Southern DHB Hospital Advisory Committee

Board Room, Community Services Building, Southland Hospital Campus, Cnr Kew and Elles Roads, Invercargill

02/11/2020 01:30 AM - 04:30 PM

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
David Perez (Acting Board 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		
	12.09.2020	Co-Director, OffTrack MTB Ltd	No conflict (Husband's bike tourism company(.	
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		
	07.10.2020	Trustee, Southern Health Welfare Trust	Trust for Southland employees - owns holiday homes and makes educational grants.	
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		

SOUTHERN DISTRICT HEALTH BOARD
INTERESTS REGISTER

Member	Date of Entry	Interest Disclosed	Nature of Potential Interest with Southern DHB	Management Approach
	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* (also A3 Kaitiaki Limited which is listed as 100% owned by Te Rūnaka Ōtākou Ltd)	Nil does not contract in health.	Updated to include A3 Kaitiaki Limited on 19 October 2020.
	09.12.2019	Member, Independent Whānau Ora Reference Group		
	08.09.2020	Member, District Licensing Committee, Dunedin City Council (1 September 2020 to 31 May 2023)		
	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)~~	Removed 07/09/2020	
	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.	
	06.05.2020	Nephew is married to a Paediatric Medicine Registrar employed by Southern DHB		
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
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
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
Hamish BROWN	22.09.2020	Nil	
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	
	~~25.09.2016~~	~~Deputy Chair, InterRAI NZ~~	Removed 23.09.2020
	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	

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
	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.
	23.09.2020	Arvida Group (aged residential care provider)	Sister works for Arvida Group (North Island only)
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	NZ InterRAI Fellow	InterRAI supplies the protocols for aged care assessment in SDHB via a licence with the MoH.
	04.07.2016	Son - employed by Orion Health	Orion Health supplies Health Connect South.
	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
	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~~

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
	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
	04.08.2020	Shareholder and Director, Inversionne Limited	Nil, clothing wholesaler.
		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.
	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
Greer HARPER	24.08.2020	Paul Harper (father) is the current Chair of HealthSource NZ which is owned by the four northern DHBs.	

Southern District Health Board

Minutes of the Hospital Advisory Committee Meeting held on Monday, 7 September 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
	Ms Justine Camp	Committee Member
	Dr John Chambers	Committee Member
	Mr Dave Cull	Committee Member
	Dr Lyndell Kelly	Committee Member
	Miss Lesley Soper	Committee Member *(by zoom)*
	Dr Moana Theodore	Committee Member
In Attendance:	Ms Ilka Beekhuis	Board Member *(by zoom)*
	Mrs Kaye Crowther	Board Member *(by zoom)*
	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
	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
	Mrs Joanne Fannin	Personal Assistant (minute taker)

1.0 WELCOME

The Chair welcomed everyone to the meeting and acknowledged Mrs Joanne Fannin as the minute taker for the Hospital Advisory Committee in her new role as Personal Assistant to the CEO's Office.

2.0 APOLOGIES

An apology for lateness was received from Ms Justine Camp (new appointment to the Committee from the Iwi Governance Committee) and an apology for early departure was received from Mr Dave Cull and Mr Gilbert Taurua.

3.0 DECLARATION OF INTERESTS

The Interests Registers were circulated with the agenda (tab 2).

The Chair asked for any changes to the registers to be sent to the Minutes 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."

4.0 PREVIOUS MINUTES

***It was resolved**:*

"That the minutes of the meeting held on 6 July 2020 be approved and adopted as a true and correct record."

D Perez/J O'Callaghan

5.0 MATTERS ARISING/REVIEW OF ACTION SHEET

The Committee reviewed the action sheet (tab 4).

Nitrous Oxide Usage

- The Executive Director Specialist Services (EDSS) advised that a report received has indicated a reduction in usage of 1301 tonnes since the reporting started. He asked that the action be carried over one more time due to concerns that there may be a reporting issue as there is no explanation for the reduction in usage.

Colonoscopy

- The standardised Colonoscopy intervention rate increased from 76 per 10,000 in 2015/16 to 100.2 in 2018/19. A request was made for a comparison to the national rates to be provided.

6.0 VALUING PATIENTS' TIME

Mrs Jane Wilson, Chief Nursing and Midwifery Officer and Dr Nigel Millar, Chief Medical Officer presented on the Patient Flow – a strategy to improve quality, performance and efficiency.

The Committee was informed on the following:

- The challenges since the last meeting with the resurgence of COVID-19 and getting data.
- Why VPT is critical in an integrated health system.
- The impact of 10 days in hospital on ageing in the muscles of people over 80.
- The pathway forward in joining up the whole system, connecting primary care initiatives to hospital patient journeys.
- The work being done with the patient cohort in the Emergency Department (ED) in Southland.
- The aligning metrics and dashboards will be provided to all staff in individual departments once they have been refined.
- The programmes of work underway, e.g. Fit to Sit in Dunedin, Generalism and Older People's Health.
- The five components of the safer patient flow bundle which is designed to expedite inpatient care and discharge.
- The importance of engagement with the Clinical Council, Clinical Directors and other Inter-professional Leads.

- Questions every patient and relative/carer should know the answer to and the senior review process.

Ms Justine Camp joined the meeting at 2.00pm.

- Rapid rounds and self-assessment. Members viewed a video clip with staff speaking on rapid rounds.

Management answered questions from members on the programme, including whether there are sufficient district nurses to support those being discharged, involvement of the Home Team and afternoon wrap-ups and evaluation.

The Hospital Advisory Committee thanked the team for their presentation and strongly endorsed the Safer Patient Flow concept and programme, whilst acknowledging that it is early days and they look forward to seeing the delivery in time.

Dr Jo Mitchell joined the meeting at 2.10pm.

The Chairman acknowledged and welcomed Ms Justine Camp and Dr Jo Mitchell to the meeting.

7.0 A JOURNEY TOWARDS INTEGRATION: A MODEL OF CARE FOR PATIENTS WITH RHEUMATOLOGICAL CONDITIONS

Dr Jo Mitchell, Rheumatologist, presented on a model of care for patients with rheumatological conditions which allows for many patients with stable rheumatological conditions to be largely managed in the community. The Committee was informed on the following:

- The journey of three years that is on-going.
- Integrated Care is a term that reflects a concern to improve patient experience and achieve greater efficiency and value from health delivery systems.
- Rheumatology is a multi-disciplinary specialty with a high level of interaction within services.
- The Rheumatology Service is an outpatient based specialty, but does have in-patients.
- The wide range of conditions that fall under the Rheumatology specialty.
- The Rheumatology team and service vision.
- Patient involvement, building relationships and engaging with primary care and the re-design of models of care.
- Consumer engagement and the establishment of the Consumer Advisory Group (CAG) in 2019.
- Patient experience surveys, developed with the Health Quality and Safety Commission.
- Survey of Rheumatology patients by telephone between February and June 2020 and the need to follow up to understand why 23% of those surveyed indicated they would not want a telephone appointment again.
- Engagement with the Health Pathways Team.
- Primary care engagement and initiatives to achieve that.
- Vision focus and transforming thinking.
- Service redesign from the learnings and region and practice specific solutions.

- Telemedicine pilot in Wanaka and meeting with Wanaka GPs.

Dr Mitchell responded to questions from management and received feedback as follows:

- Locality Network members in Central Lakes spoke highly of the Rheumatology service and other services could be integrated in a similar way.
- Communication via e-mail is not always secure and the use of the Electronic Referral Management System (ERMS) is encouraged.
- The initiative has created more of a demand on Dr Mitchell's time, but it is believed that as the new model is embraced that will change.
- Ms Camp queried how the new integrated model would facilitate more whānau care in the area of Rheumatology. Consideration is being given to whānau going to their GP and having a telemedicine consultation, so they don't need to take time off work. Any feedback on that concept or other ideas are welcome.
- The "hands on" aspect of Rheumatology is addressed by having a GP in the room with the patient and the GP does the examination. The goal is to upskill primary care in the Rheumatology examination.
- To maximise efficiencies, a remote team is required.
- The EDSS advised on the proposed funding mechanism.

The Hospital Advisory Committee thanked Dr Mitchell for her presentation, noting that it is a prototype that will affect other services. The Committee acknowledged that it is still a work in progress and undertook to support the initiatives as much as possible.

Mr Gilbert Taurua left the meeting and Mr Simon Donlevy, Ms Emma Bell and Professor Patrick Manning joined the meeting at 2.40pm. Ms Miranda Buhler joined the meeting via zoom at 2.40pm.

8.0 TELEHEALTH FOR THE SOUTHERN HEALTH SYSTEM

Professor Patrick Manning, Specialist Endocrinology; Ms Miranda Buhler, Physiotherapist; Mr Simon Donlevy, General Manager Medicine, Women's and Children's Health and Ms Emma Bell, Programme Lead, presented on Telehealth for the Southern Health System (He Hautoka, he hauora). The Committee was informed on the following:

- As part of the process discussions have been held with Dr Jo Mitchell to ensure that the respective projects dovetail in with each other. Telehealth in Rheumatology is a long way ahead of other services.
- A recap on what telehealth is.
- The benefits of telehealth for both patients and the DHB.
- Telehealth models.
- Progress since COVID – a steering group and interest group have been established.
- Progress made by the Steering Group and the development of a toolkit for services contemplating using telehealth.
- Targets and evaluation – the challenges and the measures.
- The numbers using telehealth within Southern DHB. There has been a five-fold increase in services using Telehealth since April 2019.

- Overall Telehealth is good for our population and there is plenty of enthusiasm around it. Expansion into utilisation to increase communication between Primary and Secondary care has much potential and there is a need for only relatively modest additional resource to realise the full potential.

