HOSPITAL ADVISORY COMMITTEE (HAC) MEETING

Wednesday 24th September 2014

10.45am

Note:
- Public Excluded Session 10.45am to 11.45am
- Open meeting from 11.45am

AGENDA

VENUE
Waitemata District Health Board
Boardroom
Level 1, 15 Shea Tce
Takapuna
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.

TIME 10.45a.m (please note agenda item times are estimates only and that the public excluded session is from 10.45am-11.45am)

1. AGENDA ORDER AND TIMING

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11.45am 3.1 Confirmation of Minutes of Hospital Advisory Committee Meeting (13/08/14) ..............7

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5. PROVIDER REPORT

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6. CORPORATE REPORTS

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12.40pm 6.2 Human Resources Report .................................................................................105

7. INFORMATION PAPERS
Waitemata District Health Board
Hospital Advisory Committee Member Attendance Schedule 2014

<table>
<thead>
<tr>
<th>NAME</th>
<th>FEB</th>
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<td>James Le Fevre (Committee Chair)</td>
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✓ Attended the meeting
x Absent
* Attended part of the meeting only
# Absent on Board business
^ Leave of absence
## Register Of Interests

<table>
<thead>
<tr>
<th>Board/Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
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</thead>
</table>
| **Lester Levy**        | Chair – Auckland District Health Board  
                        | Chairman – Auckland Transport  
                        | Deputy Chair – Health Benefits Limited  
                        | Independent Chairman – Tonkin & Taylor  
                        | Chief Executive – New Zealand Leadership Institute  
                        | Professor of Leadership – University of Auckland Business School  
                        | Trustee - Well Foundation (ex-officio member)  
                        | Director – Orion Health  
                        | 20/08/14 |
| **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 |
| **Sandra Coney**       | Chair – Waitakere Ranges Local Board, Auckland Council  
                        | 12/12/13 |
| **Pat Booth**          | Consulting Editor – Fairfax Suburban Papers in Auckland  
                        | 24/06/09 |
| **Warren Flaunty**     | Member – Henderson - Massey and Rodney Local Boards, Auckland Council  
                        | Trustee - West Auckland Hospice  
                        | Trustee (Vice President) - Waitakere Licensing Trust  
                        | Shareholder - EBOS Group  
                        | Shareholder – Green Cross Health  
                        | Director – Westgate Pharmacy Ltd  
                        | Chair – Three Harbours Health Foundation  
                        | Director – Trusts Community Foundation Ltd  
                        | 30/07/14 |
| **James Le Fevre**     | Emergency Medicine Registrar – Waitakere Emergency Department  
                        | Auckland Helicopter Emergency Medical Service (HEMS) Doctor  
                        | Doctor, Lifeflight New Zealand Ltd  
                        | Member – Australian College for Emergency Medicine, Hospital  
                        | Overcrowding Subcommittee  
                        | From 1st September 2014 James’ wife is an employee of the Waitemata DHB, Department of Anaesthesia  
                        | 28/07/14 |
| **Anthony Norman – Deputy Chair** | Board Chair - Northland DHB  
                        | Director - Health Alliance NZ Ltd  
                        | Director - Health Alliance (FPSC) Ltd  
                        | Chair - DHB Shared Services Executive Committee  
                        | Trustee and Treasurer - Kerikeri International Piano Competition Trust  
                        | Partner - Mill Bay Haven, Mangonui (accommodation provider)  
                        | Member - representing the interests of 20 DHBs, of the following committees: Health Sector Forum; Medication Safety Committee and Health Sector Relationship Committee  
                        | 23/01/14 |
| **Morris Pita**        | Board Member – Auckland District Health Board  
                        | Owner/operator – Shea Pita and Associates Limited  
                        | Shareholder – Turuki Pharmacy Limited  
                        | Wife is member of the Northland District Health Board  
                        | 13/12/13 |
| **Christine Rankin**   | Member - Upper Harbour Local Board, Auckland Council  
                        | Director - The Transformational Leadership Company  
                        | CEO – Conservative Party  
                        | 17/05/13 |
| **Allison Roe**        | Member – Devonport-Takapuna Local Board, Auckland Council  
                        | Chairperson – Matakana Coast Trail Trust  
                        | 02/07/14 |
### Gwen Tepania-Palmer
- Chairperson - Ngatihine Health Trust, Bay of Islands
- Life Member – National Council Maori Nurses
- Alumni – Massey University MBA
- Director – Manaia Health PHO, Whangarei
- Board Member – Auckland District Health Board
- Committee Member – Lottery Northland Community Committee

**11/03/13**

### Co-Opted Members

<table>
<thead>
<tr>
<th>Susanna Galea</th>
<th>Member – New Zealand Medical Association</th>
<th>31/03/14</th>
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<tr>
<td></td>
<td>Member – Association of Salaried Medical Specialists (ASMS)</td>
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<td>Member – Medical Protection Society</td>
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<td>Associate Director – Centre for Addictions Research</td>
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<th>Andrew Jones</th>
<th>No current listings.</th>
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2 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:

<table>
<thead>
<tr>
<th>General subject of items to be considered</th>
<th>Reason for passing this resolution in relation to each item</th>
<th>Ground(s) under Clause 32 for passing this resolution</th>
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</thead>
<tbody>
<tr>
<td>1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 13/08/14</td>
<td>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&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>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&amp;D Act.</td>
</tr>
<tr>
<td>2. Quality Report</td>
<td>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&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>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)]</td>
</tr>
<tr>
<td>3. HR Update Report</td>
<td>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&amp;D Act 2000 Schedule 3, S.32 (a)]</td>
<td>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)]</td>
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3.1 Confirmation of Minutes of the Hospital Advisory Committee Meeting Held on 13\textsuperscript{th} August 2014

Recommendation:

That the Minutes of the Hospital Advisory Committee meeting held on 13\textsuperscript{th} August 2014 be approved.
Minutes of the meeting of the Waitemata District Health Board

Hospital Advisory Committee

Wednesday 13 August 2014

held at Waitemata District Health Board Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 10.08a.m.

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT

James Le Fevre (Committee Chair)
Lester Levy (Board Chair)
Max Abbott
Pat Booth
Sandra Coney (Deputy Committee Chair) (present from 11.00a.m.)
Tony Norman
Morris Pita
Allison Roe
Gwen Tepania-Palmer
Susanna Galea
Andrew Jones

ALSO PRESENT

Dale Bramley (Chief Executive)
Andrew Brant (Chief Medical Officer)
Robert Paine (Chief Financial Officer and Head of Corporate Services)
Jocelyn Peach (Director of Nursing and Midwifery)
Phil Barnes (Director of Allied Health)
Fiona McCarthy (Director of Human Resources)
Debbie Eastwood (GM Medicine and Health of Older People)
Jonathan Christiansen (Head of Department, Medical)
John Cullen (Director ESC)
Jo Brown (Acting Director Funding)
Paul Garbett (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

Lynda Williams (Auckland Womens Health Council) (present from 10.50a.m)

LEAVE OF ABSENCE: Christine Rankin

APOLOGIES

Apologies were received and accepted from Warren Flaunty and for late arrival from Sandra Coney.

WELCOME

The Committee Chair welcomed all those present including the new Director of Human Resources, Fiona McCarthy, who was introduced to the Committee.
DISCLOSURE OF INTERESTS

There were no changes to the Interests Register.

There were no declarations of interest relating to the open section of the agenda.

Morris Pita noted that he is starting exploratory work with the Ministry of Health on a project concerning primary care and would not participate in any items relevant to that. He would advise if anything arose during the meeting related to that.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed in the agenda, with the public excluded session being held first, from 10.12a.m. until 10.50a.m.

2. RESOLUTION TO EXCLUDE THE PUBLIC (agenda page 6)

Resolution (Moved Gwen Tepania-Palmer/Seconded Tony Norman)

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:

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<tbody>
<tr>
<td>1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 02/07/14</td>
<td>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&amp;D Act 2000, Schedule 3, S.32 a]</td>
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Waitemata DHB, Meeting of the Hospital Advisory Committee 24/09/14
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
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3. HR Update 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)]

Carried

10.12a.m to 10.50a.m – public excluded session

10.50a.m – the Committee resumed in open session.

3. COMMITTEE MINUTES

3.1 Confirmation of the Minutes of the Meeting of the Hospital Advisory Committee held on 2nd July 2014 (agenda pages 7-21)

Resolution (Moved Pat Booth/Seconded Max Abbott)

That the minutes of the meeting of the Hospital Advisory Committee held on 2nd July 2014 be approved.

Carried

Actions Arising

It was noted that the review report on Breast Screening was coming to the Board on 13 August, earlier than indicated in the Actions Arising report.

4. ITEMS FOR CONSIDERATION AND RECOMMENDATION TO THE BOARD

There were no decision items.
5. PROVIDER ARM PERFORMANCE REPORT

5.1 Provider Arm Performance Report – June 2014 (agenda pages 22-103)

Executive Summary/Overview/Scorecard/Human Resources

Robert Paine summarised the financial results. He noted that the June results reflect a number of year end provisions credited prudently. The Provider Arm results for June need to be read in that context. The overall DHB consolidated financial result for 2013/14 was a $3.5M surplus.

Andrew Brant highlighted how extremely busy the hospitals had been in recent weeks, with a great deal of pressure on beds. On some days they had been more than 20% busier than for the same days last year. There had been a lot of pressure on the six hour ED target and clinicians had worked hard to manage that. Some additional spaces such as in PACU and Radiology had needed to be used for patients. For a time, complaint response times had also slipped, however over the last three to four weeks that was coming back towards target.

Matters covered in discussion and response to questions on this section of the report included:

- With the current situation, ESC capacity is not designed to take acute demand; however the transfer of acute ankle fractures to ESC had been initiated and they are looking at other possible cohorts. On the most recent weekend they had transferred some patients post procedure for hip operations to ESC for ongoing rehabilitation, while trying to make sure that this was done as safely as possible.
- The Committee Chair noted that lots of little things tend to go wrong when types of patient are located in areas that they are not normally.
- The Chief Executive commented that there is a Winter Plan, but this cannot cope with 20% increases in medical admissions. On several days there had been no spare beds in either hospital. They had talked to Auckland DHB and Counties Manukau DHB, but on those days unfortunately their hospitals had absolutely no spare capacity as well. The risk to the public meant that permanent solutions needed to be found to increase beds available by next winter, which was the basis for some of the recommendations on the Board agenda.
- National data on influenza had shown a later peak in cases this year compared to 2013, but overall not as high a number of cases. However Waitemata DHB had topped the national table about three weeks previously. Questions have also been raised about the efficacy of the influenza vaccine this year. The problems experienced here relate to a large elderly population, in many cases frail and with comorbidities.
- Andrew Brant expressed his concern at having patients in areas not normally utilised and the clinical risk of that. He would like to see a position where this is not necessary; but when such decisions are made there is a lot of clinical discussion about appropriateness and how risks will be mitigated.
- When people are admitted to hospital with influenza, whether or not they have been previously immunised is not systematically recorded, although the question will often be asked.
The Board Chair commented that the influenza vaccine can only cover a number of strains and its effectiveness relates to those particular strains and is variable between them. This year the H1N1 strain had caused a lot of problems, with some prolonged stays in ICU in excess of four weeks.

In answer to a question relating to why Waitakere Hospital normally had better results than North Shore Hospital in terms of the six hours ED target, Jonathan Christiansen advised that this partly related to the fact that many patients are transferred from there quickly to North Shore Hospital and that also there are some differences in the set up there.

11.00a.m – Sandra Coney arrived during the course of the above discussion.

**Medicine and Health of Older Peoples Services**

Debbie Eastwood (General Manager, Medicine and Health of Older Peoples Services) and Dr Jonathan Christiansen (Head of Division Medical) presented this section of the report.

Matters highlighted or updated by Jonathan Christiansen included:

- The high patient volumes in July in the West as well as the North.
- The frailty issue – not just the large elderly population, but the level of frailty. There is a philosophy to keep people living in their homes as long as possible, but it takes very little to put them in hospital and these are often fairly long stays. There is a large number of elderly people awaiting placement in aged residential care and a large number too sick to be living by themselves at home, particularly over 85 year olds.
- There is a comprehensive Winter Plan, but there are limits to flexibility that can be required of staff and particularly there are contractual obligations to RMOs. They are carrying a number of vacancies at the moment for which it has not been possible to recruit New Zealand graduates and that leaves holes in the roster. When extra nursing is needed, for example for ADU, often the skill set needed is not available.
- With regard to the figures for ADU for the time to be seen from triage, percentage compliance to 60 minutes (page 37 of the agenda), the target may have been slightly unrealistic and the Governance Group for ADU had suggested that the two hour percentage also be looked at as being more clinically meaningful.
- ADU is under enormous pressure. Some additional medical support has been arranged at both North Shore and Waitakere Hospitals.
- With colonoscopies, as at 1 August, 76% of urgent colonoscopies are taking place within the 14 day target and 63% of non-urgent colonoscopies within the 42 day target.

Matters highlighted by Debbie Eastwood included:

- With regard to current pressures, they are working closely with Surgical Services, keeping in mind elective targets as well. There is a whole of hospital approach, balancing acute and elective needs and making sure patients are safe.
- Staff turnover is currently 9.4% and they are looking at how they can decrease that.
In response to questions the Committee was advised that with the Slark Hyperbaric Unit all costs incurred are recoverable under the agreement for this national service. The issue noted in the report is in error. The facility is working to full capacity, but that involves only modest acute volumes as expected. The threshold for receiving treatment is very clear and international guidelines are adhered to. It is not used for the wider range of extraneous conditions that it could be applied to.

Mental Health and Addiction Services

Helen Wood (GM Mental Health and Addiction Services), Alex Craig (Associate Director of Nursing Practice, Mental Health) and Megan Jones (Clinical Effectiveness Lead) were present for this section of the report.

The Chief Executive acknowledged the work of Helen Wood for the DHB over many years as an exemplary GM. Helen is leaving to undertake one year’s post-graduate study in MSc Global Mental Health at King’s College London’s Institute of Psychiatry and the London School of Hygiene and Tropical Medicine. Following that she will come back to the DHB in a different role to lead Mental Health planning.

Helen Wood conveyed apologies from Jeremy Skipworth and Murray Patton.

Matters highlighted or updated included:

- The analysis of the breaches for Mental Health of the shorter waits in ED target (page 60 of the agenda) and the links to overall acute demand. She noted that Megan Jones audits all breaches and that some issues have been worked on and process improvements have been made. For Waitakere ED they are looking at basing some specific staffing there, with coverage from 7 or 8a.m in the morning to 11p.m at night. For the period from 11p.m it is envisaged that there would be one person on duty but also covering other areas.
- There has been a high level of occupancy of acute beds in recent months. Quite a lot of work had been put into identifying people who could be moved from acute facilities to respite facilities. The additional beds approved for high and complex needs patients will improve the overall situation when implemented. Work is underway with the Funder on this.
- With the Waves support group (page 64), Helen Wood advised that they are working with the Funder to provide better support to the mother who has been the key facilitator of the group.
- The evaluation of the review of administration services in the mental health services group (page 66) – in many cases reported impacts appear to be linked with clinical and administrative processes that could benefit from review rather than loss of FTE. Most of the focus is on the West Auckland site at Paramount Drive. Work is being done to see if they can improve the system there.
- Ha Puna Waiora – construction continues to make good progress.
- Additional services to support mothers with acute mental health needs (detailed on page 67 of the agenda) – the launch is expected to take place on 15 or 16 September.

Helen Wood was acknowledged by Gwen Tepania-Palmer, James Le Fevre and Susanna Galea for the extensive contribution that she had made and for being
available and supportive. A resolution acknowledging her contribution was passed at the conclusion of consideration of the Provider Arm report.

Elective Surgical Centre (ESC)

John Cullen (Director ESC) and Mark Watson (Group Manager ESC) were present for this section of the report.

Matters highlighted or updated included:
- ESC has significantly increased the volumes delivered, with over 100 patients per week. At this early point in the financial year they are at 115% of overall budget volumes and positive in terms of WIES as well.
- The Package of Care SMO Contract Review is complete and there is no change to the fee calculation methodology. A small fee increase has been applied to a small percentage of the procedures.
- The review/upgrade of the Nexus CSSD/Theatre Management System, as detailed on page 73.
- The full contingent of surgeons is now in place for the ESC.
- The ‘acute arranged’ fractured ankle service is now underway, with three or four cases operated on each Friday morning.

Matters covered in discussion and response to questions included:
- John Cullen outlined the normal process with fractured ankles: if there is swelling, put into a cast, send home to rest the ankle and keep the leg elevated, bring back for the operation when the swelling has reduced.
- The question of possible impact of priority for Neck of Femur patients on other operations was raised (a Surgical and Ambulatory Services question). Michael Rodgers (Chief of Surgery) advised that there does not seem to be a major impact at the moment, partly because of the introduction of additional capacity in Orthopaedics.
- With regard to fractured ankles being dealt with by the ESC, this had been identified as one type of acute operation that it is sustainable to send there; in effect these cases can be converted from an acute episode into a type of elective case.
- In answer to a question, John Cullen advised that while it was optimal to have early surgery on ankles if not swollen, if there was swelling then operating on a swollen ankle could well increase the likelihood of CRPS (complex regional pain syndrome).
- In answer to a question as to whether Vitamin C should be offered in hospitals in fracture cases, John Cullen advised that one of the registrars in Orthopaedics is running a trial of this. Before considering introduction there needs to be a trial with a comparable cohort. This will take time to show results. After discussion it was agreed that a review be carried out of the current state of evidence and the results be brought back to the Committee.

Surgical and Ambulatory Services

Michael Rodgers (Chief of Surgery) presented this section of the report. He commented that as he became involved in his new role he was seeing fantastic work being done in extremely difficult circumstances. Matters that he highlighted included:
The review of Orthopaedic breaches of the shorter waits in ED target (page 78). There is a definite opportunity to improve results and he will be reporting further on this.

- Elective surgery volumes are on track.
- The Did Not Attend (DNA) Project (pages 78-79). A lot of work is taking place and it is hoped that there will be significant progress soon.
- The e-triage process for e-referrals — they are trying to get surgeons involved as quickly as possible.
- The new MRI scanner and upgrading of the existing one.
- ESPI compliance — results are looking good. There is an issue with Spinal Surgery which Cath Cronin is reviewing.

Ward 8 refurbishment means re-engaging staff who had worked on the original plan, which is not easy.

Andrew Brant commented that the Regional E-referrals Project Phase 2 is currently underway. This Phase will mean that clinicians can triage electronically and a message from that can go back electronically to the GP. It will enable much better communication with GPs. The later phases 3 and 4 involve refinement in and between hospitals. There is still some development work to be programmed for that.

**How Triage Works and the Clinical Decision involved**

A briefing on this had been requested at the previous Committee meeting and was provided by John Cullen and Michael Rodgers.

John Cullen circulated and explained the form used for triage in Orthopaedics. The aim of the process is to determine firstly who is the appropriate surgeon for the patient to see and secondly the grading and urgency of the case. He noted that it is vital that the clinician has enough information to base a triage decision on. If there is not enough information, the referral is sent back to the GP with a request for further information. An issue is whether the grading clinician should take into account the finite volume capacity to carry out that type of operation. While he had taken that approach with Orthopaedics, not all grading clinicians agreed with or followed that.

Michael Rodgers described the approach taken in General Surgery, which is dominated by cancer cases. The principles to be followed are: firstly, the process should be transparent; secondly, there needs to be consistency between graders; thirdly there needs to be equity, not favouring one group of patients over another. With regard to the issue of where responsibility lies for resource issues, he felt very strongly that this should not be part of the grading process that the individual clinician is undertaking. In General Surgery, cases are assigned to Priority 1, 2 or 3. Then there are sub-categories depending on how severe symptoms are.

The Committee Chair thanked John Cullen and Michael Rodgers for giving the Committee a valuable understanding of what occurs.

In answer to a question, John Cullen advised that until now the record for this process had been a paper one; the next stage with e-referrals will be to provide the ability to triage electronically.
Child, Women and Family Services

Linda Harun (General Manager, Child, Women and Family Services) and Dr Peter van de Weijer (Interim HOD Medical) presented this section of the report.

Matters highlighted by Linda Harun included:
- Late winter pressure, with a very big influx of children over the most recent two weeks. They had pulled in nursing staff from across child services to support the Rangatira Ward and were looking at additional medical staff for the weekends.
- There had been an increase in referrals from GPs on the North Shore straight to Rangatira Ward and they were also seeing more children referred with complex conditions.
- Complaint response times for June were longer than expected due to complexity.
- Oral Health arrears are already better than target for the year.

Matters highlighted by Peter van de Weijer included:
- It is always a challenge to meet the needs of women, children and families in the winter months. They are trying to accommodate needs as best they can and every child and every woman does get care. With referrals, while they prioritise, they still try to meet every patient; each will receive a personalised answer. Between 20% and 23% will not need to be seen in hospital, but their GP will receive advice on how to continue their care.
- On page 56 of the agenda is the information about rates of Caesarean births, as promised at the last meeting. These have been taken out of the Maternity Quality Report for 2013/14. The objective has been to bring down the number of Caesareans, despite the challenge that the rate has been increasing elsewhere. The rate for the year was 29.6% for Waitemata DHB compared to the average for New Zealand of 24.7%, however the Waitemata DHB rate was a reduction on the previous year’s 33%. In the last year the rates for Auckland DHB and Counties Manukau DHB have both increased.
- The main cause of Caesarean births is prolonged labour. Prolonged labour has a subjective factor. The main reason for prolonged labour is induction of labour. A quality project is underway on the induction of labour. The Caesarean rate will never be zero, but it is still too high.
- In Australia the Caesarean rate is 32.3%, but in the Netherlands it is lower than New Zealand. The neo-natal mortality rate for New Zealand and the Netherlands is about the same. Two major differences in the health services are that in the Netherlands there are no private practices and there are strongly established relationships between midwives and obstetricians; they form a team.

Matters covered in discussion and response to questions included:
- Peter van de Weijer advised that it does happen that women sometimes seek Caesareans for non-medical reasons, such as wanting a birth to occur on a particular date. Such requests are increasing. Unless there are striking circumstances, they are not agreed to. In the end a Caesarean is a medical procedure.
It was agreed that be six monthly reports to the Committee on the issue of Caesarean births.

Peter van de Weijer advised that the quality project on the induction of labour is a regional project with Auckland and Counties Manukau DHBs.

In answer to a question, Peter van de Weijer advised that Caesareans do not impact adversely on the child. For some conditions they provide a safer way for the child to be born; however they may harm the mother.

It is important to counter negative messaging about natural births, a major driver for women becoming insecure and turning towards a Caesarean.

Peter van de Weijer was commended for the very humanitarian way that he approached this issue.

**Hospital Operations**

Leith Hart (Group Manager Hospital Operations) presented this section of the report. Matters that she highlighted or updated included:

- Reasons for the high vacancy rate in Pharmacy included a number of staff being on maternity leave or having left to go overseas. Fortunately some good candidates had been recruited and they will start later in 2014.
- The visitor shuttle service between Waitakere and North Shore hospitals had been well received.
- An Operations Manager for Surgical Pathology and Radiology had been appointed, Sue Miller. The position is part of Surgical and Ambulatory Services. It is felt that there is a close association between Surgical Pathology and Radiology.

Matters covered in discussion and response to questions included:

- Dale Bramley advised that with the visitor shuttle service, this utilised the staff shuttle service, with a few extra runs added. The issue would be if there were too many people wanting to use the service and an extra shuttle was needed.
- The Board Chair advised that he had taken the opportunity to meet security and seen their whole system, which was sophisticated. Waitemata DHB is one of the few DHBs to have an in house security service. The service is oriented to de-escalation. It is important not to underestimate the difficult situations the security staff have to respond to.

**Provider Arm Support Services**

No issues were raised.

**Resolution** (Moved Tony Norman/Seconded Sandra Coney)

a) That the report be received.

b) That the Committee thank Helen Wood for her contribution to Mental Health Services and congratulate her and wish her well for her upcoming studies.

**Carried**
6. CORPORATE REPORTS

6.1 Clinical Leaders’ Report (agenda pages 104-108)

Phil Barnes (Director of Allied Health) presented the Allied Health section of the report, highlighting:

- The announcement of the CEO Professional Development Fund had received an extremely positive reaction from Allied Health staff.
- The Laboratory Service Quality Overview information included in the report. The North Shore Hospital Laboratory has very high level of quality control and a pre-analytical quality programme that greatly exceeds IANZ expectations. The Committee Chair commended the quality standards achieved as a model for the whole organisation and advised that the doctors often make comment about the high quality of the laboratory service.
- The Board Chair noted the space issue in the Laboratories, particularly for Surgical Pathology.

