HOSPITAL ADVISORY COMMITTEE (HAC) MEETING
1 July 2020

Venue: Middlemore Hospital - Ko Awatea, Room 101
100 Hospital Road, Otahuhu, Auckland

Time: 1.00 pm

Committee Members	CMDHB Management
Catherine Abel-Pattinson – HAC Chair	Avinesh Anand – Deputy CFO Provider
Dr Lana Perese – HAC Deputy Chair	Chris Mallon – Chief Midwife
Colleen Brown – CMDHB Board Member	Dr Jenny Parr – Chief Nurse and Director of Patient and Whaanau Experience
Dianne Glenn – CMDHB Board Member	Jessica Ibrahim - Executive Advisor, CEO's Office
Garry Boles – CMDHB Board Member	Dr Kate Yang – Funder Manager, Hospital
Katrina Bungard – CMDHB Board Member	Mary Burr – General Manager Women's Health
Paul Young – CMDHB Board Member	Dr Mary Seddon – Director Ko Awatea
Apulu Reece Autagavaia – CMDHB Board Member	Dr Peter Watson – Chief Medical Officer
Tipa Mahuta – CMDHB Board Member	Sanjoy Nand – Chief of Allied Health, Scientific & Technical Professions
Barry Bublitz – Mana Whanua	Teresa Opai – Secretariat
Robert Clark – Mana Whenua	

PART I – Items to be Considered in Public Meeting

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BOARD MEMBER ATTENDANCE SCHEDULE – HAC 2020

Name	Jan	26 Feb	Mar	08 Apr	27 May	Jun	01 Jul	12 Aug	09 Sep	Oct	04 Nov	16 Dec
Catherine Abel-Pattinson	No Meeting	✓	No Meeting	✓*	✓*	No Meeting				No Meeting		
Colleen Brown		✓		✓*	✓*							
Dianne Glenn		✓		✓*	✓*							
Garry Boles		x		x	x							
Katrina Bungard		✓		✓*	✓*							
Lana Perese		✓		✓*	✓*							
Paul Young		✓		✓*	x							
Reece Autagavaia		✓		✓*	x							
Tipa Mahuta		✓		✓*	✓*							
Barry Bublitz		x		✓*	x							
Robert Clark		x		✓*	✓							

* Via video conference call

HOSPITAL ADVISORY COMMITTEE
DISCLOSURE OF INTERESTS
1 July 2020

Member	Disclosure of Interest
Catherine Abel-Pattinson (Chair)	• Board Member, healthAlliance NZ Limited. • Board Member, CMDHB; Chair, Hospital Advisor Committee; Member, Audit & Risk Committee • Member, NZ Nurses Organisation (previous Board member) • Member, Directors Institute • Board Member, IAN - International Accreditation NZ • Husband (John Abel-Pattinson): o Director, Blackstone Group Limited o Director and Shareholder, Blackstone Partners Limited o Director, Blackstone Treasury Limited o Director, Bspoke Group Limited o Director, Barclay Management (2013) Limited o Director, AZNAC (JAP) Limited o Director, Chatham Management Limited o Director, MAFV Limited o Director, Wolfe No. 1 Limited o Director, 540 Great South Motels Limited o Director, Silverstone Property Group Limited o Director, various single purpose property owning companies o Director and Shareholder, various Trustee Companies related to shareholding in the above
Lana Perese (Deputy Chair)	• Director & Shareholder, Malatest International & Consulting • Director, Emerge Aotearoa Limited Trust • Trustee, Emerge Aotearoa Housing Turst • Director, Vaka Tautua • Director, Malologa Trust
Colleen Brown	• Chair, Disability Connect (Auckland Metropolitan Area) • Member, Advisory Committee for Disability Programme Manukau Institute of Technology • Member, NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • Director, Charlie Starling Production Ltd • District Representative, Neighbourhood Support NZ Board • Chair, Rawiri Residents Association • Director and Shareholder, Travers Brown Trustee Limited

Dianne Glenn	• Member, NZ Institute of Directors • Life Member, Business and Professional Women Franklin • Member, UN Women Aotearoa/NZ • Past President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust • Life Member, Ambury Park Centre for Riding Therapy Inc. • Member, National Council of Women of New Zealand • Justice of the Peace • Member, Pacific Women's Watch (NZ) • Member, Auckland Disabled Women's Group • Life Member of Business and Professional Women NZ • Interviewer, The Donald Beasley Research Institute for the monitoring of the United Nations Convention on the Rights of Persons with Disabilities
Garry Boles	• Member, C and R • NZ Police Constable
Katrina Bungard	• Chairperson MECOSS – Manukau East Council of Social Services. • Deputy Chair Howick Local Board • Member of Amputee Society • Member of Parafed disability sports • Member of NZ National Party
Paul Young	• TBC
Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Trustee, Epiphany Pacific Trust • Trustee, The Good The Bad Trust • Member, Otara-Papatoetoe Local Board • Member, District Licensing Committee of Auckland Council • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation • Board of Trustees Member, Holy Cross School • Member of the Cadastral Surveyors Board • Assessor of the Creative Communities Scheme South & East Auckland
Tipa Mahuta	• Deputy Chair, Te Whakakitenga o Waikato • Councillor, Waikato Regional Council

HOSPITAL ADVISORY COMMITTEE MEMBERS' REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 1 July 2020

Director having interest	Interest in	Particulars of interest	Disclosure date	Board Action
Catherine Abel-Pattinson	Whaanau Accommodation Options at MMH	Catherine's husband owns a business that has hotel/motels in the Counties Manukau catchment area that are from time to time used for CM Health or WINZ clients.	4 April 2018	That Catherine Abel-Pattinson's specific interest be noted and that the Board agree that she may remain in the room and participate in any deliberations, but be excluded from any voting.

Minutes of Counties Manukau District Health Board
Hospital Advisory Committee

Held on 27 May 2020 at 1.00pm
Ko Awatea Room 101, Middlemore Hospital
100 Hospital Road, Otahuhu, Auckland

PART I – Items Considered in Public Meeting

BOARD MEMBERS PRESENT

Catherine Abel-Pattinson (Chair)
Dr Lana Perese (Deputy Chair)
Mark Gosche (DHB Chair)
Colleen Brown
Dianne Glenn
Katrina Bungard
Tipa Mahuta (exited meeting at 2.30pm)
Robert Clark

ALSO PRESENT

Avinesh Anand (Deputy CFO, Provider)
Dr Jenny Parr (Chief Nurse and Director of Patient and Whaanau Experience)
Dr Kate Yang (Executive Advisor, CEO's Office)
Margie Apa (Chief Executive)
Mary Burr (General Manager Women's Health)
Dr Peter Watson (Chief Medical Officer)
Sanjoy Nand (Chief of Allied Health, Scientific & Technical Professions)
Teresa Opai (Secretariat)
(Staff members who attended for a particular item are named at the start of their item)

PUBLIC PRESENT

Carol Gosche (via Zoom)

1. AGENDA ORDER AND TIMING

The meeting commenced at the later time of 1.00pm due to the CPHAC meeting running late. The meeting started with item 1.1, moved to item 2.3, then returned to item 1.2.

1.1 Apologies/Attendance Schedule

Apologies were noted from Paul Young, Apulu Reece Autagavaia, Garry Boles and Barry Bublitz.

1.2 Disclosed Interests

There were no Disclosures of Interest to note requiring update.

1.3 Special Interests

There were no Special Interests to note requiring update.

DRAFT

1.4 Ways of Working Under COVID-19 Restrictions – Discussion

Ms Abel-Pattinson asked that attendees utilise the 'raise your hand' button if they wished to speak.

1.5 Online Meeting Etiquette

Noted.

2. CORPORATE REPORTS – PART A

2.1 Price Volume Schedule (Ms Haggie and Ms Wilson)

Ms Wilson provided a presentation to the meeting.

Key points:

- Common acronym definitions were explained for the benefit of new members and a refresher for others. This included the setting of WIES, the PVS, what is purchased, who purchases, key stakeholders, considerations, funding and volume and oversight strategies. Details of these are contained in the attached presentation.

Action: ***Secretariat to attach a copy of the presentation to the Minutes for reference purposes and to place a copy in the Resource Centre.***

2.2 Planned Care

Ms Wilson provided a presentation to the meeting.

Key points:

- Planned Care is the new term used by the Ministry of Health to refer to care that includes elective surgery and non-urgent ambulatory care or specialist clinics that are mostly First Specialist Assessments (FSA) and Follow Ups (FU), whether provided by CM Health or other DHBs.
- Within the DHB this includes inpatient arranged and elective surgical specialties, minor inpatients procedures, minor outpatients procedures, minor community procedures and non surgical interventions.
- Compares actual activity against contract volumes. To be eligible for additional funding over base, the DHB needs to meet at least 95% of total contracted discharges.
- A future presentation will include more detail of what is included in the Price Volume Schedule and the Planned Care volumes, once advised by the Ministry.

Ms Apa advised that the MoH does not fully fund the cost of providing the electives. The Ministry is trying to reset their framework and incentivise via primary care.

Ms Abel-Pattinson suggested that the presentation is shared with other DHBs with a copy provided to the Committee for reference purposes.

Action: ***Secretariat to attach a copy of the presentation to the Minutes for reference purposes, place a copy in the Resource Centre and share the presentation with other DHBs.***

2.3 SAPS Planned Care Recovery Plan

Dr Kenealy and Ms McGrath provided a presentation to the meeting.

Key points:

- Outsourcing was suspended during Level 4 which impacted volumes.
- Surgery and clinics was restricted to urgent and cancer patients and those that needed treatment within 6 weeks.

- Acute cases were significantly reduced at 45-50% of acute volumes.
- Approximately 1500 surgical services cases have been deferred.
- With a full month of lockdown in April, productivity was 29% of normal elective activity.
- Ophthalmology was significantly impacted, with overdue First Specialist appointment (FSA) and Follow-up appointment (FU), increasing by 1900 patients as at the end of April.
- YTD operating volumes as at April are down 10% with Case Wait down 8%.
- Several months will be required to recover from COVID-19 deferred activity.
- A collaborative 3-pronged approach is being taken across the DHB:
    - Optimise DHB capacity to address deferred surgery, procedures and clinics.
    - Resume outsourcing of current contracts and plan 2020/21 volumes.
    - Insourcing initiative planned for June over 4 weekends involving extended and evening surgeries, procedures and clinics which should see 2604 patients processed.
- Reviewing models of care to create efficiencies, maximising internal capacity, theatre improvement project at MSC and MMH and optimising existing outsourced services to September 2020.
- Next steps will evaluate insourcing initiative alongside review of outsourced services to formulate consolidated roadmap.

Mr Kenealy advised that the surgical and clinical staff are keen to support these initiatives. Whilst the insourcing initiative is not sustainable long term, it is an opportunity to reduce the deferred cases.

Mr Gosche advised that he would like the Board to receive the presentation. He expressed his interest in the expectation of the short anticipated period of recovery.

Action: ***Secretariat to notify Board Secretary to schedule the SAPS Planned Recovery Plan presentation at a future meeting.***

Mr Kenealy advised that the service had managed to continue to do P1s and to some extent P2s throughout the COVID-19 period which has helped. While referrals for all levels of cases decreased over the COVID-19 period, Mr Kenealy anticipates a surge of urgent referrals but not of routine referrals because of access to GPs. A second wave of COVID-19 would also impact any predictions.

Ms McGrath noted that a plan would be put in place to ramp up activity, with a need for a more detailed analysis of capacity and impact going into next year. Mr Kenealy noted that the funding envelope will also have an impact.

Ms Abel-Pattinson suggested the DHB issue a press release to explain to the public that the DHB has undertaken this work and that it empathises with their concerns over delayed appointments and surgeries. Mr Kenealy advised that both medicine and surgical services had already communicated via the Comms team to the community, but agreed it was worth re-emphasising.

Action: ***Ms Apa to speak with Ms Baker about the community communications that have been issued about the impact of COVID-19 on appointments and surgeries and what more may be appropriate.***

Ms Apa acknowledged the work of the service and their additional efforts for the weekend sessions.

3. BOARD COMMITTEE MINUTES

3.1 Minutes of the Joint HAC/CPHAC/DiSAC Meeting – 8 April 20209

Resolution (Moved: Ms Glenn/Dr Perese)

That the Minutes of the Joint HAC/CPHAC/DiSAC meeting held on 8 April 2020, as they relate to the Hospital Advisory Committee, be approved.

Carried

3.2 Action Items Register – Public

Action 3.1 Birthing Unit Report – Ms Burr to confirm a date to the Secretariat.

Action 2.4 Draft Work Plan – DHB staff to work with Ms Abel-Pattinson to finalise draft for 1 July meeting.

Action 2.1 Equitable Health Outcomes – Board workshop dates to be agreed by Ms Apa prior to the next Board meeting with an update provided to HAC after the workshops have been held.

Action 4.4 Patient Flow – letters of thanks have been sent, remove from register.

Action 4.5.1 Safety, Experience, Compliance and Measurement Dashboard - Mr Nand to confirm a date to Secretariat once data relating to sentinel events is available.

Action: ***Secretariat to update Action Items Register to reflect the above and notify actions to relevant individuals.***

4. PROVIDER ARM PERFORMANCE REPORT

4.1 Executive Summary (Mary Burr)

The report was taken as read.

Ms Burr provided key points:

- State of Emergency was declared 25 March with the first in-hospital COVID-19 case presenting on 29 March in the birthing unit. The hospital has had 11 COVID-19 positive patients and 127 positive or probable cases in the community as at 11 May.
- Community response was coordinated by the local and regional IMT's.
- Obtaining PPE was a challenge and was an issued faced worldwide.
- Strong decision-making around difficult and challenging decisions were made through IMT and shared relationships between CEO, IMT and ELT with daily reports through IMT via Zoom and CTAG.
- Negative pressure rooms were a focus and the engineering team were able to put together two full wards to manage COVID-19 in wards 6 and 7 with green and red zones set up in ED.
- Planning for outpatients with the use of telehealth, virtual consultations and zoom was put in place quickly.
- Hospital occupancy by the end of March had dropped significantly with only essential services operating. Staff took the opportunity to train and prepare for COVID-19.
- Elective activity reduced and it is estimated it will take 12-18 months to recover volumes.
- Restricted visitor policy still in place and has been well supported by the community.
- Work is continuing on the winter plan.

4.2 Hospital Services Project Portfolio Overview (Margie Apa)

The report was taken as read.

DRAFT

Ms Apa provided key points:

- The portfolios of Every Dollar Counts and Every Hour Counts suffered from the COVID-19 disruption. Every Hour Counts are stepping back and taking a reset. Every Dollar Counts did not make as much progress as planned, achieving 69%of target.

Ms Glenn asked if the lower hospital occupancy provides a better opportunity to build a home ward system as the hospital increases capacity. Ms Apa advised that the hospital occupancy was a blip and has since increased back up to normal levels.

4.3 Finance Results – CMDHB Provider Arm (Avinesh Anand)

The report was taken as read.

Mr Anand provided key points:

- The March result was impacted by variances attributable to COVID-19. These included high net annual leave accrual due to staff not taking leave, additional capital required for COVID-19, Apex strikes that have impacted delivery of Planned Care volumes and unrealised target savings.

Resolution (Moved: Ms Brown/Seconded: Ms Bungard)

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

5. CORPORATE REPORTS – PART B

5.1 Certification Update (Dr Jenny Parr)

The report was taken as read.

Key points:

- Dr Parr advised that a tentative date of early December had been advised for the next surveillance audit. The DHB is still awaiting a response from the MoH with respect to the progress reports submitted for moderate and low risk corrective actions and will update the Committee once a response has been received.

Mr Gosche queried corrective action HDS(C)S.2008 Criterion 1.4.6.2 which relates to an annual audit of Taylors Laundry which has a 90 day timeframe. Dr Parr undertook to follow through and suggested that it may one of the corrective actions awaiting a response from the MoH.

Action: ***Dr Parr to provide an update on the status of corrective action HDS(C)S.2008 Criterion 1.4.6.2.***

Note: Prior to the meeting concluding Dr Parrr advised via Zoom Chat that the above corrective action 'The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness' has been assessed as completed and this CAR has been closed. This means the DHB no longer has any moderate CARs. The surveillance audit will commence on 8 December.

DRAFT

5.2 Fundamentals of Care Results September 2019 Review (Dr Jenny Parr)

The report was taken as read.

Key points:

- Dr Parr advised that the delay in getting results was due to timing, firstly with Christmas, then COVID-19. Action plans have been discussed with the nursing team. Dr Parr noted the poor satisfaction rating for Maaori consumers as compared with others as a compelling reason as to why this work must continue.

Resolution (Moved: Mr Clark/Seconded: Dr Perese)

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

5.3 Fundamentals of Care Results March 2020 Review (Dr Jenny Parr)

Dr Parr provided a verbal update to the meeting.

Key points:

- The long delay is staffing related as a resource to undertake the analysis is identified. Ko Awatea has supported this historically but are no longer able to, following the departure of a biostatistician. Dr Parr is working to bring the responsibility in-house and following consultation, six months of funding has been allocated to enable a pilot. In the interim, planning for the September review continues.

Mr Gosche noted there is a breakdown on ethnicity and queried whether there should be one around disability. Dr Parr advised that there has not been a disability breakdown in the past, but as the DHB is not reliant on patient information systems for the review, this could be incorporated into the survey monkey approach when patients are interviewed.

Ms Abel-Pattinson commented that she was keen to see a reduction in health inequalities for Maaori within the Counties Manukau area and is keen for it to be highlighted. She asked that Dr Parr advise if further support is required.

Mr Gosche offered his thanks for the excellent content in the last three reports and expressed his deep appreciation. Further, Mr Gosche expressed his wish that people would look at the public papers and see what tremendous work had been done by the DHB, and the possibility of alerting our local MPs to this comprehensive report about how CM Health stood up under COVID-19.

5.4 Patient Experience and Safety Report (Dr Mary Seddon)

The report was taken as read.

5.4.1 Safety, Experience, Compliance and Measurement Dashboard

The report was taken as read.

Dr Seddon provided key points:

- The report is presented on behalf of Dr Watson and Dr Parr and relates to March data.
- There was a mechanical fault with phxis machine, which caused a delay in medication. The patient died but the DHB is not entirely sure the machine fault is related to the death but a full investigation is underway.

- There were 6 falls during April. The Falls Action Group has been asked to present at the Clinical Governance meeting.
- Due to COVID-19, some of the infectious diseases indicators have not been updated but will be by the next meeting.

Mr Clark asked for further details regarding the abovementioned death. Dr Seddon advised that the ED patient had arrested prior to coming into hospital. The Physix machine had a bag of magnesium fluid stuck between drawers, so medication could not be dispensed. Medication was received from ICU within 10 mins.

To remove any vulnerability the pharmacy have put into place a number of improvements including the way the machine is stacked, training of the nursing team to access the rear of the machine, and storing of medications in multiple areas to avoid a single source of failure.

Dr Watson advised that an internal review has been undertaken to determine the likelihood that the machine fault contributed in any way to the outcome. An external expert is also undertaking a review and providing comment.

Ms Abel-Pattinson asked what process was in place to notify other hospitals that have this machine of this potential fault. Dr Watson advised that once the investigation and review is concluded an alert will be put out to other hospitals if appropriate.

Ms Abel-Pattinson asked if the DHB has notified the manufacturer. Dr Watson advised that the manufacturer had not been contacted as the suspected cause of the fault is the storing of large fluid bags at the back of the drawer, which has been rectified. For now, the DHB is working to ensure they understand what the issue was in a very short period of time.

Ms Abel-Pattinson advised she was keen for others who use the machine to know of the DHB's experience. Dr Watson advised that the internal review is expected by the end of next week and the external review shortly thereafter, and within 3-4 weeks the DHB will be able to pass its findings on.

5.4.2 QSM Local Report

The report was taken as read.

Dr Seddon provided key points:

- Most indicators are performing very well.
- Note that CM Health has fewer cardiopulmonary arrests than the NZ average and has a higher rate of rapid response escalation.

5.5 Patient Flow – Every Hour Counts Update (Dr Mary Seddon)

The report was taken as read.

Dr Seddon provided key points:

- During lockdown there was a dramatic decrease in ED presentations and ward occupancy but this has since recovered. 'To be seen' times improved but the 6-hour target and 8-hour to ward did not improve, even though there were fewer presentations. A workshop was held this week to review learnings.
- The MRI waiting list has been impacted by lockdown and numbers have increased.

DRAFT

- Ambulatory flow programme – COVID-19 has broken down many barriers that the DHB was facing for virtual outpatient appointments and clinical engagement has been positive. In recent weeks 55-60% of appointments have been via phone. The average Did Not Attend (DNA) across all clinics has dropped from an average 11% to 2-3% however the Maaori and Pasifika DNA rates were still disproportionate.
- Telehealth consultations were viewed positively in general but created some concern about privacy and confidentiality when conducting virtual or telephone outpatient appointments. Most clinicians now see this as part of normal business.
- Remote monitoring for cardiac patients with heart failure has been agreed and blood pressure monitors and scales will be sent to a test group of up to 25 patients.
- Work continues in Ophthaology to streamline the process for patients undergoing cataract surgery.

Resolution (Moved: Ms Brown/Seconded: Ms Glenn)

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

5.6 National Bowel Screen Programme Update (Catherine Tracy)

The report was taken as read.

Ms Tracy provided key points:

- The MoH stopped the distribution of test kits in late March and it is likely to be June before distribution of tests kits resumes.
- Some P1 work continued during lockdown with people already in the system. There are currently 110 BSP participants waiting for a colonoscopy of which 75 are already booked in with a further 75 appointments available to the end of June.
- The service is engaging with the MoH on funding as the modelling completed by the DHB shows a deficit in the 2021/22 year. The MoH are pushing back and requesting evidence which the DHB is compiling.

Mr Clark asked if there had been any movement on Maaori coming back earlier for testing. Ms Tracy advised that this is delayed at the moment. The MoH have committed to doing it but the DHB cannot do it on its own as it does not have the funding. Ms Tracy will contact the MoH and ask for some indication as to when the Ministry will provide funding for this.

Action: ***Ms Tracy to contact the MoH and ask for an indication as to when the Ministry will provide funding for Maaori to return earlier for testing.***

Ms Glenn congratulated the service for their work and the number of people who have been diagnosed through this programme. Ms Tracy advised that more cancers have been identified than were forecast.

DRAFT

5.7 Faster Cancer Treatment Quarterly Update (Catherine Tracy)

The report was taken as read.

Ms Tracy provided key points:

- FCT performance is 85% for 62 day target reflecting the impact of industrial action, White Island and COVID-19.
- Gynaecology is the source of the majority of the capacity breaches (14 out of total 30), mainly endometrial cancer timeframe breaches due in the most part to theatre access, which remains a key focus.

Ms Abel-Pattinson noted that delays in gynaecology has been an ongoing problem for the past 3 years and needs to be addressed. Ms Apa advised that Ko Awatea have a project looking specifically at the areas and the pathway where either the patient or service is adding to the breach. Ms Apa noted that there are two key contributors, patients accessing treatment in a timely way and access to theatre. Ms McGrath and Mr Kenealy are reviewing how the DHB is prioritising lists and gynaecology in particular.

Ms Abel-Pattinson requested an update on the current status and the estimated timeframe for a final report at the next meeting. Ms Burr will provide an update to the next meeting.

Action: ***Ms Burr to provide an update to the 1 July HAC meeting on the current status of delays to Gynaecology treatments and estimated timeframe for a final report.***

Ms Tracy advised that whilst access to theatre is the primary issue, the sonographers strike and delays in getting treatment at ADHB due to capacity, were contributing factors.

Ms Abel-Pattinson noted that the DHB needed to explore other options, as it was not meeting international standards, and needed to be addressed. Ms Abel-Pattinson acknowledged that the answer is complex.

Resolution (Moved: Ms Glenn/Seconded: Ms Bungard)

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

5.8 Human Resources Update (Elizabeth Jeffs)

The report was taken as read.

Ms Jeffs provided key points:

- Much of the report content is pre COVID-19.
- A reduction in turnover during lockdown has been noted.
- The DHB entered lockdown with 22 FTE vacant in sonography which historically has been difficult to fill and came out of it with all roles filled by people returning to NZ.

DRAFT

Resolution (Moved: Mr Clark/Seconded: Dr Perese)

That the Hospital Advisory Committee:

Note and receive the report.

Carried

6. INFORMATION PAPERS

6.1 Emergency Department and Middlemore Central (John Cartwright)
The report was noted and taken as read.

6.2 Medicine and Integrated Care (Catherine Tracy)
The report was noted and taken as read.

6.3 Surgery, Anaesthesia and Perioperative Services (Pauline McGrath)
The report was noted and taken as read.

6.4 Central Clinic Services (Ian Dodson)
The report was noted and taken as read.

6.5 Women's Health (Mary Burr)
The report was noted and taken as read.

6.6 Kidz First (Nettie Knetsch)
The report was noted and taken as read.

6.7 Adult Rehabilitation and Health of Older People (Dana Ralph-Smith)
The report was noted and taken as read.

6.8 Mental Health and Addictions (Tess Ahern)
The report was noted and taken as read.

6.9 Facilities, Engineering and Asset Management (Anton Venter)
The report was noted and taken as read.

Ms Abel-Pattinson noted that a revised report had been uploaded to Diligent earlier in the day reflecting a change in status for both Scott and AMHU2 from red to amber, the removal of the reason for the red status in AMHU2, and an amendment to the second paragraph in the Cath Lab and Dialysis Expansion commentary.

Resolution (Moved: Ms Glenn/Seconded: Dr Perese)

That the Hospital Advisory Committee:

Note and receive the reports.

Carried

DRAFT

7. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Ms Glenn/Seconded: Dr Perese)

That the Hospital Advisory Committee in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
Public Excluded Minutes of 8 April 2020 and Actions	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.

Carried

The Public Meeting closed at 3.00 pm.

The next meeting of the Hospital Advisory Committee will be held on Wednesday, 1 July 2020.

Signed as a true and correct record of Counties Manukau District Health Board's Hospital Advisory Committee meeting held on 27 May 2020.

Catherine Abel-Pattinson
Chair

Date

DRAFT

Note: Items ticked (other than Standing Action Items) and completed are included on the Register for the next meetings review and can then be removed the following month.

Hospital Advisory Committee Meeting – Public Action Items Register – 01 July 2020

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
26 February 2020	2.1	**Minutes of HAC 20 November 2019** Item 4.5 Equitable Health Outcomes	24 June 2020	Ms Apa	Board workshop dates to be agreed by Ms Apa prior to the next Board meeting with an update provided to HAC after the workshops have been held.	
26 February 2020	4.5.1	**Safety, Experience, Compliance and Measurement Dashboard** Mr Nand to provide data relating to MedChart sentinel events and schedule a report for a future meeting.	4 November 2020	Mr Nand	Mr Nand has advised the data will not be available until September and therefore will provide a report at the November meeting.	
27 May 2020	2.1	**Price Volume Schedule** Secretariat to attach a copy of the presentation to the Minutes for reference purposes and to place a copy in the Resource Centre.	1 July 2020	Secretariat		✓
27 May 2020	2.2	**Planned Care** Secretariat to attach a copy of the presentation to the Minutes for reference purposes, place a copy in the Resource Centre and share the presentation with other DHBs.	1 July 2020	Secretariat	Dr Yang has notified Funder Directorate of presentation	✓
27 May 2020	2.3	**SAPS Planned Care Recovery Plan** Secretariat to notify Board Secretary to schedule the SAPS Planned Recovery Plan presentation at a future meeting.	1 July 2020	Secretariat		✓

Note: Items ticked (other than Standing Action Items) and completed are included on the Register for the next meetings review and can then be removed the following month.

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
27 May 2020	2.3	**SAPS Planned Care Recovery Plan** Ms Apa to speak with Ms Baker about the community communications that have been issued about the impact of COVID-19 on appointments and surgeries and what more may be appropriate.	1 July 2020	Ms Apa	Update provided in Executive Summary	✓
27 May 2020	5.1	**Certification Update** Dr Parr to provide an update on the status of corrective action HDS(C)S.2008 Criterion 1.4.6.2	1 July 2020	Dr Parr	Update provided prior to the meeting conclusion via Zoom Chat - refer Minutes	✓
27 May 2020	5.6	**National Bowel Screen Programme Update** Ms Tracy to contact the MoH and ask for an indication as to when the Ministry will provide funding for Maaori to return earlier for testing.	1 July 2020	Ms Tracy		✓
27 May 2020	5.7	**Faster Cancer Treatment** Ms Burr to provide an update to the 1 July HAC meeting on the current status of delays to Gynaecology treatments and estimated timeframe for a final report.	1 July 2020	Ms Burr	Update to be included in Corporate Reports section	✓

Note: Items ticked (other than Standing Action Items) and completed are included on the Register for the next meetings review and can then be removed the following month.

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
Standing Action Items						
31 January 2018	2	**Patient Experience and Safety Report** Provide a **regular update at each meeting** on response rates to the patient survey and the complaints review process	12 August 2020	David Hughes	Include in Corporate Reports	
18 August 2018	3	**Chronic Conditions** Provide a **regular update at each meeting** as part of the Executive Summary.	01 July 2020	Penny Magud to provide update to Mary Burr	Relates to 2017 locations strategy and no longer applicable. Remove from register	✓
19 February 2019 Email from M Apa 28 August 2019	 4.3	**Patient Flow – Every Hour Counts** Provide a **regular update at each meeting**. Track KPI progress and provide a **regular update at each meeting.**	12 August 2020	Mary Seddon	Include in Corporate Reports	
31 January 2018	6.1	**Hospital Services 2018/19 Project Initiatives** Provide a **regular update at each meeting** on current projects.	12 August 2020	Alan Whiting	Include in Provider Arm Performance Reports	
31 January 2018	6.11	**Bowel Screening Programme** Provide a **regular update at each meeting.**	12 August 2020	Catherine Tracy	Include in Corporate Reports	

Note: Items ticked (other than Standing Action Items) and completed are included on the Register for the next meetings review and can then be removed the following month.

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
Quarterly Standing Action Items (Every Alternate Meeting)						
4 October 2017	2.4	**Human Resources Report** Provide a **quarterly report** for those staff that have had annual leave paid out, their current leave balance, leave accrual and leave taken. This report will not specifically identify particular individuals due to privacy issues.	09 September 2020	Elizabeth Jeffs	Include in Corporate Reports	
15 November 2011	5.1	**Certification** Provide a **quarterly report** showing progress being made against each corrective action.	09 September 2020	Jenny Parr	Include in Corporate Reports	
9 April 2019 CM Health Board Meeting		**Fast Cancer Treatment** Regularly monitor and **provide a quarterly report** for these actions: • Service-led action plans for each of the 4 tumour streams. • Gynaecology, Head & Neck, Lower GI (Bowel) and Lung Cancer team to take a more detailed look at hot spots and stream-specific issues. • Cancer Nurse Coordinators and Cancer Trackers meetings to be held to review and discuss hotspots.	12 August 2020	Catherine Tracy	Include in Corporate Reports	
14 March 2018	3	**Finance – Non Resident Bad Debt Summary** Provide a **quarterly report** to HAC.	tbc	Avinesh Anand	To go to ARF, not HAC. Remove from register.	✓

Counties Manukau District Health Board
Hospital Advisory Committee
Hospital Services Report – July 2020

Recommendation
It is recommended that the Hospital Advisory Committee:

Receive the Hospital Services Report covering activity in May 2020. Please note the additional update related to Covid-19 activity.

Prepared and submitted by Mary Burr, General Manager, Division of Women's Health on behalf the Hospital Services Directorate.

Glossary

EWS	Early Warning Score
ESPI	Elective Service Productivity Indicator
FCT	Faster Cancer Treatment
FSA	First Specialist Appointment
LOS	Length of stay
MECA	Multi-Employer Collective Agreement
MERAS	Midwifery Employment Relations Advisory Service (union)
MOH	Ministry of Health
NHI	National Health Index
NZNO	New Zealand Nurse Organisation (union)
PSA	Public Service Association (union)
SMO	Senior Medical Officer
WIES	Weighted Inlier Equivalent Separations (MOH activity based funding methodology)

Overview

This report provides an overview of the performance of all CM Health Hospital Services Divisions and includes finance and divisional highlight reports which provide a consolidated view of organisational performance in these areas.

It is important to note that this report reflects hospital operations during the Covid-19 pandemic Levels Three and Two and this still dominates performance.

Part A – CM Health Hospital Services Covid-19 Impact and Recovery

As we progressed through May 2020, CM Health hospital operations were still influenced by the Covid-19 response Level 3 and then Level 2 from 14 May 2020 when the hospital daily occupancy began to return to more normal levels. By the end of the month, most staff had returned to work (if they had been vulnerable workers at home) and many services continued utilising some aspects of virtual Covid work such as telehealth where appropriate. The following provides an overview of the CM Health COVID-19 Impact and Recovery Phase through Level 3 and then Level 2.

Current Covid-19 Status
At the time of writing this report there are no Covid-19 positive patients in the hospital. Over the course of the last three months CM Health has had in total 12 Covid-19 positive patients through the hospital and 131 in the community in total. The Counties Manukau Covid-19 response to date has been impressive and is due to great preparation and extremely good fortune.

Communications about outpatient appointments and surgery delays through Covid-19 Alert Levels

From a communications perspective, our community was advised that we were using telephone/video outpatient consultations during Covid-19 lockdowns and patients may not need to come in to Middlemore or other clinical sites such as the Manukau Super Clinic, Botany Super Clinic, Mangere or Pukekohe clinics to have a face to face meeting with their doctors. They were advised they would receive a text or telephone call which would give them an approximate time that their doctor would call them.

The messaging was distributed through radio advertising, digital banners and videos which were posted on our website, sent out through social media channels and also translated and used across our Pasifika, Maaori and Asian channels. When we moved to Alert Level 2 (mid May), another radio advertisement and video was produced thanking the community for their patience and assuring them that whilst there had been some delays and disruptions to outpatient appointments and planned surgeries, we were working through impacted appointments and would contact patients as soon as possible.

Overview of the CM Health COVID-19 Pandemic Impact and Recovery by Division

Division of Medicine - COVID19 Impact and Recovery

Bed occupancy and home-ward placement has returned to near normal levels in the post COVID19 recovery period. For the month of May, across the whole of acute Medicine bed occupancy averaged 87% while General Medicine occupancy averaged 93%.

Faster Cancer Treatments referral volumes are increasing again as we move through the COVID alert levels. Analysis is on-going to review how many patients present acutely if they have not sought appointments during lockdown. Any patients who have been delayed due to service restrictions have a plan in place to ensure they are not lost within the system.

There continues to be a number of instances where patients have chosen to delay appointments until after the lockdown has ended. Cancer Nurse Coordinators are working with patients to support them to come to appointments and reengage with the services.

Division of Surgery (SAPS) – COVID19 Impact and Recovery

The number of elective surgeries deferred by the end of May 2020 was between 1,400 and 1,500. The exact quantity of Outpatient Appointments deferred has yet to be fully quantified for every service, however in Ophthalmology, General Surgery and Plastic 1,550 FSAs were deferred. The Division is taking a three pronged approach to assisting the recovery:

- Increasing planned care productivity/activity back to normal levels by end of June 2020 within the processes required in the COVID-19 environment.
- Recommenced outsourcing to Private Providers in line with our contracted volumes (this had ceased during NZ COVID-19 Alert Levels 4 & 3).
- Insourcing initiative in the month June 2020 to maximise internal capacity for both planned care and outpatient appointments (FSAs and FU).

The insourcing initiative in June 2020 includes:

- Eight theatres being run at MSC for four Saturdays across all surgical specialities except orthopaedics.
- Procedure Rooms for Gastroscopy and Plastics over four Saturdays and some evenings.
- Additional ECHO clinics.
- Outpatient clinics in all surgical subspecialties and a number of Medical subspecialties, four Saturdays and some evening.

Division of Women's Health- COVID19 Impact and Recovery

Women's Health developed a number of processes to help women manage during Alert Levels including a procedure for women to undertake self-monitoring of their blood pressure at home with portable battery operated blood pressure machine.

The women were taught how to use the machine and test their urine. They were then given an individualised plan from the Consultant Obstetrician. The MAC Midwife contacted the women and the plan was supervised by phone consultation. This gave women an active part in their care in the convenience of their own home, reduced the expense for women involved in clinic visits and time for midwives to make home visits, but maintained the vital monitoring required for safe pregnancy outcomes. We will keep this innovation after all Covid19 restrictions are removed.

Diabetes in Pregnancy (DiP) Team at CM Health

The Diabetes in Pregnancy (DiP) Team was also faced with the challenge of providing care to women at risk of poor outcomes in the Covid19 lockdown situation. Placing our local South Auckland demographics and limited resources at the centre of our plan, we devised a Counties Manukau solution to the diagnosis of Diabetes in Pregnancy.

- The process was uploaded onto Auckland Health Pathways for GPs and health professionals to use as well as offering clear communications to LMCs and DHB staff.
- A virtual review of all new referrals produced individual electronic care plans on MCIS and enabled phone consultations with women by their Obstetricians and Diabetes Physicians.
- The DiP Midwives working with our Maternity Quality & Safety colleagues, dieticians and our DiP Obstetric Lead produced good quality instructional videos for women. These have been uploaded onto CM Health Vimeo site and cover blood glucose meter use, learning to give insulin, eating for diabetes in pregnancy, safe exercise and an outline of care by the Obstetrician.
- Our Community Health Workers provided non-contact equipment drop-off as well as phone support to engage women. We were able to replace our traditional group education session with phone support and videos, thus providing the required care without compromising quality or safety.

We will be keeping many of our Covid19 related changes in order to offer women choices about how they would like their care provided. Phone consultations are very well received by women who like their convenience and personal nature.

<u>Division of Kidz First- COVID19 Impact and Recovery</u>

During and post Covid-19 the volumes and occupancy in the Neonatal Unit have dropped dramatically. In May in the Neonatal Unit was down compared to April with an average of 65% occupancy, i.e. an average of 22 cots for the whole month against the 34 resourced cots. By June, occupancy has begun to rise again. The service is undertaking an audit of the sudden and pronounced reduction in admissions and acuity in the unit since COVID-19 lockdown commenced at the end of March.

For the month of May 2020, Kidz First ED attendances were at 898 (prior year 2,524) a 64% reduction. This is mostly due to the sudden and pronounced decrease in attendances since the COVID-19 National Alert commenced. Year to date attendances are 19,032 (prior year 23,435) a 23% reduction. Paediatric Medicine discharges were 187 for May- a 62% decrease on the prior year, also impacted by the lockdown (year to date a 17% reduction).

<u>Division of Mental Health and Addictions (MH&A) - COVID19- Impact and Recovery</u>

In May, there had been a marked increase in the length of stay in Tiaho Mai during the “lockdown” period related to Covid-19. The service struggled to discharge people mainly due to anxiety about breaking a “bubble”. There was also a marked increase in referrals to Intake and Assessment following the end of lockdown, with increased referrals from both internal and external referrers. Of note the largest increase came from ED. Referrals increased across both genders, with the majority being females. The ratio of ethnicities remained much the same, and reflective of our population.

The adult community teams also experienced a significant increase in referrals requiring brief interventions. We expect this trend will continue as people begin to grapple with their new reality post-COVID19 with job losses and adjusting to a new norm with new challenges as the result of the nationwide lockdown.

Our CAMHS (Child & Adolescent Mental Health Services) service has also seen a sharp increase in referrals attributed to schools/GPs re-opening again. The service expects a sustained increase in referrals relating to a range of social-economic factors with parents becoming unemployed resulting in financial strains/stressors taking a toll on overall wellbeing and mental stamina, limited capacity to cope with post-COVID19 new norms and care and protection issues as a result of family violence and complex family dynamics.

Division of Adult Rehabilitation and Health of Older People (ARHOP)- Covid-19- Impact and Recovery

All staff have returned to work where possible, with some teams now able to work from home for some periods e.g. the Lymphedema team have now developed a new way of working included telehealth for one day a week.

Zoom daily triage for Assessment, Treatment and Rehabilitation (AT&R) will be continued with a meeting format introduced and attendance from the whole HOP (Health of Older People) team – Medical and Nursing attending daily.

Aged Residential Care Preparation for an Outbreak

A response plan has been completed by the Health of Older People Technical Advisory Group team which has now been circulated widely. A request for expressions of interest from staff to volunteer to assist in the staffing of a residential care facility, should an outbreak occur, has been actioned. This has been a good example of cross-division and regional working.

Change in visitor policy over Covid-19 was perceived to have impacted positively on patient engagement and rehabilitation culture. Further investigation is required to determine how these benefits can be sustained as the alert levels change.

Division of Central Clinical Services- COVID19 Impact and Recovery

A huge effort from managers and teams has gone in over April and May by the Pharmacy Service to successfully ensure staff safety and continuity of service throughout the Covid-19 alert levels.

Most of the Radiology waiting lists ballooned over the Covid-19 lockdown period. Once we moved to Level 2 we accelerated our bookings and are beginning a recovery plan.

There has been a significant increase in Laboratory workload due to Covid-19. Continually changing volumes and uncertainty of consumable supply also made for a challenging month, however the Laboratory have adapted well in response to the changing environment.

Middlemore Central, ED and Critical Care Complex-Covid-19 Impact and Recovery

Support of IMT

The Incident Management Team (IMT) has operated out of Meeting Room 2 during April/May 2020. The role of MMC during this period was to ensure business as usual hospital operations ran smoothly.

Critical Care Complex

During May COVID-19 lockdown Level 2 resulted in a more business as usual type occupancy. PAR (Patient at Risk) team referrals have picked up again after April's lull mainly due to an increase in the number of emergency calls and critical care discharge follow-ups.

Emergency Response

- Organisational planning and response to Covid-19 pandemic is in the process of scaling down due to the change in alert levels made by the Government. Work continues at a National and Regional level. The Northern Region Health Coordination Centre (NRHCC) will continue to monitor the response and lead the DHBs (Northland, Waitemata, Auckland and Counties Manukau).
- Quarantine and isolation facilities still have a large number of occupants. This is likely to be handed over from the MoH to the DHBs to manage.

Visitor Policy

Through the Covid-19 alert levels, CM Health has restricted visiting to hospital sites. In the current environment it is important that we know who is on our sites, that we screen visitors and that we manage the risk of any infection. We have an obligation to keep all who enter our sites safe – staff, patients, visitors and key supports. Registering and managing visitors will be an important health and safety activity as we move forward post Covid-19.

Part B - Hospital Services Report - May 2020

Key Highlights for May 2020

- Priority 1 national targets for CM Health colonoscopy and gastroscopy were achieved in May 2020.

- Total Planned Care delivery (Electives) for April was confirmed by the MOH at 103% of planned production for the month. Indicative Planned Care result for May 2020 is at 100%.

- Kidz First ED attendances for May 2020 are 898 (prior year 2,524) – a 64% reduction (much of this Covid related) and Paediatric Medicine discharges are at 187 for May- a 62% decrease on the prior year, also impacted by the lockdown (year to date a 17% reduction).

- There has been marked improvement in the level of breaches for ESPI 2 FSA access during May 2020 with a reduction of 370 cases and a smaller reduction of 60 cases for ESPI 5 Treatment.

Finance Overview- May 2020

The Provider Arm produced a $1.80M favourable result against budget for the month of May 2020, YTD $(4.06)M unfavourable to budget.

The May result was driven by major variances driven by:

- Whakaari incident of the 9th December.
- CMH response to COVID-19 pandemic.
- Unbudgeted additional capacity in Ward 17, Ward 34 and Ophthalmology.
- Unrealised target savings.
- Vacancies.

Additional pressure on services due to the Whakaari incident and COVID-19 has severely impacted our ability to carry out our planned elective surgery programme, delivering -11.0% below contract for the month, YTD -6.9% behind contract. Additional outsourced services were deployed in May to reduce the under delivery to contract of elective procedures.

The COVID-19 Pandemic Level-4 Lockdown since 25 March has had a significant impact on April and May volumes. Overall WIES volumes were down -21.9% (YTD -6.3%) on contract, occupancy rates saw a marked decline mainly in Surgical Services (~50%) and Medicine (~40%).

ED presentations for the month of May were -27.4% below last year's volume (10,418 in 2019, 7,561 in 2020). Average daily presentations are 27% lower than previous year (336 in 2019, 244 in 2020) reflecting the impact of COVID-19.

Hospital services are now transitioning back to Pre-Covid business as usual now that NZ has moved from Level 4 Lockdown to Level 2.

Key Updates requested by the Hospital Advisory Committee
(*The Committee has requested regular update on the following items each month).*

National Bowel Screening Programme (NBSP)
Since the commencement of the programme, there has been 1,526 positive FIT tests; 1,142 colonoscopies completed, out of which 1,018 of those patients had biopsies. 104 cancers have been diagnosed since the programme commenced in the DHB in July 2018.

During COVID-19 Alert Level 4, the Ministry put a hold on any new participants being invited into the programme however, around 2,000 kits were sent out during lockdown. Participants were asked to not return kits till lockdown was lifted. The programme started again on 8th of June 2020. The average number of invitations to participants for each DHB will remain as prior to COVID-19. For CM Health this means that our first screening round will take longer (27 months) to complete. As at the end of May, the total participation in the programme was at 53.8%, broken down further to Maaori 53%, Pacific 40.9%, Asian 50.9%, and other 60.4%.

Our Community Co-ordinators have started our outreach process and we are telephoning priority participants who have not returned a kit. The regional co-ordination group is commencing a media campaign at the end of June to inform GPs and potential participants of the restart of the NBSP.

Further advice was sought from the MoH regarding the commencement of screening Maaori and Pacific people from 50 years of age. We have been advised that if this change is agreed by Government, it is unlikely to go ahead until all DHBs have implemented the programme which will at the end of 2021.

Proportion of 8 month olds who have their primary course of immunisation on time (Target 95%)
This target measures the proportion of 8 month olds who have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.

NATIONAL HEALTH TARGETS- Q3	Total	Maaori	Pacific	
Proportion of 8 month olds who have their primary course of immunisation (six weeks, three months and five months immunisation events) on time (Target 95%)	93%	86%	94%	Preliminary result for quarterly target. Maaori coverage has increased by 2% from the previous quarter whilst Pacific coverage at eight months has decreased by 1% this quarter.

Currently there is a small immunisation team to serve a large population and geographical area. There is a need for a greater outreach and an engagement team. Better systems linkages, for example collaboration with WINZ would assist. Incentivising using petrol/nappy/grocery vouchers is working currently but does not change attitudes to immunisation.

Goals for 20-21 include:
- Outreach Immunisation Service (OIS) will continue to work with the NIR (National Immunisation Register) team to prioritise Maaori and Pacific babies
- Continuing the collaboration with Well Child providers to support family engaging with OIS
- Awaiting the evaluation of incentives programme to inform decisions to continue 8 month, 24month and 4 year incentives programme
- Working to establish a formal relationship with Department of Social Development (Immigration services and Winz) to access current addresses and ascertain whether families are overseas
- Prioritising data cleansing activity within the NIR team

Ophthalmology Overdue Follow up Appointments
Routine follow up clinics only recommenced in mid-May and at reduced capacity to enable distancing. The focus on FSAs and the reduced capacity of follow up clinics has meant the number of overdue follow ups has increased by 1777 patients compared to pre-COVID 19 lockdown. Saturday clinics every fortnight have recommenced with up to 10 clinics operating (200 to 220 patients). Additional evening clinics are scheduled twice a week with up to 4 clinics in each evening. The staging of the fortnightly weekend and regular evening clinics has been configured for the long term.

During May, the clinic operated at 80% capacity to facilitate physical distancing but still managed to see 3000 patients. This is assisted by a reduction in the DNA rate from an average of 10% to 6% which can be attributed to the establishment of customised clinics and phone calls from the ophthalmology admin team to ensure patients were able to attend.

Celebrating Our People

The first round of Local Hero awards were presented by CEO Margie Apa in Ko Awatea during May 2020. In her presentation speech, Margie reflected on how humbled she was by the number of nominations that came through. She also talked about how so often we think of heroes as other people, like people in the media for example. But to her, there are so many heroes within our organisation and the name 'Local Heroes' was chosen to reflect that. Normally, there would be just one overall Local Hero award winner but, in light of the challenges of COVID-19, and to celebrate the successful inaugural launch; it was decided there would be additional winners identified as Local Heroes. The Local Hero award winners were Jo Friend, Charge Nurse Manager MSC 1, Lucy Ackroyd, Physiotherapist Community Stroke Team, Joanne Paton, Rehabilitation Assistant and the Kidz First Community Teams.

During May we celebrated International Nurses' Day across the organisation in a variety of different ways. We are very proud of our nurses and the dedication and commitment they demonstrate in some very challenging times.

International Midwives' Day was also celebrated across Women's Health and the community in May 2020. We acknowledge all our midwives for their hard work and dedication to the women and whanau in our community. 2020 is also the International Year of the Midwife so our celebrations will continue throughout this year.

The Division of Mental Health and Addictions (MH&A) are very pleased to welcome Melodie Barr in her new role as Clinical Director Allied Health Scientific and Technical (CDAHST). We look forward to working with Melodie as together we develop and incorporate this role within our leadership team.

We are also very pleased for Joanna Dickens to be authorised as a Nurse Practitioner (NP) in Mental Health and Addiction with a focus on Primary Mental Health. Jo is Counties first NP within the MH & A Division with a focus on Adult and Primary Mental Health service delivery.

Divisional Highlights for May 2020

Women's Health

There were 569 births at MMH and 44 at the community units making a total of 613 births for March 2020. This is down 7% compared to March 2019; year to date births are now 2% lower than the prior period.

Recruitment of midwifery staff continues through internal and external web-based advertising, agencies and universities. Stage Three of the 2018 Workforce and Bed Capacity Plan will be implemented by end June 2020, with 6 further transitional beds on level 4, and 5 gynaecology beds opening on Ward 21 with the potential to flex to 10 further gynaecology beds once full midwifery/nursing recruitment is achieved. Experienced registered nurses on Maternity South/Ward 21 have undertaken rotation to up skilled in gynaecology care ready for opening additional beds on Ward 21.

Kidz First

For May 2020, Kidz First ED attendances were at 898 (prior year 2,524) – a 64% reduction – mostly due to the sudden and pronounced decrease in attendances since COVID-19 National Alert commenced. Year to date attendances are 19,032 (prior year 23,435) – a 23% reduction. Paediatric Medicine discharges were 187 for May - a 62% decrease on the prior year, also impacted by the lockdown (year to date a 17% reduction).

Neonatal volumes

As noted earlier, after many months of high occupancy in the Neonatal Unit (with March still at 104%), the volumes in May decreased again with an average of 65% occupancy, i.e. an average of 22 cots for the whole month against the 34 resourced cots. For year to date May 2020, the total Neonatal WIES (i.e. Neonatal Unit and those babies graduating from Neonatal Unit to Postnatal ward and then discharged) is at 99% of the contract level (cf 104% of the prior year). As of 11 June we are back to occupancy of 33 babies.

Central Clinical Services (CCS)

Pharmacy

Scoping and roll-out plans for Medchart into Gynaecology are underway. The Medication Safety Service is actively engaging with stakeholders and discussions are also underway with Women's Health and Paediatrics. Implementation in these areas will complete the organisation wide roll out.

Radiology

Most of the Radiology waiting lists ballooned over the Covid-19 lockdown period. Once we moved to Level 2 we accelerated our bookings. Major inroads have been made into both CT and Ultrasound waitlists. Waitlists across all modalities have reduced as referrals continue to be lower than normal levels and additional evening and weekend sessions have been added to clear the backlog. Significant numbers of staff have volunteered to work additional sessions to support clearing the waitlists. Outsourcing for MRI and Ultrasound will resume in June to support waitlist reduction.

Laboratory Services

Normal hospital lab referral volumes have resumed and additional funding has been approved to resource long-term COVID-19 testing.

Mental Health and Addictions Service

A 'refresh' of the programme of work in relation to integration is currently underway. The development of an integrated model of care is a complex piece of work, spanning a number of years, and it is vital to continually take a fresh look at the focus and priorities, ensuring that momentum is being maintained, and that broader developments/external issues are being taken into consideration and reflected in the direction of the work. This is particularly relevant with the MoH's 'Increasing Access and Choice' initiatives in response to *He Ara Oranga* and taking into consideration the demands and requirements post Covid-19. Discussions are focussed on where the system needs to be in two years' time; the deliverables that need to be achieved over the next year; the equity considerations of those deliverables; and how we flex as the 'Increasing Access and Choice' capacity starts to come on line over the next 12-15 months.

New Acute MH Unit Progress Update - Good progress is being made on Stage 2 with the construction team working hard to deliver defect free. Progress toward migration is occurring but no firm date has been agreed for the opening as yet. Many lessons have been learnt from Stage 1 and the new team is ensuring these learnings have been carried over to Stage 2 to improve the facility.

