27 June 2022

[redacted]

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Official Information Act Request

Thank you for your request dated 25 May 2022 pursuant to the Official Information Act (OIA) 1982, for information in relation to hospital wait times and emergency department (ED) delays. I enclose the following information which is covered by your request.

1. **The average wait time to see an oncologist after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date**

   Average days between referral received date and patient arriving and being seen for treatment by a health practitioner /consultant for the first time:

Question 1	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	28 days	28 days	27 days	31 days	33 days

   The average wait time to see an oncologist involves patients who were delayed due to patient reasons and / or clinical reasons, which is standard practise for certain clinical treatments. For example, a patient waiting for Radiation Oncology First Specialist Appointment (FSA) will not infrequently have to wait for chemotherapy treatment to be completed or for recovery time after surgery before they are well enough to undergo Radiation Treatment.

2. **The longest and shortest wait time to see an oncologist after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date**

   Longest days and shortest days waiting to be seen for treatment by a health practitioner / consultant for the first time:

Question 2	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	62 days	98 days	91 days	98 days	98 days
Minimum wait	0 days	0 days	0 days	0 days	0 days

   The comments made under Q1 table also applies to maximum wait times in Q2 table.

3. **The average wait time for cancer surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Average days between the patients arriving and being seen for treatment by a health practitioner / consultant for the first time and surgery treatment date:

Question 3	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	28 days	28 days	27 days	31 days	33 days

The average wait time from FSA to cancer surgery covers patients who have been reported to the national Faster Cancer Treatment collection and meeting the criteria for the 62-day indicator (those who start their cancer pathway from a referral triaged as a high suspicion of cancer and receiving first cancer treatment in public).

The average and maximum wait times from FSA to surgery include patients who were delayed due to patient reasons as well as clinical reasons e.g. patient having comorbidities that needed to be treated first before proceeding with cancer treatment.

4. **The longest and shortest wait time for cancer surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Longest days and shortest days between the patients arriving and being seen for treatment by a health practitioner / consultant for the first time and surgery treatment date:

Question 4	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	55 days	83 days	83 days	123 days	82 days
Minimum wait	0 days	0 days	0 days	0 days	0 days

The above comments relating to agreed criteria for patients not being treated straight away, either for patient recovery or clinical reasons.

5. **The average wait time to see a cardiologist after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date**

Question 5	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	99 days	116 days	157 days	118 days	141 days

6. **The longest and shortest wait time to see a cardiologist after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date**

Question 6	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	562 days	564 days	589 days	581 days	598 days
Minimum wait	0 days	6 days	1 day	2 days	0 days

Cardiology referrals often require diagnostic tests (echocardiograms and angiograms) to be undertaken prior to the patient being seen in a specialist clinic. This can lead to a delay for the FSA.

7. **The average wait time for heart surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Question 7	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	107 days	97 days	91 days	90 days	104 days

8. **The longest and shortest wait time for heart surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Question 8	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	313 days	326 days	308 days	305 days	315 days
Minimum wait	1 day	3 days	0 days	0 days	0 days

The longest wait time for a patient to have cardiac surgery and thoracic surgery following a FSA is frequently due to personal reasons. The patient needs to consider the complexity and life altering surgery and need time to make the decision. Patients are often required to complete dental treatment and commence certain medication to which they need time to consider. The longer length of time on the waiting list relates to a number of patients being offered dates for their surgery, however they respond that they need time to consider whether they wish to proceed. They continue to be on the wait list pending their decision.

9. **The average wait time to see an orthopaedic surgeon after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date**

Question 9	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	90 days	92 days	85 days	96 days	94 days

10. **The longest and shortest wait time to see an orthopaedic surgeon after a referral has been sent from the patient's GP, for the last five years between 2018 to this year to date**

Question 10	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	298 days	297 days	296 days	299 days	299 days
Minimum wait	0 days	0 days	0 days	0 days	0 days

11. **The average wait time for orthopaedic surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Question 11	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	184 days	190 days	196 days	194 days	219 days

12. **The longest and shortest wait time for orthopaedic surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Question 12	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	865 days	867 days	858 days	847 days	848 days
Minimum wait	0 days	0 days	0 days	0 days	0 days

13. **The average wait time for a gynaecologist appointment after a referral has been sent from the patient's GP for the last five years between 2018 to this year to date**

Question 13	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	23 days	29 days	44 days	41 days	67 days

14. **The longest and shortest wait time for a gynaecologist appointment after a referral has been sent from the patient's GP for the last five years between 2018 to this year to date**

Question 14	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	177 days	163 days	182 days	182 days	182 days
Minimum wait	0 days	0 days	0 days	0 days	0 days

15. **The average wait time for gynaecological surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Question 15	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	29 days	38 days	45 days	65 days	67 days

16. **The longest and shortest wait time for gynaecological surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Question 16	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	433 days	428 days	433 days	426 days	431 days
Minimum wait	0 days	0 days	0 days	0 days	0 days

17. **The average wait time for a urologist appointment after a referral has been sent from the patient's GP for the last five years between 2018 to this year to date**

Question 17	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	69 days	66 days	60 days	48 days	55 days

18. **The longest and shortest wait time for a urologist appointment after a referral has been sent from the patient's GP for the last five years between 2018 to this year to date**

Question 18	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	187 days	195 days	191 days	187 days	196 days
Minimum wait	0 days	0 days	0 days	0 days	0 days

19. **The average wait time for urology surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Question 19	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	104 days	119 days	106 days	128 days	130 days

20. **The longest and shortest wait time for urology surgery after a patient's First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Question 20	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	389 days	457 days	463 days	462 days	473 days
Minimum wait	2 days	0 days	1 day	0 days	2 days

21. **The average wait time for a respiratory specialist appointment/ or general medicine specialist for respiratory problems after a referral from a GP, for the last five years between 2018 to this year to date**

Question 21	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	80 days	83 days	79 days	72 days	94 days

All referrals to the respiratory team are triaged and seen dependent on urgency. For example, all High Suspicion of Cancer referrals are triaged as urgent and seen accordingly. Referral wait times were reducing with a targeted approach. Recent COVID-19 lock downs and cancellation of some clinics as a result has impacted on this improvement.

22. **The longest and shortest wait time for a respiratory specialist appointment/ or general medicine specialist for respiratory problems after a referral from a GP, for the last five years between 2018 to this year to date**

Question 22	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	310 days	302 days	267 days	317 days	320 days
Minimum wait	3 days	3 days	0 days	1 day	0 days

Please note our response above (21).

23. **The average wait time for respiratory surgery after a First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Question 23	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	36 days	37 days	61 days	57 days	40 days

24. **The longest and shortest wait time for a respiratory surgery after a First Specialist Appointment (FSA), for the last five years between 2018 to this year to date**

Question 24	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	392 days	221 days	442 days	443 days	132 days
Minimum wait	5 days	6 days	0 days	0 days	4 days

As mentioned in our response above (8) - the longest wait time for a patient to have cardiac surgery and thoracic surgery following a FSA is frequently due to personal reasons. The patient needs to consider the complexity and life altering surgery and need time to make the decision. Patients are often required to complete dental treatment and commence certain medication to which they need time to consider. The longer length of time on the waiting list relates to a number of patients being offered dates for their surgery, however they respond that they need time to consider whether they wish to proceed. They continue to be on the wait list pending their decision.

25. **The average wait time for a patient visiting the emergency department, for the last five years from 2018 to this year to date**

Question 25	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Average wait	91 minutes	88 minutes	91 minutes	102 minutes	107 minutes

26. The longest and shortest wait time for a patient visiting the emergency department for the last five years from 2018 to this year to date

Question 26	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Maximum wait	1436 minutes	1439 minutes	1441 minutes	1462 minutes	1456 minutes
Minimum wait	0 minutes	0 minutes	0 minutes	0 minutes	0 minutes

The table above shows:

- The shortest wait time defined as - 'minimum wait' to see a doctor; and
- The longest wait time defined as - 'maximum wait' a patient may have been in the department receiving care prior to discharge or inpatient admission.

All patients are triaged on arrival to the emergency department and are prioritised based on clinical need, with urgent and acute patients seen first. There are a number of points that could be considered a 'wait time': triage, ED seen, specialty seen, bed request and leaving department.

27. All reports discussing hospital wait times and emergency department delays, dated between Jan 2021 to date, held by the DHB

Emergency department wait times are reviewed 'live' on electronic dashboards throughout the day. An Emergency Department Standard Operating Procedure then triggers actions in response.

Please find attached (Appendix One) a comprehensive evaluation report of emergency department presentations and time frames that has been used to establish base line data and support targeted service improvement. Information has been redacted from page 3 as this information is not publically available and was supplied in confidence, and is therefore withheld under section 9(2)(ba)(i) of the Official Information Act 1982 as subject to an obligation of confidence. Information has been redacted from pages 12-13 because the information requested is not publically available, and we have sourced this from our own internal systems. However, if this information would be helpful to you, please contact us by reply email and we will work towards obtaining permission to release this information.

Hospital wait times are reported in the monthly Chief Executive (CE) report to the Commissioner for information and discussion. Please see attached (Appendix Two) excerpts from these reports. Note there is no CE report for January and May 2021, and January and April 2022.

28. All reports discussing increasing patient transfers between hospitals under the new Health New Zealand model, between Jan 2021 to date, held by the DHB

The Waikato DHB does not hold any reports discussing increasing patient transfers between hospitals under the new Health New Zealand model, between Jan 2021 to date. Accordingly, Waikato DHB is refusing the request pursuant to s18(e) of the Official Information Act 1982 because the information requested does not exist.

Waikato DHB supports the open disclosure of information to assist community understanding of how we are delivering publically funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

You have the right to request the Ombudsman investigate and review the decision to withhold the information. The Ombudsman's postal address is:

Office of the Ombudsmen
P O Box 10-152
WELLINGTON

Yours sincerely

Christine Lowry
Executive Director - Waikato Hospital and Community Services
Waikato District Health Board

Appendix One - Report, Emergency Department Presentations and Time Frames

To:	Chris Lowry, Executive Director
From:	Graham Guy, Operations Director Medicine and OPR
Subject:	Initial analysis exploring ED presentation behaviour
Date:	16 March 2021

PURPOSE

To provide initial analysis of ED presentation using a range of demographic variables. This represents an initial review only and more extensive inferential analysis is underway. The purpose of the analysis is to explore Triage Level IV/V presentations, though for the sake of completeness, results are presented by all five Triage Levels.

KEY POINTS

1. Triage Level IV and V represent 40% of total ED presentations per annum;
2. The numbers of Triage Level IV and V presentations have altered little over the preceding decade, with the largest increase in Level II and III;
3. In comparison to other large DHBs, Waikato has a higher proportion of Level V;
4. Males, aged from 15 to 35 are more likely to present at Level IV and V than other men of other ages or women of all ages. Children and older people are more likely to present at a higher Triage level.
5. Māori and Pacific are more likely to present at Triage Levels IV and V than other ethnic groups;
6. There appears to be little correlation between deprivation level (1 to 10) and Triage Level on presentation;
7. Triage Level IV and V are more likely to be seen within six hours than other Triage Levels;
8. Generally, the older a person is, the more likely they are to breach the six hour target; and
9. Almost a half of those triaged at level IV and V are referred to AMU.

1 INTRODUCTION

Crowded Emergency Departments (ED) have been acknowledged internationally as a barrier to providing timely and effective health care for more than a decade (Committee on the Future of Emergency Care in the United States Health System, 2007). Despite having been identified as a trend, progress in addressing crowding has been largely unsuccessful (Bellow & Gillespie, 2014), and crowding in ED continues to be problematic, negatively impacting both patients and healthcare providers (Mason, Knowles, & Boyle, 2016). There are many reasons for increases in ED attendances, from simple demographic changes to more complex interplays of gender, age, ethnicity, poverty and access.