- How can the HAC support increased adoption of Telehealth?
- Professor Manning provided an update on the evolution of his use of Telehealth in his specialty of Endocrinology following COVID, citing the positive feedback from patients re the time saving and the increased productivity. He advised the need to educate people about the use of telehealth and reported on the increase in work involved for administration staff. Telehealth is time efficient for people living locally as well as those based rurally.
- Ms Buhler provided an update on the benefits of Telehealth for her as a Hand Therapist. She noted barriers in the past with availability of facilities with access to the technology and noted the benefits of being able to link directly into people's homes. The age of some devices can cause connection issues, but overall interactions have been successful remotely. Telehealth is worth the investment and allows less people to miss out on good quality care.

The team answered questions from members on Telehealth, including providing statistics on Did Not Attends (DNAs). Feedback was provided on the issue of risk and Medico-Legal considerations, with Professor Manning acknowledging risk and outlining mitigation strategies, noting that where there are concerns the patient would need to attend a meeting in person. Education in primary care and good quality cameras would assist in addressing some of the issues. There is currently no telehealth system that interfaces with the Inpatient Management System (IPM), which is causing the additional burden for administration. There is a booking function within Microsoft Teams, which is being developed and will make it easier for administration staff to book Telehealth appointments, but this is still an extra step. Canterbury DHB has managed to integrate Microsoft Teams with the South Island Patient Administration System. Professor Manning advised of enhancements being developed that will enable a field to be added to ERMS to indicate when a Telehealth appointment is acceptable to the patient.

Discussion was held on equity and the use of community hubs to increase cultural capacity within the DHB for whānau. Telehealth also provides a tool to reach back out in to the community, accommodating whānau support.

The team consider that Telehealth has now reached a stage where it can be considered a standard procedure. It was agreed that the public need to be educated on the benefits of Telehealth so they know it is an option available to them. The CEO has asked the Community Health Council to look at how they can engender a process where the community ask for it. Work is being done to roll Telehealth out in a measured way to ensure that Clinicians and other health professionals can cope with the demand created.

The Hospital Advisory Committee thanked the team for their presentation, noting that it is good to see Telehealth imbedded in the system and members look forward to receiving future updates.

Mr Simon Donlevy, Ms Emma Bell, Professor Patrick Manning, Dr Jo Mitchell and Ms Miranda Buhler left the meeting at 3.40pm.

9.0 SPECIALIST SERVICES MONITORING AND PERFORMANCE REPORTS

Executive Director Specialist Services' Report

The Executive Director Specialist Services (EDSS)' monthly report (tab 8.1) was taken as read and the EDSS drew the Committee's attention to the following items:

Surgical Case Weights

The EDSS advised that for the month of July 2020, 350 case weights more than plan were completed. Of this, 100 case weights were additional outsourcing due to initiating recovery of surgery early, leaving 250 case weights delivered more than plan. Most of the activity was due to a clear run with cardiothoracic cases and a catch up of cardiac activity following the closure of the Catheter Laboratory during the COVID lockdown earlier in the year. This was a positive result in terms of catching up with plan, but resulted in additional costs for clinical supplies. An expenditure problem has resulted and a special report on that is included as part of the financial section.

Outpatients performance

Good performance was recorded, with activity starting to recover to pre COVID levels of outpatient reaches and good initiatives driving improvement.

Prioritisation tool

The prioritisation tool is continuing to achieve good results for the services it has been rolled out to. An innovation funding request has been put in to the Ministry of Health (MoH). Resourcing would allow systematic delivery across all specialties.

Inpatient waitlist (patients waiting more than 120 days for surgery)

There are currently 1000 patients on the inpatient waitlist. Most services are in balance so what is being accepted on the inpatient waitlist on a weekly basis on average matches what is being taken off through surgical activity. COVID, strikes pre COVID and some history has caused a high accumulation of long waiting patients. It is expected that recovery money will assist in clearing 60% of the list over the next three years, but some action will need to be taken in the short term. One initiative has been to build dashboards so that management can see by specialty every patient waiting greater than 120 days. Every patient who has been waiting over two years will be looked at and a call will be made to discharge or fast track back through the outpatient process.

Medical Imaging

A lot of work has been put in to recover MRI and CT following two recent equipment failures in Dunedin, resulting in one machine being out of commission for two weeks and a second machine expected to be out of commission for one week. The supply of parts from overseas has been impacted by COVID.

Emergency Department (ED)

Management has undertaken a special analysis, with a view to understanding quantitatively what happened to ED volumes during COVID. Data was available showing every transaction over the past five years. An update was given on the percentage change in volumes for both Dunedin and Southland Hospitals. Of note was the difference in reduction of presentations between Māori and non-Māori on the Dunedin and Southland Hospital sites and the slight decrease in the time spent waiting for a clinician following triage on the Dunedin site, offset by a longer wait before being discharged. In Southland there was a significant reduction in the time spent waiting for a clinician and the overall time spent waiting between triage and

discharge. The work to review and treat patients more quickly in Southland appears to be producing results.

Oncology 31 Day Target (85%)

The new dashboard for Oncology is showing good results with the 85% target being exceeded. One of the determinants of the performance is Urology. Though their average is within a timeframe, the key reason for their wait is Computed Tomography (CT). If the urgency of Urology CT referrals can be better managed the Urology result can be improved and the overall 31-day cancer performance can also be improved.

Gastroenterology

Good progress is being made in getting back to MoH target timeframes for Gastroenterology. The 14-day target for Class A patients is being exceeded across the district and the 42-day target for Class B patients is now at 66% against the MoH target of 70%. A lot of focus has gone in to Gastroenterology and a modest investment was made to get Endoscopy Nurses to run additional Endoscopy Clinics. This will ensure recovery against the 42-day target in the coming months. The surveillance performance is 36% against a 70% target and it is expected that this will be fully recovered by February 2021. Reference was made to the table included on page 12 of the EDSS report and clarity was provided in relation to the header references, which have been changed to align to the Ministry of Health (MoH) reporting requirements, i.e. "A" is urgent two-week indicator; "B" is non-urgent six-week indicator and "C" is routine.

The Chair requested that colonoscopy rates for SDHB are included in the gastroenterology dashboard. This will allow comparison with national rates.

Management received feedback and answered questions from members on the EDSS report, which included the following:

- Concern was raised over the risk with patients with co-morbidities being on the waiting list for excessive amounts of time without being treated. Further concern was raised over the impact of this on ethnicity. The EDSS provided a further breakdown of those on the waiting list and advised that the issue had not been visible in the past. A request was made for the EDSS to include ethnicity in to future reports, with a focus on Māori and Pasifika in particular.
- The EDSS reported that the prioritisation tool is working well in Urology, but needs to be working well in all other specialties as well. There is a need to establish where the line should be drawn based on capacity and clarity is required around whether where the line is drawn is safe. Where a service cannot be managed safely, a request would need to be made for additional SMO resource through a business case. Members advised the need for them to be made aware of any unmet need in the community. The CEO advised the need to look at intervention rates as well. The use of Telehealth may add a volume advantage when following up, especially in some of the surgical disciplines.

Financial Performance Summary and Surgical Services

The EDSS presented the July 2020 financial results for Specialist Services (tab 8.2) and the special report on clinical supplies variances for Surgical Services and Radiology Directorate for July 2020 and drew the Committee's attention to the following:

- The financial variance of approximately $700K for the month is in the Clinical Supplies line. $400K of that amount relates to surgical services and radiology.
- Management has determined that the case weight delivery was 9% more than planned and clinical supplies expenditure was 14% higher than planned.
- Further investigation showed $81K related to an accrual issue where hips and knee costs from June weren't picked up and accrued for in June and the expenditure was incurred in July 2020. Secondly, the radiology expenditure in clinical supplies does not correlate to case weights; that ties in to Radiology delivery.
- In summary, more than 100% of elective case weight delivery target was achieved, but management only accrue to 100% of case weight activity being earned. If the additional case weights had been recognised, it would have more than offset the additional clinical supplies costs.
- Looking at the August 2020 results as stand alone, there has been less case weight activity delivered than planned due to bed block, etc. Clinical supplies are not reflecting the reduction they should and this is being investigated.

10.0 GENERAL

The Chairman requested feedback from members on the recommendation to go to the Board from the Committee in relation to Post COVID initiatives. Members provided feedback on the proposed recommendations as indicated below:

- Implementation of Telehealth (as represented in the presentation). The Board Chair advised that the learnings coming out of Telehealth need to be feeding in to the planning for the Information Technology component of the new Dunedin Hospital Build. The change is required to optimise the use of the new Hospital.
- Seven-day Hospital Services (primarily Allied Health component). It has been recommended that there is greater allied input to enable patients to be discharged faster and more allied input over the weekend when working towards generalism. More surgery could be done over the weekends – this is currently being done as part of the recovery work. Discussion was held on review and discharge processes over weekends. The EDSS is to review five years of data on hospital activity and this will enable trends to be identified. The CMO advised that waiting lists are created through variation in either demand or supply and if that can be remedied then the result will be less people waiting for surgery. A request was made for a report giving a stocktake of the seven-day Hospital Services proposal and identification of where the barriers are. The report is to include commentary on access to diagnostics, i.e. inflow, in the middle and outflow.
- Streamlining of Cancer Pathways (work in progress).
- Regular co-ordinating meetings across services (mainly Surgical).

***It was resolved**:*

"That the Hospital Advisory Committee recommends that the Board endorse in principle the inclusion of the following two programmes in the District Strategic Plan and 2020/21 Annual Plan, with periodic reporting back on progress:

1. Exploration of seven-day hospital service provision, and

2. The comprehensive implementation of telehealth."

D Perez/L Soper

***It was resolved**:*

"That the reports be noted."

Ms Lesley Soper left the meeting at 4.15pm.