Middlemore Central and Emergency Care

Visitors' Policy

During mid-May 2020 Middlemore Central accepted responsibility to implement the new visitors' policy. In the interest of staff and patient safety, ensuring patients are well rested and patients receive a high quality of service, the new visitors' policy will stipulate visiting guidelines including times and the number of visitors allowed at any one time. A pool of staff is being recruited and building and infrastructure arrangements are being implemented. Security and Visitor Screeners will be posted at each entrance to greet, register and monitor visitors into the hospital.

Work on refining the Winter Plan has continued over the Alert Level 3 and 2. We have seen a remarkable decrease in the volume of patients coming into the hospital over this period.

Medicine & Integrated Care

Faster Cancer Times

FCT performance has not been achieved this month at 88%. Patients on 62 day pathway have predominately managed to remain on track throughout Covid-19 service changes however those on the 31 day pathway have been impacted with rescheduling of theatres, diagnostic and clinic cancellations. Previously reported low referrals into service seem to be increasing, particularly in respiratory and gynaecology with higher volumes in the past 2 weeks. Gynaecology and ORL cancer teams and are reviewing current resourcing and identifying through business plans where additional resourcing is required to meet demand.

Occupancy and Average Length of Stay

Bed occupancy and home-ward placement versus outlier accommodation returned to near normal levels in the post COVID19 stand-down period. Across all acute Medicine bed occupancy averaged 87% while General Medicine occupancy averaged 93% for the month of May.

Local Delivery Oncology (LDO)

All patients that were attending ADHB as part of Covid-19 planning have now returned and LDO is fully restored in the Galbraith Infusion Centre. Some outpatient appointments continue to be provided through telehealth, mainly telephone and this may continue to be the preferred appointment method for some patients. The clinic rooms in Galbraith Infusion Centre have been set up with multimedia monitors to facilitate this.

Respiratory are currently in discussions to take over management of Cardiology's outpatient Spirometry workload via the allocation of the vacant technician FTE (from Cardiology) to Respiratory, to enable recruitment of a Respiratory Physiologist. Respiratory is also currently developing a proposal to use a vacant Community Health Worker FTE to recruit a Sleep Physiologist. This will be highly beneficial for the Respiratory Service, allowing the implementation of a number of positive service-delivery changes.

Psychological Medicine has developed a survey to assess clinicians and patients perceptions of virtual appointments with the aim of determining if (post-COVID) virtual delivery of healthcare is a viable long-term option to include in our model of care. Results will be shared once received.

Surgery, Anaesthesia and Perioperative Services (SAPS)

The planned care levels of activity have returned to usual pre-COVID-19 numbers at MSC and about 85% at MMH, this was above the predicted levels of productivity at the end of March 2020. The outsourcing in May 2020 is estimated to be at 60-70% of the contracted volumes and is expected to reach normal levels in June 2020.

The SAPS Division began their Theatre Improvement Project on the 29 May 2020 with a second Solutions Based Workshop on the 8 June 2020. There was excellent engagement and a high representation from the SMOs. There is a series of Workshops / Focus Groups planned with the final workshop facilitating a prioritisation of agreed actions and an implementation plan by the team.

The team has continued to engage in the MHP Expansion DBC group and will be reinstating the Theatre and CSSD projects in the coming two weeks.

Adult Rehabilitation and Health of Older People (ARHOP)

All staff have returned to work, with some teams having the ability to work from home for some periods for example the Lymphedema team have now developed a new telehealth process for one day a week.

Zoom AT&R daily triage will be continued with a meeting format introduced and attendance from the whole HOP team – Medical and Nursing attending daily.

Occupied Bed Days were 944 bed days below target for the month and 5,574 bed days below target year-to-date. The largest decrease in demand has been in inpatient rehabilitation for older people, mainly due to decreased occupancy due to Covid-19.

National Health Targets

	Result **April (actual)**	**Result** **May (indicative)**
SS07 Measure 1 **Total Planned Care Interventions**	Achieved ✓ 103.0% Variance from Plan 760	Achieved ✓ 100.0%
SS07 Measure 2 **Elective Service Patient Flow Indicators (ESPI)** ESPI 2 (FSA) and ESPI 5 (Treatment) wait time targets	FSA: 2505 breaches Treatment: 485 breaches	FSA: 2132 breaches Treatment: 424 breaches
SS07 Measure 4 **Ophthalmology Follow-up Waiting Times**	Overdue: 5672 Overdue 50%: 2345 Overdue 100%: 1155	Overdue: 5968 Overdue 50%: 3005 Overdue 100%: 1706

Note: SI4 Standardised Intervention Rates are no longer a planned care KPI for 19/20

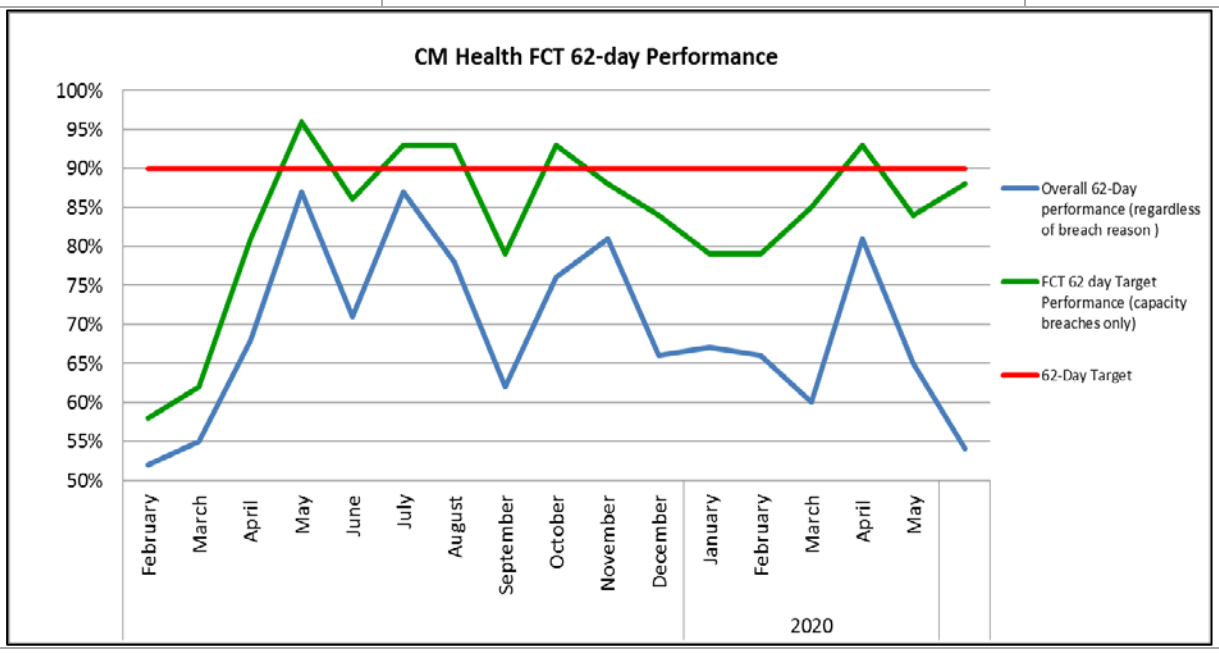
Commentary

CM Health has come through the COVID-19 period with the April results continuing to demonstrate an overall positive variance in total planned care production YTD of 760 interventions being 103.0% of planned production. Caseweight delivery remains over the 95.0% threshold as do minor procedures. If 70% of total planned production is delivered for May 2020 the results are expected to remain positive at 100% of planned YTD delivery levels.

There has been marked improvement in the level of breaches for ESPI 2 FSA access during May 2020 with a reduction of 370 cases and a smaller 60 cases for ESPI 5 Treatment.

Cancer Treatment

	Description	**May**
Faster Cancer Treatment	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	**Achieved** **88%**



Commentary

May Performance: **FCT 88% (26/31 patients)**

Overall performance is at 64% (14/16 patients). Of the 2 breaches:

- 1 lower GI, 1 gynae
- Both breached by less than 20 days
- 1 patient took 46 days from referral to ADHB to receiving chemotherapy

Much lower volumes recorded this month as most delays were due to patient choice and therefore excluded from the target. Referral volumes are increasing as we have moved through the COVID alert levels. There continues to be a number of instances where patients have chosen to delay appointments until after the lockdown has ended. Cancer Nurse Coordinators are working with patients to support them to come to appointments and reengage with the services.

Cardiology Angiography

Description	**May**
Cardiology - 95% elective angiograms within 90 days	Not Achieved **X 85%**
Commentary: Target not achieved due to one patient being on the list for an extended period of time for numerous clinical reasons.	

Colonoscopy

	Description	**May**
Colonoscopy Targets	• 90% urgent (P1) colonoscopies done within 14 days • 70% non-urgent (P2) colonoscopies done within 42 days • 70% of Surveillance colonoscopies done with 84 day	**100%** **61%** **99%**

Gastroscopy

	Description	**May**
Gastroscopy Targets (CM Health Targets)	• 85% urgent (P1) gastroscopies done within 14 days • 70% non-urgent (P2) gastroscopies done within 42 days • 70% of Surveillance gastroscopies done with 84 days	**100%** **34%** **100%**

Commentary

MoH and CM Health targets were achieved for P1 and surveillance colonoscopies and P1 and surveillance gastroscopies for May 2020. Targets for P2 colonoscopies and gastroscopies (within 42 days were not met), although we are seeing an improving trend with P2 colonoscopies (and this is expected to continue). This is due to the national lockdown response to COVID, which resulted in contracted outsourcing providers closing. Furthermore, in-house gastroscopy production was scaled back to only acute and P1s, due to the nature of these aerosol generating procedures and the associated infection risks in the midst of COVID-19. This has left a significant backlog, with the gastroscopy waiting lists at approximately 609. We are anticipating 2-3 months before we are able to attain our P2 gastroscopy targets again, and this will rely on increased production by means of weekend lists and the conversion of some in-house colonoscopy slots to gastroscopy slots.

Diagnostic Access

Radiology

We continue to report on what were the National Health Targets- Diagnostic Access Targets. As requested we have added in the percentage of Maaori and Pacific people who were seen within 6 weeks. The statistics for this month (May) are shown below.

	March	April	May	Maaori	Pacific
% MRI scans completed within 6 weeks from acceptance of referral (average weekly)	54%	43.3%	41.5%	46%	41%
% CT scans completed within 6 weeks from acceptance of referral (average weekly)	65%	59%	51%	56%	50%

MRI

Commentary

- Acute demand increased by 47% in May. This was as a result of coming out of Level 4 lockdown and our increased booking activity. GP/OP demand increased by 70%.
- Alternate weekend sessions that were stopped with the Covid-19 lockdown have re-commenced.
- We continue to outsource 15 cases per week.
- Staff adequate. Second grader in place and doing well.
- Improvement project still running. New production planning tool to be formalised. Booking issues have been sorted out.

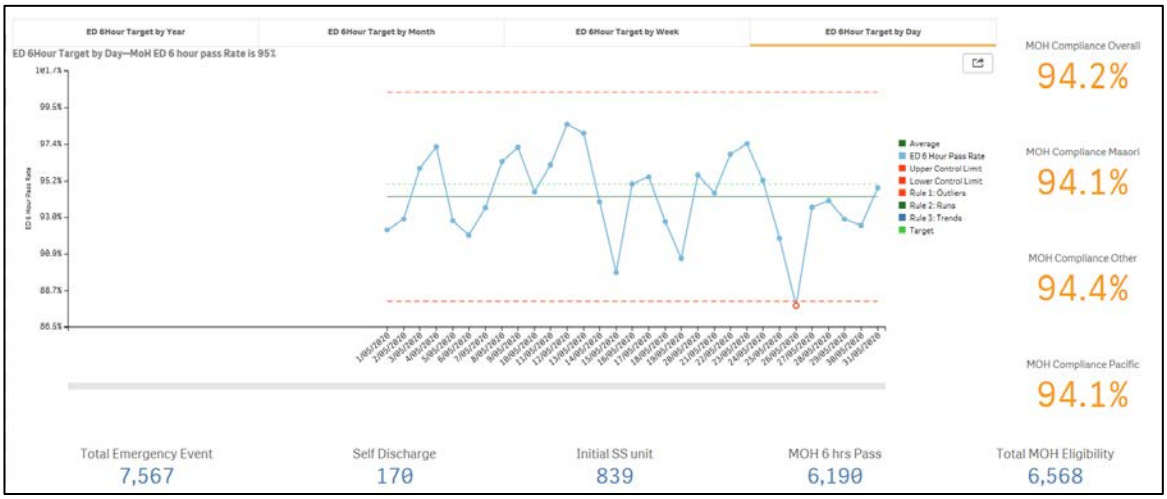
CT

Commentary

- Acute demand increased in May by 34% and GP/OP demand by 42%. This was a result of coming out of Level 4 lockdown and our increased booking activity.
- Training is going very well, a further new trainee commences at the beginning of June.

Shorter Stays in the Emergency Department

The 6 hour target was met thirteen times in May 2020, with a 0.4% improvement in overall performance compared to April 2020. There was a significant increase (27%) in ED presentations for May compared to April (1,598 more presentations), mainly related to easing of national responses to COVID-19. The chart below shows ED performance over the past 18 months, with significant improvement since quarter 1, trending upwards towards the target.



ED 6 hour target	95% of patients will be admitted, discharged, or transferred from an emergency department within six hours	**May** Not Achieved **✖ 94.2%**

Hospital Services Directorate – Challenges reported to HAC in July 2020 (March Activity). This table provides a snapshot of current challenges - ***For more detail, see individual services reports attached.***				
Division	**Challenges**	**Reported**	**Update July 2020 (May activity)**	**Mitigation Strategies**
Hospital Directorate	Acute Demand –Beds and TBS	Jan 16	Acute bed availability can be inadequate in times of peak demand. Patient volumes, surges and times taken to be seen mean we have been unable to meet the ED Waiting Time target.	By the end of May 2020, ED presentations had returned to pre-Covid levels. Our Winter Plan in now in action.
	Outpatient Demand	Jan 18	Increased referral inflow for outpatient care is challenging many services. Patient Flow- Every Hour Counts Project is addressing this beginning with the establishment of a Manukau site planning group.	Projects are returning to previous levels of activity as the organisation retuned to Business as Usual work.
	Theatre Access	Dec 2017	Shortage of Anaesthetists has impacted upon our ability to increase theatre access to run all theatres.	Three new anaesthetists have been employed to start imminently. Note that overseas recruitment maybe impacted by Covid 19.
Division	**Challenges**	**Reported**	**Update July 2020 (May activity)**	**Mitigation Strategies**
Kidz First	Neonatal Unit capacity	Apl 16	The volumes in May decreased again with an average of 65% occupancy (an average of 22 cots against the 34 resourced cots).	An audit is being undertaking about the reduction in admissions and acuity in the neonatal unit since COVID-19 lockdown commenced at the end of March. June sees the unit back to full capacity.
	Planned Appointments	May 19	Delays in allocating planned follow up appointments is an ongoing concern.	Dedicated SMO resources have to work through the Planned Expired Appointments list resulting in the Planned Expired Appointments decreasing further by 58 to 628 in May (April was 686).
Division	**Challenges**	**Reported**	**Update July 2020 (May activity)**	**Mitigation Strategies**
Women's Health	Caesarean Rate	Jan 17	CS rate for May at its highest to date at 32.8%. YTD CS rate is 29.8% (prior year 29.0%) May IOL rate up to a high of 34%. YTD Induction of Labour rate now 34% for May (average 19/20 year was 28%).	Visit in May 20 planned from MCDHB experts to explore use of Misoprostol for IOL Continue to monitor- Now delayed.
	Midwifery workforce	Jan 17	• Midwifery vacancies for May 36.9. 19 employed graduate midwives started end April 2020.	The large intake of new graduate midwives has started. Continuing to try to recruit registered nurses alongside midwives to enable opening of further beds at Middlemore Hospital.
	MCIS	Apl 17	• Roll out of Maternity Early Warning System completed. • Planning underway for change management in 2020 to Badgernet Global Platform. Project commencement planned for April 20.	Vendor workshops on hold due to COVID-19 pandemic. Potential to restart Global MCIS in later in the year for April 2021 roll out.
	Gynaecology	Apl 17	Due to the on-going reduced theatre capacity issues we have needed to decrease FSA volumes with more women now being placed on the GP residual list (P3 patients).	On-going work in this area to ensure all opportunities for surgery are used including outsourcing, wet leasing, Saturday lists, Acute Arranged planning.

Division	Challenges	Reported	Update July 2020 (May activity)	Mitigation Strategies
Medicine and Integrated Care	Bronchoscopy	Oct 18	There is urgent and escalating need for more access to GA lists for Bronchoscopy. The current waiting list is at 25 patients (and this is leading to delays to diagnosis and treatment, increasing clinical risk for acutely unwell patients and impacting on those patients on the FCT pathway.	COVID-19 has also caused delays to procedure. The service is currently working with the Theatre coordinator to try and source an additional GA list every second month and endoscopy nurses to support this.
	Increased numbers patients requiring In-Centre Dialysis		The Renal Service has completed the change of self-care Satellite (MSC) patients with Rito 2 (MMH) dependent patients and associated staff. This was done primarily to create more in-centre capacity at the Satellite unit, but it also enables the lower dependency/self-care patients to co-locate with the home therapies area on the Western Campus by being dialysed in Rito 2.	Phase 3; the final phase of the approved business case for more staff (to increase capacity), will enable more shifts. This will be brought about by supplying an additional 7.4 FTE for Rito, enabling an additional 27 patients to be dialysed. Home Dialysis is looking at additional capacity on the Western Campus. A feasibility investigation is underway.
	Local Delivery Medical Oncology	May 19	The regional Cancer Services Group (NRICS) has approved in principle the next stage for local delivery of medical oncology. This is now going through a series of groups regionally and locally for further discussion and approval. If approved it will mean that CMH patients with breast cancer will receive all of their medical oncology treatment at Middlemore and lessen the burden of travel for treatment at the Auckland Regional Cancer Services at ADHB.	A paper has been produced for submission to the Funder Forum/ ELT seeking approval for extending local delivery to provide a comprehensive medical oncology service to patients with breast cancer. The Region is undertaking modelling/ production planning to identify opportunities to further expand the local delivery model.
	Medical Staffing	Nov 2019	SMO recruitment remains ongoing with several contracts confirmed however new appointments are not planned to come on stream until later in the year. As a result significant FTE vacancies remain in the current period.	Successful recruitment to date will enable General Medicine to stand up a 13th medical team from the beginning of July. The Koromiko team will support home based medical cover in Ward 17 increasing the number of wards with HB teams from 4 to 5.
	Cardiology Demand	Nov 2019	Demand continues to outstrip the capacity of the cardiology service to deliver within acceptable clinical timeframes across the following areas:	There has been some improvement in our ability to meet demand, particularly in the areas of cardiac intervention. Long waiting times still exist in the areas of echos, holter/event, cardiac MRI/ CT and elective out-patient consultations (FSA). A recovery plan is created to reach our cardiology targets for the upcoming months.

Division	Challenges	Reported	Update July 2020 (May activity)	Mitigation Strategies
Central Clinical Services	Pharmacy	March 2020	Increasing Medicine Shortages/Outages due to COVID-19: Medicines supply chains continue to be under pressure globally. An interdisciplinary team has been meeting regularly to discuss shortages of critical medicines and implement strategies to minimise wastage.	Actively monitoring the situation and liaising with areas that may experience shortages regarding potential alternatives. Continue to liaise closely with regional pharmacy colleagues and medicines wholesaler and communicate supply issues with PHARMAC. Report created to increase visibility of stock levels of critical drugs across the organisation and estimate usage.
	General X-ray/MRT FTE	Sep16	The general x-ray service waiting list normally increases over winter due to MRT vacancies and additional seasonal volumes.	This year, due to Covid-19 issues, we have had no resignations from staff heading overseas due to travel restrictions and lockdown. The waitlist is expected to be back within clinical target levels by the end of June.
	MRT FTE	Apr 2017	March vacancy rate at 3.29FTE (see above). Long-term planning for staff retention and recruitment will continue despite the positive short-term situation the long-term risks remain.	Long term recruitment and retention planning.
Division	**Challenges**	**Reported**	**Update July 2020 (May activity)**	**Mitigation Strategies**
Mental Health	CAMHS Growth in Service Demand		Te Puawaitanga, the Child & Adolescent Mental health team located at Springs Road, East Tamaki are struggling to meet service demands due to continued escalating clinical demands and decreased capacity. This has impacted service delivery, with lengthy delays occurring for young people waiting for treatment and a reduction in the number of therapeutic groups offered. The areas which continue to be difficult to recruit to and remain a significant concern are nursing and psychiatry.	Work continues with the Recruitment Department to strategize various approaches to assist with attracting suitable candidates. One of these strategies has been to positively promote the profile of current team members on CMH Facebook page and across other social media platforms.
	Workforce Recruitment		Across the CM Health MH&A division there continues to be areas with significant workforce recruitment and retention issues. There are currently 36 RN and EN vacancies across acute MH services. This has been compounded by the aging workforce and the number of very experienced RNs are who retiring with further retirements over the next 5 years. The vacancies mean it is a challenge to facilitate release for staff with high annual leave balances.	Despite ongoing repeated advertising and extensive recruitment efforts, including exploring recruitment agencies and overseas candidates, the service has not been able to make any significant impact on reducing the number of vacancies. Adding to the recruitment issues has been COVID19 with 11 nurses who had been contracted from overseas not being able to enter the country. Three of these nurses have since pulled their contracts. A meeting is scheduled with the GM, CND, Recruitment and Service Manager to canvass the issues and develop a workforce plan that may need to be innovative and "outside of the box".

Division	Challenges	Reported	Update July 2020 (May activity)	Mitigation Strategies
Surgery, Anaesthesia Perioperative Services	Demand for Ophthalmology Services	Jul16	We continue to have extremely high demand for FSA and follow ups. Overdue follow ups slots were hit hard during Covid and have increased by 1777. The total number of procedures completed in May of 320 is a new high for the service.	Four Saturday surgical lists are planned for June to address cataract surgery deferred due to COVID 19. Several ophthalmologists have expressed an interest in regular weekend surgical lists if the organisation is able to support it.
	Anaesthetists' shortage	Oct 17	Electronic rostering is running side by side with existing Excel rostering. The eRoster is now accessible remotely on mobiles in 2 formats – by week/theatre/specialty/surgeon and by week/anaesthetist/theatre/specialty/surgeon	Our SMO FTE will remain higher than the pre-COVID-19 numbers and it is noted that we have lost no sessions due to a shortfall of Anaesthetic staff for the first five months of 2020. Electronic Rostering has continued to deliver what was planned within Anaesthesia. No interviews for new staff were conducted in May 2020. There are two interviews planned for June 2020. Although it is yet to be official it appears as though there will be 1-2 retirements within the next 12 months.
	Elective performance is under threat	Oct 17	The ESPI 2 and 5 targets have been impacted by COVID-19 and the modelling to full recovery of ESPI will have to be fully analysed as we drop through the Alert Levels but it is estimated to take 12 to 18 months to recover volumes ad ESPI compliance.	The FSA volumes breaching the 120-day requirement have however shown considerable improvement in May 2020 and dropped by 370 over the month with improvements in many services. There is concern though at the continued deterioration in the Orthopaedic service position against the run of most other services.
Division	**Challenges**	**Reported**	**Update July 2020 (May activity)**	**Mitigation Strategies**
ARHOP	Safe Patient Handling	10/10/2019	Hospital wide safe patient handling and mobility training	Will update post Covid

Hospital Services Project Portfolio Report

Monthly Report - June 2020

Hospital Services Project Portfolio Overview

The workplan across Hospital Services consists of a number of service-led transformation and improvement initiatives aligned with our Healthy Together strategy.

Work has focussed on continuing with projects already underway from the previous year based on established portfolios to drive our strategic goals around improving services for patients and health equity, with a particular focus on Improving Acute Flow, Ambulatory Flow, Choosing Wisely ('Every Hour Counts') and maintaining financial sustainability ('Every Dollar Counts').

Strategic capital and change projects are delivered in collaboration with Hospital Services and the Facilities Team and Healthy Together Technology (ICT).

Each of these initiatives has identified benefits (either financial benefits, non-financial benefits, or both) which are being tracked, and a standardised process whereby all active Hospital Services initiatives are reported on each month by the respective managers is in place.

Covid 19 Response

In addition to the many tactical initiatives in response to the Covid 19 pandemic, via the Incident Management Team, several specific projects had been undertaken and tracked. These are all in the 'Close Out' phase now as the work transitions to business as usual operation.

Delivery Progress

Across Hospital Services Divisions and related programmes, there are currently 70 total projects being monitored, which range from localised service improvements through to major transformational activities.

There are six currently in initiation, with the majority of projects moving forward with planning and execution. It is likely that once the organisational strategy refresh is completed, a number of new projects will be initiated in order to deliver on the agreed strategic goals.

In total 31 projects are now in Execution (44% of total), demonstrating the bulk of the work plan is progressing with delivery, with a number of projects this period fully transitioned to BAU.

A number of projects have been put On Hold within this period, largely due to Covid 19 reprioritisation, although several projects have recommenced this month as workloads transition back towards normal.

Every Dollar Counts Portfolio

As part of ensuring financial sustainability within CM Health, a financial affordability plan has been developed across the organisation to ensure that benefits are delivered and maintained across a number of initiatives.

Delivery and tracking of benefits across these areas is now underway, with plans in place for each Division which are reported on each month.

Every Hour Counts Portfolio

The Every Hour Counts portfolio aim is to improve patient flow to optimise the quality of care, the experience of care, and the experience of caring whilst improving the efficiency of the system, and optimising access to community services. Projects contributing to this portfolio sit across a number of divisions, working towards common goals.
Achieving the desired outcomes of the collective patient flow initiatives will support CM Health to deliver a more effective, timely, end to end, patient-focused system of care. This portfolio also aims to optimise and value the time of staff, by reducing the steps in patient care to get the best out of the highly skilled workforce we have.

Figure 1: Breakdown of project delivery by Division, June '20

Lead Division:	1. Initiation	2. Planning	3. Execution	4. Close Out	5. Operations	On Hold	Grand Total
ARHOP	1		2			1	4
Central Clinical Services			3				3
ED & Middlemore Central				3			3
Healthy Together Technology		2	5		1		8
Kidz First	1	9	9				19
Medicine	2					2	4
Mental Health & Addiction	1	5	1		1	1	9
Surgical		2	9				11
Women's Health		2	2			2	6
Covid 19 Response	1	1				1	3
Grand Total	6	21	31	3	2	7	70

Figure 2: Project Portfolio Progression – Last Six Reports

	Number of initiatives in phase:						
Delivery Phase	Aug '19	Sep '19	Nov '19	Jan '20	May '20	Jun '20	Shift since last report
1. Initiation	5	11	12	3	5	6	1
2. Planning	9	6	6	10	17	21	4
3. Execution	45	38	36	36	33	31	-2
4. Close Out	4	1	1	0	3	3	0
5. Operations / BAU	5	11	9	13		2	2
On Hold	3	4	6	6	10	7	-3
	71	71	70	68	68	70	2

Figure 3: Overall progress of Hospital Services projects through delivery lifecycle

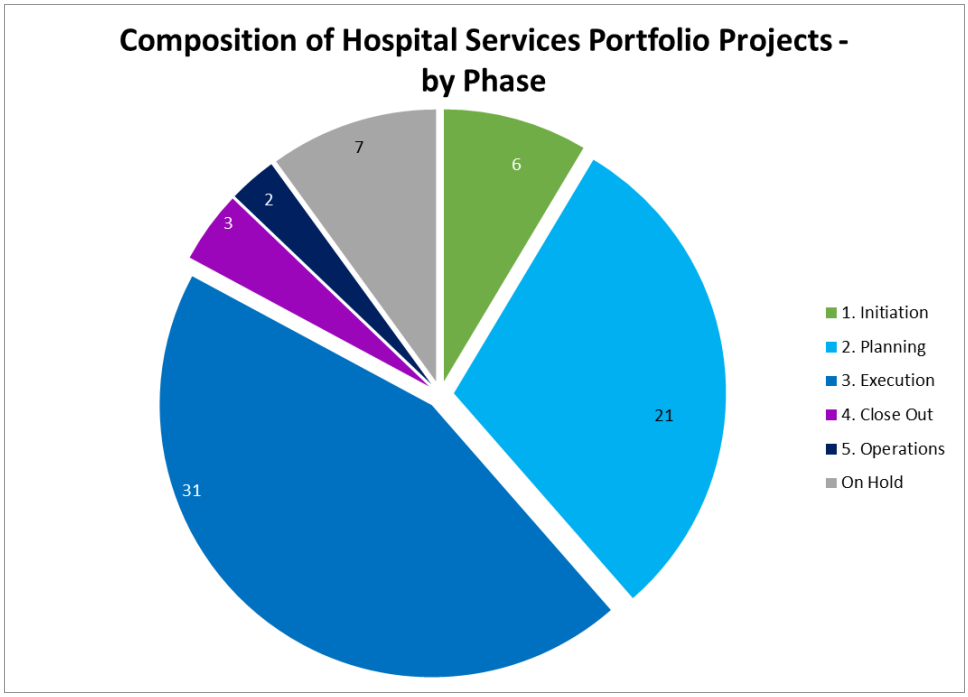
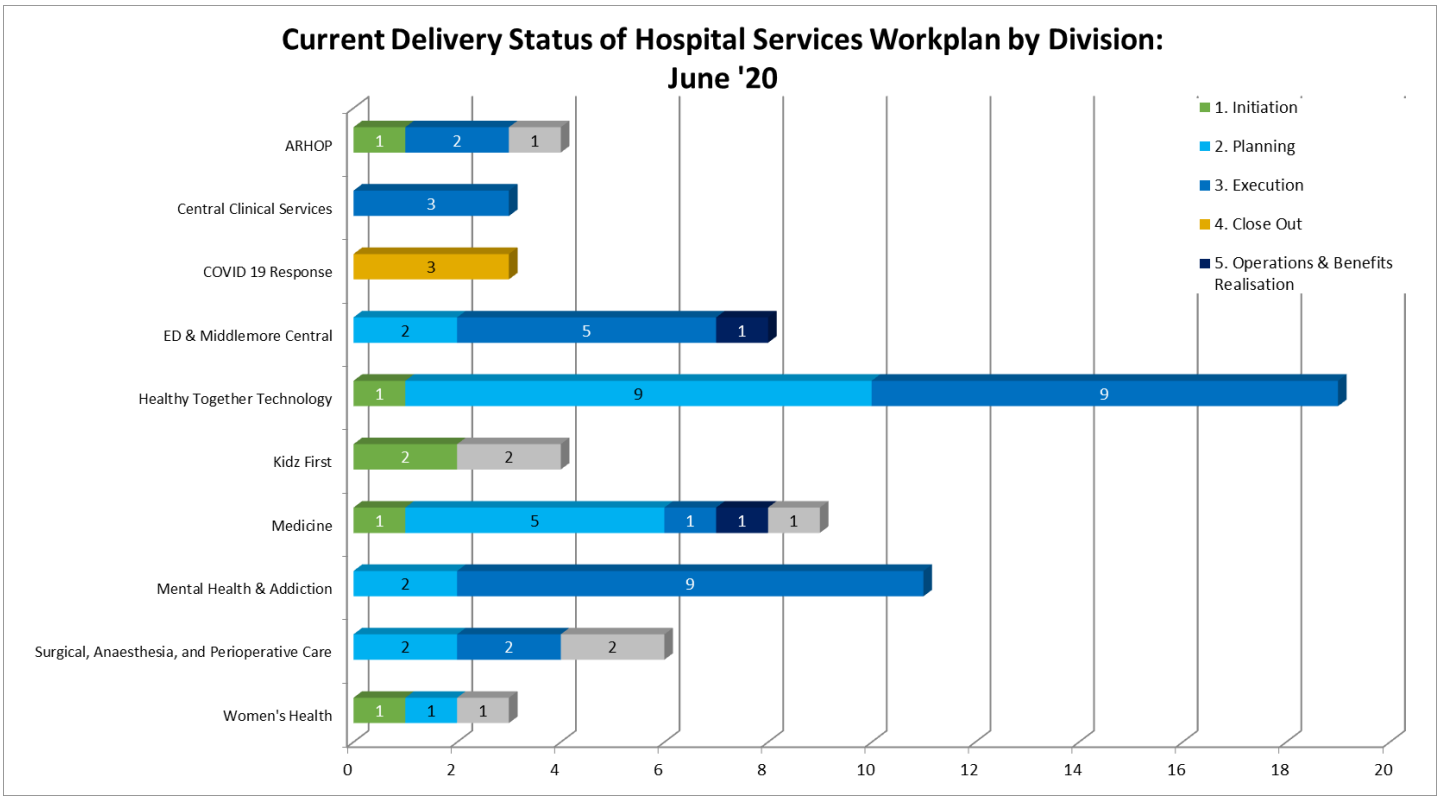


Figure 4: Number of initiatives within each division, and the current state of these projects



Portfolio Benefits Realisation –FY19/20 Performance

The full FY19/20 financial benefit target for CM Health is **$30.00M** across all areas of the organisation.

In total, **$9.76M** of this target is attributable to Hospital Services initiatives (excluding cross-directorate and whole of system benefits)

Currently, the YTD actuals to the end of March indicate actual savings of **$16.92M** against a target of **$24.25M,** which represents **70%** of the target met to date.

Monthly tracking and reporting is in place across all of these initiatives, with regular reporting to the Every Dollar Counts Operations Group, as well as ELT and Audit, Risk and Finance in place identifying any issues around benefit realisation, and how risks and issues are being mitigated.

Figure 5: Divisional Benefits Delivery for FY19/20 / Apr '20 Period – All Figures in $K

	Full Savings Plan FY19/20			YTD SAVINGS PERFORMANCE			
Division / Delivery Type / Benefit Name	Full FY Baseline Target	Full FY Current Forecast	Full Year Variance	YTD Target	YTD Actual	YTD Variance	YTD % of Target
ARHOP	740	740	0	616	326	(290)	53%
Central Clinical Services	988	988	0	779	527	(252)	68%
Centralised	2,992	4,436	1,444	2,488	1,792	(696)	72%
ED & MMC	1,146	1,146	0	941	931	(10)	99%
Facilities & Asset Management	530	562	32	439	586	147	133%
Funder	12,000	12,000	0	8,830	6,629	(2,201)	75%
Governance Corporate	3,441	3,441	0	3,351	451	(2,900)	13%
Kidz First	750	0	(750)	625	0	(625)	0%
Ko Awatea	350	350	0	292	393	102	135%
Localities	719	719	0	599	461	(138)	77%
Medicine	1,325	1,325	0	1,104	1,078	(26)	98%
Mental Health & Addiction	2,200	2,200	0	1,833	1,833	0	100%
Provider Corporate	200	200	0	167	291	124	174%
Surgical	1,870	1,895	25	1,558	1,621	62	104%
Women's Health	750	0	(750)	625	0	(625)	0%
Grand Total	**30,000**	**30,000**	**0**	**24,247**	**16,919**	**(7,328)**	**70%**

Financial Results – CMDHB Provider Arm

Monthly Report – May 2020*

Consolidated Statement of Financial Performance CMDHB Provider	Month				Year to Date			Full Year Forecast		
	Actual $(000)	Budget $(000)	Variance $(000)	Variance Prior	Actual $(000)	Budget $(000)	Variance $(000)	Forecast $(000)	Budget $(000)	Variance $(000)
Income										
Government Revenue	84,872	80,689	4,183 F	↑	897,993	887,514	10,479 F	984,968	968,208	16,760 F
Patient/Consumer Sourced	995	1,067	(72) U	↑	12,091	11,734	356 F	13,126	12,802	324 F
Other Income	1,945	2,215	(270) U	↓	26,673	25,191	1,482 F	31,867	27,405	4,462 F
Total Income	**87,812**	**83,971**	**3,841 F**	↑	**936,756**	**924,439**	**12,317 F**	**1,029,961**	**1,008,415**	**21,547 F**
Expenditure										
Personnel	60,626	60,704	79 F	↑	652,275	652,273	(2) U	714,301	713,092	(1,210) U
Outsourced Personnel	1,794	942	(852) U	↑	20,606	10,325	(10,280) U	22,298	11,264	(11,035) U
Outsourced Clinical	2,785	2,623	(162) U	↓	29,918	28,163	(1,755) U	33,283	30,739	(2,544) U
Outsourced Other	4,074	4,222	148 F	↑	46,370	46,446	76 F	50,622	50,668	46 F
Clinical Supplies (excluding Depreciation)	11,354	10,831	(523) U	↓	120,735	113,217	(7,517) U	131,711	123,725	(7,986) U
Other Expenses	7,351	6,893	(458) U	↓	73,146	75,811	2,665 F	80,563	82,697	2,134 F
Total Operating Expenditure	**87,984**	**86,216**	**(1,768) U**	↑	**943,049**	**926,236**	**(16,813) U**	**1,032,779**	**1,012,184**	**(20,595) U**
Total Operating Surplus/(Deficit)	**(172)**	**(2,245)**	**2,073 F**	↑	**(6,293)**	**(1,797)**	**(4,496) U**	**(2,818)**	**(3,769)**	**952 F**
Depreciation	3,561	3,267	(294) U	↓	35,757	35,936	179 F	39,024	39,203	179 F
Interest	-	-	0 F	⇔	-	-	0 F	-	-	0 F
Capital Charge	2,802	2,825	23 F	⇔	30,823	31,080	257 F	33,625	33,905	281 F
Total Depreciation, Interest and Capital	**6,363**	**6,092**	**(271) U**	↓	**66,580**	**67,016**	**436 F**	**72,649**	**73,108**	**459 F**
Net Surplus/(Deficit)	**(6,535)**	**(8,338)**	**1,802 F**	↑	**(72,873)**	**(68,813)**	**(4,060) U**	**(75,466)**	**(76,877)**	**1,411 F**

Personnel Costs By Professional Group	Month				Year to Date			Full Year Forecast		
	Actual $(000)	Budget $(000)	Variance $(000)	Variance Prior	Actual $(000)	Budget $(000)	Variance $(000)	Forecast $(000)	Budget $(000)	Variance $(000)
Medical Personnel	20,187	19,967	(221) U	↑	209,545	213,363	3,819 F	230,006	233,591	3,584 F
Nursing Personnel	22,990	23,461	471 F	↑	255,855	250,308	(5,547) U	279,474	273,476	(5,998) U
Allied Health Personnel	7,979	7,842	(137) U	↑	84,989	84,954	(35) U	93,317	92,921	(396) U
Support Personnel	2,997	2,951	(47) U	↑	31,987	32,583	596 F	34,963	35,532	569 F
Management/Administration Personnel	6,471	6,483	12 F	↑	69,899	71,064	1,164 F	76,540	77,571	1,031 F
Total (before Outsourced Personnel)	**60,626**	**60,704**	**79 F**	↑	**652,275**	**652,273**	**(2) U**	**714,301**	**713,092**	**(1,210) U**
Outsourced Medical	756	486	(270) U	↑	10,127	5,315	(4,812) U	11,126	5,797	(5,329) U
Outsourced Nursing	253	81	(172) U	↓	2,190	885	(1,305) U	2,389	965	(1,423) U
Outsourced Allied Health	51	19	(32) U	↑	792	210	(581) U	894	230	(663) U
Outsourced Support	192	-	(192) U	↑	2,393	-	(2,393) U	2,399	-	(2,399) U
Outsourced Management/Admin	542	356	(186) U	↑	5,104	3,914	(1,190) U	5,491	4,270	(1,221) U
Total Outsourced Personnel	**1,794**	**942**	**(852) U**	↑	**20,606**	**10,325**	**(10,280) U**	**22,298**	**11,264**	**(11,035) U**
Total Personnel	**62,420**	**61,646**	**(773) U**	↑	**672,880**	**662,598**	**(10,282) U**	**736,600**	**724,355**	**(12,245) U**

Surplus / (Deficit) by Division	Month				Year to Date			Full Year Forecast		
	Actual $(000)	Budget $(000)	Variance $(000)	Variance Prior	Actual $(000)	Budget $(000)	Variance $(000)	Forecast $(000)	Budget $(000)	Variance $(000)
Central Clinical Services	(7,439)	(7,773)	334 F	↓	(86,813)	(87,134)	321 F	(94,852)	(95,062)	210 F
ED, MMC & CCC	(8,722)	(9,342)	620 F	↑	(100,797)	(102,076)	1,279 F	(110,103)	(111,392)	1,288 F
Emergency Response	(3,764)	0	(3,764) U	↓	(10,951)	0	(10,951) U	(10,951)	0	(10,951) U
Facilities Services	(2,372)	(2,170)	(202) U	↓	(22,944)	(23,873)	929 F	(25,915)	(26,043)	128 F
ARHOP	(3,782)	(4,037)	256 F	↑	(41,996)	(42,939)	943 F	(46,151)	(46,952)	802 F
Child Youth & Maternity	(538)	(488)	(50) U	↓	(4,679)	(5,352)	674 F	(5,136)	(5,838)	702 F
Innov Hub & Ko Awatea	(338)	(794)	456 F	↑	(6,093)	(8,474)	2,382 F	(6,825)	(9,268)	2,443 F
Primary Care	(162)	(214)	52 F	↑	(2,000)	(2,417)	417 F	(2,221)	(2,638)	417 F
Child Health Kidz First	(2,800)	(3,380)	580 F	↑	(34,062)	(35,828)	1,766 F	(37,297)	(39,188)	1,891 F
Localities	(2,582)	(2,612)	30 F	↑	(27,644)	(28,073)	428 F	(30,338)	(30,695)	356 F
Medicine	(11,369)	(11,382)	13 F	↑	(127,835)	(127,123)	(712) U	(139,623)	(138,598)	(1,025) U
Mental Health	(6,450)	(6,793)	343 F	↑	(71,924)	(72,344)	421 F	(78,439)	(79,100)	660 F
Provider Management	65,154	62,653	2,501 F	↑	690,354	689,167	1,187 F	760,678	751,757	8,922 F
Surgical & Ambulatory	(16,891)	(17,489)	598 F	↓	(179,007)	(175,838)	(3,169) U	(197,411)	(193,011)	(4,400) U
Women's Health	(4,481)	(4,515)	34 F	↑	(46,484)	(46,509)	24 F	(50,881)	(50,850)	(32) U
Net Surplus/(Deficit)	**(6,535)**	**(8,338)**	**1,802 F**	↑	**(72,873)**	**(68,813)**	**(4,060) U**	**(75,466)**	**(76,877)**	**1,412 F**

***Due to rounding, numbers presented throughout this document may not add up precisely to the totals provided.**

Contract Performance WIES	Month				Year to Date			
	Actual Volume	Contract Volume	Variance Volume	Variance %	Actual Volume	Contract Volume	Variance Volume	Variance %
M00001 - General Medicine Inpatients	1,248	1,566	(317) U	-20.3%	15,475	16,874	(1,399) U	-8.3%
S00001 - General Surgery Inpatients	685	914	(229) U	-25.0%	8,795	9,416	(621) U	-6.6%
S45001 - Orthopaedic Inpatients	468	718	(250) U	-34.8%	6,848	7,372	(524) U	-7.1%
W10001 - Maternity Inpatients	668	675	(7) U	-1.0%	7,166	7,318	(152) U	-2.1%
S60001 - Plastic & Burns - Inpatients	355	491	(136) U	-27.7%	5,413	4,992	421 F	8.4%
M05001 - Emergency Medical Services Inpatients	323	470	(147) U	-31.3%	4,026	5,098	(1,072) U	-21.0%
W06003 - Secondary Neonatal	225	366	(140) U	-38.4%	3,918	3,963	(45) U	-1.1%
M10001 - Cardiology - Inpatients	198	286	(88) U	-30.8%	2,556	3,104	(548) U	-17.7%
M55001 - Paediatric Medicine Inpatients	97	245	(148) U	-60.6%	2,270	2,656	(386) U	-14.5%
M65001 - Respiratory - Inpatients	100	163	(63) U	-38.8%	1,446	1,770	(323) U	-18.3%
S30001 - Gynaecology Inpatients	154	162	(8) U	-4.8%	1,649	1,732	(83) U	-4.8%
M25001 - Gastroenterology - Inpatients	78	101	(22) U	-22.2%	918	1,090	(172) U	-15.7%
All Others	295	339	(45) U	-13.1%	4,271	3,616	655 F	18.1%
Acute Total	**4,895**	**6,496**	**(1,601) U**	**-24.6%**	**64,753**	**69,002**	**(4,249) U**	**-6.2%**
S45001 - Orthopaedic Inpatients	518	461	57 F	12.4%	4,240	4,563	(323) U	-7.1%
S00001 - General Surgery Inpatients	336	380	(44) U	-11.5%	3,796	3,759	37 F	1.0%
S60001 - Plastic & Burns - Inpatients	176	283	(107) U	-37.8%	2,234	2,801	(566) U	-20.2%
S30001 - Gynaecology Inpatients	107	129	(22) U	-16.7%	1,320	1,278	43 F	3.4%
S25001 - ORL Inpatients	100	147	(47) U	-32.1%	1,148	1,452	(304) U	-21.0%
S40001 - Ophthalmology Inpatients	132	157	(25) U	-15.6%	1,292	1,554	(262) U	-16.9%
M10001 - Cardiology - Inpatients	42	43	(0) U	-0.5%	467	462	5 F	1.2%
S70001 - Urology - Inpatients	19	22	(3) U	-11.8%	269	219	50 F	22.9%
All Others	32	22	10 F	42.5%	432	232	200 F	86.1%
Elective Total	**1,463**	**1,643**	**(180) U**	**-11.0%**	**15,198**	**16,319**	**(1,121) U**	**-6.9%**
Total WIES	**6,358**	**8,138**	**(1,781) U**	**-21.9%**	**79,951**	**85,321**	**(5,370) U**	**-6.3%**
ED Discharges	**7,561**	**10,395**	**(2,834) U**	**-27.3%**	**98,329**	**112,138**	**(13,809) U**	**-12.3%**
Planned Care WIES	**1,873**	**2,143**	**(269) U**	**-12.6%**	**21,653**	**21,333**	**320 F**	**1.5%**
Planned Care Volumes	**1,742**	**1,965**	**(223) U**	**-11.3%**	**19,690**	**19,568**	**122 F**	**0.6%**

Prior Period Comparisons	Month				Year to Date			
	This Year	Last Year	Variance	Variance %	This Year	Last Year	Variance	Variance %
Acute WIES	4,895	6,536	(1,642) U	-25.1%	64,753	67,452	(2,700) U	-4.0%
Elective WIES	1,463	1,577	(114) U	-7.2%	15,198	15,716	(517) U	-3.3%
Acute Discharges	6,409	7,838	(1,429) U	-18.2%	77,276	81,462	(4,186) U	-5.1%
Elective Discharges	1,315	1,408	(93) U	-6.6%	13,336	14,064	(728) U	-5.2%
Births	619	636	(17) U	-2.7%	6,695	6,869	(174) U	-2.5%
ED Discharges	7,561	10,418	(2,857) U	-27.4%	98,329	108,438	(10,109) U	-9.3%
FSA Volumes	4,521	5,978	(1,457) U	-24.4%	55,135	56,353	(1,218) U	-2.2%
FU Volumes	10,112	12,907	(2,795) U	-21.7%	116,811	118,140	(1,329) U	-1.1%

Glossary

ACC	Accident Compensation Corporation
BOY	Balance of Year
ED	Emergency Department
FSA	First Specialist Assessment
FTE	Full Time Equivalent
FU	Follow Up Appointment
HWFNZ	Health Workforce New Zealand (previously CTA (Clinical Training Agency))
MECA	Multi-Employer Collective Agreement
MoH	Ministry of Health
WIES	Weighted Inlier Equivalent Separation (activity based measurement)
YTD	Year to Date

Finance Overview

The Provider Arm produced a $1.80M favourable result against budget for the month of May 2020, YTD $(4.06)M unfavourable to budget.

The May result was driven by major variances as follows:

- Capital charge adjustment as a result of the Holiday's Act provision of $527k was received in May, YTD $5.79M, with a further $527k expected for June.
- Whakaari incident of the 9th December. Residual cost wash-up of $13k for the month, YTD $(3.80)M.
- CMH response to COVID-19 pandemic, $(6.10)M for the month, YTD $(9.75)M.
- YTD April Planned Care revenue clawback reversal, $3.90M reflecting balance of year expecation to meet MoH planned care volumes.
- Unbudgeted additional capacity in Ward 17, Ward 34, Ophthalmology, $(247)k for the month, YTD $(2.6)M.
- Unrealised target savings, $(1.66M), YTD $(19.11M)
- Estimated vacancies for May $2.08M, YTD $13.87M

Annual leave uptake has again been significantly lower due to the COVID-19 Level 3/4 lockdown and imposed travel restrictions. Annual leave additional costs inherent in the May result is $640k and $2.5m for the last 3 months (Mar-20 $457k, Apr-20 $1.4M and May-20 $640k).

Additional pressure on services due to the Whakaari incident and COVID-19 has severely impacted our ability to carry out our planned elective surgery programme, delivering -11.0% below contract for the month, YTD -6.9% behind contract. Additional outsourced services were deployed in May to reduce the under delivery to contract of elective procedures.

The COVID-19 Pandemic Level-4 Lockdown since 25 March has had a significant impact on April and May volumes. Overall WIES volumes were down -21.9% (YTD -6.3%) on contract, occupancy rates saw a marked decline mainly in Surgical Services (~50%) and Medicine (~40%).

ED presentations for the month of May were -27.4% below last year's volume (10,418 in 2019, 7,561 in 2020). Average daily presentations are 27% lower than previous year (336 in 2019, 244 in 2020) reflecting the impact of COVID-19.

Hospital services are now transitioning back to Pre-Covid business as usual now that NZ has moved from Level 4 Lockdown to Level 2. Patient visiting remains at Level 2 at the Middlemore Site with contact tracing protocols continuing at the front door.

The May YTD result reflects the following factors:

- Vacancies across the system in difficult to recruit to positions.
- High net Annual Leave accrual due to the impact of the level 3/4 lockdown.
- Cover provided by locums, bureau, overtime and casual staff.
- Additional outsourced clinical services to meet Planned Care contract that were deferred or cancelled due to the Whakaari incident and COVID-19 Response.
- The measles epidemic that occurred in the first quarter of the year.
- Whakaari incident of the 9th December 2019.
- Apex Strikes that have impacted delivery of planned care volumes.
- COVID-19 Pandemic.

Unrealised savings programmes and YTD overspends for unbudgeted additional capacity has also reflected unfavourably on the YTD result.

Volumes

CMH productivity volumes reflect the impact of the COVID-19 Lockdown and the Whakaari incident earlier in the year.

Overall WIES volumes were down by -21.9% on contract for the month, a direct impact COVID-19. YTD May WIES were below contract -6.3%.

Acute volumes are -24.6% below contract for the month, YTD -6.2% behind contract.

ED discharges are -12.3% below contract YTD reflecting the impact of COVID-19. The Emergency Q initiative continues to impact front door admissions as patients are referred for treatment in the community relieving ED of some volume pressure.

Our ability to carry out planned elective surgery has been hindered by the additional pressure on services as a result of the Whakaari incident and COVID-19. External Outsourcing, diversion of procedures to the Auckland Metro DHBs and deferral of procedures to a later date have resulted in Elective volumes delivering -11.0% behind contract for the month.

Increased activity is planned (outsourcing and wet-leasing) over the June month to meet MoH elective and planned care delivery expectation.

Key Drivers of the YTD May Result

Revenue

Revenue: May $3.84M favourable, YTD $12.32M favourable

- Capital charge adjustment as a result of the Holiday's Act provision of $527k was received in May, YTD $5.79M, with a further $527k expected for June.
- Higher than budgeted Non-Resident revenue (including long term Tongan patient), YTD $1.89M (partly offset by bad debt provision)
- Higher than budgeted CTA revenue due to timing, YTD $489k
- ACC revenue is lower than budget due to the cancellation or deferrals of elective procedures to prioritise CMH response to COVID-19, YTD $(821)k
- Bad debts recovered higher than budgeted, YTD $234k
- Favourable revenue from Research Grants, YTD $421k
- Favourable revenue from Retail Pharmacy, offset by Cost of Sales, YTD $1.89M
- Favourable non PCT drug revenue, offset by expenditure, YTD $2.28M
- CCDM revenue to fund nursing personnel costs for Accord FTE now on-board, YTD $1.55M
- MECA relief for MERAS and PSA, YTD $779k
- Unrealised target savings, YTD $(1.49)M
- Reversal of April Planned Care revenue clawback, $3.9M reflecting balance of year expecation to meet MoH planned care volumes.

Expenditure

Overall operational expenditure is $(1.77)M unfavourable for the month of May, YTD $(16.81)M.

