Waitematā
District Health Board

Best Care for Everyone

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING

Wednesday 17 June 2020
1.30pm

AGENDA

VENUE
Waitematā District Health Board
Boardroom, Level 1, Shea Tce, Takapuna
Zoom: https://waitematadhb.zoom.us/j/99920442990
Meeting ID: 999 2044 2990

Waitematā District Health Board
Best Care for Everyone

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING
17 June 2020

Venue: Waitematā DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna **Time: 1.30pm**
Zoom: https://waitematadhb.zoom.us/j/99920442990 Meeting ID: 999 2044 2990

Committee Members	WDHB Management
Sandra Coney –Committee Chair	Dale Bramley – Chief Executive Officer
Edward Benson-Cooper – Deputy Committee Chair	Andrew Brant – Deputy Chief Executive Officer
Judy McGregor – WDHB Board Chair	Robert Paine – Chief Financial Officer and Head of Corporate Services
Max Abbott – WDHB Board Member	Dr Jonathan Christiansen - Chief Medical Officer
John Bottomley – WDHB Board Member	Jocelyn Peach – Director, Nursing and Midwifery
Chris Carter - WDHB Board Member	Debbie Holdsworth – Director, Funding
Warren Flaunty – WDHB Board Member	Tamzin Brott – Director, Allied Health
Allison Roe – WDHB Board Member	Mark Shepherd – Director, Provider Healthcare Services
Renata Watene - WDHB Board Member	Fiona McCarthy – Director, Human Resources
	Lorraine Bailey – IDF, Performance Manager

APOLOGIES: Max Abbott

AGENDA

DISCLOSURE OF INTERESTS

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

PART I – Items to be considered in public meeting

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

	1.	**AGENDA ORDER AND TIMING**
	2.	**CONFIRMATION OF MINUTES**
1.30pm	2.1	Confirmation of Minutes of Hospital Advisory Committee Meeting (05/02/20) Actions Arising from previous meetings
	3.	**PROVIDER REPORTS**
1.35pm	3.1	Provider Arm Performance Report – March
	3.1.1	Executive Summary
	3.1.2	Human Resources
	3.1.3	Acute and Emergency Medicine Division
	3.1.4	Specialty Medicine and Health of Older People Services
	3.1.5	Child, Women and Family Services
	3.1.6	Specialist Mental Health and Addiction Services
	3.1.7	Surgical and Ambulatory Services/Elective Surgery Centre
	3.1.8	Diagnostic Services
	3.1.9	Clinical Support Services
2.20pm	3.1	Provider Arm Performance Summary Report - April
	4.	**CORPORATE REPORTS**
2.25pm	4.1	Clinical Leaders' Report
2.40pm	4.2	Quality Report - March/April
	5.	**GENERAL BUSINESS**
2.55pm	**6.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Waitematā District Health Board

Hospital Advisory Committee Member Attendance Schedule 2020

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

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

REGISTER OF INTERESTS

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

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

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

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

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

IMPORTANT

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

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

Note: This sheet provides summary information only.

2.1 Minutes of the Hospital Advisory Committee meeting held on 05 February 2020

Recommendation:

That the Minutes of the Hospital Advisory Committee meeting held on 05 February 2020 be approved.

Draft Minutes of the meeting of the Waitematā District Health Board

Hospital Advisory Committee

Wednesday, 05 February 2020

held at Waitematā District Health Board Boardroom, Level 1, 15 Shea Terrace, Takapuna, commencing at 1.30pm.

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT

Sandra Coney (Committee Chair)
Judy McGregor (from 1.43pm)
Max Abbott
Edward Benson-Cooper
John Bottomley
Warren Flaunty
Allison Roe
Renata Watene
Arena Williams

ALSO PRESENT

Dale Bramley (Chief Executive Officer) (from 2.45pm)
Andrew Brant (Deputy Chief Executive Officer)
Robert Paine (Chief Financial Officer and Head of Corporate Services)
Jonathan Christiansen (Chief Medical Officer)
Jocelyn Peach (Director of Nursing and Midwifery) (until 3.00pm)
Fiona McCarthy (Director Human Resources)
Deanne Manuel (Committee Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item.)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

No public and media representatives were present during the meeting.

WELCOME

The Committee Chair welcomed those present

APOLOGIES

Apologies were received and accepted from Chris Carter, Debbie Holdsworth and Lorraine Bailey and for late arrival from Judy McGregor and Dale Bramley.

DISCLOSURE OF INTERESTS

Warren Flaunty advised that he had been appointed Chair of the Trust Community Foundation and requested that his registered interest related to shareholding of Genesis Energy be removed.

1. AGENDA ORDER AND TIMING

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

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Hospital Advisory Committee Meeting held on 04 December 2020 (agenda pages 6-13)

Resolution (Moved Warren Flaunty /Seconded Sandra Coney)

That the Minutes of the Hospital Advisory Committee meeting held on 04 December 2019 be approved.

Carried

Actions Arising (agenda page 14)

No issues were raised.

3. PROVIDER ARM PERFORMANCE REPORT

3.1 Provider Arm Performance Report – November 2019 (agenda pages 15-81)

Executive Summary/Overview
Jonathan Christensen (Chief Medical Officer) summarised this section of the report, highlighting the following:

- The ongoing disruption in service due to continued industrial actions by MITs and Sonographers leading to the deferment of Echo tests resulting in longer waiting times for patients. However, there continues to be a focus on mitigating clinical and patient risk.
- There is a region-wide shortage of specialists in ORL which contributes to lower electives.
- Following the Whakaari White Island incident, Waitematā DHB accommodated a number of acute surgery patients from Counties Manukau DHB.
- The Annual Plan 2019/20 has been signed by the Minister and the 'Strategic Initiatives' table will be updated in the next agenda.

In response to a question, it was noted that the matters highlighted by Jonathan could impact 'revenue' of the DHB as a provider of service.

This section of the report was received.

Human Resources

Fiona McCarthy (Director Human Resources) was present for this report.

This section of the report was received.

Acute and Emergency Medicine Division

Gerard de Jong (Division Head, Acute and Emergency Medicine), Alex Boersma (General Manager, Acute and Emergency Medicine) and Melody Rose Mitchell (Associate Director of Nursing) were present for this section of the report.

Alex Boersma introduced the report highlighting ECHO performance below target due to industrial action. There was also a breach with respect to pressure injuries; the division is constantly monitoring practices align with pressure injury prevention strategies.

This section of the report was received.

Specialty Medicine and Health of Older People Division

John Scott (Head of Division, Specialty Medicine and Health of Older People) and Brian Millen (General Manager) were present for this section of the report.

Brian introduced the report highlighting the kidney transplant liaison service. The service provides support to potential donors to improve kidney transplant access to. There are a number of Māori on the waiting list and the extension of funding for this service will help contribute to equity outcomes.

In response to a query on Clinical Supplies expenditure, it was noted that requisitions and approvals have now been centralised to enhance cost control and efficient use of equipment.

This section of the report was received.

Child, Women and Family Services

Stephanie Doe (General Manager), Marianne Cameron (Head of Division – Nursing) and Diana Ackermann (Clinical Director) were present for this section of the paper.

Stephanie Doe introduced the report and highlighted the growing number of nurse practitioners at Waitematā DHB uplifting the clinical teams' skills. Other matters covered in the discussion and responses to questions included:

- While the service has seen an increase in demand for maternity services, the number of births has not increased. Increased demand is a result of various factors including the change of birth type (normal delivery to caesarean), increased obesity and diabetes in pregnancy as well as change in clinical practice. These factors are being reviewed along with the review of staffing to increase FTE, review of the model of care as well, as development of future workforce.
- There is a nationwide gap of midwives, but the DHB continues to attract new graduates as well as retain existing midwives.
- In response to a question, it was clarified that caesarean (CS) rates are not electives and are a result of several drivers. It was also noted that once a patient has had CS it can result in future caesareans. A review is on-going and a 'deep dive' on this matter was requested by the Committee.

Stephanie also summarised the Oral Health services. Matters covered in the discussion and responses to questions included:

- The Qlik dashboard is in place and is now able to capture those children with missed appointments. The service is prioritising those children who have not been seen for some time.
- The Committee requested that the next report show more detail, including the number of children who have been 'in arrears' for an extended period and those who have recently missed appointments. Information on types of treatments the children are undergoing will also be included.
- The 'Standardised pathway' for Oral Health will also be included in the next report as a focus of the Committee.
- In response to a question, it was clarified that the service accepts walk-in patients who are in pain.

This section of the report was received.

Specialist Mental Health and Addiction Services

Pam Lightbrown (General Manager), Derek Wright (Interim Lead), Murray Patton (Consultant Psychiatrist) and Alex Craig (Associate Director of Nursing) were present for this item.

Derek Wright highlighted the Mason Clinic expansion, the placement of long-stay clients to funded community beds and increased ED presentations of people with mental health issues. Matters covered in the discussion and responses to questions included:

- Regarding post discharge community care for adults, it was noted that transitioning the patients will reduce the deferment of services to those in need. The assistance of NGOs is also recognised, but they have also reached capacity.
- The 'self-harm and agitation' bundle was developed to help ED staff identify patients that require mental health services.
- In response to a question, it was clarified that the current focus and approach is preventative care and holistic care, using more of primary care to address the gap in the current model of care.
- There are government funded NGOs as a complementary service and/or in coordination with the DHBs, however, they are also facing challenges in terms of the capability of workforce.

Surgical and Ambulatory Services

John Cullen (Interim Chief of Surgery) was present for this item.

John highlighted the impact of the increased acute elective volumes on service delivery. The division has implemented the 'agreed cancellation' process which has lessened the number of cancellations. John also acknowledged the work of Sam Titchener (General Manager) on improvements made on the system which reduced clinical risks for 'long-waiting' patients

Other matters covered in the discussion and response to questions included:

- There is a specific structure and process adopted to respond to incidents such as the eruption of Whākaari White Island. Efforts are coordinated between the DHBs.
- Waitematā DHB's surgical volumes were impacted by the White Island eruption, but it is not clear yet how the Novel Coronavirus [COVID-19] will impact our surgical services. There are regional and local teams managing this and the expectation is that the impact will be lesser.

Dr Dale Bramley (Chief Executive) joined the meeting at 2.45pm.

This section of the report was received.

Diagnostic Services

Brad Healey (General Manager and Head of Division) presented this section of the report. He highlighted the CT and MR performance versus target has been affected by industrial actions. The service is reviewing is production planning.

This section of the report was received.

Clinical Support Services

Brad Healey presented this section of the report noting that a current focus for the division is food services. The contractor has indicated commitment in working with the DHB to improve the service with an update to be presented to the Board at its next meeting.

This section of the report was received.

Asian Health Services

Grace Ryu (Operations Manager) was present for this section of the report. As this is the first profile highlight of the service, she was welcomed by the Committee members.

Grace introduced the report noting that following the Novel Coronavirus outbreak, the team has assisted in the development of information materials and public guidelines to keep people safe.

This section of the report was received.

Resolution (Moved Sandra Coney /Seconded Max Abbott)

That the report be received.

Carried

3.00pm - Jocelyn Peach retired from the meeting

3.2 Provider Arm Performance Summary Report – December 2019 (agenda pages 82-93)

The report was noted by the committee and no issues were raised.

Resolution (Moved Sandra Coney /Seconded Max Abbott)

That the report be received.

Carried

4. CORPORATE REPORTS

4.1 Clinical Leaders' Report (agenda pages 94-105)

Jonathan Christiansen (Chief Medical Officer) and Sharon Russell (Associate Director) were present for this item.

Medical Staff

Jonathan Christiansen highlighted the completion of the Health and Disability services certification audit of Waitematā DHB. The auditors noted the continued prioritisation of quality improvements with some minor corrective actions. The report will be published in the next couple of months. He also acknowledged the efforts of the staff for this achievement.

This section of report was received.

Allied Health, Scientific and Technical Professions

Sharon Russell summarised the report in particular the implementation of the new team structure for Allied Health Services. The structure was developed in consultation with staff and is expected to align teams with clinical workload and patient pathways. She also noted the graduate trainee programme, which supports the transition from student to professionals, now has 47 graduates.

This section of the report was received.

Nursing and Midwifery and Emergency Planning Systems

This section of the report was received.

Resolution (Moved Sandra Coney/ Second Warren Flaunty)

That the report be received.

Carried

4.2 Quality Report (agenda pages 102-187)

Jacky Bush (Quality and Risk Manager) and Penny Andrew (Director, i3 and Clinical Lead) were present for this section of the report.

Quality Update

Jacky Bush summarised the Quality section of the report noting the significant improvements on markers including the reduction of falls and falls with major harm, decrease in unstageable pressure injuries, reduction in ESBL, robust infection control and reduction of the turn-around time for complaints response to 12 days. She acknowledged the efforts by the clinical teams for the improvements achieved.

In response to a question and following the Novel Coronavirus outbreak, it was noted that Waitematā DHB is one of the DHBs with the highest compliance rate and this is being constantly monitored.

This section of the report was received.

i3 update

Penny Andrew presented the 'Surgical Implant Tracking System,' which will enable easier tracing of implants and linking to patient and theatre information; this is currently being done manually. User feedback has been positive. In response to a query, Penny confirmed that the system will be shared with other DHBs as well as with the MoH.

This section of the report was received.

Patient and Whānau Centered Care

This section of the report was received.

Resolution (Moved Sandra Coney/ Second Warren Flaunty)

That the report be received.

Carried

5. INFORMATION ITEMS

There were no information items in the agenda.

6. RESOLUTION TO EXCLUDE THE PUBLIC (agenda page 203)

Resolution (Moved Edward Benson-Cooper/Seconded Max Abbott)

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 04/12/19	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2. Quality Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]
3. Human Resources Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

Carried

The open session of the meeting concluded at 3.25p.m.

SIGNED AS A CORRECT RECORD OF THE WAITEMATĀ DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 05 FEBRUARY 2020.

_____CHAIR

Actions Arising and Carried Forward from
Meetings of the Hospital Advisory Committee
as at 10 June 2020

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back	Comment
04/12/19	3.1	Provider Arm Performance Report Revisit the notice/language used in communicating with DNA patients	Stephanie Doe	09/09/20	Noted for action
05/02/20	3.1	Provider Arm Performance Report The Committee requested for a deep dive on the drivers for the increase in caesarean rates	Stephanie Doe	09/09/20	Noted for action

3.1 Provider Arm Performance Report – March 2020

Recommendation:

That the report be received.

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

This report summarises the Provider Arm performance for March 2020.

Table of Contents

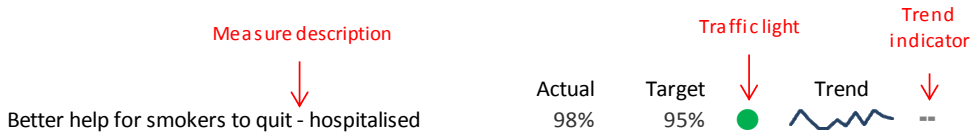
Glossary

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

How to interpret the scorecards

Traffic lights

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



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

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

Trend indicators

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

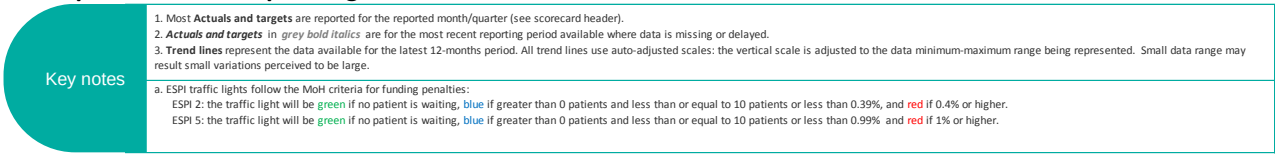
Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance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

The trend indicator criteria and interpretation rules:

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

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

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



Provider Arm Performance Report

Executive Summary/Overview

Summary

Mark Shepherd commenced as Director, Provider Healthcare Services on 6 April 2020. At this time, the hospital and broader health service was part way through the COVID-19 level 4 lockdown restrictions period and was being managed under an emergency management operating model, known as the Incident Management Team (IMT). COVID-19 has had a significant impact on our available staff resources. This was due to the need to stand down vulnerable staff in order to protect them from potential infection and in addition, have large numbers of staff work from home or take special leave to ensure appropriate social distancing across the organisation. Further staffing challenges ensued, initially with the need to stand down those in contact with COVID positive staff.

The COVID-19 level 4 restrictions have meant all non-urgent elective work has been suspended with an overall reduction in outpatient waitlists of 12% in March, compared to the average of the prior quarter. This in part may be due to the reduction in overall referrals received and accepted in the organisation which was down 19% compared to prior months. Further, given the limitations of seeing patients face to face, the rapid development of Telehealth initiatives saw an increase in First Specialist Assessments (FSA) which increased 80% in March and 340% in April compared to the previous year's average. There has also been a significant increase in Telehealth follow up appointments which increased 20% in March.

With the exception of planned care volumes and the reduction in activity impacted by COVID-19 during the last weeks of March, overall service delivery performance of the Provider Arm remains stable. We have retained the Emergency Department (ED) target above 95%, one of few DHBs to do so. We have continued to respond to patient and family concerns with the Complaint Response time now an average of nine days. Staff sick leave, turnover and vacancies all remain within acceptable limits. All quality metrics are being achieved and/or exceeded.

Highlight of the month

The demands of COVID-19 have seen staff effect a large degree of change over a very short period of time, to ensure we were adequately prepared. Standing down the Elective Surgical Centre ESC to re-establish it as a COVID ready Intensive care surge site has been a major undertaking. Staff in Surgical and Ambulatory Services have pulled together, to collaborate, problem solve and demonstrate flexibility with the aim of providing the best service possible for patients given the unprecedented circumstances. The service has ensured access to surgery for their priority patients by scheduling P1 and P2 clinically urgent patients to available operating theatres . They have worked collectively with the acute and emergency medical division to redevelop a Surgical Short Stay Unit discretely from the previously larger Assessment and Diagnostic Unit. This has resulted in reduction of acute surgical patients length of stay and, combined with increased access to acute theatres, has reduced unnecessary after hours surgery.

Key Issue of the Month

Elective performance indicators across all services, have been impacted by level 4 restrictions, however, mainly affecting surgical services. While Telehealth initiatives have been implemented for clinic or outpatient services, face to face services such as Diagnostic Imaging have been limited in their ability to provide access to services for our patients. This in turn, in many clinical services, has limited their ability to progress treatment.

Scorecard – All services

Waitematā DHB Monthly Performance Scorecard

ALL Services
March 2020
2019/20

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	96%	95%	--
Faster cancer treatment (62 days)	82%	90%	▼

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	9 days	≤14 days	▲
Net Promoter Score FFT	82	65	▲
Improving Outcomes			
Better help for smokers to quit - hospitalised	99%	95%	▲
Quality & Safety			
Older patients assessed for falling risk	100%	90%	▲
Rate of falls with major harm	0.14	≤2	▼
Good hand hygiene practice	93%	80%	▲
S. aureus infection rate	0.1	≤0.25	▼
Occasions insertion bundle used	100%	95%	--
Pressure injuries grade 3&4	0	0	--
HR/Staff Experience			
Sick leave rate	3.5%	≤3.4%	▼
Turnover rate - external	12%	≤14%	--
Vacancies - %	6%	≤8%	▼

Service Delivery

Elective Volumes	Actual	Target	Trend
Provider Arm - Overall	94%	100%	▼
Waiting Times			
ESPI 2 - % patients waiting > 4 months for FSA		*Non-Compliant*	
ESPI 5 - % patients not treated w/n 4 months		*Non-Compliant*	
ESPI 1 - OP Referrals processed w/n 10 days		*Compliant*	
Patient Flow			
Outpatient DNA rate (FSA + FUs) - Total	7%	≤10%	▲
Outpatient DNA rate (FSA + FUs) - Māori	15%	≤10%	▲
Outpatient DNA rate (FSA + FUs) - Pacific	14%	≤10%	▲

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue	747,267 k	755,633 k	▼
Expense	782,185 k	761,109 k	▼
Net Surplus/Deficit	-34,918 k	-5,476 k	▼
Contracts (YTD)			
Elective WIES Volumes	13,086	13,787	▼
Acute WIES Volumes	50,165	50,580	▼

How to read

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

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

Key notes

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

A question?

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

Scorecard Variance Report

Health Outcomes

Faster Cancer Treatment (62 days)

Non achievement of the Faster Cancer Treatment target for this continues to be a challenge, however, the increased access to operating theatres over this period has created the opportunity to focus on improving access to all P1 cancer cases, which has especially benefited Gynaecology and Urology patients. A review of access for all P1 cancer patients across the DHB identified that all patients had clinically appropriate plans for care.

Service Delivery

Elective Volumes

Due to COVID-19 and lockdown to Level 4 occurring on 26 March, Elective volumes for the month were reduced as services only assessed and treated P1 and urgent patients.

Outpatient DNA rate

There continues to be sustained improvement in overall Did Not Attend (DNA) rates across all services in 2020 with ongoing rollout of patient focused booking. There is still work to do across priority populations with plans currently being developed.

Waitematā DHB Priorities Variance Report

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

Areas off track for month and remedial plans
Equity Committee endorsed the key priorities and gaps identified within a paper about Māori Patient and Whānau Experiences at Waitematā DHB. Approval received to recruit a Māori Patient Experience and Whānau Lead position to lead the areas of work identified. Following a delay with finding a suitable candidate for the role, we are very pleased our new Māori Patient and Whānau Experience Lead started in April 2020. We have a plan in place for medication communication with our pharmacists at Auckland DHB and Waitematā DHB, however, this work is currently on hold due to COVID-19 and resourcing challenges.

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

Areas off track for month and remedial plans
Awaiting confirmation that the data for unplanned return to surgery is held within the General Surgical Audit system.

Financial Performance Summary

The Provider Arm result YTD March 2020 was a deficit of $34.919m against a budgeted deficit of $5.476m, and therefore unfavourable to budget by $29.443m.

Key financial performance factors

- Delays in the realisation of savings under the financial sustainability programme ($14.2m)
- Deferral of sale of 44 Taharoto Road ($10.1m)
- Under delivery of Electives resulting in lower revenue from the MOH ($2.0m)
- Three Harbours investment revaluations ($1.4m)
- COVID-19 impacts including increased staff costs due to planning and leave ($1.0m)
- COVID-19 related operational costs and reductions in car park revenues ($0.6m)

The financial YTD impacts noted above were partially offset by savings due to:

- Additional ACC revenue, $1.4m
- The favourable settlement of MECAs below provision amount, $1.0m.

The following service commentaries reference 'business as usual' financial pressures in the first eight months from July to February and COVID-19 impacts starting to be realised in March.

Surgical and Ambulatory Services (YTD $2.370m unfavourable to budget)

COVID-19 impacts:

- Increased leave costs, $185k
- Cancellation of 42 elective lists for NSH/WTH (which would normally generate around 112 WIES, $584k)
- Cancellation of ESC lists impacting internal recharges, $210k

Acute and Emergency Medicine Services (YTD $2.119m unfavourable to budget)

COVID-19 impacts:

Emergency Department (ED) presentations have dropped by 1,362 in the single month of March, which brings total of 260 less presentations than this time last year. Inpatient numbers have also significantly reduced since mid-March with the service opening up as much capacity as possible, bracing for the impact of COVID-19. Additional budget has been endorsed by the executive and recruitment is being fast tracked to increase capacity in Ward 11. In early March, 54 employees were asked to self-isolate on paid leave. Staff coming from overseas will also be placed in self isolation - this imposes a big challenge for recruitment. Clinical supplies for face masks, protective clothing and related products will increase in coming months.

Specialty Medicine and Health of Older Persons Services (YTD $0.874m unfavourable to budget)

COVID-19 impacts:

The service has realised in additional staff costs in the month due to less leave being taken $200k (additional cover for special leave at this stage is not material). There is anticipated to be an unfavourable impact on ACC revenue due to reduced patient numbers in rehabilitation wards. The total negative impacts YTD from COVID-19 are approx. $250k, with a full year forecast impact of $500k. The service has reduced gastroenterology outsourced volumes $150k (noting this financial benefit is considered short term, with catch-up costs now anticipated in the new financial year). NASC Respite will be impacted during lock down. The positive financial impacts YTD from COVID-19 are approximately $150k, with a forecast impact of $350k.

Child, Women and Family Services (YTD $1.156m unfavourable to budget)

COVID-19 impacts have resulted in the following service closures:

- Regional Dental – no routine appointments, except for relief of pain (six clinics)
- Colposcopy – as per national agreement, except for urgent cancer cases
- Vasectomy – sending referrals to other providers
- Gynaecology – all P3s and most P2s, except for cancer cases
- New born hearing screening outpatients, except for inpatients (as per NSU recommendations)
- Pregnancy and Parenting classes – moving online
- Breastfeeding clinics – virtual only
- Children's respite services
- School based immunisations services (on MoH advice)
- B4 School Check (on MoH advice)
- Children's food challenge service
- Family violence multidisciplinary Safety Assessment Meeting (SAM) table participation

The full impact of these closures will be evident in April. In the meantime the service is tracking public health nursing costs to Auckland airport, reduced respite bed day funding, and clinical supplies across Maternity and Neonatal services.

Specialist Mental Health and Addiction Services (YTD $937k favourable to budget)
COVID-19 impacts: While favourable year to date, in the month, the service has seen a financial step backwards as we invest in preparations for a range COVID-19 eventualities. Our top priority has been to prepare two Urgent Care Centres at 33 Paramount drive and 44 Taharoto road with the mission of supporting the Emergency Department in the event of high demand for services. Planning has taken an estimated 90% - 95% of management time in the month. Services have been moved online from face to face where possible with the teams touching base with as many service users to ensure treatment is available where needed. Community Alcohol, Drug and Addiction Services (CADS) have closed the Detox unit and redeployed resource into the community. Group therapies have ceased. Mason Clinic clients will require significant on-going care to manage clinical risk.

Elective Surgery Centre (YTD $0.260m favourable to budget)
COVID-19 impacts:
The cancellation of 40 elective lists in ESC since 23 March (a loss of around 120 WIES) has resulted in a significant reduction in costs in the month, including:

- Reduced staff costs and package of care fees for service, $213k
- Clinical supply costs, $207k
- Other direct patient costs (meals and laundry), $20k
- Note that the ESC has been closed completely for elective surgery as of 23rd March, and has been converted to an overflow stand-alone COVID-19 ICU unit and ward facility.

Clinical Support Services (YTD $1,085m unfavourable *to budget)*
The unfavourable variance is driven by:

- Increased equipment and bed repairs in Clinical Engineering, ($364k).
- Traffic management costs are high than plan due to delays in the implementation of integrated rosters pending union consultation, and recent changes in available spaces and shuttles from the North Shore Event Centre, ($429k).

Diagnostics Services (YTD $1.502m favourable to budget)
The favourable variance is driven by:

- Lower inpatient drug costs $303k, and the receipt of additional rebates, $675k
- Outpatient pharmacy $161k favourable YTD.
- Laboratories $547k favourable due to the write-off of a prior year accrual.

- The radiology service has realised a material negative financial variance for March 2020. This was largely due to costs being realised for 800 additional outsourced CT procedures approved by the Board in response to recent strike action.

Corporate and Provider Arm Support Services (YTD $24.538m unfavourable to budget)

The unfavourable variance is driven by:

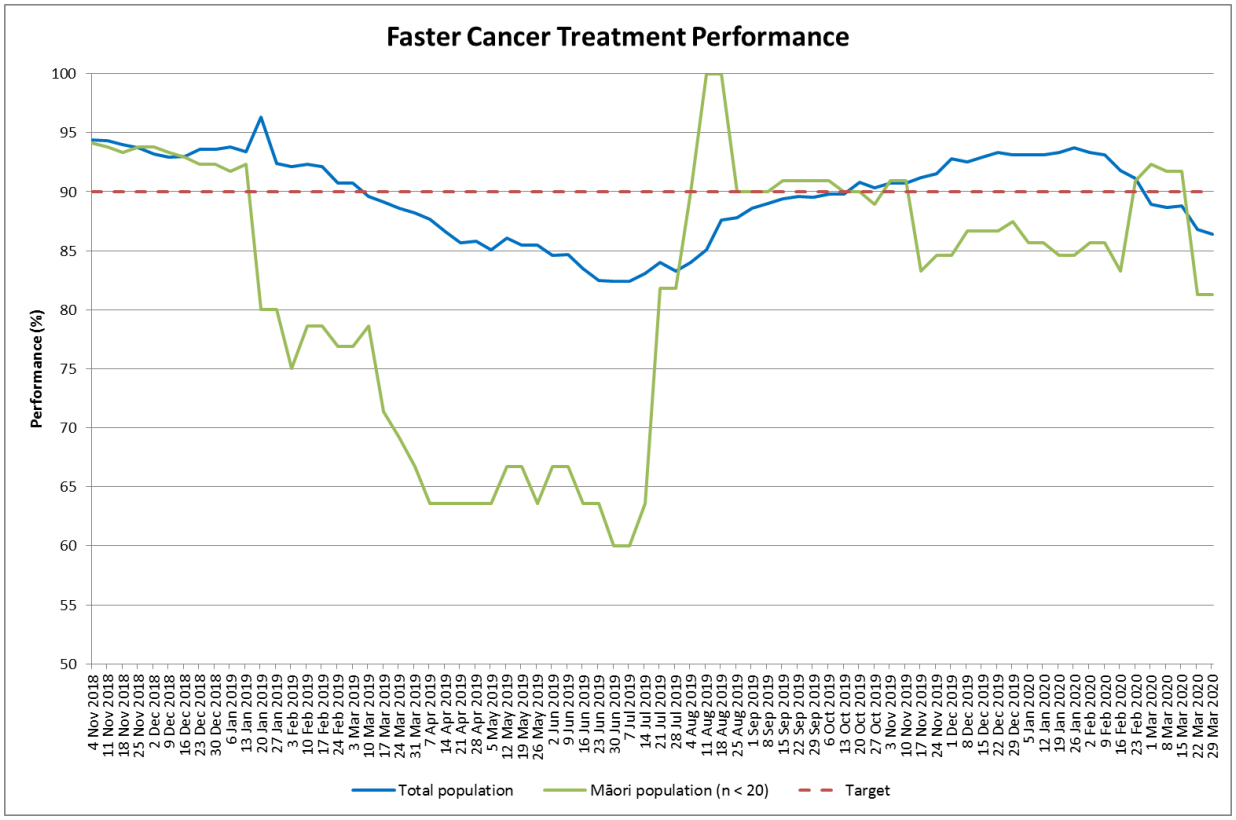
- Delayed realisation of financial savings obligations, ($12.9m).
- Deferred sale of 44 Taharoto Road, ($10.1m).
- Adjustment to planned care revenue based on current under delivery of YTD volumes, ($2.0m).
- Three Harbours investment revaluations, ($1.4m)

Offsets to the shortfall in savings obligations include:

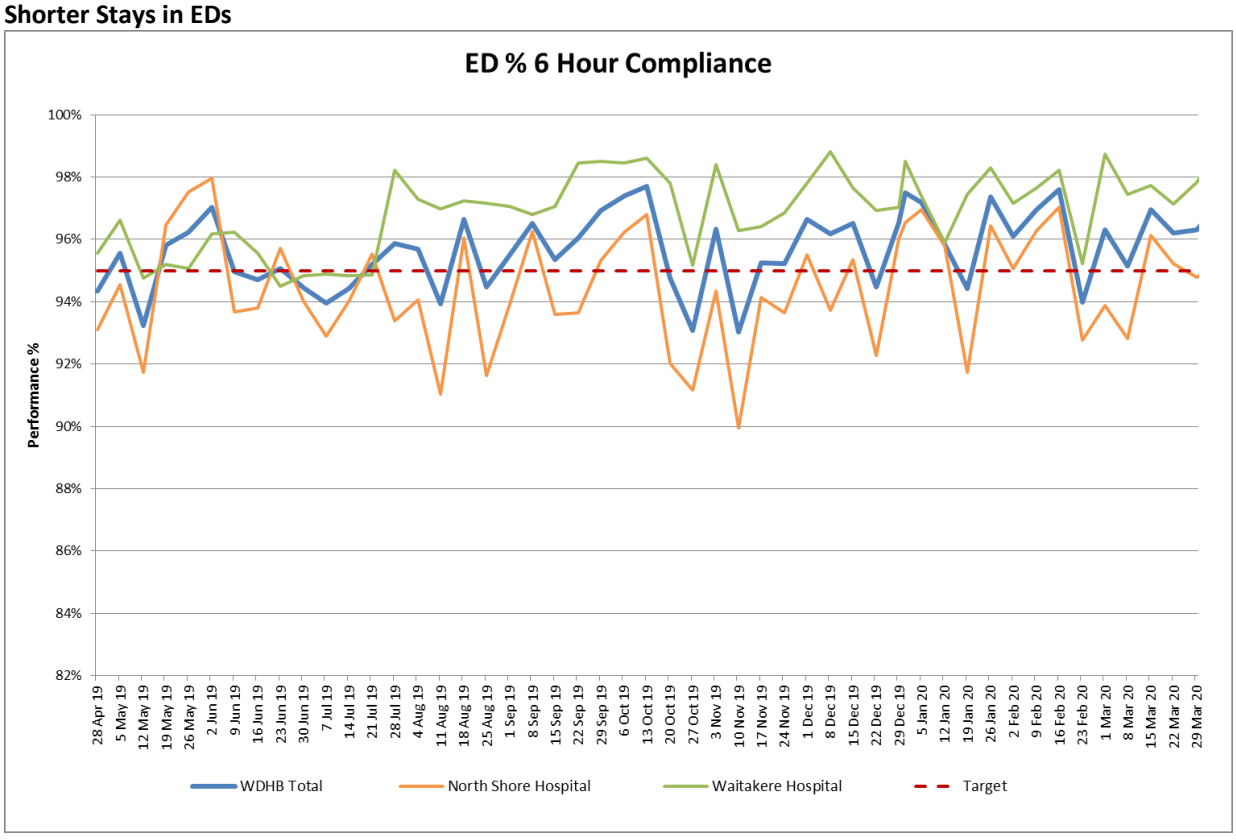
- Release of residual provisions for settled MECA, $1.0m.
- Various, including savings due to current vacancies.

Priority Health Outcome Areas

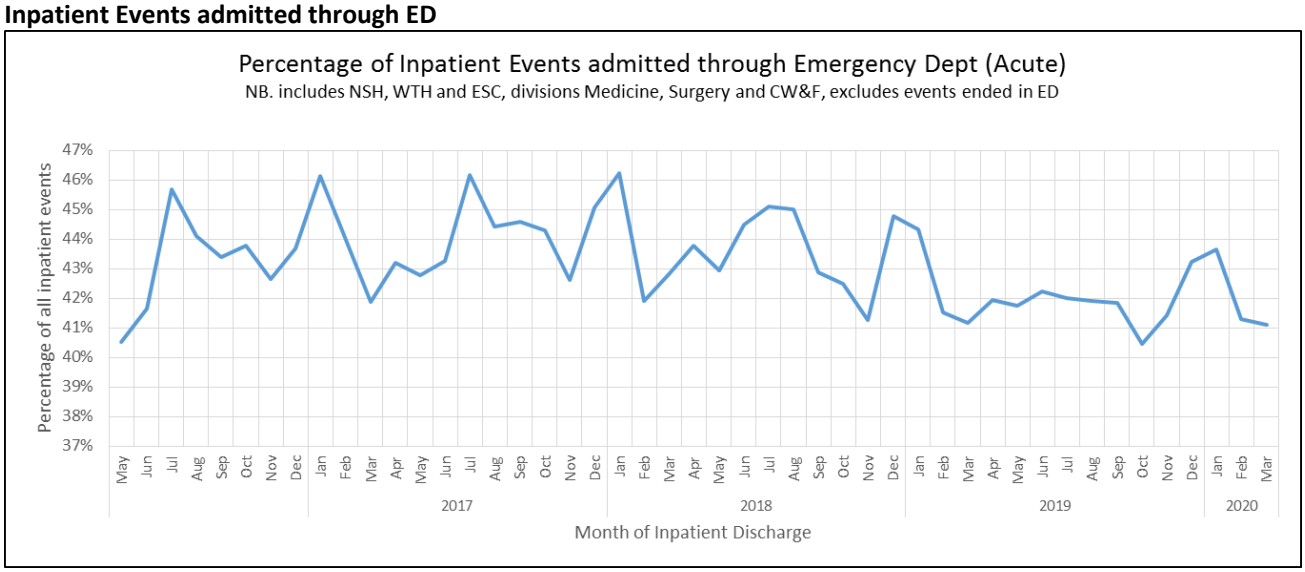
Faster Cancer Treatment



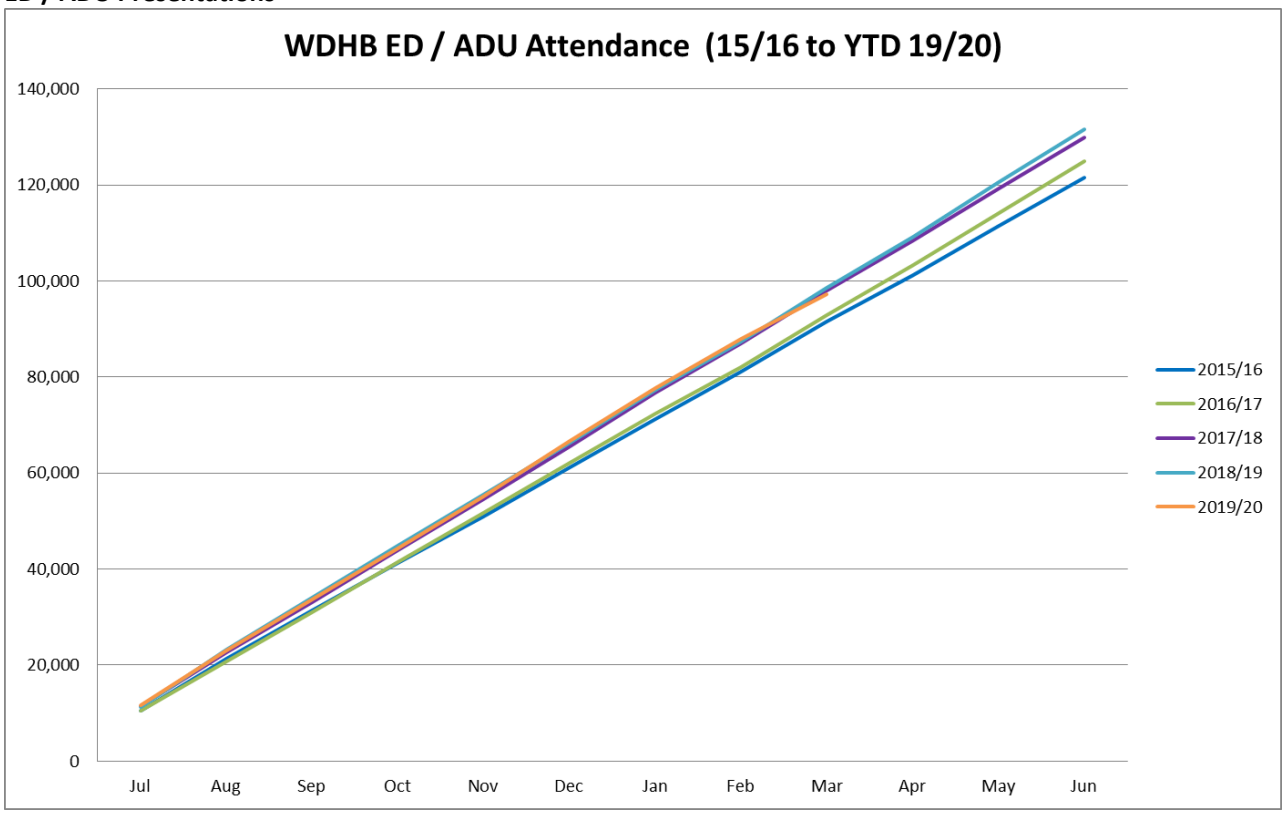
Shorter Stays in EDs



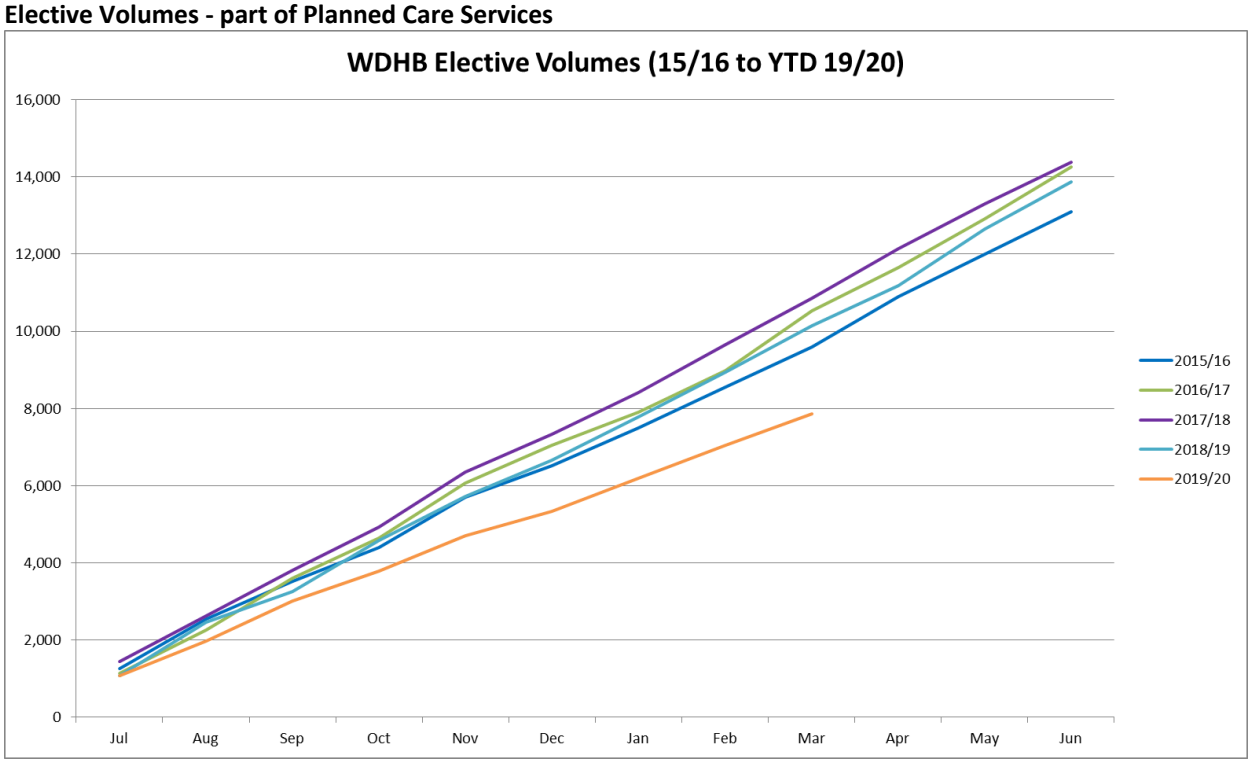
Inpatient Events admitted through ED



ED / ADU Presentations



Elective Volumes - part of Planned Care Services



Percentage Change ED and Elective Volumes

March 2020	Month Volumes	% Change (last year)	YTD Volumes	% Change (last year)
ED/ADU Volumes	9,211	-18%	97,227	-1%
Elective Volumes	816	-33%	7869	-22.5%

