Waitemata
District Health Board

Best Care for Everyone

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING

Wednesday 16th December 2015

2.00pm

A G E N D A

VENUE

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

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING
16th December 2015

Venue: Waitemata DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna Time: 2.00pm

Committee Members	WDHB Management
James Le Fevre – Committee Chair	Dale Bramley – Chief Executive Officer
Lester Levy – WDHB Chair	Robert Paine – Chief Financial Officer and Head of Corporate Services
Max Abbott – WDHB Board Member	Andrew Brant – Chief Medical Officer
Kylie Clegg – WDHB Board Member	Jocelyn Peach – Director of Nursing and Midwifery
Sandra Coney – Deputy Committee Chair	Cath Cronin – Director of Hospital Services
Warren Flaunty – WDHB Board Member	Debbie Holdsworth – Director Funding
Tony Norman – WDHB Deputy Chair	Jenny Parr – Acting Director of Allied Health
Morris Pita – WDHB Board Member	Fiona McCarthy – Director Human Resources
Christine Rankin – WDHB Board Member	Paul Garbett – Board Secretary
Allison Roe – WDHB Board Member	
Gwen Tepania-Palmer – WDHB Board Member	
Susanna Galea – Co-opted Member	
Willem Landman – Co-opted Member	
Donna Riddell – Co-opted Member	
David Ryan – Co-opted Member	

Apologies: Tony Norman, David Ryan and Jenny Parr

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 2.00pm

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Waitemata District Health Board

Hospital Advisory Committee Member Attendance Schedule 2015

NAME	FEB	APR	MAY	JULY	AUG	SEPT	NOV	DEC
Dr Lester Levy (Chair)	✓	x	x	✓	x	x	*	
Max Abbott	✓	✓	✓	✓	✓	✓	✓	
Pat Booth	✓	^	^	N/A				
Sandra Coney	x	✓	✓	✓	x	✓	✓	
Warren Flaunty	✓	x	✓	✓	✓	*	x	
James Le Fevre (Committee Chair)	✓	✓	✓	✓	✓	x	✓	
Tony Norman(Deputy Chair)	✓	✓	✓	*	✓	✓	✓	
Morris Pita	x	✓	✓	x	✓	✓	✓	
Christine Rankin	✓	✓	✓	✓	✓	✓	✓	
Allison Roe	✓	✓	✓	✓	x	✓	✓	
Gwen Tepania – Palmer	x	✓	✓	✓	✓	✓	x	
Co-opted members								
Susanna Galea	✓	✓	✓	✓	✓	x	✓	
Willem Landman	x	✓	✓	x	✓	✓	✓	
Donna Riddell	✓	✓	✓	✓	✓	✓	✓	

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

Register of Interests

Board/Committee Member	Involvements with other organisations	Last Updated
Lester Levy	Chair – Auckland District Health Board Chairman – Auckland Transport Independent Chairman – Tonkin & Taylor Chief Executive – New Zealand Leadership Institute Professor of Leadership – University of Auckland Business School Trustee - Well Foundation (ex-officio member)	11/09/15
Max Abbott	Pro Vice-Chancellor (North Shore) and Dean – Faculty of Health and Environmental Sciences, Auckland University of Technology Patron – Raeburn House Advisor – Health Workforce New Zealand Board Member, AUT Millennium Ownership Trust Chair – Social Services Online Trust Board member – Rotary National Science and Technology Forum Trust	19/03/14
Kylie Clegg	Board Member - Hockey New Zealand Trustee and Chairman - the Hockey Foundation Trustee and Beneficiary - Mickyla Trust Trustee and Beneficiary - M&K Investments Trust (includes a share of less than 1% in Orion Health Group) Trustee and Beneficiary - M&K Investments Trust (owns 99% share in MC Capital Ltd, MC Securities Ltd and MC Acquisitions Ltd)	25/11/15
Sandra Coney	Chair – Waitakere Ranges Local Board, Auckland Council	12/12/13
Warren Flaunty	Member – Henderson - Massey and Rodney Local Boards, Auckland Council Trustee (Vice President) - Waitakere Licensing Trust Shareholder - EBOS Group Shareholder – Green Cross Health Owner – Life Pharmacy North West Director – Westgate Pharmacy Ltd Chair – Three Harbours Health Foundation Director - Trusts Community Foundation Ltd	25/11/15
James Le Fevre	Emergency Physician – Auckland Adults Emergency Department Pre-hospital Physician – Auckland HEMS – ARHT/Auckland DHB Co-opted Member – Whanganui District Health Board Hospital Advisory Committee Trustee – Three Harbours Foundation Member – Association of Salaried Medical Specialists Shareholder – Pacific Edge Ltd James' wife is an employee of the Waitemata DHB, Department of Anaesthesia and Perioperative Medicine	12/08/15
Anthony Norman – Deputy Chair	Board Chair - Northland DHB Director - Health Alliance NZ Ltd Director - Health Alliance (FPSC) Ltd Trustee and Treasurer - Kerikeri International Piano Competition Trust Partner - Mill Bay Haven, Mangonui (accommodation provider)	05/11/14

Board/Committee Member	Involvements with other organisations	Last Updated
Morris Pita	Board Member – Auckland District Health Board Owner/operator – Shea Pita and Associates Limited Shareholder – Turuki Pharmacy Limited Wife is member of the Northland District Health Board	13/12/13
Christine Rankin	Member - Upper Harbour Local Board, Auckland Council Director - The Transformational Leadership Company	15/07/15
Allison Roe	Member – Devonport-Takapuna Local Board, Auckland Council Chairperson – Matakana Coast Trail Trust	02/07/14
Gwen Tepania-Palmer	Chairperson- Ngatihine Health Trust, Bay of Islands Life Member – National Council Maori Nurses Alumni – Massey University MBA Director – Manaia Health PHO, Whangarei Board Member – Auckland District Health Board Committee Member – Lottery Northland Community Committee	11/03/13

Co-Opted Members

Susanna Galea	Member – New Zealand Medical Association Member – Association of Salaried Medical Specialists (ASMS) Member – Medical Protection Society Associate Director – Centre for Addictions Research	31/03/14
Willem Landman	No current listings	10/12/14
Donna Riddell	Member – New Zealand Nurses Organisation (NZNO)	08/12/14
David Ryan	To be advised	

2.1 Confirmation of Minutes of the Hospital Advisory Committee Meeting Held on 04th November 2015

Recommendation:

That the Minutes of the Hospital Advisory Committee meeting held on 04th November 2015 be approved.

Minutes of the meeting of the Waitemata District Health Board

Hospital Advisory Committee

Wednesday 04 November 2015

held at Waitemata District Health Board Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 10.12a.m.

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT

James Le Fevre (Committee Chair)
Lester Levy (Board Chair)
Max Abbott
Sandra Coney (Deputy Committee Chair)
Tony Norman (Deputy Board Chair)
Morris Pita
Christine Rankin
Allison Roe
Willem Landman (co-opted member)
Donna Riddell (co-opted member)

INVITED OBSERVER Kylie Clegg

ALSO PRESENT

Dale Bramley (Chief Executive)
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)
Fiona McCarthy (Director of Human Resources)
Debbie Eastwood (GM, Medicine and Health of Older People)
Shirley Ross (HOD Nursing, Medicine and Health of Older People)
John Cullen (Director ESC)
Ian McKenzie (GM, Mental Health)
Murray Patton (Clinical Director, Mental Health)
Michelle Sutherland (GM, Surgical and Ambulatory Services)
Paul Garbett (Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item.)

PUBLIC AND MEDIA REPRESENTATIVES

Lynda Williams (Auckland Womens Health Council) (present from 11.15a.m)

APOLOGIES Apologies were received and accepted from Warren Flaunty and Gwen Tepania-Palmer.

WELCOME The Committee Chair welcomed those present.

DISCLOSURE OF INTERESTS

Morris Pita advised that he had designed an App with the purpose of enabling Emergency Departments to encourage patients with non-urgent conditions to seek treatment at community based primary care clinics. He had begun preliminary discussions with management to determine whether Waitemata DHB would be interested in piloting this product to improve patient health outcomes and reduce congestion. If following a pilot the DHB wished to continue its use of the App, this would be on commercial terms.

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. The public excluded session was held first, from 10.13a.m until 11.15a.m.

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

Resolution (Moved Tony Norman/Seconded Donna Riddell)

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 23/09/15	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 that meeting, in terms of the NZPH&D Act.
2. Quality Account 2014/15	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)]

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
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)]

Carried

10.13a.m to 11.15a.m – public excluded session.

11.15a.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 23rd September 2015 (agenda pages 7-16)

Resolution (Moved Tony Norman /Seconded Christine Rankin)

That the minutes of the meeting of the Hospital Advisory Committee held on 23rd September 2015 be approved.

Carried

Actions Arising (agenda page 17)

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 2015 (agenda pages 18-83)

Executive Summary/Overview/Scorecard

Cath Cronin (Director of Hospital Services) introduced the report. She advised that credentialing for anaesthesia was occurring on 4 November, which was why a number of the clinical leaders had not been able to attend the Committee meeting. If there were any questions requiring their response, answers would be brought back to the next meeting.

Matters highlighted or updated by Cath Cronin Included:

- The 95% ED six hour health target had not been met for the July-September Quarter; however staff had worked hard to maintain a 93% level in challenging circumstances. There had been a significant improvement in October and the intention is to meet the target for the second quarter.
- With the Faster Cancer Treatment health target they had now reached 77% compliance against the target of 85%. They are working to achieve the target as quickly as possible.
- All ESPI targets are being met.
- With DNA (Did not attend appointments) they were linking in with Margaret Wilshire of Auckland DHB. As reported previously there had been some good work done on this at Waitemata DHB, with small improvements in particular cohorts, but not the overall improvement needed.
- The section of the report on Renal Transplantation (pages 23-24 of the agenda) was in response to some broader questions from the Committee on transplant donations; however Waitemata DHB only manages donations for renal transplants. Since appointing a Donor Liaison Coordinator there had been good advances in terms of identifying potential donors. There had been uplift in the number of people engaging with their families on this. 14 new donors had been listed for working up over this quarter.

Debbie Eastwood commented that as they are now engaging more potential donors they will need to look at the services needed to follow through.

The Committee Chair noted that the Ministry of Health is formally reviewing the organ donation process. There would probably be public consultation on this in the middle part of 2016.

Robert Paine summarised the financial results in the report. A common theme in the Provider Arm was high levels of activity, meaning that fewer people had taken annual leave. A number of services had vacancies, often meaning higher costs from outsourced services. There had been an increase in drug costs, partly because of a significant increase in new patients receiving PCT drugs, and other demand driven pressures had added to the overall picture. In each divisional report in the Provider Arm report there is a section on what action is being taken to get matters back on track financially. At the Corporate level they are working hard to deliver some of the bigger projects and are also continuing to work with Deloitte on the more complex projects identified by them. Overall it is still expected that the DHB would be within budget at the end of the financial year.

In answer to a question on the number of nursing vacancies in Mental Health, Murray Patton advised that this is a real concern. They are just in the process of developing some "hot house" recruitment processes for this. They are also looking at the skills needed within teams.

Human Resources

Fiona McCarthy (Director Human Resources) presented this section of the report. Fiona noted that for the first time in recent months there had been a decrease in rates of sick leave and overtime. These are cyclical, but they will continue to monitor them and looked for a sustained improvement. More detailed summaries by service for sick leave and overtime are included in the agenda (pages 34-36).

Matters covered in discussion or response to questions included:

- Willem Landman commented that if staff members are working more hours, they are more likely to need sick leave. It may be more accurate to measure sick leave taken per hours worked.
- In answer to a question, Fiona McCarthy confirmed that the overtime graph (page 35 of the agenda) shows overtime as a percentage of total hours worked. Willem Landman commented that this level seemed far less than what he observed nursing staff working. Fiona McCarthy advised that there is an issue separating out overtime rates and on call rates in some budgets. They were trying to resolve this. She also agreed that there is a definite link between levels of sick leave and overtime required of other staff. They are taking a closer look at this.
- Willem Landman expressed his concern at the inability to fill vacant positions despite best efforts. A smaller number of staff members are left to cover those vacancies and sick leave. The Committee Chair suggested that there may be an opportunity to develop some solutions over summer and bring back to the Committee, with a view to minimising the impact on staff next winter.
- The Committee Chair asked if people leaving Auckland because they can no longer afford to live here is affecting recruitment. Fiona McCarthy advised that she had asked managers to flag cases where people are not accepting positions because they cannot afford to live in Auckland. Anecdotally this was only the reason in a small number of cases. Generally speaking DHBs traded staff amongst themselves or imported from overseas, which was not always easy because of accreditation requirements.
- The Chief Executive noted that there was more information on the recruitment situation in the separate Human Resources report later in the agenda. The recruitment issues for DHBs tend to be in specific areas of medicine, of highly

skilled nursing and in Allied Health. He saw three needs. Firstly, some work could be done to define areas of difficulty for recruitment more clearly. Secondly, a more robust Winter Plan is needed, probably involving recruiting prior to winter and accepting some over staffing at the start of winter. Thirdly, there is a need to increase the reserve pool of nurses that can be allocated when needed. There needs to be agreement from the charge nurses on how to treat that pool and not to recruit from it for permanent staff positions. Proposals on planning for next winter will be given thought and brought back to the Committee in the New Year.

Medicine and Health of Older Peoples Services

Debbie Eastwood (General Manager, Medicine and Health of Older Peoples Services) and Shirley Ross (Head of Division Nursing) were present for this section of the report.

Matters highlighted or updated included:

- The improvement in Dermatology Service delivery capability (detailed on page 39 of the agenda).
- Debbie Eastwood noted that there are still some vulnerable services within Medicine and Health of Older People Services – like Obstetric Medicine, where it is difficult to recruit suitably skilled staff.
- The information on the work of the Nutrition Support Team (pages 39-40 of the agenda). A key point made is that the Provider Arm will be developing more robust processes for identifying and funding support services like nutrition as a result of either increased volumes or acuity.
- Recruitment of additional medical staff as a result of business case approvals (outlined on page 41 of the agenda) has been going well with some exceptionally good candidates. A number of people have been offered roles and will be starting between December 2015 and June 2016.
- The pilot of a Constant Observation programme on Ward 5 from January to June 2016, training healthcare assistants with senior nurse oversight, instead of using external bureau staff for watches.

Matters covered in discussion or response to questions included:

- With regard to the Scorecard on page 43 of the agenda, the Best Care target of PCI within 120 minutes (STEMI patients), the Committee Chair noted the importance of trying to increase the percentage achieved.
- Allison Roe noted positively the Nutrition Support team being rated as one of the best in New Zealand on a recent survey, and asked what criteria was applied in assessing that. Shirley Ross offered to check and advise Allison of that subsequently.
- In answer to a question about the shortage of radiologists, Cath Cronin advised that with Fiona McCarthy she is looking at alternative workforce options for this and other high risk groups. An overview will be given at the next meeting. Max Abbott advised that Health Workforce New Zealand is also concerned about the radiography issue.

Child, Women and Family Services

Dr Peter van de Weijer (Head of Division Medical) and Stephanie Doe (Acting General Manager Child, Women and Family Services) presented this section of the report.

Matters highlighted included:

- The pilot programme that proactively identifies children who frequently present to the Emergency Department (detailed on page 48 of the agenda).
- The disappointing drop in the Net Promotor Score (page 49 of the agenda). The process for encouraging people to complete the survey in each of the wards has been reviewed, to make sure that patients have every opportunity to participate in the survey.

With regard to the pilot that proactively identifies children that frequently present to the Emergency Department, the meeting was advised that the process involves the social worker contacting the family of the child and offering them the opportunity to talk, including about the possibility of support. Max Abbott commented that if this process of acting as a catalyst could be followed on a wider basis it could have a very significant impact. In answer to a question, Stephanie Doe advised that there had been liaison with Counties Manukau DHB about this initiative. The next step is to consider how this might be used as a broader approach.

Mental Health and Addiction Services

Ian McKenzie (General Manager, Mental Health and Addictions Services) and Dr Murray Patton (Clinical Director, Mental Health Services) presented this section of the report.

Matters highlighted or updated by Murray Patton included:

- Metabolic Screening (pages 55-56 of the agenda) – statistically people with mental health problems have high rates of premature mortality. People typically die between 10 and 30 years earlier than the average for the population as a whole. That applies not just to people seeing Mental Health Services, but to the estimated one in five people in the population with mental health problems. It is commonly thought that this relates to suicide, but in fact in most cases it is other health problems such as respiratory disease, cardiac arrest and cancer. The focus on cardiovascular screening described in the agenda is only a small part of addressing this issue, but an important one. In many cases there is some increase in risk relating to treatments used for the mental health problem. Whether the programme is making a difference is hard to assess yet, but there is good anecdotal feedback that it is making a positive difference.
- Murray Patton advised that the metabolic screening programme was really a joint initiative with colleagues in primary care. A lot of the people Mental Health Services see are accessing primary care for a number of conditions. With regard to technology, the Service is trying to have a screening tool developed that the whole region could use.
- An issue not in the report, but which had come to attention with the publication of the New Zealand Police Annual Report, was the very significant percentage of police time involved in dealing with people with

mental health problems in the community. Another report produced earlier had shown the high rates of people with mental health problems held in police custody. In that report Waitemata had been featured as a good example of a low rate of use of police cells for detaining people with mental health problems. A lot of credit for this should go to the Emergency Departments, who were much more willing to accept people with such problems into the EDs than those at some other DHBs.

Matters covered in discussion and response to questions included:

- Murray Patton commented that he thought frontline staff had become more sensitive to risk, particularly as a result of greater use of substances by the people they dealt with. The ideal response is a conjoint response with the Police.
- The Committee Chair noted that from an Emergency Department perspective there is a very small group of people too dangerous to deal with.
- In answer to a question about dealing with the high smoking rate among people with mental health issues, Murray Patton advised that Mental Health Services had been addressing that for a number of years. They had a very active smoking cessation co-ordinator. The Chief Executive noted that one of the problems is that the evidence shows that the chance of relapsing is much higher if you are around smokers. Max Abbott pointed out that giving up smoking often involved multiple attempts. Over a longer term a higher percentage of people finally succeed.
- The Committee Chair noted that stigma often gets attached to people with mental health issues. It is useful to give reminders about preconceptions and the need to control them.

Murray Patton and Ian McKenzie were thanked.

<u>Elective Surgery Centre (ESC)</u>

John Cullen (Director, ESC) and Gerda du Preez (Charge Nurse Manager, ESC) were present for this section of the report. John Cullen conveyed an apology from Mark Watson (Group Manager ESC).

John Cullen highlighted:

- Utilisation of beds at ESC (page 62 of the agenda). He outlined the reasons for some beds being available for non – ESC purposes (because of future proofing when the ESC was established) and current use of such beds. He advised that he would like to see these beds used in future for post-operative patients and emphysema patients. A case for this will be worked up.
- The review into the type of procedures being undertaken (page 68 of the agenda) – some procedures are outside what the ESC was originally expected to be doing. If it is established that they are being done in ESC for the right clinical reasons, then the issue of additional funding will be looked at.

There was a discussion about hospital readmission rates that included:

- John Cullen noted that hospital readmission rates are often skewed by readmission for reasons entirely unrelated to the first admission.

- The Committee Chair commented that the issue to look at is preventable re-admissions, but the quality of data made that difficult. The estimate of 10% preventable re-admissions is arbitrary.
- The Chief Executive advised that issues had been raised with the Ministry of Health, which is reviewing the question of what is appropriate in terms of measuring readmission rates and whether they should even be included in national measures.
- It was also noted that these rates also differ for different services, for example one would expect services for older patients to have a much higher readmission rate than ESC.
- The Chief Executive advised that they would wait for the Ministry review and then bring back to the Committee the findings from that and how they relate to the DHB.
- Willem Landman also commented that the notion that readmissions are always a bad thing needs to be re-examined. Some re-admissions are totally appropriate. So really it is the trend over time that is important.

Surgical and Ambulatory Services

Michelle Sunderland (General Manager, Surgical and Ambulatory Services) and Kate Gilmour (Head of Division Nursing) were present for this section of the report. An apology was conveyed from Michael Rodgers (Chief of Surgery).

Kate Gilmour highlighted nurse facilitated discharges from ADU/Short Stay and PACU (page 69 of the agenda). She noted that for August and September (35 working days as the nurse for this is employed part time), 105 patients were discharged through this process, freeing up House Officer time. The Chief Executive commented that an evaluation of this initiative showed that the process was leading to discharges occurring much earlier in the day, with resulting bed days saved. One of the drivers for this initiative was utilisation and efficiency of beds. The analysis that had been done looked very favourable. In addition the nurse has been useful for other tasks, as described in the agenda report.

In discussion of the above initiative, Andrew Brant commented that it led to a focus on where the energies of House Officers should be targeted and forced management to think clearly about the House Office role. It was also noted that some other initiatives in Medicine assisting discharging of patients had shown some validity too.

Michelle Sutherland highlighted:

- The decline in theatre utilisation at Waitakere Hospital (discussed on pages 69-70 of the agenda). A number of actions are being taken to address this, as detailed in the agenda report.
- The issue with the ultra-sonographer workforce being well below required levels to provide timely service (page 70 of the agenda). They are working on this and a more detailed report will be brought to the Board.

Hospital Operations

Cath Cronin noted that with the new food services system, improvements are occurring and a close watch is being kept on quality.

Provider Arm Support Services

This section of the report was taken as read.

The Committee Chair noted that the turnaround time for Clinical letters is very impressive.

Resolution (Moved Donna Riddell/Seconded Tony Norman)

That the report be received.

Carried

6. CORPORATE REPORTS

6.1 Clinical Leaders' Report (agenda pages 84-86)

Dr Andrew Brant highlighted the Medical Council accreditation visit on 1-2 October, relating to ongoing accreditation of PGY1 and PGY2 training at Waitemata DHB. Since then they had received a verbal response and an interim report, overall favourable. They are making sure that sufficient time is allocated to training; that there is adequate supervision; and that there are open communication channels with the RMOs.

The Committee Chair noted that the views of RMOs in governance matters are largely absent. He pointed out that the way RMOs move from hospital to hospital means that they don't have a home hospital. He wondered if they should be allocated a home hospital or at least ongoing mentors. In response Andrew Brant said that the main issue is a practical one about freeing up time, to get representation on the quality improvement projects for example. If there are clear concerns over issues of performance the arrangement is that the RMO stays with the particular DHB while those are addressed. However the absence of a home hospital means that it is hard to engage with RMOs on other issues. The challenge for the organisation is how to bring our values and culture to some of the RMO groups. The Committee Chair suggested that the concept of mentors should be pursued strongly with NORTH and the colleges.

12.58p.m – Donna Riddell retired from the meeting.

Dr Jocelyn Peach referred to the information relating to healthcare assistants in the Nursing and Midwifery section of the report, which hopefully covered what the Committee had wanted to know.

Resolution (Moved Willem Landman/Seconded Tony Norman)

That the report be received.

Carried

6.2 Human Resources (agenda pages 87-92)

Fiona McCarthy (Director Human Resources) presented this report. Matters that she highlighted included:

- The new graduate nurse programme (page 87 of the agenda).
- The 2016 Health Excellence Awards (page 88 of the agenda).
- The revised format for the recruitment dashboard (page 88).
- The vacancy rate of 7.1% and the actions being taken on nursing recruitment (page 88).
- The Workforce development initiatives (pages 92-94)

No issues were raised.

Resolution (Moved Willem Landman /Seconded Tony Norman)

That the report be received.

Carried

The Committee Chair thanked those present.

The meeting concluded at 1.00p.m.