CONFIDENTIAL SESSION

At 4.15pm 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. 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.
2. Executive Director of Specialist Services Report i. Surgical Performance case weights and discharges ii. Inpatient Performance (ESPI5) iii. Generalism iv. 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.
3. Previous Public Excluded Meeting Minutes and Action Sheet	As set out in previous agenda.	As set out in previous agenda.
4. 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 11 September 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 April 2020 confirmed there has been a reduction of 1301 tonnes of Nitrous Oxide N20), which has mainly resulted from a drop in use	Complete

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
Sept 2020				of G cylinders piped N20 at Dunedin Hospital. A further report is required to explain the reason for the reduction in usage of N2O. A verbal update will be provided.	2 November 2020
July 2020 Sept 2020	**Colonoscopy Services Recommendations** (Board minute item 5.0) Matters Arising/Review of Action Sheet (HAC 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. ▪ A request was made for a comparison of Southern's colonoscopy rate to the national rates.	Deputy CMO/ EDSS	Noted. The Chair requested that colonoscopy rates for Southern DHB be included in the gastroenterology dashboard to allow comparison with national rates. Included in the EDSS report.	2 November 2020 **Complete**
Sept 2020	**EDSS Monitoring and Performance Report** (HAC minute item 9.0)	▪ Ethnicity reporting is to be included in future reports to HAC, with a focus on Māori and Pasifika in particular. ▪ The prioritisation tool is to be used across all services and members are to be kept appraised of unmet need in the community.	EDSS	▪ The reports for HAC have been completed with a focus on ethnicity, especially Māori and Pasifika. ▪ Provide an update on the prioritisation tool and unmet need in the community. Included in the EDSS report for this meeting and all subsequent meetings.	2 November 2020 and ongoing **Complete**
Sept 2020	**General** (HAC minute item 10.0)	• The learnings coming out of Telehealth need to be feeding in to the planning for the Information Technology component of the new Dunedin Hospital Build. The change is	EDSS	Will be reported to CPHAC and HAC respectively from November.	2 November 2020 and ongoing

DATE	SUBJECT	ACTION REQUIRED	BY	STATUS	EXPECTED COMPLETION DATE
		required to optimise the use of the new Hospital. • Seven-day Hospital Services (primarily Allied Health component). It has been recommended that there is greater allied input to enable patients to be discharged faster and more allied input over the weekend when working towards generalism. The EDSS is to review five years of data on hospital activity and this will enable trends to be identified. A request was made for a report giving a stocktake of the seven-day Hospital Services proposal and identification of where the barriers are. The report is to include commentary on access to diagnostics, i.e. inflow, in the middle and outflow.		The concept of a 7-day hospital service represents a significant change and needs to be incorporated into the change programme that accompanies the new hospital build. The team associated with the new hospital business case are well aware of the requirements in respect of this as it is an essential part of enabling the overall services (including future growth) to be delivered from the new buildings. In the meantime, we are undertaking practical changes to provide more services outside of regular hours. This includes weekend theatre list work and the generalism business case proposes weekend allied health cover to ensure the right level of input to support timely discharge. We will collectively advocate for the need to move our services towards a 7-day model in the lead up to the new hospital. This is a logical part of the change programme that will be necessary and some of the challenges will be complex – e.g. agreeing 7-day cover for Allied Health and Medical workforces who are accustomed to working on a Monday to Friday roster pattern.	Early 2021
Oct 2020	**Valuing Patient Time** (Board minute item 9.0)	Update to be provided to every second HAC meeting.	CN&MO CMO	A report is due to the next HAC meeting.	Early 2021

SOUTHERN DISTRICT HEALTH BOARD

5.1

Title:	**Executive Director of Specialist Services Report**		
Report to:	Hospital Advisory Committee		
Date of Meeting:	02 November 2020		
Summary: Considered in these papers are: ▪ September 2020 DHB activity.			
Specific implications for consideration (financial/workforce/risk/legal etc):			
Financial:	Yes, as covered in the body of the report.		
Workforce:	Yes, as covered in the body of the report.		
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:** 12/10/2020		**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 – September 2020

Recommendation

That the Hospital Advisory Committee notes this report.

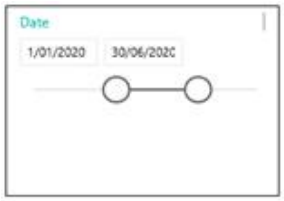
We have introduced a new section (equity). This section is only in its formative stages, but we plan to systematically build up an equity picture for secondary services over time.

1. Ethnicity

The following table shows the proportion of our population who are European (and other), and the proportion who are Maori and Pasifika. The data is from our planning and funding team who have used Statistics NZ input to create the population splits. We have then calculated the percentage of first specialist referrals received for each of these categories using the ethnicity individuals identified as in IPM. We have then also converted this into a percentage. At this stage we have not been able to reliably break European and Other down to European, Asian, Middle Eastern etc. so we have deliberately kept this grouping. However, the Maori and Pasifika categories should be accurate.

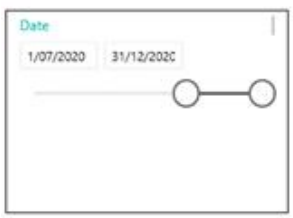
On the right hand side of the table we have then calculated the number of referrals that each group should have had accepted if the referrals accepted reflected their share of the population. We have run this over two time periods:

a. The first 6 months of the year which includes the COVID period.
b. The period from 1 July to date, which includes a burst of post COVID activity.



FSA Ethnicity report southern - Duration 1

Ethincity (groups)	Total Population	Population Percentage of Total	FSA Authorised	FSA Authorized percentage of Total	Additional FSA to meet population target for the selected duration
European & Asian and Other	298,489	86.13%	28,449	87.74%	-522
Maori	38,026	10.97%	3,350	10.33%	208
Pacific	10,037	2.90%	625	1.93%	314
Total	**346,552**	**100.00%**	**32,424**	**100.00%**	**0**



FSA Ethnicity report southern - Duration 2

Ethincity (groups)	Total Population	Population Percentage of Total	FSA Authorised	FSA Authorized percentage of Total	Additional FSA to meet population target for the selected duration
European & Asian and Other	298,489	86.13%	20,096	87.75%	-370
Maori	38,026	10.97%	2,333	10.19%	180
Pacific	10,037	2.90%	473	2.07%	190
Total	**346,552**	**100.00%**	**22,902**	**100.00%**	**0**

Pro Forma Findings

- The European, Asian and Other category is over-represented (relative to their proportionate share of the population) in terms of the referrals that were accepted after triaging. Maori were slightly below their proportionate share. Pasifika appear to be materially underrepresented relative to their share of the population.
- The disproportionate share identified for each of the categories appears to be relatively the same both during the period including COVID and during the period of recovery immediately post COVID.

This report highlights for us that there appears to be a low rate of referrals being accepted for our Pasifika population. We appreciate that there are other factors which may determine referral rates (e.g. genetic pre-disposition to conditions, average age of individuals in particular cohorts), but the disparity appears significant enough that it warrants further investigation. We will raise this with our equity partners and propose that we partner with them to explore the reasons (and potential remedies) further. We are able to produce similar reporting broken down by speciality and for surgery as well. On the assumption that the HAC Committee would like to see further reporting of this nature we will continue to refine our reporting on this.

2. Surgical Performance – Case Weights and Discharges

According to our Board reporting we were 333 case weights ahead of our production plan (service provider) for the year to date 30th of September 2020. However, we have accrued the revenue for 305 case weights worth of outsourcing that we did pre-emptively (before we received recovery funding, which we are still finalising with the Ministry). We will be claiming this against the recovery trajectories once these have been finalised. So, we appear to be 28 case weights ahead of plan on a year to date basis. However, the plan that is currently loaded is last years' plan, whereas the new plan that was agreed amounted to an increase of about 250 case weights. This translates into an additional circa 63 case weights that we must deliver for year to date September. On the above numbers, we are (+28 – 63) equals -35 case weights behind plan on year to date volumes of circa 4,250 case weights. So, we are materially on plan on a year to date basis but with no safety margin. We therefore need to manage our elective delivery carefully.

We were ahead of plan (after adjusting for the components noted above), in July, but we appeared to see an even greater bed access issue in August and September than we saw in the same period last year, despite lower winter volumes than last year for July, August and September at Dunedin hospital. To get a better understanding of what was driving the frequent bed access related cancellations we organised a 'big data' clinic on a Sunday and myself and members of the team who were particularly keen to understand what was driving our challenges worked through the available data sets at the clinic.

A. We obtained records at unit level (e.g. NHI) for admissions, discharges and bed night stays for Dunedin hospital over several years. Based on the manner in which this information is captured this amounted to 2m plus records.

B. We found (which is consistent with previous analysis) that there was a step change in demand in 2019 compared with prior years so we focused our comparison analysis on August 2019 compared to August 2020.
C. As the last week in August 2020 was incomplete, we compared the first 3 full weeks in August 2019 with August 2020.

Initial findings (based on the 3-week period compared to the same three weeks last year):

A. For the period in question there were 80 fewer admissions and 78 fewer discharges compared to the same period last year. This amounts to a 5.6% reduction year on year which is material.
B. Further investigation identified that the impact was in surgery and ICU – medical admissions and discharges were almost identical for the same period last year.
C. The numbers admitted into the 6 Assess Unit were down 28 for the same period in the previous year, and the balance of reduced admissions were in the surgical wards (52).
D. The length of stay went up from 4.5 to 4.9 days in surgery overall, but notably, the length of stay in the ICU went up from 7.4 to 10 days and the length of stay in 3B (the orthopaedic ward) went up from 4.4 to 7.6 days.

We then triangulated the findings against what we know (our empirical information).