Elective Performance Indicators (part of Planned Care Services)

Zero patients waiting over four months

Summary (March 2020)	
Speciality	Non Compliance %
ESPI 2 - Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	6.19%
ESPI 5 - Patients given a commitment to treatment but not treated within the required timeframe.	16.32%

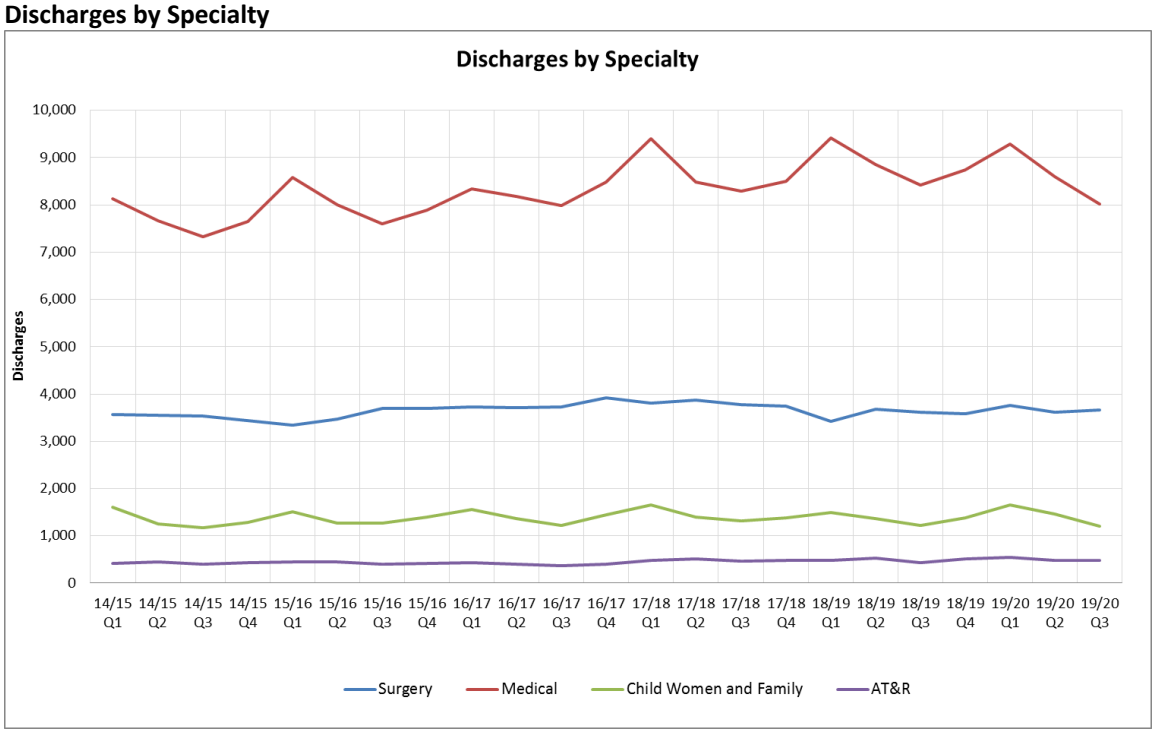
ESPI	WL Specialty	Compliant	Non Compliant	Non Compliant
ESPI 2	Anaesthesiology	104	-	0.00%
	Cardiology	1,133	10	0.87%
	Dermatology	249	1	0.40%
	Diabetes	188		0.00%
	Endocrinology	248	1	0.40%
	Gastro-Enterology	748	1	0.13%
	General Medicine	140	-	0.00%
	General Surgery	1,423	295	17.17%
	Gynaecology	936	13	1.37%
	Haematology	113	-	0.00%
	Infectious Diseases	66	2	2.94%
	Neurovascular	95		0.00%
	Orthopaedic	1,581	96	5.72%
	Otorhinolaryngology	905	237	20.75%
	Paediatric MED	780	12	1.52%
	Renal Medicine	235	-	0.00%
	Respiratory Medicine	647	5	0.77%
	Rheumatology	191	-	0.00%
	Urology	500	6	1.19%
	Total	10,282	679	6.19%
ESPI 5	Cardiology	87	-	0.00%
	General Surgery	1,943	71	3.53%
	Gynaecology	564	121	17.66%
	Orthopaedic	1,050	441	29.58%
	Otorhinolaryngology	376	79	17.36%
	Urology	374	145	27.94%
	Total	4,394	857	16.32%

90% of outpatient referrals acknowledged and processed within 10 days

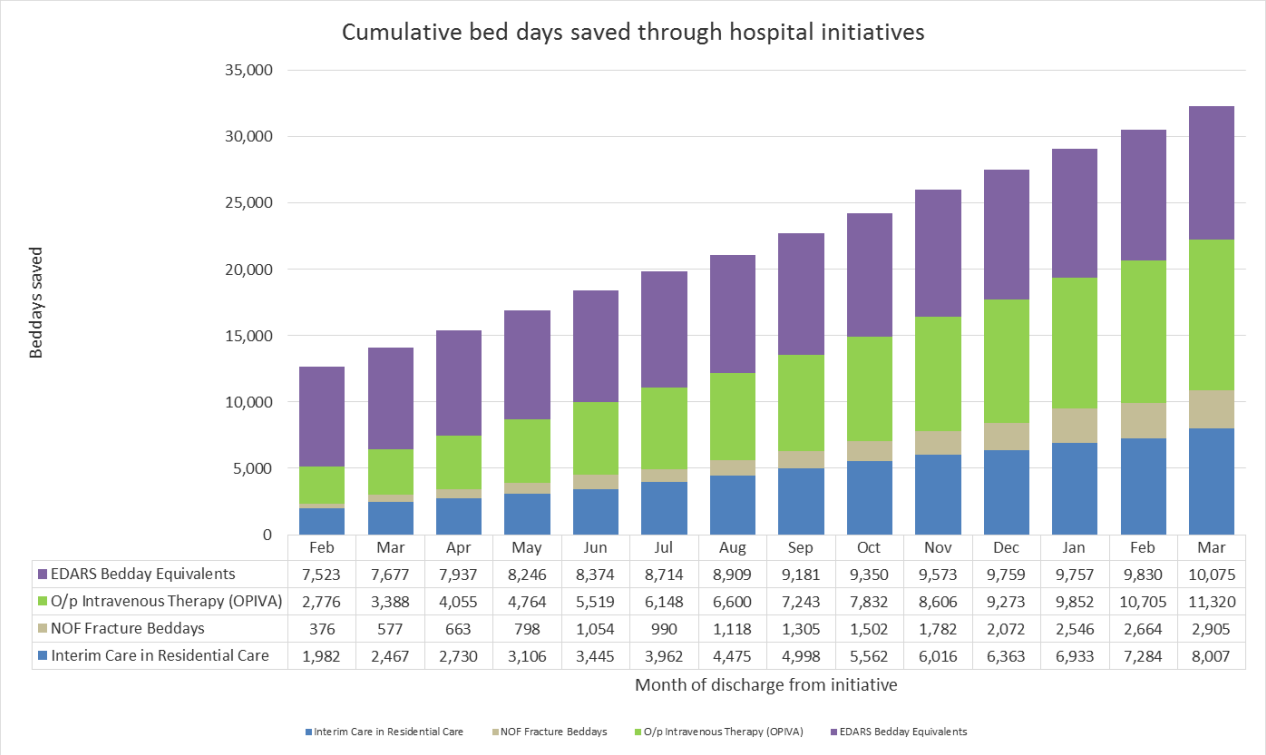
ESPI 1 (March 2020)	
Specialty	Compliance %
Anaesthesiology	90.63%
Cardiology	100.00%
Dermatology	100.00%
Diabetes	100.00%
Endocrinology	99.48%
Gastro-Enterology	99.51%
General Medicine	98.60%
General Surgery	93.00%
Gynaecology	98.57%
Haematology	99.53%
Infectious Diseases	98.63%
Neurovascular	100.00%
Orthopaedic	94.95%
Otorhinolaryngology	99.30%
Paediatric MED	97.49%
Renal Medicine	100.00%
Respiratory Medicine	99.39%
Rheumatology	100.00%
Urology	100.00%
Total	97.80%

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

Discharges by Specialty

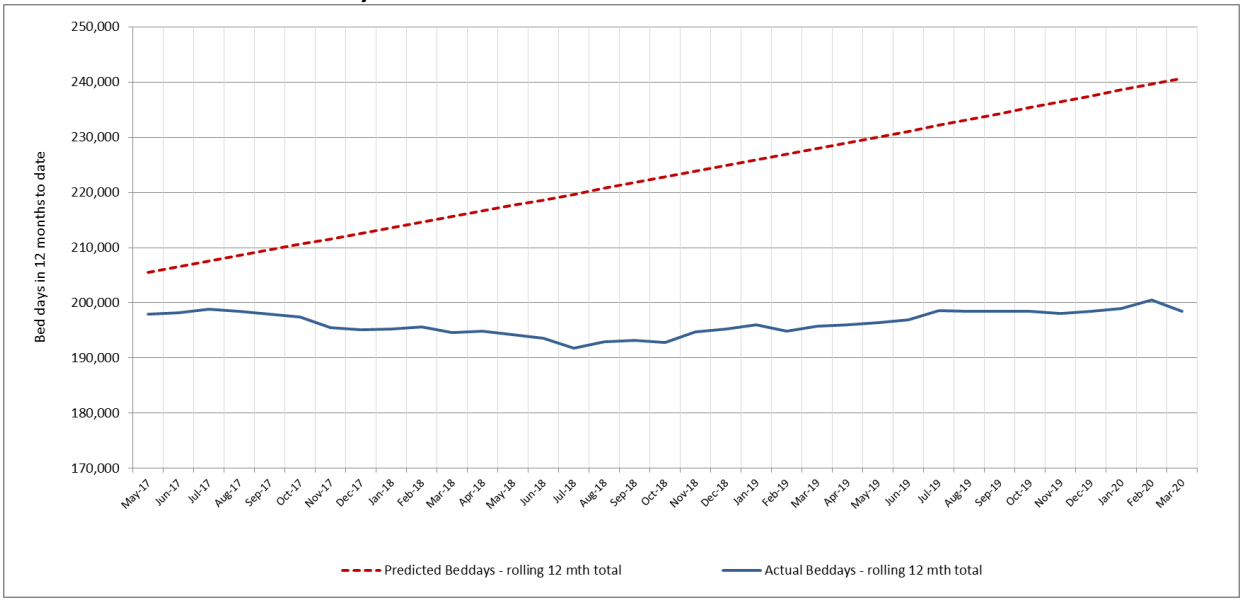


Cumulative Bed Days saved through Hospital Initiatives



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
EDARS Bedday Equivalents	7,523	7,677	7,937	8,246	8,374	8,714	8,909	9,181	9,350	9,573	9,759	9,757	9,830	10,075
O/p Intravenous Therapy (OPIVA)	2,776	3,388	4,055	4,764	5,519	6,148	6,600	7,243	7,832	8,606	9,273	9,852	10,705	11,320
NOF Fracture Beddays	376	577	663	798	1,054	990	1,118	1,305	1,502	1,782	2,072	2,546	2,664	2,905
Interim Care in Residential Care	1,982	2,467	2,730	3,106	3,445	3,962	4,475	4,998	5,562	6,016	6,363	6,933	7,284	8,007

Predicted versus Actual Bed Days



Financial Performance

Waitematā DHB Statement of Financial Performance

Provider - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	80,962	80,719	243	730,077	726,785	3,292	968,899
Other Income	774	12,199	(11,425)	17,190	28,847	(11,657)	40,209
Total Revenue	81,737	92,918	(11,182)	747,267	755,633	(8,365)	1,009,108
EXPENDITURE							
Personnel							
Medical	17,269	16,208	(1,061)	154,761	156,094	1,333	201,652
Nursing	23,506	22,082	(1,424)	209,918	204,136	(5,782)	275,119
Allied Health	11,527	10,151	(1,377)	95,768	95,768	1	128,764
Support	1,901	2,078	177	17,552	18,357	804	24,898
Management / Administration	6,537	5,982	(554)	57,493	55,270	(2,223)	74,560
Outsourced Personnel	2,077	1,340	(737)	16,301	11,095	(5,206)	14,586
	62,817	57,841	(4,976)	551,793	540,720	(11,073)	719,579
Other Expenditure							
Outsourced Services	5,452	5,275	(177)	46,055	46,810	755	62,530
Clinical Supplies	11,252	11,934	682	96,858	100,561	3,702	133,548
Infrastructure & Non-Clinical Supplies	8,693	8,348	(346)	87,478	73,018	(14,460)	93,450
	25,398	25,557	160	230,392	220,389	(10,003)	289,528
Total Expenditure	88,215	83,399	(4,816)	782,185	761,109	(21,076)	1,009,108
Cost Net of Other Revenue	**(6,478)**	**9,520**	**(15,998)**	**(34,918)**	**(5,476)**	**(29,441)**	**(0)**

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

Waitematā DHB Statement of Financial Performance

Provider - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
CONTRIBUTION							
Surgical and Ambulatory	(8,893)	(8,623)	(270)	(67,487)	(66,331)	(1,156)	(88,546)
Acute and Emergency	(14,431)	(13,492)	(939)	(116,714)	(114,594)	(2,119)	(154,459)
Specialty Medicine and HOPS	(13,112)	(12,742)	(370)	(98,649)	(99,587)	938	(133,679)
Child Women and Family	(6,478)	9,520	(15,998)	(34,918)	(5,476)	(29,441)	(0)
Specialist Mental Health and Addiction	87,123	87,896	(773)	677,132	687,486	(10,354)	912,236
Elective Surgery Centre	(3,144)	(3,225)	81	(24,940)	(23,856)	(1,085)	(31,885)
Clinical Support	(9,360)	(8,910)	(450)	(69,875)	(69,001)	(874)	(92,920)
Diagnostics	(10,310)	(9,630)	(680)	(75,317)	(76,820)	1,502	(102,250)
Corporate and Provider Support	(33,574)	(21,047)	(12,527)	(253,341)	(237,100)	(16,241)	(300,833)
Net Surplus/Deficit	**(12,179)**	**19,745**	**(31,924)**	**(64,110)**	**(5,280)**	**(58,830)**	**7,663**

Comment on major variances by Provider Service

The overall result for Provider was $31,924m unfavourable for March and $58,830m unfavourable for the YTD.

Acute and Emergency Medicine ($2,119k favourable YTD)

The unfavourable revenue variance for March is due to a budget adjustment of Clinical Training Agency (CTA) revenue in March. The unfavourable expenditure variance for March was mainly due to high staff cost due to COVID-19, estimated at $500k per month.

Sub Specialty Medicine and HOPS ($874k unfavourable YTD)
The unfavourable variance was due mainly to high demand for mobility aids and Mental Health Services for Older Adults respite, as well as the over allocation of RMOs and low leave taken.

Child Women and Family (CWF) ($1,156k unfavourable YTD)
The favourable variance was due to reduced Colposcopy activity, a delay in the commencement of the ARDS Free Oral Health Service for Pregnant Women in Tamaki service level agreement and a ceased ARDS pre-school contract. Also impacting the result is high demand for Maternity and Neonatal inpatient services, covering gaps in maternity rosters, ARDS clinical equipment maintenance, processing of aged invoices and staff claims, high dental supplies costs, patient laundry and food expenses.

Specialist Mental Health and Addiction (SMHA) ($5938k favourable YTD)
The unfavourable variance was due to revenue for court reporting continuing to be higher than budgeted volumes, (which is not expected to continue) and staff vacancies.

Surgical and Ambulatory Service (S&A) ($2,370k unfavourable YTD)
The unfavourable variance was due to the lower than planned production volumes in Orthopaedics and ORL provided a favourable variance in clinical supplies which been offset by higher than expected locum costs as well as reliance in NSH Theatres on bureau nurses to cover unplanned vacancies and an over-allocation of RMOs in the current run.

Elective Surgery Centre (ESC) ($260k favourable YTD)
The favourable variance was due to The favourable variance was due to lower than planned volumes being completed at ESC resulting in lower variable costs, as well as under activity savings in other clinical supplies including implants and prostheses and treatment disposables, these savings were magnified in March due to the closure of ESC at the end of the month as part of the COVID-19 preparedness plan.

Diagnostics ($1,502k favourable YTD)
The favourable variance for the YTD in revenue is due to rebates received from Pharmac for hospital medicines and savings in clinical supplies.

Clinical Support ($1,085k favourable YTD)
The favourable variance was due to new concession levies from staff café sales as well as Security Services charging for the issue of ID cards.

Corporate and Provider Support ($16,241m unfavourable YTD)
The unfavourable variance is being impacted by large on-off items and additional costs in relation to the Covid-19 response.

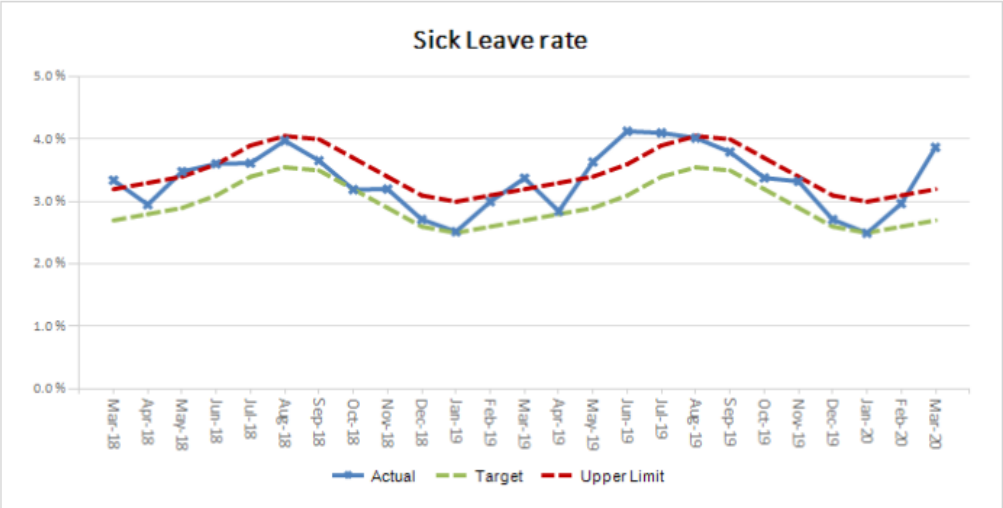
Human Resources

Method of calculation of graphs:

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

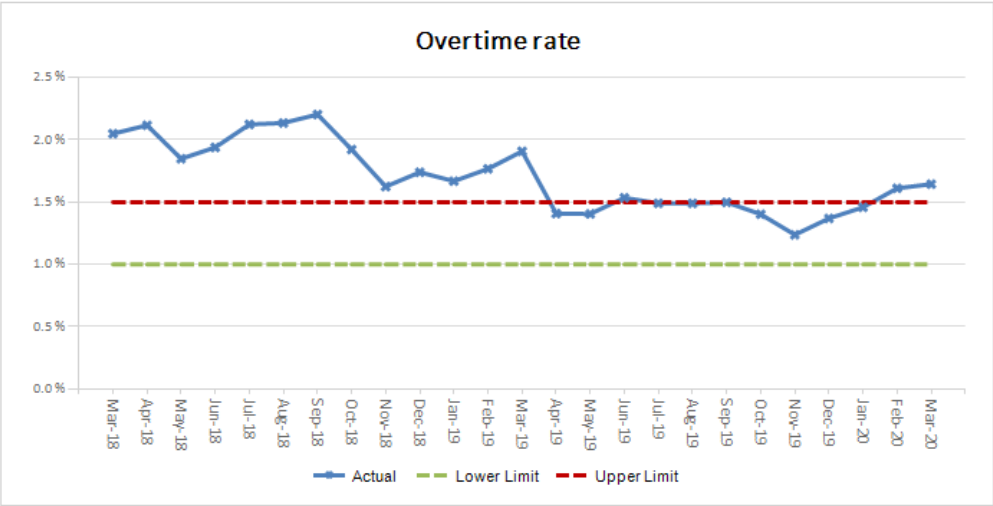
Sick Leave

Sick leave increased in late March due to some COVID-19 special leave recorded as sick leave. Sick leave reduces in April and May.



Overtime

Overtime continues at low levels across the organisation dropping to below 1% in May.



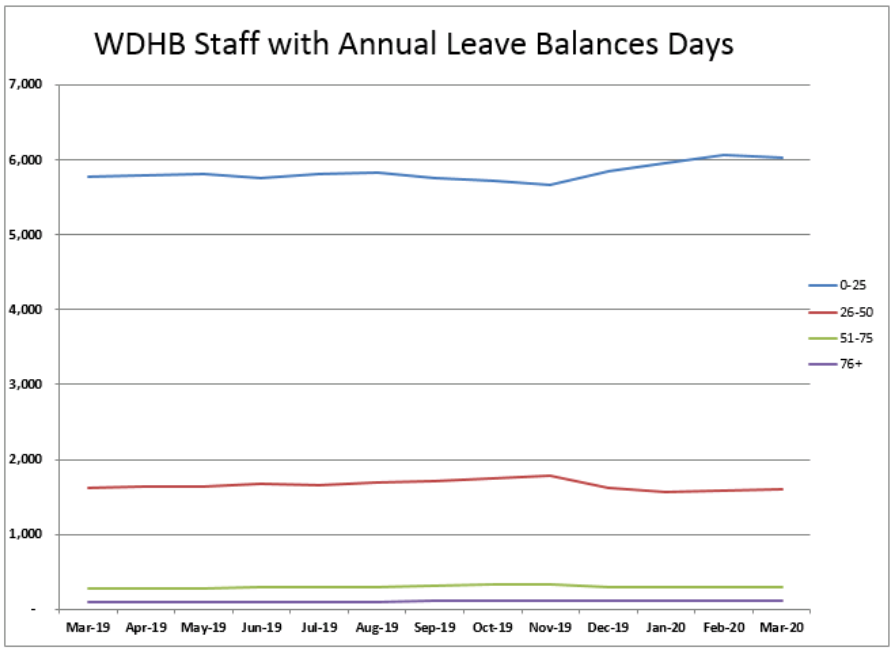
Annual Leave

Overall the DHB has been making good progress on leave management with the average annual leave balance for the organisation at 22 days which is the same as last year. This shows we are managing leave well taking account of the growth our workforce.

Over coming months the annual leave balances have increased by 1 additional day per annum due to the COVID-19 lockdown in late March- May.

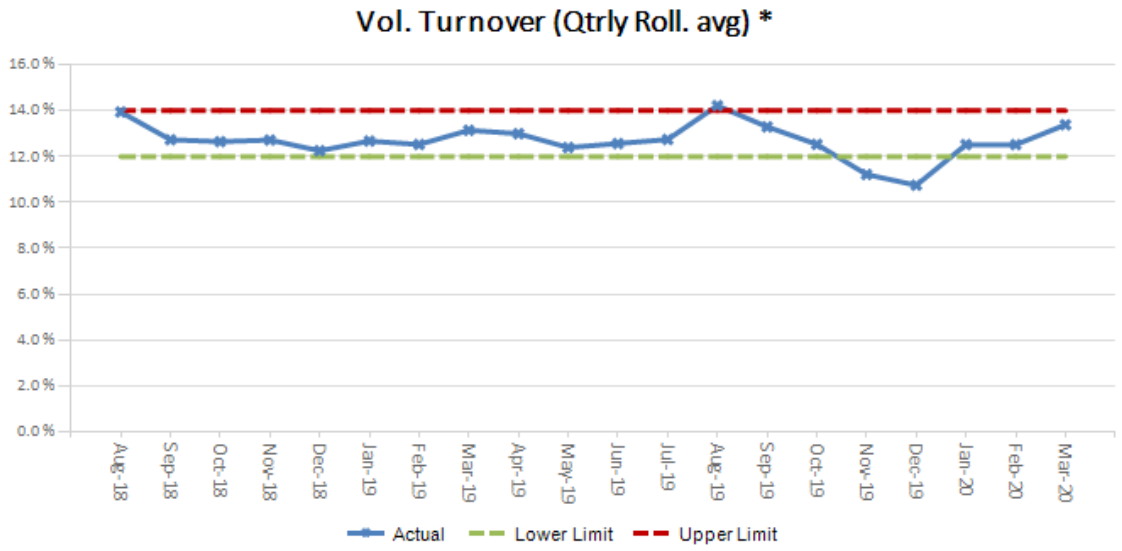
Active leave planning continues across the divisions including cover to ensure staff with large leave balances can take leave.

Annual Leave Mar 2020	Leave Bal 0-25 days	Leave Bal 25-50 days	Leave Bal 50-75 days	Leave Bal 75 days +
Surgical and Ambulatory	739	261	57	23
Elective Surgery Centre	80	20	1	-
Child Women & Family	950	159	22	10
Facilities and Development	32	10	3	-
Corporate	369	87	11	4
Acute and Emergency Medical Divison	982	328	69	36
Clinical Support	258	72	12	2
Diagnostics	350	127	36	11
Director Hospital Services	230	50	9	2
Elective and Outpatient Services	79	19	5	-
Mental Hlth & Addiction	1,127	260	23	3
Sub Specialty Med and HOPS	741	195	36	11
Governance and Funding	91	12	4	4
Total	**6,028**	**1,600**	288	106
Comparison - Mar 2019	**5,785**	**1,621**	273	99



Staff Turnover

Staff turnover has remained stable with this pattern reducing to just over 10% in May.



Divisional Reports

Acute and Emergency Medicine Division

Service Overview

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

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

Highlight of the Month

Preparing for COVID -19

New Zealand went into Level 4 lockdown on 26 March. As a result, a number of new processes were instigated to manage any potential COVID-19 patients flow through the EDs at WTH and NSH.

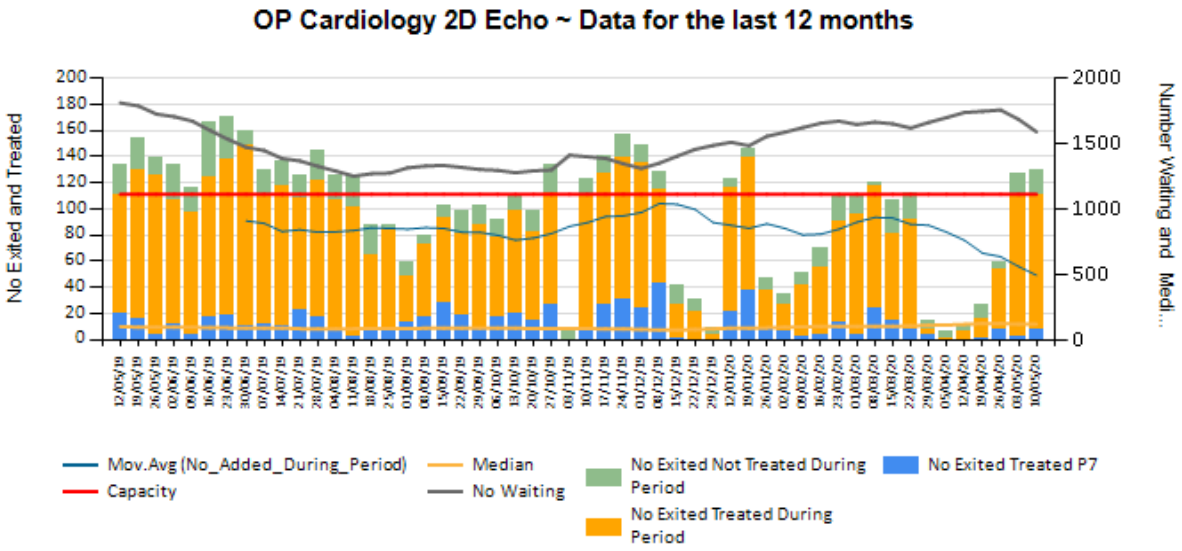
- The process for screening of all patients was a priority. Screening questions and the acquisition of screening and forward triage tents began.
- Patients were to be screened into white or blue stream according to their COVID-19 risk. Separate triage areas were also put in place for white and blue streams. Processes were discussed and agreed with St John local managers.
- The two negative pressure rooms were converted into COVID-19 resus rooms to enable aerosol generated procedures such as intubation to occur safely for patients and staff. All staff received education and auditing of PPE procedures and daily simulation exercises commenced with other services such as Anaesthetics involved.
- The ED management team met with a number of specialties and agreed clear pathways of care that ensured patients were seen and managed in a timely way in order to ensure that the patient flow through ED was augmented.
- ED and Mental Health developed new model of care and community pathways for patients that required Mental Health input but not ED care. Acute clinics in the North and West were commissioned. This resulted in a decrease in the number of mental health patients presenting to ED. The improved availability of mental health inpatient capacity also meant that there were no issues with patient flow.

Key Issues

ECHO Cardiology

There was a major impact on outpatient waiting times due to sonographers' industrial action. This has been further impacted by the COVID-19 response. While the waiting time for P1 patients has been maintained the median wait time for P2 ECHOs is now over 20 weeks. The improvement we had been seeing in the waiting times for P3 patients has been eroded as a result of the period of industrial action and the further impact of COVID-19. The number of patients on the waiting list for ECHO has increased from 1,274 in September 2019 to 1,736 at the beginning of April 2020, an increase of over 500 patients.

The graph below show the two periods impacted clearly. From 15 December 2019 the service was impacted by the strike and from 29 March the service was impacted by the COVID-19 response.



The COVID-19 response also impacted on our ability to trial the rapid access clinic which had already been deferred due to industrial action. The aim of this clinic was to trial an alternative model of care to potentially reduce the number of patients requiring a full ECHO. It was anticipated that the rapid access clinic would have a positive impact on the number of full ECHOs required and also on the number of follow ups required.

The ECHO service recommenced at the beginning of May 2020 and is in the process of developing a recovery plan, which may need to include outsourcing as an option.

Scorecard – Acute and Emergency Medicine Division

Waitematā DHB Monthly Performance Scorecard

Acute and Emergency Medicine
March 2020
2019/20

Priority Health Outcomes

	Actual	Target	Trend
a. Shorter Waits in ED	97%	95%	--

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	7 days	≤14 days	▲
Net Promoter Score FFT	82	65	▲
Improving Outcomes			
PCI w/in 120 minutes (STEMI patients)	91%	80%	▲
Better help for smokers to quit - hospitalised	99%	95%	--
Quality & Safety			
Older patients assessed for falling risk	100%	90%	--
Rate of falls with major harm	0	≤2	▲
Good hand hygiene practice	94%	80%	▲
Pressure injuries grade 3&4	0	0	--
HR/Staff Experience			
Sick leave rate	3.6%	≤3.4%	▼
Turnover rate - external	14%	≤14%	--
Vacancies - %	4%	≤8%	▼

Service Delivery

Waiting Times	Actual	Target	Trend
General Medicine - % seen w/in 120 mins	84%	85%	▲
Elective coronary angiography w/in 90 days	100%	95%	▲
b. Angiography for ACS w/in 72 hours	73%	70%	▼
Chest pain clinic wait time under 6 weeks	89%	80%	▲
O/P Transthoracic Echo wait time under 12 weeks	28%	95%	▼
Patient Flow			
Elective Discharge Volumes (Cardiology)	106%	100%	▼
Outpatient DNA rate	7%	≤10%	▼
Patients with EDS on discharge	91%	85%	▲

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue	2,857 k	2,660 k	▼
Expense	119,570 k	117,255 k	▼
Net Surplus/Deficit	-116,714 k	-114,594 k	▼
Contracts (YTD)			
Elective WIES Volumes	849	958	▲
Acute WIES Volumes	27,195	28,047	▼

How to read

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

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

Key notes

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

a. Data for Medicine overall
b. Quarterly, Mar 20

A question?

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

Best Care

Sick Leave rate – 3.6% against a target of <3.4%

This figure remains relatively unchanged, which is positive, however we anticipate an increase in sick leave rate over the next few months in response to the COVID pandemic.

Service Delivery

Outpatient transthoracic echo wait time under 12 weeks

There was a major impact on outpatient waiting times due to sonographers' industrial action. This has been further impacted by the COVID-19 response. We are in the process of developing a recovery plan, including additional weekend shifts.

Value for Money

Elective WIES Volumes *– 849 against a target of 958*

This is an improvement on the previous month. Elective work was stopped at the end of March, in response to COVID-19. It was significantly reduced in April and was reinstated from the 10th of May, but at reduced volumes.

Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Planned Care Actions to ensure that our population receives equitable and timely access to services in the most appropriate setting to support improved health outcomes		
Coronary angiography Review the current referral and booking process to ensure capacity is maximised to achieve the 95% target	Dec 2019	✓
Acute readmissions Work with pharmacy and primary care to ensure that medicine reconciliation is conducted for 100% of patients, including those aged 75+ years	Ongoing	✓
Acute Demand Actions to improve the management of patient flow and data in the Emergency Department		
Acute data capturing • Implement SNOMED coding of ED presenting complaints • Investigate and scope requirements for ED Procedures and Diagnosis codes	Jul 2019 Dec 2019	✗
Improving patient flow for admitted patients Improve the multidisciplinary governance model within the inpatient home-based wards, with a focus on further improving patient flow and patient whānau care standards, including for Māori and Pacific patients (EOA) • Improvements include implementing regular meetings and reviews of ward performance to improve the functionality of home-based wards	Implement model in all medical wards by Sep 2019	✓
Implement Home-Based Wards at Waitakere Hospital	May 2020	✓
Improving the management of patients in ED with long-term conditions (LTCs) Expand the role of the CNS/NP in the ED to include active management of acute exacerbations of LTCs; develop bundles of care for patients with LTCs e.g. chronic obstructive pulmonary disease (COPD)	Jan 2020	✓
Improving wait times for patients requiring mental health and addiction services who present to ED Review the current model of care to minimise patient waiting times; action at least one recommendation • With Mental Health services, develop a model of care for patients in ED, including Mental Health representation at daily patient access meetings to review delays and daily flow and care of mental health patients • Develop a rapid assessment process for mental health patients to ensure timely assessment	Sep 2019; Jun 2020 Dec 2019 Dec 2019	✓ ✓ ✓
Improving the patient experience of Māori in ED • Greet all patients attending our EDs at triage in Te Reo Māori • Ensure diversity in our workforce to represent our patient population (EOA)	Nov 2019 Ongoing	✓
Addressing barriers to accessing primary care services With the Ministry's Kārearea Service and Te Whānau o Waipareira, develop a navigator service to support frequent users of ED services aged 0-24 years and their whānau with referrals to primary care (including holistic Māori healing), where clinically appropriate (EOA)	Implement at WTH from Dec 2019	✓
95% of patients admitted, discharged or transferred from an emergency department within six hours (SS10 measure)		✓

Areas off track for month and remedial plans
Acute data capturing • **Implement SNOMED coding of ED presenting complaints** • **Investigate and scope requirements for ED Procedures and Diagnosis codes** There are three parts to SNOMED coding in ED the coding of presenting complaints, the coding of procedures and the coding of diagnosis. The Waitematā DHB IT service has assessed and scoped the implementation of SNOMED and have concluded that they cannot support this with the current IT tools. A capital request has been made and work is underway on the capital request process to secure funding.

Financial Results - Acute and Emergency Medicine

Waitematā DHB Statement of Financial Performance

Acute & Emergency Medicine - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	236	261	(25)	2,277	2,178	99	2,961
Other Income	59	54	5	580	483	97	644
Total Revenue	295	315	(19)	2,857	2,660	196	3,605
EXPENDITURE							
Personnel							
Medical	6,221	5,898	(323)	41,742	41,696	(46)	54,989
Nursing	5,711	5,223	(487)	54,877	53,626	(1,252)	74,015
Allied Health	305	322	17	2,106	2,097	(9)	2,746
Support	0	0	0	0	0	0	0
Management / Administration	726	701	(25)	5,088	4,895	(193)	6,464
Outsourced Personnel	138	104	(35)	1,556	919	(637)	1,223
	13,101	12,249	(853)	105,368	103,232	(2,137)	139,437
Other Expenditure							
Outsourced Services	27	39	12	226	344	118	458
Clinical Supplies	1,199	1,202	3	10,566	10,837	271	14,392
Infrastructure & Non-Clinical Supplies	399	318	(82)	3,410	2,843	(567)	3,776
	1,625	1,558	(67)	14,202	14,023	(179)	18,626
Total Expenditure	14,726	13,807	(919)	119,570	117,255	(2,315)	158,064
Cost Net of Other Revenue	**(14,431)**	**(13,492)**	**(939)**	**(116,714)**	**(114,594)**	**(2,119)**	**(154,459)**

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

Comment on major financial variances

The overall result for Acute and Emergency was $939k unfavourable for March and $2,119k unfavourable for the YTD.

Revenue ($19k unfavourable for March, $196k favourable YTD)

The unfavourable variance for the month is due to a budget adjustment of CTA revenue in March. The favourable YTD variance was due to revenue received from non-residents and University of Auckland teaching. Also there are more cases qualified for ACC from hyperbaric unit this year.

Expenditure ($919k unfavourable for March, $2,315k unfavourable YTD)

The unfavourable variance for March was mainly due to high staff cost due to COVID-19, estimated at $500k per month. In addition, there is a continuing overspend in ED/ADU nursing budget due to a mismatch between the budget and the current roster. The unfavourable variance for YTD was mainly due to the nursing cover in ED and

ADU, and high additional duties and outsourced personnel cost for ED doctors has offset the saving made in general medicine SMOs as a result of vacancies.

Personnel ($2,137k unfavourable YTD)
Medical ($46k unfavourable YTD)
The unfavourable variance was due to high ED medical cover cost from additional sessions is offset by vacancies in general medicine and a saving from skill mix in general medicine for senior doctors. Over allocations of registrars and house officers also imposes some cost pressure for the division. Savings in general medicine will reduce with the implementation of home based warding at WTH in December 2019.

Nursing ($1,252k unfavourable YTD)
The unfavourable variance was due to sick leave in the winter months, high ED and ADU nursing cover and watch cost across the division. There was high sick leave due to COVID in March 2020 and additional nursing positions were covered for screening etc.

Support and Management/Administration ($193k unfavourable YTD)
The unfavourable variance due to 80% budgeted cover.

Outsourced Personnel ($637k unfavourable YTD)
The unfavourable nursing variance was due to outsourced expenditure for watches. The medical outsourced costs related to locum cover for ED.

Other Expenditure ($179k unfavourable YTD)
Outsourced Services ($118k favourable YTD)
The favourable variance was due to the reduction in annual leave taken resulting in more medical cover by existing staff.

Clinical Supplies ($271k favourable YTD)
The favourable variance was due to lower number of cardiology procedures performed and the ongoing price reduction of cardiac implants.

Infrastructure and Non-Clinical Supplies ($567k unfavourable YTD)
The unfavourable variance was due to high ED security watch cost ($279k) and unbudgeted software cost for Emergency Q ($214k).

COVID-19 impact
In March, ED presentations fell by 1,362 and this resulted in a reduction in the YTD volumes of 260 presentations compared to last year. Inpatient numbers also significantly reduced in mid-March. There was an expectation that we would experience an increase in COVID related demand and the Executive Leadership Team (ELT) endorsed the budget to recruit the nurses required to increase the capacity on Ward 11 (scheduled for May 2020 as part of the winter plan). In early March, 54 employees were required to self-isolate and in addition there were a number of staff returning from overseas who were also required to self-isolate. This will be an ongoing challenge for recruitment. Clinical supplies for PPE equipment - face masks, protective clothing and related products will increase as the requirement for this equipment increases.

Specialty Medicine and Health of Older People Division

Service Overview

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

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

Highlight of the Month

Allied Health Services

In response to the actual and potential increased demand on hospital services as a result of COVID-19 presentations, Allied Health services were reviewed and revised to be able to respond to the following drivers;

- Need to decompress demand on inpatient services
- Facilitate early safe discharge from hospital
- Reduce unnecessary admissions
- Support people to remain safe and well in the community.

The Allied Health pre-COVID-19 model of community services was designed for planned care and therefore not well equipped to be a responsive model. Waitlists for services meant it had no immediate capacity to support rapid engagement for patients on discharge (other than the Early Discharge and Rehabilitation Services [EDARS] service) or the ability to provide support that could actively prevent hospital admission.

To enable community staff to respond to more acute demand, caseloads were reviewed and prioritised ensuring patients had equipment and information available to enable them to be safe in their homes and to continue with self-directed programmes as needed.

