SOUTHERN DISTRICT HEALTH BOARD
HOSPITAL ADVISORY COMMITTEE MEETING

Wednesday, 1 April 2015, 2.00pm

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

AGENDA

Tab

1. Presentation: Telemedicine Clinics in Paediatrics
   - Dr Ben Wheeler, Specialist Paediatrician

2. Welcome, Introduction and Apologies

3. Interests Registers

4. Minutes of Previous Meeting

5. Matters Arising

6. Review of Action Sheet

7. Monitoring and Performance Reports

   a) Executive Director of Patient Services Report

   b) Key Performance Indicators

   c) ESPI Progress

   d) Healthy Food and Beverages Environments Policy

   e) Financial Performance Summary

   f) Occupational Health and Safety Report

   g) Information Systems Report
      - ePrescribing Project Implementation Report

Public Excluded Session:

RESOLUTION: That the Hospital Advisory Committee 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 32, Schedule 3 of the NZ Public Health and Disability Act 2000 for the passing of this resolution are as follows:

General subject:	*Reasons for passing this resolution:*	*Grounds for passing the resolution:*
Previous Public Excluded Hospital Advisory Committee Minutes	As per reasons set out in previous agenda	S 32(a), Schedule 3, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.
Review of Public Excluded Action Sheet	Personal privacy and to allow activities to be carried on without prejudice or disadvantage	*As above, sections 9(2)(i), 9(2)(j) and 9(2)(a).*
Risk	To allow activities to be carried on without prejudice or disadvantage	*As above, sections 9(2)(i) and 9(2)(j).*
Serious Adverse Events	To allow activities to be carried on without prejudice or disadvantage	*As above, sections 9(2)(i) and 9(2)(j).*
Facilities update	Commercial sensitivity and to allow activities to be carried on without prejudice or disadvantage	*As above, sections 9(2)(i) and 9(2)(j).*
Hospital Services update	To allow activities to be carried on without prejudice or disadvantage	*As above, sections 9(2)(i) and 9(2)(j).*

Diabetes Telemedicine clinics – The Southern experience

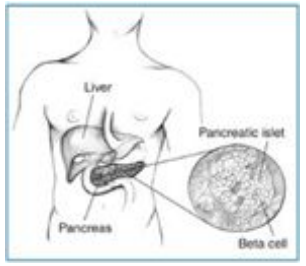
Dr Ben Wheeler

Paediatric Endocrinologist / Senior lecturer

University of Otago / SDHB

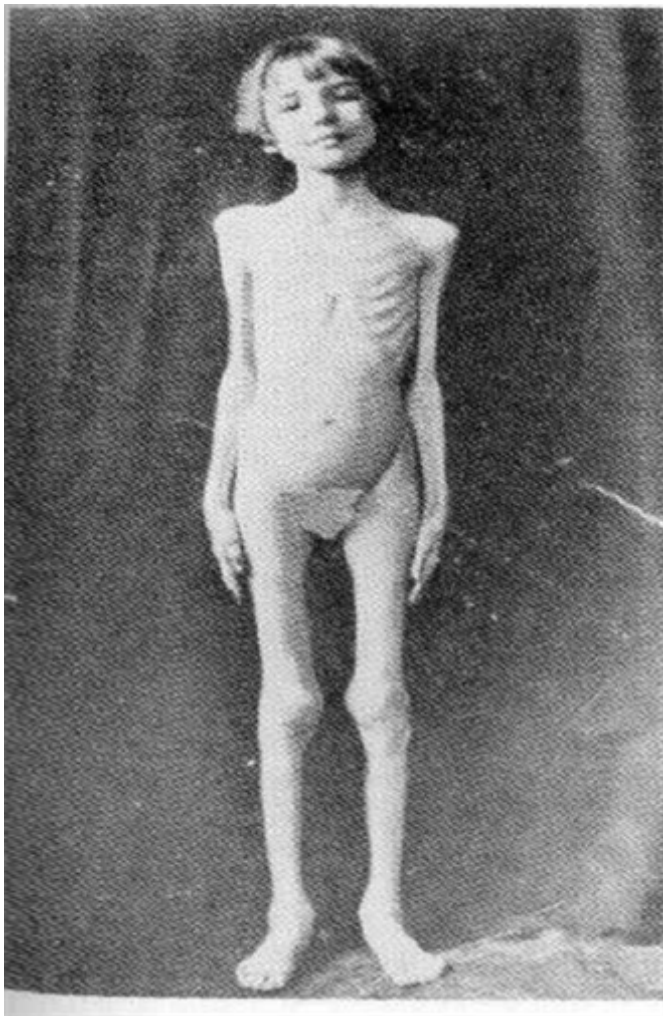
What is Diabetes?

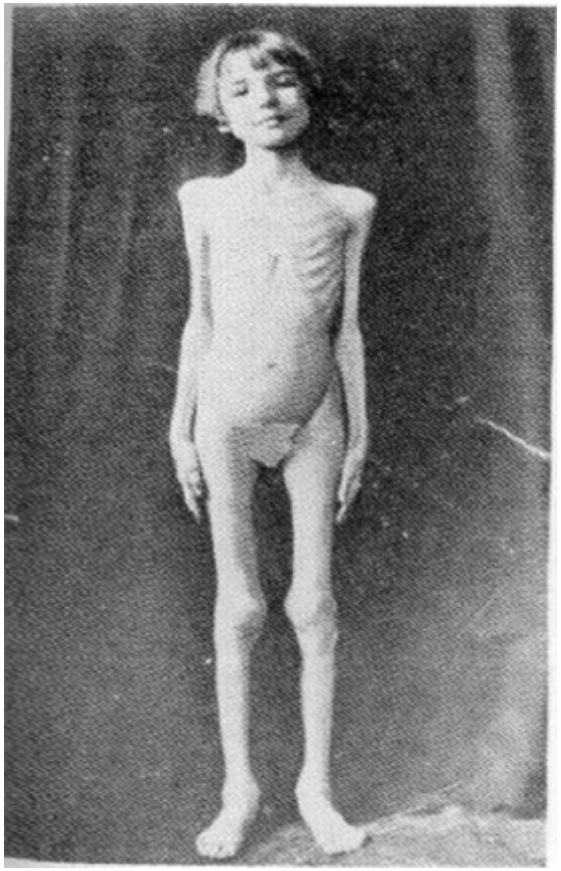
- A variety of disorders:
  - Failure of **Production and/or action** of insulin
  - Results in Hyperglycaemia

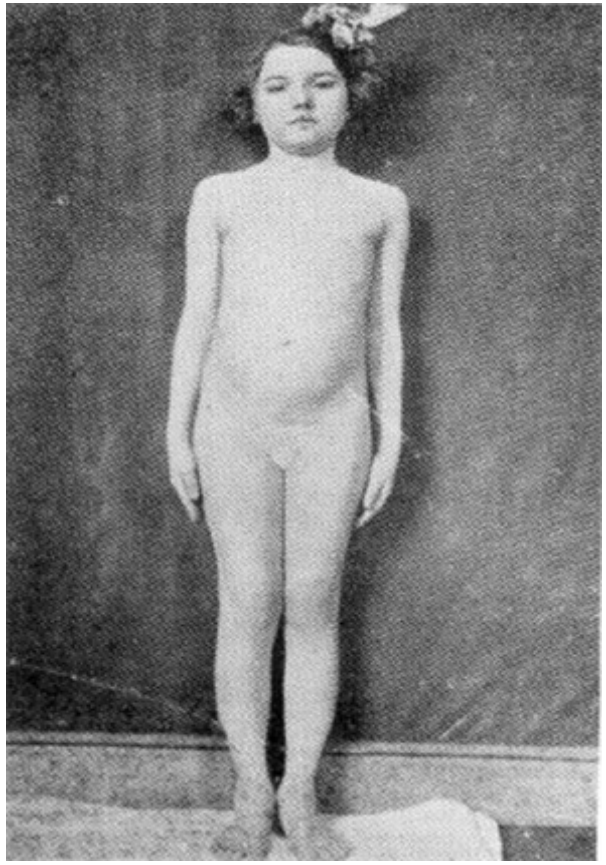


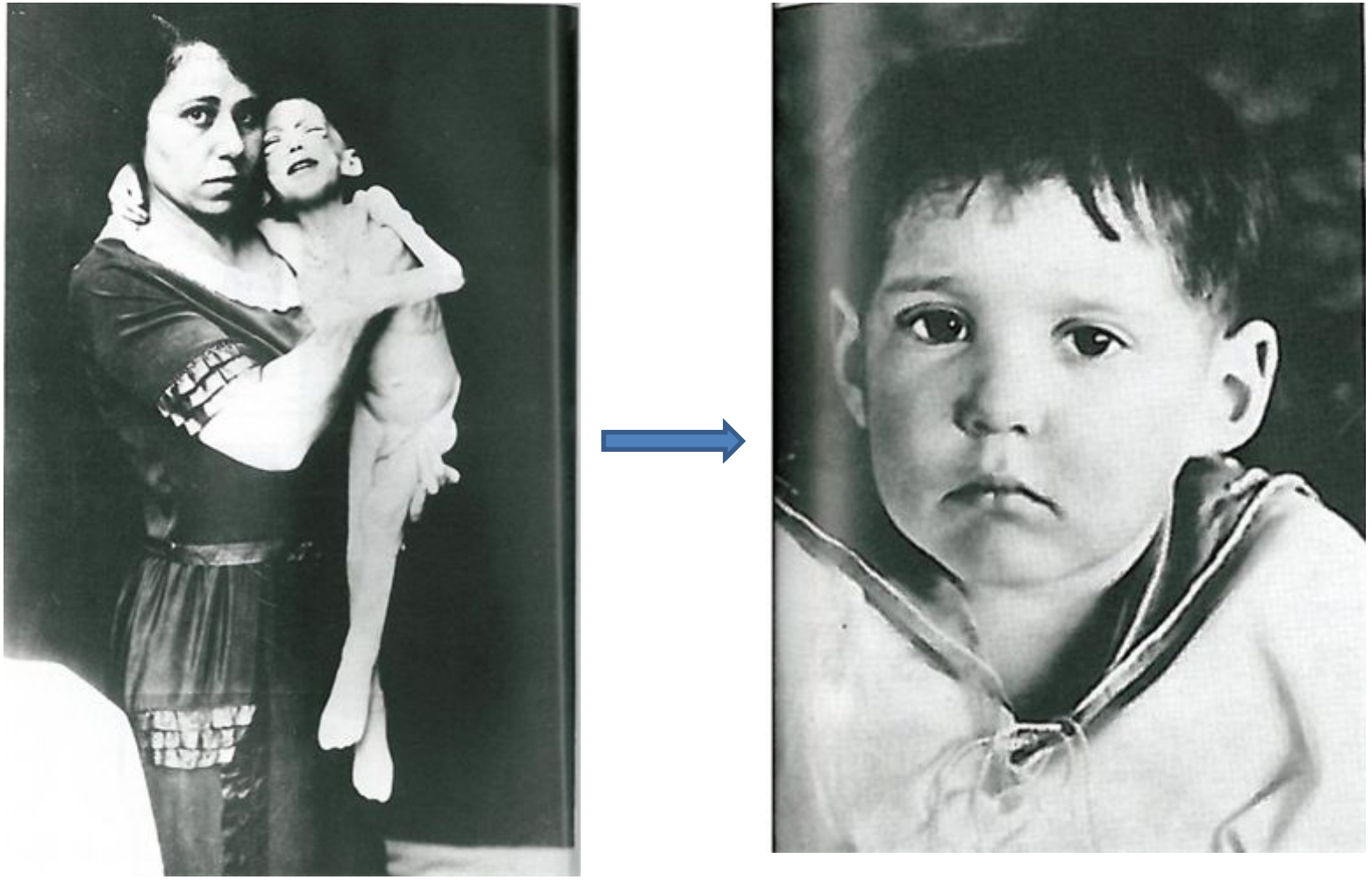
- Two main types: (recognised 1950's)
  - Type I diabetes (~90% of paediatric patients)
  - Type II diabetes (~90% of adult patients)
  - + other rarer situations

- Type I diabetes represents one of the most common chronic diseases in children









Background

- **<u>Intensive insulin regimens</u>** and support
  - can prevent and delay the onset of diabetes complications[1,2,3]
  - now the mainstay of modern T1DM management
    - MDI / Insulin Pumps
- Intensive therapy requires considerable support, education, and medical/team input
- Partnership between family/patient and MDT

[1]DCCT. NEJM. 1993;329(14):977-86; [2]Nathan DM et al. NEJM. 2005;353(25):2643-53; [3]DCCT. J Peds. 1994;125(2):177-88;

- Recommendations by all major bodies (in children) for at minimum 3 monthly review with a specialist[4,5]
  - How to do this in NZ and Australian contexts?
  - Many with T1DM living outside of main centres

- Telemedicine may have a role
  - "real time videoconference consultations with direct patient involvement"

[4]Craig ME et al. National evidence-based clinical care guidelines for type 1 diabetes. Australian Government, Canberra. 2011;
[5]Colaguiri S et al. Global IDF/ISPAD guideline for diabetes in childhood and adolescence. Brussels: 2011.

Telemedicine

- Allows a patient and clinician to see/talk
  - even though they are in different locations

- Potential benefits include:
  - Avoiding travel for the patient or clinician
    - Including all the costs / opportunity costs that go with this
    - Travel time
    - Time off work / school
  - Access to specific expertise
  - Decreasing the time patients wait to be seen

- Video superior to phone for transfer of clinical information
  - Also allows more participants

- T1DM represents an illness ideally suited for the development of telemedicine services
  - does not usually rely on clinical examination
  - based around support, education, and evaluation of medication dosage and blood glucose data

- Local experience:
  - Tele-diabetes clinics used in Queensland and NSW.

- In addition, in NZ two paediatric tele-diabetes clinics have recently commenced
  - Based out of Dunedin and Nelson

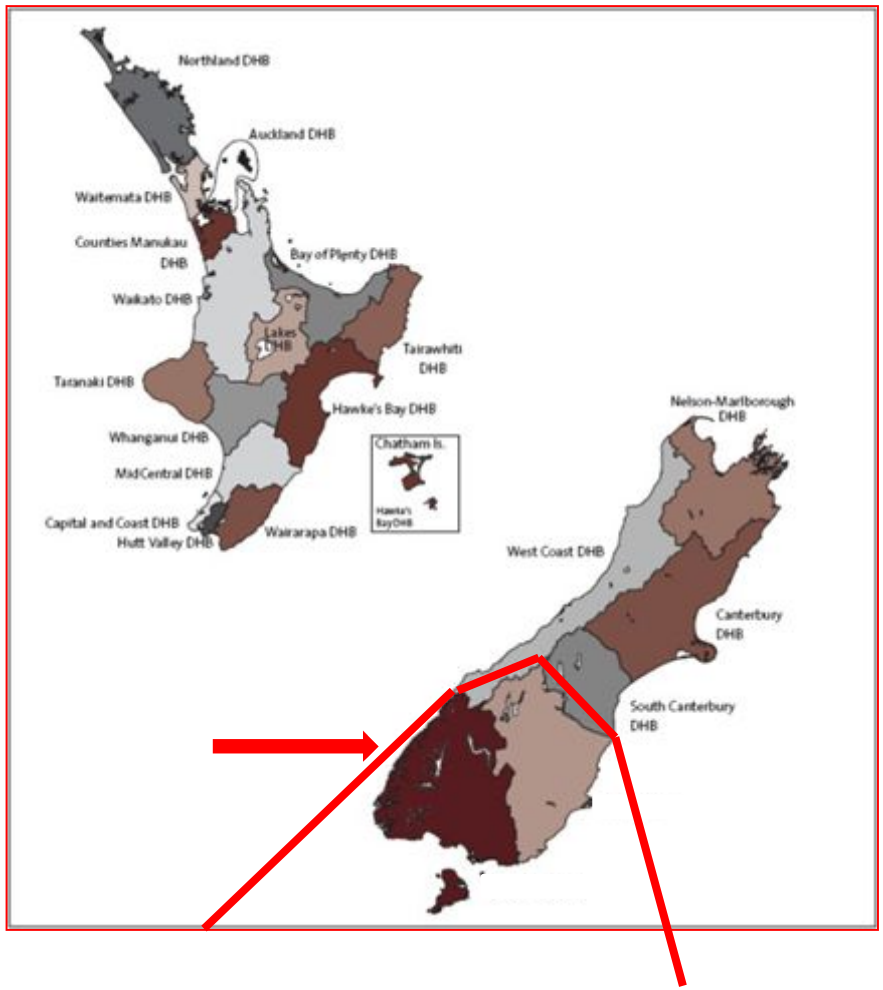
Evidence for Tele-diabetes clinics:

- Some evidence to suggest tele-diabetes clinics are well tolerated by families [1,2]
  - High levels of satisfaction and reliability reported
  - 95% felt little self-consciousness[2]
  - No data in the Australasian context
- Cost savings reported in Australia & US settings[2,3]
  - Reduced travel costs – patients and clinicians
  - Reduced hospitalisation costs
- Improved equity of care
- Reliability

[1] Guljas R et al. Impact of telemedicine in managing type 1 diabetes among school-age children and adolescents. J Pediatr Nurs. 2014;29(3):198-204.
[2]Malasanos et al. Improved access to subspecialist diabetes care by telemedicine. J Telemed and telecare. 2005;11:S1:74-76
[3]The costs and potential savings of a novel telepaediatric service in Queensland. BMC Health Services Research 2007, 7:35

SDHB –

- Paediatric diabetes southern region
- Largest geographical region in NZ
- Most sparsely populated
  - But
  - 160-170 children/families affected by diabetes
- Services from Dn & Inv
- Geography well suited to telemedicine…….



Paediatric Diabetes Team:

- Dunedin:
  - Dr Ben Wheeler – Paed Endo
  - Prof. Barry Taylor – Paed Endo
  - Ms Jenny Rayns – DNS
  - Ms Ruth Thomson – Dietician
  - Ms Carla Frewen – Diabetes nurse
- Invercargill/Queenstown:
  - Dr Paul Tomlinson – Diabetologist
  - Ms Julie Symons – DNS
  - Julia Cappie - Dietician
- Central Otago:
  - Ms Sharron Sandilands - DNS
  - Ms Nicky McCarthy – Dietician

Tele-diabetes services:

- ~20% of our diabetes population - Central & Oamaru
  - Traditional model – Dunedin based clinic
  - Outreach – minimum $2-3000/clinic (direct costs only)
- Central Otago - running
  - 6 - 8 hour round trip to Dunedin (~$1000/patient/yr)
  - Attend 30 minute clinic
  - Full day off work / school
  - Winter – frost / ice, occasional snow
  - +/- overnight stay hotel ($100/clinic)
- Oamaru – pending….
  - 2.5 - 4 hour round trip to Dunedin
  - Half -> full day off work / school
  - Winter – frost / ice
- Other sites???

