SOUTHERN DISTRICT HEALTH BOARD

HOSPITAL ADVISORY COMMITTEE

Wednesday, 27 November 2019

Commencing at 9.00am

Board Room, Level 2, Main Block,
Wakari Hospital Campus, 371 Taieri Road, Dunedin

A G E N D A

Lead Director: Patrick Ng, Executive Director Specialist Services

Item

1. Public Forum

2. Apologies

3. Interests Register

4. Minutes of Previous Meeting

5. Matters Arising/Action Sheet

6. Specialist Services Monitoring and Performance Reports

6.1 Executive Director of Specialist Services Report
6.2 Key Performance Indicators
6.3 Financial Performance Summary

7. Resolution to Exclude Public

Southern DHB Values			
Kind *Manaakitanga*	Open *Pono*	Positive *Whaiwhakaaro*	Community *Whanaungatanga*

No apologies for the Hospital Advisory Committee meeting had been received at the time of publishing the agenda.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Hospital Advisory Committee
Date of Meeting:	27 November 2019

Summary:

Commissioner, Committee and Executive Team members are required to declare any potential conflicts (pecuniary or non-pecuniary) and agree how these will be managed. A member who makes a disclosure must not take part in any decision relating to their declared interest.

Interests declarations, and how they are to be managed, are required to be recorded in the minutes and separate interests register (s36, Schedule 3, NZ Public Health and Disability Act 2000).

Changes to Interests Registers over the last month:

- Julie Rickman, Excutive Director Finance Procurement & Facilities - Chartered Accountants Advisory Group added.

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	n/a
Workforce:	n/a
Other:	

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 12/11/2019

RECOMMENDATION:

1. That the Interests Registers be received and noted.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
COMMISSIONER TEAM

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Kathy GRANT	25.06.2015	Chair, Otago Polytechnic	Southern DHB has agreements with Otago Polytechnic for clinical placements and clinical lecturer cover.	
(Commissioner)	25.06.2015	Deputy Chair, Dunedin City Holdings Limited	Nil	
	25.06.2015	Trustee of numerous private trusts	Nil	
	25.06.2015	Deputy Chair, Dunedin City Treasury Limited	Nil	
	18.09.2016	Food Safety Specialists Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	18.09.2016	Director, Warrington Estate Ltd	Nil - no pecuniary interest; provide legal services to the company.	
	18.09.2016	Tall Poppy Ideas Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	18.09.2016	Rangiora Lineside Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	18.09.2016	Otaki Three Limited	Nil. Co-trustee in client trusts - no pecuniary interest.	
	21.09.2018	Deputy Chair, Dunedin Stadium Property Ltd (from 1 July 2018, updated 24/04/2019)		
	01.09.2019	Establishment Board member of NZ Institute of Skills and Technology		
		Spouse:		
	25.06.2015	Consultant, Gallaway Cook Allan	Nil	
	25.06.2015	Chair, Slinkskins Limited	Nil	
	25.06.2015	Director, South Link Health Services Limited	A SLH entity, Southern Clinical Network, has applied for PHO status.	Step aside from decision-making (refer Commissioner's meeting minutes 02.09.2015).
	25.06.2015	Board Member, Warbirds Over Wanaka Community Trust	Nil	
	25.06.2015	Director, Warbirds Over Wanaka Limited	Nil	
	25.06.2015	Director, Warbirds Over Wanaka International Airshows Limited	Nil	
	25.06.2015	Board Member, Leslie Groves Home & Hospital	Leslie Groves has a contract with Southern DHB for aged care services.	
	25.06.2015	Chair Dunedin Diocesan Trust Board	Nil (Updated 16 April 2018)	
	25.06.2015	Trustee of numerous private trusts	Nil	
	25.06.2015 (updated 22.04.2016 and 29.06.2019)	Past President, Otago Racing Club Inc.	Nil	
Jean O'Callaghan (Deputy Commissioner)	13.05.2019	Employee of Geneva Health	Provides care in the community; supports one long term client but has no financial or management input.	
	13.05.2019	St John Volunteer, Lakes District Hospital	Nil	Taking six months' leave.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
COMMISSIONER TEAM

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
David Perez (Deputy Commissioner)	13.05.2019	Director, Mercy Hospital, Dunedin	SDHB holds contracts with Mercy Hospital.	Step aside from decision making.
	13.05.2019	Fellow, Royal Australasian College of Physicians		
	13.05.2019	Trustee for several private trusts		
Richard THOMSON (Deputy Commissioner)	13.12.2001	Managing Director, Thomson & Cessford Ltd	Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it.	
	13.12.2002	Chairperson and Trustee, Hawksbury Community Living Trust (24.06.2019 Acting CEO)	Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB.	
	24.06.2019	Chair, Hawkesbury Property Trust	Owns the properties that Hawkesbury Trust residents live in.	
	23.09.2003	Trustee, HealthCare Otago Charitable Trust	Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations.	
	05.02.2015	One immediate family member is an employee of Dunedin Hospital (Anaesthetic Technician)		
	07.10.2015	Southern Partnership Group	The Southern Partnership Group will have governance oversight of the Dunedin Hospital rebuild and its	
	24.07.2018	Son's partner works for Southern DHB, Ophthalmology Service.		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
ADVISORY COMMITTEE MEMBERS

Committee Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Susie JOHNSTONE	21.08.2015	Independent Chair, Audit & Risk Committee, Dunedin City Council	Nil	
(Consultant, Finance Audit & Risk Committee)	21.08.2015	Advisor to a number of primary health provider clients in rural Otago	All of the primary health provider clients in rural Otago are likely to have a contract through Southern DHB and/or the WellSouth Primary Care Network.	
	18.01.2016	Audit and Risk Committee member, Office of the Auditor-General	Audit NZ, the DHB's auditor, is a business unit of the Office of the Auditor General.	
	16.09.2016	Director, Shand Thomson Ltd	Nil	
	16.09.2016	Director, Harrison Nominees Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	16.09.2016	Director, Abacus ST companies.	Nil. Co-trustee in client trusts - no pecuniary interest.	
	16.09.2016	Director, Shand Thomson Nominees Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	16.09.2016	Director, Johnstone Afforestation Co Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	16.09.2016	Director, Shand Thomson Nominees (2005) Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	16.09.2016	Director, McCrostie Nominees Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	28.05.2018	Clutha Community Health Company Co Ltd	Client of Shand Thomson. Two retired Shand Thomson partners are on the board, one is a long standing Chair.	
	23.07.2018	Trustee, Clutha Community Foundation (appointed June 2018)		
		Spouse is Consultant/Advisor to:		
	21.08.2015	Tuapeka Community Health Co Ltd & Tuapeka Health Incorporated	Tuapeka Community Health Co Ltd & Tuapeka Health Incorporated have a contract with Southern DHB.	
	21.08.2015	Wyndham & Districts Community Rest Home Inc	Wyndham & Districts Community Rest Home Inc has a contract with Southern DHB.	
	21.08.2015	Roxburgh District Medical Services Trust	Roxburgh District Medical Services Trust has a contract with Southern DHB.	
	21.08.2015	A number of primary health care providers in rural Otago	All of the primary health provider clients in rural Otago are likely to have a contract through Southern DHB and/or the WellSouth Primary Care Network.	
	26.09.2016	Director, Abacus ST companies.	Nil. Co-trustee in client trusts - no pecuniary interest.	
		Daughter:		
	21.08.2015	Junior Doctor, Nelson Marlborough DHB	(Updated 25.01.2019)	
		Son:		
	29.04.2019	Employee of Deloitte	Deloitte are the internal auditors of SDHB	
		Sister:		
	06.09.2019	Ultrasonographer, Pacific Radiology	Occasionally does relief work for Southern DHB.	
Donna MATAHAERE-ATARIKI	27.02.2014	Trustee WellSouth	Possible conflict with PHO contract funding.	
IGC Member - Ōtākou Rūnanga	27.02.2014	Trustee Whare Hauora Board	Possible conflict with SDHB contract funding.	
	27.02.2014	Chair, Ōtākou Rūnanga	Nil	
	17.06.2014	Gambling Commissioner	Nil	
	05.09.2016	Board Member and Shareholder, Arai Te Uru Whare Hauora Limited	Nil - charitable entity.	
	05.09.2016	Southern DHB, Iwi Governance Committee	Possible conflict with SDHB contract funding.	
	09.02.2017	Director and Shareholder, VIII(8) Limited	Nil	
	07.06.2018	Chairperson, Te Rūnanga o Otākou Incorporated	Registered Charity - not contracting in Health.	
	07.06.2018	Director, Te Rūnanga Ōtākou Ltd	Nil does not contract in health.	Update to nature of interest 2 July 2018
	07.06.2018	Trustee, Kaupapa Taiao	Registered Charity - not contracting in Health.	
	02.07.2018	Board member, Ōtākou Health Ltd (Shareholder of Te Kaika and its subsidiaries Mataora Health and Forbury Cnr Medical Centres)	Possible conflict with SDHB contract funding. (Registered Charity - no pecuniary interest)	Interest advised 2 July 2018
Odele STEHLIN	01.11.2010	Waihopai Rūnaka General Manager	Possible conflict with contract funding.	
Waihōpai Rūnaka – Chair IGC	01.11.2010	Waihopai Rūnaka Social Services Manager	Possible conflict with contract funding.	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
ADVISORY COMMITTEE MEMBERS

