HOSPITAL ADVISORY COMMITTEE (HAC) MEETING

Wednesday 17th December 2014

10.00am
Note:
• Public Excluded Session 10.00am to 11.00am
• Open meeting from 11.00am

AGENDA

VENUE
Waitemata District Health Board
Boardroom
Level 1, 15 Shea Tce
Takapuna
HOSPITAL ADVISORY COMMITTEE (HAC) MEETING
17th December 2014

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna
Time: 10.00am

Committee Members
James Le Fevre – Committee Chair
Lester Levy – WDHB Chair
Max Abbott – WDHB Board Member
Pat Booth – WDHB Board Member
Sandra Coney – Deputy Committee Chair
Warren Flaunty – WDHB Board Member
Tony Norman – WDHB Deputy Chair
Morris Pita – WDHB Board Member
Christine Rankin – WDHB Board Member
Allison Roe – WDHB Board Member
Gwen Tepania-Palmer – WDHB Board Member
Susanna Galea – Co-opted Member
Andrew Jones – Co-opted Member
Willem Landman – Co-opted Member
Donna Riddell – Co-opted Member

WDHB Management
Dale Bramley – Chief Executive Officer
Robert Paine – Chief Financial Officer and Head of Corporate Services
Andrew Brant – Chief Medical Officer
Jocelyn Peach – Director of Nursing and Midwifery
Cath Cronin – Director of Hospital Services
Debbie Holdsworth – Director Funding
Jenny Parr – Acting Director of Allied Health
Fiona McCarthy – Director Human Resources
Paul Garbett – Board Secretary

Apologies:

AGENDA

DISCLOSURE OF INTERESTS

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

PART I – Items to be considered in public meeting

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

TIME 10.00a.m (please note agenda item times are estimates only and that the public excluded session is from 10.00am-11.00am)

1. AGENDA ORDER AND TIMING

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Waitemata District Health Board
Hospital Advisory Committee Member Attendance Schedule 2014

<table>
<thead>
<tr>
<th>NAME</th>
<th>FEB</th>
<th>APR</th>
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<td>Dr Lester Levy (Chair)</td>
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<td>James Le Fevre (Committee Chair)</td>
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<td>Tony Norman (Deputy Chair)</td>
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<td>Morris Pita</td>
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<td>Christine Rankin</td>
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<td>Gwen Tepania – Palmer</td>
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- ✓ Attended the meeting
- x Absent
- * Attended part of the meeting only
- # Absent on Board business
- ^ Leave of absence
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<tr>
<th>Board/Committee Member</th>
<th>Involvements with other organisations</th>
<th>Last Updated</th>
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<tbody>
<tr>
<td>Lester Levy</td>
<td>Chair – Auckland District Health Board&lt;br&gt;Chairman – Auckland Transport&lt;br&gt;Deputy Chair – Health Benefits Limited&lt;br&gt;Independent Chairman – Tonkin &amp; Taylor&lt;br&gt;Chief Executive – New Zealand Leadership Institute&lt;br&gt;Professor of Leadership – University of Auckland Business School&lt;br&gt;Trustee - Well Foundation (ex-officio member)&lt;br&gt;Director – Orion Health (includes Director – Orion Health Corporate Trustee Limited)</td>
<td>26/11/14</td>
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<tr>
<td>Max Abbott</td>
<td>Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology&lt;br&gt;Patron – Raeburn House&lt;br&gt;Advisor – Health Workforce New Zealand&lt;br&gt;Board Member, AUT Millennium Ownership Trust&lt;br&gt;Chair – Social Services Online Trust&lt;br&gt;Board member – Rotary National Science and Technology Forum Trust</td>
<td>19/03/14</td>
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<tr>
<td>Sandra Coney</td>
<td>Chair – Waitakere Ranges Local Board, Auckland Council</td>
<td>12/12/13</td>
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<tr>
<td>Pat Booth</td>
<td>Consulting Editor – Fairfax Suburban Papers in Auckland</td>
<td>24/06/09</td>
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<tr>
<td>Warren Flaunty</td>
<td>Member – Henderson - Massey and Rodney Local Boards, Auckland Council&lt;br&gt;Trustee (Vice President) - Waitakere Licensing Trust&lt;br&gt;Shareholder - EBOS Group&lt;br&gt;Shareholder – Green Cross Health&lt;br&gt;Director – Westgate Pharmacy Ltd&lt;br&gt;Chair – Three Harbours Health Foundation&lt;br&gt;Director - Trusts Community Foundation Ltd</td>
<td>26/11/14</td>
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<tr>
<td>James Le Fevre</td>
<td>Emergency Medicine Registrar – Waitakere Emergency Department&lt;br&gt;Auckland Helicopter Emergency Medical Service (HEMS) Doctor&lt;br&gt;Doctor, Lifeflight New Zealand Ltd&lt;br&gt;Member – Australian College for Emergency Medicine, Hospital Overcrowding Subcommittee&lt;br&gt;From 1st September 2014 James’ wife is an employee of the Waitemata DHB, Department of Anaesthesia</td>
<td>28/07/14</td>
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<tr>
<td>Anthony Norman – Deputy Chair</td>
<td>Board Chair - Northland DHB&lt;br&gt;Director - Health Alliance  NZ Ltd&lt;br&gt;Director - Health Alliance (FPSC) Ltd&lt;br&gt;Trustee and Treasurer - Kerikeri International Piano Competition Trust&lt;br&gt;Partner - Mill Bay Haven, Mangonui (accommodation provider)&lt;br&gt;Member – DHB Shared Services Committee</td>
<td>05/11/14</td>
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<tr>
<td>Morris Pita</td>
<td>Board Member – Auckland District Health Board&lt;br&gt;Owner/operator – Shea Pita and Associates Limited&lt;br&gt;Shareholder – Turuki Pharmacy Limited&lt;br&gt;Wife is member of the Northland District Health Board</td>
<td>13/12/13</td>
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<td>Name</td>
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<td>Christine Rankin</td>
<td>Member - Upper Harbour Local Board, Auckland Council</td>
<td>17/05/13</td>
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<td>Director - The Transformational Leadership Company</td>
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<td>CEO – Conservative Party</td>
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<tr>
<td>Allison Roe</td>
<td>Member – Devonport-Takapuna Local Board, Auckland Council</td>
<td>02/07/14</td>
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<td>Chairperson – Matakana Coast Trail Trust</td>
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<tr>
<td>Gwen Tepania-Palmer</td>
<td>Chairperson- Ngatihine Health Trust, Bay of Islands</td>
<td>11/03/13</td>
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<td>Life Member – National Council Maori Nurses</td>
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<td>Alumni – Massey University MBA</td>
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<td>Director – Manaia Health PHO, Whangarei</td>
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<td>Board Member – Auckland District Health Board</td>
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<td>Committee Member – Lottery Northland Community Committee</td>
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<td>Co-Opted Members</td>
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<tr>
<td>Susanna Galea</td>
<td>Member – New Zealand Medical Association</td>
<td>31/03/14</td>
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<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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<tr>
<td>Andrew Jones</td>
<td>No current listings.</td>
<td>14/08/14</td>
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<tr>
<td>Willem Landman</td>
<td>To be advised.</td>
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<td>Donna Riddell</td>
<td>To be advised.</td>
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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>
</tr>
</thead>
</table>
| 1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 05/11/14 | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)] | Confirmation of Minutes  
As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&D Act. |
| 2. Quality Report | That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)] | Privacy  
The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] |
| 3. 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)] |
| 4. Provider Arm Performance 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)] | Protect Health or Safety  
The disclosure of information would not be in the public interest because of the greater need to protect the health or safety of the public. [Official Information Act 1982 S.9 (2) (c)] |
3.1 Confirmation of Minutes of the Hospital Advisory Committee Meeting Held on 05\textsuperscript{th} November 2014

Recommendation:

That the Minutes of the Hospital Advisory Committee meeting held on 05\textsuperscript{th} November 2014 be approved.
PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT
James Le Fevre (Committee Chair)
Lester Levy (Board Chair) (present from 11.50a.m.)
Max Abbott
Pat Booth
Sandra Coney (Deputy Committee Chair)
Warren Flaunty
Tony Norman
Morris Pita
Christine Rankin
Allison Roe
Gwen Tepania-Palmer
Susanna Galea

ALSO PRESENT
Dale Bramley (Chief Executive)
Andrew Brant (Chief Medical Officer)
Robert Paine (Chief Financial Officer and Head of Corporate Services)
Phil Barnes (Director of Allied Health)
Jocelyn Peach (Director of Nursing)
Fiona McCarthy (Director of Human Resources)
Cath Cronin (GM Surgical and Ambulatory Services)
Debbie Eastwood (GM Medicine and Health of Older People)
Jonathan Christiansen (Head of Department, Medical)
Linda Harun (GM Child, Women and Family Services)
Peter van de Weijer (Head of Department, Medical)
Ian McKenzie (GM Mental Health and Addictions Services)
Murray Patton (Clinical Director, Mental Health Services)
John Cullen (Director ESC)
Mark Watson (Group Manager ESC)
Jenny Parr (Associate Director of Nursing)
Jo Brown (Acting Funding Manager)
Paul Garbett (Board Secretary)

(Staff members who attended for a particular item are named at the start of the minute for that item.)

APOLOGIES
Apologies were received and accepted from Andrew Jones, together with an apology for late arrival from Lester Levy.

WELCOME
The Committee Chair welcomed those present. On behalf of the Committee he thanked Phil Barnes, whose last meeting this would be,
for his hard work, passion and enthusiasm and the amusing anecdotes which the Committee had enjoyed.

**DISCLOSURE OF INTERESTS**

Tony Norman advised that he is no longer Acting Chair of healthAlliance and that from 20 November 2014 he will no longer be Chair of the DHB Shared Services Executive Committee, although he will remain a member of that Committee. Linked to that from 20 November he will no longer be a member representing the interests of 20 DHBs on the Health Sector Forum and on the Medication Safety Committee and from 28 November he will no longer be a member of the Health Sector Relationship Committee.

Andrew Brant advised that he has been appointed as a member of the healthAlliance Board.

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

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 10.40a.m. until 11.25a.m.

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

   Resolution (Moved Gwen Tepania-Palmer/Seconded Warren Flaunty)

   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 24/09/14</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 that meeting, in terms of the NZPH&amp;D Act.</td>
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<tr>
<td>General subject of items to be considered</td>
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<td>Ground(s) under Clause 32 for passing this resolution</td>
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<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>
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<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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**Carried**

10.40a.m to 11.25a.m – public excluded session

11.25a.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 24th September 2014 (agenda pages 7-19)

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

That the minutes of the meeting of the Hospital Advisory Committee held on 24th September 2014 be approved.

Carried

Actions Arising

No issues were raised.

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 – September 2014 (agenda pages 20-106)

Executive Summary/Overview/Scorecard

Robert Paine summarised the financial results as outlined on page 23 of the agenda and the Financial Overview of the first quarter result (page 29 of the agenda). Significant factors affecting expenditure in the Provider Arm had been the high levels of acute demand and bringing forward of elective surgery to enable the start of theatre refurbishments later in the year.

Matters that Andrew Brant highlighted included:

- The extremely high level of winter demand on the hospitals this year, which had eased somewhat in the previous three weeks.
- The continuing increased levels of Emergency Department presentations, week by week, as illustrated by the graph on page 26 of the agenda.
- With elective surgery, the DHB is on track to meet the four months ESPI targets by the end of the year.

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

- Andrew Brant confirmed that there is some overbooking in anticipation of DNAs (appointments not attended). Cath Cronin advised that they are trying to get clinic profiles set up to reduce overbooking.
- Cath Cronin commented on the approach being taken to DNAs. The experience in recent years has taught that it is important not to make quick changes; there has to be sustained improvement. They are engaging with five or six general practices in West Auckland and getting really good “buy in” from them. They have also identified twelve services with the highest rates of DNA. They are trying to get the focus down to manageable groups and then have each speciality work on a manageable group. They have found that those families with the highest rates of DNA tend to be well known already. Other DHBs have a similar pattern.

Human Resources

Fiona McCarthy highlighted:

- The sick leave graph on page 32 of the agenda – despite effort being put in, sick leave remains higher than in 2013, with a higher winter peak and also because September sick leave has not dropped as quickly as last year. There is a systematic review of sick leave taking place, looking at the 100 staff members recording the highest sick leave absences. Trigger points are looked at.
- With overtime, they are looking at what is included in overtime, separating out other elements such as call back costs. The intention is to provide a more accurate picture of overtime.
- Annual leave situation (detailed on page 34 of the agenda). Overall the position is reasonable.
Matters covered in discussion and response to questions on this section of the report included:

- The Committee Chair noted the problem with sick leave is that a lot of cover is provided by other staff members, who in turn get sick or burn out. Managing staff members’ sick leave seems to always be a difficult issue. Fiona McCarthy suggested that part of the solution may be a more enriched discussion by managers with staff earlier in the sick leave period.
- Most agreements applying in the DHB allow the accumulation of sick leave to a certain level.
- Morris Pita advised that some organisations have a system of “my days” which allows people who feel worn out to take some time off in an honest way, but without exhausting their annual leave.

**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 level of demand on the hospitals is still high and in terms of staff morale there is a feeling that it is going to be a hard grind towards summer.
- With regard to the new ESPI compliance targets of four months, there are two areas where this is going to be challenging to achieve: cardiology and gastroenterology. He thought that they will make it, but it will be tight.
- The Division is in a place where many staff are acknowledging that changes are needed in how things are done to improve patient care and increase efficiency. Many initiatives are underway such as the chest pain project, the tele-health projects and the shift to more community based rehabilitation.
- For the December HAC meeting they will report on the proposed changes to the Model of Care for General Medicine.
- The e-prescribing rollout at Waitakere Hospital had not been without challenges as it went ahead across a very busy winter period. The RMOs are becoming more familiar with the technology and generally it had gone well.
- Electronic triage is being rolled out by specialities and is proving very good for all procedures and particularly in assisting contact with G.Ps.

Debbie Eastwood commented on:

- Sick leave – one issue had been the norovirus outbreak when affected staff had been asked to stay at home.
- They are working on a summer plan and want to be ready to employ 40 new graduates in February, which is important to the ongoing nursing workforce.
- The e-learning modules relating to older adults (page 41 of the agenda) will be made available to Aged Residential Care facilities.

11.50a.m. – Lester Levy present.

Matters covered in discussion and response to questions included:

- With the Allied Health Telehealth Project (referred to on page 42 of the agenda), Phil Barnes advised that this trial involves community teams using IPADs. They are looking for a possible 25% to 30% increase in efficiency. The
trial had about two months to go and will be evaluated before deciding whether to implement on a wider basis.

- Jonathan Christiansen advised that the Chest Pain Project (page 42 of the agenda) is based on a well-established model from Christchurch. It provides a pathway for those who present to ED with low risk chest pain to be discharged fairly early and have follow up as an outpatient.

Jonathan Christiansen and Debbie Eastwood were thanked.

Child, Women and Family Services

Linda Harun (GM Child, Women and Family Services), Peter van de Weijer (HOD Medical, Child, Women and Family Services) and Emma Farmer (HOD Midwifery) presented this section of the report. Matters that Peter van de Weijer and Linda Harun highlighted included:

- The New Zealand Maternity Clinical Indicators Report for 2012 (detailed on pages 55-56 of the agenda).
- The scorecard results (pages 50-52 of the agenda).
- The decrease in Gateway Assessment referrals in September (discussed on page 51 of the agenda).
- The extension of Ministry of Health funding for the Maternal Oral Health programme (page 55 of the agenda). An external review is underway and in the meantime the funding has been continued. There has been very positive feedback on the programme.

Matters that Emma Farmer highlighted included:

- The national biennial midwifery conference highlighted a number of Waitemata DHB initiatives: Pacific Island engagement; diabetes in pregnancy and Te Aka Ora – Vulnerable Families.
- The New Zealand Maternity Clinical Indicators Report for 2012.
- Work on the induction of labour project (pages 57-58 of the agenda).
- Caesarean rates are significantly higher at North Shore Hospital than Waitakere Hospital (page 58 of the agenda).
- The promoting natural births project and the assumptions used (detailed on pages 58-59 of the agenda).
- The work on gestation at booking with a LMC (pages 59-60 of the agenda).

Matters covered in discussion and response to questions included:

- On the question of why caesarean rates differ at North Shore and Waitakere Hospitals, Emma Farmer advised that there seem to be multiple factors. North Shore Maternity has more older women and more Europeans and Asians.
- There is a website for women to find a midwife, hosted by the New Zealand College of Midwives; however it seemed that many GPs may not be aware of it. Remediying that is a piece of work that they are looking at doing. Allison Roe suggested that based on a family member’s experience the website may need updating.
- The Board Chair noted that midwifery is the only health service where private providers can access a public facility for a private fee. Auckland DHB is looking at that. One possibility would be to establish clear rules of engagement about how people access and use DHB facilities.
• The question was asked whether or not the rate of caesarean section is higher at night. Emma Farmer advised that it is higher at night. Babies are born 24 hours a day, seven days a week. Timing is unpredictable. One of the reasons which may make caesareans more likely at night is that overnight North Shore Hospital has junior doctors available and senior clinicians on call. There will be a tendency when a junior doctor decides on a caesarean and phones the senior doctor for the senior doctor to accept that decision rather than getting up, coming to the hospital and looking at different options. A second reason is that scheduled inductions generally take place in the morning.

• Peter van de Weijer confirmed that most interventions start in the early morning. They had trialled starting them early evening, however there had been drawbacks with that and they had reverted to mornings.

• Emma Farmer advised that there are guidelines for inducing labour which included the birth being 10 days over term.

• The Committee Chair commented that it had been useful to have the Head of Midwifery’s perspective and that it might be valuable to have that more regularly.

• In answer to a question Peter van de Weijer said that Waitakere Maternity is doing remarkably well in terms of comparative performance and the need is to concentrate on quality improvement at North Shore.

• Max Abbott suggested that the question of quantifying demographic and cultural differences between the patients of the two hospitals and the impact on such matters as those just discussed would lend itself to a useful study. The Board Chair also asked if the performance metric for Waitakere Hospital is corrected for the number of patients who transfer from there to North Shore Hospital. What is the level of sophistication of evaluations?

• In response, Emma Farmer advised that they attempt to compare like with like; in age groups etc. Another factor is that Waitakere Maternity is very community based, people walk into it on the ground floor and it has a community feel to it. There is a lot of evidence on the impact of positive surrounding environment on births.

• In answer to a question, Andrew Brant commented that probably Womens Health was the most advanced hospital service in terms of regional collaboration, both in terms of having one model of care and in collaboration from a clinical perspective.

• Sandra Coney suggested that it would be worthwhile for consideration to be given to the issue of reducing epidurals.

Mental Health and Addiction Services

Ian McKenzie (General Manager, Mental Health and Addictions Services), Murray Patton (Clinical Director, Mental Health Services), Alex Craig (Associate Director of Nursing, Mental Health) and Nevine Jones (Quality Improvement) were present for this section of the report.

Ian McKenzie commented on the further analysis carried out of the reasons for not achieving the shorter waits in ED target for Mental Health (pages 66-67 of the agenda). This had led to developing a case to extend Mental Health Service coverage at Waitakere Hospital ED. He also advised that He Puna Waiora (the new acute unit) will open on 15 May 2015.
In answer to a question about the issue with coding, Nevine Jones advised that people who present are coded into the system; often they are presenting with a psychiatric problem. The aim is to draw down on what the problem is so that staff can be more responsive to particular issues.

The Committee Chair advised that the Mental Health Services staff members that he had contact with in his work worked extremely hard. Ian McKenzie said that he would pass that comment on.

**Elective Surgical Centre (ESC)**

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

Matters highlighted included:
- Continuing deliberate over delivery of elective surgery volumes for North Shore Hospital and ESC for the period reported on. All four ESC theatres are being utilised.
- The ground floor reconfiguration to provide provision for gynaecology, six clinic rooms and two colposcopy rooms.
- The upcoming ACC Partnership Programme Audit.
- The multi-disciplinary operating room simulation training (page 76 of the agenda).
- The Registrar teaching update (page 76 of the agenda).
- The acute fractured ankle lists (page 76 of the agenda).

Matters covered in response to questions included:
- John Cullen advised that after some initial surprise from the College of Surgeons, the programme of registrar training had now been accepted positively.
- The average length of stay for ESC is slightly less than in the Waitakere pilot.
- A quality audit has just been completed for ESC and copies have gone to Dale Bramley and Andrew Brant. In general it is very supportive of the ESC.

**Surgical and Ambulatory Services**

Cath Cronin (GM Surgical and Ambulatory Services) presented this section of the report. She conveyed an apology for Michael Rodgers (Chief of Surgery). Matters that she highlighted or updated included:
- The division is working hard to achieve the four month treatment times target. This involves quite a lot of pressure and intensive waiting list management. The risk areas are ORL and orthopaedics, cardiology and enterology. She is meeting regularly with those teams.
- ESC had over delivered and the challenge for the next six months will be to align and take back volumes to target which will also reduce costs.
- Radiology – the work needed to meet the MRI scans target (page 82 of the agenda) and the initiatives underway to review process flows within the department, resources required to match increase in demand and the overall utilisation of the capital equipment (pages 86-87).
- Involvement in the national project on better measures and plan production.
Service improvements (pages 88-89 of the agenda) including the trialling of a hand service at Waitakere Hospital, delivery of breast reconstruction procedures and introduction of the collaborative Ophthalmology hub and spoke service model with Auckland DHB.

Matters covered in discussion and response to questions included:
- With regard to the cost of DNAs, that is hard to quantify. It includes the cost of re-booking and rescheduling and the cost of chasing some patients numerous times.
- With the closure of Ward 8 for renovation, there will be a four week period when the ward has to be closed completely. This is a staged renovation and they will quickly have half the ward re-opened again. They are working to keep staff with their patients during this period.
- With the patient owned food diaries (page 85 of the agenda), the patients are supplied with the diaries in an effort to make sure that they are getting the right calories. The patients are actively helped with the diaries. Jocelyn Peach explained that patients are assessed for nutrition needs. Those at high risk are given a food diary. In answer to further questions, she advised that patients can bring in their own nutrients/food, but how it can be stored on the ward can be a problem.

Hospital Operations

With regard to this section of the report, Cath Cronin highlighted or updated the following:
- No major changes from the previous report to the Committee.
- The main issue at the moment is security. A high level review at Waitakere Hospital is taking place, to be followed by a more intensive review. Where issues are being found they are being addressed.
- Changes in Pharmacy (page 92 of the agenda).

The Committee Chair thanked Cath Cronin for the work that she is leading on DNAs.

Provider Arm Support Services

Robert Paine noted that Allan Johns has been appointed as the GM Facilities for both Auckland and Waitemata DHBs and the work to finalise the next tier of appointments is underway.

The Provider Arm Report and Diligent Boardbooks

Requests were made for:
- Organising the report so that the different sections of the report can be accessed directly from the index on Boardbooks.
- Better legibility of scorecards and charts.

Resolution (Moved Gwen Tepania-Palmer/Seconded Sandra Coney)

That the report be received.

Carried
6. CORPORATE REPORTS

6.1 Clinical Leaders’ Report (agenda pages 107-110)

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

- His departure will provide an opportunity to review the leadership and structure of Allied Health.
- Health and Safety in the laboratories is taken very seriously.
- Errors in patient identification are a serious issue which also applies to the collection of blood samples in the laboratories.

At his last meeting, Phil Barnes took the opportunity to thank Waitemata DHB for what it had given him and to express his appreciation of Dale Bramley as an outstanding Chief Executive.

Andrew Brant (Chief Medical Officer) highlighted the values and behaviours programme for Senior Medical Officers (page 107 of the agenda). Tim Keogh has assisted the invited group in going through what it means for them to put the patient at the centre of care and what working effectively in teams involves. The aim is for this group to influence their colleagues and put together a programme that will work for their colleagues. The reaction has been encouraging, with a lot of enthusiasm to get involved in the work. 40 to 50 SMOs are involved. He will report further in December on this.

Jocelyn Peach (Director of Nursing and Midwifery) presented the Nursing and Midwifery section of the report. Matters that she highlighted included:

- Cohort 1 of the Charge Nurse Programme “Leading Quality Care” had been completed. It was good to see Charge Nurses leading so strongly, ready to partner with medical colleagues and to make a difference at the bedside. The second cohort commenced in October.
- Recruitment of new nurse graduates for the February intake, with attention to the values of the organisation in that process. There had been over 400 applicants for the positions and the quality was good.
- Plans for the possibility of Ebola are coming together nicely. Equipment is there and training is starting now.
- There will be an evacuation exercise at North Shore Hospital in November (floors 7-10) as part of emergency planning.

The Committee Chair thanked Phil Barnes again on behalf of the Committee for the contribution that he had made.

Resolution (Moved Sandra Coney/Seconded Gwen Tepania-Palmer)

That the report be received.

Carried

6.2 Human Resources (agenda pages 111 -122)

Fiona McCarthy (Director Human Resources) presented this report. Matters that she highlighted included:
The new graphs introduced to the recruitment section of the report.

Time to hire had been increasing. They were looking at processes to see if there was any duplication that could be avoided or other ways to reduce the time taken.

As requested previously a new graph had been introduced (page 114 of the agenda) which included ethnicity of health assistant new starts.

With the values programme they are looking at the next tranche of work over the next 1-3 years.

The Waitemata DHB Demographic Snapshot attached as Appendix 1 to the report.

