SOUTHERN DISTRICT HEALTH BOARD
HOSPITAL ADVISORY COMMITTEE MEETING

Wednesday, 04 February 2015, 2.00pm

Board Room, Community Services Building, Southland Hospital Campus, Invercargill

AGENDA

Tab

1. Pacific Island Nursing Model of Care (presentation by Pacific Island Specialist Nurses)
2. Welcome, Introduction and Apologies
3. Interests Registers
4. Minutes of Previous Meeting
5. Review of Actions
6. Monitoring and Performance Reports
   a) Executive Director of Patient Services Report
   b) Key Performance Indicators
   c) ESPI Progress
   d) ED Vouchers
   e) Radiology Project Plan
   f) Southern Patient Safety Process
   g) Health and Disability Commissioner Report
   h) Financial Performance Summary
   i) Human Resources Report
   j) Information Systems Report
   k) Building and Property Report

Confidential Session:

RESOLUTION:

That the Board 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	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).

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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 21.11.2013 & 03.04.2014	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. Three immediate family members are employees of Dunedin Hospital (Radiographer and 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) but these cannot be effected until contract variation executed by SDHB and SCLOS constitution varied.

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SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at November 2014

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	
Richard Bunton	17.03.2004 22.06.2012 29.04.2010	3. Managing Director of Rockburn Wines Ltd. 4. Director of Mainland Cardiothoracic Associates Ltd. 5. Director of the Southern Cardiothoracic Institute Ltd. 6. Director of Wholehearted Ltd. 7. Chairman, Board of Cardiothoracic Surgery, RACS. 8. Trustee, Dunedin Heart Unit Trust. 9. Chairman, Dunedin Basic Medical Sciences Trust.	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 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	

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Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
		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.

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Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Wednesday, 5 November 2014, 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	
	Mr Tuari Potiki	
	Mr Richard Thomson	(via videolink)
In Attendance:	Dr Jan White	Crown Monitor
	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 David Tulloch	Chief Medical Officer
	Mr Richard Bunton	Medical Director of Patient Services
	Mr Grant Paris	Senior Business Analyst (via videolink)
	Mrs Joanne Fannin	Board Secretary Southland

Unconfirmed

1.0 PRESENTATION – ENDOSCOPY FROM WOE TO GO – THERE IS LIGHT AT THE END OF THE TUNNEL

Mr Simon Donlevy, Service Manager, joined the meeting in Invercargill and Mr Jason Hill, Clinical Leader Gastroenterology and Ms Janine Cochrane, Service Manager Medical joined the meeting via videolink from Dunedin. A presentation was provided by Mr Jason Hill outlining the development of the district gastroenterology service, including progress made to reduce waiting lists over the past 15 months. The Chairman and CEO acknowledged Mr Hill's leadership and the work undertaken by the team to achieve the significant improvement to the service. Mr Hill responded to queries regarding 'single point of entry' and provision of service by Doctors versus Nurse Practitioners. Mr Donlevy, Mr Jason Hill and Ms Kempin left the meeting.

2.0 WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting. An apology was received from Mrs Mary Gamble.

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 3 September 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 154 – acute readmission rates – a common denominator and numerator is to be selected to allow accurate alignment with other DHBs when benchmarking and an update will be provided at the HAC meeting in February 2015. A number of DHBs, including Southern DHB, have detected an anomaly with the transfer of some patients, e.g. between the Medical Ward and Assessment Treatment and Rehabilitation Ward. Unless patients are discharged and readmitted, they show as a readmission on the system. This is being addressed.

Action point 155 – phasing of budget for Radiology Services – the savings have not been re-phased at the current time as the budget has not been resubmitted to the Ministry of Health (MoH). The savings plan provided for the Audit and Risk Committee (ARC) has been re-phased to reflect that the Radiology savings will not impact until the second half of the year.

Action Point 156 – HR Occupational Health and Safety report – further discussion with ACC is underway re benchmarking data.

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 Committee:

- Acknowledged the favourable results for the Provider Arm in the first quarter performance.
- Received advice on the new funding received from the MoH for additional Gastroenterology procedures and noted the improvement in the percentage of patients receiving colonoscopies.
- Received advice that a Project Manager has been appointed and a Project Plan in relation to the Radiology Service Improvement initiative will be provided for the HAC meeting in February 2015.
- Received advice on progress in the development of a Trauma Service and noted that a Trauma Committee should be up and running by 1 July 2015.
- Received advice on the work streams in place for staff development and the adoption of lean methodologies within the organisation. There have now been 80 staff though the skills for change innovation programme.

8.0 KEY PERFORMANCE INDICATORS (KPIs)

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

- Received an update on trend of progress to four months wait for Outpatient and Inpatient Elective Services and noted that a quarterly update will be provided to the HAC.
- Noted the trend for October 2014 and requested a comparison be made with the figures for October 2013 to establish whether there is a seasonal trend.
- Received an update on expanding day surgery and ambulatory care (EDSAC), Dunedin Hospital and noted that investigations are being made as to where Day Surgery could be done in the future. Received advice that procedures are undertaken in Theatres in Dunedin Hospital that are undertaken in a procedure room at other hospitals.
- Received an update on the Patient Safety Process Measures from the Executive Director of Nursing and Midwifery.

Unconfirmed

- Received advice that Southern DHB is hosting a South Island forum in Dunedin where Dr James Bagian (MD, PE), Engineer and former NASA Astronaut, an internationally renowned expert on human factor science, will present to a number of staff.
- Received the Serious Adverse Events (SAE) Report 2013-2014 and noted that falls account for over half the adverse events nationally.

9.0 FINANCIAL REPORT

The Committee received and considered the Financial Report and a verbal update by the Senior Business Analyst. In discussion, the Committee received advice as follows:

- The unfavourable variance in Infrastructure costs relates to some one off costs and timing issues. The over-runs in cleaning and orderlies costs are expected to reduce once the new contract is in place.
- A number of the donations received are for assets and only a portion of the amount will be offset in depreciation. It was acknowledged that donations are difficult to forecast.
- A request was made for the forecast budget amount for a three month period to be depicted in the Provider Arm Monthly FTE Variance – Actuals v Budget graph.

10.0 HUMAN RESOURCES OCCUPATIONAL HEALTH AND SAFETY REPORT

The Committee received and considered the Human Resources Occupational Health and Safety Report. The Crown Monitor advised that under new legislation the Board is responsible for the health and safety of staff and she advised that staff sickness should be included in the Occupational Health and Safety Report.

11.0 INFORMATION SERVICES DASHBOARD

The Committee received and considered the Information Services Dashboard. The Committee:

- Received advice on the significant amount of change happening in this area.
- Received advice that Southern DHB has received a letter congratulating it on being one of the few DHBs who have successfully completed stage one of the National Patient Flow Project.
- Received advice that the Regional ED white board project is at a scoping stage and has not been presented locally at this point.

12.0 TERMS OF REFERENCE

The Committee received and reviewed the Hospital Advisory Committee Terms of Reference, noting the minor change to meeting frequency and the change to the review period.

It was resolved:

> "That the Hospital Advisory Committee recommends that the Board approve the modified Terms of Reference for the Hospital Advisory Committee."

Sandra Cook joined the meeting at 3.05pm.

13.0 CONFIDENTIAL SESSION

At 3.05pm, it was resolved:

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

Unconfirmed

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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).
Hospital Services update	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).
Human Resources updates	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 - The Energy Efficiency and Conservation Authority Energy Performance Contract and Honeywell Ltd Contract (Southland Hospital) - ISS Facilities Services Ltd (ISS) contract renewal	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).

Unconfirmed

The Committee resumed in public session at 5.05pm.

The meeting closed at 5.05pm.

Confirmed as a true and correct record:

Chairman: ____________________________ Date: _____________

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HOSPITAL ADVISORY COMMITTEE (HAC)

Action Sheet from meeting held on 5 November 2014

Action Point No.	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
154 2014/09	Key Performance Indicators (Minutes Item 8.0)	A report is to be provided for the next HAC meeting outlining the results of the benchmarking between DHBs and the results from the survey undertaken by Southern DHB on acute readmission rates.	EDPS/DCEO	Work is being done to address an anomaly detected with the treatment of transfer of patients as readmissions and to ensure a common denominator and numerator are selected to allow accurate alignment with DHBs nationally. A report is to be provided for the HAC meeting to be held in February 2015.	4 February 2015
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	A request has been made for ACC to provide benchmarking information and an update will be provided for the HAC meeting to be held in February 2015.	4 February 2015
157 2014/11	EDPS Report – Radiology Services (Minutes Item 7.0)	A Project Plan for the Radiology Service Improvement initiative is to be provided for the next HAC meeting.	EDPS/DCEO	A Project Plan for the Radiology Service Improvement initiative will be provided for the HAC meeting to be held in February 2015.	4 February 2015
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 February 2015.	4 February 2015
159 2014/11	KPIs (Minutes Item 8.0)	A comparison is to be made with the figures for October 2013 on the trend	EDPS/DCEO	A comparison between October 2013 and October 2014 will be	4 February 2015

Action Point No.	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		of progress to four months wait for Outpatient and Inpatient Elective Services to establish whether there is a seasonal trend.		provided to establish whether there is a seasonal trend and an update will be provided for the HAC meeting to be held in February 2015.	
160 2014/11	Financial Report (Minutes Item 9.0)	The forecast budget amount for a three month period is to be depicted in the PA monthly FTE Variance – Actuals v Budget graph.	SBA	The forecast budget amount is to be depicted in the PA monthly FTE Variance – Actuals v Budget graph in the financial report for the HAC meeting to be held in February 2015.	4 February 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.	1 April 2015

6.1

SOUTHERN DISTRICT HEALTH BOARD

Title:	Executive Director of Patient Services
Report to:	Hospital Advisory Committee
Date of Meeting:	04 February 2015

Summary:

Considered in these papers are:

- December 2014 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:	Presented by:
Executive Director of Patient Services/Deputy CEO Date: 22/01/2015	Lexie O'Shea Executive Director of Patient Services

RECOMMENDATION:

That the Committee receive the report.

Executive Director of Patient Services Report – December 2014

6.1

Recommendation

That the Hospital Advisory Committee notes this report.

1. Contract Performance

- Total acute caseweights delivered (cwd) by the Southern DHB Provider Arm were 153 under plan in December 2014 (5%). Year to date, they are 420 cwd over plan (3%).
- Total elective caseweights delivered (cwd) by the Southern DHB Provider Arm were 147 over plan in December 2014 (14%). Year to date, they are 308 cwd over plan (4%).

2. Financial Performance

- An unfavourable variance of $831k was recorded by the Southern DHB Provider Arm for the month of December 2014. Year to date, the provider arm is $1.1m unfavourable.
- Revenue for December 2014 was favourable by $521k. Expenses for December 2014 were unfavourable against plan by $1.3m.

3. Health Targets

Shorter Stays in Emergency Departments (ED)

- Across the district December 2014 had 1.2% more presentations to ED than December 2013.
- Performance against the '6 Hour Target' across the district was 93.1% in December 2014. The district-wide 2014/15 quarter two result was 93.1%.
  - Dunedin ED – 93.3% for December
    - Presentations for the month of December increased with 3426 in 2014, a 3.4% increase on the 3426 presentations in December 2013.
  - Southland ED – 92.9% for December
    - Presentations for the month of December decreased with 3139 in 2014, a 1% decrease on the 3172 presentations in December 2013.

Immunisation

- In December 2014 Southern DHB again achieved 97% for coverage of children aged 8 months of age. This is an increase on November figure of 3%. Coverage for children at 2 years of age has remained consistently high at 95%.

Better Help for Smokers to Quit

- The December 2014 result for the Better Help for Smokers to Quit health target was 93.1% which is a slight decrease of 0.2% from the November 2014 result.
- This is a 4.3% increase from the October result. This month Public Health staff met with the smokefree champion and senior medical staff in Emergency Department (ED) to look at ways of supporting the staff to improve their ABC results. The smokefree coordinator developed a small business card with the quit local and national quit services on them, to assist staff in the B and C (brief advice and cessation support) part of the process. These have been very useful in the ED work

environment where staff are short of time. There has been a 14% improvement in the ED figures for ABC this month which is a very pleasing result. Patient Safety Week provided an opportunity to promote smokefree services that we provide. The revised Stop Smoking guidelines were distributed and staff were reminded about recommending referrals to stop smoking services.

6.1

Shorter Cancer Wait Times

- We have experienced an increase in service delivery of both conventional radiation therapy and stereotactic radiosurgery/radiotherapy in December and our continued compliance with the MoH's shorter waits for cancer treatment health target has been achieved in spite of eight weeks shared resource with Radiology due to CT scanner replacement. The stereotactic service, for which we hold the national contract, has had a marked increase in referrals, and treatments delivered. The trend appears to be a sustained one which could have a positive impact from an incoming revenue perspective through Intra District Flows (IDFs).
- Chemotherapy waiting times were maintained.
- Faster cancer treatment target - performance as per the below table. The new target requires identification of 15% of all patients with cancers under this target and SDHB currently achieves this. In December there were lower numbers of patients identified under this target and we achieved 65% for patients under 31 day target (decision to treat to treatment date) and 77% under the 62 day target (from General Practitioner referral to treatment).

	Patients captured under 31 day target	31 days Achieved	Patients captured under 62 day target	62 days Achieved	Total
August 2014	19	84%	25	76%	44
September 2014	42	88%	21	62%	63
October 2014	42	83%	27	85%	69
November 2014	35	71%	27	74%	62
December 2014	20	65%	26	77%	46

Improving Access to Elective Services

Elective Surgical Discharges December 2014

	Elective Surgical Discharge Activity - Southern DHB population								
	Dec-14				Year to Date				Annual
	Actual	Plan	Var	Var %	Actual	Plan	Var	Var %	Plan
SDHB population treated inhouse	857	703	154	22%	5,449	5,143	306	6%	10,008
SDHB population treated by other DHB	21	47	(26)	(55%)	262	282	(20)	(7%)	563
SDHB population outsourced	10	5	5	0%	76	51	25	0%	96
	888	755	133	18%	5,787	5,476	311	6%	10,667

4. Operational Performance

- Elective Service Performance Indicators (ESPIs). The final ESPI graphs for November 2014 shows Southern DHB a red status for ESPI 2 (Patients waiting for First Specialist Assessment (FSA) and a yellow status for ESPI 5 (Inpatients). Preliminary results for December 2014 has Southern DHB with a yellow status for all ESPIs. This report is (attached).
- Key performance indicator graphs are attached and show operational performance.

6.1

5. Medical Directorate

- Cardiology angiogram waiting times, 97.8% for the month and above target of 90% of patients accepted for elective angiography receive their procedure within three months (90 days).
- The percentage of patients receiving colonoscopies has been steadily improving with all three measures met for December2014. This means that additional funding will be received from the Ministry of Health:

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

- Nephrology, the Ministry of Health has offered Southern DHB a contract to support donor recruitment and coordinate the renal transplant process. This funding is available for three years. This funding will provide a full time donor co-ordinator. A staff member is currently seconded into the role whilst the recruitment process is completed (applications close January 2015). This is initiative is supported nationally with the view that more patients should receive kidney transplants from live donors, thus reducing mortality and morbidity through kidney failure and reducing costs the burden of costs associated with lifelong dialysis.
- An update on the Emergency Department General Practitioner voucher trial has been provided as requested at the Board meeting held on 11 December 2014 action point 298 (attached)

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

- The directorate has completed a Children of Parents with Mental Illness and Addiction (COPMIA) project, developing a comprehensive system COPMIA Manual and Guidelines district-wide and also has an across sector focus, as we link our service-users (who are parents) up with relevant supports. This was launched to the service in December 2014 with implementation to commence in February 2015.
- The directorate has continued its focus on the increase in serious staff injuries. A workshop was held with a wider multidisciplinary and occupational health and safety focus. This workshop explored the challenges that clinical teams have when caring for people in a compulsory setting, highlighting the needs for staff and this group of patients who experience complex and severe mental illness from a clinical care and responsiveness perspective. A work plan to implement the outcomes from the workshop is in development.
- A review of crisis (mental health emergency) services in rural areas after hours is underway. A small project team will engage widely across primary, secondary, non-governmental organisations (NGOs) and community groups as part of this project, which is targeted for completion in February 2015.
- The Office of the Director of Mental Health Annual Report for 2013 has been released. Overall, Southern DHB has improved performance in this year's report over previous reports. The improvement in this year's report reflects the positive work by the service with a 40% decrease in the number of people secluded in the adult service and a 25% decrease in the number of people secluded in the forensic service.

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

- Work began on the building of the new Community Oral Health Clinic in Frankton. Meeting held with local school principals prior to Christmas to inform them of the clinic development, and to ask them for ideas regarding community engagement in the coming months through to the clinic opening (estimated May 2015).
- A new monthly Dietitian clinic will start in Lakes in February 2015. This is a contracted service to a locally based Dietitian, who also provides services to other district rural hospitals. This will improve access to Dietetic services for the Lakes District area.
- District wound assessment rolled out in December 2014. This has been a great example of cross district working by our two Wound Care Clinical Nurse Specialists, and covers all inpatient and community wound care assessments.

8. Surgical Directorate

- The Breast Service continues to evolve with staff expected to be at recruit to levels by next month. The aim of the one stop breast clinic in Southland is developing well but the final step of ensure imaging staff are available on the same day is still progressing. A meeting is scheduled to review the contract for breast imaging which has been in place for almost six months and ensure any residual issues are identified and have a plan to resolve.
- A seasonal trend analysis, comparison in orthopaedic waiting list numbers between October 2013 and October 2014 has been provided as requested by the Hospital Advisory Committee from the meeting held on 05 November 2014, action number 159 (attached).

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

- The first child diabetic telemedicine clinic was held at Dunstan Hospital in January 2015 went well. The clinic means that patients and their families will save up to eight hours travel time every time a patient needs to attend a clinic which is usually at least four times a year depending on the patient's needs. Patients will now be able to attend the local clinic and in the main only have to travel to Dunedin Hospital for an appointment once a year.
- 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 the new provider with staff engaged in this process. The scheduled date for transition to is April 2015.
- The directorate is contributing to a number of national reviews, Immunisation Outreach Services, B4 School Checks and Cervical Screening.
- Southern DHB is continuing to work nationally to develop and implement the Violence Intervention Programme Plan. Southern underwent an audit of this programme in early September and has now received the report. Requested actions are being worked through. On the whole the report is favourable with a number of activities to be completed in the 2014/15 year.
- Radiologist recruitment across the district continues. A radiologist commences in Dunedin at the end of January 2015 and one in Southland at the end of February 2015.
- The target waiting times for November 2014 (latest times available) for CT and MRI are as follows:
  - 82% of CT referrals were scanned within 6 weeks against a target of 90%. Performance is likely to reduce slightly for December due to some level of downtime related to the replacement of the CT scanner in Dunedin. Once the December information is available from the Ministry of Health in February we will know the impact.

  - 43.9% of MRI referrals were scanned within 6 weeks against a target of 85%. Increased inpatient demand reduced the number of routine category outpatients able to be scanned in MRI. This is anticipated to improve with increased scanning hours commencing 19 January 2014 – this will enable 24 additional scans per week.
- The Radiology Service has commenced a National Radiology Service Improvement initiative (NRSII) in conjunction with the Ministry of Health. The outcome of this initiative is to achieve a sustainable access to high tech imaging within target timeframes. The timeframe for this initiative is 18 months. A project facilitator role has been appointed to facilitate and support clinical leadership of the programme. A Project Plan is (attached).
- The Radiology CT scanner was successfully replaced with the new scanner becoming operational mid December 2014. Radiology and Oncology teams have worked extremely well to ensure there was minimal disruption to patient service during the time both CT scanners were being replaced.
- From early February 2015, our vacant sonographer positions will be filled with staff returning from parental leave.
- Food Service staff have been informed of the Board's decision in principle to outsource food services to Compass Group as part of the national arrangement subject to consultation with Food Service staff. Two weekly meetings are being held with staff and unions to provide support and answer questions prior to consultation commencing. The DHB is working with unions to work through the development of the consultation process.

10. Performance Excellence and Quality

- Southern DHB continue to exceed the threshold in Central Line Associated Bacterimia (CLAB), Surgical Safety Checklist, and Hand Hygiene measures. Central Line Insertion bundle measurements will be extended to include Southland Critical Care unit next quarter, we expect to sustain performance in this measure.
- All markers in Surgical Site Infection (Hip and Knee) have improved. The new measures for Cardiac Surgery will begin in the first quarter of 2015.
- We have not yet achieved the threshold in the Falls Markers. Whilst some wards/services achieve a high standard of performance in assessing and putting in place appropriate care plans, many areas are not meeting the required standard of this marker. The Nurse Director team supported by Allied Health and Patient safety staff are focussing strongly on this improvement.
- A system of manual mini audit has been put in place. Charge Nurse Managers are reviewing a set of notes each day (5 per week 20 per month) and following up with the nursing staff if they have not completed the Assessment and Plan for those identified to be at risk of a fall. The results of the mini audits demonstrate a significant improvement.
- A care plan summary is placed above each patient's bed that identifies the falls risk and records if the assessment and plan are in place. This along with the Patient Safety Boards gives a visual reference for frontline leaders to check and highlight importance to staff. Intentional rounding and bed side handover practices continue to be implemented across the wards. Provision results for the next quarter show significant improvement.
- The Quality Process Measure graphs have been included (attached).
- The report and analysis for the period 1 January to 30 June 2014 from the Health and Disability Commission has been provided for your information (attached)

Lexie O'Shea, Executive Director of Patient Services

Leanne Samuel, Executive Director of Nursing and Midwifery

Mr Richard Bunton, Medical Director of Patient Services

6.2

Southern DHB
Hospital Advisory Committee - KPIs
December 2014 Data

Patient Safety and Experience - Hospital Healthcheck

Monthly	Actual	Plan / Target	Variance	Trend/rating
3 - Improved access to elective surgical services monthly (population based)	888	755	133 (17.6%)	
3a - Improved access to elective surgical services ytd (population based)	5,786	5,476	310 (5.7%)	

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	93%	95%	-1.9%	
15 - Acute Readmission Rates	10.7%	9.2%	-1.5%	

Population Health

16 - Smoking cessation - hospitalised smokers provided with advice and help to quit	93%	95%	-1.9%	

Key -

- (green) Meeting target or plan
- (amber) Underperforming against target or plan but within thresholds or underperforming but delivering against agreed recovery plan
- (red) Underperforming and exception report required with recovery plan