To get started:

- Idea from training in NSW
- Prompted regularly by one family
  - Mother very keen
- Initial funding via Children's Health
- Southern Innovation Challenge

What is required:

- Equipment:
  - My office (with two monitors)
  - Clinic room at distant site + computer
  - Camera x 2 / Speakers x 2
  - Microsoft Lync ("skype for business") – standard on hospital system
  - Diasend - **vital**
  - Cables for meter download / scanner for log books

- Personnel:
  - Me
  - Health professional at distant site (Nurse and/or Doctor)
  - +/- Dietician at distant site (ideally)

Costs…..

- Equipment – minimal
  - Cameras etc. ~ $400 total
- Health Staff – as per traditional clinic
  - On salary
  - Me + Sharon (DNS) at distant end
  - Nurse prescriber
- My office
- Clinic room at distant site
- Administration
  - Booking at both ends

Advantages

- Families want / requesting this.....
- More patient centred- fits Southern DHB values
  - –MDT care delivered in their own region
  - –Less cost / inconvenience / safer
- Fosters inter-professional cooperation/ integration
- Significant cost savings over current and team outreach options
  - –Outreach minimum $2000-3000 / clinic
  - –Current travel costs to DHB $1000/patient/yr

Advantages (cont.)

- Optimises system capability, using current resources more efficiently
  - Ben only accredited Paed Endo south of Christchurch
- Small reduction in clinic work load for over worked Dunedin nursing/allied health staff
- Improved education and support for central DNS / team
- Improved transition to adult care
- Model could be used in other sites – Invercargill->QL

Disadvantages

- Retail economy of Dunedin may suffer slightly
- Potential for IT issues
  - Connection issues
  - Pump/meter Download issues

- Still need 1-2 face-face clinics/year face to face
  - ? more for newly diagnosed/complex patients

Remaining issues:

- Administrative
  - Few minor issues with bookings
    - Booking two locations
    - Text message reminders
- Funding
  - Few unanticipated issues regarding trust hospitals
    - ? Charges for clinic rooms / admin
    - Staff time
  - Working through this now

Evaluation:

- Recent funding application – SDHB health excellence awards
  - Collaborative study between SDHB and NMDHB teams
- Aims:
  - To evaluate the impacts of tele-diabetes clinics in the NZ context
    - From both family/patient and health professional perspectives
- Design:
  - Interviews of families/patients and staff
  - Survey of families/patients and staff

Final thoughts: Establishing a service

- **Determining need**
  - How far are patients/clinicians travelling to be seen?
  - Is access to care otherwise difficult? - disability, institutionalization, other factors
  - Are waiting times currently longer than they should be?
  - Are patients being seen by the right clinician for their condition?

- **Determining appropriateness -** It may not be appropriate to use if:
  - the primary driver is to save money
  - a physical examination is required for accurate assessment
  - For a first clinical assessment
  - The patient is unwilling

- **Patient engagement –** they appear to understand the value
  - Often they who go to the greatest effort to participate
  - Important to avoid assumption patients are willing
  - Ensure service developed in a way patients/families find acceptable
  - Cultural appropriateness

Acknowledgements:

- All members of our team
- Patients and their families
- Southern Innovation team

An apology has been received from Mrs Mary Gamble.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Joe BUTTERFIELD (Chairman)	21.11.2013 06.12.2010	Membership/Directorship/Trusteeship: 1. Beverley Hill Investments Ltd 2. Footes Nominees Ltd 3. Footes Trustees Ltd 4. Ritchies Transport Holdings Ltd (alternate) 5. Ritchies Coachlines Ltd 6. Ritchies Intercity ltd 7. Robert Butterfield Design Ltd 8. SMP Holdings ltd 9. Burnett Valley Trust 10. Burnett Family Charitable Trusts Son-in-law: 11. Partner, Polson Higgs, Chartered Accountants. 12. Trustee, Corstorphine Baptist Community Trust	1. Nil 2. Nil 3. Nil 4. Nil 5. Nil 6. Nil 7. Nil 8. Nil 9. Nil 10. Nil 11. Does some accounting work for Southern PHO. 12. Has a mental health contract with Southern DHB.
Tim WARD* (Deputy Chair)	14.09.2009 01.05.2010 01.05.2010	1. Partner, BDO Invercargill, Chartered Accountants. 2. Trustee, Verdon College Board of Trustees. 3. Council Member, Southern Institute of Technology (SIT).	1. May have some Southern DHB patients and staff as clients. 2. Verdon is a participant in the employment incubator programme. 3. Supply of goods and services between Southern DHB and SIT.
John CHAMBERS	09.12.2013	1. Employee Southern DHB and Vice President of ASMS (Otago Branch) 2. Employed 0.05 FTE as an Honorary Lecturer of the Dunedin Medical School 3. Director of Chambers Consultancy Ltd Wife: 4. Employed by the Southern DHB (NIR Co-ordinator)	1. Union (ASMS) role involves representing members (salaried senior doctors and dentists employed in the Otago region including by SDHB) on matters concerning their employment and, at a national level, contributing to strategies to assist the recruitment and retention of specialists in New Zealand public hospitals. 2. Possible conflicts between SDHB and University interests. 3. Consultancy includes performing expert reviews and reports regarding patient care at the request of other DHBs and the Office of the Health and Disability Commissioner.
Neville COOK	04.03.2008 26.03.2008 11.02.2014	1. Councillor, Environment Southland. 2. Trustee, Norman Jones Foundation. 3. Southern Health Welfare Trust (Trustee).	1. Nil. 2. Possible conflict with funding requests. 3. Southland Hospital Trust.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Sandra COOK	01.09.2011	1. Te Runanga o Ngāi Tahu	1. Holds a "right of first refusal" over certain Crown properties. Also seen as a Treaty partner and affiliates may hold contracts from Southern DHB from time to time. Is also a founding member of the Whānau Ora commissioning agency, Te Putahitanga o Te Waipounamu, established March 2014.
Kaye CROWTHER	09.11.2007 14.08.2008 12.02.2009 05.09.2012 01.03.2012	1. Employee of Crowe Horwath NZ Ltd 2. Trustee of Wakatipu Plunket Charitable Trust. 3. Corresponding member for Health and Family Affairs, National Council of Women. 4. Trustee for No 10 Youth Health Centre, Invercargill. 5. DHB representative on the Gore Social Sector Trial Stakeholder Group.	1. Possible conflict if DHB contracts HR services from JCL and Progressive Consulting, which are subsidiaries of Crowe Horwath NZ Ltd 2. Nil. 3. Nil. 4. Possible conflict with funding requests. 5. Nil.
Mary GAMBLE	09.12.2013	1. Member, Rural Women New Zealand.	1. RWNZ is the owner of Access Home Health Ltd, which has a contract with the Southern DHB to deliver home care.
Anthony (Tony) HILL	09.12.2013 02.12.2014	1. Chairman, Southern PHO Community Advisory Committee and ex officio Southern PHO Board. 2. Secretary/Manager, Lakes District Air Rescue Trust. Daughter: 3. Registrar, Cardiothoracics, Southern DHB	1. Possible conflict with PHO contract funding. 2. Possible conflict with contract funding.
Tuari POTIKI	09.12.2013 05.08.2014	1. University of Otago staff member. 2. Deputy Chair, Te Rūnaka o Ōtākou. 3. Chair, NZ Drug Foundation. 4. Director, Te Tapuae o Rehua Ltd 5. Director Te Rūnaka Ōtākou Ltd	1. Possible Conflicts between Southern DHB and University interests. 2. Possible conflict with contract funding. 3. Nil. 4. Nil 5. Nil
Branko SIJNJA*	07.02.2008 04.02.2009 22.06.2010 08.05.2014	1. Director, Clutha Community Health Company Limited. 2. 0.8 FTE Director Rural Medical Immersion Programme, University of Otago School of Medicine. 3. 0.2 FTE Employee, Clutha Health First General Practice. 4. President, New Zealand Medical Association	1. Operates publicly funded secondary health services under contract to Southern DHB. 2. Possible conflicts between Southern DHB and University interests. 3. Employed as a part-time GP.

Board Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB
Richard THOMSON	13.12.2001 23.09.2003 29.03.2010 06.04.2011 05.02.2015	1. Managing Director, Thomson & Cessford Ltd. 2. Chairperson and Trustee, Hawksbury Community Living Trust. 3. Trustee, HealthCare Otago Charitable Trust. 4. Chairman, Composite Retail Group. 5. Councillor, Dunedin City Council. 6. One immediate family member is an employee of Dunedin Hospital (Anaesthetic Technician).	1. Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it. 2. Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB. 3. Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations. 4. May have some stores that deal with Southern DHB.
Janis Mary WHITE (Crown Monitor)	31.07.2013	1. Member, Pharmac Board. 2. Chair, CTAS (Central Technical Advisory Service).	

*Mr Ward and Dr Sijnja have both tendered their resignations from SCL Otago Southland Ltd (SCLOS) and are not receiving directorship fees. SCLOS have advised their resigantions cannot be effected until contract variation executed by SDHB and SCLOS constitution varied.

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at February 2015

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Steve Addison	16.08.2014	1. Chair, Board of Trustees, Columba College 2. Mother-in-law, Gore District Councillor	
Peter Beirne	20.06.2013	Nil	
Sandra Boardman	07.02.2014	Nil	
Pania Coote	30.09.2011 30.09.2011 30.09.2011 30.09.2011 29.06.2012 26.01.2015 26.01.2015 26.01.2015 26.01.2015	1. Affiliation to Awarua, Puketeraki and Moeraki Rūnaka. 2. Member, Southern Cancer Network. 3. Member, Aotearoa New Zealand Association of Social Workers (ANZASW). 4. Member, SIT Social Work Committee. 5. Member, Te Waipounamu Māori Cancer Leadership Group. 6. National Māori Equity Group (National Screening Unit) – MEG. 7. SDHB Child and Youth Health Service Level Alliance Team 8. South Island DHBs Medcal Diagnostic Laboratory Steering Group. 9. Various SDHB operational Advisory Committees.	1. Possible conflict when contract with Southern DHB comes up for renewal. 2. Nil. 3. Nil. 4. Nil. 5. Nil. 6. Nil. 7. Nil. 8. Nil. 9. Nil.
Richard Bunton	17.03.2004 22.06.2012	1. Managing Director of Rockburn Wines Ltd. 2. Director of Mainland Cardiothoracic Associates Ltd. 3. Director of the Southern Cardiothoracic Institute Ltd. 4. Director of Wholehearted Ltd. 5. Chairman, Board of Cardiothoracic Surgery,	1. The only potential conflict would be if the Southern DHB decided to use this product for Southern DHB functions. 2. This company holds the Southern DHB contract for publicly funded Cardiac Surgery. Potential conflict exists in the renegotiation of this contract. 3. This company provides private cardiological services to Otago and Southland. A potential conflict would exist if

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	29.04.2010	RACS. 6. Trustee, Dunedin Heart Unit Trust. 7. Chairman, Dunedin Basic Medical Sciences Trust.	the Southern DHB were to contract with this company. 4. This company is one used for personal trading and apart from issues raised in '2' no conflict exists. 5. No conflict. 6. No conflict. 7. No conflict.
Carole Heatly	11.02.2014	1. Southern Health Welfare Trust (Trustee).	1. Southland Hospital Trust.
Lynda McCutcheon	22.06.2012	1. Member of the University of Otago, School of Physiotherapy, Admissions Committee.	1. Lead contact for University of Otago undergraduate clinical placements (Allied Health, Scientific & Technical professions) in Southern DHB.
Lexie O'Shea	01.07.2007	1. Trustee, Gilmour Trust.	1. Southland Hospital Trust.
John Pine	17.11.201	Nil.	
Dr Jim Reid	22.01.2014	1. Director of both BPAC NZ and BPAC Inc 2. Director of the NZ Formulary 3. Trustee of the Waitaki District Health Trust 4. Employed 2/10 by the University of Otago and am now Deputy Dean of the Dunedin School of Medicine. 5. Partner at Caversham Medical Centre and a Director of RMC Medical Research Ltd.	
Leanne Samuel	01.07.2007 01.07.2007 16.04.2014	1. Southern Health Welfare Trust (Trustee). 2. Member of Community Trust of Southland Health Scholarships Panel. 3. Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	1. Southland Hospital Trust. 2. Nil. 3. Nil.
David Tulloch	23.11.2010 02.06.2011 17.08.2012	1. Southland Urology (Director). 2. Southern Surgical Services (Director). 3. UA Central Otago Urology Services Limited (Director). 4. Trustee, Gilmour Trust.	1. Potential conflict if DHB purchases services. 2. Potential conflict if DHB purchases services. 3. Potential conflict if DHB purchases services. 4. Southland Hospital Trust.

4

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Wednesday, 4 February 2015, commencing at 2.00pm in the Board Room, Community Services Building, Southland Hospital Campus

Present:	Mr Tony Hill	Chairman
	Mr Joe Butterfield	
	Dr John Chambers	
	Mrs Mary Gamble	
	Mr Tuari Potiki	
	Mr Richard Thomson	
In Attendance:	Dr Jan White	Crown Monitor
	Mr Tim Ward	Deputy Chairman
	Mrs Kaye Crowther	Board member
	Dr Branko Sijnja	Board member
	Ms Carole Heatly	Chief Executive Officer
	Mrs Lexie O'Shea	Executive Director of Patient Services/Deputy CEO
	Mr Peter Beirne	Executive Director Finance
	Mrs Leanne Samuel	Executive Director Nursing and Midwifery
	Mr Richard Bunton	Medical Director of Patient Services
	Mr Grant Paris	Senior Business Analyst (via videolink)
	Ms Melissa Garry	Communications Officer (via videolink)
	Mrs Joanne Fannin	Board Secretary Southland

1.0 PRESENTATION – PACIFIC ISLAND NURSING MODEL OF CARE

The Executive Director of Nursing and Midwifery introduced the Pacific Island nursing team made up of Ms Aniva Ripley, Ms Litia Sabela and Ms Sandy Borland, Pacific Island Nurse Specialists; Ms Amanda McCracken, Nurse Practitioner and Ms Wendy Brown, Community Linkage Advocate, who joined the meeting to provide a presentation on the work done by the Pacific Island Nurse Specialist Service. The Pacific Island nursing model of care works well as the clinic is set in the community and patients engage well with the service. The model works well and could be used in other environments. The Chair thanked the Pacific Island team for their commitment over many years and commended them on the work they are doing for their people in the community.

The Pacific Island team left the meeting.

2.0 WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting. There were no apologies.

3.0 MEMBERS' DECLARATION OF INTEREST

The Chairman called for any adjustments or amendments to the Interests Register. None were received.

4.0 CONFIRMATION OF PREVIOUS MINUTES

It was resolved:

> "That the minutes of the 5 November 2014 Hospital Advisory Committee meeting be approved and adopted as a true and correct record."

5.0 MATTERS ARISING

There were no matters arising from the previous minutes that were not covered by the agenda.

6.0 ACTION SHEET

The Committee reviewed the action sheet and noted that:

Action Point 156 – HR Occupational Health and Safety report – ACC has advised that they no longer provide the benchmarking information requested.

It was resolved:

"That the action sheet be received."

7.0 EXECUTIVE DIRECTOR OF PATIENT SERVICES (EDPS) REPORT

The Committee received and considered the report from the EDPS. The Chair commended and congratulated staff on the outstanding results achieved within the Provider Arm.

The Committee received advice:

- That there were a number of acute trauma presentations towards the end of December that are not reflected in the numbers because they are only able to be counted on discharge and will be included in the January 2015 reporting.
- That the unfavourable financial result was due to one off expenses.
- That a media release has been issued around the pleasing result with the high immunisation rates achieved.
- On the media release issued in relation to the two new Computed Tomography (CT) scanners in Dunedin. The CT scanners went live in December 2014 with minimal disruption to patients.

8.0 KEY PERFORMANCE INDICATORS (KPIs)

The Committee received and considered the KPI reports and the Committee received advice:

- Relating to First Specialist Assessments (FSAs) and the follow-up area and that Clinicians are currently investigating processes in the area of out patients. The target date for the transition from a five to a four month wait time is July 2015.
- On the need to change the way in which follow-ups are done and have a greater focus on the FSAs.
- On day of surgery (DoS) admissions and that SDHB's expectation for DoS admissions is better than the national average.
- On SDHB's performance relating to readmissions.
- On the progress to four months wait for Outpatient and Inpatient Elective Service Performance Indicators (ESPI) markers – January 2015.
- In relation to the additional funding from the Ministry of Health (MoH) relating to the improvement in the percentage of patients receiving colonoscopies.
- And an assurance that staff keep a close watch to ensure that SDHB's standardised intervention rates are in line with other DHBs nationally.

9.0 QUALITY PROCESS MARKERS

The Committee received advice that the graph regarding the percentage of patients with an individualised care plan relates to patient falls. An update was received on actions being taken to progress to the national threshold identified. A request was made for future graphs to be linked to the report identifying the number of falls within SDHB.

10.0 HEALTH AND DISABILITY COMMISSIONER'S REPORT

The Committee received and considered the report and noted that the number of complaints received relating to SDHB were significantly below the national average and the number investigated by the HDC were comparatively low.

11.0 FINANCIAL REPORT

The Committee received and considered the Financial Report and a verbal update by the Executive Director of Finance. In discussion, the Committee received advice as follows:

- The unfavourable variance of $831K for the month is due to a number of one off costs.
- Due to the difficulties with budgeting over the December/January period, the December and January budgets should be considered together.
- In relation to Clinical Supply Costs, activity is 3-4% ahead of budget and costs are only 1% ahead of budget.
- An update was provided on the increased nursing costs related to unbudgeted resourcing required to cope with high activity and acuity, sickness and new projects and contracts. There have been some positive off-sets, e.g. the employment of spinal nurses in lieu of Senior Medical Officers (SMOs). Employment of Registered Nurses (RNs) was at a higher level of remuneration than anticipated in a number of areas and a budget anomaly, identified earlier in the year and reported on, has resulted in the majority of the unfavourable variance. Kiwisaver, parental leave, gratuities and a significant amount of other dollar impacts have also impacted the bottom line from a nursing perspective. In depth analysis is on-going relative to the issues identified.
- Discussion was held on the impact of Kiwisaver and the change from 2 to 3% contributions. The trends are being looked at as part of the 2015-16 budgeting round. The Executive Director of Finance advised that a report on the impact of Kiwisaver would be provided for the April 2015 Board meeting.

12.0 HUMAN RESOURCES OCCUPATIONAL HEALTH AND SAFETY REPORT

The Committee received and considered the Human Resources Occupational Health and Safety Report. Advice was received that it is proposed to undertake the staff vaccination campaign in a different way in 2015 with a view to increasing staff uptake. The main aim is to reduce harm to patients, staff and their families.

It was resolved:

"That the Hospital Advisory Committee recommends that the Board:

- Receive the report and supports the work being undertaken to address Southern DHB's strategy.
- Receives the report (appendix 1) and notes the comprehensive report relating to accident and injury data. Forthcoming health and safety legislation reform relating to governance, requires directors to exercise 'due diligence' which includes the establishment of strong and objective lines of reporting and communication to and from the board
- Receives the report (appendix 2) and notes the update from Worksafe New Zealand regarding the Health and Safety Reform Bill progress towards the new Health and Safety at Work Act 2015.

