SOUTHERN DISTRICT HEALTH BOARD

HOSPITAL ADVISORY COMMITTEE

Monday, 07 September 2020

Commencing at 1:30pm

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

A G E N D A

Lead Director: Patrick Ng, Executive Director Specialist Services

Item

1. **Apologies**
2. **Interests Register**
3. **Minutes of the Previous Meeting**
4. **Matters Arising/Action Sheet**
5. **Valuing Patient Time update (Jane Wilson, Director of Nursing and Midwifery and Dr Nigel Millar, Chief Medical Officer)** (*1.40 – 2.10*)
6. **A journey towards integration: a model of care for patients with rheumatological conditions (Dr Jo Mitchell, Rheumatologist)** (*2.10 – 2.40*)
7. **Tele-Health. Progress and approach (Simon Donlevy- General Manager, Medicine Women's and Children, Professor Patrick Manning- Specialist, Endocrinology Miranda Buhler- Physiotherapist)** (*2.40 – 3.10*)
8. **Specialist Services Monitoring and Performance Reports**
   - 8.1 Executive Director of Specialist Services Report
   - 8.2 Financial Performance Summary
   - 8.3 Surgical Services and Radiology Directorate – Special Report on Clinical Supplies Variances for July 2020
9. **Resolution to Exclude Public**

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

No apologies noted at the time of uploading the agenda.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**INTERESTS REGISTERS**
Report to:	Hospital Advisory Committee
Date of Meeting:	7 September 2020

Summary:

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

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

Additions to Interests Registers over the last month:

- Moana Theodore and Roger Jarrold's entries updated.

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

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

Prepared by:

Jeanette Kloosterman
Board Secretary

Date: 27/08/2020

RECOMMENDATION:

1. That the Interests Registers be received and noted.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Dave Cull (Board Chair)	09.12.2019	Daughter-in-law employed as a nurse by Southern DHB		
	25.02.2020	Board Member, Cosy Homes Trust		
	25.02.2020	President, Local Government New Zealand (until July 2020)		
	25.02.2020	Trustee, Weller Trust (Property investment)		
	25.02.2020	Director, Popaway Ltd (Property investment)		
David Perez (Deputy Chair)	13.05.2019	Director, Mercy Hospital, Dunedin	SDHB holds contracts with Mercy Hospital.	Step aside from decision making.
	13.05.2019	Fellow, Royal Australasian College of Physicians		
	13.05.2019	Trustee for several private trusts		
Ilka Beekhuis	09.12.2019	Patient Advisor, Primary Birthing FiT Group for Dunedin Hospital Rebuild		
	09.12.2019	Member, Otago Property Investors Association		
	09.12.2019	Secretary, Spokes Dunedin (cycling advocacy group)		
	15.01.2019	Paid member, Green Party		
	15.01.2019	Former employee of University of Otago (April 2012-February 2020)		
	07.07.2020	Trustee, HealthCare Otago Charitable Trust		
John Chambers	09.12.2019	Employed as an Emergency Medicine Specialist, Dunedin Hospital		
	09.12.2019	Employed as Honorary Senior Clinical Lecturer, Dunedin School of Medicine	Possible conflicts between SDHB and University interests.	
	09.12.2019	Elected Vice President, Otago Branch, Association of Salaried Medical Specialists	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.	
	09.12.2019	Wife is employed as Co-ordinator, National Immunisation Register for Southern DHB		
	09.12.2019	Daughter is employed as MRT, Dunedin Hospital		
Kaye Crowther	09.12.2019	Life Member, Plunket Trust	Nil	
	09.12.2019	Trustee, No 10 Youth One Stop Shop	Possible conflict with funding requests.	
	09.12.2019	Employee, Findex NZ		
	14.01.2020	Trustee, Director/Secretary, Rotary Club of Invercargill South and Charitable Trust		
	14.01.2020	Member, National Council of Women, Southland Branch		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Lyndell Kelly	09.12.2019	Employed as Specialist, Radiation Oncology, Southern DHB	Involved in Oncology job size and service size exercise and may be involved in employment contract negotiations with Southern DHB.	
	18.01.2020	Honorary Senior Lecturer, Otago University School of Medicine		
	18.01.2020	Daughter is Medical Student at Dunedin Hospital		
Terry King	28.01.2020	Member, Grey Power Southland Association Inc Executive Committee		
	28.01.2020	Life Member, Grey Power NZ Federation Inc		
	28.01.2020	Member, Southland Iwi Community Panel	ICP is a community-led alternative to court for low-level offenders. The service is provided by Nga Kete Matauranga Pounamu Charitable Trust in partnership with police, local iwi and the wider community.	
	14.02.2020	Receive personal treatment from SDHB clinicians and allied health.		
	03.04.2020	Client, Royal District Nursing Service NZ Ltd		
Jean O'Callaghan	13.05.2019	Employee of Geneva Health	Provides care in the community; supports one long term client but has no financial or management input.	
	13.05.2019	St John Volunteer, Lakes District Hospital	No involvement in any decision making.	~~Taking six months' leave.~~ Recommencing 22.08.2020.
Tuari Potiki	09.12.2019	Employee, Otago University		
	09.12.2019	Chair, NZ Drug Foundation		
	09.12.2019	Chair, Te Rūnaka Ōtākou Ltd*		
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	09.12.2019	*Shareholder in Te Kaika		
Lesley Soper	09.12.2019	Elected Member, Invercargill City Council		
	09.12.2019	Board Member, Southland Warm Homes Trust		
	09.12.2019	Employee, Southland ACC Advocacy Trust		
	16.01.2020	Chair, Breathing Space Southland (Emergency Housing)		
	16.01.2020	Trust Secretary/Treasurer, Omaui Tracks Trust		
	19.03.2020	Niece, Civil Engineer, Holmes Consulting	Holmes Consulting may do some work on new Dunedin Hospital.	
	21.07.2020	Trustee, Food Rescue Trust		
	21.07.2020	Shareholder 1%, Piermont Holdings ltd	Coporate Body for apartment, Wellington	
Moana Theodore	15.01.2019	Employee, University of Otago		
	15.01.2019	Co-director, National Centre for Lifecourse Research, University of Otago		
	15.01.2019	Member, Royal Society Te Apārangi Council		
	15.01.2019	Sister-in-law, Employee of SDHB (Clinical Nurse Specialist Acute Mental Health)		
	15.01.2019	Shareholder, RST Ventures Limited		
	27.04.2020	Nephew, Casual Mental Health Assistant, Southern DHB (Wakari)		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	17.08.2020	Health Research Council Fellow		
Andrew Connolly (Crown Monitor)	21.01.2020	Employee, Counties Manukau DHB		
	21.01.2020	Deputy Commissioner, Waikato DHB		
	21.01.2020	Southern Partnership Group		
	21.01.2020	Health Quality and Safety Commission		
	21.01.2020	Health Workforce Advisory Board		
	21.01.2020	Fellow Royal Australasian College of Surgeons		
	21.01.2020	Member, NZ Association of General Surgeons		
	21.01.2020	Member, ASMS		
	05.05.2020	Member, Ministry of Health's Planned Care Advisory Group	Will be monitoring planned care recovery programmes.	
Roger Jarrold (Crown Monitor)	16.01.2020	CFO, Fletcher Construction Company Limited	Have had interaction with CEO of Warren and Mahoney, head designers for ICU upgrade.	
	16.01.2020	Member, Audit and Risk Committee, Health Research Council		
	16.01.2020	Trustee, Auckland District Health Board A+ Charitable Trust		
	16.01.2020	Former Member of Ministry of Health Audit Committee and Capital & Coast District Health Board		
	23.01.2020	Nephew - Partner, Deloitte, Christchurch		
	16.08.2020	Son - Auditor, PwC, Auckland	PwC periodically undertake work for SDHB, eg valuations	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

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

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
Kaye CHEETHAM	~~08.07.2019~~	~~Ministry of Health Appointed Member of the Occupational Therapy Board~~	(05/08/2020 - Stood down from the Occupational Therapy Board)
Mike COLLINS	15.09.2016	Wife, NICU Nurse	
	01.07.2019	Capable NZ Assessor	Asked from time to time to assess students, bachelor and masters students final presentation for Capable NZ.
	21.05.2020	Director, New Zealand Institute of Skills and Technology	
Matapura ELLISON	12.02.2018	Director, Otākou Health Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
	12.02.2018	Deputy Kaiwhakahaere, Te Rūnanga o Ngai Tahu	Nil
	12.02.2018	Chairperson, Kati Huirapa Rūnaka ki Puketeraki (Note: Kāti Huirapa Rūnaka ki Puketeraki Inc owns Pūketeraki Ltd - 100% share).	Nil
	12.02.2018	Trustee, Araiteuru Kokiri Trust	Nil
	12.02.2018	National Māori Equity Group (National Screening Unit)	
	12.02.2018	SDHB Child and Youth Health Service Level Alliance Team	
	12.02.2018	Otago Museum Māori Advisory Committee	Nil
	12.02.2018	Trustee, Section 20, BLK 12 Church & Hall Trust	Nil
	12.02.2018	Trustee, Waikouaiti Maori Foreshore Reserve Trust	Nil
	29.05.2018	Director & Shareholder (jointly held) - Arai Te Uru Whare Hauora Ltd	Possible conflict when contracts with Southern DHB come up for renewal.
Chris FLEMING	25.09.2016	Lead Chief Executive for Health of Older People, both nationally and for the South Island	
	25.09.2016	Chair, South Island Alliance Leadership Team	
	25.09.2016	Lead Chief Executive South Island Palliative Care Workstream	

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	25.09.2016	Deputy Chair, InterRAI NZ	
	10.02.2017	Director, South Island Shared Service Agency	Shelf company owned by South Island DHBs
	10.02.2017	Director & Shareholder, Carlisle Hobson Properties Ltd	Nil
	26.10.2017	Nephew, Tax Advisor, Treasury	
	18.12.2017	Ex-officio Member, Southern Partnership Group	
	30.01.2018	CostPro (costing tool)	Developer is a personal friend.
	30.01.2018	Francis Group	Sister is a consultant with the Francis Group.
	20.02.2020	Member, Otago Aero Club	Shares space with rescue helicopter.
Lisa GESTRO	06.06.2018	Lead GM National Travel and Accommodation Programme	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	NASO Governance Group Member	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
	04.04.2019	Lead GM Perinatal Pathology	This group works on behalf of all DHBs nationally and may not align with SDHB on occasions.
Nigel MILLAR	04.07.2016	Member of South Island IS Alliance group	This group works on behalf of all the SI DHBs and may not align with the SDHB on occasions.
	04.07.2016	Fellow of the Royal Australasian College of Physicians	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	Fellow of the Royal Australasian College of Medical Administrators	Obligations to the College may conflict on occasion where the college for example reviews training in services.
	04.07.2016	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	29.05.2018	Council Member of Otago Medical Research Foundation Incorporated	
	12.12.2019	Daughter employed by Harrison-Grierson	A NZ construction and civil engineering consultancy - may be involved in tenders for DHB or new Dunedin Hospital rebuild work
Nicola MUTCH		Chair, Dunedin Fringe Trust	Nil

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	02.04.2019	Husband - Registrar and Secretary to the Council, Vice-Chancellor's Advisory Group, University of Otago	Possible conflict relating to matters of policies, partnership or governance with the University of Otago.
Patrick NG	17.11.2017	Member, SI IS SLA	Nil
	~~17.11.2017~~	~~Wife works for key technology supplier CCL~~	~~Nil~~
	18.12.2017	Daughter, medical student at Auckland University.	
	23.07.2020	Wife, Chief Data Architect, Inde Technology	
Julie RICKMAN	31.10.2017	Director, JER Limited	Nil, own consulting company
	31.10.2017	Director, Joyce & Mervyn Leach Trust Trustee Company Limited	Nil, Trustee
	31.10.2017	Trustee, The Julie Rickman Trust	Nil, own trust
	31.10.2017	Trustee, M R & S L Burnell Trust	Nil, sister's family trust
	23.10.2018	Shareholder and Director, Barr Burgess & Stewart Limited	Accounting services
		Specified contractor for JER Limited in respect of:	
	31.10.2017	H G Leach Company Limited to termination	Nil, Quarry and Contracting.
	21.10.2019	Member, Chartered Accountants Advisory Group	
Gilbert TAURUA	05.12.2018	Prostate Cancer Outcomes Registry (New Zealand) - Steering Committee	Nil
	05.04.2019	South Island HepC Steering Group	Nil
	03.05.2019	Member of WellSouth's Senior Management Team	Reports to Chief Executives of SDHB and WellSouth.
Gail THOMSON	19.10.2018	Member Chartered Management Institute UK	Nil
	22.11.2019	Deputy Chair Otago Civil Defence Emergency Management Group, Coordinating Executive Group	
Jane WILSON	16.08.2017	Member of New Zealand Nurses Organisation (NZNO)	No perceived conflict. Member for the purposes of indemnity cover.

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
EXECUTIVE LEADERSHIP TEAM

Employee Name	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern District Health Board
	16.08.2017	Member of College of Nurses Aotearoa (NZ) Inc.	Professional membership.
	16.08.2017	Husband - Consultant Radiologist employed fulltime by Southern DHB and currently Clinical Leader Radiology, Otago site.	Possible conflict with any negotiations regarding new or existing radiology service contracts. Possible conflict between Southern DHB and SMO employment issues.
	16.08.2017	Member National Lead Directors of Nursing and Nurse Executives of New Zealand.	Nil

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER
HOSPITAL ADVISORY COMMITTEE EXTERNAL APPOINTEES

Committee Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
Justine CAMP	31.01.2017	Research Fellow - Dunedin School of Medicine - Better Start National Science Challenge	Nil	
IGC - Moeraki Rūnaka		Member - University of Otago (UoO) Treaty of Waitangi Committee and UoO Ngai Tahu Research Consultation Committee	Nil	
		Member - Dunedin City Council - Creative Partnership Dunedin	Nil	
		Moana Moko - Māori Art Gallery/Ta Moko Studio - looking at Whānau Ora funding and other funding in health setting	Possible conflict with funding in health setting.	