Committee Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	01.11.2010	WellSouth Iwi Governance Group	Nil	
	01.11.2010	Recognised Whānau Ora site	Nil	
	24.05.2016	Healthy Families Leadership Group member	Nil	
	23.02.2017	Te Rūnanga alternative representative for Waihopai Rūnaka on Ngai Tahu.	Nil	
	09.06.2017	Director, Waihopai Runaka Holdings Ltd	Possible conflict with contract funding.	
	07.06.2018	Director of Waihopai Hauora.	Possible conflict with contract funding.	
Sumaria BEATON	27.04.2017	Southland Warm Homes Trust	Nil	
IGC - Awarua Rūnaka	09.06.2017	Director and Shareholder, Sumaria Consultancy Ltd	Nil	
	09.06.2017	Director and Shareholder, Monkey Magic 8 Ltd	Nil	
	07.06.2018	Treasurer, Community Energy Network Incorporated	Nil	
Taare BRADSHAW	17.03.2017	Director, Murihiku Holdings Ltd	Nil	
IGC - Hokonui Rūnaka	07.06.2018	Trustee, Hokonui Rūnanga Health & Social Services Trust	Possible conflict with contract funding.	
	07.06.2018	Vice Chairman, Hokonui Rūnanga Incorporated	Possible conflict with contract funding.	
Victoria BRYANT	06.05.2015	Member - College of Primary Nursing (NZNO)	Nil	
IGC - Puketeraki Rūnaka	06.05.2015	Member - Te Rūnanga o Ōtākou	Nil	
	06.05.2015	Member Kati Huirapa Rūnaka ki Puketeraki	Nil	
	06.05.2015	President Fire in Ice Outrigger Canoe Club	Nil	
	24.05.2017	Member, South Island Alliance - Raising Healthy Kids	Nil	
	06.03.2018	SDHB, Te Punaka Oraka, Public Health Nursing, Charge Nurse Manager	Nil	
	06.03.2018	Member of the New Zealand Nurses Organisation	Possible conflict when negotiations are taking place.	
	06.03.2018	Member of the Public Service Association (PSA)	Possible conflict when negotiations are taking place.	
Justine CAMP	31.01.2017	Research Fellow - Dunedin School of Medicine - Better Start National Science Challenge	Nil	
IGC - Moeraki Rūnaka		Member - University of Otago (UoO) Treaty of Waitangi Committee and UoO Ngai Tahu Research Consultation Committee	Nil	
		Member - Dunedin City Council - Creative Partnership Dunedin	Nil	
		Moana Moko - Māori Art Gallery/Ta Moko Studio - looking at Whānau Ora funding and other funding in health setting	Possible conflict with funding in health setting.	
Terry NICHOLAS	06.05.2015	Treasurer, Hokonui Rūnanga Inc.	Nil	
IGC - Hokonui Rūnaka	06.05.2015	Member, TRoNT Audit and Risk Committee	Nil	
	06.05.2015	Director, Te Waipounamu Māori Cultural Heritage Centre	Nil	
	06.05.2015	Trustee, Hokonui Rūnanga Health & Social Services Trust	Possible conflict when contracts with Southern DHB come up for renewal.	
	06.05.2015	Trustee, Ancillary Claim Trust	Nil	
	06.05.2015	Director, Hokonui Rūnanga Research and Development Ltd	Nil	
	06.05.2015	Director, Rangimanuka Ltd	Nil	
	06.05.2015	Member, Te Here Komiti	Nil	
	06.05.2015	Member, Arahua Holdings Ltd	Nil	
	06.05.2015	Member, Liquid Media Patents Ltd	Nil	
	06.05.2015	Member, Liquid Media Operations Ltd	Nil	
	09.06.2017	Director, Murihiku Holdings Ltd	Nil	
	09.06.2017	Director and Shareholder, Real McCoy Owner Ltd	Nil	
	09.06.2017	Director and Shareholder, Real McCoy Operator Ltd	Nil	
Ann WAKEFIELD	03.10.2012	Executive member of Ōraka Aparima Rūnaka Inc.	Nil	
IGC - Ōraka Aparima Rūnaka	09.02.2011	Member of Māori Advisory Committee, Southern Cross	Nil	
	03.10.2012	Te Rūnanga representative for Ōraka-Aparima Rūnaka Inc. on Ngai Tahu.	Nil	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Management of staff conflicts of interest is covered by SDHB's Conflict of Interest Policy and Guidelines.

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Kaye CHEETHAM	08.07.2019	Ministry of Health Appointed Member of the Occupational Therapy Board	
Mike COLLINS	15.09.2016	Wife, NICU Nurse	
	01.07.2019	Capable NZ Assessor	Asked from time to time to assess students, bachelor and masters students final presentation for Capable NZ.
Matapura ELLISON	12.02.2018	Director, Otākou Health Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	12.02.2018	Deputy Kaiwhakahaere, Te Rūnanga o Ngai Tahu	Nil
	12.02.2018	Chairperson, Kati Huirapa Rūnaka ki Puketeraki (Note: Kāti Huirapa Rūnaka ki Puketeraki Inc owns Pūketeraki Ltd - 100% share).	Nil.
	12.02.2018	Otago Museum Māori Advisory Committee	Nil
	12.02.2018	Trustee, Section 20, BLK 12 Church & Hall Trust	Nil
	12.02.2018	Trustee, Waikouaiti Maori Foreshore Reserve Trust	Nil
	29.05.2018	Director & Shareholder (jointly held) - Arai Te Uru Whare Hauora Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	25.09.2016	Deputy Chair, InterRAI NZ	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
Lisa GESTRO	06.06.2018	Lead GM National Travel and Accommodation Programme	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	NASO Governance Group Member	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	Lead GM Perinatal Pathology	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	Fellow of the Royal Australasian College of Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	04.07.2016	Clinical Lead for HQSC Atlas of Healthcare variation	HQSC conclusions or content in the Atlas may adversely affect the SDHB.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	29.05.2018	Council Member of Otago Medical Research Foundation Incorporated	
Nicola MUTCH		Deputy Chair, Dunedin Fringe Trust	Nil
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
	07.08.2019	Father, Mayoral candidate for Waitaki District	
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	17.11.2017	Wife works for key technology supplier CCL	Nil
	18.12.2017	Daughter, medical student at Auckland University and undertaking Otago research project over summer 2017/18.	
Julie RICKMAN	31.10.2017	Director, JER Limited	Nil, own consulting company
	31.10.2017	Director, Joyce & Mervyn Leach Trust Trustee Company Limited	Nil, Trustee
	31.10.2017	Trustee, The Julie Rickman Trust	Nil, own trust
	31.10.2017	Trustee, M R & S L Burnell Trust	Nil, sister's family trust
	23.10.2018	Shareholder and Director, Barr Burgess & Stewart Limited	Accounting services
		Specified contractor for JER Limited in respect of:	
	31.10.2017	H G Leach Company Limited to termination	Nil, Quarry and Contracting.
	21.10.2019	Chartered Accountants Advisory Group	
Gilbert TAURUA	05.12.2018	Prostate Cancer Outcomes Registry (New Zealand) - Steering Committee	Nil
	05.04.2019	South Island HepC Steering Group	Nil

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	03.05.2019	Member of WellSouth's Senior Management Team	Reports to Chief Executives of SDHB and WellSouth.
Gail THOMSON	19.10.2018	Member Chartered Management Institute UK	Nil
Jane WILSON	16.08.2017	Member of New Zealand Nurses Organisation (NZNO)	No perceived conflict. Member for the purposes of indemnity cover.
	16.08.2017	Member of College of Nurses Aotearoa (NZ) Inc.	Professional membership.
	16.08.2017	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Thursday, 26 September 2019, commencing at 9.10 am in the Board Room, Southland Hospital Campus, Invercargill

Present:	Mrs Kathy Grant	Commissioner
	Mrs Jean O'Callaghan	Deputy Commissioner
	Dr David Perez	Deputy Commissioner
	Mr Richard Thomson	Deputy Commissioner (by videoconference)
In Attendance:	Mr Chris Fleming	Chief Executive Officer
	Mr Patrick Ng	Executive Director Specialist Services
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community (by videoconference from 10.20 am)
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary (by videoconference)

1.0 APOLOGIES

An apology was received from Ms Odele Stehlin, Committee Member.

2.0 DECLARATION OF INTERESTS

The Interests Registers were circulated with the agenda (tab 3).

The Commissioner asked for any changes to the registers and reminded everyone of their obligation to advise the meeting should any potential conflict arise during discussions.

Recommendation:

"That the Interests Registers be received and noted."

3.0 PREVIOUS MINUTES

Recommendation:

"That the minutes of the meeting held on 31 July 2019 be approved and adopted as a true and correct record."

Agreed

4.0 MATTERS ARISING/REVIEW OF ACTION SHEET

The Committee received the action sheet (tab 4) and the Executive Director Specialist Services (EDSS) provided the following updates.

- *Mental Health Facilities* - A paper had been prepared but was in a holding pattern while consideration was being given to the next steps.