13.0 INFORMATION SERVICES DASHBOARD

The Committee received and considered the Information Services Dashboard and agreed that in future quarterly reports only from the South Island Information Systems Alliance will be included in the agenda.

14.0 BUILDING AND PROPERTY REPORT

The Committee received and reviewed the Master Site Planning Stage Two BECA Peer Review of Asset Condition Assessment Report on the economic viability of the Clinical Services Building, Dunedin. A further verbal update on the background to the report was provided and it was agreed that Southern DHB should limit expenditure on the Dunedin Clinical Services Building to urgent work.

It was resolved:

"That the Hospital Advisory Committee recommends that the Board receives the BECA Peer Review of the 2012 Dunedin Hospital Relifing Analysis with commentary on the future viability of the Clinical Services Building and resolves to:

1. Limit expenditure on the Dunedin Clinical Services Building to urgent work required to maintain current services and meet health and safety requirements.
2. Support the prioritising of work on a business case for the Dunedin Campus in collaboration with the National Health Board."

15.0 CONFIDENTIAL SESSION

At 3.35pm, it was *resolved*:

"That the public be excluded from the meeting for consideration of the following agenda items:

General subject:	*Reasons for passing this resolution:*	*Grounds for passing the resolution:*
Previous Public Excluded Hospital Advisory Committee Minutes	As per reasons set out in previous agenda	S 32(a), Schedule 3, NZ Public Health and Disability Act 2000 – that the public conduct of this part of the meeting would be likely to result in the disclosure of information for which good reason for withholding exists under sections 9(2)(a), 9(2)(f), 9(2)(i), 9(2)(j) of the Official Information Act 1982, that is withholding the information is necessary to: protect the privacy of natural persons; maintain the constitutional conventions which protect the confidentiality of advice tendered by Ministers of the Crown and officials; to enable a Minister of the Crown or any Department or organisation holding the information to carry on, without prejudice or disadvantage, commercial activities and negotiations.
Review of Public Excluded Action Sheet	Personal privacy and to allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i), 9(2)(j) and 9(2)(a).
Risk	To allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Serious Adverse Events	To allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Facilities Update	To allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).

Hospital Services update	To allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
Contracts - Moray Place Investments Limited Contract for the renewal of existing lease Level 2, 9 Moray Place - Lease for 78 Ribble Street, Oamaru - South Island Alliance Patient Information Care System (PICS)	Commercial sensitivity and to allow activities and negotiations to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).

The Committee resumed in public session at 5.15pm.

The meeting closed at 5.15pm.

Confirmed as a true and correct record:

Chairman: _____ Date: _____

HOSPITAL ADVISORY COMMITTEE (HAC)

Action Sheet from meeting held on 4 February 2015

Action Point No.	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
156 2014/09	HR Health & Safety Report (Minutes Item 10.0)	Future HR Occupational Health and Safety reports are to include a benchmark against other DHBs. This information should be accessible via ACC.	EDHR	ACC has advised that they no longer provide the benchmarking information requested.	Actioned.
158 2014/11	KPIs (Minutes Item 8.0)	Quarterly updates to be provided updating on trend of progress to four months wait for Outpatient and Inpatient Elective Services.	EDPS/DCEO	A quarterly update on trend of progress to four months wait for Outpatient and Inpatient Elective Services will be provided for the HAC meeting to be held in June 2015.	3 June 2015
161 2014/11	HR Occupational Health and Safety Report (Minutes Item 10.0)	To meet the requirements of the proposed new Health and Safety at Work Act 2015 (scheduled for April 2015), staff sickness is to be included in the Occupational Health and Safety Report.	EDHR	Staff sickness is to be included in the Occupational Health and Safety Report once the new Health and Safety at Work Act comes into effect. The information is included in the report.	1 April 2015
162 2015/02	Quality Process Markers (Minutes Item 9.0)	The graph heading 'Percentage of patients with an Individualised Care Plan' is to be changed to clearly identify it relates to patient falls and future graphs are to be linked to the report identifying the number of falls within SDHB.	EDPS/DCEO	The changes requested will be made and included with the reporting for the HAC meeting to be held in June 2015.	3 June 2015
163 2015/02	Financial Report (Minutes Item 11.0)	A report on the impact of Kiwisaver is to be provided for the Board meeting to be held on 2 April 2015.	EDF	A report on the impact of Kiwisaver is to be provided for the Board meeting to be held on 2 April 2015.	2 April 2015

SOUTHERN DISTRICT HEALTH BOARD

Title:	Executive Director of Patient Services
Report to:	Hospital Advisory Committee
Date of Meeting:	01 April 2015

Summary:

Considered in these papers are:

- February 2015 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 HAC agenda.	Date:
Approved by:		Date:

Prepared by: Executive Director of Patient Services/Deputy CEO Date: 17/03/2015	Presented by: Lexie O'Shea Executive Director of Patient Services

RECOMMENDATION:

That the Committee receive the report.

Executive Director of Patient Services Report – February 2015

Recommendation

That the Hospital Advisory Committee notes this report.

1. Contract Performance

- Total acute caseweights delivered (cwd) by the Southern DHB Provider Arm were 86 under plan in February 2015 (3%). Year to date, they are 313 cwd over plan (1%).
- Total elective caseweights delivered (cwd) by the Southern DHB Provider Arm were 4 under plan in February 2015 (0%). Year to date, they are 121 cwd over plan (1%).

2. Financial Performance

- An unfavourable variance of $49k was recorded by the Southern DHB Provider Arm for the month of February 2015. Year to date, the provider arm is $0.9m unfavourable.
- Revenue for February 2015 was unfavourable by $399k. Expenses for February 2015 were favourable against plan by $350k.

3. Health Targets

Shorter Stays in Emergency Departments (ED)

- Across the district February 2015 had 7% more presentations to ED than February 2014 (6247 in 2015 and 5832 in 2014).
- Performance against the '6 Hour Target' across the district was 93.3% in February 2015.
    - Dunedin ED – 93.6% for February
        - Presentations for the month of February increased with 3400 in 2015, a 7% increase on the 3173 presentations in February 2014.
    - Southland ED – 92.9% for February
        - Presentations for the month of February increased with 2847 in 2015, a 7% increase on the 2659 presentations in February 2014.

Immunisation

- The Immunisation health target for children aged 8 months continues to be 95%.
- The Target for Coverage for 2 year old children remains at 95%.
- For the month of February 2015 Southern DHB achieved 95% for coverage of children aged 8 months of age; with the interim quarterly coverage tracking at 95%.
- Coverage for children at 2 years of age is currently tracking at 94% for the quarterly result.

Better Help for Smokers to Quit

- The last quarterly result for the Better Help for Smokers to Quit health target was 95.4% of patients offered advice and help to quit at end of December 2014. The next quarterly result will be known at the end of March. The smokefree team is working with different wards to lower the number of post discharge calls needed. Smokefree support coverage is being broadened to help provide support to more people in the

community with projects like Babies and Mothers, as well as education and resources for wider teams like Neonatal Hearing Screening, Sexual Health Clinic and the Well Child Clinic. The Stop Smoking clinic continues to grow in Dunedin and is being promoted in every available opportunity.

- The first Southern Smokefree Planning Day for 2015 with Pubic Health South and WellSouth took place to maintain a joint approach to planning and delivering smokefree work across the district.

Shorter Cancer Wait Times

- Treatment within four weeks of their first specialist assessment 100% of the time.
- We are continuing to take certain cohorts of South Canterbury patients based on diagnosis types and fractionation. This was initiated by Canterbury DHB who would be the 'normal' providers for these patients. However, the principle behind the agreement is in line with the Ministry of Health's protocols around capacity sharing and which are designed to facilitate a regional, collaborative approach to the delivery of cancer services. We do monitor this carefully to ensure it can be achieved without impacting adversely on Southern's ability to deliver timely radiation therapy to its own population or to meet the shorter waits for cancer treatment health target.

- Improving Access to Elective Services

Elective Surgical Discharges February 2015

Elective Surgical Discharge Activity - Southern DHB population

	February 2015				Year to Date				Annual
	Actual	Plan	Var	Var %	Actual	Plan	Var	Var %	Plan
SDHB population treated inhouse	887	787	100	13%	7,161	6,697	464	7%	10,008
SDHB population treated by other DHB	32	47	(15)	(32%)	319	376	(57)	(15%)	563
SDHB population outsourced	2	8	(6)	0%	81	67	14	0%	96
	921	842	79	9%	7,561	7,140	421	6%	10,667

Elective Surgical Caseweights February 2015

Elective Surgical Caseweight Activity - Southern DHB population

	February 2015				Year to Date				Annual
	Actual	Plan	Var	Var %	Actual	Plan	Var	Var %	Plan
SDHB population treated inhouse	1,082	1,107	(26)	(2%)	9,184	9,425	(241)	(3%)	14,120
SDHB population treated by other DHB	75	85	(10)	(12%)	732	684	48	7%	1,025
SDHB population outsourced	3	11	(8)	(74%)	126	94	32	34%	179
	1,160	1,204	(44)	(4%)	10,042	10,202	(160)	(2%)	15,324

4. Operational Performance

- Elective Service Performance Indicators (ESPIs). The final ESPI graphs for January 2015 shows Southern DHB a red status for both ESPI 2 and ESPI 5, this was expected. Preliminary results for February 2015 have Southern DHB with a red status for both ESPI 2 and ESPI 5. The DHB will be red for two consecutive months and is planned to be amber for March 2015. The DHB is not at risk of funding impact unless a red status is recorded for four consecutive months.
- There are 17 patients in ESPI 5 without a date before the end of March and five patients in ESPI 2. Both ESPIs will be within the allowable buffer at the end of March if all surgery and outpatient clinics go ahead as planned.
- Key performance indicator graphs are attached and show operational performance.

5. Medical Directorate

- Cardiology angiogram waiting times, 97.7% for the month and above target of 90% of patients accepted for elective angiography receive their procedure within three months (90 days).
- Faster cancer treatment target the performance as per the below table. Southern achieved the third highest of the DHBs for quarter two. This is the first time the results have been published. SDHB achieved 75% (target is 85% of patients receiving their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016).

	Patients captured under 31 day target	31 days Achieved	Patients captured under 62 day target	62 days Achieved	Total
August 2014	28	89%	28	71%	56
September 2014	45	89%	23	65%	68
October 2014	46	85%	28	86%	74
November 2014	41	76%	33	73%	74
December 2014	34	79%	30	73%	64
January 2015	48	63%	36	78%	84
February 2015	27	70%	26	77%	53

- The percentage of patients receiving colonoscopies has been steadily improving with all three measures met for February. This means that additional incentive funding will be received from Ministry of Health for quarter three.

Performance against Ministry of Health Colonoscopy Waiting Times									
	Target 14/15	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15
Percentage of patients receiving urgent colonoscopy within 2 weeks/14 days	*75%*	76%	78%	78%	80%	81%	80%	70%	84%
Percentage of patients receiving non -urgent colonoscopy within 6 weeks/42 days	*60%*	69%	68%	74%	85%	86%	85%	73%	88%
Percentage of patients receiving surveillance colonoscopy within 12 weeks/84 days	*60%*	47%	66%	74%	89%	85%	97%	90%	91%

- A Dunedin Oncology Nurse has achieved Nurse Practitioner status. She is only the second nurse to achieve Nurse Practitioner status in Oncology in NZ. This is part of an immediate strategy to support the oncology assessment unit and the longer term strategy for service development moving to 2031.
- The Oncology service is proposing to commence a pilot of senior medical office (SMO) led virtual (telephone) clinics at the beginning of March. This is a pilot study over three months to determine whether a proportion of patients would prefer some of their follow-up clinic assessments to be conducted by telephone with their consultant.

Based on a recent head-count of patients who do not require physical examination at their next assessment it is estimated that 25% of patients will be eligible for the pilot study. The pilot concludes in June and results available in July 2015.

6. Mental Health, Addictions and Intellectual Disability Directorate (MHAID)

- Dr Brad Strong has been appointed as Medical Director for the directorate. The Minister of Mental Health has also appointed Dr Strong as our Director of Area Mental Health Services (DAMHS).
- An expression of interest has been submitted to participate in the Mental Health Commission led *Real Time Feedback* project. This project will enable service users to provide timely feedback following their intervention into an electronic system that will in turn provide service user satisfaction back to MHAID. This project is subsidised by the Mental Health Commission.
- The first *Safewards* workshop was held in February 2015. The Safewards model, developed in the United Kingdom after extensive research, encourages staff and patients on the ward to work together to reduce and manage patient behaviours that threaten their safety or the safety of others.
- Awareness raising sessions were facilitated around the launch of the Children of Parents with Mental Health Illness/Addiction (COPMIA) project. Whilst many children of parents who have mental health and/or addiction problems fare well, a proportion are vulnerable to a range of poor outcomes, including increased risk of developing mental health issues. This project aims to increase the capability of clinicians to identify and attend to the needs of these children and their family/whānau.

7. Older Person's Health, Clinical Support and Community Services Directorate

- Ministry of Health target of < 10% arrears (patients not seen in specified time frame) has not been met this month and was at 13%. However, Southern DHB has been successful in recruiting new graduate Dental Therapists in January and so this figure should come back into line.
- The Oral Health Service is currently working towards compliance with Dental Council Medical Emergencies in Dental Code of Practice. This requires all mobile dental units and fixed dental clinics to have resuscitation equipment and oxygen available by September 2015. This will incur costs (capital and on-going training requirements) to Southern DHB, which the clinical leadership team are currently evaluating.
- A district wide referral process for Dental Therapists referring to private dentists for work that is outside of their scope of practice has been implemented. Having a consistent district wide process will allow the Clinical Leadership to audit the type and level of referrals.
- A monthly Dietetic clinic at Lakes District Hospital commenced in February. This is contracted to a private provider, who also provides Dietetic services to Central Otago Health Services. The outpatient (with ability to see in-patients on an as and when needed basis) service means that Wakatipu residents no longer have to travel to Invercargill for this service.

8. Surgical Directorate

- A production planning workshop was held in February on the Dunedin site where the Midland DHBs presented their reports and provided guidance and advice on how Southern DHB undertakes this activity. Their input will assist the organisation in develping a more sophisticated production plan.
- Phase one of the National Patient Flow Project data is being submitted to the Ministry of Health. A road show around the rural and main sites will occur in April 2015. This will educate staff on what is required for phase two including the use of internal referrals. Phase two will require clincial staff to record outcomes from clinic visits. Clinician centric information is being developed by the Ministry of Health and this will

be distributed when available. This project will assist with data gethering for targets such as faster cancer wait times and it will enable a patient journey to be tracked.

- Quality Care at Best Cost is the district wide initiative within the operating theatres of the surgical directorate to investigate the prospect of working within our means and reducing waste. Opportunities have been identified in reviewing current controls, measures and processes around the supply and utilisation of theatre consumables. The main cost drivers have been identified in treatment disposables, instruments and equipment and implants. The collaborative multi-disciplinary work undertaken to date has resulted in the 14/15 goal of $500K being on track to be achieved.
- The two new urologists are now both at Dunedin Hospital in position. This brings the number of urologists to three. Urology multidisciplinary meetings commenced this month. This month has seen an increase in urology throughput however theatre capacity constraints remain. The haematuria see and treat clinic will begin next month. It is hoped that this, along with other ambulatory initiatives, will increase day case procedures. In Southland, it has been necessary to arrange locum assistance to cover on call requirements to maintain volumes in light of the reduction in tenths by the resident urologist. A meeting with all urologists within the district is planned for March to explore all aspects of service delivery now that the new urologists are all in place.
- The progress to meet four months data is attached.

9. Women's, Children's, Public Health and Support Directorate

- The diabetic telemedicine clinics held at Dunstan Hospital have set the scene for providing some clinics differently. This is being progressed by the Children's Health Service in conjunction with other key stakeholders.
- Regular communication continues with staff regarding the process for future service provision of the Tertiary Fertility Service. Transition planning has commenced between the DHB and Fertility Associates (FA), with staff engaged in this process. The scheduled date for transition to FA is 1 July 2015.
- Following notification by the Ministry of Primary Industries that it will not be renewing the contract where the Public Health team provide activities related to food compliance, from 30 June 2015, the service has been working with staff to manage this change.
- Southern DHB is continuing to implement the Violence Intervention Programme Plan. Training for staff who work with vulnerable children and the implementation of an alert system are the key priorities being implemented currently.
- Radiologist recruitment across the district continues. Two Radiologists commenced in the service recently. One is Dunedin Hospital based and the other one commenced in Southland Hospital taking the number to three Radiologists on this site. Further recruitment is in progress for remaining vacant positions and upcoming vacancies.
- The target waiting times for January 2015 (latest times available) for CT and MRI are 62.3% of CT referrals were scanned within six weeks against a target of 90%. A work plan is in place to improve this.
- 35.4% of MRI referrals were scanned within six weeks against a target of 85%. Radiology is in the process of investigation of this drop in performance for January.
- From early February 2015, all sonographer positions were filled. This has had a positive impact on our Ultra Sound (US) waiting time with routine US now being 16-21 weeks.
- Consultation with Food Service staff continues for the proposal to outsource food service provision. An extension to the timeframe was approved with the consultation period now closing on 9 April 2015. Two weekly meetings continue to be held with staff and unions to provide support and answer questions prior to consultation commencing. Other meetings are being held regularly with unions to clarify information required by the unions to be fully informed.

- A project is underway to identify and implement a staff travel strategy and process to ensure the provision of support to enable clinically and financially sustainable service delivery across the district.

10. Building and Property Services/Security

- Activity has increased this month as staff have returned from annual leave. A significant amount of planning and scheduling is still occurring to confirm the workload for the next six months. There are a large number of projects commencing which will be challenging and some external resources will be required to meet the demand.
- Security activity at the Dunedin site has been steady with a noticeable decrease in the duration of restraint events compared to January 2015. Concerns arising from Orientation Week activities and Cricket World Cup fixtures proceeded without any major disruptions. The congregation of large groups of friends of patients in the Emergency Department waiting room was closely monitored throughout this period. There were ten 'removal from site' events for the month but these also involved the removal of intoxicated visitors and ex-clients behaving inappropriately.
- The Energy Performance Contract V (EPC) - Southland project commenced on site on 26 January 2015 with work packages 1 – 8 completed. The work packages for the Clinical Services Building are programmed to be completed on 31 March 2015. This work has seen a number of faults within the system and plant which were unknown until this time. While this is an excellent result, carrying out the repairs is affecting our reactive budget. We have been advised by various departments that heating and cooling within their area has significantly improved.
- The work on the helipad continues as planned. The safety netting has all been replaced and completed. Work has now focused on the structural strengthening and everything is on track with no issues to date.
- The property at 257 High Street was offered to Ngai Tahu as per the Ngai Tahu Claims Settlement Act and the offer was declined. This property will be offered on the open market.
- Suppliers will be submitting quotations by mid-March to provide a radio communications system at Southland Hospital that will link security, the orderly service and Emergency Operations Centre (EOC) to facilitate operational requirements and disaster response. The radio communications system will also be upgraded at Dunedin, with an aim to connect radio communications between the Wakari and Dunedin sites to increase safety for the Wakari daytime officer and during after-hours site patrols. This level of coverage will have positive spinoffs when transporting staff to their vehicles and assist EOC communication with off-site health liaisons.

