SOUTHERN DISTRICT HEALTH BOARD

HOSPITAL ADVISORY COMMITTEE

Thursday, 26 July 2018, 9.30 am

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

A G E N D A

Lead Director: Patrick Ng, Executive Director Specialist Services

Item

1. **Apologies**
2. **Presentation: Southland Hospital Ophthalmology Service Redevelopment (Judith Kissell)**
3. **Interests Register**
4. **Minutes of Previous Meeting**
5. **Matters Arising/Action Sheet**
6. **Specialist Services Monitoring and Performance Reports**
   - 6.1 Executive Director Specialist Services Report
   - 6.2 Key Performance Indicators
   - 6.3 Financial Performance Summary
   - 6.4 Did Not Attend (DNA) Rate - update
7. **Resolution to Exclude Public**

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

APOLOGIES

No apologies noted at time of publishing the agenda.

Southland Hospital Ophthalmology Service Redevelopment

SOUTHLAND OPHTHALMOLOGY IN 2015

The demand on the Ophthalmology team had escalated due to:

- Introduction of Avastin injection for the treatment of Macular Degeneration (ARMD)
- Treatment of Diabetic and retinal occlusive disease
- Significant aging population in Southland means that demand for all services, and in particular complex glaucoma and neurovascular ARMD have steadily climbed over time
- No private general practice Ophthalmology care in Invercargill. Only service provided privately is cataract surgery and limited medical glaucoma services
- Referrals are increasing from both Optometrists and General Practitioners, who are aware of the possibilities available for treatment of more Ophthalmic diseases

Capacity to meet the increased demand had not changed due to:

- No increase in resourcing resulted in
  - Nurse Specialist unable to work to scope as frequently needing to assist in clinics in an RN role
  - Little capacity for training new and existing staff resulting in restricted ability to respond flexibly to demand.
  - Ideas for improving efficiency are very difficult to progress as there is no capacity
  - Cancellation of clinics or use of locums to clear backlogs

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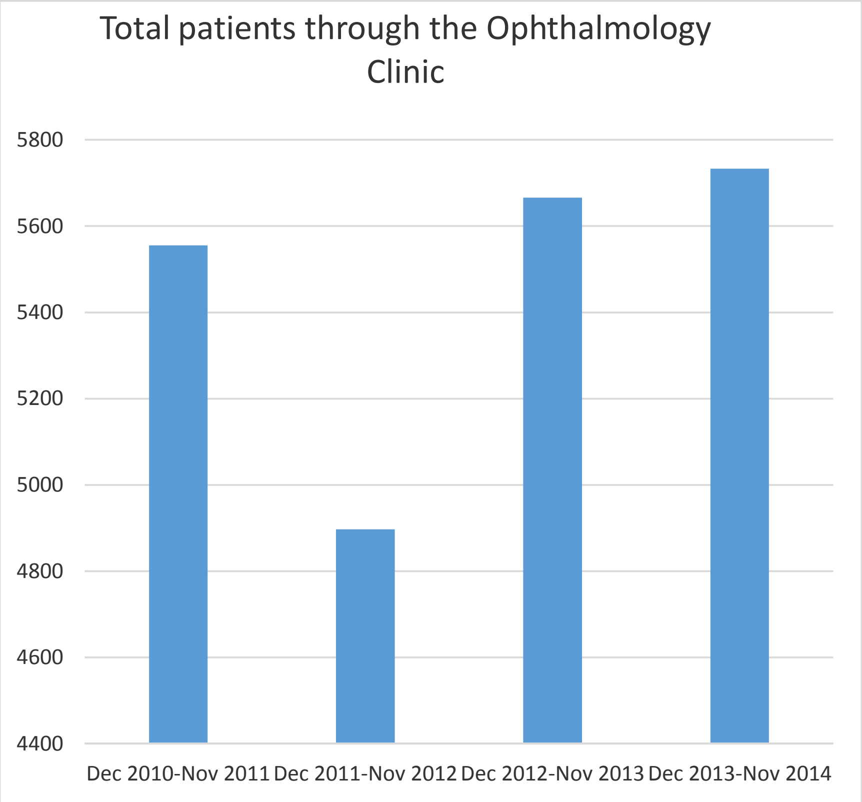
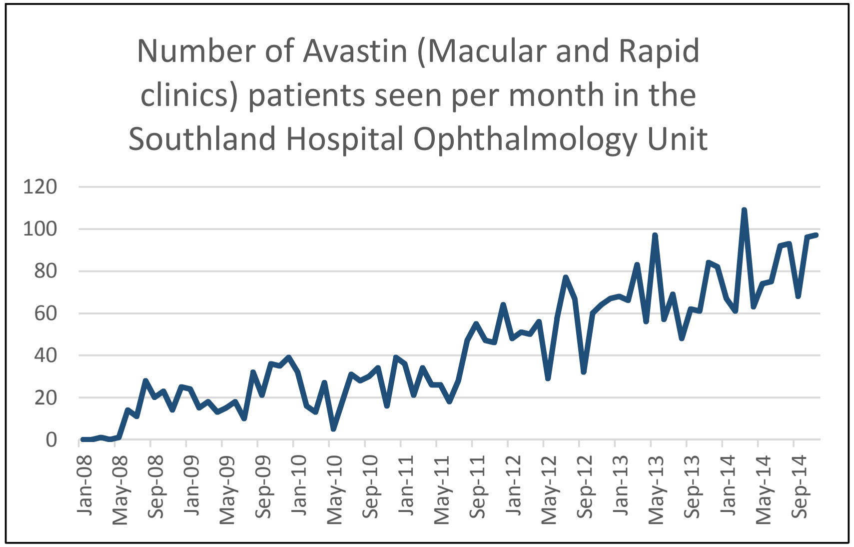
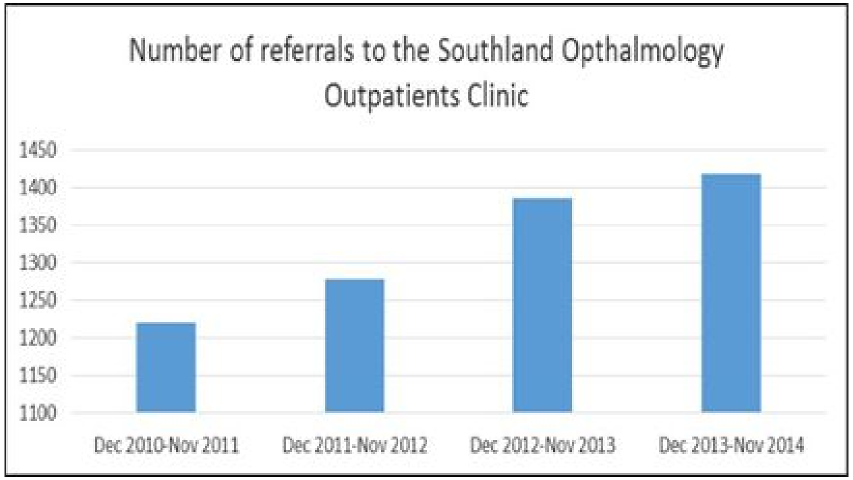
GROWING DEMAND – CAPACITY INSUFFICIENT



2011-12 impact due to a consultant resigning and difficulty recruiting a replacement.





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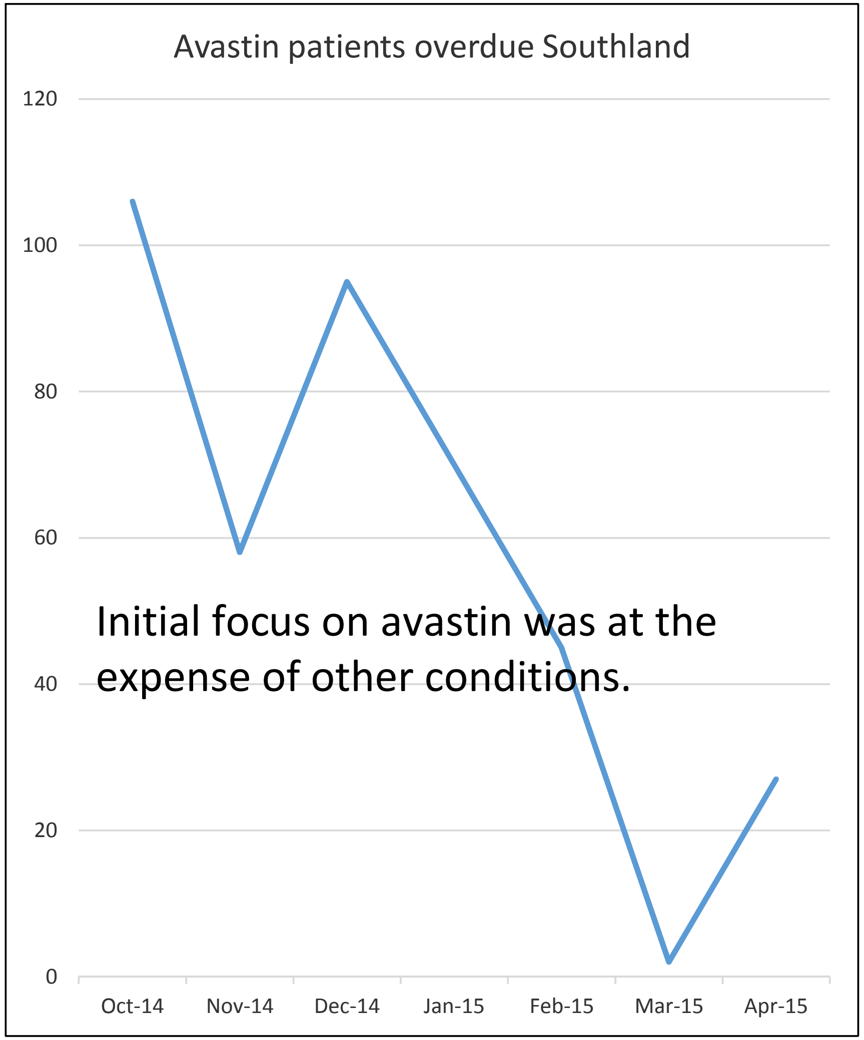
FIREFIGHTING APPROACH