Resolution (Moved Allison Roe/Seconded Morris Pita)

That the report be received and a letter be sent to the Laboratory Service on behalf of the Board congratulating the Service on their quality standards achievements and thanking them for the hard work that has gone into that.

Carried

6.2 Human Resources (agenda pages 109-116)

Fiona McCarthy (Director Human Resources) introduced the report. Matters that she highlighted included:

- Values implementation (page 112) including the roll out of approximately 6,500 leaflets across the organisation. The next step is working with standards and behaviours to make sure that the values are living aspects of the organisation.
- The Pacific Health Science Academy and Mentoring Programme (page 113) – Waitemata DHB is one of several DHBs participating in this. This is being scoped with the schools.
- “Everyone matters” – the programmes reflecting this value, as listed on page 115 of the agenda. Likewise those reflecting “Better, best, brilliant” on page 116.

In answer to a question concerning time to hire, the Chief Executive commented that the only areas where recruitment may be held up are those under restructuring. There is a difference between having people available for hire and having the right workforce. They only wished to recruit people with the right values and are making sure they get the right people. Fiona McCarthy noted that it is traditionally quite difficult to recruit in the health sector. Some positions are particularly difficult to recruit to and the process for them takes longer than others.
Resolution (Moved Gwen Tepania-Palmer/Seconded Max Abbott)

That the report be received.

Carried

7. INFORMATION PAPERS

There were no information papers.

The Committee Chair thanked those present.

The meeting concluded at 12.48p.m.

SIGNED AS A CORRECT RECORD OF THE WAITEMATA DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 13 AUGUST 2014

_________________________________________ COMMITTEE CHAIR
### Actions Arising and Carried Forward from Meetings of the Hospital Advisory Committee as at 16th September 2014

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Agenda Ref</th>
<th>Topic</th>
<th>Person Responsible</th>
<th>Expected Report Back</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAC 26/02/14</td>
<td>5.1</td>
<td>Provider Arm Report:  - Visits to hospitals facilities to be arranged for Board members, particularly new Board members.</td>
<td>Peta Molloy</td>
<td></td>
<td>Visits to be held in November 2014.</td>
</tr>
<tr>
<td>HAC 02/07/14</td>
<td>5.1</td>
<td>Provider Arm Report:  - Toddlers Days Out – suggestion of more healthy food options to be followed up with CWFS or the Funder.  - Information being gathered for the Ministry of Health on the number of patients per service who do not make it onto hospital waiting lists but are referred back to Primary Care to be included in the Provider Arm Report.</td>
<td>Linda Harun/ Andrew Brant/ Penny Andrew</td>
<td>HAC 05/11/14</td>
<td>In progress.</td>
</tr>
<tr>
<td>HAC 13/08/14</td>
<td>5.1</td>
<td>Provider Arm Report:  - Vitamin C and Fractures Review of the current state of evidence for the use of Vitamin C in fracture cases to be carried out and the results to be brought to the Hospital Advisory Committee.  - Caesarean Births Six monthly updates to be provided to HAC on this issue.</td>
<td>Andrew Brant/ Peter van de Weijer/ Linda Harun</td>
<td>HAC 25/02/15</td>
<td>Pending</td>
</tr>
</tbody>
</table>
5.1 Provider Arm Performance Report – July 2014

Recommendation

That the report be received.

Prepared by: Robert Paine (Chief Financial Officer and Head of Corporate Services) and Dr Andrew Brant (Chief Medical Officer)

This report summarises the Provider Arm performance for July 2014. A short summary of the August 2014 financial position has been included in the Executive Summary.
Provider Arm Performance Report

Table of Contents

Glossary
Executive summary
Scorecard
Health Targets
Financial Performance
Human Resources
Divisional Reports
  - Medicine and Health of Older People services
  - Child, Women and Family services
  - Mental Health and Addiction services
  - Elective Surgery Centre
  - Surgical and Ambulatory services
  - Hospital Operations
  - Provider Arm support services
**Glossary**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Commission</td>
</tr>
<tr>
<td>ADU</td>
<td>Assessment and Diagnostic Unit</td>
</tr>
<tr>
<td>ARDS</td>
<td>Auckland Regional Dental Service</td>
</tr>
<tr>
<td>BT</td>
<td>Business Transformation</td>
</tr>
<tr>
<td>CADS</td>
<td>Community Alcohol, Drug and Addictions Service</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child, Adolescent Mental Health Service</td>
</tr>
<tr>
<td>CNM</td>
<td>Charge Nurse Manager</td>
</tr>
<tr>
<td>CLAB</td>
<td>Central Line Associated Bacteraemia</td>
</tr>
<tr>
<td>CT</td>
<td>Computerised Tomography</td>
</tr>
<tr>
<td>CW&amp;F</td>
<td>Child, Women and Family service</td>
</tr>
<tr>
<td>DNA</td>
<td>Did not attend</td>
</tr>
<tr>
<td>ESPI</td>
<td>Elective Services Performance Indicators</td>
</tr>
<tr>
<td>FSA</td>
<td>First Specialist Assessment (outpatients)</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>iFOBT</td>
<td>Immuno Faecal Occult Blood Test</td>
</tr>
<tr>
<td>MHSG</td>
<td>Mental Health service group</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MTD</td>
<td>Month To Date</td>
</tr>
<tr>
<td>MOSS</td>
<td>Medical Officer Special Scale</td>
</tr>
<tr>
<td>NOF</td>
<td>Neck of Femur</td>
</tr>
<tr>
<td>NSH</td>
<td>North Shore Hospital</td>
</tr>
<tr>
<td>OHBC</td>
<td>Oral health business case</td>
</tr>
<tr>
<td>ORL</td>
<td>Otorhinolaryngology (ear, nose, and throat)</td>
</tr>
<tr>
<td>PACU</td>
<td>Post-operative Acute Care Unit</td>
</tr>
<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
</tr>
<tr>
<td>PoC</td>
<td>Point of Care</td>
</tr>
<tr>
<td>SCBU</td>
<td>Special care baby unit</td>
</tr>
<tr>
<td>SMO</td>
<td>Senior Medical Officer</td>
</tr>
<tr>
<td>SSU</td>
<td>Sterile Services Unit</td>
</tr>
<tr>
<td>TLA</td>
<td>Territorial Locality Areas</td>
</tr>
<tr>
<td>WIES</td>
<td>Weighted Inlier Equivalent Separations</td>
</tr>
<tr>
<td>WTH</td>
<td>Waitakere Hospital</td>
</tr>
<tr>
<td>YTD</td>
<td>Year To Date</td>
</tr>
</tbody>
</table>

**Information to assist with understanding the scorecard:**

For each measure the green bar reflects how well we are doing against the target for the period (ie. July 2013). The progress green bar is weighted for each measure based on the degree of concern of any short fall in meeting the target. The analysts within each service have provided an initial estimate of the weighting for each measure based on prior performance; however this element of the scorecard is still work in progress for some of the measures. For example, this weighting is noticeable for Elective Volumes where the scale is very sensitive so that any variance is deemed to be significant. If performance is achieving or better than target, the bar will display as a solid green line.
Executive Summary / Overview

OVERALL ASSESSMENT

Financial Performance
For the month of July, the provider arm had a deficit of $42k against planned surplus of $129k and was therefore slightly unfavourable by $171k. The entire DHB result was slightly favourable to budget by $121k for the month.

For the month of August, the Provider Arm had a surplus of $358k against a budgeted surplus of $1.192M and is therefore slightly unfavourable to budget $835k. The entire DHB result was favourable to budget by $101k for the month.

SERVICE DELIVERY

The health targets for better help for smokers to quit and elective surgery have all been met in July. The increased number of patients presenting to the emergency departments at both sites and increased medical admissions has put pressure on all services. This impacted on the shorter waits in ED health target, which achieved 94% against the organisational 96% target this month.

The overall Did Not Attend rate (DNA) for first specialist attendances was 11% in July, a slight decrease on the previous month.

The targets for ESPI2 and ESPI5, the MoH indicators for outpatient and inpatient waiting times, are moving to no patients waiting for longer than 4 months by December 2014 (currently 5 months). In July, 6% of patients waited longer than 4 months for an FSA or treatment, but Waitemata DHB is on track with plans to meet 4 month treatment times over the next two months.
### Waitemata DHB Monthly Performance Scorecard

**ALL Services**

**July 2014**

#### Priority One

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admissions</td>
<td>97.3%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Provider Arm (Active Volumes)</td>
<td>94.3%</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

#### Quality

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance Average Response Time</td>
<td>14.64%</td>
<td>15.30%</td>
</tr>
<tr>
<td>Rate of Fall with major harm</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Pressure Injuries grade BIA</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Emergency &amp; Family First</td>
<td>72.0%</td>
<td>75%</td>
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</table>

#### Service Delivery

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Flow</td>
<td>8.20%</td>
<td>8.00%</td>
</tr>
<tr>
<td>Average Length of Stay - Acutes</td>
<td>3.0%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Average Length of Stay - Electives</td>
<td>15%</td>
<td>15%</td>
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</tbody>
</table>

#### Finance

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>48,590</td>
<td>45,450</td>
</tr>
<tr>
<td>Expenses</td>
<td>52,740</td>
<td>50,500</td>
</tr>
<tr>
<td>Personnel Costs</td>
<td>63,774</td>
<td>65,500</td>
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<tr>
<td>Outhommed Services</td>
<td>5,950</td>
<td>6,300</td>
</tr>
<tr>
<td>Clinical Supply Costs</td>
<td>8,658</td>
<td>8,112</td>
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<tr>
<td>Non-Clinical Supply Costs</td>
<td>8,182</td>
<td>8,112</td>
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<tr>
<td>Contribution</td>
<td>54,644</td>
<td>58,144</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>5,540</td>
<td>7,049</td>
</tr>
</tbody>
</table>

#### How to read

- **Indicator Title**: Shows actual and target values.
- **Growth**: Green arrow indicates improvement.
- **Improvement**: Green bar indicates actual performance above target.
Health Targets

Better Help For Smokers To Quit

Shorter Stays in Emergency Departments
Emergency Department Presentations

Improved Access to Elective Surgery
Elective Performance

Zero patients waiting over 5 and over 4 Months

90% of outpatient referrals acknowledged and processed within 10 days
### Financial Performance

#### All Services

<table>
<thead>
<tr>
<th>Provider</th>
<th>($000s)</th>
<th>MONTH</th>
<th>YEAR TO DATE</th>
<th>FULL YEAR</th>
<th>Reporting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government and Crown Agency</td>
<td>65,212</td>
<td>63,351</td>
<td>1,862</td>
<td>65,212</td>
<td>63,351</td>
</tr>
<tr>
<td>Other Income</td>
<td>2,226</td>
<td>2,105</td>
<td>(85)</td>
<td>2,220</td>
<td>2,305</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>67,438</td>
<td>65,456</td>
<td>1,777</td>
<td>67,432</td>
<td>65,655</td>
</tr>
<tr>
<td><strong>EXPENDITURE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>13,172</td>
<td>12,298</td>
<td>(874)</td>
<td>13,172</td>
<td>12,298</td>
</tr>
<tr>
<td>Nursing</td>
<td>17,136</td>
<td>16,804</td>
<td>(302)</td>
<td>17,136</td>
<td>16,804</td>
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<tr>
<td>Allied Health</td>
<td>8,394</td>
<td>8,547</td>
<td>(446)</td>
<td>8,394</td>
<td>8,547</td>
</tr>
<tr>
<td>Support</td>
<td>1,081</td>
<td>1,406</td>
<td>326</td>
<td>1,081</td>
<td>1,406</td>
</tr>
<tr>
<td>Management / Administration</td>
<td>4,969</td>
<td>4,743</td>
<td>(226)</td>
<td>4,969</td>
<td>4,743</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>45,372</td>
<td>41,849</td>
<td>(1,523)</td>
<td>45,372</td>
<td>43,849</td>
</tr>
<tr>
<td>Other Expenditures</td>
<td>4,950</td>
<td>4,472</td>
<td>(478)</td>
<td>4,950</td>
<td>4,472</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>8,790</td>
<td>8,593</td>
<td>(167)</td>
<td>8,790</td>
<td>8,593</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>8,382</td>
<td>8,613</td>
<td>231</td>
<td>8,382</td>
<td>8,613</td>
</tr>
<tr>
<td>Infrastructure &amp; Non-Clinical Supplies</td>
<td>22,102</td>
<td>21,478</td>
<td>(624)</td>
<td>22,102</td>
<td>21,478</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>67,474</td>
<td>65,526</td>
<td>(1,947)</td>
<td>67,474</td>
<td>65,526</td>
</tr>
<tr>
<td><strong>Contribution</strong></td>
<td>(42)</td>
<td>129</td>
<td>(171)</td>
<td>(42)</td>
<td>129</td>
</tr>
<tr>
<td><strong>Allocations</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Result</strong></td>
<td>(42)</td>
<td>129</td>
<td>(171)</td>
<td>(42)</td>
<td>129</td>
</tr>
</tbody>
</table>

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**CONSORTIUM STATEMENT OF FINANCIAL PERFORMANCE**

<table>
<thead>
<tr>
<th>Provider</th>
<th>($000s)</th>
<th>MONTH</th>
<th>YEAR TO DATE</th>
<th>FULL YEAR</th>
<th>Reporting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONTRIBUTION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surg &amp; Ambulatory</td>
<td>(1,063)</td>
<td>(1,370)</td>
<td>(313)</td>
<td>(1,063)</td>
<td>(1,170)</td>
</tr>
<tr>
<td>Medical &amp; HOPS</td>
<td>7,137</td>
<td>7,137</td>
<td>(176)</td>
<td>7,137</td>
<td>7,313</td>
</tr>
<tr>
<td>Child Women Family</td>
<td>3,184</td>
<td>3,150</td>
<td>(34)</td>
<td>3,184</td>
<td>3,650</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2,692</td>
<td>2,442</td>
<td>246</td>
<td>2,692</td>
<td>2,542</td>
</tr>
<tr>
<td>Elective Surgery Centre</td>
<td>280</td>
<td>389</td>
<td>(109)</td>
<td>280</td>
<td>389</td>
</tr>
<tr>
<td>Provider Support</td>
<td>(11,055)</td>
<td>(12,230)</td>
<td>646</td>
<td>(11,655)</td>
<td>(12,220)</td>
</tr>
<tr>
<td>Total Contribution</td>
<td>(42)</td>
<td>129</td>
<td>(171)</td>
<td>(42)</td>
<td>129</td>
</tr>
</tbody>
</table>

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**CONSORTIUM STATEMENT OF PERSONNEL by PROFESSIONAL GROUP**

<table>
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<tr>
<th>Provider</th>
<th>($000s)</th>
<th>MONTH</th>
<th>YEAR TO DATE</th>
<th>FULL YEAR</th>
<th>Reporting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FTE</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Medical</td>
<td>658</td>
<td>670</td>
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<tr>
<td>Nursing</td>
<td>2,508</td>
<td>2,048</td>
<td>140</td>
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<td>Allied Health</td>
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<tr>
<td>Support</td>
<td>258</td>
<td>335</td>
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<tr>
<td>Management</td>
<td>773</td>
<td>809</td>
<td>36</td>
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<tr>
<td>Total FTE</td>
<td>5,642</td>
<td>6,027</td>
<td>385</td>
<td>5,642</td>
<td>6,027</td>
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</table>
COMMENT ON MAJOR VARIANCES

Revenue
Revenue for the month is $1.777M ahead of budget. The main contributors to this favourable position are an additional interest income of $151k received during the year (as a result of higher cash balance in the overnight HBL sweep than planned), additional funding for Acute IDF $212k and acuity adjustor of $1.122M for increased costs incurred in meeting additional demand, favourable revenue position for Non-resident billing $117k, $95k for Wilson Centre Out of Area inpatient activity with 166 bed days utilised well in excess of the average 58 bed days budgeted and unbudgeted revenue of $90k for Pacific Cancer Care Services.

Expenditure
Overall the expenditure for the Provider arm was unfavourable for the month ($1.947M). Within this is an overspend in personnel costs of $1.523M.

Personnel Costs
- **Medical Personnel ($874k unfavourable)** – The overspend arises in Medhops ($419k) and SAS ($413k). The Medhops overspend was due to additional SMO sessions ($117k), more RMO FTE than planned ($139k) and some staff employed at higher grades than budgeted ($115k). In SAS the overspend ($339k) arose mainly in Anaesthesia due to: payment of prior year on call allowances, unbudgeted ESC resourcing requirements and the incorrect phasing of annual leave.
- **Nursing Personnel ($302k unfavourable)** – This unfavourable variance is primarily due to increased activity in the wards. In Child Women Services, nursing costs for July were predominately high across Maternity $90k and Paediatrics services $55k with SCBU $50k, with high inpatient activity across Maternity 104% and Paediatrics 128% having a significant impact. Medicine and Health of Older People services have covered roster gaps and increased inpatient activity has been filled through Internal Bureau, overtime, and staff not taking leave $281k. An additional $95k of unbudgeted retirement gratuities and maternity leave also impacted on the nursing overspend. Increased use of external bureau nursing is reflected as overspends in outsourced costs. Offsetting these overspends is a $161k underspend due to vacancies and a lower skill mix in Mental Health.
- **Allied Health Personnel ($446k unfavourable)** – CWF division is $398k unfavourable as anticipated turnover in dental therapists and other allied health staff has not occurred at planned levels. The service budgets are reflective of a higher turnover as has been the trend over the previous years. These were 48.99 FTE’s under budget in July 13 compared with 15.76 FTE in July 14, leading to an overspend of $308k. Retirement gratuities and maternity leave of $59k have contributed to the overspend as well. The service will selectively hold vacancies if staff turnover does not pick up in Q1. The $80k overspend in SAS is due to additional evening CT/MRI sessions and delayed savings initiatives.
- **Support and Admin Personnel ($99k favourable)** – The bulk of the underspend in support staff costs relates to vacancies in orderlies and cleaning staff ($221k) which are covered by the use of outsourced agency casual staff. Offsetting this is $100k of unmet savings in MedHops. Management and Admin staff costs are unfavourable by $36k mostly due to centrally budgeted savings initiatives of $165k, lower than planned annual leave $24k.

Other Expenditure
Other expenditure was $424k overspent for the month.

Clinical Supplies have contributed $167k to the overspend principally due to high volumes and unmet savings budgets.
• Medicine and Health of Older People services ($112k), mostly due volume driven costs in Medical Wards and Emergency Department; there were 4721 patients discharged in July. High medical inpatient volumes and increased Emergency Department presentations have led to an overspend of $188k in Treatment Disposables and Diagnostics Supplies. Savings targets of $114k were not achieved. These are partially offset by volume driven underspends in PCT pharmaceuticals $153k and Implantable Cardiac Defibrillators (ICD) devices $38k.

• Surgical and Ambulatory services ($214k), mainly volume driven costs in surgical theatre due to increased activity. Orthopaedic acute and elective volumes are 120% on a planned case basis. As well as the volume driven cost overruns, the service has a savings initiative of $190k which is contributing to the overspend in clinical supplies.

• Elective Services Centre ($101k), mainly volume driven costs due to over delivery on elective volumes, the service delivered 115% of the budgeted production plan.

• Child Women Services ($63k), mainly due to unrealised savings initiatives of $50k, unexpected Air Ambulance costs $7k and overspends in Treatment Disposables of $27k higher than anticipated Paediatric inpatient volumes – 128% in July.

• Hospital Operations ($46k), volume driven inpatient pharmacy costs and diagnostic $52k and overspends in clinical engineering equipment repairs $41k, partially offset against underspend in Pharmaceuticals $48k.

Outsourced services were $489k unfavourable due to overspends in casual cleaning and support staff costs offsetting vacancies in HospOps ($211k), high external bureau to meet nursing roster and cover requirements for medical wards and emergency department, clinical typing and outsourced staff costs (to cover unplanned leave and vacancies) and unmet savings in MedHops ($89k) and production ahead of plan in ESC ($114k).

The $232k favourable variance in Infrastructure costs includes $90k underspend from outsourced cleaning, laundry and orderlies $57k in HospOps, $81k saving on software charges and telecommunications costs and $114k interest saving from lower debt balances and improved interest rates. The underspends were offset with some prior year costs for rental contracts $48k.
Human Resources

Sick Leave

Trends
The rate for average days per fte has continued to increase. July has reached an average of 10 days. While figures reflect similar trending in terms of fluctuations for sick leave levels over the year, winter 2014 is tracking higher which is reflected in increased sick leave cost for July 2014 against the same time last year.

Highlights/risks
Based on 2013 it would be expected that average days per fte will peak higher in August 2014 with the end of winter effects on staff wellbeing and resilience. This will impact further on budgets in terms of unplanned cost. While this is a concern for the 2014/2015 year, an ongoing concern is the static nature of the longer term tracking of sick leave. While fluctuations over the past three years graphed show periods of decrease to, or below organisational target, overall tracking continues to be above target with only slight downwards trending, which will continue to impact on budgets.

The sick leave average would be expected to reduce over the next few months in line with previous years but this will not result in a decrease in the long term tracking levels.

Planned actions
The July report detailed current actions in place to assist managers address high rates of sick leave across services and with individuals. These actions include extended access to flu vaccinations and other occupational health management strategies, training, coaching and direct support to teams and managers to address highlighted issues within our sick leave management policy and processes.

These supports will continue and do provide guidance for addressing issues. However, there is also a need to look at additional strategies focussed on both current intervention and longer term improvement.

Further actions to be undertaken will include:

- Detailed analysis of sick leave across the Divisions to identify where any trends of higher absence exist to support development of targeted responses. Work has commenced in some areas to enhance reporting to management teams and provide more detailed analysis and trending so that responsive strategies can be implemented. Continuing to develop reporting functionality and accessibility will provide more accurate information and indicators of areas that need to be addressed.

- Review of procedures for management of sick leave absences, for example, ensuring pro-active rehabilitation and return to work programmes are in place and a consistent approach to managing longer term absences.

- Review of current training for managers against trends to identify any additional skill sets that need to be included.

- Continued development and promotion of the Healthy Workplaces programme and strategies which address both organisational initiatives and promotion of individual responsibility for wellbeing. The range of activities already implemented or being considered include more immediate activities to promote good health and longer term health and wellbeing strategies.
Overtime
It has been previously noted that there is a correlation between sick leave and overtime and reduction in organisational sick leave rates should impact positively on overtime levels and costs. The long term tracking for overtime however reflects a steady increase, while sick leave is tracking level with minimal downwards movement. While focus needs to continue on sick leave reduction this will not on its own address increasing overtime rates.

The continued development of reporting and analysis tools for managers and increased accessibility to information will contribute to a more detailed understanding of where overtime rates are peaking and identify key contributors. Effective management of overtime levels will continue to be a challenge and isolated solutions will not result in sustained improvement. An integrated approach to developing and implementing strategies should support sustainable alternative practices across a range of areas – i.e. including vacancy management, rostering practices and leave management.

Annual Leave Management (headcount)

<table>
<thead>
<tr>
<th>Service</th>
<th>0-24 days</th>
<th>25-49 days</th>
<th>50-74 days</th>
<th>75+ days</th>
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<tbody>
<tr>
<td>01-WIIM Medical and HOPS</td>
<td>1336</td>
<td>544</td>
<td>103</td>
<td>38</td>
</tr>
<tr>
<td>01-WSAS Surgical and Ambulatory</td>
<td>884</td>
<td>312</td>
<td>61</td>
<td>22</td>
</tr>
<tr>
<td>01-WWCC Child Women &amp; Family</td>
<td>804</td>
<td>168</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>01-WECS Elective Surgery Centre</td>
<td>57</td>
<td>12</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>01-WMHS Mental Health Services</td>
<td>860</td>
<td>287</td>
<td>36</td>
<td>8</td>
</tr>
<tr>
<td>01-WHOG Hospital Operations</td>
<td>290</td>
<td>112</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>01-WACP Corporate</td>
<td>234</td>
<td>92</td>
<td>15</td>
<td>5</td>
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<tr>
<td>01-WCPA Facilities and Development</td>
<td>24</td>
<td>14</td>
<td>0</td>
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<tr>
<td>Grand Total</td>
<td>4,491</td>
<td>1,592</td>
<td>156</td>
<td>83</td>
</tr>
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</table>

Trends
While the number of balances of between 50-74 days remains stable there have been increases across the other three leave sets, of most concern being an increase in staff with a balance of over 75 days.

Highlights/risks
Over 70% of staff in this group are within Medicine and Health of Older People and Surgical and Ambulatory services. While these are large Divisions high levels of employees with excessive annual leave accrual can pose risks in terms of both costs carried and health and safety.

