SOUTHERN DISTRICT HEALTH BOARD
HOSPITAL ADVISORY COMMITTEE MEETING

Wednesday, 3 June 2015, 2.00pm

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

AGENDA

Item

1. Presentation: Why?
   - Provider Arm Executive

2. Welcome, Introduction and Apologies

3. Interests Registers

4. Minutes of Previous Meeting

5. Matters Arising

6. Review of Actions

7. Monitoring and Performance Reports

   a) Executive Director of Patient Services Report

   b) Key Performance Indicators

   c) Progress to four months wait for Outpatient and Inpatient Elective Service Performance Indicators (ESPI) markers

   d) Complaints to the Health and Disability Commissioner involving DHBs – report analysis 1 July – 31 December 2014

   e) Financial Performance Summary

   f) Occupational Health and Safety Report

   g) Information Systems Report

   h) Post Project Review Master Site Planning

Public Excluded Session:

RESOLUTION:

That the Board exclude the public for 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	To allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).
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).
KiwiSaver	To allow activities to be carried on without prejudice or disadvantage	As above, sections 9(2)(i) and 9(2)(j).

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

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

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

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

SOUTHERN DISTRICT HEALTH BOARD

INTERESTS REGISTER FOR THE EXECUTIVE MANAGEMENT TEAM

As at May 2015

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Steve Addison	16.08.2014	1. Chair, Board of Trustees, Columba College 2. Mother-in-law, Gore District Councillor	
Peter Beirne	08.04.2015	1. Wife employed as Team Leader, Public Health South	
Sandra Boardman	07.02.2014	Nil	
Pania Coote	30.09.2011 30.09.2011 30.09.2011 30.09.2011 29.06.2012 26.01.2015 26.01.2015 26.01.2015 26.01.2015	1. Affiliation to Awarua, Puketeraki and Moeraki Rūnaka. 2. Member, Southern Cancer Network. 3. Member, Aotearoa New Zealand Association of Social Workers (ANZASW). 4. Member, SIT Social Work Committee. 5. Member, Te Waipounamu Māori Cancer Leadership Group. 6. National Māori Equity Group (National Screening Unit) – MEG. 7. SDHB Child and Youth Health Service Level Alliance Team 8. South Island DHBs Medcal Diagnostic Laboratory Steering Group. 9. Various SDHB operational Advisory Committees.	1. Possible conflict when contract with Southern DHB comes up for renewal. 2. Nil. 3. Nil. 4. Nil. 5. Nil. 6. Nil. 7. Nil. 8. Nil. 9. Nil.
Richard Bunton	17.03.2004	1. Managing Director of Rockburn Wines Ltd. 2. Director of Mainland Cardiothoracic Associates Ltd. 3. Director of the Southern Cardiothoracic Institute Ltd. 4. Director of Wholehearted Ltd.	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

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	22.06.2012 29.04.2010	5. Chairman, Board of Cardiothoracic Surgery, RACS. 6. Trustee, Dunedin Heart Unit Trust. 7. Chairman, Dunedin Basic Medical Sciences Trust.	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 and am now Deputy Dean of the Dunedin School of Medicine. 5. Partner at Caversham Medical Centre and a Director of RMC Medical Research Ltd.	
Leanne Samuel	01.07.2007 01.07.2007 16.04.2014	1. Southern Health Welfare Trust (Trustee). 2. Member of Community Trust of Southland Health Scholarships Panel. 3. Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	1. Southland Hospital Trust. 2. Nil. 3. Nil.
David Tulloch	23.11.2010 02.06.2011 17.08.2012	1. Southland Urology (Director). 2. Southern Surgical Services (Director). 3. UA Central Otago Urology Services Limited (Director). 4. Trustee, Gilmour Trust.	1. Potential conflict if DHB purchases services. 2. Potential conflict if DHB purchases services. 3. Potential conflict if DHB purchases services. 4. Southland Hospital Trust.

4

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Wednesday, 1 April 2015, commencing at 2.00pm in the Board Room, Level 2, Main Block, Wakari Hospital Campus

Present:	Mr Tony Hill	Chairman
	Mr Joe Butterfield	
	Dr John Chambers	
	Mr Tuari Potiki	
	Mr Richard Thomson	
In Attendance:	Dr Jan White	Crown Monitor
	Mrs Kaye Crowther	Board member
	Mr Tim Ward	Board member
	Ms Carole Heatly	Chief Executive Officer
	Mrs Lexie O'Shea	Executive Director of Patient Services/Deputy CEO
	Mr Richard Bunton	Medical Director Patient Services
	Mrs Leanne Samuel	Executive Director Nursing and Midwifery
	Mr David Tulloch	Senior Medical Officer
	Mr Grant Paris	Senior Business Analyst
	Mr Steve Addison	Executive Director Communications
	Mrs Joanne Fannin	Board Secretary Southland

1.0 PRESENTATION

The Medical Director of Patient Services introduced Dr Ben Wheeler, Paediatric Endocrinologist, Southern DHB and Senior Lecturer at the University of Otago, who joined the meeting to provide a presentation on the Southern experience with the new Paediatric Diabetes Telemedicine Clinics. He provided an update on the advantages of Telemedicine and the potential for use in other specialties. Dr Wheeler advised the need to evaluate Telemedicine and develop it in a manner that patients and their families are happy with.

Dr Wheeler left the meeting at 2.30pm.

2.0 WELCOME AND APOLOGIES

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

3.0 MEMBERS' DECLARATION OF INTEREST

The Chairman called for any adjustments or amendments to the Interests Register. The Board Chairman requested that the word 'alternate' be removed from bullet point four of his Interests.

4.0 CONFIRMATION OF PREVIOUS MINUTES

It was resolved:

> "That the minutes of the 4 February 2015 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 received and considered the action sheet.

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 received advice:

- That the health target for improved waiting times in the Emergency Department (ED) is being maintained between 90 and 95% and the Dunedin ED was over target for five out of seven days in the last month. The Chairman noted his concern over the increased presentations at ED over the past two months and suggested it may be timely to run another campaign encouraging the public to keep ED for emergencies only.
- On the financial position relating to revenue being $400K over budget.
- That a Psychiatrist has recently been appointed at Southland Hospital who has expertise in Telepsychiatry and is keen to use Telemedicine.
- On the benefits of telemedicine from a convenience and cost perspective.
- On production planning and work proposed to progress in this area.
- On Urology services and the progress made with increased staffing in this specialty. Pathways are being developed to ensure equity of access.
- From the HAC Chairman on the building work being done on Dunedin Hospital and the article in the Otago Daily Times (ODT) acknowledging the work being done. It is anticipated that the work will be ahead of time and favourable to budget.

8.0 KEY PERFORMANCE INDICATORS (KPIs)

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

- That acute readmissions were within normal variation levels.
- The good progress made with active review and patients given certainty and their wait time for treatment.
- That projects are in place to address the specialties where the Elective Service Performance Indicators (ESPI) targets are not being met.

9.0 HEALTHY FOOD AND BEVERAGES ENVIRONMENTS POLICY

The Committee received and considered the draft Healthy Food and Beverages Policy and position statement and noted that, should it be awarded the food services contract, Compass has indicated that it is happy to work with any District Health Board's healthy food policy. The policy is aligned to the healthy food policy of other DHBs and will be reviewed after a 12 month period. The approach when developing the policy has been to make a healthy choice an easy choice.

It was resolved:

"That the Hospital Advisory Committee recommends that the Board:

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

- Approves the adoption of the Healthy Food and Beverages Environments Policy."

10.0 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 February result was close to budget and year to date the Provider Arm is about $1M over budget.
- The drivers for the unfavourable revenue result.
- The drivers for the unfavourable result against budget for Nursing. A request was made for the information provided in the June 2015 report to be more specific around the higher nursing costs.
- The rationale for the reclassification of approximately 11 staff from Allied to Nursing in the current year.
- The underspend on the building work at Dunedin Hospital has been included in the budget forecast.
- The reversal of $100K from air ambulance costs, charged in error to Southern DHB in January 2015.
- The process for the capitalisation of staff. The Board Chairman requested that the categorisation of the capitalisation of staff be discussed further at the Audit and Risk Committee (ARC) meeting.

11.0 OCCUPATIONAL HEALTH AND SAFETY REPORT

The Committee received and considered the Occupational Health and Safety Report and a verbal update by the Executive Director of Patient Services (EDPS). In discussion, the Committee received advice as follows:

- In relation to blood and body fluid exposure injuries, the Executive Director of Nursing and Midwifery (EDNM) advised on the national procurement work being undertaken around safety devices specifically relating to cannulation. Local IV staff are actively involved in this process.
- In relation to patient and manual handling injuries, the EDPS advised on the work that is being done. There is currently a manual handling person on one site and it is proposed to have a consistent programme on both sites. The difference in equipment between Southland and Dunedin was noted and the more modern equipment will be included in the Dunedin Hospital rebuild. A request was made for a cost analysis to be done, looking at the difference in outcomes between Southland and Dunedin relating to manual handling injuries. It may be more cost effective to buy the required equipment for Dunedin now to mitigate the risk.
- A request was made for more detail to be included in the Occupational Health and Safety Report in relation to sick leave as a proxy for stress, noting that the risk is higher for some occupational groups. All sick leave is to be included in the report. A request was made for confirmation of whether ACC is included with the recorded sick leave in the graph included in the report.
- The Crown Monitor advised the need for Southern DHB to ensure a safe and secure environment for its staff, noting legal action being taken by Work Safe New Zealand against another Government Department. It was suggested that Southern DHB undertake a review in the area of staff exposure to unhappy clients to test the safety and security measures in place. The Crown Monitor suggested that a report be provided for Board and on-going reviews be undertaken bi-annually.

It was resolved:

"That the Hospital Advisory Committee recommends that the Board:

- Receives the report and supports the work being undertaken to address Southern District Health Board's strategy.

- Receives the report attached as appendix one to the Occupational Health and Safety Report and notes the current accident and injury reports, together with the work related Accident Compensation claims data and sick leave data, benchmarked across all other DHBs."

12.0 INFORMATION SERVICES DASHBOARD

The Committee received and considered the South Island Information Services Dashboard and the ePrescribing Project Implementation Report and a verbal update from the Medical Director of Patient Services relating to the success of electronic prescribing. It was noted that Southern DHB is the first DHB in the country to implement electronic prescribing.

13.0 CONFIDENTIAL SESSION

At 3.30pm, it was *resolved*:

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

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

The Committee resumed in public session at 4.20pm.

The meeting closed at 4.20pm.

Confirmed as a true and correct record:

Chairman: _____ Date: _____

HOSPITAL ADVISORY COMMITTEE (HAC)

Action Sheet from meeting held on 4 February 2015

Action Point No.	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
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 September 2015.	30 September 2015
162 2015/02	Quality Process Markers (Minutes Item 9.0)	The graph heading 'Percentage of patients with an Individualised Care Plan' is to be changed to clearly identify it relates to patient falls and future graphs are to be linked to the report identifying the number of falls within Southern DHB.	EDPS/DCEO	The heading has been changed as indicated and future graphs will be linked to the report identifying the number of falls within Southern DHB	Actioned
164 2015/04	Interests Register (Minutes Item 3.0)	The Board Chairman's Interests are to be amended with the word 'alternate' to be removed from bullet point four	BSS	The change has been made to the Interests Register.	Actioned
165 2015/04	Financial Report (Minutes Item 10.0)	The information relating to the higher nursing costs is to be more specific for the report to the June 2015 HAC meeting.	SBA	Specifics relating to the unfavourable budget result for nursing are included in the finance report.	Actioned
166 2015/04	Financial Report (Minutes Item 10.0)	The categorisation for the capitalisation of staff is to be discussed at the Audit and Risk Committee (ARC) meeting.	EDF	The categorisation for the capitalisation of staff is to be discussed at the next ARC meeting.	Actioned
167 2015/04	Occupational Health and Safety Report (Minutes Item 11.0)	A cost analysis is to be done looking at the difference in outcomes between Southland and Dunedin relating to manual handling injuries to establish whether it would be more cost effective and mitigate risk by buying the relevant equipment for Dunedin	DONM	A cost analysis is to be prepared for a future HAC meeting.	5 August 2015

Action Point No.	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		now.			
168 2015/04	Occupational Health and Safety Report (Minutes Item 11.0)	More detail is to be included in the report in relation to sick leave as risk is higher for some occupational groups. All sick leave is to be included in the report. Establish whether ACC is included with the recorded sick leave in the graph included in the report.	EDHR	A more comprehensive report on sick leave is to be included in the Occupational Health and Safety Report for the next HAC meeting.	Actioned
169 2015/04	Occupational Health and Safety Report (Minutes Item 11.0)	A review is to be undertaken in the area of staff exposure to unhappy clients to test the safety and security measures in place. On-going reports to be provided for HAC bi-annually.	EDHR	A review is to be undertaken to test the safety and security measures in place for staff exposure to unhappy clients. A report will be provided for the August HAC meeting.	5 August 2015

SOUTHERN DISTRICT HEALTH BOARD

Title:	Executive Director of Patient Services
Report to:	Hospital Advisory Committee
Date of Meeting:	03 June 2015

Summary:

Considered in these papers are:

- April 2015 DHB activity.

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

Financial:	Yes
Workforce:	Yes
Other:	No

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

Prepared by: Executive Director of Patient Services/Deputy CEO Date: 15/05/2015	Presented by: Lexie O'Shea Executive Director of Patient Services

RECOMMENDATION:

That the Committee receive the report.

Executive Director of Patient Services Report – April 2015

Recommendation

That the Hospital Advisory Committee notes this report.

1. Contract Performance

- Total acute caseweights delivered (cwd) by the Southern DHB Provider Arm were 198 under plan in April 2015 (7%). Year to date, they are 372 cwd over plan (1%).
- Total elective caseweights delivered (cwd) by the Southern DHB Provider Arm were 93 under plan in April 2015 (8%). Year to date, they are 89 cwd over plan (1%).

2. Financial Performance

- An unfavourable variance of $202k was recorded by the Southern DHB Provider Arm for the month of April 2015. Year to date, the Provider Arm is $1.36m unfavourable.
- Revenue for April 2015 was favourable by $402k. Expenses for April 2015 were unfavourable against plan by $604k.
- The full financial report, included in the agenda, provides information on the April 2015 monthly and year to date financials, with explanations about the material variances.

3. Health Targets

- Across the district April 2015 had 1.2% less presentations to Emergency Department (ED) than April 2014 (6347 in 2015 and 6424 in 2014).
- The quarter three result for Southern DHB was 93.3% and the quarter four result to the end of April 2015) is 93.8%.
- Performance against the '6 Hour Target' across the district was 93.7% in April 2015.
    - Dunedin ED – 94.8% for April 2015
        - Presentations for the month of April decreased with 3491 in 2015, a 0.6% decrease on the 3513 presentations in April 2014.
    - Southland ED – 92.4% for April 2015
        - Presentations for the month of April decreased with 2856 in 2015, a 1.9% decrease on the 2911 presentations in April 2014.

Planning for the Dunedin Hospital eight bed short stay unit on Ward 7C is on track and due to open on 11 May. This is an opportunity to utilise the winter flex beds differently this year, with the aim that patient flow in ED over winter improves, along with a reduction in the average length of stay (part of the 6000 bed days project). We will be using A3 methodology (A3 methodology uses a problem solving approach to Improving quality of care). The clinical team use it to show the extent of the problem and how they are making improvements) to monitor the effectiveness of the unit. The unit will initially open with four beds and increase to eight beds as staff complete their orientation.

Immunisation

- The eight month old coverage for April is 94%.
- The two year old coverage for April is 93%. The decline rate for the two year olds continues to be an issue at 4.3% and this directly impacts on the service ability to

meet the 95% target. We are giving the option of re-engagement by way of pamphlet for all parents who decline.

Better Help for Smokers to Quit

- The last quarterly result (Quarter 3) for Better Help for Smokers to Quit health target was 95%. Efforts continue on reducing post discharge follow up phone calls with particular emphasis on improving the ED results.

Shorter Cancer Wait Times

- April was a quieter month for radiation oncology with the numbers of new starts down to 86 from the previous run of months that saw 100+ new starts. We therefore had little trouble achieving the Ministry of Health (MoH) target of 100% of patients starting treatment within four weeks of their first specialist assessment 100% of the time. The stereotactic service, a service for which we hold the national contract, however, continued to be very busy with the previously noted marked increase in referrals, acceptances (not all referrals are automatically accepted, each referral being assessed at a multi-disciplinary meeting before acceptance for appropriateness of referral) and treatments delivered. The trend is still suggestive of an overall significant increase in these cases over previous years which should have a positive impact from an incoming revenue perspective.
- We are continuing to take certain cohorts of South Canterbury patients based on diagnosis types and fractionation. This was initiated by Canterbury DHB who would be the 'normal' providers for these patients. The quantity of patients being sent through though is much lower than we had been led to believe they would be and discussions have taken place to understand the reasons behind this. However, the principle behind the agreement is in line with the MoH's protocols around capacity sharing and which are designed to facilitate a regional, collaborative approach to the delivery of cancer services. We do monitor this carefully to ensure it can be achieved without impacting adversely on Southern's ability to deliver timely radiation therapy to its own population or to meet the shorter waits for cancer treatment health target.

- Improving Access to Elective Services

Elective Surgical Discharges April 2015

Elective Surgical Discharge Activity - Southern DHB population

	April 2015				Year to Date				Annual
	Actual	Plan	Var	Var %	Actual	Plan	Var	Var %	Plan
SDHB population treated inhouse	772	770	2	0%	8,571	8,327	244	3%	10,008
SDHB population treated by other DHB	34	47	(13)	(28%)	423	470	(47)	(10%)	563
SDHB population outsourced	10	9	1	0%	114	82	32	0%	96
	816	826	(10)	(1%)	9,108	8,879	229	3%	10,667

Elective Surgical Caseweights April 2015

Elective Surgical Caseweight Activity - Southern DHB population

	April 2015				Year to Date				Annual
	Actual	Plan	Var	Var %	Actual	Plan	Var	Var %	Plan
SDHB population treated inhouse	978	1,113	(134)	(12%)	11,422	11,745	(323)	(3%)	14,120
SDHB population treated by other DHB	75	85	(11)	(13%)	944	855	90	11%	1,025
SDHB population outsourced	16	11	5	42%	170	116	53	46%	139
	1,069	1,210	(140)	(12%)	12,536	12,716	(180)	(1%)	15,284

4. Operational Performance

- The final ESPI graphs for March 2015 show Southern District Health Board an amber status for ESPI 2 and ESPI 5 (Inpatients). Preliminary results for April 2015 have Southern District Health Board with a red status for both ESPI 2 and ESPI 5.

- Predicted results for May 2015 have Southern DHB with a red status for both ESPI 2 and ESPI 5. This will be two consecutive months of non compliance. Funding implications will occur if the DHB is non compliant for four consecutive months. There is considerable focus to ensure compliance at the end of June. While the four month target is stabilising, many services are under pressure to retain compliance for the next few months. Services at the greatest risk of not meeting the four month target in June are Urology (Dunedin site), Plastics (District service) and Orthopaedic surgery (Dunedin site).
- The key performance indicator matrix graphs are provided (Appendix a).
- Number of patients on active review graph provided (Appendix b).
- Number of patients given certainty and their wait time for treatment graph (Appendix c).

5. Medical Directorate

- Faster cancer treatment target, quarter three performance is as per the below table. The target is that by July 2016 85% of patients receive their first treatment within 62 days.

	Number of patients within target	Percentage achievement
62-day indicator (health target)	138	73.4%
31-day indicator (policy priority	296	69.0%

- Services are currently working through the request for proposal (RFP) process for the second round of faster cancer treatment funding from the Ministry of Health. Our submissions are likely to include initiatives around health pathway referrals, abnormal radiology results, first cancer presentation via ED and initiatives such as telemedicine, Teach Back and patient focused booking. Teach Back is a system for giving patient information in a way that addresses poor health literacy and makes consumer engagement the central aspect of education provision. It likely that there will be both a local and regional RFP process.

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

- The service received a visit from Marama Real Time Feedback to raise awareness and understanding of *Real Time Feedback* which will be implemented later in 2015. This project will enable service users to provide timely feedback, following their intervention, into an electronic system that will in turn provide service user satisfaction back to the directorate.
- South Community Mental Health team will move and commence operating from Helensburgh House (Wakari site) from mid May 2015. The remaining Intellectual Disability Service staff on Helensburgh House's first floor are now settled in their refurbished offices. This completes the first stage of the process.
- Formal links have been established with Department of Corrections. This will lead to a closer, more connected way of agencies working together.
- Southland's Inpatient Mental Health Unit has begun a review of occupancy over the past 12 months.
- A review of serious adverse events, triage and investigation process has commenced, to bring it in line with Safety1st, the new electronic system which collects and reports on safety and risk event data.
- Dr Tom Flewett and nurse, Pip Bradley, Capital and Coast DHB, were invited by Dr Brad Strong to present to staff on 13 March as they both have expertise in management of people with a diagnosis of Borderline Personality Disorder (complex Post-Traumatic Stress Disorder) and risk factors associated with this illness. Both presented to various groups of staff throughout the day.

