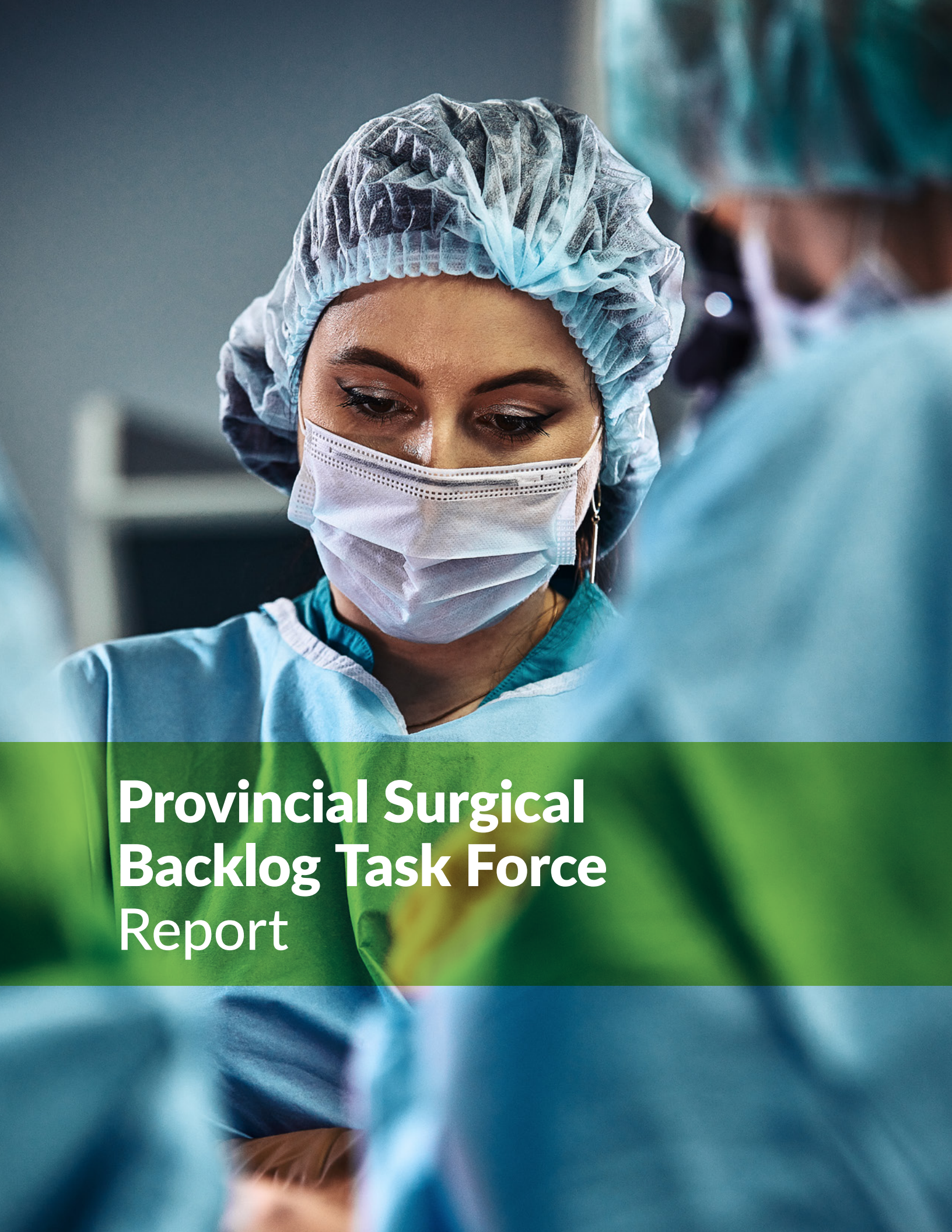


Provincial Surgical Backlog Task Force Report

Honourable Tom Osborne
Minister of Health and Community Services

June 12, 2023

Dear Minister:

We are pleased to present you with the report and recommendations of the Provincial Surgical Backlog Task Force.

This report reflects the deliberations of a volunteer group of dedicated government and health care professionals who have worked tirelessly over the last several months. Our discussions covered many aspects of the surgical backlog and waitlists and we are very grateful for the responses from our colleagues and stakeholders.

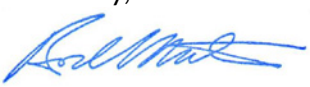
In addition to the Task Force members, we also had meaningful contributions from and conversations with many colleagues and stakeholders who are faced with the realities of our current health care situation. Recent unprecedented events, including Snowmageddon, COVID-19 and the cyber attack, have exacerbated the surgical backlog and wait times; however, Newfoundland and Labrador has faced these challenges long before these events.

In medicine, early diagnosis and treatment can reduce morbidity and mortality rates. The recommendations contained in this report can have an immediate impact on the surgical backlog and waitlist. Better access will result in better outcomes and reduced costs. As the Government of Newfoundland and Labrador works through these recommendations and begins implementation, the Task Force will continue to meet to discuss medium- and long-term recommendations to further address the surgical backlog and wait times.

The reasons behind the extensive surgical backlog are many and complex. This would suggest that there must be many complex faulty components to correct and resolve this situation. While there is some truth to that theory, to overcome any backlogs, the basic solution involves increasing the volume of completed per time interval in a way that recognizes the backlog and the number of new cases being added. To put it another way, we need to overcome the backlog to “catch up” and increase the overall throughput to meet the increasing demand. This is a very dynamic and fluid situation. Once achieved, a more steady state completion rate is required to maintain an acceptable and appropriate wait time for surgical treatment. In recent years, an unprecedented number of cancellations has escalated an already overburdened system. Fundamentally, we must address both our cancellation crisis and elevate our overall throughput if we are to successfully address the issue.

I am grateful for the hard work of my fellow Task Force members, including staff from the Department of Health and Community Services, and thank you for the opportunity to serve the people of this province.

Sincerely,



Dr. Rod Martin
Chair

Task Force Members

Rod Martin, Chair
Former Chief of Surgery, Eastern Health

Antionette Cabot
Transition Vice President/Chief Operating Officer, Labrador Grenfell Zone

Cherry Pike
Clinical Chief of Children and Women's Health, Eastern Health

Chris Cox
General Surgery, Newfoundland and Labrador Medical Association

Debbie Walsh
Vice President/Chief Operating Officer, Eastern Rural Zone

Dorothy Senior
Patient Advisor

Greg Browne
Chief of Staff, Eastern Health

Jeannine Herritt
Assistant Deputy Minister, Regional Services, Department of Health and Community Services

Lesley Johnston
Anesthesiology, Newfoundland and Labrador Medical Association

Mark Spurrell
Chief of Surgery, Central Health

Matthew Andrews
Urology, Newfoundland and Labrador Medical Association

Nicole Parsons
Regional Representative, Registered Nurses Union of Newfoundland and Labrador Board of Directors

Scott Mackenzie
Senior Medical Director, Western Zone

Will Moores
Orthopedic Surgery, Newfoundland and Labrador Medical Association

Yvette Coffey
President, Registered Nurses Union of Newfoundland and Labrador

Task Force Support

Annette Bridgeman
Department of Health and Community Services

Jonathan Carpenter
Newfoundland and Labrador Medical Association

Melissa Bath
Department of Health and Community Services

Paulette Morgan
Senior Director Hospital and Clinical Services, Western Zone

Tracy Parsons
Manager Analytics, Data and Information Services, Digital Health

Table of Contents

Executive Summary of Recommendations

The burden of surgical demand continues to grow especially in the division of urology, general surgery, ophthalmology, and orthopedics. The number of waitlist cases is growing based on cases being added far exceeding capacity. This, coupled with cancellations has resulted in a system which is failing the people of our province. Much of our reduced capacity to complete cases and cancellations are related to a severe nursing (and associated allied health and support staff) shortage.

Recent estimates suggest 750 nursing positions are currently vacant and there are vacancies across other positions as well. Measures to correct this are required immediately. Inadequate staffing of Long Term Care homes has resulted in 20 per cent of acute care beds being utilized for ALC patients. Staffing shortages at all levels need to be addressed.

The long-term solution will likely require expansion of facilities. The immediate and most urgent priority must be the filling of current vacancies to first optimize the existing facilities' capacity. Recruitment, retention and return of retirees are the three R's to be considered.

Myself and the Task Force members remain eager and available to assist in any way required.

