Waitematā
District Health Board

Best Care for Everyone

HOSPITAL ADVISORY COMMITTEE (HAC) MEETING

Wednesday 23 June 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
23 June 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 David Lui - WDHB Board Member Eru Lyndon - WDHB Board Member Allison Roe – WDHB Board Member Renata Watene - WDHB Board Member Board Observers Wesley Pigg Amber-Paige Ngatai	Mark Shepherd – Executive Director, Hospital Services Robert Paine – Executive Director, Finance People and Planning Jonathan Christiansen – Chief Medical Officer Jocelyn Peach – Director Nursing and Emergency Systems Planner Tamzin Brott – Director Allied Health, Scientific Technical Professions Deanne Manuel – Committee Secretary

APOLOGIES:

AGENDA

DISCLOSURE OF INTERESTS

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

PART I – Items to be considered in public meeting

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

	1.	**AGENDA ORDER AND TIMING**
	2.	**CONFIRMATION OF MINUTES**
1.30pm	2.1	Confirmation of Minutes of Hospital Advisory Committee Meeting (19/05/21) Actions Arising from previous meetings
	3.	**HOSPITAL SERVICES REPORT**
1.35pm	3.1	Hospital Services Report – April
	4.	**CORPORATE REPORTS**
2.00pm	4.1	Clinical Leaders' Report
2.10pm	4.2	Quality Report - April and May
2.20pm	**5.**	**GENERAL BUSINESS**
2.25pm	**6.**	**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	✓	✓	✓					
David Lui								
Eru Lyndon								
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) Appointed Member - New Zealand Chiropractic Board (NZCB) Member– New Zealand Chiropractic Board (NZCB) Professional Conduct Committee (PCC) 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	11/06/21
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
David Lui	Director – Focus on Pacific Limited Board Member – Walsh Trust (MH provider in West Auckland that has contracts with WDHB) Chairman – Henderson High School BOT Executive Member – Waitakere Health Link (holds a contract with WDHB)	22/05/21
Eru Lyndon	Regional Commissioner (employee) - Ministry of Social Development Board member - Advisory Board, University of Auckland Business School Chair, - Waitangi Ltd Director - National Hauora Coalition Trustee - The Lyndon Family Trust	22/04/21
Allison Roe	Acting Chairperson and Deputy Chair Matakana Coast Trail Trust Member, Wilson Home Committee of Management (past role)	07/04/21
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.

2.1 Minutes of the Hospital Advisory Committee meeting held on 19 May 2021

Recommendation:

That the Draft Minutes of the Hospital Advisory Committee meeting held on 19 May 2021 be approved.

Draft Minutes of the meeting of the Waitematā District Health Board

Hospital Advisory Committee

Wednesday, 19 May 2021

held at Boardroom Level 1, 15 Shea Tce Takapuna and by video conference commencing at 10.31am.

PART I – Items considered in public meeting

COMMITTEE MEMBERS PRESENT

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

ALSO PRESENT

David Lui (Board member)
Mark Shepherd (Executive Director, Hospital Services)
Robert Paine (Executive Director, Finance, People and Planning)
Jocelyn Peach (Director of Nursing and Midwifery)
Sharon Russell (Associate Director, Allied Health)
Andrew Old (Associate Chief Medical Officer)
Peta Molloy (Board Secretary)
(Staff members who attended for a particular item are named at the start of the minute for that item.)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

No public and media representatives were present during the meeting.

WELCOME

The Committee Deputy Chair welcomed those present. He noted that rescheduled meeting date to accommodation the Ministry of Health Wānanga Hauora for Board members.

APOLOGIES

There were no apologies received. Prior to the meeting the Committee Chair requested that the Committee Deputy Chair take the meeting as she was joining the meeting via video conference and may not be able to stay for the duration of the meeting.

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 in the agenda.

2. COMMITTEE MINUTES

2.1 Confirmation of the Minutes of the Hospital Advisory Committee Meeting held on 31 March 2021

Resolution (Moved Edward Benson-Cooper/Seconded Allison Roe)

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

Carried

Actions Arising

Updates (page 15 of the agenda) on the matters arising were noted, a verbal update on the regional vascular services was provided as follows:

Regional Vascular Services

Mark Shepherd noted that clinicians across the metro-Auckland region were engaged and a steering group had been established. The steering group aims to achieve a model to centralise the vascular workforce into one roster coordinated across the region. Included in the regional model is where the more complex level of surgery and luminal work occurs; part of the model for Waitematā DHB is to do more complex and luminal work, growing this area over the next 12 months.

In response to discussion on this item, it was noted that:

- Counties Manukau DHB is engaged in the conversation for regional vascular services.
- The vulnerable services committees include representation from Northland DHB.

A further verbal update is to be provided to the Committee on the northern component of the vascular service review.

3. PROVIDER ARM PERFORMANCE REPORT

3.1 Provider Arm Performance Report – February 2021

Executive Summary/Overview

Mark Shepherd (Executive Director, Hospital Services) summarised this section of the report, highlighting the following:

- Noting the two COVID-19 alert level lockdowns during February/early march. During this time the DHB had to stand-up its lockdown processes.
- During the reported period, the first COVID-19 vaccinations commenced with borders and then the DHB staff, which has now been completed. Vaccinations have now moved into the community. Approximately 17,000 vaccinations have been given across the services, with 96 per cent of staff having received one vaccination and 76 per cent two; the residual second dose vaccinations will be given in the community.
- Noting the highlight of the month reported (page 20 of the agenda) "Shifting the balance of care to the community".

Matters covered in discussion and response to questions included:

- ED presentation growth is being seen in category 2 and 3 presentations (there are five triage categories). The voucher system remains in place for patients that can be seen at an urgent care clinic.
- ED is working with mental health services to ensure demand capacity plans are in place. There is a preference to treat mental health clients concurrently with a physical condition and an assessment.
- Noting clinical thresholds. Orthopaedic thresholds, for example, are now the same as Auckland and Counties Manukau DHBs. In response to a question, it was noted that PHOs are aware of the orthopaedic threshold; Andrew Old, in his role as the Chair of the primary secondary interface group for the metro-Auckland DHBs and PHOs, advised the topic has and continues to be discussed.

Human Resources

Fiona McCarthy (Director, People and Culture) was present for this report.

The annual leave update was acknowledged.

In response to a question about staff turnover being a result of the health transition, later in the meeting it was noted and agreed that the 'reasons for leaving' options would be updated to include this as an option for staff who are exiting the DHB.

Acute and Emergency Medicine Division

Mark Shepherd summarised the update provided. Matters covered in discussion and response to questions included:

- Noting the shift in cardiology. The target has previously been high; this is being addressed with the Funder.
- A deep dive into wait times has been undertaken, with three bespoke programmes of work across endoscopy, radiology and outpatients. In brief, endoscopy has been able to reduce Māori DNA rates by half in over the first six-weeks of the programme. The programme is designed to ensure an agile process; patients are encouraged to provide their availability for bookings.
- Community health telepods are being tested, with one in a centre and one in the community. Telepods will give patients an option to attend bookings remotely (when applicable) rather than in person.

- The current appointment text message system does not allow for replies. This is being revised to allow a Yes/No response.
- The UK booking system was referenced (patients can choose and book their preferred date/time).
- i3 has been looking at various booking systems on behalf of the DHB.

Specialty Medicine and Health of Older People Division
Mark Shepherd summarised the update provided, noted the key highlights reported and the work being done in these areas.

Child Women and Family Division
Mark Shepherd summarised the update provided. Matters covered in discussion and response to questions included:

- Noting the oral health update (page 55 of the agenda). There have been significant delays due to COVID-19. It was agreed that looking at other dental authority processes related to COVID-19 would be beneficial to identify alternative processes.
- That work is underway on current and future recruitment for Māori and Pacific undergraduates.

Surgical and Ambulatory Services/Elective Surgical Centre
Mark Shepherd summarised this section of the report.

The Provider Arm report was received.

3.2 Provider Arm Performance Report – March 2021

Robert Paine summarised the summary report for March 2021.

4. CORPORATE REPORTS

4.1 Clinical Leaders' Report (agenda pages 73-85)

Andrew Old (Associate Chief Medical Officer), Jocelyn Peach (Director, Nursing) and Sharon Russell (Associate Director, Allied Health) were present by for this item

Medical Staff

Andrew Old presented this section, noting the reported highlights.

In response to a question, it was noted that community placements are relatively new with a process of gradually increasing the placements year-on-year.

The Health Workforce NZ funding for training (page 84 of the agenda) and whether it will be put on hold with the Health Reform was queried, in response it was noted that current funding will continue.

Allied Health, Scientific and Technical Professions

Sharon Russell summarised this section of the report. Matters covered in discussion and response to questions included:

- Work is underway to visit secondary schools to promote the Allied Health, Scientific and Technical Professions. At this time, speech and language therapists are visiting two high schools in West Auckland. The Committee requested more information on this programme of work as it develops.

Nursing and Midwifery and Emergency Planning Systems

Dr Jocelyn Peach (Chief Nursing Officer and Emergency Systems Planner) was present for this section of the report.

Matters covered in discussion and response to questions included:

- In reference to Māori and Pacific Health Service Assistants (page 91 of the agenda), it was noted that there is a recruitment programme that is run three times per year to engage with people who would consider a career in health. There are currently recruitment/retention pressures with international opportunities available.
- Noting that workforce modelling is underway.
- The recruitment strategy will be presented to the Committee at its next meeting.

The report was received

4.2 Quality Report – January and February (agenda pages 84-131)

Jacky Bush (Quality and Risk Manager), Penny Andrew (Executive Director, Innovation and Improvement) and David Price (Director Patient Experience) were present for this section of the report.

Matters covered in discussion and response to questions included:

- Noting that the Wards manage the Friends and Family test survey and do not necessarily target Māori or Pacific patients/whanau. It is also up to a patient to participate in the survey. To engage with Māori and Pacific patients, the best approach has been to go out into the community for a specific targeted approach. The Māori and Pacific teams are both engaged on this matter.
- Noting the Consumer Council youth representatives; both students are able to attend the meetings via Zoom. The students are alternating meeting attendance; they can attend additional meetings subject to permission from their respective school.

The report was received.

5. GENERAL BUSINESS

There were no items of general business.

6. RESOLUTION TO EXCLUDE THE PUBLIC (agenda pages 139)

Resolution (Moved Edward Benson-Cooper/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 31/03/21	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)]

Carried

The open session of the meeting concluded at 12.09pm

SIGNED AS A CORRECT RECORD OF THE WAITEMATĀ DISTRICT HEALTH BOARD HOSPITAL ADVISORY COMMITTEE MEETING OF 19 MAY 2021.

_____CHAIR

Actions Arising and Carried Forward from
Meetings of the Hospital Advisory Committee
as at 17 June 2021

Meeting	Agenda Ref	Topic	Person Responsible	Expected Report Back/Comment
31/03/21	5.1	DNA Strategy update	Mark Shepherd / Alison Bowden	Deferred to 15/09/21 meeting

3.1 Hospital Services Performance Report – April 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 Hospital Services performance for April 2021.

Table of Contents

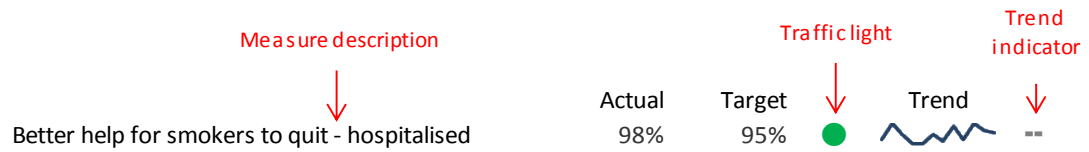
Glossary

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.

