Waitematā
District Health Board

Best Care for Everyone

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING

Wednesday 31 March 2021
1.30pm

AGENDA

VENUE:
Boardroom, Level 1, 15 Shea Tce
Takapuna

Waitematā District Health Board
Best Care for Everyone

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING
31 March 2021

Venue: Boardroom, Level 1, 15 Shea Tce Takapuna **Time: 1.30pm**

Committee Members	WDHB Management
Sandra Coney –Committee Chair Edward Benson-Cooper – Deputy Committee Chair Judy McGregor – WDHB Board Chair John Bottomley – WDHB Board Member Chris Carter - WDHB Board Member Warren Flaunty – WDHB Board Member Allison Roe – WDHB Board Member Renata Watene - WDHB Board Member Board Observers Wesley Pigg Amber-Paige Ngatai	Dale Bramley – Chief Executive Officer Robert Paine – Executive Director, Finance People and Planning Mark Shepherd – Executive Director, Hospital Services Jonathan Christiansen – Chief Medical Officer Jocelyn Peach - Director of Nursing and Emergency Systems Planner Tamzin Brott - Director of Allied Health, Scientific and Technical Professions

APOLOGIES:

AGENDA

DISCLOSURE OF INTERESTS

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

PART I – Items to be considered in public meeting

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

	1.	**AGENDA ORDER AND TIMING**
	2.	**CONFIRMATION OF MINUTES**
1.30pm	2.1	Confirmation of Minutes of Hospital Advisory Committee Meeting (17/02/21) Actions Arising from previous meetings
	3.	**PROVIDER REPORTS**
1.35pm	3.1	Provider Arm Performance Report – January 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 Surgical and Ambulatory Services/Elective Surgery Centre 3.1.7 Diagnostic Services 3.1.8 Clinical Support Services
	4.	**CORPORATE REPORTS**
2.05pm	4.1	Clinical Leaders' Report
2.20pm	4.2	Quality Report - January/February
	5.	**INFORMATION PAPER**
2.35pm	5.1	Auckland and Waitematā DHB Joint DNA Strategy (July 2016) Update
2.45pm	**6.**	**GENERAL BUSINESS**
2.50pm	**7.**	**RESOLUTION TO EXCLUDE THE PUBLIC**

Waitematā District Health Board

Hospital Advisory Committee Member Attendance Schedule 2021

NAME	FEB	MAR	MAY	JUN	AUG	SEP	OCT	DEC
Sandra Coney (Committee Chair)	✓							
Edward Benson Cooper (Deputy Committee Chair)	✓							
Judy McGregor	✓							
John Bottomley	✓							
Chris Carter	✓							
Warren Flaunty	✓							
Allison Roe	*x*							
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
Sandra Coney (Committee Chair)	Member – Waitakere Ranges Local Board, Auckland Council Patron – Women's Health Action Trust Member – Cartwright Collective	16/12/20
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
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
Judy McGregor (Board Chair)	Chair – Health Workforce Advisory 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	03/12/20
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 Member- Te Pae Reretahi (previously Toi Ora Advisory Board) Professional Teaching Fellow, University of Auckland Optometry Department	17/02/21
Wesley Pigg (Board Observer)	Employee (physiotherapist) – Waitematā DHB	14/10/20
Amber-Paige Ngatai (Board Observer)	Employee (nurse) – Waitematā DHB	14/10/20

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

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

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

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

IMPORTANT

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

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

Note: This sheet provides summary information only.

2.2 Minutes of the Hospital Advisory Committee meeting held on 17 February 2021

Recommendation:

That the Draft Minutes of the Hospital Advisory Committee meeting held on 17 February 2021 be approved.

Draft Minutes of the meeting of the Waitematā District Health Board

Hospital Advisory Committee

Wednesday, 17 February 2021

held at Boardroom Level 1, 15 Shea Tce Takapuna and by video conferencing commencing at 1.31pm.

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT

Sandra Coney (Committee Chair) - *by video conference*
Judy McGregor - *by video conference*
Edward Benson-Cooper - *by video conference*
John Bottomley - *by video conference*
Chris Carter - *by video conference*
Warren Flaunty - *by video conference*
Renata Watene – *by video conference*

ALSO PRESENT

Jonathan Christiansen (Chief Medical Officer)
Mark Shepherd (Executive Director, Hospital Services)
Jocelyn Peach (Chief of Nursing Officer, Professional Leadership) – *present from2.01pm*
Geoff Goodwin (Manager, Financing)
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 Allison Roe, Robert Paine and Tamzin Brott.

DISCLOSURE OF INTERESTS

There were no additions to the Interest Register.

There were no interests declared that might give conflict with a matter on the open agenda.

1. AGENDA ORDER AND TIMING

Items were taken in the same order as listed on the agenda, however, in view of the COVID-19 Alert Level 3 in place in the Auckland region and the response required by DHB Management, agenda timings for the meeting have been reduced.

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Hospital Advisory Committee Meeting held on 02 December 2020 (agenda pages 6-15)

Resolution (Moved Sandra Coney/Seconded Chris Carter)

That the draft Minutes of the Hospital Advisory Committee meeting held on 02 December 2020 be approved.

Carried

Actions Arising (agenda pages 16)

Updates on the matters arising were noted. No issues were raised.

3. PROVIDER ARM PERFORMANCE REPORT

Items 3.1 and 3.2 were discussed simultaneously.

3.1 Provider Arm Summary Report – November (agenda pages 17-32)
3.2 Provider Arm Performance Report – December 2020 (agenda pages 33-98)

Mark Shepherd (Executive Director, Hospital Services) was present for these items. Papers were taken as read.

Matters covered in discussion and response to questions included:

- There is work underway with the services to update the definition and treatment of did-not-attend (DNA) patients as an issue on the data capture resulted in overstated numbers.
- Noting the outcome of prior strategies, it was highlighted that reviewing and understanding the DNA data will allow for development of targeted approach to address DNA rates. There is focus on cultural competence to improve service delivery for Māori and Pacific patients. The strategy is being updated and some initiatives are underway. Text message reminders to patients are being implemented in a number of services including telehealth appointments.
- Data for Pacific patients will be included as part of the Faster Cancer Treatment table.
- Increased demand in Emergency Department (ED) account for the breach in compliance to the six-hour ED target. Data has improved for the month of January and compliance is back on track.
- The service is looking into an integrated model of care for stroke patients; this will provide patients better access to medical management and rehabilitation.

- Variance reports may not provide the whole picture but will allow for services to look into deviations closely and identify improvements.
- The Committee acknowledged the effort of the staff in the delivery of delivery of both elective and acute surgical volumes.

Resolution (Moved Sandra Coney/Seconded John Bottomley)

That the report be received.

Carried

4. CORPORATE REPORTS

4.1 Clinical Leaders' Report (agenda pages 99-108)

Jonathan Christiansen (Chief Medical Officer) was present for this item. The report was taken as read.

The Committee noted the achievement of Joanna Hikaka who was named was named 2019 Pharmacist of the Year in October 2020 by the Pharmaceutical Society of New Zealand.

Resolution (Moved Sandra Coney/Seconded Chris Carter)

That the report be received.

Carried

4.2 Quality Report –November/December (agenda pages 109-178)

Jacky Bush (Quality and Risk Manager) and Penny Andrew (Director, i3 and Clinical Lead) joined by video conference for this item. The report was taken as read.

Matters covered in discussion and response to questions included:

- In response to a query about the rate of patients with pressure injury care plans implemented, it was noted that a review of the data is underway as an issue with documentation has been identified. Strategies to make documentation easier are being explored. It was further clarified that the number of patients with confirmed pressure injuries has reduced and more information can be provided at the next meeting.
- With regard to the variation on data for surgical site infections, it was noted that Infection Prevention and Control reviews data on a case to case basis as infection could be a result of a number of contributing factors.

Resolution (Moved Sandra Coney/ Second Chris Carter)

That the report be received.

Carried

Dr Jocelyn Peach joined the meeting from 2.01 pm.

5. GENERAL BUSINESS

No matters of general business were discussed.

6. RESOLUTION TO EXCLUDE THE PUBLIC (agenda pages 179)

Resolution (Moved Sandra Coney/Seconded Chris Carter)

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 02/12/20	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

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
		prejudice or disadvantage, negotiations. [Official Information Act 1982 S.9 (2) (j)]

Carried

The open session of the meeting concluded at 2.03p.m.

SIGNED AS A CORRECT RECORD OF THE WAITEMATĀ DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 17 FEBRUARY 2021.

_____CHAIR

Actions Arising and Carried Forward from Meetings of the Hospital Advisory Committee as at 25 March 2021

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back/Comment
29/07/20	3.1	Provider Arm Performance Report Update on vascular services	Mark Shepherd	Deferred to 12/05/21 as regional work underway
09/09/20	3.1	Provider Arm Performance Report Review/update DNA strategy paper	Mark Shepherd	Please refer to Agenda Item 5.1
02/12/20	3.1	Provider Arm Performance Report Provide an overview of the Clinician graduate pipeline	Fiona McCarthy	Due to work required COVID-19 response activities this paper has been postponed to 12/05/21

3.1 Provider Arm Performance Report – January 2021

Recommendation:

That the report be received.

Prepared by: Mark Shepherd (Executive Director Hospital Services) and Robert Paine (Executive Director Finance, People and Planning)

This report summarises the Provider Arm performance for January 2021.

Table of Contents

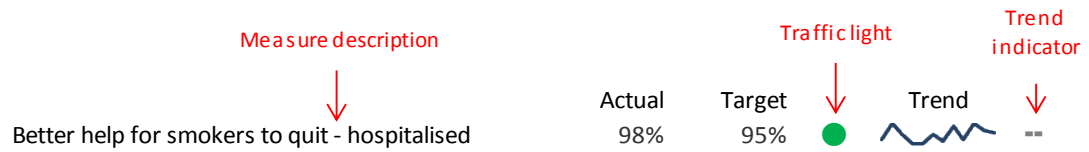
Glossary

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
DCNZ	-	Dental Council of New Zealand
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
HT	-	Hypertensive Disorders
ICU	-	Intensive Care Unit
KMU	-	Kingsley Mortimer Unit
LMC	-	Lead Maternity Carer
LOS	-	Length of Stay
SMHOPS	-	Specialty Medicine and Health of Older People Services
MRI	-	Magnetic Resonance Imaging
MoH	-	Ministry of Health
NGO	-	Non Government Organisation
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
SADU		Surgical Assessment and Diagnostic Unit
SCBU	-	Special Care Baby Unit
SGA	-	Small for Gestational Age Baby
SMHA	-	Specialist Mental Health & Addiction Services
SMO	-	Senior Medical Officer
WIES	-	Weighted Inlier Equivalent Separations

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.

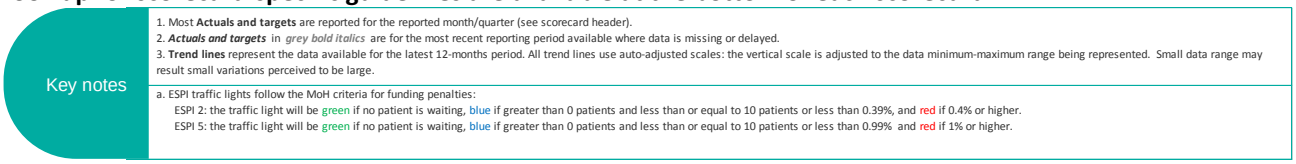
Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance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



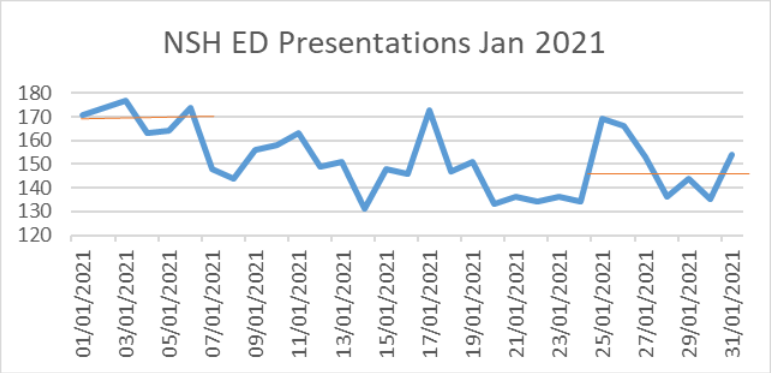
Provider Arm Performance Report

Executive Summary/Overview

The January period is often a period of planned reduction of elective services aligning with the holiday period. Further, while this has still occurred in 2021, our planning for this period including improved ability to ensure P1 urgent surgeries and procedures occurred and that patients had access to care as required. Activity in the hospital remained high over the Christmas and New Year periods, however settled in the early weeks of January. The increase in annual leave and decreased onsite staff, reduced salaried expenses and saw the Hospital Services financial results improve close to break even for the month.

Highlight of the month

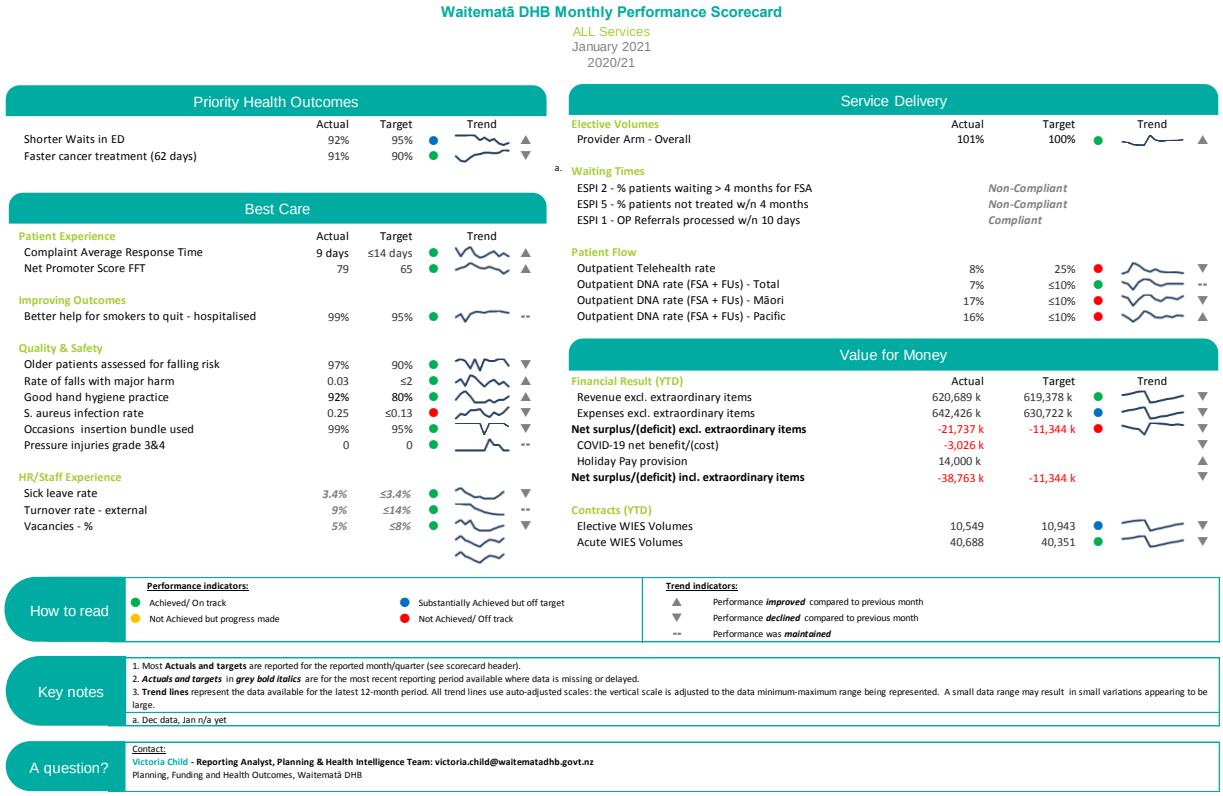
January also saw a material reduction in the high emergency presentations to the North Shore Hospital that had occurred for the last quarter (Q4) in 2020. Average daily presentations to the Emergency Department NSH dropped from 180 per day in Q4 to 170 per day on average week 1 January to 145 average week 4 January. This has allowed the summer bed plan to be implemented reducing wards 11 and 15 bed base, increasing annual leave allocations and reducing congestion and high occupancy within the hospital.



Key Issue of the Month

- Although the overall surgical health target volumes are being met, compliance to ESPI 2 and 5 remains challenging. All services had made significant gains in reducing patient waitlists for both FSA and surgery. However, increased referral volumes, increased P1 demand, increased acute demand (particularly in orthopaedics and general surgery) and nursing shortages in theatres, are impacting ESPI 2 and ESPI 5 position. Work is underway to assess our intervention rates against national rates, aligning these with our thresholds for FSA and surgical waitlists. Options for evening lists in ESC are also being worked through.
- Theatre nursing staff shortages. Staff retention remain challenging. This is requiring the planned closure of some elective lists to ensure priority is given to acute and urgent cases in the first instance. We are working through our Surgical Improvement Programme on new initiatives that will attract and retain staff with recruitment underway. However, the current vacancies are impacting our elective programme.

Scorecard – All services



Waitematā DHB Monthly Performance Scorecard

ALL Services
January 2021
2020/21

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	92%	95%	
Faster cancer treatment (62 days)	91%	90%	

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	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	9 days	≤14 days	
Net Promoter Score FFT	79	65	
Improving Outcomes			
Better help for smokers to quit - hospitalised	99%	95%	
Quality & Safety			
Older patients assessed for falling risk	97%	90%	
Rate of falls with major harm	0.03	≤2	
Good hand hygiene practice	92%	80%	
S. aureus infection rate	0.25	≤0.13	
Occasions insertion bundle used	99%	95%	
Pressure injuries grade 3&4	0	0	
HR/Staff Experience			
Sick leave rate	*3.4%*	*≤3.4%*	
Turnover rate - external	*9%*	*≤14%*	
Vacancies - %	*5%*	*≤8%*	

Service Delivery

	Actual	Target	Trend
Elective Volumes			
Provider Arm - Overall	101%	100%	
Waiting Times [a.]			
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 Telehealth rate	8%	25%	
Outpatient DNA rate (FSA + FUs) - Total	7%	≤10%	
Outpatient DNA rate (FSA + FUs) - Māori	17%	≤10%	
Outpatient DNA rate (FSA + FUs) - Pacific	16%	≤10%	

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue excl. extraordinary items	620,689 k	619,378 k	
Expenses excl. extraordinary items	642,426 k	630,722 k	
Net surplus/(deficit) excl. extraordinary items	-21,737 k	-11,344 k	
COVID-19 net benefit/(cost)	-3,026 k		
Holiday Pay provision	14,000 k		
Net surplus/(deficit) incl. extraordinary items	-38,763 k	-11,344 k	
Contracts (YTD)			
Elective WIES Volumes	10,549	10,943	
Acute WIES Volumes	40,688	40,351	

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. Dec data, Jan n/a yet

A question?

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

Scorecard Variance Report

Best Care

S. Aureus infection rate 0.25 against the target of ≤0.13

In January 2021, there were six hospital associated S. aureus infections across 23,550 bed days (0.25/1000 bed days) against a target of <0.13. Of these infections, three were in-patients under the care of the Renal service. Renal patients are at an increased risk of hospital associated infections due to the nature of dialysis care which requires frequent access to the blood stream. Work has now been completed by the Renal service in collaboration with i3 to develop a quality improvement (ANTT8) framework which drives how care is delivered in our dialysis units. Increased compliance to the ANTT8 framework will result in fewer infections. Results will be monitored

Service Delivery

Waiting Times, ESPI 2 and ESPI 5 non-compliance

ESPI 2 and 5 remain challenging to achieve, however our medical divisions continue to remain fully compliant. The surgical division have had significant improvement in both waiting times and ESPI 2 and 5 compliance in the second half of 2020 and have trajectories for improvement to guide timelines. Orthopaedics and ORL services have had marked increase in referrals and high priority cases that have impacted on wait times and overall compliance. Actions plans are in place to improve wait times towards compliance.

Outpatient Telehealth – 8% against target of 25%

Telehealth volumes for January 2021 continue to remain at a lower level than the target however a comparison between January 2020 and January 2021 shows a positive growth of 5% across services. The Electives Services team will continue to promote the benefits of telehealth appointments as alternative to face to face appointments wherever clinically appropriate.

DNA rates for Māori 17% and Pacific 16% are higher than the target rate of 10%
DNA rates for January are higher than the target of 10%. The January holiday period had a higher than average DNA rate which may be due to patients' conflicting personal commitments at this busy time of the year.

A detailed analysis and assessment of DNA's rates across services is being undertaken by the Electives Services to understand the areas within services which require further investigation and targeted action to work towards reducing Māori and Pacific DNA rates which continue to remain higher than non-Māori and Pacific .

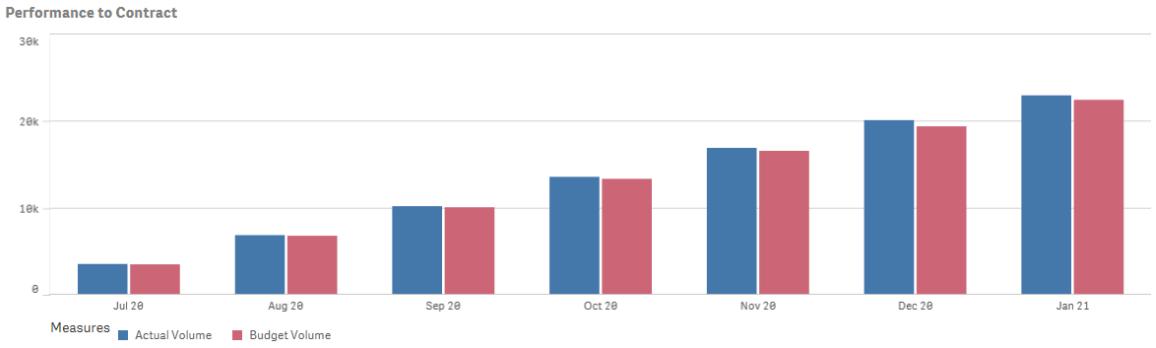
Value for Money
The YTD Provider Result is $10.393m unfavourable against a budget deficit of $11.343m YTD January before the impacts of Holiday Pay and COVID-19

The main contributors to the year to date variance were;

- Planned care revenue claw back of $2.388m due to under delivery in WEIS/case weights quarter one, which was largely caught up at December 2020. While elective surgical *discharges* have remained at 100% of the planned care schedule to January YTD, it has been challenging to maintain the WIES totals due to a shortage of theatre nurses which is now acknowledged will unavoidably worsen in the period January to April 2021.
- Unfavourable personnel costs, primarily in Mental Health Nursing with higher than usual staff retention rates and sick leave.
- Unfavourable clinical supply costs, primarily in Diagnostics and Surgery and Ambulatory due in part to unmet savings and increased activity.
- These unfavourable variances are partially offset by staff vacancies in other services and releases of prior year MECA and ACC provisions.

Combined Acute & Elective WIES actuals vs budget:

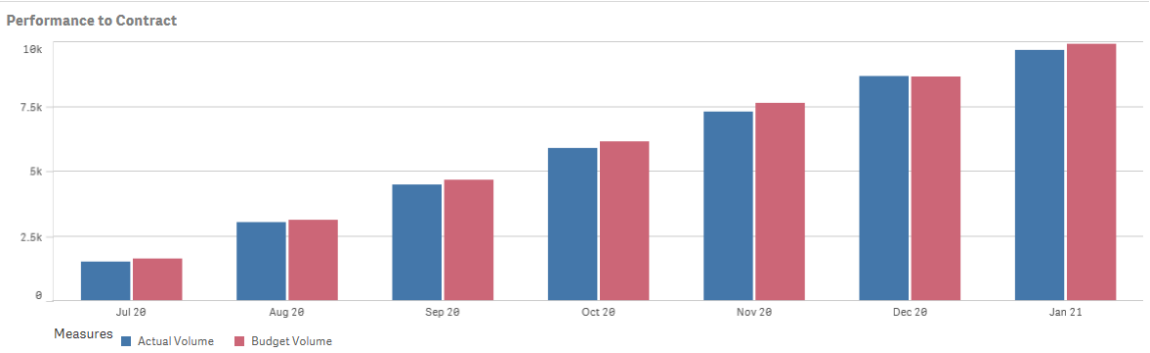
With regard to the Ministry's planned care definition of services provided by the Waitematā DHB's Provider Arm, being Orthopaedics, ORL, General Surgery, Urology, Gynaecology and Cardiology, combined acute and elective volumes are well ahead of the internal budgeted contract as at January YTD by over 500 WIES cost-weights ($2.84 million).



Specialty – Acute + Elective volumes to contract	***Actual Volume***	***Contract Volume***	***Variance***	***%***
Cardiology - Inpatient Services (DRGs)	3,117	3,020	96	103%
General Surgery - Inpatient Services (DRGs)	8,418	8,023	395	105%
Ear, Nose and Throat - Inpatient Services (DRGs)	669	690	-21	97%
Gynaecology - Inpatient Services (DRGs)	1,925	1,822	103	106%
Orthopaedics - Inpatient Services (DRGs)	7,920	8,040	-119	99%
Urology - Inpatient Services (DRGs)	829	769	60	108%
Total	22,878	22,364	514	102%

Elective WIES actuals vs budget:

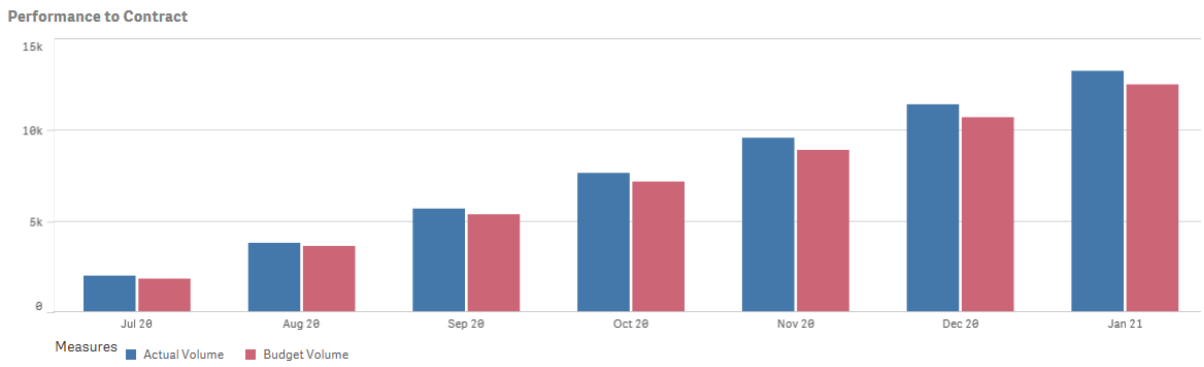
- Elective volumes have been directly impacted by acute or emergency care volumes. This has meant there is reduced access to theatres, beds and resources for the planned care patients. Acute demand also creates expenditure pressure which are direct results of the growing demand in this area, which is suggested as being due to a continuing indirect consequence of COVID-19 coupled with a shortage of theatre nurses to impact the period January to April 2021, has already seen the 'on budget' situation as at December YTD erode rapidly in January:



Specialty – Elective volumes to contract	***Actual Volume***	***Contract Volume***	***Variance***	***%***
Cardiology - Inpatient Services (DRGs)	541	628	-87	86%
General Surgery - Inpatient Services (DRGs)	3,398	3,377	20	101%
Ear, Nose and Throat - Inpatient Services (DRGs)	665	685	-20	97%
Gynaecology - Inpatient Services (DRGs)	1,038	981	58	106%
Orthopaedics - Inpatient Services (DRGs)	3,214	3,474	-260	93%
Urology - Inpatient Services (DRGs)	812	756	56	107%
Total	9,668	9,902	-233	98%

Note the Cardiology elective volume is similar in discharges compared to previous years but the case-weight (WIES) price for around 70% of the key procedures (DRGs) performed by this service have dropped between 7.5% and 19.6% in the past couple of years as a result of cheaper clinical implant costs, but the contract target volume has not been adjusted to reflect this. This is further impacted by a slight switch from elective to acute demand since COVID-19 as shown in the following acute data.

Acute WIES actuals vs budget:



Specialty – Acute volumes to contract	*Actual Volume*	*Contract Volume*	*Variance*	*%*
Cardiology - Inpatient Services (DRGs)	2,576	2,392	184	108%
General Surgery - Inpatient Services (DRGs)	5,020	4,645	375	108%
Ear, Nose and Throat - Inpatient Services (DRGs)	3	5	-1	72%
Gynaecology - Inpatient Services (DRGs)	887	842	46	105%
Orthopaedics - Inpatient Services (DRGs)	4,706	4,565	141	103%
Urology - Inpatient Services (DRGs)	17	13	3	126%
Total	13,210	12,463	747	106%

Financial Sustainability and reducing expenses

The Financial Sustainability Programme (FSP) is progressing well with almost fifty different initiatives having been developed and implemented over the past seven months. The programme to date has delivered 107.3% of target YTD January with $9.61m in expense reduction having been realised.

Further, $14.35m in annual savings initiatives, have been identified and work is ongoing to both implement these initiatives and identify a further $1.65m in savings to reach the target savings of $16m for the full financial year.

	Measure	**January Actuals**	**Year to Date**	**% vs Target**	**Identified Annual Savings**	**Target**	**% vs target**
Hospital Services	**Primary – Expense**	$1,696,796	$7,701,207	94.3%	$12,249,716	$14,000,000	87.5%
Corporate	**Budget**	$ 168,538	$1,913,457	116.67%	$2,102,789	$2,000,000	105.1%
FSP Overall Programme Total		**$1,865,334**	**$9,614,664**	**107.3%**	**$14,352,505**	**$16,000,000**	

Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Improving quality Actions to improve equity in outcomes and patient experience		
Improving consumer engagement • Implement actions identified in the Consumer Council annual plan	Jun 2021	✓
• Set up a governance group and structure to guide implementation of the Consumer Engagement QSM	Jul 2020	✘
• Upload data on to Consumer Engagement QSM dashboard and report against the framework twice yearly	Dec 2020, ongoing	✓
• Conduct gap analysis from Consumer Engagement QSM participation to identify areas of improvement	Jun 2021	✓

Areas off track for month and remedial plans
Governance structure for implementation of the Consumer Engagement QSM not supported by the Senior Management Team.

DHB activity	Milestone	On Track
New Zealand Cancer Action Plan 2019-2029 Actions that demonstrate collaboration with all stakeholders to prevent cancer and improve detection, diagnosis, treatment and care after treatment		
Actions to maintain 31- and 62-day FCT targets (as well as other ongoing BAU actions): • Customise contact and care plans for Māori and Pacific patients on the 62- and 31-day report by our Māori and Pacific Clinical Nurse Specialists - Cancer Coordination (EOA) • Customised breach reports to each tumour stream Operations Manager and Clinical Director to identify improvement areas	Ongoing	 ✓ ✓
Improve post-cancer support for Māori and Pacific women who had endometrial cancer (EOA) • Complete a co-design project to identify how to support patients to live well after cancer and address risk factors to improve their quantity and quality of life • Review findings and recommendations and plan appropriate next steps; plan implementation for one action	Sep 2020 Dec 2020	 ✘ ✘
Extend local delivery of all medical oncology care for patients diagnosed with breast cancer • Obtain local and regional approval • Implement plan to extend local delivery	Aug 2020 Nov 2020	 ✓ ✓

Areas off track for month and remedial plans
Endometrial cancer co-design project delayed to March 2021 due to COVID-19 Extension of medical oncology breast cancer care has been delayed from November 2020 due to lack of Oncologists. Provisional date is March 2021

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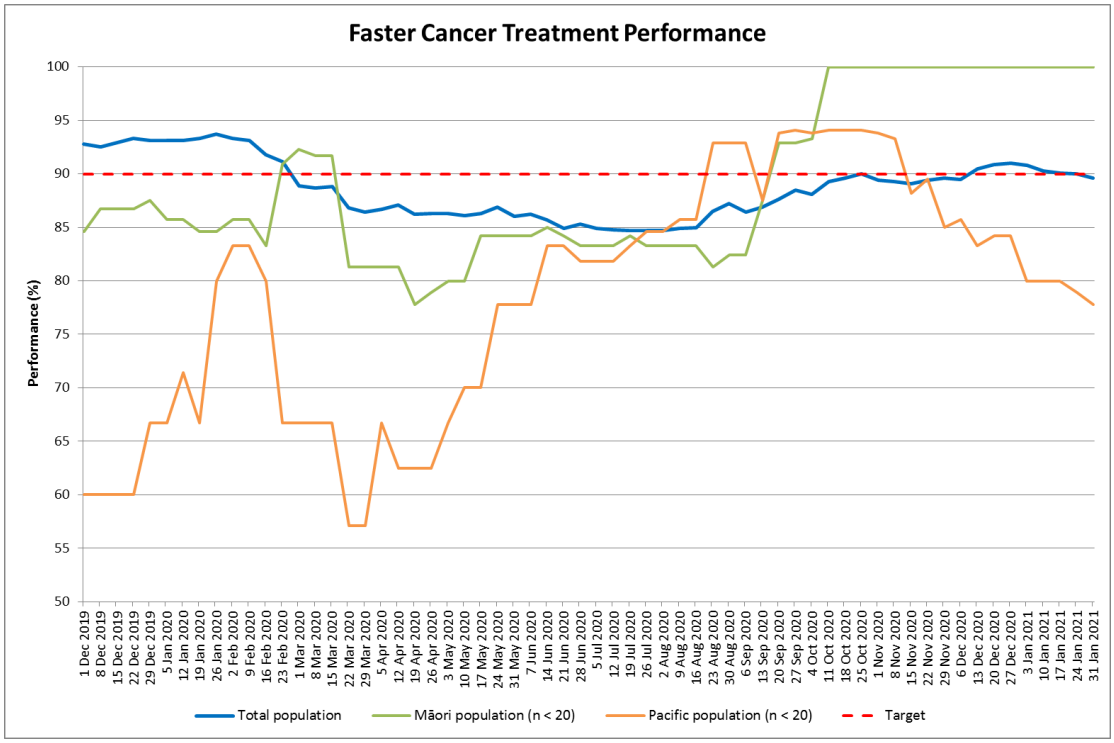
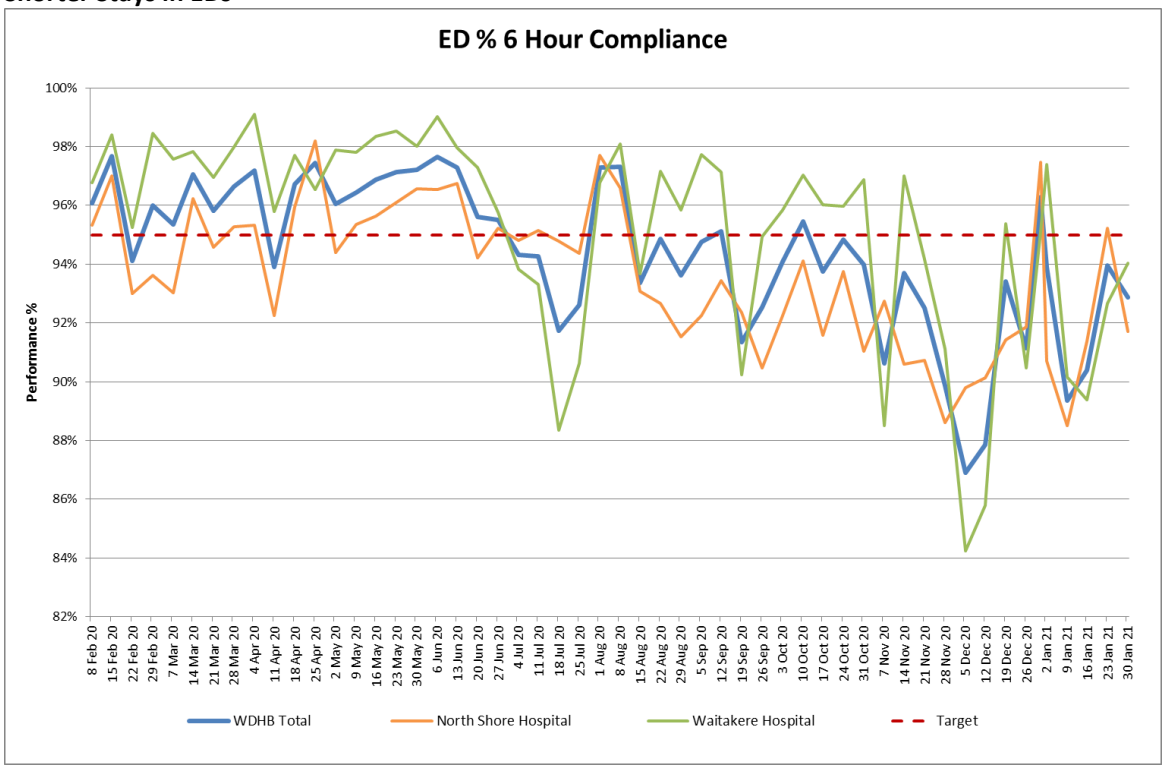
Priority Health Outcome Areas