Cost/Productivity - Hospital Healthcheck

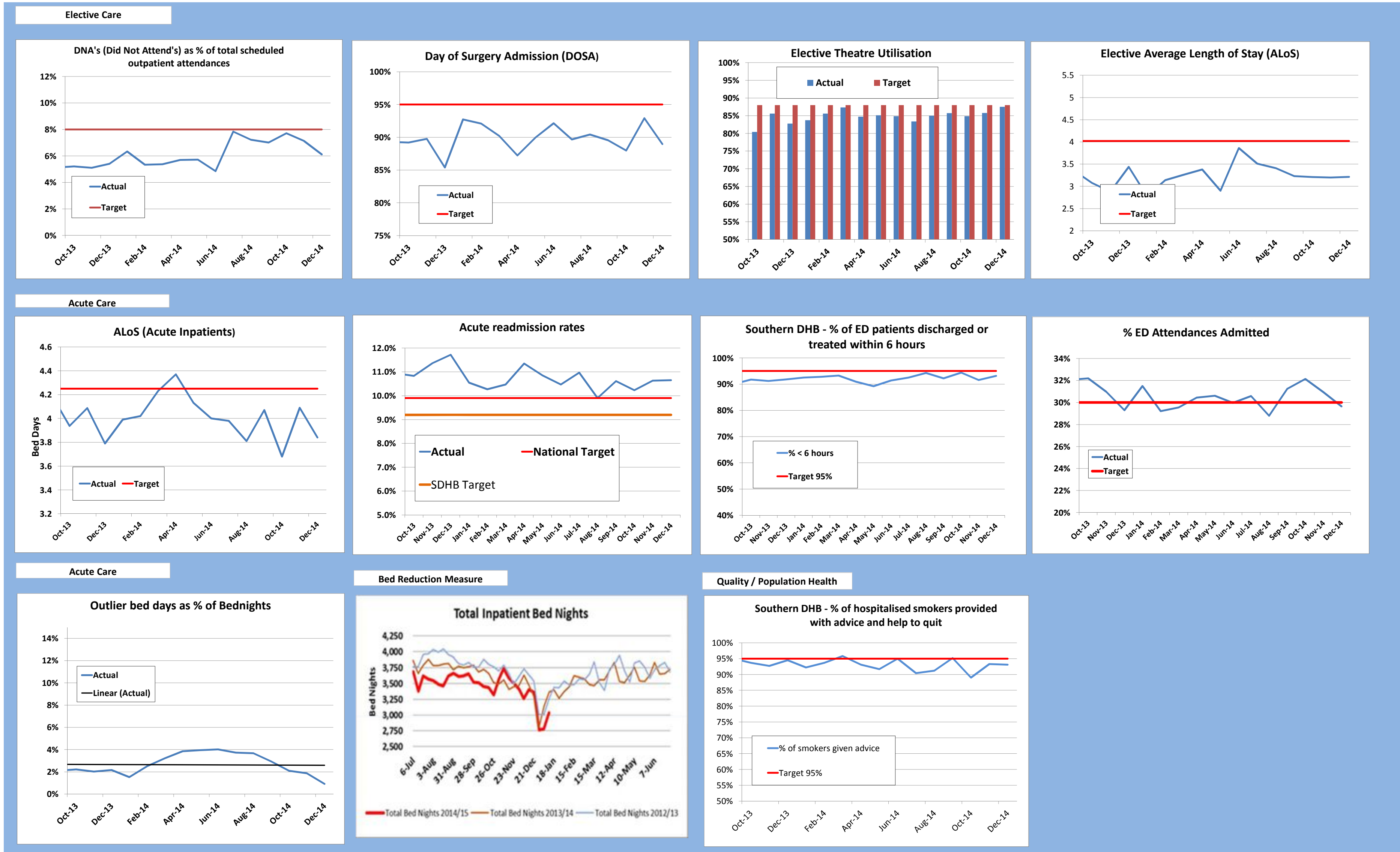
Monthly	Actual	Plan / Target	Variance	Trend/rating
1 - Waits >5 months for FSA	6	0	-6	
2 - Treatment >5 months from commitment to treat	19	0	-19	
4a - Elective caseweights versus contract (monthly provider arm delivered)	1,235	1,088	147 (13.5%)	
4b - Elective caseweights versus contract (ytd provider arm delivered)	7,911	7,603	308 (4.1%)	
7a - Acute caseweights versus contract (monthly provider arm delivered)	2,641	2,795	-153 (-5.5%)	
7b - Acute caseweights versus contract (ytd provider arm delivered)	17,020	16,600	420 (2.5%)	
10 - Voluntary staff turnover	0.6%	0.3%	-0.4%	
9 - Staff sick leave rates	3.1%	3.5%	0.4%	

Cost/Productivity - Performance Report

Monthly	Actual	Plan / Target	Variance	Trend/ rating
5 - Reduction in DNA rates	6.1%	8.0%	-1.9%	
7 - DOSA rates	89%	95%	-6.0%	
9 - ALoS (elective)	3.21	4.02	0.81 (20.1%)	
ALoS (Acute inpatient)	3.84	4.25	0.41 (9.6%)	
14 - % ED attendances admitted	29.7%	30.0%	0.4%	
13 - Outlier bed days	0.9%			
Quarterly				
8 - Elective Theatre utilisation	87.5%	88.0%	-0.5%	

Southern DHB
Hospital Advisory Committee - Performance Report
December 2014 Data

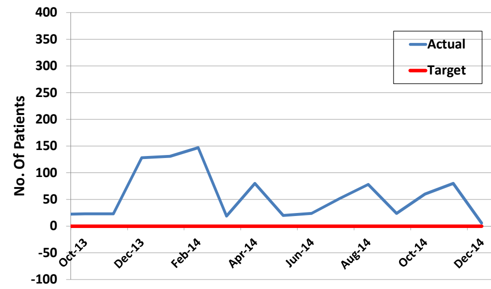
6.2

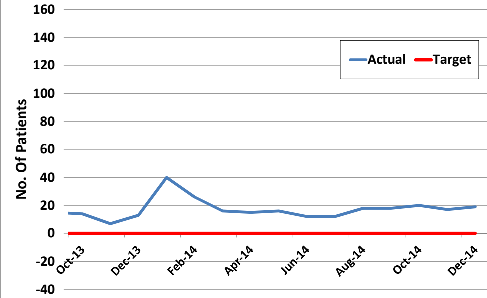


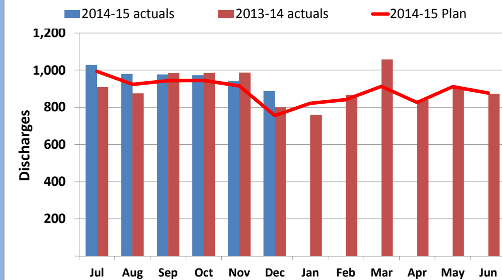
Southern DHB
Hospital Advisory Committee - Hospital Healthcheck
December 2014 Data

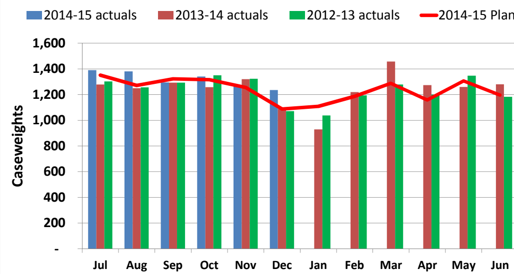
6.2

Elective Care

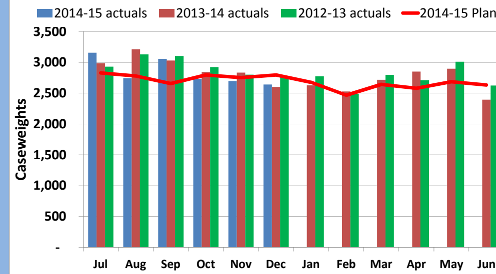




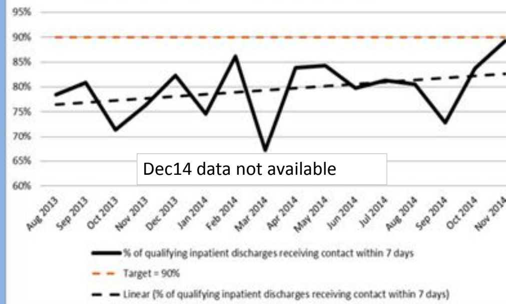




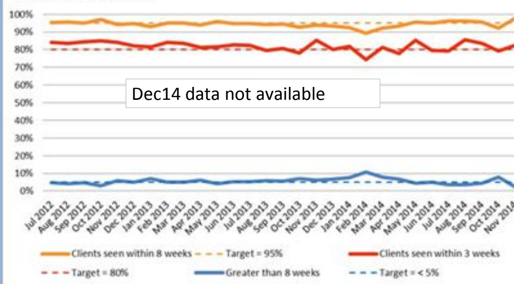
Acute Care



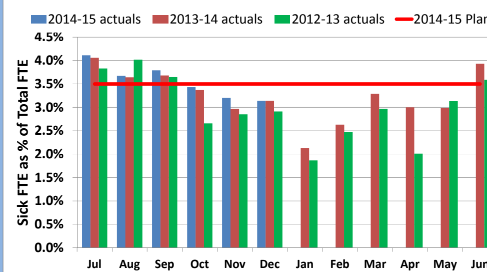
Mental Health and Addictions

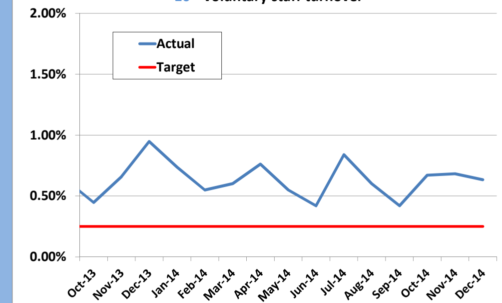


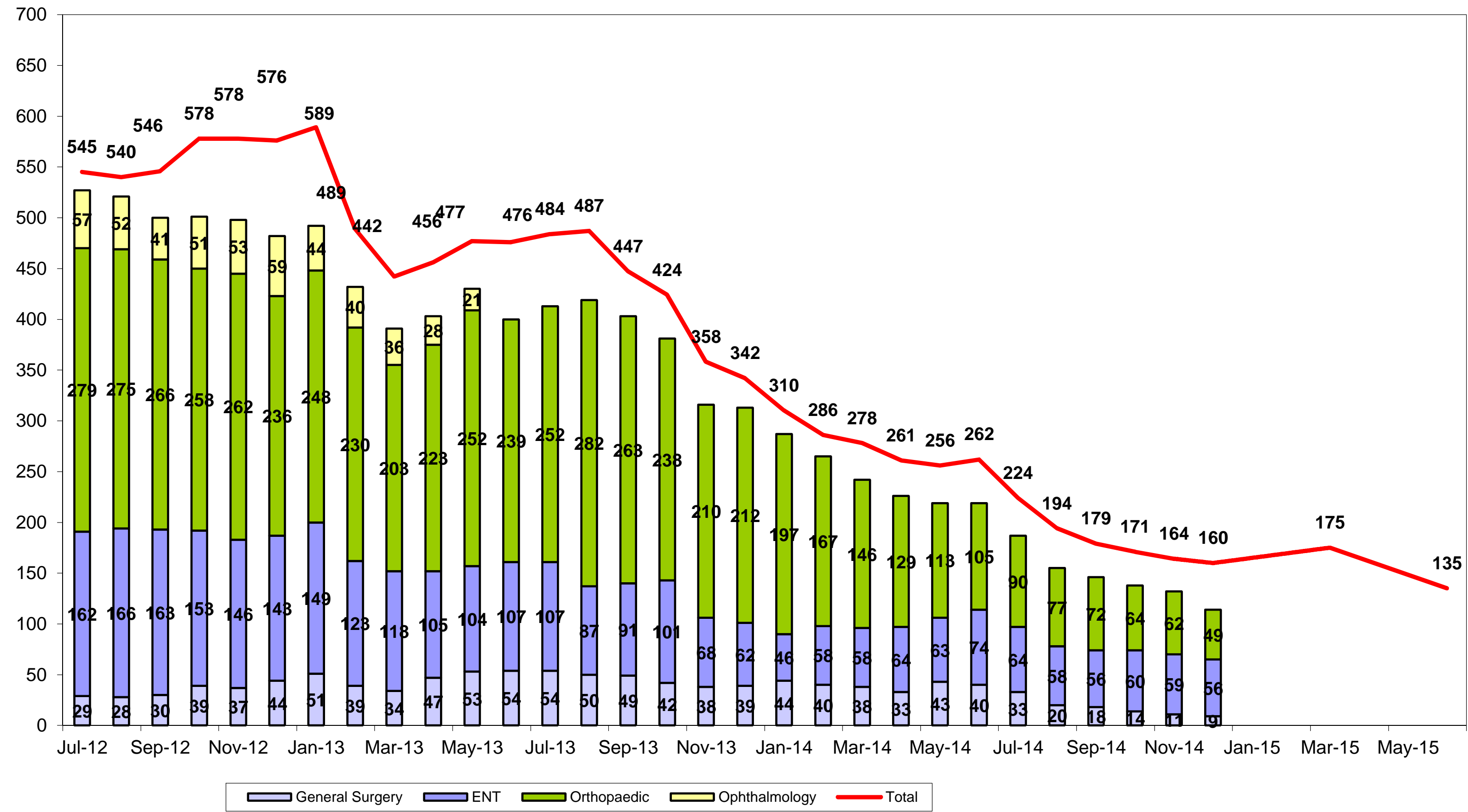
Mental Health and Addictions



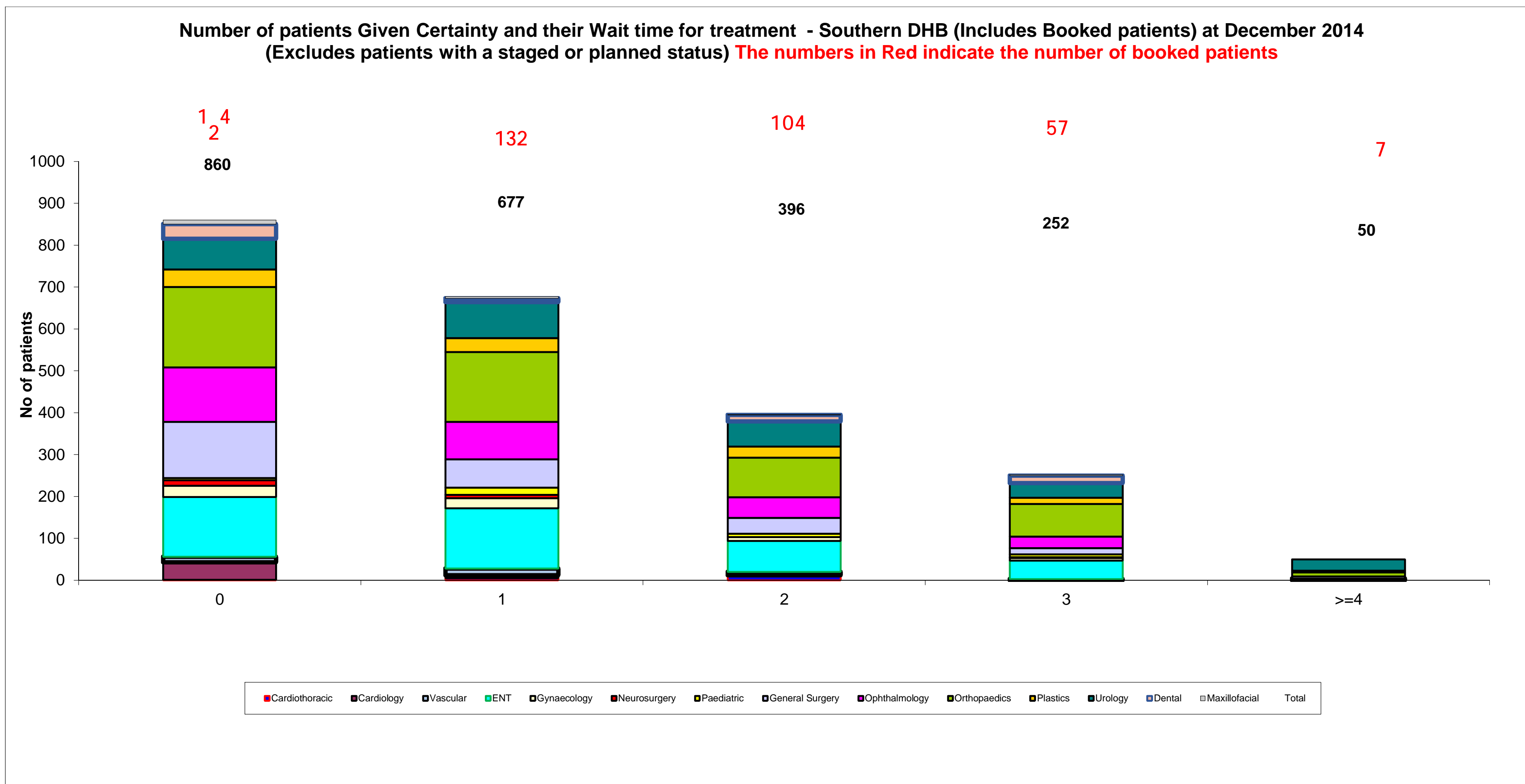
Service and Organisation Quality







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
General Surgery
ENT
Orthopaedic
Ophthalmology
Total


Number of patients Given Certainty and their Wait time for treatment - Southern DHB (Includes Booked patients) at December 2014
(Excludes patients with a staged or planned status) The numbers in Red indicate the number of booked patients
1 4
2
132
104
57
7
860
677
396
252
50
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

6.3

SOUTHERN DISTRICT HEALTH BOARD

Title:	Progress to Four Months Wait for Outpatient and Inpatient Elective Service Performance Indicators (ESPI) Markers
Report to:	Hospital Advisory Committee
Date of Meeting:	04 February 2015

Summary:

Update report, progress to four months wait for outpatient and inpatient ESPI markers.

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

Financial:	Not applicable
Workforce:	Not applicable
Other:	Not applicable

Document previously submitted to:		Date:
Approved by:		Date:

Prepared by:	Presented by:
Lynley Irvine, General Manager on behalf of the Surgical Directorate Leadership Team Date: 21/01/2015	Lexie O'Shea Executive Director of Patient Services

RECOMMENDATION:

That the Committee receive the report.

Progress to Four Months Wait for Outpatient and Inpatient Elective Service Performance Indicators (ESPI) Markers – January 2015

Recommendation
That the committee receive and note the report.

1. Background

The maximum waiting time for patients accepted for a first speciality assessment (FSA) or assured to receive elective surgery reduced from five months to four months for 2015 ESPIs. The DHB was working to a target of no patients over four months by 31 December 2014, along with the ESPI five month ESPI compliance target.

Southern DHB obtained ESPI compliance by 31 December 2014 and the majority of services within the DHB achieved the four month target. The DHB is focused on retaining the four month target for services that have reached it and obtaining the DHB target of no patients waiting longer than four months across all services.

2. Trend of Progress to Four Months

Internal reporting tracks the progress of each service in reaching a four month waiting time. The ESPIs measure if a patient has waited over four months at month end. During the first week of each month the numbers on the internal reports increase as the patients that were previously waiting three months become due.

The Committee requested a comparison of figures for October 2013 on the trend of progress to four months waiting for Outpatient and Inpatient Elective Services to establish whether there is a seasonal trend. In the main departments our review has shown that services do not exhibit a seasonal trend. However the number of patients added to the first specialist list for the orthopaedic outpatient service on the Dunedin site showed an increase compared to the previous year. There were 592 referrals accepted (average of 148 per month) compared to a 24 month average of 130 referrals. This was compared with the previous year to determine if this was due to a seasonal variation. While an increase was seen in July 2013, the average for the 4 month period June to September 2013 was below the 24 month average.

While the increase in referrals made management of the outpatient waiting list difficult the service did meet the four month target for outpatients at the end of December 2014.

An internal report that is distrubuted monthly showing additionals and exits off the orthopaedic waiting list for each site along with the total waiting.

The orthopaedic service is combining the internal reports with a new referral prioritisation process. All referrals are now re-reveiwed after prioritisation before being placed on the outpatient waiting list. The number of patients added to the waiting list is compared to the number of clinic appointments available.

3. Conclusion

Southern DHB is on track to reach four month compliance by the end of March 2015 for both ESPI2 and ESPI5.

6.3

Progress to meeting 4 months

Report date: 26 January

Key: Red >10 patients, Yellow <10 patients, Green 0 patients

Speciality	Outpatients				Inpatients				Comments
	Dunedin		Southland		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	Pts	Risk	Pts	Risk	
Anaesthesia	1								
Cardiothoracic									
Cardiology	5								
Dermatology									
Dental							4		
Endocrinology									
ENT			2						
Gastro			4						
General Medicine			2						
General Surgery	31				11				
Gynaecology	1								
Haematology	1								
Infectious Disease									
Neurology	6								
Neurosurgery	1								
Ophthalmology			4				2		
Oral Maxillo									
Orthopaedics	23				25				
Paed Medicine	1								
Paed Surgery			1				2		
Pain									
Plastics	9				10		5		
Renal Medicine									
Respiratory									
Rheumatology	1								
Radiation Oncology									
Urology	17		3		42				
Vascular	13				7				
Total	131				108				

	18-Aug	25-Aug	01-Sep	08-Sep	15-Sep	22-Sep	29-Sep	06-Oct	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
OP 4mth	260	254	503	383	338	283	276	407	316	284	242	451	370	279	280	270	116	82	50	217	131
OP 3mth	942	935	1250	1108	1009	924	896	1134	1013	923	852	1092	951	813	802	887	698	628	577	1112	1010
IP 4mth	171	151	199	170	134	115	105	187	152	143	136	228	196	168	157	161	99	69	51	134	108
IP 3mth	381	343	475	422	394	361	333	494	423	401	386	468	431	317	241	424	312	256	197	364	274

6.4

SOUTHERN DISTRICT HEALTH BOARD

Title:	Update - Emergency Department (ED) General Practitioner (GP) Vouchers Trial
Report to:	Hospital Advisory Committee
Date of Meeting:	04 February 2015

Summary:

Considered in this paper is:

- This paper is a report requested by Board (action point 298-2014/08) as an update on the trial.

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

Financial:	No
Workforce:	No
Other:	No

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

Prepared by:	Presented by:
Janine Cochrane Acting General Manager Medical Directorate Date: 19 January 2015	Lexie O'Shea Executive Director of Patient Services

RECOMMENDATION:

That the Committee receives the report.

Update - Emergency Department (ED) General Practitioner (GP) Vouchers Trial

Recommendation

That the Committee receives the report.

6.4

1. Introduction

Emergency departments in Dunedin and Invercargill have been experiencing increased patient numbers year on year. SDHB staff were asked to help support efforts to reduce these numbers through the use of vouchers at ED. Vouchers allow patients to be redirected to Primary Care from the Dunedin and Invercargill Emergency Departments.

There are four conditions that must be met to get a voucher:

1) A condition that has been assessed for management by a GP,
2) Unable to pay (or a community/high users card),
3) Securing an appointment at the GP for that day and
4) The patient needs to agree to attend GP (and pay an additional costs – voucher worth $40.

2. Update

- The uptake on the voucher system over the last three months (since October 2014) has been below expectations:
  - The Southland ED has issued four vouchers.
  - The Dunedin ED has issued four vouchers.

- From the sample data that was collected at both sites there were multiple reasons for vouchers not being used. A sample audit was undertaken in each of the EDs over one month. Southland identified 12 patients and Dunedin identified 20 patients as potentially suitable for vouchers. Reasons for not taking up the voucher option included:
  - Patients had already tried to get an appointment at their GP prior to presentation.
  - A small number of patients that had accepted a voucher in principle were unable to get an appointment.
  - The value of the voucher is less than the cost of consultation at some GP practices.
  - The number of patients presenting that meet criteria has been smaller than expected, especially in regard to the requirement for a community services card.
  - The length of time to assess and confirm whether the patient is eligible for a voucher is similar to time taken to treat the patient.
  - Healthline had directed a number of patients to ED and patients were reluctant to be moved elsewhere.
  - There were no dedicated urgent slots available for patients in their GP practice.

- Overall, the voucher system has not reduced the number of patients attending the EDs at Southern DHB. The voucher system was utilised during a bed crisis at Dunedin Hospital. In this case it was planned that patients who could be were directed to the Dunedin After Hours Service over a three day period. Even under these circumstances there were only two patients re-directed.

6.5

SOUTHERN DISTRICT HEALTH BOARD

Title:	Radiology Services
Report to:	Hospital Advisory Committee
Date of Meeting:	04 February 2015

Summary:

Considered in these papers are:

- Southern DHB is required to implement this national project as outlined by the following service description contained within the contract between the Ministry of Health and Southern DHB.