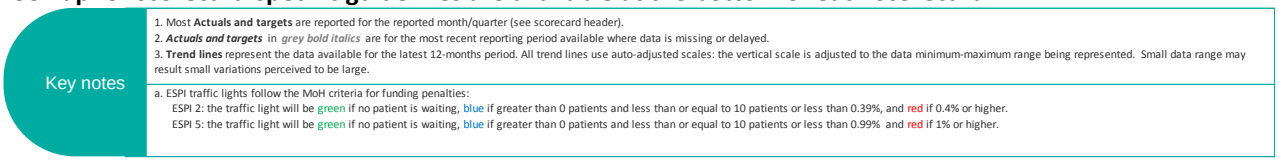
Note that YTD measures (e.g., WIES volumes, revenue) are cumulative by definition. As a result, their trend line will always show an upward trend that resets at the beginning of the new financial year. The line direction is not necessarily reflective of positive performance. To assess the performance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



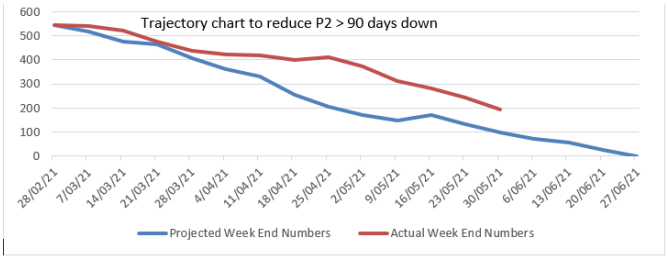
Hospital Services Performance Report

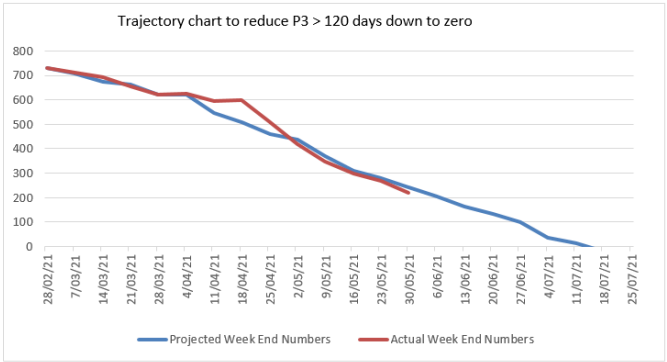
Executive Summary/Overview

Overall acute activity and planned care referral numbers remained higher than previous averages, which created pressure on emergency departments, bed occupancy and operating theatres. Difficulty in staffing and resourcing all units, on a day to day basis, across the hospitals has been challenging, with sick leave rates higher than previously identified. April, however, did see recruitment for operating theatre nurses improve which allowed, in particular North Shore Tower Block, operating theatres to increase production and reduce cancelled sessions.

Highlight of the month

Significant progress has been made on reducing overdue Endoscopy patient wait times, with the service on track to have no patients waiting longer than the maximum acceptable wait time (90 days) by July 2021. This is seen as the best position the service has been in for a number of years and will mean that in 2021/22 patients wait times will be able to be reduced to the minimum acceptable wait times. This has been achieved through increasing internal production, weekend sessions, outsourcing larger volumes of activity and also nationally leading the implementation of new surveillance guidelines which reduces patients requiring Endoscopy as frequently.

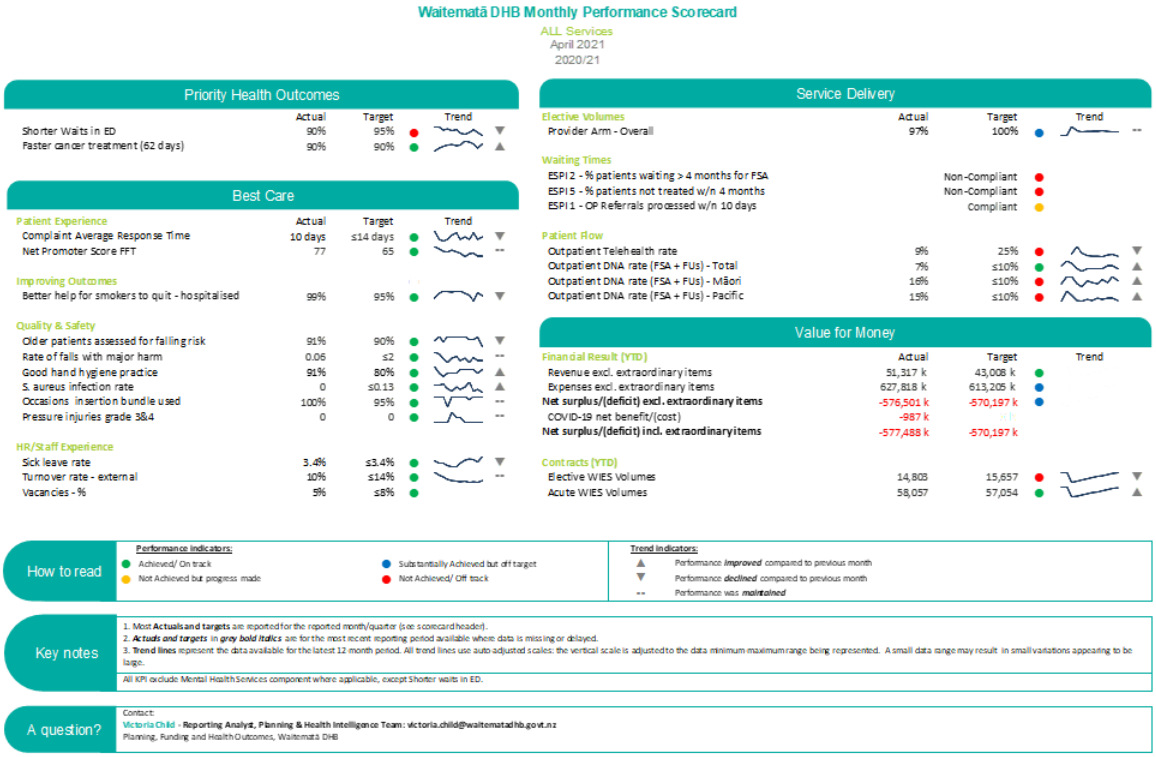




Key Issue of the Month

The DHB is seeking to employ over 100 new nurses (twenty of which we anticipate to be Māori) over our baseline as part of our Care Capacity Demand Management (CCDM) implementation. This extra recruitment on top of our normal turnover means there is significant capacities and demand for extra nurses.

Scorecard – All services



Waitematā DHB Monthly Performance Scorecard

ALL Services
April 2021
2020/21

Priority Health Outcomes

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

Best Care

Patient Experience	Actual	Target	Trend
Complaint Average Response Time	10 days	≤14 days	
Net Promoter Score FFT	77	65	
Improving Outcomes			
Better help for smokers to quit - hospitalised	99%	95%	
Quality & Safety			
Older patients assessed for falling risk	91%	90%	
Rate of falls with major harm	0.06	≤2	
Good hand hygiene practice	91%	80%	
S. aureus infection rate	0	≤0.13	
Occasions insertion bundle used	100%	95%	
Pressure injuries grade 3&4	0	0	
HR/Staff Experience			
Sick leave rate	3.4%	≤3.4%	
Turnover rate - external	10%	≤14%	
Vacancies - %	5%	≤8%	

Service Delivery

Elective Volumes	Actual	Target	Trend
Provider Arm - Overall	97%	100%	
Waiting Times			
ESPI 2 - % patients waiting > 4 months for FSA		Non-Compliant	
ESPI 5 - % patients not treated w/n 4 months		Non-Compliant	
ESPI 1 - OP Referrals processed w/n 10 days		Compliant	
Patient Flow			
Outpatient Telehealth rate	9%	25%	
Outpatient DNA rate (FSA + FUs) - Total	7%	≤10%	
Outpatient DNA rate (FSA + FUs) - Māori	16%	≤10%	
Outpatient DNA rate (FSA + FUs) - Pacific	15%	≤10%	

Value for Money

Financial Result (YTD)	Actual	Target	Trend
Revenue excl. extraordinary items	51,317 k	43,008 k	
Expenses excl. extraordinary items	627,818 k	613,205 k	
Net surplus/(deficit) excl. extraordinary items	-576,501 k	-570,197 k	
COVID-19 net benefit/(cost)	-987 k		
Net surplus/(deficit) incl. extraordinary items	-577,488 k	-570,197 k	
Contracts (YTD)			
Elective WIES Volumes	14,803	15,657	
Acute WIES Volumes	58,057	57,054	

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.

All KPI exclude Mental Health Services component where applicable, except Shorter waits in ED.

A question?

Contact:
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Planning, Funding and Health Outcomes, Waitematā DHB

Scorecard Variance Report

Service Delivery

Shorter Waits in ED – 90% against a target of 95%

Waitematā DHB performance with regards to the MOH shorter waits in ED has slightly declined. We have implemented a number of strategies to improve our performance in this area:

- In ED we continue to divert low acuity patients to urgent care services through the use of vouchers (approximately 10% of patients at both sites).
- As well as implementing a Mental Health Bundle of care, the Emergency Department is working closely with the Mental Health Service to implement a model of care that minimises delays to definitive care.
- In Medicine, we are continuing to develop the ADU model of care at both sites and have implemented daily acute clinics and an evening SMO roster with the aim of increasing the number of same day discharges from Medicine.
- To further support the daily Red to Green review process of inpatients in the medical wards we have implemented a weekly stranded meeting with the aim of reducing the number of patients with a length of stay of over ten days. Patients who have had more than four admissions in the last six months are also reviewed on a regular basis in order to develop a management plan that best supports their care.

There is a 'Better at Home' programme with a number of work streams including an expansion of the current home antibiotic programme (OPIVA) with the aim of reducing reliance on inpatient beds and therefore improving flow from ED and ADU.

Waiting Times, ESPI 2 and ESPI 5 non-compliance
Services emphasis continues to focus on reducing the long wait times for our ESPI 2 and ESPI 5 elective patients. Options to increase capacity are being implemented as able across all specialties. For ESPI 2 services running additional clinics both weekday and weekends, adding patients to the beginning and end of clinic sessions and using telehealth as appropriate.

ESPI 5 volumes are being supported by improved theatre staffing, weekend theatre lists, backfilling of vacant sessions, improving WTH utilisation with low acuity low complexity work.

For surgical services, the MoH have requested updated recovery trajectories demonstrating when services will achieve compliance. These have been formulated and submitted to the MoH awaiting approval.

Outpatient Telehealth – 10 % against target of 25%
March saw Auckland in lockdown resulting in a fluctuation of telehealth appointments with the March percentage of 12%. April was more balanced dropping back to 10% as lockdown lifted. However, there was a small uplift in video appointments and continued to trends upwards in April and May. A programme of work continues to assist clinicians improve their utilisation of e-tools which support the telehealth pathway such as the 'Paperless Toolkit' designed to make Outpatient appointments easier to deliver

DNA rates for Maori 16% and Pacifica 15% are higher than the target rate of 10%
Initial test of change work streams related to DNA have commenced in March / April within Radiology and Endoscopy with these changes incorporating a more patient centric approach and a change to language used when communicating with whanau. These and other initiatives will be rolled out across the wider Patient Service Centre.

As the work is in the early stages it is yet to demonstrate a positive impact on the organisational results however the Pacifica DNA rate improved by 2% on the February volume of 17%.

Value for Money

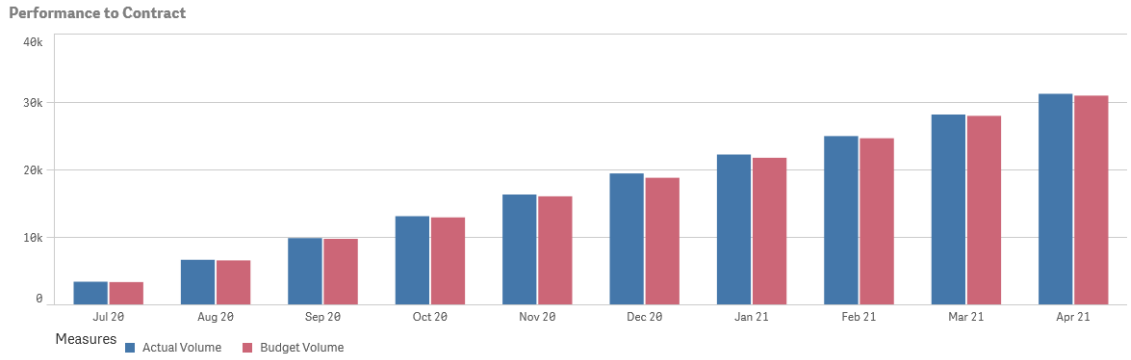
The YTD Hospital Services Result is $6.304 unfavourable to budget year to date to April 2021 (excluding COVID-19 impacts).

