment	20%	Inadequate/ inappropriate examination/ assessment	22%	Inadequate/ inappropriate examination/ assessment	24%	Inadequate/ inappropriate testing	25%	Inadequate/ Inappropriate examination & inadequate/ inappropriate monitoring	25% each

Case study: General Medicine and communication issues (15HDC00937)

Follow-up of clinically significant result

A woman went to a public hospital feeling unwell. She was transferred to the General Medical Service of the hospital with a suspected viral infection and an incidental finding of lower abdominal tenderness. She was placed under the care of a consultant general physician.

The consultant general physician ordered a priority ultrasound scan, and a query of ovarian cancer was listed in the "question to be answered" section of the scan request. The possibility of ovarian cancer was not discussed directly with the woman at the time due to her history of anxiety and depression.

The consultant general physician's documented plan was to discharge the woman after the ultrasound scan had been performed, with a recommendation that she follow up with her GP if her symptoms did not settle. Contrary to the plan, however, the woman was discharged by a house officer prior to the scan being carried out. The scan was changed to an outpatient scan, and the request contained no specific reference to ovarian cancer and was given normal status. The request also did not indicate that the report was to be copied to the woman's GP, although the discharge summary noted that her GP was to follow up on the result of the scan. The consultant general physician does not recall being made aware of these arrangements.

The woman's outpatient scan noted a mass likely to be of ovarian origin, and recommended gynaecological referral and tumour marker correlation. Neither the woman nor her GP received a copy of the scan or a report relating to it. The ultrasound report was viewed and accepted electronically by the consultant general physician. The consultant general physician did not take any action in relation to the findings. Over a year later, the woman was found to have a large ovarian mass, and she was diagnosed with high-grade serous carcinoma of the ovary.

Findings

The Commissioner was critical of the consultant general physician's failure to inform the woman of his concerns about ovarian cancer when he decided to order an ultrasound initially, and, after viewing the scan result, his failure to inform the woman of her result. The Commissioner considered that this was information that a reasonable consumer in the woman's circumstances would expect to receive, and by failing to provide this information the consultant general physician breached Right 6(1) of the Code.

The Commissioner noted that the basic premise, as stated in *Coles Medical Practice 2013*, is: "If you are responsible for conducting a clinical investigation you are also in charge of conducting follow up and keeping the patient informed." The Commissioner found that, by not taking any follow-up action on the woman's clinically significant test results, whether that be further investigations, or contacting her GP to ensure that someone was taking the follow-up action required, the consultant general physician failed to adhere to fundamental basic medical practice and breached Right 4(1) of the Code.

HDC's clinical advisor noted that this case includes issues of communication, documentation, and oversight of resident medical officers. The Commissioner agreed that a mix of these issues were likely at play, and considered that a series of acts and omissions by DHB staff led to the woman receiving poorly coordinated care. In particular:

- The initial inpatient scan was changed without documented explanation to an outpatient scan, and from having priority status to having only normal status;

- The house officer completing the request for an outpatient scan did not request a copy of the scan to be directed to the woman's GP, even though the discharge summary said that the GP was to follow up on the results. The concerns about ovarian cancer were not transcribed from

the inpatient scan request to the outpatient scan request;

- The woman was discharged contrary to the consultant general physician's documented plan in her clinical notes, without any documented explanation and without informing the consultant;

- There were no concerns about a possibility of ovarian cancer documented by the General Medical Service, other than on the in-patient scan request.

The Commissioner considered that these failings paint a picture of poorly coordinated and documented care, and found that the DHB failed to provide the woman with services with reasonable care and skill in breach of Right 4(1) of the Code.

The Commissioner recommended that the consultant general physician undertake a random audit of a selection of radiology test results received in the last three months to ensure that such test results have been followed up appropriately and communicated to his patients.

The Commissioner recommended that the DHB:

- Provide a report to HDC regarding the steps it has taken to facilitate systems to enable patients to receive a copy of their test results directly, including consideration that has been given regarding those patients without electronic access.

- Use this case as an anonymised case study for the education of staff, particularly around oversight of junior clinicians, communication and documentation.