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: N/A
Approved by:	N/A	Date: N/A

Prepared by:	Presented by:
Elaine Chisnall General Manager, Women's, Children's, Public Health and Support Directorate Date: 15 January 2015	Lexie O'Shea Executive Director of Patient Services/Deputy CEO

RECOMMENDATION:

That the Committee receive the report.

6.5

Project Plan

Title	National Radiology Service Improvement Initiative
Group / Service	Women's, Children's, Public Health and Support Directorate – Radiology Service
Sponsor	Lexie OShea

Southern District Health Board is required to implement this national project as outlined by the following service description contained within the contract between the Ministry of Health and Southern District Health Board.

Service Description

2.1. The District Health Board will implement a programme of Radiology Service improvement according to principles described in "The Ministry of Health and National Radiology Service Improvement Workbook", which has been sent to the District Health Board prior to the date of this agreement.

2.2. In order to plan the implementation of the initiative, the District Health Board has prepared a 'Project Brief' which has been agreed with the National Health Board, is appended to this agreement, and forms part of this agreement.

2.3. The District Health Board will establish an effective Service Improvement Initiative Governance Group comprised of representatives as agreed with the National Health Board.

2.4. The District Health Board will send relevant delegates to the various national learning sessions which the National Health Board will organise, including at least four general sessions concerning broad service improvement issues and concepts; and a number of targeted sessions for specific staff groups to address more practical matters in a 'hands-on' manner.

2.5. The National Health Board will provide central co-ordination for these sessions, and pay for certain attendees' travel and accommodation costs to attend. These attendees will be identified at the time in consultation with the District Health Board and according to the nature of the session.

2.6. The National Health Board will create and maintain a website to support the initiative, to which the District Health Board will have access and which will contain various reports, resources, or communication facilities.

2.7. The National Health Board will retain and make available to the District Health Board at no cost certain experts in quality and service improvement, in communications, or in project management, to support the District Health Board in the achievement of its service improvement goals. This provision is dependent upon the availability of the experts concerned.

2.8. The National Health Board will provide local and national progress reports as relevant, from a central reporting database.

2.9. The National Health Board will facilitate wide communications among all District Health Boards participating in the initiative.

Purpose	The purpose of the programme is to implement the requirements of the service description. The outcome of this programme is for Southern District Health Board to provide sustainable and timely access to high tech imaging services, and thereby achieving and maintaining the national targets for these services.
Programme Description	Southern District Health Board is to focus on two high tech modalities being CT and MRI.

Southern District Health Board commences the workbook programme from the beginning. Each module will focus on CT and MRI although much of what is learned could be applied to other modalities at a later time if this is a requirement to do so.
The programme is split into the following three parts with the work flow moving through the corresponding modules sequentially:

Further understanding of the current situation in CT and MRI
- Establishing our current situation in CT and MRI
- Analysing current demands on CT and MRI

Establishing performance standards
- Establish standard scanning time
- Understand the Radiologist capacity and benchmarking in these two modalities

Increasing patient access to CT and MRI
- Production planning
- Optimising patient flow
- Demand management

Southern District Health Board will have project support to work with the wider team and services to work through these workbook processes, subject to the data and other information gathered at the initial stages of the project.

Project Framework

Governance Group

The Governance Group is established to provide clinical and management leadership of the project and to ensure all key stakeholders are engaged. Terms of reference for the Governance Group have been developed separately. This group is chaired by Senior Leadership.

Project Group

Chaired by Service Manager supported by Clinical Leader.
- Programme facilitator
- Involve senior service staff
- Include stakeholder representation from other services
- Manages programme plan
- Undertakes monitoring and reporting requirements

Work groups

It is envisaged that established work groups would progress activities within each module of work.
- Chaired by programme facilitator or senior staff
- Involve relevant staff and stakeholders
- Task oriented

Southern District Health Board has appointed a project facilitator to support the Project. The employment of some data analysis capacity is required through a short to medium period of the programme. Initially this will be to provide additional quality assurance to data obtained from RIS and also to tabulate data that will need to be collated manually.

Funding to support

- Employment of a project facilitator
- Resource to undertake data collection and analysis
- Cost of overheads for project

- Staff backfill as required for key staff engagement

6.5

Project objectives

The project objectives include:

- Timely access for patients to high tech imaging (CT and MRI) improving patient outcomes.
- District Health Board to achieve and maintain the high tech imaging national targets.
- Timely access to high tech imaging minimises delays in diagnosis, treatment and discharge and in some instances prevent the need for admission.
- A clinically and financially sustainable process in place to ensure on-going appropriate response timeframes for access to high tech imaging.
- The project is delivered within the project timeframe, critical milestones and funding.

Project Assumptions

- Processes for implementing identified efficiencies are progressed throughout the project.
- Monitoring and reporting requirements are met.
- All data is gathered and analysed prior to any assumptions being made.
- Referrers and other key stakeholders would be involved at all levels of project (e.g. governance, management, workgroups)

Project Milestones

Work programme:
Set up phase
October - December 2014

Southern District Health Board would start the workbook programme from its beginning. Each module would focus on CT and MRI although much of what is learned could be applied to other modalities as required at a later time.
The programme falls into three parts with the work flow moving through the corresponding modules sequentially:

Finalise service specifications and more detailed plan with the Ministry of Health. Includes confirmation of Key Performance Indicators. (KPIs)

Develop governance structure to embed wider District Health Board support to project and maintain oversight of phases, monitoring and reporting.

Identify level of resource required for project facilitation, staff engagement and other non-operational support

Phase One
December 2014 - March 2015

Further understanding of the current situation in CT and MRI

- Establish our current and potential baseline capacity in CT and MRI
- Analyse current demands on CT and MRI
- Staff and stakeholder engagement (visioning and buy in)
- Undertake further programme planning and development
- Commencement of information collection
- Further development of functional relationships with referrers both within and outside of Southern District Health Board, other providers of radiology services within Southern District, and other relevant stakeholders.
- Evaluation of work to date against plan.

Phase Two
March 2015 - July 2015

Establishing performance standards:

- Establishing standard scanning times
- Understanding our Radiologist capacity and benchmarking in these two modalities
    - Data analysis
    - Capacity
    - Standard scan
    - Radiologist Productivity Module
- Identification of set projects to advance areas identified to date.
- Evaluation of work to date against plan

Mid-point review - July 2015.

Phase Three
August - December 2015

Increasing patient access to CT and MRI

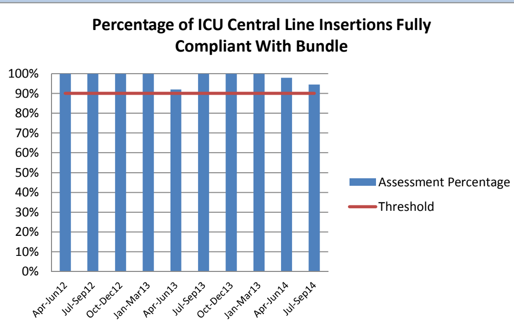
- Production planning
- Optimising patient flow
- Demand
- Continue to work on plan including components of the four original modules
- Commencement of the remaining modules
- Identification of projects to advance areas identified to date.
- Evaluation of work to date.

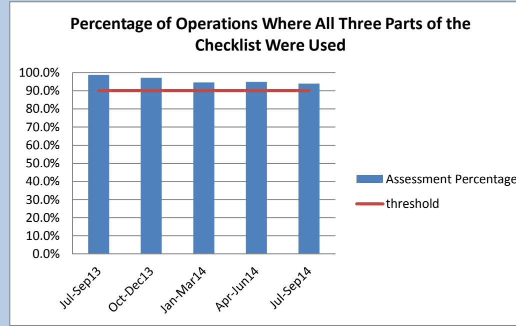
Monitoring and Reporting.

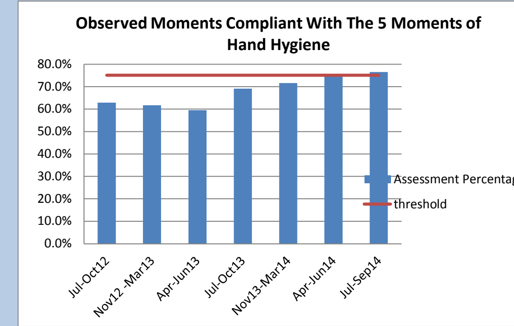
Instalment number	Acceptance criteria
1. Execution of agreement	Receipt by both parties of signed agreement
2. Submission of Report One	Completion of the stage and the report to the satisfaction of the National Health Board
3. Submission of Report Two	Completion of the stage and the report to the satisfaction of the National Health Board
4. Submission of Report Three	Completion of the stage and the report to the satisfaction of the National Health Board
5. Submission of Final Report	Final report accepted by the National Health Board

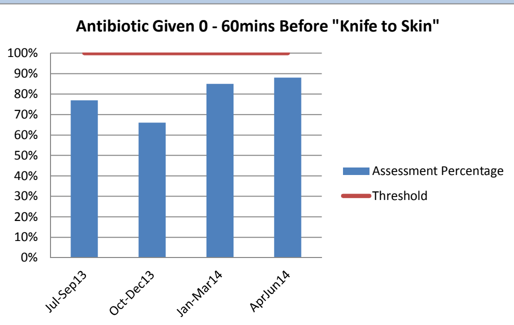
6.6

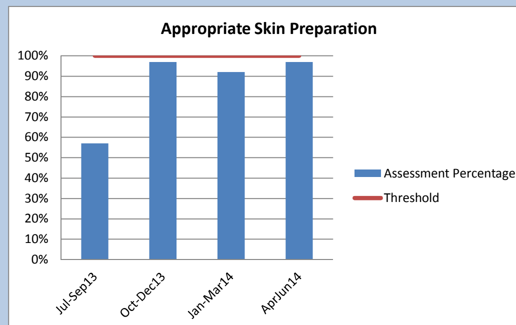
Southern DHB
Quality Process Measures

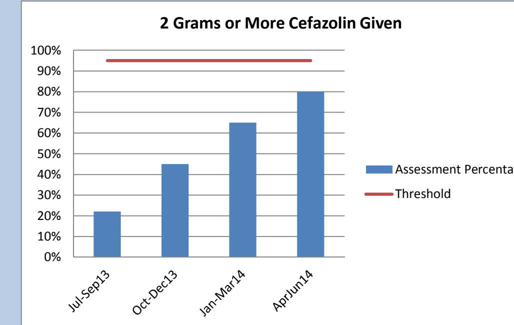


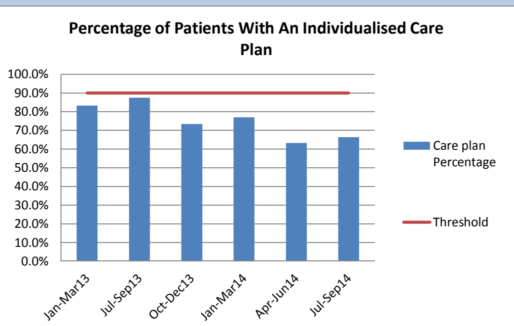


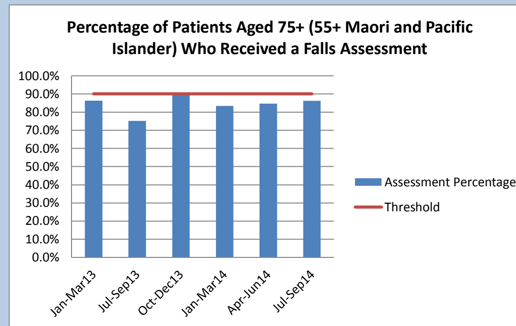












6.7

SOUTHERN DISTRICT HEALTH BOARD

Title:	Complaints to Health and Disability Commission (HDC) involving Southern DHB - Summary
Report to:	Hospital Advisory Committee
Date of Meeting:	04 February 2015

Summary:

Considered in this paper is:

A summary of Data and Analysis of Complaints to HDC involving Southern DHB.

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

Financial:	No
Workforce:	No
Other:	Patient Experience of Care/Risk

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

Prepared by:	Presented by:
HDC Received: December 2014	Mr Richard Bunton Medical Director of Patient Services

RECOMMENDATION:

That the Committee receive the report.

Complaints to HDC involving District Health Boards

Southern DHB

Report and Analysis for period 1 January to 30 June 2014

Health and Disability Commissioner
Te Toihau Hauātanga

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Commissioner's Foreword

I am pleased to bring you HDC's second six-monthly DHB complaint report for the 2013/2014 year.

The trends reported within this report are broadly similar to those seen in the first half of the financial year. Over half of all complaints received in January to June 2014 about DHBs were primarily about care/treatment issues. The most prominent specific primary issue continues to be that of missed, incorrect or delayed diagnoses, which was the primary issue in around a fifth of complaints about DHBs. When we consider all issues raised in DHB complaints, we see that concerns about communication and manner continue to feature in around a quarter of complaints. Taken together this indicates that although care/treatment issues may be the primary reason behind a complaint, consumers often also feel that the way they were communicated with in the context of that care/treatment issue was inappropriate. I note that engagement is an important aspect of a consumer-centred system. An engaged consumer is an empowered consumer. Involved and informed consumers are more able to self-manage their conditions, better adhere to treatment regimes and have increased levels of patient satisfaction.

I trust that this report will prove useful to you. I continue to welcome your feedback on how we can further improve the usefulness of these reports.

Anthony Hill
Health and Disability Commissioner

6.7

National Data for all District Health Boards

1.0 Number of complaints received

1.1 Raw number of complaints received

In the period Jan-Jun 2014, HDC received a total of **330** complaints about care provided by all District Health Boards. Numbers of complaints received in previous six-month periods are reported in Table 1.

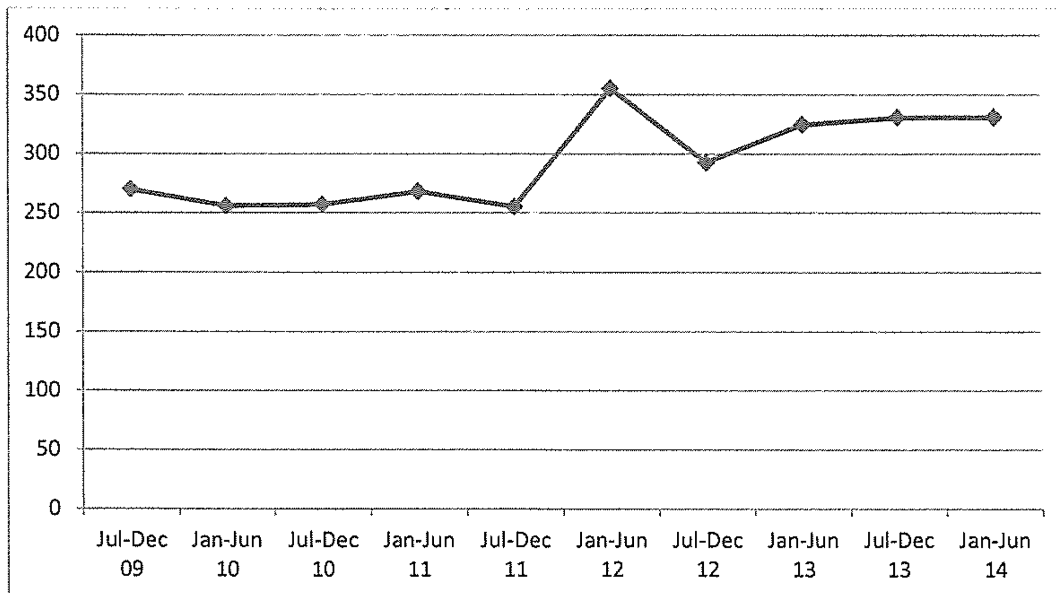
Table 1. Number of complaints received in last five financial years

Jul–Dec 09	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Average of last 4 6-month periods	Jan–Jun 14
270	256	257	268	255	355	292	324	330	**325**	**330**

The total for Jan-Jun 2014 shows an increase of 2% over the average number of complaints received for the previous four periods.

The number of complaints received in Jan-Jun 2014 and previous six-month periods are also displayed below in Figure 1.

Figure 1. Number of complaints received



1.2 Rate of complaints received

When numbers of complaints to HDC are expressed as a rate per 100,000 discharges, comparisons can be made between DHBs, and within DHBs over time, enabling any trends to be observed.

Frequency calculations are made using discharge data provided by the Ministry of Health (provisional as at the date of extraction, 15 August 2014).

Table 2. Rate of complaints received per 100,000 discharges during Jan–Jun 2014

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
330	451,839[1]	**73.03**

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jan-Jun 2014 and previous six-month periods.

Table 3. Rate of complaints received in last five financial years

	Jul–Dec 09	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13[2]	Average of last 4 6-month periods	Jan–Jul 14
Rate per 100,000 discharges	61.63	60.19	57.16	62.48	55.86	80.22	62.59	72.67	71.15	71.66	**73.03**

The rate of complaints received during Jan–Jun 2014 (73.03) shows a 2% increase over the average rate of complaints received for the previous four periods.

Table 4 shows the rate of complaints about DHBs received by HDC per 100,000 discharges for each DHB (not named[3]) relative to other DHBs for Jan-Jun 2014. Each DHB's complaint rate on the tables can be identified from its individual report.

All individual DHBs were subject to some complaints to HDC. As shown in Table 4, for individual DHBs, the rate of complaints received ranged from 27.29 complaints per 100,000 discharges to 192.51 complaints per 100,000 discharges against the national rate of 73.03 complaints per 100,000 discharges. The raw number of complaints received about individual DHBs ranged from 3 complaints to 48 complaints.

[1] The total number of discharges excludes short stay emergency department discharges and patients attending outpatient units and clinics.
[2] The rate for Jul–Dec 2013 has been recalculated based on the most recent discharge data.
[3] Individual DHBs have not been named in this report given the small sample size and the short period covered (six months).

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Table 4. Rate of complaints received per 100,000 discharges

DHB	Rate of complaints to HDC per 100,000 discharges	DHB	Rate of complaints to HDC per 100,000 discharges
DHB 1	27.29	DHB 11	71.63
DHB 2	53.88	DHB 12	80.57
DHB 3	55.68	DHB 13	82.01
DHB 4	60.60	DHB 14	84.08
DHB 5	60.68	DHB 15	90.74
DHB 6	64.42	DHB 16	91.02
DHB 7	66.10	DHB 17	95.20
DHB 8	66.35	DHB 18	130.78
DHB 9	66.60	DHB 19	181.23
DHB 10	71.18	DHB 20	192.51
		All DHBs	**73.03**

2.0 Service types complained about

2.1 Service type category

Complaints to HDC are shown by service type in Table 5. Please note that some complaints involve more than one DHB and/or more than one hospital, therefore, although there were 330 complaints against DHBs, 355 services have been complained about.

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Table 5. Service types complained about

Service type	Number of complaints	Percentage
Accident and emergency (including paramedics)	43	12.1%
Aged care (long-term care facility)	2	0.6%
Alcohol and drug	7	2.0%
Dental	8	2.3%
Diagnostics	7	2.0%
District nursing	3	0.8%
General medicine	64	18.0%
Cardiology	8	2.3%
Endocrinology	4	1.1%
Gastroenterology	6	1.7%
Geriatric medicine	4	1.1%
Haematology	1	0.3%
Neurology	11	3.1%
Oncology	7	2.0%
Palliative care	2	0.6%
Renal/nephrology	5	1.4%
Respiratory	8	2.3%
Other/unspecified	8	2.3%
Hearing services	2	0.6%
Intensive care/critical care	7	2.0%
Maternity	17	4.8%
Mental health	65	18.3%
Paediatrics (not surgical)	16	4.5%
Rehabilitation services	4	1.1%
Surgery	101	28.5%
Cardiothoracic	6	1.7%
General	26	7.3%
Gynaecology	14	3.9%
Maxillofacial	1	0.3%
Neurosurgery	2	0.6%
Ophthalmology	1	0.3%
Orthopaedics	38	10.7%
Otolaryngology	4	1.1%
Paediatric	3	0.8%
Urology	5	1.4%
Vascular	1	0.3%
Vision/eye services (not surgical)	3	0.8%
Other health service	6	1.7%
TOTAL	355	

The five service types with the greatest number of complaints were surgery (28.5%), mental health (18.3%), general medicine (18.0%), accident and emergency (12.1%) and maternity (4.8%). This is broadly similar to what was seen last period. It should be noted that the increase in complaints relating to surgical services and consequent decrease in complaints about general medicine during Jan-Jun 2014 is directly attributable to changes made as a result of DHB feedback indicating that some of the services previously grouped under general medicine (gynaecology, orthopaedics, otolaryngology and urology) are more appropriately grouped under surgery. Table 5 now also shows the surgical service complaints by individual service involved.

3.0 Issues complained about

3.1 Primary complaint issues

For each complaint received by HDC, one primary complaint issue is identified. Due to the introduction of more nuanced complaint issue terms, and therefore a much higher degree of granularity, those complaint issues listed in only one complaint have been classified as 'other'. The primary issues identified in complaints received in Jan-Jun 2014 are listed in Table 6.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints primarily about this issue	Percentage
Access/Funding	***28***	***8.5%***
Lack of access to services	8	2.4%
Lack of access to subsidies/funding	5	1.5%
Waiting list/prioritisation issue	15	4.5%
Boundary violation	***5***	***1.5%***
Inappropriate sexual physical contact	4	1.2%
Other	1	0.3%
Care/Treatment	***197***	***59.7%***
Delay in treatment	4	1.2%
Delayed/inadequate/inappropriate referral	11	3.3%
Inadequate coordination of care/treatment	5	1.5%
Inadequate/inappropriate clinical treatment	36	10.9%
Inadequate/inappropriate examination/assessment	10	3.0%
Inadequate/inappropriate monitoring	3	0.9%
Inadequate/inappropriate non-clinical care	11	3.3%
Inadequate/inappropriate testing	4	1.2%
Inappropriate/delayed discharge/transfer	14	4.2%
Inappropriate withdrawal of treatment	2	0.6%
Missed/incorrect/delayed diagnosis	56	17.0%
Refusal to assist/attend	4	1.2%
Refusal to treat	3	0.9%
Rough/painful care or treatment	8	2.4%
Unexpected treatment outcome	20	6.1%
Unnecessary treatment/over-servicing	3	0.9%
Other	3	0.9%
Communication	***34***	***10.3%***
Disrespectful manner/attitude	21	6.4%
Failure to communicate openly/honestly/effectively with consumer	4	1.2%
Failure to communicate openly/honestly/effectively with family	9	2.7%

Primary issue in complaints	Number of complaints primarily about this issue	Percentage
Consent/Information	***22***	***6.7%***
Consent not obtained/adequate	5	1.5%
Inadequate information provided regarding options	2	0.6%
Inadequate information provided regarding treatment	2	0.6%
Issues with involuntary admission/treatment	8	2.4%
Other	5	1.5%
Documentation	***7***	***2.1%***
Delay/failure to transfer documentation	2	0.6%
Inadequate/inaccurate documentation	5	1.5%
Facility issues	***11***	***3.3%***
Cleanliness/hygiene issue	2	0.6%
General safety issue for consumer in facility	2	0.6%
Staffing/rostering/other HR issue	2	0.6%
Waiting times	3	0.9%
Other	2	0.6%
Medication	***12***	***3.6%***
Administration error	3	0.9%
Inappropriate prescribing	5	1.5%
Other	4	1.2%
Reports/Certificates	***5***	***1.5%***
Inaccurate report/certificate	5	1.5%
Disability-specific issues	***2***	***0.6%***
Other professional conduct issues	***7***	***2.1%***
TOTAL	***330***	

The most common primary issue categories in complaints concerned care/treatment (59.7%), communication (10.3%) and access/funding (8.5%). Among these, the most common specific primary issues in complaints against DHBs were missed/incorrect/delayed diagnosis (56 complaints), inadequate/inappropriate treatment/procedure (36 complaints), disrespectful manner/attitude (21 complaints) and unexpected treatment outcome (20 complaints). This is broadly similar to what was seen in the previous 6 month period.