It was acknowledged that prolonged rehabilitation services could not continue to be delivered in the same way and that, where possible services needed to be provided with minimal face to face contact and where required in a way that ensured safety for patients, families and staff. The existing EDARS and community services were revised with the following services being developed;

Rehab Safe - focusing on safety and education to set rehab patients up at home and prevent readmission:

- Reviewing transfer ability and equipment needs at home
- Ability to safely access meals / medications
- Education to patient / family / whānau on self-management strategies and home exercise programmes

- Maximum two to three visits to establish safety and provide education (some or all virtual) with follow-up phone call after one week to assess if further limited rehab input is required or can be provided by team, or discharge if appropriate.

Community Safe team - providing rapid response to patients presenting with needs as identified through ED attendance or on discharge from inpatient setting and support for patients in interim care beds who could then be discharged safely home and not be readmitted to rehabilitation.

- Provide a rapid response initial visit / virtual contact to ensure the patient is safe at home
- Follow up assessment and intervention as clinically indicated
- Focused on preventing re-admission by provision of equipment, advice and education.

Where the patient is in a Waitematā DHB interim care scheme (ICS) bed, the intervention focuses on discharging the patient directly to home without the need for re-admission to hospital, with the therapist providing one to three interventions as needed to achieve this.

Community Connection Calling Service - a phone or social media based wellbeing check-in for vulnerable adults. Community Connection Callers are Waitematā DHB staff with clinical competencies providing support and assessment and able to offer escalation of service if required either within the Allied Health services or through community referrals.

All of these services have been well received. In particular, the benefit of early engagement with patients has been recognised in its ability to prevent complications, reduce the chance of deconditioning and better support patients to be safe in their own homes. As we progress through to level 2, with the expected increase in referrals to our community services, the challenge will be to ensure that we are able to continue to deliver responsive services as demand increases. Our ability to continue these services within existing resources will be helped by utilisation of technology to fully realise the benefits of virtual assessments.

Key Issue

Mitigating the impact on COVID-19 outpatient care

The COVID-19 pandemic has forced us to change the way that we deliver outpatient care and has provided an opportunity for our clinical teams to utilise their time differently and with some unexpectedly welcome outcomes.

Prior to the implementation of level 4 lockdown rules for COVID-19, most outpatient clinics within medical sub-specialty services were face to face clinics. This involved a significant commitment from the patient both in terms of time and cost. With the widespread adoption of virtual assessments and appointment suddenly patients were able to complete their consultations from the privacy of their own home and they have loved it!

This has worked especially well for our elderly and frail patients who in general do not find it as easy to attend appointments. That said, we have also experienced increased engagement from young patients with virtual clinics and a marked decrease in DNA rates for many clinics. There is of course a risk that this level of engagement may not necessarily continue once the general population are released from lockdown and return to work but this certainly has given patients a taste of a new reality - many aspects of which can remain in place.

Clinicians have found that some telephone consultations have not taken as long as face to face appointments which has released time for them to review overdue wait lists and prioritise patients. Services are now looking at models of care where face to face appointments only being booked when clinically necessary to see someone in person.

For some services, the use of technology has been challenging. Dermatology for example tried Zoom Telehealth calls but found that the picture quality was not of a high enough standard to be able to visualise skin lesions

clearly. For others such as our Diabetes Health Psychologist, the sense is that people have opened up more readily in a remote conversation than face to face.

Most importantly, despite the challenges of lockdown, most sub-speciality outpatient appointments have been maintained with minimal disruption or delay in being seen.

Scorecard – Specialty Medicine and Health of Older People Services

Waitematā DHB Monthly Performance Scorecard

Specialty Medicine and Health of Older People
March 2020
2019/20

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	13 days	≤14 days	● ▲
Net Promoter Score FFT	83	65	● ▼
Improving Outcomes			
Patients admitted to stroke unit	71%	80%	● ▼
Acute Stroke to rehab w/in 7 days	77%	80%	● ▼
a. InterRAI assessments - LTHSS clients	*98%*	*95%*	● --
Better help for smokers to quit - hospitalised	100%	95%	● ▲
Quality & Safety			
Older patients assessed for falling risk	100%	90%	● --
Rate of falls with major harm	0.14	≤2	● ▼
Good hand hygiene practice	94%	80%	● ▲
Pressure injuries grade 3&4	0	0	● --
HR/Staff Experience			
Sick leave rate	3.3%	≤3.4%	● --
Turnover rate - external	13%	≤14%	● --
Vacancies - %	5%	≤8%	● ▼

Service Delivery

Waiting Times	Actual	Target	Trend
Urgent diagnostic colonoscopy w/in 14 days	100%	90%	● --
Diagnostic colonoscopy w/in 42 days	42%	70%	● --
Surveillance colonoscopy w/in 84 days	47%	70%	● ▲
Patient Flow			
Outpatient DNA rate	6%	≤10%	● ▲
Patients with EDS on discharge	88%	85%	● ▼

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue	7,442 k	6,563 k	● ▼
Expense	77,317 k	75,564 k	● ▼
Net Surplus/Deficit	-69,875 k	-69,001 k	● ▼
Contracts (YTD)			
Elective WIES Volumes	358	355	● ▼
Acute WIES Volumes	1,856	1,818	● ▼

How to read

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

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

Key notes

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

a. Quarterly Dec 19 latest data

A question?

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

Scorecard Variance Report

Best Care

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

In March, 60 out of 85 patients (70.6%) with Acute Stroke were admitted to a Stroke Unit. At NSH this was 39 of 54 patients (72.2%) and at WTH this was 21 of 31 patients (67.7%). A review of all patients that did not get admitted to a stroke unit has been completed. Of the 25 patients that did not get admitted to a Stroke ward; five required palliation and were not able to be accommodated on one of our stroke wards, four required input from other specialities (orthopaedics – three, cardiology – one) and were best managed on the appropriate speciality ward. Of the remaining 16, no clear reason for not being admitted to a stroke ward could be identified.

Acute Stroke to rehab with-in seven days *– 77% against a target of 80%*

In March, ten out of 13 patients (76.9%) of patients requiring rehabilitation following an acute stroke were transferred to rehab within seven days. At NSH this was six of nine patients (66.7%) and at WTH this was four of four patients (100%). A review of all patients not transferred to a rehab ward within seven days has been completed. Of the three patients that did not get transferred to rehab within seven days; one had a prolonged medical admission complicated by aspiration pneumonia which delayed their transfer to rehab, one was admitted under orthopaedics and required these issues to be resolved before transfer to rehab, for the third patient there was no clear reason to explain the delay.

Service Delivery

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

The endoscopy service did not achieve the MoH target for Normal Diagnostic Colonoscopy (70% patients seen within 42 days) and Surveillance colonoscopy (70% within 84 days) in March 2020. While some progress had been made in early March the month end result was negatively impacted by the cancellation of non-urgent elective procedure due to COVID-19. Outsourcing of procedures was also cancelled. A recovery period is expected to start in May/June following the lifting of restrictions for COVID-19.

Surveillance colonoscopy with-in 84 days *– 47% against a target of 70%*

As per above.

Compliance with patient safety checks in Adult Mental Health Ward

Ten clinical notes were randomly audited throughout from 1-31 March. The need for safety checks was correctly documented in all cases and all current risk assessments were up to date.

Waitematā DHB Priorities Variance Report

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

Areas off track for month and remedial plans
Stroke: the rehabilitation wards at NSH were closed late March in response to COVID-19 and remain closed. Rehabilitation is currently occurring on the stroke ward. **Colonoscopy:** demand for colonoscopy and gastroscopy is forecast to grow in FY2020/21 at a rate of around 10% for colonoscopy and 4% for gastroscopy. Pre COVID-19 internal production was fully utilising all of the theatre space available. Utilisation at both North Shore and Waitakere sites was routinely exceeding 90% and non-attendance rates were consistently below 3%. Grading has also been blind tested on numerous occasions to ensure it aligns with national pathways and found to have less than 5% inconsistency. This leaves little opportunity to significantly increase internal production over the forecast for the current year. There is however some potential to reduce demand. Internationally, polyp follow up recommendations are being revised in order to reflect latest evidence. The main difference is a reduction in the intensity of post-polypectomy surveillance for most groups. Under the revised guidelines some groups of patients are no longer recommended to receive surveillance colonoscopy. At this stage, we believe the revisions have the potential to re-categorise or remove around 800 people from our waitlist. We are looking at these developments with close interest and have almost completed cross-referencing our surveillance waitlist with the new guidelines to better understand the implications. In addition to the above it will be necessary for Waitematā DHB to continue with its outsourcing arrangements and engage providers early to ensure appropriate levels of access to these procedures is maintained for the Waitematā DHB population.

Financial Results – Specialty Medicine and Health of Older People

Waitematā DHB Statement of Financial Performance

Specialty Medicine and HOPS - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	621	671	(49)	6,770	6,015	755	8,027
Other Income	143	62	81	672	548	124	734
Total Revenue	764	733	32	7,442	6,563	879	8,762
EXPENDITURE							
Personnel							
Medical	2,671	2,480	(191)	18,068	17,412	(656)	23,015
Nursing	2,480	2,453	(26)	23,408	23,438	29	32,615
Allied Health	2,666	2,503	(164)	16,710	16,568	(142)	21,788
Support	0	0	0	0	0	0	0
Management / Administration	484	497	13	3,396	3,326	(70)	4,367
Outsourced Personnel	67	49	(17)	705	437	(268)	582
	8,367	7,982	(385)	62,286	61,180	(1,106)	82,367
Other Expenditure							
Outsourced Services	282	498	216	3,209	3,974	765	5,398
Clinical Supplies	1,246	958	(288)	9,739	8,572	(1,167)	11,478
Infrastructure & Non-Clinical Supplies	229	204	(24)	2,083	1,838	(245)	2,438
	1,757	1,660	(96)	15,031	14,384	(647)	19,315
Total Expenditure	10,124	9,643	(481)	77,317	75,564	(1,753)	101,682
Cost Net of Other Revenue	**(9,360)**	**(8,910)**	**(450)**	**(69,875)**	**(69,001)**	**(874)**	**(92,920)**

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

Comment on major financial variances

The overall result for Specialty Medicine and Health of Older People Service was $450k unfavourable for March and $874k unfavourable for the YTD.

Revenue ($32k favourable for Mar, $879k favourable YTD)

The favourable variance YTD was mainly due to higher volumes of bed nights qualifying for reimbursement from ACC under the Non-Acute Rehab contract. These volumes were particularly high in July-September, and January at over 1,000 bed nights per month. Historically this is unusual and not forecasted to continue.

Expenditure ($481k unfavourable for Mar, $1,753k unfavourable YTD)

The March variance was due to RMO over allocation as well as low leave taken (in part due to COVID-19) in both medical and allied staff. The YTD unfavourable variance was due mainly to high demand for mobility aids and Mental Health Services for Older Adults respite, as well as the over allocation of RMOs. Note FTE variances in this report take into account the impact of churn targets and casual usage and thus are showing as negative numbers.

Personnel ($1,106k unfavourable YTD)

Medical ($656k unfavourable YTD)

The YTD unfavourable variance is partly due low leave taken in March and an over allocation of Registrars and House Officers, which equates to 2.9 FTE over the budget. There is also unbudgeted costs for cross cover for a Registrar gap on the first rotation. Sick leave is unfavourable by $15k, and overtime is unfavourable by $2k.

Nursing ($29k favourable YTD)

Nursing is on budget YTD. Sick leave is $5k unfavourable, and overtime is $42k unfavourable. This is being offset by vacancies. Nursing FTE is 26.9 over budget, and the financial impacts of this is not seen in the division due to

the first six months of watches cost being centralised. The service is currently reviewing the AT&R watch cost to better understand the drivers and formulate a budget bid.

Allied Health ($142k unfavourable YTD)
The YTD variance is due to low leave taken and thus higher worked hours in March. Allied Health has also improved recruitment and retention over the last year, and vacancies are now at a historic low, but due to the churn target, are 3.2 FTE over budgeted levels. This is also partially due to positions employed into but not yet budgeted, including for the Early Discharge and Rehabilitation Service (EDARS) team (budget bid in place), and temporary resource for the centralised equipment team as further described below. Sick leave is $49k favourable, and overtime is $71k unfavourable.

Support and Management/Administration ($70k unfavourable YTD)
Support and Management/Administration is unfavourable as the vacancy level was slightly below the anticipated churn savings target, at 0.8 FTE over budgeted levels. Sick leave is $14k favourable, and overtime is $2k unfavourable.

Outsourced Personnel ($268k unfavourable YTD)
Outsourced Personnel is unfavourable due to unbudgeted outsourced watches in the AT&R wards and the Mental Health Services for Older Adults ward. This is partly offset by underspend in the Healthcare Assistant budget. As mentioned, the watch costs are under review at present.

Other Expenditure ($647k unfavourable YTD)

Outsourced Services ($765k favourable YTD)
Outsourced services are favourable YTD partly due to a lag in Gastro outsourced procedures being performed both due to a late start with one supplier's contract, but also due to COVID-19 preventing these procedures from being performed during Level 4 in March. Discussions are underway as to timing of the catch up in these procedures with the third party suppliers. There is also a one off prior year accrual release for NASC Respite.

Clinical Supplies ($1,167k unfavourable YTD)
Clinical Supplies is unfavourable YTD due to a higher demand for mobility aids as well as a higher demand for respite for Mental Health Services for Older Adults patients. Budget bids are in place for these items, as well as additional temporary FTE resources to help clear the backlog of long standing mobility aid rentals out in the community. The centralised equipment team track and monitor items on rental to ensure timely collection and to minimise costs. They also apply for ACC reimbursement where applicable. A review of the policy, ordering and monitoring systems for older adult respite is currently taking place.

Infrastructure and Non-Clinical Supplies ($245k unfavourable YTD)
Infrastructure and non-clinical supplies is unfavourable due to additional equipment repairs fully funded by additional research revenue.

Child, Women and Family Services

Service Overview

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

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

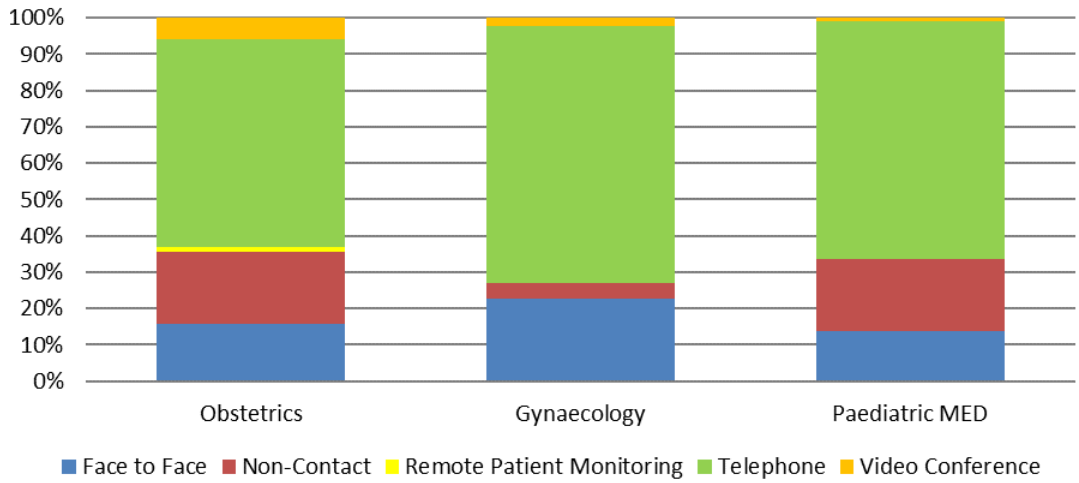
Highlight of the Month

March saw an unprecedented and exponential rise in telehealth in our division. The rapid decision to move the country to Level 4 meant that all providers had to revise how services were delivered to ensure that essential and on-going care could continue. This has resulted in rapid changes in our division and the willingness of staff to adjust and adapt their models of care delivery to continue to meet the needs of women, children and families has been impressive.

Examples of this include:

- Pregnancy and parenting education groups by zoom
- Obstetrics and Gynaecology appointments by telehealth
- Child health and child allied health appointments by telehealth

Figure 1 Percentage of appointments being delivered by mode of delivery



One example of staff adaptability included the construction of a homemade mannequin to use when demonstrating positions to parents of disabled children with complex presentations. This enabled therapists to complete needs assessments and order the appropriate equipment for the children which has significantly reduced the wait time for this equipment.

Photo of Rona (positioning assistance mannequin)

Despite the extreme restriction on mobility in Lockdown Level 4, care has continued to be delivered throughout the division due to the willingness of staff and families to innovate.

As we move away from the acute phase of the response we will be able to examine the innovations more closely and decide what aspects could be implemented into usual care, and what safeguards should be implemented to ensure equity of access.

Key Issues

Impact of COVID-19 on the provision of the Auckland Regional Dental Service

Oral health practitioners were notified by the Ministry of Health and Dental Council to suspend all non-essential and elective dental treatment from 23 March 2020. This is because, unlike other services, the majority of dental procedures (including examinations) use aerosol generating procedures. These include the use of dental hand pieces, sonic and ultrasonic instruments and air/water syringes.

Only essential emergency treatment which includes: telephone triage and advice; limited treatment of children in severe pain; and referral of non-cooperative children for emergency hospital and specialist dentistry has been provided.

The combined Dental Council and Ministry of Health guidance under COVID-19 alert level three was issued on 22 April 2020. This advised that dental services must continue to limit service provision following the same restrictions as under alert level four.

Dental Council and Ministry of Health guidance for operation under COVID-19 alert level two has yet to be released. However, is anticipated that there will continue to be restrictions in service provision.

ARDS has therefore been unable to offer any routine services to children since 23 March 2020. This has resulted in a significant increase in the number of children in arrears - as at 8 May 2020, there are 135,290 children who are overdue an appointment (this represents a 5% increase).

The service is currently working on a strategy to maximise the number of children that can be safely seen within the current and anticipated guidance.

Appointments will only be offered to highest priority children based on clinical criteria set by ARDS Clinical Leads aligning with the Dental Council New Zealand (DCNZ) and the Ministry of Health (MOH) guidelines. Resources (staff and equipment) will be re-distributed to our highest needs communities in each DHB.

1. **Unscheduled appointments (that is, children in pain or where there is immediate urgent concern about their teeth)**
   The service will continue to offer advice over the phone to parents/caregivers of children who are in pain or where there is immediate concern about their teeth. It is anticipated that in alert level 2 the triaging therapists will be able to offer the child an assessment appointment, and triaging clinics will be located in Albany clinic and Green Lane clinic to start with.

2. **Priority children**
   As a first phase children with an extraction on their current open treatment plan, or who are identified as requiring an extraction as a result of the telephone triaging during COVID-19 levels 3 and 4, will be prioritized. Clinicians are reviewing the clinical records of these children and assigning them a priority rating. Sixteen clinics will be operating initially with more opened as required. Eight clinics in Counties Manukau DHB, four clinics in Waitematā DHB (Glenfield, Silverdale, Henderson, Glen Eden), and four clinics in Auckland DHB

3. **Telehealth assessments**
   Parents/caregivers of children between six and 12 months will receive a telehealth appointment. This enables early intervention oral health promotion at a time when the first teeth are appearing. A caries risk assessment will be completed, and the parents/caregiver will be able to raise concerns or questions they have around infant oral health. This also provides an opportunity to update contact details.

4. **Fluoride varnish and examinations at pre-schools**
   Children aged from 12 months who attend kōhanga reo, language nests and pre-schools with high enrolments of Māori and Pacific children will be seen in their centre for an examination and fluoride varnish application. This is an extension of the current model of care for fluoride varnish and enables an examination in addition to the application. This programme will be started in centres where we already have an existing relationship. Centres will then be added on a priority needs basis.

5. **Data Quality**
   Staff not engaged in clinical care will continue to work on data cleaning and quality.

Scorecard – Child, Women and Family Services

Waitematā DHB Monthly Performance Scorecard

Child Women and Family Services and Elective Surgery Centre

March 2020

2019/20

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	96%	95%	

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	8 days	≤14 days	
Net Promoter Score FFT	77	65	
Improving Outcomes			
Exclusive breastfeeding on discharge	76%	75%	
Women smokefree at delivery	95%	95%	
Better help for smokers to quit - hospitalised	95%	95%	
a. Oral health - % infants enrolled by 1 year	97%	95%	
a. Oral health - exam arrears 0-12 yr	44%	≤10%	
Quality and Safety			
Good hand hygiene practice	93%	80%	
HR/Staff Experience			
Sick leave rate	3.9%	≤3.4%	
Turnover rate - external	12%	≤14%	
Vacancies - %	4.9%	≤8%	

Service Delivery

	Actual	Target	Trend
Elective Volumes			
CWF Services	112%	100%	
Waiting Times			
b. Gateway referrals waiting over 8 weeks	*2*	*5*	
Patient Flow			
Outpatient DNA rate	9%	≤10%	
Theatre utilisation Gynaecology	79%	85%	
Patients with EDS on discharge	92%	85%	
a. Oral Health - chair utilisation	10.0	11	

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue	6,397 k	6,851 k	
Expense	73,884 k	73,182 k	
Net Surplus/Deficit	-67,487 k	-66,331 k	
Contracts (YTD)			
Gynaecology Elective WIES (excl ESC)	849	724	
Gynaecology Acute WIES	1,087	1,066	
Maternity WIES	5,994	5,790	
Paediatrics WIES	1,319	1,378	
Neonatal WIES	1,651	1,814	

How to read

Performance indicators:

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

Trend indicators:

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

Key notes

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

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

A question?

Contact:

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

Planning, Funding and Health Outcomes, Waitematā DHB

Scorecard Variance Report

Best Care

Oral health exam arrears 44% against a target of 10%

All non-urgent dental treatment was ceased by the Ministry of Health in response to the potential for cross infection. This has significantly increased arrears. The team are focused on a recovery plan that prioritises those most at risk of dental disease.

Sick leave 3.9% against a target of 3.4%

All sick leave is monitored and individual staff members supported to return to work as able. COVID-19 occupational health advice saw more staff members on sick leave than is usual.

Service Delivery

Theatre utilisation for gynaecology 79% against a target of 85%

Reduction in theatre sessions as a result of COVID-19 preparations reduced access to theatre.

Oral Health – Chair utilisation 10 against a target of 11

All non-urgent dental treatment was ceased by the Ministry of Health in response to the potential for cross infection. This has significantly increased arrears. The team are focused on a recovery plan that prioritises those most at risk of dental disease.

Value for Money

Revenue 6,397k against a target of 6,851K

The service has under delivered in terms of meeting funded budget obligations for this service direct funding. This has been a combination of reduced fee for service Colposcopy and Respite activity due to fewer referrals, delays in the initiation of new service level agreements due to resourcing requirements and the impact of a ceased contract that is in the process of being removed from the budget.

Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Review the regional midwifery workforce plan	Jun 2020	✓
Support new graduates by providing dedicated clinical coach support in the first year of practice	Jun 2020	✘
Implement recently revised maternity model of care, including: • additional staffing • best quality learning experiences to undergraduate students • Quality Leadership Programme for all core midwives	Jun 2020	✘
Implement the regionally agreed Midwifery Workforce Plan, which includes: • flexible (24/7) student placements • joint appointment of clinical coaching roles to support undergraduate and newly qualified midwives (with AUT) • focus on study pathways and continue investment to support Māori and Pacific students (EOA)	Jun 2020	✘
Continue to ensure that all midwives operate to their competencies and to a full scope of practice (this is business as usual)	On-going	✓

Areas off track for month and remedial plans
COVID-19 has changed the health landscape and the spending priorities for the DHB. It is unclear whether CCDM will progress at this stage and the additional support for the new graduate midwives has not been progressed at this point.

Financial Results - Child, Women and Family Services

Waitematā DHB Statement of Financial Performance

Child Women and Family - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	665	706	(41)	5,692	6,087	(395)	8,205
Other Income	49	75	(27)	705	763	(58)	990
Total Revenue	714	781	(67)	6,397	6,851	(454)	9,195
EXPENDITURE							
Personnel							
Medical	2,375	2,170	(205)	15,651	15,343	(309)	20,150
Nursing	2,455	2,286	(169)	23,397	22,626	(771)	31,122
Allied Health	3,000	3,277	277	20,014	21,947	1,933	28,792
Support	30	36	5	218	231	14	310
Management / Administration	568	596	28	3,880	3,727	(153)	5,009
Outsourced Personnel	222	111	(111)	1,555	982	(574)	1,306
	8,651	8,476	(175)	64,715	64,856	141	86,689
Other Expenditure							
Outsourced Services	39	46	8	463	411	(52)	547
Clinical Supplies	567	517	(50)	4,753	4,622	(131)	6,138
Infrastructure & Non-Clinical Supplies	350	366	15	3,954	3,293	(660)	4,367
	956	929	(27)	9,169	8,326	(843)	11,052
Total Expenditure	9,607	9,405	(202)	73,884	73,182	(702)	97,742
Cost Net of Other Revenue	**(8,893)**	**(8,623)**	**(270)**	**(67,487)**	**(66,331)**	**(1,156)**	**(88,546)**

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

Comment on major financial variances

The overall result for CWF was $270k unfavourable for March and $1,156k unfavourable for the YTD.

Revenue ($67k unfavourable for March $454k unfavourable YTD)

The unfavourable month and YTD variance reflects reduced Colposcopy activity including a one off $76k adjustment relating to 2018/19, a shortfall in fee for service respite activity, a delay in the commencement of the ARDS Free Oral Health Service for Pregnant Women in Tamaki service level agreement and a ceased ARDS pre-school contract.

Expenditure ($202k unfavourable for March $702k unfavourable YTD)

The YTD unfavourable position was due to high demand for Maternity and Neonatal inpatient services, covering gaps in maternity rosters, ARDS clinical equipment maintenance, processing of aged invoices and staff claims, high dental supplies costs, patient laundry and food expenses. These costs are being partly offset by dental service vacancies.

Personnel ($141k favourable YTD

Medical ($309k unfavourable YTD)

The unfavourable variance is predominately Obstetrics and Gynaecology demand driven with acute and Elective activity along with support for a junior registrar workforce. Acute activity remains at 102% of contract WIES with Electives at 117% of contract WIES.

Nursing ($771k unfavourable YTD)

The unfavourable variance was due to ongoing variable demand for Neonatal services and high Maternity caesarean section and antenatal assessment demand resulting in roster gaps currently being covered by expensive overtime. A recent strategy to increase part time staff contract hours to reduce the overtime impact is

continuing to yield benefits through reduced overtime hours. The service will also recruit 11 new graduate midwives in April and once orientated will help ease some of these cost pressures. Maternity acute activity tracks at 105% of contract WIES YTD.

Allied Health ($1,933k favourable YTD)
The favourable variance was due to ongoing therapist and therapy assistant vacancies across ARDS. It is also inclusive of under spends associated with a delay in the start of budgeted service level agreements for Free Oral Health Service for Pregnant Women in Tamaki (ARDS) and Child Development Service Northern Region Expansion Programme.

Support and Management/Administration ($139k unfavourable YTD)
The unfavourable variance is associated with an FTE reduction initiative particularly across ARDS from July 2019 through to February 2020.

Outsourced Personnel ($574k unfavourable YTD)
The unfavourable variance was due to medical locum and after hours cover along with external nursing costs associated with increased service demand and for vacancies where internal cover options are not available.

Other Expenditure ($843k unfavourable YTD)
Outsourced Services ($52k unfavourable YTD)
The unfavourable variance was due to delayed invoicing of Urodynamic Studies activity from 2018/19 and the outsourcing of postnatal care due to bed capacity and/or safe staffing levels within the North Shore Hospital Maternity Facility.

Clinical Supplies ($131k unfavourable YTD)
The unfavourable variance remains solely driven by increased patient demand across ARDS, Community Child Nursing and Neonatal services and includes dental supplies, continence and hygiene supplies and syringe, needles and sharps products.

Infrastructure and Non-Clinical Supplies ($660k unfavourable YTD)
The unfavourable variance to date is a combination of ARDS repairs and maintenance and cleaning outsourced costs, staff uniforms, demand driven food and groceries across both Maternity facilities, new ARDS titanium license fees and motor vehicle repairs and maintenance charges across the division.

Specialist Mental Health & Addiction Services

Service Overview

This service is responsible for the provision of specialist community and inpatient mental health services to Waitematā residents. This includes child, youth and family mental health services, adult mental health services including two acute adult in-patient units, community alcohol, drug and other addiction services across the Auckland metro region, Whītiki Maurea providing mental health services to Waitematā residents and addiction services across metro-Auckland, Pasifika Peoples mental health services and regional forensic services that deliver services to the five prisons across the northern region as well as eight in-patient villas and a regional medium secure Intellectual Disability unit including an intellectual disability offenders liaison service. Mental Health and Addiction services has around 9,000 active clients in our care at any point in time. Less than 1% of these clients would be in an inpatient unit. This means 99% of the clients in our care are living in the Community.

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

Highlight of the Month

1) Development of Clinical & Support Outreach for people in Emergency Housing who access Mental Health Services:

The Specialist Mental Health and Addiction services are developing a collaborative outreach offering clinical and support interventions to service users in Non-Government Organisation Housing Support Providers, Vision West and Kahu Tu Kaha, in response to the COVID-19 pandemic crisis.

The Non-Government Organisation Housing Support Providers initiated placements for people identifying as "rough sleepers" in contracted motels and hotels across the Auckland region. Over the past month, mental health services within the Urgent Care Centres at the Waitematā District Health Board have seen an increasing number of people, particularly on the North Shore, where there are approximately 100 placements.

The collaborative operates across Specialist Mental Health and Addictions services as well as Cultural Services. The Non-Government Organisation support teams provide interventions aimed at assisting with management of acute mental health/alcohol and other drug issues, cultural and social needs support.

2) Medical Detox Covid-19 response:

The Medical Detox Inpatient Unit in Point Chevalier, which serves the Metro Auckland region with 10 funded (11 actual) beds, has been closed during COVID-19 in response to the Ministry of Health direction to defer all elective admissions.

Nurses from both the in- and out-patient teams were re-deployed to the community CADS units (Manukau, Takapuna, Henderson, Pitman/Central) to provide closer to home managed withdrawal and direct support to all health organisations needing medical and nursing detox expertise.

We implemented a rapid step-down pathway to assist hospitals (taking over care after 24-76 hours within a general hospital bed) to continue detox in the community (in clients' homes) in a new seven-day detox support model with greater emphasis on tele-support (zoom, phone) and email support before, during and after detox. This included the implementation of an innovative group programme including daily online zoom groups for those undergoing and having completed a managed withdrawal. We also provided in-reach/consult-liaison nursing and medical capability to three District Health Board hospitals, Emergency Departments, mental health services via

zoom, phone, in-services and in person (Non-Government Organisations had largely stopped taking new admissions).

Since the lockdown, the Community Drug and Alcohol Service (CADS) received 129 referrals for managed withdrawal and 57 clients have undergone managed withdrawals of which:

- 48 relate to alcohol, nine other (five benzos, three meth, two opioids, one GHB, one cannabis)
- 39 European, five Māori, nine Other European, four Other.
- 24 Auckland DHB domiciled, 19 Waitematā DHB, 14 Counties Manukau DHB.

Clinically we learned:

- We can detox more people at home than we thought by using virtual/tele-health, whānau support and pharmacies
- Medication doses were lower and treatment was matched to client need
- Presence at the Community Alcohol and Drug Services units allowed rapid response to the local community and health services
- Of the need for a full consult liaison addiction service to support clients presenting with addiction as a secondary diagnosis.

Community Alcohol and Drug Services Consumer Liaison contacted clients who had had a medically managed withdrawal during COVID 19. They said:

> *"Assessment on the phone, medication was dropped at the door. It was great - it nipped it in the bud before drinking got out of control, as has happened in the past".*
>
> *"Detoxed started three weeks ago and nurse is still calling twice a week to check with me".*
>
> *"CHDS have gone out of their way during this time" (This client has been with the service long term with multiple admissions. The client was able to receive service very close to their lapse before they had deteriorated.)*
>
> *"I was more comfortable at home as I have children and have always found it more stressful to be away from them and have someone else look after my autistic daughter, so I was much more relaxed". (This client had done an IPU stay in the past but had found it very difficult for her and her daughter worrying about each other the whole time.)*
>
> *"The information was sent via email which was great because I can now refer back to it much more easily and have several times".*
>
> *"Helpful, supportive and understanding, felt heard and listened to, really appreciated the contact – it made the weekend more bearable at the end of detox" (re: contact over the weekend in the new 7-day support model).*

Key Issues

Obstacles for flow through Inpatient services due to lack of options for people with complex needs.

There continues to be a concern regarding the long stay patients in the Adult Inpatient Units with some of these patients' length of stay exceeding 12 months. The issues such as diversity and amount of supported accommodation for people with complex needs in the community, coupled with limited funding streams such as Intellectual Disability, some patients continue to be unable to gain access to long term supported living options. The increased length of stay significantly reduces the capacity of the units to admit people requiring acute admission, with increased pressure on Emergency Departments in both hospitals. Also, the impact of not having access to appropriate Emergency Department assessment rooms due to COVID-19 has impacted on flow.

We continue working with Funders, Taikura Trust and Local Co-ordination Services (LCS) to put packages is place for individuals as well as working with Accident Compensation Corporation (ACC) and Non-Government

Organisation providers. Also, we continue working with Emergency Departments around suitable rooms for assessment and a timeframe for access with a more sustainable plan going forward.

One size doesn't fit all:
Specialist Mental Health and Addiction Services have been reviewing some of the innovative ways we have delivered services over the last few weeks, for example we have set up urgent care centres, linking with our Non-Government Organisation colleagues to facilitate peer support and many staff embracing technology. Feedback from some service users around technology has been positive explaining that they felt they were connecting with others more using Zoom. Whilst this has worked well across some teams, others have had varied responses. In particular the Māori and Pacifica services, service users and whānau/family preferred the face to face contacts and interactions.

Surveys are under way to gauge what has worked well (or was not as successful) to guide changes in future service provision.

Scorecard – Specialist Mental Health & Addiction Services

Waitematā DHB Monthly Performance Scorecard
Specialist Mental Health and Addiction Services
March 2020
2019/20

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	67%	80%	--

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	47 days	≤14 days	▼
Improving Outcomes			
Better help for smokers to quit	98%	95%	--
Seclusion use Forensics - Episodes	51	≤14	▼
Seclusion use Adult - Episodes	4	≤5	▼
Adult Inpatient Unit AWOL (clients)	1	≤1	▼
Forensic Unit AWOL (clients)	1	≤1	▼
c. CTO - Māori (Rate per 100,000)	*323*	*≤274*	
High Care Area/ICU 15 min observations	100%	95%	--
a. MH Access Rates 0-19 years (Total)	*3.77%*	*3.49%*	▼
a. MH Access Rates 0-19 years (Māori)	*5.19%*	*4.70%*	▼
a. MH Access Rates 20-64 years (Total)	*3.73%*	*3.43%*	▲
a. MH Access Rates 20-64 years (Māori)	*9.27%*	*7.80%*	▲
HR/Staff Experience			
Sick leave rate	3.7%	≤3.4%	--
Turnover rate - external	10%	≤14%	--
Vacancies - %	7%	≤8%	--

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue	12,297 k	11,058 k	▲
Expense	110,946 k	110,645 k	▼
Net Surplus/Deficit	-98,649 k	-99,587 k	▼

Service Delivery

Waiting Times (latest available)	Actual	Target	Trend
a. Adult (20-64) <3 weeks	*83%*	*80%*	--
a. CADS (0-19) <3 weeks	*90%*	*80%*	--
a. CADS (20-64) <3 weeks	*96%*	*80%*	--
CYF <3 weeks	100%	95%	--
a. Forensic (20-64) <3 weeks	*84%*	*90%*	▼
Prison inpatient waiting list	2	0	▼
b. Patient Flow			
Bed Occupancy - Adult Acute	89%	80-90%	--
Bed Occupancy - CADS Detox	94%	80-90%	--
Bed Occupancy - Forensics Acute&Rehab	101%	80-90%	▲
Bed Occupancy - ID	86%	80-90%	--
Community Care			
Preadmission community care - adult	66%	75%	▼
Post discharge community care - adult	78%	90%	▲
Clinical contact directly with consumer - adult	85%	80%	▲
Clinical contact directly with consumer- CADS	89%	80%	▼
Clinical contact directly with consumer - CYF	89%	80%	--
Clinical contact directly with consumer - Forensic	73%	80%	--
Whanau contacts per service user - adults	52%	70%	▼
Whanau contacts per service user - child	100%	80%	--
Whanau contacts per service user - youth	100%	80%	--

How to read

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

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

Key notes

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

a. Reported approx 3 months in arrears (Jan data).
b. Rolling 3 month indicator
c. Quarterly, latest avail Sep 19

A question?

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

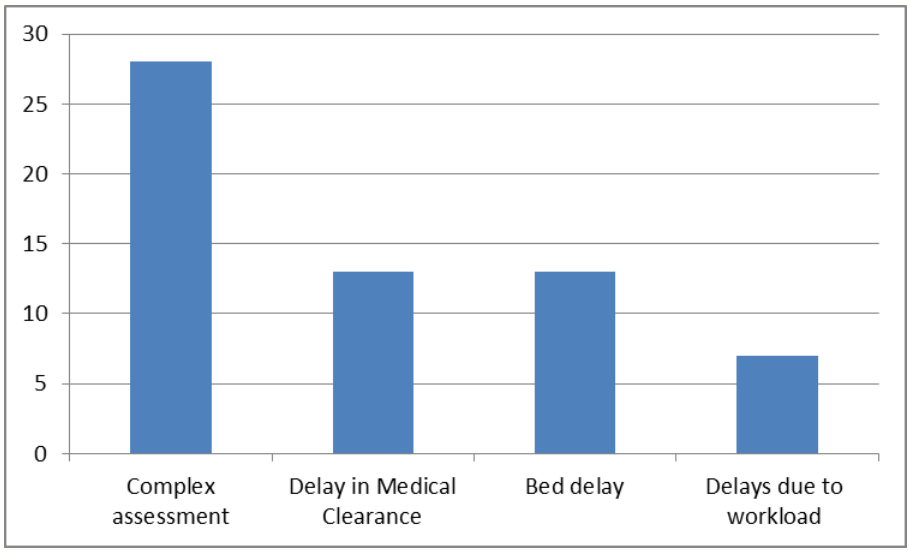
Scorecard Variance Report

Priority Health Outcome Areas

Shorter Waits in ED – 67% against 80%

Following reviewing the reasons for ED breaches, these can be broken down into the following areas:

Reasons for MH Breaches in WDHB from 1st March 2020 to 19th April 2020



It is often identified that the key issue for people waiting in Emergency Departments is that they are waiting for a Mental Health bed to become available. However, in reviewing the reasons for breaches, by far the majority are related to the complexity of assessment followed by delays in waiting for medical clearance. It is notable that with the Urgent Care Centres coming to a close at the end of May, it is likely that more people will be seen in the Emergency Departments and the number of breaches will increase. Further review on delays that are due to workload and bed availability will be undertaken over the next month.

Best Care

Complaint Average Response Time - 47 days against a target of ≤ 14 days

The complaint response time remained within or close to target for some time now. The high average complaint response time in March was due to one complaint to Community Drug and Alcohol Services from December 2020. The complainant requested a face to face meeting to resolve the complaint. Unfortunately this meeting was rescheduled multiple times to accommodate the complainant, the HDC advocate and the manager involved, and was eventually held on 13 March 2020. There was contact with the complainant throughout this period. Excluding this complaint, the average response time was 14 days.

Seclusion use for Forensics – Episodes – 51 against a target of <14

There were four service users who continued to present as acutely unwell over the month of March. They contributed to multiple episodes for example 26 episodes for one service users in Totara. The other episodes were spread across Pohutukawa, Te Aka and Kauri.

CTO – Māori (Rate per 100,000) (323 compared to target of < 274)

It is proposed that this target be removed from the scorecard. The data is received from the Ministry of Health as a rolling year's data, usually several months behind and therefore not suited for the purposes of a scorecard. This is an annual plan target and the related improvement activity is captured on the Priorities Variance section of this report.

Sick leave rate – 3.7% against a target of <3.4%

We continue working at reducing sick through various ways including on-going discussions and developing management plans with staff with low sick leave balances and general reminder to all staff on importance of maintaining adequate sick leave balances and supports that are available. We also work with the unions on supporting staff around appropriate sick leave and annual leave management.

Service Delivery

Forensic (20-64) <3 weeks – 84% against a target of 90%

The decrease of new referrals seen face to face within three weeks is COVID-19 related due to reduced access to prisons brought about by the Department of Corrections in National Alert Levels 3 and 4. This trend will likely continue during April and May.

Prison inpatient waiting list – 2 against a target of 0

Both these prisoners are sub-acute and are not considered to require an urgent admission. During the time on the wait list, both prisoners' mental health care needs continue to be addressed by the forensic prison team.
Bed occupancy has exceeded capacity due to very high demand from Courts and Prisons and difficulty with finding safe and sustainable places to discharge those with enduring psychiatric and cognitive disability. The Service cannot directly influence the demand from Courts and Prisons but maintains good working relationship with both those stakeholders and are always working to find better ways of meeting mental health needs of those in custody.

Patient Flow

Bed Occupancy – Forensics Acute and Rehabilitation – 101% against a target of 90%

The Service continues to have supernumerary ID contracted beds. This is on the Risk Register and a dialogue has begun with the Ministry of Health in relation to the purchase of additional substantive ID beds.

The Service anticipates improved capacity for discharge with re-opening of Kaupapa Maori step down beds in August 2020. This should relieve some of the inpatient pressures and occupancy rates are expected to fall.

Community Care

Preadmission community care – adult – 66% against 75%

This is due to the changes in the way that follow up occurred in relation to restrictions as a result of COVID-19. Whilst follow up did occur via zoom sessions and phone calls, the usual face to face meetings were not occurring. This will be mitigated as the national alert levels reduce and more face to face contact occurring.