1.1 TRIAGE LEVELS

The Australasian Triage Scale is used to rate patient urgency levels on presentation to ED. Over the last decade, there has been a reduction in Category 5 triages (the least urgent category) across Aotearoa-NZ; from a mean national 9.7 percent in 2011, to 6.7 percent in 2015 (Ministry of Health, 2016). During the same period, the number of people triaged into categories 1 to 3 (those presenting with conditions deemed to be immediately or potentially life-threatening) increased. Within the Waikato region, more than 50 percent of ED attendees were triaged into categories 1 to 3 in 2014/2015 (Ministry of Health, 2016).

Despite this national trend, Waikato DHB remains an anomaly in relation to Triage level 5 presentations. District Health Board (DHB) regularly benchmark ED activities in order to identify trends and differences and Table 1 presents recent data in relation to presenting Triage levels.

Table 1: Benchmarking Triage levels across largest DHBs

Triage level	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	MEAN	Waikato DHB
1	2,013	573	412	510	185	739	454
2	9,668	9,333	5,930	5,872	11,829	8,526	11,125
3	22,099	35,819	18,588	32,572	35,477	28,911	33,199
4	24,540	23,529	11,608	22,081	12,386	18,829	22,764
5	2,541	3,675	2,530	1,927	1,013	2,337	7,210
Total	60,861	72,929	39,068	62,962	60,890	59,342	74,752
1	3%	1%	1%	1%	0%	1%	1%
2	16%	13%	15%	9%	19%	15%	15%
3	36%	49%	48%	52%	58%	49%	44%
4	40%	32%	30%	35%	20%	32%	30%
5	4%	5%	6%	3%	2%	4%	10%

4 TRIAGE CATEGORY 4 AND 5 PRESENTATIONS

The motivations of non-urgent attendees presenting to ED for care are among the most scrutinised in crowding research (Uscher-Pines, Pines, Kellarman, Gillen, & Mehrotra, 2013). A lack of access to primary healthcare services is acknowledged as contributing to non-urgent presentations to ED, although rationales differ both between and within groups (Coster, Turner, Bradbury, & Cantrell, 2017). The financial barriers to accessing primary care are noted as one of the most serious causes of non-urgent ED presentations, with those unable to pay compelled to attend ED for routine care (Committee on the Future of Emergency Care in the United States Health System, 2007). Concerningly, for patient and provider, a lack of access to regular primary care can add an extra element of complexity, as conditions customarily managed in the community are not optimised and can become urgent before patients do seek medical attention (Uscher-Pines et al., 2013). However, patterns of so-called non-urgent attenders presenting to ED is repeated in health settings that offer robust primary care services at little or no cost to the user, suggesting an overall preference on the part of healthcare consumers for ED-based care (Coster et al., 2017; Mason et al., 2014; Unwin, Kinsman, & Rigby, 2016).

2.1 AN AREA OF INVESTIGATION

Although Category 4 and 5 patients do not represent the most significant group of presentations, they do warrant a particular focus as utilisation of ED as a primary care alternative is not consistent with good health outcomes. Given that a wealth of information is available from Waikato DHB ED on this group, it is proposed that data analysis is undertaken to help inform future directions. Table 2 illustrates specific questions.

Table 2: Analysis questions

Data analysis questions	
1	How do Category 5 presentations present across the days, week and year?
2	What is the age, gender, ethnicity breakdown of Category 5 presentations?
3	What is domicile distribution of presenters?
3	What proportion of individuals represent at the same level or different level over a 3, 6, 9 and 12 month period?
4	What percentage of presentations are enrolled with a PHO?
5	What is the distribution across primary care practices?

3 INITIAL FINDINGS

Analysis occurred over a 12-months period, 01/01/20 to 31/12/20, unless otherwise stated. Where Null data were reported, this was removed (where the percentage was less than 1%).

Table 3: IDF versus Base presentations, by Triage Level

	1	2	3	4	5	4 & 5 % of total	Grand Total
Waikato DHB	471	13,803	41,601	19,544	2,814	29	78,233
IDF	132	1,193	2,242	1,069	171	26	4,807

Table 3 illustrates that over a quarter of all ED presentations over a year arise from Triage Level IV and V.

Figure 1 highlights Triage Category on presentation over time.

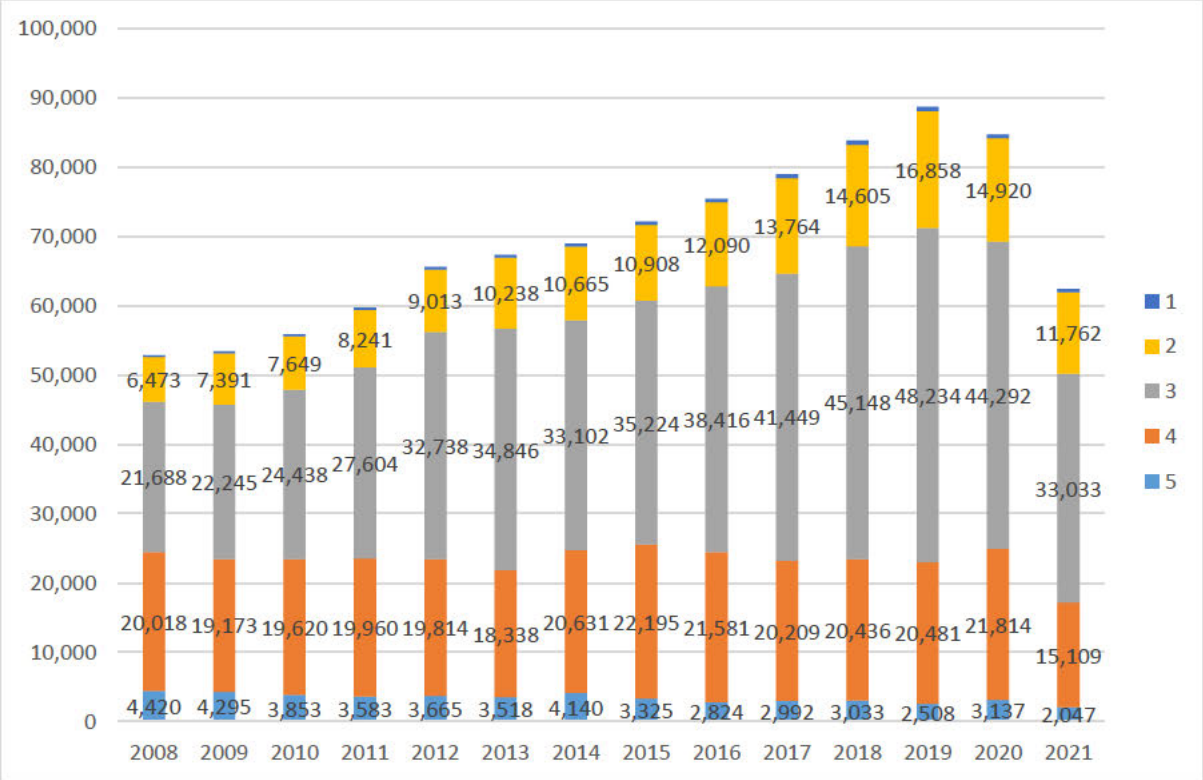

Figure 1: Volume of Triage presentations - Fiscal Year

Table 4: Gender and age, by Triage Level

Row Labels	1	2	3	4	5	4 & 5 % of total	Grand Total
Female	**245**	**7,080**	**23,669**	**9,932**	**1,271**	**27**	**42,197**
under 01 month	1	9	29	4		9	43
01 month to 12/12	3	105	591	144	13	18	856
01 to 04 years	7	222	1,023	441	40	28	1,733
05 to 09 years	1	127	655	341	17	31	1,141
10 to 14 years		145	668	336	37	31	1,186
15 to 17 years	7	218	726	374	36	30	1,361
18 to 24 years	17	709	3,020	1,511	211	31	5,468
25 to 34 years	30	893	3,768	1,677	252	29	6,620
35 to 44 years	21	634	2,356	1,062	167	29	4,240
45 to 54 years	28	803	2,363	1,064	163	28	4,421
55 to 64 years	37	892	2,334	970	130	25	4,363
65 to 74 years	35	975	2,359	915	124	24	4,408
75 to 84 years	39	828	2,174	641	62	19	3,744
85 years or over	19	498	1,547	446	19	18	2,529
Male	**358**	**7,911**	**20,160**	**10,678**	**1,714**	**30**	**40,821**
under 01 month		5	31	2		5	38
01 month to 12/12	2	170	770	157	4	15	1,103
01 to 04 years	8	367	1,399	591	54	27	2,419
05 to 09 years	5	156	770	427	32	33	1,390
10 to 14 years	4	208	737	451	41	34	1,441
15 to 17 years	11	157	393	370	57	43	988
18 to 24 years	28	501	1,463	1,339	249	44	3,580
25 to 34 years	54	746	2,157	1,845	359	43	5,161
35 to 44 years	33	719	1,828	1,282	264	37	4,126
45 to 54 years	51	960	2,143	1,190	254	31	4,598
55 to 64 years	55	1,278	2,312	1,064	191	26	4,900
65 to 74 years	45	1,242	2,662	901	104	20	4,954
75 to 84 years	42	989	2,284	710	80	19	4,105
85 years or over	18	389	1,142	334	25	19	1,908
Grand Total	**603**	**14,996**	**43,843**	**20,613**	**2,985**	**28**	**83,040**

The data reveals that there is a reasonably consistent theme in relation to Triage Level IV and V by age, though males from 15 to 35 are more likely to present at that level. Children and older people are more likely to present at a higher Triage level.

Table 5: Ethnicity, by triage level

Row Labels	1	2	3	4	5	4 & 5 % of total	Grand Total
NZ Māori	210	4,277	12,545	6,790	1,055	32	24,877
Other	376	10,285	29,921	12,964	1,782	27	55,328
Pacific Islander	17	434	1,377	859	148	36	2,835
Grand Total	**603**	**14,996**	**43,843**	**20,613**	**2,985**	**28**	**83,040**

Data analysis reveals that Māori and Pacific are more likely to present at Triage Levels IV and V than 'other' ethnic groups (inclu. NZ European and other ethnicities).

Table 6: Deprivation, by triage level

Row Labels	1	2	3	4	5	4 & 5 % of total	Grand Total
1	19	764	2,164	995	126	28	4,068
2	24	975	2,830	1,277	161	27	5,267
3	15	686	1,953	844	118	27	3,616
4	25	742	1,943	922	141	28	3,773
5	43	1,353	3,793	1,563	177	25	6,929
6	51	1,490	4,317	2,080	260	29	8,198
7	52	1,565	4,496	1,999	303	27	8,415
8	110	2,620	8,017	3,580	551	28	14,878
9	150	2,606	7,742	4,100	708	31	15,306
10	112	2,164	6,518	3,210	427	29	12,431
Grand Total	**603**	**14,996**	**43,843**	**20,613**	**2,985**	**28**	**83,040**

There appears to be little correlation between deprivation level and Triage Level on presentation.