- We know that a highly complex patient consumed 4 beds in surgery for the entire August period and the majority of September. At circa four days average length of stay and four beds this reduced the number of surgical patients able to be provided with a bed by (21 days / four days Average Length of Stay X four beds) equals 21 patients. For the full month it would have had an impact of circa 30 patients.
- We know that since the 6 Assess unit moved up the hill (in response to COVID) it has been harder to get access to assessment beds in the hospital – this appears to be borne out in the above analysis.

We have asked for the same analysis to be performed on the full data set for all of August and all of September but we suspect that the same pattern was present for this entire period – i.e. reduced bed availability led to more elective cancellations than usual which resulted in less elective surgery and attributed to these key drivers. The highly complex patient was relocated to Auckland in late September, so those beds have now been freed up. There are plans to bring the 6 Assess unit back to the hospital and despite the reservations of some this would appear to be the right decision if we are to address the impact the move had on reduced bed availability overall.

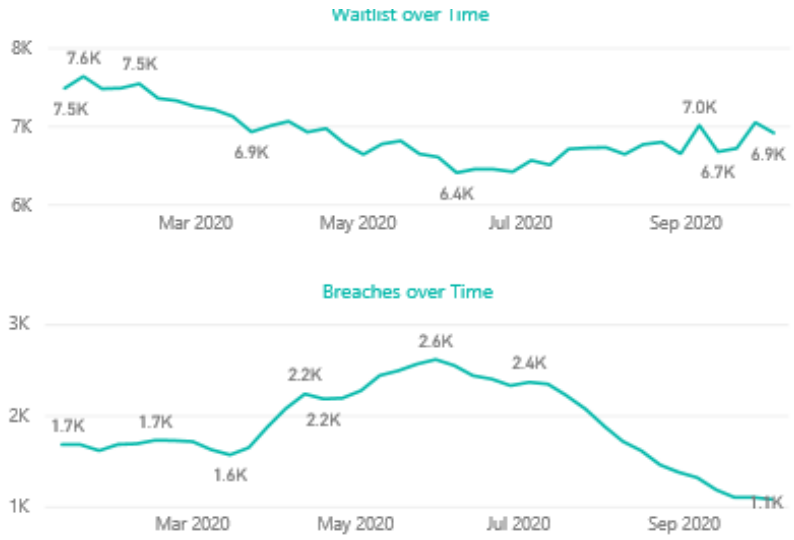
As noted earlier we are materially on plan for case weight delivery year to date but will need to monitor the situation carefully and the above factors appear to have lost us the ability to build a year to date buffer into what has been delivered.

3. Outpatient Performance ESPI 2's

Good progress has been made in recovering outpatient performance. Immediately post COVID (June) we had circa 2,600 breaches (patients who were accepted but waiting > 120 days for their outpatient appointment) out of a total wait list of 6,400. This represented a breach rate of circa 41% and was the situation we found ourselves in

during the immediate aftermath of COVID. Since then we have managed to reduce the number of breaches and we are currently circa 1,100 breaches for a total wait list of 6,900. This translates into a breach percentage of 16%.

Historically, SDHB was the worst performing DHB in terms of total ESPI breaches (one of the worst in percentage of breaches and the worst in total number of breaches). With our improvement programme we have been aiming to get SDHB to the average percentage for breaches across all DHBs, which is circa 11%, and from there we want to continually improve until all services have zero breaches and are therefore fully compliant. We are hoping to achieve our 11% target by late this year / early next year and we will then progressively improve our performance from there, with some assistance from the recovery funding.



Our initiatives for improving outpatient FSA ESPI compliance are as follows:

a. Implementation of the prioritisation tool for the surgical specialities. This continues to work well in Urology and Orthopaedics in Dunedin and is implemented in General Surgery in Southland. It has been implemented in test format in General Surgery in Dunedin. The ENT service has agreed to trial it in Dunedin for both Dunedin and Southland (they triage Southland referrals), and we have resumed discussions with the O&G service in Southland about the implementation of the tool. We really do need project support / project resources to systematically implement the tool across all services and this is one of the initiatives we have put forward when we applied for initiative money as part of overall recovery. We should find out on 23 October whether or not we have been successful in securing the necessary funding to put project and change resources in to support the roll out of the tool.
b. Review of the longest waiting patients in the Medicine, Women and Children portfolio and ensure these are booked. We have tasked the General Manager with reviewing the longest waits with each of the services on a weekly basis and

organise for these to be booked and we have built a Power BI tool that facilitates this review.

c. Implementation and use of the 'acuity' tool across all specialities. A number of specialities are using the tool well but after an initial implementation in O&G in Southland we appear to have some hiccups. The Planned Care Manager is travelling to Invercargill at the end of this week and will spend a day with the booking teams and others to work through expectations with the aim of the acuity tool being in place across all of the specialities (who are booked by a central administration team in Southland).
d. Implementation of recovery initiatives once the trajectories are agreed to with the Ministry.

We continue to meet with the surgical and medicine, women and children GM's and Service Managers on a weekly basis to track performance against these initiatives and to determine whether additional initiatives need to be added to the programme.

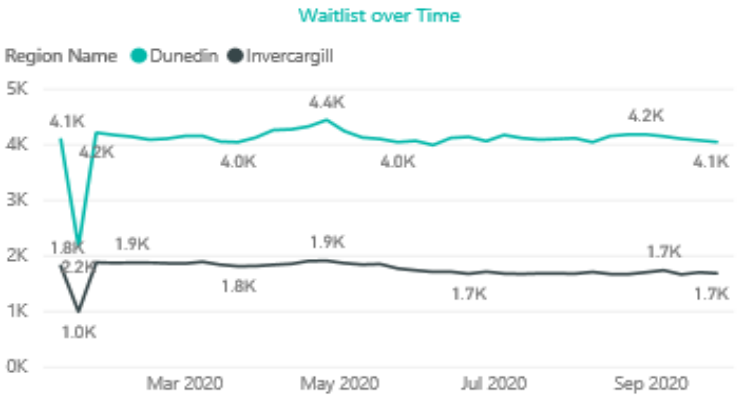
4. **Inpatient Performance ESPI 5's**

Unfortunately, the inpatient wait list is less easy to resolve (as reflected in the relatively static number of ESPI breaches as a proportion of the ESPI wait list in the diagram below.

The recovery funding will enable us to catch up some surgical activity with outsourcing or weekend lists but access to additional theatre lists is the inhibitor to making rapid progress. In the meantime, we have focused our energies on the longest waiting patients, as follows:

A. We have developed a Power BI report which shows us all patients waiting > 8 months. We have started with all patients waiting > 24 months and set the expectation (with General Surgery and Orthopaedics in particular) that all patients waiting > 24 months must be systematically booked or otherwise appropriately removed from the waiting list. We are reviewing this on a weekly basis.
B. To support the above decision making we have systematically reviewed all patients across all specialities > 8 months and have provided an initial assessment for the Service Manager to work from.
C. The team has developed a 'transfer of care' policy and approach that had been partially developed by our predecessors but was never implemented. This is currently undergoing testing. Its intention is that if a patient is languishing on the wait list because a condition needs to be addressed before they will be eligible for surgery (for example, weight loss or cessation of smoking) that their care is transferred until these conditions are met and they can then be reintroduced to the wait list.

Our aim/s with the above initiative/s is to systematically pull back the longest wait from 2+ years in some cases to < 18 months and then < 12 months, then < 8 months and eventually < 4 months, whilst also having a good understanding of what is sitting on the wait list. However, it is the recovery money, both from this year and in the next 2 years that will enable us to meaningfully address those patients who have been waiting a long time on the wait list for their surgery.

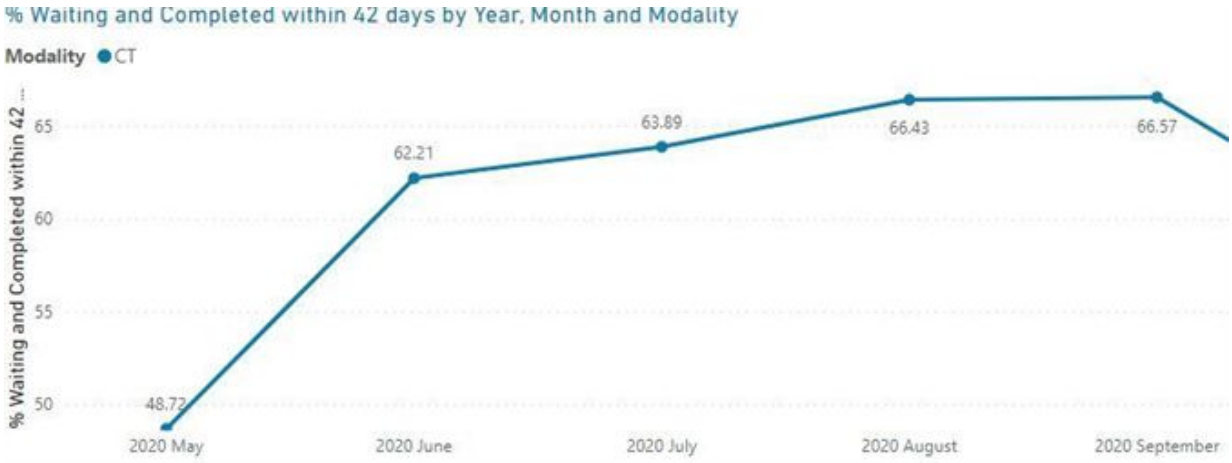


5. **Medical Imaging Diagnostics**

CT Performance

As shown by the following chart, CT performance (against the Ministry 42-day elective target) has systematically improved from circa 50% at the latter end of COVID to 66% currently. One off initiative money (which we applied to the Ministry for and subsequently received) in August assisted with initial improvement (enabling us to get more volumes done in Oamaru and with a provider). However, performance gains were subsequently impacted by an unplanned outage of the CT machine in Dunedin which required parts from Siemens in Germany. Performance in Dunedin was 52% at the end of September, whereas performance in Southland was 96%. The overall Ministry target is 95% scanned within 42 days so our performance in Dunedin is our key focal area.