Introduction

The Provincial Surgical Backlog Task Force (Task Force) was announced on June 16, 2022 in an effort to address the surgical backlog worsened by multiple health system shutdowns in Newfoundland and Labrador resulting from the state of emergency experienced with the January 2020 blizzard, followed by the COVID-19 pandemic, and the cyber attack on health care IT systems.

The Task Force brought together government officials and health care professionals to address the surgical backlog (elective/non-urgent and inpatient/outpatient) and associated surgical waitlists in Newfoundland and Labrador. The goal is to achieve or exceed wait time targets in line with national benchmarks, where they exist.

The Task Force was asked to consider and make recommendations to the Minister of Health and Community Services regarding:

a. Short- and long-term solutions to address the surgical backlog in the province; and,
b. New and innovative solutions to manage surgical wait times across the province.

Mandate

The mandate of the Task Force is to:

a. Develop a data informed understanding of the magnitude of the surgical backlog.
b. Provide information and advice to the Minister of Health and Community Services on how to address and actively manage the surgical backlog in the short- and long-term.
c. Make recommendations to the Minister of Health and Community Services on how to effectively target one-time funding from the Government of Canada to address surgical backlogs.
d. Explore options that would contribute to sustainable active surgical waitlist management.
e. Explore the development of a centralized intake system for surgeries.
f. Increase transparency, accountability and efficient management of surgical waitlists.
g. Upon the request of the Minister of Health and Community Services, review and provide timely advice on issues that may be directed to the Task Force.

Deliverables

The Task Force is required to deliver short-term and long-term recommendations to the Minister of Health and Community Services.

Health Care Environment

Newfoundland and Labrador has a unique and particularly challenged health care system relative to other provincial jurisdictions. This has existed long before the COVID-19 pandemic and other recent health system shutdowns. An outward migration of our young adults and a disproportionate escalation of our elderly population has strapped an already overburdened system. Quality of Care NL has identified Newfoundland and Labrador as one of the provinces with the greatest burden of chronic disease. The vast geography for our relatively small population poses further difficulty.

In medicine, early diagnosis and treatment has a strong correlation to decreased morbidity and mortality rates. Easier access to appropriate health care frequently results in less invasive and lengthy procedures, shorter recovery times and better surgical outcomes. Delayed access to surgical procedures has not only resulted in reduced patient satisfaction, but it also creates an escalatory cost to the health care system. This needs to be reversed.

Surgical Patient Pathway

Surgical throughput usually occurs in three phases:

1. Pre-op evaluation;
2. Surgery; and,
3. Post-op care/patient disposition.

All three phases have areas that need to function effectively and in harmony to ensure a smooth transition through the system. A problem or delay in any area can derail the overall throughput and will often negatively affect the other phases.

Surgery is a multidisciplinary team effort and requires a symphony of people and resources to ensure its success. Currently, system deficiencies are greatly restricting our teams' efforts and patients are bearing the detrimental consequences. If the current level of resources is maintained, the backlog will continue to grow.

A two-pronged approach is required to address the current backlog and to prevent any reoccurrences:

1. Proportionate increases in resources to the most challenged areas to address the existing backlog. Frequent audits and review will allow a more steady state.
2. Permanently increase resources over current state to keep up with the demand and prevent any future backlogs from occurring.

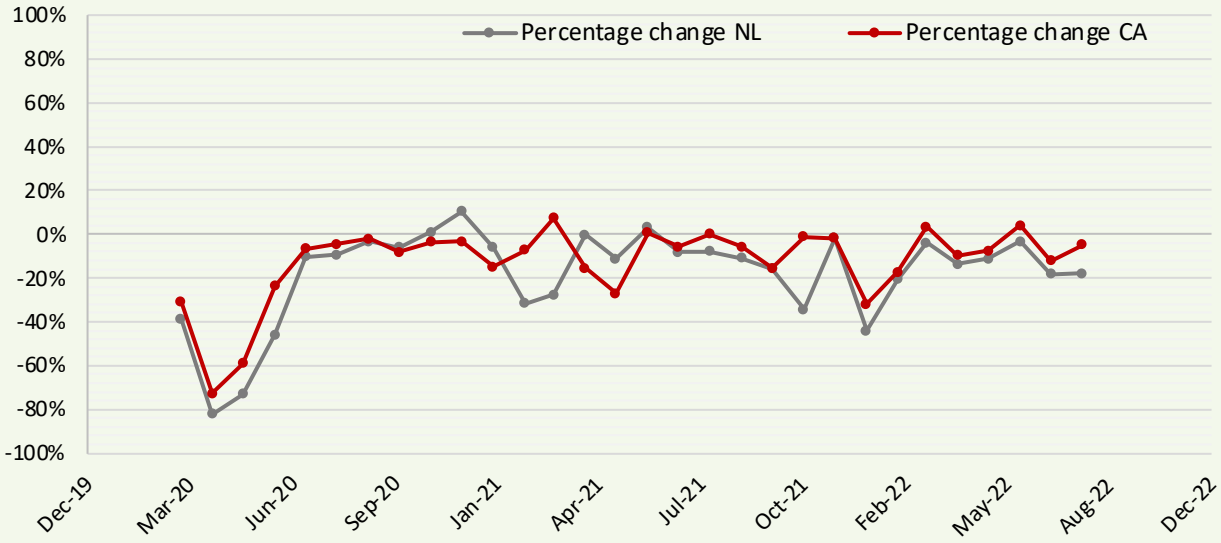
Current Surgical Backlog

The following graphs illustrate the backlogs and issues facing the surgical patients of our province. During the preparation of these graphs and collecting data, it has become apparent that more extensive and detailed information needs to be collected in a way that allows for it to be reportable provincially. This will serve as the foundation to further address ongoing and ever-changing demands.

Change in Surgical Volume Over Time

This first section shows data comparing surgical volume compared to that prior to COVID. A report by the Canadian Institute for Health Information (CIHI) in March 2023 showed that nationally there has been a decrease in surgeries performed in the years since the pandemic when compared to 2019.

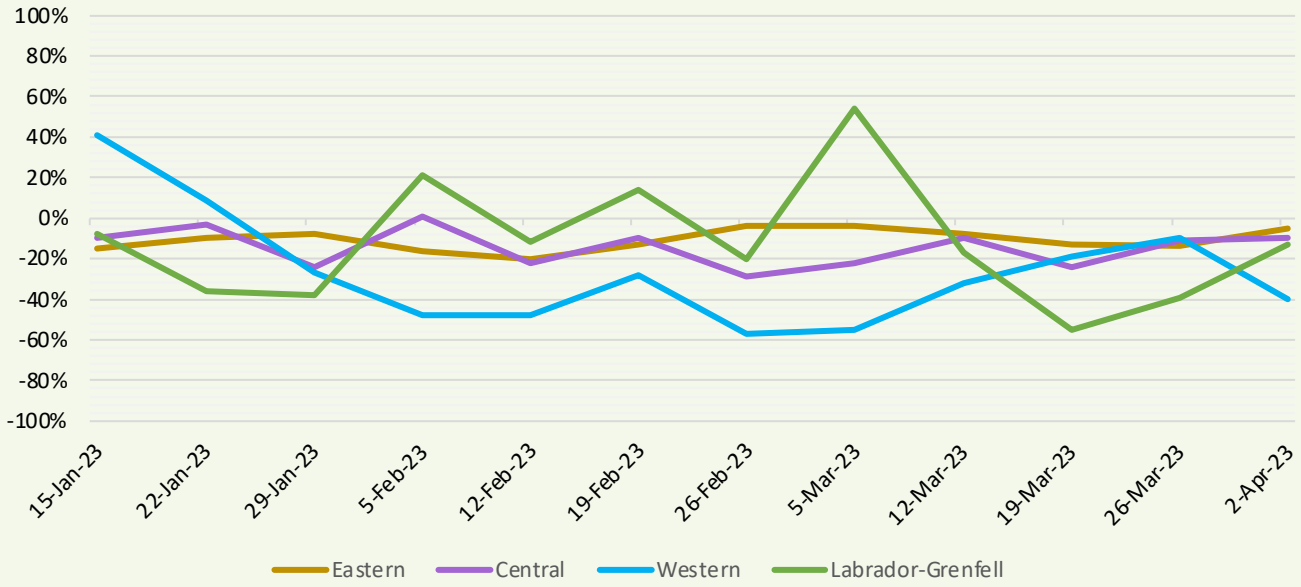
Figure 1. Percentage change in Surgical Volume, NL and Canada[1,2]



Percentage change for surgical volumes is calculated using 2019 as a baseline comparator. Analysis is based on Provincial Discharge Abstract Data submitted to CIHI as of December 31, 2022, and compares the volume of surgical procedures since COVID-19 with the volume of surgical procedures completed in 2019. Values below zero indicate less procedures compared to 2019. This graph illustrates that Newfoundland and Labrador usually had a greater percentage of cases not being completed than the national average.