Post discharge community care – adult – 78% against 78%

This measures face to face seven day post discharge contact only. This has increased by 2% from last month's reporting data. Anecdotally the reasons for the increase are due to a focus on more essential work across the service as part of the COVID-19 response. This has resulted in the post seven- day discharge follow up being prioritized.

Clinical contact directly with consumer – Forensics – 73% against a target of 80%

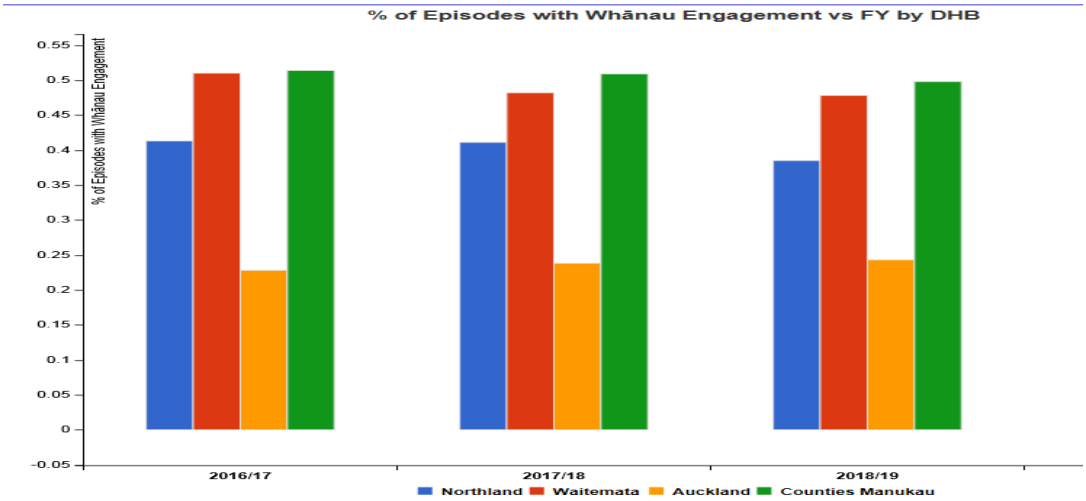
This has not decreased from February month reporting which is positive given going into lockdown 25.3.20. Alert Level 4 and 3 resulted in a reduced contact with service users, with only face to face occurring when required by ministerial warrants, or clinical need required and limited to nursing and medical staff to reduce possibility of contact with COVID-19 patients, however actual clinical time spent with service users increased, with changes to travel times and individual sessions. Certain specific clients had increased daily contact due to issues relating to stressors around lockdown or deteriorating mental health.

Limits imposed by NGOs' own COVID-19 lockdown restrictions also had an impact on contacts with service users.

Allied Health staff either phone contact or remained in the office completing documentation updates or planning for reduction in community lockdown levels. No therapeutic groups occurred due to lock down, this included psychology, OT and AOD sessions, which further impacted in contact numbers. Most contact remained as phone calls during this period, with an adapted business as usual for most of April and May.

Whanau contacts per service user- adult- 52% against 70%

Regionally WDHB is comparable with CMDHB in relation to Whanau Engagement and contacts, with the highest rating for whānau contacts in NZ.



Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Inquiry into mental health and addiction Working in partnership with all stakeholders to build an integrated approach to mental health, addiction and wellbeing in response to He Ara Oranga		
Embedding a wellbeing focus Collaborate with schools to expand access to programmes led by Child Youth and Family Mental Health services on school sites, including those with high Māori and Pacific populations (EOA); expand the programme to two further schools	Jun 2020	✓
Building the continuum/increasing access and choice Increase access to Pacific children and youth by receiving referrals from NGOs, existing services, and Pacific parents who are clients of mental health and addictions services, consistent with the Takanga A Fohe service delivering a family-inclusive service; evaluate outcomes, including youth and family feedback	Dec 2019	✓
Review current primary care liaison programmes with a view to expanding effective programmes	Dec 2019	✓
Crisis Response Improve the consistency of crisis team responses and grow staff capability in standardised assessment tools and evidence-based brief interventions across all population groups	Jun 2020	✓
Workforce Develop a centralised workforce capability database to track staff training initiatives progress, including cultural competency training for working with Māori and Asian patients (EOA)	Dec 2019	✓
Forensics Provide a summary of existing workforce development plans or programmes within Waitematā DHB and work to expand the volume and capability of the forensic specialist staff group	Summary by Sep 2019; expansion by Dec 2019	✖ Awaiting guidance from MoH re Wellbeing budget

DHB activity	Milestone	On Track
Confirm the establishment of any new roles allocated to Waitematā DHB during 2019/20, including risks identified, mitigated, and any impact on other essential services	Jun 2020	✘ Awaiting guidance from MoH re Wellbeing budget
Contribute as appropriate to the MoH Forensic Framework project to identify an agreed Forensic model of care, including provision of kaupapa Māori services (EOA)	Ongoing	✓
Population mental health Actions to improve population mental health and addiction, particularly in our priority populations		
Implement phase II of Supporting Parents Healthy Children	Dec 2019	✓
With Equally Well sector partners, determine and plan an appropriate response to Māori and Pacific with enduring co-morbid health issues (EOA)	Dec 2019	✓
Continue to reduce Māori compulsory treatment order rates (EOA)	Ongoing	✓
Mental health and addictions improvement activities Actions to support an independent and high quality of life in our population		
Participate in the HQSC project to improve service transitions to primary care by ensuring transition plans/discharge letters contain a follow-up plan (with a copy to the person concerned); this activity is supported across all services, including kaupapa Māori and Pacific mental health and addiction services (EOA)	Nov 2019	✓ In progress – timeframe extended by HQSC
Minimise restrictive care through engagement in HQSC Zero Seclusion project activities, with a focus on the regional forensic services, which has a high prevalence of Māori patients (EOA)	Sep 2019	✓ In progress – timeframe extended by HQSC
Participate in the HQSC project to reduce the occurrence of serious adverse events through ensuring learnings are introduced into clinical practice in a responsive manner, including Māori and Pacific representation in the adverse event investigation and recommendation process (EOA)	Dec 2019	✓ In progress – timeframe extended by HQSC
Participate in the HQSC project to improve physical health	Jun 2020	✘ Deferred by HQSC
Addiction Actions to support an independent and high quality of life in people with addiction issues, particularly priority groups		
Increase access to Māori kaupapa addiction services for Māori who are in community probation services (EOA)	Jun 2020	✓
Improve access for Pacific youth with substance use issues; establish a consult-liaison relationship with 5 schools across Auckland with high proportions of Pacific students (EOA)	Jun 2020	✓
Identify an appropriate outcome measure for Maternal Mental Health specialist services, ensuring cultural acceptability to Māori and Pacific (EOA)	Jun 2020	✓

Financial Results – Specialist Mental Health & Addictions Services

Waitematā DHB Statement of Financial Performance

Specialist Mental Health and Addiction - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	1,088	995	92	9,907	9,207	700	12,149
Other Income	290	227	63	2,389	1,851	538	2,518
Total Revenue	1,377	1,223	155	12,297	11,058	1,239	14,668
EXPENDITURE							
Personnel							
Medical	3,265	3,462	197	21,746	23,887	2,140	31,408
Nursing	5,196	4,917	(279)	48,204	47,339	(866)	65,173
Allied Health	4,039	3,735	(304)	25,036	24,941	(95)	32,615
Support	199	186	(13)	1,311	1,198	(113)	1,593
Management / Administration	782	730	(53)	5,098	4,976	(122)	6,561
Outsourced Personnel	263	187	(75)	2,653	1,669	(985)	2,167
	13,744	13,217	(527)	104,048	104,009	(39)	139,516
Other Expenditure							
Outsourced Services	12	13	1	98	112	14	149
Clinical Supplies	106	107	0	714	947	233	1,260
Infrastructure & Non-Clinical Supplies	628	629	1	6,085	5,577	(508)	7,423
	746	748	2	6,897	6,636	(262)	8,831
Total Expenditure	14,490	13,965	(525)	110,946	110,645	(301)	148,347
Cost Net of Other Revenue	**(13,112)**	**(12,742)**	**(370)**	**(98,649)**	**(99,587)**	**938**	**(133,679)**

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

Comment on major financial variances

The overall result for SMHA was $370k unfavourable for March and $938k favourable for the YTD.

Revenue ($155k favourable for March, $1,239k favourable YTD)

The favourable variance for March was due to a combination of additional revenue for service users with high care needs (intellectual disability) in the Pohutakawa ward of the Mason Clinic. The MOH provides additional funding in recognition that the level of care needed far exceeds what is provided in our base level funding. Revenue for court reporting continued to be higher than budgeted volumes due to high levels of activity (which is not expected to continue).

Expenditure ($525k unfavourable for March, $301k unfavourable YTD)

The unfavourable variance for March was mainly due to additional nursing and allied health costs, offset by medical positions not yet recruited into. Overtime remains an issue though driven more in March by acuity than by vacancies. The unfavourable YTD in Non-Clinical supplies is mainly due to independent consultant reports following major adverse incidents and cover for Divisional Lead, with additional repairs & maintenance.

Personnel ($452k unfavourable for March and $946k favourable YTD)

Medical ($2,140k favourable YTD)

The favourable variance was due to vacancies, 14.0FTE in March and an average of 13.9FTE YTD.

Nursing ($866k unfavourable YTD)

The unfavourable variance was due to 78.0FTE nursing vacancies in March and an average of 92.0FTE YTD offset by substantial overtime and the use of Healthcare Assistants to support gaps in Registered Nursing positions. The

tail of March also saw the beginning of COVID-19 stand downs and changes to service provision resulting in roster gaps.

Allied Health ($95k unfavourable YTD)
The unfavourable variance was due to COVID-19 stand downs and backfill requirements.

Other Expenditure ($2k favourable for March, $262k unfavourable YTD)

Outsourced Services ($985k unfavourable YTD)
The unfavourable variance was due to the use of locums to cover medical vacancies along with outsourced forensic court reporting due to increased volume of court reports.

Clinical Supplies ($233k favourable YTD)
This was favourable due to underspend in the Flexifund worth $241k and is expected to be utilised in the coming months.

Infrastructure and Non-Clinical Supplies ($508k unfavourable YTD)
The unfavourable variance was mainly due to Consultant resource to support the five independent In Patient Unit (IPU) reviews ($133k) cleaning and food ($112k), facility charges and outsourced maintenance ($226k).

Surgical and Ambulatory Services/Elective Surgical Centre

Service Overview

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

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

Highlight of the Month

The demands of COVID-19 have seen a huge level of change over a very short period of time. It has been both energising and rewarding to see all staff in Surgical and Ambulatory Services pull together, collaborate, problem solve and demonstrate flexibility with the sole aim of providing the best service possible for patients given the unprecedented circumstances . The service has ensured a clinically targeted approach to scheduling P1 and P2 clinically urgent patients during the COVID-19 period and there has been improvement in waiting times for some of these patient cohorts. Changes within the division have been rapid during this period, the development of the surgical short stay is one area that has improved flow, patient experience and length of stay for surgical patients. This will require review in the coming months to ensure it remains fit for purpose and is achieving the expectations set out for this new initiative.

Key Issues

- Deteriorating ESPI 2 and 5 position across all surgical services, most pronounced in Orthopaedics due to the cessation of all elective orthopaedic surgery from 27 March
- The reconfiguration of ESC into an ICU for COVID-19 patients and a ward for COVID-19 patients has reduced elective theatre and inpatient ward capacity. Planning is underway to return ESC theatres and ward to full operating capacity from 25 May. ESC Point of Care/Fee For Service (POC/FFS model) suspended for COVID-19 capacity which needs to be reviewed and progressed as soon as possible. Potential increased sick leave due to COVID-19 case definition that may impact on S&A ability to deliver services.

Scorecard - Surgical and Ambulatory and Elective Surgical Centre

Waitematā DHB Monthly Performance Scorecard

Surgical and Ambulatory Service / Elective Surgery Centre

March 2020

2019/20

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	93%	95%	

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	8 days	≤14 days	
b. Complaint Average Response Time - ESC	*7 days*	*≤14 days*	
Net Promoter Score FFT - S&A	84	65	
Improving Outcomes			
Better help for smokers to quit - hospitalised	100%	95%	
a. #NOF patients to theatre w/in 48 hrs	100%	85%	
Skin Abscess - median LOS hrs	27	≤24	
Laproscopic Cholecystectomy - median LOS hrs	86	≤48	
Laparoscopic Appendicectomy - median LOS hrs	49	≤36	
Quality & Safety			
Older patients assessed for falling risk	100%	90%	
Occasions insertion bundle used	100%	95%	
Good hand hygiene practice	93%	80%	
ICU - rate of CLAB per 1000 line days	0.6	≤1	
HR/Staff Experience			
Sick leave rate	3.3%	≤3.4%	
Sick leave rate - ESC	4.2%	≤3.4%	
Turnover rate - external	13%	≤14%	
Turnover rate ESC - external	12%	≤14%	
Vacancies - %	4%	≤8%	

Service Delivery

	Actual	Target	Trend
Elective Volumes			
Provider Arm - Overall	94%	100%	
Surgical and Ambulatory Services	95%	100%	
Elective Surgical Centre - ESC (YTD)	94%	100%	
Elective Surgical Centre - ESC (month)	79%	100%	
Patient Flow			
Outpatient DNA rate (S&A)	7%	≤10%	
Theatre utilisation - NSH	89%	85%	
Theatre utilisation - WTH	80%	85%	
Theatre utilisation - ESC	90%	85%	
Patients with EDS on discharge	91%	85%	
Day of surgery cancellations	5.6%	6%	

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue	7,911 k	7,244 k	
Expense	135,101 k	132,325 k	
Net Surplus/Deficit	-127,190 k	-125,080 k	
Contracts (YTD)			
Elective WIES Volumes - S&A	5,376	5,973	
Elective WIES Volumes - ESC	4,671	4,988	
Acute WIES Volumes - S&A	11,790	11,398	

How to read

Performance indicators:

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

Trend indicators:

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

Key notes

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

a. Coding dependent

b. Sep 17 data - no complaints since

A question?

Contact:

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

Planning, Funding and Health Outcomes, Waitematā DHB

Scorecard Variance Report

Best Care

Skin Abscess Median LOS *– 27 hours against a target of ≤24*

This has significantly improved from the January result of 40 hours. We do expect to see a further drop due to an increase in acute capacity as part of our COVID-19 response and the Surgical ADU model.

Laparoscopic Cholecystectomy Median LOS *– 86 hours against a target of ≤48*

This is slightly above the January result of 79 hours. Again, with an increase in acute capacity this should show a significant improvement in April.

Laparoscopic Appendicectomy Median LOS *– 49 hours against a target of ≤36*

This is slightly above the January result of 46 hours and should also show improvement in April for the reasons above.

Sick leave rate ESC *– 4.2% against a target of ≤3.4%*

The sick leave for ESC whilst higher than our target number remains stable. For the month of March it is impacted by events for two specific staff.

Service Delivery

Provider Arm Overall Elective Volumes *– 94% against a target of 100%*

Elective volumes were impacted by the COVID-19 response from 23 March with only P1 work being done. ESC theatres were reduced from 23 March and ceased on 27 March.

ESC Elective Volume (YTD) *– 94% against a target of 100%*
ESC has continued to work to ensure surgical diaries are being managed to make certain that full list utilisation is being realised. Elective volumes in ESC ceased from 26 March in line with COVID-19 response.

ESC Elective Volume (month) *– 79% against a target of 100%*
ESC volumes for March have been impacted by the COVID-19 response. Two lists were cancelled in the middle of the month due to surgeons being contact traced for COVID-19. Volumes then reduced from 23 March, with all elective work ceasing on 27 March.

WTH Theatre Utilisation *– 80% against a target of 85%*
The WTH theatre utilisation was impacted by some cancelled ADHB dental lists and the COVID-19 response.

Value for Money

Elective WIES Volumes – S & A – *5376 against a target of 5973*
The elective shortfall was due to cancelled Orthopaedic lists arising from nursing shortages (July - October) and the continuing impact of acute volumes (7% over budget) on elective lists including the acceptance in December - January of Counties Manukau DHB Neck of Femur patients to release capacity at Middlemore for White Island patients. There has also been the impact of the Radiology strikes which resulted in Q2 for the need to put through simpler cases with a lower WIES. January also saw the use of Fellows to backfill SMO annual leave which has a double impact on WIES as fewer cases are scheduled per list and the complexity of cases is lower. COVID-19 had an impact in late March as elective theatres were closed and surgeries were restricted to P1 cases.

ORL WIES is below plan due to ongoing SMO vacancies and difficulties securing locum cover to backfill. The under-delivery above has been partly offset by over-delivery in General Surgery and Urology.

Elective WIES Volumes – ESC – *4671 against a target of 4988*
The elective WIES was lower in the main due to inability to backfill orthopaedic and general surgery lists in October (-74) and January (-108) and the ramp down of ESC as it was converted into a COVID-19 ready in late March (-116).

Surgical and Ambulatory Services

Waitematā DHB Priorities Variance Report

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

Financial Results - Surgical and Ambulatory and Elective Surgical Centre Combined

Waitematā DHB Statement of Financial Performance

S&A and ESC Combined - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	787	758	28	7,169	6,674	494	8,949
Other Income	66	66	(0)	742	570	172	767
Total Revenue	852	824	28	7,911	7,244	666	9,716
EXPENDITURE							
Personnel							
Medical	6,604	6,119	(485)	43,992	42,952	(1,040)	56,861
Nursing	4,148	3,948	(200)	39,252	38,077	(1,174)	52,739
Allied Health	775	718	(56)	4,973	4,735	(237)	6,242
Support	281	304	23	1,893	2,120	227	2,780
Management / Administration	586	546	(40)	3,831	3,512	(319)	4,654
Outsourced Personnel	808	718	(90)	6,522	5,493	(1,028)	7,204
	13,201	12,353	(848)	100,462	96,890	(3,572)	130,481
Other Expenditure							
Outsourced Services	181	117	(63)	1,130	1,032	(98)	1,374
Clinical Supplies	3,367	3,794	427	30,587	31,105	518	41,377
Infrastructure & Non-Clinical Supplies	301	378	76	2,922	3,298	376	4,398
	3,849	4,289	440	34,639	35,435	796	47,149
Total Expenditure	17,051	16,642	(408)	135,101	132,325	(2,776)	177,630
Cost Net of Other Revenue	**(16,198)**	**(15,818)**	**(380)**	**(127,190)**	**(125,080)**	**(2,110)**	**(167,914)**

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

Comment on major financial variances

The overall result for S & A and ESC was $380k unfavourable for January and $2,110k unfavourable for the YTD.

The YTD S & A result was driven by higher personnel costs due to the over-allocation of registrars ($1.2mn) and the reliance on bureau nurses ($216k) and nursing overtime ($146k) in the first five months of the year to cover staff vacancies in the theatre roster. Medical personnel vacancies have continued to cause both Anaesthesia and ORL to rely on locums ($751k over budget) to fulfil rosters which has offset the savings arising from any vacancies. Anaesthesia is now recruited to budget. Moving skin surgery from ORL to General Surgery has created opportunity to fill a small portion of vacant FTE while two fixed term SMO options have arisen to cover other ORL vacancies .

The under-delivery against the elective production plan in S & A resulted in a significantly lower than budgeted spend on implants and prostheses although this was in part offset by higher than budgeted instrument and equipment costs.

Due to COVID-19 the ESC was closed to patients from 26 March to allow the building to be repurposed as a COVID-19 ICU facility. It should be noted that there was very little operating done in the previous three days as well. This had significant consequences for the month both in terms of WIES revenue volumes (213 under budget) and in variable costs such as clinical supplies ($207k under budget). Personnel costs at ESC remained as normal for the month as nursing staff were either deployed elsewhere of were being upskilled for ICU duties. YTD ESC is on budget.

Surgical and Ambulatory Service – S & A

Waitematā DHB Statement of Financial Performance

S&A - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	787	758	28	7,169	6,674	494	8,949
Other Income	66	66	(0)	742	570	172	767
Total Revenue	852	824	28	7,911	7,244	666	9,716
EXPENDITURE							
Personnel							
Medical	6,600	6,116	(484)	43,967	42,930	(1,037)	56,832
Nursing	3,643	3,462	(181)	34,613	33,633	(980)	46,547
Allied Health	775	718	(56)	4,972	4,735	(237)	6,242
Support	270	292	22	1,817	2,043	227	2,678
Management / Administration	567	524	(43)	3,689	3,364	(325)	4,457
Outsourced Personnel	(12)	(319)	(307)	(1,218)	(2,280)	(1,062)	(2,967)
	11,843	10,793	(1,050)	87,840	84,426	(3,414)	113,789
Other Expenditure							
Outsourced Services	163	97	(66)	1,005	858	(147)	1,142
Clinical Supplies	2,621	2,841	219	23,052	23,300	249	31,028
Infrastructure & Non-Clinical Supplies	234	291	56	2,281	2,557	276	3,409
	3,019	3,228	210	26,337	26,716	378	35,579
Total Expenditure	14,861	14,021	(840)	114,178	111,142	(3,036)	149,368
Cost Net of Other Revenue	**(14,009)**	**(13,197)**	**(812)**	**(106,267)**	**(103,897)**	**(2,370)**	**(139,652)**

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

Comment on major financial variances

The overall result for S & A was $812k unfavourable for March and $2,370k unfavourable for the YTD.

Revenue ($28k favourable for March, $666k favourable YTD)
The YTD variance to March was due to a $312k positive variance in ACC Orthopaedic revenue as well as additional revenue related to activities provided to ADHB at Waitakere Hospital and additional CTA revenue arising from the over allocation of RMOs.

Expenditure ($840k unfavourable for March, $3,036k unfavourable YTD)
March expenditure was above plan due to an overspend in Personnel costs offset by savings in other expenditure. YTD the lower than planned production volumes in Orthopaedics and ORL provided a favourable variance in clinical supplies which been offset by higher than expected locum costs as well as reliance in NSH Theatres on bureau nurses to cover unplanned vacancies and an over-allocation of RMOs in the current run. Outsourced skin lesion surgery continued to be higher than planned. There was also a one-off accrual release benefit in August relating to prior year Orthopaedic wait list costs that has helped the YTD position.

Personnel ($3,414k unfavourable YTD
Medical ($1,034k unfavourable YTD)
The unfavourable variance YTD (2.5%) was driven by higher than expected costs, YTD $1.2mn due to a higher than budgeted allocation for Registrars and House Officers which has more than offset vacancy savings in medical officers.

Nursing ($980k unfavourable YTD)
The unfavourable variance was driven operationally by high levels of overtime in Theatres ($112k) and the critical care ICU outreach team ($116k). There was also $290k spent on and the use of internal bureau nurses to help cover vacancies in surgical wards.
Although vacancy savings within the Senior Nursing cohort absorbed $224k of the budgeted vacancy factor for nursing ($348k), higher than planned budgeted leave costs within Registered Nurses has added to the overall unfavourable result.

Allied Health ($237k unfavourable YTD)
The unfavourable variance is due to less turnover and therefore vacancies than budgeted within the Anaesthetic Technician cohort.

Support and Management/Administration ($98k unfavourable YTD)
The favourable variance arising from vacancies within Central Sterile Supply Department (CSSD) support officers was offset by fewer vacancies than expected within Management and Admin staff across the division, resulting in a net unfavourable position.

Outsourced Personnel ($1,062k unfavourable YTD)
The unfavourable variance YTD was driven by locum costs incurred to cover vacancies within Anaesthesia and ORL as well as high sick leave in Anaesthesia ($751k). YTD there have been lower than planned production at ESC thereby resulting in lower Anaesthesia recharges to ESC ($483k), this was exacerbated by the closure of ESC in late March due to its re-purposing as a COVID-19 ICU. There was also a higher than planned reliance on external bureau nurses within theatres due to the need to cover unplanned leave and vacancies in the July to November period.

Other Expenditure ($378k favourable YTD)
Outsourced Services ($147k unfavourable YTD)
The unfavourable variance arose due to higher than expected outsourcing of skin lesion procedures to GPs ($285k) and varicose vein catch-up of wait list volumes which existed prior to the transfer of the service to ADHB ($184k). These costs were mostly offset by the release of an accrual relating to the wait lists at the end of the previous financial year of $437k.

Clinical Supplies ($249k favourable YTD)
The positive variance was driven by savings in implants and prostheses which arose due to the lower than planned volume of orthopaedic cases. This was partially offset by an increase in other clinical supply costs particularly within the surgical wards.

Infrastructure and Non-Clinical Supplies ($276k favourable YTD)
The favourable variance has been driven by lower costs in Sterile Supply. COVID-19 has delayed the annual technical compliance reviews of equipment which resulted in a $64k benefit YTD. However this cost will need to be accrued for. Laundry costs on Sterile Supply remained under budget and savings have increased due to a move to disposable items. There has also been a significant savings in repairs and maintenance YTD.

Elective Surgical Centre - ESC

Waitematā DHB Statement of Financial Performance

ESC - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	0	0	0	0	0	0	0
Other Income	0	0	0	0	0	0	0
Total Revenue	0	0	0	0	0	0	0
EXPENDITURE							
Personnel							
Medical	4	3	(1)	25	22	(3)	29
Nursing	505	486	(19)	4,639	4,444	(195)	6,192
Allied Health	0	0	0	0	0	0	0
Support	0	0	(0)	0	0	(0)	0
Management / Administration	11	12	1	76	76	0	102
Outsourced Personnel	813	1,037	223	7,715	7,773	59	10,172
	1,333	1,538	205	12,455	12,316	(139)	16,495
Other Expenditure							
Outsourced Services	7	0	(7)	25	0	(25)	0
Clinical Supplies	18	20	3	124	174	49	232
Infrastructure & Non-Clinical Supplies	746	953	207	7,535	7,804	269	10,349
	770	974	204	7,685	7,978	293	10,581
Total Expenditure	2,103	2,512	409	20,140	20,294	154	27,076
Cost Net of Other Revenue	**(2,103)**	**(2,512)**	**409**	**(20,140)**	**(20,294)**	**154**	**(27,076)**

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

Comment on major financial variances

The overall result for ESC was $432k favourable for March and $260k favourable for the YTD. The favourable variance was due to lower than planned volumes being completed at ESC resulting in lower variable costs. March's underproduction was driven by the closure of ESC as an operating suite for elective surgery on 26th March. For the three days prior to closure ESC only ran 4 out of 24 lists.

Personnel ($205k unfavourable YTD

Nursing ($195k unfavourable YTD)

Nursing costs were above budget due to the cost of new graduate nurses and several one-off costs. There has also been an increase in the volume of day cases at ESC which has negatively impacted on nursing costs in Post Anaesthetic Care Unit (PACU). As a fixed cost the closure of ESC did not result in any significant savings in Nursing as the staff were either redeployed or upskilled to be ICU nurses.

Outsourced Personnel ($34k unfavourable YTD)

The lower than planned volumes at ESC has resulted in lower package of care costs. An un-accrued package of care cost earlier in the year has suppressed the favourable variance.

Other Expenditure ($418k favourable YTD)

Clinical Supplies ($269k favourable YTD)

The favourable variance was due to under activity savings in other clinical supplies including implants and prostheses and treatment disposables, these savings were magnified in March due to the closure of ESC at the end of the month as part of the COVID-19 preparedness plan. Savings are partly offset by the continued spend over budget for laparoscopic costs.

Infrastructure and Non-Clinical Supplies ($100k favourable YTD)

The favourable variance is due to savings in laundry which are partially offset by overruns in other non-clinical costs such as patient meals.

Diagnostic Services

Service Overview

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

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

Highlight of the Month

The effort across all services that went into planning the response to COVID-19 that including the standing up of COVID-19 testing in the laboratory, setting up of radiologist workstations for remote reporting and pod staffing system to address physical distancing. In addition we had positive discussion around establishing a formal paid Tier A after-hours on-call interventional radiology roster and this will be implemented in late May 2020.

Key Issues

The need to outsource CT, MRI and Plain Film X-rays due to impact of COVID-19 and the recent industrial action.

Complete the service level agreement and implementation planning for the establishment of the single Auckland DHB/Waitematā DHB interventional radiology service.

Undertake senior medical officer job sizing and review medical imaging technologist staffing levels.

Scorecard – Diagnostic Services

Waitematā DHB Monthly Performance Scorecard

Diagnostic Services
March 2020
2019/20

Best Care

HR/Staff Experience	Actual	Target		Trend
Sick leave rate	2.9%	<3.4%	●	▼
Turnover rate - external	11%	<14%	●	▼
Vacancies - %	5%	<8%	●	▲

Service Delivery

Waiting Times				
% of CT scans done within 6 weeks	71%	95%	●	▲
% of MRI scans done within 6 weeks	90%	90%	●	▲
% of US scans done within 6 weeks	86%	75%	●	▲

Value for Money

Financial Result (YTD)	Actual	Target		Trend
Revenue	4,060 k	3,087 k	●	▲
Expense	79,378 k	79,906 k	●	▼
Net Surplus/Deficit	-75,317 k	-76,820 k	●	▼

How to read

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

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

Key notes

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

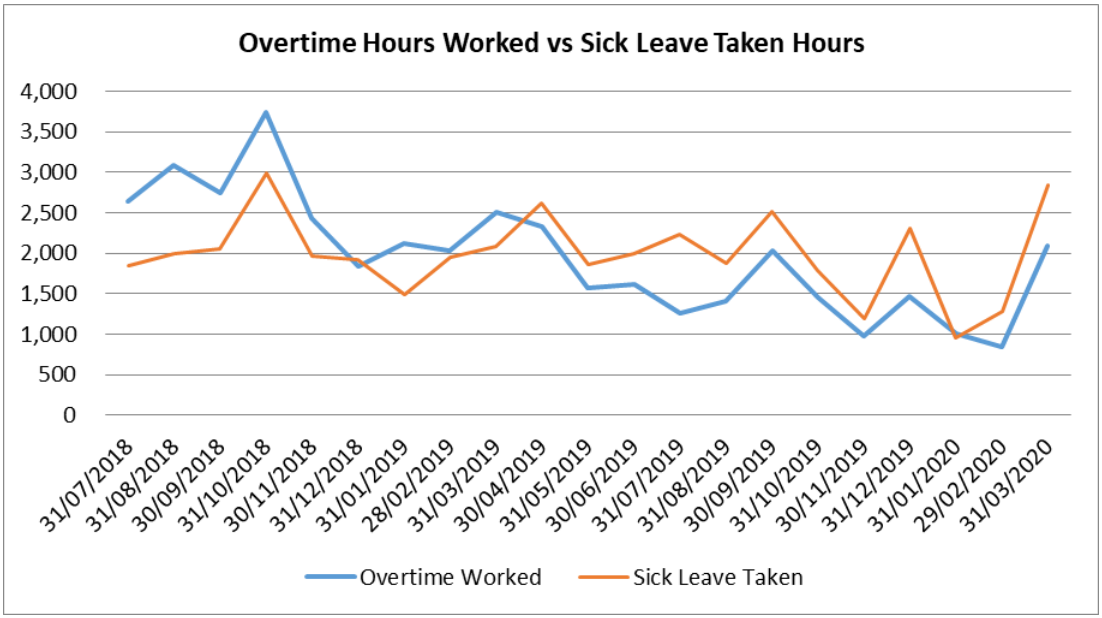
A question?

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

Scorecard Variance Report

% of CT scans done within six weeks *– 71% against a target of 95%*

In March, CT continued to make progress towards compliance due to additional voluntary weekend lists. Regrettably, this will be eroded by the impact of COVID-19 and we will need to consider additional outsourcing to respond to the increasing CT waiting list.



FTE Analysis

Row Labels	YTD Mar-20 Ave. Budgeted FTE	YTD Mar-20 Ave. Churn FTE	YTD Mar-20 Actual Accrued FTE	YTD Mar-20 Ave. FTE Variances
01-WDGN Diagnostics				
Medical Personnel	53.5	0.0	50.9	2.5
Nursing Personnel	32.2	0.0	34.2	-2.0
Allied Health Personnel	322.4	0.0	316.4	6.0
Admin Personnel	37.6	0.0	35.9	1.8
01-WDGN Diagnostics Total	445.6	0.0	437.4	8.2
Grand Total	445.6	0.0	437.4	8.2

Waitematā DHB Priorities Variance Report

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

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

Areas off track for month and remedial plans

Financial Results

Waitematā DHB Statement of Financial Performance

Diagnostic Services - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	306	163	143	3,246	1,618	1,627	2,109
Other Income	169	163	6	815	1,468	(654)	1,958
Total Revenue	476	327	149	4,060	3,087	974	4,066
EXPENDITURE							
Personnel							
Medical	1,710	1,628	(82)	11,344	11,651	307	15,360
Nursing	268	227	(41)	2,261	2,143	(118)	2,992
Allied Health	3,469	3,052	(417)	22,355	21,849	(506)	28,746
Support	0	0	0	0	0	0	0
Management / Administration	271	308	38	1,858	2,046	187	2,693
Outsourced Personnel	22	4	(18)	57	36	(20)	48
	5,740	5,219	(521)	37,875	37,726	(149)	49,839
Other Expenditure							
Outsourced Services	858	533	(325)	5,679	4,742	(937)	6,332
Clinical Supplies	4,025	4,025	(0)	34,528	35,851	1,324	48,021
Infrastructure & Non-Clinical Supplies	162	179	17	1,296	1,588	291	2,125
	5,046	4,737	(309)	41,503	42,181	678	56,477
Total Expenditure	10,786	9,956	(830)	79,378	79,906	529	106,317
Cost Net of Other Revenue	**(10,310)**	**(9,630)**	**(680)**	**(75,317)**	**(76,820)**	**1,502**	**(102,250)**

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

Comment on major financial variances

The overall result for Diagnostic Services was $680k unfavourable for March and $1,502k favourable for the YTD.

Revenue ($149k favourable for March, $974k favourable YTD)
The favourable variance for the YTD is due to rebates received from Pharmac for hospital medicines.

Expenditure ($830k unfavourable for March, $529k favourable YTD)
The favourable variance for the YTD was due to pharmaceutical and radiology clinical supplies.

Personnel ($149k unfavourable YTD)
Allied Health personnel costs are over in Radiology as anticipated vacancy savings have not materialised due success in recruitment initiatives. This has been partially met by savings in Medical personnel costs due to SMO vacancy within Advanced Interventional Radiology which means outsourcing some volumes for this service.

Other Expenditure ($678k favourable YTD)
Outsourced Services ($937k unfavourable YTD)
The unfavourable variance YTD is due to outsourced radiology volumes which are offset by favourable variances in personnel and clinical supplies.

Clinical Supplies ($1,324k favourable YTD)
The favourable variance for the YTD was due to drug costs in the inpatient pharmacy being $293k favourable YTD as total drug costs are at similar level to 2018/19. Radiology supplies are also $954k favourable for the YTD due to Advanced Interventional Radiology and CT services not operating at capacity due to staffing shortages.

Infrastructure and Non-Clinical Supplies ($291k favourable YTD)
The favourable variance for the YTD was due to savings in information technology connectivity costs for the Rural Point of Care project as this component of the project has not yet progressed.

Clinical Support Services

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

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

Highlight of the Month
The commitment shown by the management team and in turn their teams to step up to the challenge of planning our response to COVID-19.

Key Issues
Food Services
We have worked closely with Compass-Medirest to develop our Business Continuity response to COVID-19. This has enabled us to develop a more constructive relationship with Compass-Medirest which should in turn better position both parties to address and resolve the food service issues discussed in the recent Board paper. It should be noted that COVID-19 has slowed this process down.

Clinical Engineering
Inspection and Preventive Maintenance (IPM) – Completion of IPM has fallen further due to COVID-19 (70% end of April compared with 78% February 2020). A proposal to address this issue by an increase in 2.0FTE was included within the 20/21 budget initiatives with net cash cost being $25,000 (reflecting saving in unbudgeted overtime of $125,000) with the increase in budget FTE being $150,000.

Bringing in-house bed maintenance and repairs. This project has been delayed due to COVID-19. Candidates for the 3.0FTE roles have been shortlisted and will be interviewed in the next two weeks.

Clinical Support Services
There will be significant unbudgeted costs for cleaning and security in April due to COVID-19 response.

Scorecard – Clinical Support Services

Waitematā DHB Monthly Performance Scorecard

Clinical Support
March 2020
2019/20

Best Care

HR/Staff Experience	Actual	Target	Trend
Sick leave rate	3.6%	<3.4%	--
Turnover rate - external	17%	<14%	▲
Vacancies - %	14%	<8%	▼

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue	198 k	143 k	▼
Expense	25,138 k	23,998 k	▲
Net Surplus/Deficit	-24,940 k	-23,856 k	▼

How to read

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

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

Key notes

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

A question?

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

Scorecard Variance Report

Sick Leave Rate *– 3.6% against a target of3.4%*

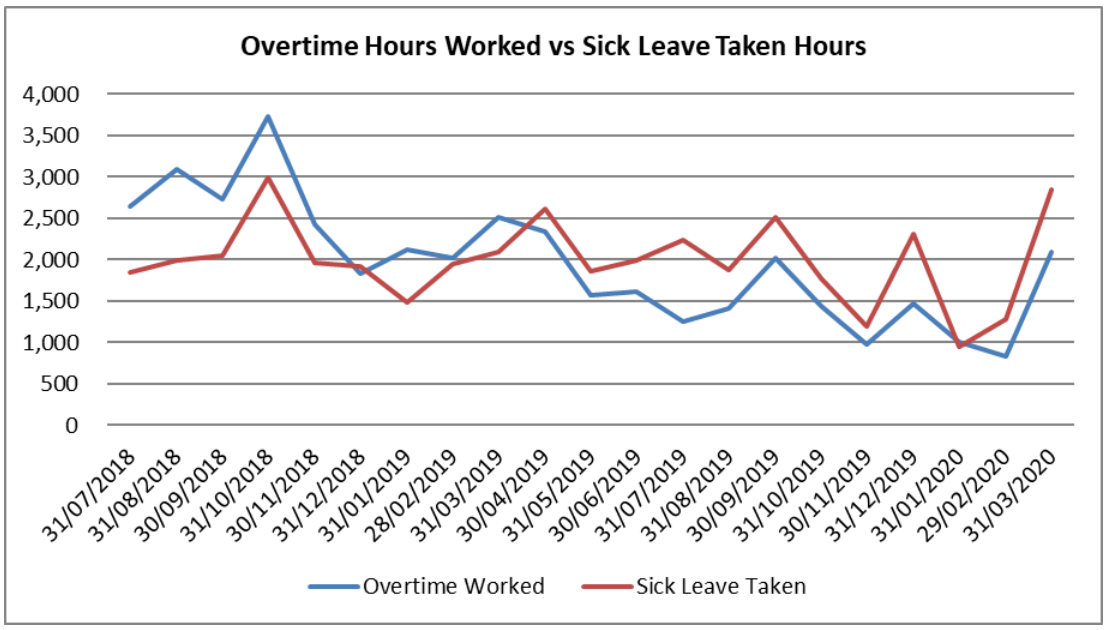
Sick leave rate remains above the target at 3.6% for 12 month rolling average. Sick leave is actively monitored and managed and the KPI has reduced from a rate of 4% as at Mar-19.

Turnover Rate – external - 17% against a target of 14%

Turnover rate has reduced in the month to 17% for 12 month rolling average. Turnover is primarily in Support personnel of cleaning, orderly, traffic and security staff and vacancies are covered by casual staff. This KPI is lower than the 22% rate as at Jan-19 reflecting the concerted effort being done in recruitment and retention of this staff group.

Vacancies *– 14% against a target of 8%*

Vacancies have risen in the month due to approval to recruit 25 additional fixed term security guards in response to COVID-19.



FTE Analysis

Row Labels	YTD Mar-20 Ave. Budgeted FTE	YTD Mar-20 Ave. Churn FTE	YTD Mar-20 Actual Accrued FTE	YTD Mar-20 Ave. FTE Variances
⊟01-WHOG Clinical Support				
⊞Nursing Personnel	0.0	0.0	0.0	0.0
⊞Allied Health Personnel	0.0	-3.4	0.0	-3.4
⊞Support Personnel	317.5	-9.5	306.3	1.7
⊞Admin Personnel	24.9	-1.0	23.7	0.2
01-WHOG Clinical Support Total	342.3	-13.8	330.0	-1.5
Grand Total	342.3	-13.8	330.0	-1.5

Financial Results

Waitematā DHB Statement of Financial Performance

Clinical Support Services - March 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	0	0	0	0	0	0	0
Other Income	5	16	(11)	198	143	56	190
Total Revenue	5	16	(11)	198	143	56	190
EXPENDITURE							
Personnel							
Medical	0	0	0	0	0	0	0
Nursing	0	0	(0)	0	0	(0)	0
Allied Health	1	(16)	(17)	1	(147)	(148)	(197)
Support	1,884	1,965	81	13,111	13,050	(61)	17,457
Management / Administration	209	204	(5)	1,475	1,428	(48)	1,885
Outsourced Personnel	24	13	(11)	265	114	(151)	152
	2,118	2,166	48	14,852	14,445	(407)	19,297
Other Expenditure							
Outsourced Services	0	0	0	0	0	0	0
Clinical Supplies	132	94	(39)	1,146	834	(313)	1,109
Infrastructure & Non-Clinical Supplies	899	981	82	9,140	8,720	(421)	11,669
	1,031	1,075	44	10,287	9,553	(733)	12,778
Total Expenditure	3,149	3,241	92	25,138	23,998	(1,140)	32,075
Cost Net of Other Revenue	**(3,144)**	**(3,225)**	**81**	**(24,940)**	**(23,856)**	**(1,085)**	**(31,885)**

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

Comment on major financial variances

The overall result for Clinical Support Services was $81k favourable for March and $1,085k unfavourable for the YTD.

Revenue ($11k unfavourable for March, $56k favourable YTD)

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

Expenditure ($92k favourable for March, $1,140k unfavourable YTD)

The unfavourable variance for the YTD was due to staff related costs and equipment repairs.