SIGNED AS A CORRECT RECORD OF THE WAITEMATA DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 04 NOVEMBER 2015

_____COMMITTEE CHAIR

Actions Arising and Carried Forward from
Meetings of the Hospital Advisory Committee
as at 12th November 2015

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
HAC 04/11/15	5.1	Winter Plan – more robust plan for 2016 to be developed and brought back for consideration.	Cath Cronin	HAC 24/02/16	
HAC 04/11/15	5.1	Recruitment – report covering some further analysis of challenging areas and recruitment processes to address them to be provided.	Fiona McCarthy	HAC 16/12/15	Included in HAC Public Excluded agenda.
HAC 04/11/15	5.1	Nutrition Support Team – rated as one of the best in New Zealand – Allison Roe to be advised of the criteria used in assessing that.	Shirley Ross		Actioned – e-mailed 18/11/15

4.1 Provider Arm Performance Report – October 2015

Recommendation

That the report be received.

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

This report summarises the Provider Arm performance for October 2015.

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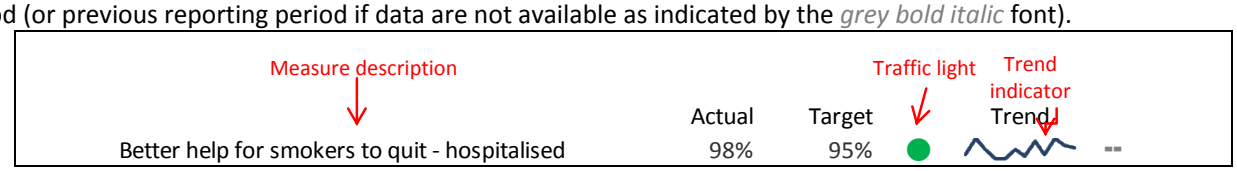
Glossary

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

How to interpret the scorecards

Traffic lights

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



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

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

Trend indicators

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

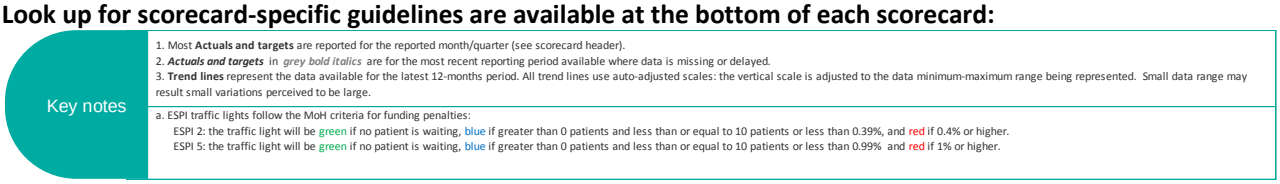
Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance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

The trend indicator criteria and interpretation rules:

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

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

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



Provider Arm Performance Report – October 2015

Executive Summary/Overview

Highlight and Key Issue of the month

Waitemata 2025

Work is progressing with great priority and speed under the Waitemata 2025 project. The health service plan will be focussed on work with the divisions to determine the levels of service delivery required in each of our hospitals for the future. The outcome of this work will inform the master site plan which is also underway.

Hine Ora Ward and the clinical team have welcomed their first patients on to the ward and we have received overwhelmingly positive feedback from patients and staff.

The Spiritual Centre has opened in December. This special and tranquil place will be an integral part of healing for our patients and respite and comfort for everyone.

Scorecard Variance Report

Health targets

Shorter Waits in ED

We have improved performance and achieved the target for November and we will be on track to achieve the second quarter target. There are still challenges with timely progression of care in ED which is an area of focus and target for improvement in December. We are still experiencing delays in access to inpatient beds due to capacity constraints, but coming into December we are seeing some overall decrease in demand and increased availability of beds.

Service Delivery

Maori and Pacific DNA

DNA remains an area of focus for all our specialties. Auckland DHB and Waitemata DHB will continue to work together from the Health Gain and Manawa Ora teams' perspective. This requires a multipronged systems approach and tailored projects at specific condition and patient subset to be trialed, all under one programme of work.

Waitemata DHB will also revisit the success identified in the pilot with our GP partners in West Auckland.

Best Care

Acute Readmission Rates

The overall trend is improving. We are maintaining current work plans to ensure patients are well prepared and supported for discharge from hospital.

Turnover Rate

The turnover rate is marginally above target. Each service is reviewing individual performance to determine if there are issues we can address to decrease our turnover rate.

Financial performance

The financial result for the Provider Arm was adverse to budget by $313k in October, and is $3,485k adverse year to date. The result reflects continual cost pressures on the Provider especially in Medical Services, including ED. Services have introduced a number of monitoring programmes for the management of annual leave, sick leave and overtime, and Corporate are implementing a

number of procurement and supply chain initiatives to reduce cost. The rate of overspend in the Provider Arm has reduced in October from that incurred in the first quarter. The result is consistent with the overall year end forecast of a modest surplus.

Scorecard – All services

Waitemata DHB Monthly Performance Scorecard

ALL Services
October 2015
2015/16

Health Targets

	Actual	Target		Trend	
Better help for smokers to quit - hospitalised	98%	95%	●		--
Shorter Waits in ED	94%	96%	●		▲
Faster cancer treatment (62 days)	71%	85%	●		▼

Best Care

	Actual	Target		Trend	
Patient Experience					
Complaint Average Response Time	14 days	<14 days	●		▼
Improving Outcomes					
Acute Readmission Rate within 28 days	13%	<9%	●		▼
Quality & Safety					
Older patients assessed for falling risk	97%	90%	●		▼
Rate of falls with major harm	0.20	<2	●		▼
Good hand hygiene practice	85%	80%	●		▲
S. aureus infection rate	0.07	<0.2	●		▼
Occasions insertion bundle used	100%	95%	●		▲
Pressure injuries grade 3&4	0.00	0.00	●		--
HR/Staff Experience					
Sick leave rate	7.7 days	<7.5 days	●		▲
Turnover rate	11%	<10%	●		▼

Service Delivery

	Actual	Target		Trend	
Elective Volumes					
Provider Arm - Overall	97%	100%	●		▼
Waiting Times					
ESPI 2 - % patients waiting > 4 months for FSA	*compliant*				
ESPI 5 - % patients not treated w/n 4 months	*compliant*				
ESPI 1	*compliant*				
Patient Flow					
[a] Average Length of Stay - Electives	1.21 days	1.77 days	●		▲
[a] Average Length of Stay - Acutes	2.6 days	2.76 days	●		▼
Outpatient DNA rate (FSA + FUs) - Total	10%	<10%	●		--
Outpatient DNA rate (FSA + FUs) - Māori	20%	<10%	●		▲
Outpatient DNA rate (FSA + FUs) - Pacific	19%	<10%	●		▲

Value for Money

	Actual	Target		Trend	
Financial Result (YTD)					
Revenue	275,402 k	272,245 k	●		▼
Expense	285,543 k	278,901 k	●		▲
Net Surplus/Deficit	-10,141 k	-6,656 k	●		▼
Capital Expenditure	15,501 k	29,562 k	●		▲
Contracts (YTD)					
Elective WIES Volumes	5,650	5,992	●		▼
Acute WIES Volumes	20,589	19,853	●		▲

How to read

Performance indicators:

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

Trend indicators:

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

Key notes

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

a. 2015/16 new MoH Average length of stay definition. Only 4 months data so shorter trendlines

A question?

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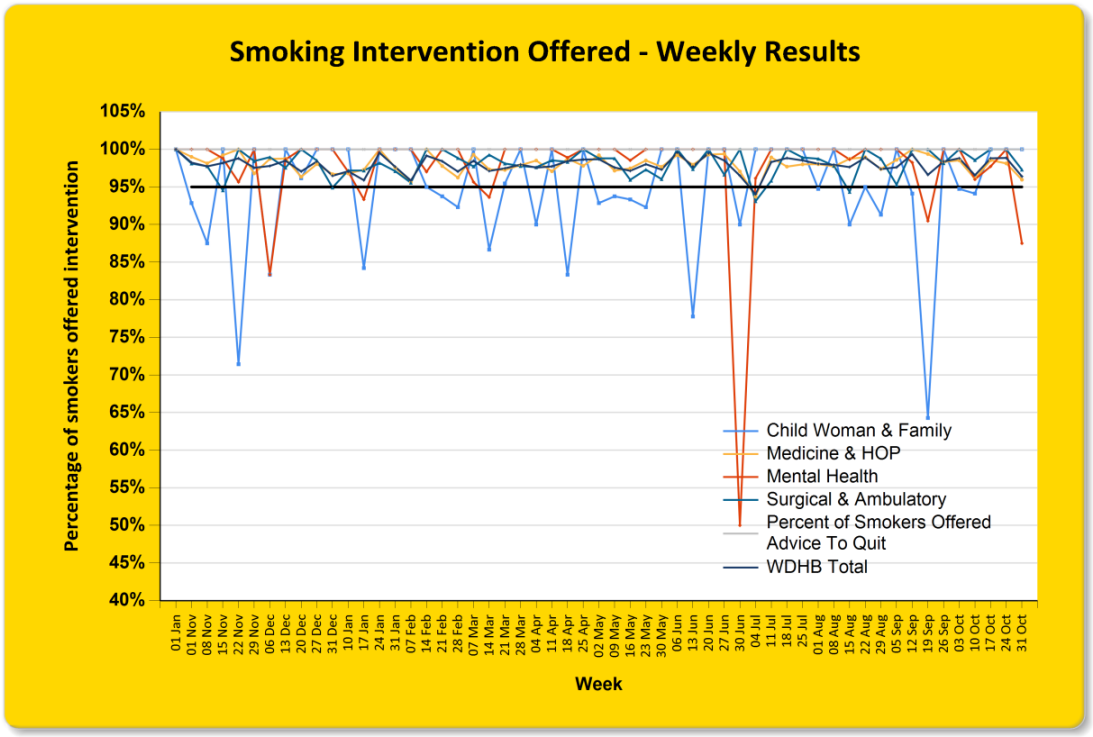
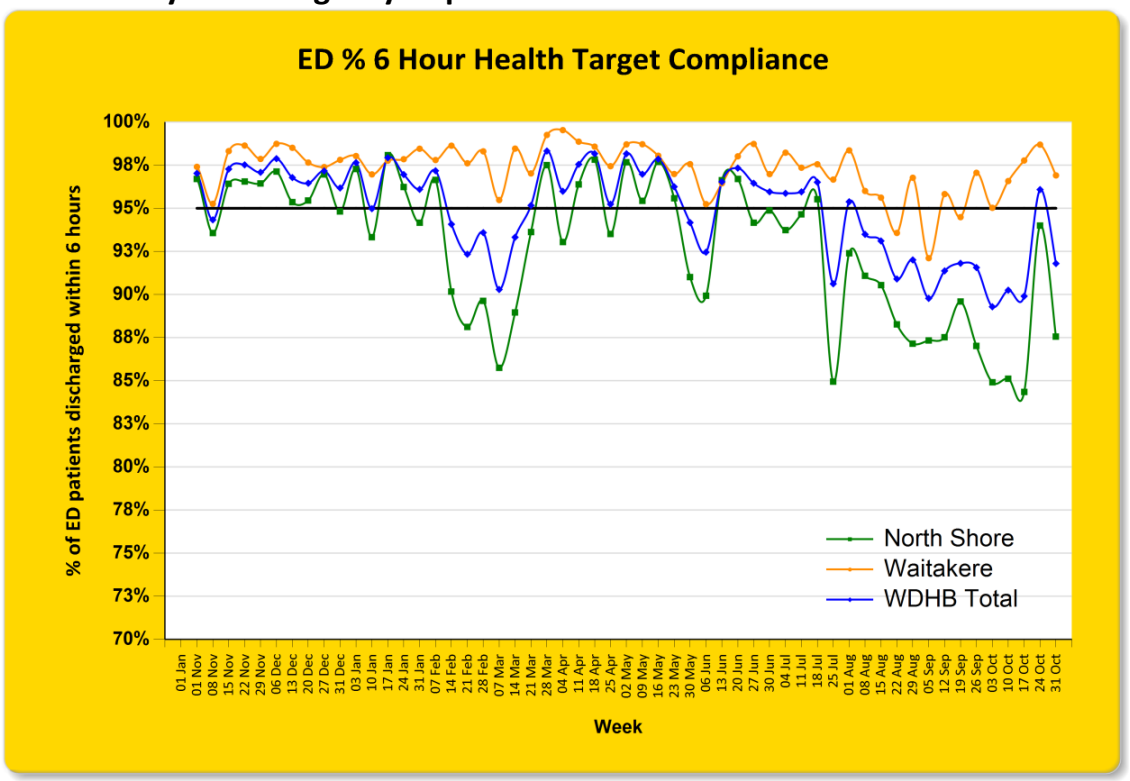
Health Targets

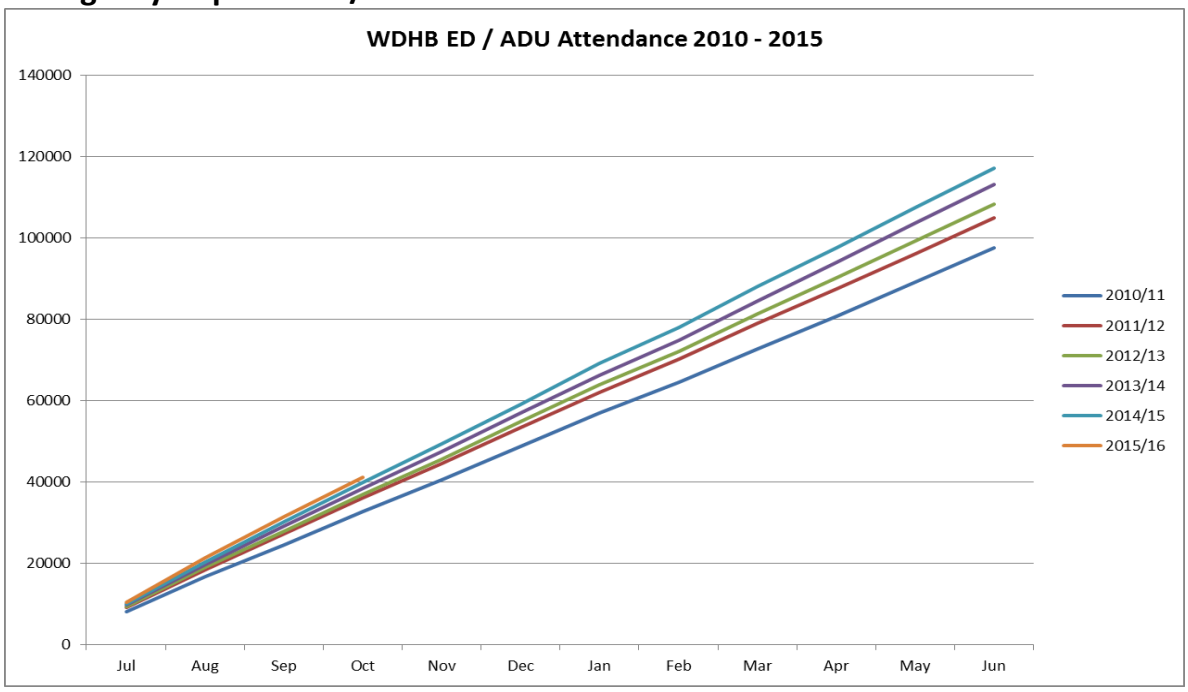
Better Help for Smokers to Quit



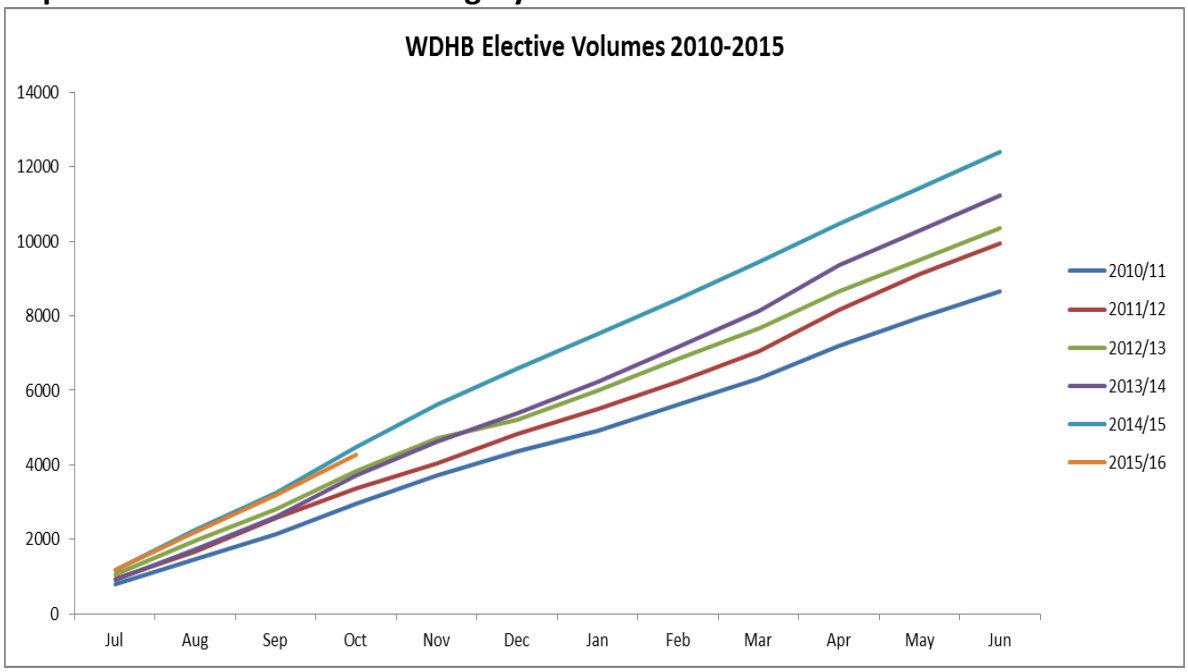
Shorter Stays in Emergency Departments



Emergency Department/ ADU Presentations



Improved Access to Elective Surgery



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

Percentage Change ED & Elective Volumes

October 2015	Month Volumes	% Change (last year)	YTD Volumes	% Change (last year)
ED / ADU Volumes	9774	1%	41196	3%
Elective Volumes	947	-15%	4284	-4%

Elective Performance Indicators

Zero patients waiting over 4 months

Summary (Oct 15)	
Speciality	Non Compliance %
ESPI2	0.02%
ESPI5	0.40%

ESPI		Compliant	Non Compliant	Non Compliant %
ESPI 2	Anaesthesiology	82	-	0.00%
	Cardiology	1,304		0.00%
	Dermatology	170	-	0.00%
	Diabetes	206	-	0.00%
	Endocrinology	309	-	0.00%
	Gastro-Enterology	812	1	0.12%
	General Medicine	282	-	0.00%
	General Surgery	1,237	-	0.00%
	Gynaecology	750	1	0.13%
	Haematology	131	-	0.00%
	Infectious Diseases	32	-	0.00%
	Neurology	0	-	0.00%
	Orthopaedic	1,341		0.00%
	Otorhinolaryngology	1,756	-	0.00%
	Paediatric MED	990	-	0.00%
	Renal Medicine	144	-	0.00%
	Respiratory Medicine	569	-	0.00%
	Rheumatology	187	-	0.00%
	Urology	539	-	0.00%
	Total	**10,841**	**2**	0.02%
ESPI 5	Cardiology	82	-	0.00%
	General Surgery	1,091		0.00%
	Gynaecology	562		0.00%
	Orthopaedic	873	14	1.60%
	Otorhinolaryngology	519	-	0.00%
	Urology	363	-	0.00%
	Total	**3,490**	**14**	0.40%

90% of outpatient referrals acknowledged and processed within 10 days

ESPI 1 (Oct 15)	
Specialty	Compliance %
Anaesthesiology	100.00%
Cardiology	97.19%
Dermatology	100.00%
Diabetes	97.98%
Endocrinology	98.82%
Gastro-Enterology	95.19%
General Medicine	97.08%
General Surgery	98.07%
Gynaecology	100.00%
Haematology	98.41%
Infectious Diseases	100.00%
Orthopaedic	96.54%
Otorhinolaryngology	97.16%
Paediatric MED	99.29%
Renal Medicine	100.00%
Respiratory Medicine	98.32%
Rheumatology	100.00%
Urology	94.14%
Total	97.47%

Legend

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

Financial Performance

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date		Oct-15
Provider									
($000's)	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
REVENUE									
Government and Crown Agency	65,915	65,861	54	266,379	263,663	2,717	789,863	789,863	0
Other Income	2,142	2,218	(76)	9,023	8,582	441	28,149	28,149	0
Total Revenue	68,057	68,079	(22)	275,402	272,245	3,158	818,012	818,012	0
EXPENDITURE									
Personnel									
Medical	17,846	18,468	623	55,394	55,503	109	162,067	162,067	0
Nursing	16,180	15,972	(208)	71,633	72,154	521	213,375	213,375	(0)
Allied Health	11,667	12,149	482	35,926	36,701	775	105,708	105,708	0
Support	1,614	1,845	231	4,923	5,523	600	15,858	15,858	0
Management / Administration	6,465	6,865	400	20,420	20,623	202	59,554	59,554	0
	53,772	55,299	1,528	188,296	190,503	2,207	556,562	556,562	(0)
Other Expenditure									
Outsourced Services	5,280	4,994	(286)	22,817	20,172	(2,645)	59,998	59,998	0
Clinical Supplies	9,153	8,579	(573)	37,764	34,924	(2,841)	101,429	101,429	0
Infrastructure & Non-Clinical Supplies	9,246	8,287	(959)	36,665	33,302	(3,363)	99,023	99,023	0
	23,679	21,860	(1,818)	97,247	88,398	(8,849)	260,449	260,449	0
Total Expenses	77,450	77,160	(291)	285,543	278,901	(6,643)	817,012	817,012	(0)
Net Surplus/Deficit	**(9,394)**	**(9,081)**	**(313)**	**(10,141)**	**(6,656)**	**(3,485)**	**1,000**	**1,000**	**(0)**

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date		Oct-15
Provider									
($000's)	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
CONTRIBUTION									
Surg & Ambulatory	(14,747)	(15,458)	710	(53,144)	(52,837)	(307)	(156,424)	(156,424)	0
Medical & HOPS	(19,639)	(19,440)	(199)	(71,312)	(69,405)	(1,907)	(208,035)	(208,035)	0
Child Women Family	(7,108)	(7,184)	76	(24,842)	(24,399)	(443)	(71,538)	(71,538)	(0)
Mental Health	(10,395)	(10,980)	585	(38,133)	(39,185)	1,052	(114,025)	(114,025)	0
Elective Surgery Centre	(1,544)	(1,925)	382	(7,492)	(7,946)	454	(22,384)	(22,384)	0
Hospital Operations	(6,102)	(5,812)	(290)	(21,060)	(20,094)	(965)	(57,723)	(57,723)	(0)
Provider Support	50,140	51,718	(1,578)	205,841	207,211	(1,370)	631,130	631,130	0
Net Surplus/Deficit	**(59,534)**	**(60,799)**	**1,265**	**(215,983)**	**(213,867)**	**(2,115)**	**(630,130)**	**(630,130)**	**(0)**

CONSOLIDATED STATEMENT OF PERSONNEL by PROFESSIONAL GROUP							Reporting Date		Oct-15
Provider									
	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
FTE									
Medical	671	710	39	688	704	16	708	708	0
Nursing	2,668	2,765	97	2,661	2,774	112	2,771	2,771	0
Allied health	1,495	1,543	48	1,498	1,564	67	1,552	1,552	0
Support	304	340	35	298	339	42	339	339	0
Management	798	822	25	789	822	33	820	820	0
Total FTE	**5,936**	**6,181**	**244**	**5,934**	**6,203**	**270**	**6,190**	**6,190**	**0**

COMMENT ON MAJOR VARIANCES

Revenue

Revenue for October was $22k unfavourable for the month and $3.158M favourable year to date. This is summarised in the table below:

Revenue Variance to budget	Month $'000	YTD $'000
Contribution to the cost of delivery of acute volumes	-	756
Outsourced Colonoscopy	-	967
SLA's signed during the year	-	228
MoH Direct funding	63	250
Recharges to other DHBs	61	183
Non resident	(102)	16
Interest	36	230
ACC	(34)	294
CTA	90	44
Donations	(86)	42
Other Variances (large number of small value)	(50)	148
Total	(22)	3,158

Expenditure

Overall the expenditure for the Provider arm was $291k unfavourable for the month and $6.643M YTD. Within this is an under spend in personnel costs of $1.528M for the month and a YTD underspend of $2.207M. These underspends are driven predominantly by vacancies. No clinical vacancies are being deliberately held for financial reasons.