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

- The Allied Health Manager is working on prioritisation matrix which will be applied when the service is unable to respond to all service demands. Once this is in final draft, a review will be held with clinical teams and Charge Nurse Managers (CNMs), prior to implementation.
- Both Allied Health Managers have been working with Information Technology to develop district wide reporting on referrals and current waiting times for all allied health services. This is very near completion.
- The Directorate Leadership team and Lakes team are continuing to work on plans to manage expected increase in Emergency Department presentation at Lakes this winter.
- Referrals continue to grow for Rapid Response Service and the service is evolving to accommodate this growth. A meeting of all Primary Response in Medical Emergencies (PRIME) and rural nurses within Southland is being held to look at short term cover and ongoing rostering for Stewart Island.
- Assessment, Treatment and Rehabilitation Unit Geriatrician Staffing, has three vacancies across the district. Three offers have been made across the district with one being accepted, one declined and the other likely to be accepted.
- A discussion document 'Shaping Services for the Future' has been released for feedback on the configuration of our current inpatient Assessment, Treatment and Rehabilitation (ATR) services on the Dunedin and Wakari sites. This covers Health of Older People (Wards 6a and 6b), Mental Health of Older People (Ward 6c) and Disability Support Services (DSS) under 65 years' service (ISIS Ward).

8. Surgical Directorate

- The Proposal for Change Consultation incorporating Main Operating Theatre, Day Surgery Unit, Post Anaesthetic Care and Intensive Care (Dunedin hospital site only) was released to staff mid April 2015. There has been a significant number of submissions and these are now being considered to inform a final decision.
- There have been two key appointments made to the surgical directorate during this month and these include the service manager for general surgical services, Dunedin site and 0.4 FTE rheumatologist in Southland.
- The number of surgical services utilising the Anaesthesia Pre-assessment Clinic (APAC) has increased, as has the staffing resource. An Anaesthetist has been made available to staff the clinic on a daily basis. Permanent nursing appointments have now been made to the APAC service. This initiative is now district wide and is a nurse led Anaesthetist support triaging process to ensure that all patients are screened and seen as appropriate prior to day of surgery by the Anaesthetist to ensure safe anaesthetic procedures.
- The Day of Surgery Admission (DOSA) rates were low in April due to Cardiology and Cardiac surgery day of surgery admissions. The reason for the low rate of DOSA in Cardiology (at 66.7%) was due to patients who are acutely admitted and then transferred into the service from other hospitals. These patients show up on our system as arranged even though they are acute. All true elective angiography are admitted on the day of surgery (and are performed as day cases). In Cardiac surgery there are two different issues. A survey carried out across New Zealand in 2014 showed that none of the elective patients are admitted on the day of surgery. The second issue for Cardiac surgery is that a proportion of patients are admitted electively for angiography and then have an acute Cardiac surgical procedure (but show up as arranged).

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

- The Children's Health Services on both sites are involved in the preparation for the 2015 launch of the Countdown Kids Fundraising, identifying added value items for sick children and not funded through Ministry of Health funding.

- Regular meetings continue with staff regarding the process for future service provision of the Tertiary Fertility Service. Transition planning has commenced between the DHB and Fertility Associates (FA) with staff engaged in this process. The scheduled date for transition to FA is September 2015.
- Staff have been preparing for World Smokefree Day (31 May) distributing resources and organising displays to promote the World Smokefree Day message. Work in the community continues with extension of support to include rural nurse led clinics and continuation of Stop Smoking clinics at Dunedin and Invercargill. Southern DHB continues to work with lead maternity carers to ensure that women who identify as smokers in pregnancy are provided with information regarding the benefits of ceasing smoking early in pregnancy and are referred to support agencies for further support and advice.
- Radiologist recruitment across the district continues. There are a number of potential candidates being progressed.
- The target waiting times for March 2015 (latest times available). Results show an improvement in both CT and MRI from February 2015. In CT, 73.4% of patients were scanned within six weeks or less, against the target of 95%. This is an improvement of 3.1% on February. In MRI, 50.5% of patients were scanned within six weeks or less, against the target of 90%. This is an improvement of 8.3% in February. We anticipate that we will continue to see improvements in MRI performance as the number of patients waiting for MRI in Dunedin continues to reduce in response to the additional 24 scans undertaken each week from 19 January 2015.
- From early February 2015, our vacant sonographer positions were filled with staff returning from parental leave and a locum arriving on site in Dunedin. This has had a positive impact on our Ultra Sound (US) waiting time with routine US now being 16-21 weeks.
- The Board decision to proceed with outsourcing the Food Service to Compass Group was provided to staff following the Board meeting. Regular follow-up meetings with the unions and staff to engage in the process for implementation of this change have commenced.

10. Performance Excellence and Quality

- Quality and Safety Commission Patient Safety Markers October-December 2014 Quarter (Appendix d).
- We continue to meet or exceed threshold with the process markers for Central Line Associated Bacterimia (CLAB), Surgical Safety Checklist, and Hand Hygiene. Fall assessment now only 1.2 % under threshold.
- Good progress on improving Falls care plan and Surgical Site Infection (SSI) Hip and Knee arthroplaties - antibiotic timing and skin preparation.

Lexie O'Shea, Executive Director of Patient Services

Leanne Samuel, Executive Director of Nursing and Midwifery

Mr Richard Bunton, Medical Director of Patient Services

Southern DHB - **Appendix a**

Hospital Advisory Committee - KPIs April 2015 Data

Patient Safety and Experience - Hospital Healthcheck				
Monthly	**Actual**	**Plan / Target**	**Variance**	**Trend/rating**
3 - Improved access to elective surgical services monthly (population based)	816	826	-10 (-1.2%)	
3a - Improved access to elective surgical services ytd (population based)	9,108	8,879	229 (2.6%)	

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	94%	95%	-1.3%	
15 - Acute Readmission Rates	11.2%	9.2%	-2.0%	

Population Health				
16 - Smoking cessation - hospitalised smokers provided with advice and help to quit	95%	95%	0.0%	

Key -

Meeting target or plan

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

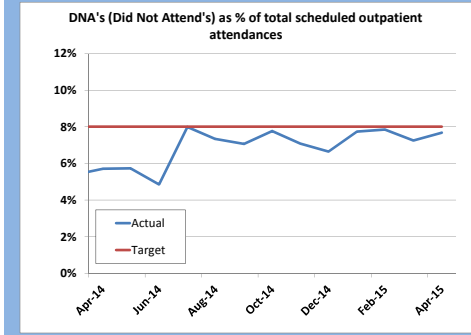
Underperforming and exception report required with recovery plan

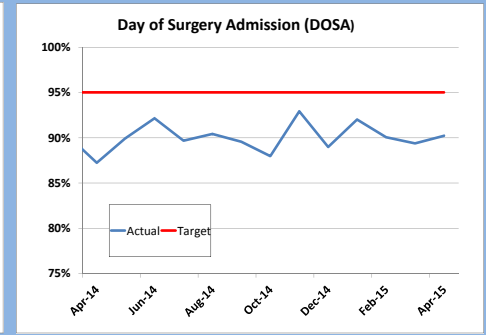
Cost/Productivity - Hospital Healthcheck				
Monthly	**Actual**	**Plan / Target**	**Variance**	**Trend/rating**
1 - Waits >4 months for FSA	0	0	0	
2 - Treatment >4 months from commitment to treat	0	0	0	
4a - Elective caseweights versus contract (monthly provider arm delivered)	1,073	1,165	-92 (-7.9%)	
4b - Elective caseweights versus contract (ytd provider arm delivered)	12,442	12,352	90 (0.7%)	
7a - Acute caseweights versus contract (monthly provider arm delivered)	2,453	2,651	-198 (-7.5%)	
7b - Acute caseweights versus contract (ytd provider arm delivered)	27,654	27,283	371 (1.4%)	
10 - Voluntary staff turnover	0.7%	0.3%	-0.4%	
9 - Staff sick leave rates	2.6%	3.5%	0.9%	

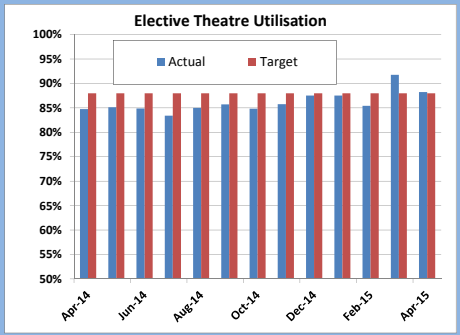
Cost/Productivity - Performance Report				
Monthly	Actual	Plan / Target	Variance	Trend/ rating
5 - Reduction in DNA rates	7.7%	8.0%	-0.3%	
7 - DOSA rates	90%	95%	-4.8%	
9 - ALoS (elective)	3.05	4.02	0.97 (24.1%)	
ALoS (Acute inpatient)	3.81	4.25	0.44 (10.4%)	
14 - % ED attendances admitted	31.5%	30.0%	-1.5%	
13 - Outlier bed days	1.6%			
Quarterly				
8 - Elective Theatre utilisation	88.2%	88.0%	0.2%	

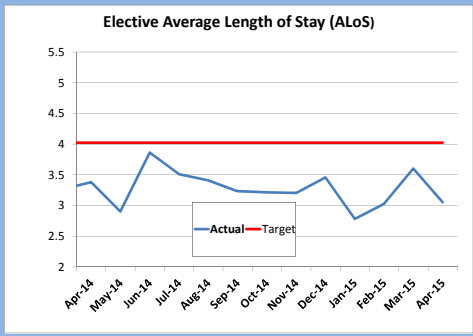
Southern DHB - Appendix a
Hospital Advisory Committee - Performance Report
April 2015 Data

Elective Care

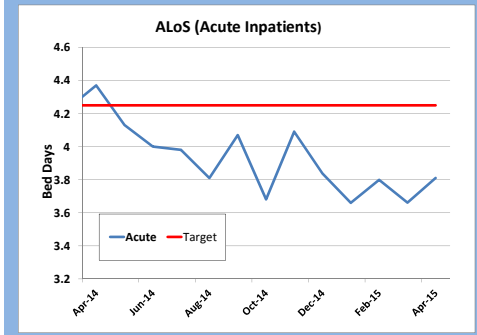


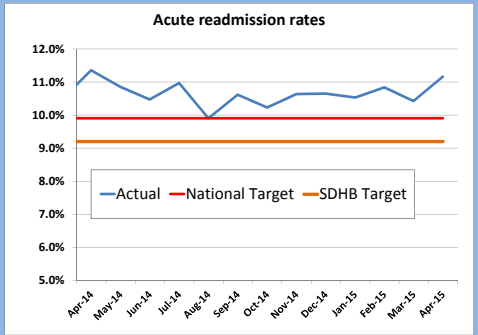


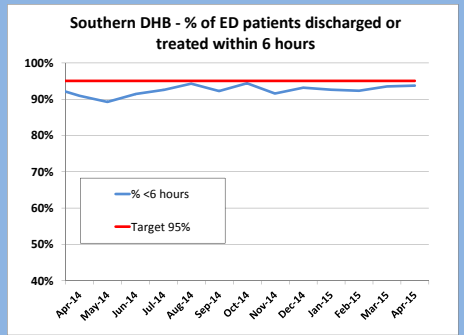


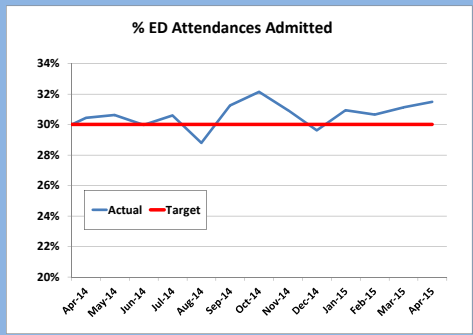


Acute Care

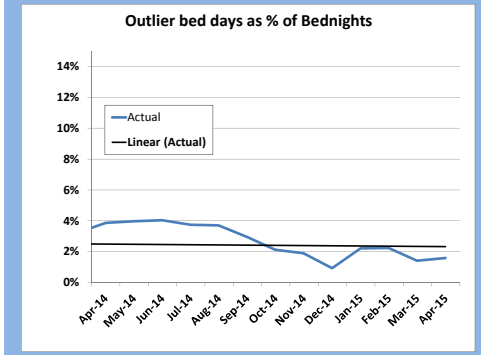








Acute Care



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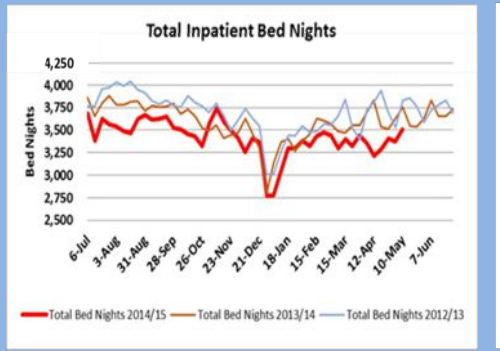

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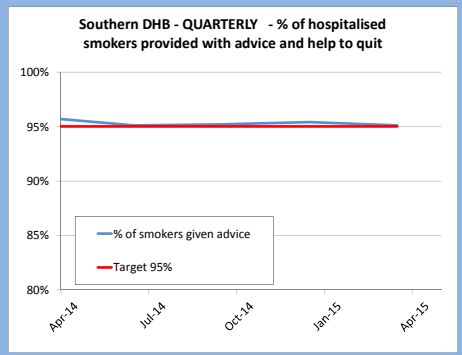
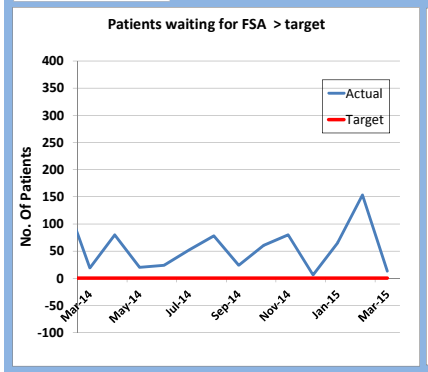
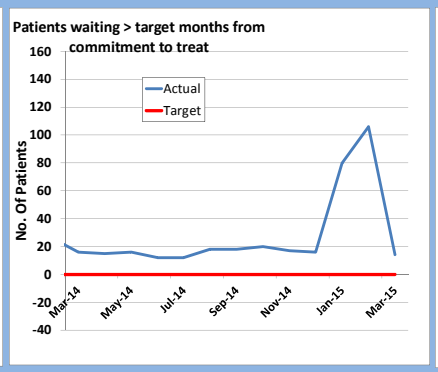
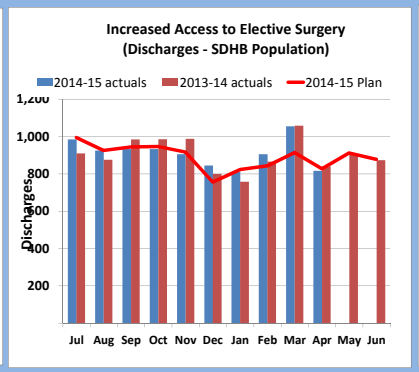


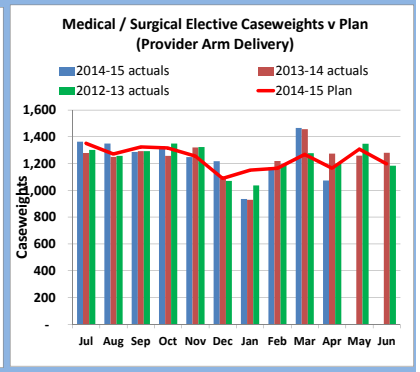
Southern DHB - Appendix a
Hospital Advisory Committee - Hospital Healthcheck
April 2015 Data