- *Clerical and Administration Transformation* - High engagement, high performance workshops had been held and had gone well. These were designed to provide a model to address administration challenges in partnership with the PSA.

- *Radiology Virtual Ward* - The virtual ward was in place. The EDSS had requested further information and would provide a more comprehensive response at the next meeting.

Environmental Sustainability and Green Development

The Committee requested information on Southern DHB's high use of nitrous oxide.

5.0 PROVIDER ARM MONITORING AND PERFORMANCE REPORTS

Executive Director Specialist Services' Report (tab 5)

The Executive Director Specialist Services (EDSS)' monthly report was taken as read and the EDSS commented on the following items.

- *Radiation Oncology* - The service had brought the wait list down to normally indicated volumes and timeframes. To assist with managing the challenges arising from a number of sabbaticals occurring prior to the end of the year, periodic clinic cover would be provided by Canterbury clinicians.
- *Linear Accelerator Implementation* - The commissioning of the first Elekta linear accelerator, with the assistance of the Canterbury DHB Chief Physicist, was progressing well.
- *Emergency Departments (EDs)* - The EDSS summarised an analysis of ED presentations from 2016 to August 2019, which showed that acuity, the amount of time spent in ED, the number of patients who did not wait to be seen, and the number of patients arriving by ambulance, had all increased. The data showed an increase in demand and pressure on the EDs and would inform long term planning.
- *Elective Delivery* - As at the end of July 2019 elective delivery was 100 caseweights ahead of target and at the end of August 2019 50 caseweights ahead of target for the year to date. The deterioration during August was due to the cancellation of 30 caseweights for the SMO engagement days, the cancellation of elective lists in order to manage acute workload and bed block. September elective delivery was looking better.

  The same planning process as last year was being followed for December/January, with the January 2020 schedule about 80% populated.
- *Conversion of Anaesthetic Procedure Room to a Minor Operating Theatre, Dunedin Hospital* - The estimated cost of this project was $1 million and was included in the Capital Plan. A supporting business case would now be developed.
- *Elective Service Performance Indicator (ESPI) Delivery* - The EDSS outlined the steps that were being taken to address ESPI compliance and advised that the Urology, Ear, Nose and Throat (ENT) services had reached ESPI compliance; the numbers in the Orthopaedic Service, Dunedin, were static; Southland Orthopaedics breaches had been halved, and ESPI General Surgery, Dunedin,

breaches had been reduced from 200 to 85. Following RDA strike action, breaches had occurred in Medicine, Women and Children's and these services were now included in weekly ESPI planning. Numbers had also grown in General Surgery, Southland, and a workshop to develop a recovery programme for this service was scheduled for the following week.

A workshop on ESPI 5 compliance was held the previous day.

The EDSS then answered questions on the anticipated improvement in CT performance, Faster Cancer Treatment (FCT), and planned care interventions inpatient surgical discharges. The EDSS undertook to provide a clearer chart of surgical discharges for the next meeting.

Financial Performance Summary (tab 5.3)

The EDSS presented the August 2019 financial report for Specialist Services and explained the variances.

***Recommendation**:*

"That the reports be noted."

Agreed

CONFIDENTIAL SESSION

At 10.10 am it was resolved that the Hospital Advisory Committee move into committee to consider the agenda items listed below.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.
2. Dunedin Hospital Redevelopment	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the OIA.
3. Building Projects	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the OIA.

Confirmed as a true and correct record:

Commissioner: _____

Date: _____

Southern District Health Board
HOSPITAL ADVISORY COMMITTEE
ACTION SHEET

As at 19 November 2019

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Nov 2018	**Mental Health** (Minute item 5.0)	Consultation on the discussion paper on MH facilities to be widened.	~~EDSS~~ EDSPC	A paper on the mental health facilities at Wakari hospital was completed recently. The level of investment required to bring the facilities up to contemporary practice standards is significant and we are working through the most appropriate next steps. Further activity will be undertaken through the business case development which will occur in 2020. This service has also been transferred to Strategy, Primary & Community so will report through CPHAC moving forward.	To close
Jan 2019	**Clerical and Administration Transformation** (Minute item 5.0)	Progress reports to be provided.	EDSS	A second workshop is scheduled for 20 September. An update will be provided for the November HAC meeting. Due to conflicting priorities, a report will be provided at the first scheduled HAC meeting for 2020.	~~November 2019~~ 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
July 2019	**Radiology** (Minute item 7.0)	Report to be provided on the establishment of a virtual ward for diagnostics.	EDSS	A virtual ward was trialled as part of the 'red to green' initiative in the valuing patient time work streams. However, the study concluded that there was not a significant benefit in having a 'virtual ward', for example, CT did not come up in the 5 top reasons for disruption to patient flow. The virtual ward requires resourcing and as the trial has not proven significant benefits we have concluded that the trial should come to an end. The virtual ward has been in place since 18 June 2019. Radiology has put aside 2 one hour sessions of capacity per week (on Tuesdays and Thursdays) for this. Capacity was 'provided' from time previously dedicated to inpatient scanning. However to date we have received one referral. Un-utilised capacity is filled by inpatient and acute scanning. There is a meeting to discuss improving utilisation.	
Sept 2019	**Nitrous Oxide Usage** (Minute item 5.0)	Information to be provided on SDHB's high use of nitrous oxide.	EDSS/ EDFP&F	The nitrous oxide leak finding has been progressed from the VIE cylinder room (near the pool), Fraser Building, with no leaks found. The only place that remains to be tested is MOT 4,5,6,7,8, and 9 from the isolation valves outside each theatre and the pipework in the 4th	

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				floor CSB ceiling space to each theatres isolation valve unit. This work is being progressed and is expected to be completed by 16 December 2019.	
Sept 2019	**Planned Care Interventions Inpatient Surgical Discharges** (Minute item 6.0)	Clearer chart to be provided.	EDSS	Noted.	

5.1

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Executive Director of Specialist Services Report**
Report to:	Hospital Advisory Committee
Date of Meeting:	27 November 2019

Summary:

Considered in these papers are:

- October 2019 DHB activity.

Specific implications for consideration (financial/workforce/risk/legal etc):

Financial:	Yes
Workforce:	Yes
Other:	No

Document previously submitted to:	Not applicable, report only provided for the Hospital Advisory agenda.	**Date:**
Approved by:		**Date:**

Prepared by: Executive Director of Specialist Services **Date:** 11/11/2019	**Presented by:** Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:

That the Hospital Advisory Committee receive the report.

Executive Director of Specialist Services (EDSS) Report – October 2019

Recommendation

That the Hospital Advisory Committee notes this report.

1. Operational Overview Highlights

Emergency Department (ED), Dunedin

The ED management team, acting General Manager Operations and EDSS met to de-brief on the recent winter demands in Dunedin and to determine what can be pro-actively planned for ahead of next winter. We were advised that the 'Fit to Sit' plans have been delayed in getting to Council for consent and have subsequently followed this up. We now believe that Fit to Sit will become available in February 2020.

We have concluded that ahead of next winter what will become key is the following:

- We need to move the Generalism business case through as the fundamental basis for improving the assessment and flow of ED patients. We have undertaken to ensure that the ED management team is copied to the initial draft of the Generalism business case and has the opportunity to contribute from the earliest draft.
- As construction work (i.e. for the relocation of the medical assessment unit as part of the Generalism proposal) is unlikely to be completed before next winter we need a mitigation plan to help us best meet peak demands with what we currently have.

A workshop is being organised with assistance from the consultants who have been working with us on 'valuing patient time' to develop a mitigation plan that will assist us next winter. We will run two workshops, one for the Southland ED and one for the Dunedin ED.

Radiation Oncology

The wait list for first specialist appointments is growing again and we are concerned. Canterbury DHB's wait list is also growing and the ability of their Senior Medical Officers (SMOs) to provide assistance to our first specialist assessment wait list is therefore diminishing. At the same time, it is proving immensely challenging to identify locum support. The locum we have traditionally used from Australia is no longer available and advertising to date has had minimal success. We are investigating the use of a Resident Medical Officer who has recently returned to the district to provide us with additional capacity which would enable us to reconfigure the clinic schedules of the SMO's. We need to sit down with the key leaders in this service and undertake comprehensive planning. We will seek to get this underway in the coming weeks.

The oncology service is looking to implement modest improvements to the Oncology Building that would provide for some much needed assessment unit and clinic spaces. We met with the building and property team and worked through what these might translate to in terms of effort and cost. We concluded that the requests were modular (could be completed independently, so a request could be made and depending on the capital available, some or all of the requests could be implemented. The highest priority is the creation of 6 additional chair spaces for chemotherapy delivery. This would cost circa $30k. The next priority is the creation of 2 clinic rooms (at a cost of circa $50k per room including relocations etc.). And the final priority is the creation of a further 2 clinic rooms at an additional cost of $100k. I.e. a CAPEX spend of between $30k and $230k would provide much needed clinical space in the oncology building, which in turn will have a life well beyond 10 years as it is out of scope for the initial new hospital build. Given the modest cost and the benefits that will come from investing in these enhancements we have undertaken to put forward the full $230k for CAPEX prioritisation for 2020/21.