Table 7: Area, by triage level

Row Labels	1	2	3	4	5	Grand Total
Ashburton		1	2	4		7
Auckland	5	62	164	106	16	353
Carterton					1	1
Central Hawkes Bay	1	3	6	1		11
Central Otago			3			3
Chatham Islands			1			1
Christchurch	2	10	42	19	3	76
Clutha		2	2	3		7
Dunedin	2	5	17	9	1	34
Far North	1	19	25	18	4	67
Franklin	3	48	133	71	9	264
Gisborne	12	79	115	53	8	267
Gore			2	1		3
Grey			1			1
Hamilton	225	6,770	21,200	11,104	1,789	41,088
Hastings	4	21	31	16	4	76
Hauraki	17	227	752	331	28	1,355
Horowhenua		1	7	3	1	12
Hurunui			1	1		2
Invercargill		1	5	3	1	10
Kaikoura				1		1
Kaipara		4	10	6	2	22
Kapiti Coast		5	12	5		22
Kawerau	2	15	29	9	1	56
Lower Hutt	1	14	25	15	1	56
MacKenzie			1			1
Manawatu	2	6	10	9		27
Manukau	6	60	132	73	13	284
Marlborough			7	1	1	9
Masterton		5	2	1	1	9
Matamata-Piako	39	1,195	3,242	1,244	143	5,863
Napier	1	11	22	11	5	50
Nelson		2	6	2		10
New Plymouth	8	75	94	40	8	225
North Shore		32	60	26	1	119
NULL		1		2		3
Opotiki	4	12	28	7	3	54
Otorohanga	16	345	823	327	26	1,537
Outside Territorial Authority		1	2	2	1	6
Palmerston North	1	13	30	14	2	60
Papakura		12	37	20	3	72
Porirua		7	18	12	1	38
Queenstown Lakes		3	7	3		13
Rangitikei	1	6	3	4		14
Rodney		14	31	21	3	69
Rotorua	12	128	216	80	15	451
Ruapehu	7	109	364	130	11	621
Selwyn		3	2	3		8

South Taranaki	3	36	39	17	3	98
South Waikato	31	487	1,482	472	59	2,531
South Wairarapa		2				2
Southland		2	2	1	1	6
Stratford	1	13	6	4	2	26
Tararua		2	5	2		9
Tasman		1	6	3		10
Taupo	18	120	146	60	16	360
Tauranga	10	113	281	101	11	516
Thames-Coromandel	14	312	1,008	424	47	1,805
Timaru	1	4	6	5	1	17
Upper Hutt		4	9	5		18
Waikato	59	2,072	6,003	2,881	386	11,401
Waimakariri		3	5	2		10
Waimate				2	1	3
Waipa	54	2,070	6,146	2,369	287	10,926
Wairoa	1	7	8	7	2	25
Waitakere	2	22	66	23	5	118
Waitaki		1	2	1		4
Waitomo	8	190	520	223	27	968
Wanganui		11	27	9	1	48
Wellington	1	8	33	21	8	71
Western Bay of Plenty	11	68	96	40	3	218
Westland			1	1		2
Whakatane	15	80	123	54	4	276
Whangarei		13	35	35	3	86
Grand Total	**603**	**14,996**	**43,843**	**20,613**	**2,985**	**83,040**

Further analysis is required around area.

Table 8: Six hour target breach, by Triage level

Row Labels	1	2	3	4	5	4 & 5 % of total	Grand Total
TargetBreached	102	4,447	12,215	2,173	84	12	19,021
TargetMet	501	10,549	31,628	18,440	2,901	33	64,019
Grand Total	**603**	**14,996**	**43,843**	**20,613**	**2,985**	**28**	**83,040**

Breaching as a quality indicator against Triage Level indicates that higher proportion of IVs and Vs are seen within six hours.

Table 9: Six hour target breach, by age

Row Labels	Target Breached	Target Met	Percentage meeting target	Grand Total
00 months (under 01 month)	17	64	73	81
01 month to 12 months	286	1,673	83	1,959
01 to 04 years	612	3,540	83	4,152
05 to 09 years	284	2,247	87	2,531
10 to 14 years	301	2,328	87	2,629
15 to 17 years	404	1,945	79	2,349
18 to 24 years	1,508	7,542	80	9,050
25 to 34 years	2,008	9,781	79	11,789
35 to 44 years	1,678	6,688	75	8,366
45 to 54 years	2,028	6,991	71	9,019
55 to 64 years	2,490	6,776	63	9,266
65 to 74 years	2,814	6,548	57	9,362
75 to 84 years	2,807	5,048	44	7,855
85 years or over	1,771	2,667	34	4,438
Grand Total	**19,021**	**64,019**	**70**	**83,040**

Although not related to Triage Levels, age by Breach of six hour target remains a critical area of attention and underlines the need for an alternative approach.

Table 10: Six hour target breach, by ethnicity

Row Labels	Target Breached	Target Met	Percentage meeting target	Grand Total
NZ Māori	5,348	19,529	73	24,877
Other	13,120	42,208	69	55,328
Pacific Islander	553	2,282	76	2,835
Grand Total	**19,021**	**64,019**	**70**	**83,040**

Māori and Pacific are more likely to meet the six hour target than other.

Table 11: Outcome of attendance by triage level

Row Labels	1	2	3	4	5	4 & 5 % of total	Grand Total
AMU	9	697	2,652	2,463	502	47	6,323
ASU		266	3,478	968	41	21	4,753
Ed Only	270	6,079	23,446	12,945	2,148	34	44,888
Referred to Specialty	81	2,601	7,529	3,143	255	25	13,609
Transferred to Specialty	243	5,353	6,738	1,094	39	8	13,467
Grand Total	**603**	**14,996**	**43,843**	**20,613**	**2,985**	**28**	**83,040**

A particularly important table, in that although individuals are triaged at Level IV and V, almost a half are referred to AMU.

Table 12: Re-presentation to ED within three months, by Triage level

Row Labels	1	2	3	4	5	4 & 5 % of total	Grand Total
No representation	476	10,412	30,516	15,074	2,074	29	58,552
Represent < 1 Week	13	1,226	4,078	2,075	388	32	7,780
Represent < 3M	114	3,358	9,249	3,464	523	24	16,708
Grand Total	**603**	**14,996**	**43,843**	**20,613**	**2,985**	**28**	**83,040**

A high proportion of Triage Level IV and Vs are representing within 1 week (almost a third) and within three months (almost a quarter).

Table 13: **GP, by triage level (10 highest of Triage Level 5), ordered by highest percentage of Triage Level IV and V as a total**

Row Labels	1	2	3	4	5	4 & 5 % of total	Grand Total
General Doctor, Unknown	20	387	1,143	974	215	43	2,739
[redacted]		24	110	83	17	43	234
[redacted]		20	52	39	10	40	121
[redacted]		18	84	51	11	38	164
[redacted]	2	43	151	97	19	37	312
[redacted]	15	136	337	232	48	36	768
[redacted]	1	39	124	83	10	36	257
[redacted]	1	75	243	161	11	35	491
[redacted]	2	124	426	233	60	35	845
[redacted]	1	50	206	117	16	34	390
[redacted]		45	177	95	19	34	336
[redacted]	4	110	340	202	31	34	687
[redacted]	1	54	168	103	11	34	337
[redacted]	5	91	286	167	26	34	575
[redacted]	1	34	169	92	11	34	307
[redacted]	10	388	1,178	655	133	33	2,364
[redacted]	3	51	193	101	22	33	370
[redacted]	5	156	501	290	39	33	991
[redacted]		106	316	183	26	33	631
[redacted]		103	272	165	18	33	558
[redacted]	2	68	212	114	19	32	415
[redacted]	6	66	170	98	14	32	354
[redacted]	7	165	472	257	40	32	941
[redacted]	43	947	3,159	1,627	246	31	6,022
[redacted]	1	72	177	93	19	31	362
[redacted]	3	113	284	154	25	31	579
[redacted]	1	44	165	82	11	31	303
[redacted]	3	110	293	148	30	30	584
[redacted]	3	76	171	97	12	30	359
[redacted]	1	60	178	94	10	30	343
[redacted]	7	46	92	51	12	30	208
[redacted]	1	22	118	49	12	30	202
[redacted]	3	64	290	130	24	30	511
[redacted]	5	63	202	98	12	29	380
[redacted]	3	102	278	129	27	29	539
[redacted]	2	50	126	58	14	29	250

[redacted]	2	93	273	129	19	29	516
[redacted]	4	53	186	79	18	29	340
[redacted]	2	62	189	90	10	28	353
[redacted]	1	36	121	49	12	28	219
[redacted]	3	135	382	183	13	27	716
[redacted]	1	91	230	103	18	27	443
[redacted]	2	58	210	88	11	27	369
[redacted]	6	72	200	81	20	27	379
[redacted]		65	187	80	11	27	343
[redacted]	1	44	139	54	12	26	250
[redacted]	6	76	215	92	14	26	403
[redacted]		41	149	56	11	26	257
[redacted]	4	73	187	76	17	26	357
[redacted]	4	95	225	95	19	26	438
[redacted]		81	244	102	11	26	438
[redacted]	2	42	124	48	10	26	226
[redacted]	2	91	248	101	16	26	458
[redacted]	1	41	168	61	11	26	282
[redacted]		65	146	62	10	25	283
[redacted]		52	163	61	12	25	288
[redacted]	1	71	201	77	14	25	364
[redacted]	1	78	239	92	10	24	420
[redacted]		52	158	54	10	23	274
[redacted]		48	162	53	10	23	273
[redacted]	2	54	126	39	14	23	235
[redacted]		74	199	65	13	22	351
[redacted]		84	231	73	11	21	399
[redacted]	5	111	292	93	15	21	516

Further analysis is required around identified GP, although the results are interesting when informing decision making

Table 14: Top 20 diagnoses, by Triage level, organised by percentage of Triage Level IV and V

Row Labels	1	2	3	4	5	4 & 5 % of total	Grand Total
Open wound of finger(s) without damage to nail		16	155	355	69	71	595
Other specified general symptoms and signs	42	704	4,664	5,529	1,361	56	12,300
Unknown and unspecified causes of morbidity	3	143	652	749	224	55	1,771
Pain, unspecified		78	350	229	18	37	675
Low back pain		60	596	234	10	27	900
Injury, unspecified	13	170	297	158	18	27	656
Acute upper respiratory infection, unspecified		61	454	122	13	21	650
Headache	3	102	712	181	17	20	1,015
Unspecified injury of head	31	275	898	278	7	19	1,489
Urinary tract infection, site not specified		97	410	110	4	18	621
Nausea and vomiting		94	607	111	3	14	815
Abnormal uterine and vaginal bleeding, unspecified	1	95	391	73	1	13	561
Unspecified acute lower respiratory infection	1	147	392	78	2	13	620
Other and unspecified abdominal pain		610	5,557	735	7	11	6,909
Fever, unspecified	1	260	472	72	7	10	812
Suicidal ideation		183	482	62	4	9	731
Syncope and collapse	13	193	704	85	3	9	998
Unspecified threat to breathing	9	207	433	42	4	7	695
Other and unspecified abnormalities of breathing	13	205	380	36	2	6	636
Chest pain, unspecified	15	2,033	1,361	111	56	5	3,576
Other and unspecified drugs, medicaments and biological substances	25	400	392	34	2	4	853

Further analysis is required around diagnosis

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Appendix Two - Excerpt from CE reports to the Commissioner

Report dated 24 February 2021:

Services Not Meeting Waiting Times Guarantees

The preliminary results for the month of January 2021 are not yet available.

The December results are as detailed below.

ESPI 2 - First Specialist Assessment (FSA).
The number of patients waiting greater than four months for an FSA increased slightly to 15.5 % (1604) in December 2020 compared to 14.5% (1511) in November. This is, however, a reduction from the peak of 29.4% (2707) in May 2020.

ESPI5 - In Patient procedures.
The number of patients waiting greater than four months for a procedure increased slightly to 12.1% (543) in December 2021 compared to 11.4% (464) in November 2020. This has reduced from the peak of 30.5% (1489) in May 2020, and has returned a similar level to what was reported pre COVID in January 2020 of 11.8% (579)
The preliminary result for January 2021 is 15.6% (794). This reflects the annual leave taken over January and the impact of the increase in acute demand for surgery.

Report dated 24 March 2021:

Services Not Meeting Waiting Times

Triage Wait times (ESPI 1)
As at January 2021, 24 services are not meeting triage wait time targets. The primary issue is with the referral centre capacity to load and modify referrals. A pilot of robot technology is currently in progress to assist in addressing the issue in the future.