- Resources focused on Avastin patients who are considered the highest risk patients for developing blindness.
- Each push to review more patients in consultant clinics resulted in a surge of patients requiring a course of Avastin injections placing extra pressure on the resources.
- While locum work addressed the Avastin overdue patients and decreased in the number of outstanding follow up appointments, the work undertaken did not make a sustainable change to the departments practice or outcomes.
- The high risk areas of Avastin, glaucoma screening and diabetic retinal screening still continued to grow.
- These clinics rely extensively on nursing input, which was limited

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CHANGES IMPLEMENTED

Changes made since that have resulted in significant improvement

- Free up CNS position to undertake a mentoring and supporting role as well as higher level nursing practice
- Secured a workable site with additional equipment for a larger Ophthalmology department, to enable additional efficiently run clinics
- Altered the work flow of clinics by changing equipment location
- Redesign of macula clinics incorporated with a rapid Avastin injection clinic, maximizing SMO time with ability to see more patients.
- Introduction of nurse administered Avastin therapy freeing up the SMOs
- Changes in avastin model has maximized SMOs scheduling
- Administration scheduling patients using acuity index tool to enable appropriate clinic bookings/wait list management
- Implementation of a one stop cataract assessment service combining four consultation appointments into one.
- Redesign clinics with staff working to their scope
- Co-located administration staff/clinical staff

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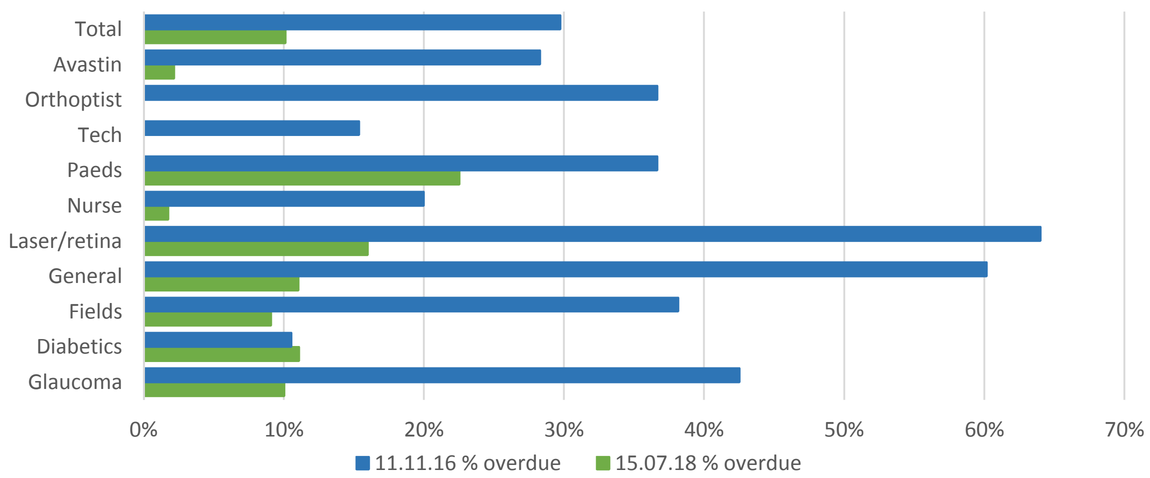
IMPROVEMENTS IN OVERDUE PATIENT NUMBERS ACROSS THE BOARD

	11.11.16			15.07.18		
	Total patients	Total overdue	% overdue	Total patients	Total overdue	% overdue
Glaucoma	522	222	43%	578	58	10%
Diabetics	2208	233	11%	2315	257	11%
Fields	186	71	38%	66	6	9%
General	580	349	60%	507	56	11%
Laser/retina	428	274	64%	344	55	16%
Nurse	50	10	20%	57	1	2%
Paeds	210	77	37%	204	46	23%
Tech	26	4	15%	18	0	0%
Orthoptist	210	77	37%	46	0	0%
Avastin	265	75	28%	276	6	2%
Total	**4684**	**1394**	**30%**	**4933**	**500**	**10%**

% of patients overdue, 2016 vs 2018



WHERE TO FROM HERE?

Work on various models of care in the subspecialties within Ophthalmology e.g:

- Implement a cataract pathway to include Optometrist involvement with decision making for patients who potentially required cataract surgery and then follow up appointment postoperatively with the Optometrist.
- Appoint and train a further senior nurse to administer Avastin therapy
- Review paediatric service requirements and maximise the use of a recently appointed Orthoptist.
- Investigate further extensions to the Ophthalmic department as physical space continues to be an issue particularly in the waiting area
- Continue to strive towards improving efficiencies within the department

Without the dedication and commitment from the fabulous Ophthalmology staff we would never have achieved what we have to date.

Patients waiting > 1.5 times their appointment date are now at **zero** across all conditions

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SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Hospital Advisory Committee
Date of Meeting:	26 July 2018

Summary:

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

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

Changes to Interests Registers over the last month:

- Nil

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

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

Prepared by:

Joanne Fannin
Personal Assistant

Date: 17 July 2018

RECOMMENDATION:

1. **That the Interests Registers be received and noted.**

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SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
COMMISSIONER TEAM

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Kathy GRANT	25.06.2015	Chair, Otago Polytechnic	Southern DHB has agreements with Otago Polytechnic for clinical placements and clinical lecturer cover.	
(Commissioner)	25.06.2015	Director, Dunedin City Holdings Limited	Nil	
	25.06.2015	Trustee of numerous private trusts	Nil	
	25.06.2015	Consultant, Gallaway Cook Allan	Nil	
	25.06.2015	Director, Dunedin City Treasury Limited	Nil	
	18.09.2016	Food Safety Specialists Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	18.09.2016	Director, Warrington Estate Ltd	Nil - no pecuniary interest; provide legal services to the company.	
	18.09.2016	Tall Poppy Ideas Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	18.09.2016	Rangiora Lineside Ltd	Nil. Co-trustee in client trusts - no pecuniary interest.	
	18.09.2016	Otaki Three Limited	Nil. Co-trustee in client trusts - no pecuniary interest.	
		Spouse:		
	25.06.2015	Consultant, Gallaway Cook Allan	Nil (Updated 8 June 2017)	
	25.06.2015	Chair, Slinkskins Limited	Nil	
	25.06.2015	Director, South Link Health Services Limited	A SLH entity, Southern Clinical Network, has applied for PHO status.	Step aside from decision-making (refer Commissioner's meeting minutes 02.09.2015).
	25.06.2015	Board Member, Warbirds Over Wanaka Community Trust	Nil	
	25.06.2015	Director, Warbirds Over Wanaka Limited	Nil	
	25.06.2015	Director, Warbirds Over Wanaka International Airshows Limited	Nil	
	25.06.2015	Board Member, Leslie Groves Home & Hospital	Leslie Groves has a contract with Southern DHB for aged care services.	
	25.06.2015	Chair Dunedin Diocesan Trust Board	Nil (Updated 16 April 2018)	
	25.06.2015	Trustee of numerous private trusts	Nil	
	25.06.2015 (updated 22.04.2016)	President, Otago Racing Club Inc.	Nil	
Graham CROMBIE	27.06.2015	Independent Director, Surf Life Saving New Zealand	Nil	
(Deputy Commissioner)	25.06.2015	Chairman, Dunedin City Holdings Ltd	Nil	
	25.06.2015	Chairman, Otago Museum	Nil	
	25.06.2015	Chairman, New Zealand Genomics Ltd	Nil	
	25.06.2015	Independent Chairman, Action Engineering Ltd	Nil	
	25.06.2015	Trustee, Orokonui Foundation	Nil	
	25.06.2015	Chairman, Dunedin City Treasury Ltd	Nil	
	25.06.2015	Independent Chair, Innovative Health Technologies (NZ) Ltd	Possible conflict if Southern DHB purchased this company's product.	