Personnel ($407k unfavourable YTD)

The unfavourable variance for the YTD does not include $335k of casual security guard costs that are coded in Infrastructure and Non-Clinical Supplies. Vacancy factor savings are partially being met by turnover in Clinical Support cleaners and orderlies where approximately 17% of shifts are covered by lower cost casual workforce.

Other Expenditure ($733k unfavourable YTD)

Clinical Supplies ($313k unfavourable YTD)

The unfavourable variance for the YTD was due to clinical equipment repairs and maintenance particularly older beds which has had repair costs of $186k YTD. This was necessary to utilise our maximum bed stock over winter period.

Infrastructure and Non-Clinical Supplies ($421k unfavourable YTD)

The unfavourable variance YTD was due to outsourced casual security guards where the budget is held as personnel cost as well as increased costs relating to traffic management changes recently implemented.

3.2 Provider Arm Performance Summary Report – April 2020

Recommendation:

That the report be received.

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

This report summarises the Provider Arm performance for April 2020.

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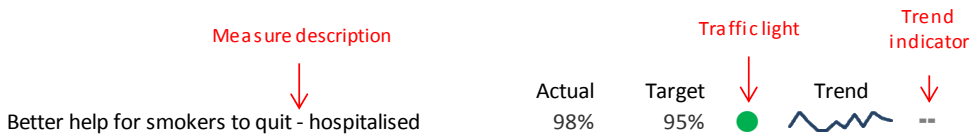
Glossary

ACC	-	Accident Compensation Commission
ADU	-	Assessment and Diagnostic Unit
ALOS	-	Average Length of Stay
ARDS	-	Auckland Regional Dental Service
AT&R	-	Assessment Treatment and Rehab
ASA	-	American Society of Anaesthesiologists
CADS	-	Community Alcohol, Drug and Addictions Service
CAMHS	-	Child, Adolescent Mental Health Service
CT	-	Computerised Tomography
CWF	-	Child, Women and Family service
DHB	-	District Health Board
DNA	-	Did not attend
ED	-	Emergency Department
ECHO	-	Echocardiogram
ESC	-	Elective Surgery Centre
ESPI	-	Elective Services Performance Indicators
FTE	-	Full Time Equivalent
GP	-	General Practitioner
HCA	-	Health Care Assistant
ICU	-	Intensive Care Unit
KMU	-	Kingsley Mortimer Unit
SMHOPS	-	Specialty Medicine and Health of Older People Services
MRI	-	Magnetic Resonance Imaging
MoH	-	Ministry of Health
NSH	-	North Shore Hospital
NZNO	-	New Zealand Nurses Organisation
ORL	-	Otorhinolaryngology (ear, nose, and throat)
RMO	-	Registered Medical Officer
SAS	-	Surgical and Ambulatory Services
SCBU	-	Special care baby unit
SMHA	-	Specialist Mental Health & Addiction Services
SMO	-	Senior Medical Officer

How to interpret the scorecards

Traffic lights

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



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

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

Trend indicators

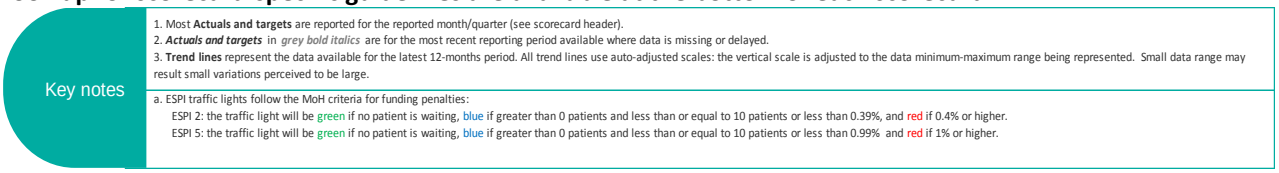
A trend line and a trend indicator are reported against each measure. Trend lines represent the actual data available for the latest 12-months period. All trend lines use auto-adjusted scales: the vertical scale is adjusted to the data minimum-maximum range being represented. The small data range may result in small variations appearing to be large.
Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance trend, use the trend indicator as described below.

The trend indicator criteria and interpretation rules:

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

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

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



Scorecard – All services

Waitematā DHB Monthly Performance Scorecard

ALL Services
April 2020
2019/20

Priority Health Outcomes

	Actual	Target		Trend	
Shorter Waits in ED	96%	95%	●		--
Faster cancer treatment (62 days)	81%	90%	●		▼

Best Care

	Actual	Target		Trend	
Patient Experience					
Complaint Average Response Time	13 days	≤14 days	●		▼
Net Promoter Score FFT	83	65	●		▲
Improving Outcomes					
Better help for smokers to quit - hospitalised	97%	95%	●		▼
Quality & Safety					
Older patients assessed for falling risk	99%	90%	●		▼
Rate of falls with major harm	0.04	≤2	●		▲
Good hand hygiene practice	94%	80%	●		▲
S. aureus infection rate	0.07	≤0.25	●		▲
Occasions insertion bundle used	100%	95%	●		--
Pressure injuries grade 3&4	0	0	●		--
HR/Staff Experience					
Sick leave rate	3.4%	≤3.4%	●		▲
Turnover rate - external	12%	≤14%	●		--
Vacancies - %	5%	≤8%	●		▲

Service Delivery

	Actual	Target		Trend	
Elective Volumes					
Provider Arm - Overall	88%	100%	●		▼
Waiting Times					
ESPI 2 - % patients waiting > 4 months for FSA	*Non-Compliant*				
ESPI 5 - % patients not treated w/n 4 months	*Non-Compliant*				
ESPI 1 - OP Referrals processed w/n 10 days	*Compliant*				
Patient Flow					
Outpatient DNA rate (FSA + FUs) - Total	4%	≤10%	●		▲
Outpatient DNA rate (FSA + FUs) - Māori	7%	≤10%	●		▲
Outpatient DNA rate (FSA + FUs) - Pacific	8%	≤10%	●		▲

Value for Money

	Actual	Target		Trend	
Financial Result (YTD)					
Revenue	829,790 k	838,379 k	●		▲
Expense	875,292 k	850,748 k	●		▼
Net Surplus/Deficit	-45,502 k	-12,369 k	●		▼
Contracts (YTD)					
Elective WIES Volumes	13,493	15,220	●		▼
Acute WIES Volumes	54,227	56,098	●		▼

How to read

Performance indicators:

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

Trend indicators:

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

Key notes

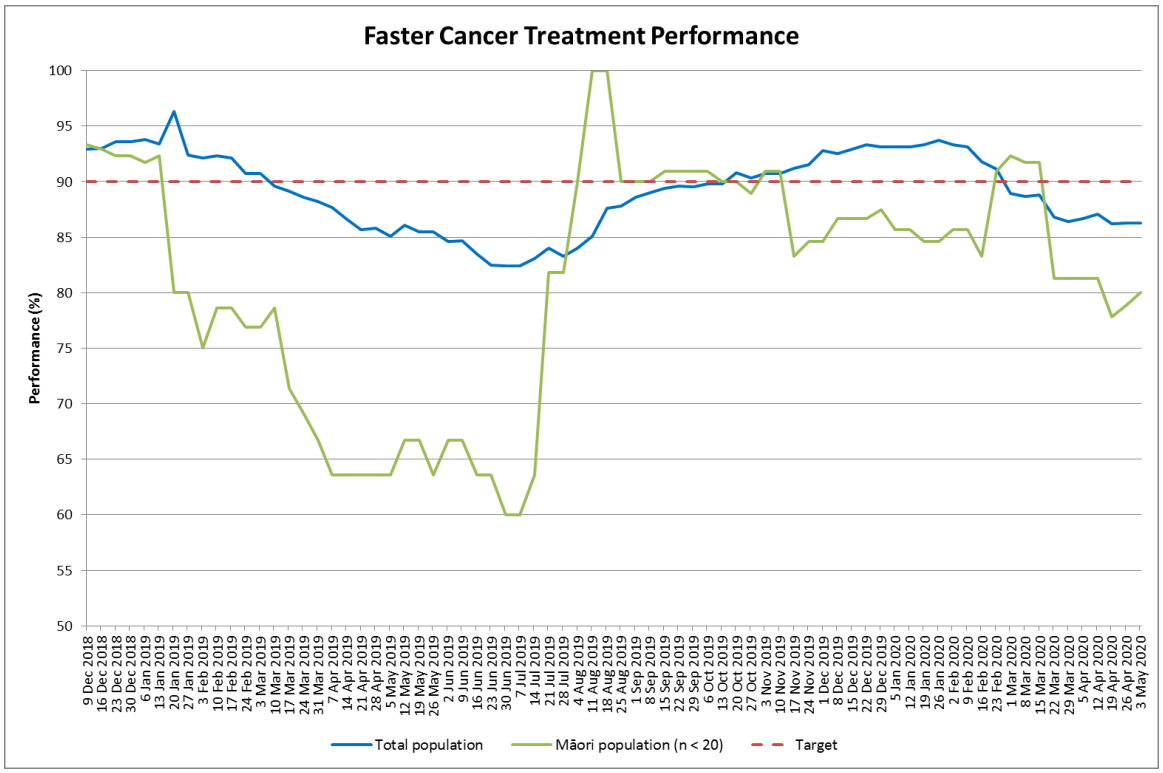
1. Most **Actuals and targets** are reported for the reported month/quarter (see scorecard header).
2. ***Actuals and targets*** in ***grey bold italics*** are for the most recent reporting period available where data is missing or delayed.
3. **Trend lines** represent the data available for the latest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

A question?

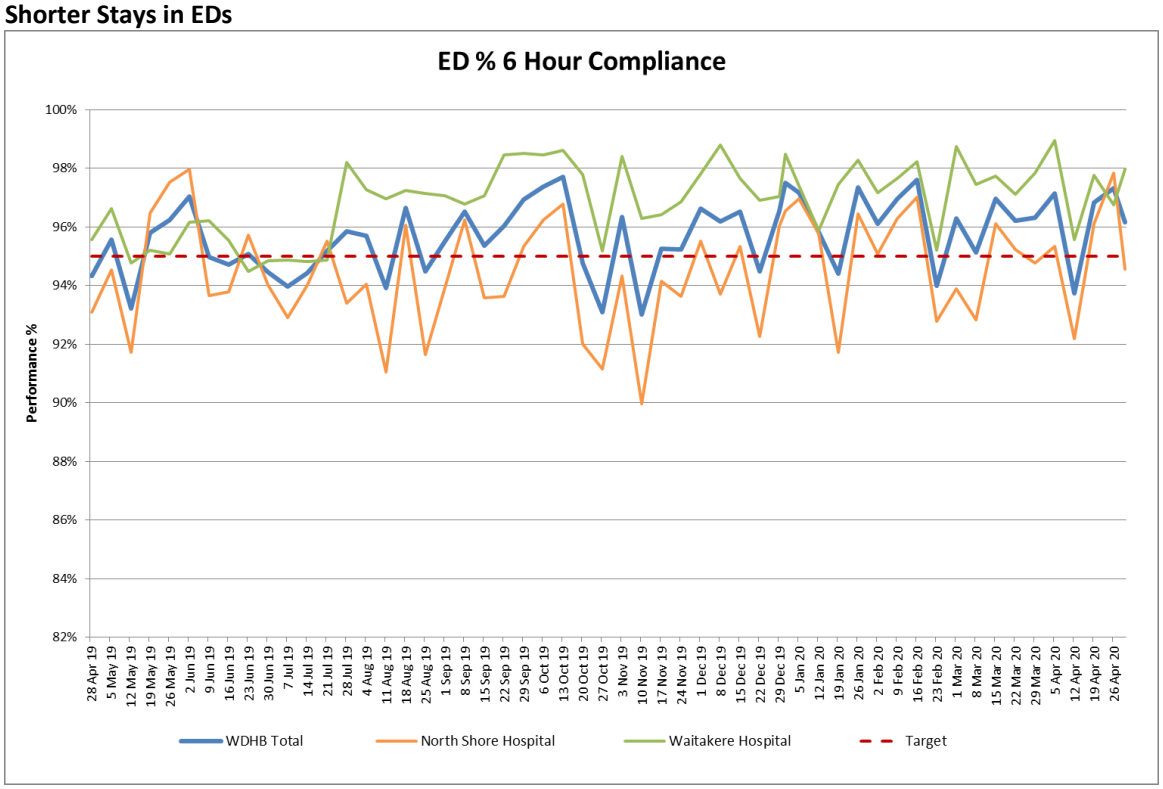
Contact:
Victora Child - **Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz**
Planning, Funding and Health Outcomes, Waitematā DHB

Priority Health Outcome Areas

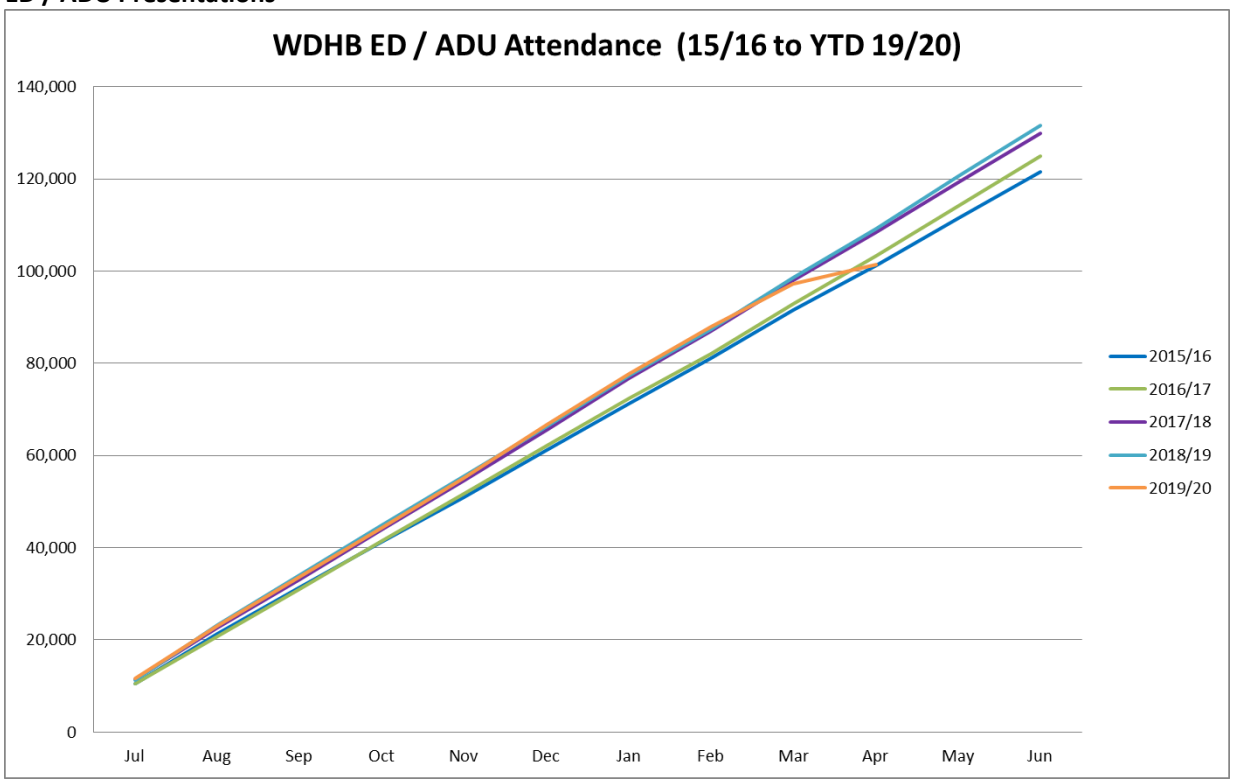
Faster Cancer Treatment



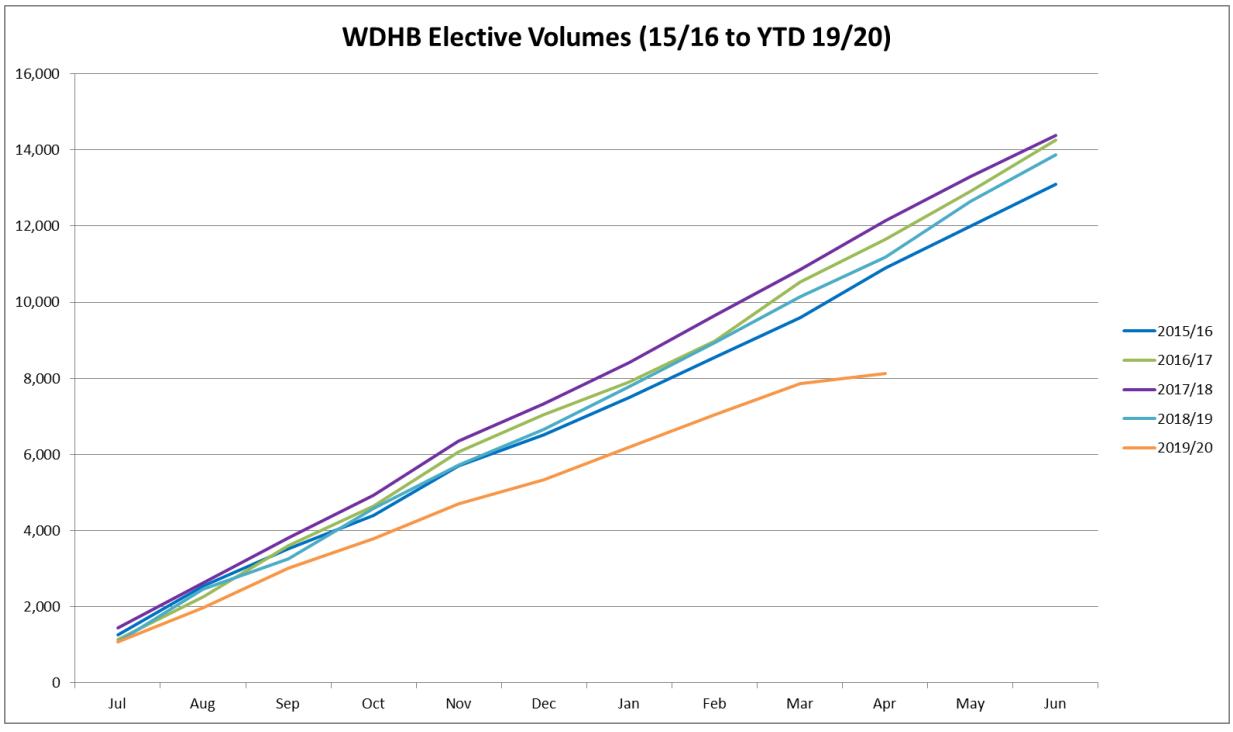
Shorter Stays in EDs



ED / ADU Presentations



Elective Volumes – Part of Planned Care Services



Percentage Change ED and Elective Volumes

April 2020	Month Volumes	% Change (last year)	YTD Volumes	% Change (last year)
ED/ADU Volumes	4,108	-61%	101,335	-7%
Elective Volumes	259	-75%	8128	-27.3%

Elective Performance Indicators (part of Planned Care Programme)

Zero patients waiting over 4 months

Summary (April 2020)	
Speciality	Non Compliance %
ESPI 2 - Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	14.25%
ESPI 5 - Patients given a commitment to treatment but not treated within the required timeframe.	28.77%

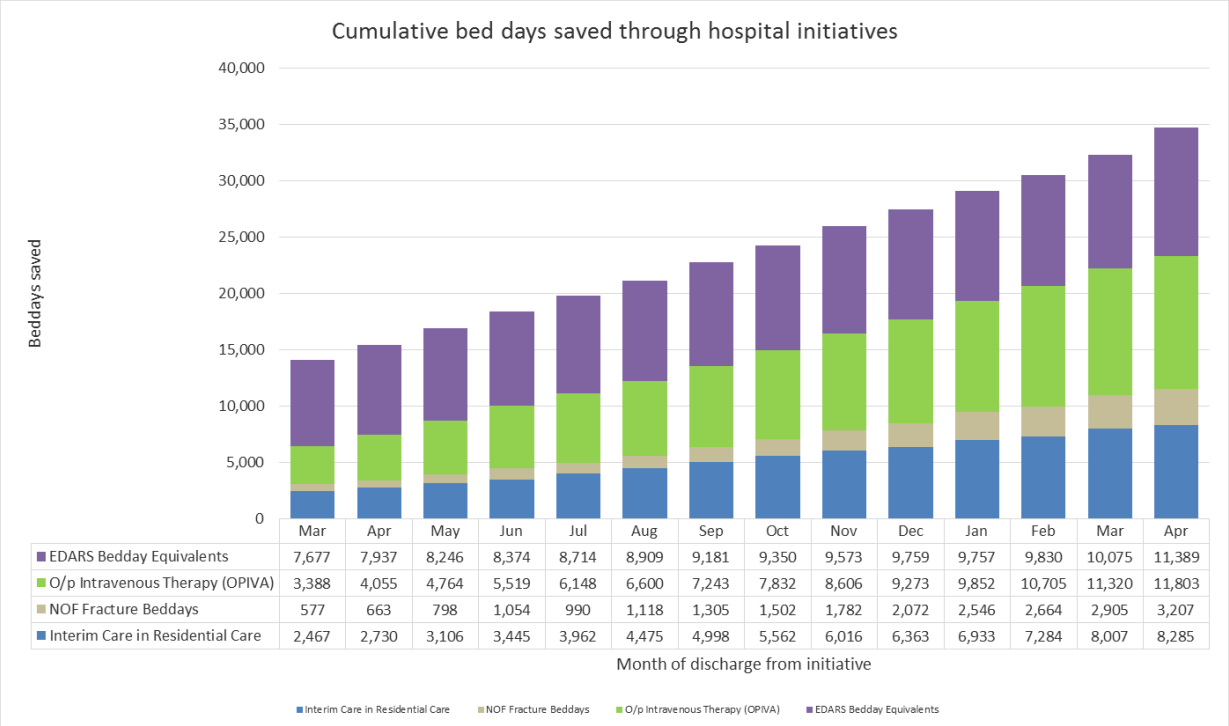
ESPI	WL Specialty	Compliant	Non Compliant	Non Compliant
ESPI 2	Anaesthesiology	108	-	0.00%
	Cardiology	860	18	2.05%
	Dermatology	199	-	0.00%
	Diabetes	128	-	0.00%
	Endocrinology	155	3	1.90%
	Gastro-Enterology	666	-	0.00%
	General Medicine	116	-	0.00%
	General Surgery	1,236	513	29.33%
	Gynaecology	826	68	7.61%
	Haematology	63	2	3.08%
	Infectious Diseases	27	2	6.90%
	Neurovascular	80		0.00%
	Orthopaedic	1,425	345	19.49%
	Otorhinolaryngology	744	295	28.39%
	Paediatric MED	460	57	11.03%
	Renal Medicine	193	-	0.00%
	Respiratory Medicine	430	-	0.00%
	Rheumatology	109	-	0.00%
	Urology	406	65	13.80%
	Total	8,231	1,368	14.25%
ESPI 5	Cardiology	102	-	0.00%
	General Surgery	1,444	175	10.81%
	Gynaecology	418	218	34.28%
	Orthopaedic	849	676	44.33%
	Otorhinolaryngology	328	141	30.06%
	Urology	326	190	36.82%
	Total	3,467	1,400	28.77%

90% of outpatient referrals acknowledged and processed within ten days

ESPI 1 (April 2020)	
Specialty	Compliance %
Anaesthesiology	94.12%
Cardiology	98.08%
Dermatology	100.00%
Diabetes	100.00%
Endocrinology	97.65%
Gastro-Enterology	98.22%
General Medicine	94.12%
General Surgery	99.70%
Gynaecology	100.00%
Haematology	97.96%
Infectious Diseases	94.12%
Neurovascular	97.50%
Orthopaedic	98.48%
Otorhinolaryngology	100.00%
Paediatric MED	98.40%
Renal Medicine	100.00%
Respiratory Medicine	100.00%
Rheumatology	96.61%
Urology	100.00%
Total	98.85%

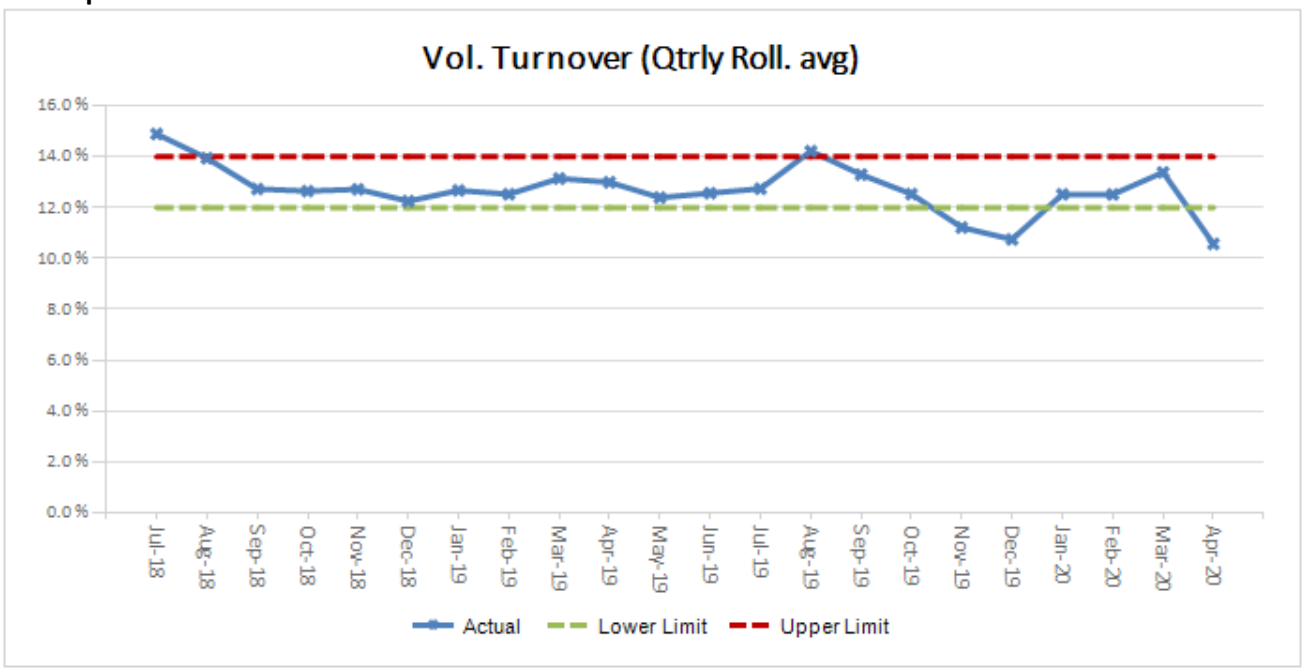
Legend	
ESPI 1	Green if 100%, Yellow if between 90% and 99.9%, and Red if 90% or less.
ESPI 2	Green if 0 patients, Yellow if greater than 0 patients and less than or equal to 10 patients or less than 0.39%, and Red if 0.4% or higher.
ESPI 5	Green if 0 patients, Yellow if greater than 0 patients and less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

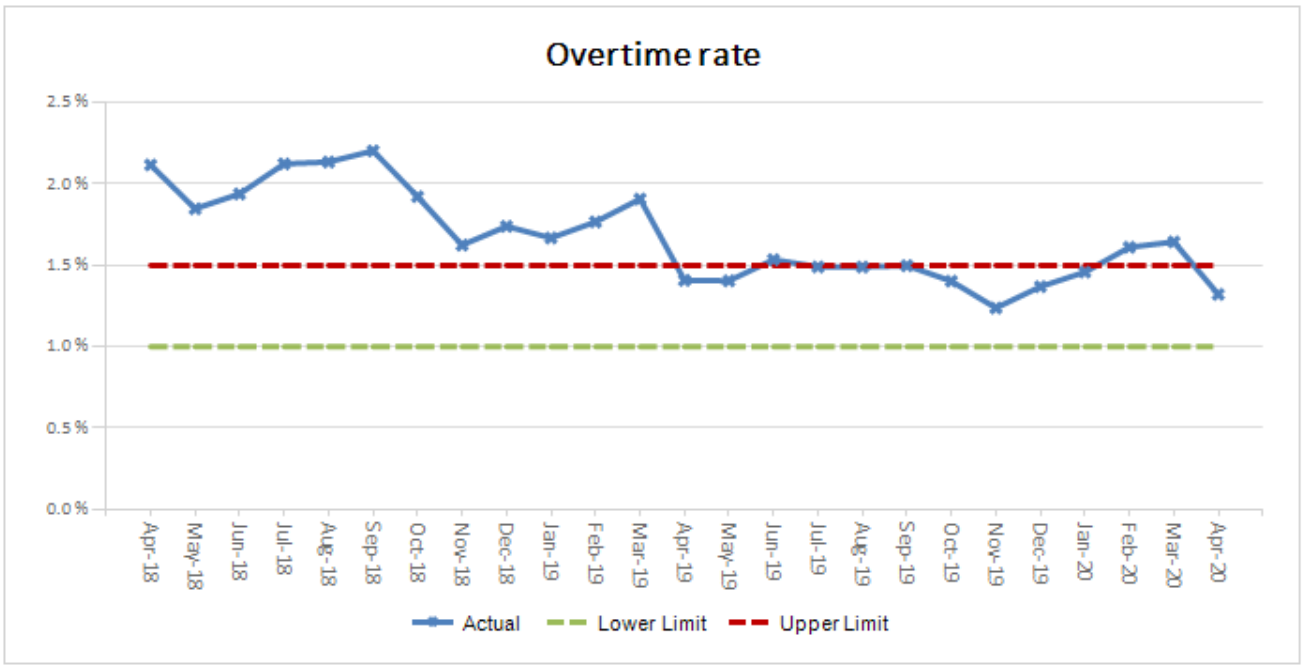
Cumulative Bed Days saved through Hospital Initiatives



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
EDARS Bedday Equivalents	7,677	7,937	8,246	8,374	8,714	8,909	9,181	9,350	9,573	9,759	9,757	9,830	10,075	11,389
O/p Intravenous Therapy (OPIVA)	3,388	4,055	4,764	5,519	6,148	6,600	7,243	7,832	8,606	9,273	9,852	10,705	11,320	11,803
NOF Fracture Beddays	577	663	798	1,054	990	1,118	1,305	1,502	1,782	2,072	2,546	2,664	2,905	3,207
Interim Care in Residential Care	2,467	2,730	3,106	3,445	3,962	4,475	4,998	5,562	6,016	6,363	6,933	7,284	8,007	8,285

HR Graphs


Vol. Turnover (Qtrly Roll. avg)
16.0 %
14.0 %
12.0 %
10.0 %
8.0 %
6.0 %
4.0 %
2.0 %
0.0 %
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
Actual
Lower Limit
Upper Limit


Overtime rate
2.5 %
2.0 %
1.5 %
1.0 %
0.5 %
0.0 %
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
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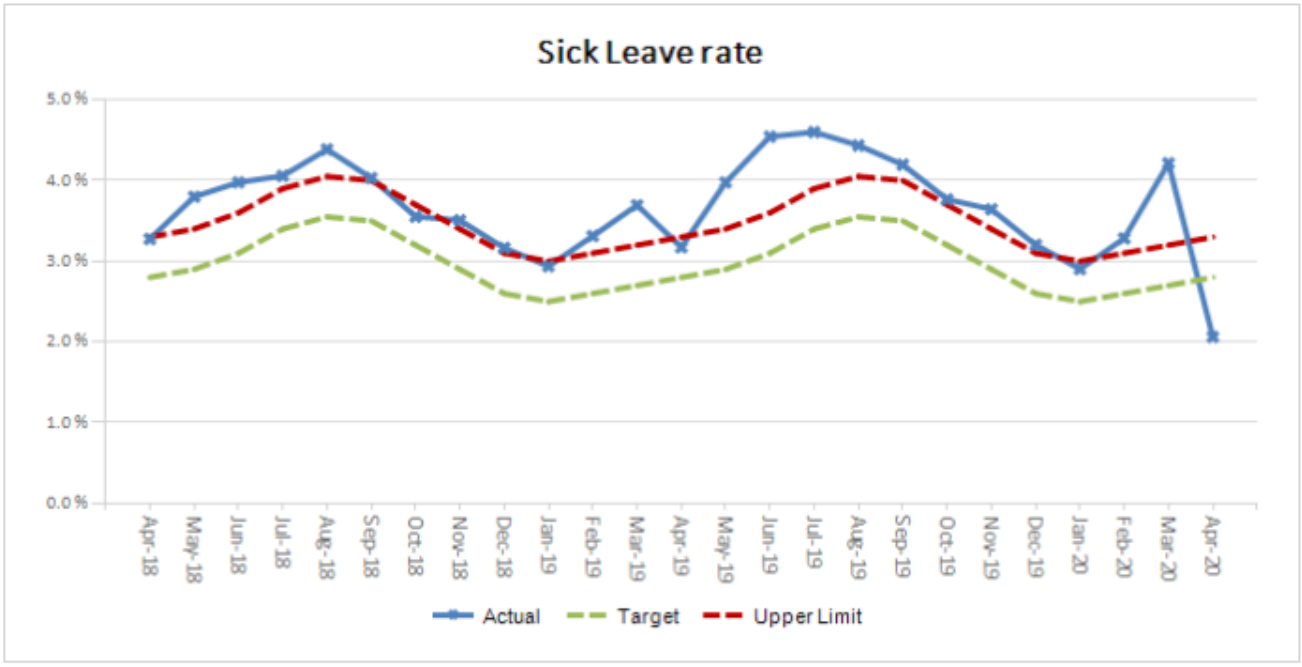
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
Actual
Lower Limit
Upper Limit


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

Financial Performance

Waitematā DHB Statement of Financial Performance

Provider - April 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	81,117	80,697	420	811,195	807,483	3,712	968,899
Other Income	1,406	2,049	(644)	18,596	30,897	(12,301)	40,209
Total Revenue	82,523	82,747	(223)	829,790	838,379	(8,589)	1,009,108
EXPENDITURE							
Personnel							
Medical	19,963	20,013	50	174,724	176,107	1,383	201,652
Nursing	26,604	24,698	(1,906)	236,522	228,834	(7,688)	275,119
Allied Health	11,940	11,278	(662)	107,707	107,046	(661)	128,764
Support	2,474	2,232	(242)	20,026	20,589	562	24,898
Management / Administration	7,445	6,653	(791)	64,938	61,923	(3,015)	74,560
Outsourced Personnel	1,364	1,104	(260)	17,665	12,200	(5,466)	14,586
	69,790	65,978	(3,811)	621,582	606,699	(14,884)	719,579
Other Expenditure							
Outsourced Services	4,966	5,227	261	51,021	52,037	1,016	62,530
Clinical Supplies	8,671	10,420	1,748	105,530	110,980	5,450	133,548
Infrastructure & Non-Clinical Supplies	9,680	8,015	(1,666)	97,159	81,033	(16,126)	93,450
	23,318	23,661	343	253,710	244,050	(9,660)	289,528
Total Expenditure	93,107	89,639	(3,468)	875,292	850,748	(24,544)	1,009,108
Cost Net of Other Revenue	**(10,584)**	**(6,893)**	**(3,691)**	**(45,502)**	**(12,369)**	**(33,133)**	**(0)**

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

Waitematā DHB Statement of Financial Performance

Provider - April 2020

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
CONTRIBUTION							
Surgical and Ambulatory	(12,532)	(11,351)	(1,181)	(118,800)	(115,248)	(3,551)	(139,495)
Acute and Emergency	(13,090)	(12,643)	(447)	(129,804)	(127,237)	(2,566)	(154,634)
Specialty Medicine and HOPS	(7,662)	(7,627)	(34)	(77,537)	(76,628)	(908)	(93,066)
Child Women and Family	(7,094)	(7,003)	(92)	(74,581)	(73,334)	(1,247)	(88,486)
Specialist Mental Health and Addiction	(11,803)	(11,221)	(582)	(110,453)	(110,808)	355	(134,273)
Elective Surgery Centre	(442)	(2,120)	1,678	(21,365)	(23,303)	1,937	(28,262)
Clinical Support	(2,875)	(2,668)	(207)	(27,815)	(26,524)	(1,291)	(31,885)
Diagnostics	(7,567)	(8,415)	849	(82,884)	(85,235)	2,351	(102,331)
Corporate and Provider Support	52,481	56,155	(3,674)	597,736	625,948	(28,212)	772,432
Net Surplus/Deficit	**(10,584)**	**(6,893)**	**(3,691)**	**(45,502)**	**(12,369)**	**(33,133)**	**(0)**

Comment on major variances by Provider Service

The overall result for Provider was $3.691m unfavourable for April and $33,133m unfavourable for the YTD.

Surgical and Ambulatory Services (SAS) 3,551 unfavourable YTD)

The unfavourable variance ($ prior to COVID-19 was driven by the need to use outsourced personnel costs to cover vacancies in ORL, Anaesthesia and Theatre Nursing ($1mn). The division has also been significantly impacted by the continued over-allocation against budget of RMOs to Surgical Services ($1.3mn).

COVID-19 has had a significant impact on the revenue and costs within SAS since the end of March when three elective operating theatres were converted into COVID-ready theatres. Elective surgery was halted for three weeks completely which, along with 25% lower acute presentations, provided a significant benefit in clinical supplies, which was approximately $500k under budget for the period despite a significant spend on personal protective equipment.

The reduction in volumes was not reflected in personnel costs which rose $422k in April. To ensure COVID-19 preparedness ICU and Anaesthesia had to run additional rosters to ensure 24/7 infection control appropriate rosters and Medical Staff were arranged into roster pods which increased allowances and penal costs. Restrictions on nursing and allied health staffing in conjunction with the need to backfill staff who were on various COVID related leave were another driver of costs. The final element in higher personnel costs was in theatres where, although three elective theatres were closed, rosters were required to staff them in the event of COVID surgical presentations.

The closure of ESC resulted in costs accruing to SAS that would not have occurred without COVID. Surgical and Ambulatory service absorbed the ESC nursing cohort after ESC closed, which resulted in an additional $478k of costs. The budgeted recharge of $273k for Anaesthetists working in ESC did not occur which resulted in SAS wearing the full cost of Anaesthesia since ESC closed.

Acute and Emergency Medicine (YTD $2.566 unfavourable YTD)

The unfavourable variance is driven by:

- Emergency departments were seeing high attendance rates prior to any consideration of COVID-19, anticipating around 2,000 attendances above plan by financial year end. ED had realised the financial benefit of six medical officers coming on board to complement senior medical staffing. Financial pressures were most evident in nursing with ongoing demand for additional 'hours on the floor'. In response, the service completed a review of cover model requirements for ED and ADU in support of prioritised budget submissions (an additional 15 FTE) in FY20/21. Noting the anticipated impact of COVID-19 may result in earlier consideration of this uplift.
- Inpatient wards were tracking close to plan, both in terms of bed days and WIES. The service had contained costs successfully with active control of staffing around flex bed management. Nursing costs were higher for patient watches and the service is reviewing this. Medical costs were anticipated to increase in the remaining months with recruitment now underway for the home based wards initiative.
- Cardiology services are slightly lower than this time last year, the volume for April 2020 and April 2019 is: 3 and 7 for ICD, 8 and 21 for pacemakers, 54 pacemakers and 2 ICD YTD less than this time last year. The WIES differential in Cardiology, due to the drop in National Price of some of the main procedures undertaken, also contributed to a lower cardiology WIES volume of 3,153 which is 223 less than this time last year.

<u>COVID-19 impacts</u>: The Covid-19 adverse cost impact is estimated at 634k for the month, which is offset by savings of 461k, bringing the net Covid-19 impact for April at 173 for additional cost.

<u>COVID - Factors with adverse cost impact:</u>

- 366k is paid to staff stood down/self-isolation; casual staff top-up 13k;
- Annual leave (AL) taken has dropped by 23% or 3,892 hours, with a cost of 195k. This is due to cancelled AL for Easter, ANZAC day and school holiday;
- Extra 50k of flexi-bed budget transfer due to the lower ward occupancy

<u>COVID - Factors with positive cost saving impact:</u>

- Lower sick leave, a 37% or 2,112 hours drop and is 106 lower than the average prior Covid-19;
- Lower additional sessions reduced by 94k due to low ED presentations (-19% NSH and -43% WTH) and lower activity in general (-15% bed utilisation and 17% discharges);
- 50k savings on external bureau versus run rate;
- 250k saving from cardiology clinical supplies for implants and treatment disposables.

Sub Specialty Medicine and Health of Older People Services (SMHOPS) ($908k unfavourable YTD)
The unfavourable variance is driven by increased clinical supply costs for medical aids and Mental Health Services Older Adults (MHSOA) respite. The service also has an over-allocation of resident medical officers, and is suffering from low leave taken (see below for COVID-19 commentary).

This is partly offset by an increase in Non-Acute Rehab ACC revenue, and a decrease in gastro outsourced costs due to delays with outsourced providers performing these procedures.

The service has a number of savings initiatives including a review of ACC events, a review of MHSOA respite, and enhanced services for mobility aid managements.

COVID-19 impacts:
Additional costs/reduced revenue realised due to COVID-19 include additional staff costs in the months of March and April due to less leave being taken, whilst additional cover was required in some areas for special leave. There has been an unfavourable impact on ACC revenue in March and April, and this is anticipated to continue, to a lesser extent, in May and June due reduced patient numbers in rehabilitation wards.

Savings realised YTD due to COVID include Needs Assessment Service Coordination (NASC) Respite being reduced during lockdown and Gastroenterology's outsourced volumes being reduced in March and April over level 4 (noting this financial benefit is considered short term, with catch-up costs anticipated in the new financial year). Nursing personnel costs were saved on the Assessment Treatment and Rehabilitation (AT&R) wards as staff were redeployed to other parts of the hospital. There were savings in watches due to reduced bed occupancy from the closure of the AT&R wards and there were savings in the outsourced bureau requirements in MHSOA over April due to reduced occupancy.