Outpatient Wait times (ESPI 2)
Month end January, 12 services did not meet the expected four month wait time for outpatient with 18.4% of patients (2,023) exceeding the four month wait time. This position has deteriorated as a result of service reductions over December and January. All services did achieve the agreed quarter 2 waitlist reduction trajectory agreed with the Ministry of Health as part of the Improvement Action Plans.

Inpatient Wait times (ESPI 5)
Month end January, nine services did not meet the expected four month wait time for outpatient with 14.5% of patients (718) exceeding the four month wait time. This position has deteriorated following the Christmas theatre and ward shutdown for maintenance. All services did achieve the agreed quarter two waitlist reduction trajectory agreed with the Ministry of Health as part of the Improvement Action Plans.

Report dated 28 April 2021:

Services Not Meeting Waiting Times

Elective Services

Triage Wait times (ESPI 1)

As at February 2021, 24 Services are not meeting triage wait time targets. The primary issue relates to referral centre capacity to load and modify referrals. A pilot of robot technology is currently in progress to assist in addressing the issue in the future. In the interim additional staff have been allocated to address the back log over the next ten weeks while ongoing resourcing requirements are confirmed.

Outpatient Wait times: (ESPI 2)

As at the end of February 2021, 18 Services did not meet the expected four month wait time for outpatient with 20.9% of patients (2,325) exceeding the four month wait time. The three month trend shows an increase in patients waiting greater than four months. The recovery plan is currently being reviewed and strategies identified to assist with reducing the number of patients exceeding the four-month wait.

Inpatient Wait times: (ESPI 5)

As at the end of February 2021, 13 Services did not meet the expected four month wait time with 16.3% of patients (820) exceeding the four month wait time. The three month trend shows an increase in patient waiting greater than four months. The recovery plan is assisting with this however is under review alongside the theatre production plan. The current focus is on maximising theatre throughput, funded outsourcing and booking processes to ensure both clinical priority and length of time waiting are taken into account. The theatre production plan is also under review as part of the planning for the next financial year.

ACCESS, TIMELINESS

ESPI RESULTS	29 Consecutive Months Red	FCT (31 DAY)	87.8%

	2020						2021		Consecutive months red ESPI to Feb 21	3 month trend
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb		
ESPI 1	55.6%	51.9%	59.3%	48.1%	33.3%	11.1%	11.1%	11.1%	0	–
Level	12	13	11	14	18	24	24	24		
ESPI 2	24.2%	17.0%	13.6%	13.6%	14.5%	15.5%	18.4%	20.9%	29	▲
Level	2,240	1,691	1,377	1,403	1,511	1,604	2,023	2,325		
ESPI 3	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.2%	0.2%	0	▲
Level	21	24	27	26	21	25	32	36		
ESPI 5	23.6%	18.1%	13.9%	11.9%	10.3%	11.0%	14.5%	16.3%	28	▲
Level	1,012	718	545	471	403	473	706	820		
ESPI 8	93.6%	91.6%	93.2%	94.3%	97.1%	98.3%	98.3%	99.3%	0	▲
Level	90	104	106	84	43	22	19	9		

Faster Cancer Treatment	2020						2021		3 month trend
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
FCT %	99.2%	94.9%	96.3%	96.4%	92.4%	93.9%	82.8%	87.8%	▼
Level	127	111	156	134	122	154	106	86	

Report dated 23 June 2021:

Nothing reported this month in relation to hospital wait times.

Report dated 28 July 2021:

Nothing reported this month in relation to hospital wait times.

Report dated 25 August 2021:

Nothing reported this month in relation to hospital wait times.

Report dated 22 September 2021:

Planned care

Overview of impact from Cyber outage

An analysis of the impact of the cyber attack on the planned care wait lists has been completed.
Key baseline metrics have been confirmed as follows:

- FSA wait list – the number of patients waiting >120 pre and post attack
- Surgical wait list – the number of patients waiting >120 days pre and post attack
- Other PCI Performance indicators including MRI, CT and Angiography wait times

- Ophthalmology follow-ups outside of wait time
- Cardiac surgery waitlist and patients waiting outside of clinically indicated wait- time.

FSA Wait List
Almost all services were ESPI 2 non-compliant following the cyber outage with an increase of 1008 patients waiting greater than 120 days for FSA from 1 May 2021 to 31 July 2021.
As at the end of April 2021, the number of patients waiting greater than 120 days for FSA was 2258.
As at the end of July 2021, the number of patients waiting greater than 120 days for FSA was 3266.

In Patient Wait List
All services were ESPI 5 non-compliant following the Cyber outage with an increase of 437 patients waiting greater than 120 days for a procedure from 1 May 2021 to 31 July 2021.
As at the end of April 2021, the number of patients waiting greater than 120 days for a procedure was 832.
As at the end of July 2021, the number of patients waiting greater than 120 days for a procedure was 1269.
The figures referred to above are a subset of the 4,500 referred to earlier in the document which will also include outpatients and diagnostics.

Actions being progressed to address the impact
Directors have been working through a process to confirm what would be required to recover (resource and capacity) to allow for plans to be identified and costs quantified. Recovery plans are being developed to address the backlog. These plans have however been further impacted on by the RSV outbreak and now the current COVID-19 resurgence and will be revised to include the full impact of all events.
The full impact of the COVID-19 resurgence will not be fully understood for some weeks as reprioritisation of urgent cases will continue to impact on the wait time of the routine patients over the next two months. We do expect a negative impact on both ESPI 2 and ESPI 5 as a result of the COVID 19 resurgence.
The production planning aspects of the recovery and the monitoring of this will become part of overall recovery and theatre productions plans and be merged into BAU.

Report dated 27 October 2021:

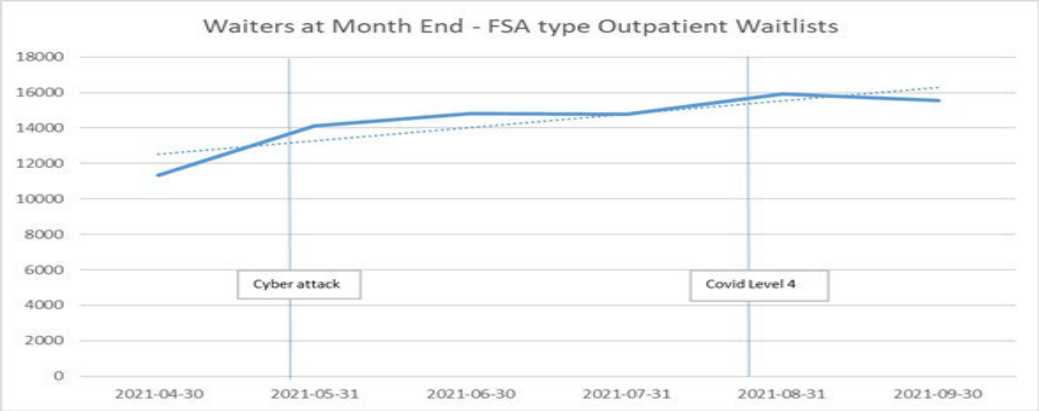
Waiting List Indicators
Waiting times for time to assessment or treatment have continued to decline with routine patients being deferred due to COVID restrictions. The increase in the number of patients waiting greater than four months reflects the impact of the cyber security attack and COVID

Patient Flow Indicator (ESPI) Waikato DHB													
		Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
ESPI 1	DHB Services that appropriately acknowledge and process referrals within required timeframe	13 of 27	9 of 27	3 of 27	3 of 27	3 of 27	4 of 27	No result due to Cyber outage			4 of 27	11 of 27	12 of 26
		48.1%	33.3%	11.1%	11.1%	11.1%	14.8%				14.8%	40.0%	46.15%
ESPI 2	Patients who wait longer than required timeframe for the first specialist appointment	1403	1511	1604	2023	2325	2285	2258	2286	2720	3266	3726	3809
		13.6%	14.5%	15.5%	18.4%	20.9%	21.8%	21.5%	22.6%	32.7%	24.2%	35.5%	27.30%
ESPI 5	Patients given a commitment to treat but not treated within the required timeframe	468	397	458	680	777	741	823	885	1008	1168	1377	1370
		11.9%	10.3%	10.9%	14.4%	16.1%	14.8%	15.9%	19.5%	24.6%	23.9%	24.7%	24.4%

There has been an improvement in ESPI 1 as a result of improved processes for the management of referrals. For the month of September, ESPI2 and 5 remain non-compliant. The level of non-compliance for FSAs has reduced from August, however the total number waiting has increased, and remained at a similar level for ESPI 5.

First Specialist Assessments

The total number of patients waiting for an FSA has increased to 16,204. The graph below shows the outpatient wait list trend since prior to the cyber attack through to the end of September. This reflects the impact of the cyber security attack and COVID resurgence.

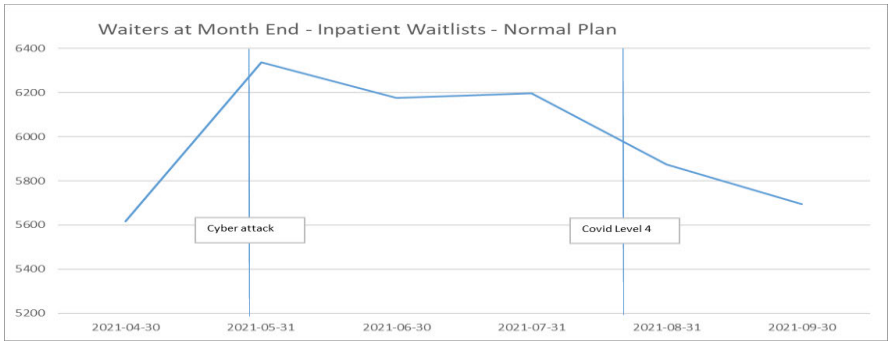


The DHB currently has 5,562 patients waiting greater than 4 months for an FSA. 90% of the total volume waiting greater than four months relate to the specialties identified in the table below.

	Total	Vol. >120days	% >120days
Outpatient FSA	**16204**	**5562**	**34%**
Otorhinolaryngology (ENT)	1862	970	52%
Orthopaedic Surgery	2151	845	39%
Plastic Surgery Non Burns	1790	788	44%
Neurology	816	449	55%
Cardiology	751	319	42%
General Surgery	1167	256	22%
Gynaecology	1051	206	20%
Respiratory Medicine	622	199	32%
Maxillofacial Surgery	359	187	52%
Paediatric Medicine	645	186	29%
Gastroenterology	411	180	44%
Ophthalmology	901	172	19%
Pain Management	309	150	49%
Rheumatology	303	100	33%
SubTotal	**13138**	**5007**	
% of Total	81%	90%	

Inpatient Wait List

The graph below shows the trend for the inpatient waitlist from the period prior to the cyber-attack through to the end of September. While there was an initial increase when the cyber-attack occurred the total number of patients on the surgical wait list has been decreasing since June. This reflects the level of surgery that was able to continue during the cyber outage and in part, the growth in the number of patients waiting for an FSA and therefore a delay in conversion for treatment.



There are 1,816 patients waiting greater than 4 months for a procedure. 83% of this volume relates to the specialties identified in the table below.

Current Waitlist - 18 Oct 21	Total	Vol. >120days	% >120days
Inpatient (Normal)	**6007**	**1816**	**30%**
Top Specialties			
Ophthalmology	943	403	43%
Dental Surgery	586	322	55%
Otorhinolaryngology (ENT)	416	176	42%
Orthopaedic Surgery	622	166	27%
Gynaecology	564	160	28%
Plastic Surgery Non Burns	484	148	31%
General Surgery	819	127	16%
SubTotal	**4434**	**1502**	**34%**
% of Total	74%	83%	

Current Focus

The current focus is on:

- Continuing to deliver the maximum service that can safely be achieved within the current environment.
- Refocusing on areas where clinical and equity risk is considered to be greatest.