1. Data for surgical volumes for March 2020-March 2022 is closed. Data for April 2022-August 2022 is provisional and subject to change
2. Source: Discharge Abstract Database, 2018/19-2022/23. Canadian Institute for Health Information

Figure 2. Percentage change in surgical volume by RHA[3], January 2023-April 2023



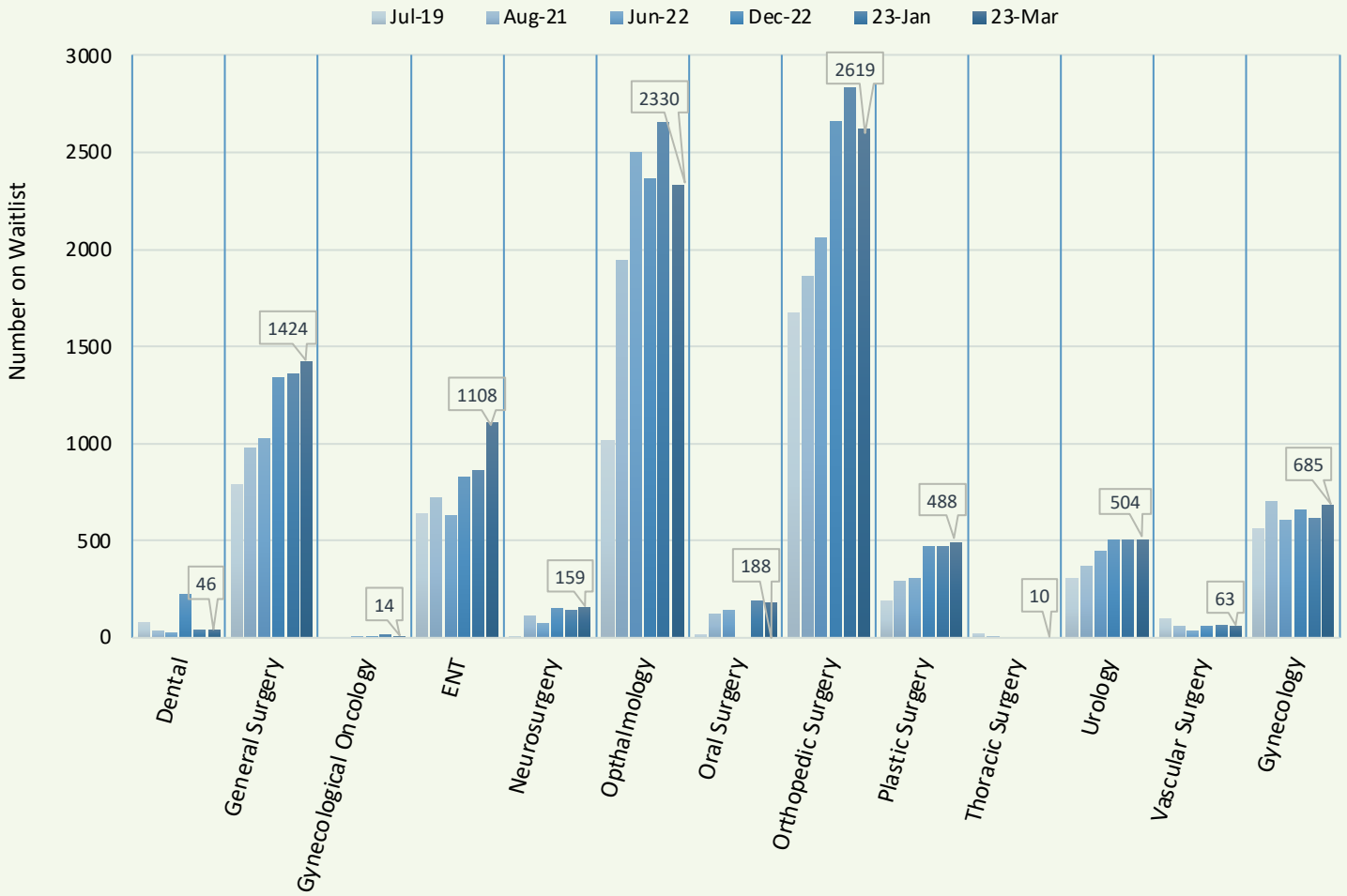
Similar to the previous figure, this graph also shows the percentage change using 2019 as the baseline comparison, however this figure highlights surgical volumes within each health zone for 2023. Analysis is based on data reported by the zones as of April 2023. Values below zero indicate less procedures compared to 2019. This graph illustrates that all regions, to a varying degree, remain in a deficit to surgical case completion.

3. Source: Data reported from RHAs/Zones from January 2023-April 2023 as part of the Resumption of Services Reporting Surgical Wait Times and Resumption of Services

Waitlist Volume Over Time by RHA/Zone

This next section illustrates waitlist volume over time, by surgical disciplines for each regional health zone within Newfoundland and Labrador Health Services. The data availability from each RHA/zone differs. Data is available for Eastern Urban from all disciplines (Figure 3), but nothing was reported for Eastern Rural (as this data was not available at the time of report writing). Figure 4, 5 and 6 show the data reported from Central, Western and Labrador-Grenfell, respectively. Data from Central Health is limited and includes only total joint replacements and cataract procedures from James Paton Memorial Hospital (Figure 4).

