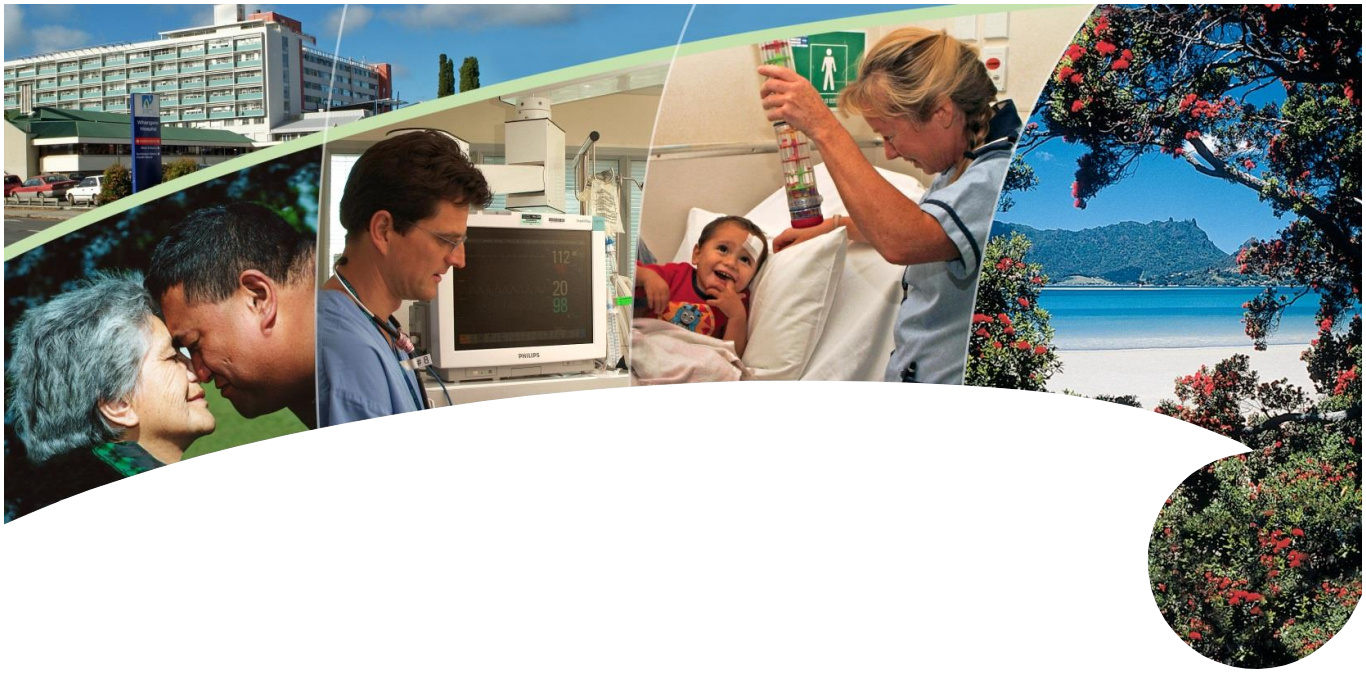


Northland District Health Board

Hospital Advisory Committee

AGENDA

DATE: Monday 15 July 2019

TIME: 9.00am

VENUE: Tangihua Meeting Room
Tohora House
Whangarei Hospital

NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Ā Rohe O Te Tai Tokerau

AGENDA

HAC MEETING
MONDAY 15 JULY 2019

9.00am		Karakia	
		Apologies	
		Register of Interests	3
		• Does any member have an interest they have not previously disclosed? • Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?	
		Attendance Register	5
9.00am	1.0	General Business	6
		1.1 Changing Face of Northland DHB Mental Health Services – Presentation Ian McKenzie, GM MHAS, Dr Margaret Aimer, Clinical Director MHAS, Jane Simperingham Professional Leader, MHAS Nursing	
9.30am	2.0	Committee Minutes	7
		2.1 Confirmation of Minutes 27 May 2019	8
		2.2 Matters/Actions Arising	10
		2.2.1 Dispensing medications on discharge rather than giving patients prescriptions to take to a community pharmacy.	11
9.40am	3.0	Chair's Report	17
9.45am	4.0	System Performance	18
		4.1 Operational Report	19
		4.2 Orthopaedic Department Electives: Presentation – Dr Margie Pohl, Clinical Director, Orthopaedic Department	
10.30am	5.0	Next Meeting Details	61
10.30am		Closure	

HAC INTERESTS REGISTER

Name	Nature of Interest	Date Updated
BAIN John (Chair)	• Councillor - Northland Regional Council • Member – St John Chapter • Director - Noble Imports Ltd. • Director -Banjo Trading Co Ltd • Trustee – Northland Road Safety Trust • Justice of the Peace	29/1/19
BROWN Sue	• Owner and Executive Director – Papatoetoe Residential Care • Chair – Auckland Northland Regional Bridge Committee • Business consultant to Aged Care Facility businesses.	25/3/19
EVANS Debbie	• CEO – Kaipara Community Health Trust (KCHT) • KCHT Community Representative – Kaipara Total Health Care Joint Venture Board • KCHT Representative Kaipara Care Committee • Member Dargaville Integrated Family Health Centre Committee • Member – Northland Community Foundation Grassroots Funding Allocation Committee • Member – Rural Women • Member Habitat for Humanity Dargaville Sub-committee Family Members associated with NDHB employment/programmes • Bernadette Buisman, Registered Nurse – Renal Unit • George McNally, Lecturer at North Tec – Nursing Department	29/5/17
JENSEN Denise	• Chief Financial Officer and Company Secretary – New Zealand Refining Company Limited • Chair – Independent Petroleum Laboratories Limited • Director – New Zealand Refining Nominees Limited • Chair of Trustees – The New Zealand Refining Company Pension Fund	5/12/16
JONES Libby	• Councillor – Kaipara District Council • Deputy Chair – Otamatea High School • Trustee - Rural Support Northland • Trustee - Sport Northland • Deputy Chair - Paparoa Medical Society • Member - Rural Health Alliance Aotearoa New Zealand (RHAANZ) • Member – Rural Women NZ • Manager Jigsaw North Family Services • Trustee – Volunteering Northland	6/6/19
MACAULEY Sally	• Representative - Northern Regional DHB Executive • Councillor – Far North District Council • FNDC Committee member: Corporate, Strategy and Operations • Chairman – FNDC Creative Communities – Creative NZ • Chairman – Northland Community Response Forum (MSD) • Chairman – Bay of Islands Arts Festival Trust • Director/Trustee – Kerikeri International Piano Competition Trust	10/4/17

Name	Nature of Interest	Date Updated
	• Director – Kaikohe Education Trust • Director- Kaikohe Community and Youth Centre Trust • Judicial and Ministerial Justice of the Peace – Far North Justice of the Peace Association Inc. • Latterly visiting Justice Northern Regional Corrections Facility • Northern Regional Representative – Benefits Review Committee (WINZ) • Director - Turner Arts Centre, kerikeri Peter Macauley (Husband) • Partner Palmer Macauley Lawyers • Member of Priority Chapter NZ St John	
PAYINDA Gary	• Employee – Northland DHB • Member – Huanui College Advisory Board • Medical Director for Surf Lifesaving New Zealand • Expert advisor – Health and Disability Commissioner • Member – NZ Medical Assistance Team Kristy Wolff (Wife) • Employee - Northland DHB	13/11/17

CALANDER YEAR MEMBER ATTENDANCE - 1 JANUARY - 31 DECEMBER 2019

	2019											
HAC	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
John Bain (Chair)	✓		✓	✓	✓							
Sue Brown	×		✓	✓	✓							
Debbie Evans	✓		✓	✓	✓							
Denise Jensen	✓		✓	✓	×							
Libby Jones	✓		✓	✓	✓							
Sally Macauley	✓		✓	✓	✓							
Gary Payinda	✓		✓	✓	✓							

FINANCIAL YEAR MEMBER ATTENDANCE - 1 JULY 2018 - 30 JUNE 2019

	2018						2019					
HAC	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**
John Bain (Chair)	✓	✓		✓	×		✓		✓	✓	✓	
Sue Brown	✓	✓		✓	×		×		✓	✓	✓	
Debbie Evans	✓	✓		✓	×		✓		✓	✓	✓	
Denise Jensen	✓	✓		✓	×		✓		✓	✓	×	
Libby Jones	✓	✓		✓	×		✓		✓	✓	✓	
Sally Macauley	✓	✓		✓	×		✓		✓	✓	✓	
Gary Payinda	✓	✓		×	×		✓		✓	✓	✓	

	No meeting held

1.0 GENERAL BUSINESS

Changing Face of Northland DHB Mental Health Services – Presentation Ian McKenzie, GM MHAS, Dr Margaret Aimer, Clinical Director MHAS, Jane Simperingham Professional Leader, MHAS Nursing

2.0 COMMITTEE MINUTES

2.1 Confirmation of Minutes 27 May 2019
2.2 Matters/Actions Arising
2.2.1 Dispensing medications on discharge rather than giving patients prescriptions to take to a community pharmacy.

Northland District Health Board
HOSPITAL ADVISORY COMMITTEE (HAC)
Monday 27 May 2019, 9.00- 10.30
Dargaville Hospital

DRAFT MINUTES

Present

John Bain (Chair)	Gary Payinda	Debbie Evans	
Sally Macauley	Sue Brown	Libby Jones	

In Attendance

Nick Chamberlain	Meng Cheong	Dee Telfer	
Paul Welford	Mike Roberts	Kathryn Leydon	Sarah Fox (minutes)

Board Member - Craig Brown

Apologies
Denise Jensen

1.0 General Business

1.1 A presentation was given by Karen Katipa and Andrew Mardon on Dargaville Hospital Service Initiatives including:

- Population data
- What is working well
- Inpatient and outpatient activity and specialist clinics
- Repatriation of Kaipara residents
- Current initiatives and future opportunities
- Patient feedback and staff perspectives

It was agreed to report on actions to increase both inpatient and outpatient utilisation at future meetings.

2.0 Committee Minutes

2.1 Confirmation of Minutes 15 April 2019

It was moved that the minutes of the meeting held on 15 April 2019 be approved.
MOVED Sally Macauley SECONDED Debbie Evans CARRIED

2.2 Matters/Actions Arising

2.2.1 Single service approach to youth school-based health services

- Update noted. Action closed.

2.2.2 Food waste

- Update noted. Action closed.

2.2.3 Recruitment data

- Update noted. Action closed noting: a) the report shows time from vacancy approval; b) actively delaying vacancy approval is a legitimate tactic for controlling spend in non-essential services; c) other streams of work were in parallel such as controlling locum spend reported at the Finance Risk and Assurance Committee (FRAC).

3.0 Chair's Report

The Chair reported that he had recently witnessed excellent treatment provided to a patient at Whangarei Hospital and commended staff. Agreed that the Board needed to continue its strong support for the campaign for a new hospital.

4.0 System Performance

4.1 Operational Report

The Chief Operating Officer highlighted the following points:

- In continuing to improve reporting to HAC, some of the less meaningful trending items have been removed. Members' feedback continued to be welcomed.
- In response to a question at the previous HAC meeting on falling ASH rates in adults, it was found that there were many interventions which might have had an impact. It was most likely the result of many incremental changes. The most significant likely being: a) the increased admission threshold created through demand rising faster than capacity and b) St John initiatives to treat in the community rather than bring patients to ED. The re-launch of Primary Options Acute Demand Management Service (POADMS) was hoped to contribute further.
- The organisation was on track for agreed deficit this year but next year would be far more challenging. The organisation is tightening up on applying agreed criteria to travel and training requests and would be improving transparency and tracking of decisions to approve or decline.
- Stewardship Committee meetings had commenced. As previously reported, the aim of the committee is to provide recommendations on how to make best use of all NDHB's available resources so as to minimise harm and maximise total health gain. Progress would be reported at future HAC meetings.
- The Executive Leadership Team recently discussed staffing business cases from ED, Medicine and Podiatry.

There was discussion on the following items:

- Strikes, acute demand, sickness and other factors all had an effect on ability to meet targets during the March reporting month.
- The acting Chief of Nursing and Midwifery was preparing a paper on Nurse Practitioners.
- The challenges faced by services, such as orthopaedics, in determining which patients to put forward for surgery is one of the areas being addressed by Stewardship Committee.

5.0 Next Meeting Details

The next meeting would be held at 9.00am on Monday 15 July 2019, Whangarei Hospital

There being no further business, the meeting closed at 10.25am.

_____ _____

CHAIR **DATE**

Actions Arising from the Minutes of the
Northland District Health Board Hospital Advisory Committee Meeting
27 May 2019

	ACTION	BY	WHEN	COMMENTS
1.	Report on dispensing medications on discharge rather than giving patients prescriptions to take to a community pharmacy.	General Manager, Medicine, Health of Older People, Emergency and Clinical Support	July 2019	Paper attached
2.	Changing face of NDHB mental health services.	General Manager Mental Health and Addiction Services	July 2019	Presentation to meeting

Northland District Health Board
Briefing Paper to HAC

SUBJECT DISPENSING MEDICATION ON THE WHANGAREI HOSPITAL CAMPUS

Background

At the November Board meeting, during discussion, a question was raised "would it be possible for Northland DHB (NDHB) to provide a dispensing service on the Whangarei site, particularly for at-risk patients." The Board asked that this be investigated.

Primary medication non-adherence (PMNH) is defined as failure to fill at least one prescription item. A recent review of 79 studies from around the world identified the annual adjusted disease specific economic cost of PMNH as ranging from US$4,949 to $44,190 per person.

Closer to home this was estimated in the same study as being equivalent to AU$7 billion in Australia. Additionally 10% of hospitalisations in older adults are attributed to PMNH with the typical patient requiring three extra medical visits per year leading to US$2,000 increased treatment costs per annum.

Further, the cost specifically for cardiovascular disease ranged from US$3,347 to $19,472, and for respiratory disease $804 to $36,259, both of which are two of our commonest reasons for admission.

A recent study of 1,000 patients at Counties Manukau Health Emergency Department (CMDHB) identified that there was a 50% rate of primary medicine non-adherence.

Based on the findings at CMDHB we can infer that the medication non-adherence rate in Northland will be similar at around 50% of ED discharges. The accepted overall level of non-compliance in the literature is around 40%. Overall it seems likely then that medication non-adherence in our population is between 40 and 50%.

A recent paper from Pharmac on 'Achieving Medicine Access Equity in Aotearoa New Zealand' gave the following summary of the issues:

New Zealand researchers Norris and Horsburgh describe the barriers to access that may be present for people along this journey:
"Firstly, patients have to identify that something is wrong with them or their family member's health, or something needs to be checked, and decide that this justifies a visit to the prescriber. Social circumstances and where on the list of concerns, are going to affect the likelihood of any action. People who are struggling with paying bills, feeding their families and dealing with other family members needing care and attention are less likely to do this. High rates of poverty and poor health make this a reality for many Māori and Pacific families.