Elective Care

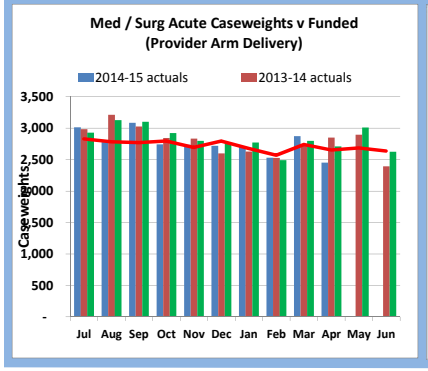




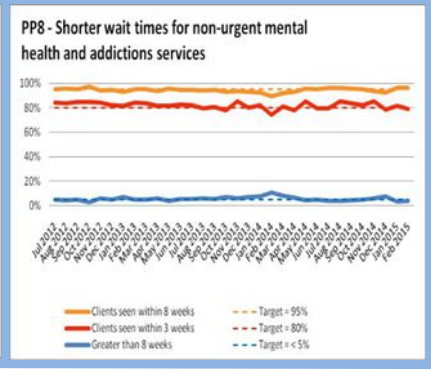




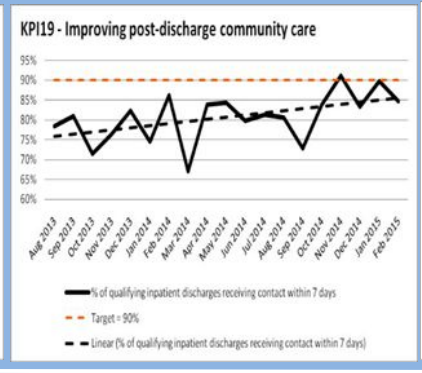
Acute Care



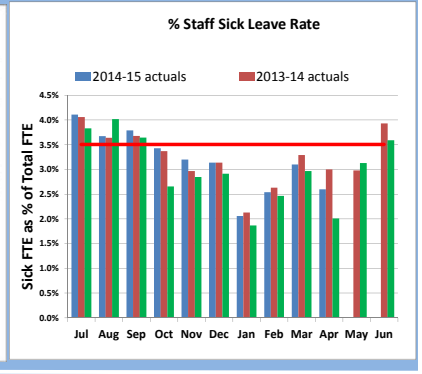
Mental Health and Addictions

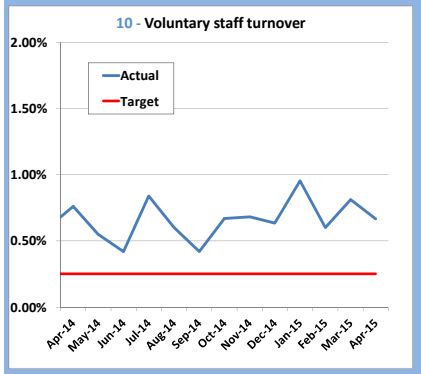


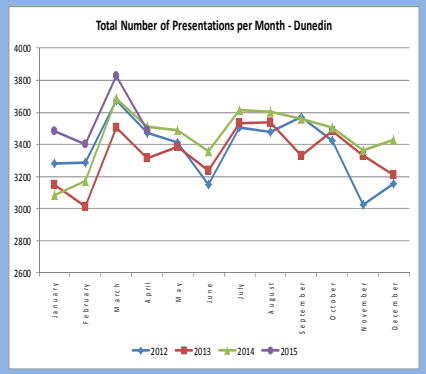
Mental Health and Addictions

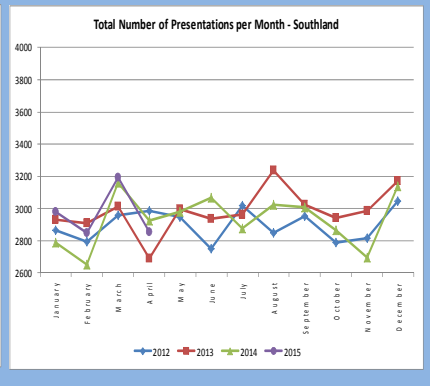


Service and Organisation Quality



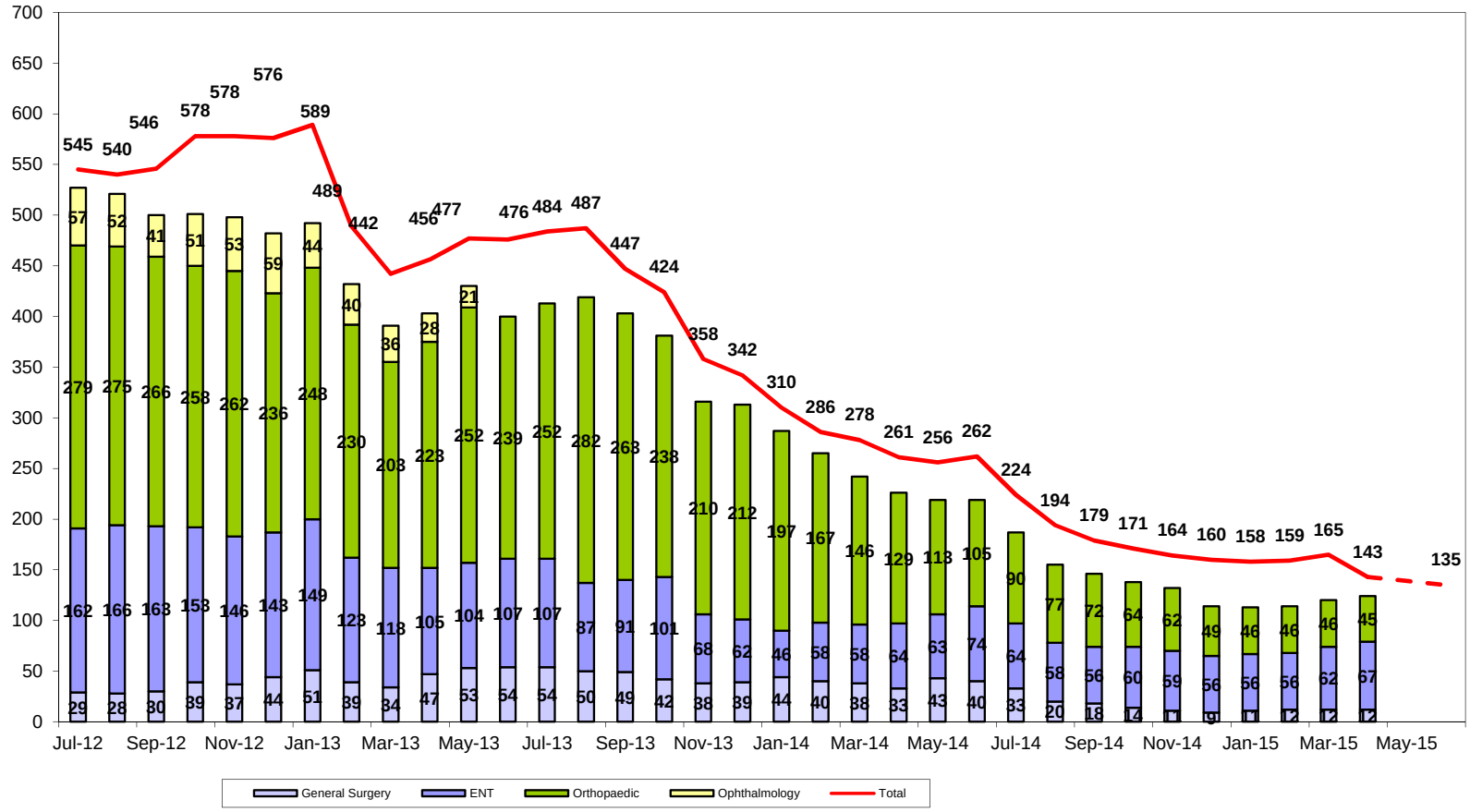






7.2

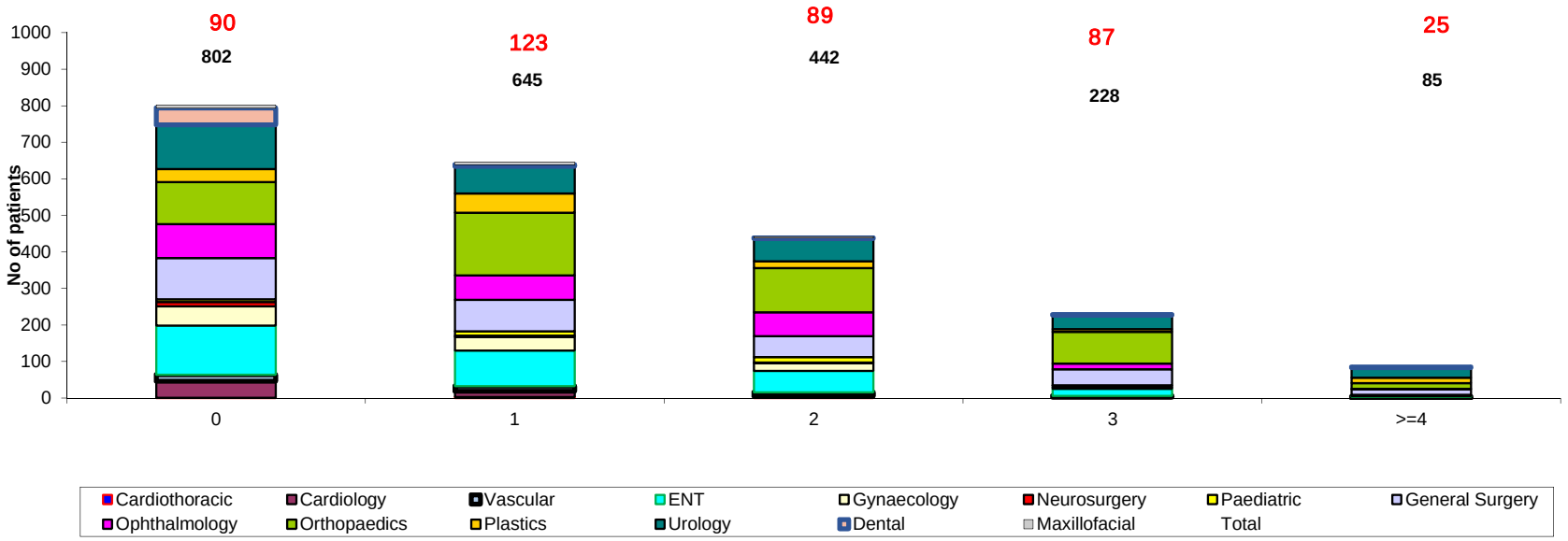
Number of Patients on Active Review Southern DHB
Target: Total number in Active Review by June 2015 will be approximately 135 patients or 5% of total waiting list
Stack represents only those services with volumes greater than 20



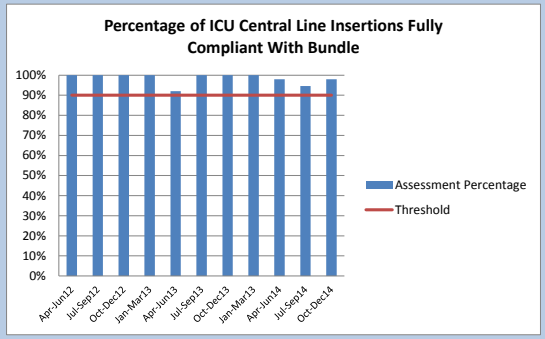
Appendix c

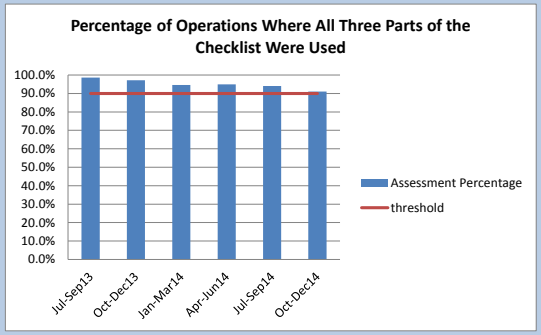
Number of patients Given Certainty and their Wait time for treatment - Southern DHB (Includes Booked patients) at April 2015

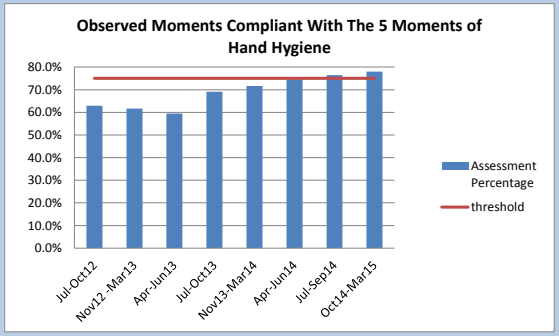
(Excludes patients with a staged or planned status) The numbers in Red indicate the number of booked patients

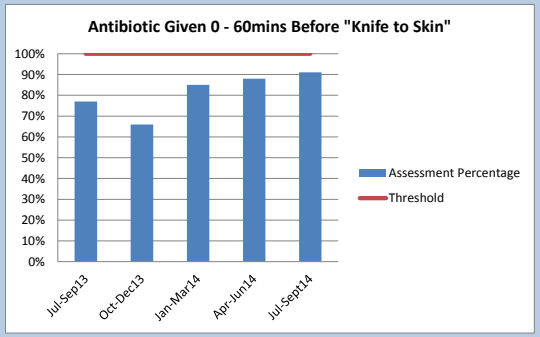


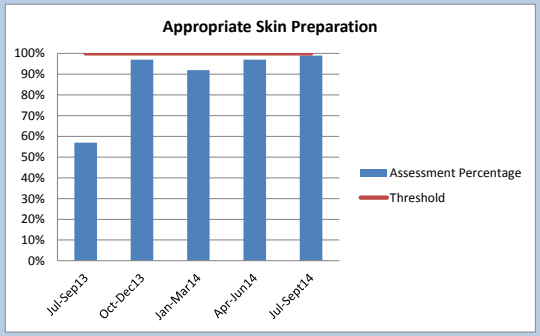
Southern DHB
Quality Process Measures

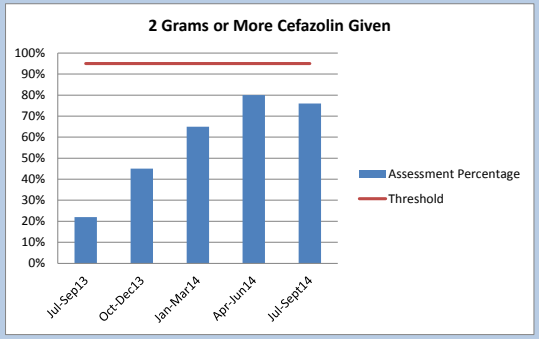


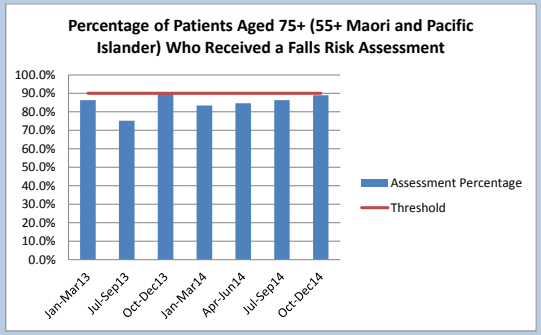


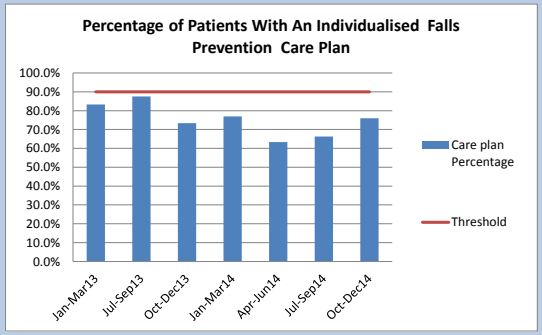












SOUTHERN DISTRICT HEALTH BOARD

7.3

Title:	Surgical Directorate - Elective Services Performance Indicators (ESPI) targets		
Report to:	Hospital Advisory Committee		
Date of Meeting:	03 June 2015		
Summary: Update report regarding progress to meeting Elective Services Performance Indicators (ESPI) targets.			
Specific implications for consideration (financial/workforce/risk/legal etc):			
Financial:	N/A		
Workforce:	N/A		
Other:	N/A		
Document previously submitted to:	N/A	Date:	
Approved by:	N/A	Date:	
Prepared by: Lynley Irvine, General Manager on behalf of the Surgical Directorate Leadership Team Date: 15/5/2015		Presented by: 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 – April 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 is four months, this reduced from five months in December 2014.

2. Trend of Progress to Four Months

Southern DHB obtained ESPI compliance in December 2014 for five months with the majority of services within the DHB reaching the target of a four month waiting time. When the ESPI target reduced to four months for the end of January 2015, the DHB exceeded the allowable buffer and was non compliant in both ESPI2 and ESPI5. The DHB remained non compliant for February at four months. The DHB retained compliance in all ESPIs for March 2015.

It is predicted that the DHB will be non compliant at the end of May. There is a considerable focus to ensure compliance at the end of June as there is a risk that the DHB will be non compliant for three consecutive months.

The four month target is stabilising across all services however some are under pressure to retain compliance over the next few months. Services at the greatest risk of not meeting the four month target in June are Urology (Dunedin site), Plastics (District service) and Orthopaedic surgery across the district. These services have active management plans to achieve compliance.

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.

3. Conclusion

The DHB is focused on retaining the four month target for services that have reached the target. The additional focus has been placed on the services at greatest risk of not meeting the four month target going forward.

Progress to meeting 4 months

Report date:14 May 2015

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									
Cardiothoracic									
Cardiology									
Dermatology	6								
Dental							1		
Endocrinology									
ENT									
Gastro	1		7						
General Medicine									
General Surgery					16		1		
Gynaecology									
Haematology									
Infectious Disease									
Neurology									
Neurosurgery	2								
Ophthalmology	2		21				4		
Oral Maxillo									
Orthopaedics					11		4		
Paed Medicine	3		1						
Paed Surgery									
Pain									
Plastics	3				12		4		
Renal Medicine									
Respiratory			2						
Rheumatology									
Radiation Oncology									
Urology	12		3		34				
Vascular					4				
Total	63				91				

Trend of Patients waiting over 4 months and 3 months for Outpatients (OP) and Inpatients (IP)

	15 Dec	22 Dec	12 Jan	19 Jan	26 Jan	02 Feb	09 Feb	16 Feb	23 Feb	02 Mar	09 Mar	16 Mar	23 Mar	30 Mar	13 Apr	20 Apr	28 Apr	04 May	11 May	14 May
OP 4mth	82	50	217	131	105	472	285	211	151	410	184	92	25	29	113	91	75	270	155	83
OP 3mth	628	577	1112	1010	968	1396	1158	1039	971	1221	906	743	608	579	712	679	645	934	765	653
IP 4mth	69	51	134	108	97	184	151	132	129	234	136	35	23	13	123	93	82	161	135	112
IP 3mth	256	197	364	274	231	545	470	394	336	557	417	277	203	166	351	266	193	463	408	350

SOUTHERN DISTRICT HEALTH BOARD

7.4

Title:	Complaints to Health and Disability Commissioner involving District Health Boards: Southern DHB. Report and Analysis 1 July-31 December 2014.
Report to:	Hospital Advisory Committee
Date of Meeting:	03 June 2014

Summary: Considered in this paper is:

- National data for all DHBs.
- Data for Southern DHB: Rate of complaints received; Service types complained about at Southern DHB; Department/facility and service type complained about; Issues complained about at Southern DHB; Closed complaints against Southern DHB.
- It should be noted that there has been a large increase in the number of complaints during the July-December 2014 period, including a significant increase in the number of complaints about mental health services.
- It should be noted that in this period the Commission closed 28 complaints about Southern DHB (including two that were outside of jurisdiction). 25 of these complaints were managed without progressing to formal investigation (one progressed to formal investigation). Outcomes were as follows: one was referred to the District Inspector, four were referred back to the DHB to manage, three went to advocacy and 17 resulted in no further action (except in the case of five, which had some follow up requirement or educational comments made).

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: Attached is a report prepared by the Health and Disability Commissioner's Office Date: 12/05/2015	Presented by: Mr Richard Bunton Medical Director of Patient Services

RECOMMENDATIONS:

That the Committee receive the report.

Complaints to HDC involving District Health Boards

Southern DHB

Report and Analysis for period 1 July to 31 December 2014

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

7.4

Contents

Commissioner's Foreword

I am pleased to present you with HDC's six monthly DHB complaint report for the period July to December 2014.

The trends within this report continue to be consistent with those seen in previous reports. Over half of all complaints received in July to December 2014 about DHBs were primarily about care/treatment issues. The most prominent specific primary issue continues to be that of a missed, incorrect or delayed diagnosis, which was the primary issue in around 15% of complaints about DHBs. When we consider all issues raised in DHB complaints, we see that concerns about communication continue to feature in around a quarter of complaints, with failure to communicate effectively with the consumer showing an increase within this period as compared to last period. Communication is a key component of a consumer-centred culture. As I have noted previously, in the margins where we do not do well, culture often plays a part. It is seen in the failure to speak up, to raise a question, to make the connection, to listen – to patients, family, colleagues. That is why I am so focussed on cultures that empower people; cultures that embody transparency, engagement, and seamless services; cultures that put consumers at the centre of services.

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

National Data for all District Health Boards

1.0 Number of complaints received

1.1 Raw number of complaints received

In the period Jul–Dec 2014, HDC received a total of **368** complaints about care provided by all District Health Boards. Numbers of complaints received in previous six month periods are reported in Table 1.

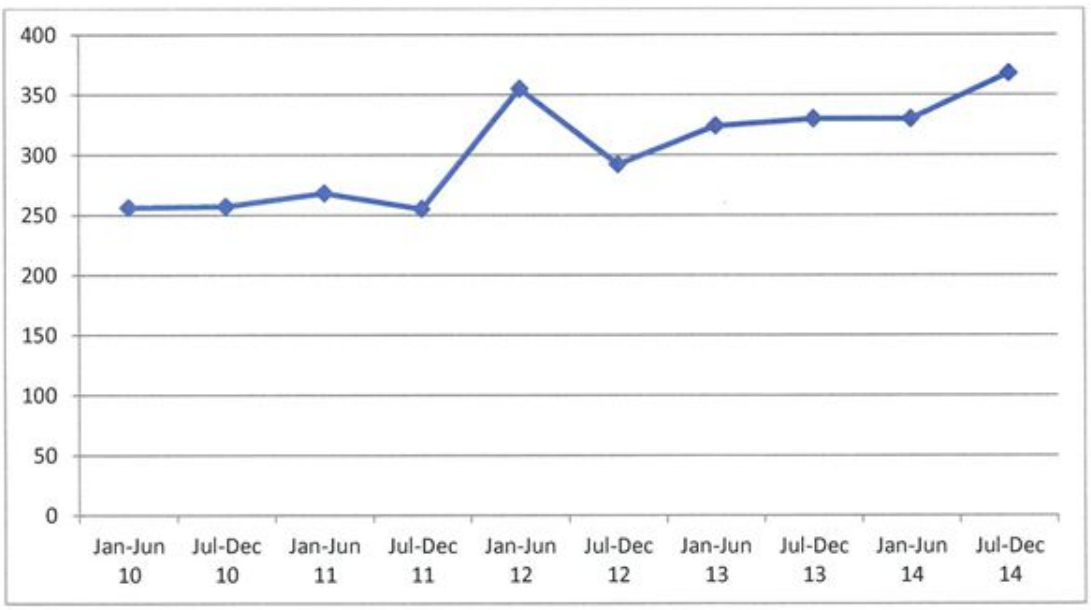
Table 1. Number of complaints received in last five years

	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Average of last 4 6-month periods	Jul–Dec 14
Number of complaints	256	257	268	255	355	292	324	330	330	**319**	**368**

The total for Jul–Dec 2014 (368) shows an increase of 15% over the average number of complaints received for the previous four periods.

The number of complaints received in Jul–Dec 2014 and previous six month periods are also displayed below in Figure 1. The number of complaints received in Jul–Dec 2014 is the highest number of complaints about DHBs ever received in a six month period.

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, 11 March 2015).

Table 2. Rate of complaints received per 100,000 discharges during Jul–Dec 2014

Number of complaints received	Total number of discharges	Rate per 100,000 discharges
368	477,859[1]	**77.01**

Table 3 shows the rate of complaints received by HDC per 100,000 discharges, for Jul–Dec 2014 and previous six month periods.

Table 3. Rate of complaints received in last five years

	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14[2]	Average of last 4 6-month periods	Jul–Dec 14
Rate per 100,000 discharges	60.19	57.16	62.48	55.86	80.22	62.59	72.67	71.15	72.99	**69.85**	**77.01**

The rate of complaints received during Jul–Dec 2014 (77.01) shows a 10% 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 Jul–Dec 2014. Each DHB's complaint rate on table 4 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 41.65 complaints per 100,000 discharges to 146.20 complaints per 100,000 discharges as compared to the national rate of 77.01 complaints per 100,000 discharges. The raw number of complaints received about individual DHBs ranged from 3 complaints to 47 complaints.

[1] The total number of discharges excludes short stay emergency department discharges and patients attending outpatient units and clinics.
[2] The rate for Jan–Jun 2014 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).