Generalism

Good work has occurred on progressing the concept of Generalism and articulating it in a business case which follows the Treasury 5 case model – strategic case, economic case, commercial case, financial case and management case.

In terms of the strategic case a first draft has been completed, outlining the concept of Generalism, which, in its simplest form is the concept of assessing, admitting, caring for and discharging more patients through internal medicine rather than through the sub-specialities. The strategic case refers to other hospitals in New Zealand who have adopted the approach of admitting more patients via a generalist admitting model and makes reference to contemporary good practice both in New Zealand and overseas. Although not extensively researched in our concept work thus far, the work outlines the reasons we would want to move towards this model reasonably well. The reasons for the change translate into benefits that will be further elaborated in the financial and management cases. The benefits relate primarily to the speed with which patients are assessed, admitted, receive their treatment and are then discharged. These translate directly into bed night reductions which in turn, with a robust benefit realisation plan will translate into a combination of notional (avoided growth) and tangible (bankable – bed closure) financial benefits.

Our economic case needs further elaboration. In the economic case several robust options should be articulated and the preferred option outlined. Although we have a well-articulated option we do not have a strong set of options yet and this needs further work. The options also need to consider the timing of the proposed changes. Ideally, Generalism needs to be incorporated into the relocation of the medical assessment unit from the 7th floor to be co-located with the Emergency Department. The timeframes associated with recruiting the additional SMO workforce, construction of the medical assessment unit and re-shuffling on the wards need to be worked through carefully and we need to understand from within our set of options whether we should target a phased implementation of Generalism which initially utilises the 7th floor medical assessment

unit, or whether the full model should be implemented once the relocated medical assessment unit is available.

The commercial case will describe how the medical assessment unit relocation project would work and we still need to get clarification on this from our building and property colleagues.

We will work up the financial case soon. Fundamentally the financial case will be predicated on recruiting an additional 4 SMO to create an additional two internal medicine teams, reconfiguration of the RMO workforce, validation that we have an appropriate allied health workforce and incorporation of the costs of the relocation of the medical assessment unit. These components will fundamentally require investment and this will need to occur early in the investment cycle of the overall proposition. Realistic scenarios of bed day savings then need to be developed to outline the benefits that can be achieved. Benefits will be in proportion to actual bed days which can be saved in terms of the 0 night stay, 1-2 night stay 3-5 night stay and 5 nights plus cohorts. There are a large number of variables which will ultimately determine the overall benefits which are achievable, so we will develop a sensitivity model that will enable us to change the benefits and re-run the model without having to continuously re-build it. A high level pro-forma look at the potential benefits suggested that a scenario that did not include relocation of the medical assessment unit would have very modest benefits whereas an aggressive model predicated on the relocation of the medical assessment unit could have net bed day savings of circa $1-$2m per annum. As well as the tangible benefits (which would be achieved by physically closing beds), less tangible (notional) benefits will also need to be considered. Notional benefits come from the fact that our acute admissions will grow in the coming years and without a means of addressing this growth we will have to invest more (the benefit is then the cost of avoided additional investment). Our objective is to ensure that this proposition has net tangible financial benefits (clearly pays for itself), but also articulates further, notional benefits.

We are yet to work up the management case, but will be doing so in the next two weeks. The management case will outline how we will manage the necessary changes and is intended to provide the business case approver with sufficient confidence that the project can be delivered successfully. There are a number of changes that will need to be made which include changing some SMO rosters to include evenings, reviewing call back arrangements, altering the manner in which the junior medical workforce is used and developing and establishing protocols for how patients are reviewed and their care transferred between ED doctors, generalist and sub-specialists. The implementation of these changes will be the most complex component of the overall programme and the management case will therefore need to be carefully worked up.

Overall, it is our intention to release a full business case in draft form. The case will deliberately be in draft because a number of stakeholder groups will need to provide their feedback. The intention is to then iteratively improve the draft case to get to the point where we have a case which has been robustly consulted on and corrected.

The medical director, clinical leader and key internal medicine clinicians have been an integral part of developing the concept to this point, together with the service manager.

Secondary Care Strategy and Action Plan

The building blocks for a robust secondary care strategy and action plan are emerging. On a modular basis, key components need to include:

- Improving performance at the front door (ED). This needs to incorporate Generalism / acute medical assessment.
- Improving flow through the hospital. This needs to incorporate the work in valuing patient time and again ties into the generalist admitting approach.
- Managing outpatient services so that these are sustainable. This incorporates the work on Elective Services Performance Indicators (ESPI) management (including prioritisation), which needs further ramping up, and managing follow up volumes so that they are managed in a similar manner to ESPI's in terms of prioritisation and risk.
- Maintaining a robust model for elective service delivery. This includes improving ESPI 5 flow and ensuring that production planning joins up outpatient management, the timing of surgery and meeting planned care targets.
- Ensuring that capacity exists in the right places at the right time for overall flow, e.g. radiology.
- Underpinning this with accurate data capture and improved processes and systems which prevent patients from falling through the gaps.

Key aspects of what is developed then need to tie back in to the primary and community strategy (e.g. what gets accepted into a hospital outpatient appointment versus treated in the community, follow up care post hospital discharge). And there needs to be an overlay which accounts for:

- Equity – How we ensure that the outcome of an outpatient appointment, acute admission or surgery is identical to the general population for Maori and Pacifica.
- Workforce – How we ensure that the size and shape of the workforce is developed over time to match the needs of the new hospital, ahead of us moving into it and how we ensure that we deliver the best care for a finite level of resource. This in turn needs to link back into the organisations' workforce strategy at the appropriate connection points.
- Sustainability – How we ensure overall affordability.

Although Generalism is our current priority, early in the calendar year we will put together a reference group to construct a first draft secondary care strategy and action plan. Contextual documents (where relevant) need to include the recommendations from the Heather Simpson review, reference to how others have improved equity outcomes in secondary care settings and the primary and community strategy to the extent that this impacts on what is delivered in secondary care. In a similar manner to Generalism, a strategy will be completed in draft form to allow for consultation and iterative improvement.

Elective Service Performance Indicator (ESPI) Recovery

ESPI 2 (outpatient). We had a very productive meeting with the Clinical Leader and a Senior SMO for General Surgery in Southland where we agreed to implement the Ministry of Health prioritisation tool, to ensure that referrals are stratified in priority order, allowing us to make decisions about how many referrals we will accept on the basis of the underlying capacity of the service.

We also have willingness to implement the Ministry of Health Prioritisation tool in General Surgery in Dunedin.

The services which have reached compliance (Urology and Ear Nose Throat ENT) are maintaining compliance (or are within 5-7 breaches of compliance). We have had the Ministry of Health prioritisation tool in place in Orthopaedics in Dunedin for a number of months now and the clinical leader undertook a study in the use of the tool and has presented this as an academic paper to his peers nationally. We have not seen significant reductions in the wait list over 120 days in the service, but there have been a number of vacancies which led to reduced clinic capacity and this has masked the impact of the tool. Without implementing the tool we would have seen the number of breaches increasing significantly. We have now recruited into the vacancies and we believe we will see the tool really start to work in the coming months. We should see the service address its historic breaches in the coming 6 months, broadly in line with the recovery plan we submitted to the Ministry.

We have started to introduce the easier ESPI management tools into the medicine, women and children services who are breaching ESPI 2 (outpatient appointments completed within 120 days). These include the acuity booking tool, which is an online tool which helps to make the prioritisation of the patients who get booked for appointments more consistent. The acuity tool ensures that bookings are presented in priority order based on a function of both the patients' acuity and how long they have been waiting for their appointment.

We have also asked the business support and development team to develop a paper outlining a proposal for how follow up appointments can be tracked, prioritised and managed on a similar basis to how we are now managing first specialist appointments (ESPI 2).

The business support and development team has also been tasked with developing an ESPI 5 recovery programme. ESPI 5 tracks whether a patient, upon confirmation of eligibility for surgery, receives their surgery within 120 days.

Our overarching plan is to develop similar reporting for ESPI 5 as are being used for ESPI 2 management.

Elective Delivery

Elective delivery ended October circa 100 case weights ahead of plan on a year to date basis. Although favourable to plan on a year to date basis we saw a deterioration in

performance for the month of October. The primary reason for our relatively low performance in October has been the impact of the medical imaging technologists (MIT) strikes. These strikes have required us to cancel high case weight cases such as cardiothoracic cases and by way of example we lost almost a week's worth of cardiothoracic cases early in the month as a consequence.

Now that the strikes have concluded we hope to improve elective performance in November and to build additional buffer to provide us with natural contingency should we need it later in the year.

January elective list planning has progressed well and only a handful of main operating theatre lists remain vacant, with work continuing on ensuring that day surgical lists are also utilised. Dental drop a number of lists over January and we are utilising this as an opportunity to do more in specialities which need more operating time, particularly general surgery. Our overall goal for January is for every elective list to be picked up and utilised.

MIT Strike

Although the MIT strike reduced our wage bill, it has also added costs across Specialist Services including lost case weight delivery (although this did not impact us in October as we remain ahead of plan on a year to date basis) and costs associated with managing the life preserving services (LPS) arrangements. The General Manager Surgical and Radiology has been asked to quantify the overall costs associated with the strikes.