Table 7 shows a comparison over time for the top five categories of primary issues complained about. Please note that, due to the introduction of new categories, comparisons over time have limitations.

Table 7. Top five primary issues in complaints received over last four six-month periods

Top five primary issues in all complaints (%)							
Jul–Dec 12 n=292		Jan–Jun 13 n=324		Jul–Dec 13 n=330		Jan–Jun 14 n=330	
Treatment	60%	Treatment	57%	Treatment	55%	Treatment	60%
Communication	11%	Communication	15%	Communication	12%	Communication	10%
Consent/ Information	7%	Access/Funding	9%	Consent/ Information	9%	Access/Funding	9%
Access/Funding	6%	Consent/ Information	8%	Medication	7%	Consent/ Information	7%
Discharge & transfer arrangements	3%	Medication and Professional conduct	3% each	Access/Funding	6%	Medication	4%

The top five categories of primary issues in Jan-Jun 2014 are similar to primary issues reported in previous periods. Treatment and communication are consistently the most common primary issues across all periods. Complaints about access and funding were more prominent in Jan-Jun 2014 than in the previous 6 month period, while complaints about medication decreased within this period.

3.2 All complaint issues

As well as the primary complaint issue, up to six additional other complaint issues are identified for each complaint received by HDC. Table 8 includes these additional complaint issues as well as the primary complaint issues to show all issues identified in complaints received. Complaint issues listed in only one complaint have been classified as 'other'.

On analysis of all issues identified in complaints against DHBs, the five most common issues were inadequate/inappropriate treatment (38.2%), missed/incorrect/delayed diagnosis (28.2%), failure to communicate openly/honestly/effectively with consumer (27.6%), disrespectful manner/attitude (22.4%), and inadequate response to consumer's complaint by a DHB (23.9%). This is broadly similar to what was seen in Jul-Dec 2013, with inadequate response to complaint increasing from being an issue in 52 complaints to being mentioned in 79 complaints received within Jan-Jun 2014, while failure to communicate effectively with the consumer increased from being mentioned in 46 complaints last period to being an issue in 91 complaints this period. Failure to communicate with family, on the other hand, decreased from being an issue in 74 complaints in Jul-Dec 2013 to being mentioned in 62 complaints during this period.

Many complaints involved issues with a consumer's care/treatment, such as inadequate examination/assessment, delay in treatment, inadequate testing, inappropriate/delayed discharge/transfer, inadequate coordination of care/treatment and unexpected treatment outcome; each of these were mentioned in around 17% of complaints. This is an increase from last period, where each of these issues was mentioned in around 10% of complaints.

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding		
ACC compensation issue	7	2.1%
Lack of access to services	40	12.1%
Lack of access to subsidies/funding	10	3.0%
Waiting list/prioritisation issue	29	8.8%
Boundary violation		
Inappropriate non-sexual contact	2	0.6%
Inappropriate sexual physical contact	4	1.2%
Care/Treatment		
Delay in treatment	57	17.3%
Delayed/inadequate/inappropriate referral	42	12.7%
Inadequate coordination of care/treatment	57	17.3%
Inadequate/inappropriate clinical treatment	126	38.2%
Inadequate/inappropriate examination/assessment	57	17.3%
Inadequate/inappropriate follow-up	30	9.1%
Inadequate/inappropriate monitoring	15	4.5%
Inadequate/inappropriate non-clinical care	30	9.1%
Inadequate/inappropriate testing	59	17.9%
Inappropriate admission/failure to admit	8	2.4%
Inappropriate/delayed discharge/transfer	56	17.0%
Inappropriate withdrawal of treatment	8	2.4%
Missed/incorrect/delayed diagnosis	93	28.2%
Personal privacy not respected	9	2.7%
Refusal to assist/attend	24	7.3%
Refusal to treat	9	2.7%
Rough/painful care or treatment	19	5.8%
Unexpected treatment outcome	59	17.9%
Unnecessary treatment/over-servicing	7	2.1%
Communication		
Disrespectful manner/attitude	74	22.4%
Failure to accommodate cultural/language needs	10	3.0%
Failure to communicate openly/honestly/effectively with consumer	91	27.6%
Failure to communicate openly/honestly/effectively with family	62	18.8%
Insensitive/inappropriate comments (non-sexual)	27	8.2%
Complaints process		
Inadequate response to complaint	79	23.9%
Consent/Information		
Coercion by provider to obtain consent	4	1.2%
Consent not obtained/adequate	17	5.2%
Failure to assess capacity to consent	3	0.9%
Inadequate information provided regarding adverse event	14	4.2%
Inadequate information provided regarding condition	10	3.0%
Inadequate information provided regarding options	9	2.7%

All issues in complaints	Number of complaints	Percentage
Inadequate information provided regarding results	6	1.8%
Inadequate information provided regarding treatment	22	6.7%
Incorrect/misleading information provided	24	7.3%
Issues regarding consent when consumer is not competent	3	0.9%
Issues with involuntary admission/treatment	13	3.9%
Documentation		
Delay/failure to disclose documentation	6	1.8%
Delay/failure to transfer documentation	3	0.9%
Inadequate/inaccurate documentation	31	9.4%
Facility issues		
Cleanliness/hygiene issue	10	3.0%
Failure to follow policies/procedures	15	4.5%
General safety issue for consumer in facility	7	2.1%
Inadequate/inappropriate policies/procedures	12	3.6%
Issue with quality of aids/equipment	5	1.5%
Staffing/rostering/other HR issue	13	3.9%
Waiting times	12	3.6%
Other	2	
Medication		
Administration error	8	2.4%
Inappropriate administration	10	3.0%
Inappropriate prescribing	14	4.2%
Prescribing error	2	0.6%
Refusal to prescribe/dispense/supply	13	3.9%
Reports/Certificates		
Refusal to complete report/certificate	2	0.6%
Inaccurate report/certificate	14	4.2%
Teamwork/Supervision		
Delayed/inadequate/inappropriate handover	8	2.4%
Inadequate supervision/oversight	5	1.5%
Other professional conduct issues	26	
Disability-specific issues	6	
Other	13	

3.3 Service type and primary issues

Table 9 shows the top three primary issues in complaints concerning the most commonly complained about service types.

Table 9. Three most common primary issues in complaints by service type

Surgery n=101		Mental health n=65		General medicine n=64		Accident & emergency n=43		Maternity n=17	
Missed/ incorrect/ delayed diagnosis	21%	Issues with involuntary admission/ treatment	12%	Missed/ incorrect/ delayed diagnosis	14%	Missed/ incorrect/ delayed diagnosis	30%	Missed/ incorrect/ delayed diagnosis	29%
Unexpected treatment outcome	17%	Failure to communicate effectively with family	12%	Inadequate/ inappropriate treatment	11%	Inadequate/ inappropriate treatment	9%	Inadequate/ inappropriate treatment	12%
Inadequate/ inappropriate treatment	14%	Inadequate/ inappropriate treatment	9%	Disrespectful attitude/ manner	8%	Disrespectful attitude/ manner	8%	Disrespectful attitude/ manner	12%

4.0 Complaints closed

HDC closed **411**[4] complaints involving DHBs in the period Jan–Jun 2014. Table 10 shows the number of complaints closed in previous six-month periods.

Table 10. Number of complaints closed in last five financial years

Jul–Dec 09	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Average of last 4 6-month periods	Jan–Jun 14
228	262	257	246	217	302	254	337	280	293	411

The total number of complaints closed for Jan-Jun 2014 shows an increase of 22% over the same period last year and an increase of 40% over the average of the last four six-month periods.

4.1 Outcomes of complaints closed

Complaints that are within HDC's jurisdiction are classified into two groups according to the manner of resolution — whether formal investigation or non-investigation. Within each classification, there is a variety of possible outcomes. Once HDC has notified a DHB that a complaint concerning that DHB is to be investigated, the complaint remains classified as a formal investigation, even though an alternative manner of resolution may subsequently be adopted. Notification of formal investigation generally indicates more serious or complex issues.

In the Jan-Jun 2014 period, **3** DHBs had no investigations closed, **7** DHBs had one investigation closed, **5** DHBs had two investigations closed, **3** DHBs had three investigations closed, **1** DHB had four investigations closed, and **1** DHB had six investigations closed by HDC.

The manner of resolution and outcomes of all DHB complaints closed in Jan-Jun 2014 is shown in Table 11.

[4] Note that complaints may be received in one six-month period and closed in another six-month period — therefore, the number of complaints received will not correlate with the number of complaints closed.

6.7

Table 11. Outcome for DHBs of complaints closed by complaint type[5]

Outcome for DHBs	Number of complaints closed
Investigation	***35***
Breach finding	14
No further action[6] with follow-up or educational comment	15
No further action	6
Non-investigation	***362***
No further action with follow-up or educational comment	101
Referred to Ministry of Health	2
Referred to District Inspector	12
Referred to DHB[7]	76
Referred to Advocacy	30
No further action	131
Withdrawn	10
Outside jurisdiction	***14***
TOTAL	411

4.2 Recommendations made to DHBs following a complaint

Regardless of whether or not a complaint has been investigated, the Commissioner may make recommendations to a DHB. HDC generally then follows up with the provider to ensure that these recommendations have been acted upon. Table 12 shows the recommendations made to DHBs in complaints closed in the current period. Please note that more than one recommendation may be made in relation to a single complaint.

[5] Note that outcomes are displayed in descending order of seriousness. If there is more than one outcome for a DHB upon resolution of a complaint then only the outcome which is listed highest in the table is included

[6] The Commissioner has a wide discretion to take no further action on a complaint. For example, the Commissioner may take no further action because careful assessment indicates that a provider's actions were reasonable in the circumstances, or a more appropriate outcome can be achieved in a more flexible and timely way than by means of formal investigation, or that the matters that are the subject of the complaint have been, or are being, or will be appropriately addressed by other means. This may happen, for example, where a DHB has carefully reviewed the case itself and no further value would be added by HDC investigating, or where another agency is reviewing, or has carefully reviewed the matter (for example, the Coroner, the Director-General of Health, or the District Inspector). Assessment of a complaint prior to a decision to take no further action will usually involve obtaining and reviewing a response from the provider and, in many cases, expert clinical advice.

[7] In line with their responsibilities under the Code, DHBs have increasingly developed good systems to address complaints in a timely and appropriate way. It is often appropriate for HDC to refer a complaint to the DHB to resolve, with a requirement that the DHB report back to HDC on the outcome of its handling of the complaint.

Table 12. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	30
Audit	36
Meeting with consumer/complainant	6
Personal reflection	7
Presentation/discussion of complaint with others	3
Provision of information	22
Review of policies/procedures	52
Training/professional development	24
Total	**180**

The most common recommendation made to DHBs was that they review their policies/procedures (52 recommendations). Recommended audits were most commonly of policies/procedures followed by documentation and a root cause analysis/internal investigation. Written apologies were recommended on 30 occasions and feedback from complainants suggests that these were often highly valued.

5.0 Learning from complaints — HDC case reports

The four complaints below were closed following an investigation by the Commissioner.[8] Each of these cases raises issues particularly relevant to the Commissioner's vision of a consumer-centred system, which is a system built on the concepts of seamless service, engagement, transparency, and an empowering culture. These issues arise across all DHBs, and therefore the cases provide learning relevant to all DHBs.

Care provided during labour to a woman with diabetes (12HDC00932)

Background

Ms A, aged 34 years, had a history of type 1 diabetes and was pregnant with her first child. She went into labour at 36 weeks plus 6 days' gestation and presented to the local public hospital in the early hours of the morning.

Monitoring of Ms A and the fetal heart rate commenced and continued throughout the morning. Later that morning, three decelerations on the CTG were noted following the insertion of an epidural, and the obstetrics registrar was asked to review Ms A. Following review, the registrar requested that monitoring continue, with the plan to review the CTG again in half an hour.

The CTG remained normal, and so usual monitoring continued into the afternoon. At 3pm, Syntocinon was commenced, and the epidural was re-sited half an hour later. At 5.10pm, the registrar again reviewed Ms A. He noted that she had a mild temperature, and that there was a change on the CTG which he considered indicated fetal compromise. Following a discussion of management options, a decision was made to attempt instrumental delivery.

The registrar commenced delivery on the ward using a Kiwicup ventouse. After five traction attempts the head was crowning, and the Kiwicup "popped off". The registrar converted to a forceps delivery, and the baby was delivered with one traction. The baby initially required respiratory resuscitation. Two hours after birth, the baby was noted to be displaying unusual movements and was transferred

[8] The fully anonymised/partially anonymised reports for the cases cited are available on the HDC website: www.hdc.org.nz.

to the Neonatal Intensive Care Unit. Ms A's daughter still has some weakness down one side, and continues to be followed up by the paediatric team at the DHB.

Findings

The Commissioner found that the registrar made a series of poor clinical decisions, and underestimated the complexity of the instrumental delivery. The registrar's decision to proceed with an instrumental delivery failed to take into account unfavourable factors, including that the baby's head was high and in a transverse position, that Ms A was a diabetic who was small in stature and carrying a large baby, that it had already been a long labour, and that this was Ms A's first pregnancy. The Commissioner also considered that it was inappropriate to perform the instrumental delivery on the ward, and that the registrar should have considered converting to a Caesarean-section when delivery was not imminent. The Commissioner found that the registrar breached Rights 4(1) and 4(4) of the Code of Health and Disability Services Consumers' Rights (the Code).

The Commissioner was of the view that systemic issues at the DHB had contributed to the registrar's failures in this case. In particular, at the time of events, the DHB had a culture which placed the onus on more junior staff to identify the limits of their expertise and ensure that they were operating within safe and acceptable margins. The Commissioner found that the DHB breached Right 4(1) of the Code for failing to discharge its responsibility to ensure its staff were adequately supported and guided in their decision-making.

Recommendations

The Commissioner recommended that the DHB carry out an audit of all mid-cavity and rotational instrumental deliveries, in order to assess compliance with its new policy for mandatory consultant involvement. The DHB was also asked to communicate with all other DHBs in New Zealand to ensure that their policies in relation to the supervision of obstetrics registrars are consistent. These recommendations have been met by the DHB.

Concentrated feeding and fluid balance assessment of baby (12HDC00115)

Background

An 11 month-old child (Baby A) was admitted to a public hospital for management of on-going issues with vomiting, oral aversion, and poor weight gain. A treatment plan of concentrated feeding was developed. Baby A initially responded well, with a small weight gain and a reduction in her vomiting.

Six days after her admission, Baby A developed diarrhoea. A stool sample was taken on the eighth day of her admission, which returned a positive result for rotavirus. The treatment plan was adjusted, with concentrated feeding continuing and enerlyte to be used for rehydration. Neither Baby A's primary paediatrician nor her dietician were informed of the rotavirus diagnosis.

A multi-disciplinary team (MDT) meeting was held nine days after Baby A's admission, in order to plan her discharge. The rotavirus diagnosis was not discussed at the meeting.

That night Baby A's respiration rate and oxygen saturation rates were found to be low. A Senior House Officer (SHO) reviewed her, and recommended continued observations. The SHO formed the impression that Baby A may have had a respiratory tract infection. Baby A's vital signs were monitored overnight and remained stable.

At 9.30am the next morning Baby A's temperature was 38°C. Nursing notes recorded that Baby A was "miserable", not tolerating feeds, and frequently vomiting and passing diarrhoea. At 12.15pm Baby A was reviewed by a registrar, who recommended that the treatment plan continue.

Baby A's vital signs were checked by nursing staff at 3.45pm and found to be "not dissimilar" to recent observations. Baby A's vital signs were not checked again until 9.35pm, but which point she was noted to be "miserable" and "quiet" with a temperature of 39.2°C and an increased heart rate.

At midnight Baby A's temperature and heart rate had decreased. At 3.30am, nursing staff found Baby A "not responsive, eyes rolled back, all extremities cold to touch". An emergency call was made, with

a consultant paediatrician and SHO attending. Baby A was found to be in respiratory distress, with "mottled" extremities and "equal but sluggish" pupils, and a 39.2°C fever.

Baby A was transferred to the hospital's Intensive Care Unit, where tests led to a diagnosis of hypernatraemia and severe dehydration, with acute respiratory distress and renal failure. Baby A was transferred to another hospital with multiple organ failure and significant swelling in her brain. Baby A was taken off life support the next day, and died shortly afterwards.

Findings

The Commissioner found that a number of service failures led to Baby A receiving sub-optimal care and treatment in the period between her diagnosis with rotavirus and her fatal collapse three days later. These failings were caused, in part, by poor assessment, monitoring, and treatment of Baby A's developing dehydration, and poor communication within the MDT.

From a clinical perspective, the Commissioner considered that there was inadequate monitoring of Baby A's fluid balance and weight, that clinicians should have considered whether to continue concentrated feeds given Baby A's diarrhoea, and that there was a failure to arrange medical review when Baby A was ill the night before her collapse. The DHB was found to have breached Right 4(1) of the Code.

The Commissioner found that communication within the MDT in regard to Baby A's rotavirus diagnosis was inadequate, and led to missed opportunities for review of the treatment plan. The DHB was, therefore, found to have breached Right 4(5) of the Code.

Recommendations

The Commissioner made a number of recommendations to the DHB, including that staff meet with Baby A's family to discuss the care provided and the changes made at the DHB as a result. The Commissioner also asked the DHB to review its nursing handover systems, the level of support and oversight available to junior doctors, and the content of paediatric fluid balance charts. The Commissioner also requested reports on the progress of the DHB's improvements, including the implementation of the Early Warning Score system and new gastroenteritis guidelines. The DHB has met these recommendations.

Failure to follow-up chest X-ray results (12HDC00112)

Background

Mrs B, aged 66 years, had a history of heavy smoking. Her general practitioner (GP) referred her to the Dental Unit of a public hospital. Mrs B saw a locum dental surgeon who booked her for removal of all her teeth under general anaesthetic, and requested a pre-anaesthetic assessment. The dental surgeon understood that any abnormal test findings identified at the pre-anaesthetic assessment would be reported to, and acted on, by the anaesthetic team.

When Mrs B saw an anaesthetist for assessment, the anaesthetist noted a heart murmur and an ECG showed sinus tachycardia. The anaesthetist therefore requested a chest X-ray and echocardiogram be done before surgery. However, the anaesthetist did not document that she had requested these, nor did she document Mrs B's smoking history.

Mrs B underwent a chest X-ray the next day. The radiologist reported an abnormal opacity on the lung and recommended a follow-up investigation. However, the wording of his report was unclear, and the radiologist did not follow the process to "red flag" the abnormal result. The X-ray result was automatically faxed to the Dental Unit, with the referrer listed under the generic name "Dr Dental Dental". No one in the Dental Unit sighted the results and they were not put on Mrs B's file.

On the day of Mrs B's operation, she was seen by another anaesthetist who checked her medical history and the notes from the pre-anaesthetic assessment. The anaesthetist did not review Mrs B's heart murmur. As there was no record that an X-ray had been requested, the anaesthetist did not expect to see one. Surgery went ahead, and Mrs B was discharged home.

A year later, Mrs B visited a GP complaining of chest pain. A chest X-ray showed an upper lobe lung mass, and subsequent investigations diagnosed an inoperable carcinoma with metastases. DHB staff met with Mrs B to explain what had happened and apologise. Sadly, Mrs B died later that year.

Findings

The Commissioner found that the failure to follow up the abnormality on the chest X-ray occurred in the context of serious organisational and systemic failures by the DHB. In particular, an effective and formalised system for reporting test results was not in place. The DHB breached Right 4(1) of the Code.

Adverse comment was made about the first anaesthetist's documentation deficiencies. The radiologist was found in breach of Right 4(1) of the Code for failing to bring the abnormal result to the attention of clinicians caring for Mrs B. The second anaesthetist was found in breach of Right 4(2) of the Code for failing to address the issues identified in the pre-anaesthetic assessment, most notably Mrs B's heart murmur.

Recommendations

The Commissioner made detailed recommendations to the DHB, to be attended to as a matter of priority, which they are currently undertaking. In particular, he recommended that the anaesthetic department review and develop a formalised process governing follow-up of investigations ordered at pre-anaesthesia clinics. The Commissioner also recommended that the DHB provide an evaluative report on the effectiveness of all system changes implemented as result of this case, with specific reference to:

- the radiology service's performance in relation to distribution of dental X-ray reports;
- adherence to the Radiology Red Flagging Protocol;
- feedback from the anaesthetic department on the improvements made to communication, and new Anaesthetic Record templates;
- audit of the Dental Unit's compliance with the new system of review and sign-off of investigation results it receives;
- the electronic radiology information system; and
- the new anaesthetic alerts sent by email to anaesthetists with details of any expected problems, a day prior to the theatre list being produced.

Triage assessment of patient with reported exposure to meningitis; delays in treatment (12HDC01172)

Background

Teenager, Miss C, presented to the Emergency Department at a public hospital complaining of a sore throat, stiff neck, headache, and vomiting. Miss C's classmate had been diagnosed with meningococcal meningitis 10 days earlier.

Miss C was triaged by a registered nurse as an Australasian Triage Scale (ATS) 3 patient (to be seen within 30 minutes). Miss C was not seen by a doctor for approximately three hours and 20 minutes. While she was waiting she was given anti-nausea medication, paracetamol and ibuprofen. Her vital signs were not taken, and her condition was not reassessed while she waited to be seen.

Miss C was seen by a registrar, who diagnosed pharyngitis. She received intravenous antibiotics overnight, and was discharged the next morning with instructions to return if she felt worse.

Over the course of the day, Miss C developed a rash on her hands and legs. She returned to the Emergency Department and was triaged as an ATS 2 patient (to be seen within 10 minutes). Miss C was not seen by a doctor for approximately 55 minutes. Blood cultures taken from her previous presentation indicated that she had contracted meningococcal meningitis. Miss C was admitted to hospital, and received five days of intravenous antibiotics.

During her admission, Miss C developed additional symptoms including another rash, a painful lump on her leg, and ongoing joint aches. These were diagnosed as an immunological response to her illness. Miss C was discharged with a five-day prescription for oral antibiotics.

After returning home, Miss C continued to experience joint pain, lumps on her legs, and her rash became worse. She was taken to another public hospital, where she was diagnosed with rheumatic fever.

Findings

While the Commissioner considered that the clinical treatment Miss C was ultimately provided was of an acceptable standard, he was concerned that the Emergency Department's triage process was not implemented effectively on two successive visits. The Commissioner considered this was a systemic issue that was directly attributable to the DHB, and therefore found the DHB in breach of Right 4(4) of the Code.

The Commissioner also made adverse comment about the care provided by the registered nurse who triaged Miss C at her first presentation to the Emergency Department, and about the registrar's decision not to discuss Miss C's case with a Senior Medical Officer before she was discharged.

Recommendations

The Commissioner made a number of recommendations to the DHB which are currently being undertaken. These recommendations including a review of its triage policy and the need for a triage assessment nurse to be allocated to the waiting room, and an audit of the effectiveness of the changes it made to the systems operating in the Emergency Department, including its revised Emergency Department staffing levels, its triage categorisation process, the development of an Escalation Policy, and the introduction of a system to fast track lower acuity patients through the Emergency Department (the 'Minor Care Zone').