We have made progress on the initiative agreed to earlier in the year. The Nuclear Medicine CT scanner is now equipped to do regular CT scans. And we have secured the first of the medical imaging technologists (MIT) staff who are required for us to complete the additional scanning proposed. We still need to recruit the registered medical officer (RMO) who will enable overnight contrast CT's to be completed but with the recruitment we have been able to achieve to date we are now able to do 20 more CT scans per week (non-contrast scans) and this will start to improve Dunedin CT performance going forward.

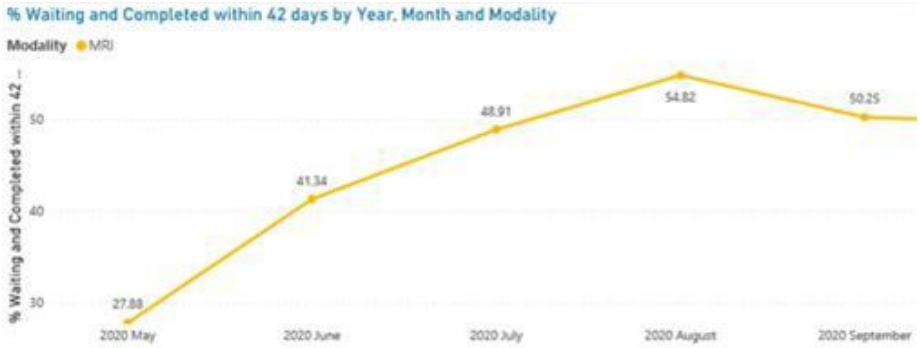


MRI Performance

MRI performance at the tail end of COVID (in terms of the Ministry 42-day elective target) was at 27% and in a similar manner to CT, subsequent one-off recovery money funded additional activity that enabled this performance to be improved. However, we had two extended outages in September which impacted on MRI performance and will be reflected in our performance in October, too.

The first of these was a planned outage to replace the MRI machine in Southland. The machine that was replaced is 14 + years old and there were significant reliability challenges with it. Initially the new machine was going to be put in a new location, enabling the existing machine to remain in situ until the new machine had been installed. However, this proved to be too complex and the machine was pulled out and replaced in situ, leading to a 6-week period of not having a machine on site. This was managed using a provider (outsourcing) for emergencies, and some use of the Dunedin scanner, and the team managed to get a bit ahead of their wait list ahead of the implementation. As a consequence, Southland performance was still reasonable for September at 77% overall.

Dunedin had a major MRI outage during September. A major component failed, and the initial diagnosis led to a part being ordered from Singapore, which then got delayed due to COVID logistics. In parallel a new diagnosis confirmed a different part, and this had to come from Chicago, and also faced COVID related logistics delays. As a consequence, there was a 2-week unplanned outage which impacted on performance. Whilst the decline in overall performance was moderate when compared to the previous month (down from 55% to 50%) we anticipate that the impact will be felt in our October performance measures.



6. **Emergency Department**

The first point to note with respect to the Emergency Departments is that overall volumes have been down during the quarter in Dunedin (and relatively static but down in September for Southland) when compared to the same period in the previous year.

Southland ED Volumes

	2019	2020	Change
July	3,256	3,238	-1%
August	3,389	3,419	1%
September	3,243	3,018	-7%

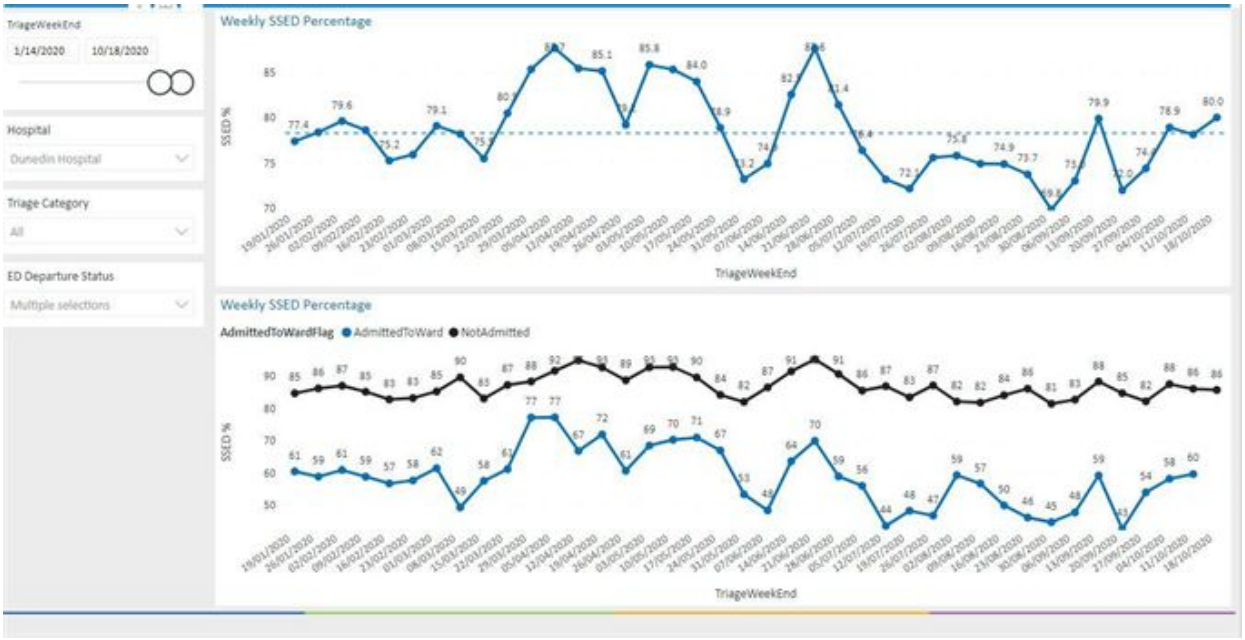
Dunedin ED Volumes

	2019	2020	Change
July	4,222	3,913	-7%
August	4,180	4,046	-3%
September	4,060	3,733	-8%

As noted in the commentary about bed access block for surgery, this appeared counter intuitive given that empirically we felt that we were seeing more access block issues than in previous years, which led to the analysis commentary in the earlier part of this report.

ED performance in Dunedin (against the 6-hour target) varied on a weekly basis during September from 70% to 80% with an average of about 75%. As noted in the chart below, those who were not admitted had an average close to 85% whilst those who were admitted had an average that was closer to 55%. The Chief Medical Officer and General Manager Operations are working on the implementation of an escalation plan with the intention of getting specialist assessments happening faster and therefore reducing the time patients who are admitted spend waiting for a specialist assessment as part of their overall journey prior to inpatient admission. On the face of it, increased waiting times in the context of lower volumes (and better performance) in the previous year seems odd and requires further investigation.

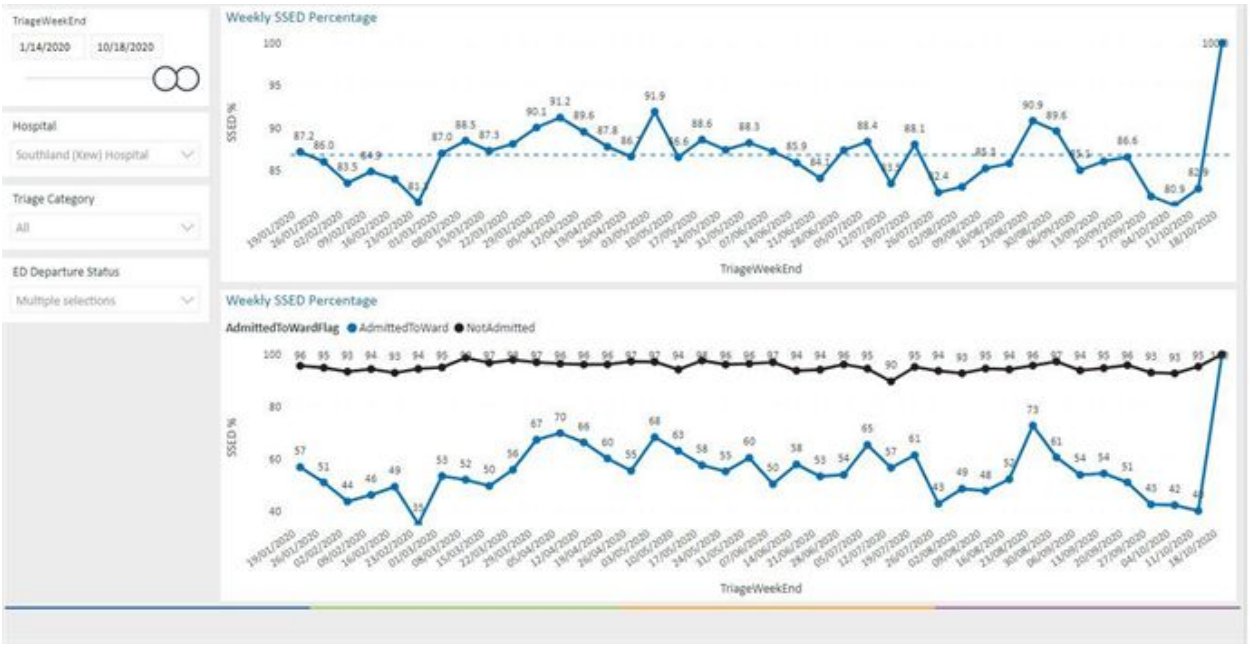
Our key initiative which will meaningfully improve ED assessment times is the proposed business case for the implementation of the generalist admitting model and the development of a medical assessment unit which would be built next to the ED. Following further feedback from the Chief Executive we are completing the final steps to finalise the case before socialising it with relevant stakeholders and then putting it to the Board for their consideration.