The new learning programmes described on pages 116-117 of the agenda.

Matters covered in discussion and response to questions included:

- The continuing disappointingly low level of Maori and Pacific new starts. The question was asked where Maori and Pacific new graduates are going. Dale Bramley advised that Jocelyn Peach and he would talk with the President of the Maori Nursing Council to see what initiatives might be feasible. There have been media reports that Maori nurses have been unable to find jobs. It is a concern that the employee demographics are not that representative of the population of the district. The issue is being actively looked at as part of a Maori/Pacific Workforce Plan. This will also be looked at as part of Northern regional planning.

- The DHB scholarship programme for 2014 was on the same basis as last year, available to Maori and Pacific applicants.

- Warren Flaunty advised that on behalf of the Board he had attended the launch of the Health Science Academy at Waitakere College.

**Resolution** (Moved Warren Flaunty/Seconded Tony Norman)

*That the report be received.*

**Carried**

7. INFORMATION PAPERS

There were no information papers.

The Committee Chair thanked those present.

The meeting concluded at 1.17p.m.
**Actions Arising and Carried Forward from Meetings of the Hospital Advisory Committee as at 9th December 2014**

<table>
<thead>
<tr>
<th>Meeting Date</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 late January 2015.</td>
</tr>
<tr>
<td>HAC 13/08/14</td>
<td>5.1</td>
<td>Provider Arm Report: - Caesarean Births Six monthly updates to be provided to HAC on this issue.</td>
<td>Peter van de Weijer/ Linda Harun</td>
<td>HAC 25/02/15</td>
<td></td>
</tr>
<tr>
<td>HAC 24/09/14</td>
<td>3.1</td>
<td>Evaluation of Evidence for Use of Vitamin C - Request for an evaluation to be made to the Health Research Council. - Auckland Regional Clinical Practice Committee to be asked to check whether there is any new evidence on Vitamin C since their last review which would justify a further update from them.</td>
<td>Dale Bramley</td>
<td></td>
<td>Letter sent. Response was that any research proposal would be assessed using HRC’s usual processes and the next funding round is not until mid-2015.</td>
</tr>
<tr>
<td>HAC 24/09/14</td>
<td>6.2</td>
<td>Human Resources: - Information to be provided on how nursing staff (existing and new) are trained on understanding and responding to Asian cultural differences.</td>
<td>Jocelyn Peach</td>
<td>HAC 17/12/14</td>
<td>Included in Clinical Leaders’ report.</td>
</tr>
<tr>
<td>Meeting Ref</td>
<td>Agenda Ref</td>
<td>Topic</td>
<td>Person Responsible</td>
<td>Expected Report Back</td>
<td>Comment</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
</tbody>
</table>
| HAC 05/11/12 | 5.1        | Provider Arm Report on Diligent Boardbooks – requests for:  
- Links from agenda index to different sections of the report. 
- Better legibility of scorecards and charts. | Paul Garbett/Peta Molloy | | Links arranged for December HAC agenda. |
5.1 Provider Arm Performance Report – October 2014

Recommendation

That the report be received.

Prepared by: Cath Cronin (Director of Hospital Services)

This report summarises the Provider Arm performance for October 2014.
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
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 October the provider arm had a deficit of $2.180M against a planned deficit of $1.449M and was therefore unfavourable by $731k. Overall, the DHB was slightly favourable by $29k for the month.

Year to date the provider arm is unfavourable to budget by $3.0M while the DHB is favourable by $168k.

SERVICE DELIVERY

All health targets have been met in October. The Shorter Waits in ED target has improved to 97% compliance, after the impact of winter pressures saw performance drop below 95% in July.

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). By the end of October, less than 1.5% of patients waited longer than 4 months for an FSA or treatment, a significant improvement on September’s result of 3% and Waitemata DHB is on track with plans to meet the 4 month target.
### Waitemata DHB Monthly Performance Scorecard

#### ALL Services

**October 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>96.3%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Provider arm elective volumes</td>
<td>100.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Shorter waits in ED</td>
<td>97.9%</td>
<td>96.3%</td>
</tr>
</tbody>
</table>

#### Service Delivery

<table>
<thead>
<tr>
<th>Productivity</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESP1 - % patients waiting &gt;3 months for PSA</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>ESP2 - % patients not treated within 6 months</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

#### Quality

<table>
<thead>
<tr>
<th>Quality</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average length of stay - Acutes</td>
<td>3.31</td>
<td>4.00</td>
</tr>
<tr>
<td>Acute WES volumes</td>
<td>6,218</td>
<td>6,302</td>
</tr>
</tbody>
</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>0.0 days</td>
<td>3.0 days</td>
</tr>
<tr>
<td>Overtime Rate (%)</td>
<td>1.1%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

### Financials

<table>
<thead>
<tr>
<th>Financial Result FY16</th>
<th>Actual $000s</th>
<th>Target $000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>280,540 k</td>
<td>282,488 k</td>
</tr>
<tr>
<td>Expense</td>
<td>227,508 k</td>
<td>232,000 k</td>
</tr>
<tr>
<td>Pers. Costs</td>
<td>179,986 k</td>
<td>175,983 k</td>
</tr>
<tr>
<td>Ongoing Services</td>
<td>21,985 k</td>
<td>18,111 k</td>
</tr>
<tr>
<td>Clinical Supply (OSG)</td>
<td>56,009 k</td>
<td>54,913 k</td>
</tr>
<tr>
<td>Non-Clinical Supply Costs</td>
<td>34,077 k</td>
<td>34,310 k</td>
</tr>
<tr>
<td>Contribution</td>
<td>-1,013 k</td>
<td>13 k</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>16,794 k</td>
<td>25,877 k</td>
</tr>
</tbody>
</table>
Health Targets

Better Help For Smokers To Quit

![Smoking Intervention Offered - Weekly Results](image)

Shorter Stays in Emergency Departments

![ED % 6 Hour Health Target Compliance](image)
Waitemata DHB, Hospital Advisory Committee Meeting 17/12/2014

Emergency Department Presentations

Improved Access to Elective Surgery
Elective Performance

Zero patients waiting over 5 and over 4 Months

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Cases</th>
<th>Authourised In Time Frame</th>
<th>ESPI 1 Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthesiology</td>
<td>104</td>
<td>102</td>
<td>98.1%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1740</td>
<td>1620</td>
<td>93.1%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>64</td>
<td>63</td>
<td>98.4%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>341</td>
<td>336</td>
<td>98.5%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>240</td>
<td>239</td>
<td>99.6%</td>
</tr>
<tr>
<td>Gastro-Enterology</td>
<td>1395</td>
<td>1322</td>
<td>94.8%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>416</td>
<td>404</td>
<td>97.1%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>741</td>
<td>735</td>
<td>99.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>480</td>
<td>478</td>
<td>99.6%</td>
</tr>
<tr>
<td>Haematology</td>
<td>161</td>
<td>156</td>
<td>96.9%</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>26</td>
<td>25</td>
<td>96.2%</td>
</tr>
<tr>
<td>Oncology</td>
<td>50</td>
<td>50</td>
<td>100.0%</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>897</td>
<td>880</td>
<td>98.1%</td>
</tr>
<tr>
<td>Otorhinolaryngology</td>
<td>660</td>
<td>637</td>
<td>96.5%</td>
</tr>
<tr>
<td>Paediatric MED</td>
<td>471</td>
<td>462</td>
<td>98.1%</td>
</tr>
<tr>
<td>Renal Medicine</td>
<td>108</td>
<td>108</td>
<td>100.0%</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>312</td>
<td>295</td>
<td>94.6%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>150</td>
<td>150</td>
<td>100.0%</td>
</tr>
<tr>
<td>Urology</td>
<td>340</td>
<td>325</td>
<td>95.6%</td>
</tr>
<tr>
<td><strong>Total Services Compliant</strong></td>
<td>16,974</td>
<td>16,918 (96.8%)</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

All Services

<table>
<thead>
<tr>
<th>CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE</th>
<th>Reporting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider (5000's)</td>
<td>Oct-14</td>
</tr>
<tr>
<td>MONTH</td>
<td>YEAR TO DATE</td>
</tr>
<tr>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>REVENUE</strong></td>
<td></td>
</tr>
<tr>
<td>Other Income</td>
<td>2,351</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>67,448</td>
</tr>
<tr>
<td><strong>EXPENDITURE</strong></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>13,411</td>
</tr>
<tr>
<td>Nursing</td>
<td>17,808</td>
</tr>
<tr>
<td>Allied Health</td>
<td>9,086</td>
</tr>
<tr>
<td>Support</td>
<td>1,157</td>
</tr>
<tr>
<td>Management / Administration</td>
<td>5,030</td>
</tr>
<tr>
<td><strong>Total Personnel</strong></td>
<td>46,492</td>
</tr>
<tr>
<td>Other Expenditure</td>
<td></td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>5,207</td>
</tr>
<tr>
<td>Clinical Supplies</td>
<td>9,013</td>
</tr>
<tr>
<td>Infrastructure &amp; Non- Clinical Supplies</td>
<td>8,232</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>23,156</td>
</tr>
<tr>
<td><strong>Contribution</strong></td>
<td></td>
</tr>
<tr>
<td>(2,180)</td>
<td>(1,460)</td>
</tr>
<tr>
<td><strong>Allocations</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>NET RESULT</strong></td>
<td>(2,180)</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE</th>
<th>Reporting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider (5000's)</td>
<td>Oct-14</td>
</tr>
<tr>
<td>CONTRIBUTION</td>
<td></td>
</tr>
<tr>
<td>MONTH</td>
<td>YEAR TO DATE</td>
</tr>
<tr>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>CONTRIBUTION</strong></td>
<td></td>
</tr>
<tr>
<td>Surg &amp; Ambulatory</td>
<td>(2,645)</td>
</tr>
<tr>
<td>Medical &amp; HOOPS</td>
<td>6,074</td>
</tr>
<tr>
<td>Child &amp; Women Family</td>
<td>3,111</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2,471</td>
</tr>
<tr>
<td>Elective Surgery Centre</td>
<td>1,955</td>
</tr>
<tr>
<td>Provider Support</td>
<td>(11,186)</td>
</tr>
<tr>
<td><strong>Total Contribution</strong></td>
<td>(2,180)</td>
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<table>
<thead>
<tr>
<th>CONSOLIDATED STATEMENT OF PERSONNEL by PROFESSIONAL GROUP</th>
<th>Reporting Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider (5000's)</td>
<td>Oct-14</td>
</tr>
<tr>
<td>FTE</td>
<td></td>
</tr>
<tr>
<td>MONTH</td>
<td>YEAR TO DATE</td>
</tr>
<tr>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>FTE</strong></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>663</td>
</tr>
<tr>
<td>Nursing</td>
<td>2,553</td>
</tr>
<tr>
<td>Allied Health</td>
<td>1,473</td>
</tr>
<tr>
<td>Support</td>
<td>285</td>
</tr>
<tr>
<td>Management</td>
<td>782</td>
</tr>
<tr>
<td><strong>Total FTE</strong></td>
<td>5,756</td>
</tr>
</tbody>
</table>

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Waitemata DHB, Hospital Advisory Committee Meeting 17/12/2014
COMMENT ON MAJOR VARIANCES

Revenue
Revenue for October is $1.797M favourable to budget - the main contributors being an additional $550k for elective activity together with additional funding for project initiatives including a Hyperbaric catch-up of $292k, outsourced colonoscopies of $124k, volume related deficit support of $417k and $202k for surgical and pharmacy demand. In addition, positive variances arose for interest earnings of $223k and non-resident and court report billing of $100k. Offsetting these was $105k unfavourable results for ACC billing and the CTA nursing contract.

The YTD position has increased to $7.071M favourable. Electives remain ahead of budget by $2.4M. Additional funding has also been received for outsourced colonoscopies ($431k), endoscopy procedures ($225k), quality initiatives ($260k), surgical demand ($418k), and volume related deficit support ($2.787M). Favourable YTD variances also arose from bank deposits ($736k), court reporting and non-resident billing ($391k) and the release of $439k from the Infant and Perinatal Establishment Fund. Unfavourable variances arise in the CTA nursing contract ($273k), ACC billing ($209k), car parking revenue ($79k), Colposcopies and Outpatient Pharmacy sales ($194k), Bowel Screening ($90k) and NASC revenue ($39k).

Expenditure
Overall the expenditure for the Provider arm was $2.529M unfavourable for the month and $10.103M YTD. Within this there is an over spend in personnel costs of $1.233M for the month and $3.967M YTD.

Personnel Costs YTD
• Medical Personnel ($1.906M unfavourable) – The over spend arises in Medhops ($1.621M) and SAS ($617k). The effect of higher than planned volumes earlier in the year continues to adversely impact Medhops medical budgets. General Medicine and ED volumes are still 10% ahead of YTD contract and acute Cardiology is 25% ahead. This additional volume has contributed to the $1.023M overspend in medical overtime, penal payments, additional locum shifts and higher SMO leave balances. Changes to CME entitlements, SMO job size allowances and pay scales has resulted in a $397k unfavourable variance and unmet savings and additional cost of the hyperbaric service have contributed $150k to the MedHops underspend. The SAS overspend arose primarily in Radiology SMO costs ($329k) and Anaesthesia ($526) offset by $122k savings in surgical specialties. The radiology overspend relates to staff overtime and recruitment costs incurred in getting the second MRI scanner on stream. Overall the Anaesthesia department is on budget as this overspend is offset by recharges to ESC in outsourced costs.

• Nursing Personnel ($1.568M unfavourable) – The $1.453M overspend in MedHops is due primarily due to increased activity in the wards with General Medicine and Cardiology volumes 10% and 25% over YTD contract respectively. The cost of this activity arises in internal bureau spending covering watches and ward vacancies totalling $333k and additional nursing FTE and overtime of $428k. The cost of sick leave, rising annual leave balances, maternity leave, gratuities and recruiting at salary levels above the cost of financed vacancies has added a further $359k to the overspend. The cost of orientating new nursing staff has added $270k to the overspend and unmet savings amounted to $114k. In SAS, the $735k overspend is due to high elective volumes and unmet savings. In CWF, the $520k overspend is due to lower than planned savings from staff turnover and increased overtime and allowances costs associated with managing breaches from ED to Rangitira and high occupancy across Paediatrics and Maternity (126% and 113% respectively of YTD contract). Offsetting these, is a $1.139M underspend in Corporate positions.

• Allied Health Personnel ($981k unfavourable) – CWF division is $779k 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. Unmet savings targets of $147k and annual leave balance growth of $209k have also contributed to the over spend. The service will selectively hold vacancies if staff turnover does not pick up in Quarter 2 and anticipates higher annual leave over the school holiday period. The $350k overspend in SAS is due to additional evening CT/MRI sessions and
delayed savings initiatives. Vacancies in Medhops Allied Health has resulted in a $218k underspend net of overtime costs and higher annual leave balances.

- Support and Admin Personnel ($489k favourable) – The bulk of the underspend in support staff costs relates to vacancies in trades, security, orderlies and cleaning staff ($857k) some of which are covered by the use of outsourced agency casual staff. Management and Admin staff costs are unfavourable by $547k mostly due to centrally budgeted savings initiatives of $713k.

Other Expenditure YTD

Other expenditure was $1.296M overspent for the month and $6.135M YTD. Clinical Supplies have contributed $2.499M to the over spend principally due to high volumes and unmet savings budgets; the overspends in the Services were as follows:

- Medicine and Health of Older People services ($861k), mostly due to unmet savings of $459k. High volumes have driven supplies costs overspend in Cardiology ($447k), Wards and Older Adults ($409k) and Emergency Department ($168k). The service also incurred costs of $270k in filling a gap in contracted mobility aid suppliers. These are partially offset by volume driven underspends in Haematology pharmaceuticals ($560k).
- Surgical and Ambulatory services ($1.982M), mainly volume driven costs in theatre due to increased activity. Orthopaedic and General Surgery elective volumes are 110% of YTD contract. As well as the volume driven cost overruns, the service has an unmet savings initiative of $764k which is contributing to the over spend in clinical supplies.
- Elective Services Centre ($410k), mainly volume driven costs due to over delivery on elective volumes, the service delivered 113% of the budgeted orthopaedic production plan.
- Child Women Services ($321k), mainly due to unrealised savings initiatives of $92k, unexpected Air Ambulance costs $25k, $28k for sterilising consumables, protective clothing and dressings in line with new dental model of infection control and overspends in treatment disposables of $80k due to higher than anticipated inpatient volumes.
- Hospital Operations ($394k), volume driven inpatient pharmacy and diagnostic costs ($330k) and a reduction in the community pharmacy recoveries from inpatient services of $48k.

Outsourced services were $3.874M unfavourable. $1.471M of this arose in Medhops due to $747k of outsourced gastroscopy (fully offset with additional revenue), $743k of external nursing costs (to meet nursing roster and cover requirements for medical wards and emergency department), and unmet savings of $234k. Overspends in casual cleaning and support staff costs off setting vacancies in Hosp Ops contributed $911k and production ahead of plan in ESC a further $790k. SAS have overspent by $782k due to outsourcing ORL for ESPI compliance and unmet savings.

The $239k favourable variance in Infrastructure costs includes set up costs for a new MHSG infant and perinatal facility ($429k) and unmet savings offset by lower than expected interest costs ($304k) and risk pool adjustments ($781k).
**Human Resources**

**Sick Leave**

**Trends**
The October figure has mirrored the trend of the previous two years with a significant decrease in average sick leave days per fte for the month. While this is positive, the 2014 October average is slightly higher than that for the same time in 2012 and 2013.

The most recent national KPIs reported Waitemata DHB as having the second lowest average for percentage of sick leave hours across the six large DHBs. However it is acknowledged that there needs to be an increased focus on developing a range of more pro-active strategies and responses for sick leave management to both reverse the long term trend and reach and sustain levels on or below the organisational target.

**Commentary and planned actions**
Sick leave management processes, reporting and guidance are in place and being implemented by managers to respond to instances of high sick leave for both individual employees and in services. Since the last report further work on data collection in Child, Women and Family Services and Allied Health has been completed to identify patterns of high sick leave for individuals and teams. A ‘traffic light’ priority system is in place and the HR Manager is working within teams to implement appropriate strategies with key focus being in the ‘red’, i.e. employees with highest sick leave absence levels.

To further enhance reporting and support to the Divisions in reducing sick leave rates, a workshop is being scheduled in December with Finance Managers and HR Managers/Advisors. This will provide a forum to review current processes and provide support from Finance and Human Resources to explore opportunities for additional strategies and actions. Our Healthy Workplaces activities are also being reviewed with workshops planned for December.

**Overtime**
**Trends**
The October overtime rate has continued to decrease following the peak in July. It continues to be well above both the organisational target and results for the same time in the previous two years. The most recent national KPI report also shows Waitemata DHB has the highest overtime rates. The recent figures will be partly related to the recent spike in hospital activity with ED attendances 10% above prior years and elective surgery showing similar trends.

**Commentary and planned actions**
Initial investigations into separating components reported in overtime that are not related to overtime (i.e. call backs) through our payroll system have indicated that it is not possible to separate out these components, so overtime rates will likely continue to be higher than other DHBs.

However, we have access to good reporting at individual responsibility code level so we can target our discussions on overtime to key services. The upcoming workshop with Finance and Human Resources will provide an opportunity to discuss overtime reporting and how this can be enhanced and inform organisational discussions on actions to reduce current rates both within Divisions and professional groups.

**Annual Leave Management (headcount)**

<table>
<thead>
<tr>
<th>Service</th>
<th>AL bal 0-24 days</th>
<th>AL bal 25-49 days</th>
<th>AL bal 50-74 days</th>
<th>AL bal 75+ days</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-WIMO Medical and HOPS</td>
<td>1334</td>
<td>569</td>
<td>111</td>
<td>33</td>
</tr>
<tr>
<td>01-WSAS Surgical and Ambulatory</td>
<td>876</td>
<td>351</td>
<td>59</td>
<td>21</td>
</tr>
<tr>
<td>01-WWCW Child Women &amp; Family</td>
<td>773</td>
<td>206</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>01-WESC Elective Surgery Centre</td>
<td>65</td>
<td>12</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>01-WMHS Mental Health Services</td>
<td>857</td>
<td>304</td>
<td>37</td>
<td>9</td>
</tr>
<tr>
<td>01-WHOG Hospital Operations</td>
<td>311</td>
<td>147</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>01-WACP Corporate</td>
<td>236</td>
<td>101</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>01-WCFA Facilities and Development</td>
<td>21</td>
<td>13</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>4,473</strong></td>
<td><strong>1,703</strong></td>
<td><strong>255</strong></td>
<td><strong>82</strong></td>
</tr>
</tbody>
</table>

**Trends**
The October leave figures have not changed significantly from the previous month with no change in the 75+ days leave group. This will be because leave is traditionally not taken by hospital teams over winter. The most recent national KPI report shows Waitemata DHB is in the top third of DHBs with the lowest Annual Leave accruals greater than two years.

**Commentary and planned actions**
Work is continuing to investigate leave claims and records in the Leader pay system and HR Managers/Advisors are continuing to work directly with managers in their Divisions to implement both pro-active leave management strategies for individuals with high annual leave balances and service leave planning to reduce continued leave accrual. The toolkit for managers has been reviewed and provides a range of resources to support discussions with employees about their leave management.

The workshop to be held in December with Finance Managers and HR Managers/Advisors will provide a further opportunity to discuss and develop recommendations for additional annual leave management strategies.
Staff Turnover

Trends
Voluntary turnover has remained relatively stable since last month and continues to be on target with an overall downward trend.
Medicine and Health of Older Peoples Services

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
Across all divisions, we achieved 98% in October for this target. In total, 1,109 of the 1,129 identified smokers were offered advice and support to quit. MHOPS achieved 98.4% for the month. 99% of identified Maori smokers were offered support to quit in October with just 3 missed.

<table>
<thead>
<tr>
<th>Ethnicity Group</th>
<th>Smokers Supported to Quit</th>
<th>Identified Smokers (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>60</td>
<td>61</td>
</tr>
<tr>
<td>European</td>
<td>699</td>
<td>713</td>
</tr>
<tr>
<td>Maori</td>
<td>221</td>
<td>224</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>28</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>102</td>
<td>103</td>
</tr>
<tr>
<td>Total</td>
<td>1,109</td>
<td>1,129</td>
</tr>
</tbody>
</table>

Shorter Stays in ED
The Shorter stays in ED health target result for the organisation was 97.2% with MHOP achieving 96.9%.

For North Shore ED we saw an average 136 patients per day in October compared to 140 in September and for Waitakere Hospital ED we saw an average of 121 patients compared to 128 in September. We expect the number of patients and, in particular, paediatric patients at Waitakere to reduce as we move into the summer months. We have also been developing an electronic breach form for all breaches (superseding written reports). This new system is in the process of being rolled out and we are focusing on ensuring we capture all of the breaches. One of the barriers to staff using the electronic system is the lack of ease in accessing the form, so we are working with IS to improve this aspect of the form. We are also working with the duty managers and services to develop management reports that are meaningful for the various stakeholders.

ED Transit area – we have purchased lazy boy chairs to be used in the observation area which will increase capacity by three spaces. These are for patients who are well enough to go home, but waiting for test results.
Quality
Complaints
We received 33 complaints in the month with a turnaround time of 16 days. Our complaints were spread evenly across our division – ED, Wards, General Medicine and Older Adults.

HQSC Markers
Falls
There were 100 falls across our division in October, of which 3 were falls with fracture. Our falls risk assessment audits were carried out on 75 patients in October and 100% of these patients had a falls risk assessment and pleasingly, 95% of these assessments were completed within 8 hours of admission. Ninety two per cent of the patients also had a documented care plan in place. We are measuring the days between falls and this shows that the days between falls is increasing with 58% of wards achieving the target of 2 weeks or more without a fall. Forty two per cent of the wards achieved fall free days of between 1-2 weeks.

Hand Hygiene
The MHOP wards have continued to improve over time and the average compliance rate is now over 80%.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anawhata</td>
<td>82%</td>
<td>83%</td>
<td>79%</td>
<td>84%</td>
<td>84%</td>
<td>86%</td>
</tr>
<tr>
<td>Wainamhu</td>
<td>79%</td>
<td>78%</td>
<td>80%</td>
<td>84%</td>
<td>84%</td>
<td>81%</td>
</tr>
<tr>
<td>Ward 10</td>
<td>64%</td>
<td>68%</td>
<td>58%</td>
<td>69%</td>
<td>84%</td>
<td>81%</td>
</tr>
<tr>
<td>Ward 14</td>
<td>70%</td>
<td>72%</td>
<td>74%</td>
<td>67%</td>
<td>73%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Assessment & Diagnostic Unit (ADU) – time to be seen from triage – 75% (target 85%)
Unfortunately in October we have seen high rates of sick leave amongst our junior medical staff and at times we have had to redeploy the ED/ADU registrar and house officer to cover other roles. We anticipate this will happen less often going forward and we will be able to focus on improving ADU seen by times.

Service Delivery
Average Length of Stay
AT&R
For the AT&R specialty, the average length of stay was 18.8 days for October; this is similar to September and both months were impacted by Norovirus. The Norovirus outbreak impacted on the wait time for patients in both acute Medicine and Surgery who have been accepted for rehabilitation. In order to try and minimise this impact a small number of patients were cared for on ward 11 under the AT&R speciality. However the waiting list for AT&R remained in the double figures over this time. The impact of this is a significant number of patients are in acute medical and surgical beds when they no longer require this level of care. Whilst we endeavour to support patients to engage in low levels of rehabilitation on the medical and surgical wards, the nursing staff work in an acute model of care and the allied health staff ratios do not support a rehabilitation model.