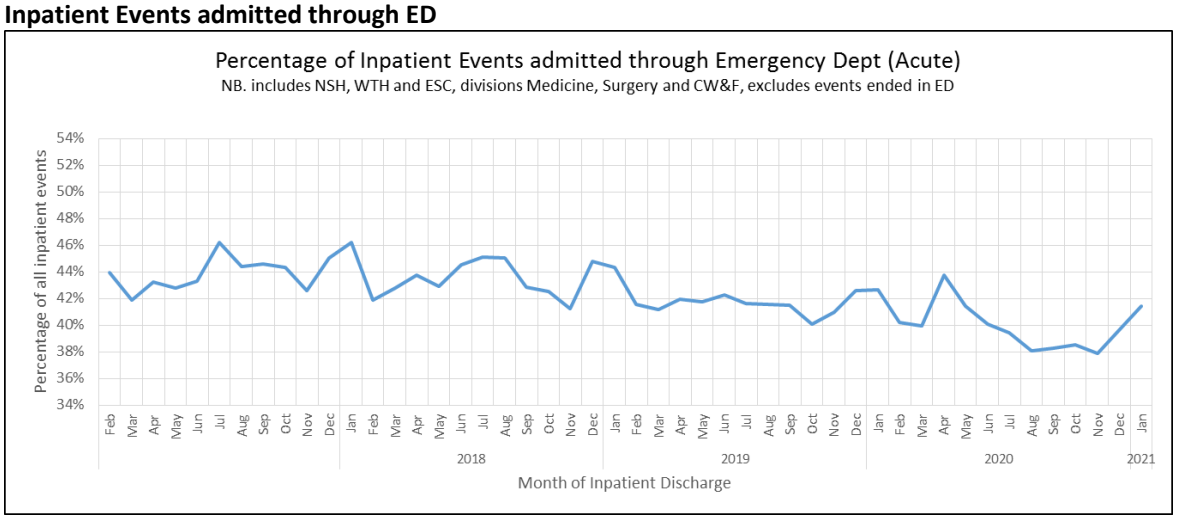
Faster Cancer Treatment



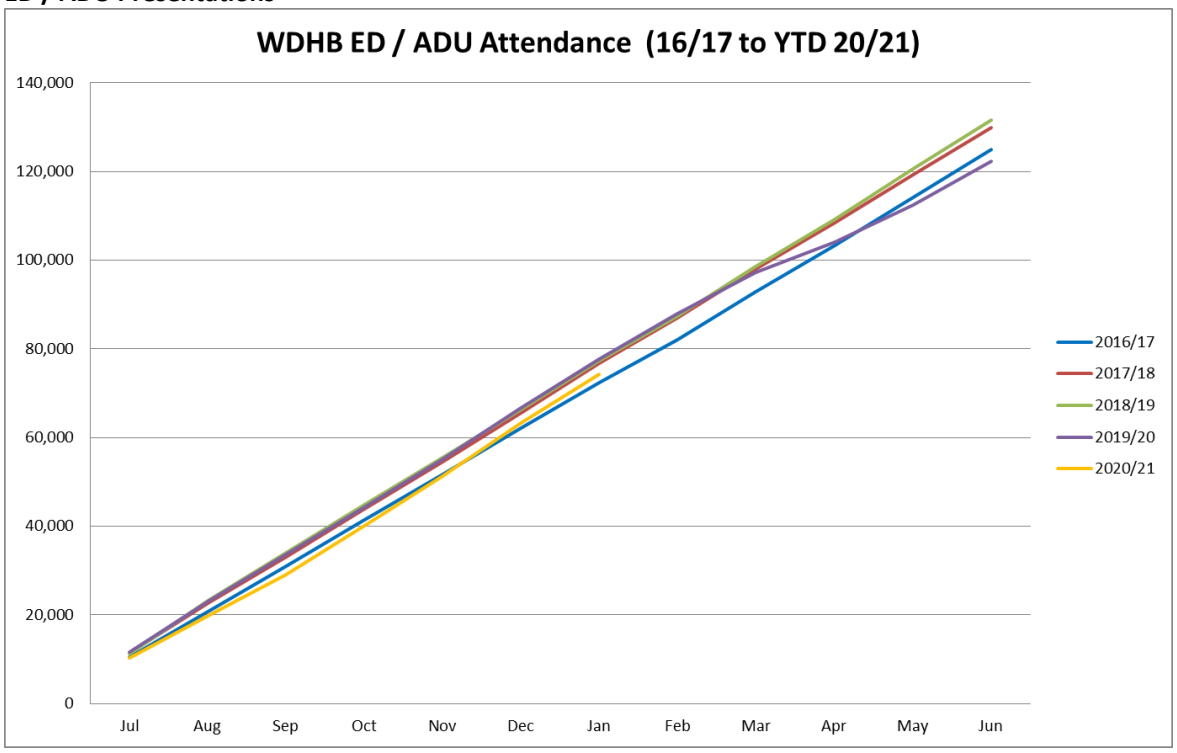
Shorter Stays in EDs



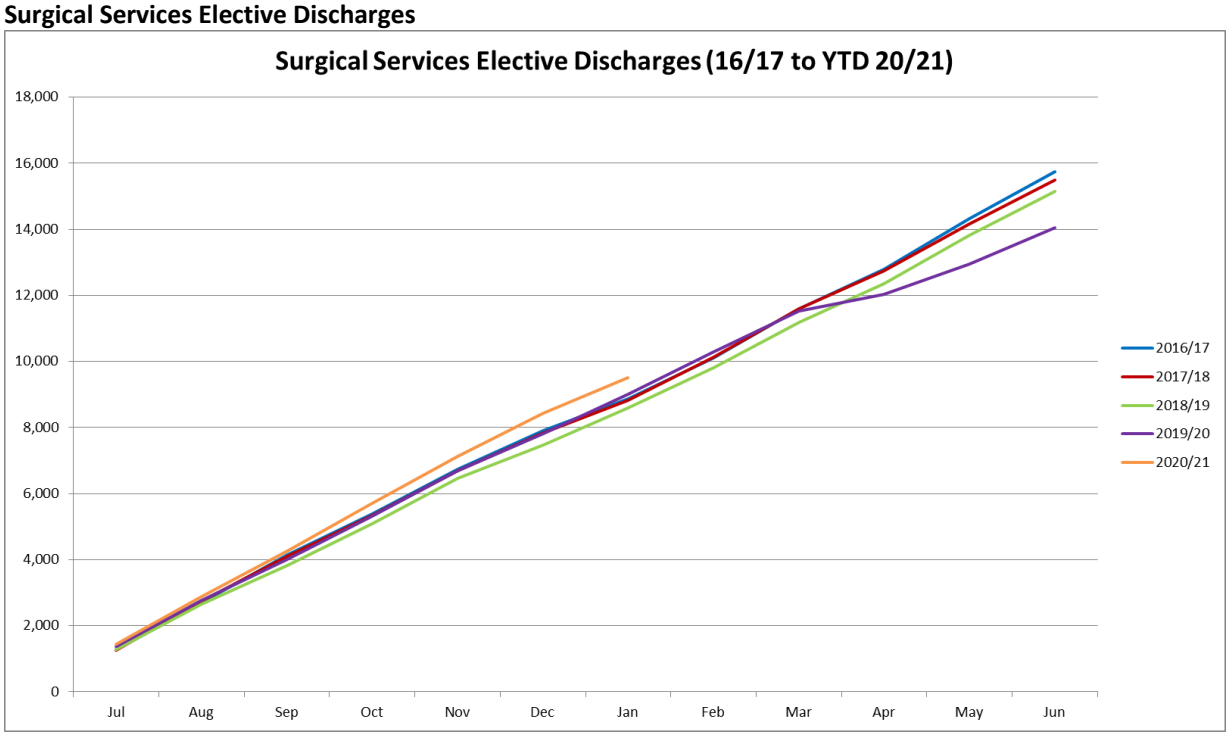
Inpatient Events admitted through ED



ED / ADU Presentations



Surgical Services Elective Discharges



* Surgical discharge volumes include all elective Orthopaedic, Gynaecology, ORL, Urology and General Surgery discharges (including skin lesions).

Percentage Change ED and Elective Volumes

January 2021	Month Volumes	% Change (last year)	YTD Volumes	% Change (last year)
ED/ADU Volumes	11,072	1%	74,222	-4%
Surgical Services Elective Discharge Volumes	1080	-9%	9513	6%

Elective Performance Indicators (part of Planned Care Services)

Zero patients waiting over four months

Summary (January 2021)	
Speciality	Non Compliance %
ESPI 2 - Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	10.31%
ESPI 5 - Patients given a commitment to treatment but not treated within the required timeframe.	25.13%

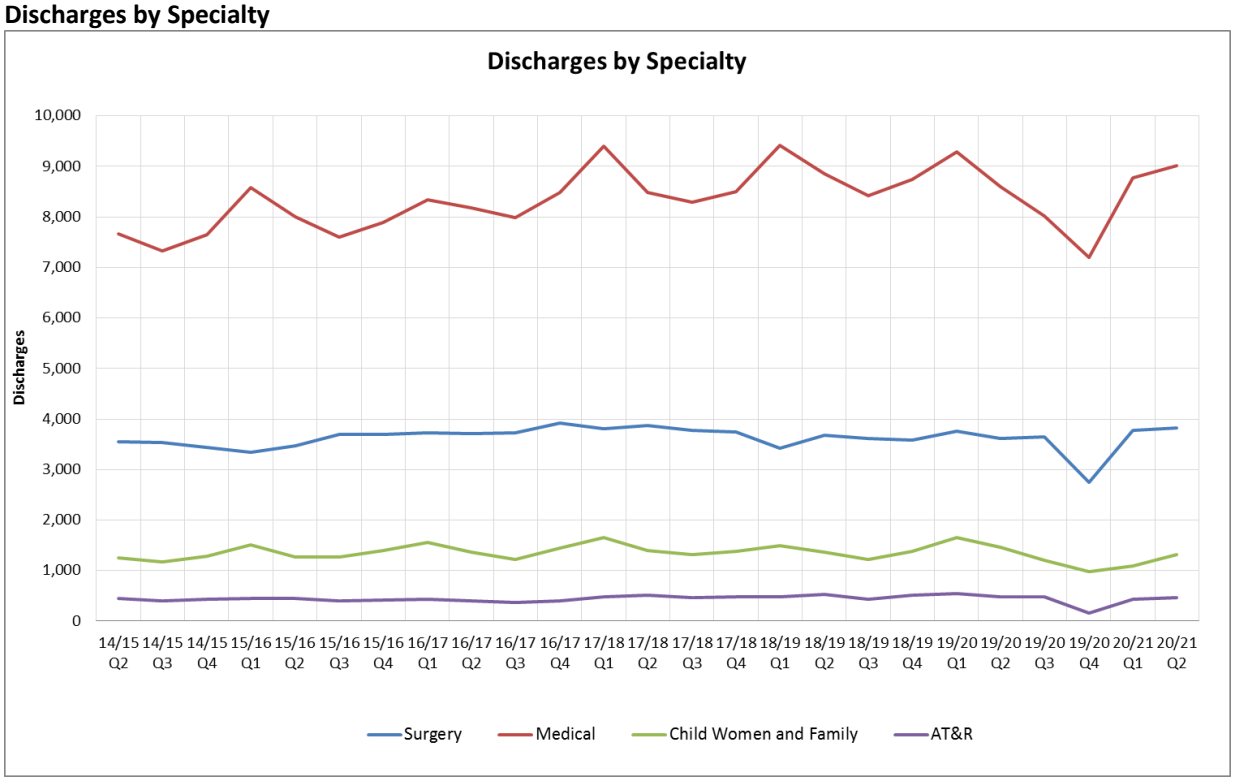
ESPI	WL Specialty	Compliant	Non Compliant	Non Compliant
ESPI 2	Anaesthesiology	76	-	0.00%
	Cardiology	1,346	-	0.00%
	Dermatology	297	-	0.00%
	Diabetes	230	-	0.00%
	Endocrinology	172	-	0.00%
	Gastro-Enterology	1,045	2	0.19%
	General Medicine	272	-	0.00%
	General Surgery	1,500	176	10.50%
	Gynaecology	940	80	7.84%
	Haematology	181	-	0.00%
	Infectious Diseases	62	-	0.00%
	Neurovascular	126		0.00%
	Orthopaedic	2,006	461	18.69%
	Otorhinolaryngology	1,263	442	25.92%
	Paediatric MED	899	7	0.77%
	Renal Medicine	285	-	0.00%
	Respiratory Medicine	613	-	0.00%
	Rheumatology	330	-	0.00%
	Urology	705	252	26.33%
	Total	12,348	1,420	10.31%
ESPI 5	Cardiology	122	-	0.00%
	General Surgery	1,711	228	11.76%
	Gynaecology	513	186	26.61%
	Orthopaedic	1,052	655	38.37%
	Otorhinolaryngology	254	50	16.45%
	Urology	356	226	38.83%
	Total	4,008	1,345	25.13%

90% of outpatient referrals acknowledged and processed within 10 days

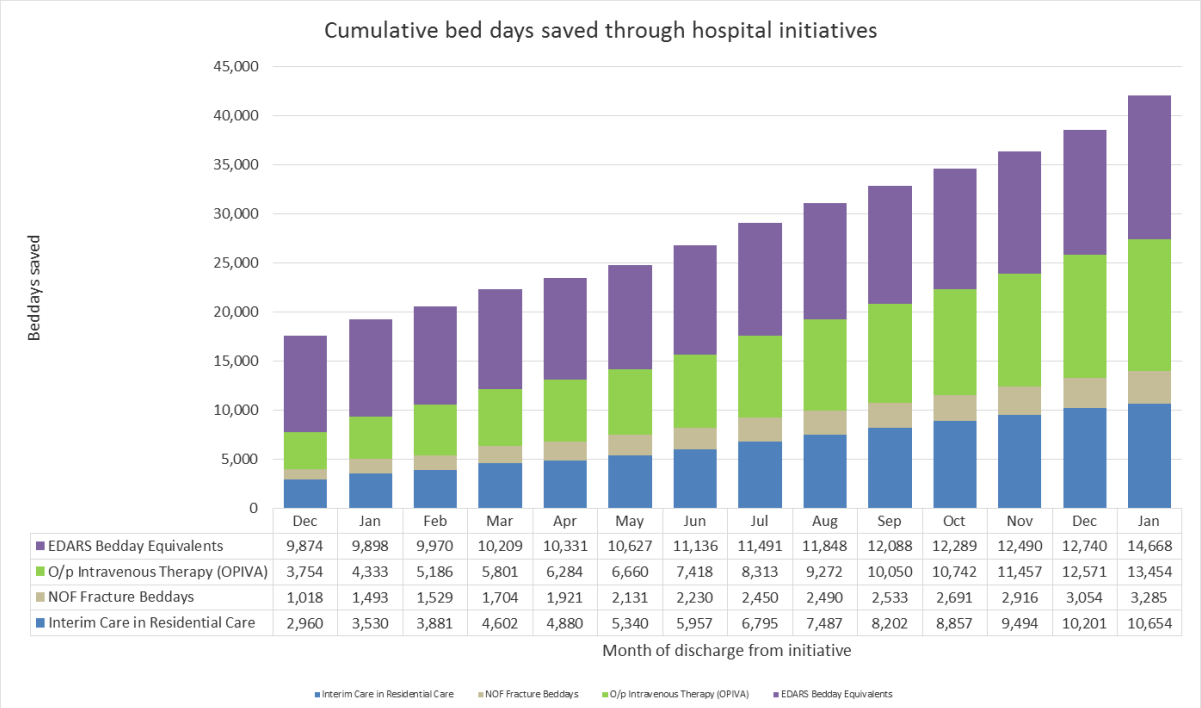
ESPI 1 (January 2021)	
Specialty	Compliance %
Anaesthesiology	100.00%
Cardiology	99.22%
Dermatology	99.38%
Diabetes	94.17%
Endocrinology	99.10%
Gastro-Enterology	96.78%
General Medicine	97.60%
General Surgery	94.82%
Gynaecology	99.78%
Haematology	99.07%
Infectious Diseases	99.04%
Neurovascular	100.00%
Orthopaedic	95.37%
Otorhinolaryngology	99.85%
Paediatric MED	99.11%
Renal Medicine	98.95%
Respiratory Medicine	98.75%
Rheumatology	98.80%
Urology	100.00%
Total	98.01%

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



	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
EDARS Bedday Equivalents	9,874	9,898	9,970	10,209	10,331	10,627	11,136	11,491	11,848	12,088	12,289	12,490	12,740	14,668
O/p Intravenous Therapy (OPIVA)	3,754	4,333	5,186	5,801	6,284	6,660	7,418	8,313	9,272	10,050	10,742	11,457	12,571	13,454
NOF Fracture Beddays	1,018	1,493	1,529	1,704	1,921	2,131	2,230	2,450	2,490	2,533	2,691	2,916	3,054	3,285
Interim Care in Residential Care	2,960	3,530	3,881	4,602	4,880	5,340	5,957	6,795	7,487	8,202	8,857	9,494	10,201	10,654

Financial Performance

Waitematā DHB Statement of Financial Performance

Provider - Jan-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	83,662	83,897	(235)	585,080	588,562	(3,482)	1,008,037
Other Income	2,138	2,093	45	35,609	30,816	4,793	41,825
Total Revenue (excl. extraordinary items)	85,799	85,990	(190)	620,689	619,378	1,311	1,049,862
EXPENDITURE							
Personnel							
Medical	17,804	18,051	246	125,781	126,204	423	221,100
Nursing	25,475	26,152	677	173,172	172,479	(694)	296,150
Allied Health	10,613	10,480	(133)	79,696	78,144	(1,553)	134,634
Support	2,143	2,164	22	15,385	15,693	308	27,550
Management / Administration	5,978	6,630	652	46,621	50,627	4,006	88,151
Outsourced Personnel	1,832	1,262	(571)	14,128	8,939	(5,189)	15,503
	63,845	64,738	893	454,784	452,085	(2,699)	783,088
Other Expenditure							
Outsourced Services	5,331	5,407	76	39,300	38,785	(514)	66,234
Clinical Supplies	11,231	11,582	351	81,622	81,712	91	138,622
Infrastructure & Non-Clinical Supplies	11,454	8,335	(3,119)	66,721	58,140	(8,582)	98,719
	28,016	25,324	(2,692)	187,643	178,637	(9,005)	303,575
Total Expenditure (excl. extraordinary items)	91,861	90,062	(1,800)	642,426	630,722	(11,704)	1,086,662
Surplus/(Deficit) excl. extraordinary items	**(6,062)**	**(4,072)**	**(1,990)**	**(21,737)**	**(11,344)**	**(10,393)**	**(36,800)**
Extraordinary items							
COVID-19 Net benefit/(cost)	(359)	0	(359)	(3,026)	0	(3,026)	0
Holiday Pay provision	(2,000)	0	(2,000)	(14,000)	0	(14,000)	0
Surplus/(Deficit) incl. extraordinary items	**(8,421)**	**(4,072)**	**(4,349)**	**(38,763)**	**(11,344)**	**(27,419)**	**(36,800)**

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

Waitematā DHB Statement of Financial Performance

Provider by service - Jan-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
CONTRIBUTION (excl. extraordinary items)							
Surgical and Ambulatory	(11,363)	(11,266)	(97)	(91,013)	(87,482)	(3,531)	(148,948)
Acute and Emergency	(12,769)	(12,510)	(258)	(94,130)	(92,729)	(1,401)	(157,057)
Specialty Medicine and HOPS	(6,988)	(7,041)	53	(55,631)	(55,871)	240	(94,640)
Child Women and Family	(4,677)	(5,282)	605	(37,134)	(37,449)	315	(62,828)
Regional Dental	(1,771)	(2,164)	392	(15,348)	(16,676)	1,328	(27,565)
Specialist Mental Health and Addiction	(10,181)	(10,758)	577	(83,556)	(81,200)	(2,357)	(136,895)
Elective Surgery Centre	(1,747)	(2,108)	361	(16,772)	(16,412)	(360)	(28,439)
Clinical Support	(2,646)	(2,505)	(141)	(21,015)	(19,615)	(1,400)	(33,034)
Diagnostics	(7,358)	(8,187)	829	(60,412)	(62,945)	2,533	(105,967)
PHSCC	237	141	96	511	603	(92)	1,148
Corporate and Provider Support	53,203	57,609	(4,406)	452,765	458,432	(5,667)	757,426
Net Surplus/(Deficit) excl. extraordinary iten	**(6,062)**	**(4,072)**	**(1,990)**	**(21,737)**	**(11,344)**	**(10,393)**	**(36,800)**
Extraordinary items							
COVID-19 Net benefit/(cost)	(359)	0	(359)	(3,026)	0	(3,026)	0
Holiday Pay provision	(2,000)	0	(2,000)	(14,000)	0	(14,000)	0
Surplus/(Deficit) incl. extraordinary items	**(8,421)**	**(4,072)**	**(4,349)**	**(38,763)**	**(11,344)**	**(27,419)**	**(36,800)**

Financial Performance Summary

The Provider Arm operating result for YTD January 2021, prior to the extraordinary impacts of COVID-19 and Holidays Act accruals, was a deficit of $21.736m against a budget deficit of $11.344m and therefore $10.393m unfavourable.

The overall result however shows an unfavourable variance of $27.42m after the extraordinary impacts of COVID-19 (net of revenue and expenses) of $3.027m and of $14.00m for accruals in relation to the Holidays Act, which will continue to be booked on a monthly basis for the 2020/21 financial year, as directed by the Ministry of Health (MoH).

Further commentary on financial performance is included for each service further in this report.

Human Resources

Method of calculation of graphs:

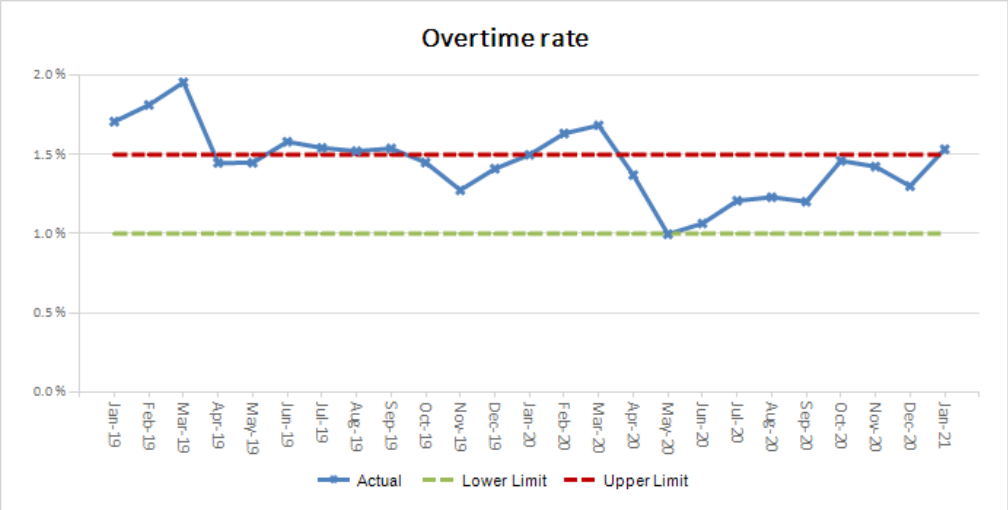
1. Overtime Rate: The sum of overtime hours worked over the period divided by worked hours over the period.
2. Sick Leave Rate (days): The sum of sick leave hours over the period divided by total hours over the period.
3. Annual Leave balance days: Count of staff with 0-76+ days equivalent 8 hour days 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 is tracking within the expected range, although is slightly higher than last year.

Overtime

As noted at the February meeting agenda, over time increased from 1.3% in December to 1.5% in January and February due to an increase in COVID-19 activity in response to active cases at that time in the Northern region.

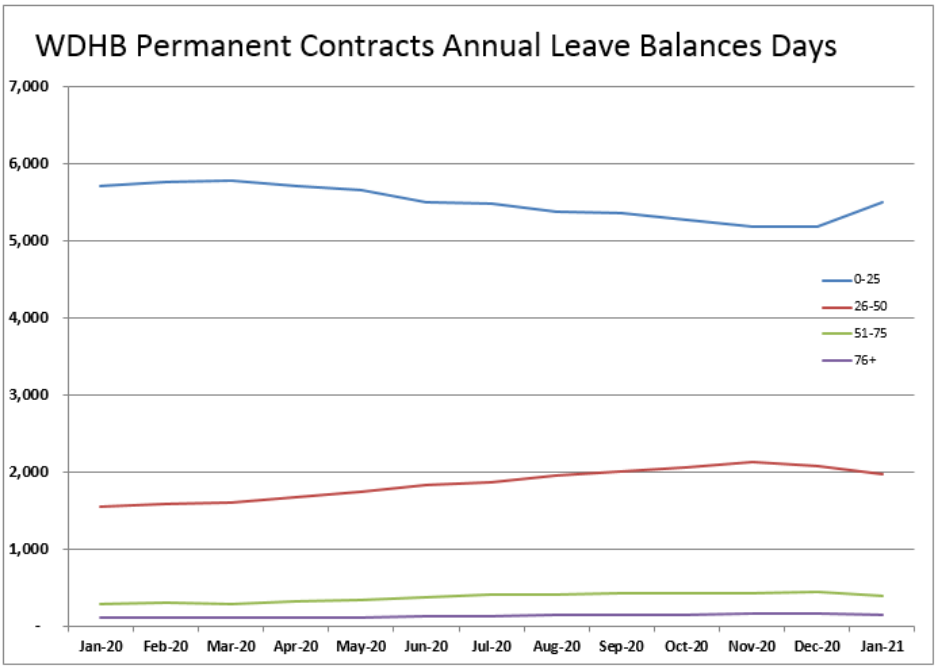


Annual Leave

Annual leave balances have increased on average three additional days (23 to 25 days) per annum due to the impact of National COVID-19 Alert levels 4, 3 and 2 during March-September 2020 and January – March 2021. The additional days are a decrease on an average of 27 days in December, which shows the impact of annual leave taken over the Christmas and New year break.

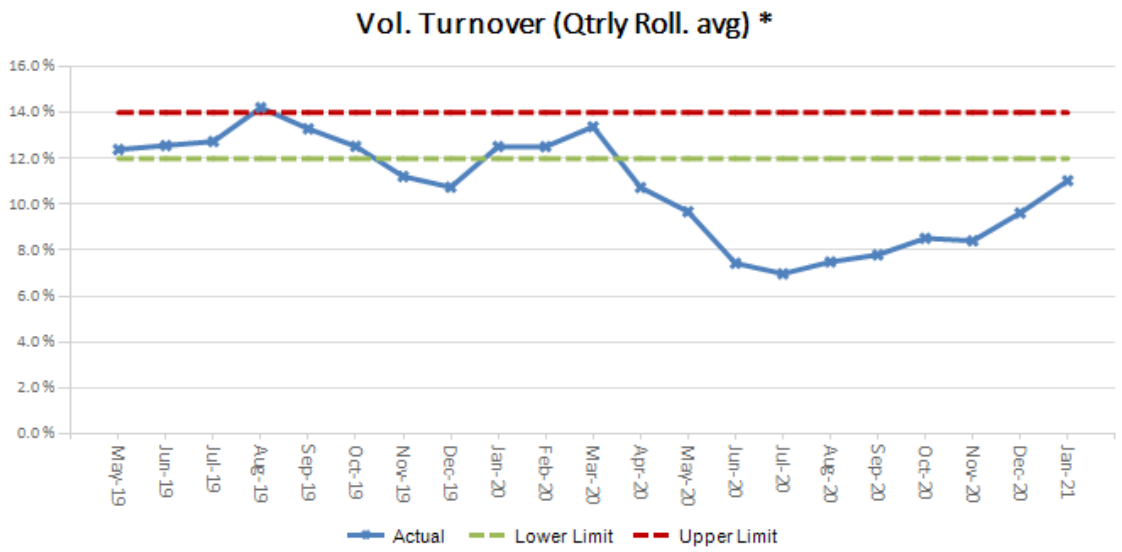
Staff are being requested to take leave over the Holiday season – including Auckland Anniversary, Waitangi Day and Easter. We have also let staff know they can cash up one week's leave, in line with the Holidays Act and over 800 staff have nominated to do this so far. The leave cash ups will be processed through March and April.

Annual Leave January 2021	Leave Bal 0-25 days	Leave Bal 25-50 days	Leave Bal 50-75 days	Leave Bal 75 days +
Surgical and Ambulatory	701	292	74	36
Elective Surgery Centre	74	26	1	-
Child Women & Family	597	153	18	14
Facilities and Development	50	17	4	2
Corporate	338	112	18	10
Acute and Emergency Medical Divison	876	399	104	47
Clinical Support	222	107	19	1
Diagnostics	304	152	46	17
Director Hospital Services	132	54	20	4
Elective and Outpatient Services	78	21	5	-
Mental Health & Addiction	1,034	331	33	5
Regional Dental	312	58	3	
Sub Specialty Med and HOPS	671	240	46	16
Governance and Funding	104	19	4	4
Total	**5,493**	**1,981**	**395**	**156**
Comparison - January 2020	**5,708**	**1,558**	**290**	**110**



Staff Turnover

The 12 month turnover is tracking at 10% with our quarterly average at 11%. November to February is a typical time for some movement. At this stage, a decrease in March turnover is seen.



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

Asian Health Best Practice Award

Lakeview Cardiology and Ward 11 were amongst the top three wards to receive the Best Practice Award during 2020 from the Asian Health Services for "Patient Whānau and Friends Survey".

Lakeview - L-R: Annie Hooker, Grace Ryu, Dr Dale Bramley, Suzanne Loader, Laurice Martin

Ward 11 - L-R: Grace Ryu, Dr Dale Bramley, Gizelle Suguitan

Key Issues

SSED Target

Since the beginning of the financial year(July 2020), performance against the Ministry of Health Shorter Stays ED target has fluctuated. This is demonstrated in the graph below.

This is due to a number of factors:

- The impact of COVID-19 and the screening and treatment pathways were implemented across the two Emergency Departments (EDs).
- There has been an increase in the number of presentations to the EDs. North Shore Hospital (NSH) has consistently high numbers since July 2020, and overall NSH ED has seen a 9% increase in presentations. Waitakere Hospital (WTH) ED initially experienced a 20% reduction in presentations, until October 2020. As a result of this initial reduction year to date there has been a reduction of 5% in presentations at WTH, however, since October there has been a consistent increase of between 3%-6% per month in presentations. The Emergency Medicine clinical teams rapidly assess patients during times of high flow

and the EDs have experienced prolonged surges of patients presenting, particularly in the early evenings leading to delays in patients being seen.

- Increased presentations has resulted in an increase in admissions to the hospital, and although this has been limited by the capacity available at NSH and WTH, it has meant that at NSH have had to keep Ward 11 (the winter ward) fully open throughout November, December and January. It has also had a significant impact on the Medical ADU which has been over capacity on a number of occasions, creating flow issues for ED. WTH has also experienced high patient flow..

- There has been an increase in Mental Health (MH) presentations and the inpatient bed capacity issues with MH have meant that patient transfers have been delayed and at times patients have had to remain in ED for longer than six hours.

A workplan is being developed to address these issues. COVID-19 continues to impact the health service and there are now clear, practiced pathways of care in both EDs with regards to the management and screening of COVID-19 patients.

We are completing a number of cycles of change to improve our patient pathways and to further improve efficiency within our current services. We are looking to increase the number of discharges before 11:00am and to reduce delays in bed turnover. Patients (with a length of stay of over seven days) are regularly reviewed. We are working closely with Allied Health and other services to explore options for early discharge, in particular hospital in the home models.

A project has been initiated to review the Mental Health Model of care from community assessment and access through to admission and assessment in ED and admission to the inpatient unit. ED will be represented on this group.

Scorecard – Acute and Emergency Medicine Division

Waitematā DHB Monthly Performance Scorecard

Acute and Emergency Medicine
January 2021
2020/21

Priority Health Outcomes

	Actual	Target	Trend
a. Shorter Waits in ED	92%	95%	▲

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	7 days	≤14 days	▼
Net Promoter Score FFT	66	65	▼
Improving Outcomes			
PCI w/in 120 minutes (STEMI patients)	92%	80%	▲
Better help for smokers to quit - hospitalised	99%	95%	--
Quality & Safety			
Older patients assessed for falling risk	97%	90%	▼
Rate of falls with major harm	0	≤2	▲
Good hand hygiene practice	92%	80%	--
Pressure injuries grade 3&4	0	0	--
HR/Staff Experience			
Sick leave rate	3.6%	≤3.4%	--
Turnover rate - external	10%	≤14%	▲
Vacancies - %	5%	≤8%	▼

Service Delivery

	Actual	Target	Trend
Waiting Times			
General Medicine - % seen w/in 120 mins	72%	85%	▼
Elective coronary angiography w/in 90 days	94%	95%	▼
b. Angiography for ACS w/in 72 hours	*70%*	*70%*	▲
Chest pain clinic wait time under 6 weeks	89%	80%	▼
O/P Transthoracic Echo wait time under 12 weeks	54%	95%	▼
Patient Flow			
Elective Discharge Volumes (Cardiology)	90%	100%	▲
Outpatient DNA rate	7%	≤10%	--
Patients with EDS on discharge	90%	85%	▼

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue excl. COVID-19	2,325 k	1,909 k	▼
Expenses excl. COVID-19	96,455 k	94,638 k	▼
Net surplus/(deficit) excl. COVID-19	-94,130 k	-92,729 k	▼
COVID-19 net benefit/(cost)	-160 k	0 k	▼
Net surplus/(deficit) incl. COVID-19	-94,290 k	-92,729 k	▼
Contracts (YTD)			
Elective WIES Volumes	594	722	▲
Acute WIES Volumes	22,437	22,026	▲

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, Dec 20

A question?

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

Scorecard Variance Report

Best Care

Sick leave rate – 3.6% against a target of ≤3.4%

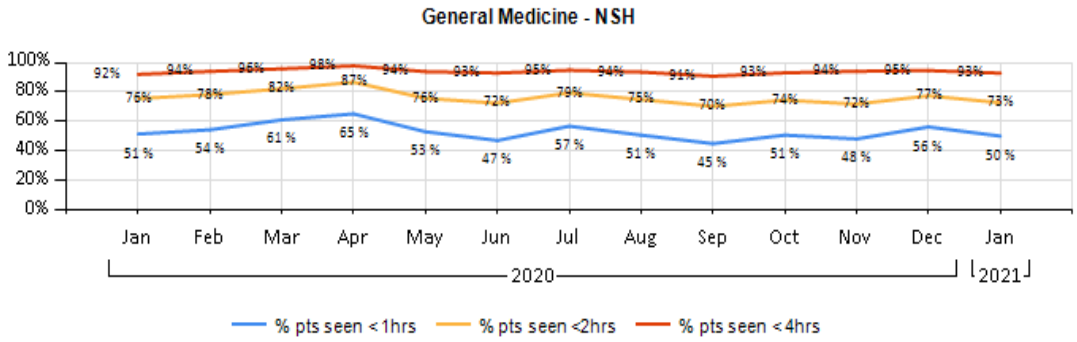
Sick Leave Rate – 8.1 days (per FTE) compared to a target of 8.0 days. We have seen a significant drop in the sick leave rate (per FTE) since November 2020 which is promising.

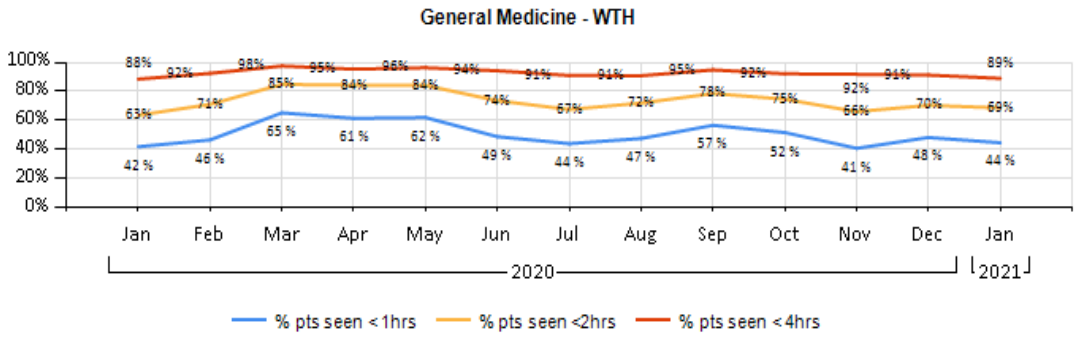
Sick Leave Rate – 12 month rolling average – 3.6% compared to a target of 3.4%.
The 12 month rolling average sick leave rate has remained relatively stable over the last 12 months.