11. Performance Excellence and Quality

- Safety1st the Regional electronic integrated risk management system went live in Southern at the beginning of March 2015. This is part of the South Island (SI) regional initiative to support continuous improvements in safety and the experience of care. The implementation of this system is scheduled for all SI DHB hospitals and associated community services and may be extended to wider DHB services in the future.
- Safety1st will standardise the way in which information about risk, incidents and patient feedback is captured at both a local and regional level and it will enable services to better utilise this meaningful information to manage risk, report and make safety and experience of care improvements.
- The National Steering group established to develop Consumer Engagement Guidelines and resources for DHBs is expected to have the draft of the guidelines ready for regional consultation in May 2015. Southern DHB has provided the South Island clinical lead for this group Tim McKay, Clinical Director of Oral Health and he is working with a Canterbury consumer representative. Consultation meetings for the

SI are presently being organised. The guidelines will be finalised in June and Southern will work to develop the structure, systems and resources of consumer engagement in line with these. As a first step a stocktake of the consumer engagement activities in Southern is being undertaken.

- The Skills for Change Programme is a team-based training programme to teach staff skills to improve and solve problems within their services. The approach of the programme is part of Southern DHB's Performance Excellence and Quality Improvement Strategy, based on the proven methodology developed by Toyota, which provides a suite of tools for quality improvement work and structured problem solving.
- The fourth cohort, or intake of groups, commenced in Southland in March, with the Dunedin intake due to start in April 2015.
- So far there have been 22 teams through Skills for Change, and 80 staff. The teams come from a cross section of the DHB and some have also involved Non Government Organisation providers, demonstrating a cross-sector approach to health service problem solving.
- There is continued demand for the programme so cohort 5 is scheduled for July 2015 and more programmes are being planned for 2016.

Lexie O'Shea, Executive Director of Patient Services
Leanne Samuel, Executive Director of Nursing and Midwifery
Mr Richard Bunton, Medical Director of Patient Services

Southern DHB
Hospital Advisory Committee - KPIs
February 2015 Data

Patient Safety and Experience - Hospital Healthcheck				
Monthly	**Actual**	**Plan / Target**	**Variance**	**Trend/rating**
3 - Improved access to elective surgical services monthly (population based)	921	842	79 (9.4%)	
3a - Improved access to elective surgical services ytd (population based)	7,559	7,140	419 (5.9%)	

Patient Safety and Experience - Performance Report				
Monthly	Actual	Plan / Target	Variance	Trend/ rating
Waits for Cancer Services	100%	100%	0.0%	
11 - Reduced in stay in ED	92%	95%	-2.7%	
15 - Acute Readmission Rates	10.9%	9.2%	-1.7%	

Population Health				
16 - Smoking cessation - hospitalised smokers provided with advice and help to quit	95%	95%	0.4%	

Key -

Meeting target or plan

Underperforming against target or plan but within thresholds or underperforming but delivering against agreed recovery plan

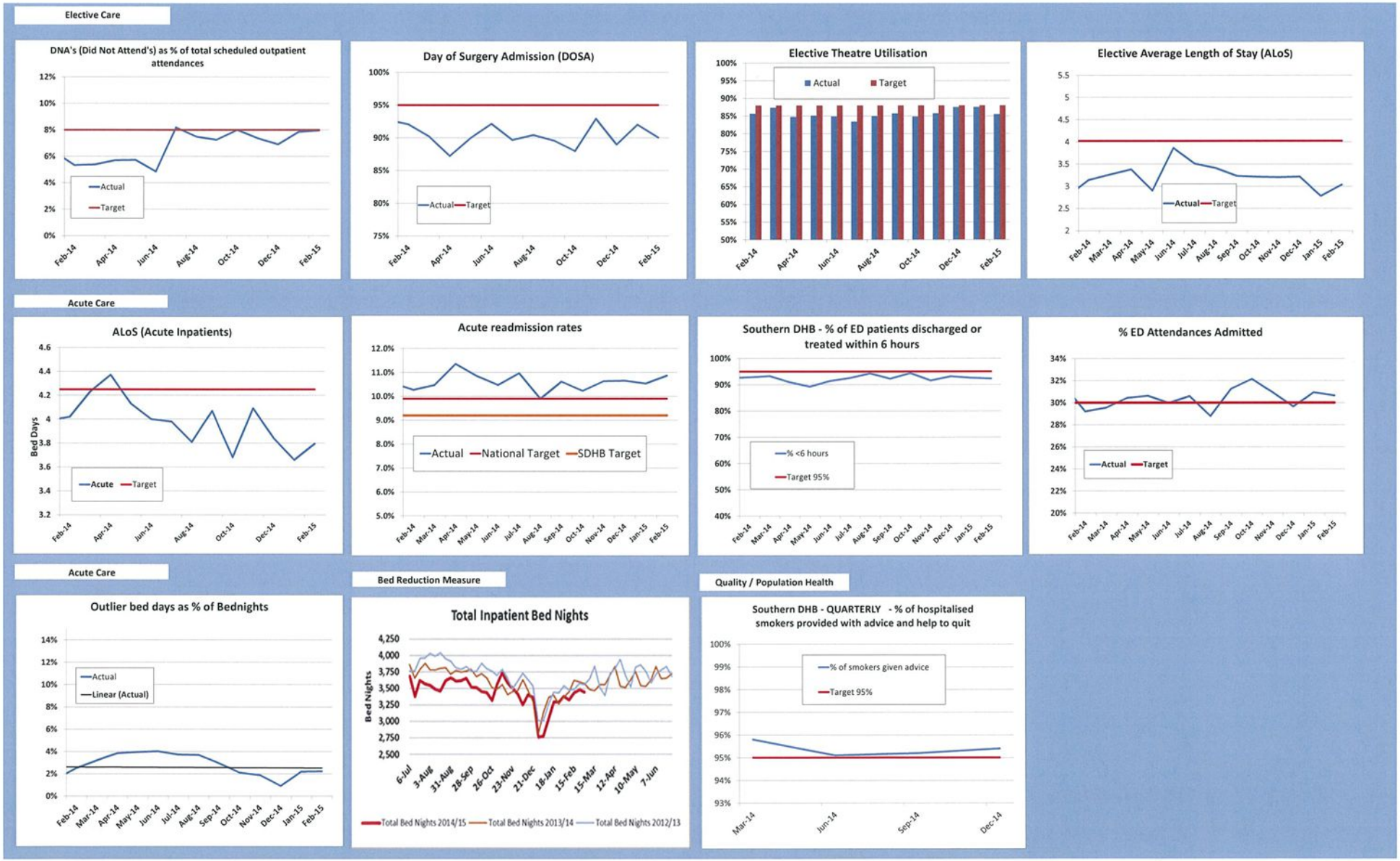
Underperforming and exception report required with recovery plan

Cost/Productivity - Hospital Healthcheck				
Monthly	**Actual**	**Plan / Target**	**Variance**	**Trend/rating**
1 - Waits >4 months for FSA	153	0	-153	
2 - Treatment >4 months from commitment to treat	114	0	-114	
4a - Elective caseweights versus contract (monthly provider arm delivered)	1,161	1,165	-4 (-0.3%)	
4b - Elective caseweights versus contract (ytd provider arm delivered)	9,996	9,918	78 (0.8%)	
7a - Acute caseweights versus contract (monthly provider arm delivered)	2,476	2,561	-85 (-3.3%)	
7b - Acute caseweights versus contract (ytd provider arm delivered)	22,072	21,893	179 (0.8%)	
10 - Voluntary staff turnover	0.6%	0.3%	-0.4%	
9 - Staff sick leave rates	2.5%	3.5%	1.0%	

Cost/Productivity - Performance Report				
Monthly	Actual	Plan / Target	Variance	Trend/ rating
5 - Reduction in DNA rates	8.0%	8.0%	0.0%	
7 - DOSA rates	90%	95%	-5.0%	
9 - ALoS (elective)	3.03	4.02	0.99 (24.5%)	
ALoS (Acute inpatient)	3.80	4.25	0.45 (10.7%)	
14 - % ED attendances admitted	30.7%	30.0%	-0.7%	
13 - Outlier bed days	2.2%			
Quarterly				
8 - Elective Theatre utilisation	85.5%	88.0%	-2.5%	

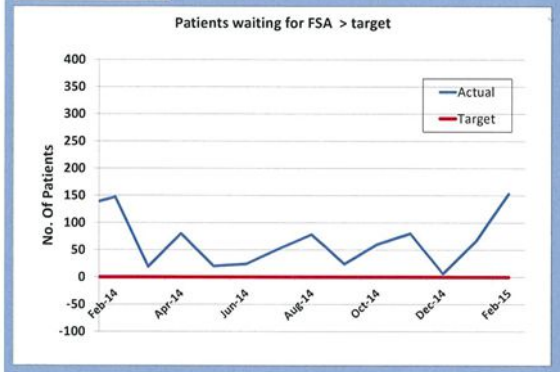
7.2

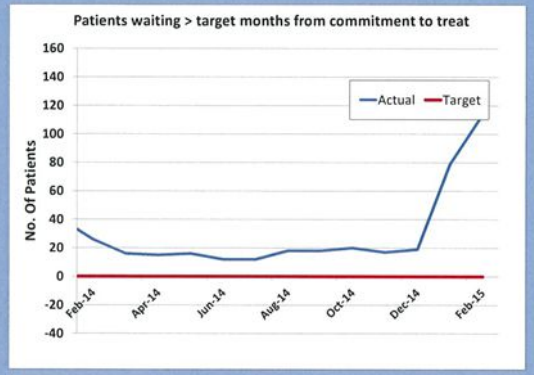
Southern DHB
Hospital Advisory Committee - Performance Report
February 2015 Data

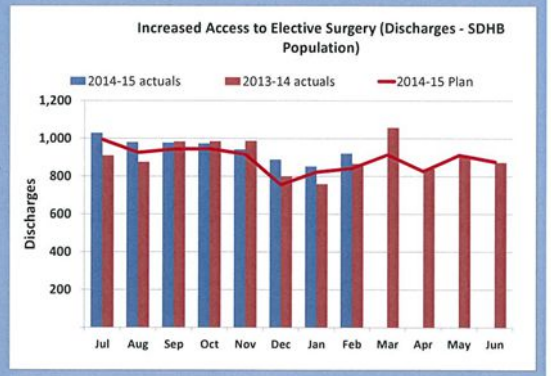


Southern DHB
Hospital Advisory Committee - Hospital Healthcheck
February 2015 Data

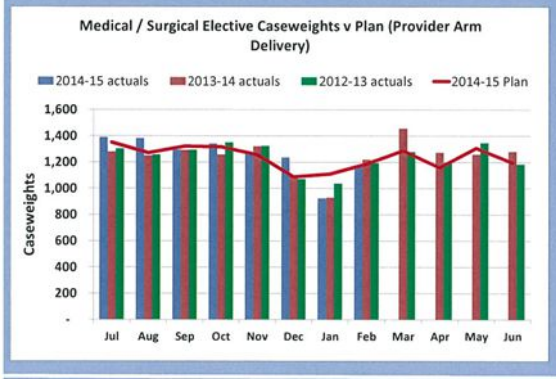
Elective Care

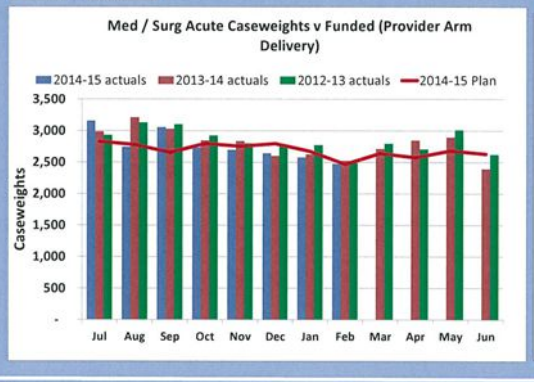




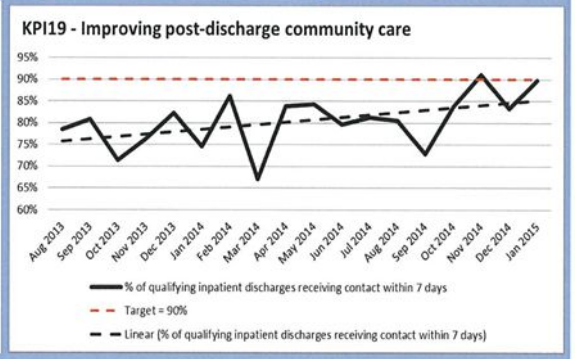


Acute Care

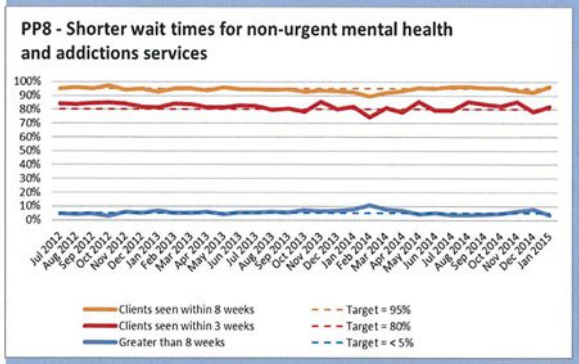




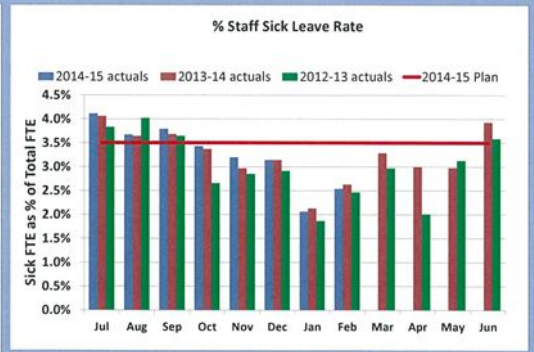
Mental Health and Addictions



Mental Health and Addictions

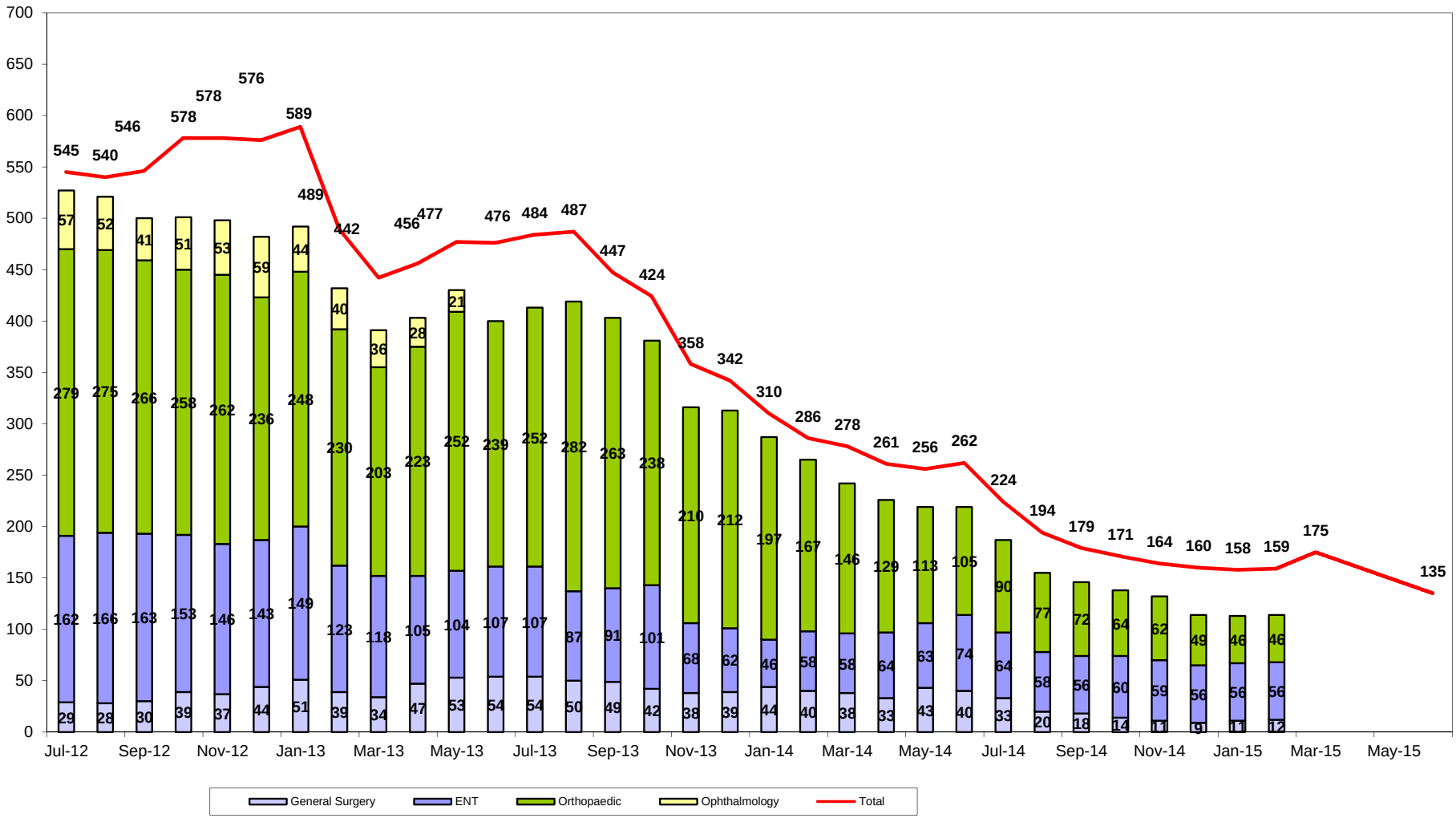


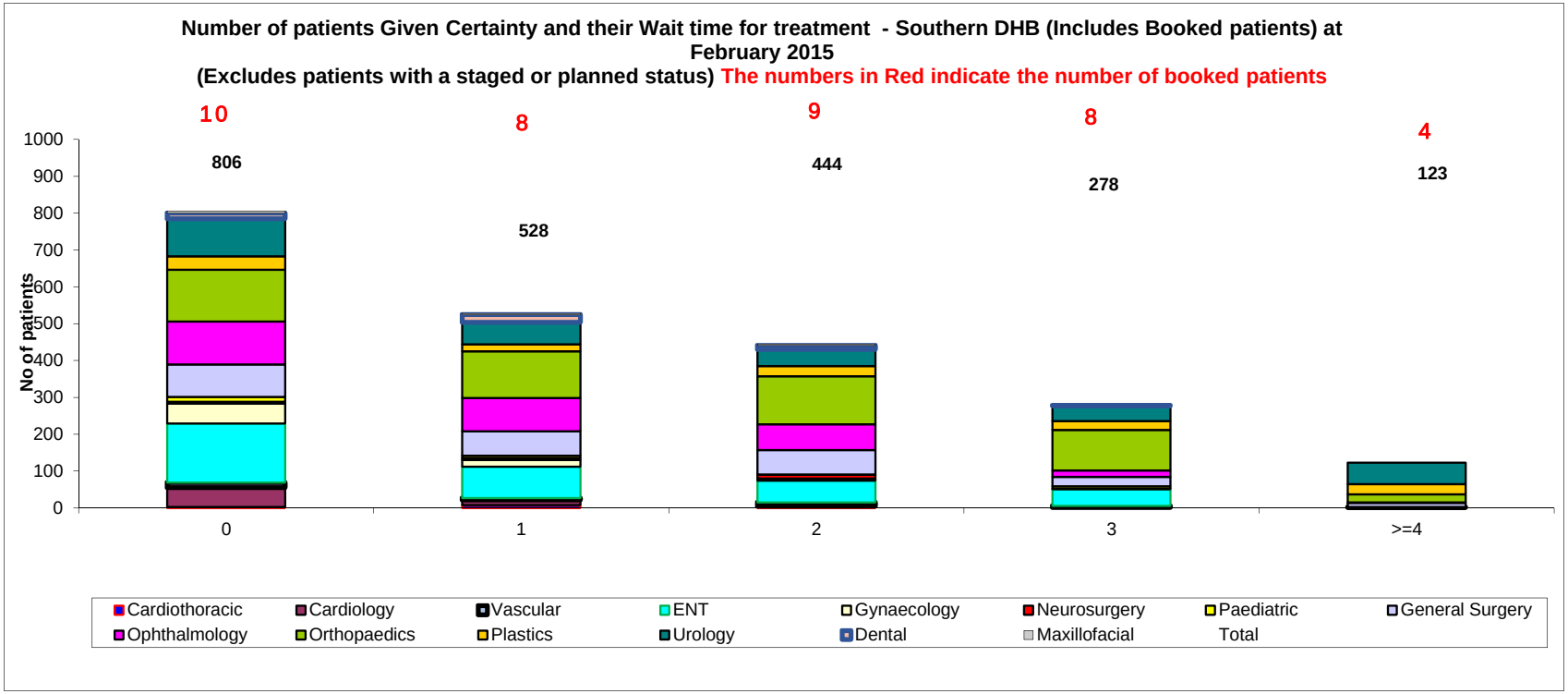
Service and Organisation Quality



7.2

Number of Patients on Active Review Southern DHB
Target: Total number in Active Review by June 2015 will be approximately 135 patients or 5% of total waiting list
Stack represents only those services with volumes greater than 20