Personnel Costs YTD

- Medical Personnel ($109k favourable) – The under spend arises in Mental Health Services (MHS) ($205k) and Surgical and Ambulatory Services (SAS) ($218k). The MHS underspend stems from vacancies ($193k) and favourable annual leave balances ($76k) offset by the cost of SMOs covering vacant Registrar shifts ($131k) and unbudgeted outsourced locum costs. Vacancies in SAS contributed to the $218k underspend. These under spends are offset by a MedHops overspend due to higher than expected sick leave ($64k),leave balance revaluation ($147k), unbudgeted allowances in ED ($52k) and an unbudgeted haematologist position ($65k).
- Nursing Personnel ($521k favourable) – The $669k underspend in Mental Health reflects the prioritisation of recruitment against 56 vacant nursing FTE. The 20 vacant FTE in the Child and Woman's Services (CWF) have also contributed $258k to the under spend.
- Allied Health Personnel ($775k favourable) – The bulk of the underspend stems from the 38 vacancies in MHS ($534k), Anaesthetic Techicians and Medical Radiation Technologists (MRT) vacancies in SAS ($260k), MRTs and Physiotherapists in Medhops ($225k) and Labs and Pharmacy vacancies in Hospital Ops ($159k). This is offset by unmet savings in Provider Management ($436k) and unfavourable annual leave costs ($141k) in CWF.

Support and Admin Personnel ($802k favourable) – The favourable variance in Corporate ($648k) and support staff vacancy related underspends in HospOps ($401k) across CWF ($130k) and in SAS ($198k) services have been offset by overspends in Facilities ($268k) and MedHops ($267k). The vacant HospOps cleaning and orderly positions are being filled by outsourced staff. The $268k overspend in Facilities is due to the write off of project

costs and in Medhops it stems from unmet savings ($200k) and engaging of staff at rates higher than budgeted ($46k).

Other Expenditure YTD

Other expenditure was $1.818M overspent for the month and $8.849M YTD.

Clinical Supplies have contributed $2.841M YTD to the over spend, principally due to unmet savings in Provider Management ($1.768M) and volume related overspends in outpatient pharmaceuticals ($305k), test kits and lab blood products ($338k) in HospOps. The MedHops clinical supplies overspend is due to high PCT drug costs ($180k) stemming from high haematology patient numbers and the expanded use of those drugs in rheumatology, volume related cardiology and ward costs ($387k) and increased costs for mobility aids under a new contract ($104k). CWF services experienced unfavourable supplies variances ($197k) due to unmet savings and costs associated with higher use of gloves and other supplies in ARDS.

Outsourced services were $2.645M overspent YTD. Within this Provider Management is overspent by $1.143M due to unmet savings and Hospital Ops were $747k overspent due to the costs of outsourced cleaners, orderlies and lab tests and unmet savings. High patient volumes lead to SAS and Medhops $1.007M overspends to cover the cost of bureaux staff and watches. General Medical Acute WIES was 111% of YTD budget and ED attendances were up 16% over budget and 10% greater than last year.

The $3.363M unfavourable YTD variance in infrastructure costs relates to unmet savings of $3.635M and overspends in Facilities due repairs and maintenance costs ($468k) and utilities and waste removal costs ($263k). These overspends are offset by Corporate risk pool adjustments of $1.379M.

Human Resources

Glossary

Method of calculation of graphs:

1. Overtime Rate: The sum of Overtime Hours worked over the period divided by Worked Hours over the period.
2. Sick Leave Rate (days): The sum of Sick Leave Hours over the period divided by Total Hours over the period.
3. AL bal 0-24 days: Count of Staff with less than 25 equivalent 8 hour days accumulated leave entitlement.
4. AL bal 25-49 days: Count of Staff with between 25 and 50 equivalent 8 hour days accumulated leave entitlement.
5. AL bal 50-74 days: Count of Staff with between 50 and 75 equivalent 8 hour days accumulated leave entitlement.
6. AL bal 75+ days: Count of Staff with over 75 equivalent 8 hour days accumulated leave entitlement.
7. Voluntary Turnover Rate: Count of ALL staff resignations in the last 12 months. This data excludes RMOs, casuals, and involuntary reasons for leaving such as redundancy, dismissal and medical grounds.

Sick Leave

Legend

YTD actual sick leave
DHB target
YTD trend

TRENDS

Sick leave rates continue to reflect the annual seasonal trend with a further reduction in this reporting period with similar averages to the past two years over all.

COMMENTARY AND PLANNED ACTIONS

While positive, this result reflects the annual cycle of sick leave fluctuation and it will be necessary to continue to implement and enhance the focus and activities across the Divisions to achieve and maintain the organisational target.

October results reflect all Divisions sitting above the organisational target of 7.5 days with Mental Health, Child Woman and Family and Surgical and Ambulatory services reporting highest rates. It should be noted however that Child Women and Family services have recorded a decreased sick leave rate from the previous month. A summary of the key contributors and actions underway are summarised below for each of these Divisions.

Child Women and Family Services

October DHB average (days per fte)	Divisional Average	Breakdown by key contributors	Mitigation strategies/Initiatives (new or updates)
8.6	9	Regional Dental Service and Women's Health reflect the highest rates, both reporting over 10 days per fte. Child Services are sitting only below however at 9.9 days per fte.	A significant contributor to the average is the rate of longer term absences due to injury and serious or chronic health issues. Managers are continuing to address issues with individuals as highlighted through the traffic light system in place. Reporting, resources and support continues to be provided by the HR Manager/Advisor with the HR Manager actively working with managers and sick leave management is a standing agenda item on divisional management and governance meetings.

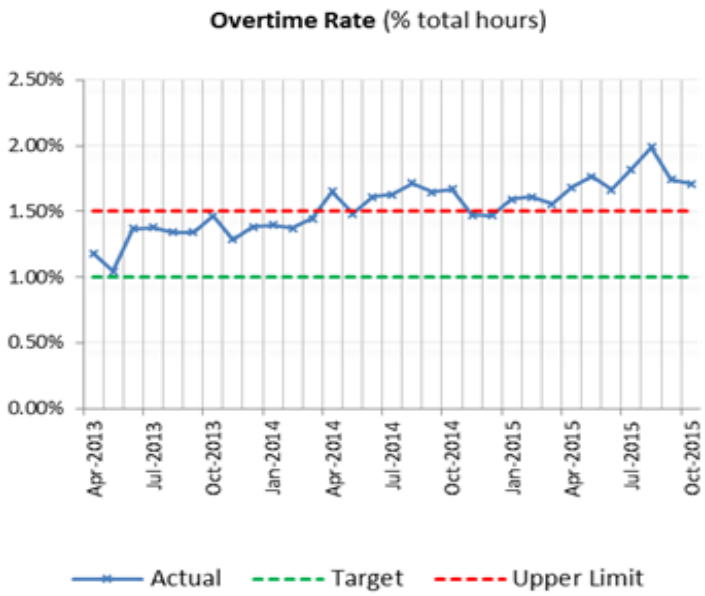
Mental Health Services

October DHB average (days per fte)	Divisional Average	Breakdown by key contributors	Mitigation strategies/Initiatives (new or updates)
8.6	10	Adult services continue to reflect the highest rate of sick leave with an average in excess of 10.	The reporting activities and strategies, including return to work discussions, implemented during the last report period are continuing to be applied. It would be expected to see the results of this work reflected in rates in the new year as the effects bed in.

Surgical and Ambulatory Services

October DHB average (days per fte)	Divisional Average	Breakdown by key contributors	Mitigation strategies/Initiatives (new or updates)
8.6	9.3	Bowel Screening, Outpatients and Surgical Wards are the highest contributors to the sick leave average, all sitting over 10.	Bowel screening has two ongoing sick leave/health situations that are being actively managed. The average is impacted due to the smaller size of the service. Outpatients and Surgical Wards have introduced return to work discussions with employees and appropriate strategies to respond to longer term absences are being discussed.

Overtime



Legend
YTD actual overtime
DHB target
Upper limit

TRENDS

October results reflect a further, although very slight, decrease in the overtime rate. The organisational percentage for this year however remains higher than results for the same period over the past two years and is still above the upper tolerance limit.

COMMENTARY AND PLANNED ACTIONS

Mental Health Services continue to report the highest variance at 4.22% but this reflects a slight decrease against the result for previous reporting month both by Division and in Forensics, which is the highest contributing service to the overall result. This should be a reflection of the very focussed effort on reporting and managing overtime in the past two to three months and would be expected to continue with ongoing mitigation strategies in place.

Hospital Operations and Facilities and Development are also above target but at around 2% their figures are to some extent impacted on due to their smaller size but also contributed to by penals and overtime linked to necessary weekend services provided by Pharmacy and Traffic and Fleet.

Mental Health Services

October DHB average (%)	Divisional Average	Breakdown by key contributors	Mitigation strategies/Initiatives (new or updates)
1.34%	4.22%	Forensic services are the most significant contributor sitting at 8.73%. Acuity and ACC/sick leave absences are continuing to impact.	Monitoring and reporting processes implemented in the past couple of months are continuing. Recruitment is underway to the additional positions approved and to the sick leave floater roles for Forensics.

Annual Leave Management (headcount)

Service	AL bal 0-24 days	AL bal 25-49 days	AL bal 50-74 days	AL bal 75+ days
01-WIMO Medical and HOPS	1411	526	139	35
01-WSAS Surgical and Ambulatory	839	369	63	25
01-WWCW Child Women & Family	784	217	15	14
01-WESC Elective Surgery Centre	65	12	6	
01-WMHS Mental Health Services	854	307	37	6
01-WHOG Hospital Operations	330	154	15	
01-WACP Corporate	246	96	25	4
01-WCFA Facilities and Development	25	13		
Grand Total	4,554	1,694	300	84

TRENDS

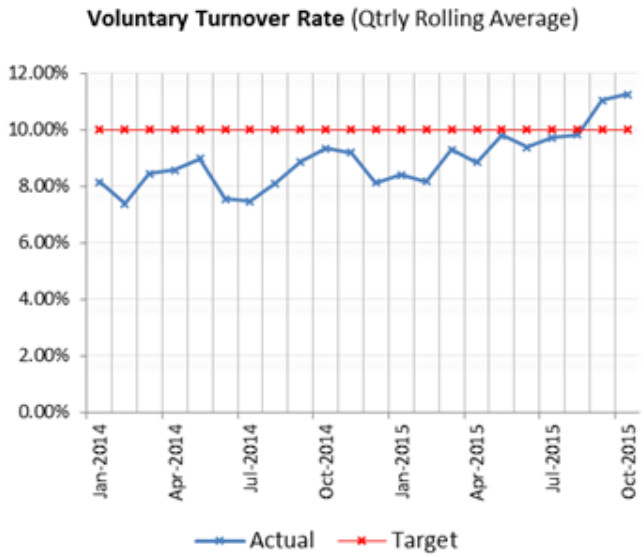
There has been an upwards shift in balances across all categories which will most likely reflect the impact of anniversary dates and additional leave entitlements being credited. However, it would be expected that the targeted approach to managing high sick leave balances now being implemented should offset this into the future.

COMMENTARY AND PLANNED ACTIONS

All areas are now actively working with identified staff to establish annual leave plans over the summer months into 2016. A key focus is working with staff holding balances of 50 or more days.

The specific activities highlighted in the previous report continue to be implemented, including more focus, especially in MEDHOPs, on making buy out of leave available to employees with excessive balances, in conjunction with an agreed leave management plan.

Staff Turnover



Legend
YTD actual staff turnover
DHB target
YTD trend

TRENDS

The October turnover has reflected a very minimal increase in comparison to the previous month and continues to be above the organisational target.

COMMENTARY AND PLANNED ACTIONS

An initial overview of reasons for leaving has not highlighted an increase in resignations due to dis-satisfaction. The primary reasons reported are travel, personal reasons or alternative employment.

MedHoPs has reported decrease in the divisional turnover rate to be sitting on target at 10%. The service is currently collating the results of their pilot retention survey and this is not yet complete across all areas. The more detailed feedback collated to date from this survey has not indicated any specific trends or concerns but a broader analysis will be undertaken once the feedback from all areas has been collated.

Once the full summary from this pilot has been collated, indicators for further actions will be considered, ie roll out to other Divisions, more in depth investigation into any specific reasons for leaving which may assist development of retention strategies.

The recently appointed project manager for the DHB's patient and staff experience survey tool has convened the steering group to progress this work with the first key task underway being finalising the RFP for a system provider.

Divisional reports

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 Departments: 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 Stephen Burmeister for Gastroenterology, Dr Simon Young 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.

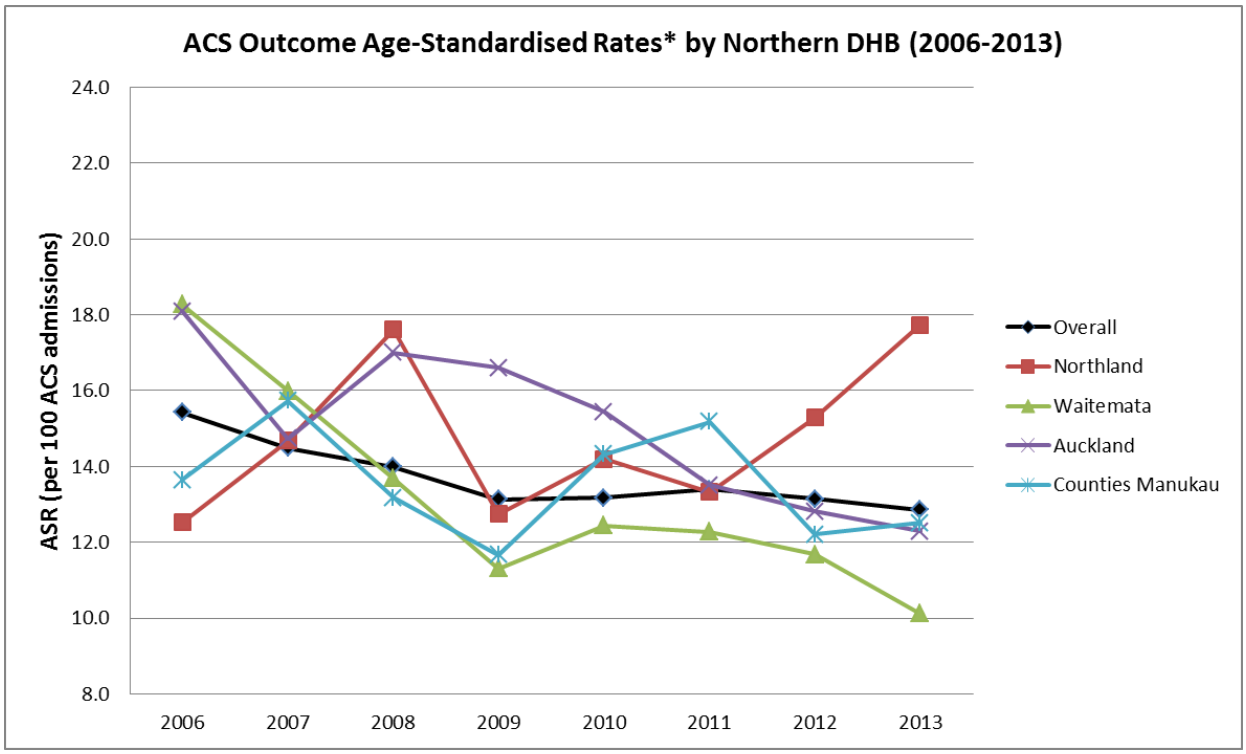
HIGHLIGHT OF THE MONTH

Patient outcomes in Acute Coronary Syndromes

The clinical term “Acute coronary syndrome” (ACS) refers to impairment of blood flow to heart muscle, largely as a result of disease of the coronary arteries. Patients with ACS are an important cohort to focus on for inpatient specialist cardiac care. Included within this group of patients are those with “heart attacks” and also those with “angina”. The majority of such patients undergo detailed investigation and treatment including coronary angiography and stenting of narrowed or blocked arteries.

The overall quality of care provided to ACS patients in hospital is best encapsulated in their clinical outcome at 28 days. Better outcomes occur when patients have timely appropriate care from the entire cardiac clinical team, including: inpatient nursing in an appropriate ward, guideline-based medication prescription, inpatient education, rapid access to coronary angiography and good discharge instructions and education.

A recent initiative led by Dr Andrew Kerr has examined the outcomes (death and further heart attack) for ACS patients in New Zealand. The graph below shows the outcomes over time (2006-2013) for the 4 Northern Region DHBs. Waitemata has shown the greatest degree of improvement in that time period, reflecting the emphasis on care for ACS patients and investment in facilities and skilled staff.



KEY ISSUES

Patient Falls

As noted on our October scorecard we have achieved 97% of older patients being assessed for falling, and with 0.20 being our rate of falls with harm (target <2). However we still have a large number of patients who fall in our hospital even though they don't suffer major harm. In order to reduce all falls and improve our patients' experiences and outcomes we remain committed to improving the care we provide. We were fortunate to have the opportunity to host the regional Falls Stop seminar on 20 October with 90 participants attending from across the region. Dr Jocelyn Peach opened the day and welcomed everyone, setting the scene and sharing some of our local experiences.

The Director of Nursing from Whanganui was the guest speaker and stressed the importance of focusing on individualised patient assessment and care plans in our continued struggle to prevent falls and falls with harm. She shared a success story from Whanganui where their medical ward has reduced falls with harm by 30% through a health care assistant led intervention programme. We will be piloting a similar programme within MHOP on wards 5 and 10 from January 2016.

Dr Anne-Marie Hill, Research Fellow at the Institute for Health Research and School of Physiotherapy at the University of Notre Dame Australia was the key note speaker. She leads the Healthy Ageing Agenda and presented her research and effective falls prevention project. Essentially this is a patient education programme led during the hospital stay and encourages patients to ring the bell and ask for help. This is particularly pertinent to MHOP where a number of falls with harm in the last year have been attributed to patients not asking for assistance. The programme utilises a short video and quick face to face intervention with a professional as well as focussing on a positive and welcoming attitude from the staff when answering the call bell.

We are now working on a proposal to implement a pilot of this project and the learning in the 2 AT&R wards at North Shore Hospital next year. These wards have the highest falls and falls with harm in our DHB currently.

Allied Health Recruitment
Attracting Allied Health staff is an ongoing challenge which is further compounded by the high turnover (14% Jun – July 15) for this professional group. The primary reason given for staff terminations in allied health within MHOP and SAS is to go overseas, which is not a factor that we can easily influence.

One example of the challenge is the difficultly we have had to recruit a staff grade physiotherapist. We now have an inpatient physiotherapist role that is being advertised for the 4th time, along with our pain physiotherapist role which has also been advertised over 4 times. We are advertising on our usual sites and have now also extended this to include journals and other recruitment websites both here and in Australia.

We have plans in place to mitigate the risk of vacancies via expanding our pool of casual staff from those who have left following completing parental leave and by utilising our part time staff to work up where possible to fill temporary vacancies. We are also exploring fixed term options with additional support for some of our current students in their final year of study.

Whilst our ability to recruit is challenging we do have some positives.

Scholarship Students – we have identified two occupational therapy and one physiotherapy vacancies that are suitable for our new graduate scholarship students in our inpatient teams. Indicators are that they will all pass and be applying for their APCs in December.

Top Maori Physiotherapy Student - we are delighted to announce that the top AUT Maori Physiotherapy student for the year graduating 2015 has been awarded to the Waitemata DHB scholarship student Leighton Francis Tetorutama Broughton. Leighton is due to start his post graduate career with Waitemata DHB in December 2015.

We would also like congratulate Andrew Fegan, also one of our Waitemata DHB students, who was awarded second place in the Asics award for best year 4 research project in the AUT graduate Physiotherapy class 2015.

SCORECARD VARIANCE REPORT

HEALTH TARGETS VARIANCE REPORT

Shorter Waits in ED – 94% versus a target of 96%
Emergency Department (ED) – North Shore ED has particularly felt the pressure of patient volumes in October. An additional 585 patients presented to the North Shore ED, or approximately 20 patients per day in October this year compared to October last year. There was a high number of breaches in October that resulted from a delay in the patient being seen by the ED medical teams. We aim for the Emergency Department medical staff to see and if required refer patients to other sub specialties within three hours. We have struggled to achieve this timeframe and work has started to specifically review how we can improve the performance of our North Shore ED in particular. As noted in last month's report we have also been actively recruiting medical staff, however the start dates for the new appointments span over the coming months. We have seen the nursing workforce at the North Shore settle with a significant amount of recruitment now completed, resulting in minimal vacancies going forward. We have also seen a reduction in turnover, however we need to continue to monitor this closely to identify any opportunities to continue to reduce our turnover for nursing in the ED.

General Medicine – General Medicine has tried to focus on supporting ED by actively reviewing ED patients, however this has been balanced with ensuring our medical staff are also seeing patients who present to ADU and ensuring timely discharges from the wards. The service will be better equipped from a medical staffing perspective as we recruit to the positions identified in the 2 business cases related to the General Medicine blueprint. We have also extended our winter strategy of senior medical officers in ADU from 1700 to 2000 into October to support patient flow.

As noted on our scorecard the acute general medicine WIES YTD is 11,933 versus a target of 11,066.

BEST CARE VARIANCE REPORT

Patient Experience

Complaints Average response time 18 days versus target of 14 days

We received 28 complaints in October with a turnaround time of 18 days and 17 complaints were closed in the month. This target remains a priority for our service and the Operations Managers along with clinical teams and Quality Assurance Lead endeavour to prioritise a timely response. Unfortunately we had a small number of complex complaints that exceeded the target timeframe.

Improving Outcomes

Acute Readmission Rate within 28 days 13.9% versus a target of 9%

Our performance remains fairly stable for this indicator. We do not have any specific work plans in place, however continuing to focus on ensuring discharge summaries are completed and available for patients and their families remains a priority and supports patients to manage their care post discharge. The MoH is reviewing this indicator so there may be further advice.

PCI within 120 minutes (STEMI Patients, 75% versus target 80%)

We had 11 patients in October of which 8 were door to device < 90 minutes, 1 patient was door to device <120 minutes and the other 2 patients breached. One patient went from White Cross New Lynn directly to Auckland City Hospital and had a total time of 133 minutes and the second patient was picked up by St Johns from home, went to Waitakere Hospital and subsequently required transfer to North Shore and had a total time of 135 minutes.

HR/Staff Experience

Sick Leave 8.3 days versus target of 8 days

Our sick leave rate has remained unchanged over the last quarter at 8.3 days against the organisational target of <8 days. We have a small number of wards/departments where sick leave has spiked in recent weeks and the managers have indicated that accidents/injuries and cancer treatments have contributed to this. In partnership with our HR advisors we are continuing with our previously mentioned initiatives to improve our performance. A number of individuals with serious illnesses which have resulted in long term absence have either returned to work or been medically retired this month.

Turnover rate 10% versus a target of 8%

Turnover in the division has decreased by 2% to 10% this month. Our HR advisors are following up with individual departments and services based on feedback from exit interviews and surveys as information becomes available. The main areas of high turnover for the MHOP Division are; Allied Health – MHOP & SAS, Medical Wards and the Emergency Departments.

SERVICE DELIVERY VARIANCE REPORT

Waiting Times

ADU % seen from triage within 120 minutes – 62% versus a target of 85%

The implementation of our second general medicine business case; that is to create 4 teams (SMO, registrar & house officer) who work in the ADU, will enable us to meet the increasing patient demand and this target on a consistent basis. The development of these teams has commenced however due to both regional processes and suitable candidates it will take some time to fully implement. We have met to discuss how we can best maximise our SMO resources as they come on line as part of the business cases. As an outcome of our initial meeting the Clinical Director for ADU is identifying where we should target our initially limited SMO resources. She is considering both the busiest days and times of the day where an SMO can contribute most to supporting patient flow and decision making as well as providing some continuity of patient care.