Service Delivery

General Medicine - % seen within 120 minutes of triage – 72% against a target of 85%

There has been a slight reduction in time to be seen at both Waitakere and North Shore Hospitals over the last month. The New House officers commenced in January required a period of orientation and took slightly longer to assess patients while familiarising themselves with the hospital systems. The service was also impacted by the change in registrar rotation to the beginning of February and many registrars who worked over the Christmas and New Year period used their STIL leave in January. This resulted in a number of registrar vacancies and occasionally cover was from a house officer rather than registrar. RMOs were supported by SMOs on days where there were vacancies but this led to increased waiting times at both sites. Patients waiting more than four hours are reported and monitored daily.



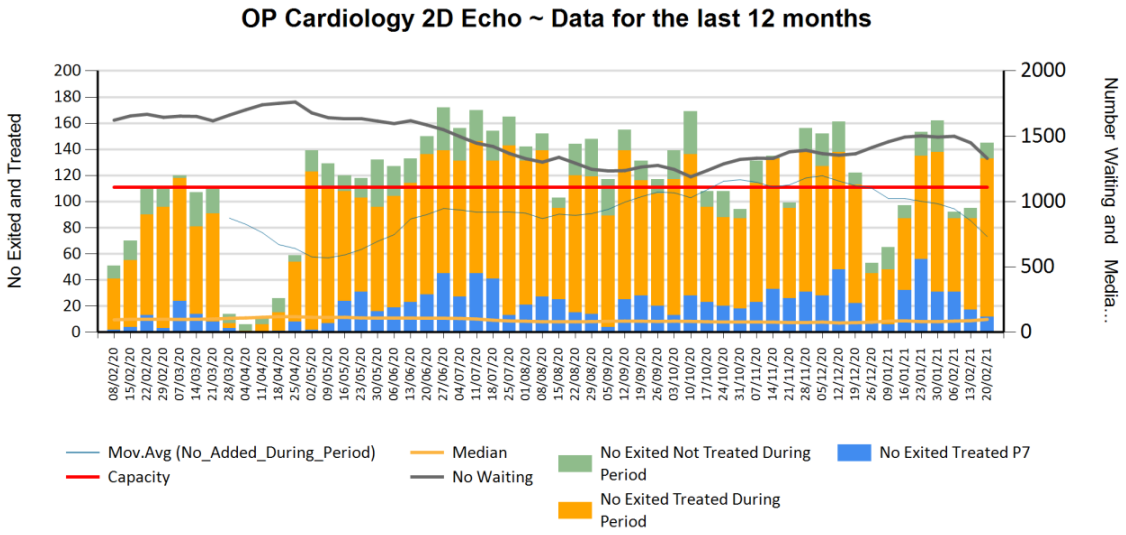


O/P Transthoracic Echo wait time under 12 weeks – 54% against a target of 95%

In January, 54% of ECHOs were completed in outpatients within the 12-week Northern Region target. While the waiting time for P1 patients has been maintained, the median wait time for all patients is 12 weeks – an improvement in comparison to 2019 when the median was as high as 22 weeks. P2 patients are now down to eight weeks and P3 patients are at eight months.

The graph below shows the improvements made since the beginning of June, the sustained increase in productivity since production resumed in May and the continued downward trend on the waiting list, which at

the beginning of January sits at 1,331. Whilst there was a decline in patient volumes over the Christmas period due to shorter weeks and a focus on clearing inpatient referrals, we are in a good position going forward.



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		
Quality. Support consumers to navigate their health journeys *Acute readmissions* • Establish effective outpatient management pathways and clinics for patients with heart failure and monitor the impact of this on their readmission rate	Dec 2020	✓
• Utilise both General Medicine and cardiology resources to support and further develop the chronic heart failure management system/clinic	Jun 2021	✓
Acute demand Actions to improve the management of acute inpatient demand and data in the Emergency Department		
Acute data capturing Pending funding approval, develop a project to clarify ED clinician workflow and interactions with clinical systems and develop and enhance ED workflow user experience tools to better support data capture • Initiate project • Development and delivery of SNOMED • Optimisation	Jul 2020 Dec 2020 Jun 2021	✘
Acute demand *Improving patient flow for admitted patients* Continue to support inpatient home-based wards in Medicine at both hospitals with a focus on further improving patient flow through daily consultant-led ward rounds, daily multidisciplinary board rounds supported by a daily review of patients with a length of stay (LOS) >7 days. Further enhance these processes by providing cultural support to facilitate discharge planning for Māori and Pacific patients (EOA)	Ongoing	✓
Acute clinics	Ongoing	✓

Continue to develop same-day acute outpatient clinics in Medicine as an alternative to assessment in the Admissions and Diagnostic Unit (ADU)		
Establish the baseline and for virtual clinics and develop a robust virtual clinic follow-up process in General Medicine	Dec 2020	✓
Geriatric Medicine in ED and ADU Work with the Health Care of the Elderly to develop a system to ensure the early assessment and management of frail elderly patients presenting to the hospital to facilitate early discharge to community geriatric support or direct admission for rehabilitation	Dec 2020	✓
Acute Care of the Elderly Provide a more co-ordinated and specialised care pathway for the acute care of frail elderly (evidence suggests that this facilitates earlier discharge and shorter LOS in secondary services) • Trial concept • Implement	Jul 2020 Jun 2021	✖
Improving wait times for patients requiring mental health and addiction services who present to ED • Implement a rapid assessment process for mental health patients to ensure timely assessment	Dec 2020	✓
• Review the current model of care to minimise patient waiting times; action at least one recommendation	Jun 2021	✓

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. They have made a capital request for $400k, however funding for this IT project was not approved. Plan to link the implementation of the ED white board in July 2021.
Acute Care of the Elderly Provide a more co-ordinated and specialised care pathway for the acute care of frail elderly (evidence suggests that this facilitates earlier discharge and shorter LOS in secondary services). This project is currently on hold.

Financial Results - Acute and Emergency Medicine

Waitematā DHB Statement of Financial Performance

Acute & Emergency Medicine - Jan-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	254	215	39	1,870	1,502	368	2,574
Other Income	62	58	4	455	407	48	698
Total Revenue (excluding COVID)	316	273	43	2,325	1,909	416	3,272
EXPENDITURE							
Personnel							
Medical	4,375	4,242	(133)	34,335	34,618	283	56,881
Nursing	6,233	6,225	(8)	43,923	43,331	(593)	75,525
Allied Health	218	244	26	1,952	1,936	(17)	3,213
Support	0	0	0	0	0	0	0
Management / Administration	495	517	22	4,234	4,199	(35)	6,823
Outsourced Personnel	131	142	11	770	985	215	1,673
	11,453	11,370	(83)	85,215	85,069	(146)	144,115
Other Expenditure							
Outsourced Services	54	39	(15)	248	270	21	458
Clinical Supplies	1,262	1,285	23	8,713	8,700	(13)	14,768
Infrastructure & Non-Clinical Supplies	315	89	(226)	2,278	599	(1,679)	989
	1,631	1,413	(219)	11,240	9,569	(1,671)	16,214
Total Expenditure (excluding COVID)	13,084	12,783	(301)	96,455	94,638	(1,817)	160,329
Surplus/(Deficit) excluding COVID	**(12,769)**	**(12,510)**	**(258)**	**(94,130)**	**(92,729)**	**(1,401)**	**(157,057)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	(10)	0	(10)	(160)	0	(160)	0
Surplus/(Deficit) including COVID	**(12,779)**	**(12,510)**	**(269)**	**(94,290)**	**(92,729)**	**(1,561)**	**(157,057)**

* 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 $269k unfavourable for January and $1,561k unfavourable for the YTD.

Revenue ($43k favourable for January, $416k favourable YTD)

The favourable variance for the month was due to ACC revenue. The favourable YTD variance was due to higher ACC revenue and University of Auckland teaching.

Expenditure excluding COVID-19 ($301k unfavourable for January, $1,817k unfavourable YTD)

The unfavourable variance for January was mainly due to RMO over-allocation from NRA and opening unfunded beds in NSH ADU and ward 11. The unfavourable variance for the YTD was mainly due to unmet saving target.

Personnel ($146k unfavourable YTD)

Medical ($283k favourable YTD)

The favourable variance was due to reduced ED medical cover cost from additional sessions and savings from skill mix in general medicine for junior doctors. Overspending on cardiology medical cost due to high activity level had offset some savings from other areas.

Nursing ($593k unfavourable YTD)

The unfavourable variance was due to opening of unfunded beds in NSH ADU and ward 11. Additional nursing at NSH ED for COVID-19 patients screening since Alert level 3 in August. In addition, as one of the longer term

COVID-19 impacts, there is extra cost pressure on the areas of accumulated annual leave and additional safety measures implemented in some areas caring for COVID-19 patients.

Allied Health ($17k unfavourable YTD)
The unfavourable variance was due to the afterhours work for cath lab rebuild period from September to December.

Support and Management/Administration ($35k unfavourable YTD)
The unfavourable variance was due to high sick leave cover in ED and additional cover provided for Surgical Assessment and Diagnostic Unit (SADU).

Outsourced Personnel ($215k favourable YTD)

Other Expenditure ($1,671k unfavourable YTD)
Outsourced Services ($21k favourable YTD)

Clinical Supplies ($13k unfavourable YTD)
The unfavourable variance was due to high cardiology catheter and implant costs.

Infrastructure and Non-Clinical Supplies ($1679k unfavourable YTD)
The unfavourable variance was the saving target.

COVID-19 impact
Total COVID-19 impact (160k for YTD):
There was extra cover cost for staff stood down or were under self-isolation for various reasons in relation to COVID-19. Additional RN and HCAs have been deployed at NSH ED, ADU, ward 10 and ward 11 since August incurring extra nursing cost. In addition, COVID-19 restrictions on travels have caused an increase on accumulated annual leave balance. Clinical supplies for face masks, protective clothing and related products also increased during last few months. A breakdown by account group as follows:

Waitematā DHB COVID summary

Acute & Emergency Medicine - Jan-21

($000's)	MONTH Actual	YTD Actual
REVENUE		
* Government and Crown Agency	0	0
Other Income	0	0
COVID Revenue	0	0
EXPENDITURE		
Personnel		
Medical		105
Nursing	10	113
Allied Health		0
Support		0
Management / Administration		0
Outsourced Personnel		(81)
	10	137
Other Expenditure		
Outsourced Services		24
Clinical Supplies		0
Infrastructure & Non-Clinical Supplies		0
	0	24
COVID Expediture	10	160
Net COVID Surplus/(Deficit)	**(10)**	**(160)**

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 Willem Landman, 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 Naveed Ahmed (Acting) for Renal, Dr Megan Cornere for Respiratory, Dr Eileen Merriman 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

Stroke Service

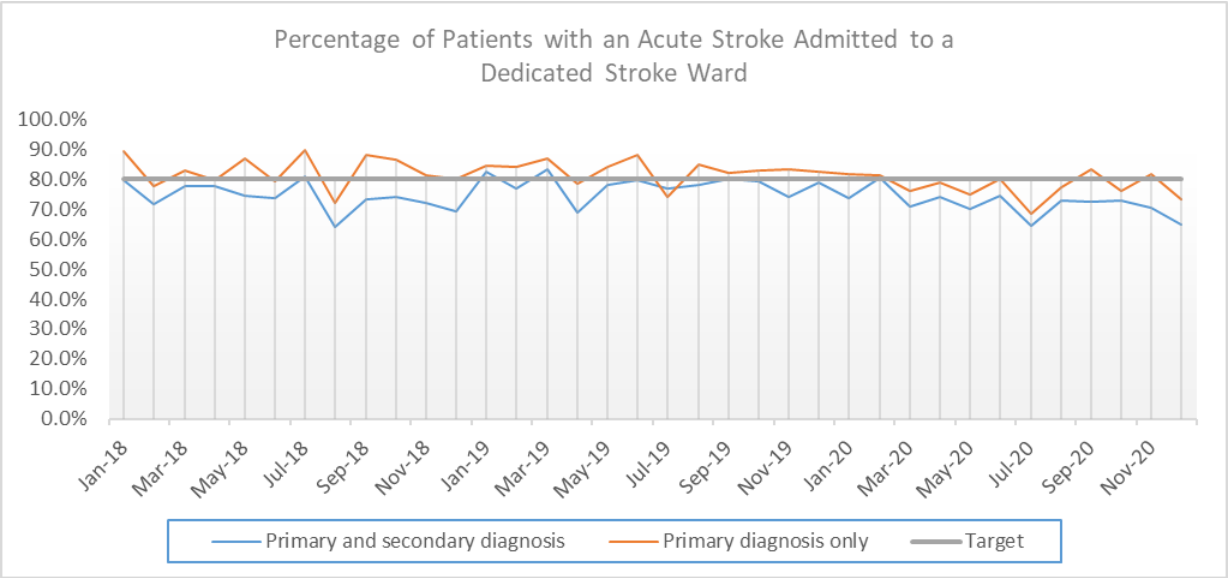
A clinical review of all patients that met the criteria to be included in the Ministry of Health Key Performance Indicator KPI was undertaken as part of the associated quality improvement initiatives aimed at improving performance level for KPI1 (80% of patients presenting with an acute stroke to be admitted to a dedicated stroke ward) which has been achieved for five months within the previous three years

During the analysis, it was noted that there were several patients without a history of an acute stroke being included in these reports and it was noted that these patients actually had a history of previous stroke. Initially it was unclear why old cases of stroke were being included. A review of data capture and definitions via our Business Analysts and Clinical Coding teams identified that patients coded with a secondary or previous diagnosis of stroke were inappropriately being included in the reports.

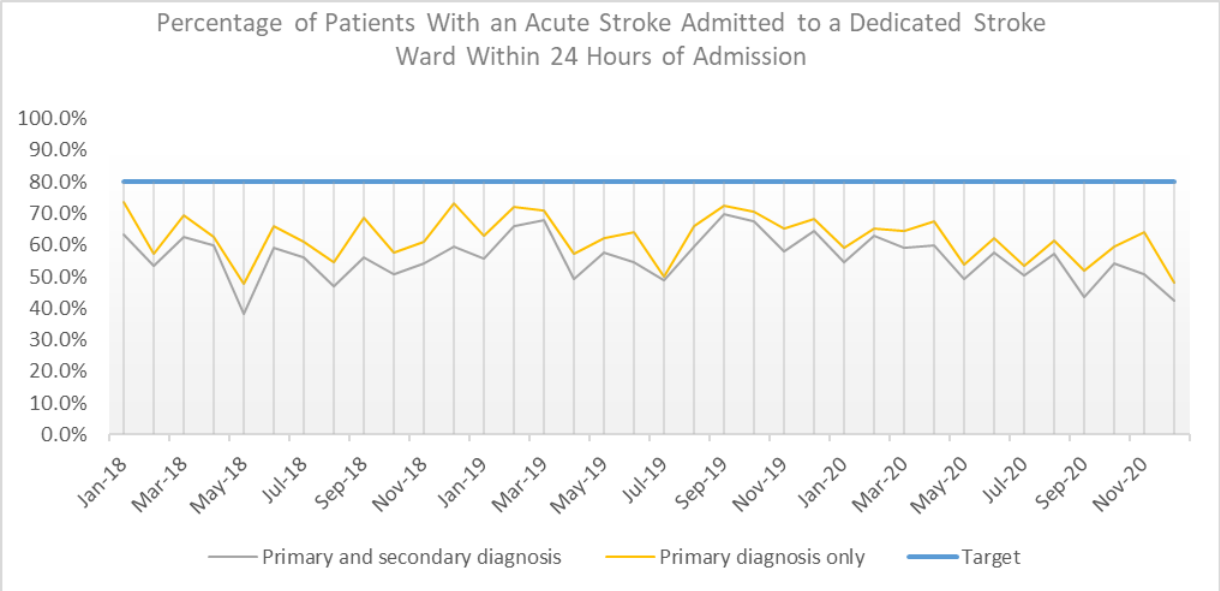
To ensure that a shift to using reporting which only uses a Primary diagnosis of stroke would not miss any acute strokes, a review of all stroke patients (both primary and secondary coding) was completed by Dr Nicholas Child. This review confirmed that the inclusion of patients with a secondary diagnosis was inappropriate for our Ministry of Health reporting. The impact of this is on our historical reporting is presented below.

In summary

KPI1 has historically been for 80% of patients presenting with an acute stroke to be admitted to a dedicated stroke ward. Now that the data only includes a primary diagnosis we can see that the service actually achieved this KPI in 23 months of the previous three years rather than only 5 months.



As of the first quarter 2020/21 FY, the KPI1 target has been updated by the MoH to achieve 80% of patients with an acute stroke being admitted to a dedicated stroke ward *within 24 hours*. Applying the new KPI retrospectively, the overall performance is improved when looking only at the primary diagnosis. It also demonstrated the need to move an additional 20% of acute strokes to a dedicated unit within 24 hours. Work is well underway to achieve this in collaboration with Emergency Medicine, General Medicine, Neurology, and Health of Older People.



Key Issue

Dermatology Inpatient Service

The Dermatology service is a small but passionate group of SMOs who actively seek to improve outcomes for all Waitematā patients.

Dermatology is almost exclusively an outpatient based service at Waitematā and is therefore a relatively inexpensive service on a per capita basis compared to other hospital specialties.

Waitematā DHB Dermatology service currently consists of 1.9 FTE Dermatologists, made up of four SMOs. There is one acute patient slot after the end of the dermatology out-patient clinic, if time allows, which is used to review an acute referral.

There is a wide spectrum of inpatients who have dermatological conditions. Without a specialist dermatological assessment such patients tend to have prolonged stays and are more likely to receive ineffective treatments. On the other end of the spectrum, a small number of inpatients are seriously ill with dermatological conditions and specialist dermatological assessment is critical to achieving a good patient outcome.

Currently our Waitematā DHB inpatient teams do not always have access to Specialist Dermatological assessment for seriously ill or dermatologically complicated patients under their care. This represents a clinical risk and has been identified on the Waitematā DHB Risk register.

There is currently very limited cover to see in-patient referrals or reviews. There is also no on-call service available after hours or over the weekend. Very urgent cases are referred to Auckland DHB (provide in-patient Dermatology care for Waitematā DHB patients).

A recent review of the in-patient dermatology consultations showed that:

- More than half of all referrals received were for patients admitted *primarily* with a skin disease
- One third of all referrals were declined due to lack of availability of Dermatologist
- 90% of patients reviewed with primary skin condition were able to be discharged within 48 hours of being seen by a Dermatologist

Consideration needs to given to development of the service over time to meet the needs of the organisation.

Scorecard – Specialty Medicine and Health of Older People Services

Waitematā DHB Monthly Performance Scorecard

Specialty Medicine and Health of Older People
January 2021
2020/21

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	13 days	≤14 days	▼
Net Promoter Score FFT	79	65	▲
Improving Outcomes			
a. Patients admitted to stroke unit w/in 24 hrs	*42%*	*80%*	▼
a. Acute Stroke to rehab w/in 7 days	*33%*	*80%*	▼
b. InterRAI assessments - LTHSS clients	*99%*	*95%*	
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	92%	80%	--
Pressure injuries grade 3&4	0	0	--
HR/Staff Experience			
Sick leave rate	3.3%	≤3.4%	--
Turnover rate - external	10%	≤14%	▼
Vacancies - %	4%	≤8%	▲

Service Delivery

Waiting Times	Actual	Target	Trend
Urgent diagnostic colonoscopy w/in 14 days	94%	90%	▼
Diagnostic colonoscopy			
Within 42 days	33%	70%	▼
Number waiting over 42 days	986	505	▼
Number waiting over 90 days	337	0	▼
Longest wait time (days)	539		
Surveillance colonoscopy w/in 84 days	36%	70%	▼
Patient Flow			
Outpatient DNA rate	7%	≤10%	--
Patients with EDS on discharge	88%	85%	▼

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue excl. COVID-19	6,333 k	5,623 k	▼
Expenses excl. COVID-19	61,963 k	61,494 k	▲
Net surplus/(deficit) excl. COVID-19	-55,631 k	-55,871 k	▼
COVID-19 net benefit/(cost)	-725 k	0 k	▼
Net surplus/(deficit) incl. COVID-19	-56,356 k	-55,871 k	▼
Contracts (YTD)			
Elective WIES Volumes	306	282	▲
Acute WIES Volumes	1,629	1,445	▼

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. Dec 2020 - coding dependent
b. Quarterly Mar 20 latest data

A question?

Contact:
Victoria 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 *– 42% against a target of 80%*

This is the first month we have reported against this updated KPI. Previously this measure did not include a 24 hour timeframe. Our service has completed a review of the reports that contribute to the service scorecard, however this review was not finalised ahead of their publication. Following this review we have identified an improvement in our performance against this KPI to 48% (35 patients out of 72) against a target of 80%.

Of the 37 patients that did not get admitted to a Stroke ward within 24 hours, 18 were admitted to a stroke ward during their admission (outside the 24 hour target). A clinical review of the remaining 19 patients has been completed to identify the reasons for these patients not being admitted to a dedicated Stroke ward. Eight of these patients were not initially transferred to a Stroke ward; four patients required end of life cares and as such it was deemed inappropriate to transfer them to a stroke ward; and one patient was admitted directly to inpatient rehabilitation without being admitted to a Stroke ward. For the remaining six patients it is unclear why they did not get admitted to a stroke ward. None of these patients received input from our Stroke service.

The move to a time based KPI for admission to a stroke ward requires a significant change in how care is managed within the hospital for Stroke patients and work is already underway in to improve this.

Acute Stroke to rehab with-in seven days *– 33% against a target of 80%*

For the month of December 2020 33% (5 out of 17) of patients requiring inpatient rehabilitation were transferred to an appropriate ward within seven days. A clinical review of the 12 patients that did not meet this target has been completed. Nine of these patients were found to have been too unwell for transfer to rehabilitation; two were delayed as they were initially considered for outpatient rehabilitation whilst one patient experienced a delay in receiving therapy input. Our service anticipates that with an increased focus on collaboration between the Older Adult and General Medicine services there will be an improvement in our performance against this KPI.

Service Delivery

Diagnostic colonoscopy within 42 days *– 33% against a target of 70%*

Scorecard targets for Colonoscopy were achieved for P1 but not for P2 (normal diagnostic) and surveillance

While the target was not met in terms of compliance against the indicators, the total number of people waiting for their colonoscopy (non-urgent and surveillance) is still on track with our forecast in our improvement action plan prior to December. The numbers for December and January were behind forecast as outsourcing was temporarily stopped in 11 November and did not fully resume until early January 2021. This resulted in the 399 fewer colonoscopies completed than planned over this period. While this will also negatively impact February results, the lost volume will be fully recovered prior to June 2021.

- 30 Nov: forecast waiting 2667, actual 2574
- 31 Dec: forecast waiting 2696, actual 2806
- 31 Jan: Forecast waiting 2549, actual 2815

The service has restarted the Saturday endoscopy lists from 13 February which will enable another 20 endoscopy procedures to be done each week. This will be a combination of colonoscopy and/or gastroscopy procedures. The retrospective and prospective implementation of the new national surveillance guidelines is continuing. At the end of January 2021, a total of 921 patients had been reviewed and identified 241 patients whose surveillance could be deferred while 242 patients were identified as no longer requiring surveillance, out of domicile or having had their procedure done in private.

Surveillance colonoscopy with-in 84 days *– 36% against a target of 70%*

As above

Compliance with patient safety checks in Adult Mental Health Ward
Fourteen clinical notes were randomly audited from 1-31 January. 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

DHB activity	Milestone	On Track
Healthy ageing Actions to care for our older population, as identified in the Healthy Ageing Strategy 2016		
Non-acute rehabilitation pathway • Work with ACC to develop a new model of care (MOC) for non-acute rehabilitation, which spans community-based provision and minimises unnecessary inpatient stays	Jun 2021	✖
• Include in the new MOC a proactive consideration of policy, practice and service delivery issues to maximise cultural safety and relevance for older Māori, Pacific and Asian people (EOA)	Jun 2021	✖
Bowel screening and colonoscopy wait times Actions to meet colonoscopy wait times and equitable access to bowel screening		
Colonoscopy wait times Implement a revised scheduling process to clinically review all patients waiting >100 days and a proportion of those waiting >120 days to ensure no new patients wait >120 days, and a planned and progressive reduction of patients currently waiting >120 days	Dec 2020	✖
Review options to lower demand while continuing to maximise internal production by maintaining utilisation rates above 85% and DNA rates below 5%	Jun 2021	✓
Building on 2019/20 work, further develop our understanding of barriers resulting in Māori non-attendance with direct phone contact by ENCs with Māori patients on the waitlist that focus on overcoming barriers (EOA)	Jun 2021	✓

Areas off track for month and remedial plans

Non-acute rehabilitation pathway: a number of facilitated planning workshops with medical, nursing and allied health staff have been used to cement the values and principles that will underpin the development of our hospital based and non-acute community rehabilitation services. The principles agreed include:

- Assessment and care should be provided in the most appropriate place for the patient.
- Care should be provided to the patient at the earliest opportunity.
- Care is overseen by experts in geriatric medicine and provided by an inter-disciplinary team supported by up to date research and technology.
- Care provision should be seamless with limited transfers of care between teams.
- Patients should have equitable access to Older Adults services at any point in their journey.

Working groups are now being established to review and develop new care pathways that align with these principles. The implication of the NAR ACC contract changes scheduled for January 2022 have yet to be fully understood including the demand and financial implications of moving to case mix funding model. This remains a work in progress.

Colonoscopy wait times: the total number of people waiting for their colonoscopy (non-urgent and surveillance) is aligned to the recovery trajectory forecast in our improvement action plan.

Supporting this work, we have retrospectively and prospectively implemented the new national surveillance guidelines that will reduce or defer demand by up to 1,000 colonoscopies in 2020/21. In January 2021, a total of 921 patients had been reviewed and identified 241 patients whose surveillance could be deferred while 242 patients were identified as no longer requiring surveillance, out of domicile or having had their procedure done in private
2019/20 outsourced contracts were extended through to early November 2020. Noting that outsourcing stopped early November 2020 and resumed in January 2021 with 2 new providers.

Additional internal sessions are on track to deliver an extra 400 colonoscopies by June 2021.

Financial Results – Specialty Medicine and Health of Older People

Waitematā DHB Statement of Financial Performance

Specialty Medicine and HOPS - Jan-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	446	736	(290)	5,284	5,171	113	8,850
Other Income	156	65	91	1,049	452	597	774
Total Revenue (excluding COVID)	602	800	(198)	6,333	5,623	710	9,625
EXPENDITURE							
Personnel							
Medical	1,675	1,855	180	14,556	15,085	530	25,049
Nursing	2,394	2,757	363	18,093	19,258	1,165	33,745
Allied Health	1,647	1,352	(296)	14,490	13,390	(1,100)	22,290
Support	0	0	0	0	0	0	0
Management / Administration	322	269	(52)	2,724	2,605	(119)	4,348
Outsourced Personnel	65	54	(11)	469	352	(117)	614
	6,103	6,287	184	50,331	50,690	359	86,046
Other Expenditure							
Outsourced Services	221	456	235	2,611	3,165	554	5,168
Clinical Supplies	1,022	1,049	27	7,230	7,292	62	12,467
Infrastructure & Non-Clinical Supplies	244	50	(195)	1,791	346	(1,445)	583
	1,487	1,554	67	11,632	10,804	(828)	18,218
Total Expenditure (excluding COVID)	7,590	7,842	251	61,963	61,494	(470)	104,264
Surplus/(Deficit) excluding COVID	**(6,988)**	**(7,041)**	**53**	**(55,631)**	**(55,871)**	**240**	**(94,640)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	(59)	0	(59)	(725)	0	(725)	0
Surplus/(Deficit) including COVID	**(7,048)**	**(7,041)**	**(6)**	**(56,356)**	**(55,871)**	**(485)**	**(94,640)**

* 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 was $6k unfavourable for January and $485k unfavourable for the YTD.

Revenue ($198k unfavourable for Jan, $710k favourable YTD)

The January revenue result is driven by a deferral of revenue for gastro procedures not yet performed YTD and is offset by a favourable outsourced expenditure line. The YTD the favourable result contains research revenue, revenue from financial sustainability projects. This is partly being offset by lower numbers of bed nights qualifying for reimbursement from ACC under the Non-Acute Rehab contract, due to admitting much fewer patients from

interim care services back to the hospital for rehab. In reality the YTD revenue result would be impacted by $279k as ACC's July and August revenue is also down from lower demand as we recover slowly from the COVID-19 lockdown impacts, and this is reported in the last line under extraordinary COVID-19 impacts.

Expenditure ($251k favourable for Jan, $470k unfavourable YTD)
The favourable variance for January was due to high uptake of annual leave in nursing and medical personnel, and delivery of financial sustainability project savings in Ward 15 bed closures and watches. YTD the overspend is due to allied personnel which, due to improved retention and recruitment, have vacancies below the churn savings target level as well as lower leave taken..

Personnel ($359k favourable YTD)
Medical ($530k favourable YTD)
The YTD favourable medical variance is mainly due to underspend in allowances and vacancies. In reality, this result is impacted due to an annual leave taken deficit YTD of $108k which is at partially attributable to the COVID-19. This figure is included and reported in the COVID-19 extraordinary cost line above.

Nursing ($1,165k favourable YTD)
The YTD favourable nursing variance is mainly due to savings in Ward 15, with nursing staff redeployed across the hospital whilst bed numbers have been flexed and closed during the year in this ward. In reality, this result is worsened due to an annual leave taken deficit YTD of $288k which is at least partially attributable to COVID-19. This figure is included and reported in the COVID-19 extraordinary cost line above.

Allied Health ($1,100k unfavourable YTD)
The YTD unfavourable variance for allied was mainly due to improved retention and recruitment, with vacancies now below the churn savings target level, worth ($600k), as well as a skill mix variance worth ($229k) YTD. There was also a couple of one off back payments for allied staff to correct a pay error spanning across a few years in August ($80k). In reality, this result is worsened due to an annual leave taken deficit YTD of $68k which is at least partially attributable to COVID-19. This figure is included and reported in the COVID-19 extraordinary cost line above.

Support and Management/Administration ($119k unfavourable YTD)
Support and Management/Administration is slightly unfavourable due to at times vacancies being below the churn savings target level. In reality, this result is impacted by an annual leave taken deficit YTD of $44k which is reported in the COVID-19 extraordinary cost line.

Outsourced Personnel ($117k unfavourable YTD)
Outsourced Personnel mainly contains spend for external bureau nursing when internal bureau cannot be sourced. It has been adjusted to account for savings YTD attributed to COVID-19 given the higher retention and lower vacancies and thus the lower need for outsourcing compared to the equivalent periods in the previous year, which is reported in the COVID-19 extraordinary cost line as a savings.

Other Expenditure ($828k unfavourable YTD)
Outsourced Services ($554k favourable YTD)
Outsourced services are favourable due to lower than budgeted volumes of outsourced endoscopy procedures being performed.

Clinical Supplies ($62k favourable YTD)
Clinical Supplies in favourable due to savings in respite services, slightly offset by pharmaceutical purchases associated with additional research revenue income.

Infrastructure and Non-Clinical Supplies ($1,445k unfavourable YTD)

The YTD unfavourable infrastructure and non-clinical supplies is mainly due to the savings target allocated to the service, met in other areas above, worth ($1,107k). There are also expenses relating to research which are offset by additional revenue ($375k).

COVID-19 impact

Total COVID-19 impact ($725k YTD)

As broken down in account groups above, this is a combination of lost ACC revenue, annual leave taken deficits in all personnel groups and a small amount of personnel cost associated with staffing MIQ facilities.

Child, Woman 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 Michele Kooiman, acting 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, Dr Diana Ackerman for Women's Health and Dr Kirsten Miller (acting) for ARDS.

Highlight of the Month

The maternity services has started a new induction of labour protocol, this is in two parts:

1. All inductions are formally requested using a new process that outlines the reason for induction to bring all requests in line with the National Guidelines.
2. Labour is now being induced using predominantly oral Misoprostol instead of vaginal prostaglandins this has been shown to reduce the caesarean section rate in women who are being induced and it is less invasive and more acceptable to women. This change in practice is in line with national recommendations.

These changes in practice are being closely monitored but the initial response is very positive.

Key Issues

From February 22, half our Public Health Nurse workforce will be re-deployed to support the administration of the COVID-19 vaccine to staff in the Managed Isolation Facilities across the region. It is recognised that usual service delivery will be affected.

Current workload has been reviewed and highest priority work streams identified. Public Health Nurses will focus their attention on low decile schools for the school based immunisation programme with higher decile schools being rescheduled to later in the year. Prophylactic antibiotics for children and young people who have or have had rheumatic fever will also remain a priority. The service also aims to respond to high priority referrals. The Awhi Tamariki programme (Early intervention Health Programme) which provides new entrant health checks, formal education on health topics and designated public health time to see children and parents with health concerns has been put on hold. There has been a reduction in ear nursing clinics. Continence and Triage 3 referrals have been wait listed. It is anticipated that the majority of PHNs will return to the service in April and the service will develop a recovery action plan

Scorecard – Child, Women and Family Services

Waitematā DHB Monthly Performance Scorecard

Child Women and Family Services
January 2021
2020/21

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	98%	95%	▲

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	7 days	≤14 days	▲
Net Promoter Score FFT	79	65	▲
Improving Outcomes			
Exclusive breastfeeding on discharge	73%	75%	▼
Women smokefree at delivery	94%	95%	--
Better help for smokers to quit - hospitalised	97%	95%	▼
a. Oral health - % infants enrolled by 1 year	91%	95%	--
a. Oral health - exam arrears 0-12 yr	62%	≤10%	--
Quality and Safety			
Good hand hygiene practice	89%	80%	▲
HR/Staff Experience			
Sick leave rate	*3.7%*	*≤3.4%*	▼
Turnover rate - external	*10%*	*≤14%*	--
Vacancies - %	*7%*	*≤8%*	▼

Service Delivery

	Actual	Target	Trend
Elective Volumes			
CWF Services	106%	100%	▲
Waiting Times			
Gateway referrals waiting over 8 weeks	18	5	▲
Patient Flow			
Outpatient DNA rate	10%	≤10%	--
Theatre utilisation Gynaecology	84%	85%	▲
Patients with EDS on discharge	91%	85%	▼
a. Oral Health - chair utilisation	9	11	▲

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue excl. COVID-19	5,917 k	6,138 k	▲
Expenses excl. COVID-19	43,052 k	43,587 k	▲
Net surplus/(deficit) excl. COVID-19	-37,134 k	-37,449 k	▼
COVID-19 net benefit/(cost)	-459 k	0 k	▼
Net surplus/(deficit) incl. COVID-19	-37,593 k	-37,449 k	▼
Contracts (YTD)			
Gynaecology Elective WIES (excl ESC)	721	716	▲
Gynaecology Acute WIES	888	842	▼
Maternity WIES	4,375	4,899	▼
Paediatrics WIES	693	1,081	▼
Neonatal WIES	1,507	1,429	▼

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.

A question?