Planned actions
Divisions continue to actively work with employees with high leave balances and HR Managers/Advisors are supporting with escalation processes reflecting DHB policy and practice to focus on reduction through active leave planning. However, while this is generally maintaining levels, existing strategies are not resulting in significant
decreases in annual leave accruals. Additional strategies, which may include leave buy outs (within legislative and policy requirements), will need to be identified to bring about impact on current accrual levels.

Staff Retention and Turnover

Voluntary turnover rate has remained static into July. Retention levels are currently positive and within organisational target. A comprehensive range of employee retention strategies are in place under the ‘everyone matters’ staff programme including employee recognition activities, staff training programmes, support for professional development and health and wellbeing initiatives, including the staff gymnasium at North Shore Hospital and planned gymnasium at Waitakere Hospital.

All employees who resign are encouraged to complete an exit interview and this will be further developed to enhance reporting to the organisation and include an on-boarding interview to capture information about our existing employee’s experiences within their first three months

As part of the Our Values Your Values programme an on line employee engagement measurement tool is being developed which will provide ongoing insight into how our employees view the organisation and their work environment to identify opportunities for improvement.
**Service Overview**

This Division is responsible for the provision of emergency care, medical services and sub-specialties (including cardiology, dermatology, diabetes, endocrinology, gastroenterology, haematology, infectious diseases, renal, respiratory and rheumatology), and services for older people including assessment, treatment and rehabilitation (A,T& R), mental health services, and home based support services.

The service is managed by Debbie Eastwood with the Heads of Department Dr Jonathan Christiansen, Medical; Shirley Ross, Nursing; and Tamzin Brott, Allied Health. The Clinical Directors are Dr Hamish Hart for Medicine, Dr John Scott for Health of Older Adults, Dr Rob Butler for Psychiatry for the Older Adult, Dr Willem Landman for Emergency Care, Dr Ali Jafer for Gastroenterology, Dr Rick Cutfield for Diabetes/Endocrinology, Dr Tony Scott for Cardiology, Dr Hasan Bhally for Infection Diseases, Dr Janak De Zoysa for Renal, Dr Megan Cornere for Respiratory, Dr Ross Henderson for Haematology, Dr Cathy Miller for Palliative, Dr Blair Wood for Dermatology and Dr Michael Corkill for Rheumatology.

**SCORECARD**

**Health Targets**

**Smokefree**

MHoPS achieved 97.4% in July, with an organisational result of 97.1% for the month against a target of 95%.

**Elective WIES & Discharges for Cardiology**

Cardiology exceeded the discharge target by 20% in July and completed 102 actual WIES against a contract of 116 WIES, therefore 14 WEIS less than contract. We had a busy month for acute Cardiology WIES at 133% of contract.

**Shorter Stays in ED**

We achieved 95% against our organisation target of 96%. The increased volume of patients presenting to the ED's at both sites has put pressure on all services. At times we have had surges in patient presentations that have put ED staff under pressure and at other times it has been sub specialty medical staff availability and/or appropriate beds. We have held organisational escalation meetings as needed and all services have enacted their winter demand strategies.

The Waitakere ED has had an increase in presentations which started in mid-July and has continued throughout August. Paediatric patients represent a third of the presentation to Waitakere ED and the paediatric service have responded to this demand. North Shore whilst experiencing winter volumes has seen a more settled pattern in the latter part of August compared to Waitakere and this has enabled us to continue our elective program.

**Quality**

**Complaints**

We received 29 complaints in the month with the majority being related to ED and General Medicine. We closed 33 in the month with a turnaround time of 18 days.

**Assessment & Diagnostic Unit (ADU) – time to be seen from triage**

We achieved 44.5% against a target 70%. We have found this target challenging over the winter months due to the increased volume of patients presenting to ADU. However from July we have had a fourth registrar in ADU and from August a senior medical officer has been in ADU from 5pm to 8pm to assist with increased patient demand.

**Acute readmission rate within 28 days**
Our acute readmissions rate was 12.6% in July against a new internal target of 8.8%, which equates to the Ministry’s standardised target of 7.75%. The previous target was 9%. The electronic discharge summary (EDS) project is one area we are focusing on to support the reduction in readmissions. This project is designed to look at how we can improve our support and advice to patients and their GP’s. There are many components to the EDS and a number of work streams underway across the DHB. Currently we are doing a stock take of the various work streams with a view to improving coordination and reducing duplication. Our standardised readmission rate for the Quarter 4 Ministry of Health national readmission data (all ages) using the updated methodology shows Waitemata DHB at a similar rate to Auckland and Counties DHBs and less than Canterbury and Waikato DHBs. The new methodology will be used by the MoH for 2014/15 reporting.

**Mental Health for Older Adults (MHSOA)**
The documentation of the process for patients requiring admission to KMU is in its final consultation phase. The patient entry criteria for MHSOA are in draft and being discussed regionally prior to signoff.

**Gastroenterology**
A cross unit meeting was held for all endoscopy staff to celebrate our achievements in reducing the endoscopy waiting lists, improving the department’s performance along with increasing the Global Rating Scale quality scores across several of the domains. The entire team attended including CSSD, nursing, medical, surgical, administrative staff and managers.

**Infection control**
The workflow of the Infection Control team has been restructured to provide better support to the hospital when it is in escalation. This includes:
- Twice weekly review of all side rooms (plus additional review at duty manager’s (DNM) request).
- Improved communication with ward teams and DNMs to provide instructions during an outbreak/cluster.
- Enhanced auditing support to the wards in times of outbreak.
- Weekend working where an outbreak extends over a weekend.

**Companion supported exercise project**
One of our allied health staff is leading a project supporting older adults living at home who are identified as requiring low needs supports, to increase strength and resilience to prevent falls. To date the following milestones have been reached:
- Training of Age Concern support workers.
- The 4th year physiotherapy students have completed a background literature review on the barriers and facilitators to physical activity for community dwelling older adults.
- Live audits of the exercise intervention and interviews of Age Concern support workers and their older adult clients have been completed. Data collection is due to finish in August.
- Interviews are being transcribed as they come in with the first transcripts being produced.
- Data analysis is due to happen in August as the students start their 4 week break between placements.

**Chest Pain Project**
This project is reviewing current practice and pathways for patients presenting with chest pain to ED. Currently the project team is working on identifying the low risk group and developing a streamlined pathway for this cohort of patients. The outcomes we are seeking are an improved patient experience and journey along with an improved patient flow through ED to ADU and the efficient use of monitored beds. There are many components to this pathway which need to be worked through by the project team. This project is being sponsored by Dr Jonathan Christiansen and has good clinical representation.
FAST project – update
In service education and workbooks for every nurse have been completed and the learning reinforced clinically. Time has been set aside in the first two weeks of September to re audit the patients and staff on ward 6. Results and implementation plan will be ready for presentation to Clinical Governance Board in November.

Serious and Sentinel Events
All investigations are on track.

E prescribing- Waitakere
Training for the nursing staff commenced in July and the project is on track for implementation in late August.

HQSC Markers
Falls – 96% (target 90%)
Falls risk assessment audits that inform the HQSC data continue and are conducted monthly. MHoP is achieving 96% in falls risk assessments being completed on patients within 8 hours of admission and 88% of patients have a corresponding falls prevention care plan in place. Part of the recommended nursing care for high risk patients is a higher level of observation and in some case a constant observer / watch. Where indicated patients are placed on a “package of care” that includes 15 minute checks, a personal alarm and floor line bed. Groups of patients with a similar risk and same gender are cohort together in two and four bedded rooms in order to reduce the strain on human resources and watches while still maintaining patient safety. There was one fall with harm in July on ward 15.

Pressure Injury
The focus on pressure injuries is increasing as these audits are now also reported in Qlickview. MHoP has some work to do as our results show only 67% of patients are assessed for risk to pressure injury within 8 hours of admission with 83% of patients having a care plan for prevention. Risk reporting is being encouraged with any grade 3 or 4 pressure injury investigated by HOD nursing and the case presented by the Charge Nurse to the Associate Director of Nursing.

Hand Hygiene - 81% (target 70%)
The medical wards involved in the national hand hygiene audits achieved 84% compliance with practice and ward 14 achieved 73%, an improvement on the 67% achieved in March.

Most celebrated was the improvement in practice on ward 10. The improved from 69% in March to 84% in July. Local hand hygiene audits are being done monthly on the wards and data is now being captured in Qlickview. MHoP is currently achieving 93% compliance with practice in standard precautions.

Human Resources
- Tutor Specialist role from December is currently being advertised.
- Consumer Advisor role for MHSOA - an offer has been made.
- Operations Manager is being advertised.

Charge Nurse Manager (CNM) role review, Nursing Leadership
Planning is underway for the second cohort of CNMs to commence the programme in October 2014. Cohort 1 completes the programme in October culminating in a quality improvement project.

The CNMs are focussing on implementation of projects that relate to essentials of care:
- Communication: Bedside handovers, discharge planning and information on discharge
- Nutrition: protected mealtimes and providing assistance to patients when eating.
- Shortage of Health Care Assistants (HCAs). There are still five vacant FTE on the medical wards and daily unfilled shifts for bureau HCAs. HCAs are crucial for clinical support and to provide observations for at risk patients. The HOD nursing is working with S&AS and recruitment to run an HCA assessment and recruitment centre on 4 September 2014. The aim will be to interview 20 potential HCAs and appoint into the vacancies and bureau, creating a talent pool of HCA resource.
Service Delivery
General Medicine
The commencement of the tutor specialist role for general medicine at Waitakere Hospital has been very successful and well received by the junior and senior medical staff. This role has also been critical in enabling us to raise the admission cap at Waitakere, which has assisted with bed management at North Shore.

Average Length of Stay
AT&R
For the AT&R specialty, the average length of stay was 19.3 days, down by a day on the previous month. There were 135 discharges in the month across the three wards. We were unable to maximise our occupancy in July due to infection control outbreaks which resulted in bed closures and significant time taken to clean rooms and equipment. We also needed to close the gym for cleaning which impacted on patients’ rehabilitation, resulting in discharge delays.

Medicine
July LOS increased across Medicine. This was partly impacted by the wait times for patients to transfer to AT&R which were delayed due to the outbreaks and high demand from both medicine and surgery. However we also reviewed other patients with a LOS >10 days and many patients were extremely unwell and not ready for discharge. There are also limitations in moving patients from hospital to ARRC both due to patients and families needing to identify a suitable facility and facilities being able to accept patients in a timely manner. The trial of the senior medical officer working in ADU from 5pm to 8pm may impact favorably on LOS by supporting the junior staff to make decisions. Informal feedback from the floor is positive in terms of accessing senior input for complex patients and those who may be able to be discharged. ED medical staff have also appreciated the value in being able to access a senior opinion and on some occasions have not transferred care but discharged as a result of the SMO advice. Another initiative to support reducing LOS and facilitating discharges has been the voluntary introduction of additional weekend occupational therapist and physiotherapist cover – we have managed to fill the rosters for additional weekend cover with volunteers. We have obtained support from the PSA as the roster is an arduous one, outside the MECA 1:4. This initiative started in August and will conclude at the end of September.

Endoscopy Targets
Preliminary August performance figures as anticipated show a marked improvement for urgent (84%) and non-urgent (65%) diagnostic colonoscopy procedures. Compliance with the surveillance indicator will be a focus in 2014/15.

ESPI
ESPI 1
Medicine specialties achieved 96% compliance against a target of 90%. We are continuing to streamline our processes to ensure both timely grading and patients being put on to the waiting list.

ESPI 2
All medicine specialties continue to be 100% compliant with the 5 month target. A number of medicine specialties achieved a four months wait time for ESPI2 by the end of July 2014 (target date of October 2014 for Cardiology and Gastroenterology). This remains a challenge for cardiology and gastroenterology and both services are working on plans to achieve this target.

ESPI 5
Cardiology remains compliant in July.

Elective coronary angiography within 90 days - 88% (target 90%)
This result was impacted by the reduction in PCI operator resource during most of July (planned leave) which coincided with high acute demand. The recruitment of the 4th PCI operator will support consistent achievement of this target.
Scorecard

Waitemata DHB Monthly Performance Scorecard
Medical and Health of Older People

July 2014

Priority One

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<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
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<tr>
<td>Better help for smokers to quit</td>
<td>97.4%</td>
<td>95.6%</td>
</tr>
<tr>
<td>Provider Electronic Volume (Cardiology)</td>
<td>120.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Shorter waits in ED</td>
<td>33.0%</td>
<td>36.6%</td>
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Productivity

<table>
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<tr>
<th>Productivity</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy waiting times - within 4 weeks</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>% elective coronary angiography within 90 days</td>
<td>66%</td>
<td>75%</td>
</tr>
<tr>
<td>% urgent diagnostic endoscopy done within 24 days</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>% diagnostic colonoscopy done within 42 days</td>
<td>47%</td>
<td>60%</td>
</tr>
<tr>
<td>% surveillance colonoscopy done within 88 days</td>
<td>30%</td>
<td>60%</td>
</tr>
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Quality

<table>
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<th>Quality</th>
<th>Actual</th>
<th>Target</th>
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<tr>
<td>Compliment Average Response Time</td>
<td>14.30</td>
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<tr>
<td>Rate of fall with major harm</td>
<td>1.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Friends and Family Test</td>
<td>44.5%</td>
<td>84.0%</td>
</tr>
<tr>
<td>HAQ Markers (Non-hospital ward)</td>
<td>99%</td>
<td>96%</td>
</tr>
<tr>
<td>% notified patients assessed for falling risk</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>% good hand hygiene practice</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Other Key Measures

| % Compliant to asthma                             | 44.5%  | 70.0%  |
| % Adherence to treatment                          | 32.6%  | 32.6%  |

Human Resources

<table>
<thead>
<tr>
<th>Human Resources</th>
<th>Actual</th>
<th>Target</th>
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<tr>
<td>Sick Leave Rate (days) *</td>
<td>1.7 days</td>
<td>7.5 days</td>
</tr>
<tr>
<td>Overtime Rate (%)</td>
<td>0.7%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Annual Leave/Absence &gt; 7 days</td>
<td>0.3%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Turnover Rate % *</td>
<td>3.9%</td>
<td>10.0%</td>
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<tr>
<td>Clinical Employment (FTE)</td>
<td>3.540 FTE</td>
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Financial

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<td>Revenue</td>
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<tr>
<td>Expense</td>
<td>19,040</td>
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<tr>
<td>Personnel Costs</td>
<td>18,160</td>
<td>15,282</td>
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<tr>
<td>Outpatient Services</td>
<td>450</td>
<td>255</td>
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<tr>
<td>Medical Supply Costs</td>
<td>2,100</td>
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<tr>
<td>Non-Medical Supply Costs</td>
<td>1,440</td>
<td>1,342</td>
</tr>
<tr>
<td>Contribution</td>
<td>7,147</td>
<td>7,531</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>114</td>
<td>75</td>
</tr>
</tbody>
</table>

How to read

<table>
<thead>
<tr>
<th>Indicator Title</th>
<th>Improvement from previous result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual DHB/Pension</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

Improvement from previous result:
DHB performance rating is shown in yellow to display as a target of green. I
## STRATEGIC INITIATIVES

<table>
<thead>
<tr>
<th>Deliverable /Action</th>
<th>On Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orient all new staff to the care bundle clinical pathways during 2014/15</td>
<td>✓</td>
</tr>
<tr>
<td>Develop a dedicated transit care team at Waitakere Hospital by late 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Review accelerated chest pain pathway currently used in the emergency department to ensure it meets the National Cardiac Network framework by June 2015.</td>
<td>✓</td>
</tr>
<tr>
<td>Monitor quality indicators - including the mandatory ED Quality Framework Suite of Quality Measures – on-going</td>
<td>✓</td>
</tr>
<tr>
<td>Work with the Ministry of Health to implement the ED Quality Framework as appropriate – commenced by 31 March 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Implement the Quality Endoscopy Improvement programme to address productivity and capacity issues over two sites and introduce a daily report which identifies actual capacity used by the provider. Commence this reporting 1 July 2014 and respond to issues as they arise over 2014/15</td>
<td>✓</td>
</tr>
<tr>
<td>Establish a five year colonoscopy capacity plan that includes a regional view by 31 December 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Implement a nurse endoscopist training programme regionally by late 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Use CT colonography as a diagnostic tool instead of colonoscopy in 25% of colonoscopy referrals, where clinically appropriate, which will increase colonoscopy capacity - measured monthly</td>
<td>✓</td>
</tr>
<tr>
<td>Follow up Māori and Pacific people seeking post discharge support to quit smoking to ensure they have had every opportunity to engage with a smoking cessation service best suited to their needs - follow up support process in place by December 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Provide training to all Māori Health Service/He Kamaka Waiora registered staff to be smoking cessation leads with on-going support through the Waitemata DHB Smokefree Team by June 2015.</td>
<td>✓</td>
</tr>
<tr>
<td>Develop and maintain a centralised triage and referral system for smokers identified in hospital for on-going support in the community by December 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Improve access to cardiovascular diagnostics by investigating current delays and developing an action plan to be implemented by July 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Identify initiatives to address the causes of ethnic differences in outcomes of cardiovascular disease for Māori and Pacific identified in the work completed in 2013/14 with a specific action plan by February 2015</td>
<td>TBC</td>
</tr>
<tr>
<td>Implement regionally agreed protocols for prompt local risk stratification by December 2014</td>
<td>TBC</td>
</tr>
<tr>
<td>Plan and deliver alternative cardiac rehabilitation programmes which meet the needs of Māori, Pacific and Asian populations in collaboration with our DHB and primary care/non-governmental agency partners in a minimum of two localities by June 2015</td>
<td>TBC</td>
</tr>
<tr>
<td>Ensure a Māori cardiac rehabilitation nurse specialist is supported to work effectively within our community and with all our providers to influence issues relating to access for Māori by July 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Utilise audit data to inform an action plan to identify barriers to thrombolysis and raise the number of eligible patients being thrombolysed – plan developed by October 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Review the admission and discharge criteria for North Shore and Waitakere Stroke Units to ensure consistent best practice across the service by June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Refinement of the acute stroke pathway to ensure that 80% of stroke patients will be accommodated on the stroke units as best practice business as usual by June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Continue to develop the model of care for the delivery of secondary preventative care for fragility sufferers (through identification, investigation and intervention) to prevent hip fractures by June 2015</td>
<td>✓</td>
</tr>
</tbody>
</table>

* include a ✓ or a ×
Key achievements for month

- Orientate all new staff to the care bundle clinical pathways during 2014/15 - We achieved our target of 5 care bundles developed by June 2014 with 3 Paediatric bundles being rolled out on both sites. There are a further 4 bundles underway. As and when new bundles are implemented there is an education programme and competency assessment for nurses. New medical staff also receive orientation to the care bundles. This is delivered as part of their introduction to the department program.
- Review accelerated chest pain pathway used in the emergency department to ensure that it meets the National Cardiac Network framework by June 2015. The development of this pathway is in conjunction with cardiology and general medicine – Chest Pain Project as noted earlier in the report.
- Monitor quality indicators – including the mandatory ED quality framework suit of quality measures and work with the MoH to implement the ED quality framework as appropriate –
- We are continuing to work on data quality issues and therefore the information captured in the reports.
- Implement a nurse endoscopist training programme regionally by late 2014 – interviews are being planned for the regional project manager for the programme and the Clinical Director Gastroenterology from our DHB will present Waitemata on the interview panel.
- ADU Nursing MoC to be reviewed addressing patient acuity - this is being led by Jenny Parr. We are meeting week commencing 1st September 2014 to discuss how the data will be collected and for how long. The data collection may be onerous initially and we need to find the best time/person to do this, ensuring the data is robust.

Areas off track for month and remedial plans

1. Further discussion is required regarding Maori CNS prior to progressing these strategic initiatives

KEY ISSUES/INITIATIVES IDENTIFIED IN COMING MONTHS

- Evaluation of the senior medical officer working 5-8pm in ADU.
- Follow up planning half day for General Medicine.
- All Medicine outpatient teams are working on their MOC.

OTHER HIGHLIGHTS

Cardiology Inpatient Service Review

Three Month Status of Outcome Principles

1. Waitemata DHB will provide a comprehensive cardiology inpatient service at Waitakere Hospital by transitioning the existing six Coronary Care Unit bed area to become an extension of Waitakere ADU with 10 nominated cardiology beds allocated within the total twenty eight (28) beds in the combined area. Patients with lesser cardiac acuity but requiring specialist cardiology attention may be admitted into remaining beds in the unit or into other General Medical wards at the Waitakere site. Patients admitted to the 10 bed area under cardiology will be managed by a full cardiology medical inpatient team of consultant, registrar and house officer.

The six beds in the previously named Coronary Care Unit (CCU) have become part of a ten bed cardiology area within the Assessment Diagnostic and Cardiology Unit (ADCU) on the Waitakere site. The eighteen remaining beds in the ADCU area function as Assessment and Diagnostic Unit (ADU) beds receiving patients mostly from the Emergency Department, some directly from GP referral and less often from the Waitakere wards as a temporary placement before they are moved to another hospital.
The cardiology medical team has functioned without a permanent House Officer (HO) role however this will be rectified from the Q4 House Officer run starting August 25th 2014 when there will be a dedicated HO to support the Cardiology team.

2. The combined area currently operating independently as Waitakere CCU and Assessment & Diagnostic Unit (ADU) will be renamed Assessment Diagnostic & Cardiology Unit (acronym ADCU) to reflect the dual purpose of the area.

The name changing process included the Maori Health team and was managed appropriately in context of cultural considerations. The way finding signs have been changed to organisation standardised signs and now read “Assessment Diagnostic & Cardiology Unit” or “ADCU”.

3. The Cardiology service will provide rapid access to NSH catheter laboratories for all patients referred for angiography with clear clinical and operational guidelines to support decision making. Sustainable catheter laboratory efficiency gains are contingent on recruitment of a fourth (4th) coronary interventional cardiologist during 2014. This will enable all available catheter laboratory sessions to be well used and provide rapid access for patients to coronary angiography and intervention.

This status of this principle is covered fully below.

4. The Cardiology Service will maintain all other in and out patient support functions which are currently provided by the cardiology service at the Waitakere site

All other pre-existing in and outpatient support functions contingent on cardiology resource continue to be provided. There is increased inter site use of the nursing resource for the cardiology procedures group.

5. Waitemata DHB will maintain the required level of nursing experience to meet the requirements of a) and c) at the Waitakere site by providing 13.70 FTE expert cardiology RN positions in ADCU so that there are minimally two (2) expert cardiac RNs on each shift seven days per week plus a dedicated telemetry nurse.

Since implementing the new model of care we have recruited 13.70 FTE registered nurses to support the 10 cardiology beds in the Assessment, Diagnostic and Cardiology Unit (ADCU) at Waitakere Hospital. In order to ensure patient safety and achieve the agreed skill mix during this recruitment phase we seconded nurses from Lakeview Cardiology Centre (LCC) to support the ADCU staff. As the new staff have increased their skills we have reduced the number of nurses coming from LCC to 2 experienced nurses each day. We will continue to provide this resource from LCC until the Head of Nursing and the cardiology medical team are confident that the permanent ADCU nurses are practicing at the required level to ensure optimum patient care.

Forecast Outcomes and Benefits
The expected measurable outcomes for the project were:

Reduced length of time from referral for angiogram to procedure for patients admitted to Waitakere; Optimising this outcome on a consistent basis will be realized when we appoint a 4th PCI operator. The recruitment process for this role is currently underway with an expected start date of December 2014. In the interim we have provided some additional sessions from within our current PCI operator resource. Unfortunately doing regular additional sessions has not always been possible due to PCI operator leave both planned and unplanned.

The Health Information Group (HIG) provides a weekly report on the Inpatient Average Waiting time to angiogram by site and by week. The graph below shows that during the first weeks of the change wait times were reduced for patients at both sites.
Reduced length of stay for all patients admitted to the cardiology service;

AND

Increased volume and turnover of patients in Lakeview Cardiology Centre (LCC) NSH.

Available data shows that the volume of patients discharged from the North Shore Cardiology service between April 1st and June 30th 2014 has increased by 22% (657 to 803) from the same period in 2013. Comparative data for the same two periods was not available for the Waitakere site because patients were not admitted under cardiology prior to the service change on March 31st 2014.
Financial Results

![Consolidated Statement of Financial Performance]

Waitemata DHB, Hospital Advisory Committee Meeting 24/09/2014
COMMENT ON MAJOR FINANCIAL VARIANCES

Summary

July 2014 was the busiest month for Medical Inpatients and Emergency Presentations of any over the last two years. A total of 4,721 patients were discharged from General Medicine or Emergency Department during the month. There were an estimated 12,071 bed days utilised across North Shore and Waitakere in the month of July with an ALOS of 3.9 days compared to an ALOS of 3.5 days in the previous 2 months (the ALOS for General Medicine in 2013/14 was 3.2 days). There were 10,046 Emergency Department presentations in July while there were 9,242 average presentations in 2013/14.