Secondly, the patients have to get to a prescriber which is influenced by several factors such as geographical location, ability to get time off work, user charges, availability and cost of transport, availability and cost of care for dependents.

Thirdly, the interaction with the prescriber has to result in a prescription. The nature of this interaction is complex as there is an intersect between the clinical expertise, knowledge and belief of the prescriber and the patient/whānau/ carer expertise and knowledge and beliefs. When the differences and fit at this intersect is not tailored to suit the patient/whānau/carer or designed to include their contributions it may result in different outcomes for different groups of people.

Fourthly, the patient has to take the prescription to a pharmacy (or have it sent there) and they have to pick up the medicine. User charges are a significant barrier to picking up prescriptions, and previous research has shown that these are more likely to prevent Māori and Pacific people from obtaining their medicines. These ethnic differences persist after adjusting for socioeconomic deprivation. Factors such as geographical locality, ability to get time off, availability and cost of transport are also likely to affect whether people pick up their prescriptions."

The primary drivers for change to eliminate inequities in access to medicines we have identified are:

1. **availability** – how PHARMAC makes and implements funding decisions so that everyone who is eligible can access funded medicines;
2. **affordability** – reducing cost barriers for priority populations so that people can afford funded medicines;
3. **accessibility** – ensuring people don't face challenges getting to see a prescriber or to the pharmacy;
4. **acceptability** – the ability of health services to create trust, so patients are informed and engaged enough to accept the medicines they've been prescribed; and
5. **appropriateness** – the adequacy and quality of prescribing to ensure equitable health outcomes.

Pharmac identified the following barriers relating to getting to the pharmacy and picking up the medicine:

- Patient centred barriers:
  - Transport
  - Physical/mental condition
  - Travel
  - Cost
  - Prior debt
  - Availability

- Health system barriers:
  - Inconvenience
  - Availability
  - Paper based prescriptions
  - Stock availability

The issues of affordability and accessibility were identified by the inpatient paediatric team at NDHB and a process was established where selected patients identified as having respiratory ambulatory sensitive (avoidable) hospital admissions are supported to pick up their medications. This includes faxing of scripts twice daily to the local pharmacy where an HCA or RN picks them up and gives them to the patient or their whanau.

Other areas did not report any specific issues with access or risk. Medical wards can fax prescriptions from the ward to the patient's preferred pharmacy for the patient to collect and pay once they have discharged. Very occasionally they will use the local pharmacy and will pay from their own budget to ensure that a prescription is filled. In the case of inability to pay the patient co-payment a, social worker will have been engaged as early as possible during the patient stay to develop long term solutions.

Ward teams believe they are getting the prescriptions to the patient's pharmacy in plenty of time for them to be filled and then communicating with the family if the patient can't collect it. They also advise on the availability of the extended hours pharmacies where appropriate.

A project is currently underway to improve the process for patients returning to aged residential care homes. It is planned to have a suitable prescription and administration chart that can be used for up to 48 hours until the residential home can ensure proper long term prescribing, as per their usual procedures.

1. Hospital pharmacy

- The pharmacy at Whangarei Hospital provides for inpatient hospital services only, i.e. hospital medicine supply functions and clinical pharmacy support to prescribers and administrators of medicines
- Hospital clinical pharmacists focus on safe and appropriate use of medicines, including reconciliation and advising clinicians. Supply is a crucial role of the pharmacy department, however, the majority of supply is managed through medication imprest in clinical areas – patient-specific dispensing is performed only when a required medicine is not available on imprest
- On discharge and during an outpatient clinic, patients who require medicine supply will be issued a prescription for them to take to a community pharmacy
- Current hospital pharmacy opening hours are 0800 to 1630 Monday to Friday. An on-call pharmacist is available outside of these hours
- The hospital pharmacy can supply medicines at discharge according to PHARMAC hospital medicines list (HML) rules (see below). In practice (consistent with other DHB hospital pharmacies) this occurs in emergency circumstances if there may be an access or timeliness issue for a prescription to reach a community pharmacy, or where continuation of a medicine started in hospital is not possible in the community, either due to subsidy or availability.

  3.5 Community supply of Hospital Pharmaceuticals from DHB Hospitals: Except where otherwise specified in Section H of the Schedule, DHB Hospitals may Give any Hospital Pharmaceutical, including a Medical Device, to a patient for use in the community, provided that:
  3.5.1 the quantity dispensed at any one time does not exceed the amount sufficient for up to 30 days' treatment, unless:
  a it would be inappropriate to provide less than the amount in an original pack, or
  b the relevant DHB Hospital has a policy covering dispensing for discharge and the quantity dispensed is in accordance with that policy, and

  3.5.2 the Hospital Pharmaceutical is supplied consistent with any applicable restrictions in Section H of the Schedule (includes Indication Restrictions, Local Restrictions and Prescriber Restrictions

2. Community Pharmacy

- Community pharmacy is operationally different in many respects to hospital pharmacy; community requires more focus on supply (versus clinical), different software systems enabling claims, separate PHARMAC schedule and associated rules, different staff skills and knowledge, links with other community health providers, $5 patient co-payment, different physical space requirements
- Opening hours are mixed; there are three community pharmacies which operate over 7-days and have extended hours until 2000-2100hrs. Others across Northland are open on Saturdays to up to 1400hrs
- Maunu Unichem Pharmacy is open to 1730hrs on weekdays and to 1400hrs on Saturdays
- It is important for community pharmacy to maintain the long-term relationship with their patients and in particular they will do education when filling a prescription and establish an ongoing relationship.

3. Volumes

Currently we have been unable to establish with any certainty the numbers of prescriptions and items issued by Whangarei Hospital. In common with other DHBs that do not have electronic prescribing we can only access the most basic information which is essentially the name and cost of drugs dispensed in the community and hospital. On discharge from an inpatient ward it is most likely that prescriptions are generated from the Concerto system; most outpatient clinic prescriptions are handwritten; whilst ED can use Concerto or handwritten prescriptions.

It is not possible to determine the number of prescriptions generated from Whangarei Hospital or the numbers of prescriptions not filled.

Investigation

A literature search was disappointing with nothing directly related to an onsite pharmacy adding value although access is a key issue.

Other DHBs

DHB hospital pharmacies were surveyed by our Pharmacy Manager on the service that they provide. Two useful responses were received from tertiary DHBs which operate an onsite community pharmacy. Both were owned and operated by the DHB at Waikato and Waitemata. Neither DHB was able to produce pre and post implementation data; the justification for developing the service was that this was needed at Waikato due to the size and throughput of the DHB. At Waitemata DHB a business case was developed based on the premise that North Shore Hospital had had an onsite service for many years and that Waitakere patients were not receiving an equitable service.

The options investigated by Waitemata were:

- Open an outpatient pharmacy operated by the DHB
- Rent foyer space designated for a pharmacy to a third party. This option was thought less favourable as it limited flexibility to change services, ensure quality and ability to assist with high needs/high risk groups
- Status quo which was not acceptable.

The decision was taken to open a DHB operated pharmacy operating from 0900hrs to 1800hrs from Monday to Friday.

This service is provided in a fit-for-purpose space in the foyer. The cost of drugs is claimed by claim reimbursement from the Funder on a monthly basis (i.e. run by the hospital pharmacy service and funded by the Funder).

In regards to the co-payment it was determined by them that a proportion of lower socioeconomic patients are unlikely to be able to pay for prescriptions. The co-payments are applied on a case-by-case basis to ensure parity with community pharmacies. Discretion is applied to ensure that vulnerable patients have access to medication.

Generally the tertiary DHBs all have a separate outpatient pharmacy onsite. The majority of other DHBs do not have such a facility on site but have existing community pharmacies close by.

Of note, Whangarei now has three 7-day pharmacies that operate to 2100hrs each day and the local pharmacy whilst not opening late, is as near the hospital as other pharmacies on big campuses.

Discussion

The issue of PMNH is present in all health systems. A particular issue has been identified at NDHB and a specific response has been put in place. This targeted approach appears to be successful. A recent PHARMAC paper identifies some specific issues in NZ related to inequity. It is clear from this paper that the cause of PMNH is multifactorial of which physical access is but one factor. It seems unlikely that an onsite pharmacy will reduce the likelihood of PMNH as a single intervention. This is confirmed by the study from CMDHB where a high rate of PMNH has been identified despite there being an onsite pharmacy on the campus.

Any investment in reducing PMNH should probably be targeted to specific high risk groups in a similar way to that undertaken on the paediatric ward and by a greater use of clinical pharmacists.

On the current footprint even opening the minimum 40 square metre NDHB managed pharmacy would be a significant challenge.

Cost of onsite NDHB managed dispensing pharmacy

Capex cost				
Build	40sqm	$7,000	280,000	
Security, A/C, CD safe			100,000	
Contingency and fees			120,000	
Build				**500,000**
Set up FFE (fridges, IT, desk, chairs, pill counter etc)			50,000	
IT and Toniq licensing			20,000	
Set up				**70,000**
One off Capex costs				**570,000**
Ongoing Opex costs				
Staff				
Pharmacist	2	85,000	170,000	
Tech	1.2	60,000	72,000	
Associated salary costs			25,000	
Salaries				**267,000**
SW licensing			5,000	
Cleaning	52	500	26,000	
Drugs would be reimbursed through the community contract				
Co-payment discretionary			10,000	
Courier/postage/delivery			10,000	
Servicing			5,000	
Stationery			10,000	
Supplies				**66,000**
Annual Opex costs				**$333,000**

Commercial Pharmacy onsite

"The funder advises there are significant risks that would need to be mitigated prior to any development where the DHB could enter into an agreement with itself or a wholly owned subsidiary of itself with respect to the Integrated Pharmacist Services in the Community agreement (IPSCA). Such a development would not be congruent with NDHB's recent strategic pharmacy vision accepted by the Board. The Funder advises that more information is needed to be able to provide a suitable solution to the perceived issue."

Currently there is a very limited footprint on the ground floor for the high traffic, easily accessible area that a commercial pharmacy would require. Short to medium-term there are challenges with parking. In order to be an attractive proposition a significant investment would be required to build a suitable space. Revenue generated would be based on current market rates.

It is estimated that the investment required by the DHB would be between $500,000 and $750,000 to build a suitable facility, unless a joint venture was established. Either option would require a full procurement process compliant with current government policy.

As part of the new hospital building programme it may be appropriate to consider some commercial space including room for a pharmacy for convenience for the public.

Conclusion

Based on the information in the literature it is very unlikely that investing in an onsite dispensing pharmacy will resolve issues around primary medication non-adherence. There is insufficient space in the current footprint to develop an onsite commercial pharmacy in a high traffic area without

compromising interim flexibility for expanding current services on the ground floor. The return on investment for a commercial pharmacy would need careful examination.

The operational costs of a dispensing pharmacy managed by the DHB would be better invested in other proven options such as discharge pharmacists, pharmacists in ED and clinical pharmacists on the ward. Other options to reduce PMNH should also be explored and this might form the basis of an improvement project for discussion with the NDHB Medicines Committee. This would enable targeting of high risk groups and is more likely to help resolve some of the inequity issues.

Signature  Date 26/6/19

Neil Beney - General Manager
Medicine, Health of Older People,
Emergency Department & Clinical Support

3.0 CHAIR'S REPORT

4.0 SYSTEM PERFORMANCE

4.1 Operational Report
4.2 Orthopaedic Department Electives: Presentation –
Dr Margie Pohl, Clinical Director, Orthopaedic Department

Report to the
Hospital Advisory Committee
Northland District Health Board

Reporting Month: May 2019

For the meeting of 15 July 2019

Contents

Executive Summary

Overview
High patient demand (acuity and volume) combined with staff sickness has created prolonged pressure on many services. In June, Laboratory services had excellent verbal feedback from their International Accreditation NZ (IANZ) review and are awaiting formal feedback on this and the requested closure of corrective actions in the blood bank. The whole DHB also hosted a certification audit in June which also had excellent verbal feedback and a relatively small number of corrective actions.

Commentaries

Safety and Quality	Reviewing Morbidity and Mortality meetings DHB wide to improve shared learning between clinical services.
Health Targets	Improved access to elective surgery and Faster Cancer Treatment (62 days) this month. The new government planned care scheme will add further pressure next financial year.
Service Delivery	Improved endoscopy and MRI waiting times but slight worsening of FSA in four months. Especially high activity in Dargaville, including having to divert ambulances recently.
Population Health Status	Infectious diseases such as measles and flu while Whangarei ED's isolation room is being upgraded. Interim room, masks, hand gel and notices to reduce cross infection.
Financial Sustainability	Overall on track for approved $7.5m deficit but high pressures for the coming financial year.
Engaged Workforce	Piloting new methods of advertising to potential staff for highest need services eg echosonography and medical physicians. Offers out to radiologists and interviewing further.

3. Strategic Initiatives / Health Services Planning

- Planning antenatal classes in Dargaville.

4. Emergent Issues and Initiatives Identified

- Adjustment to clarity of rehabilitation criteria to improve length of stay. Approval (reported verbally last month) of business cases for ED (2.4FTE SMO, 1.8FTE Nurse practitioners), Medicine SMO 1.0 FTE and 1.0FTE Podiatrist all being acted on.
- Planning underway for demand surge for DHB midwifery predicted for December and January.

Information to assist with understanding the scorecards
The scorecards provide a high level status of performance. The indicators are summarised where appropriate for the organisation and service specific indicators are presented within separate service area sections of the report. Indicators are usually updated monthly or as soon as information becomes available

Performance Colours	
	Green indicates achieved
	Light Green indicates just missed achieving target
	Orange indicates significantly missed target
	Red indicates substantially missed target
	Grey indicates no data available
Please refer to Scorecard Definitions for threshold tolerances	

Performance Indicators	
↑	Indicates performance has improved
●	Indicates no change from previous month
↓	Indicates performance has deteriorated

Denotes a cell where no data is being collected

Surgical

1. Overview

Additional elective activity, above budgeted levels, resulted in an improvement in the target *Improved Access to Elective Surgery*. The rationale for the increase in activity was in order to minimise risk in relation to revenue. There was also no further industrial action during May and therefore disruptions to elective operating were at a minimum and driven by acute demand.