Discussions are occurring with the ministry relating to how PCI will be managed for the rest of this financial year. This includes strategies and national initiatives to support the management of demand and waitlists in the foreseeable future

Report dated 24 November 2021:

Waiting List Indicators

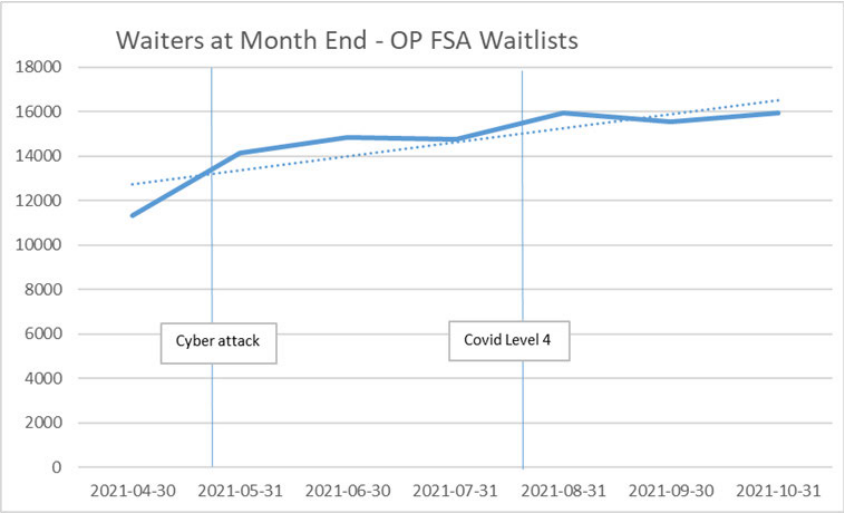
Waiting times for time to assessment or treatment have continued to decline with routine patients being deferred due to COVID restrictions. The increase in the number of patients waiting greater than four months reflects the impact of the cyber security attack and COVID.

Patient Flow Indicator (ESPI) Waikato DHB													
		Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
ESPI 1	DHB Services that appropriately acknowledge and process referrals within required timeframe	9 of 27	3 of 27	3 of 27	3 of 27	4 of 27	No result due to Cyber outage			4 of 27	11 of 27	12 of 26	
		33 3%	11.1%	11.1%	11.1%	14.8%				14.8%	40 0%	44.40%	
ESPI 2	Patients who wait longer than required timeframe for the first specialist appointment	1511	1604	2023	2325	2285	2258	2286	2720	3266	3726	3764	4535
		14 5%	15.5%	18.4%	20.9%	21.8%	21.5%	22.6%	32.7%	24.2%	35 5%	35.9%	31.4%
ESPI 5	Patients given a commitment to treat but not treated within the required timeframe	397	458	680	775	738	817	877	993	1144	1338	1294	1636
		10 3%	10.9%	14.4%	16.1%	14.7%	15.8%	19.5%	24.6%	23.8%	24.4%	23.7%	29.8%

There has been an improvement in ESPI 1 as a result of improved processes for the management of referrals. For the month of October, ESPI2 and 5 remain non-compliant. The level of non-compliance for First Specialist Assessments (FSAs) has reduced from October, however the total number waiting has increased. The level of non-compliance for ESPI 5 has increased from October.

First Specialist Assessments

The total number of patients waiting for an FSA has increased to 16,204. The graph below shows the outpatient wait list trend since prior to the cyber-attack through to the end of October. This reflects the impact of the cyber-attack and COVID resurgence.

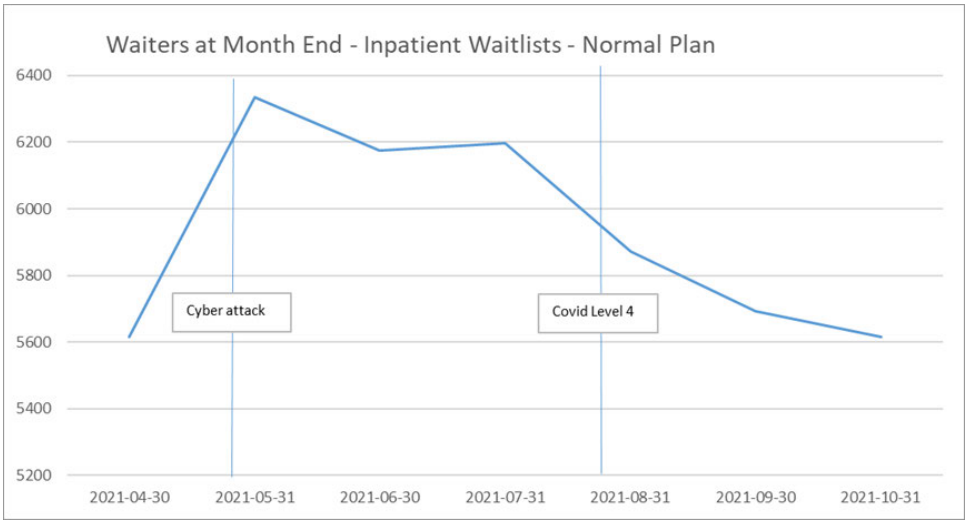


The DHB currently has 5,654 patients waiting greater than 4 months for an FSA. 89% of the total volume waiting greater than four months relate to the specialties identified in the table below.

	Total	Vol. >120days	% >120days
Outpatient FSA	**15618**	**5654**	**36%**
Otorhinolaryngology (ENT)	1819	1020	56%
Orthopaedic Surgery	2111	938	44%
Plastic Surgery Non Burns	1784	737	41%
Neurology	817	437	53%
Cardiology	723	330	46%
General Surgery	1114	229	21%
Respiratory Medicine	632	218	34%
Maxillofacial Surgery	360	211	59%
Ophthalmology	829	204	25%
Paediatric Medicine	582	203	35%
Gastroenterology	424	195	46%
Gynaecology	1002	192	19%
Pain Management	297	146	49%
SubTotal	**12494**	**5060**	**40%**
% of Total	80%	89%	

Inpatient Wait List

The graph below shows the trend for the inpatient wait list from the period prior to the cyber-attack through to the end of October. While there was an initial increase when the cyber-attack occurred the total number of patients on the surgical wait list has been decreasing since June. This reflects the level of surgery that was able to continue during the cyber outage and in part, the growth in the number of patients waiting for an FSA and therefore a delay in conversion for treatment.



There are 1,922 patients waiting greater than 4 months for a procedure. 82% of this volume relates to the specialties identified in the table below.

Current Waitlist - 11 Nov 21			
	Total	Vol. >120days	% >120days
Inpatient (Normal)	**5631**	**1922**	**34%**
Top Specialties			
Ophthalmology	876	413	47%
Dental Surgery	556	366	66%
Otorhinolaryngology (ENT)	399	188	47%
Orthopaedic Surgery	563	185	33%
Gynaecology	517	154	30%
Plastic Surgery Non Burns	477	141	30%
General Surgery	798	137	17%
SubTotal	**4186**	**1584**	**38%**
% of Total	74%	82%	

Current Focus

The current focus is on:

- Continuing to deliver the maximum service that can safely be achieved within the current environment.
- Refocusing on areas where clinical and equity risk is considered to be greatest.

Discussions are occurring with the Ministry of Health relating to how PCI will be managed for the rest of this financial year. This includes strategies and national initiatives to support the management of demand and waitlists in the foreseeable future. Discussions have also commenced with the GP Liaison roles to review how we manage the number of patients being referred for an FSA particularly in Orthopaedics and ENT.

Report dated 15 December 2021:

Waiting List Indicators

Waiting times for time to assessment or treatment have stabilised as we begin to transition from COVID-19 restrictions to the resurgence environment and the traffic light alert level system. Some restrictions remain in place to achieve flow and safe distancing. Re-prioritisation of urgent and deferred patients means we continue to experience some cumulative growth in long waiters and variability in waitlist numbers month to month.

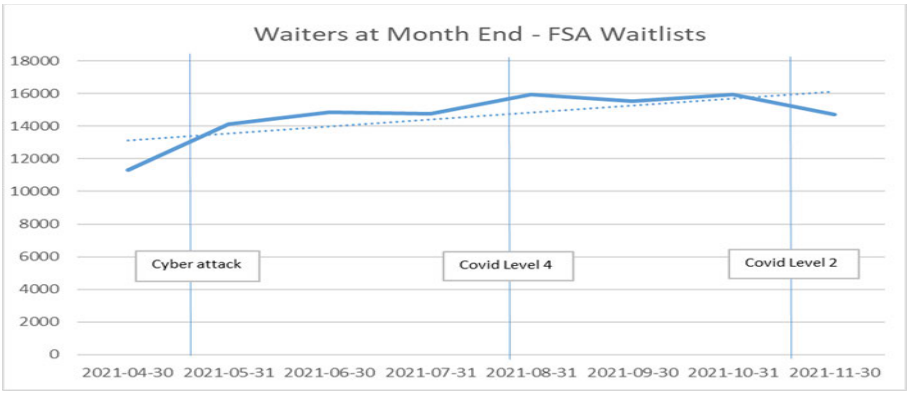
Patient Flow Indicator (ESPI) Waikato DHB													
		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
ESPI 1	DHB Services that appropriately acknowledge and process referrals within required timeframe	3 of 27	3 of 27	3 of 27	4 of 27	No result due to Cyber outage			4 of 27	11 of 27	12 of 26	22 of 27	
		11.1%	11.1%	11.1%	14.8%				14.8%	40.0%	44.40%	87%	
ESPI 2	Patients who wait longer than required timeframe for the first specialist appointment	1604	2023	2325	2285	2258	2286	2720	3266	3726	3764	4463	4241
		15.5%	18.4%	20.9%	21.8%	21.5%	22.6%	32.7%	24.2%	35.5%	35.9%	30.90%	32.0%
ESPI 5	Patients given a commitment to treat but not treated within the required timeframe	460	681	776	739	817	875	988	1125	1312	1245	1582	1658
		10.9%	14.4%	16.1%	14.7%	15.8%	19.5%	24.7%	23.7%	24.3%	23.2%	29.5%	29.4%

(ESPI 1 results unavailable until 16/12/21)

There has been an improvement in ESPI 1 as a result of improved processes for the management of referrals. For the month of November, ESPI2 and 5 remain non-compliant. The number of long waiting patients waiting for FSA has reduced from October, however the level of non-compliance has increased as the overall waitlist numbers have reduced in line with strategies to increase capacity and reduce waitlists. The level of non-compliance for ESPI 5 has remained stable with a slight increase in the number of long waiting patients in November.

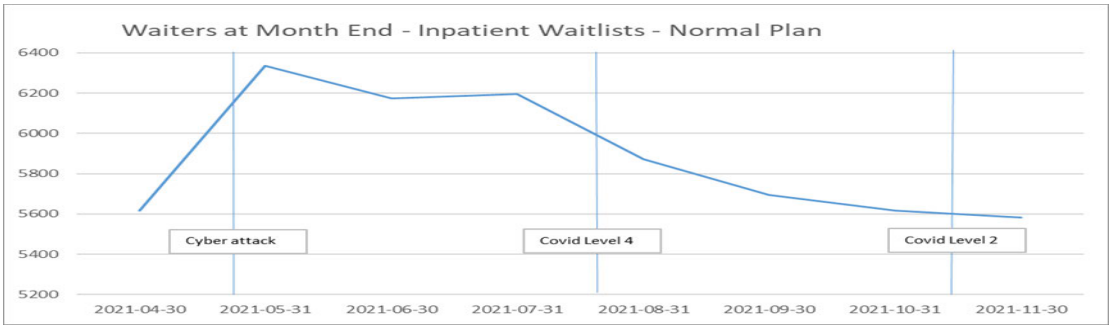
First Specialist Assessments (FSA)

The total number of patients waiting for an FSA has reduced to 14,577. The graph below shows the outpatient wait list trend since prior to the cyber attack through to the end of November. This reflects the impact of the cyber security attack and COVID restrictions. Reductions in patients waiting for FSA reflect the transition to delivering the maximum service that can safely be achieved within the current environment.