July’s key reasons for financial variance to budget are centred around this high demand for inpatient beds and ED attendances, negative expenditure savings lines in non-personnel costs. Less SMO leave was taken than prior year leave trend suggested, and cost coding questions around some RMO positions have inflated the costs of medical care in the month. Nursing vacancies have been more than offset by additional watches and bureau usage, overtime and reduced levels of Annual Leave taken.

Forecasted inpatient demand is anticipated to remain a key pressure point over the year. Ten beds are planned to be closed in summer, however if summer bed demand aligns with the current CapPlan forecast volumes this may prove difficult to achieve. A focus on annual leave will aim to ensure staff take their leave entitlement over the year. If this is achieved it will reverse the current overspend arising from this not occurring as anticipated to date.

Some early indications of favourable variances due to community pharmaceuticals schedule changes are offset by forecast overspends in Hospital Ops as this represent a change in the bill payer after budgets are set for the year.

Revenue ($1,134k favourable Month)

July saw acute Inpatients WIES at 115% and Emergency volumes at 106% of contracted volumes. An acuity adjuster of $1.199M was transferred to MHOPs to account for the additional costs this high demand was generating.

ACC Revenue in Older Adults was low in July, being $74k short of budgeted levels. July is often a low month for ACC revenue as ATR wards fill up with General Medical overflow from full wards. ATR Bed Days were at 144% of the contracted volumes for the month.

Expenditure

Medical personnel: ($419k unfavourable Month)

July has historically been a time of year that a number of SMOs take annual leave; in July 2013 7.3 FTEs took leave for the month, and in July 2012 3.6 FTEs took leave. July 2014 budget was set on the assumption that 6.4 FTEs would be taking leave, in line with this prior pattern: however only 1.2 FTEs took leave in the month. The additional costs for the month resulting from this were approximately $117k. RMOs also worked a higher number of hours than was expected for July based on prior year’s trends, at an additional cost of circa $139k. These additional hours are due to the high inpatient volumes.

In addition to this, a number of RMOs have been miscoded to MHOPs; these staff are assigned to runs elsewhere in the DHB and the service is working with Northern Regional Alliance (NRA) to identify which run these staff are on and to correct to cost coding accordingly. $65k of additional costs were carried by MHOPs for the month from these staff, however this will be reducing costs elsewhere in the DHB.

Nursing: ($349k unfavourable Month)

There were high levels of Nursing vacancies in July, resulting in a large underlying underspend. These vacancies were filled through Internal Bureau ($66k), Overtime ($112k), and staff not taking leave ($250k). An additional $72k of unbudgeted Retirement Gratuities and Maternity leave also impacted on the nursing overspend.
A factor built into Senior Nursing budgets for staff ‘Churn’, being temporary vacancies due to staff turnover and the time to recruit, was the equivalent of 10.16 FTE at any one time. This was achieved in July.

**Allied Health staff: ($41k unfavourable Month)**
Unbudgeted Allied Health costs in July include $11k of Maternity Leave, and $10k of extra allowances paid; these include relocation costs, ACC top up costs, and practicing certificates which are once a year expenses.
Allied Health staff also have a ‘churn’ factor built into budgets based on the staff turnover trend and the time to recruit. In July this was the equivalent of 1.7 FTE, and was achieved.

**Support staff: ($23k unfavourable Month)**
MHOPs hold a negative expense savings line of $54k per month against Support staffing, which allows for 10 FTE across any staff category at any one time to be unfilled due to staff turnover and the time to recruit. This is additional to specific savings line under Senior Nursing and general Allied Health also tagged to staff ‘churn’. As there are no Support staff employed by MHOPs this line will always show as unfavourable; it should be considered in line with temporary vacancies arising elsewhere in MHOPs. Offsetting this is a $31k favourable variance relating to the misalignment of budgeted support roles in ED who are employed as administration staff.

**Admin staff: ($77k unfavourable Month)**
Admin costs were adversely affected $16k through annual leave earned but not yet taken by staff. Over the course of a 12 month period all annual leave earned should be taken. $38k of overspend is due to the misalignment of budgets across administration and support. There is a corresponding $31k underspend in Support. There are also a number of minor one-offs across the services such as Gastro outsourcing administration costs (circa $5k) and cover for long term paid sick leave.

**Outsourced personnel: ($89k unfavourable Month)**
Outsourced expenditure in July is made up of additional Watches to budget ($89k) and also additional outsourced nursing to fill shifts where vacancies have not been able to be filled ($50k). Additional watches have been associated with increased compliance with the falls risk assessment and implementation of care plans for all inpatients. Work is ongoing to track and quantify the benefits of these additional watches.

**Outsourced services: ($97k unfavourable Month)**
MHOPs has two negative expenditure savings lines entered under Outsourced services; one of $500k for the year and $42k each month, and another of $200k which represents a plan to match the prior year ACC revenue. This is valued at $17k per month. This will be monitored over the coming months, any achievement of this savings line will show as favourable ACC revenue to offset this apparent overspend.

**Clinical supplies: ($112k unfavourable Month)**
High inpatient and ED volumes have been tied to a $65k and $54k overspend respectively on clinical supplies in July; additional revenue received for high acute demand offsets this.
There is a negative expenditure savings line of $1.3m for the year, being $115k per month which should be considered against any underspends arising.

PCT pharmaceuticals were significantly underspent at $117k in July. A small amount of this will be due to long term SMO sick leave in Haematology. New indications for some PCT drugs may increase future usage and therefore costs. In addition the Community Drugs schedule has changes, which will mean an ongoing favourable pharmaceuticals variance in MHOPS this year, which will be offset by an anticipated overspend in the Hospital Ops pharmacy costs. In July this underspend was $29K. The full year impact for MHOPs is estimated at circa $200k, the impact on Hospital Ops will depend on whether there is a behaviour change where patients seek these medications from their community pharmacy rather than continue to visit the Hospital Pharmacy.

Waitemata DHB, Hospital Advisory Committee Meeting 24/09/2014
Renal fluid usage was $35k above budget for the month of July. Within this, PD fluid costs were $25k above the expected volumes; this will be due to timing of deliveries and over a 12 month period will ‘wash up’. Offsetting this is a $37k underspend on Cardiology ICD devices; SMO leave in July resulted in a decrease in volumes, however this is not expected to continue.

**Infrastructure and Non Clinical Supplies: ($102k unfavourable Month)**

High demand from Inpatient volumes saw a $42k overspend on laundry, cleaning, patient meals, in July. This may continue into August and possibly September while inpatient levels remain at Winter levels.

In addition to this MHOPs has a negative expenditure savings line of $42k per month, $500k for the full year with an aim to seek any available reduction in non-clinical supplies and Infrastructure costs.

**Progress towards Savings Initiatives:**

MHOPs has a number of unspecified savings lines embedded in budgets in order to reach our assigned target of $4m. Work is underway to identify ways in which these may be achieved.

Savings lines relating to staff ‘churn’ are counted against the reported FTEs in each month; in July these lines were achieved for Senior Nursing and Allied Health staff, but not medical staffing. The unspecified 10 FTEs was not achieved, as while Nursing FTEs were below budgeted levels these vacancies were backfilled using internal and external bureau due to the high demand for Bed Days and ED presentations in the month.
**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 and the Auckland Regional Dental Service (ARDS) for metro-Auckland. Services are provided within our hospitals, e.g. births, outpatient clinics and gynaecology surgery, and within our community, e.g. community midwifery and mobile/transportable dental clinics. The division is managed by Linda Harun with Dr Peter van de Weijer HOD Medical CWF, Emma Farmer HOD Midwifery; Marianne Cameron HOD Nursing, Ronelle Baker Allied Health Lead, Dr Sathananthan Kanagaratnam Clinical Director ARDS, Dr Sue Belgrave Clinical Director Obstetrics, Dr Peter van de Weijer Clinical Director Gynaecology and Dr Meia Schmidt-Uili Clinical Director Child Health.

**SCORECARD**

**Health Targets**
The better help for smokers to quit remains below the target at 93.4%. Investigation into the causes of this low rate indicate that the data is captured from the maternity system (Healthware) in a way that does not accurately reflect when the assessment is undertaken. The service is working to improve this data capture to better reflect actual timeliness of assessments.

Elective volumes were slightly below target for NSH and WTH at 96% while ESC was on target at 100%. There were a number of operating lists cancelled in July due to the ASMS SMO forum.

Shorter waits in ED is reported as 92.8% which is below the target of 96%. These breeches are largely paediatrics at Waitakere and are a combination of high winter presentations, a lack of staff and a lack of space for a paediatric observation area at Waitakere Hospital. Strategies that paediatrics have put in place since the last HAC report to reduce the number of breaches occurring include:

- An additional SMO has been rostered on Saturday and Sunday mornings to assist with discharging children from Rangatira ward
- The Rangatira Co-ordinator is actively monitoring the ED whiteboard to identify children under paediatric medicine and assist with patient flow
- A paediatric bed escalation plan has been developed and agreed in consultation with Maternity, Emergency Medicine, General Medicine and the Duty Managers

The future expansion of the ED area at Waitakere will have to take into account that there is a need to upscale the paediatric space and services to meet winter demand.

**Quality**
Complaint average response time of 10 days is better than the target of 14 days this month. The CW&F team have been focused on fast turnaround of complaints whenever possible.

Results for the Friends and Family Test have not been received due to the devices not being in use this month. This has now been resolved and recording is now occurring again. ARDS is developing a parental consumer feedback questionnaire which will be made available at hub clinics throughout the year via tablets so that collation is automatic.

HSQC markers of hand hygiene and surgical checklist remain better than target for the service as does the acute readmission rate.
**Human Resources**
The sick leave rate of 9.7 days is higher than the target partly due to increased rates of winter illness. The service is looking to engage with Fiona McCarthy GM HR to identify a work plan to reach the target of 7.5 days. The number of staff with a high annual leave balance has decreased from the previous month as the Obstetrics and Gynaecology SMO’s were able to take leave due to locum cover in the month.

**Service Delivery**
The Oral Health arrears total is 6% overall and 6% for Maori which is better than the new MoH targets of 7%. Arrears have been at or better than the MOH targets consistently since September 2013. Theatre utilisation remains problematic for gynaecology and an audit of this has revealed that there is a high rate of cancellations on the day of surgery. It is apparent that many women change their mind regarding the need for surgery and only inform the service at the last minute. A number of procedures also require a pregnancy test to be undertaken just prior to the day of surgery and often if these are positive then the surgery cannot continue. Exclusive breastfeeding on discharge continues to remain above the target at 81%.

Birth numbers for the month of July are slightly above the target.

**Gateway Assessment Programme**

*Referrals*
There has been a significant increase in the number of referrals this month. There were 43 referrals received during August 2014. During this month there has been one family of eight children and one with nine children referred. The increase in referrals is getting us closer to the targeted number of referrals. Staff are allocated to this work. An additional FTE (from a vacancy) was recruited this year with this in mind.

*Children Waiting Beyond Contracted Wait Times*
The number of children waiting beyond contracted time frames has decreased this month (n=13). The service continues to work closely with CYFS to manage this process to ensure that children are seen in a timely way.

**Patient Flow**
Average length of stay rates for maternity and SCBU remain at or better than target. Rangatira has shown an increase due to patient acuity and complexity. Now that physiotherapy is available in Rangatira ward, the service is seeing increasing numbers of children with bronchiectasis and complex disabilities who in the past would have received treatment at Starship Hospital.

Discharge at weekends remains better than target.

**ESPI**
ESPI 1 target achieved at 100% for gynaecology above the target of 90%.
The ESPI compliance target for ESPI 2 and 5 has now been lowered to 4 month compliance for gynaecology. The service has not been able to achieve ESPI 2 for the month of July despite an increase in the number of FSA clinics provided. The plan is to have additional clinics in August so that the backlog of patients waiting for a FSA is cleared and the service should then achieve 4 month compliance in September and thereafter. The support of a perioperative nurse co-ordinator in gynaecology has been highly effective as she is able to review all the theatre lists two weeks in advance ensuring that they are fully booked.

**Contracts**

Gynaecology elective WIES volumes are above target.

Gynaecology FSA’s achieved 100% (on target) for the month and FUP’s continue the trend of exceeding the target. This is mainly due to meeting the needs of patients who have urogynaecology conditions. The model of care includes a number of diagnostic investigations / treatments the patient may require before surgical intervention is considered.

**Rangatira**

Year to date inpatient paediatric medical activity is 37% higher than contracted volumes. Patient acuity and complexity has been high over August. This has had a particular impact on physiotherapy (children with bronchiectasis and complex disabilities). To meet demand child development physiotherapists have been redeployed into Rangatira, which has resulted in delayed treatment for children with disabilities in the community.

**Neonatal – Special Care Baby Units (SCBU)**

Year to date SCBU activity is 6% higher than contracted volumes.
Child Rehabilitation Activity

Rehabilitation Activity – In Area Bed Days
Year to date ‘in area’ activity is lower than contracted volumes.
Auckland DHB has been the highest user of ‘in area’ bed days this month.

<table>
<thead>
<tr>
<th>DHB</th>
<th>August Utilisation (n)</th>
<th>August Utilisation (%)</th>
<th>YTD Utilisation (n)</th>
<th>YTD Utilisation (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>8</td>
<td>100%</td>
<td>48</td>
<td>73%</td>
</tr>
<tr>
<td>Counties-Manukau</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>23%</td>
</tr>
<tr>
<td>Waitemata</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>5%</td>
</tr>
</tbody>
</table>

Rehabilitation Activity – Out of Area Bed Days
Year to date ‘out of area’ activity is higher than contracted volumes.
Year to date Bay of Plenty and Tairawhiti DHB’s are the highest users of ‘out of area’ bed days.

Rehabilitation Activity – Total Bed Days (In and Out of Area)
Year to date total rehabilitation bed activity is 20% lower than contracted volumes.
Scorecard

Waitemata DHB Monthly Performance Scorecard
Child Women and Family Service and Elective Surgical Centre
July 2014

Priority One

Health Targets
Better help for smokers to quit
Provider Elective Volumes
- Child, Women & Family Services
- Elective Surgical Centre
Shorter waits in ED

Quality
Compliant Average Response Time
Friends and Family Test
Not Promoter Score
HRO Factors (% good hand hygiene practice)
% operations where all 8 parts of surgical checklist used
Others Key Measures:
Acute Readmission Rate within 30 days *

Human Resources
HRAbsenteeism
Sick Leave Rate (Days) *
Overtime Rate (%) *
Annual Leave Balance > 7 days
Clinical Employment (FTE)

Finance
Financial Result YTD
Revenue
Expense
Personnel Costs
Outsourced Services
Clinical Supply Costs
Non-Clinical Supply Costs
Contribution
Capital Expenditure

Productivity
Oral Health Arrangements
Oral Health Arrangements (Main)
Oral Health New Enrolments (Preschool)
Theatre utilisation Gynaecology
Exclusive breastfeeding on discharge
Births

Gateway Assessment Programme
Gateway referrals waiting over contracted timetable

Patient Flow
Average Length of Stay - Maternity
Average Length of Stay - Paediatrics
Average Length of Stay - SCBU
Discharges at weekends

ESP9 - % patients waiting longer than 5 months for SA
Gynaecology

ESP9 - % of Patients not treated within 6 months
Gynaecology

Contracts
Elective WMS Volumes
- Child, Women & Family Services
- Elective Surgical Centre

WMS Volumes
Gynaecology Acute
- Maternity
- Paediatrics
- Neonatal

Other Contracted Volumes
Child Rehabilitation bed days

Non-Cost Weighted Discharges (PTT)
First specialist assessment (RIA)
Subsequent Attendance (RIA)

How To
Indicator Title
Actual
Target
Improvement against previous result
Did performance achieve or surpass the target? Will display a solid green line.

Waitemata DHB, Hospital Advisory Committee Meeting 24/09/2014
<table>
<thead>
<tr>
<th>Deliverable /Action</th>
<th>On Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that staffing policies and procedures and contracts entered into align with the Vulnerable Children’s Act once passed into law (in June 2014)</td>
<td>✓</td>
</tr>
<tr>
<td>Establish multi-disciplinary Children’s Teams, as and when appropriate</td>
<td>✓</td>
</tr>
<tr>
<td>Strengthen the work of Te Aka Ora - Vulnerable Families Forum to increase identification during pregnancy; support lead maternity carers (LMCs) and other key workers to implement effective interventions – on-going</td>
<td>✓</td>
</tr>
<tr>
<td>Report on the number, ethnicity and issues raised of women referred to vulnerable families groups quarterly</td>
<td>✓</td>
</tr>
<tr>
<td>Monitor the number of babies under Maternity Services that are taken into the care of Child, Youth and Family Services over 2014/15</td>
<td>✓</td>
</tr>
<tr>
<td>Identify and implement specific actions to increase referrals to the Gateway Assessment Programme by December 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Maintain and strengthen existing VIP champion roles within the organisation – on-going</td>
<td>✓</td>
</tr>
<tr>
<td>The Maternity Plan will be updated with new activities to encourage pregnant Māori women to quit smoking by June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Waitemata DHB Child and Family Services will work with West Fono to identify and follow-up children enrolled with West Fono but who did not attend (DNA) their specialist appointments; apply learnings from this process to other children if appropriate by June 2015.</td>
<td>✓</td>
</tr>
<tr>
<td>Monitor accuracy of data of staff trained and screening rates in services that have been trained in child protection and partner abuse over 2014/15</td>
<td>✓</td>
</tr>
<tr>
<td>Provide patient-centred dental appointments, confirming attendance either by texting or telephoning and by extending clinic hours to suit parents/caregivers to reduce preschool dental non-attendance (DNAs) by March 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Monitor engagement of Māori infants with community oral health providers, and work on whānau engagement with community oral health services –on-going</td>
<td>✓</td>
</tr>
<tr>
<td>Implement the revised Ministry of Health Pregnancy and Parenting service specifications through a request for proposals process to provide more effectively targeted pregnancy and parenting education and information services by 31 January 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Following implementation of the service specification, establish baseline data on engagement in pregnancy and parenting education services by ethnicity 31 July 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Progress specific identified projects under the Maternity Quality and Safety Plans, including: o Promoting the Normal Birth project, and o Promoting increasing early engagement with a LMC by June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Identify quality improvement priorities from the Maternity Quality and Safety plan. This will include reporting on the New Zealand Maternity Clinical Indicators to identify outliers. Programmes will then be implemented to reduce variation in service and practice – on-going</td>
<td>✓</td>
</tr>
<tr>
<td>Work on improvements to the collection and reporting of needs to identify system for collecting consumer satisfaction data by February 2015.</td>
<td>✓</td>
</tr>
</tbody>
</table>
Key achievements for month

Violence Intervention Programme

The Child Protection alerts process has been successfully implemented and systems are now operational.

Reporting is now able to identify the percentage of women screened for Family Violence in most services.

The national audit of the VIP programme has been completed with positive initial feedback. We are awaiting the final report.

A staff survey regarding knowledge and attitudes of identification and management of child protection concerns has been undertaken with Emergency Department medical staff, Child Health and Child and Youth Mental Health staff (administration, managerial and clinical). Recommendations included a more robust training plan in place for services and a higher level of accountability to be familiar with Waitemata DHB child protection policy and to attend training.

The VIP coordinator met with Child Health managers to discuss support for meeting the quality plan focus on improving screening rates.

The Family Violence Prevention coordinator has resigned to go overseas and finished on the 4th September. Nikki Hill, Child Protection Coordinator, has also resigned to go overseas and finished in August. Both of these Coordinator positions are advertised. Interim cover has been organised from within existing staff to cover essential training and co-ordination tasks until the positions are filled. The VIP National Manager and National Trainer have been approached to assist with orientation of the new coordinators. The service is working to minimise the inevitable loss of momentum in the programme with the change to new coordinators.

Gateway

Targeted strategies to improve the referral rate continue. For example, an audit has been completed to identify children currently in care at the Westgate site (the site with the lowest referral rate) who have not been referred for a Gateway assessment.

Monthly referral data is sent to the Regional Child, Youth and Family (CYF) management team, which details referrals by site. Feedback has been provided to the CYF regional team on the processes that have been put in place at the site from which the most referrals are being received. The team is looking for opportunities to replicate these processes across all sites in the Waitemata area.

There has been an increase in the number of clinics delivered from community sites, in particular Whanau House. Child Health attended a workshop with key NGOs and primary care providers (including The Fono) to identify the current programmes that can be utilised to assist patients to attend appointments.

OTHER HIGHLIGHTS

The detailed design of the gynaecology ward on level 2 has commenced with the user group and steering groups meeting weekly. In order to commence building of the ward and meet the deadline of opening the ward in July 2015 a number of Women’s Health Services have been relocated to alternative sites on the NSH campus.
The Gynaecology / Colposcopy outpatient clinics have moved from the ground floor in the Out Patients Department to the 1st floor in ESC. In a separate area within the Cullen Ward a number of single rooms have now been developed into clinic rooms. In the four weeks these clinics have been in operation the feedback from women has been immensely positive. Each room has a toilet / changing room (bathroom) and the rooms are light and spacious.

The antenatal and maternity clinics have moved to the vacated outpatient gynaecology clinic space in NSH. This space is considerably smaller than the area the service has had previously, however the staff have been very creative in finding ways to accommodate the needs of all the users. One of the larger clinic rooms has been converted into the administration area with hot desks for midwives and social workers working in the clinic setting and a room has been assigned for CTG scanning while alternative separate office space for the midwives and social workers has been identified for use.

All the staff involved in these moves have managed the process extremely well and are to be congratulated for their “can do” attitude, thus ensuring a smooth transition for our consumers.

The clinical staff also met with the Women’s Health Management group to discuss the needs of the services and the permanent location of these services in the future. A planning session will be held in October to commence this strategic planning as well as to monitor the transits to the temporary locations.

Auckland Regional Dental Service
Appointment processes
One of the areas of focus in the new business rules is the management of DNAs. Unfortunately little impact has been made regionally. The ideal model would be to fully implement client centred booking to avoid DNAs. Non-attendees should be followed up by telephone, on the day of their missed appointment and re-scheduled. Rules apply to patients who have previously DNA’d. This takes huge resource and impacts on the productivity of the service. Negotiating appointments via the telephone with patients and parents also requires a particular skill set.

Many studies have attempted to explain why people fail to attend their appointments. Evaluative research in previous years has indicated that small changes in service provision, e.g. provision of information about a service prior to the appointment and sending reminders to service users prior to appointments, can positively affect clinic attendance rate (James I and Milne J 1997).

Recent surveys in Counties Manukau among Pacific community patients to understand why a higher proportion DNA their specialist appointments at Manukau Super Clinic found that the longer the time from initial discussion, the appointment being sent and the actual appointment date led to less importance being attached to the appointment. (CMDHB 2005)

Researchers have sought, for a number of years, to understand why people fail medical and dental appointments. Patel et al (2000) found that by changing the appearance of recall and appointment cards there was a decrease in failed appointments.

In an audit of 214 people attending a community dental clinic, it was shown that attendance was 25 per cent higher in those people contacted by phone prior to the appointment. Telephone and postal reminders have also been shown to be effective in other health care situations, and are therefore well worth considering (Blankenstein 2003). This approach has also been shown to be effective in general practice and hospital settings (Reekie and Devlin 1998; Shaw and Watts, 2001).
With the support and expertise of the decision support team, a production plan has been produced. This can now be used by the team leaders to improve efficiencies within their teams. The plan gives clear targets of visits with clear capacity goals in addition to team level information including specific targets e.g DNA and arrears.

The main focus of the service in the coming financial year is to achieve the MoH target for DNA of 10%.

The Ministry of Health’s definition of a failed appointment or DNA is: “the number of booked visits/appointments resulting in Did Not attends without advice only”. The CFA six monthly reporting for the Oral Health Business Case to reconfigure facilities and the Model of Care for children and adolescents (OHBC) now requires monitoring of DNAs and explanation of the “impact of DNAs on service productivity, the issues contributing to DNA rate and the actions planned/taken to manage the levels of DNAs.” The national benchmark is 10% of booked appointments resulting in DNA.

**Rationale**

The current percentage of children who do not attend the appointments either for examination and/or treatments needs to reduce. This will help to ensure that the majority, if not all children are examined and treated within the appropriate intervals. There is a need to specifically target the under five year old age group to enable provision of oral health education, detection of caries at early stages and to provide preventive and minimal restorative treatment. Focus needs to be with Maori and Pacific children.

In order to maintain the efficiency and productivity of ARDS and utilisation of each dental chair in the service at 80% or more, it is important to focus on the failed appointments/Did Not Attend (DNA). When children fail the appointments with no prior notification it is not always possible to bring another child from the school. As such that appointment time is not used productively. On average appointments are made for 30 minutes.