Figure 3. Wait List Volume over time by Discipline, Eastern Urban[4], 2019-2023



4. Source: Data reported from Eastern Health

Figure 4. Wait List Volume over time by Discipline, Central[5], 2022-2023

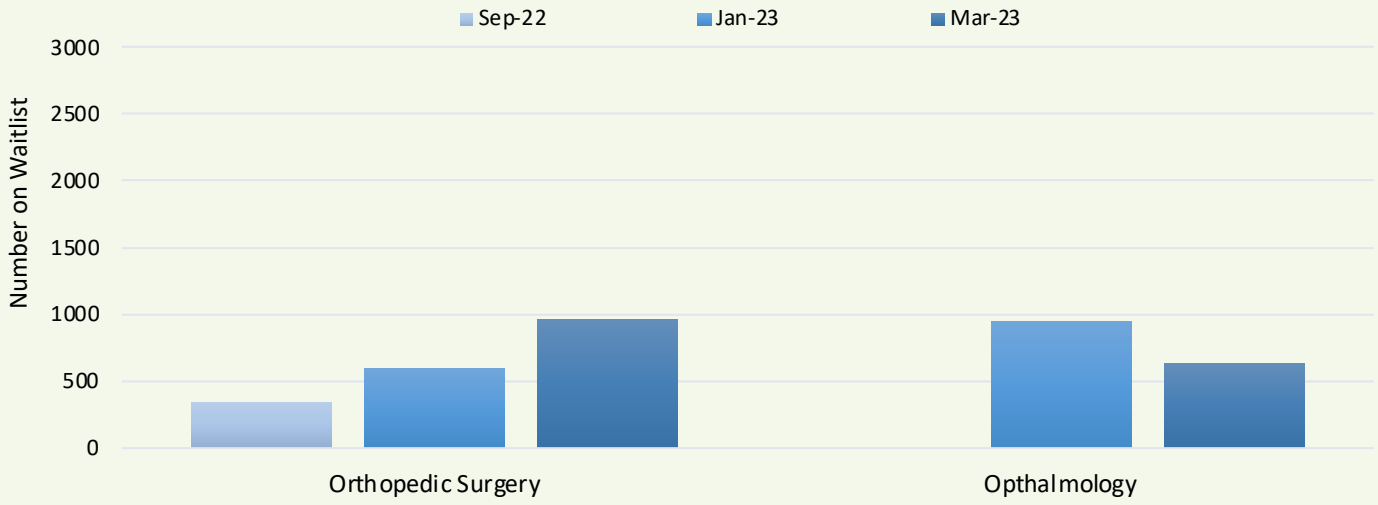
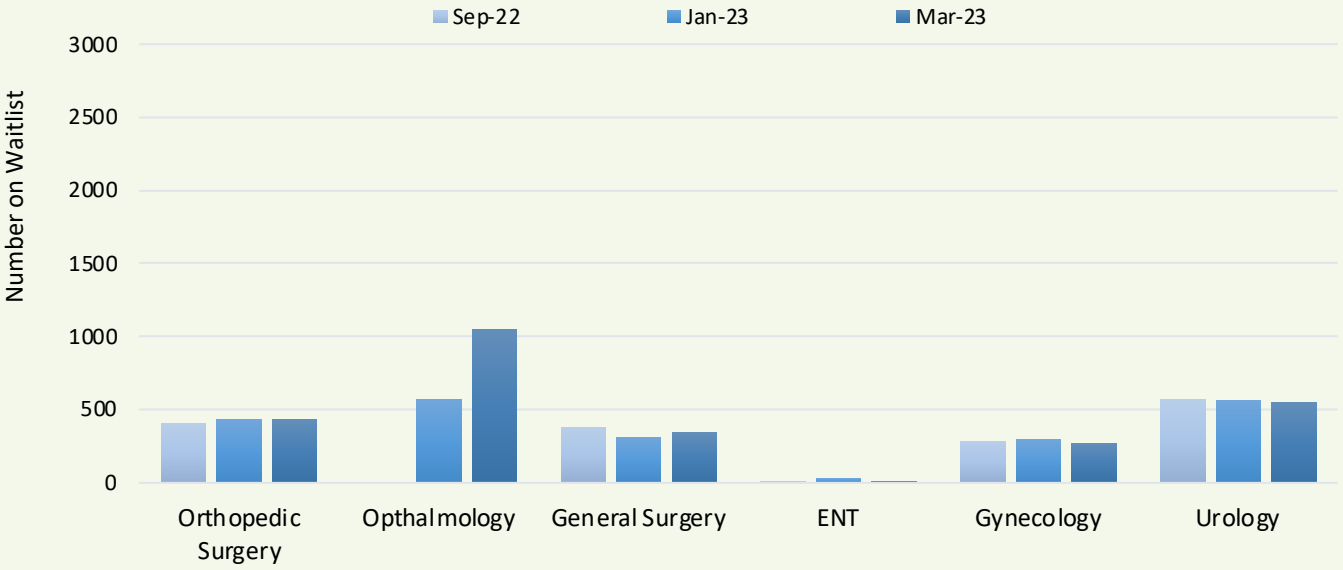
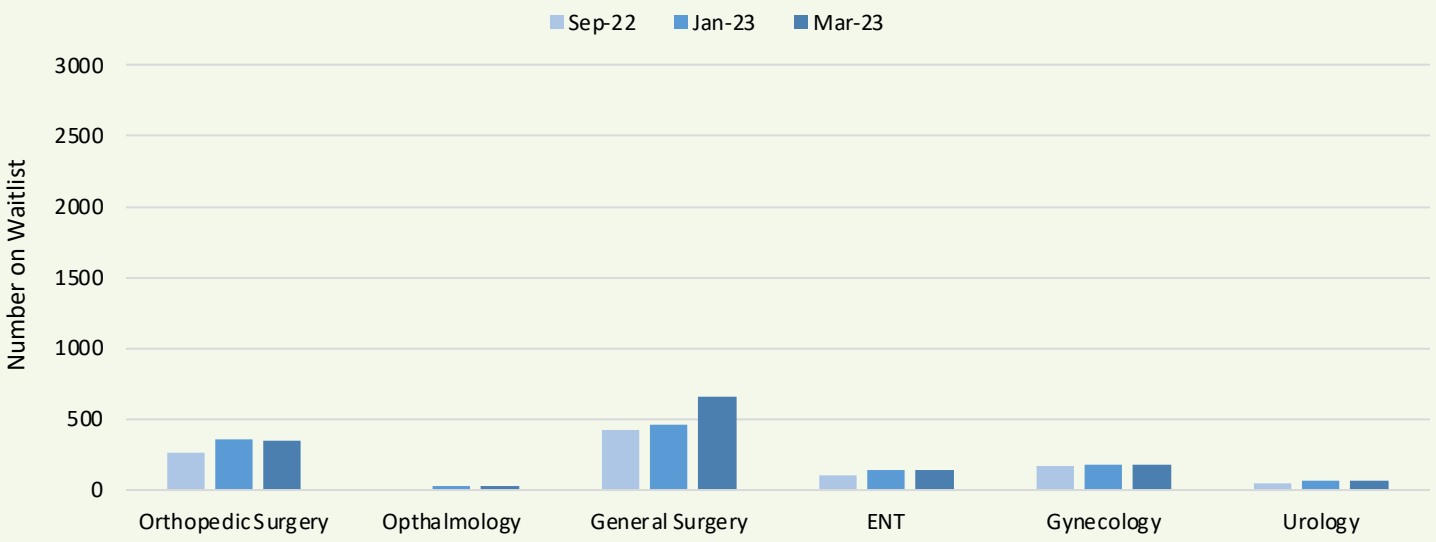


Figure 5. Wait List Volume over time by Discipline, Western[6], 2022-2023



5. Source: Data reported from Central
6. Source: Data reported from Western

Figure 6. Wait List Volume over time by Discipline, Labrador-Grenfell[7], 2022-2023



Surgical Cancellations

Surgical cancellations have been shown to be increasing over time in Eastern (Figure 7). Reasons for surgical cancellations are varied and include:

- Equipment/Infrastructure issues: booking errors, test results not yet available, medical devices not available, or issues with temperature or humidity, etc.
- Patient Issues: patient illness or medically unfit, patient did not show or did not have transportation, patient did not comply, etc.
- HR Staff Issues/Bed: bed unavailable, surgeon unavailable, nursing unavailable, etc.
- Schedule Change or Delays: schedule delays or changes.
- Other: weather, activation of emergency codes, pandemic, etc.

Over time, the coding and categorization of the reasons for surgical cancellation has been modified to more accurately capture the reasons for the cancellations. Eastern has provided data on cancellations over time, by category and by discipline. A trend towards increases in cancellations due to staffing and bed unavailability has been observed (Figure 7). The surgical discipline with the highest volume of cancellations in Eastern is orthopedics and this has been shown to have increased over time (Figure 8). Western has provided the most recent year of reasons for cancellations, and this is shown in Figure 9. See Appendix A for more details on the broad categories and the reasons that correspond to each of the broad categories. It is important to note that approximately one-third of cancellations are due to schedule delays or changes, however these include changes to accommodate urgent and emergent patients, due to cases being prolonged, or rescheduling and not due to physician delays.

7. Source: Data reported from Labrador-Grenfell

Figure 7. Surgical Cancellations over time, Eastern[8]