Failure to provide information about infertility to young man prior to chemotherapy (13HDC00475)

Background

On 5 June 2008, when Mr A was 14 years old, he underwent a biopsy which indicated that he had Ewing sarcoma (cancer) of the pelvis. Mr A was admitted to hospital five days later for surgical treatment, to be followed by chemotherapy treatment.

Mr A's first chemotherapy treatment was scheduled for the afternoon of 12 June 2008. That morning, on-call paediatric oncologist Dr B met with Mr A and his parents to discuss the treatment. Dr B mentioned the potential impact of chemotherapy on fertility, but did not emphasise it. The discussion focussed mainly on the potential adverse effects of the drugs to be used during the treatment. Mr A and his parents were provided with written information about the chemotherapy drugs, but those information sheets did not refer to the potential impact of chemotherapy on fertility.

The DHB advised that, at the time of these events, the normal process was for fertility to be discussed with the patient by an adolescent nurse specialist as part of a checklist prior to chemotherapy starting. However, on 12 June 2008 the nurse specialist was on leave and there was no apparent system in place to ensure that the checklist was covered by someone else in the nurse specialist's absence.

Mr A underwent his first chemotherapy treatment on the afternoon of 12 June 2008. The next day, a nurse mentioned fertility to Mr A and his parents when completing a routine checklist. Mr A's mother was upset when advised of the risk of infertility. Dr B met with Mr A and his parents on 13 June 2008 to discuss fertility and the option of storing a sperm sample. Part of this discussion took place in private with Mr A, without his parents being present.

Findings

The Commissioner acknowledged the efficient and appropriate clinical care Mr A received overall in relation to his management from the point of diagnosis to the commencement of his chemotherapy. However, the Commissioner was concerned about the information Mr A was provided.
Prior to consenting to chemotherapy treatment, Mr A and his parents, who were his legal guardians at the time, were entitled to the information that a reasonable consumer, in Mr A's circumstances, would expect to receive. The Commissioner found that, in this case, that would include information about the risk of chemotherapy treatment in respect of fertility, and the option for banking sperm in light of that risk.

The Commissioner made adverse comment about Dr B's failure to provide that information to Mr A prior to his first chemotherapy treatment, and his decision to, in the absence of his parents, discuss the option of the Mr A providing a sperm sample.

The Commissioner found that the DHB breached Right 6(1) of the Code for failing to have adequate mechanisms in place at the time of these events to ensure the provision of fertility information and treatment options to consumers prior to them undertaking chemotherapy treatment.

Recommendations

The Commissioner noted that steps have been taken since 2008 by Dr B, the DHB, and by providers nationally to improve the provision of information about fertility to consumers in these circumstances. Those steps include a number of initiatives undertaken at the DHB, as well as the establishment of a national Fertility Preservation Working Group responsible for developing nationally agreed approaches to minimise the impact of cancer and cancer treatment on future fertility of people of any age (national guidelines). The Commissioner encouraged all providers working in the area to adopt the national guidelines and ensure that future practice is improved.
The Commissioner recommended that the DHB review its current policies, information sheets and practice with regard to discussions of infertility with patients undergoing chemotherapy.

6.7

Data for Southern District Health Board

Please note that data reported captures only those complaints in which the DHB was identified as a provider by the complainant or was subsequently identified by HDC as a party. Where a complaint is made about an individual practitioner at a DHB and the DHB is not identified, the complaint may not be included in these reports.

6.0 Complaints received about Southern DHB

In the period Jan-Jun 2014, HDC received a total of **17** complaints about care provided by Southern District Health Board.

6.1 Rate of complaints received

Table 13 shows the rate of complaints to HDC per total discharges from Southern DHB (25,718) compared to the rate of complaints per total discharges nationally (451,839).

The number of total discharges excludes short-stay discharges from emergency departments, and patients attending outpatient units and clinics.

Table 13. Number and rate of complaints per total discharges

Southern DHB			National (All DHBs)
Number of complaints	Number of discharges	Rate per 100,000 discharges	Rate per 100,000 discharges
17	25,718	66.10	73.03

Southern DHB is identified on the overall DHB complaint rate list (Table 4) as **DHB 7**. Southern DHB was identified as DHB 8 in the previous six-month period. As can be seen from the above table, Southern DHB's complaint rate for Jan-Jun 2014 was lower than that of the national complaint rate for the same period.

Table 14 shows the number and rate of complaints about Southern DHB received by HDC per 100,000 discharges, for Jan-Jun 2014 and previous six-month periods.

Table 14. Number and rate of complaints received in last five financial years

	Jul–Dec 09	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13[9]	Average of last 4 6-month periods	Jan–Jun 14
Complaints received	20	19	11	13	15	25	19	14	20	20	17
Rate per 100,000 discharges	80.26	78.49	42.50	53.47	56.56	96.53	69.89	55.25	73.25	73.73	66.10

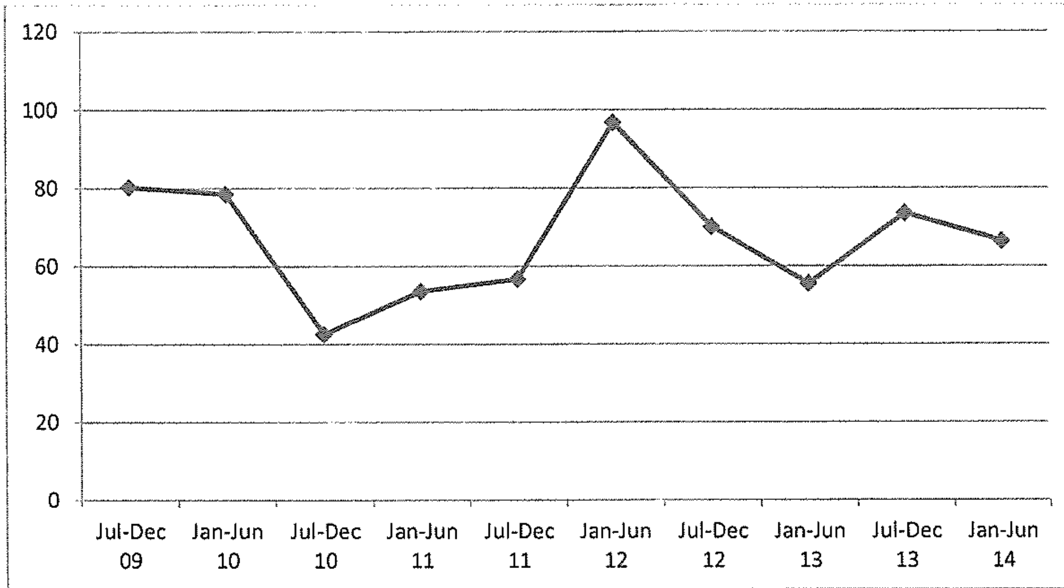
[9] The rate for Jul–Dec 2013 has been recalculated based on the most recent discharge data.

6.7

The rate for Jan-Jun 2014 shows a decrease of 10% over the average rate of complaints received for the previous four periods.

Figure 2 shows the rate of complaints received about Southern DHB for Jan-Jun 2014 and previous six-month periods.

Figure 2. Rate of complaints received per 100,000 discharges in last five financial years



6.7

7.0 Service types complained about at Southern DHB

7.1 Service type

For the 17 complaints received, the services concerned, and numbers of complaints within these services, are shown in Table 15.

Southern DHB had a higher proportion of complaints directed at general medicine (29.4%) than was seen nationally.

Table 15. Service types complained about

Service type	Number of complaints	Percentage
Accident and emergency	2	11.8%
Diagnostics	1	5.9%
General medicine	5	29.4%
Cardiology	2	11.8%
Gastroenterology	1	5.9%
Other/unspecified	2	11.8%
Maternity	1	5.9%
Mental health	4	23.5%
Surgery	4	23.5%
Neurosurgery	1	5.9%
Orthopaedics	3	17.6%
TOTAL	17	

7.2 Department/facility and service type complained about

The service types complained about within each department/facility are shown in Table 16.

Table 16. Department/facility and service type complained about

Department/facility subject to complaint	Number of complaints
Dunedin Hospital	7
Diagnostics	1
General medicine	3
Cardiology	1
Gastroenterology	1
Other/unspecified	1
Surgery	3
Neurosurgery	1
Orthopaedics	2
Southland Hospital	9
Accident and emergency	2
General medicine	2
Cardiology	1
Other/unspecified	1
Maternity	1
Mental health	3
Surgery – Orthopaedics	1
Unspecified	1
Mental health	1
TOTAL	17

8.0 Issues complained about at Southern DHB

8.1 Primary issues

For each complaint received by HDC, one primary complaint issue is identified. The primary issues identified in complaints received about Southern DHB are listed in Table 17. Similar to national trends, the most common primary complaint issue category for Southern DHB was care/treatment (64.7%), while the most common specific primary issue was missed/incorrect/delayed diagnosis (23.5%).

Table 17. Primary issues complained about

Primary Issue	Number of complaints	Percentage
Care/Treatment	**11**	**64.7%**
Delayed/inadequate/inappropriate referral	1	5.9%
Inadequate/inappropriate examination/assessment	1	5.9%
Inadequate/inappropriate monitoring	1	5.9%
Inadequate/inappropriate non-clinical care	1	5.9%
Missed/incorrect/delayed diagnosis	4	23.5%
Refusal to assist/attend	1	5.9%
Unexpected treatment outcome	2	11.8%
Communication	**3**	**17.6%**
Disrespectful manner/attitude	2	11.8%
Failure to communicate openly/honestly/effectively with family	1	5.9%
Consent/Information	**1**	**5.9%**
Issues with involuntary admission/treatment	1	5.9%
Facility issues	**1**	**5.9%**
General safety issue for consumer in facility	1	5.9%
Medication	**1**	**5.9%**
Administration error	1	5.9%
TOTAL	**17**	

8.2 Service type and primary issues

The primary issues complained about in relation to each service are set out in Table 18.

Table 18. Primary issues complained about by service type

Service type	Number of complaints	Primary issues identified in each complaint
Accident and emergency	2	Disrespectful manner/attitude Administration error
Diagnostics	1	Missed/incorrect/delayed diagnosis
General medicine – Cardiology	2	Delayed/inadequate/inappropriate referral Inadequate/inappropriate examination/assessment
General medicine – Gastroenterology	1	Inadequate/inappropriate non-clinical care
General medicine – Other/unspecified	2	Inadequate/inappropriate monitoring Disrespectful manner/attitude
Maternity	1	Missed/incorrect/delayed diagnosis
Mental health	4	Refusal to assist/attend Failure to communicate openly/honestly/effectively with family Issues with involuntary admission/treatment General safety issue for consumer in facility
Surgery – Neurosurgery	1	Unexpected treatment outcome
Surgery - Orthopaedics	3	Missed/incorrect/delayed diagnosis x2 Unexpected treatment outcome

9.0 Closed complaints about Southern DHB

9.1 Number of complaints closed

HDC closed 15 complaints about Southern DHB in Jan-Jun 2014. HDC closed 3 complaints about Southern DHB following investigation in this period.

Table 19 shows the number of complaints closed following investigation for the Jan-Jun 2014 and previous six-month periods.

Table 19. Total number of complaints and formal investigations closed in last five financial years

	Southern DHB											All DHBs
	Jul–Dec 09	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Average of last 4 6-month periods	Jan–Jun 14	Jan–Jun 14
Total complaints closed	21	18	13	13	7	21	14	19	25	20	15	411
Investigations closed	2	0	0	0	0	1	0	3	2	2	3	35

9.2 Outcomes of complaints closed

The outcomes of all complaints closed about Southern DHB in Jan-Jun 2014 are shown in Table 20.

Table 20. Outcomes for Southern DHB of complaints closed[10]

Outcomes for Southern DHB	Number of complaints
Investigation	***3***
Breach finding	2
No further action	1
Non-investigation	***12***
No further action with follow-up or educational comment	1
Referred to DHB	1
Referred to Advocacy	3
No further action	7
Total	**15**

[10] Note that outcomes are displayed in descending order of seriousness. If there is more than one outcome for a DHB upon resolution of a complaint then only the outcome listed highest up in the table is included.

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Recommendation

That the Committee receives and notes this report.

6.8

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	YTD $ Variance %
Revenue								
Government & Crown Agency Sourced	3,003	2,667	337	17,127	17,046	81	33,436	0%
Non Government & Crown Agency Revenue	1,246	1,041	206	6,031	6,352	(321)	13,189	-5%
Internal Revenue	37,288	37,569	(281)	225,322	225,684	(362)	450,549	0%
Revenue Total	41,538	41,276	262	248,480	249,082	(602)	497,174	0%
Personnel								
Personnel								
Medical Personnel	(10,134)	(9,862)	(272)	(56,444)	(56,731)	287	(113,250)	1%
Nursing Personnel	(11,006)	(10,855)	(151)	(62,557)	(61,693)	(863)	(124,838)	-1%
Allied Health Personnel	(4,201)	(4,335)	134	(23,869)	(24,715)	847	(49,159)	3%
Support Personnel	(889)	(844)	(45)	(4,966)	(4,826)	(140)	(9,718)	-3%
Management & Administration Personnel	(3,623)	(3,442)	(182)	(20,038)	(19,623)	(415)	(38,509)	-2%
Personnel Total	(29,854)	(29,337)	(516)	(167,874)	(167,588)	(286)	(335,475)	0%
Expenditure								
Outsourced Services	(2,635)	(2,602)	(33)	(15,101)	(15,497)	397	(30,756)	3%
Clinical Supplies	(6,923)	(6,667)	(256)	(41,901)	(41,671)	(230)	(82,584)	-1%
Infrastructure & Non-Clinical Supplies	(5,994)	(5,758)	(236)	(35,610)	(35,066)	(545)	(70,032)	-2%
Expenditure Total	(15,553)	(15,027)	(525)	(92,611)	(92,234)	(377)	(183,372)	0%
Net Surplus / (Deficit)	(3,869)	(3,088)	(780)	(12,005)	(10,740)	(1,265)	(21,673)	-12%

Add Net Impact from research Accounts	(109)	0	(109)	180	0	180	0
Add Donations Received	101	44	58	167	263	(96)	525
Net Surplus / (Deficit)	(3,876)	(3,045)	(831)	(11,658)	(10,477)	(1,181)	(21,148)

The monthly result is unfavourable to budget by $831k and moves the year to date (ytd) result to $1.2m unfavourable to budget.

Revenue continues to be unfavourable ytd however December sees a favourable result of $262k. Government and Crown Agency Sourced revenue is boosted by breast screening transition funding and favourable Accident Compensation Corporation (ACC) revenue. Non-residents and asset sales contribute to Non-Government and Crown Agency revenue. Internal Revenue is unfavourable due to reduced pharmaceutical income from Community Outpatient Pharmacy revenue and Pharmaceutical Cancer treatment drug revenue (PCT). There are favourable offsets in drug costs which drive the subsequent revenue.

Payroll costs are now unfavourable both on a monthly and ytd basis, reflecting ytd adjustments, departures from seasonal phasing plans and continued rates and overtime variances. Personnel outsourcing costs are favourable to budget providing some offset to staff costs.

Clinical Supplies were 4% over budget for the month, although only 1% over budget year to date. The reasons for the monthly variance are explained in section 5.

Infrastructure and Non Clinical costs continue to be unfavourable however December includes a provision for doubtful debts.

6.8

Full Time Equivalent (FTE)

FTE is 19FTE under budget for the month (approx. 0.5%). Although we continue to see favourable variances in Allied Health (35FTE) and Senior Medical Personnel (9FTE), Nursing FTE has not dropped as budgeted. This is explained below.

2. Personnel Costs - $516k unfavourable for month and $286k unfavourable ytd (excluding research)

Total personnel variance is slightly better than the $845k unfavourable November result but moves the ytd position into the red .Unfavourable variances in rates, leave and overtime continue with seasonal phasing's from recruitment related expenses and entitlement adjustments also feature.

Medical Personnel $272k unfavourable for month - $287k favourable ytd

The SMO result is largely driven by vacancies and remains favourable for the month and ytd, both in personnel and outsourcing as shown in the table below. The RMO result is driven by variances in rates, leave and current rotation related costs. Outsourcing costs for Medical staff types is favourable for both the month and ytd. Overall Medical resource is favourable $1.06m ytd.

	Month								Year to Date							
	Actual $' 000	%	Budget $' 000	%	Var $' 000	Actual FTE	Budget FTE	Var FTE	Actual $' 000	%	Budget $' 000	%	Var $' 000	Actual FTE	Budget FTE	Var FTE
SMO Personnel	(6,708)	95%	(6,748)	95%	39	245	254	8	(37,819)	95%	(38,818)	95%	999	245	255	10
Outsourced SMO	(337)	5%	(387)	5%	50				(1,885)	5%	(2,200)	5%	314			
Total SMO	**(7,045)**		**(7,135)**		**89**	**245**	**254**	**8**	**(39,704)**		**(41,017)**		**1,314**	**245**	**255**	**10**
RMO Personnel	(3,426)	97%	(3,114)	95%	(312)	267	266	(1)	(18,625)	97%	(17,913)	95%	(712)	267	266	(1)
Outsourced RMOs	(116)	3%	(167)	5%	51				(486)	3%	(945)	5%	459			
Total RMO	**(3,541)**		**(3,281)**		**(260)**	**267**	**266**	**(1)**	**(19,111)**		**(18,858)**		**(253)**	**267**	**266**	**(1)**
Total Medical Resource	**(10,587)**		**(10,416)**		**(171)**	**512**	**520**	**8**	**(58,815)**		**(59,875)**		**1,060**	**512**	**521**	**9**

Nursing Personnel - $151k unfavourable for month - $883k unfavourable ytd (excluding research)

Nursing costs exceed the monthly budget due to the following;

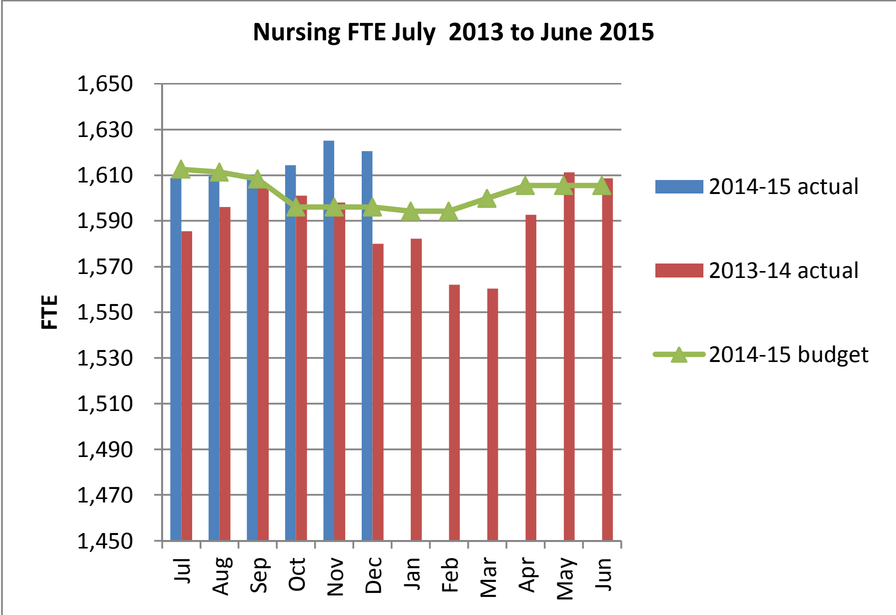
- FTE continues to exceed budget being 19 over for the month which equates to approx. $100k of the variance (YTD FTE is 9FTE over budget = $280k)
- A variance resulting from the difference in actual pay rates to those budgeted for some Nursing staff drives a monthly variance of approx. $30k. This will continue throughout the year.
- Kiwisaver and Overtime were also over budget, consistent with prior months. (combined unfavourable impact of $45k for the month and $440k ytd)
- Annual Leave FTE taken was favourable for the month although remains unfavourable year to date.

The following table shows the main areas of FTE overrun in December. Most of the over budgeted FTE relates to high acuity, sickness cover, and some additional ED nursing resourcing offset by other personnel (i.e. SMO vacancy in medical). FTE cost centres consolidated by site.

CC	CC Name	Actual FTE	Budget FTE	Variance	Reason
2365	Emergency Department (ED)	93.71	89.02	(4.69)	Winter flex reduction/Acuity / Activity
5213	Nursing Resource Unit	12.05	8.9	(3.15)	Acuity / Activity
3185	Acute Mental Health Unit	28.06	25.22	(2.84)	Acuity / Activity
2505	Ward 4C General Surgery/Urology	32.85	30.06	(2.79)	Acuity / Activity/ACC/LSL
2511	Ward 8A General Medicine	59.56	57.14	(2.42)	Acuity / Activity
3301	Day Surgery	16.38	14.35	(2.03)	Acuity / Activity/Leave taken
3300	Main Operating Theatres	58.41	56.59	(1.82)	Acuity / Activity/Leave taken
2203	Wakari Ward 9B Acute Unit	31.11	29.38	(1.73)	Acuity / Activity/ACC/sick leave
2204	Wakari Ward 11	24.1	22.39	(1.71)	Raise Hope bed reduction
5250	Knowledge Centre	6.4	4.9	(1.50)	Med Chart funded project
2350	Maternity Ward	67.4	66.04	(1.36)	ACC/Sick leave/training
2366	Neonatal (NICU) Unit	45.04	43.8	(1.24)	Acuity / Activity

The opposite graph highlights the decrease in budget in October when the winter flex up was scheduled to stop.

Due to unbudgeted resourcing required to cope with high activity, acuity and sickness, Nursing FTE in specialist areas such as NICU, Paeds ward, Mental Health and ED is higher than budget.



Allied Health Personnel - $134k favourable for month - $837k favourable ytd
The monthly and ytd variance is a direct reflection on the lower levels of FTE compared to budget. Leave variances are favourable both monthly and year to date.

Support Personnel - $45k unfavourable for month - $140k unfavourable ytd

This staff type is running unfavourable to budget due to FTE being 2 over budget (3.3FTE unfavourable ytd).

Management/Administration Personnel - $182k unfavourable for month - $415k unfavourable ytd
The main driver for the December result is to record enhanced long service leave entitlements recently ratified

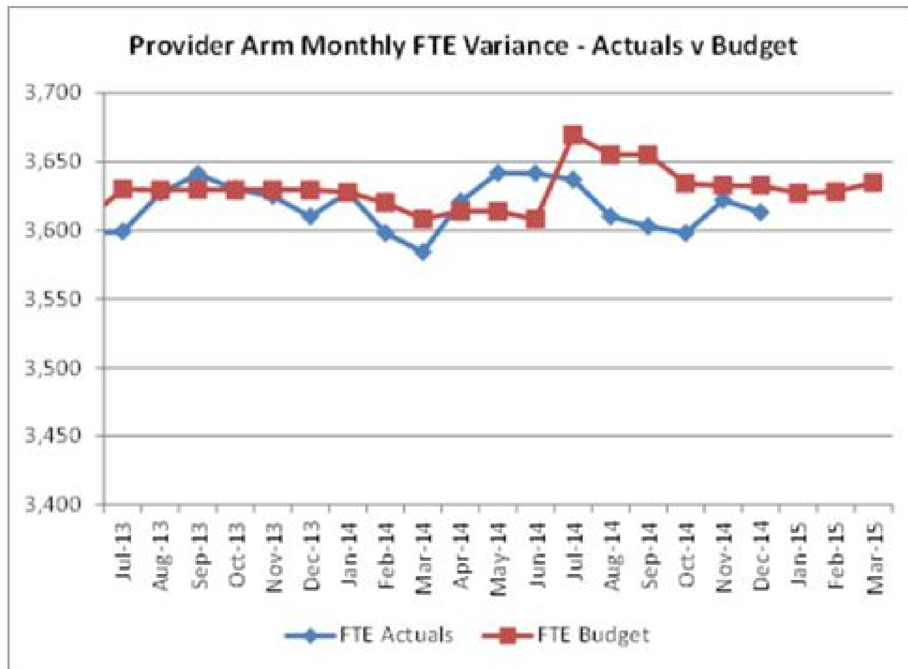
The main drivers for this unfavourable variance on a year to date basis are;

- Unbudgeted payroll increases that have incurred back-pay charges and revalued leave at rates higher than budgeted.
- Leave variances are favourable both monthly and year to date.