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SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
COMMISSIONER TEAM

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	16.01.2017	Director, Dunedin Stadium Property Ltd (previously known as Dunedin Venues Ltd)	Nil	
	08.02.2017	Independent Chair, TANZ eCampus Ltd		
	13.03.2017	Chair, South Island Alliance Information Services		
	23.11.2017	Director, A G Foley Ltd	Possible conflict if Southern DHB contracts this company's services.	
	06.06.2018	WJ Investments Ltd	Trustee for lawyer's trust, which owns this company.	Will withdraw if any conflict arises.
	18.09.2016	Director and Shareholder, Innovatio Ltd	Vehicle for governance and consulting assignments. Clients listed above.	
Richard THOMSON (Deputy Commissioner)	13.12.2001	Managing Director, Thomson & Cessford Ltd	Thomson & Cessford Ltd is the company name for the Acquisitions Retail Chain. Southern DHB staff occasionally purchase goods for their departments from it.	
	13.12.2002	Chairperson and Trustee, Hawksbury Community Living Trust	Hawksbury Trust runs residential homes for intellectually disabled adults in Otago and Canterbury. It does not have contracts with Southern DHB.	
	23.09.2003	Trustee, HealthCare Otago Charitable Trust	Health Care Otago Charitable Trust regularly receives grant applications from staff and departments of Southern DHB, as well as other community organisations.	
	05.02.2015	One immediate family member is an employee of Dunedin Hospital (Anaesthetic Technician)		
	07.10.2015	Southern Partnership Group	The Southern Partnership Group will have governance oversight of the Dunedin Hospital rebuild and its decisions may conflict with some positions agreed by the DHB and approved by the Commissioner team.	

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SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

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

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Mike COLLINS	15.09.2016	Wife, NICU Nurse	
Pania COOTE	08.12.2017	Ngāi Tahu, Ngāti Kauwhata and Ngāti Porou registered.	Nil
	30.09.2011	Member, South Island Alliance Southern Cancer Network	Nil
	30.09.2011	Member, Aotearoa New Zealand Association of Social Workers (ANZASW)	Nil
	29.06.2012	Member, Te Waipounamu Māori Cancer Leadership Group	Nil
	26.01.2015	National Māori Monitoring Equity Group (National Screening Unit) – MMEG.	Nil
	26.01.2015	Member, Child Health Network (Alliance South)	Nil
	19.09.2016	Shareholder (2%), Bluff Electrical 2005 Ltd	Nil
	08.12.2017	South Island Alliance, Strategic Planning and Integration Team (SPaIT)	Nil
	28.05.2018	SDHB National Bowel Screening Programme Governance Group	Nil
	28.05.2018	Hei Ahuru Mowai (Māori Cancer Leadership Aotearoa)	Nil
Matapura ELLISON	12.02.2018	Director, Otākou Health Services Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	12.02.2018	Director, Otākou Health Ltd	Nil
	12.02.2018	Deputy Kaiwhakahaere, Te Rūnanga o Ngai Tahu	Nil
	12.02.2018	Chairperson, Kati Huirapa Rūnaka ki Puketeraki	Nil
	12.02.2018	Trustee, Araiteuru Kōkiri Trust	Nil

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	12.02.2018	Otago Museum Māori Advisory Committee	Nil
	12.02.2018	National Māori Equity Group (National Screening Unit) – MEG.	Nil
	12.02.2018	SDHB Child and Youth Health Service Level Alliance Team	Nil
	12.02.2018	Trustee, Section 20, BLK 12 Church & Hall Trust	Nil
	12.02.2018	Trustee, Waikouaiti Maori Foreshore Reserve Trust	Nil
	29.05.2018	Director & Shareholder (jointly held) - Arai Te Uru Whare Hauora Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	
	25.09.2016	Deputy Chair, InterRAI NZ	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
Lisa GESTRO	06.06.2018	Lead GM National Travel and Accommodation Programme	
Lynda McCUTCHEON	19.08.2015	Member of the National Directors of Allied Health	Nil

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SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	04.07.2016	NZ Physiotherapy Board: Professional Conduct Committee (PCC) member	No perceived conflict. If complaint involves SDHB staff member or contractor, will not sit on PCC.
	18.09.2016	Shareholder, Marketing Business Ltd	Nil
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	Fellow of the Royal Australasian College of Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	04.07.2016	Clinical Lead for HQSC Atlas of Healthcare variation	HQSC conclusions or content in the Atlas may adversely affect the SDHB.
	29.05.2018	Council Member of Otago Medical Research Foundation Incorporated	
Nicola MUTCH		Deputy Chair, Dunedin Fringe Trust	Nil
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	17.11.2017	Wife works for key technology supplier CCL	Nil
	18.12.2017	Daughter, medical student at Auckland University and undertaking Otago research project over summer 2017/18.	
Julie RICKMAN	31.10.2017	Director, JER Limited	Nil, own consulting company
	31.10.2017	Director, Joyce & Mervyn Leach Trust Trustee Company Limited	Nil, Trustee

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SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	31.10.2017	Trustee, The Julie Rickman Trust	Nil, own trust
	31.10.2017	Trustee, M R & S L Burnell Trust	Nil, sister's family trust
		Specified contractor for JER Limited in respect of:	
	31.10.2017	H G Leach Company Limited to termination	Nil
Jane WILSON	16.08.2017	Member of New Zealand Nurses Organisation (NZNO)	No perceived conflict. Member for the purposes of indemnity cover.
	16.08.2017	Member of College of Nurses Aotearoa (NZ) Inc.	Professional membership.
	16.08.2017	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Thursday, 24 May 2018, commencing at 9.30 am in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Mrs Kathy Grant	Commissioner
	Mr Graham Crombie	Deputy Commissioner (by teleconference until 10.55 am, then by videoconference from 11.55 am)
	Mr Richard Thomson	Deputy Commissioner
In Attendance:	Mr Chris Fleming	Chief Executive Officer (until 12 noon)
	Mrs Lisa Gestro	Executive Director Strategy, Primary & Community
	Dr Nigel Millar	Chief Medical Officer (from 10.32 am)
	Dr Nicola Mutch	Executive Director Communications
	Mr Patrick Ng	Executive Director Specialist Services
	Ms Julie Rickman	Executive Director Finance, Procurement & Facilities
	Mrs Jane Wilson	Chief Nursing & Midwifery Officer (until 12 noon)
	Ms Jeanette Kloosterman	Board Secretary

1.0 PRESENTATION: *A JOURNEY TO THE NATIONAL BOWEL SCREENING PROGRAMME - THE SOUTHERN DHB STORY*

The Commissioner welcomed Dr Jason Hill, Consultant, and Gastroenterology Service staff to the meeting.

Dr Hill gave a presentation on the development and implementation of the Bowel Screening Programme in the Southern District (tab 2). This included an outline of the key principles followed, predicted growth and the challenges of meeting increased demand, what had been achieved, the benefits of the bowel screening programme and what was being done to encourage participation.

Dr Hill and his colleagues then answered questions on the improvements they had made within their service, what was being done to encourage Māori and Pasifika participation, and their relationship with Primary Care.

In thanking Dr Hill and his team, the Commissioner advised that she was looking forward to viewing the new Gastroenterology Unit.

2.0 APOLOGIES

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

3.0 DECLARATION OF INTERESTS

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

The Commissioner reminded everyone of their obligation to advise the meeting should any potential conflict arise during discussions.

Recommendation:

"That the Interests Registers be received and noted."

Agreed

4.0 PREVIOUS MINUTES

Recommendation*:*

"That the minutes of the meeting held on 21 March 2018 be approved and adopted as a true and correct record."

Agreed

5.0 MATTERS ARISING/REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 5).

Elective Surgical Discharges

The Executive Director Specialist Services (EDSS) reported that the dip in elective discharges in December 2017 was due to the planned seasonal shutdown.

DSS Mental Health

The EDSS was asked to check whether the contract for DSS Mental Health beds was reviewed and varied on a regular basis according to the care costs of individual occupants.

6.0 PROVIDER ARM MONITORING AND PERFORMANCE REPORTS

Executive Director Specialist Services' Report (tab 6.1)

The Executive Director Specialist Services (EDSS)' monthly report was taken as read and the EDSS provided the following updates.

Radiology Accreditation

The EDSS reported that:

- The facilities work required for re-accreditation had been completed but the health and safety check had had been delayed because the Health & Safety Manager had been on sick leave;
- Philips had confirmed support for the radiology information system (RIS) to mid 2020;
- Staff were being recruited to fill vacancies and cover additional shifts;
- A full report would be submitted to the next Commissioner's meeting.

Elective Service Performance Indicators (ESPIs)

The EDSS reported that advice had been sought from Capital & Coast and Canterbury DHBs on how they had improved the management of their Elective Service Performance Indicators (ESPIs).

Dr Nigel Millar, Chief Medical Officer, joined the meeting at 10.32 am.

Cardiothoracic Surgery

The EDSS reported that access block to the Intensive Care Unit (ICU) over the last couple of months had led to the cancellation of cardiothoracic surgery and an increase in the waitlist. Several meetings had been held with the Cardiothoracic Surgery Clinical Director, the General Manager, and the management of Mercy Hospital, with the aim of having an additional list at Mercy one Friday per month. The Ministry of Health also recommended that a contract be put in place with another provider, eg Auckland or Waikato, as a backstop for urgent cases.