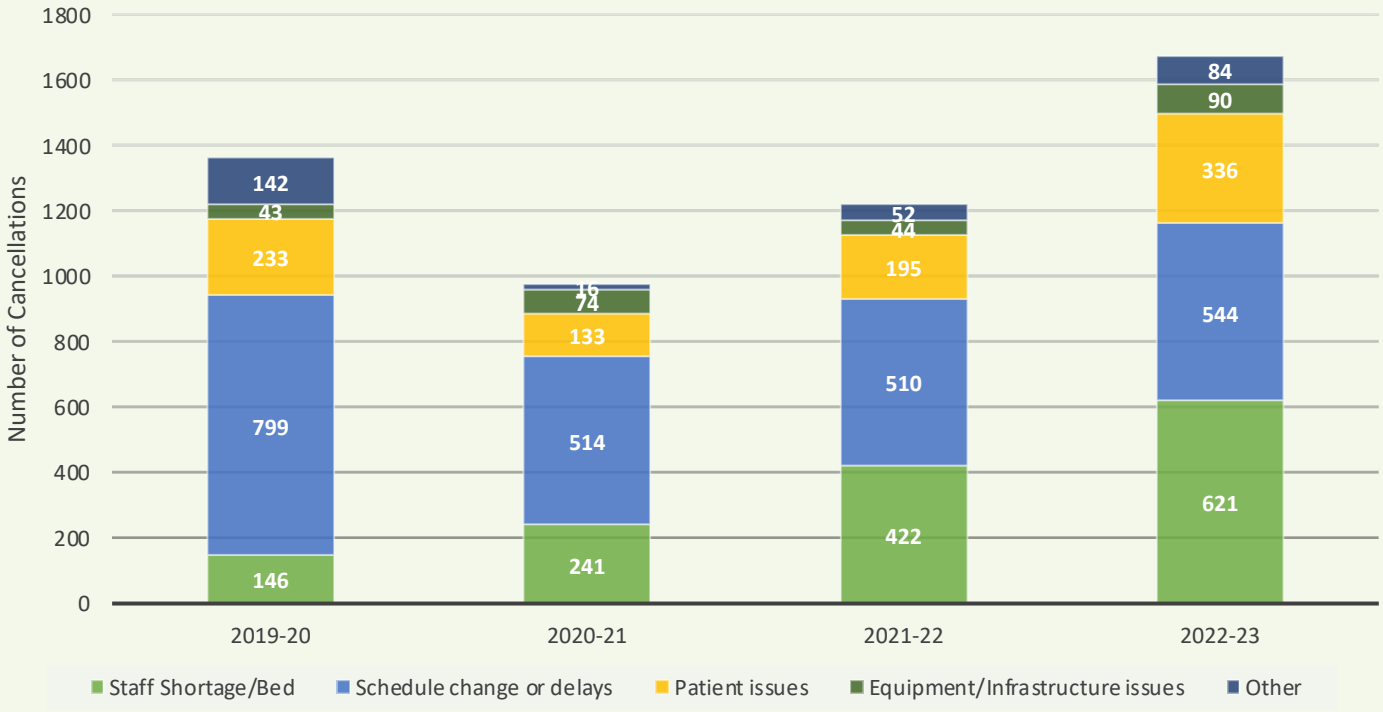
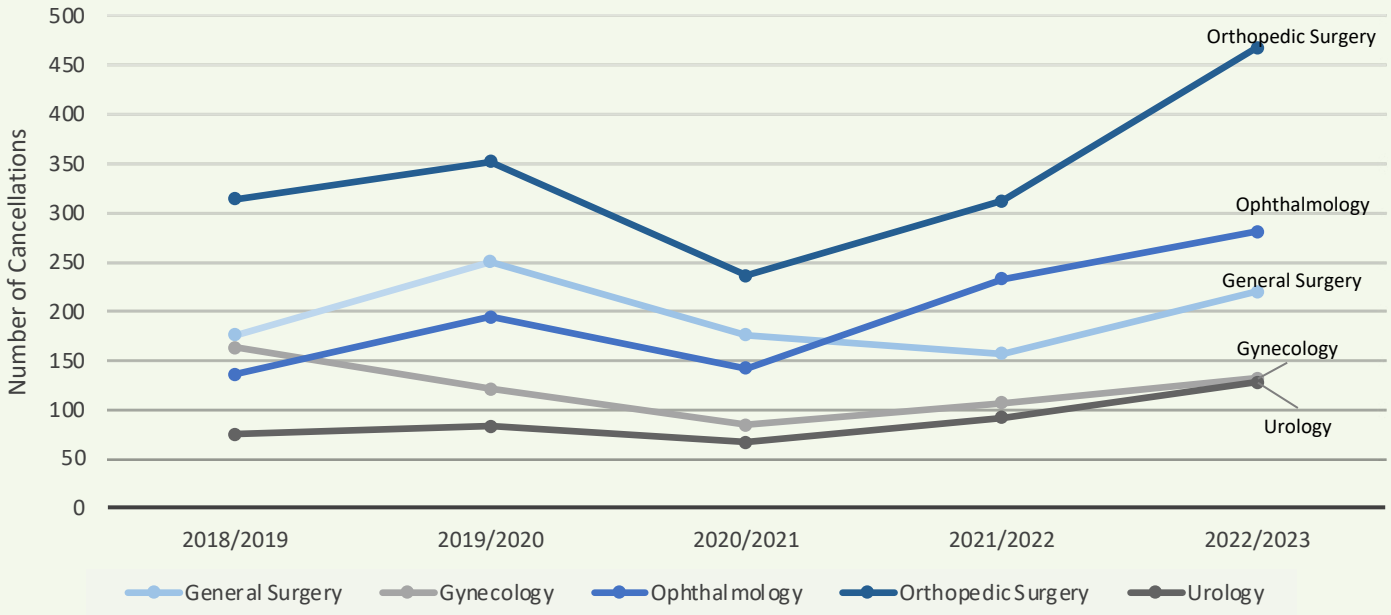
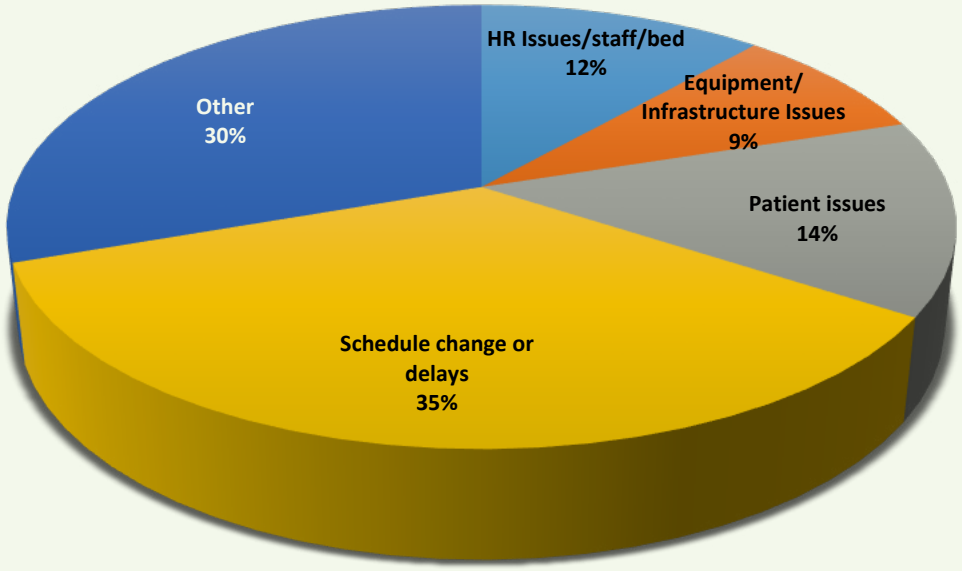


Figure 8. Cancellations over time (Top 5 in cancellation volume), Eastern[8,9]



8. Source: Data reported from Eastern
9. Figure 8 included only the top 5 highest volume of cancellations among surgical disciplines

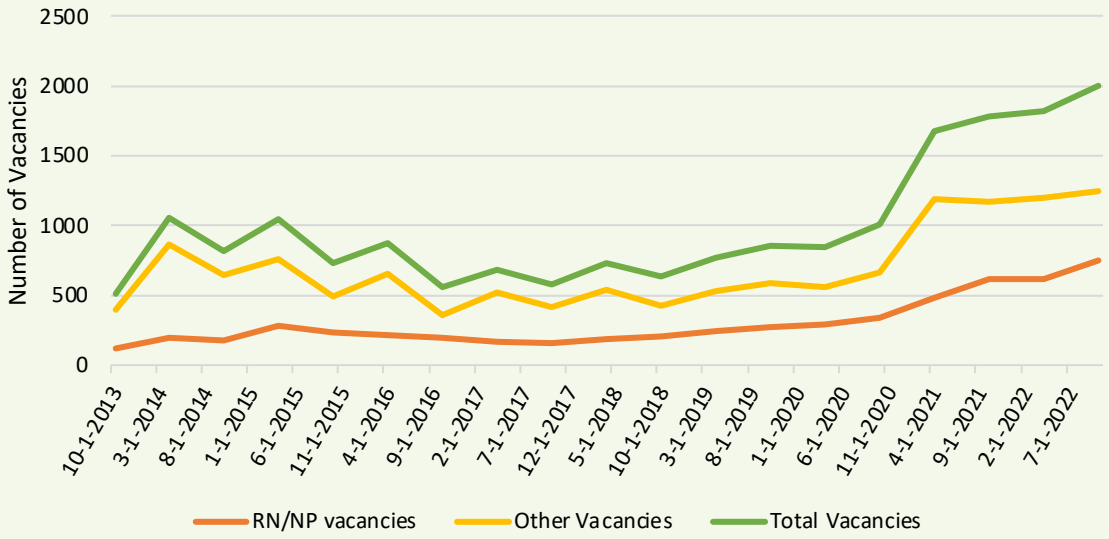
Figure 9. Surgical Cancellations, Western[10], 2022/23