2. Scorecard

IP Events Coded For Period 80%

	Surgical Scorecard - Whangārei Hospital							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Safety and Quality	Reducing Acute Readmissions to Hospital	↓	5.0 %	6.1 %	6.3 %	6.0 %	5.0 %	6.8 %
	Elective Day of Surgery Admission rate - DOSA	↑	90 %	96 %	95 %	96 %	90 %	96 %
	Hospital Acquired Pressure Injuries	↓	0	1	0	1	0	17
	Falls with major harm within facility	●	0	0	0	0	0	1
Health Targets	Improved Access to Elective Surgery – (All NDHB)	↑	810	951	247	704	8,332	8,145
Service Delivery	Inpatient Average Length of Stay (ALOS) Acute (excludes Day Cases)	↓	3.9	3.8	3.2	4.0	3.9	3.9
	Inpatient Average Length of Stay (ALOS) Elective (excludes Day Cases)	↑	3.1	2.7	2.0	2.9	3.1	2.7
	Elective Caseweights to contract	↑	550	599			6,045	5,250
	Acute Caseweights to contract	↑	620	652			6,820	6,787
	Patients on the Surgical Booking List given a commitment to treatment but not treated within four months	↑	1.00 %	27.90 %				
	Theatre cancellations by Hospital	↓	2.0 %	4.0 %			2.0 %	4.1 %
	% Overdue Surveillance colonoscopy within twelve weeks	↑	70 %	100 %			70 %	68 %
	% Urgent Colonoscopy within two weeks	↑	90 %	96 %			90 %	77 %
	% Non-Urgent Patients Receiving a Colonoscopy within 42 days	↑	70 %	55 %			70 %	27 %
	Number of elective operation short notice cancellations - acute overload	↑	0	5			0	95
Population Health Status	Ambulatory sensitive (avoidable) hospital admissions by weighted value.			37	19	18		487
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	1,093
	YTD Variance to Savings plan ($000)	●						1,796
Engaged	FTE employed to budget	↓	444.2	433.5			444.2	420.4

Workforce	Percentage Sick Leave Taken	↓	3.00 %	2.72 %		3.00 %	2.68 %
	Total Employees in Excess of 240 hours Accrued Leave	↓				0	136
	Percentage Annual Leave Taken	↑	11.0 %	10.0 %		11.0 %	10.4 %

Commentaries for Scorecard

Safety and Quality	Readmissions for the month were in line with YTD averages but above target range. Increased pressure on beds can result in accelerated discharge, but we are investigating whether this is a driver of our result.
Health Targets	Our YTD result is adverse by 197 discharges. The primary reasons for this and challenge for the future, have been discussed in detail in previous reports. Analysis of the government's new planned care scheme appears to have increased this challenge by removing ambulatory interventions. This will require significant increases in theatre efficiency and will cause further cost pressure.
Service Delivery	Our revised policy of only booking patients who can be treated within four months is delayed to increase clinical consultation about it. We are looking at options to increase our elective output (as above) further, so as to reduce waiting times. Colonoscopy waiting list volumes continue to stabilise, but with an improvement in performance against waiting time targets. Non-urgent patients receiving treatment within 42 days has historically been at around 20%. This increased to 55% in May.
Population Health Status	There have been no specific initiatives which have reduced this month's result compared with YTD average.
Financial Sustainability	The service remains favourable YTD primarily due to delays in establishing sustainable twilight and weekend theatre lists. This provides a favourable result mainly in staffing costs (due to under-recruitment). The majority of the adverse outsourcing expenditure was due to activity related to achieving the elective surgery targets. This was delivered across the full range of surgical specialties. As noted previously we expect to under-deliver against MoH elective surgery targets. We are mitigating this loss as much as possible but the additional output required will have a cost attached and so presents financial risk.
Engaged Workforce	We are continuing to develop alternative strategies for the recruitment of certain roles that have historically proven challenging to secure quality candidates.

3. Strategic Initiatives / Health Services Planning

As noted in prior months, we have experienced an extended period of non-compliance in relation to our waiting targets, both for first specialist appointments and surgery. Finalisation and implementation of a revised approach remains our focus. We aim to implement this work in the new financial year.

4. Emergent Issues and Initiatives Identified

There are no new emergent issues or initiatives identified. Planning for the two major construction projects (theatre expansion and endoscopy suite) is ongoing and remains broadly on target.

Outpatients/Cancer and Blood Services

1. Overview

Faster Cancer Treatments (FCT) performance remains challenging with a number of patients adversely affected by delays, due to a variety of reasons. These include industrial action locally and regionally as well as timing of access to radiation therapy at Auckland DHB.

2. Scorecard

	Outpatients/Cancer and Blood Services Scorecard - Whangārei Hospital							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Health Targets	Provisional percentage of patients referred with high suspicion of cancer commencing treatment within 62 days		90 %	93 %	83 %	85 %	90 %	85 %
Service Delivery	Patients waiting longer than four months for their FSA		0.40 %	14.41 %				
Financial Sustainability	YTD Variance to net Result ($000)						0	(586)
	YTD Variance to Savings plan ($000)							254
Engaged Workforce	FTE employed to budget		133.0	136.6			133.0	134.5
	Percentage Sick Leave Taken		3.00 %	3.64 %			3.00 %	3.44 %
	Total Employees in Excess of 240 hours Accrued Leave						0	15
	Percentage Annual Leave Taken		11.0 %	8.4 %			11.0 %	9.3 %

Commentaries for Scorecard

Health Targets

We are working on a plan to recover FCT performance and put further safeguards in place to ensure compliance is regained and maintained. These options will include flexibility with respect to outsourced procedures in order to smooth demand peaks and internal supply troughs.

Service Delivery

As noted in the Surgical section.

Financial Sustainability

Financial performance was adverse during May, with a range of factors contributing to the result. These included unbudgeted depreciation, locum usage (particularly cardiac sonographers to support the echo service) and high use of the relief pool for nursing and administration staff.

Engaged Workforce

Nothing of note for the month.

3. Strategic Initiatives / Health Services Planning

As noted in the Surgical section.

4. Emergent Issues and Initiatives Identified

Nothing of note for the month.

Radiology

1. Overview

We have recently conducted a number of positive interviews with overseas radiologists, as a result it is expected that some of the current recruitment challenges will ease over the next six months. We have noted previously, that difficulties in the recruitment of radiologists, is consistent with trends across New Zealand in both the private and public sector.

2. Scorecard

	Radiology Scorecard - Whangārei Hospital							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Service Delivery	Improving waiting times for diagnostic services - CT % receiving CT scans within 6 weeks	↑	95 %	73 %			95 %	71 %
	Improving waiting times for diagnostic services - MRI % receiving MRI scans within 6 weeks	↑	90 %	66 %			90 %	53 %
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	(442)
	YTD Variance to Savings plan ($000)	●						(434)
Engaged Workforce	FTE employed to budget	↑	74.2	73.2			74.2	73.7
	Percentage Sick Leave Taken	↓	3.00 %	3.34 %			3.00 %	3.08 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	21
	Percentage Annual Leave Taken	↓	11.0 %	9.6 %			11.0 %	12.1 %

Commentaries for Scorecard

Service Delivery	While waiting times are not yet delivered within target levels, MRI waiting volumes have reduced from around 400 patients in January 2019 to approximately 50 at the end of May. The longest waiting patient's referral was received on 1 May 2019, so is now only slightly outside the six week target period. Given the reduction we would expect the performance against this target to improve over the coming months. CT volumes are relatively stable, at around 200 currently on the waiting list. These are largely follow ups. The service plans to operate weekend elective activity between the CT and MRI to aid in a stable reduction in the waiting list.
Financial Sustainability	The result was again materially affected by the level of additional reporting required to offset vacant positions and increasing demand. This is the highest level of financial risk to the department and is borne in both staff costs and additional outsourcing.
Engaged Workforce	Nothing of note this month.

3. Strategic Initiatives / Health Services Planning

No further progress has been made on the development of a "Radiology Ward", as described in last month's report. This will in part be driven by final decisions on the Cath Lab location and layout.

4. Emergent Issues and Initiatives Identified

Nothing of note this month.

Pathology Services

1. Overview

IANZ conducted a mix of peer reviews and surveillance checks across a range of disciplines at the Whangārei and Dargaville Laboratories. This did not however include Whangārei Blood Bank.

2. Scorecard

	Pathology Services Scorecard							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Service Delivery	Laboratory Test Orders			131,182				1,324,750
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	(1,027)
	YTD Variance to Savings plan ($000)	●						(520)
Engaged Workforce	FTE employed to budget	↓	92.6	93.8			92.6	91.5
	Percentage Sick Leave Taken	↓	3.00 %	4.47 %			3.00 %	3.07 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	31
	Percentage Annual Leave Taken	↓	11.0 %	6.6 %			11.0 %	9.9 %

Commentaries for Scorecard

Service Delivery	The number of tests within the month was above the YTD average. Drivers of this include May being a 31 day month and high activity levels across other disciplines (ie surgery). Complexity continues to be a factor and will need to be monitored by the Laboratory.
Financial Sustainability	Blood products usage stabilised within the month, although there has been a spike in testing kits (related to testing for influenza) and increased stock holding in range of chemicals and reagents. One of the major suppliers has planned maintenance on its manufacturing plant and therefore lower volumes will be available through June. Outsourcing costs also remain high as histology demand both within the hospital and within the community increases.
Engaged Workforce	The draft management restructure proposal for Whangārei Laboratory was not accepted by staff. Accordingly we are working to redevelop a proposal which will be acceptable.

3. Strategic Initiatives / Health Services Planning

Nothing of note this month.

4. Emergent Issues and Initiatives Identified

A supplier of outsourced histology services has advised of a number of changes to its requirements given its current workload. This has resulted in additional work being required within the histology department before specimens can be shipped for review and reporting.

Older People and Clinical Support

1. Overview

May was a busy month for the service with most targets being exceeded while remaining favourable to budget.

2. Scorecard

	Older People and Clinical Support Scorecard							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Safety and Quality	Falls with major harm within facility	↓	0	1	0	1	0	3
	Hospital Acquired Pressure Injuries	↑	0	1	0	1	0	12
Service Delivery	Assessment and Rehabilitation Bed Days	↑	717	684			7,667	7,402
	Inpatient Contacts	↑	2,519	3,105			26,188	29,703
	Outpatient Contacts	↑	1,093	899			10,443	9,790
	Community Contacts	↑	2,806	2,642			27,597	27,831
	Retinal Screens	↑	373	457			3,727	3,868
	Breast Screens	↑	990	1,283			9,908	14,169
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	784
	YTD Variance to Savings plan ($000)	●						0
Engaged Workforce	FTE employed to budget	↓	231.7	224.6			231.7	224.1
	Percentage Sick Leave Taken	↓	3.00 %	2.83 %			3.00 %	2.85 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	40
	Percentage Annual Leave Taken	↑	11.0 %	7.6 %			11.0 %	8.9 %

Commentaries for Scorecard

Safety and Quality

The reported number of hospital acquired pressure injuries has halved from prior months. Previous inputs were double counted. This has now been corrected.

Service Delivery

Assessment and Rehabilitation bed days have continued below target due to fewer eligible patients. The service uses spare capacity in rehab for stroke or medical overflow. A slight increase was noted during May.

Financial Sustainability

Revenue was favourable to budget by $971k.

Personnel Costs were $900k underspent YTD, partly offset by overspend on locum geriatricians of $194k.This is due to the service's average vacancy rate of 7.7 FTE YTD which is mainly the result of Allied Health vacancies of 5.6 FTE, 2x SMOs and prioritisation funding not being recruited to until the second half of the year.

Outsourced Clinical Services expenditure was $92k favourable to budget due to lower than budgeted use of respite care and pharmacy outsourced costs.

	Clinical Supplies were $244k overspent due to District Nursing and Occupational Therapy supplies being overspent as a direct result of patient volumes. All staff are aware of the requirement to limit waste of resource.
Engaged Workforce	Excess annual leave balances remain static. While leave is encouraged and supported, cover can be an issue due to the above vacancies.

3. Strategic Initiatives / Health Services Planning

Deliverable / Action	Planned Outcome	Status
Stroke Hospital to Home	Implementation phase continues	Behind Schedule
Pharmacy Service Review Implementation	Implementation phase focus	Behind Schedule
Central Community Hub	Initial information collection phase underway	New
Acute Care of the Elderly (ACE)	Business Case developed, phase one funding approved and recruitment underway for a GNS & Geriatric CNS.	Behind Schedule

4. Emergent Issues and Initiatives Identified

Nothing of note for the month.

5. Other Highlights

The rehabilitation criteria have been revisited and documentation reviewed. A trial of new processes has commenced during June on orthopaedic and medical wards.

The pharmacy SECA was ratified by union members. This has been a prolonged bargaining process as the PSA settlement scales offered were not advantageous to this professional group.

Recruitment of 0.7 FTE to the 1.4 FTE Acute Care of the Elderly (ACE) clinical nurse specialist role has occurred and will commence in July.

Medical

1. Overview

May was a busy month with all wards at capacity.

2. Scorecard


IP Events Coded For Period - 82%

	Medical Scorecard - Whangārei Hospital							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Safety and Quality	Reducing Acute Readmissions to Hospital	↑	10 %	12 %	15 %	11 %	10 %	14 %
	Hospital Acquired Pressure Injuries	↓	0	1	1	0	0	13
	Falls with major harm within facility	●	0	0	0	0	0	1
Service Delivery	Inpatient Bed Days	●		2,063	541	1,522		21,912
	Inpatient Average Length of Stay (ALOS) Acute (excludes Day Cases)	↑	4.1	4.1	3.9	4.2	4.1	4.3
	Acute Caseweights to contract	↑	524	609			5,762	5,954
Population Health Status	Ambulatory sensitive (avoidable) hospital admissions by weighted value.			103	41	62		1,243
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	(2,268)
	YTD Variance to Savings plan ($000)	●						0
Engaged Workforce	FTE employed to budget	↓	179.1	197.7			179.1	197.0
	Percentage Sick Leave Taken	↓	3.00 %	3.87 %			3.00 %	2.94 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	54
	Percentage Annual Leave Taken	↓	11.0 %	8.5 %			11.0 %	8.9 %

Commentaries for Scorecard

Safety and Quality	Nothing of note for the month.
Service Delivery	Nothing of note for the month.
Population Health Status	Fewer ambulatory sensitive admissions than average for the year to date. Ongoing reductions likely due to pressure on beds increasing the threshold for admission as well as ambulances managing patients in the community.
Financial Sustainability	Personnel Costs are $639k unfavourable to budget YTD. While $578k savings are being achieved due to medical vacancies, this is more than offset by $1.1m spent on locums not budgeted covering vacancies. As at the end of April, nursing was $1.3m overspent due to additional staff required to flex Ward 14 above 26 beds during Jul - Nov, Ward 12 operating beyond Nov with a limited budget of $50k p/m from Jan 19 against average costs of $117k p/m, $101k of 2018 Winter resource, $281k New graduate nurses

	approved but unbudgeted and $648k impact of annual leave accruals following new MECA pay rates and step increases for a number of number of specialities. New graduate nurses have now been absorbed within approved staffing levels. YTD 44,260 watch hours have been required, costing ~ $1.1m YTD against an annual budget of $600k. Watch criteria are in place, requiring Service Manager / General Manager approval from mid Feb 19 with a noticeable decrease in watches since. Clinical supplies remain underspent YTD by $116k but below the $160k YTD savings plan. All staff are aware of the need to make savings where possible.
Engaged Workforce	Excess annual leave balances remain static. While leave is encouraged and supported, cover can be an issue due to the busyness of the service.