Inpatient Wait List

The graph below shows the trend for the inpatient wait list from the period prior to the cyber attack through to the end of November. While there was an initial increase when the cyber attack occurred the total number of patients on the surgical wait list has been decreasing since June. This reflects the level of surgery that was able to continue during the cyber outage and in part, the growth in the number of patients waiting for an FSA and therefore a delay in conversion for treatment.



Current Focus

Resurgence/resilience plans have been developed at specialty level to address outpatient and inpatient waitlists. The focus of these plans is on achieving planned delivery for 2022 through increased capacity and strategies to reduce waitlists and waiting times, with a focus on waitlists identified as representing the highest levels of risk.

The Ministry of Health has re-allocated the Improvement Action Plan Funding for 2021/22 - ($6m).

The funding was originally linked to the achievement of waitlist trajectories. The revised funding is now able to be committed to achievement of increased volumes and/or reduction in the number of patients waiting greater than acceptable timeframes.

The Ministry has also indicated there is additional funding available for Waikato DHB given the impact of the cyber attack and the recent COVID-19 outbreak.The DHB's plan has been developed and submitted for consideration.

Report dated 23 February 2022:

Waiting List Indicators

Waiting times for time to assessment increased as a result of planned reductions in delivery over the Christmas closure period. Some restrictions remain in place to achieve flow and safe distancing as part of the Omicron management plans. Re-prioritisation of urgent and deferred patients does mean we continue to experience some cumulative growth in long waiters and variability in waitlist numbers month to month.

Waiting times for treatment continue in increase. This has been impacted by reduced activity as a result of planned Christmas theatre closures combined with theatre and bed capacity constraints through January.

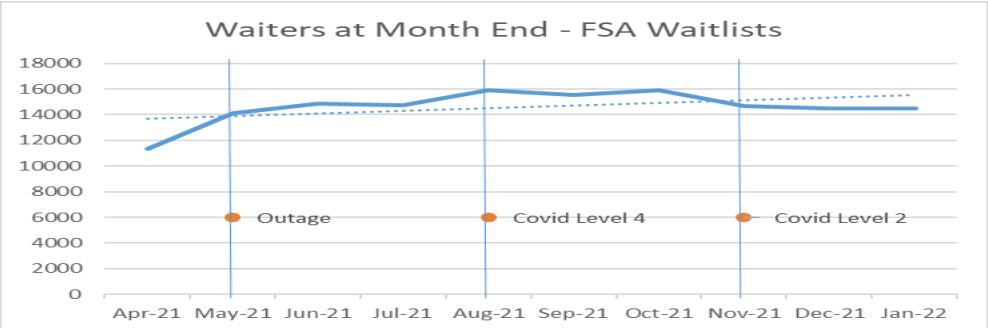
There has been an improvement in ESPI 1 as a result of improved processes for the management of referrals. For the month of January ESPI 2 non-compliance returns to above 30% impacted by planned service reduction through December and January. For the month of December ESPI 5 remains non-compliant. The level of non-compliance has increased, impacted by higher than planned acute volumes and planned Christmas theatre and interventional service reductions, and reductions in the theatre master schedule due to high staff vacancy.

Waiting Lists

An analysis of the impact of the cyber security attack on access to planned care was undertaken in August 2021 and measures were put in place to manage the impact of this to reduce the equity impact. However, the cumulative impact of the RSV outbreak and COVID has further impacted on wait lists and the length of time patients are waiting. This is outlined for FSAs and surgery in the sections below.

First Specialist Assessments

The total number of patients waiting for an FSA has reduced slightly to 14,545. The graph below shows the outpatient wait list trend since prior to the cyber-attack through to the end of December. This reflects the impact of the cyber security attack and COVID restrictions. Reductions in patients waiting for FSA over the last three months reflects the focus on delivering the maximum service that can safely be achieved within the current environment.

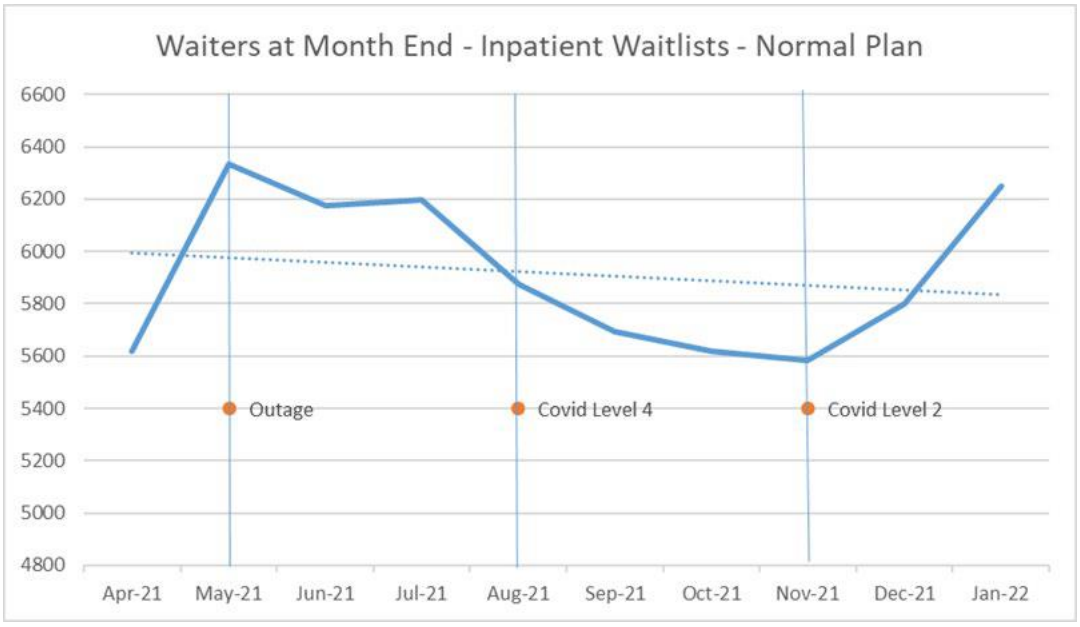


The DHB currently has 5,264 patients waiting greater than 4 months for an FSA. 90% of the total volume waiting greater than four months relate to the specialties identified in the table below.

Current Waitlist - 08 Feb 22			
	Total	Vol. >120days	% >120days
Outpatient FSA	**14545**	**5863**	**40%**
Otorhinolaryngology (ENT)	1630	1058	65%
Orthopaedic Surgery	2135	1049	49%
Plastic Surgery Non Burns	1335	549	41%
Neurology	852	443	52%
Cardiology	695	344	49%
General Surgery	1155	329	28%
Respiratory Medicine	618	319	52%
Maxillofacial Surgery	381	268	70%
Gynaecology	871	239	27%
Ophthalmology	792	228	29%
Pain Management	328	179	55%
Gastroenterology	366	149	41%
Paediatric Medicine	465	110	
SubTotal	**11623**	**5264**	**45%**
% of Total	80%	90%	

In Patient Wait List

The graph below shows the trend for the inpatient wait list from the period prior to the cyber attack through to the end of January. While there was an initial increase when the cyber attack occurred, the total number of patients on the surgical wait list had been decreasing since June but shows an increase in December and January. This growth reflects the increase in FSA activity and conversion for treatment and reduced activity in December and January due to Christmas reductions and capacity constraints.



The increase that has occurred over December and January reflects the reduced volume of surgery over the Christmas holidays and the current staffing vacancies which is having an impact on the theatre throughput. There are currently 2,394 patients waiting greater than 4 months for a procedure. 87% of this volume relates to the seven specialties identified in the table below.

Current Waitlist - 08 Feb 22			
	Total	Vol. >120days	% >120days
Inpatient (Normal)	**6424**	**2394**	**37%**
Top Specialties			
Ophthalmology	1033	455	44%
Dental Surgery	641	390	61%
General Surgery	837	286	34%
Orthopaedic Surgery	629	259	41%
Gynaecology	564	214	38%
Otorhinolaryngology (ENT)	450	196	44%
Cardiology	479	151	32%
Plastic Surgery Non Burns	648	143	22%
SubTotal	**5281**	**2094**	**40%**
% of Total	82%	87%	

Current Focus

The current focus remains as follows:

- Resurgence/resilience plans have been developed at specialty level to address backlogs in outpatient and inpatient activity. The focus is on developing revised plans to achieve planned delivery for 2022 through increased capacity and strategies to reduce waitlists and waiting times, with a specific focus on waitlists identified as representing the highest level of risk.
- The Ministry of Health has reallocated the Inpatient Action Plan Funding for 2021/22 ($6m). The DHB plan was approved in December and is in the process of being implemented. The focus is on increasing capacity and strategies to reduce waitlists and waiting times, with a specific focus on waitlists identified as representing the highest level of risk.
- An operational meeting structure has been implemented to focus on delivery to plans and achieving waitlist and wait time reductions across services. Additional waiting list reporting was developed to support recovery from the Cyber incident and has been further enhanced to assist with management of all DHB waitlists recorded in iPM. The reports provide waitlist, wait times, acuity scores and ethnicity at summary and detailed (patient) level.
- Resource has been committed to a new process that has been implemented to centrally review and monitor wait times on all DHB waitlists recorded in iPM and liaise with services to ensure plans are in place for the longest waiting patients, or a review is undertaken. The process includes a pro equity lens, with a lower threshold on wait times for Māori and Pacific to be identified to the service to ensure plans are in place

Report dated 23 March 2022:

Waiting List Indicators

Waiting times for time to assessment increased further as a result of reductions in delivery which have been ongoing and increasing since the Christmas closure period. Omicron management plans have triggered increased levels of escalation and reduced activity in February. Re-prioritisation of urgent and deferred patients means we continue to experience cumulative growth in long waiters and variability in waitlist numbers month to month.

Waiting times from time of assessment to treatment continue to increase as well. This has been impacted by reduced capacity as a result of planned Christmas theatre closures combined with theatre and planned care reduction continuing through February due to staffing deficits and in response to Omicron.