The following are the key financial performance factors influencing the actual deficit:

- Diagnostic and Clinical Support Services revenue is $6.812m favourable for the YTD. This is mainly driven by increased rebates for Hospital Pharmaceuticals and funding for Outpatient Pharmacy.
- The Emergency Department (ED) at North Shore continues to be busier than prior year, with presentations up 14% YTD and ED at Waitakere also up by 1%.
- Surgical services continue to have higher than expected nursing and outsourced personnel cost which is driven mainly by high acute volumes and additional sessions for planned care patients.
- Unfavourable supply costs, primarily in Diagnostics and Surgical Services due in part to unmet savings and increased activity

Combined Acute & Elective WIES actuals vs budget:

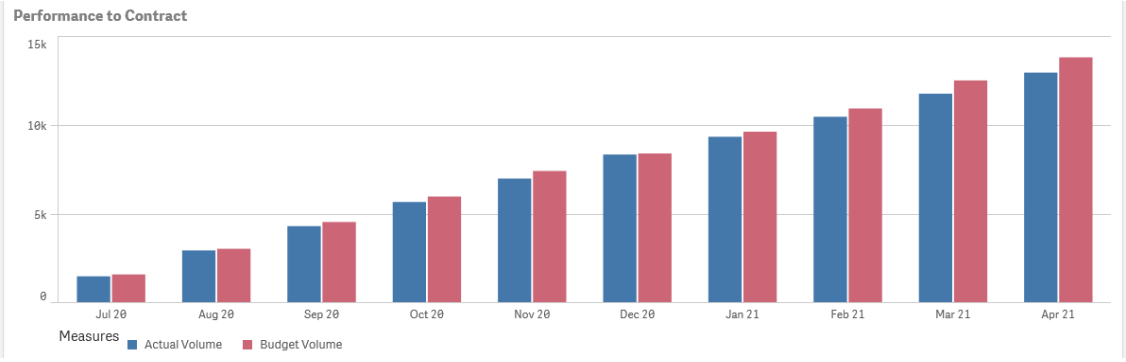
The Waitematā DHB's Hospital Services of Orthopaedics, ORL, General Surgery, Urology, Gynaecology and Cardiology, have combined acute and elective volumes ahead of the internal budgeted contract as at April 2021 YTD just over 270 WIES case-weights ($1.5m).



Specialty – Acute and Elective volumes to contract	*Actual Volume*	*Contract Volume*	*Variance*	*%*
Cardiology - Inpatient Services (DRGs)	4,288	4,220	67	102%
General Surgery - Inpatient Services (DRGs)	11,154	10,802	352	103%
Ear, Nose and Throat - Inpatient Services (DRGs)	907	972	-65	93%
Gynaecology - Inpatient Services (DRGs)	2,619	2,535	84	103%
Orthopaedics - Inpatient Services (DRGs)	11,020	11,204	-184	98%
Urology - Inpatient Services (DRGs)	1,119	1,099	20	102%
Total YTD April 2021	**31,106**	**30,832**	**274**	**101%**

Elective WIES actuals vs budget:

However, elective volumes have been directly impacted by acute and emergency care volumes; coupled with a shortage of theatre nurses that was signalled for the period January to April 2021, which has already seen the 'close to budget' situation as at December YTD erode rapidly in January to April. Acute volumes have caused reduced access to theatres, beds and resources for the planned care patients.



Specialty – Elective volumes to contract	*Actual Volume*	*Contract Volume*	*Variance*	*%*
Cardiology - Inpatient Services (DRGs)	767	891	-125	86%
General Surgery - Inpatient Services (DRGs)	4,284	4,529	-245	95%
Ear, Nose and Throat - Inpatient Services (DRGs)	901	965	-64	93%
Gynaecology - Inpatient Services (DRGs)	1,365	1,381	-16	99%
Orthopaedics - Inpatient Services (DRGs)	4,538	4,950	-411	92%
Urology - Inpatient Services (DRGs)	1,080	1,081	0	100%
Total YTD April 2021	**12,936**	**13,797**	**-861**	**94%**

Note that the deficit of 861 WIES is purely an internal measure to elective contract, and may differ from the Ministry view of our Planned Care performance, which includes acute arranged procedures, IDF-out and minor procedures. The MoH views as at March 2021 YTD are shown here, and include both discharges and WIES:

Waitemata District Health Board
2020/21 Planned Care Initiative Report

2020/21 Planned Care Interventions Delivery

	Year to Date Plan	Year to Date Delivery	Variance from plan	2020/21 Total Planned Care Interventions
Inpatient Surgical Discharges	16,076	16,285	209	32,531
Minor Procedures	7,714	10,070	2,356	
Non Surgical Interventions	252	0	-252	
YTD Planned Care Interventions	**24,042**	**26,355**	**2,313**	109.6%

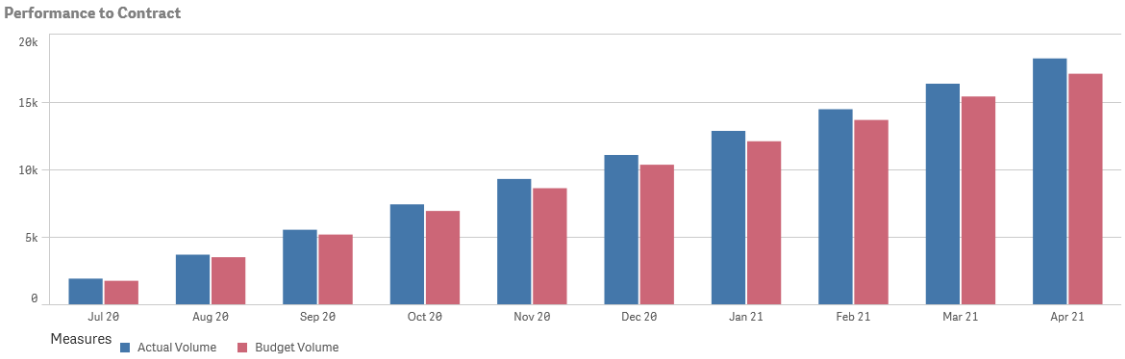
2020/21 Year to Date Contracted Volume Summary

	Base YTD Planned Volume	Additional YTD Planned Volume	Total YTD Planned Volume	Actual Delivery	YTD Delivery %	2020/21 Total Planned Volume
Inpatient Caseweight Delivery	15,898.9	6,479.4	22,378.3	21,531.0	96.2%	29,691.5
Inpatient Surgical Discharges	11,339	4,737	16,076	16,285	101.3%	21,331
Minor Procedures	5,538	2,176	7,714	10,070	130.5%	10,866
Non Surgical interventions	81	171	252	0	0.0%	334

The table above shows that the Ministry view of the shortfall in Planned Care case-weight delivery as at March YTD of 847 WIES (22,378 less 21,531) is coincidentally similar to the Hospital Services variance of 861 ($4.8m).

Acute WIES actuals vs budget:

Materially ahead of budget as per previous comments.
The 1,135 WIES surplus represents $6.3 million.



Specialty – Acute volumes to contract	*Actual Volume*	*Contract Volume*	*Variance*	*%*
Cardiology - Inpatient Services (DRGs)	3,521	3,329	192	106%
General Surgery - Inpatient Services (DRGs)	6,869	6,273	597	110%
Ear, Nose and Throat - Inpatient Services (DRGs)	6	7	-1	82%
Gynaecology - Inpatient Services (DRGs)	1,254	1,154	100	109%
Orthopaedics - Inpatient Services (DRGs)	6,482	6,254	227	104%
Urology - Inpatient Services (DRGs)	38	19	20	207%
Total Acute and arranged April YTD	**18,170**	**17,035**	**1,135**	**107%**

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 ten months. The expense savings are down this month as we experience the impact of COVID-19 on our comparative month. The programme to date has delivered 91.7% of target YTD April with $9.9m in expense reduction having been realised.

Further, $14.10m in annual savings initiatives, have been identified and work is ongoing to both implement these initiatives and identify a further $1.9m in savings to reach the target savings of $16m for the full financial year.

	Measure	April Actuals	Year to Date	% vs Target	Identified Annual Savings	Target	% vs target
Hospital Services	Primary – Expense	$340,821	$9,947,920	85.3%	$11,729,201	$14,000,000	83.8%
Corporate	Budget	$92,692	$2,276,888	136.6%	$ 2,373,384	$2,000,000	118.7%
FSP Overall Programme Total		$ 433,513	$12,224,808	91.7%	$14,102,585	$16,000,000	88.1%

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	Jun 2021 **Completed/Ongoing**	✓

plan		
• 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 **Completed**	✓
• Conduct gap analysis from Consumer Engagement QSM participation to identify areas of improvement	Jun 2021 **Completed**	✓

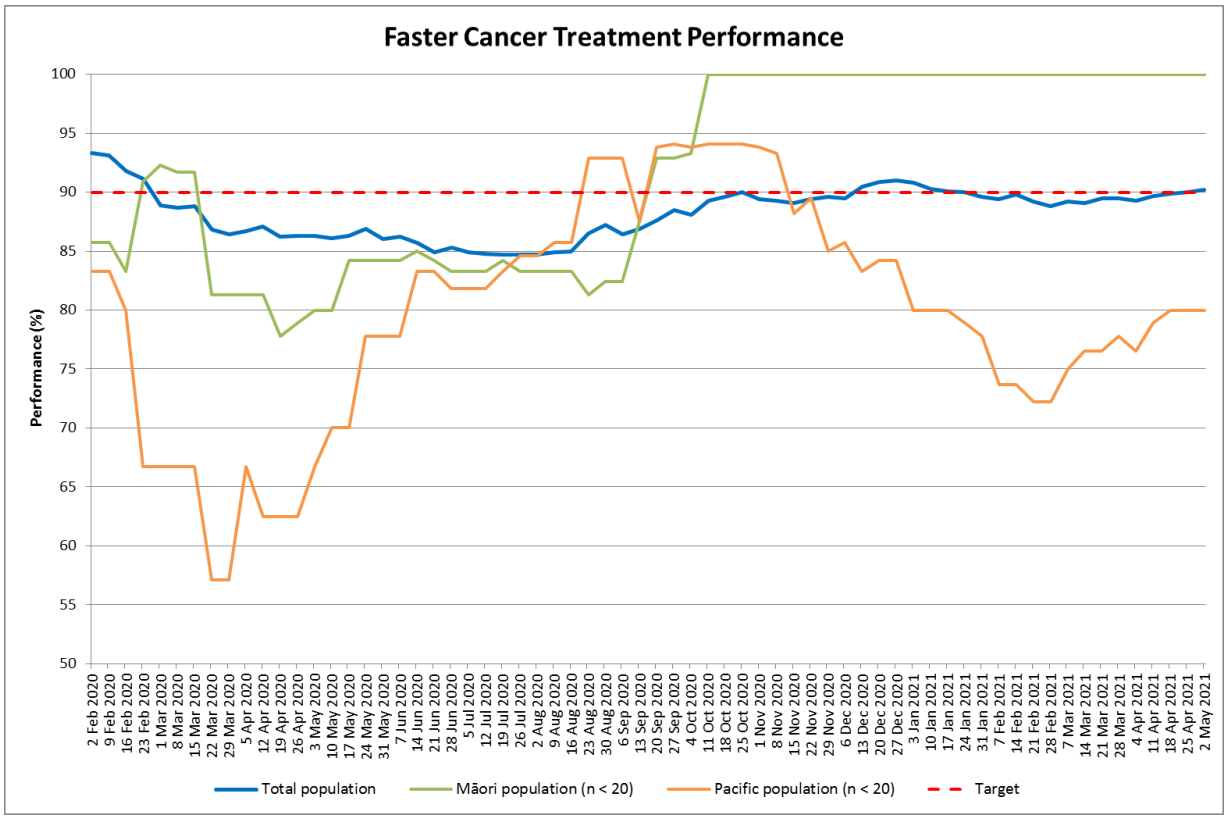
Areas off track for month and remedial plans
Governance structure for implementation of the Consumer Engagement QSM not supported by the Senior Management Team. Consumer Engagement QSM governed via Quality Executive Committee and Consumer Council.