HEALTH TARGETS

Indicator	Last Quarter – MOH	Current Quarter To Date Estimate	Actions if falling short of target
Shorter Stays in Emergency Department – Target 95%	90%	84%	Continuing to look at patient flow through the Emergency Department and also across the whole hospital.
Colonoscopy Urgent – 85% **Colonoscopy Non Urgent – 70%** **Colonoscopy Surveillance – 70%**	86% 82% 70%	71% 80% 62% October to date	Surveillance scoping represents high volumes and variable demand. Additional weekend lists are being undertaken. Urgent colonoscopies represent small numbers and patient factors often result in difficulties getting patients into colonoscopy within two

			weeks.
Coronary Angiograms 95%		100%	
Radiology **Diagnostic indicator CT, 95% of patients referred for elective CT have report distributed within 42 days**	April 2019 64.9% May 2019 64.3% June 2019 64.5%	July 2019 64.3% August 2019 66% September 2019 69.5%	CT performance improved slightly by end September but can be expected to deteriorate at both sites, due to the MIT strikes. Additional capacity at Queenstown will over time offset this as will additional capacity being sought at Oamaru.
Radiology **Diagnostic indicator MRI, 85% of patients referred for elective MRI have report distributed within 42 days**	April 2019 54.9% May 2019 48% June 2019 50.1%	July 2019 52.3% August 2019 56% September 2019 54.4%	Slight deterioration seen in September. October's result is expected to see this continue due to the MIT strikes.
Faster Cancer Treatment (FCT) – Target 90% of patients referred with a high suspicion of cancer and triaged as urgent receive their first definitive cancer treatment within 62 days of the date of receipt of referral (as of July 2017).	April - September 2019 tracking 83.5%	June – September 2019 tracking 88.9%	

Planned Care Interventions Inpatient Surgical Discharges - Annual target 12,588	**4,129** Actual YTD vs **4,367** Plan YTD, as at October 2019.

Refer to page 9 - Caseweight and discharge volumes graph.

Patrick Ng, Executive Director of Specialist Services

Southern District Health Board
Piki Te Ora

Hospital Advisory Committee KPI Summary - Discharges and CWD Volumes

Planned Care Interventions Inpatient Surgical Discharges - October 2019

Planned Care Interventions Inpatient Surgical Discharges - Southern DHB population

	October 2019				Year to Date				Annual
	Actual	Plan	Variance	Var %	Actual	Plan	Variance	Var %	Plan
SDHB population treated in-house	827	878	(51)	(6%)	3,314	3,475	(161)	(5%)	10,197
SDHB population treated by other DHBs	47	47	0	%	182	188	(6)	(3%)	565
SDHB population outsourced	131	115	16	14%	410	460	(50)	(11%)	1,150
SURGICAL ELECTIVE DISCHARGES	**1,005**	**1,040**	**(35)**	**(3%)**	3,906	4,123	**(217)**	**(5%)**	**11,912**
Surgical Discharges from a Non-Surgical PUC	52	78	(26)	(33%)	223	244	(20)	(8%)	675
TOTAL DISCHARGES	**1,057**	**1,118**	**(61)**	**(5%)**	**4,129**	**4,367**	**(238)**	**(5%)**	**12,588**

Planned Care Interventions Inpatient Surgical CWD Volumes - October 2019

Planned Care Interventions Inpatient Surgical CWD Volumes - Southern DHB population

	October 2019				Year to Date				Annual
	Actual	Plan	Variance	Var %	Actual	Plan	Variance	Var %	Plan
SDHB population treated in-house	1,149	1,193	(45)	(4%)	4,889	4,721	168	4%	13,854
SDHB population treated by other DHBs	76	76	0	%	319	304	15	5%	912
SDHB population outsourced	155	158	(3)	(2%)	561	630	(70)	(11%)	1,576
SURGICAL ELECTIVE DISCHARGES	**1,379**	**1,427**	**(47)**	**(3%)**	5,769	5,656	**113**	**2%**	**16,342**
Surgical Discharges from a Non-Surgical PUC	137	217	(81)	(37%)	598	635	(37)	(6%)	1,792
TOTAL CWD VOLUMES	**1,516**	**1,644**	**(128)**	**(8%)**	**6,367**	**6,291**	**76**	**1%**	**18,134**

(1) Actual IDF Outflow volumes for the current month are not available, and have been reported based on the planned numbers.
(2) The Planned Volumes have been agreed in total with the Ministry of Health, with the draft phasing by month of the targets to be confirmed.

Southern DHB
Hospital Advisory Committee - KPIs October 2019 Data

Patient Safety and Experience - Hospital Health Check					
	Prior year	Actual	Plan / Target	Variance 'v Plan /Target	Trend/rating
3 - Improved access to Elective Surgical Services monthly (population based) Discharges Health Target	1,172	1,057	1,118	-61 (-5.4%)	
3a - Improved access to elective surgical services ytd (population based) Discharges Health Target	4,563	4,129	4,367	-238 (-5.4%)	

Patient Safety and Experience - Performance Report					
Monthly	Prior year	Actual	Plan / Target	Variance 'v Plan /Target	Trend/ rating
Faster Cancer treatment; 90% of patients to receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer seen within 2 weeks *Latest available March 19 quarterly report from MoH website	79.4%	85.7%	90.0%	-4.3%	
11 - Reduced stay in ED	88.4%	84.2%	95.0%	-10.8%	
15 - Acute Readmission Rates (Note 1)	11.5%	12.5%	9.9%	-2.6%	

Cost/Productivity - Hospital Health Check					
Monthly	Prior year	Actual	Plan / Target	Variance 'v Plan /Target	Trend/rating
1 - Waits >4 months for FSA (ESPI 2)	958	958	0	-958	
2 - Treatment >4 months from commitment to treat (ESPI 5)	391	823	0	-823	
% of accepted referrals for CT scans receiving procedures within 42 days	81.9%	66.3%	95.0%	-28.7%	
% of accepted referrals for MRI scans receiving procedures within 42 days	47.6%	50.8%	90.0%	-39.2%	
% accepted referrals for Coronary Angiography within 90 days	90.0%	100.0%	95.0%	5.0%	
4a - Elective Medical & Surgical caseweights versus contract (monthly provider arm delivered)	1,707	1,625	1,740	-115 (-6.6%)	
4b - Elective Medical & Surgical caseweights versus contract (ytd provider arm delivered)	6,697	6,892	6,724	168 (2.5%)	
7a - Acute Medical & Surgical caseweights versus contract (monthly provider arm delivered)	2,653	2,675	2,676	-1 (0%)	
7b - Acute Medical & Surgical caseweights versus contract (ytd provider arm delivered)	11,102	11,246	11,002	244 (2.2%)	

Key -

- Meeting target or plan
- Underperforming against target or plan but within thresholds or underperforming but delivering against agreed recovery plan
- Underperforming and exception report required with recovery plan

Note 1 Awaiting new definition from Ministry

Note 2 DOSA rates excludes Cardiac/Cardiology

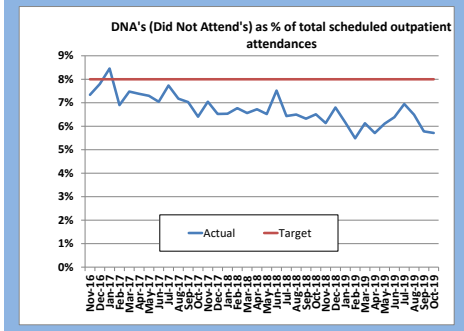
Note 3 Using SDHB historic definition not the one reported on by the MoH

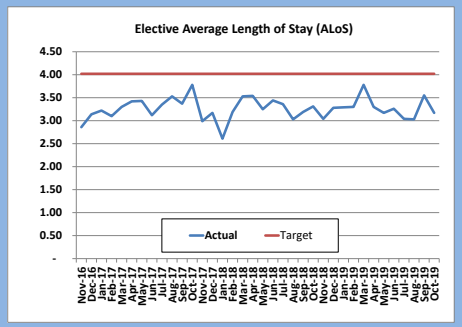
P = Pending

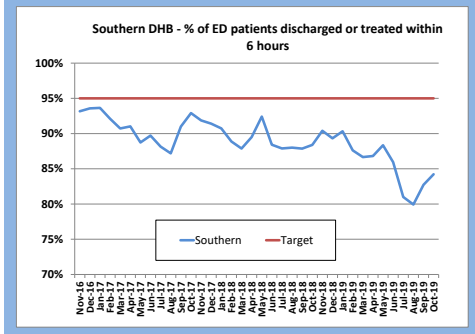
Cost/Productivity - Performance Report					
Monthly	Prior year	Actual	Plan / Target	Variance 'v Plan /Target	Trend/ rating
5 - Reduction in DNA rates	6.5%	5.7%	8.0%	2.3%	
9 - ALoS (elective) (Note 3)	3.31	3.17	4.02	0.85 (21.1%)	
ALoS (Acute inpatient) (Note 3)	4.11	3.70	4.25	0.55 (12.9%)	
DOSA (Note 2)	92.8%	91.4%	95.0%	-3.6%	