Number of patients Given Certainty and their Wait time for treatment - Southern DHB (Includes Booked patients) at February 2015
(Excludes patients with a staged or planned status) The numbers in Red indicate the number of booked patients
10
8
9
8
4
806
528
444
278
123
No of patients
1000
900
800
700
600
500
400
300
200
100
0
0
1
2
3
>=4
Cardiothoracic
Cardiology
Vascular
ENT
Gynaecology
Neurosurgery
Paediatric
General Surgery
Ophthalmology
Orthopaedics
Plastics
Urology
Dental
Maxillofacial
Total

7.2

Progress to meeting 4 months

Report date: 16 March
Key Red >10, Yellow <10, Green 0

Speciality	Service Manager	Outpatients				Rurals			Inpatients				Comments
		Dunedin		Southland		Om	Du	Bal	Dunedin		Southland		**Note: This report is a compilation of feedback - critique of the report occurs during the week and is updated for the weekly report.**
		Pts	Risk	Pts	Risk					Risk	Pts	Risk	
Anaesthesia													
Cardiothoracic	Janine Cochrane												
Cardiology	Simon Donlevy, Noelle Bennett												
Dermatology	Simon Donlevy,	1											
Dental	Irene Wilson												
Endocrinology				1									
ENT	Judith Kissell, Carolyn Preston	1							5				
Gastro	Simon Donlevy			2									
General Medicine	Jenny Hansen Simon Donlevy,												
General Surgery	Judith Kissell, Helen Williams	16				1			1				
Gynaecology	Alison Gemmell,												
Haematology	Noelle Bennett												
Infectious Disease	Jenny Hansen												
Neurology	Judith Kissell, Helen Williams	10											**The neurology patients all have an appointment date in the Southland iPM**
Neurosurgery	Helen Williams	1											
Ophthalmology	Judith Kissell, Carolyn Preston	3		1									
Oral Maxillo													
Orthopaedics	Judith Kissell, Carolyn Preston	1					1		8		1		
Paed Medicine	*Caroline Folland*												
Paed Surgery	*Caroline Folland*												
Pain	Michael Dodds												
Plastics	Helen Williams Judith Kissell	19							6		1		
	Noelle Bennett												
Respiratory	Simon Donlevy												
Rheumatology	Judith Kissell, Carolyn Preston												
Urology	Judith Kissell, Helen Williams	25							13				
Vascular	Helen Williams	5											
Total		92							35				

	13-Oct	20-Oct	28-Oct	03-Nov	10-Nov	17-Nov	24-Nov	01-Dec	08-Dec	15-Dec	22-Dec	12-Jan	19-Jan	26-Jan	02-Feb	09-Feb	16-Feb	23-Feb	02-Mar	09-Mar	16-Mar
OP 4mth	316	284	242	451	370	279	280	270	116	82	50	217	131	105	472	285	211	151	410	184	92
OP 3mth	1013	923	852	1092	951	813	802	887	698	628	577	1112	1010	968	1396	1158	1039	971	1221	906	743
IP 4mth	152	143	136	228	196	168	157	161	99	69	51	134	108	97	184	151	132	129	234	136	35
IP 3mth	423	401	386	468	431	317	241	424	312	256	197	364	274	231	545	470	394	336	557	417	277

SOUTHERN DISTRICT HEALTH BOARD

7.4

Title:	Healthy Food and Beverages Environments Policy
Report to:	Hospital Advisory Committee
Date of Meeting:	01 April 2015

Summary:

The issues considered in these papers are:

Enclosed are the following draft documents for consideration and approval to adopt on behalf of Southern DHB.

- Healthy Food and Beverages Environments (2014)
- Healthy Food and Beverages Environments Policy District
- Healthy Food and Beverages Environments Policy and Position Statement

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

Financial:	N/A
Workforce:	N/A
Other:	N/A

Document previously submitted to:	N/A	Date:
Approved by:	N/A	Date:

Prepared by: Elaine Chisnall General Manager on behalf of Women's, Children's, Public Health and Support Directorate Date: 18/02/2015	Presented by: Lexie O'Shea Executive Director of Patient Services/Deputy CEO

RECOMMENDATION:

That the Hospital Advisory Committee recommends that the Board:

- Notes that the Committee endorses the Healthy Food and Beverages Environments Policy.
- Approves the adoption of the Healthy Food and Beverages Environments Policy.

Southern District Health Board - Healthy Food and Beverages Policy and Position Statement

Key Actions

1. Draft implementation plan with impact summary.
2. Endorsement by Senior Leadership Team including HR.
3. Endorsement by DHB Executive to progress.
4. Communication /consultation process.
5. Finalisation and Implementation.

Draft Implementation Plan

It is proposed to implement this policy in a number of phases.

PHASE One -

Activity	Action	Impact	Mitigation
Develop Communication plan.	Communication plan to include processes for communicating/ consulting with staff/ unions, contracted providers, and other key stakeholders.	Staff dissatisfaction. Media Interest. Contract provider dissatisfaction.	Clear communication regarding rationale. Phased approach to manage changes. Proactive communication. Proactive communication and align with contracts.
Implement healthy beverage guidelines.	Propose 3 month timeframe to move to full implementation.		
Remove sugary drinks from vending machines and beverage fridges .	Establish date to have all vending machine and beverage fridges free of sugary drinks – propose three month timeframe following approval of policy.	Changes / discussions required with contract providers to align with current contracts Incorporate into future contracts. Process for running down content of sugary drinks within vending machines and beverage fridges .	Proactive communication with contractors.

Activity	Action	Impact	Mitigation
Implement healthy beverage guidelines into Food Services catering /function guidelines.	Amend current catering/ function guidelines.	Change in documentation. Communication of new guidelines to all staff .	
Ensure all fundraising activities on DHB premises are in line with healthy food and beverage policy	Update requirements for approval to use DHB premises for fundraising activities.	All managers to monitor individual employee fundraising activities on DHB premises. Staff dissatisfaction limitations on fundraising activities.	
Evaluation of process for Phase One	Evaluate effectiveness of implementation.	Review any identified issues from the evaluation.	

PHASE Two

Activity	Action	Impact	Mitigation
Implement healthy food guidelines .	Propose 6 – 9 month timeframe to move to full implementation.		
Implement healthy food guidelines in DHB provided services and vending machines in the first instance.	Establish date to have staff cafeterias and vending machines providing an increased range of healthier options.	Changes/ discussions required with vending machine contract provider. Changes to food options available in staff cafeterias, including portion sizes. Any change in portion size and such like will require a revisit of prices.	
Remove snack boxes from DHB areas unless provider moves to providing options that fit with healthy food and beverage policy.	Remove snack boxes from DHB areas.	Changes/ discussions with current providers of snack boxes. There is no contract for this that we are aware of.	
Evaluation of implementation .	Evaluate effectiveness of implementation.	Review any identified issues from the evaluation.	

Communication Plan

- Communication/Consultation
  - Unions
  - Staff
- Communication with contract providers.
- Communication with other stakeholders such as University .

HEALTHY FOOD AND BEVERAGES ENVIRONMENTS POLICY (District)

Overview

The food and beverages New Zealanders eat and drink, balanced with the physical activity they undertake, has a major influence on their health. New Zealand is facing an epidemic of obesity, diabetes and other diet-related illnesses. Southern District Health Board (Southern DHB) is committed to promoting good health for all employees, patients and visitors by providing an environment that makes the healthy choice the easy choice. Southern DHB desires to be a positive role model for the community through the development and implementation of healthy food and beverage policies and supporting practices.

Purpose

The purpose of this policy is to ensure Southern DHB:

- provides an environment that actively promotes healthy eating and beverage choices
- demonstrates a commitment to the health and wellbeing of its employees by providing healthy eating and beverage options which meet the New Zealand Food & Nutrition Guidelines
- acknowledges the needs of different cultures, religious groups and those with special dietary needs, and will accommodate these on request, where possible and practicable.

Scope

This policy applies to:

- all food and beverages provided or able to be purchased within Southern DHB premises for consumption by employees or visitors
- any external parties contracted to provide food or catering services at any Southern DHB facility or function.

This policy excludes:

- patient meals and meals on wheels
- food and beverages brought to work by employees for their own consumption
- food and beverages provided by visitors/patients for their own use
- employees shared meals and celebratory events
- gifts from families/whanau of patients to employees.

However employees, clients/patients and families are encouraged to provide healthy eating options.

Policy

Southern DHB is committed to promoting good health for all employees and visitors by providing an environment that is supportive of healthy eating and beverage choices. These choices will reflect the Ministry of Health NZ Food and Nutrition Guideline statements for healthy adults.

Food and beverages provided for all employees and visitors to Southern DHB should meet the Catering Guidelines in Appendix 1 and the Beverage Guidelines in Appendix 2. Guidelines relating to vending machines and snack boxes; fundraising and gifts are located in Appendices 3 and 4.

This policy will be reviewed 12 months after initial adoption and thereafter in accordance with the MIDAS review cycle.

Responsibilities

DHB Executive	**Governance of Policy**
Senior Leadership Team	Implementation and monitoring of this policy within their Directorates. Using the relevant guidelines (see Appendices) as service specifications.
Service Clinical-Management Partnership	Implementation and monitoring of this policy throughout their service. Using the relevant guidelines (see Appendices) as service specifications.
All managers and team leaders	Implementation and monitoring of this policy within their area of responsibility. Using the relevant guidelines (see Appendices) as service specifications.
Food service providers on Southern DHB premises	Comply with the requirements of this policy for all food and beverages provided to or available for purchase by employees and visitors on Southern DHB premises or at any Southern DHB function.
Food Services – catering	Employees shall use the *DHB* Food Services for DHB funded functions on site. If the function is off-site then employees are encouraged to use Food Services or, when this is not possible, to follow the Catering Guidelines.

Associated documents

Breastfeeding-friendly Environments at Work (District) 44650

References

Healthy Eating - Healthy Action, Oranga Kai Oranga Pumau. Implementation plan 2004-2010. Wellington: Ministry of Health *(refer to page 4 for Key Messages)*

Food and Nutrition Guidelines for Healthy Adults - A Background paper (October 2003). Wellington: Ministry of Health

NZ Food and Nutrition Guideline statements for healthy adults. Wellington: Ministry of Health

Draft Guideline: Sugars intake for adults and children (March 2014). World Health Organisation

Nelson Marlborough District Health Board. (2014.) Healthy Eating for Staff and Visitors – Nelson Marlborough District Health Board Policy.

APPENDIX 1: CATERING GUIDELINES

Offer a variety of food and beverages to ensure healthy choices are always available:

- provide vegetable and/or fruit choices at every meal or function
- provide bread, pasta, rice, cereals and other grain products (at least 50% of sandwiches should be on wholemeal, rye or wholegrain)
- use low-fat milk and dairy products in cooked food where possible, e.g. trim milk, light cream cheese/sour cream, light yoghurt - and always offer low-fat milk with hot drinks
- provide a choice of lean meat, poultry, eggs, seafood, dried peas beans and lentils
- make at least 25% of sandwiches or savoury dishes vegetarian. Not all vegetarians eat eggs and dairy products, so it is advisable to include at least one vegetarian option without eggs or dairy
- portion sizes should meet the guidelines of the Food Service Provider contract and not be up-sized
- where practicable, food provided should be appropriate to the dietary, cultural and/or religious beliefs of individuals
- prepare and offer food and beverage choices with minimal fat, salt and sugar
- always provide water as a beverage option

Catering Orders:

When ordering lunches, it is recommended that high-fat baked products (pastries, cakes, biscuits, slices) are limited to one per person.

For morning and afternoon tea, it is recommended that lower-fat options such as muffins, scones, fresh fruit or sandwiches are ordered.

APPENDIX 2: BEVERAGE GUIDELINES

These guidelines apply to vending machines and beverage fridges

Sugar-sweetened beverages (SSBs) are a major risk factor for obesity, type II diabetes, tooth decay and a number of other diseases.

From **DATE**: do not offer any beverages that have added sugar pre-point of sale: this includes soft drinks, sugar-added fruit juices, sports drinks and sugar-added flavoured milk

- offer sugar-free versions of soft drinks, no-sugar-added juices, and water
- water can be provided in any portion size
- all remaining beverages sold need to have portion sizes less than 355ml

Excluded are hot beverages, such as tea and coffee, where sugar is added after point of sale

APPENDIX 3: VENDING MACHINES AND SNACK BOXES

Vending machine and commercial snack box contents should seek to achieve the "Better Vending for Health" nutritional criteria specified below. A minimum of 60% Better Choices and 40% Other Choices will be encouraged, with changes to this ratio being considered at each review of this policy.

	ENERGY	SATURATED FAT	SODIUM
BETTER CHOICES	≤ 800Kj per packet*	≤ 1.5g/100g	≤ 450mg/100g
	Excludes confectionary items - e.g. soft/hard lollies (candy), marshmallows, licorice, chocolate, carob or chewing gum. Sugar-free varieties are also excluded.		
OTHER CHOICES	≤ 800kJ per packet	Not restricted	

* For packets containing more than one serving of an item it is the packet size (not the serving size) that must meet these guidelines.

APPENDIX 4: FUNDRAISING AND GIFTS

• Items used, sold or promoted for fundraising on Southern DHB premises should be in keeping with the Southern DHB *Healthy Food and Beverage Environments* policy.

• Gifts offered to or by employees on behalf of Southern DHB if containing food (e.g. employees Christmas gifts or gifts to guest speakers) should be in keeping with the Southern DHB *Healthy Food and Beverage Environments* policy.

• Sponsorship arrangements within Southern DHB should be in keeping with the Southern DHB *Healthy Food and Beverage Environments* policy.

POSITION STATEMENT:

HEALTHY FOOD AND BEVERAGE ENVIRONMENTS (2014)

The food and beverages New Zealanders eat and drink, balanced with the physical activity they undertake, impacts upon their health.

The purpose of this position statement is to describe how the Southern District Health Board, as a lead provider and funder of health services, can contribute to reducing the harm caused by overweight and obesity.

The Southern District Health Board (Southern DHB) notes the growing burden of overweight and obesity experienced by people within the Southern District. This burden falls unequally on the population, as there is a clear association between deprivation and overweight and obesity which are a major risk factor for numerous health conditions. This results in significant impacts on individuals, family / whanau as well as a significant cost to the health system.

To reduce the impacts of the obesity epidemic, a range of strategies will be needed – as shown in the box below.

Southern DHB Strategies

- Provide leadership to facilitate effective implementation of evidence-based strategies to support the Southern district population to make healthy food and beverage choices
- Promote the health and wellbeing of DHB staff, patients and visitors by providing healthy food and beverage options in accordance with the New Zealand Food & Nutrition Guidelines
- Create an environment in DHB premises that makes healthy choices easy choices
- Support the development of a Health in All Policies (HiAP) approach across all sectors to reducing obesity. HiAP was defined at the World Health Organisation's 8th Global Conference on Health Promotion as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity." (World Health Organisation, 2013)

Supporting Evidence

Preamble

Overweight and obesity, and associated comorbidities contribute to create poor health outcomes which have been recognised as a global problem for the last two decades. New Zealand's obesity rates places it fourth worst in the OECD countries behind the United States, Mexico and Hungary (OECD 2013). Two in three adults and one in three children in known to be New Zealand overweight or obese (ANS08, CNS02).

The harmful effects of preventable diet-related non-communicable diseases – such as type 2 diabetes, heart disease and many cancers, including colon and post-menopausal breast cancers – are well documented. High body mass index (BMI) is now one of the three top risk factors contributing to ill health and disability, and shortening the life expectancy of New Zealanders (Ministry of Health, 2013).

Food environments

Little progress has been made in effectively changing what has been termed the "obesogenic environment", where unhealthy food consumption is encouraged and physical activity discouraged. Overweight and obesity are the natural consequences of an obesogenic environment. In New Zealand, the food environment is such that, energy-dense and nutrient poor food products (those with high levels of saturated fats, sugars and salt) are both readily and constantly available and also highly promoted – for instance as loss leaders in supermarket advertising. These products are formulated to be palatable, attractive to children and cheap. Combined with increasing portion sizes, these attributes contribute to overconsumption by individuals and thus to an overweight and obese society. Our more sedentary work and transport patterns exacerbate this situation.