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 6 July 2020, commencing at 1.30 pm in the Board Room, Wakari Hospital Campus, Dunedin

Present:	Dr David Perez	Chair
	Mrs Jean O'Callaghan	Deputy Chair *(by Zoom)*
	Dr John Chambers	Committee Member
	Mr Dave Cull	Committee Member
	Dr Lyndell Kelly	Committee Member
	Dr Moana Theodore	Committee Member
In Attendance:	Mrs Kaye Crowther	Board Member
	Mr Terry King	Board Member
	Mr Andrew Connolly	Crown Monitor *(by Zoom)*
	Mr Chris Fleming	Chief Executive Officer
	Mr Patrick Ng	Executive Director Specialist Services
	Ms Janine Cochrane	General Manager, Surgical Services and Radiology *(until 4.11 pm)*
	Mrs Lisa Gestro	Executive Director Strategy, Primary and Community *(until 4.00 pm)*
	Dr Nigel Millar	Chief Medical Officer
	Dr Nicola Mutch	Executive Director Communications
	Mr Gilbert Taurua	Chief Māori Health Strategy and Improvement Officer
	Mrs Jane Wilson	Chief Nursing and Midwifery Officer
	Ms Jeanette Kloosterman	Board Secretary

1.0 WELCOME

The Chair welcomed everyone to the meeting.

2.0 APOLOGIES

Apologies were received from Miss Lesley Soper, Committee Member, Mr Roger Jarrold, Crown Monitor, and Ms Kaye Cheetham, Chief Allied Health, Scientific and Technical Officer.

3.0 PREVIOUS MINUTES

***It was resolved**:*

"That the minutes of the meeting held on 2 March 2020 be approved and adopted as a true and correct record."

D Perez/D Cull

4.0 MATTERS ARISING

Fifth Operating Theatre, Southland Hospital

The Executive Director Specialist Services (EDSS) reported that a fifth operating theatre at Southland Hospital was subject to a business case, which was being worked up. The CEO advised that the additional theatre was not on the 2020/21 capital plan, so would only be recommended if it made sense financially, ie by bringing outsourcing back in.

5.0 VALUING PATIENTS' TIME

Mrs Jane Wilson, Chief Nursing and Midwifery Officer, Dr Nigel Millar, Chief Medical Officer, Ms Gail Thomson, Executive Director Quality and Clinical Governance Solutions (EDQ&CGS), and Dr Hywel Lloyd, Medical Director, Strategy Primary and Community, presented an overview of *Valuing Patients' Time (VPT)* Acute Patient Flow Programme, with a focus on the Emergency Department, General Medicine, Red2Green, and Older Persons' Health workstreams, which were aimed at achieving shorter stays in ED, reduced length of stay, reduced stranded patients, reduced occupancy, and improved patient experience (tab 9).

The Committee was informed that the VPT concept was based on improving patient flow by avoiding processes that waste patients' time. The Older Peoples Assessment Liaison (OPAL) Unit was outlined as an example of this.

In concluding the presentation, management advised that the future focus would be on:

- Joining up the whole system (VPT had been very hospital centric to date);
- Health pathways to complement the programme;
- Continuing and spreading the culture of improvement.

Management then answered questions from members on the programme, including the obstacles encountered, investment in the programme, ED waiting times, and the criteria for the OPAL Unit.

The Hospital Advisory Committee thanked the team for their presentation and expressed its support for:

- An acute medical assessment unit, and
- The further development of engagement across all staff groups.

6.0 TERMS OF REFERENCE

The Committee reviewed its terms of reference (tab 4) and requested that point 5 under "Responsibilities" be amended to reflect that the Committee's role is advisory and the executive is accountable for managing clinical and operational risks.

***It was resolved**:*

> **"That, with the above amendment, the Committee recommend the Board approve its revised terms of reference."**

7.0 DECLARATION OF INTERESTS

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

The Chair asked for any changes to the registers to be sent to the Board Secretary and reminded everyone of their obligation to advise the meeting should any potential conflict arise during discussions.

It was resolved:

"That the Interests Registers be received and noted."

8.0 MATTERS ARISING/REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 6).

Nitrous Oxide Usage

The Committee noted that there did not appear to be any leaks in the nitrous oxide system and requested that management investigate why Southern DHB was an outlier in its nitrous oxide usage rate.

9.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Executive Director Specialist Services' Report

The Executive Director Specialist Services (EDSS)' monthly report (tab 7.1) was taken as read and the EDSS drew the Committee's attention to the following items.

Reporting Format

The EDSS informed the Committee that the commentary in his report had been aligned with the Ministry of Health's key operational performance measures and dashboard graphs would be added as they were developed.

Equity

Reporting was being developed to identify the proportion of Māori and Pasifika referrals received to ensure that these were consistent with population cohorts. Specialist Services would work alongside the Māori Health Directorate and/or Pasifika health experts to address any outliers.

Case Weights and Discharges

The EDSS advised that his report covered the month of May, which was characterised by ramping up activity again after COVID-19 level 3 and 2 alert levels. Theatres were back in full production and some outsourcing and weekend lists were being undertaken, so by the end of June 2020 it was expected that about 200 case weights would be recovered.

Emergency Department (ED), 6 Hour Target and Generalism

The business case for Generalism and a Medical Assessment Unit, to improve flow in ED, should be completed within the next four weeks.

Cancer Treatment Within 31 Days

A dashboard was being developed for this target, which would be an important step in making the pinch points visible.

First Specialist Assessments Within Four Months

The EDSS advised that one of the most important initiatives for achieving this target was implementation of the Ministry of Health's prioritisation tool and outlined the process that had been followed to implement that in various services.

Elective Treatment Within Four Months

The EDSS noted that there had been a further deterioration in patients waiting for surgery during the COVID-19 pandemic response.

Medical Imaging, CT and MRI

The EDSS reported that:

- The initiative approved by the Board for additional CT resources was being worked on and there had been some success in recruiting CT staff;
- The Ministry had made some short term funding available to DHBs and Southern DHB had received $250,000 from that fund;
- The annual IANZ audit had gone well.

Key Building Projects

The EDSS reported that finding a solution for the Intensive Care Unit (ICU) air handling system was receiving an intensive focus. To address this issue, a separate piece of work to design specific plant for the ICU was being commissioned, alongside the work being undertaken to get the existing plant to work. A report and recommendations would be submitted to the Finance, Audit and Risk Committee.

Movement of Activity from Secondary to Primary Care

An opportunity had been identified to shift 30-45% of skin lesion removals undertaken by the Ear Nose and Throat (ENT) service to primary care. This would enable the service to catch up on some of its backlog.

The EDSS advised that services that were free when performed in the secondary care setting would continue to be free when transferred to primary care.

Performance Indicators

The Chair encouraged members to raise any areas they thought should be added to the hospital performance dashboards.

It was agreed that Mental Health discharge planning and diabetes management would be reported to the Community and Public Health Advisory Committee.

Gastroenterology

The EDSS reported that a dashboard was being developed to measure gastroenterology performance. A pathway had been put in place in Dunedin to recover performance to pre-COVID levels and achieve Ministry of Health targets by early August 2020. Work was ongoing to determine what was required to get Southland caught up.

The overall participation rate for Southern in the bowel screening programme was 70%, against a national average of 63%. The participation rate for Māori in Southern DHB was 72%.

It was noted that gastroenterology would be further discussed at the Board meeting the following day.

Recovery (Improvement) Planning for Planned Care

The EDSS informed the Committee that planned care improvement was focused on overall hospital performance, not just catching up on activity lost due to the COVID-19 pandemic, so a much wider improvement plan was needed to achieve revenue. The Ministry of Health had budgeted $282m over three years for this across the health sector.

As well as reducing waiting lists, the EDSS advised that mechanisms needed to be put in place to enable sustainability to prevent future backlogs.

Clerical and Administration Transformation

The EDSS presented an update on hospital administration processes and the opportunity to make improvements from the introduction of the electronic referral management system (ERMS), electronic referral triaging (e-triage), new transcription software, paper-lite initiatives, and the pending Patient Information Care System (PICS) project (tab 6).

It was noted that the PICS business case would be considered by the Board the following day.

Hospital Response to COVID-19 and Opportunities Identified Post COVID-19

The Committee received a presentation from Dr Janine Cochrane, General Manager Surgical Services and Radiology, on reflections and learnings from the hospital response to the COVID-19 pandemic, and the impact of the pandemic on cancer waiting times and inequities (tab 7).

Productive changes during the lockdown period included: regular co-ordination sessions involving multiple services, seven day availability of allied health services, telehealth delivery of outpatient consultations, and streamlining of hospital pathways for cancer services. A fuller presentation on telehealth will be on the agenda for the next HAC meeting.

The Executive Director Strategy, Primary and Community left the meeting at 4.00 pm.

Management then took questions from members on the response and the opportunities for improvement.

Dr Cochrane was thanked for her presentation and left the meeting at 4.11 pm.

Financial Performance Summary

The EDSS presented the May 2020 financial results for Specialist Services (tab 7.2)

Measurement of Need

The Committee considered a report comparing Southern DHB's standardised intervention rates for each surgical category with national intervention rates (tab 6) and agreed to continue the discussion at the next meeting.

***It was resolved**:*

"That the reports be noted."

CONFIDENTIAL SESSION

At 4.17 pm it was resolved that the Hospital Advisory Committee move into committee to consider the agenda items listed below.

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

Confirmed as a true and correct record:

Chair: _____

Date: _____

Southern District Health Board
HOSPITAL ADVISORY COMMITTEE
ACTION SHEET

As at 28 August 2020

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Sept 2019	**Nitrous Oxide Usage** (Minute item 5.0)	Information to be provided on SDHB's high use of nitrous oxide.	EDSS/ EDFP&F		
Mar 2020	(Minute item 5.0)	Outcome of investigation to be reported back to HAC.	EDSS	The Building and property team have been systematically testing the system over the past year and have completed the checks as per the diagram (attached to the action sheet). We have also checked the outlets and done some washer replacements at the same time. The colour coding and key shows the process and has subsequently proven the integrity of the pipework. The recommendation is to proceed from the fixed pipework out onto the next part of the chain which is the equipment being connected to the pipes/outlets.	
July 2020	(Minute item 8.0)	Management to investigate why Southern DHB is an outlier.	EDSS	An updated report prepared by Dr M Jenks, Specialist Anaesthetist on 13	Complete

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
				April 2020 confirmed there has been a reduction of 1301 tonnes of Nitrous Oxide N20), which has mainly resulted from a drop in use of G cylinders piped N20 at Dunedin Hospital.	
Mar 2020	**Telemedicine** (Minute item 6.0)	Reporting, including targets, to be submitted to the Committee.	EDSS/ EDSP&C	This will be discussed as part of the presentation (at the September meeting). Measures will be agreed and then reported on moving forward. Included in the September agenda.	On Agenda
Mar 2020	**Health Targets - Radiology**	Reporting to be expanded to include other modalities, eg ultrasonography.	EDSS	Noted, this report once created will be included in the EDSS monthly report ongoing.	Complete
July 2020	**Colonoscopy Services Recommendations** (Board minute item 5.0)	▪ HAC to keep a watching brief on progress. ▪ Management to advise when Southern's colonoscopy rate was likely to reach the national level.	Deputy CMO/ EDSS	Noted. Report to be provided to HAC.	September HAC meeting

Strategic Direction for Telehealth within the Southern District Health Board

7 May 2020

Author: Professor Patrick Manning
Endorsed by the Southern DHB Telehealth Steering Group

Executive Summary

In response to the COVID-19 outbreak the use of telehealth became essential for the continuation of the delivery of patient care and to minimise staff exposure to the virus. Telehealth had previously used in an ad hoc manner within the DHB with no standardisation or guidelines as to how it should be implemented or utilised. The requirement to use telehealth as a means of delivering care to patients during the COVID-19 outbreak effectively served as an enforced trial of utilising telehealth. Feedback from 'trial' this has more positive than anticipated. Telehealth has been met with a significant level of satisfaction from the clinicians involved and anecdotally from the patients too.

The current situation provides an opportunity to embrace telehealth and harness its full potential within the DHB. To do this a framework needs to be established to allow for the provision of optimal telehealth services.

Benefits to the DHB

1. In the pandemic situation it reduces the amount of time that a patient has to be removed from their "bubble", reduces the risk of COVID-19 entering the hospital, and reduces risk to staff by enabling them to work within their bubble.
2. Post – pandemic telehealth and in business as usual:
    a. improves access to care for all patients, especially in non-metropolitan areas within the DHB.
    b. removes boundaries between Southland and Otago and allows services to provide care across boundaries seamlessly.
    c. may be more cost – effective compared to usual outpatient care
    d. is more patient centred – bring care to the patient rather than the other way around
    e. reduces travel burden on patients and clinicians

What are the Critical Success Factors for Effective Telehealth Models of Care?