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	41.65	DHB 11	81.02
DHB 2	44.05	DHB 12	87.98
DHB 3	51.26	DHB 13	111.39
DHB 4	54.92	DHB 14	115.77
DHB 5	55.82	DHB 15	115.79
DHB 6	67.62	DHB 16	118.57
DHB 7	75.80	DHB 17	121.61
DHB 8	78.00	DHB 18	132.16
DHB 9	78.58	DHB 19	142.35
DHB 10	80.39	DHB 20	146.20
		All DHBs	**77.01**

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 368 complaints about DHBs, 387 services were complained about.

The five service types with the greatest number of complaints were surgery (27.1%), mental health (20%), general medicine (19.1%), accident and emergency (9.5%) and maternity (6.7%). This is broadly similar to what was seen last period.

Table 5. Service types complained about

Service type	Number of complaints	Percentage
Accident and emergency (including paramedics)	**37**	**9.6%**
Aged care (long-term care facility)	**1**	**0.3%**
Alcohol and drug	**4**	**1.0%**
Anaesthetics/pain medicine	**5**	**1.3%**
Dental	**4**	**1.0%**
Diagnostics	**11**	**2.8%**
Disability services	**6**	**1.6%**
District nursing	**1**	**0.3%**
General medicine	**74**	**19.1%**
Cardiology	7	1.8%
Dermatology	1	0.3%
Endocrinology	1	0.3%
Gastroenterology	6	1.6%
Geriatric medicine	8	2.1%
Hepatology	1	0.3%
Infectious diseases	4	1.0%
Neurology	9	2.3%
Oncology	11	2.8%
Palliative care	3	0.8%
Renal/nephrology	1	0.3%
Respiratory	4	1.0%
Rheumatology	1	0.3%
Other/unspecified	17	4.4%
Hearing services	**1**	**0.3%**
Intensive care/critical care	**5**	**1.3%**
Maternity	**26**	**6.7%**
Mental health	**77**	**20.0%**
Paediatrics (not surgical)	**16**	**4.1%**
Rehabilitation services	**9**	**2.3%**
Surgery	**105**	**27.1%**
Cardiothoracic	4	1.0%
General	22	5.7%
Gynaecology	14	3.6%
Neurosurgery	5	1.3%
Ophthalmology	3	0.8%
Orthopaedics	30	7.8%
Otolaryngology	6	1.5%
Paediatric	2	0.5%
Plastic and Reconstructive	3	0.8%
Urology	15	3.9%
Vascular	1	0.3%
Vision/eye services (not surgical)	**1**	**0.3%**
Other health service	**2**	**0.5%**
Outside jurisdiction	**2**	**0.5%**
TOTAL	**387**	

3.0 Issues complained about

3.1 Primary complaint issues

For each complaint received by HDC, one primary complaint issue is identified. Those complaint issues listed in only one complaint are classified as 'other'. The primary issues identified in complaints received in Jul–Dec 2014 are listed in Table 6.

Table 6. Primary issues complained about

Primary issue in complaints	Number of complaints	Percentage
Access/Funding	***41***	***11.1%***
Lack of access to services	15	4.1%
Lack of access to subsidies/funding	4	1.1%
Waiting list/prioritisation issue	21	5.7%
Other	1	0.3%
Boundary violation	***1***	***0.3%***
Inappropriate sexual communication	1	0.3%
Care/Treatment	***201***	***54.6%***
Delay in treatment	5	1.4%
Delayed/inadequate/inappropriate referral	3	0.8%
Inadequate coordination of care/treatment	7	1.9%
Inadequate/inappropriate clinical treatment	39	10.6%
Inadequate/inappropriate examination/assessment	13	3.5%
Inadequate/inappropriate follow-up	4	1.1%
Inadequate/inappropriate monitoring	4	1.1%
Inadequate/inappropriate non-clinical care	12	3.3%
Inadequate/inappropriate testing	2	0.5%
Inappropriate/delayed discharge/transfer	13	3.5%
Inappropriate withdrawal of treatment	5	1.4%
Missed/incorrect/delayed diagnosis	54	14.8%
Refusal to treat	7	1.9%
Rough/painful care or treatment	5	1.4%
Unexpected treatment outcome	24	6.5%
Other	4	1.1%
Communication	***46***	***12.5%***
Disrespectful manner/attitude	19	5.2%
Failure to accommodate cultural/language needs	2	0.5%
Failure to communicate openly/honestly/effectively with consumer	8	2.2%
Failure to communicate openly/honestly/effectively with family	16	4.3%
Other	1	0.3%
Complaints process	***8***	***2.2%***
Inadequate response to complaint	8	2.2%
Consent/Information	***29***	***7.9%***
Consent not obtained/adequate	9	2.4%
Inadequate information provided regarding adverse event	3	0.8%
Inadequate information provided regarding condition	2	0.5%
Inadequate information provided regarding results	2	0.5%
Inadequate information provided regarding treatment	2	0.5%
Issues regarding consent when consumer not competent	2	0.5%
Issues with involuntary admission/treatment	9	2.4%

Primary issue in complaints	Number of complaints	Percentage
Documentation	***11***	***3.0%***
Delay/failure to disclose documentation	3	0.8%
Inadequate/inaccurate documentation	7	1.9%
Other	1	0.3%
Facility issues	***6***	***1.6%***
Staffing/rostering/other HR issue	2	0.5%
Waiting times	2	0.5%
Other	2	0.5%
Medication	***11***	***3.0%***
Inappropriate prescribing	6	1.6%
Prescribing error	2	0.5%
Refusal to prescribe/dispense/supply	2	0.5%
Other	1	0.3%
Reports/Certificates	***4***	***1.1%***
Inaccurate report/certificate	4	1.1%
Other professional conduct issues	***4***	***1.1%***
Inappropriate collection/use/disclosure of information	3	0.8%
Other	1	0.3%
Disability-specific issues	***3***	***0.8%***
Other issues	***3***	***0.8%***
TOTAL	***368***	

The most common primary issue categories in complaints concerned care/treatment (54.6%), communication (12.5%) and access/funding (11.1%). Among these, the most common specific primary issues in complaints about DHBs were 'missed/incorrect/delayed diagnosis' (54 complaints), 'inadequate/inappropriate clinical treatment' (39 complaints), 'unexpected treatment outcome' (24 complaints), 'waiting list/prioritisation issue' (21 complaints) and 'disrespectful manner/attitude' (19 complaints). This is broadly similar to what was seen in the previous six month period, with the exception of 'waiting list/prioritisation issue' which appears in the most common specific primary issues for the first time.

Table 7 shows a comparison over time for the top five primary issue categories 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 (%)							
Jan–Jun 13 n=324		**Jul–Dec 13 n=330**		**Jan–Jun 14 n=330**		**Jul–Dec 14 n=368**	
Treatment	57%	Treatment	55%	Treatment	60%	Treatment	55%
Communication	15%	Communication	12%	Communication	10%	Communication	13%
Access/Funding	9%	Consent/ Information	9%	Access/Funding	9%	Access/funding	11%
Consent/ Information	8%	Medication	7%	Consent/ Information	7%	Consent/ Information	8%
Medication and Professional conduct	3% each	Access/Funding	6%	Medication	4%	Medication and Documentation	3% each

The top five categories of primary issues in Jul–Dec 2014 are similar to primary issues reported in previous periods. Treatment and communication are consistently the most common primary issues across all periods.

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 are classified as 'other'.

On analysis of all issues identified in complaints about DHBs, the five most common issues were 'inadequate/inappropriate clinical treatment' (39.9%), 'failure to communicate effectively with consumer' (34.2%), 'inadequate/inappropriate examination/assessment' (25.5%), 'disrespectful manner/attitude' (23.1%), 'failure to communicate effectively with family' (22.8%), 'missed/incorrect/delayed diagnosis' (22.3%), and 'inadequate response to the consumer's complaint by a DHB' (21.7%). This is broadly similar to what was seen in Jan-Jun 2014, with 'inadequate/inappropriate examination/assessment' increasing from being an issue in 17.3% of complaints to being mentioned in 25.5% of complaints received during Jul-Dec 2014, and 'failure to communicate effectively with consumer' increasing from being mentioned in 27.6% of complaints last period to being an issue in 34.2% of complaints in this period. 'Missed/incorrect/delayed diagnosis', on the other hand, decreased from being an issue in 28.2% of complaints in Jan-Jun 2014 to being mentioned in 22.3% of complaints made during this period.

Also similar to last period, many complaints involved issues with a consumer's care/treatment, such as 'inadequate coordination of care/treatment' (19.6%), 'unexpected treatment outcome' (15.5%), 'delay in treatment' (13.9%), and 'inadequate/inappropriate testing' (13.0%).

Table 8. All issues identified in complaints

All issues in complaints	Number of complaints	Percentage
Access/Funding		
ACC compensation issue	14	3.8%
Lack of access to services	37	10.1%
Lack of access to subsidies/funding	6	1.6%
Waiting list/prioritisation issue	25	6.8%
Boundary violation		
Inappropriate sexual communication	1	0.3%
Care/Treatment		
Delay in treatment	51	13.9%
Delayed/inadequate/inappropriate referral	38	10.3%
Inadequate coordination of care/treatment	72	19.6%
Inadequate/inappropriate clinical treatment	147	39.9%
Inadequate/inappropriate examination/assessment	94	25.5%
Inadequate/inappropriate follow-up	46	12.5%
Inadequate/inappropriate monitoring	25	6.8%
Inadequate/inappropriate non-clinical care	39	10.6%
Inadequate/inappropriate testing	48	13.0%
Inappropriate admission/failure to admit	6	1.6%
Inappropriate/delayed discharge/transfer	46	12.5%
Inappropriate withdrawal of treatment	11	3.0%
Missed/incorrect/delayed diagnosis	82	22.3%
Personal privacy not respected	9	2.4%
Refusal to assist/attend	18	4.9%
Refusal to treat	21	5.7%
Rough/painful care or treatment	20	5.4%
Unexpected treatment outcome	57	15.5%
Other	1	
Communication		
Disrespectful manner/attitude	85	23.1%
Failure to accommodate cultural/language needs	7	1.9%
Failure to communicate openly/honestly/effectively with consumer	126	34.2%
Failure to communicate openly/honestly/effectively with family	84	22.8%
Insensitive/inappropriate comments	23	6.3%
Complaints process		
Inadequate response to complaint	80	21.7%
Other	4	
Consent/Information		
Coercion by provider to obtain consent	3	0.8%
Consent not obtained/adequate	20	5.4%
Failure to assess capacity to consent	3	0.8%
Inadequate information provided regarding adverse event	9	2.4%
Inadequate information provided regarding condition	25	6.8%
Inadequate information provided regarding options	8	2.2%
Inadequate information provided regarding results	7	1.9%
Inadequate information provided regarding treatment	26	7.1%

All issues in complaints	Number of complaints	Percentage
Incorrect/misleading information provided	19	5.2%
Issues regarding consent when consumer not competent	5	1.4%
Issues with involuntary admission/treatment	11	3.0%
Other	1	
Documentation		
Delay/failure to disclose documentation	10	2.7%
Delay/failure to transfer documentation	5	1.4%
Inadequate/inaccurate documentation	48	13.0%
Inappropriate maintenance/disposal of documentation	5	1.4%
Other	1	
Facility issues		
Cleanliness/hygiene issues	5	1.4%
Failure to follow policies/procedures	6	1.6%
General safety issue for consumer in facility	5	1.4%
Inadequate/inappropriate policies/procedures	12	3.3%
Issue with quality of aids/equipment	3	0.8%
Issue with sharing facility with other consumers	4	1.1%
Staffing/rostering/other HR issue	16	4.3%
Waiting times	6	1.6%
Other	2	
Fees/costs		
Cost of treatment	2	0.5%
Medication		
Administration error	4	1.1%
Inappropriate prescribing	24	6.5%
Prescribing error	4	1.1%
Refusal to prescribe/dispense/supply	13	3.5%
Other	3	
Reports/Certificates		
Inaccurate report/certificate	13	3.5%
Other	3	
Training/Supervision		
Inadequate supervision/oversight	9	2.4%
Other professional conduct issues		
Inappropriate collection/use/disclosure of information	12	3.3%
Other	6	
Disability-specific issues	***7***	
Other issues	***11***	

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. This is broadly similar to what was seen last period, with the exception of surgery services, where 'waiting list/prioritisation issue' has become the most common primary issue for the first time.

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

Surgery n=105		**Mental health n=77**		**General medicine n=74**		**Accident & emergency n=37**		**Maternity n=26**	
Waiting list/ prioritisation	16%	Issues with involuntary admission/ treatment	12%	Missed/ incorrect/ delayed diagnosis	16%	Missed/ incorrect/ delayed diagnosis	38%	Inadequate/ inappropriate treatment	31%
Unexpected treatment outcome	12%	Failure to communicate effectively with family	9%	Inadequate/ inappropriate care	11%	Inadequate/ inappropriate treatment	14%	Missed/ incorrect/ delayed diagnosis	12%
Misdiagnosis and inadequate treatment	11% each	Inadequate/ inappropriate treatment	8%	Inadequate/ inappropriate treatment	8%	Disrespectful attitude/ manner	11%	Unexpected treatment outcome	12%

4.0 Complaints closed

4.1 Number of complaints closed

HDC closed **344**[4] complaints involving DHBs in the period Jul–Dec 2014. Table 10 shows the number of complaints closed in previous six month periods.

Table 10. Number of complaints about DHBs closed in last five years

	Jan–Jun 10	**Jul–Dec 10**	**Jan–Jun 11**	**Jul–Dec 11**	**Jan–Jun 12**	**Jul–Dec 12**	**Jan–Jun 13**	**Jul–Dec 13**	**Jan–Jun 14**	**Average of last 4 6-month periods**	**Jul–Dec 14**
Number of complaints closed	262	257	246	217	302	254	337	280	411	**321**	**344**

The total number of complaints closed for Jul–Dec 2014 shows an increase of 7% over the average of the last four six month periods.

[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.

4.2 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 an investigation, even though an alternative manner of resolution may subsequently be adopted. Notification of investigation generally indicates more serious or complex issues.

In the Jul–Dec 2014 period, **10** DHBs had no investigations closed, **6** DHBs had one investigation closed, and **4** DHBs had two investigations closed by HDC.

The manner of resolution and outcomes of all DHB complaints closed in Jul–Dec 2014 is shown in Table 11.

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

Outcome for DHBs	Number of complaints closed
Investigation	***12***
Breach finding	4
No further action[6] with follow-up or educational comment	6
No further action	2
Non-investigation	***310***
No further action with follow-up or educational comment	67
Referred to District Inspector	4
Referred to DHB[7]	65
Resolved by DHB	1
Referred to Advocacy	23
No further action	141
Withdrawn	9
Outside jurisdiction	***22***
TOTAL	**344**

[5] Note that outcomes are displayed in descending order. 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 a 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.

4.3 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 then follows up with the DHB 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.

Table 12. Recommendations made to DHBs following a complaint

Recommendation	Number of recommendations made
Apology	17
Audit	24
Meeting with consumer/complainant	3
Reflection	7
Presentation/discussion of complaint with others	4
Provision of information	18
Review of policies/procedures	33
Training/professional development	16
Total	**122**

The most common recommendation made to DHBs was that they review their policies/procedures (33 recommendations). When audits were recommended, they were most commonly in relation to adherence to policies/procedures, followed by compliance with documentation requirements. Training/professional development was most often recommended in relation to clinical issues, documentation and communication.

5.0 Learning from complaints — HDC case reports

Assessment and monitoring of an elderly man with dementia (12HDC00630)

Background

Mr A, aged 87 years, had been suffering from worsening dementia. His son, Mr B, held an enduring power of attorney (EPOA) as to Mr A's personal care and welfare, but this had not been activated.

Mr A was admitted to a public hospital with blood-tinged urine. His prescribed medications were recorded in his notes, but Mr B advised the hospital pharmacist that Mr A was non-complaint with his medications. The hospital pharmacist therefore crossed out the medications and wrote in the progress notes that the medication had been stopped. However, Mr A was administered his prescribed medication during his admission (including aspirin).

During his admission, Mr A had an unwitnessed fall. Neurological observations were carried out on the day of the fall, but were then discontinued, despite the DHB's policy requiring on-going observations. Mr A's mental state deteriorated and he was later placed on observations every 15 minutes due to his disruptive behaviour and wandering.

Two days later the registered nurse (RN) caring for the man, RN C, failed to undertake a number of the required checks. RN C handed over his patients to a second RN before taking his meal break, but did not tell the second RN to check Mr A at 15 minute intervals, or when Mr A had last been checked. RN C returned an hour later and realised that Mr A was missing. RN C contacted Security, who understood from that conversation that Mr A had gone missing in the previous 10 minutes. CCTV footage later confirmed that Mr A had left the ward approximately two hours earlier.

A member of the public found Mr A at a bus stop and called an ambulance. He was then taken back to the hospital, where he was found to have a large bilateral subdural haematoma. A registrar discussed Mr A's poor prognosis with Mr B at the bedside, which Mr B felt was inappropriate. Mr A later died in hospital. Mr B was concerned that the administration of aspirin during Mr A's admission may have contributed to his death.

Findings

RN C was found in breach of Right 4(1) of the Code for not making all the required checks, failing to hand over Mr A's care adequately and failing to ascertain the correct information and convey it to Security after he discovered Mr A was missing.

The DHB was found in breach of Right 4(1) of the Code for failing to ensure that its staff carried out the required neurological observations following Mr A's fall and failing to take action as his condition deteriorated. The DHB also had no formal process for meal break handover of patients by nurses, visual handover was not required, and there was no structure in place to ensure that appropriate staff were present during meal breaks.

Adverse comments were made about the DHB's failure to clarify the medications Mr A was receiving in the community or whether the EPOA had been activated, and in relation to the DHB's communication with Mr A and Mr B.

Recommendations

The Deputy Commissioner made a number of recommendations to the DHB, including that the DHB provide Mr A's family with an apology. The DHB was also asked to arrange for an audit of the documentation practices in the general medical ward, review its handover processes and review the training of nursing staff in the medical division regarding the care of elderly patients with dementia. The DHB has complied with all of these recommendations.

Inappropriate prescription of narcotic medication (12HDC01608)

Background

Mr A, an elderly man with complex co-morbidities including chronic renal impairment, was admitted to hospital for the management of an acutely ischaemic leg. Mr A underwent an angioplasty and his pain was noted to have improved postoperatively. Mr A was reviewed by the surgical registrar, Dr C, and the decision was made to discharge Mr A home on either the Sunday or Monday.

On Sunday morning, Dr C reviewed Mr A and changed his analgesic medication from fentanyl to Sevredol. However, Dr C did not document a discharge management plan or any details of the decision to prescribe Sevredol.

Later that day, the on-call surgical house officer, Dr D, was contacted by a nurse who requested that Dr D write a prescription for antibiotics and analgesia for Mr A so that he could be discharged. Dr D noted that Mr A had been prescribed Sevredol earlier that day by Dr C, so wrote a prescription for the same dose that had already been prescribed. Dr D did not complete the discharge documentation.

Mr A was then discharged and returned home. He took his medication as prescribed, including a total of five 10mg Sevredol tablets. The following morning Mr A was found unconscious by his daughter. He was later admitted to hospital and treated for opioid toxicity. Sadly, Mr A died a short time later.

Findings

Adverse comment was made that Dr C failed to critically assess the appropriateness of prescribing Sevredol to Mr A, given that his pain was already well-managed and he had renal impairment. The Commissioner found that having made the decision to prescribe such medication, Dr C should have proceeded with caution. The Commissioner also said that Dr C's failure to document a discharge plan and the decision to prescribe Sevredol and its monitoring requirements, demonstrated a lack of caution that placed Mr A at an unnecessary risk of harm. Accordingly, Dr C was found in breach of Right 4(4) of the Code.

Criticisms were made of aspects of the care Dr D provided, in particular the failure to critically question the prescription of Sevredol in a man who had renal impairment and the failure to complete any discharge documentation.

The DHB was found in breach of Right 4(1) of the Code for failing to ensure that its staff provided Mr A with an appropriate standard of care which had resulted from a sequence of poor communication and coordination of care, coupled with suboptimal documentation of the discharge plan.

Recommendations

The Commissioner made a number of recommendations, including that the DHB:

- Undertake monthly monitoring of discharge summaries to ensure its on-going supervision and monitoring of staff in relation to compliance with its discharge policies.
- Review its current policies and procedures with regards to discharges, in particular weekend discharges, especially in relation to the communication of discharge plans.
- Provide a report to HDC on the outcome of its most recent audit of compliance with the Admission to Discharge Plan and other aspects of discharge planning.
- Use the anonymised version of this report for education purposes, highlighting in particular the concerns raised about culture, communication and coordination of care.