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	 ✓ ✘

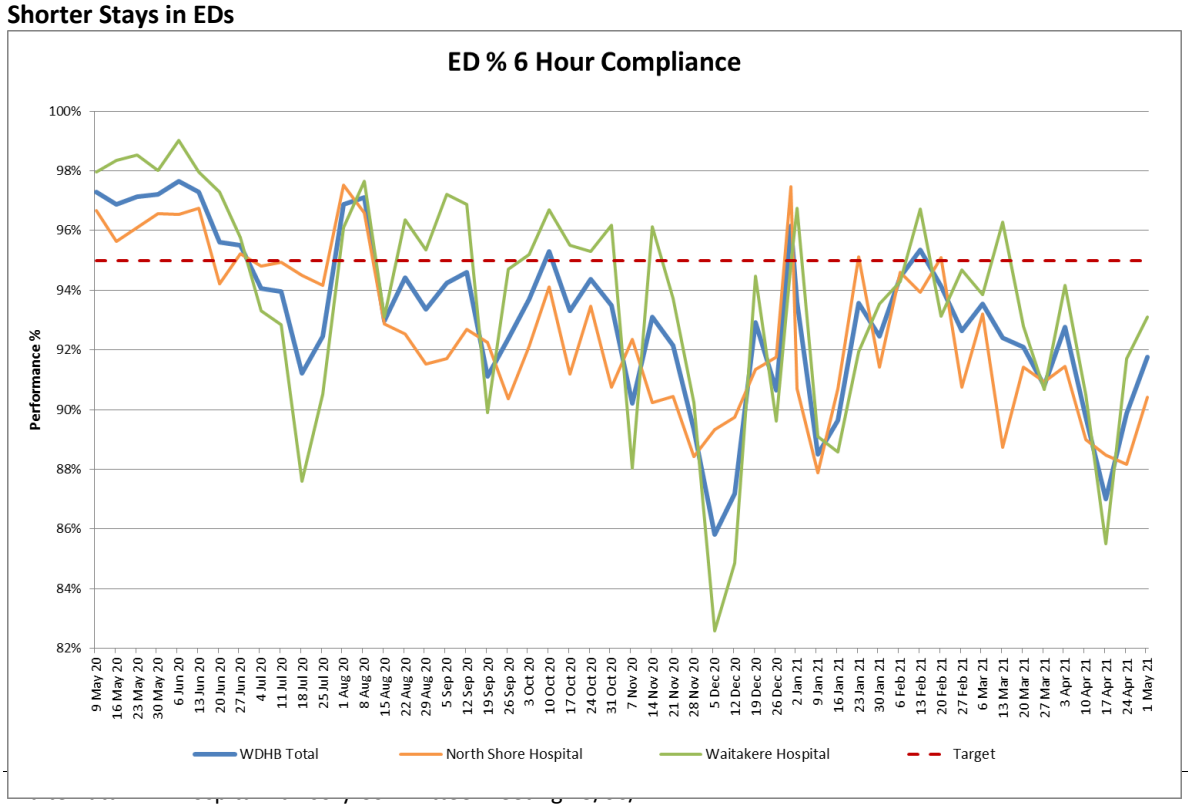
Areas off track for month and remedial plans
The endometrial cancer co-design project required modification due to recurrent COVID-19 interruptions. The direction now is the production of a patient education booklet. This has been drafted and reviewed by the hospital consumer group and is awaiting final feedback from previous patients. We anticipate the booklet will be ready for patient use by the end of July 2021. Extension of medical oncology breast cancer care has been delayed from November 2020 due to an unplanned increase in patient volumes requiring additional resourcing planning. Provisional start date is 1 July 2021

Priority Health Outcome Areas

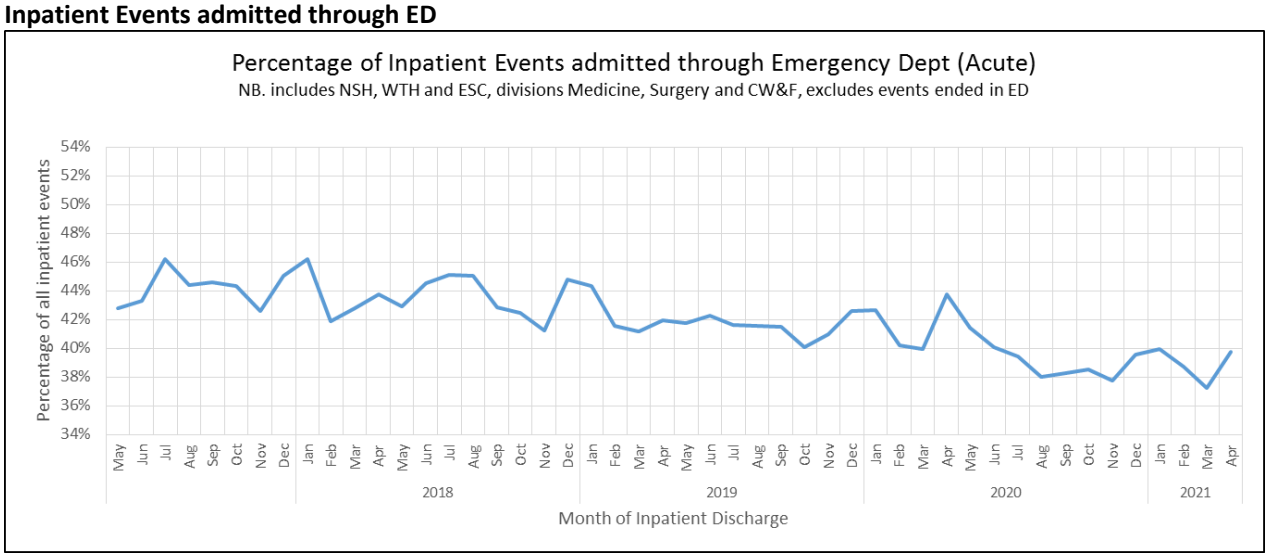
Faster Cancer Treatment



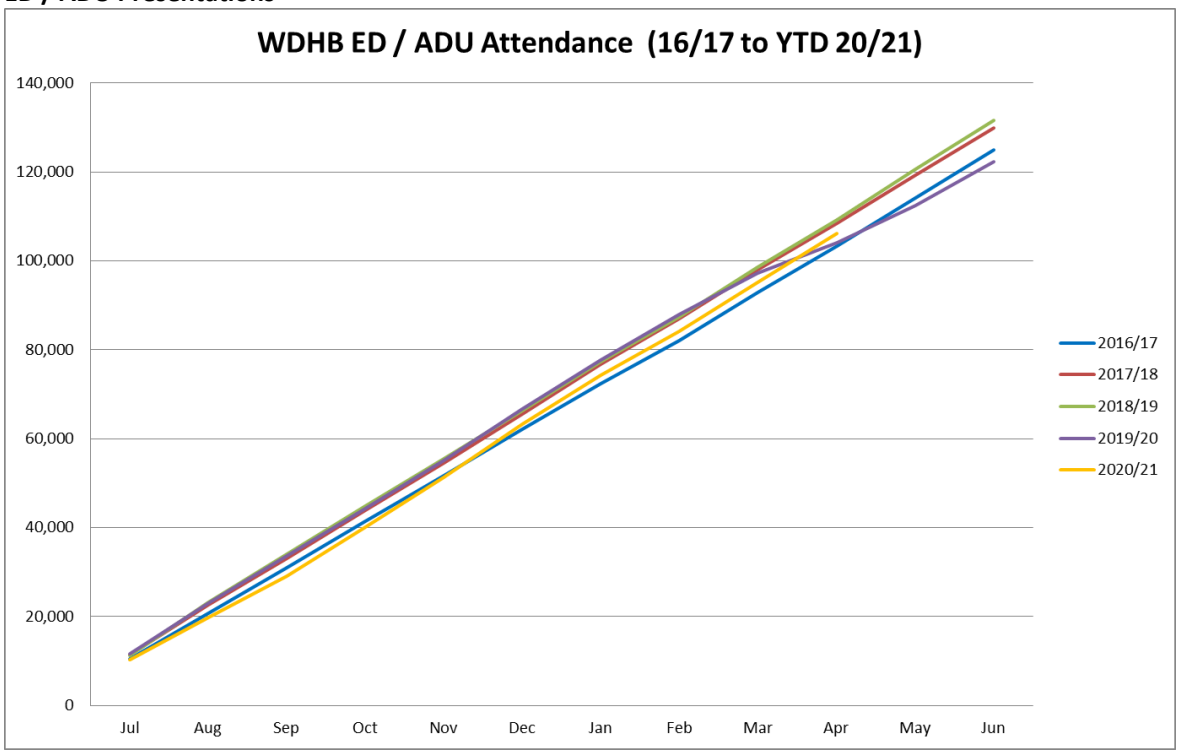
Shorter Stays in EDs



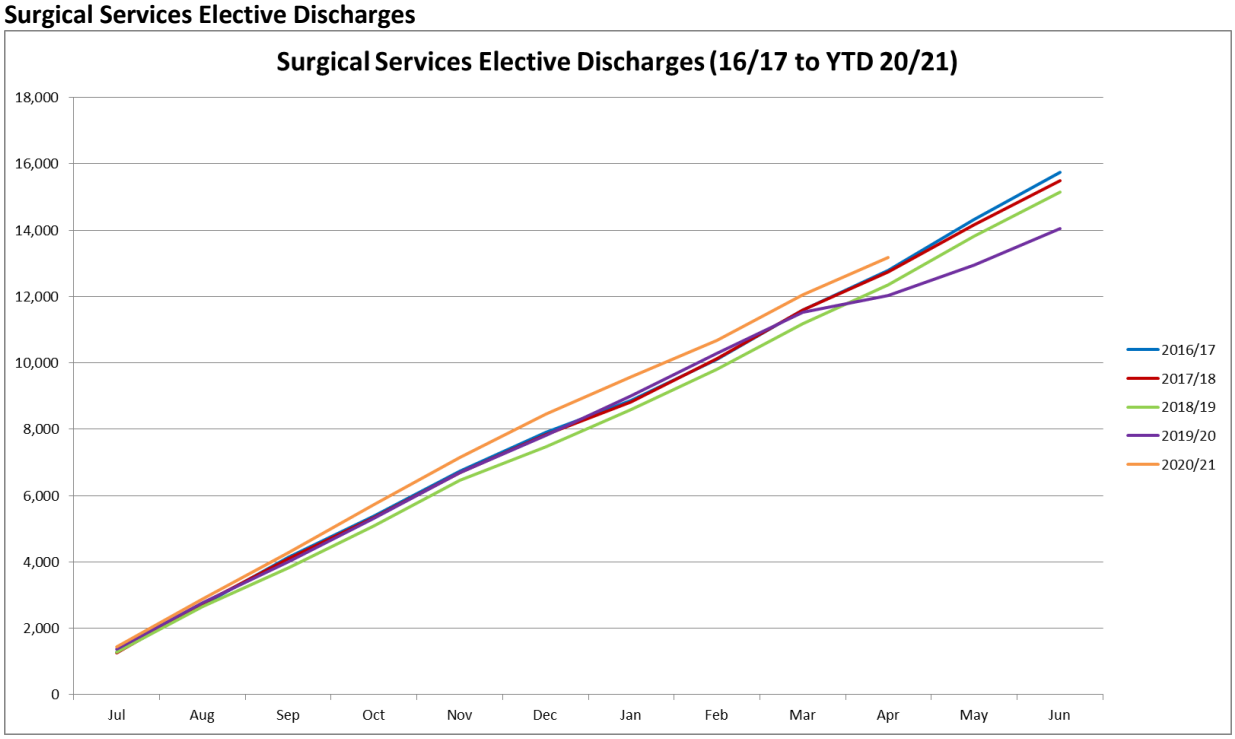
Inpatient Events admitted through ED



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

April 2021	Month Volumes	% Change (last year)	YTD Volumes	% Change (last year)
ED/ADU Volumes	11,017	60%	106,159	2%
Surgical Services Elective Discharge Volumes	1134	118%	13181	9%

Elective Performance Indicators (part of Planned Care Services)

Zero patients waiting over four months

Summary (April 2021)	
Speciality	Non Compliance %
ESPI 2 - Patients waiting longer than the required timeframe for their first specialist assessment (FSA).	8.23%
ESPI 5 - Patients given a commitment to treatment but not treated within the required timeframe.	27.70%