6.8

A comparison of FTE levels over the last year by quarter is tabled below;

Staff Type	Sep-13	Dec-13	Mar-14	Jun-14	Jul-14	Sep-14	Dec-14 Actuals	Dec-14 Budget	Variance to Budget
SMO	238	248	244	245	245	246	245	254	9
RMO	265	264	270	272	267	265	267	266	(1)
Nursing Personnel	1,605	1,580	1,560	1,609	1,609	1,609	1,621	1,596	(25)
Allied Health Personnel	681	672	675	670	663	645	648	683	35
Support Personnel	194	192	189	193	195	199	194	192	(2)
Management & Administration	658	654	647	654	657	640	638	641	3
Total Full Time Equivalents (FTE's)	**3,641**	**3,610**	**3,584**	**3,641**	**3,637**	**3,603**	**3,613**	**3,633**	**19**



The opposite graph highlights tracking actual FTE against the reducing budgeted FTE since July 2014. Spike in Nov14 actuals is nursing FTE

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

3. Outsourced Costs - $33k unfavourable for month and $397k favourable ytd (excluding research)

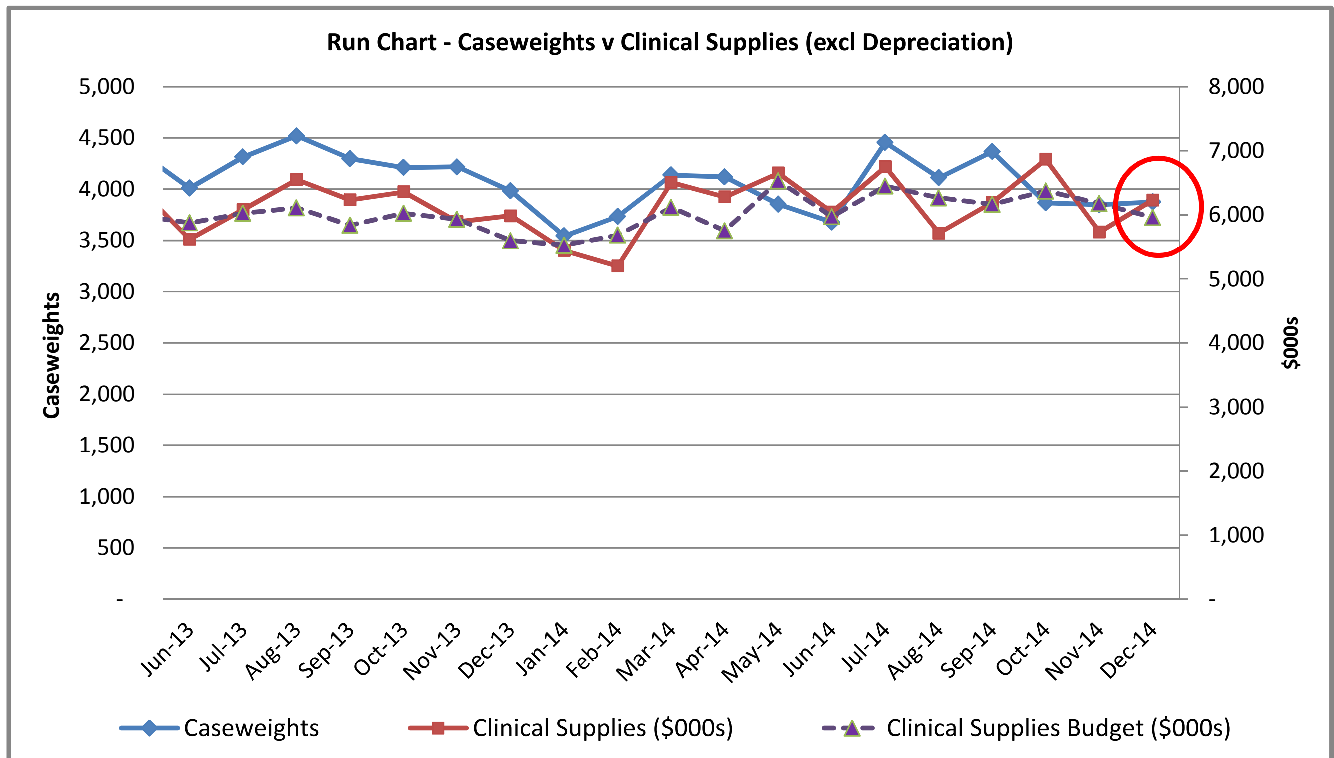
Outsourced costs were close to budget for the month, where previously there had been material favourable variances due to Medical personnel outsourcing to cover annual leave.

Outsourced radiology services were $63k unfavourable for the month and $344 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 still as the budgets have not been resubmitted at this stage).

4. Clinical Supplies - $256k unfavourable for the month and $230k unfavourable ytd (excluding research)

Clinical Supply Costs v Volumes

Decembers spend in clinical supplies (excluding depreciation) has moved closer to caseweighted activity than in recent months as shown in the run chart below.



The 4% overrun in clinical supply costs for the month (0.55% year to date) is driven by Treatment Disposables, Implants and Prostheses Instruments and Equipment as shown below.

	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD	YTD $ Variance %	$000 Full Year Budget
Clinical Supplies								
Treatment Disposables	(2,735)	(2,308)	(427)	(15,397)	(14,483)	(914)	6%	(28,710)
Diagnostic Supplies & Other Clinical Supplies	(169)	(148)	(21)	(919)	(945)	26	(3%)	(1,818)
Instruments & Equipment	(1,402)	(1,341)	(61)	(8,541)	(8,083)	(458)	6%	(16,010)
Patient Appliances	(162)	(190)	28	(1,060)	(1,133)	72	(6%)	(2,268)
Implants & Prostheses	(897)	(825)	(72)	(5,393)	(5,761)	369	(6%)	(11,607)
Pharmaceuticals	(1,278)	(1,555)	277	(8,930)	(9,360)	430	(5%)	(18,396)
Other Clinical Supplies	(281)	(300)	18	(1,660)	(1,907)	246	(13%)	(3,774)
Clinical Supplies Total	**(6,923)**	**(6,667)**	**(256)**	**(41,901)**	**(41,671)**	**(230)**	**1%**	**(82,584)**

6.8

The table below highlights the major areas of overrun within clinical supplies;

Group1	Object	Account Description	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD	$000 Full Year Budget
Implants & Prostheses	**4530**	Hip Prostheses	(221)	(147)	(73)	(1,091)	(1,263)	172	(2,628)
Treatment Disposables	**4115**	Sutures	(147)	(91)	(56)	(712)	(578)	(134)	(1,144)
Treatment Disposables	**4190**	Patient Consumables	(237)	(186)	(51)	(1,484)	(1,183)	(301)	(2,341)
Instruments & Equipment	**4315**	Disposable Instruments	(144)	(100)	(43)	(812)	(596)	(216)	(1,173)
Treatment Disposables	**4015**	Blood - Other Fractionated Products	(172)	(130)	(42)	(798)	(762)	(36)	(1,520)
Other Clinical Supplies	**4955**	Air Ambulance	(196)	(159)	(36)	(1,097)	(1,013)	(84)	(2,006)
Treatment Disposables	**4010**	Blood - Intragam	(215)	(179)	(36)	(1,126)	(1,012)	(114)	(2,016)
Treatment Disposables	**4120**	Staples & Accessories	(84)	(49)	(35)	(400)	(310)	(90)	(614)
Treatment Disposables	**4019**	Blood - Plasma Components	(49)	(15)	(34)	(177)	(97)	(80)	(195)
Implants & Prostheses	**4590**	Implants and Prostheses - Other	(91)	(63)	(28)	(511)	(403)	(108)	(798)
Treatment Disposables	**4017**	Blood - Red Cell Components	(103)	(77)	(26)	(579)	(493)	(86)	(987)
Instruments & Equipment	**4365**	Clinical Equipment - Operating Leases	(59)	(37)	(22)	(317)	(265)	(53)	(490)
Instruments & Equipment	**4320**	Laparoscopic Equipment	(29)	(8)	(21)	(124)	(47)	(78)	(93)
Treatment Disposables	**4025**	Catheters	(178)	(158)	(20)	(1,057)	(1,008)	(49)	(1,986)
			(1,924)	(1,400)	(525)	(10,285)	(9,027)	(1,258)	(17,989)

Treatment Disposables

Blood

On a year to date blood costs are now $374k (11%) over budget with the month being $170k (30%). Recent months have seen a cluster of acuity driven costs with December also including trauma cases. There is $50k favourable revenue offset from haemophilia related spend.

Renal

Increasing demand continues to see this area go over budget by $118k on an ytd basis. There has been a 14% increase in haemodialysis delivery in the unit recently however less contacts experienced in the unit during December indicate reduced fluid costs in the coming months.

Sutures and Staples

Our fixed price deal for sutures has been in place since October however costs for both supplies continue to exceed monthly budgets. December is $91k over budget and ytd is $224k due to in part this month's elective volumes exceeding plan.

Patient Consumables

Additional savings initiatives have been phased in since October for the Operating Theatre savings plan around reducing consumable spend comes into effect. This has had the impact of reducing the budget $120k ytd while the Medical directorate have also loaded savings plans against the budget totalling $100k ytd. As at December patient consumables overrun is now $301k.

Instruments and Equipment

Disposable instruments continue to exceed budget with budgeted reductions in this area not occurring. We are looking at ways to mitigate and/or reduce overspending in this area which will include a thorough review to ensure no capital items are inadvertently being expensed.

An increase in Laparoscopic surgery volumes is also increasing costs in this area.

Clinical Supplies Summary

There are areas of concern (due to their materiality) as stated above, the obvious ones being

- Instruments and Equipment. We will be looking to analyse this extensively over the coming month to identify all the drivers and ensure any item where possible can be capitalised.

- Achievement of the Theatres saving plan to reduce consumables is being offset by increasing cost pressures in other areas.

Further savings initiatives yet to impact Clinical Supplies amount to less than $100k/annum and don't come into effect until January 2015.

5. Infrastructure and Non Clinical Supplies - $236k unfavourable for the month and $545k unfavourable ytd (excluding research)

This cost category is 4% over budget for the month (2% year to date) this month largely due to providing for doubtful debts of $200k. Ytd continuing facility overruns plus one-off IT costs.

- Cleaning, Orderlies costs. The overruns in the cleaning and orderlies costs will reduce when the new contract is in place as mitigation steps are underway to decrease service as much as possible to make up for demand increases in others.

6.8

6. Financial Statements – Provider Arm December 2014

Part 2: DHB provider	Current Month				Year to Date				Annual
	Actual	Budget	Variance	Variance	Actual	Budget	Variance	Variance	Budget
	$(000)	$(000)	$(000)	%	$(000)	$(000)	$(000)	%	$(000)
REVENUE									
Ministry of Health									
MoH - Personal Health	-	28	(28) U		221	170	51 F	30%	339
MoH - Public Health	240	11	230 F		293	64	229 F	361%	127
MoH - Disability Support Services	733	740	(7) U	(1%)	4,800	4,620	180 F	4%	9,040
Clinical Training Agency	507	526	(19) U	(4%)	3,706	3,709	(3) U		7,418
Internal - DHB Funder to DHB Provider	37,288	37,569	(281) U	(1%)	225,322	225,684	(362) U		450,549
Ministry of Health Total	**38,769**	**38,874**	**(105) U**		**234,341**	**234,246**	**95 F**		**467,473**
Other Government									
Other DHB's	115	25	90 F	356%	149	151	(2) U	(1%)	302
Training Fees and Subsidies	41	17	24 F	139%	135	103	32 F	31%	206
Accident Insurance	901	846	55 F	6%	5,098	5,429	(331) U	(6%)	10,406
Other Government	466	473	(7) U	(1%)	2,725	2,801	(76) U	(3%)	5,598
Other Government Total	**1,523**	**1,361**	**161 F**	**12%**	**8,108**	**8,484**	**(377) U**	**(4%)**	**16,512**
Government and Crown Agency Total	**40,292**	**40,236**	**56 F**		**242,449**	**242,730**	**(281) U**		**483,985**
Other Revenue									
Patient / Consumer Sourced	347	230	116 F	50%	1,501	1,540	(39) U	(3%)	3,515
Other Income	1,203	854	349 F	41%	5,584	5,074	510 F	10%	10,199
Other Revenue Total	**1,550**	**1,084**	**465 F**	**43%**	**7,086**	**6,615**	**471 F**	**7%**	**13,714**
REVENUE TOTAL	**41,841**	**41,320**	**521 F**	**1%**	**249,535**	**249,345**	**190 F**		**497,699**
EXPENSES									
Personnel Expenses									
Medical Personnel	(10,134)	(9,862)	(272) U	(3%)	(56,444)	(56,731)	287 F	1%	(113,250)
Nursing Personnel	(11,045)	(10,855)	(190) U	(2%)	(62,763)	(61,693)	(1,069) U	(2%)	(124,838)
Allied Health Personnel	(4,201)	(4,335)	134 F	3%	(23,869)	(24,715)	847 F	3%	(49,159)
Support Services Personnel	(889)	(844)	(45) U	(5%)	(4,966)	(4,826)	(140) U	(3%)	(9,718)
Management / Admin Personnel	(3,623)	(3,442)	(182) U	(5%)	(20,038)	(19,623)	(415) U	(2%)	(38,509)
Personnel Costs Total	**(29,893)**	**(29,337)**	**(556) U**	**(2%)**	**(168,080)**	**(167,588)**	**(492) U**		**(335,475)**
Outsourced Expenses									
Medical Personnel	(453)	(554)	101 F	18%	(2,371)	(3,145)	774 F	25%	(6,104)
Nursing Personnel	(16)	-	(16) U		(43)	-	(43) U		-
Allied Health Personnel	(36)	(36)		(1%)	(318)	(218)	(100) U	(46%)	(421)
Support Personnel	(34)	(21)	(12) U	(57%)	(183)	(128)	(54) U	(43%)	(256)
Management / Administration Personnel	(15)	(1)	(14) U		(65)	(6)	(59) U	(977%)	(12)
Outsourced Clinical Services	(2,203)	(1,838)	(365) U	(20%)	(11,792)	(11,144)	(647) U	(6%)	(22,257)
Outsourced Corporate / Governance Services	(142)	(151)	9 F	6%	(789)	(856)	67 F	8%	(1,706)
Outsourced Funder Services	-	-			-	-			-
Outsourced Services Total	**(2,898)**	**(2,602)**	**(296) U**	**(11%)**	**(15,561)**	**(15,497)**	**(63) U**		**(30,756)**
Clinical Supplies									
Treatment Disposables	(2,737)	(2,308)	(428) U	(19%)	(15,400)	(14,483)	(917) U	(6%)	(28,710)
Diagnostic Supplies & Other Clinical Supplies	(169)	(148)	(21) U	(14%)	(919)	(945)	26 F	3%	(1,818)
Instruments & Equipment	(1,402)	(1,341)	(61) U	(5%)	(8,541)	(8,083)	(458) U	(6%)	(16,010)
Patient Appliances	(162)	(190)	28 F	15%	(1,060)	(1,133)	72 F	6%	(2,268)
Implants & Prosthesis	(897)	(825)	(72) U	(9%)	(5,393)	(5,761)	369 F	6%	(11,607)
Pharmaceuticals	(1,278)	(1,555)	277 F	18%	(8,930)	(9,360)	430 F	5%	(18,395)
Other Clinical Supplies	(285)	(300)	15 F	5%	(1,671)	(1,907)	236 F	12%	(3,774)
Clinical Supplies Total	**(6,929)**	**(6,667)**	**(262) U**	**(4%)**	**(41,913)**	**(41,671)**	**(243) U**	**(1%)**	**(82,583)**
Infrastructure & Non Clinical Expenses									
Hotel Services, Laundry & Cleaning	(1,065)	(1,036)	(29) U	(3%)	(6,633)	(6,357)	(276) U	(4%)	(12,640)
Facilities	(1,774)	(1,735)	(39) U	(2%)	(11,008)	(10,810)	(198) U	(2%)	(21,682)
Transport	(313)	(350)	37 F	10%	(2,004)	(2,127)	123 F	6%	(4,212)
IT Systems & Telecommunications	(935)	(909)	(27) U	(3%)	(5,586)	(5,460)	(127) U	(2%)	(10,930)
Interest & Financing Charges	(1,262)	(1,253)	(9) U	(1%)	(7,550)	(7,516)	(34) U		(15,032)
Professional Fees & Expenses	(116)	(115)			(604)	(696)	91 F	13%	(1,367)
Other Operating Expenses	(532)	(361)	(171) U	(47%)	(2,252)	(2,101)	(152) U	(7%)	(4,168)
Infrastructure & Non-Clinical Supplies Total	**(5,997)**	**(5,758)**	**(239) U**	**(4%)**	**(35,637)**	**(35,066)**	**(571) U**	**(2%)**	**(70,032)**
Other Costs and Internal Allocations	-	-			-	-			-
Total Expenses	**(45,717)**	**(44,365)**	**(1,353) U**	**(3%)**	**(261,191)**	**(259,821)**	**(1,370) U**	**(1%)**	**(518,846)**
Net Surplus/ (Deficit)	**(3,876)**	**(3,045)**	**(831) U**	**(27%)**	**(11,657)**	**(10,477)**	**(1,180) U**	**(11%)**	**(21,147)**

6.9

SOUTHERN DISTRICT HEALTH BOARD

Title:	Occupational Health and Safety Report
Report to:	Hospital Advisory Committee
Date of Meeting:	04 February 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 HAC members are aware of the SDHB 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 (ACC) Levies
Workforce:	Providing safer work practices
Previous:	

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

Prepared by:	Presented by:
John Pine Executive Director Human Resources	Lexie O'Shea Executive Director of Patient Services/ Deputy Chief Executive

RECOMMENDATION:

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.

1. Accident, Injury and ACC

Consistent reporting of injuries and incidents has continued across the District. There have been no reports of serious harm to staff made during December 2014.

Assault and restraint injuries are the greatest cause of injury to staff and for this reason the drill down of information is provided below to inform the organisation of the ongoing risk to staff . This report also contains district figures which have been collated to further inform the organisation of the number of injuries occurring and the risk to staff from identified hazards.

2. ACC Partnership Programme

The ACC Partnership Programme audit took place during the first week of December 2014. Tertiary status has been confirmed by ACC. The organisation has remained at tertiary level since 2003 which is a remarkable achievement as only fifteen employers in New Zealand have also achieved this record. This is an opportunity to thank all those concerned for the input which has enabled this achievement.

An action plan has been prepared following recommendations from the audit and will comprise part of the annual work-plan for this department as well as the health and safety governance committee.

Unions have been given extensive prior notification of the date for the annual self-assessment audit in preparation for the 2015 renewal process. Unions fed back that the notice period of three months was still insufficient to enable attendance at the 2014 self-assessment meeting. The date of the 2015 self-assessment meeting has therefore been set for 6 August 2015 2pm. Prior notification was sent out in December 2014. We are hopeful that this notice period will be sufficient to enable union attendance.

3. District wide approach to health and safety

Work continues to develop and implement a single unified health and safety governance structure for Southern DHB. Consultation is complete for Terms of Reference (TOR) for the district wide Health and Safety Governance Committee which now replaces former site- specific committees.

4. Health and Safety Reform Bill – Progress update from Worksafe website

The Bill is currently before parliament. The new select committee has a report back of 30 March 2015 and then the Bill will continue its progression through the parliamentary process. It is likely that the Bill will come into force in the second half of 2015. There will be adequate time of some months between when the Bill is passed and when it comes into force to make sure duty holders are aware of their responsibilities under the new law. (See Appendix 2 below for further details)

http://www.business.govt.nz/worksafe/about/reform/reform-bill-update

5. 2015 Staff Influenza Vaccination campaign

Planning has commenced for the annual staff influenza vaccination.

- A Quadrivalent vaccine is available for delivery – Southern DHB will purchase this from Sanofi Aventis as this product is unique to this manufacturer at this time
- Campaign is due to commence on 7 April 2015 – all manufacturers are experiencing vaccine supply delays and cannot guarantee delivery until early April – possibly mid-March.
- Focus is on increasing the number of in-team vaccinators which will assist with vaccine delivery to increase staff update of this fully funded initiative.
- Barriers include: Ministry compliance with Cold Chain (temperature Control mechanism) requirements; availability of equipment relating to Cold Chain requirements; vaccinator staff resourcing; inadequate allocation of suitable venues to administer vaccination. Develop a generic board reporting template – November 2014 (optional use).
- The Auckland District Health Board 2014 staff influenza vaccination programme has been used to develop a SDHB programme, with the aim of increasing staff uptake of the vaccine. Programme sponsor is Leanne Samuel.

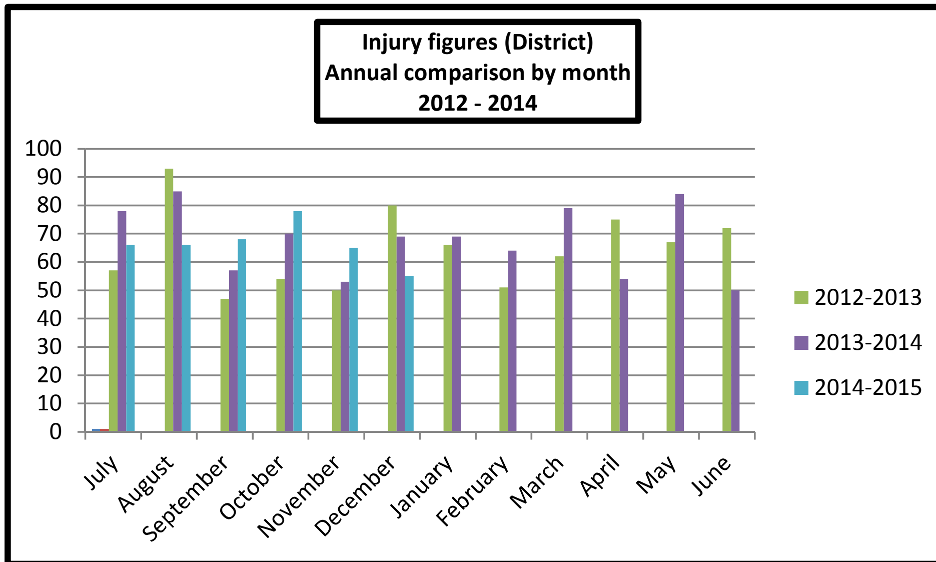
6. RL 6 Incident Register and Hazard Register

The Occupational Health and Safety team continues to prepare for the work that will be required to support the implementation of the new hazard and incident registers at SDHB.