- Provide a report to HDC regarding the status of recommendations made during it's Root Cause Analysis of this event.

These recommendations have been met.

COMPLAINTS CLOSED

1. What were the outcomes of the complaints closed?

1.1 Available resolution options

HDC is focused on fair and early resolution of complaints. Each complaint received by HDC is assessed carefully and resolved in the most appropriate manner, bearing in mind the issues raised and the evidence available. The preliminary assessment process is thorough and can involve a number of steps, including obtaining a response from the provider/s, seeking clinical advice and asking for information from the consumer or other people.

At the conclusion of a preliminary assessment, there are a number of options available to the Commissioner for the resolution of complaints. These include referring the complaint to the Advocacy Service, to a professional body, or to another agency. HDC may also refer a complaint back to the provider to resolve directly. In line with their responsibilities under the Code, DHBs have increasingly developed good systems to address complaints in a timely and appropriate way. Where complaints are assessed as suitable for resolution between the parties, it is often appropriate for HDC to refer a complaint to the DHB to resolve, with a requirement that the DHB report back to HDC on the outcome of its handling of the complaint.

The Commissioner also has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or a more appropriate outcome can be achieved in a more flexible and timely way than by means of investigation, or that the matters that are the subject of the complaint have been, or are being, or will be appropriately addressed by other means. Often a decision to take no further action will be accompanied by an educational comment or recommendations designed to assist the provider to improve services in future.

Where appropriate, the Commissioner may investigate a complaint, which may result in a DHB being found in breach of the Code. Notification of investigation generally indicates more serious issues.

1.2 Manner of resolution and outcomes in complaints closed

The manner of resolution and outcomes for all DHB complaints closed in the 2017/18 year is shown in Table 9 below. It should be noted that outcomes are displayed in a descending order. If there is more than one outcome for a DHB upon resolution of a complaint, then only the outcome listed highest in the table is included.

Table 9. Outcome for DHBs of complaints closed

Outcome for DHB	**Number of complaints**
Investigation	***51***
Breach finding – referred to Director of Proceedings	3
Breach finding	22
No breach finding with follow-up or educational comment	19
No further action	1
No breach finding	6
Other resolution following assessment	***791***
No further action with follow-up or educational comment	187
Referred to Ministry of Health	7
Referred to District Inspector	30
Referred to other agency	10
Referred to DHB	179
Referred to Advocacy	109
No further action	251
Withdrawn	18
Outside jurisdiction	***17***
TOTAL	**859**

As can be seen from the table above, in the 2017/18 year, HDC concluded 51 formal investigations involving DHBs, 25 of which resulted in a finding that the DHB had breached the Code. Three investigations resulted in a DHB being referred to the Director of Proceedings for the purpose of deciding whether any legal proceedings should be taken in the HRRT and / or HPDT.

2. Recommendations made to DHBs following resolution of complaints

Regardless of whether or not a complaint has been investigated, or whether the DHB has been found in breach of the Code, the Commissioner may make recommendations to a DHB. HDC then follows up with the DHB to ensure that these recommendations have been acted on. Many such recommendations are described in the case studies included throughout this report. In almost all cases (98.9%), recommendations made by HDC are complied with by providers, including DHBs.

Table 10 shows the recommendations made to DHBs in complaints closed in the 2017/18 year. Please note that more than one recommendation may be made in relation to a single complaint.

Table 10. Recommendations made to DHBs following a complaint

Type of recommendation	Number of recommendations made
Apology	27
Audit	35
Meeting with consumer/complainant	5
Presentat/discuss complaint with others	21
Provide evidence of change to HDC	96
Provide information to consumer/complainant	2
Reflection	13
Review/implement policies/procedures	79
Training/professional development	53
Total	**331**

As can be seen from Table 10 above, the most common recommendation made to DHBs was that they provide evidence to HDC of the changes they had made in response to the issues raised by the complaint (96 recommendations). Often, when HDC asks for this evidence, it is also recommended that the provider conducts a review of the effectiveness of the changes made. Conducting a review of their policies/procedures or implementing new policies/procedures (79 recommendations) and staff training (53 recommendations) were also often recommended. Staff training was most commonly recommended in relation to clinical issues. Where new policies/procedures have been introduced by providers following a complaint, HDC will often recommend an audit to ensure that staff are complying with these new policies/procedures.