Diagnostic Colonoscopy within 42 days – 46% against a target of 65%

We remain on track to be compliant for the non-urgent indicator in December and we have improved our performance from 46% in October to 56% for November.

Patient Flow

AT&R LOS 22.7 days versus a target of 19 days

This ALOS report includes the patients who require interim care who are in ESC being looked after by the geriatricians. These are not patients who are routinely counted under the ALOS for AT&R. However, their ALOS is 51.6 days and removing this cohort brings the ALOS in AT&R down to 21.7 days. Fifty seven per cent of Muriwai patients, 42% of ward 14 and 50% of Ward 15 patients stayed beyond 19 days. The highest length of stay was 103 days from Ward 15 which was a complex spinal patient who required significant input from the Multi Disciplinary Team and ACC and the spinal unit. One of our priorities when we appoint a new Charge Nurse Manager for Muriwai is to focus on length of stay.

Percentage of patients with an EDS – 78% versus a target of 85%

This is a challenging target for our division given the current workload for our junior medical staff. From August until December 2015 we have recruited three medical discharge coordinators on fixed term contracts who are assisting the junior medical staff with their EDS's as one of their key tasks. We have placed one of the staff at Waitakere Hospital to support the teams on this site.

Scorecard

Waitemata DHB Monthly Performance Scorecard

Medicine and Health of Older People
October 2015
2015/16

Health Targets

	Actual	Target		Trend	
Better help for smokers to quit - hospitalised	97%	95%	●		▼
Shorter Waits in ED	94%	96%	●		▲

Best Care

Patient Experience	Actual	Target		Trend	
Complaint Average Response Time	18 days	<14 days	●		▼
Improving Outcomes					
Acute Readmission Rate within 28 days	14%	<9%	●		▼
a. Patients admitted to stroke unit	80%	80%	●		▼
PCI w/in 120 minutes (STEMI patients)	75%	80%	●		
InterRAI assessments	80%	75%	●		▲
Quality & Safety					
Older patients assessed for falling risk	97%	90%	●		▲
Rate of falls with major harm	0.20	<2	●		▼
Good hand hygiene practice	84%	80%	●		▼
Pressure injuries grade 3&4	0.00	0.00	●		--
HR/Staff Experience					
Sick leave rate	8.3 days	<8 days	●		--
Turnover rate	10%	<8%	●		▲

Service Delivery

Waiting Times	Actual	Target		Trend	
ADU - % seen from triage w/in 120 mins	62%	85%	●		▲
Elective coronary angiography w/in 90 days	100%	90%	●		--
Angiography for ACS w/in 72 hours	73%	70%	●		--
Urgent diagnostic colonoscopy w/in 14 days	88%	75%	●		▲
Diagnostic colonoscopy w/in 42 days	46%	65%	●		--
Surveillance colonoscopy w/in 84 days	75%	65%	●		▲
Patient Flow					
Elective Discharge Volumes (Cardiology)	117%	100%	●		▼
Outpatient DNA rate	11%	<10%	●		▲
b. Average Length of Stay - Acutes	2.5 days	<2.67 days	●		▼
c. Average Length of Stay - Electives	#N/A	#N/A			↑↑↑
Average Length of Stay - AT&R	22.7 days	<19 days	●		▼
Patients with EDS on discharge	78%	85%	●		--

Value for Money

Financial Result (YTD)	Actual	Target		Trend	
Revenue	4,390 k	3,883 k	●		▼
Expense	75,702 k	73,288 k	●		▲
Net Surplus/Deficit	-71,312 k	-69,405 k	●		▼
Capital Expenditure	216 k	272 k	●		▲
Contracts (YTD)					
Elective WIES Volumes	535	590	●		▲
Acute WIES Volumes	11,933	11,066	●		▼

How to read

Performance indicators:

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

Trend indicators:

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

Key notes

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

a. Missing previous month's data, therefore no trend arrow indicator
b. 2015/16 new MoH Average length of stay definition
c. New internal defintion. Target yet to be derived. Not reported this month.

A question?

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Planning, Funding and Health Outcomes, Waitemata DHB

STRATEGIC INITIATIVES VARIANCE REPORT

Deliverable /Action	On Target ✓ or ✖
Better help for smokers to quit	
1. Develop a process to follow-up on patients prescribed NRT in hospital **by June 2016**	✓
2. Refresh the training provided to health professionals (to improve the quality of support to quit and increase the number of support quit attempts, particularly to Māori and Pacific patients) - **by December 2015**	✓
3. Ensure training is available to all health professionals, including community health, mental health and addictions, child health, Māori and Pacific teams in the Ask, Brief advice and Support to Quit approach - **by 30 June 2016**.	✓
Cardiac Services	
4. Best practices Cardiac rehab programmes will be established by July 2016 which will be regionally consistent and with a whole-of-system approach that includes primary care	✓
5. Measure retention rates by ethnicity on current cardiac rehabilitation programme to enable comparison once new programme established – **by September 2015**	✓
6. FSA Chest pain clinic pilot to be established by 1 July 2015, with evaluation on the impact to reduce wait times to within target post implementation **by Oct 2015**	✓
7. Audit of selected patients who have been prioritised for surgery using the CPAC tool to assess correct use of tool – completed **by November 2015**	✓
8. Work with regional colleagues to manage the acute patient flow to minimise patient wait time and refine transfer process using CPAC tool, to be regionally agreed to and applied by June 2016	✓
9. Work with the regional, and where appropriate, national, cardiac networks to improve outcomes for patients with heart failure (MoH new priority)	✓
10. Continue to work on improving systems for data input and recording for cardiac registry data – **ongoing**	✓
Stroke Services	
11. Identify Older Adult Service processes that could be integrated into the Stroke Service, which support early engagement with stroke patients' families and their journey from admission to rehabilitation and then back into the community, pending ESD business case approval **before end of 2015**	✓
12. Establish a pathway for MDT family meetings and nurse-led ward rounds within the stroke ward, to commence **by June 2016**	✓
13. Assess the swallow documentation and review the process for assessment to ensure it reflects best practice – ensure updated documentation available on the stroke and allied health intranet **by December 2015**	✓
14. Improve existing stroke thrombolysis quality monitoring e.g. door to needle, protocol adherence, and haemorrhagic complications by working with the public health specialist to ensure the accuracy of collected data (the stroke pathway will be explored in a similar way to the cardiac pathway recently developed in ED) **by October 2015**	✓
15. Review stroke thrombolysis pathway and identify aspects for improvement that would assist identification of suitable patients at the front door – review completed **by December 2015**. Identified improvements implemented **by June 2016**.	✓
16. Develop best practice clinical guidelines identifying 'appropriate' patients to be admitted to stroke ward **by June 2016**.	✓
Shorter Stays in Emergency Departments	
17. Implement five more clinical pathways/best care bundles: cellulitis, respiratory infections; renal colic gastroenteritis; and dental conditions **by 30 June 2016**	✓
18. Commence the Waitakere ED extension **by July 2015**	✓
19. Fully embed the accelerated chest pain pathway **by December 2015**: identifying the low to moderate risk patients (with a TIMI score of 0), monitor these patients in ED for two hours rather than admitting	✓
20. We will work with clinical directors to improve the timeliness of review, acceptance and transfer of patients **by June 2016** - develop and embed an escalation pathway to improve timeliness of medical and surgical review of ED patients	✓

*** include a ✓ or a ✖**

Areas off track for month and remedial plans

FINANCIAL RESULTS

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date		Oct-15
Medical & HOPS ($000's)	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
REVENUE									
* Government and Crown Agency	810	842	(32)	3,741	3,370	372	10,109	10,109	0
Other Income	201	128	73	649	513	135	1,540	1,540	0
Total Revenue	1,011	971	40	4,390	3,883	507	11,649	11,649	0
EXPENDITURE									
Personnel									
Medical	6,440	6,485	45	19,798	19,524	(274)	58,013	58,013	0
Nursing	6,650	6,516	(134)	28,431	28,201	(230)	85,964	85,964	0
Allied Health	2,239	2,476	238	7,111	7,336	225	21,833	21,833	0
Support	0	(25)	(25)	0	(78)	(78)	(214)	(214)	0
Management / Administration	1,148	1,178	30	3,660	3,471	(190)	10,191	10,191	0
	16,477	16,630	153	59,000	58,454	(546)	175,788	175,788	0
Other Expenditure									
Outsourced Services	678	429	(249)	2,636	1,790	(846)	5,633	5,633	0
Clinical Supplies	2,862	2,849	(13)	11,438	11,051	(387)	32,368	32,368	0
Infrastructure & Non-Clinical Supplies	632	502	(130)	2,628	1,994	(634)	5,895	5,895	0
	4,173	3,780	(392)	16,702	14,835	(1,867)	43,896	43,896	0
Total Expenditure	20,650	20,410	(239)	75,702	73,288	(2,413)	219,684	219,684	0
Cost Net of Other Revenue	**(19,639)**	**(19,440)**	**(199)**	**(71,312)**	**(69,405)**	**(1,907)**	**(208,035)**	**(208,035)**	**0**

COMMENT ON MAJOR FINANCIAL VARIANCES

Revenue

ACC revenue has been overachieved to plan ($260k Favourable) in the 4 months to October, in particular in the AT&R Wards. AT&R have been focusing on improving identification of ACC patients and working with the ACC team to maximise billing of eligible patients. This will be a continuing focus for the remainder of the year.

Research programmes, in particular in Haematology, have also returned greater revenue than budgeted, but as these are billed only at direct cost this indicates greater costs incurred. Haematology research does have the added benefit of relieving pressure on DHB funded PCT pharmaceutical usage, but this in turn puts additional pressure on the Haematology Day Stay where the infusions are given.

Personnel

Medical costs incurred above budget year to date have been driven by long term sick leave ($64k) and outstanding leave balance revaluations. The approved General Medicine business cases for Waitakere and ADU are currently in the roll out phase, and when fully implemented these will support our ability to cover leave and reduce these balances. A short term locum option is also being investigated.

Nursing costs are also impacted by leave revaluations, with a $185k impact in the October month due to the revaluation of leave balances following the implementation of the new MECA. In the year to date, $184k of

annual leave had also been earned but not yet taken, there will be a focus on ensuring leave is maximised over summer as patient demand allows.

Allied Health have carried high levels of vacancies this year, resulting in a large underspend YTD. This occurred as turnover of these staff remains high at 12.83% in the 12 months to October 2015, and recruitment into these roles can be challenging. MHOPs carry a general savings line of 10 FTE to be unfilled at any one point in time, under a 'support' line, and historically Allied Health vacancies have achieved this.

Non-Personnel

Outsourced costs are primarily external nursing bureau, for the provision of both constant observation shifts and the backfill of unplanned leave, such as sick leave and bereavement leave. Constant observation shifts (watches) has seen a dramatic increase in demand to date this year, and so a pilot programme has been approved to engage internal staff to provide these shifts, along with a Specialist Nurse who will provide a general control and review function over all watches requested in our division. This will include determining at what stage this level of care can cease. This pilot will run until June, however an evaluation is planned for 3 months and if successful we will develop a case to roll the concept out across our division.

Clinical Supplies demand has been far above expectations for PCT drugs used for Chemotherapy. This is due to a large number of new patients presenting in July, who will remain on their treatment courses for 6-18 months. The October YTD cost above budget of $91k will be reimbursed by the Corporate team, along with high Rheumatology demand for the same medications. Rheumatology demand increased as national indications for the drugs that can now be prescribed, has been expanded and future budgets will look to forecast the ongoing demand for these medications.

Acute demand in ED, the Medical Wards and the AT&R Wards also saw combined clinical supplies overspends of $203k. YTD demand in October was 106%, 111%, and 117% respectively of expected/contracted volumes. Recent successes in areas such as District Nursing on product substitution to cheaper but clinically equivalent products is intended to be expanded into these areas, where maximum gains could be achieved. This will require engagement with healthAlliance procurement, and significant clinical input to ensure care is not compromised for cost efficiencies, but has the potential for significant gains into the future if achieved.

MHOPs hold a savings line of $533k YTD under 'Infrastructure', and all service areas have been engaged to identify where they can support the achievement of this target. The focus on ACC revenue in the AT&R wards is one initiative put forward, as were ideas around areas of specific areas for procurement focus, and staffing skill mix reviews to ensure that staff are engaged at the top of their practice step for the tasks required. These small initiatives are all under development to ensure they are operationally practicable, and to identify what level of savings may be achieved.

MHOP - Getting back on track initiatives

The service is continuing to closely monitor leave and in particular those staff with excessive balances - >75 days. The majority of staff with the high leave balances are senior medical officers that work in ED, Cardiology and General Medicine where our ability to cover leave is limited. The first priority of managers is to ensure all staff take their current years leave entitlement during the year, to avoid the high balances growing further. The option of engaging Locum support to allow high-balance individuals to take leave is being investigated at present.

There has been a reduction in expenditure (reduction of $36k in the YTD) for wound dressing used by the district nurses; this is the result of a number of months' work by the district nursing team and the manager inventory and supply chain. We anticipate this reduction in expenditure will continue throughout the year. The ward based teams are also reviewing their wound dressings as a consequence of the work done in district nursing. Other areas where similar product substitution may be possible are also being investigated.
Progress continues with the introduction of the Kanban stock management system into Ward 10. This system will provide benefits in reducing the time it takes to complete stock ordering for the ward. The system will also be implemented in Ward 3 as part of the refurbishment in early 2016.

One of the significant expenditure lines in MHOP is for watches. Watches are used to support patients for a number of reasons; with the primary reasons being delirium, high risk of falling and behaviours of concern. A pilot on Ward 5 and Ward 10 will commence in December, and will engage a Specialist Nurse to provide clinical oversight and reviews of all watches requested. Internal staff will be recruited to undertake the watches, avoiding the cost premium of utilising external bureau staff for these shifts.

Waitemata DHB has engaged the services of Deloitte to help facilitate opportunities to control expenditure. In MHOP we have identified an opportunity to release approximately 5 beds per annum by providing an early discharge and rehabilitation service for stroke patients and/or patients with similar rehabilitation needs.

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, of the regional Out of Home Children's Respite Service, the Auckland Regional Dental Service (ARDS), and the national Child Rehabilitation Service Services are provided within our hospitals, e.g. births, outpatient clinics and gynaecology surgery, and within our community, e.g. community midwifery, mobile/transportable dental clinics and the Wilson Centre. The division is managed by Linda Harun with Dr Peter van de Weijer HOD Medical CWF and Clinical Director Gynaecology and Emma Farmer HOD Midwifery; Marianne Cameron HOD Nursing, Susan Peters Acting Allied Health Lead, Dr Sathananthan Kanagaratnam Clinical Director ARDS, Dr Sue Belgrave Clinical Director Obstetrics, and Dr Meia Schmidt-Uili Clinical Director Child Health.

HIGHLIGHT OF THE MONTH

Review of Medical Leadership Structure

Child Health has recently completed a review of its medical leadership structure. The review occurred because:

- The service has grown significantly since its inception ten years ago
- It has been challenging for the current medical leaders to meet the demands and requirements of their roles. In particular, service development is occurring haphazardly and reactively and it has been difficult to complete tasks in a timely manner.
- A number of SMOs in the service have indicated an interest in developing their clinical leadership skills and have informally taken on some tasks, but this is based on goodwill and without mandate.

In 2011 Child Health introduced a medical lead for neonates. This role has been successful. Specifically, since the role was implemented clear paediatric leadership has been provided across both neonatal and maternity services and relationships with tertiary providers have been enhanced.

The review determined that it would be beneficial to build on the success of this model by introducing five new medical leadership roles in the following areas:

1. Acute paediatrics
2. Ambulatory care
3. Community paediatrics
4. Violence prevention and child protection
5. Youth health

The medical leads work collaboratively with the clinical director and operations manager to form a medical leadership team. Together the team will oversee medical recruitment, service improvement and development, and patient flow; ensuring health targets and compliance measures are met and support the efficient and effective delivery of the service in alignment with the organisational promise and values.

It has been agreed that the new structure will be implemented in three phases. The first phase has been completed.

Dr Chris Peterson has been appointed the medical lead for acute paediatrics and Dr Todd Warner the medical lead for ambulatory care.

KEY ISSUES

Assessments for Children with Intellectual Disability

On 6 November the Child Development Services (CDS) across New Zealand received notification from the Ministry of Health that from 9 November intellectual disability assessments for children (who are eligible for CDS) should be sent from Needs Assessment and Coordination Services to the local CDS provider.

This is new work for the majority of the national CDS providers. The Ministry of Health has stated that they believe the assessment of intellectual disabilities is included within the CDS service specification (because it is not explicitly excluded).

It is estimated that a routine assessment of an intellectual disability would take an appropriately trained psychologist up to ten hours to complete. Many assessments are more complex and would require longer time. This predicted number of referrals for assessments required for the Waitemata DHB is unknown, but is anticipated to be significant. The issue is currently being worked through.

Implications of the Implementation of the new Family Violence Guidelines

The Violence Intervention Programme (VIP) Coordinator has been advised the new Family Violence Guidelines are expected to be released in early 2016. All DHBs will be expected to implement these, which will require changes to training packages and policies.

The National VIP Coordinator has indicated that one hour refresher training is provided to all DHB staff that have already completed core family violence training. This must be interactive and delivered by the DHB VIP team. New family violence cue cards will also have to be distributed. This will have a significant impact as it is estimated that the refresher training will need to be provided to approximately 500 staff across the DHB. Planning is underway to identify how this can occur in a timely way.

SCORECARD VARIANCE REPORT

BEST CARE VARIANCE REPORT

Improving outcomes – oral health

Oral health enrolment numbers at one year remain below target, despite enrolment forms being collected from Well Child agencies, schools and Early Childhood Centres and being entered promptly into Titanium (the electronic clinical system used in ARDS). WDHB and ADHB have coordinators in maternity wards offering ARDS enrolment to new parents. The service is now undertaking a mail out with information and an enrolment form to identify unenrolled children in 0-3 age group.

Quality and safety – hand hygiene

Hand hygiene results have shown a drop and staff are being reminded of the importance of good hand hygiene.

HR/Staff experience – sick leave rate

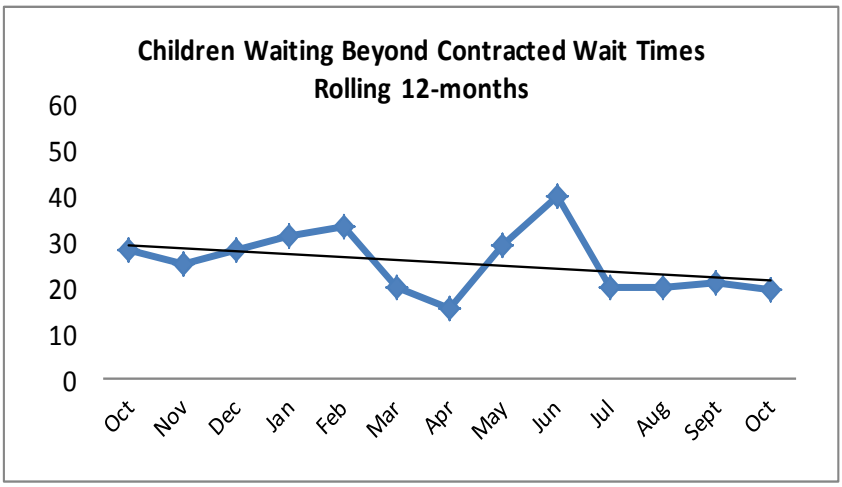
Sick leave rates have shown a decrease this month after many months of focus by managers. The service continues to manage sick leave closely.

SERVICE DELIVERY VARIANCE REPORT

Waiting Time (Gateway)

The number of children waiting for a Gateway Assessment with completed referrals beyond contracted timeframes has reduced to 19 this month. Year to date wait time continues to be primarily affected by a high number of DNAs. CYF's staff have the responsibility for ensuring attendance at appointments, and the service is continuing to work closely with CYFs' social work staff to reduce DNA numbers. This has impacted on the ability of the service to complete the assessment process and has created delays for newly referred children. Assessments are continuing to be maximised each month and the Gateway Co-ordinator continues to work closely with Child, Youth and Family to minimise the likelihood of DNAs.

Children waiting beyond 6-weeks by month are demonstrated in the graph below.



Of note, there continues to be an increase in the number of referrals to the programme. Year to date referrals received are 90% to contracted volumes (16% improvement from the same period last financial year). There has also been an increase in the number of assessments completed (n=84 completed year to date, compared to n=60 over the same period last year).

Patient Flow - Outpatient DNA

Text reminders continue to be used and in community settings a phone call is made to remind patients and their family of the appointment the next day.

Theatre Utilisation Gynaecology

Factors which have impacted the overall theatre utilisation this month have been late patient cancellations due to health reasons.

The service is monitoring theatre utilisation closely and is now planning to cover all leave to ensure theatre times are utilised.

Contracts

Neonatal WIES is 5% below target year to date. The neonatal Clinical Lead is in regular contact with ADHB to ensure timely transfers occur from NICU and SCBU at ADHB.

Scorecard

Waitemata DHB Monthly Performance Scorecard

Child Women and Family Services and Elective Surgical Centre
October 2015
2015/16

Health Targets

	Actual	Target	Trend
Better help for smokers to quit - hospitalised	99%	95%	▲
Shorter Waits in ED	97%	96%	▲

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	13 days	<14 days	▼
Improving Outcomes			
Acute Readmission Rate within 28 days	9%	<9%	--
Exclusive breastfeeding on discharge	86%	75%	▲
Women smokefree at delivery	92%	95%	▼
Oral health - % infants enrolled by 1 year	47%	98%	▼
Quality and Safety			
Good hand hygiene practice	80%	80%	▼
HR/Staff Experience			
Sick leave rate	9 days	<8 days	▲
Turnover rate	10%	<10%	▲

Service Delivery

	Actual	Target	Trend
Elective Volumes			
Provider Arm - Overall	97%	100%	▼
CWF Services	91%	100%	▲
Waiting Times			
Gateway referrals wating over 6 weeks	19	0	▲
Patient Flow			
Outpatient DNA rate	11%	<10%	▼
[b] Average Length of Stay - Maternity	2.3 days	<2.5 days	▲
[c] Average Length of Stay - Paediatrics	1.56 days	<1.56 days	▼
[b] Average Length of Stay - SCBU	6.80 days	<7.02 days	▲
Theatre utilisation Gynaecology	80%	85%	▼
Patients with EDS on discharge	85%	85%	▼

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue	4,665 k	4,578 k	▼
Expense	29,507 k	28,978 k	▲
Net Surplus/Deficit	-24,842 k	-24,399 k	▼
Capital Expenditure	248 k	402 k	▼
Contracts (YTD)			
Gynaecology Elective WIES (excl ESC)	538	564	▼
Gynaecology Acute WIES	436	416	▲
Maternity WIES	2,367	2,435	▼
Paediatrics WIES	634	596	▼
Neonatal WIES	642	726	▼

How to read

Performance indicators:

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

Trend indicators:

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

Key notes

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

b. 2014/2015 original internal definition for 'Average length of stay'
c. 2015/16 new MoH Average length of stay definition

A question?