Net Personnel Costs: May $(773)k unfavourable, YTD $(10.28)M unfavourable

The personnel costs net position is largely driven by the unbudgeted direct costs associated with the Whakaari incident YTD $(1.70)M, COVID-19 Pandemic $(1.14)M for May, YTD $(2.27)M and unrealised target savings, $(770)k for the month, YTD $(8.70)M. The YTD unbudgeted additional capacity for ward 17, Ward 34 and staff costs incurred to cover the measles epidemic, and the impact of the Apex Strikes have contributed to the adverse variance. All Apex and PSA MRT MECAs have been settled as at May 2020.

Underlying vacancies continue across the system, particularly in difficult to recruit to positions in Anaesthesia, Orthopaedics, General Medicine and Mental Health. Cover has been provided by locums, bureau, overtime and casual staff.

A lower level of annual leave uptake across the system during the month of May, $(2.52)M is reflective of the impact of COVID-19 and imposed travel restrictions.

Personnel by Professional Group - Permanent and Outsourced	Month $$$			Year to Date $$$		
	Actual	Budget	Variance	Actual	Budget	Variance
Medical Personnel	20,944	20,453	(491) U	219,672	218,679	(993) U
Nursing Personnel	23,243	23,542	299 F	258,045	251,193	(6,851) U
Allied Health Personnel	8,030	7,862	(169) U	85,781	85,165	(616) U
Support Personnel	3,190	2,951	(239) U	34,380	32,583	(1,796) U
Management Personnel	7,013	6,839	(174) U	75,004	74,978	(26) U
Totals	**62,420**	**61,646**	**(773) U**	**672,880**	**662,598**	**(10,282) U**

- Net Medical costs are $(491)k unfavourable for the month, YTD $(993)k reflecting costs associated with Whakaari and COVID-19. Unrealised target savings, $(256)k for the month, $(2.90)M YTD and the use of outsourced locums mainly in Mental Health, Anaesthesiology, Opthalmology and Gastro have been offset by vacancies across the Services in difficult to recruit to positions.

- Net Nursing costs are $299k favourable for the month and YTD $(6.85)M unfavourable. The month favourable result reflects lower activity during May due to COVID-19. Unrealised target savings, $(351)k, YTD $(3.93)M and a continued use of internal bureau staff, specials and watches to cover vacancies and planned leave have contributed to the YTD variance.

  Additional nursing staff were required in response to the Whakaari incident and COVID-19 Pandemic $(326)k for May, YTD $(1.33)M; and unbudgeted additional capacity ie; Ward 17, Ward 34, Opthalmology. Nursing vacancies continue across the the system particularly in Mental Health.

- Net Allied Health costs are $(169)k unfavourable for the month and YTD $(616)k reflecting YTD unrealised target savings, $(523)k, Whakaari and COVID-19 YTD costs $(392)k are partly offset by vacancies across the Services that are being actively recruited to (mainly for Psychologists and Community Support Workers).

- Net Support Personnel costs are $(239)k unfavourable for the month and YTD $(1.80)M, which were driven by YTD Facilities outsourced costs of $(1.29)M budgeted as maintenance costs and YTD unrealised target savings of $(459)k, partly offset by vacancies mainly in Facilities and Cleaners and Orderly Services.

- Net Management and Administration Personnel costs are $(174)k unfavourable for the month and YTD $(26)k unfavourable reflecting vacancies across the system partly offset by YTD unrealised target savings, $(884)k and the response to COVID-19, $(480)k.

Non-Staff Costs

- Outsourced Clinical: May $(162)k unfavourable, YTD $(1.76)M unfavourable
  The YTD result is driven by the catch up of elective procedures that were deferred or cancelled in response to COVID-19 and approved additional surgical procedures to meet planned care volume targets. Further outsourcing is planned to meet MoH planned care expectation to June.

- Outsourced Other: May $148k favourable, YTD $76k favourable
  The May favourable variance reflects a one-off cost transferred to capital projects of $134k. YTD favourable variance is driven by an underspend in Regional/National Shared Services $303k part offset by higher than expected costs to Health Alliance.

- Clinical Supplies: May $(523)k unfavourable, YTD $(7.52)M unfavourable
  The May unfavourable variance is driven by COVID-19 Pandemic expenses $(1.55)M, and offset by underpsends as a result of lower volumes in the hospital.. The combined YTD clinical supplies spend for Whakaari/White Island and COVID-19 are $3.92M.

  Higher than budgeted YTD costs in protective clothing $(344)k, patient consumables $(740)k and diagnostic supplies $(967)k were incurred to meet the demand in response to COVID-19. Unrealised target savings of $(6.92)M also contributed to the YTD unfavourable variance.

  An increased use of PCT drugs (Rituximab, Influximab & Tocilizumab) for non-cancer patients due to funding approval through Pharmac has resulted in a YTD overspend, $(2.28)M (offset by revenue).

- Other Expenses: May $(458)k unfavourable, YTD $2.67M favourable
  The increased costs in security and parking due to COVID-19 contributed to the unfavourable variance for the month.

  The YTD cost associated to COVID-19 is $(2.76)M in cleaning supplies, security services, parking, advertising and promotional activities.

  YTD underspend in laundry bedding & linen $601k, patient meals $631k, directly reflects occupancy and reduced ED presentations during the COVID-19 lockdown period. YTD favourable variances in maintenance outsourced $2.12M (offset by support personnel costs) and motor vehicles & IT leases $1.13M has reduced the COVID-19 additional cost impact.

  Unrealised target savings $(136)k for the month, YTD $(1.42)M.

- Interest, Depreciation and Capital Charge: May $(271)k unfavourable, YTD $436M favourable
  YTD favourable depreciation and capital charge is due to timing of capital expenditure.

Looking Ahead

Planning within the Provider Arm includes:
- 2020/21 Annual Planning underway.
- Review and finalise 2020/21 Budget.
- COVID-19 Response – Tracking and reporting of weekly costs.

PUBLIC
Counties Manukau District Health Board
Hospital Advisory Committee
Patient Experience and Safety Report

Recommendations

It is recommended that the Hospital Advisory Committee:

Note that this report was submitted to the Executive Leadership Team meeting on 16 June.

Receive the Patient Experience and Safety Report July 2020.

Prepared by: Dr David Hughes, Clinical Director Patient Safety & Quality Assurance. Submitted by Dr Peter Watson, Chief Medical Officer and Dr Jenny Parr, Chief Nurse and Director of Patient and Whaanau Experience.

Purpose

To provide a regular update to Counties Manukau Health (CM Health) on the progress of the planned actions as linked to the Annual Plan Improving Quality section work plan.

Report content

1. Monthly Safety, experience, compliance and measurement dashboard

Please note that a number of charts have not been updated during the COVID-19 response or the data is not reliable due to inconsistent reporting and auditing during this period. The Clinical Chiefs are now developing a new Quality dashboard for the organisation that will replace and enhance current reports.

Safety, experience, compliance and measurement dashboard

1. Monthly divisional summary of serious incidents – AEB As sent during May 2020

1.1 Non-falls serious adverse events

Division	Description
SAP	1) Obstructed airway during surgery
Mental Health	1) Suspected suicide

Target	Latest month
0 non-falls serious adverse events	2

These two tables show the incidents by Division reviewed by the Adverse Events Operational Group and reported to the Health Quality & Safety Commission as potentially meeting Severity Assessment Code (SAC) 1 or 2 criteria.
The incidents do not necessarily occur in the month reported due to delays in identifying the severity of the harm.

Action: Investigations are underway and will be reviewed at the Adverse Event Operational Group meeting.

1.2 Falls serious adverse events

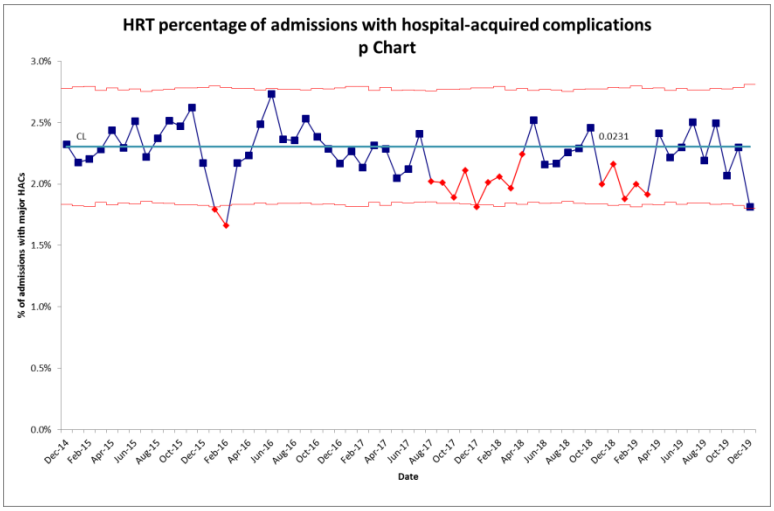
Division	Description
SAP	1) Fall resulting in total knee wound dehiscence
Mental Health	1) Fall resulting in fracture

Target	Latest month
0 falls serious adverse events	2

The incidents do not necessarily occur in the month reported due to delays in identifying the severity of the harm.

Action: Investigations are underway and will be reviewed at the Adverse Event Operational Group meeting.
Falls prevention group will undertake thematic analysis of all falls to identify systemic influences.

2. Health Roundtable - Insights



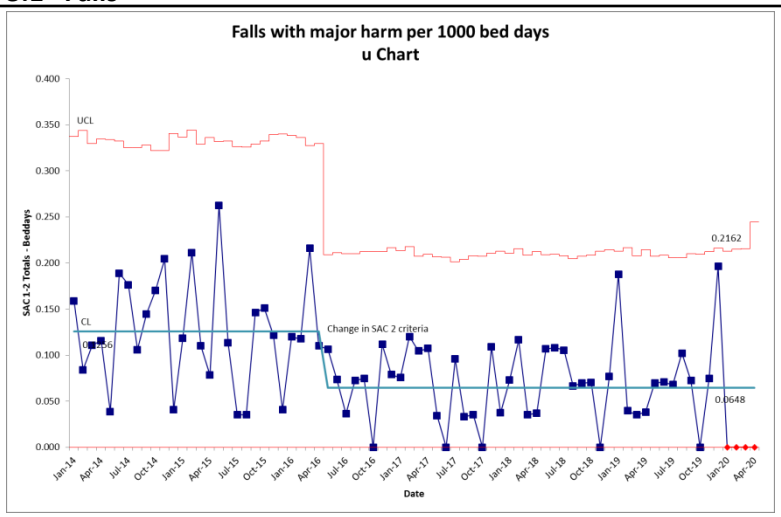
Target	Latest month
< 2.2% (baseline)	No new data

Health Roundtable (Insights) provides data based on coded discharge data. This shows percentage of admissions affected by any Classification of Hospital Acquired Diagnoses (CHADx) codes.

Data is quarterly and provided three months in arrears due to clinical coding requirements after discharge.

3. National Quality and Safety Markers (QSM); data from April 2020

3.1 Falls

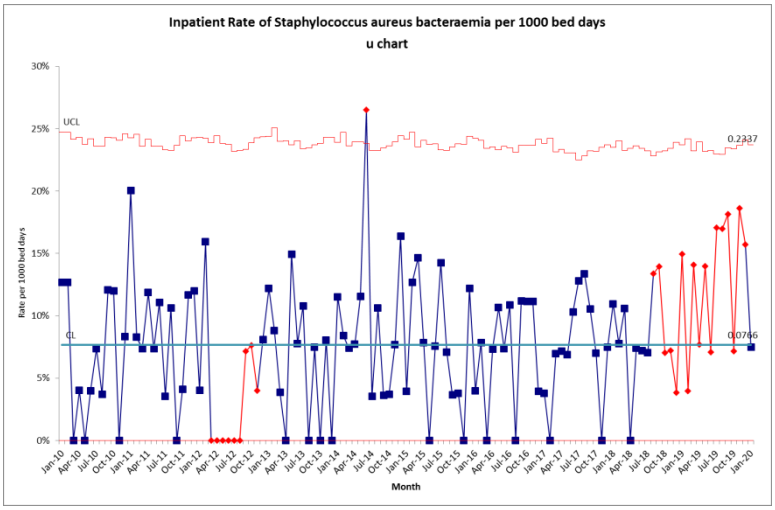


Target	Latest month
< 0.09 falls with major harm per month per 1000 bed days	0

This chart shows the number of falls with major harm per 1000 bed days. This data is sourced from the incident management system. A review has been undertaken of falls data in the system to ensure the chart is as accurate as possible.

All falls rated SAC 1 or 2 are included. The data is reported by date of fall rather than the date incident was reported to HQSC (item 1.2).

3.2 Hospital Associated Infections – Staph. aureus bacteraemia



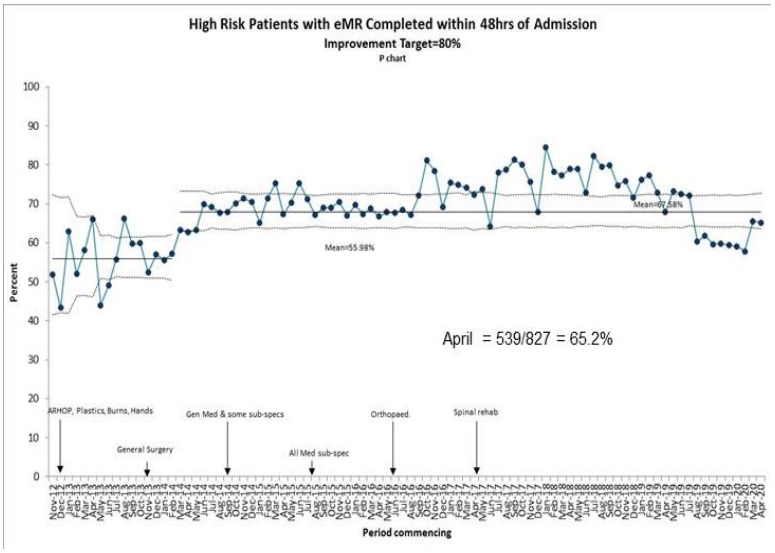
Target	Latest month
<0.06 SAB per 1000 bed days	No new data

This chart shows the inpatient rate of Staphylococcus aureus bacteraemia (SAB) per 1000 bed days. Common causes of SAB in hospital include infected peripheral and central lines.

Action:

COVID 19 has meant a delay in analyzing the SAB rate and a verbal update will be provided to the CGG.

3.3 Medication Safety



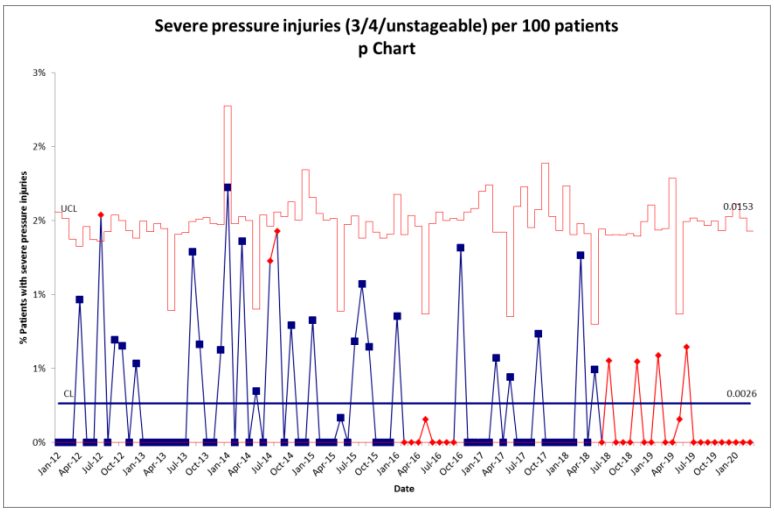
Target	Latest month
80%	65%

This chart shows the high risk patients with electronic medication reconciliation (eMR) completed within 48 hours of admission.
The reduction in completion rate relates to change in workflow and workload for pharmacy services since the implementation of MedChart and concerns about the reliability and validity of the risk tool.

Action: Clinical Quality Pharmacist appointed in May 2020 with focus on reviewing the risk tool and prioritisation process, and developing further solutions.

4. Excellent, kind, high quality experience for everyone; data from April 2020

4.1 Pressure injuries

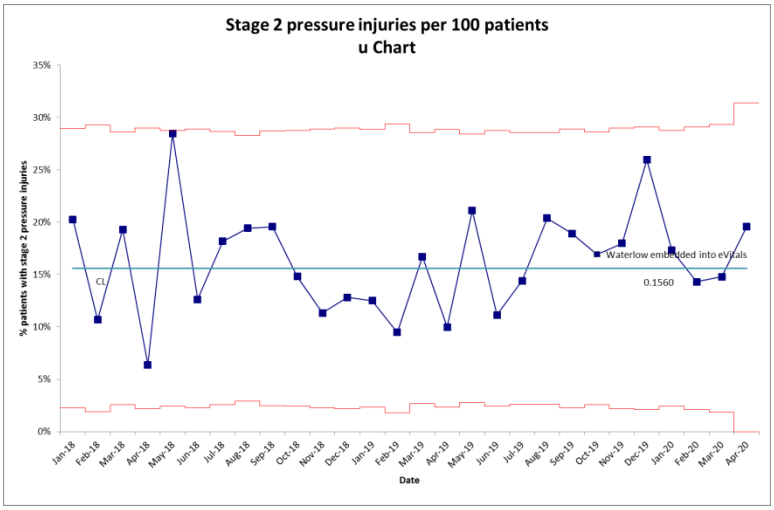


Target	Latest month
0 Stage 3, 4 or unstageable pressure injuries	No new data

This chart shows the severe pressure injuries (Stage 3, 4 or unstageable) per 100 patients on ward based monthly audits.

Note that these audits do not aim to identify all such cases as it is a random sample, however because it is standardised it does allow comparison over time. For the last 9 months this audit has not identified any of these cases.

Due to COVID 19, monthly audits were postponed and will resume as usual from 1 June.

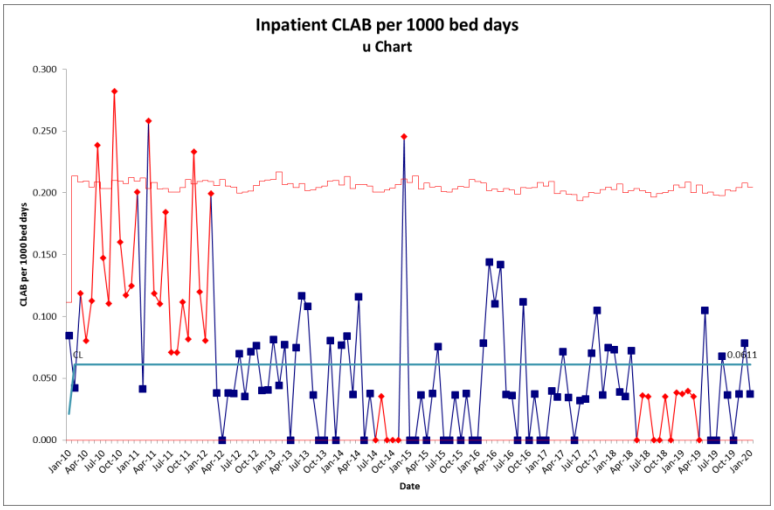


Target	Latest month
0 Stage 2 pressure injuries	11

This chart shows stage 2 pressure injuries per 100 patient admissions. This data is from Incident Reporting System (IRS). This relies on self report of stage 2 pressure injuries.

Action: Pressure injury prevention group to trial Continence Assessment in ARHOP and continue Pressure Injury Prevention and Management education.

4.2 Central line associated bacteraemia (CLAB) -

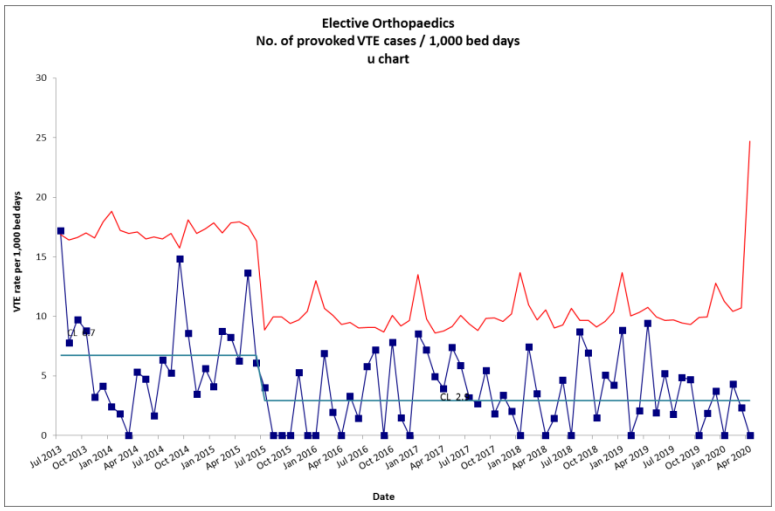


Target	Latest month
<1 CLAB per 1000 bed days	No new data

This chart shows the inpatient central line associated bacteraemia (CLAB) rate per 1000 bed days.

This chart replaces the ICU CLAB rate. It gives a broader view of CLAB in the hospital but is less reliable in signalling improvement or deterioration as the denominator of line days is not accurately available outside ICU.

4.3 Venous thromboembolism (VTE)



Target	Latest month
<2.3 per 1000 bed days	0

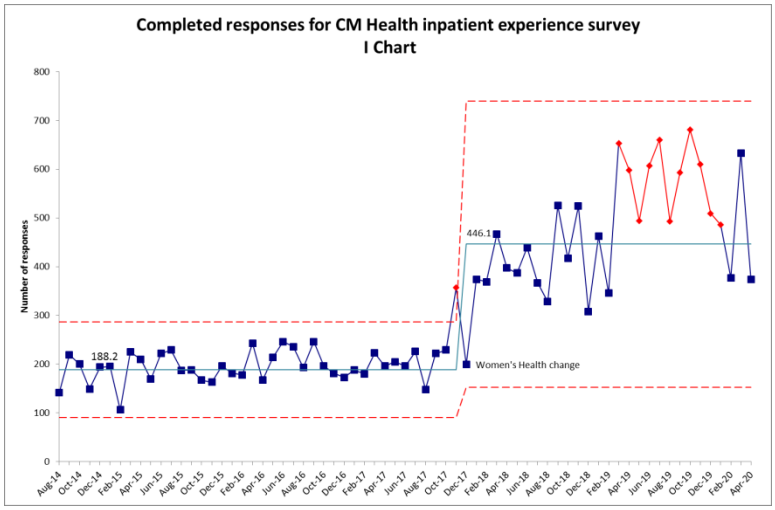
This chart shows the number of elective orthopaedic provoked venous thromboembolism (VTE) cases per 1000 bed days.

The target of <2.3 per 1000 bed days has been set following a review of the current evidence and Health Roundtable benchmarking with similar hospitals in Australasia.

Note: the high Upper control limit in April due to the very low number of elective orthopaedic admissions.

5. Improve consumer engagement; data from April 2020

5.1 Internal inpatient experience survey

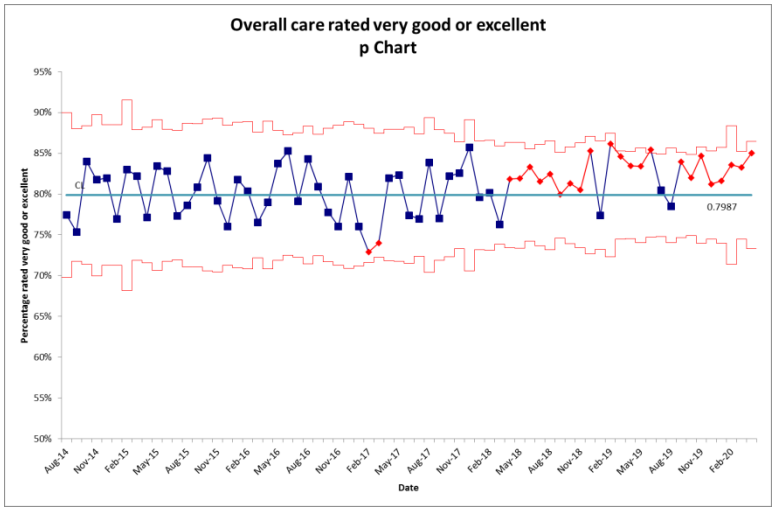


Target	Latest month
> 450 completed surveys per month	374

This chart shows the number of patients who completed the survey via email, text or tablet (Women's Health). However since January 2020, Women's Health has stopped providing the option of providing women with a tablet to complete the survey whilst in hospital.

Special cause variation due to shorter surveys implemented from March 2019.

Note: the dramatic drop (25%) in admissions during April is a contributor to the lower internal inpatient experience survey responses.

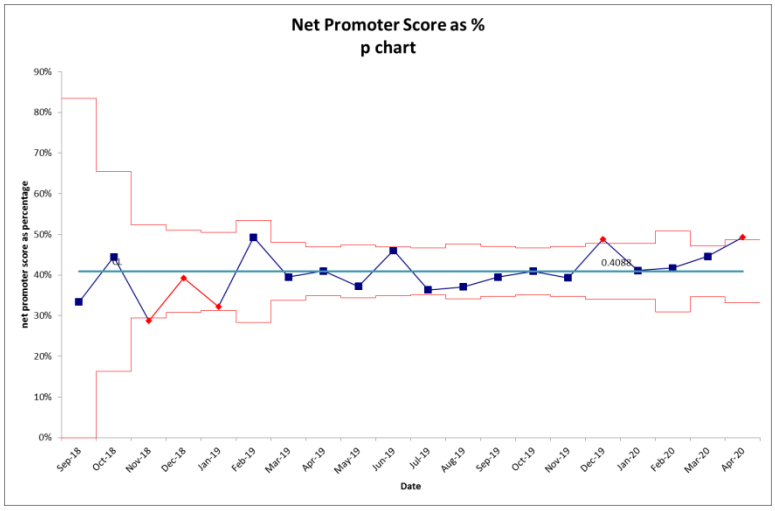


Target	Latest month
80%	85%

This chart shows the percentage of patients in our internal inpatient experience survey who rated their care as very good or excellent. The average is 80%.

The target of 80% was established by ELT in April 2017.

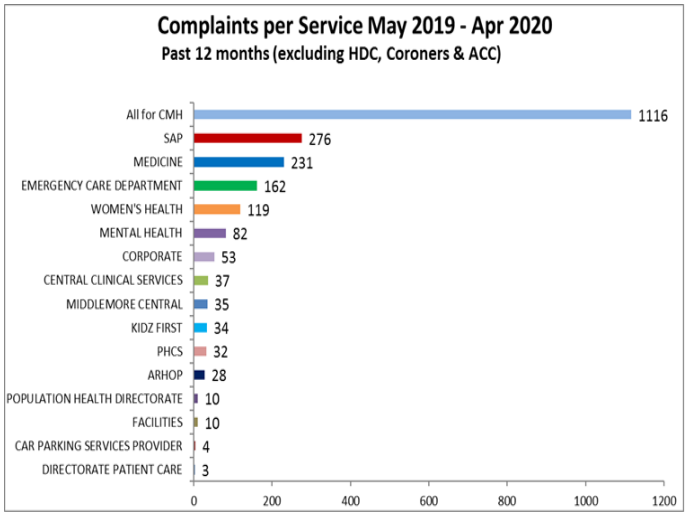
5.2 Net Promoter Score

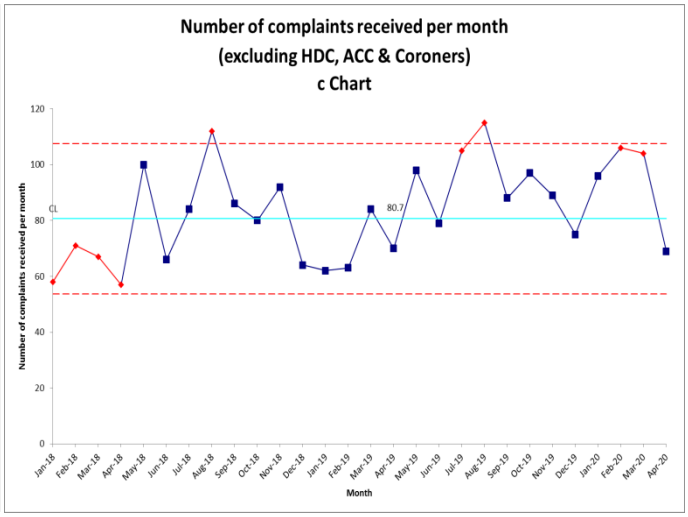


Target	Latest month
TBC	49%

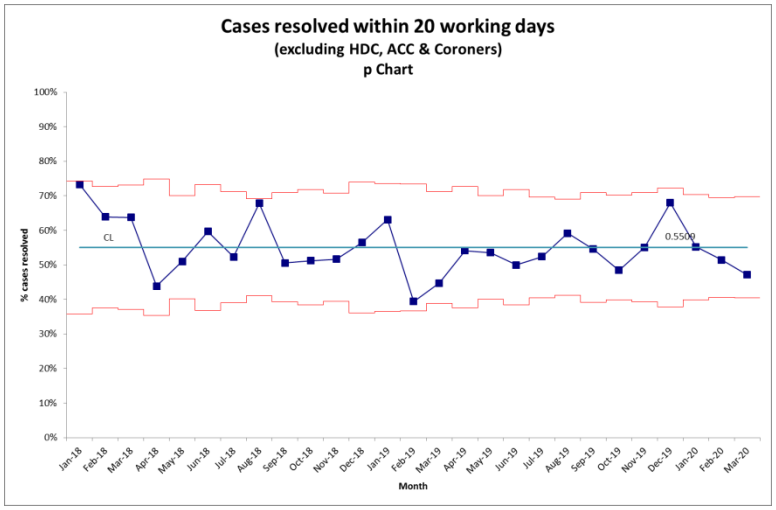
This chart displays Net Promoter Score (NPS) as a percentage. The score reflects the response to the Friends & Family question from the internal inpatient experience survey: *How likely are you to recommend our service to friends and family if they needed similar care or treatment?*.

6. Feedback central





This chart shows that the number of complaints is a stable with a mean of 80 per month. The highest number of complaints are received from our busiest areas: Surgery/anaesthetic and peri-operative (SAPs), Medicine, the Emergency Care Department, Women's Health and Mental Health.



Target	Latest month
80%	47%

This chart shows the ratio of cases resolved within 20 days of submission. This data is two months in arrears to allow 20 working days for resolution of each case.

In consultation with other DHBs, it was identified that the average performance nationally is approximately 50%. 80% (aspirational) target has been set based on the feedback for CM Health case resolution within 20 working days.

Action: Feedback Central will continue to work with services to ensure that those straightforward complaints are managed efficiently as close to the consumer as possible. Feedback Central to review the pattern of time to resolution for those complaints taking longer than 20 working days.

Counties Manukau District Health Board
Hospital Advisory Committee
Every Hour Counts Portfolio Progress Report – May 2020

Recommendation

It is recommended that the Hospital Advisory Committee:

Receive the Every Hour Counts Portfolio Progress Report for May 2020.

Note that this paper is an update of the patient flow work that has been completed whilst New Zealand has been in Alert Level 2 of the Covid-19 Emergency Response.

Prepared and submitted by: Lynne Armstrong, Change Manager Ko Awatea on behalf of Mary Seddon, Director Ko Awatea and Senior Responsible Officer for Every Hour Counts portfolio.

Glossary

APAC	Acute and Post Acute Care
ED	Emergency Department
MAU	Medical Assessment Unit
RAU	Respiratory Assessment Unit
MDT	Multi-Disciplinary Team
MSC	Manukau SuperClinic
SMO	Senior Medical Officer

Purpose

The purpose of this paper is to provide the Hospital Advisory Committee with an update of progress, issues and risks associated with the Acute and Ambulatory Flow programmes of work.

Acute Flow Programme

Patient presentations to the ED and hospital occupancy were significantly lower throughout the Covid-19 alert levels, and whilst achievement of the target to have 95% of patients through ED in six hours had improved, it was not consistently achieved. The acute patient flow team interrogated the data further, identified breaches, and challenged previous assumptions regarding barriers to achieving flow.

On 25 May, a workshop was held to explore the data and develop opportunities for improvement in acute flow. Forty-five multi-disciplinary participants, representing the Emergency Department, Middlemore Central, General Medicine, and ELT attended.

The workshop addressed three questions:

1. What are the challenges affecting flow?
2. How can we contribute to reduce the challenges identified?
3. What help do we need from others to improve flow?

The challenges affecting flow have not changed significantly since the Patient Flow portfolio was initiated, ie. lack of visibility of the patient journey, mismatch of capacity vs demand, and lack of consistency in system processes.

Due to the complexity of achieving system-wide flow, multi-disciplinary, cross departmental engagement and contribution is required. Each group identified a number of opportunities that could be implemented immediately, eg. improve the handover process from ED, finalise the escalation plan, review the skill mix profile for nursing, MDT huddles should be held in MAU, utilising Ward Coordinators to optimise flow at ward level.

A number of technological barriers were also identified, and work with the Healthy Together Technology team is ongoing.

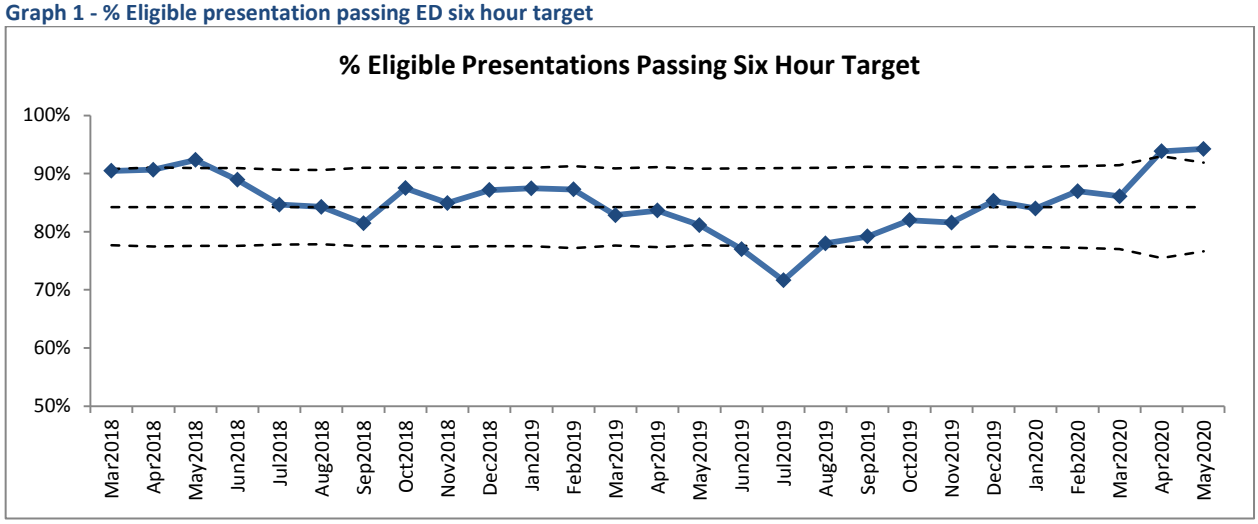
The main areas of focus for the Acute Flow programme during the next three months are:

- ED Flow
- Medical Assessment Unit (MAU)
- Efficient Ward Bed Utilisation

ED Flow

Graph 1 below highlights an improving trend in the percentage of patients meeting the six hour target in ED; during May, ED achieved 94.2% against a target of 95%.

Graph 1 - % Eligible presentation passing ED six hour target



- Throughout Covid-19 Alert Levels 4-2, the MAU was converted into an RAU; this challenged the test of having an SMO at the front door of ED to triage patients, as the SMO was required in the RAU. To support the test, some Nurse Practitioners undertook this role, with similar results, however there were less patient transfers to specialties. Testing with an SMO will recommence in June, with a plan to implement this change to business as usual activity from July 2020.
- A change in practice to register patients before they are clinically triaged has resumed, reducing duplication of administrative work for both nurses and clerical staff and allowing nurses to do more clinical work with patients. Having an SMO at the front door forms part of the triage process.

Medical Assessment Unit

In March 2020, a workshop was held with senior clinicians from the ED and General Medicine to agree service expectations for the MAU, eg. to be seen times, time to SMO decision-making, length of stay , models of care, etc. Progress was hindered by the emergency response to Covid-19 and a follow-up meeting to reconvene this work is planned for late June 2020.

Bed Utilisation

1. <u>Patient Allocation</u>

   Allocating patients from ED and MAU to General Medicine teams is complex and contributes to delays in bed allocation as it is unclear which medical team or sub specialty has responsibility for the patient. The current process means that many patients are transferred from one clinical team to another after admission and this causes work arounds for clinicians, eg. laboratory result receipt and sign-off by one team when the patient has been handed over to another team.

   A new process is being tested utilising the APAC nursing team; if an admitted patient is transferred to a different medical team, the APAC team will electronically update information to allow for more visibility and a greater opportunity to optimise home warding. It is envisaged that this process will enable more appropriate bed requests to be generated.

2. Ward Co-ordinators

The extended trial of Ward Nurse Coordinators (without a clinical caseload) on five General Medicine wards was implemented in May; an earlier trial in 2019 showed faster admission times (with a narrower admission window) and faster discharge processes in the trail wards. The average time a bed was empty decreased by 1h40m (from 4h26m to 2h46m), and also indicated a positive cultural shift and improved morale.

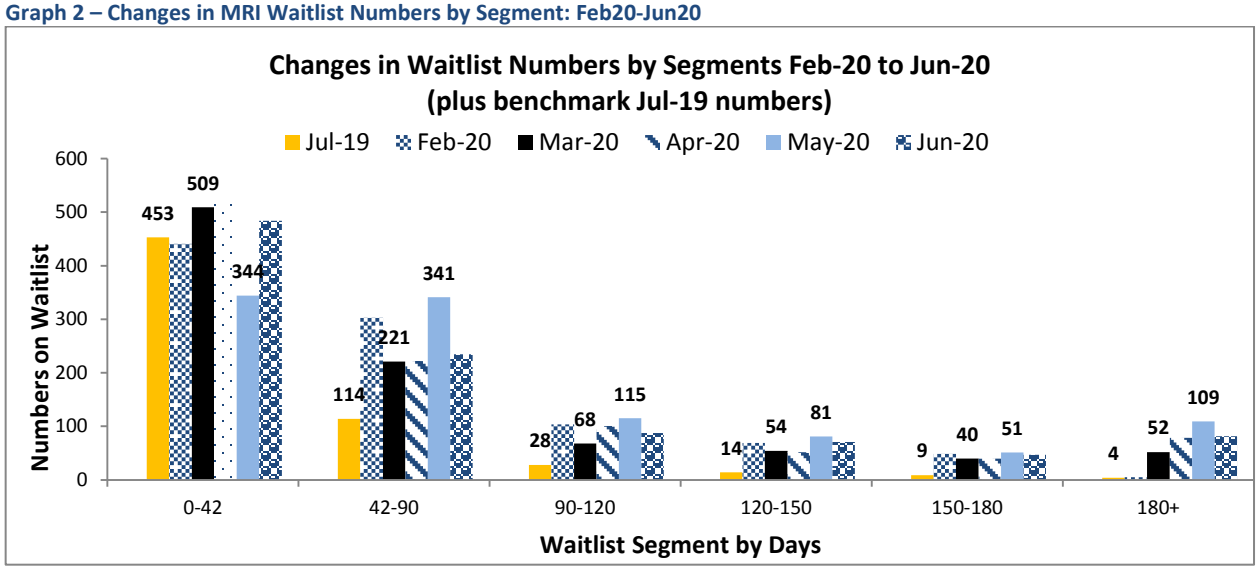
Whilst at the time of reporting it is still too early to determine any improvements, multiple data points are being collected to understand delays to discharge, time of discharge, and limited/under utilisation of the Discharge Lounge, together with the reasons for delays in admitting patients.

Rapid and Consistent Access to Diagnostics

July 2019 saw the MRI waitlist reduced from 2,019 at its peak in February 2019 to 622 following changes made to models of working, more efficient use of staff and scanners, the introduction of weekend and evening appointments, booking similar scans (eg. neck, knee or hip) in batches to save time changing plates, and outsourcing.

Whilst improvements in MRI have been operationalised, the reduction in waitlist numbers have not been sustained (n=1,076 as at 2 June 2020) due to a significant reduction in outsourcing scans (from 80 to 15 per week), lengthy industrial action taken by MRI technicians, and exacerbated further by Covid-19. Whilst the number of patients waiting longer than 42 days for a scan is beginning to reduce again (see Graph 2), the number of patients waiting longer than 120 days has increased significantly (from 27 in July 2019 to 200 in June 2020), and compliance with the Ministry of Health's target to see 90% of P2 patients within 42 days remains sub optimal (42.5%).

Graph 2 – Changes in MRI Waitlist Numbers by Segment: Feb20-Jun20



Work has begun with the MRI Graders, the Team Lead and Admin Team to revisit some of the work that was undertaken to reduce the waiting list throughout 2019, and refocus efforts on reversing this trend, ie.

- development of booking guidelines and templates.
- reinstate weekend and evening sessions.
- segmentation of waitlist by specialty.
- auto-reports of surveillance breaches and waitlist segmentations developed to increase visibility.

Ambulatory Patient Flow

Covid-19 has resulted in a number of changes for the Ambulatory Flow portfolio, with new projects emerging at MSC as a direct response to the pandemic. The main areas of focus for the portfolio are currently:

- Telehealth
- Elective theatre improvements
- Ophthalmology

Telehealth

The rapid review of the outpatient telehealth experience in response to Covid-19 has been well received and accepted by the services. Further work is now being undertaken, in conjunction with the services and Healthy Together Technology, to transform Conference Room 1 at MSC to test its use as a telehealth hub.

To support the development of telehealth for staff and patients:

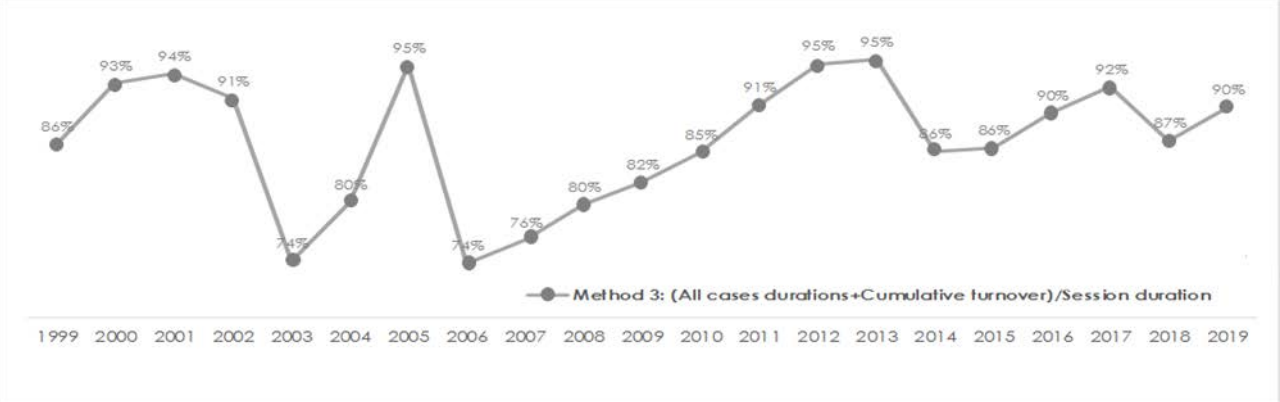
- a questionnaire is being designed to ascertain current usage of conference rooms at MSC. Data from this questionnaire will assist in identifying appropriate offsite locations for staff whilst Conference Room 1 is being used for telehealth. This will also inform the Grow Manukau business case.
- a brochure to introduce telehealth options to patients prior to being seen by a clinician is being developed. This brochure is being co-designed with staff and patients and will be available in multiple languages.

Operating Theatre Improvement

As at the end of April 2020 over 4,400 patients were waiting for elective surgery at CM Health. Of these patients, 688 waited over 120 days, with an average waiting time of 94 days. There are inefficiencies in the current system, with patients attending frequent clinic appointments before surgery, and high cancellation rates (almost 1,200 surgeries were cancelled on the day of surgery).

Despite this, as can be seen in Graph 3 below, in 2019 theatres were utilised 90% of the time.

Graph 3 - Operating Theatre Utilisation



To date, two workshops have been conducted which have generated ideas to increase the number of surgeries, reduce variation, improve booking visibility and roster management, and better utilisation of theatres sessions. The next steps are to scope, prioritise and plan the improvement ideas by the end of June, conduct focus groups SMEs, and mobilise resources for priority initiatives.

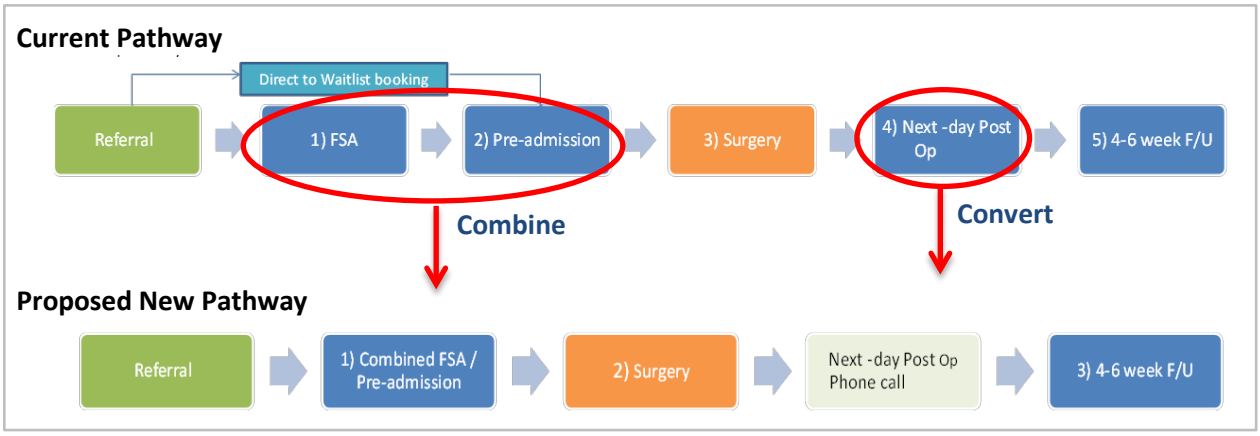
Ophthalmology

Work continues in Ophthalmology to simplify the current Cataract pathway to enable better patient experience and flow. This project has been split into three work streams, each tasked with understanding current issues, challenges, ideas and possible solutions:

1. Streamline referral through to completion of pre-admit
2. Surgical time and scheduling
3. Post-op telephone appointments

An improvement workshop was held with the service at the end of May, and agreement was reached to develop a process to test a new pathway:

- Reducing the total number of cataract patient appointments from five to four by combining the first specialist appointment (FSA) with the pre-admission appointment.
- Converting all uncomplicated cataract first day post operation to telehealth appointment.



This new pathway, which will be appropriate for approximately 80% of cataract patients, will see:

- Improved patient experience – patients only attend three appointments in person (instead of five).
- Increased SMO capacity to see more patients – reducing the number of times seeing the same patient.
- Increased Allied Health capacity – reducing eye testing from three to two.
- Improved outcomes for patients – an increase in the number of cataract surgeries performed annually.

Counties Manukau District Health Board
Hospital Advisory Committee
National Bowel Screen Programme (NBSP)

Recommendation

It is recommended that the Hospital Advisory Committee:

Receive this paper which provides an overview of current service delivery performance of the National Bowel Screening Programme (NBSP) from 10 July 2018 to 30 June 2020.

Note that the programme has been fully implemented and Counties Manukau Health (CM Health) is performing well.

Note we continue to work with the Ministry of Health (MOH) and the National Co-ordination Centre to improve coverage for Maaori and Pacific populations.

Note that there is adequate funding to deliver the service at CM Health for the current contract period to June 2020. We have commenced discussions with the MoH regarding funding for the next 2 year contract.

Prepared and submitted by: Hasitha Samarasinha**,** Bowel Screening Programme Service Delivery Manager**,** Kathy Pritchard, Service Manager, Cancer Screening Services on behalf of Catherine Tracy, General Manager Medicine.

Glossary

DHB	District Health Board
DNR	Did Not Return
HAC	Hospital Advisory Committee
MoH	Ministry of Health
NBSP	National Bowel Screening Programme

Purpose

The purpose of this paper is to provide an update to the Hospital Advisory Committee (HAC) on service delivery over the first year of the National Bowel Screening Programme (NBSP) at Counties Manukau Health (CM Health).

Executive Summary

As at the end of May total participation in the programme was 53.8%, Maaori 53%, Pacific 40.9%, Asian 50.9%, other 60.4%.

Since the commencement of the programme, there has been 1,526 positive FIT tests; 1,142 colonoscopies completed, out of which 1,018 of those patients had biopsies. 104 cancers have been diagnosed since the programme commended in the DHB in July 2018.

Discussion

Just prior to moving into COVID-19 Alert Level 4, from the 20th of March, the Ministry put a hold on any new participants being invited. However, around 2,000 kits were sent during lockdown for participants who had already received the pre-invite letter; they were informed to not return kits until lockdown was lifted. The MoH is now in process of informing these participants that it they can return kits now and we are starting to see some positive FIT results from this group. Invitation letters to participants will commence again on 8th of June 2020; the test kits will be sent 2 weeks later. The average number of invites sent out for each DHB will remain status quo as prior to COVID-19. For CM Health this means that our first screening round will take longer (27 months) to complete.

Our Community Co-ordinators have started our Outreach process and we are calling priority participants who have not returned a kit. The Regional co-ordination Group is commencing a media campaign at the end of June to inform GP's and potential participants of the restart of the NBSP. Radio ads have been confirmed.

Further advice was sought from the MoH regarding the commencement of screening Maaori and Pacific from 50 years of age. We have been advised that if this change is agreed by Government, it is unlikely to go ahead until all DHBs have implemented the programme. This will be around the end of 2021.

Counties Manukau District Health Board
Hospital Advisory Committee
Gynaecology Service at CM Health

Recommendation

It is recommended that the Hospital Advisory Committee (HAC):

Receive an overview of the current challenges being faced by the Gynaecology Service at CM Health.

Prepared and submitted by: Mary Burr, General Manager and Sarah Tout, Clinical Director, Division of Women's Health.

Purpose

This report provides an overview of the current challenges being faced by the Gynaecology Service at Counties Manukau Health (CM Health) as requested by the Hospital Advisory Committee (HAC).

Executive Summary

In this report, we provide updates on Faster Cancer Treatment (FCT) for Gynaecology, increased acuity and high Body Mass Index (BMI) and the associated challenges, areas of unmet need (P3 urogynaecology, pelvic pain), our perinatal loss service and the impact of insufficient theatre access. We propose potential solutions for consideration to improve service delivery to women in our community who would benefit from access to gynaecological assessment and treatment.

While the highest priority is to provide expert and timely care to women who are critically or acutely unwell or for those with life threatening conditions such as cancer, it is also important to be aware that many women can suffer from significantly debilitating but non-urgent conditions that impact on their lives and the lives of whanau/families. Currently we cannot provide treatment for some of these women due to the volume of patients and resources required.

CM Health is currently not meeting the Faster Cancer Treatment targets due to the volumes of referrals with a "high suspicion of cancer" and delays in diagnostic procedures such as pipelle, hysteroscopy, USS and MRI. As a result, women wait a longer time to be diagnosed. CM Health has substantially higher rates of endometrial cancer than in the rest of New Zealand (some driven by obesity and related comorbidities) and our mortality rates are not decreasing when compared to the rest of the country. Pacific women are over represented in this group.

We identify obesity as a factor which increases the likelihood of many gynaecological conditions and also complicates surgery when required, increasing theatre time which is then physically more demanding and requires more time to complete more complex surgeries, increases postoperative complications and requires longer post-operative recovery time. Gynaecology does not have enough access to theatre time, particularly at Middlemore Hospital, resulting in delays for surgery or exclusion for some women having treatment. Outsourcing surgery has improved access to theatre this but does not currently accommodate women with high BMI. This deficit in theatre access may also result in inadequate training opportunities for our trainee future specialists.

Maaori and Pacific women are over represented in gynaecological FSA and surgery data. This is in some part to do with the levels of obesity and related comorbidities present in those populations but may also be about barriers to seek medical advice and care early and this will be a focus for our Division to explore further.

Our perinatal loss service provides support for women and whanau whose baby has died. Significant work is being undertaken in regard to a holistic service design for this important activity. A proposed new midwifery or nursing position would support these women and their whanau. Our goal is that every woman will receive appropriate counselling and support throughout and after pregnancy loss.

Colposcopy is another challenge for us and we propose additional specialist nursing support to increase compliance with the National Targets.

We outline suggestions to resolve some of these challenges with a continuing investment in resources and people. Regular assessment of the workforce requirements will ensure resources are in place to meet demand, including senior doctor expertise and alternative workforce such as nurse specialists to also support expert holistic patient care for those who may not require surgery.

Discussion

The following list highlights the current pressures related to the delivery of our Gynaecology Service at CM Health. Each challenge has links to demand, complexity and waiting times for treatment and may require additional resource components to improve service delivery and outcomes for women.