If children fail two appointments they will again be contacted only after 6 or 12 months depending on the risk status of children and as such examination and treatments will be delayed. During this period caries can progress to an advanced stage and can cause pain and discomfort which may necessitate more complex treatments such as pulpotomy, root canal treatments or extractions.

Appointments are made to examine and/or treat children from the same school where the clinic is situated or from other schools and for Relief of Pain (ROP) patients. Children who are brought from classes either for examination or treatments and ROP patients who visit the clinics without appointments are not added to the denominator as appointments.

At the end of 2013 ARDS had a patient base of 261,894 children and adolescents. Each enrolled child will be seen at varying recall times. Individualised dental care ((IDC) is an assessment tool that informs the recall period. High risk has a six month recall; medium risk a one year recall period and low risk an eighteen month recall period. IDC is designed to spread the demand of the service by the use of recall times to suit the risk status of the child.

From January to December 2013 the number of DNAs across the service amounted to 96,654. In May 2014 the DNA rate for ARDS was 28.8%. Statistics trend similarly across the region. The south area have higher DNAs by age group and ethnicity, with all areas having significantly poorer attendance by Maori and Pacific peoples, with the least attendance issues within the 5-13 year age group.
The current changes in provision of dental services within ARDS to a “hub and spoke” model of care means that fewer children are brought from the classroom to be seen without appointments at school based clinics. The new fixed facilities are larger than the older school clinics but there are fewer of them, most though not all are based on school sites. The fixed facilities are supported by a mobile dental service. A proposal has been submitted to quality to take forward the concept of a ‘call centre’ for the service to better address the appointment process.

**Digital Radiography**

The ARDS digital radiography pilot has started recently at Henderson Intermediate clinic. This will be extended to two mobile clinics in the first two weeks. The length of the pilot will be dependent on the issues raised and resolution time.

**Consumer Representative**

ARDS have appointed two consumer representatives to attend the monthly clinical governance group.

**Consumer satisfaction survey**

A consumer survey has been completed with patients who attend outpatient appointments at Totara Health (New Lynn Integrated Family Health Centre). In total, 48 families completed the survey. The survey demonstrated that families were particularly positive about the availability and length of appointments, the location and physical environment, and the friendliness and responsiveness of staff. Two areas identified for improvement were signage within the centre and the information/support provided to assist families to attend appointments.

**Rheumatic Fever Prevention and Intervention Programme**

**School Based Swabbing Programme**

There has been an increase in the number of swabs completed this month (n=934). This month 68 children (7% of children swabbed) were identified with GAS+ sore throats. This month, there has been a significantly higher rate of GAS+ results at Nga Kakano (20% of those swabbed).
A health day has been planned for Pomaira School. The day is fully supported by the school and is the result of the excellent relationship that has developed between the school community and public health nurse and rheumatic fever screening team. The day will include public health nurses raising awareness of Rheumatic Fever (including the availability of rapid response clinics), Before School Check screening by Plunket and vision and hearing technicians from Child & Family, well child services. There are a number of local agencies that have been invited to participate in the day including: Te Whanau O Waipareira, The Fono, the Police and Plunket.
Financial Results

COMMENT ON MAJOR FINANCIAL VARIANCES

Revenue ($188k favourable Month)
The Government and Crown Agency favourable $145k variance for July 2014 has been driven primarily by high Child Rehab Out of Area inpatient activity $95k. The 166 bed days are well in excess of the average 58 bed day budget position. Child Health ACC funding continues to remain high with $32k favourable variance being attributed to a new Child Adolescent Rehabilitation contract established in Jan/Feb 2014. HealthWest funding for Public Health Nurse school based visits is $10k, however this contract will cease at the end of August 2014.

Other Income revenue streams contributing to the monthly favourable result is additional revenue from the University of Auckland $23k and the Health Quality and Safety Commission $13k.

Expenditure
Medical Personnel ($70k unfavourable Month)
The main driver behind the medical cost increase this month is a higher than expected planned July cost. It was planned that costs would follow a similar trend as evidenced over the past two years.
Annual leave costs were higher than the same period last year by $15k. This follows higher rates over recent months. Alongside this is a $27k savings initiative. The service is forecasting to be on budget for the full year.

**Nursing ($226k unfavourable Month)**
Nursing costs for July were predominately high across Maternity $90k and Paediatrics services $58k, with SCBU $50k. High inpatient activity across Maternity 104% and Paediatrics 128% has had a significant impact. There have been high rates of sick leave $80k ($17k higher than the 2013/14 average), overtime $22K ($11k higher than the 2013/14 average) and annual leave costs $245k ($52k higher than the 2013/14 average) across the service.

It is anticipated that cost pressures will remain high particularly in Paediatric inpatients throughout the busy winter period.

**Allied Health ($398k unfavourable Month)**
The Allied Health result has also been impacted by lower than anticipated Dental Therapist staffing vacancies. In budgeting the service had expected the historic pattern of a high number of vacancies to continue, which has not been the case. Also factored into this result is unbudgeted gratuities payment of $19k.

**Management/Administration ($64k unfavourable Month)**
A combination of High Sick leave ($10k) higher than July 13 along with incorrect coding of Dental Assistant (PCA) roles to Admin positions have contributed to this unfavourable result. This coding issue is currently being addressed. Also included is a savings initiative of $8k per month.

**Outsourced Personnel ($59k favourable Month)**
Under spends in the following accounts were the most significant drivers of this result – Waitakere on call Anaesthetist cost transfer from Surgical Services $18k, on call Obstetrician costs $32k and outsourced Paediatric Rehabilitation specialist services from ADHB $11K.

**Outsourced Services ($6k favourable Month)**
The small $6k variance this month comes as a result of under spends in Community Radiology costs $11k, Lab sendaway test costs to ADHB $8k, reduced postnatal stays at Birthcare $5k and other outsourced clinical costs $7k being partially offset by savings initiatives of $30k.

**Clinical Supplies ($63k unfavourable Month)**
Over spends in Clinical supplies have been driven by unrealised savings initiatives of $50k, sterilising consumables increase of $7k and unexpected Air Ambulance costs of $7k. The increase in consumables costs is attributed to the high Paediatric inpatient volume (128%) for July.

Much of the savings initiatives shortfall is due to timing, these will be realised over the coming months.

**Infrastructure ($104k favourable Month)**
Under spends arising from this month’s activity include cleaning outsourced $13k, electricity and water $18k, registration and maintenance on dental units $36k and postage $17k. Also included in the result is a savings initiative of $14k.
Mental Health and Addiction Services

Service Overview
This division provides specialist community and inpatient mental health services to Waitemata residents. It is also provides community alcohol, drug and other addiction services, and forensic services to the northern region. The group is managed by Helen Wood with Clinical Director Murray Patton for Mental Health and Clinical Director Forensic Services, Jeremy Skipworth.

SCORECARD

Health Targets
Better help for smokers to quit: 98%
July saw a return to high performance for inpatient units above the 95% target. During July there was training for staff in Moko services in Group Based Smoking Cessation. It is anticipated that this will provide a greater opportunity for Maori service users to become smoke free. Similar groups will be offered in the adult community mental health teams within the next few months.

Shorter Waits in ED: 77%
There has been an increase in breaches in ED during the month of July due to the demand on inpatient beds. Over this time there were 111 admissions to the 67 available mental health inpatient beds. This has contributed to the increased pressure felt across Adult Acute Services and resulted in longer waits for service users inside the Emergency Departments. Further analysis will be provided in the next HAC report.

Quality

<table>
<thead>
<tr>
<th>Types of complaints</th>
<th>Average Days to Close</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessibility</td>
<td>21</td>
</tr>
<tr>
<td>Attitude and Courtesy</td>
<td>29</td>
</tr>
<tr>
<td>Care &amp; treatment</td>
<td>17</td>
</tr>
<tr>
<td>Communication</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
</tr>
</tbody>
</table>

The average days to close complaints decreased from 28 in June down to 20 in July, this has continued to drop down to 6 days for August. The main issues raised in complaints are consistently related to communication, attitude and care and treatment. Managers have been encouraged to identify values behaviours with staff when investigating and responding to complaints.

Serious and Sentinel Events
The list for adverse reportable events (SAC 1 & 2) to the Health Quality and Safety Commission (HQSC) 2013/2014 is complete; there were 27 events in total. These will be reported through the DAMHS (Director of Area Mental Health Services) reports; the date is yet to be determined. Of these 27 serious incident reports, 16 have been signed off, 6 are awaiting sign off and 5 remain in progress.
Service Delivery
The number of referrals to the Adult, Youth and Forensic Outpatient services sit above the identified targets and higher than expected. This is consistent with overall figures showing significant rise in the overall referral rates of services compared with last year. A recent review of number of distinct clients being seen across the services identified a larger number of people being seen in comparison with the previous year for the same period:

<table>
<thead>
<tr>
<th>Mental Health Services Group including: CADS, RFPS, all MHS inpatient and outpatient</th>
<th>Number of clients seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013 Full Year from 1 January to 31 December</td>
<td>32835</td>
</tr>
<tr>
<td>2014 6 months from 1 January to 30 June</td>
<td>22241</td>
</tr>
</tbody>
</table>

Occupancy rates in the Adult Inpatient Units were 93% and the average length of stay has reduced to 20 days. Encouragingly, the occupancy rate for Koromiko House (Adult Respite Facility – 7 beds) was 80% with a total of 175 bed nights being utilised. Piri Pono, the 5 bedded Adult Community Acute Residential Service, has reported an improvement in the relationship with and clinical oversight by the Acute Adult Mental Health Team. This is thought to be the result of training for the Acute Adult Team in the ‘Intentional Peer Support Model’ model. Further training has been planned.

Service access for youth continues to be a problem area, despite working to capacity and the 98% referral acceptance rate. Service leads are actively seeking recommendations nationally from counterparts in other districts and participating in multiple forums in order to focus on improving access.

The waiting times targets of people being seen within three weeks remains relatively stable across the services, with all areas exceeding targets.

---

Waitemata DHB, Hospital Advisory Committee Meeting 24/09/2014
### Scorecard

#### Waitemata DHB Monthly Performance Scorecard

**Mental Health Service**

**July 2014**

#### Priority One

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better help for smokers to quit</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Overhear Whits in ED</td>
<td>77%</td>
<td>80%</td>
</tr>
</tbody>
</table>

#### Quality

<table>
<thead>
<tr>
<th>Quality</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaint Average Response Time</td>
<td>30 days</td>
<td>14 days</td>
</tr>
</tbody>
</table>

#### Seclusion

| Sedation/Use Forensics - Episodes | 15 | 10-14 |
| Sedation/Use Adult - Episodes | 5 | 1-5 |

#### Whistleblower Contacts per service user (community only)

| Adults | 71.0% | 70.0% |
| Child | 100.0% | 80.0% |
| Youth | 100.0% | 80.0% |

#### Acute Readmission Rates within 28 days (reported one month ahead)

| Adults | 4.0% | 10.0% |
| CAS 0.0% | 5.0% |

#### Human Resources

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick Leave Rate (days)</td>
<td>3.9 days</td>
<td>7.0 days</td>
</tr>
<tr>
<td>Overtime Rate (%)</td>
<td>2.3%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Annual Leave Balance &gt; 7 days</td>
<td>8.0%</td>
<td>10%</td>
</tr>
<tr>
<td>Turnover Rate %</td>
<td>0.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Clinical Staff (FTE)</td>
<td>1,020 FTE</td>
<td></td>
</tr>
</tbody>
</table>

#### Finance

<table>
<thead>
<tr>
<th>Financial Indicators</th>
<th>Actual $500k</th>
<th>Target $500k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>32,772</td>
<td>34,743</td>
</tr>
<tr>
<td>Expense</td>
<td>33,380</td>
<td>34,501</td>
</tr>
<tr>
<td>Personnel Costs</td>
<td>9,201</td>
<td>9,206</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>163</td>
<td>165</td>
</tr>
<tr>
<td>Clinical Supply Costs</td>
<td>117</td>
<td>127</td>
</tr>
<tr>
<td>Non-Clinical Supply Costs</td>
<td>751</td>
<td>681</td>
</tr>
<tr>
<td>Contribution</td>
<td>2,692</td>
<td>2,446</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>17</td>
<td>6</td>
</tr>
</tbody>
</table>

#### Service Delivery

<table>
<thead>
<tr>
<th>Productivity</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of Stay - Adult Acute</td>
<td>30</td>
<td>15-11</td>
</tr>
<tr>
<td>Average Length of Stay - CADS Detox</td>
<td>0</td>
<td>0-9</td>
</tr>
<tr>
<td>Bed Occupancy (midnight) - Adult Acute</td>
<td>64%</td>
<td>85%</td>
</tr>
<tr>
<td>Bed Occupancy (midnight) - CADS Detox</td>
<td>103%</td>
<td>70%</td>
</tr>
<tr>
<td>Bed Occupancy (midnight) - Forensics Acute &amp; Behav</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Bed Occupancy (midnight) - ID</td>
<td>92%</td>
<td>70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Access (mean wait time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI Access Rates 0-15 years (Total)</td>
</tr>
<tr>
<td>MI Access Rates 0-15 years (Mean)</td>
</tr>
<tr>
<td>MI Access Rates 26-44 years (Total)</td>
</tr>
<tr>
<td>MI Access Rates 26-44 years (Mean)</td>
</tr>
</tbody>
</table>

### How to read

- **Indicator Title**: 95.0% - 100.0% A
  - Improvement against previous result
  - Performance exceeding or above the target will display a solid green line.
### STRATEGIC INITIATIVES

<table>
<thead>
<tr>
<th>No.</th>
<th>Deliverable /Action – Prime Minister’s Youth Mental Health Project</th>
<th>On Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provide follow-up care plans for youth aged 12 to 19 discharged from hospital into primary care – to commence once guidelines released by Dec 2014</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>Ensure a range of psychological services are available to young people, including e-therapy during 2014/2015</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td>Set bench marks for access and readmission rates for Māori, Pacific and Asian, based on prevalence data by December 2014</td>
<td>ongoing</td>
</tr>
<tr>
<td>4</td>
<td>Further develop services for children of parents with mental illness and addictions – in place by December 2014.</td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Deliverable /Action – Mental Health Service Development Plan</th>
<th>On Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Review of duration of service use to ensure that people are engaged at the right level of service at the right time (using resources effectively/links to Stepped Care) by June 2015</td>
<td>ongoing</td>
</tr>
<tr>
<td>6</td>
<td>Improve collection and utilisation of HONOS data, and complete roll out of Hua Oranga by June 2015</td>
<td>ongoing</td>
</tr>
<tr>
<td>7</td>
<td>Integrate HONOS data into clinical pathways across adult services by June 2015</td>
<td>ongoing</td>
</tr>
<tr>
<td>8</td>
<td>Increase the focus of the mental health partnership with Whānau House on Whānau Ora by operating specialist mental health sessions at Whānau House by June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>9</td>
<td>Plan to develop mental health focus contracted employment specialists (links to welfare reforms) by March 2015</td>
<td>ongoing</td>
</tr>
<tr>
<td>10</td>
<td>Roll out training to improve risk assessment/intervention for suicidality, to secondary clinical services and NGOs by December 2014</td>
<td>ongoing</td>
</tr>
<tr>
<td>11</td>
<td>Complete a staff training programme, roll out of psychosis relapse planning, and participate in IT initiatives to develop relevant self-management tools, by March 2015</td>
<td>ongoing</td>
</tr>
<tr>
<td>12</td>
<td>Develop Children of Parents with Mental Illness or Addictions (COPMIA) services across provider arm and NGO services by March 2015</td>
<td>✓</td>
</tr>
<tr>
<td>13</td>
<td>Integrate AOD interventions across the continuum with a focus on the integrated pathways between the Waitakere District Court, Community Alcohol and Drugs Services (CADS) and NGOs for the Waitakere Drug Court (links to Drivers of Crime) by December 2014</td>
<td>ongoing</td>
</tr>
<tr>
<td>14</td>
<td>Continue to implement the WAVES programme (post suicide support and education course to provide group support to people bereaved by suicide) – fully implemented by June 2015</td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Deliverable /Action – Other</th>
<th>On Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Implement mental health initiatives including respite beds and support packages for women with maternal mental health issues by June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>15</td>
<td>Establish baseline of women with maternal mental health issues utilising primary mental health services by 31 December 2014</td>
<td>ongoing</td>
</tr>
</tbody>
</table>

* include a ✓ or a ✗
Key achievements for month

Deliverable - Action Prime Ministers Youth Mental Health Project
The MoH has released the Transition Planning Guidelines, aimed at providing a clear transition for young people from secondary care into primary care. The guidelines include templates which aim to provide consistency of information. The service is currently working with reporting services to ensure we are able to accurately capture and report on this activity.

Psychological services for young people and their families are currently available across the child and youth mental health services. Additionally there is the availability of a self-help resource pack called SPARX. It includes a recently released online self-help tool for the treatment of depression in youth and has been developed and tested in New Zealand and is currently being trialed internationally.

Deliverable - Mental Health Service Development Plan
- Child and Adolescent Mental Health Services (CAMHS) are currently running two group programmes at Whanau House: Fostering Security (co-facilitated with Child, Youth and Family) and a group programme for parents of children with Attention Deficit Hyperactivity Disorder.
- Two WAVES bereavement groups have been run with two more scheduled for completion by December 2014.

CADS reviewed its addiction services delivered to the Asian population in the Auckland region. The service now treats annually around 700 people from an Asian background compared with 200 people ten years ago. They represent 5% of all CADS clients treated annually with alcohol abuse or dependence presenting as the most common problems. Services are derived by a cluster of Asian clinicians across the teams who meet regularly to consult with each other. Stigma is a significant challenge for this client group. CADS will continue to develop its services to the Asian community by employing more staff from an Asian background, aligning it with DHB wide initiatives to develop Asian health services, and regular promotion amongst Asian communities.

OTHER HIGHLIGHTS
He Puna Waiora
The construction programme has been extended by 20 working days. WDHB has requested RCP to work with Robert Cunningham Construction to review the options for reducing the delay in the overall programme. The storm water upgrade, service trench works and Gas Main installation was completed in July. First fix Plumbing and Electrical has started in Zone 1 and 2. Windows, Masonry veneer, internal and external solid plaster have been commenced. The interior design has also been completed by Lynda Partridge with colour boards developed and approved.

The link with North Shore Hospital has been approved; however final costing is still to be approved and will be available by the end of September. Jasmax (Architects) have been engaged to develop the design, this will be completed by the end of August. Construction is due to commence in October.

Matthew Knight, Project Manager, Facilities, is overseeing the installation of the Lamson system to Wards 14, 15 and the Renal Building.

Visits to the site will continue on a monthly basis with staff from Taharoto, Mental Health Services & the DHB communications department.

The project is on track to be delivered within the total capital budget of $24.982m. The financial performance against plan is evaluated on a regular basis by the project steering group.
Primary Care Integration
Moko services are meeting monthly with Whanau House to work collaboratively and share resources that benefit tangata whaiora. Whanau House is being used to coordinate multiagency meetings for support workers. We are now able to maximise our time by using this venue to coordinate meetings for support workers in the community, this includes both GPs and WINZ.

Dr Lyndy Matthews, psychiatrist, has been appointed to work in a role working at the interface between primary care and the DHB. She will be available for telephone psychiatric advice to GPs, for some consult-liaison work with primary care, to support primary care liaison nurse roles, and to further develop referral pathway.

Gambling Audit for Tupu Services
Tupu services underwent a clinical audit undertaken by KPMG for Preventing and Minimising Gambling Harm. The purpose of the clinical audit was to assess whether counselling service providers are implementing national guidelines, industry standards and best practice. The feedback received by the auditors was very positive.

Te Whitiki Maurea:
The service delivery pathway for Whitiki Maurea services is currently being reviewed. The intention is to provide a clearer service pathway for the Adult, Child and Youth, and Pacific services in accessing the Maori mental health services for tangata whaiora. The intention is to improve access for cultural support to all other mental health services in WDHB via the Taurawhiri (Cultural Advisors).

KEY ISSUES COMING UP

Child, Youth and Family Services:
Focus for August/September will be working towards the implementation of enhancement to the Maternal Mental Health continuum of services. Key areas are:
- Recruitment for a Psychiatrist
- Participation in the Request for Proposals process for establishment of community respite and support packages.
- Implementation of acute responsiveness initiatives, specifically the opening of the Mother and Baby beds at Starship and the after-hours consultation service.

There is a 6 week period (Mid -September to end of November) where there is no Senior Medical Officer for the Early Psychosis Intervention Team. Contingency planning is currently underway with the Child and Youth Service Clinical Director and the Adult Service Clinical Director.

Regional Forensic Services (RFPs):
In preparation for the redevelopment of the Auckland regional prison in 2017, RFPs have met with the MoH and Department of Corrections to discuss Forensic input into the design and rebuild of Auckland East Prison (Paremoremo). RFPs remain cautious as to the limits of their involvement but are pleased to have been invited to participate in the design and model of care planning.

The opening of the Wiri Prison in 2015 is expected to place increased demand on RFPs. Discussions with the MoH regarding the schedule for deploying resources to enable RFPs to meet this new demand are now concluding.

Forensic Intellectual Disability Beds
There has recently been some publicity regarding a male offender with an Intellectual Disability (ID) being kept incarcerated, mainly in prison, for some decades. Discussion around this case highlighted the lack of secure health facilities for people with ID nationally, this being a particular issue in the Northern Region. A recent request from the Ministry of Health to spot purchase Forensic ID beds in the Northern Region is further evidence...
of this developing need. The Forensic Service is not currently able to assist with these requests, but we are in agreement with the Ministry of Health that there is a need for more Forensic ID beds in this region. Any discussion of this potential development will need to be cognisant of current demands on Mason Clinic land.

**FACILITIES**

Potential move of teams from North Shore Hospital site: Marinoto North, EPI, Intensive Clinical Support Services (ICSS) and Maternal Mental Health. This will require considerable resource and attention to minimise disruption to service delivery. An issue of rat infestation at both the Pupuke and Shakespeare Road Buildings is currently being managed through the use of pest control services.

The Remedial Works Steering group is planning the approach to the programme of remedial works on the Mason Clinic site. The programme will address the need for a decanting unit and in turn the increased demand for forensic beds in this region.
Financial Results

COMMENT ON MAJOR FINANCIAL VARIANCES

Revenue ($27k favourable to Month)

The favourable revenue result is driven by contracts signed after the budget was set, these contracts will also come with additional cost. Included in the month result is an unfavourable variance of $33k relating to infant and perinatal FTE’s. Revenue is transferred from the Funder to the Mental Health Service Group when the positions are filled.

Personnel ($287k favourable to Month)

The positive variances in Medical ($96k), Nursing ($161k) and Allied ($40k) are mainly driven by vacancies across the group. The service are actively recruiting to vacancies, Adult MH are covering their medical vacancies with locum staff at a cost of $17k for the month.

$6k of unbudgeted Management/Administration costs for a project manager coordinating the establishment of a new infant and perinatal service is fully funded by additional revenue received from the MoH. Annual leave earned was greater than taken for the month in Management/Admin by $20k. The budget is phased to take this into account where possible; however, it is likely that this will have a minor impact on the result.
Other Direct Costs ($64k unfavourable to Month)
The variance against budget for infrastructure and non-clinical supplies is unfavourable due to prior year costs for rental contracts equating to $48k, $25k minor purchases/maintenance and $7k for a relapse prevention in psychosis project funded by Janssen Cilag.
Elective Surgical Centre (ESC)

Service Overview
This new division provides elective surgical services to our community, working alongside the Surgical and Ambulatory and Women and Child Health Services. It provides general surgery, orthopaedic surgery, gynaecology and urology. It has its own outpatient clinic, operating theatres, CSSD and a post-operative ward. The Director of the service is John Cullen and it is managed by Mark Watson.

Scorecard

Service Delivery
Points of interest for July:
- Further increase in patient volumes
- The ESC’s First Anniversary
- Steamplicity meal publicity – NZ Herald
- Temporary set up Gynae Outpatient department within the existing Cullen Ward
- Continued impressive compliments being received from patients of ESC

Elective Surgery Volumes
Following increases in patient volumes since the beginning of the calendar year, the ESC volumes have now increased further, exceeding the budgeted volumes.

So far, for the first month of the new financial year, ESC has treated 454 patients. Of this overall number, ESC reported to the MOH that 444 patients were treated which was 116% of expected budgeted volumes. The remainder consisted of ACC/IDF/acute arranged patients.