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Planning, Funding and Health Outcomes, Waitemata DHB

STRATEGIC INITIATIVES VARIANCE REPORT

Deliverable /Action	On Target ✓ or ✖
1. ARDS will begin a training programme for WCTO and other child health providers in key messages related to oral health literacy **by December 2015**	✓
Pregnancy and Parenting **Maternity Quality and Safety Programme**	
2. Implement the new national Post-Partum Haemorrhage guideline and review incidence rates **by June 2016**	✓
3. Review the Waitemata DHB induction of labour guidelines **by September 2015**	✓
4. Review episiotomy practices and outcomes by ethnicity **by August 2016**	✓
Gestational Diabetes	
5. Implement new guidelines, as appropriate, **by June 2016**	✓
6. Work with regional counterparts to agree a regional approach for women with HbA1C of 41% to 49% in the first trimester **by June 2016**.	✓
7. Work with Waitemata DHB inpatient services to increase reporting and referral of children identified at admission who require immunisation - extend to paediatric emergency department services **by March 2016**. Review the feasibility of extending to out-patients services **by June 2016**	✓
Reducing the number of assaults on children	
8. Maintain the National Child Protection Alerts System to tackle child abuse and child vulnerability by placing Child Protection Alerts in clinical records, national health index medical warning system and DHB internal systems on all appropriately identified mothers, infants, children and youth, to be completed by March 2016	✓
9. Develop care plans following placement of alerts **by June 2016**	✓
10. Ensure all Māori wahine/women and/or their children/tamariki who are admitted to North Shore and Waitakere Hospitals are offered Whānau/Pai Ora assessments, to be implemented from March 2016	✓

*** include a ✓ or a ✖**

Areas off track for month and remedial plans

FINANCIAL RESULTS

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date		Oct-15
Child Women Family									
($000's)	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
REVENUE									
* Government and Crown Agency	992	1,095	(103)	4,368	4,445	(78)	12,906	12,906	0
Other Income	49	33	16	298	133	164	400	400	0
Total Revenue	1,041	1,128	(86)	4,665	4,578	87	13,305	13,305	0
EXPENDITURE									
Personnel									
Medical	1,891	1,917	26	5,815	5,755	(61)	16,538	16,538	0
Nursing	2,066	2,177	111	8,855	9,113	258	27,617	27,617	0
Allied Health	2,615	2,593	(22)	8,231	8,078	(154)	23,385	23,385	0
Support	23	24	1	73	72	(1)	205	205	0
Management / Administration	389	474	85	1,255	1,385	131	3,950	3,950	0
	6,985	7,185	200	24,229	24,402	173	71,695	71,695	0
Other Expenditure									
Outsourced Services	241	167	(74)	922	685	(237)	1,979	1,979	0
Clinical Supplies	420	456	36	2,075	1,877	(197)	5,323	5,323	0
Infrastructure & Non-Clinical Supplies	503	504	0	2,281	2,013	(268)	5,847	5,847	0
	1,165	1,127	(38)	5,278	4,575	(703)	13,148	13,148	0
Total Expenditure	8,150	8,312	162	29,507	28,978	(529)	84,844	84,844	0
Cost Net of Other Revenue	**(7,108)**	**(7,184)**	**76**	**(24,842)**	**(24,399)**	**(443)**	**(71,538)**	**(71,538)**	**0**

COMMENT ON MAJOR FINANCIAL VARIANCES

Contribution position for Year to Date October 2015 ($443k unfavourable)

Revenue ($87k favourable Year to Date)

The Child, Women & Family Service continues to benefit from new funding streams. A new contract variation for Newborn Hearing Screening Services $62k, the gain on the sale of 3 old transportable dental units (TDU's) $47k together with Community Dentist MoH claiming and Gynaecology training reimbursement funding from the University of Auckland $37k have been the primary drivers for this increased revenue. Partially offsetting this is a funding shortfall from an external provider relating to the Regional Dental Service that amounts to $170k Year to Date.

Demand for Child Rehab services for ACC patients is showing signs of recovering following a recent drop in patient numbers. It is expected that further funding increases above the $23k Year to Date position will be evident over the coming months.

Expenditure ($529k unfavourable Year to Date)

Personnel costs are currently $173k under spent Year to Date as a result of vacancies across Nursing and Management/Admin staffing groups $258k and $131k respectively. The service expects recruitment to pick up in the new year. Favourable signs can be seen in the recent annual leave uptake particularly within Medical staffing.

This trend may be hampered by a shortage in O&G registrar numbers when the next run commences in December. Allied Health costs continue to remain high with budgeting issues across Regional Dental Services. Higher than budgeted spending in outsourced costs $237k is a combination of external outsourcing of postnatal services $155k and embedded unmet savings initiatives. The monthly postnatal costs are expected to remain until early December when the new Hine Ora ward is expected to be fully operational.

Other over spends in Clinical Supplies $197k and Infrastructure & Non Clinical costs $268k have been driven predominately by saving initiatives $488k. Other over spends in uniforms $31k and rental costs $65k have effectively been absorbed by reduced treatment disposables $44k and transportation costs $77k.

Much of the following *"Getting back on track"* initiatives will contribute to achieving these savings targets.

Getting back on track initiatives

The service has put in place controls for managing annual leave balances that exceed organisational policy. Staff with high annual leave balances have leave plans in place for the next 12 months and leave use is being tracked on a monthly basis. Estimated saving from this initiative are expected to be in the vicinity of $200k to $250k. This leave is being managed without compromising service delivery. Sick leave management is also a focus for the group with sick leave now showing some signs of reducing from the 10 day average at the beginning of the financial year.

Financial benefits are being realised through a change in the supplier of specific dental products. Savings for the 2014/15 financial year were in the vicinity of $66k with this initiative only starting part way through the 2014/15 year. These benefits have continued through into 2015/16 and are being tracked on a monthly basis. There has also been good progress in getting non catalogue ordered products onto the catalogue which will enable Health Alliance to engage with suppliers of these products to seek better pricing.

The service is also in the mid stages of a review of clinical supplies management within Home Care for Kids services. Health Alliance has been working with supplier USL to ensure more Huggies nappies products are included on their catalogue. Further work is needed to ensure that the USL catalogue pricing is competitive with other suppliers.

Progress continues albeit slowly with the introduction of the Kanban stock management system into SCBU. This system will provide benefits in reducing the time it takes to complete stock ordering within the services thereby freeing up staff resources. A recent strategy that aligns with this is the appointment of a Clinical Supplies Coordinator for CW&F services at North Shore Hospital. This role has been created to reduce the number of staff procuring supplies within Maternity, SCBU and the new Hine Ora ward and ensure a more efficient means of stock control. The service plans to duplicate this role at Waitakere Hospital to cover Maternity, SCBU and Paediatric inpatient services and is at present determining whether there are any suitable internal applicants for this new role.

The service continues to explore options for reducing maternity related costs on specific product lines through either a change of supplier or through the use of alternative products. One of the frequently used products "Birthing packs" has now been introduced into the DHB with a change in the product configuration.

WDHB engaged the services of Deloitte to help facilitate change in clinical practice/model of care in gynaecology. The service will be undertaking work on the business case for this long term initiative during quarter 3 2015/16 with a view for a potential commencement in quarter 4.

Mental Health and Addiction Services

SERVICE OVERVIEW

This division provides specialist community and inpatient mental health services to Waitemata residents. It 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 Dr Murray Patton for Mental Health and Clinical Director Forensic Services, Dr Jeremy Skipworth.

HIGHLIGHT OF THE MONTH

Maternal Mental Health

The following story about Post Natal Depression (the pressures of parenthood) was published in the October 2015 edition of the 'Multiple Exposures Newsletter':

> *Jo shares a raw insight into her early days with newborn twins plus one, and her struggle with depression.*
>
> *"Have they smiled yet?" well-meaning visitors would ask. Then it occurred to me that no, they haven't smiled yet because smiling is a learned behaviour and I do not smile at them.*
> *That was when I realized that we did need help. Not so much for me, I'd been down this road before with depression, but I wanted to minimize any effects my depression would have on these little babies and our family.*
>
> *Until that point I had been telling myself I could handle this, what I was feeling was "just" dealing with the fact that I didn't want twins. That statement alone is massive and would take some processing and then throw in sleep deprivation, a 2yr old adjusting to new sisters and a couple of stressful trips to the paediatric ward, and I think the problem had escalated.*
>
> *We were absolutely definitely only ever intending to have two children and had thought long and hard about even having number two. I did not want twins. Our first daughter Ruby Bo was as easy as a baby could be - I was still tired and we had the odd learning curve but for the most part I enjoyed my time with her as a baby.*
> *Edie and Scout couldn't have been more different. Born at 36/6 (natural vaginal birth – nothing traumatic) they were small but healthy, no SCBU, home in 3 uneventful days, breastfeeding well. Then it was like we entered the twilight zone...on crack.*
>
> *Edie was quickly nicknamed "The Night Squawker" and Scout "The Regurgitater". They cried and screamed and cried and screamed, were difficult to get to sleep, then excruciatingly difficult to wake to feed (ultimately resulting in a hospital visit no.1 for weight loss)…pretty much all the usual stuff but I felt I knew how it was "supposed" to be from Ruby Bo, and I felt royally ripped off.*
>
> *I resented that there was no warm fuzzy early days. Breastfeeding was a logistical nightmare instead of a loving bonding time, I didn't even stop to play and chat at change time because the other would be screaming, or Ruby Bo vying for attention.*
>
> *I was hating my new life, and resented Scout and Edie for creating it. I wanted to spend all my time with Ruby Bo, I wanted to curl up in bed with her at night, and for Edie and Scout to just go away.*
>
> *At about three months, Plunket referred me to the Waitemata DHB's Maternal Mental Health Services (MMH) – ostensibly to access funded respite care and in home support – but in hindsight I suspect Plunket Nurse Anne knew exactly what was happening.*

MMH are amazing. Hands down THE best public health service I've ever come across. Rebecca from MMH was the light at the end of my tunnel for months. In the early days, if she didn't visit every day, she would call. I can't rave about her enough. She quickly organized a night nanny for 3 nights a week to help me with night feeds and resettling so Dad Luke could get some sleep too.

Luke was my rock. I was irrationally convinced he was going to leave any day and leave me alone in this nightmare. But he was reeling from the shock of everything too and it was particularly hard when he was struggling too. Luke also found it really difficult (fair enough too!) to hear me share how I felt about not wanting three children. He was desperate for me to move past this, and the more I couldn't the more guilty I felt.

I wondered if I would be sad or relieved if one died. I wallowed in the "unfairness" of it all. I wanted to hit people who said "Oh twins! You're so lucky!" I hated one baby at a time – depending on who was being "easier" at the time. It felt like Groundhog Day every day, or one step forward, two steps back. I couldn't figure out why this was so hard for me when there were so many other parents of multiples who seemed to be doing just fine – even enjoying their babies! I simply avoided them when I could – if someone came into help I would hand over Scout and Edie and spend time with Ruby Bo instead.

I was encouraged to consider antidepressant medication however I was reluctant to go down that path after taking a number of years to stop medication in the past, and I had concerns around breastmilk transfer. I was also adamant the biggest problem was still sleep deprivation (I was getting 2 – 3 hours max at night and no opportunity to sleep during the day with Ruby Bo at home fulltime) and was convinced once I cracked that, everything would be fine.

I finally admitted defeat (to myself only! No-one else thought it was a bad thing) when after having the fabulous Baby Sleep Consultant Emma visit at 7 months and magically going from 2 – 3hours sleep to 8 – 9 hours(!) I still felt the same and my scores on the post natal depression Edinburgh Test remained in the toilet. I started taking an antidepressant when Scout & Edie were almost 8 months old.

Perhaps because of my history with depression and coming off antidepressants, it's also very important for me to reflect on the psychology of what's happened and not solely rely on medication to feel better. Having Rebecca (MMH) to talk to was so important; I have a policy of always telling the balls-out truth about how I'm feeling to mental health professionals – they can't help if they don't know what I'm thinking! I was also pretty honest with my friends about how I was feeling and they blew me away with their thoughtfulness and support.

I'd recommend The Reality Slap by Russ Harris for some breastfeeding reading and in general found "mindfulness" really helpful. I also plastered my walls with mantras to recite when I was struggling – although I wrote them in Spanish because I had so many people coming and going and I was starting to feel like I had no privacy left!

Edie & Scout turned one in July and they do smile! And laugh and cry and explore and snuggle and play and generally seem to be pretty happy healthy little people. I consider that a credit to the many people who've supported me over the last year - family, friends, professionals, volunteers - and thank them from the bottom of my heart. Aroha nui, Jo.

Whilst Maternal Mental Heatlh is a well established service, there is growing development of Infant Mental Health services in response to the release of the Health Beginnings report in 2012 by the Ministry of Health.

Infant mental health is defined as "the developing capacity of the child from birth to three to: experience, regulate, and express emotions; form close interpersonal relationships; and explore the environment and learn in the context of family, community, and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development."

Marinoto (CAMHS) have been supporting a small number of clinicians working in the child focused teams to develop their skill in expertise in assessing and treating families presenting with difficulties from an early age. However demand for assessing and treating children of all ages has limited further development of an infant mental health service. The child and youth mental health portfolio are planning a dedicated infant mental health team, to establish the capacity to respond to gap in the service continuum.

Mason Clinic New Build

Further to the Board's support for the building of a fifteen bed unit on the Mason Clinic site, the business case has been reviewed by the Capital Investment Committee on 22 October. The Forensic service hosted the Committee which included a site visit walk around the units and a presentation by the Clinical Director Dr Jeremy Skipworth. The Committee provided their endorsement of the plan to go forward for ministerial approval. The Committee asked that the Northern DHBs work together to ensure aligned planning for the region's needs for secure care provision into the future. A workshop to progress this alignment is timetabled for early December.

In preparation for the new unit, three London Plane Trees have been removed, milled and the timber is now stored on site for patients interested in this area of vocational rehabilitation. The refurbishment of leaky buildings continues on track and relocation of impacted staff has proceeded smoothly in accordance with the remediation plans.

The service has progressed to being stream based (rather than unit based) service provision. This is the culmination of several years of 'lean' thinking applied. We will be monitoring a range of KPIs over coming years to quantify the effect on patient outcomes.

In response to the review of Security – the Greet report, the Physical Security Document (PSD) for the site is being drafted. This will include an action plan for procedural and physical security on the site and forms a central component of the security strategy that involves policy and procedure along with changes to the physical environment.

KEY ISSUES

Acute Adult Inpatient Unit Courtyards

The main courtyard areas of both Acute Adult Admission Units have remained closed, limiting patients' access to outside environments and resulting in a situation where only patients with leave from the unit are able to go outside. Patients and families are concerned that they cannot get out to sunny areas or for fresh air outside of buildings. However patients in the high care areas do have enclosed external courtyards.

A business case has been developed and was supported by the Audit and Finance Committee on 25/11/15, the business case sought approval for upgrades to 5 courtyard areas in the two acute units. These upgrades will take place until March or April 2016.

An interim proposal, until upgrading occurs, to open the courtyards for limited periods during the day with dedicated extra staffing has been developed.

Whitiki Maurea – Maori Mental Health Services

In Moko Mokai (Mental Health Team) there has been a focus on reviewing service measures consistently. This has included the development and reporting of:

- 90 day followup targets

- 90 day Wawata (Clinical) reviews
- case manger 30 day reviews
- taurawhiri (cultural) 30 day review
- HoNOS and Hua Oranga outcome measures
- Doctors' letters to General Practitioners

Actions are being implemented to bring all measures within the target range including a review of the booking system for Doctors and case managers and weekly case load reviews. Where service users are identified as overdue for review, follow up by the Team Leader and Clinical Nurse Consultant is occuring. In Te Pae Ahurea (Maori Cultural Team) staff will be reviewing the cultural assessment forms and cultural therapeutic programmes as well as revisiting the data collection process on HCC to more accurately reflect reporting of correct cultural data.

Takanga a Fohe, Service Demand

Demand on Tupu Service (Pacific Clinical Service) is noticeable with significant increase in referrals. Demand on Malaga Service (Pacific Cultural Service) is also high across the District services. This has been placed on the Risk Register. The service is considering how to meet this demand including changes to the model of service delivery.

SCORECARD VARIANCE REPORT

HEALTH TARGETS VARIANCE REPORT

Short Waiting Times In Emergency Departments

Presentations of people to the ED with mental health issues for the month of October 2015 included 614 at Waitakere ED and 1,417 at North Shore Hospital. Despite a rise in the number of people presenting, the mental health services are currently meeting their target of 80% for waiting times in the ED.

The impact of the Enhanced Mental Health Service based in the Waitakere Emergency department in the afternoon and at nights and the movement of 1 FTE from the community in to the ED department at North Shore have contributed towards an improvement in the speed with which people with MH issues are able to be seen. A further increase in MH capacity in the NorthShore ED will occur when a second night shift nurse starts in Mid-January 2016. MH will then have a 7 day per week awake night shift service in both Emergency Departments.

BEST CARE VARIANCE REPORT

Complaints

The average time to respond to complaints has increased for October 2015 to 19 days. This is due to two complaints that have been unable to be closed due to the complexity of the response required. The final responses to these complaints have now been delivered.

Seclusion Reginal Forensics Prison Service

RFPS seclusions have increased due to high acuity admissions.

SERVICE DELIVERY VARIANCE REPORT

Average Length of Stay Adult Acute Units

The average length of stay, 31 days, for October is influenced by the discharge of two long stay patients, the median length of stay remains steady at 15 days.

Wait times for Child and Youth

Child and Youth wait times remain below target due to increased service demand outstripping the service capacity to respond. A business case has been prepared to support additional FTE in order to address the demand capacity issue.

Scorecard

Waitemata DHB Monthly Performance Scorecard

Mental Health Services
October 2015
2015/16

Health Targets

	Actual	Target		Trend	
Better help for smokers to quit	95%	95%	●		▼
Shorter Waits in ED	80%	80%	●		▲

Best Care

	Actual	Target		Trend	
Patient Experience					
Complaint Average Response Time	19 days	<14 days	●		--
Improving Outcomes					
a. Acute readmission rate - Adults	*14%*	*<10%*	●		▼
a. Acute readmission rate - CADS	*0%*	*<5%*	●		--
Seclusion use Forensics - Episodes	6	<5	●		▲
Seclusion use Adult - Episodes	6	<14	●		▲
b. MH Access Rates 0-19 years (Total)	*3.09%*	*3.00%*	●		▲
b. MH Access Rates 0-19 years (Maori)	*4.28%*	*3.60%*	●		▲
b. MH Access Rates 20-64 years (Total)	*3.43%*	*3.50%*	●		▲
b. MH Access Rates 20-64 years (Maori)	*7.65%*	*8.00%*	●		▲
HR/Staff Experience					
Sick leave rate	10.0 days	<7.5 days	●		▼
Turnover rate	10%	<10%	●		▼

Value for Money

	Actual	Target		Trend	
Financial Result (YTD)					
Revenue	4,420 k	3,976 k	●		▲
Expense	42,553 k	43,162 k	●		▲
Net Surplus/Deficit	-38,133 k	-39,185 k	●		▼
Capital Expenditure	67 k	88 k	●		▼

Service Delivery

	Actual	Target		Trend	
Waiting Times (latest available)					
b. Youth (0-19) < 3 weeks	*63%*	*80%*	●		--
b. Adult (20-64) < 3 weeks	*88%*	*80%*	●		--
b. CADS (0-19) < 3 weeks	*96%*	*80%*	●		--
b. CADS (20-64) < 3 weeks	*96%*	*80%*	●		--
b. Forensic (20-64) < 3 weeks	*89%*	*80%*	●		--
Prison inpatient waiting list	0%	0%	●		--
Patient Flow					
Average Length of Stay - Adult Acute	31 days	<15-21 days	●		▼
Average Length of Stay - CADS Detox	7 days	<6-8 days	●		--
Bed Occupancy - Adult Acute	93%	85%	●		▼
Bed Occupancy - CADS Detox	98%	90%	●		▼
Bed Occupancy - Forensics Acute&Rehab	99%	95%	●		▼
Bed Occupancy - ID	91%	70%	●		▼
Community Care					
Treatment days per service user - adult	3.5 days	3-5 days	●		--
Treatment days per service user - child	1.8 days	2-4 days	●		▼
Treatment days per service user - youth	2.2 days	2-4 days	●		--
Treatment days per service user - CADS	2.2 days	2-4 days	●		--
Treatment days per service user - forensics	2.2 days	2-4 days	●		--
Preadmission community care - adult	83%	75%	●		▲
Post discharge community care - adult	89%	90%	●		▲
Community service user related time - adult	41%	35-45%	●		--
Contact time with client participation - adult	76%	80-90%	●		▲
Whanau contacts per service user - adults	65%	70%	●		▲
Whanau contacts per service user - child	100%	80%	●		--
Whanau contacts per service user - youth	100%	80%	●		--

How to read

Performance indicators:

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

Trend indicators:

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

Key notes

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

a. Reported 1 month in arrears
b. Reported 3 months in arrear

A question?

Contact:
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STRATEGIC INITIATIVES VARIANCE REPORT

Deliverable /Action – Prime Minister's Youth Mental Health Project	On Target ✓ or ✖
Child and Adolescent Mental Health and Youth Alcohol and Drug Services	
1. Complete primary care roll-out of e-referrals **by December 2015**	✖
2. Opportunities for delivering CAMHS and Altered High services locally are fully explored and changes implemented to maximise access (particularly in rural and under-served areas) **by June 2016**	✓
3. CAMHS will review service provision:	✖
- Develop a configuration plan to allocate resources to meet population demand, projected growth, need in rural areas and underserved populations **by December 2015**	✓
- Ensure dedicated Infant Mental Health FTE are employed **by October 2015**	
Rising to the Challenge/Mental Health and Addition Services	
4. Implement a new model of care in He Puna Waiora (the new adult inpatient unit) to be operational from May 2015, and the new model of care to be fully implemented **by December 2015**	✓
5. Implementation of sustainable community residential services for people with high and complex needs completed **by June 2016**	✓
6. Full roll-out of enhanced acute service based at Waitakere Hospital ED **by December 2015**	✓
7. Implementation of a new model of community acute response (Pilot from February 2015 and complete roll out July 2016).Will achieve district wide service consistency, earlier responses, better support to GPs, and increased capacity to deliver services in the home environment.	✓
8. Māori and Pacific service users have the highest physical health comorbidities. Ensure routine metabolic screening for secondary service users, with priority focus on Māori and Pacific clients **by June 2016**	✓
9. Facilitate whānau hui with Tagata Whai I te Ora and their whānau who receive mental health treatment from the Waitemata DHB Māori Mental Health Services to gain insights into the negative and positive effects of compulsory community treatment orders **by March 2016**	✓
10. Ensure reliable collection of data for use of seclusion and restraint for Māori, and analyse the data to understand differential rates of use for Māori, **by December 2015**	✓
11. Provider Arm will review systems to reliably collect social outcome data (housing, employment and PHO enrolment) using agreed KPI definitions and align with NGO collection approaches and PRIMHD collection protocols. This process is to commence **by July 2015**	✓
12. Ministry COPMIA guidelines (expected in April 2015) will be implemented. All staff will have increased knowledge of available COPMIA resources and increased competencies to promote COPMIA child and family focused practice.	✓

*** include a ✓ or a ✖**

Areas off track for month and remedial plans
1. The complete roll out of e-referrals is a project that sits outside of MHS. There is ongoing work towards a full roll-out including use of all functionality in the e-referral system. Currently e-referrals are being received into MHS from primary care.
2. Ensure dedicated Infant Mental Health FTE are employed by October 2015 – A business case has been developed requesting increased FTE to address increased demand on services and to support the development of new services.