ED Performance in Southland is better and has averaged closer to 85% during September. Patients who are assessed and treated but not admitted are being seen in an overall timeframe which is close to the 95% target. Those requiring admission are averaging circa early 50's. There appears to be a robust model for internal medicine clinician assessment in Southland and we are currently undertaking an assessment to compare the waiting time for an internal medicine assessment as compared to a surgical specialist assessment.

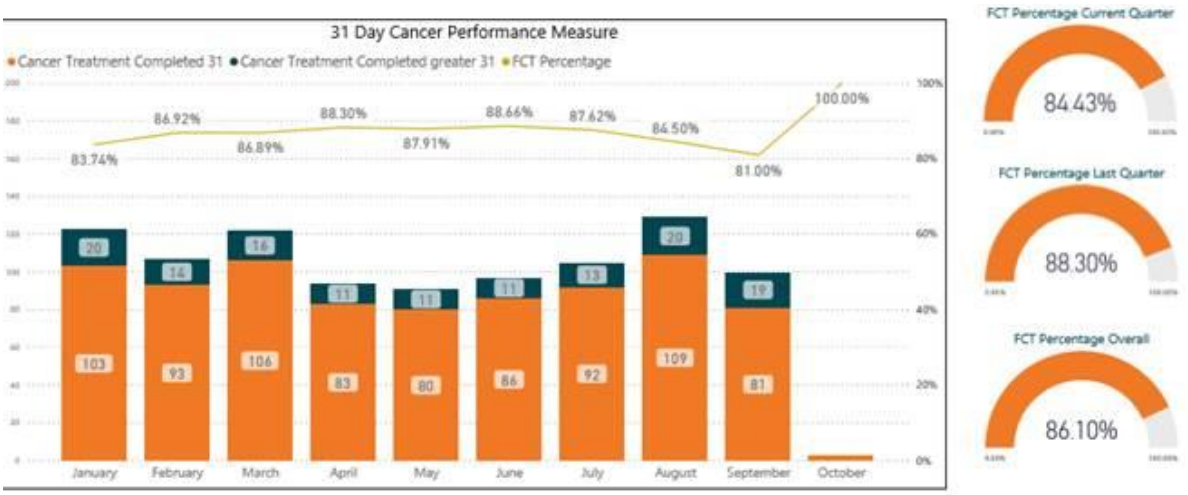
We have formed a small working group in Southland with the aim of quantitatively assessing what is required to alleviate the winter pressures the ED faces every winter. The working group is focused on the following:

- Assessment of whether assessment unit beds, flexible beds or some other configuration would make the biggest difference to ED performance. A case will then be put forward for investment prioritisation for the capital and operating requirements required to develop this additional capacity.
- The team are implementing a discharge lounge which we believe will enable another 6+ beds to be freed up quicker on a daily basis (alleviating access block, assisting with ED wait times and reducing the cancellation of surgery).
- The team is now undertaking data analysis on the components of patients' journeys where the wait is the longest.



7. **Faster Cancer Treatment**

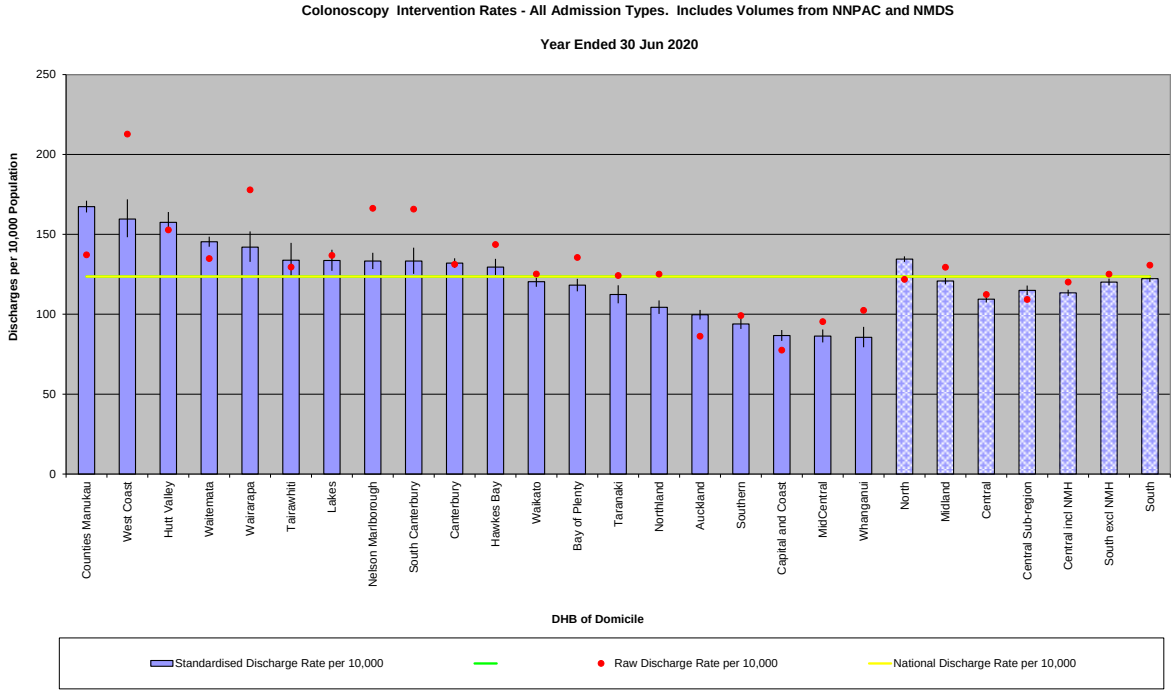
Performance in the month of September appears to have dropped compared to the previous month and the current quarter to date performance is close to but not quite at the 85% target mark.



8. **Gastroenterology**

As requested in the Board actions, the following data is included which shows June 30th year to date standardised intervention rates (SIRs). Southern's SIR is low relative to other district health boards with Capital & Coast, Mid-Central and Whanganui all having lower SIR than Southern, but the other DHB's having a higher SIR than Southern.

One of the recommendations from the Bissett report that needs to be worked through is increasing scoping rates and the new Endoscopy Oversight Committee will need to progressively work through a range of considerations to determine the most appropriate way to increase intervention rates. Possible approaches include modification of the acceptance criteria and encouraging greater referrals from primary care.



Following on from the Board Meeting in October a number of actions are being worked through in response to the Bissett report. These include the following:

A project manager has been appointed and she is developing a draft programme of work which incorporates the recommended responses to the Bissett report together with prior actions that are being rolled up in the programme of work.

A Terms of Reference has been developed in conjunction with the new Chair of the Endoscopy Oversight Group and this will be tabled at the last meeting of the Endoscopy User Group / first meeting of the Endoscopy Oversight Group on the 23rd of October.

An initial agenda is being constructed for the new Oversight Group in conjunction with the Chair. Initial items for consideration will be the classifications used for processing of referrals and a proposed definition for Gastrointestinal Specialist Override referrals (so that those which aren't intended to be override referrals can be clearly differentiated).

We have started the development of the Terms of Reference for the weekly Referral Users Group.

We have started regular meetings with the Information Technology team to work through opportunities to improve internal referral processes (e.g. digitise the internal

referrals which remain paper based) and work through a way of livening another field in IPM which will enable Colonoscopies to be separately identifiable to other Gastroenterology referrals. This in turn will improve our ability to report on Colonoscopy referrals from within our patient administration system rather than relying on out of system work around options.

There are a number of actions to now work through. However, one of the more important actions is to support the formation of the Endoscopy Oversight Group and ensure that the actions coming out of this group and worked through and create the desired improvements.

Colonoscopy waiting times as of 28/9/2020

	Dunedin					Southland				
	Bowel Screening	A	B	C	Surveillance	Bowel Screening	A	B	C	Surveillance
Number of patients	32	8	105	57	368	16	2	41	54	373
Average wait	15.97	5	26.61	31	111	22.25	13	21.02	74	153
Longest wait	32	11	202	122	253	47	17	62	237	362

Further work is underway to enhance the reporting for Colonoscopy wait times. More generally, there is a reasonable amount of information capture for the service which happens outside of the core patient administration system at present and we are hoping to enhance what can be reported from within the system. We also need to have highly robust data definitions in terms of what is reported and to be able to reconcile this accurately with Ministry reported data. This is an ongoing piece of work which we are incorporating into the overall work programme that is being developed in response to the Bissett report.

Planned Care Interventions Inpatient Surgical Discharges - Annual target 12,518	**3,304** Actual YTD vs 3,189 Plan YTD, as at September 2020

Refer to page 14 - Caseweight and discharge volumes graph.