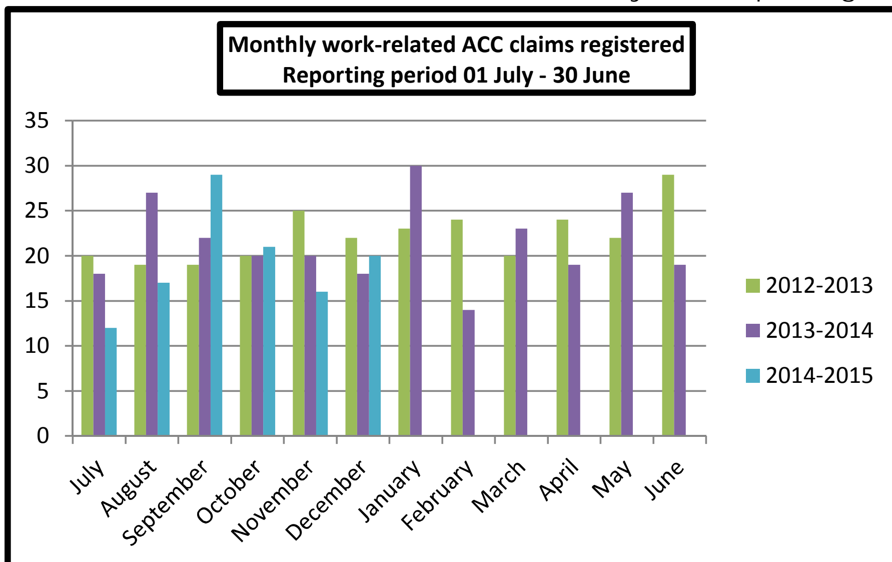
Appendix 1

1. Current District Wide Accident / Injury Activity District figures have been compiled for the first time in this report to provide comprehensive information relating to accident and injury data.

Annual injury comparison by month



2. District: Work-related ACC claims analysis – Reporting 01 July – 30 June

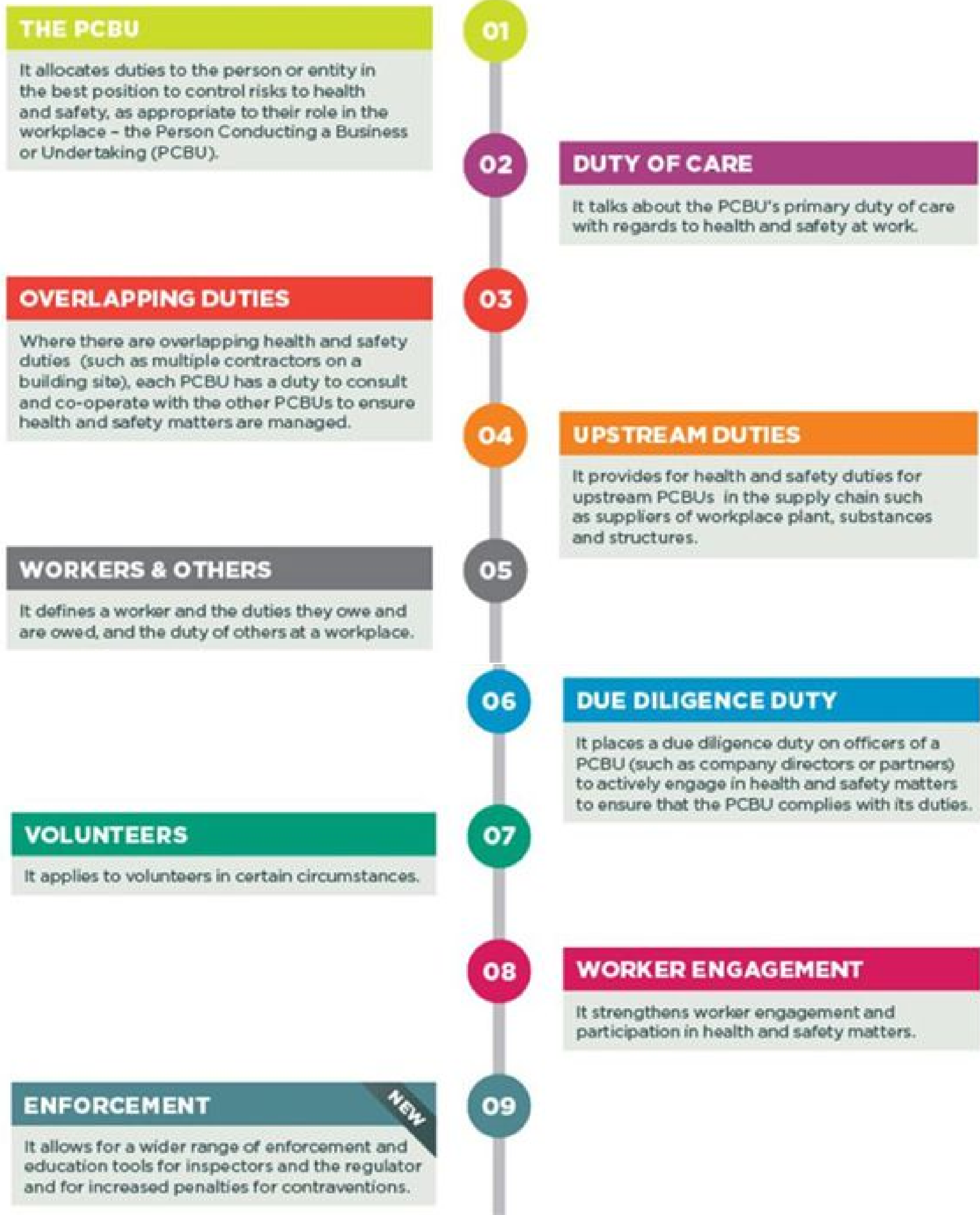


Total number of ACC claims in December totalled 20 of which 4 were time-lost claims.

The information in the graph shows the month a claim was reported, not the month the injury occurred.

6.9

Appendix 2 – Health and Safety Reform Bill – Update from Worksafe website
http://www.business.govt.nz/worksafe/about/reform/reform-bill-update



December 2014

IS SLA Dashboard

6.10

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	
Clinical Systems					
HCS - SDHB			✓		Regional HCS project in progress including the implementation of TestSafe South NHITB expectation set for completion end Q4 2014/15 due to geographical locations Onsite project meeting with regional team completed 17/12/14 Good engagement with Regional Programme Lead and Host DHB
HCS - NMDHB			✓		Implementation in progress, looking at options to expedite due to recent issues impacting OraCare and the local concerto instance NHITB expectation set for completion end Q3 2014/15 Implementing Rhapsody to decouple local concerto installation form Oracare as a risk mitigation, due for completion early February 2015
WCDHB Mental health Module	✓				Completed A new scope of works has been approved to decouple integration from WCDHB iPM PAS system. Product stabilisation in progress Solution required for SDHB & NMDHB HCS/PICS Engagement with Mid Central regards a overall regional functionality
HealthOne (formally eSCRV)			✓		WCDHB went live with HealthOne 17/11/2014, implementation was 3 weeks, no issues at go live Business Case development in progress, finalising financials Presentation by Dr Martin Wilson to NHITB in advance of BC completed, very well received SCDHB engagement commenced
eReferrals			✓		Stage 1 – NMDHB deployments in progress Stage 1 – SDHB, Mornington now in pilot 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
Meds Mgt SDHB - MedChart			✓		SDHB – Programme continues with good progress CDHB – 133 beds covered across 9 wards at Hilmorton & Princess Margaret's Hospital SCDHB – Onsite planning meeting to define dates and resources actioned, BC presented to the IS SLA for approval, target date end Q3 2014/15 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

6.10

December 2014

IS SLA Dashboard

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	
CDR8				✓	Upgrade of CDR completed
SI Patient Administration System			✓		Contract approval by SI DHB Boards completed, with CEO's for singing CDHB and NMDHB Business Case approved by both the new Health Minister and existing Finance Minister 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, tracking to revised delivery timescales
National Titanium		✓			DHB's have completed sign up, development is slow from the vendor
National Maternity System			✓		SCDHB – Live SDHB, WCDHB and NMDHB - To be planned
National Transfer of Care - eDischarge		✓			HCS Team progressing national template, this is now being worked on following recent releases
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	✓				Worksop with clinical team to be scheduled with Sysmex to review a number of product gaps, outcome will drive next steps, i.e. formal RFI for a solution Recent éclair upgrade now means functionality is available across the region should this be the appropriate way forward SDHB resources will need to be engaged in this process
RL6 Regional Incident Management System			✓		4 of the 5 DHBs progressing implementations Implementation in progress SCDHB scheduled for implementation during 2015/16 financial year
SCN – MDM Video conferencing Solution				✓	Solution completed, looking a regional pricing and support model
SCN - Metriq			✓		Oncology centre now providing live data into repository
SCN – Medical Oncology			✓		WCDHB - Issue with labs routes to be resolved NMDHB - Have visited CDHB team to review requirements
SCN – Mosaiq upgrade	✓				Planning on going due to issues with version 2.5.

December 2014

IS SLA Dashboard

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	
					recommended upgrade to MOSAIQ 2.6 to be scheduled for early Q4 2014/15
Imaging Systems					
Picture Archiving			✓		Delivered as part of the overall regional solution
Radiology Software - NMDHB				✓	Moving into project closure phase
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
Advanced Care Plan / Long Term Care Planning	✓				ACP raised for national agreement
Regional eLearning Application	✓				Project mandate approved by ALT, regional business case to be developed
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			✓		Pilot completed, raised with MoH via SCN for inclusion in the national cancer stratergy
National Data Centre (NIP)			✓		National Business Case with DHB's for approvals
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 to move towards a RDW approved by IS SLA Owned by the SI CIO's Business case to be presented to ALT for approval
Regional Ministry Extract	✓				Concept – raised with IS SLA

December 2014

IS SLA Dashboard

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	

6.10

Acronyms

IS SLA	Information Services Service Level Alliance
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

6.11

SOUTHERN DISTRICT HEALTH BOARD

Title:	Master Site Planning Stage Two: BECA Peer Review of Asset Condition Assessment Report Economic Viability of the Clinical Services Building
Report to:	Hospital Advisory Committee
Date of Meeting:	04 February 2015

Summary:

The issues considered in this paper are:

- A summary of the peer review of the Dunedin Hospital relifing analysis and future economic viability of the Clinical Services Building (CSB).
- The peer review concluded that the RLB relifing analysis is robust confirms that the CSB would be uneconomical to repair/refurbish when compared to the cost of a new facility and the building is not ideally suited for modern clinical functions.
- The peer review reinforces the current view of management to minimise capital expenditure on this building to urgent work only and to prioritise the business case for a replacement building.
- The National Health Board has indicated a joint working group, to oversee the development of a Dunedin Campus business case, should be formed early in 2015.

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

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

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

Prepared by:	Presented by:
Warren Taylor, Facilities and Site Development Manager Date: 22/01/2015	Peter Beirne, Executive Director Financial Services

RECOMMENDATION:

The 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 capital expenditure on the Dunedin Clinical Services Building to urgent work.
2. Support the prioritising of work on a business case for the Dunedin Campus in collaboration with the National Health Board.

Master Site Planning Stage Two:
Peer Review of Asset Condition Assessment Report
Economic Viability of the Clinical Services Building

Asset Condition Assessment Overview:

As part of the preliminary work for a Southern DHB Master Site Planning Stage Two Business Case, BECA consultants have undertaken a peer review of the 2012 Dunedin Hospital relifing analysis and future viability of the Clinical Services Building (CSB). The executive summary section of the peer review is attached as Appendix 1 and the full report (35MB in size) is included in Board Books for reference. The BECA peer review provided an overview condition assessment of the CSB to inform the following assessments:

- Suitability of the building for use as a clinical building into the future.
- Suitability of the building for use as a non-clinical building.
- General assessment of the condition of the building's services (mechanical, electrical and lifts).
- Review of the cost of upgrade works identified.

Peer review conclusions:

The RLB quantity surveyor relifing analysis of the Dunedin Campus concluded that the Dunedin Campus Clinical Services Block (CSB) had limited future viability. The BECA peer review concluded that the 2012 Dunedin Hospital relifing analysis "is robust, and does provide [Southern DHB] with a reasonable assessment of the economic status of the five buildings". It confirmed that the Clinical Services Building (CSB) would be uneconomic to repair / refurbish when compared to the cost of a new facility and that the building is not ideally suited for acute clinical functions.

BECA engaged Klein Ltd to undertake a CSB Health Planning and Architectural review which assessed the building against good practice in modern healthcare design. Klein concluded the building is not suitable for clinical refurbishment due to the inefficiencies caused by the grid and column spacing, building depth and footprint area. The Klein section of the report is attached as Appendix 2.

The peer review stated that the CSB:

"..older plant is generally at or beyond normal life expectancy and is showing its age. It is anticipated that the required effort to repair and maintain this plant will increase significantly if not replaced in the foreseeable future" The CSB "is intensively used and therefore any upgrade or refurbishment for continued clinical use would be difficult (possibly impractical) and inefficient to undertake with enabling, decanting, temporary accommodation requirements likely to add significant expense".

In summary the peer review stated:

- The CSB plant is generally at or beyond normal life expectancy.
- The required effort to repair and maintain this plant will increase significantly if not replaced in the foreseeable future.

- The CSB is intensively used and therefore any upgrade or refurbishment for continued clinical use would be difficult (possibly impractical) and inefficient to undertake.
- The mechanical and hydraulic services for the building and operating theatre plant have reached the end of their useful economic life.
- The majority of older heating, ventilation and air conditioning systems are non-compliant and the lifts are overdue for refurbishment and an additional lift is required.

The Beca peer review has reinforced the view that it would be impractical to refurbish the CSB for clinical use due to the building design and significant capital investment will be required to keep the building operational in the medium term, and therefore capital expenditure on this building should be limited to urgent work only, and SDHB should prioritise the business case for a replacement building.

Current proposed spending on this building, albeit limited, are attached, including addressing water tightness and cladding issues.

The National Health Board have indicated a joint working group, to oversee the development of a Dunedin Campus business case, should be formed early in 2015.

Peter Beirne
Executive Director Finance
22 January 2015

6.11

SDHB Clinical Services Block – identified shortcomings / defects/ proposed works

The 2014 BECA review identified the following items as key shortcomings / defects which require expenditure:

Detail of key shortcomings / defects	Status
Spalling concrete to external panels with underlying steel reinforcement corrosion requires investigation and repairs.	Underway
Water ingress through the roof, requires remedial works to gutters, parapets and penetrations.	Underway
Water ingress to concrete walls causing cracking and loosening of copings.	Underway
The windows are in a very poor condition and require replacement.	Temporary repair only
Replacement of large areas of internal suspended ceilings and mineral fibre tiles.	No action to be taken
Linoleum floor tiles beyond their serviceable life requiring replacement.	No action apart from urgent repair
The majority of the building internal areas are deemed to be in need of refurbishment / redecoration.	No action apart from urgent repair
Investigation is required to the 5th floor egress routes and use of the corridors for clinical equipment storage due to lack of storage space. Lack of space from theatres is causing this issue.	Work underway with service re storage
Numerous areas and building components have been identified as containing asbestos. While we are advised that this is encapsulated; these areas will need careful consideration if any refurbishment/Relifing works are to be undertaken. Where asbestos removal is required refurbishment costs will be increased.	No action apart from urgent repair, avoid refurbishment
Mechanical and hydraulic systems are beyond their serviceable life requiring replacement.	No action apart from urgent repair
Lifts are overdue for refurbishment. If the building was to be refurbished the addition of a third lift would be required.	No action apart from urgent repair

Executive Summary

The Peer review process has identified that the Rider Levett Bucknall (RLB) report Dated December 2012 relating to the REifing of the Ward Block, Clinical Services Building (CSB), Children's Pavilion, Fraser Building and Psychiatric Services buildings, is robust, and does provide Southern District Health Board (SDHB) with a reasonable assessment of the economic status of the five buildings.

We concur that the following buildings are effectively uneconomic to repair / refurbish when compared to the cost of a new facility:

- Children's Pavilion Building
- Fraser Building
- Psychiatric Services Building / Administration
- Clinical Services Building

We are advised that Southern District Health Board's current strategy is to limit expenditure to urgent and critical needs for the four buildings identified above and to limit further refurbishment in the Ward Block until a business case is completed.

Clinical Services Building (CSB)

A more detailed assessment was carried out for the CSB, including inspection and assessment of the building's condition, building services condition and a clinical health planning assessment.

- **Building condition assessment**

  The following items were identified as key shortcomings / defects requiring expenditure:

  - Spalling concrete to external panels with underlying steel reinforcement corrosion requires investigation and repairs.
  - Water ingress through the roof requiring remedial works to gutters, parapets and penetrations.
  - Water ingress to concrete walls causing cracking and loosening of copings.
  - The windows are in a very poor condition and require replacement.
  - Replacement of large areas of internal suspended ceilings and mineral fibre tiles.
  - Linoleum floor tiles beyond their serviceable life requiring replacement.
  - The majority of the building internal areas are deemed to be in need of refurbishment / re-decoration.
  - Investigation is required to 5th floor egress routes and use of the corridors for clinical equipment storage due to lack of storage space.
  - Numerous areas and building components have been identified as containing asbestos. While we are advised that this is encapsulated; these areas will need careful consideration if any refurbishment / RElifing works are to be undertaken. Where asbestos removal is required refurbishment costs will be increased.

- **Clinical health planning assessment**

  This assessment concluded that the Clinical Services Building is not ideally suited for acute clinical functions due to the buildings storey height.

The assessment also concluded that the building was not well suited for reconfiguration as ward space due to the inefficiency in space planning caused by the building's grid and column spacing, building depth and footprint area.

The building's form makes it suitable for reconfiguration for administration, education or non-acute clinical functions (clinics) which do not require high ceilings or have intensive servicing requirements.

- **Refurbishment Viability**

  The Clinical Services Building is intensively used and therefore any upgrade or refurbishment for continued clinical use would be difficult (possibly impractical) and inefficient to undertake with enabling, decanting, temporary accommodation requirements likely to add significant expense.

  Within the RLB report the figures used for replacement costs are new build costs with a 10% multiplier. This multiplier appears to be provision for removal of existing elements. In our opinion, this 10% allowance would not effectively address the costs of strip out and removal of many elements. External windows, structural frame repairs and building services replacement works will require significant enabling, isolation and temporary works in order to carry out renewals/repairs. The costs of vacating areas, decanting, temporary accommodation, screening and other enabling works to allow for items such as wall, floor and ceiling finishes are likely to be high as a proportion of the repairs / renewals.

  Under the current building code a facility that contains medical emergency or surgical facilities designated as having a post disaster function is classified as having a importance level of 4 (IL4) and as such must meet certain performance criteria in a 1/500 and 1/2500 year seismic event. The standard (AS/NZS 1170) refers to these performance criteria as Serviceability Limit State (SLS) and Ultimate Limit State (ULS). While a seismic assessment was beyond the scope of our report, we are informed by an earlier report by Hanlon and Partners Ltd that the concrete cladding panels achieved approximately 55% of the ultimate limit state (ULS) and would likely fail at the lower levels under a ULS earthquake. Given the age of the building it is considered unlikely that the internal fit out will be fully compliant with the standard. Building services systems seismic performance provisions did not typically appear to be in accordance with our expectations for an IL4 building. It is anticipated that if the building is to meet IL4 compliance requirements, work will be required to the concrete cladding panels, internal fit out elements and building services systems. This work would increase the cost of any clinical use refurbishment.

  The business case for refurbishing and reconfiguring the building for alternative use such as admin or education would need to be carefully considered and may not be economically viable. Whether or not there is a demand for a building of this size, in this location and for the proposed alternative use would need to be determined.

- **Building services assessment**

  The Clinical Services Building was suggested in the RLB report as having potential to increase useable life "RElife" to 25 years; however our site investigations have established that the majority of building services are at the end of their useful life. To reinstate as a clinical services building will require significant investment, co-ordination and enabling / decanting.

  The mechanical and hydraulic systems serving general areas of the Clinical Services Building are typically (with a few exceptions) in the order of 47 years old and operating theatre plant (with the exception of the theatre 9 system) are in the order of 20 years old. We consider that these systems have reached the end of their useful economic life and that replacement would be required for any reconfiguration or refurbishment of the building.

In addition to the mechanical services age and condition related issues identified, the majority of older heating, ventilating and air conditioning systems, even if they were in good condition, would not compare well against current best practice systems of their type with respect to infection control and energy efficiency.

The electrical infrastructure including the main switchboard and distribution boards were replaced with new in 2002 and are generally in good condition.

The floor lighting and power outlets are typically (with a few exceptions) in the order of 47 years old. While lamp replacement and upgrades have occurred, the light fixture bodies are typically original. We consider that the on-floor electrical systems have reached the end of their economic life.

- **Lifts**

  We consider that the existing CSB lifts are overdue for refurbishment. Furthermore if the building were to be refurbished or reconfigured the addition of a third lift is considered necessary to provide satisfactory performance.

Ward Block Building

The ward block building, being the largest building asset inspected / reviewed, does have the potential for extending its serviceable life, however this will need to be carefully master planned to derive an economic solution.

The building is generally considered commensurate with its age and provided regular maintenance and Opex / Capex is maintained, the building asset should provide an adequate level of service for the foreseeable future. Our assessment differs slightly from that of RLB, in that we do not consider the existing windows require replacement within 5 years. SDHB have however advised that where a complete floor is being refurbished, their current strategy is to replace the windows on that floor concurrent with the refurbishment works. We concur that this is a logical approach.

6.11

Dunedin Hospital Clinical Services Building Health Planning and Architectural Review

Southern District Health Board
For Beca

28th August, 2014 / Revision 1

Klein
www.klein.co.nz

1.0 Introduction and Purpose of Report

Klein Ltd have been engaged to carry out a desktop based study to review the existing Clinical Services Building (CSB) at Dunedin Hospital for its suitability for reconfiguration to accommodate modern clinical functions or other potential uses in the future. This report documents the review of the existing building and assesses it against good practice in modern healthcare design.

2.0 Limitations of this Review

This review has been carried out as a desktop based study only based on drawings and documents provided by SDHB. A list of the documents is attached in Appendix A. The accuracy of the supplied plans has not been checked against the current layout on site.

3.0 Executive Summary

This report concludes that the Clinical Services Building at Dunedin Hospital is not ideally suited for reconfiguration as the following functions:

- **Acute clinical functions** - in particular those that require spaces with a three metre ceiling height. This is due to the limitation of ceiling void caused by the building's storey height

- **Wards** - due to the inefficiency in space planning caused by the grid and column spacings, building depth and footprint area

The building is suited to reconfiguration as the following functions:

- Administration and education
- Non acute clinical uses with spaces that do not require a ceiling height greater than 2.7m or have intensive service requirements

4.0 Overview of Existing Building

The clinical services building was designed and built in the 1960's and comprises a concrete framed building of nine storeys (including the basement) with concrete floors, precast concrete cladding and aluminium framed windows. The style of the building is similar to the adjoining Wards Building and is typical of that era. It is located on an urban site as a part of the wider Dunedin Hospital campus in central Dunedin and is aligned with Cumberland St just South of the junction with Frederick St.

Healthcare services located in the CSB include mortuary, stores & plant at lower ground, day surgery, fracture clinic and physiotherapy at ground floor, radiology at 1st floor, CSSD & ophthalmology at 2nd, laboratories at 3rd, outpatient clinics and theatre staff facilities on 4th, theatres on 5th and plant on levels 6 and 7.

5.0 Seismic Performance

Under the current building code a facility that contains medical emergency or surgical facilities designated as having a post disaster function is classified as having an Importance Level of 4 (IL4) and as such must meet certain performance criteria in a 1/500 & 1/2500 year seismic event. The standard (AS/NZS 1170) refers to these performance criteria as Serviceability Limit State (SLS) and Ultimate Limit State (ULS) respectively.