Supervision of a registrar during a labour and delivery (13HDC00093)

Background

Mrs A went into labour at 40 weeks plus 9 days' gestation. Cardiotocography monitoring showed deep fetal heart rate decelerations and the obstetrics registrar, Dr B, was called to review Mrs A. Dr B, who at the time of these events had only been working at the DHB for two weeks, reviewed Mrs A and immediately called the on-call obstetrics consultant, Dr C. The doctors have different

recollections of the telephone conversation, but both recall that the plan was to attempt a trial of forceps and, if unsuccessful, to proceed to a Caesarean section. Dr B understood that she was to carry out the procedures unsupervised, while Dr C understood that he was to attend.

Dr B proceeded with a trial of forceps delivery unsupervised, which was unsuccessful, and then she proceeded with the Caesarean section. While Dr C had arrived in the delivery suite at the time the above procedures were commenced, he was intercepted on his way to Mrs A by another obstetric emergency.

Dr B was unable to deliver Baby A as the baby's head was impacted in the pelvis. Dr C arrived shortly after, and delivered Baby A. Baby A was born white and floppy with the umbilical cord wrapped around her neck. Baby A was resuscitated and transferred to the Neonatal Intensive Care Unit, but sadly passed away.

Findings

The Commissioner found that the hospital policy for triaging obstetric emergencies and the senior medical officer cascade process was not followed. Furthermore, the orientation and induction of Dr B had not been appropriate, in that Dr B was unaware of the level of supervision she required. For not ensuring that its staff was sufficiently supported, and that its obstetrics policies and procedures were followed the DHB was found in breach of Right 4(1) of the Code.

The Commissioner stated that "consultant oversight and input provides an important safety net ... as the senior supervising clinician, the obstetrics consultant had a responsibility to ensure that his instructions were communicated clearly and were understood". Accordingly, Dr C was found in breach of Right 4(1) of the Code for inappropriate supervision of Dr B. The Commissioner also expressed concern about the time it took Dr C to arrive at the hospital after being called and that he did not obtain an update on Mrs A's condition before attending the other obstetric emergency.

The Commissioner was critical of Dr B for proceeding with the delivery unsupervised and not recognising that she was out of her depth. However, Dr B had not been informed of the DHB's credentialing and supervision requirements, believed that Dr C had instructed her to proceed unsupervised; and the clinical situation was worsening and there was no senior consultant available immediately. In these circumstances, the Commissioner did not find Dr B in breach of the Code.

Recommendations

The DHB, Dr B and Dr C apologised to Mrs A and her husband. The Commissioner also made a number of recommendations to the DHB, including:

- Liaising with Mrs A and her husband in order to ascertain whether they would like to meet with the staff involved in Mrs A and Baby A's care in order to address the content of this report and arranging such a meeting if this is their wish.
- Review and update its policies to ensure that consultant attending times are outlined clearly and staff are advised of these requirements.
- The provision of an education seminar on calling categories, as per its 'Obstetrics Surgery/Procedures Triage' policy, including examples of when it is to be used, to all obstetric consultants and registrars.
- The provision of an education seminar on the cascade process, including examples of when it is to be used, to all obstetric consultants and associate charge midwives.
- The development of a supervision of obstetric and gynaecology registrars policy, similar to the DHB's 'Credentialing of Senior Medical Officers' (QLR-06).

These recommendations have been met by the DHB.

Monitoring of patient with pneumonia and documentation of care (12HDC00548)

Background

Mrs A was admitted to the critical care unit of a public hospital suffering from lower lobe pneumonia. While in the critical care unit Mrs A's health was variable. After several weeks, continuous monitoring, including ECG monitoring for heart rate, heart rhythm and respiratory rate, was stopped. It is not clear who made this decision and the decision was not documented in the notes. Only pulse oximetry, which monitored Mrs A's oxygen saturation via finger probe, remained in place. At times, Mrs A removed the finger probe.

Five days later, Mrs A was found to have suffered a cardiac arrest. She was not wearing her finger probe. The exact time of her arrest is unknown. Mrs A's family agreed that she was not for resuscitation. The day following her arrest she was taken off ventilation and she died the following day.

Findings

The Commissioner commented that adequate monitoring, together with vigilant staff, are core capabilities of intensive care units. Mrs A was in the critical care unit because she required intensive care, however, she was not monitored adequately and, as a result, her cardiac arrest was not noticed immediately. The Commissioner found that Mrs A should have been subject to continuous monitoring and the DHB should have in place robust guidelines to ensure that every patient is monitored appropriately while in the critical care unit. Therefore, the DHB was found in breach of Right 4(1) of the Code.

In addition, various aspects of Mrs A's care were not fully documented in the clinical notes, including her having removed her finger probe, decisions around when she was to be discharged to the ward, and, following her cardiac arrest, her treatment plan. The Commissioner considered that there was a pattern of suboptimal clinical documentation amongst multiple clinical staff, indicating a lax attitude towards documentation at the DHB. Therefore, the DHB was found in breach of Right 4(2) of the Code for failing to comply with legal standards.

Adverse comment was made in relation to the DHB's failure to mitigate the risk presented by Mrs A removing her finger probe.

Recommendations

The Commissioner recommended that the DHB review the Critical Care Unit Observations and Monitoring Guidelines and consider including a requirement that all patients must have appropriate monitoring until the patient is transferred to the ward. It was also recommended that the DHB carry out an audit of monitoring and documentation in that unit along with compliance with the modified Observations and Monitoring Guidelines. The DHB was asked to write a letter of apology to Mrs A's family that highlighted the changes the DHB had made since these events. The DHB has complied with all of these recommendations.

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 Jul–Dec 2014, HDC received a total of **32** 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 (26,988) compared to the rate of complaints per total discharges nationally (477,859).

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
32	26,988	118.57	77.01

Southern DHB is identified on the overall DHB complaint rate list (Table 4) as **DHB 16**. Southern DHB was identified as DHB 7 in the previous six month period. As can be seen from the above table, Southern DHB's complaint rate for Jul–Dec 2014 was higher 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 Jul–Dec 2014 and previous six month periods.

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

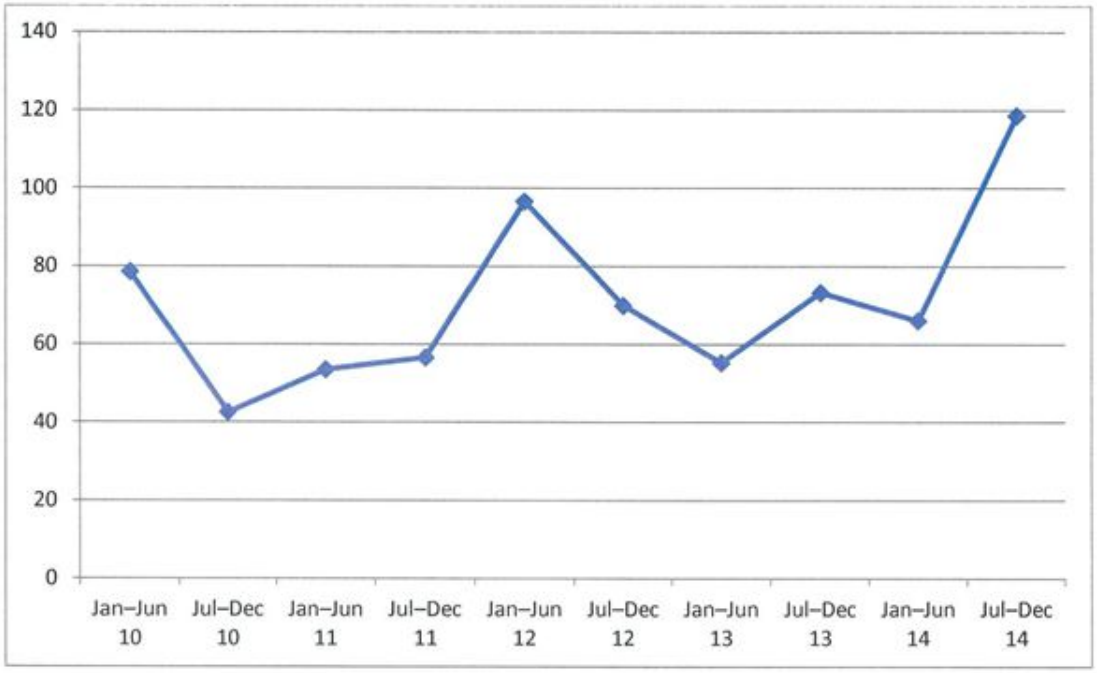
	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14[8]	Average of last 4 6-month periods	Jul–Dec 14
Complaints received	19	11	13	15	25	19	14	20	17	**18**	**32**
Rate per 100,000 discharges	78.49	42.50	53.47	56.56	96.53	69.89	55.25	73.25	66.04	**66.11**	**118.57**

[8] The rate for Jan–Jun 2014 has been recalculated based on the most recent discharge data.

The rate for Jul–Dec 2014 (118.57) shows a increase of 79% over the average rate of complaints received for the previous four periods.

Figure 2 shows the rate of complaints received about Southern DHB for Jul–Dec 2014 and previous six month periods.

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



7.0 Service types complained about at Southern DHB

7.1 Service type

For the 32 complaints received, the services concerned, and numbers of complaints within these services, are shown in Table 15. Please note that more than one hospital was complained about within one complaint about Southern DHB, and therefore 34 service types were complained about.

Southern DHB had a higher proportion of complaints about mental health services (32.4%) than was seen both nationally and in the last period at Southern DHB.

7.4

Table 15. Service types complained about

Service type	Number of complaints	Percentage
Accident and emergency (including paramedics)	4	**11.8%**
Anaesthetics/pain medicine	1	**2.9%**
Dental	1	**2.9%**
Disability services	1	**2.9%**
General medicine	5	**14.7%**
Gastroenterology	1	2.9%
Neurology	1	2.9%
Oncology	1	2.9%
Respiratory	1	2.9%
Other/unspecified	1	2.9%
Maternity	3	**8.8%**
Mental health	11	**32.4%**
Paediatrics (not surgical)	2	**5.9%**
Surgery	5	**14.7%**
General	1	2.9%
Gynaecology	2	5.9%
Ophthalmology	1	2.9%
Orthopaedics	1	2.9%
Vision/eye services (not surgical)	1	**2.9%**
TOTAL	34	

7.2 Department/facility and service type complained about

The service types complained about within each department/facility are shown in Table 16. Again, please note that more than one hospital was complained about within one complaint about Southern DHB, and therefore 34 service types were complained about.

Table 16. Department/facility and service type complained about

Department/facility subject to complaint	Number of complaints
Dunedin Hospital	***14***
Accident and emergency	**1**
Anaesthetics/pain medicine	**1**
General medicine	**4**
Gastroenterology	1
Neurology	1
Oncology	1
Other/unspecified	1
Maternity	**1**
Mental health	**3**
Paediatrics	**1**
Surgery	**3**
General	1
Gynaecology	1
Ophthalmology	1
Oamaru Hospital	**1**
Paediatrics	1
Southland Hospital	**13**
Accident and emergency	**3**
Dental	**1**
General medicine – Respiratory	**1**
Maternity	**2**
Mental health	**3**
Surgery	**2**
Gynaecology	1
Orthopaedics	1
Vision/eye services	**1**
Wakari Hospital	***2***
Mental health	**2**
Not specified	***4***
Disability services	**1**
Mental health	**3**
TOTAL	**34**

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 (50.0%), while the most common specific primary issue was 'missed/incorrect/delayed diagnosis' (21.9%). Southern DHB had a higher proportion of complaints about access/funding issues than was seen nationally.

Table 17. Primary issues complained about

Primary Issue	Number of complaints	Percentage
Access/funding	**6**	**18.8%**
Lack of access to services	1	3.1%
Lack of access to subsidies/funding	2	6.3%
Waiting list/prioritisation issue	3	9.4%
Care/treatment	**16**	**50.0%**
Delayed/inadequate/inappropriate referral	1	3.1%
Inadequate coordination of care/treatment	1	3.1%
Inadequate/inappropriate clinical treatment	4	12.5%
Inadequate/inappropriate follow-up	1	3.1%
Missed/incorrect/delayed diagnosis	7	21.9%
Unexpected treatment outcome	2	6.3%
Communication	**5**	**15.6%**
Disrespectful manner/attitude	1	3.1%
Failure to communicate openly/honestly/effectively with family	3	9.4%
Insensitive/inappropriate comments	1	3.1%
Complaints process	**1**	**3.1%**
Inadequate response to complaint	1	3.1%
Consent/information	**2**	**6.3%**
Consent not obtained/adequate	1	3.1%
Issues with involuntary admission/treatment	1	3.1%
Documentation	**1**	**3.1%**
Delay/failure to disclose documentation	1	3.1%
Other professional conduct	**1**	**3.1%**
Threatening/bullying/harassing behaviour	1	3.1%
TOTAL	**32**	

8.2 All issues

As well as the primary complaint issue, up to six additional other complaint issues are identified for each complaint received by HDC. Table 18 includes these additional complaint issues as well as the primary complaint issues to show all issues identified in complaints received about Southern DHB. Complaint issues listed in only one complaint are classified as 'other'.

Table 18. All issues complained about

All Issues	Number of complaints	Percentage
Access/funding		
Lack of access to services	6	18.8%
Lack of access to subsidies/funding	2	6.3%
Waiting list/prioritisation issue	3	9.4%
Care/treatment		
Delay in treatment	5	15.6%
Delayed/inadequate/inappropriate referral	4	12.5%
Inadequate coordination of care/treatment	6	18.8%
Inadequate/inappropriate examination/assessment	14	43.8%
Inadequate/inappropriate clinical treatment	18	56.3%
Inadequate/inappropriate follow-up	6	18.8%
Inadequate/inappropriate monitoring	3	9.4%
Inadequate/inappropriate testing	6	18.8%
Inappropriate/delayed discharge/transfer	2	6.3%
Missed/incorrect/delayed diagnosis	11	34.4%
Personal privacy not respected	3	9.4%
Refusal to treat	2	6.3%
Unexpected treatment outcome	4	12.5%
Other	4	
Communication		
Disrespectful manner/attitude	6	18.8%
Failure to communicate openly/honestly/effectively with consumer	4	12.5%
Failure to communicate openly/honestly/effectively with family	8	25.0%
Insensitive/inappropriate comments	2	6.3%
Other	1	
Complaints process		
Inadequate response to complaint	7	21.9%
Consent/information		
Consent not obtained/adequate	2	6.3%
Incorrect/misleading information provided	2	6.3%
Other	3	
Documentation		
Inadequate/inaccurate documentation	5	15.6%
Other	2	
Facility issues		
Staffing/rostering/other HR issue	5	15.6%
Other	1	
Teamwork/supervision		
Inadequate supervision/oversight	2	6.3%
Other issues	**6**	

Similar to national trends, on analysis of all issues identified in complaints about Southern DHB, the most common issues were 'inadequate/inappropriate clinical treatment' (56.3%), 'inadequate/inappropriate examination/assessment' (43.8%), 'missed/incorrect/delayed diagnosis' (34.4%), 'failure to communicate effectively with family' (25.0%) and inadequate response to a consumer's complaint by a DHB' (21.9%).

8.3 Service type and primary issues

The primary issues complained about in relation to each service are set out in Table 19.

Table 19. Primary issues complained about by service type

Service type	Number of complaints	Primary issues identified in each complaint
Accident and emergency	4	Inadequate/inappropriate clinical treatment Missed/incorrect/delayed diagnosis x3
Anaesthetics/pain medicine	1	Inadequate/inappropriate clinical treatment
Dental	1	Lack of access to subsidies/funding
Disability services	1	Lack of access to services
General medicine – Gastroenterology	1	Missed/incorrect/delayed diagnosis
General medicine – Neurology	1	Missed/incorrect/delayed diagnosis
General medicine – Oncology	1	Unexpected treatment outcome
General medicine – Respiratory	1	Waiting list/prioritisation issue
General medicine – Other/unspecified	1	Missed/incorrect/delayed diagnosis
Maternity	3	Inadequate/inappropriate clinical treatment x2 Consent not obtained/adequate
Mental health	11	Delayed/inadequate/inappropriate referral Inadequate/inappropriate follow-up Failure to communicate effectively with family x5 Inadequate response to complaint Issues with involuntary admission/treatment Delay/failure to disclose documentation Threatening/bullying/harassing behaviour
Paediatrics	2	Missed/incorrect/delayed diagnosis Insensitive/inappropriate comments
Surgery - General	1	Missed/incorrect/delayed diagnosis
Surgery – Gynaecology	2	Unexpected treatment outcome Disrespectful manner/attitude
Surgery – Ophthalmology	1	Waiting list/prioritisation issue
Surgery – Orthopaedics	1	Missed/incorrect/delayed diagnosis
Vision/eye services	1	Lack of access to subsidies/funding

9.0 Closed complaints about Southern DHB

9.1 Number of complaints closed

HDC closed **28** complaints about Southern DHB in Jul–Dec 2014. HDC closed **1** complaint about Southern DHB following investigation in this period.

Table 20 shows the total number of complaints closed and complaints closed following investigation for the Jul–Dec 2014 and previous six month periods.

Table 20. Total number of complaints and formal investigations closed in last five years

	Southern DHB											All DHBs
	Jan–Jun 10	Jul–Dec 10	Jan–Jun 11	Jul–Dec 11	Jan–Jun 12	Jul–Dec 12	Jan–Jun 13	Jul–Dec 13	Jan–Jun 14	Average of last 4 6-month periods	Jul–Dec 14	Jul–Dec 14
Total complaints closed	18	13	13	7	21	14	19	25	15	18	28	344
Investigations closed	0	0	0	0	1	0	3	2	3	2	1	12

9.2 Outcomes of complaints closed

The outcomes of all complaints closed about Southern DHB in Jul–Dec 2014 are shown in Table 21.

Table 21. Outcomes for Southern DHB of complaints closed[9]

Outcomes for Southern DHB	Number of complaints
Investigation	***1***
No further action with follow-up or educational comment	1
Non-investigation	***25***
No further action with follow-up or educational comment	5
Referred to District Inspector	1
Referred to DHB	4
Referred to Advocacy	3
No further action	12
Outside jurisdiction	**2**
Total	**28**

[9] Note that outcomes are displayed in descending order. 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.

SOUTHERN DISTRICT HEALTH BOARD

Title:	Financial Report
Report to:	Hospital Advisory Committee
Date of Meeting:	03 June 2015

Summary:

Considered in these papers are:

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

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

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

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

Prepared by: Grant Paris Finance Manager Date: 16/05/2015	Presented by: Lexie O'Shea Executive Director of Patient Services

RECOMMENDATION:

That the Committee receive the report.

FINANCIAL REPORT – PROVIDER – APRIL 2015

Recommendation

That the Board receives and notes this report.

1. DHB Provider Summary Results – April 2015

Revenue and Expenditure Summary

Description	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD	$000 Full Year Budget
Revenue							
Government & Crown Agency Sourced	2,727	2,794	(67)	27,931	27,748	183	33,436
Non Government & Crown Agency Revenue	1,047	1,077	(31)	10,584	11,081	(497)	13,189
Internal Revenue	37,889	37,478	412	375,961	375,594	367	450,549
Revenue Total	**41,663**	**41,349**	**314**	**414,477**	**414,423**	**53**	**497,174**
Personnel							
Personnel							
Medical Personnel	(10,038)	(9,821)	(217)	(94,762)	(94,209)	(553)	(113,250)
Nursing Personnel	(11,824)	(11,306)	(518)	(104,911)	(103,006)	(1,905)	(124,838)
Allied Health Personnel	(4,130)	(4,328)	198	(39,314)	(40,516)	1,202	(49,159)
Support Personnel	(908)	(863)	(45)	(8,207)	(8,029)	(178)	(9,718)
Management & Administration Personnel	(3,234)	(3,266)	32	(32,297)	(31,929)	(367)	(38,509)
Personnel Total	**(30,134)**	**(29,583)**	**(551)**	**(279,491)**	**(277,689)**	**(1,802)**	**(335,475)**
Expenditure							
Outsourced Services	(2,601)	(2,551)	(50)	(25,093)	(25,657)	565	(30,756)
Clinical Supplies	(6,650)	(6,764)	114	(68,761)	(68,702)	(59)	(82,584)
Infrastructure & Non-Clinical Supplies	(6,007)	(5,931)	(75)	(58,598)	(58,186)	(412)	(70,032)
Expenditure Total	**(15,257)**	**(15,247)**	**(11)**	**(152,452)**	**(152,546)**	**93**	**(183,372)**
Net Surplus / (Deficit)	**(3,729)**	**(3,481)**	**(248)**	**(17,467)**	**(15,812)**	**(1,655)**	**(21,673)**
Add Net Impact from Research Accounts	**79**	**0**	**79**	**509**	**0**	**509**	**0**
Add Donations Received	**10**	**44**	**(33)**	**218**	**438**	**(219)**	**525**
Net Surplus / (Deficit)	**(3,639)**	**(3,437)**	**(202)**	**(16,739)**	**(15,374)**	**(1,365)**	**(21,148)**

The monthly result is unfavourable to budget by $202k, increasing the year to date unfavourable variance to budget to $1,365k.