1. Clear Governance and strong leadership is essential
2. Patient focused and locally relevant
3. Telehealth must be integrated into "business as usual"
4. Technology must be accessible, reliable and easy to use and aligns with patient and clinical service needs
5. Service funding models do not act as disincentives to the uptake of telehealth
6. Supports a robust clinical care model and there is a clinical need

7. Staff must perceive a need to change to integrating telehealth into their practice and improves their provision of clinical care
8. Implementation is based on robust planning and effectiveness is based on robust monitoring.
9. Appropriate staff education is provided
10. Regulatory, medico-legal, ethical and privacy regulations are considered and adhered to.
11. Appropriate rules are developed to support appropriate use of telehealth
12. Flexible and adaptable models of telehealth exist to allow for differences in models of care for different services and changes to models of care in the future
13. Appropriate infrastructure exists to support telehealth - technical support and administrative support is available
14. Integration of data and information around a telehealth consult must be easily integrated into the electronic medical record

Considerations

Regulations, Standards and Guidelines

1. Medical Council of New Zealand – Statement on Telehealth (Updated March 2020)
2. Privacy Commissioner – Telecommunications Information Privacy Code 2003
3. Privacy Commissioner – Health Information Privacy Code
4. New Zealand Legislation – Health Practitioners Competence Assurance Act
5. The Health and Disability Commissioner (HDC) – Code of Health and Disability Services Consumer Rights

Resources available

The "New Zealand Telehealth Resource Centre" (https://www.telehealth.org.nz/) contains all of the important resources that need to be considered or could be utilised for implementing Telehealth within the DHB. This includes the technical aspects and the standards required to be met.

The DHB needs to consider what platform would suit its practitioners and patient population best. It needs to be simple and accessible to clinicians, patients, allied health, and primary care. It would be beneficial, although not essential, if it could be incorporated into the current Patient Management System (Health Connect South).

Options for Telehealth

Encourage all options for telehealth to be considered. Telephone consultations, where not always appropriate, are an effective means of telehealth.

Telephone consultations and video-calls must both be encouraged as appropriate means of delivering telehealth.

Hospital v Home based Telehealth

The ability for patients to access telehealth from their home or workplace has significant benefits. This saves on their travel time, costs, and time away from work or home. It also enables care to be delivered to anywhere within the DHB.

It is acknowledged that for some consultations a patient may need clinical support and there may be the need for technical support to be provided. Furthermore, patients may need a procedure performed by a local practitioner or nurse and advice given by a specialist in a main centre e.g. wound care.

Telehealth therefore needs to be developed primarily for patient access in their home (or location of choice) but also with the ability to access in district hospitals, GP surgeries or other healthcare facilities.

Prescriptions

The ability to provide a prescription for the patient must be available. Easy and seamless options to achieve this must be further developed.

While the MOH have brought in temporary changes for the ability for clinicians to scan and send prescriptions by email to pharmacies there also exists an electronic prescribing system in New Zealand (NZePS). To date this has largely been used in primary care and it is essential that a similar system is available in secondary care.

Scheduling of a Telehealth Consultation

Referrals that are received to clinical services within the DHB need to be able to be triaged to In-Person , Telehealth consultations or advice only to the referrer in a seamless fashion. The e-Triage system in HCS therefore needs to have Telehealth options included in it menu.

Telehealth can also be used at the time of receiving a referral to enable a brief consultation with the patient or the referrer to enhance and improve the triage process.

Clear rules for scheduling of appointments and the necessary administrative processes required must be available.

Pre-Telehealth Appointment Investigations

For Telehealth to be used to its maximum potential there must be the ability for clinicians to easily arrange investigations for the patient electronically prior to their Telehealth consultation.

Radiology e-requests are available however this has not yet been established for laboratory investigations and the ordering of other diagnostic tests.

A clear, preferably electronic, system needs to be developed to facilitate this.

Conducting a Telehealth Consultation

The format of telehealth consultations should be standardised within the DHB so that practitioners deliver these at "best practice" levels. These include recommendations regarding pre-consultation preparation; appropriate patient identification methodology; patient privacy; technical aspects including shared screens etc; and documentation of the consultation.

Also, it is important for clinicians to be aware of what types of consultations should probably not be delivered by telehealth e.g. breaking bad news.

Arranging Follow-up and Recording the Consultation

At the conclusion of the telehealth consultation there must be simple ways to arrange follow-up, if necessary, for the patient either by arranging a further Telehealth appointment of an In-Person consultation.

Steps to Deliver Telehealth effectively within the SDHB

Immediate

1. Establishment of an SDHB Telehealth Advisory Committee representing Secondary Care, Primary Care, Management, Consumer, Information Technology, Maori and Pasifika.
2. Develop a communication strategy to encourage the use of telehealth and to articulate the future direction
3. Develop information for clinicians so that they can easily access telehealth and incorporate it into their current practice.
4. Mitigate concerns surrounding telehealth especially prescriptions, laboratory ordering, taking of observations, medico-legal issues
5. Ensure that appropriate Telehealth equipment is available
6. Add Telehealth option to Triage system
7. Ensure administrative processes to schedule and accurately capture telehealth activity is in place.

Intermediate

1. Undertake a review of platforms for Telehealth and assess their compatibility with the DHB's Patient management System.
2. Develop protocols for the Best Practice of Telehealth
3. Develop simple but robust solutions for electronic prescriptions and laboratory ordering
4. Develop mechanisms to link to iPM for booking patients follow-up appointments
5. Explore ways to interact electronically more effectively with Primary Care and Rural Health by Telehealth
6. Develop a strategy to implement Telehealth across the DHB including upskilling clinicians and administrative staff
7. Develop methodology to measure the utilisation of Telehealth and its effectiveness
8. Utilise Telehealth to overcome boundary issues for delivery of care between Southland and Otago

9. Embed telehealth as a primary means of interacting with patients.
10. Explore how Telehealth can be utilised for interprofessional communication and education.

Future

1. Review outcome data of effectiveness measures and make appropriate changes to current model
2. Explore future advances in Telehealth and how they can be incorporated into clinical care, such as inpatient care, home monitoring of patients and access to more specialised care in other DHB's
3. Explore how Telehealth could impact on the New Hospital Build/Hubs etc

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Executive Director of Specialist Services Report**
Report to:	Hospital Advisory Committee
Date of Meeting:	07 September 2020

Summary:

Considered in these papers are:

- July 2020 DHB activity.

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

Financial:	Yes
Workforce:	Yes
Equity:	Any equity issues are covered in the body of the report.
Other:	No

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

Prepared by: Executive Director of Specialist Services **Date:** 24/08//2020	**Presented by:** Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:

That the Hospital Advisory Committee receive the report.

Executive Director of Specialist Services (EDSS) Report – July 2020

Recommendation

That the Hospital Advisory Committee notes this report.

1. Surgical Performance – Case Weights and Discharges

We are still in discussions with the Ministry of Health concerning our elective surgery 'production plan' for 2020/21. In the meantime we have rolled over last years' production plan as the starting point for this years' target. Key points that we want to discuss with the Ministry concerning this years' target (and the additional case weights we would need to deliver without additional funding) and an historic discharge 'stretch' that we are hoping to get agreement to at least partially address.

Elective performance for the month of July was in excess of the target (noting the target is currently last years' target rolled forward as we have yet to address the above issues). We achieved approximately 300 case weights more than target. Of this, 100 case weights was additional outsourcing associated with us initiating our recovery of surgery early (i.e. on the assumption that once guidance came from the Ministry about how recovery funding would be allocated we would be able to retrospectively apply it to the additional activity we have done. This accounted for 100 case weights, leaving us having delivered 200 case weights more than planned. We also ran Saturday elective lists at both Dunedin and Southland hospitals as part of our recovery efforts and this would have accounted for a reasonable proportion of the additional case weights delivered. We are still analysing where the additional case weights were delivered but at this stage they appear to be in fairly specific specialities such as cardiology, where we appear to be seeing a bow wave of late demand which we are attributing to the fact that the Catheter Laboratory was predominately closed during the COVID lockdown earlier in the year. We have higher than planned surgical consumables and prosthesis costs that are correlated to the extra volumes that have been delivered and we will may need to consider reducing elective activity in particular areas to bring our surgical clinical supplies costs back towards budget. We are initiating a savings project in late August to review how perioperative and implant and prosthesis costs are incurred with the intention of creating future state processes that will achieve savings and implementing these and thus realising savings. The majority of additional elective volumes (200 case weights) at Dunedin hospital are cardiothoracic cases 85 c.w. greater than usual – we had a very clear run with practically no ICU related cancellations in July, and cardiology procedures, 70 case weights more than usual (we appear to have had a post COVID surge – we shut the Cath Lab during COVID for all elective activity). Additional weekend elective volumes and relatively low disruption due to acute pressure (noting this pattern did not continue into August) meant that orthopaedics and a number of other specialities were able to do a bit more than usual, too.

2. Outpatient Performance ESPI 2 (Elective Specialist Performance Indicator)

We are now making reasonable progress with the implementation of the Ministry of Health prioritisation tool for surgery. Urology Dunedin, Orthopaedics Dunedin and General Surgery in Southland have now all implemented the tool. The tool is in place and will be bedded in over the coming month or so for General Surgery Dunedin, tool. By way of reminder, the tool allows us to match the underlying capacity of the service with what is accepted at triage on a weekly basis and check that we can safely balance the demands on the service with the underlying capacity within that service.

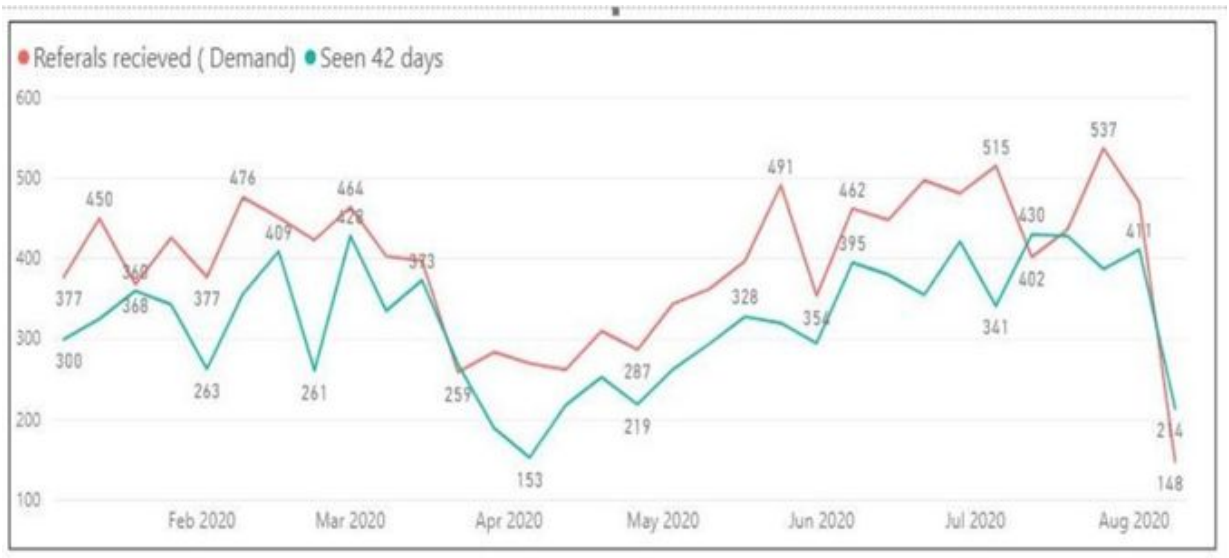
We are now starting to have more specific conversations with the Medicine, Women & Children specialities, as we have concluded that the prioritisation tool won't necessarily work as well for these services. A number of services in this directorate are now getting reasonably close to compliance and there are a couple of great initiatives underway. One of these initiatives is in the Obstetrics & Gynaecology service in Dunedin, where a telehealth FSA is being completed on approximately ¼ of referrals at the time of triage. This means that for those referrals, they are not even coming on to the outpatient wait list. They are either being completed and discharged back to the GP, or moved straight onto the inpatient wait list. This appears to be having the right impact on the ESPI 2 breaches as these are starting to trend down nicely. Obstetrics and gynaecology in Southland has improved the rate of ESPI 2 compliance since bedding in the acuity basis for booking patients onto the outpatient wait list. However, there is an underlying capacity issue with more referrals being received on a weekly basis than able to be actioned. We will revisit discussions with the Service Manager and clinicians about implementing the Ministry of Health prioritisation tool (we had initial discussions on this subject pre-COVID). It we implement the prioritisation tool and can demonstrate that at the cut off line (with all referrals stratified in priority order) those referrals at the cut-off point that must be returned to the GP in order for the service to stay in balance are inappropriate, this is the evidence that is required to make a case to say that the resourcing in this service is a high priority relative to the resourcing that is required in other services (which would be the foundation for a reasonable case in the investment priorities for the coming year).

Our overall ESPI 2 performance has steadily improved since COVID. Coming out of COVID lockdown we had 2,600 ESPI 2 breaches. As at the end of July we are down to 1,900 ESPI 2 breaches, as demonstrated from the following extracts from the relevant Power BI dashboards.