Ophthalmology

The EDSS reported that an undertaking had been given to get the 1.5 wait time for follow-up appointments down to zero by 30 June 2018 and achievement of that target was still on track. The EDSS advised that the next challenge would be maintaining it at zero, particularly on the Dunedin site, and outlined the work that was being undertaken to manage service delivery.

Mr Graham Crombie, Deputy Commissioner, left the meeting at 10.55 am.

Financial Performance Summary (tab 6.3)

The EDSS presented the financial report for April 2018 and highlighted the key factors affecting the result.

CONFIDENTIAL SESSION

At 11.00 am it was resolved that the Hospital Advisory Committee reconvene at the conclusion of the Disability Support and Community & Public Health Advisory Committees meeting and move into committee to consider the agenda items listed below.

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.
2. Serious Adverse Events	To protect information where the making available of the information would be likely to prejudice the supply of similar information and it is in the public interest that such information continue to be supplied.	Section 9(2)(ba) of the Official Information Act (OIA).

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
3. Dunedin Hospital Redevelopment	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the OIA.

Confirmed as a true and correct record:

Commissioner: ______________________________

Date: ___________________

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Southern District Health Board
HOSPITAL ADVISORY COMMITTEE
ACTION SHEET

As at 18 July 2018

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
May 2018	**DSS Mental Health** (Minute item 5.0)	Check to be made that the contract for DSS Mental Health beds is reviewed and varied on a regular basis according to the care costs of individual occupants.	EDSS	Noted.	Complete

6.1

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Executive Director of Specialist Services Report**
Report to:	Hospital Advisory Committee
Date of Meeting:	26 July 2018

Summary:

Considered in these papers are:

- June 2018 DHB activity.

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

Financial:	Yes
Workforce:	Yes
Other:	No

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

Prepared by: Executive Director of Specialist Services **Date:** 17/07/2018	**Presented by:** Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:

That the Hospital Advisory Committee receive the report.

Executive Director of Specialist Services Report – June 2018

Recommendation

That the Hospital Advisory Committee notes this report.

1. Operational Overview Highlights

Highlights for the Year

- Ophthalmology achieved the target of having no patients > 1.5 times their appointment date in June.
- Elective delivery initially indicated a full year performance of 505 case weights less than the full year plan of 15,400 case weights. However, following final adjustments and wash-ups the year end number appears to be a shortfall of only 230 case weights and with over achievement in the ambulatory initiative we have been able to recognise 100% of the combined elective and ambulatory initiative funding from the Ministry.
- The radiology service feels that it has successfully addressed two of the three corrective action requests identified by IANZ. Approvals are in place for an extra evening CT roster (to alleviate staff pressures from call backs), and for running weekend MRI sessions. These solutions are dependent on recruitment, however five of eight vacancies have recently been filled and we are confident we can run the evening CT session from September. Additional recruitment is required before we can confirm the weekend MRI sessions in Dunedin.
- Cardiothoracic patients now back to within Ministry target with a proposal close to being finalised that will provide extra capacity via the private hospital in Dunedin. The extra capacity should allow us to stay closer to Ministry targets when blockages in the hospital (ICU) would traditionally force us to cancel surgery.

Electives Performance

Electives performance for the month of June exceeded our expectations.

Total elective delivery for the month was 1,404.1 case weights, comprising of the following:

- Underlying internal elective delivery (through main operating theatres and day surgery): 1,189.2 case weights.
- Outsourced: 148.6 case weights.
- Outplacement: 16.7 case weights.
- Arranged admission corrections 49.6 case weights.

The production plan for next year is now in place. Whilst we believe it is achievable, it is a tight plan which requires strong efficiencies to be achieved out of the perioperative theatre improvement initiative that is currently underway with our consultancy partner.

ESPI Improvement Planning

Key areas of ESPI over-run are in General Surgery and Orthopaedics, followed by ENT and Urology. We are focusing on General Surgery initially, but will implement the opportunities identified in General Surgery in the other services as well. The following is underway:

- We have run an initial workshop with the Service Manager and Elective Services Manager and used this as the basis for constructing a proposed terms of reference for a working group to implement improvements. We are proposing a steering group for this initiative which includes the Clinical Director and the Ministry electives lead.
- We have initiated bringing the project lead for Canterbury's '100 days' initiative to Dunedin, which the Ministry is kindly funding. This will occur in early August. The 100 days initiative was implemented by CDHB over 2.5 years to address their Elective Service Performance

Indicators (ESPI) challenges and involved a range of initiatives which included improved pathways into the hospital for referrals, primary care support for referrals that weren't able to be accepted by the hospital, operational management of available outpatient clinics, development of reporting, production planning and forecasting, and forward planning to enable ESPI appointments to occur within 100 days rather than the 120 day ESPI limit (to allow a buffer to better allow the ESPI target to be met).

During our initial workshop for General Surgery we concluded that the non-ESPI appointments are either more important or of similar importance as the ESPI appointments and we have concluded that we need to implement an acuity based booking approach to ensure that the highest priority cases are seen first.

Acuity based booking applies an expected appointment time to each appointment based on the acuity (urgency) of the appointment and increases the acuity the longer the patient has waited beyond the expected appointment date. Organisationally we have good learning from the implementation of acuity based booking in Ophthalmology and we are excited about the opportunity to utilise this learning to improve the General Surgery outpatient appointment process. It is our team's belief that as the Ministry revisits health targets, acuity will feature as an important enhancement to ESPI management.

Initial actions for this work programme include the establishment of acuity scoring in IPM (software), implementation in consultation with Clinical Directors and booking staff and monitoring of the utilisation of this.

We are seeking to improve our management in this regard and can then link this through to the 100 day initiative (or similar exercise) that will be driven by the valuing patient time programme.

Ophthalmology

A significant push was made to create additional clinics so that follow up appointments greater than 1.5 X waiting time could be cleared, in line with the expectation we provided to the Ministry that we would get this to zero by June 30. This was achieved. However, we are still left with the challenge of maintaining this level of performance.

The team have identified a six month plan to manage volumes at this level which involves one weekend of outsourced clinics per month from August until December. Volumes will lift off zero in July but will be maintained at target levels from August/September onwards.

An appointment into the project/improvement role has been made. They will work closely with the Project Management Office Manager on the model of care work to date, along with other input as required to develop proposed changes to maintain the performance required by the service.

Although the service has taken some time to achieve the level of performance they got to in June, they are to be congratulated for achieving the required level of performance in Southland months ago and maintaining this, successfully implementing acuity based booking and managing the clerical and administrative workload associated with the additional clinics booked for locums and the outsource providers' weekend service.

Radiology

We are currently preparing a letter to IANZ which explains the progress that has been made against the Corrective Action Requests (CARS) in radiology. In terms of CAR 1 (facilities) we believe we have addressed all the previous concerns as the relevant services are now accessible below ceiling height and the air-handling unit is fully accessible below ceiling height. In terms of CAR 2 (software) we now have a contract extension in place until mid-2020, and we have the proposal evaluation process underway with a decision able to be made in September. In terms of CAR 3 (modality performance and staffing) we have approved an additional shift which will address staff concerns about the volume of call-backs, and we have approval to run weekend MRI sessions. We have several MRI vacancies that need to be filled, as well as these additional roles before we can implement these changes. The question we need to put to IANZ is whether having gained approval for these roles and actively trying to recruit them is this sufficient to address their concerns, or will they tell us we aren't compliant until we have the roles in post?

Assuming that IANZ responds positively to our letter we will request re-accreditation and prepare for this process.

During the month we also met with members of Pacific Radiology Group (PRG) to progress discussions on potentially purchasing MRI sessional capacity in Queenstown. Providing an MRI service to our central lakes patients will avoid the need for them to travel.

Southland have been successful with recent MRT recruitment which has coincided with another MRT staff member gaining MRI accreditation. As a consequence they have been able to secure weekend MRI sessions (using our own staff) until September, which will see a significant improvement in the MRI target performance for Southland.

Thanks to the UK recruitment campaign, of our 8 MRT vacancies we have now been able to recruit 5. This should be sufficient for us to start running the CT evening shift once all these roles are on board (September). We still need to recruit to the remaining vacancies before we can start the Dunedin MRI weekend sessions and the recruitment campaign is continuing.

Clerical and Administration

We are keen to look at reviewing how we handle referrals for Dunedin and Southland hospitals. Desired benefits of the review would be as follows:

- Able to implement ERMS stage 2 (where referrals are received electronically in Health Connect South), then reconcile referrals received with what is entered into the patient administration system.
- Create a more sustainable team environment that can cope with the absence of a number of team members without compromising the service that is delivered.
- Produce highly standardised processes for referrals that are consistent across all specialties.
- Set our processes up well for electronic referral triaging software implementation.

We have had an initial conversation with the PSA about the possibility of implementing these improvements, which was well received. We have agreed to establish a monthly engagement session with the PSA to collectively track progress on initiatives and to co-construct future opportunities.