Revenue (excluding Donations and Research) was favourable for the month by $314k driven by higher internal revenue (Fertility / National Patient Flow /Bariatrics revenue)
Year to date revenue is favourable to budget by $53k, increased Ministry and Internal revenue being partially offset by lower than budgeted revenues from ACC ($240k) and Cafeteria sales ($114k).

Payroll costs were unfavourable for the month by $551k (1.8%) driven by medical and nursing personnel. This is discussed later in the report.

Clinical Supplies were under budget for the month by 1.7% driven by a favourable variance in implant costs.

Infrastructure and Non Clinical costs were unfavourable to budget for the month driven by an increase in our doubtful debts provision.

FTE

FTE was 10FTE under budget for the month (excluding research)

- Junior Medical Personnel were unfavourable by 7FTE in April and 2.5FTE year to date reflecting full recruitment and a transfer of costs from positions that were budgeted as outsourced.
- Senior Medical Personnel continue to be favourable - 9FTE under budget for the month and 9FTE year to date
- Nursing personnel was 44FTE over budget for the month and 13FTE year to date (excluding research FTE). This was an increase of 29FTE from March. The reasons for this are detailed below.
- Allied Health personnel continue to be 24FTE favourable to budget in line with last month. When compared to the year to date variance of 32FTE, this reflects successful recruitment into Allied positions
- Management Administration staff were 24FTE under budget for the month and 6FTE under budget year to date. The difference from the year to date variance is due primarily to the capitalisation of staff working on the Health Connect South project. (Backdated to the start of the financial year).

2. Personnel Costs - $551k unfavourable for month and $1,802k unfavourable year to date (excl research)

Medical Personnel $217k unfavourable for month - $553k unfavourable year to date

SMO personnel costs are on budget for the month despite the fact they are 9FTE favourable. This is due to additional allowances paid to anaesthesia medical staff to cover roster gaps in ICU, including air retrieval and continued kiwisaver costs being higher than budgeted.

SMOs continue to be favourable year to date however, both in personnel and outsourcing, as shown in the table below.

The RMO unfavourable monthly and year to date result is driven by unfavourable variances in FTE, leave and overtime. This is only partially offset by favourable outsourcing variances.

Overall Medical resource is favourable $897k year to date.

	Month								Year to Date							
	Actual		Budget		Var	Actual	Budget	Var	Actual		Budget		Var	Actual	Budget	Var
	$'000	%	$'000	%	$'000	FTE	FTE	FTE	$'000	%	$'000	%	$'000	FTE	FTE	FTE
SMO Personnel	(6,708)	98%	(6,715)	95%	7	246	255	9	(63,640)	96%	(64,192)	95%	552	245	255	9
Outsourced SMO	(136)	2%	(345)	5%	209				(2,960)	4%	(3,548)	5%	588			
Total SMO	(6,844)		(7,060)		216	246	255	9	(66,600)		(67,740)		1,140	245	255	9
RMO Personnel	(3,330)	99%	(3,106)	95%	(224)	274	266	(7)	(31,122)	98%	(30,017)	95%	(1,105)	269	266	(2)
Outsourced RMOs	(22)	1%	(160)	5%	138				(708)	2%	(1,570)	5%	862			
Total RMO	(3,352)		(3,266)		(86)	274	266	(7)	(31,830)		(31,587)		(243)	269	266	(2)
Total Medical Resource	(10,196)		(10,326)		130	519	521	2	(98,430)		(99,327)		897	514	521	7

Nursing Personnel - $518k unfavourable for month - $1,905k unfavourable year to date (excl research)

Nursing costs exceed the monthly budget due to the following:

- FTE is 44 over budget having increased 29FTE from last month. FTE was forecast to flatten out this month with the graduate positions becoming part of the core roster. Due to the timing of the pay runs however, FTE in the accounts has been based on the fortnights ending 19th April and 5th April. This earlier pay run will still include graduate nurses for 8 days the impact which has been estimated below.

  The table below attempts to restate the Nursing FTE variance to remove the "one-off" adjustments that have occurred over the past few months. It is hoped this will provide clarity around FTE variations and what's driving these (with the comments below)

Analysis of Monthly Nursing FTE Variance				
	February	**March**	**April**	
Ordinary Time	(24)	(5)	(25)	Worked FTE > budget
ACC / Sick and Other	(14)	(6)	(1)	More leave taken than budgeted
Overtime	(1)	(4)	(6)	Overtime > budget
Annual + Stat taken	6	(9)	(20)	Negative represents more leave taken than budget that drives up cover
Training Leave	10	(5)	1	Negative represents more training completed than budget that drives up cover
Long Service Leave	1	2	2	
Total Nursing FTE Variance	**(22)**	**(27)**	**(50)**	
add back Capitalised FTE	(24)	(3)	(3)	E Medications project
less impact of Graduate Nurses	14	24	10	
Restated Nursing FTE Variance	**(32)**	**(6)**	**(43)**	

It is evident from the above the two main FTE drivers for this month's Nursing costs

- Worked FTE is greater than budget that has been driven up by high acuity in NICU, EDs, Surgical, Children's and Mental Health.
- Greater levels of leave taken than budgeted. If in an inpatient ward, this generally requires cover which will increase the monthly costs

Also increasing monthly nursing costs were;

- An increase of the Nursing back pay accrual given recent offers made. This accrual reflect both the expected back pay plus the increase in the value of annual leave balances held. The impact of these increases in the current month was $250k.
- Long service Leave adjustments amounting to $150k.

NB: The Nursing graduate intake came on board in February (offset by revenue) which results in a temporary increase of 24FTE (30FTE x 0.8) for seven weeks through to the last week in March. These staff will then become part of core staffing until their 10mth fixed term positions end in December or they move into other permanent vacancies.

Allied Health Personnel - $198k favourable for month - $1,202k favourable year to date

This staff type was 24FTE favourable for the month which is less than the year to date favourable variance of 32FTE. (Reflecting the filling of vacant positions). This favourable FTE variance drives the favourable financial variance.

Support Personnel - $45k unfavourable for month - $178k unfavourable year to date

This staff type is 4.0 FTE favourable for the month and 2FTE unfavourable year to date. Long service leave adjustments ($16k) and unfavourable leave variances ($35k) are driving the monthly unfavourable variance. The $178k year to date variance is driven by additional overtime ($49k), rate variances ($93k), kiwisaver ($17k) and FTE over budget ($23k).

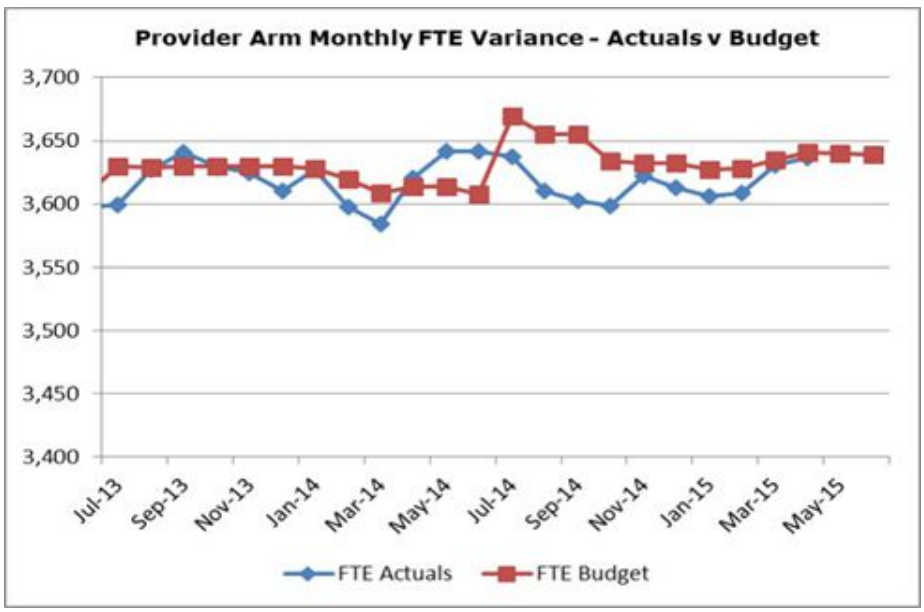
Management/Administration Personnel - $32k favourable for month - $367k unfavourable year to date

The main driver for the favourable April result is additional leave taken to budget. On a year to date basis, additional allowances, and pay rate variations drive the unfavourable variance, offset partially by the favourable FTE.

FTE

A comparison of FTE levels over the last year by quarter is tabled below. When compared to the end of last financial year, FTE is actually 5 less, although if adjusted for the impact of the administration staff capitalised it would be 6FTE over last year's actuals. The increased Nursing FTE is offset against a reduction in both Allied and Management Admin FTE. Part of the increase in Nursing however is due to a reclassification of approximately 11 staff from Allied to Nursing in the current year.

Staff Type	Dec-13	Mar-14	Jun-14	Sep-14	Dec-14	Mar-15	Apr-15	April-15 Budget	Variance to Budget	YTD Variance
SMO	248	244	245	246	245	248	246	255	9	9
RMO	264	270	272	265	267	270	274	266	(7)	(2)
Nursing Personnel	1,580	1,560	1,609	1,609	1,621	1,626	1,655	1,605	(50)	(18)
Allied Health Personnel	672	675	670	645	648	657	657	681	24	32
Support Personnel	192	189	193	199	194	196	188	192	4	(2)
Management & Administratio	654	647	654	640	638	632	616	640	24	5
Total Full Time Equivalents (F	3,610	3,584	3,641	3,603	3,613	3,630	3,636	3,640	4	23



The opposite graph shows that the gap between actual and budgeted FTE has now closed.

It has been identified during the year that areas such as overtime and kiwisaver for example were under budgeted.

Without favourable FTE to offset these known discrepancies, payroll will continue over budget for the remaining 2 months

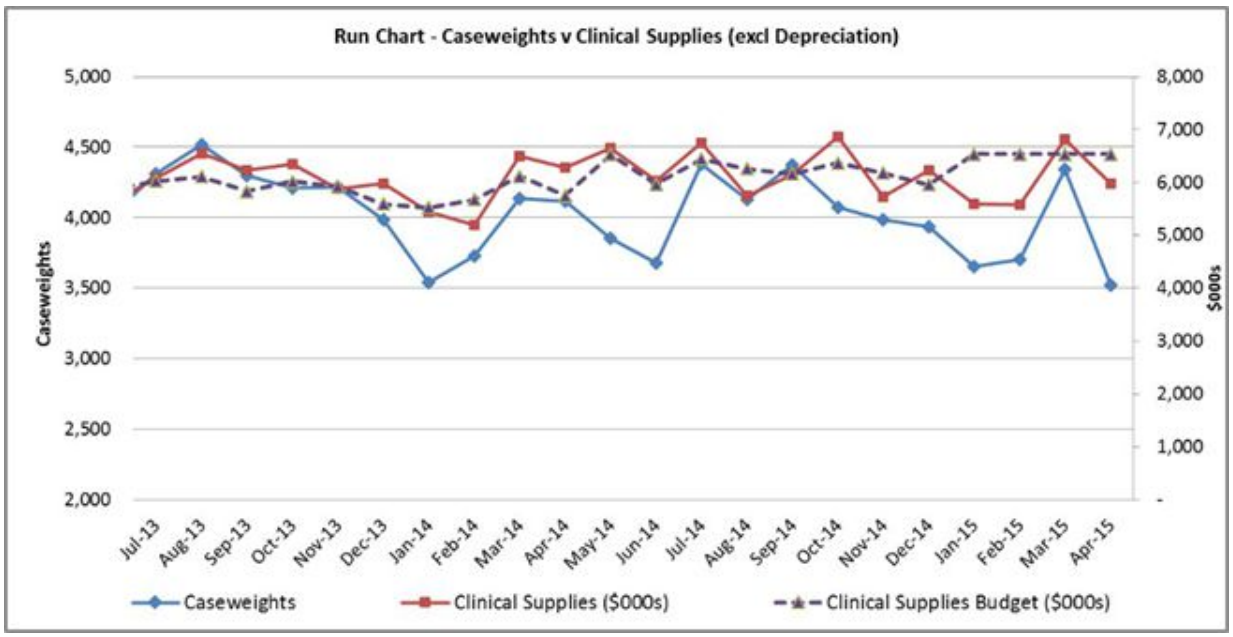
3. *Outsourced Costs - $50k unfavourable for month and $565k favourable year to date (excl research)*

Outsourced costs were over budget for the month by $50k although $359k unfavourable in outsourced clinical services. This was driven by Radiology outsourcing ($120k) plus a $200k accrual transferred from outsourced SMO's and Clinical Supply costs into Outsourced Clinical services. This reflects the likelihood that there will be outsourced volumes for Plastics, Urology and General Surgery over May and June.

4. *Clinical Supplies - $114k favourable for the month and $59k unfavourable year to date (excl research)*

Clinical Supply Costs v Volumes

The run chart below highlights the decreased spend in clinical supply costs is driven by lower caseweighted activity.



The decrease in expenditure to budget is shown below.

Description	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
Clinical Supplies						
Treatment Disposables	(2,417)	(2,330)	(87)	(24,920)	(23,864)	(1,056)
Diagnostic Supplies & Other Clinical Supplies	(154)	(143)	(11)	(1,482)	(1,522)	40
Instruments & Equipment	(1,309)	(1,360)	51	(13,935)	(13,367)	(568)
Patient Appliances	(146)	(189)	43	(1,705)	(1,885)	181
Implants & Prostheses	(744)	(927)	183	(8,943)	(9,563)	620
Pharmaceuticals	(1,590)	(1,509)	(81)	(15,007)	(15,358)	351
Other Clinical Supplies	(290)	(306)	16	(2,769)	(3,142)	372
Clinical Supplies Total	**(6,650)**	**(6,764)**	**114**	**(68,761)**	**(68,702)**	**(59)**

- Treatment disposables follow the year to date trend with blood costs driving the monthly variance ($132k over budget). Blood overruns make up 60% of the year to date variance with staples, sutures and patient consumables making up the balance

- Instruments and equipment were favourable for the month with Disposable Instruments being on budget despite being $320k unfavourable year to date. This combined with over expenditure on Laparoscopic equipment ($185k) and Respiratory equipment ($127k) drive the year to date unfavourable variance.
- Implants and Prostheses are favourable for the month due to a reduction in amounts allowed for additional Scoliosis cases over March and June. An assessment of the Hip and Knee implant volumes expected by year end also resulted in a reduction in an accrual in this area.

5. Infrastructure and Non Clinical Supplies - $75k unfavourable for the month and $412k unfavourable year to date (excl research)

Description	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	$000 YTD Actual	$000 YTD Budget	$000 Variance YTD
Infrastructure & Non-Clinical Supplies						
Hotel Services, Laundry & Cleaning	(1,069)	(1,051)	(19)	(10,952)	(10,536)	(416)
Facilities	(1,818)	(1,892)	73	(17,794)	(17,904)	111
Transport	(328)	(361)	33	(3,255)	(3,495)	240
IT Systems & Telecommunications	(917)	(913)	(4)	(9,212)	(9,103)	(109)
Interest & Financing Charges	(1,296)	(1,253)	(44)	(12,772)	(12,527)	(245)
Professional Fees and Expenses	(73)	(112)	39	(807)	(1,143)	337
Other Operating Expenses	(504)	(350)	(155)	(3,807)	(3,478)	(329)
Infrastructure & Non-Clinical Supplies Total	**(6,007)**	**(5,931)**	**(75)**	**(58,598)**	**(58,186)**	**(412)**

- Hotel Services - Cleaning charges continued to run over budget for the month ($62k) as a result of contract increases however this was largely offset by lower food costs.
- Facilities are significantly under budget for the month, driven building depreciation that was under budget for the month ($81k) due to timing differences in the capital spend to budget
- Other Operating Expenses were over budget for the month due to a further provision being made for doubtful debts of $200k

Part 2: DHB provider	Current Month Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Year to Date Actual $(000)	Budget $(000)	Variance $(000)	Variance %	Annual Budget $(000)
REVENUE									
Ministry of Health									
MoH - Personal Health	-	28	(28) U		444	283	161 F	57%	339
MoH - Mental Health	-	-			-	-			-
MoH - Public Health	10	11		(1%)	335	106	229 F	216%	127
MoH - Disability Support Services	782	736	46 F	6%	7,893	7,563	330 F	4%	9,040
MoH - Maori Health	-	-			-	-			-
Clinical Training Agency	633	637	(4) U	(1%)	6,027	6,145	(118) U	(2%)	7,418
Internal - DHB Funder to DHB Provider	37,889	37,478	412 F	1%	375,961	375,594	367 F		450,549
Ministry of Health Total	**39,315**	**38,889**	**426 F**	**1%**	**390,660**	**389,691**	**969 F**		**467,473**
Other Government									
Other DHB's	25	25	(1) U	(2%)	225	252	(27) U	(11%)	302
Training Fees and Subsidies	18	17	1 F	6%	210	171	39 F	23%	206
Accident Insurance	758	872	(114) U	(13%)	8,323	8,562	(239) U	(3%)	10,406
Other Government	500	468	32 F	7%	4,474	4,666	(192) U	(4%)	5,598
Other Government Total	**1,301**	**1,383**	**(82) U**	**(6%)**	**13,233**	**13,651**	**(418) U**	**(3%)**	**16,512**
Government and Crown Agency Total	**40,616**	**40,272**	**345 F**	**1%**	**403,893**	**403,342**	**551 F**		**483,985**
Other Revenue									
Patient / Consumer Sourced	228	267	(39) U	(15%)	3,022	3,028	(6) U		3,515
Other Income	953	854	99 F	12%	9,247	8,491	756 F	9%	10,199
Other Revenue Total	**1,181**	**1,121**	**60 F**	**5%**	**12,269**	**11,519**	**750 F**	**7%**	**13,714**
REVENUE TOTAL	**41,797**	**41,393**	**405 F**	**1%**	**416,161**	**414,861**	**1,301 F**		**497,699**
EXPENSES									
Personnel Expenses									
Medical Personnel	(10,038)	(9,821)	(217) U	(2%)	(94,762)	(94,209)	(553) U	(1%)	(113,250)
Nursing Personnel	(11,854)	(11,306)	(548) U	(5%)	(105,227)	(103,006)	(2,221) U	(2%)	(124,838)
Allied Health Personnel	(4,130)	(4,328)	198 F	5%	(39,314)	(40,516)	1,202 F	3%	(49,159)
Support Services Personnel	(908)	(863)	(45) U	(5%)	(8,207)	(8,029)	(178) U	(2%)	(9,718)
Management / Admin Personnel	(3,234)	(3,266)	32 F	1%	(32,297)	(31,929)	(367) U	(1%)	(38,509)
Personnel Costs Total	**(30,164)**	**(29,583)**	**(581) U**	**(2%)**	**(279,807)**	**(277,689)**	**(2,118) U**	**(1%)**	**(335,475)**
Outsourced Expenses									
Medical Personnel	(158)	(505)	346 F	69%	(3,668)	(5,118)	1,450 F	28%	(6,104)
Nursing Personnel	(3)	-	(3) U		(53)	-	(53) U		-
Allied Health Personnel	(48)	(34)	(14) U	(41%)	(509)	(354)	(155) U	(44%)	(421)
Support Personnel	(31)	(21)	(10) U	(46%)	(296)	(213)	(83) U	(39%)	(256)
Management / Administration Personnel	(16)	(1)	(15) U		(120)	(10)	(110) U		(12)
Outsourced Clinical Services	(2,209)	(1,846)	(363) U	(20%)	(19,669)	(18,540)	(1,129) U	(6%)	(22,257)
Outsourced Corporate / Governance Services	(140)	(145)	5 F	3%	(1,357)	(1,422)	66 F	5%	(1,706)
Outsourced Funder Services	-	-			-	-			-
Outsourced Services Total	**(2,605)**	**(2,551)**	**(54) U**	**(2%)**	**(25,672)**	**(25,657)**	**(14) U**		**(30,756)**
Clinical Supplies									
Treatment Disposables	(2,417)	(2,330)	(87) U	(4%)	(24,922)	(23,864)	(1,058) U	(4%)	(28,710)
Diagnostic Supplies & Other Clinical Supplies	(154)	(143)	(11) U	(8%)	(1,482)	(1,522)	40 F	3%	(1,818)
Instruments & Equipment	(1,309)	(1,360)	51 F	4%	(13,935)	(13,367)	(568) U	(4%)	(16,010)
Patient Appliances	(146)	(189)	43 F	23%	(1,705)	(1,885)	181 F	10%	(2,268)
Implants & Prosthesis	(744)	(927)	183 F	20%	(8,943)	(9,563)	620 F	6%	(11,607)
Pharmaceuticals	(1,590)	(1,509)	(81) U	(5%)	(15,007)	(15,357)	350 F	2%	(18,395)
Other Clinical Supplies	(293)	(306)	13 F	4%	(2,789)	(3,142)	353 F	11%	(3,774)
Clinical Supplies Total	**(6,653)**	**(6,764)**	**112 F**	**2%**	**(68,783)**	**(68,701)**	**(81) U**		**(82,583)**
Infrastructure & Non Clinical Expenses									
Hotel Services, Laundry & Cleaning	(1,069)	(1,051)	(19) U	(2%)	(10,953)	(10,536)	(417) U	(4%)	(12,640)
Facilities	(1,818)	(1,892)	73 F	4%	(17,794)	(17,904)	110 F	1%	(21,682)
Transport	(328)	(361)	33 F	9%	(3,280)	(3,495)	215 F	6%	(4,212)
IT Systems & Telecommunications	(917)	(913)	(4) U		(9,211)	(9,103)	(108) U	(1%)	(10,930)
Interest & Financing Charges	(1,296)	(1,253)	(44) U	(3%)	(12,772)	(12,527)	(245) U	(2%)	(15,032)
Professional Fees & Expenses	(73)	(112)	39 F	35%	(807)	(1,143)	337 F	29%	(1,367)
Other Operating Expenses	(510)	(350)	(160) U	(46%)	(3,821)	(3,478)	(343) U	(10%)	(4,168)
Infrastructure & Non-Clinical Supplies Total	**(6,012)**	**(5,931)**	**(81) U**	**(1%)**	**(58,637)**	**(58,186)**	**(451) U**	**(1%)**	**(70,032)**
Total Expenses	**(45,434)**	**(44,830)**	**(604) U**	**(1%)**	**(432,899)**	**(430,234)**	**(2,665) U**	**(1%)**	**(518,846)**
Net Surplus/ (Deficit)	**(3,637)**	**(3,437)**	**(199) U**	**(6%)**	**(16,737)**	**(15,373)**	**(1,364) U**	**(9%)**	**(21,147)**

SOUTHERN DISTRICT HEALTH BOARD

7.6

Title:	Occupational Health and Safety Report
Report to:	Hospital Advisory Committee
Date of Meeting:	03 June 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 Southern DHB 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:	N/A	Date:

Prepared by: John Pine Executive Director Human Resources Date: 15 May 2015	Presented by: Lexie O'Shea Executive Director of Patient Services

RECOMMENDATIONS:

That the Hospital Advisory Committee recommends that the Board:

- Receive the report and supports the work being undertaken to address Southern DHBs strategy.
- Receives the report (appendix 1) and notes the current accident and injury reports together with the work-related Accident Compensation claims data and sick leave reporting.