ESPI	WL Specialty	Compliant	Non-Compliant	Non-Compliant
ESPI 2	Anaesthesiology	105	-	0.00%
	Cardiology	1,388	1	0.07%
	Dermatology	303	3	0.98%
	Diabetes	250	-	0.00%
	Endocrinology	231	1	0.43%
	Gastro-Enterology	1,057	13	1.21%
	General Medicine	254	5	1.93%
	General Surgery	1,795	203	10.16%
	Gynaecology	974	62	5.98%
	Haematology	163	-	0.00%
	Infectious Diseases	70	-	0.00%
	Neurovascular	166	-	0.00%
	Orthopaedic	1,739	346	16.59%
	Otorhinolaryngology	1,345	309	18.68%
	Paediatric MED	879	15	1.68%
	Renal Medicine	307	-	0.00%
	Respiratory Medicine	774	5	0.64%
	Rheumatology	191	-	0.00%
	Urology	724	177	19.64%
	Total	12,715	1,140	8.23%
ESPI 5	Cardiology	133	-	0.00%
	General Surgery	1,677	309	15.56%
	Gynaecology	515	298	36.65%
	Orthopaedic	1,182	722	37.92%
	Otorhinolaryngology	277	43	13.44%
	Urology	415	237	36.35%
	Total	4,199	1,609	27.70%

90% of outpatient referrals acknowledged and processed within 10 days

ESPI 1 (April 2021)	
Specialty	Compliance %
Anaesthesiology	100.00%
Cardiology	90.33%
Dermatology	98.77%
Diabetes	89.23%
Endocrinology	99.61%
Gastro-Enterology	100.00%
General Medicine	95.51%
General Surgery	97.87%
Gynaecology	99.64%
Haematology	99.52%
Infectious Diseases	99.23%
Neurovascular	97.06%
Orthopaedic	93.89%
Otorhinolaryngology	99.60%
Paediatric MED	95.58%
Renal Medicine	100.00%
Respiratory Medicine	100.00%
Rheumatology	97.32%
Urology	100.00%
Total	97.19%

Legend	
ESPI 1	Green if 100%, Yellow if less than 100%
ESPI 2	Green if 0% , Yellow Status % is greater than 0% (1 patient or more), but less than 0.4% OR Status % is greater than or equal to 0.4% but 10 patients or less waiting over 4 months, Red Status % is greater than or equal to 0.4% and 11 patients or more waiting over 4 months
ESPI 5	Green Status if 0%, Yellow Status % is greater than 0% (1 patient or more), but less than 1% OR Status % is greater than or equal to 1% but 10 patients or less waiting over 4 months, Red Status % is greater than or equal to 1% AND 11 patients or more waiting over 4 months

Financial Performance Summary

The YTD Hospital Services Result is $6.304 unfavourable to budget year to date to April 2021 (excluding COVID-19 impacts).

The following are the key financial performance factors influencing the actual deficit:

- Diagnostic and Clinical Support Services revenue is $6.812m favourable for the YTD. This is mainly driven by increased rebates for Hospital Pharmaceuticals and funding for Outpatient Pharmacy.
- The Emergency Department (ED) at North Shore continues to be busier than prior year, with presentations up 14% YTD and ED at Waitakere also up by 1%.
- Surgical services continue to have higher than expected nursing and outsourced personnel cost which is driven mainly by high acute volumes and additional sessions for planned care patients.
- Unfavourable supply costs, primarily in Diagnostics and Surgical Services due in part to unmet savings and increased activity.

Financial Performance

Waitematā DHB Statement of Financial Performance

Hospital Services - Apr-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
REVENUE							
* Government and Crown Agency	3,647	3,465	182	38,746	33,904	4,842	40,676
Other Income	1,212	882	330	12,572	9,105	3,467	10,868
Total Revenue (excl. extraordinary items)	4,859	4,347	512	51,317	43,008	8,309	51,544
EXPENDITURE							
Personnel							
Medical	15,202	15,505	303	154,155	155,322	1,166	183,708
Nursing	25,246	25,789	543	179,538	180,204	666	214,021
Allied Health	7,690	7,876	186	79,438	78,722	(716)	93,054
Support	2,027	2,176	150	19,024	19,354	330	23,074
Management / Administration	2,827	2,793	(33)	29,210	28,820	(390)	34,049
Outsourced Personnel	972	952	(20)	11,323	9,801	(1,522)	11,794
	53,963	55,092	1,129	472,689	472,223	(466)	559,700
Other Expenditure							
Outsourced Services	1,570	1,675	105	14,853	15,610	757	19,006
Clinical Supplies	11,069	10,582	(487)	111,555	108,692	(2,863)	131,021
Infrastructure & Non-Clinical Supplies	2,842	1,642	(1,199)	28,722	16,681	(12,041)	20,068
	15,481	13,899	(1,582)	155,130	140,983	(14,147)	170,094
Total Expenditure (excl. extraordinary items)	69,444	68,991	(453)	627,818	613,205	(14,613)	729,794
Surplus/(Deficit) excl. extraordinary items	**(64,585)**	**(64,644)**	**59**	**(576,501)**	**(570,197)**	**(6,304)**	**(678,250)**
Extraordinary items							
COVID-19 Net benefit/(cost)	(165)	0	(165)	(987)	0	(987)	0
Surplus/(Deficit) incl. extraordinary items	**(64,750)**	**(64,644)**	**(106)**	**(577,488)**	**(570,197)**	**(7,291)**	**(678,250)**

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

Waitematā DHB Statement of Financial Performance

Hospital Services - Apr-21

($000's)	MONTH			YEAR TO DATE			FULL YEAR
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
CONTRIBUTION (excl. extraordinary items)							
Surgical Services	(17,057)	(16,906)	(151)	(155,030)	(149,351)	(5,679)	(178,075)
Acute and Emergency	(16,137)	(16,020)	(117)	(136,090)	(133,237)	(2,853)	(157,621)
Specialty Medicine and HOPS	(9,069)	(8,992)	(76)	(79,777)	(79,500)	(277)	(94,416)
Child Women and Family	(6,450)	(6,590)	140	(54,131)	(53,769)	(362)	(63,797)
Director Hospital Services	(1,132)	(1,034)	(98)	(9,615)	(7,813)	(1,802)	(9,147)
Elective and Outpatient Services	(761)	(749)	(12)	(6,408)	(6,359)	(49)	(7,568)
Diagnostic and Clinical Support services	(11,843)	(12,095)	252	(113,553)	(116,922)	3,369	(140,060)
Regional Dental	(2,135)	(2,257)	122	(21,898)	(23,247)	1,349	(27,565)
Net Surplus/(Deficit) excl. extraordinary iten	**(64,585)**	**(64,644)**	**59**	**(576,501)**	**(570,197)**	**(6,304)**	**(678,250)**
Extraordinary items							
COVID-19 Net benefit/(cost)	(165)	0	(165)	(987)	0	(987)	0
Surplus/(Deficit) incl. extraordinary items	**(64,750)**	**(64,644)**	**(106)**	**(577,488)**	**(570,197)**	**(7,291)**	**(678,250)**

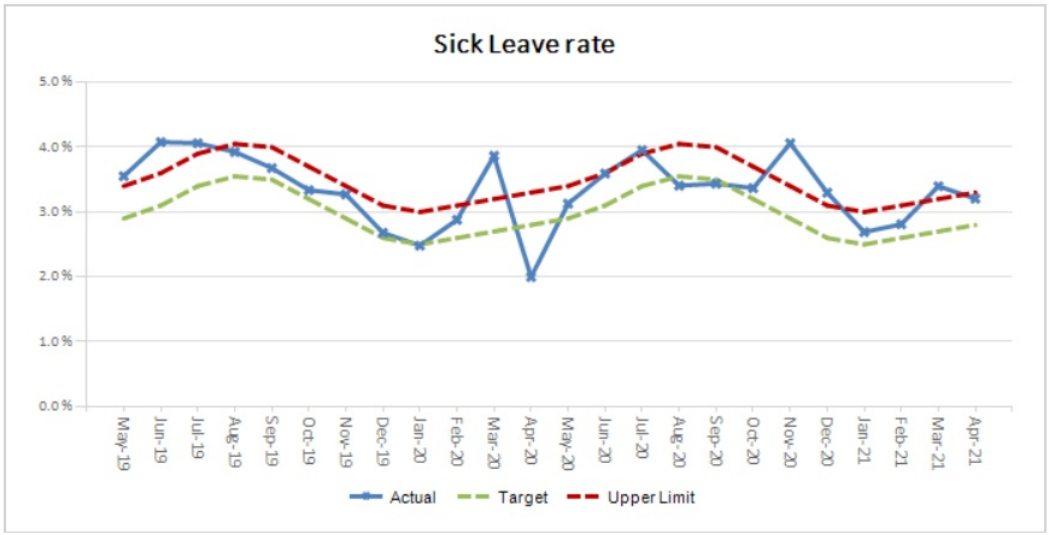
Human Resources

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.

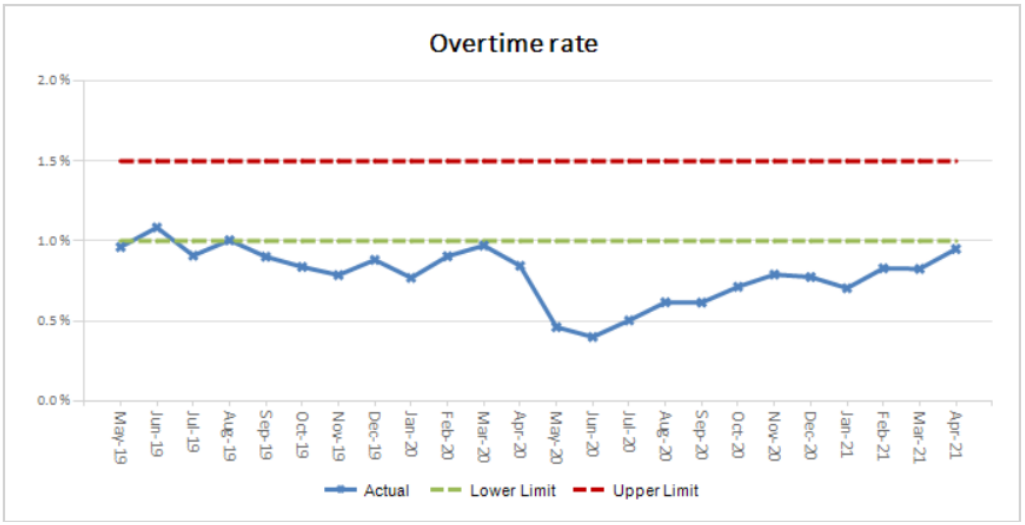
Sick Leave

Sick leave is tracking within the expected range and meets the DHB target of 3.2%.



Overtime

Overtime is tracking underneath target rates.



Annual Leave

Annual leave balances have maintained an average of 25/26 days per person from January through to May 2021, which is a good result especially given staff have continued accruing leave over that time.

Assisting with the reduction of leave since January are the following:

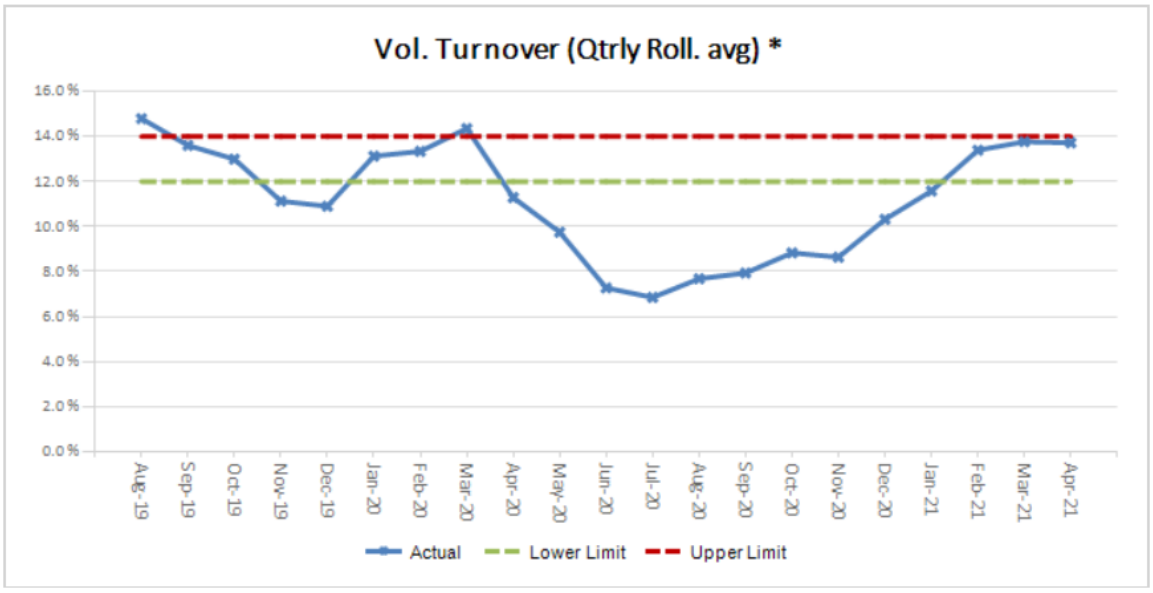
1. Leave over the Holiday season – including Auckland Anniversary, Waitangi Day and Easter.
2. 800 staff leave cash buyouts in line with the Holidays Act processed through March and April.
3. Leave plans for staff with large balances and staff encouraged to take regular leave for rest and recreation.