Southern DHB
Hospital Advisory Committee - Performance Report October 2019 Data

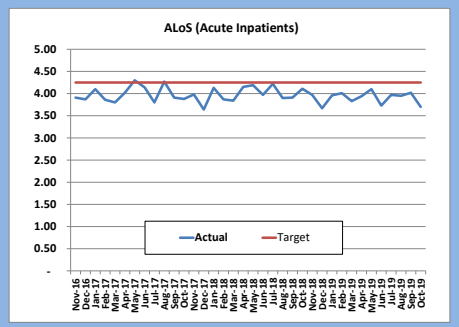
Elective Care

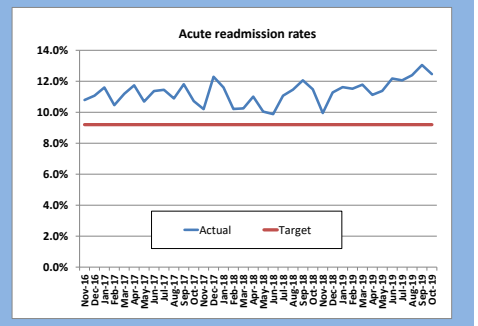






Acute Care

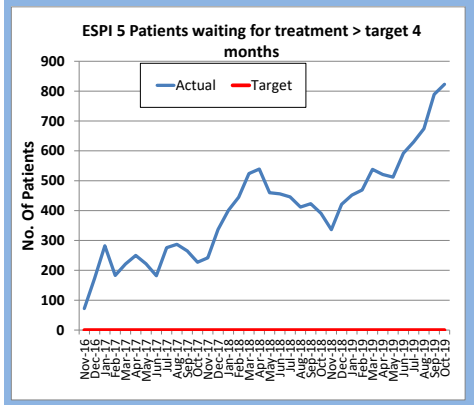


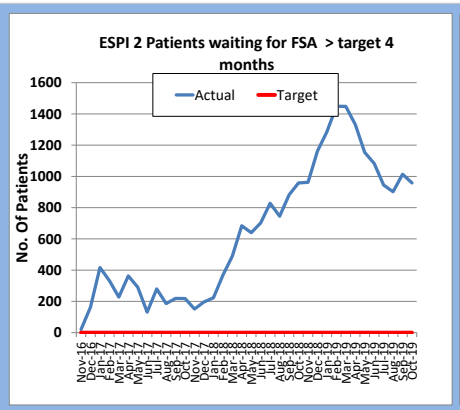


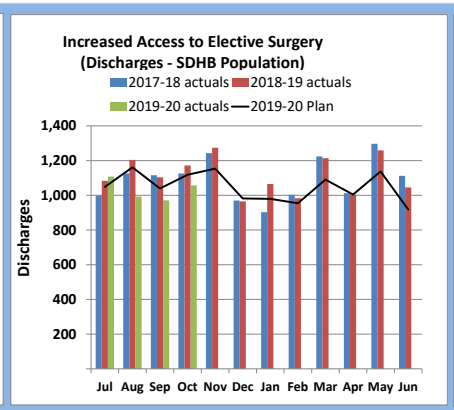
Southern DHB

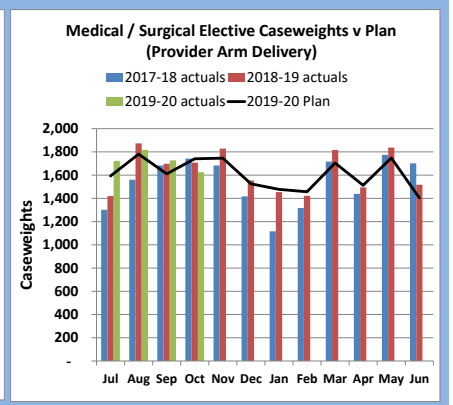
Hospital Advisory Committee - Healthcheck Report October 2019 Data

Elective Care

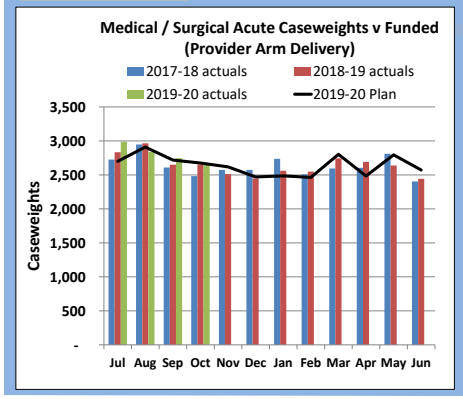








Acute Care



SOUTHERN DISTRICT HEALTH BOARD

5.1

Title:	**FINANCIAL REPORT**		
Report to:	Hospital Advisory Committee		
Date of Meeting:	27 November 2019		
SUMMARY: The issues considered in this paper are: ▪ October 2019 financial position.			
SPECIFIC IMPLICATIONS FOR CONSIDERATION (FINANCIAL/WORKFORCE/RISK/LEGAL ETC.):			
FINANCIAL:	As set out in report		
WORKFORCE:	No specific implications		
OTHER:	N/A		
DOCUMENT PREVIOUSLY SUBMITTED TO:	Not applicable, report submitted directly to Hospital Advisory Committee.	**DATE:**	
APPROVED BY CHIEF EXECUTIVE OFFICER:		**DATE:**	
PREPARED BY: Grant Paris Management Account – Clinical Analysis **DATE:** 20/11/2019		**PRESENTED BY:** Patrick Ng Executive Director of Specialist Services	
RECOMMENDATION: **That the Hospital Advisory Committee note the report.**			

SOUTHERN DHB FINANCIAL REPORT – Commissioners Summary for HAC

Financial Report for: **October 2019**
Report Prepared by: **Grant Paris**
Management Accountant
Date: **17 November 2019**

Overview

Results Summary for Specialist Services

Specialist Services encompasses the delivery of services across Mental Health, Surgical and Radiology, Medicine, Women's and Children's and Operations at SDHB at Dunedin and Invercargill Hospitals. It excludes support services such as Building and Property, Information Technology, Finance and SDHB Management.

Month				Year To Date		
Actual $000	Budget $000	Variance $000		Actual $000	Budget $000	Variance $000
53,546	53,151	395	Revenue	212,881	212,693	188
27,792	27,546	(246)	Less Personnel Costs	108,924	108,036	(888)
20,350	19,701	(649)	Less Other Costs	81,422	78,744	(2,678)
5,404	**5,904**	**(500)**	**Net Surplus / (Deficit)**	**22,535**	**25,913**	**(3,378)**

For October 2019, Specialist Services had a surplus of $5.4m, which is $0.5m unfavourable to budget. Year to date, Specialist Services surplus is $22.5m which is $3.4m unfavourable to budget.

October 2019 Result:

Year to date (YTD) surgical production plan caseweights were 107 over the budgeted 5,933 case weights, which offset the impact of inter district flows (IDF) on the 'population view' target. The production plan reflects our delivery of surgery in our own facilities (including outsourcing and outplacement) both for our own population and also for other populations, which are IDF inflows.

The population target was over achieved by approximately 76 case weights against a year to date plan of 6,291 case weights. This target includes the delivery of surgery to our population by other DHBs (IDF outflows).

The production plan was 141 case weights unfavourable for the month of October, driven partially by the MRT strike that reduced output by an estimated 60 caseweights due to;

- the unavailability of image intensifiers used in Orthopaedic surgery.
- cancelling Cardiac surgery which needed post operative imaging. (outsourced to Mercy)

The population target was 128 case weights unfavourable in October.

Planned Care Interventions Inpatient Surgical CWD Volumes - Southern DHB Summary

	October 2019				Year to Date				Annual
	Actual	Plan	Variance	Var %	Actual	Plan	Variance	Var %	Plan
SDHB Service Provider	1,416	1,557	(141)	(9%)	6,040	5,933	107	2%	17,047
Less IDF Inflows	31	44	(13)	(29%)	198	165	33	20%	482
Plus IDF Outflows*	131	131	0	%	525	523	2	%	1,569
Total Population View	**1,516**	**1,644**	**(128)**	**(8%)**	**6,367**	**6,291**	**76**	**1%**	**18,134**

(1) Actual IDF Outflow volumes for the current month are not available, and have been reported based on the planned numbers.