1. Accident, Injury and ACC

Injury and incident reporting suggests an increase over March and April. However, due to the implementation of the district wide electronic reporting tool Safety 1st, it is very likely that the availability of such a system is resulting in increased opportunities and ease of reporting as opposed to more incidents occurring. This is borne out by the fact that during these two months, there was no significant increase in the number of work-related injury claims (see appendix I). This type of behaviour is expected and welcomed as actual staff accidents will be visible in a more timely manner which will result in more effective injury management.

Serious Harm reports: There was one report of Serious Harm made to WorkSafe during March 2015. A staff member in the Emergency Department in Dunedin sustained a fracture of a bone in their foot.

2. ACC Partnership Programme

Work is underway regarding the implementation of actions identified from the plan that has been prepared following recommendations from the audit that took place in December 2014.

3. District wide approach to health and safety

A work shop was held on 25 March 2015 to determine streams of work that will be overseen by the District Health and Safety Governance Committee to enable the implementation of a single unified health and safety governance structure for Southern DHB. This includes four Action Zones aligning to the introduction of the new Health and Safety Legislation which is now due no earlier than 1 September 2015.

These action zones are

1. Reporting – metrics that matter.
2. A comprehensive review of current policy to ensure fit for purpose including refreshed training for safety representatives.
3. Staff Safety at work – including a review of staff exposure to the public (e.g. Mental Health and District Nursing). Planned to be completed by August 2015.
4. Manual Handling – Planned for August 2015.

4. 2015 Staff Influenza Vaccination campaign

The annual staff influenza vaccination campaign was due to commence on 7 April but due to late arrival of the vaccine it commenced on 29 April 2015. The target is to vaccinate at least 65% of staff this year, a 10% increase in last year.

In the first three weeks of the campaign, more than twice the number of vaccines have been given compared to any three week period in previous years. It is not possible to predict whether this momentum will continue but all efforts are being taken to offer multiple opportunities to staff to become vaccinated.

- The number of in-team vaccinators has been increased for this season

- The Executive Director of Nursing and Midwifery has been heading a project team to provide leadership and a more strategic approach to increase uptake

Statistical information shows that at the time of writing this report, a total of 2281 vaccines have been logged onto the data base. This includes over four hundred non-staff, who are considered health care workers as they work within the DHB. There are funded non-staff, i.e. student groups – medical, nursing and allied health professionals and non-funded contracted staff whose vaccine is funded at $27.00 per unit by their employers. The contractors include ALSCO, Southern Community Laboratories, ISS, Aotea Electrical, NZ Blood Service, Fire and Mechanical, St John and Pacific Radiology. We are awaiting approximately another two to three hundred notifications which have been carried out by in-team vaccinators and have yet to be entered.

At the time of writing this report (15 May 2015) the figures are as follows:

Total	Employees:	1775 (37.6%)
Southland	Employees:	505 (37.1%)
Otago	Employees:	1270 (37.8%)
Non Staff Members:		406
TOTAL:		2281

5. RL 6 (Safety1st) Incident Register

The implementation of Safety1st will result in an improvement of data integrity relating to staff injures as a single system is now in use across the district. As staff become more proficient at using the system, it is very likely that this will result in changes being seen in the number of injuries reported, the type of reporting and hopefully an increase in reporting of near miss events.

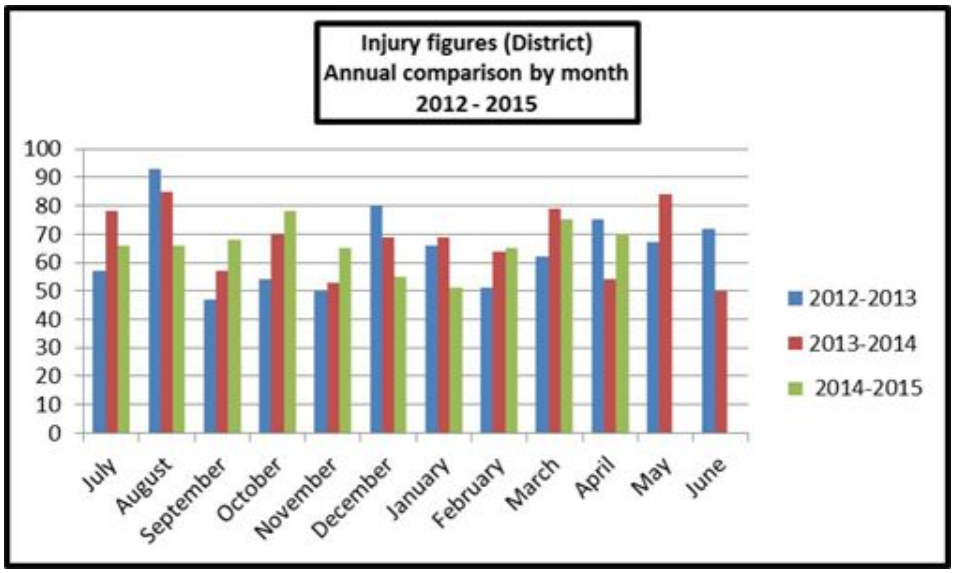
Appendix I

1. Current District Wide Accident / Injury Activity

District figures have been compiled and presented for the previous three years to provide comparable information relating to accident and injury data.

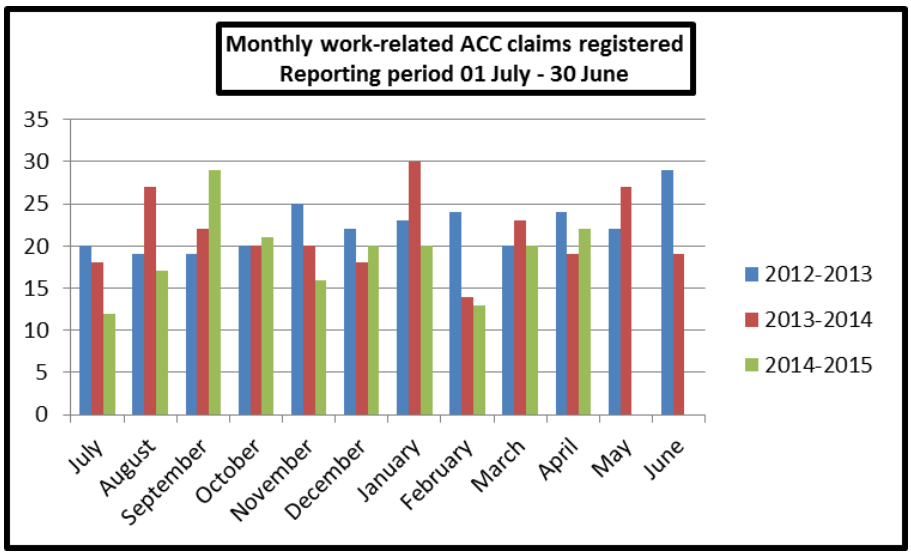
NB: The integrity of the data prior to the implementation of Safety1st may be compromised due to dual reporting systems that existed across the district.

Annual injury comparison by month – July 2012 – April 2015

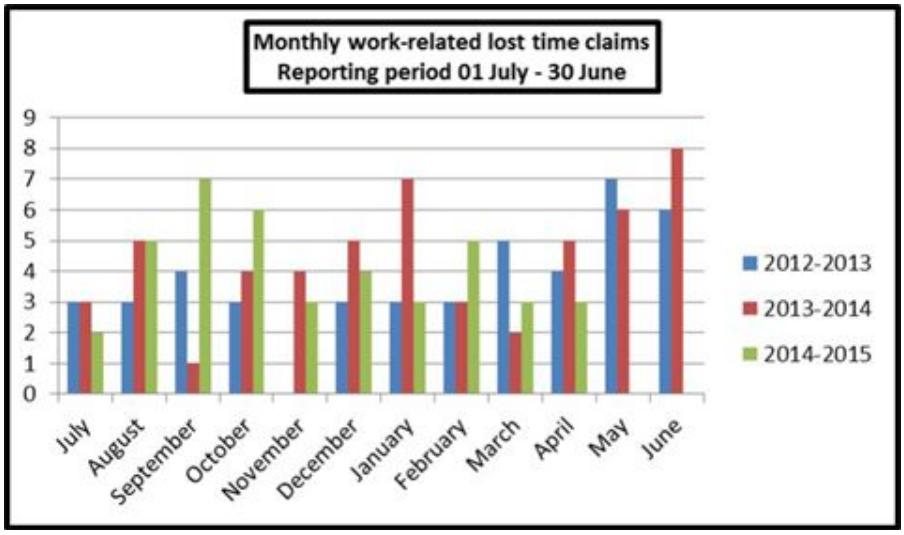


1. District: Work-related ACC claims analysis – Reporting 01 July 2012 – April 2015

a) Number of claims made remains consistent in the presence of an increase in the overall number of injuries: It is interesting to note that although there is a continuing increase in the total number of injuries reported district wide as noted above, the total number of work-injury ACC claims made by staff has remained remarkably consistent.

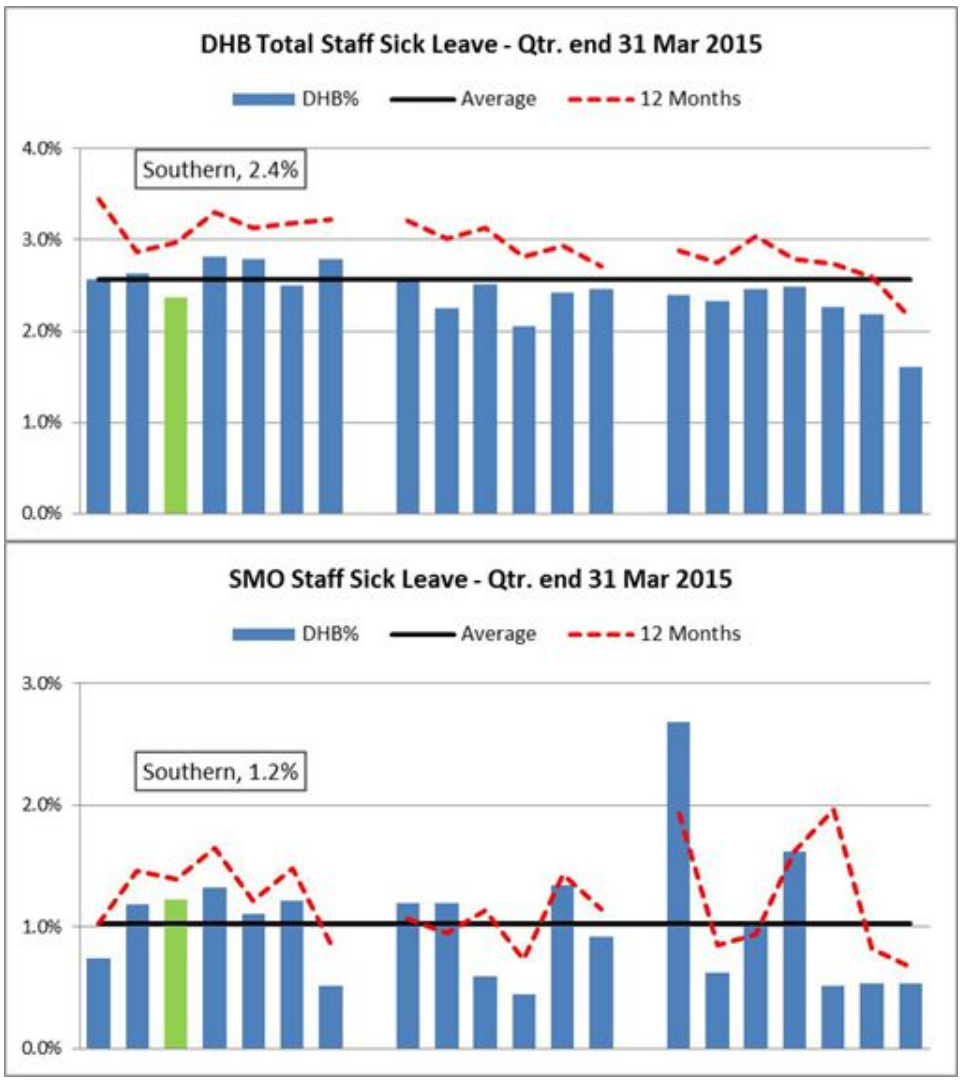


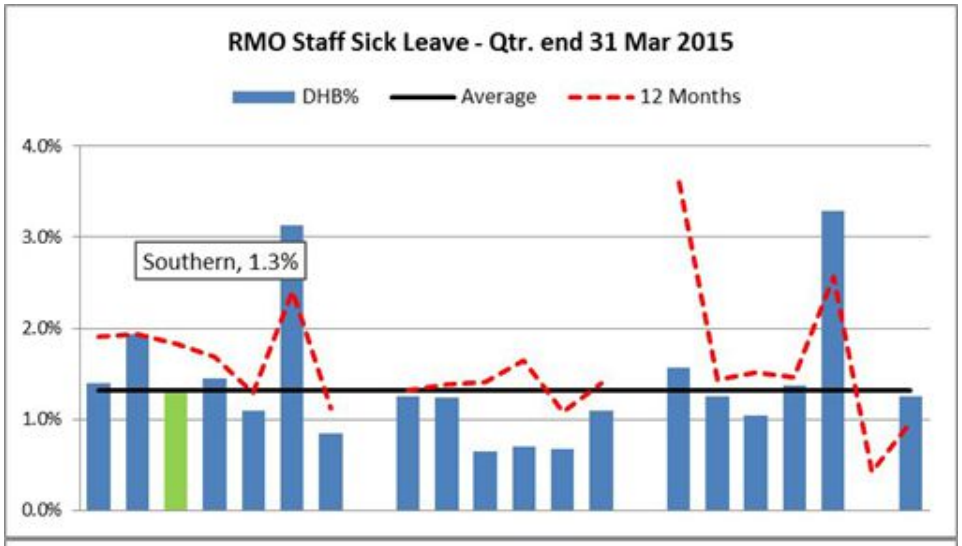
b) Lost time injury claims

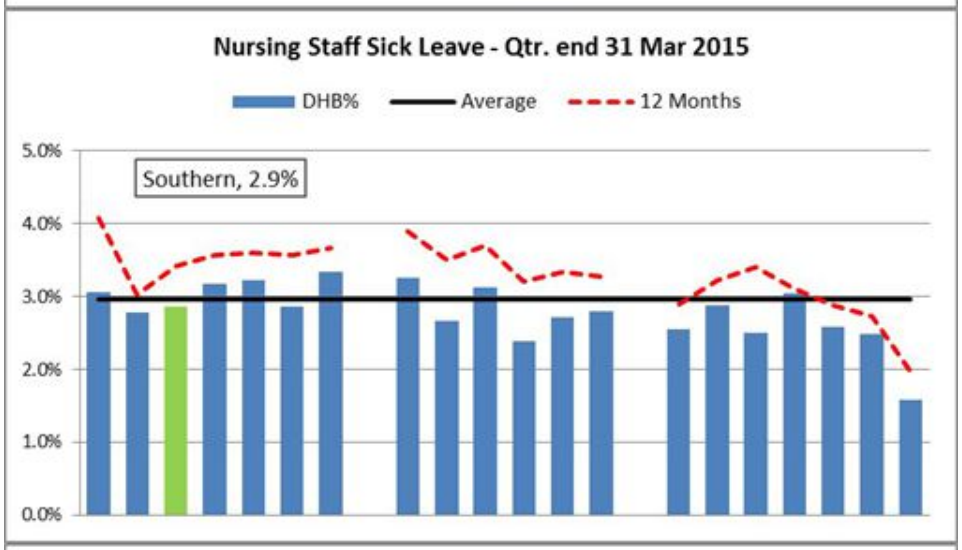


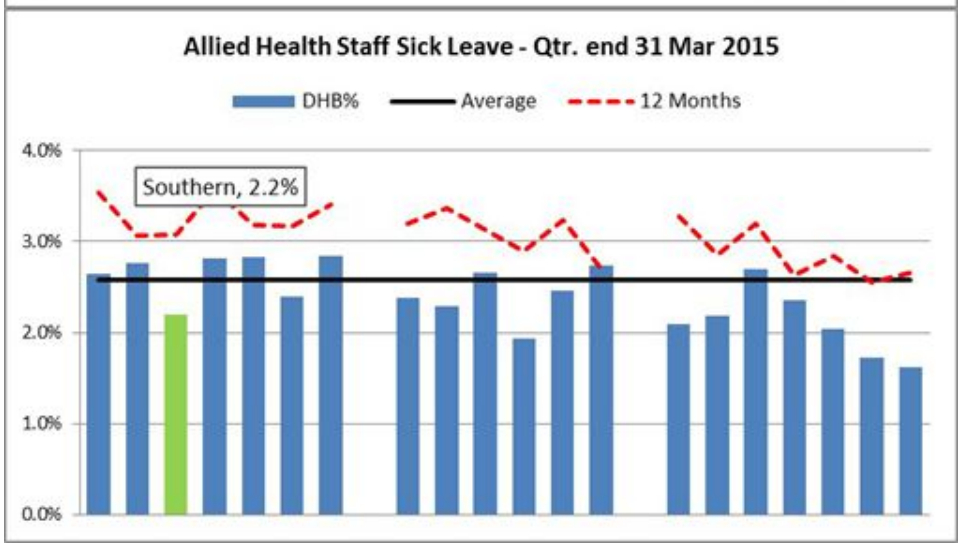
District: Total number work-related ACC claims: March 2015: 20 April 2015: 22
District: Total number <u>time-lost claims:</u> March 2015: 3 April 2015: 3