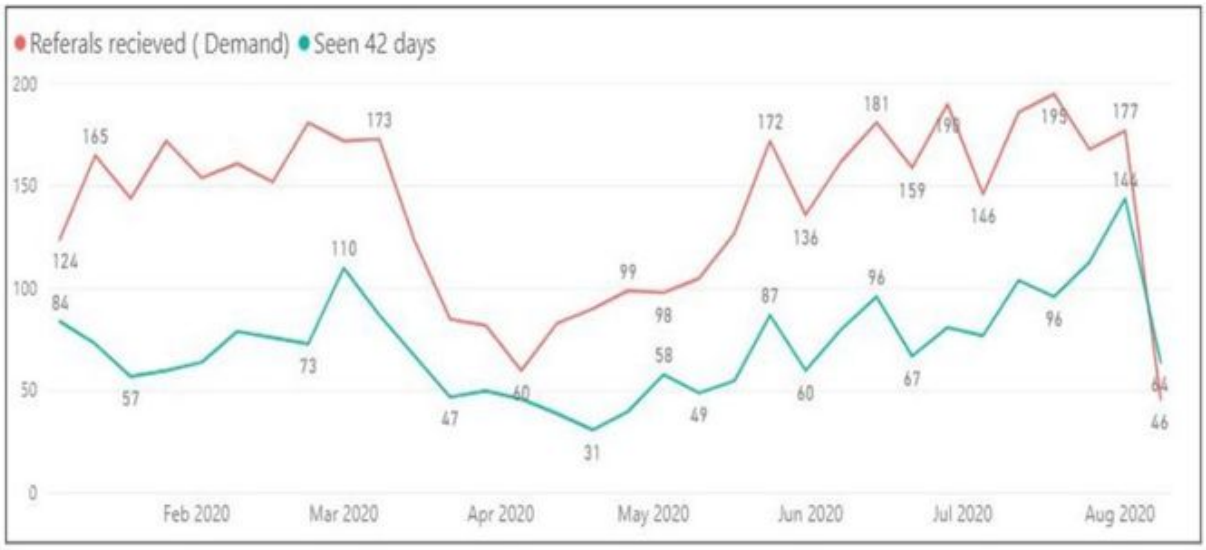
3. Medical Imaging Diagnostics

The following extracts from Power BI demonstrate that the volumes received (demand) has climbed steadily since COVID in April. Volumes seen have also climbed, steadily, however, assisted by a small sum of one-off recovery money that we applied for from the Ministry and received.

CT Supply and Demand



MRI Supply and Demand



The performance of the modalities against the 42 day elective target from the Ministry has slowly but steadily increased. CT performance was 51.8% in April, but had improved to 65.58% by July. MRI performance had dropped to 26.32% during April (COVID lockdown) but had improved to 45.54% by July. and Ultrasound performance had dipped to 42.6% in April but had improved to 50% by July.

The radiology team has advised that two of the Meter Imaging Technologist (MIT) staff required for the new CT initiative have now been hired and will commence at the end of August. Following orientation, the team envisages being able to run extra elective sessions which will enable 20 additional patients per week to be scanned from mid-September). The full CT initiative will be implemented as the remaining staff (particularly the Registrar) are hired and commence in the roles over the remainder of the year. Opportunistic use of the Spec CT machine for additional scanning is already occurring, and as the MIT and nursing staff settle into the new positions we will progress towards the additional sessions that were outlined in the CT business case.

The additional outsourcing that was made possible with the modest additional Ministry of Health funding for June and July has not made a significant difference to the numbers waiting, as demand has risen steadily (per the previous notes). However, there has been a pleasing reduction in the average wait times. MRI Dunedin average wait times have decreased from 65 days (May) to 49 days (July), whilst CT Dunedin wait times have decreased from 63 days (May) to 50 days (July). The change for both Dunedin and Southland is per the following table.

	May 2020		June 2020		July 2020	
	Electives waiting and (Planned)	Median wait time Electives (days)	Electives waiting and (Planned)	Median wait time Electives	Electives waiting and (Planned)	Median wait time Electives
MRI Dunedin	728 (495)	65	710 (487)	75	724 (477)	49
MRI Southland	346 (333)	59	258 (250)	62	182 (257)	32
CT Dunedin	816 (604)	63	819 (604)	71	806 (637)	50
CT Southland	96 (366)	27	209 (374)	12	165 (345)	17

4. Emergency Department Performance (ED 95% 6 Hour Target)

We have been able to acquire a complete data set of ED attendances for both Dunedin and Southland dating back to 2015, so we have completed a more thorough investigation of what activity occurred during the COVID months and then subsequently as the hospitals returned to normal during June and July.

The following table shows the key ED volumes information for the months of April, May, June and July from 2015 to 2020. Prior to 2018 volume growth had been fairly static. However, in the April to July period from 2019 volumes had grown reasonably substantially on the prior year with 5% growth experienced in Dunedin and 4% growth experienced in Southland, respectively. This appeared to be borne out in the pressures being experienced in the ED last year.

Count of NHI	Month				
Hospital	Apr	May	Jun	Jul	July YOY % Chg
Dunedin Hospital	21,315	22,608	21,913	23,977	
2015	3,589	3,829	3,700	4,147	0%
2016	3,885	3,928	3,719	3,991	-4%
2017	3,850	3,786	3,724	3,939	-1%
2018	3,785	3,909	3,586	3,834	-3%
2019	3,921	4,104	3,775	4,185	9%
2020	2,285	3,052	3,409	3,881	-7%
Southland (Kew) Hospital	17,420	18,505	18,421	18,897	
2015	2,908	3,081	2,858	3,045	0%
2016	3,004	3,033	3,026	3,024	-1%
2017	3,030	3,072	3,169	3,173	5%
2018	3,153	3,323	3,082	3,183	0%
2019	3,356	3,334	3,341	3,245	2%
2020	1,969	2,662	2,945	3,227	-1%

Dunedin Hospital

April 2020 vs April 2019	42%
May 2019 vs May 2020	26%
June 2019 vs June 2020	10%
July 2019 vs July 2020	7%

Southland Hospital

April 2020 vs April 2019	41%
May 2019 vs May 2020	25%
June 2019 vs June 2020	12%
July 2019 vs July 2020	1%

Dunedin Apr-Jul Growth 2019 vs 2018	871	5%
Southland Apr-Jul Growth 2019 vs 2018	535	4%

As noted previously, due to COVID, during April and May a reasonably large proportion of our regular ED activity did not arrive – in Dunedin our volumes were down 42% compared to the previous April, and 26% compared to the previous May. Volumes continued to be down (by 10%) compared to the previous June, too, and even in July volumes are down (by 7%) compared to July of the previous year. Despite lower volumes (year on year) in July, the total numbers admitted onto the ward increased from 926 to 958 year on year (3%), which is reflected somewhat in the busyness pressure that has been reported back to us by the inpatient teams during July and subsequently into August.

However, the picture for Southland is subtly different. April was down 41% compared to last year, May was down 25% and June was down 12%. However, July has been very busy and is within 1% of regular ED volume. Unfortunately the admitted numbers for Southland do not appear to have been coded correctly, which prevents us from gaining an accurate picture for how much of the Southland ED busyness led to a year on year growth in ED originating presentations onto the ward.

Average of Age at Admission	Month	
	2019	2020
Hospital		
Dunedin Hospital	41	43
Southland (Kew) Hospital	40	43
Overall Average	41	43
Median Age	37	40

Another interesting observation is that the age of ED attendances appears to have increased. Using the July month, in 2019 the overall average age of attendance was 41, for 2020 the overall average age of attendance is 43. This is also evident in the median age of attendance, which was 37 for July 2019 (across both hospitals) and is 40 for July 2020. This warrants further investigation and we will drill into this as part of our ongoing ED analysis.

There was a 5% reduction in European presentations at Dunedin hospital when July 2019 and July 2020 were compared, but a 15% reduction (345 in 2020 versus 402 in 2019) when Māori presentations were compared. We will pass this along to our colleagues in the Māori Health directorate to determine whether this is significant enough to warrant further investigation. There was no notable reduction in either ethnicity in Southland.

Our final brief piece of analysis is perhaps the most interesting. When comparing July 2020 with July 2019, in Dunedin there has been a slight decrease in the time spent waiting for a clinician after having been triaged (4 minutes), but this is essentially offset by a longer wait before being discharged (a 14 minute increase) with a longer overall wait time between triage and discharge.

In Southland, however, there appears to have been a significant reduction in the time spent waiting for a clinician (29 minutes), and the overall time spent waiting between triage and discharge (51 minutes). Unfortunately the month of July by itself is not a comprehensive data set to draw comparisons from (and we can't compare a greater number of months because of the anomalies caused by COVID). However, the outward indications are that the work we have heard about to review and treat patients more quickly in Southland appears to be producing results.

Average Patient Wait to See a Doctor and Average Patient Wait from Triage to Discharge by Site

	Month	
	July Months	
Hospital	Average of TriageToDrSeen	Average of TriageToDischarge
Dunedin Hospital	114	273
2019	116	266
2020	112	280
Southland (Kew) Hospital	77	246
2019	92	272
2020	63	221

Dunedin Dr wait 2019-2020	-5	-4%
Triage - Dischg 2019-2020	14	5%
Southland Dr wait 2019-2020	-29	-32%
Triage - Dischg 2019-2020	-51	-19%

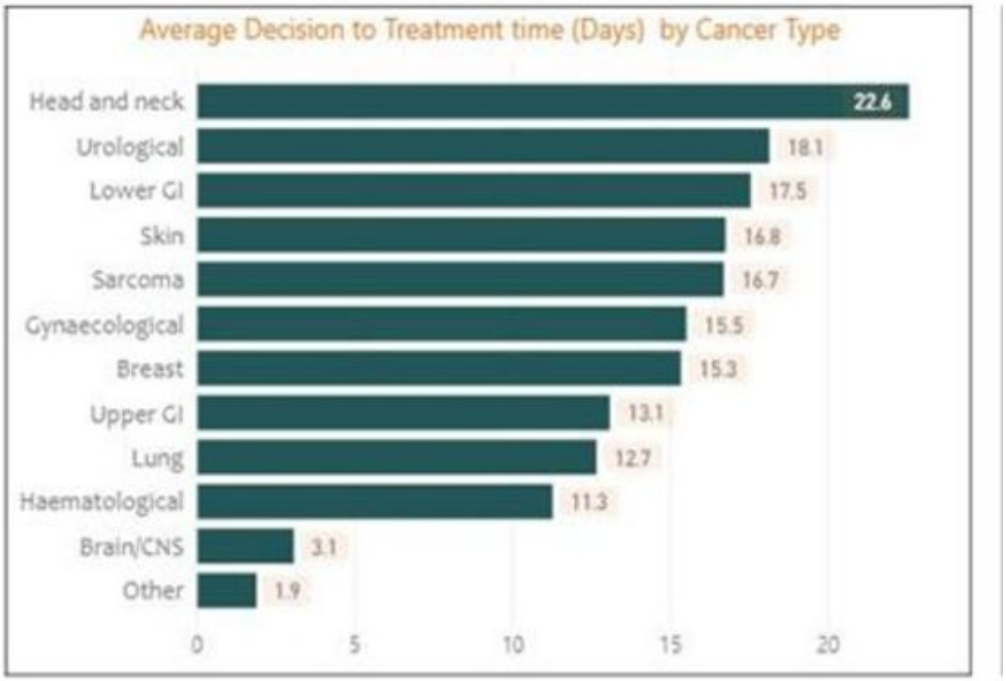
There are a number of ED initiatives now underway, with the aim of improving ED performance.

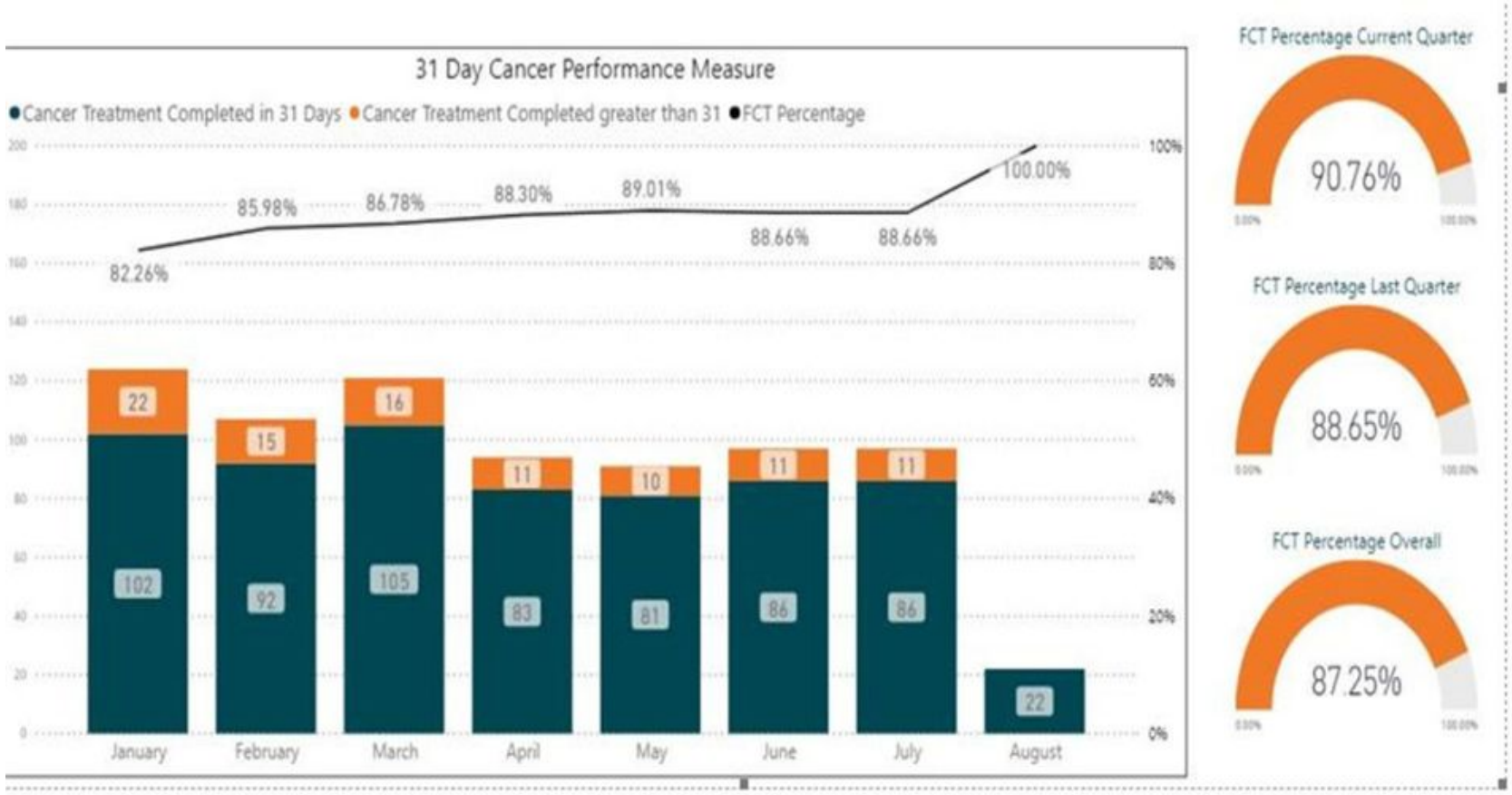
- In Dunedin the General Manager Operations and the Chief Medical Officer are leading a piece of work to improve escalation criteria that will lead to faster patient reviews and decision making).
- In Southland the EDSS is initiating a small working group comprising of the GM, Director of Nursing and relevant clinical leaders to systematically improve ED performance against the 6 hour target, with the objective of determining a work programme that would systematically shift ED performance to achieving 90% against the 6 hour target within 2 years and 95% within 4 years.