3. Strategic Initiatives / Health Services Planning

Deliverable / Action	Planned Outcome	Status
Cath Lab	Approved by MoH. Preliminary planning commenced.	New

4. Emergent Issues and Initiatives Identified

Nothing of note for the month.

5. Other Highlights

Nothing of note for the month.

Renal

1. Overview

The service is utilising additional nursing FTE approved via Care Capacity Demand Management (CCDM) to meet increasing patient demand.

2. Scorecard

IP Events Coded For Period - 81%

	Renal Scorecard - Whangārei Hospital							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Safety and Quality	Reducing Acute Readmissions to Hospital	↑					15 %	20 %
	Hospital Acquired Pressure Injuries	●	0	0	0	0	0	3
	Falls with major harm within facility	●	0	0	0	0	0	1
Service Delivery	Inpatient Bed Days	↓	100	174	140	34	1,100	1,899
	Inpatient Average Length of Stay (ALOS) Acute (excludes Day Cases)	↑	5.0	3.4	3.0	4.0	5.0	5.1
	Acute Caseweights to contract	↓	29	40			316	416
Population Health Status	Ambulatory sensitive (avoidable) hospital admissions by weighted value.			11	7	5		68
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	(273)
	YTD Variance to Savings plan ($000)	●						
Engaged Workforce	FTE employed to budget	↑	69.6	71.7			69.6	70.1
	Percentage Sick Leave Taken	↓	3.00 %	6.59 %			3.00 %	3.79 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	29
	Percentage Annual Leave Taken	↑	11.0 %	10.8 %			11.0 %	10.4 %

Commentaries for Scorecard

Safety and Quality

Nothing of note for the month.

Service Delivery

YTD treatment volumes continue to increase compared to last year, now at 6% above May 2018.

Population Health Status

Nothing of note for the month.

Financial Sustainability

Total personnel costs were $150k unfavourable to budget YTD. 2.8 CCDM nursing FTE has been approved from December 2018 with this now included in the budget. There is an overspend on internal bureau to cover sick and domestic leave, senior nursing cost for call backs for emergent patients after hours and impact of annual leave accruals following new MECA pay rates and step increases for a number of number of specialities.

	Additional senior medical officer costs from October 18 to March 19 to cover sabbaticals. Clinical Supplies expenditure were $174k favourable to budget YTD and meeting the savings line target of $137k YTD. New contract negotiated from May 2018 onwards reducing renal fluid automated peritoneal dialysis costs in future. Internal recharges were overspent due to higher than budgeted Whangārei biomedical repairs as a result of increased demand. Infrastructure and non-clinical supplies are $14k overspent due to Whangārei in centre overspend on equipment repairs and maintenance. All staff are aware of the need to make savings where possible.
Engaged Workforce	Excess annual leave balance remain static. While leave is encouraged and supported, cover can be an issue due to the specialised nature of the service.

3. Strategic Initiatives / Health Services Planning

Deliverable / Action	Planned Outcome	Status
Hypertension Clinic	Business case submitted for approval	On Hold
Moving to Home Management	Project is underway	On Track

4. Emergent Issues and Initiatives Identified

Nothing of note for the month.

5. Other Highlights

Nothing of note for the month.

Emergency

1. Overview

May YTD volumes show an increase of approximately 4%, placing significant pressure on staff and patient flow. Approved additional locum SMO staff continue as required. More senior medical officer (2.4 FTE) and nurse practitioner (1.8 FTE) have been approved in response to increased patient presentation and staff wellbeing concerns. Recruitment for these roles has started.

2. Scorecard


IP Events Coded For Period - 88%

	Emergency Scorecard							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Safety and Quality	Patients waiting in ED longer than 24 hours	●	0				0	29
Health Targets	Shorter Stays in Emergency Departments (All NDHB)	↑	95 %	84 %	87 %	83 %	95 %	84 %
Service Delivery	Percentage proportion of Triage patients seen within the recommended time for their category	↑	75 %	42 %	42 %	41 %	75 %	40 %
	Level 4 attendances to Contract – Discharges			1,639				19,403
	Level 4 attendances to Contract – Admissions (includes ED 3 Hour)			1,692				17,706
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	(1,207)
	YTD Variance to Savings plan ($000)	●						0
Engaged Workforce	FTE employed to budget	↑	89.3	94.2			89.3	95.2
	Percentage Sick Leave Taken	↑	3.00 %	3.52 %			3.00 %	2.86 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	48
	Percentage Annual Leave Taken	↓	11.0 %	9.8 %			11.0 %	11.1 %

Commentaries for Scorecard

Safety and Quality	Nothing of note for the month.
Health Targets	Nothing of note for the month.
Service Delivery	Nothing of note for the month.
Financial Sustainability	Outsourced personnel expenditure was $232k against zero budget due to locum cover for strikes, SMO bereavement leave, sick leave and Incident Management Team decision to add doctor shifts. Outsourced clinical supplies of $20k to provide GP clinics.

	Personnel costs were $649k over budget YTD. Due to additional medical staff rostered for nurses' strike as well as additional reception, RN staff rostered during ED Renovations and subsequent EDaaG implementation. Nursing costs are $495k over budget YTD due to use of internal bureau to match demand, overspend on HCAs for winter, which is approved but unbudgeted. $86k impact from annual leave accruals was noted during the month following new MECA pay rates and step increases for a number of specialities. There is an on-going requirement to staff safely and, given the volume increase, the budgeted FTE is often not adequate. Volume-driven Clinical Supplies costs were $141k over budget YTD due to high patient demand and $23k overspend on infrastructure and non-clinical supplies due to higher than budgeted spend on cleaning (including winter resource approved but unbudgeted), EDaaG enhancements and stationery and supplies not budgeted but required.
Engaged Workforce	Excess annual leave balances remain static. While leave is encouraged and supported, cover can be an issue due to the demand on the service.

3. Strategic Initiatives / Health Services Planning

Deliverable / Action	Planned Outcome	Status
EDaaG	Ongoing enhancements	On Track

4. Emergent Issues and Initiatives Identified

Increased measles cases have been noted during May and June 2019. A hospital-wide group has been established to minimise the risk to patients and staff. Initiatives include face masks being available for patients entering the hospital and a marketing campaign to ask patients not to present directly to the Emergency Department.

5. Other Highlights

The patient flow project has been enhanced in partnership with the Innovation and Excellence Team to improve patient flow through the department.

Mental Health

1. Overview

Year to date overspend is driven by unavoidable utilisation of locums to cover vacant medical roles. Active recruitment to all vacancies is ongoing.

There is substantial funding signalled for the Mental Health and Addictions sector in 2019 Wellbeing budget. We are awaiting clarity on the allocation mechanism.

2. Scorecard

IP Events Coded For Period - 100%

	Mental Health Scorecard							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Safety and Quality	Reducing Acute Readmissions to Hospital	↓	13 %	19 %	13 %	22 %	13 %	16 %
	Falls with major harm within facility	↓	0	1	1	0	0	8
Service Delivery	Inpatient Bed Days – Tumanako IPU	↓	659	637	365	272	7,272	7,172
	Detox Bed Days - Dargaville	↑	132	185	14	171	1,424	1,544
	Sub Acute Bed Days (Kaitaia, Kaikohe, Whangārei)	↓	474	508	342	166	5,126	5,307
	Inpatient Average Length of Stay (ALOS) (excludes Day Cases)	↓	24	18	20	17	24	18
Financial Sustainability	YTD Variance to net Result ($000)	↑					0	(1,670)
	YTD Variance to Savings plan ($000)	●						(698)
Engaged Workforce	FTE employed to budget	↑	374.3	347.0			374.3	347.2
	Percentage Sick Leave Taken	↓	3.00 %	4.19 %			3.00 %	4.03 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	49
	Percentage Annual Leave Taken	↑	11.0 %	8.4 %			11.0 %	9.8 %

Commentaries for Scorecard

Safety and Quality

11 patients were readmitted in May, and 102 YTD. The 11 May readmissions included:
*Two re-admissions to Tumanako IPU
*One internal transfer to/from Mental Health Subacute Unit
*Eight readmissions/transfers to ED or a Medical/Surgical Ward

Occupancy at Tumanako IPU for May was 81.0%, or 82.8% including patients on leave. YTD occupancy to May was 86.6%, or 92.2% including patients on leave. Recommended occupancy guidelines for acute mental health units to ensure access and safe practice are between 85 and 90%.

The service has had eight falls with harm this year; four younger clients (one relating to a change in level, one while showering, two unspecified) and four clients aged 65+ (three trips on level flooring, one fall involving a special purpose bed).

Service Delivery

Note current year occupancy rates are based on 29 beds. Tumanako IPU was a 25 bed unit up to Feb-18, transitioning up to 29 beds at one bed per month from Mar-18 to Jun-18.

	Prior to discharge patients commonly go on leave to home with family on a trial basis, or go into community respite or sub-acute beds. Social issues such as housing and family support (versus clinical) are often a significant factor in admissions and completing effective discharge from the inpatient unit. There were 46 admissions and 47 discharges in May, with an average length of stay of 18.73 days in Tumanako IPU (19.17 days YTD). The three sub-acute units, (Whangārei He Manu Pae, Kaitaia Te Kohanga and Kaikohe Tu Kaha), had overall occupancy of 91.0% and an average length of stay of 18.54 days for the month of May. The average length of stay by unit was Far North Kaitaia – 22.95 days; Mid North Kaikohe – 4.01 days, and Whangārei – 15.57 days. Far North was unusually high due to discharge of three complex clients with atypically long lengths of stay - 125 days, 52 days and 48 days. Mid North was unusually low due to only two clients being discharged during the month, both of whom had relatively short stays. *Community Mental Health* The community mental health teams had 10,459 client contacts in May and a further 2,480 care coordination contacts (with persons or agencies other than the client or whanau, such as WINZ)
Financial Sustainability	Mental Health was $140k unfavourable to budget for the month and $1,670k unfavourable to budget YTD. Included in the result are savings lines of $53k for the month and $782k YTD. The YTD result is driven by high locum costs and unbudgeted legal fees. The month variance is also driven by high salaries spend. Locum expenditure continues to be high, over budget by $47k for the month and $1,257k YTD. Locum utilisation is an unavoidable necessity for the service to cover vacancies and some periods of extended leave. Active recruitment is ongoing; however the pool of suitable applicants is very small and locum costs are expected to continue. Non-Medical Outsourced Personnel overspend is offset by salaries underspend and Health Promotion Agency income received. Further contributing to the YTD overspend is $26k one off bulk purchase of duress alarms for Tumanako IPU in July. Transport costs are also over budget in lease and other costs. Other Revenue was $12k unfavourable to budget YTD due to timing of actual v budget Training Fees. Salaries (excluding savings lines) were $522k favourable to budget YTD. Salaries underspend is more than offset by overspend on medical locums. May salaries overspend of $156k is driven by medical personnel costs and the relatively low annual leave rate of 8.4% for the month. In terms of medical personnel, unbudgeted relocation ($25k) and cover ($11k) payments were incurred during the month. Training ($19k) annual ($12k), sick ($13k) and other ($5k) leave were over budget for the month. Expenditure on registrars is over budget by $42k for the month and $200k YTD due to approved over-recruitment to "grow our own"
Engaged Workforce	For May, Mental Health was 27.3 FTE under budget which includes overtime and callback and part time/part time no fixed hours staff working more than contracted hours (true vacancy of 32.1 FTE, up from 33.8 FTE in April) The service's recruitment efforts to fill new and existing vacant roles continue. As at 10-Jun-19, 4.2 FTE were in the appointment process and yet to commence and 10.4 FTE

were in the shortlisting/ interview phase of recruitment. Advertising is underway for roles totalling a further 15.4 FTE. Note the service has had 53.30 FTE of new starts since Jul-18 in addition to internal redeployment.

The service had 188 ACC hours for the month of May attributable to three staff members (all non-work related)

3. Strategic Initiatives / Health Services Planning

Deliverable / Action	Planned Outcome	Status
Model of Care Implementation	Implementation of the Model of Care (MoC): • Phase 1 - All services have developed and commenced their projects. Target: 30-Sep-18 - Projects inserted into Business Plan (plan completed) Target: 30-Sep-18 • Phase 2 - First review of service projects. Target: 31-Dec-18 • Phase 3 - Evaluation of projects completed. Target: 31-Jul-19	On Track
Primary Mental Health	• ProCare Business case completed and signed off by Chief Executive. Target: 31-Jul-18 • Project Team established and GP practices identified. Target: 31-Dec-18 • Inclusion of MSD Contract with Otangarei Trust determined. Target: 31-Dec-18 • Implementation complete. Target: 30-Jun-19 • First evaluation complete. Target: 30-Sep-19	On Track
Wellbeing Budget - additional funding for Mental Health & Addictions	Funding for all of New Zealand is known, but funding at DHB-level and who funding will go to is not yet determined.	New

4. Emergent Issues and Initiatives Identified

Whangārei Community Mental Health & Addictions Location
Planning is advanced for Mental Health non-clinical management staff to move to Manaia House at the end of August 19, dependent on IT and phone availability.

Methamphetamine Demand Reduction Contract
Te Ara Oranga funding is now contracted through to 31 December 2019, with future funding confirmed at the existing level of $2m pa in 2019 budget released late May.

District Hospitals

1. Overview

The district hospitals continue to report a sizeable variance to its financial budget. Key clinical volumes in May are in line with recent trends.