We will need to carefully align improvement here with the wider 'valuing patient time' programme, as this improvement initiative would logically connect into this broader programme and any resources that may be required would logically be governed / provided via the broader programme. However, we are keen to get a bit of definitional work underway in the meantime by briefly documenting current state processes and doing a gap analysis between current state and desired future state. We will raise this appropriately at the newly created PSA engagement sessions and also with the 'valuing patient time' programme in the near future.

Workforce and Registrar Vacancies

A key challenge for us is vacancies in key workforces which are proving hard to fill. The recruitment drive in the UK seems to be going well, with several Senior House Officer and Resident Medical Officer applicants proving suitable and offers being made to them. Key workforces remain a challenge for us overall and we need to focus our workforce strategies on attracting to, and then retaining staffing in key areas.

6.1

2. Health Targets

Shorter Stays in Emergency Department – Target 95%	90%	90%	Continuing to look at patient flow through the Emergency Department and also across the whole hospital. Initiatives include: • Allied Health 7 days a week in ED/IMAU • Early discharge from the ward • Discharge lounge 8 Med • Review acute readmissions • Weekend discharges • Examining ED presentations • Working with nursing homes • Increasing utilisation of MAU • Closer liaison with Primary Care-Primary Health Looking at possibility of change in model of care in ED Dunedin - ambulatory step down in ED observations.

Colonoscopy Urgent – 85% **Colonoscopy non - urgent – 70%** **Colonoscopy Surveillance – 70%**	95% 90% 88%	88% 93% 91%	
Coronary Angiograms Target 95%	100%	100%	
Immunisation 95% of eight-month-olds will have their primary course of immunisation (six weeks, three months and five month events) on time.		N/A	
Healthy Children By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.		N/A	
Radiology Diagnostic indicator CT, 95% of patients referred for elective CT have report distributed within 42 days	February 2018 88.99% March 2018 89.7%	May 2018 87.3% June 2018 Not available	Performance against target for May improved on the previous month. CT at Invercargill continues to perform over 90%, with figures suggesting this is around 98%.

Radiology Diagnostic indicator MRI, 85% of patients referred for elective MRI have report distributed within 42 days	January 2018 25.96% February 2018 31.7% March 2018 31.02%	April 2018 27.9% May 2018 32.8% June 2018 Not available	MRI performance also improved in May at both sites. Dunedin and Southland Hospitals undertook additional examinations in May 2018 and as additional sessions continue, the Southland result should improve through until September 2018. Dunedin (and District) performance is likely to remain relatively static until sufficient staffing to introduce rostered weekend shifts is recruited.
Faster Cancer Treatment (FCT) – Target 90% of patients referred with a high suspicion of cancer and triaged as urgent receive their first definitive cancer treatment within 62 days of the date of receipt of referral (as of July 2017)	Q1 2017/18 84.7% Q2 2017/18 88.9% Q3 2017/18 90.2%	Q4 2017/18 (incomplete) 85.2%	FCT 62-day performance has decreased in Q4 2017/18 on records currently completed. Performance dropped in May 2018, but has improved again in June. The number of patient records for May was also approximately 20% higher than the median, which may account for some of the decline in performance. Breach analysis is currently being undertaken.

Elective Surgical Discharges - Annual target 13,190	13,253 Actual YTD vs 13,190 Plan YTD, 63 ahead of plan as at June 2018.

3. Contract Performance with hospital provider

- Total elective case weights delivered by Southern DHB Provider Arm were 1,426.4 in June and 15,868.7 for the full year.
- **Please note** that the year to date elective case weights reflect the service provision view of case weight delivery. The elective case weights in the financial reports reflect the overall organisational view including IDFs.

4. Operational Performance

Elective services Performance

Patrick Ng, Executive Director of Specialist Services

6.1

6.1

Southern District Health Board

Hospital Advisory Committee KPI Summary - Discharges and CWD Volumes

Elective Surgical Discharges June 2018

Elective Surgical Discharge Activity - Southern DHB population

	June 2018				Year to Date				Annual
	Actual	Plan	Variance	Var %	Actual	Plan	Variance	Var %	Plan
SDHB population treated in-house	857	933	(76)	(8%)	10,516	11,055	(539)	(5%)	11,055
SDHB population treated by other DHBs	41	41	-	-	506	484	22	05	484
SDHB population outsourced	113	-	113	-	764	-	764	-	-
SURGICAL ELECTIVE DISCHARGES	**1,011**	**974**	**37**	**4%**	**11,786**	**11,539**	**247**	**05**	**11,539**
Surgical Arranged Admissions	91	83	8	10%	831	975	(144)	(15%)	975.0
Surgical Discharges from a Non-Surgical PUC - Elective	29	33	(4)	(11%)	345	350	(5)	(1%)	350.0
Surgical Discharges from a Non-Surgical PUC - Arranged	19	27	(8)	(29%)	290	326	(36)	(11%)	325.9
HEALTH TARGET DISTCHARGES	**1,151**	**1,117**	**34**	**3%**	**13,253**	**13,190**	**63**	**-**	**13,190.0**
Additional Orthopaedic and General Surgery Discharges	**64**	**5**	**59**	**1180%**	**64**	**39**	**25**	**64%**	**39**

Elective Surgical Caseweights June 2018

Elective Surgical Caseweights Activity - Southern DHB population

	June 2018				Year to Date				Annual
	Actual	Plan	Variance	Var %	Actual	Plan	Variance	Var %	Plan
SDHB population treated in-house	1,150.0	1,247.1	(97.1)	(8%)	13,492.2	14,747.8	(1,255.6)	(9%)	14,747.8
SDHB population treated by other DHBs	113.9	113.9	-	-	1,357.8	1,342.0	15.8	05	1,342.0
SDHB population outsourced	162.6	-	162.6	-	1,018.6	-	1,018.6	-	-
SURGICAL ELECTIVE CWD	**1,426.4**	**1,361.0**	**65.4**	**5%**	**15,868.7**	**16,089.8**	**(221.1)**	**(1%)**	**16,089.8**
Additional Orthopaedic and General Surgery CWD	**28.0**	**17.6**	**207.1**	**1179%**	**224.6**	**137.0**	**87.6**	**64%**	**137.0**

(1) IDF Outflow volumes are the latest available for July-May. June IDF Outflows are based on the planned numbers.

(2) Currently 6 uncoded discharges for June 2018 have estimated CWD values.

(3) Clinical Records and Coding target is 95% of coding completed by end of third working day post discharge. 99.4% achieved this month.

(4) Total YTD Major Joints are 0 unfavourable to Additional Orthopaedic Initiative target due to Usual Expected Delivery being 0 discharges unfavourable to target.

6.2

Southern DHB
Hospital Advisory Committee - KPIs June 2018 Data

Patient Safety and Experience - Hospital Healthcheck

	Prior year	Actual	Plan / Target	Variance 'v Plan /Target	Trend/rating
3 - Improved access to Elective Surgical Services monthly (population based) Discharges Health Target	1,115	1,151	1,117	34 (3%)	
3a - Improved access to elective surgical services ytd (population based) Discharges Health Target	12,687	13,253	13,189	64 (0.5%)	

Patient Safety and Experience - Performance Report

Monthly	Prior year	Actual	Plan / Target	Variance 'v Plan /Target	Trend/ rating
Faster Cancer treatment; 90% of patients to receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer seen within 2 weeks *Reported in arrears	84.0%	P	90.0%	NA	
11 - Reduced stay in ED	89.7%	88.4%	95.0%	-6.6%	
15 - Acute Readmission Rates (note 1)	11.4%	9.9%	9.9%	0.0%	

Cost/Productivity - Hospital Healthcheck

Monthly	Prior year	Actual	Plan / Target	Variance 'v Plan /Target	Trend/rating
1 - Waits >4 months for FSA (ESPI 2)	131	702	0	-702	
2 - Treatment >4 months from commitment to treat (ESPI 5)	182	456	0	-456	
% of accepted referrals for CT scans receiving procedures within 42 days	70.0%	85.4%	95.0%	-9.6%	
% of accepted referrals for MRI scans receiving procedures within 42 days	33.0%	35.4%	85.0%	-49.6%	
% accepted referrals for Coronary Angiography within 90 days	85.0%	98.4%	95.0%	3.4%	
4a - All Elective caseweights versus contract (monthly provider arm delivered)	1,331	1,487	1,375	112 (8.2%)	
4b - All Elective caseweights versus contract (ytd provider arm delivered)	16,038	16,114	16,204	-90 (-0.6%)	
7a - Acute caseweights versus contract (monthly provider arm delivered)	3,326	3,013	3,013	0 (0%)	
7b - Acute caseweights versus contract (ytd provider arm delivered)	38,112	39,010	36,102	2908 (8.1%)	