The Southland initiative is likely to involve a combination of maintaining rapid assessment and discharge / admission, reducing ED volumes at the front door and a combination of ED and assessment unit beds to cope with peak volumes (which occur regularly) in the Emergency Department. The clinical teams are signalling that it is crucial that we improve conditions in the ED in Southland and we will carefully investigate and then make appropriate cases for the improvements that are required. In a similar manner to Dunedin, assessment unit capacity is likely to most positively impact on the ED 6 hour target. I.e. if patients are discharged from the ED, admitted into an assessment unit and are then under the care of a specialist their flow through the ED will be improved. Our working group will carefully explore the type of capacity that will make the best improvement to flow, will develop an appropriate case which takes into account the capital and operating requirements of the solution and will then promote the proposed solution (once identified) at an appropriate level of priority for future investments (when considered alongside secondary care and the wider organisation's other investment priorities).

5. Oncology 31 Day Target (85%)

The oncology 31 day measure is the time from when cancer is from decision to treat until the first treatment has occurred. Our dashboard has now been completed in first draft and an interesting snapshot is as follows:




31 Day Cancer Performance Measure
Cancer Treatment Completed in 31 Days
Cancer Treatment Completed greater than 31
FCT Percentage
82.26%
85.98%
86.78%
88.30%
89.01%
88.66%
88.66%
100.00%
22
15
16
11
10
11
11
102
92
105
83
81
86
86
22
January
February
March
April
May
June
July
August
FCT Percentage Current Quarter
90.76%
FCT Percentage Last Quarter
88.65%
FCT Percentage Overall
87.25%

Some high level observations from the dashboard

- The average wait for each tumour stream is less than the 31 day target (from diagnosis to treatment). Head and neck have the longest average wait, but these are very low volumes. The urological cases have a relatively long average wait and a relatively high number of cases. The most common first treatment is surgery (approximately 75% of first treatments is surgery).
- Of those waiting treatment the majority category – urological - has 40% of those awaiting treatment also waiting on a CT scan, which underscores the importance of getting the CT capacity established as quickly as possible.
- Of those who missed the deadline, approximately 84% were waiting on surgery, and of those, the majority category (38%) were waiting on urological surgery. Overall, performance is tracking at 87.25% (performance to date during the current reporting period), which is over the 85% target.

Having this information presented to us in this manner has given us some powerful insights. For example, by working between the urological speciality and medical imaging to try to get long waiting urological scans completed more quickly, we will be able to improve the overall 31 day waiting times even further. This information also helps to validate our proposal to the Ministry that urological surgery be one of our focal areas for planned care wait list improvement planning / recovery purposes.

Our radiation oncology wait list has drifted up and we now have in the region of 90 patients on our wait list waiting for an FSA (pre-COVID we were over 100 but during COVID we managed to get this down to circa 60). We are working on the following initiatives:

a. Hiring another trainee registrar to provide us with additional capacity, whilst we await the appointment of a 6th radiation oncologist.
b. Progressing with initiatives that we were considering pre-COVID to undertake nurse led follow up clinics and to run additional clinics.

A review of the relevant dashboard suggests that during COVID demand remained relatively steady at circa 20 FSA's accepted per week. However, also during COVID with the high availability of Radiation Oncologists we were able to see in the region of 22 FSA referrals per week. Since the start of June demand has remained relatively steady, averaging about 21 referrals per week. However, we have only been able to maintain an average of 17 First Specialist Assessment FSA's seen per week, which has led to the upward drift of the FSA volumes.

6. Gastroenterology

The gastroenterology team have worked hard to catch up the backlogs caused by COVID and at the time of writing the urgent (14 day target) and bowel screening (30 day) volumes are up to date and we are achieving this target. The non-urgent (42 day target) volumes are also up to date and we are also very close to achieving this target. This is across both sites and is a great achievement when we consider that during COVID lock down scoping had to be halted. Further work is occurring to catch up on the 84 day (surveillance) target. Bowel screening, urgent symptomatic and non-urgent symptomatic

patients have broadly been prioritised over surveillance as there is a much higher likelihood that a cancer or other sinister pathology will be found in these groups. A dashboard is under construction which will be available in the next HAC reporting cycle. The dashboard will demonstrate the following performance:

- Performance against the 14, 42 and 84 day Ministry measures split by site (Dunedin and Southland) but also with the ability to consolidate.
- Performance against the national bowel screening measures.
- Average and median wait times by category (14, 42 and 84 day targets).

In the meantime, the following chart has been developed manually, which shows performance against the 14, 42 and 84 day targets and average and median wait times in each of these categories (urgent, non-urgent, surveillance).

Average, shortest and longest wait, together with numbers of patients by category as at 02 August.

	Dunedin					Southland				
	NBSP	A (14)	B (42)	C (84)	Surveillar	NBSP	A (14)	B (42)	C (84)	Surveillance
Average	24	8	32	32	105	21	11	40	110	159
Shortest	2	4	3	3	1	2	5	3	3	1
Longest Wait	152	11	158	75	294	174	26	178	234	388
Patients	26	4	79	68	318	18	4	40	74	394

MOH Colonoscopy Waiting Time Indicators (District)

Urgent (14 day)	92% (target 90%).
Non-urgent (42 day)	66% (target 70%).
Surveillance (84 day)	36% (target 70%).

Planned Care Interventions Inpatient Surgical Discharges - Annual target 12,237 (yet to be agreed)	**1,248** Actual YTD vs 925 Plan YTD, as at July 2020

Refer to page 13 - Caseweight and discharge volumes graph.

Patrick Ng, Executive Director of Specialist Services

*Budget Plan is currently the 2019/20 rolled over - the Planned Care Interventions plan (previously known as electivie initiative) is still being finalised with the

Jul-20				Jul-19	YEAR ON YEAR		YTD 2020/21				YTD Jul-19	YEAR ON YEAR
Actual	Budget*	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,533	1,503	30	2%	1,761	(228)	Acute	1,533	1,503	30	2%	1,761	(228)
336	251	84	34%	365	(29)	Elective	336	251	84	34%	365	(29)
1,868	**1,755**	**114**	**6%**	**2,126**	**(257)**	**Total Medical Caseweights**	**1,868**	**1,755**	**114**	**6%**	**2,126**	**(257)**
						Surgical Caseweights						
1,146	1,196	(50)	-4%	1,226	(81)	Acute	1,146	1,196	(50)	-4%	1,226	(81)
1,606	1,341	265	20%	1,440	164	Elective	1,606	1,341	265	20%	1,440	165
2,751	**2,537**	**215**	**8%**	**2,667**	**84**	**Total Surgical Caseweights**	**2,751**	**2,537**	**215**	**8%**	**2,667**	**85**
						Maternity Caseweights						
122	94	28	30%	99	23	Acute	122	94	28	30%	99	23
423	371	52	14%	395	28	Elective	423	371	52	14%	395	28
546	**465**	**81**	**17%**	**494**	**52**	**Total Maternity Caseweights**	**546**	**465**	**81**	**17%**	**494**	**52**
						TOTALS						
2,801	**2,793**	**8**	**0%**	**3,087**	**(286)**	**Acute**	**2,801**	**2,793**	**8**	**0%**	**3,087**	**(286)**
2,365	**1,963**	**401**	**20%**	**2,200**	**164**	**Elective**	**2,365**	**1,963**	**401**	**20%**	**2,200**	**165**
5,165	**4,756**	**409**	**9%**	**5,286**	**(122)**	**Total Caseweights**	**5,165**	**4,756**	**409**	**9%**	**5,286**	**(121)**
				0							0	
						TOTALS excl. Maternity						
2,678	**2,699**	**(20)**	**-1%**	**2,988**	**(309)**	**Acute**	**2,678**	**2,699**	**(20)**	**-1%**	**2,988**	**(309)**
1,941	**1,592**	**349**	**22%**	**1,805**	**136**	**Elective**	**1,941**	**1,592**	**349**	**22%**	**1,805**	**137**
4,620	**4,291**	**329**	**8%**	**4,792**	**(174)**	**Total Caseweights excl. Maternity**	**4,620**	**4,291**	**329**	**8%**	**4,792**	**(173)**

SOUTHERN DISTRICT HEALTH BOARD

Title:	**FINANCIAL REPORT**
Report to:	Hospital Advisory Committee
Date of Meeting:	07 September 2020

SUMMARY:

The issues considered in this paper are:

- July 2020 financial position.

SPECIFIC IMPLICATIONS FOR CONSIDERATION (FINANCIAL/WORKFORCE/RISK/LEGAL ETC.):	
FINANCIAL:	As set out in report
WORKFORCE:	No specific implications
EQUITY:	
OTHER:	N/A

DOCUMENT PREVIOUSLY SUBMITTED TO:	Not applicable, report submitted directly to Hospital Advisory Committee.	**DATE:**
APPROVED BY CHIEF EXECUTIVE OFFICER:		**DATE:**

PREPARED BY: Grant Paris Management Accountant **DATE:** 24/08/2020	**PRESENTED BY:** Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:
That the Hospital Advisory Committee note the report.

SOUTHERN DHB FINANCIAL REPORT – Summary for HAC

Financial Report for: **July 2020**
Report Prepared by: **Grant Paris**
Management Accountant
Date: **21 August 2020**

Overview

Results Summary for Specialist Services

1. *Surgical* Performance – Case Weights and Discharges

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

Month				Year To Date			Year End
Actual $000	Budget $000	Variance $000		Actual $000	Budget $000	Variance $000	Budget $000
45,684	45,185	499	Revenue	45,684	45,185	499	541,965
24,468	24,550	82	Less Workforce Costs	24,468	24,550	82	292,043
13,398	12,152	(1,246)	Less Other Costs	13,398	12,152	(1,246)	138,761
7,818	**8,483**	**(665)**	**Net Surplus / (Deficit)**	**7,818**	**8,483**	**(665)**	**111,161**

For July 2020, Specialist Services had a surplus of $7.8m, which is $0.67m unfavourable to budget.

2. *July 2020 Result*

Provider Activity View

The Ministry of Health measures production in terms of patient discharges and the caseweights attributed to those discharges.

Case weights measure the relative complexity of the treatment given to each patient. For example, a cataract operation will receive a case weight of approximately 0.5, whereas a hip replacement will receive 3.2 case weights. The difference in case weight reflects the resources needed for each operation, in terms of theatre time, number of days in hospital, any complicating conditions with the patient and so on.

As a DHB, we compare the case weights delivered in a month against our production plan to understand the impact on our expenditure. For example, Clinical Supplies may exceed budget if we deliver more hip replacements than planned in a month.

The table below shows the volumes delivered by our Provider arm of Southern DHB; plus, any volumes the Provider arm outsources to meet targets. This Provider view includes any IDF activity delivered within our facilities for people who are domiciled in other DHBs; although, it excludes services delivered by other DHBs for our population. This shows whether the Provider arm is delivering to the expected budgeted volumes.

At the time of writing, the Production plan phasing for 2021 is yet to be finalised and loaded into the reporting systems. Therefore, comparison has been made between July

2020 activity to the same month in 2019, as shown in the table below. The elective caseweights for July 2020 are 8% higher than July 2019. The Recovery plan for delayed electives and planned care due to the cessation of these services during the COVID-19 lockdown in April and May 2020 has dominated activity in July 2020 as noted elsewhere.