Patrick Ng, Executive Director of Specialist Services

Sep-20				Sep-19	YEAR ON YEAR		YTD 2020/21				YTD Sep-19	YEAR ON YEAR
Actual	Budget*	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
						Medical Caseweights						
1,503	1,487	17	1%	1,530	(26)	Acute	4,497	4,575	(77)	-2%	4,901	(403)
331	310	21	7%	302	29	Elective	1,052	931	121	13%	989	63
1,835	**1,797**	**38**	**2%**	**1,832**	**3**	**Total Medical Caseweights**	**5,549**	**5,505**	**44**	**1%**	**5,889**	**(340)**
						Surgical Caseweights						
1,362	1,231	130	11%	1,190	172	Acute	3,788	3,752	36	1%	3,580	208
1,342	1,436	(94)	-7%	1,452	(111)	Elective	4,333	4,366	(33)	-1%	4,376	(44)
2,704	**2,668**	**36**	**1%**	**2,643**	**61**	**Total Surgical Caseweights**	**8,120**	**8,118**	**3**	**0%**	**7,956**	**165**
						Maternity Caseweights						
126	94	32	34%	84	42	Acute	333	286	46	16%	295	37
330	365	(35)	-10%	304	26	Elective	1,089	1,125	(36)	-3%	1,090	(1)
456	**459**	**(3)**	**-1%**	**387**	**68**	**Total Maternity Caseweights**	**1,422**	**1,411**	**11**	**1%**	**1,385**	**37**
						TOTALS						
2,991	**2,812**	**178**	6%	**2,804**	**187**	**Acute**	**8,618**	**8,613**	**5**	0%	**8,776**	**(158)**
2,004	**2,112**	**(108)**	-5%	**2,058**	**(55)**	**Elective**	**6,474**	**6,421**	**52**	1%	**6,455**	**19**
4,995	**4,924**	**71**	**1%**	**4,862**	**132**	**Total Caseweights**	**15,092**	**15,035**	**57**	**0%**	**15,231**	**(139)**
						TOTALS excl. Maternity						
2,865	**2,718**	**147**	5%	**2,720**	**145**	**Acute**	**8,285**	**8,327**	**(41)**	0%	**8,480**	**(195)**
1,674	**1,747**	**(73)**	-4%	**1,755**	**(82)**	**Elective**	**5,384**	**5,296**	**88**	2%	**5,365**	**19**
4,539	**4,465**	**74**	**2%**	**4,474**	**64**	**Total Caseweights excl. Maternity**	**13,670**	**13,623**	**47**	**0%**	**13,845**	**(176)**

***Budget Plan has now been finalsed after the Planned Care Interventiosn plan (previously known as electivie initiative) was finalised with the ministry.**

5.2

SOUTHERN DISTRICT HEALTH BOARD

Title:	**FINANCIAL REPORT**
Report to:	Hospital Advisory Committee
Date of Meeting:	02 November 2020

SUMMARY:

The issues considered in this paper are:

- September 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:** 15/10/2020	**PRESENTED BY:** Patrick Ng Executive Director of Specialist Services

RECOMMENDATION:
That the Hospital Advisory Committee note the report.

5.2

SOUTHERN DHB FINANCIAL REPORT – Summary for HAC

Financial Report for: **September 2020**
Report Prepared by: **Grant Paris**
Management Accountant
Date: **15 October 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
45,417	45,194	223	Revenue	137,243	135,550	1,693	541,965
24,534	24,396	(138)	Less Workforce Costs	72,867	72,122	(745)	292,043
13,037	11,926	(1,111)	Less Other Costs	39,875	36,214	(3,661)	138,761
7,845	**8,872**	**(1,027)**	**Net Surplus / (Deficit)**	**24,502**	**27,214**	**(2,712)**	**111,161**

For September 2020, Specialist Services had a surplus of $7.8m, which is $1.0m unfavourable to budget.

2. *September 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.

The elective caseweights for September 2020 are 3% lower than September 2019, while acutes were 7% higher than September 2019.

Sep-20				Sep-19	YEAR ON YEAR		YTD 2020/21				YTD Sep-19	YEAR ON YEAR
Actual	Budget*	Variance	% Variance	Actual	Monthly Variance		Actual	Budget	Variance	% Variance	Actual	YTD Variance
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***Budget Plan has now been finalsed after the Planned Care Interventiosn plan (previously known as electivie initiative) was finalised with the ministry.**

Statement of Financial Performance

Monthly					Year to date			
Actuals $000s	Budget $000s	Variance $000s	Variance FTE		Actuals $000s	Budget $000s	Variance $000s	Variance FTE
				REVENUE				
				Government & Crown Agency Sourced				
767	814	(47)		MoH Revenue	2,673	2,441	232	
0	0	0		IDF Revenue	0	0	0	
902	747	155		Other Government	2,744	2,210	534	
1,668	**1,561**	**107**		**Total Government & Crown**	**5,417**	**4,650**	**767**	
				Non Government & Crown Agency Revenue				
209	184	25		Patient related	428	553	(125)	
167	183	(16)		Other Income	507	549	(42)	
376	**368**	**8**		**Total Non Government**	**935**	**1,103**	**(168)**	
43,372	43,266	106		Internal Revenue	130,892	129,797	1,095	
45,417	**45,194**	**223**		**TOTAL REVENUE**	**137,243**	**135,550**	**1,693**	
				EXPENSES				
				Workforce				
				Senior Medical Officers (SMO's)				
6,770	6,401	(369)	10	Direct	19,216	18,790	(426)	9
326	355	29		Indirect	1,071	1,065	(6)	
253	156	(97)		Outsourced	859	469	(390)	
7,349	**6,912**	**(437)**	**10**	**Total SMO's**	**21,146**	**20,325**	**(821)**	**9**
				Registrars / House Officers (RMOs)				
3,774	3,897	123	2	Direct	11,362	11,657	295	3
147	230	83		Indirect	443	689	246	
46	29	(17)		Outsourced	88	87	(1)	
3,967	**4,155**	**188**	**2**	**Total RMOs**	**11,893**	**12,433**	**540**	**3**
11,316	**11,068**	**(248)**	**12**	**Total Medical costs (incl outsourcing)**	**33,039**	**32,758**	**(281)**	**11**
				Nursing				
9,080	9,471	391	(34)	Direct	27,618	27,589	(29)	(41)
0	1	1		Indirect	1	3	2	
3	3	0		Outsourced	11	9	(2)	
9,083	**9,475**	**392**	**(34)**	**Total Nursing**	**27,630**	**27,601**	**(29)**	**(41)**
				Allied Health				
2,285	2,102	(183)	(11)	Direct	6,719	6,363	(356)	(8)
29	25	(4)		Indirect	117	75	(42)	
98	41	(57)		Outsourced	269	127	(142)	
2,412	**2,168**	**(244)**	**(11)**	**Total Allied Health**	**7,105**	**6,566**	**(539)**	**(8)**
				Support				
176	162	(14)	3	Direct	520	536	16	2
0	1	1		Indirect	0	3	3	
0	0	0		Outsourced	0	0	0	
176	**163**	**(13)**	**3**	**Total Support**	**520**	**539**	**19**	**2**
				Management / Admin				
1,529	1,508	(21)	(7)	Direct	4,525	4,616	91	(9)
13	9	(4)		Indirect	32	26	(6)	
5	5	0		Outsourced	17	17	0	
1,547	**1,522**	**(25)**	**(7)**	**Total Management / Admin**	**4,573**	**4,658**	**85**	**(9)**
24,534	**24,396**	**(138)**	**(38)**	**Total Workforce Expenses**	**72,867**	**72,122**	**(745)**	**(45)**
3,511	3,216	(295)		**Outsourced Clinical Services**	11,020	9,477	(1,543)	
0	0	0		**Outsourced Corporate / Governance Servic**	0	0	0	
0	0	0		**Outsourced Funder Services**	0	0	0	
7,813	7,045	(768)		**Clinical Supplies**	23,634	21,758	(1,876)	
861	770	(91)		**Infrastructure & Non-Clinical Supplies**	2,598	2,331	(267)	
				Provider Payments				
0	0	0		Mental Health	0	0	0	
				Non Operating Expenses				
852	896	44		Depreciation	2,623	2,648	25	
0	0	0		Capital charge	0	0	0	
0	0	0		Interest	0	0	0	
13,037	**11,926**	**(1,111)**		**Total Non Personnel Expenses**	**39,875**	**36,214**	**(3,661)**	
37,571	**36,322**	**(1,249)**		**TOTAL EXPENSES**	**112,742**	**108,336**	**(4,406)**	
7,845	**8,872**	**(1,027)**		**Net Surplus / (Deficit)**	**24,502**	**27,214**	**(2,712)**	

3. Revenue

Ministry of Health (MoH) Revenue

MoH revenue was $0.05m unfavourable to budget for the month and $0.23m favourable year to date. The main contributors are detailed below:

Category	Monthly Variance $000s	YTD Variance $000s	Comment
Personal Health-side contracts	(28)	166	Additional revenue of $0.21m from MoH for Covid catch-up extra CT and MRI scans
Public Health-side contracts	1	126	Additional Revenue received for Cervical Screening for during the COVID period. SDHB had invoiced based on COVID volumes but MoH agreed to pay on 18_19 volumes
Clinical Training	(20)	(59)	Contracts have been reconciled to ensure eligible personnel have been recovered in billing.
Other		(1)	
Total	**(47)**	**232**	

Other Government Revenue

Other Government revenue was $0.16m favourable in September and $0.53m favourable year to date. The major drivers for this are shown below.

Category	Monthly Variance $000s	YTD Variance $000s	Comment
Haemophiliac rebate	139	455	Rebate reflecting increased cost year to date.
ACC	(45)	(1)	High tech imaging revenue lower for MRI (Otago & Southland)
Radiology	20	43	Revenue from School of Dentistry not budgeted
Other	40	35	
Total	**155**	**534**	

Patient related revenue

This is driven by non-resident revenue (the budget was reduced with the border closures due to COVID. Patient related revenue was favourable for the month by $0.02m however unfavourable year to date. by $0.13m.

Other Income

Other income is $0.02m under budget in September and $0.04m year to date. This is mainly due to shortfalls in cost recoveries (offset by reduced costs) such as;

- No Orthopaedic fellow appointed yet so no chargeback for share of salary.
- Chargeback of Mammography staff reduced as SDHB recruit less and recruitment directly by outsourced provider.

Internal Revenue

Internal revenue was $0.11m favourable in September and $1.09m favourable year to date. The favourable year to date variance is due (Improvement Action Plan) offsets additional costs in Outsourced Clinical Services. This revenue we have recognised when we started recovering surgery in July and August prior to receiving final guidance for

recovery from the Ministry. We have accrued the revenue on the assumption we can apply recovery money to the work completed once this is available.