As yet, no country has been successful in reducing the prevalence of obesity. There is an increasing body of evidence and some promising developments however there is a lack of published evidence in the area of brief interventions and population health strategies. A recent report, *Benchmarking Food Environments: Experts' Assessments of Policy Gaps and Priorities for the New Zealand Government,* has contributed much to the debate (University of Auckland, 2014). The Expert Panel recommended thirty four actions and prioritised seven for immediate action – those with particular relevance to Southern DHB are listed in Appendix 1.

Framework for action

The Ottawa Charter for Health Promotion provides a sound basis for improving population health. It recommends three key strategies - enable, mediate and advocate; and five key actions to enable people to increase their control over, and to improve their health:

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient health services

A combination of these actions is recognised as being more effective than a single action.

In its Policy Briefing, *Tackling Obesity,* the New Zealand Medical Association (NZMA) endorses a ***multi-pronged approach*** to reducing obesity. The NZMA believes that health professionals are uniquely placed to engage with obese patients. There is some evidence to suggest targeted brief interventions with obese patients can lead to changes in behaviour and body weight, at least in the short-term (Oxford, 2012).

A population health approach, tackling both policy and legislation, is recommended in order to create a supportive environment which will enable individuals to make choices that improve their health. Legislative, regulatory and policy interventions which focus of the upstream drivers of an obesity epidemic are generally more effective than those directed at modifying individual behaviours that contribute to obesity (NZMA, 2014).

Current New Zealand Status

- Overall, 31% of NZ adults are obese. The rates of obesity among adults are higher for Maori (48%) and Pacific (68%) than for Europeans (MOH, 2013b).Similarly, the rates of obesity are higher among Maori children – one in five – and Pacific children – one in four, compared with one in nine of New Zealand children overall. (ibid)
- The Southern DHB Health Profile 2013 states that Southern obesity levels are 29.8%, which is higher than the national average of 28.4%.
- A clear association between deprivation and obesity is known; with adults living in the most deprived areas being 1.5 times more likely to be obese than those living in the least deprived areas. This is even more noticeable among children, with those living in the most deprived areas being three times more likely to be obese than those living in the least deprived areas. (ibid) These are clear examples of health inequality.

- **Support for reducing the availability for sugar sweetened beverages:** Dietary sugars are accepted as a cause of weight gain and obesity. (Te Morenga, L. et al. 2013)
- The association between free sugars and dental caries has been established. (Moynihan, P, Kelly, S. 2014)
- Dietary sugar, especially from sugar-sweetened soft drinks, has been associated with cardiovascular disease, type-2 diabetes and gout. (New Zealand Beverage Guidance Panel. 2014.)
- The New Zealand Beverage Guidance Panel (2014) recommends that the health sector, including DHBs, identify sugar sweetened beverages as a priority for action and actively provide leadership on this issue which includes providing educational resources which outline the reasons for this stance. (ibid).

References:

Cavill N et al. Brief interventions for weight management. Oxford: National Obesity Observatory, 2011.

Health Partners Consulting Group.(2014) Southern District Health Board Health Profile. Auckland: HPCG. Accessed on 6 October, http://www.southerndhb.govt.nz/fil

Ministry of Health, 2013a.New Zealand Burden of Disease Study.Wellington: Ministry of Health.

Ministry of Health 2013b. New Zealand Health Survey: Annual update of key findings 2012/13. Wellington: Ministry of Health.

Moynihan, P, Kelly, S. (2014). Effect on Caries of Restricting Sugars Intake Systematic Review to Inform WHO Guidelines.*J Dent Res.* 93:8-18

New Zealand Beverage Guidance Panel. (2014). Policy Brief: Options to Reduce Sugar Sweetened Beverage (SSB) Consumption in New Zealand, Consultation Document. Retrieved from: http://www.fizz.org.nz/sites/fizz.org.nz/files/Policy%20Brief%20-%20Options%20to%20reduce%20sugary%20drink%20intake%20in%20NZ%20(2).pdf

New Zealand Medical Association 2014.Policy Briefing. 'Tackling Obesity'.

OECD (2013). "Overweight and obesity", in OECD Factbook 2013: Economic, Environmental and Social Statistics, OECD Publishing.

Te Morenga, L, Mallard, S, Mann, J. (2013). Dietary Sugars and body weight: systematic review and meta-analyses of randomised controlled trials and cohort studies. *BMJ.*346.

University of Auckland, 2014.*Benchmarking Food Environments: Experts' assessment of policy gaps and priorities for the New Zealand Government.* Auckland: University of Auckland

World Health Organisation, (2013).8th Global Conference on Health Promotion, *Conference Definition, Health in All Policies.* Retrieved from: http://www.healthpromotion2013.org/health-promotion/health-in-all-policies

Appendix One

Source: Benchmarking Food Environments: Experts' assessment of policy gaps and priorities for the New Zealand Government. Auckland: University of Auckland, 2014.

Key Definitions:

Food environments: Are the collective physical, economic, policy and socio-cultural surroundings, opportunities and conditions that influence people's food and beverage choices and nutritional status

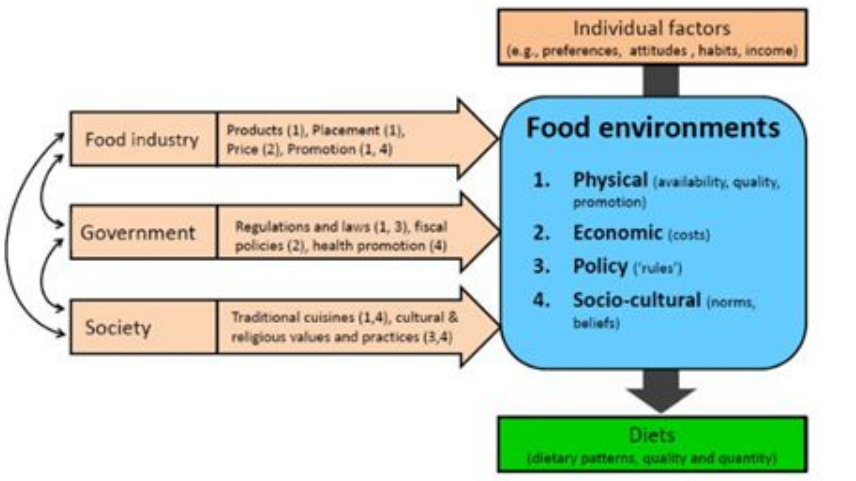
Healthy food environments: Environments in which the foods, beverages and meals that contribute to a population diet meeting national dietary guidelines are widely available, affordably priced and highly promoted.

The Expert Panel recommended 34 actions to the government – those following are particularly relevant to Southern DHB:

- Food Provision - The government ensures that there are clear, consistent policies in public settings to encourage healthy food choices. Food service activities (canteens, food at events, fundraising, promotions, vending machines, public procurement standards etc) should provide and promote healthy food choices. (30, Provision 2)
- Food Provision – The government ensures that there are good support and training systems to help schools and other public sector organisations and their caterers meet the healthy food service policies and guidelines (31, Provision 3)
- Health in All Policies – There are processes in place to ensure that population nutrition, health outcomes and reducing health inequalities are considered and prioritised in the development of all government policies relating to food (18, HIAP 1)
- Health in All Policies – There are processes in place (e.g. health impact assessments) to assess and consider health impacts during the development of other non-food policies (19, HIAP 2)
- Platforms for Interaction – The government leads a broad, effective and sustainable systems-based approach with local organisations to improve the healthiness of food environments at a national level.

  Note: This fifth recommendation specifically relates to Healthy Families New Zealand, based on Healthy Together Victoria, a state-wide, systems oriented, settings based initiative which encourages healthy eating and physical activity, and reducing smoking and harmful alcohol use. Invercargill City is one of 10 areas in New Zealand chosen to pilot Health Families NZ.

Figure 1: Food environments' components and the main influences on those environments



SOUTHERN DISTRICT HEALTH BOARD

Title:	Financial Report
Report to:	Hospital Advisory Committee
Date of Meeting:	01 April 2015

Summary:

Considered in these papers are:

- The February 2015 monthly and year to date financials, with explanations about the material variances.

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

Financial:	Monthly and Year to Date Provider Arm Result
Workforce:	FTE movement year to date
Other:	N/A

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

Prepared by: Grant Paris Finance Manager Date: 17/03/2015	Presented by: Lexie O'Shea Executive Director of Patient Services

RECOMMENDATION:

That the Committee receive the report.

FINANCIAL REPORT – PROVIDER FEBRUARY 2015

Recommendation

That the Board receives and notes this report.

1. DHB Provider Summary Results

Revenue and Expenditure Summary

Description	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD	$000 Full Year Budget
⊟ Revenue							
⊞ Government & Crown Agency Sourced	2,570	2,702	(132)	22,418	22,195	223	33,436
⊞ Non Government & Crown Agency Revenue	1,209	1,289	(80)	8,275	8,748	(473)	13,189
⊞ Internal Revenue	37,226	37,478	(251)	300,340	300,639	(299)	450,549
Revenue Total	41,006	41,468	(463)	331,033	331,582	(549)	497,174
⊟ Personnel							
⊟ Personnel							
Medical Personnel	(8,765)	(8,764)	(1)	(74,899)	(74,863)	(36)	(113,250)
Nursing Personnel	(9,814)	(9,468)	(346)	(82,499)	(81,280)	(1,220)	(124,838)
Allied Health Personnel	(3,694)	(3,705)	11	(31,062)	(31,954)	892	(49,159)
Support Personnel	(743)	(732)	(12)	(6,500)	(6,355)	(145)	(9,718)
Management & Administration Personnel	(2,913)	(2,940)	27	(25,728)	(25,373)	(355)	(38,509)
Personnel Total	(25,929)	(25,608)	(321)	(220,688)	(219,824)	(863)	(335,475)
⊟ Expenditure							
⊞ Outsourced Services	(2,343)	(2,489)	146	(19,968)	(20,534)	565	(30,756)
⊞ Clinical Supplies	(6,220)	(6,686)	465	(54,559)	(54,888)	329	(82,584)
⊞ Infrastructure & Non-Clinical Supplies	(5,563)	(5,695)	132	(46,921)	(46,422)	(498)	(70,032)
Expenditure Total	(14,126)	(14,870)	743	(121,448)	(121,844)	397	(183,372)
Net Surplus / (Deficit)	950	991	(40)	(11,102)	(10,087)	(1,016)	(21,673)
Add Net Impact from research Accounts	19	0	19	268	0	268	0
Add Donations Received	16	44	(28)	190	350	(160)	525
Net Surplus / (Deficit)	985	1,034	(49)	(10,644)	(9,737)	(908)	(21,148)

The monthly result is unfavourable to budget by $49k, increasing the year to date unfavourable variance to budget to $908k.

Revenue was unfavourable for the month driven mainly by lower internal revenue (lower pharmaceutical revenue offset by reduced costs) and lower Healthworkforce / ACC / Non Resident revenue and Donations. The year to date unfavourable revenue variance of $550k only represents 0.16% of revenue received and is also impacted by these accounts along with patient co-payments and lower than expected revenue from South Canterbury DHB.

Payroll costs were unfavourable for the month by $321k (1.2%) driven by nursing. This is discussed later in the report.

Clinical Supplies were under budget for the month, reflecting lower than budgeted activity.

Infrastructure and Non Clinical costs were also favourable to budget for the month driven by food costs and maintenance costs.

Full Time Equivalent (FTE)

FTE was 19FTE under budget for the month (approximately. 0.5%).

- The favourable monthly variance in Allied Health staff of 22FTE is greatly reduced from the year to date favourable variance of 34FTE due to the filling of vacant positions.
- Senior Medical Personnel continue to be under budget (8FTE).
- Nursing personnel were 22FTE over budget due to cover for high sick leave combined with the erosion of the budgeted vacancy factor.
- Management Administration staff were 16FTE under budget which is significantly less than the year to date favourable variance of 3 FTE due to the capitalisation of IT project staff.

2. Personnel Costs - $321k unfavourable for month and $863k unfavourable year to date (ytd) (excluding research)

Medical Personnel $1k unfavourable for month - $36k unfavourable ytd

SMO personnel costs are over budget for the month despite being 8FTE under budget. This is due both to unfavourable leave variances and average budgeted pay rates being lower than actuals (positions recruited above the amount budgeted). SMOs continue to be favourable ytd however, both in personnel and outsourcing, as shown in the table below.

The RMO favourable monthly result is also driven by favourable pay rates despite the year to date variance being unfavourable. The profile (i.e. average pay step) of the new registrar intake since January is driving this. The year to date variances remains significantly over budget due to unfavourable variances in FTE, leave, overtime, and allowances.

Outsourcing costs for Medical staff types is favourable for both the month and ytd. Overall Medical resource is favourable $967k year to date.

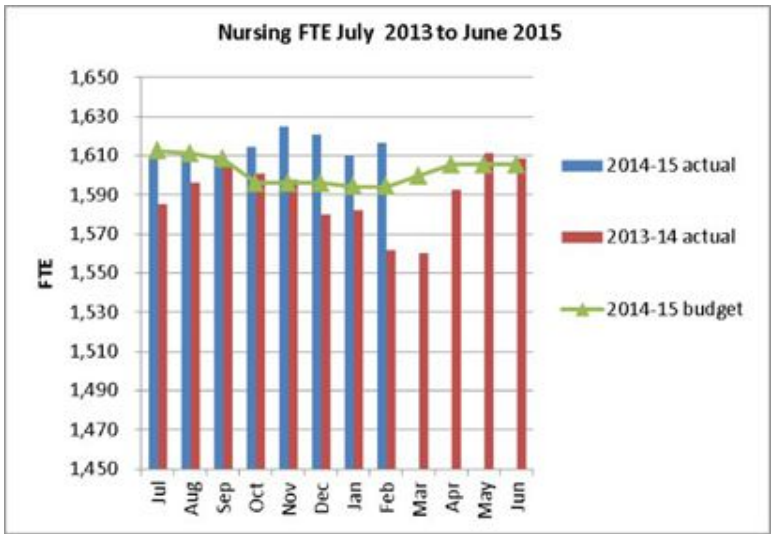
	Month								Year to Date							
	Actual		Budget		Var	Actual	Budget	Var	Actual		Budget		Var	Actual	Budget	Var
	$' 000	%	$' 000	%	$' 000	FTE	FTE	FTE	$' 000	%	$' 000	%	$' 000	FTE	FTE	FTE
SMO Personnel	(5,966)	96%	(5,940)	95%	(26)	246	254	8	(50,177)	95%	(50,935)	95%	758	245	254	9
Outsourced SMO	(259)	4%	(313)	5%	54				(2,465)	5%	(2,858)	5%	393			
Total SMO	(6,225)		(6,253)		28	246	254	8	(52,642)		(53,793)		1,151	245	254	9
RMO Personnel	(2,799)	98%	(2,824)	95%	25	270	266	(4)	(24,722)	97%	(23,928)	95%	(794)	268	266	(2)
Outsourced RMOs	(71)	2%	(146)	5%	75				(640)	3%	(1,250)	5%	610			
Total RMO	(2,870)		(2,970)		100	270	266	(4)	(25,362)		(25,178)		(184)	268	266	(2)
Total Medical Resource	(9,095)		(9,223)		128	516	520	5	(78,004)		(78,971)		967	513	521	8

Nursing Personnel - $346k unfavourable for month - $1220k unfavourable ytd (excluding research)

Nursing costs exceed the monthly budget due to the following:

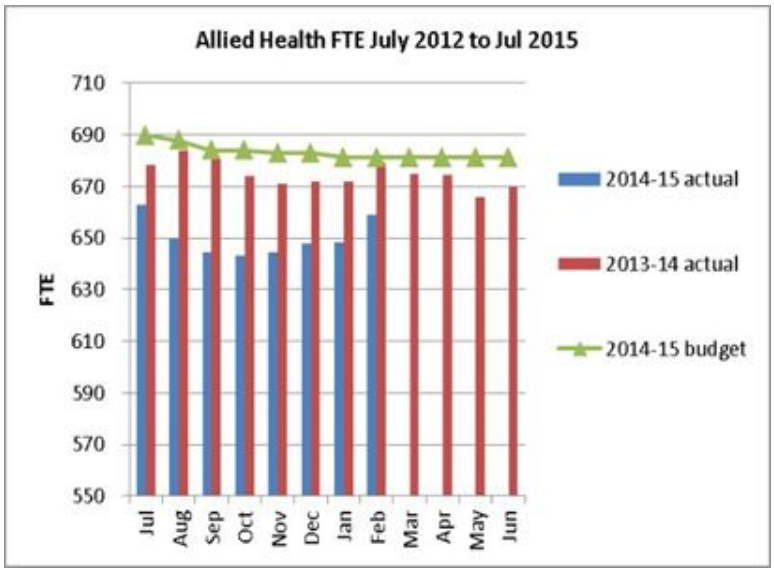
- FTE has increased by 6 from last month due primarily to high levels of sick leave requiring cover. (sick leave was 13FTE over budget – approximately $75k).
- Kiwisaver ($25k unfavourable in the month) and Overtime ($47k unfavourable in the month) were also over budget, consistent with prior months. (Budgets were not reflective of prior years' spend.)
- Leave balances (Annual Leave + Stat Leave) were unfavourable for the month by $194k, and $429k unfavourable year to date.
- Actual rates paid continue to exceed budget by around $60k per month.

NB: The Nursing graduate intake came on board in February (offset by revenue). The impact of the intake which is a temporary increase of 24FTE for 7 weeks was not evident in the monthly result as an equal and opposite capitalisation of nurses was made to the Medchart project. These two are not related in any way other than they offset each other.



Allied Health Personnel - $11k favourable for month - $892k favourable ytd

This staff type was 22FTE favourable for the month which is less than the year to date favourable variance of 34FTE, which reflects a number of vacant positions having been filled. While this should still produce a significant favourable variance of around $90k, this has been offset in February by less annual leave taken than budgeted ($30k), and indirect payroll costs greater than budget, largely one off affiliation fees ($39k) although this is favourable year to date.



Support Personnel - $12k unfavourable for month - $145k unfavourable ytd

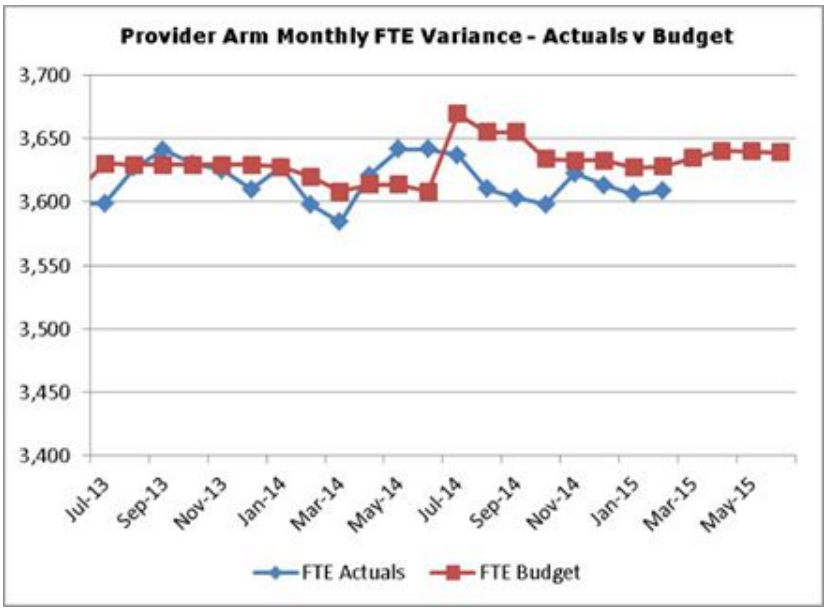
This staff type is 3.0 FTE unfavourable ytd. The $145k year to date variance is driven by additional overtime ($30k), Kiwisaver ($15k) and FTE over budget ($70k).