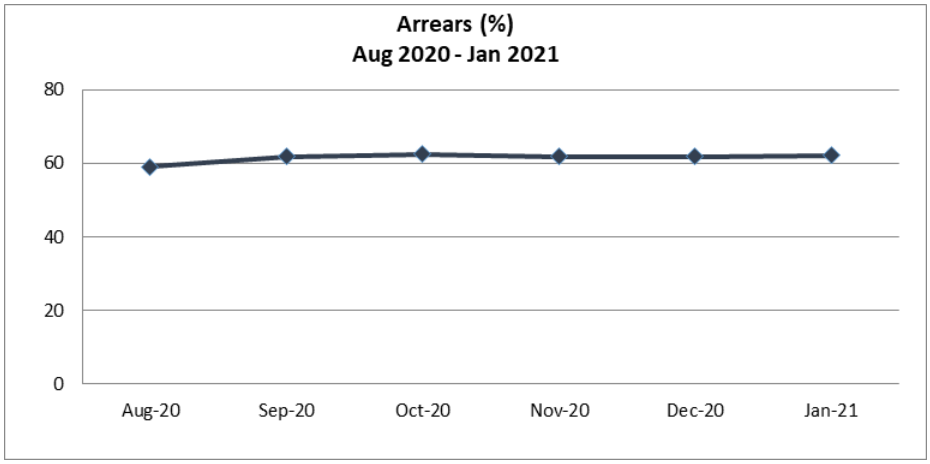
Contact:
Victoria Child - **Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz**
Planning, Funding and Health Outcomes, Waitematā DHB

Scorecard Variance Report

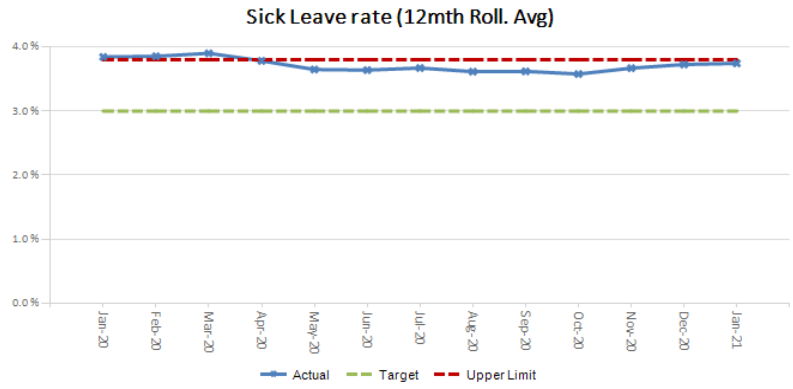
Best Care

Oral health - exam arrears 0-12 years– *62% against a target of ≤10%*

There has been a 0.4% increase in arrears this month. This was anticipated and is the result of clinic closures over the Christmas and New Year period. Over January, the service has prioritised care to children who have a history of attending appointments, which has resulted in a much lower increase in arrears than the same period last year (arrears increased by 5.1% between December 2019 and January 2020).



Sick leave rate- *3.7% against a target of ≤3.4%*
There has been no improvement in the sick leave rate this month, but it remains below the upper limit.

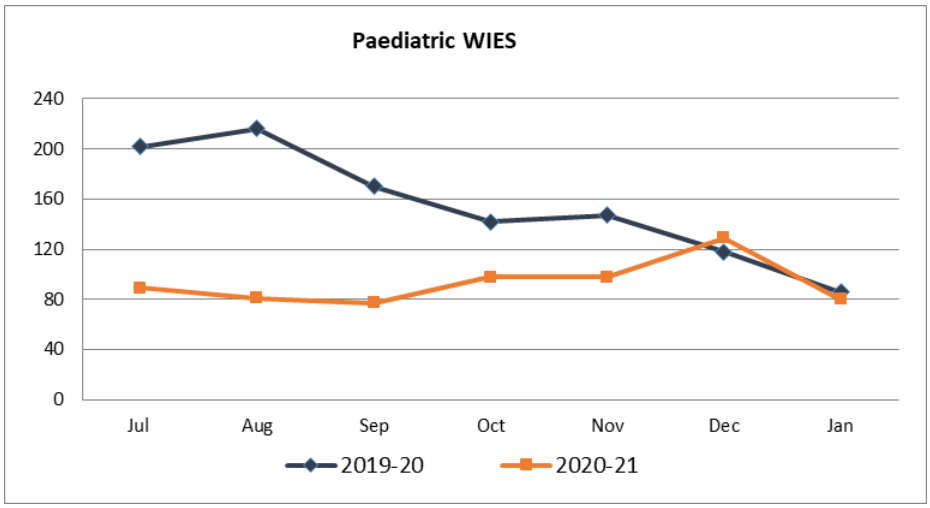


Service Delivery
Gateway referrals waiting over 8 weeks *– 18 against a target of 5*
There was a decrease in the number clients from 27 in December 2020 to 18 in January 2021, however, due clinics closure over Christmas/New Year, there is still 18 children waiting to be seen. Clinics restarted at the end of January and the service is working to prioritise these referrals.

Oral health – chair utilisation *– 9 against a target of 11*
The average number of children seen per day per chair is below target, but steady progress continues to be seen. Strategies in place to support the service to achieve expected productivity rate includes the appointment of additional booking clerks, the implementation of a daily huddle to ensure that every open chair is adequately booked and audits of the booking practices of clinics experiencing high did not attend rates.

Value for Money
Maternity WIES *– 4,375 against a target of 4,899*
Birth numbers were slightly less for December and January 2020, a project is underway to review coding practices in maternity.

Paediatric WIES *– 693 against a target of 1,081*
As demonstrated in the graph below, there has been low demand for acute paediatric inpatient care this financial year. This is attributed to physical distancing measures and lockdown, which has reduced the spread of respiratory illnesses amongst children.



Waitematā DHB Priorities Variance Report

DHB activity	Milestone	On Track
Maternity and Midwifery workforce – hospital and LMC (Waitematā DHB) Actions to train, support, recruit and retain our maternity and midwifery workforce		
Work with the National Midwifery Accord (NMA) group to implement additional clinical coach roles to support the transition of undergraduate midwives to employed practice • Develop position descriptions and agree ratio of coaches to midwives with National Midwifery Leaders group and TAS • Appoint coaches in line with new graduate intake	Jul 2020 Apr 2021	✓ ✓
Work with the NMA group to implement greater wrap-around support for Māori and Pacific undergraduate students (EOA) • Agree package of support with midwifery education providers, DHB midwife leaders and MoH working group • Implement support packages	Jul 2020 Feb 2021	× ×

Support packages are awaiting approval from the MOH.

Financial Results - Child, Women and Family Services

Waitematā DHB Statement of Financial Performance

Child Woman and Family - Jan-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	747	748	(1)	5,313	5,614	(301)	9,355
Other Income	74	75	(1)	605	524	80	898
Total Revenue (excluding COVID)	821	823	(2)	5,917	6,138	(221)	10,253
EXPENDITURE							
Personnel							
Medical	1,497	1,692	195	12,220	12,712	492	20,764
Nursing	2,481	2,966	486	18,158	19,318	1,160	33,462
Allied Health	460	598	138	4,619	4,970	351	7,889
Support	22	25	3	188	198	10	336
Management / Administration	316	294	(21)	2,712	2,712	(0)	4,389
Outsourced Personnel	181	111	(70)	1,222	770	(453)	1,306
	4,957	5,688	731	39,120	40,680	1,560	68,146
Other Expenditure							
Outsourced Services	24	46	22	232	319	87	542
Clinical Supplies	308	298	(10)	2,299	2,074	(226)	3,540
Infrastructure & Non-Clinical Supplies	209	73	(136)	1,400	515	(885)	854
	541	417	(124)	3,932	2,908	(1,024)	4,935
Total Expenditure (excluding COVID)	5,498	6,105	607	43,052	43,587	535	73,081
Surplus/(Deficit) excluding COVID	**(4,677)**	**(5,282)**	**605**	**(37,134)**	**(37,449)**	**315**	**(62,828)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	(22)	0	(22)	(459)	0	(459)	0
Surplus/(Deficit) including COVID	**(4,699)**	**(5,282)**	**583**	**(37,593)**	**(37,449)**	**(144)**	**(62,828)**

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

Comment on major financial variances

The overall result for Child, Women and Family was $583k favourable for January and $144k unfavourable for the YTD.

Revenue ($2k unfavourable for January, $221k unfavourable YTD)

The unfavourable YTD January variance is a combination of reduced funding associated with the relocation of ADHB clinics from the Wilson Centre to ADHB and a Colposcopy funding shortfall.

Expenditure ($585k favourable for January, $76k favourable YTD)

The favourable variance for January was primarily related to a budget misalignment with a high leave month. The YTD favourable position combines significant staff vacancies, variable patient demand and reduced service provision from the Wilson Centre. Embedded savings and clinical supplies pricing pressures are also features of the YTD result.

Personnel ($1,560k favourable YTD

Medical ($492k favourable YTD)

The favourable medical variance is due to multiple vacancies across Obstetrics and Gynaecology. These vacancies are being covered by locums to date. Acute and Elective Gynaecology activity tracks at 106% and 101% of contract volume as at January 2021.

Nursing ($1,160k favourable YTD)
The favourable nursing variance is due a combination midwife and nursing vacancies, timing of retention payments for core maternity staff , Paediatric ward staffing under spends due to reduced patient demand and Public Health Nursing vacancies. Paediatric inpatient service demand is tracking at 60% of contracted WIES whilst Neonatal service demand remains variable at 106% of contract YTD. Higher patient acuity along with a nursing structure change in both Special Care Baby Units has resulted in on-going cost pressures.

Allied Health ($351k favourable YTD)
The favourable variance was due to staff vacancies across Child Health services and includes the staffing impact of ADHB rehabilitation clinics relocating from the Wilson Centre to ADHB and a residual under spend from a ceased Health Promotion contract.

Support and Management/Administration ($10k favourable YTD)
The favourable variance was due to minor vacancies across the division.

Outsourced Personnel ($453k unfavourable YTD)
The unfavourable variance was due to medical locum cover for increased service demand and for vacancies where internal cover options are not available.

Other Expenditure ($1,024k unfavourable YTD)
Outsourced Services ($87k favourable YTD)
The favourable variance was due to reduced outsourcing of postnatal beds to Birthcare due to a more stable staffing position and maternity bed capacity within our hospitals. In addition to this is a reduction in Child Rehabilitation radiology services as a result of ADHB rehabilitation clinics being relocated from the Wilson Centre to ADHB.

Clinical Supplies ($226k unfavourable YTD)
The unfavourable clinical supplies variance was attributed to patient demand for continence and hygiene supplies, patient consumables, diagnostic supplies and ambulance costs.
The division continues to be impacted by COVID-19 related product price pressures due to the unavailability of certain clinical supplies.

Infrastructure and Non-Clinical Supplies ($885k unfavourable YTD)
The unfavourable variance was predominately due to embedded savings ($754k) were financial savings are being realised across other staffing and non-staffing account groups. Other notable variances include increased patient food and groceries, legal fees, cleaning costs and telecommunications.

COVID-19 impact
Total COVID-19 impact ($459k YTD)
Medical and Nursing staff leave creep and high sick leave are the most significant drivers of COVID-19 related cost pressures across the division. Partial cost mitigation through public health nurse redeployment to the Auckland Regional Public Health Service during quarter 1.
As of December 2020, there are minimal financial impacts to the division.

Waitematā DHB Statement of Financial Performance

Regional Dental - Jan-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	0	0	0	0	43	(43)	43
Other Income	63	44	19	329	306	23	525
Total Revenue (excluding COVID)	63	44	19	329	350	(20)	568
EXPENDITURE							
Personnel							
Medical	60	82	22	511	616	106	1,003
Nursing	0	0	0	0	0	0	0
Allied Health	1,367	1,625	258	11,580	12,824	1,244	21,058
Support	0	0	0	0	0	0	0
Management / Administration	75	84	8	575	694	119	1,174
Outsourced Personnel	0	0	0	0	0	0	0
	1,502	1,791	288	12,666	14,135	1,469	23,234
Other Expenditure							
Outsourced Services	1	0	(0)	6	3	(3)	5
Clinical Supplies	240	275	34	1,661	1,905	244	3,231
Infrastructure & Non-Clinical Supplies	91	142	50	1,345	983	(362)	1,663
	333	417	84	3,012	2,891	(121)	4,899
Total Expenditure (excluding COVID)	1,835	2,207	373	15,677	17,025	1,348	28,133
Surplus/(Deficit) excluding COVID	**(1,771)**	**(2,164)**	**392**	**(15,348)**	**(16,676)**	**1,328**	**(27,565)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	0	0	0	222	0	222	0
Surplus/(Deficit) including COVID	**(1,771)**	**(2,164)**	**392**	**(15,126)**	**(16,676)**	**1,550**	**(27,565)**

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

Comment on major financial variances – Regional Dental Services

The overall result for Regional Dental was $225k favourable for the month and $1,158k favourable for the YTD.

Revenue ($2k unfavourable for the month, $40k unfavourable YTD)

This is driven by ceased Service Level Agreement with Auckland DHB for a preschool coordinator role and being offset with the corresponding service vacancy.

Expenditure ($227k favourable for the month, $975k favourable YTD)

The YTD favourable position is primarily driven by service vacancies and dental supplies due to reduced service delivery.

Personnel ($225k favourable for the month, $1,181k favourable YTD)

Medical ($84k favourable YTD)

The favourable medical variance is due to a vacant Clinical Director position.

Allied Health ($986k favourable YTD)

The favourable variance is primarily due to ongoing therapist and therapy assistant vacancies across ARDS. An ongoing focus on improving recruitment and retention has enabled the service to increase its staffing levels by 7% and hold this since the last new graduate recruitment in January/February 2020.

Support and Management/Administration ($110k favourable YTD)
The favourable variance is due to vacancies across the service. Service is undergoing a reorganisation that will result in some vacancies being utilised for centralised booking and scheduling.

Other Expenditure ($205k unfavourable YTD)
Clinical Supplies ($210k favourable YTD)
The favourable clinical supplies variance is attributed to reduced dental clinic output. Dental supplies spending is expected to fluctuate as clinics reopen and chair utilisation increases.

Infrastructure and Non-Clinical Supplies ($413k unfavourable YTD)
The unfavourable variance is due to a combination of increased ARDS staff mileage claims due to staff relocating to alternate clinics to meet service need, registration and maintenance expenses on mobile dental facilities, outsourced cleaning costs and embedded savings, which are being met by reduced clinical supplies and staff vacancies.

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), Karen Hellesoe (Acting 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).

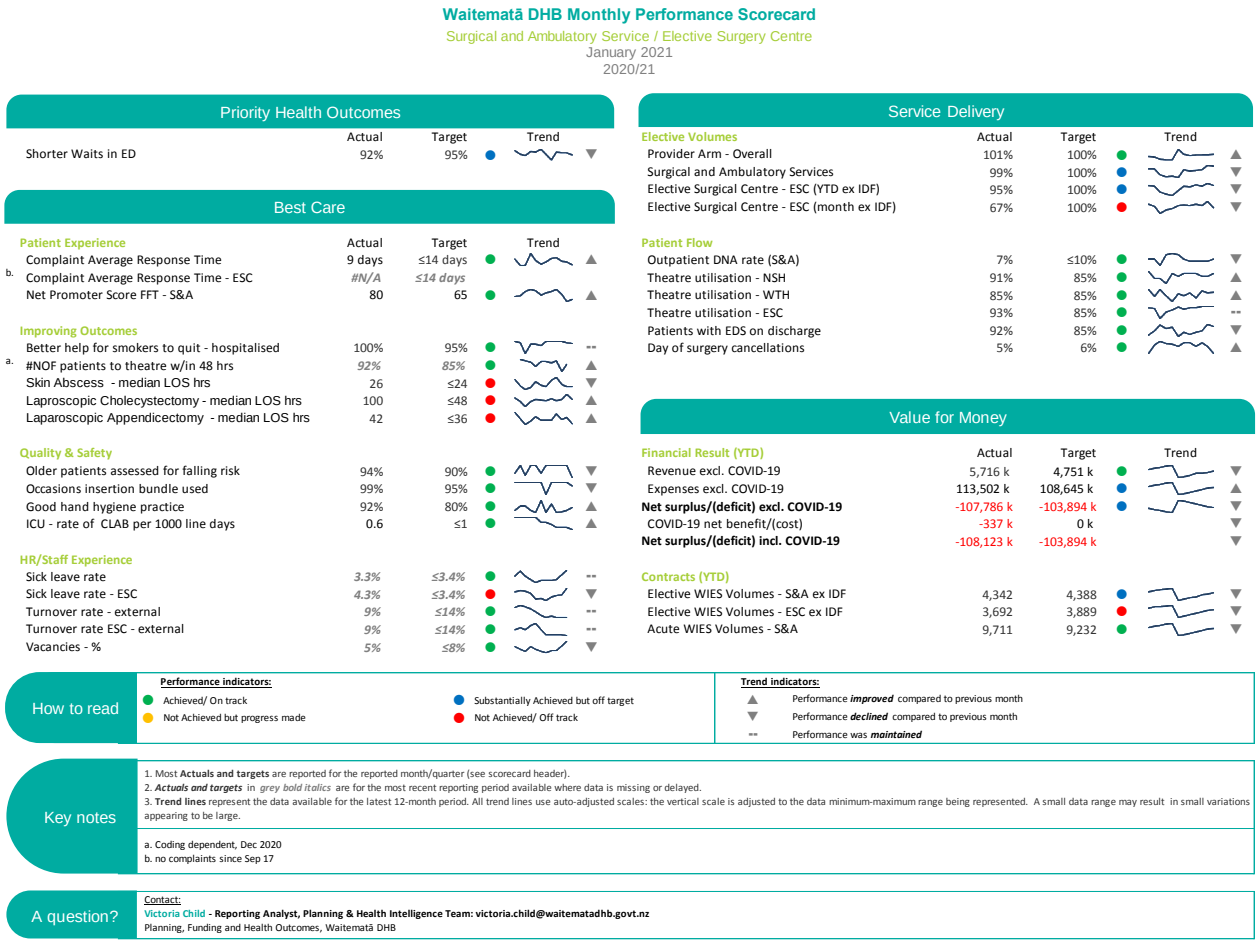
Highlight of the Month

A successful theatre nurse recruitment open day was held on 23 January. There were a range of expressions of interest including experienced theatre staff within New Zealand, experienced theatre staff from overseas, surgical registered nurses interested in moving to a theatre environment and return to practice nurses. As a result of the day, 15 people are proceeding through interview and reference checking with the first tranche of new staff expected to start early April 2021.

Key Issues

- Although we are meeting our overall surgical health target volumes, we continue to have ESPI 2 and 5 compliance challenges. All services had made significant gains in reducing patient waitlists for both FSA and surgery. However, increased referral volumes, increased P1 demand, increased acute demand (particularly in orthopaedics and general surgery) and nursing shortages in theatres, impacted ESPI 2 and ESPI 5 position. Work is underway to assess our intervention rates against national rates, aligning these with our thresholds for FSA and surgical waitlists. Options for evening lists in ESC are also being worked through.
- Theatre nursing staff shortages. Staff retention remains a challenge. This is requiring the planned closure of some elective lists to ensure priority is given to acute and urgent cases in the first instance. We are working through our Surgical Improvement Programme on new initiatives that will attract and retain staff with recruitment underway as per the highlight. However, the current vacancies are impacting our elective programme.
- There is on-going risk to full theatre and endoscopy production due to aging infrastructure in Central Sterile Services Department (CSSD) while awaiting the substantial refurbishment programme. We have received the Minister's letter approving the refurbishment and work will commence following council sign off.

Scorecard - Surgical and Ambulatory and Elective Surgical Centre



Waitematā DHB Monthly Performance Scorecard

Surgical and Ambulatory Service / Elective Surgery Centre

January 2021

2020/21

Priority Health Outcomes

	Actual	Target	Trend
Shorter Waits in ED	92%	95%	

Best Care

	Actual	Target	Trend
Patient Experience			
Complaint Average Response Time	9 days	≤14 days	
b. Complaint Average Response Time - ESC	*#N/A*	*≤14 days*	
Net Promoter Score FFT - S&A	80	65	
Improving Outcomes			
Better help for smokers to quit - hospitalised	100%	95%	
a. #NOF patients to theatre w/in 48 hrs	*92%*	*85%*	
Skin Abscess - median LOS hrs	26	≤24	
Laproscopic Cholecystectomy - median LOS hrs	100	≤48	
Laparoscopic Appendicectomy - median LOS hrs	42	≤36	
Quality & Safety			
Older patients assessed for falling risk	94%	90%	
Occasions insertion bundle used	99%	95%	
Good hand hygiene practice	92%	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	*4.3%*	*≤3.4%*	
Turnover rate - external	*9%*	*≤14%*	
Turnover rate ESC - external	*9%*	*≤14%*	
Vacancies - %	*5%*	*≤8%*	

Service Delivery

	Actual	Target	Trend
Elective Volumes			
Provider Arm - Overall	101%	100%	
Surgical and Ambulatory Services	99%	100%	
Elective Surgical Centre - ESC (YTD ex IDF)	95%	100%	
Elective Surgical Centre - ESC (month ex IDF)	67%	100%	
Patient Flow			
Outpatient DNA rate (S&A)	7%	≤10%	
Theatre utilisation - NSH	91%	85%	
Theatre utilisation - WTH	85%	85%	
Theatre utilisation - ESC	93%	85%	
Patients with EDS on discharge	92%	85%	
Day of surgery cancellations	5%	6%	

Value for Money

	Actual	Target	Trend
Financial Result (YTD)			
Revenue excl. COVID-19	5,716 k	4,751 k	
Expenses excl. COVID-19	113,502 k	108,645 k	
Net surplus/(deficit) excl. COVID-19	-107,786 k	-103,894 k	
COVID-19 net benefit/(cost)	-337 k	0 k	
Net surplus/(deficit) incl. COVID-19	-108,123 k	-103,894 k	
Contracts (YTD)			
Elective WIES Volumes - S&A ex IDF	4,342	4,388	
Elective WIES Volumes - ESC ex IDF	3,692	3,889	
Acute WIES Volumes - S&A	9,711	9,232	

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. Coding dependent, Dec 2020
b. no complaints since Sep 17

A question?

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

Skin Abscess Median LOS – *26 hours against a target of ≤24*

There were 58 patients treated surgically for acute abscess drainage. 25 patients met the less than 24 hour target. Six patients had extended stays that were appropriate to their conditions. One patient had concurrent pancreatitis, one patient required two procedures for on-going purulent discharge and had poorly controlled diabetes resulting in a ten-day stay. Another patient required a seven-day stay due to requiring daily monitoring.

Laparoscopic Cholecystectomy Median LOS – *100 hours against a target of ≤48*

55 patients underwent acute laparoscopic cholecystectomy and 31 stayed longer than 48 hours. Some patients were waiting longer to access theatre as the median time from booking theatre to actually getting to theatre was 40.5 hours making it challenging to achieve the target.. Some of the delayed patients required longer post op recuperation. Six patients required MRCP (magnetic resonance cholangiopancreatography) or ERCP (endoscopic retrograde cholangiopancreatography) procedures as well as lap chole. Those with pancreatitis required a settling down period before being booked for lap chole.

Laparoscopic Appendicectomy Median LOS – *42 hours against a target of ≤36*

There were 44 patients in this cohort. 41% met the discharge target of less than 36 hours. Eight patients had extended LOS, twoof whom required ICU admission for fourto five days due to sepsis. Six others had perforated or necrotic appendices requiring post op IV antibiotics and two had post op complication of ileus.

***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 (As ESC is a sub group of SAS the smaller number of staff can disproportionately affect the percentage).

Service Delivery

***Elective Volumes ESC (month ex IDF) –** 67% against a target of 100%*
The reason for this is that the phasing had ESC closed for two weeks in December, when in reality the bulk of the days closed was in January.

Value for Money

***Elective WIES Volume ESC ex IDF –** 3,692 against a target of 3,889*
Analysis of the 3,692 WIES volume has revealed that it is in line with the actuals for the past two financial years (YTD) as shown in the following table.

Purchase Unit	Description	Unit of Measure	FY2019	FY2020	FY2021
S00001	General Surgery - Inpatient Services (DRGs)	Cost Weighted Discharge	1,123	1,200	1,217
S25001	Ear, Nose and Throat - Inpatient Services (DRGs)	Cost Weighted Discharge	113	100	101
S30001	Gynaecology - Inpatient Services (DRGs)	Cost Weighted Discharge	297	317	313
S45001	Orthopaedics - Inpatient Services (DRGs)	Cost Weighted Discharge	1,731	1,746	1,765
S70001	Urology - Inpatient Services (DRGs)	Cost Weighted Discharge	279	327	311
			3,543	**3,690**	**3,707**

It appears that the phasing of the contract/target volumes as a whole is not in line with realistic expectations, noting our utilisation of ESC lists YTD is running at 91%.

Notwithstanding this represents a risk to revenue of $1.1m at the contracted price. The WIES shortfall was mainly due to the Orthopaedic service only achieving 94% of target year to date. This service attracts the highest average WIES per event: 1.77, equating to an average revenue of $9,815 per event. WIES was also impacted as Urology was only at 94% and General Surgery at 97%.

Surgical and Ambulatory Services

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		
Equity. Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed *Electives* Refurbish the Diagnostic Breast Service to improve coordinated and integrated service provision in one location. This aims to improve breast cancer diagnosis and treatment times, removing barriers to care for Māori and Pacific women (EOA)	Nov 2020	✓
Access. Balance national consistency and the local context *Electives* Implement bladder cancer testing in primary care, and where appropriate, to establish urothelial cancers, to reduce the need for secondary care assessments and referral to cystoscopy (currently all patients with macro and micro haematuria are referred for cystoscopy)	Oct 2020	✓
Bowel screening and colonoscopy wait times Actions to meet colonoscopy wait times and equitable access to bowel screening		
Bowel screening Continue with monthly data audits to ensure data accuracy and in preparation of transitioning to the new register (timing is subject to MoH confirmation and expected to be during 2020/21)	Ongoing	✓
Continue to provide existing and new nursing staff with training to maintain data accuracy, which impacts on monitoring of all activities along the screening pathway	Ongoing	✓
Deliver a six-week communications campaign to inform people that the bowel screening programme has re-started and that it is safe to screen, supported by ongoing health promotion and communication activities designed to restore the participation rate and equity gaps to the pre-COVID-19 levels (EOA)	Dec 2020	✓

Areas off track for month and remedial plans

Financial Results - Surgical and Ambulatory and Elective Surgical Centre Combined

Waitematā DHB Statement of Financial Performance

S&A and ESC Combined - Jan-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	680	564	115	5,223	3,931	1,292	6,753
Other Income	48	110	(63)	494	820	(326)	1,372
Total Revenue (excluding COVID)	727	675	53	5,716	4,751	965	8,124
EXPENDITURE							
Personnel							
Medical	4,670	4,381	(289)	37,819	38,099	279	63,406
Nursing	4,292	4,342	51	32,306	31,111	(1,194)	54,987
Allied Health	402	500	99	3,972	3,984	12	6,705
Support	182	189	8	1,585	1,595	10	2,593
Management / Administration	370	325	(44)	3,082	2,819	(263)	4,668
Outsourced Personnel	575	540	(35)	4,895	4,118	(778)	7,068
	10,490	10,278	(211)	83,659	81,725	(1,934)	139,428
Other Expenditure							
Outsourced Services	117	158	41	1,526	1,006	(520)	1,782
Clinical Supplies	2,936	3,556	619	26,096	25,519	(578)	43,653
Infrastructure & Non-Clinical Supplies	294	57	(238)	2,221	395	(1,826)	648
	3,348	3,770	422	29,843	26,920	(2,923)	46,084
Total Expenditure (excluding COVID)	13,837	14,048	211	113,502	108,645	(4,857)	185,512
Surplus/(Deficit) excluding COVID	**(13,110)**	**(13,374)**	**264**	**(107,786)**	**(103,894)**	**(3,892)**	**(177,387)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	(59)	0	(59)	(337)	0	(337)	0
Surplus/(Deficit) including COVID	**(13,169)**	**(13,374)**	**205**	**(108,123)**	**(103,894)**	**(4,229)**	**(177,387)**

* 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 combined was $205k favourable for January and $4,229k unfavourable for the YTD.

Revenue ($53k favourable for January, $965k favourable YTD)

The favourable variance for January was due to higher than planned revenue from ACC ($88k). The YTD favourable position was due to additional MoH revenue ($806k) received to assist in the planned care catch-up arising from the impact of COVID-19 as well as higher than planned revenue from ACC ($262k) and income from other DHBs ($185k), partly offset by a surgical pathology revenue stream which has not materialised as expected.

Expenditure ($211k favourable for January, $4,857k unfavourable YTD)

The favourable variance for January was driven by the closure of ESC for the first week of the New Year which provided clinical supply and personnel savings of $360k. There was also a clinical supplies saving at NSH. These elements combined, covered an overspend in medical costs in the month as well the embedded budget savings. The YTD expenditure was still unfavourable due to higher than budgeted costs in the first half of the year.

Personnel ($1,934k unfavourable YTD

Medical ($279k favourable YTD)

The YTD favourable position was due to challenges in recruiting into vacant SMO positions creating a saving ($399k) in addition to lower than budgeted training and study costs ($276k) and a timing benefit for membership

costs ($187k). These benefits have been offset by higher than budgeted allowances for SMOs ($405k) particularly in January ($249k) which was driven by higher than planned additional sessions. In January, there was an overspent in Anaesthesia of $137k. This was because the service had the equivalent of 2.24 SMO FTE covered by additional sessions due to three staff being on extended sick leave. In January, there was also a $90k one off impact arising from the overlap of rotations within the RMO cohort as the run dates changed nationally to a new schedule from end January.

Nursing ($1,194k unfavourable YTD)
Nursing was over budget, for which there were a number of contributing factors. Surgical and gastro theatre overspend continued to be driven by increased acute volumes (6%) and additional sessions for planned care patients both at NSH and WTH. NSH theatre was budgeted to run eight hour elective sessions, but extended theatre lists have become increasingly BAU since July in order to maximise utilisation and throughput to meet planned care targets. These factors as well as nursing vacancies required a high use of casuals, extra hours, overtime and allowances, contributing to a $547k negative variance to budget for Surgical Theatres. Following a recent review of the roster requirements for NSH theatres, the need for additional staff has been budgeted and recruitment is underway. Once complete, this should alleviate the cost pressure due to existing staff having to cover gaps.

A review is also taking place of WTH Theatres and of Gastroenterology where volumes have been growing.
The remainder of the nursing overspend was in surgical wards driven by the use HCAs for watches ($302k) on high acuity patients (Spinal, Tracheostomy, ERAS NOF, peri-prosthetic) and the use of internal bureau nurses to cover higher unplanned leave and to meet the higher than expected bed occupancy in surgical wards in the last few months ($261k). There were some one-off costs in the YTD of -$100k.

Allied Health ($12k favourable YTD)
The favourable variance has been driven by lower than budgeted training/study days due to lack of opportunity due to COVID. This saving is offset by the vacancy factor of the personnel budget which was not achieved as a result of the lower than expected turnover of staff in technicians and lab scientists.

Support and Management/Administration ($263k unfavourable YTD)
The YTD unfavourable position was due to the vacancy factor of the personnel budget which was not achieved as a result of the lower than expected turnover of staff. There was also additional cost ($72k) within Admin clerical team for casual use and extra staffing hours to meet the booking demand of the surgical services.

Outsourced Personnel ($778k unfavourable YTD)
The YTD unfavourable position was due to vacancies within Anaesthesia and ORL and leave cover within General Surgery. These resulted in reliance on locums ($160k) to assist in production to meet the planned care target. POC costs at ESC were $94k over budget in the period. This reflects increasing complexity of surgeries e.g. Bariatric, taking place at ESC as well as the increase in number of day cases.

$139k was spent on external agency theatre nursing to help provide cover for unplanned leave and vacancies within theatres and to help resource additional lists. External agency nursing costs should reduce significantly once the NSH theatre nurse recruitment drive is complete. Costs were also incurred for covering higher than planned annual leave in July and August.

Other Expenditure ($2,923k unfavourable YTD)
Outsourced Services ($520k unfavourable YTD)
The YTD unfavourable position was driven by the outsourcing of skin lesions to GPs ($389k) in addition to Interim Care costs ($99k) which are offset by budget within clinical supplies.

Clinical Supplies ($578k unfavourable YTD)
The unfavourable variance occurred across most services but most particularly in Surgical and Gastro theatres. There was a significant increase in treatment disposable costs ($300k) as well as increases in all other areas of

clinical supply. This had several reasons: higher volume of activity, supply chain issues arising from COVID-19 forcing Surgical Services to find new and often more expensive sources of product, higher usage of disposable products and higher orthotic costs ($197k).

The supply chain issues are on-going and are not expected to be resolved in this year. The cost impact is difficult to ascertain as the impacts are often ad hoc and short lived.

A cross division project, under the Financial Sustainability project, is currently reviewing the Orthotic costs to identify how orthotic purchasing is managed, identify rationalisation and cost saving opportunities. There is also a review taking place on Surgical and Ambulatory, ESC consumables to identify similar opportunities.

Infrastructure and Non-Clinical Supplies ($1,826k unfavourable YTD)
The negative variance represented the YTD embedded budgeted savings related to the Financial Sustainability Programme ($1,958k). This line was partially offset by additional revenue and cost savings in other areas e.g. locum costs. Revenue projects are recognising additional revenue in the financial year however cost savings within the current surgical environment are proving more difficult to realise.

COVID-19 impact
Total COVID-19 impact ($337k YTD)
The COVID impact represents the impact of delayed annual leave in the period being covered by outsourced personnel costs as well as the cost of backfill for surgical staff being deployed to NRHCC, MIQ facilities and Auckland Regional Public Health.

Diagnostic Services

Service Overview

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

The service is managed by Brad Healey 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 Bronwyn Ness and Dr Philip Clark (Clinical Director) for Radiology.

Highlight of the Month

The new Kia Ū Ora - Waitematā Breast Service was officially opened on Friday 12 February. The opening was attended by local MPs, donors and Breast Cancer Foundation.

The new service brings all diagnostic breast cancer services under one roof, aiming to reduce waiting times, reduce anxiety and improve outcomes for the over 100 patients referred each week from across North Shore, Waitākere and Rodney.

Waitematā DHB relocated staff to the newly refurbished area at North Shore Hospital, bringing current off-site procedures under one roof making “triple testing” (imaging, assessment, biopsy) on the same day possible if and when appropriate. The new unit also provides additional mammography and ultrasound capacity and benefits from more consultation rooms and enhanced patient waiting, reception and change areas.
Another beneficial addition is the introduction of the Wā Mārie – ‘Quiet Room’, a calm and restful space away from the main operation of the department, for use by patients and their families. This new room was sponsored by Ryman Healthcare.

Key Issues

Radiology imaging volumes
Radiology service has experienced a significantly higher growth in imaging volumes (particularly acute imaging) than forecasted six months ago. It is not known how much of this is attributable to the impact of COVID-19. This has resulted in a reduction in performance against the planned care six weeks waiting time targets for all modalities, as acute imaging is usually prioritised before planned care imaging.

We have updated our volume growth modelling and made an assessment of the additional production required to bring us back to achieving the six week waiting time targets. The modelling is based in a wide range of assumptions including that we operate our Radiology modalities at full capacity including regular after-hours and weekend sessions and recommendations are underway to address these issues.

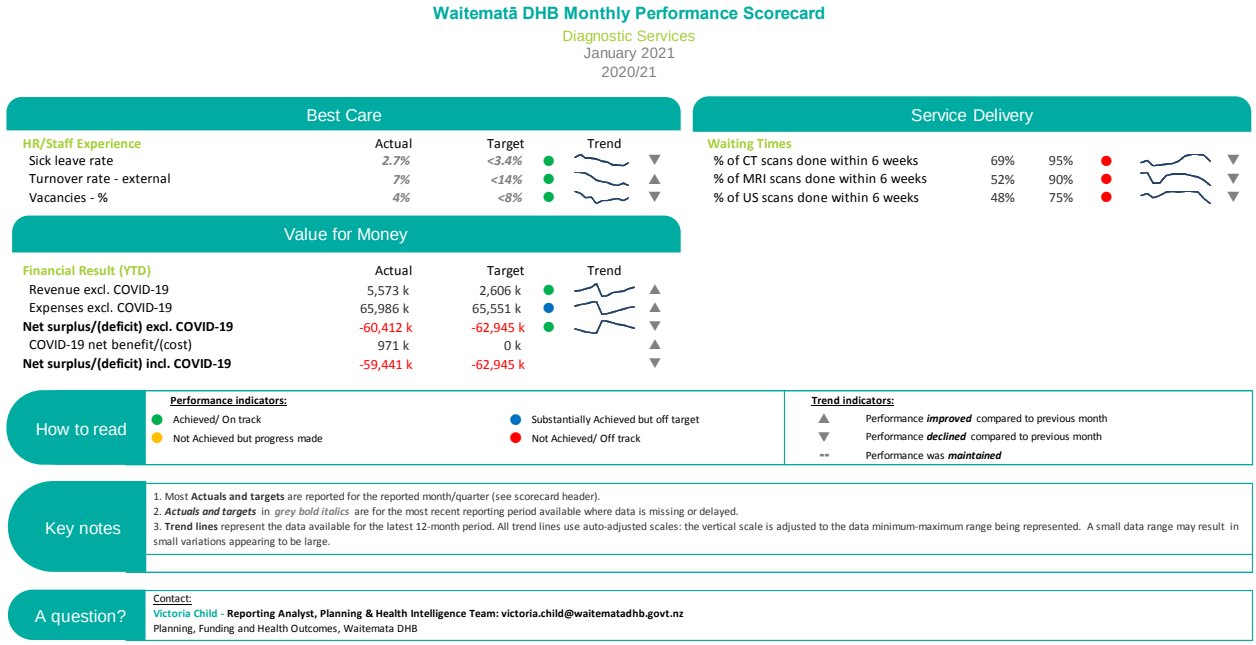
Pharmacy – Upgrading of Pyxis (Automated Dispensing Cabinet)
The Pyxis system has been due for upgrade for some time. We have been waiting on the outcome of the national procurement process undertaken through New Zealand Health Partnerships in which we participated. We are currently assessing the outcome of the procurement process which we understand will result in a national panel contract with three suppliers. At this stage we are unclear as to what the pricing in the national contract might mean for Waitematā DHB given a very wide spread of pricing. We have convened a small group to staff to develop a plan for the upgrade or replacement of Pyxis.