For comparison, the leave balance for June 2020 has been added to the table, showing most of the leave growth is in the under 50 day category.

Month	**Number of staff Leave balances 0-25 days**	**Number of staff Leave balances 25-50 days**	**Number of staff Leave balances 50-75 days**	**Number of staff Leave balances 75 days +**
December 2020	5,192	2,072	446	160
January 2021	5,493	1,981	395	156
February 2021	5,498	1,931	411	157
March 2021	5,376	2,034	449	145
April 2021	5,521	1972	422	135
May 2021	5,320	2081	458	140
% change from previous month	**3.6% decrease**	**5.5% increase**	**8.5% increase**	**3.7% increase**
June 2020 (for comparison)	5313	1891	404	141

Staff Turnover

Our 12 month rolling turnover is tracking at 10% for April with our quarterly average at 13.7%. This means turnover has been gradually increasing. November to March is a typical time for people to leave and start. There is a decrease in the May turnover.



4.1 Clinical Leaders' Report

Recommendation:

That the report be received.

Prepared by: Dr Andrew Old (Acting 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 for the HOSPITAL ADVISORY COMMITTEE

Prepared by: Dr Laura Chapman (Director of Clinical Training) and endorsed by: Dr Andrew Old (Acting Chief Medical Officer)

Context of training and education:

Achieving excellence in undergraduate and postgraduate training both enhances the quality of patient care provided, and ensures the best recruitment and retention opportunities.

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, North Shore and Waitakere Hospitals are a major site of undergraduate learning of medical students from the University of Auckland (UoA). We host almost 250 students in cohorts each year though the UoA Waitemata Clinical Campus.

Governance of education and training:

The peak body at Waitemata DHB is the Executive Education Governance Committee. Membership includes the Director HR, the Chief Medical Office (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 in governance (no significant change):

1. Associate Dean retirement: The Associate Dean (AD), Waitemata Clinical Campus is retiring in July 2021 and a replacement has yet to be appointed. The AD is the most senior University employee on site at WDHB. The AD responsibilities include driving UoA associated research, optimising delivery of undergraduate medical education and experience and coordinating new FTE for SMOs. The role is critical to Waitemata DHB reputation and recruitment amongst junior doctors. The CMO is part of the appointment process.

2. There is no forum for DHB education leads (directors of Clinical Training and similar) to share ideas and solutions around regulatory, contractual, training and other practical issues. WDHB have instigated and will host the first DCT forum for NZ wide discussion.

Delivery of education and training

The day-to-day **clinical supervision** of RMOs in training is provided by SMOs across the workforce. Significant numbers of SMOs additionally contribute to the teaching of medical students in the clinical setting.

In addition, RMOS require dedicated educational supervision (separate and additional oversight to clinical supervision), which is set by the relevant educational body or regulator e.g. Medical Council of New Zealand or a College. Continued growth in the numbers of RMOs (to meet industrial contractual roster requirements and to match the increasing volume of clinical presentations) necessitates continued growth in educational supervisor appointments and associated dedicated FTE.

The DHB commits significant resources to the operational undertaking of training: the Medical Education and Training Unit (METU) oversees pre-vocational training (PGY1,2 house officers) and each speciality division has dedicated SMO educational leadership for RMO vocational training programmes. 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 (no significant change):

1. Additional PES FTE requested: There is a requirement for **additional Prevocational 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 is in progress.

2. METU Manager role: this role has been vacant for some months which is impacting the overall delivery of operational aspects of training for PGY1 and 2. A temporary appointment has been made until June 2021, however, a two-year appointment (to cover secondment) is required. The new GM OD will be overseeing this recruitment.

3. The AD associated teaching role and FTE will be unfilled from July (see above)

Accreditation of the DHB as a training environment

All training at the DHB is accredited as meeting pre-specified standards. The **accreditation is undertaken by the relevant oversight body** (either the Medical Council or a College). Accreditation for training is essential. Failure to meet and maintain accreditation would result in immediate workforce and recruitment issues that would directly compromise patient care and service delivery.

It is valuable to note that most College vocational training accreditation standards are developed in Australia, as the majority of Colleges are trans-national (Australasian), and the Colleges themselves are accredited by the joint regulators (AMC + MCNZ) as single training programmes over multiple sites. There can be challenges in matching Australasian standards to the local New Zealand context.

All prevocational and vocational training programmes at Waitemata DHB are accredited.

Current issues in accreditation (no significant change):

1. Accreditation review: A DHB-wide review of current accreditation status across all specialties at PGY3+ level is being undertaken by METU leader, Director of Clinical Training and CMO. Accreditation status, issues, timeframes, and associated structures and FTE are being assessed to inform oversight of strengths and opportunities for improvement in medical education. It is relevant to note that it is usually the specific training site that is accredited (eg: North Shore Hospital) and not the DHB as a whole.

2. Community Based Attachments: The MCNZ require that all prevocational trainees have the opportunity to undertake a Community Based Attachment (CBA). Meeting this standard is an accreditation requirement for the DHB as a prevocational training provider.

   DHB Chairs and CEOs have received a letter from MCNZ on 21 September, highlighting this requirement and strongly urging all DHBs to continue to work towards fully achieving the CBA target as soon as possible.

   Waitematā DHB offers more CBA opportunities than the other two metro Auckland DHBs but needs a sizeable increase in additional positions to achieve the requirements of the MCNZ. Ensuring CBAs are suitable learning opportunities, appropriately supervised and sustainable has been a significant challenge.

   The Director of Clinical Training is leading a program of work to identify further positions that could be considered for CBAs, supported by the CMO. Additional funding will be needed for those positions, estimated at ~85k pa per position (NRA data). Funding for 2 new CBAs has been agreed in outline but awaiting confirmation.

Employment and training

Medical students are not employees and are supernumerary to the delivery of clinical care although year 6 students (trainee interns) receive a stipend to support study. RMOs in training are employed to provide clinical care as part of the team structure in our inpatient and outpatient services. As already noted clinical service and training are largely indistinguishable and inseparable. 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 specific obligations to education within the MECAs.

In addition to these contractual requirements, the educational oversight bodies – particularly the Colleges – impose conditions on the type of clinical work and level of supervision required by individual RMOs in specific training roles. This multi-layered 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. The factors underpinning the DHB employment choices of all medical graduates and the subset of Māori and Pacific graduates entering PGY1 training are not clear. The Director of Clinical Training is reviewing:
    a. Undergraduate medical student site selection (as presumed to influence PGY1 DHB selections)
    b. PGY1 DHB choices across Auckland
    c. Impact of WDHB Māori and Pacific health scholarships

2. Recruitment has been competitive for RMOs in the metro-Auckland area but there has been a significant reduction in house surgeon numbers for the second half of 2021. This is being actively addressed by the NRA. Recruitment of international medical graduates to staff RMO positions is reduced. The medium-long term workforce implications of COVID-19 remain unclear.

3. Trainees in difficulty: a very small number of RMOs are 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.

4. Ongoing Union negotiations with both the RDA and SToNZ

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. The CMO is involved in preliminary national discussion on new models for HWNZ funding to the sector.

Allied Health, Scientific and Technical Professions

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

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

Better, Best, Brilliant

Research funding has been secured to complete a project exploring the value of screening for swallowing difficulties in our frail and elderly population on hospital admission. The aim of the research is to ascertain if those who are at risk of dysphagia (difficulty swallowing) can be identified early and subsequently assessed and treated by a speech language therapist to display a reduction in associated complications such as aspiration pneumonia. We hypothesise that early intervention is likely to reduce dysphagia related complications, length of stay and consequently reduce cost of care for this a risk population.

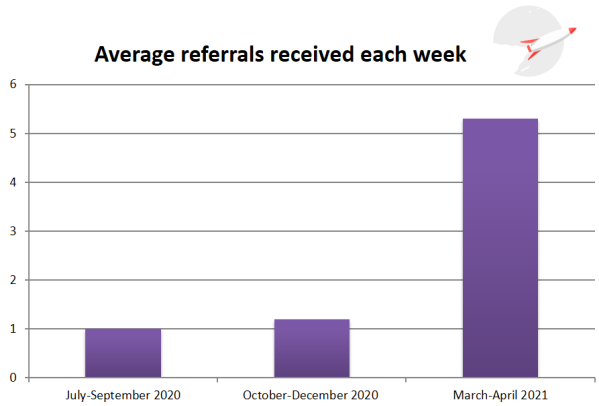
With Compassion

The pre-operative Physiotherapy-led Breast Clinic is a fully operational electronic service with dedicated clinic space in the Kia Ū Ōra Breast Clinic, offering patients and whānau clinic or telehealth-based pre-operative physiotherapy education.

From its inception as an investigation exploring the feasibility and benefit of transitioning from ward-based, post-operative breast surgery education to pre-operative physiotherapy education, the project has advanced with Waitematā DHB values at its core.

The development of this service has navigated barriers associated with accessing pre-operative physiotherapy, prioritising the patient journey and facilitating enhanced patient recovery and health engagement. The project has also allowed for the valuable clinical activity of pre-operative education to be accurately captured for the inpatient physiotherapy team. The move to an electronic referral system has resulted in a significant increase in weekly referrals, giving more patients an opportunity to benefit from this important education.

The project is underpinned by the collaborative efforts of our clinical and non-clinical team, facilitating new working relationships across different services and networking to continue to develop the wider service.



Nursing and Professional Leadership

Prepared by Jocelyn Peach, Chief Nursing Officer, Professional Leadership

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

Workforce Planning and Development for Safe Practice

Workforce availability

Availability of staff continues to be a challenge in competition with other DHBs, Aged Care and the COVID-19 programme. This is compounded by recruitment of nurses into Care Capacity Demand Management positions. Being able to appoint quality staff is essential for the quality of care. We are working nationally and regionally with other DHBs and the five nursing schools to ensure that there is good supply of students and new graduates as well as seeking more experienced nurses. There continues to be emphasis on recruitment of Māori and Pacific health care assistants, nurses and midwives.

Workforce Capability

The DHB has a good learning framework and professional development programme to develop the workforce in practice safety, expertise to contribute confidently and achieve expected outcomes. Workload pressure and seasonal demand impacts on access to learning.

Retention

There has been reduced turnover through 2020 COVID-19. However, this is changing with overseas recruiters, higher numbers of nurses retiring after 20 plus years of service and recruitment gaps. Planning is underway to address morale arising from industrial action and seasonal pressures. Practice safety relies on retention of experienced nurses to provide complex care, support development of junior nurses and co-leading care of specialty models of care.

4.2 Quality Report – April/May 2021

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

1. National Key Quality Indicators – Quality Safety Markers (QSM)

The Quality and Safety Markers (QSMs) are used by the Health Quality and Safety Commission (HQSC) 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.