1. Faster Cancer Treatment Target (FCT)

Previous presentations and papers have highlighted the issues and risks associated with the volume of referrals and delays experienced by women with a high suspicion of cancer.

The current barriers to achieving cancer assessment and treatment to meet FCT targets are:

1.1 Endometrial Cancer

- Rates of endometrial cancer (EC) at CM Health are substantially higher than in the rest of New Zealand (driven by obesity and related comorbidities) and our mortality rates are not decreasing when compared to the rest of the country.
- Diagnosis requires an initial pelvic ultrasound assessment followed by an endometrial sample. This can be by a blind endometrial pipelle sample or at hysteroscopy following direct vision of the lining of the womb. Due to the high volume of women presenting with suspicious symptoms there can be a wait for either diagnostic test with 80% of this group receiving a negative result for cancer.
- There are also significant delays for MRI which impact greatly on the waiting time pathway for definitive treatment once the diagnosis has been made.

1.2 Inadequate or incomplete referrals for Heavy Menstrual Bleeding (HMB)

Work is being undertaken to reduce the risk of endometrial cancer by improving the management of women with heavy menstrual bleeding (HMB) in primary care.

- Consideration of increasing funding for primary care for endometrial sampling and pelvic ultrasound scans would enable GPs to exclude those who do not require a referral to secondary care and can be managed in primary care. (A separate paper has been written concurrently and is under consideration). This would streamline the pathway for women and reduce referrals to secondary care services which could then triaged directly to a Hysteroscopy Clinic, avoiding the delay and cost of an extra FSA appointment to perform investigations.
- Approximately 100 women are seen under the current HMB service per year which is significantly below the need in the community.
- More investigations undertaken in primary care will also assist in improving services to ensure equitable care to Pacific women who bear a higher burden of endometrial cancer, particularly those women living in quintile 5 localities.

1.3 High volumes of patients with Post-Menopausal Bleeding (PMB)

In 2018, the CM Health Gynaecology team adopted the regional pathway for post menopausal bleeding which has led to vastly increased volumes being tracked. This has resulted in Gynaecology having one of the highest tracked volumes for P1 HSC (Priority 1, high suspicion of cancer) 62 day tracking and this is creating significant issues attaining the 62 day target.

Fortunately for the women involved, a high percentage of women being tracked for PMB do not go on to have a diagnosis of cancer (the cancer yield on the 62 day pathway for this group is 17%) but the volume of referrals creates risk, challenges and delays for those with cancer.

1.4 Delays related to Diagnostics

Volumes of referrals from GPs without diagnostic ultrasound result in long waits for ultrasound at CM Health and negatively impact on pathways and as mentioned in 1.1. delays in achieving MRIs, for those with confirmed endometrial cancer, impacts greatly on definitive treatment timeframes.

Our diagnostic hysteroscopy waitlist has a high volume of women waiting for investigation (HSC P1 women are given priority). Table One below shows an improvement in the number of women on the outpatient hysteroscopy waiting list however 60% are still waiting longer than the appropriate waiting time. The service requires another procedure room in Module 10 to improve this measure and this has been highlighted in the Grow Manukau Project. The recruitment of a Nurse Hysteroscopy role will enable improvement in the flow of women through this diagnostic process (this role is still evolving in New Zealand and so would not be available for recruitment until 2021).

Table One: Outpatient Hysteroscopy Waiting List

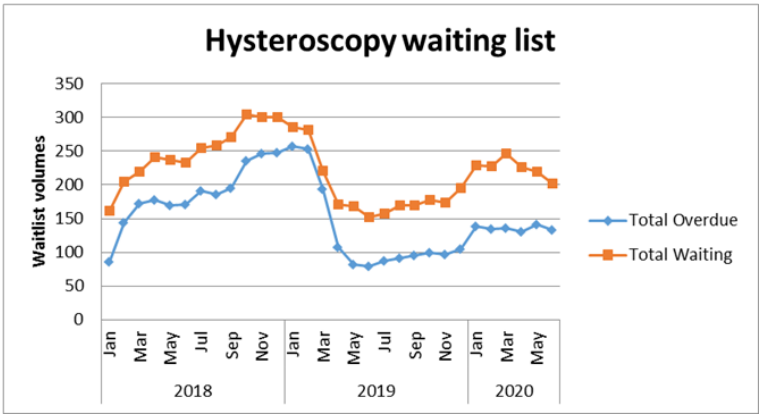


Table Two: Average waiting times for inpatient hysteroscopy for P1-HSC

Cases		Ave Days Waiting		Total			
MMH	MSC	MMH	MSC	Cases	Ave Days	Min days	Max days
6	35	57	44	41	46	0	119

Key point: CM Health is currently not meeting the FCT targets due to high volumes of high suspicion of cancer referrals and delays in diagnostic procedures such as pipelle, hysteroscopy, USS and MRI.

2. *Obesity*

Obesity increases the likelihood of many gynaecological conditions including infertility, miscarriage, heavy menstrual bleeding, endometrial cancer, pelvic floor prolapse and urinary incontinence and more general conditions such as cardiovascular disease, type 2 diabetes, and obstructive sleep apnoea. Surgery for women who are obese is technically more challenging, takes significantly longer followed by more complications after surgery; most commonly wound infection. For example, abdominal surgery wound complication rates have been shown to be 10 times more likely in women with a BMI over 40 than in normal weight women. 273 abdominal hysterectomies (where the uterus is removed through an abdominal incision) were performed in 2019 at CM Health, with 80% classified as operations performed on women who were overweight or obese.

Looking after increasing numbers of obese patients is having a major impact on our ability to provide services to our patients in Women's Health in a number of different ways, from assessment of patients to definitive care and beyond. Our staff treat women with high BMI with professionalism, skill and positive attitude and work with women to reduce BMI when appropriate. However, care of patients with high BMI puts greater pressure on staff.

As above, surgery is more physically challenging and takes longer, even for simple diagnostic procedures. Mobilising patients with high BMI puts staff at risk of lifting-related injuries particularly in theatre and special equipment is required such as theatre beds able to accommodate the weight and size whilst keeping women safe.

From an anaesthetic point of view, women with high BMI (BMI+50) are more safely managed at Middlemore Hospital (MMH) and this creates further challenges as Middlemore lists are at a premium and the majority of our current lists are at MSC. Women with high BMI cannot currently be accommodated on outsourced contracts.

Key Point: Obesity increases the likelihood of many gynaecological conditions and when surgery is necessary can require increased theatre time, physically more demanding care, longer more complex surgeries, increased postoperative complications and longer post-operative recovery time.

3. Insufficient Theatre Access

In each category mentioned above, accessing theatre time is a major factor in delays for gynaecology treatment in both acute and elective settings. We require more theatre access in general for gynaecology to meet the volume and acuity of our patients however most importantly; we require more access to Middlemore theatres to accommodate the number of our women with higher BMI and comorbidities requiring surgery and post-operative care at the major hospital. Gynaecology currently has on average 11 half day theatre lists per week. Four more half day lists per week (at least one at Middlemore) are required to enable the service to see all women currently referred to the service who then require surgery (plus those currently declined treatment).

The service also requires theatre lists to support the surgical experience of our trainees, and future specialists which will secure the longer term sustainability of our service.

Key point: Gynaecology requires more access to theatre time, in particular at Middlemore Hospital.

4. Non Urgent Uro-Gynaecology and Pelvic Pain

In 2018, in an effort to manage demand against resourced capacity for Women's Health at CM Health, the service began to restrict access to First Specialist Assessment (FSA) for women with gynecological conditions graded as non-urgent. This has resulted in an increase in declined referrals for FSA placing the woman back under the care of the GP without treatment (although some women are referred to physiotherapy in the interim). Women who currently cannot be accepted are those with common complaints such as severe urinary incontinence, pelvic organ prolapse and chronic pelvic pain.

The intended impact of restricting inflow was to reduce the then existing long waiting time for non-urgent surgery for women currently on the waiting list to less than 12 months. This has been achieved and the waiting time improvement was also assisted by surgical outsourcing initiatives. While the strategy ensures access to the service in a timelier manner for those who are critically or acutely unwell or for those with life threatening conditions such as cancer, it has had a significantly impact on the lives of those women whose referrals were/are rejected. Table Three below outlines the number of women currently declined access to gynaecology for all reasons.

Table Three: Total Gynaecology Referrals returned to GP- All reasons.

Year	Month	Returned to GP	Total Waiting List	Percentage
2019	Jul	58	231	25%
	Aug	49	267	18%
	Sep	63	233	27%
	Oct	11	181	6%
	Nov	8	193	4%
	Dec	15	215	7%
2020	Jan	23	195	11%
	Feb	12	171	7%
	Mar	5	162	3%
	Apl	3	146	2%
	May	44	176	25%

The Gynaecology Service has recently relaxed the current criteria to open access for some women with uro-gynaecological conditions by accepting referrals after a trial of physiotherapy. Women still remain excluded for pelvic pain conditions at this time and we will review access for these women in the near future. A gynaecology nurse specialist role would assist with the clinical management of those women who respond to a more supportive and conservative approach. Currently some of these women have multiple acute admissions as the only option for them.

Key points: Some women with severe urinary incontinence, pelvic organ prolapse and chronic pelvic pain are not gaining access to treatment and are living with significantly negative, debilitating and restrictive conditions.

5. Perinatal Loss Service

Our Perinatal Loss Service provides support for women and whanau whose baby has died. Currently support is provided by registered nurses on the women's health wards however the acute ward setting is not always conducive to providing the best one to one support.

Significant work is being undertaken in regard to a holistic service design for this important activity. A new midwifery or nursing position to support these women and their whanau is essential. Our goal is that every woman will receive appropriate counselling and support throughout and after pregnancy loss. The numbers are significant as seen in Table Four and Five below:

Table Four: Stillbirth, Neonatal Death

Stillbirth and Livebirth, Neonatal Death Volumes

Birth Outcome	2014/15	2015/16	2016/17	2017/18	2018/19
Antepartum Stillbirth	57	44	59	62	54
Intrapartum Stillbirth	2	8	9	13	22
Livebirth, Neonatal Death	3	25	47	31	27
Total	**62**	**77**	**115**	**106**	**103**

Table Five: Miscarriages at MMH

Miscarriages by Discharge Specialty

Discharge Specialty Group	2014/15	2015/16	2016/17	2017/18	2018/19	Gestation
Gynaecology	747	817	764	770	771	Under 20 weeks
Obstetric specialties	6	9	23	15	14	Over 20 weeks
Emergency Medicine - ED	29	28	31	46	29	Under 20 weeks
Other specialties	3	4	4	5	8	Unknown
Total	**785**	**858**	**822**	**836**	**822**	

Abortion Legislation Changes

With changes to abortion legislation passed in March 2020 women will be able to access termination of pregnancy closer to home (this is a major change to access provided prior to March 2020) and we expected to see an increase in women requiring support pre and post terminations. A project group has been set up by CM Health to implement the changes required by the new legislation focusing urgently on access to the service and clear care pathways.

Key point: There is an urgent need for a second midwife or nurse specialist to support the current Midwife *Specialist and social worker who manage perinatal loss care at over 20 weeks gestation.*

6. *Colposcopy*

Women who have an abnormal cervical screening result are referred to gynaecology for a colposcopic assessment and possible treatment. High volumes of referrals and a shortage of clinician time can impact on consistently meeting MOH targets. Recent use of a locum SMO has assisted in improving the number of women assessed and receiving a colposcopy but this is not a long term solution. Nurse specialists and nursing staff to support the clinic are also key to maintaining an effective service. We currently have one nurse colposcopist and our future plan is to recruit a second to support women referred from the screening programme in a timely manner and to ensure we have a succession plan in place.

The data below shows the July to December 2019 CM Health results. We expect improved results for the first half of 2020 because of the use of the locum. Currently there are less than 20 Priority 2 FSA women on the waiting list however Priority 3 FSA numbers are higher at over 100. Follow ups are currently not being seen on time. To improve these results in the interim (while we look to employ other clinic nursing staff and another nurse specialist), we will need to complete evening and weekend clinics. These clinics have a lower DNA rate and this enables regular management of the waiting list.

The MOH measures CM Health on a number of standards as outlined in Table Six and results for the second half of 2019 are shown in Table Seven.

Table Six- Top 3 Colposcopy Standards Definitions

1.	Standard 602: 95% of women with a high grade smear, including with a glandular abnormality receive a colposcopy appointment to be seen within the next **20 working days** from when the colposcopy unit received the referral from the smear taker / referrer.
2.	Standard 602: 95% of women with persistent low-grade abnormalities or a low-grade abnormality and positive hrHPV test receive a colposcopy appointment that should not exceed **26 weeks** of the colposcopy unit receiving the referral.
3.	Standard 605: 95% of women with confirmed high-grade lesions are treated within **8 weeks** of histological confirmation.

Table Seven: CM Health Colposcopy Results Data – July to December 2019

	Standard 602 - High Grade - 95% seen within 20 working days					
	July-Dec 2018		Jan-June 2019		July-Dec 2019	
DHB	% appt	% seen	% appt	% seen	% appt	% seen
Counties Manukau	36.4	33.5	4.2	4.2	8.3	7.7

For women referred with a low-grade result:

	Standard 602 - Low grade - 95% seen within 6 months					
	July-Dec 2018		Jan-June 2019		July-Dec 2019	
DHB	% appt	% seen	% appt	% seen	% appt	% seen
Counties Manukau	93.6	88.9	81.5	78	81.5	78.7

Data related to women treated is:

	Treated within 8 weeks		
	July-Dec 2018	Jan-June 2019	July-Dec 2019
DHB	% treated	% treated	% treated
Counties Manukau	62.5	42.5	50.6

Key point: There is a need for more specialist nursing support for colposcopy at CM Health to increase compliance with the National Targets.

7. Planned Care Targets

Planned Care (Elective Surgery) for Gynaecology is currently not meeting ESPi 5 compliance (for treatment). This can be improved by better theatre access overall, more Middlemore lists and the ability to outsourced women with high BMI to private facilities if required.

Key point: Improved access to theatre lists will improve planned care performance.

8. SMO/Registered Nursing Resource

An Obstetrics and Gynaecology SMO service sizing exercise has been undertaken recently and the service continues to recruit. CM Health Division of Women's Health is an attractive place for senior clinicians to work and there are many contenders for roles.

The Division has also developed a strong workforce plan overall to ensure succession plans within roles particularly in hard to recruit to specialist areas.

Nurse specialists can provide both independent practice and key support roles for gynaecology services. The service has future plans for four nurse specialist roles: nurse colposcopist, nurse specialist gynaecology, nurse specialist hysteroscopy and a second perinatal nurse/midwife. These roles will allow the service to offer more complete management of waiting times within a holistic approach.

Key point: Regular assessment of workforce requirements will ensure resources are in place to meet demand and employing alternative workforce such as nurse specialists support expert holistic patient care for those who may not require surgery.

Equity of Access

Providing equity of access is important to the Division and our recent Vision and Values refresh clearly identified the need to work together with consumers of our service to ensure priority populations are prioritised for care.

"As a Women's Health Service we recognise the different health needs of priority populations, the need to address gaps in services and target those population groups where the health outcomes are poorer; in particular reducing inequity for Maaori and Pacific women, and their babies."

The impact of comorbidities and obesity on postnatal and gynaecological capacity has been identified as a risk in the CM Health Corporate Risk Register. We continue to work with women to improve the wellbeing of our populations and achieve our health equity goal in relation to women's health.

As can be seen in the tables below, Maaori and Pacific women are over represented in the waiting list data for gynaecological FSA and surgery. This is in some part to do with the levels of obesity and related comorbidities present in those populations but may also be about barriers to seek medical advice and care early and this will be a focus for our Division. Pacific women bear a higher burden of endometrial cancer, particularly those women living in quintile 5 localities. Table Nine and Ten outline a breakdown of the current planned care waiting list by ethnicity and the 2018-19 data related to endometrial cancer.

Table Nine: Maaori and Pacific Women on the current Planned Care Waiting Lists

FSA Gynaecology				Hysteroscopy			
Priority	**Ethnicity**	**Volume**	**Overdue**	**Priority**	**Ethnicity**	**Volume**	**Overdue**
1	Maaori and PI	6	4	1	Maaori and PI		
	All (inc M&PI)	7	4		All (inc M&PI)		
2	Maaori and PI	61	46	2	Maaori and PI	53	47
	All (inc M&PI)	184	146		All (inc M&PI)	88	81
3	Maaori and PI	72	5	3	Maaori and PI	58	28
	All (inc M&PI)	162	17		All (inc M&PI)	122	58
Major surgery				**Day surgery (minor)**			
Priority	**Ethnicity**	**Volume**	**Overdue**	**Priority**	**Ethnicity**	**Volume**	**Overdue**
1	Maaori and PI	32	30	1	Maaori and PI	47	36
	All (inc M&PI)	66	61		All (inc M&PI)	73	57
2	Maaori and PI	7	6	2	Maaori and PI	8	6
	All (inc M&PI)	24	20		All (inc M&PI)	15	13
3	Maaori and PI	66	36	3	Maaori and PI	21	3
	All (inc M&PI)	200	98		All (inc M&PI)	51	6

Table Ten: Volume of women during 2018-2019 with endometrial cancer by ethnicity and quantile

Ethnicity	**Quantile**					
	1	2	3	4	5	Total
Maaori			3	3	11	17
Pacific	3	1	5	2	64	75
Asian	2	4		3	8	17
Other	10	7	4	3	10	34
Total	**15**	**12**	**12**	**11**	**93**	**143**

We are embarking on a co-design approach to service delivery which will assist in finding out how inequalities are being created and what we can do to eliminate any barriers to access women's health services, in particular for Maaroi and Pacific women but for all women.

Key Point: Maaori and Pacific women are over represented in gynaecological FSA and surgery data. This is in some part to do with the levels of obesity and related comorbidities present in those populations but may also be about barriers to seek medical advice and care early and this will be a focus for our Division.

Summary

The following table summarised the challenges, current strategies and the resources required to deliver the gynaecology services to our community. We continue to work with the Executive Leadership Team to deliver these strategies.

Table Eleven: Strategies to resolve challenges

Challenges	Strategies/actions already undertaken to resolve	Further Resources needed
1. Faster Cancer Treatment Target	• Recently completed outsourcing initiative provided 153 women with their hysteroscopy procedure. • Increased SMO support for grading referrals has reduced days between referral and grading by 5 days. • Access to diagnostic hysteroscopy is prioritised for women on the HSC pathway. • Access to MRI is prioritised for forms marked HSC; Gynae SMO team aware this needs to be reflected on request form. • Active negotiation with Surgical Services for access to theatre space at Middlemore. • Outsourced contracts are continuing. • Additional lithotomy bed in gynaecology outpatients to improve endometrial sampling without the need for hysteroscopy if a malignancy is confirmed at the initial investigation. • Extra Procedure Room in Module 10 requested in Grow Manukau Project	Continued outsourcing More theatre access Extra procedure room (GROW Manukau) Increased/timely access to MRI Nurse Hysteroscopy (21/22 f/y) Extra clinic RN support
2. Obesity	Obesity increases the likelihood of many gynaecological conditions and can contribute to theatre access issues, longer more complex surgeries and post-operative recovery time.	An organisational approach is required with a dedicated team leading a healthy weight strategy.
3. Insufficient theatre access	Gynaecology currently outsources two lists per week at a local private hospital but requires at least 4 extra lists per week (one of which must be at MMH)	Continued outsourcing New contract for high BMI women. Increased access- 4 extra lists pw
4. Non-urgent urogynaecology and pelvic pain	Waiting list management – women with non-urgent uro gynaecology and pelvic pain conditions are declined treatment (average of 20 per month). We have slightly opened access following a course of physiotherapy.	Continued outsourcing More theatre access Nurse specialist resource
5. Perinatal Loss Service	Building a perinatal loss team	Recruiting a nurse or midwife specialist
6. Colposcopy	Unable to meet the MOH target for colposcopy post screening. Locum SMO has assisted with volumes. A new sub specialty uro-gynaecologist will start in Dec 2020. Seeking approval for a new nurse specialist role	Evening and weekend clinics Recruitment of a nurse specialist
7. Planned Care	Non-compliance with ESPis relates to theatre access as above	Require more theatre access
8. SMO and RN resource	SMO service sizing completed. Workforce plan completed.	SMO service sizing approval 4 nurse specialist roles (nurse colposcopy, nurse specialist gynaecology, nurse hysteroscopy and perinatal nurse/midwife.

Counties Manukau District Health Board
Hospital Advisory Committee
Certification Corrective Actions Update and Surveillance Audit

Recommendation

It is recommended that the Hospital Advisory Committee:

Receive a summation of the findings of HealthCERT's corrective action monitoring report and the Surveillance Audit planned for December 2020.

Note this paper was endorsed by the Executive Leadership Team on 16 June to go forward to the Hospital Advisory Committee.

Note that HealthCERT has undertaken an assessment of all of the 12 corrective action requests (CARs) and reduced all of the moderate CARs to low risk. HealthCERT has closed two of the CARs, however, all 12 will be followed up by the DAA Group during the Surveillance audit.

Note that on the 16 June the Executive Leadership Team agreed to conduct an internal patient tracer audit late September within the divisions of Medicine, SAPS, Kidz First and ARHOP prior to the planned Surveillance Audit in December 2020**.**

Prepared and submitted by: Dr Lesa Freeman, Patient Safety and Quality Assurance Lead on behalf of Dr Jenny Parr, Chief Nurse and Director of Patient Experience.

Glossary

Auditor	An auditor is a person who holds a qualification in quality auditing that meets HealthCERT minimum requirements.
Certification Audit	A certification audit is undertaken to determine if a provider is meeting the relevant Health and Disability Service Standards. The audit should meet all relevant requirements of the HDSS NZS 8134:2008 using a streamlined audit approach.
Corrective action request (CAR)	Audit teams shall generate a corrective action request for each audit finding resulting in a partially attained or unattained rating.
Designated auditing agency	An auditing agency for the time being designated under section 32(1) of the Health and Disability Services (Safety) Act 2001.
HealthCERT	The section of the Ministry of Health responsible for the administration of the Health and Disability Services (Safety) Act 2001.
Surveillance Audit	A surveillance audit is undertaken part-way through a service provider's period of certification to assure the Ministry of Health that the provider continues to meet all relevant standards. The focus of the audit is on service delivery and review of criteria not fully attained at the previous audit.

Systems tracer	Looks at one system or programme sampling across multiple consumers. Systems-based tracer methodology can be applied to programmes such as medication management or the deteriorating patient.
Tracer methodology	A tracer follows the actual care experience of the consumer who is receiving care and treatment at the time of the audit. Selection of a tracer should include a consumer who is receiving complex care and treatment as their experience shows how the provider's systems and processes support the care they receive.

Purpose

This paper updates the Hospital Advisory Committee on Counties Manukau Health's (CM Health) progress with resolving the corrective action requests (CARs) obtained at the last Certification audit in May 2019.

Executive Summary

Twelve CARs were received during CM Health's Certification Audit in May 2019; ten low risk and three moderate risk. HealthCERT has assessed the progress reports for the moderate risk CARs that were submitted in November 2019 and the progress reports for the low risk CARs submitted in February 2020. All of the moderate risk CARs have been reduced to low risk and two CARs have been closed, however, all 12 CARs will be followed up by the DAA Group during the Surveillance audit.

HealthCERT does not require CM Health to provide further reporting on the CARs. Implementation plans for each CAR will be followed up by the DAA Group during the Surveillance audit in December 2020. It is proposed that an internal patient tracer audit is conducted at the end of September within the divisions of Medicine, SAPS, Kidz First and ARHOP.

Background

All providers of healthcare services in New Zealand are required to be certified by the Ministry of Health under the Health and Disability Services (Safety) Act 2001 to meet the NZS8134:2008 Health and Disability Services Standards. HealthCERT's role is to administer and enforce the legislation, issue certificates, review audit reports and manage legal issues.

Twelve CARs were received during CM Health's Certification Audit in May 2019; ten low risk and three moderate risk. Two continuous improvement ratings were further received for the Fundamentals of Care Programme, and Infection Prevention and Control's response to an outbreak of multiple carbapenem resistant organisms.

In July 2019 HealthCERT provided notification that Counties Manukau District Health Board continued to be certified under section 26 of the Health and Disability Services (Safety) Act 2001 to provide health care services from 08 August 2019 for a period of three years. HealthCERT requires that the Surveillance audit must be undertaken by a designated auditing agency by 8 February 2021.

HealthCERT further provided CM Health with a schedule in which to provide written progress reports that outlines all actions undertaken for each of the CARs in accordance with the level of risk and time frame (i.e. medium risk CARs due 6 November 2019, and low risk CARs due 4 February 2020). These reports are to inform the Director-General of Health of progress in accordance with the Ministry of Health requirements.

Discussion

Medium risk CARs

HealthCERT has assessed the moderate risk Certification corrective action requests (CARs) that were submitted in November 2019 and provided feedback to CM Health on 7 April (see Appendix A).

HealthCERT has reduced the following CARs from medium to low risk:

- Criterion 1.2.8.1 -Staffing shortages and skill mix i.e. MRTS (Cardiology), anaesthetists, CSSD service, psychiatrists and midwives.
- Criterion 1.4.2.4 – Spinal Unit and Dialysis Unit facilities are not fit for purpose. Equipment does not display compliance with current testing requirements.
- Criterion 3.1.9 – Sterile equipment used with the operating theatre suite is not able to be traced from the sterilisation department processing to the end patient use.

Further, Criterion 1.4.6.2 –'No audit of Taylors laundry services and linen shortages' have been assessed as completed and this CAR has been closed.

This means CM Health no longer has any moderate CARs.

Low risk CARs

HealthCERT has assessed the low risk Certification CARs that were submitted in February 2020 and provided feedback to CM Health on 15 May.

Criterion 1.2.9.10 'All records pertaining to individual consumer service delivery are integrated' (patient records and documentation integration) has been assessed as completed and this CAR has been closed.

The following low risk CARs remain open:

- Criterion 3.3.1 IV Access devices
- Criterion 2.1.1.4 Bedrails plus restraint/enabler knowledge
- Criterion 1.3.13.5 Patient fridge monitoring
- Criterion 1.3.5.2 Care Planning within Mental Health and Kidz First
- Criterion 3.1.3 Infection Control Plan
- Criterion 1.3.10.2 Discharge Planning within Surgical services and Kidz First
- Criterion 1.3.12.1 Medicine Management

HealthCERT has advised that CM Health will not be required to provide further reporting on the CARs. Implementation plans for each CAR will be followed up by the DAA Group during the Surveillance audit.

The Surveillance audit will commence on Tuesday 8 December 2020. CM Health will be required to submit Part A - the self-assessment evidence by the end of October in preparation for Part B - the on-site audit in December.

Subsequent progress with CARs

Following submission of the progress reports to HealthCERT in November 2019 and February 2020 steady progress is being made on the below CARs:

- A choosing wisely peripheral lines project commenced in May to reduce unnecessary peripheral intravenous line (PIVL) insertions and increase the monitoring of PIVLs. (Criterion 3.3.1)
- Medicine and ARHOP are undertaking monthly Care Compass bedrail auditing. A further point prevalence audit of the bedrail decision sticker is planned for 12 August (Criterion 2.1.1.4).
- An organisational patient food fridge audit is planned for July, 6 months post implementation of the new food fridge monitoring form (Criterion 1.3.13.5).
- The final draft of the Infection Control Plan will be tabled at the Infection Control Committee July meeting for endorsement, prior to being presented to the Clinical Governance Committee for ratification (Criterion 3.1.3).
- Kidz First has created a new discharge document which is commenced on admission. This discharge document was implemented in February and is currently being audited (Criterion 1.3.10.2).

- Mental Health services are currently updating all of their guidelines and procedures that are relevant to care planning and have an ongoing quality improvement initiative relating to care planning (Criterion 1.3.5.2).

It is expected that some of the CARs will remain open / un-resolved at the time of the Surveillance Audit in December. These CARs include:

- Criterion 1.4.2.4 – Spinal Unit and Dialysis Unit facilities are not fit for purpose.
- Criterion 1.2.8.1 -Staffing shortages and skill mix i.e. anaesthetists, psychiatrists and midwives.
- Criterion 3.1.9 – A project team was set up to develop a system to ensure that all sterile equipment processed through CSSD was scanned and tracked. However, the project team stopped meeting in December 2019 and it was decided that the Healthy Together Team (HTT) would manage the project. The HTT has identified that this project will commence at the beginning of July 2020.
- Criterion 1.3.5.2 - Kidz First are in the process of reviewing care planning and aligning it to their model of care. This work has been delayed due to managing COVID-19.
- Criterion 1.3.12.1 - Medicine Management. A number of issues highlighted within the CARs will be corrected by implementation of MedChart. However, MedChart is yet to be rolled out to some divisions (i.e. Women's Health, Kidz First and Tamaki Oranga).
- Criterion 1.3.10.2 - Discharge Planning within Surgical Services - This is part of a larger piece of work under acute patient flow which is primarily focussing on identifying patients with complex discharge needs and improving the co-ordination of care.

Further issues identified

Further remedial work will need to be undertaken in order to mitigate issues regarding the out of date controlled documents prior to the Surveillance Audit. The Controlled Document Committee set a target to reduce the amount of out of date controlled documents to 10% by June 2019. The percentage of out of date controlled documents has crept up by 2 to 3% since February 2020 ie: 15.6% February, 17.3% March, 17.6% April, 18.08% May, 16.9% June (see Appendix B May and June reports).

Proposal

Internal patient tracer auditing

Following the inaugural internal patient tracer audit in January 2020 a further one day tracer audit training for 15 staff was planned for April and a six monthly patient tracer audit on 24 June 2020. However, due to the impact of the COVID-19 pandemic the training workshop and June internal patient tracer audit were cancelled.

The rationale behind undertaking the six monthly internal patient tracer audits was to build capability and capacity of CM Health staff to perform the patient tracer audits and reduce the number of DAA auditors required for the Surveillance Audits by four auditors**.** This would mean that during the December 2020 Surveillance Audit the DAA Group auditors would only undertake the patient tracers for Mental Health and Maternity (a MoH requirement) and the system tracers for medication management, falls, infection prevention and control, and deteriorating patient. Reducing the size of the DAA Group audit team would result in a cost saving for the district health board of $1,100 (excluding GST) per auditor a day, plus travel and expenses. There would also be a reduction in the number of staff required to chaperone the auditors, and support the auditors in reviewing electronic information contained on eVitals and MedChart.

An internal patient tracer audit will be conducted at the end of September within the divisions of Medicine, SAPS, Kidz First and ARHOP and the patient tracer audit reports for each division are submitted as part of the self-assessment evidence. The DAA Group auditors in turn will follow-up on the identified areas that require improvement from the internal patient tracers as well as the CARs from the Certification audit.

Appendices

1. Corrective Action Progress Monitoring Report
2. Controlled Document Overviews (May and June 2020)

Corrective Action Progress Monitoring Report

Provider name	Counties Manukau District Health Board	**Primary Service Type**	Public Hospital
Auditor group	The DAA Group Limited	**Lead Auditor**	Joanna Harper
Type of audit	Certification Audit	**Date of audit**	7 May 2019 to 10 May 2019

Corrective Action Details	DHB Evidence and Assessment	HealthCERT Analysis
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. Attainment: PA Moderate Finding: Vacancies in several areas are impacting on the ability to provide timely care and/or cope with increasing demand. This was evident within the mental health services, CSSD, cardiology where there are insufficient MRTs, and for anaesthetists and midwives. Corrective Action: Strategies are progressed to fill vacancies in those areas where this has been identified as impacting on timely service delivery. Timeframe: 90 days	**DHB Evidence November 2019** Staffing Shortages Recruitment Information The Career website has been updated to improve brand awareness and reach. Future sourcing campaigns have been planned. Recruitment is working with workforce teams regarding the pipeline candidates and promoting health as a career. 1. MRTs On-going recruitment is being undertaken locally and oversees. HR is working with the service to look at how we can also retain our MRTs. Work is being undertaken to introduce a casual bureau for MRTs to attract MRTs from private sector or other areas to pick us some casual shifts so we can fill the rosters. CM Health has currently 12 FTE recruited to start between now and January 2020 and a further 9 candidates are at varying points in the recruitment process. Staff engagement work is also being	**HealthCERT Comments April 2020** Some progress made with implementation of the corrective action. Information provided showed several initiatives implemented to address the staffing shortage. Risk was reduced from Moderate to Low. The implementation of this requirement to be followed up at the surveillance audit scheduled for 8 December 2020.

	undertaken internally focussing on staff retention. 2. Anaesthetists Recruitment has had a 12 month plan this year to constantly recruit. CM Health has had a rolling advert and now have many pipeline candidates. Recruitment is also holding bi-monthly meetings with the service to discuss vacancies and candidates etc. 3. Psychiatrists Oversees recruitment has been working.- Recruitment has a few more pipeline candidates due to start in the coming months 4. Midwives In September 2019 CM Health appointed a Chief Midwife role. This new Chief Midwife role will focus on Women's Health and the on-going recruitment of midwives. Monthly Workforce meetings are set up between the Women's Health Service and Recruitment. Further a regional recruitment collaboration has been established. 5. CSSD There are currently 1.7 FTE vacancies (3%) within CSSD. CSSD has been approved an additional 3 FTE (as at Jul 2019) to support the development and training of workforce and complete the implementation of instrument tracking system. These roles are to be filled. The service has also done some addition planning around resources and is putting forward a decision paper for additional staffing over the next 3 years.	
Criterion 1.2.9.10 All records pertaining to individual consumer service	**DHB Evidence February 2020** When a patient is admitted into a ward, the ward	**HealthCERT Comments** The DHB provided evidence of a process

delivery are integrated. Attainment: PA Low Finding: In surgical services (except MSC) and ICU, not all records pertaining to individual patients are integrated. Corrective Action: Implement a system to ensure all individual patient records are integrated. Timesframe: 180 days	clerk requests the paper records from Clinical Records (aka "old notes). These "old notes" are delivered to the ward and are available for the staff to review if required. All of the paper documentation generated during the admission is clipped into a folder – they are not held loosely. The paper documentation remains in this folder until the patient is discharged. After discharge the ward clerk unclips all of the paper documentation generated during the admission and puts it into a cardboard folder which is rubber-banded to the "old notes" and sent down to Clinical Records. The Clinical Records clerks then "stack" the paper documentation generated during the admission into the "old notes" in the correct "stacking order" and each admission has its own section in the paper records. It may be possible that a clinician reviewing the "old notes" while on the ward may inadvertently place some paper information in the old notes, but this is not able to be avoided. If this occurs, it is stacked into the records in the correct place after discharge. Counties Manukau Health's Service Manager, Patient Information has advised against filing the ICU/HDU charts in the main paper record. These ICU/HDU charts are not referred to post discharge in the ward or in subsequent outpatient appointments. The electronic information is available, and the charts would increase the number of paper records needed for each patient who went through ICU/HDU, lengthen the stacking process and reduce the storage capacity in Clinical Records.	implemented to ensure all records pertaining to individual consumer service delivery are integrated. No further action is required. This CAM is now completed. 2 May 2020.

Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives. Attainment: PA Low Finding: Discharge planning is occurring; however, the documentation related to this is not consistently included in clinical records sighted in surgical areas. There is a discharge protocol for adults prior to leaving the post anaesthesia care unit (PACU); however, there is not one for paediatrics. Corrective Action: Discharge plans be documented in surgical services. A discharge protocol for the paediatric PACU be developed and utilised. Timesframe: 180 days	**DHB Evidence February 2020** Previously developed document/documents tested. In late December 2019, a workshop was held with to better understand the processes, what works well, what causes frustration, and ideas for improving the coordination and communication of activities. These ideas have been themed and the group met again in January to prioritise change ideas and plan next steps: Improve the timeliness and coordination of assessments, clarify referral criteria and develop guidelines to the specialist services that provide input into discharge decision-making. In the next 90 days to: o Establish a small working group. o Clarify criteria for referrals to NASC, ARHOP and Psychological Medicine and create guidelines for the wards to refer to these services. o Create an information decision tree for wards to support timely referrals to specialist services. o Develop and test a daily report from NASC to acute Allied Health of NASC Community waitlist patients admitted to hospital with the aim to move their assessment from community to acute without the need for an additional referral. This will reduce rework and increase visibility of at-risk patients early in their stay. o Improve the proactive management of older/frail patients to reduce risk of deconditioning,	**HealthCERT Comments** Some progress is made with implementation of this corrective action. Information provided showed several initiatives to reduce risks associated with transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives. The risk rating remains low. The implementation of this requirement to be followed up at the surveillance audit.

	In the next 30 days to: o Establish a working group. o Gain an understanding of the history of 'Get up, get dressed, get moving' which was piloted on W21 and identify current status and next steps for further testing and implementation. Improve and standardise the screening of and care for patients with delirium and dementia, including developing a dementia register, standardised care pathways and care plans for patients with delirium and/or dementia. In the next 90 days to: o Form a working group to scope the work and develop a project plan o Explore the IT requirements, feasibility and timelines for developing a Dementia register and corresponding alert system. o Support the business case to switch from the existing CAM score to 4AT as the standardised delirium screening tool. o Explore if there is an existing dementia screening tool. o Explore if there are existing care plans used elsewhere for patients with delirium and/or dementia. Implement and standardise the use of enablers of patient flow and proactive discharge planning, including: SAFER bundle on Medicine wards, Daily MDT-huddles on Medicine wards, patient bed-side 'My Care Boards'. In the next 90 days to: o Establish a working group (within 30 days), scope work involved and develop work plan (within 90 days).	

	Counties Manukau Health has initiated a 'Plan of Care 2020 Documentation and Practice of Patient Centred Care Using the Fundamentals of Care Framework' project. This project aims to develop, test and implement an electronic, person centred Plan of Care document, aligned to the Fundamentals of Care Framework and a revised Model of Care, reflecting patients' individual physical, psychosocial, spiritual and whanau needs. This new approach will assist with identifying and documenting barriers to discharge and associated actions undertaken. The project's working group is still to be formed, and early work will include developing a work plan and timeline.	
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. Attainment: PA Low Finding: Not all aspects of the medicines management system are effectively implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. Corrective Action: Consistently implement a system which ensures the following elements of medicine management comply with policy, legislative and best practice requirements: Paper National Medication Chart, Electronic MedChart	**DHB Evidence February 2020** Prescribing & Medication June CD Audit by paediatrics pharmacist showed legislative requirements being met. Audit will be conducted every 6 months. January audit showed: When new prescribers are on the ward (ie Doctor rotations) the pharmacist conducts a prescribing education session to highlight legislative requirements and provides feedback regularly if noting requirements not met Education was provided mid last year and another four sessions of education to PGY1 in November along with education to orthopaedic, plastics and paediatric house officers prior to their run. Med Chart is currently not planned. Med Chart Prescribers are all trained face to face and via an online module before receiving access to Med Chart. They are shown how to enter a reason for discontinuation and its importance. Discharge Having the ability to add comments around	**HealthCERT Comments** Some progress made with implementation of this corrective action. Information provided showed several initiatives to reduce risks associated with the medicines management system not meeting the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. More information is required around maintaining CD registers, disposal of CD's and the outcome of the medication room build at Pukekohe Hospital. The risk rating remains low. The implementation of all outstanding aspects of this requirement to be followed up at the next surveillance audit.

(e.g. comments for discontinued medicines), Controlled Drugs (C.D register 6 monthly checks and disposal of patients own controlled drugs) and at Pukekohe, Medication room temperature. Timesframe: 180 days	discharge is not currently part of their system and CMDHB is looking into the possibility of adding this into the system. Controlled Drugs This is in progress. Pharmacist complete reconciliation of CD Audit every 6 months. New method of Data collection started in August. A chart with useful tips for nurses was also provided which covers CDs. Education day called 'Summer Series' to also cover discussions regarding medications and CD. Medication Room Environment A design quoting and a business case for capital expenditure has been put forward which was approved by the capital committee around October 2019. Pukekohe Hospital is waiting for the builders to fit this in to their schedule. New tentative start date was February. Pyxis machine is not being ordered/authorized yet.	
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. Attainment: PA Low Finding: In the paediatric surgical ward, ward 32 North, ward 7 and ward 9, fridges that store patients' food are not being managed safely with temperature monitoring inadequate and/or food not stored safely within the fridge. Where temperatures are noted to be above the recommended range this has not been remedied.	**DHB Evidence February 2020** Evidence showed a new food fridge monitoring form has been developed that as well as including the daily temperature monitoring to ensure that the fridge is maintained between 1 and 5 oC, it also includes checking to ensure that all of the food is covered and dated, the fridge is in working condition,the electrical safety test sticker is up to date, and that the fridge is clean and tidy. This form also provides information on what to do if the fridge temperature is outside of range and the maintence of the forms (see attached form). This new patient food fridge monitoring form went live on Monday 3 February following extensive communication via a number of mediums including;	**HealthCERT Comments** Some progress made with implementation of this corrective action. Information provided showed the implementation of fridge temperatures monitoring and maintaining the recommended range. The systems and processes for ensuring patient food fridges are being monitored still to be implemented. The risk rating remains low. The implementation of this requirement to be followed up at the surveillance audit.

Corrective Action: Patients' food held in ward areas is stored safely, including effective monitoring of fridge temperatures and follow-up for any out of range temperatures. Timesframe: 180 days	email, forums and bureau staff facebook.	
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. Attainment: PA Low Finding: Care planning continues to improve; however, the related documentation is not being consistently completed in some areas. Evidence of the assessment process was not consistently sighted as being utilised to inform the care plan. Within the mental health area care plans are not integrated. Corrective Action: Ensure care plans in paediatric areas (Kidz First medical and surgical) reflect the required support or intervention identified by the assessment process. Review the care planning and review process to create a common MDT recovery focused care plan within mental health services. Timesframe: 180 days	**DHB Evidence February 2020** Mental Health Services From July 2019 teams sent representatives to one of the 6 Introductory Sessions provided. There were 74 attendees at these sessions. A further two sessions were provided to specific teams on request. The information presented at the sessions was emailed to all MHS staff and is available via the HCC intranet website. The Project Manager liaised with the HealthAlliance IS trainers, who attended the sessions and HealthAlliance IS trainers adjusted their training sessions for new users to include the Regional Collaborative Care plan form use and business rules within the HCC training sessions. The change from using several different forms to using the one form has meant that clinicians have used the new form for new service users, but for those who have been under the care of mental health services prior to the rollout of the new form, they have had to transfer information onto the new form when reviewing care and this has been a challenge as it creates additional work. At a recent Clinical Leaders meeting the responsibility for the on-going implementation of the RCCP was given to the four Clinical Heads. The Clinical Heads are going to work with the staff who	**HealthCERT Comments** Some progress made with implementation of this corrective action. Information provided included an overview of changes implemented however the evidence of implementation of these care plans still to be reviewed. The risk rating remains low. The implementation of this requirement to be followed up at the surveillance audit.

	have completed the training to date who will act as champions to support the full implementation. Reviews of Kidz First Care Plan – Daily Plan of Care and processes with Kidz First Inpatient Nursing teams: Developed fit for purpose care plan. Identified areas of duplication, assessed the impact of moving to increased nursing care planning documentation via the care plan - with variances recorded in clinical notes, reduced the volume of duplicate documentation, developed common (KF Surgical) conditions / day stay admissions –potentially develop Day Stay Plan of Care form and ensured alignment with CM Health and Kidz First Policies and Guidelines.	
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. Attainment: PA Moderate Finding: The physical environment is not always fit for purpose or ensures risk of harm is minimised. Corrective Action: Take actions to ensure the physical environments within the Spinal Unit and the Dialysis unit are fit for purpose and minimises risk of harm to patients and staff. Timesframe: 90 days	**DHB Evidence November 2019** The DHB provided a photo of how they are now storing oxygen bottles- secured to walls. The DHB provided a copy of the Equipment Inventory Listing including; the Description; Manufacturer; Model; serial numbers; Cost Centre; Procedure; Frequency and the next date to review. The DHB provided a copy their Test and Tag register. Standard 1.4.2.4 Equipment Compliance Testing Background Information/Introduction Please find enclosed the following documents to serve as evidence of CM Health's current Warrant of Fitness (WoF) Programme: 1. CE's Functionality Reporting Process for Clinical Equipment that provides a Standard Operating	**HealthCERT Comments April 2020** Some progress made with implementation of the corrective action. The Workplace Inspection Action Sheets do not include the dates or when the actions were completed. Information provided showed several initiatives implemented to ensure the physical environment is safe. Risk was reduced from Moderate to Low. The implementation of this requirement to be followed up at the surveillance audit.

	Procedure for our WOF Programme. 2. Latest PM Equipment Inventory Report which identify all our current overdue clinical equipment by status. 3. Two examples of correspondence Clinical Engineering had with two of our Clinical Services to inform them of overdue clinical equipment and to request that the overdue Clinical Equipment should be sent to Clinical Engineering for checking. Clinical Engineering actively monitors the outstanding WoF numbers and reports on the current state on a monthly basis. Please find attached the spread sheet generated during the latest Tag and testing round of equipment. Other evidence includes Bi-monthly workplace inspection Checklists. 1.4.2.4 Portable Oxygen Cylinders Critical Care Complex - ICU The space for the storage of portable oxygen cylinders has been set up appropriately in both ICU and HDU with chains being added. ICU undertake bi-monthly workplace H&S and Building Audit inspection audits (see attached). Kidz First Kidz First has developed an Oxygen Cylinder Action Plan to address the associated paediatric corrective action (see attached). As part of the risk mitigation, the safe storage of cylinders has be added to the Resuscitation room checks (where these cylinders are stored) and checked on a daily basis.	

	Kidz First undertake bi-monthly workplace H&S and Building Audit inspection audits (see attached)	
Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness. Attainment: PA Low Finding: There has been no audit of the Taylors laundry since December 2016. There was no evidence available that recommendations made at that audit have been addressed. It is a requirement of the contract that a yearly audit occurs. During the audit staff reported shortages of linen impacting on patient care and comfort. Corrective Action: Audit of the Taylors laundry is completed at least once a year and any recommendations are followed through to ensure completion. The supply of linen meets the requirements of the clinical areas and patient demand. Timesframe: 90 days	**DHB Evidence November 2019** The DHB provided evidence of Taylors having completed an Operational check using a monthly score-card in July; August and September 2019. This process included a list of legislative requirements, opportunity to check for compliance, and identification of corrective actions/comments. This report also provides graphs of the outcomes of this investigation. The evidence also included meeting minutes (Taylors meeting with the provider) around Health and Safety issues; Linen supply KPI tracking; outcomes of score-cards (audits); alert communication (urgent matters); General business; Taylors pending projects and any other business. The meetings also included follow-up on action points from the previous meeting. The DHB also provided evidence of the 'shortage reports' from Taylors identifying linen shortage the DHB had within each calendar month. Evidence included for the months of July and August 2019. There is also evidence of a weekly 'Business as Usual' report from Taylors to the DHB informing them of supply rate versus utilisation rate, with labour hours and weekly sales.	**HealthCERT Comments April 2020** The DHB provided evidence of audits by Taylors having been resumed and evidence of discussions between Taylors and the DHB around the management of shortages in laundry. No further action is required. This CAM is now completed. 7 April 2020.
Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.	**DHB Evidence February 2020** The draft Infection Prevention and Control Plan 2020/2021 was provided for review. This document was tabled at the November 2019 Clinical Governance Committee and further	**HealthCERT Comments** Some progress made with implementation of the corrective action. Information provided showed that the implementation will have been in early 2020,

Attainment: PA Low Finding: There is no current Infection Prevention and Control programme or plan that clearly defines the programme of work agreed by the ICC with objectives which can be monitored and allows the programme to be reviewed; this should include the work of the ISG and projects undertaken by the infection prevention and control team. Corrective Action: An infection prevention and control programme is developed and agreed by the ICC and reviewed on an annual basis. Timesframe: 180 days	suggestions were made. These suggested amendments have been incorporated into the enclosed Infection Prevention and Control Plan 2020/2021 and tabled at the February Infection and Prevention Control Committee meeting for sign off.	this evidence to be reviewed. The risk rating remains low. The implementation of this requirement to be followed up at the surveillance audit.
Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious. Attainment: PA Moderate Finding: Sterile equipment used within the operating theatre suite is not able to be traced from the sterilisation department processing to the end patient use. This is in variance to current national standards (ASNZS 4187:2014). There is a plan in progress to commence sterile equipment tracking. Corrective Action: The sterile equipment tracking commence in line with current good practice. Timesframe: 90 days	**DHB Evidence November 2019** The DHB provided information around a plan to track instruments; This plan has been developed to complete the implementation of the tracking system (T-Doc), which will follow work on patient level tracking. The document 'Scanning to patients- project. Implementation of the Tracking System (T-Doc) provided information on a variety of action having to be implemented including: Identification of the project group participants; set of regular meetings; Software and hardware requirements in order to fully implement T-Doc including the individual marking of instruments; the business cases to purchase the T-Doc soft/hardware; identification of staffing requirements; actions from meetings to be recorded; Setting up of pack scanning requirements in a test theatre, education of staff and identification of issues and to then continue setting up pack-	**HealthCERT Comments April 2020** Some progress made with implementation of the corrective action. The T-Doc has been developed, and there has been a first meeting around this project. Information provided showed that the implementation will have been in early 2020, this evidence has not been submitted yet. Risk was reduced from Moderate to Low. The implementation of this requirement to be followed up at the surveillance audit.

	scanning requirements in all other theatres and training of staff. Set up pack scanning requirements for all non-theatre areas; educate staff; set up individual markings of all relevant instruments; educate CCSD staff; review of the project and to provide a post implementation report. The document includes opportunity to identify due dates; progress notes and the date at which the actions were completed. Additional staffing resource (1 FTE) for starting this work has been already been approved.	
Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice. Attainment: PA Low Finding: Policies, procedures and guidelines related to intravenous access devices are in place and support good practice; however, documentation sighted in clinical files did not consistently comply with these. Corrective Action: The practices related to vascular access devices be in line with the organisation policy and documentation reflect this practice. Timesframe: 180 days	DHB Evidence February 2020 An organisational point prevalence PIVL audit was conducted in the majority of inpatient areas on 22 May 2019. Five-hundred-and-thirty-three patients were reviewed utilising a 77 question audit tool through survey monkey, 263 of these patients had a PIVL in situ. Results of this audit demonstrated that in 6 to 10% of patients documentation related to the location of the PIVL was not accurate, 29 to 41% of PIVLs were not assessed every nursing shift, 27% of peripheral line insertions were not documented and 30% of patients were unsure or would not ask questions regarding the care of their PIVLs. A spread sheet of results and identified areas of improvement was circulated to identified inpatient areas. Each ward/area was then responsible for developing a plan for improvement with the aim of achieving 80% compliance. A Care Compass Monthly Ward PIVL Audit Report for December 2019 and copy of Senior Leadership Monthly PIVL Dashboard Report or September 2019 was provided.	**HealthCERT Comments** Information provided showed evidence of progress being made with implementation of the corrective action. The risk rating remains low. The implementation of this requirement to be followed up at the surveillance audit.
Criterion 2.1.1.4	**DHB Evidence February 2020**	**HealthCERT Comments**

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. Attainment: PA Low Finding: There is limited understanding of the difference between enabler and restraints and their use (bedsides) in the clinical environment. Corrective Action: Ensure staff are able to make a clinical judgment for the appropriate use of enablers and/or restraint in accordance with Counties Manukau Health's policy. Timesframe: 180 days	The e-learning module on Safe Use of Bedrails became mandatory for all relevant staff to complete on as part of orientation and then on an annual basis in February 2019. Since this time all relevant staff have completed this e–learning module at least once. At the time of the Certification audit in May 2019 the bedrail decision making sticker was being audited in one ward. This bedrail decision making sticker was subsequently rolled out in late May 2019 across all of Counties Manukau Health. As part of the implementation plan communication was provided to all key stakeholders through forums, emails and posters. An audit was conducted in August which has shown an improved understanding of the use of bedrail stickers and documentation in the nursing notes (see enclosed bedrail sticker audit report). The Care Compass Falls audit tool further includes a question that looks into the discussion and agreement of bedrail use: If bed rails are in use, is there a record of the discussion and agreement for the use of bedrails documented in the patient's notes? Put N/A if no bedrails are in use. This Care Compass Falls audit is completed on a monthly basis on 5 randomly selected patients by identified wards. Restraint and Enablers The E-learning module on restraint minimisation and safe practice became mandatory for all staff to be completed during orientation and then annually in February 2019. This ensures that all staff has a review of the difference between an enabler and a restraint each year. This on-line learning module was reviewed, as part of an annual review, and updated in December	Information provided showed evidence of progress being made with implementation of the corrective action. The risk rating remains low. The implementation of this requirement to be followed up at the surveillance audit.