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		
Timeliness. Optimise sector capacity and capability *Radiology* Review production planning capability for CT and MRI, with the objective of better informing the need for internal capacity change and the need for outsourcing	Mar 2021	✓
Experience. Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future *Pharmacy* Work to ensure the accurate transfer of information about medication changes on transitions of care by completing medicine reconciliation in primary care and community pharmacy settings as well as on discharge from hospital	Ongoing	✓
Antimicrobial Resistance (AMR) Actions to improve equity in outcomes and patient experience		
Hospital Complete a hospital-wide antimicrobial prescribing survey to assess prescribing appropriateness for all patients and analyse the results for ethnic disparity to identify gaps and target initiatives for delivery of service equity (EOA) ***Measure*** *Audit 100% of medical and surgical patients*	Sep 2020	✖
Complete audit of compliance with Waitematā DHB MDRO Management Policy (consistent with national guidance, guidelines and relevant standards), including CPE, develop recommendations and implement actions	Feb 2021	✓ MDRO policy has been reviewed in November 2020 to align with international guidelines and we are on track

Areas off track for month and remedial plans
Complete a hospital-wide antimicrobial prescribing survey – on track to have this completed by June. The audit is currently in the planning stages and scheduled to be undertaken early April.

Scorecard – Diagnostic Services



Waitematā DHB Monthly Performance Scorecard

Diagnostic Services
January 2021
2020/21

Best Care

HR/Staff Experience	Actual	Target	Trend
Sick leave rate	*2.7%*	*<3.4%*	▼
Turnover rate - external	*7%*	*<14%*	▲
Vacancies - %	*4%*	*<8%*	▼

Service Delivery

Waiting Times				
% of CT scans done within 6 weeks	69%	95%	●	▼
% of MRI scans done within 6 weeks	52%	90%	●	▼
% of US scans done within 6 weeks	48%	75%	●	▼

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue excl. COVID-19	5,573 k	2,606 k	▲
Expenses excl. COVID-19	65,986 k	65,551 k	▲
Net surplus/(deficit) excl. COVID-19	-60,412 k	-62,945 k	▼
COVID-19 net benefit/(cost)	971 k	0 k	▲
Net surplus/(deficit) incl. COVID-19	-59,441 k	-62,945 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?

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Planning, Funding and Health Outcomes, Waitemata DHB

Scorecard Variance Report

Service Delivery

% of CT scans done within six weeks – 69% against a target of 95%
Demand for CT continues to be higher than previous modelling has shown. This is having a negative impact in our ability to deliver planned care volumes. Outsourcing is continuing, including additional internal volunteer sessions. We are reviewing our production plan modelling to determine the extent to which we need to increase production, and how this can be achieved.

% of MR scans done within six weeks – 52% against a target of 90%
Demand continues to be high for MRI and is significantly higher than planned. This is having a negative impact in our ability to deliver planned care volumes. Outsourcing is continuing including additional internal sessions. We are currently reviewing our production planning modelling to determine the extent to which we need to increase production and the option for achieving this.

% of US scans done within six weeks – 48% against a target of 75%
Demand continues to be high for Ultrasound, in part due to a change in referral practise. This is having a negative impact on our ability to deliver planned care volumes. While outsourcing and additional internal volunteer sessions are continuing, we are also reviewing our future modelling to determine our options for increasing production and the extent that this will be required.

Financial Results

Waitematā DHB Statement of Financial Performance

Diagnostic Services - Jan-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	289	209	80	2,167	1,464	703	2,510
Other Income	529	163	366	3,406	1,142	2,264	1,958
Total Revenue (excluding COVID)	818	372	445	5,573	2,606	2,967	4,468
EXPENDITURE							
Personnel							
Medical	1,021	1,155	134	9,343	9,433	90	15,582
Nursing	232	258	26	1,916	1,796	(120)	3,138
Allied Health	2,222	2,127	(95)	18,853	17,875	(978)	29,682
Support	0	0	0	0	0	0	0
Management / Administration	173	160	(13)	1,451	1,490	39	2,473
Outsourced Personnel	60	59	(1)	509	420	(89)	707
	3,708	3,759	51	32,072	31,014	(1,057)	51,580
Other Expenditure							
Outsourced Services	548	521	(28)	4,074	4,632	558	7,945
Clinical Supplies	3,747	4,093	345	28,489	28,583	94	48,365
Infrastructure & Non-Clinical Supplies	172	187	15	1,351	1,322	(29)	2,544
	4,468	4,801	333	33,914	34,537	623	58,854
Total Expenditure (excluding COVID)	8,176	8,560	384	65,986	65,551	(434)	110,434
Surplus/(Deficit) excluding COVID	**(7,358)**	**(8,187)**	**829**	**(60,412)**	**(62,945)**	**2,533**	**(105,967)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	161	0	161	971	0	971	0
Surplus/(Deficit) including COVID	**(7,197)**	**(8,187)**	**990**	**(59,441)**	**(62,945)**	**3,504**	**(105,967)**

* 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 $990k favourable for January and $3,504k favourable for the YTD.

Revenue ($445k favourable for January, $2,967k favourable YTD)

The favourable variance for the YTD is due to increased billing to other DHBs for Radiology scans and billing to drug trials from the Inpatient Pharmacy and Laboratory.

Expenditure ($384k favourable for January, $434k unfavourable YTD)

The unfavourable variance for the YTD was due to Outpatient Pharmacy not being fully funded for the activity per the Community Pharmacy Programme and Radiology Services performing additional volumes to aid back log of procedures.

Personnel ($1,057k unfavourable YTD)

Personnel costs are over in Radiology as the service is doing additional sessions to catch up on procedures delayed due to COVID-19 restrictions and the anticipated vacancy savings have not materialised due to retention of staff.

Other Expenditure ($623k favourable YTD)

Outsourced Services ($558k favourable YTD)

Radiology outsourcing was favourable due to the lower than budgeted volumes outsourced for Ultrasound and MRI.

Clinical Supplies ($94k favourable YTD)
The favourable variance YTD is the net result of savings in Radiology and the Inpatient Pharmacy which are favourable due to less than anticipated inpatient volumes at start of the year. Radiology also favourable due to one off accrual releases ($230k) in July relating to terminated service contracts and leases and on-going savings on contracts and leases. This off sets the drug costs in the Outpatient Pharmacy which are $1,219k unfavourable YTD primarily due to increase access to high cost drugs as prescribed in the pharmaceutical schedule. Subsidy claim for these drugs are not reimbursed to the Outpatient Pharmacy.

Infrastructure and Non-Clinical Supplies ($29k unfavourable YTD)
The unfavourable variance for the YTD was due to phasing of Laboratory and Radiology accreditation costs where budget is in future periods.

COVID-19 ($971k favourable YTD)
Laboratory revenue relating to COVID-19 testing $2.3m offset by additional costs in Laboratory $961k YTD. Radiology additional sessions for CT as part of the COVID-19 catch up plan cost approximately $195k as well as outsourcing of CT cost $778k.

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 General Manager. The Operation Managers are Barbara Schwalger for Clinical Support Services, Mark Garner 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

Food Services

On Friday 19 February, North Shore hospital kitchen produced a very successful lunch for Mason Clinic. The recipe was sent in by a patient at Mason Clinic. This was a really great opportunity to work with the stakeholders and build a relationship to develop the food service for Mason Clinic together.

Key Issues

Clinical Support

Bird control at NSH and WTH continues to be an on-going issue and health and safety concern. We have taken a range of steps to manage the problem including pulse wire, netting courtyards, "Hot foot gel" and culling via hand feeding and we continue to reassess the steps we are taking to control the pigeon population.

Food Services

The service is working on a Strategic Assessment that seeks approval to undertake an assessment of the viability of the North Shore Hospital kitchen to expand its capacity to support Tōtara Haumaru.

Scorecard – Clinical Support Services

Waitematā DHB Monthly Performance Scorecard

Clinical Support
January 2021
2020/21

Best Care

HR/Staff Experience	Actual	Target		Trend	
Sick leave rate	3.5%	<3.4%	●		--
Turnover rate - external	14%	<14%	●		▲
Vacancies - %	4%	<8%	●		▲

Value for Money

Financial Result (YTD)	Actual	Target		Trend	
Revenue excl. COVID-19	239 k	111 k	●		▼
Expenses excl. COVID-19	21,254 k	19,726 k	●		▲
Net surplus/(deficit) excl. COVID-19	-21,015 k	-19,615 k	●		▼
COVID-19 net benefit/(cost)	226 k	0 k			--
Net surplus/(deficit) incl. COVID-19	-20,789 k	-19,615 k			▼

How to read

Performance indicators:
- ● Achieved/ On track
- ● Substantially Achieved but off target
- ● Not Achieved but progr
- ● 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:
Victoria Child - **Reporting Analyst, Planning & Health Intelligence Team: victoria.child@waitematadhb.govt.nz**
Planning, Funding and Health Outcomes, Waitemata DHB

Scorecard Variance Report

Financial Results

Waitematā DHB Statement of Financial Performance

Clinical Support Services - Jan-21

($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	32	16	16	239	111	128	190
Total Revenue (excluding COVID)	32	16	16	239	111	128	190
EXPENDITURE							
Personnel							
Medical	0	0	0	0	0	0	0
Nursing	0	0	0	2	0	(2)	0
Allied Health	0	0	0	0	0	0	0
Support	1,410	1,464	54	11,680	11,885	205	20,145
Management / Administration	154	160	6	1,158	1,283	126	2,093
Outsourced Personnel	20	19	(1)	170	134	(37)	227
	1,585	1,644	59	13,010	13,302	292	22,465
Other Expenditure							
Outsourced Services	0	0	0	5	0	(5)	0
Clinical Supplies	118	118	0	910	823	(87)	1,396
Infrastructure & Non-Clinical Supplies	975	759	(216)	7,329	5,601	(1,728)	9,363
	1,093	877	(216)	8,244	6,424	(1,820)	10,759
Total Expenditure (excluding COVID)	2,678	2,521	(157)	21,254	19,726	(1,528)	33,224
Surplus/(Deficit) excluding COVID	**(2,646)**	**(2,505)**	**(141)**	**(21,015)**	**(19,615)**	**(1,400)**	**(33,034)**
Extraordinary impacts							
COVID-19 Net benefit/(cost)	0	0	0	226	0	226	0
Surplus/(Deficit) including COVID	**(2,646)**	**(2,505)**	**(141)**	**(20,789)**	**(19,615)**	**(1,174)**	**(33,034)**

* 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 $141k unfavourable for January and $1,174k unfavourable for the YTD.

Revenue ($16k favourable for January, $128k 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 ($157k unfavourable for January, $1,528k unfavourable YTD)

The unfavourable variance for the YTD was primarily due to The Financial Sustainability Programme allocated savings target for Clinical Support and Diagnostic Services which is $1,552k unfavourable YTD. A number of initiatives are being progressed that will realise benefits in future periods and other divisions.

Personnel ($292k favourable YTD)

The favourable variance for the YTD does not include $83k of casual security guard costs that are coded in Infrastructure and Non-Clinical Supplies. Vacancy factor savings are being met by turnover in Clinical Support cleaners and orderlies where approximately 17% of shifts are covered by lower cost casual workforce

Other Expenditure ($1,820k unfavourable YTD)

Clinical Supplies ($87k unfavourable YTD)

The unfavourable variance for the YTD was due to clinical equipment consumables, repair and maintenance including outsourced bed repairs.

Infrastructure and Non-Clinical Supplies ($1,728k unfavourable YTD)

The unfavourable variance YTD was due to Financial Sustainability Programme allocated savings target for Clinical Support and Diagnostic Services which is $1,552k unfavourable YTD.

Outsourced casual security guards where the budget is held as personnel cost are also $83k unfavourable YTD.

COVID-19 ($226k favourable YTD)

COVID-19 related transactions are in relation to savings in patient meal numbers due to low level of hospital occupation during lockdown as well as additional costs for ventilation equipment and consumables.

4.1 Clinical Leaders' Report

Recommendation:

That the report be received.

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

MEDICAL EDUCATION REPORT
Prepared by Laura Chapman, Director of Clinical Training, and Jonathan Christiansen, CMO

Context of training and education:

District Health Boards are amongst the largest post-graduate education providers in New Zealand, and are the primary engine room of renewal of the professional workforce across the health sector. This post-graduate training encompasses all RMOs employed by the DHB, as well as a smaller cohort of Fellows and medical officers. This training is indistinguishable and inseparable from clinical jobs the RMOs are employed to undertake.

In addition to post-graduate training, Waitematā DHB is a major site for the educational and experiential undergraduate learning of medical students from the University of Auckland. We host almost 250 students in cohorts each year.

It is well understood that achieving excellence in undergraduate and postgraduate training both enhances the quality of patient care provided, and ensures the best recruitment opportunities.

Governance of education and training:

The peak body at Waitematā DHB is the Executive Education Governance Committee (EEGC). Membership includes the Director HR, the CMO, the Directors of Nursing and Allied Health, and other key stakeholders. Dr Laura Chapman, Director of Clinical Training, has recently been appointed Chair (succeeding Dr Jonathan Christiansen). The EEGC reports to the Executive Leadership Team (ELT).

For medical students, the CMO chairs the University of Auckland **Joint Relations and Engagement** (JRE) committee, which is attended by the Dean, Head of School, key DHB professional leads and others. The JRE reports to ELT through the CMO.

Current issues:
There are no important issues in the governance of education at the DHB

Delivery of education and training:

The vast majority of SMOs are involved in the day-to-day clinical supervision of RMOs who are in training, and a significant number contribute to the teaching of medical students in the clinical setting.

In addition, there are requirements for dedicated educational supervision (separate to clinical supervision), which are set by the relevant educational oversight body or regulator – such as the Medical Council of New Zealand (MCNZ) or a College. There has been a continued growth in the numbers of RMOs (to meet industrial contractual roster requirements and to match the increasing

volume of clinical presentations). This in turn necessitates that more educational supervisors are appointed and dedicated FTE provided.

The DHB commits significant resources to the operational undertaking of training, with the Medical Education and Training Unit (METU) overseeing the pre-vocational (PGY1,2 house officers), and each speciality division having dedicated SMO educational leadership for RMO vocational training programmes. Waitematā DHB has recently taken on hosting the regional coordination of training for Psychiatry. For the vocational ("College") programmes SMOs participate in all activities of training, including assessment (examinations and workplace-based assessments), didactic teaching, College leadership roles and regional employment-training interfaces.

The University of Auckland funds dedicated teaching FTE for a cohort of SMOs (typically in the form of "buy back 10ths") to ensure there is adequate resourcing of medical student didactic teaching and formative and summative assessments where applicable.

Current issues:

1. There is a requirement for additional educational supervisors to be appointed to comply with the strict MCNZ requirements for a 1/10 ratio in the educational oversight of pre-vocational House Officers. A business case for an additional 0.2FTE will be brought to ELT.

2. The role of manager of METU has been vacant for some months, which is impacting the overall delivery of operational aspects of training for PGY1,2. A plan to address this is being developed with the Director People and Culture.

3. The oversight of the clinical work of Year 6 medical students ("Trainee Interns") was recently clarified, with the University of Auckland and DHB agreeing that all student e-note entries should be countersigned by a registered clinical professional. This has been disseminated to all departments and teaching leads.

4. The new Agreement to Treatment/Informed Consent form has been implemented, explicitly highlighting of the potential presence of students and trainees in our hospitals. The MCNZ has an ongoing consultation with the national CMOs on additions to their 2019 guidance on informed consent, which Waitematā DHB has contributed to.

Employment and training

Medical students are not employees and are supernumerary to the delivery of clinical care. RMOs in training are employed to provide clinical care as part of the team structure in our inpatient and outpatient services. As noted, this training is indistinguishable and inseparable from clinical jobs the RMOs are employed to undertake. The conditions of RMO employment are governed by the collective agreements (MECAs) for both Specialty Trainees of New Zealand (STONZ) and the Resident Doctors' Association RDA. There are some specific obligations to education within the MECAs.

In addition to these contractual requirements, the educational oversight bodies – particularly the Colleges – impose a large number of conditions on the type of clinical work and level of supervision required by individual RMOs in specific training roles. This multilayered structure of working conditions set by external agencies results in complex operational issues for the employment of RMOs. These issues are largely managed regionally, with a hierarchical governance structure of specialty "vocational training committees", the "Regional Training Committee" and the "Operational Management Group" run through the Northern Region Alliance (NRA).

Current issues for employment and training:

1. Overall the major shift in the commencement dates for the employed training year has gone well. The national annual employment and training cycle for RMOs has been shifted from late November to late January with a choice of start dates in the 2020/21 cycle. Waitematā DHB had 22 House Officers start in November and 40 start in January. This has been a smooth process locally but there are significant issues with ePort, the MCNZ system for tracking training progress across the prevocational years. This has been escalated to MCNZ for resolution but is likely to cause additional work throughout 2021.

2. Recruitment has been competitive for RMOs in the metro-Auckland area, and the full impact of the COVID-related border closures is unclear at this stage. Overall NZ typically relies on a significant number of international medical graduates to staff the RMO positions across the 20 DHBs. Vacancies have been an issue outside of Auckland.

3. The factors underpinning the DHB employment choices of Māori and Pacific medical students entering PGY1 training are not clear. The Director of Clinical Training is reviewing our DHB's recruitment within the national/regional process, and how we can better support Māori and Pacific graduates.

4. A very small number of RMOs are being closely supported after difficulties in their training. This is the normal local and regional process, and on occasion does need an HR/employment view. The Director of Clinical Training is supported by the CMO for this work.

Funding of training

Dedicated funding of training of RMOs is provided by Health Workforce New Zealand. The amount of funding attached to each training position, and the total number of training positions for the DHBs, has been static for more than a decade.

Quality and Risk

The new HDC Commissioner, Morag McDowell, has indicated her wish for improved communication and collaboration between HDC and their external stakeholders; with the aim to improving resolution timeframes. Waitematā DHB has been selected to participate in their pilot programme to better engage with stakeholders. We have been assigned a key contact person at the HDC to converse with, and regular meetings have been scheduled with our Complaints and Adverse Events Manager, Brenda Witt.

The COVID-19 policies, procedures and guidance documentation (Controlled Documents) are continually being reviewed and amended to align with National and Regional changes in response to changing alert levels and guidance. As part of the COVID-19 Incident Management Team (IMT) Clinical and Corporate Governance role Stacey Hurrell, Corporate Compliance Manager, has reviewed key DHB COVID-19 documentation i.e. the Operations and Readiness Plans in February 2021. This included finalising the COVID-19 ESC Escalation Plans (required should there be an influx of multiple COVID-19 positive patients). Visiting Guidelines at all levels have been reviewed and updated along with the associated screening processes for outpatient clinics and visitors across the DHB; screening information is also available in nine different languages.

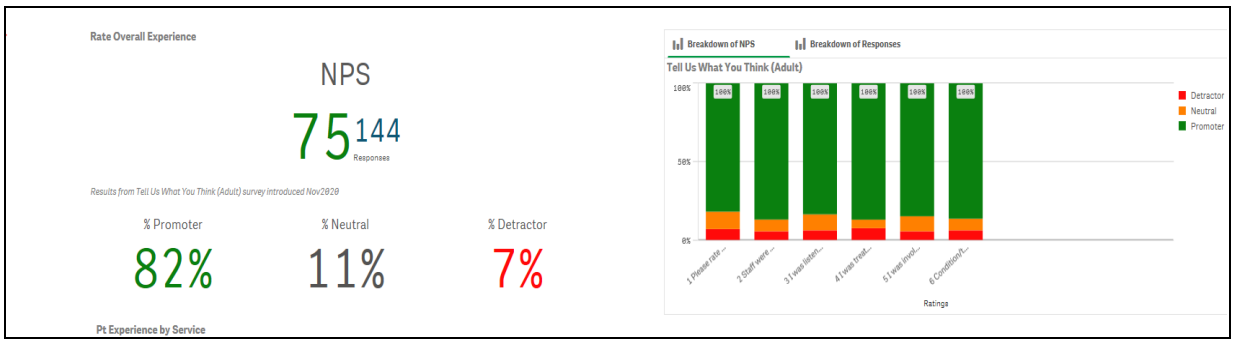
Allied Health, Scientific and Technical Professions

Prepared by Sharon Russell, Associate Director Allied Health, Scientific and Technical Professions and Tamzin Brott, Chief Allied Health, Scientific and Technical Professions Officer

(Forty-two (43) professions, accounting for 24% of the Waitematā DHB workforce.)

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

Friends and Family Test – Adult Allied Health February 2021



A selection of comments received in February 2021 for the Allied Health group:

- *"Very excellent advice and gave a lot of motivation, we are very satisfied with Karen's advice and the help she provided for my recovery."*
- *"Awesome customer service very welcoming."*
- *"Very friendly and explained what she was doing. Felt like my son was getting great care and advice."*
- *"They listened to me."*
- *"Great Physio- correct amount of praise and without being confrontational with correcting."*
- *"Very beneficial to share experiences with other patients."*
- *"Very good of all the information that will help me get better from my stroke AND I am getting better."*

Recruitment and retention of Māori and Pacific 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 Pacific clinicians reflecting the communities we serve. These workplans include maintaining links with tertiary institutions, promoting Waitematā DHB scholarship programmes across all professions within Allied Health, and encouraging the promotion of Allied Health professions within secondary education.

Current Māori and Pacific staff across those priority professions and staff required to reflect the working population as of February 2021 are:

MALT PRIORITY ALLIED	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	15	7.9%	17	2	1	-2	-1
Dietitian	3	5.9%	5	2	1	0	1
Occupational Therapist	9	5.5%	15	6	3	-3	0
Physiotherapist	8	7.3%	10	2	2	-2	0
Total AH Priority Professions	**35**	**6.8%**	**47**	**12**	**7**	**-7**	**0**

PALT PRIORITY ALLIED	Pacific in current workforce	% of Pacific a in current workforce	Number of Pacific to reflect working population	Additional Pasifika required	Recruited last 12 months	Terminated last 12 months	Last 12 months Movement
Oral Health Therapist	17	9.0%	14	0	2	0	2
Dietitian	0	0.0%	4	4	0	0	0
Occupational Therapist	2	1.2%	12	10	0	-1	-1
Physiotherapist	3	2.7%	8	5	0	0	0
Total AH Priority Professions	**22**	**4.3%**	**38**	**19**	**2**	**-1**	**1**

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

Everyone Matters

CEO Lecture Series

Dr Ashely Bloomfield

Staff from across Allied Health, Scientific and Technical Professions were extremely pleased to have had the opportunity to listen and connect with Dr Ashley Bloomfield on his recent visit to Waitematā DHB. Staff were empowered by his talk and were keen to connect with him.

Scientific and Laboratory: Pictured left to right: Tina Da Silva, Phoebe Malley**,** Melanie Adriaansen (Dr A) Lee-Ann Weiss, Stephanie Williams, Joanna Barnes

Allied Health: Pictured left to right: Rachel D'Urban Burgess (PT), Steen Bastkjaer (PT), Lynda Moloney (PT), Kate Donovan (PT), Jess Tranter (SLT) Ashley Bloomfield, Maddy Boyd (OT), Eleanor Rubio-Mackie (SLT), Caroline Bartholomew (SLT

Better, Best, Brilliant

Occupational Therapy (OT) Rotational Programme

The Occupational Therapy Rotational Programme was developed in February 2019 to provide a consistent structured approach for the Occupational Therapy Professional group to enable and support newly graduated occupational therapists whilst providing a career development and skill acquisition pathway that supports service aims and delivery across the organisation. Developing the rotational programme within current services and within our current resources has created the need for flexibility and dynamic thinking, and one that has been supported by the adult inpatient services. The programme enables our new graduates to gain experience across a wider range of services including Orthopaedics, Neurology and Rehabilitation.

The rotational Core one (1) programme enabled four (4) new graduate occupational therapists to step into the programme over a year ago. Three (3) occupational therapists have now successfully completed their core one (1) objectives and have transitioned to the recently developed core two (2) programme, which commenced in February 2021. This has enabled three (3) new graduates to be recruited into the core 1 programme.

We have been able to increase our Māori and Pacific workforce representation amongst our fantastic occupational therapy rotational staff and look forward to imbedding the core 2 programme. The final phase of the programme will see the development of an experienced pathway facilitating community practices.

Connected

New graduate/trainee support programme
We are very pleased to have started our Allied Health Scientific and Technical new graduate/trainee programme for 2021. We have a total of 46 new graduates/trainees across nine (9) disciplines who work within Waitematā DHB participating in this year's programme.

The programme provides specific skills that assist in shaping the first year of practice and starts to develop leadership skills for the future. Given the impact of COVID-19 on face-to-face meetings, we are building on new ways of providing opportunities for the new graduates/trainees to connect with each other and learn in an inter-professional framework based on our experiences of maintain connections across 2020. Digital platforms, such as zoom, continue to enable us to provide the programme whilst we experience different levels of lockdown.

Profession	Number of attendees
Anaesthetic Technician	1
Dietitian	1
Medical Imaging Technologist	4
Medical Laboratory Scientist	5
Occupational Therapist	6
Oral Health Therapist	21
Pharmacy intern	2
Physiotherapist	4
Social Worker	2

With Compassion

Level 3 Lockdown and Speech and Language Therapy
The recent lockdown following the 14 February 2021 outbreak have reinforced the benefits of Zoom video conference and telephone contacts. Patients are more willing to try Zoom sessions when it facilitates earlier appointments. Patients who have anticipated it may not go well have been complimentary following the session.

From a patient with Motor Neurone Disease (MND) who agreed to give it a try for our meeting:

"Thank you for spending time with me today on video. Also thank you for your follow-up email with all the tips and advice, especially on food choices to lessen the risk of choking."

From a patient with Parkinson's Disease, who didn't want to have a Zoom meeting, but wanted to discuss her immediate concerns on the telephone before we could meet in person:

"Thank you for your phone call yesterday and your time on the phone. It was lovely to chat with you about the Parkinsons I could really do without it and find it draining and not a nice illness. One can't get better and have to live with it. I appreciate your time and sending the information through. Many thanks and look forward to meeting you."

Nursing and Emergency Planning Systems

Prepared by Jocelyn Peach, Chief Nursing Officer, Professional Leadership

Nurses, Midwives and Health Care Assistants account for 43.9% of the total DHB workforce.

Quality, Safety and Practice Development

Competent professionals

Despite the uncertainties of lockdown and staff being deployed to support the regional vaccination programme, essential/mandatory training continues with a limited team. It has been challenging to ensure that all nurses have completed the annual safety requirements over the past 18 months. It is fortunate that there are on-line options.

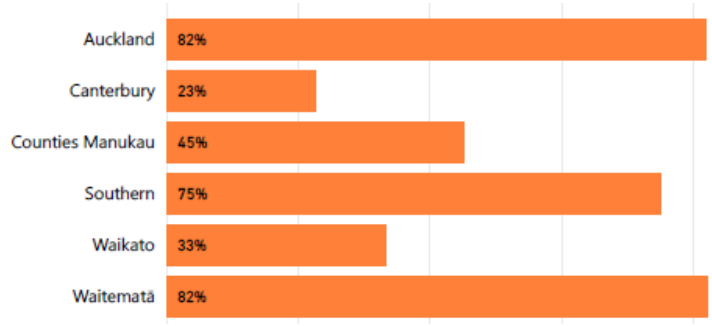
Professional Development and Recognition Programme: 45 registered nurses have presented their portfolios for recognition as expert level (RN 4) assessment in 2020. Transfer to the on-line portfolio has been generally well received.

Practice Safety

Patient and Whānau Centered Care Standards audit forms are being finalised for the annual audit on 17-28 May 2021. Regular auditing continues to ensure compliance with key standards: IV line, pressure prevention and falls management. There are key working groups of doctors, nurses and allied health working to review and improve practice based on audit results.

Safe practice Innovation/Development

Care Capacity Demand Management (CCDM): Work continues to implement the findings of CCDM. Waitematā DHB has achieved 82% implementation and has reported on planned implementation to meet June 2021 deadline. A range of reports on achievement has been provided over recent weeks. Recruitment of nurses is underway to fill the approved 104.78 FTE increase.



Workforce Planning and Workforce 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

Nursing Student Clinical Placements: Regional work is underway with the three Schools of Nursing on 19 March 2021 to agree processes for forecasted clinical placement availability and achieve alignment with supply and demand. Some of the schools have expansion numbers which needs to be planned for as actual capability in DHBs and community settings are not have sufficient for this increase. Reducing hours of undergraduate experience prior to siting registration exams has impact on employer in terms of orientation hours on employment. This work is linked to the national undergraduate workforce supply and demand work.

Waitematā DHB offers 26,185 nursing clinical day placements in 2021. Additional placements are provided for midwifery.

AUT		**AUT paramedicine**		**Massey**		**Other Schools**		**Unitec**		**UoA**	
Sem 1	***Sem 2***	***Sem 1***	***Sem 2***	***Sem 1***	***Sem 2***	***Sem 1***	***Sem 2***	***Sem 1***	***Sem 2***	***Sem 1***	***Sem 2***
7885	7615	125	91	2617	150	379	904	2085	2752	313	1269

New Graduate Nursing 'Entry to Practice' (February intake):
100 new graduate nurses commenced the Nursing Entry to Practice programme on 2 February 2021 distributed across the inpatient setting (medicine, surgery and child health, mental health and community/primary care). The first period is intensive as Nurse Educators support application of theory

to practice, focusing in safe assessment and escalation. The first orientation days are interesting as they were welcomed with a Mihi and reinforcement of key safety messaging.

Recruitment for the September 2021 intake of New Graduates will commence in April.

Other programmes in the pathway includes: The Return to Practice/Competence Assessment programme commences in April. The 'new to health' course (four weeks) for Health Care Assistants commences in late March. There is good interest in these programmes.

Advanced Practice nursing roles

Recent review of the advanced practice nursing workforce shows that the DHB provider has the following staff employed as patient facing roles:

Nurse Practitioners		**Clinical Nurse Specialist**		**Specialty Nurses**	
Head Count	*FTE*	*Head Count*	*FTE*	*Head Count*	*FTE*
13	11.77	169	138.32	11	51.8

There is a work underway to address recruitment and retention of Māori and Pacific nurses. There is a concern that there is turnover and we are looking to get some understanding from people have left.

Māori Nursing, Midwifery and Health Care Assistant workforce

MALT PRIORITY NURSING February 2021	**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	31	5.6%	51	20	8	-2	6
Registered Nurses	113	5.0%	208	95	15	-13	2
Enrolled Nurses	2	4.3%	4	2	0	-1	-1
Nurses	**146**	**5.1%**	**263**	**117**	**23**	**-16**	**7**
Registered Midwives	15	10.5%	13	0	7	-5	2
Health Service Assistants	64	12.5%	47	0	18	-8	10
Total NURSING	**225**	**6.4%**	**323**	**117**	**48**	**-29**	**19**

Pacific Nursing, Midwifery and Health Care Assistant workforce

PALT PRIORITY NURSING February 21	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	12	2.2%	41	29	1	-1	0
Registered Nurses	98	4.3%	165	67	15	-7	8
Enrolled Nurses	3	6.4%	3	0	0	0	0
Nurses	**113**	**3.9%**	**209**	**96**	**16**	**-8**	**8**
Registered Midwives	5	3.5%	10	5	0	-1	-1
Health Service Assistants	103	20.1%	37	0	19	-6	13
Total NURSING	**221**	**6.3%**	**256**	**101**	**35**	**-15**	**20**

Professional Relationships and 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

Focus groups are set up with key groups to consider staff experience and consider resilience approaches for work pressure and future changes.

There is also focus on implementing community transition of service including nurse prescribing and specialised mental health assessment in GP practices.

Emergency Systems Planning

Work is progressing with filming staff actions in a fire evacuation using the new Fire and Emergency New Zealand (FENZ) requirements. The wardens are enthusiastic to participate in the new approach and video learning.

First responder training has been well received and will continue to enhance confident team work. Resources are being updated to support staff reference.

Good work has been done by a senior ED doctor in the hospital emergency action in the event of a major incident that requires key response with the acute 'front' of the hospital services.

4.2 Quality Report – January/February 2021 Data

Recommendation:

That the report be received.