Vacancies

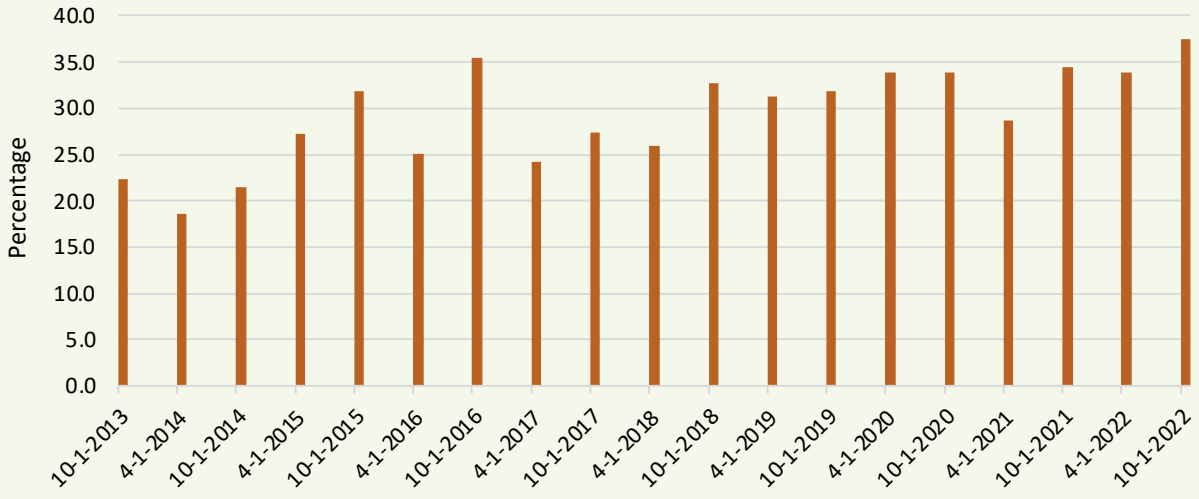
Health human resources challenges are well-known in the province and have been a topic of discussion across many areas both within government and Newfoundland and Labrador Health Services. The following figures show the staff vacancies over time and the proportion of vacancies that are specific to nursing.

Figure 10. Staff Vacancies over time among Health Zones[11]



10. Data provided by Western
11. Data provided by Department of Health and Community Services

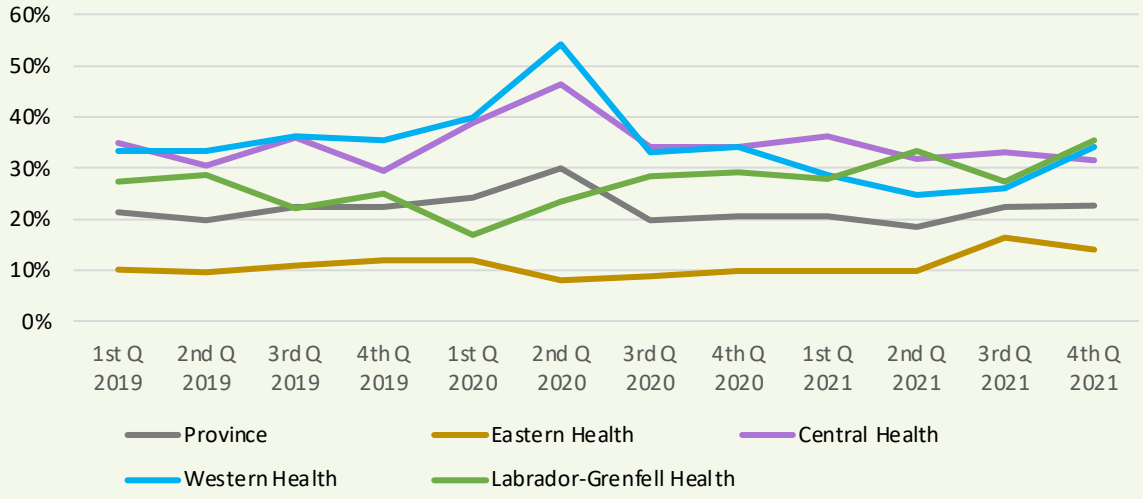
Figure 11. Proportion of vacancies that are due to RN/NPs[11]



Alternate Level of Care (ALC)

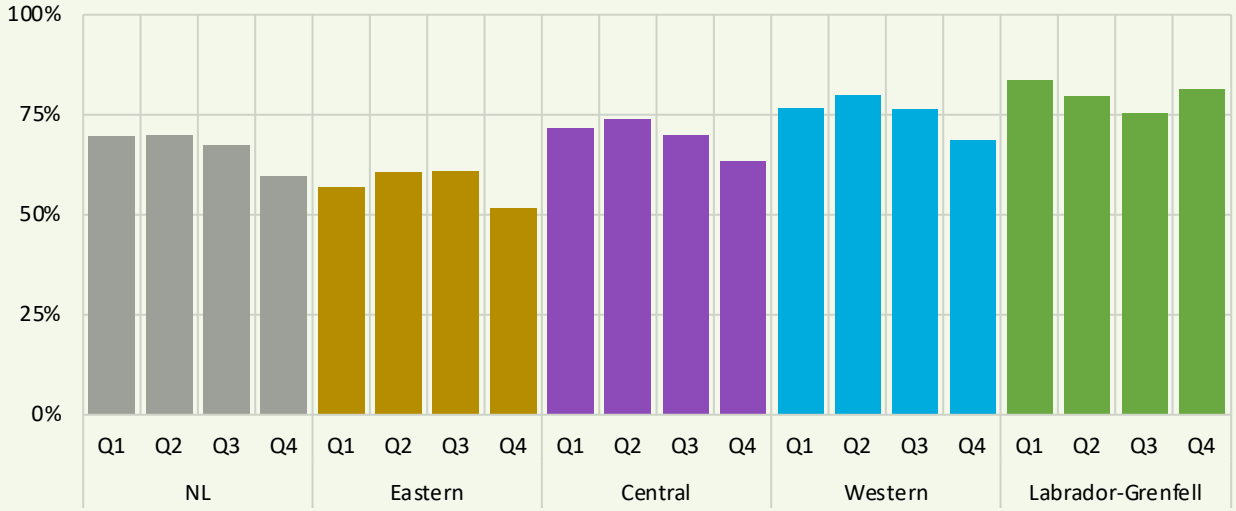
Alternate level of care has been a known issue in the health system over the last number of years. Approximately 70 per cent of ALC days are due to patients waiting for long term care, personal care home or home support (data provided by RHAs/Zones). The following charts show the proportion of ALC days and length of stay due to ALC. Around 20 per cent of overall hospital days are ALC in the province as a whole, with some variations across the RHAs/Zones as shown in Figure 12.

Figure 12. Percent of hospital days that are ALC[12]



12. Data provided by RHAs/Zones

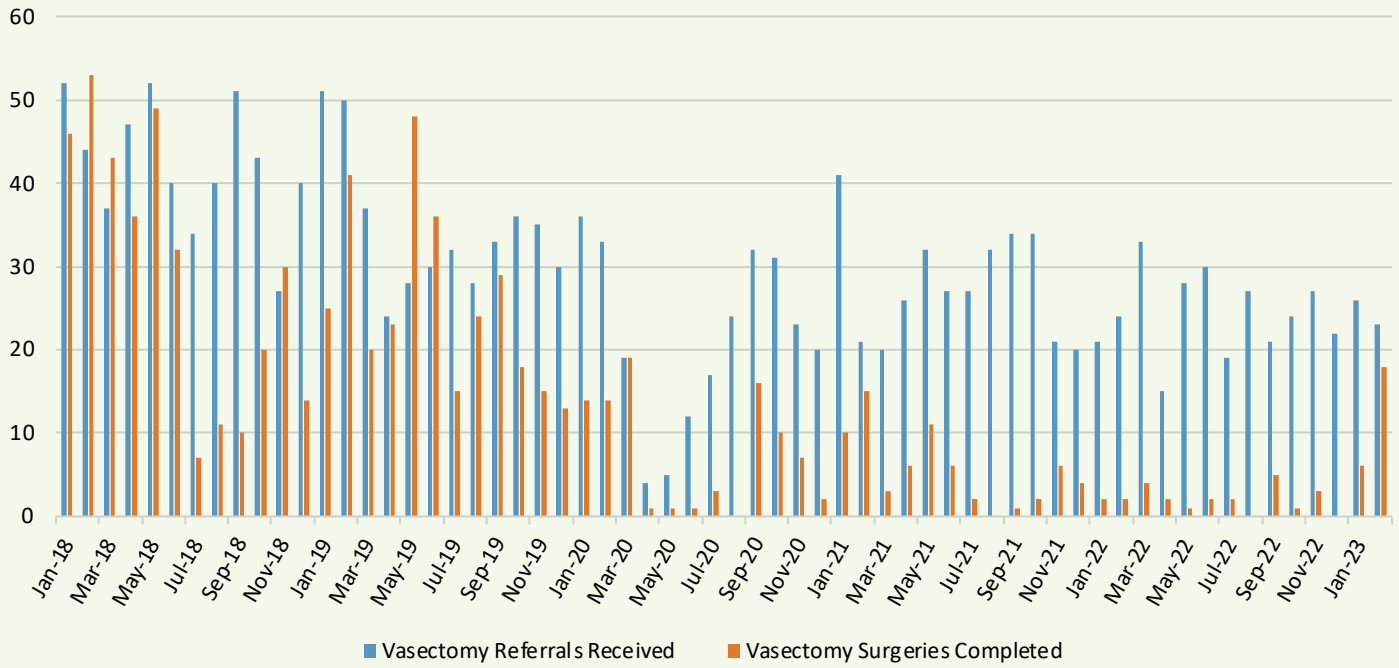
Figure 13. Proportion of LOS due to ALC, 2022[12]