Statement of Financial Performance

Monthly Actuals $000s	Monthly Budget $000s	Monthly Variance $000s	Monthly Variance FTE		Year to date Actuals $000s	Year to date Budget $000s	Year to date Variance $000s	Year to date Variance FTE
				REVENUE				
				Government & Crown Agency Sourced				
8,831	8,794	37		MoH Revenue	35,383	35,182	201	
43	43	0		IDF Revenue	170	170	0	
1,113	791	322		Other Government	3,177	3,171	6	
9,987	**9,627**	**360**		**Total Government & Crown**	**38,730**	**38,524**	**206**	
				Non Government & Crown Agency Revenue				
256	183	73		Patient related	912	806	106	
157	195	(38)		Other Income	658	782	(124)	
414	**378**	**36**		**Total Non Government**	**1,571**	**1,588**	**(17)**	
43,145	43,145	0		Internal Revenue	172,581	172,581	0	
53,546	**53,151**	**395**		**TOTAL REVENUE**	**212,881**	**212,693**	**188**	
				EXPENSES				
				Workforce				
				Senior Medical Officers (SMO's)				
6,248	6,684	436	17	Direct	25,619	26,542	923	16
341	383	42		Indirect	1,425	1,541	116	
292	249	(43)		Outsourced	1,260	983	(277)	
6,881	**7,316**	**435**	**17**	**Total SMO's**	**28,304**	**29,066**	**762**	**16**
				Registrars / House Officers (RMOs)				
3,867	3,852	(15)	3	Direct	15,096	14,839	(257)	(1)
159	253	94		Indirect	812	1,008	196	
66	28	(38)		Outsourced	202	112	(90)	
4,092	**4,133**	**41**	**3**	**Total RMOs**	**16,110**	**15,960**	**(150)**	**(1)**
10,973	**11,449**	**476**	**20**	**Total Medical costs (incl outsourcing)**	**44,413**	**45,026**	**613**	**16**
				Nursing				
11,856	11,415	(441)	(83)	Direct	45,202	44,595	(607)	(58)
0	1	1		Indirect	40	5	(35)	
2	6	4		Outsourced	10	22	12	
11,858	**11,422**	**(436)**	**(83)**	**Total Nursing**	**45,251**	**44,621**	**(630)**	**(58)**
				Allied Health				
2,866	2,621	(245)	7	Direct	10,867	10,384	(483)	1
76	37	(39)		Indirect	276	147	(129)	
56	20	(36)		Outsourced	188	81	(107)	
2,998	**2,678**	**(320)**	**7**	**Total Allied Health**	**11,331**	**10,612**	**(719)**	**1**
				Support				
195	169	(26)	2	Direct	693	665	(28)	2
3	1	(2)		Indirect	6	5	(1)	
0	0	0		Outsourced	0	0	0	
197	**170**	**(27)**	**2**	**Total Support**	**699**	**670**	**(29)**	**2**
				Management / Admin				
1,756	1,804	48	(4)	Direct	7,181	7,014	(167)	(14)
2	18	16		Indirect	21	71	50	
7	5	(2)		Outsourced	29	22	(7)	
1,765	**1,827**	**62**	**(4)**	**Total Management / Admin**	**7,230**	**7,107**	**(123)**	**(14)**
27,792	**27,546**	**(246)**	**(58)**	**Total Workforce Expenses**	**108,924**	**108,036**	**(888)**	**(54)**
2,967	2,951	(16)		**Outsourced Clinical Services**	12,332	11,799	(533)	
0	0	0		**Outsourced Corporate / Governance Servic**	0	0	0	
0	0	0		**Outsourced Funder Services**	0	0	0	
7,418	6,726	(692)		**Clinical Supplies**	28,990	27,127	(1,863)	
1,157	1,030	(127)		**Infrastructure & Non-Clinical Supplies**	4,537	4,159	(378)	
				Provider Payments				
7,998	8,130	132		Mental Health	32,339	32,321	(18)	
				Non Operating Expenses				
810	864	54		Depreciation	3,227	3,338	111	
0	0	0		Capital charge	0	0	0	
0	0	0		Interest	0	0	0	
20,350	**19,701**	**(649)**		**Total Non Personnel Expenses**	**81,422**	**78,744**	**(2,678)**	
48,142	**47,247**	**(895)**		**TOTAL EXPENSES**	**190,347**	**186,779**	**(3,568)**	
5,404	**5,904**	**(500)**		**Net Surplus / (Deficit)**	**22,535**	**25,913**	**(3,378)**	

Revenue

Ministry of Health (MoH) Revenue

MoH revenue is $0.04m favourable to budget for the month and $0.20m favourable year to date. The main contributors are detailed below:

Category	Source	Monthly Variance $000s	Year-end Variance $000s	Comment
MoH Revenue				
Personal Health-side contracts	Bowel Screening	28	138	Additional contracted revenue partially offset by cost.
Public Health	Cervical Screening / Colposcopy	15	29	Year to date volumes higher than budgeted.
Clinical Training		(20)	(35)	Contracts have been reconciled to ensure eligible personnel have been recovered in billing.
Other		14	69	
Total		**37**	**201**	

Other Government Revenue.

Other Government revenue was $0.3m in October and on budget ytd. The major drivers for this are shown below.

Category	Monthly Variance $000s	Year-end Variance $000s	Comment
Haemophiliac rebate	124	341	Rebate reflecting increased cost
Orthopaedic ACC revenue	92	(265)	Review of billing process highlighted revenue not claimed in prior periods
Dental School	73	48	Dental revenue for hiring theatres to Dental school
Clinical Access	(2)	(124)	Overaccrued clinical access revenue from prior year.

Patient related revenue.

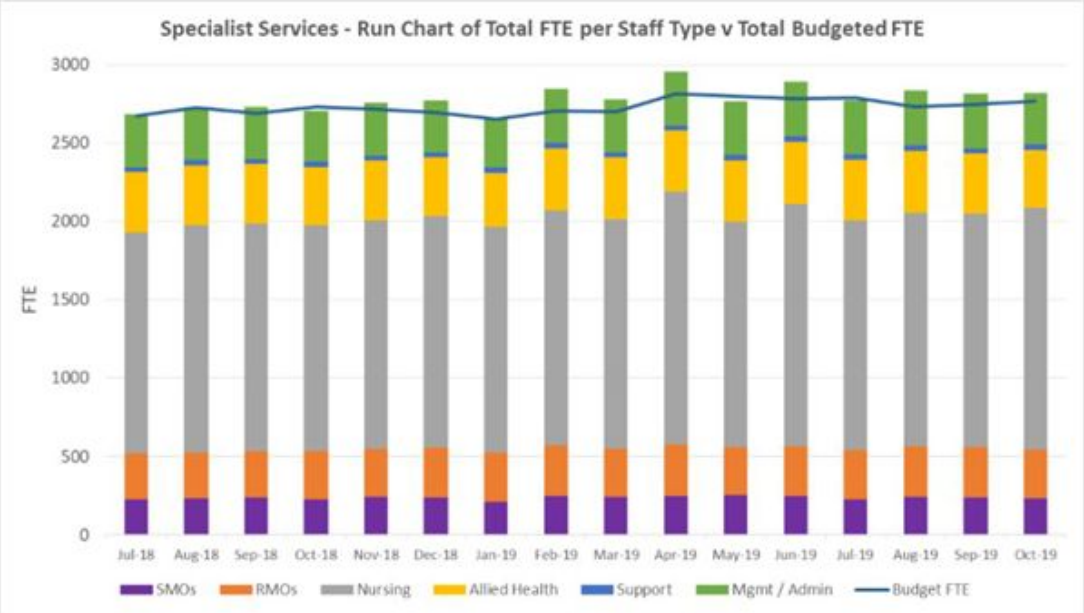
Patient related revenue is $0.1m over budget for the month and ytd driven by non-resident revenue. This revenue has been phased in the budget based on revenue received in prior years. This is unpredictable and will be subject to timing differences on a monthly basis.

Workforce Costs

Workforce costs (personnel plus outsourcing) were $0.25m unfavourable to budget in October and $0.88m unfavourable year to date. Operationally FTE were 58 unfavourable to budget in October and 54 full time equivalent (FTE) unfavourable for the year.

The main driver for the unfavourable workforce variance are direct costs which are $0.24m over budget in October due to unfavourable FTE variances

FTE



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
SMOs	229	232	238	228	243	237	213	248	242	249	252	247	229	245	241	231
RMOs	289	295	298	306	309	320	313	323	311	329	308	322	312	320	318	316
Nursing	1,412	1,449	1,451	1,445	1,453	1,478	1,441	1,496	1,462	1,614	1,438	1,541	1,468	1,492	1,490	1,540
Allied Health	383	384	378	368	380	371	345	399	392	388	392	397	381	394	383	369
Support	34	32	33	34	34	34	32	35	35	34	34	36	36	36	36	35
Mgmt / Admin	336	330	332	327	335	331	309	346	339	342	341	349	343	349	346	333
Total Actual FTE	**2,683**	**2,721**	**2,730**	**2,707**	**2,754**	**2,771**	**2,653**	**2,848**	**2,780**	**2,956**	**2,765**	**2,892**	**2,770**	**2,835**	**2,814**	**2,824**
Budget FTE	2,676	2,727	2,690	2,730	2,715	2,694	2,651	2,707	2,702	2,815	2,800	2,782	2,787	2,730	2,745	2,765
Variance	**(7)**	**6**	**(40)**	**22**	**(39)**	**(77)**	**(2)**	**(140)**	**(78)**	**(141)**	**35**	**(110)**	**16**	**(106)**	**(70)**	**(59)**

Monthly FTE is 58 over budget summarised in the following table, with the main contributor being Nursing FTE with 83 FTE over budget.