A separate report prepared by Hanlon & Partners Ltd dated 21 November 2011 concludes that the structure and stairs of the existing CSB will meet 100% of the current building code requirements for an IL4 building. However, the concrete cladding panels achieved approximately 55% of the ULS and would likely fail at the lower levels under a ULS earthquake.

To meet the current requirements of IL4 construction, works will need to be done to the building cladding. Given the age of the building it is unlikely that the current fit out is fully compliant with the requirements of IL4, though it is not possible to determine this from the drawings provided.

New internal fitout construction compliant with the requirements of IL4 involves detailing to accommodate the inter-storey drifts that can occur in a seismic event. This typically involves separating non-structural elements such as partition walls from the main building structural elements. Detailing typically includes a horizontal slip joint to walls that span full height from floor to floor and movement joints at ceiling wall junctions. The slip joint can be located at the top of partitions in which case the seismic movement needs to be accommodated in the services that pass through it or it can be located just above the ceiling which results in a reduction in depth available for services due to the framing required to form the joint.

Bracing of building elements and services equipment also needs to be co-ordinated, a requirement to ensure sufficient separation between them generally increasing the space required for service voids.

6.0 Building Plan Shape and Footprint Review

The CSB has 7 levels of accommodation from Lower Ground to Level 5 with plant and services located in the basement, level 6 and also on the roof (level 7).

The building footprint is typically rectangular in plan with its orientation roughly in a North-South direction. Approximate overall dimensions of each level are scheduled below.

Building Level	Overall Width (m)	Overall Length (m)	Approx. Area (m^2)
Basement (Plant)	16.8	16.8	282
Lower ground	20.5	77	1963
Ground	26	77	1880
Level 1	26	77	1880
Level 2	26	77	1880
Level 3	20.5	77	1575
Level 4	20.5	77	1575
Level 5	23	77	1754
Level 6 (plant)	17.5	77	1350
Level 7 (Water tanks & lift machine room)	7.3	20	145

When benchmarked against the floor plate size for other CSBs at hospitals in NZ it is significantly narrower. Other facility floor plates are as follows:

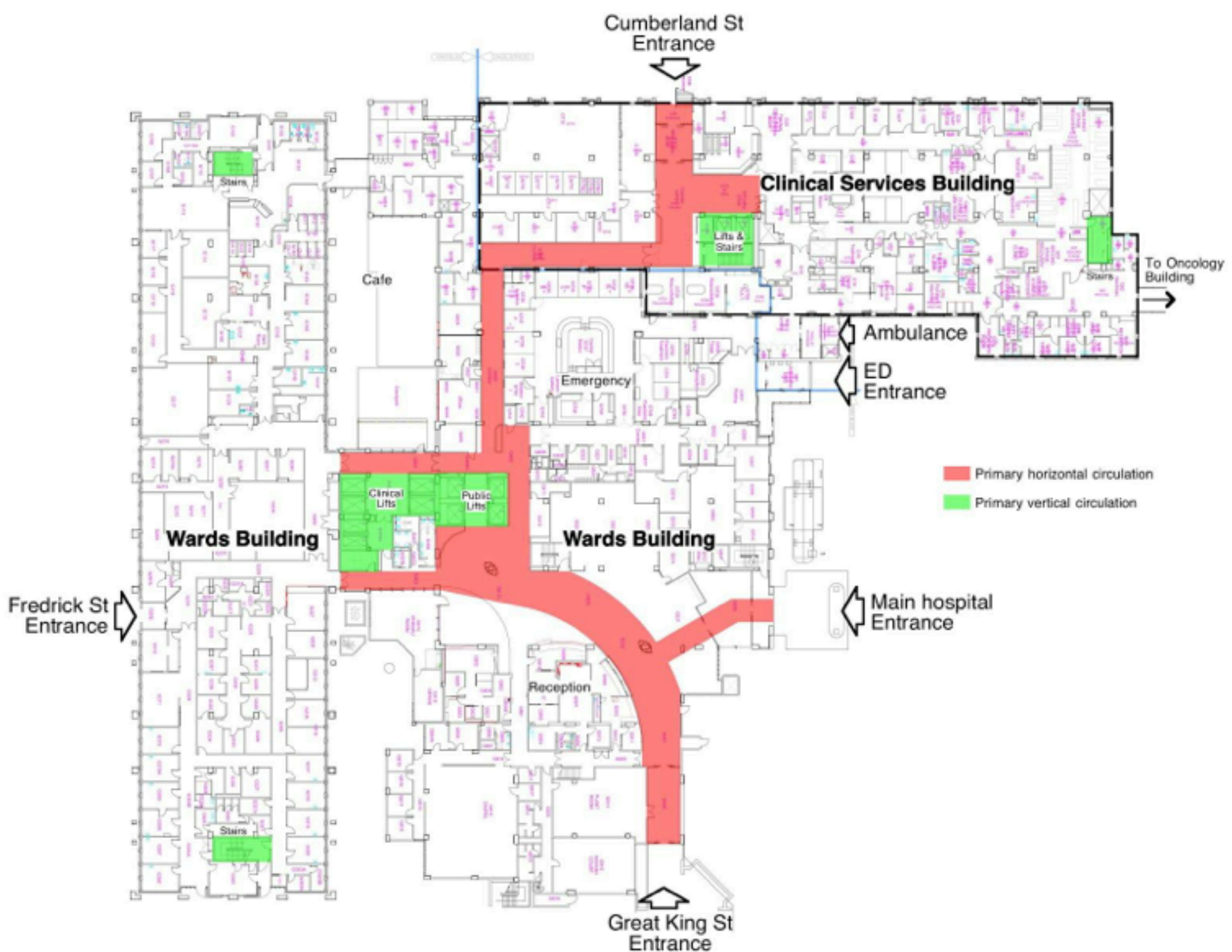
Middlemore Hospital CSB 113 x 58m
North Shore Hospital Tower 57.5 x 25 (wards accommodation)
North Shore Hospital Podium 124 x 58m
Auckland City Bldg 01 74 x 44m
Auckland A+ 117 x 82
Hutt Hospital ED & Theatres- 70.5 x 52m

The narrow plan of the upper levels is not well suited to certain clinical functions that require spatial relationships in their internal planning that result in deeper plan buildings. This is demonstrated by the current theatres layout at level 5 that has had a corridor cantilevered along the Western side to make the planning work. It does however provide good access to natural light.

7.0 Primary Circulation

Circulation within CSB

The CSB has a dedicated entrance accessed from Cumberland St that enters the building adjacent to its main circulation core. It is served by a central core of vertical circulation comprising two lifts and a stair, there is a second stair located at the southern end of the building, these serve all levels from lower ground to level 6. From the information contained in the drawings it has not been possible to determine whether these stairs comply with current standards for accessibility. There is an additional smaller stair between level 4 and 5, linking the theatres suite with the staff facilities.



Ground Floor Primary Circulation

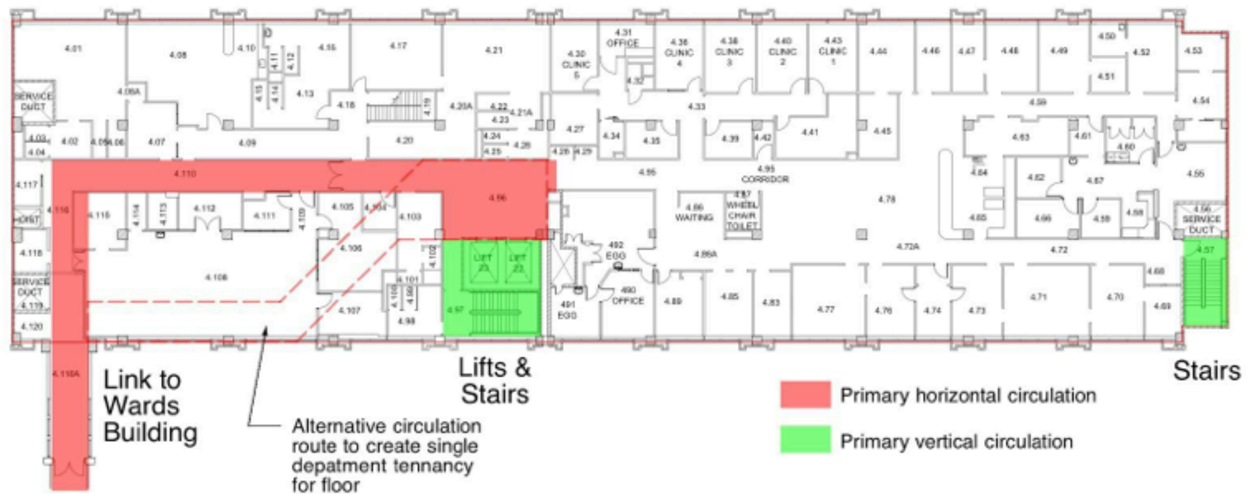
Klein

Connections to Other Buildings

CSB is linked to the Wards building via a corridor located at the northwestern corner of the CSB building this occurs from lower ground to Level 6 and consists of a link bridge with a corridor width of approximately 2.5m from level 2 upwards. At level 5 there is an additional link bridge connecting theatres to recovery.

The location of the wards building link bridge in relation to the CSB lifts results in a dog leg in the primary circulation to connect the two, this can either be central and split the departmental space as currently occurs on level 4 or it can run along the outer edge of the building before meeting the lifts as shown dashed on the level 4 plan below.

The single corridor link (other than level 5) to the wards building is likely to create planning challenges to provide suitable inter departmental connections to facilities in the ward block.



CSB Primary Circulation at Level 4

Klein

At the southern end of the building there is a link to the Oncology Building at ground floor and level 1. At Ground floor there is no direct internal circulation between this link and the main entrance area located in the wards building. At 1st floor this link connects to the the main lifts in the wards building via a corridor along the western side of the CSB and also connects to a bridge that crosses Cumberland St to the Fraser Building.

Level 1 Primary Circulation & Links to Other Buildings

8.0 Services Distribution

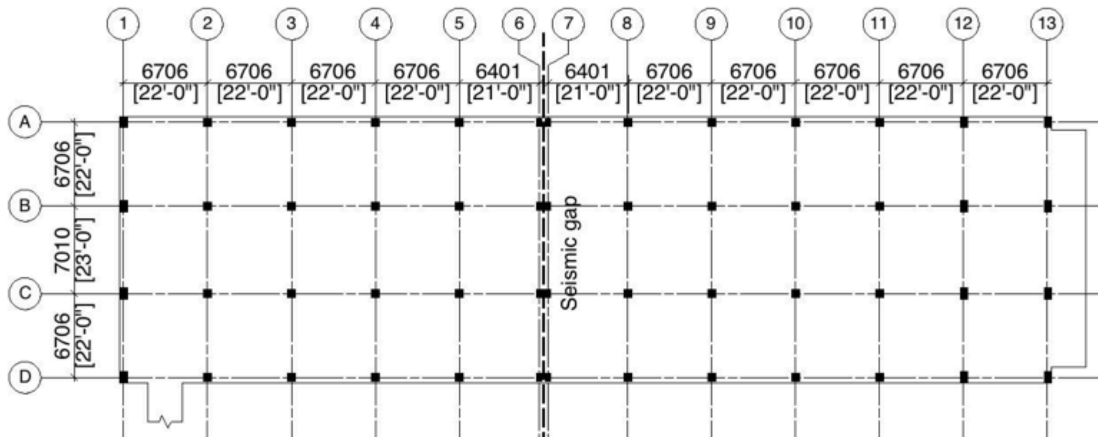
The CSB building is served by three major service risers that extend from the level 6 plant room down to the lower ground, one each at the North and South ends of the building and a central one adjacent to the lifts.

These are well located to distribute services to each floor plate and due to their locations at the edges of the building and co-located with the circulation core, have minimal impact on internal planning and future flexibility.

9.0 Grid and Column Spacings

Review of Existing Grid

The CSB grid spacings are approximately 6.7m (22') in the north-south direction and in the east-west grids are 6.7m(22') on the outer edges and 7.01m(23') in the centre. An additional grid of 5.46 (17'10") allows for the deeper footprint at Ground, first and second floors. The building structure is split in two by a seismic break located approximately across the centre of the building with a double row of columns along this.



Existing Grid and Column Spacing of Levels 3, 4, 5 & 6

Benchmarked against recent CSB Buildings

Grid dimensions of recent clinical facilities at hospitals in Australasia are scheduled below:

Facility	Typical Grid spacing (m)
Hutt Hospital ED & Theatres Building (NZ)	7.8 x 7.8
Middlemore CSB (NZ)	9.6 x 9.6
Auckland Hospital A+ (NZ)	7.2 x 7.2 and 7.2 x 9.6
Burwood Hospital (NZ)	9 x 8.4
Waikato (NZ)	9 x 9
Victorian Cancer Centre (AUS)	8.7 x 8.7
Sunshine Coast University Hospital (AUS)	8.1 x 8.1
Blacktown - Mount Druit (AUS)	8.4 x 8.4

The Australasian Health Facility Guidelines (AHFG) recommend that hospital facility planning is modular with a base dimension of 300 or 600mm and that the structural grid should be a factor of one of these. All the recent buildings noted above have structural grids that are compliant with this module.

Recent guidance coming out of Australia suggests that an 8.7 x 8.7m grid is most suitable for clinical uses [1].
The structural grid at Dunedin CSB, at 6.7-7m is smaller than current good practice and not a factor of 300 making a modular approach to planning with dimensions consistent with AHFG guidelines difficult and inefficient to achieve.

[1] Part of a Presentation by Silver Thomas Hanley at the 'Health Facilities Design Development' Conference as part of AustralianHealthcare Week 2014

10.0 Storey Heights and Ceiling Voids

The typical storey height of the CSB is 3.962m (13'), this applies to all levels from Lower Ground up to the 6th floor slab. These floor levels align with those of the adjacent wards building creating a level transition between the two buildings.

Concrete beams are haunched to allow space for services to run centrally within the grid. Beam depths are 610mm for a length of 2.5m in the central section and increase in depth at the ends to 915mm where they connect to the columns.

The majority of spaces in a hospital have a preferred ceiling height of 2.7 metres with certain clinical spaces requiring 3 metres or more due to ceiling mounted equipment. Functions typically requiring a 3 metre ceiling include operating theatres, procedure rooms, birthing rooms, CT & MRI procedure rooms, X-ray rooms and ICU bed bays. Many of these spaces are also highly serviced environments and hence require a significant amount of space in the ceiling void for services.

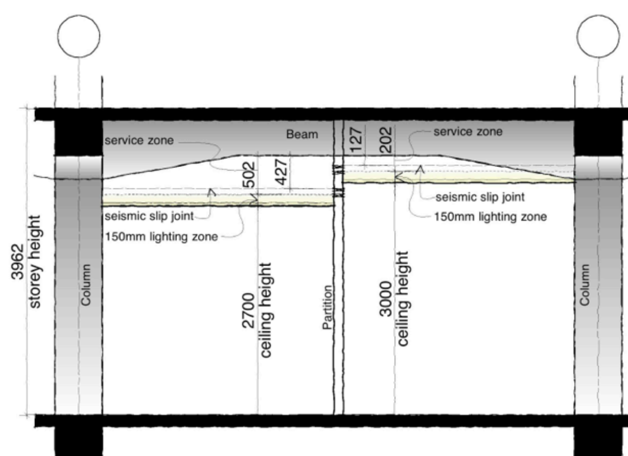
With the existing height available under the structure in the CSB it will be difficult to accommodate spaces with a 3 metre ceiling height or ceilings of 2.7m if the spaces have intensive service requirements. The schematic section on the following page demonstrates the ceiling void available above spaces in the CSB that have ceilings at 2.7m or 3m.

Currently the operating theatres are located on level 5 and are serviced directly through the slab from the plant rooms on level 6 above. It would be extremely challenging to relocate the theatres to another level in the current CSB due to difficulties in services distribution.

Similar facilities with multi use clinical functions have storey heights that are typically in the range of 4.3-4.6m to allow for services to run below structure where ceilings are 3 metres.

Benchmark storey heights from other NZ CSB facilities are scheduled below.

Facility	Floor to Floor height for clinical functions
Middlemore Hospital CSB	4.50m
Hutt Hospital ED & Theatres	4.27m (Aligns with existing floor levels)
Auckland A+	4.40m
Burwood	4.5m & 4.2m
North Shore Hospital (clinical levels)	4.57m



Schematic Section Demonstrating Effect of Ceiling Height on Service Void

11.0 Future Flexibility

Design features that allow for flexibility of internal planning include:

- A building grid in the range of 7.8m to 9.6m that is based on a module of 300mm or 600mm, larger grids will have fewer columns but require deeper structure. The CSB does not meet this criteria
- Floor slabs that have enough thickness to allow for setdowns to be created without restriction to enable level access showers and other floor drainage requirements to be accommodated. From the documents provided, it has not been possible to determine whether this criteria is met
- Storey heights sufficient to allow for ceilings at 2.7m & 3m and enough space above for services, typically in the range of 4.3 to 4.6m. Consideration of floor levels in relation to connecting buildings is also an important driver. The CSB does not meet the storey height criteria, but its floors do align with connecting buildings
- Primary circulation that is located on or can extend to the outside edge of the building to enable connection to future expansion. The vertical circulation core is well located to serve the building but it's relationship to the wards building link could be improved by relocating the link closer to the CSB lifts
- As clear a floor plate as possible with minimal obstruction from structure and having service risers at the edges of the floor plate or co-located with vertical circulation cores. The CSB partly meets this criteria, though the smaller than normal grid spacing results in more columns
- Structure and envelope constructed to IL4 requirements to allow for the full range of clinical services to be accommodated in the future. The CSB structure achieves this criteria but the cladding fails to fully meet the performance requirements of IL4

12.0 Suitability for Reconfiguration

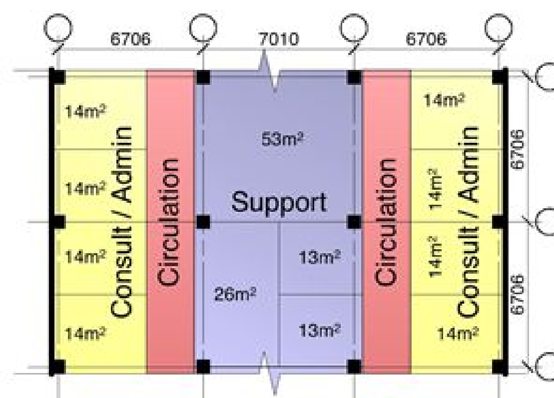
Acute Clinical Services

Due to the the difficulty in achieving a 3 metre ceiling height the building is not ideally suited to accommodating acute services such as theatres, intensive care or radiology.

Non Acute Clinical Services

Facilities such as clinics, consults, minor procedures etc with a maximum ceiling height of 2.7m can be accommodated into the building though due to the dimension of the grid it will be a challenge to plan the space efficiently and in a modular way to suit modern healthcare design.

The diagram (right) demonstrates a schematic 'race track' type layout for non-acute clinical planning. This type of layout would also suit admin and educational uses.



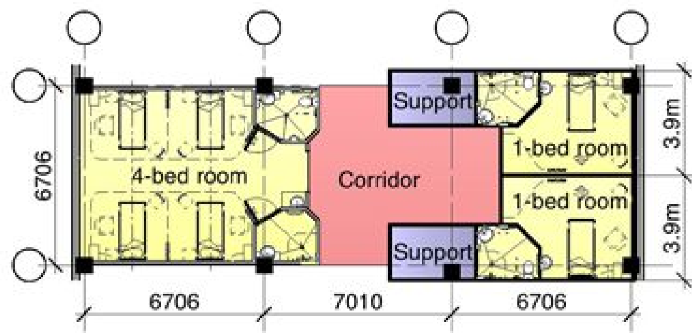
Typical Clinical Planning Module Overlay onto CSB Plan L3 & 4

6.11

Wards

Recent developments in ward design favour a grid of 8.1m or 8.4m in order to accommodate two single or twin bedrooms within a grid module. The 6.7m grid of the CSB does not satisfy this criteria.

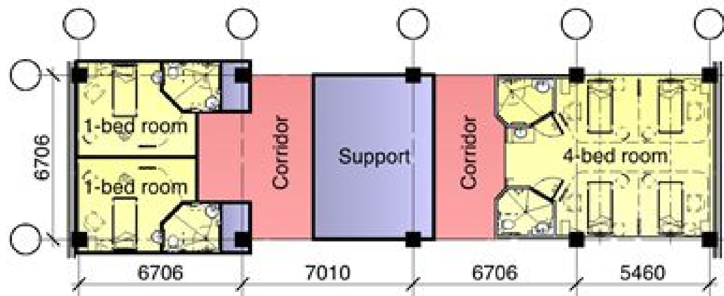
The depth of the building footprint at levels 3, 4 and 5 can be reconfigured as a ward but does not lead to an efficient use of space. The building plan is too deep for a single central corridor with rooms either side but is not deep enough to achieve a central 'racetrack' support band with rooms either side of this (similar to the layout of the existing wards). The diagram below shows a possible configuration for a wards layout with a 4-bed room on one side of a central corridor and a single bed and support space on the other. Due to the width required the single bed rooms it would not be possible to repeat this layout at consecutive grids. A minimum dimension of 3.9m centre to centre of walls is recommended for generic inpatient bedrooms single or double and this is not achievable with this grid module. With a trend to increasing numbers of single bed rooms in hospitals (30-50% in recent NZ projects and up to 100% in Australian and international examples), a grid that suits a single bedroom module is important for efficient planning.



Possible Wards Configuration - Levels 3-5

The footprint area of the floor levels is over generous for a single 28-30 bed ward at 52-62sqm/bed. Area/ bed ratios vary depending on ward type but for general medical/ surgical/ wards are in the range 42-50sqm/bed. The total floor area, while generous for a single ward, is not adequate to accommodate two wards which can have benefits with staffing efficiencies and flexible use of support spread across multiple wards.

Levels 1 and 2 could be suitable for a similar wards layout to the existing layouts in the wards building but the column spacings do not lend themselves to achieving optimal efficiency in space planning. As with the upper floors, the grid is not adequate to accommodate two single or twin bedded rooms per grid. The amount of space for support would also likely be over generous for a ward. The diagram below shows the a possible reconfiguration of the lower levels as a ward.



Possible Wards Configuration - Ground - Level 2

Administration and Education

The building is well suited to administration and educational uses due to its good access to natural light. It could be reconfigured as cellular or open plan layouts or a combination of the two.

13.0 Conclusion

In conclusion it appears that the clinical services building is not ideally suited to reconfiguration as a modern health facility for acute clinical services due to the following reasons:

- The grid dimension and column spacing at 6.7-7m is inadequate when benchmarked against modern clinical services buildings and doesn't suit a modular approach to space planning. This will likely result in inefficient space planning
- The relatively narrow plan of the building is unsuitable for clinical functions that required spatial relationships in their internal planning, eg. procedural and diagnostic areas
- The storey heights are not adequate and will create challenges to have spaces with a 3 metre ceiling height or highly serviced spaces with a 2.7 metre ceiling
- The single primary circulation connection to the building at most levels creates a 'cul-de-sac' effect and may limit its suitability within an overall masterplan for optimal flow within the hospital

The building is not ideally suited to reconfiguration as inpatient wards due to the grid dimension and column spacing at 6.7-7m being inadequate for the recommended single bedroom module and a building depth and overall floorplate area that is inefficient for modern ward planning.

Non acute clinical uses such as outpatient clinics could be accommodated but the grid spacing would be unlikely to result in optimal efficiency in space planning.

Reconfiguration as Administration and educational functions are well suited to the building.

Any reconfiguration of the CSB would need careful consideration to be given to clinical functions in adjacent buildings and their relationship to those in the CSB.