Management/Administration Personnel - $27k favourable for month - $355k unfavourable ytd

The main driver for the favourable February result is the favourable FTE variance - 16 FTE under budget due to the backdated capitalisation of IT staff.

A comparison of FTE levels over the last year by quarter is tabled below. Overall FTE levels are close to December 2013, the increased Nursing FTE is offset against a reduction in both Allied and Management Admin FTE. Part of the increase in Nursing however is due to a reclassification of approximately 11 staff from Allied to Nursing in the current year.

Staff Type	Dec-13	Mar-14	Jun-14	Sep-14	Dec-14	Jan-15	Feb-15	Feb-15 Budget	Variance to Budget	YTD Variance
SMO	248	244	245	246	245	244	245.75	254	10	9
RMO	264	270	272	265	267	271	269.76	266	(5)	(2)
Nursing Personnel	1,580	1,560	1,609	1,609	1,621	1,610	1,616	1,594	(16)	(13)
Allied Health Personnel	672	675	670	645	648	648	659	681	33	34
Support Personnel	192	189	193	199	194	195	194	192	(2)	(3)
Management & Administration	654	647	654	640	638	638	623	640	2	3
Total Full Time Equivalents (FTI	3,610	3,584	3,641	3,603	3,613	3,606	3,609	3,628	22	28



The opposite graph highlights tracking actual FTE against the reducing budgeted FTE since July 2014.

Maintenance of the gap between budgeted and actual FTE is a key management focus to ensure the financial result for 2014/15 is achieved.

7.5

3. *Outsourced Costs - $146k favourable for month and $565k favourable ytd (excluding research)*

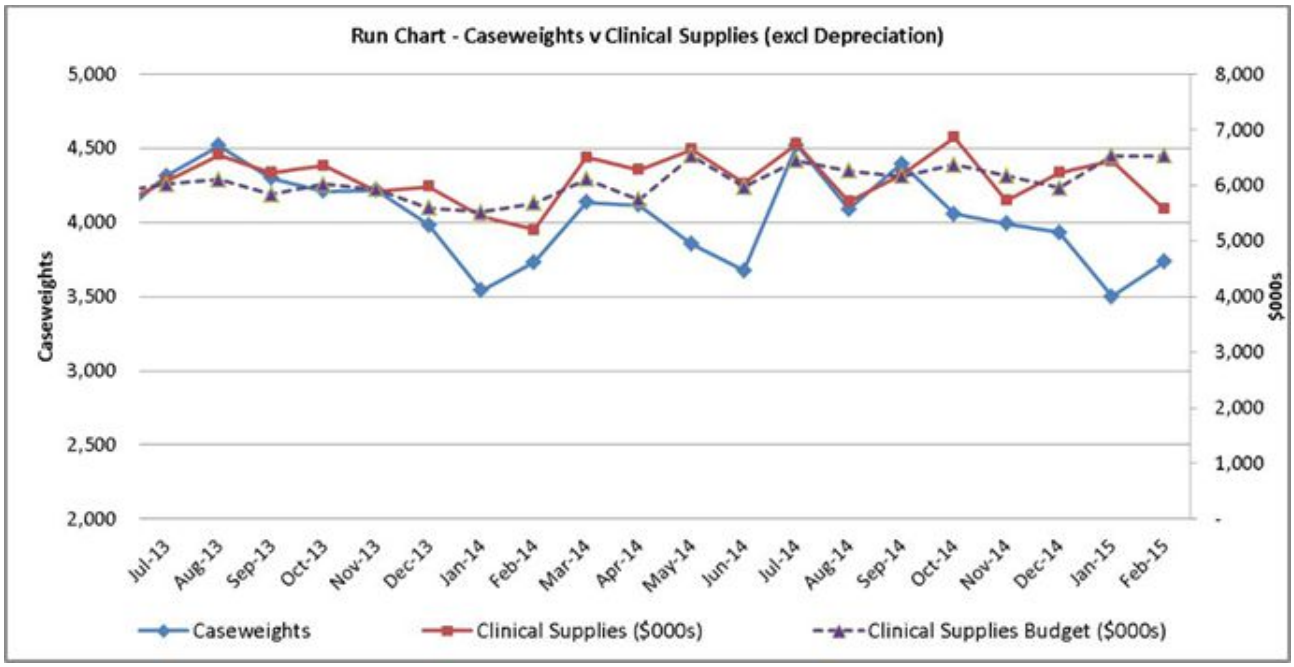
Outsourced costs were under budget for the month, driven by favourable RMO outsourcing that was $75k under budget for the month and $610k favourable ytd.

Outsourced radiology services were $62k unfavourable for the month and $504 ytd reflecting the vacant positions in this area. There is a partial offset (approx. one third) against the vacant SMO costs that were budgeted and recruitment continues. (NB: this still reflects an even phasing of the saving, as the budgets are not able to be resubmitted.)

4. *Clinical Supplies - $465k favourable for the month and $329k favourable ytd (excluding research)*

Clinical Supply Costs v Volumes

The run chart below highlights the favourable variance in clinical supply costs is matched by lower case weighted activity.

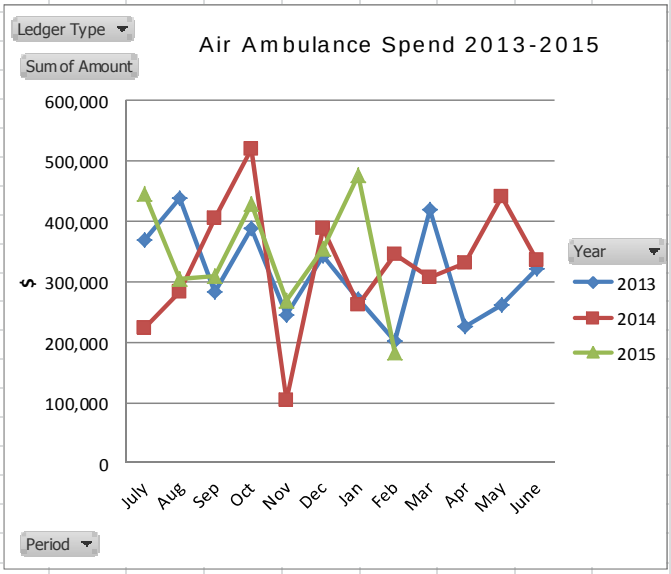


Air Ambulance

In January, a high spend in Air Ambulance prompted questions about the risk this posed to the forecast and reasons for it. Although correct at the time, approximately $100k of the January costs were reversed out in February when they were on-charged to the correct party that was not Southern District Health Board. This together with a rebate received in February corrected the average spend to be only 5% greater than 2013-14.

Air Ambulance Expenditure 2013-2015

Ledger Type	(All)		
Sum of Amount	Year		
Period	2013	2014	2015
July	369,059	223,309	444,208
Aug	437,519	281,910	303,696
Sep	281,809	405,058	309,202
Oct	386,943	518,306	429,135
Nov	243,656	104,166	268,688
Dec	343,697	386,755	354,629
Jan	270,242	261,903	476,299
Feb	202,135	344,064	181,761
Mar	419,142	307,861	
Apr	226,189	331,065	
May	262,220	440,774	
June	320,699	335,143	
Average Spend	**313,777**	**328,527**	**346,204**
Increase		5%	5%



5. Infrastructure and Non Clinical Supplies - $132k favourable for the month and $498k unfavourable ytd (excluding research)

This cost category is 2% under budget for the month (1% over budget year to date). The monthly favourable variance is due to lower than budgeted expenditure in facility costs ($70k due maintenance) and professional fees ($45k due to lower than expected affiliation costs). This is partly offset by an adjustment in the capital charge liability ($100k).

Cleaning and Orderlies costs are $56k over budget for the month and $433k year to date. We are continuing to look at ways of reducing these costs by decreasing service in non-essential areas to make up for increased demand in others.

Southern District Health Board

Feb-15

Part 2: DHB provider	Current Month Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Year to Date Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Annual Budget $(000)
Part 2.1: Statement of Financial Performance									
REVENUE									
Ministry of Health									
MoH - Vote Health Non Mental Health	-	-			-	-			-
MoH - Vote Health Mental Health	-	-			-	-			-
PBF Adjustments	-	-			-	-			-
MoH Funding Subcontracts	-	-			-	-			-
MoH - Personal Health	-	28	(28) U	(99%)	333	226	106 F	47%	339
MoH - Mental Health	-	-			-	-			-
MoH - Public Health	10	11		(1%)	314	85	229 F	270%	127
MoH - Disability Support Services	739	728	11 F	2%	6,365	6,087	278 F	5%	9,040
MoH - Maori Health	-	-			-	-			-
Clinical Training Agency	590	637	(47) U	(7%)	4,771	4,872	(100) U	(2%)	7,418
Internal - DHB Funder to DHB Provider	37,226	37,478	(251) U	(1%)	300,340	300,639	(299) U		450,549
Ministry of Health Total	38,565	38,881	(315) U	(1%)	312,122	311,909	213 F		467,473
Other Government									
IDF's - Mental Health Services	-	-			-	-			-
IDF's - All others (non Mental health)	-	-			-	-			-
Other DHB's	33	25	8 F	32%	184	202	(17) U	(9%)	302
Training Fees and Subsidies	18	17	1 F	6%	165	137	28 F	20%	206
Accident Insurance	771	797	(26) U	(3%)	6,762	6,858	(96) U	(1%)	10,406
Other Government	408	459	(51) U	(11%)	3,526	3,729	(203) U	(5%)	5,598
Other Government Total	1,231	1,299	(67) U	(5%)	10,636	10,925	(289) U	(3%)	16,512
Government and Crown Agency Total	39,797	40,179	(383) U	(1%)	322,758	322,834	(76) U		483,985
Other Revenue									
Patient / Consumer Sourced	477	479	(2) U		2,251	2,316	(65) U	(3%)	3,515
Other Income	839	854	(15) U	(2%)	7,356	6,782	574 F	8%	10,199
Other Revenue Total	1,316	1,333	(17) U	(1%)	9,607	9,098	509 F	6%	13,714
REVENUE TOTAL	41,113	41,512	(399) U	(1%)	332,365	331,932	433 F		497,699
EXPENSES									
Personnel Expenses									
Medical Personnel	(8,765)	(8,764)	(1) U		(74,899)	(74,863)	(36) U		(113,250)
Nursing Personnel	(9,840)	(9,468)	(371) U	(4%)	(82,756)	(81,280)	(1,477) U	(2%)	(124,838)
Allied Health Personnel	(3,694)	(3,705)	11 F		(31,062)	(31,954)	892 F	3%	(49,159)
Support Services Personnel	(743)	(732)	(12) U	(2%)	(6,500)	(6,355)	(145) U	(2%)	(9,718)
Management / Admin Personnel	(2,913)	(2,940)	27 F	1%	(25,728)	(25,373)	(355) U	(1%)	(38,509)
Personnel Costs Total	(25,955)	(25,608)	(347) U	(1%)	(220,944)	(219,824)	(1,120) U	(1%)	(335,475)
Outsourced Expenses									
Medical Personnel	(330)	(459)	129 F	28%	(3,105)	(4,108)	1,004 F	24%	(6,104)
Nursing Personnel	(1)	-	(1) U		(47)	-	(47) U		-
Allied Health Personnel	(51)	(34)	(17) U	(50%)	(412)	(286)	(126) U	(44%)	(421)
Support Personnel	(29)	(21)	(8) U	(38%)	(232)	(171)	(62) U	(36%)	(256)
Management / Administration Personnel	(13)	(1)	(12) U		(94)	(8)	(86) U		(12)
Outsourced Clinical Services	(1,818)	(1,842)	24 F	1%	(15,573)	(14,828)	(745) U	(5%)	(22,257)
Outsourced Corporate / Governance Services	(142)	(132)	(11) U	(8%)	(1,073)	(1,133)	59 F	5%	(1,706)
Outsourced Funder Services	-	-			-	-			-
Outsourced Services Total	(2,383)	(2,489)	105 F	4%	(20,536)	(20,534)	(3) U		(30,756)
Clinical Supplies									
Treatment Disposables	(2,314)	(2,287)	(27) U	(1%)	(19,929)	(19,075)	(854) U	(4%)	(28,710)
Diagnostic Supplies & Other Clinical Supplies	(132)	(141)	10 F	7%	(1,169)	(1,228)	59 F	5%	(1,818)
Instruments & Equipment	(1,298)	(1,343)	44 F	3%	(11,186)	(10,688)	(498) U	(5%)	(16,010)
Patient Appliances	(165)	(187)	22 F	12%	(1,375)	(1,506)	131 F	9%	(2,268)
Implants & Prosthesis	(895)	(992)	96 F	10%	(7,002)	(7,585)	583 F	8%	(11,607)
Pharmaceuticals	(1,287)	(1,433)	147 F	10%	(11,714)	(12,294)	580 F	5%	(18,395)
Other Clinical Supplies	(132)	(303)	171 F	56%	(2,201)	(2,512)	312 F	12%	(3,774)
Clinical Supplies Total	(6,223)	(6,686)	462 F	7%	(54,577)	(54,888)	311 F	1%	(82,583)
Infrastructure & Non Clinical Expenses									
Hotel Services, Laundry & Cleaning	(1,035)	(1,049)	14 F	1%	(8,776)	(8,432)	(344) U	(4%)	(12,640)
Facilities	(1,636)	(1,731)	95 F	5%	(14,312)	(14,214)	(97) U	(1%)	(21,682)
Transport	(304)	(311)	7 F	2%	(2,611)	(2,777)	166 F	6%	(4,212)
IT Systems & Telecommunications	(884)	(910)	27 F	3%	(7,384)	(7,278)	(105) U	(1%)	(10,930)
Interest & Financing Charges	(1,328)	(1,253)	(75) U	(6%)	(10,145)	(10,021)	(123) U	(1%)	(15,032)
Professional Fees & Expenses	(67)	(112)	45 F	40%	(691)	(920)	229 F	25%	(1,367)
Other Operating Expenses	(314)	(330)	16 F	5%	(3,034)	(2,779)	(255) U	(9%)	(4,168)
Democracy	-	-			-	-			-
Subsidiaries & Joint Ventures	-	-			-	-			-
Infrastructure & Non-Clinical Supplies Total	(5,566)	(5,695)	129 F	2%	(46,952)	(46,422)	(529) U	(1%)	(70,032)
Other Costs and Internal Allocations	-	-			-	-			-
Total Expenses	(40,128)	(40,478)	350 F	1%	(343,009)	(341,668)	(1,341) U		(518,846)
Net Surplus/ (Deficit)	985	1,034	(49) U	(5%)	(10,644)	(9,736)	(908) U	(9%)	(21,147)

SOUTHERN DISTRICT HEALTH BOARD

Title:	Occupational Health and Safety Report
Report to:	Hospital Advisory Committee
Date of Meeting:	01 April 2015

Summary:

The Strategy for Health Safety and Wellness is that our staff are safe and well at work so that they are able to deliver quality, consistent care to our patients.

This report is to ensure Hospital Advisory Committee members are aware of the Southern District Health Board direction, progress, and risks associated with current work in this area.

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

Financial:	Positive impact on Accident Compensation Corporation Levies
Workforce:	Providing safer work practices
Previous:	

Document previously submitted to:	N/A	Date:
Approved by Chief Executive Officer:	N/A	Date:

Prepared by: John Pine Executive Director Human Resources Date: 17 March 2015	Presented by: Lexie O'Shea Executive Director of Patient Services

RECOMMENDATIONS:

That the Hospital Advisory Committee recommends that the Board:

- Receive the report and supports the work being undertaken to address Southern District Health Board's strategy.
- Receives the report (appendix 1) and notes the current accident and injury reports together with the work-related Accident Compensation claims data, and sick leave data benchmarked across all other DHBs.

1. Accident, Injury and ACC

Contextual information is provided below relating to the five most common staff injury categories that occur as a result of the five most significant uncontrolled hazards across the District. Statistical data has been collated over the previous four years.

Serious Harm reports: It is challenging to reconcile the low number of reports of Serious Harm made annually to WorkSafe (formerly the Department of Labour and Ministry of Business, Innovation and Employment) with the serious nature of some of the staff injuries that occur. This has more to do with the confusing definition of the phrase 'Serious Harm' as opposed to the nature of the injury. This may be clarified with the forthcoming change in health and safety legislation.

Assault and restraint injuries: Assault and restraint injuries are the greatest cause of injury to staff from patients within the Mental Health and Intellectual Disability Service either as a direct unprovoked assault or occurring during a restraint event. Multiple injuries can occur to staff during assault and include being punched and kicked. Head injuries and concussion in particular result in lengthy absences with the need for significant treatment and rehabilitation. In some instances, due to the ongoing risks to the staff member, they may not be able to return to the original work area following concussion.

Blood and Body Fluid Exposures: The second most common injury occurs as a result of staff exposure to blood and body fluid (Blood and Body Fluid Exposure). Not surprisingly, staff who work within the Surgical Directorate sustain the greatest number of injuries. Most injuries are preventable and statistics show that needle stick injuries are the most common causative event. The implementation of the use of safety devices for all types of needles is recommended as this would assist in minimising the risks to staff from these types of injuries.

Patient and Manual Handling injuries: These injuries comprise the third and fourth most common mechanism of injury. There has been a steady increase in the number of staff injuries reported due to handling hazards over the last four years. The costs of injuries to staff associated with this hazard are significant and pose an on-going financial burden to the DHB. Additional resource is needed to mitigate this risk.

Slips, trips and falls: The number of staff injuries within this final category has fluctuated over the last four years and sees some of the most serious injuries to staff with associated high claims costs requiring surgery and lengthy rehabilitation.

Many of the injuries are preventable and it is clear from the data analysis that the most common reason for falling is tripping over an obstacle. These types of hazards can be controlled to reduce the risk of injury.

2. ACC Partnership Programme

Work is due to commence on the implementation of recommendations from the audit that took place in December 2014.

3. District wide approach to health and safety

A work shop is scheduled to take place in March 2015 to determine streams of work that will be overseen by the District Health and Safety Governance Committee to enable the implementation of a single health and safety governance structure for Southern DHB and to meet our obligations under new legislation.