FINANCIAL RESULTS

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date		Oct-15
Mental Health Services									
($000's)	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
REVENUE									
* Government and Crown Agency	933	844	89	3,721	3,374	347	10,123	10,123	0
Other Income	192	151	42	699	602	96	1,742	1,742	0
Total Revenue	1,125	994	131	4,420	3,976	443	11,865	11,865	0
EXPENDITURE									
Personnel									
Medical	2,727	3,106	378	8,884	9,089	205	26,240	26,240	0
Nursing	3,927	4,068	141	17,955	18,624	669	56,180	56,180	0
Allied Health	3,087	3,295	208	9,413	9,948	534	27,720	27,720	0
Support	72	84	13	223	257	34	739	739	0
Management / Administration	666	670	4	2,028	2,044	17	5,788	5,788	0
	10,479	11,223	744	38,503	39,962	1,459	116,668	116,668	0
Other Expenditure									
Outsourced Services	231	87	(144)	704	347	(357)	1,042	1,042	0
Clinical Supplies	100	132	32	481	527	45	1,582	1,582	0
Infrastructure & Non-Clinical Supplies	709	532	(177)	2,864	2,326	(538)	6,598	6,598	0
	1,040	751	(289)	4,049	3,200	(849)	9,223	9,223	0
Total Expenditure	11,519	11,974	455	42,553	43,162	609	125,890	125,890	0
Cost Net of Other Revenue	**(10,395)**	**(10,980)**	**585**	**(38,133)**	**(39,185)**	**1,052**	**(114,025)**	**(114,025)**	**0**

COMMENT ON MAJOR FINANCIAL VARIANCES

Revenue ($443k favourable for the year to date)

The favourable variance for the month of October resulted primarily from the new CADs contract ($250k fav) and the increase in the Forensics ID contract price ($34k fav), as well as from ADHB joint appointments ($38k fav). Contracts for Relapse in Prevention in Psychosis revenue ($43k fav), and the Infant Perinatal Fund ($17k fav) are revenue neutral with equivalent costs reflected in Non-Clinical Supplies and Clinical supplies respectively.

Personnel ($1,459k favourable for the year to date)

The favourable variance primarily reflects the impact of high vacancies in nursing staff and pricing ($1,579k fav). This is partially negated by the continuing high overtime and penal costs for Nursing ($911k unfav) due to the vacancies, unpredictability of high patient acuity, in particular in the Forensics inpatient units (including 3 High and Complex needs beds ($208k YTD) and the long-term ID Patient 2-on-1 care ($192k YTD). In addition, staffing has been increased in Adult Mental Health inpatient units Waiatarau and He Puna Waiora to address the security issues which are expected to be ongoing in 2015/16. Through the introduction of better management tools for overtime and sick leave, (explained below), the unfavourable nursing overtime and penals variance (Sept $138k unfav) has improved each month since July. This is despite the additional use of overtime to open the admissions area in He Puna Waiora in September. The

Medical variance ($131 unfav) reflects the makeup of the Registrar on-call roster requiring use of higher costing SMOs.

Other Direct Costs ($849k unfavourable year to date)
This unfavourable variance reflects costs of additional Forensics security after a breakout attempt ($79k unfav), the Adult MHS cost of 2 locums to cover vacancies at Rodney and West ($196K unfav), unbudgeted prior-period charges being 25 months rent of Isa Lei ($36k unfav). In addition, the targeted savings ($487k unfav) and Court reporting costs ($54k unfav) as projected in the business case, to be achieved through revenue and cost saving initiatives are reflected here.

ONGOING INITIATIVES

1. **Forensic inpatient units overtime costs** resulting from high patient acuity have been reduced from unfavourable variances of $381k unfav in July to $205k unfav in Aug, $178k unfav in Sept to $62k unfav in Oct, through continuing pro-active measures as follows:
    - Active management of overtime through provision usage graphs and "live" overtime tracking spreadsheets at unit manager level, with weekly overview of the Service Manager prompting unit managers to better understand the connection between clinical choices and the related costs, as well as to improve utilization of lower cost bureau staff. To ensure bureau staff availability, recruitment is advancing for increased staffing numbers on the bureau roster.
    - Recruitment for a nursing floater roster within the administration cost centre is underway for flexible in-house coverage of (primarily) sick leave requirements.

2. **Reduction in Sick Days – Actual 9.3 days (rolling 12 months)/ Target 7.0 days per annum.**
    - Reduction in sick days is a WDHB initiative which forms part of a health and wellbeing initiative. To assist MH Service Managers in addressing this, MH Finance provide them with monthly graphs showing the trend of sick leave and RC Managers with fortnightly reports showing staff with less than 4 days accrued sick leave left. RC Managers must address the issue with individual employees with low balances and report to HR with responses and appropriate plans of action.

3. **Long Term Conditions, Cohort #1 – Bohmer Leadership Programme**
    - This senior leadership group within MH are reviewing the group of people within services who have medium to long-term conditions. This improvement work aims to consider models of care for this group with consideration of need for support versus clinical intervention and most suitable resources to deliver this care. The service is currently progressing with identifying and costing of episodes of care for targeted group.

Elective Surgical Centre

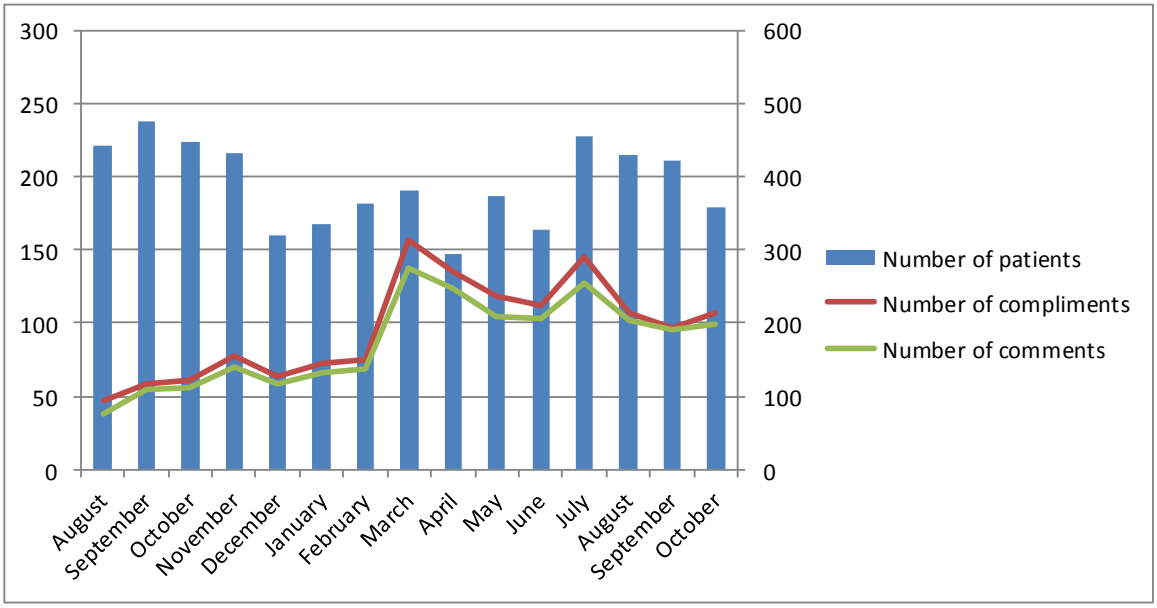
Service Overview

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.

Highlight of the Month

Patient Experience

We saw 107 patients forms returned (30% of our monthly total volume), all of which showed positive, consistent patient experience feedback. The graph below shows the trend over the past 12 months. Facebook feedback has now increased to 149 comments with star rating of 4.4 out of 5 stars.



Key Issues

Senior Level 4 Nurse Training

The ESC workload has grown in both volume and type of surgery performed, including increased complexity of surgeries and casemix in some specialities. It is envisaged that this growth will continue along with a rise in complex surgery, acuity and medically comorbid and aged patients.

We have a strong dedicated team of permanent staff nurses on the Cullen Ward, the majority have been with us since the ESC opened. Most of these highly skilled nurses are currently practicing at Level 3. Three Level 3 nurses have been identified to complete our purpose designed training programme to achieve Level 4, training will commence in December 2015.

The nurses will spend clinical time in CCU, ADU/ED, PACU and ICU Outreach; to meet key competencies in each area. In addition to the clinical placements, the nurses will attend two study days facilitated by the Cullen Ward Educator. The focus of these days will centre on further developing their knowledge and skills at an expert level.

Following completion of the programme, the ESC ward roster will be planned in order to ensure where possible, that one of these senior nurses will be on duty for the PM, night or weekend shift. They will be there to offer senior support and advice and to take over care of complex/deteriorating patients if needed. This will allow clinicians to gain more confidence in the ESC's ability to manage more complex patients out of hours.

SCORECARD VARIANCE REPORT

BEST CARE VARIANCE REPORT

Staff Sick Leave Rate

It is noted that our staff sick leave rate is slightly above expected levels and we are monitoring this closely, however, it is mainly due to seasonal illnesses for staff and also their children.

Staff Turnover Rate

It is noted that our turnover rate remains slightly above expected levels and we are monitoring this closely. There are no other HR issues to report.

SERVICE DELIVERY VARIANCE REPORT

Theatre Utilisation

Theatre utilisation for the month of October has remained lower than target. The utilisation figure provided in the scorecard is purely based on the operating lists that are booked and indicates some room for improvement. Reasons for this are multifactorial. We continue to work to rectify and have already seen improvement in general surgery utilisation during a pilot project, where ESC is directly managing the booking of its ESC general surgery lists. This type of pilot project will be offered to other specialties over coming months to see if similar utilisation results can be replicated.

Elective WIES Volumes

WIES volumes remain below budget YTD; at 88% of budget YTD. This is multifactorial, with key drivers being the increased day case rate at ESC, coupled with continued over delivery of general surgical volumes (113% YTD), which are averaging at a lower WIES than budgeted. An initial surgical forum was held in November through the Director of Hospital Services and the Chief of Surgery, to discuss the best way in which the organisation uses its surgical capacity and resource to meet all targets set. This included all the key stakeholders in the Elective Surgery Services.

Scorecard

Waitemata DHB Monthly Performance Scorecard

Elective Surgical Centre
October 2015
2015/16

Service Delivery

	Actual	Target		Trend
Provider Arm Elective Volumes (YTD)				
- WDHB Overall	97%	100%	●	▼
- Elective Surgical Centre	101%	100%	●	▼
ESC Elective Volumes (current month)	99%	100%	●	▼

Patient Flow	Actual	Target		Trend
Outpatient DNA rate	7%	10%	●	▼
b. Average Length of Stay - Electives (ESC)	1.0 days	<1.16 days	●	▲
Theatre utilisation	78%	85%	●	▲

Best Care

Patient Experience	Actual	Target		Trend
Complaint Average Response Time	1 days	<14 days	●	▼
Improving Outcomes				
a. Acute Readmission Rate within 28 days	*4%*	*<9%*	●	▲
Transfers from ESC to NSH	1.60%	5%	●	--
Quality & Safety				
Rate of falls with major harm	0.00	<2	●	--
Pressure injuries grade 3&4	0.00	0.00	●	--
HR/Staff Experience				
Sick leave rate	8.1 days	<7.5 days	●	▼
Turnover rate	11%	<10%	●	--

Value for Money

Financial Result (YTD)	Actual	Target		Trend
Revenue	309 k	198 k	●	▲
Expense	7,801 k	8,143 k	●	▲
Net Surplus/Deficit	-7,492 k	-7,946 k	●	▼
Capital Expenditure	257 k	99 k	●	▲
Contracts (YTD)				
Elective WIES Volumes	1,944	2,218	●	▼

How to read

Performance indicators:

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

Trend indicators:

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

Key notes

1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
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a. Reported 1 month in arrears
b. 2015/16 new MoH Average length of stay definition

A question?

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Planning, Funding and Health Outcomes, Waitemata DHB

STRATEGIC INITIATIVES VARIANCE REPORT

Deliverable /Action	On target
1. Continue to embed the learnings over 2015/16 from the elective productivity and Shorter Journey projects into our business as usual e.g. patient-focused bookings.	✓
2. Ensure triage consistency and equity of access by using national CPAC tools in all specialties - ongoing	✓

*** include a ✓ or a ✖**

Areas off track for month and remedial plans
None to report

FINANCIAL RESULTS

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date		Oct-15
Elective Surgery Centre									
($000's)	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
REVENUE									
* Government and Crown Agency	75	48	28	309	198	111	552	552	0
Other Income	0	0	0	0	0	0	0	0	0
Total Revenue	75	48	28	309	198	111	552	552	0
EXPENDITURE									
Personnel									
Medical	9	14	5	39	42	3	116	116	0
Nursing	405	406	0	1,723	1,744	21	4,992	4,992	0
Allied Health	1	2	2	1	7	6	20	20	0
Support	3	5	2	13	15	2	43	43	0
Management / Administration	47	52	5	144	156	11	428	428	0
	465	479	14	1,921	1,964	43	5,599	5,599	0
Other Expenditure									
Outsourced Services	589	736	147	2,946	3,050	104	8,519	8,519	0
Clinical Supplies	506	715	209	2,749	2,952	203	8,312	8,312	0
Infrastructure & Non-Clinical Supplies	59	43	(16)	185	178	(7)	506	506	0
	1,154	1,494	340	5,880	6,180	300	17,337	17,337	0
Total Expenditure	1,619	1,973	354	7,801	8,143	343	22,936	22,936	0
Cost Net of Other Revenue	**(1,544)**	**(1,925)**	**382**	**(7,492)**	**(7,946)**	**454**	**(22,384)**	**(22,384)**	**0**

COMMENT ON MAJOR FINANCIAL VARIANCES

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

Production Activity

Discharges for October were 88% (YTD 97%) of plan on elective cases and 74% (YTD 88%) of planned WIES.

Overall result

The division is $382k favourable for the month and $454k favourable YTD. It is noted that there were budget alignment adjustments of $27k in October which corrected the YTD position, as such the underlying contribution for October was $355k favourable.

Revenue

ESC is $28k favourable for October (YTD $111k fav) as a result of higher than planned ACC revenue.

Personnel

Nursing costs were on budget for the month with lower costs from production volumes offset by costs of additional shifts to resource interim care. A credit in outsourced nursing recharges these additional shifts against the risk pool.

Outsourced
Medical costs for package of care and anaesthesia are under budget year to date as a result of lower volumes through theatre, and outsourced nursing recharges for additional shifts rostered for interim care patients are partially offset by increased cost for hookwire procedures.

Non personnel
Clinical supplies costs are currently under budget predominantly due to implant costs for hips and knees which are in line with volumes which are below contract YTD. Overall year to date the clinical supplies costs are under budget and showing no areas of concern.

Savings target of $50k YTD is not yet offset by identified programmes however general cost containment is maintained spending at slightly below budget levels.

Getting back on track initiatives
ESC is currently operating within its budget, but at end of October is below contracted volumes. As volumes get back to contracted levels costs are anticipated to be at budget levels. To help achieve this:

- Elective volumes between the SAS and ESC are being managed to limit over production (leading to budget overspends) while managing ESPI compliance.
- Advance planning of theatre shut downs (during Christmas, Easter and the medical conference in May) to ensure affected staff are scheduling annual leave or being redeployed to alternative services.

Surgical and Ambulatory Services

SERVICE OVERVIEW

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 breast screening services are with this service. The service is managed by Michael Rodgers, Chief of Surgery and Michelle Sutherland, General Manager. The Head of Division Nursing is Kate Gilmour and the Head of Division Allied Health is Tamzin Brott.

HIGHLIGHT OF THE MONTH

Outpatient Intravenous Antibiotics Initiative (update 04 May to 18 November 2015)

The Outpatient IV antibiotics (OPIVA) business case was approved 6 months ago to improve the quality of care and increase opportunities for patients to be discharged on intravenous (IV) antibiotics and to have a central point of contact for co-ordination of IV antibiotic therapy.

Prior to the OPIVA CNS service some of these patients required prolonged hospitalization in acute beds for the entire duration of the antibiotic course. Since having a robust OPIVA service for the last six months, we have saved 3,750 bed days.

The OPIVA services have allowed for patient-centred, home based care which has been shown to improve patient satisfaction and reduce risk of hospital acquired infections and reduce hospital length of stay.

Since commencement of the OPIVA CNS 160 patients have been through this service. We aimed to convert 27 patients from Baxter infusors to self-administration in a one year period. We have achieved 32 patients within the six month period and 17 of these patients would have required District Nurse input for a minimum of an hour a day and now only require one hour per week for PICC dressing change.

Either the patient or their family members were given the opportunity to be taught to administer their own IV antibiotics as a patient centred alternative, giving patients increased autonomy over their care. For instance one young man wanted to be able to attend school, so he learned to administer his own twice daily antibiotics rather than need to have the District Nurse attend to this. Several patients were enabled to return to work without being attached to an infusor. Two of these were paraplegic patients who were concerned about transferring with the Baxter attached to them.

The OPIVA service has seen the number of patients discharged more than double that of 2014. A patient survey has recently been posted to the last 100 patients. We are awaiting results.

KEY ISSUES

Ultrasound Scans

The Waitemata DHB ultrasound waitlist has grown 85% since January 2015.

Waitemata DHB currently achieves 63% of ultrasounds completed within 6 weeks compared to 93% 12 months ago. Our reduction in performance is due to constraints to recruit and retain staff due to the competitive salaries being offered in the community setting.

Demand: The demand for ultrasound remains static due to the strict access criteria and triage reviews by an SMO. Demand for other modalities increases 8-9% per annum, except for MRI which averages a 12% increase per annum.

GP-referred patients (11,126 per annum) account for 35% of total ultrasound scans. These come from community referred ultrasound and the Regional Access to Diagnostics project.

Under the umbrella of GAIHN (Greater Auckland Integrated Health Network), the access to Diagnostics project has been in place since 2009 and aligns with a Ministerial focus on improving primary care access to diagnostics.

GP and DHB radiology representatives have worked together to agree a set of referral criteria for DHB funded imaging. These have been developed in consultation with relevant specialists and aim to achieve a balance between the clinical risk of undiagnosed pathology and accepted resource limitations.

Waitemata DHB has taken a lead role in this initiative and triaged all incoming requests against these or similar criteria for last five years.

Supply: A nationwide shortage of sonographers and greater than 50% vacancy rate in sonographer FTE at Waitemata DHB has compounded the demand/capacity shortfall. The wait list has steadily grown despite demand management initiatives and additional weekend sessions.

Risks: Faced with the prospect of lengthy wait times, to minimise the risk of delay of a significant diagnosis, all requests; both DHB and community are assessed on receipt and assigned a clinical priority.

Interim solution: A short term increase in outsourced volume to the current private provider while we continue recruitment both locally and internationally. We are also planning to meet with the Medical Radiation Technologists Board and are in communication with the Board currently to request assistance to reduce the waiting time for approval for overseas recruits to be credentialed to work in New Zealand.

SCORECARD VARIANCE REPORT

HEALTH TARGETS VARIANCE REPORT

Shorter Waits in ED target

S&AS has averaged 85.2% with 418 surgical discharges and 62 breaches. Delays in maintaining the ED target have predominately been as a result of bed pressures due to delays in access to inpatient beds and late referral to surgical services by Emergency Medicine. The service is reviewing all surgical ED breaches on a daily basis and working with staff to reduce the time that patients stay in ED.

BEST CARE VARIANCE REPORT

Complaints Average Response Time

Complaints Average Response Time was slightly over target at 15 days. There were a number of complex multi-service complaints this month.

Acute readmission rate within 28 days

The increase in the readmission rate in September to 12% is under review with the MoH as the data we are collecting is likely to include patients who don't meet the acute readmission criteria.

HR/Staff Experience

The sick leave rate at 9.3 days this month was higher than last month due to the number of staff with ongoing health issues, long term sickness. The HR Manager is working with the CNM's and Operations Managers to actively manage a return to work programme for staff who have been on long term sick leave.

SERVICE DELIVERY VARIANCE REPORT

Waiting Times - % of Ultrasound scans done within 6 weeks

63% of patients referred to ultrasound received their scan and had it reported on within 6 weeks. Ultrasound is not currently included in the MoH wait list indicator metrics as for CT and MRI. As noted in the risk register, the sonographer workforce is well below required levels to provide a timely service. We have recruitment for three sonographers in the pipeline from international sources. SMT has approved additional revenue to outsource more ultrasound scans to keep up with the additional demand.

Patient Flow – Theatre Utilisation Waitakere Hospital

62% against 85% target and the work to improve the utilisation continues. A forum with senior clinicians to discuss the Waitemata Surgical programme and effective utilisation of all sites is scheduled. Individual lists are being reviewed and options for alternative models of care at Waitakere Hospital are being investigated. We have seen some immediate improvement when individual data has been shared with surgeons on his/her theatre performance.

Scorecard

Waitemata DHB Monthly Performance Scorecard

Surgical and Ambulatory Service
October 2015
2015/16

Health Targets

	Actual	Target		Trend
Better help for smokers to quit - hospitalised	99%	95%	●	▲
Shorter Waits in ED	85%	96%	●	▲

Best Care

	Actual	Target		Trend
Patient Experience				
Complaint Average Response Time	15 days	<14 days	●	▼
Improving Outcomes				
Acute Readmission Rate within 28 days	12%	<9%	●	--
a. #NOF patients to theatre w/in 48 hours	*100%*	*95%*	●	▲
Quality & Safety				
Older patients assessed for falling risk	97%	90%	●	▼
Occasions insertion bundle used	100%	95%	●	▲
Good hand hygiene practice	89%	80%	●	▲
ICU - rate of CLAB per 1000 line days	0.8	<1	●	▼
HR/Staff Experience				
Sick leave rate	9.3 days	<7.5 days	●	▼
Turnover rate	8%	<10%	●	▲

Service Delivery

	Actual	Target		Trend
Elective Volumes				
Provider Arm - Overall	97%	100%	●	▼
Surgical and Ambulatory Services	112%	100%	●	▲
Waiting Times				
% of CT scans done within 6 weeks	94%	90%	●	▼
% of MRI scans done within 6 weeks	91%	80%	●	▲
% of US scans done within 6 weeks	61%	75%	●	▼
Patient Flow				
Outpatient DNA rate	10%	<10%	●	▼
b. Average Length of Stay - Acutes	3.5 days	<3.74 days	●	▼
b. Average Length of Stay - Electives	1.9 days	<2.26 days	●	▲
Theatre utilisation - NSH	88%	85%	●	▼
Theatre utilisation - WTH	62%	85%	●	▲
Patients with EDS on discharge	81%	85%	●	▼

Value for Money

	Actual	Target		Trend
Financial Result (YTD)				
Revenue	5,656 k	5,705 k	●	▼
Expense	58,799 k	58,542 k	●	▲
Net Surplus/Deficit	-53,144 k	-52,837 k	●	▼
Capital Expenditure	1,444 k	1,304 k	●	▲
Contracts (YTD)				
Elective WIES Volumes	2,584	2,527	●	▼
Acute WIES Volumes	4,427	4,908	●	▲

How to read

Performance indicators:

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

Trend indicators:

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

Key notes

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

a. Reported one month in arrears

b. 2015/16 new MoH Average length of stay definition

A question?