Among the hospitalizations involving ALC in 2022, more than half of the total length of stay (LOS) was due to the wait for health care supports/services other than the intensity of services provided in the acute care setting. The least proportion due to ALC was seen in Eastern and the highest proportion was observed in Western and Labrador-Grenfell (Figure 13).

Urology and Orthopedic Specific Data

Figure 14. Vasectomy Referrals Received and Vasectomy Surgeries Completed by Month, Eastern Health, Jan 2018 - February 2023[13]



This figure displays the number of new vasectomy referrals received on a monthly basis, compared to the number of vasectomy surgeries completed each month. The number of backlogged vasectomy referrals has now surpassed 970 patients. This data is shown to highlight that in addition to overall surgery issues, an increase in ambulatory surgical resources is also needed to address this backlog, in order to keep pace with the high volume of vasectomy referrals received by Urology.

13. Data provided by Clinical Efficiency, Eastern

Figure 15. Total Joint Replacement Surgery (Demand - Capacity = Waitlist) by Fiscal Quarter, Eastern Health[13]

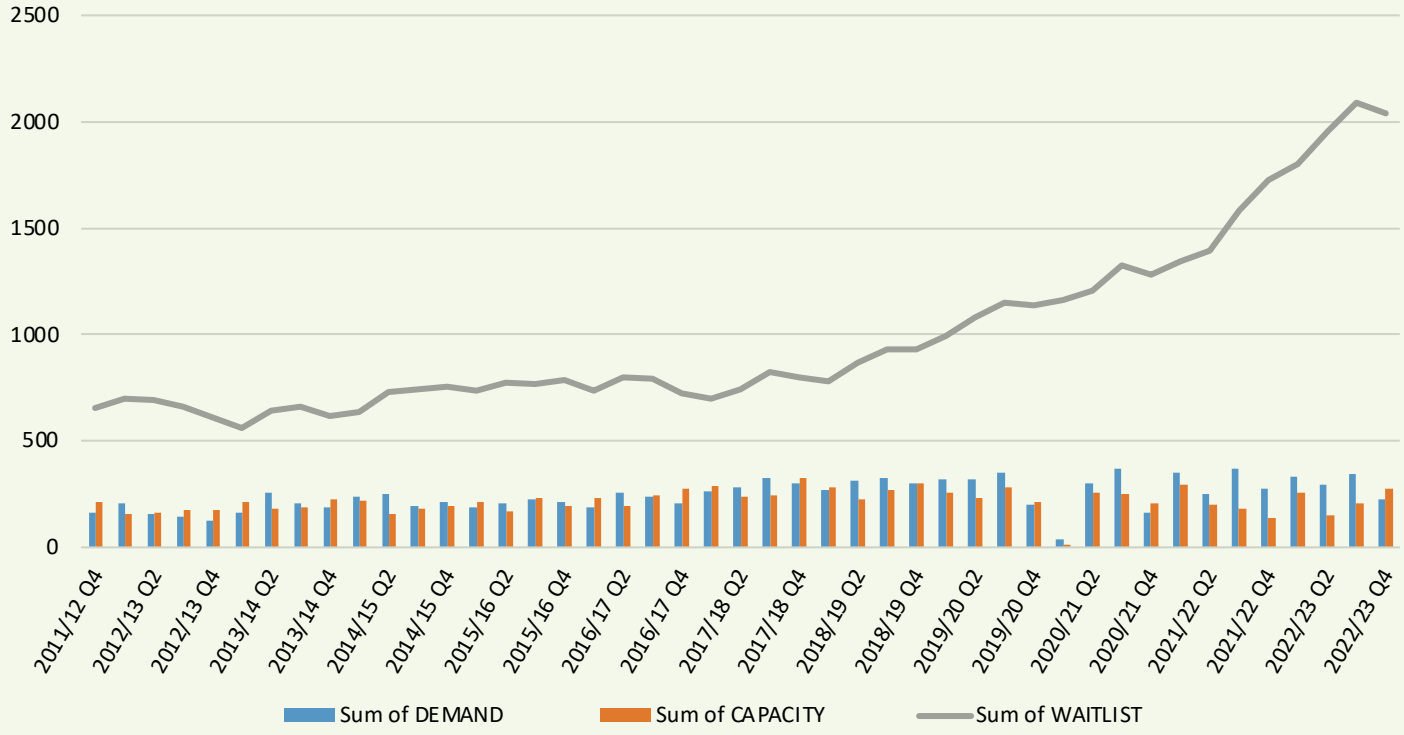


Figure 15 is an example of how waitlist reporting can allow for the visualization of trends and provide the opportunity for the appropriate monitoring and evaluation needed for waitlist management. With a more robust waitlist management system, or at the very least better data availability, this would be possible for all surgical disciplines in the province. This then, would allow for a fuller picture of the true volume of people waiting for surgery in the entire province.

Task Force Recommendations

Measuring and Monitoring

1. Develop a standardized provincial methodology for data collection of booked surgical cases and prioritize according to national and/or established benchmarks. Not all surgical disciplines have benchmarks. These need to be obtained where possible, from national associations and developed where they are absent.

2. Standardize waitlist patients' time zero. This should include an OR booking package, to be completed when the patient is ready, willing and able. This will enable more accurate data collection and better identify areas of need.

3. Develop a centralized surgical waitlist, encompassing all regions of the province, to optimize utilization of all facilities.

4. Develop a centralized list of operating rooms across the province and match surgical availability with facility underutilization.

5. Develop a provincial centralized intake system for surgical specialties for standardized, high-volume surgeries. Need a system that allows for the capacity to record and analyze the metrics associated with trends, processes and performance. There are limitations with the current systems and some waitlists exist in physician offices only and the process for ensuring the validity of the waitlist is not managed or monitored. This does not allow for appropriate OR planning or the ability to look at trends in the data.

6. Develop standardized provincial nomenclature to track surgical cancellations. Collect and review this data quarterly.

7. Implement a standardized Expected Length of Stay benchmark within all regional health zones for select procedures.

Operational Improvements

8. Maximize capacity in personal care and long term care homes for alternate level-care and non-surgical patients who are occupying surgical beds in acute care hospitals.

9. Develop a provincial patient rounding policy that tracks expected patient disposition to mitigate late cancellations and bed availability issues. The policy should include the requirement for all departments to have:
   - Rounds begin at 8:00 a.m.
   - Rounds be completed by 9:00 a.m.
   - Rounds be logged by 10:00 a.m.
   - Discharge plans tabled no later than 8:00 p.m. the day before the intended discharge.

10. Expand home care IV capacity to include selective self-care and wound care cases and nurse-assisted programs province-wide. Ensure assistance is available for patients who are otherwise able to be discharged on a weekend.

11. Require regional health zones to have post-op resources and community health nursing resources available on weekends to reduce patient length of stay (e.g., physiotherapy for joint replacements and musculoskeletal trauma).

12. Increase transportation options for patients who are otherwise ready for discharge. This should include weekend discharges.