Child Women and Family (CWF) ($1.247m unfavourable YTD)
The unfavourable variance was predominately due to increased service demand with the addition of recent COVID-19 impacts.

Demand for antenatal assessment and caesarean section services, neonatal services, elective and acute gynaecology activity has placed financial pressures on staffing and supplies resources to date. Staff roster gaps caused by staff shortages and patient demand – volume and acuity across Maternity and Neonatal services has resulted in higher cover costs being incurred. Recent recruitment of 11 new graduate midwives will ease some of the financial burden going forward.

The need to maintain safe medical rosters across Obstetrics and Gynaecology during a period of high demand is also influencing the financial result.

The adverse financial impact of COVID-19 has been more evident in our fee for service respite funding. This however is expected to be mitigated over the coming months with relief funding being made available to support the service. Significant service closures across Auckland Regional Dental Service (ARDS) has resulted in a noticeable reduction in clinical and infrastructure costs during the lockdown period.

Despite the above cost pressures the service continues to make good progress with its tactical savings initiatives with benefits being realised across the following - Obstetric and Anaesthetic on call accommodation, transitioning to digital post (ARDS), changes in Child Rehabilitation contract costs with ADHB and changes in the provision of clinical supplies to families accessing Community Child Nursing services.

Specialist Mental Health and Addiction (SMHA) Service ($355k unfavourable YTD)
The unfavourable variance was due to:

Additional revenue for Intellectual Disabilities (currently three supernumerary service users) $739k, and Court reporting $238k. Court reporting revenue has reduced significantly due to COVID-19 restrictions.

Staffing costs are slightly below budget, this being attributed to vacancies: medical (14 FTE) noting six positions will be filled by June, nursing (91 FTE) and allied (7 FTE). However locum costs and overtime remain significant until we can return all staff into the service.

Whilst SMHA service remains in favourable variance, the service had an unfavourable result for the month of $582k, driven by both COVID-19 and acuity.

COVID-19 impacts: Our top priority has been to open two Urgent Care Centres at 33 Paramount drive and 44 Taharoto road with the mission of supporting the Emergency Department in the event of high demand for services. These Centres are planned to cease after eight weeks of operation. Our IPUs have had to instigate a system of segregated "bubbles" within our facilities to ensure a COVID safe operating environment but at the cost of efficient staffing and shared resources. The service has taken the decision to provide uniforms to staff in direct contact with service users in our in-patient units (IPUs) and ED as COVID-risk mitigation.

Most services have been moved online from face to face where possible with the teams touching base with as many service users to ensure treatment is available where needed. Phone contacts have increased by over 50% and video conferences (Zoom) has enabled over 1,300 remote clinical sessions. The positive feedback we have received will enable this operating model, when appropriate, to be rolled into our business as usual (BAU) offering. Community Alcohol, Drug and Addictions Service (CADS) have closed the Detox unit and redeployed additional resource into the community. The team has undertaken an incredible 41 medical "In-home" detoxs in April (Pitman House usually processes around 50 service users per month). Unfortunately we are seeing demand for CADS services ramp up with a month's worth of referrals landing in the last week.

Other than COVID staffing impacts, Mason Clinic has continued BAU as far as possible. Acuity has impacted overtime costs – for example a service user with a broken ankle and treated at NSH required 3:1 observations 24-7 due to MOH rules around staffing levels given the service users status.

Elective Surgery Centre (ESC) ($1,937k favourable YTD)
Prior to COVID-19 the ESC was unfavourable to budget due to higher day case throughput adding to nursing costs as well as a case mix change to more laparoscopic activity than budgeted.

The YTD April favourable variance was due to the closure of the ESC and its conversion to a COVID ready ICU building in late March. The ESC was not operational during April although NSH used the theatres to compensate for the allocation of the three elective NSH theatres as COVID theatres. All activity at ESC in April was under the NSH model of operation with NSH bearing the costs.

The only personnel costs in the month related to management and support personnel as nursing staff and their attendant costs were redeployed across SAS. There was also some late billing by suppliers as well as unavoidable fixed costs such as leases.

Clinical Support ($1,291k unfavourable YTD)
The unfavourable variance is driven by:
- Increased equipment and bed repairs in Clinical Engineering.
- Traffic management costs have also increased due to recent changes in available spaces and shuttles from North Shore Event Centre.
- Increased number of Security guards on site during COVID-19 outbreak.

Diagnostics ($2,351k favourable YTD)
The favourable variance is driven by:
- Reduced pharmaceutical and lab consumables associated with reduced inpatients during COVID outbreak.
- Additional rebates received from Pharmac for hospital medicines.

Corporate and Provider Arm Support Services (YTD $28.212m unfavourable to budget)
The unfavourable variance is driven by:

- Delayed realisation of financial savings obligations, ($12.9m)
- Deferred sale of 44 Taharoto Road, ($10.1m)
- Adjustment to planned care revenue based on current under delivery of YTD volumes ($2.0m).

COVID-19 impacts

- Revenue including interest and car parking ($610k)
- Additional security and cleaning ($307)
- Redeployment and backfill of staff for Occupational Health and Emergency Planning ($522k)
- Three Harbours investment revaluation ($1.4m)

Offsets to the shortfall in savings obligations include:

- Release of residual provisions for settled MECA ($1.0m).

4.1 Clinical Leaders' Report

Recommendation:

That the report be received.

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

Quality and Risk

The project to upgrade of the current incident reporting system (Risk MonitorPro) was put on hold during the COVID-19 response. The project team have now reconvened and are currently reviewing the project plan and will agree on a revised go live date with the project running on a four to five month schedule.

Both the Controlled Documents and Clinical Electronic Decision Support System (CeDS) are undergoing review for replacement. The teams are currently working together to understand if both systems have similar enough requirements to utilise the same software platform moving forward, thereby achieving some cost benefits for the DHB.

All Divisions supported by the Quality and Risk team, the Director of Nursing and Associate Director of Allied Health Scientific and Technical Professions, are focusing on reducing the current number of open adverse event investigations.

A recruitment process is underway as replacement for a Quality and Patient Safety Lead who is taking on a new assignment as Change Lead for the Tōtara Haumaru project.

Medical Education

Office of the Director of Clinical Training – March/April 2020
The role of Director of Clinical Training (DCT) was advertised and recruited to during this reporting period. We are pleased to report that Dr Laura Chapman has taken up the role commencing 1st June 2020. Laura is a General and Acute Care Physician with a passion for medical education. She has most recently been Deputy Assistant Dean for the Waitematā University Campus. Dr Ian Wallace has stepped back from DCT responsibilities as at 29th May but he will continue to provide supervision in a half time role. Ian has made a huge contribution to the role and is looking forward to his semi-retirement.

With the increase in regulatory requirements from the Medical Council New Zealand (MCNZ), and the increase in RMOs employed at Waitematā, we have proposed that an additional position of Associate DCT (0.4FTE) will be needed to ensure we maintain a high standard of RMO training and meet our obligations.

Prevocational Educational Supervisors (PES)
During the lockdown PES have conducted virtual supervision meetings, which have been satisfactory. This was endorsed by MCNZ.

Community Based Attachments (CBAs)
All work related to CBAs was paused during the pandemic response.

Doctors in Difficulty and pastoral care of RMOs
Currently all issues are in hand. Higher levels of stress have been recorded amongst some house officers, particularly those working in ED and Gen Med, this has largely been due to concerns about potential risks associated with Covid-19 infected patients.

METU Team
Worked from home during the lock down and produced virtual and online content for the formal teaching programme and orientation.

Several wellbeing initiatives were continued and implemented during this time:

- Fortnightly Korero and Kai sessions via Zoom held with the PGY1s and Jo Egan
- Chnnl (wellbeing app)
- Individual pastoral support for house officers and medical students
- Zoom peer-to-peer support networks

Nursing and Emergency Planning Systems

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

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

Quality, Safety and Practice Development

Quality, Safety and Practice Development

- Safe Care priorities / quality framework
- Clinical Practice Effectiveness: Best Practice Essentials of Care; Patient and Whanau Centered Care Stds
- Competence assessment
- Credentialling
- Equity of care outcomes
- Workload monitoring: Trendcare, Care Capacity Demand Management [CCDM]

Throughout the COVID-19 lockdown, nurses have continued to ensure that pressure prevention requirements are followed. Seven suspected deep/unstageable tissue injuries have been identified so far in 2020. The quality improvement group is planning a further point prevalence audit. Work will continue with Aged Residential Care over the next six months to reduce number of community acquired pressure injuries.

The Falls prevention rate remains unchanged and we are looking at what we can focus on to achieve reduction. Intravenous bacteraemias have reduced over the past four months. The quality improvement group is planning a further point prevalence audit.

The annual Patient and Whānau Centred care standards audit is deferred until October.

Workforce Planning & Development

Workforce Planning & Development

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

All general learning sessions has been deferred since March. Focus has been on supporting nurses to revise application of PPE (Personal Protective Equipment).

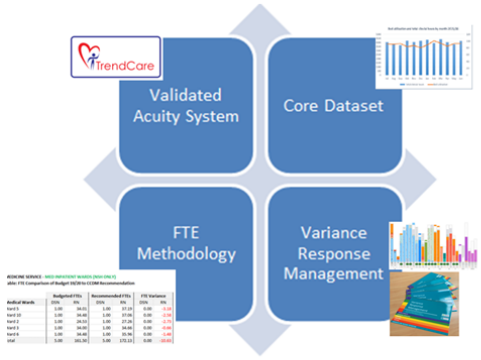
Student clinical placements have commenced with pre-registration nurses and Year 3 nurses commencing over the past month. This is important to ensure these students can sit the state examination in July and November in order to apply for employment in September and February. The pipeline is essential to workforce planning. Year 2 nurses start in semester 2 in June.

Two senior nurses have been awarded their PHD this week:
Dr Georgina MacPherson
Dr Hilary McCluskey

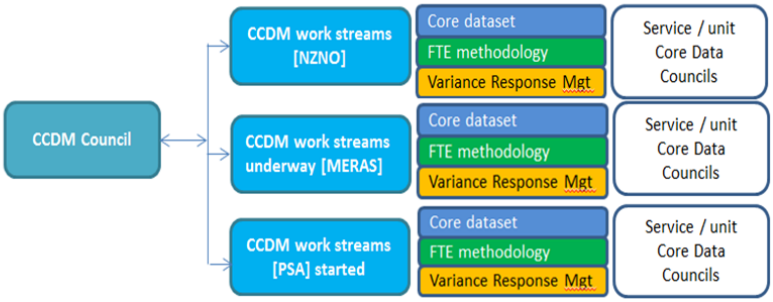
CCDM

The national **Care Capacity Demand Management (CCDM)** programme has progressed according to the approved timetable with three business cases submitted through to senior management for approval. Work has continued through the lockdown to assess the other areas outstanding. Progress on the FTE assessment needs to be advanced in order to meet Safe Staffing Executive and union expectations. All other requirements of core dataset, variance response management (VRM) are in place and used each shift.

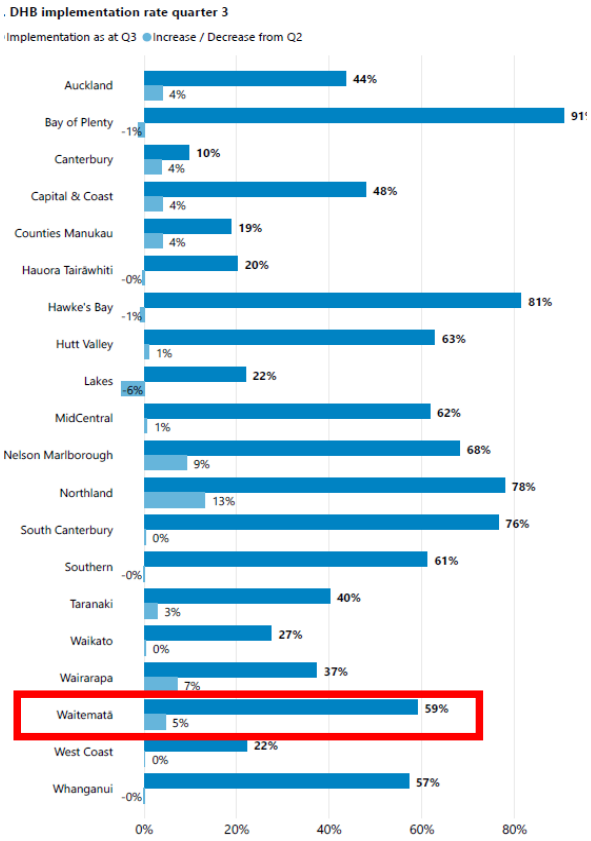
CCDM Care Capacity Demand Management

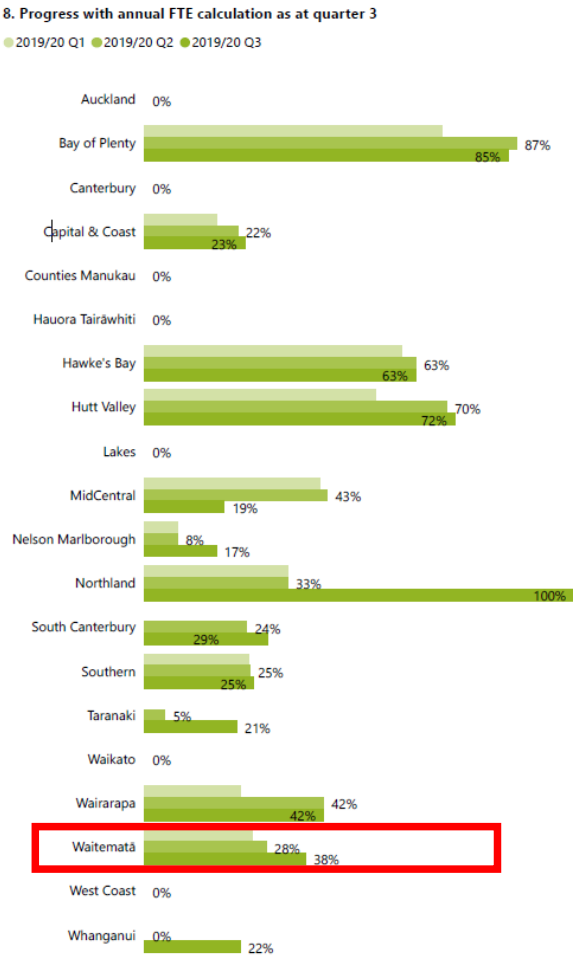


The MECA requirements, supported by the Minister of Health, requires that all **DHBs must have implemented the requirements by June 2021 in partnership with workforce unions. The NZNO reinforced this at the January 2020 CCDM Council meeting that all recommended FTE increases must be implemented by 30 June 2021**



Progress has been made with more to do to meet national expectations.





Workforce mix

Work continues to adapt processes orientation and training processes to reflect changes in workforce mix: age, ethnicity, length of service, workforce source.

Asian	European	Maori	Pacific	MELAA
39.8%	46.3%	6.2%	5.9%	2%

Considerable effort continues to actively recruit and retain Māori and Pacific nurses and midwives. There has been limited change in Māori and Pacific workforce over the past three months. Two new Māori nurse educators have been employed: Amber-Paige Primrose Ngatai (joint appointment with AUT) and Owena Zanders.

MAORI PRIORITY NURSING Apr 20	Māori in current workforce*	% of Māori in current workforce	Number of Māori to reflect working population	Additional Māori required	Recruited last 12 months	Terminated last 12 months	Last 12 months Movement
Senior Nurses	21	4.17%	46	25	2	-3	-1
Registered Nurses	115	5.25%	202	87	14	-10	4
Enrolled Nurses	2	4.35%	4	2	0	0	0
Nurses	**138**	**5.04%**	**252**	**114**	**16**	**-13**	**3**
Registered Midwives	16	11.27%	13	0	4	0	4
Health Service Assistants	60	12.12%	46	0	11	-8	3
Total NURSING	**214**	**6.34%**	**311**	**114**	**31**	**-21**	**10**

PACIFIC PRIORITY NURSING Apr 20	Pacific in current workforce*	% of Pacific in current workforce	Number of Pacific to reflect working population	Additional Pacific required	Recruited last 12 months	Terminated last 12 months	Last 12 months Movement
Senior Nurses	11	2.19%	37	26	3		3
Registered Nurses	91	4.15%	160	69	13	-8	5
Enrolled Nurses	3	6.52%	3	0	1		1
Nurses	**105**	**3.83%**	**200**	**95**	**17**	**-8**	**9**
Registered Midwives	6	4.23%	10	4			0
Health Service Assistants	97	19.60%	36	0	27	-9	18
Total NURSING	**208**	**6.16%**	**246**	**99**	**44**	**-17**	**27**

Professional Relationships & Resilience

Professional Relationships & Resilience

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

Work regionally with DHBs, community services and Schools of Nursing has increased over the past months to share ideas and plan as a region for clinical placements and workforce supply and demand.

There are good relationships and professional networks.

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

There are a number of national work streams arising out of national Nursing Now initiatives that Waitematā DHB nursing teams are participating in.

A range of initiatives are underway to recognise and celebrate nursing contribution to the health of our nation.

Acknowledging nursing contribution to our district and community

Motivating Nurses for future service needs in our community
Recruitment, Retention, Development, Aspiring leaders

Nursing role in health team connectedness
Between teams and across hospital-community interface; teamwork

Nurses in our place – New Zealand and the Pacific
Acts of Kindness / Paying Forward

Individual acknowledgement and development
- Service
- IND

Division Initiatives

Events to Inspire
Career Planning event
Leader workshop

The following nurses were acknowledged for their professionalism and contribution in 2020 as part of Nurses Day.

2020 International Nurses Day Awards

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

Emergency Systems Planning

The Incident Management Team for COVID-19 have worked very hard over the past weeks in a complex scenario. A range of staff have assumed the CIMS roles to lead the response.

With a new phase of recovery, Stephanie Vos, Emergency Response Advisor, has now been able to orient to the role and commence the DHB-wide Emergency work plan.

Allied Health, Scientific and Technical staff

Prepared by Sharon Russell, Associate Director of Allied Health, Scientific and Technical Professions and, Tamzin Brott, Director Allied Health Scientific and Technical Professions
(Forty-two (42) professions, accounting for 24% of the Waitematā DHB workforce.)

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

Friends and Family Test – Allied Health April 2020

A selection of comments received in April 2020 include:

- *"I love this service and highly recommend it to anyone needing it."*
- *"The service has been excellent and everybody very friendly."*
- *"Very helpful advice, definitely take on board great suggestions."*
- *"Incredibly helpful, inspirational in our sessions and then gave me heaps of activities to do at home and would adjust them for our circumstances."*
- *"Gained confidence, and great friendship and learned a lot."*
- *"Really sees the need and importance, listens and verifies the observation and provides relative suggestion or recommendation based from what have been observed."*
- *"Identifies person's capacity and ability to identify the right equipment for the person."*

Recruitment and retention of Māori and Pasifika workforce

Four allied health professions (Oral Health, Dietetics, Occupational Therapy and Physiotherapy) are in focus, with work plans in place locally, regionally and nationally in order to recruit and retain Māori and Pasifika clinicians reflecting the communities we serve.

We continue to connect undergraduate students who identify as Māori and Pasifika to the Waitematā DHB scholarship programme and the cultural and peer support offered throughout their undergraduate programme, and beyond as new graduates. Current Māori and Pasifika staff across those priority professions and staff required to reflect the working population as at April 2020 are:

MALT PRIORITY AH PROFESSIONS Apr 20	Māori in current workforce*	% of Māori in current workforce	Number of Māori to reflect working population	Additional Māori required	Recruited last 12 months	Terminated last 12 months	Last 12 months Movement
Oral Health Therapist	16	8.89%	17	1	2	-4	-2
Dietitian	2	4.00%	5	3	0	0	0
Occupational Therapist	8	5.00%	15	7	5	-2	3
Physiotherapist	9	8.49%	10	1	3	-1	2

Total AH Priority Professions	35	7.06%	47	12	10	-7	3
PALT PRIORITY AH PROFESSIONS Apr 20	**Pacific in current workforce***	**% of Pacific in current workforce**	**Number of Pacific to reflect working population**	**Additional Pacific required**	**Recruited last 12 months**	**Terminated last 12 months**	**Last 12 months Movement**
Oral Health Therapist	15	8.33%	13	0	1	-1	0
Dietitian	0	0.00%	4	4	1	0	1
Occupational Therapist	3	1.88%	12	9	0	0	0
Physiotherapist	3	2.83%	8	5	0	-1	-1
Total AH Priority Professions	**21**	**4.23%**	**37**	**18**	**2**	**-2**	**0**

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

Better, Best Brilliant

Throughout the COVID-19 pandemic response, Waitematā DHB Allied Health and Scientific Technical professions have continued to provide care to our communities by engaging in innovative ways of working both within the hospital and community setting. Multiple teams have utilised digital health options across the continuum of services, connecting teams across Waitematā DHB sites, providing a more efficient way of communicating. Digital health has enabled nationwide collaboration across many professions.

- **Clinical Telehealth**
  Clinical telehealth has enabled Allied Health clinicians to provide face to face contact with our communities, and work in an Interdisciplinary manner with external agencies. Within the Child Women and Family team this has supported families to feel safe within their own 'bubbles' at home, while receiving clinical care.

  Utilising telehealth has also enabled a more flexible way of interacting with families/whānau at times that have suited them. One member of the Community Child Health team created a homemade mannequin to demonstrate positioning to parents of disabled children who presented with complex needs. This approach was well received by families and enabled therapists to complete remote assessments and order appropriate equipment to meet the clinical needs of the children and their parents.

  The adult physical community teams have worked as one interdisciplinary team across multiple sites with the use of Telehealth, enabling a more responsive approach to delivering care, with close connections to the hospital services again allowing for a more seamless response and working towards a rapid response model of care delivery. Existing services were revised to respond to the change. For example, the Early Discharge and Rehabilitation service (EDARS) and adult physical community services were modified with the following services being developed.

- **Rehab Safe**
  Focusing on safety and education, the Rehab Safe team set rehabilitation patients up at home with two to three visits, either virtually or in person, to establish safety and provide education with

follow-up phone call after one week, to assess if further rehabilitation input was required. Areas of focus included, but was not limited to:

- Reviewing safe transfer ability and equipment needs at home
- Ability to safely access meals/medications
- Education with the patient/family/whānau on self-management strategies and home exercise programmes.

- **Community Safe team**
  Providing a rapid response service for patients presenting at our emergency departments or being discharged from an inpatient setting such as:

  - Providing a rapid response initial visit / virtual contact to ensure safety at home
  - Follow up assessment and intervention as clinically indicated
  - A focused approach on preventing re-admission by provision of equipment, advice and education.

- **Community Connection Calling Service**
  A wellbeing check-in for vulnerable adults via Telehealth (either by phone or virtual connection). The Community Connection Callers are Waitematā DHB clinical staff who were redeployed from their usual clinical role to provide support and assessment. The Community Connection team are able to escalate identified issues if required to Allied Health services or through community referrals.

- **Specialist Mental Health and Addiction Services**
  Psychologists within the Specialist Mental Health and Addictions Services started urgent care centres for service users with urgent mental health requirements. This has seen some reductions in the presentation to the Emergency Department (ED). In some areas such as child and youth, rural teams, and for some service users with particular disorders the use of Telehealth has improved initial engagement and access with assessments, individual and limited group therapy interventions and clinical checks and consultation completed via Telehealth.

- **Scientific and Technical Professions**
  Cardiac Physiology has reduced the number of clinic visits required by initiating an early remote monitoring system. The monitoring system has worked in conjunction with an application (App) called MyCarelink Heart for monitoring patients rather than the need for a home monitor.

  Cardiac Sonography have also seen an improvement in collaboration with their professional journal group reaching as far as Waikato and Capital Coast DHB, enabling new learning and regional and national collaboration.

Connected

Across the professions teams have worked with an increased connectedness. The Anaesthetic Technician Team has been involved in a seamless transfer process with a dedicated team at Waitakere to assist with the transportation of critical patients from Waitakere to North Shore Hospital. This group of clinicians also supported N95 mask fit testing and the Infection Prevention Control group with Personal Protection Education (PPE) training.

4.2 Quality Report – March/April 2020

Recommendation:

That the report be received.

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

Contents

Acronyms

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

1. Health Quality and Safety Markers

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

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

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

- 90% of older patients are given a falls risk assessment
- 90% of older patients at risk of falling have an appropriate individualised care plan
- 90% compliance with procedures for inserting central line catheters in ICU (insertion and maintenance bundle compliance)
- 80% compliance with good hand hygiene practice
- Surgical Site Infections rate per 100 procedures [target has not been set by HQSC)
- 100% primary hip and knee replacements antibiotic given 0-60 minutes before 'knife to skin' [first incision]
- 95% primary hip and knee replacements right antibiotic in the right dose - Cefazolin 2g or more
- 100% of audits where all components of the surgical safety checklist were reviewed
- 100% of audits with surgical safety checklist engagement scores of five or higher
- >50 observational audits are carried out for each part of the surgical checklist
- Number of DVT/PE cases per quarter *(target has not been set by HQSC)*
- Percentage of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic medicine reconciliation was undertaken within 72hrs [of admission] *(target has not been set by HQSC)*
- Percentage of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic medicine reconciliation was undertaken within 24hrs [of admission] *(target has not been set by HQSC)*
- Percentage of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic medicine reconciliation was included within as part of the discharge summary *(target has not been set by HQSC)*
- Percentage of patients with a documented sedation score*(target has not been set by HQSC)*
- Percentage of patients with documented bowel function monitored *(target has not been set by HQSC)*

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

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

Period covered	Publication date (indicative)
Q1 2020 (Jan–Mar 20)	30 June 2020
Q2 2020 (Apr–Jun 20)	30 September 2020
Q3 2020 (Jul–Sep 20)	18 December 2020

2. Health Quality and Safety Commission Quarterly QSM Dashboard

Quality Safety Markers (QSM)			*Target*	*Q1 2018*	*Q2 2018*	*Q3 2018*	*Q4 2018*	*Q1 2019*	*Q2 2019*	*Q3 2019*	*Q4 2019*	*Q1 2020*	*Last Quarter Change*
Falls		% older patients assessed for falls risk	90%	*96%*	*95%*	*98%*	*96%*	98%	97%	98%	99%	99%	⇔
		% older patients assessed as significant risk of falling with an individualised care plan	90%	*95%*	*98%*	*97%*	*96%*	94%	99%	99%	98%	99%	⇧
Health Care Associated Infections	Hand Hygiene (HH)	% of compliant HH moments	80%	*89%*	*90%*	*89%*	*89%*	89%	90%	89%	88%	93%	⇧
	CLAB	% occasions insertion bundle used in ICU	90%	*99%*	*99%*	*98%*	*100%*	99%	100%	100%	100%	100%	⇔
		% occasions maintenance bundle used in ICU (*not currently an HQSC Target*)	90%	*95%*	*91%*	*96%*	*97%*	92%	96%	97%	99%	99%	⇧

Quality Safety Markers (QSM)			Target	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Last Quarter Change
	Surgical Site Infections	Surgical Site Infections rate per 100 procedures [target has not been set by HQSC. *National Q4 2018 rate = 1.0 infection per 100 procedures*	HQSC has not defined a target	0.9	0.7	0.0	0.0	1.5	0.4	0.7	TBA	TBA	-
				Cumulative rate 1.0 (From Jul 13)									
		100% primary hip and knee replacements antibiotic given 0 -60 minutes before 'knife to skin' [first incision]	100%		98%	95%	97%	97%	97%	98%	100%	HQSC SSI data lags by one quarter	-
		95% primary hip and knee replacements right antibiotic in the right dose - Cefazolin 2g or more	90%		96%	97%	99%	98%	97%	98%	100%		-
		100% of primary hip and knee replacements will have alcohol based skin preparation	100%		94%	100%	98%	100%	95%	Not provided by HQSC	Not provided by HQSC		-
		100% of primary and knee replacements will have surgical antimicrobial prophylaxis discontinued with 24 hours post-operatively	100%	100%	100%	100%	100%	100%	99%	Not provided by HQSC	Not provided by HQSC		-
Medication Safety	eMedRec	% of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic reconciliation was undertaken - within 72hrs [of admission]	TBD	*Reporting Commenced Quarter 4 2019*							90%	82%	⇩
		% of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic reconciliation was undertaken within 24hrs [of admission]	TBD								63%	64%	⇧
		% of patients aged 65 years and over (55 and over for Māori and Pacific people) where electronic reconciliation was included within as part of the discharge summary	TBD								92%	92%	⇔
	Opioids	% of patients with a documented sedation score	TBD	*Until HQSC completes Privacy Impact Assessment for Waitematā DHB data, we will provide aggregated data only*				84%	85%	85%	86%	86%	⇔
		% of patients with documented bowel function monitored	TBD					3.0%	3.3%	4.0%	3.0%	4.3%	⇧
		% of patient with uncontrolled pain	TBD					84%	11%	0.0%	0.0%	0.8%	⇧

Quality Safety Markers (QSM)			Target	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Last Quarter Change
		% of patients with documented opioid related adverse events *HQSC Provide*	TBD	*HQSC Data provided from Q3 2019*						0.49%	0.35	TBC	-
Patient Deterioration	% of eligible wards using the NZ Early Warning System (EWS)		TBD						100%	100%	100%	100%	⇔
	% of audited patients with an EWS score calculated correctly for the most recent set of vital sign		TBD						100%	100%	100%	100%	⇔
	% of audited patients that triggered an escalation of care and received appropriate response to that escalation as per DHB agreed escalation pathway		TBD						70%	72%	78%	69%	⇩
	Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, units or departments per 1000 admissions (NMDS) *HQSC Provide*		TBD		0.9%	1.3%	1.0%	0.2%	0.6%	0.5%	1.5%	TBC	-
	Rate of rapid response escalations per 1000 admissions (NMDS) *HQSC Provide*		TBD	*HQSC Data provided from Q3 2019*						19%	19.7%	TBC	-

Pressure Injuries	% of patients audited for pressure injury risk who received a score (NMDS)	90%	*Reporting commenced Q3 2018*	88%	86%	85%	86%	87%	89%	90%	⇧
	% of patients with the correct pressure injury care plan implemented	90%		71%	62%	68%	68%	68%	65%	70%	⇧
	% of patients audited with a hospital acquired pressure injury	TBD		1.6%	2.4%	0.6%	1.2%	1.0%	0.6%	1.3%	⇧
	% of patients audited with non-hospital acquired pressure injury	TBD				2.1%	1.6%	2.2%	1.4%	2.9%	⇧

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

Note: QSMs collation suspended by HQSC until June 2020

Quality Safety Markers			Target		Q4 2017	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Last Quarter Change
Peri-Operative Care	Surgical Safety	Uptake: % of audits where all components were reviewed	100%	Sign In	98%	98%	98%	100%	100%	98%	100%		98%		
				Time Out	100%	97%	100%	98%	98%	100%	100%		100%		
				Sign Out	92%	100%	98%	98%	100%	98%	98%		100%		
		Engagement: % of audits with engagement scores of five or higher	95%	Sign In	84%	93%	85%	96%	88%	89%			97%		
				Time Out	89%	90%	92%	94%	94%	100%	98%		100%	TBC	
				Sign Out	94%	95%	95%	100%	92%	98%			98%		
		Observations: number of observational audits carried out for each part of the surgical checklist (minimum of 50 observations per quarter)	≥ 50	Sign In	57	56	56	52	51	57	48	49	65		
				Time Out	54	64	61	51	53	53	52	45	64		
				Sign Out	52	55	56	52	50	51	45	36	55		

Data not published by the HQSC if observations were <50

Less than 75%

More than 75%

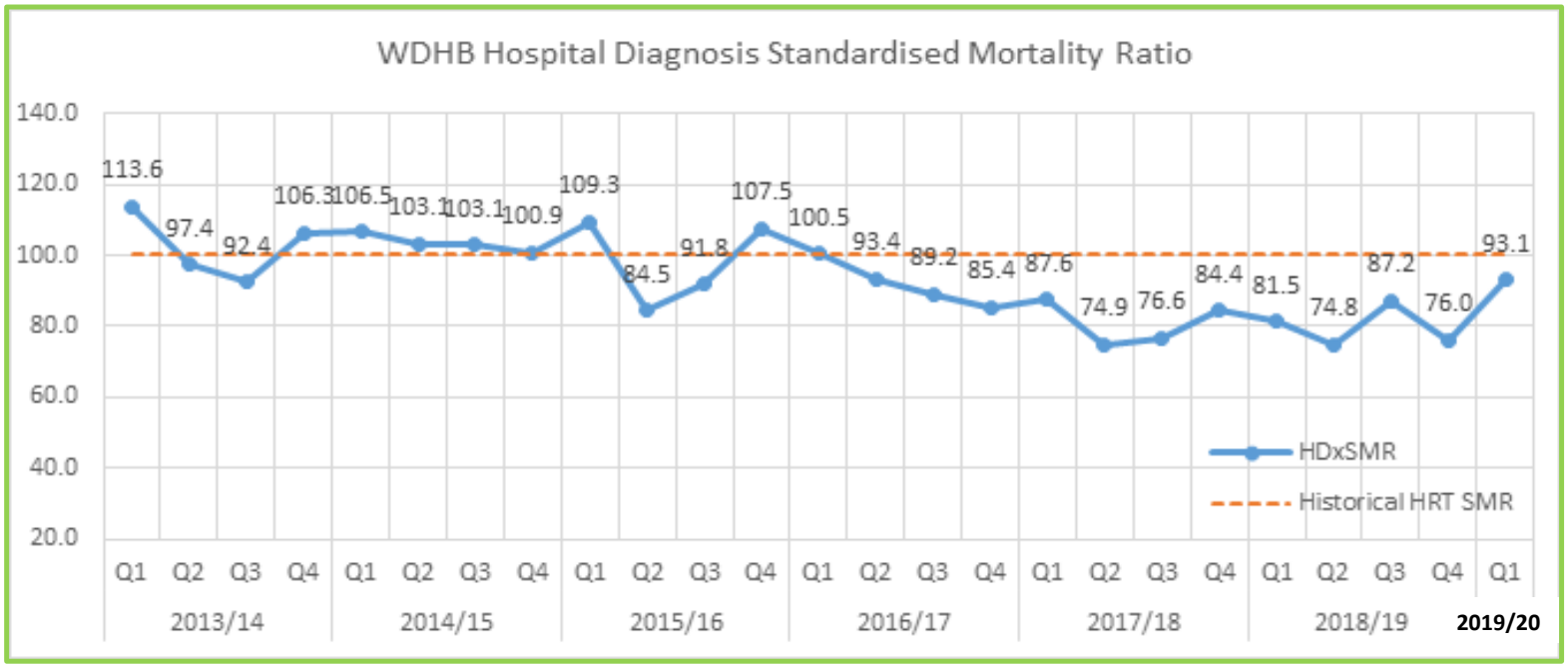
Target Achieved

3. DHB Key Quality Indicators and Trends

Quarterly HDxSMRs

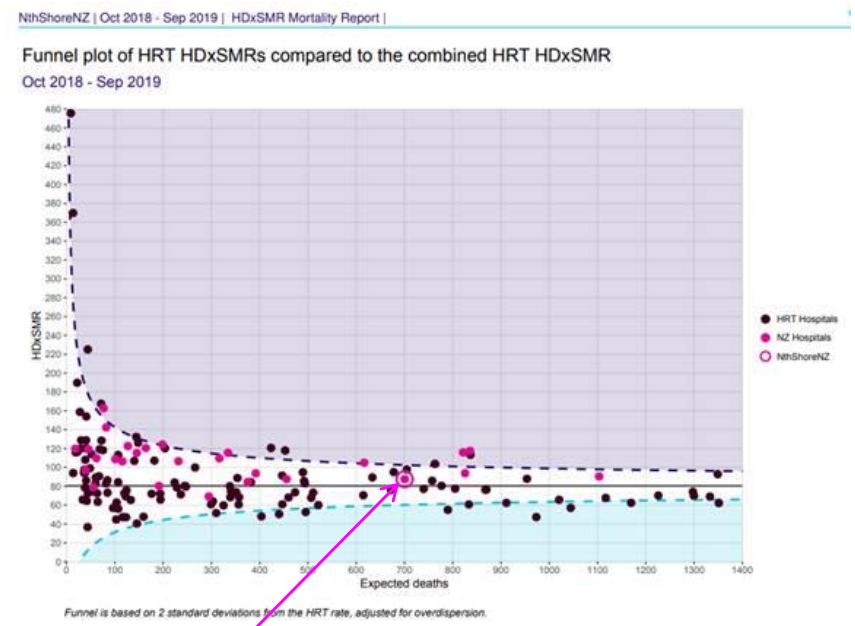
Hospital Diagnosis Standardised Mortality Ratio (HDxSMR)
The HDxSMR is expressed as a ratio and seeks to compare actual deaths occurring in hospital (or in hospital and following hospital admission), with a predicted number of deaths based on the types of patients admitted to the hospital. The HDxSMR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

Hospital Diagnosis Standardised Mortality Ratio (HDxSMR)
Waitematā DHB's HDxSMR (combined NSH + WTH) **Q1 FY2019/2020 = 93.1**



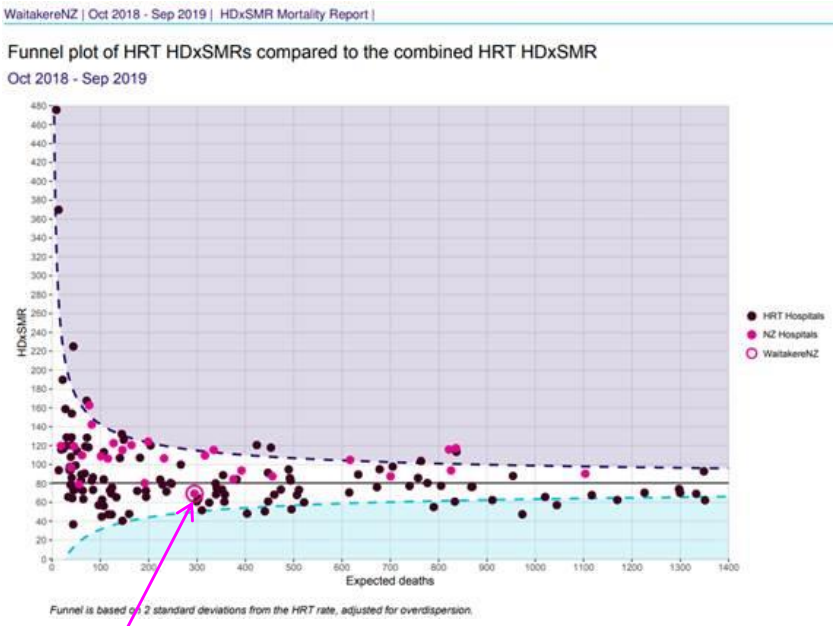
12 month Data - **HDxSMR Oct 2018 – Sep 2019**:

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



North Shore Hospital

HDxSMR	
(12 months: Oct 2018 -Sep 2019)	**88**
Episodes	**68,978**
Deaths	**613**
Expected Deaths	**700.3**
Combined HRT HDxSMR for Oct 18-Sep 19	**80**
NZ HDxSMR for Oct 18-Sep 19	**101**
Network HDxSMR	**82**

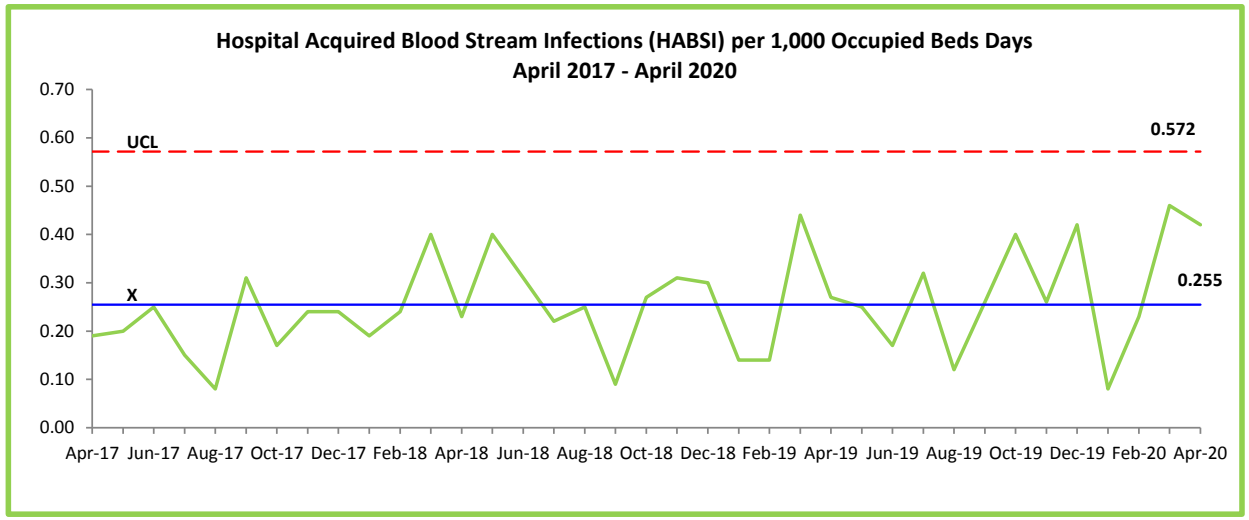


Waitakere Hospital

HDxSMR	
(12 months: Oct 2018 -Sep 2019)	**69**
Episodes	**34,214**
Deaths	**204**
Expected Deaths	**294.7**
Combined HRT HDxSMR for Oct 18-Sep 19	**80**
NZ HDxSMR for Oct 18-Sep 19	**101**
Network HDxSMR	**82**

3.1 Hospital Acquired Blood Stream Infections (HABSI)

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
0	Total # of infections	5 (Feb)	9 (Mar)	6 (Apr)	*HABSI is defined as a bloodstream infection attributable to hospital where acute or rehabilitation care is provided, if the infection was not incubating on admission. Typically bacteraemia diagnosed after 48 hours of admission, on readmission, related to a device, or within 30 days of procedure (if no alternate source identified) is categorised as a HABSI. There is no recognised national benchmark 'acceptable' rate or target for HABSI.*
0.00	# of infections per 1,000 occupied bed days	0.23 (Feb)	0.46 (Mar)	0.42 (Apr)	