Contact:
Andrea Hickman - Planning & Funding Analyst, Planning & Health Intelligence Team: andrea.hickman@waitematadhb.gov.nz
Planning, Funding and Health Outcomes, Waitemata DHB

STRATEGIC INITIATIVES VARIANCE REPORT

Deliverable /Action	On Target ✓ or ✖
1. Work with the bariatric service to identify and remedy barriers within the triage service to improve acceptance rates of Māori and Pacific people onto the bariatric surgery waiting list – **by December 2015**	✓
Cancer Services	
2. Identify existing models/processes of investigations and treatment which negatively impact on faster cancer treatment times and implement changes recommended by local and regional cancer round one improvement projects to improve performance **by June 2016**	✓
3. Clinically led implementation of key findings at Waitemata in each tumour stream of the round one MoH service improvement project by UniServices **by December 2015**	✓
4. Participate in the IT-led National Patient Flow system and track patients undergoing assessment and treatment for cancer in real time and intervene if their journey is delayed at any point, to be implemented **by June 2016**	✓
5. Ensure all tumour streams have high suspicion flags which are used actively by the clinicians **by December 2015**	✓
6. Implement guidance on active surveillance treatment for prostate cancer care (available mid 2015), ensuring clinicians receive information and care pathways and MDM proformas are updated	✓
7. Review local MDM terms of reference by December 2015	✓
8. Audit local tumour stream MDM volumes and completeness to identify which tumour streams would benefit from more MDM coordination support **by December 2015**	✓
9. Undertake annual cancer patient experience survey, commencing in February 2016 and **completing in April 2016**	✓
10. Implement the Ministry-funded Cancer Supportive Care suite of psychological and social services to improve cancer patient support **by June 2016**	✓
11. Support Northern Cancer Network (NCN) conducting at least two additional tumour type reviews against National Tumour Standards **by June 2016**	✓
12. Implement the action points of the endoscopy review undertaken in 2014 **by June 2016**	✓
Improved Access to Elective Surgery/Major Trauma	
13. Establish hand surgery and breast reconstruction services locally on eligible and agreed patients who previously would have attended Counties Manukau DHB for these services from July 2015	✓
14. Offer non-surgical pain management to appropriate patients with muscular skeletal pain through our chronic pain service from 1 July 2015 and incorporate as business as usual	✓
15. Review regional options for two surgical sub specialty procedures during 2015/16	✓
16. Continue to embed the learnings over 2015/16 from the elective productivity and Shorter Journey projects into our business as usual e.g. patient-focused bookings.	✓
17. Ensure triage consistency and equity of access by using national CPAC tools in all specialties - ongoing	✓
Improved Access to Diagnostics	
18. Participate in the National Radiology Service Improvement Initiative, with the implementation of the WISDOM project (Waitemata Imaging Services Demand OptiMisation) – over 2015/16.	✓
19. Two MRT trainee technicians to become proficient at operating the MRI scanners **by June 2017**	✓
Quality and Safety	
20. Introduce team briefing and debriefing for each operating theatre list to improve patient safety, teamwork and communication within the teams **by June 2016**	✓
21. Implement a quality improvement project co-designed with consumers to improve pain management and the safe prescribing and administration of opiate medication **by May 2016**	✓

*** include a ✓ or a ✖**

Areas off track for month and remedial plans

FINANCIAL RESULTS

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date		Oct-15
Surg & Ambulatory ($000's)	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
REVENUE									
* Government and Crown Agency	1,294	1,231	63	5,170	5,070	99	14,583	14,583	0
Other Income	44	158	(114)	486	635	(149)	1,884	1,884	0
Total Revenue	1,338	1,389	(50)	5,656	5,705	(50)	16,467	16,467	0
EXPENDITURE									
Personnel									
Medical	6,370	6,688	318	20,079	20,298	218	58,879	58,879	0
Nursing	3,304	3,287	(17)	14,046	14,085	40	42,738	42,738	0
Allied Health	1,617	1,776	160	5,069	5,328	260	15,668	15,668	0
Support	220	243	23	706	730	24	2,109	2,109	0
Management / Administration	1,178	1,271	93	3,638	3,811	174	11,097	11,097	0
	12,689	13,266	577	43,538	44,253	715	130,492	130,492	0
Other Expenditure									
Outsourced Services	406	335	(71)	1,663	1,345	(318)	3,962	3,962	0
Clinical Supplies	2,497	2,827	329	11,383	11,279	(104)	33,386	33,386	0
Infrastructure & Non-Clinical Supplies	493	419	(74)	2,216	1,665	(551)	5,050	5,050	0
	3,397	3,581	184	15,262	14,289	(973)	42,398	42,398	0
Total Expenditure	16,086	16,846	761	58,799	58,542	(257)	172,890	172,890	0
Cost Net of Other Revenue	**(14,747)**	**(15,458)**	**710**	**(53,144)**	**(52,837)**	**(307)**	**(156,424)**	**(156,424)**	**0**

COMMENT ON MAJOR FINANCIAL VARIANCES

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

Production Activity

October WIES was 86% (YTD 103%) for elective cases whilst acute was 94% (YTD 90%) of contract – overall activity at 91% of planned WIES for the month (YTD 95%).

Overall result

The division is $710k favourable for the month and $307k unfavourable YTD. It is noted that there were budget alignment adjustments of $544k in October which corrected the YTD position, as such the underlying contribution for October was $166k favourable.

Revenue

Revenue is unfavourable for October $50k (YTD $50k unfav) with Orthopaedic ACC revenue $106k under budget YTD offset by additional revenue from various sources across other services. Work is on-going to evaluate revenue opportunities for ACC revenue for high cost procedures in Radiology.

Personnel
Overall Personnel costs are $715k favourable against budget for the year to October, with all professional groups in a favourable position against budget. This has been driven primarily by vacancies, particularly in Radiology and Anaesthetic technicians and management admin roles. It should be noted that although nursing is $40k favourable to budget, this is more than offset by outsourced costs of bureau nurses to adequately cover the resourcing needs.

Non personnel
Outsourced nursing costs are contributing $205k unfavourable variance year to date with only partial offset in personnel costs. ORL outsourcing is over budget YTD but expected to reduce significantly and expected to be within budget by year end. Clinical supplies costs are over budget YTD with pharmaceuticals, and implant costs contributing to the overspend. Savings target of $533k YTD is not yet offset by identified programmes but work is in progress to contain costs.

Getting back on track initiatives

- The service is taking steps to put in place controls for managing annual leave balances that exceed organisational policy. Managers are working with staff to formulate leave plans to enable this leave reduction without compromising service delivery.

- ADHB Ophthalmology have had the complete WTH facility handed over to them as of the 31st October. All facilities work and FF & E components for the service are completed from a WDHB perspective. ADHB are now able to fully utilise the space and work towards achieving the agreed volumes from the original business case. The service will review the facilities being utilised and assess appropriate level of recharges and invoice according to the space in use.

- Waitakere theatres are currently under-utilised. The service is planning to meet with clinicians to discuss the Waitemata Surgical Programme and effective utilisation of all our sites. There is a possibility to improve utilisation through investigation of an ESC remuneration model at Waitakere for acute arranged hand surgical lists. All individual lists are being reviewed and frequency of lists will be reduced where utilisation is low. Patient focussed booking may assist in reducing the day of surgery cancellation rates. Planning to increase access for non-melanoma skin patients that are by high efficiency lists run by surgeon, GP and registrar teams is underway.

- Operations manager for theatres is currently seconded to Gastroenterology however subject to time commitments and expected length of the secondment discussions will be undertaken with the GM Medicine to recharge a share of costs from January 2016.

- High bed demand over winter has resulted in overspends in SSW and PACU 2. Analysis of forecast versus budgeted bed demand over the remainder of the year is being undertaken to ensure the staffing models are appropriate to meet bed demand.

The service continues to explore options for reducing clinical supplies costs with sutures identified as area with potential cost savings through a change of supplier. Meetings have recently taken place with suppliers to initiate a review of product and pricing. There has also been a significant focus on getting non catalogue ordered products onto the catalogue which will enable healthAlliance to engage with suppliers of these products to seek better pricing and provide better information to determine areas of high value purchasing which can be investigated for price negotiations.

(S&AS and ESC Combined)

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date		Oct-15
Surg & Ambulatory - ESC									
($000's)	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
REVENUE									
* Government and Crown Agency	1,370	1,279	91	5,478	5,268	210	15,135	15,135	0
Other Income	44	158	(114)	486	635	(149)	1,884	1,884	0
Total Revenue	1,414	1,437	(23)	5,964	5,903	62	17,018	17,018	0
EXPENDITURE									
Personnel									
Medical	6,379	6,702	322	20,119	20,340	221	58,994	58,994	0
Nursing	3,710	3,693	(17)	15,769	15,829	60	47,730	47,730	0
Allied Health	1,618	1,779	161	5,070	5,336	266	15,688	15,688	0
Support	223	248	26	719	745	26	2,152	2,152	0
Management / Administration	1,225	1,323	98	3,782	3,967	185	11,526	11,526	0
	13,154	13,745	590	45,458	46,217	758	136,090	136,090	0
Other Expenditure									
Outsourced Services	996	1,071	76	4,608	4,395	(213)	12,480	12,480	0
Clinical Supplies	3,003	3,541	538	14,132	14,231	99	41,699	41,699	0
Infrastructure & Non-Clinical Supplies	552	462	(90)	2,401	1,843	(558)	5,557	5,557	0
	4,550	5,075	525	21,142	20,469	(673)	59,736	59,736	0
Total Expenditure	17,705	18,820	1,115	66,600	66,686	86	195,826	195,826	0
Cost Net of Other Revenue	**(16,291)**	**(17,383)**	**1,092**	**(60,636)**	**(60,783)**	**147**	**(178,808)**	**(178,808)**	**0**

COMMENT ON MAJOR FINANCIAL VARIANCES

Activity

October WIES was at 81% (YTD 97%) on elective cases whilst acute WIES was 94% (YTD 90%) of contract – overall activity at 91% (YTD 94%) of planned WIES. The net result is $1,092k favourable for the month of October (noting this includes $544k adjustment to the YTD result). ESC continues to perform favourably year to date against budget. SAS result is $307k unfavourable and ESC $454k favourable for the first four months.

There is ongoing management of elective volumes between ESC and SAS to ensure ESPI compliance while not exceeding contracted volumes.

Hospital Operations

SERVICE OVERVIEW

The Group Manager of Hospital Operations is Leith Hart. Hospital Operations includes Pharmacy, Laboratories, 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).

HIGHLIGHT OF THE MONTH

Electronic Prescribing and Administration has been successfully implemented into the Waitakere ED department during October and November. All prescribers and nurses have been trained in the use of the new system and are adapting well to new work flows. Very positive feedback for the supporting team of pharmacists has been received from the Charge Nurse Manager.

KEY ISSUES

The new food service system has bedding-in issues, primarily patients not getting what they ordered from the menu which is different to what they receive. The contractor is working through their process to identify root causes for these errors and omissions.

STRATEGIC INITIATIVES VARIANCE REPORT

Specific deliverables/actions to deliver improved performance will consider:	On Target
1. Rollout Electronic Prescribing as part of Medication Safety Strategy, phase 3 **by June 2016**	✓

*** include a ✓ or a ✖**

Areas off track for month and remedial plans

FINANCIAL RESULTS

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE *Hospital Operations* ($000's)	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
REVENUE									
* Government and Crown Agency	0	0	0	1	0	1	0	0	0
Other Income	718	630	88	2,603	2,517	86	7,411	7,411	0
Total Revenue	718	630	88	2,604	2,517	87	7,411	7,411	0
EXPENDITURE									
Personnel									
Medical	53	77	23	196	234	37	669	669	0
Nursing	17	5	(12)	24	20	(4)	59	59	0
Allied Health	1,636	1,722	86	5,005	5,164	159	14,662	14,662	0
Support	1,129	1,296	167	3,390	3,878	487	11,150	11,150	0
Management / Administration	193	159	(34)	563	477	(86)	1,347	1,347	0
	3,029	3,259	230	9,179	9,773	594	27,887	27,887	0
Other Expenditure									
Outsourced Services	404	221	(183)	1,629	882	(747)	2,646	2,646	0
Clinical Supplies	2,266	2,040	(226)	8,854	8,250	(604)	23,487	23,487	0
Infrastructure & Non-Clinical Supplies	1,121	923	(198)	4,002	3,707	(295)	11,114	11,114	0
	3,791	3,183	(608)	14,485	12,839	(1,646)	37,247	37,247	0
Total Expenditure	6,820	6,442	(377)	23,664	22,612	(1,052)	65,134	65,134	0
Cost Net of Other Revenue	**(6,102)**	**(5,812)**	**(290)**	**(21,060)**	**(20,094)**	**(965)**	**(57,723)**	**(57,723)**	**0**

Reporting Date: Oct-15

COMMENT ON MAJOR FINANCIAL VARIANCES

The overall result for Hospital Operations is $965k unfavourable for the four months to 31 October 2015.

Revenue ($87k favourable for the Year to Date)

Laboratory income for tests done for other DHBs is $55k favourable year to date. Recharges to other inpatient services for security services and drugs dispensed by the outpatient pharmacy is $60k favourable for the year to date. Car Park revenue is unfavourable by $77k year to date.

Expenditure ($1,052k unfavourable Year to Date)

The unfavourable variance year to date is due to unbudgeted additional services and activity related consumable costs. Services not included in the budget include the new Outpatient Pharmacy at Waitakere Hospital $197k unfavourable; Security guard in Emergency Department Waitakere Hospital is $90k unfavourable and additional Clinical Support Services (cleaning and orderlies) is $269k unfavourable. Pharmaceutical costs for the Outpatient Pharmacy North Shore Hospital are $170k unfavourable year to date. Laboratory consumables and sendaway tests are $216k unfavourable for the year to date primarily due to a 9% increase in Microbiology testing. This includes costs relating to VRE screening of $48k and a 20% increase in influenza related tests costing an additional

$75k on last year comparison. Blood Products are also $227k unfavourable year to date due to volume particularly Intragram which has increased 89% on last year.

Hospital Operations are helping the organisation to achieve target savings by leading projects that will enable WDHB to benefit from new supply contracts. This includes:

Cleaning consumables and chemicals
An RFP process to establish a regional supply contract for cleaning tools and chemicals has been initiated. Early review of 3 suppliers shows savings can be achieved immediately just by changing supplier for some products.

Printing Services
healthAlliance have established a panel agreement with Fuji Xerox for procurement of printing services and products for clinical and corporate forms which replaces our previous expired (print-only) contract. This contract covers all printing services usually carried out externally, such as patient information sheets and publications, as well as containing options for graphic design.

Rationalising number of stationery and grocery items
Review of stationery and grocery items on Oracle catalogues has found that savings can be made by rationalising the selection from over 3000 items down to approx. 500. Rationalisation of stationery items has gone live during the month.

Food Services Agreement
Waitemata DHB have entered into a new contract with Compass for provision of patient meals. This was a national process led by HBL / NZHP. The new agreement started in Aug-15 and the day 1 price is expected to give savings which will be partially offset by expected volume increases.

Provider Arm Support Services

SERVICE OVERVIEW

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 and Awhina and Maori Services. It also includes outsourced healthAlliance services, HBL, Other affiliation costs and financing costs. Robert Paine has overall financial responsibility for the Corporate Group.

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

SCORECARD

Waitemata DHB Monthly Performance Scorecard

Provider Support Services
October 2015
2015/16

Best Care

HR/Staff Experience	Actual	Target	Trend
Sick leave rate	8.6 days	<7.5 days	▼
Turnover rate	10%	<10%	▼

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue	253,359 k	251,387 k	▼
Expense	47,518 k	44,176 k	▼
Net Surplus/Deficit	205,841 k	207,211 k	▲
Capital Expenditure	13,268 k	27,396 k	▲
% catalogue item purchases	90%	75%	▲

Service Delivery

Productivity	Actual	Target	Trend
Clinical Typing			
Clinical letters turnaround time - P1 (urgent)	1.1 days	<1 days	▲
Clinical letters turnaround time - P2	2.3 days	<5 days	▲
Clinical Coding			
a. % coding complete by 21st next month	*99%*	*95%*	--
Electronic Discharge Summary			
Percentage of patients with EDS on discharge	80%	100%	▼

Major Capital Programmes	Time	Budget	Quality
Te Atarua car park (Sep 2015)	●	●	●
Department of Medicine (Mar 2016)	●	●	●
WTH Emergency Department revelopment (Apr 2016)	●	●	●
Mason clinic - 15 Bed medium secure unit (Jun 2016)	●	●	●
Bridge ESC To Medical Tower (Jun 2016)	●	●	●
Lakefront (Dec 2016)	●	●	●
New Medical Tower (TBA)	●	●	●

How to read

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

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

Key notes

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

a. Reported 1 month in arrears

A question?

Contact:
Andrea Hickman - **Planning & Funding Analyst, Planning & Health Intelligence Team:** andrea.hickman@waitematadhb.gov.nz
Planning, Funding and Health Outcomes, Waitemata DHB

STRATEGIC INITIATIVES VARIANCE REPORT

Specific deliverables/actions to deliver improved performance will consider:	On Target
1. Support the implementation of Phase 2 of the National Patient Flow (NPF) Collection Programme led by the IT team from July 2015, collecting Phase 3 information from July 2016 to enable the Ministry to collect more patient journey data	✖
2. Inventory management for clinical and non-clinical supplies	✓
3. Infrastructure costs/contracts and energy efficiency reviews and savings (Energy NZ review has identified opportunities for Energy Savings).	✓

*** include a ✓ or a ✖**

Areas off track for month and remedial plans
National Patient Flow Project There are barriers to compliance with the National Patient Flow programme. Some mandatory data elements are unable to be supplied due to the data not being collected in a mappable format, or data not being available in our systems at all. Remedial actions: • The Ministry have amended the date that the Cancer and Radiology data becomes mandatory to 1 July 2016 • A remediation plan prepared with the Ministry • A new project governance structure created to reflect greater complexity in Phase 2 and 3, such as the introduction of SNOMED planned for 31 July 2017 • Regular onsite visits initiated with the Ministry • Working closely with the Ministry to reconcile the Phase 1 data against the existing collection

HEALTH INFORMATION GROUP

HIGHLIGHT OF THE MONTH

Sleep Space: WDHB "Better Sleep by Design" Hospital Programme

Optimal Sleep and Circadian Function is central to human health, recovery and functioning. The establishment of a "Better Sleep" in hospital steering committee, will help shape and drive immediate and strategic improvements in our clinical environment that would support better sleep and circadian alignment. Dr Martin Orr (Clinical Director IS) and Dr Robyn Whittaker (PHP Research & Innovation) are leading this, in their roles as Clinical and Research leads for the Waitemata Health IT and Creative Design Centre. The Centre has a specific focus on how we might improve patient outcomes and experience via integrated building, process and technology design.

Increasingly sleep and chronobiology research is demonstrating the importance of sleep and circadian rhythms to metabolism, recovery, repair, inflammation, immunity, mood and our sense of wellbeing. Accordingly there is significant interest and determination within WDHB to optimise the care and time space for Sleep and alignment with circadian rhythms. The WDHB 2014 essentials of care audit identified sleep disturbance as a major patient concern. The WDHB 2015 Patient and Whanau Centred care standards emphasise the importance of a care environment that promotes patient comfort, rest and sleep and the need for quiet and rest periods particularly at night. Our Quality team have identified this area as a key safety and patient experience focus.

There are a range of immediate "low lying fruit" opportunities including baseline measures of noise across the hospital, patient survey, staff education, sleep rounds, welcome packs including patient advice materials, night noise policy, lighting controls. There is also the strategic opportunity to be a world leading centre for optimising sleep and circadian function via integrated building, process and technology design.

KEY ISSUES

Mobility Strategy

Delays with the implementation of a Mobile Device Management system are adversely affecting key strategic projects such as voice to text and ePrescribing. Interim solutions have been put in place to mitigate the immediate risk.

SCORECARD VARIANCE REPORT

Clinical Letters Turnaround Time – P1 Urgent (Target = 1 Day, Achieved = 1.1 days)

The average turnaround time continues to trend down. It has shifted from 1.3 days to 1.1 days since this last report.

FACILITIES AND DEVELOPMENT

HIGHLIGHT OF THE MONTH

Facilities will implement Planview across Waitemata & Auckland DHBs. This is an all of Government shared platform project portfolio management system. This will standardise our project management processes and bring us into line with the requirements of the new Investor Confidence Rating.

KEY ISSUES

1. Resourcing to meet workload as 2025 is progressively implemented.
2. Balancing BAU with project workload.
3. Asbestos – Implementing the requirements of the new act from a resource and cost perspective.

SCORECARD VARIANCE REPORT

Mason Clinic

Waiting approval from MoH/Treasury.

FINANCIAL RESULTS

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE							Reporting Date		Oct-15
Provider Support ($000's)	MONTH			YEAR TO DATE			FULL YEAR		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
REVENUE									
* Government and Crown Agency	61,810	61,801	9	249,070	247,205	1,865	741,590	741,590	0
Other Income	938	1,118	(180)	4,289	4,181	108	15,173	15,173	0
Total Revenue	62,748	62,919	(172)	253,359	251,387	1,972	756,763	756,763	0
EXPENDITURE									
Personnel									
Medical	354	182	(172)	582	561	(20)	1,612	1,612	0
Nursing	(189)	(487)	(298)	600	367	(232)	(4,174)	(4,174)	0
Allied Health	472	284	(188)	1,096	840	(256)	2,419	2,419	0
Support	167	217	50	518	649	131	1,824	1,824	0
Management / Administration	2,843	3,061	218	9,132	9,278	146	26,752	26,752	0
	3,648	3,257	(390)	11,927	11,696	(231)	28,434	28,434	0
Other Expenditure									
Outsourced Services	2,730	3,018	289	12,317	12,072	(244)	36,217	36,217	0
Clinical Supplies	501	(439)	(940)	784	(1,012)	(1,797)	(3,030)	(3,030)	0
Infrastructure & Non-Clinical Supplies	5,729	5,364	(365)	22,490	21,419	(1,070)	64,012	64,012	0
	8,960	7,944	(1,016)	35,591	32,480	(3,111)	97,199	97,199	0
Total Expenditure	12,608	11,201	(1,406)	47,518	44,176	(3,342)	125,633	125,633	0
Cost Net of Other Revenue	**50,140**	**51,718**	**(1,578)**	**205,841**	**207,211**	**(1,370)**	**631,130**	**631,130**	**0**

COMMENT ON MAJOR FINANCIAL VARIANCES

The overall result for Facilities and Development is $1.2m unfavourable for the Year to Date Oct-15.

The unfavourable variance is due to the write-off of project costs not classified as capex at $544k for the year to date and other repairs and maintenance costs including infrastructure studies / environmental testing which are $468k unfavourable for the year to date. Utilities and waste removal costs are also unfavourable $263k for the year to date.

5.1 Clinical Leaders Report

Recommendation:

That the report be received.

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

Medical Staff

Senior Medical Officer

1. After serving 22 years, Mr William Baber will be stepping down from his role as Clinical Director of ORL/ENT. He has built the department up from the very beginning at the DHB and has been a highly respected leader of ORL for our district.
2. Dr Stephen Allpress has stepped down from his role as Clinical Director of Surgical Pathology after 10 years. He has served his department and the DHB extremely well during his tenure. Dr Reena Ramsaroop has been appointed as the Clinical Director of Surgical Pathology.
3. Dr Ian Wallace has commenced as the new Director of Clinical Training. We have also appointed new educational supervisors for PGY1 and PGY2; Dr Laura Chapman, general physician and lead of ADU, Dr Ramanamma Kalluru, general physician, Dr Naveed Ahmed, renal physician, and Dr Vinod Singh, general physician. This will ensure we have the appropriate number of supervisors for our junior doctors.
4. New SMO starters: Dr Smeeta Sinha has commenced as a nephrologist.

GP open forum

The GP open forum was help on 11th November 2015. On this occasion the GPs were shown around the new woman's ward, Hine Ora. This was concurrently done with a teaching session provided by the gynaecology service. This was followed by the service outlining the different gynaecology services available to GPs, and explaining the direction of the department. Combining an engagement forum with a teaching session was well received by the GPs as evidenced by the feedback, and we plan to undertake similar sessions in 2016.

Allied Health, Scientific and Technical Staff

"Connected"

It is with great pleasure that I announce that Tamzin Brott has been appointed to the role of Director of Allied Health, Scientific and Technical Professions and will take up her post on 18 January 2016. Tamzin is an Occupational Therapist by background, who brings over 20 years' experience in a variety of roles at Waitemata DHB to her new role. Tamzin will be known from her current role as Head of Department for Allied Health services in our Medical and Surgical Services. I will return to my role as Associate Director of Nursing and Director of Infection Prevention and Control on the 18th December 2015 after 13 months as Acting Director of Allied Health, Scientific and Technical Professions.

"Better, Best, Brilliant" and "Connected"

- **HiNZ conference, Christchurch, October 2015**
  - Kelly Bohot, Quality Improvement Fellow – Allied Health, won best poster at HiNZ for her poster demonstrating our telehealth/iPad trial titled "Using mobile technology to improve patient and

clinician experiences of Allied Health in the community setting". A business case is to be presented to the Board to support expanding this pilot to all the community based Allied Health professions.