The graph below shows us how the overall patient volumes have improved and how we have maintained a good mix of surgical complexity that has, in turn, ensured our average WIES has remained unaffected to date.
Session Utilisation/Start and Finish Times
During July the percentage of actual theatre sessions undertaken against the planned session schedule was 95%. The utilisation of the theatre time of each session was an average of 84% between all the specialties with the average length of stay staying at two days. The list utilisation is reported to each Clinical Director and individual SMO’s for action where necessary to further improve the use of the sessions booked. Each operating list is reviewed line by line a week prior to the surgery date to ensure it is correctly utilised. The graph below represents the utilisation of the actual operating sessions by each specialty.

Anaesthetic Team Compliance
Since April 2014 we have been measuring the percentage of the named anaesthetist or team of anaesthetists, attached to each surgeon, who then actually work with that surgeon on each list. When we look at the actual procedural anaesthetist compliance (one specific anaesthetist assigned to a specific surgeon), it has dropped over the past few months to an average of 35%. If we then look at the team of anaesthetists and note if one of that team has actually worked with the allocated surgeon, this compliance sits at 57%. This needs to improve as we move ahead.

Effective Waste Management at the Elective Surgery Centre
Main features of this project within the ESC are:
• Recycling in theatres of hard plastics, soft plastics, paper and kimguard (paper surgical drapes)
• Recycling in day rooms and staff areas
• Confidential paper is shredded and recycled (rather than direct to confidential destruction service)
• Baler on-site to bale kimguard for recycling

As a result of this concentrated effort to separate our recyclable waste, the chart below shows the overall breakdown of what we dispose of:

The percentage split of waste types has not changed to any meaningful level since when we last reported on this apart from a slight increase in medical waste, which is to be expected as the facility gains momentum. This clearly
demonstrates that the waste segregation processes are still effective and delivering the desired outcome. This provides a continued cost saving of approximately $260 per month, or over $3000 per year. Waste audits carried out in Aug 2014 have also shown that ESC has extremely low levels of waste contamination, where waste is incorrectly segregated, performing significantly better than either NSH or WTH.

Recycling boxes in the ESC Operating Theatres

**Steamplicity Meals**
Following the successful introduction of the new ‘Steamplicity’ meals at the ESC, the NZ Herald ran an article about hospital food and its nutritional values, etc. It used a very positive overview of how well the ESC’s meals have been received by the patients and included a patient interview, which showed ESC in a very favourable manner.

**Gynae Outpatients**
Towards the end of July, beginning of August, ESC welcomed in the Gynae Outpatient team, who have been decanted out of their area to allow the building of the fifteen additional beds on Ward 2 of the NSH. The department has taken over seven in-patient rooms and associated storage areas to accommodate their four clinic rooms and two colposcopy clinics. The move is temporary until the clinic moves down into the ESC Outpatient area before the end of this year, freeing up the seven rooms on the Cullen Ward.

**First Anniversary**
The entire ESC team attended an annual celebration to acknowledge the ESC’s first anniversary. Many of the ESC SMOs also attended to thank the team for everything the ESC has achieved over the past 12 months. The celebration was attended by nearly 100 staff and SMOs and reflected the close bond that the ESC team have generated over the year.
Scorecard

Waitemata DHB Monthly Performance Scorecard

July 2014

Prioritised

Service Delivery

Productivity

Patient Flow

Average Length of Stay - Electives

Elective Surgical Centre

Elective Surgical Centre

Finance

Revenues

Expenses

Personnel Costs

Outsourced Services

Clinical Supply Costs

Non Clinical Supply Costs

Shire

Contribution

Capital Expenditure

How to read

Scorecard

Waitemata DHB, Hospital Advisory Committee Meeting 24/09/2014
**STRATEGIC INITIATIVES**

<table>
<thead>
<tr>
<th>Deliverable /Action</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilise additional theatre capacity in the ESC to increase the volume of elective surgery over 2014/15</td>
<td>✓</td>
</tr>
<tr>
<td>Implement the new model of care for elective services delivery at the new surgery centre by December 2014.</td>
<td>✓</td>
</tr>
<tr>
<td>Implement service review changes by 31 July 2014 to ensure full compliance with elective waiting time indicators by 1 December 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Prioritise all patients for treatment using nationally recognised tools and treatment in accordance with assigned priority and waiting time - on-going</td>
<td>✓</td>
</tr>
</tbody>
</table>

* include a ✓ or a ✗

**Key achievements for month:**

- Further increase in patient volumes
- The ESC’s First Anniversary
- Steamplicity meal publicity – NZ Herald
- Temporary set up Gynae Outpatient department within the existing Cullen Ward
- Continued impressive compliments being received from patients of ESC

**Areas off track for month and remedial plans:**

- Review of the referral rates for general surgery and ensure that sufficient volumes of patients are available to book onto each operating list. Meeting with the general surgeons at their next departmental business meeting to discuss management of referrals and backfilling options available

**KEY ISSUES/INITIATIVES IDENTIFIED IN COMING MONTHS**

**Review of Direct and Indirect Costs vs Activity**

Now that the volumes have settled into a regular pattern and SMO utilisation is steady, we are now in place to drill deeper into the ESC’s cost structure to ensure everything is in place to maximise any potential savings from smarter ways of working. This will involve reviewing all above and below the line costs associated to the ESC. Outcomes of this will be reported in future HAC reports.
Financial Results

Revenue ($149k favourable Month)
Revenue was favourable for the month as overall patient throughput was well ahead of the standard phased production plan (115%) and on track against the accelerated plan. As this was a step up in terms of scheduled activity, this result is encouraging. This trend has continued throughout August. Additional revenue was recognised ($86k) to reflect this outcome. Additionally there was additional ACC revenue ($49k) which was unbudgeted and some small amount of acute activity ($14k) which is also unbudgeted. These are additional unbudgeted volumes delivered by the service.

Expenditure
Personnel: ($14k favourable Month)
Personnel costs are $14k favourable for the month mostly due to nursing costs which were just below budget levels (96%), and even allowing for some small bureau usage this represents a tidy outcome.

Outsourced services: ($150k unfavourable Month)
These expenses are primarily the Package of Care costs for surgeons, and anaesthetists costs charged by S&AS. Overall patient throughput was about 120% of (phased) plan whilst overall expenditure is 123% of budget. This represents 120% of spend for clinician costs (104% for surgeons as there was a year end reversal offset; and 149%
for anaesthetists ($44k represents a budget shortfall; $47k represents the 20% increased patient throughput; $24k represents the change in mix (more expensive orthopaedic cases done than planned compared to other activity)). Additionally there is $20k of externally supplied radiology procedures that is not budgeted explicitly in this area.

**Clinical supplies: ($101k unfavourable Month)**
Overall clinical supply costs are $101k unfavourable but this is in line with additional activity.

**Infrastructure: ($21k unfavourable Month)**
There is unbudgeted facility cost of $16k that the services has incurred during the month that will dilute across months as the year progresses. There will also be a re-coding (reduction) of some laundry costs that should be classified as clinical supply costs.

**Summary**
The July monthly result is $109k unfavourable. This is primarily a result of accelerated patient activity to mitigate ESPI compliance risk in the first half of the year. $44k of anaesthesia charges represents an ongoing budget risk whilst the balance should be able to be managed through reduced patient volumes later in the year.
Surgical and Ambulatory Services

This Division provides elective and acute surgery to our community encompassing surgical specialties such as general surgery, orthopaedics, otorhinolaryngology and urology, and includes outpatient clinics, operating theatres and pre and post-operative wards. ICU, radiology and Asian Health Services are with this service. The service is managed by Cath Cronin. The Chief of Surgery is Michael Rodgers, Head of Division Nursing is Kate Gilmour, Head of Division Allied Health is Tamzin Brott.

The Group Manager of Hospital Operations is Leith Hart. Hospital Operations includes Pharmacy, Laboratories, Surgical Pathology, Nutrition and Food Services, Traffic and Fleet, Security, Clinical Engineering, Clinical Support Services, Decanting and Migration of services and Furniture Fixtures and Equipment (FF&E).

SCORECARD

Health Targets
Better help for smokers to quit continues to be above target at 96.6%.

ED Targets
Shorter waits in ED for July was under the target at 88.9%.
Orthopaedic review of the breaches in July showed the breaches were a result of high occupancy rates and slow discharges with access to beds the biggest contributor. This continues to reflect the seasonal high Medicine admissions rates and longer length of stay for medicine patients.
For Orthopaedics, it has been noted that a number of breaches were attributed to clinicians not clicking on the “seen by” when the patient was seen in ED skewering the data. There is work being undertaken to improve this rate with clinicians. This includes meeting with Registrars and House Officers and reviewing the way they manage the ED whiteboard. We identified that staff are seeing patients within the timeframe but not completing the whiteboard electronic process.
A review of general surgical breaches in August indicates that although they show up under General Surgery, 90 percent were still under the ED team at 6 hours hence there was no ability for General Surgery to alter the breach. This data is being tracked for each patient and provided to ED management.

July saw a number of non-weight bearing patients transferred on to the Interim Care Scheme to free up beds, while the hospitals experience the seasonal flu and winter increase in Medicine admissions. By the end of July there were seven patients in the community under this scheme.

Elective Surgery Volumes
The Waitemata DHB Surgical Programme (S&AS, CW&F and ESC) is on track for year to date.

Quality
65 compliments were received by surgical services in July and August. The Breast Screening Service received 199 in July and 245 in August which has become an expected benchmark for the service and a credit to the team.

The service received 14 complaints in July and 23 in August (17 received in July and 23 in August last year), closed 32 in July and achieved a complaint response rate of 11 days. The service also closed 18 complaints in August and achieved a response rate of 10 days.

Provider Arm Did Not Attend (DNA) Project
The development of a pilot programme with GP Practices to reduce Maori and Pacific DNAs from appointments at Waitemata DHB is in progress. Organisations included in the pilot are: Wai Health Centre; The Fono; Te Puna Hauora Medical Clinics; Ranui Medical Clinic; Ratanui Medical Centre; Lincoln Road Medical Centre; Health West;
Te Whanau O Waipareira; and ProCare. The Fono and Te Puna Hauora are beginning a trial in September, and discussions are in progress with the remaining practices around a start date.

A workshop was held on 22 August with representatives from pilot participants (excluding Health West), to develop interventions. A second workshop is scheduled for 5 September, to complete discussions. Interventions to reduce DNAs includes extending the focus of existing activity and programmes currently supporting patients at higher risk of DNA. This will enable GPs, practice nurses and care workers to assist patients to better understand their scheduled appointments and either attend, reschedule or cancel.

A data quality review has been undertaken to confirm the data quality of the Waitemata DHB DNA report. Patient numbers and clinic details of specialties included within the DNA report have been reviewed, to ensure accuracy of the data. All variances identified have been investigated and resolved. Revised reporting is being developed to support specialties to focus on areas of higher DNA and assess DNA trends/ issues over a 12 month period.

The initial business case for improving the Patient Service Centre’s ability to handle inbound calls from patients is complete and will be submitted for funding by the GM of Surgical and Ambulatory Services. An extended business case exploring options to improve the utilisation of technology (text messaging email and ‘ubook’) is in development.

**July DNA rates:**

![DNA Rates](image)

* Total includes Maori, Pacific Island, Asian & Other ethnicities

**Friends and Family**

Surgical and Ambulatory Services continue to achieve greater than the target Net Promoter Score for the Friends and Family Test scoring 70 for the month of August (74% promoters, 22% neutral and 4% detractor). The inpatient settings all achieved above the target number of responses with Ward 7 continuing to achieve the greatest number of responses. The Surgical Inpatient survey will further inform us re patient satisfaction. All patients discharged from wards 4, 6, 7, 8 and 9 throughout September will be sent a postal survey two weeks after their discharge. The first surveys will therefore be sent on Monday 15 September

**Infection Control**

*August CLAB maintenance – line days and CLAB free days*

<table>
<thead>
<tr>
<th>Ward</th>
<th>CLAB</th>
<th>CLAB free days</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>83%</td>
<td>73 line days</td>
</tr>
<tr>
<td>7</td>
<td>91%</td>
<td>43 line days</td>
</tr>
<tr>
<td>8</td>
<td>81%</td>
<td>91 line days</td>
</tr>
<tr>
<td>9</td>
<td>a/w</td>
<td>from CNM Sue</td>
</tr>
</tbody>
</table>

*ESBL – HA-Def*

There has been a decrease in definite hospital acquired ESBL in the surgical wards this month. Admission screening has identified a number of ESBL positive patients.

<table>
<thead>
<tr>
<th>Ward</th>
<th>n=</th>
<th>(July n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

78
**Hand Hygiene**

As we concluded the second round of Gold Audit Hand Hygiene audits, the education that has been on-going in the wards has been reflected in their results. Overall we have improved our compliance to S&AS average of 73%. We will continue education and auditing to identify areas that we can work on to improve our practices as we work to achieving our target of ≥80%.

**Falls**

89% falls risk assessments were completed for patients with a falls risk on the surgical wards and 86% medium or high risk patients had an appropriate care plan. There has been no fall with fracture this month; however the past two months has seen an overall increase in falls without harm.

**Pressure Injuries**

95% of patients had the correct care plan actions implemented. There were zero patients with grade 3-4 pressure injury.

**Service Delivery**

S&AS has commenced the year meeting expected performance targets with ESPI and Surgical Health Target.

**Radiology**

For July the Radiology wait time indicator levels for CT and MR were 76% of patients received their CT scans within 6 weeks and 51% of MR scans within 6 weeks. The achievement levels set by the Ministry for these indicators are 85% and 75% respectively. Ultrasound wait times for scans within 6 weeks is 92%.

A MoH project has been initiated to look at service improvement across all modalities. This is a national initiative that is resourced and supported by the MoH to review demand trends, administrative processes and reporting requirements. The project started with a national meeting to review the work to date that has been lead regionally and nationally by Dr Kate Aitken. John Greenwood will be the project lead for Waitemata DHB.

The business case has been approved for new CT scanner.

**ESPI 1, 2 and 5**

We have achieved compliance for July and August. The majority of specialties have achieved 100% compliance for ESPI 2 for 5 months for August with only three Gastroenterology patients unable to be seen due to clinician illness. Eleven patients including ortho/spine, plastic/breast did not meet ESPI 5 compliance for 5 months. Four occasions for non-compliance were due to the Waitemata DHB power failure on 25 August. Waitemata DHB is on track with plan to meet 4 month treatment times over the next two months. There are some specialties with significant numbers but each Operations Manager has an agreed plan and strategy.
### Waitemata DHB Monthly Performance Scorecard

#### Surgical and Ambulatory Service

**July 2014**

### Priority One

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better help for patients to quit</td>
<td>16.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Provider relative Effective Volumes - overall</td>
<td>112.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>- Surgical and Ambulatory Services</td>
<td>114.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>- Elective Surgical Centre</td>
<td>114.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>- Increase in ED</td>
<td>98.9%</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

### Quality

<table>
<thead>
<tr>
<th>HSQI</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients screened for falling risk</td>
<td>99.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td>% of patients who had a healthcare error that was reported</td>
<td>99.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td>% of patients who were asked about their pain</td>
<td>99.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td>% of patients who had a healthcare error that was reported</td>
<td>99.0%</td>
<td>99.0%</td>
</tr>
</tbody>
</table>

### Productivity

<table>
<thead>
<tr>
<th>Productivity Area</th>
<th>Number of Procedures</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Day of Surgery cancellations</td>
<td>2.0%</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>- Surgical and Ambulatory Services</td>
<td>3.0%</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>- Elective Surgical Centre</td>
<td>0.2%</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>&lt; 30 days</td>
<td>45%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>&lt; 60 days</td>
<td>84%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>&lt; 90 days</td>
<td>1.07%</td>
<td>75%</td>
<td></td>
</tr>
</tbody>
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### Related Time

<table>
<thead>
<tr>
<th>Related Time</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of Stay - Acute</td>
<td>4.64</td>
<td>4.00</td>
</tr>
<tr>
<td>Average Length of Stay - Elective</td>
<td>6.34</td>
<td>5.14</td>
</tr>
<tr>
<td>- Surgical and Ambulatory Services</td>
<td>6.30</td>
<td>5.14</td>
</tr>
<tr>
<td>- Elective Surgical Centre</td>
<td>2.01</td>
<td>1.94</td>
</tr>
<tr>
<td>Discharges at weekends</td>
<td>5.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Discharged before 7am</td>
<td>19.0%</td>
<td>30.0%</td>
</tr>
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</table>

### Human Resources

<table>
<thead>
<tr>
<th>Human Resources</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick leave rate (days)</td>
<td>7.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Overtime Rate (hrs)</td>
<td>1.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Annual Leave Balance - 30 days</td>
<td>10.5</td>
<td>10.0</td>
</tr>
<tr>
<td>Turnaround time (days)</td>
<td>0.5</td>
<td>0.0</td>
</tr>
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### Financial

<table>
<thead>
<tr>
<th>Financial</th>
<th>Actual 500s</th>
<th>Target 500s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>123,123</td>
<td>103,789</td>
</tr>
<tr>
<td>Expenses</td>
<td>10,500</td>
<td>9,500</td>
</tr>
<tr>
<td>Ongoing Services</td>
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<td>103,789</td>
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<td>Inpatient Services</td>
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<tr>
<td>Non-Clinical Supply</td>
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<tr>
<td>Contribut</td>
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<td>103,789</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>123,123</td>
<td>103,789</td>
</tr>
</tbody>
</table>

How to read:

- **Indicators**: How well the service is performing in comparison to the target.
- **How to use the scorecard**: Use the scorecard to identify areas where improvements can be made and track progress over time.
**OTHER HIGHLIGHTS**

**Surgical Wards**

Wards 4, 7, and 9 now have their Housekeeper in post. The Housekeepers will be responsible for maintaining a safe and comfortable environment ensuring that all patients and visitors are welcomed and experience an efficient, effective and comfortable service. Ward 8 hopes to have their permanent Housekeeper in position in next few weeks; in the meantime they have developed a schedule which is having a positive impact.

**Protected mealtimes**

Plans are underway to roll out protected meal times to the remaining surgical wards. Ward 7 will support this process offering their valuable experience to help trouble shoot potential challenges. Each surgical ward has already implemented some changes in their approach to meal times such as Ward 9 giving patients a warm lavender towel prior to breakfast and Ward 8 HCAs going around ward to assist patients with meals.

**Design Innovation**

The Ward 8 user group is working on a Ward 8 Decant Option Programme.

**Ward Productivity**

There continues to be increased pressure on the surgical wards due to the increased churn of patients, increased complexity and the usual winter pressures.

**Waitemata DHB Orthopaedic Enhanced Recovery After Surgery Collaborative Project**

Waitemata DHB clinical leads and project working groups have been established for both the acute fractured neck of femur and elective hip/knee pathways as part of the National Orthopaedic Collaborative project. Change concepts have been identified and driver diagrams developed as per the framework and improvement methodology set out by the Ministry of Health. Members of the project group continue to participate in the National Collaborative Learning Sessions and National WebEx meetings provided by the Ministry of Health.

**Acute Fractured Neck of Femur Pathway**

The pilot for cohorting fractured neck of femur patients on Ward 7 is now complete and implemented as business as usual.

The Orthopaedic Trauma Anaesthesiologist phone has been implemented to support the preoperative management of the fractured neck of femur patient and expedite surgery when medically appropriate.

The Acute Fractured Neck of Femur Nursing Care Plans have been trialled in conjunction with the Cohorting pilot and will now undergo consultation and formalisation. Patient owned food diaries have been implemented in conjunction with the Fasting Times Project to assess the viability of implementing a specific diet code for this at risk patient group to ensure they receive access to optimum nutrition starting from admission. The Fractured Neck of Femur Anaesthetic Protocol remains in the final stages of formalisation. Data measurements on Time to First Postoperative Mobilisation are displayed on the Ward 7 Quality Boards, demonstrating consistent improvements from the beginning of the Cohorting Pilot.

Julie Palmer, Senior Advisor to the Service Improvement Team Electives visited with the ERAS (Early Recovery After Surgery) team on 31 July and was very impressed with the progress made in the implementation of the Acute Fractured Neck of Femur Pathway. Members of the Waitemata DHB Orthopaedic ERAS Team will be presenting the achievements to date at the third National ERAS Collaborative Learning Session in August.
### Elective Hip and Knee Arthroplasty Pathway

Members of the Waitemata DHB ERAS Project Team have collaborated with the National Collaborative Team to adapt the Waitemata Elective Hip/Knee Arthroplasty DVDs to reflect the ERAS principles.

The elective hip and knee arthroplasty nursing care plans are being redeveloped in collaboration with the multidisciplinary staff from both the Elective Surgical Centre and Ward 9/Orthopaedic department.

Preoperative processes and assessment tools are in development to improve access to the patient’s preferred mode of preoperative education and also to target those patients with the highest discharge risks to promote attendance of the Waitemata DHB multidisciplinary preoperative patient education sessions (including discharge planning) for elective hip and knee arthroplasty surgery.

The current Elective Hip/Knee Arthroplasty patient information booklets continue development to ensure they reflect the ERAS pathway and principles. Several of the Waitemata Orthopaedic Multidisciplinary Team for Electives will be attending the National ERAS Collaborative Learning Session on 29 August in preparation for the next phase of pathway development in Elective Hip/Knee Arthroplasty.

### ICU/HDU

As part of the ICU patient experience project, the unit is establishing weekly Multi Disciplinary Team (MDT) meetings for those patients who have been in ICU 5 days or more. The aim is to:

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**Waitemata DHB, Hospital Advisory Committee Meeting 24/09/2014**

---

<table>
<thead>
<tr>
<th>NOFs</th>
<th>Avg Hrs to Theatre</th>
<th>Within 24 hrs</th>
<th>Within 36 hrs</th>
<th>Within 48 hrs</th>
<th>&gt; 48 hrs</th>
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<td></td>
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<td>% Ptnts</td>
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<tr>
<td>Avg Hrs To Theatre</td>
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<td>86%</td>
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<td>Dec-13</td>
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<td>Jan-14</td>
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<td>76%</td>
<td>85%</td>
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<td>Jun-14</td>
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<tr>
<td>Jul-14</td>
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<td>60%</td>
<td>76%</td>
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**Elective Hip and Knee Arthroplasty Pathway**

**ICU/HDU**
Enable all team members involved in patient care to obtain an overview of patient’s progress and care goals
Coordinate MDT priorities, goals and interventions
Facilitate safe transition of care from ICU/HDU to ward care
Identify any new areas of concern
Enhance patient care.

Representatives from the related medical team are invited as are Duty Nurse Managers. There will be a review in two months to assess the value and outcomes for patients and staff.

**Surgical Pathology**
The service is showing a consistent accumulative 10% growth year on year.
A review is underway to ensure staff are safe in the “cutting area”. The risk is predominantly with Formaldehyde fumes. Interim solutions are keeping the air levels safe whilst a refurbishment plan is underway with facilities.

**Theatres North Shore Hospital and Waitakere Hospital**
July was another busy month for acute surgery across all specialties for NSH theatres with a continuing trend increase from 2013.

<table>
<thead>
<tr>
<th>Month</th>
<th>Acute</th>
<th>Elective</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>July 2014</td>
<td>655</td>
<td>562</td>
<td>1217</td>
</tr>
</tbody>
</table>

Additional scheduled acute theatre sessions commenced 30 June 2014. These sessions will decrease waiting time for theatre and are estimated to release approximately 4-6 beds per day. Acute arranged day surgery lists have commenced at Waitakere Surgical Unit and the theatre staff are enjoying the return of orthopaedics. In addition the acute arranged list has commenced at ESC for a specific group of patients with ankle fractures. This group of patients meet the model of care in that the lists are planned as these patients wait surgery until swelling reduces. The sessions utilise available Friday theatre time and will release inpatient beds on the surgical wards at NSH. The lists are run under the ESC remuneration model.

The reducing perioperative harm campaign continues across all theatre sites with displays in the theatres highlighting the Open for Better Care and First do No Harm campaign.

A clinical observational audit was undertaken of the surgical safety checklist. This identified that although the checklist is completed, team engagement in the checklist process is variable and is an area for improvement. We have now introduced designated lead roles for each phase of the checklist which has been shown to improve the communication within the team. An observational audit is scheduled for September to gauge effectiveness of this initiative.