- **Mean rates of HABSI/1,000 occupied bed days**

	Rate	N=
2016	0.35	89
2017	0.25	67
2018	0.26	70
2019	0.26	71
Q1 2020	0.25	16

The Executive Reports for Infection, Prevention and Control Committee are not available for March and April 2020

HABSI Analysis March 2020
Not available for this time period

Target	Measure	Prev. Report Period	Current Report Period	Commentary/Trends

HABSI Analysis April 2020

Source	Total	Area	Organism	Comments
CAUTI	1	Ward 6	Klebsiella Pneumoniae	• Patient required an indwelling urinary catheter for urinary retention; this appropriate management for this condition however, the patient developed a urinary tract infection
Other	5	Ward 8	Enterococcus Faecium	• A patient with extensive comorbidities[1] developed a hospital acquired blood stream bacteraemia (HABSI) following total abdominal resection.
		ICU/HDU	ESBL E coli/Staph aureus	• A patient was admitted to hospital with severe necrotising pancreatitis and multi-organ failure developed a hospital acquired blood stream bacteraemia (HABSI)
		Ward 4	ESBL E coli	• A patient developed a hospital acquired blood stream bacteraemia (HABSI) following the insertion of a biliary stent via and endoscopic procedure
		Muriwai Ward	Proteus Mirabilis	• A patient developed a hospital acquired blood stream bacteraemia (HABSI) due to urinary sepsis
		Ward 15	E coli	• A patient with a history of recurrent urinary tract infections developed a hospital acquired blood stream bacteraemia (HABSI)

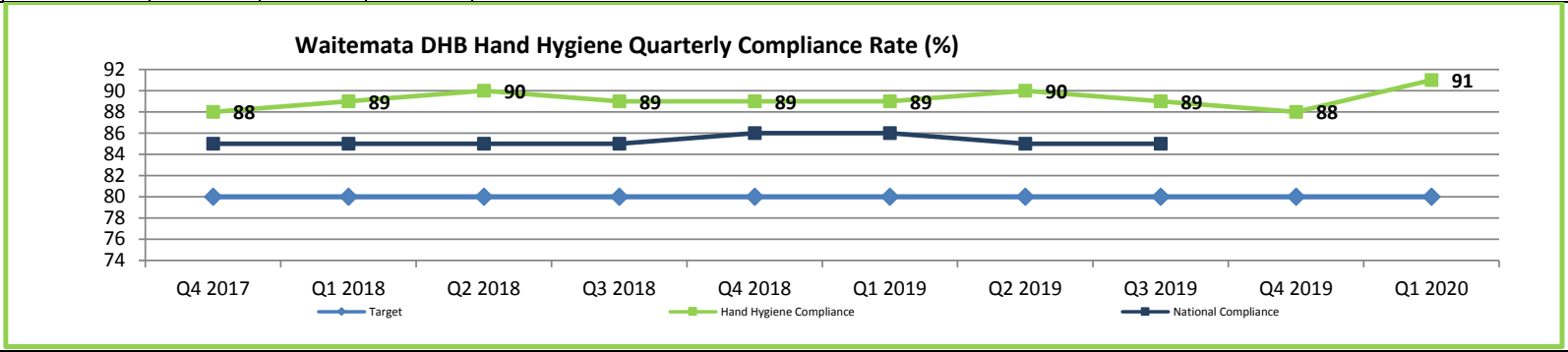
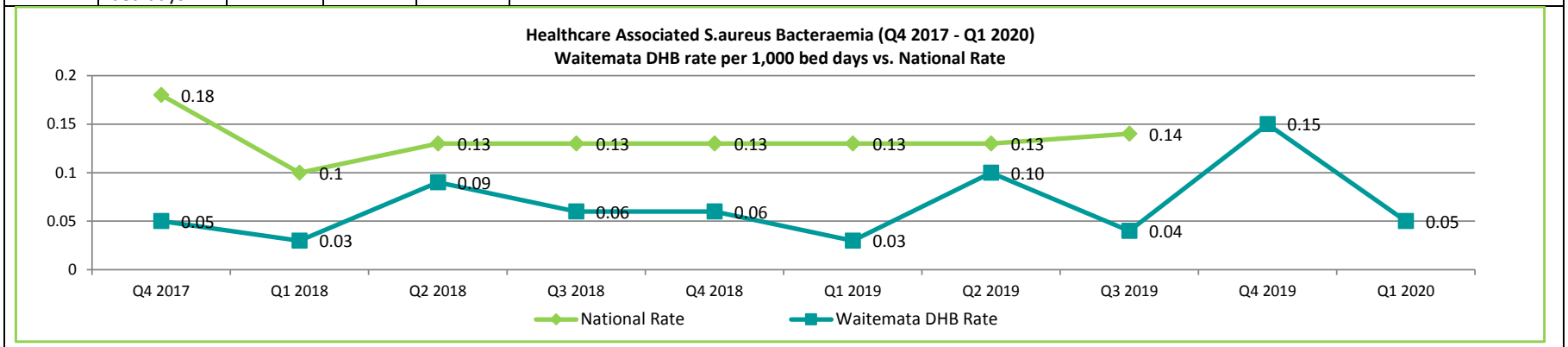
3.2 Hand Hygiene (HH) Compliance

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
>80%	% rate of compliance with five Hand Hygiene Moments	91% (Feb)	93% (Mar)	94% (Apr)	Waitematā DHB continues to achieve a Hand Hygiene compliance rate above the National Target of 80% and the National average compliance rate of 85%

Hand Hygiene Results by Division Q1 (Jan – Mar) 2020

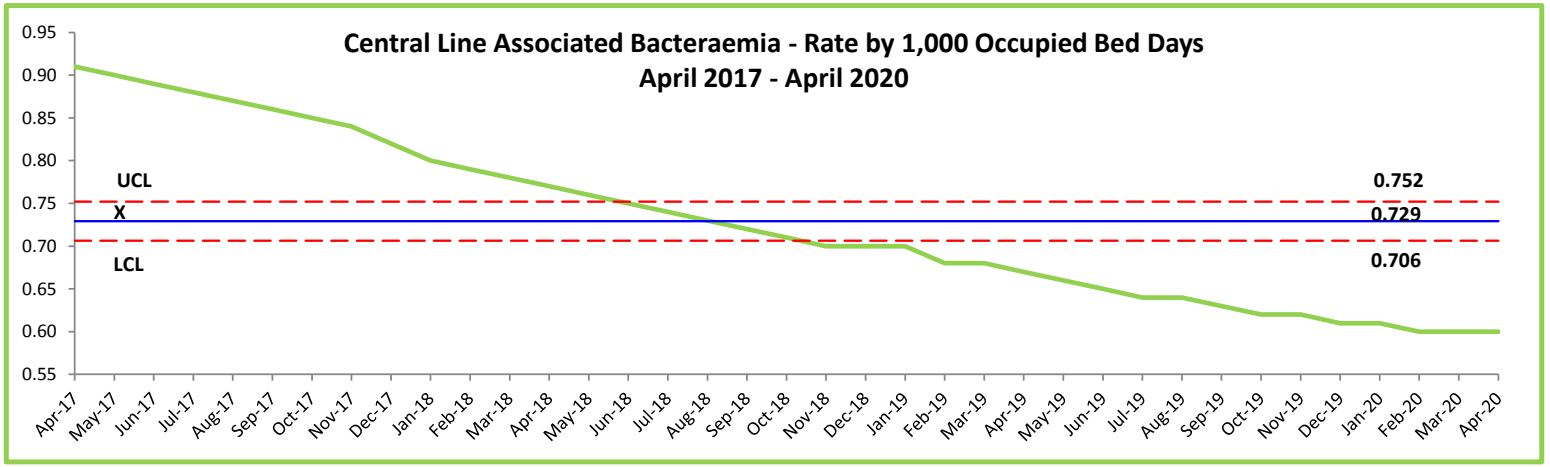
Division	Correct Moments	Total Moments	Compliance
Acute & Emergency Medicine	4,120	4,593	90%
Child Women & Family	1,808	1,974	92%
Specialty Mental Health + Addictions	661	676	98%
Specialist Medicine + Health of Older People	1,872	2,037	92%
Surgical & Ambulatory	4,276	4,724	91%
Total	**12,737**	**14,004**	**91%**

[1] **Comorbidity** is the presence of one or more additional conditions co-occurring with (that is, concomitant or concurrent with) a primary condition; in the countable sense of the term, a comorbidity (plural comorbidities) is each additional condition

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
					
0	Total # of Hospital Associated SAB infections	0 (Feb)	2 (Mar)	1 (Apr)	**Staph Aureus Blood Stream Infections/ Healthcare Associated Bacteraemia (HCA-BSI)** *The rate of S.aureus bacteraemia (SAB) infections attributed to healthcare is the national outcome measure for hand hygiene compliance. The SAB rate is based on HHNZ's definition to maintain consistency in DHB reporting.* The length of time between infections is increasing which may reflect improved compliance with hand hygiene practices. ***The Waitematā DHB Hand Hygiene Reports for March/April 2020 are not available***
0	# of Hospital Associated SAB infections per 1,000 bed days	0.00 (Feb)	0.10 (Mar)	0.07 (Apr)	
					

3.3 Central Line Associated Bacteraemias (CLAB)

Target	Measure	Previous Report Period	Current Report Period		Commentary/Trends
<1	# of CLAB infections per 1,000 line days (ICU)	0.60 (Feb)	0.60 (Mar)	0.60 (Apr)	**Central Line Associated Bacteraemia (CLAB)** *Patients with a central venous line are at risk of a blood stream infection (CLAB). Patients with a CLAB experience more complications, increased length of stay, and increased mortality; and each case costs approximate $20,000 - $54,000. CLAB infections are largely preventable using a standardised procedure for insertion and maintaining lines (insertion and maintenance bundles of care). NSH's ICUs compliance with standard procedure and rates of CLAB are Health Quality and Safety Markers.* The ICU is currently **973 days** CLAB Free as at **30 April 2020** • Central lines are inserted in the operating theatre and maintenance of the lines on the wards is followed up by theatre, ICU and the Infection Prevention and Control team staff supporting ward staff • The total number of central lines (centrally and peripherally) inserted in **March = 18 /April = 21** • CLAB rates at Waitematā DHB remain low and most wards have very long CLAB free periods due to both good compliance and infrequency of patients with central lines.
>98%	% bundle compliance at insertion (ICU)	100% (Feb)	100% (Mar)	100% (Apr)	
>98%	% bundle compliance maintenance (ICU)	97% (Feb)	97% (Mar)	89% (Apr)	



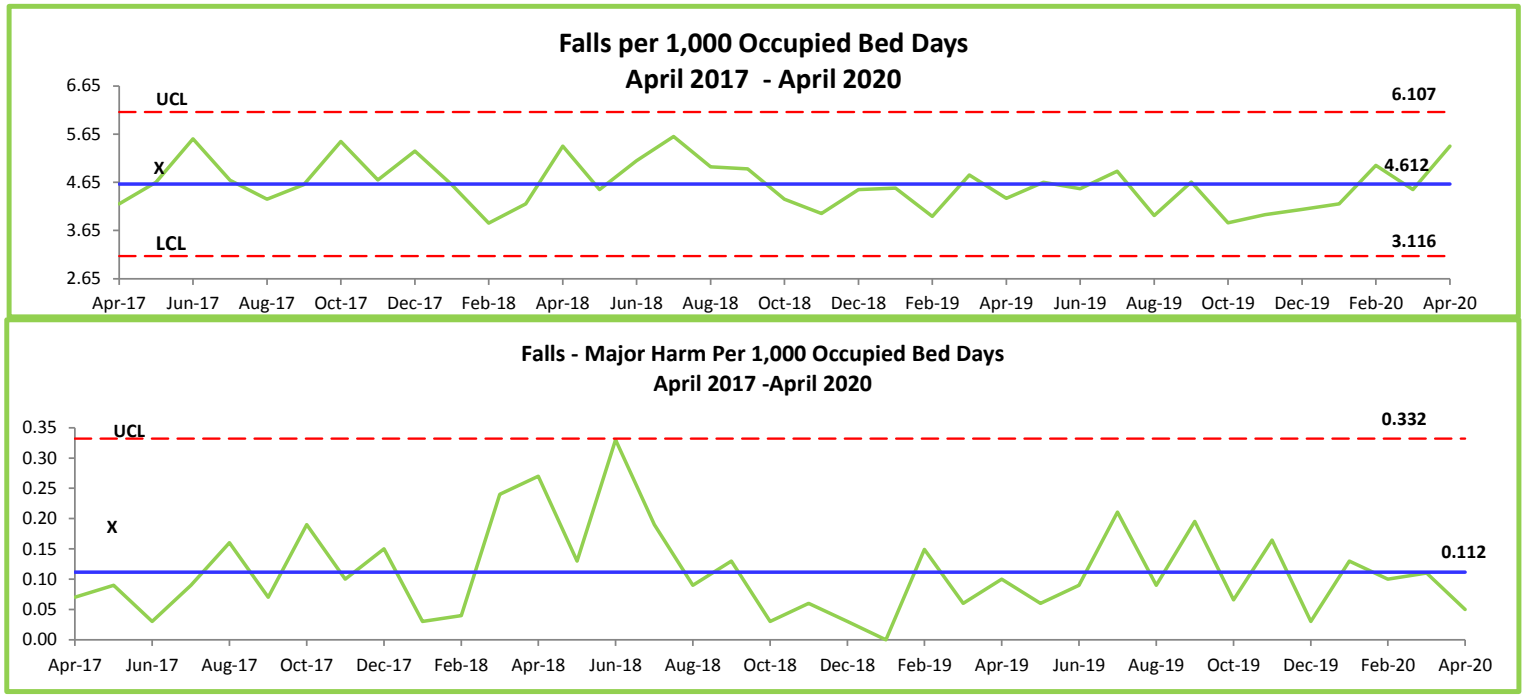
3.4 Surgical Site Infections

Target	Measure	Previous Report Period	Current Report Period	Commentary/Trends
TBA	-	0.4% (SSI Rate Q2 Apr – Jun 2019)	0.7% (SSI Rate Q3 Jul – Sep 2019)	*Surgical Site Infections (SSIs) – in scope procedures for SSI are primary and revision hip and knee arthroplasty at either North Shore Hospital or the Elective Surgery Centre (ESC) in accordance with the National Surgical Infection Improvement Programme. The surveillance criteria 90 days post-operatively for deep and 30 days for superficial infection.* • **Zero** SSI for **Q1 2020** reported by Infection, Prevention and Control

3.5 Falls with Harm

Target	Measure	Prev. Report Period	Current Report Period		Commentary
	Total number (#) of falls	146 (Feb)	121 (Mar)	113 (Apr)	*A verbal update will be provided by by Director of Nursing and Midwifery* **NB lower than average occupied beds days due to bed closures has increased the April 2020 Falls rate*
<5.0	Rate of falls per 1,000 Occupied Bed Days (OBD)	5.0 (Feb)	4.5 (Mar)	5.4* (Apr)	
	Total number of multi-fallers	16 (Feb)	17 (Mar)	13 (Apr)	
>90%	% patients 75 years and over (55 years and over Māori and Pacific) assessed for the risk of falling	99% (Feb)	100% (Mar)	99% (Apr)	
>90%	% patients 75 years and over (55 years and over Māori and Pacific) assessed for the risk of falling within eight hours of admission	82% (Feb)	81% (Mar)	85% (Apr)	
>90%	% patients 75 years and over (55 years and over Māori and Pacific) assessed as being at sufficient risk of falling have an individualised care plan in place	98% (Feb)	100% (Mar)	97% (Apr)	
	Total number of falls where an injury has occurred (including Major Harm)	48 (Feb)	29 (Mar)	30 (Apr)	
	Rate of falls where an injury has occurred (including Major Harm) per 1,000 Occupied bed day	1.6 (Feb)	1.1 (Mar)	1.4 (Apr)	
	Total number of falls with major harm (SAC 1 and 2)	3 (Feb)	3 (Mar)	1 (Apr)	
	Rate of falls with major harm per 1,000 Occupied bed day	0.10 (Feb)	0.11 (Mar)	0.05 (Apr)	
0	Total number of reported fractured neck of femurs (NOF) as a result of a fall while in hospital (included in the major falls with harm rate)	2 (Feb)	1 (Mar)	0 (Apr)	
0	Total number of coded fractured neck of femurs (NOF) as a result of a fall while in hospital	TBA (Feb)	TBA (Mar)	TBA (Apr)	

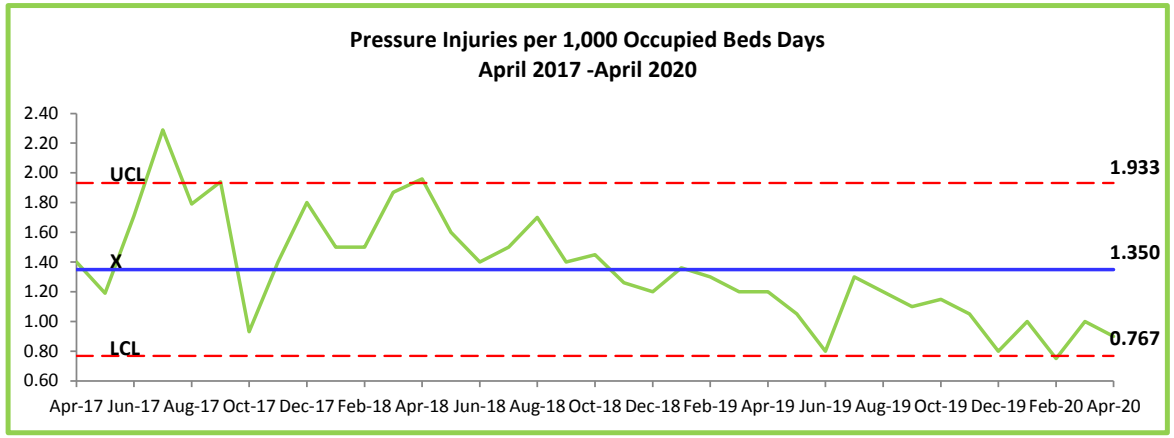
Target	Measure	Prev. Report Period	Current Report Period	Commentary

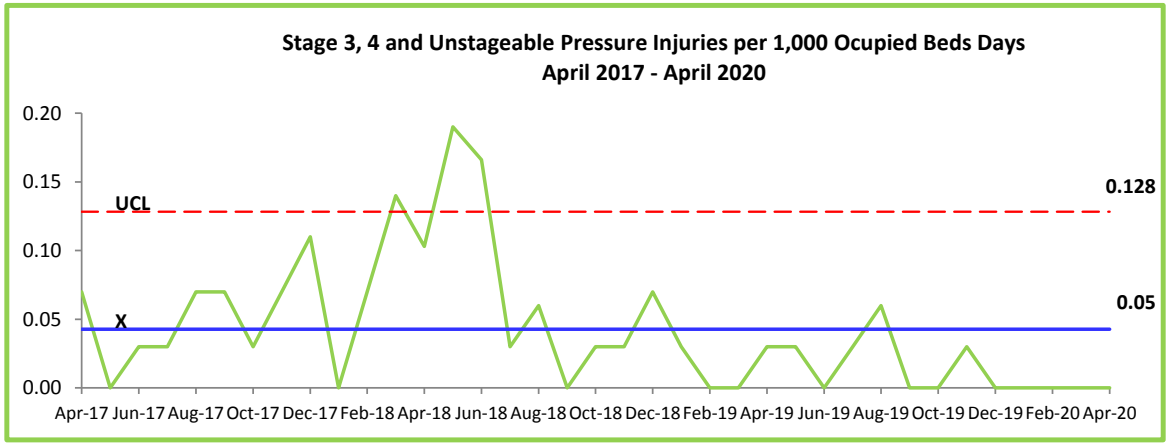


3.6 Pressure Injuries

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
100%	% patients risk assessed within specified time frame (eight hours)	74% (Feb)	72% (Mar)	71% (Apr)	
100%	% patients audited who received a score	85% (Feb)	94% (Mar)	87% (Apr)	
100%	% patients with the correct care plans implemented	72% (Feb)	65% (Mar)	78% (Apr)	
	Number of patients with reported confirmed pressure injuries (Incident Reporting System – Risk MonitorPRO)	22 (Feb)	28 (Mar)	19 (Apr)	
	Rate of confirmed pressure injuries per 1,000 Bed Days	0.8 (Feb)	1.0 (Mar)	0.9 (Apr)	

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
0	Number of reported confirmed Stage 3, 4 or unstageable pressure injuries (Incident Reporting System – Risk MonitorPRO)	0 (Feb)	0 (Mar)	0 (Apr)	
	Rate of confirmed Stage 3, 4 or unstageable pressure injuries per 1,000 Bed days	0.00 (Feb)	0.00 (Mar)	0.00 (Apr)	





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

Target	Measure	Previous Report Period	Current Report Period	Commentary
100%	% patients with eMR completed within 24 hours on admission and discharge	87%	90%/92%	**Electronic Medicines Reconciliation (eMR/eMedRec) – no change from previous report** eMedRec (electronic Medicines Reconciliation) is live across 919 acute beds at North Shore and Waitakere Hospitals. An admission Med Rec is completed for 80-90% of all ward patients (in areas where eMedRec available). The rollout of eMedRec was completed to all planned areas in 2019. Maternity and the Emergency department remain the only specialties where the software is not enabled. WDHB has been working with HQSC and other eMedRec stakeholder DHBs to agree on nationally appropriate quality and safety markers (QSMs) around the Med Rec process. After several iterations, a set of structure and process measures have been agreed upon and WDHB will be reporting these in the future. The Orion Health eMedRec software and the Soprano Medical Templates technology that eMedRec is built on an outdated technology and considered 'sunset' products by the vendor. We are approaching the limits of what these solutions are capable of and there are several areas where enhanced functionality or a new solution would be valuable e.g. the ability to do eMedRec and generate prescriptions in outpatient settings. In April 2020, during the COVID-19 lockdown, a new ePrescribing solution (from vendor Indici) was successfully implemented in outpatients to support telehealth. **Electronic Prescribing and Administration (ePA) – no change from previous report** **MedChart Performance:** We agreed with healthAlliance some time ago to move the remaining MedChart servers to the new Virtual Farm as there was some performance improvement when some were moved across. Since then there has been a focus on looking at how MedChart can be run across the region. The VMs (servers) still need to be moved. **iPad Freezing:** While the new TWA wireless network was tested and confirmed to be significantly faster; it has since been moved into production and implemented on ward 10. Testing in production has shown it is *now performing more slowly than SWA*. This has been escalated within healthAlliance and we are waiting on next steps.

3.8 Complaint Responsiveness

Target	Measure	Previous Report Period	Current Report Period		Commentary
<15 days	Average time to respond to complaints in the reporting month	14 (Feb)	9 (Mar)	13 (Apr)	• The average days to respond have gradually decreased over the last four years and services across the DHB are working diligently to ensure they meet the target of <15 calendar days to respond

	Average Days to Respond
2015	18
2016	19
2017	15
2018	14
2019	**12**

Average Days to Respond – Provider Arm		
Division	Mar 2020	Apr 2020
Acute & Emergency Medicine	7	18
Child, Women & Family	8	17
Specialist Mental Health & Addictions	47	18
Specialty Medicine and Health of Older People	13	9
Surgical & Ambulatory	8	8

4. Safe Care

4.1 Infection Prevention and Control (IP&C)

*IP&C Surveillance Overview and Audit Results for **March/April 2020***

Month	Total ESBL (Def)	Total HABSI	Total C.diff (HO-HCA)	Total Waitematā DHB Hand Moments	% National HH Moments Passed (Ave	%I&PC Facilities Standards Met Overall (Ave)	% Commodes Clean
January 2019	17	3	3	5079	89%	97%	100%
February 2019	18	3	3	4824	89%	98%	83%
March 2019	16	10	4	4939	90%	98%	98%
April 2019	15	6	4	4783	89%	97%	86%
May 2019	12	6	5	4722	90%	97%	91%
June 2019	4	4	2	4516	90%	97%	95%
July 2019	16	7	8	4859	88%	100%	97%
August 2019	7	3	5	4583	91%	96%	100%
September 2019	9	6	2	4989	89%	97%	100%
October 2019	9	8	4	5039	87%	99%	99%
November 2019	7	6	4	4486	87%	98%	99%
December 2019	8	9	5	4560	89%	98%	95%
Overall 2019	138	71	49	57,379	89%	99%	99%
January 2020	5	2	2	4897	89%	97%	100%
February 2020	6	5	2	4392	91%	98%	100%
March 2020	3	9	4	4624	93%	97%	97%
April 2020	3	6	6	3818	94%	95%	100%

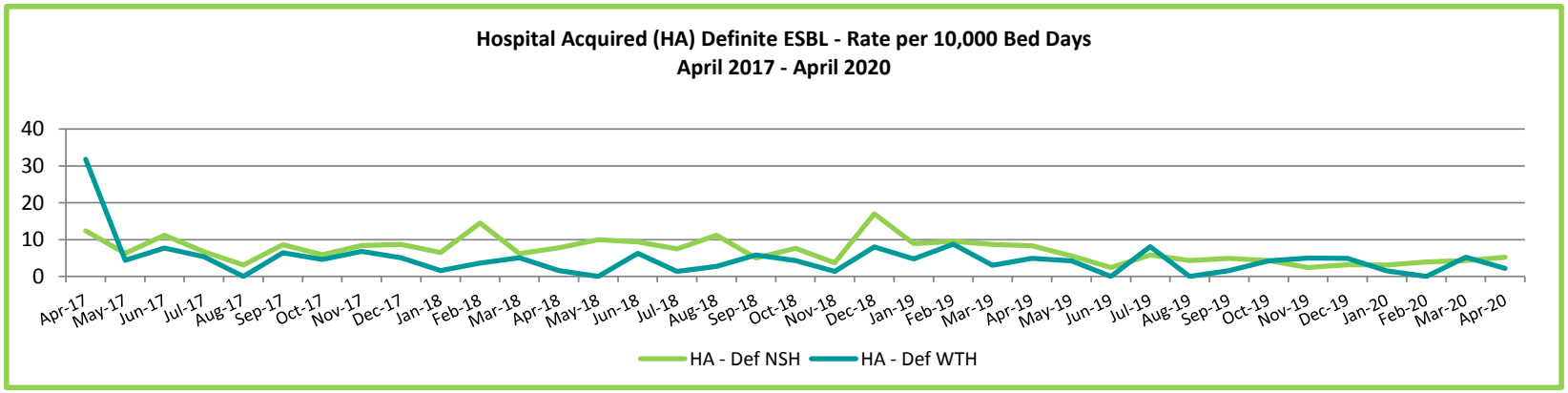
RAG Rating Legend

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

4.2 Surveillance

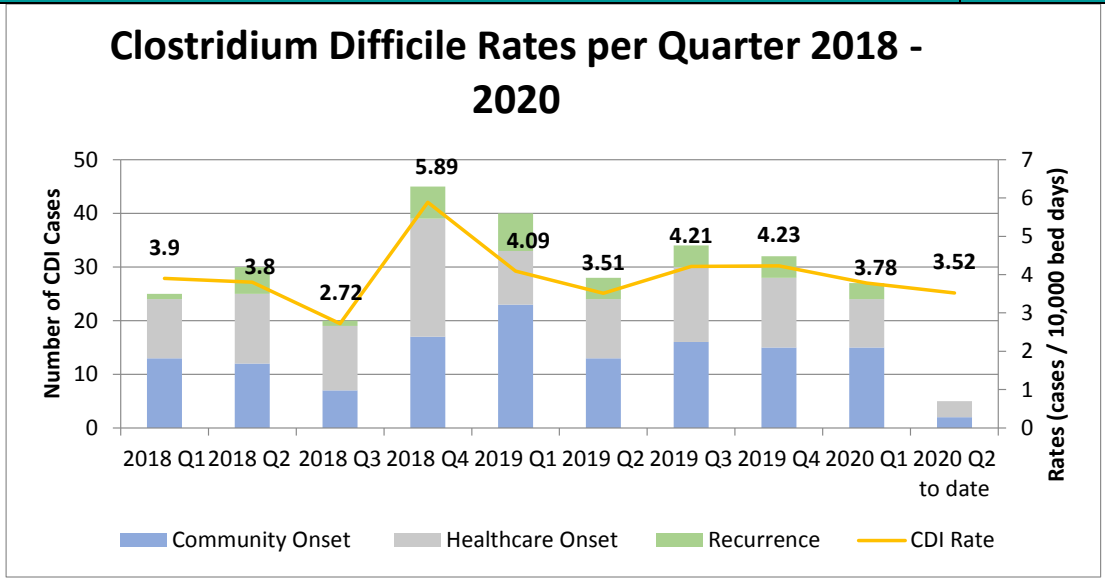
4.2.1 Extended Spectrum Beta Lactamase (ESBL)	March/April 2020
HA-ESBL is now defined as Isolation of ESBL producing Enterobacteriaceae (e.g. E.Coli or Klebsiella sp.) from a clinical or screening specimen >72 hours post admission (not 48 hours as per the old definition), in a patient with previously negative or unknown ESBL status. This new definition now aligns with ICNET and CDC Surveillance Definition	

HA –ESBL 2020	NSH		WTH	
	Counts	Rates	Counts	Rates
March	6	4.3	3	5.2
April	3	2.9	1	2.2



4.2.2 Clostridioides difficile (CDI)	Comments
Waitematā DHB Surveillance Definitions for CDI ***Healthcare facility Onset (HO-HCA)*** *- CDI symptom onset is more than 48 hours after admission (third calendar day).* ***Community Onset healthcare facility associated (CO-HCA)*** *-Discharged from a healthcare facility within previous four weeks.* ***Community Onset Community Associated (CO)*** *-No admission in the last 12 months.* ***Indeterminte*** *-Discharged from a healthcare facility within the previous 4-12 weeks.* ***Recurrent*** *-Episode of CDI that occurs eight weeks or less after the onset of a previous episode provided the symptoms from the prior episode have resolved.* ***Clostridium difficile (C.difficile) infection (CDI) Summary*** *Clostridium difficile infection (CDI) typically results from the use of antibiotics that affect the normal gut flora, promoting the growth of gut flora. Prevention, therefore, is dependent on appropriate antibiotic use.*	For **Q1 2020** total of **27** cases of CDI were detected comprising of: • 15 CO • three HO-HCA • three recurrent The proportion of HO-HCA infections for Q1 2020 was 36%; the overall rate for Q1 was 3.8 per 10,000 occupied bed days.

4.2.2 Clostridioides difficile (CDI)	Comments



4.2.3 Methicillin Resistant Staphylococcus Aureus (MRSA)
• No update for March/April 2020

4.2.4 Vancomycin Resistant Enterococci (VRE)
• No update for March/April 2020

4.2.5 Carbapenemase-producing Enterobacteriaceae	
*National concern has been raised about the emergence and spread of **Carbapenemase producing Enterobacterales and Pseudomonas (CPE)** in New Zealand since 2015. These are the "next generation" of antimicrobial resistant bacteria with minimal or no effective antibiotics that can be used for treatment of infections caused by them. In addition, CPEs have important Infection, Prevention and Control implications.* *Different types of Carbapenemase genes (NDM, OXA-48, and KPCs) confer resistance which can be detected by molecular testing. A national guidance strategy on testing and surveillance for CPE was released last month.*	• No update for March/April 2020

4.2.6 Seasonal Influenza

4.2.6 Seasonal Influenza

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

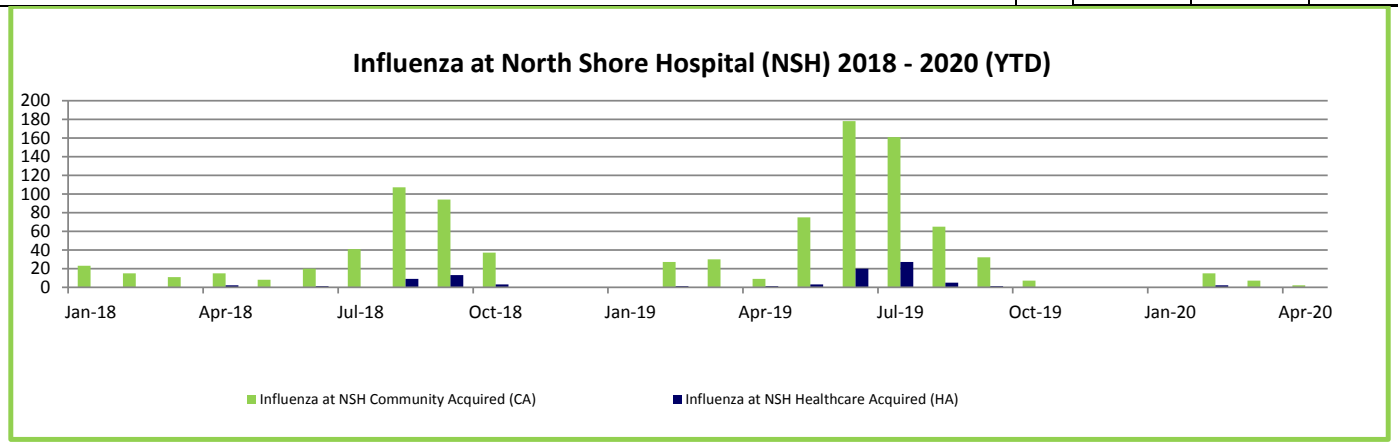
Data includes only confirmed patient cases where influenza like illness (ILI) symptoms developed 48 hours after admission. Source of acquisition variable (healthcare worker, patient, visitors)

The 2020 Influenza season has so far been characterised with very low presentation of patients with influenza like illness, total of 50 cases in 2020 YTD. For the same period in 2019 there were 158.

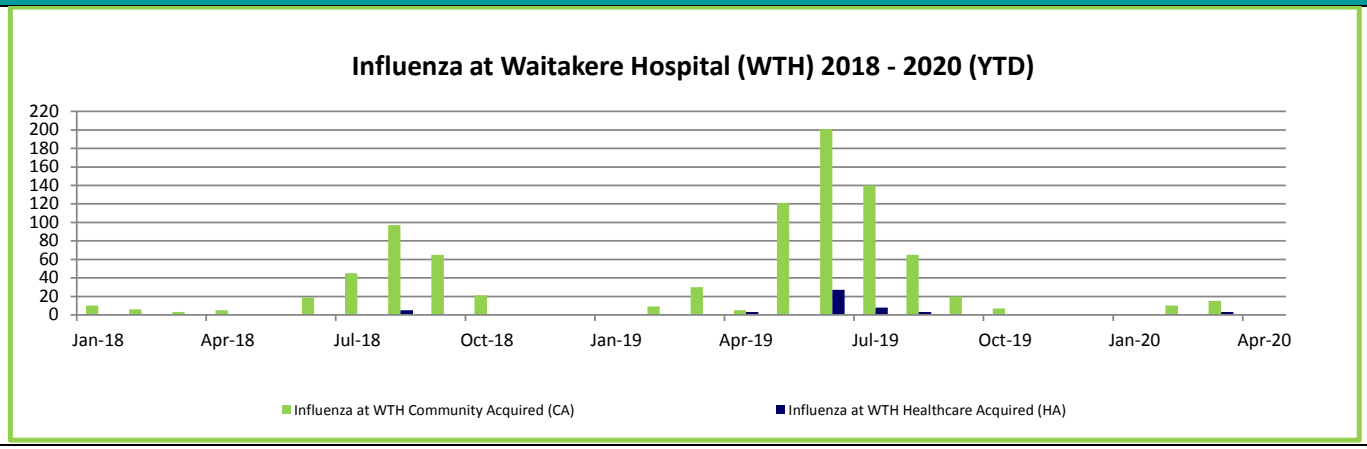
In March 2020, there was a cluster of three hospital acquired influenza in one of the mental health inpatient units.

NSH	Feb	Mar	Apr
CA-INF	15	7	2
HA-INF	2	0	0

WTH	Feb	Mar	Apr
CA-INF	10	15	1
HA-INF	0	3	0



4.2.6 Seasonal Influenza



4.2.7 Communicable Diseases, Clusters and Outbreaks

No overview March/April 2020

5. Improvement Team Active Projects Report

Innovation and Improvement Project Team: Active Projects Report

May 2020				000'000		Overall Status		
Project Name	**Project Summary**	**Requester**	**PM Resource**	**Budget**	**Forecast Variance**	**This Period**	**Last Period**	**Phase**
Organisation wide / Multiple Divisions								
COVID Intelligence Planning	Support to plan, develop and build a regional Qlik dashboard	NHRCC Delwyn Armstrong	Laura Broome					In progress
Outpatients	Expedite/sustain implementation of telephone appointments at scale across outpatients and community	Dale Bramley	Kelly Bohot Lisa Sue Danni Yu Dina Emmanuel					In progress
	Expedite/sustain implementation of video conference appointments at scale across outpatients and community	Dale Bramley	Kelly Bohot Charlie Aiken Lisa Sue Danni Yu Dina Emmanuel					In progress
	Paperlite-paperless outpatient appointments (incl ePrescribing; eOutcomes; eNotes;eLabs; eSurgical Waitlist (incl eAnaesthetic assessment, CPAC score); eForms)	Lara Hopley	Kelly Bohot Tim Alvis Dean Croft Lisa Sue					In progress
	Remote monitoring	Penny Andrew/Robyn Whittaker	Barbara Corning-Davis Kelly Bohot					In progress
	Outpatient clinic room stocktake	Outpatient Improvement Programme	Dina Emmanuel					Complete
	Telehealth hub location scoping	Outpatient Improvement Programme	Dina Emmanuel					In progress
iPM/Zoom integration testing	Follow-up with the developers who are working on the	Kelly Bohot	Mustafa					In progress

	integration of Zoom and iPM to automate scheduling zoom meeting after appointments booked in iPM		Shaabany					
Smartpage for Registrars – expedited implementation	Expedite existing Smartpage plan – roll out to registrars; plan 777 roll out	Stuart Bloomfield for IMT	Joel Rewa-Morgan					In progress
Communications	Support to plan and implement COVID-19 communications	Penny Andrew	Laura Broome					Complete
Staff Availability Whiteboard	Development and rollout of whiteboard that allows for real-time management and reporting of staff deployments	Jonathan Wallace	Lisa Sue					Complete
PSC relocation	50% of PSC off site at any one time due to limited workspace which means we are losing 180+ hours per day (level 4: staff need to be > 2 metres apart). Request to explore onsite options and feasibility of working from home	Alison Bowden/Sam Titchener	Danni Yu					Complete
Resus Training Plan	Support to develop a training plan for new resus policy	Lara Hopley/Jonathan Christiansen	Danni Yu					Complete
Staff and Patient Contact Tracing process	Map contact tracing process for COVID-19 positive DHB staff (to include staff and patient contacts)	Fiona McCarthy	Sue French Laura Broome					In progress
PPE	Support IMT with management of PPE - planning, structure, implementation	Willem Landman	Jeanette Bell					In progress
	Reusable mask pool system	PPE planning group	Mustafa Shaabany					In progress
Scanning CSSD stickers into eNotes	Theatre barcode scanners reconfiguration to scan sterlising stickers into eNotes	Lara Hopley	Mustafa Shaabany					In progress
Shared goals of care	Proposal to implement national shared goals of care form to replace DHB ceiling of care	SGOC working group –Carl Peters	Jeanette Bell					Planning
AIRVO Respiratory Support Planning	Plan and execute delivery of AIRVO device support for all designated COVID-19 clinical areas	Willem Landman	Sue French					Complete
Forward Triage	Support planning and delivery of Emergency Department COVID risk Pre-Screening question and Forward Triage process	Willem Landman Maurice Lee	Sue French					Complete
Medical								
Shared goals of care (SGOC) and serious illness	Proposal to open up page 2 of current SGOC test form for frontdoor staff with support information about serious illness	Jeanette Bell on behalf of SGOC	Jeanette Bell					Completed

conversations	conversation guides on CeDDS	working group						
Child Woman and Family								
Support with hysteroscopy models of care document	Request from CW&F leadership team for support for a hysteroscopy model of care development of a business case	Prathima Chowdary	Lisa Sue					Complete
Mental Health and Addiction Services								
Support the development of a quality improvement programme for the acute mental inpatient units and related community services in response to recent client incidents (deaths in inpatient units and community)	Support the development of a quality improvement programme for the acute mental inpatient units and related community services in response to recent client incidents (deaths in inpatient units and community)	Derek Wright Pam Lightbown	Laura Broome Barbara Corning-Davis					In progress
Community								
Reducing COPD readmissions	Reduce the readmission of COPD into hospital through engaging community pharmacies to check and implement inhaler techniques with patients	Barbara Corning-Davis	Barbara Corning-Davis Danni Yu					In progress
Remote patient monitoring	As above							
Rest home models of care	Support process mapping for DHB support during Alert and Confirmed case management process. Scope work for MOC for long term planning and management for residents and workers.	Brian Millen	Sue French					In progress

Other Work In Progress	Overview	Involvement	Sponsor(s)	PM Resource	Comment
COVID-19 Intranet site	Develop new intranet site Work with hA to enable remote access to intranet (access not requiring citrix logon)	Front and back end development Ongoing site design and navigation	IMT	Sharon Puddle	
Intelligence	Development of WDHB Covid-19 dashboard & predictive analytics dashboard Data and analysis for IMT		IMT	Delwyn Armstrong Monique Greene Jonathan Wallace Sharon Puddle	

Quality Improvement Training	Overview	Involvement	Sponsor(s)	PM Resource	Comment

Support Requests						
Current Support Requests						
Project Name	**Sponsor / Requestor**	**Description**	**Request received**	**Scoping Completed Approved date**	**Assigned to**	**Comment**
Organisation-wide/Multiple Divisions						
Welfare working group	Shirley Ross	Ongoing input from Jo Eagan	17.03.2020			Closed - No ongoing project management support
Community workstream	David Resoli		17.03.2020			Closed -No ongoing project management support Nil support requirements identified at workstream meeting.
Electronic transport form	Interhospital transport team (Jonathan Casement)	Convert current paper transfer form for Class 1 and Class 2 critically ill and unstable patients to an electronic form	31.03.2020	In progress	Jeanette Beel Lara Hopley	

Closed since last report				
Project/Work/Request	**Sponsor/Requestor**	**Overview**	**Outcome**	**Close out / summary report location**
Community workstream	David Resoli			
COVID-19 Interhospital Transport Team	Willem Landman	Augmented team based at Waitakere Hospital for COVID-19 response	Return to Business as usual 18/05/2020	Summary Report completed

6. Patient and Whānau Centered Care

6.1 Patient Experience Feedback – March / April 2020 update

6.1.1 National Inpatient Survey

Cemplicity no longer provides the service for the National Inpatient Survey, therefore there is no current data available. The new provider – Ispos was formally announced as the new provider by the Health Quality and Safety Commission in late January 2020. A review of the current survey is in progress, with many changes predicted. The new survey will be rolled out from August 2020.