Case studies
HDC recommendations to DHBs

Recommendations arising from a breach of the Code relating to failures in coordinating the evaluation of the suitability of a woman and her donor for kidney transplant
(14HDC00885)

The Commissioner considered that the continuity of the woman's care was compromised owing to the fact that there were several points in the evaluative process for which one DHB was responsible where there was delay because of error, failure to follow agreed process in communicating with the regional transplant group, resource allocation or lack of clarity regarding roles. He therefore found this DHB in breach of Right 4(5) of the Code.

Three DHBs were involved in evaluating the suitability of the woman and her donor for a kidney transplant. The Commissioner considered that the woman's experience highlighted the difficulty in coordinating renal transplant services across multiple DHBs, and the need to clarify the responsibility of each clinical team. With this in mind, he recommended that the three DHBs involved in the woman's care collaborate in reviewing their system for sharing information regarding renal transplants. He specified that a policy should be agreed upon that includes: a clear method for seeking and providing advice; the form in which information is shared; the responsibility of each party; and timeframes wherever appropriate. He also asked that: where appropriate, template letters or documents be created or amended to align with the policy; and that a system be developed that provided for regular education/training to all relevant staff to ensure that the communication pathways are understood and that practices do not deviate from the policy over time.

The Commissioner made a number of recommendations to the DHB he found in breach of the Code, including that it:

- Update HDC on the changes it had put in place since the events of the case.
- Establish, with the assistance of other DHBs, clear guidelines for the evaluation of living donors, including: what circumstances are required for evaluations to begin prior to a recipient being accepted onto the deceased donor list; which tests will be completed prior to recipient acceptance; and guidelines around timeframes for completion of tests.
- Review staffing ratios to ensure that the needs of consumers can be met safely.

The Commissioner also recommended that another DHB involved in this case establish a system for providing clear and specific instructions at the outset regarding what is necessary for recipient evaluation in circumstances that deviate from the norm (such as dealing with complex and rare diseases), including where certain evaluations may not be required.

These recommendations have been met.

Recommendations arising from a breach of the Code relating to an inadequate referrals system
(15HDC01667, 16HDC00035, and 16HDC00328)

The Commissioner found a DHB in breach of Right 4(1) of the Code for failures in their referrals system in regards to three consumers. The Commissioner considered that the three cases were concerning examples of information being available but not actioned appropriately within the DHB's system which had a direct impact on the timeliness of the consumers receiving appropriate care.

In response to recommendations made by the Commissioner, the DHB:

- Provided HDC with an update on its progress to move to a fully electronic internal referral system.

- Ensured that there was a clear procedure for ensuring that referrals, once received in the Patient Services Centre (PSC) are loaded onto the Patient Information Management System (PIMS) and actioned.

- Ensured that fundamental changes to key steps in policies are communicated across users.

- Moved away from a system that requires printing of the electronic referrals for grading (with the exception of radiology and maternity).

Recommendations arising from a breach of the Code relating to failures in ensuring an overseas trained orthopaedic surgeon was fit to practise
(15HDC01280)

The Commissioner found that for failing to have in place appropriate systems relating to recruitment and complaints management, which amounted to a failure in its duty of care, a DHB failed to provide services with reasonable care and skill in breach of Right 4(1) of the Code. This was evidenced by its lack of care in how it employed the orthopaedic surgeon, most notably for failing to secure a recent reference, and by failing to have in place adequate systems to identify an emerging pattern of concerns, and to enable the appropriate staff to be aware of, and ultimately respond to, that emerging pattern.

The Commissioner was also critical of aspects of the DHB's supervision and monitoring process and its processes around induction and orientation.

The Commissioner asked the DHB to give consideration to the following actions and report back to HDC on the outcome of that consideration:

- Ensure that policies on recruitment are understood and followed, particularly in relation to the necessity of current referees, and of verbal reference checking – the content of which is fully documented.