Quarterly QSM Dashboard

Quality Safety Markers (QSM)	Target	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Last Qtr Change
Falls											
% older patients assessed for falls risk	90%	98%	97%	98%	99%	99%	100%	98%	100%	98%	⇩
% older patients assessed as significant risk of falling with an individualised care plan	90%	94%	99%	99%	98%	96%	97%	97%	99%	98%	⇩
Health Care Associated Infections											
Hand Hygiene											
% of compliant HH moments	80%	90%	89%	90%	93%	91%	92%	90%	91%	91%	⇔
Central Line Associated Bacteraemia (CLAB)											
% occasions insertion bundle used in ICU	90%	100%	100%	100%	100%	100%	100%	99%	100%	99%	⇩
% occasions maintenance bundle used in ICU	90%	96%	97%	99%	99%	98%	91%	97%	98%	97%	⇩
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	TBD	1.5	0.3	0.7	0.4	0.4	0.0	1.0	TBA	TBA	⇧

Quality Safety Markers (QSM)	Target	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Last Qtr Change
100% primary hip and knee replacements antibiotic given 0 -60 minutes before 'knife to skin' [first incision]	100%	97%	97%	98%	100%	99%	98%	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%	98%	97%	98%	100%	99%	93%	98%			⇧
Medication Safety											
Electronic Medication Reconciliation (eMedRec)											
eMedRec on admission implemented anywhere in the hospital	TBD	New Quality and Safety Markers						Yes	Yes	Yes	⇔
% of patients with access to eMedRec Services	TBD							86%	86%	88%	⇧
% of patients where eMedRec was finished at any time during the patients' admissions	TBD							75%	73%	74%	⇧
% 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							91%	89%	91%	⇧
% of patients where eMedRec was finished within (≤) 24 hours of admission	TBD							54%	50%	53%	⇧
% 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							68%	86%	66%	⇩
Opioids											
% of patients with a documented sedation score	TBD	72%	76%	85%	86%	86%	85%	83%	79%	79%	⇔
% of patients with documented bowel function monitored	TBD	4.0%	3.0%	3.5%	3.0%	4.3%	5.0%	4%	6%	4%	⇩
% of patient with uncontrolled pain	TBD	18%	8%	0.5%	0.0%	0.8%	0.1%	0.0%	0.0%	0.1%	⇧
% of patients with documented opioid related adverse events HQSC Provide	TBD		0.49%	0.35	0.58%	0.59%	0.48%	0.74%	0.53%	TBC	⇩
% of eligible wards using the NZ Early Warning System (EWS)	TBD		100%	100%	100%	100%	100%	100%	100%	100%	⇔
Patient Deterioration											
% of audited patients with an Early Warning Score (EWS) calculated correctly for the most recent set of vital sign	TBD		100%	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%	82%	⇩
Rate of in-hospital cardiopulmonary arrests in adult inpatient wards, units or departments per 1000 admissions (NMDS) HQSC Provide	TBD	1.0%	0.2%	0.6%	0.5%	0.2%	0.7%	1.2%	0.7	TBC	⇩
Rate of rapid response escalations per 1000 admissions (NMDS) HQSC Provide	TBD			19%	19.7%	13.2%	19%	22.6%	20.6%	TBC	⇩
% of patients audited for pressure injury risk who received a score (NMDS)	90%	85%	86%	87%	89%	88%	88%	90%	92%	91%	⇩
% of patients with the correct pressure injury care plan implemented	90%	68%	68%	68%	65%	70%	69%	65%	59%	64%	⇧
% of patients audited with a hospital acquired pressure injury	TBD	0.6%	1.2%	1.0%	0.6%	1.3%	0.6%	1.4%	0.3%	0.5%	⇧
% of patients audited with non-hospital acquired pressure injury	TBD	2.1%	1.6%	2.2%	1.4%	2.9%	3.3%	0.26%	1.5%	1.5%	⇔

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 ⇩

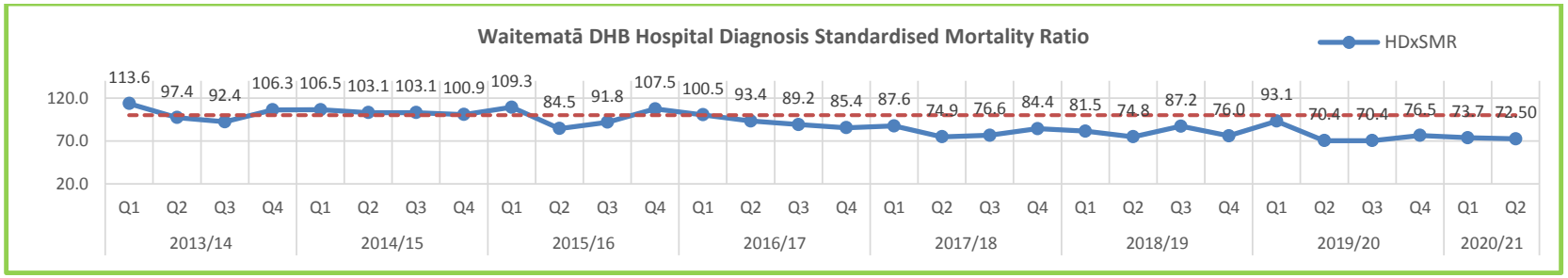
Quality Safety Markers	Target		Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Last Qtr Change
Peri-Operative Care – Surgical Safety												
Uptake: % of audits where all components were reviewed	TBD	*Sign In*	100%	98%	100%		98%		100%	100%	97%	⇩
		Time Out	98%	100%	100%		100%		100%	100%	100%	⇔
		Sign Out	100%	98%	98%		100%		100%	100%	97%	⇩
Engagement: % of audits with engagement scores of five or higher	TBD	*Sign In*	88%	89%			97%		93%	80%	91%	⇧
		Time Out	94%	100%	98%		100%		97%	100%	100%	⇔
		Sign Out	92%	98%			98%		100%	100%	97%	⇩
Observations: number of observational audits carried out for each part of the surgical checklist (minimum of 50 observations per quarter)	TBD	*Sign In*	51	57	48	49	65		40	5	35	⇧
		Time Out	53	53	52	45	64		33	3	24	⇧
		Sign Out	50	51	45	36	55		40	2	32	⇧
Data not published by the HQSC if observations were <50	Less than 75%		More than 75%					Target Achieved				

2. Local Key Quality Indicators

Hospital Acquired Blood Stream Infections (HABSI)	Target	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Total number of infections	***0***	*6*	*9*	*8*	*5*	*4*
Number of infections per 1,000 occupied bed days (OBD)	***0.00***	*0.25*	*0.43*	*0.33*	*0.21*	*0.16*
Hospital Associated Staph Aureus Blood Stream Infections (SAB) – Measure for Hand Hygiene Compliance	**Target**	**Jan 21**	**Feb 21**	**Mar 21**	**Apr 21**	**May 21**
Total number of Hospital Associated Staph Aureus Blood Stream Infections (SAB)		*6*	*1*	*2*	*0*	*2*
Number of Hospital Associated SAB infections per 1,000 occupied bed days	***< 0.13***	*0.25*	*0.05*	*0.08*	*0.00*	*0.08*
Central Line Associated Bacteraemia (CLAB) – ICU/HDU	**Target**	**Jan 21**	**Feb 21**	**Mar 21**	**Apr 21**	**May 21**
Number of CLAB infections per 1,000 Bed days	***<1***	*0.55*	*0.55*	*0.54*	*0.54*	0.54
Falls With Harm	**Target**	**Jan 21**	**Feb 21**	**Mar 21**	**Apr 21**	**May 21**
Total number of falls		*158*	*168*	*181*	*155*	*140*
Rate of falls per 1,000 occupied bed days	***<5.0***	*5.0*	*5.9*	*5.7*	*4.9*	*4.3*
Total number of falls with major harm (SAC 1 and 2)		*0*	*3*	*2*	*2*	*0*
Rate of falls with major harm per 1,000 occupied bed days		*0.0*	*0.11*	*0.06*	*0.06*	*0.00*
Pressure Injuries	**Target**	**Jan 21**	**Feb 21**	**Mar 21**	**Apr 21**	**May 21**
Number of patients with reported and confirmed pressure injuries (via Incident Reporting System RL6)	***0***	*38*	*29*	*36*	*27*	*40*
Rate of confirmed pressure injuries per 1,000 occupied bed days	***0.0***	*1.2*	*1.0*	*1.1*	*0.9*	*1.2*
Number of reported and confirmed Stage 3, 4 and unstageable pressure injuries (via Incident Reporting System RL6)	***0***	*0*	*1*	*0*	*0*	*3*
Rate of confirmed Stage 3, 4 and unstageable pressure injuries per 1,000 occupied bed days	***0.00***	*0.00*	*0.04*	*0.00*	*0.00*	*0.09*
Complaint Responsiveness	**Target**	**Jan 21**	**Feb 21**	**Mar 21**	**Apr 21**	**May 21**
Average time to respond to complaints in the reporting month	**<15 days**	*9*	*11*	*9*	*9*	9

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. **Waitematā DHB's HDxSMR** (combined NSH + WTH) **Q2 FY2020/2021= 72.5**



3. Innovation and Improvement Team

April 2021

Achievements/Events

eOrders Systems - Phinter go live for eBloods

Following the successful update of the Laboratory information system in April, we are now set to go live with the "phinter" (phone and printer combined in a 3D printed chassis) based collection. This means we can go **paperless for blood collections**, the system will allow ADU clinicians to order on a computer and then collect themselves ("collect soon"), or ADU phlebotomy to collect; and if not collected before the patient is transferred to a ward, the order will swap over to the inpatient encounter and will be collected with other ward collections so that the consumer will not miss out on the required tests.

This needs a 2D barcode with the NHI encoded, which is part of the soft wristband project. As this is working well at Waitakere Hospital we will start there while we ramp up going live with these wristbands at North Shore Hospital. Due to the faster pace needed for the ED ("collect now"), and the use of the temporary ID prior to NHI allocation, we will start with existing systems there and learn from this, while working with the vendor Sysmex to finalise the production of the "order and collect" application that we started with them during the COVID-19 work.

Outpatients Flow Tools

The Clinical Portal **eOutcomes forms** and supporting workflows, which were developed in-house, are now live across 24 specialties. The remaining two services (orthopaedics and gastro) are expected to go live in mid-May with a new version that will include a clinical 'call patient' function, nurse task lists for clinic preparation, disease codes (SNOMED) and refined procedure code lists. Online booking has commenced a design and build phase that will now also include check-in kiosks. Although the design and implementation is likely to be complex in our environment, we hope to go live with online booking for our first specialty in October 2021.

eSurvey System (PERSy) replacement procurement

The contract for our existing electronic patient and staff experience and patient reported outcome measures (PROMs) survey system (PERSy) has expired without further right of renewal. Therefore, we have gone to market to seek a replacement system(s) that provides these functions. We have extended the current contract for a further 12 months under MBIE's dispensation rules, to ensure business continuity. It is important that we can continue to collect and report patient experience (eg Friends and Family Test) and PROMs in a safe and secure way, and provides staff with data for quality improvement. The Ministry of Health has asked about the involvement of the Northern region's DHBs in the procurement process and we are responding to the Ministry - each of the DHBs have been invited to join the procurement with Counties Manakau DHB joining us and the other two DHBs observing but not in a position to consider replacing their existing systems.

Email validation and Digital Post are in the benefits realisation phase – to date we have validated over 500,000 emails across 3 core systems. We can now also consume email addresses captured and validated at CMDHB as well as through the Breast Screening system from GP eReferrals. We are currently sending ~50,000 letters per month through Digital post with 65% being sent by email. This relates to a cost avoidance of approximately $28,000/month. The Breast Screening service went live with Digital Post in December 2020, with 95% of their manual mail handling now being carried out at the Digital Post mail house. This has resulted in >40,000 letters sent, cash savings of more than $22,000 and around 32 hours per month freed up to perform higher value tasks.

ED Electronic Whiteboard

On Tuesday 11 May the new ED electronic whiteboard (eWhiteboard) went live across both hospitals. The eWhiteboard is core to the operation of EDs for both clerical and clinical purposes. The previous solution relied on legacy software (eg Internet Explorer 8) which limited the ability to utilise advantages of modern technologies, increased the security risk and the resource required to maintain the software and ensure compatibility, and incurred significant cost for any change.

As part of the COVID-19 response, time was spent implementing e-notes and e-observations in ED which reduced the movement of paper between ED and the rest of the hospital, but impacted workflow in the existing whiteboard with too many clicks to move between e-systems. In response, the HIG development team designed a modern eWhiteboard replacement using Centric - an application developed by the team using new technologies and code frameworks and is widely used on ward rounds and in outpatient clinics to give rapid access to the list of patients the clinician is looking after. Citrix is our Business Continuity Plan when Clinical Portal is unavailable.

The new eWhiteboard design incorporates all of the current functionality, but additionally caters for seamless access to core clinical information from multiple electronic applications in patient context to perform tasks in a logical and workflow-focused manner, while ensuring established clerical functions are retained, for example moving patient locations within the department.