2. Scorecard

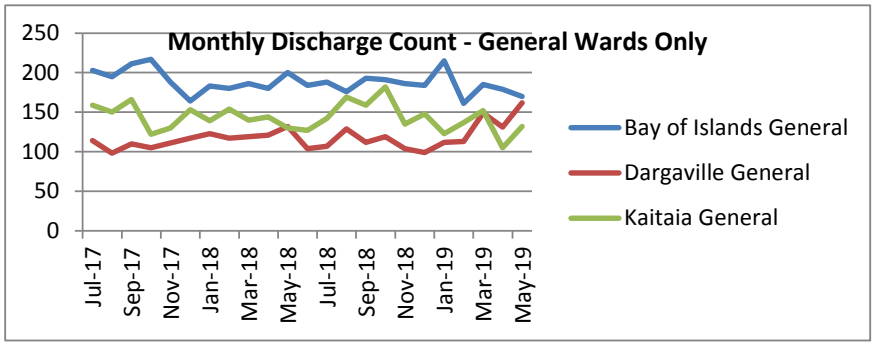
IP Events Coded For Period - 90%

	District Hospitals Scorecard							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Safety and Quality	Reducing Acute Readmissions to Hospital	↓	10 %	8 %	10 %	6 %	10 %	8 %
	Falls with major harm within facility	●	0	0	0	0	0	0
	Hospital Acquired Pressure Injuries	↓	0	2	0	2	0	4
Service Delivery	Inpatient Average Length of Stay (ALOS) (excludes Day Cases)	↑	3.0	3.1	2.7	3.3	3.0	2.6
	Acute Caseweights to contract	↑	289	345			3,182	3,469
	Elective Caseweights to contract	↑	43	56			476	462
	Percentage Attendance rate for all OP Appointments in District Hospitals	↓	95 %	86 %			95 %	88 %
	Percentage Attendance rate for all OP Appointments in Whangārei Hospital	↑	95 %	93 %			95 %	93 %
	Percentage Outpatient Bay of Islands Domicile Attendances in BOI (Quarterly)	↓	22 %	28 %			22 %	27 %
	Percentage Outpatient Dargaville Domicile Attendances in DRG (Quarterly)	↑	18 %	14 %			18 %	13 %
	Percentage Outpatient Kaitaia domicile attendances in KTA (Quarterly)	↑	55 %	60 %			55 %	61 %
Population Health Status	Ambulatory sensitive (avoidable) hospital admissions by weighted value.			115	71	44		1,286
Financial Sustainability	YTD Variance to net Result ($000)	●					0	
	YTD Variance to Savings plan ($000)	●						
Engaged Workforce	FTE employed to budget	↓	224.2	230.6			224.2	219.5
	Percentage Sick Leave Taken	↓	3.00 %	2.77 %			3.00 %	2.67 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	55
	Percentage Annual Leave Taken	↓	11.0 %	6.0 %			11.0 %	9.4 %

Commentaries for Scorecard

Safety and Quality	Two hospital acquired pressure injuries were reported this month.

Service Delivery	Volumes were fairly steady to trend in May. Discharges from the Dargaville General Ward have been particularly high in recent months.



Population Health Status	Weighted avoidable hospital admissions in the year to date (1,286) are unfavourable compared to the same time last year (954).
Financial Sustainability	The directorate continues to report a significant unfavourable variance to budget. The drivers behind this have not changed from previous months. There have been some notable blips in expenditure in May due to a contracted award/step increases occurring in MECA agreements covering large numbers of staff.
Engaged Workforce	

3. Strategic Initiatives / Health Services Planning
No actions or deliverables have been set for this Service.

4. Emergent Issues and Initiatives Identified
Nothing of note for the month.

5. Other Highlights
Nothing of note for the month.

Paediatric

1. Overview

Acuity has been high in the Paediatric ward. There is concern from the Paediatricians and the therapy team regarding the long waiting times for Visiting Neuro-developmental Therapy (VNT), essential therapy for premature infants. Initiatives to address this are being investigated.

An initiative which aims to assist the wards in managing acute clinical demand is being implemented and will be monitored in a way that will measure its success. Outcomes will be reported to the Chief Operating Officer each month once recruitment has been completed.

2. Scorecard

IP Events Coded For Period - 85%

	Paediatric Scorecard - Whangārei Hospital							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Safety and Quality	Reducing Acute Readmissions to Hospital	↓	5 %	10 %	9 %	10 %	5 %	11 %
	Falls with major harm within facility	●	0	0	0	0	0	0
Service Delivery	Inpatients with LOS > 21 days			0	0	0		7
	Inpatient Average Length of Stay (ALOS) Acute (excludes Day Cases)			2.6	2.8	2.4		2.5
	Acute Caseweights to contract	↑	164	162			1,800	1,755
	Number of Discharges from Ward 2			246				2,517
	Number of Discharges from SCBU			24				295
	Bed Utilisation for Ward 2			84.7				85.4
	Bed Utilisation for SCBU			69.8				66.4
Population Health Status	Ambulatory sensitive (avoidable) hospital admissions by weighted value.			45	17	28		534
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	(1,040)
	YTD Variance to Savings plan ($000)	●						0
Engaged Workforce	FTE employed to budget	↓	110.8	111.5			110.8	110.0
	Percentage Sick Leave Taken	↑	3.00 %	3.69 %			3.00 %	3.75 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	27
	Percentage Annual Leave Taken	↑	11.0 %	8.4 %			11.0 %	9.8 %

Commentaries for Scorecard

Safety and Quality

Nothing of note this month.

Service Delivery

Ward 2 had utilisation of 86.5% in May. There continues to be high variation in patient flow e.g. Ward 2 had total patient volumes of between 7 - 26 patients. Acuity was significantly higher this month. 16 patients required some level of 1:1 care.

SCBU utilisation was 70.11%. Fewer babies were admitted to the unit and acuity was

	lower. Total patient volume in SCBU ranged from 3 - 9 babies with only 4 babies requiring some 1:1 care. The Community Nursing Team Five Registered Nurses from the team have completed their vaccinator training. This will enable children to be vaccinated in their homes during a home visit or in clinic. The caseload for the nurse based in the Far North has increased due to the number of babies in SCBU being discharged home. Support for this caseload will be provided by the Mid North if necessary. Paediatric outpatients waiting times for FSAs are being well managed. The follow up appointment waiting times continue to be an issue. We have been supported with some project time to review our outpatient service. A report has been being finalised and sent out for feedback. Some strategies will be looked into to manage the follow up appointments, eg consider nurse-led follow up. Waiting times for Visiting Neuro-developmental Therapists (VNT) are 9 months. We are currently supporting a new therapist to upskill in this area of expertise. Once training is complete they will be able to assist. Consideration is being given to develop a business case to increase therapy FTE to manage the growing demand. Demand is growing due to the increasing number of babies being born prematurely or with disability.
Population Health Status	Nothing of note this month.
Financial Sustainability	Child services are overspent by $167k for the month. There were MECA settlements made this month which meant that annual leave balances were re-valued and this adjustment is not budgeted for. Long-term leave in medical salaries continues to cause overspend and there have been personnel changes which are no longer reflective of budget. Outsourced salaries are for locums covering RMO vacancies. There was a high level of bureau nurses utilised this month due to additional demand experienced at above average levels. A higher volume of travel associated to providing outpatient clinics in the peripheral hospitals also contributed negatively.
Engaged Workforce	The trial of employing PTNFHs (Part time no fixed hours) staff has been approved. This initiative is aimed at enabling the service to efficiently and effectively manage the acute demands in Ward 2 and SCBU where clinical care levels fluctuate to large degrees. The provision of this resource should allow the service to better manage annual leave balances, take some pressure off the bureau and enable a model more aligned to the principles of Care Capacity Demand Management (CCDM). The results of the trial will be monitored and measured. Recruitment to this pool is currently being sought.

3. Strategic Initiatives / Health Services Planning

Teleheath clinics with Starship were trialled at the Child Health Centre (CHC). They were held with the Renal and Gastro teams at Starship. The clinics were well supported by the Whangārei telehealth team and the clinic nurse based at the CHC. We are waiting for the formal feedback however the immediate feedback has been positive.

4. Emergent Issues and Initiatives Identified

Nothing of note this month.

5. Other Highlights

Nothing of note this month.

Maternal

1. Overview

Some aspects of the maternity quality safety programme are on hold, or scaled back due to the Maternity Quality and Safety Programme (MQSP) leader acting as Service Manager and not being fully replaced.

There is a moderately urgent need to restore the maternal-infant case coordination forum back to be fully functioning as the women discussed in this forum have high needs.

Work has begun on preparation for a huge increase in caseload forecast for December – January.

2. Scorecard

IP Events Coded For Period - 89%

	Maternal Scorecard - Whangārei Hospital							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Safety and Quality	Reducing Acute Readmissions to Hospital	↓	5 %	8 %	9 %	7 %	5 %	6 %
Health Targets	Better help for smokers to quit – Pregnant Women	●	95 %	94 %	93 %	100 %	95 %	96 %
Service Delivery	Inpatient Average Length of Stay (ALOS) Acute (excludes Day Cases)			2.7	2.9	1.9		2.5
	Acute Caseweights to contract	↓	129	137			1,422	1,558
	Number of Births in Whangārei Hospital			135				1,509
	Number of Discharges from Post Natal Ward (Ward 11)			251				2,775
	% Exclusive Breastfeeding Rates at Hospital Discharge	↑	90 %	92 %			90 %	93 %
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	(91)
	YTD Variance to Savings plan ($000)	●						0
Engaged Workforce	FTE employed to budget	↑	58.1	58.9			58.1	58.0
	Percentage Sick Leave Taken	↓	3.00 %	3.80 %			3.00 %	3.29 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	16
	Percentage Annual Leave Taken	↓	11.0 %	10.0 %			11.0 %	12.8 %

Commentaries for Scorecard

Safety and Quality

Staff communication

A newsletter was distributed in May to all NDHB and self-employed maternity clinicians. We anticipate this will be quarterly as one way to integrate all staff region-wide.

Maternal & Neonatal Morbidity

A maternal and neonatal morbidity process has been formulated and feedback is being sought from obstetricians, paediatricians and Quality Improvement. It will be discussed at the next meeting to ensure that all processes align and review is timely.

	Diabetes Project This is one of the projects on the MQSP Annual Plan, due for completion this year. It was brought forward slightly due to staff changes taking place within the Diabetes Service. A midwife has been allocated management of this piece of work which involves: • an audit of Northland DHB current management of diabetes in pregnancy against the national guideline • a survey of women who have experienced the service • increasing involvement of two midwives to the care of women with diabetes in pregnancy, with a view to midwives replacing nurses from the Diabetes Clinic who have historically done this work *Antenatal education in Dargaville* There has been a request from women in Kaipara that antenatal classes commence in Dargaville. This has the support of the Operations Manager and plans are underway for the childbirth educator to provide one day classes in August and November.
Health Targets	Northland continues to have the worst rate of smoking in pregnancy in NZ. A Smokefree Kaitiaki was appointed four months ago and she has been busy establishing relationships with midwives and the Toki Rau service. Referral rates are slowly increasing. Training to those people involved in the Hine Kopu antenatal classes is in progress. Sample packs of nicotine replacement therapy were distributed to LMC community midwives and DHB maternity facilities on World Smokefree day. Repeat orders have been requested. An “opt-off” approach is being planned for Dargaville. Once this is formalised it is anticipated that there will be a significant increase in women engaging with the smokefree service and there will be a corresponding increase in the number of women who quit.
Service Delivery	135 births took place in Te Kotuku in May. Northland’s vaginal birth rate (including instrumental births) was 80.5%. The total caesarean section rate for the region was 19.5% which is a fairly consistent and benchmarks well against other DHBs. There is a positive trend in the increase in the number of women who are registering with an LMC midwife in the first trimester of pregnancy (within the first 14 weeks). More accurate data entry, as well as a shortage of LMC community midwives resulting in women booking earlier to secure a midwife, may be contributing to this, along with overall increased awareness on the part of the midwives. There is a steady increase in the number of handovers of care to core midwives in Te Kotuku which places burden on staffing and cannot be planned for. Additionally, the DHB provided primary care for 11 other women in May. The Te Puawai Ora service is operating a successful immunization drop-in clinic, including an afterhours service to coincide with antenatal classes. There has been an increase in the demand on the community midwifery service, mainly due to one LMC community midwife transferring her caseload to NDHB. It has been necessary to bring on a bureau midwife to meet this need. This situation clearly portrays the interdependence of the employed and self-employed midwifery workforce. Planning is underway for the ‘Big latch-on’, the annual breastfeeding promotion day.
Financial Sustainability	Maternity services are $159k unfavourable to budget this month. Settlements for NZNO and MERAS MECA were made in May. The service has only received a partial credit to reflect the actual cost of these agreements, causing an unfavourable variance this month. Pepi Pods for safe sleeping promotion were purchased in bulk this month causing an overspend in Clinical Supplies.

Engaged Workforce	There were 956 hours of annual leave taken in May which was down by 172 hours from the previous month. Sick leave was up by 48 hours with a total of 362 hours taken. There were 196 hours of training leave taken which was up by 169 hours on the previous month. There are 27 staff with more than 200 hours of annual leave owing to them and 19 of these staff have more than 240 hours owing. Leave plans have been submitted for these staff.

3. Strategic Initiatives / Health Services Planning

Deliverable / Action	Planned Outcome	Status
Northland SUDI prevention project	Significant reduction in the 5 year rolling number of SUDI in Northland	On Track
Breastfeeding Community Education	Increase in exclusive breastfeeding rates at 6 weeks and 6 months	On Track
Clinical Risk Management	Improved maternity care for women of Northland in response to case reviews.	On Track
Smoke free	All women are screened at booking and on each admission to hospital and are offered brief intervention advice. Reduction in number of smoking mothers in Northland	On Track
Immunisation	On time immunisations for babies in Northland.	On Track
Flu and Pertussis	Pregnant women are vaccinated against flu and pertussis	On Track
Timing of Registration with an LMC	Increase in the number of pregnant women booked with a Lead Maternity Carer by 10 weeks gestation.	On Track

4. Emergent Issues and Initiatives Identified

The most pressing issue is the risk associated to December and January where a significant reduction in the availability of the self-employed community LMC numbers will mean that the DHB Midwives will provide a majority of the workload in these months. On top of an already diminishing LMC workforce, most of them have opted to take an extended break over the summer. There is a possibility that the DHB caseload will rise to approximately 100 women for each of these two months. Solutions are being sought by working with the community LMC workforce, seeking input from DHB staff and consulting with other DHB midwifery leaders around the country where this has also occurred in recent years.

5. Other Highlights

Nothing of significance this month.

Human Resources and Corporate Support

1. Overview

HR is leading the pilot on new ways of recruiting staff in the most at-risk areas.

2. Scorecard

	Human Resources and Corporate Support Scorecard							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	110
	YTD Variance to Savings plan ($000)	●						0
Engaged Workforce	FTE employed to budget	↓	51.8	54.6			51.8	52.6
	Percentage Sick Leave Taken	↓	3.00 %	2.78 %			3.00 %	2.41 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	12
	Percentage Annual Leave Taken	↑	11.0 %	7.2 %			11.0 %	9.0 %

Commentaries for Scorecard

Financial Sustainability

The roles below are current vacancies within the following services:
- Senior vacancy in HR (partially offset by a part time consultant)
- Library

The underspend equates to supplies in the following areas:
- Customer Services, RMO Coordinator Unit, Payroll, Learning and Development and Occupational Health.

The Revenue stream has ceased due to (a) Payroll agreement with Northable was not renewed and (b) ACC E-Lodging rebate for ACC45 forms is no longer an option.

Engaged Workforce

Currently there are 12 staff, with a leave balance of over 240 hours which is a decrease against April 2019.

There was 2.8% sick leave in May. There was approved overtime of 59.73 hours (0.68%) in Payroll.

3. Strategic Initiatives / Health Services Planning

No actions or deliverables have been set for this service

4. Emergent Issues and Initiatives Identified

Nothing of note for the month.

5. Other Highlights

From an organisational perspective, the following workforce indicators summarise the employee activity with regards to FTE and hours for May 2019.