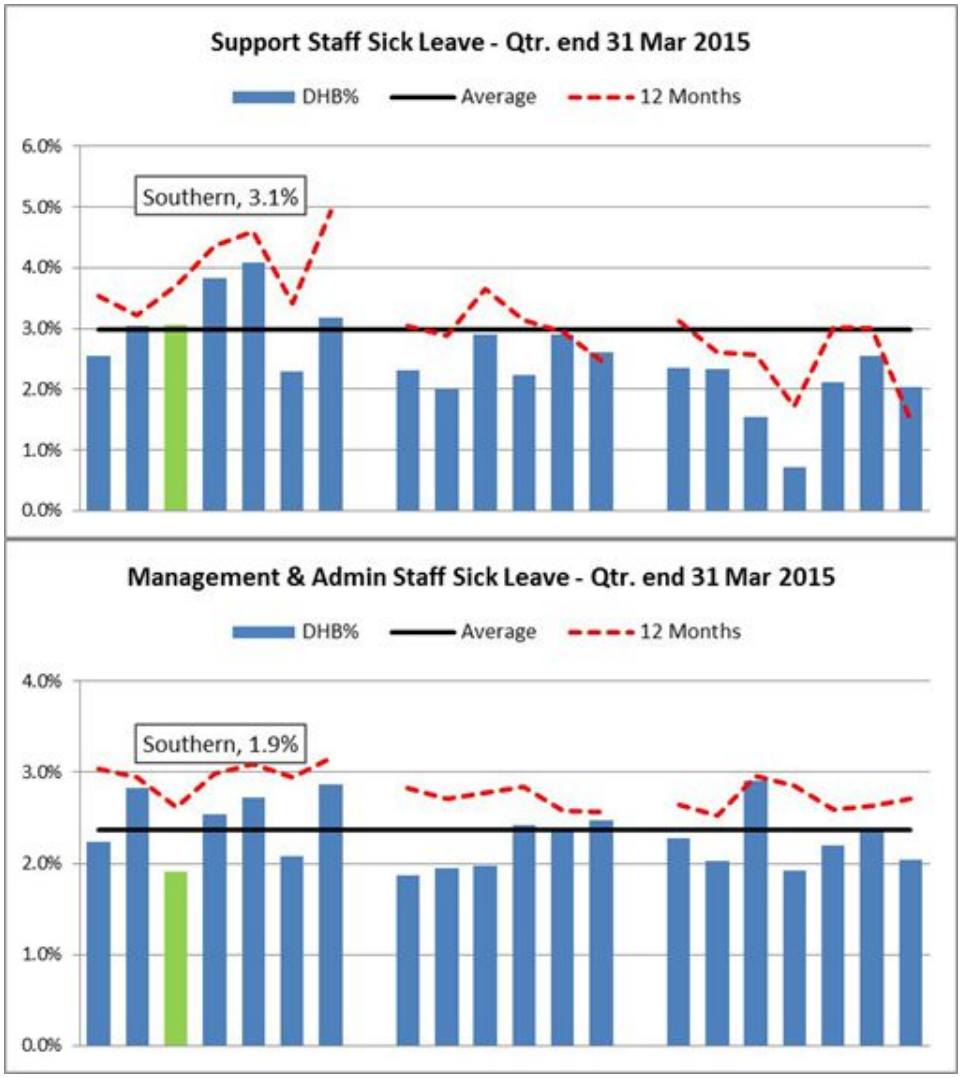
Sick Leave Comparison with other DHBs




RMO Staff Sick Leave - Qtr. end 31 Mar 2015
DHB%
Average
12 Months
4.0%
3.0%
2.0%
1.0%
0.0%
Southern, 1.3%

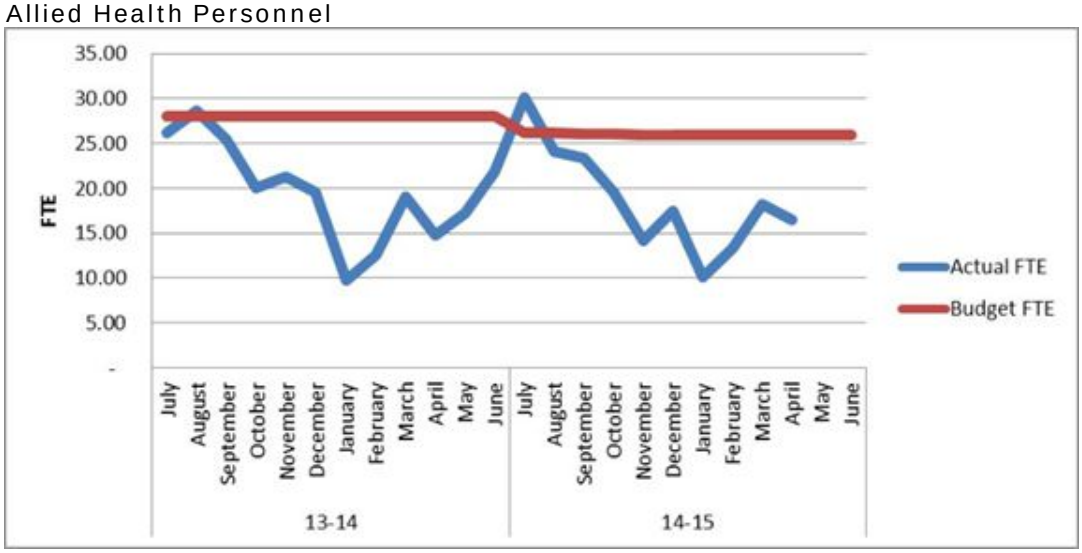

Nursing Staff Sick Leave - Qtr. end 31 Mar 2015
DHB%
Average
12 Months
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Southern, 2.9%


Allied Health Staff Sick Leave - Qtr. end 31 Mar 2015
DHB%
Average
12 Months
4.0%
3.0%
2.0%
1.0%
0.0%
Southern, 2.2%

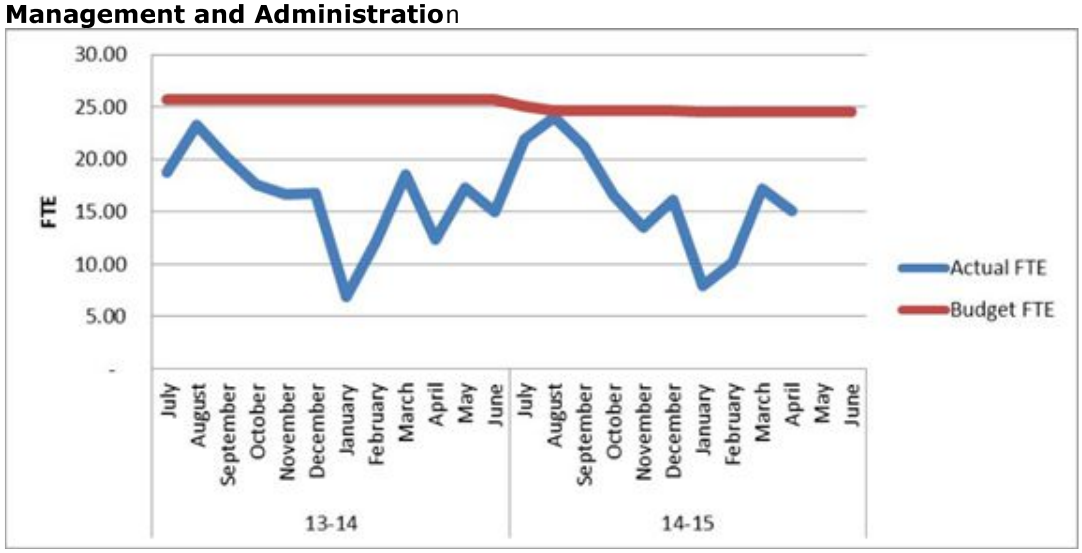

Support Staff Sick Leave - Qtr. end 31 Mar 2015
DHB%
Average
12 Months
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Southern, 3.1%
Management & Admin Staff Sick Leave - Qtr. end 31 Mar 2015
DHB%
Average
12 Months
4.0%
3.0%
2.0%
1.0%
0.0%
Southern, 1.9%

Southern DHB Sick Leave by Occupation Group

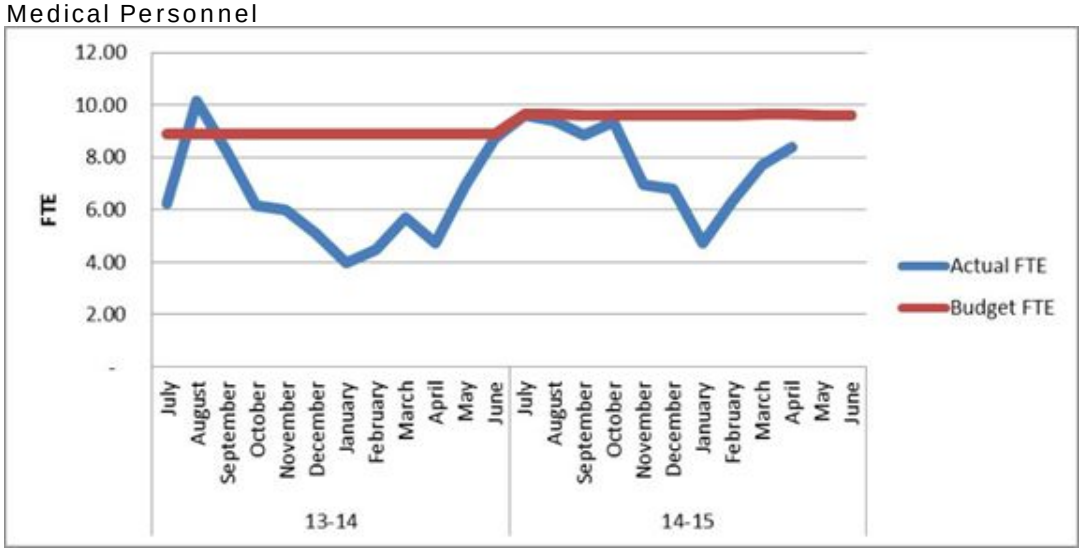
Allied Health Personnel



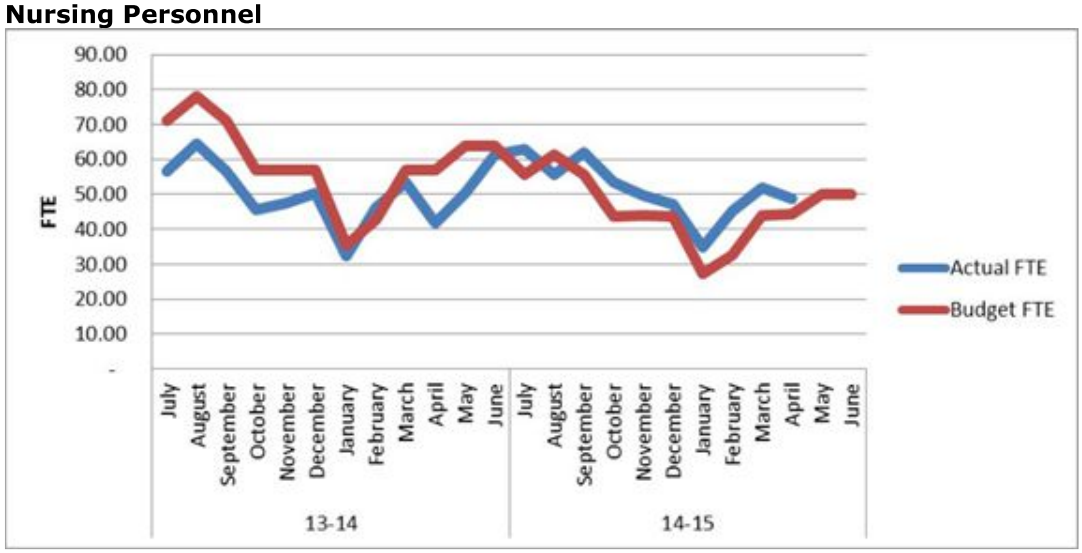
Management and Administration



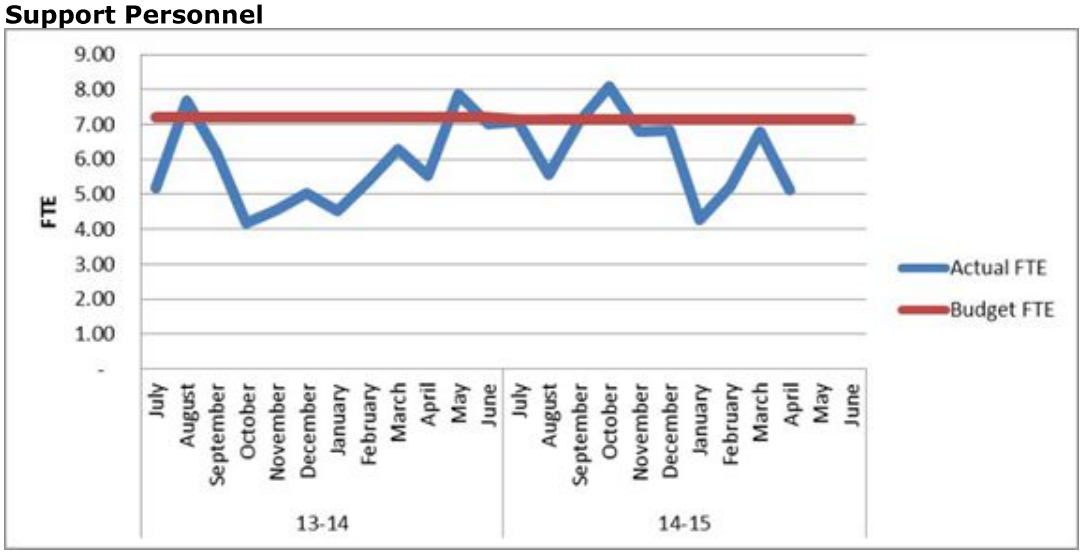
Medical Personnel



Nursing Personnel



Support Personnel



SOUTHERN DISTRICT HEALTH BOARD

Title:	Information Services - Service Level Alliance
Report to:	Hospital Advisory Committee
Date of Meeting:	03 June 2015

Summary:

Considered in these papers are:

- April 2015 DHB activity.

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

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

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

Prepared by: John Simpson Director of Information Services Date: 11/05/2015	Presented by: Lexie O'Shea Executive Director of Patient Services

RECOMMENDATION:

That the Committee receive the report.

April 2015

Information Services - Service Level Alliance Dashboard

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* *Executive Sponsor identified* *Wider Clinical and business engagement now required (priority)* *DHB communications required (priority)* *Tracking to September go live – Risk this starts to be impacted by PICS software delivery*
HCS - NMDHB			✓		*Implementation progressing to a go live August / September.*
WCDHB Mental health Module	✓				Base module - Completed A new scope of works has been approved to decouple integration from WCDHB iPM PAS system, work is on going Product stabilisation in progress Engagement with Mid Central regards overall regional functionality in progress, project start commenced
HealthOne (formally eSCRV)			✓		Business Case financials have been reviewed in detail due to the financial restraints with this year's health budgets SCDHB have declined for 2015-16 financial year due to costs Business case shared with SI CFO's and CIO's for approval Business shared with NHITB for feedback
eReferrals			✓		Stage 1 – Moving into project closure stage Stage 2 - CDHB, WCDHB, SCDHB pending break glass solution for sensitive referrals, due in HCS release 36 May 2015 Stage 2 - SDHB / NMDHB will follow HCS implementations Stage 3 - Orion's eTriage HCS module due for release into test project space end May 2015 Pilot expected to commence August / September 15
Meds Mgt SDHB - MedChart			✓		SDHB – ICU deployment has been completed CDHB – Deployment of Older Persons Health is expected by end May 2015 SCDHB – Southern DHB team continue to provide

April 2015

Information Services - Service Level Alliance Dashboard

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	
					training for end users ready for go live Expected go live at SCDHB end May / early June 2015, this will be a first for MedChart by providing cross boundary functionality. WCDHB – Capital planning has been completed to budget for both ePharmacy and MedChart, team yet to engage NMDHB – Capital planning has been completed to budget for both ePharmacy and MedChart, discussions commenced ePharmacy – Monitoring Midland implementation Progressing the development of the SI business case for ePhamacy
CDR8				✓	Upgrade of CDR completed
SI Patient Administration System			✓		April software delivery was not achieved Additional development identified which has impacted the delivery dates for the programme Programme team working through the mitigations with the Senior Responsible Officer (Nigel Trainor) Independent Quality Assurance vendor selected and engaged with the programme CDHB Programme Manager leaving in May
Provation			✓		SCDHB – Project in progress, tracking to revised delivery timescales Some issues identified
National Titanium		✓			DHBs have completed sign up, development is slow from the vendor
National Maternity System			✓		SCDHB – Live SDHB, WCDHB, CDHB & 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 – The MoH has advised that three South Island DHBs still to complete, IS SLA has been contacted to follow up. SDHB has completed Stage 1 to MoH requirements.
eProSafe				✓	Regional solution now live and in use across all SI DHBs
Regional Clinical Data			✓		In progress, will be incorporated within the

April 2015

Information Services - Service Level Alliance Dashboard

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	
Repository – TestSafe South (éclair)					overall HCS programme for SDHB Architecture issues identified and under action
eOrders - CDHB			✓		Radiology orders live in CDHB (pilot) Labs orders project has commenced
Growth Weight Charts	✓				SDHB Solution for growth charts has been approved as the preferred regional solution Project start up to be commenced
RL6 Regional Incident Management System			✓		4 of 5 DHBs live with the solution SCDHB scheduled for implementation starting July 2015
SCN – MDM Video conferencing Solution				✓	Completed
SCN - Metriq				✓	Completed
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. 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 completed in CDHB

April 2015

Information Services - Service Level Alliance Dashboard

KEY PROJECTS / ACTIVITY AREAS 2014/15	PROGRESS				COMMENT
	Scoping	Behind	On Track	Completed	
					Programme Manager reviewing vendor options
Advanced Care Plan / Long Term Care Planning	✓				National project team scheduled to meet in May National template to be approved
Regional eLearning Application	✓				South Island strategic direction agreed Business Case under development
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			✓		Options paper to be presented to SPAiT
National Data Centre (NIP)			✓		National Business Case with DHB's for approval Engagement with DHBs commenced
TeleHealth	✓				Meeting scheduled for May 2015 to commence discussion and agree actions to progress
Mobility	✓				Draft strategic paper shared by CDHB with SI CIOs to agree a regional strategy
National Trauma Registry	✓				Requirements gathering to be actioned – owned outside of the IS SLA
Regional Data Warehouse	✓				CDHB and NMDHB to utilise the existing data warehouse capabilities
Regional Ministry Extract	✓				Concept – raised with IS SLA (SI PICS related)

Acronyms

IS SLA	Information Services Service Level Alliance
CDR8	Central Data Repository version 8
ALT	Alliance Leadership Team
RCIC	Regional Capital and Investments Committee
NHITB	National Health Information Technology Board
SDHB	Southern District Health Board
NMDHB	Nelson Marlborough District Health Board
SCDHB	South Canterbury District Health Board
WCDHB	West Coast District Health Board
CDHB	Canterbury District Health Board
EMT	Executive Management Team

April 2015

Information Services - Service Level Alliance Dashboard

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

HOPSLA	The Health of Older People Service Level Alliance
SCN	Southern Cancer Network
HCS	Health Connect South system
eSCRV	Electronic Shared Care Record system
eReferrals	Electronic Referrals system
eTriage	Electronic Referrals Triage system
Meds Mgt	Safe Medications Management systems
SaaS	Software as a Service

SOUTHERN DISTRICT HEALTH BOARD

Title:	Post Project Review Master Site Planning Stage 1 Spire Consulting Report
Report to:	Hospital Advisory Committee
Date of Meeting:	03 June 2015

Summary:

A post audit review has been completed on the master site planning project undertaken 2010-2013, this included the two priority clinical projects Acute Mental Health Inpatient Ward and the NICU/Paediatrics Ward, plus the Staff Cafeterias and other infrastructure / enabling works.

The author reviewed the project files and undertook site based interviews with both the clinical teams and the Building and Property Services (BPS) teams who undertook and managed the project.

7.8

The findings were:

In the author's experience, this is one of the best scoped, planned, communicated and delivered project programmes we have ever seen. The critical project success factors can be described as:

1. Quality of pre-project planning;
2. Commercial business case compilation;
3. Robust, comprehensive procurement programme;
4. Early customer engagement;
5. Committed suppliers, contractors and consultants;
6. Earlier contractor engagement;
7. Lean, effective project control managed by the Building and Property Services team;
8. Superb communication; and
9. Continuous feedback.

The lessons learnt should be applied for any further project programmes.

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

Financial:	Project was approved at $24.38m and the final spend was $12,458 under budget.
Workforce:	N/A
Other:	N/A

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

Prepared by: Warren Taylor, Facilities and Site Development Manager Date: 20/05/2015	Presented by: Lexie O'Shea, Executive Director Patient Services

RECOMMENDATION:

1. That the Committee receive the report.