**Patient Service Centre**
Updated Patient Service Centre Business Process Rules will inform training workshops to be held with clerical staff through September. Fortnightly Patient Service Centre staff meetings continue with a recent focus on preparing for change imminent with redesign of the Patient Service Centre and Waitemata DHB shared values and behaviours. Patient Service Centre redesign is progressing through FF&E procurement and construction EOIs processes. The Specialty Team Leaders development training plan is in progress and updates to new staff orientation programmes and annual updates are continuing. Call management assessment has progressed with review of technology and resource required to support improved inbound call management completed. Automation of text messaging is being explored with the vendor. Development of a framework for clerical workload analysis is in progress and is intended to align with Specialty capacity planning to assess FTE allocation/model within each Specialty. Key Patient Service Centre staff along with Operations Managers are involved with planning for EDS and eReferrals implementation. Achievement of ESPI 4 month compliance is a key focus for the next 3 months.
Faster Cancer Tracking
Waitemata DHB has established a Faster Cancer Treatment Health Target Implementation Group to oversee the work required to reach the recently established MoH 62 day target being introduced on 01 October 2014. The target is 85% of patients with a high suspicion of cancer will have first treatment within 62 days of referral being received into the DHB. The Minister of Health also announced on 28 August that 90% of patients must receive their first treatment within 62 days by June 2017. The Ministry will be providing DHBs with further information on this in October 2014.

Improving Journey Project
Feedback has been received from the National Health Board on the ‘Improving the Journey to Elective Surgery’ Draft Final Evaluation Report. Minor amendments were required only and we are progressing through final sign off to enable the Final Evaluation Report to be submitted.

BreastScreen Waitemata Northland (1 July to 31 August 2014)
- Quality: Four complaints received and resolved. 444 compliments received.
- BreastScreen Aotearoa (BSA) coverage: Maori coverage at Waitemata DHB remains our top priority. The BSA programme does not have a national register and is an "opt on" versus opt off programme. We work with primary care and NGOs to locate, recruit (enrol) and recall Maori women to participate in the BSA programme.
- BSA coverage (region and DHB level) results to 31 July 2014 are set out below.

<table>
<thead>
<tr>
<th></th>
<th>Apr 14</th>
<th>May 14</th>
<th>Jun 14</th>
<th>Jul 14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maori Coverage</strong></td>
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<tr>
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<td>69.8%</td>
<td>69.8%</td>
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<tr>
<td>Waitemata DHB</td>
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<td>63.6%</td>
<td>63.6%</td>
<td>63.8%</td>
</tr>
<tr>
<td>Northland DHB</td>
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<td>74.1%</td>
<td>73.9%</td>
<td>73%</td>
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<tr>
<td><strong>Pacific Coverage</strong></td>
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<tr>
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<td>79.9%</td>
<td>79.5%</td>
<td>79.4%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>79.4%</td>
<td>78.8%</td>
<td>78.4%</td>
<td>78.2%</td>
</tr>
<tr>
<td>Northland DHB</td>
<td>66.1%</td>
<td>65.5%</td>
<td>65.4%</td>
<td>64.6%</td>
</tr>
<tr>
<td><strong>Other Coverage</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waitemata Northland</td>
<td>68.7%</td>
<td>68.5%</td>
<td>68.6%</td>
<td>68.7%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>66.8%</td>
<td>66.8%</td>
<td>67.1%</td>
<td>67.4%</td>
</tr>
<tr>
<td>Northland DHB</td>
<td>75%</td>
<td>74.5%</td>
<td>74.2%</td>
<td>73.4%</td>
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<tr>
<td><strong>Total Coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waitemata Northland</td>
<td>69.4%</td>
<td>69.1%</td>
<td>69.2%</td>
<td>69.2%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>67.3%</td>
<td>67.3%</td>
<td>67.5%</td>
<td>67.7%</td>
</tr>
<tr>
<td>Northland DHB</td>
<td>74.9%</td>
<td>74.4%</td>
<td>74.1%</td>
<td>73.3%</td>
</tr>
</tbody>
</table>

BSA coverage (50–69 years) by Lead Provider, DHB, by Ethnicity for the 24 months to 30 April to 31 July 2014.

- Volumes are down (326 screens behind YTD target) this quarter. This is due to recurring equipment failure and connectivity issues on the mobile screening units which have/are impacting on capacity. healthAlliance is on the case but the timeframes for resolution are still uncertain.
- Contract: The Ministry has renewed our contract (1 July 2014 to 30 June 2016), increased screening volumes (37,776 to 40,698 screens per annum to achieve 70%) and provided a 1% increase in funding.
### STRATEGIC INITIATIVES

<table>
<thead>
<tr>
<th>Specific deliverables/actions to deliver improved performance will consider:</th>
<th>On Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement service review changes by 31 July 2014 to ensure full compliance with elective waiting time indicators by 1 December 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Prioritise all patients for treatment using nationally recognised tools and treatment in accordance with assigned priority and waiting time - on-going</td>
<td>✓</td>
</tr>
<tr>
<td>Complete the Shorter Journey productivity project and roll out where appropriate by 30 November 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Complete the orthopaedic ERAS project by 30 June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Pilot direct primary care access to spinal MRIs by December 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Work with private and other DHB radiology partners to implement collaborative sonographer training, increasing trainees from 3 to 5 by December 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Complete the DNA project to improve DNA rates, particularly for Māori and Pacific by 30 June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Implement National Patient Flow system to collect and report patient-by-patient outpatient waiting times, outcomes of FSAs and diagnostic test and treatment metrics by 30 June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Develop and test a methodology for measuring access to elective surgery by ethnicity, accounting for need for intervention and other demographic factors by 30 June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Adopt regionally consistent CPAC tools across elective surgical services and review of regional DHB thresholds for access to services by 30 June 2015.</td>
<td>✓</td>
</tr>
<tr>
<td>Implement the Quality Endoscopy Improvement programme to address productivity and capacity issues over two sites and introduce a daily report which identifies actual capacity used by the provider. Commence this reporting 1 July 2014 and respond to issues as they arise over 2014/15</td>
<td>✓</td>
</tr>
<tr>
<td>Establish a five year colonoscopy capacity plan that includes a regional view by 31 December 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Implement a nurse endoscopist training programme regionally by late 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Use CT colonography as a diagnostic tool instead of colonoscopy in 25% of colonoscopy referrals, where clinically appropriate, which will increase colonoscopy capacity - measured monthly</td>
<td>✓</td>
</tr>
<tr>
<td>Develop and test a methodology for measuring access to elective surgery by ethnicity, accounting for need for intervention and other demographic factors by 30 June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Review cancer patient pathway within booking and scheduling (referral to FSA) Develop a plan to address bottlenecks by June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Develop MDM meetings to be highly functional locally and regionally. Use tumour stream templates live in cancer MDM meetings from July 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Implement prioritised service improvement locally and regionally arising out of the 2013/14 regional review of tumour standards by 30 June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Review compliance with three additional tumour standards including the breast tumour standards in 2014/15, identify service improvement activity by 30 June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Review the quality of ethnicity data within the breast screening programme by June 2015</td>
<td>✓</td>
</tr>
<tr>
<td>MRI replacement</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Key achievements for month:**
- Elective Surgical Health Target met
- ESPI on track

**Areas off track for month and remedial plans:**

Initial work underway with follow-ups but not as advanced as S&AS would have planned. This will progress with Outpatient Whiteboard in place.
KEY ISSUES/INITIATIVES IDENTIFIED IN COMING MONTHS

- Management of finances to break even FY15 with particular attention to clinical costs
- ESPI compliance to 4 month treatment time by December 2014
- Work ongoing to meet FY16 cancer treatment target
- On-going work in Patient Service Centre – both customer focus and business rules
- Continued engagement with primary care to increase quality of referrals including increase uptake of e-referrals.
- Review of workflow, business rules and culture in Outpatients – business case to be prepared in collaboration with Project Team/Community Outpatients building.
- Focussed work in outpatients on utilisation, scheduling and clinical indicators to reduce follow up appointments
- Review of elective surgical services and growth for FY16
- Decrease waiting time to theatre for acute patients to reduce LOS and release inpatient beds for increased number of patients
- On-going work in inpatient areas to increase patients’ satisfaction and optimise quality of care
- Review of S&AS ACC opportunities
- Refurbishment of remaining 4 NSH theatres to commence in 2015
- Refurbishment of Ward 8 to be completed over Christmas – early 2015
- Refurbishment of NSH tower to commence with Ward 3 in November 2015
- Planning for Ambulatory Centre underway – Breast Services, Breast Screening and Haematology. Focus on ambulatory services, procedural room, some diagnostics and a day unit for oncology patients
Financial Results

Surgical & Ambulatory Services

**COMMENT ON MAJOR FINANCIAL VARIANCES**
(ESC = Elective Surgery Centre; S&AS = Surgical and Ambulatory Services)

Revenue ($479k favourable Month)
Most of the favourable revenue variance is related to Corporate funding of cost variances.

In real revenue gains there was $125k revenue recognised for additional patient volumes. In relation to planned volumes overall additional activity was 111% of cases volumes (on standard phased plan) and 120% when excluding skin cases. General Surgery put through large volumes.

Additionally there was $90k additional revenue recognised on a cancer related SLA, which will not recur. ACC revenue was $23k unfavourable.

Corporate revenue accounted for $290k - in relation to theatre acute costs ($70k); unaccrued anaesthesia acute on call payments in relation to prior years ($110k) and prior year unaccrued service contract costs for anaesthesia machines ($110k). Both of these items have only come to light post year end close.
Expenditure

Medical personnel: ($413k unfavourable Month)

Of the $413k unfavourable variance $383k relates to SMO costs through radiology and anaesthesia. The balance of costs relates to a number of offsetting items, with RMO costs $20k unfavourable in aggregate. Anaesthesia costs consist of three main drivers – unaccrued acute on call payments in relation to prior years that were paid in the month ($110k); $114k of costs associated with ESC resourcing beyond the anaesthesia department July budget ($44k relates to budget shortfall; $47k relates to the greater level of activity in July than planned and $24k relates to the greater complexity than planned as more orthopaedic cases went through relative to other specialties); and lastly the phasing of the July SMO budget was quite light relative to the level of activity as leave was assumed at significantly greater levels than occurred. Radiology were over budget 1.22fte and had high costs in a number of areas such as superannuation and conference fees. There is ongoing work around managing our radiologist resources and review of costs.

Nursing: ($64k unfavourable Month)

This is primarily driven by our lack of theatre budget ($49k), which has been supported by revenue from Corporate which is reported as revenue; assumed savings initiatives of $83k have been partially met (about $40k) as our net result is less than the aggregate figure.

Allied Health staff: ($80k unfavourable Month)

Allied health results are driven primarily by technician costs in radiology ($40k U) and savings initiatives ($49k U). Radiology costs are primarily as a result of costs per FTE being much higher than budgeted with pressure on patient access and additional clinic sessions running. Further analysis will occur once August results are reviewed.

Admin staff: ($6k unfavourable Month)

Some revenue offset that specifically covers this variance.

Outsourced services: ($21k favourable Month)

Overall expenditure is $21k favourable. This reflects several key items – unmet savings initiatives of $100k although progressing on several areas around generating revenue; $124k favourable in anaesthesia for recharges to ESC; $36k unfavourable in bureau nursing costs and favourable in a number of other areas across the service ($33k F).

Clinical supplies: ($214k unfavourable Month)

Acute volumes were at 95% of budget wies activity and elective volumes at 105%, although case volumes were 20% higher than the standard phased plan in July. Overall discharges were therefore at about budget level. However orthopaedic acute theatre activity reported is much higher at 127% of last year’s volumes, and orthopaedic implant costs are significantly higher (160%) than last year and budget (variance $69k unfavourable to budget and prior year). Additionally the budget includes $191k of budget savings that have not seen any significant savings delivered against. In general clinical supply costs outside of theatre are in line or ahead of budget.

Infrastructure: ($31k unfavourable Month)

Infrastructure costs were slightly over budget due to approximately $12k unfavourable for unbudgeted additional orderlies in theatre; use of VAC equipment/pressure mattresses in wards ($9k U) and some overspends in cleaning and laundry ($18k overall).

Summary

The July monthly result of $313k unfavourable is primarily driven by overspends in radiology staff costs, principally SMOs and technicians, to the level of $110k. Additionally there are savings initiatives that have not been met totalling $290k. Offsetting this is additional SLA revenue of $90k for a cancer initiative. Other variances
tend to be offsetting and this is all in the context of an activity level of 120% of plan for non-skin elective surgical activity.

**S&AS and ESC Combined**

The combined summary offsets some of the variances occurring across S&AS and ESC. Overall elective inpatient activity is at 120% of July standard phased activity (excluding skin cases) based on discharges.

Overall July revenue is $628k ahead of budget (104.5%). As discussed approximately $211k is due to additional volumes and additionally ACC Revenue is about $26k ahead of aggregate budget. An additional $90k relates to an SLA recognised in S&AS. The balance of revenue is funding a variety of additional expenditures in the services.

Total July personnel expenditure is $554k unfavourable with most of that cost sitting in S&AS radiology and anaesthesia costs and with some unmet savings overall.

Outsourced services are $129k unfavourable, which is primarily due to unmet savings ($100k unfavourable) and nursing bureau costs ($40k unfavourable) in S&AS.
July clinical supply costs are $315k unfavourable (110%), compared to volumes at 120% of standard planned elective activity for July (on a discharge basis).

Infrastructure costs are $52k unfavourable, with a variety of relatively smaller variances driving this figure. The net result is $422k unfavourable for July.
Hospital Operations

The Group Manager of Hospital Operations is Leith Hart.

Laboratory
Advertising is underway for the recruitment of an additional 1.0 FTE microbiologist; interviews will take place early September.
The Clinical Lead of the infection control committee has requested Vancomycin-resistant enterococcus (VRE) testing to be added to Extended Spectrum Beta Lactamase (ESBL) testing from mid-July. This will add an additional 1000 tests to the current workload requiring a business case for capital and additional staffing resource to manage the increase in volumes. The business case will be presented to ELT in September.
Laboratory electronic ordering has reached the stage of having a business case for each DHB to review and sign off.
Real Time Temperature Monitoring System (RTTMS) project has now been given a project manager to progress. A trial of three appropriate systems will take place mid-September to mid-October.

Security
Security has been operating at a high level. Code Orange/Calls for assistance responses have been high with a noticeable increase at Waitakere Hospital.
The Security Manager facilitated refresher training for instructors in Invercargill for Southland and Dunedin security teams.

Pharmacy
ePrescribing kicked off at Wainamu ward at Waitakere on Tuesday 26 August; this has been going well and plans are in place to continue this rollout through the other medical wards and ADCU at Waitakere over the coming 2 – 3 months.

Clinical Engineering
The Inspection Preventive Maintenance (IPM) programme is tracking along at 98% for Risk 1 and an overall hit rate of 70%.

A number of fleet Capex replacement programmes are underway including Beds, Infusion Pumps, Tympanic thermometers and local UPS supply for anaesthetic equipment, along with specific initiatives such as the Decontamination Equipment project.

Traffic and Fleet
The extension to the shuttle bus service allowing visitor access started its journey on 28 July. To date we have averaged 10 visitors per week using this expanded service. Feedback so far has been good with minor issues only. We have noted that not all visits are return journeys and some visitors do not know when they will need transport back.

A business case for the phased replacement of fleet vehicles went to Capital Asset Management Planning (CAMP) committee on 7 August; and to the Audit and Finance Committee in September.

We have entered into an agreement with Turners Auctions that will offer Waitemata DHB some protection against the new laws under the Consumer Guarantees’ Act. Turners will provide a detailed inspection report on each vehicle and submit this to potential buyers, thereby providing information on all known faults with the vehicle. We receive a copy of this report before each vehicle goes to auction. Counties Manukau DHB are using the same service for their disposals.
A review of mechanical suppliers is underway with the assistance of healthAlliance, to establish best rates and service for the DHB. Northern Region DHB fleet initiatives have stalled for the time being.

**Clinical Support Services**
A team leadership workshop was held at Wilson Centre where we were able to have all team leaders present to begin our journey to Brilliance with our leadership team.

We undertook our first permanent recruitment for orderlies and cleaners at Waitakere Hospital in early July.

The environmental cleaning project is making slow progress. Procedure documents are currently being written for routine, discharge and isolation cleaning with a view to presenting these at Infection Control Committee (ICC) in September for sign off. Training plan for all cleaners is being developed.

Study on the NZQA Level 3 Orderly qualification has commenced with first assignments currently being marked by the Training and Quality Manager, we are still on track to have this completed by the end of January 2015.

**Contracted Services:**
- Fuji Xerox upgrade project team has been established. There is slow progress being made due to lack of project resource which is currently being worked on.
- Linen service has seen the HBL Linen contract presented to the Board this month; new linen products are going to require some evaluation in September. These include procedure gown, fitted sheets and scrubs. Linen and Laundry Committee has been established for this.
- Room Decontamination Machinery RFP has closed and two suppliers have been selected. These will both be trialled for a month on each. Auckland DHB and Waitemata DHB are working collaboratively on the practical evaluation which we hope to have underway mid September.

**Quality**
- **Complaints**
A total of one complaint was received in July. Two complaints were closed in July and there are no overdue complaints.
- **Requests/Enquires**
Two requests/inquiries/ suggestions were received in July 2014. Two requests/inquiries/ suggestions was closed in July with an average time to respond being two days.
- **Compliments**
Two compliments received in July for Hospital Operations.

**STRATEGIC INITIATIVES**

<table>
<thead>
<tr>
<th>Specific deliverables/actions to deliver improved performance will consider:</th>
<th>On Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory testing review and cost savings</td>
<td>✓</td>
</tr>
<tr>
<td>Pharmaceutical cost savings</td>
<td>✓</td>
</tr>
</tbody>
</table>
Financial Result

COMMENT ON MAJOR FINANCIAL VARIANCES

Comment on Major Financial Variances
The overall result for Hospital Operations is $212k favourable for the month.

Revenue ($49k unfavourable Month)
Car Park revenue is $44k unfavourable for the month as the budget for 2014-15 had been set at the expected levels that would have been achieved prior to the extension of free period to 30 minutes. Recharge to Inpatient services for Outpatient pharmacy dispensing is $21k unfavourable for the year. This is due to changes in the Community Pharmaceutical Schedule that has meant a reduction in the value recharged to Inpatient services.

Expenditure ($260k favourable Month)
**Personnel costs ($359k favourable Month)**
Medical staff costs are $34k favourable for the month as a result of vacancies in Laboratory Services. Support staff costs are $241k favourable. This is primarily due to the contracted FTE vacancy in Clinical Support - Cleaning and Orderly Services that are covered by agency casual staff. Allied Health staff costs are $72k favourable for the month which represents a 6.20 FTE vacancy and higher than planned levels of annual leave taken.

**Other Direct costs ($98k unfavourable Month)**
Outsourced personnel costs for casual cleaning and orderly staff are $210k unfavourable for the month offsetting vacancy savings in support personnel. Activity related variances in Clinical Supplies for Pharmaceuticals are $22k unfavourable for the month; Laboratories $15k unfavourable for the month while blood products are $15k favourable for the month. Clinical Engineering Service equipment repairs (parts) are $29k unfavourable for the month. Recharges to other operating groups for additional cleaning and orderly services are $85k favourable for the month. Patient Meals and Nutritional Food costs are also $19k favourable for the month, representing additional charges to other services for increased demand.

**Summary and Forecast Full Year:**
The overall financial position for Hospital Operations is $212k favourable for the month. This is primarily due to Personnel costs which are $149k favourable (net of outsourced cost of casuals) due to contract FTE vacancies and the level of leave taken in the month.
Provider Arm Support Services

Corporate Services: Include offices of the Chief Executive Officer/Chief Financial Officer/Chief Medical Officer/Director of Nursing/Director of Allied Health, Corporate Finance, Operational Finance, Information Systems and Management, Facilities and Development, Quality, HR & Awhina and Maori Services. It also includes outsourced healthAlliance services, HBL, Other affiliation costs and financing costs. Robert Paine has overall financial responsibility for the Corporate Group.

The management of Hospital Operations sits within Surgical and Ambulatory Services, however, the financial and scorecard data is shown as part of Provider Arm Support Services (financial data is also included in a separate table in the Hospital Operations section).

Scorecard
**STRATEGIC INITIATIVES**

<table>
<thead>
<tr>
<th>Specific deliverables/actions to deliver improved performance will consider:</th>
<th>On Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inventory management for clinical and non-clinical supplies</td>
<td>✓</td>
</tr>
<tr>
<td>Infrastructure costs/contracts and energy efficiency reviews and savings</td>
<td>✓</td>
</tr>
<tr>
<td>Commencement of new mental health facility He Puna Waiora, to replace Taharoto Unit</td>
<td>✓</td>
</tr>
<tr>
<td>Mason Clinic remedial work</td>
<td>✓</td>
</tr>
<tr>
<td>Extension of the Waitakere Hospital Emergency Department</td>
<td>✓</td>
</tr>
</tbody>
</table>

* include a ✓ or a ✗

**Key achievements for month**

- The infrastructure review for Waitakere Hospital is completed. There are a number of recommendations that are being considered. In the next two/three months, requests to complete replacements and upgrades of building services will be submitted for approval. The NSH report is pending.
- During July, there have been a number of rain storms and some leaks have appeared at Mason Clinic. The repairs are scoped and approval provided to affect the work.
- WTH ED extension developed design has been signed off by the User Group. Ground Stabilisation testing is underway with the report due 4th September. A peer review will then be undertaken.
  - The WTH ED Steering Group are aware of the business case budget constraints. The clinical teams are considering opening the facility post-Christmas 2015 due to clinical concerns during December 2015 and January 2016.

**Health Information Group**

Two new initiatives to reduce administrative workload and increase visibility of Information are underway that relate to tentative appointments that are scheduled in the patient management system (iPM). These are typically appointments that are awaiting test results or where clinic availability is limited.

- For Booking and Scheduling staff, they currently start with a hard copy report and have to re-key the NHI number into Concerto to check for results. This report has been migrated into Concerto and runs off the live iPM system. Information can be selected by single or multiple clinics and the lists can be sorted by different columns and/or exported into excel. This opens up the option of doctors reviewing these lists for appropriateness and communicating changes back to booking and scheduling. The on-line list also allows quicker navigation to the underlying support systems to check the status of requests and results. The new search is being reviewed by a pilot group of schedulers, registrars and specialist clinic nurses. It will then be rolled out to all users over the coming weeks.
- The second initiative involves including existing appointment details in the Electronic Discharge Summary. This was requested by the Cardiology department during a review of their discharge summary at their journal club meeting. The aim is to inform the doctor (to assist them in completing the follow up plan), the GP and the patient. The wording for tentative appointments has been agreed with booking and scheduling to ensure that there is no confusion. These changes have been implemented for General Medicine, Cardiology and Paediatrics. Including this section for other templates is being worked through with template owners.

Phase Two of the Electronic Ward Whiteboard implementation started this month, which will see customised versions of the board for Paediatrics, Maternity and Mental Health. The roll-out is planned for the end of the year.
A report was developed this month which brings ‘Faster Times to Cancer Treatment’ indicator information together with waitlist, outpatient and theatre information about high priority patients, for better monitoring of trends and delay reasons.

The trial of Smartpage, a solution that currently supports messaging to house doctors after hours, across both Hospital sites, continues to be well received and bring advantages to clinical staff and, ultimately, patients. Planning is underway to trial Smartpage 24x7 in the Obstetrics Emergency service at Waitakere before the end of the year.

Electronic follow up requests will improve the flow and tracking of follow ups instigated from an electronic discharge summary. Early adopters General Medicine and Paediatrics have just introduced this new functionality for their booking clerks and the features are being fine-tuned before rolling out to other services.

**Facilities & Development**

**Major Capital Projects**

**NSH Lift upgrade:** the project remains on programme to be completed in October 2014.

NSH Ward 8: due to the building services disruption throughout the main tower, ward 8 will be remodelled with the new design. Approval has been granted to seek to refurbish Ward 8. Taking the design completed in 2013, the design team has been re-established. Request for Information (ROI) will be published on GETS in September with contractors commencing working in December. Timeframes and staging works are being considered by the Steering Group based on bed availability to decant this ward. SMT have agreed remodelling will start on level 3 and graduate up through the main tower over a number of years. The design brief will take into account learnings from Ward 8.

Decant Ward: Several programmes have been tabled to design and construct a three level clinical facility to support general medicine and accommodate general decanting requirements for clinical wards. The Executive have requested this project be delivered by winter 2016. Reviews of the programme continue. Design briefs and models of care are critical to the success of this project from the clinical teams and remain in delay.

**Other**

**Facilities Maintenance**

Job cards are benchmarked at 90%. For the period ending 31 July, the completed work requests are 89% for NSH and 80% for WTH.

Legionella testing continues with test results remaining at negative.

Minor projects (capex and opex) amounting to $2.2M as requested by the Clinical Services continue to progress. This is additional work to the preventative and reactive maintenance streams programme for this team.

Emergency lighting is required to be replaced across NSH and WTH. This work has been approved and is proceeding.

Community Health Building roof replacement commenced in May, and continues. There has been a delay due to severe weather conditions across the region in June and July. Completion is now expected in early September.

**Building Compliance**

AirRestore Ltd have completed 40% certification and testing of fire dampers in the Main Tower Block at NSH. A further 20% is underway in the main hospital building at WTH.