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

Note 1 Awaiting new definition from Ministry

Note 2 DOSA rates excludes Cardiac/Cardiology

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

P = Pending

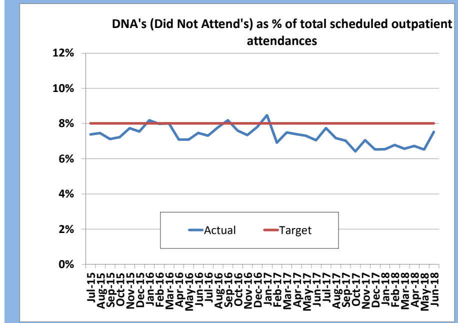
Cost/Productivity - Performance Report

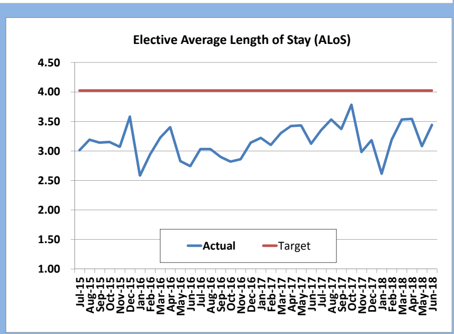
Monthly	Prior year	Actual	Plan / Target	Variance 'v Plan /Target	Trend/ rating
5 - Reduction in DNA rates	7.0%	7.5%	8.0%	0.5%	
9 - ALoS (elective) (Note 3)	3.12	3.44	4.02	0.58 (14.4%)	
ALoS (Acute inpatient) (Note 3)	4.14	3.98	4.25	0.27 (6.4%)	
DOSA (Note 2)	94.0%	95.3%	95.0%	0.3%	

6.2

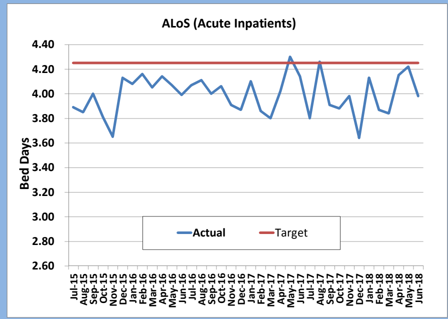
Southern DHB
Hospital Advisory Committee - Performance Report June 2018 Data

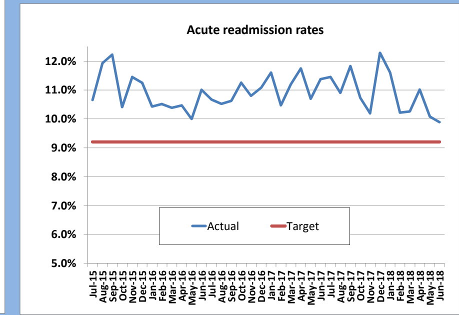
Elective Care

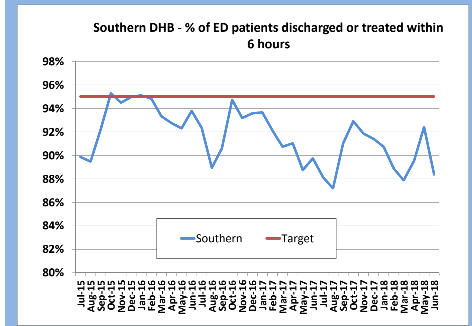




Acute Care



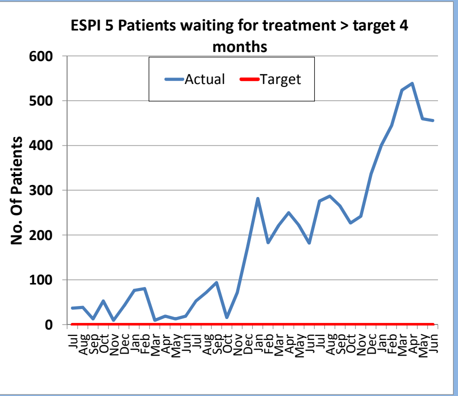


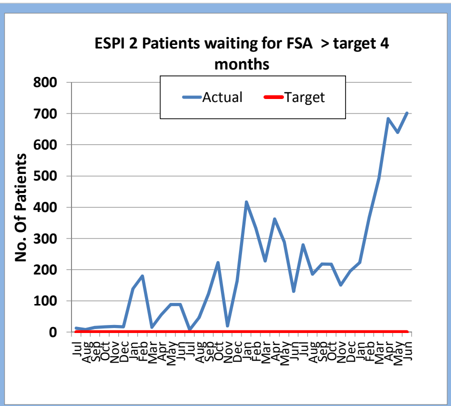


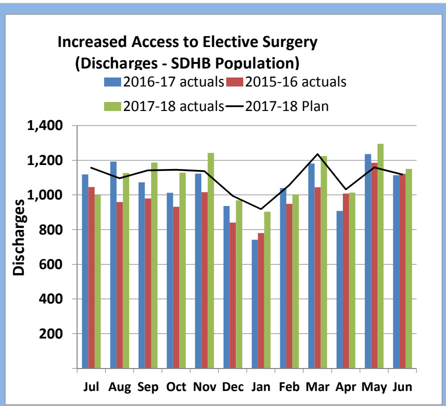
6.2

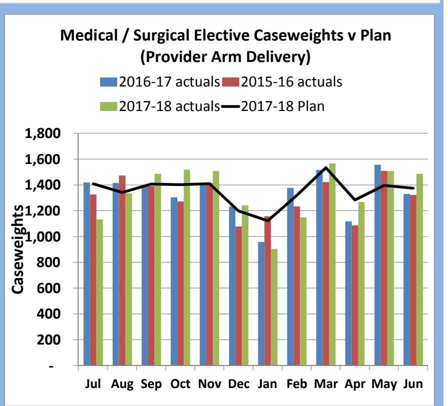
Southern DHB
Hospital Advisory Committee - Healthcheck Report June 2018 Data

Elective Care

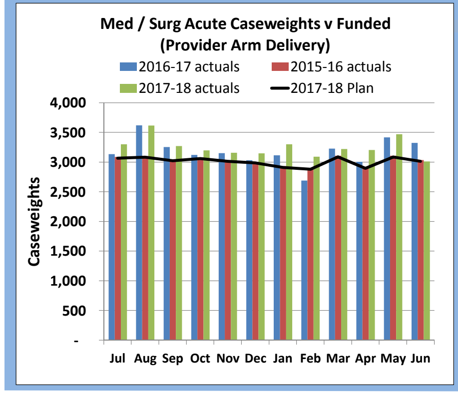








Acute Care



6.3

SOUTHERN DISTRICT HEALTH BOARD

Title:	**FINANCIAL REPORT**
Report to:	Hospital Advisory Committee
Date of Meeting:	26 July 2018

Summary:

The issues considered in this paper are:

- June 2018 financial position.

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

Financial:	As set out in report.
Workforce:	No specific implications
Other:	n/a

Document previously submitted to:	Not applicable, report submitted directly to Hospital Advisory Committee.	**Date:**
Approved by Chief Executive Officer:	Chris Fleming	**Date:** 20/7/2018

Prepared by: Geraldine Kerr Business Analyst - Clinical **Date:** 20/07/2018	**Presented by:** Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:

1. **That the report be noted.**

6.3

SOUTHERN DHB FINANCIAL REPORT – Commissioner's Summary for HAC

Financial Report for:	**June 2018**
Report Prepared by:	**Geraldine Kerr**
	Business Analyst - Clinical
Date:	**18 July 2018**

Overview

Results Summary

Month Actual $000	Month Budget $000	Month Variance $000		Year To Date Actual $000	Year To Date Budget $000	Year To Date Variance $000	Annual Budget $000
49,233	46,978	2,255	Revenue	568,288	563,330	4,958	552,818
29,845	31,612	1,767	Less Personnel Costs	378,966	379,078	112	374,362
17,720	16,326	(1,394)	Less Other Costs	202,842	192,252	(10,590)	186,456
1,668	**(960)**	**2,628**	**Net Surplus / (Deficit)**	**(13,520)**	**(8,000)**	**(5,520)**	**(8,000)**

The June result produced a surplus of $1.67m. YTD reported a $13.5m deficit. Please note that the Specialist Services result (which is usually similar to the HAC result) was a surplus of $852k with the difference between the specialist services result and the above result being a number of year end provision releases that are included in the HAC result but not in the specialist services result.

June Result:
The number of Elective case weights (157) were higher than budget in June, with the number of Acute case weights (204) higher than budget. Total case weights for June was 361 higher than budget. Year-to-date case weights are 2,818 higher than budget. Year-to-date acute volumes have impacted elective case weights delivery, electives are 90 behind budget.