Ward 12 (KMU) had 12 discharges in the month with an average length of stay of 61.8 days (the average over a year is around 42 days). The reason for the sharp increase in length of stay was the discharge of an Adult MHS patient to Te Whare Rata following an admission of 209 days. Removing this one discharge would return the LOS to the average of around 40 days over the year. However there is some delay in discharge due to the lack of available psycho-geriatric beds.

Medicine
October LOS for Medicine was 3.79 days, down from 4.07 in October against a target of 4 days. A key component of the LOS is those patients on the AT&R waiting list.
Endoscopy Targets
We have achieved 80% of urgent diagnostic colonoscopy patients receiving their procedure within 14 days against a target of 75% and 72% for non-urgent within 42 days against a target of 60%. We have achieved the surveillance target in the first week of November.

ESPI
ESPI 1
Medicine specialties achieved 95% compliance against a target of 90%. We are continuing to streamline our processes to ensure both timely grading and patients placed on to the waiting list.

ESPI 2
All medicine specialties continue to be 100% compliant with the 5 month target. The majority of medicine specialties achieved a four month wait time for ESPI2 in October, however both Cardiology and Gastroenterology remain challenging in terms of achieving 4 months. We have plans in place for both specialties; despite there being unexpected delays and/or unplanned sick leave impacting on throughput. However we are working towards achieving the target by 31 December with our contingency plans in place.

ESPI 5
Cardiology is complaint for ESPI 5.

Elective coronary angiography within 90 days
Elective volumes and <3 days to angiography was impacted by early resignation of one of our PCI operators who was on a fixed term contract. We will consider weekend sessions if our elective volumes increase between now and when the newly recruited fourth PCI operator starts on the 12 January 2015.
## 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>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 ✓ or a ✗
**Key achievements for month**

**Chest Pain Project** - The pathway has been approved by the Clinical Governance Board and will be rolled out at North Shore on 9 December. Education sessions and finalising the supporting documentation will be completed by the end of November in anticipation of the roll out date.

**Stroke** - Review the admission and discharge criteria for North Shore and Waitakere Stroke Units to ensure consistent best practice across the service by June 2015 – as part of the regular stroke governance meeting there was a presentation from both a geriatrician and allied health practitioners related to the feasibility of collecting data related to help identify discharge opportunities. It was agreed that we should review the opportunities for early supported discharge. The CD Geriatrics will lead a discussion with the key hospital based stakeholders to review and agree the cohort of patients who might be suitable, and for whom we can develop a model of care.

**Other Achievements**

- Both EDs have set up Ebola rooms with support from Infection Control and all staff have had PPE training
- National Speech Language Therapy (SLT) Leaders Forum – Waitemata DHB hosted the national SLT Leaders Forum this year. Feedback from SLTs and their operational managers has been very positive. There was ample opportunity for the sharing of ideas and innovations
- Junior Medical Staff Training - There has been agreement for allied health to train junior doctors to use the electronic whiteboard and therefore utilise an electronic referral process to allied health. The professional clinical lead SLT will be completing the first training in November. She will be training the new junior doctors on 2 elements of the electronic whiteboard as part of their orientation:
  1. Advice on how to read the whiteboard and see at a glance their patient’s status to assist them in improving patient flow. i.e. it will be clear when allied health staff have had a referral actioned, are currently involved in the patient’s care, have declined the referral or have cleared the patient for discharge from their discipline
  2. Information on how to make referrals to allied health staff via the electronic whiteboard or intranet. This will prevent significant delays in referrals being made (we have numerous examples of this happening with delays of up to 5 days). Currently the doctors often write when an onward AH referral is required in the patient’s clinical record notes and expect nurses to action it. Doctors writing their own referrals should also improve the quality (content) of the referrals so that nurses will not need to interpret what is required and why a referral is being made from limited notes.
- **Improving Diabetes Care in West Auckland** - Type 2 diabetes is a serious chronic disease affecting up to 30-45% of the population in certain ethnic groups (Maori and Pacific Island aged over 50 years). Prevalence in the Waitemata catchment is estimated to be around 30,000 and half reside in West Auckland. Morbidity and mortality associated with diabetes is high. At any time 20% of all hospital inpatients have Type 2 diabetes. Diabetes related complications in the form of heart disease, stroke, blindness, renal failure and amputations place huge financial burden on the health service and are largely preventable through early and proactive management of Type 2 diabetes. We know that Maori and Pacific patients, as well as those from lower socioeconomic backgrounds, have poor access to diabetes health care. As a consequence health outcomes are particularly poor in these groups. To try and address this problem, the DHB has been running a quality improvement project aimed at improving diabetes care in west Auckland. The project has involved multiple stake-holders from primary care, secondary care and the northern region diabetes network etc. and more recently has reported to the Alliance Leadership Group. The project has focused on three key areas:
  1. Implementation of the Quality Improvement Team (QIT)
  2. Development of an integrated diabetes model of care - Health New Lynn diabetes clinic: Totara Health Services
  3. Facilitation of network development to support improved diabetes care - Whanau House
Progress to date:

**Implementation of the Quality Improvement Team (QIT)**
The QIT is engaging with 13 GP practices in west Auckland (identified as high needs). The Quality Improvement Coordinator (full-time appointment) is engaging with each practice regularly over 12 months to review diabetes stats and undertake initiatives to improve diabetes care. By focusing on practice derived diabetes stats, emphasis on improving health outcomes for patients is highlighted.

**Development of an integrated diabetes model of care - Health New Lynn diabetes**
The pre-existing satellite clinic from Blockhouse Bay transferred to New Lynn and operates a service every Monday. The co-location of the specialist diabetes nurse and dietitian has resulted in improved support for the practice nurses and GPs leading to improved diabetes care. In addition, a diabetes specialist has visited the practice to undertake CME sessions with local GPs and to review some of Health New Lynn’s patients. Development of this service relies on the specialist team having access to stats for patients with diabetes. This work is in progress.

**Facilitation of network development to support improved diabetes care**
The Maori specialist diabetes nurse and dietitian are holding clinics regularly at Whanau House which have been well received. Similar collaboration is happening with Waipareira and ETHC which should enable greater integrated care.

### Areas off track for month and remedial plans

- The provision of training to all Māori Health Service/He Kamaka Waiora registered staff to be smoking cessation leads with on-going support through the Waitemata DHB Smoke free Team by June 2015 has not commenced due to vacancies, but deliverable is required by June 2015.
- The audit data to inform an action plan (due by October 2014) to identify barriers to thrombolysis and raise the number of eligible patients being thrombolysed will be delayed as the Operations Manager (OM) post has been vacant and the new OM who starts in October will need time to orientate. However a general update has been provided.

### KEY ISSUES/INITIATIVES IDENTIFIED IN COMING MONTHS

- Opportunities will be taken during December and January to close 5 beds at a time at short notice on the North Shore medical wards and offer annual leave to nurses – this is dependent on patient demand being in line with cap plan predictions. We also have a similar plan for Waitakere medical wards.
- There is a regional lung cancer project meeting (project is funded by MoH) planned for late November, this is to review current performance against the cancer indicators and to discuss opportunities in the current model of care that could be improved at both a local and regional level for lung cancer.
- ADU nursing FTE – a review of the ADU nursing requirements using a validated UK tool is nearing completion along with internal work by the Finance Manager on current FTE usage. A business case will be developed and presented to ELT early in 2015 which outlines the FTE required for the current workload in this department.
- General Medicine medical model of care and supporting roster – we have sent data through to Auckland University engineers to begin modeling what a roster might look like. Auckland City Hospital’s General Medicine department took a similar approach to designing their roster options.
- Waitakere Hospital junior medical staff workload – there have been meetings with the CD General Medicine, the Waitakere CL and the operations manager at the request of the medical registrars to discuss their concerns related to workload and patient care with a view to identifying solutions moving forward. This is linked to the roster work and the General Medicine model of care work.
- Complete an evaluation of our winter initiatives - as noted earlier in the report, this is underway.
• We are currently finalising the summer plan
• Continue to develop our clinical metrics with the support of the Quality Team and the Public Health Physician – new Public Health Physician is due to start in December
• Continue to work on our model of care for outpatients/procedures across the majority of medical sub specialties – Cardiology is nearly complete
• Continue to work on SMO job sizing – MHSOA, Respiratory, Haematology and Cardiology
• We are working on our capital and operating expenditure budgets as well as volumes for 2015/16 between now and 24 December 2015
• Hold a workshop with senior clinicians to discuss outpatients and how we want to structure services going forward. This links to both the support booking and scheduling functions as well as how to design an efficient and highly functional clinic space.

OTHER HIGHLIGHTS

Faecal Transplant
There has been considerable media interest recently regarding faecal transplantation. This technique allows the re-colonisation of the gut by healthy bacteria in seriously unwell patients with overgrowth of the disease causing bacterium: clostridium difficile. Inflammation of the gut (colitis) from c. difficile particularly affects frail, older or medically unwell patients who have received antibiotics. C. difficile can be very difficult to treat and hospital stays can be prolonged. Faecal transplantation offers an alternative therapy that can significantly improve the outcomes and duration of illness in this condition. Waitemata DHB began offering this procedure 12 months ago and two patients have received treatment with benefit.

FAST project: managing pain on the medical wards
The final audits have been completed on the pilot ward and the results will be presented at the November Clinical Governance Board meeting. Overall the responses demonstrate an improvement in pain management. Paracetamol is being prescribed as a regular medication 83.3% of the time when required. The incidence of patients who report severe pain has decreased from 68% to 36.6%.

Recommendations from the project and plans for 2015 include the following:
• A staged roll out of education with nurse specialist and nurse educator support through the medical and AT&R wards. Initially there will be in-service education, followed by a workbook and then clinical coaching at the patient bedside. This roll out will commence on 27 January 2015 and be implemented by one ward each week for 13 weeks
• The development of the medical pain study day which includes a patient story and a local case review is planned for 16 December 2014. This will be offered to staff annually to complement our other on line pain management education and learning
• Pain management is being incorporated into the Essentials of Care Project and regular monitoring and improvement will be part of this.

Clinical Imprest Project Ward 5
The environmental changes have been made in Ward 5 to support the new imprest system. This has included new storage shelving and relocating the Pyxis machines. The first order using the new Kan Ban system will be placed on 21 November 2014. We expect this system to reduce stock levels and the time to re-order.

Patient Experience activities in MHOP
The ‘Cleveland Clinic’ video was shown to all MHOP CNMs at their quality meeting in September and has subsequently being shown to the nurses on the medical wards, Cardiology ward, CVU and the ED. We have also provided the link to our Waitemata DHB video to all CNMs so they can share this with their staff.
A 15 step challenge has been arranged across all the MHOP wards. This involves areas ‘pairing up’ to assess one another with a ‘mystery shopper’ – the mystery shopper can be a new staff member / student / consumer who is not known to the staff. We have meetings planned for the 1st and 4th of December when each area will give their feedback and identify any opportunities for improvement. Our Patient Experience Manager will be attending these meetings to assist the teams with identifying specific improvement plans they can implement and evaluate.

### Overview of MHOP Medical Ward projects

<table>
<thead>
<tr>
<th>Ward</th>
<th>Project</th>
<th>Status Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 2</td>
<td>Bedside handover and patient information boards</td>
<td>Handover at bedside after night shift implemented. Audit of patient information boards shows 97% compliance: due to 0700 ward round / handover at patient’s bedside. Bedside handover for 1430 shift start under development</td>
</tr>
<tr>
<td>Ward 3</td>
<td>Protected mealtimes</td>
<td>Completed. After action review to be completed by 8 December</td>
</tr>
<tr>
<td>Ward 5</td>
<td>Protected mealtimes</td>
<td>Completed. After action review to be completed by 8 December</td>
</tr>
<tr>
<td>Ward 6</td>
<td>Discharge planning</td>
<td>Plan to complete repeat telephone audit by the end of November and audit the discharge plan on the new nursing documentation. Anecdotal staff feedback is positive and nurses are managing to see patients prior to discharge</td>
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<tr>
<td>Ward 10</td>
<td>Bedside handover</td>
<td>Completed. After action review planned to be completed by 15 December Currently under way</td>
</tr>
<tr>
<td>Ward 11</td>
<td>Protected mealtimes</td>
<td>Underway. After action review to be completed by 5 December Audit the week of 24 November and results to be discussed at Team meeting week of 8 December 2014</td>
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<tr>
<td>Anawhata</td>
<td>Protected mealtimes</td>
<td>Implemented. After action review 8 December 2014 Identified. Implementation planned for early 2015</td>
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<tr>
<td>Titirangi</td>
<td>Bedside handover</td>
<td>Bedside handover has been implemented: evaluation underway Protected mealtimes implemented Activities for patients are on 15/60 checks, 1:1 checks or in isolation in the planning stage. Implementation planned for 10 December 2014</td>
</tr>
<tr>
<td>Wainamu</td>
<td>Smile and Ask</td>
<td>Completed. After action review planned for 8 December 2014</td>
</tr>
</tbody>
</table>

**E prescribing- Waitakere**

This project has now rolled out to all the adult wards at Waitakere Hospital.

**Ward Clerk Project**

The ward clerk project will get underway at the beginning of December when the working group plan to meet for the first time. The group will ascertain the needs of patients and families and what is required to provide a positive patient and family experience in terms of reception duties, telephone support etc. A stocktake has already been completed to understand the current days and hours of cover provided by the ward clerks across the inpatient wards. Work will be undertaken to establish what is required to improve the patient and family experience from a non-nursing perspective. Three CNMs have been identified to work with GM MHOP, Nursing HOD and ward clerk coordinator on this project.
Financial Results

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<th>CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE</th>
<th>Reporting Date</th>
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<tr>
<td><strong>CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE</strong></td>
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<tr>
<td><strong>MONTH</strong></td>
<td><strong>YEAR TO DATE</strong></td>
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<td>Actual</td>
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<tr>
<td><strong>REVENUE</strong></td>
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<td>Medical &amp; HOPS ($000's)</td>
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<tr>
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<tr>
<td>Other Income</td>
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<tr>
<td>Total Revenue</td>
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<tr>
<td><strong>EXPENDITURE</strong></td>
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<td>Personnel</td>
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<td>Medical</td>
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<tr>
<td>Nursing</td>
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<td>Allied Health</td>
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<td>Support</td>
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<td>Total Personnel</td>
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<td>Other Expenditure</td>
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<td>Outsourced Services</td>
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<td>Clinical Supplies</td>
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<tr>
<td>Infrastructure &amp; Non-Clinical Supplies</td>
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<td>Allocations</td>
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<tr>
<td>NET RESULT</td>
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</table>

**COMMENT ON MAJOR FINANCIAL VARIANCES**

Summary
The key trends of the first quarter continued into October, with Emergency Department (ED) presentations continuing at 109% of contracted volumes (YTD 108%); Acute General Medical WIES at 102% of contract (YTD 109%), and Older Adults AT&R bed days at 129% of contracted volumes (YTD 105%). In ED, additional costs relating to the increased presentations have been incurred in medical and nursing personnel, and also in clinical supplies and some infrastructure expenses such as cleaning. Significant additional revenue ($1,866k including a $277k CEO adjuster) has been received to reimburse the costs related to these additional volumes. In the General Medical and Older Adults wards nursing, including nursing bureau, as well as clinical supplies costs are most affected by the increased workload. The temporary additional measures for seasonal demand such as additional Senior Medical Officer (SMO) afternoon shifts in Assessment and Diagnostic Unit (ADU) mostly ceased in early October. The watches expenditure continues to be above budgeted levels, with overspend of $415k for the year to date.
As noted in September’s report, the cost of orientation of new staff, particularly staff new to the New Zealand health system has been significant. YTD the cost of orientating new RNs other than new graduate nurses has reached $270k.

**Revenue ($3,824k favourable YTD)**

Due to the high acute demand, an additional $1,289k has been received from internal sources for General Medical services (from the Waitemata DHB Funder and Corporate pools), plus a further $300k for increased ED presentations, and a $277k adjuster from the CEO pool.

In addition to this revenue for acute volumes, the Funder has paid $659k for outsourced Gastroscopy procedures (fully offset by costs) and a further $395k for Cardiology elective volumes above contract YTD. This cardiology revenue will gradually reduce over the remainder of the year, anticipated to end the year back at budgeted levels. There was an additional funding of $142k for gratuity and maternity leave costs.

Unbudgeted SLAs for the Needs Assessment and Service Coordination (NASC) have now totalled $102k at YTD October; while the revenue is a favourable variance, the additional staffing and related expenses were budgeted, so are not additional costs for the first 6 months of the year. However, the main component of this has now been extended until the end of the financial year. In this case, the extension of fixed term staffing contracts will result in unbudgeted additional costs as well as a continuum of the additional revenue.

ACC revenue is $210k unfavourable for the year to date. A project has commenced to identify the cause of this significant decrease from the prior year’s achieved revenue level. An additional $200k ($17k per month, $67k YTD October) was assigned as a savings plan for 2014/15 to match last year’s ACC revenue, but booked under outsourced expenditure, so the true shortfall at the end of October is actually $277k.

Research and Drug trial revenue, which is recognised only to fully offset expenses incurred, is $52k favourable to budget YTD; however there are additional costs equivalent to this. Other external revenue includes $31k for increased SMO time oncharged to external agencies, and this is fully offset by an increase in medical staffing costs. A further $55k has been received from other agencies such as NRA and MoH for services provided and ‘buy back’ of Waitemata DHB staff time.

Hyperbaric revenue is $67k favourable for the YTD. We have billed $96k to other DHBs for treatments provided in the prior financial year, plus $15k favourable ACC revenue received. The agreed NHB funding of $1.2m for the 2014/15 financial year is slightly below the $1.3m budgeted.

**Expenditure**

**Medical personnel: ($1,621k unfavourable YTD)**

In line with the high acute demand noted above, the first four months of the year have seen a high number of additional sessions which have been covered by senior medical staff at a cost of $46k YTD, excluding the additional staff rostered to cover the ADU in the afternoons, costing $68k YTD. Junior Medical staff (RMOs) have also worked additional duties to those anticipated based on prior year trends, at an additional cost of $108k YTD.

Significant additional sessions have been paid in ED to ensure sufficient clinical staffing on each shift. At the end of October, the YTD overspend to budget was $482k, excluding a further $40k one-off cost of revaluation on annual leave, a one-off late claim of $40k for allowances earned in prior years and $51k of special leave with pay for senior medical staff.

Annual leave earned not taken was $153k YTD. Medical education entitlements (CME) is significantly over budget by $145k, however $87k of this relates to backdated CME entitlements for newer staff, or increased entitlements to a five year entitlement. The remainder is CME leave earned not taken to date this year.
Due to extended Haematology sick leave, $75k in additional sessions have been paid to ensure service provision continues. Haematology volumes have been maintained above or near to the contracted level with this backfill from existing staff.

Hyperbaric medical expenses are $43k higher than budget, but this is due to cover being budgeted as outsourced locums but performed by Waitemata DHB internal staffing. The outsourced costs therefore show as a significant underspend. The Hyperbaric service is favourable to budget YTD October.

**Nursing: ($1,453k unfavourable YTD)**

Acute inpatient demand plus staff ‘churn’ required $363k of overtime from nursing staff in the first four months of the year. In addition to this, agreed additional staffing in the ADUs to improve patient flow added $65k of costs since being implemented in July and August.

Unbudgeted gratuities for retiring staff have incurred costs of $67k over four months, and maternity leave return payments an additional $115k; in September $142k additional revenue was funded to offset the YTD costs.

MHOPs recently began tracking the costs of orientating new staff, as these staff need to be buddied up with an experienced staff member until they are deemed safe to take on a case load. Orientation time is budgeted for new graduate RNs, but only minimally (circa 1 day per new FTE) for other nurses. After the first four months, $270k of unbudgeted orientation time has been incurred, and this excludes new staff in some of the smaller specialty settings.

Annual leave earned but not yet taken by nursing staff was $402k in the first four months of the year, however, as some wards close beds over summer this should partially recover. One driver of this increase in liabilities relates to high levels of ‘churn’ and short term vacancies arising, as well as outbreaks in some wards: Staff have been unable to take leave due to high inpatient volumes, sick colleagues, the need to buddy up new staff, and backfill temporary vacancies due to maternity leave. A further implication of these staffing shortages is $442k of additional internal bureau staffing used in the four months to date, plus a further $221k of outsourced nursing backfill.

Sick leave has been high in the four months of the financial year; with an average of 7,302 sick leave hours per month across all nursing roles, compared to an average of 6,445 hours for the same period last year.

A $109k favourable variance YTD comes from the internal bureau budget to provide watches being underspent, but the increase in demand for watches over the last two years has continued; these watches are mostly undertaken by external staff, with outsourced nursing expenses for watches currently at $524k overspent to budget.

**Allied Health staff: ($218k favourable YTD)**

Allied Health staff traditionally have a longer time to recruit into vacancies arising due to ‘churn’; there has been an underspend of $377k resulting from the temporary vacancies arising in the first four months to date. This favourable variance include unbudgeted maternity leave return payments of $58k, along with $24k in unbudgeted costs for winter weekend staffing to expedite discharges while there was high demand for inpatients beds.

**Administration staff: ($289k unfavourable YTD)**

As noted above, $121k of the administration overspend relates to ED support roles which have been coded as Administration.

A further $30k of the overspend relates to maternity leave and gratuities which are not budgeted in the services.

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Waitemata DHB, Hospital Advisory Committee Meeting 17/12/2014
There are two additional staff employed than are budgeted for the Medicine Patient Service Centre. These additional staff have cost circa $38k above budgeted levels to the end of October. Bureau administration brought in to assist with the Gastroscopy outsourcing programme added $24k of costs to date.

Penals budgeted for 24/7 ED administration have been at higher levels than budgeted, at an additional cost of $32k to date. (This was a budget error not a change in practice for the ED administration team).

**Outsourced personnel: ($630k unfavourable YTD)**

External nursing bureau at $743k overspent to budget YTD continues to be one of the major variances for the MHOPs division. $524k of this total relates to watches; the volumes of watch shifts have increased significantly over the last few years as a focus is put on completing care plans and ensuring all identified risks such as falls have mitigation plans, such as watches, in place. There is a budget for watches within internal nursing staffing, which is underspent $109.1k at the end of October.

The remaining $221k overspend in external nursing are shifts for backfilling vacancies; the majority of bureau usage will be for unplanned leave cover such as sick leave and bereavement leave.

Medical locums are underspent $90k YTD October. The bulk of this is due to the budget for Hyperbaric 24/7 on call cover initially being assumed as invoiced locum costs. Instead, medical staff from Waitemata DHB are picking up additional allowances and hours to provide this cover, increasing medical costs reported. The Hyperbaric medical expenses are $43k overspent as a result.

**Outsourced services: ($841k unfavourable YTD)**

$747k of the outsourced services overspent is due to Gastroscopy outsourcing; expenses incurred include the procedure ($666k) and the lab testing of biopsies taken ($81k). This outsourcing programme has been funded via additional revenue from the Funder; $659k of additional revenue has been received by the end of October.

NASC respite care is $161k favourable to budget after the first four months. This expenditure traditionally increases over summer.

Bone density testing for the Diabetes service was not correctly budgeted, the costs to date of $54k will continue at a rate of circa $11k per month, and will remain unfavourable.

There are two savings lines within the outsourced services account group; the first for $500k over a full year is to be found though identifying areas where outsourced expenditure may be reduced, or may be assigned to other savings programmes identified. YTD this savings line shows as $167k unfavourable.

The second savings line is $200k tagged as an increase of ACC revenue, with an aim to match the 2013/14 achieved income. All ACC volumes have been significantly decreased YTD compared to last year, with ACC revenue above noted as $210k unfavourable to budget. With the YTD savings of $67k unfavourable added to this, the shortfall in ACC revenue is currently $277k.

**Clinical supplies: ($861k unfavourable YTD)**

Implantable cardiac device (ICD) volumes have led to a significant overspend of $308k on ICD devices in the first four months of this financial year. The Cardiology division has a budget equivalent to circa 7-8 devices per month, but 10-14 implants per month have been the norm to date. This is expected to continue into the next two months, but then volumes are expected to dip over summer.

Acute demand in the general medical and AT&R wards has seen clinical supplies in these areas overspent by $201k YTD. The additional revenue received for acute demand will be offsetting this overspend, as well as staffing. High demand in the ED at both sites has also led to an overspend of $168k on clinical supplies for these areas.
The mobility aids short-term contract ended on 1 October, with the new supplier coming on board. While the October month’s mobility aid expenditure was $11k favourable to budget, the impact of the short term contract leaves these supplies $274k overspent YTD.

PCT drugs are currently $412k underspent to budget over the first four months. Pharmaceuticals are further underspent by another $107k YTD due to a change in the community pharmaceuticals schedule; medications previously billed to the service are now paid by Hospital Ops/Pharmacy. They will have a corresponding overspend.

Renal fluids are currently $93k favourable to budget, this variance is hoped to increase significantly in the coming months as a new contract with lower prices is rolled out.

There is a one-line savings initiative of $1,377k over a full year, intended to be assigned to any identified savings initiatives. This savings line has given a YTD unfavourable variance of $459k. One initiative agreed to reduce respiratory supplies is in place, and this has saved $17k in the first four months.