	Jul-20 Actual	Jul-19 Actual	YEAR ON YEAR Variance	% Movement
Medical Caseweights				
Acute	1,533	1,761	(228)	-13%
Elective	336	365	(29)	-8%
Total Medical Caseweights	1,868	2,126	(257)	-12%
Surgical Caseweights				
Acute	1,146	1,226	(81)	-7%
Elective	1,606	1,440	165	11%
Total Surgical Caseweights	2,751	2,667	85	3%
Maternity Caseweights				
Acute	122	99	23	23%
Elective	423	395	28	7%
Total Maternity Caseweights	546	494	52	10%
TOTALS				
Acute	2,801	3,087	(286)	-9%
Elective	2,365	2,200	165	8%
Total Caseweights	5,165	5,286	(121)	-2%

TOTALS excl. Maternity				
Acute	2,678	2,988	(309)	-10%
Elective	1,941	1,805	137	8%
Total Caseweights excl. Maternity	4,620	4,792	(173)	-4%

Statement of Financial Performance

Monthly Actuals $000s	Monthly Budget $000s	Monthly Variance $000s	Monthly Variance FTE		Year to date Actuals $000s	Year to date Budget $000s	Year to date Variance $000s	Year to date Variance FTE
				REVENUE				
				Government & Crown Agency Sourced				
768	814	(46)		MoH Revenue	768	814	(46)	
0	0	0		IDF Revenue	0	0	0	
803	738	65		Other Government	803	738	65	
1,570	**1,552**	**18**		**Total Government & Crown**	**1,570**	**1,552**	**18**	
				Non Government & Crown Agency Revenue				
135	184	(49)		Patient related	135	184	(49)	
163	183	(20)		Other Income	163	183	(20)	
298	**368**	**(70)**		**Total Non Government**	**298**	**368**	**(70)**	
43,815	43,266	549		Internal Revenue	43,815	43,266	549	
45,684	**45,185**	**499**		**TOTAL REVENUE**	**45,684**	**45,185**	**499**	
				EXPENSES				
				Workforce				
				Senior Medical Officers (SMO's)				
6,283	6,502	219	15	Direct	6,283	6,502	219	15
364	355	(9)		Indirect	364	355	(9)	
302	164	(138)		Outsourced	302	164	(138)	
6,949	**7,021**	**72**	**15**	**Total SMO's**	**6,949**	**7,021**	**72**	**15**
				Registrars / House Officers (RMOs)				
3,958	4,079	121	7	Direct	3,958	4,079	121	7
78	230	152		Indirect	78	230	152	
5	30	25		Outsourced	5	30	25	
4,040	**4,339**	**299**	**7**	**Total RMOs**	**4,040**	**4,339**	**299**	**7**
10,989	**11,360**	**371**	**22**	**Total Medical costs (incl outsourcing)**	**10,989**	**11,360**	**371**	**22**
				Nursing				
9,294	8,985	(309)	(33)	Direct	9,294	8,985	(309)	(33)
0	1	1		Indirect	0	1	1	
5	3	(2)		Outsourced	5	3	(2)	
9,300	**8,989**	**(311)**	**(33)**	**Total Nursing**	**9,300**	**8,989**	**(311)**	**(33)**
				Allied Health				
2,316	2,234	(82)	(4)	Direct	2,316	2,234	(82)	(4)
42	25	(17)		Indirect	42	25	(17)	
70	43	(27)		Outsourced	70	43	(27)	
2,428	**2,302**	**(126)**	**(4)**	**Total Allied Health**	**2,428**	**2,302**	**(126)**	**(4)**
				Support				
175	201	26	2	Direct	175	201	26	2
0	1	1		Indirect	0	1	1	
0	0	0		Outsourced	0	0	0	
175	**201**	**26**	**2**	**Total Support**	**175**	**201**	**26**	**2**
				Management / Admin				
1,558	1,683	125	(9)	Direct	1,558	1,683	125	(9)
14	9	(5)		Indirect	14	9	(5)	
5	6	1		Outsourced	5	6	1	
1,577	**1,697**	**120**	**(9)**	**Total Management / Admin**	**1,577**	**1,697**	**120**	**(9)**
24,468	**24,550**	**82**	**(23)**	**Total Workforce Expenses**	**24,468**	**24,550**	**82**	**(23)**
3,679	3,138	(541)		**Outsourced Clinical Services**	3,679	3,138	(541)	
0	0	0		**Outsourced Corporate / Governance Servic**	0	0	0	
0	0	0		**Outsourced Funder Services**	0	0	0	
8,027	7,359	(668)		**Clinical Supplies**	8,027	7,359	(668)	
808	785	(23)		**Infrastructure & Non-Clinical Supplies**	808	785	(23)	
				Provider Payments				
0	0	0		Mental Health	0	0	0	
				Non Operating Expenses				
884	871	(13)		Depreciation	884	871	(13)	
0	0	0		Capital charge	0	0	0	
0	0	0		Interest	0	0	0	
13,398	**12,152**	**(1,246)**		**Total Non Personnel Expenses**	**13,398**	**12,152**	**(1,246)**	
37,866	**36,702**	**(1,164)**		**TOTAL EXPENSES**	**37,866**	**36,702**	**(1,164)**	
7,818	**8,483**	**(665)**		**Net Surplus / (Deficit)**	**7,818**	**8,483**	**(665)**	

3. Revenue

Ministry of Health (MoH) Revenue

MoH revenue was $0.05m unfavourable to budget for the month. The main contributors are detailed below:

Category	Monthly Variance $000s	YTD Variance $000s	Comment
Personal Health-side contracts	(19)	(19)	Correction to MoH reimbursement of costs for patient overseas travel costs (over accrued)
Clinical Training	(21)	(21)	Contracts have been reconciled to ensure eligible personnel have been recovered in billing.
Other	(6)	(6)	
Total	**(46)**	**(46)**	

Other Government Revenue

Other Government revenue was $0.06m favourable in July. The major drivers for this are shown below.

Category	Monthly Variance $000s	YTD Variance $000s	Comment
Haemophiliac rebate	136	136	Rebate reflecting increased cost year to date.
ACC	(10)	(10)	General Surgery Treatment Injury claims (timing)
Radiology ACC	(12)	(12)	Reduced volumes in Radiology & MRI
University of Otago	(33)	(33)	Dental School volumes less than budgeted
Other	(16)	(16)	
Total	**65**	**65**	

Patient related revenue

Patient related revenue was under budget for the month by $0.05m due to lower than budgeted levels of non-resident revenue (the budget was reduced with the border closures due to COVID, however actuals are running under this reduced budget).

Other Income

Other income is $0.2m under budget in July due to shortfalls in cost recoveries (offset by reduced costs).

Internal Revenue

Internal revenue was $0.55m favourable in July due to money transferred for COVID Recovery Plans. This has a direct cost offset in Outsourced Clinical Services.

4. Workforce Costs (see appendix 1 for definition)

Monthly result
Workforce costs (personnel plus outsourcing) were $0.8m favourable to budget in July 2020. Operationally full time equivalent (FTE) were 23 unfavourable to budget in July 2020.

FTE
Monthly FTE is 23 over budget in July summarised in the following table, unfavourable variances in Nursing, Allied and Management/Admin partially offset by favourable variances in the other staff types.

Staff Type	Actual FTE May20	Budget FTE May20	Monthly Variance	%	Actual FTE YTD May20	Budget FTE YTD May20	YTD Variance
SMO	232	247	15	6%	232	247	15
RMO	307	314	7	2%	307	314	7
Nursing	1,176	1,143	(33)	-3%	1,176	1,143	(33)
Allied	290	286	(4)	-2%	290	286	(4)
Support	36	38	2	5%	36	38	2
Mgmt / Admin	282	273	(9)	-3%	282	273	(9)
	2,324	**2,301**	**(23)**	**-1%**	**2,324**	**2,301**	**(23)**

Senior Medical Officer (SMOs)
SMOs were $0.07m and 15 FTE favourable for the month. Based on an average salary, we would expect the $ variance to be higher given the 15FTE favourable. This has not occurred in July due to the following;

- Annual leave was 5FTE less than budgeted. Any difference in annual leave taken to budget will have an impact on both annual leave earned and allowances. This is because we have budgeted allowances taken while on annual leave in annual leave in compliance with the Holidays Pay Act.
- Revaluation of CME balances. As a large percentage of SMO's have their anniversary date on 1 July, the major impact of this is in this month. This increases the dollar variance but has no impact on FTE.
- Overtime was $0.09m unfavourable driven by
    - Vacancies
    - SMOs covering RMO roster gaps
    - Extra hour's payments for Theatres and ICU teams.

RMOs
RMOs were $0.3m and 7 FTE favourable. Given the FTE variance, we would only have expected the dollar variance to be around $0.07m favourable based on average rates. This still needs to be investigated and understood.

Indirect RMO costs were $0.15m favourable to budget due mainly to $0.11m lower levels of course fees compared to budget. This is not unexpected given the current restrictions on travel and is also reflected in the $0.06m favourable RMO training time which is part of the direct cost variance.

Outsourcing was also lower than budgeted with sufficient RMO's available due to lower levels of annual leave, RMO's only taking 20.5FTE of the 38.7FTE annual leave budgeted. In addition, SMO's covered some roster gaps.

Nursing
Nursing was $0.31m and 33FTE unfavourable for the month.

1) FTE

The unfavourable FTE variance is driven by the following

- ICU 20 FTE favourable partially offset by nurses working in Ward 4A (5.7 FTE unfavourable) resulting in net 14 FTE favourable due to the ward not being fully recruited.
- Newly approved positions that are currently vacant including Variance Response Management (11.2 FTE) and Care Capacity Demand Management (8 FTE).
- Other vacant positions, both newly established and pre-existing including Maternity Southland (4 FTE), ACNM Southland (1 FTE), APAC Southland (0.9 FTE), CNS Podiatry and Colorectal (1 FTE).
- Sick leave was unfavourable by 10FTE, which is not unexpected as vigilance to the possible spread of any illness means those unwell stay home.
- The favourable FTE movements are more than offset by the FTE savings in Nursing for Valuing Patient Time (-22 FTE), Positive shifts (-10 FTE), Vacancy factors (-14.5 FTE).
- Health Care Assistants patient watch hours were recorded as 4,777 hours (29.1 FTE) which were only partially offset by the HCA budget increase of 10.75 FTE in 2020/21.

2) $ Variance

The unfavourable dollar variance of $0.31m is due to;

	Monthly $000s	**Year to Date $000s**	**Comment**
Monthly FTE 33.15 unfavourable to budget	(261)	(261)	See above FTE comments.
Rate Variance (higher or lower $s per FTE)	(48)	(48)	Negative rate variance driven by annual leave accrued
Indirect Costs	1	1	
Outsourced	(2)	(2)	
Total Variance	**(310)**	**(310)**	

Allied Health

Allied Health personnel were $0.13m and 4.4FTE unfavourable for July.

Direct costs were $0.08m and 4.5FTE unfavourable for the month. A large proportion of the dollar variance is due to leave adjustments being greater than budget.

Allied Health outsourced personnel were $0.03m over budget for the month, mostly in Anaesthesia for the continuing use of anaesthetic technicians to cover vacant roles.

Support

Support staff are favourable to budget (both dollars and FTE) for the month.

Annual leave taken was on budget for the month.

Management and Administration

Management and Administration staff were $0.12m favourable and 8 FTE unfavourable for the month.

The annual leave revaluation budget phasing in July 2020 delivered a favourable variance of $0.14m. This is one-off favourable impact and should be noted as part of the assessment of the overall result for the month.

Annual leave taken is 7FTE less than budgeted. As the majority of these staff are not covered when on annual leave, we expect this to have a direct correlation to ordinary time, which for the month is 12FTE unfavourable.

5. Outsourced Clinical Services Costs

Outsourced services were $0.54m unfavourable in July as shown below.

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	Annual Budget $
Outsourced Surgical Services	1,156	759	(397)	7,813
Radiology Service	281	183	(98)	2,192
Outsourced Clinical Services - Other	571	479	(92)	5,747
Vascular Assessments	100	76	(24)	913
Other Radiology Procedures	32	16	(16)	195
Audiology	14	2	(12)	24
Laboratory Sendaway Tests				5
Laboratory O/P Tests				
Laboratory Service	1,476	1,477	1	17,728
MRI Scans	30	34	4	404
Lithotripsy		6	6	77
Ophthalmology	7	45	38	535
CT Scans	11	60	49	716
	3,678	**3,137**	**(541)**	**36,349**

1) Improvement action plan expenditure of $0.55m relating to COVID catch up (offset by Ministry funding) forms the basis for the budget overruns in Surgical Services.

2) Ear Nose and Throat Emergency and Medicine Southland Service: This service drives the overrun in Outsourced Clinical Services, with a high number of discharges in July to meet the Planned Care Intervention discharge target.

3) Radiology outsourcing continues to be over budget for online reporting in Southland to cover vacancies. Volumes were higher than anticipated.

6. Clinical Supplies (excluding depreciation)

Clinical supplies were unfavourable to budget by $0.67m in July 2020 reflecting the uplifted level of activity as part of the COVID recovery.

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	Annual Budget $
Blood and Tissue Supplies	810	689	(121)	7,490
Hip Prostheses	357	255	(102)	3,053
Pacemakers	193	103	(90)	1,213
Disposable Instruments	292	216	(76)	2,507
Cardiac Implants	267	200	(67)	1,420
Patient Consumables	328	271	(57)	2,207
Catheters	225	183	(42)	2,142
Spinal plates and screws	104	69	(35)	829
Implants and Prostheses - Other	127	94	(33)	1,124
Clinical Equipment - Operating Leases (non-financinç	27	3	(24)	127
Shunts and Stents	200	180	(20)	2,162
Blood Diagnostic Services	95	76	(19)	908
Clinical Equipment - Repairs & Maintenance	105	87	(18)	1,017
Dressings	126	108	(18)	1,278
Sutures	113	96	(17)	1,150
Respiratory Equipment	69	86	17	979
Staples & Accessories	52	86	34	1,030
Air Ambulance	364	415	51	4,971
Knee Prostheses	105	167	62	2,006
Material Clinical Supply Variances	**3,959**	**3,384**	**(575)**	**37,613**

1) Blood and Tissue Supplies
This $0.12m unfavourable variance reflects the increased usage of Haemophiliac products and is offset by the Haemophiliac rebate (Other Government revenue)

2) Implants (Hips / Pacemakers / Cardiac Implants / Spinal Plates / Other Implants)
These unfavourable variances reflect the increased level of throughput in these areas as we seek to recover from the delays due to COVID. This comprises;
   - High acuity and activity in Cath Lab including 6 ICDs (implantable defibrillators), where there is only 2 budgeted
   - 2 additional high cost TAVI's (transcatheter aortic valve implantation) @ $30k each
   - Additional hip volumes partially offset by fewer Knee implants.