	2019 to ensure it continues to reflect best practice and is engaging staff. Following the May 2019 Certification audit, the understanding of an enabler and restraint has been included as a Fundamentals of Care benchmark and was incorporated into our fundamentals of care audit undertaken in September 2019.	

May 2020 Overview

Below is the latest report providing an overview of the status of CMH Controlled Documents by LDC, showing documents which will soon be due for review, and those documents which are currently overdue.

Documents reported as being overdue require immediate attention. If you have any questions or issues regarding the review process, please contact your Local Document Controller.
LDC contact details are available on Paanui

All Controlled Documents	1812	17.6%	319 281 1212

Breakdown by LDC

Local Document Controller	Total Documents	Percent Overdue	Breakdown by Status
LDC - ARHOP	108	3.7%	4 14 90
LDC - Clinical Governance	63	0.0%	10 53
LDC - Corporate	180	28.88%	52 26 102
LDC - Emergency Department (ED)	101	3.96%	4 14 83
LDC - Infection Prevention and Control	20	20.0%	4 1 15
LDC - Infectious Diseases	23	21.73%	5 9 9
LDC - Kidz First	237	8.01%	19 55 163
LDC - Medicine	174	25.28%	44 27 103
LDC - Mental Health	74	40.54%	30 1 43
LDC - Nursing	73	15.06%	11 11 51
LDC - Pharmacy	23	4.34%	1 4 18
LDC - Primary Health Services	54	3.7%	2 14 38
LDC - Radiology	8	0.0%	1 7
LDC - Renal	87	13.79%	12 21 54
LDC - Surgical and Ambulatory Care Services	417	18.94%	79 50 288
LDC - Women's Health	170	30.58%	52 23 95

Key: Overdue for Review | Review due within the next 6 months | No review due

June 2020 Overview

Below is the latest report providing an overview of the status of CMH Controlled Documents by LDC, showing documents which will soon be due for review, and those documents which are currently overdue.

Documents reported as being overdue require immediate attention. If you have any questions or issues regarding the review process, please contact your Local Document Controller.
LDC contact details are available on Paanui

All Controlled Documents	1816	16.9%	307 267 1242

Breakdown by LDC

Local Document Controller	Total Documents	Percent Overdue	Breakdown by Status
LDC - ARHOP	108	5.55%	6 15 87
LDC - Clinical Governance	63	1.58%	1 10 52
LDC - Corporate	177	22.03%	39 31 107
LDC - Emergency Department (ED)	101	1.98%	2 10 89
LDC - Infection Prevention and Control	20	25.0%	5 1 14
LDC - Infectious Diseases	23	21.73%	5 9 9
LDC - Kidz First	241	8.29%	20 49 172
LDC - Medicine	187	26.73%	50 7 130
LDC - Mental Health	74	35.13%	26 6 42
LDC - Nursing	67	16.41%	11 3 53
LDC - Pharmacy	23	8.69%	2 3 18
LDC - Primary Health Services	54	12.96%	7 13 34
LDC - Radiology	8	0.0%	1 7
LDC - Renal	87	25.28%	22 17 48
LDC - Surgical and Ambulatory Care Services	413	11.38%	47 73 293
LDC - Women's Health	170	37.64%	64 19 87

Key: Overdue for Review | Review due within the next 6 months | No review due

Counties Manukau District Health Board
Hospital Advisory Committee

Human Resources Report

Recommendation

It is recommended that the Hospital Advisory Committee:

Receive the Human Resources report for month ending 30 April 2020

Prepared and submitted by Nirmal Sinha, HR Performance & Systems Development Manager on behalf of Elizabeth Jeffs, Director of HR.

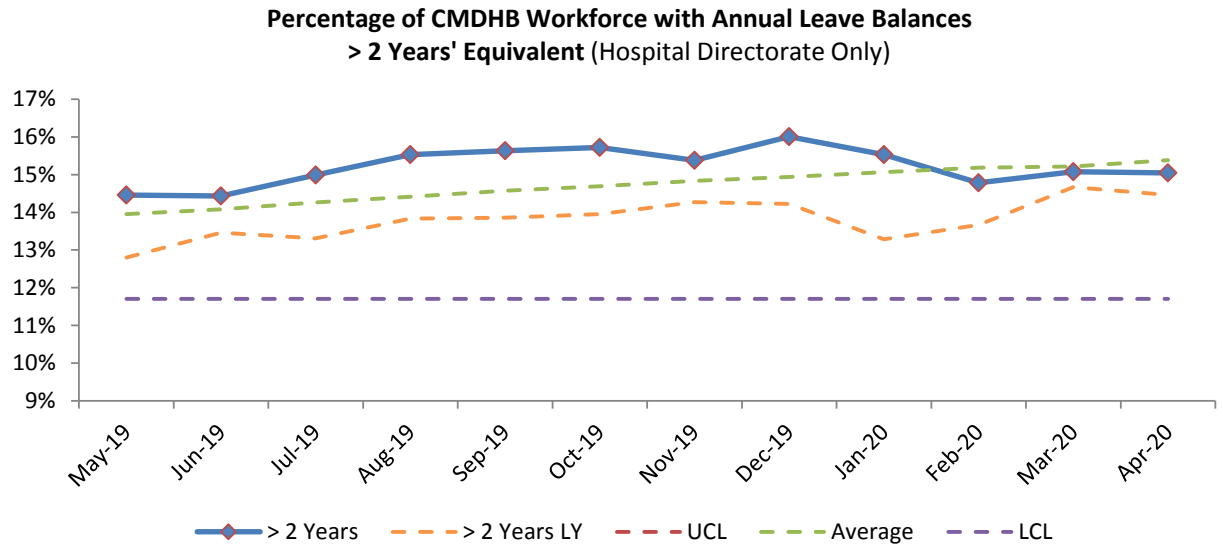
Executive Summary

HR metrics are provided to outline performance for Annual Leave Balances, Sick Leave, Turnover rates, Recruitment Average Time to Hire and Annual Leave Cashups. Below are the 12-month trend graphs to April 2020.

Background

The data in this report is to 30 April 2020. New Zealand entered Covid-19 lockdown on 28 March 2020 and remained in lockdown through April. The data in this report reflects a mix factors - the staff who left were already in the pipeline to leave from before lockdown, annual leave taken was minimal because staff were either working or at home on lockdown with no options to travel and sick leave was minimal because about 800 staff were not working due to their vulnerability, 50% of staff were working from home and there was minimal community transmission of virus and head colds.

Annual Leave Balance >2Years Equivalent in Percentage

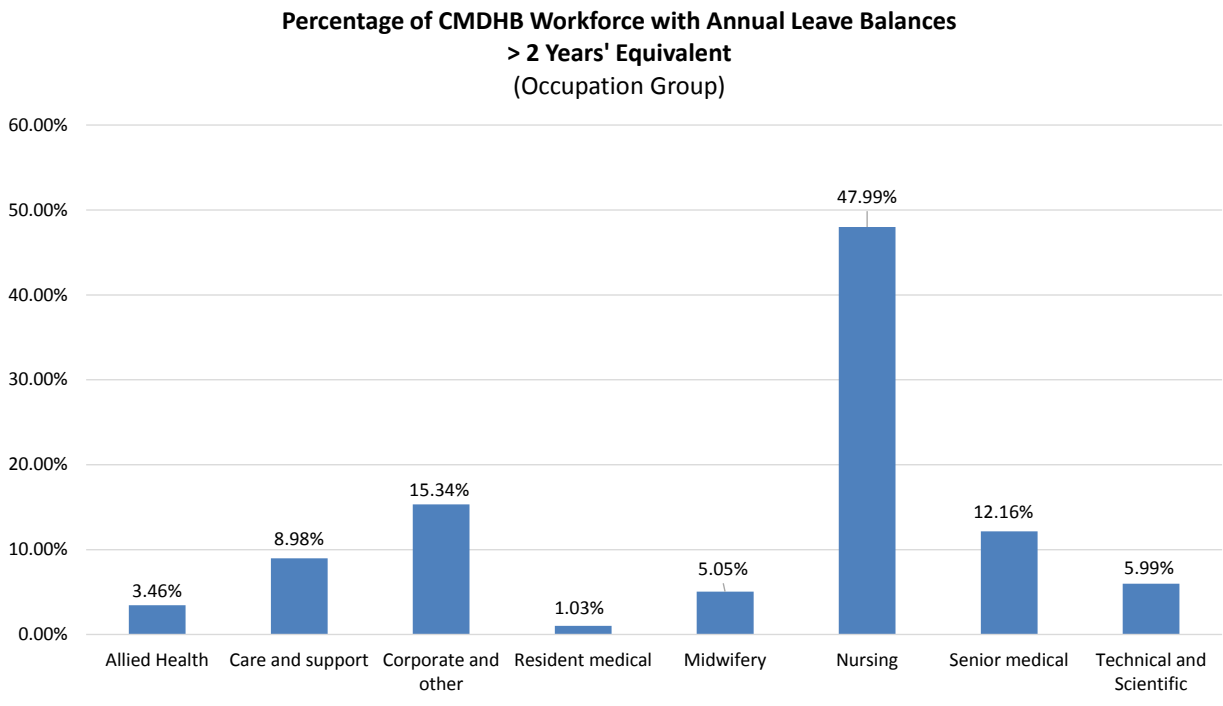


- The Percentage of Staff with more than 2 Years' Annual Leave balance is slightly (0.04%) decreased (↓) in March 2020 compared to February 2020.
- In comparison to the March 2019, Annual Leave balance for March 2020 increased by 0.38% (↑).
- In coming months, Annual Leave balance may increase due to Winter and Covid-19.

HR has following improvement initiatives in place to manage high annual leave balance:

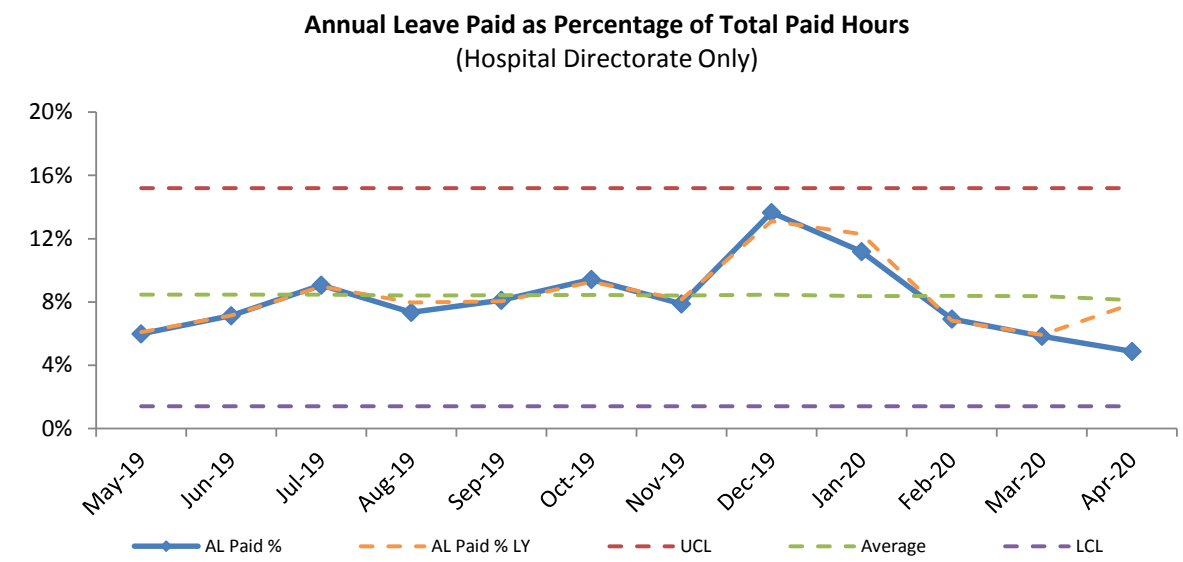
- A monthly automated annual leave balance report is emailed to line managers that have staff with high annual leave balance usage, i.e. who have over 2 years' equivalent annual leave (equivalent annual leave takes FTE into account), or those that are getting close to 2 years equivalent.
- Training programme to assist line managers in better annual leave management is in place.
- "Managing leave" section under 'myPeople' page on Paanui (intranet) provides a quick guide to managers about annual leave and review process.
- Leave balances are readily available on Kiosk for manager and staff.

Annual Leave Balance > 2 Years Equivalent by Occupation Group



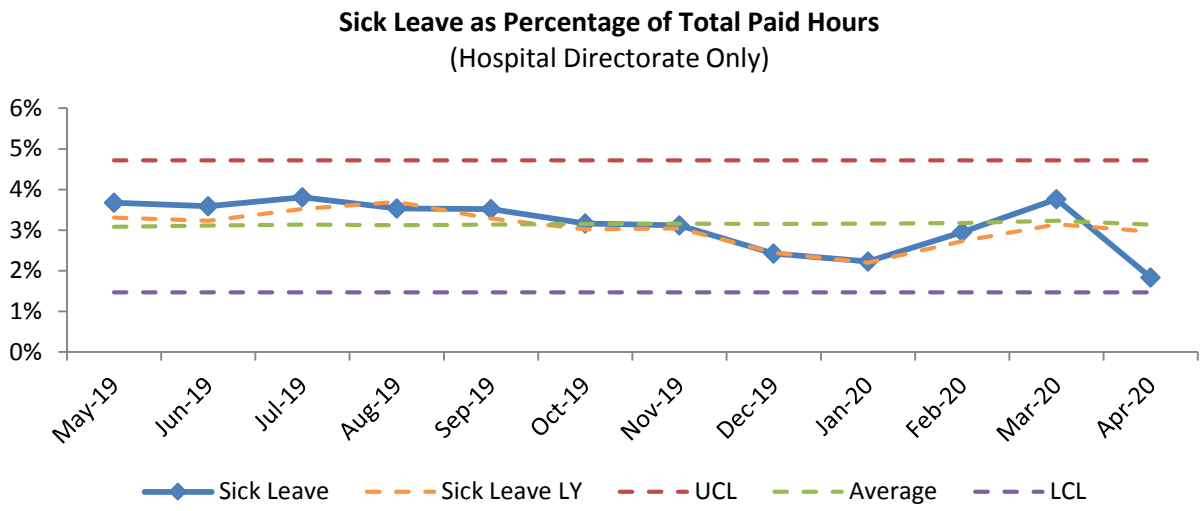
- The Percentage of Staff with more than 2 Years' Annual Leave balance is highest in Nursing, followed by Corporate and Senior Medical.

Total Annual Leave Paid Hours in Percentage



- As expected, Annual Leave usage is higher for December (13.66%) and January (11.19%).
- In comparison to March 2019, Annual Leave utilisation for April 2020 was less.

Sick Leave as Percentage of Total Paid Hours

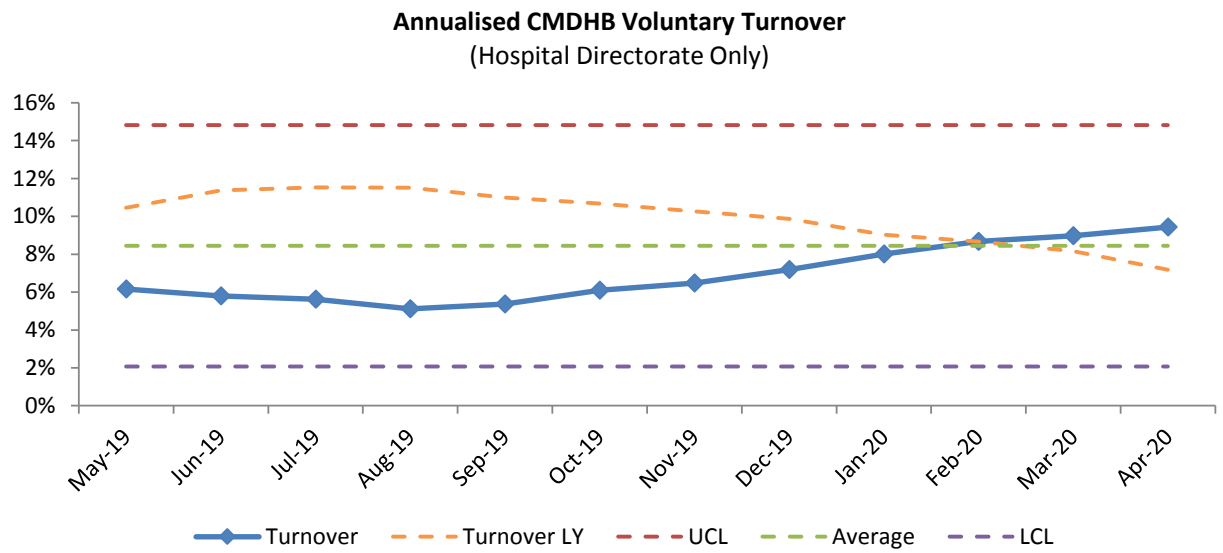


- Sick leave for April 2020 is below average at 2.15%.
- In comparison to the April 2019, sick leave utilisation for April 2020 decreased by 0.73% (↓).
- A target of 3% has been set for sick leave metric and based on previous 12-month utilization; CM Health is averaging at 3.21%.

HR has the following improvement initiatives in place to support Sick Leave metric:

- A monthly automated sick leave report is emailed to line managers that have staff with high sick leave usage, i.e. sick leave taken in 33% or more of months the employee has worked.
- Training programme to assist line managers in better sick leave management.
- "Managing leave" section under 'myPeople' page on Paanui (intranet) provides a quick guide to managers in relation to sick leave and review process.

Annualised CM Health Voluntary Turnover



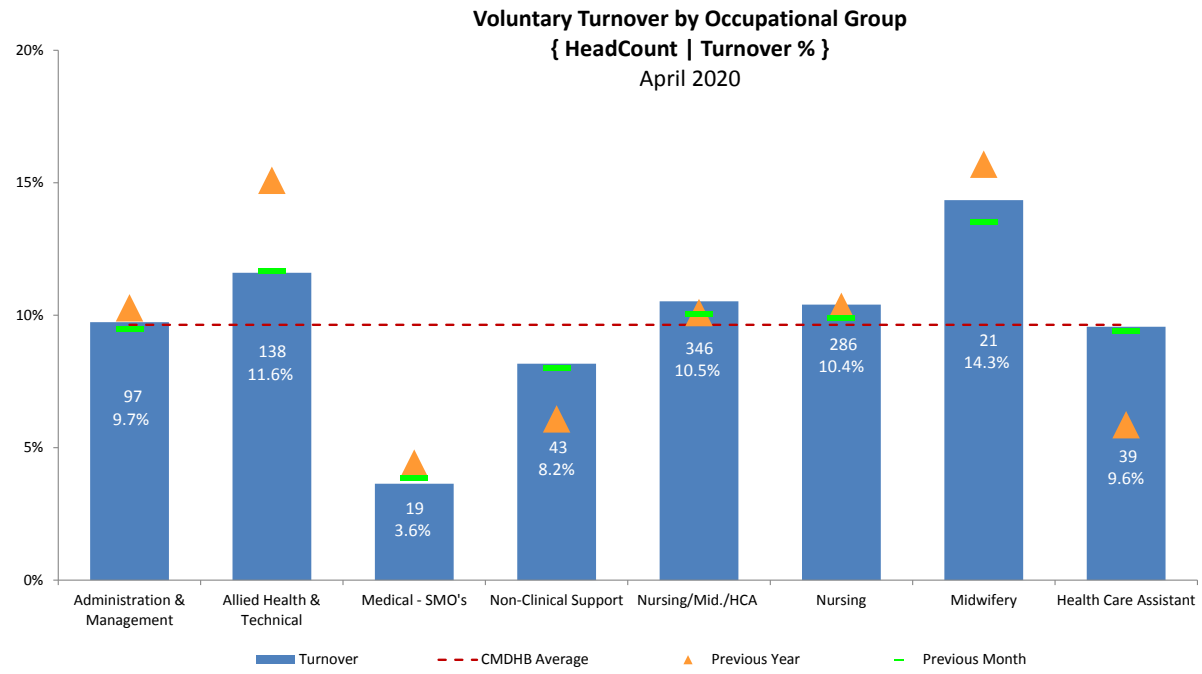
- Annual Voluntary Turnover for April 2020 has increased (0.28%) compared to March 2020.
- In comparison to April 2019, Annualised Turnover for April 2020 increased (↑) by 0.69%
- Turnover is anticipated to decrease (↓) in the following months due to Covid-19.

The organization has the following initiatives in place to manage turnover:

- A target of 12% turnover has been set to show that if new employees joining CMDHB can add value and outweigh the cost attached to recruitment, on boarding and training, then high turnover is a positive outcome.
- Engaging with direct managers to ensure when a key role gets vacant, a proactive process is in place.
- Reviewing leaving FTE to work on proactively retaining talent by focusing on employee experience.
- Staff engagement opportunities are in place to ensure job satisfaction.
- "My employee is leaving" section under 'myPeople' page on Paanui (intranet) provides a quick guide to managers about various termination categories.

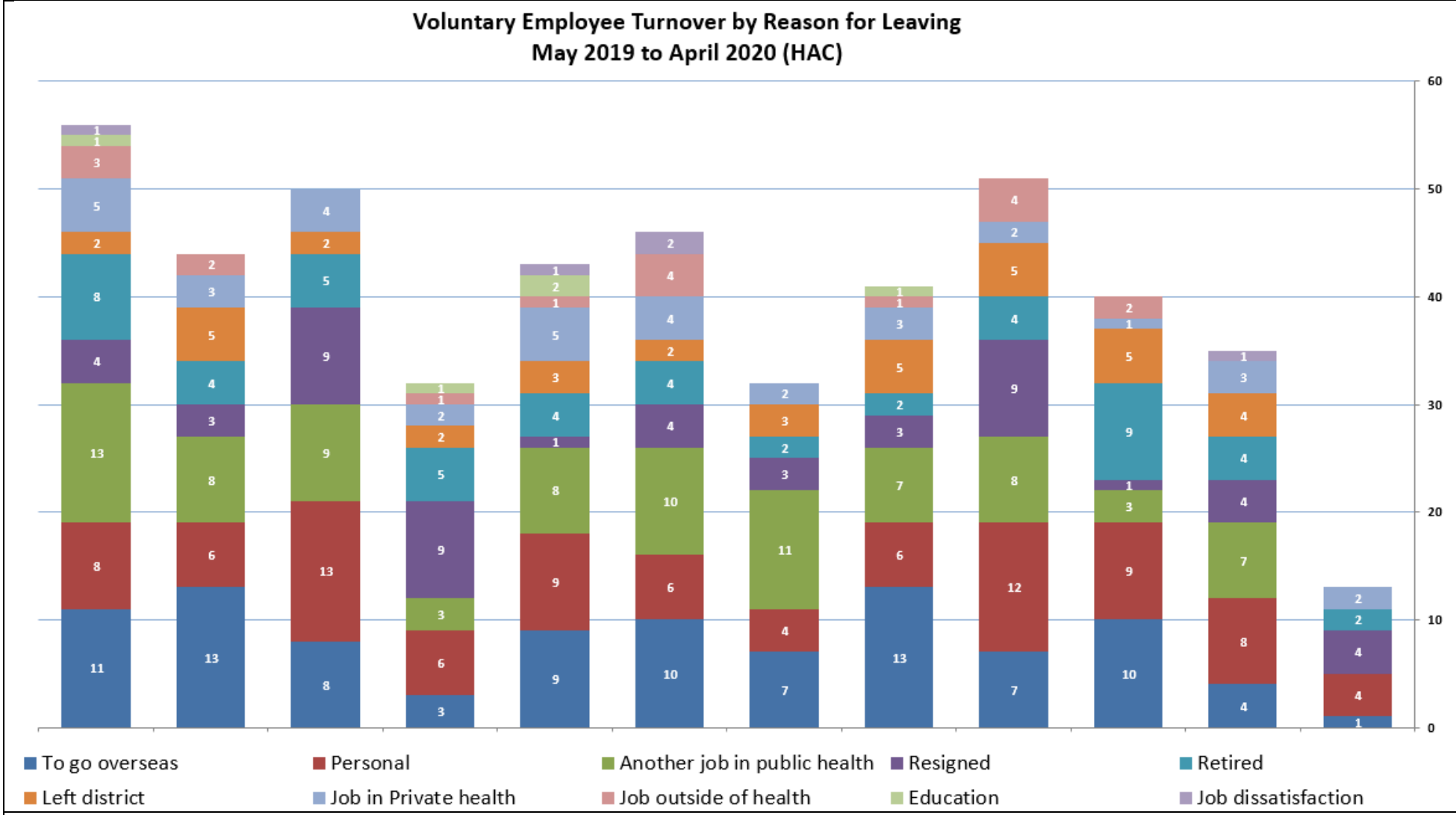
CMDHB's HR team is looking for opportunities to reduce unwanted turnover and analyzing exit reason information and length of service for exiting staff to help develop workforce strategies by retaining key personnel and top performers.

Voluntary Turnover by Workforce Group



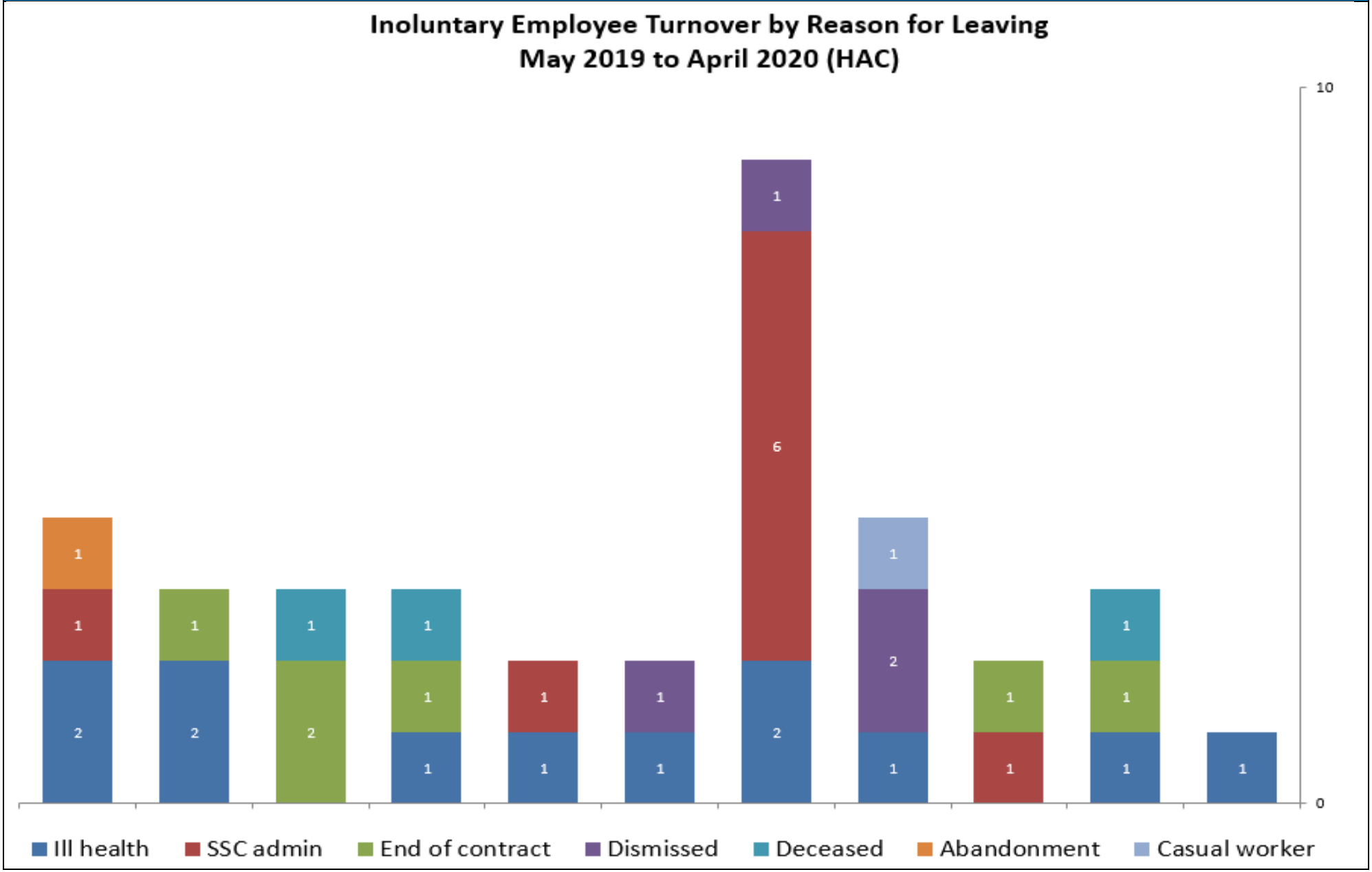
- This graph represents CMH as a whole and cannot be split to identify Hospital Advisory Committee only data.
- On a 12-month average, highest turnover was recorded for Midwifery group at 14.3%, followed by Allied Health at 11.6% and Nursing at 10.4%.
- Overall CM Health's turnover has decreased by 0.4% in comparison April 2019

Voluntary Turnover Reason Categorisation



- During May 2019 – April 2020 the top three reasons for staff leaving:
  - Personal
  - Another job in public health
  - To go overseas

Involuntary Employee Turnover by Reason for Leaving



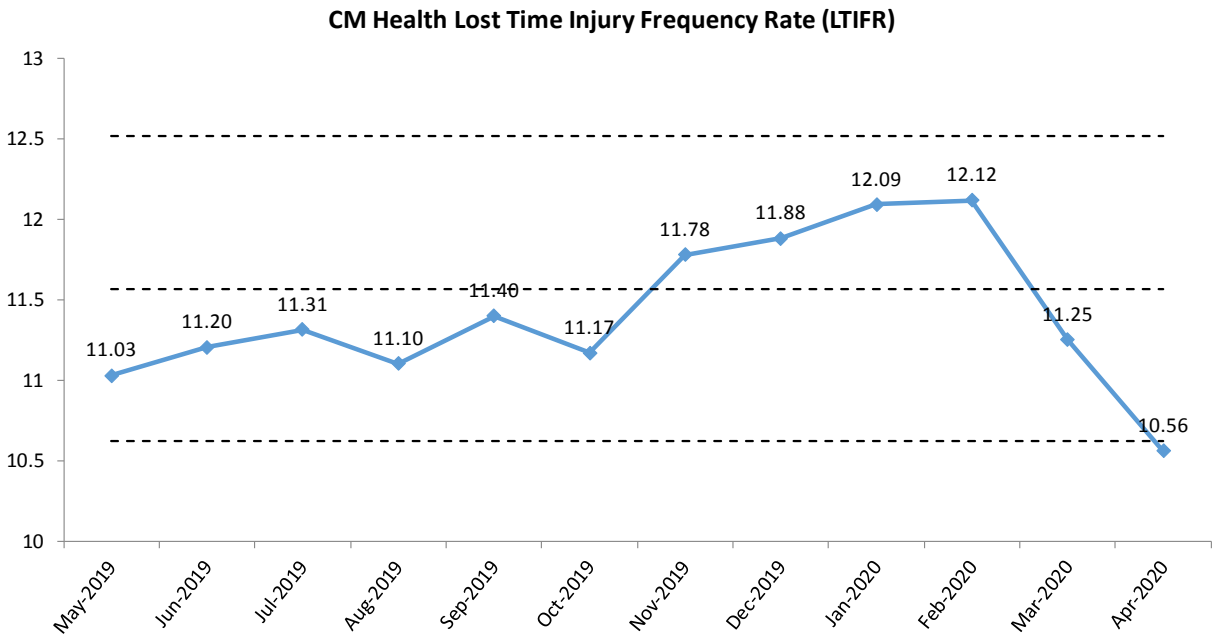
LTIFR (Lost Time Injury Frequency Rate)

LTIFR

12 month rolling average figure remains slightly above the target (10) at 10.56 in April 2020 (1 lost time incident). The April 2020 figure (10.56) decreased from the March (11.25).

The figures reported below have decreased from previously reported figures due a change in the reporting methodology to include all hours worked within the organisation to determine the LTIFR 12 month rolling average figure.

The historical LTIFR figures will continue to fluctuate due to possible changes in the overall hours worked (due to directorates getting in hours late to payroll) and an increase in accepted LTI claims (due to the timeframe set by ACC to accept/ decline a claim).



LTIFR - Number of Lost Hours per million hours worked

- This graph represents CMH as a whole and cannot be split to identify Hospital Advisory Committee only data.
- **LTIFR** (**L**ost **T**ime **I**njury **F**requency **R**ate) = (Number of Lost Time Injuries / Hours Worked) x 1,000,000.

Note:

- In April, there were 17 new claims registered with 1 lost time claim.
- Current claims being managed by the CM Health and WellNZ Case Managers was 86 in April

Lost Time Injury Frequency Rate (LTIFR) as an indicator of safety performance.

As a means of identifying if businesses are continuously improving and reducing incidents causing significant workplace injury or illness, LTIFR is often used across industry groups.

LTIFR is a measurement of safety performance representing;

- the number of incidents per month that required the injured person to take days off work for their recovery
- the total number of hours worked across the organisation in that month

Because this figure is very tiny, the recognised calculation across industries is to multiply this figure by 1 million (or 200,000 for some organisations).

The calculation for Counties Manukau is therefore; (the number of Lost Time Injuries / total hours worked) x 1,000,000.

It should be noted that LTIFR does not mean a safe or unsafe work environment, but it represents a simple way to calculate injuries and illnesses over time and to benchmark and compare the organisation against other similar organisations. As in the above statistics, LTIFR is a Lag Indicator (focusses on past events) whereas Lead Indicators can be implemented to help avoid future incidents.

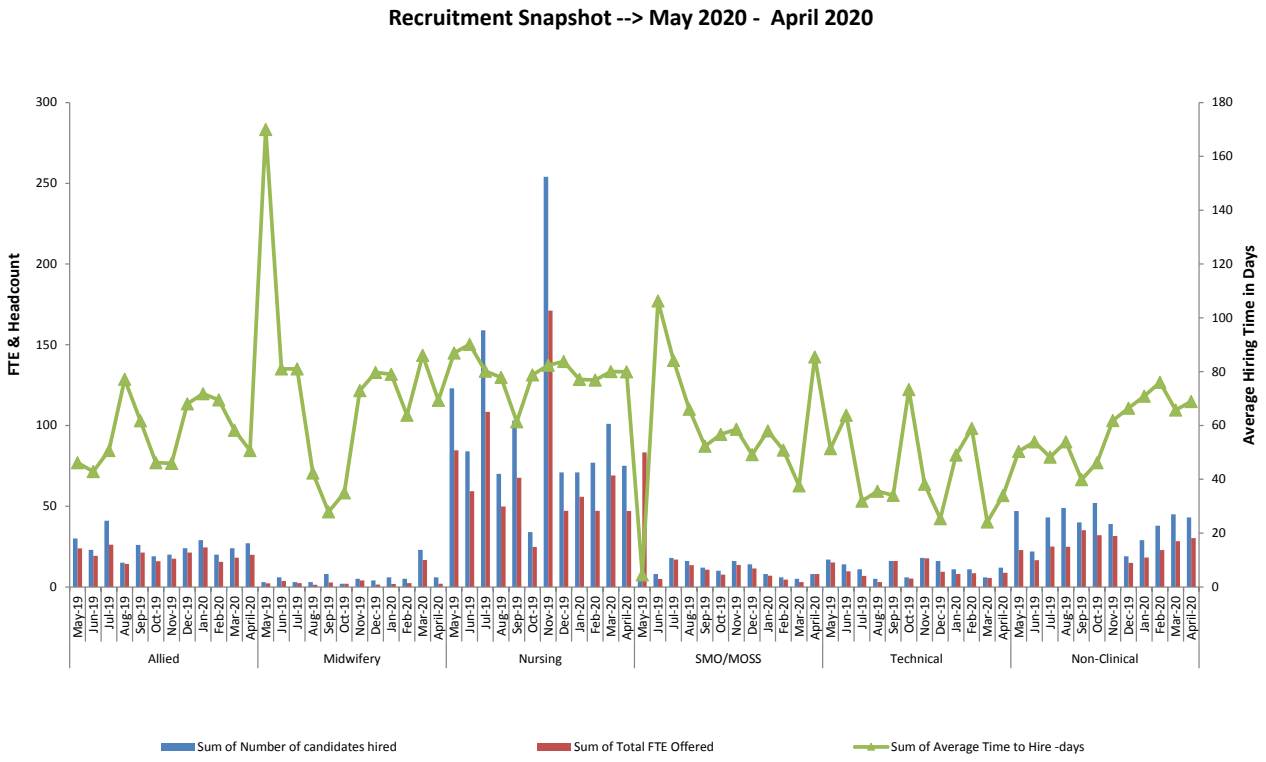
Severity Rate measures how critical the injuries and illnesses were for work related claims. Severity Rate describes the number of actual lost work days including those where medical restrictions are applied (eg alternate duties).

Injury Severity Rate = (number of work days lost + light duty days lost) x 1,000,000/ total hours worked

Lead and Lag indicators are often used to measure improvements and challenges across the organisation however it is worth noting caution must be applied when recording incidents as a lag indicator. The aim is always to ensure all incidents are reported, regardless of their severity so an increase in incidents (and near misses) being reported is generally acceptable. This enables us to focus on our trends and critical H&S Risks. Lead indicators should assist in reducing harm across the organisation and should be a big focus for Counties Manukau Health. Increased Lead Indicator reporting should be noted this year.

Organisational Recruitment Indicators

Recruitment – Hired FTE, Headcount and Average Time to Hire in Days

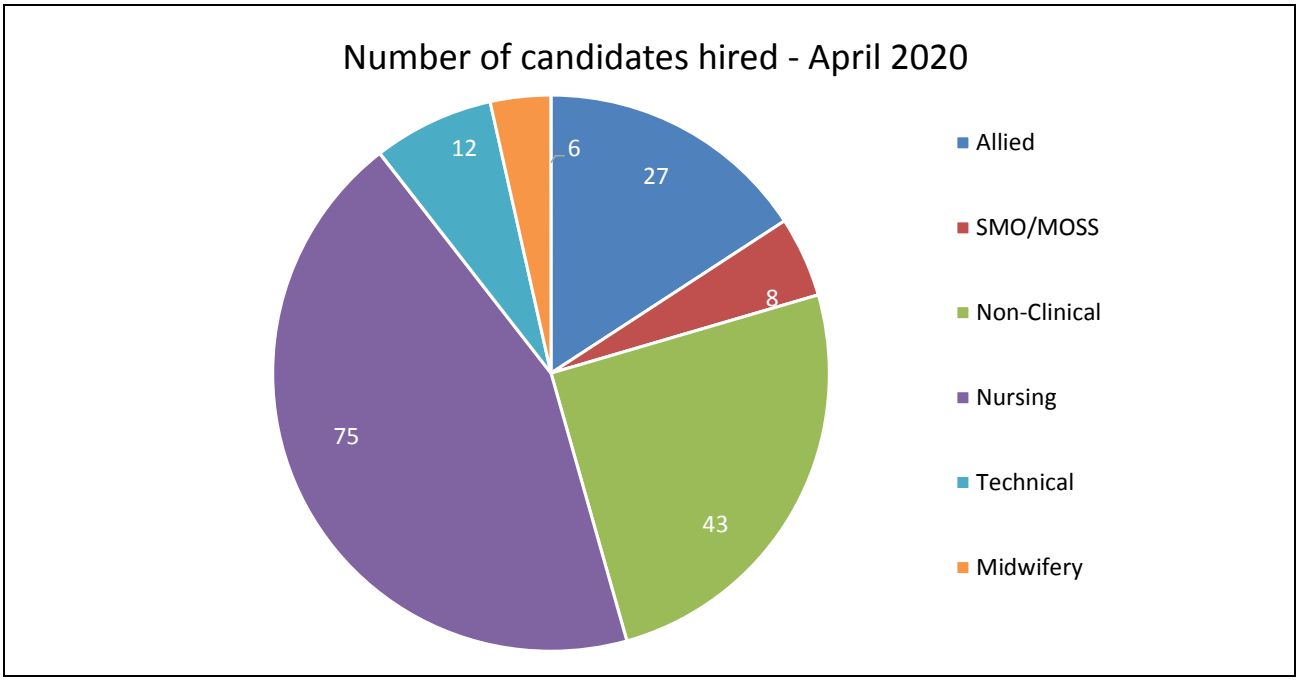


Recruitment – Hired FTE, Headcount and Average Time to Hire in Days

Professional Group	Average Time to Hire Days	Total FTE Offered	Number of Candidates Hired
Allied	50.67	19.95	27
SMO/MOSS	85.50	8.0	8
Non-Clinical	68.92	24.32	43
Nursing	79.97	47.0	75
Technical	34.0	5.0	12
Midwifery	69.33	2.0	6
Totals	**70.44**	**116.17**	**171**

This graph is for CMH including Hospital Advisory Committee

*The Time to hire includes the full end to end recruitment process from the Time the Vacancy (ATR) has been approved until the candidate accepts the offer online by ticking the acceptance box. There are many steps which include advertising the role, CV screening, Hiring manager reviewing and shortlisting CV's, interview set up and interview conducted, reference checks, offer of employment process of contract being approved and then the candidate accepting the offer. The process is the same for internal staff moving into another role.



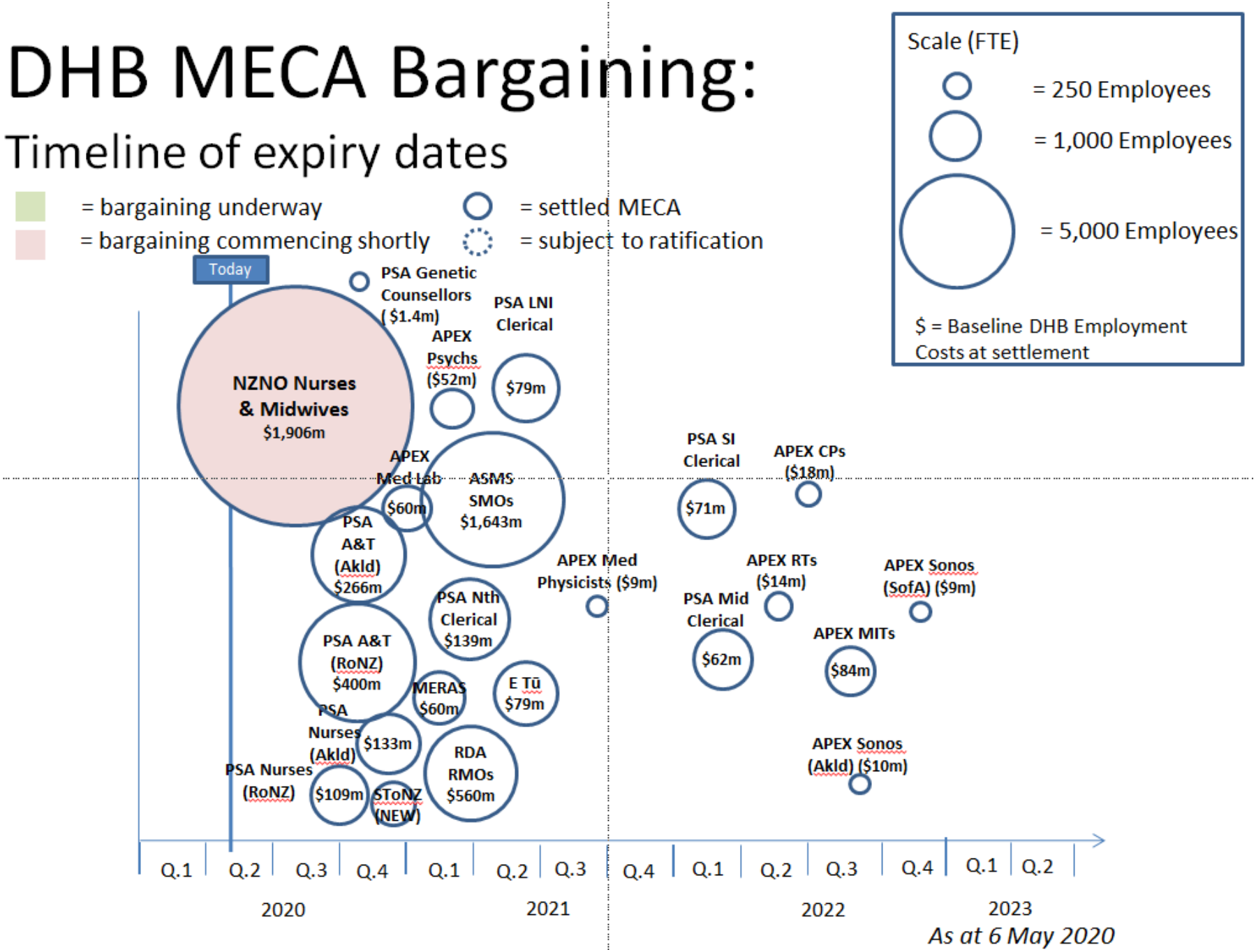
Summary of Annual Leave Cash-ups – Breakdown by Designation (HAC)

Data from 01 May 2019 to 30 April 2020

Designation	Month Leave cashed	Sum of hrs	Sum of Current AL Balance	Sum of AL Taken in 12 Months
HEALTH CARE ASSISTANT	Jun 19	24.2	840.16	306
CLINICAL NURSE SPECIALIST	Jun 19	185.96	468.04	136
REGISTRAR	Dec 2019	70.46	24.12	110.46
MOSS	Dec 2019	303.16	128.26	476.32
MEDICAL OFFICER	Dec 2019	40.5	20.68	88.5
COMMUNITY MIDWIFE	Feb 2020	120	369.97	128
Grand Total		**744.28**	**1851.23**	**1245.28**

DHB MECA Bargaining:

Timeline of expiry dates



Emergency Department, Critical Care Complex and Middlemore Central

Monthly Report – May 2020

Glossary

CCC	Critical Care Complex
HTT	(Healthy Together Technology)
IMT	Incident Management Team
MMC	Middlemore Central
SSHW	Safe Staffing Healthy Workplace
VRM	Variance Response Management
CQRM	Clinical Quality & Risk Manager
CAG	Capacity at a glance
CDAHST	Clinical Director of Allied Health Scientific & Technical

Service Overview

The Emergency Department, Critical Care Complex and Middlemore Central ("ED, CCC & MMC") Division is managed Dr Vanessa Thornton (Clinical Director) with John Cartwright (General Manager) and Fleur Collins (Clinical Nurse Director). Critical Care Complex is supported by Kirstine Kent (Service Manager) and Jacqui Wynne-Jones (Clinical Nurse Director).

Overview for May 2020

ED, CCC & MMC teams prepared to return to business with the new normal while New Zealand went into COVID-19 level two and then level one lock down. New members of the governance team joined us during the month (the CDAHST, CQRM Finance Business Partner and HR Business Partner).

Occupancy in ED and CCC continued to be low during May 2020 due to national COVID-19 level lock downs. However, this is expected to increase over the next few weeks.

MMC has taken up responsibility for implementing the updated visitor's policy. This will include extra staffing at the door, building works and infrastructure. The new visitors' policy will help ensure patients get the rest they need, staff are safe and give quality care and visitors can see patients within guidelines.

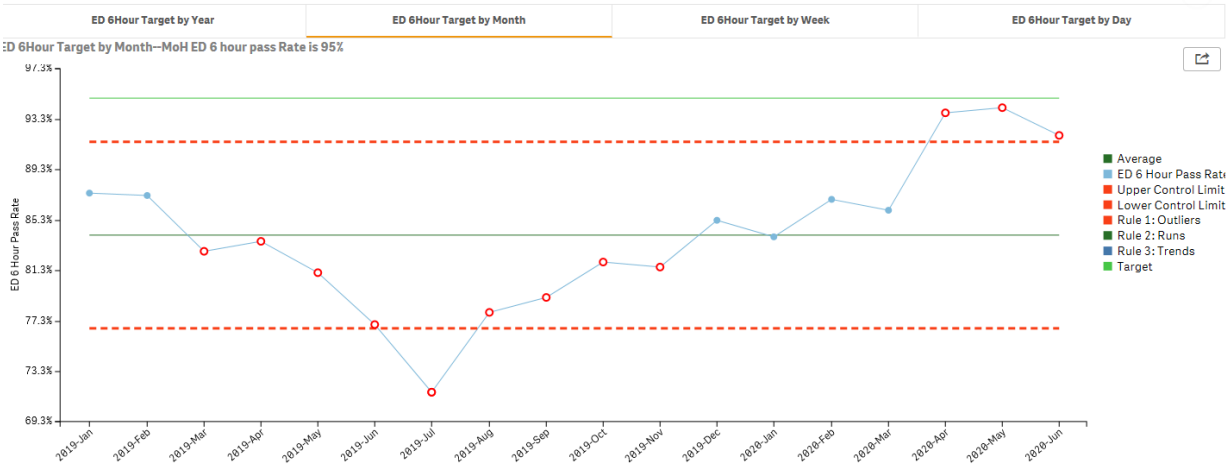
Security has dealt with a major incident when two Security guards and one Health Care Worker were injured. The CQRM is investigating to ensure any improved practice can reduce future risk.

Command Centre project is being implemented. Dashboards are producing real time data to help identify capacity.

Emergency Department

National Health Target: Right Care Right Time

The 6 hour target was met thirteen times in May, with a 0.4% improvement in overall performance compared to April 2020. There was a significant increase (27%) in ED presentations compared to April (1,598 more presentations), mainly related to easing of national responses to COVID-19. The chart below shows ED performance over the past 18 months, with significant improvement since quarter 1, trending upwards towards the target.



Finance

Timeframe	Result	Commentary
Month	$273K	Favourable monthly variance due to: • Staffing costs associated with COVID-19 response coded correctly • Reduced locum and bureau utilisation • Very limited nursing overtime • Reduced use of clinical supplies as a result of reduced ED presentations
YTD	-$255K	YTD unfavourable variance related mainly to nursing workforce overspend (unbudgeted NETP supernumerary period of 3 months, nursing overtime and bureau utilisation as well as unbudgeted parental leave costs)

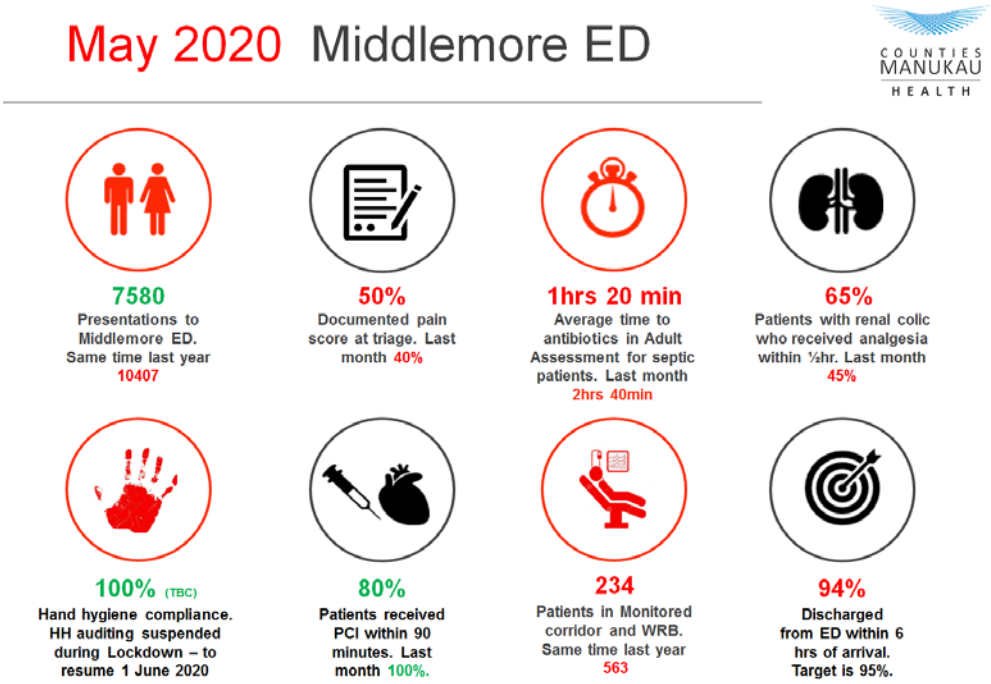
Quality – Complaints/Incidents/Risks

Risk	Commentary
Environmental/ infection control	• Plywood on walls in assessment area – trialled product in January 2020, awaiting replacement plan from building services –work plan will recommence June 2020 • Infection prevention and control plan in place
Workforce	• Recruiting to establishment FTE, planning to better manage rostering to meet demand • Nursing restructure consultation completed, to better align workforce to demand and proposed model of care changes - decision document due June 2020 • Development of an ED workforce strategy required
Violence and aggression	• Increased security presence in ED, further work required to manage, mitigate and/or eliminate risks and implement training for all staff
Access	• Work underway with other Counties services to improve processes to facilitate better service wide access and flows to meet demand

Feedback

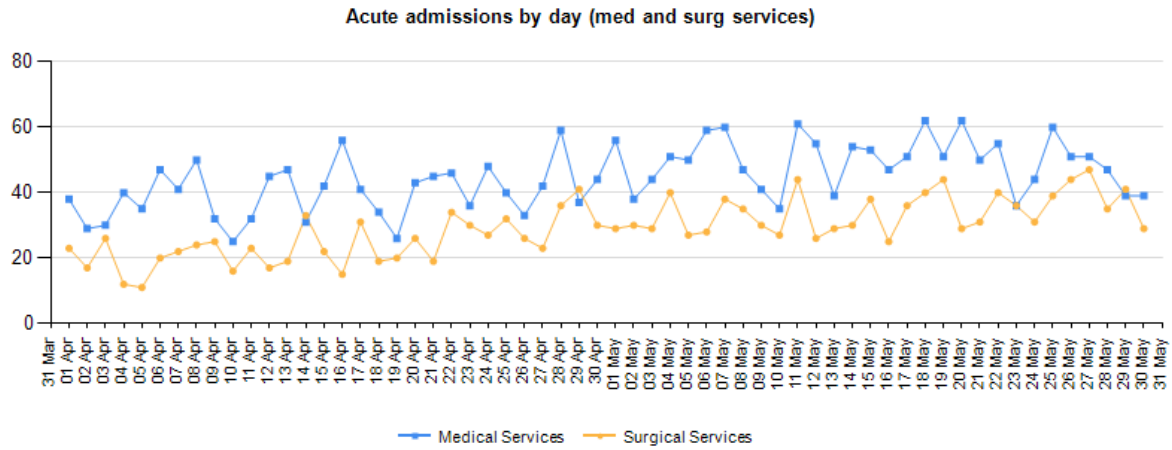
Feedback	Number received May 2020	Commentary
Compliments	9	"From the moment we arrived at the doors to ED we were met with professionalism and kindness…I was very impressed by the obvious evidence of the DHB's values and I think your team is fantastic". "My stay here was very welcoming and warm. Thank you to all staff at Middlemore."
Complaints	13	Increase compared to last month, related mostly to communication/information, but also treatment, pain relief and visitor policy

DAASH Report



Commentary: Dramatically reduced presentations to ED during May 2020 assisted with compliance to targets.