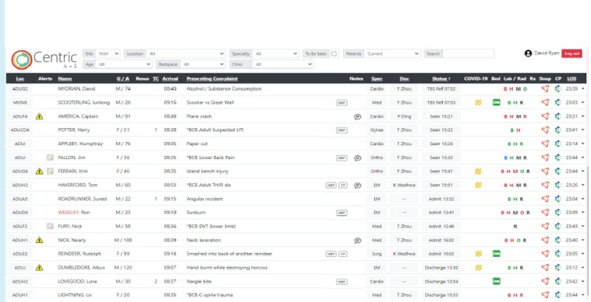
Approximately 75% of the work required to enhance Centric to provide e-whiteboard capability had already been developed by the team when building other applications eg Snapshot and eNotes. This is an example of how we have created a series of logical building blocks, and can leverage these by putting them together in multiple different ways to achieve the desired workflow for staff. Leveraging off this previous work has allowed us to deliver significant additional value with a fraction of the effort and cost that would be needed to develop a product from scratch.

ED Whiteboard

Single-click to clinical systems

Streamlined workflow

Fast



6. Patient and Whānau Centered Care

6.1 Patient Experience Feedback – February 2021 update

6.1.1 National Inpatient Survey

A summary of the specific performance measures from the February 2021 National Patient Survey is presented below. Patients who were emailed the survey were discharged from Waitematā DHB hospitals from February 1st to February 14th. Waitematā DHB recorded 780 responses in which 50 responses were from Māori patients and 29 were from Pacific patients.

Highest performing results for Waitematā DHB

The table below shows the highest performing questions for Waitematā DHB in February 2021. Click on the question title to see more details on specific questions.

⚠ Low sample size

Question Click on a question to see more detail		Overall	C.I.	n
Patient did NOT identify perceived unfair treatment	Feb 2021	91.8%	(89.7%-93.9%)	656
Patient definitely treated with respect by other members of health care team.	Feb 2021	90.6%	(88.5%-92.7%)	716
Patient definitely treated with respect by nurses.	Feb 2021	90.6%	(88.5%-92.7%)	742
Before the operation(s), staff definitely helped patient to understand what would happen and what to expect.	Feb 2021	89.5%	(86.2%-92.8%)	325
Patient definitely treated with kindness and understanding by nurses whilst in hospital.	Feb 2021	89.4%	(87.2%-91.6%)	747
Patient definitely treated with respect by doctors.	Feb 2021	89.2%	(87.0%-91.4%)	738

Lowest performing results for Waitematā DHB

The table below shows the lowest performing questions for Waitematā DHB in February 2021.

⚠ Low sample size

Question Click on a question to see more detail		Overall	C.I.	n
Patient was definitely told the possible side effects of the medicine (or prescription for medicine) they left hospital with, in a way they could understand.	Feb 2021	63.4%	(59.4%-67.4%)	563
Hospital staff definitely talked with the patient about whether they would have the help they needed when they left the hospital.	Feb 2021	64.0%	(60.0%-68.0%)	564
Patient definitely had enough information about how to manage their condition or recovery after they left hospital.	Feb 2021	68.5%	(65.2%-71.8%)	739
Towards the end of the patient's visit, they were definitely kept informed as much as they wanted about what would happen and what to expect before they could leave the hospital.	Feb 2021	72.2%	(69.0%-75.4%)	748
Patient always involved as much as wanted to be in made decisions about treatment and care.	Feb 2021	73.7%	(70.6%-76.8%)	763

A summary of results where there is significant low differences when comparing Māori with non-Māori respondents is below.

There were no questions in which Māori results for Waitematā DHB were signficantly higher than the non-Māori, non-Pacific results.

Questions in which Māori results for Waitematā DHB were signficantly lower than the non-Māori, non-Pacific results.

⚠ Low sample size

Question Click on a question to see more detail		Overall	C.I.	n
Patient did NOT identify perceived unfair treatment	Feb 2021 Māori	75.6%	(63.0%-88.2%)	45
	Non-Māori, non-Pacific	93.0%	(90.9%-95.1%)	587
Patient definitely treated with kindness and understanding by doctors whilst in hospital.	Feb 2021 Māori	76.0%	(64.2%-87.8%)	50
	Non-Māori, non-Pacific	86.3%	(83.7%-88.9%)	665
Hospital rooms or wards (including bathrooms) were always kept clean.	Feb 2021 Māori	69.2%	(56.7%-81.7%)	52
	Non-Māori, non-Pacific	83.0%	(80.2%-85.8%)	677
Hospital staff always helped patient to get to the bathroom or to use a bedpan as soon as desired.	Feb 2021 Māori	64.7%	(48.6%-80.8%)	34
	Non-Māori, non-Pacific	79.7%	(75.8%-83.6%)	414
Hospital staff definitely talked with the patient about whether they would have the help they needed when they left the hospital.	Feb 2021 Māori	43.5%	(29.2%-57.8%)	46
	Non-Māori, non-Pacific	65.7%	(61.5%-69.9%)	495

6.1.2 Friends and Family Test

ADULT SURVEY

In April the Net Promoter Score (NPS) was 77 with feedback from 896 people. The NPS score is on a par with the previous month however the response rate has fallen 26% from 1,217 responses in March. 'Welcoming and friendly' and 'treated with compassion' are our highest performers achieving 85 and 83 respectively, followed closely by 'listened to' achieving 81. The areas most in need of improvement are 'explaining things in a way the patient understands' and 'involving patients/whānau in decision making', achieving scores of 70 and 72 respectively.

Friends and Family Test Overall Results

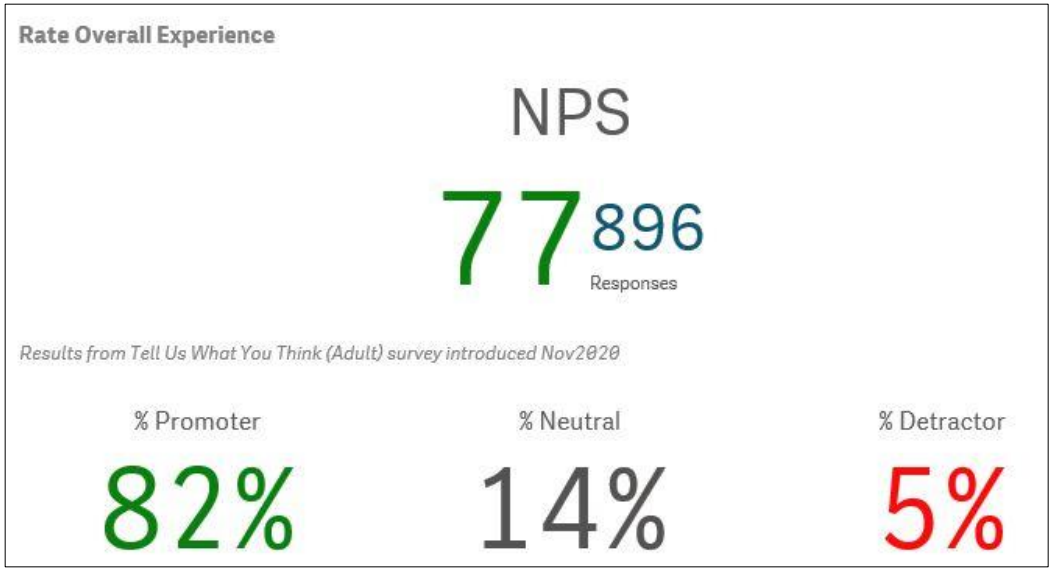
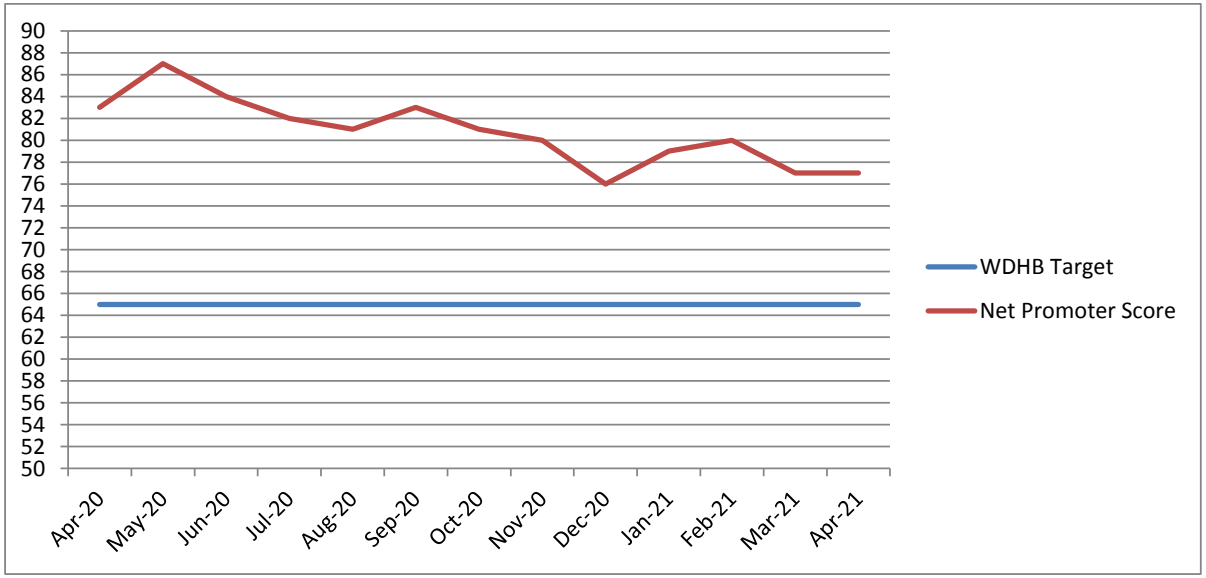


Figure 1: Waitematā DHB overall NPS

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	**896**	**77**	**85**	**81**	**83**	**72**	**70**
Apr-2021	896	77	85	81	83	72	70

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

April 2021	NZ European	Māori	Asian	Pacific	Other/ European
Responses	536	61	89	61	149
NPS	76	87	73	75	76

Table 2: NPS by ethnicity

In April, all ethnicities met the Waitemata DHB NPS target and score 65 and above. Maori achieved the highest NPS score of 87.

April 2021	NZ European	Māori	Asian	Pacific	Other/ European
Staff were welcoming and friendly	84	91	82	81	88
I was listened to	81	84	85	70	83
I was treated with compassion	84	91	77	75	83
I was involved in decision making	69	79	71	75	79
My condition/treatment was explained in a way that I understood	70	77	67	75	66

Table 3: NPS for all questions by ethnicity

This month, all measures score at or above the DHB target. The highest NPS score was for 'welcoming and friendly' and 'treated with compassion' with both achieving scores of 91 from Maori. The lowest performing measures for nearly all ethnicities are 'condition/treatment explained in a way that was understood' and 'involvement in decision making'.

6.2 Māori Patient and Whānau Experience Lead Highlights

Māori and Pacific Equity in Outpatients Project

The project comes from the Ministry of Health sustainability funding work-stream. The main goal is to reduce DNA's (Did Not Attend). Due to the deficit labelling and assumptions this term places on our whānau, it has been recommended to start the project by using the term "Non-Completion of Service" in its place.

Key tests of change include the following:

- Intentional wording in patient appointment letters to invite and share how they can change their appointments if required.
- Ensuring accessibility/ availability of a bookings team member to our reception spaces to support appointment changes where possible and immediately for whānau.
- Introduction of the concept of a "Care Coach" – a position that supports coaching teams on how to host, receive and support whānau when they come to service – and works with whānau on how to make the most and understand their appointments.
- Intentional reflection on our patient spaces in outpatient clinic areas and ensuring that our spaces support whānau comfort when coming for appointments and positively influence the interactions of staff members with each other and whānau.

Volunteer Recruitment Statistics

Volunteer numbers have increased by eight compared to previous report. The recruitment drive is going well. A new programme with West Lake students will commence in May where 45 students will be orientated for our weekend volunteer service.

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	94	3	145

Table 4: Volunteers Recruitment

Consumer Council Update

The Consumer Council met on May 5th 2021. David Lui stood down as Chair after sharing with the Council that he has accepted a position on the Waitematā DHB Board. Deputy Chair DJ Adams was appointed to the role of new Chair.

They discussed the following agenda items at their most recent meeting:

- COVID-19 Vaccination Programme
- Waitakere Hospital Master planning
- Lung Cancer Screening Programme
- Health Sector Reform
- Māori and Whānau Patient Experience Update
- Patient Experience Report

6. Resolution to Exclude the Public

Recommendation:

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

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
1. Confirmation of Public Excluded Minutes – Hospital Advisory Committee Meeting of 19/05/21	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)]