Staff Type	Actual FTE Oct19	Budget FTE Oct19	Monthly Variance	Actual FTE YTD Oct19	Budget FTE YTD Oct19	YTD Variance
SMO	231	249	17	237	253	16
RMO	316	319	3	317	316	(1)
Nursing	1,540	1,457	(83)	1,498	1,440	(58)
Allied	369	376	7	382	382	1
Support	35	37	2	36	37	2
Mgmt / Admin	333	329	(4)	344	330	(14)
	2,825	**2,767**	**(58)**	**2,812**	**2,759**	**(54)**

SMOs
SMOs were $435k favourable and 17 FTE favourable for the month. Joint Clinical (University of Otago/Southern DHB) continues to contribute 5 FTE of the favourable variance with vacancies for retirements that are yet to be filled.

RMOs
RMOs were $41k favourable and 3 FTE favourable for the month, reflecting a favourable variance in Course fees and Conferences offset by Overtime, Allowances and RMO Outsourced.

Nursing

The monthly unfavourable variance of $436k is due to;

	Monthly $000s	Year to Date $000s	Comment
Volume Variance	(519)	(1,630)	See below.
Rate Variance	103	1,105	Driven mainly by leave valuation caused by MECA changes and resulting valuation changes
Other	(15)	(85)	Allowances > budget
Indirect Costs	1	(35)	
Outsourced	4	12	
Total Variance	(436)	(630)	

Volume Variance – 83FTE unfavourable to budget
The volume variance, being the $ variance caused by the unfavourable variance in actual FTE and budgeted FTE is driven by;

- Management expenditure plans including valuing patient time and optimising positive shifts that are being implemented but as yet have not delivered the expected benefits.
- Consistent high numbers of patient watches resulting in Health Care assistants being 37 FTE over budget for the month & ytd.
- Higher levels of sick leave and training leave over budget for the month (17FTE).

Allied Health
Allied Health was ($320k) unfavourable and 7 FTE favourable for the month.

Allied Health had a MECA step increase in August 2019 which was budgeted for in November 2019 and that is contributing to the variance in the Allied Health workforce costs. In addition, the month end adjustment at September caused an understatement of costs ($94k) which reversed in October, causing an unfavourable dollar variance of $94k.

YTD Allied Health costs are $719k over budget.

- Indirect costs $129k over budget due to recruitment and relocation costs.
- Outsourced costs $107k over budget due to Anaesthetic Techs vacancies.
- Direct costs $483k over budget due to a combination of the MECA steps referred to above, overtime greater than budget by $393k and annual leave $200k over budget.

Support
Support were ($27k) unfavourable and 2 FTE favourable for the month.

There was an unfavourable ordinary rate variance this month due to a subset of Sterile Supply staff being budgeted for 2 payruns when they were actually paid for 3. This is a timing difference offsetting a July favourable ordinary time variance.

Overall ytd Support staff are unfavourable due to accident leave ($15k unfavourable) and annual leave ($11k unfavourable).

Management / Admin
Management Admin was $62k favourable for the month however 4 FTE unfavourable.

This was mainly due to an ordinary time favourable rate variance of $45k due to a different mix of staff in the Directorates than budgeted. Some staff have been seconded outside Specialist Services.

Outsourced Clinical Services costs
Outsourced services were on budget for the month and $0.53m unfavourable year to date.

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $
Radiology Service	335	244	(91)	1,388	976	(412)	2,827
Senior Medical Staff Surgical Service	350	270	(80)	1,201	1,081	(120)	2,709
Specialist Surgical Services Dunedin Service	467	406	(61)	1,796	1,622	(174)	3,882
General Surgery, Orthopaedics and Plastics Servi	230	326	96	1,263	1,302	39	3,320
Southern Blood and Cancer Service	1,399	1,516	117	5,815	6,061	246	17,873
Outsourced Clinical Services - Other	186	189	3	869	757	(112)	2,140
	2,967	**2,951**	**(16)**	**12,332**	**11,799**	**(533)**	**32,751**

Outsourcing in Radiology is unfavourable, reflecting cover for the lack of radiologists in Southland due to Parental leave and vacancies. This is partially offset by reduced SMO workforce costs. Ophthalmology is $83k favourable as there were no outsourced lists in October, assisting the pathway of managing the outsourcing cost down through to December when long-term SMO vacancies will be filled.

Vascular Assessments remain a focus in the coming months in both Surgical and Operations Directorates, the current YTD ($116k) unfavourable variance reflects a combination of higher costs and higher volumes than were budgeted. The Service Manager is directing workload to achieve expenditure at budget by year end.

Clinical Supplies (excluding depreciation)

Clinical supplies were unfavourable to budget by $0.69m in October and $1.86m year to date.

	Monthly Actual	Monthly Budget	Monthly Variance	YTD Actual $000s	YTD Budget $000s	YTD Variance	Annual Budget $
Blood	915	714	(201)	3,228	2,873	(355)	8,413
Air Ambulance	480	325	(155)	1,746	1,300	(446)	3,832
Pharmaceuticals	2,029	1,890	(139)	7,576	7,594	18	22,298
Hip Prostheses	343	211	(132)	1,151	870	(281)	2,590
Knee Prostheses	231	115	(116)	641	475	(166)	1,414
Cardiac Implants	155	87	(68)	534	357	(177)	1,062
Screws, nails and plates	256	188	(68)	957	771	(186)	2,298
Clinical Equipment - R&M	106	69	(37)	337	278	(59)	836
Implants and Prostheses - Other	104	83	(21)	292	343	51	1,021
Other monthly variances < $20k	2,159	2,194	35	9,249	8,805	(444)	26,030
Disposable Instruments	186	207	21	813	850	37	2,532
Ophthalmic Implants (Lenses)	(3)	18	21	84	72	(12)	215
Dressings	91	113	22	433	455	22	1,347
Catheters	144	170	26	695	693	(2)	2,016
Ambulance	66	100	34	355	400	45	1,179
Shunts and Stents	98	136	38	648	556	(92)	1,616
Spinal plates and screws	58	106	48	251	435	184	1,296
	7,418	**6,726**	**(692)**	**28,990**	**27,127**	**(1,863)**	**79,995**

The monthly unfavourable variance is driven by:

- $0.08m - Treatment disposables was unfavourable, the main driver being Blood costs which were $0.2m over budget. These exceed budget for a number of reasons;
    - Use of haemophiliac products is $0.1m over budget. Usage is dependant on if any of these patients present for treatment and is variable month to month. This is offset by the rebate received however.
    - Price increase is higher than the 2% budgeted resulting in a forecast overspend estimated at $0.01m per month.
    - Use of other high cost blood products such as Privigen and Intragam over budget. Privigen is an expensive medication that must be preapproved. It is for short term use before the patient moves to Intragam. On the Otago site there were two patients that received one off intensive therapy

  YTD treatment disposables are $0.57m unfavourable to budget.

- $0.30m unfavourable Implants and Prostheses – Implant costs are directly related to patient activity. Expenditure on:
    - Cardiac implants $0.07m over budget due to more TAVI's than budgeted,
    - Hip prostheses costs $0.13m over budget due to increased volumes of higher cost revision procedures than budgeted,
    - Knee prostheses costs $0.12m over budget due to increased volumes of higher cost revision procedures than budgeted and
    - Screws, nails and plates $0.07m unfavourable for the month.

  There was a partial offset favourable variance in spinal plates and screws and shunts and stents of $0.09m.

- $0.14m unfavourable Pharmaceutical spend in the Oncology Service, and Rheumatology, however on budget YTD.

- Air ambulance costs are $0.15m unfavourable for the month compared to budget reflecting continued high flight demand, (41 missions) including a PICU flight which incurs a higher cost than normal flights. The PICU flights attract a rebate and that has been accrued in October to offset against the cost. As at 31 October 2019 the MoH has still not confirmed the activity for the period January to August 2019, as a result the accrual for Air Ambulance services is $2,191k.

Infrastructure and Non-Clinical

These costs were $0.13m unfavourable to budget in the month and $0.38m unfavourable year to date, split per the cost categories below.

Group1	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD	$000 Full Year Budget
Hotel Services, Laundry & Cleaning	541	490	(50)	2,151	1,946	(206)	5,789
Facilities	99	69	(30)	300	280	(20)	827
Transport	197	173	(24)	730	749	18	2,220
IT Systems & Telecommunications	130	119	(11)	526	475	(51)	1,425
Professional Fees and Expenses	44	40	(4)	172	161	(11)	483
Other Operating Expenses	147	138	(9)	656	548	(108)	1,579
	1,157	**1,030**	**(127)**	**4,537**	**4,159**	**(378)**	**12,324**

Hotel services, laundry and cleaning reflect both the patient volume on patient meals and one-off cleaning. In addition, the impact of MECA settlements on food, cleaning and orderly service contracts have increased the cost.

Provider Payments

These costs were $0.13m favourable for the month and on budget year to date.

Non-Operating Expenses

These costs are favourable to budget made up of depreciation charges for clinical equipment and other equipment.

In Confidence Session:

RESOLUTION:
That the Hospital Advisory Committee reconvene at the conclusion of the public Hospital Advisory Committee meeting and move into committee to consider the agenda items listed below.

The general subject of each matter to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under section 34, Schedule 4 of the NZ Public Health and Disability Act (NZPHDA) 2000 for the passing of this resolution are as follows:

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.
2. Dunedin Hospital Redevelopment	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the OIA.
3. Building Projects	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the OIA.