**Infrastructure and Non Clinical Supplies: ($333k unfavourable YTD)**

Additional cleaning and laundry costs associated with the Norovirus outbreak in September / October resulted in an additional $69k of costs. Additional laundry relating only to high demand in the medical and AT&R wards added a further $11k in costs.

The main driver other than these in non-clinical supplies is a savings target of $500k for the full year, $167k YTD. As with the savings targets in outsourced and clinical supplies; this is a goal for identified savings programmes to be assigned against as they are implemented.

**Progress towards Savings Initiatives:**

MHOPs full year savings target is $4m. Of this total, $1,622k was tagged against known undertakings, the remaining $2,378k was embedded as one-line targets.

In October, $306k of savings has been made YTD through achievement of some of the embedded savings. Areas where these savings have not been achieved include $55k for medical ‘churn’, which has not occurred to date, as well as $67k flagged against the intention to match the prior year’s ACC revenue achievement.

The unembedded savings target YTD October of $793k has been much harder to achieve: one savings plan to hold respiratory supplies usage at recent levels has saved $17k YTD and the full year target of $50k is likely to be achieved.

Despite the significant shortfall to date, MHOPs remain committed to working within our means. The level of service changes required to find savings of this magnitude are requiring careful consideration to ensure no disruption to ongoing operations or patient outcomes.
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 CWFS has exceeded the target for better help for smokers to quit this month as the administrative processes have improved. The gynaecology surgical elective volumes continue the trend of slightly exceeding the target at 106% and this is due to all operating sessions being backfilled for leave. The closure of some sessions over the Christmas and New Year period will assist in bringing this back to target.

The service had an overall result of 96.5% compliance with the 6 hour ED target. The two CDs for Gynaecology and ED continue to monitor this target between the two services. During October, there were 1,129 children under 15 years who presented to the Waitakere Emergency Department and 12 breaches (paediatric) of the ED 6-hour target (98.9% compliance).

Quality
The overall complaint response time for the month has been 21 days for the service. Response times for Child Health and ARDS were within the target of 14 days, however the complexity of a number of complaints in Women’s health has resulted in longer response times.

ARDS continues to focus on consumer experience. The customer questionnaire is now on survey monkey and will be trialled in a fixed clinic early next year.

The customer experience DVD is being progressed by the customer experience manager. Eight families have volunteered to take part. Initial planning has also taken place for a DVD of a ‘patient journey’ through the clinic to be played in the waiting rooms.

Human Resources
Sick leave continues to exceed the target and is due to a number of staff on extended sick leave for accident and illness reasons. A number of staff are on return-to-work programmes which are made up of both some work hours and sick leave.

High annual leave balances are being addressed within services with the expectation that these balances will show a decrease after the Christmas holiday period. SMOs with high leave balances (above 75 days) are each completing a leave plan for the next 12 months.
Service Delivery

Productivity
The percentage of ARDS arrears continues to meet MoH targets. ARDS arrears are 5.8% currently, performing better than the 7% MoH target.

Gynaecology theatre utilisation has improved significantly from last month’s actual of 74% to 84% in October. The utilisation is being monitored closely by the Operations Manager for Women’s Health and the O&G SMOs are asked for an explanation if the target is not met. Theatre utilisation at Waitakere continues to be problematic due to previously stated reasons, in particular the elective caesarean section case which is booked for the end of the gynaecology list and if the woman has recently birthed there is no opportunity to replace the case on the list.

Gateway Assessment Programme
Referrals to the programme have decreased again this month – just 12 referrals were received during October 2014. Year to date, the referrals received are 76% of the anticipated volume. The number of children waiting beyond contracted timeframes has increased to 28 this month. The increase is a result of the continued delay in receiving education profiles and DNAs. Of note, 19 children who are waiting have an assessment scheduled for November 2014.

ESPI Compliance
The service has met ESPI 1, 2 and 5 and the 5 month compliance target. The service has also met the ESPI 2 and 5 four month target as at the end of November. A plan to continue to meet this 4 month target into December and going forward has been undertaken by the service, working closely with the gynaecology Patient Service Centre team and the gynaecology Perioperative Nurse Co-ordinator.

Contract Volumes
Gynaecology elective WIES volumes are above target and this is due to the slight increase in productivity. Maternity WIES volumes are above target and this is due to an increase in the birth volumes for the month and an indication of how busy the maternity facilities have been in October. Gynaecology follow up appointments have risen in October due to an increase in volumes from last month in the Early Pregnancy clinic. There is no definitive number of follow up visits a woman may require following an early pregnancy loss as it is based on clinical need.

Year to date inpatient paediatric medical activity is 26% higher than contracted volumes, but is consistent with 2013/14 volumes for the same period.

Year to date SCBU activity is 7% higher than contracted volumes and is consistent with 2013/14 volumes for the same period.

Year to date paediatric FSAs are 7% lower than contracted volumes, but activity is higher (n=164) than 2013/14 volumes for the same period. It is anticipated that volumes will increase over the summer months.

Year to date paediatric follow ups are 13% higher than contracted volumes, but activity is consistent with 2013/14 volumes for the same period. Of note, there has been a reduction in the contracted volume this financial year.

Year to date total rehabilitation bed activity is 4% lower than contracted volumes.
### Waitemata DHB Monthly Performance Scorecard

**Child Woman and Family Service and Elective Surgical Centre**

**October 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>
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<td>Provider Elective Volumes</td>
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<tr>
<td>Elective Surgical Centre</td>
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<td>Shorter stays in ED</td>
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#### Quality

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<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliant Average Response Time</td>
<td>21.59 days</td>
<td>14 days</td>
</tr>
<tr>
<td>Friends and Family Test</td>
<td>89</td>
<td>65</td>
</tr>
<tr>
<td>HOSQ Markers</td>
<td>82%</td>
<td>70%</td>
</tr>
<tr>
<td>% operations where all 5 parts of surgical checklist used</td>
<td>58%</td>
<td>90%</td>
</tr>
</tbody>
</table>

#### Human Resources

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick Leave Rate (days)</td>
<td>10.80 days</td>
<td>7.5 days</td>
</tr>
<tr>
<td>Overtime Rate (%)</td>
<td>0.9%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Annual Leave Balance &gt; 75 days</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Clinical Employ (FTE)</td>
<td>779 FTE</td>
<td>169 FTE</td>
</tr>
</tbody>
</table>

#### Finance

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual 500s</th>
<th>Target 500s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>43,214</td>
<td>42,384</td>
</tr>
<tr>
<td>Expenses</td>
<td>26,473</td>
<td>26,617</td>
</tr>
<tr>
<td>Personnel Costs</td>
<td>23,123</td>
<td>21,762</td>
</tr>
<tr>
<td>Outsourced Services</td>
<td>2,225</td>
<td>1,179</td>
</tr>
<tr>
<td>Clinical Supply Costs</td>
<td>2,044</td>
<td>1,722</td>
</tr>
<tr>
<td>Non-Clinical Supply Costs</td>
<td>2,029</td>
<td>2,113</td>
</tr>
<tr>
<td>Contribution</td>
<td>12,797</td>
<td>13,988</td>
</tr>
<tr>
<td>Capital Expenditure</td>
<td>164</td>
<td>124</td>
</tr>
</tbody>
</table>

### Service Delivery

#### Productivity

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Health Aims</td>
<td>5.8%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Oral Health Aims (Maxor)</td>
<td>4.4%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Oral Health New Enrolments (Preschool)</td>
<td>14,252</td>
<td>13,107</td>
</tr>
<tr>
<td>Theatre utilisation - Gynaecology</td>
<td>84.6%</td>
<td>95%</td>
</tr>
<tr>
<td>Exclusive inpatient inpatientatre</td>
<td>79.2%</td>
<td>79%</td>
</tr>
<tr>
<td>Births</td>
<td>2,390</td>
<td>2,273</td>
</tr>
</tbody>
</table>

#### Gateway Assessment Programme

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateway referrals waiting over contracted timeframe</td>
<td>28</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Patient Flow

**EXP1 - % of patients waiting longer than 5 months for FMA**

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Papillomavirus</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>EXP2 - % of Patients not treated within 5 months</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

#### Electronic Discharge Summary

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients with SDS on discharge</td>
<td>1</td>
<td>55%</td>
</tr>
</tbody>
</table>

### Contracts

<table>
<thead>
<tr>
<th>Health Targets</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective WES Volumes Gynaecology</td>
<td>809</td>
<td>888</td>
</tr>
<tr>
<td>- Child, Women &amp; Family Services</td>
<td>391</td>
<td>380</td>
</tr>
<tr>
<td>- Elective Surgical Centre</td>
<td>214</td>
<td>208</td>
</tr>
<tr>
<td>WES Volumes Gynaecology</td>
<td>266</td>
<td>382</td>
</tr>
<tr>
<td>Maternity</td>
<td>2,246</td>
<td>2,305</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>725</td>
<td>583</td>
</tr>
<tr>
<td>Neonatal</td>
<td>165</td>
<td>685</td>
</tr>
<tr>
<td>Other Contracted Volumes</td>
<td>666</td>
<td>677</td>
</tr>
<tr>
<td>Non-Care weighted Discharges (YTD)</td>
<td>4,108</td>
<td>4,078</td>
</tr>
<tr>
<td>First specialist Assessment (FMA)</td>
<td>4,304</td>
<td>3,168</td>
</tr>
<tr>
<td>Subsequent Attendance (FPA)</td>
<td>4,264</td>
<td>3,168</td>
</tr>
</tbody>
</table>
**STRICTIC INITIATIVES**

<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:</td>
<td>✓</td>
</tr>
<tr>
<td>o Promoting the Normal Birth project, and</td>
<td>✓</td>
</tr>
<tr>
<td>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**

**Gateway**
- Concerns about the low referral rate continue to be highlighted to the Child, Youth and Family Waitemata DHB, Hospital Advisory Committee Meeting 17/12/2014
regional management team. Despite the actions taken to date, there has not been a sustained increase in referrals to the programme.

**Reducing DNAs in Paediatrics**
- Patient focused booking has been fully implemented. Issues are being identified and are continuing to be addressed
- A meeting has been held with the Fono to discuss the factors that are impacting on DNAs and to identify solutions to support clinic attendance. It has been agreed that Paediatrics will trial delivering a clinic from the Fono from February 2015.

**Improving the collection and reporting of consumer satisfaction survey**
- The friends and family test is now operational in the Rangatira ward and SCBU
- A consumer satisfaction survey has been sent to families accessing the Child Rehabilitation Service under the ACC contract. There has been a high return rate and the feedback indicates that families are extremely satisfied with the services provided
- The Child Health consumer advisor has developed a consumer satisfaction survey using Survey Monkey for families accessing the community child health services. This system will replace the existing paper based survey, which traditionally has had a very low response rate
- The service has identified three families who are willing to have their experience with Child Health services recorded. The timeframe for filming is being negotiated with the patient experience team.

**OTHER HIGHLIGHTS**

**Te Aka Oranga Wahakura Waikawa Wananga**
This was held in the Waitakere Hospital Marae on 17 October. Four master weavers and Maori providers that are involved with maternity or early childhood were invited along with Maori hapu mammas. Nine wahakura were woven and education messages were interwoven throughout the day. Feedback was highly positive and a successful template was developed on which to base the next Wananga on the North Shore in 2015.

**Local implementation of national maternity referral guidelines**
This has been a significant piece of work undertaken by the community liaison midwives and quality midwife to develop a document to ensure secondary services work in partnership with primary care. It provides local recommendations on when to refer and the screening tests or treatments recommended. Focus is on women having the right care at the right time. The resource is available for GPs and LMCs and will be published on Healthpoint.

**Kanban Clinical Supplies System**
The Kanban system for ordering clinical supplies has been fully implemented in the maternity facility at Waitakere. The ordering of supplies is now less time consuming, more efficient and reduces the over-ordering of supplies. The feedback from staff and LMCs has been extremely positive.

**SMO Leadership Day (paediatrics)**
A successful leadership day has been held with the paediatricians working in Child Health Services. The day focused on team building and values based leadership. Attendance and participation was excellent. A further day has been tentatively scheduled for March 2015. This will build on the work undertaken and focus on specific service improvement opportunities (e.g. care co-ordination and vulnerable families; acute paediatric care; supporting primary care and interface with tertiary services).
**Integrated Community Child Health Teams**
There has been agreement that the development of a ‘virtual’ integrated community child health and disability team will be trialled in New Lynn. This involves clinicians from Home Care for Kids, Paediatrics, the Child Development Service and the Child and Family Service working together to improve co-ordination, care planning and outcomes for children and families residing in the New Lynn (and surrounding suburbs) area.

The clinicians have decided to meet monthly to discuss referrals, complex cases and vulnerable families. They will be focusing on identifying opportunities to improve co-ordination and patient experience.

The progress of the initiative is being overseen by a representative working group and opportunities to roll out the model across other parts of the district will be identified.

**Ranui Caravan Park Initiative**
The additional public health nursing time (8hrs per week) allocated to the park has been operationalised this month. The number of referrals being received at this point in time is manageable, but the complexity of the health and social issues facing residents is significant. Many issues are intergenerational and will require time and a collaborative approach to improve outcomes. There are large numbers of Maori in the park, many of them families with extended whanau living with them. Drugs and alcohol, mental health and family violence issues are widespread and there are many residents who report they are smoking synthetic drugs.

Tasks completed this month include:
- Meeting with the owners and managers to discuss the initiative and gain consent for an increased presence in the park.
- Welcome packs have been developed for all new residents. These include basic hygiene products and information about health and community services available locally.
- Leaflets have been circulated to all residents about the availability of the public health nurse
- Regular visits have been established with the mobile van. This enables residents to meet with staff in a confidential, appropriate space.

**Violence Intervention Programme**
The ViP programme is maintaining core training and the Child Protection Alert process. Debbie Fielding has been appointed to the ViP coordinator role and starts 19 January. Interviews took place for the CP role but no suitable candidate was found. It has been decided to reconfigure the role slightly, increase to 1.0 FTE in order to ‘future proof’ the role in view of Children’s Teams, vulnerable families work etc.

The White Ribbon Day march was held on Friday 28 November.

**Auckland Regional Dental Service**

**Digital Radiography (DR)**
The DR pilot is currently being evaluated. Anecdotally the feedback is positive. An alternate digital machine is to be trialled within the next four weeks, prior to purchasing more of the currently used scanex machines. This may provide better images and negate the requirement of a computer for each machine which could save costs. The thirteen machines that are available are being operationalised to the plan.

**Scanning Process**
Scanning of enrolment documentation has been rolled out across the service. All new enrolment forms are scanned at data entry. All documents for children seen in mobile facilities have been scanned to
ensure they are available to clinicians on site. This has addressed the clinical risks that existed with the paper system where clinicians did not have access to the enrolment form.

ARDS Appointment management system project
Appointments are provided for 270,000 children across 84 clinics. Children are seen 6, 12 or 18 monthly depending on their risk status. Currently appointments are booked through a variety of methods, via letter with an appointment, via letter requesting the parent contact for an appointment or by telephone. To book or change appointments parents are asked to call a specific clinic. Given the work flow in the clinics, it is often difficult for parents to call through to book or change appointments (this has been highlighted in a number of complaints). If staff do answer the phone, it will often take them away from providing direct care to patients. To understand the current system and identify issues and frustrations, a project has been scoped in alliance with the quality team. Once a clear understanding has been reached, ARDS can start to address the issues and look for solutions.

Preschool Focus
ARDS has been focusing on the early enrolment of children. Ideally children are seen between 9 months and 1 year of age. In Waitemata, a preschool coordinator has been visiting the postnatal wards at Waitakere and North Shore hospitals since the end of 2011, to speak with new mothers and enrol their babies and any siblings that are not enrolled. The chart below demonstrates the improvement in early enrolment since this initiative started and comparison with the Auckland district where the same system is not in place.

The Well Child Book now contains a transfer of care form for LMCs to complete and send to the Well Child Provider, the GP and Oral Health. These are being used by some LMCs and once embedded will help the early enrolment of children across these areas.
Financial Results

COMMENT ON MAJOR FINANCIAL VARIANCES

Revenue ($998k favourable Year To Date)
Government and Crown Agency favourable funding of $841k for year to date reflects the greater demand and higher acuity across inpatient services. All services are tracking above ytd plan with Paediatrics the highest at 126% of budgeted beds. More recently Paediatric numbers are showing signs of returning back to normal levels after a busy winter period. In funding terms this additional activity amounts to a $583k favourable WDHB funder allocated revenue position. $75k of additional revenue has also been received from other funders such as ACC and the National Screening Unit. Invoicing to Counties Manukau DHB for costs associated with maintaining fixed dental clinics and transportable dental units amounts to $100k year to date.

Other income also tracks favourably $157k for year to date Oct 14. The main features of this result are Northern Regional Alliance funding ($69k) and University of Technology Bachelor of Health Science student training for the 2014 year ($46k).

Waitemata DHB, Hospital Advisory Committee Meeting 17/12/2014
Expenditure

Medical Personnel ($114k favourable Year To Date)
The main driver behind the $114k medical cost under spend continues to be the 3 FTE vacant positions within Women’s and Child Services. Outsourced locum cover is being used to support gaps in rostered activity while the services progress with planned recruitment during quarter 2.

Partially offsetting these underspends is the funded cost of additional medical staff rostered on during weekends to help combat Waitakere ED Paediatric breaches ($41k). There has been a notable reduction in the need for these additional rostered shifts in October. There is also an initiative in place for 2014/15 to reduce spending on allowances of $110k to date in Paediatrics.

Nursing ($520k unfavourable Year To Date)
High Nursing costs are being driven predominately by funded acute activity within Paediatrics (126% of planned bed days) and SCBU (107%) together contributing $297k of additional cost during the busy winter period. Paediatric inpatient activity is showing signs of reducing back to normal levels which will allow more effective annual leave management in the remainder of the year. Maternity Services are also experiencing high demand (108% of planned bed days) which is the main cause of a $126k overspend to date. Maternity inpatient volumes are expected to remain high in the short term. The overall Nursing annual leave accrued to taken rate stands at $65k unfavourable year to date.

Allied Health ($779k unfavourable Year To Date)
Allied Health staffing costs overruns are predominately being driven by lower than anticipated turnover of Dental therapists ($421k) and unmet savings initiatives ($181k). High annual leave costs have also adversely impacted the result by $171k. This will reduce over the December/January period with the closure of dental clinics.

Low Child Health service annual leave has also contributed $186k to the overspend. These staff also typically take leave over the Christmas/New Year holiday period so we will see an improved result in this area over the coming months. Unexpected gratuity payments incurred during the first quarter amount to $39k.

Management/Administration ($147k unfavourable Year To Date)
Management/Admin costs continue to be high with overspending of $147k year to date. Recently identified staff miscoding is having a significant impact on this result. Staff will be recoded to their appropriate Allied Health professional groups and an improved financial position will eventuate. In addition to this are unanticipated gratuities payments of $22k and savings initiatives $33k that also feature in the ongoing cost pressures within this staffing group.

Other Expenditure Costs ($273k unfavourable Year To Date)
Other expenditure cost increases $273k year to date relate predominately to Clinical supplies $321k driven by significant volume increases and higher acuity levels across the group during the first quarter. Treatment disposable costs $206k such as sterilising consumables, protective clothing and dressings along with ambulance and unbudgeted air ambulance costs account for a large part of this elevated spend. Savings initiatives aligned with clinical supplies amount to $99k year to date. Partial offsets are evident in non-clinical supplies such as transportation costs $85k due to underspending in Transportable Dental Unit registration and maintenance costs $74k year to date. As previously reported the service is progressing with a change in the supplier of dental gloves and other commonly used clinical products. This change is expected to yield further savings in the vicinity of $130k.

Outsourced costs for year to date October continue to be overspent. These costs are being driven by high use of locum cover, costs that are being offset by SMO vacancies. This will change when SMO positions are filled in the new year.
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 Ian McKenzie with Clinical Director Murray Patton for Mental Health and Clinical Director Forensic Services, Jeremy Skipworth.

SCORECARD

Health Targets
Both the Better Help for Smokers to Quit and Shorter Waits in ED health targets were met this month.

Service Delivery
Adult Inpatient Unit Occupancy Rate and Length of Stay
The adult occupancy rate reduced in October as has the average length of stay. The occupancy rate is 93% (target 85%) and length of stay has decreased to 21 days.

Koromiko House (Adult respite North Shore – 7 beds)
The occupancy rate at Koromiko House for the month of October was 85%, a total of 184 bed nights were occupied out of a possible 217.

Piri Pono (Adult Community Acute Residential Service – 5 beds)
The bed occupancy rate for Piri Pono is 95% for the month of October. The occupancy rate remains the same as last month. A total of 148 bed nights were used of the available 155 bed nights.

Te Kotuku Ki Te Rangi (Adult Respite West Auckland – 6 beds)
The bed occupancy rate for Te Kotuku Ki Te Rangi was 52%. A total of 95 bed nights were used of the available 186 bed nights.
# Waitemata DHB Monthly Performance Scorecard

## Mental Health Service

**October 2014**

### Priority One

**Health Targets**
- Better help for smokers to quit: Actual 100% vs Target 95%
- Shorter Waits in ED: Actual 83% vs Target 80%

### Quality

**Quality Indicators**
- Complaint Average Response Time: Actual 17 days vs Target 14 days
- Sequestration: Actual 34 vs Target 14
- Sequestration Adult - episodes: Actual 13 vs Target 3

**Mental Contacts per service user (community only)**
- Adults: Actual 65% vs Target 70%
- Child: Actual 100% vs Target 80%
- Youth: Actual 100% vs Target 80%

**Acute Readmission Rates within 28 days (reported one month behind)**
- Adults: Actual 1.8% vs Target 10.0%
- CADS: Actual 2.0% vs Target 5.0%

### Human Resources

**HR Wellbeing**
- Sick Leave Rate (days): Actual 9.1 days vs Target 7.5 days
- Overtime Rate (%): Actual 3.5% vs Target 3.0%
- Annual Leave Balance + 75 days: Actual 9.0 vs Target 9.0
- Turnover Rate %: Actual 8.1% vs Target 10.0%
- Clinical Employ (FTE): Actual 1,093 FTE vs Target 1,093 FTE

### Finance

**Financial Result YTD**
- Actual $: 52,686 vs Target $: 31,764
- Revenue: Actual $: 41,427 vs Target $: 41,034
- Expenses: Actual $: 36,762 vs Target $: 37,222
- Personnel Costs: Actual $: 677 vs Target $: 379
- Clinical Supply Costs: Actual $: 451 vs Target $: 307
- Non-Clinical Supply Costs: Actual $: 3,517 vs Target $: 2,720
- Contribution: Actual $: 11,205 vs Target $: 10,720
- Capital Expenditure: Actual $: 85 vs Target $: 30

**Financial YTD Distinct Clients with open referral**
- Inpatient Adults: Actual 158 vs Target 337
- Inpatient CABS: Actual 179 vs Target 160
- Inpatient Forensics: Actual 149 vs Target 141
- Outpatient Adults: Actual 454 vs Target 427
- Outpatient CABS: Actual 170 vs Target 166
- Outpatient Forensics: Actual 119 vs Target 111
- Outpatient Youth: Actual 2,238 vs Target 1,884
- Outpatient CADS: Actual 9,163 vs Target 5,317
- Outpatient Forensics: Actual 1,665 vs Target 1,223

**New referrals during the month**
- Inpatient Adults: Actual 99 vs Target 108
- Inpatient CABS: Actual 53 vs Target 46
- Inpatient Forensics: Actual 13 vs Target 16
- Outpatient Adults: Actual 823 vs Target 762
- Outpatient CABS: Actual 16 vs Target 10
- Outpatient Forensics: Actual 12 vs Target 18
- Outpatient Youth: Actual 303 vs Target 244
- Outpatient CADS: Actual 1,190 vs Target 1,190
- Outpatient Forensics: Actual 232 vs Target 218

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**How to read**

Indicator Title: 85% vs 100% vs Actual vs DHB Performance vs Target

- Improvement against previous result: DHB performance achieving or above the target will display as 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>✓</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>On-going</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>On-going</td>
</tr>
<tr>
<td>7</td>
<td>Integrate HONOS data into clinical pathways across adult services by June 2015</td>
<td>On-going</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>✓</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>On-going</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>✓</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>On-going</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>✓</td>
</tr>
<tr>
<td></td>
<td>Implement relevant responses to Rising to the Challenge (eg. Children of Parents with Mental Illness or Addictions (COPMIA)), and Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand - on-going</td>
<td>✓</td>
</tr>
</tbody>
</table>

* include a ✓ or a ×
Key achievements for month

<table>
<thead>
<tr>
<th>He Puna Waiora</th>
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<tbody>
<tr>
<td>Robert Cunningham Construction have submitted a draft programme, showing early completion for approximately 50% of the building. Early completion would enable access for the delivery of furniture, the installation of fittings, equipment and staff orientation. The programme for completion of the second half of the building is being finalised and Robert Cunningham Construction will be able advise whether they can claw back any of the current 20 days extension of contract.</td>
</tr>
</tbody>
</table>

The Operations Manager Adult MHS, Clinical Specialist and a Communications Department representative visited Carmel Collage to view He Puna Waiora from Carmel College’s classrooms. Classrooms can see directly into the male bedroom wings of the unit. The project team will investigate a range of window finishing and landscape options for both wings.