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

Contents

Acronyms

Acronym	Definition	Acronym	Definition
ADU	Assessment and Diagnostic Unit	IT	Information Technology
ACP	Advance Care Planning	IVL	Intravenous luer
AKI	Acute Kidney Injury	KPI	Key Performance Indicator
AMS	Antimicrobial Stewardship	LOS	Length of Stay
ANTT	Aseptic non-Touch Technique	LCC	Lakeview Cardiology Centre
BSI	Blood Stream Infections	MACE	Major Adverse Cardiac Events
CADS	Community Alcohol and Drug Service	MALT	Māori Alliance Leadership Team
CAUTI	Catheter Associated Urinary Tract Infection	M&M	Mortality and Morbidity
CCOT	Critical Care Outreach Team	MRSA	Methicillin Resistant Staphlococcus aureus
CDI (C.diff)	*Clostridium difficile (C.difficile) infection*	MRO	Micro Resistant Organism
CeDSS	Clinical e-Decision Support	MSU	Mid-Stream urine
		NMDS	National Minimum Data Set
CGB	Clinical Governance Board	N/A	Not Applicable
CLAB	Central Line Associated Bacteraemia	NRFit	Neuroaxial and Regional connectors
CPP	Chronic Pelvic Pain	NZEWS	New Zealand Early Warning Score
CWFS	Child Woman and Family Service	NPS	Net Promoter Score
CXR	Chest X-Ray	PACE	Pathway for Acute Care of the Elderly
ESC	Elective Surgery Centre	PDP	Patient Deterioration Programme
ePA	Electronic Prescribing and Administration	PERSy	Patient Experience Reporting System
eMR	E-Medicine Reconciliation	PICC	Peripherally Inserted Central Catheter
ED	Emergency Department	PROM	Patient Reported Outcome Measure
EDARS	Early Discharge and Rehabilitation Services	PWCCS	Patient Whānau Centre Care Standards
ELT	Executive Leadership Team	QI	Quality Improvement
ETT	Exercise Tolerance Test	QoL	Quality of Life
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

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 where eMedRec was finished at any time during the patients' admissions *(target has not been set by HQSC)*
- Percentage of patients aged 65 years and over (55 and over for Māori and Pacific people) where eMedRec was finished at any time during the patients' admissions *(target has not been set by HQSC)*
- Percentage of patients where eMedRec was finished within (≤) 24 hours of admissions *(target has not been set by HQSC)*
- Percentage of patients aged 65 years and over (55 and over for Māori and Pacific people) where eMedRec was finished within (≤) 24 hours of admissions *(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 2021 is:

Period covered	Publication date (indicative)
Q4 2020 (Oct-Dec 20)	31 March 2021
Q1 2021 (Jan-Mar 21)	30 June 2021
Q2 2021 (Apr-Jun 21)	30 September 2021
Q3 2021 (Jul–Sep 21)	17 December 2021

2. Health Quality and Safety Commission Quarterly QSM Dashboard

Quality Safety Markers (QSM)			Target	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Last Quarter Change
Falls		% older patients assessed for falls risk	90%	96%	98%	97%	98%	99%	99%	100%	98%	100%	⇧
		% older patients assessed as significant risk of falling with an individualised care plan	90%	96%	94%	99%	99%	98%	96%	97%	97%	99%	⇧
Health Care Associated Infections	Hand Hygiene (HH)	% of compliant HH moments	80%	89%	90%	89%	90%	93%	91%	92%	90%	91%	⇧
	CLAB	% occasions insertion bundle used in ICU	90%	99%	100%	100%	100%	100%	100%	100%	99%	100%	⇧
		% occasions maintenance bundle used in ICU (*not currently an HQSC Target*)	90%	92%	96%	97%	99%	99%	98%	91%	97%	98%	⇧
	Surgical Site Infections	Surgical Site Infections rate per 100 procedures [target has not been set by HQSC. *National Q1 2020 rate = 1.1 infection per 100 procedures*	HQSC has not defined a target	0.5	1.5	0.3	0.7	0.4	0.4	0.0	0.9	TBA	⇧
											Prelim Results		
		100% primary hip and knee replacements antibiotic given 0 -60 minutes before 'knife to skin' [first incision]	100%	97%	97%	97%	98%	100%	99%	98%	*HQSC SSI data lags by one – two quarters*		⇩
		95% > primary hip and knee replacements right antibiotic in the right dose - Cefazolin 2g or more	90%	99%	98%	97%	98%	100%	99%	93%			⇩
		100% of primary hip and knee replacements will have alcohol based skin preparation	100%	98%	100%	95%	95%	100%	99%	100%			⇧
		100% of primary and knee replacements will have surgical antimicrobial prophylaxis discontinued with 24 hours post-operatively	100%	100%	100%	99%	99%	99%	98%	100%			⇧
	eMedRec	eMedRec on admission implemented anywhere in the hospital	TBD	*New Quality Safety Marker*							Yes	Yes	⇔
		% of patients with access to eMedRec Services	TBD	*New Quality Safety Marker*							86%	86%	⇔
		% of patients where eMedRec was finished at any time during the patients' admissions	TBD	*New Quality Safety Marker*							75%	73%	⇩

Quality Safety Markers (QSM)			Target	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Last Quarter Change
Medication Safety		% of patients aged 65 years and over (55 and over for Māori and Pacific people) where eMedRec was finished at any time during the patients' admissions	TBD	*New Quality Safety Marker*							91%	89%	⇩
		% of patients where eMedRec was finished within (≤) 24 hours of admission	TBD	*New Quality Safety Marker*							54%	50%	⇩
		% of patients aged 65 years and over (55 and over for Māori and Pacific people) where eMedRec was finished within (≤) 24 hours of admission	TBD	*New Quality Safety Marker*							68%	86%	⇧
	Opioids	% of patients with a documented sedation score	TBD		72%	76%	85%	86%	86%	85%	83%	67%	⇩
		% of patients with documented bowel function monitored	TBD		4.0%	3.0%	3.5%	3.0%	4.3%	5.0%	4.5%	5.6%	⇧
		% of patient with uncontrolled pain	TBD		18%	8%	0.5%	0.0%	0.8%	0.1%	0.3%	0.1%	⇩
		% of patients with documented opioid related adverse events *HQSC Provide*	TBD			0.49%	0.35	0.58%	0.59%	0.48%	TBC	TBC	⇩
Patient Deterioration	% of eligible wards using the NZ Early Warning System (EWS)		TBD			100%	100%	100%	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%	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%	70%	86%	84%	⇩
	Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, units or departments per 1000 admissions (NMDS) *HQSC Provide*		TBD	1.3%	1.0%	0.2%	0.6%	0.5%	0.2%	0.7%	TBC	TBC	
	Rate of rapid response escalations per 1000 admissions (NMDS) *HQSC Provide*		TBD				19%	19.7%	13.2%	19%	TBC	TBC	

Pressure Injuries	% of patients audited for pressure injury risk who received a score (NMDS)	90%	86%	85%	86%	87%	89%	88%	88%	90%	92%	⇧
	% of patients with the correct pressure injury care plan implemented	90%	62%	68%	68%	68%	65%	70%	69%	65%	59%	⇩
	% of patients audited with a hospital acquired pressure injury	TBD	2.4%	0.6%	1.2%	1.0%	0.6%	1.3%	0.6%	1.4%	0.0%	⇩

	% of patients audited with non-hospital acquired pressure injury	TBD		2.1%	1.6%	2.2%	1.4%	2.9%	3.3%	0.26%	⇩

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

Quality Safety Markers			Target		Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Last Quarter Change
Peri-Operative Care	Surgical Safety	Uptake: % of audits where all components were reviewed	100%	Sign In	100%	100%	98%	100%		98%				*NB: During Q1-2 2020 QSM submission for Safe Surgery was suspended due to COVID-19.* *Q3 2020: - only 11/20 DHBs were able to submit the required 50 observational audits.* *Q4 2020 data to be advised.*
				Time Out	98%	98%	100%	100%		100%				
				Sign Out	98%	100%	98%	98%		100%				
		Engagement: % of audits with engagement scores of five or higher	95%	Sign In	96%	88%	89%			97%				
				Time Out	94%	94%	100%	98%		100%				
				Sign Out	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	52	51	57	48	49	65	40		5	
				Time Out	51	53	53	52	45	64	40		3	
				Sign Out	52	50	51	45	36	55	33		2	

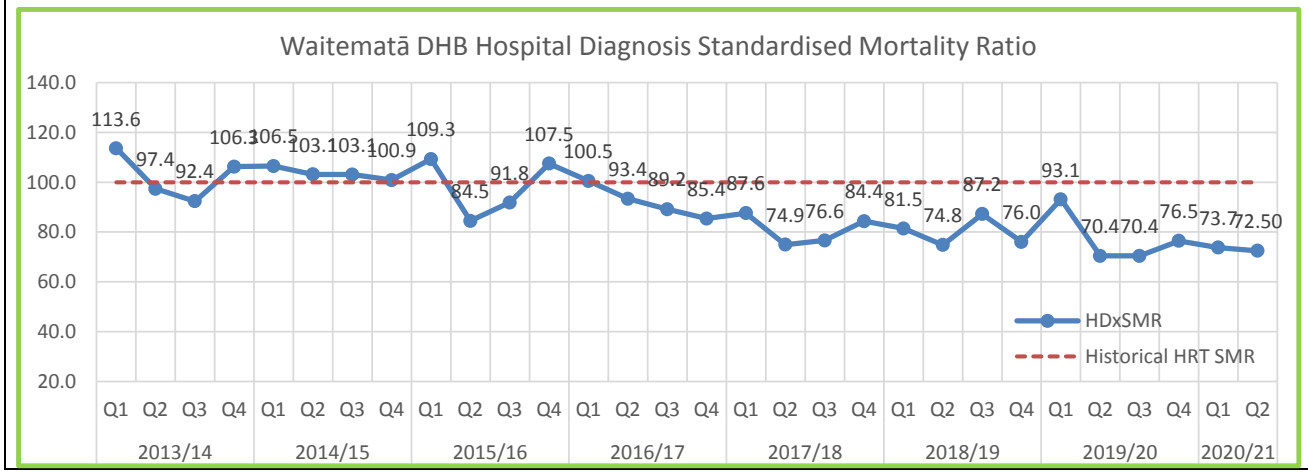
Data not published by the HQSC if observations were <50	
Less than 75%	
More than 75%	
Target Achieved	

3. DHB Key Quality Indicators and Trends

Quarterly HDxSMRs

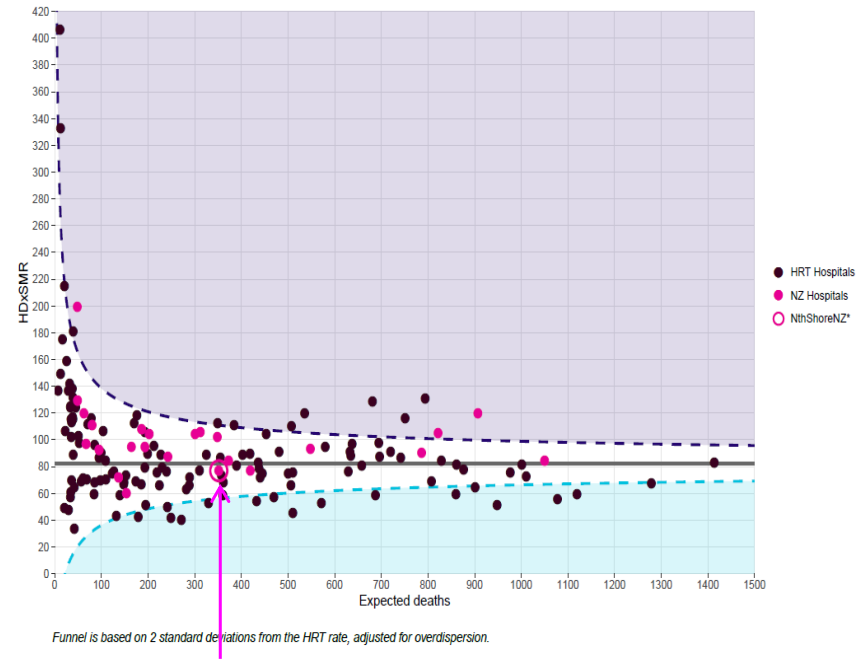
Hospital Diagnosis Standardised Mortality Ratio (HDxSMR)
The HDxSMR is expressed as a ratio and seeks to compare actual deaths occurring in hospital (or in hospital and following hospital admission), with a predicted number of deaths based on the types of patients admitted to the hospital. The HDxSMR 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) **Q2 FY2020/2021= 72.5**



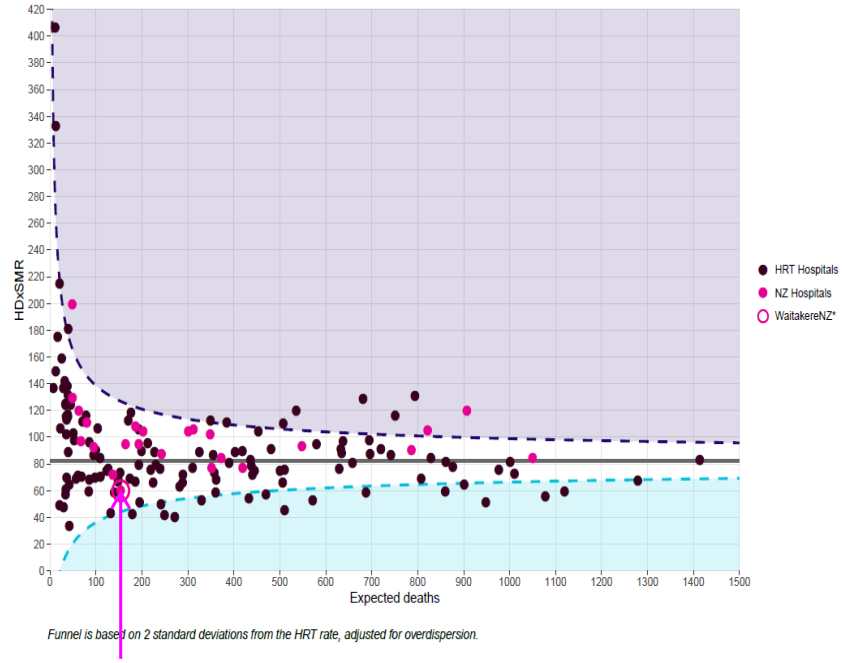
12 month Data - HDxSMR Jan 2020 – Dec 2020:

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



North Shore Hospital 77

HDxSMR	
(12 months Jan 2020 – Dec 2020)	
Episodes	**31,226**
Deaths	**270**
Expected Deaths	**351.7**
Combined HRT HDxSMR for Jan20 – Dec20	**82**
NZ HDxSMR	**96**
Network HDxSMR	**72**



Waitakere Hospital 60

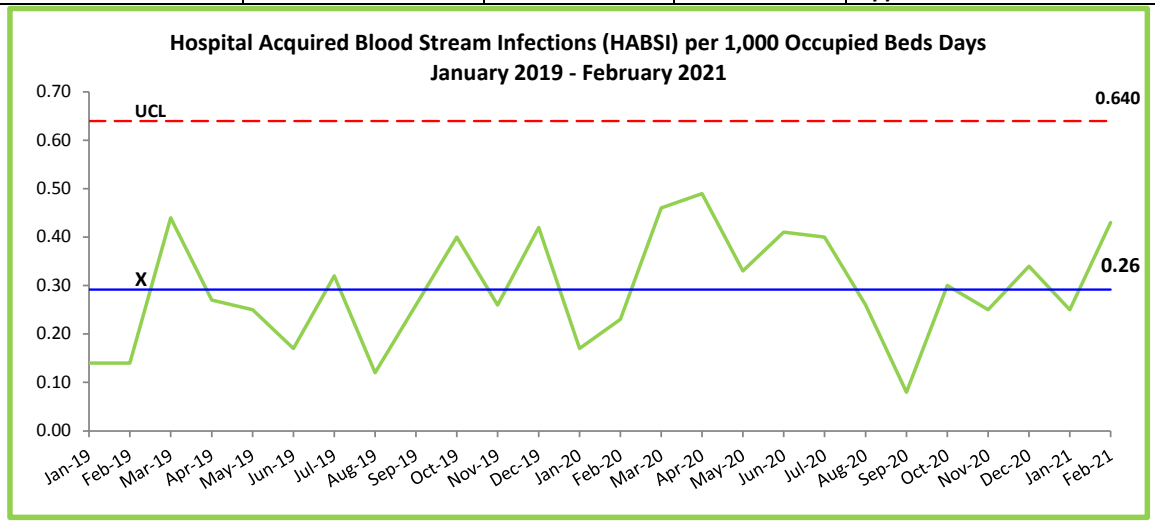
HDxSMR	
(12 months Jan 2020 – Dec 2020)	
Episodes	**13956**
Deaths	**92**
Expected Deaths	**153.8**
Combined HRT HDxSMR for Jan20 – Dec20	**82**
NZ HDxSMR	**96**
Network HDxSMR	**72**

Hospital Acquired Blood Stream Infections (HABSI)

HABSI is defined as a bloodstream infection attributable to hospital where acute or rehabilitation care is provided, if the infection was not incubating on admission. Typically bacteraemia diagnosed after 48 hours of admission, on readmission, related to a device, or within 30 days of procedure (if no alternate source identified) is categorised as a HABSI. There is no recognised national benchmark 'acceptable' rate or target for HABSI.

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
		Dec	Jan	Feb	
0	Total # of infections	8	6	9	**Mean rates of HABSI/1,000 occupied bed days**
0.00	# of infections per 1,000 occupied bed days	0.34	0.25	0.43	*The Infection, Prevention and Control Committee's Executive Reports for **January/February 2021 are attached as Appendices 1 and 2***

	Rate	N=
2016	0.35	89
2017	0.25	67
2018	0.26	70
2019	0.26	71
2020	0.30	79



HABSI Analysis Jan 2021

Source	Total	Area	Organism	Comments
IVL	1	Ward 4	MRSA	• A patient with known MRSA colonisation developed an MRSA bacteraemia secondary to an intravenous luer which had been placed into the ante-cubital fossa (crook of the elbow)
Other	3	Ward 4	Pseudomonas Aeruginosa	• A patient developed an abscess and a hospital acquired bacteraemia following a Whipples procedure (removal of the head of the pancreas)

Target	Measure			Prev. Report Period	Current Report Period		Commentary/Trends
				Dec	Jan	Feb	
		Ward 7 Muriwai Ward	Staph. aureus E coli				• A patient developed a hospital acquired bacteraemia from a wound infection following surgery at Counties Manukau DHB for spinal surgery • A patient developed a hospital acquired bacteraemia from a urinary tract infection; the patient did not have an indwelling urinary catheter
Unknown	2	ICU Ward 14	Staph aureus Candida albicans				• A patient developed a hospital acquired bacteraemia; the source could not be identified • A patient with known immuno-suppression and a history of recurrent thrush secondary to long term steroidal therapy developed a hospital acquired bacteraemia; the source could not be identified

HABSI Analysis Feb 2021

Source	Total	Area	Organism	Comments
CAUTI	1	Ward 6	Pseudomonas aeruginosa	• A patient with neutropenic sepsis[1] and a prolonged duration urinary catheter, developed a hospital acquired bacteraemia; the catheter was required for fluid monitoring
CLAB	1	Ward 2	Pantoea agglomerans	• A patient with end stage renal failure and a previous history of a Staph. aureus bacteraemia, developed another bacteraemia secondary to a femoral line being left in place while the patient waited for a permanent tunnel line insertion; the patient required the line for haemodialysis
IVL	1	Ward 2	Staphylococcus epidermis	• A patient developed a hospital acquired bacteraemia secondary to an intravenous luer; an investigation identified inconsistent maintenance and monitoring of the line
Other	5	Ward 8 Ward 14 Ward 6 Ward 5 Titirangi Ward	Escherichia coli Staphylococcus aureus Escherichia coli Escherichia coli Klebsiella pneumoniae	• A patient developed a hospital acquired bacteraemia following an abdominal washout for a perforated appendix • A patient developed a hospital acquired bacteraemia secondary to an infected heel wound • A patient with end stage renal failure developed a hospital acquired bacteraemia secondary to urosepsis • A patient with a history of recurrent urinary tract infections developed a hospital acquired bacteraemia secondary to urosepsis • A patient developed a hospital acquired bacteraemia secondary to a urinary tract infection while an inpatient in Auckland City Hospital

[1] **Neutropenic sepsis** - life-threatening reaction to an infection, which can happen in patients with neutropenia (a low level of neutrophils in the blood); neutrophils are a type of white blood cell that work as part of the immune system to fight off infections

Target	Measure			Prev. Report Period	Current Report Period		Commentary/Trends
				Dec	Jan	Feb	
Unknown	1	Ward 10	Bacteroides thetaiotaomicron	• A patient developed a hospital acquired bacteraemia secondary to partial bowel obstruction from a malignant tumour			

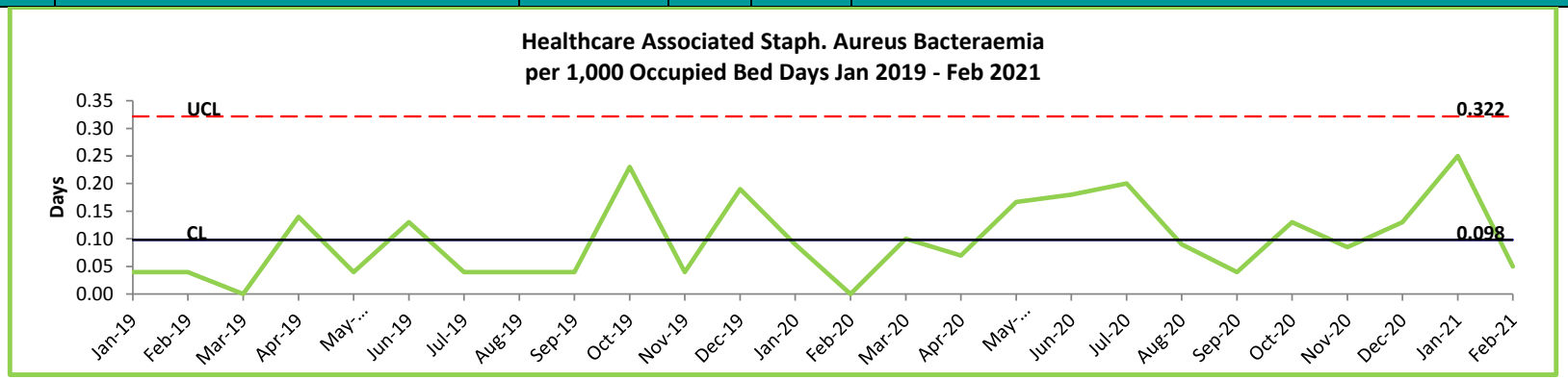
3.1 Hand Hygiene (HH) Compliance

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
		Dec	Jan	Feb	
>80%	% rate of compliance with five Hand Hygiene Moments	91%	92%	91%	Waitematā DHB continues to achieve a Hand Hygiene compliance rate above the National Target of >80%. In Q3 2020 Waitematā DHB led the DHBs with **90%** compliance, while the National average compliance rate is 86%. In Q4 2020, our compliance rate was **91%**; data from other DHBs is to be advised.
0	*Total # of Hospital Associated SAB infections*	3	6	1	**Staph Aureus Blood Stream Infections/Healthcare Associated Bacteraemia (HCA-BSI)**
≤ 0.13	*# of Hospital Associated SAB infections/1,000 bed days*	0.13	0.25	0.05	*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 Waitematā DHB Hand Hygiene Reports for **January/February 2021 are attached as Appendices 3 and 4***

Hand Hygiene Results by Division	Jan 21	Feb 21
Division	**Compliance**	
Acute & Emergency Medicine	92%	91%
Child Women & Family	89%	92%
Specialty Mental Health + Addictions	99%	88%
Specialist Medicine + Health of Older People	92%	95%
Surgical & Ambulatory	92%	90%
Total	**92%**	**91%**

- There was an **increase** in the SAB rate in **January 2021**, with a rate of **0.25/1000 Bed Days** against a target of ≤ 0.13. The average rate over 12 months, **Jan 2019 to Feb 2021** was **0.098** (≤ 0.13)

Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
		Dec	Jan	Feb	



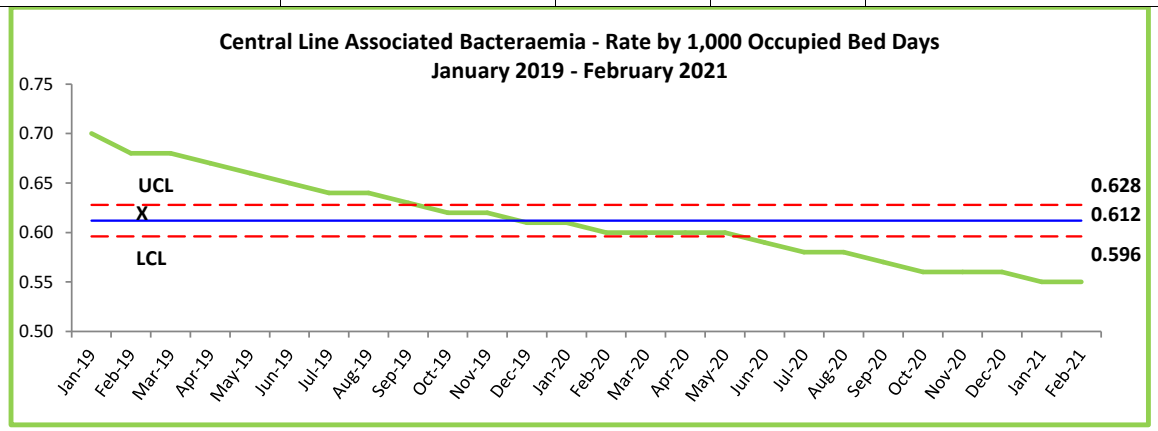
- Three of six SABs were HABSI[2] (discussed above under *Hospital Acquired Blood Stream Infection*)
- The other three were healthcare associated bacteraemias (HCA-BSI[3]) all related to renal patient haemodialysis venous access (lines); all three patients have end stage renal disease
- The renal service has undertaken a quality improvement programme to minimise line related infections this includes:
  - A review of staff aseptic non-touch technique via audit. The audit identified areas of improvement and changes were implemented
  - Further staff education
  - Haemodialysis patients are receiving regular advice and guidance regarding looking after their lines; a video has been made for patients new to dialysis

[2] **HABSI** – positive blood culture greater than 48hrs after admission, procedure in last 48hrs , previous admission in last 48hrs
[3] **HCA-BSI** – Occurred within 48 hrs of admission from patients that had a procedure in the last 30 days from Waitematā DHB, include dialysis and home dialysis patients

3.2 Central Line Associated Bacteraemias (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.

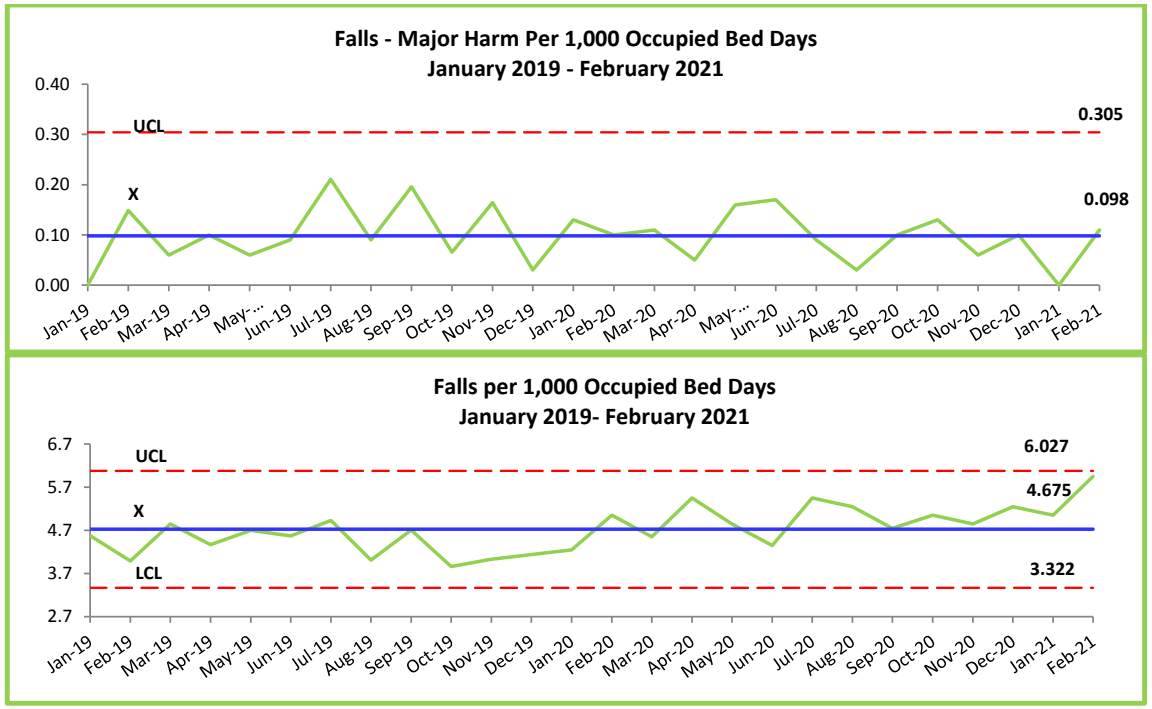
Target	Measure	Prev. Report Period	Current Report Period		Commentary/Trends
		Dec	Jan	Feb	
<1	# of CLAB infections per 1,000 line days **(ICU)**	0.56	0.55	0.55	**Central Line Associated Bacteraemia (CLAB)**
>98%	% bundle compliance at insertion **(ICU)**	100%	99%	100%	
>98%	% bundle compliance maintenance **(ICU)**	97%	99%	95%	The ICU is currently **1,277 days** CLAB Free as at **28 February 2021**



3.3 Falls with Harm

Target	Measure	Prev. Report Period	Current Report Period	
		Dec	Jan	Feb
	Total number (#) of falls	162	158	168
<5.0	Rate of falls per 1,000 Occupied Bed Days (OBD)	5.2	5.0	5.9
	Total number of multi-fallers	25	24	23
>90%	% patients 75 years and over (55 years and over Māori and Pacific) assessed for the risk of falling	100%	97%	97%
>90%	% patients 75 years and over (55 years and over Māori and Pacific) assessed for the risk of falling 8 hours of admission	89%	82%	78%
>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	100%	100%	98%
	Total number of falls where an injury has occurred (including Major Harm)	42	39	39
	Rate of falls where an injury has occurred (including Major Harm) per 1,000 Occupied bed day	1.4	1.2	1.4
	Total number of falls with major harm (SAC 1 and 2)	3	0	3
	Rate of falls with major harm per 1,000 Occupied bed day	0.10	0.0	0.11

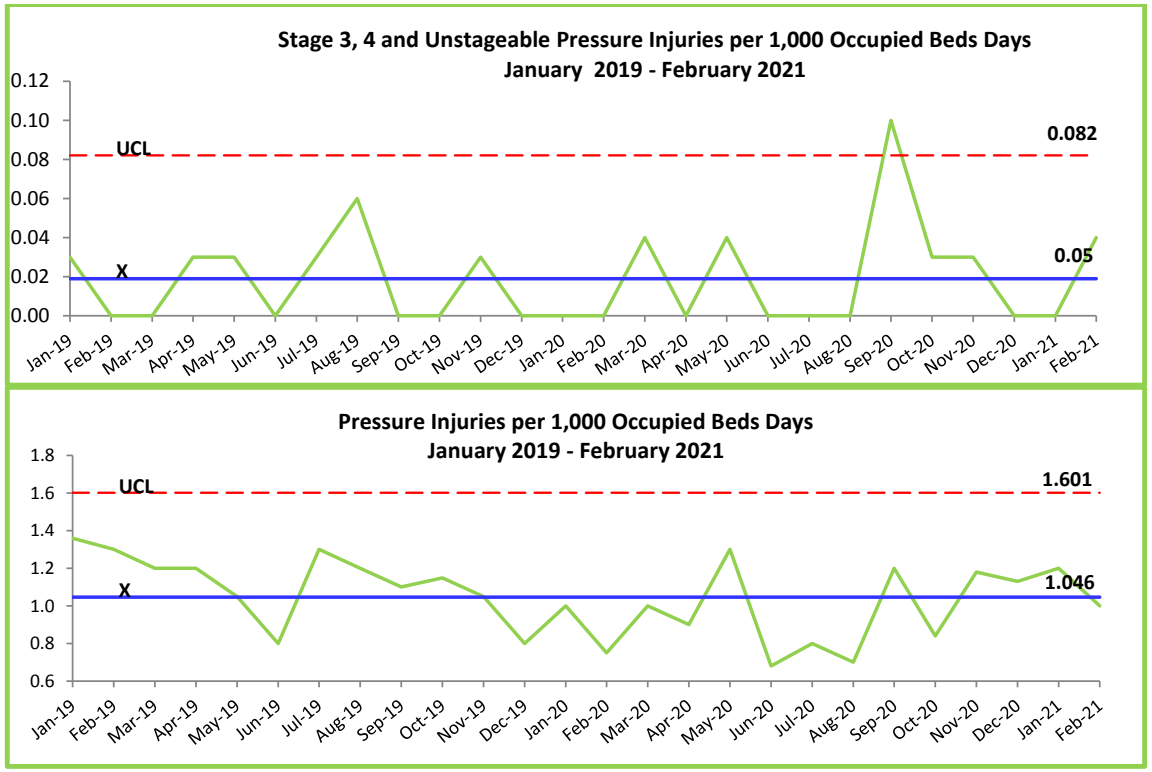
Target	Measure	Prev. Report Period	Current Report Period	
		Dec	Jan	Feb
0	Total number of reported fractured neck of femurs (NOF) as a result of a fall while in hospital (included in the major falls with harm rate)	2	0	0
0	Total number of coded fractured neck of femurs (NOF) as a result of a fall while in hospital	TBC	TBC	TBC



3.4 Pressure Injuries

Target	Measure	Prev. Report Period	Current Report Period	
		Dec	Jan	Feb
100%	% patients risk assessed within specified time frame (eight hours)	75%	66%	68%
100%	% patients audited who received a score	93%	95%	94%
100%	% patients with the correct care plans implemented	60%	56%	61%
	Number of patients with reported confirmed pressure injuries *(Incident Reporting System – RL6)*	35	38	29
	Rate of confirmed pressure injuries per 1,000 Bed Days	1.1	1.2	1.0
0	Number of reported confirmed Stage 3, 4 or unstageable pressure injuries *(Incident Reporting System – RL6)*	0	0	1

Target	Measure	Prev. Report Period	Current Report Period	
		Dec	Jan	Feb
	Rate of confirmed Stage 3, 4 or unstageable pressure injuries per 1,000 Bed days	0.00	0.00	0.04



3.5 Complaint Responsiveness

<table>
<tr><th>Target</th><th>Measure</th><th>Previous Report Period</th><th colspan="2">Current Report Period</th><th>Commentary</th></tr>
<tr><td><15 days</td><td>Average time to respond to complaints in the reporting month</td><td>11 (Dec)</td><td>9 (Jan)</td><td>11 (Feb)</td><td>
The average days to respond has 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.
<table>
<tr><th></th><th>Average Days to Respond</th></tr>
<tr><td>2015</td><td>18</td></tr>
<tr><td>2016</td><td>19</td></tr>
<tr><td>2017</td><td>15</td></tr>
<tr><td>2018</td><td>14</td></tr>
<tr><td>2019</td><td>12</td></tr>
<tr><td>2020</td><td>12</td></tr>
</table>
<table>
<tr><th colspan="3">Average Days to Respond – Provider Arm</th></tr>
<tr><th>Division</th><th>Jan 2021</th><th>Feb 2021</th></tr>
<tr><td>Acute & Emergency Medicine</td><td>7</td><td>14</td></tr>
<tr><td>Child, Women & Family</td><td>7</td><td>10</td></tr>
<tr><td>Specialist Mental Health & Addictions</td><td>15</td><td>8</td></tr>
<tr><td>Specialty Medicine and Health of Older People</td><td>13</td><td>7</td></tr>
<tr><td>Surgical & Ambulatory</td><td>9</td><td>6</td></tr>
</table>
</td></tr>
</table>

4. Safe Care

4.1 Infection Prevention and Control (IP&C)

*IP&C Surveillance Overview and Audit Results for **January/February 2021***

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 2020	6	4	2	4897	89%	97%	100%
February 2020	6	5	2	4392	91%	98%	100%
March 2020	9	9	4	4624	93%	97%	97%
April 2020	3	7	6	3818	93%	95%	100%
May 2020	3	6	4	4730	92%	99%	100%
June 2020	4	9	5	4656	90%	97%	100%
July 2020	9	10	4	4750	91%	97%	96%
August 2020	7	6	4	5457	90%	98%	100%
September 2020	12	2	4	5267	91%	98%	97%
October 2020	8	7	2	5246	90%	97%	100%
November 2020	10	6	4	5097	91%	98%	100%
December 2020	10	8	4	4847	91%	98%	94%
Overall 2020	87	79	45	58,252	91%	97%	97%
January 2021	9	6	6	4771	92%	98%	90%
February 2021	6	9	NA	4717	91%	97%	100%

RAG Rating Legend

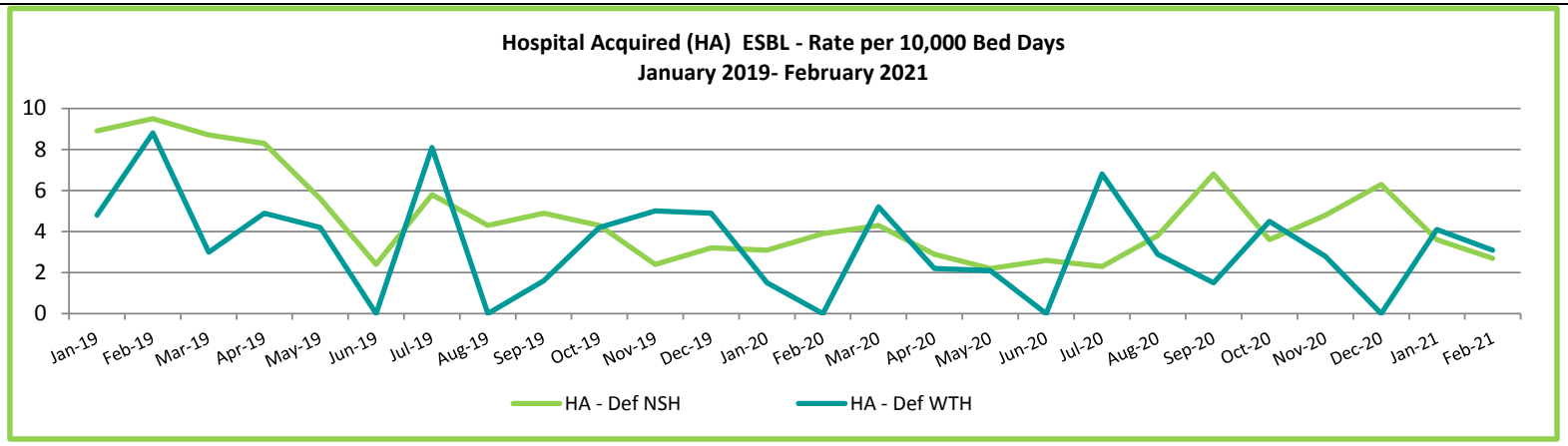
% National HH Moments Passed	% I&PC Facilities Standards Met	% of Clean Commodes
≥ 80%	≥ 99%	≥ 99%
≥ 70%	≥ 90%	≥ 90%
< 70%	< 90%	< 90%

4.2 Surveillance

4.2.1 Extended Spectrum Beta Lactamase (ESBL)

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

			2021	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
HA-ESBL rate/10,000 bed days (number)	**2019 Rate 5.1 (138)**	**2020 Rate 3.1 (87)**	**NSH**	3.6 (6)	2.7 (4)										
			WTH	4.1 (3)	3.1 (2)										



4.2.2 Communicable Diseases, Clusters and Outbreaks

- *Overview will be provided in the May 2021 HAC Report*

5. Innovation and Improvement Team Active Projects Report

Overview of Work Programmes

February 2021

institute for innovation + improvement

CURRENT i3 WORK IN PROGRESS

Leapfrog Programme

- *See Leapfrog Programme Report – Phase 3 projects (separate report)*
- Information Systems Strategic Group (meets fortnightly)

Data/Analytics

- Qlik Sense
  - completed upgrade to Sep 2020 version
  - currently in development: Congestive Heart Failure; COVID-19 Staff Availability app; Surgical Pathology, Costing, PPE Mask Fit Testing
  - Regional COVID-19 health information platform
- DataRobot implementation for Flow Predictions commenced 15 Jan 2021. The development of predictive algorithms will be done in collaboration with CMH
- Regional Data Design Authority – preparing business case for regional data platform support and development
- AI lab concept (see Innovation)
- Collaboration with HQSC on impact of COVID on health service delivery
- MH Snapshot – design + implementation planned Feb 2021
- Care Pathways test cases – currently outpatients eOutcomes (with SNOMED coding); surgical waitlist; ED best care bundles
- Clinical calculator register/approval process – review of existing calculators

Digital Transformation

- i3 website: **http://i3.waitematadhb.govt.nz/** (upgrade in progress)
- Waitematā DHB website rebuild
- Intranet website migration to Office 365
- Sharepoint development (Intranet update + off-site access; preparation for potential Controlled Docs and CeDS transition)
- PERSy analytics + PROMs: Bulk/individual emailing surveys to patients – continuing roll-out to support Outpatients + Telehealth
- Web Apps (MHS: THEO)

Health Leadership + QI

- Tier 1: QI e-learning via Awhina Learning for all staff
- Tier 2: Annual QI Workshop series; Safety in Practice Programme (Primary Care and Community Pharmacies);
- Fellows Programme – currently 4 fellows (range of FTE among fellows)
- Public Health Registrars – new registrar commencing 2021
- Summer students –x13 studentships completed and presented in March 2021
- Health Excellence Awards – Planning for 15 June 2021

Care Redesign Innovation and Improvement Team Projects

- *See Innovation and Improvement Project Team report (below)*

Innovation + Research

Leapfrog Programme – *see separate report*

Regional + National IS Development – Clinical Director of Innovation

- Business Design Council MoH + national Digital Investment Board
- HSDC: refresh of Northern Region's ISSP; review of data governance/RDDA
- Managed Isolation/Quarantine Facilities COVID health IS roll out

Digital Academy

- 2nd academy held 2-6 Nov 2020, follow up session Jan; 1st 2020/21 fellow commenced in i3

Academic Partnership Programmes

- AUT Good Health Design partnership –Integrated Design Studio
- Summer studentships (13) underway

Innovative Design

- Design Space (Portacom) mock-ups double rooms for Tōtara Haumau

AI Lab

- Development of foundation structures: principles, commercial models, governance, ethics, guidelines

Precision Driven Healthcare (research projects)

- Smart Search/ NLP of free text documents for clinical use (ICU)
- GP referrals triage (cardiology + gynae)
- Risk calculators – validation process in development
- Inpatient and Outpatient Survey patient perspectives on use of info – survey completed, results being analysed

Horizon Scanning/ Innovation Library

- Hospital in the Home models and Patient Focused Booking completed in 2020

Research

- Gynae – endometriosis in Māori + Pacific; oestrogen pessary
- Tranexamic sutures – pharmacokinetic study
- mPR – mobile pulmonary rehab development

Person Centered Design

- Patient reported outcome measures (PROMS)
- PREMs
- Values Programme – appreciative inquiry
- Patient Engagement System – see Leapfrog Programme
- AUT Good Health Design – Design space mock-ups; Masters students' projects (Stroke ward; rehab gym; ARDS)

Achievements/Events

ED Whiteboard

The Health Information Group (HIG) development team has enhanced the functionality of Centric (an application that that allows clinicians to search for patients by ward, team or NHI, and access core clinical systems without needing to access Clinical Portal) to encompass the features of the aging ED Whiteboard. This has been a significant piece of work over the last 6-9 months and will shortly be rolled out in our EDs. The new whiteboard will offer significant benefits:

- Provide a modern platform that is fast and reliable for ED clinicians to use, which has been designed for their workflow
- Enable direct launching of clinical systems, including the Inpatient Snapshot, ePrescribing, eVitals, and eNotes, providing clinicians with faster access to information
- Provide a foundation we can build on to incorporate new technologies – e.g. SNOMED coding for the patient's presenting complaint, ED procedures, and discharge diagnosis.