- Review the position descriptions of the service manager and clinical leader to ensure that both parties understand their responsibilities in respect of recruitment of SMOs, and in particular in respect of international medical graduates (IMGs).

- Ensure that supervisors are aware of their responsibilities in regards to MCNZ's supervision requirements for IMG locum tenens. Particular care should be taken in respect of any pre-employment concerns such as those indicated in reference checking.

- Ensure that complaints regarding clinical staff are shared with relevant professional clinical leaders, who in turn should contribute to the response.

- Ensure that data regarding number of complaints by individual practitioners is monitored and, where there are more than two complaints in one year, or three in total, then consideration is given to further investigation and, as appropriate, performance management.

- Link complaints to adverse events in their incident reporting system, and provide reports to clinical leaders and management, who in turn should take joint responsibility for the review

and resultant actions.

- Consider a formal policy for annual performance appraisal/professional development for all SMOs, and develop a process whereby anonymous multisource feedback can be used in providing feedback about performance.
- Consider peer support/mentoring, independent of clinical supervision, for all IMGs in their first year of employment.
- Provide clinical leadership training for all clinicians in responsible roles.
- Consider performing yearly review of credentials for all IMG SMO appointments.

These recommendations have been met.

4.2 Human Resources Report

Recommendation:

That the report be received.

Prepared by: Fiona McCarthy (Director Human Resources)

Purpose of report

This report outlines key people and organisational development activities across Waitemata DHB and reports on progress with workforce plan actions.

1. Strategic Alignment

Community, whanau and patient centred model of care	The report outlines recruitment, workforce or organisational development programmes and actions that can impact internal and external models for care.
Service integration and/or consolidation	The report outlines work undertaken collaboratively across the organisation.
Intelligence and insight	The recruitment and ethnicity dashboards give information and insight into the impact of our recruiting processes.
Evidence informed decision making and practice	Where possible, all improvement or new programmes of work will use evidence based frameworks to develop and/or evidence to enhance existing work. All programmes are evaluated to understand the value and return on investment.
Outward focus and flexible, service orientation	Improvements sought in relation to policy, process or programmes will be co-designed with service users.
Operational and financial sustainability	Robust recruitment, workforce and organisational development frameworks, strategies and actions support sustainable business practises.

2. Recruitment

2.1 Recruitment Dashboard

	March 2019		April 2019	
Total number of hires (Headcount)	244 offers accepted (headcount)		231 offers accepted (headcount)	
Average time to hire	68.83 days		74.90 days	
Current number of vacancies by speciality we are recruiting to (FTE)	Medical Nursing Allied Health Support Mgmt./Admin	34.13 137.41 151.61 25.37 64.26 412.78	Medical Nursing Allied Health Support Mgmt./Admin	33.90 121.25 158.18 27.11 61.46 401.90

2.2 Robotic Process Automation

We are scoping various recruitment processes to assess the introduction of robotic technology to remove previously manual processes. A review of possible opportunities is due in July.

2.3 Additional Nursing Roles (Nursing Accord)

Members will be aware that one of the outcomes form the Nursing and Midwives Collective Agreement Negotiations was the provision of additional funding for new Nursing roles. We have completed recruitment to 82% of the 46 roles identified for this funding and are progressing well with recruitment for the remainder of the roles.

2.4 Top sources of Applications

Rank / Source		March 2019	April 2019
1.	DHB website	32%	33%
2.	A Friend, referral	22%	19%
3.	DHB internal website	7%	8%
4.	www.kiwihealthjobs.co.nz	5%	8%
5.	www.seek.com	9%	7%

Table 1: Top Sources of Hire

*The above source dashboard is taken from Taleo E Recruitment system. Applicants enter where they heard about the position when they apply for a job.

2.5 Giving back

On 29 March, the Recruitment team undertook volunteer work at the DHB – this is the third time they have undertaken volunteer work, this time improving the front of the Shea Terrace vehicle entrance way – go team!

3. Workforce Development

3.1 Strengthening Health Equity

3.1.1 Progress and targets to grow Māori Workforces

The DHB has made good progress over the last 12 months in our commitment to grow our Māori workforce. The DHB has 507 staff who identify as Māori. Our June target is 509 staff. In April 9.4% of new staff who commenced in April identified as Māori. The monthly average is 7.7%.