Council building consent has been obtained for the renal link. A variation request for the renal link has been escalated to the CFO, with a business paper being presented at the November Audit and Finance Committee meeting. The Lamson Tube is dependent on the final decision on the renal link, as the tube is planned to go through the link.

<table>
<thead>
<tr>
<th>Regional Forensic Psychiatry Services (RFPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Following the Board approval of a new 15 bed unit to be built on the Mason Clinic site, the announcement was recently made to staff and other stakeholders. The decision was well received and the announcement enables the planned Remedial Works programme to begin in earnest in early 2015.</td>
</tr>
</tbody>
</table>

National Forensic Key Performance Indicator project: a template of forensic KPIs is to be completed within the next week to be followed by data collection across the country. The first forensic benchmarking forum will take place in early 2015.

<table>
<thead>
<tr>
<th>Community Alcohol and Drug Services (CADS)</th>
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<tbody>
<tr>
<td>CADS is funded through a Ministry of Health contract to provide services to the courts and received 152 referrals from the Auckland and Henderson District Courts for drug court assessments in the 12 months to October 2014. This was a 23% reduction in the volume of referrals compared to the previous 12 months. The Drug Courts operated close to capacity and the drop of referrals did not affect the regular operations of the Drug Courts. The reduction is regularly discussed at the AODTC Steering Group with the Drug Court judges and the participating NGOs. CADS continued to provide regular group interventions for drug court participants awaiting release to NGO residential treatment programmes in the community.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maori Mental Health and Addiction services</th>
</tr>
</thead>
<tbody>
<tr>
<td>There has been increased attendance of tangata whai i te ora (Maori service users) at Hotaka Hauora which is a programme that helps people to strengthen knowledge of Maori cultural values, concepts and ie hinengaro (mental awareness). The service has commenced the adoption of the Takarangi Competency Framework – the development of cultural evidence based portfolios by Taurawhiri (cultural workers) for both mental health and addictions staff. Two day training will commence in November and continue into 2015.</td>
</tr>
</tbody>
</table>

The Service Delivery Pathway for Moko Services and Te Atea Marino is progressing, with consultation and feedback now being received from operational staff and other stakeholders. This will give increased clarity to the tangata whai i te ora pathway through our services. Moko Services (North) is actively engaging with Te Puna Hauora (North Shore) including holding monthly meetings with Community Support Workers. Shaping our Values sessions are occurring within the service. These are 60 minutes sessions with staff, tangata whai i te ora and other stakeholders.
OTHER HIGHLIGHTS
Community Alcohol and Drug Services (CADS)

Methamphetamine consumption and use remains high in New Zealand. The Global Drug Survey (2014) had a sample of 5,731 New Zealand participants, with 4.9% of them indicating they had used an amphetamine-type stimulant in the past 12 months. In the 2013 New Zealand Arrestee Drug Use Monitoring System (NZADUM) survey, 50% of the police detainees had tried methamphetamine in their lifetimes, 30% had used it in the past year and 19% had used it in the past month. Detainees in Auckland Central were more likely to have recently used methamphetamine than those in Christchurch Central and Whangarei.

CADS were contracted by the Ministry of Health to provide specialist clinical methamphetamine interventions between 1 March 2010 and 30 June 2012 as part of the Government’s Methamphetamine Action Plan. The service has continued to provide these interventions since as part of CADS’ generic service clinical pathways. The services were asked by the Ministry of Health to report on the volume of clients they treated with a methamphetamine related diagnosis in 2013/14 as part of the evaluation of the Action Plan.

Between 1 July 2013 to 30 June 2014, 1,203 individual CADS clients were diagnosed with methamphetamine abuse or dependence. Of these, 61% were male and 39% female; 5% were under the age of 21, 70% aged 21 to 40 and 24% aged 40 and older; 61% were European, 25% Maori, 9% Pacific, 5% other (including Asian) and 23% lived in an area with a Deprivation Index of 1-4, 31% within a Deprivation Index area of 5-7 and 45% within a Deprivation Index area of 8-10. This demographic profile is similar to the profile of the overall client cohort of the services (14,847 individual clients). Methamphetamine abuse or dependence was recorded in 9.4% of all treatment episodes delivered during the period. Ninety-seven per cent of interventions were delivered in the community. Only 3% required hospitalisation for detoxification. Treatment was integrated with standard service clinical pathways. The majority of the cohort resided in the poorer localities in Auckland and faced significant socio economic challenges in addition to overcoming their substance abuse and dependence.

Takanga a Fohe

Ava Ceremony: A traditional Samoan ritual was held to welcome new General Manager Ian McKenzie. Charles Joe, the new acting manager for Whitiki Maurea was also welcomed.

Malu I Kainga (Family event): This was an evening event for significant others funded via a gambling problems contract with CMDHB. Evaluations were completed for 55 attendees that were highly positive and provided some ideas for future events. There were also 42 gambling screens completed. Twelve children aged 3-10 participated in developmentally appropriate COPMIA (Children of parents with mental illness and addictions) activities in a separate room. Most Tupu (AOD) staff were involved including the consumer advisor, family advisors and the manager. Speakers also included the Police. The Takanga a Fohe band provided entertainment. Feedback included: “Always good to hear the stories of others who can give insight to other/similar experiences. Is enlightening and encouraging, good to also know about services that support.” “We were invited along to listen and glad we did. Weren’t aware of the services available to those who are in this situation. We know of some people who are experiencing problems and can now refer which is very cool.”

WDHB Inaugural Pasifika Health Week

Several Takanga a Fohe staff were involved in this. It was led by the Pacific Health Team and supported by the Chief Executive, Dale Bramley. The emphasis was on identifying and celebrating the Pasifika workforce in Waitemata, including orderlies, support staff, clinicians and managers. The many activities included: decorating foyers with Pasifika items, hosting a women’s group with Well Foundation Board member Beatrice Faumuina speaking. This was organised by the Takanga a Fohe Service Manager, Epenesa Olo-Waanga. The Mason Clinic was also recognised with Tagaloa (Pacific service) hosting events including a ‘Men’s’ event with a current service user as the keynote speaker. Most of the activities took place in the Waitakere district - given the locality of the workforce. Future Pacifika weeks are planned.
Waitemata DHB Coexisting Problems (CEP) Project

The workforce centre for addictions (Matua Raki) is providing training in December to CEP Champions across the DHB. A modular package on motivational enhancement is being developed for mental health teams to focus on skill-based interventions. The training will begin within one of the adult teams in January 2014.

Isa Lei and Tupu are currently implementing CEP (mental health and addictions) training in their in-service meetings and are focusing on building foundation knowledge.

Nursing

2014 New Entry to Speciality Practice (NESP) - the class graduated earlier this month, with 15 of the 16 new graduate nurses finishing the programme, one will complete the second semester in 2015. 14 have remained in Waitemata DHB employment. We are currently recruiting to 16 positions for the 2015 cohort.

KEY ISSUES/INITIATIVES IDENTIFIED IN COMING MONTHS

Marinoto North Capacity Issues

Both Marinoto North and West have experienced notable increases in referrals between the year ending September 2012 up to year ending September 2014. Specifically: an increase of 675 referrals or 63.5% for Marinoto North and 287 or 29.5% for the West.

In view of the rapidly increasing demand (particularly in the North Rodney area), the Child, Youth and Family Portfolio in partnership with the service has undertaken a project to review the population spread, growth, anticipated growth and resource allocation. We are currently awaiting the release of population data from the 2013 census, due in February 2015.

Service leaders recently met with the Marinoto North staff to discuss workload pressures. The service has responded with a range of short and medium term remedial actions including a pro-active recruitment campaign. Staff were made aware of the review of population spread, growth, increased demand and resource allocation. Staff have also been offered support where appropriate. Service level changes have been put in place to better manage workload and include the utilisation of external community resources (HealthWEST). These arrangements are reviewed on a weekly basis by the Marinoto North Team Manager, the Operations Manager and the Service Clinical Director.

Facilities

Community Alcohol and Drug Services (CADS)

The current lease for CADS Mt Eden will expire in June 2015. A staff and client consultation is underway to review options for a new location for the service. Under consideration are moving the service to CADS Pitman House (Pt. Chevalier) or CADS Central (Kingsland). The service treated 446 new clients in 2013/14 through its abstinence based 12 Step facilitation programmes.

Psych Liaison Service

Planning work continues with facilities to enable the Psychiatric Liaison Service to move to its new location in 2015. The staff and service are ready for this move and only require the building alterations to be completed.
Financial Results

COMMENT ON MAJOR FINANCIAL VARIANCES

Revenue ($922k favourable YTD)
The favourable revenue result is driven by an establishment fund for a new infant and perinatal service held by WDHB on behalf of the region ($438k), contracts signed after the budget was set ($252k) and Forensic court reports ($221k). The court report variance is driven by an unbudgeted price increase and volume. All of these contracts come with additional cost.

Personnel ($440k favourable YTD)
The positive variance to budget of $504k on Medical staff for the year to date is a result of four key items. The first item being, better coverage on the registrar on-call roster ($96k). Secondly, an accrual for SMO job-sizing was reduced by $96k as a number of staff either left the DHB before signing a revised job-sized agreement or settled at a lower level than the job-size offered. Thirdly, annual leave taken was greater than annual leave accrued for the year to date by approximately $89k. The remainder of the variance is a consequence of vacancies. Adult MHS have employed a locum psychiatrist paid for via outsourced services to cover a vacancy in the psychiatric liaison service costing $122k for the year to date.
The favourable Nursing result of $23k against budget is driven by vacancies held across the group. The positive financial impact of vacancies is reduced because of high patient acuity, particularly on the Forensics inpatient units which has meant that staffing numbers per shift have increased, $20k of unbudgeted maternity leave payments and annual leave taken being less than earned by $62k.

The positive impact of vacancies is also masked in Allied Health by unbudgeted maternity leave payments of $20k and annual leave taken being less than earned by $139k. The majority of Allied Health positions are not backfilled with additional cover when taking annual leave, so we would expect this variance to reduce over the holiday season.

Spend on Support personnel is favourable to budget by $22k due to a vacancy in the Forensic multi-skilled worker team. This position is in the process of being filled.

$10k of unbudgeted Management/Admin 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. The remainder of the negative result is due to an unfavourable price variance arising as a result of staff employed being more expensive than budgeted.

**Other Direct Costs ($834k unfavourable YTD)**

Spend against Outsourced Services is unfavourable by $99k due to use of outsourced personnel used to cover vacancies ($135k) and court reports completed by outsourced medical staff. The court reports are fully funded by revenue. Within the outsourced account group there is also a savings line of $33k for the year to date which represents a fully achieved savings target for revenue generation. The unfavourable variances referred to above mask an underspend against budget of $75k on Forensic step down beds.

Clinical Supplies is favourable to budget by $56k for the year to date due to underspends against Adult and Forensic flexi-funds.

Infrastructure and non-clinical supply costs are unfavourable to budget by $791k. Of the $791k variance, $458k is fully financed by additional revenue from Janssen Cilag for an extension to the relapse in psychosis project ($30k) and a MoH regional establishment fund for a new infant and perinatal service ($428k). $48k of additional operational costs have been incurred for prior year rental contracts. The group are overspent on electricity by $73k because of a 7% price increase agreed after the budget was set, a low accrual for four months of outstanding invoices (three of which were relating to the previous financial year), seasonality and a duplicate electricity invoice equating to $64k received in September. Contact Energy will reduce bills going forward to account for this overpayment, it is expected that the overspend will reduce over the next two months as a consequence. The remainder of the variance includes overspends on outsourced maintenance ($42k), security services ($30k), staff travel ($18k), taxis ($16k), minor purchases ($79k) and one off costs for two HR reports ($24k).
Elective Surgical Centre (ESC)

Service Overview
This 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 Dr John Cullen and it is managed by Mark Watson.

Scorecard

Service Delivery
Points of interest for October:
• Continued over-delivery of patient volumes
• Review of patient information tools for ESC
• On-going inventory/procurement review
• Registrar training
• Presentation to NZ Health Design Council

Elective Surgery Volumes
Volumes for October were slightly lower than September, due to the public holiday, however still well ahead of budgeted volumes for the month and the current financial year. The current over-delivery has been required to mitigate the risk of ESPI non-compliance in the first part of the financial year. Work is underway to manage the volume levels for the latter part of the financial year, as well as maintain ESPI compliance.

The two graphs below show the monthly breakdown of patient volumes, per specialty and a weekly comparison of budgeted procedure volumes against actuals.
For October, ESC treated 448 patients and of this overall number, ESC reported 427 of them to the Ministry of Health. Year to date, the total reportable volumes to the Ministry have been 1,735, which is 114% of expected budgeted volumes. There have also been a total of 82 patients year to date, who are non-reportable patients consisting of ACC/IDF/acute arranged procedures.

The graph below indicates the overall patient volumes alongside the average WIES. We are budgeted at an average WIES of 1.5 and currently sit at 1.4.

Session Utilisation/Start & Finish Times
During October the percentage of theatre sessions undertaken was 99% of the planned session schedule. The monthly utilisation of the actual theatre time used in each of these sessions improved in October, reaching 87% between all specialties, with the average length of stay remaining at two days. The graph below represents the utilisation of the actual operating sessions by specialty.

Review of Patient Information Tools
We are currently undertaking a review of key patient information and are working closely with the DHB Communications Team to provide a specific web page for ESC that we can direct our patients to, pre-operatively, for information that will help them prepare adequately for their surgery. We have also upgraded the information on the Healthpoint website and we are now looking at ways in which we can use social media to collate patient feedback from ESC patients. We are collecting 50+ written compliments from our inpatients every month and they are extremely positive, so we need to make these available to provide future patients with some patient experience information. We will make some screenshots of the final outcome available in future reports.

On-going Inventory/Procurement Review
The Health Alliance team have been working with the ESC team to consolidate the management of the stock in ESC, to ensure we only have stock on hand that is required, reducing any overstocking of items and associated costs. Regular meetings are in place reviewing data that now shows us the minimum and maximum levels of stock
items and where we are holding too much stock. Because of this, the overstocking levels are significantly reducing.

**Registrar Training Update**

Additional registrar training has continued under the oversight of Prof. Pat Alley and Helen Olsen, Project Manager. Consultants and registrars have received confirmation of exactly what can and can’t be done, in terms of registrar training within ESC. In addition to this, there have been a number of directly supervised training lists, involving one registrar and the consultant undertaking a standard ESC elective list. This has been predominantly in orthopaedic, urology and general surgery services and it has not affected productivity. In addition, there have been more formalised theoretical sessions, followed by a simulation session, concluding with the registrars observing the actual procedure being performed by the consultant in the operating theatre. This involves the registrars watching the procedure from our ESC Seminar Room, via a live audio-visual link allowing direct communication with the surgeon during the case. The pictures show the last orthopaedic session with Mr Ali Bayan.

(Pictured above) Boom mounted camera system allowing unrestricted access to film the external aspects of the surgical site.

(Pictured above) Operating monitor allowing the camera controller (staff member) to see what the image looks like to the on-looking registrars upstairs (pictured below)
Presentation on the design of ESC to NZHDC

Mark Watson was asked by Jasmax Architects to present to the NZ Health Design Committee, highlighting the operational aspects of the ESC and its design. The committee was made up of all the key architects from around the country, who meet every quarter to discuss specific projects in health. This was a good opportunity to continue sending out the very positive message of the ESC’s success and how the design of the facility has allowed for operational productivity and efficiency gains. The discussion was very well received by the committee.

Scorecard
**STRATEGIC INITIATIVES**

<table>
<thead>
<tr>
<th>Deliverable /Action</th>
<th>✓</th>
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<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>
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<table>
<thead>
<tr>
<th>Key achievements for month:</th>
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<tbody>
<tr>
<td>• Continued over-delivery of patient volumes</td>
</tr>
<tr>
<td>• Review of patient information tools for ESC</td>
</tr>
<tr>
<td>• On-going Inventory/Procurement review</td>
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<tr>
<td>• Registrar Training</td>
</tr>
<tr>
<td>• Presentation to NZ Health Design Council</td>
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<table>
<thead>
<tr>
<th>Areas off track for month and remedial plans:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Significant over-delivery to date, requiring close management of volumes</td>
</tr>
<tr>
<td>through the second part of the financial year</td>
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**KEY ISSUES/INITIATIVES IDENTIFIED IN COMING MONTHS**

**ESC Patient Bookings**

We are in discussion with S&AS to commence a trial of booking ESC lists to predetermined surgeon ‘templates’. The ESC Perioperative Nurse Coordinators (PNCs) would select the patients from the waitlist and the ESC administrator would then book them directly to the operating list. This trial is to enable the ESC to book its own patients, as opposed to the S&AS Patient Service Centre team undertaking this role, as they do currently.

**Specialty Split**

Currently, the ESC and funder has agreed to a specialty split of General Surgery 47%, Orthopaedic surgery 31%, Gynaecology 13% and Urology 9%. In addition to this, average WIES, per specialty, has been set by the funder. For 2015/16, this needs to be reviewed and expectations based on the 2014/15 actual data. It is possible that ESC would be able to cater for 50% of the overall DHB elective volume and this could be provided through a different specialty split, taking into account those patients best suited to the ESC and those patients’ best suited to S&AS. A natural split would be focused more around Orthopaedics, Gynaecology, Urology, ORL and breast cancer/benign colorectal General Surgical work. More work needs to be done regarding the exact split, but it is clear that we would be able to operate on an increased volume of patients in 2015/16.
Financial Results

COMMENT ON MAJOR FINANCIAL VARIANCES

(ESC = Elective Surgery Centre; S&AS = Surgical and Ambulatory Services)

Revenue ($796k favourable YTD)
Revenue was favourable for the month ($316k F) as overall patient throughput was well ahead of the standard phased production plan (114%) whilst wies was at 104%, and year to date equivalents at 113% (cases) and 101% (wies) respectively. IDF revenue flows have also been solid with year to date revenue now at $115k (nil budgeted); and acute revenue of $151k (nil budgeted). During the month there was a significant recoding of previously classified elective cases being recoded as acute and this drove the additional acute gains of $111k for the month (with a commensurate offset in S&AS acute revenue). ACC Revenue is $4k unfavourable for the month as a $100k provision has been made to offset duplicated revenue across ACC/Elective wies for ACC cases that have been classified as elective discharges in the patient management system (ie these cases have been counted as ACC revenue and elective discharges as at the end of October with ongoing work). The year to date position for ACC revenue is still $153k favourable. There was also $50k revenue recognised for the MOH funded...
research project into alternative junior doctor training approaches that has been running over the past six months.

**Expenditure**

**Nursing: ($28k unfavourable YTD)**
The Medical budget line is actually for Health Care Assistant costs so should be also classified as nursing. The aggregate nursing position is therefore $14k unfavourable year to date, which essentially all relates to unbudgeted maternity leave top-up payments of $14k.

**Allied Health: ($11k unfavourable YTD)**
This is for a small component of physiotherapist costs which were omitted from the budget process.

**Admin staff: ($45k unfavourable YTD)**
Essentially in line with budget. The $50k revenue recognised during October has an offsetting $50k administration staff cost, and the balance of costs is in line with budget.

**Outsourced services: ($790k unfavourable YTD)**
These expenses are primarily the Package of Care costs for surgeons, and anaesthetist costs charged by S&AS. Overall patient throughput was approximately 118% of (phased) plan year to date whilst overall expenditure is 129% of budget. This represents 127% of spend for clinician costs (117% for surgeons and 145% for anaesthetists ($180k represents a budget shortfall; $171k represents the 18% increased patient throughput; $80k represents the change in mix (more expensive orthopaedic cases done than planned compared to other activity)). Additionally there is $63k of externally supplied radiology procedures that are not budgeted explicitly in this expenditure line.

**Clinical supplies: ($410k unfavourable YTD)**
Overall clinical supply costs are $410k unfavourable (115% of year to date budget) against 118% cases over-delivery and 109% revenue achievement. Implant costs at 111% of budget are in line with joint replacement volumes at 111% of funded levels. Most of the variance is within treatment disposable expenditure (126% of year to date budget) however these expenditures look consistent with trends in late 2013/14 which suggests this is a real increase in recognised expenditure relative to expenditure over the first half of 2013/14.

**Infrastructure: ($32k unfavourable YTD)**
There is $16k of unbudgeted facility costs charged in July, whilst the non-clinical depreciation budgets are understated with a $5k/month unfavourable impact ($20k U year to date). Other expenditures have been at budget levels or offsetting.

**Summary**
The October monthly result is $161k unfavourable with a year to date position of $505k unfavourable. This is primarily a result of accelerated patient activity to mitigate ESPI compliance risk in the first half of the year, combined with a decreased average wies that is not aligned to a reduced cost profile relative to budget. Thus whilst revenue was positive, the year to date expenditure position increased from budgeted 83.1% of revenue to actual 89.7% of revenue, with the reduction in average wies remaining a key financial risk. $45k of anaesthesia charges per month represents an ongoing budget risk whilst the other clinical supply costs and outsourced costs will reduce over the second half, provided patient volumes are reduced over that period.
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, and 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
Shorter waits in ED for October was under the target at 94.5%. We reviewed all waits in ED that were over six hours and there were very few that could be influenced differently in October.

Better help for smokers to quit continues to be above target at 97.4%.

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

Quality
61 compliments were received by surgical services in October. The Breast Screening Service received 191 in October for Waitemata domiciled patients.

The service received 22 complaints in October (24 received in October last year). The service has consistently achieved its complaints closure rate target of less than 14 days in the last four months and for the last quarter.

Provider Arm Did Not Attend (DNA) Project
The DNA project is continuing to focus on engaging with individuals and families to support them to confirm, cancel or reschedule their appointments. The partnership programme with GP practices to reduce DNA rates for Maori and Pacific patients is in progress. The practices participating are: The Fono Henderson; Wai Health Centre; Ratanui Medical Centre and the Te Puna Haoura medical centres. Where possible, care workers from GP practices are also involved to support patients with their appointments.

Information collected to date, has shown an increase in attendance and reschedule rates for patients contacted. However, there is still a high DNA rate for patients unable to be contacted. The main reason for no contact is incorrect phone numbers on file. The Project Manager is working with practices to coordinate and track activity and to develop a sustainable proposal for activities post pilot.

DNA action plans have been developed with the Operations Managers for each of the 12 specialties with the highest number of Maori and Pacific patient DNAs. These are currently being reviewed by the teams involved. Weekly reporting of these patients who DNA from the six clinics with the highest DNA rates in each of these 12 specialties has been developed to assist the specialties with managing these DNAs. The cultural support staff have increased their patient reminder phone calls to include the patients who are not contacted by their GP practice, but will be seeing one of the high risk specialties.

Additionally, as parking and transport costs have been identified as an area of concern for low income patients, work is in progress with Waitemata DHB’s Parking and Transport services to develop a proposal to assist high risk patients in this area.
Service Delivery
Radiology
Radiology has achieved the waiting time indicator for CT, reaching 95% against a target of 90%. The target for MRI has not been achieved, 55% against a target of 90% for October 2014. Given the constraints and challenges we have experienced to date, we are aiming to meet the MRI target by 30 June 2015. There is a significant backlog of MRI referrals, which will be completed with internal resource (staff working overtime on weekends), and a moderate amount of outsourcing to achieve the required volumes. The demand for MRI has been consistently increasing at 18% per annum and, even with the MRI clinical lead radiologist reviewing all referrals, we have a very low decline rate. We have been fortunate to have the support for an additional MRI scanner and the plan is to have this fully operational from 7am-7pm weekdays with a weekend session available for patients also. Currently the only constraint for this is the staffing levels as the MRT Board requirements for MRT MR scope of practice are unique to New Zealand and create an additional challenge for recruitment of trained and qualified MRTs to work in this modality. Dr Kate Aitken is addressing this with Health Workforce NZ as an issue inhibiting engagement of a wider workforce including experienced MRTs from overseas.

Taking all of this into account our response has been and continues to be focused on improving access for our patients. The multipronged approach includes:

- Engaging with modelling analyst experts to fully understand the management of the wait list, and referral patterns as per the criteria for achieving the target
- Outsourcing minimal amounts of work (least cost effective)
- Requesting staff to do additional weekend sessions
- Recruiting casual staff to support the additional weekend sessions
- Recruiting Waitemata DHB MRTs to complete the post graduate diploma with Waitemata DHB support in place
- Reviewing booking procedures and move to a ‘first in first out’ booking practice
- Reviewing workflow processes to ensure maximum efficiencies
- Working with MRT Board to review the requirements for overseas trained in MRT MR scope.

ESPI 1, 2 and 5
We have maintained compliance for the quarter. Highly monitored plans are underway to ensure achievement of four month compliance requirements by 31 December.

The complexity of waiting list management is increasing as we manage patient access and thresholds to capacity within the four month indicator for both inpatient and outpatient waiting lists. We are seeing increased referrals for surgery overall, including an increasing referral rate from the private sector.

The intensity and added complexity to achieve the four month treatment times has added stress across both our clinical and support staff in relation to availability to run additional clinics and theatre sessions and an increased administrative oversight of capacity, demand and waitlist management that was not so evident at five and six month targets. It is envisaged that the close waiting list management to ensure patients accepted to both outpatient and inpatient waitlists to match capacity will be ongoing.