Month Actual	Month Budget	Month Variance		Year To Date Actual	Year To Date Budget	Year To Date Variance	Annual Budget	YTD June 2017 Actual	YTD June 2017 Variance
			Medical Caseweights						
1,517	1,460	57	Acute	18,347	17,478	869	17,478	18,449	(102)
187	103	84	Elective	2,035	1,220	815	1,220	1,738	297
1,705	**1,563**	**142**	**Total Medical Caseweights**	**20,382**	**18,698**	**1,684**	**18,698**	**20,187**	**194**
			Surgical Caseweights						
1,262	1,183	79	Acute	15,625	14,328	1,297	14,328	15,578	46
1,331	1,243	88	Elective	13,950	14,633	(682)	14,634	13,502	449
2,593	**2,426**	**167**	**Total Surgical Caseweights**	**29,575**	**28,960**	**615**	**28,961**	**29,080**	**495**
			Maternity Caseweights						
438	370	68	Acute	5,039	4,296	742	4,296	4,069	969
14	29	(16)	Elective	129	351	(222)	351	846	(718)
452	**399**	**52**	**Total Maternity Caseweights**	**5,167**	**4,647**	**520**	**4,647**	**4,915**	**252**
			TOTALS						
3,217	**3,013**	**204**	**Acute**	**39,010**	**36,102**	**2,908**	**36,102**	**38,097**	**913**
1,532	**1,375**	**157**	**Elective**	**16,114**	**16,204**	**(90)**	**16,205**	**16,086**	**28**
4,749	**4,388**	**361**	**Total Caseweights**	**55,124**	**52,306**	**2,818**	**52,306**	**54,183**	**941**

			TOTALS excl. Maternity						
2,779	**2,643**	**137**	**Acute**	**33,972**	**31,806**	**2,166**	**31,806**	**34,028**	**(56)**
1,519	**1,346**	**172**	**Elective**	**15,985**	**15,853**	**132**	**15,854**	**15,240**	**745**
4,298	**3,989**	**309**	**Total Caseweights excl. Maternity**	**49,957**	**47,659**	**2,298**	**47,659**	**49,268**	**689**

Elective Initiative:
The elective initiative is the key Ministry target we have been monitoring elective surgical delivery against for the year. Catching up to this target is what the elective recovery programme (including outplacement and outsourcing) has been focused on since February of this year. The final result has been moving around since the year closed as wash-ups are completed and as data is validated by the Ministry. It has moved from being 505 case weights behind plan to 235 behind plan but the final guidance from our Planning & Funding team is that we were 325 case weights behind plan for the Specialist Services share of the Elective Initiative target. The target was 15,261 case weights for the year.

Despite being 325 case weights behind target, due to over delivery in the outpatient initiative we have been able to recognise 100% of the elective initiative revenue for the year. This is a very positive message to feed back to the team who have worked hard to increase the level of elective services delivery since February.

Revenue and Expenditure:

Statement of Financial Performance

Monthly Actuals $000s	Monthly Budget $000s	Monthly Variance $000s	Monthly Variance FTE		Year to date Actuals $000s	Year to date Budget $000s	Year to date Variance $000s	Year to date Variance FTE
				REVENUE				
				Government & Crown Agency Sourced				
2,030	1,635	395		MoH Revenue	21,047	19,622	1,425	
0	0	0		IDF Revenue	0	0	0	
1,513	1,392	121		Other Government	16,407	15,367	1,040	
3,543	**3,027**	**516**		**Total Government & Crown**	**37,455**	**34,989**	**2,466**	
				Non Government & Crown Agency Revenue				
186	151	35		Patient related	3,814	2,889	925	
712	617	95		Other Income	7,494	7,624	(130)	
898	**768**	**130**		**Total Non Government**	**11,308**	**10,513**	**795**	
44,791	43,183	1,608		Internal Revenue	519,525	517,828	1,697	
49,233	**46,978**	**2,255**		**TOTAL REVENUE**	**568,288**	**563,330**	**4,958**	
				EXPENSES				
				Workforce				
				Senior Medical Officers (SMO's)				
6,236	6,801	565	12	Direct	78,022	81,535	3,513	13
(390)	468	858		Indirect	4,725	5,687	962	
776	234	(542)		Outsourced	5,966	3,067	(2,899)	
6,622	**7,503**	**881**	**12**	**Total SMO's**	**88,713**	**90,288**	**1,575**	**13**
				Registrars / House Officers (RMOs)				
3,405	3,437	32	22	Direct	40,467	40,834	367	18
307	240	(67)		Indirect	2,665	2,828	163	
214	16	(198)		Outsourced	1,202	207	(995)	
3,926	**3,693**	**(233)**	**22**	**Total RMOs**	**44,333**	**43,870**	**(463)**	**18**
10,548	**11,196**	**648**	**34**	**Total Medical costs (incl outsourcing)**	**133,046**	**134,158**	**1,112**	**32**
				Nursing				
11,797	11,623	(174)	(11)	Direct	141,089	139,019	(2,070)	4
110	165	55		Indirect	1,693	2,441	748	
26	4	(22)		Outsourced	183	45	(138)	
11,933	**11,791**	**(142)**	**(11)**	**Total Nursing**	**142,965**	**141,505**	**(1,460)**	**4**
				Allied Health				
4,111	4,093	(18)	1	Direct	49,307	48,870	(437)	(3)
12	120	108		Indirect	1,253	1,440	187	
131	30	(101)		Outsourced	930	368	(562)	
4,254	**4,243**	**(11)**	**1**	**Total Allied Health**	**51,490**	**50,677**	**(813)**	**(3)**
				Support				
440	517	77	8	Direct	5,602	6,244	642	5
14	7	(7)		Indirect	94	83	(11)	
104	52	(52)		Outsourced	773	632	(141)	
558	**576**	**18**	**8**	**Total Support**	**6,469**	**6,960**	**491**	**5**
				Management / Admin				
3,237	3,748	511	(14)	Direct	44,759	45,066	307	1
(689)	56	745		Indirect	(48)	683	731	
4	2	(2)		Outsourced	285	29	(256)	
2,552	**3,806**	**1,254**	**(14)**	**Total Management / Admin**	**44,996**	**45,777**	**781**	**1**
29,845	**31,612**	**1,767**	**17**	**Total Workforce Expenses**	**378,966**	**379,078**	**112**	**39**
3,606	2,293	(1,313)		**Outsourced Clinical Services**	31,389	27,301	(4,088)	
221	183	(38)		**Outsourced Corporate / Governance Services**	2,355	2,197	(158)	
183	184	1		**Outsourced Funder Services**	2,155	2,208	53	
6,265	6,487	222		**Clinical Supplies**	84,786	76,853	(7,933)	
4,927	4,278	(649)		**Infrastructure & Non-Clinical Supplies**	51,434	50,131	(1,303)	
				Non Operating Expenses				
1,786	1,979	193		Depreciation	21,593	22,736	1,143	
731	922	191		Capital charge	9,122	10,826	1,704	
0	0	0		Interest	10	0	(10)	
17,720	**16,326**	**(1,394)**		**Total Non Personnel Expenses**	**202,842**	**192,252**	**(10,590)**	
47,565	**47,938**	**373**		**TOTAL EXPENSES**	**581,808**	**571,330**	**(10,478)**	
1,668	**(960)**	**2,628**		**Net Surplus / (Deficit)**	**(13,520)**	**(8,000)**	**(5,520)**	

6.3

June Full Year Summary

The adverse result for the full year is primarily driven by the following:

- Outsourced Clinical Services: The need to outsource elective delivery in order to meet elective initiative targets (which explains the vast majority of the $4m adverse result for Outsourced Clinical Services YTD).
- Clinical Supplies: Blood products, implants and prosthesis, pharmaceuticals and air ambulance - actual costs are all higher than was budgeted for.

A key change to the 2018/19 budget is the inclusion of a budget for outsourcing the elective case weights anticipated to be required in order to deliver the 2018/19 elective initiative.

The key clinical supplies costs are highly correlated to demand. However, further development of controls to minimise unnecessary expenditure in these categories is a key focus for 2018/19.

Revenue

Ministry of Health (MoH) Revenue
MoH revenue is favourable to budget for both the month and the year. The main items making this up are:

Category	Source	Monthly Variance $000s	YTD Variance $000s	Comment
MoH Revenue				
Personal Health	Ophthalmology	(68)	249	Funding for reducing patient waiting lists
	Colonoscopy	0	272	
	Bowel Screening	738	1,615	Funding for service establishment & operation
	Faster Cancer Treatment	(140)	251	Project completed in 2017/18
Disability Support Services	Mental Health Bed Utilisation	(43)	(531)	Bed utilisation is lower than budgeted
Clinical Training		(150)	(198)	
Public Health		13	(166)	
Other		45	(67)	

Other Government Revenue
Other Government revenue was $0.12m favourable to budget, primarily due to training fees and ACC billing. Year-to-date revenue is $1.04m favourable, primarily driven by contributions to lecture theatre refurbishment from the University of Otago, NZ Blood Haemophiliac rebates and training income.

Internal Revenue
Internal revenue was $1.6m favourable to budget for the month, driven by elective case weight delivery in the month. Year-to-date revenue is $1.7m favourable due to close to budget elective case weight delivery and funding for cancer and community pharmaceuticals. As noted previously, 100% of elective initiative revenue has been able to be recognised.

Workforce Costs
Workforce costs (personnel plus outsourcing) were $1.77m favourable to budget in June. Operationally in June FTE were 17 favourable to budget. Year-to-date workforce costs are $.1m favourable and 39 FTE favourable to budget.

Senior Medical Officers (SMOs)
SMOs direct costs were $0.56m favourable and 12 FTE favourable for the month.

Indirect costs were $0.86 favourable in the month due to the phasing of training costs and accruals. The result for the month included corrections to prior period entries for CME entitlements in indirect costs.

Outsourced costs were $0.50m higher than budget in the month due to the use of locums to cover leave and vacant roles.

Registrars / House Officers (RMOs)
RMOs direct costs were $0.02m favourable and FTE was 22 favourable for the month. The favourable cost effect from lower than budgeted FTE was partially offset by overtime, leave and a higher uptake to kiwisaver than budgeted.