In relation to our initiative to interview all Maori staff who meet minimum standards as defined in the position description, over the last 12 months an average of 69% of candidates interviewed have been offered and accepted roles with Waitematā DHB. Of the total number of Māori candidates over the last 12 months who have applied for roles 21% of applicants have accepted roles.

The percentage of applicants moving from shortlist to interview to acceptance has increased over time. All but three divisions have Māori applicant acceptance rates greater than those across all applicants.

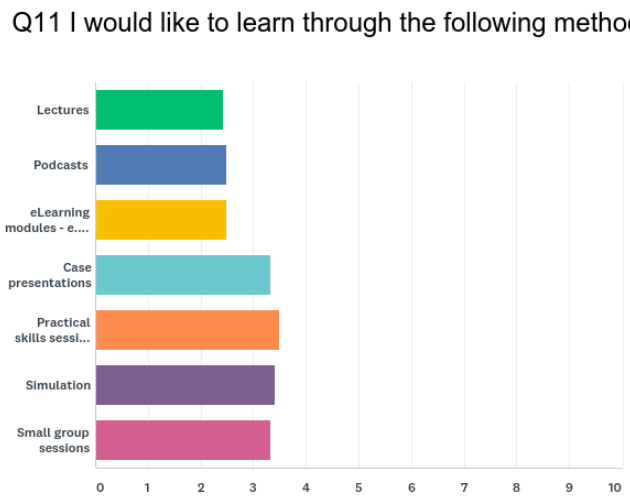
We look forward to upcoming initiatives including our June "new to Health Care Assistant" programme; engagement of a Māori Recruitment Consultant and additional support for our Māori nursing student and new graduates.

4. Learning and Education

4.1 Clinical Education

4.1.1 Small scale evaluation of medical learning methods

Dr Kate Richardson, one of our Medical Education Fellow has been working with the current second year Resident Medical Doctors to clarify current methods of learning and activities that this group are engaging in. While the group is highly technology driven with their learning activities, they have indicated a continued desire to attend in-person workshops/skills sessions as well as simulation training. This work will be helpful in ensuring we offer learning and education that is engaging and of interest. Results of the evaluation of learning methods are outlined below.

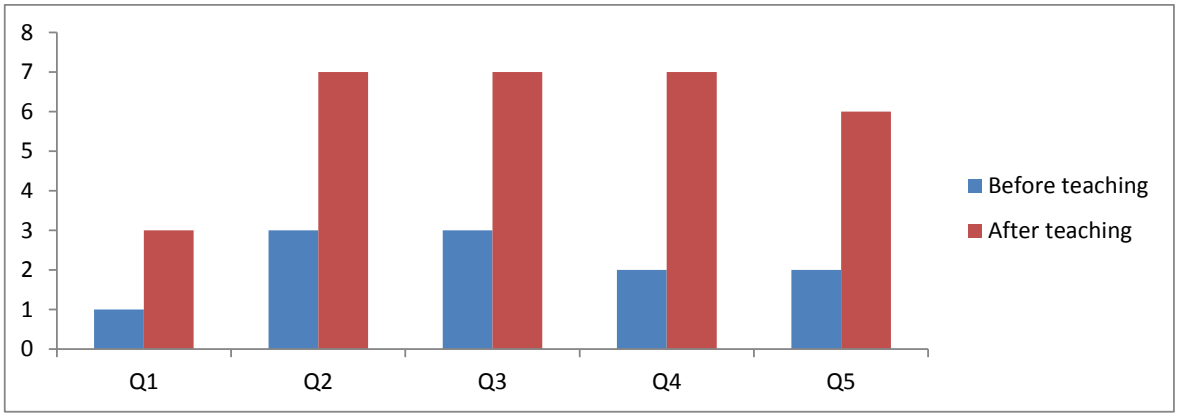


4.1.2 Medical Student teaching

Dr Ellen Miller, another of our medical education fellows has been working with pharmacist Avril Lee to arrange prescribing and therapeutics teaching for 4th year students. Following on from the formal workshop run by Ellen and Avril last month, students have completed a clinical pharmacist attachment. Ellen has received feedback from students and plans to analyse this to work on improvements in the training.