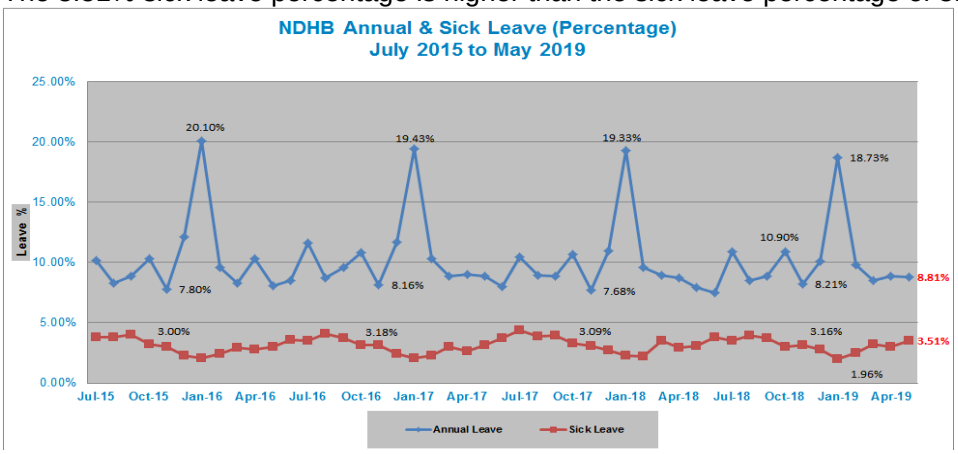
	Actual	*Budget*	*Difference*
FTE – Month (Paid)	***2,585***	***2,632***	***47***
FTE – Month (Accrued FTE)	***2,484***	***2,632***	***148***
FTE – YTD (May 2018- May 2019) (Average)	***2,522***	***2,632***	***110***

	Previous Month Hours (April 2019)	Current Month Hours (May 2019)	% of Total Hours (May 2019)	
Actual Hours – Productive[1]	401,604	354,903	85.2%	
Actual Hours - Annual leave	41,363	36,693	8.8%	
Actual Hours - Sick leave	14,061	14,607	3.5%	
Actual Hours – Training	5,174	5,744	1.4%	
Actual Hours - Other Leave	2,863	4,393	1.1%	
Actual Hours – Overtime	4,240	3,917	0.9%	
Actual cost – locums	588,511	410,285		

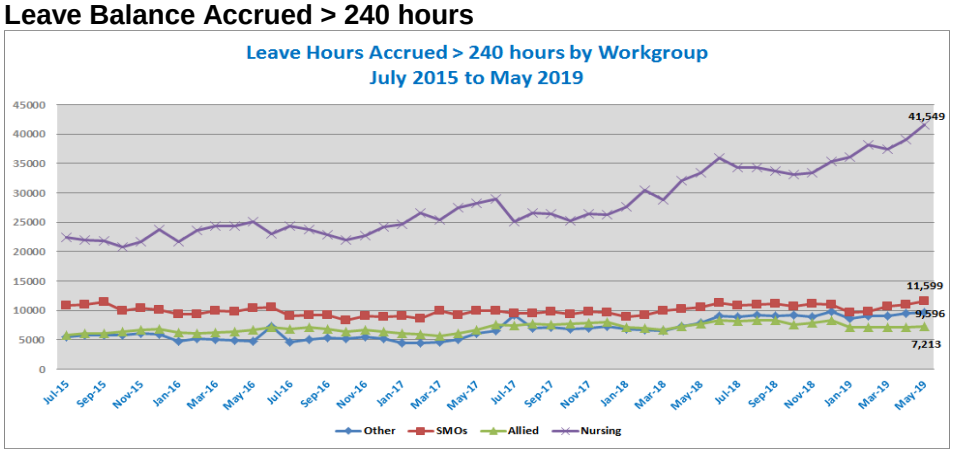
Staffing Analysis

Sick leave increased in May 2019 (3.51%) against April 2019 (3.02%).

The 3.51% sick leave percentage is higher than the sick leave percentage of 3.05% in May 2018.

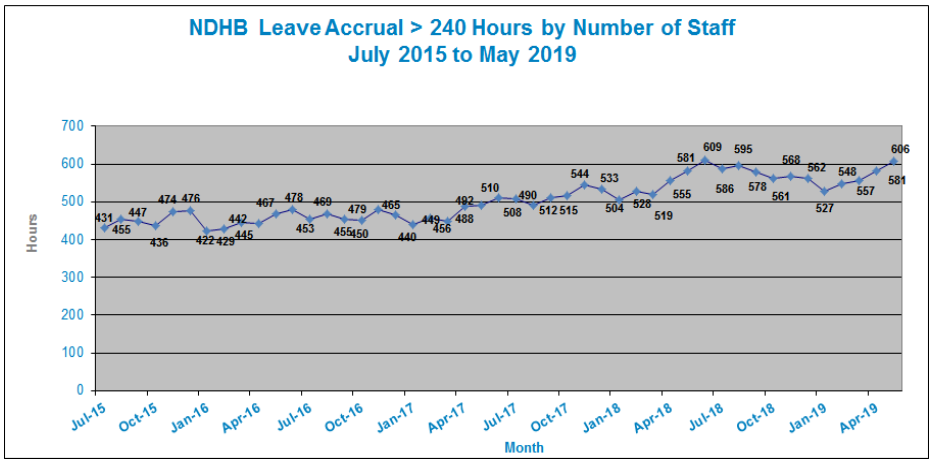


Leave Balance Accrued > 240 hours

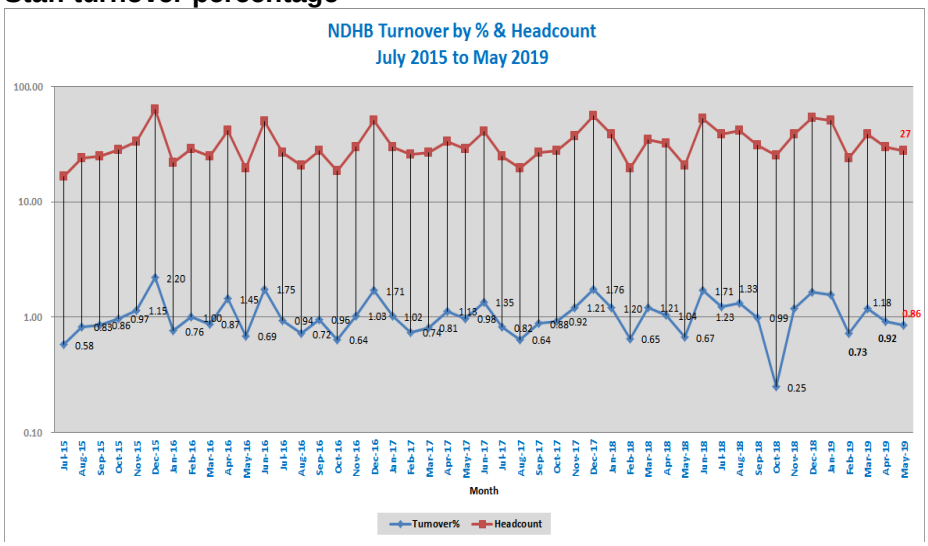


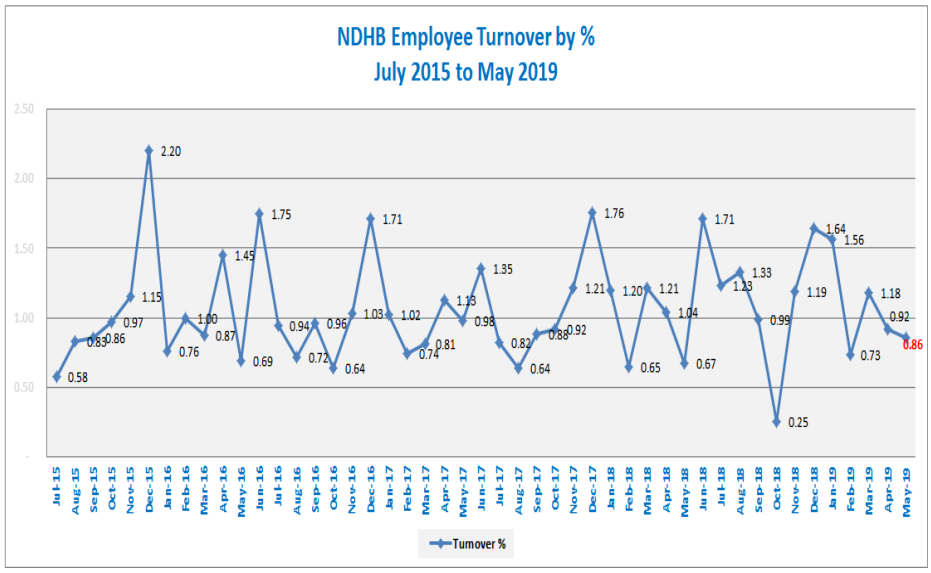
Leave Hours Accrued > 240 hours by number of staff

[1] Productive Hours – Ordinary Hours exclusive of Overtime and Call back



Staff turnover percentage





Facilities and Hotel Management

1. Overview

Facilities and Commercial services continue to provide excellent non-clinical support services.

2. Scorecard

	Facilities and Hotel Management Scorecard - Whangārei Hospital							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Safety and Quality	Food Complaints received		0	0			0	0
	Cleaning Audits – results All hospitals		99 %	97 %			99 %	97 %
	Cleaning Complaints received		0	0			0	0
	Laundry and Porter Staff Injuries		0	0			0	7
	Estate Services Staff Injuries		0	0			0	0
Service Delivery	BEIMS – Requests Completed		90 %	81 %			90 %	94 %
	Energy Consumption – All Hospitals - Kilowatt (kWh)		900,000	799,349			9,900,000	9,376,618
	Natural Gas – Whangārei Hospital - Gigajoules (GJ)		570,000	508,539			6,270,000	6,278,850
	Fuel Usage – All Vehicles (petrol and diesel) - Litres (Ltrs)		40,000	48,872			440,000	532,054
	Medical Waste Volumes - Kilograms (Kgs)		6,900	7,361			75,900	69,781
	Completed Programmed Maintenance Jobs for Clinical Engineering		450	434			4,950	4,629
	Outstanding Programmed Maintenance Jobs for Clinical Engineering		0	3,099			0	31,987
	Number of Patient Meals (All Sites)		27,000	28,033			297,000	305,294
	Number of Meals on Wheels (All Sites)		290	407			3,190	4,433
	Spotless Patient Satisfaction Survey – All Hospital Patient Meals		90 %	95 %			90 %	95 %
	Spotless Patient Satisfaction Survey – All Hospital Cleaning		90 %	95 %			90 %	95 %
	Laundry Washes (Wet Kg's) - Kilograms (Kgs)		82,000	94,269			902,000	1,015,027
	Laundry Issued Out - Kilograms (Kgs)		80,000	83,445			880,000	829,934
	Laundry Re Washes - % of Total Laundry Washes		3.20 %	3.20 %			3.20 %	3.20 %
Financial Sustainability	YTD Variance to net Result ($000)						0	(1,224)
	YTD Variance to Savings plan ($000)							683

Engaged Workforce	FTE employed to budget	↑	78.2	76.1		78.2	76.1
	Percentage Sick Leave Taken	↓	3.00 %	4.27 %		3.00 %	2.95 %
	Total Employees in Excess of 240 hours Accrued Leave	↓				0	18
	Percentage Annual Leave Taken	↓	11.0 %	10.7 %		11.0 %	10.1 %

Commentaries for Scorecard

Safety and Quality

Commercial Services
Audit results show lower scores at Kaitaia and Bay of Island Hospitals, attributed to more detailed audits being undertaken to improve general standards and staff performance.

There have been some weather-related delays in the repair of the kitchen roof. It is due for completion in early July.

Facilities
Three Building Warrants of Fitness (BWOFs) completed during the month (3 Grant St, MH Inpatient Unit and BOI Hospital)

Fire Warden Training was completed in the below areas and included a fire drill with a good result in each.

- Ward 16/CCU – 8 participants
- Ward 3 – 7 participants
- Ward 14 – 12 Participants
- Maternity – 10 participants
- Service Wing – 8 participants

Contractor Statistics for all Hospitals

- Contractors Onsite - 530
- Inductions - 24
- Job Safety Assessments - 70
- Permits issued - 9
- Site Audits - 8
- Accident/Injury/Near Miss – 2

Service Delivery

Commercial Services

- Draft contract for services for main Food and Cleaning contract has been reviewed by Health Alliance legal and submitted to Spotless for legal review.
- RFP for waste management contract is being evaluated by hA procurement.

Locally sourced products

- 376Kg apples, 152Kg oranges, 232Kg pears and 106kg mandarins.
- Eggs were purchased locally (as February) – pushing total % up from 19% to 29%.

A food wastage audit was undertaken on 3 May at the request of the NDHB Board.

- Kitchen waste – 3kg; patient tray waste – 29Kg; café waste 7Kg.
- Patient waste was half a black bin bag so more dense waste rather than volume.
- Generally, the waste composed of fruit cores and skins, bread rolls, yoghurt pottle and main meals left overs.
- Patient and café waste goes to landfill due to contamination risk.
- Kitchen waste goes to a local pig farm.

Whangārei kitchen supplies approximately 22,000 meals per month to patients.

Vibe café update
Sales have been steadily increasing year on year. Barista coffee service has been discontinued and new products introduced. A new line of gluten free breads will be

	trialled shortly. The hot lunch menu options have been reviewed to provide some consistency and control over costs. *Facilities* A slightly busier month as winter approaches with most areas now in heating mode. Security • 18 x Code orange events • 4 x Additional aggressive events • 1 x Car break-in • 6 x Cows herded
Financial Sustainability	Facilities is $1 million unfavourable to budget YTD at the end of May 2019 largely due to centralisation of Philips Monitoring equipment depreciation to Facilities and additional stock to support the equipment, additional security at regional hospitals, asbestos removal costs, insurance costs, centralisation of bed store costs to Facilities. Hotel Management is $211k unfavourable to budget YTD at the end of May 2019. The majority of the overspend is due to backpay via Spotless for the recently negotiated Etū contract.
Engaged Workforce	• Five Whangārei Porters have signed up for NZQA orderlies qualification with Careerforce. • Currently sourcing options with Competenz for the Laundry service staff who are eligible to obtain NZQA in Laundry processing. • Medical issues continue to challenge the Porter service.

3. Strategic Initiatives / Health Services Planning
No actions or deliverables have been set for this Service.

4. Emergent Issues and Initiatives Identified
Nothing of note for the month.

5. Other Highlights
Nothing of note for the month.

NDHB Wide Patient Transport

1. Overview

The Renal Transport Team and NTA worked well under pressure this month.