13. Explore the use of "step down" or transition facilities for patients who do not need acute care services but still require assistance (e.g., IV treatment or physiotherapy). These facilities can also be used to house patients who are medically ready to be discharged from the hospital but have needs that do not allow them to return home yet (e.g., patients with mobility issues). Consideration should be given to using the following as potential sites:
   - Offsite facilities, such as a hotel;
   - Creation of a dedicated hostel;
   - Vacant space at the Janeway;
   - Former Women's Health space (Health Sciences Centre).

14. Ensure that health authority policies and practices enable surgical staff to have full autonomy over its resources. This will ensure capacity issues in other areas of health care do not impede the surgical program. Other disciplines should be discouraged from utilizing surgical resources. Off-service patients greatly impair the throughput resulting in cancellations.

15. Develop a Pre-Admission Clinic (PAC) policy whereby:

    a. PAC appointments occur three to five days before a scheduled surgery, where possible. This will allow for further perioperative investigation and/or treatment to prevent surgical cancellations.

    b. Under certain circumstances, the booking surgeon can select when a patient's PAC appointment is scheduled. Healthy patients undergoing minor procedures may be suitable to be seen the day before surgery, whereas others may be better seen several days pre-op.

    c. In situations where there is a significant delay between booking and performing a procedure, the booking surgeon or designate completes a phone review with the patient to ensure there have been no notable changes in their medical status.

16. Explore the use of virtual stethoscopes and virtual PAC assessments to support pre-admission assessments close to home. When necessary, a second in-person PAC appointment may still be required closer to the day of surgery.

17. Develop a policy whereby in-person PAC assessments can occur at a facility near the patient's home when the patient's surgery is being performed at another facility not within a reasonable distance of their home.

18. Explore and implement the use of ambulatory surgery centres – facilities focused on providing same-day surgical care.

19. Extend OR days to complete backlogged cases – once staffing and bed constraints have been addressed. Number of cases to be completed over a given timeline will vary by division and regional zone.

20. Develop a new policy for joint replacements where the first surgery is done on an outpatient basis and the next three are done as inpatients.

21. Establish anesthesia block rooms for procedures, as appropriate, to maximize OR rooms. Much of the anesthesia preparation and intervention can be completed outside of the operating room. This will require a compensation package for physicians. This will maximize operating room case completion and throughput.

22. Subsidize Obstructive Sleep Apnea assessments and, when necessary, Continuous Positive Airway Pressure (CPAP) equipment. CPAP use should be considered equivalent to other sponsored medical care such as medical implants and medications.

23. Explore the use of personal care homes to accommodate short stay patients. This will require input from many levels of patient caregivers (e.g., RN, LPN, NP, etc.).

24. Develop a program that involves willing family members in pre-operative assessments (PAC and Total Joint Assessment Clinics) so that they can better assist family members in post-operative care.

25. Develop standardized medical directives for common routine elective procedures and authorize senior nursing staff to authorize progression and discharge on the physician's behalf.

26. Provide funding to Eastern Urban Zone to maximize surgical capacity at the Janeway by opening the sixth, unused, operating room. Expand staff to allow any available Janeway beds to be utilized.

27. Review and evaluate inpatient resource allocations to ensure resources meet current demand. This will ensure insufficient inpatient resources do not negatively affect surgical beds. ALC patients should not occupy acute care beds.

28. Form a LEAN team, consisting of individuals with Lean expertise from NL Health Services, mandated to facilitate Lean improvement initiatives in priority areas to realize OR efficiencies.

Maximizing the Workforce - Recruitment and Retention

29. Current and future surgeons' recruitment and retention may be significantly impacted by COVID-19 and recent case completion data. There are few specialty vacancies, however, the physician group is concerned that without a reasonable cancellation agreement with government, significant deficiencies are likely to occur. A protective, proactive discussion with MCP and government is required to ensure FFS specialists remain in the province. There have been an unacceptable number of cancellations in recent months without any financial compensation. This poses a significant threat to the long-term stability of the entire surgical discipline.

30. Establish and maintain a list of nursing and related allied health professionals who are interested in overtime and/or additional shifts.

31. The Task Force would like an update from government and RNUNL regarding their strategy to increase number of staff. Much of the current situation is related to nursing and related provider human resource shortfalls.

32. Explore the possibility of increasing final year nursing students' placement on surgical wards with appropriate and graduated levels of care. This will lessen the extreme burden of our nursing shortage and provide additional experience and income for senior nursing students. Explore compensation for nursing students' placement on surgical wards.

Acronyms

ALC	Alternate Level of Care
CPAP	Continuous Positive Airway Pressure
FFS	Fee for Service
GNL	Government of Newfoundland and Labrador
IV	Intravenous
LPN	Licensed Practical Nurse
NLMA	Newfoundland and Labrador Medical Association
NP	Nurse Practitioner
RNUNL	Registered Nurses Union of Newfoundland and Labrador
RN	Registered Nurse
OR	Operating Room
PAC	Pre-Admission Clinic
RHA	Regional Health Authority

Appendix A:
Categorization for Surgical Cancellations

Equipment/Infrastructure Issues

SURGERY ALREADY COMPLETED..... 65

INFRASTRUCTURE ISSUES.....31

DIAGNOSTIC TEST INCOMPLETE 28

BOOKING ERROR.....27

MECHANICAL FAILURE 25

EQUIP/SUPPLIES/DEVICES NOT AVAILABLE.....24

DIAGNOSTIC TEST RESULTS NOT AVAILABLE.....12

HUMIDITY HIGH.....10

NOTIFICATION ERROR 7

SURGEON NOT IN PRACTICE.....5

MEDICAL IMAGING INCOMPLETE.....3

NO DISCHARGE PLAN 3

SCHEDULE DELAY-EQUIPMENT CONCERNS 3

HUMIDITY LOW.....2

INCORRECT PREOPERATIVE INSTRUCTIONS 2

MEDICAL DEVICE(S) NOT AVAILABLE 2

MEDICATIONS NOT AVAILABLE.....1

TEMPERATURE TOO HIGH.....1

HR Staff Issues/Bed

INPATIENT UNIT BED 489

OR NURSING UNAVAILABLE 399

SURGEON UNAVAILABLE-UNAVOIDABLE..... 167

SPECIAL CARE UNIT BED..... 121

PACU NURSING UNAVAILABLE 60

SURGEON UNAVAILABLE - AVOIDABLE 47

ANESTHESIOLOGIST UNAVAILABLE UNAVOIDABLE..... 43

PERFUSION UNAVAILABLE 26

INPATIENT UNIT NURSING UNAVAILABLE 18

ANESTHESIA ASSISTANT UNAVAILABLE 15

ANESTHESIA UNAVAILABLE-AVOIDABLE 11

NO ICU BED 11

SURGEON OVER BOOKED 10

SURGICAL ASSIST UNAVAILABLE 7

CVICU BED UNAVAILABLE.....6

Patient Issues

PATIENT ILL 224

MEDICALLY UNFIT 215

PATIENT DECLINED PROCEDURE 158

NOT MEDICALLY READY FOR OR AS PER ANESTHESIA 105

NONCOMPLIANT PREOP 66

PATIENT NO SHOW - DID NOT PRESENT FOR SURGERY 51

PROCEDURE NOT NECESSARY 44

LACK OF TRANSPORTATION-PATIENT 14

PATIENTS URGENCY CHANGED-PT DONE AS EMERGENCY 7

PATIENT DONE AS EMERGENCY 5

PATIENT EXPIRED 4

NO CURRENT CONTACT INFO 2

CONSENT NOT SIGNED 1

PATIENT NOT ACCOMPANIED POST ANESTHESIA 1

Schedule Change or Delays

SCHEDULE DELAY 1109

SCHEDULE CHANGE FOR PRIORITY (URGENT AND EMERGENT) 847

IF TIME PERMITS CASE 342

HDS USE ONLY-RESCHEDULED BY OFFCIE 55

SCHEDULE DELAY-PREVIOUS CASE PROLONGED 14

Other

WEATHER 155

ACTIVATION OF EMERGENCY CODES 91

INFECTIOUS OUTBREAK/ PANDEMIC 18

OTHER AVOIDABLE (NOT ELSEWHERE CLASSIFIED) 17

OTHER-UNAVOIDABLE (NOT ELSEWHERE CLASSIFIED) 7

FAMILY EMERGENCY 5