ED Admissions



Commentary: note the considerable drop in surgical admission during the lockdown periods in May 2020. However, Medical admissions have stayed the same this is because lockdown was reduced to level 2 in May 2020.

Middlemore Central

Support of IMT

The IMT is now operating out of Meeting Room 2 during April/May 2020. The role of MMC during this period was to ensure business as usual hospital operations ran smoothly.

Visitors' Policy

During mid-May 2020 Middlemore Central took responsibility to implement the visitors' policy. Implementing the new policy, Middlemore Central have been tasked with ensuring Security and Visitor Screeners are posted at each of the following entrances Middlemore Hospital Main Entrance, ED, Kidz First and Galbraith to monitor visitors into the wards.

In the interest of staff and patient safety, ensuring patients are well rested and patients receive a high quality of service the new visitors' policy will control visiting hours and also the number of visitors at any given time who see patients. To achieve this, a pool of staff are being recruited, building and infrastructure arrangements are being implemented.

MMC Projects

- Bureau Efficiency
  Dashboard created by Service Manager to look at reasons for requests, supply and demand across last year.
- Workforce Central
  Developer resigned. Analytics reporting that there remains a handful of corrections for One Staff before prepared to go live in the form of dashboard MMC.
- Command Centre
  Major progress has been made. Identification of missing info from CAG and this is now being slowly moved across.
- Patient Flow
  Review of work streams – focus move from bed request, to bed to allocation and the absence of data transparency as to reasons for the wait to transfer.
- CAG
  Predominantly nursing subjective (VIS) sense of skill mix, acuity, support for decisions etc.
- One Staff – Cronin (option replacement)
  Timeframe 2 years for completion.
- Trendcare - Core Data Set
  Acumen (Developer) preference for 3 month. Need sources defining.

- Smart Page
  First full month in production, including reports visibility of information being captured. Smart Page being used across MMC to book both clinical (Transit) and non-clinical – (Orderlies, Cleaning) services.

Bureau
- Bed escalation plan: is in its final stages of completion.
- Patient allocation: meeting regularly to engage key areas and find solutions to blocks for patient flow.

Emergency Response
Organisational planning and response to Covid-19 pandemic is in the process of scaling down due to the change in alert levels made by the Government. Work continues at a National and Regional level. The Northern Region Health Coordination Centre (NRHCC) will continue to monitor the response and lead the DHBs (Northland, Waitemata, Auckland and Counties Manukau).

Quarantine and isolation facilities still have a large number of occupants. This is likely to be handed over from the MoH to the DHBs to manage.

Flipchart review is underway. The Emergency Response team plan to roll out the new flip chart for 777 by the 30 June 2020 and 111 flip chart by the 31 July 2020.

Critical Care Complex
CCC like other areas in the division CCC is working towards business as usual.
- PACU KPI for length of stay is 2 hours
- There are ongoing challenges with long stay patients in PACU – resulting in releasing a PACU Long Stay Guideline to support PACU discharge planning

PAR Referrals
PAR referrals are picking up again after April's lull mainly due to an increase in the number of emergency calls and critical care discharge follow-ups. There were 286 referrals to the PAR service in May compared to 235 in April, the majority of which were in response to 777 calls (n119). This was followed by Critical Care discharge follow-ups (n 90) up from 65 the previous month, EWS triggers other than 777 (n 54) and medical or nursing call for concern (n 22). There were in total 564 PAR patient reviews this month down from 466 in March.

Non Clinical Support

Security
Security continues to have guards stationed at four entrances at MMH.

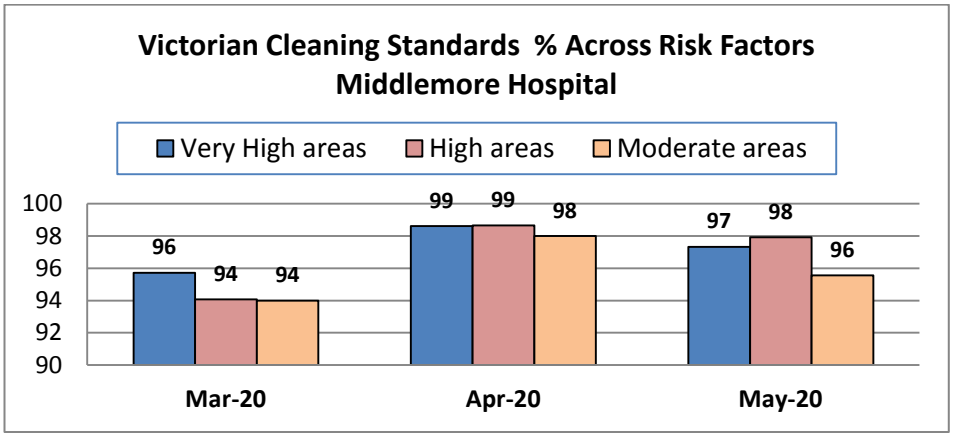
Security Projects
Security Enhancement Project and MMH Lockdown project are ongoing

Cleaning
Victoria Cleaning Standards (see table below):

Very high areas – pass mark 99%
- 5 out of the 7 areas audited achieved 100%
- 2 areas scored 94%.

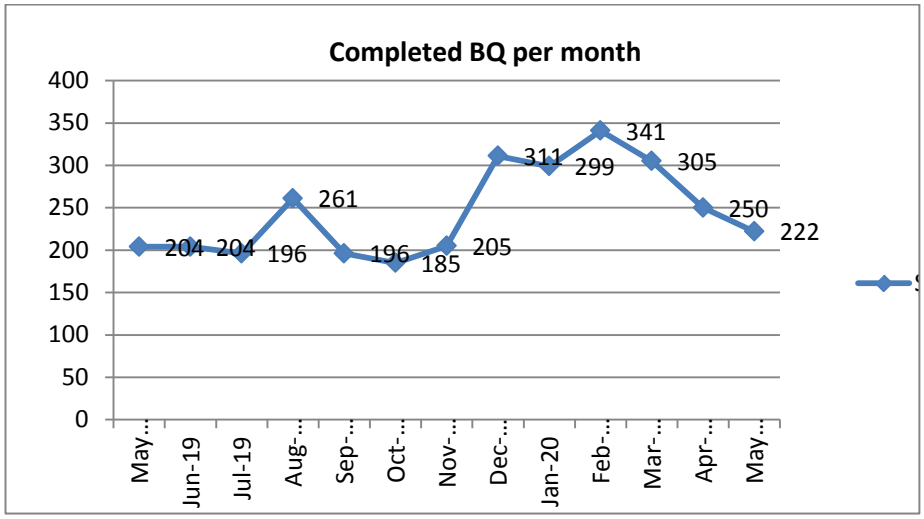
High areas – pass mark 99%
- 3 out of the 5 areas audited achieved 100%
- 2 areas achieved 94%.

Moderate areas – pass mark 85%
- No Moderate areas were audited in April- only audited three monthly.



Bioquell Cleans

The table below indicates the number of bioquell cleans completed per month. From February 2020 there has been a steady decline in bioquell cleans. This could be due to COVID-19 lock down period as less patients presented into Middlemore Hospital.



Department of Medicine

Monthly Report – May 2020

Glossary

ALOS	Average Length of Stay
CNS	Clinical Nurse Specialist
ELT	Executive Leadership Team
FTE	Full-time Equivalent
HCA	Health Care Assistant
LOS	Length of Stay
MoH	Ministry of Health
MSC	Manukau Superclinic
NFD	Nurse Facilitator Discharge
RMO	Resident Medical Officer
SMO	Senior Medical Officer

Service Overview

The Department of Medicine is managed by Dr Chris Hood, Clinical Director and Catherine Tracy, General Manager.

Report back on actions assigned during previous Hospital Advisory Committee meetings
The Committee asked for a "Bowel Screening Programme regular update via the Medicine report each meeting" to be provided.

National Bowel Screening Programme (NBSP) – regular update for the Hospital Advisory Committee
As at the end of May total participation in the programme was at 53.8%, Maaori 53%, Pacific 40.9%, Asian 50.9%, other 60.4%.

Since the commencement of the programme, there has been 1,526 positive FIT tests; 1,142 colonoscopies completed, out of which 1,018 of those patients had biopsies. 104 cancers have been diagnosed since the programme commenced in the DHB in July 2018.

Just prior to moving into COVID-19 Alert Level 4, from the 20th of March, the Ministry put a hold on any new participants being invited. However, around 2,000 kits were sent during lockdown for participants who had already received the pre-invite letter. They were informed to not return kits till lockdown was lifted. The MoH is in process of informing these participants that it they can return kits now and we are starting to see some positive FIT results from this group. Sending out of invitation letters to participants will commence on 8th of June 2020; the test kits will be sent 2 weeks later. The average number of invitations sent out for each DHB will remain status quo as prior to COVID-19. For CM Health this means that our first screening round will take longer (27 months) to complete.

Our Community Co-ordinators have started our Outreach process and we are calling priority participants who have not returned a kit. The Regional Co-ordination Group is commencing a media campaign at the end of June to inform GPs and potential participants of the restart of the NBSP. Radio ads have been confirmed.

Further advice was sought from the MoH regarding the commencement of screening Maaori and Pacific from 50 years of age. We have been advised that if this change is agreed by Government, it is unlikely to go ahead until all DHBs have implemented the programme. This will be around the end of 2021.

Highlights

General Medicine

COVID19 Pandemic and Bed Occupancy

Bed occupancy and Home-Ward placement versus outlier accommodation returned to near normal levels in the post COVID19 stand-down period as illustrated in Figure 1 below. Across the whole of acute Medicine bed occupancy averaged 87% while General Medicine occupancy averaged 93% for the month of May.

WIES volumes began to increase with post-COVID19 presentation growth although remain lower than the same time in previous years at 11% below current contract (Fig 2). The impacts of coding discrepancies and contract smoothing have been previously reported.

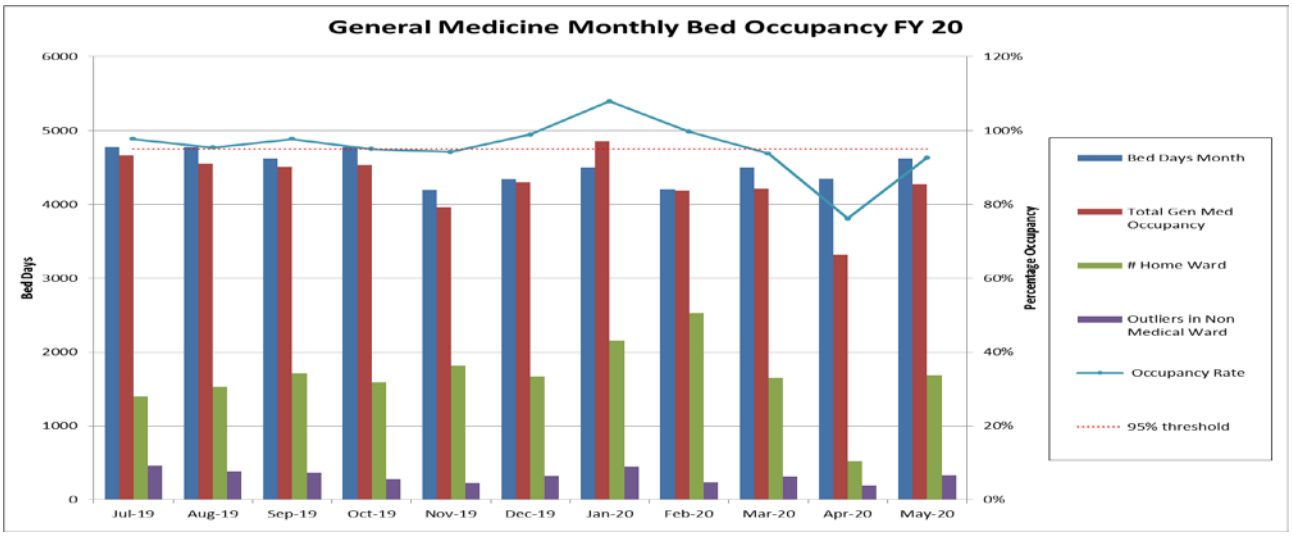


Figure 1: % Bed Occupancy v % Home Based Ward

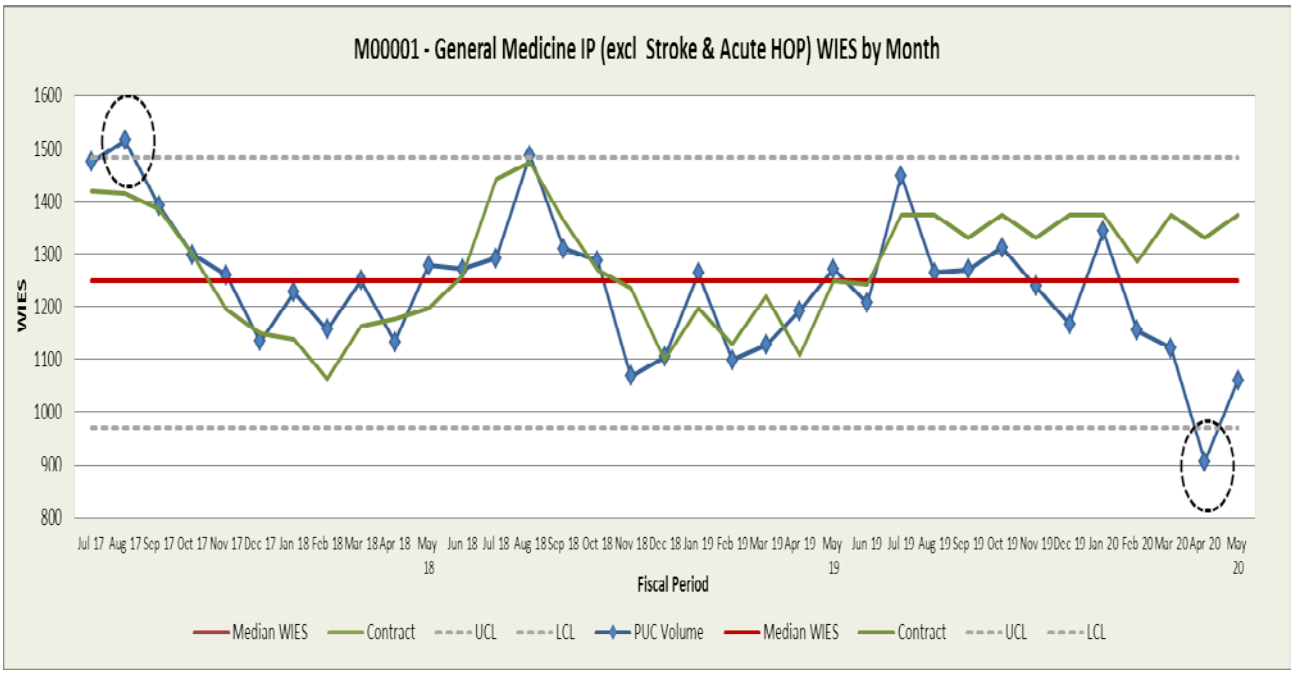


Figure 2: Core Adult Medical WIES by Contract and PUC Volume

Average Length of Stay (ALOS)

ALOS remains just below the median of 3.3 days across General Medicine despite the impact of a long stay social care admission remaining within the service now at 240 days[1].

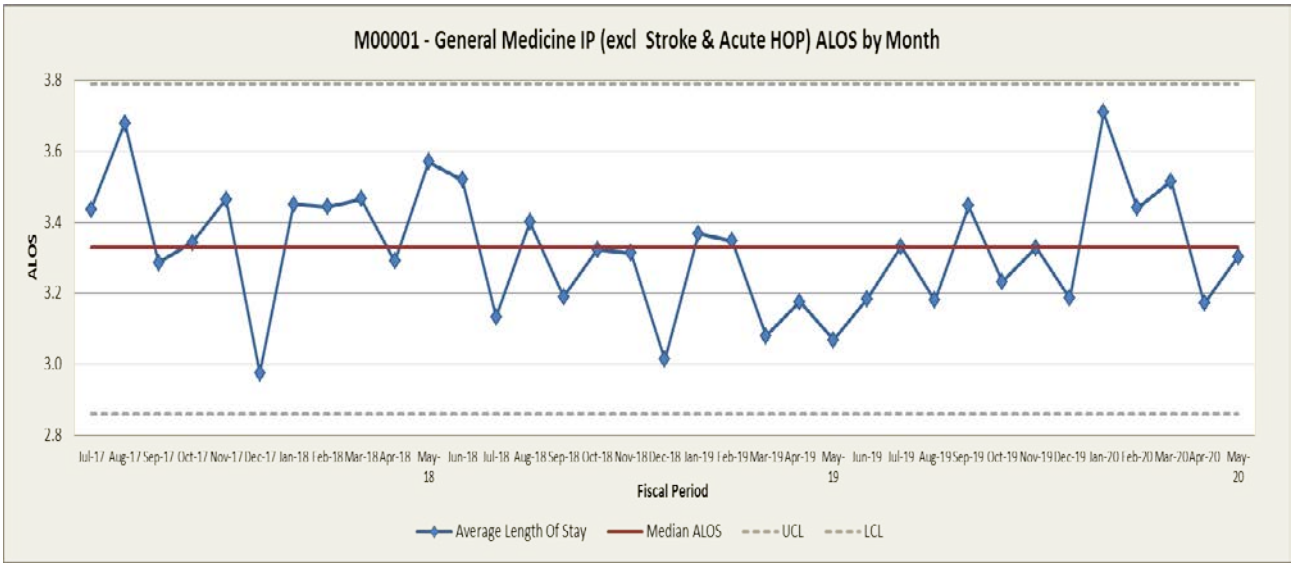


Figure 3: Average Length of Stay General Medicine FY 17 – YTD FY 20

General Medicine Ward 17 Acute Transition

Nursing recruitment remains on track to enable the opening to 26 beds for acute medicine requirements from the 1st July aligned with budget forecasts. Year to date Ward 17 is forecast to return expenditure within the required additional 19/20 budget of $2.43M however, a further $600K in unanticipated external care support costs have been incurred related to the extended social admission previously reported. Revenue received from agreements with Taikura Trust has provided $164K of partial offset YTD.

General Medicine SMO Recruitment

Successful recruitment to date will enable the General Medicine service to stand up a 13th medical team from the beginning of July. The Koromiko team will support the capability to provide Ward 17 with Home based medical cover increasing the number of wards with Home Based teams from 4 to 5.

Faster Cancer Treatment (FCT)

FCT performance has not been achieved this month at 88%. Only 2 capacity breaches but low denominator has affected this. The denominator is lower as many breaches are patient's choice related therefore excluding them from the target.

Patients on 62 day pathway have predominately managed to remain on track throughout Covid-19 service changes. Patients on the 31 day pathway however have been impacted with rescheduling of theatres, diagnostic and clinic cancellations. This data is under review and most patients who have been delayed have a plan in place to ensure they are not lost in the system. Previously reported low referrals into services seem to be turning around, particularly in respiratory and gynaecology with increasing volumes in the past 2 weeks. Gynaecology and ORL cancer teams and are reviewing current resourcing and identifying through business plans where additional resourcing is required to meet demand.

Local Delivery Oncology

All patients who were attending ADHB as part of Covid-19 planning have now returned and LDO is fully restored in the Galbraith Infusion Centre. Some outpatient appointments continue to be telehealth, mainly telephone and this may continue to be the preferred appointment method for some patients. The clinic rooms in Galbraith Infusion Centre have been set up with multimedia monitors to facilitate this. An ELT paper has been produced for submission to the Funder forum and ELT seeking approval for extending local delivery to provide a comprehensive medical oncology service to patients with breast cancer, where by patients will only attend ADHB when they receive radiotherapy treatment.

[1] As at the time of reporting

In addition the Region is undertaking modelling and production planning to identify further tumour streams and opportunities to further expand the local delivery model. Relocation of the Galbraith Infusion Centre allows for expansion and growth, however a location for this has yet to be decided and further planning is needed.

Gastroenterology
The Gastro expansion build has entered the design phase of the project, with work expected to commence in January 2021.

Respiratory
Respiratory are currently in discussions with Cardiology with respect to taking over management of Cardiology's outpatient Spirometry workload. This may be possible via the allocation of the vacant Technician FTE (from Cardiology) to Respiratory, in order to recruit a Respiratory Physiologist to support the delivery of this service. This will start a process whereby increasing volumes of Spirometry become managed by the Respiratory Service (where it should be), supporting the implementation of quality control policies and procedures, and allowing more planning and development around the future delivery of Spirometry to the CM Health population.

Respiratory is currently developing a proposal to use a vacant Community Health Worker FTE (the Community Health Workers deliver the Sleep walk-in clinic) to recruit a Sleep Physiologist instead of a Community Health Worker. This will be highly beneficial for the Respiratory Service, allowing us to implement a number of positive service-delivery changes.

Psychological Medicine
Psychological Medicine has developed (after being granted ethics approval) a survey to assess clinicians and patients perceptions of virtual appointments. Our aim is to use our findings to help determine if (post-COVID) virtual delivery of healthcare is a viable long-term option to include in our model of care. This survey is still open for completion and the results will be reviewed and shared once we have closed the survey and collated our findings.

Emerging Issues/Challenges

General Medicine
Previous reports have raised and highlighted the risks to staff and other patients' of the practise of referring behaviourally disturbed patients from Emergency Care to General Medicine for non-medical reasons. General Medicine is increasingly pressured to absorb these admissions to minimise the impact on patient flow and to mitigate capacity or resourcing constraints in other areas better equipped to appropriately care for these patients. These admissions have demonstrated that inappropriate placement into General Medicine does not support the patient's best interests and on several occasions has caused harm. During May the admission of a psychotic patient to a General Medical ward resulted in a stabbing incident and physical assault of 3 members of staff. Internal reviews are currently underway.

Renal/Diabetes Health Psychologists
There is an expectation of a wave of new referrals post COVID. Currently the HPs are looking at doing extra hours as there are currently 60 patients waiting on the waitlists. The second intern is working from home and working through the wait list.

Gastroenterology
There is an on-going issue of lack of capacity (due to insufficient GA lists in theatre) to perform endoscopy under anaesthetic (for Gastroenterology and Respiratory bronchoscopy). Currently discussions are underway between Service Managers to try and remedy this by means of sourcing 6 extra GA lists per year for Gastroenterology and 6 extra GA lists per year for Respiratory (bronchoscopy).

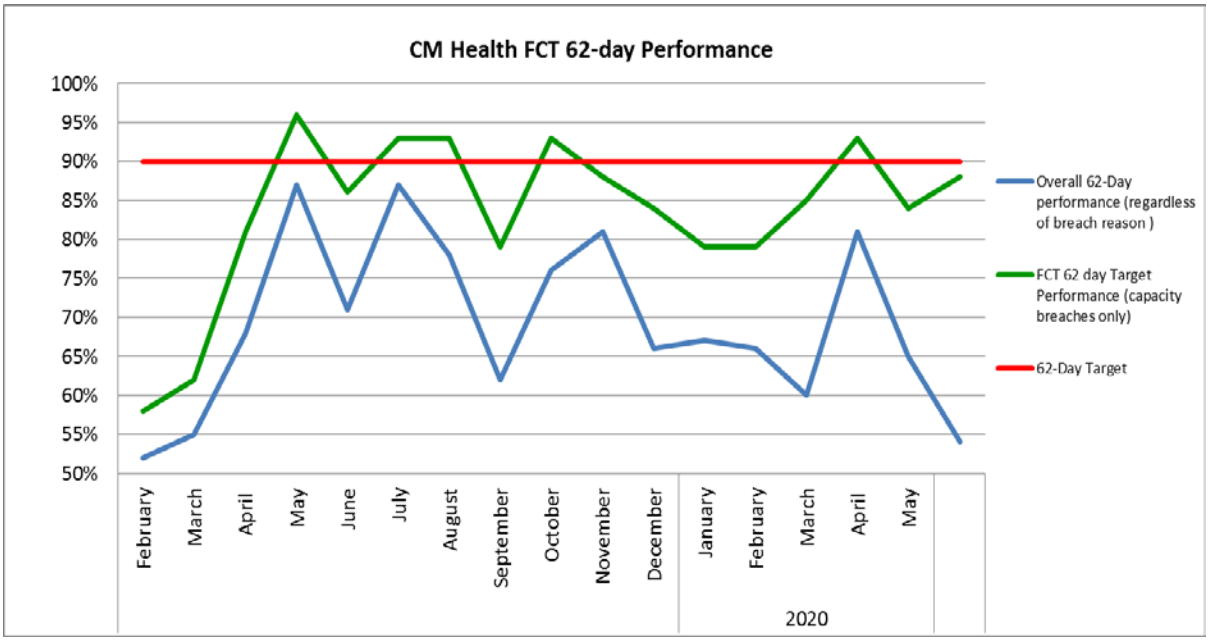
Radiology ERCP suite is undergoing a refurbishment. This has impacted on the availability of our "usual" radiology facilities for the performance of ERCP. The Gastroenterology Service has liaised with the Nurse Manager for Middlemore Operating Theatres, and we have been able to source a procedure room within the theatre suite (ad hoc) to support the delivery of some of our displaced endoscopy lists (in order to accommodate ERCP up in the Gastroenterology Day Stay unit). There is likely to be a small loss in production during this time, as a result of this, however we are currently working to find facilities (in-house) to cover as many of the displaced lists as possible.

Work continues on the business case for upgrading the endoscopy equipment in Theatre 26 at MSC (from Pentax to Olympus), however in the meantime, the Gastroenterology Service is trialing a new version of the current Pentax equipment used in Theatre 26 at MSC. We are currently reviewing the evaluations of this equipment by the Gastroenterologists.

National Health Targets

Cancer Treatment

	Description	October Achieved 88%
Faster Cancer Treatment	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	



Commentary

May Performance: **FCT 88% (26/31 patients)**

Overall performance 64% (14/16 patients) Of the 2 breaches:

- 1 lower GI, 1 gynae
- Both breached by less than 20 days
- 1 patient took 46 days from referral to ADHB to receiving chemotherapy

Much lower volumes recorded this month as most delays were due to patient choice and therefore excluded from the target. Referral volumes are increasing as we have moved through the COVID alert levels. Analysis is on-going to review how many patients present acutely as they have not sought appointments during lockdown. If this is the case there may be an increase in 31 day volumes in the coming 2-3 months. Any patients that have been delayed due to service restrictions have a plan in place to ensure they are not lost within the system. Cancer Nurse Coordinators are navigating patients through the cancer pathways and escalating where required to expedite appointments if possible

There continues to be a number of instances where patients have chosen to delay appointments until after the lockdown has ended. Cancer Nurse Coordinators are working with patients to support them to come to appointments and engage with the services.

Cardiology Angiography

Description Cardiology - 95% elective angiograms within 90 days	**May** Not Achieved **X 85%**
Commentary Target not achieved due to one patient being having to be on the list for an extended period of time due to numerous clinical reasons.	

Colonoscopy

Colonoscopy Targets	**Description** • 90% urgent (P1) colonoscopies done within 14 days • 70% non-urgent (P2) colonoscopies done within 42 days • 70% of Surveillance colonoscopies done with 84 day	**May** 100% 61% 99%

Colonoscopy	**2019**									**2020**				
Period end	Apr	May	Jun	Jul	Aug	Sept	Oct	NOV	Dec	Jan	Feb	Mar	April	May
P1 – % within 14 days (target 85%)	%		%	99%					97%	98%	100%	100%	99%	100%
P1 – % within 30 days (target 100%)	0%	0%	0%	100%	0%	0%	0%	0%	0%	0%	100%	100%	100%	100%
P2 – % within 42 days (target 70%)	75%	75%	75%	73%	82%	81%	80%	80%	79%	72%	84%	89%	55%	61%
P2 – % within 90 days (target 100%)	0%	0%	00%	100%	0%	0%	0%	0%	0%	0%	100%	100%	100%	95%
Surveillance – % within 84 days (target 70%)	99%	94%	95%	98%	98%	99%	100%	100%	100%	100%	100%	100%	100%	99%
Surveillance – % within 120 days (target 100%)	100%	98%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Gastroscopy

Gastroscopy Targets (CM Health Targets)	**Description** • 85% urgent (P1) gastroscopies done within 14 days • 70% non-urgent (P2) gastroscopies done within 42 days • 70% of Surveillance gastroscopies done with 84 days	**June** 100% 34% 100%

Gastroscopy	**2019**									**2020**				
Period end	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May
P1 – % within 14 days (target 85%)	100%	99%	100%	99%	99%	100%	98%	99%	100%	99%	100%	100%	100%	100%
P1 – % within 30 days (target 100%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
P2 – % within 42 days (target 70%)	53%	57%	59%	64%	77%	76%	78%	77%	77%	70%	85%	87%	39%	34%
P2 – % within 90 days (target 100%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	82%
Surveillance – % within 84 days (target 70%)	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	100%	100%	98%	100%
Surveillance – % within 120 days (target 100%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Commentary

MoH and CM Health targets were achieved for P1 and surveillance colonoscopies as well as P1 and surveillance gastroscopies for May 2020. Targets for P2 colonoscopies and gastroscopies (within 42 days were not met), although we are seeing an improving trend with P2 colonoscopies (and this is expected to continue). This is due to the national lockdown response to COVID, which resulted in contracted outsourcing providers closing (therefore no outsourcing occurred during the level 4 lockdown). Furthermore, in-house gastroscopy production was scaled back to only acute and P1s, due to the nature of these aerosol generating procedures and the associated infection risks in the midst of COVID-19. This has left a significant backlog, with the gastroscopy waiting lists at approximately 609.

We are anticipating 2-3 months before we are able to attain our P2 gastroscopy targets again, and this will rely on increased production by means of weekend lists and the conversion of some in-house colonoscopy slots to gastroscopy slots. We are estimating that we will attain P2 colonoscopy targets by the end of June 2020. The service was also affected by childcare requirements, in that several of our nursing staff were unable to work due to requirements to look after their children. This resulted in the closure of theatres 25 and 26 at MSC, and the consolidation of nursing staff to the MMH site in order to be able to maintain P1 and acute production.

In May 2020, referral volumes decreased by 20% as a direct comparison to the May 2019 referral volume. The May 2020 referral volumes however had a significant increase of 42% when compared to April 2020.

BSP list utilisation; 4-5 procedure lists per week have been utlised for BSP colonoscopies. 1142 BSP colonoscopies have been completed from July 2018 through to May 2020. 104 patients were referred to surgical services from July 2018 to May 2020. For May 2020, BSP received 12 referrals, had 18 procedure lists with 81 procedures perfomed and 9 patients referred to Surgical Services. We estimate the the increase in BSP volumes from late 2021 with lowering the age to 50 for the Maaori and Pacific population. Outsourcing for colonoscopy continues throuhg to FY19/20 to accommodate the volumes of discplaced lists as a result of BSP requirments.

MEDICINE AND INTEGRATED CARE SCORECARD

May-20

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Total Caseweight		**2,081**	2,681		**26,075**	29,057			
	Elective Caseweight		**67**	49		**733**	533			
	Acute Caseweight (includes Intensive Care Unit)		**2,013**	2,632		**25,342**	28,524			
	Outpatient First Specialist Assessment (FSA) Volumes		**1,000**	1,559		**13,153**	14,652			
	Outpatient Follow Up Volumes		**3,964**	3,870		**40,087**	38,435			
	Virtual First Specialist Assessments (FSAs)		**213**	233		**3,727**	2,537			

		Trend				12 month average			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years		**15.4%**	5.0%		**14.6%**	5.0%			
	% Staff Turnover		**7.6%**	10.0%		**4.3%**	10.0%			
	% Sick Leave		**0.0%**	2.8%		**0.0%**	2.8%			
	Workplace Injury per 1,000,000 hours		**0.0**	10.5		**0.0**	10.5			

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Safety	No. Falls causing major harm		**0**	0	0	**7**	0	7		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Timely	% Radiotherapy commences in 4 weeks		**100%**	100%	0%	**100%**	100%	17%		
	% Chemotherapy commences in 4 weeks		**100%**	100%	0%	**100%**	100%	0%		
	P1 (urgent) % diagnostic colonoscopy patients receive the procedure within 14 days		**100%**	85%	15%	**99%**	85%	14%		
	P2 (routine)% diagnostic colonoscopy patients receive the procedure within 42 days		**61%**	70%	-9%	**75%**	70%	-5%		Due to national level 4 lockdown (COVID-19), our outsourcing providers shut down, therefore no outsourcing was completed until we moved to level 4 lockdown. Hence failure to meet target. We are expecting to meet this target by mid-July 2020 again as outsourcing has resumed.
	% surveillance colonoscopy patients receive their procedure within 84 days of planned date		**99%**	70%	29%	**99%**	70%	29%		
	P1 (urgent) % diagnostic gastroscopy patients receive the procedure within 14 days		**100%**	85%	15%	**99%**	85%	14%		
	P2 (routine)% diagnostic gastroscopy patients receive the procedure within 42 days		**34%**	70%	-36%	**69%**	70%	-1%		Due to national level 4 lockdown (COVID-19),all P2 gastroscopsy and top and tail production was halted, due to risks arounds AGP's and loss of staffing (childcare requirements during lockdown). we were only able to maintain acute and P1 gastroscopies. Hence failure to meet target. We are expecting to meet this target within 2-3 months provided we are able to increase production by means of some additonal weekend procedure lists.
	% surveillance gastroscopy patients receive their procedure within 84 days of planned date		**100%**	70%	30%	**100%**	70%	30%		
	% cardiac STEMI - PCI (angiography) within 120 mins - Northern Region Target		**100%**	80%	-3%	**100%**	80%	1%		
	% Coronary Angiography within 90days (1 month in arrears)		**85%**	95%	-10%	**85%**	95%	5%		One patient is longer on the waitinglist
	Medical Assessment –Triage 3-5 patients seen within 60 minutes		**57**	60	-3	**92**	60	32		
	Door to Cathlab suspected Acute Coronary Syndrome < 3 days (median time)		**79%**	70%	9%	**79%**	70%	9%		
Timely (continued)	General Medicine - Seen By Time (minutes)									
	1st Time to be seen Triage 1 & 2 patients (median time in minutes)		**44**	30	-14	**52**	30	-22		TBS times remain largely improved over previous months due to the ongoing impact of COVID19 in April, however the Triage 1 & 2 within 30 mins 1st TBS as begun to creep up over the target as presentation volumes have increased. Gen Med continues to work with EC on Flow based strategies designed to minimise wait times for appropriately triaged and re-triaged patients.
	1st Time to be seen Triage 3 - 5 patients (median time in minutes)		**42**	60	18	**51**	60	-1		
	2nd Time to be seen Triage 1 & 2 patients (median time in minutes)		**25**	30	5	**27**	30	0		
	2nd Time to be seen Triage 3-5 patients (median time in minutes)		**55**	60	5	**69**	60	13		
	FCT - % high suspicion first cancer treatment within 62 days - MOH Health Target		**88%**	90%	-2%	**87%**	90%	-3%		On going activity with cancer tumour streams to improve performance.
	FCT - %confirmed diagnosis first cancer treatment within 31 days		**93%**	85%	8%	**89%**	N/A			

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
System Integration (Effective)	Average Length of Stay - Acute		**3.3**	3.5	0.2	**3.3**	3.5	0.2		
	Acute Readmissions within 28 days - Total		**10%**	10%	1%	**13%**	10%	3%		Acute readmissions for all age groups met the 10% target during May however this data is coding dependent and may still increase as coding completion improves. YTD remains above target contributed to largely by the over 75yrs target which includes readmissions from the aged residential care sector during the COVID response.
	Acute Readmissions within 28 days - 75+		**12%**	10%	1%	**14%**	10%	5%		
	% of patients on home wards in General Medicine		**40%**	75%	-41%	**36%**	75%	-39%		The number of patients assigned to Home Wards significantly improved during May as occupancy rates improved and presentations volumes returned to near normal as the COVID 19 response was stood down. Medical team arrangements are still in a state of flux as new recruitment comes on stream and post-COVID structures are re-established.
	% of Outliers on non-medicine wards		**7.8%**	0.0%	-7.8%	**8.0%**	0.0%	-8.0%		
		Trend				Year			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Efficient	% Discharges from transit lounge or home by 1100hrs		**31%**	30%	1%	**37%**	30%	7%		
	% of patients <28 hrs discharged from inpatient wards		**14%**	10.0%	-4%	**10.0%**	10%	0%		159 patients were discharged from the Medicine wards within 28hours during May from 1154 discharges. This is the 3rd highest volume of monthly ward discharges in the last 6 months but the 2nd highest volume of discharges with 28 hrs for the previous 18 months and perhaps reflects an increasing tendency to admit to a ward to free up EC flow rather than assess to discharge and avoid unnecessary admission. We will continue to review for an ongoing trend.
	Implement Home First Renal policy - (increase Continuous Ambulatory Peritoneal & HD rate)		**36%**	50%	-14%	**36%**	50%	-14%		Home therapy ratio remains at 36% even if 3 patients have started PD in May. There were 4 patients from Home Haemodialysis who went on Respite (MAUR) and 1 went on permanent HD at AMC thereby making it just about the same as last April.
		Trend	Volumes Screened			% Screened in last 24 Months			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Equity	% Women with Breastscreen in last 24 months - total		**1368**	2472	-1104	**66%**	70%	-4%		Decline in coverage due to COVID 19 . No screening from 23 March to 11 May. Production planning underway to increase screening volumes.
	% Women with Breastscreen in last 24 months - Maaori		**172**	320	-148	**62%**	70%	-8%		
	% Women with Breastscreen in last 24 months - Pacific		**243**	395	-152	**77%**	70%	7%		

Surgery, Anaesthesia and Perioperative Services

Monthly Report – May 2020

Glossary

AT	Anaesthetic Technician
CLAB	Central Line Associated Bacteraemia
CCC	Critical Care Complex
DNA	Did Not Attend
DOSA	Day of Surgery Admissions
ESPI	Elective Services Patient Flow Indicator
FCT	Faster Cancer Treatment
FSA	First Specialist Assessment
HoD	Head of Department
ICU	Intensive Care Unit
LOS	Length of Stay
MMH	Middlemore Hospital
MoH	Ministry of Health
MSC	Manukau Super Clinic/Surgery Centre
ORL	Otorhinolaryngology
PAR	Patient at Risk
PCIMS	Perioperative Clinical Information Management System
RMO	Registered Medical Officer
SAPS	Surgery, Anaesthesia and Perioperative Services
SMO	Senior Medical Officer
VTE	Venous Thrombosis
WIES	Weighted Inlier Equivalent Separations
YTD	Year to Date

Service Overview

Surgery, Anaesthesia, and Perioperative Services (SAPS) is managed by Mr John Kenealy (Clinical Director, Surgery, Anaesthesia and Perioperative Services), Pauline McGrath (General Manager, Surgery, Anaesthesia and Perioperative Services), Simon Kerr (Clinical Director, Allied Health, Scientific and Technical Professions, Surgery, Anaesthesia and Perioperative Services) Jacqui Wynne-Jones (Clinical Nurse Director, Surgery, Anaesthesia and Perioperative Services and Critical Care Complex).

Highlights

The SAPS Division are implementing the recovery plan from COVID-19; to end of April 2020 the number of surgeries deferred was 1,203, it estimated that this will be between 1,400 and 1,500 by the end of May 2020. The exact quantity of Outpatient Appointments deferred has yet to be fully quantified for every service, however in Ophthalmology, General Surgery and Plastic 1,550 FSAs were deferred. The Division is taking a three pronged approach to assisting the recovery:

- Increasing planned care productivity / activity back to normal levels by end of June 2020 (low of 29%) within the process required in the COVID-19 environment
- Recommenced outsourcing to Private Providers in line with our contracted volumes (this had ceased during NZ CIVID-19 Alert Levels 4 & 3)
- Insourcing initiative in the month June 2020 to maximise internal capacity for both planned care and outpatient appointments (FASs and FU).

The insourcing initiative in June 2020 includes:

- Eight Theatres being run at MSC for four Saturdays across all surgical specialities except orthopaedics
- Procedure Rooms for Gastroscopy, Plastics and CTCA over four Saturdays and some evenings
- Additional EHCO clinics
- Outpatient clinics in all surgical subspecialties and a number of Medical subspecialties, four Saturdays and some evening.

The planned volumes to be seen for this initiative is- 264 surgeries, 144 procedures and 2,196 outpatient appointments. The aim will be to keep the DNA rate to a minimum. There is engagement with the Maaori and Pacific Health teams to assist with maximum attendance by Maaori and Pacific patients for their planned care and appointments (DNA rates are consistently higher for Maaori and Pacific). There has been excellent engagement and a willingness to participate in this insourcing initiative by the teams. This is being done on a voluntary basis and is over and above the staff normal hours, this level of activity would not be sustainable long-term and is a concentrated effort to assist in addressing the COVID-19 backlog.

The initiative will be reviewed and evaluated at the end of June 2020 and this will help inform if insourcing can be part of the ongoing recovery plan for 2020/21. Ko Awatea team will be assisting in carrying out this review. It will involve in capturing the volumes of patients seen, financial analysis, patient and staff experience and if it has helped address inequity. If insourcing is to be considered an ongoing part of the COVID-19 recovery in 2020/21, the model would be different to the one that was applied for this initiative; a revised model would have to be applied taking into account the overall PVS volumes and production plan for Planned Care.

It will take several months to catch-up on all of the deferred cases and outpatient appointments due to COVID-19. The planned care levels of activity have returned to usual pre-COVID-19 numbers at MSC and about 85% at MMH, this was above the predicted levels of productivity at the end of March 2020. The outsourcing in May 2020 is estimated to be at 60-70% of the contracted volumes and is expected to each normal levels in June 2020.

The SAPS Division began their Theatre Improvement Project on the 29 May 2020 with a second Solutions Based Workshop on the 8 June 2020. Pauline McGrath is the Project Sponsor and Valerio Malez from the Ko Awatea is the Project Manager. There was excellent engagement and a high representation from the SMOs. There is a series of Workshops / Focus Groups planned with the final workshop facilitating a prioritisation of agreed actions and an implementation plan by the team.

The Acute Hands Service has developed a Nurse Coordinator role and relocated the service from Emergency Department (ED) to TADU. This has assisted in patient flow, ED meeting their targets and improved the patient experience. This is currently being resourced from the Plastics/ Hands team and was sustainable as staff resource could be diverted during COVID-19, additional resource will be required to maintain this going forward.

A Bone Clinic has been established in ED where patients are receiving their interventions at the “front door” and this is facilitating admission avoidance, patient flow, patient experience and meeting ED targets.

The T-Doc and CSSD projects will be progressing in June / July 2020.

The team has continued to engage in the MHP Expansion DBC group and will be reinstating the Theatre and CSSD projects in the coming two weeks.

Emerging Issues

The recovery from COVID-19 will be an ongoing challenge into 2020/21 as will the costs incurred as a result of the planned care and outpatient backlog. The recovery will take several months, taking into account the waitlist and access issues that existed pre-COVID-19 this has compounded the demand and capacity gap for the surgical services and impacted on the ESPI 2 and 5 compliances in April; the ESPI 2 breaches were 2,505 and ESPI 5 at 485 and May 2020 ESPI 2 were 2,132 and ESPI 5, 424.

The services most impacted for ESPI 2 (April) were Ophthalmology at 981, General Surgery at 643 and Orthopaedics at 342 and ESPI 5 General Surgery at 142 and Plastics and 109.

A focus on the recovery plan from COVID-19 will have to be analysed in line with PVS volumes for 2020/21, production plans for each service and waitlist positions in order to accurately quantify the demand and capacity forecast for 2020/21. This will inform the completion of a comprehensive plan for SAPS that will assist in prioritisation and budget allocation for 2020/21.

Challenges – Emerging Issues and Update on Items Previously Reported

Challenges	Date Reported	Update
Demand on Ophthalmology Services	July 2016	Reduction in service availability due to COVID-19 has had a significant impact on Ophthalmology and the level of overdue follow-ups. Much of the progress made earlier in the year has unfortunately been undone. Ophthalmology will get back to full levels of surgical activity in May 2020 for MSC, Surgery South and fully outsourced cataracts.
Anaesthetists' shortage	Oct 2017	• Electronic Rostering has continued to deliver what was planned within Anaesthesia. Planning and training for the launch of Core Schedule into the Theatre Schedule has been completed and this will commence with dual functioning for the last week in June 2020. No interviews for new staff were conducted in May 2020. There are two interviews planned for June 2020. Although it is yet to be official it appears as though there will be 1-2 retirements within the next 12 months. • During COVID-19 the Anaesthetist SMO FTE increased significantly and with private coming back it was assumed that this would drop back to pre-COVID-19 numbers. While this has happened in two instances the remainder have been quiet and it appears as though our SMO FTE will remain higher than the pre-COVID-19 numbers. It is noted that we have lost no sessions due to a shortfall of Anaesthetic staff for the first five months of 2020. • Discussions were held with Radiology about anaesthetic manage for Radiology paediatrics. As a result, the waitlist of Radiology paediatric will be brought back under control by the end of June 2020. At this point there is no plan to sustain the service delivery beyond the end of June 2020 and further discussions will be required. A Radiology paediatric forecast with respect to Anaesthetics will be developed by Radiology and provided in June 2020. Our ability to service this will then be assessed. • The plan for ASA1 and ASA2 Saturday lists at MSC has been supported by Anaesthesia to consume a backlog of some 200 elective patients. Strong planning has been under way to ensure that this is, in a 1-off sense, totally successful.
Central Sterile Services Department		• Interviews for the remaining vacant 1.7 FTE set up to occur in June 2020.
NBC Review	Dec 2018	• ELT paper with request for increase in staff to support NBC – Estimated Cost between $1.5 & 2 million for 21/22 budget

Planned Care Measures: Elective Access

	Result **April (actual)**	**Result** **May (indicative)**
SS07 Measure 1 **Total Planned Care Interventions**	Achieved ✓ 103.0% Variance from Plan 760	Achieved ✓ 100.0%
SS07 Measure 2 **Elective Service Patient Flow Indicators (ESPI)** ESPI 2 (FSA) and ESPI 5 (Treatment) wait time targets	FSA: 2505 breaches Treatment: 485 breaches	FSA: 2132 breaches Treatment: 424 breaches
SS07 Measure 4 **Ophthalmology Follow-up Waiting Times**	Overdue: 5672 Overdue 50%: 2345 Overdue 100%: 1155	Overdue: 5968 Overdue 50%: 3005 Overdue 100%: 1706

Note: SI4 Standardised Intervention Rates are no longer a planned care KPI for 19/20.

Highlights

Counties has performed well during the COVID-19 period with the April results continuing to demonstrate an overall positive variance in total planned care production YTD of 760 interventions being 103.0% of planned production. Caseweight delivery remains over the 95.0% threshold as do minor procedures. If 70% of total planned production is delivered for May 2020 the results are expected to remain positive at 100% of planned YTD delivery levels.

There has been marked improvement in the level of breaches for ESPI 2 FSA access during May 2020 with a reduction of 370 cases and a smaller 60 cases for ESPI 5 Treatment.

Emerging Issues

The introduction of the Planned Care Intervention strategy for 19/20 has disrupted the planning, counting and reporting methodologies which have been in place for many years. We have had to understand and adapt to these significant changes when trying to compare data from previous years to current.

As anticipated the COVID-19 environment has had a severe impact on both the service production levels and timeliness of access for patients such that there has been significant drops in the interventions delivered and substantial increases in both ESPI 2 and ESPI 5 breaches in most services.

Amongst all services, in May 2020 the Orthopaedic service has an increase of 100 in the level of ESPI 2 FSA breaches whilst most services have shown improvement in this performance measure.

With the addition of the COVID-19 impacts on ability to treat patients, to the White Island and other recent scenarios, CM Health will continue to have issues in providing treatment within the 120 days to all patients. For many months to come it is expected CM Health will still have red level of breaches with the continuing need to be balancing between those that need to be treated and addressing previous month's breaches CM Health has now had 28 consecutive months with red ESPI. Planning is underway to develop initiatives to help recovery from this position, starting with all the Saturday clinics and theatre sessions.

Hand Service IPWL waiting list volumes remain of continuing concern with the volume to be treated far in excess of capacity. Some of these patients are now being transferred to the Plastics service and affecting the Plastics ESPI results.50% of the Hand IPWL list has waited 120+ days for access to treatment. Whilst these waiting list moves are having a detrimental impact on the Plastics ESPI results ultimately it will improve equity of access for Hand patients and provide more transparency in reporting. The Hand Service has 22 patients waiting 12m+ for treatment and a further 4 patients waiting 2yr+.

Planned Care Measure 1: Total Planned Care Interventions

Total Planned care Interventions for April continued to remain positive, albeit with a diminishing surplus to planned delivery. Delivered were 25775 interventions against a planned delivery of 25015 which equates to 103.0% of planned from the additional 760 interventions. The over delivery of minor procedures YTD continues to offset the shortfall YTD in both Inpatient Surgical Discharges and Non-Surgical Interventions.

Inpatient surgical discharge volumes have dropped to 89.7% with (1679) less than planned YTD. Initiatives to increase throughput, in the brief post COVID-19 environment, and before the FY end are underway.

Planned Care Measure 2: Elective Service Patient Flow Indicators

Principle: Timeliness
Patients receive care at the most appropriate time to support improved health. (ESPIs 1, 2, and 5)

ESPI 2: No patients will wait more than 120 days for their First Specialist Assessment (FSA)

CM Health compliance with the 120-day MOH ESPI 2 target for April 2020 continues to show a high level of breaches, with an increase of 1000 over the reported March results. There were significant volumes in General Surgery, Orthopaedics and Ophthalmology. Results are confirmed as remaining in red territory with 2505 breaches, a result of 20.1% against an orange upper limit of 0.39%.

The FSA volumes breaching the 120-day requirement have however shown considerable improvement in May 2020 and dropped by 370 over the month with improvements in many services. There is concern though at the continued deterioration in the Orthopaedic service position against the run of most other services.