Indirect costs were $0.06m favourable, driven by training and recruitment costs.

Outsourced costs were higher than budget in the month and year-to-date due to the use of locums to cover leave, vacant roles and workload.

Nursing
Nursing costs were $0.14m and 11 FTE unfavourable to budget for the month. The unfavourable FTE variance was primarily driven by workload requirements with staffing numbers being higher than the budget when vacancy factor is taken into account.

Direct costs were $0.17m unfavourable in the month, driven by the unfavourable FTE variance and higher than budgeted overtime and phasing of leave costs.

Indirect costs were $0.05 favourable.

Allied Health
Allied Health costs were $0.11m unfavourable and 1 FTE favourable to budget for the month.

Direct costs were $0.18m unfavourable, driven by overtime and leave costs.

Indirect costs were 0.1m favourable due to favourable training costs.

Outsourced costs were $0.11m unfavourable to budget, reflecting costs for Brief Intervention Services in central Otago.

Support
Support costs were $0.18m favourable to budget for the month.

Management / Administration
Management Admin staff were $1.25m favourable and 14 FTE unfavourable to budget. This seems to be contradictory and the EDSS has asked for a reconciliation of the costs and FTE.

Direct costs were favourable by $0.51m

Indirect costs were $0.75m favourable to budget due to release of restructure provision.

Outsourced Clinical Services costs
Outsourced clinical services were $1.31m unfavourable to budget in the month and $4.08m unfavourable year-to-date. This result is primarily driven by the elective recovery programme which was put in place in February and has primarily focused on outsourcing

and outplacement to recover elective performance. Outsourcing in June was higher than normal as 20 cardiothoracic case weights were outsourced to Mercy Private Hospital.

In the month Orthopaedic, Ophthalmology, General Surgery and Urology procedures and lab tests accounted for most of the unfavourable variance.

Clinical Supplies (excluding depreciation)
Clinical supplies were favourable to budget by $0.22m for the month.

Blood costs were $0.07m unfavourable to budget in the month and $1.1m unfavourable year-to-date, reflecting haemophiliac and transfusion requirements. Renal Fluids were also unfavourable as the price per treatment has increased as fully depreciated equipment has been replaced. A control document is being worked on to track blood costs and blood usage against budget.

Implants and prostheses were slightly favourable to budget in the month but are $1.23m unfavourable year-to-date. Year-to-date costs have been driven by case weight volumes.

Pharmaceutical costs were $0.8m favourable in the month, and $1.6m unfavourable year-to-date. The actual spend is driven by patient needs and volumes. The 17/18 budget is in-line with previous year actual costs. The drugs with the largest cost increases, year-on-year, are used in the treatment of bowel disease, haematology, cancer and HIV.

Air ambulance costs are above budget in the month by $.4m. This was driven by missions to Starship hospital being much higher in the month than average (5 missions this month, average about 1.5 missions per month over the last 12 months). This had a $.2m impact. Prior period costs relating to May which did not get fully accrued for in May contributed the remaining $.2m impact. A control document has been developed for air ambulance costs so that performance against budget and appropriateness of the costs incurred can be tracked on a monthly basis.

Year-to-date Clinical Supplies are $7.93m unfavourable, driven by bloods, implants and prosthesis (driven by acute and elective volumes), pharmaceuticals and air ambulance. This will be a key area of focus for the DHB going into the 2018/19 financial year.

Infrastructure and Non-Clinical
These costs were $0.65m unfavourable to budget in the month. Finalisation of full year utility supply costs, phasing of IT licence and outsourcing costs and costs of consultants assisting in theatre productivity and patient flow projects have driven the month's variance.

Non-Operating Expenses
Depreciation was favourable to budget in the month and year-to-date. Capital charge costs were favourable, reflecting the expected liability.

6.4

SOUTHERN DISTRICT HEALTH BOARD

Title:	**DID NOT ATTEND (DNA) RATE - UPDATE**
Report to:	Hospital Advisory Committee
Date of Meeting:	26 July 2018

Summary:

A report providing an update on the DNA rate across all services is attached.

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

Financial:	As set out in report.
Workforce:	No specific implications
Other:	n/a

Document previously submitted to:	Not applicable, report submitted directly to Hospital Advisory Committee.	**Date:**
Approved by Chief Executive Officer:		**Date:**

Prepared by: Patrick Ng Executive Director of Specialist Services **Date:** 18/07/2018	**Presented by:** Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:

1. That the report be noted.

Did Not Attend (DNA) Rate - update

Recommendation

That the Hospital Advisory Committee notes this report.

Action from the Commissioner meeting, 24 May 2018.

1. Update

The overall DNA rate across all services for the full year from July 2017 to June 2018 was 8% and the result for June was also 8%.

Some services have a propensity for higher DNA rates than others. For example, very small services may see quite a high impact even if one or two patients DNA in the month. Infectious Diseases is an example of the type of service impacted by small numbers.

Investigation by the services indicated that factors which influence DNA include snow days, shared custody arrangements, transport availability, family illness and patients choosing not to present because they felt that their condition had improved.

As with the previous report we are further investigating outliers, where the DNA rate is higher than we would expect to see. Mental Health is commented on separately. A key outlier in the non-mental health services is Southland ENT which currently has a DNA rate of 25%.

The DNA rate for ENT in Southland is largely related to paediatric appointments and we are working with this group of patients including the use of phoning and texting to follow up. DNA rates rose in Southland as we had a new administration person who was not coping with the telephone calls therefore a sentence in the appointment letter was removed until she was able to learn processes and cope with the workload. Recently the sentence has been put back into the letters which should improve the DNAs. The sentence asked the parent or care giver to ring and confirm their attendance at the clinic. The administration person will ring those who do not confirm.

In the Medicine, Women and Children's Directorate there are two regular sized services who are sitting above 10%. The services have provided the following commentary:

Paediatric Surgery (12%):

"We often have non amicable shared custody arrangements that means one parent may not bring the child when they are with them. If we uncover this information we access our social work service to ascertain the reason for the DNA and work to improve this."

Diabetology 12%:

"When dealing with diabetes these patients are chronic patients that are often in the service for many years e.g. Type 1 patients. These patients are more prone to DNA compared to patients that are seen as new patients which other specialties see more of. If you compare diabetology to other services that deal with long-term conditions, you will see that the DNA rate is not particularly concerning. Of course, we do want to work on getting it down further and do discuss this at our Tuesday morning meetings as we move towards streamlining our clinic booking structure."

Mental Health Addictions and Intellectual Disability Directorate (MHAID) collects DNA rates differently to the other services. Their DNA rates are high relative to the other services, due to the nature of the services they provide. We have provided separate commentary on MHAID, as follows:

Mental Health Addictions and Intellectual Disability Directorate (MHAID)

DNA rates remain a priority improvement initiative within the Directorate. Persistent attention and follow up is key to reducing the number of DNAs and this remains a focus for teams. Each clinical team monitors its DNA rate closely and has strategies in place for following up with individual patients. MHAID Directorate Leadership Team consistently monitor DNAs across all clinical teams with reports being shared with teams and staff. Systems are in place to follow up people who DNA and engage with them. Guidelines for formally following up people who DNA - texting, writing letters, calling them and visiting them at home are all strategies employed by MHAID to encourage attendance at appointments. Each service monitors DNAs closely and has strategies in place for following up.

The overall rate for MHAID services is 8%. This has remained fairly constant for the last 12 months with variance of 1% up or down on occasional months. Some individual teams have high monthly rates one month and zero the next- this is usually because the teams are small and the contacts low so one DNA can significantly increase the DNA percentage rate. The Invercargill Community Mental Health Team rural team, at 29% in the last report, has reduced to 20% over the last 6 months. There are no significant outliers for other Adult MHAID Community services. The range lies between 4% and 9% which is in line with expectations.

Addiction services have continued to have a higher DNA rate than other services, which is characteristic for this client group. While rates fluctuate from month to month and team to team, the average rate remains fairly consistent for the past 12 months. For the month of June the rate was 8%.

Youth forensic DNA rates remain around 20%, but well below the January 2018 peak of 49%.

2. In Summary

The services continue to use tools such as texting, letters and phone calls to minimise the overall level of DNA. Future work on 'Patient Focused Booking' will assist in reducing the overall DNA rate (as patients will be able to select appointments), along with work that is being considered to streamline booking processes.

The General Surgery and Radiology Directorate has been asked to focus on the Southland ENT DNA rates to improve them as the rates for this service stand out when compared to the other services and what we would expect to see.

Patrick Ng, Executive Director of Specialist Services

Closed Session:

7

RESOLUTION:
That the Hospital Advisory Committee reconvene at the conclusion of the public Disability Support and Community & Public Health Advisory Committees meeting and move into committee to consider the agenda items listed below.

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
1. Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.
2. Serious Adverse Events	To protect information where the making available of the information would be likely to prejudice the supply of similar information and it is in the public interest that such information continue to be supplied.	Section 9(2)(ba) of the Official Information Act (OIA).
3. Dunedin Hospital Redevelopment	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the OIA.