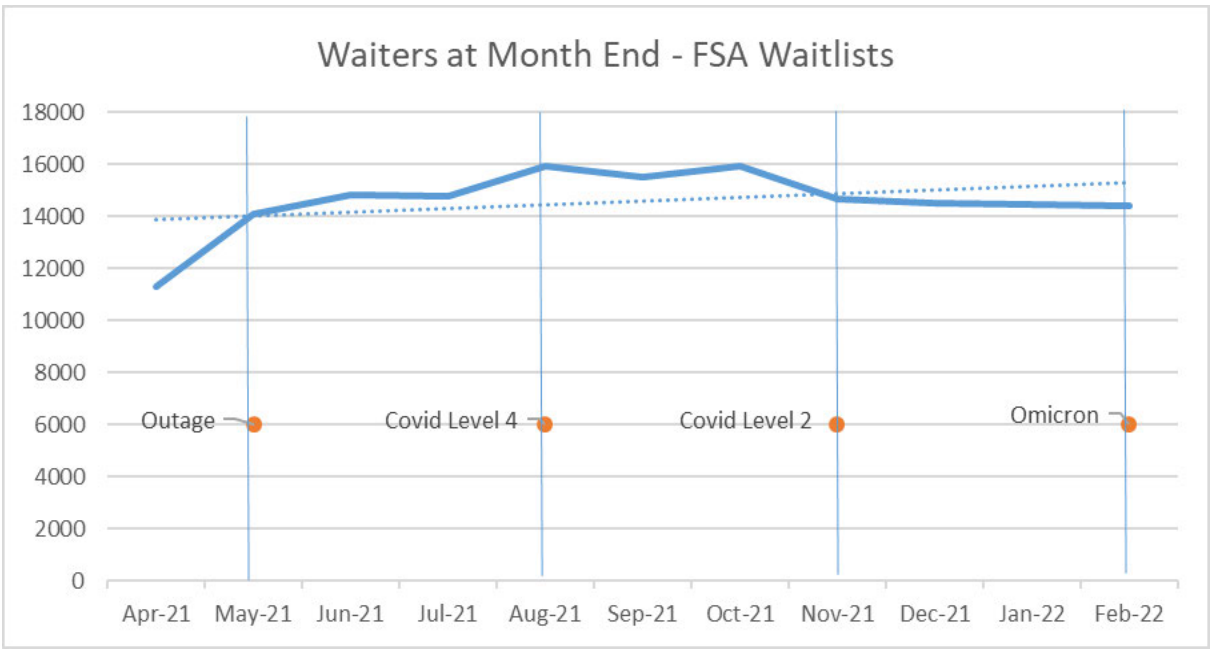
Patient Flow Indicator (ESPI) Waikato DHB															
		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
ESPI 1	DHB Services that appropriately acknowledge and process referrals within required timeframe	3 of 27	3 of 27	3 of 27	4 of 27	No result due to Cyber outage			4 of 27	11 of 27	12 of 26	22 of 27	23 of 26	18 of 27	24 of 27	
		11.1%	11.1%	11.1%	14.8%				14.8%	40.0%	44.40%	87%	88%	67%	89%	
ESPI 2	Patients who wait longer than required timeframe for the first specialist appointment	1604	2023	2325	2285	2258	2286	2720	3266	3726	3764	4463	4147	3876	4252	4194
		15.5%	18.4%	20.9%	21.8%	21.5%	22.6%	32.7%	24.2%	35.5%	35.9%	30.9%	31.3%	29.8%	32.8%	32.1%
ESPI 5	Patients given a commitment to treat but not treated within the required timeframe	460	681	776	739	817	875	984	1116	1301	1218	1535	1568	1822	2054	2140
		10.9%	14.4%	16.1%	14.7%	15.8%	19.5%	24.8%	23.8%	24.4%	23.2%	29.5%	30.5%	33.70%	34.70%	34.50%

(February ESPI 1 results unavailable until mid-March)

There continues to be an improvement in ESPI 1 as a result of improved processes for the management of referrals.
For the month of February, ESPI 2 non-compliance remains above 30% and is not expected to decrease over coming months.
For the month of February, ESPI 5 remains non-compliant. The level of non-compliance has continued to increase with ongoing reductions in the theatre master schedule due to high staff vacancy.

First Specialist Assessments (FSA)

The total number of patients waiting for an FSA has remained stable at 14,443. The graph below shows the outpatient wait list trend prior to the cyber attack through to the end of February. This reflects the impact of the cyber security attack and COVID restrictions at different points. Reductions in patients waiting for FSA reflect the transition to delivering the maximum service that can safely be achieved within the current environment.

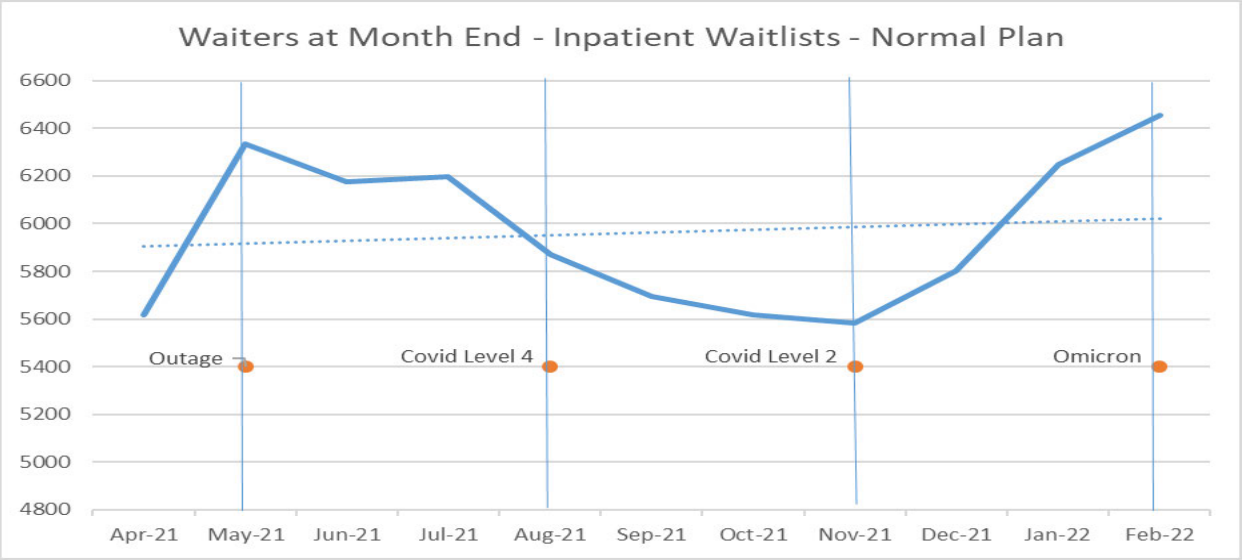


The DHB currently has 5,533 patients waiting greater than 4 months for an FSA. 88% of the total volume waiting greater than four months relates to the specialties identified in the table below.

Current Waitlist – 07 Mar 22			
	Total	Vol. >120days	% >120days
Outpatient FSA	**14443**	**5533**	**38%**
Top Specialties			
Orthopaedic Surgery	2114	1033	49%
Otorhinolaryngology (ENT)	1579	992	63%
Neurology	863	449	52%
Plastic Surgery Non Burns	1462	447	31%
Cardiology	711	356	50%
Respiratory Medicine	652	313	48%
General Surgery	1143	310	27%
Maxillofacial Surgery	376	264	70%
Gynaecology	884	262	30%
Ophthalmology	746	171	23%
Pain Management	311	151	49%
Gastroenterology	346	133	38%
SubTotal	**11187**	**4881**	
% of Total	77%	88%	

Inpatient Wait List

The graph below shows the trend for the inpatient wait list from the period prior to the cyber attack through to the end of February. While there was an initial increase when the cyber attack occurred, the total number of patients on the surgical wait list had been decreasing. This trend has changed since November 2021 with a steep increase. This is expected to be ongoing as capacity for procedures remains reduced as a result of staff vacancies and now Omicron



There are 2,405 patients waiting greater than 4 months for a procedure. 88% of this volume relates to the seven specialties identified in the table below.

Current Focus

Very limited planned care is expected to be delivered over March due to the Omicron response. Planned care has been reduced to cancer and time critical work only as part of the response plans, and staff are being re-deployed to support wards and other front line areas.

Resurgence/resilience plans have been developed at specialty level to address backlogs in outpatient and inpatient activity, however these are not able to be progressed in the current environment. The focus of these plans was on delivering maximum planned activity for the remainder of 2022 through increased capacity and strategies to reduce wait lists and waiting times, with a focus on wait lists identified as representing the highest level of risk. These plans will be revisited once the Omicron outbreak starts to resolve.

Report dated 4 May 2022:

Waiting List Indicators

Omicron management plans have triggered reduced capacity for planned care delivery in February, March and April. Re-prioritisation of urgent and deferred patients means a cumulative growth in long waiters, and variability in waitlist numbers month to month for both FSAs and treatment.

There has been an improvement in ESPI 1 as a result of improved processes for the management of referrals and the cancellation of planned care activity has released time for SMOs.

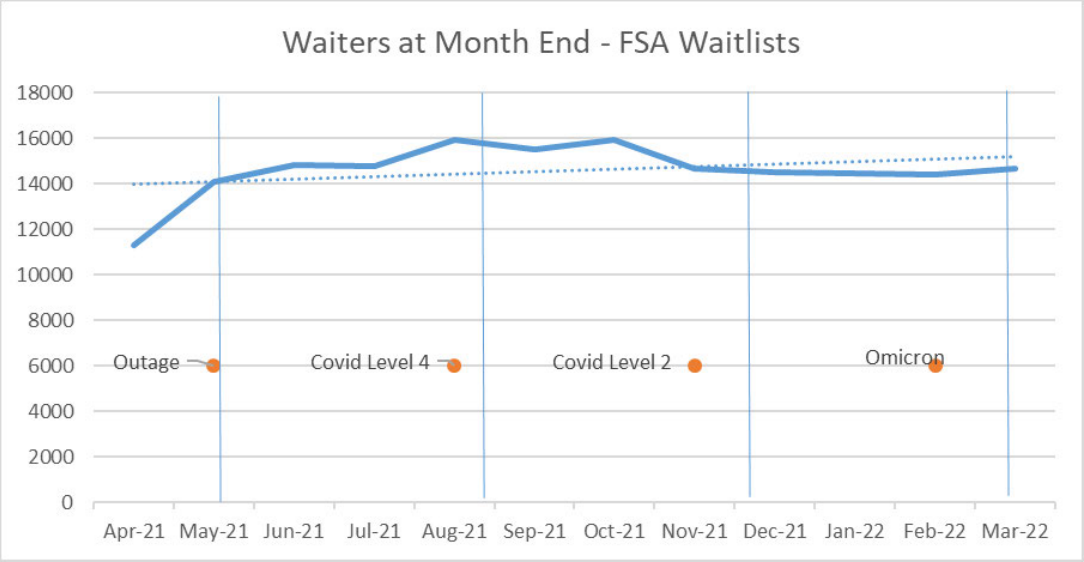
For the month of March ESPI 2 non-compliance remains above 30% and is not expected to decrease over coming months.

For the month of March ESPI 5 remains non-compliant. The level of non-compliance has continued to increase with ongoing reductions in the theatre master schedule due to Omicron and nursing and anesthetic technician workforce vacancy.

First Specialist Assessments

The total number of patients waiting for an FSA has increased slightly to 14,627. Outpatient delivery has been restricted to HSCAN, P1 and time critical assessments only through March and April as part of the Omicron management plan.

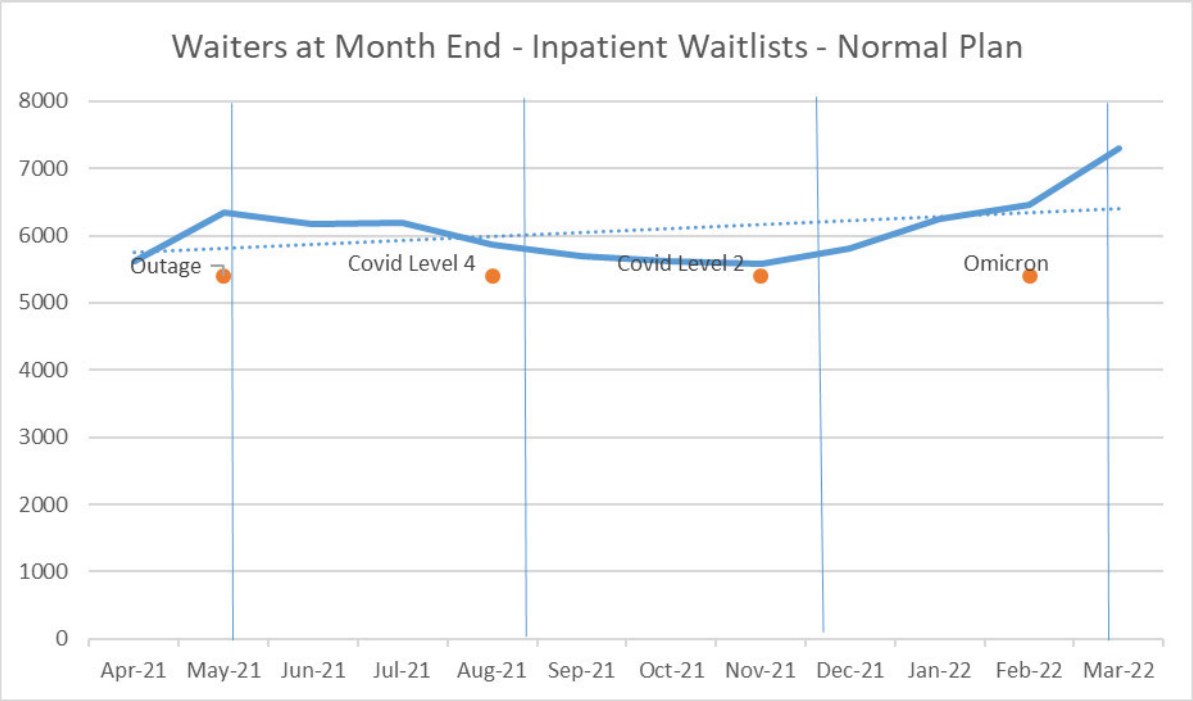
The graph below shows the outpatient wait list trend since prior to the cyber-attack through to the end of March. This reflects the impact of restrictions on delivery at different points.