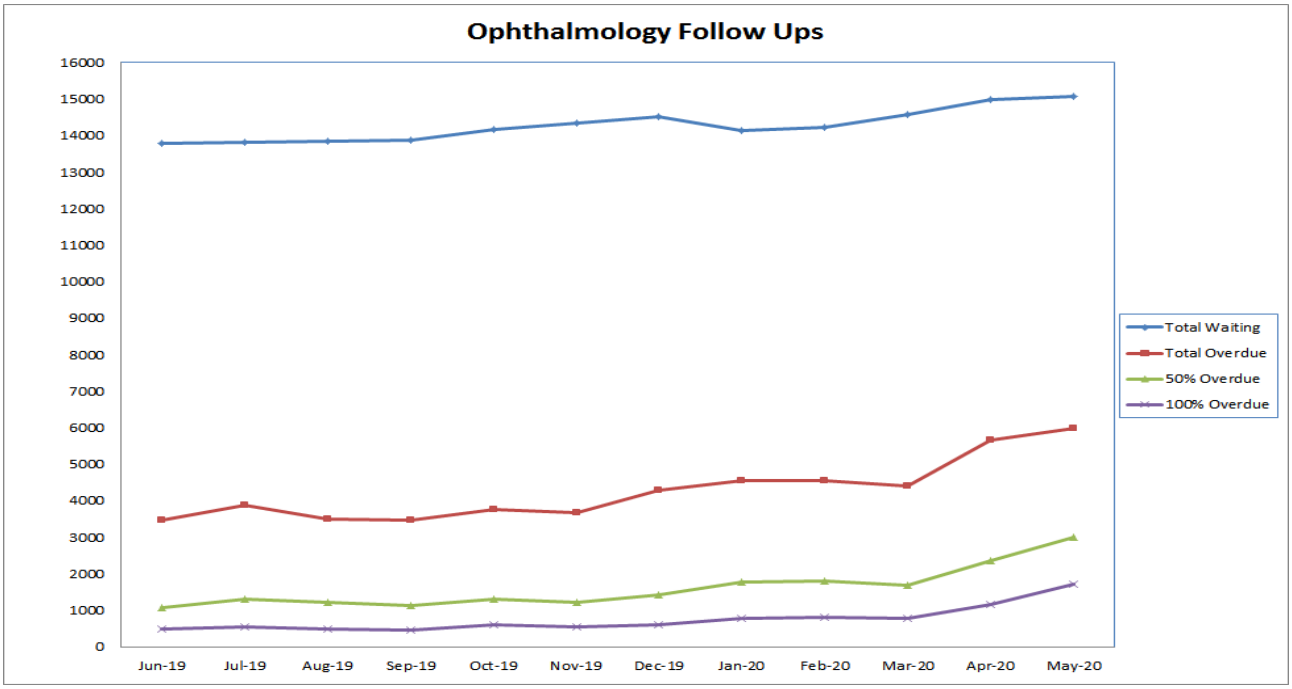
ESPI 5: Patients given a commitment to treatment will be treated within 120 days

With the release of April results CM Health has 485 ESPI 5 breaches, an increase of 240 from March levels. All surgical services have a level of breach. The major contributors to this total are General Surgery with 142, Ophthalmology with 116 and Plastics with 109.

May 2020 provisional results are showing improvement with a decrease of 60, with a notable halving to 72 in General Surgery but a small increase in Ophthalmology.

Planned Care Measure 4: Ophthalmology Follow-up Waiting Times

SS07 – Planned Care Measure 4 Principle: Timeliness	***Ophthalmology Follow-up Waiting Times***	***Waiting***	***Total***	***Overdue***	***Overdue 50% +***	***Overdue 100% +***
Patients receive care at the most appropriate time to support improved health		Jul	13803	3877	1313	540
		Aug	13833	3498	1219	496
		Sep	13880	3460	1121	473
		Oct	14178	3747	1302	602
		Nov	14350	3684	1288	533
		Dec	14520	4283	1417	601
		Jan	14140	4548	1760	781
		Feb	14231	4562	1790	812
		Mar	14587	4415	1685	775
		Apr	14984	5672	2345	1155
		May	15066	5968	3005	1706


Ophthalmology Follow Ups
16000
15000
14000
13000
12000
11000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Total Waiting
Total Overdue
50% Overdue
100% Overdue

SURGERY, ANAESTHESIA & PERIOPERATIVE SERVICES SCORECARD

May 2020

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Total Caseweight (Provider view)		2,794	3,579	-21.9%	33,026	36,225	-8.8%		
	Elective Caseweight incl Arranged Admissions		1,388	1,731	-19.8%	15,048	17,144	-12.2%		
	Acute Caseweight		1,405	1,847	-23.9%	17,978	19,081	-5.8%		
	Acute discharges		1,177	1,591	-26.0%	14,065	16,429	-14.4%		
	Elective Surgical Discharges incl Arranged Admissions		1,130	1,582	-28.6%	12,810	15,663	-18.2%		
	Outpatient FSA Volumes		2,326	2,259	2.9%	25,579	25,184	1.6%		
	Outpatient Follow Up Volumes		5,497	5,198	5.8%	51,862	56,930	-8.9%		
	Budgeted FTEs		1,392	1,341	-3.8%	1,301	1,269	-2.6%		
	Virtual FSAs/Follow ups -(GP consult and nonpatient appointments)		1,154	165	599.7%	3,542	1,801	96.7%		
	Personnel Costs ($000)		13,893	14,387	3.4%	148,743	148,783	0.0%		
	Financial Result Total ($m)		16,891	17,489	3.4%	179,007	175,838	-1.8%		
	Reduce clinical outsourcing ($000)		1,091	653	-67.1%	7,731	6,276	-23.2%		

		Trend	12 month average						Rating	Commentary (by exception)
		FY1718-1819	May-20	Target	Var		Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years			5.0%	5.0%		5.0%	5.0%		No Results Available
	% Staff Turnover			10.0%	10.0%		10.0%	10.0%		
	% Sick Leave			2.8%	2.8%		2.8%	2.8%		
	Workplace Injury per 1,000,000 hours			10.5	10.5		10.5	10.5		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)	Hand Hygiene compliance rate (based on Gold Audit) - Ward 11		85%	80%	5.0%		80%	-80.0%		
	Pressure Injuries / 100 patients		0.00	3.50	-3.50		0.00	0.00		
	Falls causing major harm / 1000 bed days		1.00	0.00	1.00		0.00	0.00		
	Severe Pressure Injury (ungradeable) per 1000 bed days		0.00	0.00	0.00		0.00	0.00		
	Surgical Site Surveillance for Major joints-									
	Antibiotics given 0-60mins before "knife to skin"			95%	-95%		95%	-95%		No Results Available
	Correct antibiotic			100%	-100%		100%	-100%		
	Appropriate skin preparation			100%	-100%		100%	-100%		
	CLAB rate/ 1000 line days		1.0	0.0	-1.0		0.0	0.0		
	Rate of S. aureus bacteraemia per 1000 bed days			0.0	0.0		0.0	0.0		No Results Available
	VTE - Ortho (Acute and Elective)		1.0	0.0	-1.0		0.0	0.0		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Timely	Pre-operative Length of Stay Days (from admit to surgery)		0.71	1.0	0.3	1.03	1.0	-0.0		
	ESPI 2 No. patients waiting >120 days for FSA - Elective (Surgical Services incl Gynae)		1988	0	-1988.0	1988	0	-1988.0		
	ESPI 5 No. patients waiting >120 days Treatment - Elective (Surgical Services incl Gynae)		462	0	-462.0	462	0	-462.0		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
System Integration (Effective)	Average Length of Stay - Acute Inpatient incl Burns		3.16	3.6	0.4	3.70	3.6	-0.1		
	Average Length of Stay - Acute Inpatient excl: Burns		3.10	3.6	0.5	3.63	3.6	0.0		
	Average Length of Stay - Acute Inpatient excl: Burns and Spinal Ortho		3.06	3.6	0.5	3.60	3.6	0.0		
	Average Length of Stay - Electives		1.09	1.5	0.4	1.27	1.5	0.2		
		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Efficient	Theatre list utilisation - % used MMH/MSC		88.5%	85%	4%	80.9%	85%	-4%		
	Theatre session utilisation - % used MMH/MSC		95.8%	95%	1%	85.4%	95%	-10%		
	Elective Theatre turnaround times- Mins (MSC only)		14.1	15	1	12.7	15	2		
	Elective cancellations - Day of surgery % of all Elective (all reasons)- SAPS only		7%	5%	-2%	8.8%	5%	-4%		
	Day of Surgery Admissions (DOSA)		99%	90%	9%	89%	90%	-1%		
	Day Case Rate (Elective/ Arranged) -Subspecialties in SAPS only Adults/kids		60%	65%	-5%	62%	65%	-3%		
	MMH % patients discharged to discharge lounge or home by 1100hrs		23%	30%	-7%	21%	30%	-9%		
	MMH % patients discharged to discharge lounge or home by 1100hrs -GEN SURG		25%	22%	3%	22%	30%	-8%		
	MMH % patients discharged to discharge lounge or home by 1100hrs- ORTHO		18%	30%	-12%	17%	30%	-13%		
	MMH % patients discharged to discharge lounge or home by 1100hrs- PLASTICS		25%	30%	-5%	20%	30%	-10%		
	Ratio FSA/FU clinic ratio		42%	34%	9%	49%	34%	16%		
	Outpatient DNA rates - overall- Surgical Services only		7.3%	10%	2.7%	8%	10%	8%		
	Outpatient DNA rates - Maori (FSA) - Surgical Services only		20.3%	10%	-10.3%	18.0%	10%	-8.0%		
	Outpatient DNA rates - Pacific (FSA)- Surgical Services only		13.3%	10%	-3.3%	14.8%	10%	-4.8%		
		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Equity	% of hospitalised smokers receiving smokefree advice & support -Total (Surgical)		95%	95%	0%		95%	-95%		
		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
P&WCC	Patient Experience Survey - month (n=91) and YTD (n=91)		96%	90%	6%		90%	-90%		

Central Clinical Services

Monthly Report – May 2020

Glossary

CM Health	Counties Manukau Health
CT	Computed Tomography
CD	Clinical Director
ePA	Electronic Prescribing and Administration (Medchart)
FTE	Full Time Equivalent
IANZ	International Accreditation New Zealand
MoH	Ministry of Health
MOW	Meals on Wheels
MRI	Magnetic Resonance Imaging
MRT	Medical Radiation Technologist
OP	Outpatient
RMO	Registered Medical Officer
SMO	Senior Medical Officer
TAP	Turn Around Plan
YTD	Year to date

Highlights

Pharmacy

- A huge amount of effort over April and May from managers and teams has gone in to successfully ensure staff safety and continuity of service throughout the Covid-19 alert levels.
- Scoping and roll-out plans for Medchart in to Gynaecology are underway. The Medication Safety Service is actively engaging with stakeholders and discussions are also underway with Womens Health and Paediatrics. Implementation in these areas will complete the organisation wide roll out.

Radiology

- Most of the Radiology waiting lists ballooned over the Covid-19 lockdown period. As we moved from lockdown National Alert Level 3 to Level 2, we have accelerated our bookings. Major inroads have been made into both CT and Ultrasound waitlists. Waitlists across all modalities have reduced as referrals continue to be lower than normal levels and additional evening and weekend sessions have been added to clear the backlog. Significant numbers of staff have volunteered to work additional sessions to support clearing the waitlists. Outsourcing for MRI and Ultrasound will resume in June to support waitlist reduction.

Laboratory Services

- There was a significant increase in Laboratory workloads due to Covid-19. Continually changing volumes and uncertainty of consumable supply also made for a challenging month, however the Laboratory has adapted well in response to the changing environment. Normal hospital lab referral volumes have resumed and additional funding has been approved to resource long-term COVID-19 testing.

Emerging Issues

Laboratory

- Border testing started for Covid-19 from 7 June 2020. In addition to border testing, all people in quarantine will be tested on Day 3 and Day 10 which will add to Laboratory workload volumes. The MoH have approved funding for ongoing COVID-19 testing which has enabled the DHB to fund long-term testing.

Update on Previously Reported Issues

Issue	Date first reported	Status update e.g. "resolved", "unchanged and actively monitored"	Mitigation Strategies
General x-ray service	Jan 2017	The general x-ray service waiting list normally increases over winter due to MRT vacancies and additional seasonal volumes. This year, due to Covid-19 issues, we have had no resignations from staff heading overseas due to travel restrictions and lockdown. The waitlist is expected to be back within clinical target levels by the end of June.	Additional evening and weekend sessions in June.
MRT FTE	Apr 2017	March vacancy rate at 3.29FTE (see above). Long-term planning for staff retention and recruitment will continue despite the positive short-term situation the long-term risks remain.	Long term recruitment and retention planning.

National Health Targets

We continue to report on what were the National Health Targets; Diagnostic Access Targets. As requested we have added in the percentage of Maaori and Pacific people who were seen within 6 weeks. The statistics for this month (May) are shown.

	March	April	May	Maaori	Pacific
% MRI scans completed within 6 weeks from acceptance of referral (average weekly)	54%	43.3%	41.5%	46%	41%
% CT scans completed within 6 weeks from acceptance of referral (average weekly)	65%	59%	51%	56%	50%

Commentary on Performance against National Health Targets

CT

Month	March	April	May
Target achieved (average weekly)	65%	59%	51%
Acute demand (average weekly)	366	351	471
OP/GP demand (average weekly)	293	223	317

- Acute demand increased in May by 34% and GP/OP demand by 42%. This was a result of coming out of Level 4 lockdown and our increased booking activity.
- Training is going very well, a further new trainee commences at the beginning of June.

MRI

Month	March	April	May
Target achieved (average weekly)	54%	43.3%	41.5%
Acute demand (average weekly)	46	52	77
OP/GP demand (average weekly)	122	95	162

- Acute demand increased by 47% in May. This was as a result of coming out of Level 4 lockdown and our increased booking activity. GP/OP demand increased by 70%.
- Alternate weekend sessions that were stopped with the Covid-19 lockdown have re-commenced.

- We continue to outsource 15 cases per week.
- Staff adequate. Second grade in place and doing well.
- Improvement project still running. New production planning tool to be formalised. Booking issues being sorted out.

Food Service

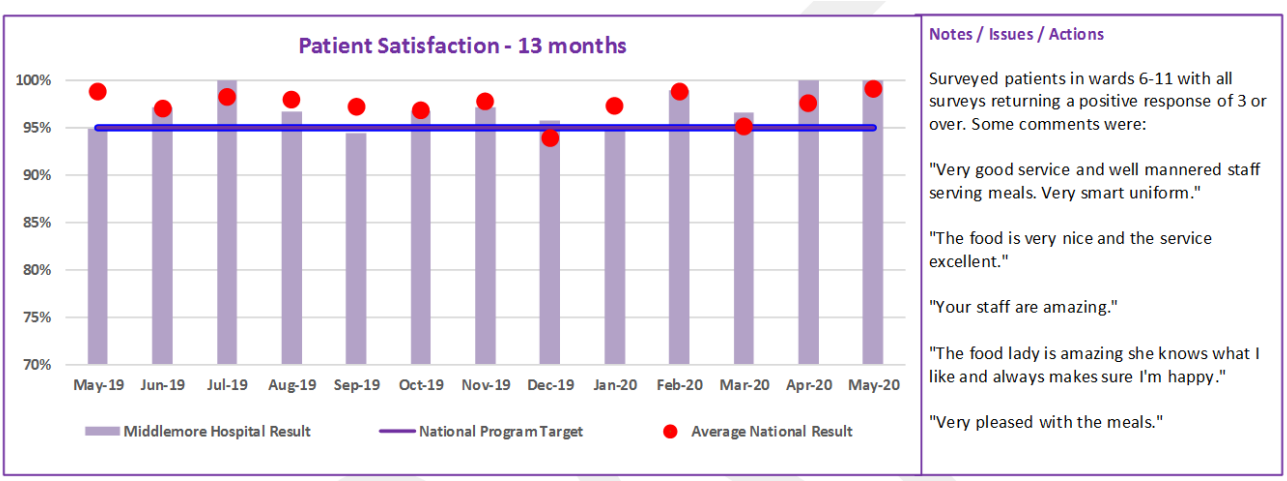
Patient Survey and KPI Reporting

The patient satisfaction survey response is a KPI in the Food Service Agreement. Discussions are occurring regarding review of the KPIs to increase quality questions in the reporting.

The survey is distributed to a small group of wards each month. In May 160 surveys were distributed to patients with 92 returned, a 58% response rate. 30 surveys were distributed to staff with 21 returned, a 70% response rate.

The survey response rate improved in May from April, most likely due to wards returning to somewhat normality after the reducing impact of Covid-19. Wards 6 and 7 which were scheduled to be surveyed in April were included in this month's survey run.

Compass KPI Reporting and Patient Satisfaction Results

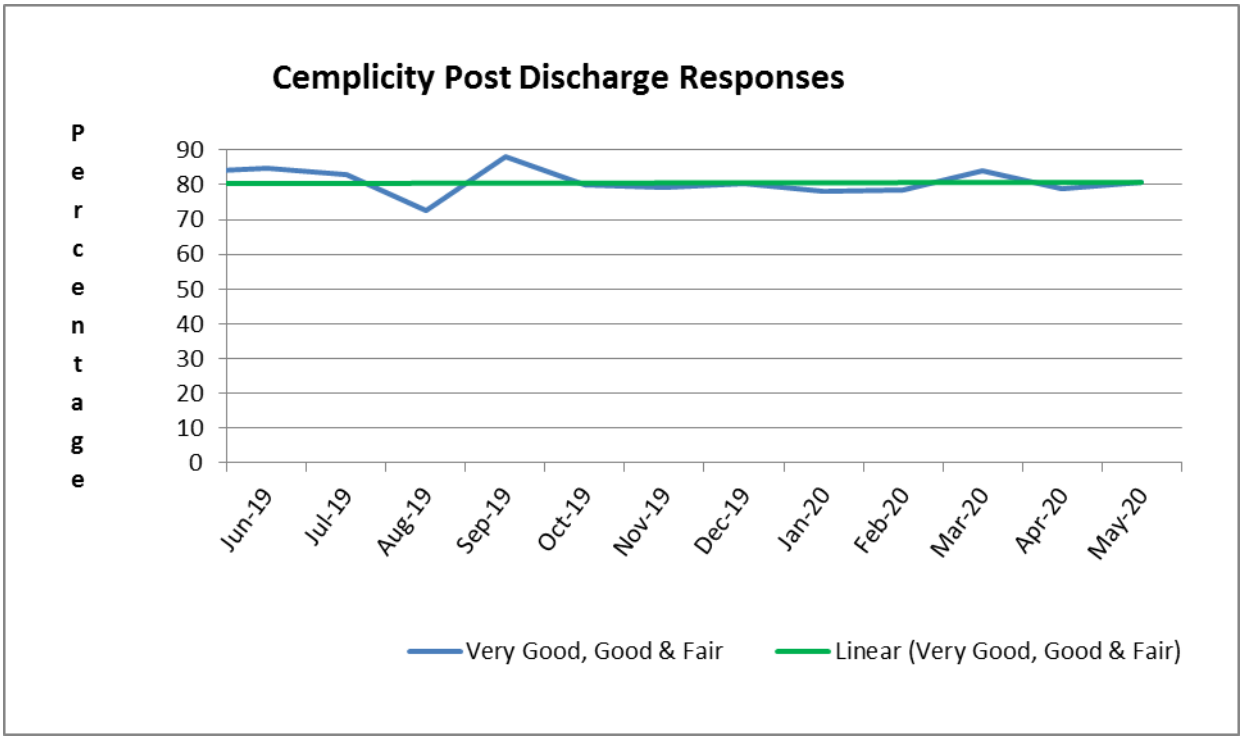


The Compass overall satisfaction score from the Ok, Good and the Very Good responses was 100%, (the same as last month) and is an improvement on May last year.

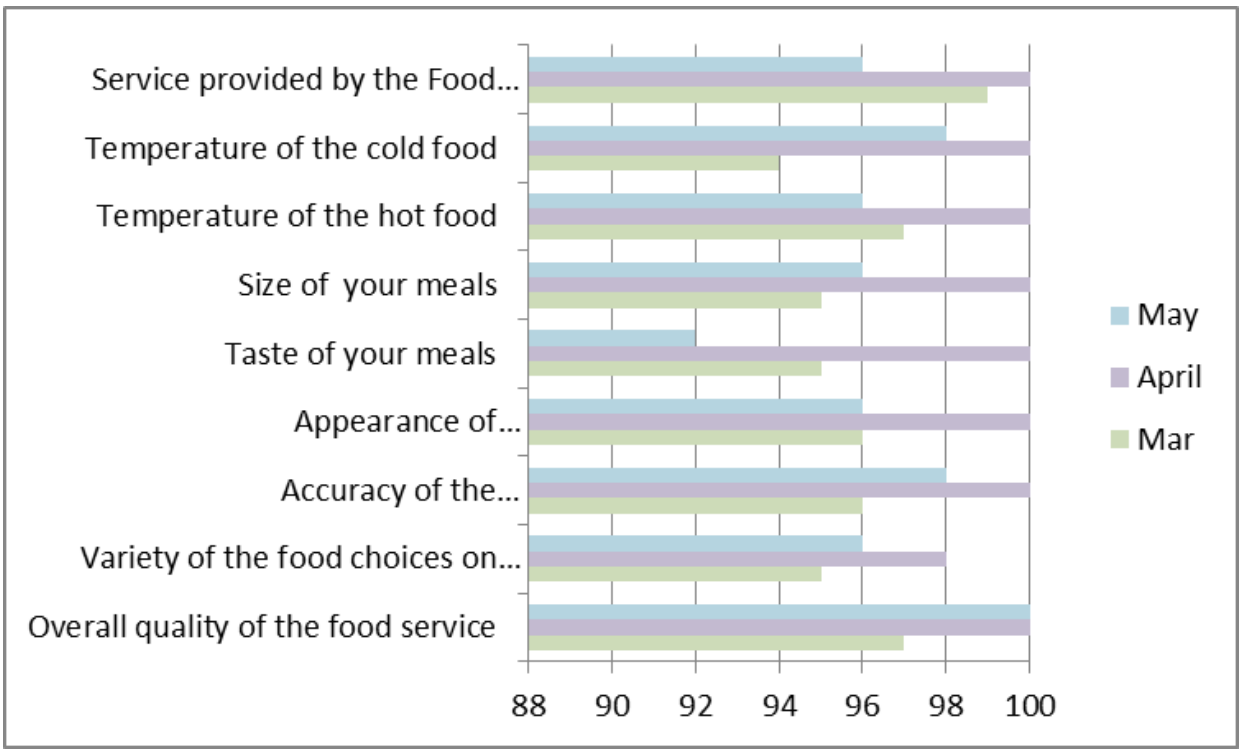
Cemplicity Survey Response

CMH patient survey responses are from the post discharge Cemplicity survey with a variable monthly response rate. In May there were 183 verbatim comment responses for Middlemore Hospital and 55 for the satellites. The overall Cemplicity patient satisfaction rating this month is 81% compared with 79% in April.

The responses in this survey differ compared with the Compass inpatient surveys, due to a different response scoring structure.

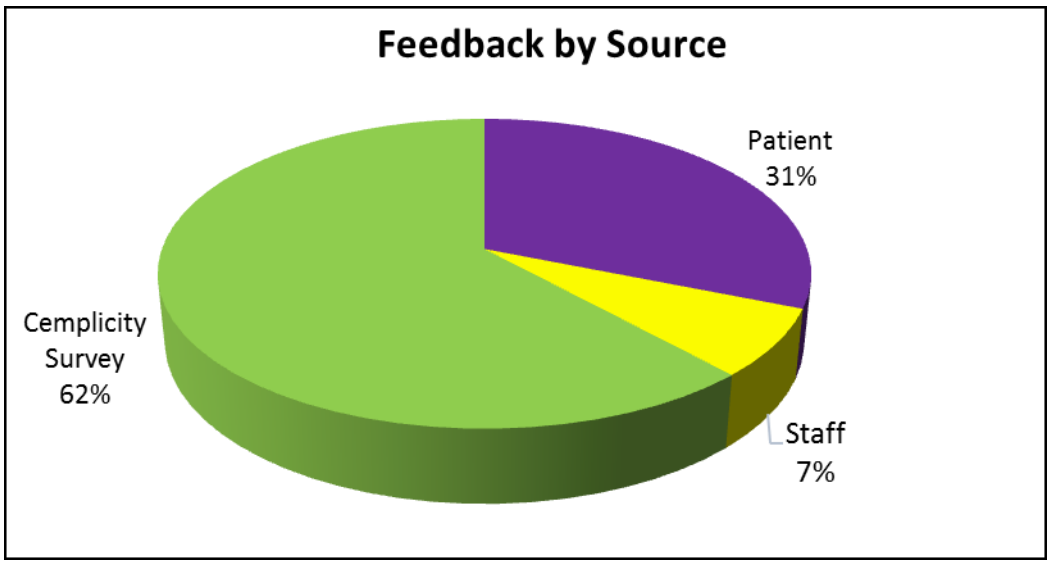


The Compass survey asks questions regarding the different elements of food service. The responses are reported in the chart below.



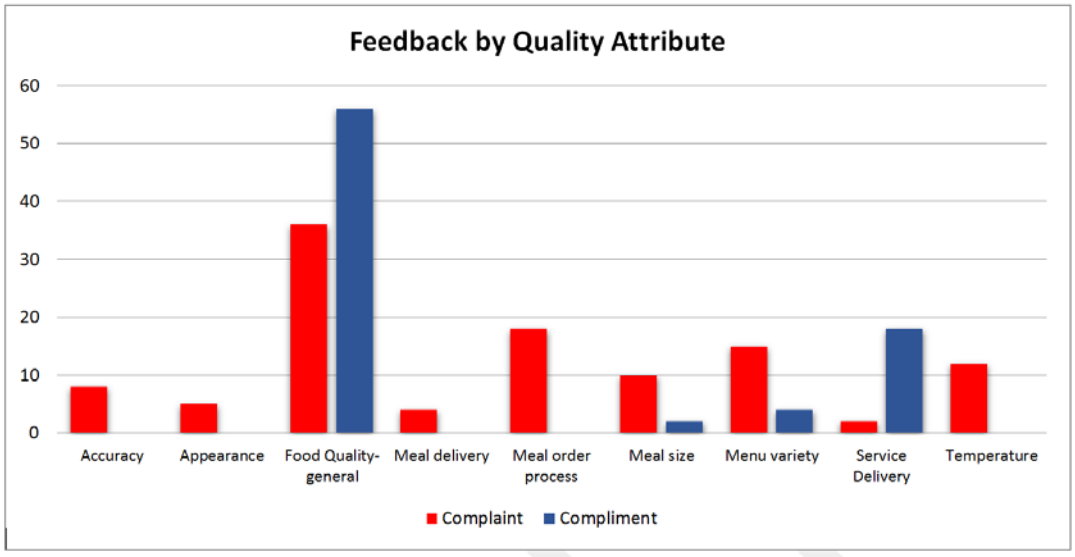
Middlemore Hospital Patient Feedback

Patient feedback is received from all sources including risk monitor, clinical staff, survey comments, issues reported directly to the kitchen. All items are categorised and placed in a feedback database. This is used as a basis for the quality improvement programme for the kitchen to target areas.



This month the Cemplicity post discharge survey accounted for 62% of feedback compared to 74% last month. The comments have been categorised to develop action plans where possible to address the issues. There was more staff feedback this month.

From the patient survey feedback



Food quality comments were again the predominant category this month. Overall there were 55 compliments and 37 complaints from the patient survey. Other categories were low this month.

Continuous Improvement

Focus Area	Identified Issue	Target/ Measure	Target Completion	Activity
Menu Photo Description Booklet	Patients unable to identify meals based on menu naming conventions	Development of visual aid for patients and staff to utilise	Continuous	Resource has been developed and distributed to specific areas for feedback – none received to date. Further rollout to wards and further copies provided to FSA team. Positive feedback from FSA team received. Laminated copies provided to FSA team for utilisation at ward level.

Focus Area	Identified Issue	Target/ Measure	Target Completion	Activity
Temperature Review	Patient feedback identifying meals not hot enough and porridge not desirable.	Reduction in constructive patient feedback	Jan 2020	Feedback identified as recurrent. Action plan to be developed to address temperature issues. Review porridge utilisation on call back meals. May not be suitable. Phase 1: review of end point temperature recording, trayline holding temperature and post Burlodge boost temperatures (underway). Phase 2: trayline loading temperatures, ward delivery temperatures and service temperatures (Dec – Jan). ↑ Completed – report presented at January Operations Meeting. Phase 3 – develop temperature map of food trolley delivery to ward area.
Foodservice Manual	Improvement of understanding and communication between foodservice and clinical teams re kitchen/ward process	Completion of manual	TBA	Currently completing initial review and content development. Work on manual has restarted.
Faxless Feb	Removal of internal fax system	Nil fax sent to kitchen	Feb 2020	Planning complete for scan to email function within kitchen. Awaiting implementation of system process by Health Alliance. Kitchen process change negligible, minimal impact expected.
Non-Compliant Menu Item Ordering	Clinical team requesting ability to order menu items which are non-compliant with patient diet code.	Process developed and agreed upon	Ongoing	Process document drafted by Foodservice and presented for review. Continued meetings re finer details of process and delegation of responsible areas. Process document finalised and agreed by all parties.

CENTRAL CLINICAL SERVICES SCORECARD — May 2020

		Trend				12 month average			Rating	Commentary (by exception)
Enabling High Performing People		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
	% Staff with Annual Leave > 2 years			5.0%	5.0%		5.0%	5.0%		
	% Staff Turnover			10%	10%		10%	10%		
		Trend				Year to date			Rating	Commentary (by exception)
Safety		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
	% electronic medication reconciliation completed for high risk patients within 48hrs			80%	-80%		80%	-80%		
		Trend				Year to date			Rating	Commentary (by exception)
Timely		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
	% MRI scans completed within 6 weeks from acceptance of referral			85%	-85%		85%	-85%		
	% CT scans completed within 6 weeks from acceptance of referral			95%	-95%		95%	-95%		
	Radiology - Inpatient radiology times < 24hours			95%	-95%		95%	-95%		
	Radiology ED radiology times < 2 hours			95%	-95%		95%	-95%		
	Laboratory -Test turnaround time (TAT) within 60mins									
	Potassium		**98%**	90%	8%	**98%**	90%	8%		
	Haemoglobin		**100%**	98%	2%	**99%**	98%	1%		
	PT/INR		**100%**	98%	2%	**99%**	98%	1%		
	Troponin T for ED		**97%**	90%	7%	**96%**	90%	6%		
	Histology - All - 5 working days		**87%**	80%	7%	**87%**	80%	7%		
	Breast - 3 working days - BRCBX		**96%**	90%	6%	**97%**	90%	7%		
	Non gynae FNAs - 3 working days		**85%**	90%	-6%	**90%**	90%	0%		
	Blood Bank - antibody screen within 4 hours		**95%**	90%	5%	**94%**	90%	4%		
	Microbiology									
	CSF cell count <30mins		**88%**	90%	-2%	**95%**	90%	5%		
	ESBL screens <2days		**88%**	95%	-7%	**92%**	95%	-3%		Affected by the changes made during Covid. These results will not return to Target Delivered for several months.
	CDT (C. diff Toxin) <25hrs		**91%**	90%	1%	**91%**	90%	1%		
	UCHM (Urine Chemistry) <60mins		**94%**	90%	4%	**95%**	90%	5%		
	% radiology results reported within 24 hours			75%	-75%		75%	-75%		
		Trend				Year to date			Rating	Commentary (by exception)
System Integration (Effective)		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
	% transcribed clinical summaries (meddocs) authorised <7 days of creation		**70%**	95%	-25%	**64%**	95%	-31%		

Women's Health

Monthly Report – May 2020

Glossary

ALOS	Average Length of Stay
CLAB	Central Line Associated Bacteraemia
DNA	Did Not Attend
ED	Emergency Department
ESPI	Elective Services Patient Flow Indicators
FSA	First Specialist Appointment
HCA	Health Care Assistant
KF	Kidz First
MECA	Multi-Employer Collective Agreement
MoH	Ministry of Health
NHPPD	Nursing Hours per Patient Day
RDA	Resident Doctors Association
SUDI	Sudden Unexplained Death of Infant
VIP	Violence Intervention Programme
YTD	Year to Date
WH	Women's Health
WIES	Weighted Inlier Equivalent Separations (Case weights – a measure of complexity)

Highlights

Overall Activity

Year to date inpatient discharges (acute and elective) as at 31 May 2020 are at 26,098 and are behind the 11 month figure to May 2019 by 5.0%. Inpatient volumes (case weights and Relative Value Units) of 18,604 are 2.0% lower than the same 2019 period. Average length of stay for the 11 months is 1.78 days (prior period 1.66). For the month of May, overall Maternity discharges are 7% behind May 2019; Gynaecology volumes are ahead of last year by 6%.

Outpatient activity is much reduced as a result of the Covid crisis – FSAs are 11% below contract for the month (but YTD up 1%) and Follow Ups are collectively 25% down on contract for the month as a result of clinic closures (YTD down 7%). Outpatient volumes now include phone consultations.

Birth numbers for the month are 3% behind May last year (YTD behind 3%).

Financially, the service is favourable to budget for the month by $34k, and under budget for the 11 months to date by $24k.

The full year adjusted forecast is virtually at breakeven to budget.

Maternity

Highlights

COVID-19 planning and preparations for admissions and management in community went well where the service responded quickly to changes in models of care, team approach and reduced or altered service delivery requirements. A comprehensive suite of documents is now available for future pandemic planning and response. Business returned to normal quickly post level 4 lockdown. Outpatient services returning to new normal over the month.

Emerging Issues

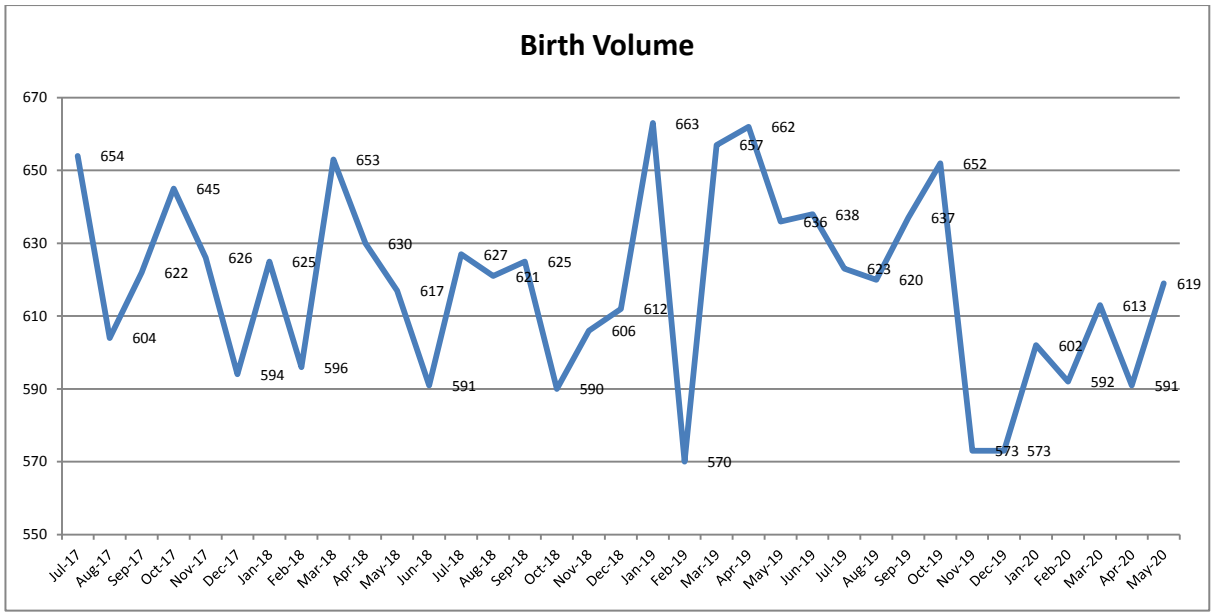
The rising intervention rates may possibly be the result of reduced volumes of care and presentations during COVID-19 lockdown period.

There is a cumulative increase in educational requirements for Registered Midwives and Nurses due to no education days being available during COVID-19 level 4-2 lockdown periods. This will impact the number of education days required in the second half of the year to ensure midwives and nurses can meet their competency and professional development requirements.

There were 569 births at MMH and 50 at the community units making a total of 619 births for May 2020. This is down 3% compared to May 2019; year to date births are now 3% lower than the prior period.

Births	May-20				Year to Date			
	2019-20	2018-19	+/-	+/- %	2019-20	2018-19	+/-	+/- %
MMH	569	584	(15)	-3%	6,084	6,181	(97)	-2%
Botany	17	21	(4)	-19%	195	241	(46)	-19%
Papakura	10	12	(2)	-17%	160	190	(30)	-16%
Pukekohe	23	19	4	21%	256	257	(1)	0%
Total Community Units	**50**	**52**	**(2)**	**-4%**	**611**	**688**	(77)	-11%
Total # of Births	**619**	**636**	**(17)**	**-3%**	**6,695**	**6,869**	**(174)**	**-3%**

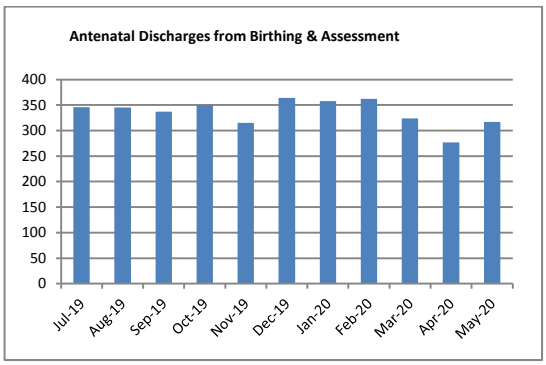
The shift in the trend of facility birth volumes from November 2019 is consistent with May, where the average of the previous 6 months was 634; now average 594. There could be various factors influencing this change in facility birth volume including the opening of a private birthing facility in Mangere.



The caesarean section (CS) rate for May 2020 was high at 32.8%; instrumentals at 9.7%; spontaneous birth rate dropped to 57.5%; average 19/20 rate has been 61.7%. During May, COVID-19 precautions at Level 3 were still influencing length of stay; however all planned procedures (Inductions of Labour (IOLs) and CS) returned to normal with an increase in secondary care appointments and midwifery surveillance.

		Fact Inpatient Count		PUC Volume		Average Length Of Stay	
PUC Code And Description	PUC Measure	Current Fiscal Year	Previous Fiscal Year	Current Fiscal Year	Previous Fiscal Year	Current Fiscal Year	Previous Fiscal Year
W02020 - Inpatient maternity care primary maternity facility	RVU	3,230	3,694	4,543	5,278	1.70	1.69
W02020-NEO - Inpatient maternity care primary maternity facility - Neonates	RVU	196	187	182	172	3.68	3.19
W02020-WNB - Inpatient maternity care primary maternity facility - Well	RVU	3,080	3,613	2,107	2,504	1.77	1.76
W06003 - Secondary Neonatal	CWD	1,969	1,780	1,624	1,148	3.50	2.75
W10001 - Maternity Inpatients	CWD	13,402	14,138	7,171	7,208	1.63	1.51
Grand Total		21,877	23,412	15,627	16,310	1.85	1.69

Postnatal bed occupancy (including boarder mums) continued to be lower during May (as with April); this was thought to be due to the strict visiting policy applied to all facilities which enabled two support person for labour/birth and one during day hours for postnatal visiting. Restrictions also continue on enabling food to be brought into facilities. The average length of postnatal stay was 2.2 days (2.4 days last year). For women after vaginal birth the ALOS is 2.2 days (Maori 1.9 days); primiparous women 3.1 days (Maori 2.8 days). Only primiparous women meeting target of 3 days postnatal stay.



Antenatal discharges from the Birthing and Assessment Unit were lower again in May but rising closer to the average of 335 per month. Maternity Assessment Clinic volumes were higher than the average (148) at 172 women attending in May. Community midwifery visits were less due to the use of telephone consultations for booking and non-urgent scheduled appointments where possible. DNA rates for midwifery appointments were low at 11-13%.

Workforce

After the large cohort of graduate midwives started in April, 3 further Registered Midwives started in May 2020. The Nurse Clinical Coach role commenced to support the large cohort of new to service registered nursing staff in the postnatal wards at Middlemore Hospital.

Current maternity bed capacity at Middlemore Hospital is now at 59 beds with 5 resourced gynaecology beds on Ward 21. There were 58 women with acute gynaecological conditions admitted to Ward 21 during May with only one outlier in 33N. A dedicated transitional baby area has been established on Maternity North (4 beds). Stage three of the 2018 Workforce and Bed Capacity Plan will be implemented by end June 2020, with 2 further transitional beds on level 4, and 5 more gynaecology beds opening on Ward 21, dependent on successful midwifery/nursing recruitment.

Update on previously reported issues - Maternity

Issue	Date first reported	Update May 2020
Rising Caesarean Section (CS)rate	January 2017	• CS rate for May at its highest to date at 32.8%. YTD CS rate is 29.8% (prior year 29.0%) • May IOL rate up to a high of 34%. YTD Induction of Labour rate is now 34% for May (average 19/20 year was 28%). Total IOL and augmentation rate is 52%. • The project with Mid Central DHB experts to explore use of a new pathway management of IOL will be reignited post Covid with some urgency for a review of CS or IOL rates.
Midwifery workforce shortage	January 2017	• Midwifery vacancies are forecast for roster beginning 15th June 2020. Vacancy rate without opening additional beds is 41.77. These vacancies are partially offset by 8.75 over appointment of permanent nurses, and 3 FTE community health workers, 12.45 FTE bureau and 16.64 additional FTE worked by our employed RM/RMs.

Issue	Date first reported	Update May 2020
		• Recruitment and retentions strategies - some interest from overseas midwifery candidates to work in New Zealand. • Trend Care roll out continued during COVID19 Level 4-2 with increase uptake in all areas.
MCIS	April 2017	• Timeline for go live with Badgernet Global extended due to COVID19 impact in the UK and change requirements to adapt to the New Zealand environment. Likely time frames for project kick off is September 2020 with go live March 2021. • Consider Cardiotocograph integration prior to Global go live. • Med Chart roll out July-Sept 2020 to all Women's Health areas. • Regional planning underway in partnership with vendor for clinical portal interface to provide snapshot view for non-maternity practitioners; also paused due to COVID-19.

Gynaecology

YTD Gynaecology discharges (both acute and elective) are 4,216 (prior year was 3,993), a 6% increase with overall WIES up by 10% compared to prior year.

		Fact Inpatient Count		PUC Volume		Average Length Of Stay	
PUC Code And Description	PUC Measure	Current Fiscal Year	Previous Fiscal Year	Current Fiscal Year	Previous Fiscal Year	Current Fiscal Year	Previous Fiscal Year
S30001 - Gynaecology Inpatients	CWD	4,216	3,993	2,977	2,697	1.45	1.48
Grand Total		4,216	3,993	2,977	2,697	1.45	1.48

A major increase in outsourcing has added to the growth of Discharges and WIES:

Discharge Facility Code And Description	PUC Measure	Current Fiscal Year	Previous Fiscal Year	Current Fiscal Year	Previous Fiscal Year
8459 - Auckland Surgical Centre	CWD	3	3	1	2
8722 - Auckland City Surgical Services	CWD	115	78	56	40
8785 - Ormiston Surgical & Endoscopy	CWD	173	0	158	0
Grand Total		291	81	216	42

Highlights

- 4th cohort of private outsourcing is ongoing and continued throughout Covid pandemic.
- On-going improvement program with Ko Awatea for Diabetes in Pregnancy model of care
- Telehealth introduced; utilised in Antenatal care on occasions where clinically appropriate
- Additional OT sessions approved for 4 Saturdays in June to assist the reduction of the Covid backlog
- Additional clinics approved for 4 Saturdays in June to help reduce Covid backlog
- Reduced numbers of patients outlying on wards other than GCU and Ward 21

Emerging Issues

- National Covid level 2 during May resulted in decreased volumes in theatre and clinics due to social distancing and cleaning.
- 23 ESPI 2 and 9 ESPI 5 breaches on the whole due to Covid 19 restrictions
- Fundamentals of Care audit occurred late March for GCU –results not yet available
- Access to service for women with uro-gynaecological issues re-assessed given impact of Covid lockdown on waitlists

Update on previously reported issues - Gynaecology

Issue	Date reported	Update
Un-met need in community for women with pelvic pain and uro-gynaecology		This was impacted by Covid 19 with elective clinics ceased for all other than cancer or urgent/time dependant needs. Additional in-house theatre and clinic session approved for Saturdays in June with volunteers sought and lists booked. 4th Cohort – commenced March with intended completion July 2020, intention to continue to December. Surgical outsource contract continues for hysteroscopy and tubal ligations, intention to continue.
Long waiting times on Gynaecology surgical waitlist		ESPI 5 for May has 9 breaches; all requiring Middlemore theatre access. Surgical Outsource contracts on going. Saturday surgery approved due to Covid backlog. Additional outsource contract recommended for higher BMI women, paper being written.
SMO rostering issues	March 2019 entered on risk register	Can now be removed from risk register as resolved. Electronic roster went into production at the end of February, successful to date. SMO after-hours questionnaire completed; highlighted current model of care is preferred (1/16).
Diabetes in Pregnancy Clinics		On-going work with Ko Awatea quality team. Model of Care currently is not enabling timely access to service for women with diabetes in pregnancy. Increased telehealth utilised throughout March and April due to COVID 19 restrictions; videos produced by DiP team.
Extended wait times in ED for women accessing Gynaecology		Attainment remains variable , deep dive currently under completion by Quality Manager to identify barriers. Gynaecology continue to engage with the ED leadership team to manage gynaecology ED; EPAC not suitable to act as Gynae ED area during covid 19.
Gynaecology does not attain Faster Cancer Tracking target on an ongoing basis	February 2020	High volumes of women requiring cancer diagnosis are waiting an unacceptable time to exclude endometrial cancer; these women frequent our breaches and have a low yield of cancer. Gynaecology cancer team engaging with Cancer team to identify barriers and/or aareas creating a bottle neck Grading identifed as an area of delay; increased SMO FTE has increased opportunity for grading to occur more frequently.

WOMEN'S HEALTH SCORECARD	May 2020							
					Year to date			Rating	Commentary (by exception)
	May-20	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability								
Acute Caseweight - Gynaecology Inpatients- acute	144	142	1%	1,497	1,538	-3%		
Acute Caseweight - Secondary Neonatal Womens health	0	4	-100%	17	39	-56%		
Acute RVU - Inpatient maternity care primary maternity facility	3	34	-91%	17	372	-95%		
Acute Caseweight - Women's Health secondary	18	10	80%	131	103	27%		
Elective Caseweight - Gynaecology Inpatients - elective (includes AA)	117	149	-21%	1,473	1,471	0%		
Hysteroscopy	40	67	-40%	376	666	-44%		
Total Discharges - Gynaecology Inpatients- acute	242	227	7%	2,610	2,483	5%		
Total Discharges - Secondary Neonatal Womens health	214	169	27%	1,968	1,780	11%		
Total Discharges - Inpatient maternity care primary maternity facility	481	719	-33%	6,491	7,473	-13%		
Total Discharges - Women's Health secondary	1,179	1,322	-11%	13,403	14,138	-5%		
Total Discharges - Gynaecology Inpatients - elective	148	170	-13%	1,606	1,510	6%		
Gynaecology - 1st Attendance	157	230	-32%	2,029	2,517	-19%		
Non-Contact FSA Gynae Virtual	7	59	-88%	568	644	-12%		
Non-Contact FSA Maternity	185	191	-3%	2,153	2,088	3%		
First Obstetric Consults S/B Doctors	246	234	5%	3,002	2,559	17%		
Foetal Medicine/Anomalies Clinic - MDC	72	75	-4%	899	825	9%		
DHB non-specialist antenatal consults	1,260	1,373	-8%	15,084	14,999	1%		
Gynaecology - Subsequent Attendance	201	243	-17%	2,817	2,662	6%		
Subsequent Obstetric Consults F/U S/B Doctors	268	206	30%	3,024	2,260	34%		
DHB non-specialist postnatal consults	472	864	-45%	7,438	9,456	-21%		
					Year to date			Rating	Commentary (by exception)
	May-20	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability								
Budgeted FTEs	410	456	10%	410	456	10%		
Operating Costs ($000)	401	391	-3%	4,077	4,387	7%		
Personnel Costs ($000)	4,154	4,123	-1%	42,431	42,158	-1%		
Financial Result Total ($000)	(4,481)	(4,515)	1%	(46,484)	(46,509)	0%		
Reduce Clinical Outsourcing ($000)	65	6	-983%	424	284	-49%		
					12 month average			Rating	Commentary (by exception)
	May-20	Target	Var	Actual	Target	Var		
Enabling High Performing								
% Staff with Annual Leave > 2 years - (one month in arrear)		5.0%	5.0%		5.0%	5.0%		
% Staff Turnover - (one month in arrear)		10.0%	10.0%		10.0%	10.0%		
% Sick leave - (one month in arrears)		2.8%	2.8%		2.8%	2.8%		
Workplace injuries recorded per 1,000,000 hours - (one months in arrears)		10.5	10.5		10.5	10.5		
				Year to date			Rating	Commentary (by exception)	
	May-20	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)								
Emergency trolley checks (days checked) per month		100%	-100%		N/A	0.0%		
Hand hygiene (compliance with checks) per month		80%	-80%		N/A	0.0%		
Safe Sleep audits compliance		100%	-100%		N/A	0.0%		
Health and Safety Environmental Audit (bi-monthly)		100%	-100%		N/A	0.0%		
Violence Intervention Programme (VIP) Screening	47%	80%	-33%	41%	80%	-39%		
				Year to date			Rating	Commentary (by exception)	
	May-20	Target	Var	Actual	Target	Var		
Timely								
ED 6 hour target - National Health target (Gynae)	80%	95%	-15%	74%	95%	-21%		
ESPI 2 - No. waiting >4 months for FSA - Elective	22.0	0.0	-22.0	22.0	0.0	-22.0		
ESPI 5 - No. waiting > 4 months for treatment - Elective	9.0	0.0	-9.0	9.0	0.0	-9.0		
				Year			Rating	Commentary (by exception)	
	May-20	arget/Last Yea	Var	Actual	arget/Last Yea	Var		
System Integration (Effective)								
% transcribed clinic letters authorised <7 days created	80%	95%	-15%	75%	95%	-21%		
ALOS Women's Health - babies (WNB and Neonates)	2.50	2.80	0.30	2.50	2.70	0.20		
Average Length of Stay Gynaecology - Middlemore	1.69	1.53	-0.16	1.67	1.73	0.06		
Average Length of Stay Gynaecology - MSC Inpatients	0.71	0.69	-0.02	0.85	0.66	-0.19		
Average Length of Stay Obstetric (DHB Mat) (1 month in arrear)	1.78	2.36	0.58	2.13	2.42	0.29		
Average Length of Stay Obstetric (Ind. Mat) (1 month in arrear)	1.92	2.16	0.24	2.26	2.43	0.17		
Average Length of Stay Vaginal Deliveries overall	1.90	2.30	0.40	2.20	2.20	0.00		
Maaori - 1st time mothers	2.30	2.30	0.00	2.80	2.50	-0.30		
Pacific - 1st time mothers	3.00	3.60	0.60	2.80	3.00	0.20		
				Year			Rating	Commentary (by exception)	
	May-20	Target/Last	Var	Actual	arget/Last Yea	Var		
Efficient								
FSA / Follow up ratio - Gynae	1:2.78	1:1	NA	1:2.78	1:1	NA		
DNA - Midwifery Antenatal clinics - First	11%	11%	0%	14%	12%	-2%		
DNA - Midwifery Antenatal clinic - Follow up	13%	9%	-4%	11%	12%	1%		
DNA - Doctor Antenatal clinics- FSA	11%	16%	5%	12%	13%	1%		
DNA - Doctor Antenatal clinics - Follow up	11%	10%	-1%	10%	10%	0%		
				Year to date			Rating	Commentary (by exception)	
	May-20	Target	Var	Actual	Target	Var		
P&WCC								
Patient experience survey v good/excellent- month (n=109), YTD (n=1216)	85%	76%	9%	90%	76%	14%		

Kidz First Divisional Report

Monthly Report – May

Glossary

ALOS	Average Length of Stay
CLAB	Central Line Associated Bacteraemia
DNA	Did Not Attend
ED	Emergency Department
ESPI	Elective Services Patient Flow Indicators
FSA	First Specialist Appointment
HCA	Health Care Assistant
KF	Kidz First
MECA	Multi-Employer Collective Agreement
MoH	Ministry of Health
NHPPD	Nursing Hours per Patient Day
RDA	Resident Doctors Association
SUDI	Sudden Unexplained Death of Infant
VIP	Violence Intervention Programme
YTD	Year to Date
WH	Women's Health
WIES	Weighted Inlier Equivalent Separations (Case weights – a measure of complexity)

Highlights

Kidz First Paediatric Medicine and ED

For the month of May 2020, ED attendances were at 898 (prior year 2,524) – a 64% reduction – mostly due to the sudden and pronounced decrease in attendances since COVID-19 National Alert commenced. Year to date attendances are 19,032 (prior year 23,435) – a 23% reduction. Paediatric Medicine discharges were 187 for May - a 62% decrease on the prior year, also impacted by the lockdown (year to date a 17% reduction). Total WIES for the month was 199, a 64% reduction on prior year (year to date a 17% decrease). The contrast with May 2019 is even more pronounce as in 2019 winter came early with high volumes in both May and June when usual winter patterns are more July and August.