- Tamzin Brott co-presented a workshop at the HINZ conference titled "Shaping informatics for Allied Health – refining our voice". The learning outcomes were for AH clinicians and managers to understand what quality is in AH, how to use informatics and data to shape services and to raise the profile of AH.

- **Top Maori Physiotherapy Student**
  - The top Maori physiotherapy student for the year graduating 2015 has been awarded to the Waitemata DHB scholarship student Leighton Francis Tetorutama Broughton. Leighton is due to start his postgraduate career with WDHB in December 2015.
  - A Waitemata DHB student Andrew Fegan was awarded second place in the Asics award for best year 4 research project in the AUT graduate Physiotherapy class 2015.

"Everyone matters" - Staff

- **Staff Experience** – The Safety Attitude Questionnaire (SAQ) has been used across community Allied Health producing a 70+% response rate. Results are currently being analysed.

With Compassion

- **Older Adult and Vulnerable Adult Abuse Prevention** - E-learning is now in an active development phase for Vulnerable Adults, to help staff identify the indicators of abuse and what action to take if there is suspicion or concern re abuse.

Nursing and Midwifery; Emergency Planning Systems

Best Quality and Safety Outcomes

The six monthly peer review of Care Standards commences from the first week of December, with the majority of ward/unit reviews completed before the summer holidays.

Staff have reviewed the past feedback and worked as a team to address areas for improvement. Additional areas have been included this time with some minor adjustments i.e. maternity and mental health. This will mean that all inpatient settings will have participated by the end of this cycle.

Workforce Development

Nursing Entry to Practice Programme [NEtP]

The February 2015 general NETP intake have completed their programme and there will be a DHB celebration in December. These nurses are in current employment and continue as part of their ward and unit teams. They have worked hard to make the adjustment from student to registered nurse in direct practice settings through the year. The new graduate intake has been ably supported by registered nurse

[RN] coaches and the Nurse Educator, Mrs Sylvie Dombroski. Sylvie with Jacqui Finch, have been involved with the general NETP programme for the past 12 years and have managed a well-regarded programme that creates critical thinking professionals who provide quality patient care.

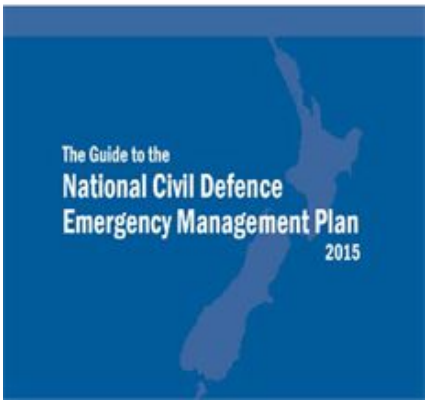
Sylvie Dombroski has resigned for a break with her husband [AUT senior lecturer] as they consider their options. Her leaving will be a great loss. I would like to publically thank her for her contribution, her pastoral care and her coaching of us all, not just the new graduates over many intakes.

The DHB has recruited to all available positions for the new graduate nurses for the February 2016 intake. The September 2015 group are doing well as part of ward and unit teams

Development in 2015
Considerable effort has been made to ensure that the health care assistants, nurses and midwives receive learning and development over the past 12 months. We are fortunate to have a small but active team of RN Coaches, Nurse/Midwife Educators and Clinical Nurse Specialists who work alongside staff in the clinical setting to assist with bedside clinical decision making, and facilitate learning according to the learning framework. This ensures that our frontline staff are supported to meet best practice standards. While a number of staff are undertaking post graduate study as well, the bedside practice development staff provide and essential role in supporting safe practice and staff confidence amidst workload pressure, clinical acuity and complexity.

Emergency Systems Planning

Mason Clinic is hosting a multi-agency exercise to test their emergency plans and response capability on 10 December. There has been excellent engagement by Police, Fire, Corrections and St John in considering contingency processes and how we can work together in an effective manner. Jackie Ferries is leading this with Pam Lightbown.



Considerable work is underway to understand and document the DHB and regional health responsibilities under the **new National Civil Defence Emergency Plan 2015**.

On 1 December 2015 the coordination of psychosocial support in the event of an emergency, is shifting to Health. Health agencies in the Auckland region are working with the Auckland Council CDEM Welfare Coordinating Group (WCG) responsibilities and supporting agencies to develop interim and then more robust procedures for working in a coordinated manner, and develop resources to support a response should this arise.

The new National Civil Defence Emergency Plan 2015 will also necessitate an update of DHB emergency plans and Incident Management Team learning. This will be done over the next 2 months.

5.2 Human Resources

Recommendation:

That the report be received.

Prepared by: Fiona McCarthy (Director, Human Resources)

Glossary

CME	-	Continuing Medical Education
FTE	-	Full Time equivalent
MRT	-	Medical Radiation Technologist
OH&SS	-	Occupational Health and Safety Service
SMO	-	Senior Medical Officer
Time to Hire	-	Calculated from the time a Recruitment Requisition is approved to the time an offer is accepted by a candidate.

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. Highlights of the month

1.1 Team based activity on values and behaviours

This month a number of sessions have been undertaken with a cross section of services focussing on the Waitemata patient and staff values and experience programme, in particular:

- Using recent patient experience feedback and to build on successes and improve in any identified areas
- How standards can be articulated so expectations of behaviours are known in a team and ways of recognising and raising concerns are identified
- How a team's culture impacts both patient and staff experience and ways to work towards healthy workplace cultures

What this team based work conveys to us is the value that various teams place on the importance of:

a) having a good culture and if you do or do not, the resulting impact on the wellbeing of multidisciplinary team; and

b) the acceptance/understanding that the evidence base clearly indicates patient experience is impacted by a staff members experience and vice versa, and that there is something you can do to build good team culture to give more positive experiences in the areas that most impact patients: being welcoming and friendly.

2 Recruitment

2.1 Recruitment Dashboard for September and October 2015

Indicators	Sept 2015	Oct 2015
Total number of hires	187	196
Average time to hire	71.51 days	70.52 days
Average number of positions vacant (FTE)	325.62 (FTE)	319.04 (FTE)
Current number of vacancies (FTE)	Medical 48.5 Nursing 174.3 Allied Health 114 Support 23 Mgt/Admin 46.8 **406.6 FTE** (vacancy rate of 7.1% of total FTE) (as at 30 Sept 2015)	Medical 55.3 Nursing 169.5 Allied Health 95.2 Support 23 Mgt/Admin 59.8 **402.8 FTE** (vacancy rate of 7.0% of total FTE) (as at 31 Oct 2015)

The number of vacancies has remained steady at over 400 in October and the vacancy rate is sitting at 7.0% which is still quite high compared to the rest of the year, mainly due to the high number of nursing vacancies - both new roles and outstanding vacancies. However, Nursing vacancies have been decreasing with recruitment hires in most areas and 109 offers made in the month. The total 196 hires for October is the most in one month we have seen in a past 18 months and includes a high number of Health Care Assistants (21) and Psychiatric Assistants (14). We have seen an increase in the recruitment in Mental Health due to the growth in services particularly in the Mason Clinic (Prison team).

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 3 shows the time to hire for SMOs which was 127 days in October. If we exclude SMOs from our overall average time to hire, the average is 57 days (Table 2).

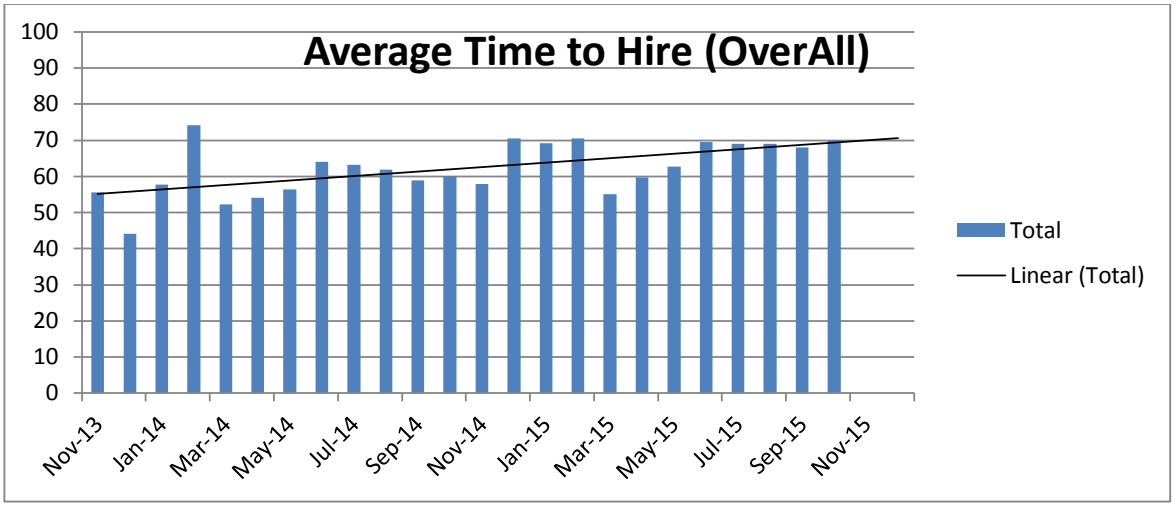


Table 1: Overall Average time to hire November 2013 to October 2015

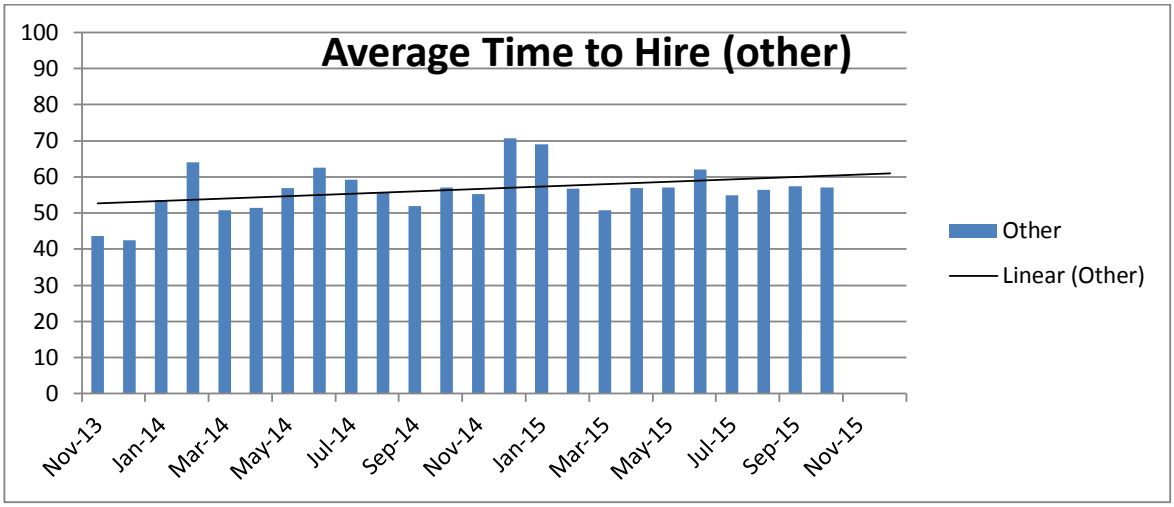


Table 2: Average time to hire for all other roles (excluding SMOs) November 2013 to October 2015

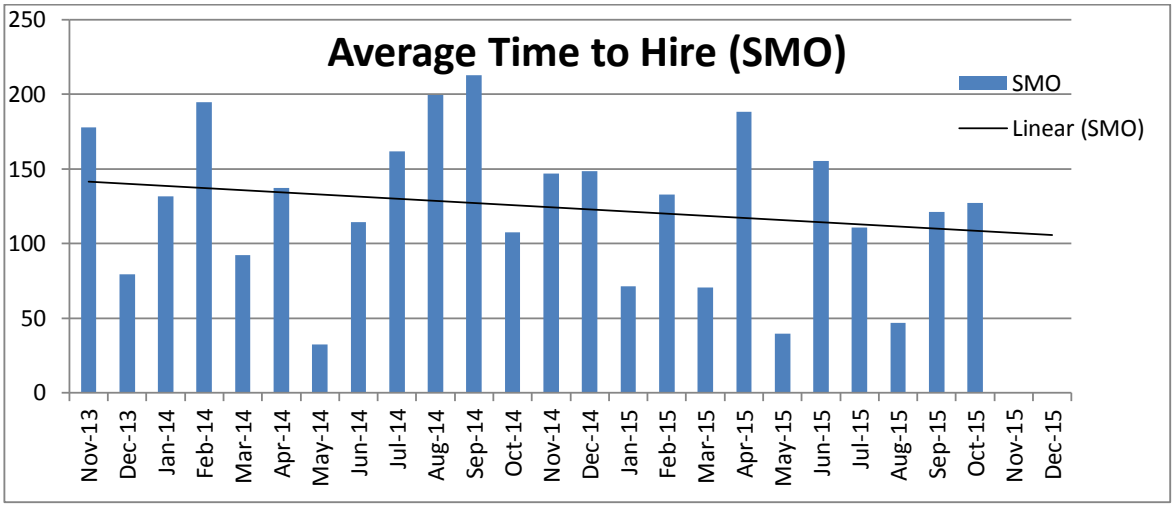


Table 3: Average time to hire for SMOs October 2013 to November 2015

2.2 Top sources for recruitment

The two highest sources for Waitemata are the friend referral and the Waitemata DHB careers site.

Rank / Source	Oct 14	Oct 15	Comments
1. A Friend	17%	18%	High referral rate within Waitemata DHB
2. www.wdhbcareers.co.nz	22%	24%	Strong Source of candidates
3. Kiwihealthjobs.com	5%	6%	Good to see this has increased which links to our goal to build the KHJ brand.
4. WDHB Intranet	16%	10%	This has increased from July
5. www.waitemata.govt.nz	11%	5%	Good to see that applicants are applying via our careers section.

Table 4: Top 5 Sources of Hire for Oct 2014 vs Oct 2015

2.3 Ethnicity of new employees

Below are two tables detailing the ethnicities of current employees by profession (Table 5) and the ethnicities of staff recruited in the last three months, also by profession (Table 6).

Analysis of the data shows us that in the last three months all hires closely match existing ethnicity profiles except for NZ/European and Asian where we recruited more staff who identify as Asian ethnicity, and most of those hires were for medical, allied health and support roles.

	NZ / European		Asian		Pacific		Maori		MELAA		Total FTE	Total %
Row Labels	**FTE**	**%**	**FTE**	**%**	**FTE**	**%**	**FTE**	**%**	**FTE**	**%**		
MEDICAL PERSONNEL	447.52	63%	206.04	29%	12.00	2%	16.54	2%	23.65	3%	705.75	100%
NURSING PERSONNEL	1,498.77	60%	783.98	32%	96.60	4%	81.20	3%	25.98	1%	2,486.53	100%
ALLIED HEALTH PERSONNEL	1,009.52	68%	278.08	19%	79.34	5%	96.80	7%	19.20	1%	1,482.94	100%
SUPPORT PERSONNEL	134.42	47%	92.76	32%	41.67	14%	17.15	6%	1.40	0%	287.40	100%
MGT/ADMIN PERSONNEL	673.84	80%	82.33	10%	34.19	4%	38.00	5%	9.74	1%	838.10	100%
Grand Total	**3,764.07**	**65%**	**1,443.19**	**25%**	**263.80**	**5%**	**249.69**	**4%**	**79.97**	**1%**	**5,800.72**	**100%**

Table 5 – Ethnicity of all staff

MELAA is a group amalgamation of Middle Eastern, Latin American and African ethnicities

	NZ / European		Asian		Pacific		Maori		MELAA		Total FTE	Total %
Row Labels	**FTE**	**%**	**FTE**	**%**	**FTE**	**%**	**FTE**	**%**	**FTE**	**%**		
MEDICAL PERSONNEL	26.00	47%	26.00	47%	1.00	2%	-	0%	2.00	4%	55.00	100%
NURSING PERSONNEL	50.78	57%	31.29	35%	1.60	2%	3.90	4%	0.90	1%	88.47	100%
ALLIED HEALTH PERSONNEL	26.66	48%	20.43	37%	4.00	7%	3.00	5%	1.00	2%	55.09	100%
SUPPORT PERSONNEL	2.55	15%	11.35	66%	2.00	12%		0%	1.30	8%	17.20	100%
MGT/ADMIN PERSONNEL	25.80	76%	4.84	14%	0.60	2%	1.00	3%	1.81	5%	34.05	100%
Grand Total	**131.79**	**53%**	**93.91**	**38%**	**9.20**	**4%**	**7.90**	**3%**	**7.01**	**3%**	**249.81**	**100%**

Table 6 – Ethnicity of staff recruited within the last 3 months

MELAA is a group amalgamation of Middle Eastern, Latin American and African ethnicities

3 Workforce Development

3.1 Waitemata Experience programme

A focus on our standards and behaviours

This month we have been focussed on preparing for Campaign Two which focusses on the standards of 'Give and Receive feedback' and 'Speak up for others'. A major part of that focus has been with the HODs Medicine across the services and the Clinical Directors.

Campaign activity has begun to roll out via general organisational communications and the appreciation card programme has begun.

3.2 Regional Pacific Health Science Academy & Mentoring Programme

Towards the end of the October, the team organised evaluation sessions at Onehunga High School and Waitakere college. The sessions were aimed at gathering feedback from the Academy students and tutor teachers around their experience of the first year of the Health Science Academy.
The feedback was mostly positive (Year 11 and Year 13 programmes). These students emphasised the importance of the Careers Exposure programme and how it has opened up views on the variety of health careers pathway.

Highlights of the year identified by students were motivational stories from health professionals, AUT science sizzler, and the Careers Conference. These sessions contributed to the increase of student confidence within the Health Science Academy programme. The students noted that being part of a group increases chances of peer learning and the sharing of knowledge with other students who are pursuing a similar career pathway.

Learning gathered from the feedback include the importance of the partnership between the school and the DHB. Messages given to students, as well as parents need to be consistent and reinforced by both stakeholders.

Senior School prize giving

The schools hosted senior prize giving earlier in November. Health Science Academy students at Onehunga High School achieved extremely well, where Academy members were leading science students at Year 11 and 12. These achievements have set the bench mark for next year. The head boy of Onehunga High School (a Health Science Academy student) was awarded a full scholarship at the University of Auckland to purse an interested career in heath (Medicine). Academy students at Waitakere College also achieved extremely well.

3.3 Scholarship Programme

In November eight students who have completed our scholarship programme will transition into graduate employment. There are three nursing students, two occupational therapy students, one physiotherapy student, one medical student and one medical laboratory science.

All three Nursing students obtained places on Nursing entry to practice programmes, two of those places were with Waitemata DHB. The third was on the Whakatupu Hauora scholarship and has secured employment at Northland DHB. The medical student will be applying for a first year post graduate House Officer in Christchurch, where she has been based for the last year. She will return to the Northern region following that and intends to return to Waitemata DHB.

The remaining students are all being interviewed for roles within Waitemata DHB.

Applications for 2016 intake will open on 18 January 2016. There will be a maximum of 10 scholarships available.

3.4 Rangatahi programme

Five cadetship placements starting in December 2015 through until end of February 2016. Cadets are being placed in Laboratory, Nursing and Orderly roles.

Recruitment is underway and the powhiri date is planned for 7th December at Waitakere Marae at 10am.

3.5 Youth Connections – Rangatahi in West Auckland

The Youth Connections project is focused on health career pathways for Rangatahi Maori in West Auckland, funded by the Tindall Foundation. The project is in response to the lack of uptake by Maori of the South Auckland Health Science Academies, and aims to trial alternative interventions. Youth Connections is a department of the Auckland Council.

There are four work-streams, and the Waitemata DHB Maori Workforce Development Consultant is involved in each:

- Cadet programme
- Vocational Pathways in the Community/PHOs
- Transitioning graduates to employment
- Building Employer Capability in PHOs and Community organisations

The most developed work-stream is the cadet programme and the MWFD Consultant is committed to finding ten placements for cadets to start in March 2016.

The other three work-streams are still in programme design stage.

3.6 Health Leadership Project – Auckland region workshop 21 October

Karina McHardy, Senior Advisor Health Leadership and Jan McCarthy, Awhina Education and Learning Manager facilitated a half-day workshop for the Auckland region on 21 October. Attendees were those who are responsible for leading health leadership development in each DHB.

The workshop provided an overview of the Leadership Domains Framework pilot at Waitemata DHB and Waikato DHB and the learning from these pilots. The regional group will come together again in March/April 2016 to discuss each DHBs approach to this work and how we might work as a region.

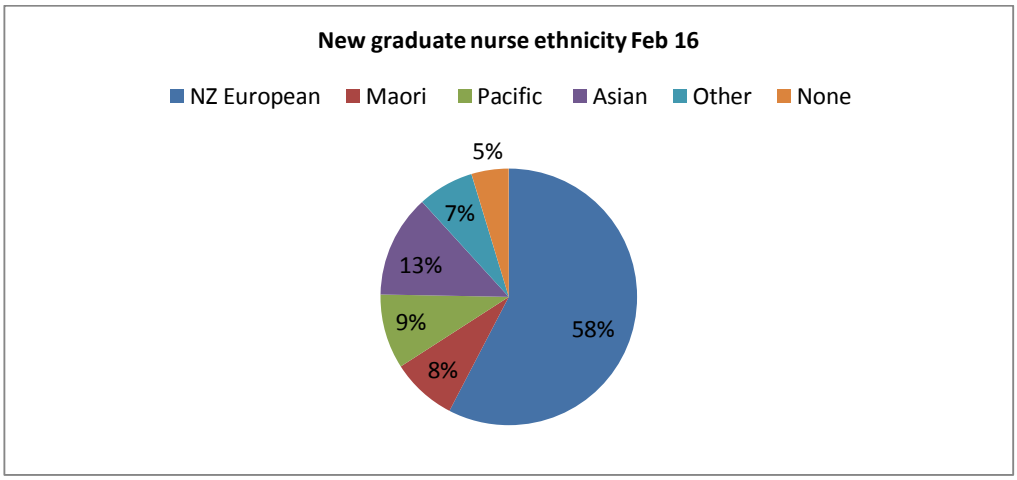
4 Education, Knowledge and Research

NETP: New Graduate Nurse ACE process

The six week process for interviewing and selecting applicants for the mid-year Advanced Choice of Employment (ACE) round continued in October.

Nine positions remain unfilled, interviews and selections will continue from 23rd November onwards. Possible additional positions have been identified; these will be included in the process.

ACE matches February 2016			
	Submitted	matched	unfilled
MHOPS	42	41	1
S&A	12	7	5
CWF	5	5	0
MH	18	15	3
PHC	8	8	0
Total	**85**	**76**	**9**



5 Internal Communications and events

5.1 Key communications projects and events occurring in October - December

Spiritual Centre, Ahurewa – 1-4 December
The Spiritual Centre, Ahurewa, opened on 1 December. Three important events were held, starting with a blessing in the morning, an official opening at 10am, to which the chaplains, Board members and donors were invited and a dedication service at 2pm to which multi denominational faith leaders, Interchurch Council of Hospital chaplaincy, past and present chaplains, volunteers and others were invited.

The remainder of the week included a number of activities celebrating our relationships with the Waitemata community.

Hine Ora opening 6 November (Gynaecology ward)
The new Hine Ora ward opened on 6 November. Minister Coleman and Hon Maggie Barrie opened the new ward, our first ward for women's health at Waitemata DHB.

Christmas activities

A month of Christmas events starts in late November though to Christmas Day. Activities include Christmas decoration competition, festive treats for staff during December and on Christmas day, free parking on Christmas Day and carol singers.

Karaka Street – Te Whare Karaka

The refurbishment of Karaka street building behind the Community Mental Health Building is now complete and an official opening is planned for 14 December.

6 Resolution to Exclude the Public

Recommendation:

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 04/11/15	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. Recruitment Analysis	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)]	**Confidence** The disclosure of information would not be in the public interest because of the greater need to protect information which if made available: i) would disclose a trade secret; [Official Information Act 1982 S.9 (2) (b)]