4. 2015 Staff Influenza Vaccination campaign

Planning continues for the annual staff influenza vaccination.

- A Quadrivalent vaccine which is a flu vaccine designed to protect against four different flu viruses has been secured for Southern DHB. A campaign is due to commence in April 2015 dependent upon vaccine availability.
- Our current focus is on increasing the number of vaccinators which will assist with vaccine delivery to increase staff uptake of this fully funded initiative.

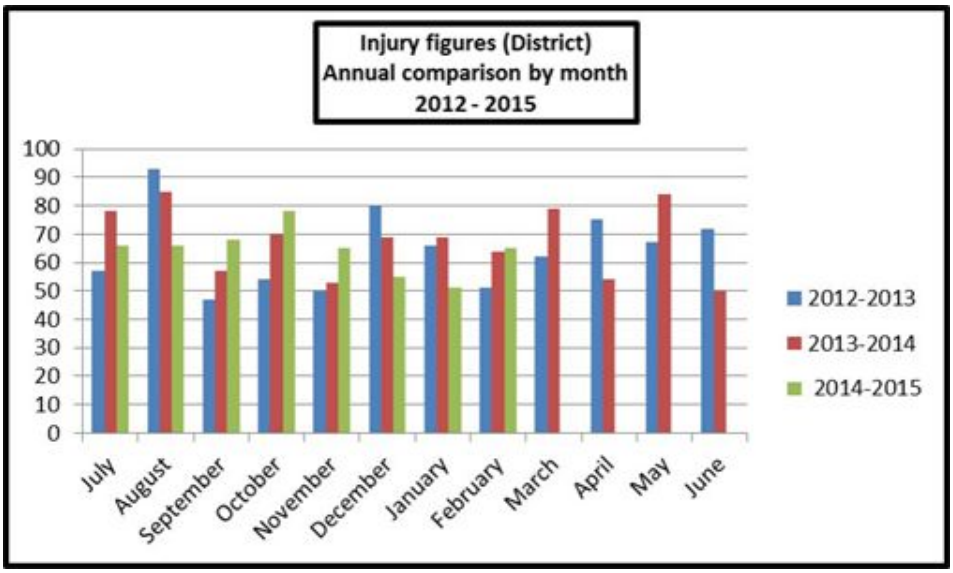
5. RL 6 (Safety1st) Incident Register and Hazard Register

The Occupational Health and Safety team continues to support the implementation of the new incident register. Further work will occur on the hazard register once the new health and safety legislation is enacted.

Appendix 1

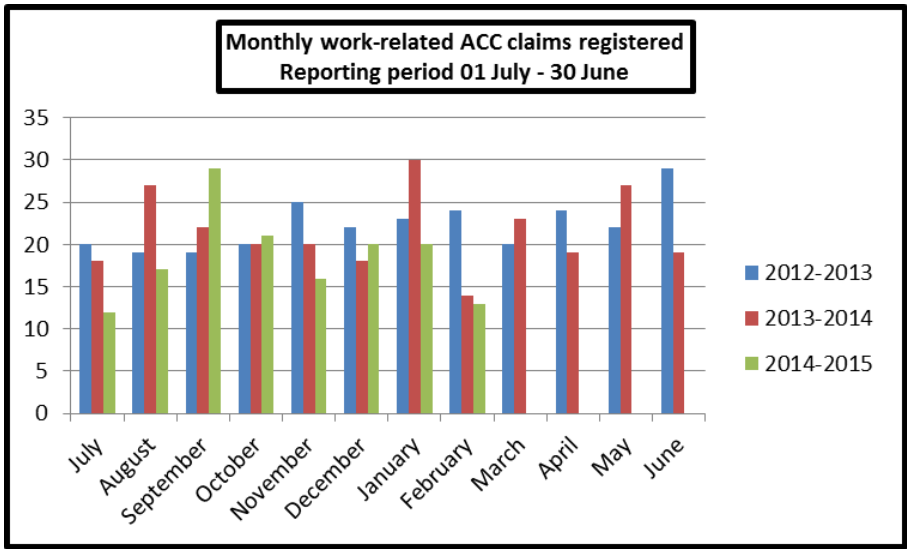
1. Current District Wide Accident / Injury Activity District figures have been compiled and presented for the previous three years to provide comparable information relating to accident and injury data.

Annual injury comparison by month – July 2012 – February 2015



2. District: Work-related ACC claims analysis – Reporting 1 July 2012 – February 2015

a) Number of claims made remains consistent in the presence of an increase in the overall number of injuries: It is interesting to note that although there is a continuing increase in the total number of injuries district wide, the total number of work-injury ACC claims made by staff has remained consistent. A comparison between 2013 and 2014 shows there were twenty fewer claims made during 2014

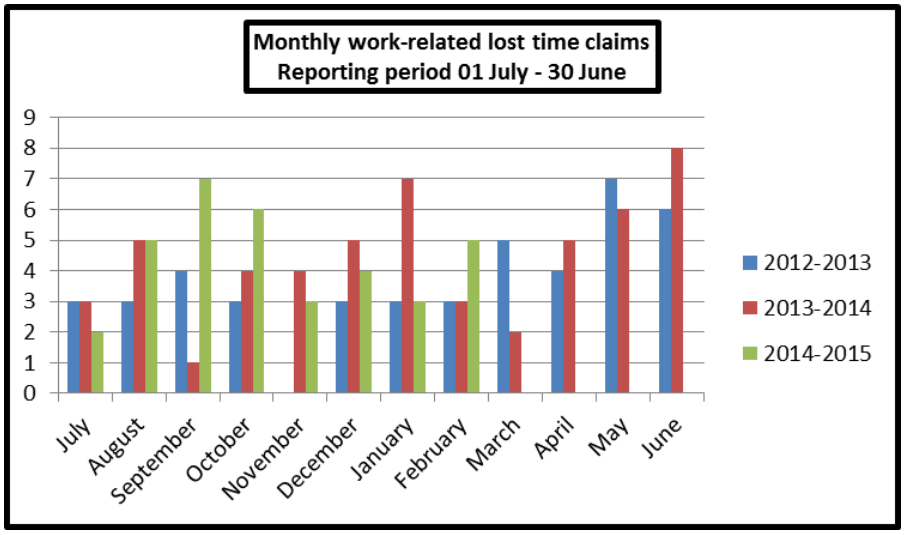


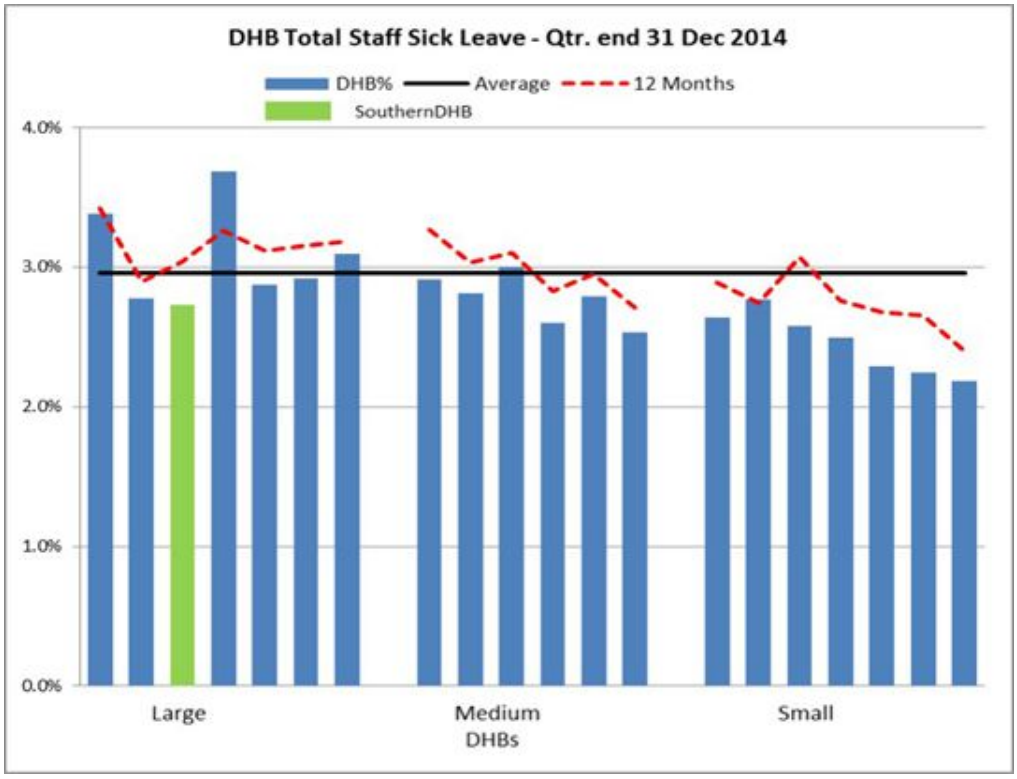
b) Lost time injury claims

Complex claims complicating return to work following injury:

The total number of lost-time injury claims has increased during the last four years and it is the serious nature of the injury that led to these claims that demonstrates the impact on the injured staff member and the service.

A complicating factor with a significant number of the time-lost claims relates to the fact that many of the claimants have extremely complex chronic underlying medical conditions that are not related to the injury. Extensive investigation is often required to determine whether on-going symptoms that are preventing the employee from returning to work are actually related to the injury. The investigation process is time consuming due to accessibility of appropriate specialists and incurs cost. While the investigations are underway, the claimant remains absent from work which increases the negative impact on both the employee and the service. In one case, this process took twelve months to complete.





District: Total number work-related ACC claims: January 2015 - 20 February 2015 - 13
District: Total number time-lost claims: January 2015: - 3 February 2015: - 5

SOUTHERN DISTRICT HEALTH BOARD

7.7

Title:	Information Services - Service Level Alliance		
Report to:	Hospital Advisory Committee		
Date of Meeting:	01 April 2015		
Summary: Considered in these papers are: ▪ February 2015 DHB activity.			
Specific implications for consideration (financial/workforce/risk/legal etc):			
Financial:	N/A		
Workforce:	N/A		
Other:	N/A		
Document previously submitted to:	Not applicable, report only provided for the HAC agenda.	Date:	
Approved by:		Date:	
Prepared by: John Simpson Date: 17/03/2015		Presented by: Lexie O'Shea Executive Director of Patient Services	
RECOMMENDATION: That the Committee receive the report.			

February 2015

IS SLA Dashboard

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	
Clinical Systems					
Health Connect South (HCS) - SDHB			✓		Regional HCS project in progress including the implementation of TestSafe South Governance in place NHITB expectation set for completion end Q4 2014/15 due to geographical locations Bi weekly operational programme schedule in place, target completion now set at 01/08/2015
HCS - NMDHB			✓		Implementation in progress, progressing to target completion 01/08/2015 NHITB expectation set for completion end Q3 2014/15 Implemented rhapsody decoupling of OraCare from local concerto instance
WCDHB Mental health Module	✓				A new scope of works has been approved to decouple integration from WCDHB iPM PAS system. Product stabilization in progress South Island Alliance and Mid Central working on a programme structure to develop a MH module with regional / national functionality
HealthOne (formally eSCRV)			✓		Business Case completed and approval process has commenced SCDHB engagement commenced NMDHB have highlight importance to board Financials under review
eReferrals			✓		Stage 1 – NMDHB deployments in progress Stage 1 – SDHB, went live 15/12/23014, 78% GP's completed Stage 2 - CDHB, WCDHB, SCDHB live, final deployments in progress Stage 2 - SDHB / NMDHB require regional HCS Stage 3 - Orion's eTriage HCS module expected May 2015 for pilot in CDHB Break glass solution in final stages of review
Meds Mgt SDHB - MedChart			✓		SDHB ICU scheduled mid-March Pediatrics base configuration in progress SCDHB resource request with Steering Committee Mental Health, Wakari being scoped Engagement from Dunedin ED commenced CDHB Specialist Mental Health completed using MIMS, 206 beds across 14 wards Migration strategy for MIMS to NZULM in progress eMR Product under review SCDHB Development environment configuration in progress Configuration of SDHB MedChart QA fof SCDHB ward naming still to be approved HL7 Messaging to Southern MedChart QA in progress

February 2015

IS SLA Dashboard

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	
					WCDHB - Capital planning has been completed to budget for both ePharmacy and MedChart, team to yet to engage NMDHB – Capital planning has been completed to budget for both ePharmacy and MedChart, request to Start discussions received ePharmacy SI Alliance monitoring Midlands project for their multi org solution with NZULM, multiple issues require fixing
CDR8				✓	Upgrade of CDR completed
SI Patient Administration System			✓		Contract approval completed Software development progressing well, additional development identified, Orion resourcing additional teams Regional and local resourcing progressing, high salary expectations from candidates, right skill and experience is limited CDHB currently recruiting for project resources
Provation			✓		SCDHB – Project in progress, go live dates April 2015
National Titanium		✓			DHB's have completed sign up, development is slow from the vendor
National Maternity System			✓		CDHB, SDHB, WCDHB & NMDHB - To be planned
National Transfer of Care - eDischarge		✓			HCS Team progressing national template Project lead assigned
National Cardiac Registers				✓	Registers completed
National Patient Flow			✓		Stage 1 being implemented across all SI DHBs
eProSafe				✓	Regional solution now live and in use across all SI DHBs
Regional Clinical Data Repository – TestSafe South (éclair)			✓		In progress, will be incorporated within the overall HCS programme for SDHB Once completed at SDHB all SI DHB's will using a single clinical data repository
eOrders - CDHB			✓		Radiology orders live in CDHB Labs orders project has commenced
Growth Weight Charts	✓				Child Health Alliance have selected SDHB solution as the appropriate regional application Recommendation paper to be presented to the IS SLA 13/03/2015 Project resource required
RL6 Regional Incident Management System			✓		SDHB & CDHB have gone live with solution NMDHB & WCDHB have been scheduled SCDHB scheduled for implementation during 2015/16 financial year

February 2015

IS SLA Dashboard

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	
SCN – MDM Video conferencing Solution				✓	Completed
SCN - Metriq			✓		Oncology centre now providing live data into repository
SCN – Medical Oncology			✓		Christchurch – Working on nursing assessments. SCDHB & WCDHB - No progress on lab results this month. NMDHB – no progress CHOC – no progress
SCN – Mosaiq upgrade		✓			CDHB testing underway with 2.6. Service pack 4 installed – did not fix the pharmacy issue Key arrived for Crystal reports Overall the project is behind schedule but aiming to make up most of this over the next month.
Imaging Systems					
Picture Archiving			✓		Delivered as part of the overall regional solution
Radiology Software - NMDHB				✓	Completed
Radiology Software SDHB			✓		Consolidation of the two solutions has commenced
Non Clinical Systems					
Finance Procurement and Supply Chain			✓		HBL dissolve will see a change in direction
Concept Projects with Regional Impact					
Regional ED White Board	✓				Project mandate approved by IS SLA National EDIT group to be involved Regional stakeholders to be involved
eMeds Reconciliation			✓		eMeds programme manager working with CDHB on the solution
Self-Care Patient portal			✓		Pilot live in CDHB Programme Manager recruited
Advanced Care Plan / Long Term Care Planning	✓				ACP raised for national agreement
Regional eLearning Application	✓				Project mandate approved by ALT, regional business case in progress Discussions in progress regards a national solution
Regional Surgical Audit Application	✓				Regional requirements to be captured and documented
Regional Surgical Site Infection Application	✓				Regional requirements to be captured and documented
MDM Module HCS	✓				Functional requirements being gathered Options paper to be prepared for SPAiT
National Data Centre (NIP)			✓		National contract signed

February 2015

IS SLA Dashboard

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	
TeleHealth	✓				Concept - SI Strategy to be defined, scope of the programme to be documented
Mobility	✓				Concept - SI Strategy to be defined, scope of the programme to be documented
National Trauma Registry	✓				Requirements gathering to be actioned
Regional Data Warehouse	✓				Business Case deferred by AL Owned by the SI CIO's
Regional Ministry Extract	✓				Workshops in progress under PICS programme

Acronyms

IS SLA	Information Services Service Level Alliance
CDR8	Central Data Repository version 8
ALT	Alliance Leadership Team
RCIC	Regional Capital and Investments Committee
NHITB	National Health Information Technology Board
SDHB	Southern District Health Board
NMDHB	Nelson Marlborough District Health Board
SCDHB	South Canterbury District Health Board
WCDHB	West Coast District Health Board
CDHB	Canterbury District Health Board
EMT	Executive Management Team
HOPSLA	The Health of Older People Service Level Alliance
SCN	Southern Cancer Network
HCS	Health Connect South system
eSCRV	Electronic Shared Care Record system
eReferrals	Electronic Referrals system
eTriage	Electronic Referrals Triage system
Meds Mgt	Safe Medications Management systems
SaaS	Software as a Service

SOUTHERN DISTRICT HEALTH BOARD

Title:	ePrescribing Project Implementation Report
Report to:	Hospital Advisory Committee
Date of Meeting:	01 April 2015

Summary:

Considered in these papers are:

- Update for Hospital Advisory Committee

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 HAC agenda.	Date:
Approved by:	N/A	Date:

Prepared by:	Presented by:
Richard Jocelyn Senior Regional Programme Manager Medications Management South Island Information System Alliance Date: 16/03/2015	Lexie O'Shea Executive Director of Patient Services

RECOMMENDATION:

That the Committee receive the report.

ePrescribing Project Implementation Report – March 2015

Recommendation

That the Committee notes this report.

1. Background

The Southern DHB Board of Directors approved the implementation of the Electronic Prescribing and Administration software (known as MedChart) across Southern DHBs core hospitals in March 2012.

Electronic Prescribing and Administration (also referred to as ePrescribing, ePA, EMM) entails the prescription and administration of medicines in an inpatient encounter using an electronic system to record and verify the medicines prescribed and administered. The result of this electronic process is a clear, legible and communicative process, which improves the quality and safety of the patient experience.

2. Current Position

MedChart is now rolled out to 77% of inpatient beds across the three DHB Hospitals (Dunedin, Southland and Wakari), encompassing all adult wards in Dunedin and Southland with the exception of their Emergency Departments.

The latest area to go-live with MedChart is Dunedin Hospital's Intensive Care Unit facility, which began using the system mid-March.

The success of the implementation comes down to the strong clinical leadership provided by clinicians and nursing staff across the district and their ability to absorb the change required to move from a paper based process to an electronic system. This is a substantial change to work practice and the impact should not be under-estimated in what is a patient safety focused system.

3. Next Steps

For the project, the next steps are to complete testing and obtain sign-off for the configuration of MedChart for safe use within Paediatrics and Neonatal wards. This encompasses senior clinician sign-off, collaboration across the South Island Paediatric leads and approval from the National eMedicines Programme under the conditions of our waiver. Progression to Mental Health Services at Wakari Hospital to implement will follow along with consideration of implementation in Dunedin and Southland Emergency Departments and implementation at Lakes District Hospital.

4. Financial

To date the project is tracking well within its financial budget and although the timeline has been affected by delays, external to the project, it is on track to deliver under budget.