3) Patient consumables over budget driven by high cost gastro patients.

4) Disposable Instruments $0.08m over budget due to increased activity.

5) Air Ambulance
Air Ambulance was $51k favourable in July 2020. There were 30 missions during the month compared to a budget of 36 missions. The expenditure in July includes one Neurosurgery transfer of $24k.

7. Infrastructure and Non-Clinical (excluding depreciation)

These costs were $0.02m unfavourable to budget in July 2020.

Group1	$000 Monthly Actual	$000 Monthly Budget	$000 Monthly Variance	$000 Full Year Budget
Hotel Services, Laundry & Cleaning	472	430	(42)	5,057
Facilities	18	22	3	250
Transport	75	92	16	1,038
IT Systems & Telecommunications	54	82	28	1,034
Professional Fees and Expenses	18	24	6	292
Other Operating Expenses	170	135	(35)	1,405
	808	**785**	**(23)**	**9,075**

Hotel Services, Laundry & Cleaning were $0.04m unfavourable for the month, as a result of the increased activity in the hospitals during the month.

Transport costs as expected are lower than budget with less travelling activity due to COVID restrictions.

IT systems are favourable due to the internal charge for line rentals not journaled to cost centres. This is a timing variance and will reverse next month.

Other operating costs were $0.04m over budget due to higher than budgeted spends in Postage, Printing and Minor purchases. Printing and forms includes an $8k procurement saving that has not yet had a tangible plan put in place to meet. We have reviewed minor purchases and although a large percentage of this spend relates to office furniture, there is a component that appears to be minor clinical equipment (approx. $8k). We will review this over the coming month to understand the coding of the transactions and if a reclassification is required.

8. Non-operating Expenses

These costs relate to depreciation charges for clinical equipment and were close to budget in July. This reflects the timing of spend and capitalisation of clinical equipment.

9. Appendix 1

Workforce Costs

Workforce costs for analysis purposes are divided into 3 categories;

4) Direct Costs – these are the payroll costs paid through the payroll system and generally form part of an employee's standard employment. These include but are not limited to:
    - Ordinary time for working standard hours
    - Sick leave
    - Allowances
    - Penal
    - Annual leave
    - Statutory leave

- Overtime
- Kiwisaver and Superannuation

5) Indirect Costs – these are generally not processed through the payroll system and while attributable to an employee, are not specifically related to the hours they work in any week. These include, but are not limited to;
    - The costs of attending courses / conferences such as travel costs, accommodation and food costs.
    - Membership fees reimbursed to individuals or paid on their behalf as part of their employment to belong to certain organisations.
    - Recruitment costs.
    - Relocation costs where negotiated as part of a contract.
    - Redundancy costs.
    - Grievance settlements.
    - Parental leave payments.

6) Outsourced costs are generally payments to organisations for locums who are not employed by Southern DHB. The locums generally cover for employee vacancies, annual leave in areas of key specialties or roster gaps.

What is an FTE?
An FTE (Full-Time Equivalent) is a number, typically between zero and one that represents how much full-time work an employee performs based on a 40 hour working week. For example, an employee who works 20 hours per week is said to be 0.5 FTE, assuming that 40 hours per week is a typical full-time employee. It is important to distinguish between headcount and FTEs; headcount counts actual numbers of people whereas FTEs are a measure of 'workforce input' or 'work done', regardless of the number of employees.

For financial reporting purposes, we calculate and report for FTE on an accrued basis. The word 'accrued' is used as this measure includes the accrual of paid leave when the entitlement has been earned, (i.e. annual leave, time off in lieu and statutory holidays). It does not include accrual of leave such as bereavement leave or sick leave as these are 'situational' leave entitlements that do not accrue; they are taken as and when an event occurs.

Accrued FTE is actually very similar to Paid FTE except that it excludes paid leave that has already been accrued (i.e. annual leave, time in lieu), but includes the proportional accrual of these leave types.

Accrued FTE is primarily a financial reporting value and can be applied to all employees regardless of occupation. It has been the main FTE reported value for DHBs since July 2006 for reporting to the Ministry of Health on a monthly basis and in the Annual Plans.

SOUTHERN DISTRICT HEALTH BOARD

Title:	**Surgical Services and Radiology Directorate – Special Report on Clinical Supplies Variances for July 2020**
Report to:	Hospital Advisory Committee
Date of Meeting:	07 September 2020

Summary:

Considered in these papers are:

- July 2020 DHB activity.

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

Financial:	Yes
Workforce:	Yes
Equity:	Any equity issues are covered in the body of the report.
Other:	No

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

Prepared by: Executive Director of Specialist Services **Date:** 24/08/2020	**Presented by:** Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:

That the Hospital Advisory Committee receive the report.

Surgical Services and Radiology Directorate – Special Report on Clinical Supplies Variances for July 2020

Recommendation

That the Hospital Advisory Committee notes this report.

1. Executive Summary

Please note: The volumes referred to in this report are different to those found in the finance report and reported elsewhere. This is because the volumes in this report were specifically compiled to match internal case weight discharge (CWD) activity in order to best explain clinical supplies over expenditure (which is driven by internal activity). For this reason outsourced CWD activity was excluded from the volumes used in this analysis. The elective volumes in this report were reconciled to the elective initiative volumes that are submitted to the Ministry. This includes some medical CWD which count towards the elective initiative but are not found in the surgical volumes in the finance report.

The directorate results for clinical supplies were adverse to plan by $418k. As this was the most material variance in the Specialist Services portfolio, the EDSS has completed a 'deep dive' to better understand and explain the results. Good information about variance to plan was difficult to find so available case weight discharge (CWD) and discharge volume information was cross referenced against available General Ledger information in an attempt to seek better clarity for what drove over expenditure when compared to budget.

At a high level, there was circa 9% more internal case weight activity but circa 14% more clinical supplies costs, when actual and planned activity are compared. However, when an $81k hip and knee accrual error is accounted for and radiology over expenditure (not correlated to surgical volumes) is also accounted for the remaining cost overrun is well explained by the additional volume. It should be noted that specific components (found later in the report) such as pharmacy costs are considerably higher than budgeted for and need further investigation. It should also be noted that the circa 141 case weights of additional elective activity that was delivered in house all attracts case weight revenue ($5,545 per case weight), and amounts to circa $782k of additional revenue that was not recognised in July 2020 financial results (we only accrue to 100% of planned revenue). If we continue to deliver to plan later in the year we would be able to reduce outsourcing and recognise this additional revenue as reduced outsourced costs of a similar value later in the year, which would more than offset the current clinical supplies over expenditure.

However, a comparison to 2019 costs and activity produces a variation that still needs more explanation, and not all the sub-categories of expenditure are well explained by volume alone. And it is likely that there are budget accuracy challenges at line item level, with a degree of *'unders and overs'.*

2. High Level Conclusions

Case weight and discharge activity July 2020 compared to budget 2020.

The more significant / important findings have been reached from comparing 2020 actual and budgeted costs.

a. 360 case weights of additional activity was delivered electively compared to the elective plan in July 2020. Excluding outsourcing a total of 141 case weights of additional elective surgery were delivered in-house.

b. It has proven challenging to find budgeted acute case weight volumes. However, if we assume 2019 acute volumes as planned volumes then acute volumes were essentially the same for 2019 and 2020 (only 1 CWD different overall).

c. Planned elective case weights (excluding outsourcing) were circa 1,277 for July 2020. Last years' acute case weights were circa 1,356 for a total 'planned' delivery of 2,633 case weights, excluding outsourcing.

d. However, actual delivery excluding outsourcing was 2,881 in July 2020 (248 case weights higher than this). This translates into 8.6% more CWD surgery delivered than planned for. Costs were $418k higher than plan on $3.027m of planned expenditure, translating into 13.8% above plan. However, there was an accrual error in hips (worth $81k) and radiology costs not explained by CWD volumes were worth $74k. Bridging these components out provides the following picture:

Clinical Supplies Budget:	3,027,420
Expenditure over Plan:	**418,014**
Percentage Over Expenditure:	14%
Explanation Summary:	
Internal CWD Volumes > Plan:	
Total Internal CWD Volumes > Plan:	248
Plan (Internal CWD Only) **:	2,633
Percentage Over Expenditure (Volume):	9%
Explanation in Dollars:	285,150
Accrual Error (Hip June costs in July):	81,000
Radiology Costs Not Explained by CWD:	74,177
Remaining movement (unexplained):	-22,313
Total Variance Explained:	**418,014**

** Internal Elective Plan + Last Years' Actual Acute Volumes

I.e. surgery related costs are well explained by the additional CWD activity.

Case weight and discharge actual activity July 2020 versus July 2019.

a. An increase in case weight activity at both Otago and Southland hospitals led to higher volumes of consumables, implants and prosthesis and consumables being used, year on year.

b. CWD were circa 141 higher in July 2020 than in July 2019, but discharges were similar (-1 difference).

c. However, total clinical supplies costs in July 2019 look incorrect at $2.6m. The 4 months on either side of July 2019 averaged circa $2.95m. The finance team have been asked to investigate the apparent anomaly in July 2019 results further.

In summary, when the hip accrual error (June hip costs being incurred in July financial results worth $81k), and radiology costs not related to surgery are accounted for, the remaining Clinical Supplies cost overrun compared to budget is well explained by volume.

3. Areas of Additional Activity and Associated Costs

Please note that our 2020/21 production plan is still being negotiated with the Ministry. In the meantime we have rolled last years' plan values forward. As there is not a high increase in expectation (in terms of additional case weight delivery) last years' plan gives us a materially correct view of the target for this year.

A summary of where the additional activity occurred is as follows:

SSRD Clinical Supplies - Over Expenditure by Main Categories

	Actual	Budget	Var
Implants & Prostheses	**1,438,780**	**1,217,584**	**221,196**
Cardiac Surgery	198,000	150,000	48,000
Cardiac Theatre Consumables	68,664	49,535	19,129
General Surgery Treatment Costs	110,307	87,665	22,642
Main Operating Theatres	729,806	595,107	134,699
Instruments & Equipment	**665,672**	**584,756**	**80,916**
Main Operating Theatres	285,155	222,264	62,891
MI - Mri	30,308	16,032	14,276
Perioperative	132,597	116,511	16,086
Radiology	50,100	61,597	-11,497
Pharmaceuticals	**219,108**	**171,489**	**47,619**
Day Surgery	18,520	12,150	6,370
Main Operating Theatres	91,913	75,774	16,139
Ophthalmology Outpatients	38,821	32,959	5,862
Perioperative	39,854	35,195	4,659
Radiology	23,526	8,019	15,507
Treatment Disposables	**1,017,720**	**951,555**	**66,165**
MI - Dsa	85,682	41,289	44,393
Perioperative	230,825	206,608	24,217
All Other	1,311,355	1,316,715	-5,360
Grand Total	**3,445,434**	**3,027,420**	**418,014**

Material Variances:

1	Cardiac and Cardiothoracic:	67,129
2	Implants & Prosthesis primarily Orthopaedic:	134,699
3	Disposable Instruments (DSU):	62,891
4	Medical Imaging - DSA and other:	58,670
5	Pharmacy:	47,619
		371,009
	Explains:	**89%**

1. Cardiac and Cardiology. We completed 109 case weights more activity than last year (94 in cardiology and 15 in cardiothoracic), and in particular, we completed 6 more TAVIS than we had planned to (8 versus 6). The implants and the consumables translated into a cost increase when compared to budget of $67k. The catheter laboratory costs are consistent with the costs seen in Medicine, Women and Children, where the Cath Lab ran over budget by $125k associated with higher volumes apparently due to the subsequent wave of activity caused by the laboratory essentially being shut during COVID.

2. Implants and Prosthesis – Primarily Orthopaedic Surgery. We did 24 case weights more activity than last year. This was evenly split between elective surgery (12 cwd) and acute surgery (12 cwd). In addition to the additional surgical activity, the BA has advised that circa $81k of June hip costs were incurred in July (i.e. mistakenly not accrued for). We have developed a Power BI dashboard (refer to appendix 3) which will enable us to forecast hip and knee expenditure and allow us to check whether the volumes and costs for hips and knees look reasonable on the basis of multiplying the admission data by the weight average for hips and for knees. The remainder of the cost overrun appears to be screws, nails, spinal plates, cement and glue.

3. Instruments and Equipment – Primarily Disposable Instruments in the DSU. We overspent primarily in the Day Surgical Unit. Approximately 18% extra CWD volume went through the DSU in July 2020 compared to July 2019.

   Medical Imaging DSA was primarily catheter costs. Upon review with the radiology team we concluded that $12k of costs were miscoded and should have been coded elsewhere. There was an increase in cases from an average of 76 to 104 cases being completed in the month (37%). Once $12k of miscoding is accounted for the 37% increase in activity reasonably explains a further $15k, with the remaining $17k potentially a budget accuracy issue. Overall, radiology had a busy month with a high level of post COVID catch up activity.

4. Pharmaceutical expenditure is $47k higher than budget which translates into 27% more than plan. We have not been able to identify any obvious reasons for the higher than anticipated variance to plan (these costs are GL transactions which have been allocated from elsewhere in the organisation). Our initial conclusion is that the budget appears to have been understated for this cost line. Further investigation will be undertaken.

4. Overall Conclusion

We had to derive the plan numbers using planned elective activity plus last years' actual acute activity. On the basis of this (derived) plan number, we delivered circa 9% more activity internally than we had 'planned' to and we incurred 14% more clinical supplies costs than we had planned.