Waitemata DHB, Hospital Advisory Committee Meeting 17/12/2014
### Waitemata DHB Monthly Performance Scorecard

#### Waitemata DHB, Hospital Advisory Committee Meeting 17/12/2014

**Surgical and Ambulatory Service**

**October 2014**

#### Scorecard

### Priority One

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Targets</td>
<td>Better help for smokers to quit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provider from Elective Visits - Dental</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Surgical and Ambulatory Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Elective Surgical Centre</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Patients in ED</td>
<td></td>
</tr>
</tbody>
</table>

### Quality

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting and Treatment Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Patients seen within 1 hour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Patients seen within 2 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Patients seen within 4 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Patients seen within 6 hours</td>
<td></td>
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### Other Key Measures

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<thead>
<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Admissions Rate (over 24 hours)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Patients seen within 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Patients seen within 48 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Patients seen within 72 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Human Resources

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<tr>
<th>Indicator</th>
<th>Actual</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Full Time Equivalents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Part Time Equivalents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Temporary Staff</td>
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<td></td>
</tr>
<tr>
<td>% of Permanent Staff</td>
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</table>

### Finance

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<thead>
<tr>
<th>Indicator</th>
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<th>Target ($000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
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<tr>
<td>Expenses</td>
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</tr>
<tr>
<td>Capital Expenditure</td>
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<td></td>
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</table>

### How to read

<table>
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<tr>
<th>Indicator Type</th>
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<tr>
<td>% Increase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Decrease</td>
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</tr>
</tbody>
</table>

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**Waitemata DHB, Hospital Advisory Committee Meeting 17/12/2014**

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**OTHER HIGHLIGHTS**

**ORCA Clinics (Acute Orthopaedic Review Clinic)**
With the secondment of a Clinical Nurse Specialist to the Trauma Coordinator position a great improvement has been seen in the access to surgery for these patients, improved flow and a reduction of waiting times. There have been no patient complaints of this service since the secondment to this position. There has been a great improvement with the flow of information between all staff involved with the care of the ORCA patients and systems are constantly being reviewed.

**Interim Care Scheme**
This scheme continues to provide the opportunity to release hospital beds over the periods for non-weight bearing patients to be transferred to the community for their care. The number of patients under this scheme has dropped to between two and three. Approval has been given to continue the scheme all year and close beds at NSH when not required for acute/complex inpatients.

**Surgical Services Charge Nurse Managers Updates:**

**Surgical Unit North Shore Hospital**
- Our refurbishment project is well on track and looking at commencing in March 2015
- A Rigor process is at scope and process stage for Pre-op project work with the goal to have 90% of first on the list patients within North Shore Tower Block Theatres into theatre ready for anaesthetic preparations by 8.10am
- PACU completed the “15 Steps” Challenge and have increased from the current Net Promoter Score of between 70 – 80% to 97% achievement rates. We plan to maintain this by the continuation of daily reinforcement of good practice and timely management of issues. Measurement of performance is via of the friends and family test and PACU survey. We will plan another 15 step challenge in 3 months to ensure we maintain our performance.

**Outpatients Waitakere**
- Ophthalmology clinics commenced in July 2014. There are approximately seven clinics per week and patient feedback has been extremely positive
- We continue to support 3rd year student nurses and receive positive feedback about their clinical experience, exposure to different conditions and the experience of the outpatient nursing staff
- We commenced using Ferrinject (new Iron infusion). This means patients are here for 2 to 2 ½ hours rather than 6-8 hours approximately with previous forms of iron infusion, and again feedback has been positive from both patients and nurses
- We continue to remain at full FTE with a very supportive, innovative, happy team.

**ICU/HDU**
- We acknowledged patient safety week with a focus board looking at various aspects of patient risk including medication safety, falls risk and pressure injury prevention. All these areas of practice have been promoted as part of our patient safety strategies
- We are working with theatre in looking at the ‘handover’ process which demonstrates our connected view to address the transfer of both the patient and key information. This is looking at the Ferrari pit stop model to ensure that we have a robust plan for these patients based on effective communication between the two teams i.e. a checklist. This project is registered with Awhina and led by both departments
- A business case has been developed and presented regarding bed replacement in the ICU to support staff and patient safety
- We have been involved in a national study Met NZ where medical emergency calls were examined and data sent.
Inpatient Wards
Kate Gilmour Head of Division Nursing is reviewing our focus on patient experience when in our wards, especially when it has been a negative experience. We are implementing an additional patient experience feedback form to be completed on discharge which we hope will provide us with more detailed information about each inpatient stay. A workshop with the charge nurse managers and the Patient Experience Manager has been arranged for December.

Some examples of our focus on patient experience from each ward are noted below:

Ward 4
As a quality initiative aimed at assisting patients and their families transitioning from hospital care to home the CNM has developed a booklet entitled “Preparing to go Home”. This is a tool aimed at engaging the patient and their family and us as providers of health as full partners in the discharge process. Research indicates that over 20% of patients discharged from hospital may have an event within the first thirty days following discharge that can be directly linked to discharge planning and communication. The most concerning incidents involve medication safety and knowledge, poor preparedness of clients and their support person regarding what life will be like at home and managing with new health needs. The booklet is designed to act as a prompt for clients and family members to consider key aspects of discharge planning that may affect them. The booklet has pages for both patient and carers to write down questions that they can then discuss with the appropriate team members before discharge.

The CNM has also compiled a guide for nursing staff that uses IDEAL as a tool that mirrors the intent of the patient booklet:
- **Include** the patient and family as full partners in the discharge process
- **Discuss** potential problems at home with the patient and family
- **Educate** the patient and family in plain language about the patient’s condition, the discharge process and the steps in their hospital stay
- **Assess** how the patient and their carer(s) understand information given to them – use “talk-back”
- **Listen** to the patient’s and family’s goals, preferences, observations and concerns.

The booklet has just completed the Customer feedback process with a few adjustments suggested by them. The CNM is meeting with Jay O’Brien in November to discuss this and then roll out the use of this booklet for surgical patients.

Ward 7
**Acute Fractured Neck of Femur Pathway**

*Anaesthetic and Post-op Nausea and Vomiting Protocol*

The protocol was approved by the Pharmaceutical and Therapies Committee and implementation was commenced the week of 20 October. Protocol compliance auditing has commenced.

*Neck of Femur Fractures (NOF) - Time to Theatre*

Since March 2014, there has been a specific focus on prioritising Fractured Neck of Femur patients as part of the acute theatre planning on a daily basis by the Orthopaedic and Anaesthetic teams. This focus has resulted in a positive increase in the number of patients receiving surgical interventions within 48 hours. The 48 hour target for all appropriate patients to access theatre was set by the Clinical Leadership Team for the project, based on the National ERAS Collaborative Expert Faculty recommendations. All patients who do not receive surgical intervention within the target of 48 hours are being reviewed by the project team to ascertain if the patients were medically unfit for surgery at 48 hours or did not progress to a surgical intervention.
Ward 8

The house keeper role has had a noticeable beneficial effect even within a few days of commencing. Some of the key areas for improvement have included: the nursing staff have noted the housekeeping role has improved efficiency with cleaning schedules being completed in a timely manner; the overall tidiness of the ward; family support in times of anxiety and general support of the staff on the ward. The housekeeper is involved in welcoming new admissions to the ward and orientating them to the ward environment and facilities.

Ward 8 CNM presented their algorithm to Frontline Focus Friday, that staff follow for patients at high risk of falling; other wards were interested to also use this tool.

The Ward 8 refurbishment commences in January and the team is very excited to be getting their ward upgraded which will benefit the patients and staff.

Ward 9

Members of the Ward 9 nursing, physiotherapy and occupational therapy teams attended the National ERAS Collaborative Learning Sessions in August. Education sessions on ERAS and the benefits of early mobilisation were then held on Ward 9 during September and the Elective Hip/Knee Arthroplasty Nursing Care plans were trialled in October. These initiatives have resulted in a significant improvement in the time to postoperative mobilisation (refer to graph below showing the decreased time before mobilisation is commenced).

Waitemata DHB ‘Your Broken Hip’ Patient Information Booklet has been through an internal review and consultation with consumer groups. It is in the final review process post graphic design work following which the booklet will be formally approved and given to patients and their family/whanau and supporters as part of the admissions process.

Ward 9 has increased their net promoter score to 92%.
Another focus for the Surgical Wards this month included the International STOP Pressure Injury Day where a quiz was presented to staff to complete and a stand with spot prizes was in the main entrance. This aims to heighten staff awareness re appropriate assessment.

**Radiology**
Radiology is focusing on service and quality improvements in the department across all modalities. The Surgical and Perioperative Excellence programme will serve as an umbrella for the clinician derived clinical indicators and quality projects. Work is required on how excellence in radiology, other than process measures, is to be done. It is anticipated that Excellence in radiology will then service as an umbrella for all the regulatory activities, audits, customer and referrer surveys, credentialing, IANZ accreditation and so on.

The WISDOM project is a national project looking at service improvement in Radiology. This has started in Waitemata DHB with a comprehensive approach to process flow mapping in partnership with the Service Improvement Specialists. All of the staff teams in radiology have reviewed the first draft and the uptake in participation has been favourable.

**Theatres North Shore Hospital and Waitakere Hospital**
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.

Changes have been introduced to the Surgical Safety Checklist to improve active participation of the surgical team in the checklist process. The introduction of designated lead roles for each phase of the checklist has seen significant improvement in team engagement. The anaesthetist now leads the sign in phase; the surgeon leads time out and nurses lead sign out.

The Values boards at both NSH and WTH theatres are updated regularly. The current focus is Better Best Brilliant and Everyone Matters. It helps in shaping the way we behave with patients, service users, Whanau and each other.

The decision to increase acute theatre sessions is demonstrating strong return on investment. Acute Theatre Compliance for Patients into theatre within 24 hours of being ready for surgery is tracking above 90% target for November.
Patient Service Centre
A key focus this month has been embedding the Patient Service Centre business process rules best practice processes. The Patient Service Centre Redesign Facilities recommendation on the FF&E vendor and construction contractor are pending approval. Decanting planning has been completed for the 4 stages of the redesign.

A recent recruitment drive to replace five clerical administrator roles in Surgical and Gynaecology Patient Service Centre teams was successful with all new staff commencing by early December.

Planning with the EReferrals Phase 2 project team continues for roll out across Surgical and Gynaecology Services. Skin Lesion services ‘go live’ commenced 17 November and Varicose Veins ‘go live’ is imminent.

Faster Cancer Treatment (FCT)
Waitemata DHB continues work to ensure 85% of patients with a high suspicion of cancer will have their first treatment within 62 days by July 2016, increasing to 90% by June 2017. A Cancer Clinical Group has now been established and tumour stream projects are underway to identify where time gains can be made along cancer patient journeys. The Breast Cancer pathway has been process mapped and modelled by UniServices through funding from a Ministry of Health FCT Improvement Programme. The pilot has generated a significant amount of information to support planning of services. The Gynae-Oncology, Colorectal and Upper GI cancer pathways are undergoing a similar process. Work is also being undertaken by Respiratory Services and the Lung Cancer Team to see where time gains as well as service improvements can be made in this pathway.

Improving Journey Project
The ‘Improving the Journey to Elective Surgery’ Final Evaluation Report has been submitted to the National Health Board, Ministry of Health.

Asian Health Support Services for the HAC REPORT
Waitemata DHB Asian Health Support Services has launched the newly developed ‘Culturally and Linguistically Diverse (CALD) Older People Resource for Health Providers’ in November 2014. This resource
covers broad topics ranging from assessment, treatment, and rehabilitation, dementia, stroke, mental health, Residential Aged Care, screening for elder abuse and neglect, advanced care planning and end of life care. It is useful for health providers working with CALD older people and their families in primary, community, mental health, secondary care, home-based support services and residential aged care settings. It is available online as well as a print resource. It contains cultural perspectives, approaches, tools and case scenarios for health providers. To find out more about this resource and how to access, go to the CALD website: www.caldresources.org.nz.

**Service Change and Improvement Update**

**Hand Service**
A regular weekly list at Waitakere will commence in February which will provide capacity to bring back Waitemata domiciled patients currently receiving treatment at Counties Manukau DHB. This has been a goal to achieve for some time and will now be actioned.

**Ophthalmology**
At the November steering group meeting, Auckland DHB presented a plan to steadily increase volumes to the expected anticipated level by June 2015. This will include offering appointments to some patients from the Waitemata DHB north / west border not currently being offered Waitakere appointments.

Patient volumes and clinic numbers are steadily increasing with all the key target patient clinics (Cataract, Medical Retinal, Glaucoma) running. Three days of clinics per week are now running. The Minor Operation Room facility work has been delayed however this has not prevented the commencement of Avastin treatment and patients being seen. It is anticipated that facilities will have completed the Minor Ops room by the end of November.

Patient feedback remains extremely positive reflecting well on the DHB with patients acknowledging service availability within the Waitemata catchment as very beneficial.

**Varicose Veins**
Investigations are underway by the lead interventional radiologist as to whether this work can be undertaken in the ESC environment. If this proves viable it will release the use of the interventional radiology suite.

**General Surgery**
E-triaging of GP referrals commenced in the skin service within General Surgery 2 weeks ago and initial feedback from clinicians is very positive. The varicose vein service will start their e-triaging next week with further parts of general surgery planned for early 2015. E-triaging provides for timely contact between the referral grader and the GP so that plans and decisions are communicated much earlier than the current manual, paper based system.

**BreastScreen Waitemata Northland**
- Harms and Benefits of Screening: Ministry of Health Position Paper (Attachment 1)
- Policy: discussions are underway with the Ministry to develop a scoping paper to support the development of a population / national register for BreastScreen Aotearoa (BSA). This will facilitate the recruitment process. The service is also considering advocating for a further policy change to make enrolment in the Programme automatic (i.e. Opt On) in line with the National Cervical Screening Programme and Bowel Screening Pilot Programme
- 2013 Census projections: the updated eligible populations (based on the 2013 Census projections) should be available before the end of the year. These revised population denominators will result in some changes to coverage, and should also provide more granular data that will allow the service to refine strategies for improving coverage and accessibility for Maori.

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Waitemata DHB, Hospital Advisory Committee Meeting 17/12/2014

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The BSA coverage target is 70%.

BSA coverage by Lead Provider and DHB to 30 September 2014

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>July 2014</th>
<th>August 2014</th>
<th>September 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waitemata Northland</td>
<td>68.9%</td>
<td>68.3%</td>
<td>68.8%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>64%</td>
<td>63.2%</td>
<td>63.4%</td>
</tr>
<tr>
<td>Northland DHB</td>
<td>72.6%</td>
<td>72.2%</td>
<td>73%</td>
</tr>
<tr>
<td>Pacific Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waitemata Northland</td>
<td>77.9%</td>
<td>77.6%</td>
<td>77.8%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>77.8%</td>
<td>77.4%</td>
<td>77.7%</td>
</tr>
<tr>
<td>Northland DHB</td>
<td>62.2%</td>
<td>62%</td>
<td>61.1%</td>
</tr>
<tr>
<td>Other Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waitemata Northland</td>
<td>68.9%</td>
<td>68.8%</td>
<td>69.2%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>67.7%</td>
<td>67.6%</td>
<td>67.8%</td>
</tr>
<tr>
<td>Northland DHB</td>
<td>73.8%</td>
<td>73.7%</td>
<td>74.7%</td>
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<tr>
<td>Total Coverage</td>
<td></td>
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<tr>
<td>Waitemata Northland</td>
<td>69.4%</td>
<td>69.2%</td>
<td>69.6%</td>
</tr>
<tr>
<td>Waitemata DHB</td>
<td>68.1%</td>
<td>67.9%</td>
<td>68.2%</td>
</tr>
<tr>
<td>Northland DHB</td>
<td>73.5%</td>
<td>73.3%</td>
<td>74.2%</td>
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</table>

BSA coverage (45–69 years) by Lead Provider, DHB, by Ethnicity for the 24 months to 30 September 2014.
## STRATEGIC INITIATIVES

### Specific deliverables/actions to deliver improved performance will consider:

<table>
<thead>
<tr>
<th>Action</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 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 2014/15 with particular attention on clinical costs and radiology
- ESPI compliance to 4 month treatment time by December 2014
- On-going work to meet 2015/16 cancer treatment target
- Work ongoing to meet 2015/16 cancer treatment target
- Continued engagement with primary care to increase quality of referrals including increasing 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
- Focused work in outpatients on utilisation, scheduling and clinical indicators to reduce follow up appointments
- Review of elective surgical services and growth for 2015/16
- Decrease waiting time to theatre for acute patients to reduce LOS and release inpatient beds for increased number of patients
- Ongoing work in inpatient areas to increase patients’ satisfaction and optimise quality of care
- Review of Surgical and Ambulatory Services ACC opportunities
- Refurbishment of remaining four 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.
HOSPITAL OPERATIONS

Food Services
Co-supervision of two Massey Masters student dietitians on their final placement has taken place during which they audited wards’ compliance and completed patient status boards by patients’ bedsides. They compared and contrasted nurses’ and patients’ perceptions of hospital food. The data will be formally presented to senior nurses later this year.

Participated in further product tasting sessions evaluating products for the Health Benefits Ltd (HBL) patient food services project, it was recommended to review a number of the products sampled.

Habitat Café in the North Shore Hospital foyer opened mid-month, commencing with a dawn karakia provided by our DHB kaumatua in association with Compass Medirest’s own lay preacher.

Laboratory
The business case for Vancomycin-resistant enterococcus (VRE) screening and Polymerase Chain Reaction (PCR -method for detection of virus) has been prepared. This was presented to the SMT on 20 November.

There is a clinical need for an i-STAT analyser for the case of suspected Ebola patient presentation. We have now received 2 instruments, one for each site.

Security
Code Orange/Calls for assistance responses have been high with a noticeable increase at Waitakere and North Shore hospital.

Due to a recent review of the security policies and procedures for maternity services at North Shore and Waitakere maternity departments, extra cameras and duress buttons have been installed.

Security has also been involved with extra training in non-violent crisis intervention de-escalation techniques at the CADS Clinics, training is on-going.

Pharmacy
Electronic Prescribing and Administration (ePA)
The ePA project is being led by the Pharmacy Operations Manager David Ryan:
- maintained in 210 beds on Wards 14 & 15, Muriwai and the Mason Clinic
- Implementation successfully completed into acute medical wards at Waitakere Hospital
- Pharmacists working on ePA project providing 24/7 pharmacist presence on site for support to prescribing doctors.

Antimicrobial Stewardship Programme:
- Monthly antimicrobial spend shows trend in reduction in expenditure per occupied bed.
• Antimicrobial expenditure for September and October significantly lower than the average for spring months over the preceding five years
• The outbreak of vancomycin resistant enterococci (VRE) at North Shore Hospital since April 2014 has the potential to result in significant increases in antimicrobial expenditure
• Cost containment for carbapenems remains challenging with the large number of ESBL colonised patients under the care of Waitemata DHB.

Ferinject
The use of Ferinject iron infusion is increasing significantly since its addition to the Hospital Medicines List. Use has increased from one ampoule in July 14 ($150) to 150 ampoules in October 14 ($22,500). Continued increases in use of this agent are anticipated.

Clinical Engineering
October saw the major focus of routine testing switch to SCBU and Maternity at Waitakere Hospital and very helpful clinical staff in both of these areas enabled us to achieve a 96% hit rate (14 assets out of 354 unaccounted for).

A senior staff member has provided input to a number of meetings regarding the planned shutdown of medical gases to the Birthing and Labour suites at North Shore Hospital to allow work to proceed on the new Gynae Ward build. His previous knowledge and experience has been invaluable to this process and in minimising the impact on the clinical service during this time.

Clinical trials of beds are now complete in the wards and ICU. Planning is underway for the business case and replacement of approximately 200 ward beds and x6 ICU beds.

Traffic and Fleet
Replacement fleet vehicles have begun to arrive on site; we expect to complete 35 replacement vehicles by mid-December.

Regional fleet developments have restarted with healthAlliance; presentations have been received on Fleet Management/Fleet Booking software options. An RFP is expected to go to market this month.

Furniture Fixtures and Equipment (FF&E) and Signage
There are a number of procurement projects in progress, all FF&E work is on track.
North Shore Hospital – day room fit out completed. The visitors, patients and nursing staff were very pleased with the fit out.
Patient Service Centre – RFP – Supplier selection completed and project will be in four phases, December to February time line.

Decanting and Migration
Moves completed October to November:
• Planning and Funding – staff from Greenlane to 15 and 17 Shea Tce
• Day room – Wards 3, 4 and 5 at NSH decanted
• HR internal office move at 43 Taharoto Road
• Piha and Te Henga wards, Waitakere decanting and reinstatement of clean utilities as part of Inventory project
• Decanting of maternity assessment room to enable Gynae ward work to commence
• Decanting requirements in Paediatric and Outpatients at Waitakere as required for Ophthalmology
• Cancer care team move from North Shore Hospital lower ground floor, Management suite to 37 Taharoto Road to make decanting space available for Patient Service Centre
• Various decanting moves within Patient Service Centre in preparation for major refurbishment project
• Recycling moves across both campuses and other satellite sites
• Decanting of Senior Medical Officer lounge space at Waitakere in preparation for refurbishment.

Clinical Support Services
Recruitment of cleaning and orderly staff for Waitakere is now complete with the exception of two weekend part time cleaning roles. Recruitment of permanent cleaning roles for North Shore has commenced with 17 staff being recruited, further recruitment will take place in the New Year for the remaining 35 roles as we progress with our shift from external bureau staff to building Waitemata DHB teams.

Enrolment on the New Zealand Qualifications Authority (NZQA) Level 3 Orderly qualification programme is progressing with 67 of our permanent orderlies enrolled and first cohort expected to graduate late January 2015.

Contracted Services:
Linen service negotiations are being undertaken for a price review at the end of the current contract (November 2014).

Room Decontamination Machinery RFP evaluation is currently underway with Bioquell and Evaluation meeting to be held on 27th November 2014, business case currently being drafted.

Work continuing with healthAlliance on other contracts including: Pest Control, Sanitary Bins, Uniforms, cleaning products and equipment. Mail franking contract currently being reviewed by healthAlliance legal team and should be circulated to DHBs for signatory in the next few months.

Quality
Complaints:
A total of three complaints were received in October. Two complaints were closed in October and there are no overdue complaints.

Requests/Enquiries:
Total of one request/enquiry/suggestion was received in October 2014. One request/enquiry/suggestion was closed in October with an average time to respond being 14 days.

Compliments:
One compliment has received in October for Hospital Operations, complimenting the Cleaning Team.

<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>X</td>
</tr>
<tr>
<td>Pharmaceutical cost savings</td>
<td>✓</td>
</tr>
</tbody>
</table>

Areas off track for month and remedial plans:
• The expected lab savings have not been realised because of not repatriating work from ADHB
**Financial Results**

**Surgical & Ambulatory Services**

<table>
<thead>
<tr>
<th>CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE</th>
<th>Reporting Date</th>
<th>Oct-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surg &amp; Ambulatory (S$000's)</strong></td>
<td><strong>MONTH</strong></td>
<td><strong>YEAR TO DATE</strong></td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Income</td>
<td>198</td>
<td>118</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>12,100</td>
<td>11,699</td>
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<tr>
<td>Expenditure</td>
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<tr>
<td>Personnel</td>
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</tr>
<tr>
<td>Medical</td>
<td>4,865</td>
<td>4,748</td>
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<tr>
<td>Nursing</td>
<td>3,570</td>
<td>3,385</td>
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<tr>
<td>Allied Health</td>
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<td>Support</td>
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<tr>
<td>Management / Administration</td>
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<tr>
<td>Other Expenditure</td>
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<tr>
<td>Outsourced Services</td>
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<tr>
<td>Clinical Supplies</td>
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<tr>
<td>Infrastructure &amp; Non-Clinical Supplies</td>
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<td>509</td>
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<tr>
<td>Total Expenditure</td>
<td>4,250</td>
<td>3,227</td>
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<tr>
<td>Contribution</td>
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<td>(1,963)</td>
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<tr>
<td>Allocations</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NET RESULT</td>
<td>(2,845)</td>
<td>(1,963)</td>
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</table>

**COMMENT ON MAJOR FINANCIAL VARIANCES**

Revenue ($2,487k favourable YTD)

Year to date elective case volumes (excluding skin cancers) are 113% of standard production plan (and 105% of the accelerated plan). Elective wies are 111% compared to budget. This is as a result of a strategy to ensure ESPI compliance at Dec 31 (nil patients waiting over 4 months). Elective revenue is recognised on that basis at $1.7M favourable year to date. IDF flows are $103k unfavourable but $7k favourable for October. Acute revenue is $148k unfavourable due to the work being done at ESC instead.

ACC revenue is $216k unfavourable (69% of budget) and further work is being done in regard to ACC revenue levels with some analysis of radiology high cost treatment revenue opportunities (note that underlying ACC revenue is essentially at budget across SAS/ESC).

Some additional revenue is recognised for $900k from Corporate for acute theatre costs and reimbursement for some other expenditures such as unbudgeted SLA’s (e.g. revenue for pain fellow appointment $21k, nurse facilitated discharge project $12k, spinal pathway development SLA 120 $27k, SLA 119 cancer co-ordinator...
$23k). Ministry of Health invoicing is $114k favourable in relation to skin cancer, radiology process redesign and service improvement projects, and other external revenue for cancer co-ordination data analysis support.