4. Workforce Costs

Monthly result
Workforce costs (personnel plus outsourcing) were $0.14m unfavourable to budget in September 2020 driven by Medical and Allied Health costs. Operationally full time equivalent (FTE) were 38 unfavourable to budget in September 2020.

FTE
Monthly FTE is 38 over budget in September summarised in the following table. Continuing unfavourable variances in Nursing, Allied and Management/Admin are 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	244	254	10	4%	239	247	9
RMO	311	312	2	0%	308	311	3
Nursing	1,173	1,139	(34)	-3%	1,182	1,141	(41)
Allied	298	287	(11)	-4%	294	286	(8)
Support	36	39	3	7%	37	38	2
Mgmt / Admin	283	276	(7)	-2%	283	275	(9)
	2,345	**2,307**	**(38)**	**-2%**	**2,343**	**2,298**	**(45)**

Senior Medical Officer (SMOs)

SMOs were $0.44m unfavourable and 10 FTE favourable for the month. The favourable FTE variance has not converted to a favourable $ variance due to the following;

- Additional $0.51m of back-pay and allowances for prior periods in various services including ED, Anaesthesia, and Oncology & Haematology. This includes both payments made and accruals for estimated future payments.
- Overtime was $0.15m unfavourable ($0.37m year to date) driven by
  - Vacancies
  - SMOs covering RMO roster gaps
  - Extra hour's payments for Theatres and ICU teams.

RMOs
RMOs were $0.19m and 1.5 FTE favourable in September continuing the year to date favourable variance trend of $0.54m and 2.75FTE.

Indirect RMO costs were $0.08m favourable ($0.25m favourable year to date) to budget due mainly to $0.06m lower levels of course fees compared to budget. Expectations are that this will be a timing difference.

Outsourcing was over budget for the first time this year, driven by General Surgery, Paediatrics (covering vacancies) and Obstetrics and Gynaecology (covering vacancies). Leave taken in these areas is a lot closer to budget than prior months which may have generated the renewed requirement for outsourced resourcing.

Nursing
Nursing was ($0.39m favourable and 34FTE unfavourable for the month.) Year to date Nursing was $0.03m unfavourable and 41 FTE unfavourable.

There have been two significant outliers year to date that distorted the relationship between $'s and FTE.

- Direct costs budgeted include $0.48m in August for the impact of the annual leave revaluation resulting from the NZNO MECA that fell due for renewal on 1 August 2020. The actual accrual for this was booked at $0.19m hence there was a $0.29m favourable variance for this in August. We will not know if this is a permanent difference until the MECA negotiations are finalised however currently is a one-off favourable impact presenting a more favourable dollar variance than was operationally achieved.
- There was a $0.38m favourable variance in September due to unpaid days (i.e. the difference between the pay fortnights paid in the month and the amount accrued so that the accounts record the number of working days). This is a timing difference and will reverse over the year.

FTE

The unfavourable monthly FTE variance is driven by the following

- 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 7,646 hours (31.9 FTE) which were only partially offset by the HCA budget increase of 10.75 FTE in 2020/21.
- Sick leave unfavourable by 9FTE, which is not unexpected as vigilance to the possible spread of any illness means those unwell stay home however also note that the unfavourable variance has reduced from earlier months.
- Additional 3 FTE in ED Dunedin (temp contracts for COVID screening ending October 2020)

Offset by:

- ICU 18.3 FTE favourable partially offset by nurses working in Ward 4A (3.3 FTE unfavourable) resulting in net 15 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 (2 FTE), APAC Southland (0.9 FTE), CNS Podiatry and Colorectal (1 FTE), PACU (2 FTE) and Palliative care (2 FTE).

Allied Health

Allied Health personnel were $0.24m and 11.0FTE unfavourable in September.

MRTs and Sonographers are $0.10m unfavourable this month due to higher than expected annual leave (not taken), overtime and allowances. Anaesthetic Technicians were a further $0.05m unfavourable in overtime and allowances with continued vacancies.

Allied Health outsourced personnel were $0.06m over budget for the month, mostly in Anaesthesia for the continuing use of anaesthetic technicians to cover vacant roles.

Support

Support staff are unfavourable to budget by $0.01m for the month and 2.67FTE favourable.

Annual leave taken was over budget for the month.

Management and Administration

Management and Administration staff were $0.03m and 6.8 FTE unfavourable for the month. ($0.09m favourable year to date and 8.54FTE over budget)

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 year to date result.

Annual leave taken is 6FTE 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 7FTE unfavourable.

5. Outsourced Clinical Services Costs

Outsourced services were $0.29m unfavourable in September and $1.543m unfavourable year to date as shown below.

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $
Outsourced Surgical Services	983	811	(172)	3,107	2,306	(801)	7,813
MRI Scans	198	35	(163)	358	103	(255)	404
CT Scans	86	62	(24)	189	182	(7)	716
Radiology Service	200	189	(11)	844	557	(287)	2,192
Audiology	4	2	(2)	22	6	(16)	24
Vascular Assessments	77	79	2	257	232	(25)	913
Other Radiology Procedures	12	17	5	132	50	(82)	195
Lithotripsy		7	7	20	20		77
Outsourced Clinical Services - Other	470	490	20	1,651	1,452	(199)	5,747
Ophthalmology	3	46	43	9	136	127	535
Laboratory Service	1,477	1,477		4,431	4,432	1	17,728
Laboratory Sendaway Tests					1	1	5
	3,510	**3,215**	**(295)**	**11,020**	**9,477**	**(1,543)**	**36,349**

1) Ear Nose and Throat Emergency and Medicine Southland Service and Orthopaedics Service drives the monthly overrun in Outsourced Surgical Services, with a high number of discharges in September to meet the Improvement Action Plans put in place with additional funding from the Ministry of Health to offset. Year to Date Improvement Action Plan expenditure is $0.91m, (offset by Ministry funding). Some of the improvement action plan is outsourced clinical services, hence why this is over YTD.

2) MRI scans were $0.16m unfavourable for the month and $0.26m YTD with unplanned outages in Dunedin and the planned outage in Southland for the installation of the new machine. However, all are expected to be operational again in October 2020

6. Clinical Supplies (excluding depreciation)

Clinical supplies were unfavourable to budget by $0.77m in September 2020, monthly variances itemised by account below.

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $	YTD Variance as % Total YTD Variance
Clinical Equipment - Service Contracts	447	327	(120)	1,129	982	(147)	3,929	8%
Air Ambulance	533	429	(104)	1,287	1,264	(23)	4,971	1%
Blood and Tissue Supplies	761	659	(102)	2,391	1,977	(414)	7,490	22%
Pacemakers	184	107	(77)	543	315	(228)	1,213	12%
Spinal plates and screws	124	72	(52)	298	211	(87)	829	5%
Disposable Instruments	249	206	(43)	804	629	(175)	2,507	9%
Cardiac Implants	151	111	(40)	723	511	(212)	1,420	11%
Patient Consumables	315	281	(34)	983	827	(156)	2,207	8%
Renal Fluids & Supplies	123	96	(27)	309	284	(25)	1,085	1%
Clinical Equipment - Minor Purchases	124	99	(25)	349	303	(46)	1,209	2%
Shunts and Stents	212	187	(25)	547	550	3	2,162	(0%)
Catheters	213	190	(23)	634	558	(76)	2,142	4%
Dressings	135	112	(23)	383	330	(53)	1,278	3%
Clinical Equipment - Operating Leases (non-	25	3	(22)	79	8	(71)	127	4%
Screws, nails and plates	204	236	32	693	695	2	2,747	(0%)
Others	4,012	3,929	(83)	12,487	12,315	(172)	46,920	9%
	7,812	**7,044**	**(768)**	**23,639**	**21,759**	**(1,880)**	**82,236**	**100%**

1) Blood and Tissue Supplies
   This $0.10m unfavourable variance reflects the increased usage of Haemophiliac products and is offset by the Haemophiliac rebate (Other Government revenue)

2) Service contracts
   This unfavourable monthly variance is due to a backdated invoice received that had not been accrued in full.

3) Implants (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 7 ICDs (implantable defibrillators), where there is only 2 budgeted
   - 2 additional high cost TAVI's (transcatheter aortic valve implantation) @ $30k each

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

5) Disposable Instruments $0.04m over budget due to increased activity, especially bowel surgery.

6) Air Ambulance
   Air Ambulance was $0.10m unfavourable in September 2020. Total missions were close to budget, however this month included a high cost rotary transfer to Auckland for a bariatric patient ($0.07m).

7. Infrastructure and Non-Clinical (excluding depreciation)

These costs were $0.09m unfavourable to budget in September 2020 and $0.27m unfavourable year to date.

	Monthly Actual $000s	Monthly Budget $000s	Monthly Variance $000s	YTD Actual $000s	YTD Budget $000s	YTD Variance $000s	Annual Budget $
Hotel Services, Laundry & Cleaning	502	416	(86)	1,442	1,276	(166)	5,057
Facilities	25	21	(4)	65	64	(1)	250
Transport	95	92	(4)	247	273	26	1,038
IT Systems & Telecommunications	89	86	(3)	300	255	(45)	1,034
Professional Fees and Expenses	36	24	(12)	87	73	(14)	292
Other Operating Expenses	114	130	16	457	390	(68)	1,405
	861	**770**	**(92)**	**2,598**	**2,331**	**(266)**	**9,075**

Hotel Services, Laundry & Cleaning were $0.09m unfavourable for the month, due mainly to increased cleaning costs (particularly high in September due to a catch up of reactive charges). New 24hr cleaning cover in the Emergency Department is also contributing to this variance. This has been put in place as a result of COVID and was not budgeted.

8. Non-operating Expenses

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

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 commercial activities and negotiations (including commercial and industrial negotiations) to be carried out without prejudice or disadvantage.	Sections 9(2)(i) and 9(2)(j) of the Official Information Act.