However, the gap is explained by a hip accrual error (where $81k of June costs were not accrued for in June and were instead incurred in July), and by backing out the radiology costs which are not correlated with CWD.

Unfortunately the GL information is quite limited and it is a bit challenging to drill further into the cost categories. By cross referencing with our CWD volumes we can see that we delivered circa 140 additional CWD when compared to July 2019, and these were in high cost areas such as cardiology, cardiothoracic and orthopaedic, whilst the overall volume of discharge activity was almost the same as in July 2019 (-1 difference).

Relatively high costs in cardiology relate to the Catheter Laboratory effectively catching up from when it was closed during COVID. Modest additional orthopaedic volumes (24 CWD compared to last year) resulted in higher supplies costs and additional activity through the DSU resulted in an increase in the costs of disposable instruments.

As noted earlier, this activity all contributed to circa 140 additional case weights of internal delivery over and above the elective plan, and if we were able to stay on plan for the remainder of the year this could be converted into a financial saving by reducing $754k of outsourcing activity later in the year.

5. Surgical Performance – Case Weights and Discharges

Actions and Next Steps

It is relatively complex to match volumes and general ledger cost information but we need to get much better at cross referencing this data to explain our performance in the clinical supplies expenditure lines.

Actions:

- We have constructed an initial Power BI dashboard that will enable month to date forecasting of the hips and knees categories and we need to build on this and extend it to other activity (e.g. spinal surgery) as well.
- We will organise to meet with the Cardiology team to understand future volumes. We need to develop a forecast for Catheter Laboratory expenditure so that we can anticipate whether it will continue to run over and to plan accordingly.
- We need the BA team to further investigate the pharmaceutical costs (which were circa 27% higher than budget and therefore not well explained by volumes). Although this was a relatively small cost element we need clarity about whether the allocations are correct and if they are with no apparent overconsumption then we need to clarify how the budget was developed.
- And we need to undertake a more comprehensive review of radiology costs, correlate them to volume and explain them in a similar manner to this report.

Appendix 1: Case Weights and Discharges 2020 versus 2019 (Internal Delivery Only)

Case Weight Delivery 2020 versus 2019

activity_type	(Multiple Items)	All Case Weights
AdmissionType	(Multiple Items)	
facility_name	(Multiple Items)	

Reported CW	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Anaesthesia	2	1	-1
Cardiology	235	329	94
Cardiothoracic	201	216	15
E.N.T	165	122	-43
General Surgery	637	727	91
Gynaecology	121	154	33
Neurosurgery	100	86	-14
Ophthalmology	70	89	19
Orthopaedics	808	831	23
Paediatric Surgery	26	15	-11
Plastic Surgery	128	64	-64
Urology	111	130	19
Vascular Surgery	140	116	-24
Grand Total	**2,744**	**2,881**	**138**

activity_type	(Multiple Items)	Elective C.W.D
AdmissionType	(Multiple Items)	
facility_name	(Multiple Items)	

Reported CW	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Anaesthesia	2	1	-1
Cardiology	79	158	79
Cardiothoracic	132	190	58
E.N.T	143	105	-38
General Surgery	238	280	41
Gynaecology	82	99	17
Neurosurgery	34	45	11
Ophthalmology	66	81	15
Orthopaedics	381	393	12
Paediatric Surgery	13	15	2
Plastic Surgery	52	48	-4
Urology	66	90	24
Vascular Surgery	99	49	-51
Grand Total	**1,387**	**1,553**	**166**

activity_type	(Multiple Items)	Acute C.W.D
AdmissionType	Acute Admission	
facility_name	(Multiple Items)	

Reported CW	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Cardiology	156	171	15
Cardiothoracic	69	26	-43
E.N.T	22	17	-5
General Surgery	398	448	49
Gynaecology	39	55	16
Neurosurgery	66	41	-25
Ophthalmology	4	8	3
Orthopaedics	427	438	12
Paediatric Surgery	13		-13
Plastic Surgery	76	16	-60
Urology	45	40	-5
Vascular Surgery	41	67	27
Grand Total	**1,356**	**1,328**	**-28**

Discharge Delivery 2020 versus 2019

activity_type	(Multiple Items)	All Discharges
AdmissionType	(Multiple Items)	
facility_name	(Multiple Items)	

Count of NHI	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Anaesthesia	5	2	-3
Cardiology	162	173	11
Cardiothoracic	41	35	-6
E.N.T	231	191	-40
General Surgery	477	522	45
Gynaecology	163	185	22
Neurosurgery	29	38	9
Ophthalmology	238	170	-68
Orthopaedics	413	415	2
Paediatric Surgery	19	20	1
Plastic Surgery	93	79	-14
Urology	103	133	30
Vascular Surgery	63	73	10
Grand Total	**2,037**	**2,036**	**-1**

activity_type	(Multiple Items)	Elective Discharges
AdmissionType	(Multiple Items)	
facility_name	(Multiple Items)	

Count of NHI	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Anaesthesia	5	2	-3
Cardiology	66	82	16
Cardiothoracic	24	28	4
E.N.T	199	163	-36
General Surgery	140	169	29
Gynaecology	97	117	20
Neurosurgery	16	17	1
Ophthalmology	232	161	-71
Orthopaedics	204	182	-22
Paediatric Surgery	16	20	4
Plastic Surgery	77	69	-8
Urology	56	85	29
Vascular Surgery	43	35	-8
Grand Total	**1,175**	**1,130**	**-45**

activity_type	(Multiple Items)	Acute Discharge
AdmissionType	Acute Admission	
facility_name	(Multiple Items)	

Count of NHI	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Cardiology	96	91	-5
Cardiothoracic	17	7	-10
E.N.T	32	28	-4
General Surgery	337	353	16
Gynaecology	66	68	2
Neurosurgery	13	21	8
Ophthalmology	6	9	3
Orthopaedics	209	233	24
Paediatric Surgery	3		-3
Plastic Surgery	16	10	-6
Urology	47	48	1
Vascular Surgery	20	38	18
Grand Total	**862**	**906**	**44**

Appendix 2: Surgical Discharge Activity (Just Otago) Showing Higher Acute Volumes Year on Year

Case Weight Delivery 2020 versus 2019

activity_type	(Multiple Items)	All Case Weights
AdmissionType	(Multiple Items)	
facility_name	Dunedin Hospital	

Reported CW	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Anaesthesia	2	1	-1
Cardiology	235	329	94
Cardiothoracic	201	216	15
E.N.T	131	96	-35
General Surgery	379	442	63
Gynaecology	73	98	25
Neurosurgery	100	86	-14
Ophthalmology	57	76	19
Orthopaedics	594	593	-1
Paediatric Surgery	20	7	-13
Plastic Surgery	123	61	-62
Urology	67	81	14
Vascular Surgery	140	116	-24
Grand Total	**2,123**	**2,202**	**79**

activity_type	(Multiple Items)	Elective C.W.D
AdmissionType	(Multiple Items)	
facility_name	Dunedin Hospital	

Reported CW	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Anaesthesia	2	1	-1
Cardiology	79	158	79
Cardiothoracic	132	190	58
E.N.T	109	78	-30
General Surgery	145	148	4
Gynaecology	53	72	19
Neurosurgery	34	45	11
Ophthalmology	52	68	16
Orthopaedics	307	275	-33
Paediatric Surgery	7	7	0
Plastic Surgery	48	45	-2
Urology	38	56	18
Vascular Surgery	99	49	-51
Grand Total	**1,106**	**1,192**	**86**

activity_type	(Multiple Items)	Acute C.W.D
AdmissionType	Acute Admission	
facility_name	Dunedin Hospital	

Reported CW	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Cardiology	156	171	15
Cardiothoracic	69	26	-43
E.N.T	22	17	-5
General Surgery	234	293	59
Gynaecology	20	26	6
Neurosurgery	66	41	-25
Ophthalmology	4	8	3
Orthopaedics	287	319	32
Paediatric Surgery	13		-13
Plastic Surgery	76	16	-60
Urology	29	25	-4
Vascular Surgery	41	67	27
Grand Total	**1,017**	**1,010**	**-7**

Discharge Delivery 2020 versus 2019

activity_type	(Multiple Items)	All Discharges
AdmissionType	(Multiple Items)	
facility_name	Dunedin Hospital	

Count of NHI	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Anaesthesia	5	2	-3
Cardiology	162	173	11
Cardiothoracic	41	35	-6
E.N.T	176	150	-26
General Surgery	236	310	74
Gynaecology	99	111	12
Neurosurgery	29	38	9
Ophthalmology	107	145	38
Orthopaedics	270	247	-23
Paediatric Surgery	14	9	-5
Plastic Surgery	86	75	-11
Urology	62	81	19
Vascular Surgery	63	73	10
Grand Total	**1,350**	**1,449**	**99**

activity_type	(Multiple Items)	Elective Discharges
AdmissionType	(Multiple Items)	
facility_name	Dunedin Hospital	

Count of NHI	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Anaesthesia	5	2	-3
Cardiology	66	82	16
Cardiothoracic	24	28	4
E.N.T	144	122	-22
General Surgery	78	93	15
Gynaecology	68	86	18
Neurosurgery	16	17	1
Ophthalmology	101	136	35
Orthopaedics	154	108	-46
Paediatric Surgery	11	9	-2
Plastic Surgery	70	65	-5
Urology	35	56	21
Vascular Surgery	43	35	-8
Grand Total	**815**	**839**	**24**

activity_type	(Multiple Items)	Acute Discharge
AdmissionType	Acute Admission	
facility_name	Dunedin Hospital	

Count of NHI	Column Labels		
Speciality	2019/2020	2020/2021	Variance
Cardiology	96	91	-5
Cardiothoracic	17	7	-10
E.N.T	32	28	-4
General Surgery	158	217	59
Gynaecology	31	25	-6
Neurosurgery	13	21	8
Ophthalmology	6	9	3
Orthopaedics	116	139	23
Paediatric Surgery	3		-3
Plastic Surgery	16	10	-6
Urology	27	25	-2
Vascular Surgery	20	38	18
Grand Total	**535**	**610**	**75**

Appendix 3: Power BI Dashboard Enabling us to Forecast Monthly Hip and Knee Expenditure from Admissions Data

Region	Dunedin		Invercargill		Total
Year	Acute Admission	Elective (> 7 days)	Acute Admission	Elective (> 7 days)	
2020	24	64	5	28	121
July	15	48	4	14	81
August	9	16	1	14	40
Total	24	64	5	28	121

Implant	Dunedin		Invercargill		Total
Year	Hip	Knee	Hip	Knee	
2020	70	18	16	17	121
July	49	14	10	8	81
August	21	4	6	9	40
Total	70	18	16	17	121

Region	Dunedin						Invercargill						Total		
Implant	Hip			Knee			Hip			Knee					
Year	Budget	Actual*	Variance	Budget	Actual*	Variance	Budget	Actual*	Variance	Budget	Actual*	Variance	Budget	Actual*	Variance
2020	926770	339,072.02	587,697.98	662946	82,046.79	580,899.21	541433	88,143.35	453,289.65	301092	113,932.66	187,159.34	2432241	623,194.81	1,809,046.19
July	161018	226,048.01	-65,030.01	115181	64,773.78	50,407.22	94069	58,762.23	35,306.77	52312	53,968.10	-1,656.10	422580	403,552.12	19,027.88
August	177602	113,024.01	64,577.99	127044	17,273.01	109,770.99	103758	29,381.12	74,376.88	57700	59,964.56	-2,264.56	466104	219,642.69	246,461.31
September	122065		122,065.00	87317		87,317.00	71312		71,312.00	39657		39,657.00	320351		320,351.00
October	177602		177,602.00	127044		127,044.00	103758		103,758.00	57700		57,700.00	466104		466,104.00
November	180302		180,302.00	128975		128,975.00	105335		105,335.00	58577		58,577.00	473189		473,189.00
December	108181		108,181.00	77385		77,385.00	63201		63,201.00	35146		35,146.00	283913		283,913.00
2021	1001593		1,001,593.00	716465		716,465.00	585144		585,144.00	325402		325,402.00	2628604		2,628,604.00
January	108181		108,181.00	77385		77,385.00	63201		63,201.00	35146		35,146.00	283913		283,913.00
February	183195		183,195.00	131044		131,044.00	107025		107,025.00	59517		59,517.00	480781		480,781.00
March	191487		191,487.00	136975		136,975.00	111869		111,869.00	62211		62,211.00	502542		502,542.00
April	149834		149,834.00	107180		107,180.00	87535		87,535.00	48679		48,679.00	393228		393,228.00
May	183195		183,195.00	131044		131,044.00	107025		107,025.00	59517		59,517.00	480781		480,781.00
June	185701		185,701.00	132837		132,837.00	108489		108,489.00	60332		60,332.00	487359		487,359.00
Total	1928363	339,072.02	1,589,290.98	1379411	82,046.79	1,297,364.21	1126577	88,143.35	1,038,433.65	626494	113,932.66	512,561.34	5060845	623,194.81	4,437,650.19

In Confidence Session:

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

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

General subject:	*Reason for passing this resolution:*	*Grounds for passing the resolution:*
Previous Public Excluded Meeting Minutes	As set out in previous agenda.	As set out in previous agenda.
Dunedin Hospital Redevelopment	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.
Sterile Services Update	To allow activities and negotiations (including commercial negotiations) to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the Official Information Act
Executive Director of Specialist Services Report • Surgical Performance case weights and discharges • Inpatient Performance (ESPI5) • Generalism • Planned Care Wait List Improvement	To allow activities and negotiations to be carried on without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.