Expenditure

**Medical personnel: ($617k unfavourable YTD)**
This variance is primarily in relation to radiology SMO’s at $280k unfavourable. This relates to fte budget overspend of $80k (1.5 FTE) partly in relation to the second MRI scanner coming on stream; and high costs across allowances, on-costs and relocation costs. Service and job-size work is underway in this service. Anaesthesia SMO expenditure is $511k unfavourable however this is offset by the recharge to ESC of $503k in out-sourced costs. This is due to the level of allowance spend being above budget levels – however there is little on-going risk in this area as the extra spend all relates to the ESC related activity and is on charged, with the exception of $110k cost in July relating to prior year that has been reimbursed with revenue. Year to date expenditure includes $162k of additional sessions that have been incurred to drive ESPI compliance for Dec 31 deadline. Other RMO and SMO costs are either in line or ahead of budget.

**Nursing: ($735k unfavourable YTD)**
Theatres are $257k unfavourable due to the unbudgeted acute sessions and $17k due to the phasing on winter overnight beds cost in PACU that have been spread all year in the budget. Maternity top up payments are not budgeted with year to date spend at $44k and transit nurses are also overspent at $60k unfavourable. Savings initiatives at $332k unfavourable are not met.

**Allied Health staff: ($350k unfavourable YTD)**
MRT’s in radiology are $144k unfavourable year to date. This is primarily due to average budgeted cost/fte being understated (approximately $120k) whilst over-time payments are $15k/month higher than budget and last year, due at least in part to additional CT evening sessions running to manage CT demand. Radiation Assistants are $58k unfavourable as they are over budget fte, whilst there are sonographer vacancies ($74k favourable) and students are $20k favourable due to also being below budget fte. There is an additional physiotherapist charged to Surgical Management ($31k) that has been funded by SLA revenue to manage spinal patients in a new model of care. Anaesthetic Technician costs are $59k unfavourable year to date as a result of unbudgeted additional acute sessions, for which revenue is being received from Corporate. Savings initiatives of $197k unfavourable are not met, although there are some favourable variances across the balance of services.

**Support staff: ($24k unfavourable YTD)**
FTE are in line with budget but costs are slightly up on last year and budget.

**Admin staff: ($10k favourable YTD)**
Administration costs are in line with budget.

**Outsourced services: ($782k unfavourable YTD)**
Key variances are recharge of anaesthesia SMOs to ESC at $503k favourable; ORL unbudgeted outsourced activity of $459k to meet ESPI and volume compliance; nursing bureau costs to manage bed pressures $186k unfavourable; hand therapist costs $30k unfavourable which are above budget but 20% below expenditure in 2013/14; radiology outsourced costs $173k unfavourable due to ongoing ultrasound vacancies and short-term MRI capacity gap; bowel screening laboratory cost increases $48k unfavourable; and savings initiatives $400k unfavourable not met in the main (however $100k has been achieved and recognised in the revenue over-delivery with some new revenue streams).

**Clinical supplies: ($1,9825k unfavourable YTD)**
Overall clinical supply costs are 121% of budget. Most of this cost/variance is driven out of surgical theatre activity however we are seeing pressure on all budgets with cost increases coming through in ambulance costs.
($51k unfavourable), interpreter costs ($36k unfavourable), orthotics costs ($65k unfavourable) and ward clinical supply costs $58k unfavourable.

Theatre costs are $501k unfavourable (excluding implants) – 115% of budget compared to total acute/elective wies activity at 103%. However this variance is primarily due to understated first half 2013/14 costs leading to an understated treatment disposables budget cost, due to issues associated with the implementation of the Oracle Perpetual Inventory System management. Joint implant expenditure at $110k unfavourable is 109% of budget which is below orthopaedic joint replacement volumes at 129% of funded plan. However overall implant costs are $509k unfavourable or 123% of budget. The area that is unusually high given the level of activity is in screws/plates which is significantly overspent $175k year to date compared to last year and $217k unfavourable to budget (148% of budget). Joint replacements are 130% of funded levels and other acute orthopaedic work is likely to be driving these costs. However review of the costs has not highlighted any unusual expenditure. We will continue to monitor this trend. Savings initiative unmet at $764k unfavourable.

**Infrastructure: ($274k unfavourable YTD)**

Primarily the unfavourable variance relates to a number of smaller items. The main significant variance is additional orderlies in theatre ($45k unfavourable) related to additional acute theatre sessions; sterilising costs at Waitakere CSSD $24k unfavourable; laundry costs $32k unfavourable; cleaning costs $27k unfavourable (mainly unbudgeted short stay ward costs $21k); postage $34k unfavourable and equipment hire $37k unfavourable due to a focus on improved patient safety; and $12k on unbudgeted smart-pagers for RMOs; outsourced orderlies $12k unfavourable in radiology; several projects running with consultancy project costs $22k unfavourable but they are funded through the revenue line.

**Summary**

The result for the October month of $882k unfavourable includes $330k of revenue/cost impact not directly related to the current month ($100k of acute revenue transferred to ESC; additional $80k accrual of anaesthesia SMO residual ESC related provisions for 2014/15; additional lab costs for Bowel Screening of $50k and an additional $100k of theatre costs related to prior months). The key variance risks in the year to date $2,267k unfavourable result are in relation to radiology personnel costs $457k; ORL outsourcing $459k and savings initiatives $1,704k unfavourable, all of which are offset partly by revenue over-delivery.

$761k of expenditure in the year to date result relates to unbudgeted ESPI compliance related expenditure, being $302k of additional surgical and theatre related costs in relation to 24 additional elective theatre lists and a number of additional clinics and $459k of outsourced costs related to ORL ESPI compliance.

**S&AS and ESC Combined**

Overall elective cases outputs year to date are at 113% of plan (excluding skin cancers) and 107% on an elective wies basis. This is driving overall elective revenue growth to a year to date result $1.7M favourable and $3.3M favourable for aggregate revenue (106%). This revenue growth will reduce month by month as volumes pull back over the second half of the financial year.

Aggregate ACC revenue is at 91% of budget ($63k unfavourable year to date) as the nil budget at ESC means a large gain in the ESC, and no budget revenue was transferred to ESC in the 2014/15 budget. A $100k provision has been made for overstated revenue for the month and the underlying level of ACC revenue is actually at aggregate budget levels year to date.

Personnel expenditure is $1.7M unfavourable – primarily radiology and anaesthesia SMO costs in S&AS and also nursing $763k unfavourable and Allied Health $361k unfavourable as described in S&AS commentary.

Outsourced services $1.6M unfavourable due to savings initiatives not met $400k unfavourable; ORL outsourcing $459k unfavourable; radiology outsourced costs in SAS of $173k unfavourable and bureau nurse
costs of $186k unfavourable at SAS; $180k unfavourable on anaesthesia costs not budgeted in ESC; and $293k unfavourable surgeon package of care costs due to volume growth in ESC.

Clinical supply costs $2.4M unfavourable (120%) compared to volume growth of 103% based on total year to date total wies delivery (and 107% year to date elective wies delivery). $764k relates to savings initiatives unmet.

Infrastructure costs are $0.3M unfavourable, with a variety of relatively smaller variances driving this figure.

The net result is $1.0M unfavourable for the month of October and $2.8M unfavourable year to date.
Hospital Operations

The overall result for Hospital Operations is $96k favourable for the Year to Date Oct-14.

Revenue ($217k favourable Year to Date)
Car Park revenue is $79k unfavourable for the Year to Date 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 $114k 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. Unbudgeted revenue to compensate for additional volume related costs is $418k favourable Year to Date.

Expenditure ($121k unfavourable Year to Date)
Personnel costs ($798k favourable Year to Date)
Medical staff costs are $102k favourable for the Year to Date as a result of vacancies in Laboratory Services. Support staff costs are $686k 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 $21k
favourable for the Year to Date which represents a 6.90 FTE vacancy and 2 unbudgeted retiring gratuity payments of $53k.

**Other Direct costs ($919k unfavourable Year to Date)**
Outsourced personnel costs for casual cleaning and orderly staff are $917k unfavourable for the Year to Date offsetting vacancy savings in support personnel. Activity related variances in Clinical Supplies for Pharmaceuticals are $266k unfavourable for the Year to Date and Laboratory consumables including blood products are $102k unfavourable for the Year to Date. Clinical Engineering Service equipment repairs (parts) are $40k unfavourable for the Year to Date. Patient Meal costs are also $19k unfavourable for the Year to Date representing increased demand. Cleaning and orderly recharges to other operating groups for increased demand is $352k favourable for the Year to Date.

**Summary:**
The overall financial position for Hospital Operations is $96k favourable for the Year to Date. This is primarily due to Personnel costs which are $219k favourable (net of outsourced cost of casuals) due to contract FTE vacancies. Increased volume related consumable costs which are $427k unfavourable for the Year to date have been offset by $418k unbudgeted revenue allocated to the Operating Group.
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.

**Scorecard**

![Scorecard](image-url)
STRATEGIC INITIATIVES

Specific deliverables/actions to deliver improved performance will consider:

| Inventory management for clinical and non-clinical supplies | On Target |
| Infrastructure costs/contracts and energy efficiency reviews and savings | ✔ |
| Commencement of new mental health facility He Puna Waiora, to replace Taharoto Unit | ✔ |
| Mason Clinic remedial work | ✔ |
| Extension of the Waitakere hospital Emergency Department | ✔ |

* include a ✔ or a ✗

Health Information Group
An extension of the SharePoint Information Portal pilot (started in ED) allows aspects of enterprise content management to be piloted. The statement of work for the 12-week SharePoint Pilot Extension includes:

- Development of an Official Information Act (OIA) controlled document. The workflow for this document is already in draft form and therefore progress should be seen within the next two months
- Development of the ‘Approval to Recruit’ form for Human Resources to align to recent changes in policy and process
- Creation of a Ward Portal displaying nursing KPIs and allowing exploration of inpatient information.

This pilot will run until end of February/beginning of March.

Wireless coverage has been deployed to all inpatient areas at Waitakere, all renal dialysis units and all haematology wards at North Shore Hospital (NSH). Maternity and SCBU areas are in progress now. The patient wireless access is live in the pilot site (NSH Renal) to evaluate how the service should be communicated to staff and patients, to allow the development of a basic set of frequently asked questions and support requirements. In total 20 of the 44 identified sites are now complete.

A Request for Proposals (RFP) has gone out to the market for a business intelligence tool (or tools) to complement our existing standard reporting tools for clinical information. The purpose of purchasing BI software is to provide improved presentation of KPIs and other metrics and an interactive, data discovery experience for users. This tool will provide users with ‘self-service’ information portals, releasing pressure on the Health Information Analysts.

Solutions Plus – the colposcopy database was successfully upgraded on Saturday 15th November to Version 7.19.54. Clinical benefits to the Waitemata DHB Gynaecology / Colposcopy Service include:

- Removal of the management / check systems related to managing paper forms sent to the National Cervical Screening Programme (NCSP) – this will result in a reduction in team support / Nurse Practitioner time dealing with form issues
- Removal of paper results as the system will provide a robust system for colposcopists to check all results have been managed appropriately. Resulting in reduction of nursing staff managing paper results / double handling of results for clinicians
- Meet contract compliance with the NCSP regarding reporting to the 2013 standards – we previously had a 2008 reporting version
- Ability to capture images which is particularly useful in managing difficult / discrepant cases and for discussing cases at multi-disciplinary meetings
- Increased functionality regarding reporting
- Reporting to ensure colposcopists meet re certification requirements / NCSP Guideline

Waitemata DHB, Hospital Advisory Committee Meeting 17/12/2014
Facilities & Development

Facilities Maintenance

Replacement of NSH vacuum pumps and controls remains outstanding from August 2013. Two reviews have been completed and the final revised business case has been delayed. The updated timeframe for the final business case to be submitted is October 2014.

Legionella tests of potable water at Waitemata DHB sites for August and September 2014 remain negative.

For the period ending 31 August, the completed work requests are 91% for NSH and 89% for WTH and Mason Clinic and for the period ending 30 September, the completed work requests are 68% for NSH and 88% for WTH and Mason Clinic.

Compliance

The annual HSNO audit and certification has been completed for all owned campuses for both the stationary container and location certificates. 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. Diesel tank No 4 at WTH was relocated and this task invalidated the certification in place. Remedial works are underway to complete the defects, followed by a re-inspection.

Leasing

15 Shea Terrace, Level 2 - the landlord has provided the deed of renewal for a further term of three years commencing 24 June 2014. The landlord has also conceded the rent review and therefore the rent will remain at the current level of $259,000 + GST per annum.

15 Shea Terrace, Level 1 – as above, the landlord has provided the deed of renewal for a further term of three years commencing 1 June 2014. The landlord has also advised that a nil increase will apply to the rental; therefore the annual rental remains $236,148.00 + GST per annum.

CADS Mt Eden Lease Renewal - The Deed of Renewal and rent review is being circulated for sign-off at 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. MHS continue to review the future location of this CADS team. The CADS Regional Manager has been advised that a final decision is required immediately.

New Lynn Integrated Health Facility - the Deed of Sub-Lease between New Lynn Health Consortium Limited and Waitemata DHB has been executed by Waitemata DHB’s Board Chair and returned to the landlord for their sign-off.

96 Apollo Drive, Albany - The schedule of Waitemata DHB fixtures and fittings has been completed and added to the lease documentation. The landlord is currently disputing Waitemata DHB’s ownership of the building fitout. The proposal to negotiate a reduced rental against the early execution of the first Right of Renewal in exchange for a fixed rental will be concluded this month.

Sustainability

LED lighting proposals are being reviewed for the retrofit of ESC and the Patient Service Centre. LEDs are on average 60% more efficient than standard lighting tubes, delivering good financial savings. A business case is being drafted for review of achieving these savings.
Work to roll out waste diversion programmes across all major facilities, both owned or leased, is currently underway with all newly built facilities such as Tātari Oranga O Te Raki having waste diversion systems implemented as soon as they open. Additional leased sites that now have waste segregation systems in place include 1, 15 and 17 Shea Terrace, Breast Screening in Takapuna and Waimarino Building in Henderson.

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.

Waste auditing has been completed at WTH, ESC and NSH with very positive results. The waste contamination is now almost completely related to co-mingled recycling, where non-recyclable items are being placed in the recycling bins, predominantly in the staff cafeterias. Although this requires additional work, the contamination levels are around 60% lower than that shown from previous audits, possibly because of new signage being developed and installed at recycling stations. ESC managed to achieve an unprecedented 0% contamination level of their recycling, an outstanding achievement.

Water usage tracking sheets are being upgraded to highlight areas that go above or below 10% of their usual average. This will allow us to quickly identify any leaks or wastage and work to fix these in a timely manner.

An Auckland Transport/Waitemata DHB collaborative Staff Travel Expo was a great success and follow up articles and promotions has 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 to reduce staff parking shortages by a significant degree. We have also recently run a bike to work expo at NSH, offering staff free bike safety training, route planning and the opportunity to hire a bike for a month for free, to give it a go.

Waitemata DHB has just won the inaugural OraTaiao: The NZ Climate and Health Council award for Leadership in Sustainability by a Health Sector Organisation, which was presented at the Population Health Congress in Auckland.

**Human Resources**

A Senior Operational Engineer has taken retirement. The job description has been reviewed and job sizing has been completed by HR. The remaining two Engineers are reporting to the DFM whilst the senior role is vacant. Negotiations are taking place with the successful candidate and appointment to this role is expected to be imminent.

An application to start the recruitment process for a Plumbing Supervisor is expected in October 2014.

The Waitemata and Auckland DHBs’ Collaboration process has been completed. Tier 3 positions have been advertised and interviewing will commence shortly.

Approval has been granted to appoint two project managers. These roles have been advertised. Shortlisting will commence with interviews scheduled to take place during the week of 20 October 2014.

The Leased Facilities Maintenance Co-ordinator has resigned and finished employment with Waitemata DHB on Friday 3 October 2014. To assist with work demand, the vacancy gap has been filled by a temp.
COMMENT ON MAJOR FINANCIAL VARIANCES

The overall result for Provider Support is $1,698k Favourable for the Year to Date October 2014.

Revenue ($2,157k Unfavourable Year to Date)
Interest received is favourable by $736k due to higher cash balance in the overnight HBL sweep than planned, and income from non-resident patients is favourable by $168k. Car Park revenue is $79k unfavourable for the Year to Date 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 $3.5M for Year to Date. These savings will be realised in the other Operating Groups.
Expenditure ($3,855k Favourable Year to Date)

Personnel Costs ($1,948k Favourable Year to Date)
The favourable variance in personnel costs are due to support staff costs being $1,130k favourable due to the contracted FTE vacancy in Clinical Support - Cleaning and Orderly Services that are covered by agency casual staff and also reflects release of corporate provisions for costs being accrued in other services.

Other Direct costs ($1,907k Favourable Year to Date)
Budget Provision held in Provider Management for non-pay inflation risk is $1.0M favourable year to date. Outsourced personnel costs for casual cleaning and orderly staff are $917k unfavourable year to date. Cleaning and orderly recharges to other operating groups for increased demand is $352k favourable for the Year to Date. Interest and financing costs are also $834k favourable year to date due to delay in loan draw down associated with capital expenditure.
Position

The National Screening Unit (NSU) of the Ministry of Health recommends eligible women participate in the BreastScreen Aotearoa (BSA) programme. Screening mammography is the only proven public health intervention for reducing mortality from breast cancer. For most women the benefits of participation in the national breast screening programme will outweigh the harms.

The NSU requires that all women participating in the national breast screening programme are appropriately informed about the harms and benefits of screening, so that they can make an informed decision about participation in the screening programme.

The benefits of breast screening are frequently discussed more than the harms, yet understanding both is important. In the context of recent major reviews of breast screening, the known harms are described below. These harms are not new, or greater than previously considered by the BSA programme.

The intended audience of this statement is primary care practitioners who discuss breast screening with their patients.

Background

BreastScreen Aotearoa provides publicly funded, two-yearly mammographic screening for eligible1 women aged 45–69, with the aim of reducing mortality from breast cancer in this population. In addition, women diagnosed with breast cancer through BSA’s programme tend to be diagnosed at an earlier stage compared with those diagnosed outside the programme. As a result, women diagnosed in BreastScreen Aotearoa are more likely to have breast-conserving surgery, are less likely to require extensive axillary surgery and are less likely to require chemotherapy and radiotherapy (Royal Australasian College of Surgeons 2013).

Informed decision-making

The NSU recognises the importance of each woman making an informed decision about participation. This choice will be based on their personal preferences given the current evidence. BreastScreen Aotearoa and its providers acknowledge their responsibility to provide accessible, appropriate and accurate information to eligible women and their whānau.

The pamphlet provided to all women before their mammograms – Having a mammogram every two years improves a woman’s chances of surviving breast cancer – was updated in 2013 to include more information about the harms of screening.

Further information is available to women who would like more detail about breast screening, including on the BSA website. The booklet More about breast screening and BreastScreen Aotearoa discusses overdiagnosis and other risks. BreastScreen Aotearoa’s quality standards require all BSA providers to ensure that women are provided with information about the benefits and harms of breast screening and have the opportunity to have any questions answered before consenting to a procedure.

Recent international reviews

The debate around the benefits versus harms of breast cancer screening dates back decades and has been regularly monitored and reviewed by all national breast screening programmes, including that of New Zealand. Many of the differences in research outcomes appear to be due to differences in study design and methodology.

In response to ongoing controversy about breast screening, an independent review was commissioned by Cancer Research UK and the Department of Health (England) and reported in 2012 (Marmot et al 2012). The review was based on both literature review and expert testimony. The review concluded that breast screening

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1 Women are eligible for free mammography every two years through the BSA programme if they are aged 45–69 years, have not had mammography within the previous 12 months, are not pregnant or breastfeeding, are free from breast cancer (at least five years after a previous diagnosis), are asymptomatic and are eligible for public health services in New Zealand.
programmes confer significant benefit, and the report recommended that the United Kingdom breast screening programme should continue. It estimated that screening reduces breast cancer mortality by 20 percent among women invited to screening.

A Cochrane Review on the benefits and harms of breast screening was released in 2013. This review is an update of one published in 2006 (Gøtzsche and Nielsen 2006) and updated in 2009 (Gøtzsche and Nielsen 2009). It estimates that screening reduces breast cancer mortality by 15 percent for women invited to screening. However, the findings of the Cochrane Review have been challenged by various expert groups.

Both the Cochrane Review and the United Kingdom expert review have been criticised due to being largely based on potentially outdated randomised controlled trials (Baum 2013). They thus do not fully incorporate the effect of advances in treatment of breast cancer, which may reduce the relative effectiveness of screening. Advances in technology and improved screening technique and experience are also not accounted for.

When considering the benefits and harms of population-based screening in practice, outside the trial setting, recent observational studies of programmes similar to New Zealand’s provide more relevant evidence. EUROSCREEN has carried out a comprehensive analysis of observational data from European screening programmes (Broeders et al 2012; Paci and EUROSCREEN Working Group 2012). It concludes that breast cancer screening reduces mortality rates by 25–30 percent among invited women and approximately 40 percent among screened women.

Harms of breast screening

Though at a population level the benefits of screening exceed the harms, harms are an important ongoing consideration. All screening has limitations. As no screening test is 100 percent accurate, well women may be subjected to unnecessary interventions as a result of screening.

Anxiety, inconvenience, discomfort, radiation exposure, false positive and false negative results, and overdiagnosis are all recognised harms of breast screening programmes.

BreastScreen Aotearoa and external organisations regularly monitor the New Zealand programme against a set of programme targets and quality standards, many of which ensure that harms are minimised.

Overdiagnosis

Overdiagnosis is defined as diagnosis of a breast cancer through screening that would not have been identified clinically in the woman’s lifetime without screening (Cancer Australia 2014). This can lead to unnecessary treatment, including surgery and radiotherapy. There is currently no test that can differentiate these cancers from cancers that would have become clinically significant if left untreated.

Estimates of overdiagnosis vary with methodology used. The Cochrane Review estimated that the number of women overdiagnosed as a result of screening outnumbers the number of breast cancer deaths averted by a factor of 10:1, while the United Kingdom report provided an estimate of 3:1. However, the EUROSCREEN analysis showed that when background breast cancer risk and lead time are appropriately adjusted for, rates of overdiagnosis are lower than previously reported; this analysis estimated that only one case of overdiagnosis will occur for every two breast cancer deaths averted by screening (Puliti et al 2012).

Ductal carcinoma-in-situ (DCIS) is the pre-invasive stage of breast cancer, although not all DCIS will progress to invasive breast cancer. Because DCIS rarely presents as a palpable lump, it is less likely to be diagnosed clinically, but may be detected by mammographic screening. Therefore, detection of DCIS may contribute to overdiagnosis in breast screening programmes. It is not possible to differentiate which women diagnosed with DCIS will or will not progress to invasive breast cancer without treatment.

2 Screening causes an initial increase in breast cancer incidence in the screened group – the so-called ‘lead time effect’ – because cancers are detected earlier. However, this is compensated for by a decrease in breast cancer incidence after cessation of screening, when the group is older (ie. if more cancers are diagnosed when the group is younger, fewer will be diagnosed when the group is older). Studies that have inadequate follow-up time or that do not adjust for this lead-time will overestimate the incidence of overdiagnosis.
However, low-grade DCIS is less likely to progress to invasive cancer than high-grade DCIS. Reassuringly, in New Zealand, low-grade DCIS is not overrepresented as a proportion of all DCIS diagnoses within the BSA programme compared with non-BSA diagnoses (Royal Australasian College of Surgeons 2013).

False positive and false negative tests
A screening mammogram by itself does not diagnose cancer but indicates if further investigations are needed. Most women recalled to assessment will not have breast cancer diagnosed. For every 1000 women who have a mammogram in the BSA programme, 42 (4%) will be recalled to have further assessment. Of the 42 women recalled to assessment out of every 1000 women screened, 35 will not have breast cancer (Robson et al 2014). The screening mammogram result for these 35 women is a false positive.

Interval cancers
Screening mammography will not detect all breast cancers and this is a known limitation of screening. Some breast cancers will become clinically apparent between screens when the result of the previous screen was normal: these are referred to as interval cancers. A potential harm is that women who have been reassured by a normal screen may not present for investigation of symptoms. Most interval cancers (>70%) are true interval cancers and were not visible on the previous mammogram. The remaining interval cancers include those with false negative results, where in retrospect an abnormality was detectable on the screening mammogram. BSA interval cancer rates are similar to comparable screening programmes internationally (Taylor 2012).

Radiation exposure
Women are exposed to a very low dose of radiation during a mammogram. Digital mammography has been shown to use lower doses of radiation than film-based mammography (Hendrick et al 2010). Estimates of the actual dose associated with a mammogram vary widely, but the benefit of early detection of breast cancer is believed to outweigh the risk of the small dose of radiation (Marmot et al 2012). BSA has always achieved a low radiation dose, by international standards, while maintaining image quality ( Nicoll 2014).

Anxiety, inconvenience and discomfort
The compression associated with a mammogram can cause discomfort or pain for some women. International evidence shows that compression force is lower with digital mammography (Hendrick et al 2010), which is now routinely used in New Zealand.

Having a mammogram is associated with anxiety for some women, particularly if they are recalled for further assessment. In BSA’s programme, 4 percent of women will be recalled to have further assessment (Robson et al 2014). This also means that 96 percent of women are advised there is no evidence of breast cancer and will return to routine screening.

Breast screening programmes try to minimise the inconvenience of attending for screening by the use of local clinics and mobile units. However, for the 4 percent of women who are recalled for further assessment, the assessment clinics in New Zealand are only performed at larger centres, and women are required to travel and attend for part or all of a day.

Conclusions
The importance of clear communication of potential benefits and harms to women eligible for breast screening has been highlighted recently in many parts of the world. Ensuring women have full, fair and balanced information is an important part of BSA’s programme. Primary care providers can be a valuable part of the decision-making process.