The DHB currently has 5,786 patients waiting greater than 4 months for an FSA. This is an increase from February.

Inpatient Wait List

The graph below shows the trend for the inpatient wait list from the period prior to the cyber attack through to the end of March. Capacity for planned care has been significantly reduced over February, March and April in response to workforce vacancy in theatre and the Omicron management plan. This has resulted in an increase in the number of patients on an inpatient waitlist.



There are 2,756 patients waiting greater than 4 months for a procedure. This is an increase since February.

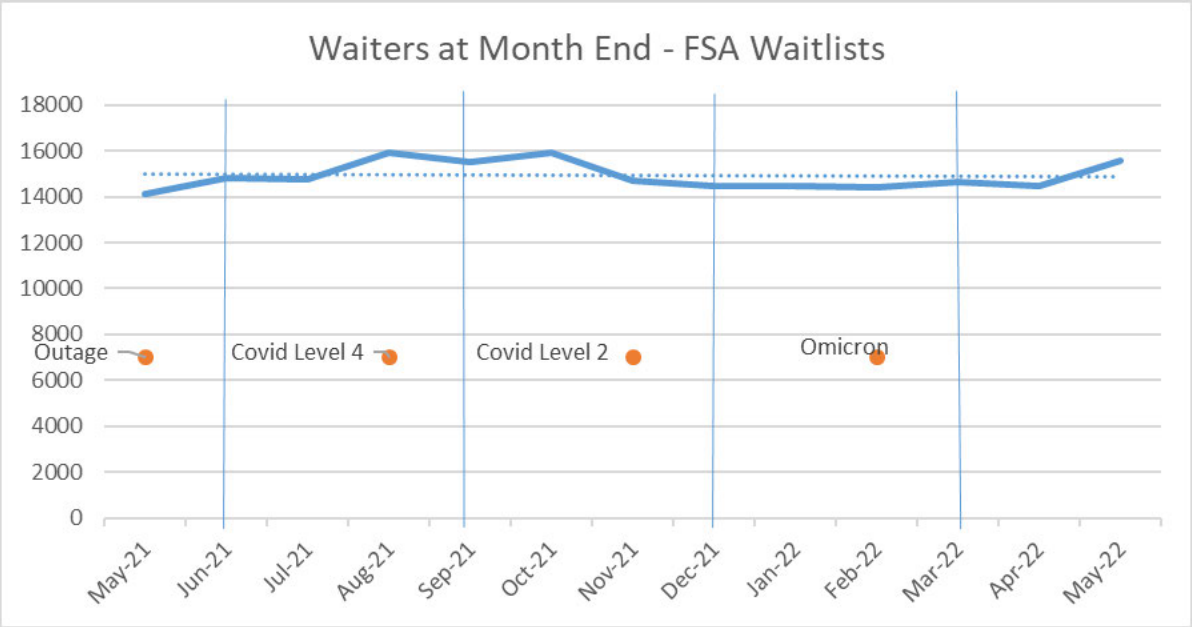
Report dated 22 June 2022:

Waiting List Indicators

Waiting times for time to assessment continue to increase as a result of reductions in delivery capacity which have been ongoing. Omicron management plans, workforce reduction and bed capacity constraints have resulted in reduced capacity for planned care delivery. Re-prioritisation of urgent and deferred patients means a cumulative growth in long waiters and variability in waitlist numbers month to month.
There has been a trend of improving ESPI 1 results with improved processes for the management of referrals and the cancellation of planned care activity releasing time for SMOs.

For the month of May, ESPI 2 non-compliance has reduced from 38.5% to 32.5% (a reduction of approximately 700 patients). Clinic capacity increased in May and a number of patients are undergoing GP review to address the longest waiting patients.
As at 10 June, there was no provisional result for ESPI 5 available. The level of non-compliance has continued to increase with ongoing reductions in theatre master schedule due to Omicron and nursing and anaesthetic technician workforce vacancies.
Planned Care taskforce recommendations with a focus on long waiting patients and addressing inequity are currently being implemented.

First Specialist Assessments
The total number of patients waiting for an FSA has continued to increase to 15,541. Outpatient delivery has been restricted to high suspicion of cancer, P1 (urgent) and time critical assessments only through April, but increased to 80-90% capacity in May. The graph below shows the outpatient wait list trend since prior to the cyber-attack through to the end of March. This reflects the impact of restrictions on delivery at different points.

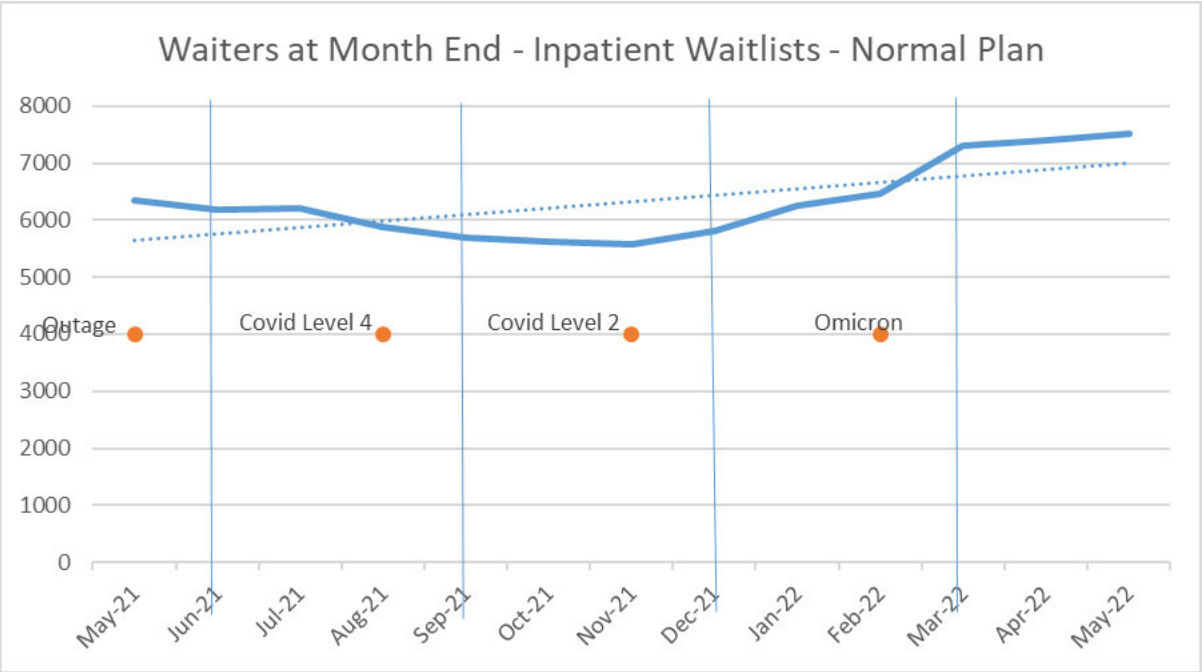


The DHB currently has 6,915 patients waiting greater than four months for an FSA. 93% of the total volume waiting greater than four months relate to the specialties identified in the following table.

Current Waitlist - 07 June 22			
	Total	Vol. >120days	% >120days
Outpatient FSA	**15541**	**6915**	**44%**
Top Specialties			
Echocardiography Department	1670	1668	100%
Orthopaedic Surgery	2249	1240	55%
Otorhinolaryngology (ENT)	1384	791	57%
Neurology	833	459	55%
General Surgery	1179	364	31%
Cardiology	711	351	49%
Respiratory Medicine	640	342	53%
Plastic Surgery Non Burns	1007	334	33%
Maxillofacial Surgery	348	202	58%
Ophthalmology	830	196	24%
Pain Management	311	161	52%
Gastroenterology	284	129	45%
Vascular Surgery	279	121	43%
Child Development Centre	191	103	
SubTotal	**11916**	**6461**	
% of Total	77%	93%	

Inpatient Wait List

The graph below shows the trend for the inpatient wait list from the period prior to the cyber-attack in May 2021 through to the end of May 2022. Capacity for planned care has been significantly reduced since January 2022 in response to the Omicron management plan, workforce vacancies in theatre and bed capacity constraints. The focus has remained on cancer and time critical care. This has resulted in an increase in the number of patients on an inpatient waitlist, increased wait times for patients, and patients experiencing multiple cancellations.



There are 3,033 patients waiting greater than four months for a procedure. 91% of this volume relates to the specialties identified in the table below.

Current Waitlist - 07 June 22			
	Total	Vol. >120days	% >120days
Inpatient (Normal)	**7870**	**3033**	**39%**
Top Specialties			
Ophthalmology	1209	522	43%
Orthopaedic Surgery	744	378	51%
Dental Surgery	606	320	53%
Plastic Surgery Non Burns	1151	315	27%
Gynaecology	619	298	48%
General Surgery	889	284	32%
Otorhinolaryngology (ENT)	518	279	54%
Cardiology	585	196	34%
Specialist Paed Oth Surg	334	168	50%
SubTotal	**6655**	**2760**	**41%**
% of Total	85%	91%	

Current Focus

In May the DHB received The Planned Care Taskforce – Immediate Recommendations, outlining focus areas for the next 90 days. The recommendations highlight the challenges within our currently constrained environment which is resulting in a reduction in capacity for planned care. There continues to be a fine balance between continuing with some planned care work for our urgent cases, and ensuring our hospital remains able to care for our sickest patients. These recommendations have been included in resurgence/resilience plans and are being progressed at specialty level.
Work has progressed on the priority areas as follows:

Existing Wait lists

We continue to schedule high priority cases and maintain this when there is a need to reduce planned care as a result of the current environment. In addition, we are working in partnership with the GP liaison team and implementing strategies for the management of the longest waiting cases and to mitigate risk in key areas through primary care review. In the first 'wave' 2,200 waiting referrals from our most at risk waitlists who have waited >9 months have been sent for GP review

The aim is to eliminate the >365 days within 90 days.

The waiting lists are under regular review to ensure we are managing high priority cases within clinically indicated timeframes and within 120 days. Good theatre planning is in place to ensure we maximize what is able to be completed within the available resources including extended sessions and additional acute sessions in the weekends to ensure acute patients are managed appropriately and reduce the impact on planned care.

We have increased the level of outsourcing to the private providers over the past four months to assist with managing the impact of the reduced levels of planned care over this period and to ensure those with the highest priorities and the longest waits have been able to be treated. Discussions are progressing with private providers with the view to increase the number of patients and the scope of procedures able to be offered treatment in a private environment.

The DHB is forecasting to complete 3087 outsourced surgical procedures in 2021/22. The plan for 22/23 is to increase this by a further 1000 procedures in the first six months of the year to assist with maintaining access over the winter months when capacity is expected to be constrained. This will then be reviewed and increased further if required and funding allows for the remainder of the year.

END