Speed and workflow are critical for ED clinicians. Our highly capable HIG development team, led by David Ryan, has a proven track record of designing solutions clinicians enjoy using; these systems follow clinical workflow rather than forcing clinical workflow to conform to the system.

Core Clinical Systems Development

Plans for our HIG development team to further enhance our core clinical systems continues to advance. We are looking to focus on three workstreams over the next twelve months: ePathways (forms and documents); eShared Goals of Care; and further eWhiteboard development.

eTasks and MH Snapshot

Two further HIG development team tools are ready for launching. One is is eTasks, which will make a significant difference for clinicians who have consistently been asking for this functionality. By linking plans in eNotes with a task function, clinicians will now have a pre-populated task list for patients that can be shared with clinical team members. This should be a vast improvement for clinicians' workflow and patients' care as tasks will be able to be completed faster and are less likely to be missed.

A Mental Health Snapshot developed with i3 has gone live in the Inpatient Snapshot. This provides clinicians with a summary view of core information from the electronic mental health record (HCC). There is a 'break glass' function that will mean clinicians accessing this information are required to specify the reason for accessing and we will be able to footprint access. The lack of quick access to core mental health information has been a significant issue for staff particularly in our EDs. The development of this system taken a long time but will be very welcome. Other DHBs face the same issues and Counties Manakau DHB has asked for the function to be made available to their clinicians.

Clinical Portal eOutcome forms are now live across 23 specialties, with over 100,000 appointment outcomes being processed since inception. An eOutcome 'task lists' function has also been developed, in order to streamline workflows for booking and scheduling, reception and nursing staff. This has resulted in appointment outcomes being available for processing into i.PM the moment the clinician has filled in the e-outcome form vs. up to three days with the old paper-based system. The eOutcome module has also resolved the issue of patients forgetting to take their outcome form to reception at the end of their consultation and means clinicians and administration staff can create and process outcome forms when working remotely, which is particularly important with the advent of COVID-19.

Innovation and Improvement Project Team: Active Projects Report Summary

Project Name	Project Summary	Requester	PM Resource	Budget	Forecast Variance	This Period	Last Period	Phase
Organisation wide / Multiple Divisions								
Outpatients *See Leapfrog Programme Report*	Expedite implementation of telephone appointments at scale across outpatients and community	Dale Bramley Jonathan Christiansen	Kelly Bohot					Executing
	Expedite implementation of video conference appointments at scale across outpatients and community	Jonathan Christiansen	Kelly Bohot Charlie Aiken					Executing
	Telehealth community pod We have purchased the pod located in NSH Outpatients. A 2nd pod is being tested – currently located outside the i3, LGF NSH. Contacts are being made through the Māori Gains team, the Helensville Community and Fono, to discuss community placements.	Penny Andrew	Tim Alvis Charlie Aiken					Executing
	Paperlite-paperless outpatient appointments (incl ePrescribing; eOutcomes; eNotes;eLabs; eSurgical Waitlist (incl eAnaesthetic assessment, CPAC score); eForms + eACC	Jonathan Christiansen Lara Hopley	Kelly Bohot Tim Alvis Dean Croft					Executing
	Remote patient monitoring	Penny Andrew/Robyn Whittaker	Barbara Corning-Davis					Executing
Patient Deterioration Programme (PDP)	An organisation and national programme to improve the management of the clinically deteriorating patient. The Programme has 3 main streams: (1) Recognition and response systems; (2) Kōrero mai: Patient, family and whānau escalation (3) Shared goals of care	Jos Peach Penny Andrew	Jeanette Bell	N/A	N/A			
	1. PDP: Recognition and Response Systems - National Early Warning System (completed) Maternity National Maternal Early Warning System (MEWS) (Executing) , NZEWS for Mental Health (Initiating)	Penny Andrew	Jeanette Bell	N/A	N/A			Executing
	2. PDP: Kōrero mai: Patient, family and whānau escalation	David Price	Jeanette Bell	N/A	N/A			Closed
	3. PDP: Shared Goals of Care	Penny Andrew Carl Peters	Jeanette Bell	N/A	N/A			Pilot closed Planning next phase
Anaesthesia Outpatients Service	Support service redesign –pre-assessment process model of care; scoping current processes in ESC, NSH + WTH	Dave Burton	Lisa Sue	N/A	N/A			Closed

Smartpage See Leapfrog Programme Report	Secure communication and task management app. Smartpage 777 module questionable due to connectivity issues. Regional RFP underway for 777 replacement.	Stuart Bloomfield	Joel Rewa-Morgan	$80k (opex) phase 2	0%			Executing
Allied Health Telehealth Toolkit	Scoping tools required to sustain telehealth in AH outpatients and community AH teams	Jude Sprott	Danni Yu	N/A	N/A			Closing
Patient Engagement System See Leapfrog Programme Report	Joel Rewa-Morgan assigned as Project Manager. PIC decision: funding on hold, however, work underway for Well Foundation funding of the Whānau Accommodation	Penny Andrew	Joel Rewa-Morgan	$88K	0			Planning
Clinical Photography Silhouettelite Test See Leapfrog Programme Report	Test Silhouettelite app to understand benefits for wound assessment and monitoring	Jos Peach Kate Gilmour	Kelly Bohot Marlé Dippenaar	N/A	N/A			Executing
Paperlite Hospital	Stocktake of e-systems and status of paper remaining in the clinical environment	Penny Andrew	Lisa Sue					In progress
Fax Free See Leapfrog Programme Report	A programme to migrate the organisation off fax use by June 2021.	Stuart Bloomfield	Lisa Sue	TBC	0			Planning
Surgical and Ambulatory Services								
Surgical Programme	Support the Surgical Division to develop an improvement programme that attracts and retains highly skilled clinicians and delivers a positive patient experience and optimal outcomes within clinically appropriate timeframes.	Mark Shepherd Richard Harman	Jonathan Wallace Laura Broome Kelly Bohot	N/A	N/A			Executing
	1. Acute Workstream		Laura Broome	N/A	N/A			Executing
	2. Staffing model workstream		Laura Broome	N/A	N/A			Planning
	3. Education and Orientation workstream		Marlé Dippenaar	N/A	N/A			Executing
	4. Booking and scheduling process mapping							
Osteoarthritis Chronic Care Programme	Support AH leader to scope a programme of work to introduce low intervention medical pathway for osteoarthritis patients; develop a project plan to create working model.	Mark Shepherd Richard Harman Matt Walker Jude Sprott	Danni Yu	N/A	N/A			Scoping
Enhancing patient safety with NRFit Neuraxial Connectors	Develop plan to pilot ISO 80369-6 NRFit connectors to replace the traditional Luer devices for all neuraxial procedures; scope scale of roll-out; develop business case for procurement; implement replacement.	Andrew Love	Dina Emmanuel	N/A	N/A			Executing

Acute and Emergency Medicine, Specialist Medicine and Health of Older People Services								
Chest Pain Pathway	Complete a review of the chest pain pathway including: - Review of local and international literature - Audit of ETTs and patient outcomes	Jonathan Christiansen Kate Allan	Kelly Bohot	N/A	N/A			On hold – closing date tbc
Rapid Cardiac Screening Clinic Model of Care	Develop a model of care for a new rapid cardiac screening (RCS) clinic model of care. Develop a business case to introduce a new model of care that will include • Improved, timely access to initial outpatient cardiology evaluation • Improved screening process to allow risk stratification that enables early intervention for higher acuity patients Identification and elimination of unwarranted tests and investigations.	Patrick Gladding Alex Boersma	Kelly Bohot	N/A	N/A			Executing
TransforMED phase 2	Support medicine and older adults to develop and implement integrated, patient centred models of care across inpatient, outpatient and community settings 1. Congestive Heart Failure 2. Integrated Stroke 3. Interim Care 4. Hospital in the Home 5. Acute Care of the Elderly	Brian Millen Alex Boersma	Kelly Bohot	N/A	N/A			Planning
Child Woman and Family Services								
Urogynaecology Service	Develop a local service for women: management of urogynaecological conditions stress urinary incontinence (SUI) + pelvic organ prolapse (POP); and management of complications associated with previously implanted surgical mesh Support development of a business case for women in Waitematā DHB and the Northern Regions with SUI or POP, and those affected by mesh complications.	Jonathan Christiansen Eva Fong	Sue French	N/A	N/A			On hold PM seconded to NHRCC
Project Management Mentoring for CWF	Project Management Support for x3 projects funded by the MoH.	Shirley Campbell Stephanie Doe	Laura Broome					In progress
Mental Health and Addiction Services								
NZEWS Implementation	Request to support the implementation of NZEWS in MHS inpatient units (He Puna; Waiatarau; Forensics) (See Patient Deterioration Programme)	Murray Paton Michelle Dawson	Jeanette Bell					Planning Acute Adults
Electronic therapeutic observation tool (THEO)	Design and implement a tool to enable staff to record electronically therapeutic observations (e.g. 15min client checks)	Derek Wright Murray Paton	David Ryan Sharon Puddle					Executing

Community Services								
PM secondment to NHRCC to support quarantine/isolation facility management processes	NHRCC – extension of secondment until June 2021		Sue French					In progress

Quality Improvement Training	Overview	Involvement	Sponsor(s)	PM Resource	Comment
Tier 2 project-based QI Training Programme	Teach QI skills to hospital and community staff and mentor each to deliver a QI project	Content development and delivery Ongoing mentorship	Penny Andrew	Barbara Corning-Davis Lisa Sue Laura Broome Dina Emmanuel Jeanette Bell	Ongoing
Safety in Practice Programme	The programme aims to promote a safety and improvement culture within community teams including general practice (GP), pharmacy and urgent care teams, within the Auckland region. The programme is adapted from the Scottish Patient Safety Programme in Primary Care	i^3 Innovation and Improvement PM	Tim Wood Stuart Jenkins	Dina Emmanuel	PM assigned to replace Sue French
RMO Clinical Governance Training	QI training involving project-based learning in the workplace with QI coaching	Content development and delivery	Andrew Brant Penny Andrew Naomi Heap Ian Wallace	Jonathan Wallace	RMO Clinical Governance Training
Management Foundations	Teach QI skills to participants and mentor each to deliver a QI project.	Content development and delivery Ongoing mentorship	Sue Christie	Barbara Corning-Davis	Management Foundations

Support Requests						
Current Support Requests						
Project Name	**Sponsor / Requestor**	**Description**	**Request received**	**Scoping Completed Approved date**	**Assigned to**	**Comment**
Organisation-wide/Multiple Divisions						
Choosing Wisely	Penny Andrew	PM support to document current state, a programme strategy and identify future opportunities	01/2019	Scoping completed Jan 2021	Jeanette Bell	
Day Case Procedures	David Wilson Merit Hanna	Follow up from adverse event investigation 4/08/2020. Request to process map day case procedures and develop e-documentation that	4/08/2020			

		aligns to outpatient processes. Explore adapting registrar credentialing app developed by Gynaecology (for procedure sign off)				
Ministry of Health Sustainability Programme	Mark Shepherd/Penny Andrew	Request to set up programme management of six improvement workstreams with Ministry of Health fixed term operational funding	12.02.2021		Laura Broome	Resource allocated for three months. Will impact Surgical Improvement Programme resource
Coordinated equity-based care (Ministry of Health Sustainability Programme)	Alison Bowden/David Price	Improving equity and coordination of care through design and implementation of a patient centred navigation service for priority patients (Maori and Pacific Endoscopy, Radiology)	12.02.2021			
Surgical and Ambulatory Services						
Transition Pain Service	Michael Kluger	Request to support the development of a transition pain service (TPS) model of care	05/08/2020			
Equity tracking in Bariatric Surgery	Jonathan Christiansen	Support HIG with implementation of equity tracking process in Bariatric Surgery in iPM	12/11/2020			
Acute and Emergency Medicine, Specialist Medicine and Health of Older People Services						
Paramedics - Economic evaluation model of care trial	Amber Smith	Economic evaluation of the Paramedic Model of Care Trial at WTH	18/11/2020			
SNOMED for ED	Delwyn Armstrong	SNOMED coding for ED mandated MOH implementation June 2021	20/11/2020			
Hospital in the Home (Ministry of Health Sustainability Programme)	Alex Boersma/Brian Millen	Design and develop comprehensive hospital in the home programme enabling a rapid access MDT service in the community.	12.02.2021			
Mental Health and Addiction Services						
Operation manual for Regional Forensic Psychiatry	Clare McCarten	Support to guide and produce a service wide operation manual for all services delivered at Mason Clinic.	21/10/2020			
MHS ED liaison and ICU step down (Ministry of Health Sustainability Programme)	Penny Andrew	PM support to run a workshop to agree a joint model of care and implementation plan for ED and MHS in preparation for project - PM funding available from Ministry of Health Sustainability Funding	15/01/2021		Jeanette Bell	

MHSOA Community Model of Care Review (Ministry of Health Sustainability Programme)	Gemma Witman	Transitioning older persons psychiatry patients to the community. Redesigning and implementing community-based models of care.	12.02.2021			
Child, Women & Family Services						
Early Supportive Discharge of Mothers (Ministry of Health Sustainability Programme)	Emma Farmer	Design and test early supported discharge model (SCBU).	12.02.2021			
COVID-19 Incident Management						
Data framework for vaccination programme	Delwyn Armstrong	PM to support analysts identify required data sources, develop visualisations, resolve data gaps	15.02.2021		Renee Kong	
Review of Blue Stream Pathways	Penny Andrew	Request to align process for our staff to that of MIF and Border workers working with Blue Stream patients (arguably the standard should be higher given our staff are working directly with positive/blue stream patients). The standards for MIF and Border staff are compulsory swabbing (not voluntary) with daily saliva testing and weekly testing of asymptomatic in quarantine/fortnightly in MIF.	15.02.2021		Jeanette Bell	
Staff drive through clinic	David Price	Support to stand up a testing station at Woodford house for 1. Asymptomatic staff testing, 2. staff who have attended a place of interest	16.02.2021			Placed on hold in lieu of further information 16.02.2021
PPE Fit Testing	Jonathan Wallace	Support to develop end user requirements for PPE fit testing Qlik app	17.02.2021		Danni Yu	

Closed since last report				
Project/Work/Request	**Sponsor/Requestor/ Project Manager**	**Overview**	**PM /Outcome**	**Close out / summary report location**

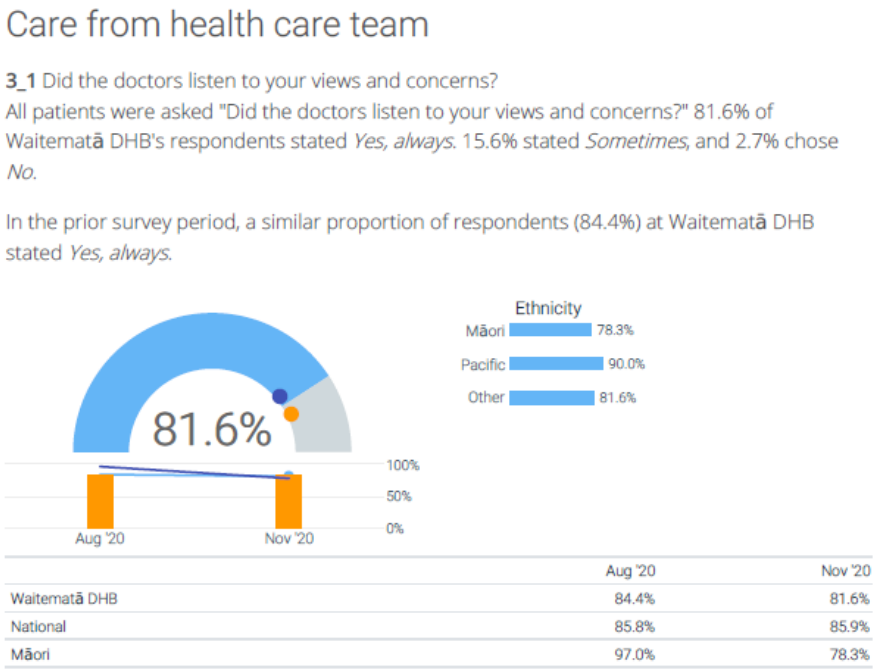
6. Patient and Whānau Centered Care

6.1 Patient Experience Feedback – February 2021 update

6.1.1 National Inpatient Survey

In January 2020, The Commission announced they had contracted Ipsos New Zealand, an independent research company, for the provision of the inpatient survey and primary care survey data collection and reporting system services. A subsequent review of the former Inpatient Patient Experience Survey was also conducted and a refresh of the survey was launched in August 2020.

The second revised survey commenced on 24th November 2020 for patients discharged between 2 November to 15 November. Waitematā DHB sample size for the survey was 1,259 patients – all were emailed the survey. 377 patients responded to the survey – 30% response rate. Below are some key questions focused on staff listening.

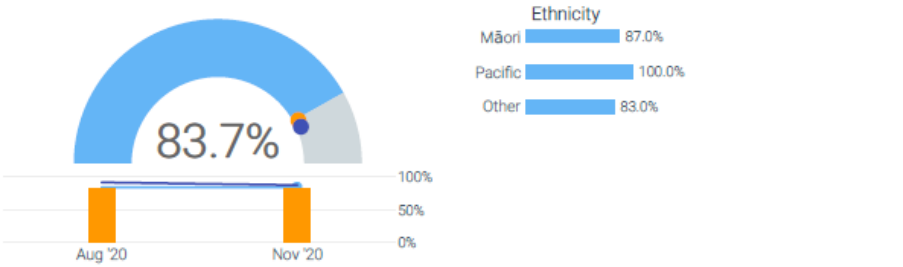


	Aug '20	Nov '20
Waitematā DHB	84.4%	81.6%
National	85.8%	85.9%
Māori	97.0%	78.3%

Figure 1: Did the doctors listen to your concerns and views?

3_2 Did the nurses listen to your views and concerns?
When asked "Did the nurses listen to your views and concerns?" 83.7% of Waitematā DHB's respondents selected *Yes, always*. 14.4% stated *Sometimes*, and 1.9% chose *No*.

In the prior survey period, a similar proportion of respondents (83.4%) at Waitematā DHB said *Yes, always*.

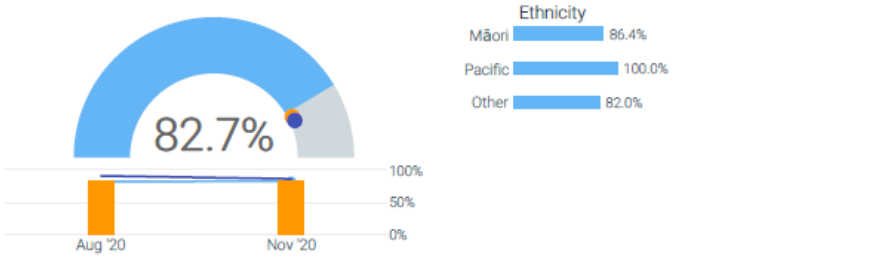


	Aug '20	Nov '20
Waitematā DHB	83.4%	83.7%
National	84.5%	84.6%
Māori	91.2%	87.0%

Figure 2: Did the nurses listen to your concerns and views?

3_3 Did the other members of your health care team listen to your views and concerns?
All patients were asked "Did the other members of your health care team listen to your views and concerns?" 82.7% of Waitematā DHB's respondents chose *Yes, always*. 14.6% chose *Sometimes*, and 2.6% chose *No*.

In the prior survey period, a similar proportion of respondents (82.2%) at Waitematā DHB chose *Yes, always*.



	Aug '20	Nov '20
Waitematā DHB	82.2%	82.7%
National	83.7%	84.9%
Māori	91.2%	86.4%

Figure 3: Did the other members of your health team listen to your concerns and views?

6.1.2 Friends and Family Test

ADULT SURVEY

In February, the Net Promoter Score (NPS) was 80 with feedback from 698 people. The NPS scores is above the DHB target of 65, however, the number of responses remains low (previously we consistently received over 1000 responses a month). 'Welcoming and friendly' and 'treated with compassion' are our highest performers achieving 87 and 86 respectively. This month, 'listened to' achieved its highest score to date of 83. 'Explaining things in a way the patient understands' is identified in the survey as needing improvement.

Friends and Family Test Overall Results

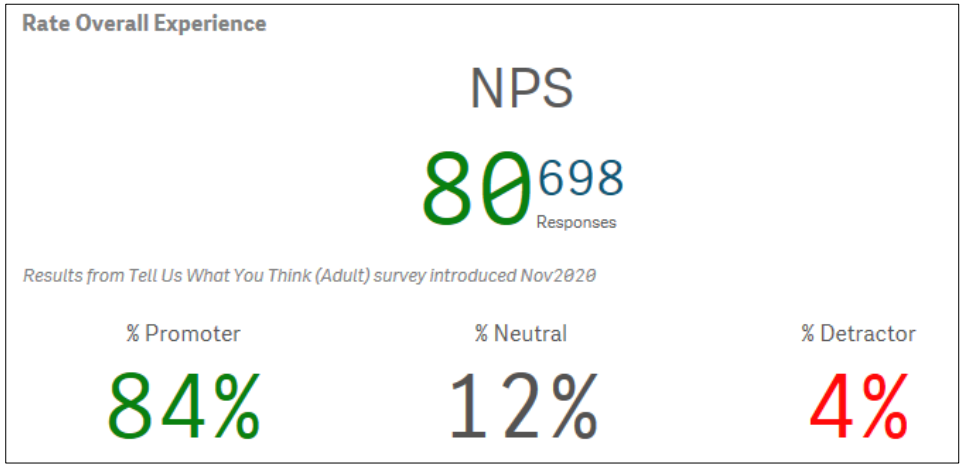
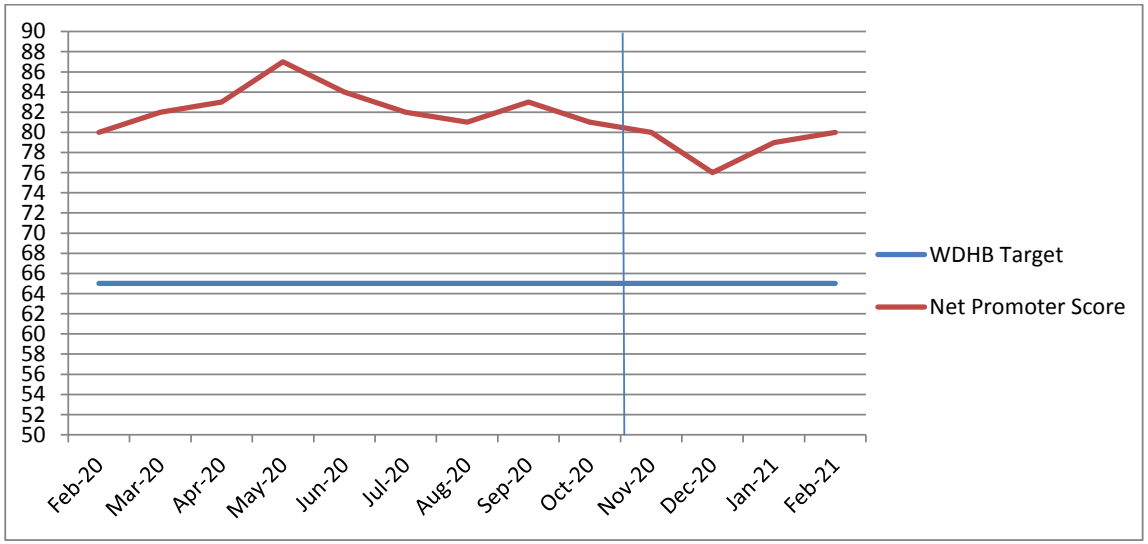


Figure 4: Waitematā DHB overall NPS

Pt Experience by Service

Month & Year	Surveys	Rate Overall Experience	Welcoming and Friendly	Listened To	Treated with Compassion	Involved in Decision Making	Explained in a Way I Understood
Totals	**698**	**80**	**87**	**83**	**86**	**78**	**72**
Feb-2021	698	80	87	83	86	78	72

Table 1: Waitematā DHB overall FFT results



Graph 1: Waitematā DHB Net Promoter Score over time

Total Responses and NPS to Friends and Family Test by ethnicity

Feb 2021	NZ European	Māori	Asian	Pacific	Other/ European
Responses	443	44	76	26*	109
NPS	81	66	79	62	84

Table 2: NPS by ethnicity
*low base size, interpret with care

In February, all ethnicities with the exception of Pacific met the Waitematā DHB NPS target and score 65 and above. Other/Europeam achieved the highest NPS score of 84, up by six points from the prior month.

February 2021	NZ European	Māori	Asian	Pacific	Other/ European
Staff were welcoming and friendly	90	75	77	79	91
I was listened to	85	75	78	68	84
I was treated with compassion	88	75	79	79	87
I was involved in decision making	78	60	79	63	84
My condition/treatment was explained in a way that I understood	78	68	52	61	72

Table 3: NPS for all questions by ethnicity

This month, most measures score at or above the DHB target. The highest NPS scores were from Other/European and NZ European for 'welcoming and friendly' achieving scores of 91 and 90 respectively. The lowest performing measures are 'involvement in decision making' and 'condition/treatment explained in a way that was understood'.

Friends and Family Test Comments

- "*I realised it had not been easy for me and for you but I couldn't fault your service on anything. It's a pleasure dealing with you all. I just want to give you all a big hug for adapting to me .*" ***Allied Health EDARS***
- *"Amazing well run and great team. I was treated with respect and compassion in this ward and I am so grateful."* ***Ward 7, NSH***
- *"For the friendliness and courtesy that I have received, but above all the thoroughness of investigation, and unfailing patience, my appreciative thanks.."* ***Assessment and Diagnostic Unit, WTH***
- *"Friendly staff that keep me informed and feeling safe and comfortable during an emotional time."* ***Wilson Centre***
- *"Staff and doctors always timely, friendly and professional."* ***Outpatients, Waitakere Hospital***
- *"Well cared for, prompt attention and great staff, kind and caring."* ***Ward 3, NSH***
- *"Son attended first time by himself, he was very happy and comfortable. I received a note saying what treatment had been done and a summary of his appointment."* ***Henderson Intermediate, ARDS***
- *"Because you have tried to help, you have listened to us and we have had a conversation about what our problems are and how you can help."* ***Allied Health Community Adults West***
- *"A big grateful thank you to the doctor, nurses, lab staff, service staff, orderlies. Staff are very efficient and courteous, warm and welcoming. I have a heart condition and have been here often for years. I always feel safe and cared for. Thank you, I am very grateful.* ***Huia Ward, WTH***

Friends and Family Test by ward

		February 2021	
Division	**Ward**	**Responses**	**NPS**
AH	Allied Health Community Adults North	7	86
AH	Allied Health Community Adults Rodney	5	100
AH	Allied Health Community Adults West	6	100
AH	Allied Health Early Discharge and Rehabilitation Service (EDARS)	12	67
AH	Allied Health Outpatients Physiotherapy Waitakere Hospital	1	100
A&EM	North Shore Hospital Assessment and Diagnostic Unit (ADU)	30	53
SMHOP	North Shore Hospital Gastroenterology	8	88
S&AS	North Shore Hospital Hine Ora Ward	3	67
A&EM	North Shore Hospital Hyperbaric Unit	6	100
A&EM	North Shore Hospital Lakeview Cardiology (LCC)	49	96
CWF	North Shore Hospital Maternity Unit	75	80
S&AS	North Shore Hospital Outpatients	12	83
CWF	North Shore Hospital Outpatients Women's Health	9	100
S&AS	North Shore Hospital Radiology	18	89

CWF	North Shore Hospital Special Care Baby Unit (SCBU)	10	60
A&EM	North Shore Hospital Ward 2	4	50
A&EM	North Shore Hospital Ward 3	4	100
S&AS	North Shore Hospital Ward 4	23	83
A&EM	North Shore Hospital Ward 6	14	79
S&AS	North Shore Hospital Ward 7	10	100
S&AS	North Shore Hospital Ward 8	20	70
S&AS	North Shore Hospital Ward 9	24	96
A&EM	North Shore Hospital Ward 10	14	93
A&EM	North Shore Hospital Ward 11	19	89
SMHOP	North Shore Hospital Ward 14	1	100
CWF	Wilson Centre	7	71
A&EM	Waitakere Hospital Assessment and Diagnostic Unit (ADU)	24	75
A&EM	Waitakere Hospital Huia Ward	18	78
SMHOP	Waitakere Hospital Muriwai Ward	7	71
S&AS	Waitakere Hospital Outpatients Mains	11	55
S&AS	Waitakere Hospital Outpatients Reception	1	0
S&AS	Waitakere Hospital Outpatients Reception 1	16	19
CWF	Waitakere Hospital Rangatira Ward	2	100
CWF	Waitakere Hospital Special Care Baby Unit (SCBU)	9	33
S&AS	Waitakere Hospital Surgical Unit	52	96

Table 4: FFT results by ward

Key for above table 4:
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 February, only 37% of wards and services met their response targets. Of these wards/services, 85% scored at or above the Waitematā DHB target. Three wards achieved an NPS score of 96, these are the Surgical Unit at Waitakere Hospital and Lakeview Cardiology and Ward 9 at North Shore Hospital (see table below). The main reasons for these positive scores include great staff (kind, caring, friendly, professional, empathetic and efficient), good food and great communication (listened to, good explanations and well informed).

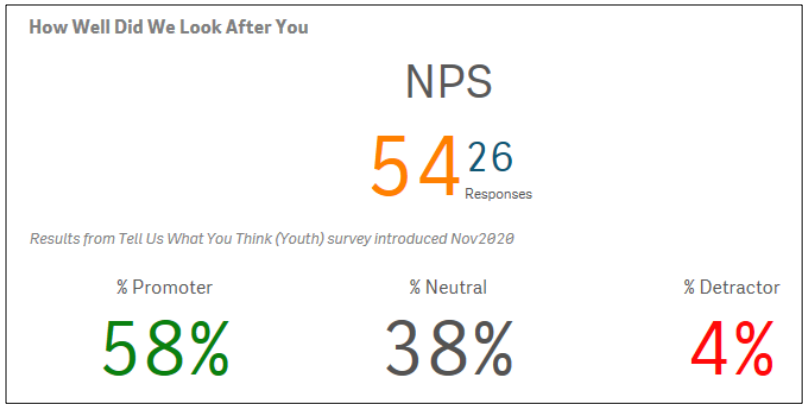
This month, the lowest NPS scores are for Assessment and Diagnostic Unit (ADU) and Special Care Baby Unit (SCBU) at North Shore Hospital. Key issues include long wait times and poor communication in ADU and a lack of space/feeling crammed in SCBU.

A summary of the FFT results can be seen below.

Ward/Service – Exceptional NPS	Target Responses	Achieved	NPS Score
Surgical Unit, Waitakere Hospital	20	52	96
Lakeview Cardiology, North Shore Hospital	10	49	96
Ward 9, North Shore Hospital	20	24	96
Ward/Service – Low NPS	**Target Responses**	**Achieved**	**NPS Score**
Assessment and Diagnostic Unit, North Shore Hospital	20	30	53
Special Care Baby Unit, North Shore Hospital	10	10	60

Table 5: FFT Results Summary

CHILD and YOUTH SURVEY
In February, the Net Promoter Score (NPS) was 54 with feedback from 26 people.



Child and Youth Friends & Family Test Overall Results

Nov 2020 to Feb 21 (4 months)	Surveys	How Well Did We Look After You	We Were Friendly	We Listened to You	We Told You Our Names	You Understood What Was Happening
ARDS Botany	12*	100	100	90	73	56
ARDS Glenfield	24*	75	89	80	57	73
ARDS Henderson Intermediate	27*	85	90	90	67	55
Child Rehabilitation Service	2*	50	100	100	100	-50

New Lynn Paediatric Outpatient Clinic	16*	63	81	81	81	81
NSH Paediatric Outpatient Clinic	25*	48	48	56	36	24
Whanāu Centre Paediatric Outpatient Clinic	69	99	100	97	84	96
Wilson Centre	3*	100	100	67	67	0

*Caution: low base sizes, interpret with care

Table 6: Child and Youth FFT Results Summary

With the exception of Whanau Centre Paediatric Outpatient Clinic, response rates are still low and therefore results are indicative only. The Whānau Centre Paediatric Outpatient Clinic continues to perform well for all measures scoring well above our DHB target of 65. For the other services, whilst many score above the DHB target of 65, there are areas for improvement including staff telling patients their names and explaining what is happening in a way that children understand. The feedback also identified the improvements needed across all measiures at the Paediatric Outpatient Clinic at North Shore Hospital.