The first 8 students have completed their evaluation. It is pleasing to see the increase in knowledge and confidence following this education.

Q1 - Confidence prescribing on a paper chart
Q2 - Confidence in taking a complete medication history from a patient
Q3 - Confidence in accessing appropriate prescribing resources
Q4 - Knowledge of the role of the clinical pharmacist
Q 5 -Knowledge of how to avoid making medication errors



4.2 Te Pumaomao Cultural Perspectives

Waitemata DHB has run the Te Pumaomao cultural perspectives 2 day programme at the Waitakere Marae for a number of years to help our staff develop an understanding of cultural perspectives.

This is a very popular 2 day face to face programme and was attended by 18 participants 25 & 26 March. Feedback from staff was mostly positive with a very small number saying it could be more informative, fun, engaging and applicable to their job.

- "The facilitators Chris and Takawai were skilled presenters/educators. The handled a highly emotive topic in a diplomatic and safe way."
- "This course is the best course I have participated in at WDHB in all my years. I rate it # 1."
- "This was run with a light human approach, which had sincerity, passion and warmth. It did not scold, judge, but the message was clear and I for the first time really understood the effect of colonization."
- "Excellent presentations, interactive informative sensitive topics delivered very respectfully and compassionately. Ways to move forward and improve health and wellbeing for Maori."

4.3 Leadership Development

4.3.1 Primary care nurse Leadership

The firth cohort of the Influential Nurse Leaders (INL) Programme is underway with 17 primary care nurses participating from across the district. For the first time nurses working in the Counties Manukau DHB area is attending this course. Due to the high demand across the Metro Auckland area, we will collaborate with Counties Manukau DHB to include them in this course going forward, with the potential to amalgamate this course with leading quality care (discussed below).

Discussions are underway to determine whether a mentorship or coaching course/programme would be feasible as a next step for the nurses who completed the INL programme.

4.3.2 Leading Quality Care Programme

The Leading Quality Care programme has been delivered over the last four months to 19 participants and 3 coaches.

In April we completed days 5 – 6 of the programme focusing on Leading Change in a complex organisation.

The three blocks of 2-day workshops are completed and participants are now preparing to present their projects.

The new developments in this programme, including the use of coaching to guide participants through their projects, have proved very successful and the feedback on leadership and personal development has been very positive. One criticism to note is the time pressure experienced with the reduction of the gap between workshops and the final presentation.

Planning is underway for the next cohort in July which will be in collaboration with Counties Manukau DHB.

4.4 Wellbeing

4.4.1 Mindfulness based resilience at work

On the 29 April we started another two Mindfulness Based Resilience @ Work programmes:

- A Level 1 cohort 10 participants in Waitakere
- Our first Level 2 cohort of 12 participants in Waitakere

Initial feedback from participants is positive.

The desire is to approach previous participants that completed the MBR@W who may be interested in becoming Champions of Mindfulness-based Resilience at work that can work within the departments and services.

4.4.2 CALM workshop

This interactive workshop is designed to follow on from the on-line CALM learning module which promotes communication and de-escalation skills and techniques. The workshop is presented by our People and Capability Consultant Christine (CJ) Jones.

Theories discussed in the on-line module are made relevant by allowing participants to work practically with scenarios specific to their workplace.

Participant satisfaction with the workshops so far has averaged at4.7/5 with comments such as:

- “I thought you did a great job, lovely relaxed atmosphere, good time keeping and a new spin on acquired knowledge made it very interesting. Role play is challenging for most people so the small group environment worked well.”
- “It was very good to know and learn and different human behaviours, classify them and could implement our line of action for a desirable outcome.”
- “This course was AMAZING! It was extremely engaging and relevant. I enjoyed splitting into groups and role-playing. I also liked the 4 different animal types- this is extremely helpful for all aspects of my life”
- “CJ was an excellent presenter, the information from the course was a good refresher of what I already knew and added to that knowledge further techniques and gaps that existed”

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 08/05/19	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)]