6.1.2 Friends and Family Test

In March, we achieved a combined Net Promoter Score (NPS) of 82 and April saw our highest ever NPS score of 83. These scores are up from February where we achieved a score of 80. In March, we received feedback from 680 people and in April we achieved a response rate of 273. The lower response rate for April is attributed to lower admission rates due to COVID-19. The NPS performs consistently above the DHB target of 65.

Friends and Family Test Overall Results

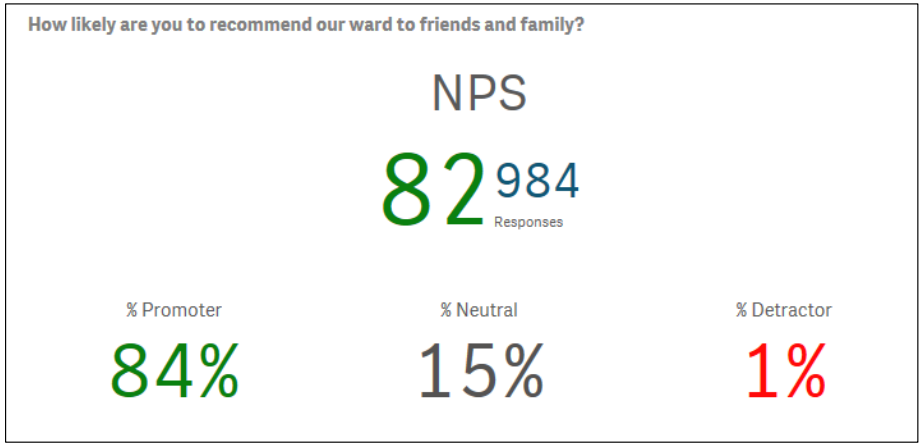
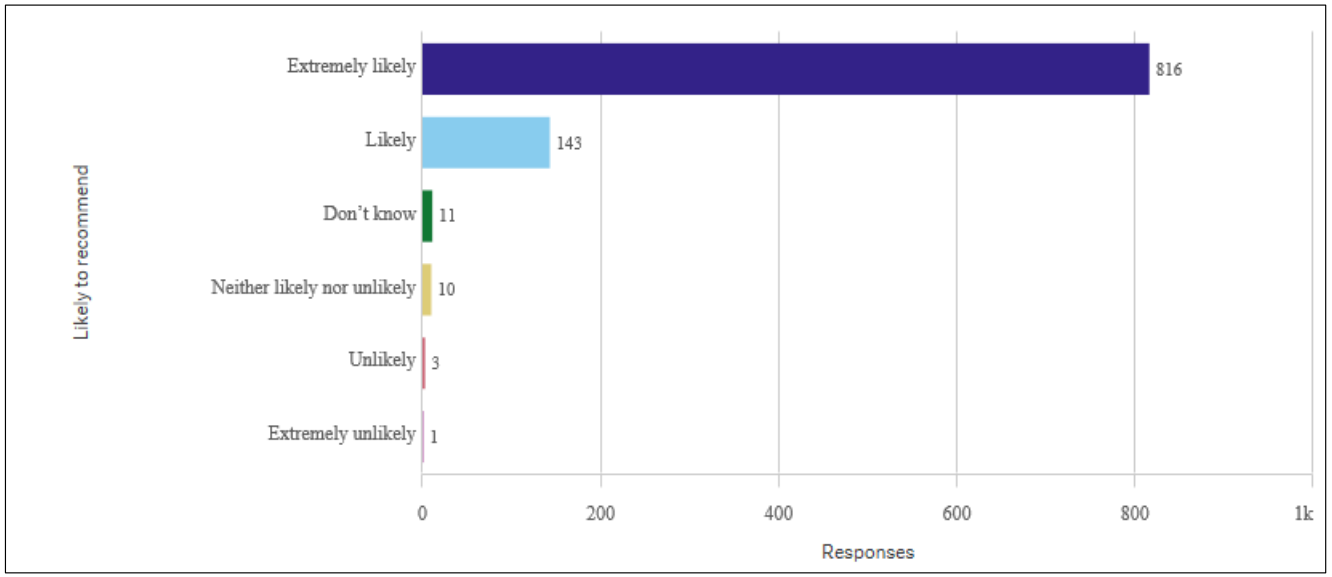


Figure 1: Waitematā DHB overall NPS



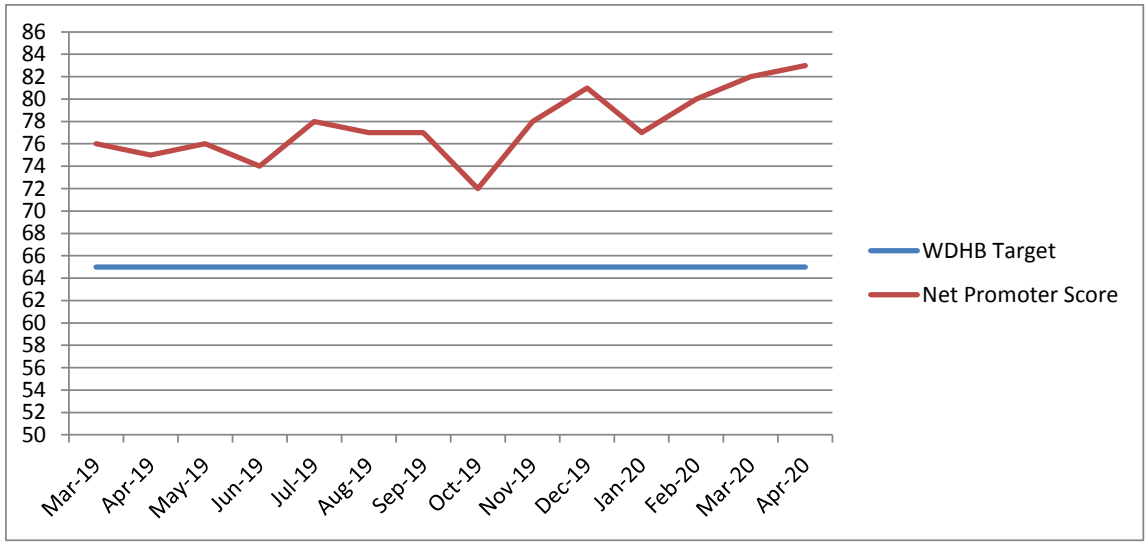
Graph 1: Waitematā DHB overall FFT results

Pt Experience Survey by Period

Month & Year	Surveys	How likely are you to recommend our ward?	Did we see you promptly?	Did we listen and explain?	Did we show care and respect?	Did we meet your expectations?	Welcoming and friendly?
Totals	**953**	**82**	**81**	**87**	**92**	**86**	**93**
Apr-2020	273	83	84	88	92	89	95
Mar-2020	680	82	79	87	92	85	92

Table 1: Waitematā DHB FFT results (each question)

The net promoter scores in March and April have met target for all Friends and Family Test questions. In April, the following measures all achieved their highest scores since the survey began - 'Likelihoood to recommend', 'did we see you promptly', 'did we meet your expectations' and 'welcoming and friendly'.



Graph 2: Waitematā DHB Net Promoter Score over time

Total Responses and NPS to Friends and Family Test by ethnicity

Mar & Apr 2020	NZ European	Māori	Overall Asian	Overall Pacific	Other/ European
Responses	650	92	84	62	230
NPS	82	75	79	94	81

Table 2: NPS by ethnicity

In March and April, all ethnicities met the Waitematā DHB NPS target and score 65 and above.

Mar & Apr 2020	NZ European	Māori	Overall Asian	Overall Pacific	Other/ European
Did we see you promptly?	82	78	80	83	80
Did we listen and explain?	87	81	85	95	86
Did we show care and respect?	94	86	87	95	88
Did we meet you expectations?	87	82	83	94	85
Were we welcoming and friendly?	94	86	94	97	91

Table 3: NPS for all questions by ethnicity

Over the last two months all measures score above the DHB target. Pacific patients gave high scores across all measures, with four out of five measures achieving a score in the 90's. 'Welcoming and friendly' remains the strongest performer, followed closely with 'showing care and respect'.

Friends and Family Test Comments

- "*The nurses are welcoming and quickly gave reassurance because I was anxious. Great communication and gave relevant information. I am very happy.*" ***Endoscopy, WTH***
- *"All the staff I have met during my stay have been so kind and down to earth, friendly as well as very professional and proficient. I feel I have been well looked after by everyone medically and emotionally. I especially liked the conversation with the nurses and the doctors – informative and entertaining."* ***ADU, WTH***
- *"Personal, caring, attentive service. Caring to my individual needs. Encouraging!"* ***Allied Health Community Adults West***
- *"The staff was first class and better than any hospital that I have been in before."* ***Cullen Ward, ESC, NSH***
- *"Everyone has been 100% amazing and supportive and helpful. Even more incredible with what's going on in the world at the moment."* ***Maternity, NSH***
- *"Service is excellent as usual. Very happy with the NZ healthcare system. Kapai, Kiaora"* ***Emergency Department, WTH***
- *"As a carer for a patient, I observed the nurses and their work was excellent."* ***Ward 6, NSH***
- *"Doctors and Nurses do their job 100% and they care about us. They always encourage us to stay positive in life. It is more like our second home."* ***Dialysis - Apollo, NSH***

Friends and Family Test by ward

		March and April 2020	
Division	**Ward**	**Responses**	**NPS**
AH	Allied Health Community Adults North	6	83
AH	Allied Health Community Adults Rodney	7	86
AH	Allied Health Community Adults West	6	83
AH	Allied Health Community Child Health West	2	100
AH	Allied Health Early Discharge and Rehabilitation Service (EDARS)	9	100
ESC	Elective Surgery Centre Cullen Ward	19	95
SMHOP	North Shore Hospital Haematology Day Stay	30	90
S&AS	North Shore Hospital Hine Ora Ward	11	90
A&EM	North Shore Hospital Lakeview Cardiology (LCC)	103	92
CWF	North Shore Hospital Maternity Unit	133	69
S&AS	North Shore Hospital Outpatients	4	75
S&AS	North Shore Hospital Radiology	2	100
CWF	North Shore Hospital Special Care Baby Unit (SCBU)	19	74
S&AS	North Shore Hospital Short Stay Ward	44	63
A&EM	North Shore Hospital Ward 2	15	80
A&EM	North Shore Hospital Ward 3	28	96
S&AS	North Shore Hospital Ward 4	45	76
A&EM	North Shore Hospital Ward 5	22	77
A&EM	North Shore Hospital Ward 6	17	80
S&AS	North Shore Hospital Ward 7	14	100
S&AS	North Shore Hospital Ward 8	47	96

S&AS	North Shore Hospital Ward 9	26	100
A&EM	North Shore Hospital Ward 10	32	97
A&EM	North Shore Hospital Ward 11	25	80
SMHOP	North Shore Hospital Ward 14	4	75
SMHOP	North Shore Hospital Ward 15	15	100
CWF	Wilson Centre	13	92
A&EM	Waitakere Hospital Assessment Diagnostic Unit (ADU)	37	67
A&EM	Waitakere Hospital Anawhata Ward	20	68
A&EM	Waitakere Hospital Emergency Department	7	86
A&EM	Waitakere Hospital Emergency Department Waiting Room	10	30
A&EM	Waitakere Hospital Huia Ward	9	67
SMHOP	Waitakere Hospital Muriwai Ward	8	63
S&AS	Waitakere Hospital Outpatients Reception 1	30	67
S&AS	Waitakere Hospital Outpatients Reception 2	5	60
S&AS	Waitakere Hospital Radiology	11	100
CWF	Waitakere Hospital Rangatira Ward	22	91
CWF	Waitakere Hospital Special Care Baby Unit (SCBU)	21	90
S&AS	Waitakere Hospital Surgical Unit	48	92
A&EM	Waitakere Hospital Wainamu Ward	5	100

Table 4: FFT results by ward

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

In March and April, 55% of services and wards met their response targets. Of these wards/services, 95% scored at or above the Waitematā DHB target. The top three ranking wards are all at North Shore Hospital – Ward 9, Ward 15 and Ward 10 (see table below). The main reasons for these positive scores include amazing staff (understanding, patient, empathetic, professional and compassionate), great care and service, high standard of food and clean and tidy environment.

This month, the lowest NPS score is for Short Stay Ward at North Shore Hospital, achieving slightly under target with a score of 63. Only a small number of reasons were given for the low scores and these include feeling ignored when in pain, long wait times and noisy at night.

A summary of the FFT results can be seen below.

Ward/Service – Exceptional NPS	Target Responses	Achieved	NPS Score
Ward 9, North Shore Hospital	20	26	100
Ward 15, North Shore Hospital	10	15	100
Ward 10, North Shore Hospital	20	32	97
Ward/Service – Low NPS	**Target Responses**	**Achieved**	**NPS Score**
Short Stay Ward, North Shore Hospital	10	44	63

Table 5: FFT Results Summary

Kōrero Mai/Talk to Me Programme

Kōrero Mai is a patient and whānau led escalation service that was launched in mid-November 2018. Patients are empowered to use a three step process to escalate their concerns. The third step instructs patients/whānau to call an 0800 number which is triaged by a Senior Nurse 24 hours/7 days a week who can request a medical review for a reported deterioration or intervene to support patient concerns.

There were four calls to the Kōrero Mai phone line in February and March, taking the total number of calls to the phone line to 41. Two of the kōrero mai calls during this period where by the same patient on different admissions – relating to his management plan for pain relief. Most calls to date relate to a breakdown in communication and an unclear management plan of the patient. All calls have been resolved promptly by staff with 90% of callers reporting they would not hesitate in calling the Kōrero Mai service in the future. The response after calling the Kōrero Mai number has prevented a formal complaint and usually led to on-going support from the Patient Experience team to ensure patient and whānau needs are met.

Ethnicity	M/F	Department	Hospital	Caller	Reason for call (as stated in RiskPro)
NZ European	F	Ward 7	North Shore	Patient Partner	Communication Breakdown
NZ European	M	ED	North Shore	Patient	Pain Control (called twice)
NZ European	F	ED	North Shore	Patient Friend	Pain Control

Table 6: Kōrero Mai December Call Summary

Patient and Whānau Centred Care Standards Programme (PWCCSP)
During the beginning of March, the focus was on continued work to implement the recommendations from the PWCCS review of last year, as well as prepare for the first annual review in May 2020. Recruitment and training of hospital volunteers to complete patient interviews (Part A data) had just finished and interviews had started. However, this focus suddenly changed when the COVID-19 pandemic. The volunteer service was put on hold as was the PWCCSP work. The May PWCCSP review is postponed until further notice.

In April, work refocused to support COVID-19 related work within Waitematā DHB. Regular weekly calls were made to most wards included in the PWCCSP to check in and see how they were. From these calls there was a theme identified of high work load associated with visitors not being able to enter the hospital. Many wards reported that the increase in phone calls from families was significant and wards were struggling to keep up. Many had implemented a proactive strategy of requesting that each patient nominate one family spokesperson whom the nurse/doctor could then connect with daily following the ward round. Fourteen areas identified that having a portable phone or an additional portable phone would make a big difference. These wards were provided with a portable phone. Also during this time any ward that had a patient who was having a birthday was notified on the day of the birthday so that they could assist with acknowledging it and providing increased family connection where able - for example via Zoom. The patient experience team supported any ward that indicated they needed help to get zoom up and running for patients. Work was also done to develop a variety of birthday cards that patients could be given from the Waitematā DHB. These were printed and distributed to the wards.

6.2 Patient Experience Activity Highlights

Consumer Council Update & Highlights
The Consumer Council met in March (via zoom) days before the lockdown announcement occurred. The March agenda continued discussions about the informed consent process. In addition, robust discussions were had about the current complaints process and views on improving approach to end of life care were provided. The Consumer Council requested an update of the COVID-19 response and Dr Matthew Rogers (Clinical Director Laboratories and COVID-19 Incident Management Team representative) spoke to the Consumer members and answered their questions.

The April Consumer Council meeting was cancelled due to COVID-19 and the next meeting is scheduled on June 10th. The Consumer Council Chair was scheduled to present to the Board for the first time in May.

Volunteer Recruitment Statistics
Volunteer number has remained the same as recruitment and on-boarding process have been suspended due to COVID-19, and this number is expected to decrease since some volunteers may not return.

Green Coats Volunteers (Front of House) (A)	Other allocated Volunteers (B)	Volunteers on boarded awaiting allocation (C)	Total volunteers available (D) (A) + (B) + (C) =(D)
54	84	4	142

Table 7: Volunteers Recruitment

Volunteer Activity Highlights

- ***Recruitment***

While the volunteer programme was suspended, the patient experience team focused on volunteer welfare and connectedness. All volunteers were contacted each week and special attention/follow up was given to the volunteers who were identified as being at risk of social isolation. Volunteers were communicated with regularly by emails, phone calls and postage. Information for communication was drawn from CEO updates, statistics from the Ministry of Health (MOH) website, as well as some puzzles, jokes etc. Sharing some information with volunteers kept them connected and engaged with the organisation. This maintained and reinforced their sense of belonging, a positive protective factor for mental well-being.

With the country moving to alert level 2, it was decided that front of house volunteers could return to their duties. The following process was taken to ensure a safe return:

- Volunteers were contacted individually to discuss personal circumstances.
- Volunteers who wanted and could return were screened.
- They completed a refresher course and signed a declaration form prior to resuming their volunteer role.

Three refresher sessions have been completed the week of the 18th May 2020 at both sites and twenty three volunteers have returned to duties so far. More sessions will be conducted in the upcoming weeks to allow other volunteers to return gradually.

Māori Patient and Whānau Experience Update (Introduction from Allanah Winiata-Kelly)

"Kia Ora e te whānau whanui o te hāpori Waitematā.
Ko Allanah Winiata-Kelly ahau. I whakapapa to Tauranga moana, Ngati Ranginui iwi, Ngai Tamarawho hapu, Takitimu waka.

I started in the role as the Māori Patient and Whānau Experience Lead in April during the lock-down. While it has been an interesting time to start, it has provided me with the opportunity to observe and explore components of the role. Reporting and engaging with both the Patient Experience team and Māori Health team. I see the role as a key support to enhancing the experience of whānau and community engaging with our DHB – furthermore as a contributor to better health outcomes of our Māori community.

While establishing and socialising the role now being active, key initiatives currently underway include:

- Pā Harakeke: The rebuilding of the pa harakeke to support the weaving of wahakura is currently in discussion as we explore the concept of it providing a therapeutic and rongoa Māori facilitation space. The intent is that this will enhance the experience of whānau and staff at our Waitakere site by using environment and natural elements to provide space for facilitating therapy and privacy to the Dialysis unit patients. The design concept is currently in conversations with the Māori Health team through Dame Whaea Naida Glavish.
- Kia Ora: the request for Kia Ora to become the official welcome of the DHB is underway. This initiative is also in conversation with Dame Whaea Naida Glavish. The recent events and the impacts of COVD-19 has provided space and opportunity for new-norms to be explored inclusive of being able to welcome all patients and whānau with 'Kia Ora' as an expression of well-wishes.
- Collaboration with Auckland DHB Māori Patient Experience Lead: Regular meetings are booked with Vanessa Duthie who currently holds the role under Auckland DHB. It is intended this could provide consistency and support across the Auckland Metro DHBs.

As the DHB come to learn of the role now being active, there is space to have conversations with those who hold a view of what they need a role like this to support in order to enhance the experience of Māori. I look forward to further developing the potential initiatives in the pipeline. The current list of potential future initiatives include:

- Support for the recruitment of Māori volunteers
- Support to review the experience and impact of recruitment and HR on patient experience
- Development of safe and trusted communication pathways for Māori community to provide feedback
- Māori Patient Experience training package for staff

Patient Experience Team Highlights

➢ ***COVID-19***

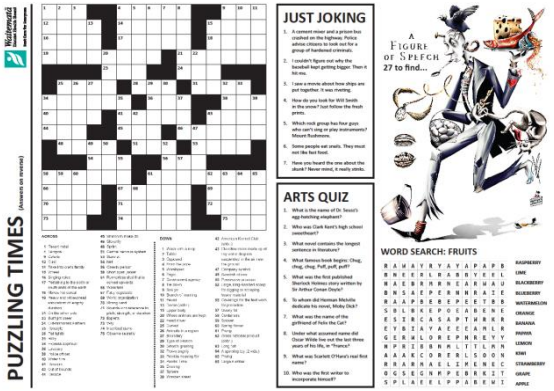
Members of the Patient Experience team were seconded to the Incident Management Team to support patient, staff and community welfare. Below are some activities the team was involved in to enhance patient and community experience.

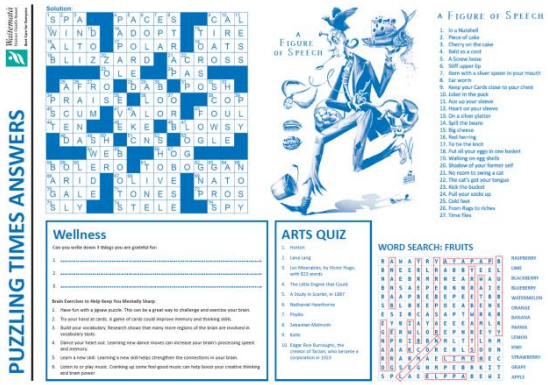
- **Zoom access** – as visitors were temporarily restricted from visiting patients, Zoom was installed on all Friends and Family Test iPads at NSH and WTH so that patients can keep in touch with their families and whānau.
- **Birthday cards** – cards were created to celebrate patient birthdays while in hospital. There were two different design concepts:

We Send You Our Art	***Staff***
The Well Foundation partnered with The Upstairs Gallery in Titirangi to create We Send You Our Art – an initiative that gives the community the chance to show its support for DHB workers through art.	A personalised greeting using staff deliver a happy birthday message
 Artist: Lynette Holtrigter	 *From all of us at Waitematā DHB*

- **Thank you cards** – cards to thank our amazing community and businesses who supported staff and our organisation during COVID. They provided maternity packs, flowers, chocolate, ice-cream, tea/coffee and so much more...

- **Meal Tray Mats** – activities for patients to complete during lockdown and visitor restrictions.





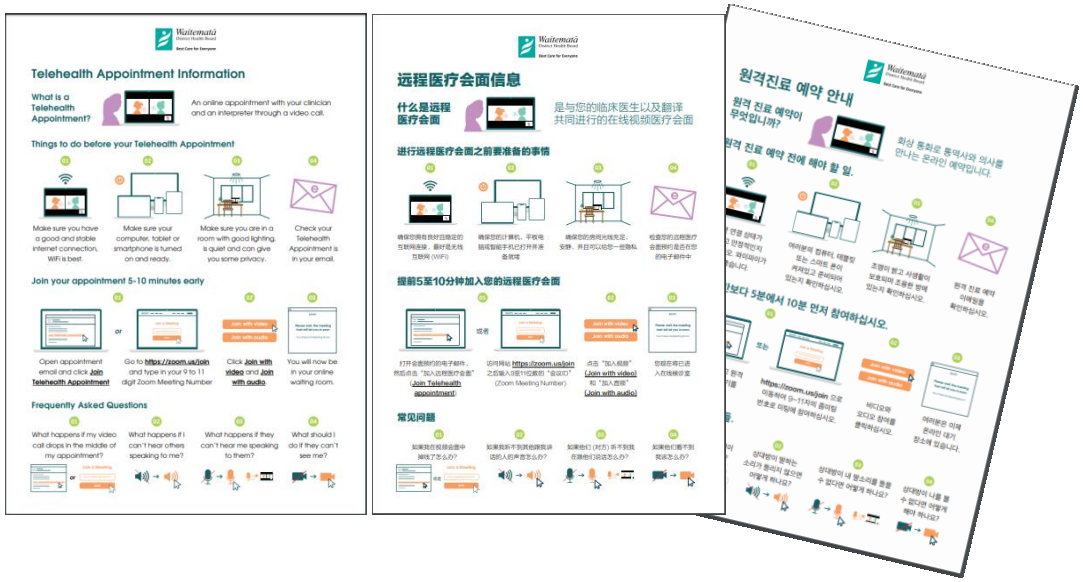
- **Meet my loved one** – designed for staff to understand patients and their needs during their stay with us.

- **Visitor Flyers** – Visitor guidance flyers to help visitors understand why visitor restrictions were in place during the lockdown periods (level 4 and level 3). Flyers were translated into Māori, Tongan, Samoan, Korean and Simplified Chinese.

Asian Health Services Team Highlights

- ***Video Interpreting Service (VIS) implementation***

A new video conferencing interpreting service is now available for online patient consultations. The Asian Health Services' WATIS team has over 100 staff who showed their interest in this project. Interpreters are now able to provide language support via TeleHealth virtual video appointments. This project was initially scheduled to begin at a later date to meet the needs of our large Asian and ethnic community. However, it was brought forward in response to COVID-19. Easy instructions to utilise 'TeleHealth - Video Call Information' was developed for DHB staff and consumers, and is available for free download on the Asian Health Services website (www.asianhealthservices.co.nz). The instructions are in English, Simplified Chinese, Korean, Hindi, Tagalog, Japanese and Samoan.



- ***COVID-19 Information – Public Health Promotion***

Asian Health Services has been working with the Auckland Regional Public Health Service (ARPHS) to provide accurate health information to the Asian community during COVID-19 Levels 2, 3 and 4. Posters for the hospital's emergency department have been updated, and relevant health messages were distributed via Asian Health Services (AHS) ethnic networks.

- ***Mental Health training for interpreters***

Many people are finding the global pandemic and lockdown situation stressful. For people in our community whose first language is not English, communicating their needs can be challenging. Thus, the WATIS team is required to facilitate clinical conversations for mental health and addiction services. WATIS has been offering mental health training for ethnic interpreters, so they can provide some much needed support. A further three mental health workshops and supervision sessions will be delivered in May 2020

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

No. of current staff	22 FTE
No. of management	1
No. of iCare Call Centre & Asian Patient Support Service (APSS)	4.7
No. of APSS Bureau (contractors)	9
No. of Asian Mental Health Service (AMHS)	5.5
No. of AMHS Bureaus (contractors)	20
No. of WATIS interpreting service	9.5
No. of contracted interpreters	186
Vacancy	1.3 (0.5 APSS & 0.75 WATIS)
Total	237 (23FTE + 214 contractors)

- ***Asian Patient Support Service and iCare call Centre (April 2020)***

No. of total enquiries	1,838
No. of iCare call centre enquiry - NZ Health info, GP, Breast Screen etc.	1,527
No. of patients under APSS care	119
No. of new inpatient referrals - complex issue & cultural support	71
No. of support episodes by cultural support coordinators	311
No. of clinical meetings & face to face liaison	0
No. of phone support	89
No. of clinical coordination	222
No. of exit	202
No. of health or cultural workshop or promotion or survey	0
No of participants of workshops	0
No. of document & resources – cultural review /input	26

- ***Asian Mental Health Service (April 2020)***

No. of active mental health clients (target KPI: 75)	80
No. of new referral - mental health client	7
No of client support hours	188
No. of support meeting hours	18
No. of liaison psychiatry referral	2
No. of active forensic MH clients	2
No. of acute MH inpatient ward or Crisis team referral	6
No. of active clients of Asian Clinical Psychological Service & referrals	8
No. of exit	14
No. of Asian Wellbeing Group Sessions	0
No. of workshops (e.g. Incredible years parenting / Sensory modulation)	0

- ***WATIS Interpreting Service (April 2020)***

No. of contracted interpreters (covering 90+ languages & dialects)	187 + NZ Sign language interpreters
No. of FTE interpreters (employed)	3.75 (0.75 FTE vacancy)
No of interpreting episodes	2,827
No. of face to face interpreting	616
No. of Video interpreting service(VIS)	27
No. of appointment confirmation	941
No. of telephone assignment	239
No. of telephone interpreting	1018
No. of primary health interpreting episodes	121
No. of document translated or proof reading	13
% DNA of WATIS users	1.52%
Booking unfulfilled	0.15%

Pastoral Care Update

New Zealand moved quickly from Level 2 to Level 4 lockdown in March which resulted in changes with the Chaplaincy Services. At Level 2, to minimise visitors into the hospital, the volunteer programme was stopped therefore all the VCAs stopped their volunteering as of 18 March. This includes the Sunday Chapel volunteers as Sunday services were also suspended. Level 4 lockdown was announced subsequently, the North Shore and Waitakere chaplains worked from home and provided pastoral care via telephone whenever possible. During the level 4 lockdown, the North Shore and Waitakere Chaplains only came into the hospital when it was required, where phone chaplaincy was not possible. During the Level 4 lockdown, the North Shore and Waitakere Chaplains attended a number of requests for face to face chaplaincy. Among the requests include, support for family in grief, blessing for the dying, blessing for babies lost by miscarriage and stillbirth and support for cancer patients, spiritual counselling and communion. Urgent requests for catholic priests from patient, family and staff were attended to by catholic priests near the hospital facilitated by out telephonists and the chaplaincy team. The chaplaincy also provided tele-chaplaincy for a number of requests, including remote blessing for a mother and baby lost by miscarriage, spiritual counselling and request for prayer.

Mason Clinic chaplains continued to work throughout the lockdown stages onsite. They provided care in person as well as via telephone, e-mail to the patients, staff and whānau. They produced creative resources (palm leaves for Palm Sunday, Anzac devotions), prayers in different languages for staff. They also distributed 180 hot cross buns, gave out food parcels and worked with doctors at the Kowhai Centre.

The Chaplains Administrator has also uploaded a 'Covid-19 Prayer book' for use by staff and in the absence of Chaplains in the hospital. During the Level 4 lockdown, there were requests for Bibles from some patients which were delivered by members of the Patient Experience team.

The daily Covid-19 communication was sent via e-mail to members on the Chaplaincy team on a daily basis. VCAs, Sunday Chapel volunteers and communion ministers were sent e-mails. During Easter, palm crosses were made and left in the chapel for any patients who celebrated Palm Sunday. Chapel was decorated with Holy Week theme during Holy Week and Easter reflections were also put around the Chapel for staff and patients. Similarly, on Anzac Day, reflections were left around the Chapel.

6.2 Patient Experience Activity Overview (*no change from January 2020 report as limited changes due to COVID-19*)

On track	*Generally on track – minor issues/delays*	*Off track/not started*

Project Name	Project Summary	Patient Experience Lead	Update	Domain	Status
Organisation wide / Multiple Divisions					
Kōrero Mai – Whānau/Patient led escalation	Kōrero Mai (Talk to Me) aims to co-design a patient/family/whānau-led escalation system for patients whose condition is deteriorating (getting worse).	David Price Ravina Patel Lara Cavit	- Over the past 14 months since Kōrero Mai went live we have had 38 calls to the phone line. Seven of these calls were not Kōrero Mai calls and were forwarded to the phone line via switchboard. - Kōrero Mai is now business as usually and will be regularly evaluated and regular campaigns to promote the service. - Next steps for this programme are to complete a further awareness campaign and design a service for our inpatient mental health units.	Patient & Community Participation	
Consumer Council	As part of the annual planning DHB priorities guidelines for 2016/17 an expected focus for improving quality at WDHB is to 'commit to either establish or maintain a consumer council (or similar) to advise the DHB'.	David Price	- 5th meeting took place in February - Consumer Chair appointed by the Council - David Lui. - Consumer Council members participating in various events and initiatives throughout the organisation. - Seeking youth representation. - Strategy session completed in February – this will be shared with the Board in April – once strategy endorsed. - Website page – now live.	Governance	
Mystery Shopping Programme	To further understand the experiences of patients and consumers accessing our services via phone a mystery shopping programme will be piloted.	Ravina Patel	- Mystery shopper phone calls are undertaken monthly. SMT has endorsed the programme. - Each month 10-12 services are contacted. Further investigation to numbers with nil response. - Telephone best practice guidelines complete and distributed to staff. - PE team has completed training sessions with Contact Centre, ARDS admin and Patient Service Centre staff. - Best practice guidelines have been co-designed with staff and have been sent out to all staff in the Patient Service Centre and ARDS.	Measurement & Evaluation Patient & Community Participation	

			- Face to face mystery shopper programme to be introduced by June 2020		
Patient Stories	Capturing patient stories on video for internal and external audiences. The purpose is for staff to learn from experiences and assist with providing the best level of support and care to our patients.	Ravina Patel	- Patient Story – Disability. Improving the patient experience for deaf people. - Patient story – Autism. Challenges people with autism face and augmented communication. Seeking a patient to support the video. Disability Advisor to provide patient details. - Maternity journey and education for new mother's to be developed.	Patient & Community Participation	
Patient Feedback - Survey Design	Advisory role supporting services to develop patient surveys which capture feedback to understand if we are providing our patients with a quality service.	David Price Ravina Patel	- Podiatry Service - HR Website - Well Foundation – Staff survey and supporters survey - Endoscopy - Establishment of a Nurse led clinic - MHSOA Rodney - Family Services – CADS - Bronchiectasis patient survey - Assistance with accessing Survey Monkey data	Measurement & Evaluation	
Health Literacy	To enhance health literacy awareness and understanding across the organisation in supporting patients to make informed choices about their healthcare and improve communication both written and verbal.	David Price Leanne Kirton	- Health Literacy Policy endorsed by Executive Leadership Team in April – now published and available. - Health Literacy intranet site updated and live. - Launch of awareness campaign across organisation to promote policy, new resource intranet page and e-learning modules adapted from a Hawkes Bay DHB resource. - Successful Health Symposium organised in October 2019 – Over 150 attended with overall positive feedback. Attendees requesting a more practical symposium in 2020. - Health Literacy planning for 2020 has commenced, working with Health Literacy NZ to design a more practical approach to training.	Communication	
Patient and Whānau Centered Care Standards (PWCCS) Review	The Patient Experience team is leading a review of the Patient and Whānau Centred Care Standards to engage the multi-disciplinary team in the process and ensure the results of the survey provide effective insight into ward performance in the fundamentals of patient and whānau centred	David Price Meg Smith	- ARDS and Community Mental Health to pilot Care Standards in their areas in early 2020. - Establishment of new governance group to oversee programme meeting in January 2020. - Progression of PWCCS review recommendations continues.	Measurement & Evaluation	

	care.		- Allied Health planning to create Multi-disciplinary team approach to care standards to commence in February 2020. - Further investigation into medical engagement in process. Early adopters in Emergency identified. - Next audit in May 2020.		
Joint Māori Health and Patient Experience Action Plan	Patient Experience reporting lacks cultural understanding and the ability to tell the story of our Māori patients and their whānau. The Māori Health and Patient Experience team have come together to align our focus and understand the Māori patient experience.	David Price Riki Nia Nia	- Joint team meeting on Waitakere Marae conducted in late November 2018. - Draft paper collated and circulated to both teams for endorsement – paper endorsed. - Māori Patient & Whānau Experience paper presented to and endorsed by Maori Equity Committee – action plan now to be created to meet objectives of the Maori Health & Patient Experience Team collaboration. - Advertising for Māori Patient and Whānau Experience Lead position for 2nd time over January 2020. - Appointment of Māori Patient and Whānau Experience Lead in final stages.	Patient & Community Participation	
Piloting new Friends and Family Test – including youth survey	Feedback about the current survey and an evaluation of our current questions and feedback outline that not all questions are aligned to our values and there is confusion about recommending a hospital. In addition, we have no surveys available to our children to provide feedback. In addition, there is limited variability in our data from our current questions over past 2 years.	Ravina Patel	- Draft surveys for youth piloted on Rangatira and ARDs services in September after testing with some local primary school classes. - Draft survey with satisfaction rating and new questions co-designed with patients and aligned with values created. Draft survey incorporates 0-10 rating scale more aligned to NPS methodology. - Pilot will start w/c 17th Feb. Wards and services involved in the trial include: ADU WTH, Ward 7, Renal, Radiology and Rangatira Ward	Measurement & Evaluation	
Volunteers					
Ward and outpatients Volunteer Programme	Waitematā DHB aims to have volunteers working on all wards throughout the organisation to support specific tasks and enhance the patient experience. Providing social connections and meeting basic patient needs in a busy ward environment is important to our patients.	Genevieve Kabuya Lara Cavit	- Waitakere ADU, Titirangi, the weekend maternity service at Waitakere, Ward 14, Short Stay ward and Outpatient North Shore are functioning independently with pool of volunteers. - Volunteer service has started in ward 10. - The volunteer service started in ward 5 is still progressing well and two volunteers have joined the team.	Patient and community participation	

			- The volunteer service started in ward 15 is progressing steadily. The Patient Experience team is having regular catch up with both staff and volunteers to make sure things progress smoothly. Recruitment in progress to cover other days. - With the support of Volunteering Auckland, recruitment continues for Front of House North Shore, Hine Ora, and Outpatient physiotherapy other departments at Waitakere and for Care Standard Patient Interviewer volunteers. - Consistent on-boarding processes and support systems have been developed.		
Better Impact	An online volunteer management system that provides access to volunteer information within one database.	Genevieve Kabuya Lara Cavit	- Since Better Impact has been linked with Waitematā DHB website the volunteer application process has been streamlined and volunteer data stored centrally. - The Patient experience team now sends birthday wishes to a volunteer on their special day - On-going data maintenance progressing with go-live date for volunteers to actively use Better Impact delayed to start in April 2020 - New volunteers from Westlake Boys an Westlake Girls to start again in March.	Patient and community participation	
On-boarding and training for volunteers	Developing systems and processes to ensure that the on boarding and training programme for staff aligns with current processes for Waitematā DHB staff/contractors. This will be linked to a central database managed through Occupational Health and Safety. This new process will ensure that volunteers have completed their mandatory training before receiving or renewing their Waitematā ID cards. The aim is to have all current volunteer on boarded into this new training system by the end of 2019.	Lara Cavit Genevieve Kabuya	- Review of previous processes was completed and progressively the revamped recruitment and on boarding process is been implemented with support of Better Impact software. - All new volunteers have been included in 'Welcome to Waitematā' for orientation with staff. - The online training module developed with Occupational Health and Safety Services including mandatory training for volunteers has been rolled out with current volunteers. - All volunteers, including St Johns volunteers, have now been uploaded in the new Health & Safety database for training. 90% of volunteers have completed their mandatory training.		
Asian Health Services					
Community Health Workshop	Asian Health Service offer 4 community workshops per year to improve the Asian community's understanding of New	Grace Ryu	- Two Chinese Health workshops scheduled in FY 2019/20 : 1st workshop completed in Mar 2019 & 2nd workshop is Oct 2019	Community Health Workshop	

	Zealand's health system and support services		- 1 Korean health workshop completed in May - 1 Indian health workshop will be held in 2020		
Let's get real - Asian Workforce Development Project	Te Pou and Asian Health Services are working together to enhance ethnic workforce development in Waitematā DHB by providing Real-skills surveys and various learning opportunities, as well as cultural workshops in FY2019-20.	Grace Ryu Tiffany Tu Carol Lee	- Real skills survey for Asian Patient Support Service team - completed - Asian Mental Health Team and WATIS team will join the survey by end of Dec 2019 - Mental Health supervision for DHB interpreters and MBIE interpreters in Sep - Let's get real workshop for DHB's mental health workforce on 13 Sep 2019 - Muslim & former Refugee cultural workshops on 15 Nov 2019 - Pacific cultural workshop for Asian & ethnic workforce on 6 Dec 2019	Workforce Development	
Youth Suicide Prevention Project	As part of the suicide prevention project of Waitematā DHB & Auckland DHB priorities guidelines for 2019/20. An expected focus for improving awareness of youth suicide prevention and mental well-being in the community.	Grace Ryu Hannah Lee Tiffany Tu	- 1st Youth Life skills workshop was held at Kristin School in May 2019 with approx. 100 participants - 2nd Youth Life skills workshop was completed at Epsom Girls Grammar School in Sep 2019 with 168 participants - Both workshops received excellent feedback	Suicide prevention Community Health promotion	
Asian Patient Support Service – Consumer & staff survey	Asian Patient Support Service conducts surveys in every 2 years to collect feedback from patients and their families, as well as DHB staff according to the service quality action plan	Grace Ryu Ivy Liang	- Written survey forms were distributed to patients and families from June 2019 - On-line Survey Monkey links were sent to DHB staff from September - Surveys will be closed by end of November and an evaluation report will be submitted by January 2020	Quality Management & Assurance	

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 05/02/20	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Confirmation of Minutes** As per resolution(s) to exclude the public from the open section of the minutes of the above meeting, in terms of the NZPH&D Act.
2. Quality Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)]
3. Human Resources Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9 (2) (g) (i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S.32 (a)]	**Privacy** The disclosure of information would not be in the public interest because of the greater need to protect the privacy of natural persons, including that of deceased natural persons. [Official Information Act 1982 S.9 (2) (a)] **Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the board to carry on, without prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]