Approval has been granted for 600 emergency lights and spitfires. These have arrived at NSH and WTH Facilities Maintenance Workshops with replacement and upgrade underway.
Mason Clinic Kauri and Totara: Due to the annual inspection of the fire separation wall to the roof space it has been determined that unknown contractors have cut holes in the fire separation making the cells non-compliant. These remedials are confirmed as completed and are due for inspection and sign-off by Active Fire Consultants Ltd.

Diesel tank No 1 is single skinned and at the end of its life cycle and requires replacement prior to July 2015. A business case will be developed for submission to CAMP in December 2014.

**Lease Management**

12 Clark St New Lynn - The landlord issued notice in February of a proposed rental increase of 8% per annum. Waitemata DHB has formally rejected this increase. The landlord has invited Waitemata DHB to arrange for a rental valuation which will be completed the week commencing 8 September 2014. The landlord produced an operating expense file of information and this is with the Service for review.

CADS Mt Eden Lease Renewal - The Deed of Renewal and Rent Review has been received and will be processed for execution by Waitemata DHB. The MHS team will relocate to Pitman House at the conclusion of this lease term and work has commenced to assist with additional space for this team.

CADS North Como Street, Takapuna – the final expiry date of this lease is 30 April 2015. The landlord has confirmed no new lease will be entered into as they are requiring the premises for their own purposes. MHS are reviewing the location that would best suit their requirements. Options being considered are 44 Taharoto or on NSH campus.

We are aware the facility (2 Lake Pupuke Drive, Breast Screening) has started to leak again, post repairs completed in the last two years. The landlord has undertaken significant repairs and additional advice from the specialist consultant firm Cove Kinloch. There have been no further leaks since March 2014. This lease has been renewed for a final term of three years commencing 1 August 2014. The landlord was not agreeable to varying the lease beyond the current final expiry date. The landlord will provide a draft deed of renewal in due course. To mitigate Waitemata DHB’s position as tenant, an amendment to Deed of Renewal will be made to facilitate action should leaks reoccur in the final term of the lease.

**Sustainability**

Mason Clinic now has waste diversion systems in place. These are anticipated to deliver financial savings of approximately $5,000 per year (year on year) in reduced waste to landfill.

Work on moving our medical waste services to a new provider is progressing well with affected staff agreeing to the new system. This will reduce medical waste costs by an estimated 20 per cent, an estimated saving per year of around $45,000, as well as allowing us to recycle scissors and tweezers and toughened medicine glass bottles, all of which currently goes to landfill or medical waste.

New signage has been developed to educate staff and patients on what items can and cannot enter our wastewater system, through sinks and toilets. We are seeking to alleviate some of the issues we have experienced with clinical items blocking filters and pharmaceuticals and chemicals being poured down sinks in sluice rooms.

An Auckland Transport/Waitemata DHB collaborative Staff Travel Expo was a great success and follow up articles and promotions have resulted in 147 staff registering for a public transport trial and an additional 47 staff registering for the Waitemata DHB Carpooling scheme. This is a great result and assists in reducing staff parking shortages by a significant degree.
Both WTH and NSH have been awarded Gold EnviroMark certification, independently verifying our best practice in sustainability practices.

The Environmental Protection Management Group (EPMG) has recently been set up to help govern and manage environmental impact areas for Waitemata DHB. This group covers any environmental or human health risks associated with our operation, from air quality to hazardous substances.

The EPMG has been initially focussed on HSNO (hazardous substances) and its management and control, relating specifically to those that do not require management unless the quantities held reach imposed trigger levels (classes 6, 8 and 9).

A Sustainability Aspects and Impacts Risk Register has been developed, which identifies all sustainability related risks Waitemata DHB has and has been adopted by the EPMG.

Human Resources

A Senior Operational Engineer has taken retirement from May 2013. A review of the job description has been completed and job sizing has been completed by HR. The remaining two Engineers are reporting to the DFM whilst the senior role is vacant. The role has been advertised and appointments are pending.

The Waitemata and Auckland DHBs’ Collaboration has commenced. Effective date for feedback based on the Proposal for Change has now ended.

Approval has been granted to appoint two project managers. These roles are being advertised.
COMMENT ON MAJOR FINANCIAL VARIANCES

The overall result for Provider Support is $640k Favourable for month.

Revenue ($201k Unfavourable Month)
Interest received is favourable by $151k due to higher cash balance in the overnight HBL sweep than planned, and income from non-resident patients is favourable by $117k and $8k other unfavourable variances. Car Park revenue is $44k unfavourable for the month as the budget for 2014-15 had been set at the expected levels that would have been achieved prior to the extension of free period to 30 minutes. Budget savings not embedded in the services has an unfavourable variance in Provider Support revenue of $417k for the month. These savings will be realised in the other Operating Groups.
Expenditure ($840k Favourable month)

Personnel Costs ($411k Favourable month)
The favourable variance in personnel costs are due to support staff costs being $210k favourable due to the contracted FTE vacancy in Clinical Support - Cleaning and Orderly Services that are covered by agency casual staff and reflects release of corporate provisions for costs being accrued in other services.

Other Direct costs ($429k Favourable month)
Budget Provision held in Provider Management for non-pay inflation risk is $549k favourable year to date. Outsourced personnel costs for casual cleaning and orderly staff are $210k unfavourable year to date. Recharges to other operating groups for additional cleaning and orderly services are $85k favourable year to date. Interest costs are also $75k favourable year to date due to delay in loan draw down associated with capital expenditure.
6.1 Clinical Leaders Report

Recommendation

That the report be received.

Prepared by: Dr Andrew Brant (Chief Medical Officer), Phil Barnes (Director of Allied Health) and Dr Jocelyn Peach (Director of Nursing and Midwifery)

Medical staff
Prepared by Dr Andrew Brant, Chief Medical Officer

A verbal update will be provided at the meeting as Dr Brant was away during the period that this report was collated.

Allied Health, Technical and Scientific staff
Prepared by Phil Barnes, Director of Allied Health

Allied Health Therapies
Items discussed and identified for action by the allied health clinical governance and management team include:

- Scheduling a half day off site session for 16 September involving senior allied health management, Professional and Clinical Leaders and Team Leaders. The session will focus on clarifying roles and responsibilities within the leadership team, creating synergistic working relationships and building morale.

- Presentation of a case to ELT for a short term project support role for allied health, to drive a number of essential cost-efficiency and quality improvement projects currently stalled through time pressures. Note: the case was approved by ELT in late August. It is intended that an “Allied Health Work-stream Coordinator” will be appointed on a fixed term contract.

- Additional allied health staffing at weekends. There is increasing evidence that additional physiotherapist and occupational therapist cover at weekends is enabling earlier discharge for some patients. However, the overtime burden has been challenging for the allied health teams and longer term 24/7 strategies will need to address this.

CEO Professional Development Fund
The allied health panel established to review applications for funding from the CEO fund received six applications at its inaugural meeting on 20 August of which five were supported and one declined. The next panel meeting scheduled for 15 September will review 14 individual applications and a group submission for an additional 14 staff members.
Laboratory Service
Interviews for a Consultant Clinical Microbiologist took place in the first two weeks of September. Five strong candidates were short listed and a preferred candidate selected from this group. The new appointee is likely to commence with Waitemata DHB in early 2015.

Nursing and Midwifery
Prepared by Jocelyn Peach, Director of Nursing and Midwifery

<table>
<thead>
<tr>
<th>Patient Experience</th>
<th>Care &amp; Safety</th>
<th>Staff Experience</th>
<th>Best Outcomes</th>
</tr>
</thead>
</table>

i. **Patient experience**
   - A range of interdisciplinary work streams continue focused on improving patient experience. The Nutrition and Hydration programme is making improvements and the Protected Meal times is being implemented through nutrition champions on each ward.
   - The End of Life programme can demonstrate improvement in staff awareness, engagement and application of best practice guidelines.
   - The Fundamentals of Care programme is focusing on Communication in order to improve patient and family experience and team effectiveness and safe outcomes.

ii. **Care and safety**
   - Despite the high workload, staff have worked hard to ensure that care and safety is maintained to the highest standard possible. Audits and trend results show continued focus on improvement, care and compassion.
   - There is good engagement by nurse leaders at ward and service level, with good ideas contributed by frontline staff.
   - Jenny Parr has led a major project to review the nursing documentation for the medical and surgical services and the new look will be launched in September. This complements a wider focus on improving documentation and interprofessional communication.

iii. **Support a positive staff experience**
   - **Build and strengthen professional leadership**
     The programme for Charge Nurse Managers “Leading Quality Care” and cohort 2 will commence in October. The first group have benefited from the focus and are applying learning. Information from the survey of the other professional senior roles is being collated and will inform development planning for the clinical leaders in the divisions.

   - **Right staff, with the right skills in the right place**
     Roll out of the new version of Trendcare [3.5] is being deferred until February 2015 as the changes do not support Allied Health processes. The new version 3.5.1 will hopefully correct issues. The delay will save double work and additional cost due to version retesting and training. This decision does not affect the effectiveness of the current system.
Work is underway with staff representatives to address issues arising from staff feedback. Staff are not as well informed as we would want, of the range of initiatives that have been put in place to ensure that systems support them in direct practice and recognise that they matter too.

c. Learning and Development: Workforce Development
43 new graduates have commenced the September 2014 intake in September. Each intake brings new energy and investment in the future workforce. This group has impressed us with their support of each other, laughter and appreciation of being employed and on our programme. The 71 February new graduates are nearing completion of their programme and have generally managed well despite a challenging winter clinical and learning workload.

Work is underway to finalise the workforce plans for Maori and Pacific workforce and enhance recruitment and career opportunities.

Emergency Systems Planning
A range of awareness initiatives are planned for the September 21 to 27 2014, Civil Defence ‘Get Ready’ Week.

- The focus in 2014 is on what individuals would do and we encourage staff to think about home readiness, organise displays.
- The new on-line Fire Training learning tool will also be available for mandatory training of all staff.
- The updated Emergency Planning webpage will be available.

Interim plans are established for clinical management and infrastructure for Evolving Infectious Diseases. Waitemata DHB is part of the decision making relating to regional planning.

Planning is in place for a November interagency exercise in called ‘Verti-evac’. This will test processes for evacuation of North Shore Hospital floors 7-10 and will involve the new evacuation stair chairs, Fire Service and Urban Search and Rescue.

After recent incidents reviews are underway relating to essential power, contingency plans for IT applications and review of the Mass Casualty plans.
6.2 Human Resources

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 District Health Board, and reports on progress with workforce plan actions.

1. People and organisational development indicators

A suite of people and organisational development indicators is currently being developed for reporting at organisational, service and divisional level. The indicators will be made up of key leading and some lagging indicators across areas such as recruitment, health and safety, organisational learning, leave, exits, turnover, etc. As indicators are tested and made available to services they will also be reported in the Hospital Advisory Committee reports.

2. Recruitment

2.1 Recruitment Dashboard as at 31 August

| Total number of hires 146 | Internal | 61  
|                          | External | 85  
| Average time to hire     |          | 67 days  
| Average number of positions vacant |          | 290.4 FTE  
| Current number of vacancies (FTE) |          | Medical – 32.73  
|                                  |          | Nursing – 159.12  
|                                  |          | Allied Health – 70.05  
|                                  |          | Support – 21.33  
|                                  |          | Mgt/admin – 22.06  
|                                  |          | Total 305.28 (vacancy rate of 5% of total FTE)  

Vacancies are less than 300 FTE at present which is an improvement from 12 months ago when the average FTE vacant was 394 FTE. We are currently finding it hard to recruit MRI Technologists, Opioid Nurses, Rotational Physiotherapists, Audiologists and Maori Mental Health Registered Nurses and Alcohol and Drug Clinicians. For these roles we are advertising in specific magazines and websites that target these individuals. We are about to start recruiting for the February 2015 Nursing Graduate intake.

2.2 Top sources for recruitment

Below is a table of the top five sources of information that new employees used to find out positions that were available at Waitemata DHB. Over the last three months, we have improved the search
engine optimisation of the Waitemata DHB Careers website to enable a better online candidate experience, and to more efficiently connect candidates with the jobs they want access to (i.e. better layout of the page and less clicks to where you want to go). We have spent some time improving the content of the careers site by adding in key words and video. We also have a campaign running in Google adwords to increase the search ability of the careers site. We stopped advertising clinical roles on Seek in August 2013 and continued to promote www.kiwihealthjobs.com and the statistics below show this increase.

<table>
<thead>
<tr>
<th>Rank / Source</th>
<th>YTD</th>
<th>Last year</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <a href="http://www.wdhb.careers.co.nz">www.wdhb.careers.co.nz</a></td>
<td>18%</td>
<td>1%</td>
<td>Improvements to our careers website are the likely reason for YTD increase</td>
</tr>
<tr>
<td>2. <a href="http://www.waitematadh.govt.nz">www.waitematadh.govt.nz</a></td>
<td>14%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>3. A friend</td>
<td>10%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>4. <a href="http://www.Kiwihealthjobs.com">www.Kiwihealthjobs.com</a></td>
<td>9%</td>
<td>0.1%</td>
<td>Good to see this increasing in the last 12 months</td>
</tr>
<tr>
<td>5. WDHB Intranet</td>
<td>7%</td>
<td>3%</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 – Top 5 sources of hire for August 2014

2.3 Ethnicity of new employees
Below is the breakdown of ethnicity of new staff who commenced with Waitemata DHB from June to August. There is a significant number of new staff who identify as Asian and 23 are from overseas.

Table 1 – Ethnicity of new starters by staff group
MELAA is a group amalgamation of Middle Eastern, Latin American and African ethnicities
3. Workforce

3.1 Best Care for Everyone – Values programme

3.1.1 Standards and Behaviours Roll out
Further work has occurred implementing the values based standards and behaviours leaflet in teams across the organisation. Distribution has been done by presentations to management teams or one on one with key managers or team leaders.

We also began our communications programme, rolling out one value based standard a month for the next 16 months. We focused the first month (six weeks from middle July to end August) on “Welcoming and Friendly” – all information regarding this can be found on: http://staffnet/bestcareforeveryone/everyoneMatters.asp#Our_focus_this_month_- _how_can_you_demonstrate_Welcoming_and_friendly_

3.1.2 Values Based Recruitment (VBR) programme
The values based recruitment (VBR) programme is a key component of the overall values programme. The intention is to develop and provide a suite of tools and learning opportunities which assist hiring managers and clinicians to recruit people who, as well as having the necessary knowledge and experience to fulfil the role, are also a good values fit for both the role and organisation. Research supports the notion that people feel more engaged and perform better and more consistently if their values match more closely than traditional interview and selection methods have been able to measure.

In July we ran training sessions for managers with adult nursing and clerical hiring responsibilities. There is more demand for these sessions and we will be booking some more of these in the coming months. The toolkit has also been finalised and over the next 2-3 weeks, these materials will be sent to those who have attended training and will now be available to give out during training.

We will also be setting up a planning sessions with service teams to decide the next stage of the roll out of this programme.

3.1.3 Values Based Appraisal
As part of the broader Our Values/Your Values programme of work we are scoping an approach for a values based appraisal process.

3.2 Pacific Health Science Academies
At the beginning of July, a panel made up of Waitemata DHB, Auckland DHB and Unitec representatives selected the two recipient schools for the Pacific Health Science Academy contract. Since then, we have been working with the schools to begin the implementation process for the Academies. Implementation has involved meeting the school leaders and we have also participated in parent engagement meetings at each college (Onehunga High School – 13/08/2014 - (approx. 60 parents and students attended); Waitakere College – 19/08/2014 – (approx. 150 parents and students attended).

Both Schools have appointed their Academy Directors and all is currently on track for the schools to start the Health Science Academy at the beginning of 2015. The aim of the Health Science Academies is to increase the Pacific clinical health workforce over time. The Academies assist this by increasing the uptake and achievement of Pacific students in Science and Mathematics so they are equipped to undertake tertiary study in a health related field.
3.3 Maori and Pacific Nursing Entry to Practise Programme

In 2014 we had a total of 102 nursing graduates join Waitemata DHB and 4% of these were Maori. There were 5 Pacifica nursing graduates. The DHB will plan how we can attract more Maori and Pacifica graduates via discussion with the Maori and Pacifica health gains teams, the Nursing Directorate and the DHB workforce teams.

<table>
<thead>
<tr>
<th></th>
<th>General</th>
<th>Maori</th>
<th>Pacific</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>59</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>September</td>
<td>43</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

4. Education and Learning

4.1 Centralised professional development fund for staff
The first round of applications to this fund commenced 1 August. The fund enhances professional development opportunities for staff and is for external courses, seminars, conferences and for tertiary study. Fifteen applications were received from Nursing and Allied Health staff and funds have been allocated based on criteria, which include supporting the realisation of Waitemata’s values and purpose. Of the $22,000 funding requested $19,000 was allocated.

4.2 Establishing a cross-DHB e-Learning system
A contract has been signed with Ko Awatea for a cross-regional e-Learning system to go live mid-October. The new platform allows us to expand our services to NGOs and tertiary students as well as provide a better service for Waitemata DHB staff. Learners at Waitemata DHB and Counties Manukau Health will have access to the e-Learning that has been developed in both DHBs.

4.3 New Conference, Learning and Research Centre
On 13 August the Board approved the concept for the planned new Conference, Learning and Research Centre on the North Shore Hospital site. It will be a staged development with completion of stage one expected to be November 2016.

4.4 WDHB Inter-professional Health Care Team Challenge
On 14 August three teams competed in the Inter-professional Health Care Team Challenge at Waitemata DHB. The competition, organised by the Medical Education and Training Unit, is a component of the Medical Education program for Junior Doctors but teams also included Nursing and Allied Health staff. It’s a live public event to present an inter-professional health plan based on a case study provided in advance. A judging panel of professional and lay person members looked for patient-centeredness, team work, collaborative leadership and conflict resolution in the team’s presentations, and marked the teams against set criteria. It was a very successful and enjoyable event and congratulations go to the winners: Sarah Firman, Dietitian (Coach); Sarah Frankish, Physiotherapist; June Chen, Pharmacist; Francis Florencio, Registered Nurse; Steven Shih, House Officer. The team now goes on to the National Competition at the National Inter-professional Health Conference to be held in September at AUT University. The winners also received complimentary places at the two day Conference. [http://www.nziphc.co.nz/](http://www.nziphc.co.nz/).
5. Knowledge and Research

5.1 Research projects underway
There are currently 356 research project underway. The distribution by type and number of research projects registered with Awhina fluctuates from month to month but overall the numbers of new projects registered are similar to this time last year.

Active Research Projects registered on Awhina Research and Knowledge database
149 (42%) Interventional Research
108 (30%) Audit/Evaluation Research
69 (19%) Observational Research
30 (8%) Non-clinical Research

5.2 Research and Clinical Audit Database
In collaboration with Waitemata DHB, the Health Information Group, Awhina Research and Knowledge continue to develop an in-house and end-user customisable clinical database platform for specified clinical research and audit activity.

The database will support clinicians to create their front end user friendly data collection instruments. This is an extraordinarily successful initiative and demand from staff is very high.

5.3 2014 Library users survey and report
The 2014 Library Survey & Report and recommendations were recently endorsed by the Executive Leadership team. The first step is to set-up a Library Advisory Committee, chaired by Director of Health Campus, to provide oversight for key decisions regarding the direction the library service should concentrate on to meet DHB needs now and in the future

Library usage for the current quarter is as follows:-

<table>
<thead>
<tr>
<th></th>
<th>Previous Quarter</th>
<th>Current Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lending to WDHB staff</td>
<td>343</td>
<td>481</td>
</tr>
<tr>
<td>Inter-library lending</td>
<td>46</td>
<td>63</td>
</tr>
<tr>
<td>Inter-library borrowing</td>
<td>85</td>
<td>83</td>
</tr>
<tr>
<td>Literature search (by librarians)</td>
<td>298</td>
<td>282</td>
</tr>
</tbody>
</table>
6. Health and Safety

6.1 New health and safety legislation
As a result of both the Pike River Tragedy and the Government Independent Taskforce reports an independent agency called Worksafe NZ (to replace Occupational Health and Safety) has been set up to carry out policy set by the Ministry of Business, Innovation and Employment. The emphasis for the new agency is on education, engagement and then enforcement.

The Health and Safety Reform Bill has been introduced to Parliament, representing a major change to New Zealand’s health and safety system. The Bill is part of ‘Working safer - a blueprint for health and safety at work’ and reforms New Zealand’s system following the recommendations from the Independent Task Force.

Working Safer is aimed at reducing New Zealand’s workplace injury and death toll by 25% by 2020.

The Health and Safety Reform Bill will create the new Health and Safety at Work Act, replacing the Health and Safety in Employment Act 1992. The Government’s intention is that the Bill will be passed in 2014, with the new Act coming into force from 1 April 2015.

A paper in the Board agenda discusses how Waitemata DHB is positioned for the implementation of the new legislation.

6.2 Accident Compensation Corporation (ACC) Partnership Programme
In October, we have our biannual review of our health and safety systems and are assessed against criteria set by ACC to see if our systems continue to meet our current tertiary level. Waitemata DHB has been at tertiary for eight years and as reward for that we are still audited for our claims management annually but only two yearly for our health and safety systems.

This year we have a new independent auditor from Verification NZ and the primary site chosen is Mason Clinic where the bulk of the audit will take place and the secondary site will be the Elective Surgical Centre. Waitemata DHB stands to gain financially for being at tertiary status of this programme and has saved over $10 million since entering the programme.

6.3 Influenza Campaign
Fifty three per cent of our staff have had the flu vaccination. This is down 2% from last year even though our Flu committee planned a process to have more vaccinators trained. Having more of them was a liability in that they were inexperienced and required constant guiding. It is better to have less who can do more. Other DHB’s have taken on the ‘in team’ concept of having vaccinators trained in clinical departments but this has not ever been an option for Waitemata DHB. The promotion by senior management is also an important part of the campaign. Although the campaign was extended this year there was only a small number of staff vaccinated at this time.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number immunised</th>
<th>Denominator</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>1222</td>
<td>2292</td>
<td>53%</td>
</tr>
<tr>
<td>Doctor</td>
<td>405</td>
<td>746</td>
<td>54%</td>
</tr>
<tr>
<td>Midwives</td>
<td>71</td>
<td>126</td>
<td>56%</td>
</tr>
<tr>
<td>Allied Health</td>
<td>665</td>
<td>1693</td>
<td>39%</td>
</tr>
<tr>
<td>Other</td>
<td>1022</td>
<td>1552</td>
<td>66%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>3385</strong></td>
<td><strong>6409</strong></td>
<td><strong>53%</strong></td>
</tr>
</tbody>
</table>

*Other = orderlies, cleaners, administration, volunteers*
7. Internal Communications

7.1 Projects underway
Internal communications is assisting with the communications across a number of projects over the past month and this will carry through to mid-2015.

This work includes newsletters to various departments advising staff of the changes coming up, posters helping to inform patients and visitors of the changes and depicting what the end result will be and what it will mean in terms of delivering the best care.

Projects include:

Women’s Health project - This refers to the Gynaecology Ward build on level two. After an initial period of limited communication while plans were finalised, we are now in a stage of intensive communication to assist in keeping staff informed and confident in the work taking place.

Ward 16 steering group - Once new location approved by the Board, we will look to arrange formal discussions with staff and unions re impact on individuals. This project is in the early stages of planning but we’re in the process of drafting an official communications strategy.

Waitakere ED expansion - At this stage, Communications is working on creating a board that features an artist’s impression of what the build will look like from the inside and outside. This will feature a timeline of the project, photos of the staff involved and pictures of planning as the project moves along. This is a way of engaging all staff.

Launch Pasifika – This is with regard to the inaugural Pacific week to be held at Waitemata DHB from October 6-9.

We are heavily involved in the promotion of this event by way of providing posters, invitations, updating the intranet site, pitching to external media and promoting it in Healthlines and Waitemata Weekly.

This event celebrates our Pacific staff as well as a few programme launches such as the Men’s Wellness and Women’s health projects. We have also started work on creating a short video of it all coming together to use to gain future sponsorship should the event happen in 2015.

Quality Boards - Communications is currently involved in redesigning the Quality Boards featured in each ward. Discussion around whether the information is relevant for both staff and patients has meant a shift in the information provided. Communications has already had discussions with community advocacy groups to work out what information is wanted. We’re now creating a mock-up of how this new and improved board may look. This will then go back to the committee and the health literacy committee.

7.2 Publications for the month

Healthlines
The September issue is due out in the next week and has a focus around Pasifika Week with profiles about various Pacific Island staff, more in depth features about the Pacific services we offer at Waitemata DHB. This edition also features an updated organisational chart featuring photos of Heads of Divisions and General Managers across the DHB.