2. Scorecard

	NDHB Wide Patient Transport Scorecard							
	Measure		**Goal**	**Month All**	**Month Maori**	**Month Non Maori**	**YTD Goal**	**YTD**
Service Delivery	Number of Fixed Wing Flights in Northland (excluding ACC)	↓	3	3			33	44
	Number of Fixed Wing Flights outside Northland (excl ACC)	●	1	0			11	0
	Total Cost (excl GST) of fixed wing flights	↑	21,250	17,280			233,750	292,062
	Number of Helicopter Flights in Northland (excl ACC)	●	25	25			275	271
	Number of Helicopter Flights Outside Northland (excl ACC)	↑	1	0			11	5
	Total Cost (excl GST) of Helicopter flights	↑	125,000	118,304			1,375,000	1,436,403
	Number of patient transfers using St John road Ambulance in Northland (excluding private, hospice and ACC transfers)	●	330	241			3,630	3,412
	Number of patient transfers using St John road Ambulance outside Northland (excluding private, hospice and ACC transfers)	●	6	5			66	62
	Total Cost (excl GST) of road ambulance patient transfers	●	100,000	83,333			1,100,000	916,663
	Number of renal patients transported by NDHB	●	110	108			1,210	1,062
	Total KM's travelled by renal transport drivers	●	100,377	103,878			1,104,147	999,282
	Total cost of Renal transport service (excl GST)	↓	130,000	166,799			1,430,000	1,641,449
	Total cost of National Travel Assistance to eligible NDHB patients (excl GST)	↑	205,000	227,254			2,255,000	2,292,982
Financial Sustainability	YTD Variance to net Result ($000)	↓					0	(175)
	YTD Variance to Savings plan ($000)	●						90,849
	YTD variance to Net Result – Patient Transport Positive /(Adverse)							-175
Engaged Workforce	FTE employed to budget	↑	21.8	22.7			21.8	22.6
	Percentage Sick Leave Taken	↑	3.00 %	2.33 %			3.00 %	3.16 %
	Total Employees in Excess of 240 hours Accrued Leave	↓					0	6

	Percentage Annual Leave Taken	↑	11.0 %	11.8 %		11.0 %	7.7 %

Commentaries for Scorecard

Financial Sustainability	Patient transport is over budget by $175k YTD at the end of May 2019. Taxi usage remains high due to driver illness and absence. Favourable result for road transfer costs due to delay in implementation of new service delivery model. Increased air transfers this year, mainly due to impact of St John strike action on ambulance availability.
Engaged Workforce	Reinstated Transport Supervisor role recruitment complete. Start date 1 July 2019. Recruitment underway for replacement Renal Transport Driver.
Service Delivery	The Renal Transport Service and National Travel Assistance team are now working more closely together and the renal drivers are being used where possible to transport patients across Northland. Communication and aircraft availability issues are being managed with National Ambulance Sector Office (NASO), DHBs and the provider. Reduction in NTA opening hours has led to improvement in overall service – faster claim and registration processing times, improved response times to patient messages and more effective management of travel bookings.

3. Strategic Initiatives / Health Services Planning

No actions or deliverables have been set for this Service.

4. Emergent Issues and Initiatives Identified

Fleet policy and management review commenced.

5. Other Highlights

St John Patient Transfer Services contract implementation update paper submitted for ELT review 18 June 2019.

Build of the new Neonate Transport rig is progressing well. A key component has arrived from the USA and is in place with the engineering company along with the required medical equipment. The planned completion date is 9 August 2019.

Scorecard Definitions

	Measure	Notes
Overview	 IP Events Coded for period - 68%	Coding data is used to generate many of the indicators, including complications of care, Falls, Better help for smokers to Quit. While the denominator includes all events, only those coded as having one of the indicators will be included in the result. The coding pie should be used to understand how close the results are to being finalized. Results are being updated as new information becomes available.
	Service and Hospital	The service is defined in 2 ways. Patient events whether they are Inpatient, Outpatient or Community events, belong to a Health Service such as Medical, Surgical, Paediatric etc. In this way any indicators that are patient related are grouped. Note that some services report specifically for a hospital. In this way you will find Surgical Discharges for Whangārei hospital reported in the Surgical Service and Surgical discharges for Kaitaia reported under the District hospitals service. Where the indicators are non patient related, (for example indicators in the financial sustainability area), indicators are reported under the service that manages that area. In this way costs relating to ICU are reported under Medical for example even though the Health Service of patients in ICU may be various.
	Timeliness of information	The latest data available is reported. This means that some data may change after the report is released. Some results are updated daily and others may be quarterly.
	Performance Indicators	Most measures have standard threshold tolerances for measuring performance and these are displayed below. Where tolerances differ from the standard, the light green and orange variances are displayed with the Measure description. Green always means achieved and red is always outside the orange indicator tolerance.
	Standard threshold tolerances	 Green indicates achieved or better than target  Light Green indicates within 2% variance from target  Orange indicates between 2% and 10% variance from target  Red means outside the orange indicator tolerance
Safety and Quality	Cleaning Audits – results All hospitals	NDHB complete monthly cleaning audits with spotless services. This shows the result of those audits
	Cleaning Complaints received	Number of complaints received from patients for cleaning through the NDHB Safety & Quality complaints process
	Elective Day of Surgery Admission rate - DOSA	Admissions where Surgery occurs on the day of admission are counted here. This excludes Day cases and counts Elective cases only
	Estate Services Staff Injuries	Number of staff injuries for NDHB estate services
	Falls with major harm within facility **Threshold Tolerance**  Within 1.0% of target  Between 1.0% and 2.0% of target	Falls are added to Datix there is major injury involved. The date of the fall and the 'Service Area' occurrence location code are used to determine if the fall happened within the DHB facility. This count should be similar to the 'with injury' figures in the Incident Reporting system. Recent month figures may be under-reported if coding is not complete.

	Food Complaints received	Number of complaints received from patients for food through the NDHB Safety & Quality complaints process
	Hospital Acquired Pressure Injuries **Threshold Tolerance** Within 1.0% of target Between 1.0% and 2.0% of target	Pressure Injuries are counted using inpatient coding and the Health Round Table rules. Effective July 2013, hospital acquired pressure injuries are based on the Condition Onset Flag. We exclude any patient whose primary diagnosis is a pressure injury and anyone that is a day case. Recent month figures may be under-reported if coding is not complete
	Laundry and Porter Staff Injuries	Number of staff injuries for the NDHB Laundry and porter services
	Patients waiting in ED longer than 24 hours **Threshold Tolerance** Within 1.0% of target Between 1.0% and 2.0% of target	
	Reducing Acute Readmissions to Hospital	A readmission is counted when any admission (the original admission) results in a subsequent acute admission to the same hospital within 28 days. This follows Health Round Table rules and counts readmissions regardless of relation to the original admission. The Original admission is only flagged for inclusion once 28 days have passed and the % reflects that.
Health Targets	Improved Access to Elective Surgery – (All NDHB)	NDHB is required to deliver a certain number of elective discharges. This includes all admitted patients including day cases for our population. The cases can be delivered in any hospital e.g. Auckland.
	Provisional percentage of patients referred with high suspicion of cancer commencing treatment within 62 days	
	Shorter Stays in Emergency Departments (All NDHB)	95 percent of patients admitted, discharged, or transferred from Whangārei or Kaitaia Emergency Departments, do so within six hours.
Service Delivery	% Exclusive Breastfeeding Rates at Hospital Discharge	The breastfeeding counts exclude the following records:
	% Non-Urgent Patients Receiving a Colonoscopy within 42 days	P2 Non Urgent Colonoscopies are required to be seen within 42 days of referral.
	% Overdue Surveillance colonoscopy within twelve weeks	Surveillance Colonoscopies are for patients at increased risk of colorectal cancer. This may be due to a family history or patients who need to be monitored on a regular basis due to previous colorectal cancer or polyps found. They are required to have a colonoscopy which is determined by the NZGG (New Zealand Guidelines Group) guidelines for surveillance colonoscopies – in either a 1, 3 or 5 year time frame.
	% Urgent Colonoscopy within two weeks **Threshold Tolerance** Within 5.0% of target Between 5.0% and 10.0% of target	P1 Urgent Colonoscopies are required to be seen within 14 days of referral.

	Acute Caseweights to contract	Caseweights can be used to measure the volume of actual activity against plan. A certain number of Elective Caseweights are planned to be delivered each year. Performance is managed to avoid under and over delivery. Acute Caseweights are managed in conjunction with population health needs and initiatives such as 'better, sooner, more convenient".
	Assessment and Rehabilitation Bed Days	Counts total number of days in a hospital bed.
	Bed Utilisation for SCBU	Bed Utilisation is based on the number of patients in a bed divided by the number of beds available.
	Bed Utilisation for Ward 2	Bed Utilisation is based on the number of patients in a bed divided by the number of beds available.
	BEIMS – Requests Completed	Number of Building maintenance and new work requests completed by estate services in the month for all hospitals.
	Breast Screens	
	Community Contacts	
	Completed Programmed Maintenance Jobs for Clinical Engineering	Number of completed programmed maintenance jobs on clinical equipment completed by clinical engineering
	Detox Bed Days - Dargaville	Beds dedicated to the Detox service for Drug and Alcohol addiction.
	Drinking Water Activities	Number of Drinking Water Activities
	Early Childcare Centres	Information about Early Childcare Centres
	Elective Caseweights to contract	Caseweights can be used to measure the volume of actual activity against plan. A certain number of Elective Caseweights are planned to be delivered each year. Performance is managed to avoid both under and over delivery. Elective Caseweights are managed in conjunction with waiting times and demand.
	Energy Consumption – All Hospitals - Kilowatt (kWh)	The energy consumption for all hospitals. Kilowatts
	Environmental Health Activities	Information about Environmental Health Activities
	Fuel Usage – All Vehicles (petrol and diesel) - Litres (Ltrs)	The total fuel (petrol & diesel) consumed for all hospitals. Litres
	Improving waiting times for diagnostic services - CT % receiving CT scans within 6 weeks	Improving waiting times for diagnostic services – MRI and CT 85% of accepted referrals for CT scans, and 75% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days)
	Improving waiting times for diagnostic services - MRI % receiving MRI scans within 6 weeks	Improving waiting times for diagnostic services – MRI and CT 85% of accepted referrals for CT scans, and 75% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days)
	Inpatient Average Length of Stay (ALOS) (excludes Day Cases)	The length of time between all admits and discharges averaged over all inpatient stays. The time is included in the calculation, to include part days.
	Inpatient Average Length of Stay (ALOS) Acute (excludes Day Cases)	The length of time between all admits and discharges averaged over all acute inpatient stays. The time is included in the calculation, to include part days.
	Inpatient Average Length of Stay (ALOS) Elective (excludes Day Cases)	The length of time between all admits and discharges averaged over all elective inpatient stays. The time is included in the calculation, to include part days.
	Inpatient Bed Days	Counts total number of days in a hospital bed for all patients. Will give a similar result to total length of stay, but does not count part days.

Inpatient Bed Days – Tumanako IPU	
Inpatient Contacts	
Inpatients with LOS > 21 days	The number of patients who had a length of stay > 21 days. 21 days is considered by the Health Round table to be an indicator for stranded patients, i.e. those patients that stay in hospital longer than they need to.
Laboratory Test Orders	
Laundry Issued Out - Kilograms (Kgs)	Total dry kilograms of Laundry issued out in the month
Laundry Re Washes - % of Total Laundry Washes	% of total laundry washes that had to be rewashed due to not being clean enough.
Laundry Washes (Wet Kgs) - Kilograms (Kgs)	Total wet kilograms of Laundry washed in the month
Level 4 attendances to Contract – Admissions (includes ED 3 Hour)	Annual plans provide for a certain number of Emergency department attendances to occur. Whangārei Emergency department is a Level 4 Emergency department and Bay of Islands is level 2 and Kaitaia is level 3
Level 4 attendances to Contract – Discharges	Annual plans provide for a certain number of Emergency department attendances to occur. Whangārei Emergency department is a Level 4 Emergency department and Bay of Islands is level 2 and Kaitaia is level 3
Medical Waste Volumes - Kilograms (Kgs)	The kilograms of medical waste for all hospitals
Mobile Ear Clinic Contacts (one month retrospective)	Number of individual children receiving assessment and treatment at the 3 MEC
Natural Gas – Whangārei Hospital - Gigajoules (GJ)	The natural gas consumption for all hospitals. Gigajoules
Number of Meals on Wheels (All Sites)	Number of meals on wheels provided for all hospitals by Spotless services
Number of Births in Whangārei Hospital	Total number of births at Whangārei Hospital, includes caesarean and vaginal births.
Number of Discharges from Post Natal Ward (Ward 11)	Count of total number of patients discharged from hospital in a period. Does not count admissions still in hospital.
Number of Discharges from SCBU	Count of total number of patients discharged from hospital in a period. Does not count admissions still in hospital.
Number of Discharges from Ward 2	Count of total number of patients discharged from hospital in a period. Does not count admissions still in hospital.
Number of elective operation short notice cancellations - acute overload	
Threshold Tolerance	
Within 3.0% of target	
Between 3.0% and 5.0% of target	
Number of Fixed Wing Flights in Northland (excluding ACC)	Number of Fixed Wing Flights in Northland (excluding ACC)
Threshold Tolerance	
Within 3.0% of target	
Between 3.0% and 5.0% of target	

	Number of Fixed Wing Flights outside Northland (excluding ACC)	Number of Fixed Wing Flights outside Northland (excluding ACC)
	Threshold Tolerance	
	Within 3.0% of target	
	Between 3.0% and 5.0% of target	
	Number of Helicopter Flights in Northland (excluding ACC)	Number of Helicopter Flights in Northland (excluding ACC)
	Threshold Tolerance	
	Within 5.0% of target	
	Between 5.0% and 10.0% of target	
	Number of Helicopter Flights Outside Northland (excluding ACC)	Number of Helicopter Flights Outside Northland (excluding ACC)
	Threshold Tolerance	
	Within 3.0% of target	
	Between 3.0% and 5.0% of target	
	Number of Oral Health treatment visits 0 - 12 year olds	
	Number of Oral Health treatment visits 13 - 17 year olds	
	Number of Oral Health treatment visits for low-income adults	
	Number of Patient Meals (All Sites)	Number of patient meals provided for all hospitals by Spotless services
	Number of patient transfers using St John road Ambulance in Northland (excluding private, hospice and ACC transfers)	Number of patient transfers using St John road Ambulance in Northland (excluding private, hospice and ACC transfers)
	Threshold Tolerance	
	Within 5.0% of target	
	Between 5.0% and 10.0% of target	
	Number of patient transfers using St John road Ambulance outside Northland (excluding private, hospice and ACC transfers)	Number of patient transfers using St John road Ambulance outside Northland (excluding private, hospice and ACC transfers)
	Threshold Tolerance	
	Within 3.0% of target	
	Between 3.0% and 5.0% of target	
	Number of renal patients transported by NDHB	Number of renal patients transported by NDHB
	Threshold Tolerance	
	Within 5.0% of target	
	Between 5.0% and 10.0% of target	