Child and Youth Friends and Family Test Comments

- *"Staff were friendly and welcoming and made the experience for us easy."* ***New Lynn Paediatric Outpatient Clinic***
- *"Good, because they made sure I was okay."* ***ARDS, Henderson Intermediate***
- *"Explained in a way I could understand."* ***North Shore Paediatric Outpatient Clinic***

6.2 Patient Experience Activity Highlights

Consumer Council Update & Highlights

The Consumer Council met on February 2nd 2021. They discussed the following agenda items at their most recent meeting:

- **COVID-19 and plans to address service impacts**
- **Consumer Council – Selection, appointment and re-appointment process**
- **Consumer Engagement for Future Facilities Design**
- **Patient Experience Report**

The Consumer Council had a strategy session in late January to review the current strategy set in early 2020 (pre-COVID-19) and updated the strategy to reflect current issues. They also discussed and agreed the self-assessment process for the Consumer Engagement Quality Safety Marker and agreed a process for Community and Youth Engagement (North Shore and Rodney Areas) that is currently not covered in the membership of the council.

Patient Experience Highlights

- Te Taura Whiri Te Reo Maori (Maori Language commission) has gifted Aotearoa NZ's Nurse Practitioners (NPs) a Maori language title - "Mātanga Tapuhi - meaning "expert nurse".
- Roll out of new signage in Emergency Department at Waitakere Hospital to promote Tikanga Best Practice awareness
- Trial of palliative care packs for whānau who are supporting loved ones at end of life in partnership with the Hospital Auxiliary volunteers. They have made 50 packs which have been delivered to some of our medical wards at Waitakere Hospital.

Volunteer Recruitment Statistics

Volunteer number has decreased by fourteen compared to previous report. About twelve students from Westlake High School have resigned as they will be starting university. We continue to experience fluctuations with volunteer numbers due to the interruptions caused by National Alert Level changes.

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)
48	112	0	160

Table 7: Volunteers Recruitment

New Volunteer Initiative – Meaningful Messages

Emily, the St John youth leader of the year 2020 contacted Waitemata DHB in January 2020 to talk about and introduce her community care initiative named "Meaningful messages". Her project consists of St John cadets writing personal letters to long-stay hospital patients. The aim is to improve patient comfort and well-being while in our care. Despite challenges and delays caused by COVID-19, the project was successfully trialled 18 December 2020. Two St John cadets aged 17 and 15 delivered over 100 written letters (pictured below) to our patients and their whānau in ward 14 and ward 15.


Dear friend
You are Beautiful!
Hope you get better soon!
We love you!
from Daniel


WARD 15
WARD 14
EXIT
ST JOHN
YOUTH

Waitematā District Health Board
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Appendix 1

Waitemata DHB Infection Prevention and Control
January 2021

Highlight:
Increase in SAB rate in January 0.25 /1000 OBD against the target of ≤0.13 (see report)

1. Hospital Acquired Bloodstream Infections

Table 1: Monthly HABSI rate (per 1000 bed days) at WDHB 2021

2021	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov
Total No. HABSI	6										
Rates/1000 Bed Days	0.25										

Table 2: HABSI cases January 2021

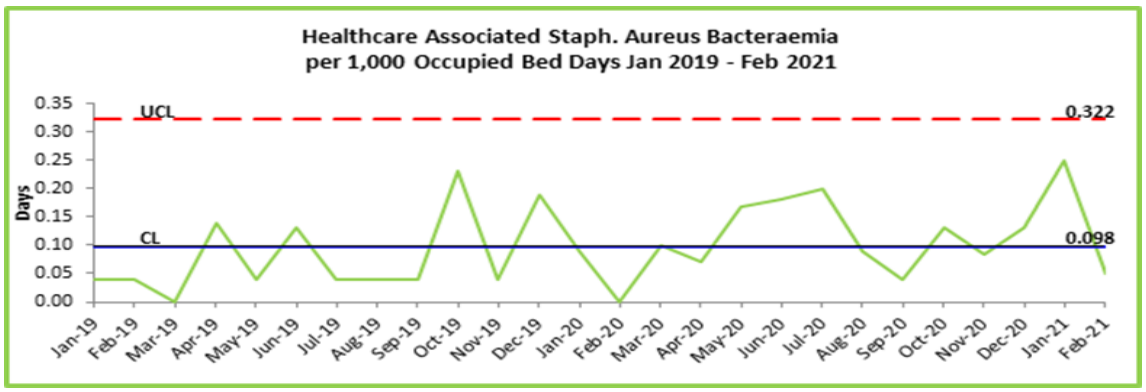
Source	Total	Ward	Organism	Comments
IVL	1	4	MRSA	Know MRSA colonisation. Developed MRSA bacteraemia secondary to IVL Secondary to IVL Root cause findings IVL inserted in ACF. Good documentation in E vitals of VIP scoring. IVL was removed in timely manner
Other	3	Ward 7 Ward 4 Muriwai	Staph aureus PAER E coli	Wound infection from surgery performed at CMDHB Whipples procedure performed , patient developed abscess postoperatively Urosepsis. No IDC insitu
Unknown	2	Ward 14 ICU	Candida Albicans Staph aureus	Unable to identify source, patient was immunocompromised and had history of recurrent thrush due to long term steroids intake Unable to identify source of SAB

2. Staph Aureus Bacteraemia

Surveillance for S.aureus HCA-BSI is a requirement from Health Quality and Safety Commission as a quality indicator and outcome measure for hand hygiene. This includes both HABSI and HCA-BSI caused by S.aureus

Bacteraemia Definitions	
Hospital Acquired BSI (HABSI)	Positive blood culture greater than 48hours after admission, procedure in last 48 hours, previous admission in last 48 hours.
Healthcare Associated BSI (HCA)	Occurred with 48 hours of admission from patients that had procedure in last 30 days from WDHB or not admitted, outpatient receiving treatment from WDHB, include dialysis and home dialysis patients.

Overall increase in SAB rate in January 0.25 /1000 OBD against *the target of ≤0.13*



Source	Defination	Ward/Unit	Comments
AV Fistula	HCA	NSH Renal OPD Haemodialysis	End stage renal disease. Previous AV fistula related SAB in 2020. Recurrent AV fistula infections
AV Fistula	HCA	WTH Satellite Haemodialysis	End stage renal disease. High staph aureus carrier from nasal swab and leg ulcer
Tunnel Line	HCA	Community Dialysis Centre (CDC)	End stage kidney disease. Receives Renal dialysis in community 3/7. Nasal swabs colonised with staph aureus
Unknown	HABSI	ICU	As per ID physician unable to identify source of bacteraemia as patient had several devices insitu
Wound –SSI	HABSI	Ward 7	Post op spinal infection. L2/3 protrusion of vertebral disc with stenosis performed CMDHB December 2020
IVL	HABSI	Ward 4	Patient with know MRSA colonisation developed thrombophlebitis. IVL was removed in timely manner as per VIP scoring. RCA - recommend decolonisation treatment for MRSA carriers

Renal Services Quality Improvement Strategies to reduce Line related infections

- **ANTT8** – Clinical staff must ensure they are using the ANTT8 framework to deliver care;
- **ANTT8 Audit** Findings – we are falling down on our audit of **Moments 5 & 7**: i) clinical staff are reminded of the importance of **scrubbing key sites for 15-20 seconds**; ii) and allowing **air-drying of key sites** before connection;
- HD staff please ensure that patients are receiving regular guidance and advice during these warmer summer days about TL etiquette – please consider using the **new dialysis access patient information leaflets** to support the information you are giving;
- Lyndell has kindly agreed to take on coordination of presenting the new short video at NSDC for all new patients to the service, but all staff are encouraged to share the resource with their patients - https://vimeo.com/475331677
- It would also be valuable if NSDC staff and CDC staff **broadcast the video on the waiting room televisions**

- For clinical staff caring for patients it is vital that a **thorough assessment of the TL exit site / dressing** is undertaken according to service polic

3. Extended spectrum Beta lactamase producing bacteria (ESBL)

The overall hospital acquired ESBL (HA-ESBL) rates remain low at both NSH and WTH.
5/6 HA ESBL was captured as a result of late screening. 3 of these were E coli, 2 KP and 1 other organism

TABLE: HA-ESBL rates/number at WDHB

HA-ESBL rate/10,000 bed days (number)	**2020 rate: 3.1 (87)**	**2021**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**	**Nov**
		NSH	3.6 (6)										
		WTH	4.1 (3)										

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Appendix 2

Waitemata DHB Infection Prevention and Control February 2021

Highlight:
Reduction in SAB for February n=1, 0.04 /1000 OBD compared to January n=6 0.25/1000 OBD

1. Hospital Acquired Bloodstream Infections

Table 1: Monthly HABSI rate (per 1000 bed days) at WDHB 2021

2021	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov
Total No. HABSI	6	9									
Rates/1000 Bed Days	0.25	0.43									

Table 2: HABSI cases February 2021

Source	Total	Ward	Organism	Comments
CLAB	1	Ward 2	Pantoea agglomerans	Patient with previous SAB and end stage renal failure. Bacteraemia secondary to femoral line confirmed by ID Physician Line was not removed as patient was awaiting permanent Tunnel line insertion
IVL	1	Ward 2	Staphylococcus epidermidis	IVL related cellulitis over left dorsum. RCA findings inconsistent documentation on maintenance of IVL in in e-vitals. IP&C. IP&C CNS working with wards and departments to improve IVL insertion and maintenance. IP&C Q I project planned to reduce IVL infection RCA findings - Poor compliance with CLAB bundle
CAUTI	1	Ward 6	Pseudomonas aeruginosa	Indication for IDC was appropriate for fluid monitoring. Prolonged duration of IDC and neutropenic sepsis was contributing factor for patient developing CAUTI.
Other	5	Ward 8 Ward 14 Ward 6 Ward 5 Titirangi	Escherichia coli Staphylococcus aureus Escherichia coli Escherichia coli Klebsiella pneumoniae	Developed BSI post washout of perforated appendix SA isolated from heel wound. Patient with end stage renal failure developed urosepsis Patient with history of recurrent UTI developed urosepsis Patient has previous KP UTI whist inpatient in ADHB
Unknown	1	Ward 10	Bacteroides thetaiotaomicron	Like malignant partially obstructing tumour in descending colon

3. Extended spectrum Beta lactamase producing bacteria (ESBL)

The overall hospital acquired ESBL (HA-ESBL) rates remain low for both NSH and WTH.

TABLE: HA-ESBL rates/number at WDHB

		2021	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov
HA-ESBL rate/10,000 bed days (number)	**2020 rate: 3.1 (87)**	**NSH**	3.6 (6)	2.7 (4)									
		WTH	4.1 (3)	3.1 (2)									

Appendix 3

Waitemata District Health Board

Best Care for Everyone

Monthly Hand Hygiene Report: January 2021

Highlights:

- One of the cornerstones of preventing the spread of COVID 19 is **hand washing**
- Well done to everyone in the DHB as every dept who submitted data has recorded above 80% compliance!

The overall Waitemata DHB hand hygiene compliance for the month of Jan 2021 91.3%

KEEP UP THE GOOD WORK

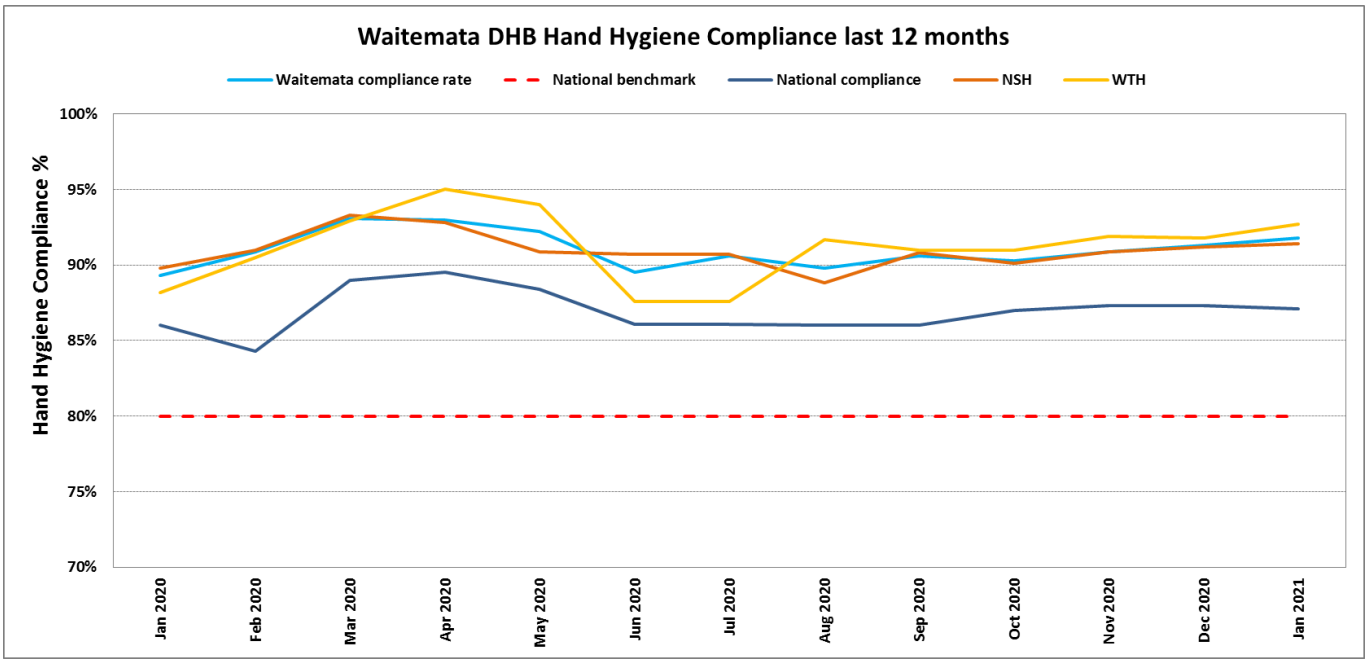

Table 1:Overall Waitemata DHB hand hygiene compliance by facility.

Name	Correct Moments	Total Moments	Compliance Rate
Waitemata DHB	4228	4608	91.8%
Elective Surgery Centre	294	328	89.6%
North Shore Hospital	2352	2574	91.4%
Waitakere Hospital	1582	1706	92.7%
Specialist Mental Health and Addictions	212	214	99.1%
Wilson Centre	50	57	87.7%

All Gold Auditors and Charge Nurses now have logins to be able their own data - It is recommended that the department reports are printed and publically displayed in each department's quality board.

Monthly Hand Hygiene Report: January 2021

Table 2: Overall Waitemata DHB hand hygiene compliance by HCW type

	Name	Correct moments	Total moments	Compliance rate
1	Nurse/Midwife	2398	2551	94%
2	Medical Practitioner	503	591	85.1%
3	Allied Health Care Worker	201	215	93.5%
4	Phlebotomy Invasive Technician	213	243	87.7%
5	Health Care Assistant	491	522	94.1%
6	Cleaner & Meal staff	164	173	94.8%
7	Administrative and Clerical Staff	20	23	87%
8	Student Doctor	12	14	85.7%
9	Other - Orderly & Not Categorised Elsewhere	214	260	82.3%
10	Student Allied Health	N/A	N/A	N/A
11	Student Nurse/Midwife	12	16	75%

Table 3:Overall Waitemata DHB hand hygiene compliance by moment.

	Correct moments	Total moments	Compliance rate
1 - Before Touching A Patient	1224	1382	88.6%
2 - Before Procedure	482	521	92.5%
3 - After a Procedure or Body Fluid Exposure Risk	551	577	95.5%
4 - After Touching a Patient	1286	1353	95%
5 - After Touching A Patient's Surroundings	685	775	88.4%

Areas which did not meet the national standard of 80%:

Ward/Area	Compliance Rate **JAN 21**	Compliance for previous 3 months	Comments

All Gold Auditors and Charge Nurses now have logins to be able their own data - It is recommended that the department reports are printed and publically displayed in each department's quality board.

Monthly Hand Hygiene Report: January 2021

National Requirements for the Hand Hygiene Program :

As part of the hand hygiene (HH) program managed by the health quality safety commission (HQSC), we are required to validate our HH audit data. The auditing process and schedule for Northshore and Waitakere hospital are available.

In addition the HQSC requires that all Gold Auditors complete annual online validation training – emails have been sent regarding the process for this.

Number of moments required by clinical units

- Inpatient medical, surgical, radiology, endoscopy, maternity, paediatric units **= 100 moments per month**
- Outpatient units (including outpatient Haemodialysis and Haematology units), Wilson Centre, Hine Ora, CVU, interventional radiology NSH (AIR) **= 50 moments per month**
- Inpatient mental health / detox units, hyperbaric unit **= 25 moments per month.**

Hand hygiene auditor training for 2020

All training for 2020 has now been completed. Dates for 2021 below:

Hand Hygiene Gold Auditor Training Workshop

Date	Time	Room	Capacity	Status	Options
2 February 2021	8:00 AM - 4:00 PM	Waitemata DHB: Manuka Room, Ground Floor, Whenua Pupuke, North Shore Hospital (Room details)	3 / 25	Booking open	Attendees Sign-up
12 May 2021	8:00 AM - 4:00 PM	Waitemata DHB: Manuka Room, Ground Floor, Whenua Pupuke, North Shore Hospital (Room details)	1 / 25	Booking open	Attendees Sign-up
5 August 2021	8:00 AM - 4:00 PM	Waitemata DHB: Manuka Room, Ground Floor, Whenua Pupuke, North Shore Hospital (Room details)	0 / 25	Booking open	Attendees Sign-up
18 October 2021	8:00 AM - 4:00 PM	Waitemata DHB: Harakeke Room, Ground Floor, Whenua Pupuke, North Shore Hospital (Room details)	0 / 25	Booking open	Attendees Sign-up

All Gold Auditors and Charge Nurses now have logins to be able their own data - It is recommended that the department reports are printed and publically displayed in each department's quality board.

Appendix 4

Monthly Hand Hygiene Report: February 2021

Highlights:

- One of the cornerstones of preventing the spread of COVID 19 is **hand washing**

The overall Waitemata DHB hand hygiene compliance for the month of Feb 2021 91.2%

KEEP UP THE GOOD WORK

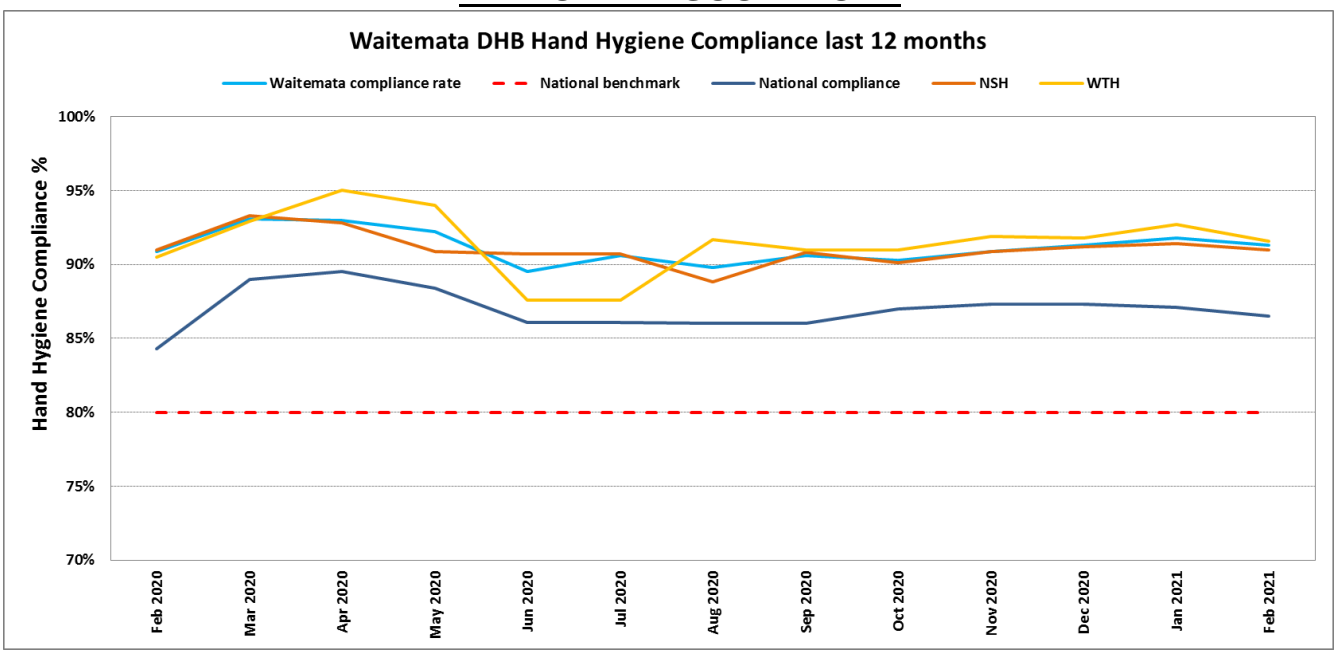

Table 1:Overall Waitemata DHB hand hygiene compliance by facility.

Name	Correct Moments	Total Moments	Compliance Rate
Waitemata DHB	4168	4576	91.2%
Elective Surgery Centre	256	289	88.6%
North Shore Hospital	2541	2791	91.2%
Waitakere Hospital	1371	1496	91.6%
Specialist Mental Health and Addictions	186	215	86.5^
Wilson Centre	45	51	88.2%

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Monthly Hand Hygiene Report: February 2021

Table 2: Overall Waitemata DHB hand hygiene compliance by HCW type

	Name	Correct moments	Total moments	Compliance rate
1	Nurse/Midwife	2330	2502	93.1%
2	Medical Practitioner	540	637	84.8%
3	Allied Health Care Worker	233	253	92.1%
4	Phlebotomy Invasive Technician	161	173	93.1%
5	Health Care Assistant	488	539	90.5%
6	Cleaner & Meal staff	161	172	93.6%
7	Administrative and Clerical Staff	20	20	100%
8	Student Doctor	17	20	85%
9	Other - Orderly & Not Categorised Elsewhere	225	261	86.2%
10	Student Allied Health	8	6	100%
11	Student Nurse/Midwife	60	69	87%

Table 3:Overall Waitemata DHB hand hygiene compliance by moment.

	Correct moments	Total moments	Compliance rate
1 - Before Touching A Patient	1274	1445	88.2%
2 - Before Procedure	497	524	94.8%
3 - After a Procedure or Body Fluid Exposure Risk	578	607	95.2%
4 - After Touching a Patient	1241	1339	92.7%
5 - After Touching A Patient's Surroundings	653	739	88.4%

Areas which did not meet the national standard of 80%:

Ward/Area	Compliance Rate **FEB 21**	Compliance for previous 3 months	Comments
ED NSH	67%	Jan21 85% Dec20 98.4% Nov20 95.7%	Only **21** moments submitted
Theatre NSH	78%	Jan21 89.5% Dec20 82.6% Nov20 86.4%	**83** moments submitted
Anawhata WTK	74%	Jan21 83.7% Dec20 85.4% Nov20 89.7%	Only **19** moments submitted

All Gold Auditors and Charge Nurses now have logins to be able their own data - It is recommended that the department reports are printed and publically displayed in each department's quality board.

Monthly Hand Hygiene Report: February 2021

National Requirements for the Hand Hygiene Program :

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18 October 2021	8:00 AM - 4:00 PM	Waitemata DHB: Harakeke Room, Ground Floor, Whenua Pupuke, North Shore Hospital (Room details)	0 / 25	Booking open	Attendees Sign-up

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5.1 Auckland and Waitematā DHB Joint DNA Strategy (July 2016) Update

Recommendation:

That the Hospital Advisory Committee:

a) **Notes Waitematā DHB's Planned Care Services 2020 – 2023 Three- Year Plan strategically aligns to the Joint DNA Strategy July 2016.**
b) **Notes that work across the nine Joint DNA Strategy is ongoing within the Waitematā DHB as we progress to meet our commitment to creating a health partnership pathway with Māori and reduce Pacific health inequities for the Waitematā population.**
c) **Notes that changes to the Ministry of Health (MoH) Planned Care Programme will assist and support the DHB to reduce DNA inequities by supporting greater flexibility in care deliver models.**

Prepared by: Alison Bowden (Electives and Outpatient Service Manager)
Endorsed by: Mark Shepherd (Director Provider Healthcare Services)

Glossary

DNA – Did Not Attend
HAC – Health Advisory Committee
PFB – Patient Focused Booking
FSA – First Specialist Appointment
PSC – Patient Service Centre
ESPI – Elective Services Patient Flow Indicators
PNC – Peri-operative Nurse Co-ordinator

1. Executive Summary

This report will provide an update with Waitematā DHB's progress against the Joint DNA Strategy with Auckland DHB, which was released in July 2016. The Health Advisory Committee (HAC) requested an update at a meeting in September 2020.

The overarching recommendation of the 2016 joint paper, "Endorse a joint DHB explicit DNA policy addressing measurement, monitoring and management with an equity (partnership) focus". This policy fits with both organisations' themes of patient, community and whānau-centred care.

The report identifies the strategies implemented and partially implemented to date and those planned to be implemented in relationship to the 2016 DNA Strategy report.

DNA reduction aligned to partnership and equity remains a clear focus for Waitematā DHB and is identified within our recently developed Planned Care Services 2020 – 2023 Three-Year Plan, with a vision statement of

"New Zealanders experience timely, appropriate access to quality Planned Care which achieves equitable outcomes".

Focused work across the DHB has continued since the 2016 report to improve our systems and processes to support equitable delivery of care for the Māori and Pacific population who live within the Waitemata domicile. There remains significant challenges and work required to fully meet our obligations to reduce DNA rates and offer health partnership, accessibility of service and equity.

2. Strategic Alignment

As stated in the Planned Care Services 2020 – 2023 Three-Year Plan "Waitematā DHB is committed to the promotion of wellness and the relief of suffering among all who use our services. Our planning and delivery of healthcare to our community supports our organisational promise to deliver "best care for everyone", with a focus on reducing health inequalities." The overarching principles of Planned Care are Equity, Access, Quality, Timeliness and Experience. These principles clearly align with the Joint DNA strategy demonstrating similar strategic themes and values. The new direction of Planned Care Services will enhance the DHB's ability to support and provide a partnership with our Māori patients while working with our Pacific patients to ensure equitable and timely access to care in the most appropriate setting. Improved flexibility in care delivery will allow better scope to meet the needs of our most vulnerable and improve inequities.

Community, whanau and patient centred model of care	MoH Planned Care expanded definition will enable changes to current care delivery models allowing for greater flexibility to meet community and whanau needs.
Emphasis and investment on both treatment and keeping people healthy	Reduction in DNA's will ensure that the wider community population receive timely, quality care to maximise health benefits and improved outcomes
Evidence informed decision making and practice	Working in partnership with our Māori and Pacific health teams will allow for informed decisions and appropriate introduction of improved equitable care delivery
Outward focus and flexible, service orientation	Ability to change service delivery models to be more flexible, community focused and based will support equity, access and improve patient experience

3. Introduction/Background

The original paper identified ten framework elements with a list for recommended high impact activities associated with them. The project team considered that all activities are required to achieve a comprehensive approach to reducing inequalities in DNA rates.

Table 3. Summary of prioritised recommendations for 'roadmap' of activities, prioritised by impact and resource

Overarching recommendation	
1. Endorse a joint DHB explicit DNA policy addressing measurement, monitoring and management with an equity focus.	
High impact, high resource	**Quick wins or lower resource**
2. Implement Patient Focused Bookings. 3. Create a tailored DNA Navigation Service. 4. Accelerate the development of clinically appropriate alternate delivery approaches, and systematically offer these to patients. This includes a requirement to determine the medical value/necessity of an appointment. 5. Conduct health literacy review of standard letters and service specific letters; develop standardised transport/parking and wayfinding (map) information.	6. Ensure standardised and optimised text reminder across all services. 7. Resolve the issues limiting use of email as a contact modality for appointments. 8. Mandate cultural competence/CALD training for booking and scheduling staff (in Patient Service Centre and services who book their own clinics). 9. Review and optimise cultural competence component and assessment of welcoming values in Human Resource processes for booking and scheduling positions.

4. Progress/Achievements/Activity

Key:
Red – not achieved. If the element has been mostly not achieved it has been coded as red even if a small amount of progress is evident
Amber – not achieved but progress made. Assumes most services have made some progress.
Green – achieved but outcomes unclear

	Overarching recommendation	WDHB
1	Endorse a joint DHB explicit DNA policy addressing measurement, monitoring and management with an equity focus. *Overarching Equity Plan (specific details identified in activities 2 - 9 below):* • *Complete an in-depth review of the DNA status of each service breaking the DNA rates down to identify First Specialist Appointment (FSA), Follow up and Procedure percentages for each specialty and clinical group, (Consultants, Fellows, Registrar and Nurse led clinics) to allow for a targeted approach for the casual factors to be identified for Māori and Pacific patients within each of the subspecialty groups. (Complete by March 2021)* • *Seek support from the Māori and Pacific health teams to develop the most appropriate strategy for each patient group. Include Māori and Pacific leaders identifying the key connections that are needed to make these processes effective for Māori and Pacific patients; a tailored service based on these principles. (Initial forum - April 2021)* • *DNA data for Māori and Pacific groups will be reported and reviewed at Operations Manager / General Manager monthly forums. (Ongoing)* • *Leadership is critical to bringing people along on the equity journey - provide leadership support and training to influence change (Work with HR)*	

	• *Identify equity champions within each service to support and direct the strategy within their teams. (April 2021)* • *MoH Sustainability Funding secured to pilot a test of change for a Patient Centred Care Coordination (Navigation) service identifying Māori patients with first diagnosis of CHF and Bariatric Surgery. (Initial work underway)* • *Engage consumers and health literacy groups to review current communication methods and redesign them to support culturally appropriate messaging. (June 2021)* • *Investigate text ability to send in alternative languages (March 2021)* • *Continue to work with i3 to develop community based telehealth pod locations.* • *Services work with the Māori Workforce Recruitment Consultant as appropriate and use the resources developed by the Recruitment team to support growing our Māori and Pacific workforce. (Ongoing)*	
High impact, high resource		
2	Implement Patient Focused Bookings (PFB). *In progress* • *A partial introduction of PFB has been completed.* • *Medical Services introduced PFB for First Specialist Appointments (FSA) early 2017 - initial focus, services high DNA inequalities - diabetes, respiratory and cardiology.* • *Further medical specialities have commenced PFB booking since this time.* • *Gynaecology services implemented with MoH funding support in August 2017.* • *Introduction of Digital Post has improved our ability to contact patients as email delivery of letters is more consistently reliable than the postal system due to changes of address.* • *PFB letters are now sent to the verified email address of the patient improving contact with patients who move residential address frequently.* *Sustainable measures identified, yet to be implemented* • *A modified version of PFB is being developed to allow the remaining Patient Service Centre (PSC) services to be able to adopt this methodology. While services capacity is outstripped by demand, PFB methodology is challenging to introduce.* • *To improve and support the partnership with Māori and assist to reduce the inequities for Pacific patients with PFB, send an automated text reminder 10 days post the PTC being sent to request patients to contact us who have yet to do so. (May 2021)* • *A partnership and equity lens can be applied to PFB for Māori and Pacific patients that have not contacted us following the PTC letter being sent. Once the standard contact process has been followed Māori and Pacific patient details would be passed to the DNA Navigation Service to engage the patient.* • *Complete implementation of PFB requires contact centre functionality and Waitematā have no contact centre and very limited customer service functionality within the Patient Service Centre.* • *To support the introduction of a contact centre an upgraded phone system is required.*	
3	Create a tailored DNA Navigation Service. *Tailored DNA Navigation service aims to provide contact management for targeted patients assisting to co-ordinate care with the patient and whanau in a holistic manner.* • *A tailored DNA Navigation Service is identified as an essential element for successful rollout of PFB to ensure partnership with Māori and equity for Pacific patients with this booking methodology as well as the overall sustainability of PFB. Progress with this initiative remains outstanding. Lack of a partnership with Māori and inequities for Pacific patients are demonstrated as DNA rates remain high for First Specialist Appointments (FSA) with PFB.*	

	In progress • *Although a dedicated Tailored DNA navigation service has not been established, surgical services within the PSC have all introduced the Peri-operative Nurse Co-ordinator (PNC) role since 2015 with the focus on high complexity high acuity patient co-ordination. Engaging with Māori and Pacific health teams in the co-ordination of patients is a crucial part of the role.* • *To support equity, both Outpatient and Inpatient DNAs by Māori and Pacific patients can be identified and contacted by the PNC. No funding currently available. Board would need to review and approve Business case.*	
4	Accelerate the development of clinically appropriate alternate delivery approaches, and systematically offer these to patients. This includes a requirement to determine the medical value/necessity of an appointment. *Waitematā has worked across a wide spectrum of services to support this recommendation with many different approaches being taken.* *In progress - examples of this are:* • *The introduction of telehealth accelerated due to lockdown has seen both telephone and video consultations more fully implemented. The next phase in this project is to have community based pods for patients to access allowing for the right technology, privacy and no technology cost implications for the patient. The pods are small inexpensive units allowing greater flexibility of service across a broader range of community locations.* • *Mode of delivery for Outpatient appointments can now be selected within the Patient Management System from grading through to follow up reducing the requirement for all patients to attend face to face appointments. This is a joint patient / clinician decision.* • *Community based service provision for lower complexity presentations have led to the introduction of the GP skin lesion scheme. Diabetes has introduced a drop in clinic allowing patients to present at a time suitable for them with no appointment necessary.* • *Alternative service delivery hours have been introduced in some services with high DNA rates including extended weekday hours and weekend service delivery e.g. Renal, ORL and Gastroenterology.* • *'SOS cards' and Open Contact letters allow patients the ability to contact the DHB for an appointment should the patient have concerns regarding their condition or select an appropriate time that they would be available for their recommended surgical procedure.* *Sustainable measures identified, yet to be implemented* • *Development of Patient Online booking system – Vendor selected*	
5	Improve all communication to patients: Conduct health literacy review of standard letters and service specific letters; develop standardised transport/parking and way finding (map) information. *In 2016, PSC completed a review and standardisation of standard letters. This did not include services outside the PSC sending letters of a variable standard.* *In progress* • *A broader service review of patient communications was completed in 2018 with a standardised approach as part of the dependencies for the introduction of digital post. Digital post has allowed for email communications with those patients who have verified email addresses and for additional patient information to be attached or in the case of paper communications included as a whole package.* • *In addition to this, an outpatient information sheet has been developed in conjunction with cultural support teams, consumer council and the communication team containing information on Waitematā Outpatient locations, transport/parking, way finding and how to make the most of your*	

	visit. *Sustainable measures identified, yet to be implemented* • *Investigating system capability to send letters in alternative languages as per Auckland DHB using language that invites partnership and demonstrates support.* • *Create letter templates with Manaaki symbol, welcoming Māori patients as partners in their health journey*	
Quick wins or lower resource		
6	Ensure standardised and optimised text reminder across all services. *Waitematā has utilised text messages for an extended period of time although messages were variable and information limited.* *In progress* • *At the end of 2019, a review was completed regarding the information contained within text messages and changes were made in line with feedback from Consumer Council, legal and i3. This has significantly improved the content, however, there remains no ability to reply to the message.*	
7	Resolve the issues limiting use of email as a contact modality for appointments *In progress* • *The introduction of Digital Post in 2018 allows for distribution of appointment and reminder letters via email. This service continues to be expanded and volumes continue to increase as the DHB in conjunction with Auckland DHB work on increasing the number of verified email addresses.* • *Trials are currently underway to allow direct email (emailer tool) communication by clinicians with their patients allowing for appropriate instructions, education and information regarding diagnostic conditions both pre appointment and post.*	
8	Mandate cultural competence/CALD training for booking and scheduling staff (in Patient Service Centre and services who book their own clinics). *Mandated cultural competence / CALD training has not been introduced.* *In progress* • *Booking and scheduling staff with the support of managers have access to all Waitematā DHB educational sessions including cultural competence / CALD training which is recorded within the individual staff electronic record.* • *Additional PSC specific training occurs related to customer service, telephone skills and value based sessions, however there remains no formal process to mandate attendance at specific training.*	
9	Review and optimise cultural competence component and assessment of values in HR processes with an initial focus on booking and scheduling positions, followed by clinical positions. *In progress* • *All recruitment within the PSC follows the Waitematā DHB Recruitment service processes and policies.* • *Work with recruitment teams to review current Booking and Scheduling / PNC advertisements and selection processes to ensure we are attracting Māori and Pacific candidates.*	

5. Conclusion

Waitematā have been steadily working towards addressing the Joint DNA Strategy prioritises since the release of the document in 2016, with this focus is clearly gaining momentum. By recognising the significance of this work in relationship to the DHB strategic themes and the core values there are vital pieces of work occurring across multiple work streams to address partnership and equity within our current environment focusing on our patients, whānau, community and the Waitematā DHB workforce.

7. 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 17/02/21	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)]