The NSU recommends eligible women participate in the national breast screening programme as the benefits exceed the harms for most women. The decision to participate remains an individual decision.
References


6.1 Clinical Leaders Report

Recommendation

That the report be received.

Prepared by: Dr Andrew Brant (Chief Medical Officer), Jenny Parr (Acting Director of Allied Health) and Dr Jocelyn Peach (Director of Nursing and Midwifery; Emergency Systems Planner)

Medical Staff

Senior Medical Officers values week 24th to 28th November

50 SMOs spent a whole day discussing the importance of our values in delivering high quality and safe care. Sessions were divided into focusing on the role of teamwork and patient centred care. During the sessions the evidence for the link between the values and patient outcomes were explored. The session’s purpose was so the SMOs involved could help design a programme that would engage their fellow SMOs in the values work throughout the organisation.

There was a strong engagement in the programme, and excellent feedback, and a surprise to many participants was many of their colleagues being interested in the same area. There was a comfort in discussing values in an organisational context rather than a purely professional (doctor) context - which was an assumed barrier before these sessions occurred. The next steps now is for the project team to distil the outcomes of the workshops, and to develop a plan to further engage doctors and their teams around the values in 2015

We held a further GP open evening on 17 November - around 20 GPs attended

The GPs were taken around the MRI suite, interventional radiology suite, as well as through the cardiology ward and cardiology intervention laboratory. The tours was then followed by a presentation on developments in the Mental Health services about engagement with primary care by Dr Murray Patton, Head of Division of Mental Health Services, and Dr Lyndy Mathews, who is the new primary care lead for mental health. An open forum for questions followed. A range of issues came up including questions about who and which organisations provide mental health services in the community and the role of our provider arm mental health services. Issues that were raised were noted and now form the basis for work in between the forums between primary care and our services.

The WDHB executive team and ASMS sponsored SMO engagement forum has been postponed until February 2015

This forum will focus on the work of the quality indicators that are being developed throughout the services. Also planned for the agenda are cultural competence, and an update on the Information services.
Allied Health, Technical and Scientific Staff

Glossary

AAW - Antibiotic Awareness Week

Allied Health, Scientific and Technical leadership review
Jenny took up position as Acting Director of Allied Health on the 17th November 2014 for 6 months. During this time she will lead a review of the leadership needs of the professions supported by Tazmin Brott, Head of Division Allied Health Medicine and Health of Older People and Surgical and Ambulatory.
The three areas of focus for the six months are to:
1. Understand the future requirements of allied health leadership using an engagement process
2. Undertake a stock take of the professions which include workforce, productivity, patient outcomes and standards being worked to.
3. Determine how quality improvement can be systematically embedded going forward

The review provides an opportunity to listen, take stock and shape out the future of allied health leadership at Waitemata DHB in partnership with the Allied Health, Scientific and Technical professions.

During the course of the six months, Jenny will also provide:
- Leadership to AH, Scientific and technical professionals in conjunction with professional leads
- A strong connection between ELT and the frontline
- Effective engagement of the Allied Health leaders
- Promote Allied Health and quality improvement and innovation
- A specific focus on quality improvement

Pharmacy
The Antimicrobial Stewardship Group organised a number of events to raise awareness of Antibiotic Awareness Week (17th – 23rd November). The events were co-ordinated by Kristen Bondesio, Antimicrobial Stewardship Pharmacist and included:
- Displaying posters around NSH and WTH with information on appropriate antibiotic prescribing
- The AMS committee and a variety of other hospital staff from different disciplines (doctors, pharmacists, nurses) wore Antibiotic Awareness Week T-shirts
- Distributing Antibiotic handbooks including incoming house officers
- A presentation at Grand Round and Frontline Focus Friday on antibiotic resistance and appropriate antibiotic prescribing
- Messages in Waitemata Weekly, on the intranet homepage with a link to a video on antibiotic resistance
- A letter from the CEO was sent out to all staff with hard copies to Clinical Directors supporting AAW
- A message in the primary healthcare bulletin with links to an article about community use of antibiotics in NZ and the Australian antibiotic awareness week website

Laboratory Service
The Laboratory Service held its annual Waitemata Scientific Seminar on Saturday 22nd November at North Shore Hospital. This event was attended by 130 participants on-site and 14 video-conference sites throughout New Zealand. A marquee occupied the car park area behind Awhina for catering and all of
the conference rooms were utilised for the day. Presentations videos will be available on our external website: www.nzice.co.nz.

Nursing and Midwifery

Glossary
CALD - Culturally and Linguistically Diverse
CIMS - Co-ordinated Incident Management System
HWNZ - Health Workforce New Zealand Funding for post graduate nursing education
NETP - Nursing Entry to Practice programme [new graduate]
PDRP - Professional Development and Recognition Programme

i. Patient experience
Over the past two years, 58 patient/health care assistants have completed the Level 3 national certificate for health care support workers, with the assistance of nurse educator Lynley Davidson. The focus of this development of the unqualified workforce has been on improving the patient experience. Participant reflections demonstrate change in practice, especially support of registered nurses in care of vulnerable elderly and people with dementia. This study has supplemented the annual training offered for this workforce to assist their effectiveness and work with patients and teams.

The senior nurses and midwives are working with their teams to address the patient experience feedback and embed improvements that will enhance patient perceptions and experience.

ii. Care and safety
Considerable work has been undertaken over the past 12 months to enhance medication administration safety. This has included update of 60 plus policies and procedures, as well as redevelopment of the
competence assessment process in liaison with Perrin Rowland of Learning and Development. The improvements made use of new technology and have created flexibility to cope with increasing specialisation and clinical complexity.

**iii. Support a positive staff experience**

**New Graduate Entry to Practice Programme**

The Nursing Development Service has hosted (on 4 December) a Nursing Council of New Zealand audit of the New Graduate Entry to Practice Programme for the general and primary health programme. This audit occurs every 3 years and ensures compliance with the Health Workforce New Zealand contract requirements and Nursing Council of New Zealand specifications. The evidence required for the audit has been compiled by nurse educators of the programme, Jacqui Finch and Sylvie Dombroski. A range of nurse managers, preceptors and new graduate participants from the provider, primary healthcare and NGO agencies that we partner with have been interviewed by the Assessor.

Waitemata DHB has provided a well-respected new graduate programme over the past fourteen years for general, primary care, mental health and midwifery. To date, 1179 nurses and midwives have been supported in their first year of practice. Retention of these new graduates is greater than 70% after 24 months and 45% in five years.

New graduate numbers in the Waitemata DHB programme

<table>
<thead>
<tr>
<th></th>
<th>February 2014</th>
<th>September 2014</th>
<th>February 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>81</td>
<td>43</td>
<td>77 *</td>
</tr>
<tr>
<td>Maori</td>
<td>2</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Pacific</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Completing Dec 2014</td>
<td></td>
<td>Underway</td>
<td>To start</td>
</tr>
</tbody>
</table>

Primary Care are still recruiting to the February NETP intake.

**Advanced Practice roles**

In 2014, two nurses have been recognised by Nursing Council of New Zealand as Nurse Practitioners: Carol Dewse, Nurse Specialist in Emergency Department Waitakere and Carole Pilcher, Gerontology Nurse Specialist working with elderly in the community and residential aged care. Coral Skipper, Diabetes Nurse Specialist, was also acknowledged last Wednesday for her work with Waipareira Maori Diabetes Service. We are very pleased with the expertise and commitment these nurses contribute to the health of our community.

**Learning and Development: Workforce Development**

**In-house Learning**

The DHB service clinical nurse/midwife educators have provided 182 study day learning sessions in 2014 and planning is underway to meet clinical safety learning needs in 2015. This learning is focused on clinical practice safety and practice that reinforces the values of the DHB.

The 2615 FTE Nurses and Midwives are required to complete at least 20 learning hours per annum to meet regulating agency credentialing. The DHB supports this through targeted learning options that assure safety and consistency of practice. The learning occurs through on-line e-learning options as well as face to face learning. This is specified in each service ‘learning framework’ and staff access is monitored in annual appraisal and three yearly in portfolio assessment. Included in the core learning is completion of the CALD e-learning modules. The following information is available regarding nurse/midwife completion of CALD learning which is a core learning requirement and being actively promoted in portfolio assessment and learning frameworks [see September 24/09/14 HAC question].
Summary of Nurses, Midwives, Health Assistants who completed CALD courses from March 2009 to October 2014

- Number of Nurses completed CALD courses: 539
- Number of Midwives completed CALD courses: 11
- Number of Health Assistants completed CALD courses: 17
- Total: 567

Detailed Information - CALD Cultural Competency Courses

Module 1: CALD 1 Culture & Cultural Competence (rolled out mid 2010) online and face to face
Module 2: Working with Asian Migrant Patients (rolled out late 2010) online and face to face
Module 3: Working with Refugee Patients (rolled out mid 2011) online and face to face
Module 4: Working with Interpreters (rolled out early 2011) online and face to face
Module 5: Working with Asian Mental Health Clients (rolled out 2010) face to face only
Module 7: Working with Religious Diversity (rolled out mid 2012) online and face to face

Working with CALD Families - Disability Awareness (rolled out late 2012) online and face to face
Working in a Mental Health Context - with CALD clients (rolled late 2013) online and face to face

NB: CALD 1 is a pre-requisite to all other CALD courses, therefore the total number of nurses completed CALD 1 refers to the total number of nurses who have taken up at least 1 or more CALD courses.

Professional Development & Recognition Programme

Over the past 11 months 545 portfolios have been assessed as part of the DHB professional credentialing process.

<table>
<thead>
<tr>
<th>Portfolios received [* to Nov]</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>375</td>
<td>554</td>
<td>544</td>
<td>578 *</td>
</tr>
</tbody>
</table>

Waitemata DHB has a 68% achievement of portfolio assessment [i.e. each nurse has a portfolio assessed every three years]. This is a high compliance rate with the Health Practitioner Competence Assurance Act requirements when compared nationally.

Level 4 highly proficient nurses recognition: 21 applications were received in October and have been acknowledged at RN Level 4. We are fortunate to have their additional contribution to safety and patient outcomes. In 2014 37 nurses have received acknowledgement at RN Level 4.

Health Workforce New Zealand (HWNZ) Post Graduate funding for Nurses

HWNZ post graduate funding has been allocated for 2015 to develop capability of the profession to respond to future health needs. All available funding is allocated which is unfortunately not sufficient for the level of interest/demand. Those unfunded have access to the post graduate fund and are also waitlisted.

PRIMaRY care [ring fenced]

<table>
<thead>
<tr>
<th>Year</th>
<th>Applications</th>
<th>Funded</th>
<th>Not funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>79</td>
<td>57</td>
<td>-22</td>
</tr>
<tr>
<td>2015</td>
<td>66</td>
<td>66</td>
<td>0</td>
</tr>
</tbody>
</table>
28 nurses have completed their qualifications in 2014. They are to be congratulated on their success, especially those who have completed Masters programmes. The majority of these nurses have worked full time and studied to achieve their qualification.

Emergency Systems Planning
In preparation for the summer holidays, key contingency plans have been reviewed and outstanding issues worked through.

The recent two-day Incident Management Team training was most successful, with a dozen senior operational staff working on a range of scenarios to reinforce how they would work together as a team to manage an emergency situation in key CIMs roles of: Incident Controller, Planning, Intelligence/Liaison, Logistics, Communications and Support roles. A second training programme will be offered early in 2015. The two groups will be assisted to develop their expertise through the 3 monthly ‘breakfast’ sessions.

The Fire Service has trained with the DHB staff to review evacuation procedures. The training, titled ‘Verti-Evac’ has involved six fire crews, an aerial appliance positioned adjacent to the Tower Block of the hospital to scope its capabilities against the height of the Tower Block; aerial evacuation off the roof of the North Shore Hospital Tower Block; and stairwell evacuation using a variety of equipment. The interim Evolving Viral Disease [EBOLA] plan has been completed and key staff trained according to our plan and the anticipated interface with the bio-containment units at Auckland and Middlemore Hospitals.

<table>
<thead>
<tr>
<th></th>
<th>Applications</th>
<th>Funded</th>
<th>Not funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>286</td>
<td>152</td>
<td>-134</td>
</tr>
<tr>
<td>2015</td>
<td>262</td>
<td>142</td>
<td>-120</td>
</tr>
</tbody>
</table>

53% funded
54% funded
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. Recruitment

1.1 Recruitment Dashboard as at 31 October 2014

| Total number of hires were 130 | Internal 55  
|                              | External 75 |
| Average time to hire          | 60 days     |
| Average number of positions   | 268.96 FTE  
| vacant as at 31 Oct 14        |             |
| Current number of vacancies   | Medical – 27.63  
| (FTE)                        | Nursing 120.49 |
|                              | Allied Health – 66.60  
|                              | Support – 27.88  
|                              | Mgt/admin – 26.36  
|                              | 268.96        |
|                              | (vacancy rate of 4.5% of total FTE) |

The average number of vacancies is down from last month to 268.96FTE which is good to see, as this time last year we were sitting at around 318FTE vacant.

The average time to hire below stays relatively consistent at between 50-70 days (Table 1). Most Senior Medical Officer roles tend to take longer to recruit to and it is possible that the time it takes to recruit to one role can lift the overall average, so Table 2 shows the time to hire for SMOs which has reduced for October from over 200 days to 107 days. If we exclude SMOs from our overall average time to hire, the average drops to 57 days (table 3).

Time to hire is calculated from the time a Recruitment Requisition is approved to the time an offer is accepted by a candidate.
Table 1: Average time to hire August 2013 to October 2014

Table 2: Average time to hire for SMOs August 2013 to October 2014

Table 3: Average time to hire for all other roles (excluding SMOs) August 2013 to October 2014
1.2 Top sources for recruitment

The WDHB Careers site still leads as the top source of hires for Waitemata DHB. It is good to see that the friend referral is still high as this means that we are getting some good referrals from our staff.

<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>22%</td>
<td>2%</td>
<td>It is worth noting that this time last year there was an issue with the Source reporting from Taleo so that only 52 out of 143 sources were recorded for October 2013.</td>
</tr>
<tr>
<td>2. <a href="http://www.waitematadhb.govt.nz">www.waitematadhb.govt.nz</a></td>
<td>11%</td>
<td>0%</td>
<td>This is a big increase from last year. The Communications department has worked on this site to improve its search ability.</td>
</tr>
<tr>
<td>3. A friend</td>
<td>17%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>4. WDHB Intranet</td>
<td>8%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>5. WDHB Careers Section</td>
<td>7%</td>
<td>3%</td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Top 5 Sources of Hire for October 2014

1.3 Ethnicity of new employees

Below is the breakdown of ethnicity of new staff who commenced with Waitemata DHB from July to October 2014. There is a mix of new staff ethnicity in the Support group and in Nursing and the Medical groups; the mix is mostly between NZ/European and Asian. We have split out the Nursing group and you can see that high number of staff identifying as an Asian ethnicity have recently been employed into Nursing and Healthcare Assistant roles.

Table 5 – Ethnicity of new starters by staff group
MELAA is a group amalgamation of Middle Eastern, Latin American and African ethnicities
2. Workforce

2.1 Best Care for Everyone – Values programme

October has been focused on preparing for the week in November when we are working with Tim Keogh from April Strategy and with HODs, CDs and other SMOs to develop an SMO specific values based patient centred care and team work programme.

We have also been working on a range of other activity which includes:
- Proposal to realign the steering group
- Communications planning
- Supporting service groups to embed patient experience and values into their service planning
- Ensuring values education is provided to all employees in their orientation period

2.2 Pacific Health Science Academy

The Regional Pacific Health Science Academies were acknowledged in a launch event on 8 October at Waitemata DHB. The launch was held during Waitemata DHB’s inaugural Pacific Week and was attended by senior DHB members from the region alongside senior Ministry of Health officials. Teachers and students from each of the Academy schools were present and feedback from them has been hugely positive about the positive messages and energy at the launch.

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Table 6 – Ethnicity of new starters broken down for the Nursing and Midwifery group
MELAA is a group amalgamation of Middle Eastern, Latin American and African ethnicities
Science Academy Student Selection

The Waitemata and Auckland DHB Health Science academies have completed their selections for 2015. For the two science academies there are altogether 56 Pasifika students across all three year groups. Further details are as follows:

### Onehunga High School

<table>
<thead>
<tr>
<th></th>
<th>Pasifika</th>
<th>Maori</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 11</td>
<td>18 (49%)</td>
<td>8 (21%)</td>
<td>11 (29%)</td>
<td>37</td>
</tr>
<tr>
<td>Year 12</td>
<td>14 (41%)</td>
<td>5 (14%)</td>
<td>15 (44%)</td>
<td>34</td>
</tr>
<tr>
<td>Year 13</td>
<td>6 (40%)</td>
<td>2 (13%)</td>
<td>7 (46%)</td>
<td>15</td>
</tr>
</tbody>
</table>

### Waitakere College

<table>
<thead>
<tr>
<th></th>
<th>Pasifika</th>
<th>Maori</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 11</td>
<td>18</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>86%</td>
<td>14%</td>
<td>100%</td>
</tr>
</tbody>
</table>

There is a difference in the way that each school has implemented the Health Science Academy model (see tables above). Onehunga High School has chosen to implement the academy across three year levels from 2015, whereas Waitakere College has opted for the conventional model of implementing a Year 11 cohort to start in 2015.

The programme at both schools is made up of:
Year 11 (NCEA Level 1) Health Science Academy (HSA) students are offered “Health Science” as a 4 hour session that all HSA students are required to take.
Year 12 and 13 (NCEA Level 2 and 3) participate in Chemistry, Biology and Physics classes that are already available.

At Onehunga High School, after school tutorials provided by parishioners from St Margaret’s Church for Year 11 HSA students are available to ensure students have the best opportunity to get through their exams.

### 2.3 Regional Tertiary Mentoring Programme

The second part of the Pacific Workforce Development Programme is the introduction of mentoring programme for Pacific tertiary students studying health. Auckland University of Technology City Campus
hosted an event on 16 October to match mentors to mentees. It was a successful evening in which 56 students and eight mentors attended. The evening was facilitated by Josephine Samuelu, Workforce Consultant from Counties Manukau District Health Board, Sina Moore Chief Executive from Leadership NZ, and the Brown Touch Down, the team of young Pacific mentors who advocate for Pacific young people in this space. The speakers were Hilda Fa’asalele, Chief Advisor Pacific, and Saleimoa Bill Sami, Pacific undergraduate medical student. There was positive feedback from both students and mentors about how valuable and fun the evening was for them.

2.4 Maori and Pacific Health Tertiary Study Scholarships

Since 2012 the DHB has granted a total of 48 scholarships. Approximately 25% of students are Maori students and 16% Pacifika students.

From the 2012/13 cohorts, 68% of scholarship students were employed. We expect over 80% of students in 2014 to be employed back to Waitemata DHB.

2.5 Rangatahi Programme

The Rangatahi Programme has been developed for Maori and Pacific Island senior secondary school students to facilitate Maori and Pacific student recruitment and retention in secondary school, tertiary education, and transition into the health workforce. The Rangatahi Programme is run and hosted by Auckland DHB and is made up of three components - An introduction day; work experience week; and cadetships (10 per annum). Waitemata DHB fund an additional five cadetships.

The cadet role has been established to introduce students to a healthcare organisation and the concept of professional practice, clinical support roles and interdisciplinary team work. The aim of the role is to give a broad understanding of what it’s like to be a qualified health professional. The cadets undertake paid workforce experience in hospital/health settings over 10 weeks. All cadets will work under the direction and supervision of a designated health professional or DHB staff member. Orientation and training to support a negotiated work plan that complements the cadet’s area of interest is provided.

There is evidence to suggest these cadetships successfully transition students into tertiary education which is a widely recognised problematic point along the pipeline model. All the cadets from 2013/14 are still engaged and have completed their first year of tertiary education.

The 2014/15 Rangatahi Programme cohort includes the first graduates of the Health Science Academy at Hato Petera College, which is a joint initiative with Waitemata DHB. The Auckland DHB and Waitemata DHB Maori Health and Pacific Health Workforce Development Consultants are working collaboratively with the team at Auckland DHB towards establishing the Rangatahi Programme for Waitemata DHB by 2015/16.

3. Education and Learning

3.1 Nurse educator and clinical coach development programme

This year the nurse consultant in the Nursing Development Service (Awhina) is leading a comprehensive programme of development for nurse educators and clinical coaches. The programme includes forums to build a community of practice and skill development sessions designed and delivered by Awhina and partners.
This month the following sessions were delivered:

- *Introduction to adult learning* for clinical coaches. Written evaluations will be collated and reviewed. The initial indications are that ‘a different level of discussions about teaching are happening’ following the session.
- Forum session including a presentation on integrating patient stories into teaching and learning.
- A workshop on knowledge and skills for enrolled nurses.

In development are courses for peer consultation – for clinical coaches; and train-the-trainer for nurse educators - a four day course which will be run and evaluated early 2015.

### 3.2 New graduate nurses - 2015 intake

We have had a very successful recruitment process for new graduate nurses starting in February 2015 with the Nursing Entry to Practice (NETP) and Nursing Entry to Specialty (NESP) programmes. NESP is for Mental Health graduates. We attracted and were chosen by a very high standard of applicants and currently have 77 places filled from 86 funded places.

The primary health care nurse development team continues to provide support and training to new graduate nurses in primary care who are not on the NETP programme. Invitations have gone out to attend study days and eight new graduate nurses in primary care have accepted.

A regular three yearly audit of the NETP programme by Nursing Council of New Zealand includes a site visit on 4th December. The programme has always met every criteria at audit and is recognised as providing good graduate support and achieving successful outcomes. Previous new graduates have been supported to continue their development, are contributing at many levels and some have been recognised as high flyers and recommended for the GROWTH Coaching programme.

A recent *creative space* day with the NETP team focused on the design of the NETP programme. The outcome is a shift to a greater patient-focused approach, problem-based learning with integrated comprehensive patient scenarios.

### 3.3 GROWTH Coaching national award

This month Waitemata DHB’s GROWTH coaching programme was awarded second place in the NZ Association of Training and Development annual awards, learning initiatives category. This award recognises excellence in the design and implementation of organisational learning and development programmes.

The judges stated “Waitemata DHB’s GROWTH programme is a personalised, in-house coaching programme that has not only increased job satisfaction for its participants, but is winning buy in and long term commitment from staff. The on-going coach development programme, which includes master-classes and supervision, helps to grow and sustain the programme.”
3.4 Training on quality tools for Senior staff

An orientation programme is being developed for senior leaders focusing on values, purpose, quality improvement, change and project management methods used at Waitemata DHB. The programme will be rolled out next year and be compulsory for all senior leaders to attend.

4. Knowledge and Research

4.1 Waitemata Health Excellence Awards:
In its 13th year, the awards showcase the outstanding work by health professionals in our district to improve the health and wellbeing of the communities we serve.
The Health Excellence Awards are about celebrating innovation and excellence in healthcare. This event promotes a sharing of knowledge gained from projects that:

- improve practice
- develop and support the workforce
- encourage community cooperation, compassionate healthcare and equitable access to health solutions.

These awards are an opportunity for individuals, teams, and collaborative groups of health workers in our district to showcase their achievements.
The Awards' aims are to:
- acknowledge work done by people working in the district to improve the quality of service and to improve health gain
- recognise achievements of individuals, teams, wards, departments, primary care providers and GPs participating in quality improvement projects
- improve co-operation and understanding between primary care providers and Waitemata DHB
- contribute to the quality and research focus of Waitemata DHB

Timelines for Entrants
10 November 2014 Online abstract registration opens (Closes 3 December 2014)
10 December 2014 Abstract review committee outcomes notified
9 February 2015 ‘Presenting with Impact’ Workshop for those who wish to hone their skills - Sponsored by Awhina Education & Learning
2 March 2015 Last date to submit posters (including an electronic file of all posters)
9 March 2015 Poster judging and online voting for People’s Choice Poster opens
17th March and 19th March 2015 Preliminary oral presentation round
23 April 2015 Grand Round Finals of Oral Presentations at Awhina Conference Rooms, North Shore Hospital

5. Internal Communications

5.1 Projects underway

Christmas 2014
Various events have been organised to celebrate Christmas this year with the staff. These include:
- A visit by the City Impact Church to help staff decorate their wards and the main foyers at both Waitakere and North Shore hospitals.
- Christmas Decorations competition judged by Dale Bramley.
- A walk-about involving Dale and the Well Foundation team going around the main hospital sites as well as some of the outlying sites to do a meet and greet with staff.
- A thank you from the CEO of a morning tea of scones and strawberries will be delivered to every department within the main hospital sites.
- Christmas carolers will perform at Waitakere Hospital.
- Participation in a children’s Christmas party at Wilson Centre.
- The parking barriers will be lifted at each hospital site from the night of Christmas Eve through to Boxing Day, giving staff and patient visitors free entry over Christmas to visit loved ones.

Sustainability Education
We are creating posters to inform staff about recycling and efficient use of resources.

5.2 Publications for the month

The DHB is producing a yearbook to be published in DHB activities throughout 2014. The yearbook will feature stories on projects completed and approved this year, an update on the Well Foundation, Health Links and Maori/Pacific Scholarships as well as photo spreads from various events throughout the year. The yearbook will be published online with a small number of print editions. Print editions have been funded by a supplier at no cost to the DHB.