	Outpatient Contacts	
	Outstanding Programmed Maintenance Jobs for Clinical Engineering	Number of outstanding programmed maintenance jobs on clinical equipment completed by clinical engineering.
	Patients on the Surgical Booking List given a commitment to treatment but not treated within four months	Those patients that have been on the Surgical waiting list for more than 4 months.
	Patients waiting longer than four months for their FSA	Those patients waiting for a First Specialist appointment that have been waiting longer than 4 months.
	Percentage Attendance rate for all OP Appointments in District Hospitals	
	Percentage Attendance rate for all OP Appointments in Whangārei Hospital	
	Percentage Outpatient Bay of Islands Domicile Attendances in BOI (Quarterly)	Of all of the attendances of the people who live in the Bay of Islands hospital area, how many attendances were carried out in the Bay of Islands hospital area.
	Percentage Outpatient Dargaville Domicile Attendances in DRG (Quarterly)	Of all of the attendances of the people who live in the Dargaville hospital area, how many attendances were carried out in the Dargaville hospital area.
	Percentage Outpatient Kaitaia domicile attendances in KTA (Quarterly)	Of all of the attendances of the people who live in the Kaitaia hospital area, how many attendances were carried out in the Kaitaia hospital area.
	Percentage proportion of Triage patients seen within the recommended time for their category	
	Port Health	Information about Port Health
	Prevention of Alcohol Related Harm	Information about Prevention of Alcohol Related Harm
	Public Health Nurse Contacts	Number of 0-18 year olds and their whanau who receive an assessment, treatment, education, communicable disease follow-up or clinic visit from a PHN.
	Retinal Screens	
	Sexual Health Contacts	Number of clients who attend sexual health clinics for assessment, education or treatment
	Spotless Patient Satisfaction Survey – All Hospital Cleaning	Spotless services complete random patient feedback surveys every month at each hospital for cleaning. This shows the result of those surveys
	Spotless Patient Satisfaction Survey – All Hospital Patient Meals	Spotless services complete random patient feedback surveys every month at each hospital for meals. This shows the result of those surveys
	Sub Acute Bed Days (Kaitaia, Kaikohe, Whangārei)	Comprehensive goal-oriented inpatient care designed for a patient who has had an acute illness. It is rendered either immediately after or instead of acute care hospitalization, to treat specific active or complex mental health conditions in the context of the person's underlying long-term condition.
	Theatre cancellations by Hospital	Counts planned theatre procedures cancelled by the hospital. Reasons for cancellation include; Patient unfit; Equipment failure; lack of time etc.
	Tobacco Control	Information about Tobacco Control

	Total Cost (excl GST) of fixed wing flights **Threshold Tolerance** Within 5.0% of target Between 5.0% and 10.0% of target	Total Cost (excl GST) of fixed wing flights
	Total Cost (excl GST) of Helicopter flights **Threshold Tolerance** Within 5.0% of target Between 5.0% and 10.0% of target	Total Cost (excl GST) of Helicopter flights
	Total Cost (excl GST) of road ambulance patient transfers **Threshold Tolerance** Within 5.0% of target Between 5.0% and 10.0% of target	Total Cost (excl GST) of road ambulance patient transfers
	Total cost of National Travel Assistance to eligible NDHB patients (excl GST) **Threshold Tolerance** Within 5.0% of target Between 5.0% and 10.0% of target	Total cost of National Travel Assistance to eligible NDHB patients (excl GST)
	Total cost of Renal transport service (excl GST) **Threshold Tolerance** Within 5.0% of target Between 5.0% and 10.0% of target	Total cost of Renal transport service (excl GST)
	Total KM's travelled by renal transport drivers **Threshold Tolerance** Within 5.0% of target Between 5.0% and 10.0% of target	Total KM's travelled by renal transport drivers
Population Health Status	Ambulatory sensitive (avoidable) hospital admissions by weighted value.	Counts those admissions that may be able to be better treated in the community. Patients who need services that can be provided in community settings receive them there rather than at hospitals.
	Newborn Hearing Screening Rates (3 Months Retrospective)	Percentage of all new born babies who receive their new born hearing screen within 3 months of birth. Includes total eligible population not just consented population
	Number of children treated for dental	

	conditions under GA	
	Number of Family Violence Positive Disclosures	Number of people who disclose to staff following routine screening that they have suffered family violence in its many forms
	Number of presentations to ED due to dental conditions	
	Number of Reports of Concern to Child Youth and Family	Number of reports of concern from NDHB staff to Child Youth and Family e.g. concern of physical, sexual, emotional abuse, neglect, family violence.
Financial Sustainability	YTD Variance to net Result ($000)	% variance of Actual Net Result (Revenue less Expenditure) to Plan
	YTD variance to Net Result – Patient Transport Positive /(Adverse) **Threshold Tolerance** Within 5.0% of target Between 5.0% and 10.0% of target	YTD variance to Net Result – Patient Transport Positive /(Adverse)
	YTD Variance to Savings plan ($000)	This is the total savings determined for each service, by financial year, and incurred YTD against annual budget. Total savings will vary for each service. The target objective is for each service to align its actual costs to the savings objective on a monthly basis concluding with the achievement of the total savings plan at financial year end.
Engaged Workforce	FTE employed to budget	Measures the number of staff by converting the paid ordinary hours of full time, part-time and casual staff into FTEs. The conversion is assumed on the standard paid ordinary hours of 40hours per week for all groups. All ordinary hours worked over 40 i.e. overtime, call hours and extra paid hours are excluded. The maximum worked FTE for an employee is 1 FTE. All annual, sick and other paid leave types are included, with the exception of annual leave paid out on termination.
	Percentage Annual Leave Taken	Annual Leave taken as a percentage of Total Hours. This is calculated using the following formula: annual leave hours * 100 / base hours. The benchmark for this across all services is between 11%, anything under should be flagged as amber or red depending on the variance
	Percentage Sick Leave Taken	Sick Leave taken as a percentage of Total Hours. This is calculated using the following formula: sick leave hours * 100 / base hours. The benchmark for this across all services is between 0% to 3%, anything over the 3% should be flagged as red
	Total Employees in Excess of 240 hours Accrued Leave	This is the total headcount of employees that have accrued leave > 240 hours. Any service operating with zero or minimal headcount over 240 hours is in the clear. We will need to determine the levels of clearance for this.

5.0 NEXT MEETING DETAILS

The next meeting will be held at **9.00am** on **Monday 26 August 2019**, **Tangihua Meeting Room, Tohora House, Whangarei Hospital**

NORTHLAND DISTRICT HEALTH BOARD

GLOSSARY OF ACRONYMS

June 2018

Acronym	Meaning
A&D	Alcohol and Drug
A&E	Accident and Emergency Department
A&M	Accident & Medical Centre
AAU	Acute Assessment Unit *(part of child health services)*
ACMO	Associate CMO
ACP	Advanced Care Planning
A&C	Audit & Compliance
ACA	Access Criteria for First Assessment
ACC	Accident Compensation Corporation
ADON	Assistant Director of Nursing
ADHD	Attention Deficit and Hyperactivity Disorder
ALOS	Average Length Of Stay
AMI	Acute Myocardial Infarction
AOD	Alcohol and Other Drugs
AoG	All of Government
AP	Annual Plan
AR	Active Review
ARRC	Age Related Residential Care
ARC	Aged Residential Care
ASH Rates	Ambulatory Sensitive Hospitalisation Rates
ASMS	Association of Salaried Medical Specialists
BAU	Business As Usual
BOI	Bay of Islands
BSC	Balanced Scorecard
BSI	Blood Stream Infections
CABG	Coronary Artery Bypass Graft
CAPD	Chronic Ambulatory Peritoneal Dialysis
CATT	Crisis Assessment Treatment Team
CBA	Cost Benefit Analysis
CCP	Contribution to Cost Pressures
CCU	Coronary Care Unit
CEA	Collective Employment Agreement
CEO	Chief Executive Officer
CFA	Crown Funding Agreement
CGB	Clinical Governance Board
CHC	Child Health Centre
CHS	Community Health Services
CIPP	Community Injury Prevention Programme
CMO	Chief Medical Officer
CME	Continuing Medical Education
COPD	Chronic Obstructive Pulmonary Disease
CPAC	Clinical Priority Assessment Criteria
CPSOG	Clinical Pharmacy Services Operational Group
CPHAC	Community and Public Health Advisory Committee
CPR	Cardio pulmonary resuscitation
CSC	Community Services Card
CSU	Central Sterilising Unit
CT	Computerised Tomography
CVD	Cardiovascular Disease

Acronym	Meaning
CWD	Caseweighted Discharge
DAO	Duly Authorised Officer
DHB	District Health Board
DHBSS	District Health Board Shared Services
DIAS	Disability Information Advisory Service
DiSAC	Disability Support Advisory Committee
DN	District Nurse
DNA	Did not attend
DONM	Director of Nursing and Midwifery
DRG	Diagnostic Related Group
DSAC	Doctors for Sexual Abuse Care
DSS	Disability Support Services
EAP	Employee Assistance Programme
ECG	Electrocardiogram
ED	Emergency Department
EENT	Eyes, Ears, Nose and Throat
EEO	Equal Employment Opportunity
ELT	Executive Leadership Team
ENT	Ear Nose and Throat
EOI	Expressions of Interest
ERA	Employment Relations Act
ESS	Elective Services Statistics
ESPI	Elective Services Performance Indicators
FAQ	Frequently Asked Questions
FBT	Fringe Benefit Tax
FFT	Future Funding Track
FRAC	Finance, Risk and Assurance Committee
FRS	Financial Reporting Standard
FSA	First Specialist Assessment
FST	Financial Sustainable Threshold
FTE	Full time equivalent
GETS	Government Electronic Tender Service
GDB	General Dental Benefit
GM	General Manager
GMS	General Medical Services Benefit
GSE	Government Special Education
hA	healthAlliance
HAC	Hospital Advisory Committee
HBSS	Home Based Support Services
HDC	Health and Disability Commissioner
HRT	Health Round Table
HHC	Home Health Care
HIN	Health Information Network
HNA	Health Needs Analysis
HOD	Head of Department
HOP	Health of Older People
HPO	Health Protection Officer
HPV	Human Papillomavirus
HQSC	Health Quality & Safety Commission
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
IAT	Income and Asset Testing
ICU	Intensive Care Unit
ICT	Intensive Care Team (Mental Health)
IDF	Inter District Flows
IEA	Individual Employment Agreement

Acronym	Meaning
IFHC	Integrated Family Health Centre
IIA	Income in Advance
InterRAI	International Research and Assessment Instruments
IR	Industrial Relations
IS	Information Systems / Information Services
ISSP	Information Systems Strategic Planning
IT	Information Technology
JV	Joint Venture
KPI	Key Performance Indicator
LMC	Lead Maternity Carer
LOS	Length of stay
LTC	Long Term Conditions
MDO	Maori Development Organisations
MECA	Multi Employer Collective Agreement
MERAS	Midwifery Employee Representation & Advisory Services
MF (score)	Missing Filled (score) *(dental services)*
MHGC	Maori Health Gains Council
MHIPU	Mental Health Inpatient Unit
MI	Myocardial infarction
MIF	Monitoring and Intervention Framework
MMR	Measles-mumps-rubella
MoH	Ministry of Health
MOH	Medical Officer of Health
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding
MPDS	Maori Provider Development Scheme
MRI	Magnetic Resonance Imaging
MRT	Medical Radiation Technologist
MSD	Ministry of Social Development
MVS	Meningococcal Vaccine Strategy
NCIC	National Capital Investment Committee
NASC	Needs Assessment and Service Co-ordination
NDHB	Northland District Health Board
NEST	Northland Emergency Services Trust
NGO	Non-Government Organisation
NHB	National Health Board
NHH	Neighbourhood Healthcare Homes
NHI	National Health Index
NHSP	Northland Health Services Plan
NHSS	National Health Supply Service
NIF	Northland Intersectoral Forum
NIR	National Immunisation Register
NRA	Northern Region Alliance (formerly NDSA Northern DHB Support Agency)
NRHP	Northern Region Health Plan
NRTH	Northern Regional Training Hub
NTA	National Travel Assistance
NZBS	New Zealand Blood Service
NZCOM	New Zealand College of Midwives
NZHS	New Zealand Health Strategy
NZHPL	New Zealand Health Partnerships Ltd
NZMC	New Zealand Medical Council
NZNO	New Zealand Nurses' Organisation
O&G	Obstetrics and Gynaecology
OIA	Official Information Act
OMG	Operational Management Group

Acronym	Meaning
OP	Outpatient
ORL	Otorhinolaryngology (=ENT)
OSH	Occupational Safety and Health
OT	Occupational Therapy *(sometimes also* Operating Theatre*)*
PACU	Post Anaesthetic Care Unit
PBFF	Population Based Funding Formula
PCO	Primary Care Organisation
PDRP	Professional Development Recognition Programme
PGY	Post Graduate Year
PHO	Primary Health Organisation
PHN	Public Health Nurse
PHU	Public Health Unit
PIPP	Planning, Integration, People and Performance
PN	Practice Nurse
POPN	Primary Options Programme Northland
PQ	Parliamentary Questions
PSA	Public Service Association
PSAAP	PHO Service Agreement Amendment Protocol
PS&QID	Patient Safety & Quality Improvement Directorate
PUC	Purchase Unit Cost
RBA	Results Based Accountability
RDA	Resident Doctors' Association
RFF	Regional Funding Forum
RFP	Request for Proposal
RG	Referral Guidelines
RICF	Reducing Inequalities Contingency Funding
RMO	Resident Medical Officer
RWL	Residual Waiting List
SAT	Self Assessment Tool
SAU	Surgical Admission Unit
SBL	Surgical Booking List
SCBU	Special Care Baby Unit
SCOPE	Service Coordination – Primary Care Navigation for Older People in their Environment
SDS	School Dental Service
SHO	Senior House Officer
SIA	Service to Improve Access
SLT	Speech Language Therapy
SMO	Senior Medical Officer
SOI	Statement of Intent
SPNIA	Service Planning and New Intervention Assessment
SSSG	Shared Support Services Group
STAH	Scientific Technical & Allied Health
STV	Single Transferable Voting
SUDI	Sudden Unexplained Death in Infancy
TAS	Technical Advisory Services
TLA	Territorial Local Authorities
TOR	Terms of Reference
TOW	Treaty of Waitangi
TPK	Te Puni Kokiri
TPOT	The Productive Operating Theatre
TROTR	Te Runanga O Te Rarawa
VCLA	Very Low Cost Access
WERO	Whanau End smoking Regional whanau Ora Challenge
WHO	World Health Organisation
WIIE	Whanau Integration Innovation & Engagement Fund

Acronym	Meaning
WOC	Whanau Ora Collective
YTD	Year-to-date

Any additions/amendments, please contact Julie Shepherd, Julie.shepherd@northlandddhb.org.nz, Extn 60308, 021 945 647