Kidz First Paediatric Medicine Outpatients (including Virtual/Telehealth consultations)

For the month of May 2020, Kidz First Outpatient FSAs are 17% ahead of contract and year to date favourable to contract by 15%. Follow-Ups are 67% ahead of contract for the month (YTD favourable 19%). During the month we changed to lockdown 3 and 2 and increased our face-to face appointments accordingly. There was only 1 ESPI 2 breach in May (decrease from the 4 in April). This was due to not able to locate this family during lockdown. From the start of lockdown and when acute volumes dropped so significantly we dedicated more SMO resources to work through the Planned Expired Appointments list resulting in the Planned Expired Appointments to decrease further by 58 to 628 in May (April was 686). We now have full SMO staffing and some 'surplus' as planned sabbaticals are not being taken and we will use this capacity to focus on reducing the Planned Expired Appointments list. With more face-to face appointments, DNAs during this time increased to 6% for FSAs and 10% for FUs.

Neonatal Volumes

Occupancy and acuity in May in the Neonatal Unit was down compared to April with an average of 65% (midnight count) occupancy, i.e. an average of 22 cots for the whole month against the 34 resourced cots. For year to date May 2020, the total Neonatal WIES (i.e. Neonatal Unit and those babies graduating from Neonatal Unit to Postnatal ward and then discharged) is at 99% of the contract level, and 104% of the prior year. Discharges for Neonates from the postnatal area and the Neonatal Unit combined are at 105% of prior year. Both average length of stay and average WIES are now slightly higher than last year's actuals.

Overview of all neonatal WIES

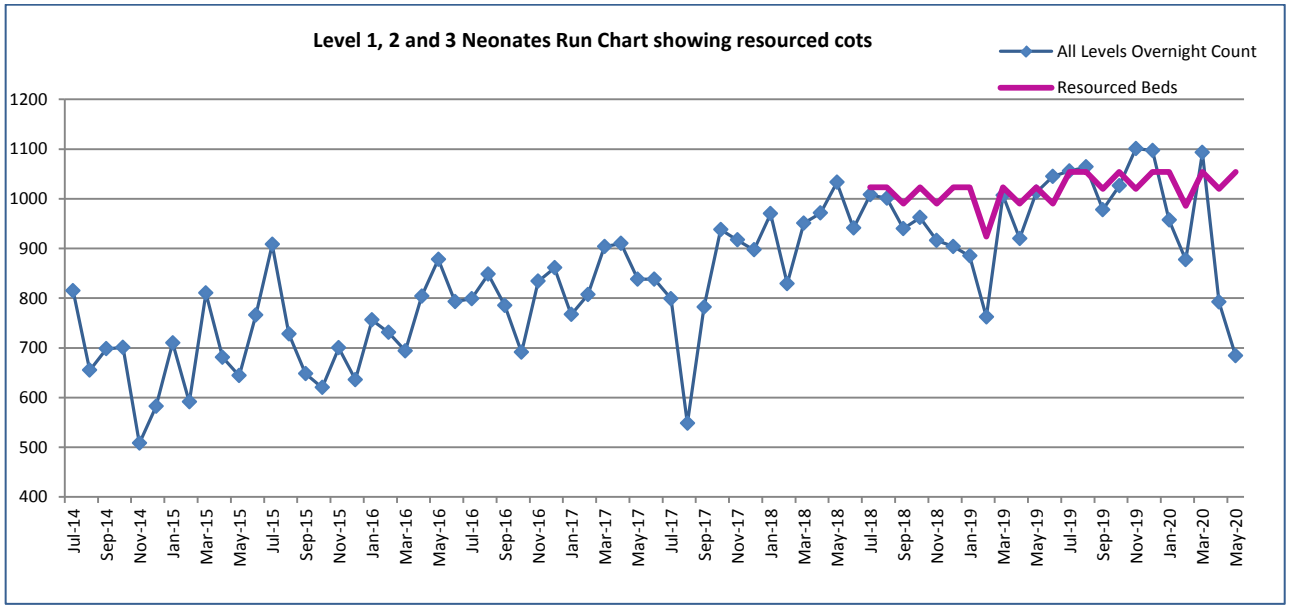
		Fiscal Period N	Values
			May YTD
Clinical Division	PUC Code A	PUC Measu	PUC Volume	Contract
KidzFirst Neonatal Care	W06003 - Secondary	CWD	2,301	2,718
Womens Health Services		CWD	1,620	1,245
Total WIES			3,921	3,963

PUC Volume			Fiscal Year	Fiscal Peric
			Current	Previous
Clinical Division	ode And De	PUC Measu	May YTD	May YTD
KidzFirst Neonatal Care	W06003 - Secondary	CWD	2,301	2,635
Womens Health Services		CWD	1,620	1,148
Total WIES			3,921	3,783

Discharge			Fiscal Year	Fiscal Peric
			Current	Previous
Clinical Division	PUC Code A	PUC Measu	May YTD	May YTD
KidzFirst Neonatal Care	W06003 - Secondary	CWD	379	441
Womens Health Services		CWD	1,968	1,780
Total Discharges			2,347	2,221

Average Length Of Stay			Fiscal Year	Fiscal Peric
			Current	Previous
Clinical Division	PUC Code A	PUC Measu	May YTD	May YTD
KidzFirst Neonatal Care	W06003 - Secondary	CWD	22.54	22.19
Womens Health Services		CWD	3.49	2.75
Total Discharges			6.57	6.61

Average WIES Per Discharge			Fiscal Year	Fiscal Period
			Current Fiscal	Previous
Clinical Division	PUC Code And	PUC Measure	May YTD	May YTD
KidzFirst Neonatal Care	W06003 -	CWD	6.07	5.98
Womens Health Services	W06003 - Secc	CWD	0.82	0.64
			1.67	1.70



One of our Neonatologists is undertaking an audit of the sudden and pronounced reduction in admissions and acuity in the neonatal unit since COVID-19 lockdown commenced at the end of March. The Neonatal Unit remained busy up till the end of March with a significant drop in admissions from early April continuing on through May. As of 11 June we are back to occupancy of 33 babies.

Child Development Services

In the 2019/20 Wellbeing Budget funding has been made available for Child Development Services (CDS) in the Northern region to grow capability, achieve a more integrated regional approach and lead initiatives that support the progressive implementation of the CDS operating model described by the Ministry of Health. The Northern region through the NRA has organized itself to be able to provide regional leadership across the proposed work programme.

In October we were advised that our Child Development Services would receive $588,600 (for the period 1 Nov 2019 till 30 June 2020) for additional positions to address the current waitlist as well as improve access to services for Maaori and Pacific children and children who live in Quintile 5. We are working together with Ohomairangi Trust in developing new service and support models for Maaori infants with disabilities/developmental delayed discharged from the Neonatal Unit as well as Maaori children requiring on-going disability services post Gateway Assessment. Recruitment for the additional positions has progressed and 6.6 FTE out of the 7 new positions are now in place with recruitment for the remainder of the FTE underway. A small working group has been set up to manage the reporting requirements as well as lead the Child Development Service improvement work which is part of the requirements for the region. The NRA is now also finalising a paper for the regional Funder/CEO forum on the funding for 20/21 as well as carrying over the 19/20 under spend. We have also just been informed that CM Health has funding approved for another improvement project shared with Altogether Autism – aiming to improve understanding and environments for children with Autism/ASD accessing health services. We aim to roll this project out from July 2020.

Other Community Services

The impacts of the COVID-19 national alert level 4 and level 3 (lockdown) has been significant for the Kidz First community services. Services such as Child Development and Centre for Youth Health continued to predominantly working remotely with virtual visits/clinics in May. Most of the staff in these services continued working from home and we are very fortunate that these services were well set up (phones and laptops) to quickly move into this new service delivery mode. Our Kidz First Home Care Nursing services have continued to see the most fragile and clinically urgent children in their homes with good preparation and setting up of PPE use and processes. Our Public Health Nursing, Vision and Hearing Screening and secondary school based services continued to be amazing in assisting in staff flu vaccination, vulnerable children and adult flu vaccination initiatives and staffing the Community Based Assessment Centres and Mobile Testing Vans since schools closed on Tuesday 24 March. From the end of May when schools went back this workforce has refocused on working in the school environment.

Update on previously reported issues

Issue	Date first reported	Update May 2020
Neonatal Unit capacity	April 2016	• Average occupancy for May 2020 was 65% of the resourced capacity of 34 cots. • Recruitment of nurses continues to be a focus. We have been very successful in recruiting 22 NETP nurses who will start across the Kidz First services (including Neonatal Unit) between January and April 2020.. • Regional Neonatal capacity eased over the lockdown period with all Units seeing this decrease in admissions. Weekly updates on capacity remain in place. • Transitional care cost i.e. graduates from the neonatal unit being reunited on the postnatal floor alongside mothers returning to facility prior to infants discharge are now in place. • The ongoing neonatal unit demand and capacity issues remains on the organisation's risk register, with monthly reviews in place. • Following two initial meetings on the planning for the additional cots (MoH confirmed funding for $5m) we have needed to pause this work to allow for COVID-19 preparation for Neonatal services (locally and regionally). We recommenced this planning in early May with meetings with the FEAM project management team and completing the functional brief. A meeting with the architect/designer is scheduled for early June. At this stage the preferred space option is to use the adjacent corridor space to the Unit for expansion of the clinical bed spaces as this will give us significant natural light advantages as well as preserve space currently occupied by Laboratory Support Services. • Initiation of Neonatal paper for SLT, ELT has been completed – resourcing to 38 cots and will be considered for prioritisation for the 20/21 budget. •

KIDZ FIRST SCORECARD	May 2020							
					Year to date			Rating	Commentary (by exception)
		May-20	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Total Caseweight	**199**	566	-65%	**5,233**	6,131	-15%		
	Acute Caseweight - Paediatric Medicine Inpatients	**94**	245	-62%	**2,248**	2,656	-15%		
	Acute Caseweight - Emergency Medicine - ED	**30**	67	-55%	**652**	730	-11%		
	Acute Caseweight - Inpatient Paediatric Intensive Care Unit	**0**	3	-100%	**29**	28	4%		Very small numbers
	Acute Caseweight -Secondary Neonatal Unit	**74**	251	-71%	**2,304**	2,718	-15%		Overall between NNU and WH, result is 138 wies more than last year.
	Total Discharges - Paediatric Medicine Inpatients	**187**	498	-62%	**4,115**	4,817	-15%		
	Total Discharges - Emergency Medicine - ED	**117**	307	-62%	**2,463**	2,830	-13%		
	Total Discharges - Inpatient Paediatric Intensive Care Unit	**0**	1	-100%	**15**	12	25%		Very small numbers
	Total Discharges - Secondary Neonatal Unit	**21**	47	-55%	**378**	441	-14%		more discharges in Womens Health, 1968 YTD, up 10%.
	Total Discharges- Acute Paed Surg - accounted under Adult Surgery	**155**	93	67%	**899**	889	1%		
	Total Discharges- Elective Paed Surg - accounted under Adult Surgery	**140**	156	-10%	**1,086**	1,003	8%		
	ED attendances	**898**	2,524	-64%	**19,032**	23,435	-19%		see comments made under the "Highlights" section of the report.
	Paed Medicine - 1st Attendance	**239**	178	34%	**2,298**	1,949	18%		
	Paed Medicine - Subsequent Attendance	**577**	341	69%	**4,601**	3,391	36%		
	Non-Contact FSA - Any Medical specialty -- Paed Medicine	**2**	27	-93%	**362**	298	21%		
	Non contact Follow Up - Any health specialty - Medical	**4**	8	-50%	**118**	93	27%		
					Year to date			Rating	Commentary (by exception)
		May-20	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Budgeted FTEs	**329**	319	-3%	**329**	319	-3%		Taking on extra grad. Nurses plus new staff members funded by CDS funding, plus additional allocation of RMOs.
	Operating Costs ($000)	**197**	294	33%	**3,135**	3,180	1%		
	Personnel Costs ($000)	**2,921**	3,217	9%	**33,561**	34,103	2%		
	Financial Result Total ($000)	**(2,800)**	(3,380)	17%	**(34,062)**	(35,828)	5%		
	Reduce Clinical Outsourcing ($000)	**4**	5	20%	**106**	57	-86%		includes SMO Sabbaticals.

First, Do No Harm (Safety)									
					Year to date			Rating	Commentary (by exception)
		May-20	Target	Var	Actual	Target	Var		
	Neonatal Rate of medication errors/1000 bed days per month	**0.17**	0	0		0.0%			696/4/1000
	Neonatal Care CLAB rate per 1000 line days per month	**0**	0	0		N/A			Completed
	CLAB insertion bundle compliance - NNU	**88.0%**	100%	12%		100%			Completed
	CLAB prevention maintenance bundle compliance- NNU	**86.8%**	90%	3%		90%			Completed
	Hand hygiene (compliance with checking)	**94.3%**	80%	-14%		N/A			KFM 90% KFS 93 % NNU 100%
	Safe sleep - audits compliance	**no data**	100%	0%		N/A			Datasets not collected due to COVID 19
	Health and Safety Environmental Audit (Bi-monthly)	**Completed**	100%	0%		N/A			Completed
	Violence Intervention Programme (VIP) Screening	**95%**	80%	-15%	**58%**	80%	-22%		0% for NICU for Dec and Jan causing the lower YTD %

Timely									
					Year to date			Rating	Commentary (by exception)
		May-20	Target	Var	Actual	Target	Var		
	ED 6 hour target - National Health target (Kidz First ED) - Initial speciality	**98%**	95%	3%	**92%**	95%	-3%		trend is increasing
	ESPI 2 - No. waiting >4 months for FSA - Elective	**1.0**	0.0	1.0	**1.0**	0.0	1.0		

System Integration (Effective)									
					Year to date			Rating	Commentary (by exception)
		May-20	LY Act	Var	Actual	YTD*	Var		
	Admission Rate Babies in the first year of life (Total)	**20%**	23%	3%	**20%**	21%	1%		
	Admission Rate Babies in the first year of life (Maaori)	**21%**	27%	6%	**23%**	25%	2%		
	Admission Rate Babies in the first year of life (Pacific)	**30%**	28%	-2%	**29%**	28%	-1%		
	ALOS - Kidz First - Surgical - Surgical Floor	**2.02**	2.60	0.6	**2.15**	2.02	-0.1		Very small numbers
	ALOS - Kidz First Medicine - Kidz First Wards	**2.55**	2.52	0.0	**2.71**	2.84	0.1		
	ALOS - Kidz First Medicine - ED Short Stay (hrs)	**3.80**	4.04	0.2	**3.88**	3.92	0.0		Very small numbers
	ALOS - Kidz First - Neonatal	**18.6**	21.1	2.5	**22.5**	22.2	-0.3		Very small numbers

Efficient									
					Year to date			Rating	Commentary (by exception)
		May-20	LY Act	Var	Actual	LY Act	Var		
	Outpatient DNA - FSA	**6%**	15%	9%	**12%**	12%	0%		
	Outpatient DNA - Follow up	**10%**	12%	2%	**11%**	11%	0%		

P&WCC									
					Year to date			Rating	Commentary (by exception)
		May-20	Target	Var	Actual	Target	Var		
	Patient experience survey v good/excellent- month (n=9) YTD (n=171)	**100%**	76%	24%	**78%**	76%	2%		Number is too small to make relevant analysis.

Further performance information

Risk Register Items

1. **Planned Expired Appointments**:
   - The Planned Expired Appointments decreased to 628 in April 2020 (Risk Register updated).

2. **Neonatal Capacity and Resource**
   - As per Update on Previously reported issues (Risk Register updated).

Quality/Improvement Projects

- Reactivation and transition of inpatient units to BAU post COVID 19 Level 4 and 3
- Neonatal Unit Expansion planning.
- Draft of Fluid Balance documents in Inpatient areas (Working group set up.)
- Review of Model of care delivery in inpatient area (Working groups set up.)
- Review of current Inpatient Nursing Uniform standard. (Early stages of discussions.)
- Manukau Health Park Detailed Business Case participation in all Steering Group Meetings
- Ambulatory capacity and demand work with Ko Awatea re-started
- Model of Care level 2 and 3 Neonatal Care with Ko Awatea recommencing in June

Adult Rehabilitation and Health of Older People

Monthly Report – May 2020

Glossary

ACE	Acute Care of the Elderly
ARHOP	Adult Rehabilitation and Health of Older People
AROC	Australasian Rehabilitation Outcomes Centre
ASRU	Auckland Spinal Rehabilitation Unit
AT&R	Assessment, Treatment and Rehabilitation Services
FLS	Fracture Liaison Service
HBSS	Home Based Support Services
HOP	Heath of Older People
IBC	Indicative Business Case
LOS	Length of Stay
MMH	Middlemore Hospital
SLT	Speech Language Therapist
SMO	Senior Medical Officer
SPHM	Safe Patient Handling and Mobility
YTD	Year to Date

Service Overview

The Adult Rehabilitation and Health of Older People (ARHOP) Division is managed by Ian Dodson (Acting General Manager), with Dr Peter Gow (Clinical Director) and Julie Beck (Clinical Nurse Director).

Highlights

Title	Notes
COVID-19 Review and Lesson Learned.	All staff have returned to work, with some teams now able to work from home. The Lymphedema team have now developed a new way of working included telehealth for one day a week. Zoom AT&R daily triage will be continued with a meeting format introduced and attendance from the whole HOP team – Medical and Nursing attending daily.
Waitlist Management	All outpatient clinics are now operational, waitlists have been reviewed and priorities adjusted as per clinical risk.
Aged Residential Care Preparation for an Outbreak	A response plan has been completed by the Health of Older People Technical Advisory Group team which has now been circulated widely. A request for expressions of interest from staff to volunteer to assist in the staffing of a residential care facility, should an outbreak occur, has been actioned. This has been a good example of cross-division and regional working.
Community Stroke Rehabilitation Service	The team has been able to significantly exceed MOH target (70%) after a sustained period of being unable to achieve it. This has been due to full staffing and the Early Supported Discharge (ESD) service has been enhanced with increased triaging on the ward, implementing an ESD coordinator role alongside telehealth provision for some patient contact.

Title	Notes
ASRU	Telehealth uptake, especially in outpatients, was significant with a mix of both growth and reduction in some waitlists. Change in visitor policy over Covid-19 was perceived to have impacted positively on patient engagement and rehabilitation culture. Further investigation is required to determine how these benefits can be sustained as the alert levels change.

Challenges

Title	Notes
Rapid Transition to Telehealth	Equipment to support telehealth is still being procured – particularly the smaller items of cameras and headphones.
Visitor Management	Visiting and visitor management has been a major challenge for Charge Nurse Managers during May.
Video Fluoroscopy Service	Sustained pressure on SLT video fluoroscopy service having limited access to fluoroscopy due to lengthy equipment replacement, coupled with discontinued community endoscopic evaluation of swallowing service. Concerted effort will be required alongside SLT professional leader to maintain sustainability of community endoscopic evaluation of swallowing service.
ASRU	Deferred outpatient appointments have been prioritised and scheduling is progressing but capacity for increased clinics is not possible. Ongoing management of site security and flow of individuals whom come on site is a particular challenge in the restricted visiting environment and whilst an opportunity is created to change expectations of all parties, resource is still required to manage the entry points.

Activity

Occupied Bed Days were 944 bed days below target for the month and 5,574 bed days below target year-to-date. The largest decrease in demand has been in inpatient rehabilitation for older people, mainly due to decreased occupancy due to Covid-19.

Volumes May 2020	Month				Year to Date			Full Year		
	Actual Volume	Budget Volume	Variance Volume	Comparative Variance to Prev Mnth	Actual Volume	Budget Volume	Variance Volume	Forecast Volume	Budget Volume	Variance Volume
AT & R	864	1,559	(695) U	↓	11,615	16,849	(5,234) U	13,123	18,357	(5,234) U
Spinal	360	508	(148) U	↓	4,990	4,739	251 F	5,464	5,213	251 F
Stroke Rehabilitation_Mainly WD 23	597	594	3 F	↓	6,713	6,414	299 F	7,287	6,988	299 F
Integrated Stroke Ward	420	530	(110) U	↓	4,686	5,711	(1,025) U	5,217	6,242	(1,025) U
Acute Care for Elderly_Mainly Ward 5	436	430	6 F	↑	4,783	4,648	135 F	5,199	5,064	135 F
Total	**2,677**	**3,621**	**(944)**	↓	**32,787**	**38,361**	**(5,574)**	**36,290**	**41,864**	**(5,574) U**

Consolidated Statement of Financial Performance May 2020	Month				Year to Date			Full Year		
	Actual $(000)	Budget $(000)	Variance $(000)	Comparative Variance to Prev Mnth	Actual $(000)	Budget $(000)	Variance $(000)	Forecast $(000)	Budget $(000)	Variance $(000)
Revenue										
Government Revenue	479	577	(98) U	↓	6,350	6,349	2 F	6,912	6,926	(14) U
Patient/Consumer Sourced	-	-	0 F	↔	-	-	0 F	-	-	0 F
Other Income	11	3	8 F	↑	83	33	50 F	83	36	47 F
Funder Payments	-	-	0 F	↔	-	-	0 F	-	-	0 F
Total Revenue	**490**	**580**	**(90) U**	↓	**6,433**	**6,381**	**52 F**	**6,995**	**6,961**	**33 F**
Expenditure										
Staff Costs	3,803	4,011	209 F	↑	41,823	42,655	832 F	45,885	46,643	758 F
Outsourced Personnel	18	22	4 F	↓	338	242	(96) U	379	264	(115) U
Outsourced Clinical	165	225	60 F	↑	2,479	2,475	(4) U	2,715	2,700	(15) U
Clinical Supplies	131	177	46 F	↑	1,885	1,948	63 F	2,080	2,125	45 F
Other Expenses	155	182	26 F	↓	1,904	2,000	96 F	2,086	2,181	96 F
Total Expenditure	**4,271**	**4,617**	**346 F**	↑	**48,429**	**49,320**	**891 F**	**53,145**	**53,914**	**769 F**
Net Surplus/(Deficit) Provider	**(3,782)**	**(4,037)**	**256 F**	↑	**(41,996)**	**(42,939)**	**943 F**	**(46,151)**	**(46,952)**	**802 F**

Personnel Costs By Professional Group May 2020	Month				Year to Date			Full Year		
	Actual $(000)	Budget $(000)	Variance $(000)	Comparative Variance to	Actual $(000)	Budget $(000)	Variance $(000)	Forecast $(000)	Budget $(000)	Variance $(000)
Medical Personnel	591	681	90 F	↑	7,020	7,245	225 F	7,698	7,922	225 F
Nursing Personnel	1,453	1,542	89 F	↑	16,314	16,397	83 F	17,902	17,930	28 F
Allied Health Personnel	1,553	1,583	30 F	↑	16,294	16,835	542 F	17,886	18,409	523 F
Support Personnel	0	0	0 F	↔	-	-	0 F	-	-	0 F
Management/Administration	206	205	(1) U	↑	2,195	2,178	(18) U	2,399	2,381	(18) U
Staff Costs	**3,803**	**4,011**	**209 F**	↑	**41,823**	**42,655**	**832 F**	**45,885**	**46,643**	**758 F**
Outsourced Medical	5	10	4 F	↓	49	107	57 F	55	116	62 F
Outsourced Nursing	7	0	(7) U	↓	191	-	(191) U	215	-	(215) U
Outsourced Allied Health	3	12	9 F	↑	91	135	44 F	104	148	44 F
Outsourced Support	0	0	0 F	↔	-	-	0 F	-	-	0 F
Outsourced Management/Admin	2	0	(2) U	↑	6	-	(6) U	6	-	(6) U
Outsourced Personnel	**18**	**22**	**4 F**	↓	**338**	**242**	**(96) U**	**379**	**264**	**(115) U**
Total Personnel Costs	**3,820**	**4,033**	**213 F**	↑	**42,161**	**42,897**	**736 F**	**46,264**	**46,908**	**643 F**

FTE By Professional Group May 2020	Month				Year to Date			Full Year		
	Actual FTE	Budget FTE	Variance FTE	Comparative Variance to	Actual FTE	Budget FTE	Variance FTE	Forecast FTE	Budget FTE	Variance FTE
Medical Personnel	41	38	(3) U	↓	39	38	(1) U	39	38	(1) U
Nursing Personnel	242	218	(24) U	↓	226	218	(8) U	225	218	(7) U
Allied Health Personnel	256	239	(17) U	↓	240	239	(1) U	239	239	(0) U
Support Personnel	0	0	0 F	↔	0	0	0 F	0	0	0 F
Management/Administration	33	32	(0) U	↑	32	32	1 F	32	32	1 F
Total (before Outsourced	**572**	**528**	**(45) U**	↓	**537**	**528**	**(9) U**	**536**	**528**	**(8) U**
Outsourced Medical	0	0	0 F	↓	0	0	0 F	0	0	0 F
Outsourced Nursing	1	0	(1) U	↓	3	0	(3) U	3	0	(3) U
Outsourced Allied Health	0	2	1 F	↑	1	2	1 F	1	2	1 F
Outsourced Support	0	0	0 F	↔	0	0	0 F	0	0	0 F
Outsourced Management/Admin	0	0	(0) U	↑	0	0	(0) U	0	0	(0) U
Total Outsourced Personnel	**2**	**2**	**0 F**	↓	**4**	**2**	**(2) U**	0	**2**	**(1) U**
Total Personnel	**574**	**529**	**(45) U**	↓	**540**	**529**	**(11) U**	**536**	**529**	**(9) U**

Revenue

Revenue is $90k below budget for the month and $52k above budget year-to-date mainly due to ACC revenue regarding treatment injuries being above budget.

Expenditure

Overall expenditure is $346k underspent for the month and $832k underspent YTD.
Key expenditure variances are summarised below:

Personnel Costs ($13k favourable for the month and $623k favourable YTD. 00 The YTD personnel cost favourable variance is partly offset by the $96k overspent relating to outsourced personnel YTD)

Variances in Personnel Cost categories were as follows:

- Medical staff costs are $90k under budget for the month and $225k underspend YTD. Partly due to registrars being at lower level than budget.
- Nursing staff costs are under spent by $89k for the month and $83k underspend YTD. The underspend for the month is partly offset by the overspend for outsourced nursing of $7k for the month and $192k overspend YTD.
- Allied Health staff costs are $30k underspent for the month and $542k underspend YTD Outsourced Personnel costs are $4k favourable for the month and $96 adverse YTD. The adverse variance is mainly due to the nursing bureau relating to patient watches.

Non Staff Costs

- Outsourced clinical costs are $60k underspent for the month mainly due to the reversal of an equipment hire invoice for $48k relating to WDHB erroneously recorded under ARHOP and $4k overspent YTD Clinical Supplies are $46k underspent for the month partly due to the release of an accrual re Patient Consumables amounting to $14k and $63k under spend YTD.
- Other Expenses are $26k underspent for the month and $96k underspend YTD. Mainly due to underspend on Laundry Bedding and Linen due to lower occupancy and underspend on Gas in respect of the Spinal Ward.

Mental Health and Addictions

Monthly Report – May 2020

Glossary

CAMHS	Child Adolescent Mental Health Service
CMH	Counties Manukau Health
MH	Mental Health
MH&A	Mental Health & Addictions
ILoC	Integrated Locality Care
NGO	Non-Government Organisation
MWiTM	Te Manawhenua i Taamaki Makaurau

Service Overview

The Mental Health and Addictions (MH&A) Division is managed by Tess Ahern (General Manager) with Dr Ian Soosay (Clinical Director) Anne Brebner (Clinical Nurse Director) and Melodie Barr (Clinical Director Allied Health Scientific and Technical).

Highlights

New Leadership Role

We are very pleased to welcome Melodie Barr in her new role as Clinical Director Allied Health Scientific and Technical (CDAHST). We look forward to working with Melodie as together we develop and incorporate this role within our leadership team. This is a new role for Allied Health (AH) in Mental Health which aligns with the AH leadership structure across the DHB alongside the other CDAHST roles and the professional leaders. The purpose of the role is to provide clinical governance, leadership and direction of allied health, scientific and technical workforce, services and strategy within mental health, ensuring alignment with the divisional, allied health strategic and organisational strategic goals. Melodie will be working 0.5 in this role and 0.5 in her clinical psychology position in the Manukau team.

This role is also works alongside the Professional Leaders for Psychology, Occupational Therapy and Social Work. In Mental health we also have Cassandra Laskey who is the Professional Leader for Peer Support who provides professional guidance and advice to staff and managers pertaining to the professional development of individual peer support specialists and development of the wider peer support workforce.

New Nurse Practitioner

We were also very pleased for Joanna Dickens to be authorised as a Nurse Practitioner (NP) in Mental Health and Addiction with a focus on Primary Mental Health. Jo is Counties first NP MH & A division with a focus on Adult and Primary Mental Health service delivery. Jo joins two other NPs in the Mental Health division and compliments their skills sets (Child and Adolescent Mental Health). She will be focussed on supporting the primary mental health and integrated work in the North of the division.

International Nurses Day

During May we also celebrated International Nurses Day in a variety of different ways. The following is one of the posts from our Facebook page. We are very proud of our nurses and the dedication and commitment they demonstrate in some very challenging times.

Covid Impact on Services

In May there has been a marked increase in the length of stay in Tiaho Mai which was impacted during the "lockdown" period related to Covid-19. The service struggled to discharge people mainly due to anxiety about breaking a "bubble".

There was also a marked increase in referrals to Intake and Assessment following the end of lockdown, with increased referrals from both internal and external referrers. Of note the largest increase came from ED. Referrals increased across both genders, with the majority being females. The ratio of ethnicities remained much the same, and reflective of our population.

The adult community teams also experienced a significant increase in referrals requiring brief interventions. We expect this trend will continue as people begin to grapple with their new reality post-COVID19 with job losses and adjusting to a new norm with new challenges as the result of the nationwide lockdown.

Our CAMHS services have also seen a sharp increase of referrals attributed to schools/GP re-opening again. The service expects a sustained increase in referrals relating to a range of social-economic factors with parents becoming unemployed resulting in financial strains/stressors taking it's toll on overall wellbeing and mental stamina, limited capacity to cope with post-COVID19 new norms and care and protection issues as a result of family violence and complex family dynamics.

Mental Health & Addiction Integration Refresh

A 'refresh' of the programme of work in relation to integration is currently underway. The development of an integrated model of care is a complex piece of work, spanning a number of years, and it is vital to continually take a fresh look at the focus and priorities, ensuring that momentum is being maintained, and that broader developments/external issues are being taken into consideration and reflected in the direction of the work. This is particularly relevant with the MoH's 'Increasing Access and Choice' initiatives in response to He Ara Oranga and taking into consideration the demands and requirements post Covid-19.

Discussions are focussed on where the system needs to be in two years' time; the deliverables that need to be achieved over the next year; the equity considerations of those deliverables; and how we flex as the 'Increasing Access and Choice' capacity starts to come on line over the next 12-15 months.

Integrated Primary Mental Health and Addiction Service (IPMHAS)

A workshop has been held to define the scope, purpose and membership of the regional Governance / Leadership structure for IPMHAS. It has been proposed there will be a Governance Group with DHB, Treaty Partners, NGO, Pacific PHO with the key focus being High level over sight of service and report to the Ministry of Health and escalation of significant issues. There will also be a Programme Board with the focus being Clinical Governance, quality and risk management, budget management.

Links with key stakeholders and groups e.g. ALT, Mental Health Network and then an Enablement team responsible for the actual implementation and engagement with practices. Provides reporting and analysis on service delivery to advise future design and scope of service. The structure will be implemented with a review after 12 months or sooner if significant issues arise.

The regional implementation plan is currently being refined to account for 10% allocation of funding to Whanau Ora Commissioning Agency. The Commissioning Agency will contract Kaupapa Maaori practices within the implementation schedule for the IPMHAS. CM Health will not be responsible for the services delivered within Kaupapa Maaori practices.

The contracts for PHOs and NGOs are due to commence 1 July 2020, including funding for actual activity that has occurred within the initial practices March to June 2020. Discussion has commenced to ensure all components of IPMHAS connect and work effectively with the CM Health integration agenda and direction, ensuring our community receives seamless care across the mental health continuum.

Youth Request for Proposal

MoH have advised that due to the number of responses from the CM Health district and the complexity of evaluating through the COVID-19 environment an outcome for the CM Health district will not be known until July / August 2020.

Maaori and Pacific Primary Mental Health and Addiction RFPs

The Primary Mental Health and Addiction Services for Pacific Peoples RFP has been released and is only open to Pacific Providers located in the following geographical areas: Auckland, Counties Manukau, Hawkes Bay, Hutt Valley, Capital and Coast, Southern. Pacific led organisations must have a predominantly Pacific ethnicity membership on their Governance Board / Trust Board and a significant number of their workforce must be Pacific. The responses must ensure services meet the needs of Pacific who are experiencing mild to moderate distress. Services can be delivered from community settings that are easily accessible for the community. The Maaori specific RFP is due to be released in approximately 4 weeks.

Maaori and Pacific Replication and Expansion of Mental Health and Addiction RFPs

MoH have advised the outcome of the Maaori and Pacific replication and expansion RFPs will be known June/July 2020.

Suicide Postvention Coordinator

Ministry of Health revenue contract has been received providing resourcing until September 2021 for a 1.0 FTE Suicide Postvention Coordinator, with a focus on supporting Maaori whanau and communities. Consultation has occurred with stakeholders including the Kaitiaki Roopu on how the role should function and where it should be placed to ensure effective outcomes for Maaori.

The feedback from those consulted with concluded that Manurewa Marae would be an appropriate provider to support the role; it is steeped in Tikanga Maaori, is located in the locality significantly affected by suicide and would prevent the role becoming isolated as connected to kaumatua. The role will work closely with CM Health Suicide Prevention / Postvention Coordinator to develop and implement a work plan to drive activity through to September 2021.

Feedback from NGO providers on their experiences of working differently during Covid-19 using telehealth
During Covid-19 our Portfolio Managers communicated regularly with our NGO partners, Acute and Community specialist services to facilitate joined up planning and service delivery for our tangata whaiora. There was very positive feedback from providers about this experience and they provided the following feedback on utilising telehealth:

Telehealth was a critical enabler of ongoing service delivery throughout Covid-19 supporting:

- Virtual clinical assessments and consults
- Virtual programmes and training
- Virtual connection with staff, tangata whaiora and stakeholders
- With benefits including:
    - Cost efficiencies for tangata whairoa and organisations
    - Time efficiencies for tangata whaiora and organisations
    - Increasing flexibility in how people work
    - Increasing flexibility in how people accessed support
    - Resulting in:
        - Improved productivity
        - Improving ease of access for whanau to participate
        - Improving the experiences for some tangata whaiora who found it a less threatening and more relaxing way to engage
        - Improving the experience for some tangata whaiora where intervention was **taken to them**
        - Improving the experience for some tangata whaiora who appreciated the shorter duration but more frequent use of phone calls
        - More empowered and independent tangata whaiora
        - More empowered and proactive support by whaanau
- Telehealth challenges included:
    - Virtual contact not suitable for all contacts and can be a barrier particularly for:
        - NEW tangata whaiora with whom a relationship has yet to be built
        - Those where culturally face to face contact is vital
        - Those who can't access technology due to cost and/ or location (remote areas) issues
        - Those who simply respond better to or need face to face
    - Ability for organisations to work remotely and widespread was not necessarily in place requiring upfront investment and work arounds by providers (eg. borrowing of equipment)
- Telehealth requests:
    - People resource to improve knowledge and adoption of best practise tools/ devices regionally
    - Resource to improve access to technology for priority cohorts in the community eg. Youth who want to engage online but can't afford phone or data plans, or tangata whaiora who don't have any devices or mobile/ data plans to keep in touch
        - It should be noted that a number of our NGOs used their own funds to purchase devices such as phones and phone plans to give to tangata whaiora to keep in touch

New Acute MH Unit Progress Update

Good progress is being made on Stage 2 with the Hawkins team working hard to deliver defect free. Progress toward migration is occurring but no firm date has been agreed for the opening as yet. Many lessons have been learnt from Stage 1 and Klein is ensuring these learnings have been carried over to Stage 2 to improve the facility.

Hawkins Current Projected Key Milestones as at 29 May:

LDU Ward

- Physical works complete 19th June
- Defecting complete 10th July

HDU Ward, Central Heart, Staff Area and Plant room

- Physical works complete 3rd July
- Defecting complete 24th July

External Work

- Physical works complete 10th July
- Defecting complete 24th July

Emerging Issues

Nursing Vacancies in Acute Services

There are currently 36 RN and EN vacancies across acute MH services. Despite ongoing repeated advertising and extensive recruitment efforts – including exploring recruitment agencies and overseas candidates, the service has not been able to make any significant impact on reducing the number of vacancies. Recruitment have advised that there is a world-wide shortage of nurses and that the usual processes to try to reduce vacancy levels are not working because the candidates do not seem to be available. This has been compounded by the aging workforce and the number of very experienced RNs are who retiring and will continue to retire over the next 5 years. Adding to the recruitment issues has been COVID19 with 11 nurses who had been contracted from overseas not being able to enter the country. Three of these nurses have since pulled their contracts. The borders are now opening up to essential workers which these staff all fit into that category.

The vacancies mean it is a challenge to facilitate release for staff with high annual leave balances.

A meeting is scheduled with the GM, CND, Recruitment and Service Manager to canvass the issues and develop a workforce plan that may need to be innovative and "outside of the box".

MENTAL HEALTH SCORECARD — May 2020

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Ensuring Financial Sustainability	Overtime costs ($000)		$151	$149	-1.2%	$2,512	$1,489	-68.7%		High acute demand, off-set by community vacancies
	Budgeted FTEs		733	745	1.7%	678	745	9.0%		
	Operating Costs ($000)		$6,589	$6,855	3.9%	$72,922	$73,027	0.1%		
	Personnel Costs ($000)		$6,044	$6,498	7.0%	$65,062	$69,093	5.8%		
	Financial Result Total ($000)		$6,450	$6,793	5.1%	$71,924	$72,344	0.6%		

		Trend				12 month average			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Enabling High Performing People	% Staff with Annual Leave > 2 years			5.0%	5.0%		5.0%	5.0%		
	% Staff Turnover			10.0%	10.0%		10.0%	10.0%		
	% Sick Leave			2.8%	2.8%		2.8%	2.8%		
	Workplace Injury Per 1,000,000 hours			10.5	10.5		10.5	10.5		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
First, Do No Harm (Safety)	Number of Seclusion events/ 100,000		3.0	5.0	2.0		N/A	N/A		)
	Seclusion hours/ 100,000		62	50	-12		N/A	N/A		)All seclusion events are reviewed at the weekly risk review meeting
	Number of Clients Secluded/ 100,000		3.0	3.0	0.0		N/A	N/A		)

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Timely	Shorter wait times for non urgent mental health and addiction Services (%< 3 week wait) - 12 months rolling									
	0-19 years		71%	80%	-9.0%		N/A	N/A		Unique Clients seen has exceeded MOH Target by 1451
	20-64 years		85%	80%	5.4%		N/A	N/A		
	65+ years		89%	80%	8.6%		N/A	N/A		
	Shorter wait times for non urgent mental health and addiction Services (%< 8 week wait)- 12 months rolling									
	0-19 years		87%	95%	-7.7%		N/A	N/A		Unique Clients seen has exceeded MOH Target by 1451
	20-64 years		95%	95%	0.2%		N/A	N/A		
	65+ years		98%	95%	2.6%		N/A	N/A		

		Trend				Year to date			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
System Integration (Effective)	Access rate - Number of CM domiciled unique clients seen by all MH services ((PRIMHD reporting services include AOD and NGO services) 12 months as a % of population) - Total									
	0-19 years		4.0%	3.2%	0.8%		N/A	N/A		
	20-64 years		4.0%	3.2%	0.9%		N/A	N/A		
	65+ years		2.2%	2.6%	-0.4%		N/A	N/A		Reviewing of the thresholds(gap) between consultation liaison and referral acceptance into specialist service
	Readmissions to Tiaho Mai within 28 days - Total (1 month in arrears)		10.9%	12.0%	1.1%		12.0%	12.0%		

		Trend				Year			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Efficient	Inpatient Occupancy - Tiaho Mai Acute Mental Health Unit		91%	85%	-6.3%	88%	85%	-2.7%		Signifies overcrowding
	Number of Tiaho Mai Inpatient LOS >35 days		14	10	-4.0	10	10	0.4		

		Trend				Year			Rating	Commentary (by exception)
		FY1819-1920	May-20	Target	Var	Actual	Target	Var		
Equity	Access rate - Number of CM domiciled unique clients seen by MH services (PRIMHD) 12 months as a % of population - Maori									
	0-19 years		5.8%	4.5%	1.4%		N/A	N/A		
	20-64 years		9.8%	7.7%	2.1%		N/A	N/A		
	65+ years		3.1%	2.6%	0.5%		N/A	N/A		

Counties Manukau District Health Board
Hospital Advisory Committee
Facilities, Engineering and Asset Management Update

Recommendation

It is recommended that the Hospital Advisory Committee:

Receive the Facilities, Engineering and Asset Management Report for May/June 2020.

Prepared and submitted by: Anton Venter, General Manager Facilities, Engineering and Asset Management

Glossary

AMP	Asset Management Plan	IQP	Independent Qualified Person
APM	Asset Performance Measure	MESH	Manukau Elective Surgery Centre
BMS	Building Management System	MHP	Manukau Health Park
ELT	Executive Leadership Team	MMH	Middlemore Hospital
EY	Ernest Young	NAMP	National Asset Management Programme
FEAM	Facilities Engineering and Asset Management	PCG	Project Control Group (Project)
FF&E	Fixtures, Fittings and Equipment	RFP	Request for Proposals
GETS	Government Electronic Tender Service	SSBC	Single Stage Business Case
HVAC	Heating, Ventilation and Airconditioning		

Highlights

- The Acute Mental Health Unit Stage 2 and the Scott remediation projects are now fully back on track.
- Awhinatia project completed and staff migrated over the Queen's Birthday weekend. Portacoms complete and occupied.
- Kone undertaking remedial fault and safety work and re-roping lifts at Middlemore.

Major Capital Works

Scott Building Reclad Works		Project Commencement:	April 2019
		Planned Completion:	February 2022
Project Manager:	Daud Suryantyo	Forecasted Completion:	September 2021

Summary

	Green	No significant issues requiring management intervention.
	Amber	Moderate risks of programme or cost overrun, patient complaints, or negative press.
	Red	Significant programme or cost overrun likely, serious complaints received, negative press

Project tracking well. All contractor KPIs are being met. Accelerated programme being worked through with likely achievement bringing cost savings to CM Health. No disruptions to CM Health from works.

Kidz First, McIndoe and MESH Remediation (Business Case writing)		Project Commencement:	February 2020
		Planned Completion:	September 2020
Project Manager:	Mark Toala	Forecasted Completion:	TBA

Summary

	Green	No significant issues requiring management intervention.
	Amber	Moderate risks of programme or cost overrun, patient complaints, or negative press.
	Red	Significant programme or cost overrun likely, serious complaints received, negative press.

The project team and the relevant consultants are currently working in conjunction with EY to facilitate business case development seeking Crown funding to remediate the Kidz First, McIndoe and Manukau Elective Surgery Centre (MESH) buildings.

Building condition assessment of the cladding systems in 2017 by Alexander & Co consultants identified three high risk buildings that require remediation due to systemic failures in construction methodology, effectively leaky buildings.

Vital Information gathered from the fortnightly business case workshops has been captured and implemented in the Single Stage Business Case (SSBC) especially learnings from the Scott building reclad.

The SSBC will also be leaning on recommendations regarding construction methodology from the project team to ensure minimal disruption to clinical business as usual functionalities and continuity.

Acute Mental Health Unit Stage 2		Project Commencement:	June 2015
		Planned Completing:	August 2020
Project Manager:	Chester Buller	Forecasted Completion:	December 2020
PIM:	Shona Rattrie (Service Representative)		

Summary

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	Amber	Moderate risks of programme or cost overrun, patient complaints, or negative press
	Red	Significant programme or cost overrun likely, serious complaints received, negative press

Physical works recommenced on 28 April under Level 3 restrictions and were further relaxed under Level 2 on 13 May 2020. The workforce responded well to the recommencement with full engagement of the workforce albeit under some lost productivity due to the restrictions. The Engineer to Contract issued a contract time extension of 23 days with practical completion now due 17 August 2020. The contractor is expected to complete a week to two weeks earlier. As COVID-19 costs are now expensed the project is regarded on time and on cost and is now shown in green.

Cath Lab and Dialysis Expansion		Project Commencement:	January 2020
Project Manager:	Daud Suryantyo	Planned Completion:	September 2022
PIM:	Taryn Kirby	Forecasted Completion:	July 2022

Summary

	Green	No significant issues requiring management intervention
	Amber	Moderate risks of programme or cost overrun, patient complaints, or negative press
	Red	Significant programme or cost overrun likely, serious complaints received, negative press

Project is currently at preliminary design, the project continues to have budget and programme pressures as we head further into design details through discoveries of pre-existing services and structural constraints. Budget constraints are being value managed in monthly Design Control Group meetings.

Gastroenterology Expansion Project		Project Commencement:	May 2019
		Planned Completion:	August 2021
Project Manager:	Alex Wright	Forecasted Completion:	September 2021

Summary

	Green	No significant issues requiring management intervention
	Amber	Moderate risks of programme or cost overrun, patient complaints, or negative press
	Red	Significant programme or cost overrun likely, serious complaints received, negative press

A moderate scope change has resulted in a delay in the design development and whilst there is broad acceptance by the PCG there are consequences to both time and cost which needs to be formalised. Progress is being maintained and the team is confident that it will have a secure, well considered and supported design moving forward. An identified risk is the budget shortfall to address oversights in preliminary design and potential services/staging disruptions.

Harley Grey Radiology		Project Commencement:	February 2020
		Planned Completion:	July 2022
Project Manager:	Alex Wright	Forecasted Completion:	December 2022

Summary

	Green	No significant issues requiring management intervention
	Amber	Moderate risks of programme or cost overrun, patient complaints, or negative press
	Red	Significant programme or cost overrun likely, serious complaints received, negative press

Johnstaff were appointed following a robust evaluation and negotiation process, there were 11 RFP submissions of which 10 were conforming responses, the volume of responses required an extension to the assessment period and the team is currently tracking three weeks behind the draft programme. Contract was signed mid-June and the development of the Design RFP has commenced. The draft programme still indicates February 2023 completion but is subject to development. Delays with MHP will impact on service transition.

Facilities and Engineering

- Asbestos clearance in Bray building basement corridor scheduled to be undertaken pre-COVID-19 has begun and is into its second week. The object of this particular removal is to give safer access to plant rooms in the corridor.
- Refurbishment of Ward 34 East is well underway. The service has also been asked to advise what other items they consider need replacement. Facilities are working with the charge nurse to manage the upgrade.
- An air rebalance was carried out in procedure rooms 25 and 26 at Manukau SuperClinic to obtain the correct number of air changes. Now achieving 7.7 air changes per hour in room 25 (up from 5.4) and 6.9 in room 26 (up from 6.8). The requirement is 6.0 changes per hour.
- Our lift maintenance contractor, Kone, is undertaking significant work at the Middlemore site at present. In particular, they re-roped three lifts, numbers 27, 28 and 30. Lifts were out of service for approximately one week whilst this task is performed. Kone have also been tasked with carrying out remedial work following IQP inspections of all our lifts. This work includes actual faults as well as safety upgrades; for instance the installation of hand rails on the roofs of lift cars and the fitting of separation barriers in the lower working spaces shared by two cars. Remedial work is expected to take up to three months to complete. Further to this the capital upgrade team from Kone are carrying out assessments on our older or less reliable lifts with a view to recommending replacement cars. They are currently looking at lifts 16, 17, 18 and 19 in Kidz First and lifts 5 and 6 at Manukau SuperClinic.
- An audit of the HVAC system and the BMS system that drives and controls it has been completed. This audit was commissioned prior to going to market to seek tenders for HVAC maintenance. The two contractors who currently contribute most to HVAC maintenance participated in the audit along with in-house personnel.

Project	Task update	Target date	Traffic light
Awhinatia Portacoms	Project completed and buildings have been occupied, one by Mental Health Service and the second is being used by Home Help Service as a store room. Final inspection has been carried out by Council, who have asked for a minor alteration to be undertaken and signed off by structural engineer.	Complete	
Radiology Intervention Suite upgrade	This project, due to have been completed by now, was significantly impacted by the COVID-19 lockdown. It is now up and running again, being project managed by DB Projects. It is estimated to be completed in eleven weeks.	Mid-August	
EC 2 X-ray system install	Although carried out by contractors we maintained a watching brief over this installation and facilitated ancillary tasks (sprinkler isolation, access control etc.) Of particular note was the use of a new system to repair existing vinyl rather than replace. Old vinyl was patched and a colour coat was "painted" on. This was followed by two clear coats which give a durability significantly superior to original vinyl. The new product is quick to apply, less expensive than vinyl, and is water based, meaning fumes are not an issue.	Complete	
Ward refurbishment	As well as Ward 34E we have made significant progress with refurbishing the emergency department and Kidz First Paediatric bathroom. These projects are nearing completion.	30 June 2020	

Asset Management

- Critical Infrastructure Review: CM Health has engaged a consultant to complete a rapid review and assessment of key infrastructure services assets at Middlemore Hospital (MMH) and the Manukau SuperClinic plus a 'single point of failure' quick review of infrastructure services systems at the Pukekohe Hospital site. The purpose of the review is to determine building services infrastructure assets which are critical to the delivery of hospital services, the current state of those assets, and the potential scope of works required to reduce operational risk associated with these assets, where that risk may be deemed high. Progress to date:
  - Completed: Galbraith (B01), Kidz First (B12), Energy Centre (B21) and Energy Centre Annex (B55).
  - Failure history and criticality ratings for all plant equipment in Edmund Hillary Block (B51) and Boiler House (B41) have been completed and we are awaiting the consultant to finalise the Asset Risk Profiling reports for these two buildings.
- Esme Green (B30) Egress Review: The original central egress route for all levels of the build opens to a ground floor safe path lobby which has two egress routes (Door C and D) direct to outside. Door C was initially blocked due to construction works in the adjacent KA2 and remains blocked at the completion of KA2 construction works. An assessment report from the consultant has demonstrated Door D is acceptable for egress with modifications if Door C is blocked. This report has been provided to Auckland Council and the consent has been granted in principle. CM Health is following up with Auckland Council to uplift the consent and complete the issuing process.

- Development of CM Health Asset Management Plan (AMP): An ELT paper has been prepared to provide an update on progress with the AMP development, highlight the challenges and request endorsement on proposed Asset Performance Measures (APMs) in the AMP.
- National Asset Management Programme (NAMP): Work in progress – Review and provide feedback on NAMP guidance drafts – Asset Management Framework, National Asset Management Policy and National Asset Management Strategy 2020-2030.
- Northern Region Asset Management Document Review: Work in progress – review Northern Region Asset Management Strategy 2020-2030, Level of Service and Asset Performance Measures (APMs).
- Information and technical review on capital projects: Assisted in providing engineering documentation and drawings for capital projects in design and development (i.e. Manukau Health Park, Cath Lab and Renal Dialysis Unit, Edmund Hillary building Gastro expansion).
- Roading Upgrade Phase 2: RFP paperwork completed and with procurement to advertise on GETS website. Project has been delayed as a result of COVID-19.
- Bray Aircon: Level 3 air-conditioning and ventilation works installation is 80% complete. Works to recommence after the lockdown period. Delayed due to COVID-19.
- Site wide Aircon: Execution stage – Colvin and Botany Maternity installations completed. Papakura and Pukekohe works to recommence after the lockdown period. Delayed due to COVID-19.

Security

- Security Enhancement Project Phase 2: Manukau SuperClinic car park lighting has been completed.
- S-Bend car park fencing has been completed.
- CCTV Camera Installations (Manukau SuperClinic, S-Bend Carpark and Western Campus Carpark) is still work in progress but has been delayed to do COVID-19.

Property

- Manukau Health Park Area B: Auckland Council (Healthy Waters) is interested in pursuing the purchase of Area B. This is still under investigation with clarification being sought with regard to area size and Resource Management Act implications. A Board paper will be prepared once further information is received.

Health & Safety

- Policies and procedures for Contractor Management, Working in Confined Spaces and Hazardous Substances Management are now completed to draft stage.
- The FEAM Emergency Response Plan continues as a work in progress. Updates are being made with the internal and external escalation process and identification of key contractors should an emergency occur.
- Contractor inductions have continued with 69 completed to date. These inductions are ongoing.
- Presentation of the Hazardous Substances Management plan to the ELT has been deferred to 21 July 2020. The majority of high priority actions for Hazardous Substance Management are complete or well progressed.
- Fire and Emergency Management is under review, with trial evacuations which are currently due being scheduled.

Hospital Advisory Committee Meeting
Resolution to Exclude the Public

Resolution
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

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

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
Public Excluded Minutes of 20 November 2019 and Actions	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
Draft Work Plan 2020	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Committee to carry out, without prejudice or disadvantage, commercial activities.